North Sound Behavioral Health Advisory Board

Agenda

November 1, 2022
1:00 p.m. – 3:00 p.m.

Call to Order and Introductions

Revisions to the Agenda

Approval of October Minutes

Announcements

- Fred Plappert, Snohomish County Recognition
- Island County Candidate – Rose Dennis
- Whatcom County Candidate – Hannah Ordos

Brief Comments or Questions from the Public

Mobile Crisis Response Program Guide – Michael McAuley, Clinical Director

Peer Support Training Project – Margaret Rojas, Assistant Director

Executive Committee Report

Executive Director's Report

- Link to the report
  - Executive Directors Report-November 1 2022.pdf (nsbhaso.org)

Executive Director's Action Items

Old Business

- Announcement of the 2023 Officer Nominees
- Advisory Board Priorities Worksheet

New Business

- 2023 Pre-Meeting Training Topics
- 2023 Proposed North Sound BH-ASO Operating Budget
  - Link to the Proposed Budget
    - Proposed 2023 Budget_with COLA_final.pdf (nsbhaso.org)
- 2023 Proposed Advisory Board Operating Budget

— Co-Occurring Disorders and Treatment Conference Report from Members

Report from Advisory Board Members

Reminder of Next Meeting

Adjourn

North Sound Behavioral Health Advisory Board

October 4th, 2022

1:00 – 3:00

Meeting Minutes

Empowering individuals and families to improve their health and well-being

Members Present

- Island County: Candy Trautman, Chris Garden
- San Juan:
- Skagit County: Jere LaFollete, Deanna Randall-Seacrest
- Snohomish County: Pat O'Maley-Lanphear, Michele Meaker, Jack Eckrem,
- Whatcom County: Kara Allen, Alan Friedlob, Mark McDonald, Arlene Feld

Members Excused:

- Island County:
- San Juan County:
- Skagit County:
- Snohomish County:
- Whatcom County:

Members Absent:

- Island County:
- San Juan County:
- Skagit County:
- Snohomish County:
- Whatcom County:

North Sound BH-ASO Staff: Joe Valentine, Executive Director; Maria Arreola, Advisory Board Coordinator

Managed Care Organization Representation:

- United Healthcare: Stacy Lopez
- Coordinated Care:
- Molina Healthcare: Ashley Nelson
- Community Health Plan of Washington [CHPW]: Marci Bloomquist

Guests: Jennifer Yuen, Brad Banks, Rosemary Webb, GayLynn Beighton, Karen Schilde

Pre-Meeting Training

Kara Allen from Whatcom County presented on her non-profit organization Ascending Opportunities. This is an organization that helps transition individuals back in the community after serving time in jail or prison, transitioning back in the community after treatment and or currently battling addiction.

Call to order and Introductions

The meeting was called to order by Chair O'Maley-Lanphear at 1:03 p.m.

Revisions to the Agenda

No revisions mentioned

Approval of September Minutes

Motion made for the approval September minutes as written. Motion seconded. All in favor, Motion carried.

Announcements

— Jennifer Yuen, Snohomish County Recognition

- Chair O'Maley-Lanphear presented an honorable plaque to Jennifer Yuen. Her commitment of 9 years to the Board came with the vision to keep the system person centered. Jennifer recognized Joe as a pivotal leader in this organization. She will be dearly missed.

Brief Comments from the Public

Karen Schilde is a Co-Chair of National Alliance on Mental Illness [NAMI] Snohomish Affiliate. Karen is one of the founding members of the Everett Clubhouse. Karen attended to learn more about the Advisory Board.

Gaylynn Beighton is a volunteer for NAMI Snohomish as a Public Policy Chair. Gaylynn has lived experience. She is attending as an interested community member to serve on the Board.

Rosemary Webb is a volunteer Bookkeeper and was Chair for 1 year for NAMI Whatcom. NAMI helped her be an advocate for her family member. Rosemary is an interested community member to serve on the Board.

Candy was accepted to serve on the North Sound BH-ASO Diversity, Racism, Equity, and Inclusion [DREI] Workgroup, which will develop the North Sound 3-year DREI Strategic Plan. The plan is a written document and roadmap for the North Sound's journey to enhance racial equity.

North Sound Youth and Family Coalition Youth Tri-Lead

Kaleb is the North Sound YFC Youth Tri-Lead. Kaleb spoke on ways to engage youth in community boards. Kaleb is an active leader in his community serving and engaged in community boards and school organizations.

Kaleb showed the new redesigned North Sound YFC website. The website includes the contest winners' entries from the 2018 Advisory Board Art Contest. The art is shown throughout the website.

Brad Banks – North Sound BH-ASO Legislative Agenda

Brad is the legislative liaison between the ASOs and the legislature. The draft legislative agenda was reviewed. The purpose of the presentation is to assist the Board in ways to support the ASO in the legislative session.

Executive Directors Report

Joe reported on the following

- Update on Behavioral Health Services Coordinating Committee
- HB 1688 – Balanced Billing Act
- Continuation of COVID Federal Block Grant Funding
- Update on Facility Needs Assessment
- Crisis Services Update
- Update on the "North Sound Rural Communities Opioid Response Program" [HRSA Grant Award]

Executive Director's Action Items

Motion made to approve the Action Items excluding the Compass Health Child Youth Mobile Crisis Outreach Team. Motion seconded. All in favor. Motion Carried.

Motion made to approve the Compass Health Child Youth Mobile Crisis Outreach Team with a condition of the award below, to move to the Board of Directors for approval.

As a condition of this award, COMPASS HEALTH shall establish a community oversight/advisory committee for its Child-Youth Crisis Outreach Team that centers the voices of youth and families affected by mental health conditions in Skagit and Whatcom Counties. The purpose of this Advisory Committee is to support program accountability and transparency to the children, youth, and families that it serves so as to inform ongoing program improvement.

The motion was seconded. All in favor. Motion carried

Executive/Finance Committee Report

The September Expenditures were reviewed and discussed. Motion to move the Expenditures to the Board of Directors for approval. Motion seconded. All in Favor. Motion Carried.

Old Business

Strategic Planning Ad Hoc Committee - Summary

Members were asked to provide responses to the Advisory Board Priorities Worksheet. The worksheet questions were developed from the Ad Hoc Committee.

It was determined to table this topic until the November meeting.

New Business

Nominations Open for the 2023 Officers

Chair O'Maley-Lanphear opened nominations for the 2023 Officers. The Nominating Committee was formed. Michelle is Chair of the Nominating Committee, Arlene, and Candy.

Announcement of Nominees will take place during the November meeting. Final vote will take place in December.

Report from Advisory Board Members

None

Reminder of Next Meeting

Tuesday, November 1, 2022

This will be a hybrid meeting. Those who are interested in attending please notify Maria.

Adjourn

Chair O'Maley-Lanphear adjourned the meeting at 3:00 p.m.

North Sound Behavioral Health Administrative Services Organization
Advisory Board Budget
October 2022

	Total	All Conferences	Board Development	Advisory Board Expenses	Stakeholder Transportation	Legislative Session
		Project # 1	Project # 2	Project # 3	Project # 4	Project # 5
Budget	**$ 20,000.00**	$ 7,900.00	$ 4,226.00	$ 7,874.00		$ -
Expense	(5,302.06)	(150.00)	(4,313.25)	(838.81)		
Under / (Over) Budget	$ 14,697.94	$ 7,750.00	$ (87.25)	$ 7,035.19	$ -	$ -
		All expenses to attend Conferences	Advisory Board Retreat/Summit	Costs for Board Members (meals mileage, misc.)	Non- Advisory Board Members, to attend meetings and special events	Shuttle, meals, hotel, travel

Rose Dennis, Island County/Camano Island, WA

Roseden21@hotmail.com **206.910.1544**

Overview

I am the mother of Matthew Harrison Dennis who died in Hospice Care in Everett WA on 1/3/21at the young age of 36. His death was due to Kidney Disease from using Fentanyl.

