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), Center for Medicare and Medicaid Services (CMS), and contracted Managed Care Organizations.

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 Mental Illness and Drug Dependency (MIDD) 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 will be referred to as BHRD. When services are specific to a particular funding stream and payer, the entities will be referred to by either the specific payer or the administrative bodies identified above.

The Administrative Services Agreement between the Managed Care Organizations (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 shall be 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 will 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.


- 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 BHRD Contract Requirements at the following website: [https://www.kingcounty.gov/depts/community-human-services/contracts/requirements/BHRDContractReq.aspx](https://www.kingcounty.gov/depts/community-human-services/contracts/requirements/BHRDContractReq.aspx)

1.4 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.
### 1.5 Reporting Requirements Across All Programs

All programs must submit the following reports:

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Report</th>
<th>Report Requirements</th>
<th>Frequency/ Schedule</th>
<th>Dollars at Risk (Per Each Due Date)</th>
<th>Program</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monthly</td>
<td>Data Certification Letter (Data Attestation)</td>
<td>Provider submits the certification letter.</td>
<td>Monthly</td>
<td>N/A</td>
<td>KCICN</td>
</tr>
<tr>
<td>Quarterly</td>
<td>Third Party Payment Report</td>
<td>Third Party Payments collected by category of payment (e.g., private pay, insurance, Medicare).</td>
<td>• January 31&lt;br&gt;• April 30&lt;br&gt;• July 31&lt;br&gt;• October 31</td>
<td>N/A</td>
<td>KCICN</td>
</tr>
<tr>
<td>Quarterly</td>
<td>Clinician Roster</td>
<td>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.</td>
<td>• March 6&lt;br&gt;• June 7&lt;br&gt;• September 6&lt;br&gt;• December 6</td>
<td>N/A</td>
<td>KCICN</td>
</tr>
<tr>
<td>Quarterly</td>
<td>Provider Profile Update</td>
<td>Provider submits up-to date Contractor profiles and licenses</td>
<td>• January 31&lt;br&gt;• April 30&lt;br&gt;• July 31&lt;br&gt;• October 31</td>
<td>N/A</td>
<td>KCICN, BH-ASO</td>
</tr>
<tr>
<td>Quarterly</td>
<td>Workforce Investment Report (Suspended for the remainder of 2020)</td>
<td>Provider submits Workforce Investment Report on a template provided by King County.</td>
<td>2020 Report Due dates:  • April 10&lt;br&gt;• July 10&lt;br&gt;• October 9&lt;br&gt;• January 8</td>
<td>SUD and/or MH payments will be withheld until report is received.</td>
<td>MH, SUD and MAT Outpatient</td>
</tr>
<tr>
<td>Annual</td>
<td>Audited Financial Statements</td>
<td>Complete audited financial statements with auditor’s opinion, management letter, and A-133 audit where federal funding threshold is met.</td>
<td>30 days after received by Provider Contractor no later than 9 months after end of fiscal period.</td>
<td>N/A</td>
<td>KCICN, BH-ASO</td>
</tr>
<tr>
<td>Frequency</td>
<td>Report</td>
<td>Report Requirements</td>
<td>Frequency/ Schedule</td>
<td>Dollars at Risk (Per Each Due Date)</td>
<td>Program</td>
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<tr>
<td>Annual</td>
<td>Agency Closure Schedule</td>
<td>All Providers submit to BHRD an annual planned closure schedule.</td>
<td>January 31</td>
<td>N/A</td>
<td>KCICN, BH-ASO</td>
</tr>
</tbody>
</table>
| 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 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. | January 31           | N/A                                | KCICN, BH-ASO    |
<table>
<thead>
<tr>
<th>Frequency</th>
<th>Report</th>
<th>Report Requirements</th>
<th>Frequency/ Schedule</th>
<th>Dollars at Risk (Per Each Due Date)</th>
<th>Program</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other</td>
<td>Client Success Stories</td>
<td>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.</td>
<td>Upon Request</td>
<td>N/A</td>
<td>KCICN, BH-ASO</td>
</tr>
</tbody>
</table>

### 1.6 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 invoice and reports templates are located here:

[Provider Invoices and Reporting Requirements](#)

#### Coordination of Other Resources:

##### 1.6.1 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.

##### 1.6.2 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 will 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.

1.6.3 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. 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 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 found at the following website:
1.8 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.

The Provider 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 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.

1.9 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 Ombuds 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 at least yearly thereafter, inform of the availability on-line and offer a copy of the following information in the client’s language of choice:

<table>
<thead>
<tr>
<th>Information Provided</th>
<th>Medicaid Enrollee</th>
<th>Client or Individual served by BH-ASO or Locally funded services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid Client Rights</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Notice of Privacy Practices</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>BH-ASO Individual and Client Rights</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>The BH-ASO Grievance and Appeal Process</td>
<td></td>
<td>✓</td>
</tr>
</tbody>
</table>

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 will be 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 Washington Apple Health: Integrated Managed Care (HCA 19-046) Booklet located here in 15 languages: https://www.hca.wa.gov/health-care-services-supports/apple-health-medicaid-coverage/apple-health-client-booklets
  • 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 within 15 days of the initiation of outpatient or residential services, and reviewed yearly.
• The understanding of rights, including the notice of privacy practices are documented in the clinical record by client signature.

<table>
<thead>
<tr>
<th>Individual Rights – How to promote and protect each right</th>
</tr>
</thead>
<tbody>
<tr>
<td>People receiving public mental health services in the community have the right to:</td>
</tr>
<tr>
<td>Be treated with respect and dignity</td>
</tr>
<tr>
<td>Staff members should:</td>
</tr>
<tr>
<td>• See clients as individuals, not cases or diagnoses.</td>
</tr>
<tr>
<td>• 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.</td>
</tr>
<tr>
<td>• Recognize the talents and capabilities of the client.</td>
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<tr>
<td>• Listen to and support the client.</td>
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<tr>
<td>This right is most frequently the subject of a grievance – it is based on how a client perceives he or she has been treated.</td>
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<tr>
<td>Have their privacy protected</td>
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<tr>
<td>Staff members should:</td>
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<tr>
<td>• Conduct confidential conversations in areas where they can’t be overheard: Waiting rooms, intake desks, offices</td>
</tr>
<tr>
<td>• Keep personal information out of public site: Computer monitors, charts, data entry documents are not visible</td>
</tr>
<tr>
<td>• Provide the client your Notice of Privacy Practices</td>
</tr>
<tr>
<td>• Comply with HIPAA and other confidentiality requirements related to the: Release, exchange, transmission, and storage of client information</td>
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<tr>
<td>Help develop a plan of care with services to meet their needs</td>
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<tr>
<td>Staff members should:</td>
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<tr>
<td>• Develop an Individual Service Plan (ISP) collaboratively with the authorized client that:</td>
</tr>
<tr>
<td>• Meets the client’s unique needs</td>
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<tr>
<td>• Is client-driven and strength-based</td>
</tr>
<tr>
<td>• Include the client in updates to his or her plan</td>
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<tr>
<td>Participate in decisions regarding their behavioral healthcare</td>
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<tr>
<td>Staff members should:</td>
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<tr>
<td>• Encourage client to express preferences about future treatment decisions. Review and update the ISP in consultation with the client:</td>
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<tr>
<td>• More often at the request of the client</td>
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<tr>
<td>Receive services in a barrier-free location (accessible)</td>
</tr>
<tr>
<td>Staff members should:</td>
</tr>
<tr>
<td>• Ensure clients can participate in mental health services:</td>
</tr>
<tr>
<td>• Regardless of disability, e.g., limited mobility or sensory impairment</td>
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<tr>
<td>• Facilities are compliant with the Americans with Disabilities Act</td>
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<tr>
<td>• TTY communication devices available</td>
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<tr>
<td>• Interpreters are provided for hearing impaired or limited English proficient clients</td>
</tr>
<tr>
<td>• Bring services to clients or service sites where there is limited transportation</td>
</tr>
<tr>
<td>Individual Rights – How to promote and protect each right</td>
</tr>
<tr>
<td>----------------------------------------------------------</td>
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</tbody>
</table>
| **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  |
| **Request information about the structure and operation of the KC 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 mental 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 he or she identifies  
  - Ensure clinical consultation with appropriate mental health specialist(s)  |
<table>
<thead>
<tr>
<th>Individual Rights – How to promote and protect each right</th>
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<tbody>
<tr>
<td>Be provided at no cost a certified interpreter and translated material</td>
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<td>Understand available treatment options and alternatives</td>
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<td>Refuse any proposed treatment</td>
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<td>Receive care that does not discriminate against them</td>
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<tr>
<td>Be free of any sexual exploitation or harassment</td>
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<td>Receive an explanation of all medications prescribed and possible side effects</td>
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<tr>
<td>Individual Rights – How to promote and protect each right</td>
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<tr>
<td>----------------------------------------------------------</td>
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</tbody>
</table>
| Make an advance directive that states their choices and preferences for mental health care | Give each adult and emancipated minor client written information about:  
  - How to execute an advance directive  
  - A brief description of the State law  
  - Ensure clients have a voice in developing their advance directive  
  For medically compromised clients:  
  - Identify if the client has a “medical” advance directive  
  - If so, obtain a copy and keep on file |
| 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 mental 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 |
| File a grievance with your agency | 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>
<thead>
<tr>
<th>Payer of Service</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>BH-ASO</td>
<td>(800) 790-8049</td>
</tr>
<tr>
<td></td>
<td><a href="mailto:BHRDComplaintsGrievances@kingcounty.gov">BHRDComplaintsGrievances@kingcounty.gov</a></td>
</tr>
<tr>
<td>Amerigroup</td>
<td>(800) 600-4441</td>
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<td></td>
<td><a href="mailto:WA-Grievance@amerigroup.com">WA-Grievance@amerigroup.com</a></td>
</tr>
<tr>
<td>Community Health Plan of WA</td>
<td>(800) 440-1561</td>
</tr>
<tr>
<td></td>
<td><a href="mailto:AppealsGrievances@chpw.org">AppealsGrievances@chpw.org</a></td>
</tr>
<tr>
<td>Coordinated Care</td>
<td>(877) 644-4613</td>
</tr>
<tr>
<td></td>
<td><a href="mailto:WAQualityDept@Centene.com">WAQualityDept@Centene.com</a></td>
</tr>
<tr>
<td>Molina Healthcare</td>
<td>(800) 869-7165</td>
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<tr>
<td></td>
<td><a href="mailto:WAMemberServices@MolinaHealthcare.com">WAMemberServices@MolinaHealthcare.com</a></td>
</tr>
<tr>
<td>UnitedHealthcare</td>
<td>(877) 542-8997</td>
</tr>
<tr>
<td></td>
<td><a href="mailto:WACS_Appeals@uhc.com">WACS_Appeals@uhc.com</a></td>
</tr>
<tr>
<td><strong>Individual Rights – How to promote and protect each right</strong></td>
<td></td>
</tr>
<tr>
<td>---------------------------------------------------------------</td>
<td>---------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| **File an appeal based on a BHRD written Notice of Action for an ASO-funded service** | If a client receives a Notice of Action from BHRD for an ASO-funded service and the client wishes to file an appeal, inform the client:  
- Of how to request assistance with the appeal from the Ombuds or BHRD Client Services Phone: 1-800-790-8049  
- That services can be continued during the appeal process if time frames on the notice are followed  
The agency may file an appeal on behalf of a client with the client’s written consent  |
| **File an appeal based on a written Notice of Adverse Benefit Determination for a Medicaid funded service.** | If a client receives a NOABD for a Medicaid funded service, and they would like to appeal, the client’s MCO should be contacted.  |
| **Payer of Service** | **Contact Information** |
| Amerigroup Healthcare | 1800-600-4441 (TTY 711) |
| Community Health Plan of Washington | 1800-440-1561 (TTY 711)  
customercare@chpw.org |
| Coordinated Care | 1877-644-4613 (TTY 711)  
WAQualityDept@centene.com |
| UnitedHealthcare | 1-877-542-8997 (TTY 711)  
WACS_Appeals@uhc.com |
| Molina Healthcare | 1800-869-7165 (TTY 711)  
wamemberservices@molinahealthcare.com |
| **For Medicaid clients, choose a behavioral health care Provider or choose one for their child who is under 13 years of age** | 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.  |
| **Request and receive a copy of their medical records and ask for changes** | • 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. |
### Individual Rights – How to promote and protect each right

<table>
<thead>
<tr>
<th>Be free from retaliation</th>
<th>Ensure clients know:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• They are free to exercise their rights without fear of retaliation</td>
</tr>
<tr>
<td></td>
<td>• How to recognize retaliation if it happens, e.g.:</td>
</tr>
<tr>
<td></td>
<td>• Threatening to or actually terminating services</td>
</tr>
<tr>
<td></td>
<td>• Discouraging or depriving clients from exercising their rights</td>
</tr>
<tr>
<td></td>
<td>• Intimidating, threatening, or coercing the client in any way</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>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</th>
<th>Inform clients if they are asked to participate in a research project:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• They may refuse – participation is voluntary</td>
</tr>
<tr>
<td></td>
<td>• If they refuse it will not impact their regular services</td>
</tr>
<tr>
<td></td>
<td>• If they agree to participate:</td>
</tr>
<tr>
<td></td>
<td>• They will be asked to sign a consent that has information about the research</td>
</tr>
<tr>
<td></td>
<td>• They can stop their participation at any time</td>
</tr>
<tr>
<td></td>
<td>• Personal information will not be release without their consent except in emergencies</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Discuss a concern with the Ombuds service, 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 Ombuds may, at their request, assist them in resolving their concerns.</th>
<th>• Make clients feel it’s safe to express concerns that their rights may have been violated</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Provide client assistance in contacting:</td>
</tr>
<tr>
<td></td>
<td><strong>Behavioral Health Ombuds</strong></td>
</tr>
<tr>
<td></td>
<td>206-205-5329 or 1-800-790-8049 #3</td>
</tr>
<tr>
<td></td>
<td><strong>BHRD Client Services</strong></td>
</tr>
<tr>
<td></td>
<td>206-263-8997 or 1-800-790-8049</td>
</tr>
<tr>
<td></td>
<td>• Monitor that no retaliation occurs</td>
</tr>
</tbody>
</table>

## 1.10 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, COD, detox, MAT and jail/CCAP-based SUD treatment.

### Attachments in this Section:

- Attachment B: [BHRD Notice of Privacy Practices](#)
- Attachment C: [BH-ASO Grievance and Appeal Template](#)
- Attachment D: [Medicaid Client Rights](#)
- Attachment E: [BH-ASO and Locally Funded Client Rights](#)
- Attachment F: [SUD Authorization for Disclosure-Required](#)
• Attachment G: SUD Health Information Exchange Consent- Voluntary
1.11 Crisis Plans and Mental Health 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. This crisis plan functions as both a crisis plan and crisis alert. Ideally, the individual in care fills out this form with agency staff. Agency staff can then transmit this plan to Crisis Connections via fax or secure e-mail. Not every individual enrolled in care requires a crisis plan or alert (criteria from our P&P is below). Crisis plans should be updated when clinically indicated.

Crisis plans will be developed with all clients who fall into one or more of the following categories:

- Clients authorized to a Mental Health 3B 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.

When developing a Crisis Plan, the following will be considered:

- A client’s crisis plan contains documentation on whether or not the client has executed a mental health or physical health care advance directive.
- The Provider makes the crisis plan available on a 24 hour a day basis. In particular, crisis plans are made available to a hospital mental health professional (MHP), Substance Use Disorder Professional (SUDP), or Designated Crisis Responder (DCR) who is evaluating a client for admission as a means of ensuring the availability of the advance directive.

**Mental Health Advance Directives**

Providers maintain and implement written policies and procedures that ensures compliance with State and Federal law on advance directives, including 42 Code of Federal Regulations (CFR) 438 and Chapter 71.32 Revised Code of Washington (RCW) or their successor through educating staff on advance directive policy and procedures.

Providers uphold and utilize advance directives for adults and emancipated minors who have completed a mental health or physical health care advance directive in the provision of behavioral health services.
• At intake, Providers ask all adults age 18 and over and emancipated minors if they have a mental health or a physical health care advance directive.

• A client’s clinical record will contain prominent documentation on whether or not the client has executed a mental health or physical health care 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 he or she has 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 he or she has a mental health advance directive or a physical health care 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.

• Providers give each adult and emancipated minor client at time of intake written information on mental health advance directives which includes at a minimum a brief description of State law and information on how to execute a mental health 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.

**Attachments in this Section:**

- Attachment H: [Fillable Crisis Plan](#)
- Attachment I: [Mental Health Advance Directives, What Clinicians Need to Know](#)

1.12 Faith-Based Organizations (FBO)

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

• Clients requesting or receiving Substance Use Disorder (SUD) services will be provided with a choice of SUD treatment Providers.

• The FBO will facilitate a referral to an alternative Provider within a reasonable time frame when requested by the recipient of services.

• The FBO will report to the Contractor all referrals made to alternative Providers.

• The FBO will provide 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.

1.13 Provider Office Closures

Providers have internal procedures, available for review and approval by Behavioral Health and Recovery Division (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;
- Answering machine message regarding closure and options for clients who call on a closed day; 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).

All Providers submit to BHRD an annual planned closure report by January 31st. Additions to the planned closure list shall be faxed to Crisis Connections, Crisis and Commitment Services (CCS), and BHRD no less than two weeks prior to any planned closure.

For unplanned closures due to disaster, inclement weather, etc., the internal procedures referenced above will be followed. In addition, 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;
- 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; and
- Crisis Connections is informed of the closure.

Unplanned closures must be reported to the Contract Monitor by phone or email on the day of the closure.

### 1.14 Disaster Recovery and Business Continuity

Providers have a primary and back-up system for electronic submission of data requests by Behavioral Health and Recovery Division (BHRD). The system includes the use of Inter-Governmental Network (IGN) Information Systems Services Division (ISSD) approved secured virtual private network (VPN) or other ISSD-approved dial-up. In the event these methods of transmission are unavailable and immediate data transmission is necessary, an alternate method of submission will be considered based on BHRD approval.

Providers create and maintain a business continuity and disaster recovery plan that ensures timely reinstitution of the Individual information system following total loss of the primary system or a substantial loss of functionality. The plan includes the following:

- A mission or scope statement
- Information services disaster recovery person(s)
- Provisions for backup 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 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

On an annual basis:
Providers must provide a copy of their up to date DRBC Plan that contains the above elements.

Providers must submit a certification statement that attests:
- The agency’s DRBC program is up to date and in place, and is guided by the above elements;
- The agency has conducted testing of their IS system for data back-up and recovery.

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 Contract Monitors. 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 will be reviewed by the Contract Monitor and will be subject to approval by the Contract Monitor. 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. Visit, https://kingcounty.gov/depts/community-human-services/mental-health-substance-abuse/for-Providers/Provider-training.aspx 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 will have frequent updates on an ongoing basis. BHRD will provide opportunity for Provider feedback prior to official release of updated versions. Providers will 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.
Chapter 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. Provider 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).

<table>
<thead>
<tr>
<th>Type of Care</th>
<th>Appointment Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergent, life threatening emergency</td>
<td>Immediately</td>
</tr>
<tr>
<td>Urgent, non-life threatening emergency</td>
<td>Within 6 hours</td>
</tr>
<tr>
<td>Urgent Care Office Visit</td>
<td>Within 24 hours</td>
</tr>
<tr>
<td>Routine Care Office Visit</td>
<td>Within 10 calendar days of request</td>
</tr>
<tr>
<td>Routine Care Follow-up Office Visit</td>
<td>Within 7 calendar days of discharge</td>
</tr>
<tr>
<td>Preventative Care Office Visit</td>
<td>Within 30 calendar days of request</td>
</tr>
</tbody>
</table>

- 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.

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 (Provider One 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).

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.

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.

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 will support 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 Workforce Investment

Note: This project is suspended for the remainder of 2020.

King County Integrated Care Network (KCICN) agencies who provide outpatient and Medication Assisted-Treatment (MAT) services receive an additional investment in 2020 to focus on workforce retention. This flexible funding through Mental Illness and Drug Dependency (MIDD) allows agencies to focus on increasing capacity to serve King County clients. Funding is most advantageous if targeted towards hiring or retention of staff who will enhance provision of Medicaid treatment services or and/or conduct outreach and engagement to serve difficult-to-reach clients.

Allowable uses of the funds include:

- Sign-on bonuses for new hires
- Salary increases for existing staff
- Spot bonuses for retention
- Hiring recruiters to assist in filling open positions
- Paid advertisement/recruiting agencies
- Reimbursement for licensure fee for new staff

Funds will be dispersed to each agency based on volume of services provided, measured by average monthly encounters. Clean encounters used to measure data accuracy in the KCICN provider performance dashboard will be measured over the same 3-month lookback period used to calculate service delivery adherence (see schedule below).

#### Workforce Investment Thresholds*

<table>
<thead>
<tr>
<th>Monthly Encounters (based on average of 3 months)</th>
<th>Total Annual Payment</th>
<th>Quarterly Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1,000 or less</td>
<td>$25,000</td>
<td>$6,250</td>
</tr>
<tr>
<td>1,001-5,000</td>
<td>$100,000</td>
<td>$25,000</td>
</tr>
<tr>
<td>5,001-10,000</td>
<td>$250,000</td>
<td>$62,500</td>
</tr>
<tr>
<td>10,001-20,000</td>
<td>$500,000</td>
<td>$125,000</td>
</tr>
<tr>
<td>20,001+</td>
<td>$1M</td>
<td>$250,000</td>
</tr>
</tbody>
</table>

*Single payment distributed at the beginning of each quarter. Payment will be adjusted quarterly based on changes in average monthly encounters over prior lookback period.
**Reporting Requirements:** Providers report on a quarterly basis 2 weeks after the end of the quarter. Reporting includes: amount expended and brief description of workforce development activities undertaken, including number of open positions filled, if applicable.

<table>
<thead>
<tr>
<th></th>
<th>Q1 2020</th>
<th>Q2 2020</th>
<th>Q3 2020</th>
<th>Q4 2020</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Date of payment</strong></td>
<td>March 13, 2020*</td>
<td>April 15, 2020</td>
<td>July 15, 2020</td>
<td>October 15, 2020</td>
</tr>
<tr>
<td><strong>Quarterly report due date</strong></td>
<td>April 10, 2020*</td>
<td>July 10, 2020*</td>
<td>October 9, 2020*</td>
<td>January 8, 2021*</td>
</tr>
</tbody>
</table>

*Subject to change

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**2.0.6 Emergency Department Utilization Management (EDUM) Behavioral Health Incentive**

Financial incentive (Mental Illness and Drug Dependency- MIDD) for each agency that provides outpatient service for developing Collective Ambulatory onboarding plan

**Rationale:** Collective Ambulatory platform supports EDUM – but also, when *crisis and individual service plan information is put into* the platform, it:

- lets non-behavioral health agencies know that individuals are in our care
- facilitates care coordination between hospitals and behavioral health agencies
- promotes integrated physical-behavioral healthcare

**Additional incentives:** Funds for one additional incentive related to the EDUM initiative. Two options:

- incentivize use of Collective Ambulatory platform OR
- incentivize reduction in patient’s ED use

An incentive for using the Collective Ambulatory platform was prioritized over incentives for reduction in ED use per se: (1) given that platform onboarding was only recently completed, (2) BHRD has not analyzed baseline data to understand how to incentivize ED reduction and (3) few agencies have begun providing information into the platform.

**Measuring use of Collective Ambulatory for EDUM**

The 3 metrics used as the basis of the incentive are:

- **Using platform:** regular (at least weekly) notifications OR logins OR patient records accessed
- **Content created:** new care guidelines or care history content created each month
- **Crisis plans uploaded:** crisis plans for clients required to have one* in platform and referenced in care guidelines or care history

Measured at end of: (1) Q1 2020 and (2) Q3 2020 to ensure sustained effort

Three payment levels – to recognize agency size/workload:

- Small – under 300 outpatient or MAT auths/year $15,000 (X 2 payments) = $30,000
- Medium – 300-999 “ $25,000 “ = $50,000
- Large – 1000+ ” $35,000 “ = $70,000

*P&P/Provider manual regarding who is required to have a crisis plan:
Clients authorized to a Mental Health 3B outpatient level of care.
Clients authorized for residential level of care.
Any client released within the past 12 months from (a) any psych inpatient; (b) jail/DOC (c) JRA or juvenile detention
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
Children and youth involved with two or more systems (school counts if problems there)
Clients who had emergency department (ED) visit due to a behavioral health crisis in past 12 months
Clients who have a mental health advance directive
Any other clients identified by clinicians as being at risk for crisis services in the next two weeks

**Attachments in this Section:**

- Attachment A: [KCICN Behavioral Health Risk Stratification Screening Tool](#)

### 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 ([https://www.hca.wa.gov/assets/program/SP-Att-3-Services-General-Provisions.pdf](https://www.hca.wa.gov/assets/program/SP-Att-3-Services-General-Provisions.pdf)) 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.
### Tier System Prior to July 1, 2020:

Mental Health Outpatient Benefits are assigned a tier-level based on level of functioning, degree of psychiatric impairment, expected service intensity, and expected outcomes and benefit period as evidenced by Level of Care Utilization System (LOCUS) scores or Child and Adolescent Level of Care Utilization System (CALOCUS). Tier levels are as follows:

<table>
<thead>
<tr>
<th>Tier Assignment</th>
<th>Description</th>
<th>Treatment Goals</th>
<th>Benefit Period</th>
<th>Admission Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health Assessment Only</td>
<td>Mental Health Assessment completed but individual did not meet medical necessity standards.</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>
| Adult 2X: Recovery, Maintenance, and Health Management | Treatment or services to assist an adult to establish, improve, or stabilize their level of functioning. | - Recovery and resiliency  
- Maintenance/stabilization in psychiatric symptoms  
- Maintenance/stabilization in level of functioning  
- Prevention of psychiatric hospitalization  
- Prevention of incarceration  
- Prevention of homelessness  
- Linkage with medical system  
- Engagement in structured activities outside the mental health center | 365 days | LOCUS 10-13        |
| Adult 3A: Low Intensity Community-Based Outpatient Services | Active rehabilitation and/or intervention services to assist an adult to stabilize or improve his or her level of functioning or to prevent deterioration below 3 level of functioning. | - Recovery and resiliency  
- Improvement/stabilization of psychiatric symptoms  
- Improvement/stabilization in level of functioning  
- Prevention of psychiatric hospitalization  
- Prevention of incarceration  
- Prevention of homelessness  
- Linkage with medical system  
- Engagement in structured activities outside the mental health center | 365 days | LOCUS 14-16        |
| Adult 3B: High Intensity Community-Based Treatment | Consistent, intensive, long-term services to assist an adult to improve functioning or to stabilize in the community. This case | - Recovery and resiliency  
- Improvement/stabilization of psychiatric symptoms  
- Improvement/stabilization in level of functioning | 365 days | LOCUS 17-19        |
<table>
<thead>
<tr>
<th>Tier Assignment</th>
<th>Description</th>
<th>Treatment Goals</th>
<th>Benefit Period</th>
<th>Admission Criteria</th>
</tr>
</thead>
</table>
| Child/Youth 2X: Recovery, Maintenance, and Health Management | Treatment or services to establish, improve, or stabilize level of functioning for children who require, at a minimum, occasional supervision. | • Improved resiliency  
• Improvement/stabilization of psychiatric symptoms  
• Improvement/stabilization in level of functioning  
• Prevention of psychiatric hospitalization  
• Prevention of juvenile detention  
• Prevention of homelessness  
• Prevention of school suspension  
• Prevention of out-of-home placement | 365 days | CALOCUS 10-13 |
| Child/Youth 3A: Low Intensity Community-Based Services | Active rehabilitation and/or intervention services to stabilize or improve a child’s level of functioning or to prevent deterioration below level of functioning. The child may have or need multi-system involvement, although this is not a requirement. | • Improved resiliency  
• Improvement/stabilization of psychiatric symptoms  
• Improvement/stabilization of level of functioning  
• Prevention of psychiatric hospitalization  
• Prevention of juvenile detention  
• Prevention of homelessness  
• Prevention of school suspension  
• Prevention of out-of-home placement. | 365 days | For children from ages 6 through 17: CALOCUS 14-16  
For children from ages 18 through 20: LOCUS 14-16 |
| Child/Youth 3B: High Intensity Community-Based Services | Consistent, intensive, long-term services to improve functioning or stabilize in the community for children who are severely impaired and for whom lack of treatment would | • Improvement/stabilization of psychiatric symptoms  
• Improvement/stabilization of level of functioning  
• Prevention of psychiatric hospitalization | 365 days | See below. |
<table>
<thead>
<tr>
<th>Tier Assignment</th>
<th>Description</th>
<th>Treatment Goals</th>
<th>Benefit Period</th>
<th>Admission Criteria</th>
</tr>
</thead>
</table>
| Child/Youth 3B: High Intensity Community-Based Services | result in serious dysfunction, failure in functioning, or involvement in more restrictive treatment. | • Prevention of juvenile detention  
• Prevention of homelessness  
• Prevention of school suspension  
• Prevention of out-of-home placement |  |  |

Admission Criteria:

For children younger than age 6:

• Have a severe developmental abnormality in the child's overall functioning as manifested by one of the following:
  • Atypical, odd, disruptive or dangerous behavior which is aggressive or self-injurious;
  • Atypical emotional responses which interfere with the child's functioning, such as an inability to communicate emotional needs and to tolerate normal frustrations;
  • Atypical thinking patterns which, considering age and developmental expectations, are bizarre, violent, or hypersexual;
  • Lack of positive interests in adults and peers or a failure to initiate or respond to most social interaction;
  • Indiscriminate sociability, for example, excessive familiarity with strangers; or
  • Fearfulness or other distress that does not respond to comfort by caregivers.

Past behavior pattern shows a chronic, high level of danger to self or others, property damage, disruption, oppositionality, or conduct difficulties. For children under age 3, this includes prolonged states of dysregulation and distress that are interfering with developmental progression, growth, and/or the establishment of a healthy, functional relationship with a primary caregiver, and that cannot be explained by a medical problem.

For children from ages 6 through 17:

• CALOCUS 17-19; Past behavior pattern shows a chronic, high level of danger to self or others, property damage, disruption, oppositionality, or conduct difficulties.

For children from ages 18 through 20:

• LOCUS 17-19; and

Past behavior pattern shows a chronic, high level of danger to self or others, property damage, disruption, opposition, or conduct difficulties.

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.

*Adults LOC based on 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).

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

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

**Timeline for Benefits Ending:**
While individual benefits for clients are open ended, the benefits are automatically closed after a period of time 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.

**Requesting Changes to LOC:**
Providers may request a higher or lower LOC if they think the assigned level does not match the client’s needs by contacting King County Client Services. In such cases, the request must meet one of the following criteria:

- Deteriorating clinical status likely to worsen without intensive intervention/support
- Change in status with or access to basic resource needs (food, healthcare, transportation) or relationships (clinician, family, friends, etc.) which has significantly impacted or will likely significantly impact the client’s physical and/or behavioral health in the near future
- Higher level of intervention required to prevent deterioration of client condition or maintain condition stability
### MH Outpatient Benefit Eligibility Criteria

<table>
<thead>
<tr>
<th>Medicaid Status</th>
<th>Yes, limited non-Medicaid funding available for priority populations as described in the BH-ASO policy and procedures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age Range</td>
<td>Full Life Span</td>
</tr>
<tr>
<td>Authorization Needed</td>
<td>No</td>
</tr>
<tr>
<td>Additional Criteria</td>
<td>Additional Criteria only necessary when utilizing non-Medicaid funding for benefit</td>
</tr>
</tbody>
</table>

### MH Outpatient Benefit Reporting Requirements

| Monthly Reports | Submission of encounters into the BHRD Management Information System |

*Note on 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 will ensure:

- 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 ([https://www.hca.wa.gov/assets/program/SP-Att-3-Services-General-Provisions.pdf](https://www.hca.wa.gov/assets/program/SP-Att-3-Services-General-Provisions.pdf)) and may include:

- Alcohol/Drug Screening and Assessment;
- Individual rehabilitative counseling;
- Group counseling;
- Laboratory services (drug and alcohol screens); and/or
• 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.

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

<table>
<thead>
<tr>
<th>Tier Assignment</th>
<th>Description</th>
<th>Treatment Goals</th>
<th>Benefit Period</th>
<th>Admission Criteria</th>
</tr>
</thead>
</table>
| Adult/Youth S01: Outpatient and 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 | 365 days | ASAM criteria of 1 or 2.1 |
| Adult/Youth S02: Recovery Support | Treatment to assist an adult in maintaining their recovery and/or their level of functioning for clients who require minimal services. | • Recovery and resiliency  
• Improvement/stabilization of SUD symptoms  
• Improvement/stabilization in level of functioning  
• Prevention of relapse  
• Prevention of incarceration  
• Prevention of homelessness  
• Linkage with medical system  
• Engagement in structured activities outside the substance use disorder treatment center | 365 days | ASAM criteria of .5 or higher |
| 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 | N/A | ASAM criteria of -1 or 2.1 |
### Tier Assignment

<table>
<thead>
<tr>
<th>Assignment</th>
<th>Description</th>
<th>Treatment Goals</th>
<th>Benefit Period</th>
<th>Admission Criteria</th>
</tr>
</thead>
</table>
| **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 | - 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 | 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 |

### SUD Outpatient Benefit Eligibility Criteria

<table>
<thead>
<tr>
<th>Medicaid Status</th>
<th>Yes, limited non-Medicaid funding available for priority populations as described in the BH-AS0 policy and procedures with BHRD approval</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age Range</td>
<td>Full Life Span</td>
</tr>
<tr>
<td>Authorization Needed</td>
<td>No</td>
</tr>
<tr>
<td>Additional Criteria</td>
<td>Additional Criteria only necessary when seeking non-Medicaid funding for benefit</td>
</tr>
</tbody>
</table>

### SUD Outpatient Benefit Reporting Requirements

| Monthly Reports | Submission of encounters into the BHRD Management Information System |
2.3 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. UA-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 funds may also be used with Kelley-Ross Pharmacy Group to purchase Naloxone and other needed pharmacy requirements. |

2.4 Assisted Outpatient Services Program (AOSP)

AOSP clients are court-ordered to engage in outpatient mental health treatment as a condition of their remaining in the community. Clients receiving AOSP services 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, Less Restrictive Order (LRO) court orders should be determined in conjunction with the treatment team at the Provider agency, and treatment plans and services should align with the LRA order and any subsequent modifications required by court. Treatment is individualized and client centered and includes the following services:

• An intake evaluation with the Provider of the LRO treatment;
• A psychiatric evaluation;
• Medication management;
• A schedule of regular contacts with the Provider of LRO Treatment for the duration of the order;
• A transition plan addressing access to continued services at the expiration of the order;
• An individual crisis plan; and
• After the first month, an evaluation to determine medical necessity for Assisted Outpatient Treatment (AOT).
### AOSP Eligibility Criteria

<table>
<thead>
<tr>
<th>Medicaid Status</th>
<th>Yes, with limited capacity to serve those who are Non-Medicaid</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age Range</strong></td>
<td>18 years or older</td>
</tr>
<tr>
<td><strong>Authorization Needed</strong></td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Additional Criteria</strong></td>
<td>- Already enrolled in KCICN services;</td>
</tr>
<tr>
<td></td>
<td>- Conditionally released from the hospital and who have been</td>
</tr>
<tr>
<td></td>
<td>issued a less restrictive alternative (LRO) order for</td>
</tr>
<tr>
<td></td>
<td>treatment;</td>
</tr>
<tr>
<td></td>
<td>- Referred by King County AOT Coordinator; and</td>
</tr>
<tr>
<td></td>
<td>- Not enrolled in an intensive community support or</td>
</tr>
<tr>
<td></td>
<td>residential program including but not limited to Program</td>
</tr>
<tr>
<td></td>
<td>for Assertive Community Treatment (PACT), Standard</td>
</tr>
<tr>
<td></td>
<td>Supportive Housing (SSH), Long Term Rehabilitative</td>
</tr>
<tr>
<td></td>
<td>Services (LTR), and Supervised Living (SL).</td>
</tr>
</tbody>
</table>

### AOSP Reporting Requirements

| Monthly Reports | AOSP Provider Tracking Form |

### 2.5 Health Homes Care Coordination Services

Health Homes promote person-centered health action planning to empower clients to take charge of their own health care. This program provides better coordination between the client and all of their health care Providers and encourages involvement and independence. The Health Home program is designed to ensure clients receive the right care, at the right time with the right Provider.

King County Integrated Care Network (KCICN) contracts with all five MCOs to provide this service. KCICN refers clients to the providing agencies for this program. Reference documents and program guidelines are included in each MCO Provider manual, MCO Provider trainings, KCICN’s Frequently Asked Questions (FAQ), HCA Care Coordination training, and the HCA website for Health Homes ([https://www.hca.wa.gov/billers-Providers-partners/programs-and-services/resources-0](https://www.hca.wa.gov/billers-Providers-partners/programs-and-services/resources-0)).

Health Homes Care Coordination provides the following services beyond the traditional Medicaid benefit package:

- Comprehensive Care Management;
- Care Coordination
- Health Promotion;
- Comprehensive Transitional Care;
- Individual and Family Supports; and
- Referral to Community and Social Supports.

### Health Homes Care Coordination Eligibility Criteria

<table>
<thead>
<tr>
<th>Medicaid Status</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age Range</strong></td>
<td>All Ages</td>
</tr>
<tr>
<td><strong>Authorization Needed</strong></td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Additional Criteria</strong></td>
<td>- Referred to Provider by KCICN;</td>
</tr>
<tr>
<td></td>
<td>- Have at least one chronic condition and are at risk for another; and</td>
</tr>
<tr>
<td></td>
<td>- Have a PRISM predictive risk score of 1.5 (per WAC 182-557-0225).</td>
</tr>
</tbody>
</table>
### Health Homes Care Coordination Reporting Requirements

<table>
<thead>
<tr>
<th>Monthly Reports</th>
<th>Health Homes Due Diligence Report (due by the 5th of the following month)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quarterly Reports</td>
<td>Health Homes Quarterly Report</td>
</tr>
<tr>
<td>Annual/Other Reports</td>
<td>If the Provider does not submit the required documents within the nine-month time frame, payment for invoices will be held in the 10th month and beyond until the documents received.</td>
</tr>
</tbody>
</table>

#### 2.6 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, and case management, 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

<table>
<thead>
<tr>
<th>Medicaid Status</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age Range</td>
<td>All Ages</td>
</tr>
<tr>
<td>Authorization Needed</td>
<td>Yes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Additional Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Determined eligible for the ECS Project through ECS screening process and referred for services by the KCHCLs;</td>
</tr>
<tr>
<td>No longer require active psychiatric treatment at an inpatient hospital level of care;</td>
</tr>
<tr>
<td>Have experienced multiple treatment failures and/or have been unable to maintain community tenure for a significant period of time;</td>
</tr>
<tr>
<td>Have significant barriers to community placement (e.g. criminal history, refusal of admission by other behavioral health Providers, etc.);</td>
</tr>
<tr>
<td>Can complete all activities of daily living (ADLs) tasks without hands on assistance; and</td>
</tr>
<tr>
<td>Are ready for engagement toward transition to the community; and</td>
</tr>
<tr>
<td>Currently in a long-term placement (15 months or more) at WSH; or</td>
</tr>
<tr>
<td>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</td>
</tr>
<tr>
<td>Eligible for Medicaid upon discharge from WSH.</td>
</tr>
<tr>
<td>Referred by the Clinical Specialist and/or the Hospital and Mental Health Residential Coordinator.</td>
</tr>
</tbody>
</table>

ICSRP Reporting Requirements

<table>
<thead>
<tr>
<th>Monthly Reports</th>
</tr>
</thead>
<tbody>
<tr>
<td>ICSRP Engagement Log</td>
</tr>
<tr>
<td>ICSRP Census Log</td>
</tr>
</tbody>
</table>

2.7 Medication-Assisted Treatment (MAT)

Medication-Assisted Treatment (MAT) 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) 388-877 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;
- Detoxification from 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 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.

**Definitions:**

Dose Day: a Medication-Assisted Treatment all-inclusive rate for face-to-face bundled services which include daily methadone dose, physical examination, urinalysis testing, medical examination, vocational rehabilitation services, individual or group counseling, family planning session, counseling and education for pregnant clients, and Human Immunodeficiency Virus (HIV) screening, counseling, and testing referral. 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. Per federal block grant requirements, Providers will 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.

<table>
<thead>
<tr>
<th><strong>MAT Eligibility Criteria</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Medicaid Status</strong></td>
</tr>
<tr>
<td>• Yes, with limited capacity to serve people who are non-Medicaid.</td>
</tr>
<tr>
<td>• Non-Medicaid clients must meet income criteria (220% of federal poverty line) and priority population guidelines.</td>
</tr>
<tr>
<td>• See MAT Out of County Admission Grid attached below for ability to serve out of county clients.</td>
</tr>
<tr>
<td><strong>Age Range</strong></td>
</tr>
<tr>
<td>18 years and older</td>
</tr>
<tr>
<td><strong>Authorization Needed</strong></td>
</tr>
<tr>
<td>Yes</td>
</tr>
<tr>
<td><strong>Additional Criteria</strong></td>
</tr>
<tr>
<td>• Adults who meet Diagnostic and Statistical Manual of Mental Disorder, Fifth Edition (DSM-5) criteria for a moderate to severe Opiate Use Disorder;</td>
</tr>
<tr>
<td>• In need of MAT services as determined by an assessment instrument that incorporates the American Society of Addiction Medicine (ASAM) Criteria</td>
</tr>
<tr>
<td>• The individual’s needs cannot be more appropriately met by any other formal or informal system of support; and</td>
</tr>
<tr>
<td>• 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.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>MAT Reporting Requirements</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Monthly Reports</strong></td>
</tr>
<tr>
<td>• MAT Co-pay Deductible Report (as funding is available)</td>
</tr>
<tr>
<td>• MAT Out of County Report</td>
</tr>
</tbody>
</table>
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 will submit a waiver request to their BHRD contract monitor.

**Evergreen Treatment Services**

<table>
<thead>
<tr>
<th>Unit</th>
<th>Capacity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unit 1</td>
<td>700</td>
</tr>
<tr>
<td>Unit 2</td>
<td>700</td>
</tr>
<tr>
<td>Unit 3</td>
<td>200</td>
</tr>
<tr>
<td>Renton Site</td>
<td>500</td>
</tr>
</tbody>
</table>

**Therapeutic Health Services**

<table>
<thead>
<tr>
<th>Branch</th>
<th>Capacity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Seneca Branch</td>
<td>385</td>
</tr>
<tr>
<td>Shoreline Branch</td>
<td>700</td>
</tr>
<tr>
<td>Eastside Branch</td>
<td>495</td>
</tr>
</tbody>
</table>

**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 KCBH MAT services is kept by the Public Health – Seattle & King County (PHSKC) Needle Exchange. The Needle Exchange will provide case management, overdose prevention, and admission support services while the client is on the wait list. 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 (LPN or 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.

**Attachments in this Section:**

- Attachment B: [MAT Out of County Admission Grid](#)
2.7.1. 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 will provide sufficient dose carries for the individual to make it to their next appointment at an MAT agency.

