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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Introduction

King County provides behavioral health services in accordance with best practice guidelines, rules and regulations, and policies and procedures set forth by the Health Care Authority, Washington State Administration Codes (WAC), and Center for Medicare and Medicaid Services (CMS) and contracted Managed Care Organizations (MCOs).
King County provides management and administration of all behavioral health services through the Department of Community and Human Services (DCHS) via the Behavioral Health and Recovery Division (BHRD). Management and/or administration of services are then separated by funding sources. Generally, services funded by Medicaid/Apple Health are managed by the King County Integrated Care Network. King County Crisis Services and programs funded by federal and state grants are managed by the Behavioral Health Administrative Services Organization (BH-ASO). All locally funded behavioral health services

including MIDD Behavioral Health Sales Tax initiatives, grants, and city- and county-funded programs are managed directly by BHRD. See attachment *King County Behavioral Health Structure* in this section for a visual guide to the behavioral healthcare system.

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

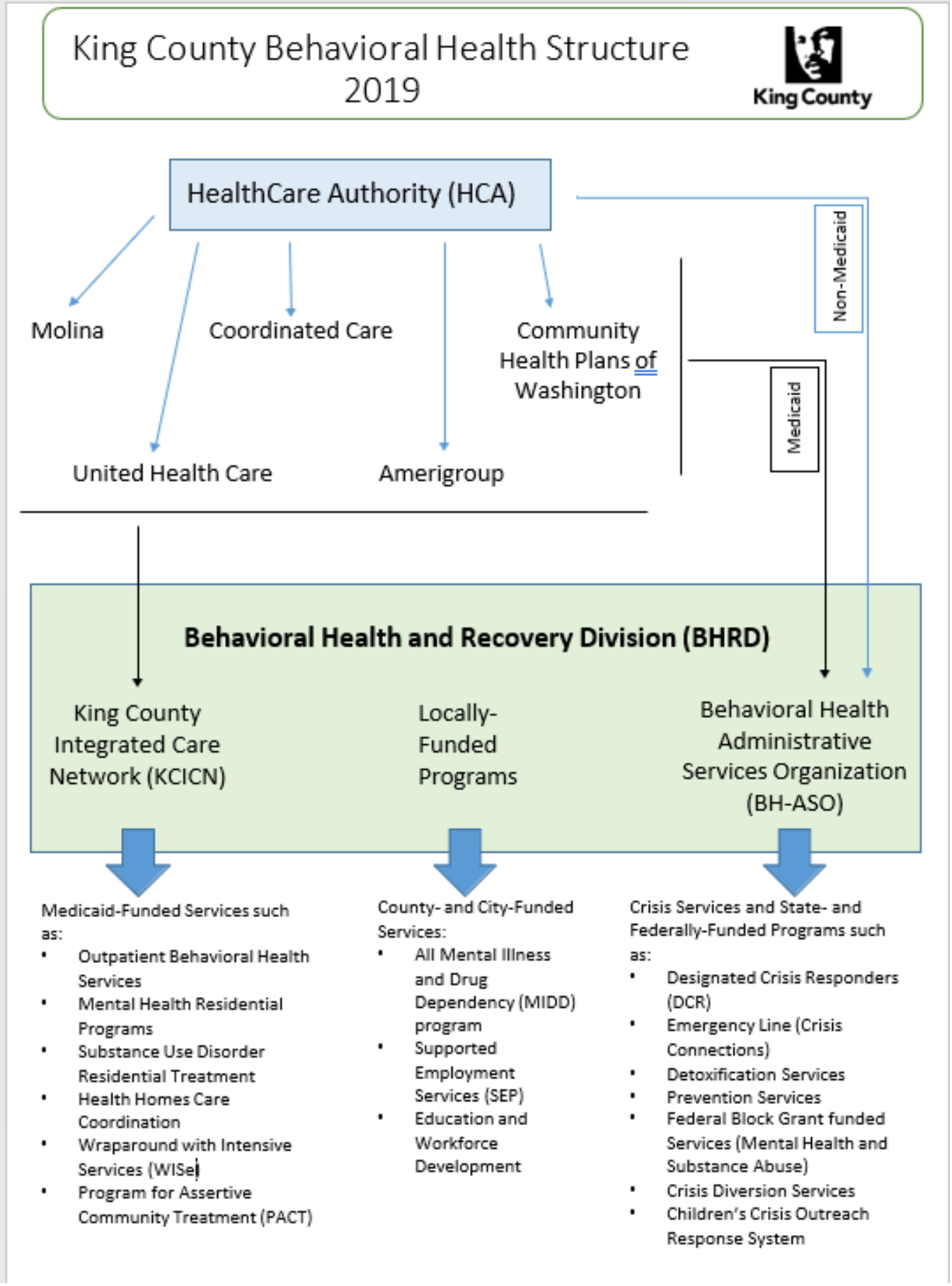
The Administrative Services Agreement between the MCOs and King County designates King County as the Managed Behavioral Healthcare Organization engaged in the business of arranging for and managing certain mental health and substance abuse services on behalf of MCO members through its network of behavioral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

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

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

Attachments in this Section:

- Attachment A: King County Behavioral Health Structure


King County Behavioral Health Structure 2019
King County
HealthCare Authority (HCA)
Molina
Coordinated Care
United Health Care
Amerigroup
Community Health Plans of Washington
Non-Medicaid
Medicaid
Behavioral Health and Recovery Division (BHRD)
King County Integrated Care Network (KCICN)
Locally-Funded Programs
Behavioral Health Administrative Services Organization (BH-ASO)
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 Programs 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

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 relationships and social networks;
- Is culturally based and influenced;
- Is supported by addressing trauma;
- Involves individual, family and community strengths and responsibility; and
- Is based on respect.
  For additional detail: SAMHSA
- BHRD ensures that the service delivery system provides equitable access and competent care to the culturally and ethnically diverse residents of King County.
- BHRD values the strengths and assets of clients, their families, and significant others, and seeks to include their participation in decision-making, policy setting, and the development of services and systems.
- BHRD ensures clinical service quality that is based on scientific research, nationally recognized standards of care for specific behavioral health disorders and is focused on recovery and resiliency.
- BHRD works in partnership with allied system providers to deliver quality-individualized services, supports and outcomes.
- BHRD is accountable to the public, including individuals receiving care, to ensure that resources are carefully managed to provide the highest quality services to a clearly defined eligible population.

BHRD is committed to establishing and maintaining a network of providers who best meet the needs of the community we serve. Providers and potential providers can access general DCHS Contract Requirements here.

1.4 Behavioral Health and Recovery Division (BHRD) General Requirements

1.4.1 Changes in Capacity

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

General Requirements

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

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

Providers ensure the following are available:

- 24-hour crisis response for authorized clients if required by contract;
- Client and network notification procedures including;
- Answering machine message and website notification regarding the closure; and
- Specific network instructions on procedures related to unplanned closures due to disaster, inclement weather, etc., and how to reach on-call staff (telephone and pager numbers).

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

The Provider refers clients to the BHRD client services line as needed and states the following: *"If you need assistance with connecting to another behavioral health provider, please call the King County Client Services Line at 206-263-8997, Monday to Friday from 8am to 5 pm."*

Temporary/Unplanned Capacity Changes and Closures

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

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

  In addition to the General Requirements above, for temporary unplanned capacity changes and/or closures of less than 14 days:
- The Provider emails their Provider Relations/Contract Specialist on or before the day of the unplanned closure to indicate the date(s) and reason(s) for the closure.

- The Provider updates the agency Vendor Profile Application within 24 hours to reflect this temporary capacity change. Instructions on how to update the Vendor Profile are located in the ISAC Notebook.
  In addition to the General Requirements above, for temporary unplanned capacity changes and/or closures more than 14 days:
- The Provider emails their Provider Relations/Contract Specialist before the closure to indicate the date(s) and reason(s) for the closure.
- The Provider emails their Provider Relations/Contract Specialist a Changes in Capacity Notification Form. The Provider includes additional information as requested.
- The Provider updates the agency Vendor Profile Application within 24 hours to reflect this temporary capacity change. Instructions on how to update the Vendor Profile are in the ISAC Notebook.
- The Provider notifies their Provider Relations/Contract Specialist at least 30 days prior to any change that would significantly affect the delivery of or payment for services provided, including changes in tax identification numbers, billing addresses or practice locations.

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

If any of the above events occur, the Provider submits a plan to BHRD and if requested, meets with BHRD to review the plan at least 30 business days prior to the event. The plan should include the following:
- Notification of service/site change;
- Client notification and communication plan;
- Plan for provision of uninterrupted services by client; and
- Plan for provision of uninterrupted services; and
- Any information that will be released to the media.

Adding New Sites
Organizations that are currently a member of the King County Integrated Care Network (KCICN) and requesting to add a new site to their program must submit a KCICN Expanded and New Program Request Form. To access this form, please contact the BHRD representative (Program Manager) connected to the program.

The King County Behavioral Health and Recovery Division (BHRD) reviews all KCICN Expanded and New Program Request Forms to decide whether the request can move forward with an application. Decisions are based on several factors, including the KCICN's current capacity and needs. Submitting a KCICN Expanded and New Program Request Form does not guarantee approval to submit a full KCICN Expanded and New Program Application. Organizations will receive a determination regarding their KCICN Expanded and New Program Request Form in writing.

KCICN contracts for new or expanded Medicaid-funded services start on either January 1st or July 1st. This timing ensures that the increase in Medicaid services is submitted to the State actuary. The application process typically needs to begin 6 months to 1 year prior to the contract start date.

Attachments in this Section

Attachment B: Changes in Capacity Notification Form

1.4.2 Client Property

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

1.4.3 Vehicles Purchased with King County Contract Funding

Providers may at times be authorized to purchase and use a vehicle to enhance or enable fulfillment of a Provider's Scope of Work contract obligations. For any vehicle purchased with County funds for County-contracted work, Providers agree to:

- Use the vehicle solely to support the transportation functions of the contracted Scope of Work.
- Be listed as the legal and registered owner of the vehicle and maintain the original vehicle title.
- Maintain property records that include a description of the vehicle, a serial number or other identification numbers, the source of funding for the vehicle, who holds the title, the acquisition date, and costs of the vehicle, percentage of County participation in the cost, the location, use and condition of the vehicle, and ultimate disposition data including date of disposal and sale price of the vehicle.
- Maintain insurance coverage on the vehicle and drivers that will indemnify the County from any and all claims arising from the operation and/or use of the vehicle. The Provider's insurance also provides for the replacement or repair of the vehicle in the event that the vehicle is rendered inoperable or stolen during the course of possession by the Provider.
- Ensure that the vehicle is regularly maintained in a manner consistent with the manufacturer's recommendations and that complete maintenance records are kept. All vehicle operation costs, including but not limited to fuel, maintenance and repair, are the responsibility of the Provider. Vehicle maintenance records and County access to the vehicle for inspection will be provided within three business days following notification of the County.
- Ensure that the vehicle is operated by individuals who are trained in its operation, have a valid and current Washington State Driver's License with appropriate endorsements for its use, and that the vehicle is operated in a safe manner at all times in compliance with the laws of the State of Washington.
- Ensure the security of the Vehicle at all times, even when not in use or in the possession of a Provider employee. In the event the vehicle is stolen, the Provider will file a police report and notify the County within 24 hours.
- Be responsible for any fines resulting from violations of state or local laws pertaining to the operation of the vehicle.
- Provide the County with the vehicle's payment documentation (receipts).
- Notify the County within one business day of any accident involving the vehicle, damage to the vehicle, personal injury or of any repairs to the vehicle in excess of $250.

- If signage is Provided by the County, display on the vehicle signage stating that the vehicle was funded by King County.
- At the discretion of the County, the Provider returns the vehicle to the County at the termination of the contracted Scope of Work. Condition of the vehicle is consistent with the age and use of the vehicle.

1.4.4 Credentialing

Initial Contracting and Credentialing

Providers are credentialed prior to inclusion in the network. Providers or Subcontractors that elect not to participate in the credentialing process are not eligible to contract with BHRD.
A complete application packet includes:

- A copy of appropriate licensure;
- A copy of accreditation certificate from the DOH-contracted accrediting organization. BHRD does not accept accreditation from non-DOH contracted entities. DOH contracts with the following entities to provide BHA accreditation:
  - CARF International (Commission on Accreditation of Rehabilitation Facilities)
  - The Council on Accreditation (COA)
  - The Joint Commission (TJC)
- Verification of current insurance coverage;
- Current staff roster;
- Current board list;
- Ownership and control disclosure statement;
- Debarment attestation;
- Documentation of any moral objections/restrictions in regard to the care provided, if applicable.
- A copy of the contract or agreement between a Provider and any Subcontractor(s); and
- Any relevant policies and procedures regarding BHRD requirements identified for the specific credentialing period.

Ongoing Contracting and Credentialing Provider Requirements

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

Credentialing and Recredentialing

Contracting and credentialing requirements may be amended over time, and currently credentialed Providers and Subcontractors may be required to update their standards or provide additional information. Providers and subcontractors are credentialed at the following intervals:

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

Facility and Site Reviews
BHRD conducts periodic reviews with Providers in the following areas:

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

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

1.4.5 Background Checks

Medicaid-funded Providers and King County Behavioral Health Administrative Services Organization (BH- ASO) funded Providers will conduct criminal background checks on Provider staff prior to hire. Providers will maintain Policies and Procedures and personnel files consistent with the requirements outlined in:

- Chapter 43.43 RCW
- WAC 110-04
- WAC 246-341
- WAC 246-341-0300
- WAC 388-06
- Any derivative or related WACs and RCWs pertaining to Agency Administration

Refer to DCHS Boilerplate for additional information and requirements related to background checks.

1.5 Reporting Requirements and Performance Measurement

1.5.1 Reporting Requirements Across All Programs

All programs must submit the following reports:

Frequency	Report	Report Requirements	Frequency/ Schedule	Dollars at Risk (Per Each Due Date)	Program
Weekly	Weekly Provider Capacity Reporting Form	See “Capacity to Intake New Clients and Support Linkage to Care” section of this manual.	Weekly as needed	N/A	KCICN (MH, SUD and OTP outpatient only)
Monthly	Data Certification Letter (Data Attestation)	Provider submits the certification letter.	Monthly	N/A	KCICN (Service encounter submitting agencies)

Monthly	*Workforce App *Monthly reporting is done within the Workforce App.	• Update clinician information, including licensure information, specialty training, etc. • As needed: Submit EAR form for any new Workforce App users. • Initial Workforce App set-up only: ○ Submit list of users with 1. read only access, and 2. write access. Review agency information in Workforce App, contact BHRD Information & Data Systems (BIDS) Team for edits	Monthly	N/A	All KCICN & BH-ASO providers
Quarterly	Provider Profile Update	Provider submits up-to-date profiles and licenses	• January 31 • April 30 • July 31 • October 31	N/A	KCICN, BH-ASO
Quarterly	Third- Party Payment Report	Third-Party Payments collected by category of payment (e.g., private pay, insurance, Medicare). Providers submit Third- Party reports for all Medicaid programs (MH & SUD outpatient, OTP, residential). Program payments can be combined, except for OTP which needs to be on a separate report.	• January 31 • April 30 • July 31 • October 31	N/A	KCICN (MH, SUD and OTP outpatient only)

Annual	Financial Reporting Package	Complete Financial Reporting Package with auditor's opinion, management letter, and A-133 audit where federal funding threshold is met.	30 days after received by Provider no later than 9 months after end of fiscal period.	N/A	All Contracted Providers
Annual	Certificate of Insurance and Endorsement	See contract boilerplate for details.	Upon expiration of previous insurance certificate	Payment is held until updated insurance is approved	All Contracted Providers
Annual	Closure Dates Report	All Providers submit to BHRD an annual planned closure schedule.	January 31	N/A	KCICN, BH- ASO (SUD and MH outpatient and OTP only)
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	KCICN, BH-ASO (excluding pharmacies)
Annual	General Compliance, Fraud, Waste, & Abuse (FWA), HIPAA Attestation	Provider submits to BHRD annual signed General Compliance, Fraud, Waste, & Abuse (FWA) & HIPAA Attestation.	January 31		KCICN, BH-ASO
Annual	SUD Attestation	Provider submits to BHRD the signed SUD Attestation.	January 31	N/A	KCICN, BH-ASO (Acute Withdrawal Management, Secure Withdrawal

					Management Only)
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. • Designated recovery options	January 31	N/A	KCICN, BH-ASO (excluding pharmacies)

		Evidence that disaster recovery tests or drills have been performed.			
Other	Client Success Stories	One or more summaries 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 public education.	Upon Request	N/A	KCICN, BH- ASO

1.5.2 Performance Measurement (PM) Plans

As specified in each program description table, programs will have an accompanying performance measurement (PM) plan detailing reporting requirements and performance measures. PM plans equip both parties with information to promote accountability, monitor program performance, facilitate program management and planning, advance data-informed decisions and continuous quality improvement, and meet external reporting requirements. If a PM plan is not specified, reporting requirements and performance measurement are guided by the "Reporting Requirements" box in each program section below, in addition to any ICN or ASO measurement activities.

What is a PM Plan?

The PM Plan explicitly connects the data collection and reporting requirements outlined above with the performance measures King County will use to monitor the program. The PM Plan includes key performance measures, types of data collection (for example, individual- or aggregate-level), and reporting cycles. The PM Plan may include additional evaluation activities, such as focus groups, surveys, or more rigorous evaluation projects. PM plans may include, but not limited to:

- Required data collection: What information providers are required to collect about program activities and participants. For instance, individual- or aggregate-level data.
- Reporting and submission requirements: How providers will share information with DCHS and with what frequency. For instance, via BHRD Information System transactions, monthly CORE reports, or ad hoc aggregate reports.
- Performance measures: What metrics of service delivery, quality, and program results will we calculate and monitor, using the data submitted. Performance measures follow the Results- Based Accountability Framework.
- Learning activities: Plans to review, share, and learn lessons from the measures above.
- Required reports and dissemination activities: How data submitted by Providers and performance measures developed by King County will be disseminated to the State, King County Council, the public, and others as required.

How are PM Plans Created and Updated?

PM plans are co-developed by King County and providers. The PM Plan will be fully developed and formally accepted within three months from the signature date of a contract with King County, unless otherwise agreed upon by both DCHS and the Provider.
PM plans are expected to receive periodic additions and adjustments as they are designed to evolve over time to accommodate programmatic changes, advancements in measurement practices, and new guidance and requirements. When additional changes are requested, the Provider and the County will discuss in good faith the original and subsequent modifications, until an acceptable PM Plan has been developed. The modified PM Plan will replace all prior versions of the PM plan.
If, through analysis of the required reports and data or through conversations with the Provider, it is determined that the program model is not successfully or sufficiently serving the targeted population, the Provider will work with the County to re-envision the program model, adjust the program activities, and make changes to the PM Plan.
Failure to participate in the PM Plan development or modification process may constitute a breach of contract.

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 in the Invoice Program Specific Requirements section of this manual.

1.6.1 Financial Business Rules

Providers are paid for the delivery of outpatient services according to a case rate model for mental health outpatient and a fee for service model for Opioid Treatment Program (OTP) and Substance Use Disorder Outpatient. Case rate Providers are prepaid monthly.

- 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.
- For services to new clients or to clients ending services, adjustments to payment may be applied retroactively.
- Additional adjustments may occur as needed.

Providers are paid for the delivery of OTP services according to a dose day payment model. In order to get paid, the client must have an open OTP benefit in Authorized Approved/Outcome Data Set Complete (AA/OC) status and have all data in before encounters are paid. See ISAC Notebook for details.
OTP providers are paid monthly as follows:

- For clients with an open OTP benefit, Providers receive payments for OTP H0020 Dose Days, H0038 Peer Support and H0050 Alcohol/Drug Services encounters according to submission date.
- BHRD pays for H0020 Dose Days, H0038 Peer Support and H0050 Alcohol/Drug Services encounters submitted for services provided within the past 12 months. BHRD will follow the Medicaid billing rule the same way as for other Medicaid outpatient services.

In general, BHRD expects that if a client is also receiving intensive behavioral health care services reimbursement through another funding source (for example, the state Children's Administration), no greater than a mental health outpatient medium level of care.

Stacked Benefits

- The "Program Overlap Rules" document provides details on which programs can overlap and under what conditions. This document is available in the ISAC Notebook.
- A client is limited to one mental health outpatient benefit and one SUD outpatient benefit authorization at a time. The Provider holding the authorization receives the case rate for the client and is responsible for coordinating all care.
- A client is limited to either one SUD outpatient benefit or an OTP benefit at a time. For an exception to policy, providers may submit an OTP SUD Outpatient Overlap Request form to Residential Authorizations resauth@kingcounty.gov or fax to 206-205-1634.

Payment of Subcontractors

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.

Attachments

Attachment C: OTP/SUD Outpatient Overlap Request Form

1.6.2 Federal Block Grant Requirements

All mental health, substance use disorders, opioid treatment program, outpatient and residential providers must verify income changes and Medicaid status for all clients each day a service is provided.

Residential providers must verify income changes and Medicaid status for all clients upon intake/assessment and at the beginning of each month.

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 with accessing Medicaid if they are eligible but not currently enrolled.

1.6.3 Invoice General Requirements

A. Billing Invoice Package

- The Provider submits a Billing Invoice Package (BIP) that consists of a completed Reimbursement Request Summary (RRS) form for the service month in a format approved provided by King County including any applicable reporting requirements and reports as noted in per the BHRD Provider Manual.
- The Provider's RRS is signed by an authorized signer on file with BHRD. The Provider provides BHRD a list of Provider-authorized signers and will update the list as needed.
- The Provider completes the BIP according to the BHRD Provider Manual or according to the latest instructions from the BHRD Contract Monitor/Program Manager.
- The Provider submits a BIP for all service months. The Provider submits an invoice even for service months when there are no services provided or no reimbursements payable to the Provider.
- The BIP is due within 15 days after the end of each month, unless otherwise specified on the invoice. An earlier due date may be required at the end of King County's

calendar year, the end of the State fiscal year, the end of the Federal fiscal year, and the end of the State biennium.

- A BIP received 45 days or more after the service month may not be accepted for payment. A BIP for scopes that use Federal Funds received 30 days or more after the service month may not be accepted for payment.
- Monthly payment will not be made until all reporting requirements (as noted in the Provider Manual) have been satisfied.
- The Provider will not invoice and charge the County for services which are specifically paid for by another source of funds.
- The Provider will notify its BHRD Contract Monitor/ Program Manager before submitting supplemental invoices. The Provider will state in the notes section of the invoice the reason for submitting a supplemental RRS.
- For programs that are based on an authorized benefit [i.e., Mental Health (MH) or Substance Use Disorder (SUD) outpatient, Opioid Treatment Program (OTP)] the Provider will be paid according to the data in the King County Behavioral Health Information System (KCBH IS) for authorized clients.
- The King County BHRD rate schedule is located here: https://kingcounty.gov/en/dept/dchs/human-social-services/behavioral-health-recovery/provider-resources

B. Additional Requirements for Invoices (Specific to Scopes of Work)

- The Provider will complete the invoice appropriate to the specific to the scope of work, using the most recent version issued by BHRD.
- The Provider must complete page one of the invoice including:
  - Entering month and year being invoiced.
  - Indicating whether this is an original or supplemental invoice.
  - Entering data into appropriate unlocked fields (i.e., cells that are not grayed out).
  - A signature from an individual who is on the authorized signers list on file with BHRD, as well as the date signed.
- The Method of Payment (MOP) may vary according to the scope of work. Examples include:
  - Equal monthly amounts, e.g., 1/12th of allocation for services each month
  - FTE cost reimbursement
  - Bed day/census day/dose day (rates per site)
  - Room and board
  - Case rate
  - Actual cost reimbursement paid retroactively.
  - Incentive-based payments paid retroactively.
  - Enhancement rates
- The Provider must follow the MOP and any additional requirements listed on the invoice.

1.6.4 Invoice Program Specific Requirements

Invoice Program Specific Requirements are located in each respective scope.

1.6.5 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.

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

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

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

Funds collected from a client without Medicaid must be refunded if the client subsequently receives retrospective Medicaid coverage.
Services funded by Behavioral Health Administrative Services Organization (BH-ASO) may not be withheld by a Provider due to the failure of a client without Medicaid to make a first party payment.

1.6.7 First-Party Payments by Medicaid Clients

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

- The KCICN's insolvency;
- The failure of any state contracted MCO to pay its subcontracted obligation to KCICN;
- KCICN's failure to pay a Provider;
- A Provider's failure to pay a subcontractor;
- The cost of a service provided on referral by KCICN to an out-of-network Provider exceeds what Behavioral Health Administrative Services Organization (BH-ASO) would cover if provided within the KCICN Provider network; or
- A community psychiatric hospital's insolvency.
- Upon approval by KCICN (who has been delegated the responsibility for payment by the Apple Health plan), Providers may collect first-party payment from a Medicaid client:
- For covered services if services are provided pending a client-initiated appeal of an adverse authorization decision and the client loses the appeal; and
- For non-covered services if the requirements of Washington Administrative Code (WAC) 182-502- 0160 or its successor are met and, prior to the provision of services, KCICN has made a written determination that KCICN does not cover these services. Inquiries should be directed to the BHRD Fraud, Waste, and Abuse Compliance Officer.

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

Under no circumstances may a publicly funded client be billed for 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.

1.6.8 Mental Health Administrative Daily Bed Rate Requests

The mental health residential administrative bed daily rate is available for a limited time when a client no longer meets medical necessity and is unable to be discharged from the facility to an appropriate placement. This rate applies to all residential programs and includes both Medicaid and non-Medicaid. The residential administrative daily bed rate is 21% of the current bed rate and does not include room and board.
To request a mental health residential administrative daily bed rate, please submit an Admin Day Request Form to the BHRD MH Residential Utilization Management Team. The Provider is informed within 14 days whether the request is approved or denied.
In addition, the MH residential admin rate is applied to all levels of care currently requiring continued stay requests or reauthorization requests who are denied. These requests are processed by the BHRD Hospital and Mental Health Residential Utilization Management Team.

Once an MH residential admin request is approved, the Provider documents the admin day on the monthly census report and corresponding invoice.
To request a MH residential administrative bed daily rate, submit an “Admin Day Request Form” to continuing.stay@kingcounty.gov.

Attachments in this Section
Attachment D: Admin Day Request Form

1.6.9 Spenddown

Provider responsibility regarding spenddown and Medicaid Coverage:

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

1.7 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 under Information Management on the Information for Providers page here.

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.

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

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

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

- Detailed provisions for detecting and preventing fraud, waste, and abuse that include the following elements:
  - A statement of the Provider's commitment to comply with all applicable federal and state standards.
  - Designation of a compliance officer and a compliance committee that is accountable to senior management.
  - Provision of effective ongoing training and education for the Provider's compliance officer and staff, to be conducted at time of hire and on an annual basis. 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)
- Detailed information about administrative remedies for false claims and statements established under chapter 38 of title 31 USC
- State laws pertaining to civil or criminal penalties for false claims and statements (Attachment B-4).
- Whistleblower protections under such laws with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in federal health care programs (Attachment B-4).

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

The Provider must include in any employee handbook for the Provider, a specific discussion of the laws described above, the rights of employees to be protected as whistleblowers, and

the Provider's policies and procedures for detecting and preventing fraud, waste, and abuse. The Provider need not create an employee handbook if none already exists.

1.9 Client Rights

General Requirements

Providers ensure the following protected rights:

- Clients are fully informed of their behavioral health status;
- Clients receive all information regarding health treatment options, including any alternative or self- administered treatment;
- Clients receive information about the risks, benefits, and consequences of behavioral health treatment (including the option of no treatment);
- Clients have the ability to participate in decisions regarding their behavioral health care, including the right to refuse treatment and to express preferences about future treatment options;
- Clients are treated with respect and with due consideration for their dignity and privacy;
- Clients receive care that does not discriminate against them.
- Clients are free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation;
- Clients may request to receive a copy of their medical records, and to request that they be amended or corrected, as specified in 45 CFR Part 164;
- Clients are free to exercise their rights and to ensure that doing so does not adversely affect the way the agency treats the client;
- Clients are provided an opportunity to complete or modify an advance directive at any time;
- Clients may file a grievance and receive assistance during the resolution process;
- Clients are aware of their right to file an appeal in the event of an adverse action and receive assistance during the resolution process;
- Clients may access assistance from the Office of Behavioral Health Advocacy for assistance in filing a grievance or appeal, or if they believe any of their rights have been violated.

Culturally and Linguistically Appropriate Services (CLAS)

- Providers will provide effective, equitable, understandable, and respectful quality of care and services that are responsive to the diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.

At a minimum, providers will:

- Offer language assistance to clients who have a limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services; (CLAS Standard 5);
- Inform all clients of the availability of language assistance services clearly and in their preferred language, verbally, and in writing (CLAS Standard 6);
- Provide easy to understand print and multimedia materials and signage in the following threshold languages (CLAS Standard 8):
    - English
    - Chinese
    - Korean
    - Somali
    - Russian
    - Spanish
    - Vietnamese

- Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the agency's planning and operations (CLAS Standard 9); Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflict or complaints (CLAS Standard 14).

Inform Clients of their Rights

- Client rights are posted at facility locations where clients will most likely be able to view them.
- Client rights are available on BHRD's website here.
- For Medicaid funded clients, client rights are available in 15 languages in the Washington Apple Health: Integrated Managed Care (HCA 19-046) Booklet.
- Rights are posted in the following threshold languages: English, Chinese, Korean, Somali, Russian, Spanish, Vietnamese.
- The understanding of rights, including the notice of privacy practices, are documented in the clinical record by client signature.
- Clients will be informed of their rights at the intake evaluation, and as needed thereafter.
- Providers will ensure clients' understanding of their rights is documented in the clinical record by client signature.
- Providers ensure clients are able to understand the information provided to them, including clients with communication barriers or sensory impairments.
- If a client is unable to understand the information provided due to cognitive impairment, the information is provided to the client's family and/or representative, if available, or re offered to the client when capacity is regained, should that occur.

The following copies of client rights are available on-line as well as in print, as requested, in any language of the client's choice:

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

The following provides additional guidance and information to support providers in promoting and protecting client rights:

Individual Rights – How to Promote and Protect Each Right

People receiving publicly funded behavioral health services have the right to:	Staff members should:
Be treated with respect and dignity	• See clients as individuals, not cases or diagnoses. • Treat clients with the courtesy, fairness, and kindness staff themselves would want to receive, inclusive of providing a complete introduction (e.g. name, title, and organization) when initiating or returning a phone call. • Recognize the talents and capabilities of the client. • Listen to and support the client. This right is most frequently the subject of a grievance – it is based on how a client perceives they have been treated.
Have their privacy protected	• Conduct confidential conversations in areas where they can't be overheard: Waiting rooms, intake desks, offices. • Keep personal information out of public site: Computer monitors, charts, data entry documents are not visible. • Provide the client with your Notice of Privacy Practices • Comply with HIPAA and other confidentiality requirements related to the: Release, exchange, transmission, and storage of client information
Help develop a plan of care with services to meet their needs	Develop an Individual Service Plan (ISP) collaboratively with the authorized client that: • Meets the client's unique needs. • Is client-driven and strength-based • Include the client in updates to their plan
Participate in decisions regarding their behavioral healthcare	Encourage clients to express preferences about future treatment decisions. Review and update the ISP in consultation with the client: • More often at the request of the client
Receive services in a barrier-free location (accessible)	Ensure clients can participate in behavioral health services: • Regardless of disability, e.g., limited mobility or sensory impairment • Facilities are compliant with the Americans with Disabilities Act • TTY communication devices available • Interpreters are provided for hearing impaired or limited English proficient clients. • Bring services to clients or service sites where there is limited transportation
Receive the amount and duration of services they need	Assist clients to achieve the goals stated in their individual service plans Provide access or referral to medically necessary services Applies to: • All Medicaid clients who meet access to care criteria • Non-Medicaid clients who meet access to care criteria and for whom funding is available.
Request information about the structure and operation of the King County BH-ASO	Inform clients if they want to make this request to call: **BHRD Client Services** 206-263-8997 1-800-790-8049 TTY 206-205-0569

Individual Rights – How to Promote and Protect Each Right	

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

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

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

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

Refuse any proposed treatment	• Ask clients if they want to: get treatment; take medication. • Provide information about how treatment or medications may help. • Provide information about adverse effects. • Answer questions the client may have. • Honor the client's decision to refuse
Receive care that does not discriminate against them	Ensure clients are not discriminated against due to their: • Race • Color • Sex • Religion • National origin • Sexual orientation • Age • Disability (sensory, mental, or physical) • Type of illness • Willingness to provide information about these personal characteristic

Be free of any sexual exploitation or harassment	• Let clients know sexual exploitation or harassment by staff or other clients will not be tolerated by the agency. • Provide client information about and assistance in reporting such an event

Individual Rights – How to Promote and Protect Each Right			
Receive an explanation of all medications prescribed and possible side effects	• Inform clients they can ask their prescriber about their medications and possible side effects. • Ask the client if they are experiencing any side effects. • Advocate for the client if necessary		
Make an advance directive that states their choices and preferences for medical and behavioral health care	Give each adult, emancipated minor, and youth aged 13 or older written information about: • Their right under state law to participate in decisions concerning them • Their right to care; including behavioral health care. give someone else legal authority to make physical health and behavioral health care decisions if the client is unable to do so; • The agency's policy regarding advanced directives; • How to execute an advanced directive; and • Their right to cancel or revoke an advance directive at any time. For additional information on mental health advance directives, see the HCA's Mental Health Advance Directives Brochure here		
Receive quality services that are medically necessary	• Ask clinically relevant questions of the client to determine if the services requested are medically necessary. • Review the ISP periodically with the client to determine if services are assisting the client to achieve their goals.		
Have a second opinion from a behavioral health professional.	Assist the client to obtain a second opinion from another mental health professional within your agency Ensure a second opinion: • Occurs within 30 days of request. • Is provided at no cost to the client. • Submit any requests to obtain a second opinion from a different mental health agency to BHRD Client Services		
File a grievance about your agency or the behavioral health services you are receiving	• 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.		
File a grievance about your agency or the behavioral health services you are receiving File an appeal based on a BHRD	To file an appeal, call the BHRD Client Services Line at 1-800-790-8049.	BH-ASO	(800) 790-8049 BHRDComplaintsGrievances@kingcounty.gov
		Amerigroup	(800) 600-4441 WA-Grievance@amerigroup.com

written Notice of Action for	For assistance in filing an appeal, call the Office of Behavioral Health Advocacy at 800-366-3103.	Community Health Plan of WA	(800) 440-1561 AppealsGrievances@chpw.org
		Coordinated Care	(877) 644-4613 WAGrievances@centene.com
		Molina Healthcare	(800) 869-7165 WAMemberServices@MolinaHealthcare.com
		UnitedHealthcare	(877) 542-8997 WACS_Appeals@uhc.com

Individual Rights – How to Promote and Protect Each Right	
an ASO-funded service	• The agency may file an appeal on behalf of a client with the client's written consent. • Services can be continued during the appeal process if time frames on the notice are followed.
File an appeal based on a written Notice of Adverse Benefit Determination (NOABD) 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.

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
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.
Be free from retaliation	

Individual Rights – How to Promote and Protect Each Right	
Be informed that research concerning clients whose cost of care is publicly funded must be done in accordance with all applicable laws, including State rules on the protection of human research subjects	Inform clients if they are asked to participate in a research project: • They may refuse – participation is voluntary. • If they refuse it will not impact their regular services • If they agree to participate: ○ They will be asked to sign a consent that has information about the research. ○ They can stop their participation at any time. ○ Personal information will not be released without their consent except in emergencies
Discuss a concern with the Office of Behavioral Health Advocacy (formerly known as Behavioral Health Ombuds), BHRD, or Provider if they believe their rights have been violated. If they discuss a concern or file a grievance or appeal, they must be free of any act of retaliation. The Office of Behavioral Health Advocacy may, at their request, assist them in resolving their concerns.	• Make clients feel it's safe to express concerns that their rights may have been violated. • Provide client assistance in contacting: **Office of Behavioral Health Advocacy (OBHA)** Toll-free: (800) 366-3103 kingcounty@obhadvocacy.org https://www.obhadvocacy.org/ **BHRD Client Services** 206-263-8997 or 1-800-790-8049 • Monitor that no retaliation occurs

1.10 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, co-occurring disorders (COD), detox, Opioid Treatment Program (OTP) and jail/Community Center for Alternative Programs (CCAP)-based SUD treatment.

Attachments in this Section:

- Attachment E: BHRD Notice of Privacy Practices
- Attachment F: BH-ASO Grievance and Appeal Template

- Attachment G: BH-ASO and Locally Funded Client Rights
- Attachment H: SUD Authorization for Disclosure - Required
- Attachment I: SUD Health Information Exchange Consent - Voluntary

King County

Your Information. Your Rights. Our Responsibilities.

NOTICE OF PRIVACY PRACTICES
KING COUNTY DEPARTEMNT OF COMMUNITY AND HUMAN SERVICES

Effective Date: February 16, 2026

This notice describes how medical information about you may be used and disclosed:

- ***How health information about you may be used and disclosed***
- ***Your rights with respect to your health information***
- ***How to file a complaint concerning a violation of the privacy or security of your health information, or of your rights concerning your information***

Please review it carefully.
You have a right to a copy of this Notice (in paper or electronic form) and to discuss it with the King County Department of Community and Human Services Privacy Officer at phone 206-263-6920 and email DCHS_Privacy@kingcounty.gov if you have any questions.

Section 1: Your Rights with respect to your health Information

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 your 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.

Ask us to correct your 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 will tell you why in writing within 60 days.

Request confidential communication

- You can ask us to contact you in a specific way (for example, home or office phone) or to mail it to an address you choose.
- 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 information 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 your information

- You can ask for a list (called an "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 shared it.
- We will include all the times we've shared your information, except for those about routine treatment, payment and health care operations.

Request disclosures by other organizations involved in your present and future substance use disorder care

- You have the right to ask for a list of times we shared your substance use disorder treatment information for treatment, payment, or health care operations. This list can cover up to the three years before the date you make your request and will include who we shared the information with and why.

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.

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 make choices about your health information.
- We will make sure the person has this power and can act for you before we take any action.

File a complaint if you feel your rights have been violated

- You can complain if you feel we have violated your rights by sending a letter to 401 Fifth Avenue, Suite 500, Seattle, WA 98104, Attn: Privacy Officer 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: 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.
- We will not retaliate against you for filing a complaint.

Run our organization

- We can use and disclose your information to provide services effectively.

Example: We may review your information to see how well the services we provide are working and to find ways to provide better care.

Pay for your health services

- We can use and disclose your health information to 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.

Section 3: Our Uses and Disclosures: 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

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease.
- Reporting suspected abuse, neglect, or domestic violence.
- Preventing or reducing a serious threat to anyone's health or safety.

For 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 (DHHS) if DHHS wants to see that we're complying with federal privacy law.

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 – in certain limited circumstances only.
- With health oversight agencies for activities authorized by law.

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

Other uses and disclosures not described in this Notice will be made only with your written authorization.

Section 4: 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 purposes, for payment purposes or to run our organization without your written consent.

Consent requirement

- You can give one consent that covers all future uses or disclosures of your information for treatment, payment, and health care operations.
- You may cancel your consent at any time by telling us in writing. The cancellation takes effect once we receive it. It will not change or undo any use or disclosure that already happened based on your earlier consent.
- Even when your information is shared with your consent, anyone who receives it must follow the same confidentiality rules. They cannot share it again without your authorization.

Disclosures without consent

Federal law allows or requires us to share your substance use disorder information, even without your written consent, in the following situations:

- With medical personnel during a medical emergency
- With authorities when reporting suspected child abuse or neglect
- To report suspected criminal activity
- For research, audits, or evaluations
- When required by a court order
- When working with a qualified service organization under an approved agreement

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

Protections against use of your information in legal proceedings:

- Your substance use disorder information - or any testimony based on it - cannot be used against you in court without your explicit written consent or a court order.
- If we receive a court order, you must be notified and given a chance to contest it.
- The court order must be accompanied by a subpoena to enforce disclosure of the information.

Section 5: Our Responsibilities

Privacy and Security of your health information

- We are required by law to maintain the privacy and security of your health information.
- We will let you know promptly if a data breach happens that may have compromised the privacy or security of your information. Violations of the federal law and regulations will be reported to appropriate authorities in accordance with federal regulations.
- 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.

Redisclosure:

- Once shared, some of your information may be redisclosed by the recipient and may no longer be protected by the same rules.

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 on request and on our web site and we will mail a copy to you.

Section 6: Additional Information

For more information see:

- www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.
- Fact Sheet 42 CFR Part 2 Final Rule | HHS.gov

King County Department of Community and Human Services
Privacy Officer (206)-263-6920
401 Fifth Avenue Suite 500, Seattle, WA 98104
email: DCHS_Privacy@kingcounty.gov

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

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)

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.

NON-DESCRIMINATION NOTICE

King County Behavioral Health & Recovery Division follows Federal civil rights laws[1].
We don't discriminate against people because of their:

- Race
- Color
- National origin
- Age
- Disability
- Sex or gender identity

That means we won't exclude you or treat you differently because of these things.

COMMUNICATING WITH YOU IS IMPORTANT

For people with disabilities or who speak a language other than English, we offer these services at no cost to you:

- Qualified sign language interpreters
- Written materials in large print, audio, electronic, and other formats
- Help from qualified interpreters in the language you speak
- Written materials in the language you speak

To get these services, call the Client Services Line at 1-800-790-8049 (TTY 711).

YOUR RIGHTS

Do you feel you didn't get these services, or we discriminated against you for reasons listed above? If so, you can file a grievance (complaint). File by mail, email, fax, or phone:

Grievance Coordinator	Phone: 1-800-790-8049 (TTY 711)
401 5th Avenue, Suite 400	Fax: 1-206-205-1634
Seattle, WA 98104	Email:
	BHRDComplaintsGrievances@kingcounty.gov

Need help filing? Call our Grievance Coordinator at the number above. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights:

- **On the Web:** https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
- **By mail:** U.S. Department of Health and Human Services
  200dependence Avenue
  201 SW Room 509F, HHH Building
  Washington, D.C. 20201
- **By phone:** 1-800-368-1019 (TTY/TDD 1-800-537-7697)

For a complaint form, visit www.hhs.gov/ocr/office/file/index.html.

[1] TITLE VI OF THE CIVIL RIGHTS ACT OF 1964 42 U.S.C. § 2000D ET SEQ.

At no cost to you, we can translate this or provide this in an alternative format (e.g. American Sign Language, oral interpretation, Braille text, large print, etc.). Call 1-800-790-8049, or TTY/TDY 711.

我们可以免费翻译或以其他格式提供（例如美国手语、口头口译、盲文文本、大号字体等）。请致电1-800-790-8049或TTY/TDY 711。	Chinese
귀하에게 비용을 부담하지 않고 이 내용을 번역하거나 대체 형식(예: 미국 수화, 구두 통역, 점자 텍스트, 큰 활자체 등)으로 제공할 수 있습니다. 1-800-790-8049 또는 TTY/TDY 711로 전화하십시오.	Korean
Si lacag la'aan ah, ayaan kuugu turjumi karnaa tani ama waxaan ku siin karnaa iyada oo qaab kale ah (t.a. Luuqadda Dhegoolayaasha ee Mareykanka (American Sign Language), tarjumaad afka ah, qoraalka Braille ee indhoolayaasha, far waaweyn, iwm.). Wac 1-800-790-8049, ama TTY/TDY 711.	Somali
Мы можем бесплатно перевести этот текст или предоставить его в альтернативном формате (например, на американском языке жестов, в виде устного перевода, набранным шрифтом Брайля, крупным шрифтом и т. д.). Позвоните по номеру 1-800-790-8049 или по телетайпу/устройству с текстовым набором для слабослышащих (TTY/TDY): 711.	Russian
Podemos traducir esto o proporcionarlo en un formato alternativo (por ejemplo, lengua de señas estadounidense, interpretación oral, texto en Braille, letra grande, etc.) sin costo para usted. Llame al 1-800-790-8049 o por TTY/TDD al 711.	Spanish
Quý vị không phải tốn một khoản phí nào, chúng tôi có thể chuyển ngữ tài liệu này hoặc cung cấp tài liệu này theo một định dạng khác (ví dụ: Ngôn Ngữ Cử Chỉ Mỹ, phiên dịch miệng, chữ Braille, chữ in lớn, v.v.). Gọi 1-800-790-8049 hoặc TTY/TDY 711.	Vietnamese

1.11 Crisis Plans and Advance Directives

Crisis Plans

Crisis Plans are individualized, pre-arranged plans created by the client in collaboration with their mental health provider. They are designed to prevent and manage mental health crises effectively. When crises do occur, the crisis plan acts as a guide for crisis responders and mental health care providers to best support the client to build trust, decrease coercive measures, prevent suicide attempts, and reduce hospitalization days.

Not every BHRD client enrolled in care requires a Crisis Plan. Crisis Plans should be updated when clinically indicated, as defined below. Crisis Plans are to be developed in collaboration with all clients who fall into one or more of the following categories:

High Levels of Care or Recent Transitions

- Currently authorized for the following care levels: high-level outpatient or residential mental health care.
- Received care or discharged in the past 12 months from:
  - Inpatient psychiatric care
  - Jail, DOC, juvenile detention
  - ED visit for behavioral health crisis
  - Crisis facility and/or MRRCT/MRSS
  - Withdrawal management (medical hospitalization, medical detox, SWMS, etc.)

Clinical Risk Factors

- Co-occurring mental health and substance use disorders where the client has had a recent escalation in substance use or mental health symptoms, or when the co-occurring disorder results in a significant impact on daily functioning, or is at risk for harm to self or others (suicidal ideation, suicide attempts, violent ideation, or acts of violence)
- Identified by a clinician as at elevated risk or likely to access crisis services within the next two weeks. (In these cases, the crisis plan should be approached with a nearer-term focus more typical of a safety plan rather than a traditional crisis plan. This plan should be updated when the client's crisis has de-escalated, and they are able to engage.)

System Involvement and Other Considerations

- Children/youth involved with two or more of the following systems: child welfare or foster care services, juvenile legal system, special education and/or school-based behavioral support, substance use disorder treatment, seeking health care due to medical complexity, homeless youth & housing services, early childhood intervention, and/or other significant system involvement.
- Has a Mental Health Advance Directive.

Expectations for providers completing Crisis Plans

- All Crisis Plans are to be completed in the standardized format provided in Attachment H BHRD Crisis Plan Form
- Crisis plans are to be completed collaboratively with all clients who meet the above clinical criteria, supporting them in better understanding their symptoms, triggers, and support plan.
- If a client is unable or unwilling to engage in the crisis planning process, providers may use historical information from the client's chart to complete the relevant fields and will confirm with the client that the information is accurate whenever possible.

- Crisis plans are to be reviewed regularly with the client to verify that the information on the plan is current and accurate, as well as to support the client's familiarity with their plan for use in their everyday life.
- Crisis plans must be updated annually if clients continue to fall into one of the above categories during the previous 12 months, or whenever there are significant changes in mental health status, support system, treatment plan, or life circumstances that impact the client's ability to navigate their mental health
- Whenever updates are made to the Crisis Plan, clients should be provided with a printed copy for their personal reference to support autonomy in managing their symptoms to prevent a crisis.
- Crisis plans are entered into PointClickCare's "Insights" tab under the "Mental Health" heading so that crisis responders and hospital staff can access them in the event of a crisis.
- Crisis plans should also be saved to the provider's EHR either as an attachment or as direct entry in an EHR-based crisis plan template that contains equivalent fields to the template in Attachment H BHRD Crisis Plan Form.

When developing a Crisis Plan, the following is considered as related to Advance Directives:
- A client's Crisis Plan contains documentation on whether or not the client has executed a mental health or physical health care advance directive and where to find it.
- DCRs and hospital staff can access Crisis Plans in PointClickCare 24/7 in order to review or locate a client's Advance Directive(s) if applicable.

Advance Directives
By law, Providers providing services paid for by Medicare or Medicaid meet certain advance directive requirements. Providers will:
- Maintain written policies and follow procedures that ensure compliance with State and federal law on advanced directives, including 42 CFR 438, 42 CFR 102, RCW 71.32, RCW 70.97.020, and WAC182-501-0125 or its successor;
- Document in the client's record whether or not the client has executed an advance directive (including a mental health advance directive);
- Educate staff and the community on issues concerning advance directives;
- Not condition the provision of care or otherwise discriminate against an individual based on whether or not the individual has executed an advance directive; and
- Inform the individual that they may file complaints concerning implementation of these advance directive requirements and where they need to file the complaint.