Matthew was introduced to Opiates at the age of 13 when he was at Seattle Children's after being diagnosed with the Acute Myelogenous Leukemia, AML Cancer of the Blood and Bone Marrow. He was on an Opiate Drip* for one year, and left the hospital cured of cancer…. but with a new disease…the disease of Substance Use Disorder.

*My husband and I were told at the hospital, because we were extremely concerned about him becoming addicted, that only 1% of those who use opiates do become addicted. Later we all learned that 1% becoming addicted was not the truth, and that research by the FDA **never** took place. This mistruth later caused a tragic pandemic throughout our country.

Matthew fought this disease for 23 years. He went to treatment over 15 times, had over 20 trips to the ER in Seattle, WA. living at times in 'The Seattle Jungle' and in tents on the Streets of Seattle.

In our country the disease of Substance Use Disease is not treated as a disease, it is treated by punishment.

Objective

Be a Peer Support /Spokesperson for the Disease of Substance Use Disorder.

BIO

- 2016 to present, Spokesperson with Attorney General Bob Ferguson and the State of Washington Legislative Sessions in Olympia, WA.

- 2018 to present, Volunteer Guardian Ad Litem for Island County, WA. VGAL's are an advocate in court and in the community on the behalf of children removed from their homes due to abuse and neglect. VGAL's protect the best interests of these children, conducting independent investigations and preparing reports for the court, which focus on the right of every child to a safe, nurturing and permanent home.

- I was born and raised in Livingston, Montana and earned a B.A. in Business Management at Seattle Pacific University; Worked in Executive Management for fifteen (15) years with the JC Penney Company; Fourteen (14) years as a tenured college professor at Edmonds Community College as the Director and Professor, teaching classes in Fashion, Retail, Marketing & PR and Business Management (includes teaching one year in Kobe, Japan); Five (5) years as the Director

of PR, Marketing and Special Events for City Centre (5th and Pike); Two (2) years as the Director of Procurement, P.R., Marketing and Development for the non-profit Art's organization PONCHO, raising over $10M. for many of the arts organizations in Seattle including the Seattle Symphony, Pacific NW Ballet, Seattle Opera, etc. Later serving on the Governing Board of both PONCHO and Pacific NW Ballet.

Washington State Health Care Authority

Mobile Crisis Response Program Guide

Introduction

A behavioral health crisis can be devastating, and even traumatic, for individuals, families, and our communities. Although we cannot know when a crisis may occur, we can create a system that is agile and responsive when the need arises. We imagine a crisis system in Washington State that minimizes delays, reduces the use of law enforcement and emergency departments, and only looks to the most restrictive responses when no other safe solution can be found. A key component of our state's crisis system must be mobile crisis response (MCR) teams that can be rapidly deployed to the location of the crisis and provide crisis assessment and stabilization services to anyone, anywhere, and at any time.

Purpose

The purpose of this guide is to accompany the Health Care Authority's (HCA) Behavioral Health Administrative Service Organization (BH-ASO) crisis contract language and provide guidance to the contracted mobile crisis response providers in best practices. This will act as a living document that can be updated outside of the strict timelines of contract amendments, and it will change over time as necessary to meet the needs of Washingtonians.

Goal of Implementing New Models

HCA is committed to implementing nationwide best practices for crisis care in alignment with Substance Abuse Mental Health Services Administration (SAMHSA) National Guidelines for Behavioral Health Crisis Care Best Practice Tool Kit[1] and the National Association of State Mental Health Program Directors (NASMHPD) to include Mobile Response and Stabilization Services (MRSS) for youth. These best practices for mobile crisis response teams are intended to improve awareness of and utilization of crisis teams when people are in crisis rather than relying on emergency responders such as law enforcement, fire, and EMS. The vision from SAMHSA is to provide someone to talk to, someone to respond, and somewhere to go for a person in crisis and to be able to access support quickly with minimal barriers.

Some of the goals of these models are:

- Reduce dependence on law enforcement, fire, EMS, and emergency departments for behavioral health crisis situations
- Provide a robust crisis workforce who are well trained to respond and address urgent and emergent needs
- Include peers in crisis work to build rapport and give people someone to connect with who has similar experience/s
- Expand the definition of crisis to whatever the person experiencing in the situation defines it as to reduce barriers to potential solutions
- Address systemic barriers by addressing the needs of underserved populations

As our state implements these best practice models, we will learn from the examples provided by other states while continually working with stakeholders to make adjustments that meet the unique needs of Washington.

Background

The National Suicide Hotline Designation Act of 2020[2] established a national, 3-digit easy to remember number to call, 9-8-8, for people to connect directly to National Suicide Prevention Lifeline services. In response to this

[1] https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf
[2] https://www.congress.gov/bill/116th-congress/senate-bill/2661

legislation, the Washington legislature passed HB 1477 (E2SHB 1477[3]), the Crisis Call Center Hubs and Crisis Services Act, in 2021 to enhance and expand behavioral health crisis response and suicide prevention services for all people in Washington State. The E2SHB 1477 was signed into law on May 13, 2021. A key component of E2SHB 1477 is to invest in an enhanced crisis response system by developing and deploying mobile rapid response crisis teams that provide professional on-site, community-based interventions and follow-up support for individuals that are experiencing a behavioral health crisis.

Scope

Mobile crisis response (MCR) services offer voluntary community-based intervention to individuals in need wherever they are including at home, work, school, juvenile courts, or anywhere else in the community where the person is experiencing a crisis. The caller, not the provider, defines the crisis.

Keys to Success

- Triage/screening, including explicit screening for suicidality and risk of harm to others
- Respond without law enforcement accompaniment, unless special circumstances warrant inclusion, to support true justice system diversion
- Reduce the use of emergency departments
- Assessing for risk and opportunities to resolve the crisis in the least restrictive setting
- Developmentally appropriate de-escalation/resolution
- Peer support; including family peers or youth peers
- Coordination with medical and behavioral health services
- Crisis planning and follow-up

Minimum requirements and mobile crisis team standards

Mobile crisis response services must be available to individuals experiencing a behavioral health crisis. Services should be provided in person for youth and to adults if they request an outreach. Trained staff should remain, in person or on the phone, with the individual in crisis to provide stabilization and support until the crisis is resolved or referral to another service is accomplished[4].

Team Composition

A mobile crisis response team must provide coverage 24 hours per day, every day of the year with at least one team of two staff per shift. Overall team composition can be flexible based on regional need and staff availability. Teams must include, at a minimum two staff to outreach. This should include a Mental Health Professional (MHP) or a Mental Health Care Provider (MHCP) with approved DOH exemption[5]and a certified peer counselor responding together to all crisis referrals. Each team shall have a mental health professional supervisor and an MHP will be available 24 hours per day for clinical consultation. The consulting MHP does not have to be the team supervisor. At the discretion of the provider, teams may also include other professional or paraprofessionals with expertise in developmentally appropriate behavioral health crisis intervention.

Location of Services

Mobile crisis response services should be provided wherever the individual in need is located including at home, school, work, or anywhere else in the community where the person is experiencing a crisis. Team will assess for risk and opportunities to resolve the crisis in the least restrictive setting.

Mobile crisis response services reduce the need for and the utilization of law enforcement, other first responders, and emergency departments. Enhanced Federal Medicaid Assistance Percentage (FMAP), the amount of federal dollars provided per state dollar, may not be available for MCR services provided in an emergency department. Services provided in an emergency department can still be billed and paid but will not qualify for the higher match.