The Provider will set-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

<table>
<thead>
<tr>
<th>Medicaid Status</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age Range</td>
<td>Adults Aged 18 Years and Older</td>
</tr>
<tr>
<td>Authorization Needed</td>
<td>Yes</td>
</tr>
</tbody>
</table>
| 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. |

2.7.2 Courtesy Dosing in a Residential Setting (Pioneer Human Services and Triumph Treatment Services Only)

Courtesy dosing is provided in the residential treatment facility by an approved 3rd party Provider. In addition, the residential Provider has policies and procedures for courtesy dosing for Medicaid-covered individuals.

### Courtesy Dosing in a Residential Setting Reporting Requirements

| Monthly Reports     | SUD Census Report and MAT Log |

2.8 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 ([https://www.dshs.wa.gov/sites/default/files/BHSIA/dbh/documents/PACTProgramStandards.pdf](https://www.dshs.wa.gov/sites/default/files/BHSIA/dbh/documents/PACTProgramStandards.pdf)).

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.

### PACT Eligibility Criteria

<table>
<thead>
<tr>
<th>Medicaid Status</th>
<th>Yes, limited funding available for Medicare only and unfunded individuals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age Range</td>
<td>Adults Aged 18 Years and Older</td>
</tr>
<tr>
<td>Authorization Needed</td>
<td>Yes</td>
</tr>
<tr>
<td>Additional Criteria</td>
<td>Refer to Washington State PACT Program Standards, Section III.A. Admission Criteria, via the following hyperlink: <a href="https://www.dshs.wa.gov/sites/default/files/BHSIA/dbh/documents/PACTProgramStandards.pdf">https://www.dshs.wa.gov/sites/default/files/BHSIA/dbh/documents/PACTProgramStandards.pdf</a></td>
</tr>
</tbody>
</table>

### PACT Reporting Requirements

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Monthly Reports</td>
<td>PACT Monthly Report</td>
</tr>
<tr>
<td>Quarterly Reports</td>
<td>PACT Quarterly Data</td>
</tr>
<tr>
<td>Semiannual Reports</td>
<td>PACT Transition Scale</td>
</tr>
</tbody>
</table>

### 2.9 Reaching Recovery Treatment for Adults with Criminal Legal System Involvement

The Reaching Recovery approach provides treatment and related support services based on assessed level of care needs in accordance with the Reaching Recovery model of care and other evidence-based practices for eligible adults who are involved with the criminal legal system. The program is available to eligible participants regardless of where they reside in King County.

Participants served under this program receive linkage with physical health care providers and other related community resources; coordination of treatment plans with the treatment provider if the participant is receiving Medication-Assisted Treatment; and coordination of withdrawal management or residential substance use disorder (SUD) treatment. Coordination and engagement efforts with probation
The Reaching Recovery model of care uses four instruments to measure recovery from various perspectives to inform practice:

a. Consumer Recovery Measure: Measure across five dimensions of recovery that is completed every three months by individuals served in the Reaching Recovery model of care. The data is used in service delivery discussions between the individual in services and provider staff to enhance and strengthen practice; it is also used to inform program decisions, clinical supervision and service allocation.

b. Promoting Recovery in Organizations Survey: The consumer's evaluation of the staff promotion of recovery in the Contractor organization.

c. Recovery Needs Level (RNL): this tool is completed at intake and at every treatment plan update for all individuals served in the Reaching Recovery model of care. It assigns the right level of service or service intensity at the right time to the individuals served, and transitions in service intensity based on the RNL score.

d. Recovery Marker Inventory: an eight-dimension tool completed by the clinician every three months, with data used in service delivery discussions between the individual in services and provider staff to enhance and strengthen practice; it is also used to inform program decisions, clinical supervision and service allocation.

Reaching Recovery services are based on the assessed level of need via the RNL.

- Level 1 (minimum of eight hours per month): Assertive Community Based Support (based on the Assertive Community Treatment model). The goal of this level is engagement in services. The clinician duties include meeting with participants in the community, linking participants with community resources and services, assisting participants with navigating systems and providing care coordination (both within the Contractor and with external Providers), transporting and escorting participants to appointments/meetings, helping participants meet basic needs, providing crisis interventions as needed, creating collaborative treatment plans and crisis plans, facilitating groups, maintaining current clinical documentation.

- Level 2 (minimum of four hours per month): Intensive Case Management. The goal of this level of care is continued engagement and initial skill building. The clinician duties include meeting with participants both off and on site, coaching participants in tasks to increase skills and independence, identify and increase support system which may include formal (Contractor internal groups, peer counselor, sober support groups. etc.) supports and/or natural supports, linking participants with community resources and services, assisting participants with navigating systems and provide care coordination, transporting and escorting participants to appointments/meetings as needed, providing crisis interventions as needed, creating collaborative treatment plans and crisis plans; facilitating groups; and maintaining current clinical documentation.

- Level 3 (minimum of two hours per month): Outpatient Case Management and Counseling. The goal of this level of care is to continue to develop and support skill building to promote participants' stability, productivity and independence. The clinician duties include providing on-site support and system advocacy for participants; using evidence-based practices to help participants build insight, supporting and encouraging participants to practice using new skills to improve participants overall quality of life, empowering participants to identify individual goals and meet own needs as participants begin to direct their own treatment, providing crisis interventions as needed, creating collaborative treatment plans and crisis plans, facilitating groups and maintaining current clinical documentation.
• Level 4 (minimum of one to two hours per month): Outpatient Therapy Services. The goal of this level of care is to foster and support participants’ ongoing personal growth and awareness. The clinician duties include providing evidenced-based therapeutic interventions, supporting participants continued independence and productivity, helping participants to hone and enhance skills to continue to improve their overall quality of life, providing crisis interventions as needed, creating collaborative treatment plans and crisis plans, facilitating groups, maintaining current clinical documentation.

• Level 5: Care Coordination. The goal of this level of care is to provide support, care coordination, and medication management. The clinician duties include checking in with participants monthly, providing supports as needed, assessing changes in participant needs and referring to appropriate service intensity, triaging medication concerns, working closely with prescribers, providing crisis interventions as needed, creating collaborative treatment plans and crisis plans, facilitating groups and maintaining current clinical documentation.

For clients who are not eligible for Medicaid benefits, the funds provided under this scope may be used to provide mental health treatment including medications.

Participants enrolled in other outpatient programs in the KCICIN are not eligible for a Reaching Recovery program tier, as per the Program Overlap Grid in the Behavioral Health and Recovery Division (BHRD) Information System (IS) Data Dictionary.

Reimbursement for current Reaching Recovery authorizations, as determined by an active authorization for Program Code 158, will be provided at the Reaching Recovery case rate when clients have received a service within the current month or within the three months preceding the current service month. Any individual enrolled in Reaching Recovery who has not received services within this timeframe will be terminated from the program. If the individual is successfully re-engaged, the individual may be re-enrolled in the program at a later date.

### Reaching Recovery Eligibility Criteria

<table>
<thead>
<tr>
<th>Medicaid Status</th>
<th>Yes, unless covered by other identified fund sources</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age Range</td>
<td>Adults Aged 18 Years and Older</td>
</tr>
<tr>
<td>Authorization Needed</td>
<td>Yes</td>
</tr>
<tr>
<td>Additional Criteria</td>
<td>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;</td>
</tr>
<tr>
<td></td>
<td>The following cohorts and associated eligibility requirements are a subset of the target populations to be served under this section;</td>
</tr>
<tr>
<td></td>
<td>• Offender Reentry Community Safety Program (ORCSP); and</td>
</tr>
<tr>
<td></td>
<td>• Integrated Dual Disorders Treatment (IDDT).</td>
</tr>
</tbody>
</table>

### Reaching Recovery Reporting Requirements

<table>
<thead>
<tr>
<th>Monthly Reports</th>
<th>IDDT Tracking Report, with referral source by court or jail identified.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>ORCSP:</td>
</tr>
<tr>
<td></td>
<td>ORCSP Invoice Report.</td>
</tr>
<tr>
<td></td>
<td>ORCSP Summary of Services Provided Report. The Provider must include the reason for suspension on the Monthly Summary for any ORCSP client for whom services were suspended.</td>
</tr>
</tbody>
</table>
### Quarterly Reports
- Reaching Recovery Marker Inventory (for all program participants)
- Reaching Recovery Consumer Recovery Measure (for all program participants)

### Semiannual Reports
- A summary of all participant current needs level based on the RNL tool, including a summary of movement through the levels during this initial six-month program implementation period.

### Annual/Other Reports
- Summary data related to the Reaching Recovery model assessment tools.
- The Contractor will track outcome performance measures including but not be limited to the following desired outcomes of the Reaching Recovery model of care:
  - Reduction in jail bookings;
  - Community tenure/housing stability;
  - Employment;
  - Quality of Life.
- At least two IDDT case studies or client vignettes describing each client’s background, services received, and outcomes, which is submitted prior to or with the September invoice due October 15 unless otherwise requested by the County.
- All service data not included in the data transmission shall be collected and reported to BHRD IS on a schedule determined by the County.

### 2.10 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

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**Chapter 2 Outpatient Services**

**ORCSP Client Change of Status Report for each month in which approval for change in status is being sought, including clients who are returning to services following a suspension or termination.**

**Quarterly Reports**
- Reaching Recovery Marker Inventory (for all program participants)
- Reaching Recovery Consumer Recovery Measure (for all program participants)

**Semiannual Reports**
- A summary of all participant current needs level based on the RNL tool, including a summary of movement through the levels during this initial six-month program implementation period.

**Annual/Other Reports**
- Summary data related to the Reaching Recovery model assessment tools.
- The Contractor will track outcome performance measures including but not be limited to the following desired outcomes of the Reaching Recovery model of care:
  - Reduction in jail bookings;
  - Community tenure/housing stability;
  - Employment;
  - Quality of Life.
- At least two IDDT case studies or client vignettes describing each client’s background, services received, and outcomes, which is submitted prior to or with the September invoice due October 15 unless otherwise requested by the County.
- All service data not included in the data transmission shall be collected and reported to BHRD IS on a schedule determined by the County.

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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.

<table>
<thead>
<tr>
<th>WISe Eligibility Criteria (Medicaid)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid Status</td>
</tr>
<tr>
<td>Age Range</td>
</tr>
<tr>
<td>Authorization Needed</td>
</tr>
<tr>
<td>Additional Criteria</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>WISe Reporting Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monthly Reports</td>
</tr>
</tbody>
</table>

2.11 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.

<table>
<thead>
<tr>
<th>Transitional Recovery Program Eligibility Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid Status</td>
</tr>
<tr>
<td>Age Range</td>
</tr>
<tr>
<td>Authorization Needed</td>
</tr>
</tbody>
</table>

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.
### 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;
  - 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

<table>
<thead>
<tr>
<th>Reports</th>
<th>Report Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monthly Reports</td>
<td>TRP Staffing Report</td>
</tr>
<tr>
<td>Quarterly Reports</td>
<td>Criminal Justice Treatment Account (CJTA) Project Plan Report</td>
</tr>
<tr>
<td>Annual/Other Reports</td>
<td>CJTA Project Plan Annual Report (for In-custody Projects that Exceed 8-Session Limit)</td>
</tr>
</tbody>
</table>

### 2.12 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 Mental Illness and Drug Dependency (MIDD) Initiative **RR-12 – Jail-based Substance Abuse Treatment**.
<table>
<thead>
<tr>
<th>Medicaid Status</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age Range</td>
<td>Adults Aged 18 Years and Older</td>
</tr>
<tr>
<td>Authorization Needed</td>
<td>Yes</td>
</tr>
</tbody>
</table>
| **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. |

### 2.13 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 will be 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

<table>
<thead>
<tr>
<th>Medicaid Status</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age Range</td>
<td>18 years and older</td>
</tr>
<tr>
<td>Authorization Needed</td>
<td>No</td>
</tr>
<tr>
<td>Additional Criteria</td>
<td>Individuals meet the standards for low-income client eligibility as described in the state Department of Social and Health Services (DSHS) 2015-2017 Biennium Low-Income Service Eligibility Table, or its successors.</td>
</tr>
</tbody>
</table>

### SUD Mobile Medical Van Outreach Services Reporting Requirements

<table>
<thead>
<tr>
<th>Monthly Reports</th>
<th>SUD Mobile Medical Van Outreach Report</th>
</tr>
</thead>
</table>
| Quarterly Reports | SUD Mobile Medical Van Evaluation Report in a format approved by the County.  
|                  | Deadlines for submitting quarterly reports to the County are as follows:  
|                  | • January through March due April 10, 2020  
|                  | • April through June due July 10, 2020;  
|                  | • July through September due October 10, 2020; and  
|                  | • October through December due January 10, 2021. |
3 Evaluation and Treatment

3.1 Sixteen-Bed Evaluation and Treatment Facility Services

Evaluation and Treatment Facility Centers provide services to clients who typically exhibit acute psychiatric symptoms and are detained according to the Involuntary Treatment Act as described in Revised Code of Washington (RCW) 71.05. Facilities provide evaluation and treatment services under the Adult Residential Rehabilitation state licensure Washington Administrative Code (WAC) 246-347. Staff facilitate referrals and ensure communication with and linkage to ongoing outpatient behavioral health services for Medicaid and non-Medicaid covered individuals.

Facilities provide:

- Sixteen residential E&T beds;
- Availability of an additional room for the purpose of temporary seclusion and restraint;
- Referrals, communication and linkage to ongoing outpatient behavioral health services and coordination of care for Medicaid and non-Medicaid-covered individuals according to the requirements regarding hospital discharge and psychiatric evaluation outlined in this manual;
- Common areas arranged and stocked (e.g. with board games, books) so as to be inviting and encourage interaction;
- Sensory tools incorporated as alternatives to seclusion and restraint that can be used on a voluntary basis by clients;
- Daily group therapies such as skill development, individual education activities, wellness and recovery-focused treatment, family therapy, scheduled community meetings, skill development, Reducing Harm, psycho-educational, recreational and exercise programs, and a treatment team that will tailor each resident’s scheduled activities to address their specific needs;
- Individual therapies such as Motivational Interviewing, Cognitive Behavioral Therapy, Dialectical Behavioral Therapy, Harm Reduction, and other client-centered therapeutic interventions to help individuals understand the cause and effect of choice-making, and to build skills that promote self-control and self-responsibility;
- The Living Room model program which includes formal peer roles and also emphasizes peer representation in all staff roles;
- A multidisciplinary, culturally competent team with appropriate licenses and credentials who will provide acute stabilization, a robust treatment plan of active therapies, discharge planning, and resource and supports mobilizations;
- Inclusion of family, significant others, and natural supports in treatment and discharge planning, with the consent of the individual served and as clinically appropriate;
- Medication evaluation, management, and monitoring by qualified staff members including a diagnostic psychiatric evaluation completed within 24 hours of admission for every individual admitted in the program (WAC 388-865-0541);
- A mental health professional (MHP) with prescriptive authority and an MHP without prescriptive authority must have contact with each individual for observation and evaluation, as well as to evaluate the individual for release from involuntary commitment into voluntary treatment (WAC 388-865-0547);
- Each client must have at least one service encounter entered daily and submitted to the Behavioral Health and Recovery Division (BHRD) Information System (IS);
• Discharge planning services that are included in the Individual Service Plan (ISP) to ensure continuity of behavioral health care; involve coordination with appropriate behavioral health outpatient Providers; and involve coordination with Peer Bridger program.

• Preparation and timely filing of legal documents pertaining to the involuntary detention of individuals at the facility as required by RCW 71.05, 71.34, applicable WACs, and the King County Superior Court system;

• Provision of appropriate facilities around video court;

• Provision of expert witness testimony at court hearings pertaining to the involuntary detention of patients at the facility; and

• Accompanying the patient throughout the time they are in court and ensure their safe return to the E&T after the proceedings if the court orders the patient to appear in person; and

• Maintenance of a medical transfer agreement between the Provider and a licensed hospital emergency department for referral and transfer of individuals needing medical care beyond the Provider’s ability to manage.

• When the facility is within two beds of full capacity, the Provider does not accept out-of-county residents for voluntary or involuntary inpatient stays.

### Sixteen-Bed Evaluation and Treatment Facility Services Eligibility Criteria

<table>
<thead>
<tr>
<th>Medicaid Status</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age Range</td>
<td>Adults Aged 18 Years and Older</td>
</tr>
<tr>
<td>Authorization Needed</td>
<td>Yes</td>
</tr>
<tr>
<td>Additional Criteria</td>
<td>Individuals eligible for this service must be 18 years of age or older and who:</td>
</tr>
<tr>
<td></td>
<td>• Have been involuntarily detained by a Designated Crisis Responder (DCR) for a 72-hour evaluation and treatment period; or</td>
</tr>
<tr>
<td></td>
<td>• 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</td>
</tr>
<tr>
<td></td>
<td>• Referred by the DMHPs through the revocation process provided in RCW 71.05 and 71.34.</td>
</tr>
</tbody>
</table>

### Sixteen-Bed Evaluation and Treatment Facility Services Reporting Requirements

<table>
<thead>
<tr>
<th>Monthly Reports</th>
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<tbody>
<tr>
<td>• E&amp;T Services Monthly Census Report;</td>
</tr>
<tr>
<td>• Treatment Services Monthly Admission Denial Log; and</td>
</tr>
<tr>
<td>• Discharge Planner Report</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Semi-Annual Reports</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Seclusion and Restraint Report</td>
</tr>
</tbody>
</table>

### 3.2 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.
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 Mental Illness and Drug Dependency (MIDD) Plan Initiative CD-14 – *Involuntary Treatment Triage Pilot*.

<table>
<thead>
<tr>
<th><strong>Involuntary Treatment Triage Program Eligibility Criteria</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Medicaid Status</strong></td>
</tr>
<tr>
<td><strong>Age Range</strong></td>
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<tr>
<td><strong>Authorization Needed</strong></td>
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<tr>
<td><strong>Additional Criteria</strong></td>
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<table>
<thead>
<tr>
<th><strong>Involuntary Treatment Triage Program Reporting Requirements</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Monthly Reports</strong></td>
</tr>
<tr>
<td><strong>Annual/Other Reports</strong></td>
</tr>
</tbody>
</table>
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.

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 Mental Illness and Drug Dependency (MIDD) 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 physician; 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 will be 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.

Crisis services are guided by the following minimum regulatory requirements:

- WAC 246-341 – Behavioral Health Services Administrative Requirements
- WAC 246-341-0900 – Crisis mental health services—General
- WAC 388-365 – Community Mental Health and Involuntary Treatment Programs
### Adult Crisis Services Eligibility Criteria

<table>
<thead>
<tr>
<th>Medicaid Status</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age Range</td>
<td>Adults Aged 18 Years and Older</td>
</tr>
<tr>
<td>Authorization Needed</td>
<td>No</td>
</tr>
<tr>
<td>Additional Criteria</td>
<td>Adults age 18 years or older who meet the crisis services eligibility criteria identified in the Standardized Initial Crisis Screening Protocol (SICSP) in the King County Behavioral Health Policies and Procedures (KCBH P&amp;P), and are not enrolled in outpatient services, and who are referred by Crisis Connections or the Designated Crisis Responder (DCRs).</td>
</tr>
</tbody>
</table>

### Adult Crisis Services Reporting Requirements

| Monthly Reports | Adult Crisis Services Report |

### 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

<table>
<thead>
<tr>
<th>Medicaid Status</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age Range</td>
<td>Adults Aged 18 Years and Older</td>
</tr>
<tr>
<td>Authorization Needed</td>
<td>No</td>
</tr>
</tbody>
</table>
| 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 |
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 Mental Illness and Drug Dependency (MIDD) Plan Initiative CD-11- Children’s Crisis Outreach and Response System (CCORS). This program also complies with the requirements of the T.R. vs Quigley and Teeter lawsuit settlement agreement and the Wraparound with Intensive Services (WISe) Manual, for the provision of additional intensive stabilization crisis services for youth enrolled in WISE in King County. 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)
- Intensive Stabilization Services (ISS) for WISECrisis Stabilization Bed (CSB)
- In-home Behavioral Support Specialist(s)

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, a CMHS and a FA or CPC who 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
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.

**CCORS 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

### 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 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 Mental Illness and Drug Dependency (MIDD)-funded wraparound facilitators.

### 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, and 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

<table>
<thead>
<tr>
<th>Medicaid Status</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age Range</td>
<td>3-17 years old</td>
</tr>
<tr>
<td>Authorization Needed</td>
<td>No</td>
</tr>
<tr>
<td>Additional Criteria</td>
<td>Crisis Outreach Services and Non-Emergent Outreach (NEO)</td>
</tr>
</tbody>
</table>

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 King County Behavioral Health (KCBH) 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; and
- 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

<table>
<thead>
<tr>
<th>Monthly Reports</th>
<th>Children’s Crisis Outreach Response System Summary</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>ISS Master Client List</td>
</tr>
<tr>
<td></td>
<td>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.</td>
</tr>
</tbody>
</table>
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). 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 the 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 are guided by the following minimum regulatory requirements:**

- WAC 388-101D-0515 Crisis diversion—Access to services
- WAC 388-101D-0525 Crisis diversion bed services—Services and activities
- WAC 246-341-0900 - Crisis mental health services—General
- WAC 246-341-0920 – Crisis Peer Support Services

4.4.1 Mobile Crisis Team

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 are available to first responders 24/7 to assist with crisis de-escalation, stabilization, and transportation. In addition, the team provides crisis phone triage to accept calls from first responders and identify MCT level of response, including dispatch, phone consult, or referral to alternative services.

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. 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.

Mobile Crisis Team services are guided by the following minimum regulatory and quality requirements:

- 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
  • 42 CFR § 438.114 - Emergency and post-stabilization services
  • WAC 246-341-0900(4)(5); - 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 on a 24 hours/7 days a week basis, 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 from law enforcement agencies. Efforts include phone screening to determine appropriate response and intervention based on the individual’s needs, clinical history, and presenting symptoms, as well as capacity of facility, which may include referrals to alternative services. Capacity issues are managed by CDF staff who may decline a referral if it does not appear that the CDF will have any discharges within two hours of the referral. Pending discharges that are intended 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 accepted by referral to the facility are provided an initial physical health screening by a medical healthcare Provider prior to admission to the CDF to determine medical eligibility, and will receive an individual needs assessment within three hours of arrival.

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 Provider 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.

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. 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 to serve the individuals within the facility, for a maximum length of stay of 14 days (exceptions allowed as per the developed exception protocols as approved by BHRD). 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 CDF and CDIS programs services include transportation coordination, psychiatric services, behavioral health services and peer support, 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. Entry and exit doors at the CDF and CDIS 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 CDF and CDIS programs include 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.
- 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
- Peer Support services

### Crisis Diversion Services Eligibility Criteria

<table>
<thead>
<tr>
<th>Medicaid Status</th>
<th>Yes and No, serves individuals regardless of Medicaid status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age Range</td>
<td>Adults Aged 18 Years and Older</td>
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<tr>
<td>Authorization Needed</td>
<td>No</td>
</tr>
<tr>
<td>Additional Criteria</td>
<td>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:</td>
</tr>
<tr>
<td></td>
<td>• Is in emotional or behavioral crisis that would benefit from crisis intervention services;</td>
</tr>
<tr>
<td></td>
<td>• Agrees to participate in the services; and</td>
</tr>
<tr>
<td></td>
<td>• Is referred by an eligible referent.</td>
</tr>
<tr>
<td></td>
<td>• 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.</td>
</tr>
</tbody>
</table>

### Crisis Diversion Services Reporting Requirements

| Monthly Reports        | CSC Actual Monthly Expenditures Report, Per Program Component; |
|                       | MCT Monthly Report; and |
|                       | CDF Monthly Report. |
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 an MHP is on site at all times, except during the midnight to 8:00 am shift, provided that mental health professional telephone consultation 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

**Voluntary Inpatient Care**
Any person who is does not have Medicaid or any other state Health Care Authority medical program that covers psychiatric inpatient care, and who resides in King County, is eligible for inpatient services through the King County BH-ASO.

Any person of at least 13 years of age currently present in King County (no matter where the person resides) may be evaluated by King County Designated Crisis Responders (DCRs) for involuntary inpatient care. The BH-ASO is responsible for payment for those persons who reside in King County and for whom no other source of funding is available.

**Medical Necessity - Voluntary Inpatient Care**
Medical necessity for the voluntary inpatient level of care requires:

- Ambulatory care resources available in the community do not meet the treatment needs of the individual;
- Proper treatment of the person’s psychiatric condition requires services on an inpatient basis under the direction of a physician (according to Washington Administrative Code (WAC) 246-322-170 or its successor);
- The services can reasonably be expected to improve the person’s level of functioning or prevent further regression of functioning; and
- The person has been diagnosed as having an emotional/behavioral disorder or a severe psychiatric disorder (as defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association) that is considered a principal covered diagnosis (see below) and warrants care in the most intensive and restrictive setting; or
- The person was evaluated and met the criteria for emergency involuntary detention (Chapter 71.05 or 71.34 Revised Code of Washington [RCW] or its successor) and agreed to inpatient care.
- Only persons who meet diagnostic criteria as specified in the Apple Health Mental Health Services Billing Guide (see “Mental Health Services” here).

**Medical Necessity - Involuntary Inpatient Care**
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 and is described in more detail below.

**Authorization for the Inpatient Level of Care: Voluntary Inpatient Care**
The individual must be evaluated within 24 hours prior to a request for admission by the mental health professional (MHP) requesting the authorization. MHP is defined in RCW 71.05.020 and WAC 388-877-0200 or its successor.

- In extraordinary circumstances, the BH-ASO may accept an evaluation by an emergency room physician or a contracted Provider staff person who is not an MHP according to the discretion of the BH-ASO care authorizer.
- Hospitals that routinely request authorizations from the BH-ASO and do not have in-house MHPs may seek a waiver of this requirement, if they can demonstrate that other staff can perform an adequate client assessment and according to agreed-upon guidelines.

If a hospital seeks an authorization after admission and within the first 24-hours of admission, the authorization will be backdated to begin on the actual date of admission.
When evaluating someone for a possible voluntary inpatient admission, the MHP will determine:

- Whether the person is currently authorized for a KC-ICN outpatient level of care with non-Medicaid funds (if not otherwise available, this information can be obtained from Crisis Connections);

- For persons authorized to the outpatient level of care, the evaluating MHP will request from the Provider clinical information regarding the client’s diagnosis, outpatient individual service plan (ISP), standardized crisis plan if applicable, advance directive if available, current mental health care Provider, current prescriptions, and other information pertinent to establishing medical necessity, including any recent failure of less restrictive alternatives to hospitalization. Outpatient Provider staff will assist with phone consultation and/or outreach to an emergency department.

- For persons who receive outpatient mental health treatment from a non-KC-ICN Provider, the evaluating MHP will attempt to contact that Provider to determine that person’s recommendations about admission and treatment.

- Whether immediate provision of an outpatient service can avert the hospitalization;

- Whether a crisis or respite bed or other crisis service can avert the hospitalization and, if so, the availability of such services;

- Whether other settings might more appropriately meet the needs of the person, such as an inpatient medical unit, detoxification unit, or intensive substance use disorder (SUD) treatment services, and, if so, the availability of such services; and

- Whether and where an inpatient psychiatric bed is available, should the admission be authorized.

The MHP will determine that medical necessity is met as follows:

- The person has been given the diagnosis of a covered psychiatric condition;

- The proposed inpatient treatment plan must be expected to improve the person’s condition or prevent further regression so that the inpatient services are no longer needed;

- The treatment plan is evaluated according to the following elements: goals for the hospitalization; likelihood that the goals can be accomplished within the usual timeframe for an acute hospitalization; proposed interventions; the person’s advance directive, if available; treatment history, if available; continuity with any current outpatient plan; and, when available, a proposed discharge plan;

- The treatment plan must also fulfill the state definition of medical necessity: “A term for describing 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, or cause suffering or pain, or result in illness or infirmity, or 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 or its successor); and

- Outpatient services available in the community do not meet the needs of the person and/or the condition requires services that can be provided only on an inpatient basis.

- The needs of the person are evaluated according to the following parameters: risk of harm or dangerousness, functional status, co-morbidity, stressors, supports, and motivation for treatment.

- For intoxicated persons, these parameters need to be assessed after a reasonable degree of sobriety is attained.

The number of days authorized in the initial authorization is based upon the acuity and complexity of the needs of the person. The BH-ASO care authorizer will:

- Utilize the LOCUS/CALEOCUS to assess acuity; and
• Authorize three, four or five initial days based upon acuity level, day of the week, and the imminent risk of harm to self or others. Weekends or holidays that will occur during the anticipated stay may increase the initial days to a maximum of five days.

The procedure for an admission authorization is as follows:

• The requesting MHP will call the BH-ASO authorization line (at Crisis Connections) at 206-461-4858 or 1-800-790-8049. This number is operational 24 hours a day, seven days a week for referrals requesting authorization for inpatient admissions;

• The BH-ASO care authorizer will speak to the MHP immediately or within 30 minutes. The BH-ASO care authorizer must be an MHP as defined in RCW 71.05.020 and WAC 388-877-0200 or its successor;

• The BH-ASO care authorizer will have access to the Behavioral Health and Recovery Division (BHRD) Information System (IS);

• The BH-ASO care authorizer will require the following clinical information in order to assess authorization criteria. If medical necessity is evident, the care authorizer may tailor the assessment to affect a faster disposition;

• Date of proposed or actual admission;

• Proposed hospital. Persons will be authorized to an inpatient facility in King County unless the BH-ASO care authorizer determines that appropriate treatment is not available in this County;

• Mental health condition parameters as noted above;

• Preliminary diagnosis(es); and

• Recommended length-of-stay to accomplish target goals of treatment plan, if known;
Timelines for inpatient authorization decisions are as follows:

- All decisions concerning the initial authorization of an acute and emergent admission will be made within one hour of direct, live contact with caller (i.e., not voicemail);
- For urgent preservice decisions, KCBHP will notify the practitioner and member within 24 hours of the request.

For any type of authorization decision, the BH-ASO may defer immediate decision-making in the absence of medical necessity information that justifies an approval. If the information is not received within 12 hours of the request, the authorization request will be categorized as either cancelled or withdrawn, not denied.

Once given, inpatient authorizations are not terminated, suspended, or reduced.

Unless approved by the BH-ASO care authorizer, an authorization expires when 24 hours have passed without the client receiving hospital services.

**Denials**

- A denial occurs only when the hospital believes medical necessity is met for the inpatient level of care and the BH-ASO care authorizer disagrees and therefore does not authorize the care.
- Only a BH-ASO psychiatrist may issue a denial.
- Alternatively, a diversion (or “negotiated diversion”) is when, following the recommendation of the KCBHP care authorizer, the hospital agrees to another level of care. A diversion can occur prior to admission or during a continued stay review.
- When care is not authorized, either at the time of admission, during an admission, or following an admission, for reasons other than disagreements over medical necessity, this is not considered a denial (and need not be issued by a BH-ASO psychiatrist).

**Expedited Reviews**

- Prior to finalizing a denial and on the request of the referring professional, the KCBHP will perform an expedited review of the denial decision. This review is a phone discussion of medical necessity between the referring professional and a KCBHP psychiatrist.
- Additionally, in the 24 hours following a denial of an authorization for admission or for a length-of-stay extension, the referring MHP or the hospital staff may request an expedited review.

If an inpatient authorization request is denied and the client is not admitted, a new admission authorization request may be made at any time, if:

- A new assessment of the client reveals that the clinical issues have changed such that the client now meets medical necessity criteria; and/or
- A new assessment of the client reveals significant information not obtained during the first assessment, such that the client meets medical necessity criteria after all.

**Special Circumstances**

- Change in primary diagnosis
- Hospitals have 24 hours to notify the KCBHP care authorizer whenever a hospitalized person’s diagnosis changes to one that is no longer covered. The care authorizer will handle 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 the KCBHP care authorizer whenever a hospitalized person’s diagnosis changes from one that is not covered to one that is. The care authorizer will consider this notification as an initial authorization request.
• Electroconvulsive therapy (ECT)

• Hospitals will seek approval by the KCBHP care authorizer before initiating a course of ECT during a voluntary inpatient stay that has already been authorized.

• If ECT is initiated without KCBHP approval, any subsequent length-of-stay authorization requests will be approved only if the ECT meets KCBHP standards of care.

• KCBHP 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: http://www.hca.wa.gov/billers-Providers/claims-and-billing/professional-rates-and-billing-guides).

• Transfers from one hospital to another are permissible. Transfers between hospitals should follow the usual authorization protocol.

• Change in legal status

• When a client changes from involuntary to voluntary or from voluntary to involuntary, the hospital must notify the BH-ASO care authorizer 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.

**Retrospective Authorizations of Voluntary Admissions**

• 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 will be considered only:

• When the failure to request a prior authorization occurred for reasons beyond the control of the hospital.

• Once a determination has been made that the above circumstances do not apply, the determination cannot be appealed.

• When a retrospective authorization request is made during an inpatient stay:

• The BH-ASO care authorizer will consider for authorization only the current day and any future days.

• The decision will be made according to the time frames for an initial authorization.

• After discharge, the hospital must make a separate request that the days provided prior to the retrospective request be considered for authorization. When a retrospective authorization request is made after discharge (either for the whole hospital stay or for the days that were provided prior to a first retrospective request that was made during the inpatient stay):

• The hospital must request the retrospective authorization in writing within 30 calendar days of the discharge of the client. The medical record for the entire hospitalization must accompany the request.
Chapter 4 Crisis Services

- A retrospective authorization request that is not received within 30 calendar days will not be considered.
- Retrospective authorization requests and the medical record must be submitted to the BH-ASO care authorizers. The record must be accompanied by a letter stating the reason the hospital was unable to request authorization in advance, the rationale for the request for authorization, and must highlight those sections of the medical record that address this specific issue.
- The retrospective authorization decision will be based on the submitted medical record documentation.
- The BH-ASO will complete the retrospective authorization determination within 30 calendar days, unless it appears that another region may be responsible for the admission. If that is the case, BH-ASO will first work with the other region to determine responsibility and then, if the BH-ASO is responsible, process the retrospective request.
- A denial of a retrospective authorization for requests submitted after discharge may be appealed by either the person or the Provider.

Authorization for the Inpatient Level of Care: Voluntary Inpatient Care

DCRs will 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 will 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 authorizations 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.

- This process is for people without funding only.
- This is optional.
- The client information will need to be resubmitted to the care authorization on discharge.

Continuing Stay Criteria and Authorization of Extensions

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.”

Voluntary Admissions

The criteria for a continued stay are the same as those for an authorization for admission. The BH-ASO will re-administer the LOCUS/CALOCUS for only the domains that are appropriate for the current clinical presentation for each length-of-stay extension request that meets medical necessity criteria. The length of an authorized extension is at the discretion of the BH-ASO care authorizer. The hospital may request as many length-of-stay extensions as needed. Extensions may be verbally requested 48 hours in advance of, but not more than 24 hours after, the expiration of the current authorization. Whenever possible, hospitals are encouraged to call and ask for extension requests during regular business hours.

The BH-ASO will make an authorization decision within 24 hours of receipt of the extension request. On the request of the hospital, the BH-ASO will perform an expedited review of a length-of-stay denial decision. This review is a phone discussion of medical necessity between the hospital and a BH-ASO psychiatrist. Requests for an expedited review must be completed within 24 hours from the time of the
determination. If the BH-ASO care authorizer is unable to make the authorization decision within 24 hours, the authorizer will authorize a single day while completing the authorization process. The hospital must allow time for adequate discharge planning should an extension be denied.

Extensions may be authorized at the administrative daily rate when the following occur:

- The client has a legal status of voluntary;
- The client no longer meets medical-necessity criteria;
- The client no longer meets intensity-of-service criteria (continued stay solely for the purpose of medication adjustments does not justify payment at the full inpatient rate and may be denied or the administrative daily rate may be offered);
- Less restrictive alternatives are not available, posing a barrier to safe discharge; and
- The hospital and BH-ASO care authorizer mutually agree to the appropriateness of the administrative day.

Hospitals are required to submit an extension request to the BH-ASO care authorizer in order to initiate an extension request. Once the extension is approved or denied, the care authorizer documents the authorization decision and returns the form to the hospital.

### Involuntary Admissions

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 the BH-ASO care authorizer in order to initiate an extension request. Once the extension is approved, the BH-ASO care authorizer documents the authorization decision and returns the form to the hospital. BH-ASO care authorizer(s) may not deny any extension request for an involuntary person.

For both voluntary and involuntary hospitalizations, the BH-ASO care authorizer will 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.

### Discharge and Termination

Discharge will occur when a client no longer meets medical-necessity criteria for admission.

Once given, an inpatient authorization will not be terminated. However, a hospital may discharge a client before an authorization has expired. When a client is discharged, the hospital must notify the BH-ASO care authorizer.

In addition to pursuing an expedited review of a potential denial, a hospital may appeal a decision to deny an authorization or length-of-stay extension. An appeal may be submitted whenever:

- An inpatient day was provided despite a denial; or
- An elective admission has been denied.

The authorization of administrative days may not be appealed.
Timelines for a Provider appeal request are as follows:

- When an inpatient day was provided despite a denial, the hospital must request an appeal in writing within 15 business days of the discharge of the client or receipt of a denial of a retrospective authorization request.
- When an elective admission or an extraordinary psychiatric service has been denied, the hospital (or outpatient Provider) must request an appeal in writing within 15 business days of the denial.
- An appeal request that is not received within the specified 15 business days will not be considered.

The appeal request must contain the following:

- When an inpatient day was provided despite a denial, the request must include the entire medical record available at the time of discharge for both initial authorization and length-of-stay extension appeals.
- When an elective admission has been denied, the hospital (or outpatient Provider) must send medical records documenting the need for the requested service.
- In addition to the requested medical records, the hospital (or outpatient Provider) must send a letter referencing the reason for the denial, the rationale for the appeal, and must highlight those sections of the medical record that address this specific issue.

Appeal requests and the medical record must be submitted to the BH-ASO Medical Director or designee. The appeal decision will be based on the submitted medical record documentation. The appeal decision may be based on factors beyond the original reason for denial. The appeal decision will be made by the BH-ASO Medical Director or designee. This psychiatrist will not be the psychiatrist that issued the original denial and will not be in the KCBHP Provider network. The BH-ASO will respond in writing to the hospital within 30 days with the Medical Director’s determination. All appeal decisions are final and binding.

When care 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 is not considered a denial. Such determinations cannot be appealed. However, if the hospital thinks that the BH-ASO care authorizer has deviated from published requirements, the hospital may take its dispute to the BH-ASO Medical Director or designee. This must occur within 30 days of the client’s discharge or of the BH-ASO decision that is the topic of the dispute. To initiate the dispute, hospital staff will first call the BH-ASO Medical Director or designee, and then send any documentation requested during the phone call. The BH-ASO Medical Director or designee will respond to the dispute within 30 calendar days of receipt of the requested documentation. Following this response, if the hospital continues to believe that BH-ASO has deviated from published requirements, the hospital may take its dispute to DSHS/Behavioral Health Administration (BHA)/Division of Behavioral Health and Recovery (DBHR). DBHR decisions are final.

### Emergency Telephone Services Eligibility Criteria

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<thead>
<tr>
<th>Emergency Telephone Services Eligibility Criteria</th>
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<tbody>
<tr>
<td>Medicaid Status</td>
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<tr>
<td>Age Range</td>
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<td>Authorization Needed</td>
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</tr>
<tr>
<td>Additional Criteria</td>
<td>Any individual or any person acting on behalf of an individual for whom a mental health disorder cannot be ruled out.</td>
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### Emergency Telephone Services Reporting Requirements

<table>
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<tr>
<th>Reports</th>
<th>Reports</th>
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<tbody>
<tr>
<td>Daily Reports</td>
<td>• Daily Crisis Log</td>
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<td>• Daily Crisis Log – CC Business Line</td>
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<tr>
<td>Monthly Reports</td>
<td>• Crisis Line Wait Time Intervals Monthly Report</td>
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<td>• Next Day Appointment Report</td>
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<td>• Mobile Crisis Team Dispatch Report</td>
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<td>• After Hours Report</td>
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<td>• Crisis Line Caller Data Report</td>
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<td>• CCPAR Line Volume and Outcomes Report</td>
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### 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

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<th>Criteria</th>
<th>Details</th>
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<tbody>
<tr>
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<tr>
<td>Age Range</td>
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<tr>
<td>Authorization Needed</td>
<td>No</td>
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<tr>
<td>Additional Criteria</td>
<td>Any individual or any person acting on behalf of an individual for whom a mental health disorder cannot be ruled out.</td>
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</tbody>
</table>
### 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 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

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<tr>
<th>Medicaid Status</th>
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<td>Additional Criteria</td>
<td>Any individual or any person acting on behalf of an individual for whom a mental health disorder cannot be ruled out.</td>
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</table>

### 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. |
4.8 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.

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<th>Warm Line Eligibility Criteria</th>
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<td>Additional Criteria</td>
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<tr>
<th>Warm Line Reporting Requirements</th>
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<tbody>
<tr>
<td>Monthly Reports</td>
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<tr>
<td>• Warm Line Call Report</td>
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<tr>
<td>• Warm Line Volunteer Report</td>
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<tr>
<td>• Warm Line Profit &amp; Loss Report</td>
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<tr>
<td>• Warm Line Trial Balance Report</td>
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<tr>
<td>Quarterly Reports</td>
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<tr>
<td>• RH Call Status Report</td>
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<tr>
<td>• Warm Line Caller Data Report</td>
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<tr>
<td>• Warm Line Access Report</td>
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<tr>
<td>• Warm Line Reconciliation Report</td>
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<tr>
<td>Annual/Other Reports</td>
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<tr>
<td>• Warm Line Yearly Access Report</td>
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</tbody>
</table>

4.9 Crisis Intervention Training

Crisis Intervention Training (CIT) equips police and other first responders with the training needed to enable them to respond most effectively to individuals in crisis and to help these individuals access the most appropriate and least restrictive services while preserving public safety. The Crisis Intervention Training initiative is funded by, and adheres to, the Mental Illness and Drug Dependency (MIDD) Plan Initiative PRI-08 – Crisis Intervention Training Program for King County Sheriff, Police, Jail Staff and Other First Responders.

Annual CIT activities are listed below.

- 40-hour Crisis Intervention Team curriculum delivered to law enforcement officers and other first responders in King County. At least 10 trainings will be offered for 12 to 25 participants per training.
- Eight-hour basic CIT in-service courses for law enforcement officers and associated stakeholder partners in King County. At least 12 basic CIT in-service courses will be offered for 12 to 50 participants per training.
- Eight-hour CIT Force Options courses for law enforcement officers who have participated in a prior 8-hour or 40-hour CIT course in King County. At least three CIT Force Options courses will be offered for 12 to 22 participants per training.
Eight-hour CIT courses for law enforcement dispatch, Fire Department/Emergency Medical Services (EMS) personnel, 911 operators, and corrections personnel. At least 4 courses across these options will be offered for 12 to 35 participants per training.

Additional specialized one-day trainings will be offered for 12 to 35 participants per training, and may include eight-hour Mental Health First Aid for Criminal Justice training curriculum; eight-hour Youth-focused CIT curriculum; and additional courses, including advanced training content, as identified and developed based on the annual training needs assessment and upon request.

A CIT Regional Conference is held annually to share information on tools, equipment, and resources available to help with providing training, education, and support to those in mental health or substance use disorder (SUD) crisis.