Providers uphold and utilize advanced directives for adults, emancipated minors, and youth ages 13 or older who have completed a mental health or medical advance directive in the provision of services. Mental health advance directives are applicable to individuals participating in behavioral health services. For individuals participating in substance abuse services, Providers ask about, uphold, and utilize advance directives as applicable.
- When clinically appropriate, providers determine client capacity, including capacity to revoke a mental health advance directive.
- Provider supports the development of MHAD forms. Forms should include, at a minimum:
  - Client right to consent to or refuse particular medications or treatments;
  - Client right to appoint an agent to make decisions or take actions on their behalf; and
  - Client's wish to include or exclude certain treatments or services.
- At intake, Providers ask all adults aged 18 and over, emancipated minors, and youth 13 and older if they have a mental health or medical advance directive.

- A client's clinical record contains prominent documentation on whether the client has executed a mental health or medical advance directive, or if the client prefers not to disclose that information.
- If a client at the time of intake is unable to articulate whether they have completed an advance directive, the Provider makes an inquiry about advanced directives as soon as the person is able to provide a response. The information is documented in the client's clinical record.
- If a client indicates they have a mental health or medical advance directive, Providers request a copy of the most recent version for the clinical record. A client's refusal to provide a copy is documented in the clinical record.
- At time of intake, Providers give each adult, emancipated minor, and youth aged 13 and older written information on advance directives which includes at a minimum a brief description of State law and information on how to execute an advance directive.
- Provider makes technical assistance available to any client who expresses an interest in developing and maintaining 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.

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

Attachments in this Section

- Attachment J: Crisis Plan Form
- Attachment K: Mental Health Advance Directives

1.12 Disaster Recovery and Business Continuity

Disaster Recovery and Business Continuity Plan

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

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

System Back-Up

Provider agencies have a primary and back-up system for electronic submission of data (45 CFR §164.308; 45 CFR §164.310). The system includes the use of Inter-Governmental Network (IGN) Information Systems Services Division (ISSD) approved secured virtual private network (VPN) or

another ISSD-approved dial-up. At least annually, BHRD and its provider network conduct a disaster recovery test or drill of their information system and back-up.

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

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

1.13 Faith-Based Organizations (FBO)

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

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

1.14 Opioid Overdose Screening and Distribution of Opioid Overdose Medication

Background
In accordance with **SB 5195 (2SSB 5195)** and **RC 71.24.594**, the Behavioral Health and Recovery Division requires that all licensed or certified behavioral health agencies that provide individuals treatment for mental health or substance use disorder, withdrawal management, secure withdrawal management, evaluation and treatment, or opioid treatment programs, must screen clients for risk of opioid overdose during a client's intake, discharge, or treatment plan review as appropriate and to either provide, prescribe, distribute or assist any client at risk of opioid overdose in obtaining naloxone.

Requirements and Guidance
In addition to SB 5195, which is now commonly referred to as **2SSB 5195**, which states that behavioral health providers and hospitals must prescribe or distribute naloxone to patients at risk of opioid overdose, we also refer to **RCW 71.24.594**, which provides the following guidance:

- Inform the client about opioid overdose reversal medication and ask whether the client has opioid overdose reversal medication; and
- If a client does not possess opioid overdose reversal medication, unless the behavioral health provider determines using clinical and professional judgement that opioid overdose reversal medication is not appropriate, the behavioral health provider must either prescribe the client opioid overdose reversal medication OR assist the client in directly obtaining opioid overdose reversal medication.
- There are multiple ways to assist a client in obtaining opioid overdose reversal medication:
- At the agency level, directly dispense the medication with stock on hand.
- Partner with a pharmacy to obtain the opioid overdose reversal medication on the client's behalf and then distribute the medication to the client.

- Assist clients in locating a local pharmacy where a kit can be purchased.
- Assist clients in utilizing a free mail order program that can mail the medication directly to the client or to the behavioral health agency who can then distribute to the client directly.
- Assist clients in locating a community partner that provides a naloxone box or vending machine.
- Assist clients in locating their nearest syringe service program.
- For clients enrolled in medical assistance, bill the client's Medicaid benefit.

A person who is provided with opioid overdose reversal medication must also be provided information and resources about medications for opioid use disorder and harm reduction strategies and services which may be available, such as substance use disorder treatment services and substance use disorder peer counselors. The information should be available in all languages relevant to the communities that the behavioral health agency serves. The individual or entity that dispenses, distributes, or delivers an opioid overdose reversal medication shall also review directions for use with the client.

These types of assistance should be documented by the agency in the client's health record and would be acceptable as a good faith effort to connect their client to opioid overdose reversal medication.

1.15 Waiver Requests

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

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

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

1.16 BHRD 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. Current training opportunities are available on BHRD's website here.

1.16.1 Relias Learning Management System (LMS) Benefit:

Program Overview

King County is increasing access to online training and free continuing education units (CEUs) and ongoing technical assistance through the Premier line via the Relias LMS. The following agencies will receive the designated number of licenses under the King County Relias contract to support access to professional development resources. If an agency needs additional licenses, please reach out to relias.training@kingcounty.gov. (Agencies need to be responsive to requests). This scope is funded by the MIDD Behavioral Health Sales Tax Initiative, Workforce Investments Strategy: SI-04.

Eligibility Criteria

Relias Learning Management System Eligibility Criteria	
Medicaid Status	N/A
Age Range	None
Authorization Needed	None
Additional Criteria	None

Current Licenses (updated 3/30/2025):

Agency	Number of Licenses Awarded under King County Contract
ACRS	200
Akin	20
Atlantic Street	50
Consejo	180
Crisis Connections	445
DESC	205
Evergreen Health	15
Hero House	10
Kent Youth and Family Services	37
Key Recovery Solutions	100
King County Sexual Assault Resource Center	20
New Traditions	20
Ryther	220
Southwest Youth and Family Services	31
Transitional Resources	55
Vashon Youth and Family Services	30
WAPI	15
YMCA	172
Youth Eastside Services	75
Harborview	115
IKRON	42
Integrative Counseling Services	7
Seneca	70
Friends of Youth	95
Community House	200
Sound	80

Program Requirements

- Provider identifies a staff person, aka “Site Administrator” to function as liaison to the King County Relias system administrator.
- The liaison (a) maintains regular communication with King County’s BHRD Relias Project Manager, (b) notifies the BHRD Relias Project Manager of changes in who functions as a liaison, (c) identifies

a ‘backup’ liaison to the BHRD Relias Project Manager and (d) notifies the BHRD Relias Project Manager if license award number changes

- Provider grants King County access to staff user data for functions such as:
  - To run reports on course enrollment and completion data within the Relias system including:
  - Test and Class Completions;
  - Compliance Reports;
  - Training Effectiveness Reports;
  - Learner Profile Reports; and
  - Survey Reports

Information System Requirements

- None

Invoice Program Specific Requirements

- There is no invoicing necessary to access this benefit. King County is paying for the agencies’ Relias licenses as part of the King County contract.

1.17 Nondiscrimination Requirements

Providers receiving Medicaid funding are subject to Section 1557 or its successors of the Affordable Care Act (42 U.S.C. § 18116) and its implementing regulations at 45 CFR Part 92. Providers may not discriminate on the basis of race, color, national origin (including limited English proficiency and primary language), sex (including pregnancy or related conditions, sexual orientation, gender identity, sex stereotypes, and sex characteristics), age, or disability in any health program or activity receiving Federal financial assistance.

Under 45 CFR Part 92, covered entities must:

- Take reasonable steps to provide meaningful access for individuals with limited English proficiency (45 CFR § 92.201).
- Ensure effective communication with individuals with disabilities, including providing auxiliary aids when required (45 CFR §§ 92.202–92.203).
- Ensure physical and digital accessibility unless doing so would cause undue financial burden or a fundamental alteration (45 CFR § 92.204).
- Provide services without discrimination on the basis of sex, consistent with 45 CFR § 92.101.
- Post required nondiscrimination notices and notices of availability of language assistance services and auxiliary aids, in accordance with (45 CFR §§ 92.10–92.11).

1.18 Updates to this Provider Manual

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

2 Outpatient Services

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

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

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

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

Providers share information with clients on the availability of services to support them twenty-four (24) hours a day, seven (7) days a week.

- Agencies are responsible for responding to all crises which occur for their enrolled clients during the business day; and meeting the applicable standards for timely access to care and services during business hours, taking into account the urgency of the need for the services.
- Crisis Connections provides after hours (5:00PM to 8:00AM), weekend, and holiday telephonic crisis response for all agencies via the Regional Crisis Line or 988.
- Crisis Connections can also dispatch Mobile Rapid Response Crisis Teams (MRRCT) or Mobile Response and Stabilization Services (MRSS) teams to provide crisis outreach response service, as needed.
- When serving out of county clients, agencies should be familiar with the crisis systems where the client lives and be prepared to coordinate care if one of their clients utilizes a particular county's crisis system.

The following Appointment Wait Time Standards follow accessibility and appointment wait time requirements set forth by the Health Care Authority and applicable regulatory (42 CFR § 438.206) and oversight agencies (CMS).

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

For mental health and substance use disorder outpatient, clients must meet medical necessity at the time of submission of anniversary data per the ISAC Notebook.

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 the BH-ASO section of this manual.

2.0.2 Eligibility and Identification of Payor

Providers check an individual's Medicaid status using the Extended Client Look-up System (ECLS) or ProviderOne once a day before the initial billable service.

2.0.3 Medication for Opioid Use Disorder (MOUD): Office-Based Opioid Treatment (OBOT)

Program Overview

Office-based opioid treatment (OBOT) is an approach to treat opioid use disorder in any outpatient clinic as opposed to an Opioid Treatment Program (OTP). Medication may either be administered or prescribed by a medical practitioner on site or picked up at a local pharmacy. OBOT treatment typically includes the following medication options:

- Buprenorphine, a partial opioid agonist that helps reduce cravings and withdrawals symptoms.
- Naltrexone, an opioid antagonist that blocks the effects of opioids and is used to prevent relapses.

Medication for Opioid Use Disorder (MOUD): *Office-Based Opioid Treatment (OBOT) Eligibility Criteria*	
Medicaid Status	Medicaid and non-Medicaid clients are eligible Medicaid-only clients are eligible for Long-Acting Injectables
Age Range	No
Authorization Needed	No
Additional Criteria	Participants must have an Opioid Use Disorder Diagnosis

Program Specific Requirements

- All clients should be screened for opioid use disorder (OUD) during an intake and or assessment.
- All clients who meet criteria for OUD should be made aware of the approved medications for opioid use disorder (MOUD) typically prescribed to treat OUD and how these medications prevent opioid overdose.
- All clients that are interested in discussing and/or receiving MOUD should either be connected to a medical practitioner onsite who can administer the medication

OR

- Obtain referrals to connect with a local medical practitioner who can administer the medication as listed under RCW 69.41.030.
- Provide naloxone to a person directly at risk of experiencing an opioid-related overdose or to a person who could be in a position to assist a person at risk of experiencing an opioid-related overdose.
- Provide referrals to a local pharmacy that can dispense naloxone under the state's "standing order" in accordance with RCW 69.41.095.
- Providers provide opioid-related counseling during the visit.

- The Revised Code of Washington State (RCW) 71.24.585 outlines the regulations for opioid and substance use disorder treatment, including office-based opioid treatment (OBOT).
- Information System Requirements- Data Submission and Program Codes
- Providers submit service encounters to the King County Information System (KCIS) under a participants Mental Health outpatient, SUD outpatient, or MOUD benefit.
- Under an MOUD benefit, use program code 451.
- MOUD service codes are located here: https://kingcounty.gov/en/legacy/depts/community- human-services/mental-health-substance-abuse/for-providers.aspx
- The HCA Physician-Related Services billing guide for criteria for enhanced Medication for Opioid Use Disorder encounters is located here: HCA Physician-Related Services bill

Invoice Program Specific Requirements

Method of Payment

- Encounters will be paid based on Fee for Service per the billing guidelines referenced above.
- Payment will be made through monthly outpatient payments to providers. Reconciliation can be made utilizing CORE-FTP reports.
- If an individual has insurance other than Medicaid, Providers must include all payers (primary, secondary, tertiary) in a separate report to allow King County to submit claims to the private payers to obtain denial or payment information so that King County may bill Medicaid as last resort.

Additional Requirements

- None

Medication for Opioid Use Disorder (MOUD): Office-Based Opioid Treatment (OBOT) Reporting Requirements	
BHRD Information System	Submit Data to the BHRD Information System as outlined in the BHRD Data Dictionary and the Required Transactions Sheet in the ISAC Notebook
Monthly Reports	None
Quarterly Reports	None
Semiannual Reports	None
Annual/Other Reports	None
Performance Measurement (PM) Plan	None

Long-Acting Injectables (LAI's)

- For a client enrolled in MOUD: OBOT (program 500 SUD Outpatient Benefit for Medicaid eligible clients or 451 MOUD: OBOT) agencies may submit CPT codes for long-acting injectables which includes the cost of medication.
- Please see the ISAC Notebook for data requirements.
- Rate schedules are located here: Information for providers and provider manual - King County, Washington

2.0.4 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 aged 18 or older who have a family income of less than 220 percent of federal poverty level; and
- The person meets clinical eligibility criteria and priorities.

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

In order to maximize the appropriate utilization of the limited non-Medicaid resources, Providers update the clients funding source in Behavioral Health Recovery Division Information System (BHRD IS) upon change as specified in the Data Dictionary.
Individuals who meet financial eligibility for Medicaid, but are not currently enrolled, will have documentation in their clinical file as to the reason they have not been enrolled. This documentation will include what the Provider is currently doing to assist in the enrollment process and be completed on a monthly basis.

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

2.0.5 Transitional Services

Transitional Services are required when an individual transfers from one care setting to another or one level of care to another. Providers should work with appropriate staff at any hospital, including a Certified Public Expenditure (CPE) facility, to implement a safe, comprehensive discharge plan that assures continued access to medically necessary covered services which supports the individual’s recovery and prevents 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 assessing 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.

2.0.6 Capacity to Intake New Clients and Support Linkage to Care

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

Providers are asked to support this linkage to care by reporting their weekly capacity to receive new individuals and schedule intake appointments (see Attachment B: Weekly Provider Capacity Reporting Form linked below). BHRD will use the Weekly Provider Capacity Reporting Form to maintain a current inventory of intake appointments that may be used to connect individuals to services. Having the most

accurate and up-to-date provider capacity information will support BHRD and ensure our Client Services Line staff can promptly connect individuals to an available ICN provider.
In the event a provider agency is unable to receive a new intake request, they are encouraged to redirect these inquiries to the BHRD Client Services Line at 206-263-8997, Monday to Friday from 8am to 5pm. Any messages left on voicemail will be answered within one business day.
The BHRD Client Services Line is staffed with behavioral health professionals who are trained to receive calls and provide care coordination for individuals and caregivers of individuals interested in behavioral health or community-based services. Using the most current provider capacity-reported information, Client Services Line staff will provide intake appointment options to callers, and when needed a warm handoff to an ICN provider agency.

Attachments in this Section:
Attachment B: Weekly Provider Capacity Reporting Form

2.1 Behavioral Health Intensive Outpatient (IOP)

Program Overview
BH Intensive Outpatient Program (IOP) is a multi-disciplinary program that provides therapeutic services for individuals in need of a higher level of service than a standard outpatient benefit. Services are based on an individualized treatment plan and may include various therapeutic modalities, such as DBT and CBT. Programming is typically 9-15 hours/week, with flexibility to meet the recommendations of the individual service plan. The goal of IOP is to stabilize the individual within the community, without requiring inpatient hospitalization. Additional Services May Include:

- Medication monitoring
- Nutritional support
- Medication management
- Family counseling
- Group counseling.
- Treatment via telemedicine
- Peer Support

Program Specific Requirements

- Intake is required prior to treatment.
- Notify King County Provider Relations Lead of substantial changes to program or staffing.

Invoice Program Specific Requirements
Method of Payment

- Reimbursement will be made monthly based on dates of service reported on the census log (as applicable: for KCICN approved authorizations).
- Reimbursement will be made as follows: Number of days of service x per diem rate = reimbursement.
- Discharge dates for Intensive Outpatient Program (IOP) are eligible for reimbursement ***if a service is provided on the discharge day.***

Additional Requirements

- None

Behavioral Health Intensive Outpatient (IOP) Eligibility Criteria	
Medicaid Status	Yes

Age Range	Youth under 21 who qualify for Early and Periodic Screening, Diagnostic and Treatment (EPSDT); Minor under 18; Adolescent under 13 or if Provider requests child benefit
Authorization Needed	No
Additional Criteria	• For services to youth ages 18-20, refer to WAC 182-534-0100, EPSDT and WAC 246-341. • Individuals enrolled in the following programs may not concurrently enroll in IOP: WISe, WA-PACT, New Journeys, High Intensity Treatment, Intensive Residential Treatment, Mental Health Services Provided in a Residential Setting.
Behavioral Health Intensive Outpatient (IOP) Eligibility Criteria	
Monthly Reports	For non-standard rates: Behavioral Health Intensive Outpatient (IOP) Census Report
Quarterly Reports	None
Semiannual Reports	None
Annual/Others Reports	None
Performance Measurement (PM) Plan	None

2.2 KCICN Youth Summer Program

Program Overview

Through MIDD funding, the King County Behavioral Health and Recovery Division (BHRD) supports the KCICN Youth Summer Program. This provides funding to KCICN youth providers who have either a Mental Health and/or Substance Use Disorder Outpatient Benefit scope of work for non-billable costs associated with engaging and sustaining engagement of youth and families in outpatient behavioral health services during the summer months.

The KCICN Youth Summer Program connects youth and their families to activities that promote wellbeing and, when appropriate, links them to behavioral health services. Additionally, it supports providers in developing and implementing summer activities and programs tailored to the unique needs of the communities they serve.

Goals & Objectives

- Provides funding for non-billable costs associated with engaging and sustaining engagement of both new and current youth and families in outpatient behavioral health services during the summer months
- Increases summer engagement in behavioral health services for youth and families
- Connects youth and families to activities that promote wellbeing and, when appropriate, links them to behavioral health services
- Supports providers in developing and implementing summer activities and programs tailored to the unique needs of the communities they serve

Program Requirements

Eligible funding expenses will be categorized by supplies and consumables.

Supplies:
Supplies are items that are multi-use, in which the Provider can use on an ongoing basis to support multiple participants, during summer activities and beyond. All items purchased as supplies will need to be justified and documented for medical necessity use and relevance to treatment.

- Examples of supplies that are appropriate use of funds from this RFA include, but are not limited to:
  - Group/Individual therapy curricula materials including but not limited to workbooks where Providers can make copies of handouts/worksheets that can be multi-use for all participants.
  - Board games, outdoor games, jerseys, sports supplies that can be used by all participants.
  - Supplies needed for hosting various events and summer camps indoors and outdoors, such as portable tents, awnings, tables, chairs, blankets, mats, carts, coolers for lunches and water and other furniture.
  - Arts and crafts supplies that can be used by multiple participants, such as digital cameras for photography and videography projects, sewing machines, 3D printers.
- Examples of supplies that are not appropriate use of funds from this program:
  - Vehicles purchased for Provider to use. Vehicle rental and expenses such as gas for vehicles already owned by Provider would be included in Consumable Expenses, as outlined below.
  - Construction or building of spaces and facilities.

Consumables:
Consumables are items and activities that are of one-time use. These items will be paid for by funding for this program and are then unable to be reused by the Provider to support other participants.

- Examples of consumables that are appropriate use of funds from this program:
  - Tickets or memberships to pay for activities and outings that participants could engage in and attend. This includes, but is not limited to tickets to movies, the zoo, ropes courses, and other developmentally appropriate activities.
  - Food, including snacks and beverages while engaging with participants during activities, treatment, and summer programming.
  - Arts and craft supplies for items to be made and taken home by participants, which may include, but are not limited to items like yarn, paper, paint, or other supplies needed that will be used in a relatively short time.
  - Rental fees for space if current location is not conducive for summer activities.
  - Rental fees for transportation such as buses, vans, etc. to transport participants to various events and activities.
  - Contract services for an event, speaker, or trainer.
  - Cash Value Cards of small amounts to participants as incentives to attend youth programing and treatment. If the Provider proposes purchasing Cash Value Cards, DCHS may ask for Provider's policy regarding their use.
  - Other small items, such as fidget toys, coloring books, stuffed animals, and pens as behavioral incentives for participants engaged in services.
  - Other items, such as headphones, tickets to events to be attended without the Provider present, to be used as incentives for youth and families to participate in behavioral health services.
  - Basic needs supplies for youth and families to engage in, or continue to be engaged in, treatment, which may include but are not limited to:
    - Hygiene Supplies;
    - Basic clothing or Cash Value Cards to purchase clothing;
    - Pre-paid cell phones for emergency/short term use;
    - Bus passes;

        - Cash Value Cards for transportation to/from youth summer services such as funds needed for gas, or taxi services like Uber/Lyft;
        - Support with childcare services, such as reasonable reimbursement of childcare services so participants can engage in summer programming; and
    - Items needed to ensure safety for youth participants such as helmets, padding, personal flotation devices.
- Examples of consumable expenses that are not appropriate use of funds within this program:
    - Rent and utility assistance for real property; and
    - Vehicle maintenance.

Expenses for Cash Value Cards must follow the following BHRD KCICN Youth Summer Program Cash Value Card Policy:

- Any use of gift cards or cash value cards must be clearly tied to service engagement, recovery, or access to care and documented accordingly. General financial assistance without linkage to behavioral health services is not an allowable use of these funds.
- Agencies who contract with BHRD must have a written internal policy governing the distribution and documentation of gift cards/cash value cards in place prior to using Youth Summer Program funds to purchase gift cards/cash value cards.
    - Agency policies must be available to BHRD upon request.
    - BHRD reserves the right to review agency policies at any time.
- Cash value cards purchased and distributed using Youth Summer Program funds must fall into one of two allowable use categories:

  Client Incentives (Behavior-Based)
    - Used to encourage engagement in behavioral health services, e.g., showing up for appointments, completing assessments, or reaching recovery milestones.
    - Allow retail-specific cards only (e.g., grocery, gas [not general Visa/Mastercard cards]). Cards for big box retailers, such as Amazon, or unrestricted cards for retailers like Wal-Mart, are not permitted.
    - Must be:
        - Tied to a specific service-related behavior
        - Documented in the client record
        - Logged and tracked by the agency
    - Providers must have written internal policy in place governing the distribution and documentation of gift cards/cash value cards for this purpose. BHRD reserves the right to review agency policies at any time.

  Supportive Resources (Barrier Reduction)
    - Used to address practical barriers that directly impact access to behavioral health services, e.g., providing a gas card to attend counseling.
    - Also limited to retail-specific cards.
    - Documented justification required (e.g., “gas card provided to facilitate transportation to IOP”)
    - Must be:
    - Tied to a specific barrier to accessing behavioral health services
    - Documented in the client record
    - Logged and tracked by the agency
    - Providers must have written internal policy in place governing the distribution and documentation of gift cards/cash value cards for this purpose. BHRD reserves the right to review agency policies at any time.
    - Cash Value Cards cannot be used for the following:
        - Alcohol, tobacco or other drugs

- General all-purpose financial aid
- General pre-paid debit cards
- Gifts with no clear link to behavioral health service access or outcomes
- Raffles

Information System Requirements

- None

Invoice Program Specific Requirements

- Method of Payment
  - Reimbursement will be made monthly on an actual cost basis for KCICN Youth Summer Program eligible expenses as outlined in the organization's KCICN Youth Summer Program application.
- Additional Requirements
  - BHRD will reimburse providers for gift cards/cash value cards after they have been distributed to a client. Agencies will use the *Cash Value Card Verification* tab of the KCICN Youth Summer Program Monthly Report to verify that a gift card/cash value card has been distributed.
  - Cash Value Cards expenses must follow the BHRD KCICN Youth Summer Program Cash Value Card Policy, including:
    - Limits: $15 per instance, $75 max per client per calendar year for Cash Value Cards that fall into the Client Incentives (Behaviors-Based) category; and
    - Limits: $50 per instance for Cash Value Cards that fall into the Supportive Resources (Barrier Reduction) category. In general, these amounts should be limited to the minimum amount necessary to help a client overcome a barrier to accessing behavioral health services.
  - The organization retains all records and supporting documentation related to the expenses incurred for the program described above.

KCICN Youth Summer Program Reporting Requirements	
BHRD Information System	None
Monthly Reports	KCICN Youth Summer Program Monthly Report
Quarterly Reports	None
Semiannual Reports	None
Annual/Other Reports	KCICN Youth Summer Program Activity Log and Narrative Report is due with the September 2026 invoice
Performance Measurement (PM) Plan	None

2.3 Mental Health Outpatient Benefit

Program Overview

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

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

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

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

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

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

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

2.3.2 Service Delivery Adherence (SDA) Calculation

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

Table 1: SDA Payment Adjustments
Quarter 4 - 2025

Service Delivery Adherence %	Payment Multiplier
0%	0%
.>0% - 4.9%	5%
05% - 9.9%	10%
10% - 14.9%	15%
15% - 19.9%	20%

20% - 24.9%	25%
25% - 29.9%	30%
30% - 34.9%	35%
35% - 39.9%	40%
40% - 44.9%	45%
45% - 49.9%	50%
50% - 54.9%	55%
55% - 59.9%	60%
60% - 64.9%	65%
65% - 69.9%	70%
70% - 74.9%	75%
75% - 79.9%	80%
80% - 84.9%	85%
85% - 89.9%	90%
90% - 94.9%	95%
95% - 99.9%	100%
100% - 104.9%	105%
105% - 109.9%	110%
110% - 114.9%	115%
115% - 119.9%	120%
120% - 124.9%	125%
125% - 129.9%	130%
130% - 134.9%	135%
135% - 139.9%	140%
140% - 144.9%	145%
145% - 149.9%	150%
150% - 154.9%	155%
155% - 159.9%	160%
160% - 164.9%	165%
165% - 169.9%	170%
170% - 174.9%	175%
175% and above	175%

Table 1: SDA Payment Adjustments 2026	
Service Delivery Adherence %	**Payment Multiplier**
0%	0%
.>0% - 4.9%	7.5%
05% - 9.9%	12.5%
10% - 14.9%	17.5%
15% - 19.9%	22.5%
20% - 24.9%	27.5%
25% - 29.9%	32.5%
30% - 34.9%	37.5%
35% - 39.9%	42.5%
40% - 44.9%	47.5%
45% - 49.9%	52.5%
50% - 54.9%	57.5%
55% - 59.9%	62.5%
60% - 64.9%	67.5%
65% - 69.9%	72.5%
70% - 74.9%	77.5%
75% - 79.9%	82.5%
80% - 84.9%	87.5%
85% - 89.9%	92.5%
90% - 94.9%	97.5%
95% - 99.9%	102.5%
100% - 104.9%	107.5%
105% - 109.9%	111.5%
110% - 114.9%	117.5%
115% - 119.9%	122.5%
120% - 124.9%	127.5%
125% - 129.9%	132.5%
130% - 134.9%	137.5%
135% - 139.9%	142.5%
140% - 144.9%	147.5%
145% - 149.9%	152.5%

150% - 154.9%	157.5%
155% - 159.9%	162.5%
160% - 164.9%	167.5%
165% - 169.9%	172.5%
170% - 174.9%	177.5%
175% and above	177.5%

Initial Calculation

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

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

Where:

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

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

Recalculation

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

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

Table 2: Example Timeframe for Recalculation Request

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

- Missing data is transmitted to the Behavioral Health and Recovery Division Information System (BHRD IS) during the quarter that the recalculated SDA is to be applied.

- A request for SDA recalculation is intended for use when there has been an unforeseen data transmission failure due to technical problems during the Look Back Period for the quarter in question that is impacting the agency's whole outpatient Medicaid population (e.g., super majority—at least 65% of encounters).

SDA Recalculation Exclusions:

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

2.3.3 Level of Care

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

- Acute Care Utilization (in last 12 months);
  - Hospitalization or Emergency Department (ED) visits
  - SUD withdrawal management
  - Involuntary Treatment Act (ITA)
  - Substance Use Disorder (SUD) residential.
- Social Determinants of Health;
  - Housing stability
  - Jail utilization
  - Jail length of stay
- Chronic Conditions; and
  - Presence of diabetes, cardiovascular disease, asthma, and/or Chronic Obstructive Pulmonary Disease (COPD)
- Clinical Assessment/LOCUS)

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

Child/Youth LOC based on PHS as follows:

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

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

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

Child/Youth: Medium	5 – 10 total points	2.5 hours
Child/Youth: High	11 + total points	7.0 hours

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

2.3.4 Mental Health Outpatient Benefit Infant-Child Expanded Assessment Services

Program Overview
Mental Health Outpatient Benefit Infant-Child Expanded Assessment Services (add-on) covers billing for additional expanded assessments for infants and children ages birth to 5 years old who are enrolled in Medicaid. Eligible agencies are contracted for a Mental Health Outpatient Scope of Work and serve children in the appropriate age range.

Program Specific Requirements
- Assessments are conducted by an MHP using the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC-05).
- Participants receive up to five sessions and 34 units of additional assessment time (over and above 6 standard assessment units).
- Agencies may bill for mileage (according to the federal rate) to provide assessment sessions in the client's home or other community location.
- Service encounters include the appropriate ICD-10 diagnosis based on the Apple Health DC-05 crosswalk.

Invoice Program Specific Requirements
Method of Payment
- Expanded assessment services will be paid monthly on a unit cost reimbursement basis for completed assessments provided to eligible individuals.
- Mileage incurred in providing expanded assessment services will be paid monthly on a unit cost reimbursement basis.

Additional Requirements
- None

MH Outpatient Benefit Eligibility Criteria	
Medicaid Status	Yes, limited non-Medicaid funding is available for priority populations as described in the BH-ASO policy and procedures
Age Range	Full Life Span
Authorization Needed	No
Additional Criteria	Additional Criteria only necessary when utilizing non-Medicaid funding for benefit
MH Outpatient Benefit Reporting Requirements	
BHRD Information System	Submit Data to the BHRD Information System as outlined in the BHRD Data Dictionary and the Required Transactions Sheet in the ISAC Notebook
Monthly Reports	None

Quarterly Reports	None
Semiannual Reports	None
Annual/Other Reports	None
Performance Measurement (PM) Plan	None

2.4 Least Restrictive Orders

Services for a client on a "less restrictive" court order
Providers are expected to provide, or monitor the provision of, court-ordered services, for both Medicaid-covered and non-Medicaid-covered clients assigned to their agency who are on a Less Restrictive court order (LRO). Providers may refuse to accept the LRO on origination of the LRO if the Provider agency and the court have mutually agreed that the Provider agency is not appropriate to be assigned the LRO. Once a Provider has agreed to provide, or monitor the provision of, court-ordered services for a client, it is the responsibility of the Provider to carry on with the obligations the Provider agreed to for the duration of the court order. If the client needs to transfer care during the duration of the LRO, the Provider agency is required to contact the court to request an amended LRO. The Provider agency is still expected to continue care for the client until the amended LRO goes into effect.
Services are provided according to the requirements in WAC 246-341-0805 or its successor.

NOTE: The following programs offer LRO services:

- Adult Outpatient Medicaid and Adult Outpatient MIDD
- Program for Assertive Community Treatment, PACT
- New Journeys - First Episode Psychosis
- Intensive and Standard Supportive Housing
- Residential Services – Long Term Rehabilitation, LTR
- WSH Intensive Community Support Program
- Expanding Community Services Intensive Community Support and Recovery Program
- Homeless Outreach Stabilization and Transition Project - Intensive Case Management, HOST
- SUD Outpatient Medicaid and MIDD

2.5 Substance Use Disorder Outpatient Benefit

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

- Alcohol/Drug Screening and Assessment;
- Individual rehabilitative counseling;
- Group counseling;
- Laboratory services (drug and alcohol screens); and
- Case Management services.
- Peer Support services

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

- Assessment;
- ISP reviews; and
- Discharge.

A Provider must be licensed as a Least Restrictive Alternative (LRA) Provider in order to monitor a client on a LRA per WAC 246-341-0805 or its successor.
SUD Outpatient Benefits are based on level of functioning, degree of psychiatric impairment, expected service intensity, and expected outcomes and benefit period. Benefit levels are as follows:

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

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

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

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

Invoice Program Specific Requirements

Method of Payment

- Reimbursement will be made for up to six drug screens or urinalysis samples (UA) per client, per month. UAs that are not medically necessary are not reimbursable
- **THS, ACRS, Consejo, Cowlitz only:** Reimbursement will be made in monthly 1/12 amounts to provide drug court enhancement services to adults involved with the King County Adult Diversion Court. UA –only clients are not eligible.
- Transportation
  1. Costs will be reimbursed for transportation for clients referred to residential treatment;
  2. Reimbursement will be made based on the actual cost of the transportation service provided;
  3. Whenever possible, Medicaid-funded transportation should be utilized; and
  4. Receipts and payment documents related to transportation costs must be submitted along with the invoice.

Additional Requirements

- None.

SUD Outpatient Benefit Eligibility Criteria	
Medicaid Status	Yes, limited non-Medicaid funding is available for priority populations as described in the BH-AS0 policy and procedures with BHRD approval
Age Range	Full Life Span
Authorization Needed	No
Additional Criteria	Additional Criteria only necessary when seeking non-Medicaid funding for benefit
SUD Outpatient Benefit Reporting Requirements	
BHRD Information System	Submit Data to the BHRD Information System as outlined in the BHRD Data Dictionary and the Required Transactions Sheet in the ISAC Notebook
Monthly Reports	None
Quarterly Reports	None
Semiannual Reports	None
Annual/Other Reports	None
Performance Measurement (PM) Plan	None

2.5.1 Brief Intervention for Substance Use

Overview

Brief Intervention is listed in the Service Encounter Reporting Instructions (SERI) substance use (SU) outpatient fee schedule (CPT code H0050 Alcohol/Drug Services). The modality is defined as:
A time limited, structured behavioral intervention designed to address risk factors that appear to be related to substance use disorders, using substance use disorder screening tools and brief intervention techniques, such as evidence-based motivational interviewing and referral to additional treatment services options when indicated.

This service may be provided prior to an intake evaluation or assessment. Services may be delivered at, but not limited to, sites exterior to treatment facilities such as hospitals, medical clinics, schools, or other non-traditional settings (Washington State Health Care Authority Service Encounter Reporting Instructions). Brief Interventions may be delivered via telehealth per the Washington State Health Care Authority Provider Billing Guide and Fee Schedule.

Some clinical examples of situations when a provider may choose to use the Brief Intervention for SU service include, but are not limited to:

- Screening and brief intervention is clinically indicated or preferred by the individual rather than an assessment.
- The individual would like to talk about their substance use without or before enrolling in a SUD treatment program.
- A student has drugs or alcohol at school, and may benefit from screening, brief intervention, and referral to services.
- Staff from opioid treatment programs visit encampments and talk with individuals about treatment options.
- After an assessment-only service where the individual chooses not to enroll.

- Individuals in Mental Health Residential who are not yet ready for SUD treatment and might benefit from a brief intervention.

Brief Intervention for Substance Use Eligibility Criteria	
Medicaid Status	Yes, Medicaid is required.
Age Range	Youth and adults age 13 and up.
Target Population	No
Authorization Needed	No
Authorization Criteria	Use the appropriate diagnosis code to designate treatment is for an SUD. Use a diagnosis code falling in this ICD-10 range F10 - F19.99; or When the specific diagnosis cannot be made or is unknown: Z7141 for alcohol abuse; and Z7151 for drug abuse.
Other Criteria	This modality may be provided prior to an assessment. Could include the use of screening tools such as AUDIT, DAST, ASSIST, etc.

Goals & Objectives

- To increase access to evidence-based and person-centered substance use care from qualified practitioners prior to assessment.

Program Requirements

- Please see SERI: Medicaid allowable services; Substance use service modalities; Brief Intervention.

Information System Requirements

- The program code to be used for submitting authorization requests is 531.
- Required transactions are listed below. Please refer to the Required Transaction Spreadsheet in the ISAC Notebook for more details.
  - Authorization Request
  - Client Demographics
  - CPT Service Detail (HIPAA 837P)
  - Medicaid Coverage
  - Staff Person (NPI)
  - Staff Qualifications
  - Substance Use
  - SUD Release of Information
- This program will have a pre-set same day expiration date. Notice of Exit is not required.

Invoice Program Specific Requirements

- Method of Payment:
  - Reimbursement will be made monthly on an actual cost basis for brief intervention SU services.
  - Reimbursement will be made per 15 minute units according to the King County SUD Fee for Service Rate Schedule.
- Additional Requirements (if applicable): None

Brief Intervention for Substance Use Reporting Requirements	
BHRD Information System	Submit Data to the BHRD Information System as outlined in the Program Instructions in the Information Systems Advisory Committee (ISAC) Notebook.
Monthly Reports	None
Quarterly Reports	None
Semiannual Reports	None
Annual/Other Reports	None
Performance Measurement (PM) Plan	None

2.6 Assisted Outpatient Services Program (AOSP)

Program Overview

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

Since AOSP is a court-ordered treatment, LROs should be determined in conjunction with the treatment team at the Provider Agency, and treatment plans and services must align with the LRO, and any subsequent modifications required by court.
Treatment is individualized and client centered and includes the services defined in WAC 246-341- 0805 or its successor.

Invoice Program Specific Requirements

Method of Payment

- Monthly reimbursement will be paid retrospectively for clients enrolled in AOSP who meet the encounter requirement based on duration of enrollment as indicated below:
  - Full enhancement case rate – for each client enrolled in AOSP prior to the 15th day of the month.
  - Half of the enhancement case rate – for each client enrolled in AOSP after the 15th day of the month.
  - Full enhancement case rate – for each client exited from AOSP after the 15th day of the month.
  - Half of the enhancement case rate – for each client exited from AOSP prior to the 15th day of the month.
- If client(s) lose Medicaid status, the enhanced rate will be suspended until Medicaid is reinstated. Reimbursement will be made retroactively if Medicaid is reinstated retroactively.

Additional Requirements

- For programs during initial implementation of AOSP, reimbursement of the full enhanced case rate amount will be made for each client enrolled in AOSP if the encounter requirement is met as noted below:

Month of Program Implementation	Encounters Required to Receive the Full Enhanced Case Rate Per Client

1	0
2	6
3	9
4	12

AOSP Eligibility Criteria	
Medicaid Status	Yes, with limited capacity to serve those who are non-Medicaid
Age Range	18 years or older
Authorization Needed	Yes
Additional Criteria	• Already enrolled in KCICN services; • Conditionally released from the hospital and who have been issued a less restrictive alternative (LRO) order for treatment; • Referred by King County AOT Coordinator; and • Not enrolled in an intensive community support or residential program including but not limited to Program for Assertive Community Treatment (PACT), Standard Supportive Housing (SSH), Long Term Rehabilitative Services (LTR), and Supervised Living (SL).
AOSP Reporting Requirements	
Monthly Reports	AOSP Provider Tracking Form
Quarterly Reports	None
Semiannual Reports	None
Annual/Other Reports	None
Performance Measurement (PM) Plan	None

2.7 Assisted Outpatient Treatment (AOT) and Behavioral Health Treatment

Program Overview

Assisted Outpatient Treatment (AOT) Behavioral Health Treatment, part of the Involuntary Treatment Act (ITA), is designed to help people who are unable to voluntarily receive the treatment they need to live and thrive safely in the community. This state-wide, evidence-based program is court-ordered outpatient behavioral health treatment for individuals who cannot successfully engage in voluntary outpatient services as part of their behavioral health conditions and have recently been in behavioral health crisis within the last 36 months resulting in hospitalizations or incarcerations. AOT provides robust, wrap-around treatment services in conjunction with a therapeutic court model.

Court orders are customizable, up to 18 months, and can be petitioned by a variety of professional per RCW 71.05.148. AOT services are individualized to support the program participant and care team, and may include engagement, intake, assessments, and ongoing behavioral health treatment.

AOT services are available for all qualifying individuals in Washington State. Terms for AOT court orders, population, and petitioning providers are set in RCW 71.05.148

Program Specific Requirements
While AOT orders are involuntary, the corresponding AOT services center the Recovery principles with a focus on individual voice and choice. AOT orders are intended to offer increased outpatient services and wraparound support at the least restrictive level of care, shortening or reducing hospitalization and incarceration. The purpose of AOT services is to help those that the system has not worked for and knock down barriers and creating pathways to Recovery for those who have yet to find it.

Services
- Wraparound services to individuals being evaluated or on AOT court orders, pursuant to RCW 71.0585. All services are needs blind and service intensity is based on clinical need, not a specific number of contacts.
- Supportive services such as housing search and applications (as available) and limited material support, including cell phone access. Participate in ITA Court and AOT Court as a primary member of a team that includes the Judge and/or Commissioner, the individual's legal counsel, a Prosecutor, the King County BH-ASO BHRD AOT team, and any member of the Court team who is needed, with timely response.
- The provider will be present in ITA court and AOT court as a partner in providing services to individuals.
- Present (in person or virtual- depending on the requirement of the Court) in ITA and AOT court for all stages of the AOT process from petition through the end of the court order. The AOT orders involve regular check-ins with individuals on AOT orders with the AOT court team. The AOT treatment team is actively engaged as a member of the team using a Trauma-Informed and client centered approach.
- Work in concert and participate in collaboration meetings with many diverse stakeholders including King County BHRD AOT team members, KCSC, King County Prosecuting Attorney's Office (PAO), defense agencies representing individuals, Designated Crisis Responders (DCRs), other outpatient agencies, families and loved ones of individuals in need of AOT, first responders, natural supports, and other relevant groups.
- Provide timely and accurate documentation to the Court including but not limited to petitions, revocation documentation, updates as requested by the court, and documentation placed in the court record.
- Outreach individuals in the community for engagement, evaluation and crisis services. Individuals may be in either AOT phase.
    - Engagement phase- Engagement and evaluation of individuals who may qualify for AOT services, based on criteria in 71.05.148, who are not currently on an AOT order.
    - Enrollment phase- Individuals who have been placed on an AOT order and will be in treatment for the length of their order.
- Provide timely access to psychiatric providers and medication management.
- Communicate directly with the AOT Monitor and/or the AOT Coordinator at BHRD. The AOT Monitor will be closely tracking the care of individuals on AOT orders and will be the primary point of contact. Providers will accept referrals to the AOT program, screened by the AOT Monitor and Coordinator. Provide ongoing updates and data regarding individuals on AOT orders to BHRD staff.

- Ensure work is aligned with RCW 71.05, HCA guidelines, Washington State Department of Health (DOH) guidelines, all applicable Washington Administrative Code (WACs), and "User Guide for the Petition for Assisted Outpatient Treatment" published by the Administrative Office of the Courts.

Additional Information
Engrossed House Bill (HB) 1773 clarifies the process for petitions for AOT. HB 5540 also creates one pathway for referrals to AOT from the criminal legal system through the forensic navigators.

Service Coding
- Engagement code - Engagement and evaluation of individuals who may qualify for AOT services who are not currently on an AOT order.
- Enrollment code - Individuals who have been placed on an AOT order and will be in treatment for the length of their order.
- Submit all service encounters to the King County Information System, using SERI codes.

Invoice Program Specific Requirements
Method of Payment
- Reimbursement will be made monthly on 1/9th payment amount for ongoing services.
- Reimbursement will be made monthly on an actual cost basis for start-up costs. An itemized expenditure list is required.

Additional Requirements
On-going costs include all items listed in approved grant funded budget with BHRD. Start-up costs may include but are not limited to:
- Client discretionary funds
- Incentives for engagement, direct items, gift cards
- Phones and minutes
- Staff transportation
- Vehicle for client outreach
- Insurance and maintenance
- Gas cards
- Program set up
- Recruitment, credentialling, or training
- Set-up costs for computer equipment, IT
- Administrative costs to set up program.
- Other
- Funding for temporary, set-aside shelter/respite/motel lodging
- Office space rental

Assisted Outpatient Treatment Behavioral Health Treatment Eligibility Criteria	
Medicaid Status	No
Age Range	Over 18 years old
Authorization Needed	Yes

Additional Criteria	All eligibility is determined by criteria in 71.05.148, including:
	• behavioral health disorder
	• not able to participate in voluntary behavioral health treatment, as based on treatment history, and
	• is found to either:
	  ○ not "survive safely in community without supervision"; or
	  ○ in need of treatment to prevent a relapse or deterioration that would likely result in grave disability; or
	  ○ has a history of lack of compliance with treatment resulting in prior hospitalization, or incarceration in the last 36 months; or has a history of violent acts or threats in the last 48 months.

Assisted Outpatient Treatment Behavioral Health Treatment Reporting Requirements	
Monthly Reports	None
Quarterly Reports	AOT Behavioral Health Treatment Narrative Summary
Semiannual Reports	None
Annual/Other Reports	None
Performance Measurement (PM) Plan	None

2.8 Clubhouse Services (Day Support)

Program Overview

Individuals enrolled in Behavioral Health and Recovery Division (BHRD) programs are eligible for Clubhouse services. Clubhouse services are available to eligible adults who are interested in participating in the Clubhouse as a way to pursue work. The Clubhouse is a community intentionally organized to support individuals living with the effects of mental illness and certified by the International Center for Clubhouse Development (ICCD). Through participation in a Clubhouse, members are given the opportunities to rejoin the worlds of friendships, family, important work, employment, education, and to access the services and supports they may individually need. A Clubhouse is a restorative environment for people who have had their lives drastically disrupted and need the support of others who believe that recovery from mental illness is possible for all.

The Provider operates the Clubhouse according to the ICCD Clubhouse Standards and meets state certification requirements per Washington Administrative Code (WAC) 246-341-0730 through 246-341-0736 or its successors. During hours of operation, the Clubhouse is available on a drop-in basis to provide a work-ordered day, TE services, supported employment services, independent employment services, supports, and help to any member. The Provider coordinates services with the Outpatient Benefit holder as needed to ensure effective and efficient service provision. The Provider sends a monthly progress note to the Outpatient Benefit holder, containing a summary of consumer activities at the Clubhouse and that records their days of attendance. Individuals receiving Medicaid are also eligible to receive Day Support Services within the Clubhouse. These services must adhere to all relevant and appropriate Medicaid requirements. Day Support Services are described in the Medicaid State Plan.

Invoice Program Specific Requirements

Method of Payment

- Reimbursement will be paid retrospectively each month for eligible individuals for attendance days and hours reported on the Clubhouse Services census log.

Additional Requirements

- Non-compliance with the MIDD evaluation data requirements may result in withholding of payment for all associated contracted services.

Clubhouse Services (Hero House NW) Eligibility Criteria	
Medicaid Status	No, for Clubhouse Services; yes, for Day Support Services.
Age Range	18 and older
Authorization Needed	No
Additional Criteria	Participants must be receiving outpatient and/or residential services. Clients may self-refer, but reimbursement is if services are within the context of ongoing collaboration with the outpatient and/or residential treatment Provider. Clubhouse services must be deemed medically necessary as evidenced by assessment and diagnosis conducted by the outpatient and/or residential treatment Provider. For Day Support Services, it is not required that a client is receiving outpatient and/or residential services. Day Support Services must be deemed medically necessary as evidenced by assessment and diagnosis conducted by the Clubhouse.
Clubhouse Services (Hero House NW) Reporting Requirements	
Monthly Reports	Clubhouse Census Log
Quarterly Reports	None
Semiannual Reports	None
Annual/Other Reports	None
Performance Measurement (PM) Plan	None

2.9 New Journeys Coordinated Specialty Care (formerly New Journeys)

Program Overview

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

King County NJ CSC Services are delivered by three contracted mental health providers who work collaboratively, have multi-disciplinary teams and provide treatment, rehabilitation, and supports to assist individuals to achieve their goals. The service array is provided on an outpatient basis with options for home and community settings, based on each individual's needs and what they identify as helping them achieve a more meaningful life. The service components include individual and/or group psychotherapy, family psychoeducation and support, medication management, supported employment and education, case management and peer support.

A full fidelity NJ CSC Team:

- serves up to 30 individuals ages 15-40 years old, allows for up to a 5-year lifetime benefit limit per program participant.
- engages in ongoing NJ training with University of Washington (UW) and Washington State University (WSU),
- has an HCA approved New Journeys Attestation Form, and
- actively participates in the NJ fidelity review process.
- Response to program inquiries/referrals require prompt response by the Program Director (usually within 72 hours).
- Teams should continue to increase their caseloads by 4-5 per month, develop internal processes, and ensure they meet training requirements.