[3] https://lawfilesext.leg.wa.gov/biennium/2021-22/Pdf/Bills/Session%20Laws/House/1477-S2.SL.pdf?q=20220914155211
[4] WAC 246-341-0900
[5] WAC 246-341-0302

Best Practice: Teams will respond with a multi-disciplinary team of clinicians and a peer. This will give the person in crisis and the team multiple perspectives to problem solve.

Availability

Mobile crisis response services must be available 24 hours a day, every day of the year, and be able to respond to an emergent crisis within 2 hours of the referral for an emergent crisis and within 24 hours for an urgent crisis. Telephonic support will be provided until in-person response arrives[6].This telephonic support can include the caller with a call back number, the NSPL or RCL staying on the line with them depending on need, or mobile response team cell phone numbers for callback.

Referral type	Definition
Emergent	An emergent crisis is an extreme risk and requires a 2-hour response time.
Urgent	Urgent crises are moderate to serious risk and require a 24-hour response.
Routine/Follow-up	Routine/Follow-up care occur after crisis response services are provided.

Best Practice: Best practice response time to all crisis referrals is 60 minutes or less.

To ensure safety for responders and clients, mobile crisis response team shift schedules shall be designed to build in respite and downtime in lieu of responders being "on-call" for days at a time. These schedules should be focused on workforce selfcare and stress reduction to improve workforce retention. Schedules can be adjusted according to outreach activities or peak times for calls, and rural vs. urban demand. Shifts in urban areas may be 8-hour shifts, or 12-hour shifts, while rural areas may consider employing fire schedules such as 24 on 48 off or any similar combination. This staffing pattern will ensure safety, improve critical decision making and rapport building with clients, support work life balance, and improve recruitment and retention efforts.

All members of the team must be trained in trauma-informed care, de-escalation strategies, and harm reduction. Youth mobile crisis teams shall be trained in developmentally appropriate trauma informed care, de-escalation, harm reduction, and crisis and safety planning for youth and families. Additional recommended training for team members will continue to be developed and could include developmentally appropriate nonviolent crisis intervention, conflict resolution, interpersonal violence, motivational interviewing, risk management and crisis planning (including WRAP and crisis safety planning tools), cultural awareness and responsiveness, CPR/First Aid, and basic overview of psychiatric medications and side effects.

Community Coordination

Due to 24/7 availability requirements and the unpredictability of community crisis needs, mobile response team staff shall not be expected to maintain a quota of direct contact hours. If teams are not responding to crisis referrals, they should be building relationships in the community through outreach and engagement. These efforts work to educate the public and providers on mobile crisis response and offer opportunities for upstream interventions. Working relationships with NSPLs, RCLs, emergency departments, schools, providers, primary care clinics, Indian Community Health Programs (ICHP), Tribal Nations, community corrections officers, respite care providers, community health care facilities, behavioral health care facilities, universities, rural and agricultural extension offices, fire departments, EMS responders, law enforcement, probation officers, inpatient discharge planners, 23-hour triage and stabilization facilities, substance use providers, foster care social workers, parents, caregivers and managed care organizations (MCOs) will encourage use of MCR teams over the ED and offer true justice system diversion. These efforts will increase the likelihood of a person in crisis receiving an appropriate response from a trained crisis team and establish mutual relationships with emergency response system providers.

Privacy and Confidentiality

Teams must maintain privacy and confidentiality of information consistent with federal and state requirements. Minors aged 13-17 may initiate and consent to evaluation and treatment for mental health, substance use disorder treatment, or withdrawal management without parental knowledge or consent.

[6] WAC 246-341-0900

Documentation

Documentation of mobile crisis response must be completed by the on-scene clinician responding. This can be a MHP or MHCP (with approved DOH exemption) under the supervision of the MHP supervisor[7]. Peers can add additional note to the documentation, but it must also contain the clinician's notations and be signed by the clinician. Documentation must include the following[8], as applicable to the crisis service provided:

- A summary of each crisis service encounter, including the date, time, nature of the crisis, and duration of the encounter
- The time elapsed from the initial referral to the in-person or telehealth response
- The names of the participants
- A follow-up plan or disposition, including any referrals for services, including emergency medical services
- Whether the individual has a crisis plan and any request to obtain the crisis plan
- The outcome, including the basis for a decision not to respond in person when a telehealth intervention was provided; and
- The name and credential of the staff person providing the service.

Teams should document services provided as soon as they are able to do so. This will ensure they are able to provide notes to any follow-up services about the encounter. Documentation should be done in an EHR following employer guidelines and procedures and within confidentiality laws.

Staff roles and descriptions

Required Staff

Below is an outline of staffing expectations for mobile crisis teams. Teams are required to have a licensed or credentialed Mental Health Professional as a supervisor. Teams have flexibility in overall team composition. Outreach should occur via a team of at least two staff. Preferably with one clinician and one peer Teams need to have an MHP available 24/7 for support and clinical consultation. This does not have to be the supervisor if other MHPs are on staff.

Supervisor MHP

Provides clinical supervision and oversight of the mobile response teams. Is responsible to ensure the service provided by the team meets medical necessity, is clinically appropriate, and meets all necessary requirements. The person in crisis is assumed to need crisis intervention based on them reaching out for help. Further services will need to be made with clinical judgement on medical necessity.

Minimum position requirements

Must meet the requirements as a Mental Health Professional and meet all licensure or credentialing requirements from DOH to provide services. Recommended to have experience supervising and overseeing crisis services.

SPA definition

Mental Health Professional means:

(A) A psychiatrist, psychologist, psychiatric nurse, or social worker as defined in chapter 71.05 and 71.34 RCW;

(B) A person with a master's degree or further advanced degree in counseling or one of the social sciences from an accredited college or university. Such person shall have, in addition, at least two years of experience in direct treatment of persons with mental illness or emotional disturbance, such experience gained under the supervision of a mental health professional.

(C) A person who meets the waiver criteria of RCW 71.24.260 which was granted prior to 1986.

(D) A person who had an approved waiver to perform the duties of a mental health profession that was requested by the regional support network and granted by the mental health division prior to July 1, 2001; or

[7] WAC 246-341-0910.

[8] WAC 246-341-0900 and WAC 246-341-0910

(E) A person who has been granted a time-limited exception of the minimum requirements of a mental health professional by the mental health division consistent with WAC 388-865-265. This includes qualified individuals with an agency affiliated credential or associate license who qualify as an MHP.

Clinician

Provides crisis services and uses clinical judgement within the scope of their education and training to deescalate and stabilize the individual in crisis and assist them in next steps. These positions may be filled by MHPs or MHCPs that meet the additional requirements below. Mobile crisis response staff must have immediate access to an on-call MHP, 24/7, to provide clinical oversight and supervision when needed. This MHP does not need to be the supervisor of the team.

Minimum position requirements

Must have at least a BA/BS degree or higher in a behavioral health field and be licensed and/or credentialed by DOH to provide services.

MHCP exemption requirements

For the clinician who qualifies as an MHCP to provide initial services with a peer the provider agency must obtain an exception from rule from DOH using the process outlined in WAC 246-341-0302.

SPA definition

"**Mental Health Care Provider**" means the individual with primary responsibility for implementing an individualized plan for mental health rehabilitation services. Minimum qualifications are B.A. level in a related field, A.A. level with two years of experience in the mental health or related fields.

Certified Peer Counselor (CPC)

Provides peer support to a person in crisis with the focus of building trust, rapport, and helping the person in crisis feel heard and understood while crisis services work to resolve the crisis or find the next steps to resolve the crisis.