Train-the-Trainer class curriculums may be offered as resources allow to agencies that request it in order to become in-house trainers for crisis intervention or Mental Health First Aid for 12 to 25 participants per training. The class will train the students to teach the eight-hour CIT-King County In-Service or the Mental Health First Aid for Criminal Justice courses.

Coordination with other relevant law enforcement agencies may be provided to facilitate access, as able and allowable, to these agencies’ in-house CIT-related courses for other law enforcement agencies outside the host agency who wish to participate. Training support may be provided, if requested by the outside agency, based on County approval. Backfill and overtime support may be provided to agencies outside of the host agency that send staff to attend these CIT related courses.

Support is provided for, and facilitation of, the CIT Coordinators Committee meetings, as well as assistance with collaboration efforts in regard to coordinating trainings, communications, and resources. In addition, the Provider represents King County CIT at any statewide meetings regarding crisis intervention programs and practices.

Additional innovative trainings related to crisis intervention and response may be developed and implemented, with prior approval by the Provider and Behavioral Health and Recovery Division (BHRD), to address specialized populations and topics as requested or identified though the annual needs assessment and/or stakeholder feedback.

A team-taught model is provided; utilizing the King County Sheriff’s Office (KCSO) CIT Coordinator or other applicable subject matter experts (i.e. Fire/EMS, Corrections) and a Mental Health Professional trainer with crisis response expertise, for the de-escalation and resource presentations in the basic 8-hour in-services and 40-hour courses currently available or developed under this scope. Common interactions and available techniques for responding will be built into the curriculum. Mock scenes will include consistent expectations and delivery, as well as clearly defined learning objectives.

The CIT program incorporates training components that address the impacts of trauma on crisis response, and the de-escalation presentation will include interactive discussions with first responders to determine their main concerns and/or difficulties regarding specific populations and how to intervene. The de-escalation section is intended to provide skills-based focused learning activities, utilizing research on best practices for promoting adult learning.

Program and training development activities are piloted with law enforcement, consumers/advocates, behavioral health Provider agencies, and other experts in the field to ensure presentations are clear and provide an accurate representation of material being taught. Pilot testing provides opportunities to address potential issues prior to implementation and help ensure the presenter(s) is prepared to respond to subject matter questions outside or beyond the scope of the presentation material that may arise. Ongoing program development activities are based on program evaluation activities and recommendations, including a yearly review of stakeholder and trainee participant feedback for potential curriculum revisions. This may include:
• A developed plan for ongoing audit and feedback structure utilizing law enforcement, other first responders in the community, consumers, advocates, behavioral health Providers, and community stakeholders.

• Opportunities to observe training content, provide programmatic feedback, and allow for continual quality improvement activities, as well as assess for programmatic drift away from objectives of the trainings.

• Identified strategies and protocols for consumers, advocates and behavioral health Providers to observe CIT training activities to provide programmatic feedback and to share their perspectives with the Provider and, if relevant, the CIT Coordinator’s group.

<table>
<thead>
<tr>
<th>Crisis Intervention Training Eligibility Criteria</th>
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<tbody>
<tr>
<td><strong>Medicaid Status</strong></td>
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<tr>
<td><strong>Age Range</strong></td>
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<tr>
<td><strong>Authorization Needed</strong></td>
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<tr>
<td><strong>Additional Criteria</strong></td>
</tr>
</tbody>
</table>

| Training Development                          | The Provider will develop an 8-hour Advanced CIT course that includes skills-based refresher training and advanced de-escalation techniques. This training should be ready for pilot testing within the first six months of 2019. |

<table>
<thead>
<tr>
<th>Crisis Intervention Training Reporting Requirements</th>
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<tbody>
<tr>
<td><strong>Monthly Reports</strong></td>
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</table>

| **Quarterly Reports**                              | Quarterly data on the number of participants who complete training, by participating agency and by type of training in a reporting format approved by BHRD. Quarterly data on the number of participants, by participating agency, who completed Train-the-Trainer classes basis in a reporting format approved by BHRD. Copies of the meeting agendas and minutes as well as a current list of CIT Coordinators Committee members. Documentation of participation in community meetings and trainings by the KCSO staff funded by King County MIDD, including trainings provided by KCSO staff with supporting documentation consisting of a |
### Annual/Other Reports

- Data on the number of participants by participating agency who attend the annual Regional Conference in a reporting format approved by BHRD.
- An annual training plan, including operating budget, by February 4, 2019 and February 3, 2020 for instructor development and training costs for the KCSO staff funded by King County MIDD. Reimbursement for all instructor development and training costs are paid based on actual expenditures with supporting documentation.
- Schedule and estimated budget by February 4, 2019, for implementation of the CIT Coordinators Committee meetings and statewide CIT coordination efforts. Reimbursement will be paid based on actual expenditures with supporting documentation.
- An annual training needs assessment of participating law enforcement and corrections agencies, within the scope of available resources, which will inform the training schedule.
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) 388-877B 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:

- 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.

The initial length of stay is based on medical necessity and cannot be longer than 5 days for alcohol and other drugs. If an exception is needed, the Provider must receive prior approval from BHRD via an Exception to Policy (ETP) for withdrawal management services request form provided by BHRD.

The Provider will observe 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;
• DSSC;
• 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

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<th>Medicaid Status</th>
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<td>Authorization Needed</td>
<td>Yes, if the Withdrawal Management Provider is outside of King County</td>
</tr>
</tbody>
</table>
| 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:  
  • Dutch Shisler Sobering Support Center (DSSC);  
  • Harborview Emergency Department;  
  • other King County emergency departments;  
  • King County Substance Use Disorder Involuntary Treatment Specialists (SUDITS);  
  • King County Crisis and Commitment Services;  
  • REACH case managers;  
  • Law enforcement;  
  • King County Providers who are seeking detoxification 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 |
5.2 Secure Detoxification

In response to House Bill 1713 (“Ricky’s Law”), secure detoxification 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 Detoxification are approved substance use disorder treatment programs for not more than 72 hours (RCW 71.05.153). Clients receive a medical exam and an evaluation, and get a recommendation for treatment from a psychiatric nurse practitioner. The detox 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.”

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<th>Secure Detoxification Eligibility Criteria</th>
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<tr>
<th>Secure Detoxification Reporting Requirements</th>
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<td>Monthly Reports</td>
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<tr>
<td>Quarterly Reports</td>
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<tr>
<td>Annual/Other Reports</td>
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</tbody>
</table>

Attachments in this Section:

- Attachment A: [Withdrawal Management—Acute Inpatient Substance Use Disorder Withdrawal Management to Clients](#)
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 will 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) 388-877 or 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 388-877-1110 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 adult 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:

- Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) criteria for SUD;
- Specific ASAM criteria for placement;
- The individual’s needs cannot be more appropriately met by any other formal or informal system or support; and
- Authorized by King County for SUD residential services.

Residential Admissions Process

Providers participate in the admissions process described below.

Residential Admissions

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.

**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 KCBH 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 under this Contract beginning at intake. Discharge planning will apply 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 will be 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 Programs Eligibility Criteria

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<th>Parameter</th>
<th>Description</th>
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<td>Age Range</td>
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<td>Additional Criteria</td>
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### SUD Residential Programs Reporting Requirements

<table>
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<tr>
<th>Monthly Reports</th>
<th>Description</th>
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<tbody>
<tr>
<td>SUD Residential Census Report</td>
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#### 6.1 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.

#### 6.2 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).
6.3 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-occuring mental health issue.

6.4 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).

6.5 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).

6.6 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).

6.7 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.

6.8 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 will send 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
• Report quarterly to the County the number of clients in the residential facility who are taking their own medications with minimal prompting and supervision.

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 will apply 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 will be 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

<table>
<thead>
<tr>
<th>Medicaid Status</th>
<th>Yes, limited non-Medicaid funding available with BHRD approval</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age Range</td>
<td>18 years and older</td>
</tr>
<tr>
<td>Authorization Needed</td>
<td>Yes</td>
</tr>
</tbody>
</table>

**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

<table>
<thead>
<tr>
<th>Monthly Reports</th>
<th>Benson Heights Rehabilitation Center Census Log</th>
</tr>
</thead>
<tbody>
<tr>
<td>Semi-Annual Reports</td>
<td>The Provider combines information with that identified in the KCBHP Outpatient Benefit Scope and follow the Outpatient Benefit Scope Reporting Requirements.</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>Eating Disorder Services Eligibility Criteria</th>
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<tbody>
<tr>
<td>Medicaid Status</td>
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<tr>
<td>Additional Criteria</td>
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</tbody>
</table>

Eating Disorder Services Reporting Requirements

| Monthly Reports | Eating Disorder Census Report |
7.3 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**

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<tr>
<th>Medicaid Status</th>
<th>Yes, limited non-Medicaid funding available with BHRD approval</th>
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</tr>
</tbody>
</table>

**ISH Reporting Requirements**

- **Monthly Reports**: ISH Monthly Report

7.4 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**

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<tr>
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</table>

**LTR Reporting Requirements**

- **Monthly Reports**:
  - LTR Billing Report Services Summary
  - LTR Residential Invoice Report
- **Quarterly Reports**: LTR Self-Medication Report
7.5 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

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<thead>
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</table>

### SSH Reporting Requirements

| Monthly Reports                  | SSH Monthly Report                                           |

7.6 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.
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<tr>
<th><strong>SL Eligibility Criteria</strong></th>
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<tbody>
<tr>
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<tr>
<td>• SL Billing Report Services Summary</td>
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<td>• SL Residential Invoice Report</td>
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<tr>
<td>Quarterly Reports</td>
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<tr>
<td>• SL Self-Medication Report</td>
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</table>
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 2020 Funding Summary 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).

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;
- Case 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; and
- Provide treatment services in penal or correctional institutions of the State.

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:
### 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 (https://www.theathenaforum.org/cpwi-community-coalition-guide), and updates/ other documents provided by HCA/DBHR and/or BHRD.

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 federal award 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.

The Provider participate in an annual on-site visit by the County as requested in order to monitor contract compliance and to observe programs that directly serve CPWI participants. The on-site visit 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 onsite visit is be held at the Provider’s facility and/or the program site 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 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.

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 State of Washington Health Care Authority. The Provider may use current 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 State of Washington Health Care Authority.


The Provider adheres to HCA policies related to reimbursement for the use of CPWI light refreshments and meals, which include the following:

- 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 at least 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 www.ofm.wa.gov/policy/10.90.htm; 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 www.ofm.wa.gov/policy/10.90.htm.

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.
### ATOD Prevention Coalition Eligibility Criteria

<table>
<thead>
<tr>
<th>Medicaid Status</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age Range</td>
<td>N/A</td>
</tr>
<tr>
<td>Authorization Needed</td>
<td>No</td>
</tr>
<tr>
<td>Additional Criteria</td>
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<tr>
<td></td>
<td>• Community members, organizations, and groups in King County per the approved coalition strategic plan/ action plan</td>
</tr>
<tr>
<td></td>
<td>• 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</td>
</tr>
</tbody>
</table>

### ATOD Prevention Coalition Reporting Requirements

<table>
<thead>
<tr>
<th>Monthly Reports</th>
<th>All hours provided and services delivered during the preceding month will be submitted into the Minerva Information System (MIS) by the 10th day of each month. The Provider will submit all required data including 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.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quarterly Reports</td>
<td>Due October 15, January 15, April 15, and July 15 in the MIS</td>
</tr>
</tbody>
</table>

### 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) 388-865-0700 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.

Per federal block grant requirements, Providers will 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.

### Consumer-Driven Services Eligibility Criteria

<table>
<thead>
<tr>
<th>Medicaid Status</th>
<th>Client cannot be Medicaid-Eligible for coverage under this program</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age Range</td>
<td>N/A</td>
</tr>
<tr>
<td>Authorization Needed</td>
<td>No</td>
</tr>
<tr>
<td>Additional Criteria</td>
<td>• Individuals in King County who experience barriers to employment due to mental health issues.</td>
</tr>
<tr>
<td></td>
<td>• Clients may self-refer but the Clubhouse may only request reimbursement under this program if the consumer is not Medicaid-eligible.</td>
</tr>
</tbody>
</table>
### Consumer-Driven Services Reporting Requirements

| Monthly Reports                      | Consumer-Driven Services Clubhouse Census Log  
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Progress note to the Outpatient Benefit holder for each enrolled consumer served that contains a summary of activities and attendance.</td>
</tr>
<tr>
<td>Semi-Annual Reports</td>
<td>Consumer-Driven Services Clubhouse Services Summary Report for June with the June Invoice and for December with the December invoice.</td>
</tr>
<tr>
<td>Annual/Other Reports</td>
<td>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.</td>
</tr>
</tbody>
</table>

#### 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

<table>
<thead>
<tr>
<th>Medicaid Status</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age Range</td>
<td>N/A</td>
</tr>
<tr>
<td>Authorization Needed</td>
<td>No</td>
</tr>
<tr>
<td>Additional Criteria</td>
<td></td>
</tr>
</tbody>
</table>
- 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

<table>
<thead>
<tr>
<th>Monthly Reports</th>
<th>King County Consumer Training Fund Expenditures Report in a format provided by BHRD in hard copy with the invoice.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Semi-Annual Reports</td>
<td>King County Consumer Training Fund Status Report in a format provided by the County in hard copy with the June and December BIP.</td>
</tr>
</tbody>
</table>
| 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 housing placement and support services designed from a recovery perspective based on Permanent Supportive Housing principles. Services are intended to support individuals that are homeless or at-risk of homelessness and are exiting - or at-risk of entering - psychiatric or substance use disorder (SUD) inpatient facilities. Per Health Care Authority (HCA) requirements, the team consists of one full-time equivalent (FTE) Program Coordinator and two FTE Certified Peer Counselors (or certification is completed within 6 months of employment). HARPS staff coordinate and work with Behavioral Health and Recovery Division (BHRD), network Providers, housing authorities, housing Providers, and housing planning groups in order to maintain and increase housing resources and options for clients, as well as ensure that HARPS clients transition smoothly to appropriate supports and services (e.g., primary care, behavioral health treatment, housing, and employment resources).

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 supports 30 – 50 individuals at any given time with an expected total annual enrollment of approximately 65 participants. The type, mix, duration, and intensity of services provided by HARPS team varies depending upon the identified needs of each individual client. HARPS assists most clients 90-180 days based on a case-by-case assessments of client need and the housing placement plan. Housing placements are individualized and responsive to the needs, interests, and priorities of each client. In addition to housing support, the HARPS team helps clients obtain the necessities of daily living, including medical and dental health care, legal and advocacy services, financial support such as entitlements, housing subsidies, money-management services, and transportation.

HARPS services are reimbursed according to the Provider’s performance on the following tasks.
<table>
<thead>
<tr>
<th>Goal</th>
<th>Task</th>
<th>Performance Measure</th>
<th>Due Date</th>
<th>Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Weekly updates on number of referrals from state psychiatric hospitals</td>
<td>Send a Word document via email to the HCA with the number of individuals referred by the State Hospitals, date of the referral, and current housing status of hospital referrals.</td>
<td>Tuesday of each following week.</td>
<td>$200 per HARPS team weekly update X 4 weeks per month X 12 month for a maximum of 12 months</td>
</tr>
<tr>
<td>2</td>
<td>At least 2 FTE HARPS staff attend HCA facilitated training event on SAMHSA Permanent Supported Housing (PSH) model</td>
<td>Sign in sheet verifying program staff attended the PSH training event,</td>
<td>As determined by HCA</td>
<td>1 payment of $5,000 for training participation</td>
</tr>
<tr>
<td>3</td>
<td>Document landlord outreach and engagement activities in monthly HARPS Participant Log uploaded to King County secure FTP site using designated naming convention.</td>
<td>At least 5 landlord/property manager contacts document in the Landlord Outreach tab of the monthly HARPS Participant Log</td>
<td>Due by the 10th of each following month.</td>
<td>12 months (assuming full staffing) @ $5,000 per report received and approved</td>
</tr>
<tr>
<td>4</td>
<td>Document and submit monthly HARPS Participant Log detailing HARPS enrolled participants that receive services and/or subsidies. Information submitted shall include participants that are: actively receiving supported housing services as well as those achieving 6 months of housing retention. Payment may be pro-rated for unfilled positions based upon 3FTE.</td>
<td>Monthly HARPS Participant Log submitted to King County secure FTP site using designated naming convention.</td>
<td>Due by the 10th of each following month.</td>
<td>12 months (assuming full staffing) @ $5,000 per monthly HARPS Participant Log received.</td>
</tr>
<tr>
<td>5</td>
<td>Document and submit HARPS Quarterly Report with results of project activities including participant success story with signed release.</td>
<td>HARPS Quarterly Report submitted to King County secure FTP site using designated naming convention</td>
<td>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</td>
<td>4 quarterly reports @ $10,000 per report</td>
</tr>
<tr>
<td>6</td>
<td>One HARPS team member shall participate as a review in one PSH cross-site fidelity review facilitated by</td>
<td>A copy of the consensus scored report with recommendations from</td>
<td>As determined by the HCA</td>
<td>Minimum of one FTE staff participant in at least one cross-</td>
</tr>
</tbody>
</table>
HCA Housing Bridge Subsidies and Commerce housing subsidies provide temporary rental assistance to clients who are homeless or at risk of homelessness. HARPS must apply internal controls to ensure that invoiced costs are accurate, reasonable and aligned with both reimbursement and generally accepted accounting principles. It is expected that HARPS will deny payment or appeal invoiced costs that are deemed unreasonable and/or unsubstantiated. Reimbursable expenditures include:

- Monthly rent and utilities, and any combination of first and last months’ rent for up to three months. Payments beyond three months may be provided with county pre-approval.
- 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;
- 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. Payments beyond three months may be provided with 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 County pre-approval.

**HARPS Eligibility Criteria**

<table>
<thead>
<tr>
<th>Medicaid Status</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age Range</td>
<td>18 years of age or older</td>
</tr>
<tr>
<td>Authorization Needed</td>
<td>Yes</td>
</tr>
<tr>
<td>Additional Criteria</td>
<td>Medical Necessity for behavioral health disorders, Willing to participate in HARPS program, Released from or at risk of entering:</td>
</tr>
</tbody>
</table>
- Psychiatric inpatient settings, or
- SUD Residential Treatment Programs, and
- Homeless/at risk of homelessness, using a broad definition of homeless (couch-surfing included).

### HARPS Reporting Requirements

<table>
<thead>
<tr>
<th>Monthly Reports</th>
<th>Quarterly Reports</th>
</tr>
</thead>
<tbody>
<tr>
<td>HARPS Participant Log – due the 10(^{th}) of the month following the reporting period</td>
<td>HARPS Quarterly Report – due the 15(^{th}) of the month following the reporting period</td>
</tr>
<tr>
<td>HARPS Commerce Funds Subsidy Log – due the 10(^{th}) of the month following the reporting period</td>
<td></td>
</tr>
</tbody>
</table>
8.5 New Journeys Demonstration Project

Providers implement and deliver a First Episode Psychosis (FEP) specialized team treatment program based on the NAVIGATE Model for individuals 15 to 40 years old. The program implements evidence-based Coordinated Specialty Care (CSC) principles and practices. Providers participate in all meetings to enhance the Washington State New Journeys NAVIGATE model implementation and evaluation efforts, including the following components:

**Trainings and Meetings:**
- Clinical Trainings (NAVIGATE introduction and orientation, Structured Clinical Interview for DSM (SCID), Evaluation Component specific training)
- 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 individuals 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);
• 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.

Per federal block grant requirements, Providers will 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.

<table>
<thead>
<tr>
<th>New Journeys Demonstration Project Eligibility Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid Status</td>
</tr>
<tr>
<td>Age Range</td>
</tr>
<tr>
<td>Authorization Needed</td>
</tr>
</tbody>
</table>
| Additional Criteria | • Experiencing a first-episode psychosis  
• Meet the diagnostic criteria of a diagnosis of schizophrenia, schizoaffective disorder, schizophreniform disorder, brief psychotic disorder, delusional disorder, or other specified schizophrenia spectrum and other psychotic disorder;  
• Have a duration of symptoms of greater than one week and less than two years; and  
• Reside in King County.  
• Exclusionary Criteria includes:  
  • A current diagnosis of:  
  • Mood disorder with psychotic features;  
  • Pervasive developmental disorder and/or autism spectrum disorder;  
  • Psychotic disorder due to another medical condition;  
  • Substance/medication-induced psychotic disorder;  
  • Documented IQ of less than 70.  
• Potential New Journeys participant entry is co-managed by BHRD and the Providers offering this specialized treatment team approach.  
• Potential pilot participants will be prioritized in the following order:  
  • Enrolled with a Medicaid or non-Medicaid outpatient behavioral health benefit,  
  • Medicaid-eligible but not currently enrolled in a BHRD outpatient benefit,  
  • Low-income, non-insured individuals, or  
  • Privately insured. |
### New Journeys Demonstration Project Reporting Requirements

| Monthly Reports | • New Journeys Progress Form  
|                 | • New Journeys New Provider Start-up Narratives |
| Quarterly Reports | Providers submit a New Journeys Demonstration Project Quarterly Federal Block Grant Reconciliation Summary and as requested, meet with BHRD’s Children’s Mental Health Planner and Contract Monitor to review grant fund status and any related issues. |

#### 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 | FTE Staffing Report |

#### 8.7 Pregnant/Postpartum and Parenting Women (PPW) Enhancement Rate

This enhancement rate was created so that Providers can offer an expanded body of outpatient services to pregnant and postpartum women and women with dependent children that provides a continuum of outpatient and recovery support services designed from a recovery and resiliency perspective. The treatment is designed to provide substance use disorder (SUD) and/or medication-assisted treatment (MAT) outpatient treatment and case management services specific to the recovery needs of the low-income PPW population. Providers review client eligibility for the PPW services on a monthly basis and document findings in the clinical file.
PPW clients and their family members are treated as a family unit. The family needs are assessed and identified at the time of the PPW assessment and also identified on the ISP. Progress notes include documentation of services provided to the client, any children, and any identified family members who are treated with the primary client. In cases of CPS involvement, reunification is addressed in the ISP and progress notes. When the client’s children are in custody and under age six with no open CPS case, the Provider refers the PPW client to Childhaven when therapeutic childcare, parenting assistance, and family support are considered beneficial or needed.

To facilitate treatment and participation, the Provider also offers safe and developmentally appropriate on-site childcare services for parents who are participating in on-site SUD treatment services. This on-site childcare maintains a minimum of 30 hours availability per week for direct childcare and an additional 10 hours per week to be used for parenting education and support if not used for direct childcare hours. The Provider has a designated coordinator who has completed at least 45 college credits in early childhood education or child development. 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. Admissions sheets to the on-site childcare include 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, and admission date. 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 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; and
- 1 adult to 10 children 2½ to 5 years old; and
- 1 adult to 15 children 5 years and older.

Whenever possible, clients are assigned to gender-specific primary counselors. Assessment and treatment services are provided within 14 days of being requested. Assessments for this program must include:

- 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; and
- An assessment of any imminent or future risk of child abuse and neglect related to the parents’/guardians’ substance use.

In addition to the services the PPW client receives through their outpatient benefit, they also receive services through their PPW Enhancement to include:

- PPW specific assessments at the time of intake or an update when initially requesting a PPW enhancement;
- Gender-specific SUD treatment and other therapeutic interventions for women which may address issues of relationships, sexual and physical abuse, parenting, custodial issues including Child
Protective Services (CPS) involvement, and child care while the women are receiving these services, including but not limited to the following service types: individual face-to-face treatment sessions; group treatment; urinalyses; and Case Management.

- 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;
- 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;
- Job-seeking motivation and assistance;
- Evidence-based parenting support and education; and
- Family counseling.

Clients receive interim services for within 48 hours of requesting treatment if treatment services are not available within the designated time frame. Interim services include, at a minimum:

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

Per federal block grant requirements, Providers will 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.

<table>
<thead>
<tr>
<th><strong>PPW Enhancement Rate Eligibility Criteria</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid Status</td>
</tr>
<tr>
<td>Age Range</td>
</tr>
<tr>
<td>Authorization Needed</td>
</tr>
<tr>
<td>Additional Criteria</td>
</tr>
<tr>
<td>Individuals receive priority services as described in the King County BH-ASO Policies and Procedures.</td>
</tr>
<tr>
<td>Individuals must have an authorized SUD or MAT outpatient benefit.</td>
</tr>
<tr>
<td>Eligible individuals must be:</td>
</tr>
<tr>
<td>Women who are pregnant;</td>
</tr>
<tr>
<td>Women who are postpartum during the first year after pregnancy completion, regardless of the outcome of the pregnancy or placement of children; or</td>
</tr>
<tr>
<td>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).</td>
</tr>
</tbody>
</table>
### PPW Enhancement Rate Reporting Requirements

<table>
<thead>
<tr>
<th>Monthly Reports</th>
<th>On-site Child Care Services Report</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quarterly Reports</td>
<td>Federal Block Grant Quarterly Report of total program expenditures and revenue.</td>
</tr>
</tbody>
</table>

#### 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. Individuals in this program must also be enrolled in the Reaching Recovery Treatment for Adults with Criminal Legal System Involvement (section 2.8 as described above) outpatient program. Utilizes ongoing assessment and survey tools as determined by the Reaching Recovery model of care. Program staff meet with the County as requested to share learnings and discuss data milestones such as:

- Recovery Needs Level (RNL) as service needs change and participants move through recovery;
- Recovery Marker Inventory completed quarterly by Reaching Recovery staff;
- Consumer Recovery Measure completed quarterly by program participants; and
- Promoting Recovery in Organizations client surveys.

### Reaching Recovery Housing Eligibility Criteria

<table>
<thead>
<tr>
<th>Medicaid Status</th>
<th>Yes, unless covered by other identified fund sources</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age Range</td>
<td>Adults Aged 18 Years and Older</td>
</tr>
<tr>
<td>Authorization Needed</td>
<td>Yes</td>
</tr>
</tbody>
</table>
| Additional Criteria             | • 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;  

#### Reaching Recovery Housing Reporting Requirements

| Monthly Reports                  | Housing Status Report, due at the same time as BIP, which includes an update of each client engaged in a Housing Program within this scope, with the following additional data elements in order to track participant housing:  

- Name of individual participant;  
  - King County Identification (KCID) Number;  
  - Cohort as identified by referral code  
  - Other housing subsidies utilized, if any;  
  - Housing status;  
  - Rent costs per fund source; and  
  - Utilities and other housing-related expenses |

- The following cohorts and associated eligibility requirements are a subset of the target populations to be served under this section;  
- Offender Reentry Community Safety (ORCS); and  
- Integrated Dual Disorders Treatment (IDDT). |
### 8.9 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 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.

<table>
<thead>
<tr>
<th>Recovery Support Services (OUD) Eligibility Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid Status</td>
</tr>
<tr>
<td>Age Range</td>
</tr>
<tr>
<td>Authorization Needed</td>
</tr>
<tr>
<td>Additional Criteria</td>
</tr>
<tr>
<td>An individual whose earnings meet the agency’s criteria for eligibility for social services;</td>
</tr>
<tr>
<td>Individuals with a diagnosis of an opioid use disorder or individuals with a demonstrated history of opioid overdose problems; and</td>
</tr>
<tr>
<td>American Indian or Alaska Native individuals are prioritized for services.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Recovery Support Services (OUD) Reporting Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monthly Reports</td>
</tr>
<tr>
<td>• Recovery Support Services (OUD) Billing Summary</td>
</tr>
<tr>
<td>Annual/Other Reports</td>
</tr>
<tr>
<td>• If requested by the state Health Care Authority</td>
</tr>
<tr>
<td>• 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.</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Medicaid Status</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age Range</td>
<td>Adults and emancipated youth</td>
</tr>
<tr>
<td>Authorization Needed</td>
<td>No</td>
</tr>
</tbody>
</table>
| 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 will be prioritized for services. |

### Recovery Support Services (SUD) Reporting Requirements

<table>
<thead>
<tr>
<th>Monthly Reports</th>
<th>Recovery Support Services (SUD) Billing Summary</th>
</tr>
</thead>
</table>
| 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. |

## 8.10 Sobering Services

DCHS funds sobering services to strengthen the availability, quality, and coordination of crisis services for homeless persons.

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 disorder (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 general health screening interview. The Provider also provides 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, 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.
### Sobering Services Eligibility Criteria

<table>
<thead>
<tr>
<th>Medicaid Status</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age Range</td>
<td>18 years or older</td>
</tr>
<tr>
<td>Authorization Needed</td>
<td>No</td>
</tr>
</tbody>
</table>
| Additional Criteria | • Impacted by SUD,  
|                    | • Experiencing homelessness,  
|                    | • Impacted by a co-occurring mental health disorder, and/or  
|                    | • High utilizers of publicly funded crisis services.  
|                    | • Priority Populations: homeless veterans, American Indians, and Alaska Natives |

### Sobering Services Reporting Requirements

<table>
<thead>
<tr>
<th>Monthly Reports</th>
<th>Sobering Services Census Report</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual/Other Reports</td>
<td>If requested by DCHS.</td>
</tr>
</tbody>
</table>

8.11 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

<table>
<thead>
<tr>
<th>Medicaid Status</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age Range</td>
<td>Birth to 6 years of age</td>
</tr>
<tr>
<td>Authorization Needed</td>
<td>No</td>
</tr>
</tbody>
</table>
| 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.
8.12 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.

Per federal block grant requirements, Providers will 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.

<table>
<thead>
<tr>
<th>Tribal Mental Health Services Eligibility Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid Status</td>
</tr>
<tr>
<td>Age Range</td>
</tr>
<tr>
<td>Authorization Needed</td>
</tr>
<tr>
<td>Additional Criteria</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Tribal Mental Health Services Reporting Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quarterly Reports</td>
</tr>
<tr>
<td>The Provider submits the Mental Health Services Quarterly Report with the BIP in hard copy to the Behavioral Health and Recovery Division (BHRD) Contract Monitor as follows:</td>
</tr>
<tr>
<td>- The report for January 1, 2019 through March 31, 2019 is due by April 17, 2019;</td>
</tr>
<tr>
<td>- The report for April 1, 2019 through June 30, 2019 is due by July 17, 2019;</td>
</tr>
<tr>
<td>- The report for July 1, 2019 through September 30, 2019 is due by October 16, 2019; and</td>
</tr>
<tr>
<td>- The report for October 1, 2019 through December 31, 2019 is due by January 15, 2020.</td>
</tr>
</tbody>
</table>
8.13 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.

Per federal block grant requirements, Providers will 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.

<table>
<thead>
<tr>
<th>Tribal SUD Treatment Services Eligibility Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid Status</td>
</tr>
<tr>
<td>Age Range</td>
</tr>
<tr>
<td>Authorization Needed</td>
</tr>
<tr>
<td>Additional Criteria</td>
</tr>
</tbody>
</table>

**Tribal SUD Treatment Services Reporting Requirements**

<table>
<thead>
<tr>
<th>Quarterly Reports</th>
<th>The Provider submits the SUD Services Quarterly Report with the BIP in hard copy to the Behavioral Health and Recovery Division (BHRD) Contract Monitor as follows:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• The report for January 1, 2019 through March 31, 2019 is due by April 17, 2019;</td>
</tr>
<tr>
<td></td>
<td>• The report for April 1, 2019 through June 30, 2019 is due by July 17, 2019;</td>
</tr>
<tr>
<td></td>
<td>• The report for July 1, 2019 through September 30, 2019 is due by October 16, 2019;</td>
</tr>
<tr>
<td></td>
<td>• The report for October 1, 2019 through December 31, 2019 is due by January 15, 2020;</td>
</tr>
</tbody>
</table>
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.

<table>
<thead>
<tr>
<th>Adult Inpatient Diversion Bed Eligibility Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid Status</td>
</tr>
<tr>
<td>Age Range</td>
</tr>
<tr>
<td>Authorization Needed</td>
</tr>
</tbody>
</table>
| Additional Criteria | • 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. |

<table>
<thead>
<tr>
<th>Adult Inpatient Diversion Bed Reporting Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monthly Reports</td>
</tr>
</tbody>
</table>

9.2 Behavioral Health Ombuds Service of King County

The provision of Behavioral Health Ombuds Service in King County that assists with advocacy, support, client education, and investigation of an assistance with grievances and complaints. This program is designed to ensure that all eligible service recipients and their family members have access to advocacy and information that enables them to receive quality, medically necessary behavioral health services to which they are entitled. Direct service includes phone shifts, investigations, and other direct client...
contacts, site visits, grievances, fair hearings, and contract-required training. The Provider investigates formal or informal complaints or grievances brought to their attention about the County.

The Provider maintains an office approved by the County where clients can call, write, and/or visit to discuss their complaint or grievance. The Behavioral Health Ombuds Service of King County:

- Provides approximately 230 direct services hours per month,
- Is adequately staffed to ensure the Provider can act on client requests Monday through Friday 9:00 am to 5 pm (excluding King County recognized holidays) and other times as necessary,
- Maintain staff in the office at adequate levels to respond to walk-in requests for services Monday through Friday for a minimum of three hours per day,
- Post office hours at the Provider’s site,
- Offers live phone contact, Monday through Friday, 9:00 am to 5:00 pm,
- Maintains the availability of confidential voice mail that is accessible 24 hours a day and checked at least hourly during normal business hours;
- Maintains a voicemail message that identifies the hours staff are available by phone, hours staff are available in the office for walk-in appointments, and information as to when staff will return calls or respond to requests for services that occur after normal business hours or during weekends or holidays;
- Returns calls or requests for services that occur after normal business hours or during weekends and holidays by the next normal business working day;
- Allows the Ombuds Service team members to honor client choice in meeting with clients outside of the Provider place of business;
- Is accessible to all persons involved with the delivery of public behavioral health services in King County;
- Provides a service that respects cultural and ethnic diversity and is responsive to the needs of individuals with physical and sensory disabilities, including Homebound; sensitivity to cultural differences and maintaining policies and procedures to access cultural and language assistance when necessary; maintaining and following procedures on the use of interpreters, listening devices, braille or large print materials, and other accommodations upon request as required under the Americans with Disabilities Act (ADA); and
- Assists the County and contracted Providers to encourage access to service by designated special population groups: African Americans, Asian/Pacific Islanders, Hispanics, American Indians and Alaska Natives, sexual minorities, older adults, individuals who are deaf or hard of hearing, and the medically compromised Plan and carry out a public education campaign aimed at Providers, service recipients and their families, and the general public to advertise the service, including the development and maintenance of current brochures, posters, and promotional materials;
- Builds and maintains working relationships with the County and its subcontractors and allied service systems to ensure that all are aware of the service and how to access it;
- Maintains Ombuds Service policies and procedures (P&P) for accessing relevant information for the purpose of investigating individual grievances;
- Keep current copies of the King County Behavioral Health Administrative Services Organization (BH-ASO) Policies and Procedures and each contracted behavioral health service Provider complaint and grievance policies and procedures on file and make them accessible to service recipients and their family members; and
• Ensure each Ombuds Service investigative staff completes Washington State and County-authorized trainings annually and at minimum, with three of the following training topics: behavioral health service delivery system in King County, child behavioral health care issues, including what is included at the King County Cross Agency Systems Training (CAST) for children, Wraparound Model Training, Family/Professional Partnership Training, and training offered by allied child-serving systems (juvenile justice, schools, child welfare), such as Individual Education Plan information; referral organizations and their functions; (e.g. Home and Community Services and the Department of Health and Human Services); confidentiality statutes including the Health Insurance Portability and Accountability Act of 1996 (HIPAA); culturally appropriate services; legal system functions, including involuntary commitment, documents and authorization regarding client consent, and release of information; and skills in mediation and conflict resolution.

### Behavioral Health Ombuds Service Eligibility Criteria

<table>
<thead>
<tr>
<th>Medicaid Status</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age Range</td>
<td>N/A</td>
</tr>
<tr>
<td>Authorization Needed</td>
<td>No</td>
</tr>
</tbody>
</table>

**Additional Criteria**

- All Medicaid-eligible recipients in King County who are receiving publicly funded behavioral health services or, in the case of a child, a parent or family member of a service recipient, or a Medicaid-enrolled individual who may wish to receive publicly funded behavioral health services.
- All non-Medicaid residents of King County who are receiving publicly funded behavioral health services or a financially eligible resident who may wish to receive publicly funded behavioral health services as funding and resources allow.

### Behavioral Health Ombuds Service Reporting Requirements

<table>
<thead>
<tr>
<th>Monthly Reports</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ombuds Service Report</td>
</tr>
<tr>
<td>Ombuds Service Time Sheet</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Quarterly Reports</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ombuds Service Telephone Contact Log</td>
</tr>
<tr>
<td>Grievances and Fair Hearings Report</td>
</tr>
<tr>
<td>The report includes the number and type of grievances received and the number resolved and fair hearings according to the template format.</td>
</tr>
<tr>
<td>The report includes grievances occurring at subcontractors, combine information with that identified in the KCBHP Outpatient Benefit Scopes, and follow the Outpatient Benefit Scope Reporting Requirements.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Semi-Annual Reports</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ombuds Service Semi-Annual Reports</td>
</tr>
</tbody>
</table>
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 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

<table>
<thead>
<tr>
<th>Medicaid Status</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age Range</td>
<td>18 years and older</td>
</tr>
<tr>
<td>Authorization Needed</td>
<td>Yes</td>
</tr>
</tbody>
</table>

**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 Detoxification Service;
- The Mobile Crisis Team if not referred to the CSC;
- HMC Psychiatric Consultation Services: and
- Internal referrals including CDIS, CDF, PACT, 3B, 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.

<table>
<thead>
<tr>
<th>Diversion and Reentry Care Coordination Eligibility Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid Status</td>
</tr>
<tr>
<td>Age Range</td>
</tr>
<tr>
<td>Authorization Needed</td>
</tr>
<tr>
<td>Additional Criteria</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Diversion and Reentry Care Coordination Reporting Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monthly Reports</td>
</tr>
</tbody>
</table>

9.5 HARPS Housing Bridge Subsidy for SHARP

The Services and Housing to Access Recovery Program (SHARP) uses the Housing and Recovery through Peer Services (HARPS) Housing Bridge Subsidy funds for expenses related to housing placement and time-limited housing supports. SHARP must apply internal controls to ensure that invoiced costs are accurate, reasonable and aligned with both reimbursement criteria and generally accepted accounting principles. It is expected that SHARP will deny payment or appeal invoiced costs that are deemed unreasonable and/or unsubstantiated. Reimbursable expenditures include:

Expenditures may include:

- Monthly rent and utilities, and any combination of first and last months’ rent for up to three months. Payments beyond three months may be provided with county pre-approval.
- 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;
- 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. Payments beyond three months may be provided with 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), SHARP may pay for the household’s rent for up to 60 days per year. Payments beyond 60 days may be provided with County pre-approval.

<table>
<thead>
<tr>
<th>HARPS Housing Bridge Subsidy for SHARP Eligibility Criteria</th>
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<tbody>
<tr>
<td><strong>Medicaid Status</strong></td>
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<tr>
<td><strong>Age Range</strong></td>
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<tr>
<td><strong>Authorization Needed</strong></td>
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</tbody>
</table>
| **Additional Criteria** | • Referred to Provider by King County Coordinated Entry for All (CEA)  
  • King County Resident  
  • Meets the federal definition for chronically homeless,  
  • Diagnosed with mental health, SUD or co-occurring mental health disorders and SUD;  
  • Significant functional impairment, and  
  • Voluntarily consents to SHARP services |

<table>
<thead>
<tr>
<th>HARPS Housing Bridge Subsidy for SHARP Reporting Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Monthly Reports</strong></td>
</tr>
</tbody>
</table>

9.6 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 100 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 will 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**

<table>
<thead>
<tr>
<th>Medicaid Status</th>
<th>N/A</th>
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</thead>
<tbody>
<tr>
<td>Age Range</td>
<td>N/A</td>
</tr>
<tr>
<td>Authorization Needed</td>
<td>No</td>
</tr>
</tbody>
</table>

**Additional Criteria**

- Individuals meet the standards for low-income client eligibility as described in the state Department of Social and Health Services (DSHS) 2012-2014 Biennium Low-Income Service Eligibility Table, or its successors.
- 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**

<table>
<thead>
<tr>
<th>Monthly Reports</th>
<th>A HASAP Adult Care Enhancement report that lists total payroll hours and days worked each month.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quarterly Reports</td>
<td>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).</td>
</tr>
</tbody>
</table>

9.7 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 ensures that:

- Services are provided to a minimum of 360 individuals annually;
- At least 92 percent (331) of the people served during contracted period are homeless;
• Of the PATH-eligible individuals contacted, at least 150 unduplicated individuals become enrolled in PATH annually and of the PATH-eligible individuals contacted, at least 150 unduplicated individuals become enrolled in PATH annually; and

• At least 92 percent of the individuals served annually receive community mental health services.

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 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

<table>
<thead>
<tr>
<th>Medicaid Status</th>
<th>N/A</th>
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</thead>
<tbody>
<tr>
<td>Age Range</td>
<td>Adults Aged 18 Years and Older</td>
</tr>
<tr>
<td>Authorization Needed</td>
<td>No</td>
</tr>
</tbody>
</table>
| 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

<table>
<thead>
<tr>
<th>Monthly Reports</th>
<th>KCMHP Transition Report in an electronic format provided by the County.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quarterly Reports</td>
<td>HOST Report</td>
</tr>
</tbody>
</table>

#### 9.8 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

<table>
<thead>
<tr>
<th>Medicaid Status</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age Range</td>
<td>Ages 13 and Up</td>
</tr>
<tr>
<td>Authorization Needed</td>
<td>Yes</td>
</tr>
<tr>
<td>Additional Criteria</td>
<td>Individuals coming from community hospitals that utilize the King County Involuntary Commitment Court and Evaluation and Treatment (E&amp;T) facilities</td>
</tr>
</tbody>
</table>

### ITA Transportation Reporting Requirements

| Monthly Reports | Court Times Report |

### 9.9 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

<table>
<thead>
<tr>
<th>Medicaid Status</th>
<th>N/A</th>
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</thead>
<tbody>
<tr>
<td>Age Range</td>
<td>Adults Aged 18 Years and Older</td>
</tr>
<tr>
<td>Authorization Needed</td>
<td>Yes</td>
</tr>
<tr>
<td>Additional Criteria</td>
<td></td>
</tr>
</tbody>
</table>
- 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

<table>
<thead>
<tr>
<th>Monthly Reports</th>
<th>LINC Report</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Annual/Other Reports</strong></td>
<td></td>
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<tr>
<td>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.</td>
<td></td>
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<tr>
<td>Any other requested reports by the County.</td>
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</tbody>
</table>

### 9.10 PATH

Outreach, engagement, and transitional support services to individuals in communities of south and east King County 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, at minimum, 1.6 FTE outreach case managers to provide outreach, engagement, and/or case management services for individuals experiencing homelessness in the communities of south and east King County and 0.1 FTE to provide clinical supervision for the staff providing PATH services. These staff members have received training on the Theoretical Model of Outreach and Engagement Process developed by Craig Rennebohm. Each client has client records which include identification of presenting problems, condition and functioning of the client throughout treatment, history and symptoms of the client’s mental illness, assessment of basic needs, assessment of SUD needs, a service plan, regular notation of client’s progress, and documentation that a client rights statement was shared and informed consent was signed (or not signed). The PATH program can allow a 45-day period of overlap in services when needed to help ensure a treatment alliance is formed with new care staff.