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

Trainings and Meetings

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

Direct Services

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

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

- Program Director - 0.5 full-time equivalent (FTE) often combined with the Family Educator role;
- Prescriber - 0.25 FTE;
- Individual Resiliency Trainer (IRT) - 1.0 FTE;
- Family Education Clinician - 0.5 FTE;

- Supported Employment and Education Specialist (SEE) - 1.0 FTE;
- Case Management - 0.5 FTE; and
- Peer Support Specialist - 0.5 FTE

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

Invoice Program Specific Requirements

Method of Payment

- Reimbursement will be made monthly based on unit costs for participants in services between 1 to 6 months (T2022).
- Reimbursement will be made monthly based on unit costs for participants in services between 7 to 24 months (T2023).
- Reimbursement will be made monthly based on encounters for participants in services (H2041) that don't meet the threshold for T2022 and T2023.
- Reimbursement for T2022, T2023, and H2041 will be made in monthly 1/12 payments for New Journeys FEP State Non-Medicaid funding.
- Reimbursement will be made through the case rate from encounters and case rates noted on the invoice for Medicaid clients.
- Reimbursement will be made in monthly 1/12th amounts for non-Medicaid encounters.
- Reimbursement will be made in monthly 1/12 amounts for MCO non-Medicaid wraparound funds.

Additional Requirements

- A full program will not exceed a total of 30 clients (Medicaid 28 slots and non-Medicaid 2 slots)
- T2022: 1-6 months (8 or more encounters per month)
- T2023: 7-24 months (6 or more encounters per month)
- H2041: over 24 months (up to 5 encounters) or 1-24 months under the above thresholds for T2022 and T2023

New Journeys Coordinated Specialty Care Project Eligibility Criteria	
Medicaid Status	*Medicaid and meet A in the Additional Criteria Section described below *Up to two non-Medicaid individuals per site who meet the Additional Criteria Section described below
Age Range	15 to 40 years old
Authorization Needed	Yes, up to 5 years of service (average 24 months)

Additional Criteria	• Psychotic symptoms have been present between 1 week and 3 years. • Diagnosis of schizophrenia, schizoaffective disorder, schizophreniform disorder, brief psychotic disorder, delusional disorder, major depression with psychotic features, bipolar disorder with psychotic features, or other specified psychotic disorder and • Reside in King County. • Psychosis is not known to be caused by one of the following: Pervasive developmental disorder and/or autism spectrum disorder, the temporary effects of substance use or withdrawal, or another medical condition including medication-induced psychotic disorder. • Potential New Journeys participant entry is co-managed by BHRD and the Providers offering this specialized treatment team approach. • Potential program participants will be prioritized in the following order: ○Enrolled with a Medicaid or non-Medicaid outpatient BH benefit, ○Medicaid-eligible but not currently enrolled in a BHRD outpatient benefit, ○Non-insured individuals, ○Low-income individuals, or ○Privately insured
New Journeys Coordinated Specialty Care Reporting Requirements	
Monthly Reports	• Monthly invoices that accurately identify if program participants are in Tier 1 or Tier 2 of the case rate model and whether their program payment coverage is Medicaid or non-Medicaid. • Each New Journeys site is expected to keep the two non-Medicaid slots full and to notify BHRD's Children's Mental Health Planner if either is vacant and the plan to fill it.
Quarterly Reports	None
Semiannual Reports	None
Annual/Other Reports	None
Performance Measurement (PM) Plan	None

2.10 Occupational Therapy

Program Overview

Occupational Therapy (OT) is a Mental Health Outpatient program that covers a range of occupational therapy services, including assessment, analysis and therapeutic activities with program participants. Occupational therapists and occupational therapy assistants perform comprehensive person-centered evaluations to determine needs and offer a wide range of supports. OT staff use a recovery model to help individuals engage with daily activities that are person-centered and meaningful to their recovery. OT staff may work with participants on daily habits, routines, and progress towards independent living (i.e. community/work reintegration training or promotion of functional participation in independent activities of daily living such as navigation of public transit or a grocery store.)

Occupational Therapy Eligibility Criteria	
Medicaid Status	Yes
Age Range	21+
Target Population	None
Authorization Needed	No for initial evaluation and 24 units (per calendar year); Yes, for additional 24 units (per calendar year)
Authorization Criteria	Meets assessment criteria performed for OT
Other Criteria	None

Goals & Objectives
TBD.

Program Requirements
- Providers are licensed Occupational Therapists and Occupational Therapy Assistants.
- Occupational Therapy Evaluation: One per client, per calendar year
- Occupational Therapy Reevaluation at time of discharge: One per client, per calendar year
- Occupational Therapy: 24 Units (approximately 6 hours), per client, per calendar year
- Up to 24 additional units (approximately 6 hours), when medically necessary, per client, per calendar year.
- Client record contains evidence of medical necessity for the services and a care plan.
- Utilization management process TBD.

Information System Requirements
- Agencies submit service encounters with Current Procedural Terminology (CPT) OT codes per SERI.
- These services will be paid for through the fee for service process (FFS) using Health Care Authority (HCA) billers guide. Refer to Information Sharing and Analysis Center (ISAC) notebook for additional information.

Invoice Program Specific Requirements
Method of Payment
- Reimbursement will be made monthly based on encounter data in the King County Information System.

Additional Requirements
- TBD.

Occupational Therapy Reporting Requirements	
BHRD Information System	Submit Data to the BHRD Information System as outlined in the BHRD Data Dictionary and the Required Transactions Sheet in the ISAC Notebook
Monthly Reports	TBD
Quarterly Reports	TBD
Semiannual Reports	TBD
Annual/Other Reports	TBD

Performance Measurement (PM) Plan	None

2.11 Opioid Treatment Program

Program Overview

Opioid Treatment Program (OTP) is offered seven days a week to provide a continuum of treatment and recovery support services. OTP 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.

Contracting agencies secure and maintain licensure with pertinent regulations including Washington Administrative Code (WAC) 247-341 and/or its successors; the Food and Drug Administration—21 Code of Federal Regulations (CFR) 291.505 and/or its successors; and the Drug Enforcement Administration –21 CFR 1301, 1304, 1305, and 1306 and/or its successors; as such regulations now exist or are hereafter amended. A Provider must be licensed as a Least Restrictive Alternative (LRA) Provider in order to monitor a client on a LRA per WAC 246-341-0805 or its successor.

OTP services include:

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

OTP Benefit Characteristics

- OTP services are authorized for an open-ended benefit period.
- 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.
- During the benefit, the full array of OTP outpatient services is available to the client, according to need and mutually negotiated goals of treatment.

Availability of OTP Services

- Intake Appointment and initiation of services complies with Managed Care CFR's and WAC 246-341-0610 or its successors.
- 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 interim services is kept by Public Health – Seattle & King County (PHSKC) Needle Exchange. The Needle Exchange provides case management, overdose prevention, and admission support services while the client is on the waitlist.

- 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.

OTP Eligibility Criteria	
Medicaid Status	• Yes, client must have coverage with one of the 5 MCO'S (CHPW, UHC, Molina, CCW, Amerigroup). • If Medicaid client resides outside of King County, provider should bill the MCO directly and not King County when agency has a contract or billing relationship with the MCO. • There is limited capacity to serve people who are non-Medicaid. • Non-Medicaid clients must meet income criteria (220% of federal poverty line).
Age Range	18 years and older
Authorization Needed	Yes
Additional Criteria	• Adults who meet Diagnostic and Statistical Manual of Mental Disorder, Fifth Edition (DSM-5) criteria for a moderate to severe Opiate Use Disorder; • In need of OTP services as determined by an assessment instrument that incorporates the American Society of Addiction Medicine (ASAM) Criteria • The individual's needs cannot be more appropriately met by any other formal or informal system of support; and • Individuals receive priority services as described in this Manual.
OTP Reporting Requirements	
BHRD Information System	Submit Data to the BHRD Information System as outlined in the BHRD Data Dictionary and the Required Transactions Sheet in the ISAC Notebook
Monthly Reports	None
Quarterly Reports	None
Semiannual Reports	None
Annual/Other Reports	None

The Provider maintains policies and procedures for courtesy dosing for Medicaid individuals.
When OTP services are determined to be appropriate, but not immediately available, individuals receive Interim Services via the King County Needle Exchange.
Interim Services: A centralized waiting list for the BHRD MAT services is kept by the Public Health – Seattle & King County (PHSKC) Needle Exchange. The Needle Exchange provides case management, overdose prevention, and admission support services while the client is on the waitlist.
Pregnant women are provided with comprehensive assessment services within 48 hours of referral and treatment services no later than seven days after the assessment has been completed. Waiting List Interim Services must commence upon request for services when comprehensive services are not immediately available.

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

OTP Vans

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

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

Invoice Program Specific Requirements

Method of Payment

- Transportation:
  - Costs will be reimbursed for transportation for clients referred to residential treatment;
  - Reimbursement will be made based on the actual cost of the transportation service provided.
  - Whenever possible, Medicaid-funded transportation should be utilized; and
  - Receipts and payment documents related to transportation costs must be submitted along with the invoice.

ETS Only

- Reimbursement will be made on flat monthly rate for mobile medical van dosing operations (maximum 2 vans).

THS Only

- Reimbursement for Urinalysis Only-CJTA is made monthly on a unit reimbursement basis.

Additional Requirements

THS Only

- Reimbursement for UA Only-CJTA is for King County Adult Drug Diversion Court individuals not enrolled in SUD or OTP outpatient treatment.

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

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

MOUD Dosing in a Residential Setting Reporting Requirements	
Monthly Reports	SUD Census Report and MAT Log
Quarterly Reports	None
Semiannual Reports	None
Annual/Other Reports	None
Performance Measurement (PM) Plan	None

2.12 Program Gambling

Program Overview

Problem Gambling programs serve individuals and their families who are experiencing a spectrum of impacts—mental, financial and relational—resulting from gambling addictions. Treatment ranges from intake and assessment, to education, prevention, intervention and outpatient services. Intake, assessment and therapy are provided by licensed/certified clinicians who are trained in evidence-based practices designed to address Problem Gambling.

Program Requirements

Provider complies with requirements outlined in: WAC 246-341-1200, "Problem Gambling and Gambling Disorder Services—Certification Standards," HCA Service Encounter Reporting Instructions (SERI) and HCA guidelines.

Assessments

- Assessments and treatment are completed by a licensed/certified practitioner who:
  - holds a Gambling Counselor certification; or
  - is under the supervision of a Certified Gambling Counselor Supervisor
- Assessments are comprehensive, including:
  - review of current intoxication and withdrawal potential
  - biomedical, emotional, behavioral, and cognitive complications
  - readiness to change.
  - relapse potential.
  - recovery environment
- A new assessment is not required if an assessment was complete and medical necessity established within the previous 12 months.

Services Included

- diagnostic screening and assessment
- individual and group counseling
- couples and family therapy
- case management

Problem Gambling Eligibility Criteria	
Medicaid Status	Yes, Medicaid only
Age Range	18+
Authorization Needed	No
Additional Criteria	None
Problem Gambling Reporting Requirements	
Monthly Reports	TBD
Quarterly Reports	None
Semiannual Reports	None
Annual/Other Reports	Standard KCICN reporting requirements
Performance Measurement (PM) Plan	None

2.13 Program for Assertive Community Treatment (PACT)

Program Overview

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

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

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

MIDD Housing Supports (DESC, IKRON, Navos only; MIDD Initiative SI-03)

Purpose MIDD PACT Housing Supports are intended to facilitate access to affordable and supportive housing by Program for Assertive Community Treatment (PACT) teams for individuals who are **experiencing homelessness** or discharging from an **institutional setting** (jail, hospital, WSH) and would otherwise discharge into homelessness. Once housed, teams provide support services to assist PACT participants in maintaining housing and increasing independent living/tenancy skills.

Additional Information

For the MIDD PACT Housing Supports, each PACT provider will support at least two staff focused on housing support services, with positions and duties tailored to the unique needs of each provider agency. Any deviation from the position descriptions below must be agreed upon by the agency and the King County PACT Program Manager.

- DESC PACT employs two case managers on the PACT team, which are not required by state PACT staffing standards. Positions include a full-time Housing Access Case Manager and a full-time Housing Retention Case Manager.
- IKRON employs two staff on the PACT team to support housing access and retention. Positions include a full-time Housing Case Manager and a Housing Occupational Therapist.
- Navos PACT employs two staff to support housing safety in Navos-operated housing units and promote housing retention for all participants. Positions include a full-time Life Skills Coach on the PACT team, and staff to ensure PACT participant/tenant safety in Navos-operated housing units.

Expected Outcomes

- *Primary Outcomes*
  - Increased number of PACT participants with stable housing
  - Decreased psychiatric hospital admissions/days for PACT participants in MIDD-funded housing
- *Additional outcomes*
  - Improved individual wellbeing and quality of life, including decreased symptoms
  - Decreased crisis utilization
  - Consistent enrollment rates for PACT teams to achieve and maintain full census (80-100 participants)
  - Decreased time from referral to enrollment of PACT participants, particularly for those exiting long term hospitalization

HARPS Housing Bridge Subsidy Funds for PACT Consumers

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

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

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

HARPS Housing Bridge Subsidies are estimated at $3,000 per person but can be adjusted as needed to meet Fair Market Rental Housing rates as long as the total is within the contracted amount.
A PACT participant is eligible for HARPS Housing Bridge Subsidy if they meet the following eligibility criteria:

- The individual is a King County PACT participant with an open authorization for either PACT Engagement or PACT Enrollment; and
- Is 18 years of age or older; and
- Is experiencing a serious mental illness, SUD, or co-occurring serious mental illness and SUD; and
- Is homeless or at risk of homelessness with a broad definition of homeless (couch surfing included) and/or is being released from or at risk of entering an inpatient behavioral healthcare setting.

Allowable expenses for HARPS Housing Bridge Subsidy include:

- Monthly rent and utilities, and any combination of first and last months' rent for up to three months. Rent may only be paid one month at a time, although rental arrears, pro-rated rent, and last month's may be included with the first month's payment.
- Rental and/or utility arrears for up to three months if the payment enables the household to remain in the housing unit for which the arrears are being paid or move to another unit. The HARPS Housing Bridge Subsidy may be used to bring the program participant out of default for the debt and the PACT Provider will assist the participant to make payment arrangements to pay off the remaining balances.
- Security deposits and utility deposits for a household moving into a new unit;

- 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.
- Temporary absences. If a household must be temporarily away from unit, but is expected to return (e.g., client violates conditions of their Department of Corrections (DOC) supervision and is placed in confinement for 30 days or re-hospitalized), HARPS Housing Bridge Subsidy may pay for the household's rent for up to 60 days.
- Rental payments to Oxford House or other Recovery Residences. Information regarding Recovery Residences located on the Recovery Residence Registry located here: Workbook: Residence/Oxford House Locations (wa.gov) is provided to HARPS Housing Bridge Subsidy participants. HARPS Housing Bridge Subsidy can pay for rental payments at Recovery Residences that are not listed on the registry, but it should be documented in the client record why the HARPS participant was not a good match for the Recovery Residences listed on the registry.

If the individual is enrolled in Foundational Community Supports (FCS) Supportive Housing, there cannot be duplication between HARPS Housing Bridge Subsidy and Transitional Assistance Program (TAP) costs.

Invoice Program Specific Requirements

Method of Payment

All Providers

- Base Rate fee-for-service reimbursement will be made monthly for minimum standard capacity (80 participants); or
- Lower Base Rate fee-for-service reimbursement will be made monthly for less than minimum standard capacity (79 participants or fewer).
- For participants over minimum standard capacity (80), reimbursement is made monthly based on number of units for each additional participant over 80.
- Reimbursement will be made monthly based on actual costs for HARPS Short Term Bridge Subsidy costs for HARPS eligible individuals. An administrative fee of 5% can be included in actual costs for reimbursement.

Telecare ONLY

- Reimbursement will be made monthly based on actual expenditures allowable within the SAMHSA Grant agreement for SAMHSA-PACT (CDFA 93.243) funds.

DESC, IKRON, Navos ONLY

- Reimbursement will be made in monthly 1/12th amounts for MIDD PACT Housing Supports, with quarterly reconciliation of actual, documented costs.

Additional Requirements

- The agency retains all records and supporting documentation related to expenses incurred for HARPS and may be required to provide these upon request.

- HARPS eligibility criteria, funding priorities, and allowable short term bridge subsidy costs are outlined in the BHRD Provider Manual.
- Invoices must be submitted by the 10th of the month following the reporting period. Final invoices for the biennium may be due sooner.

PACT Eligibility Criteria	
Medicaid Status	Yes, limited funding is available for Medicare only and unfunded individuals
Age Range	Adults Aged 18 Years and Older
Authorization Needed	Yes
Additional Criteria	Refer to Washington State PACT Program Standards Section III.A. Admission Criteria
PACT Reporting Requirements	
Monthly Reports	PACT Monthly Report HARPS Participant Log-due the 10th of the month following the reporting period
Quarterly Reports	General Ledger (GL) for reconciliation MIDD PACT Housing Supports
Semiannual Reports	PACT Transition Scale
Annual/Other Reports	None
Performance Measurement (PM) Plan	Reporting requirements and performance measures are further detailed in an accompanying Performance Measurement plan. See "Performance Measurement (PM) Plans" section on the Provider Manual and specific program PM Plan for more information

3 Inpatient Psychiatric Services

3.1 Behavioral Health Partial Hospitalization Program (PHP)

Program Overview

Behavioral Health Partial Hospitalization Program (PHP) is a multi-disciplinary program that provides therapeutic services for individuals in need of a higher level of service than a standard outpatient benefit, but who no longer require inpatient hospitalization. Services are based on an individualized treatment plan and may include various therapeutic modalities, such as DBT and CBT. Programming is typically 15-20 hours/week, with flexibility to meet the recommendations of the individual treatment plan. The goal of PHP is to stabilize the individual within the community, without requiring inpatient hospitalization.

Additional services may include:

- Medication monitoring
- Nutritional support
- Medication management
- Family counseling
- Group counseling.
- Treatment via telemedicine
- Peer Support

Program Specific Requirements

- Intake is required prior to treatment.
- Notify King County Provider Relations/Contract Specialist of substantial changes to program and/or staffing.

Invoice Program Specific Requirements

Method of Payment

- Reimbursement will be made monthly based on dates of service reported on the census log (as applicable: for KCICN approved authorizations).
- Reimbursement will be made as follows: Number of days of service x per diem rate = reimbursement.
- Reimbursement will be made as follows:
- Number of bed days (actual occupancy) x daily bed rate = reimbursement.
- Discharge dates for the Partial Hospitalization Program (PHP) are eligible for reimbursement ***if a service is provided on the discharge day.***

  Additional Requirements
- None

Behavioral Health Partial Hospitalization (PHP) Eligibility Criteria	
Medicaid Status	Yes
Age Range	Youth under 21 who qualify for Early and Periodic Screening, Diagnostic and Treatment (EPSDT); Minor under 18; Adolescent under 13 or if Provider requests child benefit
Authorization Needed	Yes
Additional Criteria	Individuals enrolled in the following may not concurrently enroll in IOP: WISe, WA-PACT, New Journeys, High Intensity Treatment, Intensive Residential Treatment, MH Services provided in a Residential Setting.
Behavioral Health Partial Hospitalization (PHP) Eligibility Criteria	
Monthly Reports	Non-standard rates: Behavioral Health PHP Census Report
Quarterly Reports	None

Semiannual Reports	None
Annual/Other Reports	None
Performance Measurement (PM) Plan	None

3.2 Sixteen Bed Evaluation and Treatment Facility Services

Program Overview

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

All individuals are eligible for crisis services in the Behavioral Health-Administrative Services Organization (BH-ASO). E&T Facilities provide evidence-based treatment and recovery services in the inpatient setting that meet compliance criteria for patient rights while they are involuntarily detained.

E&T facilities are expected to adhere to treatment guidelines for timely evaluation, discharge planning, safety, and ITA laws and regulations as outlined in WAC 246-322 and RCW 71.05 for adults (RCW 71.34 for youth if applicable).

Program Specific Requirements

For each individual, E&T facilities provide:

- Admissions of an individual twenty-four hours a day, seven days a week, per WAC 246.341-0810(4) or its successor.
- A comprehensive diagnostic psychiatric evaluation and an initial treatment plan completed by MD/ARNP within 24 hours of admission as described in RCW 71.05.210.
- This evaluation includes a review of any applicable Mental Health Advanced Directives as described in RCW 71.32.
- A comprehensive History and Physical examination completed by MD/ARNP/RN within 24 hours of admission as described in WAC 246.322.170 or its successor.
- A daily evaluation including current progress towards treatment plan goals, medication management and justification of continued detainment based on imminence criteria as described in RCW 71.05.
- Clinical documentation includes a description of current status and clinical acuity, current diagnosis or changes in diagnosis, symptoms that support diagnostic criteria, current medications and any changes, interventions used to address symptoms, relevant lab results, and any other relevant medical data.
- Daily coordinated efforts to evaluate an individual's readiness to move towards a lower level of care including coordination with outpatient behavioral health providers, social service providers or individual's natural supports.
- Services and treatment that align with Individual Rights as outlined in this manual in Section 1.9. In addition, individuals who have been involuntarily detained have additional rights as described in RCW 71.05.360.
- Use of multidisciplinary team for the development of a comprehensive treatment plan to ensure patient care services as outlined in WAC 246.322.170 or its successor. Services ideally include, but are not limited to:

  - Person centered treatment with a recovery focus, utilizing trauma informed care principles, and demonstrating cultural competence;
  - Daily services and therapeutic strategies to promote safety and healing;
  - Medication management services;
  - Psychotherapeutic interventions – individual and group;
  - Address any presenting co-occurring disorders;
  - Peer Support Services;
  - Engaging the individual in discussing treatment options and partnering in treatment planning.
  - Daily review of the individual's willingness to engage in a less restrictive treatment option and/or voluntary treatment options including outpatient behavioral health services;
  - Address care of co-morbid physical health conditions and any needed coordinated care efforts;
  - Safety planning.
- Discharge planning is completed by a designated discharge planner. Responsibilities include, but are not limited to:
  - Involvement of the individual, family, and natural supports throughout the discharge planning process;
  - Providing linkage to outpatient behavioral health services, coordination with existing outpatient resources and ensure the individual leaves with medications in hand (if an individual does not have ongoing outpatient behavioral health services in place, the discharge planner facilitates linkage to these services prior to discharge);
  - Review of the individual's insurance coverage status upon intake;
  - Assisting all individuals who are not enrolled, but eligible for Medicaid, to apply for coverage;
  - Scheduling follow-up visits with outpatient behavioral health providers for continuity of care and medication management no later than 7 days from time of discharge;
  - Use of PointClickCare to improve system wide coordinated care efforts;
  - Coordination with community resources, including discharge to stable, safe, and secure housing with a specific transportation plan at the time of discharge, whenever possible; and
  - Contacting the individual's county of residence outside King County for purposes of discharge planning. This applies to individuals who were detained by King County Designated Crisis Responders (DCRs) and reside outside of King County.
- There must be an Attending MD/ARNP available 24-7 for emergent consultation (WAC 246-322- 170).
- The following requirements for safety, seclusion care and restraints according to WAC 246-322-180 and WAC 246-377-110 include, but are not limited to:
  - E & T facilities having a minimum of one seclusion room for seclusion or temporary holding of individuals
  - E&T facilities having a minimum of one seclusion room for seclusion or temporary holding of individuals;
- Individuals have the right to be free of all forms of seclusion and physical and chemical restraints;
  - Seclusion and restraints will not be used as a means of coercion, discipline, convenience, or retaliation;
  - Seclusion and restraints may only be used for the purpose of protecting the individual or others and only if less restrictive de-escalation interventions have been determined to be ineffective; and
  - If seclusion and restraints are used, the duration will be as brief as possible.
- E&T facilities provide court evaluation and testimony services including, but not limited to, preparation, documentation and timely filing of legal documents and pre-court planning pertaining to the involuntary detention of individuals at the facility as required by RCW 71.05 (71.34 for youth), applicable WAC's and the King County Superior Court Systems.
- For clients that elope from facilities:
  - When a client on a 14 or 90-day order elopes from a certified E&T, a facility representative immediately calls 911 to report the elopement.

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

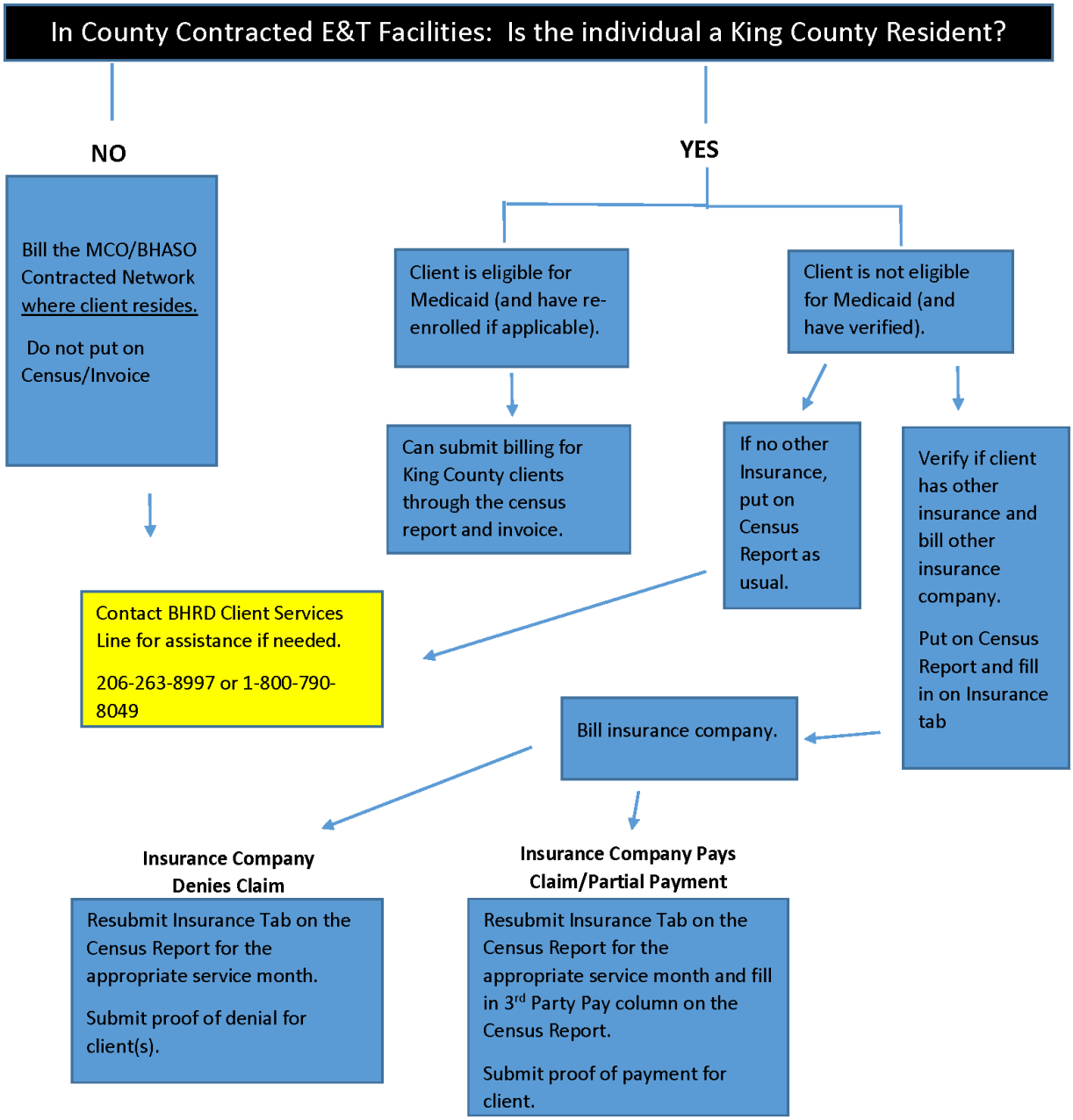
Additional Program Specific Requirements

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

Please see process walk below for information on billing guidelines.

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

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


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

OTHER CIRCUMSTANCES

Is this an AI/AN client?

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

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

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

Does the client have a spenddown?

If Spenddown has NOT BEEN MET:

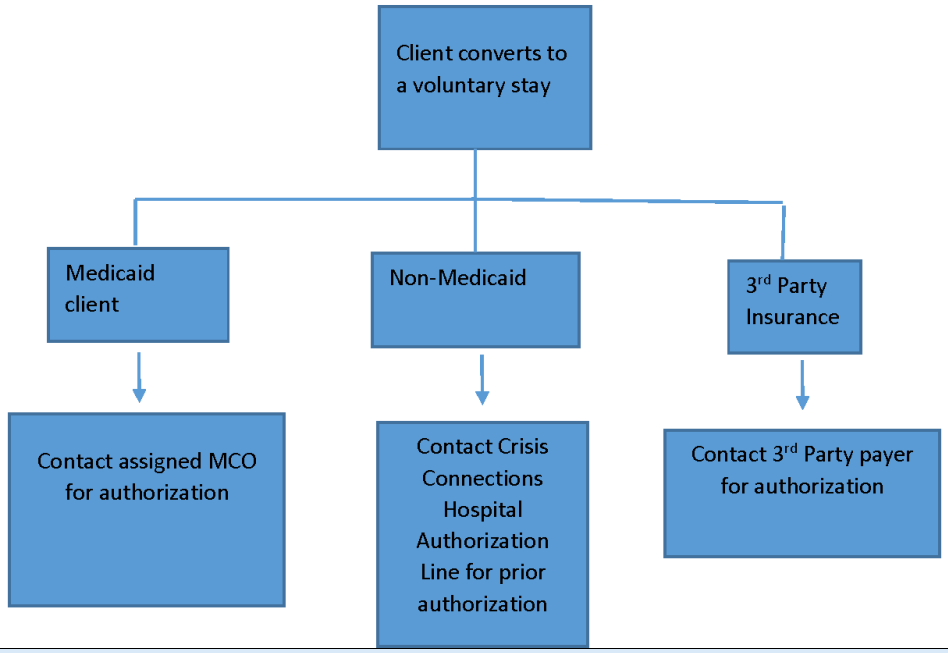
Place the spenddown amount in the appropriate column in the Census spreadsheet. BHRD will pay the spenddown only.

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

If Spenddown HAS BEEN MET:

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

Voluntary Stays for King County Residents



Sixteen-Bed Evaluation and Treatment Facility Services Eligibility Criteria	
Medicaid Status	No
Age Range	Adults: Age 18 years and older (If applicable, Youth: 17 years and younger)

Authorization Needed	Involuntary Treatment must be authorized by the DCRs. For Voluntary hospitalizations, prior authorization must be approved by MCOs (Medicaid eligible individuals) or Care Authorizers at Crisis Connections (Non-Medicaid eligible individuals)
Additional Criteria	Individuals eligible for this service must: • Have been involuntarily detained by a Designated Crisis Responder (DCR) for a 120-hour evaluation and treatment period; or • Committed by the King County Superior Court for a 14-day period of evaluation and treatment under Revised Code of Washington (RCW) 71.05 and 71.34; or • Referred by the DCR's through the revocation process provided in RCW 71.05 and 71.34.
Sixteen-Bed Evaluation and Treatment Facility Services Reporting Requirements (For providers located in King County only)	
Monthly Reports	• E&T Census Report • E&T Admission/Denial Log • E&T Discharge Planner Report (VCCC and Telecare only) • E&T Seclusion and Restraint Report
Quarterly Reports	None
Semiannual Reports	None
Annual/Other Reports	None
Performance Measurement (PM) Plan	None

Invoice Program Specific Requirements (For providers located in King County only)

Method of Payment

- Daily bed rates will be reimbursed retrospectively on a monthly basis based on actual occupancy as reported on the monthly census log.
- Reimbursement will be calculated as follows:
- Number of bed days (actual occupancy) x daily bed rate = reimbursement.
- Administrative bed rate payments will be made for a limited period for individuals who no longer meet medical necessity criteria but have been unable to be discharged from the facility to an appropriate placement.

Additional Requirements

- None

Invoice Program Specific Requirements (For ConnectionsWA LLC only)

Method of Payment

- Reimbursement will be made monthly on a per diem basis for Crisis Stabilization services.

Additional Requirements

- Invoice will be submitted by the 15th of the month following the service month.

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

Program Overview

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

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

Program Specific Requirements

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

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

Services within this scope of work include:

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

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

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

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

Additional Information

Out-of-State Residents

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

Alien Emergency Medical Status (AEM)

If you believe an individual qualifies for this program because ProviderOne shows ERSO as the benefit or for other reasons, contact Crisis Connections. Crisis Connections will confirm if the individual is AEM

eligible. Crisis Connections will provide a pre-authorization number that can be used to bill HCA directly. Crisis Connections can be contacted via Email: ur@crisisconnections.org

J. Doe (Unidentified Client)

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

Instructions for Submitting Claims to King County

Options for claim submission include fax or secure email. **Verify residency.**

- The county listed on ProviderOne and claim address should both be King County.
  - If this is the case, no additional information is required to verify King County residency.
  - If this is not the case, but you still believe that King County is the county of residence, provide a total of 2 sources of documentation which verify King County residency. In addition to ProviderOne or the address on the claim, examples of documents that can be used to verify King County residency include the following:
    - ITA paperwork showing King County as the county of residence.
    - Current identification or driver's license showing King County as the county of residence.
    - Intake paperwork that clearly indicates the individual's living situation is located in King County.
  - If you are unable to determine residency, contact the county that detained the individual with this information, so that the county that detained can partner with other involved counties to determine which county is responsible for payment.

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

- For ITA and voluntary stays that went through King County ITA court or Crisis Connections, no supporting documentation is needed, unless requested. For all inpatient stays, submit the discharge grid to Crisis Connections when the client discharges.
- For ITA stays that went through a non-King County ITA court, contact Crisis Connections to inform them of this individual's hospital stay. When the client discharges, submit the discharge grid to Crisis Connections.

Submit third-party payment documentation.

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

Paper claims and supporting documentation can be submitted by:

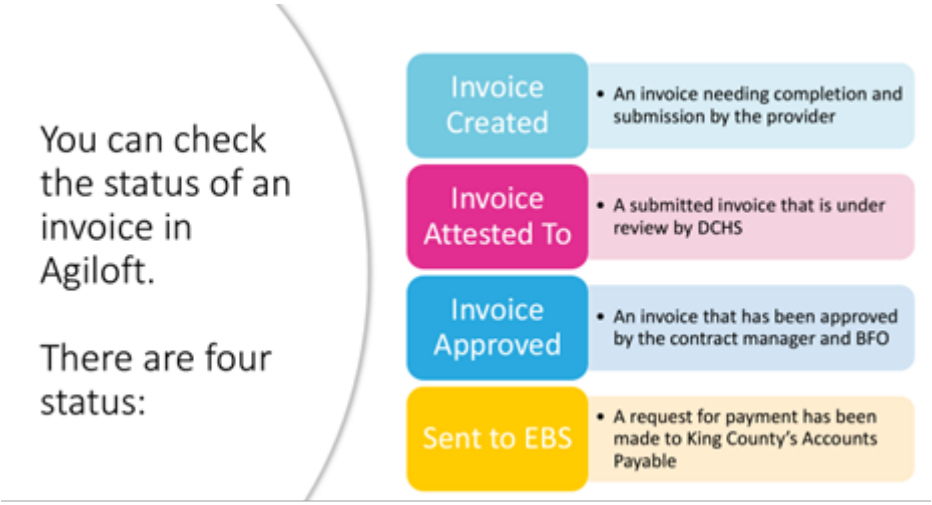
Email: KCASOHospitalBilling@kingcounty.gov. Please include Attn: Your Hospital's King County Provider Relations/Contract Specialist's Name

Fax: 206-788-8506 Please include Attn: Your Hospital's King County Provider Relations/Contract Specialist's Name

Instructions for Reviewing Claims

Eligible Claims

- Each agency must have an Agiloft account. Please click this link for Agiloft directions and resources: Accessing Agiloft to apply for and manage contracts with DCHS - King County, Washington.
- Once eligible claims are processed by the Provider Relations Specialist, you will receive notification of the invoice number and that the invoices are in process.
- You may check the status of your eligible invoices by logging into Agiloft (see image below).



The original claim, billing form, Provider One, and EOB (if applicable) will all be attached to the invoice to allow hospitals to easily view the backup documentation for payments.

Ineligible Claims

- PR staff will return ineligible claims to the submitting hospital.
- If the claim is not clear, the Provider Relations Specialist will reach out to the hospital to request supporting documentation.
- We request any supporting documentation be returned to King County within 60 days.

If you have any questions, please reach out to your Provider Relations Specialist.

Voluntary and Involuntary Treatment Act (ITA) Inpatient Psychiatric Services for Non-Medicaid Individuals Eligibility Criteria	
Medicaid Status	N/A
Age Range	Children, youth, adults, older adults as contracted
Authorization Needed	Yes, for voluntary hospitalizations
Additional Criteria	Individuals must be residents of King County

4 Crisis Services

Program Overview
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 King County. The goal of crisis services is to stabilize the individual and family in the least restrictive setting appropriate to their needs, considering the strengths of the individual, resources, and choice.

Interventions are age and developmentally appropriate and contribute to and support the individual's innate resiliency. For individuals with a previously identified behavioral health issue, crisis services are delivered in a manner that supports the individual's recovery. All crisis services are delivered in accordance with applicable Washington Administrative Codes and will, at a minimum, comply with *WAC 246-341-0900 - Crisis mental health services—General*.

Eligibility
Crisis services are available to any individual at no cost, regardless of income, age, or residency, who is experiencing a behavioral health crisis in King County. Additional eligibility requirements 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 anyone with a mental health, substance use, or emotional distress issue.

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 transitions to another source and/or level of care.

Notices
There are no Notice of Action or Notice of Determination requirements for 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 and follow Emergent Care or Urgent Care guidelines (See Definitions). Emergency crisis services must be initiated within two hours of the initial request from any source. Mobile crisis outreach services are held to this response time. These services include Mobile Rapid Response Crisis Teams for adult crisis outreach, Mobile Response and Stabilization Services for youth crisis outreach, and Designated Crisis Responders for ITA evaluation.

Urgent crisis services must be initiated within 24 hours of the initial request from any source. Mobile crisis outreach services are held to this response time. These services include Mobile Rapid Response Crisis Teams for adult crisis outreach, Mobile Response and Stabilization Services for youth crisis outreach, and Designated Crisis Responders for ITA evaluation.

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).

4.1 Emergency Telephone Services

Program Overview

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

This crisis line provides access to the King County Next Day Appointment (NDA) system, dispatches the Mobile Rapid Response Crisis Team (MRRCT) and Mobile Response and Stabilization Services (MRSS) 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 246-341-0670 Crisis telephone support services – Service standards
- 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

Invoice Program Specific Requirements

Method of Payment

- Reimbursement will be made in monthly 1/12th amounts for emergency crisis telephone service activities noted above.
- Reimbursement will be made monthly as needed based on actual costs for supplemental expenses.
- The agency retains all records and supporting documentation (including receipts) related to the expenses incurred.

Additional Requirements

- Non-compliance with the MIDD evaluation data requirements may result in withholding of payment for all associated contracted services.

Emergency Telephone Services Eligibility Criteria	
Medicaid Status	N/A
Age Range	N/A
Authorization Needed	No
Additional Criteria	Any individual or any person acting on behalf of an individual for whom a mental health disorder cannot be ruled out.
Emergency Telephone Services Reporting Requirements	
Daily Reports	• Daily Crisis Log • Daily Crisis Log –CC Business Line • Daily Crisis Log –CC Crisis Line
Monthly Reports	• Crisis Line Wait Time Intervals Report • Next Day Appointment Report • Mobile Crisis Team Dispatch Report • CCPAR Business Line • CCPAR Line Volume and Outcomes Report • Crisis Line Caller Data Report • FTE Call Screener Report • Voluntary Hospital Authorization Report • UM Report
Quarterly Reports	• Crisis Line Caller Data Report • Crisis Line Access Report • CCPAR Crisis Line Report • CCPAR Business Line Report
Semiannual Reports	None
Annual/Other Reports	Crisis Line Caller Data Report
Performance Measurement (PM) Plan	Reporting requirements and performance measures are further detailed in an accompanying Performance Measurement plan. See “Performance Measurement (PM) Plans” section on the Provider Manual and specific program PM Plan for more information

4.1.1 OneCall

Program Overview

OneCall is dedicated 24-hour phone line for King County first and second responders when responding to calls related to behavioral health. One Call is a single-portal referral service, accessible via telephone that provides access to information, problem-solving, de-escalation and crisis intervention services,

community-based resources, and assistance for responders when encountering individuals experiencing behavioral health crises and challenges.

Participant Eligibility Requirements
All King County first and second responder programs, including Fire, Police, and Emergency Medical Services (EMS), including embedded or affiliated behavioral health crisis or outreach teams, and Emergency Services Patrol (ESP) can use OneCall to assist individuals who are experiencing a behavioral health crisis.

Goals and Objectives
OneCall supports information, coordination and referral services with first and second responders to increase access to available services and resources, promote effective crisis response interventions, and facilitate collaborations to best support individuals in crisis and reduce unnecessary crisis system engagement,

Program Requirements
OneCall will adhere to the following standards:

- Provide 24/7 access to phone responses and availability
- Provide first and second responders with consultation, problem solving, information sharing, and/or referral of individuals to established or new mental health treatment
- Assist first and second responders in averting serious threats to public health and/or safety during a crisis event or emergent situation.

OneCall provides responders with important personal health information from PointClickCare, the Extended Client Lookup System (ECLS) and other databases (in accordance with the Health Insurance Portability and Accountability Act, or HIPAA), to support the effective direction of individuals in crisis to community care.

OneCall staff receive training and supervision relevant to their position, such as information and referral services, resource coordination, and crisis de-escalation, and follow current best practices for this scope of work. OneCall provides and supports the ongoing technological infrastructure necessary to implement this service.

Staffing
OneCall operators have access to on-site licensed Mental Health Professionals (MHPs) for consultation and assistance at all times and staffing schedules ensure operator coverage 24 hours a day, all days of the year (including holidays) to offer responders behavioral health consultations, guidance, information, and referrals.

Reporting Requirements

BHRD Information System	Submit Data to the BHRD Information System as outlined in the BHRD Data Dictionary and the Required Transactions Sheet in the ISAC Notebook
Monthly Reports	• Actual Monthly Expenditures Report, and Detailed Budget Breakdown for All Program Expenditures • OneCall Monthly Reports (*141_CT_MH_YEAR_MONTH_OneCallRpt_V1, Crisis Connections OneCall Data Report)*
Quarterly Reports	OneCall Quarterly Reports (*Crisis Connections OneCall Quarterly Narrative Report, Crisis Connections OneCall City of Seattle Quarterly Report)*

Semiannual Reports	None
Annual/Other Reports	Other reports as needed
Performance Measurement (PM) Plan	None

Invoice Program Specific Requirements

Method of Payment

- Reimbursement will be made on an actual cost basis for allowable OneCall costs.

Additional Requirements

- The Contractor must retain all records and supporting documentation (including receipts, invoices, timesheets, and copies of checks) related to the expenses incurred for the program described above.
- Allowable costs are outlined in the agency's approved budget. Providers shall receive approval from King County prior to purchasing any items not included in the approved budget.
- Provide copies of proof of purchases and payments for expenses not included as part of basic program operations upon request from BHRD.

4.2 Adult Crisis Services (Mental Health Next Day Appointments – Adults)

Program Overview

Adult Crisis Services are Mental Health Next Day Appointments for Adults (MH NDA). MH NDA Providers ensure at least ten (10) mental health NDAs are available per week. Provider agencies provide geographic access to crisis services at their sites. The following services must be provided Monday through Friday, 8 a.m. to 5 p.m., excluding holidays:

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

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

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

Follow-up visits include:

- The attempt to provide a minimum of one follow-up visit with the client within the first 10 days of treatment, unless an appropriate transfer to another Provider has occurred. Follow-up is provided by a crisis service 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.

Invoice Program Specific Requirements

Method of Payment

- Reimbursement made in monthly 1/12th amounts to maintain capacity for Next Day appointments.
- **VCCC only:** Reimbursement will be made in monthly 1/12th amounts for crisis respite services and capacity for eligible individuals in crisis that are referred to the program.

Additional Requirements

- Non-compliance with the MIDD evaluation data requirements may result in withholding of payment for all associated contracted services.

Adult Crisis Services Eligibility Criteria	
Medicaid Status	N/A
Age Range	Adults Aged 18 Years and Older
Authorization Needed	No
Additional Criteria	Meet crisis services eligibility criteria identified in the Standardized Initial Crisis Screening Protocol (SICSP), not enrolled in outpatient services, and are referred by Crisis Connections or the Designated Crisis Responder (DCRs)
Adult Crisis Services Reporting Requirements	
Monthly Reports	Adult Crisis Services Report
Quarterly Reports	None
Semiannual Reports	None
Annual/Other Reports	None
Performance Measurement (PM) Plan	Reporting requirements and performance measures are further detailed in an accompanying Performance Measurement plan. See “Performance Measurement (PM) Plans” section on the Provider Manual and specific program PM Plan for more information

4.3 Substance Use Disorder Crisis Services Next Day Assessment

Program Overview

Substance Use Disorder (SUD) Crisis Services Next Day Assessment (NDA) appointments are available for youth and adults, in SUD crisis and who are not currently enrolled in Behavioral Health and Recovery Division contracted treatment services or not currently engaged in SUD treatment services. Services provided under the scope of this work are provided in accordance with the MIDD Behavioral Health Sales Tax Plan Initiative CD-10 – Next Day Crisis Appointments (NDAs).

The following services must be provided Monday through Friday, 8 a.m. to 5 p.m., excluding holidays.

Program Specific Requirements

- Provide clinical assessment that meets WAC 246-341-0640 requirements, performed by a licensed SUDP or an SUDP Trainee under direct supervision of an SUDP as defined by WAC 246-811-010, to establish an SUD diagnosis. Based on diagnostic criteria, recommend placement in an appropriate ASAM level of care.
- Interpreter services, including sign language interpretation and other services for clients who are sensory-impaired, must be made available as needed.
- Providers will collectively ensure the availability of 120 SUD NDA appointments per month across the network, Hours of appointments will be negotiated to ensure accessibility.
- Provide induction of Buprenorphine or Naltrexone within 24 hours or provide low barrier, walk in referrals for medications used to treat opioid use disorder.

- Collaborate with BHRD staff and the other SUD NDA awarded agencies to review program data and SUD NDA protocols.
- Provide follow-up to ensure SUD NDA clients are enrolled in outpatient services (i.e. SUD or MAT) within 5 business days of assessment, as appropriate.
- Provide access/connection to residential and long-term SUD treatment directly to the client, based on client choice, ensuring that within 3 business days of the assessment, clinical documentation is sent to BHRD's Care Coordination team for review and/or approval of residential treatment services.
- Provide Medicaid eligible clients with assistance in obtaining benefits that will enable clients to qualify for ongoing behavioral health and medical services.
- Provide referrals and assistance with connecting to long-term behavioral health or additional recovery supports as appropriate.
- Coordinate the gathering of demographic and project data for evaluation purposes.

Invoice Program Specific Requirements

Method of Payment

- Reimbursement will be made in monthly 1/12 amounts, based on the provider's capacity to hold open a designated number of appointments each month.
- Reimbursement amount is subject to adjustment if fewer appointments were made available throughout the month.

Additional Requirements

- Non-compliance with the MIDD evaluation data requirements may result in withholding of payment for all associated contracted services.
- To retain full reimbursement for all designated appointments, the agency should reschedule appointments that fall on holidays or when changes in staffing or agency closures lead to cancellations.
- The agency will communicate with the County Program Manager re: dates and times of cancelled appointments (for any reason) and any subsequent reschedules.

Substance Use Disorder Next Day Assessment Appointment Eligibility Criteria	
Medicaid Status	Serves individuals regardless of Medicaid status
Age Range	N/A
Authorization Needed	No
Additional Criteria	Not currently enrolled in SUD treatment services **OR** not currently engaged in SUD treatment services
Substance Use Disorder Next Day Assessment Appointment Reporting Requirements	
Monthly Reports	SUD NDA Referral Report
Quarterly Reports	None
Semiannual Reports	None
Annual/Other Reports	MIDD Annual Report
Performance Measurement (PM) Plan	Reporting requirements and performance measures are further detailed in an accompanying Performance Measurement plan. See "Performance Measurement (PM) Plans" section on the Provider Manual and specific program PM Plan for more information

4.4 Adult Inpatient Diversion Bed

Program Overview

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

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

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

Adult Inpatient Diversion Bed Eligibility Criteria	
Medicaid Status	N/A
Age Range	Adults Aged 18 Years and Older
Authorization Needed	No
Additional Criteria	Individuals eligible for this service must be 18 years of age or older and meet each of the following criteria: • Referred by the DCRs or Crisis Connections; • Are in crisis; • A mental disorder cannot be ruled out; • Are at immediate risk for voluntary or involuntary psychiatric hospitalization; • Are able to ambulate without assistive devices; and • Are willing to receive this service.
Adult Inpatient Diversion Bed Reporting Requirements	
Monthly Reports	Adult Inpatient Diversion Bed Report in an electronic format approved by the County
Quarterly Reports	None
Semiannual Reports	None
Annual/Other Reports	None
Performance Measurement (PM) Plan	None

4.5 Mobile Crisis Team/Mobile Rapid Response Crisis Team (MRRCT)

Program Overview

Mobile Rapid Response Crisis Teams (MRRCT) provide voluntary community-based interventions to adults, ages 18 and older, within King County who are experiencing an emotional or behavioral health crisis. MRRCT operates within the framework that defines the necessary parts of an effective crisis response system: “someone to talk to, someone to respond, somewhere to go”. MRRCTs are dispatched to the location of the crisis to any adult, anywhere in King County, at any time.