Minimum position requirements

Must be a certified peer counselor and credentialed by DOH to provide services, typically as an Agency Affiliated Counselor. Peers will receive additional training on providing crisis peer services in the future to improve service delivery and resilience for the workforce. This training will not be required for the current workforce until it is available on a wider basis. CPCs can only provide services when accompanied by a licensed or credential staff or their supervisor. All services provided by CPC must be provided under the oversight of the MHP supervisor.

WAC definition

"Peer counselor" means a person recognized by Medicaid agency as a person who:

(a) Is a self-identified consumer of behavioral health services who:

(i) Has applied for, is eligible for, or has received behavioral health services; or

(ii) Is the parent or legal guardian of a person who has applied for, is eligible for, or has received behavioral health services;

(b) Is a counselor credentialed under chapter **18.19** RCW;

(c) Has completed specialized training provided by or contracted through the Medicaid agency. If the person was trained by trainers approved by the department of social and health services before October 1, 2004, and has met the requirements in (a), (b) and (d) of this subsection by January 31, 2005, the person is exempt from completing this specialized training;

(d) Has successfully passed an examination administered by the Medicaid agency or an authorized contractor; and

(e) Has received a written notification letter from the Medicaid agency stating that the Medicaid agency recognizes the person as a "peer counselor."

Service Delivery and Modalities

Mobile crisis response services consist of many different modalities to ensure services are delivered in a safe and effective manner. These modalities include but are not limited to the following:

Triage/Screening

The initial step in providing mobile crisis response is to determine the level of risk present in the crisis and determine the most appropriate response. This screening process must include screening for suicide or self-harm and risk of harm to others. The triage and screening process may be completed by crisis call line staff, by the mobile crisis response team staff, or both. When the initial triage/screening is done by crisis call line staff they must share this information with the mobile crisis team. As part of the triage and screening process, a determination should be made regarding the need for support from law enforcement and/or emergency medical personnel. When making this decision, special consideration should be given to any risk of harm to self and/or others and whether the individual is known to have the means to act on those thoughts and whether they have a history of dangerousness or potential dangerousness.

Best Practice: To support true justice system diversion, respond without law enforcement accompaniment unless special circumstances warrant inclusion

Scene Safety

Ensure that responding staff members have access to any available information regarding dangerousness or potential dangerousness of the individual experiencing the crisis. This information must be made available without unduly delaying the crisis response in compliance with WAC 246-341-0900.

When responding to non-secure locations, ensure that two staff members are present for safety and that team members have mobile devices that can be used to call for help if needed. Crisis response staff cannot be required by their employer to respond to a crisis without a second person. Best practice is to always respond to crisis calls with two staff members[9].

Best Practice: Respond to all crisis referrals with a team of two staff members regardless of the location or risks identified.

When arriving to the location of the crisis, it is important to take a few moments to assess the location for safety for both staff members and individuals in crisis. Pay special attention to the location of exits, potentially dangerous implements or weapons, and signs of agitation or hostility from anyone in the vicinity.

Best Practice: Ensure other team members know the exact location you are responding to and when they should expect to get contact from you. GPS monitoring through mobile apps or cell phones is used in other states for safety.

Assessment

The MHP, MHP supervisor, or clinician responding to the crisis are responsible for completing an assessment. This assessment should address the causes leading to the crisis event, any safety concerns for the individual or others, strengths, resources available to the person in crisis, recent inpatient hospitalizations and/or enrollment with mental health providers, any prescribed medication and compliance with those medications, and any related medical history. Determine if the individual in crisis has a crisis plan or mental health advance directive (MHAD) and request a copy, if available.

Best Practice: Assess collateral contacts for distress and provide support when possible. People supporting other people in crisis are affected and need support too. Supporting them can help resolve the crisis quicker with better outcomes.

De-escalation/Resolution

Mobile crisis response providers engage the individual in counseling throughout the encounter and actively work to de-escalate the crisis. Providers may utilize therapeutic models such as such as Motivational Interviewing and Brief Therapy to help resolve the crisis and avoid the need for a higher level of care.

Crisis Peer Response

Incorporating peers into mobile crisis response teams can provide the individual in crisis with someone to relate to who has their own experience with the behavioral health symptoms and the crisis system. Peers should focus on building rapport, sharing experiences, and strengthening engagement. They may also engage family members or other natural supports to provide ideas around self-care and providing support. When engaging the individual in

[9] WAC 246-341-0900

crisis, it is often most effective for the CPC to take the lead. Documentation for peers should be completed by the clinician noting the peer's presence and interactions with person in crisis.

Coordination

An important focus for mobile crisis response teams should be identifying and addressing the recovery needs of individuals and families by linking them with needed medical and behavioral health services that can help resolve the current crisis and help prevent a return to a crisis state in the future. Include family members, significant others, and other relevant treatment providers, as necessary, to provide support to the individual in crisis.

Transport

When working with individuals in crisis, they may need transportation to places that can help resolve their crisis. These places can be pharmacies, food banks, crisis stabilization or other facilities, or other locations relevant to their current challenges. MCR teams may arrange for transport or provide transportation to these places when safe[10].

ITA Investigations

Individuals in crisis may present at imminent or serious risk of harm to themselves or others or be unable to care for their basic needs of health and safety due to their behavioral health symptoms. When they are unwilling to engage in safety planning and other stabilization efforts by MCR team members or there is no appropriate or available alternative that could mitigate the level of risk, it is important to work with DCRs to ensure that an Involuntary Treatment Act (ITA) investigation is completed, if appropriate.

Best Practice: Whenever possible, MCR teams should engage a person in crisis first and attempt to resolve the crisis with interventions less restrictive than hospitalization, before bringing in a DCR for an ITA investigation. Persons in crisis may respond best to a MCR intervention lacking the legal authority dynamic inherent to the DCR role.

Crisis Planning and Follow-up

As part of the mobile crisis response intervention, team members should initiate a crisis planning process that can help the individual prevent future crises. This process may include the development or modification of a safety plan. This is a good time to introduce Mental Health Advance Directives (MHAD), if the individual does not already have one, and support the individual in developing their MHAD. Youth 13-17 can create a MHAD, and have it executed, and teams should work with the youth and/or families to create this when clinically appropriate. When appropriate, telephonic, or in-person follow-ups should be provided to determine if any services the individual was referred to were provided and if they met their needs.

Peers can help a person start or complete a WRAP plan[11] with the individual to provide agency and insight for the person to manage their current crisis and prevent future crisis. Documentation for the development of a WRAP plan needs to be done by the clinician.

Mobile Response and Stabilization Services (MRSS) for Children, Youth and Families

Purpose

MRSS is a child and family specific crisis intervention model that recognizes the developmental needs of children, young adults, parents, and caregivers. Caregivers and children are interconnected in their relationship and thus, crisis situations for children impact the parent's ability to respond to the crisis and de-escalate the situation. Supporting the caregiver's response to the behavioral health crisis decreases the likelihood of child welfare and juvenile justice involvement.

A comprehensive crisis continuum acknowledges that youth can be screened upstream of a crisis event and stabilized and connected to resources and supports downstream. This reduces return to an acute crisis phase, improves

[10] WAC 246-341-0900

[11] https://www.wellnessrecoveryactionplan.com/what-is-wrap/.

outcomes, and offers a cost-effective alternative to the re-traumatization and stress of costly out of home interventions.

Outreach and Engagement

Successful MRSS teams perform robust outreach and engagement to inform regional, family, community, and system partners about the availability of MRSS crisis response. Law enforcement should consider the team a reliable, consistent referral for any youth encounter, day, or night. States delivering youth crisis services under the MRSS model are reporting successful ED diversion by building relationships with local school districts.

Other outreach areas for consideration include pediatric primary care providers, emergency departments, inpatient adolescent units, juvenile justice, schools, Department of Children, Youth, and Families (DCYF), foster parents, after school programs, substance use, co-occurring disorder providers, and shelters.