The Provider meets BHRD requirements as follows:

• A minimum of 250 to 375 individuals are contacted during the federal fiscal year.
• At least 175 of the individuals contacted during the federal fiscal year are homeless.
• A minimum of 150 unduplicated individuals are enrolled in PATH during the federal fiscal year.
• At least 55 percent of the individuals served during the federal fiscal year.

Case Management services in this program include the following:

• In partnership with the PATH-eligible client, preparing a plan for the provision of community mental health services or co-occurring mental health and SUD services to PATH-eligible clients experiencing homelessness involved and reviewing the plan not less than once every three months;
• Providing assistance in obtaining and coordinating social and maintenance services for PATH-eligible clients experiencing homelessness, including services relating to daily living activities, personal financial planning, transportation, habilitation and rehabilitation services, prevocational and vocational services, and housing services;
• Providing assistance to PATH-eligible clients experiencing homelessness in obtaining income support services, including housing assistance, food stamps, supplemental security, disability income benefits, and veterans’ benefits;

• Referring the PATH-eligible client experiencing homelessness for other services consistent with the PATH client’s needs; and

• Providing representative payee services in accordance with Section 161(a) (2) of the Social Security Act if the PATH-eligible client experiencing homelessness is receiving aid under Title XVI of the Act.

PATH staff ensure that enrolled PATH clients have access to medical services including the prescribing of medication, health screening and referral/linkage for services they are eligible for. PATH clients are screened for eligibility for all possible benefits, including at a minimum:

• Services under the KCBHP and BHRD including but not limited to emergency services, psychiatric and medical, residential, employment, and community support services;

• Housing services and resources;

• Veterans services;

• Supplemental Security Income/Social Security Disability Income (SSI/SSDI) or other disability and financial benefits;

• American Indian/Native American benefits;

• Economic services;

• Medical services;

• SUD services; and

• Vocational rehabilitation services.

**PATH Eligibility Criteria**

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<thead>
<tr>
<th>Medicaid Status</th>
<th>N/A</th>
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<tbody>
<tr>
<td>Age Range</td>
<td>Adults Aged 18 Years and Older</td>
</tr>
<tr>
<td>Authorization Needed</td>
<td>No</td>
</tr>
</tbody>
</table>
| 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 unable or unwilling to access community-based services through the King County Behavioral Health Plan (KCBHP) due to clinical reasons and not just financial limitations; and
  • Are not receiving other Behavioral Health and Recovery Division (BHRD)-funded ongoing services.
  
Individuals are not PATH-eligible when:
  • The Veterans Administration (VA) and/or subcontractors of the VA are providing the full range of needed services stipulated by PATH statutes and regulations;
  • They are enrolled in the KCBHP and/or 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;

- They are housed for a period up to one year; or
- They are receiving all necessary services from other treatment systems.

**PATH Reporting Requirements**

<table>
<thead>
<tr>
<th>Monthly Reports</th>
<th>LINC Report</th>
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</thead>
<tbody>
<tr>
<td>Quarterly Reports</td>
<td>PATH FTE Report</td>
</tr>
<tr>
<td>Annual/Other Reports</td>
<td>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.</td>
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<td></td>
<td>Any other requested reports by the County.</td>
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</table>

### 9.11 Pathfinder Peer Project

The Pathfinder Peer Project is a grant-funded program under the State Opioid Response (SOR) and will build 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 will link individuals to needed treatment, including Medication-Assisted Treatment (MAT) services, and assist in navigating systems and addressing barriers to independence and recovery. 2.0 FTE SUD Peers work with clients to obtain health coverage by navigating the Medicaid application process and tracking the application through the application process. These SUD Peers provide outreach and engagement services in emergency rooms and homeless encampments to individuals who are homeless or at risk of homelessness. Clients are screened using the SBIRT tool for behavioral health issues and provided warm hand-offs to behavioral health services. Service plans are created that include SUD and Mental health needs, assessments, activities of daily living needs, and linkages as well as client voice.

**Pathfinder Eligibility Criteria**

<table>
<thead>
<tr>
<th>Medicaid Status</th>
<th>N/A</th>
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<tbody>
<tr>
<td>Age Range</td>
<td>Adults Aged 18 Years and Older</td>
</tr>
<tr>
<td>Authorization Needed</td>
<td>Yes</td>
</tr>
<tr>
<td>Additional Criteria</td>
<td>Individuals with an unmet treatment need who are experiencing an OUD and are:</td>
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<td></td>
<td>• Reentering into the community from correctional facilities;</td>
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<td>• Experiencing homeless;</td>
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<td>• At risk of overdose; or</td>
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<td></td>
<td>• A member of a Tribal community.</td>
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</table>

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.

Quarterly Reports

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.

9.12 Services and Housing to Access Recovery Program (SHARP)

Services and Housing to Access Recovery Program (SHARP) provides housing placement and behavioral health supports to homeless single adults through community-based services. Individuals are prioritized and referred to SHARP through King County’s Coordinated Entry for All (CEA) system. SHARP is typically assigned adults that are highly vulnerable with little or no connection to other service Providers. SHARP is a multidisciplinary team consisting of a mental health professional, case managers, housing specialists, substance use disorder professional, peer counselor and nurse. Services are intended to be temporary with the eventual goal of enrolling clients in clinic-based, behavioral health services and/or other relevant community supports. The duration of a client’s enrollment in SHARP is person-specific, dependent on the needs, objectives and abilities of each individual. SHARP services include

- Outreach and engagement;
- Individual and group interventions;
- Mental health and substance use disorder (SUD) treatment services;
- Housing placement and support services;
- Peer support services;
- Assessment, referral and coordination of medical treatment;
- Assessment, prescribing and monitoring of medication treatment; and
- Assistance in accessing financial support and cash benefits, transportation, social services and legal assistance

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<tr>
<th>SHARP Eligibility Criteria</th>
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<td>Medicaid Status</td>
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<td>Age Range</td>
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<td>Authorization Needed</td>
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<td>Additional Criteria</td>
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• Voluntarily consent to SHARP services.
9.13 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.

<table>
<thead>
<tr>
<th>Youth Support Services Outstation/Recovery School Eligibility Criteria</th>
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<tbody>
<tr>
<td>Medicaid Status</td>
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<tr>
<td>Age Range</td>
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<tr>
<td>Authorization Needed</td>
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<td>Additional Criteria</td>
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9.14 Transition Support Program

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, 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 consist of the following specialties and capacities.

• Peer Specialists;
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 complement 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;
- Assists program clients with transportation, which may include accompanying clients to appointments and/or helping to increase their skills in using public transportation; and

<table>
<thead>
<tr>
<th>Transition Support Program Services Eligibility Criteria</th>
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<tbody>
<tr>
<td>Medicaid Status</td>
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<tr>
<td>Age Range</td>
</tr>
<tr>
<td>Authorization Needed</td>
</tr>
<tr>
<td>Additional Criteria</td>
</tr>
<tr>
<td>Individuals involuntarily detained at King County psychiatric hospitals and E&amp;T facilities and who meet the following conditions:</td>
</tr>
<tr>
<td>Not enrolled or marginally engaged in the publicly funded behavioral health system; and</td>
</tr>
<tr>
<td>Willing to participate in the TSP.</td>
</tr>
<tr>
<td>Priority is given to individuals that are placed on Single Bed Certifications (SBCs) and/or exhibit a history of frequent psychiatric hospitals admissions or other high-intensity services.</td>
</tr>
<tr>
<td>The majority of individuals are King County residents, but the program serves individuals without regard to their county of residence.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Transition Support Program Reporting Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monthly Reports</td>
</tr>
</tbody>
</table>
9.15 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 will 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 do 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.

<table>
<thead>
<tr>
<th>Telephone Support for CCS Reporting Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monthly Reports</td>
</tr>
<tr>
<td>• Triage Summary Report – CCS Public Phone Line</td>
</tr>
<tr>
<td>• Telephone Summary Report – CCS Professional Phone Line</td>
</tr>
<tr>
<td>Annual/Other Reports</td>
</tr>
<tr>
<td>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.</td>
</tr>
</tbody>
</table>
9.16 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.

<table>
<thead>
<tr>
<th>Intensive Care Management Team (Vital) Eligibility Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Medicaid Status</strong></td>
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<tr>
<td><strong>Age Range</strong></td>
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<tr>
<td><strong>Authorization Needed</strong></td>
</tr>
<tr>
<td><strong>Additional Criteria</strong></td>
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</table>

<table>
<thead>
<tr>
<th>Intensive Care Management Team (Vital) Reporting Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Monthly Reports</strong></td>
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<tr>
<td></td>
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<tr>
<td><strong>Annual/Other Reports</strong></td>
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</tbody>
</table>

9.17 Diversion and Reentry Housing and Support

Diversion and Reentry Housing and Support programs provide 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

<table>
<thead>
<tr>
<th>Medicaid Status</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age Range</td>
<td>Adults Aged 18 years and Older</td>
</tr>
<tr>
<td>Authorization Needed</td>
<td>No</td>
</tr>
</tbody>
</table>
| 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

<table>
<thead>
<tr>
<th>Monthly Reports</th>
<th>DRS Interim Housing Report</th>
</tr>
</thead>
</table>
| 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 |

### 9.17.1 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

<table>
<thead>
<tr>
<th>Medicaid Status</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age Range</td>
<td>Adults Aged 18 years and Older</td>
</tr>
<tr>
<td>Authorization Needed</td>
<td>No</td>
</tr>
</tbody>
</table>
| 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 | Data and Status Report  
• Housing Data Log, as provided by the County |
9.19 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.

<table>
<thead>
<tr>
<th>Veterans Reentry Services Program Eligibility Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid Status</td>
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<tr>
<td>Age Range</td>
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<tr>
<td>Authorization Needed</td>
</tr>
<tr>
<td>Additional Criteria</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Veterans Reentry Services Program Reporting Requirements</th>
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</thead>
<tbody>
<tr>
<td>Monthly Reports</td>
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<tr>
<td></td>
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<tr>
<td>Annual/Other Reports</td>
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<tr>
<td></td>
</tr>
</tbody>
</table>
10 Mental Illness and Drug Dependency (MIDD) Locally Funded Programs

The following programs receive funding through Mental Illness and Drug Dependency (MIDD). 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 Evaluation Plan and MIDD Data Submission Plan

Providers comply with the MIDD Evaluation Plan and MIDD Data Submission Plan. Data is submitted 15 calendar days after the end of the month for which data is being reported, unless stated otherwise. DCHS reviews each data submission and notifies the Provider of any needed corrective action. Data is corrected and resubmitted within 14 calendar days of notification.

10.1 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 Mental Illness and Drug Dependency (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

<table>
<thead>
<tr>
<th>Medicaid Status</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age Range</td>
<td>Over 18</td>
</tr>
<tr>
<td>Authorization Needed</td>
<td>No</td>
</tr>
<tr>
<td>Additional Criteria</td>
<td>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: Dutch Shisler Service Center (DSSC), Harborview Medical Center (HMC), and/or King County Correctional Facility.</td>
</tr>
</tbody>
</table>
Chapter 10 MIDD Locally Funded Programs

10.2 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 Mental Illness and Drug Dependency (MIDD) 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.

<table>
<thead>
<tr>
<th>CDVRT Eligibility Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid Status</td>
</tr>
<tr>
<td>Age Range</td>
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<tr>
<td>Authorization Needed</td>
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</tbody>
</table>
### Additional Criteria
Reside in King County and experience domestic violence

### CDVRT Reporting Requirements

<table>
<thead>
<tr>
<th>Monthly Reports</th>
<th>CDVRT Summary; client data submission through CORE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quarterly Reports</td>
<td>CDVRT Outcomes Report</td>
</tr>
<tr>
<td>Annual/Other Reports</td>
<td>CDVRT Outcomes Report</td>
</tr>
</tbody>
</table>

## 10.3 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 Mental Illness and Drug Dependency (MIDD) Initiative RR-12 – *Jail-based Substance Abuse Treatment*. 
### Corrections-based SUD Services Eligibility Criteria

<table>
<thead>
<tr>
<th>Medicaid Status</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age Range</td>
<td>Adults aged 18 Years or Older</td>
</tr>
<tr>
<td>Authorization Needed</td>
<td>Yes</td>
</tr>
</tbody>
</table>
| 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

<table>
<thead>
<tr>
<th>Annual/Other Reports</th>
</tr>
</thead>
</table>
|                      | • 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 and the MIDD Data Submission Plan. |

### 10.4 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

<table>
<thead>
<tr>
<th>Medicaid Status</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age Range</td>
<td>18-24 years old</td>
</tr>
<tr>
<td>Authorization Needed</td>
<td>No</td>
</tr>
</tbody>
</table>
| 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 |

### 10.5 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 Mental Illness and Drug Dependency (MIDD)
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

<table>
<thead>
<tr>
<th>Monthly Reports</th>
<th>DV-BH Staffing, DV-BH Service Summary, client data submission through CORE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual/Other Reports</td>
<td>DV-BH Annual Outcomes Report</td>
</tr>
</tbody>
</table>

### 10.6 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 Mental Illness and Drug Dependency (MIDD) 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 will 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.

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**Domestic Violence Behavioral Health (DV-BH) Services and Culturally Specific Supports Eligibility Criteria**

<table>
<thead>
<tr>
<th>Medicaid Status</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age Range</strong></td>
<td>Youth or adults (no age restrictions) who identify as domestic violence survivors. Primary population served are refugees or immigrants.</td>
</tr>
<tr>
<td><strong>Authorization Needed</strong></td>
<td>No</td>
</tr>
<tr>
<td><strong>Additional Criteria</strong></td>
<td>Must have no other source of payment for services (i.e. does not have Medicaid, other insurance, etc.)</td>
</tr>
</tbody>
</table>

**Domestic Violence Behavioral Health (DV-BH) Services and Culturally Specific Supports Reporting Requirements**

<table>
<thead>
<tr>
<th>Monthly Reports</th>
<th>DV-BH Staffing, DV-BH Service Summary, Interpreter Services Summary, Monthly client data submission through CORE</th>
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</thead>
<tbody>
<tr>
<td>Annual/Other Reports</td>
<td>DV-BH Annual Outcomes Report</td>
</tr>
</tbody>
</table>

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### 10.7 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 Mental Illness and Drug Dependency (MIDD) 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.
Chapter 10 MIDD Locally Funded Programs

- Coordination of specialized cross-system training for up to 160 clinical or advocacy staff from community behavioral health, domestic violence and/or sexual assault agencies each year.

- 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.

- 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 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                | No               |
| Additional Criteria                 | Community-based Providers who provide domestic violence, sexual assault or behavioral health services to survivors are eligible for this service. |

<table>
<thead>
<tr>
<th>Domestic Violence-Sexual Assault Behavioral Health Systems Coordination Reporting Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monthly Reports</td>
</tr>
<tr>
<td>System Coordination Staffing, Training Report, Activity Report</td>
</tr>
<tr>
<td>Annual/Other Reports</td>
</tr>
<tr>
<td>Annual Outcomes Report</td>
</tr>
</tbody>
</table>

10.8 Emergency Dept/Psych Emergency Services Care Manager

Harborview Medical Center (HMC) Psychiatric Emergency Services (PES) will employ 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 Mental Illness and Drug Dependency (MIDD) 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 will be focused on high utilizer clients defined as a person who visits the PES or ED 4 or more times within 90 days, uses the Dutch Shisler Services Center 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 will provide coverage between the hours of 8 am to 5 pm Monday through Friday. Staffing, at minimum, will be 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 will 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 and MIDD Data Submission 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     |

<table>
<thead>
<tr>
<th>Emergency Department/Psych Emergency Services Care Manager Reporting Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monthly Reports</td>
</tr>
<tr>
<td>- ED PES Care Manager FTE Report</td>
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<tr>
<td>- ED PES Care Manager Voucher Detail Report</td>
</tr>
<tr>
<td>Quarterly Reports</td>
</tr>
<tr>
<td>ED PES Care Manager Log</td>
</tr>
<tr>
<td>Annual/Other Reports</td>
</tr>
<tr>
<td>ED PES Annual Outcome Report</td>
</tr>
</tbody>
</table>

10.9 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

<table>
<thead>
<tr>
<th>Medicaid Status</th>
<th>Medicaid eligible individuals are prioritized</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age Range</td>
<td>Adults at 18+</td>
</tr>
<tr>
<td>Authorization Needed</td>
<td>No</td>
</tr>
</tbody>
</table>
| 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 will develop (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 will submit 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.

10.10 Family Support Organization

This program provides resources and support to families in King County, including youth peer and parent partner supports. The program is provided in accordance with the Mental Illness and Drug Dependency (MIDD) Plan Initiative CD-12- Parent Partners Family Assistance as outlined in the MIDD initiative description: [CD-12 Description](#)

The Provider ensures equitable access to services throughout the King County Region. The Family Support Organization hires staff that are:

- Washington State Certified Peer counselors or have experience providing or receiving paraprofessional child/parent peer supports,
- Have lived experience as a parent of youth receiving services from child serving systems (e.g., mental health treatment system, substance abuse treatment system, child welfare and juvenile justice system); and
- Reflect the cultural and ethnic diversity of the children, youth and families engaged in the services.
- Program staff provide (including Parent Partners):
  - Flexible and accessible parent/caregiver 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 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; and
  - 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.

The Provider organizes and provides a family social event, at minimum, once per quarter. 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 Provider, in collaboration with other child-serving organizations, participates in or sponsors up to four distinct classes for parents as identified in the annual work plan. 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 provides sponsorship of trainings by providing the location, publicizing the training through the Provider network and collaborating partnerships, and providing additional supports as needed 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 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.
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.

The Provider maintains an information and referral line. 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; and pilots and implements the information and referral line as identified in the annual work plan.

<table>
<thead>
<tr>
<th><strong>Family Support Organization Eligibility Criteria</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Medicaid Status</strong></td>
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<tr>
<td><strong>Age Range</strong></td>
</tr>
<tr>
<td><strong>Authorization Needed</strong></td>
</tr>
<tr>
<td><strong>Additional Criteria</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Family Support Organization Reporting Requirements</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Monthly Reports</strong></td>
</tr>
<tr>
<td><strong>Quarterly Reports</strong></td>
</tr>
<tr>
<td><strong>Annual/Other Reports</strong></td>
</tr>
</tbody>
</table>

10.11 **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 will work with FTC staff to maintain a steady stream of referrals and waitlist for Wraparound Services. When capacity becomes available, ETC Facilitator will reach 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. |

<table>
<thead>
<tr>
<th>FAMILY TREATMENT COURT WRAPAROUND Reporting Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monthly Reports</td>
</tr>
<tr>
<td>Annual/Other Reports</td>
</tr>
</tbody>
</table>

10.12 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 Mental Illness and Drug Dependency (MIDD) Initiative RR-02 – Behavior Modification Classes for Community Center for Alternative Program Clients.

<table>
<thead>
<tr>
<th>Forensic Treatment Program at CCAP Eligibility Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid Status</td>
</tr>
<tr>
<td>Age Range</td>
</tr>
<tr>
<td>Authorization Needed</td>
</tr>
<tr>
<td>----------------------</td>
</tr>
<tr>
<td><strong>Additional Criteria</strong></td>
</tr>
<tr>
<td>• 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;</td>
</tr>
<tr>
<td>• SUD Outpatient Services: CCAP participants who meet medical necessity for outpatient or intensive outpatient (IOP) treatment services; and</td>
</tr>
<tr>
<td>• Mental Health Outpatient Services: CCAP participants who are assessed as appropriate and eligible for a Mental Health Outpatient Benefit as described in the Medicaid State Plan.</td>
</tr>
</tbody>
</table>
## Forensic Treatment at CCAP Reporting Requirements

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Monthly Reports</strong></td>
<td>• As requested by DCHS evaluator CCAP Staffing Report;</td>
</tr>
<tr>
<td></td>
<td>• Flex Fund Expenditures Report;</td>
</tr>
<tr>
<td></td>
<td>• Subsidized Client Report;</td>
</tr>
<tr>
<td></td>
<td>• Treatment Services Denial Report.</td>
</tr>
<tr>
<td><strong>Quarterly Reports</strong></td>
<td>As requested by DCHS evaluator</td>
</tr>
<tr>
<td><strong>Semiannual Reports</strong></td>
<td>As requested by DCHS evaluator</td>
</tr>
<tr>
<td><strong>Annual/Other Reports</strong></td>
<td>• 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.</td>
</tr>
<tr>
<td></td>
<td>• Participates with the MIDD Evaluation Plan and the MIDD Data Submission Plan.</td>
</tr>
</tbody>
</table>

### 10.13 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 Mental Illness and Drug Dependency (MIDD) Initiative S103.

### Program Specific Requirements:

Teams will 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 will work collaboratively with HA staff who will facilitate introduction to target buildings and provide assistance in identifying HA residents with suspected unmet needs. In SHA buildings HOP teams will also need to work collaboratively with other service Providers to maximize effectiveness and avoid duplication of service. HOP teams will 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 will 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 each 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: (a) directly from HA building staff and (b) from BHRD based on client lists from HAs matched to BHRD service data. Sound will provide regular communication with HA building management regarding the status of service engagement with individuals referred.

Performance Measurement and Evaluation
The HOP program will work 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**

<table>
<thead>
<tr>
<th>Metric name</th>
<th>Definition/How measured</th>
<th>Upfront %/Incentive %</th>
<th>Upfront month</th>
<th>Incentive pay determination month (by 15th of last month listed)</th>
<th>Incentive payment month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Early implementation - 3 months (Dec – Feb) total</td>
<td>$437,218</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Collaborative design</td>
<td>Developed written referral and operating protocols with Crisis Connections, SHA, KCHA and BHRD</td>
<td>70%/30%</td>
<td>January</td>
<td>February</td>
<td>March</td>
</tr>
<tr>
<td>Hiring rapidly</td>
<td>9 of 11 staff hired</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Data flow</td>
<td>Initiated electronic data and report transmission (per PME plan)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Process - 4 months total $582,958</td>
<td>(March – June performance)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>How much?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>New enrollees</td>
<td>Monthly avg of 35 new enrollees</td>
<td>60%/40%</td>
<td>March</td>
<td>March-June</td>
<td>July</td>
</tr>
<tr>
<td># Served</td>
<td>Monthly avg of 125 enrolled with at least one service in month</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>How well?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Linkage to care</td>
<td>65% of enrollees exited in month have at least 1 confirmed linkage</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outcome – 6 months total $874,437</td>
<td>(July - December performance)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anyone better off?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Housing stability</td>
<td>Statistically significant reduction in challenging behaviors log (by 6 months post) as leading indicator of housing instability (per PME plan)</td>
<td>50%/50%</td>
<td>July</td>
<td>July-December</td>
<td>January</td>
</tr>
</tbody>
</table>

NOTE: Must also maintain “How much” and “How well” rates for incentive
**PME/BHRD Activities**

PME/BHRD will provide 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 will collaborate 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 will facilitate meetings with the agency and HA – at least quarterly - in which performance measurement and data from reporting and evaluation will be discussed as a means to identify program strengths and areas for further improvement. These meetings will also be the forum for determining steps that the program, SHA/KCHA and/or BHRD may take to support program improvement efforts.

<table>
<thead>
<tr>
<th>Housing Outreach Partners Eligibility Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid Status</td>
</tr>
<tr>
<td>Age Range</td>
</tr>
<tr>
<td>Authorization Needed</td>
</tr>
<tr>
<td>Additional Criteria</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Housing Outreach Partners Reporting Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monthly Reports</td>
</tr>
<tr>
<td>Other Data</td>
</tr>
</tbody>
</table>

**10.14 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 Professional’s, one Family Partner 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 Family Partner compliments the JJAT team and provides significant support to the youth and their family other than screening and assessment. The Family Partner is responsible for providing enhanced liaison services to selected youth and their significant supports that may include developing an individualized action plan that includes the recommendations from the assessment; providing linkage to services within their community to meet these needs; supporting youth and their supports through the court process (court hearings, probation appointments, detention visits, etc.); engaging in treatment and other services; and linking youth with pro-social activities in their community – mentorship, athletics, arts, employment, etc.

The JJAT team is responsible for following: the JJAT Program Guidelines and Protocols document.

<table>
<thead>
<tr>
<th>Juvenile Justice Assessment Team Eligibility Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid Status</td>
</tr>
<tr>
<td>Age Range</td>
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<tr>
<td>Authorization Needed</td>
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<tr>
<td>Additional Criteria</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Juvenile Justice Assessment Team Reporting Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monthly Reports</td>
</tr>
</tbody>
</table>

10.15 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. Engagement in the community and addressing neighborhoods’ concerns with criminal activity and public safety, while providing ongoing education and ongoing dialogue with community leaders, are essential components. 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.
## Law Enforcement Assisted Diversion Eligibility Criteria

<table>
<thead>
<tr>
<th>Medicaid Status</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age Range</td>
<td>Adults Aged 18 Years and Older</td>
</tr>
<tr>
<td>Authorization Needed</td>
<td>Yes</td>
</tr>
<tr>
<td>Additional Criteria</td>
<td></td>
</tr>
</tbody>
</table>
- 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

<table>
<thead>
<tr>
<th>Monthly Reports</th>
<th>Staffing Report for all contracted and subcontracted agencies providing LEAD services.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quarterly Reports</td>
<td>Summary Reports</td>
</tr>
<tr>
<td>Annual/Other Reports</td>
<td></td>
</tr>
</tbody>
</table>
- Two vignettes from individuals served in the program
- Any other requested reports by the County

### 10.16 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, will 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 will be filled through pharmacies which have working relationships with the Provider. For those participants without Medicaid, flexible funds built into the program budget will be 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 will 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.
Chapter 10 MIDD Locally Funded Programs

<table>
<thead>
<tr>
<th>Low Barrier Buprenorphine Service Coordination Eligibility Criteria</th>
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<tbody>
<tr>
<td>Medicaid Status</td>
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<tr>
<td>Age Range</td>
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<tr>
<td>Authorization Needed</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Additional Criteria</th>
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<tbody>
<tr>
<td>Individuals will receive priority services as described in the King County Behavioral Health Organization (KCBH) Provider Manual</td>
</tr>
<tr>
<td>Individuals reside in King County</td>
</tr>
<tr>
<td>Individuals meet the medical criteria as identified by the attending physician</td>
</tr>
<tr>
<td>Individuals meet the Provider’s program eligibility criteria</td>
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</table>

<table>
<thead>
<tr>
<th>Low Barrier Buprenorphine Service Reporting Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quarterly Reports</td>
</tr>
<tr>
<td>Low-Barrier Buprenorphine Report in a format approved by BHRD.</td>
</tr>
<tr>
<td>Annual/Other Reports</td>
</tr>
<tr>
<td>The Provider participates with the MIDD Evaluation Plan and the MIDD Data Submission Plan.</td>
</tr>
<tr>
<td>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.</td>
</tr>
</tbody>
</table>

10.17 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 will provide Medication-Assisted Treatment (MAT) to people utilizing King County shelters and encampments. This program is funded by the Mental Illness and Drug Dependency (MIDD) 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 contractor’s knowledge of high need areas of the County. The Provider will consult 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 will keep 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 will collect client enrollment and demographic data in a format that aligns with King County. The format that data will be 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 will be collected in a format appropriate to the program model. Information about clients served should be collected continuously by the funded program and will be regularly reported via DCHS’ online reporting system currently under development. Data will be used to assess the quality of the services that clients receive, and the outcomes related to the program participants. Client-level data elements will include client demographics, basic information about services provided, and outcomes of those services. The County will work 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 will 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 will be 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

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<thead>
<tr>
<th>Medicaid Status</th>
<th>N/A</th>
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<tbody>
<tr>
<td>Age Range</td>
<td>Adults and Youth</td>
</tr>
<tr>
<td>Authorization Needed</td>
<td>No</td>
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<tr>
<td>Additional Criteria</td>
<td>None</td>
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</table>

#### SOR Recovery Support Services Reporting Requirements

<table>
<thead>
<tr>
<th>Monthly Reports</th>
<th>MAT – Shelters/Encampments FTE Report</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quarterly Reports</td>
<td>MAT- Shelters/Encampments Quarterly Report</td>
</tr>
</tbody>
</table>
| Annual/Other Reports          | • Upon request, contribute to the MIDD Sales Tax annual report  
                                 | • MIDD Sales Tax Evaluation Plan & MIDD Data Submission Plan |
10.18 Older Adult Substance Use

The Older Adult SUD program provides substance use disorder services at Aging and Disability Services (ADS) offices and within the community. The program serves people age 60 or older or Medicaid Title XIX Case Management Core clients who are in need of substance use disorder (SUD) services. The Older Adult SUD program provides outreach, engagement, and treatment services to clients, including evaluations, ongoing counseling, and referrals to appropriate resources, treatment, and medical care, and individualized treatment plans. The Older Adult SUD program also researches and develops resources, provides case staffing, and provides consultation to mental health staff and professionals from community agencies, including the ADS and ADS subcontracted agency case managers, related to substance use issues, assessment, and care planning.

- 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 SUD 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) will provide 35 consultation sessions (each of 7 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: 1.0 FTE Substance Use Disorder Professional (SUDP) will provide 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 will notify Behavioral Health and Recovery Division (BHRD) of all staff changes affecting the program funded through this Agreement within seven (7) days of the resignation, firing or any other change. A plan for replacing the staff person including a timeline will be submitted within fourteen (14) days of the resignation, firing or any other change. This will include 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 will be 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 staffings, 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 will communicate or correspond 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 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 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 shall be completed in the residences of the referred adults. Documentation shall become 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 shall arrange for a psychiatrist to evaluate the clients.
  • Case Staffing: The SUDP will participate 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 will research 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

<table>
<thead>
<tr>
<th>Medicaid Status</th>
<th>Yes</th>
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</thead>
<tbody>
<tr>
<td>Age Range</td>
<td>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.</td>
</tr>
<tr>
<td>Authorization Needed</td>
<td>Yes</td>
</tr>
<tr>
<td>Additional Criteria</td>
<td>Individuals must be in need of substance use disorder services and agree to services. Individuals must reside in King County.</td>
</tr>
</tbody>
</table>

### Older Adult Substance Use Reporting Requirements

| Monthly Reports | • Older Adult SUD FTE Report  
|                | • Older Adult SUD Performance Report  
| Semiannual Reports | • Older Adult SUD Narrative Report regarding program challenges and successes  

#### 10.19 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

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<thead>
<tr>
<th>Medicaid Status</th>
<th>N/A</th>
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<tbody>
<tr>
<td>Age Range</td>
<td>N/A</td>
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<tr>
<td>Authorization Needed</td>
<td>No</td>
</tr>
<tr>
<td>Additional Criteria</td>
<td>None</td>
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</table>

### 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.  

10.20 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.

<table>
<thead>
<tr>
<th>RR-11a Peer Bridger Program</th>
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<tbody>
<tr>
<td>Medicaid Status</td>
<td>N/A</td>
</tr>
<tr>
<td>Age Range</td>
<td>N/A</td>
</tr>
<tr>
<td>Authorization Needed</td>
<td>No</td>
</tr>
<tr>
<td>Additional Criteria</td>
<td>King County resident hospitalized psychiatrically at Navos and Harborview</td>
</tr>
</tbody>
</table>

10.21 Rapid Re-housing

The provision of housing services to eligible King County residents. Services are provided in accordance with the Mental Illness and Drug Dependency (MIDD) 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 will help 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.

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<tr>
<th>RR-04 Rapid Re-housing Oxford House Model Eligibility Criteria</th>
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<tbody>
<tr>
<td>Medicaid Status</td>
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</tr>
<tr>
<td>Age Range</td>
<td>N/A</td>
</tr>
<tr>
<td>Authorization Needed</td>
<td>No</td>
</tr>
<tr>
<td>Additional Criteria</td>
<td>King County resident living in a King County Oxford House</td>
</tr>
</tbody>
</table>
RR-04 Rapid Re-housing Oxford House Model Reporting Requirements

<table>
<thead>
<tr>
<th>Monthly Reports</th>
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<tbody>
<tr>
<td>• Rapid Re-Housing FTE Report</td>
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<tr>
<td>• Rapid Re-Housing Report</td>
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<tr>
<td>Annual/Other Reports</td>
</tr>
<tr>
<td>MIDD Evaluation Plan and the MIDD Data Submission Plan</td>
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</tbody>
</table>

10.22 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 Mental Illness and Drug Dependency (MIDD) 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

<table>
<thead>
<tr>
<th>Medicaid Status</th>
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<tbody>
<tr>
<td>Age Range</td>
<td>N/A</td>
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<tr>
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<td>Additional Criteria</td>
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RR 09 – Recovery Café

<table>
<thead>
<tr>
<th>Monthly Reports</th>
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<tbody>
<tr>
<td>Recovery Café Development Monthly Costs</td>
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<thead>
<tr>
<th>Annual/Other Reports</th>
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<tbody>
<tr>
<td>MIDD Evaluation Plan and the MIDD Data Submission Plan</td>
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</tbody>
</table>
10.23 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 will work 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 will work 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)

<table>
<thead>
<tr>
<th>Reentry Case Management Services Program Eligibility Criteria</th>
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<tbody>
<tr>
<td><strong>Medicaid Status</strong></td>
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<tr>
<td><strong>Age Range</strong></td>
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<tr>
<td><strong>Authorization Needed</strong></td>
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<tr>
<td><strong>Additional Criteria</strong></td>
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<thead>
<tr>
<th>Reentry Case Management Services Program Reporting Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Monthly Reports</strong></td>
</tr>
</tbody>
</table>
| **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. |
10.24 Rural Behavioral Health Projects

The Rural Behavioral Health Projects are focused on supporting rural, community-driven behavioral health services in unincorporated King County and will contribute to the Mental Illness and Drug Dependency (MIDD) 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 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

| Rural Behavioral Health Projects Eligibility Criteria |
|-----------------------------------------------|------|
| Medicaid Status                              | N/A  |
| Age Range                                    | N/A  |
| Authorization Needed                         | No   |
| Additional Criteria                          | N/A  |

| Rural Behavioral Health Projects Reporting Requirements |
|---------------------------------------------------------|------|
| Monthly Reports                                         | Rural Behavioral Health Project Report |
| Annual/Other Reports                                    | MIDD Evaluation Plan |

10.25 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.

<table>
<thead>
<tr>
<th>South King County Pretrial Services Eligibility Criteria</th>
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<tbody>
<tr>
<td><strong>Medicaid Status</strong></td>
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<tr>
<td><strong>Age Range</strong></td>
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<tr>
<td><strong>Authorization Needed</strong></td>
</tr>
<tr>
<td><strong>Additional Criteria</strong></td>
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</tbody>
</table>

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<thead>
<tr>
<th>South King County Pretrial Services Reporting Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Quarterly Reports</strong></td>
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<tr>
<td><strong>Semiannual Reports</strong></td>
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<tr>
<td><strong>Annual/Other Reports</strong></td>
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</table>

**10.26 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: [http://clubhouse-intl.org/resources/quality-standards/](http://clubhouse-intl.org/resources/quality-standards/) and meets state certification requirements per Chapter 388-865-0700 through 0725 Washington Administrative Code (WAC). 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 ([https://www.hca.wa.gov/assets/program/SP-Att-3-Services-General-Provisions.pdf](https://www.hca.wa.gov/assets/program/SP-Att-3-Services-General-Provisions.pdf)).

<table>
<thead>
<tr>
<th>Clubhouse Services (Hero House NW) Eligibility Criteria</th>
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<tbody>
<tr>
<td><strong>Medicaid Status</strong></td>
</tr>
<tr>
<td>No for Clubhouse Services, Yes for Day Support Services within the Clubhouse model</td>
</tr>
<tr>
<td><strong>Age Range</strong></td>
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<tr>
<td>18 and older</td>
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<tr>
<td><strong>Authorization Needed</strong></td>
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<tr>
<td>No</td>
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</table>

**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.

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<thead>
<tr>
<th>Clubhouse Services (Hero House NW) Reporting Requirements</th>
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<tbody>
<tr>
<td><strong>Monthly Reports</strong></td>
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<tr>
<td>Clubhouse Census Log</td>
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<tr>
<td><strong>Semiannual Reports</strong></td>
</tr>
<tr>
<td>Clubhouse Services Summary Report (for June with the June invoice and December with the December invoice)</td>
</tr>
</tbody>
</table>

### 10.27 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 Mental Illness and Drug Dependency (MIDD) Plan Initiative PRI-09 – Sexual Assault and Behavioral Health Services as outlined in the MIDD initiative description: [PRI-09 Description](https://www.hca.wa.gov/assets/program/SP-Att-3-Services-General-Provisions.pdf).

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:
  o Assessment to identify individual’s specific behavioral health needs and the types of interventions to address those needs.
  o Evidence-based trauma-focused therapy for those children, teen, and adult survivors of sexual assault who would benefit from the therapy.
  o Culturally relevant services to sexual assault survivors from immigrant and refugee communities in their own language.
  o Sexual assault-specific advocacy services on behalf of survivors until they are able to act on their own behalf.
  o 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.

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<tr>
<th>Sexual Assault Behavioral Health (SA-BH) Services Eligibility Criteria</th>
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<td>Medicaid Status</td>
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<td>Age Range</td>
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<td>Authorization Needed</td>
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<td>Additional Criteria</td>
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<tr>
<th>Sexual Assault Behavioral Health (SA-BH) Services Reporting Requirements</th>
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<tr>
<td>Monthly Reports</td>
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<td>Annual/Other Reports</td>
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10.28 Substance Use Disorder Peer Recovery Services
Substance use disorder (SUD) peer recovery services are provided in accordance with the Mental Illness and Drug Dependency (MIDD) 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 will have a record established that records items such as screenings, documentation of services and any program agreements such as recovery plans.

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<th>Substance Use Disorder Peer Recovery Services Eligibility Criteria</th>
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<td>Medicaid Status</td>
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<td>Age Range</td>
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<tr>
<td>Authorization Needed</td>
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<tr>
<td>Additional Criteria</td>
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<tr>
<td>• Meet the standards for low-income individual’s eligibility.</td>
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<td>• Individuals are amenable to and requesting peer recovery services.</td>
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**Substance Use Disorder Peer Recovery Services Reporting Requirements**

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<tr>
<th>Monthly Reports</th>
<th>SUD Peer Recovery Services FTE Report</th>
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<tbody>
<tr>
<td>Annual/Other Reports</td>
<td>MIDD Evaluation Plan and the MIDD Data Submission Plan</td>
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### 10.29 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 Mental Illness and Drug Dependency (MIDD) 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 will dispatch 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 will receive 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.

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<th>Youth Connection Services Eligibility Criteria</th>
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<td><strong>Medicaid Status</strong></td>
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<td><strong>Age Range</strong></td>
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<tr>
<td><strong>Authorization Needed</strong></td>
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<tr>
<td><strong>Additional Criteria</strong></td>
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<tr>
<td>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:</td>
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<tr>
<td>• Criminal activity;</td>
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<tr>
<td>• Truancy;</td>
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<tr>
<td>• Family conflict;</td>
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<td>• Homelessness or at-risk of homelessness;</td>
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<tr>
<td>• Gang involvement/association; or</td>
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<tr>
<td>• Substance use or abuse behaviors</td>
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<tr>
<td>Referrals may come from anywhere, but priority will be given to youth referred by law enforcement personnel in Auburn, Federal Way and Kent.</td>
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<tr>
<td>Service Area: encompasses King County geographic areas including the following cities and zip codes:</td>
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<td>Auburn (98001, 98002, 98071, 98092),</td>
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<tr>
<td>Federal Way (98003, 98023, 98063, 98093) and Kent (98030, 98031, 98032, 98035, 98042, 98064, 98089).</td>
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<tr>
<th>Youth Connection Services Reporting Requirements</th>
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<td><strong>Monthly Reports</strong></td>
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10.30 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.

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, (e) Psychologist, and/or (f) Registered Nurse, Licensed Practical Nurse, or Advanced Registered Nurse Practitioner. Additionally, they (a) have experience working with patients 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 (AUDIT), and (d) have skills in Motivational Interviewing to facilitate effective brief interventions and referrals to treatment.

The Providers has a SBIRT Implementation Lead in accordance with funding stipulations. In addition to meeting the qualifications for the SBIRT Clinician, the 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 collaboratives and other initiatives.

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<tr>
<th>SBIRT-EDS Eligibility Criteria</th>
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<td>Medicaid Status</td>
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<td>Age Range</td>
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<td>Authorization Needed</td>
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<td>Additional Criteria</td>
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<tr>
<th>SBIRT-EDS Reporting Requirements</th>
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<tr>
<td>Monthly Reports</td>
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<td>Annual/Other Reports</td>
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10.31 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 school students (age 10-14). 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 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 schools to create an SB-SBIRT workflow attending to each tiered level of support.
- Supports and collaborates with their identified middle 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 schools to conduct brief interventions with students utilizing the SB-SBIRT model.
- Supports and collaborates with their identified middle schools to engage with parents/caregivers to participate in individual/family brief interventions or parent group sessions.
- Supports and collaborates with their identified middle schools to provide students with individualized referrals and follow-up as needed.
• Supports and collaborates with their identified middle 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 school SB-SBIRT practitioners and/or school counselors have access, attend, and participate in:
  • The annual SBIRT Institute;
  • The monthly Practitioner Workgroup, a hybrid of in-person and web-based monthly learning collaborative sessions starting October 2019; and
  • Other grant related trainings.

• Identifies and assigns an SB-SBIRT district lead (or designee) to participate in:
  • The annual SBIRT Institute; and
  • The Evaluation and Implementation Workgroup meetings in October and December of 2019 and January, March and May of 2020 to collaborate with participating districts regarding the progress of the evaluation and implementation activities.

• Review, 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 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 will be submitted to the County within seven business days of the resignation, firing, or any other change. This plan will include timelines for replacing the staff person.

• Ensures identified middle schools available for onsite visit by the county if necessary and the on-site visit will be 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 Mental Illness and Drug Dependency (MIDD) are committed to being able to tell communities and stakeholders what happened as a result of this funding. The Provider will name a person who will lead evaluation activities for this contract. The Provider and the BSK Evaluation Team will work collaboratively to track the strengths and challenges of implementing funded activities. The evaluation protocol and set of performance measures for the activities will be 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 transmission 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 will use a format to be supplied by King County or their Provider(s) and will include, at minimum: performance measures and reporting requirements. At least one of each type of performance measure (below) will be included in the final Evaluation Plan. When there are multiple Providers working on a related strategy, the Evaluation Plan will also include 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 will usually be 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 will be considered final after email confirmation of acceptance is received by both parties.

### SB-SBIRT Eligibility Criteria

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<thead>
<tr>
<th>Medicaid Status</th>
<th>N/A</th>
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<tr>
<td>Age Range</td>
<td>Ages 10-14</td>
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<tr>
<td>Authorization Needed</td>
<td>No</td>
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### SB-SBIRT Reporting Requirements

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<thead>
<tr>
<th>Monthly Reports</th>
<th>SB-SBIRT Financial Budget Report</th>
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<tr>
<td>Semiannual Reports</td>
<td>SB-SBIRT Narrative Report</td>
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<td>SB-SBIRT Report in Tickit Health</td>
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<tr>
<td>Annual/Other Reports</td>
<td>SB-SBIRT Client Satisfaction Survey</td>
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#### 10.32 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 school year in which King County will fund 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 Sealth 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 will be responsible for participating in the SB-SBIRT program, including providing staff to deliver required services. Specifically, PSESD will ensure that, in addition to screening students as referenced in the 2019-2020 agreement between PSESD and the School District/ Fiscal Agent affiliated with CPWI, Student Assistance Professionals (SAPs) working in CPWI-identified middle schools will screen a minimum of one classroom using the Check Yourself screener, moving toward universal screening.