Eligibility Criteria

Medicaid Status	Serves individuals regardless of Medicaid status
Age Range	Adults Aged 18 Years and Older
Authorization Needed	No
Additional Criteria for MRRCT	Any individual at least 18 years of age experiencing an emotional and/or behavioral disturbance, including substance use/abuse, who meets the following criteria is eligible for services: • Is in emotional or behavioral crisis that would benefit from crisis intervention services; • Agrees to participate in the services; and • Is referred by an eligible referent. • MRCCT’s will serve non-Medicaid Individuals who have been diagnosed with a Behavioral Health condition and who cycle through the criminal court system.

Goals and Objectives

MRRCT provides community-based outreach services to reduce the utilization of crisis system services and engagement with first responders. MRRCT engages with individuals to provide crisis stabilization services, help identify and directly link individuals to immediate resources and supports, and increase community tenure. All MRRCT programs work to decrease response time to individuals experiencing a behavioral health crisis.

MRRCT supports the coordination of mobile crisis response services with emergency responders including co-responders, law enforcement, fire and Emergency Medical Services (EMS), and other first responder teams, to support the diversion of individuals from incarceration and emergency department utilization. The intent is to minimize the involvement of emergency responders while reducing the need for more involuntary processes, including detaining persons under the Involuntary Treatment Act (ITA).

Program Requirements

The help seeker defines the nature of the crisis. MRRCT provides immediate de-escalation and stabilization services in a person -centered, non-coercive manner, and assists the individual in finding resources and supports to address the current crisis. Services are provided in the community at any location in King County that is best suited to meet the needs of the individual, with the intent of serving the individual in the least restrictive manner possible. Services are provided in a non-judgmental, trauma-informed approach, utilizing strategies to support individuals in crisis in making safe, informed, and healthy decisions.

MRRCTs are dispatched by a centralized provider who triages the crisis as emergent, requiring a response within 2 hours, or urgent, requiring a response within 24 hours. Dispatches sent to MRRCT are no-decline. The centralized dispatch provider collects and shares the information needed for MRRCT to respond to the crisis.

MRRCT programs meet the requirements indicated by WAC 246-341-0901 and BH-ASO contract. The following MRRCT requirements are derived from the Washington State Health Care Authority (HCA)'s MRRCT Best Practice Guidelines.

MRRCT Outreach

- Maintain adequate staffing to assure MRRCT services are available 24/7/365.
- Recruit, hire and train MRRCT outreach staff, including Mental Health Professionals, Mental Health Care Providers (MHCP), Certified Peer Counselors (CPC)/Certified Peer Support Specialists (CPSS)/CPSS trainees.
- Assure that CPCs/CPSS/CPSS trainees are integrated into the MRRCT staffing model to draw on the Peer support provider's lived experiences and unique perspective. This can help to reduce barriers and improve empathy and rapport during the crisis intervention.
- MRRCTs provides in-person responses for all dispatches to individuals in crisis at the location determined by the dispatcher.
- If MRRCT is unable to locate an individual during the initial outreach, they will attempt to call the referent prior to making another attempt. An in-person follow-up may occur at the initial location within 24 hours of the referral.
- Provide a Trauma Informed Approach (TIA) that acknowledges the potential trauma experienced by those in crisis, recognizes the signs and symptoms of trauma, and actively seeks to avoid re-traumatization.
- Provide developmentally and age-appropriate interventions.
- Provide culturally competent, compassionate, and linguistically appropriate crisis intervention services to the diverse populations of each primary service area, focusing on the individual's needs in the moment.
- MRRCTs must respond within two hours of a referral for an Emergent Care crisis and within 24 hours of a referral for an Urgent behavioral health situation crisis.
- Assess for risk and opportunities to resolve the crisis in the least restrictive setting.
- Complete an assessment that includes, but is not limited to, nature of the crisis, risk, safety concerns, strengths, natural supports and resources available to the individual, recent inpatient hospitalization, enrollment with other providers, related medical history (if known).
- Determine if there is a current crisis plan and/or Mental Health Advanced Directive (MHAD) for the individual being outreached.
- Attempt multiple engagement strategies when an individual in crisis is resistant to services, utilizing creative interventions when appropriate.
- Divert those in crisis from jail and hospital admissions, reduce dependence on first responders and emergency departments and reduce DCR interventions by offering a least restrictive alternative to involuntary treatment.
- Support justice system diversion by responding without law enforcement accompaniment unless special circumstances warrant inclusion.
- Complete crisis planning with the individual for each crisis outreach, which may include referrals to community supports, providing, or arranging for transportation and connecting individuals to ongoing services and supports that promote community tenure.
- Coordinate with medical, housing, behavioral health services, and/or any other relevant service provider related to current crisis and ongoing support needs.

- When possible and appropriate, provide referents or service partners, including but not limited to medical, behavioral health, and housing providers, with information on any referrals and/or recommendations made.
- Provide an estimated time of arrival (ETA) to the centralized dispatch provider and notify the dispatch provider when MRRCT has completed the outreach and is back in service.
- Complete narrative documentation of each crisis outreach as part of an individual's record, including but not limited to a summary of the outreach, nature of crisis, crisis planning, follow-up planning, and Mental Health Advanced Directive (MHAD), and the outcome including the basis for a decision not to respond in person when a telehealth intervention was provided.
- In addition to narrative documentation, collect and report data elements, including but not limited to client information, outreach timestamps, and encounter information, as detailed in the BHRD Data Dictionary and Program Instructions.
- MRRCT will follow Tribal Crisis Coordination Protocols when protocols are available. Informal tribal crisis care practices will be followed when formal protocols do not exist.

Follow Up Responsibilities

The MRRCT initiates a crisis planning process that can help prevent a future crisis and include specific steps to take if the individual experiences the crisis again. The MRRCT provides follow-up -services with the individual's consent.

- MRRCT must obtain an individual's consent to receive follow-up services.
- MRRCT provides up to three (3) follow up attempts for anyone who receives an in-person crisis intervention outreach.
- Follow-up services may be in-person or by phone, as appropriate to the individual's needs.
- The purpose of follow-up contact is to determine if any services the individual was referred to were provided and if they met their needs.
- All follow-up attempts and their outcomes are documented.
- MRRCT can provide additional support after the crisis intervention episode of care if needed up to 72 hours.
- MRRCT may provide additional in-home stabilization after the initial 72-hour crisis intervention as needed for up to eight weeks to ensure the least restrictive care is used to stabilize Individuals in the community.

Training

MRRCT Providers ensures each MRRCT staff maintains a Washington State Department of Health (DOH) license or credential in good standing. Documentation of training completion is maintained in the staff's personnel record.

MRRCT staff meet the HCA core competency crisis trainings, follow current best practices for crisis outreach services, and complete any additional trainings required for their positions.
Each MRRCT staff receive the following HCA required trainings within the first 90 days of employment:

- HCA approved certification crisis intervention specialist trainings
- Trauma Informed Care
- De-escalation Techniques
- Harm Reduction
- Developmentally appropriate services

Link and instructions: (https://crisisacademywa.com/)

Each MRRCT, CPC/CPSS must complete the HCA sponsored Operationalizing Peer Support continuing education training for peers working in crisis.

MRRCT supervisors of CPC/CPSS must complete the HCA sponsored Operationalizing Peer Support training for supervisors withing six months of hire.

Staffing
MRRCT provides Mobile Crisis Outreach services with a minimum of a two-person team per shift and meet the staffing model requirements.

Staffing per Primary Service Area should include for overnight up to 2 teams; for day shift up to 3 teams, and for swing shift up to 4 teams. Each two-person team should include an MHP and/or, MHCP. Team composition should comply with WAC 246-341-0901 to "ensure that a peer responding to an initial crisis" intervention "is accompanied by a mental health professional or individual appropriately credentialed to provide substance use disorder treatment as appropriate to the crisis."

MRRCT has access to a supervising MHP 24/7/365. The supervisor will provide clinical supervision of MRRCT service providers and is responsible for ensuring the services provided by the team are clinically appropriate.

Endorsement Standards
MRRCT's are able to be endorsed, if they choose, following endorsement standards found in WAC 182-140 and RCW 43-70-442. Once a team is endorsed, the team is eligible for performance payments and supplemental performance payments in the form of an enhanced case rate for meeting specific response times and in-route times.

Seeking endorsement is optional and does not preclude non-endorsed MRRCT's from being dispatched, however the centralized dispatch provider will prioritize using endorsed teams over non-endorsed teams, limited to region.

Endorsed MRRCT programs engage in annual performance monitoring by BHRD to ensure compliance with the endorsement standards including staffing standards, training standards, transportation, equipment, and communication standards as identified in chapter 182-140 WAC.

Reporting Requirements

BHRD Information System	Submit Data to the BHRD Information System as outlined in the BHRD Data Dictionary and the Required Transactions Sheet in the ISAC Notebook
Monthly Reports	• MRRCT Actual Monthly Expenditures Report, and Detailed Budget Breakdown for All Program Expenditures • MRRCT Monthly Report
Quarterly Reports	• MRRCT Quarterly Report • City of Seattle Narrative Report for Central Region MRRCT • Trueblood Enhanced Mobile Crisis Response Quarterly Report • Enhanced Mobile Crisis Response Staff Details
Semiannual Reports	None
Annual/Other Reports	• MIDD Annual Narrative Report • Staffing Reports (bi-weekly unless otherwise determined by BHRD) • Other reports as needed
Performance Measurement (PM) Plan	Reporting requirements and performance measures are further detailed in an accompanying Performance Measurement plan. See "Performance Measurement (PM) Plans" section on the Provider Manual and specific program PM Plan for more information

Invoice Program Specific Requirements

Method of Payment

- Reimbursement will be made monthly on an actual cost basis for allowable MRRCT costs.

Additional Requirements

- Provide detailed monthly breakdown of expenses by budget category. Allowable costs are outlined in the agency's approved budget. Providers will receive approval from King County prior to purchasing any items not included in the approved budget.
- Provide copies of proof of purchases and payments for client assistance, equipment, or miscellaneous expenses not included as part of basic program operations upon request from BHRD.
- The Contractor must retain all records and supporting documentation (including receipts, invoice, and copies of checks) related to the expenses incurred for the program described above.

4.6 Mobile Response and Stabilization Services (MRSS)

Program Overview

Mobile Response and Stabilization Services (MRSS) provides 24/7 crisis outreach and response to children, youth, and any person acting on behalf of a child or youth in King County. MRSS teams provide rapid response home and community crisis intervention to any individual reporting a need for crisis response and crisis stabilization. The MRSS program meets the requirements below as indicated by WAC 246-341-0715 and BH-ASO contract.

MRSS Eligibility Criteria	
Medicaid Status	No
Age Range	Children, youth, and young adults up to 21 years of age.
Target Population	Children, youth and their families in crisis
Authorization Needed	No
Authorization Criteria	None, crisis is defined by the individual(s) seeking help

Goals & Objectives

- Universal access to crisis services/outreach for all children, youth, young adults, and families in King County.
- 24/7 crisis support accessed through Crisis Connections.
- 24/7 mobile response outreach
- Ongoing stabilization services for up to 8 weeks.
- An in-person response is the default response, unless the help seeker refuses.
- The caller defines the crisis.
- Children, youth, and young adults are assessed face to face.
- Reduce the use of emergency departments (ED), hospital boarding, and detention centers due to a behavioral health crisis.
- Support and maintain Individuals in their current living situation and community environment, reducing the need for out-of-home placements, which reduces the need for inpatient care and residential interventions.
- Assist children, youth, young adults, and families in accessing and linking to ongoing support and services, including intensive clinical and in-home services, as needed.
- Provide trauma informed care.
- Promote and support safe behavior in home, school, and community settings.

Program Requirements

Staffing

The MRSS team is comprised of the following staff:

- Mental Health Professionals (MHP) (RCW 71-05-020), Mental Health Care Provider (MHCP) (WAC 182-140-0020, WAC 246-810-015), and Certified Peer Counselor (CPC) (WAC 182-115- 0100).
- Supervisor who, at a minimum, holds a master's degree in a human service field and are clinically licensed in the state of Washington.
- Substance Use Disorder Professional (SUDP) and CPC consultant with experience providing behavioral health crisis support
- In person initial response team are composed of, at minimum, one MHP or MHCP and one CPC.

Staff are trained in the following areas:

- Crisis de-escalation
- HCA-sponsored certification crisis intervention specialist training
- Trauma-responsive care (HCA training)
- HCA sponsored peer crisis training (CPC's only)
- Harm reduction training (HCA training)
- Any training that BH-ASO requires

Crisis Response and Outreach

- MRSS staff provide Emergent Outreach to the individual's location within 2 hours of crisis dispatch
- A 60-minute response time is best practice within the MRSS Best Practice Guidelines.
- MRSS staff provide Urgent Behavioral Health Outreach within 24 hours of initial outreach from the help seeker. Refer to *Section 4. Crisis Services* for definitions of Emergent [Care] and Non-Emergent [Urgent Care] Services.
- MRSS teams pursue the least restrictive response for individuals seeking assistance.

Stabilization and Support

MRSS teams provide up to eight weeks of post-crisis stabilization services, including:

- Care coordination
- Skill building
- Peer support
- Safety monitoring
- Brief clinical interventions
- Intensive in-home services
- Identifying and strengthening natural and community supports
- Education on the effects of medication

Endorsement Standards

MRSS teams are able to be endorsed, if they choose, following endorsement standards found in WAC 182-140 and RCW 43-70-442. Once a team is endorsed, the team is eligible for performance payments and supplemental performance payments in the form of an enhanced case rate for meeting specific response times and in-route times.

Seeking endorsement is optional and does not preclude non-endorsed MRSS teams from being dispatched, however the centralized dispatch provider will prioritize using endorsed teams over non-endorsed teams, limited to region.

The response times and enroute times are established in two phases so that:

- Between January 1, 2025, and December 31, 2026, endorsed teams must achieve the following response times at least 80% of the time:
  - Arrive at the person's location within 30 minutes of being dispatched to an urban area
  - Arrive at the person's location within 40 minutes of being dispatched to a suburban area
  - Be enroute to a person's location within 15 minutes of being dispatched to a rural area
- On and after January 1, 2027, endorsed teams must achieve the following response times at least 80% of the time:
  - Arrive at the person's location within 20 minutes of being dispatched to an urban area
  - Arrive at the person's location within 30 minutes of being dispatched to a suburban area
  - Be enroute to a person's location within 10 minutes of being dispatched to a rural area

Invoice Program Specific Requirements

Method of Payment

- Reimbursement will be made monthly on an actual cost basis for MRSS program costs.

Additional Requirements

- Costs incurred are outlined in the agency's approved budget. Providers receive approval from King County prior to purchasing of any items not included in their approved budget.
- Cost will be reimbursed for transportation when the MRSS staff use their own vehicle for program related travel based on mileage. Whenever possible, agency vehicles should be used by staff for program related travel.

MRSS Reporting Requirements	
BHRD Information System	Submit Data to the BHRD Information System as outlined in the BHRD Data Dictionary and the Required Transactions Sheet in the ISAC Notebook.
Monthly Reports	CORE CD-11 Monthly Report (Excel)
Quarterly Reports	None
Semiannual Reports	None
Annual/Other Reports	MIDD Annual Narrative Summary MRSS Aggregate Survey Responses Report (Excel)
Performance Measurement (PM) Plan	Reporting requirements and performance measures are further detailed in an accompanying performance measurement (PM) plan. See "Performance Measurement (PM) Plans" section above and MRSS PM Plan.

4.6.1 Intensive Stabilization Services (ISS)

Program Overview

Intensive Stabilization Services (ISS) provides stabilization support to families in crisis and to stabilize a youth's placement (e.g., by reducing out of home placements, changes in placement, or hospitalization).

Eligibility Criteria

Medicaid Status	No
Age Range	Children and youth 3- 17 years of age
Target Population	Children, youth and their families in crisis.
Authorization Needed	No
Other Criteria	Child or youth is connected to King County Integrated Care Network or Department of Children, Youth, and Families, resides in King County, and the functioning of the child and/or family is severely impacted due to child's significant emotional or behavioral problems. i. At least one of the following is true: a. The current living situation is at risk of disruption; or b. The child is at risk of hospitalization. ii. For any child who has been screened and referred to CCORS/ISS by the DCYF King County staff, the following additional criteria shall apply: c. The child is not currently being served through the Behavioral Rehabilitation Services, and d. Intensive Stabilization Services are needed to support the child's current placement, or to safely transition the child into a more appropriate living situation.

Goals & Objectives

- Serve a maximum of 50 open cases at any given time and accept a maximum of 17 new referrals for ISS each month. Of these, 7 will come from DCYF staff in King County;
- Provide services in the community where the child and family reside (e.g., the family home, school, hospital, DCYF office, and other community locations) for up to 12 weeks;
- Services are provided on a 24/7 basis;
- Assess the child and caregiver's strengths and needs;
- An in-person response is the default response, unless the help seeker refuses;
- Provide creative and flexible solutions to stabilize the child;
- Support linkage to additional resources as necessary;
- Reduce the use of emergency departments (ED), hospital boarding, and detention centers due to a behavioral health crisis;
- Support and maintain Individuals in their current living situation and community environment, reducing the need for out-of-home placements, which reduces the need for inpatient care and residential interventions;
- Provide trauma informed care;
- Promote and support safe behavior in home, school, and community settings;
- Services shall be flexible and respond to each child and family, to include, but not limited to:
    - Create and implement a "Client and Family Safety Plan" within the 24-hours of the first in-person meeting with the family to address triggers and warning signs exhibited by the child, and then people, activities, or skills which will reduce the frequency and intensity of the crisis episodes, help the child and family manage stress in a more constructive manner, and increase the safety of everyone in the house;
    - Create a "Client and Family Action Plan" during the early stage of the ISS intervention, within the first 2 weeks, which identifies the family's stabilization goals; and specific steps

which will be taken by the individual, family, ISS team members, and community providers to meet those goals. If DCYF involvement, inclusion of the DCYF Social Service Specialist.

- ISS teams pursue the least restrictive response for individuals seeking assistance.

Program Requirements

Staffing

- The ISS team is comprised of the following staff:
    - Mental Health Professionals (MHP), Mental Health Care Provider (MHCP), and Certified Peer Counselor (CPC);
    - Supervisor who, at a minimum, holds a master's degree in a human service field and are clinically licensed in the state of Washington and;
    - Substance Use Disorder Professional (SUDP) and CPC consultant with experience providing behavioral health crisis support.
- In person initial response team are composed of, at minimum, one MHP or MHCP and one CPC.

Crisis Response

- ISS staff provide Emergent Response to the individual's location within 2 hours of crisis dispatch;
- ISS staff provide 24-hour response time for all other referrals;
- ISS teams pursue the least restrictive response for individuals seeking assistance.

Stabilization and Support

ISS teams

- Provide up to 12 weeks of post-crisis stabilization services;
- Implement the "Client and Family Action Plan" collaboration with the family, DCYF staff, ISS team members, and other identified parties through steps such as:
    - If there is DCYF involvement, assisting with creating a permanency plan for the child by providing intensive and comprehensive services to stabilize the child's current situation and/or placement, or work with the team to determine a more suitable alternative permanent placement.
    - If there is DCYF involvement, concurrent planning with other parties directly related to stabilizing the placement and/or preventing placement disruption. (i.e., CASA's or GAL's, school staff, probation or parole officers, behavioral health, or substance abuse counselors, etc.).
    - If there is DCYF involvement, working with community partners to help the family/DCYF staff achieve a level of functioning where a hand-off to natural supports and/or other formal systems can safely occur. (e.g., enrollment with a community-based behavioral health agency for counseling and medication management, referral for WISe or King County wraparound services, implementation of an effective Individualized Education Plan (IEP) or 504 plan at the child's school, plan for respite provided by extended family members, etc.)
- Provide direct behavioral services for the child and caregiver, including teaching and modeling:
    - Crisis stabilization and de-escalation skills;
    - Education about mental and behavioral health conditions;
    - Conflict resolution skills;
    - Safety Planning;
    - Problem solving skills and;
    - General and trauma-informed parenting skills.
- Provide other stabilization services support:
    - Care coordination;
    - Peer support;

  - Safety monitoring;
  - Intensive in-home services and;
  - Identifying and strengthening natural and community supports.
- Case management services including referral to and resource coordination with community behavioral health providers as applicable to the specific case;
- Ongoing work with the family/caregiver in the event of the child's brief hospital or detention stay to ensure continuity of care and;
- Placement in a Crisis Stabilization Bed may occur when clinically necessary to keep the child safe while family members and other supports are engaged, and the crisis plan is updated. If this placement occurs, it will be for as short a time as possible until the child can return to their prior placement or another minimally restrictive setting.

Invoice Program Specific Requirements

Method of Payment

• Reimbursement will be made monthly on an actual cost basis for ISS program costs.

Additional Requirements

• Costs incurred are outlined in the agency's approved budget. Providers must receive approval from King
County prior to purchasing any items not included in their approved budget.
• Cost will be reimbursed for transportation when the ISS staff use their own vehicle for program related travel based on mileage. Whenever possible, agency vehicles should be used by staff for program related travel.

Reporting Requirements

BHRD Information System	Submit data to the BHRD Information System as outlined by the BHRD Data Dictionary and the Required Transactions Sheet in the ISAC Notebook.
Monthly Reports	CORE CD-11 Monthly Report (Excel)
Quarterly Reports	ISS Report
Semiannual Reports	None
Annual/Other Reports	• MIDD Annual Narrative Summary • Aggregate survey responses report
Performance Measurement (PM) Plan	Reporting requirements and performance measures are further detailed in an accompanying performance measurement (PM) plan. See "Performance Measurement (PM) Plans" section above and MRSS PM Plan.

4.6.2 Crisis Stabilization Bed(s) (CSBs)

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

CSB capacity must be sufficient to meet the need of the MRSS and ISS programs and ensure access or intake to the CSBs can be obtained 24/7 through the MRSS 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 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.

Invoice Program Specific Requirements

Method of Payment

- Reimbursement will be made monthly on a per diem basis for Crisis Stabilization services.

Additional Requirements

- Invoice will be submitted by the 15th of the month following the service month.

4.7 Opioid Recovery and Care Access (ORCA) Center

Program Overview

The Opioid Recovery and Care Access (ORCA) Center delivers harm reduction-oriented clinical and supportive services that improve post-overdose care and expand rapid access to medications for people who use drugs, including those with opioid use disorder. This includes operating welcoming, trauma-responsive spaces where clients arriving via first responder drop off or walk-in, receive immediate stabilization following an opioid overdose. All services are grounded in harm-reduction principles, delivered without judgment, and tailored to the needs of people who use drugs. The provider agency maintains and applies clear admission criteria, including medical stability and ability to consent to voluntary treatment to ensure patient safety and appropriate placement.

Eight stabilization recliners are available 24/7 for low-barrier access to continuous observation, timely clinical assessment, and supportive monitoring for individuals who do not require emergency department-level care. Care navigation is integrated throughout the patient experience to ensure warm handoffs, continuity of care, and effective transitions to longer-term treatment settings. The provider ensures continuous monitoring, safety checks, real-time clinical oversight, de-escalation practices, and the maintenance of a calm, trauma-responsive environment for individuals who may be disoriented or distressed following an overdose. Peer specialists and staff with lived and living experience are included in the program model whenever possible to support client engagement. Staff deliver education on reducing health risks associated with opioid use and provide access to basic needs such as food, showers, and laundry services to support patient stabilization and dignity. The provider offers timely connection to ongoing follow-up care such as medication for opioid use disorder (MOUD), primary care, and behavioral health services.

The provider delivers longitudinal MOUD as described separately (see chapter Medication for Opioid Use Disorder (MOUD): Office-Based Opioid Treatment (OBOT)).

The provider participates in program evaluation, community collaboration, and continuous quality improvement to ensure the ORCA Center meets its goals of reducing unnecessary emergency-department utilization, increasing MOUD initiation and retention, and improving health outcomes for people who use drugs. This includes collecting and submitting required reports, as well as engaging with partners such as emergency medical services (EMS), emergency medicine, opioid treatment programs (OTPs), behavioral health providers, and other community partners. The provider contributes to a model that is scalable, replicable, informed by people with lived experience, and adapts clinical workflows based on data and feedback.

Eligibility Criteria

Medicaid Status	Yes, Medicaid is required for billing; non-Medicaid clients may still receive services
Age Range	18 years and older
Target Population	Adults who overdose in King County
Authorization Needed	No
Authorization Criteria	None
Other Criteria	None

Goals & Objectives

- Improve post-overdose outcomes by providing immediate, harm-reduction–oriented stabilization, rapid access to MOUD, and continuous 24/7 supportive care for individuals recovering from an opioid overdose.
- Strengthen care continuity by integrating care navigation and peer support when available, and timely linkage to ongoing MOUD, primary care, behavioral health services, and other essential health interventions.
- Advance system-level impact by reducing avoidable emergency-department utilization, collaborating with EMS and community partners, and using data-driven quality improvement.

Program Requirements

Key Services

- 24/7 post-overdose stabilization for up to eight individuals who have just experienced an opioid overdose and do not require emergency-department–level care.
- Harm-reduction–oriented clinical support delivered in welcoming, trauma-responsive spaces for first-responder drop-offs and walk-ins.
- Clear admission screening based on medical stability, orientation, and ability to consent to voluntary treatment.
- Continuous monitoring and safety oversight, including observation, de-escalation, and supportive care for clients who may be disoriented or distressed.
- Rapid access to MOUD, including methadone and buprenorphine, with warm handoffs to ongoing treatment providers.
- Integrated care navigation and peer support when available to ensure continuity of care and smooth transitions to longer-term MOUD, primary care, and behavioral health services.
- Education on safer use, overdose risk reduction, and how to reduce health risks from opioid use, tailored to the needs of people who use drugs.
- Basic needs support, including food, showers, and laundry services to promote stabilization and dignity.
- Program evaluation and community collaboration, including data reporting, quality improvement, and coordination with EMS, emergency medicine, OTPs, behavioral health, and community partners.
- DESC will report ORCA critical incidents to the Managed Care Organizations (MCO) where the Medicaid client is enrolled and send a copy to BHRD. DESC will also report ORCA critical incidents involving non-Medicaid clients to BHRD for review. DESC will report ORCA critical incidents according to the categories listed on the corresponding critical incident form for submission to that MCO/BHRD. DESC will report critical incidents that occur at the ORCA Center or during an ORCA Patient Outreach Division (POD) outreach care encounter (and not critical incidents that occur before or after ORCA encounters). See Critical Incidents Program and Reporting Requirements chapter in this provider manual for more details.

Information System Requirements

- See Data Dictionary for program specific data requirements.

Reporting Requirements

BHRD Information System	Submit Data to the BHRD Information System as outlined in the BHRD Data Dictionary and the Required Transactions Sheet in the ISAC Notebook
Monthly Reports	None
Quarterly Reports	None
Semiannual Reports	None
Annual/Other Reports	None
Performance Measurement (PM) Plan	Not currently applicable; reporting requirements and performance measures may be further detailed in an accompanying Performance Measurement plan at a future time. See “Performance Measurement (PM) Plans” section on the Provider Manual and specific program PM Plan for more information

Invoice Program Specific Requirements

Method of Payment

Reimbursement will be made monthly on a unit reimbursement basis until maximum annual allocation is reached.

Additional Requirements

None

4.8 Crisis Diversion Services (Crisis Facilities)

Crisis Diversion Services (Crisis Facilities) provide 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.

4.8.1 Crisis Solution Center (CSC)

The Crisis Solution Center is comprised of two programs: The Crisis Diversion Facility (CDF) and Crisis Diversion Interim Services (CDIS). The CSC programs meet the requirements in WAC 246-341-0901 and the BH-ASO contract.

All CSC staff members have an annual training plan that addresses issues relevant to their work and the populations that they serve. All completed training is documented in each individual staff’s personnel records. CSC staff receive regular, documented clinical supervision from an appropriately qualified professional. Substance use disorder professional trainees (SUDPTs) receive supervision from a certified Substance Use Disorder Professional (SUDP) who meets the requirements in WAC 246-811-049 as an approved supervisor. Supervisory staff will participate in clinical supervision Training relevant to their position.

All CSC staff receive training or provide documentation of previous training that remains currently relevant in, at a minimum, the following topics within the first 90 days:

- Crisis intervention and de-escalation training.

- Contract requirements, as relevant to position, and BHRD Provider Manual overview regarding program service expectations.
- Data collection, reporting, and input expectations.
- Provider clinical program requirements and policies and procedures which guide the program.

Program staff attend relevant community meetings as needed to address neighborhood or program concerns and support, promote the intention of the Good Neighbor Agreement, and to maintain collaboration and communicating with the neighborhood and other local partners. In addition, the program maintains current memoranda of agreement to ensure collaboration and communication with Valley Cities Recovery Place, King County Emergency Services Patrol (ESP), and/or other programs as indicated for specific coordination and care purposed with prior notification to BHRD.
CSC Providers ensure the collection and timely submission of required data and documentation:

- All CSC programs provide and document in the clinical chart referrals and linkages to appropriate community-based services and supports, as well as efforts to assist people in accessing appropriate services and benefits, as indicated, based on the identified needs of each participant.
- Clinical records include documentation of an individual's stated willingness to accept a recommended referral and any reasons provided for refusing a referral.

4.8.1.1 Crisis Diversion Facility

Program Overview

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

Crisis Diversion Facility Eligibility Criteria

Medicaid Status	Serves individuals regardless of Medicaid status
Age Range	Adults Aged 18 Years and Older
Authorization Needed	No
Additional Criteria for CDF	Any individual at least 18 years of age experiencing an emotional and/or behavioral disturbance, including substance use, who meets the following criteria is eligible for services: • Is in emotional or behavioral crisis that would benefit from crisis intervention services; • Agrees to participate in the services; and • Is referred by an eligible referent. Individuals referred to the CDF on a jail diversion 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.

Goals and Objectives

The CDF is a pre-booking or pre-hospitalization diversion program intended to reduce the cycling of individuals with mental health or substance use disorders through the criminal and crisis systems. This facility allows individuals to receive services to both stabilize crises in the moment and to address the situations that cause or exacerbate crises. The CDF focuses on an individual's immediate needs and

facilitating engagement in services and supports in the community to increase community tenure and decrease law enforcement interactions.

Program Requirements
CDF staff have the necessary skills and knowledge to provide crisis stabilization services, with a minimum 4:1 client to staff ratio, including access to medical staff, 24 hours/7 days (24/7) a week. CDF is available 24/7 to respond to and accept referrals. The facility maintains capacity for 16 stabilization beds, with a maximum length of stay of 72 hours, to serve the individuals within the facility. Exceptions to the length of stay will be communicated to Behavioral Health and Recovery Division (BHRD) by email prior to or within 12 hours after the decision is made. BHRD will determine whether follow-up is indicated based on the rationale for the extension.
The CDF program accepts referrals from the following first responders:

- Law enforcement agencies in King County;
- Fire Department agencies in King County;
- Designated Crisis Responders (DCRs) in King County;
- Hospital Emergency Departments (EDs) in King County;
- Mobile Rapid Response Crisis Teams (MRRCT) in King County;
- King County Emergency Service Patrol; and
- Seattle Community Assisted Response and Engagement (CARE)

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

Every effort will be made to accommodate referrals that meet eligibility criteria for the program. CDF staff participate in a telephone screening call with all referral sources prior to accepting an individual into the facility. This screening allows the facility to determine appropriate response and intervention based on the individual's needs, clinical history, and presenting symptoms, as well as capacity to accept referrals, and may include referrals to alternative services in lieu of admission. Capacity issues are managed by CDF staff who may decline a referral if it does not appear that the facility will have any discharges within 2 hours of the referral. Pending discharges that are expected to occur within 2 hours of the referral will allow an individual to be brought to the facility despite full capacity at time of referral.

Individuals accepted by referral to the facility via phone screening will be seen in a timely manner upon arrival at the CDF to minimize the waiting time for law enforcement and other first responders. All individuals will receive an initial physical health screening by a medical provider prior to admission to determine medical eligibility; individuals admitted to the facility will receive an individual needs assessment within three hours of admission. Individuals who arrive at the facility without a referral from an eligible referent, i.e., walk-ins, will not be admitted to the facility; however, will be provided with assistance in identifying available resources and support services as indicated.

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

CDF program services include: stabilization services; behavioral health services and peer support; psychiatric services; case management services that focus on specific linkage with needed services

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

Clinical records are maintained for all CDF participants admitted to the facility that detail the current presenting problem, the context of the referral, condition and functioning of the individual, an assessment of the individual's basic needs and mental health and substance use disorder service needs, and regular notations regarding services provided and progress on goals.

CDF provides a seclusion and restraint-free environment that utilizes a recovery-oriented care system model and principles of trauma-informed care, maintains the safety of service recipients and staff, and promotes dignity and self-determination for individuals who are in crisis. Entry and exit doors are equipped with time delay locks and other security measures, such as video monitoring of all entrances and exits, to allow for continuous monitoring of the facility space and the ability to immediately address client crisis response needs or safety concerns.

Jail diversions to the CDF from law enforcement are done in line with the CSC Law Enforcement Protocol, Jail Diversion Criteria for Crisis Diversion Facility. CDF staff will ask law enforcement's preference regarding notification if an individual who is brought to the CDF on a jail diversion agreement chooses to leave the facility without clinical agreement. In instances where law enforcement requests notification, the CDF staff ensures law enforcement is 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 completed all requirements as determined by CDF staff, the Provider may also contact the appropriate prosecuting authority to report the individual's success.

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

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

Crisis Diversion Facility services are guided by the following WACs or any successors:
WAC 246-341-0715 – Crisis support services—Service standards

Crisis Diversion Facility Reporting Requirements

BHRD Information System	Submit Data to the BHRD Information System as outlined in the BHRD Data Dictionary and the Required Transactions Sheet in the ISAC Notebook

Monthly Reports	• CDF Actual Monthly Expenditures Report, and Detailed Budget Breakdown for All Program Expenditure; • CDF Monthly Report;
Quarterly Reports	• CDF Quarterly Report. • Trueblood Enhanced Crisis Stabilization Services Quarterly Report • Enhanced Crisis Stabilization Services Staff Details
Semiannual Reports	None
Annual/Other Reports	• MIDD Annual Narrative Report • Other reports as needed
Performance Measurement (PM) Plan	Reporting requirements and performance measures are further detailed in an accompanying Performance Measurement plan. See "Performance Measurement (PM) Plans" section on the Provider Manual and specific program PM Plan for more information

Invoice Program Specific Requirements

Method of Payment

- Reimbursement will be made monthly on an actual cost basis for allowable CDF costs.

Additional Requirements

- Provide detailed monthly breakdown of expenses by budget category.
- Allowable costs are outlined in the agency's approved budget. Providers will receive approval from King County prior to purchasing any items not included in the approved budget.
- Provide copies of proof of purchases and payments for client assistance, equipment, or miscellaneous expenses not included as part of basic program operations.
- Receipts will be maintained for all purchased and will be made available to BHRD for review upon request

4.8.1.2 Crisis Diversion Interim Services

Program Overview

Crisis Diversion Interim Services (CDIS) provides step-down, facility-based services for individuals discharging from the CDF as needed and appropriate, to support them in their transition to the community or other supportive services.

Eligibility Criteria

Medicaid Status	Serves individuals regardless of Medicaid status
Age Range	Adults Aged 18 Years and Older
Authorization Needed	No
Additional Criteria for CDIS	Any individual at least 18 years of age referred by the CDF staff based on the following eligibility criteria: • Homeless or at risk for homelessness, • Current living situation may be dangerous or has the potential to send the individual into crisis again, • Additional support needed address immediate needs, or • If clinically indicated and appropriate as assessed by program staff, and • Agrees to participate in the services

Goals and Objectives
The CDIS program works to increase access to support the individual upon discharge and reduce the utilization of crisis system services and engagement with first responders. CDIS staff engage with individuals to help identify and directly link them to ongoing services in the community, utilizing case management, resource navigation, and other needed services.

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

CDIS staff have the necessary skills and knowledge to provide intensive case management services, including access to medical staff, 24 hours/7 days per week. The facility provides an environment that maintains the safety of service recipients and staff and promotes dignity and self-determination for individuals in crisis. CDIS maintains capacity for 30 interim respite beds with a maximum length of stay of 14 days, to serve the individuals within the facility. Exceptions to the length of stay are allowed only with prior approval by Behavioral Health and Recovery Division (BHRD). In circumstances where prior notice is not possible, the exception to and rational for the extended length of stay will be communicated to Behavioral Health and Recovery Division (BHRD) via email within 12 hours after the decision is made. BHRD will determine whether follow-up is indicated based on the rationale for the extension. Case management services focus on accessing benefits/entitlements as well as coordination and linkage with needed community services and supports as soon as possible to ensure linkages are made with new or current services Providers before discharge.

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

The CDIS provides a seclusion and restraint-free environment that utilizes a recovery-oriented care model and principles of trauma-informed care, maintains the safety of service recipients and staff, and promotes dignity and self-determination for individuals who are in crisis. Entry and exit doors are equipped with time delay locks and other security measures, such as video monitoring of all entrances and exits, to allow for continuous monitoring of the facility space and the ability to immediately address client crisis response needs or safety concerns.
The CDIS program includes the following validated tools and evidence-based practices:

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

- Peer Support services

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

- *WAC 246-341-0715 – Crisis support services—Service standards.*
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Reporting Requirements

Crisis Diversion Services Reporting Requirements	
BHRD Information System	Submit Data to the BHRD Information System as outlined in the BHRD Data Dictionary and the Required Transactions Sheet in the ISAC Notebook
Monthly Reports	• CDIS Actual Monthly Expenditures Report, and Detailed Budget Breakdown for Each Program Expenditure; • CDIS Monthly Report;
Quarterly Reports	CDIS Quarterly Report.
Semiannual Reports	None
Annual/Other Reports	MIDD Annual Narrative Report
Performance Measurement (PM) Plan	Reporting requirements and performance measures are further detailed in an accompanying Performance Measurement plan. See “Performance Measurement (PM) Plans” section on the Provider Manual and specific program PM Plan for more information

Invoice Program Specific Requirements

Method of Payment

- Reimbursement will be made monthly on an actual cost basis for allowable CDIS costs.

Additional Requirements

- Provide detailed monthly breakdown of expenses by budget category.
- Allowable costs are outlined in the agency’s approved budget. Providers will receive approval from King County prior to purchasing any items not included in the budget.
- Provide copies of proof of purchases and payments for client assistance, equipment, or miscellaneous expenses not included as part of basic program operations.
- Receipts will be maintained for all purchases and will be made available to BHRD for review upon request

4.8.2 Crisis Response Center

Crisis Response Center is a Behavioral Health treatment hub offering multiple levels of care, from monitoring and assessment to referrals and inpatient treatment. The Crisis Response Center is open 24 hours per day, seven days per week, and utilizes a "no wrong door" approach by accepting walk-ins, referrals, and drop-offs. Staffing is made up of nurses, behavioral health medical practitioners, case managers, and peer support specialists, ensuring appropriate, least-restrictive levels of care and continuity of treatment upon discharge. Contracted services may include Urgent Care, Crisis Stabilization, 23 Hour Observation, Evaluation and Treatment, and Transitional Care.

4.8.2.1 Crisis Response Center Transitions

Program Overview

Crisis Response Center Transitions is post-acute, outpatient, wraparound care for an individual exiting Crisis Response Center behavioral health services. Registered Nurses ensure appropriate follow-up care and connection to services by following up with patients via phone or text with 72 hours of

discharge. These follow-up calls include assessment of needs, medication management, and care coordination, working toward a warm hand-off to a suitable long-term outpatient provider. Services are scalable and tailored to individual needs and may last for up to 90 days following discharge.

Invoice Program Specific Requirements

Method of Payment

- Reimbursement will be made in monthly 1/12th amounts for Crisis Response Center Transitions.

Additional Requirements

- Payment will be made by the 11th of the month for the month in which services are being provided.

Crisis Response Center Transitions Eligibility Criteria	
Medicaid Status	N/A
Age Range	Youth (over 8) or Adults
Authorization Needed	No
Additional Criteria	Services are for patients who have been discharged from Crisis Response Center post-acute care
Crisis Response Center Transitions Required Reports	
Monthly Reports	TBD
Quarterly Reports	TBD
Semiannual Reports	TBD
Annual Reports	TBD
Performance Measurement (PM) Plan	None

4.8.2.2 Sixteen Bed Evaluation and Treatment

Refer to Provider Manual section Sixteen Bed Evaluation and Treatment Facility Service.

4.9 Voluntary Inpatient Care

Receipt of Referral Request

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

Healthcare Professionals Involved in UM Decision-Making

- Crisis Connections uses licensed health care professionals to make authorization decisions that require clinical judgement.
- The following persons may approve services:
- Licensed health care professionals (WAC 246-341-0200) and/or training as substance use disorder professional (WAC 246-811-010 and RCW 18.205)

- Crisis Connections uses a senior-level behavioral health physician to oversee UM activities and make medical necessity denial decisions. The senior-level behavioral health physician is board-certified or board eligible in Psychiatry, Child and Adolescent Psychiatry, or Addiction Medicine.

Medical Necessity Review

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

UM Decision-Making Criteria

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

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

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

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

Prior-Authorization Decision-Making and Notification
Crisis Connections carries out a thorough medical necessity review according to standards and guidelines described above.

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

Notification of Service Coverage or Authorization

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

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

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

The Notice of Service Authorization is created by Crisis Connections at the time of authorization. All Notice of Authorizations forms are sent in accordance with timeframe standards described below.

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

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

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

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

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

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

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

- The reviewer's handwritten signature or initials (including credentials and title); or
- The reviewer's unique electronic signature (including credentials and title) or;
- A signed or initialed note from the UM staff person, attributing the denial decision to the professional (including credentials and title) who reviewed and decided the case.
- Crisis Connections provides an opportunity for a peer-to-peer review with the referring Provider, prior to the final denial decision being made.
- The peer-to-peer review is conducted between the Crisis Connections behavioral health physician and the referring Provider or facility.

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

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

Retrospective Authorization Requests

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

For non-Medicaid individuals:

- A retrospective authorization may occur when an inpatient day was provided without a previous request for authorization. This applies to cases where initial authorization was not obtained or when a length-of-stay extension request was not made within the requested timeframe for a person currently admitted to the hospital.
- Requests for retrospective authorization are considered only:
- When the person applies for Health Care Authority (HCA) medical program coverage during the course of the hospitalization (for the days which have occurred prior to the application) or following discharge; or
- When the failure to request a prior authorization occurred for reasons beyond the control of the hospital.

Retrospective Authorization Decision-Making and Notification Timeliness

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

Continued Stay Authorization Request

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

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

Continued Stay Authorization Decision-Making and Notification Timeliness

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

Special Circumstances

Change in Primary Diagnosis

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

Electroconvulsive therapy (ECT)

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

Change in Legal Status

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

Children and Youth

- Children 13 years of age or older can be admitted for treatment with their written consent if the treatment facility's professionals agree and parents or guardians are not available. Parent(s)/ guardian(s) must be notified of such an admission, and they have the right to demand release

unless the treatment facility petitions the court, or the youth has requested that the parent not be notified.
- A minor (any person under age 18) may be voluntarily admitted by application of the parent or guardian ("parent-initiated treatment" or PIT). The consent of the minor is not required for the minor to be evaluated and admitted as appropriate

.

4.10 Involuntary Inpatient Care

Medical Necessity

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

Initial Screening and Admission

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

Continuing Stay Criteria and Authorization of Extensions

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

Discharge and Termination

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

- Once given, the available number of admission days will not be terminated. However, a hospital may discharge a client before maximum number of allowable admission days has been reached. When an individual is discharged, the hospital must notify the BH-ASO care authorizer.

4.11 Other Crisis Services

Other Crisis Services consist of programs that fall outside of Crisis Response Centers and Crisis Outreach Services.

4.11.1Patient Placement Coordination

Patient Placement Coordination is 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.

Invoice Program Specific Requirements

Method of Payment

- Reimbursement will be made in monthly 1/12th amounts for services provided.

Additional Requirements

- None

Patient Placement Coordination Eligibility Criteria	
Medicaid Status	N/A
Age Range	N/A
Authorization Needed	No
Additional Criteria	Any individual or any person acting on behalf of an individual for whom a mental health disorder cannot be ruled out
Patient Placement Coordination Reporting Requirements	
Monthly Reports	Patient Placement Coordination (PPC) Outcomes Summary Report Patient Placement Coordination (PPC) Call Volumes Summary Report
Quarterly Report	None
Semiannual Reports	None
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

Performance Measurement (PM) Plan	None

4.11.2 Phone Support for Crisis and Commitment Services

Program Overview

Phone Support for Crisis and Commitment Services is 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.

Public Telephone Line: 206-263-9200 Professional Telephone Line: 206-263-9202

Phone Support for Crisis and Commitment Services Eligibility Criteria	
Medicaid Status	N/A
Age Range	N/A
Authorization Needed	No
Additional Criteria	Any individual or any person acting on behalf of an individual for whom a mental health disorder cannot be ruled out
Phone 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
Quarterly Reports	None
Semiannual Reports	None
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.
Performance Measurement (PM) Plan	None

4.11.3 Warm Line

Program Overview

The Warm Line is emergency telephone support services with Certified Peer Support Specialists for individuals experiencing a non-life-threatening behavioral health crisis. Warm Line services are available for a minimum of seven 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.

Invoice Program Specific Requirements

Method of Payment

- Reimbursement will be made in monthly 1/12th amounts for telephone services provided by a peer.

Additional Requirements

- None.

Warm Line Eligibility Criteria	
Medicaid Status	N/A
Age Range	N/A
Authorization Needed	No
Additional Criteria	Any individual or any person acting on behalf of an individual for whom a mental health disorder cannot be ruled out.
Warm Line Reporting Requirements	
Monthly Reports	• Warm Line Call Report • Warm Line Volunteer Report • Warm Line Profit & Loss Report • Warm Line Trial Balance Report
Quarterly Reports	• RH Call Status Report • Warm Line Caller Data Report • Warm Line Access Report • Warm Line Reconciliation Report
Semiannual Reports	None
Annual/Other Reports	Warm Line Yearly Access Report
Performance Measurement (PM) Plan	None

4.12 Post-Crisis Follow-Up by Providers with Expertise in Culturally and Linguistically Appropriate Services

Program Overview

Post-Crisis Follow-Up (PCFU) by Providers with Expertise in Culturally and Linguistically Appropriate Services (CLAS) is a voluntary clinical service that supports the ongoing recovery and well-being of individuals after they have experienced a behavioral health crisis and have been cared for by a Crisis Care Center. PCFU serves as a bridge to provide short-term high-intensity support services for mental health and substance use needs while linking individuals to ongoing community-based services. CLAS

is emphasized within this program to ensure that PCFU services meet the needs of those who experience ongoing inequities related to behavioral health.

Eligibility Criteria	
Medicaid Status	No
Age Range	Adults 18 and older
Target Population	Individuals who have recently experienced a behavioral health crisis and accessed a Crisis Care Center or other similar service who would be likely to benefit from time-limited high-intensity behavioral health supports
Authorization Needed	No prior authorization required. Concurrent review at 30, 60, and 90 days
Authorization Criteria	Level of Care Utilization System (LOCUS) care recommendation at level 4 or above
Other Criteria	Crisis Care Center referrals prioritized

Goals & Objectives
The goal of PCFU is to provide direct support and connect clients to new and/or existing community-based services after they have experienced a behavioral health crisis and access a Crisis Care Center, regardless of Medicaid status. This additional post-crisis support is intended to help ensure clients receive sufficient follow-up and are successfully linked to behavioral health treatment, additional community-based resources, and relevant social services.