Crisis Mobile Response (up to 72 hours)

The crisis response, or intervention phase, is the initial response and can last up to 72 hours. Since MRSS may be the first point of contact a family has with the behavioral health system, the team should build a trusting relationship of mutual respect and provide individualized care including family voice.

Teams should intentionally include parents, caregivers, natural supports, and relevant treatment providers to stabilize the person in crisis. This should be in accordance with Washington state law when encountering youth ages 13-17, and within the limits of confidentiality.

The responding team can assess risk and safety needs, provide developmentally appropriate de-escalation, deliver peer support, help caregivers secure the home, or increase supervision depending on safety concerns. Safety planning is a collaborative process that includes the identified client, caregivers, natural supports, and existing providers. When creating or updating existing safety plans, teams will empower the family to recognize their needs, risk factors, triggers, and identify existing strengths that can inform coping skills moving forward. Teams should identify and connect families with existing systems of care and natural supports through warm handoffs, including to the stabilization phase.

This service should be billed using service encounter code H2011 - Crisis Intervention Services[12].

Crisis Response Goals:

- The crisis is defined by the youth, young adult, parent, or caregiver
- The team responds in person to the location of the person in crisis, home, school, or community within 2 hours and with telephone support available until arrival.
- Respond without law enforcement
- Work with the youth and caregivers to reduce unnecessary admissions to EDs, inpatient adolescent units, unnecessary contact with law enforcement, detention centers, residential treatment centers, or foster care transitions
- Initial response should include developmentally appropriate de-escalation, a children or youth risk assessment, safety planning, peer support, and skill-building
- Support and maintain youth in their living and community environment, reducing out of home placements
- Promote and support safe behavior in the home, schools, and community
- Ensure staff are trained in culturally responsive, developmentally appropriate trauma-informed care, de-escalation, safety planning for youth and families, and harm reduction

Stabilization

After families have experienced an initial mobile crisis response encounter, best practices in MRSS include an in-home stabilization phase, which is separate but must be connected to the mobile response phase. A stabilization phase provides *up to* 14 days of intensive in-home services. Funding for stabilization services is approved by the MCOs, fee for service, BH-ASO for uninsured, or commercial carriers. MCOs and commercial insurance carriers are

[12] http://hca.wa.gov/billers-providers-partners/program-information-providers/service-encounter-reporting-instructions-seri

required to cover this intervention as part of their network adequacy. In-home stabilization supports the child's ability to manage daily activities and establishes clear connections to treatment service and community supports to reduce the likelihood of returning to the acute crisis phase. Providers may need to support families in accessing and following through with ongoing care.

This phase can include identifying and addressing ongoing needs, reviewing safety plans, skill building, youth and/or family peer support, parent support and skill building, and care coordination to identify and connect families with community providers through family facing systems of care, and natural supports. Community connections are linked to inherent strengths and interests of the youth and provide opportunity for connection, relationships, skill building, and built-in community-based respite support. This may include extracurricular activities, after school programs, sports, arts, community events, church groups, 4-H, neighbors, and family members.

This service should be billed using service encounter code S9484 – Stabilization Services[13].

Stabilization Goals

- Support and maintain youth in their current living situation and community
- Services are provided face to face in the youth's natural environment, home, school, and community
- Support youth and families with developmentally appropriate and culturally appropriate trauma-informed care
- Assist youth and families in identifying, accessing, and linking to community systems of care and refer to additional clinical services if needed
- Care coordination to assist youth and families in identifying and linking to ongoing natural and system supports to reduce return to the crisis phase. Include peer support for youth or caregivers as appropriate

Implementation

Shared understanding of the MRSS model with system partners will aide in implementation of MRSS best practices. Collaboration with community partner and stakeholders to understand care pathways and interruption points will provide early identification and prevention of more costly interventions. Working with the following systems and implementing a system of care language is essential to the success of MRSS.

- Behavioral Health Administrative Service Organizations
- Managed Care Organizations
- Juvenile Justice, Law Enforcement and Family Courts
- Schools and Universities
- Pediatric Primary Care Providers
- Department of Health
- Department of Children, Youth and Families
- Emergency Departments, Inpatient Adolescent Units, and Children's' Hospitals
- Community Mental Health Providers and Mental Health Agencies
- Community Organizations, Shelters
- Center for Parent Excellence (COPE), Family Youth System Partner Round Tables (FYSPRTs)

Looking Forward

This guide will evolve with the implementation of HB 1477. Future versions will incorporate tools developed through the technical and operational plan and best practices developed from it. This guide will continue to align further with

[13] http://hca.wa.gov/billers-providers-partners/program-information-providers/service-encounter-reporting-instructions-seri

SAMHSA's National Guidelines for Behavioral Health Crisis Care Best Practices toolkit and MRSS. As tools and trainings allow for implementation of other aspects, the plan will also evolve based on recommendations from the CRIS committee and sub-committees set up through HB 1477.

This guide will also evolve with feedback from MCR teams and BH-ASOs. These models we are introducing are based on successful models from other states, but we need to adapt it to work for all of Washington. Your feedback is important to ensure MCR can meet the needs of our people.

References

SAMHSA's National Guidelines for Behavioral Health Crisis Care Best Practice Toolkit

Mobile Crisis Teams: A State Planning Guide for Medicaid-Financed Crisis Response Services

Hoover, S., Bostic, J. (2020). Improving the Child and Adolescent Crisis System: Shifting from a 9-1-1 to a 9-8-8 Paradigm. Alexandria, VA: National Association of State Mental Health Program Directors.

2022 SAMHSA's *Children's Crisis Response and Stabilization* – (publication in process)

2018 NASHHPD *Making the Case for a Comprehensive Children's continuum of Care*

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

Crisis mental health services – Outreach services – WAC 246-341-0910

Agency licensure and certification—Exemptions and alternative means or methods – WAC 246-341-0302

Behavioral Health Data Guide for Supplemental Data

Service Encounter Reporting Instructions

Introduction Motions

The contracts being introduced this month fall into four distinct categories:

- Health Care Authority (HCA) contract to include funding for the period of January 1, 2023, through December 31, 2023, the contract term is January 1, 2023 through December 31, 2025.
- Downstream contracts for General Fund-State (GF-S) Mandatory Services (Crisis Outreach, Involuntary Treatment Act (ITA) Services, ITA inpatient, Secure Withdrawal Management, Proviso Funding)
- Downstream contracts for Substance Abuse Block Grant (SABG) Priority Services (Pregnant & Parenting Women Housing Services (PPW), Individuals using Intravenous Drugs (IUID) Opiate Outreach)
- Downstream contracts for GF-S/Federal Block Grant (Mental health and Substance use) Services within Available Resources (Mental Health & Substance Use Disorder Outpatient, SUD Residential, Triage Services)

The downstream contracts follow the HCA contract. The funding for the downstream contracts is included in the same amendment, which is why you will see the same numbered amendment under a different category of funding. The funding allocations for the downstream contracts will be developed over the next month.

Health Care Authority

- K- is providing the GF-S funding for the period of January 1, 2023, through June 30, 2023 and Federal Block Grant funds for the period of January 1, 2023, through September 30, 2023. The contract term is January 1, 2023 through December 31, 2025.

Motion #XX-XX

HCA-NS BH-ASO-K-- providing the ASO GF-S funding and legislative provisos for the period of January 1, 2023, through June 30, 2023, and Federal Block Grant Funding for the period of January 1, 2023, through September 30, 2023. The contract term is January 1, 2023 through December 31, 2025.

GF-S Mandatory Services

The following contracts are providing mandatory/proviso behavioral health services.