PSESD staff, including SAPs, will work with the school district and identified middle school administration to determine workflow plan for follow up interventions. This plan will be due no later than January 31, 2020 and needs to be approved by Behavioral Health and Recovery Division (BHRD) prior to screening.

SAPs working in CPWI-identified high schools will follow PSESD approved work plan, and will use the Global Assessment of Identified Needs–Short Screener (GAIN-SS) Reclaiming Futures version.

In addition to all required SAP trainings/meetings, PSESD will ensure 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 starting October 2019
• Other grant related trainings

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<tr>
<th>SB-SBIRT-CPWI Pilot Partnership Eligibility Criteria</th>
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<td>Medicaid Status</td>
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<td>Age Range</td>
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<td>Authorization Needed</td>
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<td>Additional Criteria</td>
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<th>SB-SBIRT-CPWI Pilot Partnership Reporting Requirements</th>
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<td>Monthly Report</td>
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<td>Quarterly Report</td>
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### 10.33 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 will be 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 will include 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 spend downs, 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 will 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.

This program is fully funded by the Mental Illness and Drug Dependency (MIDD) Plan Initiative [RR-10-Behavioral Health Employment Services and Supported Employment](https://ipsworks.org/wp-content/uploads/2017/08/IPS-Fidelity-Scale-Eng1.pdf). Program design and service delivery should adhere to the IPS fidelity scale located at [https://ipsworks.org/wp-content/uploads/2017/08/IPS-Fidelity-Scale-Eng1.pdf](https://ipsworks.org/wp-content/uploads/2017/08/IPS-Fidelity-Scale-Eng1.pdf) and maintain an overall “good fidelity” rating. 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 six months prior to enrollment are not eligible to enroll in King County funded SE services. Further County reimbursement criteria are detailed in the Outcomes Reimbursement Table below and the Specialty Employment Program Reimbursement Criteria document and its successors.

<table>
<thead>
<tr>
<th>Supported Employment Program Eligibility Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Medicaid Status</strong></td>
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<tr>
<td><strong>Age Range</strong></td>
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<tr>
<td><strong>Authorization Needed</strong></td>
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</tbody>
</table>
### Supported Employment Program Reporting Requirements

<table>
<thead>
<tr>
<th>Monthly Reports</th>
<th>Quarterly Reports</th>
<th>Annual/Other Reports</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Supported Employment Provider Report</td>
<td>Supported Employment Provider Report</td>
<td>Provide specific information for the MIDD Annual Report as requested by the County.</td>
</tr>
<tr>
<td>• Supported Employment Provider Supplemental Report (as needed)</td>
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</table>

#### 10.34 Seven Challenges

Seven Challenges® (the Program) is a proprietary, copyrighted and trademarked psychological 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 King 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 Provider is provided with general office tools, appropriate classroom, support/fidelity space, and audio/visual equipment at no charge to Seven Challenges, to permit Seven Challenges to accomplish the support described herein. Each trained clinician will be provided with his or her own copy of 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. Conducting quarterly support calls with designated Seven Challenges Leaders to provide ongoing clinical and technical assistance to implement the Seven Challenges model.

#### Seven Challenges Eligibility Criteria

<table>
<thead>
<tr>
<th>Medicaid Status</th>
<th>N/A</th>
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<tbody>
<tr>
<td>Age Range</td>
<td>N/A</td>
</tr>
<tr>
<td>Authorization Needed</td>
<td>Yes</td>
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<tr>
<td>Additional Criteria</td>
<td>Provider personnel covered under the BHRD umbrella license.</td>
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</table>

#### Seven Challenges Reporting Requirements

<table>
<thead>
<tr>
<th>Quarterly Reports</th>
<th>Annual/Other Reports</th>
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</thead>
<tbody>
<tr>
<td>N/A</td>
<td>Fidelity Visit and Summary for The Seven Challenges agencies, complete with recommendations for improved fidelity and supervision.</td>
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</tbody>
</table>

#### 10.35 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 |

10.36 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 Mental Illness and Drug Dependency (MIDD) 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.

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<tr>
<th>Workforce Development Plan Eligibility Criteria</th>
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<tr>
<td>Medicaid Status</td>
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<tr>
<td>Age Range</td>
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<tr>
<td>Authorization Needed</td>
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<tr>
<td>Additional Criteria</td>
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<thead>
<tr>
<th>Workforce Development Plan Reporting Requirements</th>
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<tbody>
<tr>
<td>Monthly Reports</td>
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<tr>
<td>• Training evaluations and sign-in sheets must be submitted within five business days after a training is provided.</td>
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<tr>
<td>• Professional Support Services Report, if applicable.</td>
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<tr>
<td>Quarterly Reports</td>
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10.37 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.

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<thead>
<tr>
<th>EDUM Rapid Response Teams Client Eligibility Criteria</th>
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<tr>
<td><strong>Medicaid Status</strong></td>
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<tr>
<td><strong>Age Range</strong></td>
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<tr>
<td><strong>Authorization Needed</strong></td>
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<td><strong>Additional Criteria</strong></td>
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<tr>
<th>EDUM – Rapid Response Teams Reporting Requirements</th>
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<tbody>
<tr>
<td><strong>Monthly Reports</strong></td>
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<tr>
<td><strong>One-time report</strong></td>
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</table>

**10.38 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 Mental Illness and Drug Dependency (MIDD) 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

<table>
<thead>
<tr>
<th>Medicaid Status</th>
<th>Not Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age Range</td>
<td>Ages 12-18</td>
</tr>
<tr>
<td>Authorization Needed</td>
<td>None</td>
</tr>
<tr>
<td>Additional Criteria</td>
<td>Accept referrals solely made by King County Superior Courts Family Court Services</td>
</tr>
</tbody>
</table>

### Zero Youth Detention Behavioral Health Pilot Project Reporting Requirements

- Monthly Reports: IFD Service Report

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**10.39 Wraparound**

Mental Illness and Drug Dependency (MIDD) 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.” [https://nwi.pdx.edu/](https://nwi.pdx.edu/)

Effective June 1, 2020, there are three (3) agencies contracted to provide this service. Each is responsible to serve at minimum 10 and a maximum of 20 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 20.
- Records and reports pending, enrolled and discharged clients on a twice 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 and/or consultations 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)

<table>
<thead>
<tr>
<th>Medicaid Status</th>
<th>N/A</th>
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<tbody>
<tr>
<td>Age Range</td>
<td>0-21</td>
</tr>
<tr>
<td>Authorization Needed</td>
<td>Yes</td>
</tr>
</tbody>
</table>

### 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

<table>
<thead>
<tr>
<th>every 2 weeks Report</th>
<th>enrollees pending list and discharges</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monthly Reports</td>
<td>Wraparound Data Outcome Tool and Caregiver Strain Questionnaire</td>
</tr>
<tr>
<td></td>
<td>Wraparound Monthly Invoice to include a list of KCIDs for clients served in each month</td>
</tr>
<tr>
<td></td>
<td>Wraparound Flex Fund Expenditure Report</td>
</tr>
</tbody>
</table>
11 Other Locally Funded Programs

11.1 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.

<table>
<thead>
<tr>
<th>Evidence Based Practices Eligibility Criteria</th>
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<tbody>
<tr>
<td>Medicaid Status</td>
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<tr>
<td>Age Range</td>
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<tr>
<td>Authorization Needed</td>
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<tr>
<td>Additional Criteria</td>
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</tbody>
</table>

**Evidence Based Practices Reporting Requirements**

| Annual/Other Reports | A summary of trainings provided with an assessment of Provider understanding and recommendations of next steps. |

11.2 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.
Community Outreach and Advocacy Team (COAT) Eligibility Criteria

<table>
<thead>
<tr>
<th>Medicaid Status</th>
<th>N/A, but Medicaid can be used for outpatient services, if eligible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age Range</td>
<td>Adults Aged 18 Years and Older</td>
</tr>
<tr>
<td>Authorization Needed</td>
<td>Yes</td>
</tr>
<tr>
<td>Additional Criteria</td>
<td>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.</td>
</tr>
</tbody>
</table>

Community Outreach and Advocacy Team (COAT) Reporting Requirements

<table>
<thead>
<tr>
<th>Monthly Reports</th>
<th>Monthly report as provided by the County</th>
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</thead>
<tbody>
<tr>
<td>Quarterly Reports</td>
<td>Quarterly report as provided by the County</td>
</tr>
</tbody>
</table>
| 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. |

11.3 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 detoxification 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.

<table>
<thead>
<tr>
<th>Family Integrated Traditions (FIT) Eligibility Criteria</th>
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<tbody>
<tr>
<td>Medicaid Status</td>
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<tr>
<td>Age Range</td>
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<tr>
<td>Authorization Needed</td>
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<td>Additional Criteria</td>
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<tr>
<th>Family Integrated Transitions (FIT) Reporting Requirements</th>
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<tbody>
<tr>
<td>Monthly Reports</td>
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</table>

11.4 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 will remove 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

<table>
<thead>
<tr>
<th>Medicaid Status</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age Range</td>
<td>11-18</td>
</tr>
<tr>
<td>Authorization Needed</td>
<td>Yes</td>
</tr>
<tr>
<td>Additional Criteria</td>
<td>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.</td>
</tr>
<tr>
<td></td>
<td>Referrals to the FFT Program may only be made by staff designated by the JCS Project Manager.</td>
</tr>
<tr>
<td></td>
<td>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:</td>
</tr>
<tr>
<td></td>
<td>The JPC does not want services and/or does not support the program;</td>
</tr>
<tr>
<td></td>
<td>The youth refuses to participate;</td>
</tr>
<tr>
<td></td>
<td>The caregiver refuses to participate;</td>
</tr>
<tr>
<td></td>
<td>The youth is on the run and/or a warrant is issued;</td>
</tr>
<tr>
<td></td>
<td>There is not enough time left in the period of probation;</td>
</tr>
<tr>
<td></td>
<td>Youth did not show up for any sessions;</td>
</tr>
<tr>
<td></td>
<td>Youth moved or is moving out of state;</td>
</tr>
<tr>
<td></td>
<td>Youth is in foster care or other placement less than 90 days or there is a plan for reunification in less than 120 days;</td>
</tr>
<tr>
<td></td>
<td>A Diagnostic and Statistical Manual of Mental Disorders-Fifth Edition (DSMV) diagnosis of Schizophrenia or Personality Disorder;</td>
</tr>
<tr>
<td></td>
<td>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;</td>
</tr>
<tr>
<td></td>
<td>Youth going into inpatient mental health services;</td>
</tr>
<tr>
<td></td>
<td>Youth diagnosed with a moderate or severe substance use disorder by a certified Substance Use Disorder Professional (SUDP);</td>
</tr>
<tr>
<td></td>
<td>Chemical Dependency Disposition Alternative (CDDA) youth;</td>
</tr>
<tr>
<td></td>
<td>Youth with Intelligent Quotient (IQ) scores of 69 or below; or</td>
</tr>
</tbody>
</table>
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

<table>
<thead>
<tr>
<th>Monthly Reports</th>
<th>FFT Report</th>
</tr>
</thead>
</table>
| Quarterly Reports | FFT Client Demographic Report  
|                   | FFT TOM/COM Summary Report  |
| Semiannual Reports| FFT Data Elements Report |

**11.5 Infrastructure Development**

Infrastructure Development projects aim to strengthen and expand KCBH’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 Behavioral Health and Recovery Division (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 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**

<table>
<thead>
<tr>
<th>Monthly Reports</th>
<th>As requested by BHRD per specific project</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quarterly Reports</td>
<td>As requested by BHRD per specific project</td>
</tr>
<tr>
<td>Semiannual Reports</td>
<td>As requested by BHRD per specific project (i.e. status reports in electronic copy that describe the status of the facility purchase)</td>
</tr>
<tr>
<td>Annual/Other Reports</td>
<td>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.</td>
</tr>
</tbody>
</table>
11.6 LEAD Expansion for Trueblood Class Members

LEAD is a program to divert adult individuals with behavioral health conditions, who are engaged in low-level drug crime, prostitution and other identified offenses, from the criminal legal system. 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. Trueblood Phase III specifically is targeted towards those individuals who have a history of using legal competency services or are identified as likely to have legal competency raised in future court proceeding if not for diversion to the LEAD program. 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.

**LEAD Expansion for Trueblood Class Members Eligibility Criteria**

<table>
<thead>
<tr>
<th>Medicaid Status</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age Range</td>
<td>Adults Aged 18 Years and Older</td>
</tr>
<tr>
<td>Authorization Needed</td>
<td>Yes</td>
</tr>
<tr>
<td>Additional Criteria</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- <strong>Trueblood</strong> class members and potential future members.</td>
</tr>
<tr>
<td></td>
<td>- Residents of, or are experiencing homelessness in, King County, or were immediately prior to incarceration or another institutional stay.</td>
</tr>
<tr>
<td></td>
<td>- 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.</td>
</tr>
<tr>
<td></td>
<td>- Meet one of the following criteria:</td>
</tr>
<tr>
<td></td>
<td>- 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</td>
</tr>
<tr>
<td></td>
<td>- Eligible for the LEAD program as identified by law enforcement partners under expanded eligibility criteria.</td>
</tr>
</tbody>
</table>

**LEAD Reporting Requirements**

| Monthly Reports       | Staffing Report for all contracted and subcontracted agencies providing LEAD services. |
|                      | Community outreach activities. |
|                      | Trueblood Phase III report. |
| Quarterly Reports     | Summary Reports, including any specific activities related to systems coordination and community involvement regarding Trueblood Phase III. |
| 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. |
|                      | Any other requested reports by the County. |
11.7 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 two Medication-Assisted Treatment Expansion or MAT-EPIC projects. 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. These SAMHSA funded projects will increase Provider capacity to prescribe buprenorphine or naltrexone and leverage existing resources such as Medicaid to provide low barrier services 150 individuals each year for 3 years.

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 projects will obtain a data waiver. The SAMHSA grant will fund nurse care managers and navigators that will allow the sites to serve new clients. The practitioner will prescribe 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-PDOA projects by providing services in locations where individuals with OUD already receive care;
- Refer and link patients for ongoing MAT-PDOA and other needed services, which will be offered at a needle exchange and a public health clinic;
- Screen all individuals with OUD for appropriateness for MAT-PDOA;
- Conduct an appropriate clinical assessment to determine clients meeting the diagnostic criteria for OUD relative to MAT-PDOA, including a determination of opioid dependence, a history of opioid, 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-PDOA 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-PDOA 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-PDOA and facilitate long term recovery;
- Build funding mechanisms and service delivery models in order to provide a robust suite of MATPDOA 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

<table>
<thead>
<tr>
<th>Medicaid Status</th>
<th>Medicaid and non-Medicaid clients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age Range</td>
<td>18 years and Older</td>
</tr>
<tr>
<td>Authorization Needed</td>
<td>No</td>
</tr>
<tr>
<td>Additional Criteria</td>
<td>None</td>
</tr>
</tbody>
</table>

### Medication-Assisted Treatment Expansion Reporting Requirements

<table>
<thead>
<tr>
<th>Monthly Reports</th>
</tr>
</thead>
<tbody>
<tr>
<td>Government Performance and Results Act (GPRA) data (twice a month)</td>
</tr>
<tr>
<td>MAT Expansion Staffing Report</td>
</tr>
</tbody>
</table>

| Annual/Other Reports | To be determined by SAMHSA-grant evaluator |

### 11.8 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**

<table>
<thead>
<tr>
<th>Medicaid Status</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age Range</td>
<td>11-17.5 years</td>
</tr>
<tr>
<td>Authorization Needed</td>
<td>Yes</td>
</tr>
<tr>
<td>Additional Criteria</td>
<td></td>
</tr>
</tbody>
</table>

- 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**

<table>
<thead>
<tr>
<th>Monthly Reports</th>
</tr>
</thead>
<tbody>
<tr>
<td>MST FTE Report</td>
</tr>
<tr>
<td>MST City of Seattle Status Report</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Annual/Other Reports</th>
</tr>
</thead>
<tbody>
<tr>
<td>MST City of Seattle Annual Report</td>
</tr>
</tbody>
</table>

### 11.9 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 will prescribe and dispense naloxone kits to these clients.

Program website and forms located here:

11.10 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 Training 2) Work-Based Learning Activities and 3) 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, 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
- Anticipating in work-based learning activities such as job site tours, job shadowing, and informational interviewing
- Short-term, paid, work-based learning experiences in an integrated employment setting

The Provider provides Pre-ETS in accordance with all requirements in the DVR Pre-ETS contract with DCHS that has been provided to the Provider.

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, not to exceed two (2) tours per student
  - Job Shadow Visit, not to exceed two (2) visits per student
  - Informational Interview, not to exceed four (4) informational interviews per student
  - Paid Work-Based Learning Experiences, limited to one, predetermined level of Paid Work-Based Learning Experience per student, according to the following levels from the total agency levels allotted: 5 Students with a Paid Work-Based Learning Experience, Level 1 - At least 40 hours;
  - 5 Students with a Paid Work-Based Learning Experience, Level 2 – At least 75 hours;
  - 10 Students with a Paid Work-Based Learning Experience, Level 3 - At least 100 hours;
  - 5 Students with a Paid Work-Based Learning Experience, Level 4 - At least 101 hours up to 120 hours maximum.
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 will 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

<table>
<thead>
<tr>
<th>Medicaid Status</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age Range</td>
<td>Ages 16-21</td>
</tr>
<tr>
<td>Authorization Needed</td>
<td>Yes</td>
</tr>
<tr>
<td>Additional Criteria</td>
<td>Refer to DVR/DCHS Pre-ETS Contract</td>
</tr>
</tbody>
</table>

### Pre-Employment Transition Services (PRE-ETS) Reporting Requirements

<table>
<thead>
<tr>
<th>Monthly Reports</th>
<th>Pre-ETS DVR Monthly Report</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pre-ETS BHRD Monthly Report</td>
</tr>
<tr>
<td></td>
<td>Pre-ETS Provider-Supplemental Report (as needed)</td>
</tr>
<tr>
<td>Quarterly Reports</td>
<td>Pre-ETS Quarterly Report</td>
</tr>
<tr>
<td>Annual/Other Reports</td>
<td>As requested</td>
</tr>
</tbody>
</table>

#### 11.11 Sobering Adult Case Management

Case management services are provided to adults who use sobering services through funding provided by the City of Seattle. A 1.0 full-time equivalent (FTE) case manager provides direct case management services including; screening, engagement and motivation to receive services, engagement and motivation for recovery, file documentation, referral and linkages to community resources, assisting people to receive appropriate services and benefits, assisting people to receive admission to withdrawal management services and support for people who do not complete or successfully engage in other services. The Provider maintains timely and accurate records, which reflect service levels, participant characteristics, action taken to assist participants, and service outcomes and expenditures and maintain person demographic data and complete the required Behavioral Health and Recovery Division (BHRD) reports. The Provider must notify BHRD of all staff changes affecting the program within five days of the resignation, firing, or any other change and provide a plan for replacing the staff person within 10 days of the resignation, firing, or any other change 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

<table>
<thead>
<tr>
<th>Medicaid Status</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age Range</td>
<td>18 and older</td>
</tr>
<tr>
<td>Authorization Needed</td>
<td>No</td>
</tr>
<tr>
<td>Additional Criteria</td>
<td>Individuals are identified as people using sobering services</td>
</tr>
</tbody>
</table>

### Sobering Adult Case Management

<table>
<thead>
<tr>
<th>Monthly Reports</th>
<th>CDI Status Report, Case Manager Days</th>
</tr>
</thead>
</table>
11.12 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 provides assertive outreach and engagement 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. 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 1 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 the homeless in south King County.
- 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.

<table>
<thead>
<tr>
<th>SKCHF Program Eligibility Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid Status</td>
</tr>
<tr>
<td>Age Range</td>
</tr>
<tr>
<td>Authorization Needed</td>
</tr>
<tr>
<td>Additional Criteria</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>SKCHF Program Reporting Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monthly Reports</td>
</tr>
</tbody>
</table>
11.13 Substance Use Treatment and Recovery (STAR) Program for Individuals with Intellectual and Developmental Disabilities

The Substance Use Treatment And Recovery (STAR) Program provides outreach, engagement, and recovery-oriented services to adults with intellectual and developmental disabilities (IDD) in need of substance use disorder (SUD) treatment. Activities are focused on maintaining the client’s participation in substance use disorder treatment for individuals with IDD who are enrolled with Washington State Department of Social and Human Services/Developmental Disabilities Administration (DSHS/DDA) services. Additionally, STAR Program staff members are available to deliver training events, establish community partnerships, and offer consultation services to King County Providers on the delivery of SUD treatment services to individuals with IDD, as needed.

This program:

• Employs qualified staff members, such as Substance Use Disorder Professionals (SUDP) or Substance Use Disorder Professional Trainees (SUDPT).
• Screens clients in the STAR Program using the Global Assessment of Individual Needs – Short Screen (GAIN-SS), and assesses each client using an instrument that incorporates the American Society of Addiction Medicine (ASAM) multidimensional assessment model to determine level of care, and the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-V), or their successors.

Examples of activities available through the STAR Program include but are not limited to:

• Connection to benefits and community resources that will lead to engagement in SUD treatment;
• Gainful activity motivation and assistance;
• Referral coordination for support in seeking or maintaining housing;
• Relapse prevention; and/or
• Similar services not covered by other funding sources.

Program staff are available to conduct training and education events within Washington State. Program staff are also available to perform consulting and outreach activities to create linkages with community partners in collaboration with DDA and King County.

The Provider maintains an updated resource manual of the engagement and intervention exercises utilized in the STAR Program, and other information needed to replicate the program at other sites. The Provider works with the County to develop a Results-Based Accountability framework (i.e., how much services were done, how well they were done, whether or not anyone is better off).

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<thead>
<tr>
<th>STAR Program Eligibility Criteria</th>
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<tbody>
<tr>
<td>Medicaid Status</td>
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<td>Age Range</td>
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<tr>
<td>Authorization Needed</td>
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<td>Additional Criteria</td>
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</table>
### STAR Program Reporting Requirements

<table>
<thead>
<tr>
<th>Monthly Reports</th>
<th>Quarterly Reports</th>
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<tbody>
<tr>
<td>• STAR Program Status Report</td>
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<tr>
<td>• STAR Program Staffing Report</td>
<td></td>
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<tr>
<td>STAR Cumulative Program Client List</td>
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#### 11.14 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 will be 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 will 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:

- Career Counseling: identifying Individuals’ interests, talents, skills
- 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.
**Chapter 11 Other Locally Funded Programs**

**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.

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<th>Ticket to Work Eligibility Criteria</th>
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<td>Medicaid Status</td>
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<td>Age Range</td>
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<td>Authorization Needed</td>
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<td>Additional Criteria</td>
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<tr>
<th>Ticket to Work Reporting Requirements</th>
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<tr>
<td>Monthly Reports</td>
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<td>Annual/Other Reports</td>
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11.15 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 will 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:

- **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.

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<th>TRACE Eligibility Criteria</th>
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<td>Medicaid Status</td>
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<td>Age Range</td>
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<td>Authorization Needed</td>
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</tbody>
</table>
| 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) |

<table>
<thead>
<tr>
<th>TRACE Reporting Requirements</th>
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<tr>
<td>Monthly Reports</td>
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</table>
  - TRACE Service Summary  
  - TRACE Narrative Summary |
| Annual/Other Reports | TRACE Project Evaluation due January 31st. |

**11.16 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.

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<tr>
<th>Trueblood Phase III Interim Housing and Supports Eligibility Criteria</th>
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<td>Medicaid Status</td>
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<td>Age Range</td>
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<td>Authorization Needed</td>
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| 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). |

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<tr>
<th>Trueblood Phase III Interim Housing and Supports Reporting Requirements</th>
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<td>Monthly Reports</td>
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<td>Annual/Other Reports</td>
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  - 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 |
11.17 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 shall 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.

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<th>Washington Recovery Alliance (WRA)</th>
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<tr>
<td>Medicaid Status</td>
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<td>Age Range</td>
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<td>Additional Criteria</td>
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<tr>
<th>Washington Recovery Alliance (WRA)</th>
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<tr>
<td>Annual/Other Reports</td>
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<tr>
<td>• WRA Social Media Campaign Report</td>
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<tr>
<td>• WRA Recovery Events Report</td>
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<tr>
<td>• WRA Recovery Coalition Sustainability Report</td>
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</table>
11.18 Youth Engagement Program

The Youth Engagement Program (YEP) provides outreach and engagement services linking underserved youth to behavioral health treatment and other services, with an emphasis on (and not limited to) connecting with youth: (a) Of color, and/or who are Lesbian, Gay Bisexual, Transgender, Queer, or Intersex (LGBTQI); (b) Who may have behavioral health concerns, including mental health and substance use disorders; (c) Involved in risky behaviors; and/or (d) Currently or potentially involved in the juvenile justice system.

Engagement activities motivate youth to consider making changes that are consistent with their personal goals, values, and culture, and connect youth to resources available through case management, schools, school-based health clinics (SBHC), youth behavioral health treatment programs, services for youth experiencing homelessness, and other programs that support recovery and wellness. Providers deliver outreach and engagement in the Central District, Rainier Valley, West Seattle, and South Seattle, and in the catchment areas of Franklin and West Seattle High Schools as approved by Behavioral Health and Recovery Division (BHRD).

Definitions:

- **Engagement**: A process where individuals are encouraged and assisted in making positive changes in their lives and activities and help the individuals to be on a pathway to entering treatment services.

- **Outreach**: Services provided to identify and engage hard-to-reach individuals who are misusing alcohol and/or drugs, or who meet criteria for behavioral health disorders. Outreach includes linking individuals to treatment and/or other necessary support services where they might not otherwise have access to those services. Outreach services can be provided on an individual basis or to a group of twelve or fewer individuals.

- **Written Engagement Plan (WEP)**: A written plan that documents the activities for further engagement and/or referral for services that will eliminate or ameliorate problems that seriously limit the youth’s major life activities. The WEP need not be completed with the youth’s direct involvement and should only be completed for youth where further engagement is planned or where a referral is made for other services. Planned objectives should be achievable, time-linked, measurable, and under the individual’s control.

Providers ensure that youth and young adults are approached at a variety of venues, such as the Seattle Youth Violence Prevention Initiative case management program, school-based health clinics (SBHCs), behavioral health treatment, housing, and other programs. Providers ensure that engagement services are delivered in a manner that recognizes the youth’s current stage of change and invites them to consider making changes consistent with their goals, value and culture within their own environment.

Providers identify YEP services as funded by the City of Seattle Human Services Department in all communication with members of the public and recipients of services. Providers also post a notice to this effect in a prominent place at each Agency location where such services are provided.

Providers will ensure the WEP includes appropriate goals and referrals to meet basic needs, health, and/or behavioral health options; that the WEP is developed in collaboration with the individual; that the WEP review occurs monthly review or sooner if clinically indicated; and that the WEP documentation describing progress toward written goals.

Providers ensure that youth who have a WEP developed are screened for behavioral health needs by utilizing the Global Appraisal of Individual Needs – Short-Screener (GAIN-SS). Providers ensure that participants have immediate access to behavioral health outpatient treatment services. Providers ensure that the following milestones are met:
<table>
<thead>
<tr>
<th>Milestones and Performance Commitments (PC) not linked to Reimbursement</th>
<th>1st Quarter</th>
<th>2nd Quarter</th>
<th>3rd Quarter</th>
<th>4th Quarter</th>
<th>Total</th>
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<tbody>
<tr>
<td><strong>Base Performance</strong></td>
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<tr>
<td>PC #1: 35 youth will enroll in activities that support recovery and wellness. (Unduplicated)</td>
<td>9</td>
<td>9</td>
<td>9</td>
<td>8</td>
<td>35</td>
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<tr>
<td>PC #2: 140 youth will establish treatment, school, and life skill goals and develop written plans. (Duplicated)</td>
<td>35</td>
<td>35</td>
<td>35</td>
<td>35</td>
<td>140</td>
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<tr>
<td><strong>Performance Commitments linked to 25 percent Reimbursement</strong></td>
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<tr>
<td>PC #3: 50 youth will be admitted to and begin behavioral health treatment. (Duplicated)</td>
<td>13</td>
<td>13</td>
<td>12</td>
<td>12</td>
<td>50</td>
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<tr>
<td>PC #4: 90 youth will demonstrate fulfillment of one or more goals on their Written Engagement Plans. (Duplicated)</td>
<td>23</td>
<td>23</td>
<td>22</td>
<td>22</td>
<td>90</td>
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<tr>
<td>PC #5: 300 youth will receive outreach in an effort to engage them in health and behavioral health services. (Duplicated)</td>
<td>75</td>
<td>75</td>
<td>75</td>
<td>75</td>
<td>300</td>
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</table>

Providers maintain timely and accurate records which reflect service levels, participant demographics, and specific actions taken to assist participants, service outcomes and expenditures. Providers ensure that this record is kept on youth who have a GAIN-SS screening, behavioral health assessment, WEP, and/or are referred to treatment and/or are admitted to treatment. The record includes, but is not limited to:

- As many elements as possible from the YEP Monthly Report;
- Documentation of the client’s WEP and progress on that plan;
- Progress notes that include documentation of services provided to participants;
- Referral to treatment or other services;
- Record of admission to treatment if applicable;
- Record of reengagement in treatment if applicable; and
- Appropriate consents for the release of information.

Providers coordinate and collaborate with any other agencies providing outreach services in order to maximize outreach efforts. Providers develop and have on file a Memoranda of Agreement with the following entities: Seattle Public Schools; and other agencies providing YEP services in the same school. Providers partner with the SBHCs at Franklin and West Seattle High Schools and other Seattle schools as appropriate in the following ways: coordinate with the SBHC managers and staff to establish a process to receive referrals for students identified by the SBHCs for YEP services; prioritize SBHC-referred students for services and regularly communicate with SBHC staff around the status of their referrals; schedule regular meeting times to discuss student cases and program collaboration; and
ensure, in partnership with the SBHC, that appropriate consents are in place to communicate about student cases.

Providers give information about, and referrals to, other appropriate agencies if participants cannot be served by the Provider. Providers implement and maintain a tool to determine participant satisfaction with services provided under this scope of work. No fees are collected from participants served in the YEP. Providers notify the County of all staff changes affecting the program funded through this scope of work within three days of the resignation, termination, or any other change. A plan for replacing the staff person will be submitted to the County within seven days of the resignation, firing, or any other change. This plan will include timelines for replacing the staff person. Providers report any concerns about working with the SBHC to the Provider’s BHRD Contract Monitor on a timely basis. Providers maintain a log of YEP activities performed at the schools. The log includes date, duration of service, location, and name of staff conducting the service. Providers notify the County of changes to service delivery location and/or additions of school locations for services within three days of the change. Providers participate in County-convened meetings. Attendance at these forums will include, at a minimum, one agency representative.

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<th><strong>YEP Eligibility Criteria</strong></th>
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<td>Medicaid Status</td>
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<td>Age Range</td>
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<td>Authorization Needed</td>
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<td>Additional Criteria</td>
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<th><strong>YEP Reporting Requirements</strong></th>
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<td>Monthly Reports</td>
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<td>Annual/Other Reports</td>
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12 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 will work 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 shall review their Quality Management Plan at least annually. Such review shall incorporate updates and quality initiatives in line with the organization’s quality goals. The Provider is responsible for maintaining this documentation internally. A revised date shall be 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.

12.1 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 will not be 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 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 and grievances 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:

<table>
<thead>
<tr>
<th>Organization</th>
<th>Phone number</th>
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<tr>
<td>Amerigroup</td>
<td>1-800-600-441</td>
</tr>
<tr>
<td>Community Health Plan of Washington</td>
<td>1-800-440-1561</td>
</tr>
<tr>
<td>Coordinated Care of Washington</td>
<td>1-877-644-4613</td>
</tr>
<tr>
<td>Molina Healthcare of Washington, Inc.</td>
<td>1-800-869-7165</td>
</tr>
<tr>
<td>United Healthcare Community Plan</td>
<td>1-877-542-8997</td>
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</table>
12.2 Critical Incidents Program and Reporting Requirements

All Programs will 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 will maintain appropriate policies and procedures outlining response, and follow-up to Critical Incidents. Providers are expected to 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 will track critical incidents, identify trends, and address any patterns or trends identified that negatively affect individual and client safety or outcomes.

Providers will increase intervention for clients when incident behavior escalates in severity or frequency.

Critical Incident (CI) Reporting Criteria for non-Medicaid and Medicaid funded individuals or programs

Providers shall submit an individual Critical Incident Report for the following incidents that occur:

- Incidents that occur to an individual:
  - **Abuse, neglect, or sexual/financial exploitation** that occurred within a contracted behavioral health facility (inpatient psychiatric, behavioral health agencies), Federally Qualified Health Center (FQHC), or by independent behavioral health Provider.
  - **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 (Contractor shall include 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 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.

<table>
<thead>
<tr>
<th>Organization</th>
<th>Contact/Phone Number</th>
<th>CI Reporting Form</th>
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</thead>
</table>
| 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.

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<thead>
<tr>
<th>Organization</th>
<th>Contact/Phone Number</th>
<th>Link to CI Reporting Form</th>
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| Amerigroup (P1: AMG)                        | E-mail: QMNNotification@anthem.com                         | [https://Providers.amerigroup.com/Document  
s/WAWA_CAIestringanGroupCriticalIncidentReport  
Form.pdf](https://Providers.amerigroup.com/Document  
s/WAWA_CAIestringanGroupCriticalIncidentReport  
Form.pdf) |
| Community Health Plan of WA (P1: CHPW)      | E-mail: Critical.Incidents@chpw.org  
Fax: (206) 652-7056 | [https://www.chpw.org/resources/Forms_and  
_Tools/Critical-Incident-Form_Providers-  
12132019.pdf](https://www.chpw.org/resources/Forms_and  
_Tools/Critical-Incident-Form_Providers-  
12132019.pdf) |
| Coordinated Care (P1: CCC)                  | E-mail: wa_gocci_reporting@centene.com                     | [https://www.coordinatedcarehealth.com/content  
dam/centene/Coordinated%20Care/Provider/PDFs/508-CCW-  
CriticalIncidentNotification-Form.pdf](https://www.coordinatedcarehealth.com/content  
dam/centene/Coordinated%20Care/Provider/PDFs/508-CCW-  
CriticalIncidentNotification-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 will also provide 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 will focus on risk, safety, and quality of services using the BH-ASO Critical Incident Review Guide and will 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
13 Practice Guidelines

13.1 Behavioral Health Administrative Services Organization (BH-ASO) and King County Integrated Care Network (KCICN) Practice Guidelines

The purpose of these clinical practice guidelines is to provide a reference resource to the network. These guidelines are meant to help behavioral health Providers and agencies pursue clinical excellence in their daily work in serving our community. The King County Integrated Care Network and Administrative Services Organization (ASO) will not audit agencies against these practice guidelines, given the scope and depth of most of these guidelines.

The BH-ASO Medical Director works with Providers to establish Practice Guidelines. Adopted guidelines are behavioral health practices known to be effective in improving outcomes and based on:

- The needs of clients and families,
- Valid and reliable clinical scientific evidence, and
- In the absence of scientific evidence and professional standards, a consensus of Health Care Professionals in that field.

Providers are responsible for:

- Participating with the BH-ASO in the review, adoption, and update of practice guidelines at least every two years or more often if national guidelines change during that time;
- Maintaining awareness of the adopted practice guidelines,
- Referring to them when indicated; and
- Applying them as necessary.

Attachments in this Section:

- Attachment A: Practice Protocols for Peer Support
- Attachment B: Practice Protocols for Recovery and Resiliency-Oriented Behavioral Health Services
- Attachment C: Care Coordination Practice Guidelines
- Attachment D: Co-Occurring Disorders Practice Guidelines
- Attachment E: Wraparound Practice Guidelines
- Attachment F: BH-ASO Practice Guidelines
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 KCICN and the BH-ASO share the same requirements, the King County entity responsible for meeting or overseeing those requirements will be 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 KC BH-ASO will prioritize 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 will be 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 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 will be considered KC 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, KC 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 KC BH-ASO coverage for the first full month; and

c. There must be non-KC 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 KC 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.

B. Actual authorization to a non-Medicaid outpatient benefit is dependent upon the availability of KC BH-ASO financial resources.

C. 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 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 spend down.

D. The following table describes first and second priority populations for the use of non-Medicaid resources for routine MH outpatient benefits.

<table>
<thead>
<tr>
<th>Criteria</th>
<th>First Priority for MH Benefits</th>
<th>Second Priority</th>
</tr>
</thead>
</table>
| 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. |                 |
| Extraordinary Treatment Plan | Individual has a current non-Medicaid outpatient benefit; and  
Is receiving Extraordinary Treatment Plan (ETP) funds. |                 |
<table>
<thead>
<tr>
<th>Criteria</th>
<th>First Priority for MH Benefits</th>
<th>Second Priority</th>
</tr>
</thead>
<tbody>
<tr>
<td>Housing</td>
<td>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.</td>
<td></td>
</tr>
<tr>
<td>Community Inpatient Hospital Discharge (includes E&amp;Ts)</td>
<td>Individual is being discharged within next 30 days or was discharged within last 30 days from inpatient stay.</td>
<td>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.</td>
</tr>
<tr>
<td>Chronic Homelessness</td>
<td></td>
<td>Or, see below on Frequent Admissions/ Detentions/Incarcerations.</td>
</tr>
<tr>
<td>Discharge from PACT</td>
<td>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.</td>
<td>Individual is experiencing chronic homelessness (see Definitions); and LOCUS/CALOCUS score of at least 14-16.</td>
</tr>
<tr>
<td>3B for All Ages</td>
<td></td>
<td>CALOCUS score is 17-19; LOCUS score is 17-19; and Individual is being referred for 3B case rate.</td>
</tr>
<tr>
<td>3A for Children and Older Adults</td>
<td></td>
<td>Children; or Older adults; and Meet criteria for 3A level of care.</td>
</tr>
<tr>
<td>Criteria</td>
<td>First Priority for MH Benefits</td>
<td>Second Priority</td>
</tr>
<tr>
<td>----------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>King County Residents without Medicaid or other insurance</td>
<td>Individuals without Medicaid or other insurance; Children of Individuals without Medicaid or other insurance; and LOCUS/CALOCUS score is at least 14-16.</td>
<td></td>
</tr>
<tr>
<td>Medicare Qualifiers</td>
<td>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</td>
<td></td>
</tr>
<tr>
<td>Current Non-Medicaid Benefit with Medicaid Application Pending</td>
<td>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.</td>
<td></td>
</tr>
</tbody>
</table>
| 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.  
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.

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Enhanced Second Priority</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single Admission/Detention/Incarceration</td>
<td>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.</td>
</tr>
<tr>
<td>3A for all Ages</td>
<td>Individual meets the criteria for a 3A level of care.</td>
</tr>
<tr>
<td>Homeless</td>
<td>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.</td>
</tr>
</tbody>
</table>

F. The following table describes first priority populations for the use of non-Medicaid resources for routine SUD outpatient benefits.

<table>
<thead>
<tr>
<th>Criteria</th>
<th>First Priority for SUD outpatient benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>People leaving SUD residential treatment service including secure detox</td>
<td>Admission to residential treatment occurred within six months of request for authorization; and Has an ASAM level of 1.0 or 2.1.</td>
</tr>
<tr>
<td>Pregnant or Post-Partum Women</td>
<td>Has an ASAM level of 1.0 or 2.1.</td>
</tr>
<tr>
<td>IV drug users</td>
<td>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.</td>
</tr>
<tr>
<td>People who have high utilization of sobering, Detox, EDs, jail and/or a history of multiple DUls</td>
<td>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.</td>
</tr>
<tr>
<td>People who are military veterans</td>
<td>Has an ASAM level of 1.0 or 2.1. Reports participation in military service.</td>
</tr>
</tbody>
</table>

G. Second priority benefits are funded as resources permit.

H. For MH agencies that get a quarterly allocation, first priority benefits can be funded using the allocation or using the KC BHRD Clinical Specialist’s non-Medicaid fund source, at the discretion of the agency.

I. For MH agencies without a quarterly allocation, both first and second priority benefits are drawn from the KC BHRD Clinical Specialist’s non-Medicaid fund source.
J. For SUD agencies, first priority benefits are drawn from the KC BHRD Clinical Specialist’s non-Medicaid fund source. Attachment C-3 must be submitted for all non-Medicaid SUD benefit requests.

3.3 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.

3.3.1 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 will be available to the client, according to need and mutually negotiated goals of treatment.

3.3.2 Availability of MAT Services

A. Intake Appointment and initiation of services will comply with Managed Care CFR’s, and WAC 246-341-0610 or its successors.

B. A client will be 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 will 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 will provide case management, overdose prevention, and admission support services while the client is on the wait list.

   a. Pregnant women will be 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 BHRD 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 KC BHRD outpatient or residential levels of care, an ETP funding request may be made to the KC BHRD. ETP funds are provided only as resources permit. Requests for ETP funding will be submitted in accord with Attachment H.

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 will 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 will be 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 will document efforts to assist the individual in establishing care with one.

4.1.3 The following are also available:
Appendix A: BH-ASO Policies and Procedures

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 https://www.hca.wa.gov/billers-Providers-partners/programs-and-services/interpreter-services;

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 will be 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 246-341-0722 or 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:
1. Crisis services;
2. Withdrawal management services;
3. Stabilization services; or
4. 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. Be client-driven and strengths-based;
3. Meet the individual’s unique behavioral health needs; and
4. 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;

5. 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 will be documented and available for ISP revision.

B. Crisis services for clients receiving any behavioral health outpatient benefit.

C. 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.)

D. 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. These will include:

1. 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;

   c. There will be 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.

2. Other crisis services to be provided by all agencies contracted to provide behavioral health outpatient services:

   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 will be access to the client’s WRAP.

3. The crisis intervention staff will be qualified to provide crisis services.

a. The qualifications will 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 will educate clients and/or individuals who have legal responsibility for the client about when and how to use the designated crisis number. Providers will provide this same information to families and/or other natural supports as appropriate.

ii. Providers will supply their clients with a wallet card that includes necessary crisis information. This information will also be posted at the Provider’s clinical site(s).
iii. Clients will be educated about how to access psychiatric inpatient services, should such services be necessary.

E. Clients will participate in the development of a crisis plan (see Attachment K, Crisis Plan Form). Where appropriate, family members, significant others, behavioral health specialists, and/or cultural consultants will also be involved in the crisis plan development.

   1. All plans will be in the standardized format.

4.1.6 Services for an individual in a hospital ED

A. Providers will respond to all hospital EDs for any individual:

B. Enrolled in a behavioral health outpatient level of care; or

C. On a less restrictive order to their agency, even if a benefit has not yet been confirmed as follows:

   1. Upon the request of hospital ED staff, the Provider will give a telephone response as soon as possible and within two hours of the request;

   2. Providers will give all information that might assist ED staff in resolving the emergency without a hospitalization. This information will include:

      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 individual's WRAP plan)

   3. Phone contact with the ED will include 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 will continue efforts as follows:

   1. Hospital ED and Provider will 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 will go 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 will evaluate 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 will go to the ED, if not already there.