Program Requirements
PCFU provides post-crisis support for a period of 30 – 90 days, after an individual has experienced a behavioral health crisis and accessed a Crisis Care Center. PCFU services utilize clinical best practices that are trauma-informed, recovery-oriented, and person-centered to offer direct support and connect each person to community-based services to promote longer-term stability in the community.
PCFU providers meet the requirements as indicated in WAC 246-341-0700 as well as the following:

Staffing

- PCFU providers utilize multidisciplinary teams and at a minimum include one or more Mental Health Professionals (MHP), Peer Specialists, and Care Coordinators.
- PCFU providers may have the opportunity to expand operational capacity in alignment with anticipated increases in referral volume as additional Crisis Care Centers open. PCFU providers may request additional financial resources to support team expansion, which may be approved at the sole discretion of DCHS. If approved, PCFU providers develop and maintain a staffing plan that ensures the timely scaling of capacity consistent with these expectations.
- PCFU providers ensure each PCFU staff maintains a Washington State Department of Health (DOH) license or credential in good standing.

Increase Equitable Access to Behavioral Health Care

- Per National CLAS Standards, PCFU providers implement CLAS best practices, including but not limited to:
  - Provide effective, equitable, understandable, and respectful quality of care and services that are responsive to the diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs, including American Sign Language (ASL);

- Recognize the need for culturally appropriate explanations of mental health concepts and accommodate alternative therapies, culturally specific healing practices, and religious practices (e.g., prayer times, dietary restrictions);
- Ensure timely access to translation and interpretation services;
- Ensure accessibility for clients who are experiencing or at risk of homelessness to address significant barriers to accessing behavioral health care for this population;
- Develop tailored approaches to emphasize frequent engagement and lower threshold entry points in accessing services;
- Recruit and retain a representative, diverse, qualified, and multidisciplinary workforce of the communities served;
- Providing culturally appropriate trainings for all staff;
- Participate in and respond to equity-focused evaluation activities, including those aimed at identifying disparities, intervening with community-driven solutions, and monitoring for ongoing improvements or persistent inequities in need of further action; and
- Develop quality improvement strategies to promote health equity.

Support and Center the Work of Certified Peer Support Specialists

Certified Peer Support Specialists are embedded within PCFU Services. Certified Peer Support Specialists:

- Provide 1:1 engagement with clients to enhance overall PCFU program engagement, promote recovery, support navigation to subsequent services, and strengthen coordination with the broader PCFU team;
- Attempt to be among the first staff members to engage newly referred PCFU clients, when feasible; initiate engagement when referred to a PCFU provider, when feasible;
- Collaborate with peer-led and peer-driven organizations and community groups, and refer and/or link clients to them when appropriate;
- Develop a peer supervision structure (see WAC 182-115-0100); and
- Receive training within their scope of practice.

Referral Routing

- PCFU providers prioritize clients referred from Crisis Care Centers. Additional referral sources may be established and approved, as is mutually agreed upon.
- All individuals receiving services at a Crisis Care Center may be eligible for PCFU; however, in the event that projected demand exceeds available capacity, referral prioritization criteria may be implemented by the referring Crisis Care Center, with prior approval by DCHS, based on the following conditions:
  - Discharge from the 23-Hour Observation Unit or Crisis Stabilization Unit of a Crisis Care Center;
  - Ongoing, persistent safety concerns (risk of harming self or others after the crisis), not requiring inpatient or involuntary care;
  - Identified needs for ongoing support and follow-up to address unmet behavioral health needs and/or social determinants of health (e.g., homelessness, lack of access to behavioral health & medical care, socioeconomic status, lack of social supports, facing systemic discrimination and/or trauma) to mitigate future crises;
  - Being part of marginalized and/or underserved groups requiring CLAS;
  - While at a Crisis Care Center prior to referral for PCFU services, received a Level of Care Utilization System (LOCUS) assessment that results in a recommendation of level 4 (Medically Monitored Non-Residential Services), level 5 (Medically Monitored Residential Services) if the client declines residential placement or none is available in a timely manner, or level 6 (Medically Managed Residential Services) if inpatient hospitalization is voluntarily declined and no other appropriate options are available.

- PCFU providers accept referrals from Crisis Care Centers, which will be routed in the following manner:
  - PCFU providers receive referrals equitably on a regular rotation;
  - If a client need is identified that may benefit from a PCFU provider's specialized expertise, the referral may be prioritized for the PCFU provider that most appropriately aligns with the client's identified behavioral health needs, including but not limited to language capacity, housing status, geographic location, and the PCFU provider's specialty population;
  - If a client has previously been referred to a PCFU provider, the referral may be prioritized to refer back to that same provider, subject to the client's preference, when known; and
  - If the identified specialty team is unable to accept the referral, the Crisis Care Center reassign the referral to an alternative PCFU provider with the same identified specialty if applicable or based on the ongoing referral rotation.
  - PCFU providers may decline referrals based on criteria including, but not limited to:
    - LOCUS assessment that results in recommendation of level 3 or lower;
    - Referral made by non-Crisis Care Center referral source or the Behavioral Health Urgent Care (BHUC) component of the Crisis Care Centers; and
    - PCFU Provider is above 20% surge census, as indicated in 'PCFU Engagement' section.

Services

PCFU delivers services to eligible individuals during the high-risk period immediately following a behavioral health crisis, addressing a full range of behavioral health needs. PCFU also functions as a bridge to connect individuals with ongoing services including mental health treatment, substance use services, medical care, housing resources, and other community-based social supports. Additional services include:

- Proactively initiate initial contact with the client, either prior to or following discharge from a Crisis Care Center (see 'PCFU Engagement' for additional details), through in-person or telehealth modalities based on staffing capacity, and maintain regular engagement while a client is connected to PCFU services;
- Facilitate linkages and referrals to community-based behavioral health, healthcare, housing, and social service resources that align with the client's identified needs and preferences;
- Deliver brief interventions to address any mental health and/or substance use treatment needs while the client awaits connections to ongoing community-based services or higher levels of care;
- Support access to psychiatric medications, which may be arranged through the BHUC, or directing providing psychiatric evaluations and medication management directly as clinically indicated;
- Conduct risk assessments and update safety planning, as clinically indicated; and
- Work collaboratively with community-based partners to ensure coordinated care transitions both from and to community-based services. PCFU providers support clients in navigating services provided directly by PCFU and by local community partners, taking into account geographic considerations and transportation infrastructure. Activities may include, but are not limited to:
  - Establishing and implementing standards for regular communication with new and existing providers;
  - Conducting warm handoffs that include direct team-to-team communication regarding relevant clinical information and service needs to support transition of care from PCFU to the next appropriate, least restrictive care level of care; and
  - Maintaining current and accurate information regarding local community resources.

PCFU Engagement

- PCFU providers engage proactively with clients throughout PCFU engagement. PCFU providers meet high-acuity needs by engaging with clients frequently – at least once per week, with

engagements lasting 1-2 hours for each individual per week, adjusting for participant preference and clinical acuity while still maintaining weekly engagement requirements.

- PCFU services may be provided via in-person office visits, community-based outreach, or telehealth (e.g. video calls, telephone calls, etc.).
- PCFU providers and DCHS collaboratively establish baseline caseload expectations and operational thresholds for temporary surge capacity.
- Initial contact and engagement timeline after receiving a referral are determined by a PCFU's team's availability to accept new clients into their program:
  - When PCFU provider has availability:
    - PCFU providers initiate outreach attempts by the next business day following referral receipt. Initial engagement includes successful in-person, telehealth, phone, text, outreach-based, or collateral contact efforts documented in the client record. Providers make best efforts to complete direct client engagement as clinically appropriate and feasible, preferably prior to Crisis Care Center discharge;
    - PCFU providers provide at least one direct contact with 90% of referrals, excluding clients that decline PCFU services after initial referral. After initial engagement is completed, PCFU providers schedule and complete the first post-Crisis Care Center discharge contact within three (3) business days.
  - When PCFU team is at capacity:
    - PCFU providers continue to accept any new referrals, creating capacity by discharging clients who are clinically assessed to not require PCFU-level of need within the next 7 business days in order to ensure flow through the program and maintain ability to accept new referrals;
    - PCFU providers may surge 20% beyond typical caseloads under extenuating circumstances on a short-term basis;
  - When normal caseloads, as agreed upon with DCHS, are exceeded for longer than a week and/or beyond 20% above the usual maximum, the PCFU provider may request DCHS approve a pause on new referrals.
  - PCFU hours of operation range from Monday – Friday with the goal of the overall PCFU referral system demonstrating that 90% of initial engagements occur by the next business day.
  - If clients experience an imminent behavioral health crisis, they will be directed to call 988/Regional Crisis Line at Crisis Connections for a Mobile Rapid Response Crisis Team (MRRCT) referral, or potentially to return to the Crisis Care Center.

Psychiatric Provider/Medications Access

PCFU providers will be able to utilize Regional Crisis Care Centers' Behavioral Health Urgent Care (BHUC) or directly provide psychiatric evaluations and medication management to facilitate timely access to psychiatric medications for clients who require such treatment.

Transition Planning

- PCFU providers collaborate with each client to determine appropriate referrals to community-based services with the goal of supporting the client in the least restrictive, clinically appropriate setting.
- PCFU providers ensure all referral, transition, and discharge decisions incorporate CLAS best practices, see 'Increase Equitable Access to Behavioral Health Care' for additional details.
- PCFU providers regularly monitor their census monthly and proactively plan for clients who are sufficiently stable for discharge to ensure capacity for new PCFU referrals.
- PCFU providers re-evaluate each client's LOCUS score at the 30, 60, and 90-day mark and evaluate whether clients have achieved sufficient stability, including LOCUS score below 4, to transition out of PCFU services.

- PCFU Providers provide care coordination to support safe, smooth, and effective transition, including facilitating warm handoffs to transfer care to existing or newly identified providers and connecting clients with appropriate behavioral health, medical, or social services referrals as needed.
- PCFU providers maintain regular engagement until confirmation of successful linkages and/or transition to ongoing services.
- PCFU providers collaborate with DCHS to develop and implement an intake assessment workflow that supports smooth and timely connection of clients to outpatient behavioral health services.
- Clients are generally expected to discharge from PCFU services prior to 90 days; a short-term extension of services may be requested to DCHS for the following reasons, including, but not limited to:
  - Persistent LOCUS care recommendation at level 4;
  - External delays driven by community-based providers unable to facilitate timely connections to behavioral health resources and services; and
  - Ongoing, persistent safety concerns at time of PCFU discharge.

Provide Housing/Rental Assistance Resources

- PCFU teams provide outreach-based follow-up and facilitate linkages to existing housing and social service resources for clients experiencing or at risk of experiencing homelessness.
- When necessary, and contingent upon both the availability of CCC Levy funds and prior approval by DCHS, PCFU providers may access limited housing/rental assistance resources made available by DCHS and/or other entities, including but not limited to:
  - Hotel vouchers/short-term hotel stays (maximum of 5 nights per PCFU Episode, defined as the full duration of a client's participation in PCFU from initial engagement through program exit), for clients that have been clinically assessed by an MHP to be independently successful in those environments and have confirmed availability of longer-term housing (90 days or longer);
  - First and/or last month's rent and/or security deposit if the client is able to independently sustain ongoing monthly rent payments;
  - Rapid rehousing funds;
  - Rental assistance housing vouchers;
  - Other housing subsidies;
  - Plane or bus ticket(s) for clients moving to a confirmed, longer-term housing option of 90 days or longer;
- PCFU providers confirm longer-term housing options lasting 90 days or longer prior to utilizing housing/rental assistance funds. PCFU teams submit invoices for housing/rental assistance funds monthly to DCHS, up to the annual maximum Not to Exceed (NTE) amount. Housing/Rental Assistance funds are subject to change based on DCHS' sole discretion.

Provide Transportation while Accessing the Program

- PCFU providers arrange transportation assistance for clients currently engaged with PCFU and maintain sufficient mobile capacity to support geographically distributed client needs.
- Transportation support prioritizes enabling client needs to access services to which they have been referred to by PCFU providers. Transportation is provided or arranged whenever feasible to ensure that clients can efficiently attend PCFU appointments and subsequent care settings.
- Providers may utilize transportation funds to support travel between PCFU appointments and other community-based behavioral health and social services appointments, as clinically or programmatically appropriate. PCFU providers first seek reimbursement through all available funding mechanisms, including Medicaid-funded Non-Emergent Medical Transport brokerage programs, whenever possible. Modes of transportation include, but are not limited to:

- Drivers from PCFU providers utilizing vehicles purchased, licensed, and maintained by the PCFU provider;
- Access to Metro (bus/train passes, other ways of arranging payment);
- Taxi vouchers and/or re-payment through rideshare platforms;
- Non-Emergency Medical Transport (NEMT), which is an insurance-reimbursed service arranged through a broker (e.g., HopeLink) with wait times 1-2 days for scheduled pickup (e.g., planned appointments to community-based behavioral health and/or social services).

Engage Crisis System Partners

- PCFU providers collaborate with Crisis Care Center operators and other referral sources, subject to available capacity, through coordination facilitated by DCHS. DCHS leads and supports ongoing and active coordination, refine referral criteria, and improve overall workflows. Collaborative activities may include, but are not limited to, the following:
  - Participating in regular ongoing (meeting cadence TBD) check-in meetings facilitated by DCHS to review processes, identify issues or concerns, share successes, review data, and provide program updates;
  - Engaging in onboarding support, cross-training, and other opportunities coordinated by DCHS to enhance mutual understanding of roles, responsibilities, and procedures;
  - Participating jointly in community engagement activities, including co-hosting events;
  - Establishing and maintaining clear pathways for partners to provide feedback and for such feedback to be reviewed and addressed by the parties.
  - Engaging with jurisdictions within each Crisis Response Zone and throughout King County, under the leadership and coordination of DCHS, to maintain working relationships with elected officials and municipal government leaders, to co-convene community engagement opportunities, and address community concerns and complaints in partnership with local jurisdictional representatives.

Facilitate Community Engagement

- PCFU providers collaborate with community partners, with the support of DCHS, to ensure that the PCFU clinical model is responsive to local community needs and reflective of the diversity and unique characteristics of the populations served. Community collaboration and responsiveness include, but not limited to:
  - Actively and regularly seeking input from clients and families with lived or living experience, community members representing the populations served, and partners in community-based organizations, religious institutions, schools, and other relevant settings to assess whether services are meeting community needs and identify service gaps; and
  - Incorporating community feedback into program improvements to enhance service quality responsiveness, with progress on these efforts reviewed during regular check-in meetings with DCHS.

Engage in Continuous Quality Improvement and Technical Assistance

- PCFU providers participate in ongoing oversight and quality improvement activities led by DCHS related to administration and performance of the crisis services continuum in King County. Activities include, but not limited to:
  - Participating in quality improvement initiatives designed to enhance coordination, communication, and operational alignment across crisis system partners;
  - Reviewing and analyzing service delivery data including data reflecting disparities in access, utilization; and
  - Collecting satisfaction surveys regarding clients' experience in the program.

Follow Up Responsibilities
PCFU providers proactively attempt to engage with the client to initiate and maintain engagement throughout a client's PCFU episode of care If PCFU providers are unable to locate or directly initiate engagement with a client within the first 30 days, the participant will be discharged from PCFU.
If a client ceases to engage, PCFU provider make at least three (3) separate efforts to re-engage. If a client specifically requests to be discharged from PCFU, PCFU provider make every effort to provide options for care, and honor client's choice by discharging from PCFU.
As a client is nearing their transition from PCFU services, PCFU may support care continuity through offering ongoing community-based services when appropriate for a period to be determined by the provider as long as capacity is maintained for PCFU services. PCFU client assistance, housing assistance, and/or transportation funds are not be used to support a client after they have been exited from services.

Capacity Building/Technical Assistance (CB/TA)
PCFU providers may request access to resources for CB/TA to support high-quality clinical service, provide inclusive care for populations experiencing behavioral health inequities, and comply with regulatory requirements. PCFU providers must provide 30 days' notice via email and must receive approval from DCHS prior to utilizing funding dedicated to CB/TA.
Activities related to assisting PCFU providers to deliver high-quality clinical services include, but not limited to:

- Building their organizational capacity to provide and secure payment for delivering post-crisis follow-up and related services;
- Strengthening organizational infrastructure;
- Enhancing data and information technology systems;
- Developing Medicaid and other health insurance billing infrastructure; and
- Investing in workforce development, staff training, and worker wellbeing.

Formal Agreements
PCFU providers and Crisis Care Center operators maintain a system for coordinating processes through a mutually agreed-upon formal agreement that defines relevant processes to support both programs and their clients to facilitate effective and efficient referral processes, transfer of care, and information sharing. The formal agreement will be collaboratively reviewed and updated annually by PCFU providers and Crisis Care Center operators. Payment are withheld until the formal agreement has been received by DCHS.
The formal agreement is maintained by both PCFU providers and Crisis Care Center operators and includes, but not limited to:

- Facility access and space coordination (e.g. appropriate access into the CCC facility, staff coordination, dedicated space for PCFU providers, emergency contacts, etc.);
- Care coordination (e.g. collaborating to exchange relevant collateral information, coordination of care, transition planning, etc.);
- Medication access at BHUC (e.g. medication refill limitations, etc.);
- Referral routing and capacity management (e.g. how referrals will be routed, communication of capacity limitations, see 'Referral Routing' for additional details, etc.); and
- Ongoing consultation and handoff support (e.g. establish care consultation meetings as needed to facilitate warm handoffs or discuss complex care needs for individuals, see 'Engage Crisis System Partners' for additional details, etc.)

Training
Documentation of training completion is maintained in the staff's personnel record.
PCFU providers will also partner with the Crisis Training Academy provider – Harborview Behavioral Health Institute (BHI), to identify training needs, develop training plans for PCFU staff, and

schedule/complete trainings in established safety parameters for outreach engagements, including but not limited to:

- Trauma Informed Care
- De-escalation Techniques
- Harm Reduction
- Developmentally Appropriate Services

Invoice Program Specific Requirements

Method of Payment

- Reimbursement is made monthly for services on a cost reimbursement based on reconciliation of actual, documented costs for PCFU services.
- DCHS provides funds that may be used to cover a client's modest and variable needs subject to available funding. Not to Exceed (NTE) limits are implemented to function as budgetary controls that establish maximum allowable spending for each expense category and ensure all expenditures remain aligned with PCFU program intent, fiscal accountability requirements, and available funding. Each PCFU provider ensures that all expenditures remain within their assigned NTE limits. The following expense categories are subject to each PCFU provider's NTE limits and shall not exceed each PCFU provider's specified NTE amount:
  - One-Time Start-Up
  - Transportation Costs
  - Client Assistance
  - Housing Assistance
  - Workforce Wellbeing
  - Indirect Costs

Additional Requirements

Documentation of training completion is maintained in the staff's personnel record.
PCFU providers will also partner with the Crisis Training Academy provider – Harborview Behavioral Health Institute (BHI), to identify training needs, develop training plans for PCFU staff, and schedule/complete trainings in established safety parameters for outreach engagements, including but not limited to:

- Trauma Informed Care
- De-escalation Techniques
- Harm Reduction
- Developmentally Appropriate Services
- PCFU providers are responsible for tracking expenditures, maintain adequate internal controls,
- and submitting monthly expenditure reports to DCHS to demonstrate ongoing compliance with their assigned NTE limits and PCFU budget overall. Expenditures exceeding a PCFU provider's NTE may result in denied reimbursement beyond the NTE limits and may result in corrective action at the discretion of DCHS.
- Funding availability and NTE limits are subject to change at the discretion of DCHS. PCFU providers will be notified of any adjustments in accordance with DCHS procedures.

Reporting Requirements	
BHRD Information System	Submit Data to the BHRD Information System as outlined in the BHRD Data Dictionary and the Required Transactions Sheet in the ISAC Notebook
Monthly Reports	PCFU Expenditures Report

Quarterly Reports	TBD
Semiannual Reports	TBD
Annual/Other Reports	Crisis Care Centers Levy Provider Narrative Survey Documents for Annual Crisis Agency Review
Performance Measurement (PM) Plan	Reporting requirements and performance measures are further detailed in an accompanying Performance Measurement plan. See "Performance Measurement (PM) Plans" section on the Provider Manual and specific program PM Plan for more information

4.13 Regional Crisis Care Center

Program Overview

Regional Crisis Care Centers, which are defined in King County Ordinance 19572, are Behavioral Health care facilities where a person experiencing a mental health and/or substance use crisis (referred to collectively as a Behavioral Health crisis) can access in-person behavioral health services and supports. People visiting the Regional Crisis Care Centers feel welcome and safe and are treated as guests, and this is the term that will be used throughout the rest of this scope of work to describe people who access services at Regional Crisis Care Center.

A Regional Crisis Care Center has four attributes:

1. Clinical scopes of work (see respective entries in the BHRD Provider Manual)
    - Regional Crisis Care Center Behavioral Health Urgent Care (BHUC)
    - Regional Crisis Care Center 23-Hour Observation Unit and
    - Regional Crisis Care Center Crisis Stabilization Unit (CSU)
2. Services
    - Triage
    - Screening
    - Interventions
    - Transition Planning
3. Facility: Physical location where clinical scopes are delivered
4. Operator: Contracted Behavioral Health Agency that provides Regional Crisis Care Center services

Including these three clinical scopes in each Regional Crisis Care Center helps provide different levels of care depending on each guest's needs. By providing a range of levels of care within a single setting, Regional Crisis Care Centers meet the needs of all people coming for help, which is essential to the "No Wrong Door" model. See Attachment A Crisis Care Center Model

Crisis Care Centers operate as their own continuum of care that facilitate flow between the three clinical scopes, as well as with other referral partners in its Crisis Response Zone and countywide. Crisis Care Centers work with each other to function as a network that serves the behavioral health crisis needs of the entire county. Crisis Care Centers may be located in a single facility or multiple contiguous facilities and may be co-located with other services. Each Crisis Care Center serves a wide range of clinical and psychosocial needs as a "No Wrong Door" entry point and facilitate timely access to care through:

- Efficient clinical assessment;
- Peer engagement, support, and service navigation;
- Care coordination with health and social service providers;
- Short-term stabilization;
- Triage to subsequent services and supports;
- Referral to appropriate level of care both within the Regional Crisis Care Center and follow-up care upon discharge from the Regional Crisis Care Center;
- Workflows and partnerships designed to support care transitions, with a focus on minimizing unnecessary use of higher acuity, more restrictive settings such as inpatient psychiatric care; and
- Intensive crisis stabilization interventions.

Eligibility Criteria
See individual Regional Crisis Care Center Scopes of Work for eligibility criteria.

Goals & Objectives
- Provide in-person Behavioral Health services tailored to the needs of people in Behavioral Health crisis twenty-four hours per day, seven days per week (24/7);
- Create dedicated places for people in crisis to receive effective care from specialized Behavioral Health providers using Trauma-Informed, Recovery-Oriented, Person-Centered, integrated and co-occurring capable, and cultural humility best practices;
- Reduce reliance on hospital emergency departments, hospitals, and jails as places that people go when in Behavioral Health crisis; and
- Serve as a destination for First Responders, including law enforcement, to bring people who need Behavioral Health crisis care.

Program Requirements
All programs meet applicable licensing and regulatory requirements. The BHUC meets Washington Administrative Code (WAC) 246-341-0901 and Revised Code of Washington (RCW) 71.24.037. The 23-Hour Observation Unit meets WAC 246-341 and RCW 71.24.916. The Crisis Stabilization Unit (CSU) meets WAC 246-341-1140 and RCW 71.24.645.
In addition to clinical scope-specific requirements, the following general requirements apply to all clinical scopes:

Increase Equitable Access to Behavioral Health Crisis Care
- Make services available to all guests regardless of their insurance status or ability to pay;
- Identify and address potential contributors to disparities in access to Behavioral Health crisis services, both in the designated Crisis Response Zone and countywide;
- Recruit and train staff who represent, understand and respect diverse cultural backgrounds, who can communicate in various languages and dialects, and who reflect the diversity of the community being served;
- Implement Culturally and Linguistically Appropriate Services (CLAS), including:
  - Provide effective, equitable, understandable, and respectful quality of care and services that are responsive to the diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs, including American Sign Language (ASL);
  - Recognize the need for culturally appropriate explanations of mental health concepts and accommodate alternative therapies, culturally specific healing practices, and religious practices (e.g., prayer times, dietary restrictions);
  - Seek out cultural consultants in program development and implementation;
- Ensure Language Access at no cost to guests, in their preferred language, verbally, in writing, or via ASL, which includes meaningful access to programs, services and activities for diverse populations including:
  - People who speak a language other than English (LOTE);
  - People with disabilities, such as those needing American Sign Language (ASL) or Communication Access in Real-Time (CART) services; and
  - Other access considerations, such as using plain language to honor different reading levels;
  - Provide easy to understand print and multimedia materials and signage in the following threshold languages: English, Chinese, Korean, Somali, Russian, Spanish, and Vietnamese;
  - Prioritize interpretation in person (with incentives for bilingual staff) or by video whenever possible, with consideration of local dialects, interpreter confidentiality, and cultural dynamics impacted by use of language services;
  - Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the agency's planning and operations; and

- Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflict or complaints.

Implement Clinical Best Practices

Each scope of work within the Regional Crisis Care Center, and the continuum as a whole, fosters a welcoming environment and operates in accordance with clinical best practices to deliver care that is:

- Accessible 24/7 to all people, regardless of income level or insurance status, as required through a "No Wrong Door" approach;
- Welcoming to all guests by showing respect, restoring dignity, instilling hope, building trust, and reducing harm, which form the essential foundation of recovery and better health;
- Trauma-informed, Recovery-Oriented, and Person-Centered;
- Capable of providing integrated services, including evidence-based medication interventions, for people with crises related to both mental health and/or substance use, with the expectation that many people have co-occurring mental health and substance use conditions;
- Supportive of both immediate crisis intervention and transitions to long-term support;
- Therapeutic for a wide range of behavioral health presentations and needs;
- Able to facilitate access to integrated interventions for physical health and social service needs, either directly on site or through referral pathways with service partners, given that crises often involve multiple factors (e.g., housing instability, employment challenges, medical illness, pregnancy and parenting, relationship stressors with family and peer groups, etc.);
- Tailored to the needs of specific age groups (including transitional age youth and older adults), people with intellectual and developmental disabilities, people with other cognitive impairments such as dementia and traumatic brain injury, and other disabilities;
- Responsive to each guest's basic needs and rights, including through providing access to resources such as food and water, clean clothes, and a safe place to rest;
- Prioritizing peer support services that engage and support people to take steps towards their recovery goals;
- Open to accommodating alternative and complementary interventions alongside traditional treatments when requested by guests and communities served;
- Able to minimize the impacts of uniformed security personnel and instead prioritizes safety through Trauma-Informed care training for all onsite personnel;
- Delivered in an environment that maintains privacy and dignity, ensures autonomy and choice for guests, provides secure and welcoming spaces for youth and adults in crisis, and provides support and care to anyone in need;
- Collaborative with outside service providers to ensure continuity of care whenever possible;
- Delivered in the least restrictive way so that guests are empowered partners who remain in control of their own care as much as possible; and
- Utilizes evidence-based assessment tools for all assessments, to the extent practicable.

Regional Crisis Care Center operators have policies and procedures that minimize the use of involuntary interventions, such as administration of medications over objection (e.g., by intramuscular injection), use of seclusion, and use of manual or physical restraints. Regional Crisis Care Center operators report on the frequency and duration of involuntary interventions, including assessing for potential disparities by race and other demographics. Regional Crisis Care Center operators use approaches such as, but not limited to, the Six Core Strategies to Reduce Seclusion and Restraint Use to promote alternative interventions such as prevention of escalation, Trauma-Informed and Person-Centered approaches, and de-escalation techniques like affording the guest ample space and time.

Support and Center the Work of Certified Peer Support Specialists

Certified Peer Support Specialists (RCW 18.420.010) are embedded within Regional Crisis Care Center services. Certified Peer Support Specialists:

- Have 1:1 engagement with guests and members of their support system (e.g., family, friends, etc.) to support guests throughout their stay;
- Attempt to be one of the first staff members to speak with a guest when they first arrive at the Regional Crisis Care Center, whenever safe;
- Lead groups to enhance and develop behavioral health and health literacy, coping skills, and problem-solving;
- Collaborate with peer-led and peer-driven organizations and community groups;
- Develop a peer supervision structure (see WAC 182-115-0100); and
- Receive training within their scope of practice, including specific to working in crisis services.

Facilitate Transition Planning

Regional Crisis Care Center team members work with guests to determine appropriate referrals to ongoing services with the goal of maintaining guests in a least restrictive setting. Guests who are ready for discharge to the community receive care coordination to transition back to existing providers, initiate new outpatient referrals, provide prescription refills and medications for opioid use disorder, facilitate referrals to primary care (e.g., federally qualified health centers), and link people to the Post-Crisis Follow-Up Program. Regional Crisis Care Centers implement discharge protocols that include, but are not limited to:

- As capacity allows and if clinically appropriate, transfer within the Regional Crisis Care Center scopes, such as from the Behavioral Health Urgent Care into the 23-Hour Observation Unit, and then into the Crisis Stabilization Unit;
- Completion of crisis plans when clinically indicated;
- Use of level of care tools such as the Level of Care Utilization System (LOCUS) and American Society of Addiction Medicine (ASAM) Criteria when preparing for discharge planning from the 23-hour Observation Unit or the Crisis Stabilization Unit in order to standardize recommendations for next level of care upon discharge, including training staff in use of these tools;
- Care coordination with external providers (e.g. outpatient mental health, SUD treatment, primary care, housing supports) to ensure warm handoffs and timely follow-up appointments;
- Coordination with other Crisis Care Centers, including the Youth Regional Crisis Care Center, to develop and implement protocols for notifications regarding availability for new admissions, and to facilitate transfers between Crisis Care Centers when needed;
- Referrals for voluntary hospitalization, residential crisis stabilization, continuing substance use treatment, involuntary hospitalization, and other facility-based programs;
- Access to care options that are consistent with client rights (see Individual and Client Rights) and offered regardless of ability to engage in recommended services; and
- Coordination with the Post-Crisis Follow-up (PCFU) Program, which includes:
    - Consistently identify and refer eligible guests to the PCFU Program prior to discharge from the Regional Crisis Care Center;
    - Make referrals in a timely manner, follow established workflows, and include all necessary information for PCFU staff to engage clients effectively;
    - Establish clear referral criteria for when a referral should be made, along with referral prioritization and workflows, in collaboration with PCFU providers;
    - Facilitate warm handoffs that support client engagement;
    - Coordinate with PCFU staff to allow them access to clinical spaces within the facility to meet with referred guests, including space for initial handoff meetings, which are essential for building rapport, assessing immediate needs, and coordinating ongoing care.

Provide Transportation from the Program

Regional Crisis Care Center operators arrange transportation assistance for guests who receive services at Regional Crisis Care Centers. Transportation is provided whenever possible to ensure that guests are able to efficiently get to subsequent care settings and/or their identified discharge

destination. Operators may use transportation funding for post-stay outgoing transportation, interfacility transportation between Regional Crisis Care Center clinical scopes (if not co-located), and Regional Crisis Care Centers in other Crisis Response Zones. Regional Crisis Care Center operators pursue additional reimbursement options for transportation funding, including through Medicaid-funded Non-Emergent Medical Transport brokerage programs, whenever possible. Modes of transportation may include, but are not limited to:

- Staff escorts for guests who walk out themselves;
- Drivers and/or transportation support staff hired by the Regional Crisis Care Center operator using vehicles purchased, licensed and maintained by the Regional Crisis Care Center operator;
- Access to Metro (bus/train passes, other ways of arranging payment);
- Taxi vouchers and/or pre-payment through rideshare platforms;
- Non-Emergency Medical Transport (NEMT), which is an insurance-reimbursed service arranged through a broker (e.g., HopeLink) with wait times 1-2 days for scheduled pickup (e.g., planned discharges from 14-day Crisis Stabilization Unit);
- Ambulance for interfacility transport, including through contracts with private ambulance companies to cover the cost of transport, when insurance billing is not possible, to:
  - Inpatient psychiatry and E&Ts; and
  - Between Crisis Care Centers (due to availability or for the Youth Crisis Care Center); and
  - Other transportation assistance as available.

Deliver Pharmacy and Laboratory Services

Regional Crisis Care Center operators make medications available to guests and ensure timely access to laboratory testing, including testing that may be required for demonstrating medical stability prior to transfer for inpatient admission, in accordance with RCW 18.64, RCW 18.64A, RCW 70.42, RCW 71.05, RCW 71.24, WAC 246-338, WAC 246-341, WAC 246-945, and WAC 388-877B.

Regional Crisis Care Center operators provide access to medications by doing the following:

- Partner and/or subcontract with one or more pharmacies to purchase, store, and dispense medications, provide 24/7 pharmacy support, and pursue insurance billing of pharmacy benefits;
- Obtain and maintain necessary Health Care Entity licensure;
- Utilize automated drug dispensing devices as appropriate;
- Obtain non-formulary medications from off-site pharmacies as needed;
- Monitor and minimize the use of controlled substances;
- Develop policies and procedures related to medication reconciliation and coordinating medication treatment with outside providers;
- Provide developmentally appropriate review of risks, benefits, and alternatives for recommended medications or interventions;
- Develop and implement policies and procedures related to providing medication refills, including providing medications in-hand upon discharge to support medication adherence until subsequent follow-up;
- Administer urgent or emergent medications;
- Administer long-acting injectable medications;
- Provide access to basic preventive sexual health resources (e.g., contraception, pre/post-exposure prophylaxis, testing for sexually transmitted infections, pregnancy tests, Plan B, etc.);
- Provide access to basic Harm Reduction supplies (e.g., nasal naloxone, fentanyl test strip kits, would care kits, hygiene wipes, etc.);
- Maintain an on-site supply of medications that include, but are not limited to:
  - Routine psychiatric medications (e.g., antipsychotics, antidepressants, mood stabilizers, etc.) including oral solids, dissolve tabs, and long-acting injectable formulations;
  - Benzodiazepines for as needed or short-term administration;
  - Medication for opioid use disorder, including buprenorphine in oral and long-acting injectable formulations and, if possible, methadone under the 72-hour rule;

- Other as needed medications for withdrawal management;
- Intramuscular formulations of medications for emergent administration;
- Basic formulary of primary care medications;
- Floor stock for epinephrine and crash cart;
- Narcan for use on site and to provide to guests to take home in hand upon discharge; and
- Other medications as determined by the Regional Crisis Care Center operator.

Regional Crisis Care Center operators provide access to laboratory testing by doing the following:

- Obtain necessary Clinical Laboratory Improvement Amendment (CLIA) waivers;
- Perform point-of-care laboratory testing (e.g., blood glucose, urine toxicology, urine pregnancy, urinalysis, etc.);
- Perform phlebotomy on site to collect specimens for processing at outside labs (e.g., routine screening labs, pre-admission labs, testing for bloodborne pathogens related to drug use, etc.);
- Partner and/or subcontract with one or more laboratory service providers to cover the costs and develop workflows to send specimens for efficient processing; and
- Communicate results of laboratory testing to outside parties, including testing that may be required for demonstrating medical stability prior to transfer for inpatient admission.

Pharmacy funds may be used for the following expenses:

- Costs of medications used for patients who are uninsured and unable to become insured retroactively, including immigrants who are unable to access Medicaid;
- Costs of medications where a patient's insurance denies the pharmacy claims submitted by the Regional Crisis Care Center operator and/or a contracted pharmacy provider;
- Costs of medications used for insured patients, only through the end of the calendar year in which Regional Crisis Care Center operations initiated;
- Costs related to lease or purchase of automated drug dispensing devices (e.g., Pyxis, OmniCell, etc.);
- Costs related to lease or purchase of point of care laboratory machines (e.g., Piccolo machine); and
- Use of automated drug dispensing devices (e.g., Pyxis, OmniCell, etc.) in compliance with WAC 246-874-010 through –070;

  Costs of laboratory services for patients who are uninsured and unable to become insured retroactively, subject to available funds.

  If pharmacy funds are exhausted in a calendar year, the Regional Crisis Care Center operator assumes responsibility for covering the full remaining costs of pharmacy and laboratory services.

Provide Dietary Services

Regional Crisis Care Center operators provide 24/7 dietary services available to all guests, including:

- Warm food and snack provision, preparation, and service for guests, and in compliance with WAC 246-377-111 as required by licensure;
- Healthy, nutritious, and dietary appropriate meals and snacks;
- Dietary options that are responsive to guests' health needs, allergies, religious and cultural requirements, and dietary preferences; and
- Access to registered dietitian consultation services.

Provide Guest Clothing and Personal Hygiene

Regional Crisis Care Centers ensure that all guests have access to clean, fitting clothing during their stay, including undergarments such as bras and underwear. The operator also provides personal hygiene products, including menstrual and incontinence supplies, for all guests, regardless of sex or gender identity, in a respectful and non-discriminatory manner. Clothing and dress protocols should remain flexible and may vary by unit, acuity level, and guest needs. The following apply:

- Guests are encouraged to wear operator-provided clothing due to short stays, high acuity, and infection control concerns;
- Guests may wear personal clothing, by default or at a minimum upon request, with safeguards for laundering and ensuring safety of garments;

- Guests are not required to change out of personal clothing, if they prefer to remain in their own clothing;
- Guests' personal clothing can be laundered onsite; and
- Clean clothing is offered upon discharge.

Engage Crisis System Partners

The Regional Crisis Care Center operator works collaboratively with a range of partners to ensure highly coordinated care transitions both from and to local service providers. Regional Crisis Care Center operators coordinate care for guests in crisis who may already be connected to community services, as well as facilitation of continuity of care following discharge through effective referral partnerships. Regional Crisis Care Center operators support guests to navigate to services both at the Regional Crisis Care Center itself and in the local community, including accounting for surrounding geography and transportation infrastructure. Regional Crisis Care Center operators also collaborate with crisis system partners to develop protocols to manage new admissions when the center is at full capacity. The implementation of a Regional Crisis Care Center and development of multi-system policies and procedures must therefore be pursued in collaboration with a wide range of crisis system partners, including:

- Crisis service providers responsible for crisis call centers, mobile crisis, and other crisis facilities, including other Regional Crisis Care Centers;
- Community-based outpatient and residential mental health and substance use service providers, primary care and other physical health care providers, social service agencies, outreach programs, and other community-based organizations;
- First responders including 911 public safety answering points, law enforcement, emergency medical services, co-responder programs, and others;
- Courts, jails, probation and parole offices, and other components of the criminal-legal system;
- Local hospitals, emergency departments, evaluation and treatment facilities, and other health systems;
- Social service agencies, such as adult and child protective services, housing and homeless service providers, aging and older adult services, intellectual and developmental disability services, and brain injury services; and
- King County and local jurisdictions.

Facilitate Community Engagement

Regional Crisis Care Centers are planned in collaboration with community partners to ensure that the Regional Crisis Care Center clinical model is tailored to local community needs. The Regional Crisis Care Center works collaboratively with a range of partners to facilitate access to services by guests, families and caregivers, First Responders, and other referents. Regional Crisis Care Center operators ensure that the Regional Crisis Care Center is responsive to the diversity and unique needs of the population it serves. This community collaboration and responsiveness includes:

- Actively and regularly seeking input from people and families with lived and living experience, community members that represent local communities served, as well as partners in community-based organizations, religious institutions, schools, and other settings to assess how they are or are not meeting the needs of communities;
- Participate in the development and implementation of a Good Neighbor Agreement, including attending relevant community meetings to support and promote the agreement's intention and to address neighborhood or program concerns;
- Incorporating feedback to improve services and better respond to community needs;
- Convene a community advisory board, or similar venue that may be integrated into an existing community body, that is representative of communities served and includes members with lived experience to guide program development and implementation;
- Promotion of available services using a range of outreach methods including social media, radio, and community news outlets, creating printed materials in multiple languages to distribute widely, and attending and participating in existing cultural events and community gatherings; and

- Engage with jurisdictions within the Crisis Response Zone and throughout the rest of King County to maintain working relationships with elected officials and municipal government leaders, to co-convene community engagement opportunities, and to address community concerns and complaints in partnership with local jurisdictional representatives.

Engage in Continuous Quality Improvement and Technical Assistance

The Department of Community and Human Services (DCHS) requires and supports the Regional Crisis Care Center operators to monitor and promote quality of care and to develop continuous quality improvement practices. Regional Crisis Care Center operators identify and initiate continuous quality improvement activities internally and also engage with DCHS-led efforts to improve quality in the network of Regional Crisis Care Centers and in the overall county crisis system. Improvement efforts are supported by data sharing and Continuous Quality Improvement practices in partnership with DCHS and community partners listed above to monitor shared measures of success and respond with action to address growth areas.

Regional Crisis Care Center operators may request to access resources for technical assistance and capacity building activities to support high quality clinical service, provide inclusive care for populations experiencing behavioral health inequities, and comply with regulatory requirements. These supports may include DCHS contracted consultants with relevant subject matter expertise. Regional Crisis Care Center operators must provide 30 days notice and receive approval from DCHS prior to utilizing funding dedicated to Capacity Building and Technical Assistance.

Activities related to assisting Regional Crisis Care Center operators to deliver high quality clinical services include, but are not limited to:

- Developing clinical policies and procedures;
- Implementing care coordination, clinical workflows and technology;
- Implementing evidence-based and promising clinical practices;
- Adopting de-escalation and least restrictive care best practices;
- Building capacity for clinical quality improvement activities;
- Increasing specialization in serving youth and people living with intellectual and developmental disabilities, and
- Implementing best practices to support workforce development and staff wellbeing.

Activities related to providing inclusive care to populations experiencing behavioral health inequities include, but are not limited to:

- Assisting Regional Crisis Care Center operators to institute CLAS best practices for providing culturally and linguistically appropriate services;
- Providing cultural humility and health equity training for Regional Crisis Care Center staff;
- Providing organizational leadership training on best practices to advance health equity at an organizational level, and
- Consulting with organizations with expertise in serving populations that experience behavioral health inequities around adopting clinical best practices and supporting individual client case consultations when appropriate.

Activities related to regulatory technical assistance and capacity building include, but are not limited to, assisting Regional Crisis Care Center operators to comply with applicable local, state, and federal regulatory rules, and licensing, auditing, and accreditation requirements.

DCHS may work with Regional Crisis Care Center operators to develop and implement payment methodologies that are tied to performance on quality measurements.

Recruit and Retain a Representative, Diverse, Qualified, and Multidisciplinary Crisis Workforce

Regional Crisis Care Center operators recruit and retain a diverse and multidisciplinary workforce capable of meeting programmatic objectives and delivering required services by implementing the following:

- Recruitment and retention, including through competitive and livable wages for all staff, incentives at time of hiring and for off-hour shifts, robust health insurance coverage and other benefits, cost-reduction of eligible expenses (e.g., tuition, childcare, housing), and other strategies using dedicated CCC Levy funds for crisis workforce development;
- Direct recruitment of candidates who are embedded in and have experience serving diverse communities, and who have lived experience (including but not limited to certified peer support specialists);
- A qualified staff specially trained to provide crisis services and made up of psychiatric providers, nurses, mental health providers, substance use disorder professionals, certified peer support specialists, behavioral health technicians, and others;
- Regular review of staffing ratios, patterns, and cross-program coverage (e.g., swinging staff between programs to cover 24/7 services and account for fluctuating patient volumes) to ensure high quality care and safety for both staff and guests;
- Trainings, workforce development, and other professional advancement opportunities, including those provided through the King County Integrated Care Network and the Crisis Training Academy;
- Operator will ensure that all required trainings are provided to staff upon hire and, at a minimum, on an annual basis thereafter. Operator is solely responsible for ensuring that all training obligations are fulfilled in accordance with applicable licensure requirements, including but not limited to staff professional licensure, Behavioral Health Agency (BHA) licensure, and any other relevant regulatory or accreditation standards. Clinical supervision for all levels of staff, including certified peer support specialists, with expertise in responding to both mental health and substance use crises;
- Development of specific competencies in welcoming, hopeful, Trauma-Informed, Person-Centered, Recovery-Oriented crisis care, responding to both individuals as well as families, friends, loved ones, and other providers;
- Specific training in the collection of clinical information, including demographic data, and facilitation of information sharing during crisis episodes in order to promote care coordination and achieve the best outcomes;
- Interdisciplinary teamwork, leadership trainings, and promotion of staff from diverse backgrounds;
- Wellbeing and burnout mitigation and supports through activities such as supervision and mentorship, accommodating creative scheduling options, creating opportunities for staff to participate in self-directed program development and quality improvement initiatives, and access to robust Behavioral Health benefits;
- Human resources capacity to hire a large new cohort of employees as well as conducting equitable hiring, administration of benefits, oversight of a safe workplace, and other core functions; and
- Process to review that all required staff licensures and certifications are valid and current.

Workforce activities may include:

- Increase wages for certified peer support specialists, substance use disorder professionals, mental health professionals, Behavioral Health technicians, nurses, nurse practitioners, physicians, and other direct service professionals;
- Improving benefits for the direct service professionals listed above;
- Reducing the cost of living for workers, such as housing, education, or childcare;
- Provide supervision and education to trainees;
- Support worker wellbeing through activities such as supervision and mentorships, covering staff time for self-directed program development and quality improvement initiatives, and access to behavioral health benefits.

Regional Crisis Care Center operators follow all applicable requirements outlined in the Behavioral Health Career Pathways Program Scope of Work.

Collect Guest Satisfaction Surveys

Regional Crisis Care Centers consistently offer all guests the opportunity to complete a guest satisfaction survey about their experience at the facility. This survey is provided either before discharge or immediately after discharge, while the guest is still at the facility. Survey responses are collected and reviewed regularly to inform service improvements. Surveys are administered in a manner that protects guest privacy and promotes candid feedback, including via telephone and text options.

Guests are informed, both verbally and in writing, that survey participation is voluntary, anonymous, and does not influence the care they receive. DCHS and the operator will collaborate to develop and implement an optional guest satisfaction survey that includes, but is not limited to, questions about:

- Overall satisfaction with their stay;
- Quality of food services;
- Treatment and interactions with staff;
- Whether their needs were addressed in a timely manner;
- Willingness to return to the facility in the future;
- Likelihood of recommending the service to others;
- Suggestions for improvement; and
- Free text box for other feedback or concerns.

Comply with Licensure, Certification and Accreditation

Regional Crisis Care Center operators obtain and maintain licensures, certifications and accreditations as required by Federal regulations, Revised Code of Washington (RCW) 71.24, RCW 71.12, Washington Administrative Code (WAC) 246-341, WAC 246-377, King County Code, the BHRD Provider Manual, and other applicable laws and regulations, including but not limited to:

- Facility licensure by the Washington State Department of Health, including:
  - BHA license;
  - For the Behavioral Health Urgent Care, either certification in Behavioral Health outpatient crisis, observation, and intervention, or certification as a 23-hour crisis relief center;
  - For the 23-hour Observation Unit, certification as a 23-hour crisis relief center;
  - For the Crisis Stabilization Unit, licensure as a Residential Treatment Facility, certification as a Crisis Stabilization Unit, and certification for withdrawal management;
- Health Care Entity licensure by the Washington State Pharmacy Commission (to store and dispense medications on site) in accordance with WAC 246-945-245 and WAC 246-945-410;
- Controlled substances registration;
- Certificate of Waiver as a Medical Test Site (to conduct laboratory testing on site);
- Relevant professional licensures for all licensed staff;
- Accreditation through an entity like the Joint Commission or the Commission on Accreditation of Rehabilitation Facilities (optional though preferred);
- Ability to provide American Society of Addiction Medicine (ASAM) Level 3.7 Medically Monitored Intensive Withdrawal Management Services;
- Participation as a provider in the King County Integrated Care Network (KCICN) and Behavioral Health Administrative Services Organization (BH-ASO); and
- Other licensure, certification and accreditation, as applicable.

Operators provide copies of Washington State Department of Health audit reports to DCHS upon request.

Administration

Regional Crisis Care Center operators are responsible for a range of administrative activities, such as:

- General operational activities;
- Safe storage of guest belongings;

- Coordination of pet care, including in partnership with local animal shelters;
- Laundering of linens, uniforms, and scrubs;
- Pest and infection control;
- Procurement of supplies (office, arts, cleaning, hygiene, clothing donations for guests, etc.);
- Hygiene products and services (guest showers, laundry, disinfection, etc.); and
- Janitorial and environmental management;
- Obtaining and maintaining liability insurance and in accordance with DCHS's Standard Terms and Conditions;
- Facility maintenance for routine repairs and improvements (capital funding to support more substantial renovations and expansions would be awarded through additional procurement and/or contracting mechanisms); and
- Other administrative needs.