- Compass Health
    - Mobile Crisis Outreach, Child/Youth Mobile Crisis Outreach, ITA services, Program for Assertive Community Treatment (PACT), Evaluation and Treatment Services (E&T) Discharge Planners, Whatcom Triage Diversion Pilot
- Snohomish County
    - Mobile Crisis Outreach, ITA services
    - Proviso Funding-Jail Transition Services, Designated Cannabis Account, Trueblood Funds
- Volunteers of America
    - Toll Free Crisis Hotline

- Telecare
    - Evaluation and Treatment Services, Discharge Planners
- American Behavioral Health Services (ABHS)
    - Secure Withdrawal Management
- Sea Mar
    - Assisted Outpatient Treatment
- Lifeline Connections
    - PACT
- Evergreen Recovery Centers
    - Homeless Outreach Stabilization Team (HOST)
- Snohomish County Superior Court
    - Juvenile Treatment Services
- Island County
    - Proviso Funding-Jail Transition Services, Trueblood Funds, Designated Cannabis Account
- San Juan County
    - Proviso Funding-Jail Transition Services, Designated Cannabis Account
- Skagit County
    - Proviso Funding-Jail Transition Services, Designated Cannabis Account, Trueblood Funds
- Whatcom County
    - Proviso Funding-Jail Transition Services, Designated Cannabis Account, Trueblood Funds

Motion #XX-XX

NS BH-ASO-Compass Health-ICCN-23-25 to provide the funding to continue services under this contract. The contract term is January 1, 2023 through December 31, 2025 with an automatic one-year renewal on January 1, 2024 based on continued compliance with the terms of the contract.

NS BH-ASO-Snohomish County-ICCN-23-25 to provide the funding to continue services under this contract. The contract term is January 1, 2023 through December 31, 2025 with an automatic one-year renewal on January 1, 2024 based on continued compliance with the terms of the contract.

NS BH-ASO-VOA-ICCN-23-25 to provide the funding to continue services under this contract. The contract term is January 1, 2023 through December 31, 2025 with an automatic one-year renewal on January 1, 2024 based on continued compliance with the terms of the contract.

NS BH-ASO-Telecare-ICCN-23-25 to provide the funding to continue services under this contract. The contract term is January 1, 2023 through December 31, 2025 with an automatic one-year renewal on January 1, 2024 based on continued compliance with the terms of the contract.

NS BH-ASO-ABHS-ICN-23-25 to provide the funding to continue services under this contract. The contract term is January 1, 2023 through December 31, 2025 with an automatic one-year renewal on January 1, 2024 based on continued compliance with the terms of the contract.

NS BH-ASO-CASC-ICN-23-25 to provide the funding to continue services under this contract. The contract term is January 1, 2023 through December 31, 2025 with an automatic one-year renewal on January 1, 2024 based on continued compliance with the terms of the contract.

NS BH-ASO-Sea Mar-ICN-23-25 to provide the funding to continue services under this contract. The contract term is January 1, 2023 through December 31, 2025 with an automatic one-year renewal on January 1, 2024 based on continued compliance with the terms of the contract.

NS BH-ASO-Lifeline Connections-ICN-23-25 to provide the funding to continue services under this contract. The contract term is January 1, 2023 through December 31, 2025 with an automatic one-year renewal on January 1, 2024 based on continued compliance with the terms of the contract.

NS BH-ASO-ERC-ICN-23-25 to provide the funding to continue services under this contract. The contract term is January 1, 2023 through December 31, 2025 with an automatic one-year renewal on January 1, 2024 based on continued compliance with the terms of the contract.

NS BH-ASO-Snohomish County Superior Court-ICN-23-25 to provide the funding to continue services under this contract. The contract term is January 1, 2023 through December 31, 2025 with an automatic one-year renewal on January 1, 2024 based on continued compliance with the terms of the contract.

NS BH-ASO-Island County-ICN-23-25 to provide the funding to continue services under this contract. The contract term is January 1, 2023 through December 31, 2025 with an automatic one-year renewal on January 1, 2024 based on continued compliance with the terms of the contract.

NS BH-ASO-San Juan County-ICN-23-25 to provide the funding to continue services under this contract. The contract term is January 1, 2023 through December 31, 2025 with an automatic one-year renewal on January 1, 2024 based on continued compliance with the terms of the contract.

NS BH-ASO-Skagit County-Interlocal-23-25 to provide the funding to continue services under this contract. The contract term is January 1, 2023 through December 31, 2025 with an automatic one-year renewal on January 1, 2024 based on continued compliance with the terms of the contract.

NS BH-ASO-Whatcom County-ICN-23-25 to provide the funding to continue services under this contract. The contract term is January 1, 2023 through December 31, 2025 with an automatic one-year renewal on January 1, 2024 based on continued compliance with the terms of the contract.

Federal Block Grant (FBG)) Priority Services

The following contracts are providing priority Services:

- Brigid Collins
  - Pregnant and Parenting Women (PPW) Housing Support Services
- Evergreen Recovery Centers
  - PPW Housing Support Services
- Catholic Community Services
  - PPW Housing Support Services
- Compass Health
  - San Juan HARPS subsidies
  - Certified Peers on Mobile Crisis Teams
- Therapeutic Health Services
  - Medication Assisted Treatment

- Island County
    - Opiate Outreach, HARPS subsidies
- Community Action of Skagit County
    - Opiate Outreach
- Snohomish County
    - Opiate Outreach
- Whatcom County
    - Opiate Outreach
- Lifeline Connections
    - Peer Pathfinder, Peer Pathfinder Incarceration Transition Pilot, HARPS Team and Skagit & Whatcom HARPS subsidies
- Telecare Corp.
    - Peer Bridger Program, Peer Bridger Participant Relief Funds

Motion #XX-XX

NS BH-ASO-Brigid Collins-ICN-23-25 to provide the funding to continue services under this contract. The contract term is January 1, 2023 through December 31, 2025 with an automatic one-year renewal on January 1, 2024 based on continued compliance with the terms of the contract.

NS BH-ASO-ERC-ICN-23-25 to provide the funding to continue services under this contract. The contract term is January 1, 2023 through December 31, 2025 with an automatic one-year renewal on January 1, 2024 based on continued compliance with the terms of the contract.

NS BH-ASO-CCS NW-ICN-23-25 to provide the funding to continue services under this contract. The contract term is January 1, 2023 through December 31, 2025 with an automatic one-year renewal on January 1, 2024 based on continued compliance with the terms of the contract.

NS BH-ASO-Compass Health-ICCN-23-25 to provide the funding to continue services under this contract. The contract term is January 1, 2023 through December 31, 2025 with an automatic one-year renewal on January 1, 2024 based on continued compliance with the terms of the contract.

NS BH-ASO-THS-ICN-23-25 to provide the funding to continue services under this contract. The contract term is January 1, 2023 through December 31, 2025 with an automatic one-year renewal on January 1, 2024 based on continued compliance with the terms of the contract.

NS BH-ASO-Island County-ICN-23-25 to provide the funding to continue services under this contract. The contract term is January 1, 2023 through December 31, 2025 with an automatic one-year renewal on January 1, 2024 based on continued compliance with the terms of the contract.

NS BH-ASO-CASC-ICN-23-25 to provide the funding to continue services under this contract. The contract term is January 1, 2023 through December 31, 2025 with an automatic one-year renewal on January 1, 2024 based on continued compliance with the terms of the contract

NS BH-ASO-Snohomish County-ICN-23-25 to provide the funding to continue services under this contract. The contract term is January 1, 2023 through December 31, 2025 with an automatic one-year renewal on January 1, 2024 based on continued compliance with the terms of the contract.

NS BH-ASO-Whatcom County-ICN-23-25 to provide the funding to continue services under this contract. The contract term is January 1, 2023 through December 31, 2025 with an automatic one-year renewal on January 1, 2024 based on continued compliance with the terms of the contract.