1. If the Provider recommends the commitment, before leaving the ED, the Provider staff will call the Designated Crisis Responders (DCRs) to offer assistance with declarations and any other activities to support CCS staff.

2. If the Provider does not recommend the commitment, the Provider staff need not complete a declaration for the detention.

F. Whenever outreach to the ED is given, the Provider will document 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 will be 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 will make 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 will be provided to the adult inpatient and residential liaison;

d. If clinically indicated, the Provider will have a face-to-face contact with the client within three working days;

e. The Provider will contact the inpatient team within three working days to discuss treatment planning;

f. The Provider will notify 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 will have ongoing face-to-face or telephone contact with the client and inpatient team while the client is hospitalized; and

h. The Provider will actively assist 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) will assist in the development of a less restrictive court order in order to enable the client to return to the community.

4. Providing timely care upon discharge which includes, at a minimum, a face-to-face direct service within seven calendar days following discharge.

5. 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.

B. For referred individuals who are not yet authorized to an MH outpatient level of care but who are eligible for BHRD services, BHRD Providers are responsible for:

1. Providing timely assessment, enrollment, and care on discharge which includes, at a minimum, providing a face-to-face direct service within five working 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;

2. 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.

C. 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 may not refuse to serve a client covered by Medicaid on a “less restrictive” court order.

B. Services will be provided according to the requirements in WAC 246-341-0805 or its successor.

4.1.9 Medication Evaluation Services

A. Each Provider agency will ensure 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 will have 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 will be met through the provision of outpatient services.

B. Providers will 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 will be 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 will maintain 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 will be 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 will include:

1. A written notice replying to the Physician, ARNP, Physician Assistant, trained public health nurse, or RN who made the EPSDT referral. This notice will include at least the date of the intake and diagnosis; and

2. If the child or family does not identify a medical care Provider, the Provider will inform the family of the EPSDT rights.
4.1.11 If the child or family does not identify a medical care Provider, the Provider will inform 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 will occur 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 will 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 will 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 will review the agency-specific outpatient service utilization reports provided by BHRD to identify service utilization patterns for all behavioral health outpatient benefits. Providers will 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 will 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 will track 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 Provider; 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 will produce 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 will include the client’s outpatient Provider.

B. Individuals who are not authorized with an outpatient Provider will be identified on the report separately.

C. Provider-specific client lists will be shared quarterly with each Provider’s clinical director.

D. Providers will participate in BHRD approved quality improvement initiatives.

E. 4.3.6 Provider agencies will 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 services to clients with ongoing benefits, Providers receive the monthly payments for each dose day a client provided during that month and adjustments made to previous months.

2. For services to new clients or to clients ending services, adjustments to payment may be applied retroactively.

3. Additional adjustments may occur as needed.

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 3A case rate will be requested.

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 will receive 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 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 The National Committee for Quality Assurance (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 the BHRD will follow-up on opportunities for improvement.
- BH-ASO will use 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 will work 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.
**Provision of Member Data to Delegates**

When requested, BH-ASO provides delegated agencies with data necessary to assess member experience and clinical performance. The member of the BH-ASO contracts team assigned to the delegate or vendor will coordinate requests for member experience and/or clinical performance data when requested. Activities delegated by BH-ASO to contracted agencies or vendors are outlined in Delegation Agreements. Delegated activities are mutually agreed on before delegation begins, in a dated, binding document or communication between BH-ASO and the delegated entity.

Member experience data includes but is not limited to:

- Complaints, feedback and other information collected from members that relates to the member’s experience with the delegates services. These include but are not limited to:
- BH-ASO Quality Review Satisfaction Survey
- Grievances filed of perceived violations of client rights
- Extraordinary occurrences or critical incidents across BH-ASO service Providers

Clinical performance data includes but is not limited to:

- Utilization data
- Cost data

All data transferred to a delegate or vendor is done via a secured process and in accordance with regulatory privacy and security protection standards.

**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 will require routine reports and documentation as listed in the delegation grid and will use 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,
Appendix B: Delegation Agreement for Contracted Crisis Services

- 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 will work 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.

<table>
<thead>
<tr>
<th>Function</th>
<th>Sub-Delegate Activities</th>
<th>Reporting: Data, Frequency, &amp; Submission</th>
<th>King County BH-ASO Activities</th>
</tr>
</thead>
</table>
| 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 will receive and review the IRR scores. |
| Members and practitioners can access staff to | • Staff are available at least eight hours a day during normal business hours for inbound collect or toll-free calls regarding UM issues. [UM | None. | Manager of Delegation will oversee services to |
| 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 will oversee 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 | 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 will receive and review compliance during the annual file review. |
Appendix B: Delegation Agreement for Contracted Crisis Services

calendar days of the decision. [ASO contract, 11.4.3.3]

<table>
<thead>
<tr>
<th>CRISIS LINE TELEPHONE ACCESS DELEGATION GRID</th>
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<tbody>
<tr>
<td><strong>Function</strong></td>
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<tr>
<td>----------------------------------</td>
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<tr>
<td>Behavioral Health Telephone Access [ASO Contract, Exhibit E]</td>
</tr>
<tr>
<td>Behavioral Health Telephone Access [ASO Contract, Exhibit E]</td>
</tr>
<tr>
<td>Call Center Reports [ASO Contract, Exhibit E]</td>
</tr>
<tr>
<td>Call Center Reports [ASO Contract, Exhibit E]</td>
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<tr>
<td>246-341-0900 Crisis mental health (MH) services—</td>
</tr>
</tbody>
</table>

Crisis Line Call Center Reports to include:
- Caller demographics
## General

<table>
<thead>
<tr>
<th>Receiving any crisis mental health service in WAC 246-341-0905 through 246-341-0920 receives:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Clinical supervision from a mental health professional and/or an independent practitioner licensed by department of health; and</td>
</tr>
<tr>
<td>• 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.</td>
</tr>
<tr>
<td>• 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:</td>
</tr>
<tr>
<td>• A psychiatrist;</td>
</tr>
<tr>
<td>• A physician; or</td>
</tr>
<tr>
<td>• An advanced registered nurse practitioner (ARNP) who has prescriptive authority.</td>
</tr>
</tbody>
</table>

## 246-341-0905 Crisis mental health services—Telephone support services

<table>
<thead>
<tr>
<th>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.</th>
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<tbody>
<tr>
<td>The agency must:</td>
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<tr>
<td>• Respond to crisis calls twenty-four-hours-a-day, seven-days-a-week;</td>
</tr>
<tr>
<td>• 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;</td>
</tr>
<tr>
<td>• Assure communication and coordination with the individual's mental health care Provider, if indicated and appropriate.</td>
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</table>

## Documentation

<table>
<thead>
<tr>
<th>Clinical supervisors.</th>
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<tbody>
<tr>
<td>Documentation of violence prevention training.</td>
</tr>
<tr>
<td>List of current professional consultants.</td>
</tr>
<tr>
<td>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.</td>
</tr>
</tbody>
</table>

## Manager of Delegation will receive and review the policies and procedures, protocols, documentation and reports including monthly summary call logs.
Definitions

This section is currently under construction.
King County Behavioral Health Funding Structure

HealthCare Authority (HCA)

- Molina
- Coordinated Care
- Community Health Plans of Washington
  - United Health Care
  - Amerigroup

Behavioral Health and Recovery Division (BHRD)

- Medicaid-funded Services such as:
  - Outpatient Behavioral Health Services
  - Mental Health Residential Programs
  - Substance Use Disorder Residential Treatment
  - Health Homes Care Coordination
  - Wraparound with Intensive Services (WISe)
  - Program for Assertive Community Treatment (PACT)

- County- and City-funded Services:
  - All Mental Illness and Drug Dependency (MIDD) program
  - Supported Employment Services (SEP)
  - Education and Workforce Development

- Crisis Services and State- and Federally-funded Services such as:
  - Designated Crisis Responders (DCR)
  - Emergency Line (Crisis Connections)
  - Detoxification Services
  - Prevention Services
  - Federal Block Grant funded Services (Mental Health and Substance Abuse)
  - Crisis Diversion Services
  - Children’s Crisis Outreach Response System
### Your Information, Your Rights, Our Responsibilities

#### NOTICE OF PRIVACY PRACTICES
King County Behavioral Health and Recovery Division

**Effective Date:** January 1, 2019

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. This notice also describes how substance use disorder information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Section 1 describes your rights; Section 2 describes our uses & disclosures for health information; Section 3 describes our uses & disclosures for substance use disorder Information; Section 4 describes our responsibilities; and Section 5 is additional information.

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### Section 1: Your Rights

When it comes to your information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

- **Get a copy of health information.**
  - You can ask to see or get a copy of your health information we have about you. Ask us how to do this.
  - We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

- **Ask us to correct health information.**
  - You can ask us to correct your health information if you think it is incorrect or incomplete. Ask us how to do this.
  - We may say “no” to your request, but we’ll tell you why in writing within 60 days.

- **Request confidential communications.**
  - You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
  - We will consider all reasonable requests and must say “yes” if you tell us you would be in danger if we do not.

- **Ask us to limit what we use or share.**
  - You can ask us not to use or share your health information for treatment, payment, or our operations. We are not required to agree to your request and we may say “no” if it would affect your care.
  - We cannot share your substance use disorder information for treatment or payment purposes without your written consent.

- **Get a list of those with whom we’ve shared information.**
  - You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with and why.
  - We will include all the disclosures except for those about treatment, payment and health care operations and certain other disclosures (such as any you asked us to make). We’ll provide
one accounting a year for free but will charge a reasonable, cost-based fee if you ask for
another one within 12 months.

- **Get a copy of this privacy notice.**
  - You can ask for a paper copy of this notice at any time, even if you have agreed to receive
    the notice electronically. We will provide you with a paper copy promptly.

- **Choose someone to act for you.**
  - If you have given someone health care power of attorney or if someone is your legal
    guardian, that person can exercise your rights and make choices about your health
    information.
  - We will make sure the person has this authority and can act for you before we take any
    action.

- **File a complaint if you feel your rights are violated.**
  - You can complain if you feel we have violated your rights by contacting us using the
    information on page 3.
  - You can file a complaint with the King County Department of Community and Human
    Services Privacy Officer by sending a letter to 401 Fifth Avenue, Suite 400, Seattle, WA
    98104 or with the U.S. Department of Health and Human Services Office for Civil Rights by
    sending a letter to 200 Independence Avenue S.W., Washington, D.C. 20201, calling 1-877-
    696-6775 or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/
  - We will not retaliate against you for filing a complaint.

### Section 2: Our Uses and Disclosures of Health Information

**How do we typically use or share your health information?**

- **Help manage the health care treatment you receive.**
  - We can use your health information and share it with professionals who are treating you,
    coordinating your care or assisting with housing placement (if you don’t have housing).
    
    *Example: A provider sends us information about your treatment services so we can arrange
    for coverage or to coordinate additional services.*

- **Run our organization.**
  - We can use and disclose your information to run our organization and contact you when
    necessary.
    
    *Example: We use health information about you to develop better services for you.*

- **Pay for your health services.**
  - We can use and disclose your health information as we pay for your health services.
    
    *Example: We share information about you with the Washington State Department of Social
    and Health Services and Health Care Authority for payment of the services you receive.*

**How else can we use or share your health information?** We are allowed or required to share your
information in other ways. Usually in ways that contribute to the public good, such as public health and
research. We have to meet many conditions in the law before we can share your information for these
purposes. For more information see:

[www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html](http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html)
• **Help with public health and safety issues.**
  We can share health information about you for certain situations such as:
  ○ Preventing disease.
  ○ Reporting adverse reactions to medications.
  ○ Reporting suspected abuse, neglect, or domestic violence.
  ○ Preventing or reducing a serious threat to anyone’s health or safety.

• **Do research**
  ○ We can use or share your information for health research.

• **Comply with the law**
  ○ We will share information about you if state or federal laws require it, including with the
    Department of Health and Human Services if it wants to see that we’re complying with
    federal privacy law.

• **Respond to organ and tissue donation requests, work with medical examiner or funeral director**
  ○ We can share health information about you with organ procurement organizations.
  ○ We can share health information with a coroner, medical examiner, or funeral director when
    an individual dies.

• **Address workers’ compensation, law enforcement, and other government requests**
  ○ We can use or share health information about you:
    ○ For workers’ compensation claims.
    ○ For law enforcement purposes or with a law enforcement official.
    ○ With health oversight agencies for activities authorized by law.
    ○ For special government functions such as military, national security, and presidential
      protective services.

• **Respond to lawsuits and legal actions**
  ○ We can share health information about you in response to a court or administrative order, or
    in response to a subpoena.

• **Other Uses and Disclosures**
  ○ Disclosures for psychotherapy notes, disclosures for marketing purposes and disclosures that
    constitute a sale of protected health information require your authorization. Other uses and
    disclosures not described in this Notice will be made only with your written authorization.

### Section 3: Our Uses and Disclosures of Substance Use Disorder Information

The confidentiality of substance abuse disorder information is protected by regulations that are stricter than the regulations for more general health information. For example, we cannot share your substance use disorder information for treatment or payment purposes without your written consent.

We are allowed or required by federal law to share your substance use disorder information without your written consent in the following ways:

- To medical personnel in a medical emergency.
- To appropriate authorities to report suspected child abuse or neglect.
- To report suspected criminal activity.
- For research, audit or evaluations.
As allowed by a court order.
Pursuant to an agreement with a qualified service organization.

Other uses and disclosures of your substance use disorder information not described in this Notice will be made only with your written consent.

Violation of the federal law and regulations by a program is a crime. Suspected violations may be reported to appropriate authorities in accordance with federal regulations.

Section 4: Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this Notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

Changes to the Terms of this Notice

We can change the terms of this Notice, and the changes will apply to all information we have about you. The new Notice will be available upon request and on our web site and we will mail a copy to you. For more information see www.kingcounty.gov/healthservices/MentalHealth.aspx

Section 5: Additional Information

For more information see:
- www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

King County Department of Community and Human Services
Behavioral Health and Recovery Division
Privacy Officer (206)-263-9000
401 Fifth Avenue Suite 400, Seattle, WA 98104
GRIEVANCE AND APPEAL PROCESS BH-ASO
King County Behavioral Health And Recovery Division

Grievance Process
You can file a grievance if you are not happy with the way you were treated, the quality of care or services you received, or you have problems getting care. If you need help filing a grievance, call 1-800-790-8049, or if you have a machine for telephone calls because you do not hear well, please call TTD/TTY: 711. To file a grievance, contact:

King County Behavioral Health and Recovery Division/BH-ASO
401 5th Avenue, Suite 400 Phone: 1-800-790-8049
Seattle, WA 98104 Fax: 1-206-205-1634
Email: BHRDComplaintsGrievances@kingcounty.gov

We will keep your grievance private. We will let you know we received your grievance within two business days. We will try to take care of your grievance right away. We will resolve your grievance within 45 days and tell you how it was resolved.

Appeal Process An appeal is a request to review a denied service or referral. You can appeal our decision if a service was denied, reduced, or ended early. Below are the steps in the appeal process:

STEP 1: King County BH-ASO
STEP 2: State Administrative Hearing
STEP 3: Health Care Authority (HCA) Board of Appeals Review Judge

STEP 1 – BH-ASO Appeal
You have 60 calendar days after the date of our denial letter to ask for an appeal. You or your representative may request an appeal or may submit information about your case over the phone or in writing. You may fax the information to 1-206-205-1634. Within 3 calendar days, we will let you know in writing that we got your appeal. We can help you file your appeal. If you need help filing an appeal, call the Client Services Line at 1-800-790-8049.

You may choose someone, including a lawyer or provider, to represent you and act on your behalf. You must sign a consent form allowing this person to represent you. We do not cover any fees or payments to your representatives. That is your responsibility.

Before or during the appeal, you or your representative may look at your file, medical records, or other documents considered in the appeal. If you want copies of the guidelines we used to make our decision, we can give them to you. We will keep your appeal private. We will send you our decision in writing within 14 calendar days, unless we tell you we need more time. Our review will not take longer than 28 calendar days, unless you give us written consent.

STEP 2 – State Administrative Hearing
If you disagree with our decision, you can ask for a State Administrative Hearing. You must complete our appeal process before you can have an administrative hearing. You must ask for a hearing within 120 calendar days of the date on the appeal decision letter. When you ask for a hearing, you need to say what service was denied, when it was denied, and the reason it was
denied. Your provider may not ask for a hearing on your behalf. To ask for an Administrative Hearing, contact:

Office of Administrative Hearings
Phone: 1-800-583-8271
P.O. Box 42489, Olympia, WA 98504-2489

You may consult with a lawyer or have another person represent you at the hearing. If you need help finding a lawyer, check with the nearest Legal Services Office or call the NW Justice CLEAR line at 1-888-201-1014 or visit their website at www.nwjustice.org.

STEP 3 – Health Care Authority (HCA) Board of Appeals
You can ask for a final review of your case by the HCA Board of Appeals Review Judge. Notice of this right shall be included in the Initial Order from the Administrative Hearing. The decision of the HCA Board of Appeals is final. To ask for this review contact:

HCA Board of Appeals Phone: (360) 725-0910 Fax: (360) 507-9018
P.O. Box 42700 Toll-free: (844) 728-5212
Olympia, WA 98504-2700

Expedited (faster) Decisions: If you or your provider think waiting for a decision would put your health at risk, you may ask for an expedited (faster) appeal or Administrative Hearing. Information you think we need to look at must be given to us quickly. We will review your request and make a fast decision. If we decide your health is not at risk, we will let you know and we will follow the regular timeframe to make our decision.

Funding for some services is Limited by Available Money: Services paid by State Only or Federal Block Grant dollars are limited. If the money runs out, we cannot approve the service for you even if we agree the service is needed. If you are in the middle of an appeal or administrative hearing when the money runs out, we cannot continue the process.

Other Information
Billed for services: If you get a bill for services call Client Services Line at 1-800-790-8049.

Regional BH-ASO Ombuds
The Ombuds is someone that can help you with questions and filing grievances. For help, contact:

BH-ASO Ombuds Service at:
1-800-790-8049 (ext. 3)
Medicaid Client Rights

You have the right to:

1. Help make decisions about your health care, including refusing treatment
2. Be informed about all treatment options available, regardless of cost
3. Get a second opinion from another provider in your health plan
4. Get services without waiting too long
5. Be treated with respect and dignity. Discrimination is not allowed. No one can be treated differently or unfairly because of their race, color, national origin, gender, sexual preference, age, religion, creed, or disability
6. Speak freely about your health care and concerns and exercise your rights without any bad results
7. To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation
8. Be free of any sexual harassment
9. Be free of exploitation, including physical and financial exploitation
10. Have your privacy protected and information about your care kept confidential
11. Ask for and get copies of your medical records
12. Review your clinical record in the presence of the administrator or designee
13. Ask for and have corrections made to your medical records when needed
14. Ask for and get information about:
   - Your health care and covered services.
   - Your provider and how referrals are made to specialists and other providers.
   - How the health plan pays your providers for your physical and behavioral health care.
   - All options for care and why you are getting certain kinds of care.
   - How to get help with filing a grievance or complaint about your care.
   - Your health plan’s organizational structure including policies and procedures, practice guidelines, and how to recommend changes.
15. Receive your Member’s Rights and Responsibilities in writing at least yearly. Your rights include mental health and substance use disorder services.

16. Receive a list of crisis phone numbers

17. Choose a Behavioral Health Care Provider

18. Create a mental health advance directive

19. Be informed of and receive help completing mental or medical health advance directive forms

20. Appeal an authorization decision resulting in a denial of any aspect of care or service (Notice of Adverse Benefit Determination), and to receive help in filing it.

21. Practice the religion of choice as long as the practice does not infringe on the rights and treatment of others or the treatment service. You can refuse participation in any religious practice.

22. Be reasonably accommodated in case of sensory or physical disability, limited ability to communicate, limited English proficiency, and cultural differences:
   - Receive information you request and help in the language or format of your choice
   - Be provided a certified interpreter and translated material at no cost to you
   - Receive services in a barrier free location (accessible)

23. Submit a report to the Department of Health when you feel a provider has violated a rule for behavioral health agencies.

**If you’re unhappy with your health plan or services**
You or your Authorized Representative have the right to file a grievance. A grievance is a spoken or written complaint regarding your quality of care or how you were treated by your doctor or health plan. Once a grievance is filed:

- Your health plan must let you know by phone or letter within two working days that it received your grievance.

- Your concerns must be addressed as quickly as possible, not taking more than 45 days.

*Your health plan must help you file a grievance.*
<table>
<thead>
<tr>
<th>Health Plan</th>
<th>Phone number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amerigroup</td>
<td>1-800-600-441</td>
</tr>
<tr>
<td>Community Health Plan of Washington</td>
<td>1-800-440-1561</td>
</tr>
<tr>
<td>Coordinated Care of Washington</td>
<td>1-877-644-4613</td>
</tr>
<tr>
<td>Molina Healthcare of Washington, Inc.</td>
<td>1-800-869-7165</td>
</tr>
<tr>
<td>United Healthcare Community Plan</td>
<td>1-877-542-8997</td>
</tr>
</tbody>
</table>
Individual and Client Rights

King County Behavioral Health Administrative Services Organization (BH-ASO)

You have the right to:

1. Receive information regarding your behavioral health status

2. Receive all information regarding behavioral health treatment options including:
   - alternative or
   - self-administered treatment

3. Receive information about the risks, benefits, and consequences of behavioral health treatment (including the option of no treatment)

4. Participate in decision regarding your behavioral health care, including the right:
   - to refuse treatment, and
   - to express preferences about future treatment decisions

5. Choose a qualified behavioral health service provider when available and medically necessary

6. Receive age and culturally appropriate services

7. Practice the religion of choice as long as the practice does not infringe on the rights and treatment of others or the treatment service.

8. Refuse participation in any religious practice

9. Receive services without regard to race, creed, national origin, religion, gender, sexual orientation, age, or disability

10. Be reasonably accommodated in case of sensory or physical disability, limited ability to communicate, limited English proficiency and cultural differences:
    - Receive information you request and help in the language or format of your choice
    - Be provided a certified interpreter and translated material at no cost to you
    - Receive services in a barrier free location (accessible)
11. Be treated with respect and dignity regardless of race, gender, veteran status, religion, marital status, national origin, physical disabilities, mental disabilities, age, sexual orientation, or ancestry.

12. Be free of any sexual harassment or exploitation including physical and financial exploitation.

13. Be treated with consideration of your privacy to the extent required by law.

14. Exercise rights regarding your personal and health information in accord with state and federal confidentiality regulations.

15. Request and receive a copy of your medical record and be given an opportunity to request amendments or corrections.

16. Right to review your record in the presence of the administrator or designee.

17. Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.

18. Be free to exercise your rights and to ensure that to do so does not adversely affect the way you are treated.

19. Receive a copy of complaint or grievance procedures.

20. Submit a complaint or concern (or have a designee do so on your behalf), verbally or in writing, about any aspect of care or service other than a Notice of Action.

21. Submit a report to the Department of Health when you feel a provider has violated a rule for behavioral health agencies.

22. To appeal a King County BH-ASO authorization decision resulting in a denial of any aspect of care or service (Notice of Action), and to receive help from the BH-ASO in filing it.

23. Access emergency care 24 hours a day, 7 days a week; regardless of insurance status, income level, ability to pay and county of residence.

24. Be informed of your right to create and maintain a mental health advance directive (MHAD), and
   • Receive help in creating and maintaining one,
• Decide who will make medical decision for you if you cannot make them.

For more information see: https://www.hca.wa.gov/health-care-services-supports/behavioral-health-recovery/mental-health-advance-directives

25. To access the Ombuds for help regarding your rights regardless of insurance status, income level, ability to pay and county of residence

To reach the King County Behavioral Health Ombuds call: 1-800-790-8049 (ext. 3)

You may also contact the Office of Civil Rights for more information at http://www.hhs.gov/ocr.

Assistance is Available:

If you have questions about any part of this letter, or need this form in another language or a different format such as American Sign Language (ASL), oral interpretation, Braille, or large print, please call us at 1-800-790-8049 or please contact us through our Telecommunication Relay Service (TTY) at 1-800-833-6384 or dial 7-1-1. All accommodations or requests for alternative formats are provided at no cost.

Si tiene alguna pregunta de la información en esta correspondencia, o si necesita la información en otro idioma, o en un formato diferente (lenguaje de señales americano, interpretación oral, braille, o letra grande), llámenos al 1-800-790-8049 o comuníquese con nosotros a través de nuestro Servicio de retransmisión de telecomunicaciones (TTY) al 1-800-833-6384 o marque 7-1-1. Todos los alojamientos de formatos alternativos se proporcionan sin costo.
AUTHORIZATION FOR DISCLOSURE AND USE OF
SUBSTANCE USE DISORDER PROTECTED HEALTH INFORMATION

Name: ___________________________ DOB: _______________ Previous Name: ___________________________

By signing below, I authorize:

________________________________________________________
(name of substance use disorder treatment provider)

To disclose to the following organizations and for the following organizations to redisclose and share with each other:

The King County Behavioral Health and Recovery Division (KCBHRD), the Washington State Health Care Authority, and one of the following Managed Care Organization(s) as applicable, Amerigroup, Community Health Plan, Coordinated Care, United Healthcare, or Molina,

The following information related to my substance use disorder treatment:

- This signed consent form
- Identifying information
- Financial information
- Admission date(s)
- Service encounters
- Diagnosis(es)
- Clinical information
- Program specific substance use disorder assessment
- Anticipated discharge date
- Discharge Information (if applicable)

Purpose of the disclosure: To support treatment, coordination of care, payment and health care operations.

By signing this form, I understand:

- When I am asked to fill out this consent, I am entitled to a copy.
- I have the right to revoke this consent at any time. Any revocation will not affect any action that has already been taken based on the original authorization.
- Without my express revocation, this consent will expire upon the completion of treatment and exit from the KCBHRD; unless I am under the supervision of the Washington State Department of Corrections at the time of exit from the KCBHRD, then this authorization will expire at the end of the term of supervision.
- My substance use disorder records are protected by federal regulations that prohibit the recipient from making any further disclosure of this information unless further disclosure is expressly permitted by my consent or as otherwise permitted by 42 CFR Part 2.
- I will be denied substance use disorder services funded by KCBHRD if I refuse to sign this form.

Signature (Client or Person Authorized to Give Authorization) ___________________________ Date ___________________________

10/11/2018
All disclosures and redisclosures must be accompanied by the following notice: “This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR Part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2; a general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminal investigation or prosecute any alcohol or drug abuse patient.”
CONSENT for RELEASE of SUBSTANCE USE DISORDER TREATMENT
INFORMATION for SERVICE COORDINATION
King County Behavioral Health and Recovery Division
The Chinook Building, 401 Fifth Ave, Suite 400, Seattle, WA 98104
Fax: 206-205-1634

I, ______________________________ authorize the King County Behavioral Health and Recovery
Division (BHRD), to 1) disclose substance use treatment information to Public Health Seattle and King County,
mental health treatment agencies, substance use treatment agencies, and healthcare agencies, as needed, if
they are involved in my past, present or future care, and 2) disclose substance use treatment information to One
Health Port and Collective Medical who may disclose this information to mental health treatment agencies,
substance use treatment agencies, and healthcare agencies, as needed, if they are involved in my past, present
or future care.

The following information related to my substance use disorder treatment will be shared as needed: name and
other identifying information (such as DOB, gender, race), ProviderOne ID, disabilities, diagnosis, case manager
name and contact information, where and when I was enrolled and the types of substance use disorder and/or
mental health treatment services received within the King County Provider Network.

The purpose of this disclosure is to support service coordination, continuity of care and healthcare operations
for my treatment.

By signing this form, I understand:

• When I am asked to fill out this consent, I am entitled to a copy.
• I have a right to request and receive a list of agencies that have received my substance use treatment
  information.
• I have the right to revoke this consent at any time. Any revocation will not affect any actions that have
  already been taken based on the original authorization.
• Without my express revocation, this consent will expire upon the completion of treatment and exit from
  King County Provider Network.
• My substance use disorder records are protected by federal regulations that prohibit the recipient from
  making any further disclosure of this information unless further disclosure is expressly permitted by my
• I do not have to sign this form to receive substance use disorder services from the King County Provider
  Network.

Signature (Client or Person Authorized to Give Authorization)  Date

If Signed by Person Other Than the Client, Print Name, Provide Reason, relationship to the Client, Description of
Their Authority

10/30/18 v2
All disclosures and redisclosures must be accompanied by the following notice: “This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.”

For Program Use Only: The client chooses not to sign this form.
Staff signature ____________________________ Date ________________
### CRISIS PLAN

<table>
<thead>
<tr>
<th>Client Name:</th>
<th>DOB:</th>
</tr>
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<tbody>
<tr>
<td>Client Phone #:</td>
<td>Behavioral Health Agency:</td>
</tr>
</tbody>
</table>

#### Client Information

- **Primary Language:**
- **Interpreter Needed:** □ Yes □ No
- **Type of residence (check one):**
  - □ Facility
  - □ Independent
  - □ Foster
  - □ Care Group Care (Youth)
  - □ No residence
- **Residence Address:**
  - STREET
  - CITY
  - STATE
  - ZIP
- **Emergency Contact/Next of Kin/Natural Support:**
- **Phone:**
- **LR:**
  - Active ROI:
  - Expiration Date:
- **Current Access to Firearms:** □ Yes □ No
- **History of violence:** □ Yes □ No
  - *List methods, weapons and any recent dates below.*
- **History of suicide/self-harm:** □ Yes □ No
  - *List methods and any recent dates below.*
- **Substance use:** □ Yes □ No
  - *List all substances used including the type and frequency below.*
- **Baseline Behavior/Mental Status:**

#### Health History

- **Psychiatric Diagnoses:**
- **Medical Diagnoses, if known:**
- **Allergies:**
- **Prescribed medications (include date(s) prescribed):**
- **Useful Interventions/Recommendations:**
### Mental Health Advance Directives – What clinicians need to know

| Why clinicians need to know about mental health advance directives | • Clients have the right to have a mental health advance directive  
  • Clinicians:  
    o Inform clients of this right when client rights are reviewed  
    o Are required by Federal law to document whether or not a client has an advance directive  
    o Must provide written information to clients about mental health advance directives |
|---|---|
| What is an advance directive? | • An advance directive is a legal document that:  
  o Is created by the client at a time when he or she is capable of making treatment decisions in anticipation of a time when he or she is not able to do so.  
    • A person is presumed “capable” unless formally determined NOT to be capable.  
  o Tells other people what his or her treatment choices are when he or she is unable to make those choices.  
  • Advance directives exist for both physical health and mental health.  
  • This information will focus on mental health advance directives in Washington State. |
| Washington State Law | • Engrossed Substitute Senate Bill 5223  
  • Established guidelines for using Mental Health Advance Directives for adults in 2003  
  • Codified as Chapter 71.32 Revised Code of Washington (RCW)  
  • Purposes:  
    o Allows a person to get treatment if incapacitated and unable to provide consent  
      • Early treatment may prevent the need for involuntary treatment  
    o Allows a person to express instructions and preferences to either consent to treatment or to refuse treatment |
| What are the potential benefits of an advance directive? | • Provides information about:  
  o What worked in the past  
  o Early symptoms and care alternatives that may reduce hospitalization  
  • Empowers clients regarding treatment decisions  
  • Can provide for a substitute decision-maker called an “agent”  
  • Increased willingness of clients to seek voluntary treatment because they have more control over the process  
  • Offers a vehicle to share information that normally would be unavailable to crisis/emergency staff |
<table>
<thead>
<tr>
<th>Mental Health Advance Directives – What clinicians need to know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Who would benefit from having an advance directive?</td>
</tr>
<tr>
<td>• Anyone a judge, mental health professional, or health care provider might decide is not capable of making decisions for his or her self</td>
</tr>
<tr>
<td>• Anyone who might be:</td>
</tr>
<tr>
<td>o In crisis; and</td>
</tr>
<tr>
<td>o In a position in which he or she could not express his or her treatment preferences</td>
</tr>
<tr>
<td>Terminology used in an advance directive</td>
</tr>
<tr>
<td>• Principal</td>
</tr>
<tr>
<td>o The term used in statute to refer to the person executing a directive</td>
</tr>
<tr>
<td>• Agent</td>
</tr>
<tr>
<td>o Also referred to as an attorney-in-fact, surrogate decision maker, or a proxy; and</td>
</tr>
<tr>
<td>o Named in a Durable Power of Attorney</td>
</tr>
<tr>
<td>• Incapacitated</td>
</tr>
<tr>
<td>o Means a person cannot make sound decisions about his or her care or treatment</td>
</tr>
<tr>
<td>o Incapacity is determined by:</td>
</tr>
<tr>
<td>• Superior Court (client or agent can request it)</td>
</tr>
<tr>
<td>• One mental health professional and one health care provider* OR</td>
</tr>
<tr>
<td>• Two health care providers*</td>
</tr>
<tr>
<td>o Client must be told that determination is being sought</td>
</tr>
<tr>
<td>o Client can challenge a determination of incapacity</td>
</tr>
<tr>
<td>*One must be a psychiatrist, psychologist, or psychiatric ARNP</td>
</tr>
<tr>
<td>Key components of an advance directive</td>
</tr>
<tr>
<td>• Provides instructions about a person’s treatment wishes, what a person:</td>
</tr>
<tr>
<td>o Wants in the way of treatment or services; and</td>
</tr>
<tr>
<td>o Doesn’t want</td>
</tr>
<tr>
<td>• Appointment of an “agent”</td>
</tr>
<tr>
<td>o When a person gives power to another individual to make decisions when he or she is incapacitated</td>
</tr>
<tr>
<td>• The advance directive does not need to contain both of these components</td>
</tr>
</tbody>
</table>

*One must be a psychiatrist, psychologist, or psychiatric ARNP
### Mental Health Advance Directives – What clinicians need to know

<table>
<thead>
<tr>
<th>Required elements of a valid Advance Directive</th>
<th>Provisions that can be included in an advance directive</th>
<th>Examples of instructions that may be in an advance directive</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Must be in writing</td>
<td>• Preferences and instructions for mental health treatment</td>
<td>• Preferences for:</td>
</tr>
<tr>
<td>• Contains language that the person intends to create a directive</td>
<td>• Consent to specific types of mental health treatment</td>
<td>o Pre-emergency interventions</td>
</tr>
<tr>
<td>• Dated and signed by the person executing the directive</td>
<td>• Refusal to consent to specific types of mental health treatment</td>
<td>o Medications and treatments</td>
</tr>
<tr>
<td>• Designates whether or not the person wishes to be able to revoke his or her directive during incapacity</td>
<td>• Consent for admission to and retention in a facility for mental health treatment for up to 14 days</td>
<td>o Handling emergency situations (e.g., use of restraints, seclusion, or tranquilization</td>
</tr>
<tr>
<td>• Was witnessed in writing by two adults who each:</td>
<td>• Descriptions of situations that may cause the person to experience a mental health crisis</td>
<td>o A specific hospital or alternatives to hospitalization</td>
</tr>
<tr>
<td>o Personally know the person (cannot be family members, treatment providers, or named Agent)</td>
<td>• Instructions for care of children, pets, finances, and home</td>
<td>• Consents to contact previous care providers</td>
</tr>
<tr>
<td>o Was present when the directive was signed and dated by the person</td>
<td>o Suggested alternative responses that may supplement or be in lieu of direct mental health treatment (i.e. treatment approaches from other providers)</td>
<td>• Identification of who:</td>
</tr>
<tr>
<td>o Can declare the person did not appear to be incapacitated or under duress</td>
<td>• Appointment of an agent to make mental health treatment decisions on the person’s behalf - including authorizing the agent to provide consent on the person’s behalf for voluntary admission to inpatient mental health treatment.</td>
<td>o Should be notified if hospitalized</td>
</tr>
<tr>
<td></td>
<td></td>
<td>o May or may not come to visit in the hospital</td>
</tr>
<tr>
<td></td>
<td></td>
<td>o Should have access to mental health care records</td>
</tr>
<tr>
<td>Effective date, revocation, and expiration</td>
<td>Mental Health Advance Directives – What clinicians need to know</td>
<td></td>
</tr>
<tr>
<td>------------------------------------------</td>
<td>-------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>• A directive is valid upon execution</td>
<td></td>
<td></td>
</tr>
<tr>
<td>o All or part of the directive may take effect at a later time as designated in the directive</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• A directive may be:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>o Revoked, in whole or in part</td>
<td></td>
<td></td>
</tr>
<tr>
<td>o Time-limited (expiration date is identified in the directive), or have no expiration date</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Revocation of a Directive</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• A directive may be revoked by a person:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>o With capacity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• A person with capacity may revoke a directive in whole or in part.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>o When incapacitated</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• An incapacitated person may revoke a directive only if he or she elected at the time of executing the directive to be able to revoke when incapacitated</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• The revocation:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>o Must be in writing. A copy must be given to:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• The person’s agent, if there is one</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Any health care providers who already have a copy of the directive</td>
<td></td>
<td></td>
</tr>
<tr>
<td>o Is effective upon receipt by the agent and provider</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• A directive also may:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>o Be revoked, in whole or in part, by a subsequent directive</td>
<td></td>
<td></td>
</tr>
<tr>
<td>o Be superseded or revoked by a court order, including any order entered in a criminal matter</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A directive may be superseded by a court order even if the order doesn’t explicitly reference to the directive</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Extension of expiration date</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Extension of date</td>
<td></td>
<td></td>
</tr>
<tr>
<td>o A directive that would have otherwise expired remains effective until the person is no longer incapacitated</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• No extension of date</td>
<td></td>
<td></td>
</tr>
<tr>
<td>o If the person has elected to be able to revoke while incapacitated and has revoked the directive</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental Health Advance Directives – What clinicians need to know</td>
<td></td>
<td></td>
</tr>
<tr>
<td>---------------------------------------------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Time frames for determination of incapacity</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Must occur within 48 hours of initial request for capacity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>determination</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• If client is hospitalized under the advance directive:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>o Re-evaluate within 72 hours or upon change in condition</td>
<td></td>
<td></td>
</tr>
<tr>
<td>and then as requested by client or agent</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• If client is in outpatient treatment:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>o Re-evaluate within five days of the initial determination</td>
<td></td>
<td></td>
</tr>
<tr>
<td>and then as requested by client or agent</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Client is considered to have capacity if time frames are not</td>
<td></td>
<td></td>
</tr>
<tr>
<td>met</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Inpatient admission under an advance directive</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Client can be admitted as a <strong>voluntary</strong> patient for up to</td>
</tr>
<tr>
<td>14 days in any 21 day period</td>
</tr>
<tr>
<td>• After 14 days (or less if specified in MHAD) the client must:</td>
</tr>
<tr>
<td>o Be referred to a Designated Mental Health Professional (DMHP),</td>
</tr>
<tr>
<td>o Remain as voluntary patient (can be encouraged to stay), or</td>
</tr>
<tr>
<td>o Be released during daylight hours</td>
</tr>
<tr>
<td>• Client cannot be:</td>
</tr>
<tr>
<td>o Physically forced or restrained to prevent leaving if voluntary</td>
</tr>
<tr>
<td>o Retained in a hospital unless advance directive instructions are being substantially followed</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Honoring advance directives</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Directives are not entitlements to care</td>
</tr>
<tr>
<td>• But must be honored unless instructions:</td>
</tr>
<tr>
<td>o Conflict with involuntary treatment order</td>
</tr>
<tr>
<td>o Conflict with accepted standards of care</td>
</tr>
<tr>
<td>o Indicate treatment that is unavailable</td>
</tr>
<tr>
<td>o In an emergency, would endanger any person's life or health</td>
</tr>
<tr>
<td>o Indicate personal services (care of pets, household, finances) that facility doesn't normally provide</td>
</tr>
<tr>
<td>o Violate law</td>
</tr>
<tr>
<td>• Clinicians are not subject to civil liability or sanctions for unprofessional conduct:</td>
</tr>
<tr>
<td>o If directives are honored in good faith and without negligence</td>
</tr>
<tr>
<td>o If directives cannot be honored and the client and agent are informed and reasons documented in chart</td>
</tr>
<tr>
<td>• The inability to honor one section does not affect the validity of other sections</td>
</tr>
</tbody>
</table>
### Mental Health Advance Directives – What clinicians need to know

**What clinicians should document**
- Document if a client **does or does not** have an advance directive (for mental health or physical health)
- Keep a copy of advance directives:
  - In the client’s record
  - With the client’s crisis plan
- Note any revocation or changes in the client record
- Upon receipt of the advance directive, if unable or unwilling to comply with any part or parts of the directive for any reason:
  - Promptly notify the client and agent of the reason
  - Document the reason in the client’s record

**Agents and what they can do**
- Make decisions on behalf of the client:
  - Consistent with the directive or otherwise known by the agent
  - Based on the “best interest” of the client if instructions or preferences are not known
- Receive, review, and authorize use and disclosure of medical records
- Authority can be limited in the directive
- May resign at any time by written notice to client and providers
- Are not liable for cost of treatment
- May not be paid
- May not be the client’s provider
- Decisions are subordinate to decisions of a competent client

**Other provisions**
- If there is more than one directive, follow the directive most recently created
- Directives validly executed in another jurisdiction are considered valid

**Complaints about non-compliance with an advance directive**
- Clients may make a complaint about a provider’s non-compliance with an advance directive with:
  - KCBHASO Client Services
    - 206-263-8997
  - The Ombuds
    - 206-205-5329
  - The Washington State Department of Social and Health Services (DSHS)
    - 1-888-713-6010
<table>
<thead>
<tr>
<th>Mental Health Advance Directives – What clinicians need to know</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What clinicians should do</strong></td>
</tr>
<tr>
<td>● Understand the law</td>
</tr>
<tr>
<td>● Develop and follow policies and procedures</td>
</tr>
<tr>
<td>● Ask clients if they have an advance directive</td>
</tr>
<tr>
<td>● If not, provide:</td>
</tr>
<tr>
<td>○ Information about advance directives</td>
</tr>
<tr>
<td>○ A copy of the DSHS brochure available in English and other</td>
</tr>
<tr>
<td>languages at: [<a href="https://www.dshs.wa.gov/bha/division-behavioral-">https://www.dshs.wa.gov/bha/division-behavioral-</a></td>
</tr>
<tr>
<td>health-and-recovery/mental-health-advance-directives]</td>
</tr>
<tr>
<td>○ Assistance or referral to the state Office of Consumer</td>
</tr>
<tr>
<td>Partnerships at</td>
</tr>
<tr>
<td>1-800-446-0259 for assistance to complete an advance</td>
</tr>
<tr>
<td>directive</td>
</tr>
<tr>
<td>● Keep documentation in client record</td>
</tr>
<tr>
<td>● Integrate with treatment and crisis plans</td>
</tr>
<tr>
<td>● Use and support the use of the advance directive once it’s</td>
</tr>
<tr>
<td>completed</td>
</tr>
<tr>
<td><strong>Resources for clients and clinicians</strong></td>
</tr>
<tr>
<td>● <strong>Washington State Department of Social and Health Services</strong></td>
</tr>
<tr>
<td>○ Brochure and Forms</td>
</tr>
<tr>
<td>● [<a href="https://www.dshs.wa.gov/bha/division-behavioral-health-and-">https://www.dshs.wa.gov/bha/division-behavioral-health-and-</a></td>
</tr>
<tr>
<td>recovery/publications]</td>
</tr>
<tr>
<td>○ Office of Consumer Partnerships</td>
</tr>
<tr>
<td>● provides assistance in completing advance directives</td>
</tr>
<tr>
<td>1-800-446-0259</td>
</tr>
<tr>
<td>○ Complaints about a provider’s noncompliance with an advance</td>
</tr>
<tr>
<td>directive</td>
</tr>
<tr>
<td>1-888-713-6010</td>
</tr>
<tr>
<td>● <strong>Washington State Department of Health</strong></td>
</tr>
<tr>
<td>○ Online forms and electronic registration</td>
</tr>
<tr>
<td>● [<a href="http://www.doh.wa.gov/AboutUs/ProgramsandServices/Disease">http://www.doh.wa.gov/AboutUs/ProgramsandServices/Disease</a></td>
</tr>
<tr>
<td>ControlandHealthStatistics/CenterforHealthStatistics/LivingWillR</td>
</tr>
</tbody>
</table>
|       egistry]
The following are intended to present minimum criteria for King County Integrated Care Network (KCICN) services. The following Behavioral Health Risk Assessment shall be used consistently for all clients entering services to establish whether KCICN shall be the payer for client’s care. For clients who do not meet the below criteria, agencies must assist with appropriate linkages to appropriate levels of care.