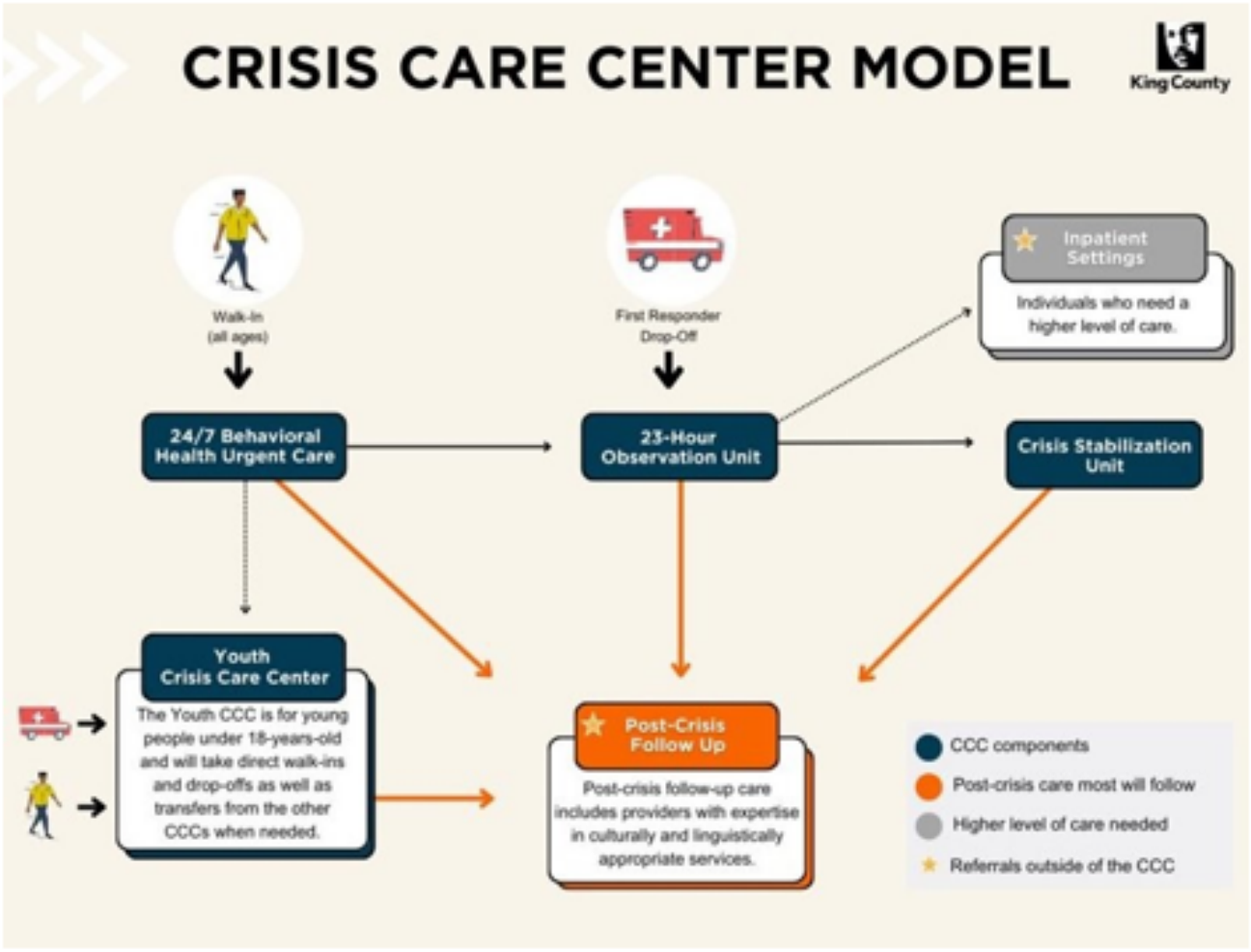
Reporting Requirements

BHRD Information System	Submit Data to the BHRD Information System as outlined in the BHRD Data Dictionary and the Required Transactions Sheet in the ISAC Notebook
Monthly Reports	• Expenditures Report • Capacity Report • Seclusion & Restraint Report • Declines Report • Behavioral Health Education and Advancement Model (BEAM) Wage Report(s) • Behavioral Health Career Pathways Report Expenditure Report
Quarterly Reports	Behavioral Health Career Pathways Summary Report Discharge Survey Report
Semiannual Reports	CCCL Provider Narrative Survey
Annual/Other Reports	BEAM Annual Report Behavioral Health Career Pathways Annual Report
Performance Measurement (PM) Plan	Reporting requirements, performance measures, and documentation for annual crisis agency reviews are further detailed in an accompanying performance measurement (PM) plan. See Performance Measurement (PM) Plans" section above and Regional Crisis Care Centers PM plan.

Regional Crisis Care Center Facility Naming
The Regional Crisis Care Center operator obtains prior written authorization from King County regarding the public-facing name of the Regional Crisis Care Center facility.

Invoice Program Specific Requirements
Method of Payment
Reimbursement will be made for workforce investments on an actual costs basis for transportation expenses, pharmacy expenses, capacity building and technical assistance activities. (Staff salaries or fringe are not included).
Additional Requirements
See specific clinical components (BHUC, 23-hour observation, or CSU) for more information on program specific invoicing requirements.

Attachments This Section
Attachment B Crisis Care Center Model



Regional Crisis Care Center Model Figure A-1.1.

The five Crisis Care Centers that are eligible for funding through the Crisis Care Centers Levy and are selected through a competitive procurement process include:

1. Four Regional Crisis Care Centers geographically distributed across King County, as follows (see Crisis Response Zone map and details in the CCC Levy Implementation Plan):
    a. North Crisis Response Zone Crisis Care Center
    b. East Crisis Response Zone Crisis Care Center
    c. South Crisis Response Zone Crisis Care Center
    d. Central Crisis Response Zone Crisis Care Center
2. One Youth Crisis Care Center located anywhere in King County

4.13.1 Regional Crisis Care Center 23-Hour Observation Unit

Program Overview

The 23-Hour Observation Unit is one of the three clinical scopes delivered in a Regional Crisis Care Center. This unit is for guests who have higher acuity symptoms such as high risk of suicide or violence, grave disability, behavioral distress, or withdrawal from substances. This crisis observation unit provides stabilization services for up to 23 hours and 59 minutes with limited extensions permitted in accordance with WAC 246-341-0903. The 23-Hour Observation Unit maintains a dedicated first responder entrance to facilitate timely drop-offs of guests.

All Regional Crisis Care Center Scopes of Work adhere to applicable requirements for Regional Crisis Care Centers.

Eligibility Criteria

Medicaid Required	No
Age Range	Adults 18 and older
Target Population	Individuals who have higher acuity symptoms such as a high risk of suicide or violence, grave disability, behavioral distress, or withdrawal from substances
Authorization Needed	No
Authorization Criteria	None
Other Criteria	None

Goals & Objectives

The goal of the 23-Hour Observation Unit is to provide full-scope psychiatric emergency services and to serve as a preferred destination for first responders to bring people for specialty behavioral health treatment as an alternative to the emergency department.

Program Requirements

The 23-Hour Observation Unit follows Washington Administrative Code (WAC) Chapter 246-341-0903 and Revised Code of Washington (RCW) 71.24.916.

Triage and Screening

- Individuals who enter the 23-Hour Crisis Observation Unit are immediately triaged for the presence of emergency medical needs that may require transfer to a medical emergency department (ED).
- After triage, all guests are engaged and assessed for the level of care that is most appropriate for them. Those who are brought in on an involuntary transport receive welcoming engagement with the goal of encouraging them to accept needed help voluntarily. Conversion from involuntary to voluntary status during the 23-hour observation period is an important measure of delivering least restrictive care.
- Involuntary treatment is only to be considered when there is significant concern that a guest meets statutory criteria for involuntary treatment and the guest has declined treatment despite every effort to engage them in care voluntarily.
- In these scenarios, clinical staff request an evaluation for potential involuntary treatment by a Designated Crisis Responder (DCR), as required by the Involuntary Treatment Act (RCW 71.05 and RCW 71.34).
- Under RCW 71.05 and 71.34 current state law dictates that a DCR must respond within 12 hours of the initial referral.

- The DCR will then conduct an evaluation onsite at the Regional Crisis Care Center and, if a DCR determines that the guest requires involuntary treatment, they will make the referral. Until then, the Regional Crisis Care Center staff continue to provide services, up until transfer to an appropriate treatment setting, such as a hospital or a facility certified to provide Evaluation and Treatment (E&T) services.
- These types of interventions are implemented with a welcoming, Trauma-Informed, Recovery-Oriented approach, with the goal always to maintain safety for the guest and staff with the minimal use of coercion possible.

Services

This setting serves the full range of mental health and substance use crises, akin to a psychiatric emergency service. Clinicians provide additional assessment, maintain a safe and healing environment, collaborate with guests and their support systems to obtain collateral information and create safety plans and crisis plans, facilitate group sessions, and provide intensive evidence-based therapies and substance use counseling.

- Psychiatric providers initiate medications when appropriate, including to treat substance use disorders and initiate withdrawal management.
- Proactive peer engagement and support is available to promote recovery and resiliency.
- Regional Crisis Care Centers provide 24/7 nursing care and attend to immediate co-occurring physical health needs that do not require emergency room level care (e.g., wound care, basic diabetes management, localized infections, sexual and reproductive health, etc.), to the extent possible. This setting directly provided for a guest's basic needs (e.g., food, water, and clean clothes; hygiene services like a shower and laundry; and a safe place for a brief rest).
- Regional Crisis Care Center team members are trained to use Trauma-Informed, Recovery-Oriented, and culturally and linguistically appropriate approaches as well as verbal de-escalation skills.
- This setting has more staff per guest than the other Regional Crisis Care Center components to maintain a therapeutic milieu that is safe for guests and staff.
- Guests may be admitted from the Behavioral Health Urgent Care (BHUC) if they are likely to benefit from a higher level of care, or they may be dropped off by First Responders such as mobile crisis teams, co-responder teams, emergency medical services, and law enforcement on either a voluntary or involuntary status.
- First responder drop-offs are made directly through a dedicated first responder entrance in an efficient manner so that First Responders can return to their duties as quickly as possible, ideally within 10-15 minutes of when the guest arrived at the Regional Crisis Care Center.

Medical Transfers and Discharges

Regional Crisis Care Center operators have clear protocols and documentation practices for situations when guests require external medical care. These protocols support care continuity, regulatory compliance, and discharge planning. Operators:

- Document pre-admit medical transfer. In cases where a guest is diverted for emergency medical care (e.g., via 911 call) before being formally admitted, such as being redirected before reaching a chair, staff document the incident clearly, even though the individual was not formally admitted.
- Allow temporary medical transfer with return within 6 hours. When a guest temporarily leaves for medical care and returns within 6 hours, staff resume the stay without initiating a formal discharge. Documentation reflects the time away and the reason for return.
- Discharge guests for extended absences or hospital admissions. Guests admitted to a medical unit or are absent for more than 6 hours are formally discharged. If they return after this time, staff initiate a new admission and complete documentation.

Transition Planning

23-Hour Observation team members work with guests to determine appropriate referrals to ongoing services with the goal of maintaining guests in a least restrictive setting.

Refer to Regional Crisis Care Center See Regional Crisis Care Center scope of work for more details on transition planning requirements.

If longer-term or more intensive supports are needed, care may be transitioned to appropriate settings such as mental health or substance use residential treatment.

Reporting Requirements

BHRD Information System	Submit Data to the BHRD Information System as outlined in the BHRD Data Dictionary and the Required Transactions Sheet in the ISAC Notebook
Monthly Reports	Expenditures Report
Quarterly Reports	None
Semiannual Reports	None
Annual/Other Reports	None
Performance Measurement (PM) Plan	Reporting requirements, performance measures, and documentation for annual crisis agency reviews are further detailed in an accompanying performance measurement (PM) plan. See Performance Measurement (PM) Plans" section above and Regional Crisis Care Centers PM plan.

Invoice Program Specific Requirements

Method of Payment

- Reimbursement is made monthly for services based on a 24-chair capacity, on a cost reimbursement basis and based on reconciliation of actual, documented costs.

Additional Requirements

- None

4.13.2 Regional Crisis Care Center Behavioral Health Urgent Care

Program Overview

The Behavioral Health Urgent Care (BHUC) is one of the three clinical scopes of work delivered in a Regional Crisis Care Center. Individuals access care by scheduled appointment or self-presenting to the BHUC clinic on a 24/7 basis. Just like a physical health urgent care clinic, people seeking same-day behavioral health care outside the traditional outpatient clinic setting are able to access the BHUC clinic as a "front door" to services. Individuals who present a behavioral health crisis with other complex but non-emergent medical needs are welcomed and assessed for appropriate care and referral.

All CCC Scopes of Work adhere to applicable requirements for Regional Crisis Care Centers.

Regional Crisis Care Center Behavioral Health Urgent Care Eligibility Criteria	
Medicaid Required	No
Age Range	All ages
Target Population	Individuals requesting Behavioral Health urgent care who may have all types of co-occurring social service needs and non-emergent physical health needs.
Authorization Needed	No
Authorization Criteria	None

Other Criteria	Individuals who present in a behavioral health crisis with other complex but non-emergent medical needs.

Goals and Objectives
The goal of the BHUC is to serve as a low barrier "front door" for a wide range of non-emergent behavioral health services. The BHUC is an alternative to the Emergency Department for same-day access to urgent behavioral health needs.

Program Requirements
BHUC meets applicable licensing and regulatory requirements. The BHUC follows Washington Administrative Code (WAC) 246-341 and Revised Code of Washington (RCW) 71.24, including WAC 246-341-0901 and RCW 71.24.037

Access To Services
The Behavioral Health Urgent Care (BHUC) clinic serves as a "front door" to services and follows the "No Wrong Door" approach. This means that access is:
- Available regardless of ability to pay and without a prescheduled appointment;
- Available to youth aged 4-17, including those who are unaccompanied by parents or caregivers as permitted by state law;
- Provided without requirements for a behavioral health pre-screening or medical clearance; and
- Provided regardless of active substance use or housing status.

Triage and Screening
The BHUC addresses the needs of most guests without needing to refer them to a higher level of care. Screening and triage services include:
- Guests are immediately engaged by a Certified Peer Support Specialist (as appropriate) upon arrival.
- Implement triage criteria for guests upon arrival to ensure routing based on acuity, safety risk, and medical stability.
- Implement standardized exclusionary criteria for individuals requiring emergency medical intervention beyond the BHUC's scope of services.
- If there is no serious emergent need, an initial screening to determine how best to respond to their request for help, and for any additional mental health and substance use service needs, social service needs, and medical care.
- Identification of the person's requests and needs.
- Collaboration with the individual seeking help to make shared decisions about what services and supports would be most helpful and responsive.
- If a walk-in guest presents with a more urgent behavioral health need than a guest with a scheduled appointment, clinical staff may prioritize the walk-in for services.

Services
Following initial triage and screening, clinical staff conduct an intake evaluation using standardized tools for risk assessment (such as a validated suicide risk assessment) and develop a safety plan and/or crisis plan. Key components of services following the intake evaluation include:
- Psychiatric providers (including psychiatrists, nurse practitioners, and physician assistants) available on site 24/7 (including using shared staffing to cover multiple Regional Crisis Care Center components, especially overnight).
- Medication refills, administration of long-acting injectable medications (both antipsychotics and buprenorphine), and initiation of medications for psychiatric symptoms, opioid use disorder, and mild substance use withdrawal.

- Supports for people with co-occurring Behavioral Health needs and intellectual and developmental disabilities, dementia, or acquired brain injury.
- Access to social service providers and/or care coordinators to directly provide or arrange services for a guest's basic needs (e.g., providing food, water, and clean clothes; hygiene services like a shower and laundry; and a safe place for a brief rest).
- Assistance with accessing existing homeless and housing services, such as congregate and non-congregate shelter, hygiene centers, diversion programs, rapid rehousing programs, safe parking, transitional housing, and King County's Coordinated Entry System.
- Referral to higher level of care (ex: 23-hour observation unit) as appropriate with clinical necessity documented in guest's record of care.

Youth Services

The BHUC is the only setting where youth are served in the Regional Crisis Care Center. Given that youth with higher acuity needs are not able to move into the 23-Hour Observation Unit or Crisis Stabilization Unit, the Crisis Care Center is best suited for youth with urgent, non-emergent behavioral health care needs, and therefore does not operate as a "no wrong door" entry point specifically for youth. In order to safely provide services to youth, the scope of services available to youth should be clearly communicated to the public and first responders so as to minimize scenarios where a youth in a high acuity crisis require transportation to another facility, to the extent possible.

Although the BHUC accepts walk-ins without a scheduled appointment, the Crisis Care Center operator also offers youth the option to schedule appointments in advance. Online and/or telephonic appointment scheduling is available 24 hours a day, 7 days a week. The online scheduling system allows guests to provide the reason for their visit with making an appointment and is implemented within 120 days of contract execution. If all same-day appointment slots are filled, the BHUC still accepts walk-ins. The operator makes this clear via their website and through online scheduling around what services are and are not offered through the urgent care.

The Crisis Care Center BHUC offers the following services for youth:

- Evaluate the guest and the reason for the urgent concern. In some instances, discuss medicines;
- Help create safety plans, which may include parent or caregiver-focused behavior management support; and
- Offer treatment recommendations and may provide referrals to additional services in the community.

The Crisis Care Center BHUC does not offer the following services for youth:

- Diagnostic evaluations for autism spectrum disorder;
- Perform return-to-school evaluations;
- Complete any forms, including forms for court, child protective services, or school placement;
- Any additional documentation beyond what is in the medical record;
- Provide ongoing mental health treatment; or
- Perform medical assessments, physical exams, laboratory tests, or tests to diagnose medical problems.

For youth aged 4-17 with an emergency behavioral health need, a referral is made to the Youth Crisis Care Center. If the Youth Crisis Care Center is not yet operational at the time of the Regional Crisis Care Centers' operations, then the Regional Crisis Care Center triages to clinically appropriate available resources. Transportation is arranged and/or provided as appropriate.

Psychiatric Services for Post-Crisis Follow Up Guests

The Regional Crisis Care Center BHUC offers psychiatric evaluation and treatment services to individuals referred through the PCFU program. These services may include medication management, psychiatric assessments, and short-term stabilization to ensure continuity of care.

Transition Planning

Regional Crisis Care Center BHUC team members work with guests to determine appropriate referrals to ongoing services with the goal of maintaining guests in a least restrictive setting [See Regional Crisis Care Center SOW for more details on transition planning requirements]. If longer-term or more intensive supports are needed, care may be transitioned to appropriate settings such as mental health or substance use outpatient or residential treatment.

Regional Crisis Care Center Behavioral Health Urgent Care Reporting Requirements	
BHRD Information System	• Submit Data to the BHRD Information System as outlined in the BHRD Data Dictionary and the Required Transactions Sheet in the ISAC Notebook.
Monthly Reports	• Expenditures Report
Quarterly Reports	None
Semiannual Reports	None
Annual/Other Reports	None
Performance Measurement (PM) Plan	• Reporting requirements, performance measures, and documentation for annual crisis agency reviews are further detailed in an accompanying performance measurement (PM) plan. See Performance Measurement (PM) Plans" section above and Regional Crisis Care Centers PM plan.

Invoice Program Specific Requirements

Method of Payment

Reimbursement is made monthly for services on a cost reimbursement basis and based on reconciliation of actual, documented costs for BHUC services.

Additional Requirements

None

4.13.3 Regional Crisis Care Center Crisis Stabilization Unit

Program Overview

The Regional Crisis Care Centers Crisis Stabilization Unit (CSU) Program is one of the three clinical scopes of work delivered in a Regional Crisis Care Center. The CSU is a voluntary, lower acuity 16-bed crisis stabilization and withdrawal management unit that is available to guests with mental health and/or substance use treatment needs who would benefit from engaging in a safe and therapeutic environment for up to 14 days. These Residential Treatment Facility beds are dual licensed to provide both crisis stabilization and withdrawal management services.

All Regional Crisis Care Center Scopes of Work adhere to applicable requirements for Regional Crisis Care Centers.

Eligibility Criteria

Medicaid Required	No
Age Range	Adults 18 and older
Target Population	Adults from the Regional Crisis Care Center 23-Hour Observation Unit needing additional stabilization or withdrawal management time.

Authorization Needed	No
Authorization Criteria	None
Other Criteria	None

Goals & Objectives
The CSU is designed to accept guests quickly at all hours, including those who, after up to 23 hours and 59 minutes in the 23 Hour Observation unit, are unable to be served in the community due to continued high acuity mental health and/or substance use service needs, but who do not meet criteria for hospitalization or residential substance use treatment.

Program Requirements
The CSU follows Washington Administrative Code (WAC) 246-341, WAC 246-377, Revised Code of Washington (RCW) 71.24, RCW 71.12, and Medically Monitored Inpatient Withdrawal Management ASAM Level 3.7.

Access To Services
The operator must ensure the CSU and Withdrawal Management Services (WMS) meets the following access standards:
- Provide voluntary services in a 16-bed unit for guests experiencing mental health and/or substance use challenges.
- Accommodate stays of up to 14 days in a safe and therapeutic environment such as:
  - A physically and emotionally safe setting that protects guests from harm, including access to supervision, de-escalation supports, and a secure, trauma-informed space;
  - An environment that promotes healing and recovery through structured daily routines, access to evidence-based clinical and peer services, and person-centered care tailored to each guest.
  - Accept guests from the 23-Hour Observation Unit who require continued stabilization or withdrawal management.
- Allow referrals from additional sources at the discretion of the operator, based on clinical need and bed availability. The 23-Hour Observation Unit referrals are prioritized over other referral sources.
- For stays beyond 14 days, the operator obtains prior authorization and provides verification that the continued stay is clinically justified.

Triage
The operator must establish and maintain a triage process that ensures:
- Prioritization of referrals from the 23-Hour Observation Unit.
- Within 2 hours of drop-off or referral, acceptance of guests who meet criteria for crisis stabilization or withdrawal management.
- Guests better served in other settings are referred within 24 hours and connected to those services.
- The unit accepts guests 24/7, including those who cannot safely return to the community after completing the 23-Hour Observation Unit stay but who do not meet inpatient or residential treatment criteria.
- Guests are admitted only for short-term stays where there is likely therapeutic benefit. The unit must not be used as transitional housing or for long-term stays without clinical justification.
- Bed availability and care flow are actively managed to maintain access throughout the Regional Crisis Care Center.

Services
The operator must provide the following services in the CSU:
- Short-term, lower-acuity care including evidence-based therapies and substance use counseling services.

- Continuation of services from the 23-Hour Observation Unit, including:
- Case management
- Crisis intervention
- Individual and group therapy
- Medication management
- Transition and discharge planning
- Peer supports, nursing care, and psychiatric services must be available 24/7
- The unit must be dual licensed to provide both crisis stabilization and WMS.

Medical Transfers and Discharges

Regional Crisis Care Center operators have clear protocols and documentation practices for situations when guests require external medical care. These protocols support care continuity, regulatory compliance, and discharge planning. Operators:

- Document pre-admit medical transfer. In cases where a guest is diverted for emergency medical care (e.g., via 911 call) before being formally admitted, such as being redirected before reaching a chair, staff document the incident clearly, even though the individual was not formally admitted.
- Allow temporary medical transfer with return within 6 hours. When a guest temporarily leaves for medical care and returns within 6 hours, staff resume the stay without initiating a formal discharge. Documentation reflects the time away and the reason for return.
- Discharge guests for extended absences or hospital admissions. Guests admitted to a medical unit or are absent for more than 6 hours are formally discharged. If they return after this time, staff initiate a new admission and complete documentation.

Transition Planning

CCL-CS team members work with guests to determine appropriate referrals to ongoing services with the goal of maintaining guests in a least restrictive setting. Refer to *CCC SOW for more details on transition planning requirements*. If longer-term or more intensive supports are needed, care may be transitioned to appropriate settings such as mental health or substance use residential treatment.

Reporting Requirements

BHRD Information System	• Submit Data to the BHRD Information System as outlined in the BHRD Data Dictionary and the Required Transactions Sheet in the ISAC Notebook.
Monthly Reports	• Census Report • CSU Insurance Submission and Spenddown
Quarterly Reports	• Trueblood Enhanced Crisis Stabilization/Triage Report • Trueblood Enhanced Crisis Stabilization/Triage Service Staff Details Report
Semiannual Reports	None
Annual/Other Reports	None
Performance Measurement (PM) Plan	• Reporting requirements, performance measures, and documentation for annual crisis agency reviews are further detailed in an accompanying performance measurement (PM) plan. See Performance Measurement (PM) Plans" section above and Regional Crisis Care Centers PM plan.

Invoice Program Specific Requirements

Method of Payment

- Reimbursement will be made monthly for services delivered on a per diem basis
- Invoices reflect the number of patients served multiplied by the contracted per diem rate

- Reimbursement is made monthly for 25% of the Regional Crisis Care Center services on a cost reimbursement basis and based on reconciliation of actual, documented workforce-related costs (as defined in the Allowable Expense Listing).
- If the operator consistently (three or more months) achieves or exceeds eighty-five percent (85%) capacity, the per diem rate may be renegotiated at BHRD's discretion. BHRD retains sole authority to decide whether renegotiation will occur and to approve any adjustments.

Additional Requirements

- None

5 Withdrawal Management Services

5.1 Acute Withdrawal Management

Program Overview

Behavioral Health and Recovery Division (BHRD) contracts with Acute withdrawal management (AWM) providers in King County and throughout the state of Washington. AWM services are an essential part of the continuum of care, grounded in a recovery and resiliency-oriented approach and delivered in accordance with Washington Administrative Code (WAC) 246-341 or its successors.

AWM services support individuals through withdrawal management from psychoactive substances in a safe, medically supervised environment. Individuals are screened prior to admission to determine their treatment needs. A variety of counseling and treatment strategies are used, including motivational interviewing and developing an Individual Service Plan (ISP), to encourage engagement, enhance motivation, support referral to additional treatment, and promote long-term recovery.

Eligibility Criteria

Medicaid Status	Yes, limited non-Medicaid funding available with BHRD approval
Age Range	13 years and older
Target Population	Providers ensure that priority admission is given to the Priority Populations as defined in the BH-ASO section of this manual. Providers shall also give admission priority to individuals referred from the following King County referral sources: • Sobering Services; • Harborview or other King County emergency departments; • King County Crisis and Commitment Services; • REACH case managers; • Law enforcement; • King County Providers who are seeking withdrawal management services in preparation for entry to residential treatment; and • Crisis Diversion Facility (CDF) or Crisis Diversion Interim Services (CDIS).
Authorization Needed	In accordance with RCW 71.24.618 or its successors, individuals seeking AWM are automatically authorized for 3 days from their date of admission. Additional days must be authorized by King County. To obtain authorization, the Provider must submit a Withdrawal Management Continued Stay Request Form by fax (206-205-1634) or secure email (resauth@kingcounty.gov). See Attachment: Withdrawal Management Continued Stay Request Form.

Authorization Criteria	Individuals must demonstrate the need for AWM using the six dimensions of the American Society of Addiction Medicine (ASAM) Criteria, Third Edition and the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) or their successors. Providers will submit clinical documentation that supports this level of care (LOC). This includes: • Toxicology screen; • CIWA/COWS score; • ASAM assessment; and • Clinical description of the client's needs, dates of last use, and severity of symptoms.
Additional Criteria	The individual must be a resident of King County, be enrolled with an MCO or BH-ASO (or qualify for non-Medicaid funding) and have an income below 220% of the Federal Poverty Level for adults or 300% for youth.

Goals & Objectives

Each client is screened for SUD treatment and referred for treatment within 48 hours of admission. Clients receive at least one counseling session with a SUD Professional (SUDP) or a SUDP Trainee (SUDPT) under the supervision of a SUDP to develop an ISP and encourage engagement and enhance motivation for referral to ongoing treatment. As part of this process, staff actively assist clients in transitioning to the next appropriate level of SUD residential treatment, including coordinating referrals, communicating with receiving programs, and supporting continuity of care. Clients also receive personalized care coordination and discharge planning services that include assistance in accessing and maintaining housing, assistance with accessing public transportation, coordination with medical care, and mental health (MH) or other social services, and SUD treatment or self-help groups. Naloxone kits are provided to Medicaid-funded clients who have an opioid substance use disorder and are willing to take one.

Program Requirements

Access

- Providers maintain the capacity and ability to assess and accept individuals 24/7 unless BHRD approves a different schedule in advance. Phone calls regarding referrals are responded to within 12 hours of receiving the referral.
- Individuals that meet the established admission criteria shall not be denied admission based on drug(s) of choice, taking an FDA-approved medically prescribed medication, using over-counter nicotine cessation medications, actively participating in a Nicotine Replacement Therapy regimen, or prior instances of discharging from the facility prior to a clinical determination that the individual completed treatment.
- Providers must update their current bed availability in the SUD Residential (SUDR) Bed Tracker each business day (Monday–Friday), with the exception of the crisis care centers. When a waitlist exists, Providers must record this as a negative number (e.g., "-3"). Providers are encouraged to use the "Notes" field to include details that may affect placement—such as waitlist timelines, special populations served, program features, or temporary capacity changes. Accurate daily updates support real-time visibility of system capacity and help individuals access care without delay.

Individual Service Plan

- An ISP must be developed within 72 hours of admission and serve as the foundation for discharge planning and transition to ongoing care.

- The ISP should include at least one goal identified by the client during the initial assessment or during the first treatment session following the assessment.
- The client should have a voice in developing their ISP. Treatment goals should be written in the client's own words, and documentation of progress must reflect the client's perspective on how they are progressing.
- The ISP should include clearly defined objectives that represent short-term, measurable, and observable steps toward each treatment goal; be updated whenever the client's needs, status, or progress change, or upon the client's request; and reflect mutual agreement between the client and the provider.
- The ISP should include the anticipated date or conditions for completion of each treatment goal, as well as the therapeutic strategies and interventions that will be used to resolve the identified problem(s).
- The ISP should be individualized, strengths-based, and informed by needs identified through diagnostic evaluations.
- A copy of the current, active ISP should be provided to the client.

Care Coordination

- Providers must coordinate with the individual's current SUD and MH treatment provider, if applicable, to assure continuity of care during admission and upon discharge.
- Providers must make a LOC recommendation to identify the most appropriate next treatment setting (e.g., residential, outpatient, or medication-assisted treatment services).
- In accordance with SB 6228, providers must ensure a seamless transition to the next LOC before utilization review begins. If additional treatment days are needed to support transition, the provider must document all actions taken to assist the client. Providers are responsible for coordinating the client's timely movement to the appropriate next level of SUD care by arranging referrals, communicating with receiving providers, and ensuring treatment continues without interruption.
- Care coordination efforts must be clearly documented within the client's record.
- Providers must maintain a system for coordinating services through mutually agreed upon protocols or Memorandum of Agreement (MOA). These define coordination of relevant services that support the withdrawal management program and its clients and facilitate effective and efficient referral, transfer, and information sharing. Protocols and MOA must be updated every three years. Payment will be withheld until receipt of all protocols or MOAs. These are to be maintained with the following agencies:
  - CDF or CDIS;
  - Downtown Emergency Service Center;
  - Evergreen Recovery Center Detox Branch;
  - Evergreen Treatment Services – REACH Project;
  - Harborview and other King County Emergency Departments;
  - Sobering Services; and
  - Tacoma Detoxification Center in Pierce County.

Discharge Planning

- Discharge planning applies to all clients, regardless of length of stay or if the client completes treatment.
- Providers document appropriate linkages for ongoing SUD or MH treatment and other referrals and provide written information on how to access treatment to clients who decline a referral.
- The discharge plan should include all scheduled follow-up appointments, including the time and date of the appointment(s), when possible.
- Each client must be given a copy of their discharge plan, and a copy retained in the client record.

Termination of Services

- Upon exit from treatment, the treatment facility will send the King County Discharge Report in the format provided by BHRD within 1 business day of the benefit termination to close out the authorization and receive payment.
- The AWM 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
  - Disciplinary reasons and/or to ensure the safety of other clients and staff

Information System Requirements
Within 24 hours from Admission the provider should transmit the following data through nightly batch processing or the web portal:

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

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

- Case manager link
- COD screening/assessment
- Disability
- Program referral
- SUD release of information

Invoice Program Specific Requirements
<u>Method of Payment</u>

- Daily bed rate payments will be made based on dates of admission and discharge reported on the census log for KCICN approved authorizations. Transportation costs for clients going to residential treatment may be reimbursed based on the actual cost. Medicaid-funded transportation should be used whenever possible. Receipts and payment documents for transportation costs are submitted with the invoice.
- 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.

<u>Additional Requirements</u>

- BHRD will not reimburse AWM providers for any services provided following the initial 3-day period without documented authorization by BHRD. Nor will BHRD reimburse services provided without receipt of clinical information and a documented authorization.
- BHRD is not required to pay for services delivered after the start of the UM review period, upon timely notification of the determination in writing. If untimely notification occurs, BHRD must pay for the services rendered from the time of admission until the time the UM review is completed, and the Provider is notified of the determination in writing.

- Medicaid is payer of last resort. If an individual has private insurance in addition to Medicaid, the provider must bill the insurance company prior to invoicing BHRD. BHRD will not pay above the contracted daily rate after insurance payment.
- If an individual has Medicare, Medicare will not pay for AWM 3.7 services. However, if the provider determines the individual meets criteria for non-Medicaid funds and has been approved by a BHRD care authorizer then they can submit an invoice for reimbursement.
- (For Valley Cities Counseling and Consultation ONLY) A linkage to treatment incentive payment of $10 per bed day per client will be made on any AWM length of stay where the client is linked to a MH or SUD residential benefit, MH or SUD outpatient benefit, or OTP benefit within 5 business days of discharge.

Reporting Requirements	
BHRD Information System	Submit Data to the BHRD Information System as outlined in the BHRD Data Dictionary and the Required Transactions Sheet in the ISAC Notebook.
Monthly Reports	AWMS Census Report
Quarterly Reports	None
Semiannual Reports	None
Annual/Other Reports	None
Performance Measurement Plan	None

Attachment A: Withdrawal Management Continued Stay Request Form

5.2 Secure Withdrawal Management (SWM)

Program Overview

In response to House Bill 1713 (“Ricky’s Law”), secure withdrawal management is a program for individuals who have been referred to Designated Crisis Responders (DCR’s) because they, as a result of a substance use disorder, present an imminent likelihood of serious harm. Secure Withdrawal Management and stabilization services are provided to voluntary or involuntary individuals to assist the process of withdrawal from psychoactive substances in a safe and effective manner, or medically stabilize an individual after acute intoxication, in accordance with chapters 71.05 and 71.34 RCW. The length of stay for secure withdrawal management is up to 120 hours. Clients receive a medical exam and an evaluation and get a recommendation for treatment from a psychiatric nurse practitioner. SWM facilities are medically monitored and have a regimen for evaluation and treatment. Substance Use Disorder Professionals provide onsite assessments and recommendations for the next level of care. Clients can have their 72-hour hold extended by court order to 14 days for acute treatment, and then up to 90 days in a “less-restrictive-alternative.” Admissions are available to an individual twenty-four hours a day, seven days a week, per WAC 246.341-0810(4) or its successor.

For clients that elope from SWM facilities:

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

Invoice Program Specific Requirements

Method of Payment

- Secure withdrawal management will be paid on an occupancy basis.
- The Contractor will inform the KCICN-KCASO if actual client admission or discharge dates differ from those authorized by the KCICN-KCASO. The KCICN-KCBHO may recoup payments should Contractor fail to notify the KCICN-KCBHO of changes in admission or discharge dates or provide incorrect dates resulting in benefit payment that exceeds the resident's actual length of stay.

Additional Requirements

- None

Secure Withdrawal Management *Eligibility Criteria*	
Medicaid Status	N/A
Age Range	18 years and older
Authorization Needed	Yes
Additional Criteria	○ Have been involuntarily detained by a Designated Crisis Responder (DCR) for a 72-hour evaluation and treatment period; or ○ Committed by the King County Superior Court for a 14-day period of evaluation and treatment under Revised Code of Washington (RCW) 71.05 and 71.34; or ○ Referred by the DCRs through the revocation process provided in RCW 71.05 and 71.34.
Secure Withdrawal Management Reporting Requirements	
Monthly Reports	Secure Withdrawal Management Census Report
Quarterly Reports	None
Semiannual Reports	None
Annual/Other Reports	None
Performance Measurement (PM) Plan	None

6 Substance Use Disorder Residential

Program Overview

Behavioral Health and Recovery Division (BHRD) contracts with substance use disorder residential (SUDR) programs in King County and throughout the state of Washington. SUDR is an essential part of the continuum of care, grounded in a recovery and resiliency-oriented approach and delivered in accordance with Washington Administrative Code (WAC) 246-341 or its successors. Additionally, SUDR 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).

SUDR services are delivered in a 24-hour supervised residential setting. The length of stay is individualized and determined by initial and ongoing assessments using American Society of Addiction Medicine (ASAM) criteria, as well as the client's progress toward treatment goals. BHRD provides authorization for the following SUDR levels of care (LOC): 3.1 Recovery House, 3.3 Long Term, and 3.5 Intensive Inpatient. Each level has distinct components and placement criteria based on the client's needs. Across all levels, treatment consists of individual and group counseling, educational services, and other interventions identified- in the client's Individualized Service Plan (ISP).

Eligibility Criteria

Medicaid Status	Yes, limited non-Medicaid funding available with BHRD approval
Age Range	Youth residential: 12-17 years old Adult residential: 18 years and older
Target Population	Providers ensure that priority admission is given to the Priority Populations as defined in the BH-ASO section of this manual.
Authorization Needed	In accordance with RCW 71.24.618, individuals seeking SUDR are automatically authorized for 2 days from their date of admission. Additional days must be authorized by King County. To obtain authorization, the Provider must submit an Authorization Request Cover Sheet by fax (206-205-1634) or secure email (resauth@kingcounty.gov). See Attachment: Authorization Request Cover Sheet.
Authorization Criteria	Individuals must demonstrate the need for SUDR using the six dimensions of the ASAM Criteria, Third Edition and the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), or their successors. Providers must submit clinical documentation that supports this LOC. This includes: Authorization Request Cover Sheet Full ASAM assessment (the requesting facility must be the one to have completed the assessment OR made an update to an outpatient provider's assessment conducted in the past 6 months) Clinical description of the client's needs and severity of symptoms Providers must also submit 3 Releases of Information (ROI): KCBHRD Redisclosure ROI KCBHRD Voluntary Consent ROI KCBHRD Disclosure ROI
Additional Criteria	The individual must be a resident of King County, be enrolled with an MCO or BH-ASO (or qualify for non-Medicaid funding) and have an income below 220% of the Federal Poverty Level for adults or 300% for youth.

Goals & Objectives

SUDR services are designed to provide a structured therapeutic environment where individuals can stabilize, address the root causes of their substance use, and build the skills needed for long-term recovery. SUDR services support individuals to achieve abstinence, develop healthy coping strategies, and understand the patterns that contribute to their substance use. Each client will collaborate with a Substance Use Disorder Professional (SUDP) or a SUDP Trainee under SUDP supervision to develop an ISP within 5 days of admission. The ISP is developed with the active participation of the client and any supportive individuals the client chooses to involve. Clients also receive personalized discharge planning services that include assistance in accessing and maintaining housing, assistance with accessing public transportation, coordination with medical care, mental health or other social services, and access to ongoing SUD treatment or self-help groups. Providers ensure clients have the necessary personal 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.

Program Requirements

Access

- Individuals that meet the established admission criteria shall not be denied admission based on drug(s) of choice, taking an FDA-approved medically prescribed medication, using over-counter nicotine cessation medications, actively participating in a Nicotine Replacement Therapy regimen,

or prior instances of discharging from the facility prior to a clinical determination that the individual completed treatment.

- Providers must update their current bed availability in the SUD Residential (SUDR) Bed Tracker each business day (Monday–Friday), with the exception of the crisis care centers. When a waitlist exists, Providers must record this as a negative number (e.g., "-3"). Providers are encouraged to use the "Notes" field to include details that may affect placement—such as waitlist timelines, special populations served, program features, or temporary capacity changes. Accurate daily updates support real-time visibility of system capacity and help individuals access care without delay.
- Providers reserve the right to deny admission when it is determined that the individual is beyond the scope of the Providers ability to safely or adequately provide treatment or that the inclusion of the individual in the treatment setting may interfere with or detract from the treatment of other clients.

Individual Service Plan

- An ISP should be developed within 72 hours of admission and serve as the foundation for discharge planning and transition to ongoing care.
- The ISP should include at least one goal identified by the client during the initial assessment or during the first treatment session following the assessment.
- The client should have a voice in developing their ISP. Treatment goals should be written in the client's own words, and documentation of progress must reflect the client's perspective on how they are progressing.
- The ISP should include clearly defined objectives that represent short-term, measurable, and observable steps toward each treatment goal; be updated whenever the client's needs, status, or progress change, or upon the client's request; and reflect mutual agreement between the client and the provider.
- The ISP should include the anticipated date or conditions for completion of each treatment goal, as well as the therapeutic strategies and interventions that will be used to resolve the identified problem(s).
- The ISP should be individualized, strengths-based, and informed by needs identified through diagnostic evaluations and periodic reviews.
- The ISP should address all substance use requiring treatment—including tobacco when clinically indicated—and incorporate the client's biopsychosocial needs.
- A copy of the current, active ISP should be provided to the client.

Care Coordination

- 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.
- Providers must coordinate with the individual's current SUD and MH treatment provider, if applicable, to assure continuity of care during admission and upon discharge. This includes the exchange of assessment, admission, treatment progress, and continuing care information with the referring entity. Initial contact with the referral source should occur within the first week of residential treatment.
- 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 accept and make the necessary adjustments to continue treatment for any clinically appropriate client utilizing Medication for Alcohol Use Disorder (MAUD) or Medication for Opioid Use Disorder (MOUD), including methadone.
- Providers must make a LOC recommendation to identify the most appropriate next treatment setting (e.g., a lower level of residential care, outpatient care, or medication-assisted treatment services).

- In accordance with SB 6228, providers must ensure a seamless transition to the next LOC before utilization review begins. If additional treatment days are needed to support transition, the provider must document all actions taken to assist the client. Providers are responsible for coordinating the client's movement to the appropriate next LOC care by arranging referrals, communicating with receiving providers, and ensuring treatment continues without interruption.
- Care coordination efforts must be clearly documented within the client's record.
- The referent is responsible for arranging the individual's transportation to the facility and ensuring necessary processes/documents are completed and communicated to the SUDR provider.

Discharge Planning

- Discharge planning applies to all clients, regardless of length of stay or if the client completes treatment.
- Providers maintain referral relationships with assessment agencies, outpatient treatment providers, vocational or employment services, and courts which specify aftercare expectations and services. Providers ensure a procedure for involvement of entities making referrals in treatment activities.
- Providers coordinate, as needed, with prevention programs, vocational services, housing supports, and other community resources, including the Department of Social and Health Services (DSHS) Children's Administration and the DSHS Economic Services Administration, such as Community Services Offices (CSOs).
- Providers shall document appropriate linkages for ongoing SUD or MH treatment and other referrals and provide written information on how to access treatment to clients who decline a referral.
- The discharge plan should include all scheduled follow-up appointments, including the time and date of the appointment(s), when possible.
- Each client must be given a copy of their discharge plan, and a copy retained in the client record.

Termination of Services

- Upon exit from treatment, the treatment facility will send the King County Discharge Report in the format provided by BHRD within 1 business day of the benefit termination to close out the authorization and receive payment.
- The SUDR 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
  - Disciplinary reasons and/or to ensure the safety of other clients and staff

Invoice Program Specific Requirements

Method of Payment

- Daily bed rate payments will be made based on dates of admission and discharge reported on the census log for KCICN approved authorizations. A terminated benefit is payable to the date prior to termination.
- Reimbursement will be made as follows:
- Number of bed days (actual occupancy) x daily bed rate = reimbursement. The date of discharge is not reimbursable for services provided at the residential level of care.
- Transportation costs for clients going to residential treatment may be reimbursed based on the actual cost. Medicaid-funded transportation should be used whenever possible. Receipts and payment documents for transportation costs must be submitted with the invoice.
- 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.

Additional Requirements

- BHRD will not reimburse services provided beyond the initial authorization period without receipt of clinical information and a documented authorization by BHRD. Nor will BHRD reimburse services provided without receipt of clinical information and a documented authorization.

- BHRD is not required to pay for services delivered after the start of the UM review period, upon timely notification of the determination in writing. If untimely notification occurs, BHRD must pay for the services rendered from the time of admission until the UM review is completed and the Provider is notified of the determination in writing.
- Medicaid is payer of last resort. If an individual has private insurance in addition to Medicaid, the provider must bill the insurance company prior to invoicing BHRD. BHRD will not pay above the contracted daily rate after insurance payment.
- If an individual has Medicare, Medicare will not pay for SUDR services. However, if the provider determines the individual meets criteria for non-Medicaid funds and has been approved by a BHRD care authorizer then they can submit an invoice for reimbursement.

Reporting Requirements

BHRD Information System	• Submit Data to the BHRD Information System as outlined in the BHRD Data Dictionary and the Required Transactions Sheet in the ISAC Notebook.
Monthly Reports	• SUD Residential Census Report
Quarterly Reports	• None
Semiannual Reports	• None
Annual/Other Reports	• None
Performance Measurement Plan	• None

Attachments in this Section

- Attachment A: Authorization Request Cover Sheet
- Attachment B: SUDR Authorization and Billing Instructions—Planned Requests
- Attachment C: SUDR Authorization and Billing Instructions—Urgent/Concurrent Requests

SUD Residential Authorization and Billing Instructions—Planned Requests

The first 2 days of SUD Residential (SUDR) do not require authorization. Any additional treatment days must be authorized by King County.

Administrative Eligibility and Medical Necessity

Administrative Eligibility	- Resident of King County as determined by the County Code in Provider One - Assigned to a Medicaid MCO or BH-ASO or qualify for Non-Medicaid funding - Program-Specific Eligibility
Medical Necessity	- Diagnosis of a classified substance-related disorder as defined by the DSM-5 - ASAM level of care ranging from 3.1 to 3.5 - Needs cannot be more appropriately met by any other formal or informal system or support

Planned Authorization Requests

Planned authorization requests are pre-approved and occur prior to admit. Required documentation must be completed in full and submitted within the identified time frame to ensure timely authorization. Continued stay reviews are based upon the client's treatment needs and progress in residential treatment. Continued stay criteria must also be met. Failure to provide complete information may result in a delay or denial.

Planned Authorization Instructions

Initial Stay

1. The Provider will verify administrative eligibility and document the client's income on the Authorization Cover Sheet to determine eligibility for non-Medicaid funding if needed.
2. The Provider will submit clinical documentation that demonstrates this level of care to BHRD via fax (206-205-1634) or secure email (resauth@kingcounty.gov). This includes:
   - Authorization Cover Sheet
   - Full ASAM assessment (the requesting facility must be the one to have completed the assessment OR made an update to an outpatient providers assessment conducted in the past 6 months)
   - Clinical description of the client's needs and severity of symptoms

   Providers must also submit 3 Releases of Information (ROI). If the client has an open SUD outpatient benefit with the referent, only asterisked ROI is required:

   - KCBHRD Redisclosure ROI*
   - KCBHRD Voluntary Consent ROI
     KCBHRD Disclosure ROI
3. If no additional information is needed, BHRD will make an authorization determination within 5 calendar days from receipt of the clinical documentation.
4. If additional information is needed to make an authorization decision, BHRD will make a request within 1 calendar day from the receipt of the request for authorization. The Provider must submit the additional information within 4 calendar days of the request for additional information. BHRD will make a final authorization decision within 7 calendar

days from the original request for authorization. The authorization review period may be extended up to 14 calendar days when in the best interest of the client. Only one extension may be granted.

5. If it is determined that medical necessity is not met, the requested program is inappropriate, or the referent did not provide the required documentation within the identified time frame, BHRD will consult with the referring facility to see if they are willing to transfer to a more appropriate program or level of care to address the client's assessed needs or withdraw the request. If a revision is agreed upon, BHRD will notify the referring facility of the number of authorized days.
6. If it is determined that administrative eligibility is not met, a denial decision will be made and the referent informed of the reason. The treatment facility has 365 days to submit clinicals for a retrospective review and to receive payment for services rendered.
7. A Letter of Authorization or Denial Decision will be sent to the referring facility and client within 5 calendar days if no additional information is needed. Alternatively, within 3 calendar days of the authorization decision if additional information is requested or an extension is granted. If there is no address for the client, the referring facility will be asked to provide the letter to the client.
8. BHRD will send a Certificate of Admission to the referring facility indicating the authorization number, type of admission, initial length of stay, and date of the last authorized day.