NS BH-ASO-Lifeline Connections-MHBG-23-25 to continue services under this contract. The contract term is January 1, 2023 through December 31, 2025 with an automatic one-year renewal on January 1, 2024 based on continued compliance with the terms of the contract.

NS BH-ASO-Telecare-MHBG-23-25 to continue services under this contract. The contract term is January 1, 2023 through December 31, 2025 with an automatic one-year renewal on January 1, 2024 based on continued compliance with the terms of the contract.

GF-S/Federal Block Grant Services within Available Resources

- Compass Health
  - SUD outpatient services in San Juan County
  - Snohomish & Whatcom County Triage Services
- Consejo Counseling and Referral Services
  - Mental health outpatient services
  - Substance use outpatient services
- Evergreen Recovery Centers
  - Withdrawal Management Services
  - Mental Health Infant Specialist
- Island County
  - Co-Responder project
- Lifeline Connections
  - SUD Outpatient services
  - Recovery Housing
- Lake Whatcom Center
  - PACT
  - Mental Health outpatient services
  - Substance Use outpatient services
- Pioneer Human Services
  - Island, Skagit & Whatcom withdrawal management services
  - SUD residential services
- Sea Mar
  - Mental health outpatient services
  - Substance use outpatient services
  - SUD residential services
- Sunrise Services
  - Mental health outpatient services
  - Substance use outpatient services
- Volunteers of America (VOA)
  - Emergency Response for Suicide Prevention (ERSP)
  - Peer Outreach follow up services

- Whatcom County
    - Co-responder project
- WCHS-Bellingham Treatment Solutions
    - Medication Assisted Treatment (MAT)

Motion #XX-XX

NS BH-ASO-Compass Health-ICCN-23-25 to provide the funding to continue services under this contract. The contract term is January 1, 2023 through December 31, 2025 with an automatic one-year renewal on January 1, 2024 based on continued compliance with the terms of the contract.

NS BH-ASO-Consejo-ICN-23-25 to provide the funding to continue services under this contract. The contract term is January 1, 2023 through December 31, 2025 with an automatic one-year renewal on January 1, 2024 based on continued compliance with the terms of the contract.

NS BH-ASO-ERC-ICN-23-25 to provide the funding to continue services under this contract. The contract term is January 1, 2023 through December 31, 2025 with an automatic one-year renewal on January 1, 2024 based on continued compliance with the terms of the contract.

NS BH-ASO-Island County-ICN-23-25 23-25 to provide the funding to continue services under this contract. The contract term is January 1, 2023 through December 31, 2025 with an automatic one-year renewal on January 1, 2024 based on continued compliance with the terms of the contract.

NS BH-ASO-Lifeline Connections-ICN-23-25 to provide the funding to continue services under this contract. The contract term is January 1, 2023 through December 31, 2025 with an automatic one-year renewal on January 1, 2024 based on continued compliance with the terms of the contract.

NS BH-ASO-LWC-ICN-23-25 to provide the funding to continue services under this contract. The contract term is January 1, 2023 through December 31, 2025 with an automatic one-year renewal on January 1, 2024 based on continued compliance with the terms of the contract.

NS BH-ASO-PHS-ICN-23-25 to provide the funding to continue services under this contract. The contract term is January 1, 2023 through December 31, 2025 with an automatic one-year renewal on January 1, 2024 based on continued compliance with the terms of the contract.

NS BH-ASO-Sea Mar-ICN-23-25 to provide the funding to continue services under this contract. The contract term is January 1, 2023 through December 31, 2025 with an automatic one-year renewal on January 1, 2024 based on continued compliance with the terms of the contract.

NS BH-ASO-Sunrise Services-ICN-23-25 to provide the funding to continue services under this contract. The contract term is January 1, 2023 through December 31, 2025 with an automatic one-year renewal on January 1, 2024 based on continued compliance with the terms of the contract.

NS BH-ASO-VOA-ICCN-23-25 to provide the funding to continue services under this contract. The contract term is January 1, 2023 through December 31, 2025 with an automatic one-year renewal on January 1, 2024 based on continued compliance with the terms of the contract.

NS BH-ASO-Whatcom County-ICN-23-25 to provide the funding to continue services under this contract. The contract term is January 1, 2023 through December 31, 2025 with an automatic one-year renewal on January 1, 2024 based on continued compliance with the terms of the contract.

NS BH-ASO-WCHS-Bellingham Treatment Services-ICN-23-25 to provide the funding for Medication Assisted Treatment services under this contract. The contract term is January 1, 2023 through December 31, 2025 with an automatic one-year renewal on January 1, 2024 based on continued compliance with the terms of the contract.

2023 North Sound BH-ASO Proposed Operating Budget Overview

Presented by:
Joe Valentine, Executive Director

Agenda

- Budget Highlights
- Key Events
- 2023 Strategic Goals
- Revenues and Expenditures 2022 vs. 2023
- Revenue Forecast
- 2023 Organizational Chart

Budget Highlights

- 2023 will be our 4th year of operation as a BH-ASO
- Administering the Crisis Services system continues to be our core responsibility
- Over the last two (2) years the legislature has added new programs to expand the scope of non-Medicaid services
- COVID relief related federal block grant funds allowed us to expand and provide other new services
- Continued roll out of the 988 line and the other crisis services enhancements established by HB 1477 will also be a major priority

Key Events

- Implemented and put contracts in place for new programs:
  - Recovery Navigator
  - Community Behavioral Health Rental Assistance
  - Children, Youth, and Family Crisis Teams
  - Homeless Outreach Stabilization Team
- Continued expansion of “co-responder” teams: Whatcom, Skagit, Mt. Vernon, Island, Snohomish County

Key Events

- Continued the Diversity, Racism, Equity, and Inclusion project. Most of the training has been completed, work on strategic plan begun
- Provided start-up funding to support a new behavioral health clinic in Mt. Vernon operated by Consejo Counseling and Referral Services
- Provided start-up funding to assist with the opening of a new Evaluation & Treatment Facility in Sedro Wooley
- Contracted for an updated behavioral health needs assessment

Key Events

- Provided an update presentation on BH-ASO programs and services to all 5 County Councils and Commissions
- Successfully passed the annual Team Monitor Review by HCA
- Re-opened the North Sound BH-ASO office for staff to work on site and began to hold on-site team meetings and hybrid meetings for the Advisor Board and Board of Directors

2023 Strategic Goals

1. Remain fully compliant with the HCA-BH ASO Contract
2. Support continuous process improvement of the Crisis Services System
3. Implement the updated Quality Management Plan
4. Support regional and state planning efforts to improve access to care for behavioral health services
5. Develop and implement a plan to address social equity and systemic racism
6. Advocate for funding to meet the behavioral health needs of all at-risk persons

Revenues & Expenditures
2022 vs. 2023

BUDGET	REVENUES	EXPENDITURES
2022 ADOPTED	$38,951,174	$38,951,174
2022 PROJECTED	$42,291,833*	$37,020,345
2023 PROPOSED	$43,365,760	$43,365,760

*Includes (1) revenue allocated in 2021 but not received until 2022, and (2) funds for new programs where there was a delay in start-up

Revenue Forecast

REVENUE SOURCE	2022 ADOPTED	2023 PROPOSED
Mental Health Block Grant	3,278,880 (1)	2,458,494
Substance Abuse Block Grant	5,330,865 (1)	4,679,433
Other Federal Grant [HRSA]	333,333	333,333
MCO Medicaid PMPM	5,102,632	8,751,820
State General Fund	15,186,567	15,742,824
State Provisos	9,706,397	11,389,856
Investment Interest	3,500	10,000
TOTAL REVENUE	**38,951,174**	**43,365,760**