**Functional Criteria for Severe Emotional Disturbance (SED) Determination (Mental Health services only—under age 21)**

To meet the functional criteria for SED, a person must have, as a result of a mental health diagnosis, current dysfunction in at least one of the following five (5) domains, as described below.

<table>
<thead>
<tr>
<th>Functioning in self-care</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Impairment in age-appropriate/developmental age self-care demonstrated by a person’s consistent inability to take care of ADLs.</td>
<td></td>
</tr>
<tr>
<td>Notes:</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Functioning in community</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Inability to maintain safety without assistance, a consistent lack of age-appropriate/developmental age behavioral controls, decision making, and/or judgment.</td>
<td></td>
</tr>
<tr>
<td>Notes:</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Functioning in social relationships</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Impairment of social relationships demonstrated by consistent inability to develop and maintain normal relationships with peers and adults, and/or children.</td>
<td></td>
</tr>
<tr>
<td>Notes:</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Functioning in the family</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Impairment in family function demonstrated by a pattern of significantly disruptive behavior exemplified by repeated and/or unprovoked violence to siblings and/or parents and/or caretakers, disregard for safety and welfare of self or others (e.g., fire setting, serious and chronic destructiveness, inability to conform to reasonable expectations that may result in removal from the family or its equivalent), and/or child-caregiver and family characteristics do not include developmentally based adaptive patterns that support social-emotional well-being. For early childhood functioning, individual rarely or minimally seeks comfort in distress, has limited positive affect and excessive levels of irritability, sadness, or fear, and/or demonstrates disruptions in feeding and sleeping patterns.</td>
<td></td>
</tr>
<tr>
<td>Notes:</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Functioning at school/work</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Impairment in school/work function demonstrated by individual’s inability to pursue educational goals in a normal time frame, identification by an IEP team as having an Emotional/Behavioral Disability, and/or inability to be consistently employed at a self-sustaining level.</td>
<td></td>
</tr>
<tr>
<td>Notes:</td>
<td></td>
</tr>
</tbody>
</table>
**Functional Criteria for Serious Mental Illness (SMI) Determination (Mental Health services only—over age 21)**

To meet the functional criteria for SMI, a person must have, **as a result of a mental health diagnosis**, current dysfunction in at least one of the following four (4) domains, as described below.

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Inability to live in an independent or family setting without support</strong></td>
<td></td>
</tr>
<tr>
<td>Neglect or disruption of ability to attend to basic needs. Individual demonstrates a need for assistance in Activities of Daily Living (ADL) and/or assistance accessing appropriate medical or dental care.</td>
<td></td>
</tr>
<tr>
<td><strong>A risk of serious harm to self or others</strong></td>
<td></td>
</tr>
<tr>
<td>Pervasive or imminent danger to self or others. Individual demonstrates assaultive behavior, has been arrested, incarcerated, hospitalized, or at risk of confinement because of dangerous behavior, is persistently neglectful or abusive towards others, and/or severe disruption of daily life due to frequent thoughts of death, suicide, or self-harm, often with behavioral intent and/or plan.</td>
<td></td>
</tr>
<tr>
<td><strong>Dysfunction in role performance</strong></td>
<td></td>
</tr>
<tr>
<td>Frequently disruptive or in trouble at work or at school, requires structured or supervised work or school setting, performance significantly below expectation for cognitive/developmental level, and/or unable to work, attend school, or meet other developmentally appropriate responsibilities.</td>
<td></td>
</tr>
<tr>
<td><strong>Risk of deterioration</strong></td>
<td></td>
</tr>
<tr>
<td>Individual’s gains in functioning have not solidified or cannot be maintained without treatment and/or supports.</td>
<td></td>
</tr>
</tbody>
</table>

If a person does not meet the above criteria, but clinician believes the person still meets requirements for KCICN to act as payor, explain the rationale below:

<table>
<thead>
<tr>
<th>Rationale</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Substance Use Disorder (SUD) Benefit Criteria (all ages)**

An individual’s eligibility for SUD benefits is determined by American Society of Addiction Medicine (ASAM) criteria.
<table>
<thead>
<tr>
<th>Client's Benefit Status (CSCO)</th>
<th>King County</th>
<th>NorthSound</th>
<th>Pierce County</th>
<th>Sallah (No OTP in Kittitas)</th>
<th>Thurston-Mason</th>
<th>Greater Columbia</th>
<th>Great Rivers</th>
<th>North Central</th>
<th>Spokane</th>
<th>SW WA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identified MCO</td>
<td>yes</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>no</td>
<td>T</td>
<td>T</td>
<td>T</td>
<td>T</td>
</tr>
<tr>
<td>No Identified MCO</td>
<td>yes</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>no</td>
<td>no</td>
<td>no</td>
<td>no</td>
<td>no</td>
</tr>
<tr>
<td>KC Drug Court Client</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>no</td>
<td>no</td>
<td>no</td>
<td>no</td>
<td>no</td>
<td>no</td>
<td>no</td>
</tr>
</tbody>
</table>

**Financial Eligibility Screens (All clients)**

MAT providers must complete the following steps before admitting a client to KC funded MAT services:
1. Verify that the client has an active Medicaid enrollment, or has an income that is 220% or lower of the federal low income scale.
2. The MAT provider will complete monthly income verifications with the client once they are enrolled.

**C = Conditional Admission (Additional requirements for Out of County Clients):**

MAT provider must complete these additional steps before admitting an Out of County client to KC funded MAT services:
1. The MAT provider does not have a contract or billing relationship with a funding entity within the client's county of residence that currently
2. The MAT provider verified that the client has chosen to attend an out of region provider instead of services in their area.

**T = Transitional Admission**

1. The client is in process of transitioning their CSCO to KC. This transition must be completed within 30 days.

**Reporting Requirements (for C and T clients):**

1. The MAT provider will submit the MAT Out of County Monthly Report (including Provider’s verification that the newly enrolled client meets the criteria for “C” or “T” admission, who they are and what region they are coming from).
Sobering Services – Short-term Emergency Shelter, Screening, and Recovery Referral Services to Adults under the Effects of Acute Intoxication

**Purpose:**
To describe sobering services details.

**Services:**
Sobering services shall be provided 24 hours per day, 7 days per week, 365 days per year.

1. **Service components:**
   a. Medical screening based on the Contractor’s physician approved protocols; and
   b. Observation and regular monitoring including:
      i. Breathalyzer testing;
      ii. Vital signs;
      iii. Head-to-toe physical scan of the person’s condition; and
      iv. General health screening.

2. **Additional supportive services:**
   a. Housing;
   b. Recovery support;
   c. Income support;
   d. Primary and mental health care;
   e. Clothing; and
   f. Personal hygiene.

3. **Case Management:** All sobering services clients will be offered a referral to case management services.

4. **Treatment:** All sobering services clients will be referred to continuing treatment, including detoxification and emergency medical care as required.

**Eligibility Criteria:**
1. Eligible persons shall be persons who are age 18 years or older and who are impacted by chronic substance use disorders (SUDs).

2. Priority populations are persons age 18 years or older and who:
Sobering Services

a. Do not have housing;

b. Are impacted by a co-occurring mental health (MH) disorder;

c. Frequently use publicly funded crisis services; and/or

d. Are Veterans, American Indians, and Alaska Natives.
Withdrawal Management – Acute Inpatient Substance Use Disorder Withdrawal Management to Clients

**Purpose:**
To describe withdrawal management services details.

**Service:**
1. The withdrawal management providers shall maintain the capacity and ability to assess and accept individuals 24 hours a day, 7 days a week unless King County Behavioral Health and Recovery Division (BHRD) approves a different schedule in advance.

2. Substance use disorder (SUD) withdrawal management services shall be provided only in facilities licensed by the Department of Health (DOH).

3. Providers shall guarantee that there will be no denial of services for referrals of priority individuals without a review by designated supervisory staff.

4. Providers shall ensure that no client shall occupy a withdrawal management bed for more than three days for alcohol and other drugs (AOD) withdrawal management or five days for opiate withdrawal management. Any exceptions to this must receive prior approval from King County via an exception to policy (ETP) for withdrawal management services request form provided by King County.

5. Providers shall maintain and implement policies and procedures regarding admissions and transfer of individuals between acute withdrawal management services that ensure utilization of all contracted beds, while ensuring all necessary medical criteria for transfer to interim services.

6. Providers shall maintain protocols for individuals who receive medication-assisted treatment (MAT) who need withdrawal management from other substances.

7. Providers shall conduct screening for mental health (MH) issues and make referrals for alcohol and other drug assessments within 48 hours of admission, using Global Appraisal of Individual Needs – Short Screen (GAIN-SS) and American Society of Addiction Medicine (ASAM) Criteria as per Washington Administrative Code (WAC) 388-877.

8. Providers shall ensure counseling of each individual by a chemical dependency professional (CDP) at least once during the individual’s stay and provide motivation to accept referral into a continuum of care for SUD treatment. Any counseling services shall be documented in the individual file.

9. Providers shall actively pursue and shall document appropriate linkages for ongoing SUD or MH treatment or referral.

10. Discharge planning shall include assistance in accessing and maintaining housing, assistance with accessing public transportation, coordination with medical care, coordination with MH or other social services, and accessing SUD treatment and self-help groups.

    a. Providers shall evaluate each client when developing a discharge plan and provide referrals to the level and type of service that best meets the client’s needs.
Withdrawal Management

b. Providers shall provide each client with a copy of their discharge plan and retain a copy in the client’s file.

c. Providers shall document linkages for SUD or MH treatment or referral to other services.

**Eligibility Criteria:**

1. Individuals must be determined to have a substance use disorder and in need of withdrawal management services using an assessment instrument that incorporates the ASAM Criteria and the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), or their successors.

2. Priority admission shall be given to the following adults in King County with Medicaid who are indigent and low-income:

   a. Women who are pregnant, parenting, or postpartum;
   
   b. Individuals who are transitioning from residential care to outpatient care;
   
   c. Individuals referred from a drug court; and
   
   d. Individuals referred by Screening, Brief Intervention, and Referral to Treatment (SBIRT) programs.
Critical Incident Report – Confidential
King County Behavioral Health and Recovery Division (BHBD)

Provider Agency: ___________________________ Date of Incident and time of incident (if known): ___________________________

Individual’s Date of Birth __________ Age ________ KCID #: __________

Gender ________ Ethnicity ________

Individual Receiving ☐ Mental Health Services ☐ King County Crisis and Commitment (CCS)
☐ Substance Use Disorder Services ☐ MH Services from another provider
☐ Both MH and SUD Services ☐ SUD Services from another provider

Type of Incident (click on right-side arrow to see options): ___________________________

Description of Incident (including what took place and, if known, the location of the incident; names, ages, services, histories, and nature of involvement of all individuals involved in the incident; and whether eloped individual was classified as mentally ill offender or sexually violent offender). Please include any relevant media links:

Provider Response to the Incident (including steps taken to minimize harm, and, if applicable, whether reported to law enforcement, restraining/protection order sought, workplace safety/personal protection plan developed or implemented; summary of debriefings):

Date Provider Learned of Incident: __________ Date of Last Face-to-Face Visit Prior To this Incident: __________
Individual's Current Location (click on right-side arrow): --select option--

Individual's location is unknown, describe attempts to locate:

Individual's Current Condition/Status:

Programs (please check all that apply):
- Crisis and Commitment Services (CCS)
- Evaluation and Treatment (E&T)
- Next-Day Appointments (NDA)
- Children's Crisis Outreach Response System (CCORS)
- Outpatient Mental Health
- Mobile Crisis Team
- Residential Housing (e.g., Supervised Living, Long-Term Rehabilitation, Standard Supportive Housing)
- Withdrawal Management Services
- Opiate Substitution Therapy
- Criminal Justice Initiatives
- Outpatient Substance Use Disorder
- Residential Substance Use Disorder
- Program for Assertive Community Treatment (PACT)
- Crisis Respite Program
- Crisis Solutions Center / Crisis Diversion Facility

Other Program

Incident Reported to (please check all that apply):
- Child Protective Services
- Law Enforcement
- Adult Protective Services
- Other Regulating Body

Date of Last Medication Management Session (if applicable):

Person Completing Form (Name/Title):

Phone  Email

Supervisor's Name/Title, verifying that standard review procedures for this critical incident are being followed:

Phone  Email

This form can be saved, printed, and faxed to King County BHRD at 206-296-0563. You can also send it (using secure email) as an email attachment. If you are sending it via email, please send it to BHRDCriticalIncidents@kingcounty.gov.
Practice Protocols for Peer Support

Purpose:
To be used as a guide to increase understanding, reduce confusion, and provide a path to successful integration of peer support specialists in the delivery of quality services. Peer Standards were originally developed in 2007 in response to requests from local mental health agencies who were seeking guidance on how to incorporate peer services into their current array of services. The 2013 retitled revision was informed by the national Pillars for Peer Support Services (2009, 2010, 2011, and 2012) and the 2009 Clark County Peer Support Guidelines. This 2018 revision was further informed by Core Competencies for Peer Workers in Behavioral Health Services (SAMHSA, 2015), National Practice Guidelines for Peer Supporters (International Association of Peer Supporters, 2013), and Understanding the Role of Peer Recovery Coaches in the Addiction Profession (NAADAC, the Association for Addiction Professionals, 2014).

These protocols were developed in a robust process with input from community mental health agency and Behavioral Health and Recovery Division (BHRD) staff including administration, supervisors, and peer support specialists as well as community stakeholders.

Expected System Outcomes:
The desired outcome is a clearer understanding of the roles, responsibilities, and value of peer support specialists working within an agency setting, and the achievement of a mutually respectful, cohesive, and effective working relationship for peers and non-peers within the behavioral health system. The ultimate goal is better outcomes for the people participating in services.

Provider agencies that integrate peer support specialists into their workforces find that they have a heightened awareness of the struggles faced by the people they are serving. Stigma is often reduced as negative attitudes toward people living with behavioral health challenges shift. Peer support specialists who work alongside other professionals provide living proof that recovery is possible. This can raise morale by providing evidence to service providers that people are resilient and can (and do) recover. Peers' personal experiences are a valuable asset to the clinical team. When they add their first-person knowledge and their stories of recovery to the service mix, services are enhanced and extended, as well as infused with hope and self-determination.

Definitions:
Certified peer counselors – Are self-identified consumers of mental health services (including parents or caretakers of children and youth with mental health challenges) who have completed specialized training provided or contracted by the Washington State Health Care Authority (HCA) and have successfully passed an examination administered by the HCA or an authorized contractor. Once employed by an agency, they must register with the Washington State Department of Health (DOH) as an Agency Affiliated Counselor.

Implementation guidelines – Are offered as suggestions for each protocol and should be adapted to fit the unique needs of each agency or program. The guidelines can be a demonstration that the protocol has been achieved, as in “You’ll know you’ve achieved this protocol when...” If an agency meets the protocols in ways other than those suggested by the guidelines, the methods must be articulated in agency policy and procedures.
Paraprofessional peer specialists – Are self-identified consumers of behavioral health services, including people with legal histories, who may be unable to become certified peer counselors because they have barriers to being approved as an Agency Affiliated Counselor or who have other barriers to becoming certified. Because of their own experience, these paraprofessional peers can share their strength and hope in their decision to stay in recovery even when they are challenged with systemic barriers.

Parent partners – Are parents or caretakers of a child who has had a history of mental health and/or behavioral issues and an experience of recovery and resiliency and who have completed training in providing peer support to families.

Peer recovery coaches – Are individuals who promote recovery from substance use/addiction issues based on shared lived experience. Peer recovery coaches help individuals seeking recovery by identifying and overcoming barriers, developing recovery capital, and supporting the individual’s recovery choices, goals, and decisions.

Peer support – Is the process of giving and receiving help between people in similar situations based on key principles that include respect, shared responsibility, and mutual agreement of what is helpful. The goal of peer support is to assist others in initiating and maintain mind-body recovery and resiliency.

Peer support specialists – Are people who are trained to provide peer support. They may be certified peer counselors, paraprofessional peers, parent partners, or peer recovery coaches. Note that the Washington State Plan service modality titled “peer support” funded by Medicaid must be provided by certified peer counselors. Peer support specialists may be paid or in volunteer or internship positions. Peer support specialists include:

1. Adults and youth who have a history of mental health and/or substance use issues who also have a personal experience of recovery and resiliency;

2. Parent partners; and

3. Same-age peers working with older adults.

Protocols – Are universal requirements. Each of 14 protocols includes a description and implementation guidelines. Several of the protocols touch on hiring practices and other issues usually handled by human resources (HR). It will be important to share this work with agency HR staff and to work together towards implementation of each of the protocols in a manner that fits with agency policies, and in context with all state, federal, and other regulatory guidelines. A number of the protocols and guidelines express policies and procedures that are usual and customary for all staff. Because some peers report their experience of agency employment differs from usual human resource policies and procedures (P&Ps), these expectations are reiterated in the protocols. The protocols include:

1. Valuing the provision of peer support services in community behavioral health settings;

2. Integrating peer support specialists into the culture of each agency;

3. Providing peer support within teams and promoting integration of peer support specialists as valued team members;

4. Respecting shared experiences as the foundation of peer support;
5. Ensuring clear employment practices for peer support specialists, including recruitment, job descriptions, orientation, and opportunities for advancement;

6. Ensuring equitable pay for peer support specialists;

7. Ensuring the provision of peer support specialist training and orientation to agency policies and procedures;

8. Supportive supervision practices for peer support specialists;

9. Individualized support and reasonable accommodations for peer support staff;

10. Providing opportunities for professional growth and development;

11. Promoting ethical practice for peer support specialists;

12. Promoting understanding of the role of mutual support in the provision of peer support;

13. Promoting self-care for peer support staff; and

14. Fighting the stigma associated with mental health and substance use disorders.

Same-age peers – Are persons trained to provide recovery and resiliency support services to older adults. These same-age peers need not necessarily have a lived experience of recovery, as many older adults do not see themselves as having a mental illness. Their need may be more for companionship as they build resiliency and attend to the tasks of aging, including life review, health concerns, and adjusting to loss. Same-age peers are considered paraprofessional peer specialists.

Requirements

Protocol 1 – Valuing the provision of peer support services in community behavioral health

Peer support specialists provide a living example of hope for others faced with the challenges of mental and/or substance use issues. The “if I can do it, you can do it” message doesn’t even have to be spoken – it’s right before their eyes. This often allows peer support specialists to engage and bond with people who otherwise would be reluctant to trust and use clinical services. They are advocates for recovery by virtue of the example they set as they work and share hope throughout their community. Peer support specialists can reach out and engage people otherwise unwilling to use behavioral health services. This is especially important because only 15 percent of people with serious mental illnesses are estimated to receive minimally adequate treatment (note: this is for the general population).

Hiring an individual who is in recovery and/or a parent or caregiver of a child or youth facing behavioral challenges to help others is empowering and provides an opportunity for them to utilize their unique knowledge and experiences as either a consumer of behavioral health services or a parent/caregiver of a child receiving behavioral health services. The work validates their prior experiences and can help them move toward a more fulfilling life.

Implementation guidelines:

1. Peer support specialist voices are respected and avenues are present at different levels of the agency to provide input and hope for recovery.
2. Peer support specialists are given meaningful assignments that really use their strengths and skills – not only driving, straightening the waiting room, or ordering/delivering lunches.

3. Formal peer support services delivered by peer support specialists are available in some format to all consumers utilizing the agency.

4. There are opportunities for input from peer support specialists relating to planning, development, and implementation of policy within the agency.

**Protocol 2 – Integrating peer support specialists into the culture of each agency**

Provider agencies and peer support specialists identified a need to recognize that hiring peer support specialists often leads to a cultural shift in traditional behavioral health settings. Provider agencies provide opportunities and support for that change to happen. The integration of peer support staff into a community behavioral health agency, while proven to be beneficial, can also be challenging for the peer and fellow agency staff. It is essential to recognize the degree to which the job of a peer support specialist includes the role of a change agent and to ensure that peer support specialists understand and explicitly choose this potential role and the manner in which they will carry it out.

Implementation Guidelines

1. Each network provider agency is encouraged to draft a plan to foster successful integration of peer support specialists into their agency. The peer support implementation plan would cover hiring practices and a plan for the integration of peer support specialists into the philosophy and working practices of the agency.

2. Training regarding the benefits of peer support is incorporated into the agency’s orientation process for all staff. In addition, agency staff are encouraged to participate in training on peer support that BIRD and HCA will make available to the provider network as needed and within available resources.

3. Peer support specialists are given opportunities to speak at staff meetings and trainings, as appropriate to the training/meeting content and as they are comfortable, and share their stories of success.

4. Peer support specialists working within an agency are allowed time to network, meet together, and debrief their roles in support of each other. If there is only one peer support specialist within an agency or organization, allowances are made for the peer support specialist to connect at least monthly with a fellow peer support specialist from a similar position for mutual support. This could be accomplished by attending a network of peer support specialist meetings provided by King County or other meetings facilitated by network providers.

5. Peer support specialists are helped to voluntarily understand their potential role as an agent of change and explicitly choose that role and the manner in which they will carry it out. To the extent that organizations expect peer support specialists to act as change agents, this is explicitly defined in the job description. In addition, staff are educated about this aspect of peer support services. As acting as a change agent is a challenging while fulfilling role, supervisory support for this role is imperative. The assigned supervisor understands the nature and challenges of acting as a change agent. If this aspect of the peer support specialist role is not expected, this is noted in the job description. Training in the role of the peer support specialist as an agent of change will be provided
by BHRD and HCA, as needed and within available resources, to ensure that this is understood across the provider network.

6. Provide training for all staff, including peer support specialists and their supervisors, to help them recognize that the experience of stigma can be victimizing and that combating stigma is the responsibility of all staff, rather than just the responsibility of the peer support specialist or other staff members with a history of behavioral health issues.

**Protocol 3 – Providing peer support within teams and promoting integration of peer support specialists as valued team members**

Provider agencies and peer support specialists identified the need for peer support specialists to be a respected and responsible part of the treatment/recovery team. They must be integrated and included as valued team members.

**Implementation Guidelines**

1. There is a clearly defined team structure outlining specific roles and values to promote integration of peer support specialists with clinical staff. The team structure:
   
   a. Describes the importance of consultation across disciplines for all team members.
      
      i. Peer support specialists to mental health professionals (MHPs), chemical dependency professionals (CDPs), physicians, and other clinical staff;
      
      ii. MHPs to physicians, peer support specialists, and other clinical staff;
      
      iii. Physicians to MHPs, peer support specialists, and other clinical staff; and
      
      iv. Other clinical staff to MHPs, peer support specialists, and physicians.

   b. Defines what is and is not part of each team member’s role.

   c. Highlights the shared value across team members of helping people to recover.

   d. Supports routine communication between all team members.

   e. Clarifies that the peer support specialist represents the parent/consumer perspective to the team. When indicated, the peer support specialist also represents the guidance of the team to the parent/consumer.

   f. Describes the extent to which and how the peer support specialist carries out engagement, including limitations related to safety.

   g. If applicable, defines the peer support specialist role in assessment (for example, conducting a strengths summary), including any assessment activities that fall outside of the peer support specialist role.
2. The team supervisor role is critically important for creating and maintaining a team culture that understands and values the peer support specialist’s role. The supervisor for the peer support specialist helps to create a team culture in which differences can be addressed in a productive and supportive manner.

3. Specific team structure and roles are documented by the organization in a manner that either:
   a. Addresses all of the suggested areas in this protocol; or
   b. Notes why any suggested area is not addressed.
   c. The agency’s organizational chart represents the presence of the peer support specialists in the organization.

4. When peer support is requested by an individual, the delivery of peer support is evident in the clinical record by review of the treatment plan, progress notes, and treatment reviews. Peer support specialists use standard documentation methods for recording consumer progress toward recovery goals.

5. King County and HCA will provide training (as needed and within available resources) in the incorporation of peer support specialists into the treatment team.

Protocol 4 – Respecting shared experiences as the foundation of peer support
Provider agencies and peer support specialists identify a need to recognize that the role of a peer support specialist is based on shared experiences, and it is essential that those experiences sufficiently match the population they are hired to serve. Peer support comes in many different formats. It can be provided as an individual service recipient for other individuals, parent/caregiver for parents/caregivers, youth for youth, or family member for family members. Each of these groups has unique experiences that must be respected and supported within the behavioral health system. However, it should be recognized that, while common experiences are needed, there will never be an exact match between the experiences of two different people.

Implementation Guidelines

1. Provider agencies recruit and hire peer support specialists who have similar experiences and background to the population they are being hired to serve through the use of clearly defined job descriptions and recruitment materials.

2. Provider agencies have policies that require a basis of common experience between peer support specialists and the people they serve.

3. King County will ensure that training and technical assistance are provided as needed and within available resources to support provider agency implementation.
Protocol 5 – Ensuring clear employment practices for peer support specialist, including recruitment, job descriptions, orientation, and opportunities for advancement

Provider agencies and peer support specialists identify a need to have clear employment policies for peer support specialists. Peer support specialist positions have a specific purpose. The role of peer support specialist is an important and challenging position. It is essential that the person hired to fill this role be well qualified to provide support and ready to perform their specified job role in their community. A clearly defined and supportive job description allows the peer and those with whom they work to better understand the role they are being asked to play in the recovery process of others. Because peers are in their own process of recovery, and may be in transition from a dependence upon financial benefits and insurance provided by the state, many peers choose to work part-time. Provider agencies should support part-time work when necessary, appropriate, and possible.

Implementation Guidelines

1. Each agency has a clearly defined employment plan including non-discriminatory recruitment practices, a job description, hiring practices, and supporting policies in place to ensure the integrity of all agency roles including that of the peer support specialist. The plan should include:
   a. The process by which all peer employees will be recruited and hired;
   b. A general plan for professional development and growth-promotional opportunities for the role of peer within the agency, including a variety of positions that take into account their own strengths and desires, including leadership and non-peer-specific positions; and
   c. A clear outline of the chain of supervision for peer support specialists within the agency.

2. Job postings for peer support specialist positions include a clear description of what is being sought. In general, a peer support specialist ought to:
   a. Have relevant experience to the population being served by the program or agency;
   b. Have an understanding of the basic principles of recovery as it relates to behavioral health;
   c. Be at a point in their recovery where they are able to serve as a role model to others;
   d. Be willing and able to share their personal story; and
   e. Be able to articulate what has helped them in their recovery.

3. The hiring process takes into account the qualities that are needed for the peer support specialist position and candidates are screened accordingly. Peer support specialists are included on interview panels for new peer support specialist hires.

4. Provider agencies are flexible in setting work schedules, accommodating part-time peers whenever possible.
Protocol 6 – Ensuring equitable pay for peer support specialists
Provider agencies and peer support specialists observe that positions for peer support specialists are often viewed as entry-level positions and receive minimal pay, which sometimes does not fit the personal responsibility afforded to this position. Peer support specialists play an important role in the support of an individual’s recovery and wellness. They are asked to share of their personal lives and are often put in difficult and challenging positions with the people they serve. This position needs to be compensated appropriately.

Implementation Guidelines

1. Peer support specialists are compensated based on data from a market analysis of like positions within their community. This analysis includes:
   a. Consideration of special circumstances/job activities related to the role of peer support specialist;
   b. The salary structure takes into account the value of life experience as well as formal education; and
   c. The salary is commensurate with responsibilities and incorporated into the agency structure at an appropriate level.

2. King County and HCA will provide available information to support agencies as available and as requested.

Protocol 7 – Ensuring the provision of peer support specialist training and orientation to agency policy and procedures
Provider agencies and peer support specialists identify a need for peer support specialists to be trained to the body of work. In addition, peer support specialists must be oriented to the agency and provided with training in the same manner as any other employee of the agency who provides direct services. The orientation should include information specific to the role of the peer support specialist within that agency. Personnel records reflect appropriate training, orientation, and ongoing training as for any other employee.

Implementation Guidelines

1. Peer support specialists may receive training that is part of a certified or non-certified curriculum. All peer support specialists must receive training in basic concepts of peer support as reflected in the manual used for the certification training, including:
   a. Active listening skills with the ability to pick up cues while listening and then respond appropriately;
   b. Using personal experience to build empathy and rapport;
   c. How to be validating, provide information, and provide emotional support and encouragement;
   d. Assisting in developing and implementing the recovery plan, including identifying life goals and the steps needed to achieve them;
e. Assisting in reducing the sense of isolation and helplessness that consumers and families often feel;

f. Assisting in building resiliency to the impact of stigma encountered by persons and families living with behavioral health challenges, including internalized stigma;

g. Assisting in the development of self-advocacy skills;

h. When to seek consultation and practicing within the scope of their training;

i. Sharing their own recovery and resilience stories in ways that are relevant to the obstacles faced by consumers of behavioral health services;

j. Recognizing and utilizing one’s own unique strengths and experiences and applying them appropriately to the tasks at hand and to the relationships they have, both with colleagues and the consumers with whom they are working; and

k. Ethics, including:

   i. Dual relationships and role conflicts;
   
   ii. Confidentiality and privacy;
   
   iii. Mandatory reporting; and
   
   iv. Appropriate boundaries.

2. Peer support specialists shall receive continuing education as available internally or externally to the agency. The BHRD and HCA will assist, as resources are available. Topics shall include:

   a. Training in illness self-management, such as the Wellness Recovery Action Plan (WRAP) process as developed by Mary Ellen Copeland or Illness Management and Recovery, among others; and for children, youth, and families, awareness of the principles of Wraparound, is strongly recommended.

   b. Understanding the prevalence and impact of trauma in the lives of service recipients and trauma’s demonstrated link to overall health in later life, including the principles of trauma informed care;

   c. Principles of motivational enhancement;

   d. The unique aspects of working with someone who has a co-occurring disorder, including substance use disorders, developmental disabilities, etc.; and

   e. Principles of whole health, including:

      i. Encouraging and supporting self-directed recovery;

      ii. Illness self-management and disease management;
iii. Supporting choices to live tobacco-free, increasing physical activity, healthy diet choices, and social integration; and

iv. Facilitating linkage and integration of primary health care and behavioral healthcare.

3. Orientation for the peer support specialist shall cover:
   a. General information about the agency and the programs they provide;
   b. The newly hired peer support specialist’s chain of command;
   c. Safety practices for direct service staff, including self-care (managing stress, and burnout);
   d. Overview of job description;
   e. Overview of agency expectations regarding ethics and boundaries;
   f. Agency personnel and HR policies (hiring, discipline, separation from employment, grievance, leave procedures, accommodations);
   g. Training is provided to all staff, including peer support specialists, to promote understanding of differences between employee rights and consumer rights. For example, consumers are protected by laws guarding their right to confidentiality, but employees, including peer support specialists, are not. The training should encourage staff to be mindful of these differences. BHMD and/or HCA will provide or support training in this area as requested and within available resources; and
   h. Training in dealing with secondary trauma is provided to all direct services staff, including peer support specialists. BHMD and/or HCA will provide or support training in this area as requested and within available resources.

4. There is continuing education and training on at least an annual basis to ensure continued understanding of the topics covered in the orientation. In addition, the agency should identify at least one additional training issue to cover per year. Annual training shall include content addressing guidelines regarding mutual support (see protocol 12).

Protocol 8 – Supportive supervision practices for peer support specialist

The professional success of peer support specialist depends greatly on the quality and quantity of supervision they receive. The supervisor focuses on supporting the employee as they work to meet the expectations articulated in their job description within the context of agency values and the practice protocols.

Peer support specialists are to be held to the same level of accountability as other employees within the agency. To hold a peer support specialist to a lower or higher standard of accountability is stigmatizing, is unfair to other employees, and denies the peer support specialist opportunities for professional growth. Peer support specialists are to be treated as employees, not behavioral health consumers or family members.
Implementation Guidelines

1. Supervisors treat peer support specialists as they would any other employee including:
   a. Avoid under or over-supervising peer support specialists;
   b. Respect and treat peer support specialists as valued employees;
   c. Keep the focus of supervision on the job;
   d. The supervisor recognizes that the peer support specialist may pursue therapeutic support for issues that fall outside of the supervisor/supervisee relationship and may recommend resources as appropriate. Example: referring a peer support specialist to the agency’s Employee Assistance Program as would be the procedure for any staff employed by the agency; and
   e. Be familiar with these protocols and the content of the Peer Counselor Certification Training used by HCA and/or participate in training for peer supervision as available and offered by HCA and/or King County to ensure understanding of the body of work by peer support specialists.

2. Peer support specialist supervisors exhibit the knowledge, skills, and attitudes necessary to supervise peer support specialists, including evidence that they:
   a. Are invested in the agency’s decision to hire peer support specialists;
   b. Have an appreciation of the challenges faced by peer support specialists; and
   c. Have access to additional support and technical assistance.

3. Supervisors provide supervision only to individuals with whom they have never had a therapeutic or personal relationship.

4. Provide training for supervisors to help them be sensitive to the presence of stigma and proactive in supporting staff they supervise (including peer support specialists) to take steps to cope positively with its effects.

5. Supervision for all staff, including peer support specialists, is attuned to the need to support decision-making around appropriate and unethical mutual support. Supervisory meetings include discussions regarding boundary issues.

6. Supervisors of peer support specialists receive training on the Americans with Disabilities Act, Family Medical Leave Act, and Washington Family Leave Act and how to work with accommodations from request to implementation, in concert with agency human resources staff.

7. Supervision and any disciplinary actions taken are documented in accord with broader requirements for supervision, performance, and accommodation of disabilities.
Protocol 9 – Individualized support and reasonable accommodations for peer support staff

Peer support specialists qualify for their jobs to a significant degree because of a difficulty in their life rather than instead of it, so there may be the need for accommodations to support the person in the event of relapse or recurrence of these difficulties. It should never be assumed that because an employee is a peer support specialist that they will necessarily require extra support or accommodations. However, because peer support specialists by definition are either persons who have a history of behavioral health issues or are the parent of a child who has had a history of behavioral health issues, many peer support specialists may benefit from individualized support, as would any other staff person facing similar issues.

Examples of reasonable accommodations for people with behavioral health issues included providing self-paced workloads and flexible hours, modifying job responsibilities, allowing leave (paid or unpaid) while experiencing a disabling condition, assigning a supportive and understanding supervisor, modifying work hours to allow people to attend appointments with their medical provider, providing easy access to supervision and supports in the workplace, and providing frequent guidance and feedback about job performance.

An employer is not required to provide an accommodation if it will impose an "undue hardship" on the operation of its business such as accommodations that are excessively costly, extensive, substantial, or disruptive, or would fundamentally alter the nature or operation of the business.

Implementation Guidelines

1. All requests for accommodation are documented in accord with broader agency policy and procedures related to disabilities. The requests are handled professionally and expeditiously.

2. If a peer support specialist has a reasonable accommodation in place related to a disclosed disability, it is appropriate to use a different standard if that is part of the accommodation. However, the agency has a right to require adequate performance of documented job duties.

Protocol 10 – Providing opportunities for professional growth and development

Peer support is a valuable resource in a recovery-based system and peer support specialists need opportunities to gain knowledge and advance within the profession. Some peer support specialists may choose to advance as peer support specialists, including the potential of developing supervisory skills. Other peer support specialists may choose to pursue other jobs within the agency for which they qualify, including other clinical, MHP, and administrative jobs.

Implementation Guidelines

1. As with any staff member, the agency provides clearly defined policies and procedures regarding opportunities for training and advancement for peer support specialists which may include:

   a. Expanded responsibilities as a peer support specialist;

   b. Potential advancement into supervisory roles over other peers/agency staff; and

   c. Opportunities to pursue other clinical and administrative positions for which they qualify.

2. Peer support staff are encouraged to work with their supervisor to create a personal training, growth and development plan.
Protocol 11 – Promoting ethical practice for peer support specialists

Peer support specialists are held to the same ethical standards as other members of agency staff. All staff, including peer support specialists, who work in King County provider agencies are held to high ethical standards in their work with consumers and families. Agencies that hire peer support specialists who receive services from the agency or have received services from the agency in the past shall proactively manage resulting dual relationship and conflicts of interest issues.

Implementation Guidelines

1. Agencies employing peer support specialists ensure that their staff receive the state-approved peer counselor certification training or the equivalent (see protocol 7). This training may be provided on-the-job with close supervision and support from other trained peers during an initial probationary period during which a peer support specialist is awaiting a training opportunity (due to an often long wait list to get into the state approved training).

2. Peer support specialists are provided with the same training as other clinical staff within their agency regarding the agency’s ethical guidelines. Training is provided at orientation and ongoing, in accord with agency policy and state requirements.

3. The agency has a plan and policies and procedures in place to protect the confidentiality and rights of any employee who also receives services from the agency or has received services from the agency in the past.

4. Clinical records of employees who are receiving services within the agency are only accessible to their direct service providers, to the extent feasible.
   a. The employee is made aware of any limitations in this confidentiality protection of their clinical records.
   b. A method for inquiry and issue resolution is identified and communicated to any employees who are also clients. This process offers recourse for any employee who believes their dual role as a client has been compromised.

5. Agency staff, including supervisors and peer support specialists, shall be provided information about emerging core ethical standards, including the code of ethics for parent partners articulated in the Wraparound Parent Partner Manual and those developed by the organization InterNational Association of Peer Supporters, released nationally in 2013 (see References).

Protocol 12 – Promoting understanding of the role of mutual support in the provision of peer support

The boundaries involved in the provision of peer support services are different than those involved in the provision of other clinical services. These boundaries need to be clearly defined to provide protection for the peer support specialist and for the people they are asked to serve. All team members need to understand the boundary between appropriate mutual support and inappropriate seeking of support or providing “counseling” to each other.

Implementation Guidelines

1. The provider agency has policies and procedures that address appropriate boundaries for all staff and provides regular training for staff to define and promote a positive understanding of mutual support
that includes the following definitions and boundaries. BHRD and/or HCA will provide or support training in this area as requested and within available resources. Key components of the policies, procedures and training should include:

a. A definition of mutual support (two people helping each other) as a positive occurrence and one of the principles underlying the positive impact of peer support;

b. Recognition that mutual support can occur freely if there is no power differential between the two people helping each other;

c. When a person is in the role of providing services or being a mentor, that peer support specialist should limit their sharing to positive, proactive elements and avoid unburdening themselves of unmet challenges, which may be overwhelming them. It is important to give the people receiving support the opportunity to be empowered through the experience of giving back support to the peer specialist. This is one of the essential aspects of mutual support. However, the peer support specialist or facilitator should not be unburdening themselves of problems which are beyond what can reasonably be expected to be handled by the people who are supposed to be the ones receiving the services or support. When the exchange of support becomes overburdened by the demands of the peer support specialist or facilitator, an unacceptable burden is placed on those who come to the experience seeking help for themselves;

d. Acknowledgement that power differentials can lead to situations in which limits must be put on the receipt of mutual support by the person in the more powerful position; these include if a person is in a formal role to provide help, there is a duty to provide help on the part of the person in the formal role. This is true whether or not the peer support specialist is in a paid or volunteer position (including internships).

2. There is consultation available in the organization to help any staff member determine when the receipt of support by the helper becomes unethical.

Protocol 13 – Promoting self-care for peer support staff

Like other direct service roles in community behavioral health settings, the role of a peer support specialist is a stressful position and the person filling the role must be cognizant of personal limitations and practice good self-care in the same manner as would any other staff member providing direct services in an agency. Peer support specialists also face stresses unique to their role. Provider agencies and peer support specialists must recognize the challenges faced in their role and be supported and encouraged in practicing good self-care so that they may be successful in their position. In addition, supervisors and co-workers need to respect the difficulties peer support specialists face and be supportive of their self-care activities.

Implementation Guidelines

1. All staff, including peer support specialists, are encouraged to use good self-care as a way to manage stress in their work.

2. Peer support specialists and all clinical staff are given opportunities to debrief difficult job-related situations with supervisors as part of regularly scheduled supervision.

3. Peer support specialists are supported when they need to utilize sick leave and vacation to take care of personal or family needs per agency policies.
4. All staff are encouraged to participate in training and other activities that provide support for self-care within their roles in the agency.

**Protocol 14 – Fighting the stigma associated with mental health and substance use disorders**

Provider agencies and peer support specialists observe the need to actively combat the effects of the stigma of mental health and substance use issues within the employment setting on an ongoing basis.

**Implementation Guidelines**

1. The provider agency has policies, procedures, and regular training for staff regarding the reduction of the stigma of mental health and substance use issues and the promotion of social inclusion.

2. The policies, procedures, and training also promote diversity.

3. The provider agency has policies and procedures that define how any staff member (including peer support specialists) that experiences stigma can positively address the stigmatizing experience.

4. Provide opportunities for peer support specialists to receive regular mutual support and peer consultation from other peer support specialists that includes mutual support to cope with the effects of stigma.

5. Agency policies, procedures, and practices promote the use of person-first language and discourage references to people by labels such as diagnoses.

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Practice Protocols for Recovery- and Resiliency-Oriented Behavioral Health Services

Purpose:
King County Ordinance #17553, passed in 2013, required implementation of the King County Recovery- and Resiliency-Oriented Behavioral Health Services Plan. Building upon progress made over the past decade, BHIRD continues to implement the Recovery- and Resiliency-Oriented Behavioral Health Services Plan to shift to a fully integrated service model grounded in recovery. The practice protocols for recovery- and resiliency-oriented behavioral health services is one of a set of strategies used to accomplish this shift. People who live with mental health challenges identified the fundamental components of recovery to include:

- Self-Direction
- Individualized and Person-Centered
- Empowerment
- Holistic
- Non-Linear
- Strengths-based
- Peer Support
- Respect
- Responsibility
- Hope
- Resiliency

Existing policies and procedures specify what needs to happen for people participating in behavioral health services. The practice protocols address the way services are provided to better express the fundamental components of recovery. The protocols reflect the dictum articulated by the community of people living with disabilities, “nothing about us without us” as they have been developed in partnership with providers and people living with behavioral health issues.

Expected System Outcomes:
The expected outcome is a system that continues to evolve to meet the promise of recovery. The recovery initiatives to date have created a strong foundation from which to build these protocols. The protocols address recovery and resiliency as supportive of overall health and wellness. The ultimate goal is better outcomes for the people receiving services.