Continued Stay

1. The Provider will submit clinical documentation that demonstrates continued need for this level of care to BHRD via fax (206-205-1634) or secure email (resauth@kingcounty.gov) 3-5 business days before expiration of the initial authorization. This includes:
    - Updated Authorization Cover Sheet
    - ASAM placement for the requested residential service level
    - Updated individual service plan (ISP) demonstrating ASAM placement and progress toward treatment goals
    - Discharge plans pertinent to housing and continued recovery support
2. If no additional information is needed, a determination will be made within 1 business day of receipt of the request.
3. If additional information is needed to make an authorization decision, BHRD will make a request within 1 business day of receipt of the request. The Provider must provide the additional information as soon as possible and no later than 3 p.m. the following business day.
4. BHRD will make a final authorization decision within 3 business days of receipt of the authorization request and provide notification of authorization or denial within 1 business day of the authorization decision, not to exceed 3 business days from the original receipt of the request.
5. If it is determined that continued stay criteria are not met, the Care Authorizer will consult with the inpatient facility regarding withdrawal or revision or, the approved board-certified physician for a denial determination.

Termination or Discharge

1. The SUD residential benefit will terminate if/when:
    - The authorization period expires
    - The client permanently exits the program prior the authorization period expiration
    - The client's Medicaid coverage is terminated, and they're ineligible for non-Medicaid
    - The provider discharges the person for disciplinary reasons and/or to ensure the safety of other persons and staff
    - The person meets medical necessity for a lower level of care
2. Upon termination or exit from treatment, the Provider will submit the King County Discharge Report within 1 business day of client's exit from treatment to close out the authorization and receive payment.
3. BHRD will provide a discharge summary if available, to the referent and/or aftercare provider.

Authorized or Unauthorized Leave

To request a bed hold

Complete the King County Absence Request form and send via fax to the assigned Care Authorizer for review. A covered residential bed hold of up to 5 days may be granted. Notification of absence or leave of less than 24 hours is not required.

If a client leaves Against Medical Advice (AMA) within the first 2-3 days of their stay

Submit a Notice of Admission that includes the date of admission as well as the King County Discharge Report to provide a date of discharge and relevant demographic information.

Questions and Additional Information

The following phone lines and email inbox are answered M-F between 8:00am and 5:00pm.

- Client Services Line: 206-263-8997 or 1-800-790-8049
- SUD Residential Treatment Line: 855-682-0781
- SUD Residential Email Address: resauth@kingcounty.gov

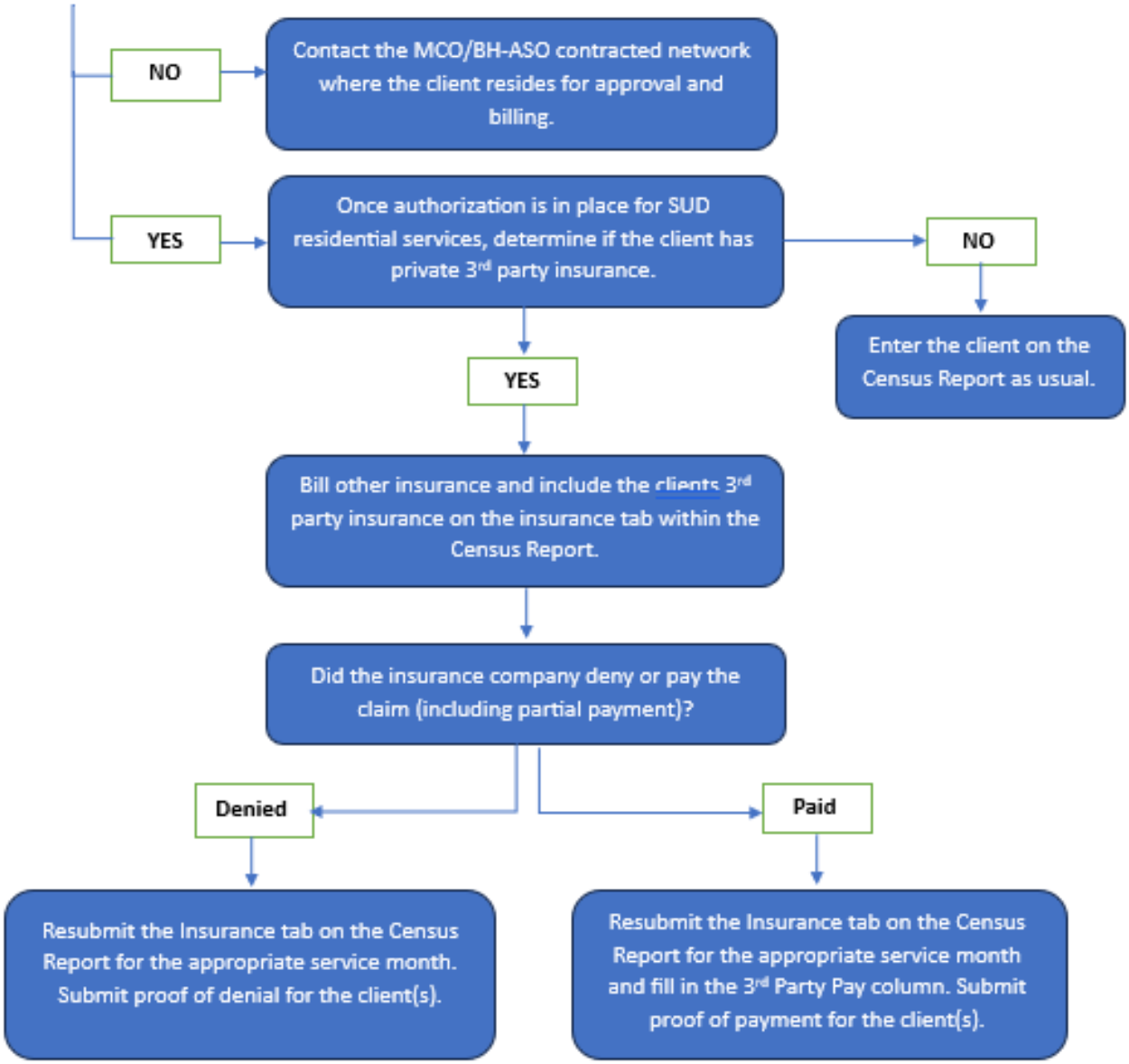
Additional information, required forms, and care coordination contact information for providers can be found on the BHRD Care Coordination SharePoint: DCHS BHRD Care Coordination and Quality Resources.

To request access to the SharePoint, email: DCHSadminteam@kingcounty.gov.

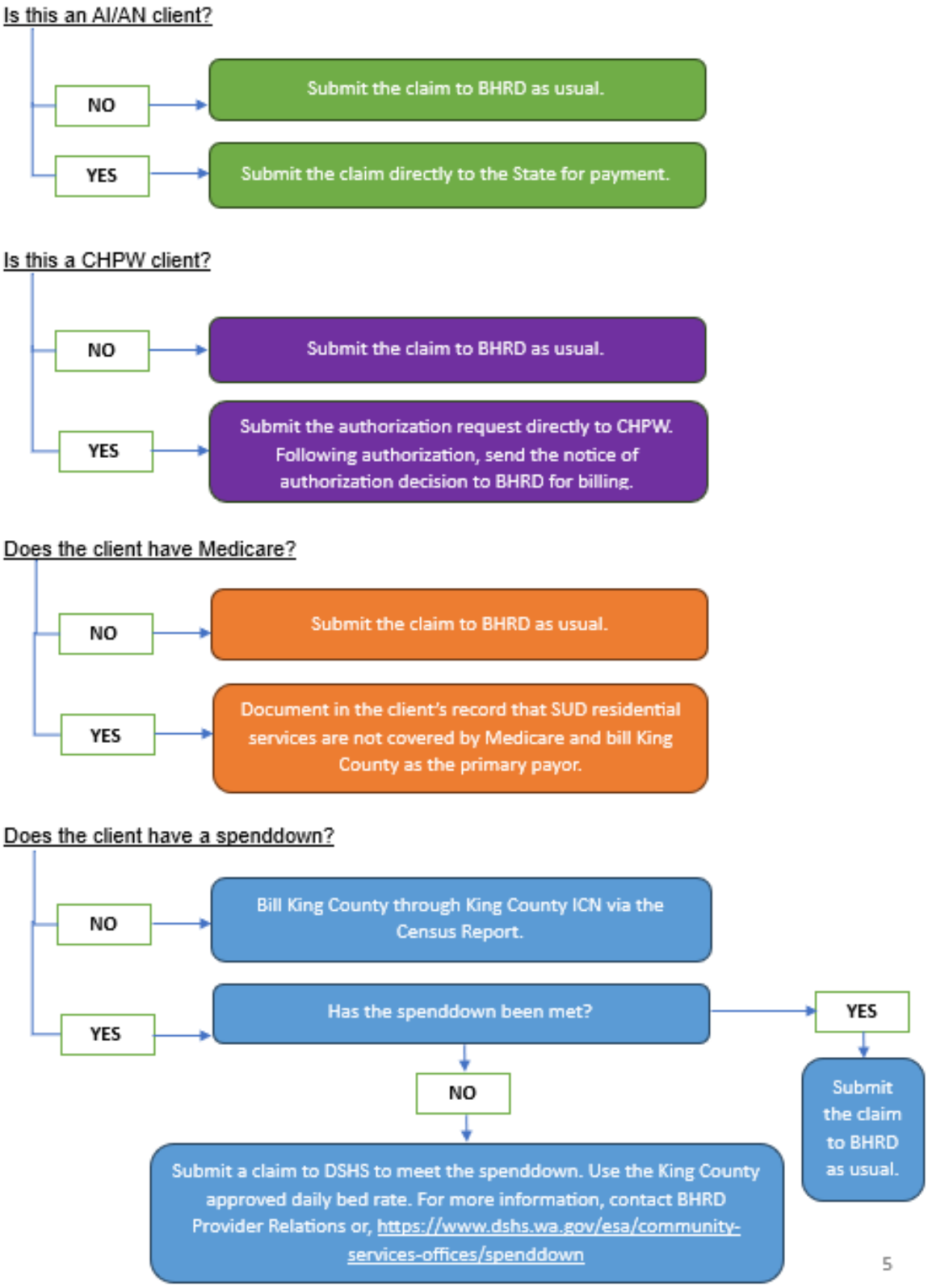
SUD Residential Authorization and Billing Instructions—Planned Requests

SUD Residential Billing Process

Is the individual a King County Resident?



SUD Residential Authorization and Billing Instructions—Planned Requests



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SUDR Authorization and Billing Instructions—Urgent/Concurrent Requests

The first 2 days of SUD Residential (SUDR) do not require authorization. Any additional treatment days must be authorized by King County.

Administrative Eligibility and Medical Necessity

Administrative Eligibility	- Resident of King County as determined by the County Code in Provider One - Assigned to a Medicaid MCO or BH-ASO or qualify for Non-Medicaid funding - Program-Specific Eligibility
Medical Necessity	- Diagnosis of a classified substance-related disorder as defined by the DSM-5 - ASAM level of care (LOC) ranging from 3.1 to 3.5 - Needs cannot be more appropriately met by any other formal or informal system or support

Urgent/Concurrent Authorization Requests

Urgent/concurrent authorization requests occur when the client is currently admitted to treatment. Required documentation must be completed in full and submitted within the identified time frame to ensure timely authorization. Continued stay reviews are based upon the client's treatment needs and progress in residential treatment. Continued stay criteria must also be met. Failure to provide complete information may result in a delay or denial.

Urgent/Concurrent Authorization Instructions

Initial Stay

1. A notice of admission must be sent to BHRD within 1 business day of admit into treatment.
2. The Provider will submit clinical documentation that demonstrates this level of care to BHRD via fax (206-205-1634) or secure email (resauth@kingcounty.gov) within 2 business days of the client's admit to treatment. This includes:
    - Authorization Cover Sheet
    - Full ASAM assessment (the requesting facility must be the one to have completed the assessment OR made an update to an outpatient providers assessment conducted in the past 6 months)
    - Clinical description of the client's needs and severity of symptoms
    - Initial ISP/treatment plan

    Providers must also submit 3 Releases of Information (ROI). If the client has an open SUD outpatient benefit with the referent, only asterisked ROI is required:

    - KCBHRD Redisclosure ROI*
    - KCBHRD Voluntary Consent ROI
    - KCBHRD Disclosure ROI
3. If no additional information is needed, a determination will be made within 1 business day of receipt of the request.

4. If additional information is needed to make an authorization decision, BHRD will make a request within 1 business day of receipt of the request. The Provider must provide the additional information as soon as possible and no later than 3 p.m. the following business day.
5. BHRD will make a final authorization decision within 3 business days of receipt of the authorization request and provide notification of authorization or denial within 1 business day of the authorization decision, not to exceed 3 business days from the original receipt of the request.
6. If it is determined that continued stay criteria are not met, the Care Authorizer will consult with the inpatient facility regarding withdrawal or revision or, the approved board-certified physician for a denial determination.

Continued Stay

1. The Provider will submit clinical documentation that demonstrates continued need for this level of care to BHRD via fax (206-205-1634) or secure email (resauth@kingcounty.gov) 3-5 business days before expiration of the initial authorization. This includes:
    - Updated Authorization Cover Sheet
    - ASAM placement for the requested residential service level
    - Updated individual service plan (ISP) demonstrating ASAM placement and progress toward treatment goals
    - Discharge plans pertinent to housing and continued recovery support
2. If no additional information is needed, a determination will be made within 1 business day of receipt of the request.
3. If additional information is needed to make an authorization decision, BHRD will make a request within 1 business day of receipt of the request. The Provider must provide the additional information as soon as possible and no later than 3 p.m. the following business day.
4. BHRD will make a final authorization decision within 3 business days of receipt of the authorization request and provide notification of authorization or denial within 1 business day of the authorization decision, not to exceed 3 business days from the original receipt of the request.
5. If it is determined that continued stay criteria is not met, the Care Authorizer will consult with the inpatient facility regarding withdrawal or revision or, the approved board-certified physician for a denial determination.

Termination or Discharge

1. The SUD residential benefit will terminate if/when:
    - The authorization period expires
    - The client permanently exits the program prior the authorization period expiration
    - The client's Medicaid coverage is terminated, and the client is ineligible for ~~Non-~~ Medicaid
    - The provider discharges the person for disciplinary reasons and/or to ensure the safety of other persons and staff
    - The person meets medical necessity for a lower level of care

2. Upon termination or exit from treatment, the Provider will submit the King County Discharge Report within 1 business day of client's exit from treatment to close out the authorization and receive payment.
3. BHRD will provide a discharge summary if available, to the referent and/or aftercare provider.

Authorized or Unauthorized Leave

To request a bed hold

Complete the King County Absence Request form and send via fax to the assigned Care Authorizer for review. A covered residential bed hold of up to 5 days may be granted. Notification of absence or leave of less than 24 hours is not required.

If a client leaves Against Medical Advice within the first 2-3 days of their stay

Submit a Notice of Admission that includes the date of admission as well as the King County Discharge Report to provide a date of discharge and relevant demographic information.

Questions and Additional Information

The following phone lines and email inbox are answered M-F between 8:00am and 5:00pm.

- Client Services Line: 206-263-8997 or 1-800-790-8049
- SUD Residential Treatment Line: 855-682-0781
- SUD Residential Email Address: resauth@kingcounty.gov

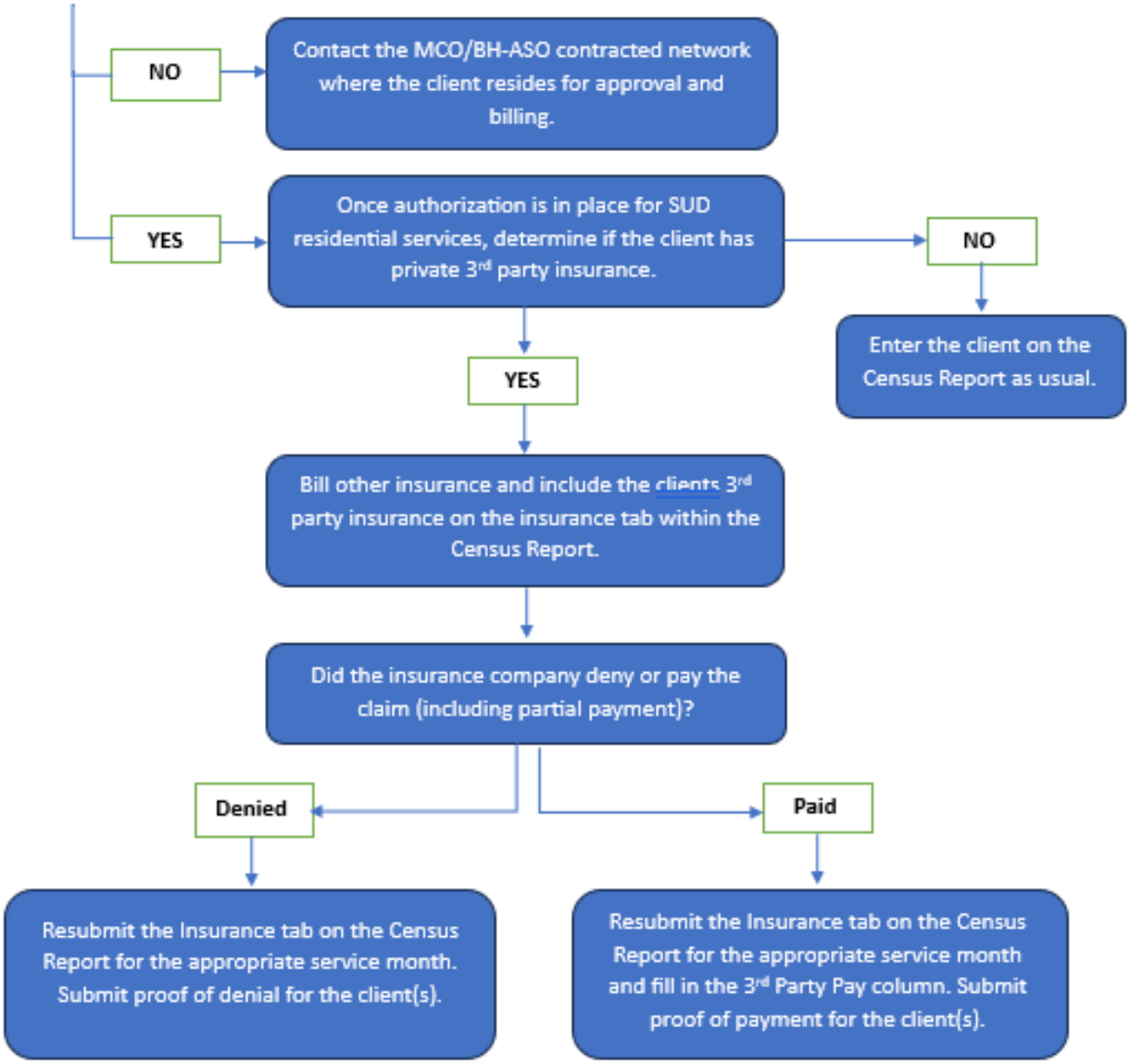
Additional information, required forms, and care coordination contact information for providers can be found on the BHRD Care Coordination SharePoint: DCHS BHRD Care Coordination and Quality Resources.

To request access to the SharePoint, email: DCHSadminteam@kingcounty.gov.

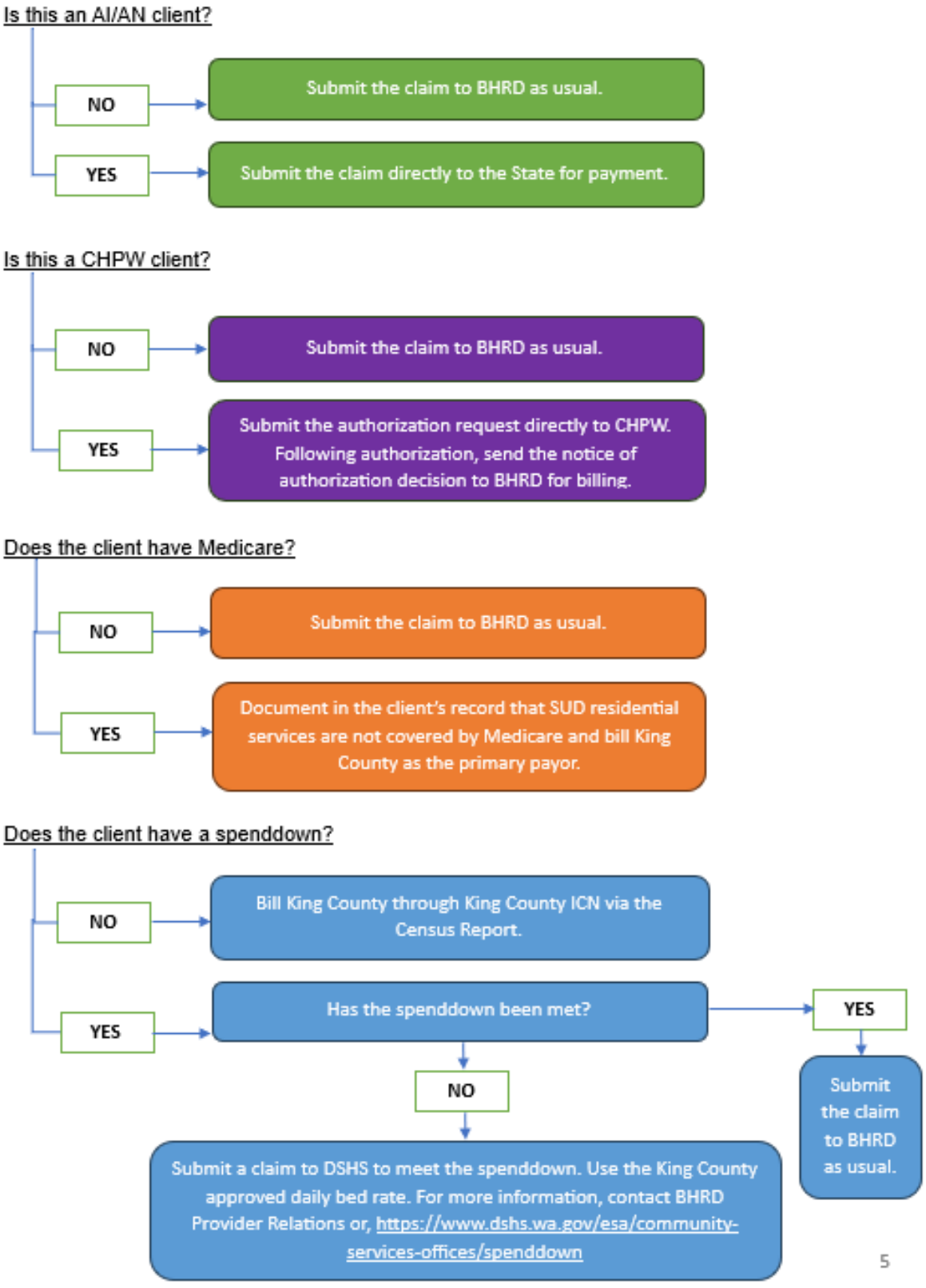
SUDR Authorization and Billing Instructions—Urgent/Concurrent Requests

SUD Residential Billing Process

Is the individual a King County Resident?



SUDR Authorization and Billing Instructions—Urgent/Concurrent Requests



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6.1 Adult Co-Occurring Disorders Residential Treatment Services

Program Overview

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

Invoice Program Specific Requirements

Method of Payment

- Daily bed rate and room and board payments will be made retrospectively based on dates of admission and discharge reported on the census log for KCICN approved authorizations.
  - Reimbursement will be made as follows:
- Number of bed days (actual occupancy) x daily bed rate = reimbursement. The date of discharge is not reimbursable for services provided at this residential level of care.
- Transportation:
  - Costs will be reimbursed for transportation for clients returning from residential treatment;
  - Reimbursement will be made based on the actual cost for the transportation service provided;
  - Whenever possible, Medicaid-funded transportation should be utilized; and
  - Receipts and payment documents related to transportation costs must be submitted along with the invoice.
- Administrative bed rate payments will be made for a limited period of time for individuals who no longer meet medical necessity criteria but have been unable to be discharged from the facility to an appropriate placement.
- **PHS ONLY** – Start-up costs will be paid on a cost-reimbursement basis for hiring and operational costs incurred prior to being fully staffed and able to provide services, for the period of January 1, 2024 – December 31, 2024.

Additional Requirements

- None

6.2 Adult Intensive Inpatient

Program Overview

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

Invoice Program Specific Requirements

Method of Payment

- Daily bed rate and room and board payments will be made retrospectively based on dates of admission and discharge reported on the census log for KCICN approved authorizations.

Reimbursement will be made as follows:

- Number of bed days (actual occupancy) x daily bed rate = reimbursement. The date of discharge is not reimbursable for services provided at this residential level of care.
- Transportation:
  - Costs will be reimbursed for transportation for clients returning from residential treatment;
  - Reimbursement will be made based on the actual cost for the transportation service provided;
  - Whenever possible, Medicaid-funded transportation should be utilized; and
  - Receipts and payment documents related to transportation costs must be submitted along with the invoice.
- Administrative bed rate payments will be made for a limited period of time for individuals who no longer meet medical necessity criteria but have been unable to be discharged from the facility to an appropriate placement.

Additional Requirements
None

6.3 Adult Long-Term Care

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

Invoice Program Specific Requirements
Method of Payment
- Daily bed rate and room and board payments will be made retrospectively based on dates of admission and discharge reported on the census log for KCICN approved authorizations.
- Transportation:
  - Costs will be reimbursed for transportation for clients returning from residential treatment;
  - Reimbursement will be made based on the actual cost for the transportation service provided;
  - Whenever possible, Medicaid-funded transportation should be utilized; and
  - Receipts and payment documents related to transportation costs must be submitted along with the invoice.
- Administrative bed rate payments will be made for a limited period of time for individuals who no longer meet medical necessity criteria but have been unable to be discharged from the facility to an appropriate placement.

Additional Requirements
- None

6.4 Adult Recovery House

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

Invoice Program Specific Requirements
Method of Payment
- Daily bed rate and room and board payments will be made retrospectively based on dates of admission and discharge reported on the census log for KCICN approved authorizations.
- Transportation:
  - Costs will be reimbursed for transportation for clients returning from residential treatment;
  - Reimbursement will be made based on the actual cost for the transportation service provided;
  - Whenever possible, Medicaid-funded transportation should be utilized; and
  - Receipts and payment documents related to transportation costs must be submitted along with the invoice.
- Administrative bed rate payments will be made for a limited period of time for individuals who no longer meet medical necessity criteria but have been unable to be discharged from the facility to an appropriate placement.

Additional Requirements
- None

6.5 CJTA Adult Opioid Use Disorder Residential

Program Overview

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

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

6.6 Pregnant and Parenting Women

Program Overview
The scope title is anticipated to transition to more inclusive language, removing women and replacing it with “individual.”

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.

Invoice Program Specific Requirements
Method of Payment
- Daily bed rate and room and board payments will be made retrospectively based on dates of admission and discharge reported on the census log for KCICN approved authorizations.
- Transportation:
  - Costs may be reimbursed for transportation for clients returning from residential treatment;
  - Reimbursement will be made based on the actual cost for the transportation service provided;
  - Whenever possible, Medicaid-funded transportation should be utilized; and
  - Receipts and payment documents related to transportation costs must be submitted along with the invoice.
- Administrative bed rate payments will be made for a limited period of time for individuals who no longer meet medical necessity criteria but have been unable to be discharged from the facility to an appropriate placement.

Additional Requirements
- None

6.7 Youth Co-Occurring Disorders Intensive Inpatient

Program Overview
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.

Invoice Program Specific Requirements
Method of Payment
- Daily bed rate and room and board payments will be made retrospectively based on dates of admission and discharge reported on the census log for KCICN approved authorizations.
- Transportation
  - Costs will be reimbursed for transportation for clients returning from residential treatment;

  - Reimbursement will be made based on the actual cost for the transportation service provided;
  - Whenever possible, Medicaid-funded transportation should be utilized; and
  - Receipts and payment documents related to transportation costs must be submitted along with the invoice.
- Administrative bed rate payments will be made for a limited period of time for individuals who no longer meet medical necessity criteria but have been unable to be discharged from the facility to an appropriate placement.

Additional Requirements
- None.

6.8 Youth Intensive Inpatient

Program Overview

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).

Invoice Program Specific Requirements

Method of Payment
- Daily bed rate and room and board payments will be made retrospectively based on dates of admission and discharge reported on the census log for KCICN approved authorizations.
- Daily bed rate and room and board payments will be made retrospectively based on dates of admission and discharge reported on the census log for KCICN approved authorizations.
- Transportation
  - Costs will be reimbursed for transportation for clients returning from residential treatment;
  - Reimbursement will be made based on the actual cost for the transportation service provided;
  - Whenever possible, Medicaid-funded transportation should be utilized; and
  - Receipts and payment documents related to transportation costs must be submitted along with the invoice.
- Administrative bed rate payments will be made for a limited period of time for individuals who no longer meet medical necessity criteria but have been unable to be discharged from the facility to an appropriate placement.

Additional Information
- None

6.9 Youth Recovery House

Program Overview

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

Invoice Program Specific Requirements

Method of Payment
- Daily bed rate and room and board payments will be made retrospectively based on dates of admission and discharge reported on the census log for KCICN approved authorizations.
- Transportation:
  - Costs will be reimbursed for transportation for clients returning from residential treatment;
  - Reimbursement will be made based on the actual cost for the transportation service provided;
  - Whenever possible, Medicaid-funded transportation should be utilized; and
  - Receipts and payment documents related to transportation costs must be submitted along with the invoice.

- Administrative bed rate payments will be made for a limited period of time for individuals who no longer meet medical necessity criteria but have been unable to be discharged from the facility to an appropriate placement.

Additional Requirements

- None.

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 Requests

For any invoice that includes the following requests (Unfunded Benefits, Absence Requests), the signed and approved form must be attached in Agiloft, or the invoice cannot be processed. This is to ensure the provider is still requesting this funding.

Unfunded Benefits

There are two types of unfunded benefit coverage that can be requested: Non-Medicaid Treatment Coverage and Room & Board Coverage.

Treatment coverage for clients who do not yet have Medicaid and/or are structurally ineligible for Medicaid may also be available. A subsidy for client participation (Room & Board Coverage) may be available for Medicaid-eligible individuals with no income or those who only qualify for Aged, Blind and Disabled (ABD) cash assistance.

Approval from the Behavioral Health and Recovery Division (BHRD) either prior to MHR placement or after MHR placement is required to access this benefit:

- Prior to MHR placement, an Unfunded Benefits Coverage request can be made via 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.
- After MHR placement, a request for Residential Absence Authorization from the MHR provider to the Utilization Management Team is required. The request is reviewed and returned with either approval or denial to providers within 14 days.

In both instances, clients must meet medical necessity standards.

Non-Medicaid treatment coverage is available for ISD, LTR, E-ICSRP, ICSRP, and SL clients using the Unfunded Benefits Coverage Authorization Request Form.

- Please make sure you are choosing “benefits coverage” in the drop-down
- This is a 30-day benefit in most instances
- Mental Health Residential Utilization Management Team can grant a renewal after 30 days upon determination of a reasonable request (some examples are inability to obtain Medicaid due to spenddowns, immigration status, or having AI/AN insurance).
    - If there is structural ineligibility for Medicaid treatment for a client, the Utilization Management Team may approve the request for up to 6 months.

- Once the client obtains Medicaid, the provider must alert the UM team that the request is no longer needed.

Room & Board coverage is available for LTR and SL clients using the Unfunded Benefits Coverage Authorization Request Form. See Attachments in this Section

- Please make sure you are choosing "room and board" in the drop down
- This is a 6-month benefit in most instances
- UM can grant a renewal after 6 months if a request is made with documentation that depicts a good faith effort to obtain SSI or other payment options
- Once the client obtains funding for participation fees, the provider must alert the UM team that the request is no longer needed.

Absence Requests

Any absences from MHR for longer than 5 days must be reviewed and approved by Hospital Mental Health Residential's (HMHR's) UM team to receive payment; please submit the form after the 6th day and provide an expected return date if applicable.

- Absence requests are available for IBHTF, ISD, LTR, E-ICSRP, SL, and ICSRP clients using the Residential Absence Authorization form.
- The maximum requested absence is 30 days outside of extraordinary circumstances with appropriate clinical justification.
- Documentation of care coordination, and anticipated return to the facility within 30 days may be requisite for payment.
- Rate of payment for approved absences:
    - For days 1-5: IBHTF, ISD, LTR, E-ICSRP, SL, and ICSRP are paid at the daily rate established with King County.
    - For days 6+: LTR, E-ICSRP, SL, and ICSRP are paid at the daily rate established with King County.
    - For days 6+: IBHTF and ISD are paid at the administrative rate established with King County (21%).

Attachments in this Section:

Attachment A: Unfunded Benefits Coverage Auth Request Form

Attachment B: Residential Absence Authorization

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 the BH-ASO section of this manual. Priority groups for Mental Health Residential programs is as follows:

First priority group:

- A client from Western State Hospital (WSH);
- A client from a local psychiatric hospital;
- A client from a higher level of care; or Second priority group:
- A client who is at risk of psychiatric hospitalization and needing a higher level of services over time to remain stable in the community; or
- A client who experiences serious and persistent mental illness and is chronically homeless.

Residential Admissions

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

Duties of Providers

- Offer interviews to individuals according to date and receipt of the Residential Application and Screening Form;
- Submit a Tracking Form to the KCHL if the Provider makes a determination that an individual is not appropriate for admission;
- Provide suggestions and/or recommendations to KCHL to overcome potential barriers for individuals determined not appropriate for admission;
- Participate in a weekly conference call with BHRD and other residential Providers; and
- Collaborate as needed with the KCHL to consult about individuals with high needs or unique
- circumstances that would prioritize the referral for placement;
- Seek approval from the KCHL Supervisor before moving a MH Residential client to a new facility;
- Notify the KCHL when the client's MH Residential services will be 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 their 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

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;
- Discharge planning and transition services.

Required Staff Trainings

For clients to receive services that are based in Recovery and Resiliency, staff complete annual training in the following subjects (WAC 246-641-1118):

- Recovery and resiliency principles and practices;
- The least restrictive alternative treatment options available in the community and how to access them;
- How to provide individualized treatment;
- De-escalation training and management of assaultive and self-destructive behaviors;
- 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;
- Goals developed with the participation of the client and support persons as identified by the client;
- Objectives, defined as short-term steps that are timely, measurable, and observable toward 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;
- A written protocol specifying that the mental health residential facilities do not administer involuntary antipsychotic medications (WAC 246-341-1124) or its successor;
- Medical appointments;
- 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 supports that both the client and treatment team have identified.
- Annual eligibility reviews for continued stay clients as specified by BHRD.

Termination and Discharge

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

- Coordinate a community-based discharge plan for each client served under this Contract beginning at intake. Discharge planning applies to all clients regardless of length of stay or whether they complete treatment.
- Coordinate exchange of assessment, admission, treatment progress, and continuing care information with the referring entity. Contact with the referral agency is made within the first week of residential treatment.

- Establish referral relationships with assessment entities, outpatient Providers, vocational or employment services, and courts which specify aftercare expectations and services, including procedure for involvement of entities making referrals in treatment activities.
- Coordinate, as needed, with prevention services, vocational services, housing services and supports, and other community resources and services that may be appropriate, including the DSHS Children's Administration, and the DSHS Economic Services Administration including Community Service Offices (CSOs).
- Coordinate services to financially eligible clients who need medical services.

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

Program Overview

BHRC is a program designed for 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.

Invoice Program Specific Requirements

<u>Method of Payment</u>

- The maximum capacity to be reimbursed is 40 beds.
- Monthly reimbursement will be made in the following manner:
  - Total number of days of service in the month x Daily Bed Rate = Reimbursement.

<u>Additional Requirements</u>

- None

BHRC Eligibility Criteria	
Medicaid Status	Yes, limited non-Medicaid funding available with BHRD approval
Age Range	18 years and older
Authorization Needed	Yes
Additional Criteria	• Referred by King County Hospital and Community Liaisons (KCHL) based on the Residential Services Screening Form (Screening Form) and Residential Services Placement Request Form (Residential Application) and meets medical necessity. • 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; • Has a mental illness diagnosis which is considered to be a serious and persistent mental illness. • 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. • Is willing and able to actively participate in mental health services. • Has impairment(s) and corresponding service need(s) as a result of the covered mental illness. • Has unmet need(s) which cannot be more appropriately met by Home and Community Services (HCS), mental health services, or informal systems or supports. • Is not eligible to receive other mental health or HCS services in a less restrictive setting. • Has failed in previous community-based settings and requires skilled nursing services.
BHRC Reporting Requirements	
Monthly Reports	Benson Heights Rehabilitation Center Census Log
Quarterly Reports	None
Semiannual Reports	Provider combines information with that identified in the BHRD Outpatient Benefit Scope and follow the Outpatient Benefit Scope Reporting Requirements.
Annual/Other Reports	None
Performance Measurement (PM) Plan	None

7.2 Eating Disorder Services

Program Overview

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. 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 include an updated treatment plan. How to obtain authorization depends 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.

Invoice Program Specific Requirements

Method of Payment

- Daily bed rates will be reimbursed retrospectively based on dates of admission and discharge reported on the census log for KCICN approved authorizations.
- Reimbursement will be made as follows:
  Number of bed days (actual occupancy) x daily bed rate = reimbursement. Discharge dates for Intensive Outpatient Program (IOP) and Partial Hospitalization Program (PHP) levels of care are eligible for reimbursement.
- Administrative bed rate payments will be made for a limited period of time for individuals who no longer meet medical necessity criteria but have been unable to be discharged from the facility to an appropriate placement.

Eating Disorder Services Eligibility Criteria	
Medicaid Status	Yes
Age Range	N/A
Authorization Needed	Yes

Additional Criteria	The individual must be a King County resident with active Medicaid status
Eating Disorder Services Reporting Requirements	
Monthly Reports	Eating Disorder Census Report
Quarterly Reports	None
Semiannual Reports	None
Annual/Other Reports	None
Performance Measurement (PM) Plan	None

7.3 Intensive Behavioral Health Treatment Facilities (IBHTFs)

IBHTFs are a voluntary 16-bed psychiatric facility where clinical staff provide recovery-based treatment using evidence-based practices, independent living skills training, social skills, and community integration. Intensive Behavioral Health Treatment Facilities (IBHTFs) serve individuals discharging from Washington State Hospital Facilities, Long-Term Civil Commitment (LTCC) facility, community based psychiatric hospitals, or community-based agencies. The IBHTFs model of care offers long- term treatment, estimated to be approximately one year in length. The goal of IBHTFs is to provide ongoing voluntary psychiatric treatment to individuals who no longer fully benefit from psychiatric treatment at State hospitals or community based psychiatric hospitals but need further treatment and support to fully integrate back into their community.

Program Specific Requirements

Treatment at IBHTF facility will be carried out in accordance with WAC 246-341-1137 and should be informed by the Intensive Behavioral Health Treatment Services: Toolkit for Implementation, including but not limited to:

- Treatment is provided in a residential setting 24/7 where individuals receive intensive onsite behavioral health interventions, psychosocial rehabilitation, and work towards the development of skills and discharge plan to integrate back into the community.
- IBHTFs have dedicated medical services, including onsite nursing support and prescriptive services to help individuals learn more about their overall health, medications, and develop the skills necessary to be successful in the community.
- IBHTFs develop care plans and crisis plans with participants to address specific barriers in their lives and to work towards a higher level of independence.
- NOTE: IBHTFs are not designed to care for people with dementia or those with prominent medical needs that prevent them from being independent in their activities of daily living (ADLs).

Referral Process, Placement, and Prioritization

The initial placement and continued stay of clients into IBHTF are coordinated between the payor and the facility.

- For individuals assigned to Wellpoint, United Healthcare, or Community Health Plan of WA, authorizations will be processed and determined by the MCO.
- For individuals assigned to Molina Healthcare or Coordinated Care of WA, authorizations will be processed and determined by King County Hospital and Mental Health Residential Liaison.

For initial stay referral requests, once an authorization decision is made, the payor will send relevant clinical information to IBHTF facility and coordinate timely transition of care and admission.

IBHTFs will admit individuals who meet placement criteria described in WAC 246-341-1137 (1a-f). Additionally, IBHTFs will receive clients discharging from Washington State Hospital Facilities, Long-

Intensive Behavioral Health Treatment Facilities (IBHTFs) Eligibility Criteria	
Medicaid Status	Medicaid and/or Medicaid Eligible.
Age Range	Adults 18 years of age or older
Authorization Needed	Yes, for individuals assigned to Wellpoint, United Healthcare, or Community Health Plan of WA, authorizations will be processed and determined by the MCO. For individuals assigned to Molina Healthcare or Coordinated Care of WA, authorizations will be processed and determined by King County Hospital and Mental Health Residential Liaison.
Additional Criteria	The following criteria must be met for initial stay and continued stay medical necessity: • Medical necessity for LOCUS level 5. • Clinical information that demonstrates continued complex histories of aggressive, assaultive, and emotionally dysregulated behaviors.
Intensive Behavioral Health Treatment Facilities (IBHTFs) Reporting Requirements	
Monthly Reports	IBHTF Monthly Census Report Log
Quarterly Reports	None
Semiannual Reports	None
Annual/Other Reports	None
Performance Measurement (PM) Plan	None

Term Civil Commitment (LTCC) facility, community based psychiatric hospitals, or community-based agencies. Of these referral sources, the IBHTF will prioritize receiving clients referred from Washington State Hospital Facilities and Long-Term Civil Commitment facilities in accordance with WAC 246-341-1137 (1).

Invoice Program Specific Requirements

Method of Payment

- Reimbursement will be made monthly based on actual bed days on census per MCO.

Additional Requirements

- None.

7.4 Intensive Community Support and Recovery Program (ICSRP)

Intensive Community Support and Recovery Program LOCUS Level 4 - medically monitored non-residential service program that provides residential treatment and housing supports for participants.

It is designed for individuals who are transitioning to the community and into independent living settings, who may require regular staff contact and the minimal availability of staff 24 hours a day, 7 days a week, but who do not need the physical safety and structure of a residential facility. Individuals may be housed in cluster or independent settings. For those programs that utilize cluster housing for the residential setting, staff are required to be on-site and available to clients 16 hours a day, with an additional availability to respond during the remaining 8 hours. ICSRP maintains a client-to-staff ratio of 1:10.

ICSRP services include those of the Care Environment, Clinical and Rehabilitation Services, and Supportive Services. They include but are not limited to:

- Care Environment:
  - Encouraging community living and engagement.
  - Teaching and monitoring ADLs.
- Clinical Services:
  - Treatment Programming includes group, individual, and family therapy.
  - Available 3 days a week, 2-3 hours per day.
  - Psychiatric assessment and staffing
  - Medication monitoring
- Rehabilitation Services:
  - Nursing services for acute and chronic medical conditions
  - Supervised health care (e.g., nutrition management and chronic health condition management)
  - Transition and discharge planning
  - Crisis and stabilization services located in close proximity to clients' settings.
- Supportive Services:
  - Case management for financial supports, supportive housing, system management, transportation, and ADL maintenance.
  - Liaison with mutual support networks, facilitation of recreational and social activities
  - Coordination with educational or vocational programming according to individual need.

EICSRP
Some ICSRP programs also offer Enhanced ICSRP (E-ICSRP) services. In addition to the services noted above, E-ICSRP also offers on-site staffing support 24 hours a day, 7 days a week, including crisis intervention and medication prescription and monitoring, to provide a highly supportive environment. E-ICSRP also offers treatment programming, including group, individual, family therapy, daily between three to five hours a day.

How to Access Services
There are up to 71 contracted beds within the ICSRP Program.

To enter this program for both ICSRP and EICSRP, Hospital Mental Health Residential (HMHR) Liaison team receive referrals from all referent sources, and complete assessments to determine medical necessity prior to authorization for placement. An authorization for placement must be received from the HMHR Liaison team for initial placement. Internal transitions after initial placement are reviewed and processed by the HMHR Utilization Management team. An authorization from the HMHR Utilization Management team must be received prior to a transition placement.

Absences
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, local jail or DOC facility, or is on unauthorized leave, please see the Mental Health Residential Chapter for information on Absence Requests.

Invoice Program Specific Requirements
Method of Payment – **Multicare Navos**
• Reimbursement will be paid monthly on a per diem rate for each day-of-service in the community per client per day up to a maximum of 38 clients.
• Reimbursement will be calculated as follows:
  o Total number of days of service in the month x per diem rate = reimbursement.
• The agency retains all records and supporting documentation related to expenses incurred.
Method of Payment – **Community House Mental Health**
• Reimbursement will be paid monthly on a per diem rate for each day-of-service in the community per client per day up to a maximum of 12 clients.

• Reimbursement will be calculated as follows:
  o Total number of days of service in the month x per diem rate = reimbursement.
• The agency retains all records and supporting documentation related to expenses incurred.

Method of Payment **– Transitional Resources**

• Reimbursement will be made monthly on a per diem rate for each day-of-service in the community per client per day up to a maximum of 10 clients for Intensive Community Support level of care, and 17 clients for Enhanced Intensive Community Support level of care.
• Reimbursement will be calculated as follows:
  o Total number of days of service in the month x per diem rate = reimbursement.
• The agency retains all records and supporting documentation related to expenses incurred.

Additional Requirements

- None

ICSRP Eligibility Criteria	
Medicaid Status	Medicaid or Medicaid Eligible
Age Range	Adults 18 years of age or older
Authorization Needed	Yes
Additional Criteria	• Determined eligible via referral and assessment process through HMHR Liaisons (initial) or Utilization Management Specialists (continuing stay, transitions). No longer require active psychiatric treatment at an inpatient hospital level of care. • Are at risk of psychiatric hospitalization and needing a higher level of services than what can be provided in outpatient setting to remain stable in the community. • Have experienced multiple treatment failures and/or have been unable to maintain community tenure for a significant period of time. • Have significant barriers to community placement (e.g. criminal history, refusal of admission by other behavioral health providers, etc.); • Can complete all activities of daily living (ADLs) tasks without hands on assistance; and • Are ready for engagement toward transition to the community; and • Currently hospitalized in psychiatric setting, or in an outpatient setting and at risk of psychiatric hospitalization. • Eligible for Medicaid. • Referred by an Outpatient Provider or Hospital/Facility Staff to a HMHR Liaison.
ICSRP Reporting Requirements	
Monthly Reports	• ICSRP Census Log
Quarterly Reports	• None
Semiannual Reports	• None
Annual/Other Reports	• None
Performance Measurement (PM) Plan	• None

7.5 Intensive Residential Treatment (IRT)

Program Overview

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

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

Please see the Health Care Authority IRT Program Guidelines here: irt-program-guide.pdf

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

Invoice Program Specific Requirements

Method of Payment

- Reimbursement will be made monthly based on case rate for each month a client is enrolled in the program.
- Monthly reimbursement will be calculated as follows:
  - Total number of clients enrolled x monthly case rate = reimbursement.

Additional Requirements

- Monthly reimbursement will not exceed 50 clients per month.

Intensive Residential Treatment Eligibility Criteria	
Medicaid Status	Yes (excludes CHPW)
Age Range	18 years old and above
Authorization Needed	Yes, King County Hospital Mental Health Residential (HMHR) must approve and ALTSA Home and Community Services (HCS) must agree
Additional Criteria	Eligible individuals must meet the following criteria: • Diagnosed with a DSM 5 (or its successor) mental health diagnosis which with the appropriate clinical interventions can be reasonably assumed to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions in the recipient; • Receiving services in a DSHS/ALTSA/HCS residential facility; • Presenting with symptoms of their DSM V mental health diagnosis which without this level of intervention, could put their continued success in the community at-risk; The individual being referred to services must also meet **one** of the following criteria at intake:

	• Diversion: A diversion means an individual who resides in their community presenting with symptoms that puts the individual at risk for a higher level of care without the intervention of an IRT team. Examples of diversion are below: ○At risk for involuntary treatment; or ○psychiatric hospitalization; or ○at risk of losing their living arrangement in their community; or ○is currently held in an emergency department or hospital awaiting placement in an inpatient facility; or ○Is currently held in an emergency room with no placement available due to presenting symptoms or level of need; or ○In a community diversion, stabilization, or triage facility that is unable to find placement due to level of acuity or need; or ○Will be released from a jail or prison and will need support to stay in their community. • Discharge: An individual admitted to a psychiatric inpatient facility, ready for discharge from the facility, with a discharge plan that includes placement in an ALTSA facility, but the symptoms of their current mental illness jeopardize or pose an obstacle for admission to and/or continued success in an ALTSA facility.
Intensive Residential Treatment Reporting Requirements	
BHRD Information System	• Submit Data to the BHRD Information System as outlined in the BHRD Data Dictionary and the Required Transactions Sheet in the ISAC Notebook.
Monthly Reports	• IRT Census Report
Quarterly Reports	• None
Semiannual Reports	• None
Annual/Other Reports	• None
Performance Measurement (PM) Plan	• None

7.6 Intensive Step-Down

Program Overview

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

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

Program Specific Requirements

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

Invoice Program Specific Requirements

Method of Payment

- Daily bed rate payments will be made retrospectively based on dates of admission and discharge reported on the census log for KCICN approved authorizations.
- Administrative bed rate payments will be made for a limited period of time for individuals who no longer meet medical necessity criteria but have been unable to be discharged from the facility to an appropriate placement.