(1) Initial 2022 FBG allocations included more than 12 months

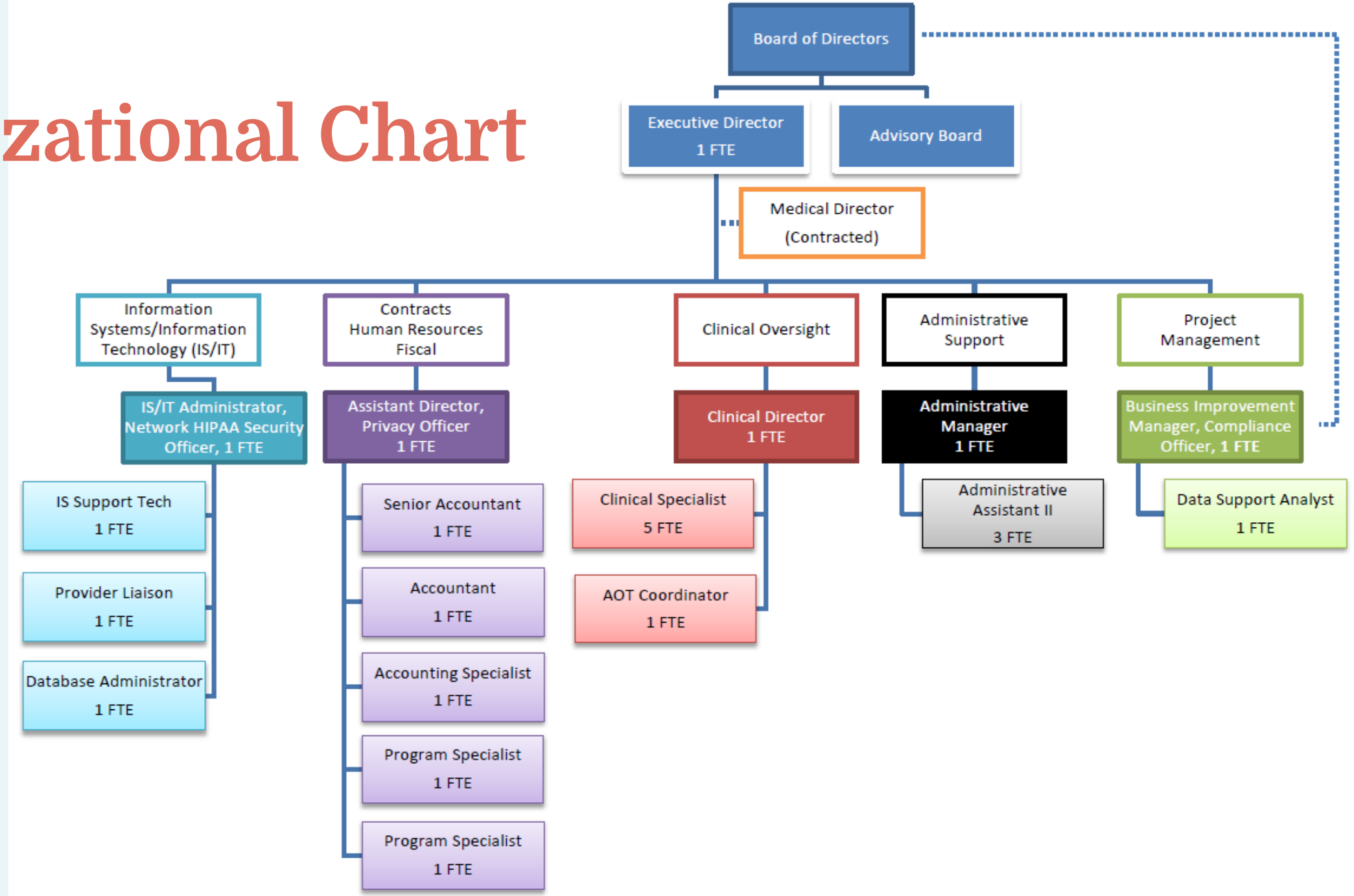
Expenditure Detail

CATEGORY	2022	2023	Difference	Percent	Notes
Salaries & Benefits	3,163,633	3,556,086	392,453	12.41%	Addition of 2 FTE
Other Administrative (1)	1,188,989	870,182	(318,807)	(26.81%)	Reductions in administrative reserve and professional services
Total Administration	4,352,622	4,426,268	73,646	1.69%	15% Admin limit = 6,129,801
Behavioral Health Services (2)	34,598,552	38,939,492	4,340,940	12.55%	Increased revenue (see previous slide)
TOTAL	31,338,766	43,365,760			

(1) Includes Advisory Board

(2) Includes Hospital Inpatient

2023 Organizational Chart



Empowering individuals and families to improve their health and well-being.

Serving Island, San Juan, Skagit, Snohomish and Whatcom Counties

BOD Introduction items November 10, 2022

NS BH-ASO-WCHS-Bellingham Treatment Services-ICN-23-25 to provide the funding for Medication Assisted Treatment services under this contract. The contract term is January 1. 2023 through December 31, 2024 with an automatic one-year renewal on January 1, 2025 based on continued compliance with the terms of the contract.

Date	2022 Pre-Meeting Training Topics	Note
January		
February		
March	North Sound Youth and Family Coalition	Val Jones
April	Co-Responder Models	Michael McAuley
May	Regional Navigator Program	James Dixon
June	June Meeting Cancelled	
July	*Summer Recess - No Pre-Meeting*	
August		
September		
October	Ascending Opportunities	Kara Allen
November		
December	Holiday Potluck - TBD	
	PPW - Evergreen Recovery	
	MAT - PDOA	
	Board of Directors - Elected Officials	
	MCO Board Representation Update	
	Snohomish County Opioid Outreach Program	

Date	Site Visits	Note
TBD	Denny Juvenile Justice Center - Everett	**No In Person Site Visits Due to COVID**
TBD	Ituha Stabilization Facility - Oak Harbor	**No In Person Site Visits Due to COVID**
TBD	Mukilteo Evaluation and Treatment Facility - Mukilteo	**No In Person Site Visits Due to COVID**
TBD	Whatcom County Crisis Stabilization - Bellingham	**No In Person Site Visits Due to COVID**

Date	Advocacy	Note
December 30, 2021, January 5, 2022	Held on virtual Zoom platform	

Date	Conferences	Location
June	WA Behavioral Healthcare Conference	**Kennewick In Person**
October	WA State Co-Occuring Disorders and Teatment Conference	**Yakima Hybrid**

Legend		
Salmon	Completed	
Green	Available topics to schedule - Not Completed	
Yellow	Non pre-meeting training month	
Red	Not Completed	

Date	Draft 2023 Pre-Meeting Topics	Note
January		
February		
March		
April		
May		
June		
July	*Summer Recess - No Pre-Meeting*	
August		
September		
October		
November		
December	Holiday Potluck - TBD	
	PPW - Evergreen Recovery	
	MAT - PDOA	
	Board of Directors - Elected Officials	
	Snohomish County Opioid Outreach Program	

Date	Site Visits	Note
TBD	Denny Juvenile Justice Center - Everett	
TBD	Ituha Stabilization Facility - Oak Harbor	
TBD	Mukilteo Evaluation and Treatment Facility - Mukilteo	
TBD	Whatcom County Crisis Stabilization - Bellingham	

Date	Advocacy	Note

Date	Conferences	Location
June	WA Behavioral Healthcare Conference	**TBD**
October	WA State Co-Occuring Disorders and Teatment Conference	**TBD**

Legend		
Salmon	Completed	
Green	Available topics to schedule - Not Completed	
Yellow	Non pre-meeting training month	