While the protocols may become a guideline for practice liable to be reviewed for compliance, they are intended to be a blueprint for system change, and are understood as ideals representing a developmental process that will take a number of years to fully implement.

Definitions:
Service participant: a youth, adult, or older adult; OR the family and/or caregiver of a child who participates in behavioral health services in the publicly funded behavioral health system in King County. People who live with behavioral health challenges have the right to self-define in terms of how they are addressed, understanding that they are people first.

Trauma-informed care (TIC): the protocols begin with an attitude of respect; emphasize the sharing of information; support connection to self, family, and community; and perhaps most importantly, offer hope for recovery and resiliency. Choices are offered whenever possible and appropriate. This is important for recovery and resiliency as people living with mental health and substance use disorders have a high incidence of trauma.

Protocols: practices that demonstrate the fundamental components of recovery-oriented services. These practices can be adapted to fit the unique needs of each agency or program.
Examples are offered as suggestions and should be adapted to fit the unique needs of each agency or program. The examples can be a demonstration that the protocol has been achieved, as in “You’ll know you’ve achieved this Protocol when...” If an agency meets the protocols in ways other than those suggested by the examples, the methods must be articulated in agency policy and procedures.

Other definitions and principles of recovery- and resiliency-oriented behavioral health services are described elsewhere in the King County Behavioral Health and Recovery Division (BHRD) Policies and Procedures (P&P).

**Protocols:**

1.0 Governance

1.1 The governing board of each behavioral health provider agency shall be briefed at least quarterly by agency management regarding agency progress relative to the King County recovery and resiliency initiatives.

1.2 The governing board shall include a role for at least one person who self-identifies as a person with lived experience of behavioral health recovery.

1.2.1 If the behavioral health services are part of a much larger organization where the governing board is elected and/or has responsibility over many unrelated programs, the behavioral health program may substitute a local advisory committee that includes at least one person who self-identifies as a person with lived experience of behavioral health recovery.

1.2.2 Service participants who become members of boards shall receive appropriate orientation to board function and how to be an active member.

2.0 Culture

2.1 Agencies shall provide waiting rooms, reception areas, and other areas service participants gather that are welcoming and communicate a sense of safety, respect, and hope. Those serving children, youth, and families shall likewise provide an appropriate environment for their needs.

Examples include:

- Reception staff that are accessible, friendly, and welcoming;
- Colorful and interesting art;
- Magazines and other reading material that is in good repair, relatively current, and reflect the cultures and ages of the persons served;
- Plants, aquariums, toys, crayons, etc.;
- Facility, furniture and carpets in good repair;
- Lighting that is sufficient to read;
- Posters and literature about recovery and resiliency; and
- Staff help create a space that is physically and emotionally safe for those using the space.
2.2 Common areas are to be inclusive for those that use them. In as much as possible, agencies avoid giving the impression of “us versus them.”

Examples include:

- Reception staff easily accessible (rather than behind bullet proof glass with small windows); and
- Bathrooms inclusive of everyone (rather than staff bathrooms separate from service participants).

2.3 All staff engages with the person rather than with the diagnosis or disability, building trust over time.

2.4 Throughout care, efforts are made to record the person’s responses in their own words and in context rather than translating the information into professional language.

2.5 Agencies offer evidence-based practices as much as possible and when practical to do so.

2.6 To integrate employment within the larger system, the task of encouraging people to consider and engage in employment and/or education is the responsibility of the entire network, including those not specifically charged with supported employment or education tasks.

2.7 Recovery and resiliency principles and practices are considered for each special population served by the agency (e.g. youth, gender, older adults, diverse cultures, etc.)

2.8 Recovery and resiliency principles and practices are incorporated throughout all agency-written materials, including policies and procedures, clinical forms, records, brochures, client handbooks, websites, or other media.

2.9 Respect is demonstrated by simple courtesy (as age appropriate.)

Examples include:

- Phone calls returned in a timely manner;
- Personal boundaries and personal space are respected;
- Everyone is treated in an age-appropriate manner;
- Privacy is protected; and
- Appointments begin and end on time, as much as possible.

2.10 Relapses in substance use and exacerbations of psychiatric symptoms are to be viewed as evidence of the challenges of the person’s condition and the non-linear nature of recovery; rather than indicative of a poor prognosis, non-compliance, or the person is not trying hard enough to recover.

2.11 Agency policies shall support hiring persons who live with behavioral health challenges for a variety of positions, not only peer support specialists.
2.12 All staff work as partners with service participants, collaborating to assist the person/family to reach their goals.

2.13 Services are grounded in an appreciation of the probability of improvement in the person’s life, offering people faith and hope that recovery is “possible for me.”

2.14 The focus of services is on recognizing, enhancing, and using existing strengths and resiliency, sometimes called “building recovery capital.”

3.0 Service Participants

3.1 Service participants including families, shall be offered information about recovery and resiliency at intervals appropriate to the individual or family’s needs and interests. King County shall provide technical assistance and resources when available.

Examples include:

- Literature provided at the time of intake;
- Posters and literature available in the waiting rooms/reception area and other places clients congregate, including virtual space, e.g., on an intranet available to service participants;
- Psycho-educational groups;
- One-on-one by a behavioral health worker, who may be a peer support specialist;
- Celebratory and educational events provided for service participants to provide information and resources about behavioral health recovery and resiliency; and
- Other methods as identified by the agency.

3.2 Each person served is provided with an orientation to agency practices, how best to utilize services and what to expect as well as what will be expected. This can be provided in a variety of ways.

Examples include:

- Via the intake process;
- A behavioral health worker who may be a peer support specialist;
- Written and electronic materials; and
- Other methods as identified by the agency.

3.3 The agency shall establish and support an ongoing consumer advisory group(s):

3.3.1 The group(s) may be called a committee, a panel, a bureau, etc.

3.3.2 The agency shall provide a group charter or group description.

A. The charter or description shall outline the expectations and responsibilities of the group, including:
1. Review of the agency’s planning, implementation, and evaluation of recovery- and resiliency-oriented initiatives, both those required by King County and those generated by the agency itself.

2. Methods whereby the group provides input, assists in identifying barriers, recommends strategies to address those barriers, and receives feedback regarding those recommendations.

3. A process for resolution of conflicts among members when indicated, with the participation of agency staff.

B. Once the committee is formed, the committee shall review the description/charter and provide feedback and recommendations for changes.

C. The agency shall have final authority and responsibility for the content of the charter or description.

3.3.3 The agency shall provide a staff liaison that may or may not be a co-facilitator of the group.

3.3.4 This group must have a formal relationship with the agency’s quality management process. This shall include:

A. A way for the group to provide recommendations for improvement;

B. A way for the group to be updated about the agency’s plan and progress to a recovery and resiliency orientation; and

C. A way for the group to receive feedback about recommendations to the agency.

Examples include:

- A staff liaison who also sits on the agency’s quality management team;
- A member of the group who also sits on the agency’s quality management team; and/or
- Written reports from one group to another.

D. The majority of the members of the group shall be service participants of the agency who are not also employed by the agency.

E. The group must be of a size and composition commensurate with the size and complexity of the behavioral health services of the agency.

F. The agency’s executive leadership shall participate in meetings of the group periodically.

G. The group members shall be provided with an orientation, including:
1. How the group functions (Robert’s Rules of Order, steps involved in conflict resolution, etc.);

2. Roles in the group (chair, vice chair, etc.);

3. The publicly funded behavioral health system in King County;

4. The Practice Protocols for Recovery- and Resiliency-Oriented Behavioral Health Services;

5. The agency’s structure, funding, and organizational hierarchy; and

6. The agency’s plan and progress on recovery and resiliency initiatives.

3.3.5 Stipends

A. Stipends are encouraged where possible.

B. If stipends are provided, clients shall be informed that stipends must be reported as income.

C. Clients shall be offered appropriate benefits counseling if receiving stipends.

3.3.6 The committee shall be informed that they are invited to send a member to attend any consumer workgroup or committee sponsored by King County.

3.4 The agency’s executive director, chief executive officer, or their designee shall meet at least quarterly with clients to listen and respond to their concerns and perspectives. (Meeting quarterly with the agency’s client advisory group would meet this standard.)

3.5 Information and agency updates are available routinely to people in recovery and their loved ones.

Examples include:

- A newsletter;
- Website;
- Postings in the reception area;
- Information shared in ongoing consumer groups, etc.

4.0 Staff Reference: Foundational Mental Health Recovery Competencies and Curricula – Attachment L, Appendix 1.

4.1 Job announcements and recruitment and hiring processes (job interviews) shall include a review of an applicant’s recovery competencies according to the Foundational Mental Health Recovery Competencies and Curricula.

4.2 Performance evaluations shall include the following considerations where possible:

4.2.1 Assessment of Foundational Mental Health Recovery Competencies.
4.2.2 Assignment of Foundational Mental Health Recovery Curricula for any competencies not already met.

4.2.3 Review of recovery outcomes of the clients on a staff person’s caseload, e.g. housing, employment, etc.

4.3 Clinical staff recognition, promotion, and financial incentives (when available) shall take into account recovery- and resiliency-oriented skills and outcomes.

4.4 Clinical staff shall participate in training to build skills and practices in accord with the King County Mental Health Recovery- and Resiliency-Oriented Clinical Skills Inventory (Attachment L, Appendix 2). Clinical staff includes:

4.4.1 Psychiatric practitioners; and

4.4.2 All other clinical staff that has direct contact with clients, including peer support specialists.

4.5 Organizations are encouraged to provide recovery and resiliency training for non-clinical staff that have direct contact with clients. King County Behavioral Health and Recovery Division (BHRD) will provide training as resources permit.

4.6 Persons with lived experience of recovery shall participate in training staff about recovery and resiliency. This may include service participants and/or peer support specialists. Stipends to recognize this contribution and the expenses people may incur for this participation are encouraged.

4.7 Staff are given multiple opportunities to hear recovery stories from the people they have worked with, and known in times of severe illness.

4.8 Staff members from all levels of the organization are informed about the agency’s planning, implementation, and evaluation of efforts to provide services from a recovery and resiliency orientation, including initiatives required by BHRD (e.g. performance toward incentive targets).

4.9 In as much as possible, program designs prioritize therapeutic relationships. Research has repeatedly shown that a therapeutic relationship perceived by the client as safe and positive is critical to good outcomes.

4.10 Staff encourage people to claim their rights and to make meaningful contributions to their own care and to the system as a whole.

4.11 Language

4.11.1 Staff are mindful of the power of language and carefully avoid the subtle messages that professional language has historically conveyed to persons living with behavioral health issues, and their loved ones.
Examples include:

- Referring to someone who lives with depression as “suffering from depression,” as “suffering” is a self-description concept to be used only by the person who is experiencing the “suffering”;
- “Case management” as people are not cases to be managed; and
- “Compliance” which suggests mindless conformity and the need to be taken care of as like a child. Terms like involvement, adherence, partnership, and cooperation are less passive, and more suggestive of someone taking responsibility for his or her own recovery.

4.11.2 Staff educate people about their diagnosis while avoiding the use of diagnosis as a short cut to refer to a person or as a label because labels yield minimal information regarding the person’s experience or manifestation of illness or addiction. Two people who both have the diagnosis of schizophrenia are more different than they are alike.

4.11.3 Language used by staff is neither stigmatizing nor objectifying. “Person first” language is used to acknowledge that the person’s individuality and humanity is more important than their illness.

4.11.4 Exceptions to person-first and empowering language that are preferred by some persons in recovery are respected.

5.0 Access to Care

5.1 The agency shall promote access to care by facilitating swift and uncomplicated entry, and by removing barriers to receiving care, as much as possible, given access to care rules.

5.2 People can access a wide range of services from many different points.

6.0 Assessment

6.1 Assessment begins at intake and is revisited during recovery planning, and periodically throughout services.

6.2 Assessment includes listening and clarifying with the person their life story, not simply a recording of reported symptoms and problems. Simple, yet powerful, questions can be helpful, such as “What happened? What do you think would be helpful? What are your goals in life?”

6.3 The message that recovery is not only possible but probable is communicated explicitly via statements and questions.

Examples include:

- “This is your recovery; how can we be helpful?”
- “I believe your life can get better;”
- “Working together, we will get your life back on track;”
• “What would your best life look like?”

6.4 Staff realize and communicate that all parties bring a certain expertise to the table, understanding that individuals (and parents and caregivers of children,) have learned much in the process of living with and working through their struggles.

6.5 Staff include the subjective experience of the person. This includes what motivates them, their hopes and dreams, what they are concerned about. Staff endeavor to see their situation from their perspective.

6.6 Agencies balance the requirement to establish medical necessity with an approach that is solution-focused and supportive of recovery. Medical necessity requires identifying what isn’t working in a person’s life. Much of the information required for medical necessity will emerge from the person’s life story and the reasons they have come in for services.

For example:

• The person’s stated goals are frequently the positive outcome of changes to what isn’t working. If the service participant’s goal is to get a job, when discussed, the person reveals difficulty in social situations, disorganized thought processes, etc.; and
• When the person describes symptoms that interfere with life goals, a hopeful and strengths-based response can acknowledge that symptoms are often disguised strengths. The ability to dissociate can be powerfully protective when a person is in a traumatic situation. Thus, recording symptoms to establish medical necessity can include reframing the symptoms in ways that acknowledge strengths.

6.7 A discussion of strengths is a central focus of every assessment. Challenges, problems, and issues should be addressed within a strengths and resilience-based framework. Exploring areas not traditionally considered “strengths,” can be helpful.

Examples include:

• The individual’s most significant or most valued accomplishments;
• Preferred ways of relaxing and having fun;
• Adaptive techniques the person has developed;
• Personal heroes; and
• Educational and social achievements, etc.

6.8 While strengths of the individual are a focus of the assessment, thoughtful consideration also is given to potential strengths and resources within the individual’s family, natural support network, service system, and community at large.

6.9 Assessments explore the whole of people’s lives while ensuring emphasis is given to the individual’s expressed and pressing priorities. This includes life roles such as parent, spouse, partner, worker, etc.
6.10 Cause-and-effect explanations are offered with caution; as such thinking can lead to simplistic resolutions that fail to address the person’s situation. In addition, simplistic solutions may be perceived as assigning blame for the problem to the individual.

6.11 Assessment shall be trauma-informed in that the focus is on what happened to the person, rather than a sole focus on what is wrong in the person’s life. Many individuals with behavioral health disorders also have histories of trauma. Attending to such histories may support the person’s recovery and resiliency.

7.0 Recovery Planning for the Individual Service Plan (ISP)

7.1 Development of individualized, person-centered plans shall occur in a process of shared decision making – see this link (as of 2014) [http://store.samhsa.gov/shin/content/SMA09-4371/SMA09-4371.pdf](http://store.samhsa.gov/shin/content/SMA09-4371/SMA09-4371.pdf)

7.2 Opportunities for employment, education, recreation, social and civic involvement, and religious participation are identified by the person in recovery via any useful or effective means such as community resource guides like #2-1-1.

7.3 The focus of care shifts from preventing relapse to promoting recovery and resiliency.

7.4 Goals and objectives are defined by the person with support from staff, with a focus on pursuing a life in the community, rather than defined by staff-based on clinically-valued outcomes (e.g., reducing symptoms, increasing adherence). The focus of planning is about building a meaningful and successful life in the community, including employment and/or other meaningful life activities, not merely maintaining clinical stability or abstinence.

7.5 People are asked what has worked for them in the past and when useful, these strategies may be incorporated in the ISP.

7.6 Plans respect the fact that services and practitioners may not remain central to a person’s life over time. As appropriate, strategies to transition to independence from the behavioral health system are clearly defined.

7.7 The ISP shall reflect the range of formal and informal supports a person might utilize for their recovery, not only those provided by the agency.

Examples include:

- Peers in paid or volunteer positions;
- Mutual aid groups;
- Indigenous healers;
- Faith community leaders;
- Schools;
- Community and social groups and clubs;
- Primary care providers; and
- Other natural supports.
7.8 Individuals are seen as capable of illness self-management. Interventions support this as a valued goal of recovery-oriented services. Illness self-management strategies and daily wellness approaches, such as Wellness Recovery Action Plan (WRAP), are respected as highly effective, person-directed recovery tools, and are fully explored and utilized.

7.9 Within the planning process, a diverse, flexible range of options are available so that people can access and choose those supports that will best assist them in their recovery.

7.10 Plans consider not only how the individual can access and receive needed supports from the behavioral health system and the community, but how the individual can connect with others for mutual support.

7.11 Movement through a pre-set sequence of care is not required, as recovery is neither a linear process nor a static end product or result.

8.0 Ongoing Services

8.1 An individual’s stage of change is considered at all points in time. Providers endeavor to meet each person where he or she is in the change process. Motivational assessment is continual and interventions are designed to enhance wellness and recovery.

8.2 Individuals are allowed the right to make mistakes, and this is valued as an opportunity for them to learn.

8.2.1 Unless determined by a court to require guardianship, individuals are presumed competent and entitled to make their own decisions.

8.2.2 Staff offer their expertise and suggestions respectfully while working with the person to identify the range of options and their possible consequences, both positive and negative.

8.2.3 Staff continue to try different ways of engaging and persuading individuals that respect the person’s ability to make choices on their own behalf.

Examples include:

- Phone calls;
- Letters;
- Visits to locales the person is known to visit;
- Contacting other professionals involved with the person; or
- Contacting informal supports for whom staff has a release of information.

8.2.4 Even in the earliest stages of recovery, staff assume the person’s mental health and/or substance use disorder is less a defining characteristic and more simply one part of a multi-dimensional sense of identity.
8.3 Interventions are aimed at helping people to gain autonomy, power, and connections with others.

8.4 Opportunities and supports are provided for the person to enhance his or her own sense of personal and social efficacy.

8.5 People are allowed to express their feelings, including anger and dissatisfaction, without having these reactions automatically attributed to an illness.

8.6 Care is attentive to cultural differences across ethnicity, and other distinctions of difference (e.g., age, sexual orientation, gender, gender history, socio-economic status, religious affiliation/belief, language, national origin, immigration status/history, developmental and intellectual ability, mobility, and/or sensory impairments).

8.7 Staff focus on preparing people for the next steps of the recovery process by anticipating what lies immediately ahead, by focusing on the challenges of the present situation, and by identifying and helping the person address anticipated potential obstacles versus dwelling on the past or worrying about the future.

8.8 When people express reluctance, fear, mistrust, and even disinterest in assuming the right and support to take control of their treatment and life decisions, staff assist them to explore and address the many factors influencing such responses. This is an important component of assessment and ongoing care and is basic to the recovery process.

8.9 When a service participant appears to disengage, the central concern shifts from: “How do we get the person into treatment?” to: “How do we support the process of recovery within the person’s natural environment?”

8.10 Staff look for signs of systemic, social, and/or organizational barriers or other obstacles to care before concluding that a service participant is non-compliant or unmotivated.

8.11 Agencies do not exclude people from ongoing care based on symptomatology, substance use, or unwillingness to participate in prerequisite clinical or program activities.

9.0 Crisis Services

9.1 Staff encourage individuals to devise and consult their own crisis plan, advance directives, Wellness Recovery Action Plan (WRAP), and/or other documents designed to reduce, modify, or eliminate distressing feelings and behaviors. Staff also assist the person with updating these documents when indicated, including identification of natural supports, respite locations in the community, complementary interventions, and a timetable for resuming responsibilities.

9.2 Staff take a holistic approach to assessing a crisis, considering that adults, children, families, and older adults with behavioral health issues often lead lives characterized by recurrent, significant stressors. Crises often represent the combined impact of
multiple factors including lack of access to essential services and supports, poverty, unstable housing or homelessness, coexisting substance use, other health problems, discrimination, institutionalization, and victimization.

9.3 Staff understand that a crisis often severely impacts a person’s normal abilities and responses, particularly a person with a history of trauma. Choices are offered in as much as possible.

9.4 Staff anticipate that a crisis event may become a cascading crisis that may be traumatic in and of itself. Crisis management may include forcible removal from one’s home; being taken into police custody, handcuffed and transported in the back of a police car, and incarceration; evaluation in the emergency department of a general hospital; admission to withdrawal management services; transfer to a psychiatric hospital; a civil commitment hearing; and so on. At multiple points in this series of interventions, there is the possibility that physical restraints, seclusion, involuntary medication or other coercion may be used.

Intense feelings of disempowerment are definitional of behavioral health crises, yet as the individual becomes the subject of an intervention, the person may experience diminishing sense of control. In addition, when a person is detained in jail or the hospital or is voluntarily hospitalized, additional crisis can result such as rent having not been paid, the person’s pet not having been attended to, etc. Natural supports may be a resource in attending to ancillary concerns such as a pet being fed, rent covered, etc.

9.5 Staff endeavor to respond to crises according to the following values and principles of crisis services identified and defined by SAMHSA in the document, “Practice Guidelines: Core Elements in Responding to Mental Health Crises” (see: [http://store.samhsa.gov/shin/content/SMA09-4427/SMA09-4427.pdf](http://store.samhsa.gov/shin/content/SMA09-4427/SMA09-4427.pdf) for more information).

9.6 Coercive measures are used only as a last resort, after all less restrictive measures are employed.

9.7 Staff endeavor to consider the following ten essential values when responding to crises:

- Reducing or minimizing risks of additional harm and ensuring a sense of emotional and physical safety.
- Intervening in person-centered ways.
- Sharing responsibility, including responsibility for managing risk in accordance with the capacity of the client.
- Providing trauma-informed care.
- Establishing feelings of personal safety.
- Basing interventions on strengths.
- Addressing the whole person.
- Addressing the person as a credible source.
- Preserving dignity, supporting ongoing recovery, resiliency, and natural supports.
- Prevention of future crises.
9.8 The following principles are to be employed when enacting the ten essential values for crisis services (in as much as possible):

- Access to supports and services is timely.
- Services are provided in the least restrictive manner.
- Peer support is available.
- Adequate time is spent with the individual in crisis.
- Plans are strengths-based.
- Emergency interventions are considered in the context of the individual’s overall plan of services, advance directives (if available,) and any other plan for crisis management.
- Crisis services are provided by individuals with appropriate training and demonstrable competence to evaluate and effectively intervene.
- Individuals with a self-defined crisis are not turned away.
- Interveners have a comprehensive understanding of crisis.
- Helping individuals regain a sense of personal control is a priority.
- Services are congruent with the culture, gender, race, age, sexual orientation, and communication needs of the individual being served.
- Rights are respected.
- Services are trauma-informed.
- Recurring crises signal a possible mismatch between care and needs. A review of the assessment and the individual services plan may be useful.
- Meaningful measures are taken to reduce the likelihood of future emergencies.
Care Coordination Practice Guideline

**Purpose:**
To ensure the health needs of individuals and families in the King County Behavioral Health and Recovery Division (BHRD) region are met through the coordination and provision of high-quality health care. A Care Coordinator organizes activities and information across service teams in alignment with the needs and preferences of the individuals receiving services to ensure the best possible outcomes.

**Coordination of Care:**
Coordination of care involves organization and collaboration of a client's care and involves two or more people who are a part of the client's care team. This can be individuals internal to the organization as well as external. Care coordination is a set of activities whereby every person served by the system has an individualized coordinated plan.

A. Care Coordination ensures the health needs of individuals in the region are met by:

1. Monitoring engagement and service activities of individuals;
2. Facilitating communication and collaboration between members of service teams. Ensuring the needs and preferences of the individual in services needs are known and met;
3. Engaging allied systems to address service gaps and resource shortages;
4. Providing discharge planning support to psychiatric inpatient units when barriers are encountered; and
5. Clearly documenting the coordination activity by way of consent, coordination log.

B. Activities include, but are not limited to:

1. Participation in meetings with allied systems, including collaboration on projects intended to address barriers which interfere with recovery efforts;
2. Data gathering, including review of treatment records and contact with members of service teams;
3. Consultation with KC BHRD staff and formal and informal supports; and
4. Provide service recommendations.
Co-occurring Disorders Practice Guidelines – Adults

Introduction:
A co-occurring disorder (COD) is the presence of both a mental health condition and substance use disorder (SUD). People with co-occurring disorders experience worse health outcomes, higher service utilization, higher costs over time.

1. Due to more severe symptoms in both domains, more hospital readmissions, and medical comorbidity (HIV, hepatitis B and C, high blood pressure, etc. – many of which are preventable).

2. Over the course of a lifetime, the prevalence of CODs can approach 50 percent.

3. People with CODs often end up coordinating their own care, which is often difficult, frustrating, and can result in stigma and prejudice.

4. Untreated and unidentified CODs associated with more difficulties in treatment engagement, the development of a therapeutic alliance, agreement with treatment recommendations, and increased odds for medical illness, suicide, and early mortality (i.e., people with mental health or substance use disorders die, on average, over 20 years sooner than people without either condition).

5. Therefore, COD may be considered a chronic condition for certain populations, so long-term services and continuity of care across programs and time must be available.

   Clinical conceptualization and interventions should vary for different populations, such as children and adolescents, transition-age youth, and older individuals.

Integrated care can make treatment more attractive to individuals in care, increase retention rates, and promote better outcomes.

1. Data exists to suggest that:

   a. People with CODs who engage in services have better mental health and substance use outcomes at six months.

   b. Individuals working with COD-trained clinicians had better mental health outcomes at 18 months than those who participated in mental health-only services.

   c. People with COD who engage in 12-step programs seem to benefit as much or more than individuals with SUDs only.

2. Conceptual models of COD:

   a. SAMHSA’s “four quadrant model” related to intensity of symptoms.

   b. COD care delivery: serial, simultaneous/parallel, coordinated/parallel, and integrated.

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1 https://store.samhsa.gov/SHOWCONTENT/PHD1130/PHD1130.pdf page 5
c. Center for Integrated Health Solutions: coordinated, co-located, integrated.

**Care Delivery**

People with diagnoses of both mental health and SUDs should receive concurrent treatment for both. Agencies and their staff should not prioritize treatment for SUDs over mental health disorders or vice versa, unless the individual chooses to address one before the other. This is consistent with the application of motivational interviewing and principles of recovery and harm reduction. Agencies and staff meet individuals where they are at and give them autonomy to shape their treatment and define their recovery goals.

**Engagement**

1. Single point of entry or “no wrong door.”

2. Assertive outreach and retention activities. “Outreach” does not refer to seeking new people for enrollment. This refers to engaging with individuals who would clearly benefit from services, but individual or systemic barriers are in their way.

*Recommendation: Reduce organizational red tape and create pre-treatment programming, perhaps with peer specialists, that can engage individuals while they wait for initial appointments and reduce wait times as much as possible.*

**Conduct intake/assessment**

1. Empathy

2. Person-centered

3. Trauma-informed

4. Culturally sensitive

   a. The underrepresentation of people of color, ethnic minorities, and LGBTQ in mental health and SUD treatment may be due to the lack of culturally sensitive services or culturally relevant staff.

   b. Many treatment agencies do not provide on-site childcare, which makes it challenging for single mothers to access care.

   c. Some individuals often have prefer gender-specific treatment (e.g., women-only groups).

*Recommendation: Use one single assessment that addresses both substance use and mental health disorders. Create specialized programs that consider various individual characteristics for mental health conditions, SUDs, or both.*

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2 For further suggestions about care delivery (e.g., potential targets for outreach, multidisciplinary teams, etc.), please see the fidelity scale from the integrated treatment for COD EBP (https://store.samhsa.gov/shin/content/SSMA08-4367/EvaluatingYourProgram-ITC.pdf, pp. 27-34)
Obtain collateral information

Universal screening across service settings for both mental health and SUDs.

1. This includes:
   a. Screening for alcohol misuse by all adults, including pregnant women.
   b. Screening for COD at initial presentation.
   c. Screening of youth entering child welfare and juvenile justice systems.

2. Screening should occur on-site.

Determine severity of symptoms

Determine appropriate level of care (CALOCUS/LOCUS/ASAM)

Recommendation: Use one single tool that addresses both substance use and mental health disorders, if regulations allow, to determine the levels of care for individuals.

Formulate diagnosis

1. All types of disorders are considered “primary”. While an assessment, such as SAMHSA’s four quadrant model, may suggest that one condition is more severe than another, the treatment focus should reflect individual choice. As such, no program, type of disorder, or approach to treatment is considered more important than others.

2. Diagnoses in COD are often unclear for a period of time, but this should not interfere with ongoing engagement and interventions.

Determine disability and functional impairment

1. Identify strengths and supports

2. Identify cultural and linguistic needs and supports

3. Identify problem domains

4. Determine stage of change (use of motivational interviewing)

5. Plan treatment / Continuity of care / Discharge planning
**Interventions**

There should be comprehensive services across programs and across disorders. Furthermore, staff should receive ongoing supervision and support in their use of evidence-based practices (EBPs). At minimum:

1. EBPs for:
   a. Individuals with co-occurring disorders:
      - Motivational interviewing (MI)
      - Cognitive behavioral therapy (CBT)
      - Skill-building
      - Medication assisted treatment (MAT)

      *Recommendation: COD services should include an on-site psychiatrist or ARNP.*
   
   b. Group interventions
      - Psychoeducation (e.g., Seeking Safety, Seven Challenges)
      - Dialectical behavioral therapy (DBT) skills groups
      - Wellness groups

      *Recommendation: Staff should receive training and supervision on how to facilitate groups.*
   
   c. Recovery communities (family, friends, other supports)
      - “Family” collaboration
      - “Family” education
      - Multiple family group
      - Peer support services

2. Other treatment approaches may have value if they help reach the individual’s desired outcomes and improves their health.

**References**

SAMHSA TIP 42: Substance Abuse Treatment for Persons with Co-Occurring Disorders


Integrated Treatment for Co-Occurring Disorders Evidence-Based Practices (EBP) KIT
Wraparound Practice Guidelines

Purpose:
To provide guidelines for best practice implementation of the wraparound process for outpatient providers who are serving clients not enrolled in MIDD Wraparound or Wraparound with Intensive Services (WISE).

Target Population:
Children and adolescents from birth up to age 21 who are receiving behavioral health services funded in whole or in part by the King County Behavioral Health and Recovery Division (BH&RD), who are authorized for a “high intensity” case rate, and who are involved with at least one other child-serving system.

Expected System Outcomes:
It is expected that by implementing a high-quality wraparound delivery model children and youth will demonstrate improved functioning at home, school/work, and within the community and will be maintained within their home and community environments, decreasing the utilization of more restrictive placements such as inpatient hospitalization, residential placement, or juvenile justice involvement. Additionally, the implementation of the wraparound delivery model will allow providers to meet the goals that the family has set for itself while evolving to the point where the family is empowered to engage more informal community supports.

Requirements:
Providers shall improve quality and consistency in the implementation of the wraparound process for children, youth, and families by developing internal policies and procedures that lead to the integration of the Ten Principles of the Wraparound Process, as described below, into service provision. The policies and procedures will also ensure that the wraparound process consistently follows the phases and activities detailed in the guidelines. When the guidelines are not followed for a particular client, the rationale for not following the guidelines shall be documented in the chart.

Ten Principles of the Wraparound Process:
Providers shall ensure that all staff provides services in accordance with the Ten Principles of the Wraparound Process:

1. Family voice and choice: Ensure that the needs and priorities of the family determine how and when services are rendered, and that the intervention goals and desired outcomes are mutually defined with the family and youth. Family and youth/child perspectives are intentionally elicited and prioritized during all phases of the wraparound process. Planning is grounded in family members’ perspectives, and the team strives to provide options and choices such that the plan reflects family values and preferences;

2. Team-based: The wraparound team consists of individuals committed to the family and youth through informal, formal, and community support and service relationships. The family and youth will agree on all team members;

3. Natural supports: The team actively seeks out and encourages the full participation of team members drawn from family members’ networks of interpersonal and community relationships. The wraparound plan reflects activities and interventions that draw on sources of natural support;
4. **Collaboration:** All team members work cooperatively and share responsibility for developing, implementing, monitoring, and evaluating a single wraparound plan. The plan reflects a blending of team members’ perspectives, mandates, and resources. The plan guides and coordinates each team member’s work towards meeting the team’s goals;

5. **Community-based:** The wraparound team implements service and support strategies that take place in the most inclusive, most responsive, most accessible, and least restrictive settings possible; and that safely promote child and family integration into home and community life;

6. **Culturally competent:** The wraparound process demonstrates respect for and builds on the values, preferences, beliefs, culture, and identity of the child/youth and family, and their community;

7. **Individualized:** To achieve the goals laid out in the wraparound plan, the team utilizes the particular strengths, assets, resources, and needs of the youth and family to develop and implement a customized set of strategies, supports, and services;

8. **Strengths-based:** The wraparound process and the wraparound plan identify, build on, and enhance the capabilities, knowledge, skills, and assets of the child and family, their community, and other team members;

9. **Persistence:** Despite challenges, the team persists in working toward the goals included in the wraparound plan until the team reaches agreement that formal wraparound support is no longer required and eventually evolving into a team of community support; and

10. **Outcome-based:** The team ties the goals and strategies of the wraparound care plan to observable and measurable indicators of success, monitors progress in terms of these indicators, and revises the plan as necessary.

**Recommended Guidelines for the Wraparound Process:**

The activities and phases described below are recommended as critical and necessary components for the implementation of high quality wraparound. The activities identify a facilitator as responsible for guiding, motivating, or undertaking the various activities. This is not meant to imply that a single person must facilitate all of the activities. The various activities may be split up among a number of different people. For example, on many teams, a parent partner or advocate takes responsibility for some activities associated with family and youth engagement, while a facilitator is responsible for other activities. On other teams, a facilitator takes on most of the facilitation activities with specific tasks or responsibilities taken on by a parent, youth, and/or other team members. In addition, facilitation of wraparound team work may transition between individuals over time, such as from a facilitator to a parent, family member, or other natural support person, during the course of a wraparound process.

Families, as defined by the wraparound process, may be a single biological or adoptive parent and child or youth, or may include grandparents and other extended family members as part of the central family group. If the court has assigned custody of the child or youth to some public agency (e.g., child protective services or juvenile justice), the caregiver in the permanency setting and/or another person designated by that agency (e.g. foster parent, social worker, probation officer) takes on some or all of the roles and responsibilities of a parent for that child and shares in selecting the team and prioritizing objectives and options. As youth become more mature and independent, they begin to make more of their own decisions, including inviting members to join the team and guiding aspects of the wraparound process.
The use of numbering for the phases and activities described below is not meant to imply that the activities must invariably be carried out in a specific order, or that one activity or phase must be finished before another can be started. Instead, the numbering and ordering is meant to convey an overall flow of activity and attention. For example, focus on transition activities is most apparent during the latter portions of the wraparound process; however, attention to transition issues begins with the earliest activities in a wraparound process.

**Phase 1  Engagement and team preparation:**
During this phase, the critical components and elements of the wraparound process are initiated. The family and youth are oriented to the wraparound process. The foundation of wraparound is built around the essential characteristics of the family and youth. In some situations, this may happen prior to the formal beginning of wraparound services.

1.1 **Orient the family and youth to wraparound:** The facilitator describes in detail the wraparound process and what level of participation is needed from each member of the group. The facilitator actively works to engage the family and youth in the wraparound process.

1.2 **Address pressing needs and concerns:** The family and facilitator identify the immediate needs in a way that provides for present and future stability. Any skills that need to be acquired to meet future needs may be identified at this time and used in the development of the wraparound care plan.

1.3 **Explore strengths, needs, culture and vision with child and family:** The facilitator leads the family through a process of identifying strengths of individual members and the family as a whole. The facilitator gathers information from the family in regards to the identified culture, values, and the vision the family has for itself. Goals and tasks of the wraparound care plan will be based on strengths and aligned to the family vision. Outcomes will be based on progress toward this vision.

1.4 **Solicit participation of team members, build team cohesion:** The family and facilitator work together to identify potential team members and decide how to illicit their participation. The facilitator and family work to ensure representatives from all systems involved with the family participate on the team. This might require exploring options regarding who is the most appropriate member of each system to attend. Peer counselors may be utilized in this process.

1.5 **Arrange meeting logistics:** Meetings should be arranged at a time and location convenient to the family. This may mean meetings outside of regular business hours at locations in the community, which are easily accessible and convenient to the family.

**Phase 2  Initial plan development:**
During this phase, the team works to develop the initial wraparound care plan. This care plan should utilize existing strengths and identify skills that need to be developed over the course of care. The plan should be developed with the ultimate goal of transitioning to informal and community supports.

2.1 **Identify goals and tasks of the wraparound care plan:** The team identifies goals and tasks needed to help the family move toward its vision and sets appropriate timeframes for completion of each task. The wraparound care plan uses existing strengths and builds skills needed to accomplish goals. The wraparound care plan addresses the family’s transition into the community and informal supports.

2.2 **Develop a crisis prevention plan:** The team works together to create a crisis prevention plan that utilizes community and natural supports as well as formal services to resolve a crisis as quickly as
possible at the least restrictive level of intervention. The plan should also incorporate strategies to prevent future crises. Any skills needed to resolve or prevent future crises should be identified and incorporated into the overall wraparound care plan.

**Phase 3 Implementation:**
During this phase, the initial wraparound care plan is implemented, progress and successes are continually reviewed, and changes to the wraparound care plan are made as needed. The activities of this phase are repeated until sufficient progress toward the goals identified in the wraparound care plan is made and the family is empowered to transition to less formal supports.

3.1 **Implementation of the wraparound care plan:** For each goal in the wraparound care plan, team members assume responsibility for tasks. Tasks should be shared amongst team members.

3.2 **Track progress and evaluate successes:** At each meeting, the team evaluates and monitors progress toward existing goals and modifies or adds any new goals identified by the team.

3.3 **Increase and strengthen informal and community supports:** New members may be added to the team to reflect identified post-transition goals, services, and supports. The team discusses and plans for responses to potential future situations, including crises, and negotiates the nature of each team member’s post-wraparound participation with the team/family.

3.4 **Maintain team cohesiveness and trust:** The facilitator helps the team to maintain cohesiveness and satisfaction by continually educating team members – including new team members – about wraparound principles and activities. The team shares the responsibility of open communication, active problem-solving, and ensuring adherence to the values and principles of wraparound.

**Phase 4 Transition:**
As the implementation of the wraparound care plan evolves and progress toward goals is achieved, the team moves toward a purposeful transition where the family is empowered to engage more informal community supports.

4.1 **Empower informal and/or community supports to take on increasing leadership of the team:** The facilitator and team work to identify an informal or community support person or persons to facilitate the team process. First consideration should always be given to the family, caregiver, or youth. This process may begin during the implementation phase through shared responsibility for leadership of the team.

4.2 **Implement transition to informal supports:** The team is continually supporting a natural progression from a team of formal support and service professionals to a team made up largely of community and natural supports. The family and youth are empowered to utilize their natural support systems to assist in skill building and resource gathering. The team reviews strengths and needs and identifies services and supports that can meet the needs that will best serve the youth and family beyond the formal wraparound team.

4.3 **Ongoing process:** As determined by the family, the team of natural and community supports continues to meet and support the family on an ongoing basis. To ensure that the family is continuing to experience success in meeting its goals, the team develops a procedure that empowers the family to identify and access appropriate services when needed. This may include inviting formal services to join the ongoing team to address a specific need or goal.
These guidelines meet the State Department of Social and Health Services (DSHS)-contracted mandate for practice parameters in accordance with the Balanced Budget Act.

For further detail regarding the phases and activities of the wraparound process, please refer to the following references and all subsequent practice guidelines accessed at the National Wraparound Initiative website: http://nwi.pdx.edu.


# KING COUNTY BH-ASO PRACTICE GUIDELINES

The following BH-ASO Practice Guidelines were reviewed by Quality Improvement Committee on 11/19/18 and approved by Clinical Director's Group on 12/19/2018.

<table>
<thead>
<tr>
<th>Disorder</th>
<th>Reference</th>
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<tbody>
<tr>
<td>Anxiety Disorders</td>
<td>The BH-ASO could not find any recent or up-to-date clinical practice guidelines related to anxiety disorders.</td>
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<tr>
<td>Bipolar Disorder</td>
<td>AACAP: Practice Parameter for the Assessment and Treatment of Children and Adolescents With Bipolar Disorder (2007) — use with caution, as these were developed prior to the establishment of Disruptive Mood Dysregulation Disorder (DMDD) <a href="https://www.aacap.org/article/50890-3567/09161968-7/pdf">https://www.aacap.org/article/50890-3567/09161968-7/pdf</a></td>
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<tr>
<td>Care Coordination</td>
<td>Quality Management Section 10, Attachment E: Care Coordination Practice Guideline</td>
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<td>Co-Occurring Disorders</td>
<td>Quality Management Section 10, Attachment D: Co-occurring Disorders Practice Guidelines – Adults</td>
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<td>Disorder</td>
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<td>Gender And Sexual Diversity</td>
<td>AACAP: Practice Parameter on Gay, Lesbian, or Bisexual Sexual Orientation, Gender Nonconformity, and Gender Discordance in Children and Adolescents (2012) <a href="https://www.aacap.org/article/56890-5567-1200500-X/pdf">link</a></td>
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<tr>
<td>Older Adults</td>
<td>Am. Psychological: Guidelines for Psychological Practice With Older Adults (2014) <a href="https://www.apa.org/journals/features/old-age-adults.pdf">link</a></td>
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<td>Recovery</td>
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<td>Quality Management Section 10, Attachment B: Practice Protocols for Peer Support</td>
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<td>Quality Management Section 10, Attachment C: Practice Protocols for Recovery and Resiliency-Oriented BH Services</td>
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<tr>
<th>Substance Use Disorders</th>
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<tbody>
<tr>
<td>AAP: Medication-Assisted Treatment of Adolescents With Opioid Use Disorders (2016)</td>
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<tr>
<td><a href="http://pediatrics.aappublications.org/content/pediatrics/138/3/e20161893.full.pdf">http://pediatrics.aappublications.org/content/pediatrics/138/3/e20161893.full.pdf</a></td>
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<tr>
<td>AACAP: Practice Parameter for the Assessment and Treatment of Children and Adolescents With Substance Use Disorders (2005)</td>
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<tr>
<td>APA: PRACTICE GUIDELINE FOR THE Treatment of Patients With Substance Use Disorders (2006)</td>
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<tr>
<td>APA: PRACTICE GUIDELINE FOR THE Pharmacological Treatment of Patients With Alcohol Use Disorder (2018)</td>
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<td><a href="https://psychiatryonline.org/jb/assets/pdf/10.1176/appi.books.9781615191969">https://psychiatryonline.org/jb/assets/pdf/10.1176/appi.books.9781615191969</a></td>
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<tr>
<td>Practice Guideline for the Assessment and Treatment of Patients With Suicidal Behaviors (2003)</td>
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<tr>
<td>National Suicide Prevention Lifeline (NSPL) Suicide Risk Assessment Standards (2007)</td>
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</table>
| Trauma     | SAMHSA: TIP 57: Trauma-Informed Care in Behavioral Health Services (2014)  
             | National Child Traumatic Stress Network: Tip Sheets for responding to different types of potentially traumatic interactions  
             | https://www.nctsn.org/resources/all-nctsn-resources?search=&resource_type=24&trauma_type=All&language=All&audience=All&other=All  
 | Tele-Psychiatry | AACAP: Clinical Update: Telepsychiatry With Children and Adolescents (2017)  
                     | https://www.aacap.org/article/18390-856/17/1/0333-7/pdf  
| Wrap Around | Quality Management Section 10, Attachment A: Wraparound Practice Guidelines |