Additional Requirements

- Review and approval of authorizations, continuing stay and administrative bed days must be completed prior to payment for bed days on the census.

Intensive Step-Down Eligibility Criteria	
Medicaid Status	Medicaid is required
Age Range	18+ for the ISD level of care
Authorization Needed	Yes, from the Hospital Placement and Diversion Liaison staff. LOCUS Level 5 required for authorization.
Additional Criteria	The same overall requirements for the mental health residential continuum
Intensive Step-Down Reporting Requirements	
Monthly Reports	• ISD Billing Report Services Summary • ISD Residential Invoice Report
Quarterly Reports	• ISD Billing Report Services Summary • ISD Residential Invoice Report
Semiannual Reports	• None
Annual/Other Reports	• Intensive Step-Down Continuing Stay Review TBA
Performance Measurement (PM) Plan	• None

7.7 Intensive Supportive Housing (ISH)

Program Overview

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.

Information System Requirements

Intensive Supportive Housing will have service data submitted daily as a per diem code (H2022). Documentation must occur according to the requirements for High Intensity Treatment found in the SERI.

Invoice Program Specific Requirements

Method of Payment

- Reimbursement will be made on a one-time basis for startup funding to support the Intensive Supportive Housing Program.

Additional Requirements

- None.

ISH Eligibility Criteria	
Medicaid Status	Yes, limited non-Medicaid funding available with BHRD approval
Age Range	18 years and older
Authorization Needed	Yes
Additional Criteria	Referred by King County Hospital and Community Liaisons (KCHL) based on the Residential Services Screening Form (Screening Form) and Residential Services Placement Request Form (Residential Application) and meets medical necessity
ISH Reporting Requirements	
Monthly Reports	• ISH Monthly Report
Quarterly Reports	• None
Semiannual Reports	• None
Annual/Other Reports	• None
Performance Measurement (PM) Plan	• None

7.8 Long-Term Rehabilitation Services (LTR)

Program Overview

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. Facilities will have at least 0.5 FTE MHP devoted to direct therapy services or clinical supervision per 16 beds, not to include administrative services.

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 facilities provide:

- specific evidence-based therapeutic services offered at least once per week
- individual counseling offered once per week by a Mental Health Certified Practitioner (MHCP) or Mental Health Practitioner (MHP)
- group services occurring at least twice per day and available 7 days/week, to include:
  - Psychoeducation
  - Community Integration
  - Skills Building
- SUD services available to all residents.
- Daily face-to-face encounter available with case manager, MHCP or MHP.

Invoice Program Specific Requirements

Method of Payment

- Daily bed rate and small facility enhancement (where appropriate) will be paid retrospectively monthly based on reported occupancy.
- An additional small facility enhancement rate per day will be paid for facilities of less than 17 beds.
- Occupancy
  - In a small facility, the occupancy standard is 92 percent to receive full reimbursement;
  - In facilities of 17 beds or more, the occupancy standard is 95 percent to receive full reimbursement;
  - The monthly occupancy rate is calculated as follows: Monthly Occupancy = Actual Bed Days/Available Bed Days.
- Reimbursement when minimum occupancy is met:
  - For small facilities, reimbursement will be calculated as follows:
    - Available Bed Days x (Daily Bed Rate + Small Bed Enhancement rate)
  - For facilities with 17 or more beds, reimbursement will be calculated as follows:
    - Available Bed Days x Daily Bed Rate
- Reimbursement when minimum occupancy is not met:
  - For small facilities, reimbursement will be calculated as follows:
    - Actual Bed Days x (Daily Bed Rate + Small Bed Enhancement rate)
  - For facilities with 17 or more beds, if the occupancy rate drops below 95 percent, reimbursement will be calculated as follows:
    - Actual Bed Days x Daily Bed Rate
- Client Participation
  - The Provider will collect Client Participation up to the state-authorized allowable amount.
  - For individuals with no income or those who only qualify for Aged, Blind and Disabled (ABD) cash assistance the County will pay a daily ABD Room and Board (R & B) rate as outlined in published King County rate schedule for R & B costs for persons approved for the payment by the BHRD Utilization Management Supervisor or their designee.
- Administrative bed rate payments will be made for a limited period of time for individuals who no longer meet medical necessity criteria but have been unable to be discharged from the facility to an appropriate placement.

Additional Requirements

- CHMH
  - Capacity
    - Hilltop Manor 16 beds
    - Firwood 16 beds
    - Spring Manor 16 beds (effective December 1, 2020)
    - Cascade Hall
  - Effective January 1, 2023: 30
  - Effective February 1, 2023: 40
- SND
  - Maximum reimbursement for SBAO is based on the number of eligible authorized LTR residents.
  - Capacity:
    - Stillwater: 16 beds
    - Keystone: 64 beds
- TR
  - Agency will be reimbursed for a maximum of 16 beds per month effective March 1, 2023.

LTR Eligibility Criteria

Medicaid Status	Yes
Age Range	18 years and older
Authorization Needed	Yes
Additional Criteria	Referred by King County Hospital and Community Liaisons (KCHL) based on the Residential Services Screening Form (Screening Form) and Residential Services Placement Request Form (Residential Application) and meets medical necessity
LTR Reporting Requirements	
Monthly Reports	• Long-Term Residential (LTR) Services Reimbursement Request & Billing Report Services Summary
Quarterly Reports	• None
Semiannual Reports	• None
Annual/Other Reports	• None
Performance Measurement (PM) Plan	• None

7.8.1 Service Based Add On (SBAO)

Service Based Add On (SBAO) is used to augment long-term residential treatment (LTR) provided at Sound's Keystone Mental Health Residential treatment facility. These services are based upon the Level of Care Utilization System (LOCUS) assessment for psychiatric and addiction services for the placement of individuals in mental health services. This level of care has traditionally been provided in non-hospital; freestanding residential facility based in the community. The facility will continue to follow all facility licensing requirements as outline by the Washington Administrative Code (WAC) or Regional Code of Washington (RCW).

Eligible Population

Adults 18 and above who, due to psychiatric symptoms and behaviors, require extended intensive and comprehensive treatment, and 24-hour supervision in a residential treatment setting. In addition, priority placement will be for adults who need additional medical care beyond the scope of traditional Mental Health Residential Treatment.

Documented Facility Based Nursing Interventions

- Individualized nursing assessment and treatment plan completed by an RN and included in the interdisciplinary treatment plan within 14 days of client admission to the program per WAC 388-78A-2090 or its successor. This interdisciplinary plan includes a nursing assessment, diagnosis, measurable treatment goals and staff interventions to facilitate stated goals.
- Individualized nursing treatment planning specifically addresses client skill building with an emphasis on working towards increased client independence. Nursing interventions identify and demonstrate increased client autonomy around medication management, activities of daily life, personal care needs, diabetic care, symptom management, pain management, etc.
- Nursing interventions in the treatment plan clearly correlate with identified placement criteria as defined by the Department of Behavioral Health and Recovery Division (BHRD) and identify both frequency and duration of said services provided to client.
- The client participates in their individualized nursing assessment and treatment plan to reinforce and promote client engagement and recovery.

Long-Term Expected Outcomes

- Improvement/stabilization of psychiatric symptoms and medical needs.
- Improvement/stabilization in level of functioning.
- Discharge to a less restrictive treatment setting as clinically indicated.

SBAO Eligibility Criteria	
Medicaid Status	Yes, limited non-Medicaid funding available with BHRD approval
Age Range	18 years and older
Authorization Needed	Yes
Additional Criteria	This level of care refers to enhanced services provided to residents of a Long-Term Rehabilitation (LTR) facility who need assistance with their medical care to ensure they remain stable and able to live in the community. Priority placement is for clients with a need for nursing services in addition to other treatments provided in LTR settings. Examples may include clients with the following conditions: • Respiratory conditions • Blind and Vision Issues. • Diabetes • Fluid Monitoring. • Ambulation Issues. • Incontinence. • Kidney disease • Hypertension. • Heart disease. • Wound Care. • Pain Management and Monitoring. • Hands on assistance with Activities of Daily Life (ADLs). • Presence or risk of significant medical complications related to diet.
BHRC Reporting Requirements	
Monthly Reports	• None
Quarterly Reports	• None
Semiannual Reports	• Utilization Reviews, with cadence determined by HMHR UM team
Annual/Other Reports	• None
Performance Measurement (PM) Plan	• None

7.9 Standard Supportive Housing Program (SSH)

Program Overview

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.

Information System Requirements

- Supportive Housing will have service data submitted daily as a per diem code (H2022). Documentation must occur according to the requirements for High Intensity Treatment found in the SERI.

SSH Eligibility Criteria	
Medicaid Status	Yes, limited non-Medicaid funding available with BHRD approval
Age Range	18 years and older
Authorization Needed	Yes
Additional Criteria	Referred by King County Hospital and Community Liaisons (KCHL) based on the Residential Services Screening Form (Screening Form) and Residential Services Placement Request Form (Residential Application) and meets medical necessity
SSH Reporting Requirements	
Monthly Reports	• SSH Monthly Report
Quarterly Reports	• None
Semiannual Reports	• None
Annual/Other Reports	• None
Performance Measurement (PM) Plan	• None

7.10 Supervised Living Residential Services (SL)

Program Overview

Supervised Living Residential Services are facility-based, medically monitored services for residents who need additional support. Trained staff members are present 24/7 to provide 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 best for clients experiencing a serious mental illness which may affect their ability to perform 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.

Invoice Program Specific Requirements

Method of Payment

- Daily bed rate will be paid retrospectively monthly based on reported occupancy.
- Occupancy
  - The occupancy standard is 95 percent to receive full reimbursement;
  - The monthly occupancy rate is calculated as follows:
    - Monthly Occupancy = Actual Bed Days/Available Bed Days.
- Reimbursement
  - When minimum occupancy is met:
    - Reimbursement will be calculated as follows: Available Bed Days x Daily Bed Rate
  - When minimum occupancy is not met:
    - If the occupancy rate drops below 95 percent, reimbursement will be calculated as follows: Actual Bed Days x Daily Bed Rate
- Client Participation
  - The Provider will collect Client Participation up to the state-authorized allowable amount.
  - For individuals with no income or those who only qualify for Aged, Blind and Disabled (ABD) cash assistance the County will pay a daily ABD Room and Board (R & B) rate as outlined in published King County rate schedule for R & B costs for persons approved for the payment by the BHRD Hospital Mental Health Residential (HMHR) Utilization Management Supervisor or their designee.

Additional Requirements

CHMH Capacity

- Spring Manor
  - Effective September 2022: 36 beds
- Cascade Hall
  - Effective January 1, 2023: 30
  - Effective February 1, 2023: 20

SL Eligibility Criteria	
Medicaid Status	Yes
Age Range	18 years and older
Authorization Needed	Yes
Additional Criteria	• Referred by King County Hospital and Community Liaisons (KCHL) based on the Residential Services Screening Form (Screening Form) and Residential Services Placement Request Form (Residential Application) and meets medical necessity. • LOCUS Level 4
SL Reporting Requirements	
Monthly Reports	Supervised Living (SL) Services Reimbursement Request Billing Summary
Quarterly Reports	None
Semiannual Reports	None
Annual/Other Reports	None
Performance Measurement (PM) Plan	None

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

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

The MHBG and SUPTRS-BG Block Grant requires an annual peer review by individuals with expertise in the field of drug abuse treatment (for SUPTRS-BG) 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

USC 300x-53(a) and 45 CFR 96.136 MHBG and SUPTRS-BG Block Grant funds may not be used to pay for services provided prior to the execution of Subcontracts, or to pay in advance of service delivery.

Substance Use Prevention, Treatment, and Recovery Services Block Grant (SUPTRS-BG) Funding Requirements and Limitations

The Provider does not use SUPTRS-BG funds for the following:

- Services and programs that are covered under the capitation rate for Medicaid-covered services to Medicaid enrollees;
- The Provider's administrative costs associated with salaries and benefits at the Provider's organization level;
- Inpatient mental health services;
- Mental health services;
- Construction and/or renovation;
- Capital assets or the accumulation of operating reserve accounts;
- Equipment costs over $5,000;
- Cash payments to individuals;
- To purchase or improve land;
- To purchase, construct or permanently improve any building or other facility;
- To purchase major medical equipment;
- Satisfy any requirement for the expenditure of non-Federal funds as a condition for the receipt of Federal funds;
- Provide financial assistance to any entity other than a public or nonprofit private entity;
- Make payments to intended recipients of health services;
- Provide individuals with hypodermic needles or syringes;
- Provide treatment services in penal or correctional institutions of the State; and
- The Provider ensures that SUPTRS-BG funds are used only for services to individuals who are not enrolled in Medicaid or for services that are not covered by Medicaid as follows:

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

8.1 Alcohol, Tobacco and Other Drug Prevention Coalition

This program is designed to provide effective prevention and intervention strategies for those most at risk and most in need to prevent or reduce more acute illness, high-risk behaviors, incarceration and other emergency medical or crisis responses. The Provider functions as the fiscal agent for the designated alcohol, tobacco and other drug (ATOD) prevention coalition (the Coalition) to provide services as part of the statewide Community Prevention and Wellness Initiative (CPWI). The Provider manages and supports the CPWI coalition focused on preventing ATOD use and related problems among children and youth in King County, specifically, in the community identified in the approved strategic plan/ action plan. The Provider also coordinates and implements prevention programs designed to prevent or delay the misuse and abuse of alcohol, cannabis, opioids, 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 on the Athena Forum at www.theathenaforum.org/cpwi-community-coalition-guide, and updates/ other documents provided by HCA/DBHR and/or BHRD.

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

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

The Provider complies with all applicable local, state and federal laws and requirements including: (a) audit requirements described in federal Office of Management and Budget Super Circular 2 CFR 200.501 and 45 CFR 75.501; (b) prohibition of using these federal funds as a match or cost-sharing provision to secure other federal monies without prior written approval by HCA; and (c) SAMHSA Award Terms. This includes that the Provider complies with Charitable Choice Requirements of 42 CFR Part 54 and that Faith-Based Organizations (FBO) are provided opportunities to compete with traditional alcohol/drug abuse prevention Providers for funding.

The Provider participates in a minimum of one annual review by the County and HCA as requested in order to monitor contract compliance and to observe programs that directly serve CPWI participants. The annual review includes compliance with CPWI program-specific requirements, subcontracting requirements, funding source requirements, and discussion about coalition progress/ delivery including

system collaboration, cultural relevance and equity/social justice. The annual review is held at a mutually agreed upon time.

The Provider 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. The Provider ensures that the Coalition Coordinators are Certified Prevention Professionals (CPP). 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 or its successor. At the request of HCA or King County, the Provider must provide policies and procedures and verification of completed background checks. The Provider expends its funding allocation within the state fiscal year (July 1 through June 30) unless an exception is granted in advance.

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

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

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

The Provider ensures that funding source acknowledgements are made on all media materials and publications (including news releases and advertising messages) developed with CPWI funds.

Specifically, the materials will include text that cites the funding sources as: King County Department of Community and Human Services and Washington State Health Care Authority. The Provider may use

current approved logos in lieu of the citations written in text.

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

The Provider and the Coalition will follow branding/logo and media requirements and guidance in the CPWI Community Coalition Guide as well as on The Athena Forum including the guidelines found at https://theathenaforum.org/providers/communication-strategies-guidelines-and-tools. The Provider and the Coalition will also ensure adherence to King County guidance related to flyers and publications.

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

- For approved uses of food or light refreshments, the maximum amount that the Coalition may expend for food or light refreshments is $1,500 per year;
- Light refreshment costs for training events and meetings that are longer than two hours in duration are allowable and the cost for light refreshments will not exceed $3.00 per person or $10.00 per person when utilizing SOR funds;
- 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 SUPTRS-BG funds may be provided for participants and will not exceed the current Washington State per diem rates as referenced in the Office of Financial Management State Administrative and Accounting Manual at Per Diem Rate Tables | Washington Travel Rates | OFM
- For approved substance abuse prevention training events that are at least four hours in duration, the cost for meals supported with SUPTRS-BG funds may be provided for participants and will not exceed the current Washington State per diem rates as referenced in Per Diem Rate Tables | Washington Travel Rates | OFM As a recipient of SOR funds, the Provider will implement the either the Starts With One opioid prevention campaign, the Friends for Life campaign, the For Our Lives campaign, or other opioid campaign as approved by HCA, and also participate in the National Drug Take-Back Days in October and April, according to the Drug Enforcement Agency (DEA) guidelines, recommendations, and regulations described at https://www.dea.gov/takebackdayThe Provider will adhere to HCA and BHRD issued program and fiscal policies and requirements including the HCA Supplemental Instructions and Fiscal Policy Standards for Reimbursable Costs, located at www.theathenaforum.org/billing.

In addition to complying with HCA and BHRD program and fiscal requirements, the Provider must also following funding source requirements including those specified by the Substance Abuse and Mental Health Services Administration (SAMHSA)" per www.samhsa.gov/grants/grants-management/notice-award-noa/standard-terms-conditions.
The following are not allowable (not an exhaustive list):

- Funds to supplant current funding of existing activities.
- Incentives (including cash, gift certificates and non-cash incentives) for the federal and state funds.
- Equipment purchases over $5,000.
- Entertainment costs, which include movie tickets, theaters, amusements, diversion, social activities, sporting tickets, and incidental costs relating thereto such as meals, beverages, lodging, rentals, transportation, and gratuities (unless prior written approval granted by HCA and BHRD).
- Needle exchange programs.

- Honorariums, giveaways, and door prizes.
- Funds to pay for enforcement nor schoolteacher salaries.
- Promotional materials, e.g., clothing and commemorative items such as pens, mugs/cups, folders/folios, lanyards, and conference bags, etc. (unless approved by HCA and BHRD and includes an acceptable prevention message).
- Costs of organized fund raising.
- Funds to purchase, prescribe, or provide marijuana or treatment using marijuana.
- Lobbying expenses (i.e., cost of attempting to influence legislation pending before any federal or state legislative body) except as provided for in RCW 42.17.190.
- Excessive costs and executive pay above $212,100.

If the Provider participates in a Secure Prescription Take-Back and/or Lock Box Project that is supported with CPWI funding, the Provider will follow guidelines and requirements issued by HCA and BHRD. If the Provider receives other special and/ or enhancement funding from BHRD related to CPWI, the Provider will follow guidelines and requirements issued by HCA and BHRD.

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

Invoice Program Specific Requirements

Method of Payment

- Reimbursement will be made monthly for Community Prevention and Wellness Initiative services:
  - As defined by HCA/ DBHR and King County,
  - Per actual documented monthly expenditures with reported hours, services and other deliverables in the Minerva data system,
  - For administrative expenses based on actual costs or an equal monthly amount. Special exceptions may be made when BHRD and HCA/ DBHR grants an allowance for the Provider to be reimbursed in advance or in anticipation of the delivery of goods or services to be provided. For the local funds intended to support the 20% cash match related to the Student Assistance Professional (SAP) in each CPWI community, the funds will primarily pay for SAP staffing costs but may also include other necessary project-related expenditures such as supplies, training, and travel. If positions are unfilled for part of the month or vacant, amounts must be pro-rated.

Additional Requirements

- Unallowable costs are according to the funding sources, i.e., HCA/ DBHR, BHRD, the federal Substance Use Prevention Treatment and Recovery Services block grant, and any other funding streams.
- If the Provider claims and the County reimburses for expenditures under this contract that are later found to be claimed in error or to be unallowable costs, the County will recover those costs, and the Provider will fully cooperate with the recovery.

ATOD Prevention Coalition Eligibility Criteria	
Medicaid Status	N/A
Age Range	N/A
Authorization Needed	No

Additional Criteria	• Community members, organizations, and groups in King County per the approved coalition strategic plan/ action plan • School staff, at-risk youth (focused on middle school through 10th grade), families, and other community members in King County, in particular those identified in the approved coalition strategic plan.
ATOD Prevention Coalition Reporting Requirements	
Monthly Reports	• All hours provided and services delivered during the preceding month will be submitted into the HCA Substance Use Disorder Prevention and Mental Health Promotion Online Reporting System or Minerva Information System (MIS) by the 10th day of each month. • The Provider will ensure accurate, unduplicated reporting and will submit all required data including coalition staff hours, demographic information (related to staff, coalition members and participants), service information (hours, counts, and other descriptive data), evaluations and assessments as applicable, and training information. • The Provider will ensure an 80% survey completion rate per cohort and that program results show positive outcomes for at least half the participants. • Any requests for extensions to reporting deadlines must be requested in writing to the County a minimum of six (6) business days before the report due date. • Unless an exception is granted, Monthly Actual Expenditure Reports are also required by the fifteenth day of each month that provide additional information related to monthly original and supplemental invoices.
Quarterly Reports	• Due October 15, January 15, April 15, and July 15 in the MIS
Semiannual Reports	• None
Annual/Other Reports	• None
Performance Measurement (PM) Plan	• None

8.2 Consumer-Driven Services

This program provides a recovery-oriented Clubhouse service for King County residents who experience mental health issues. This funding is meant to ensure that Clubhouse services are available to eligible adults who are interested in participating in the Clubhouse as a way to pursue work. The Provider achieves certification from the International Center for Clubhouse Development (ICCD). The Clubhouse is operated according to the ICCD Clubhouse Standards and meets state certification requirements per Washington Administrative Code (WAC) 246-341-0730 or its successor. 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.

Invoice Program Specific Requirements

Method of Payment

- Reimbursement will be paid retrospectively each month for eligible individuals for attendance days reported on the Consumer-Driven Services census log.

Additional Requirements

- No

Consumer-Driven Services Eligibility Criteria	
Medicaid Status	Client cannot be Medicaid-Eligible for coverage under this program
Age Range	N/A
Authorization Needed	No
Additional Criteria	• Individuals in King County who experience barriers to employment due to mental health issues. • Clients may self-refer but the Clubhouse may only request reimbursement under this program if the consumer is not Medicaid-eligible.
Consumer-Driven Services Reporting Requirements	
Monthly Reports	• Consumer-Driven Services Clubhouse Census Log • Progress note to the Outpatient Benefit holder for each enrolled consumer served that contains a summary of activities and attendance.
Quarterly Reports	• None
Semiannual Reports	• None
Annual/Other Reports	• Upon request from BHRD, the Provider submits an annual report that specifies justification for the unit cost. • The Provider complies with the specific requirements for financial audits or alternative as required in the Standard Contract.
Performance Measurement (PM) Plan	• None

8.3 Hospital and Mental Health Residential (HMHR) Treatment Substance Use Disorder (SUD) Pilot Program

Program Overview

The Hospital and Mental Health Residential (HMHR) Substance Use Disorder (SUD) Pilot Program connects individuals living in Long-Term Rehabilitative (LTR) mental health (MH) residential settings with SUD services. The objective of this program is to provide SUD services to participants of LTR programs who have SUD needs and to also provide SUD support and consultation services to LTR program providers.

Program Specific Requirements

The Provider will hire and oversee 1.0 FTE Substance Use Disorder Professional (SUDP) to outreach and engage individuals within LTR programs regarding their SUD needs and readiness to change. The Provider will conduct weekly SUD groups in at least six of the seven mental health residential programs that provide LTR programming.

The HMHR SUD Pilot Program Provider will complete the following performance requirements that were developed by the King County Behavioral Health and Recovery Division (BHRD).

- Facilitate, at a minimum, 1 weekly SUD group within each of the 6 King County LTR settings.
- Provide case consultation to LTR staff at the 6 LTR program settings.
- Provide SUD trainings to LTR program staff to include informational handouts, presentations, care conferences and learning sessions. Training will be targeted at identifying an individual's readiness for change and how to intervene and support the individual through the Stages of Change.

- Conduct SUD assessments and care coordination to determine if inpatient SUD treatment is appropriate (as staffing permits).
- SUD treatment is provided within MH residential treatment programs where LTR services are provided.
- Use template Memorandum of Understanding (MOU) provided by King County for service agreements between the Provider and each of the mental health residential treatment providers.

Referral Process
Individuals will be identified and referred to the Substance Use Disorder (SUD) Pilot Program by the MH residential treatment providers and by the Provider through outreach and engagement.

Invoice Program Specific Requirements
Method of Payment
- Reimbursement will be made in monthly 1/12th amounts for 1.0 FTE Substance Use Disorder Professional (SUDP) within the HMHR SUD Pilot Program for the period of January 1, 2024, through December 31, 2025.

Additional Requirements
- If the position becomes vacant, notification to King County is required in writing within seven business days. Notification should also include a plan for filling the position within 60 days of vacancy.

HMHR Substance Use Disorder (SUD) Pilot Program	
Medicaid Status	Medicaid and/or Medicaid Eligible
Age Range	Adults 18 years of age or older
Authorization Needed	No
Additional Criteria	Active or historic SUD needs or considered to be at-risk, as determined by Provider SUDP.
HMHR Substance Use Disorder (SUD) Pilot Program Reporting Requirements	
Monthly Reports	Substance Use Disorder (SUD) Pilot Program Monthly Census Report
Quarterly Reports	None
Semiannual Reports	None
Annual/Other Reports	None
Performance Measurement (PM) Plan	None

8.4 KC Housing and Recovery Through Peer Services (HARPS)

Program Overview
Housing and Recovery Through Peer Services (HARPS) provides time-limited supportive housing services and housing bridge subsidy which are intended to support individuals who are exiting an inpatient behavioral healthcare setting. HARPS is designed from a recovery perspective based on Evidence-Based Practice of Permanent Supportive Housing (EBP PSH) principles. The HARPS Team has a strong commitment to the right and the ability of each person to live in normal community residences, to work in competitive market-wage jobs, and to have access to helpful, adequate, competent, and continuous supports and services in the community of their choice.

Per Health Care Authority (HCA) requirements, the HARPS Team consists of one full-time equivalent (FTE) Housing Case Manager/Supervisor and two FTE Certified Peer Counselors (CPC).

CPC must be certified by the State at the time of hire or must complete certification within six months of hire, have good oral and written communication skills, and the skills and competence to establish supportive trusting relationships with persons living with severe and persistent mental illnesses and/or substance use disorder and respect for client rights and personal preferences in treatment. The principal duties and responsibilities outlined in the CPC job description include:

- Provide peer counseling and support with an emphasis on enhancing access to and retention in permanent supported housing.
- Draw on common experiences as a peer, to validate client experiences and to provide empowerment, guidance, and encouragement to clients to take responsibility and actively participate in their own recovery.
- Serve as a mentor to client to promote hope and empowerment.
- Provide education and advocacy around understanding culture-wide stigma and discrimination against people with mental illness and develop strategies to eliminate stigma and support client participation in consumer self-help programs and consumer advocacy organizations that promote recovery.
- Teach symptom-management techniques and promote personal growth and development by assisting clients to cope with internal and external stresses.
- Coordinate services with other mental health and allied providers.

The Housing Case Manager/Supervisor should have supportive housing background and be able to mentor CPC in their role and duties while also carrying a reduced caseload. If the HARPS supervisor does not have Mental Health Professional (MHP) credentials, then the project needs to demonstrate access to a MHP for clinical supervision.

A representative from the HARPS Team attends monthly administrative conference calls with the HCA and other HARPS providers across Washington State as well as quarterly meetings with the HCA and King County HARPS Program Manager.

The HARPS Team accepts referrals from State Hospitals as well as other community referral sources. State Hospital referrals are submitted by the King County Hospital Liaisons. The King County Hospital Liaisons will actively coordinate the transition of individuals from behavioral healthcare inpatient treatment center discharge to the HARPS Team in the community of residence in order to minimize gaps in outpatient health care and housing.

A HARPS-eligible individual can apply for and receive time-limited HARPS Housing Services, HARPS Housing Bridge Subsidy, or both HARPS Housing Services and Housing Bridge Subsidy. A HARPS-eligible individual can receive HARPS Housing Services and/or HARPS Housing Bridge Subsidy for up to 3 months.

An individual is unable to be enrolled in and receiving supportive housing services from FCS Supportive Housing and HARPS Housing Services simultaneously. However, HARPS-eligible individuals can be enrolled in and receive supportive housing services from FCS Supportive Housing and accessing HARPS Housing Bridge Subsidy, as long as there is no duplication between HARPS Housing Bridge Subsidy and Transitional Assistance Program (TAP) costs.

The HARPS Team does not suggest or provide medication prescription, administration, monitoring, or documentation.

HARPS Housing Services

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

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

The HARPS team caseload remains manageable, allowing for the flexibility to provide the intensity of services required for each individual, according to the medical necessity. It is estimated that 50% of individuals accessing HARPS housing bridge subsidy funds will receive HARPS housing services. The HARPS Team must have the capability to provide support services related to obtaining and maintaining housing and must be capable of rapidly increasing service intensity and frequency for an individual their status requires it or if an individual requests it.

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

The HARPS Team must have a response contact time of no later than two calendar days upon discharge from a behavioral healthcare inpatient setting, such as an evaluation & treatment center, residential treatment center, detox, or state psychiatric hospital. Responses include meetings with patient before discharge to establish housing goals and resources, basic needs, and community integration. This may include in person, virtual, and over the phone consultation.

HARPS Housing Services

- **Peer/Housing Specialist Roles:** Each HARPS participant is assigned a Peer Specialist or Housing Specialist who assists in locating housing and resources to secure housing as well as maintain housing. The Peer/Housing Specialist will:
  - Work with the participant to find, obtain, and maintain housing to promote recovery;
  - Locate and secure resources related to housing and utilities;
  - Offer information regarding options and choices in the types of housing and living arrangement; and
  - Advocate for the individual's tenancy needs, rights (including ADA Accommodations), and preferences to support housing stability; and
  - Coordinate with community resources, including consumer self-help and advocacy organization that promote recovery.
- **Service Coordination:** Service coordination must incorporate and demonstrate basic recovery values. The individual has a choice of their housing options, are expected to take the primary role in their personal housing plan development and will play an active role in finding housing and decision-making.
- **Assessment and Planning:** Assess housing needs, seek out and explain housing options in the area, and resources to obtain housing. Assist participants to find and maintain a safe and affordable place to live. Identify the type and location of housing with an exploration of access to natural supports and the avoidance of triggers.
- **Participant Housing Plan**: Collaborate with each participant to create an individualized strength-based housing plan that includes action steps for when housing related issues occur. As with the

treatment planning process, the participant takes the lead role in setting goals and developing the housing plan.

- **Housing Search and Placement:** Includes services or activities designed to assist households in locating, obtaining, and retaining suitable housing. Services or activities may include tenant counseling, assisting households to understand leases, securing utilities, making moving arrangements, representative payee services concerning rent and utilities, and mediation and outreach to property owners related to locating or retaining housing.
- **Landlord/Property Manager Engagement and Education:** Direct contact with landlords/property managers on behalf of participants. Ongoing support for the participants and landlords/property managers to resolve any issues that might arise while the individual is occupying the rental. Recruit and cultivate relationships with landlords/property management agencies, leading to more housing options for HARPS participants. Make use of printed materials and in-person events, such as landlord organization or rental housing association meetings, to educate landlords/property managers about the benefits of working with supportive housing providers, individuals with treated behavioral health conditions, subsidies, housing quality and safety standards, and the Department of Commerce's Landlord Mitigation Program. Educate participants on factors used by landlords to screen potential tenants. Mitigate negative screening factors by working with the participants and landlord/property manager to clarify or explain factors that could prevent the individuals from obtaining housing.
- **Housing Stability:** Includes activities for the arrangement, coordination, monitoring, and delivery of services related to meeting the housing needs of individuals exiting or at risk of entering inpatient behavioral healthcare settings and helping them obtain housing stability. Services and activities may include developing, securing, and coordinating services including:
  - Developing an individualized housing and service plan, including a path to permanent housing stability subsequent to assistance;
  - Referrals to Foundational Community Supports (FCS) supportive housing and supported employment services;
  - Seeking out and assistance in applying for long-term housing subsidies;
  - Affordable Care Act activities that are specifically linked to the household's stability plan;
  - Activities related to accessing Work Source employment services;
  - Referrals to vocational and educational support services such as Division of Vocational Rehabilitation (DVR);
  - Monitoring and evaluating household progress;
  - Assuring that households' rights are protected; and
  - Applying for government benefits and assistance including using the evidence-based practice SSI/SSDI through SSI/SSDI Outreach, Access, and Recovery (SOAR).
- **Practical Help and Supports**: Mentoring, teaching self-advocacy, coordination of services, side- by-side individualized support, problem solving, direct assistance and supervision to help clients obtain necessities of daily living including, medical and dental health care, legal and advocacy services, accessing financial support such as government benefits and entitlements, accessing housing subsidies, money-management services, and use of public transportation.
- **Education Services Linkage:** Supported education related services are for individuals whose high school, college, or vocational education could not start or was interrupted and made educational goals a part of their recovery (treatment) plan. Services include providing support to applying for schooling and financial aid, enrolling and participating in educational activities, or linking to supported employment/supported education services.
- **Vocational Services Linkage:** Services may include work-related services to help individuals value, find, and maintain meaningful employment in community-based job sites as well as job development and coordination with employers. These activities should also be part of the individual's recovery (treatment) plan or linkage to supported employment. Assist with referrals to job

training and supported employment services provided by FCS or Division of Vocational Rehabilitation or other supports.

- **Daily Living Services:** Services to support activities of daily living in community-based settings.
- **Social and Community Integration Skills Training:** Social and community integration skills training.
- **Substance Use Disorder Treatment Linkage**: If clinically indicated, the HARPS team may refer the individual to a DBHR-licensed SUD treatment program.
- **Peer Support Services:** These include services to validate individuals' experiences and to inform, guide, and encourage individuals to take responsibility for and actively participate in their own recovery, as well as services to help individuals identify, understand, and combat stigma and discrimination against mental illness and develop strategies to reduce individuals' self-imposed stigma. Peer support and wellness recovery services include:
  - Promote self-determination;
  - Model and teach advocating for oneself;
  - Encourage and reinforce choice and decision-making;
  - Introduction and referral to individual self-help programs and advocacy organizations that promote recovery; and
  - "Sharing the journey" (a phrase often used to describe individuals' sharing of their recovery experience with other peers). Utilizing one's personal experiences as information and a teaching tool about recovery.
  - The peer specialist will serve as a consultant to the treatment team to support a culture of recovery in which each individual's point of view and preferences are recognized, understood, respected, and integrated into treatment, rehabilitation, support, vocational, and community activities.
- **Social and Interpersonal Relationships and Leisure Time**: Provide side-by-side support, coaching and encouragement to help clients socialize (going with a client to community activities, including activities offered by consumer-run peer support organizations) and developing natural supports. Assist clients to plan and carry out leisure time activities on evenings, weekends, and holidays. Organize and lead individual and group social and recreational activities to help clients structure their time, increase social experiences, and provide opportunities to practice social skills.
- **Collaboration with Treatment Team:** The HARPS Team can provide direct observation, available collateral information from the family and significant others as part of the comprehensive assessment. In collaboration with the individual, assess, discuss and documents the individual's housing needs and other basic needs to be addressed. Review observations with the individual and treatment team.

HARPS Housing Bridge Subsidy

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

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

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

HARPS Housing Bridge Subsidies are estimated at $3,000 per person but can be adjusted as needed to meet Fair Market Rental Housing rates as long as the total is within the contracted amount. Allowable expenses for HARPS Housing Bridge Subsidy include:

- Monthly rent and utilities, and any combination of first and last months' rent for up to three months. Rent may only be paid one month at a time, although rental arrears, pro-rated rent, and last month's may be included with the first month's payment.
- Rental and/or utility arrears for up to three months if the payment enables the household to remain in the housing unit for which the arrears are being paid or move to another unit. The HARPS Housing Bridge Subsidy may be used to bring the program participant out of default for the debt and the HARPS Peer Specialist will assist the participant to make payment arrangements to pay off the remaining balances.
- Security deposits and utility deposits for a household moving into a new unit;
- 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.
- 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. While the household is temporarily absent, they may continue to receive HARPS services.
- Rental payments to Oxford House or other Recovery Residences. Information regarding Recovery Residences located on the Recovery Residence Registry located here: Workbook: Residence/Oxford House Locations (wa.gov) is provided to HARPS participants. HARPS Housing Bridge Subsidy can pay for rental payments at Recovery Residences that are not listed on the registry, but it should be documented in the client record why the HARPS participant was not a good match for the Recovery Residences listed on the registry.

In addition to following the guidelines in Section 13.2 Critical Incidents Program and Reporting Requirements in the Provider Manual, the HARPS providers should follow the process outlined in Section 13.2 to submit an individual Critical Incident Report if, to a service participant and occurring within a contracted behavioral health facility, Federally Qualified Health Clinic, or by independent behavioral health provider, there is a severely adverse medical outcome or death occurring within 72 hours of transfer from a contracted behavioral facility to a medical treatment setting.

HARPS services are reimbursed according to the Provider's performance on the following tasks. Payment for all reports will be prorated for understaffed teams if a position is not filled within three months.

Goal	Description	Due Date	Payment

3	**Fidelity Review Training:** Confirmation that 2 HARPS FTE completed the HCA PSH Fidelity Review training by providing a sign-in sheet or screen shot of completion. Submit confirmation in Microsoft Word or Adobe PDF format to King County.	6/15/26	$20,000 per report x 1 report
4	**State Psychiatric Hospital Orientation:** At least 2 HARPS CPC will provide a HARPS orientation at Western State Hospital once per year. Orientation will include services offered such as assessment, intake, goal setting, peer services, short term housing subsidies and housing. HARPS Team must coordinate with HCA State Hospital Discharge Analysts to schedule and coordinate orientation.	6/30/26	$20,000
5	**Program Data Acquisition Management and Storage (PDAMS):** Use HCA's PDAMS web portal to submit data for individuals, including program services, program subsidies, and landlord outreach activities. There must be at least 5 landlord outreach contacts per month. Data entry into PDAMS will be in accordance with timeliness criteria. Data entry will be considered timely when all services, subsidies, and landlord outreach activities have been entered by the 15th of the month for the previous month of services and the average cumulative number of days between dates of services and dates of entry into PDAMS is no more than 30 days.	Due by the 15th of the month following each month of services	$16,500 per month x 12 months
6	**Quarterly HARPS Report**	Due by the 15th of the month following the quarter, according to the following schedule: • Quarter 1: July- Sept. • Quarter 2: Oct.-Dec. • Quarter 3: Jan.- March • Quarter 4: April- June	$7,500 per report x 4 report
8	**Fidelity Review:** 1 HARPS FTE will attend a PSH Fidelity Review of another HARPS team facilitated by the HCA once per year.	6/30/26	$13,380

Invoice Program Specific Requirements

Method of Payment

- Reimbursement will be made in monthly 1/12th amounts for program operations costs. (MIDD)

- Reimbursement will be made monthly based on actual costs for SUD Short Term Bridge Subsidy costs for HARPS eligible individuals with a SUD only diagnosis. SUD Short Term Bridge Subsidy administrative costs may be reimbursed up to a State Fiscal Year maximum of $13,500. (State)
- Reimbursement will be made monthly based on actual costs for Short Term Bridge Subsidy costs for HARPS eligible individuals with a Severe Mental Illness (SMI) diagnosis. Funds may be used for HARPS eligible individuals with a SUD only diagnosis once the SUD Short Term Bridge Subsidy funds are exhausted. Short Term Bridge Subsidy administrative costs may be reimbursed up to a State Fiscal Year maximum of $74,650 (State).
- Reimbursement will be made monthly based on specific deliverables for the HARPS Team. Payment will be prorated for understaffed teams if a position is not filled within three months. (Federal)

Additional Requirements

- The agency retains all records and supporting documentation related to expenses incurred for HARPS and may be required to provide these upon request.
- HARPS eligibility criteria, funding priorities, and allowable short term bridge subsidy costs are outlined in the BHRD Provider Manual.

HARPS Eligibility Criteria	
Medicaid Status	N/A- unable to be enrolled in and receiving supportive housing services from FCS Supportive Housing and HARPS Housing Services simultaneously
Age Range	18 years of age or older
Authorization	Yes
Additional Criteria	• The individual is experiencing a serious mental illness, SUD, or co-occurring serious mental illness and SUD; and • Is being released from or was recently released from an inpatient behavioral healthcare setting*; and • Is homeless or at risk of homelessness, with a broad definition of homeless (couch surfing included). *recent release from an inpatient behavioral healthcare setting is typically defined as within 4 months from the time of release but can be longer on a case-by-case basis, as determined by the HARPS Team, if there is an unforeseen circumstance that is impacting the individual's recovery and ability to stay safely housed.
HARPS Reporting Requirements	
Monthly Reports	• HARPS FTE Report-due the 10th of the month following the reporting period. • HARPS Deliverable Report-due the 10th of the month following the reporting period
Quarterly Reports	• HARPS Quarterly Report-due the 15th of the month following reporting period
Semiannual Reports	• None
Annual/Other Reports	• None
Performance Measurement (PM) Plan	• None

8.5 Outreach and Engagement at Matt Talbot Center (MTC)

Program Overview

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.

Invoice Program Specific Requirements

Method of Payment

- Reimbursement will made in monthly 1/12th amounts for 2.0 full-time employees (FTE) staff to provide outreach and engagement services.
- The reimbursement will be pro-rated if less than the required FTE hours are provided. The adjusted reimbursement amount will be computed as follows:
  - Total actual payroll hours provided for the period divided by total hours that should have been provided equals percent of FTE the Provider provided; and
  - Percent of FTE Provider provided multiplied by the monthly allotment equals adjusted reimbursement for the month.

Additional Requirements

- None

Outreach and Engagement at MTC Eligibility Criteria	
Medicaid Status	N/A
Age Range	Adults Aged 18 Years and Older
Authorization Needed	No
Additional Criteria	Individuals are identified as individuals seeking assistance at MTC
Outreach and Engagement at MTC Reporting Requirements	
Monthly Reports	• Outreach and Engagement FTE Staffing Report
Quarterly Reports	• None
Semiannual Reports	• None
Annual/Other Reports	• None

Performance Measurement (PM) Plan	• None

8.6 Pregnant and Parenting Women (PPW) Services

Program Overview

The scope title is anticipated to transition by removing “women” and replacing it with “individual.”

Pregnant and Parenting Women (PPW) Services provides specialized PPW services for PPW clients enrolled in substance use disorder (SUD) outpatient or Opioid Treatment Program (OTP) or Medication for Opioid Use Disorder: Office-Based Outpatient Treatment (MOUD: OBOT). PPW provides a continuum of outpatient and recovery support services designed from a recovery and resiliency perspective.

Goals

- To provide intensive PPW services within a SUD outpatient, OTP, or MOUD: OBOT setting specific to the recovery needs of the low-income PPW population.
- To provide structured intensive PPW services with a family focus to promote child safety, healthy child development, and healthy family interaction and to assist the client in reaching recovery from SUD. These services include but are not limited to arranging for other services as necessary, including prenatal and postpartum care, parenting support, health care, relapse prevention, employability assessments, and job-seeking motivation and assistance.

Program Specific Requirements

The provider will, when possible, assign a primary counselor whose gender reflects the client’s request.
The provider provides treatment staff with PPW-specific information and educational resources.
The provider ensures that interim services for PPW individuals are provided, or arrangements are made for the provision of, within 48 hours of requesting treatment, if treatment services are not available within the designated time frame. Interim services must be documented and include, at a minimum:

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

Assessment

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

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

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

- A review of the gestational age of fetus;
- Mother’s age;
- Living arrangements which include but are not limited to housing status, housing type, co-inhabitants, and details around whether the living arrangements are conducive to recovery;
- Family support data which includes a description of relationships with the children, significant others, and other identified family members;

- An assessment of any imminent or future risk of child abuse and neglect related to the parents'/guardians' substance use;
- An assessment of family needs; and Information obtained from at least two collateral contacts and UA results (for Children's Administration involved individuals)

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

Individual Service Plan
The ISP, at minimum includes:
- The family, parent and child needs that are identified during the PPW assessment.
- Intensive SUD outpatient or intensive OTP services are prescribed.
- Intensive PPW services and childcare that are prescribed.
- Specific interventions for family, parent, and child which meets the individualized needs of the child and consultation with a therapeutic childcare expert.
- Integration of other involved parents and/or partners are included in treatment as appropriate.
- Active coordination of care across systems the family, parent, and child are involved in
- In cases of CPS involvement, family reunification is addressed.

The Agency documents in the individual's service plan when their child is being returned to their care and the plans to facilitate this transition, when applicable. In addition to SUD outpatient, OTP, or MOUD: OBOT treatment or that the client is enrolled in, the provider delivers PPW services that may include but are not limited to:
- Evidenced-based, family-centered approach that includes family counseling, parenting support and education;
- Treatment for family, parent and child that is trauma informed;
- Treatment that is focused on parent child relationship;
- Gender-specific treatment and other therapeutic interventions for women which may address issues of relationships, sexual and physical abuse, parenting, custodial issues;
- Therapeutic interventions for children in custody of women in treatment which may, among other things, address their developmental needs and any issues of sexual abuse, physical abuse, and/or neglect;
- Linkage to co-occurring treatment and coordination of care between providers, if clinically indicated;
- Linkage to primary care for women, including prenatal care when applicable, and their children;
- Linkage to primary pediatric care including immunization for children in client's custody;
- Linkage to infant mental health services;
- Active coordination of care across systems the family, parent, and child are involved in, with a focus on parent and child treatment coordination;
- Active coordination between the childcare provider, treatment provider and parent to address and respond to the child's needs;
- Referrals to other systems and services to meet the needs of the family, parent, and child and actively coordinate care with outside systems, providers, and services;
- Job-seeking motivation and assistance; and
- Peer support services.

Childcare

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

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

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

Childcare complies with all applicable Revised Code of Washington (RCW) and Washington Administrative Code (WAC) .

The Provider admits each child to services with an individual admission sheet, completed by the parent receiving intensive outpatient services, that at minimum includes:

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

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

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

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

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

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

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

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

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

The Childcare provider encourages each parent to obtain health care for their child when necessary. The Provider implements and maintains current childcare policies and procedures in the childcare room, copies of which are readily available to childcare staff.

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

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

The Provider ensures those PPW services that are not encounterable to BHRD are sufficiently documented in the client's record to reflect PPW Enhancement services have been provided.

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

Invoice Program Specific Requirements

Method of Payment

- Reimbursement will be made monthly on an actual cost basis for PPW staff time.
- Reimbursement will be made monthly based on an actual cost basis for allowable PPW program related costs.
- Reimbursement will be made monthly for childcare services on an actual cost basis.
- Receipts and supporting documentation will be retained on file by the provider.
- Reimbursement will be made monthly for indirect costs not to exceed 10% of the invoice subtotal.

Additional Requirements

- Providers will submit PPW job description(s) on a one-time basis or any time a job description(s) or pay rate adjustments are made. If there any changes to the position, such as unpaid leave, the provider will notify the Provider Relations/Contract Specialist.
- Providers will deduct staff time for services provided to private pay/non-KCICN clients.
- Allowable program related start-up and ongoing costs are defined by 2 CFR 200 (https://www.ecfr.gov/current/title-2/subtitle-A/chapter-II/part-200/subpart-E).

PPW Services Eligibility Criteria	
Medicaid Status	N/A
Age Range	N/A
Authorization Needed	No

Additional Criteria	• Individuals receive priority services as described in the King County BH-ASO Policies and Procedures.
	• Individuals must have an authorized BHRD SUD outpatient, OTP or MOUD: OBOT benefit.
	• Eligible individuals must be:
	  ○ Women who are pregnant; or
	  ○ Women who are postpartum during the first year after pregnancy completion, regardless of the outcome of the pregnancy or placement of children; or Women who are parenting children aged 17 and under, including those attempting to gain custody of children supervised by the Department of Social and Health Services (DSHS), Division of Children and Family Services (DCFS).

PPW Services Reporting Requirements	
BHRD Information System	• Submit Data to the BHRD Information System as outlined in the BHRD Data Dictionary and the Required Transactions Sheet in the ISAC Notebook
Monthly Reports	• PPW & On-site Childcare Services Report
Quarterly Reports	• None
Semiannual Reports	• None
Annual/Other Reports	• None
Performance Measurement (PM) Plan	• None

8.7 Reaching Recovery Housing for CJ Involved

Program Overview

The Reaching Recovery Housing for Criminal Justice (CJ) Involved program provides housing and appropriate housing supports for eligible adults who are involved with the criminal legal system. All program participants are provided with assistance in obtaining and maintaining their housing as well as with assistance identifying and securing long-term housing plans and resources and facilitating transitions to new housing.

The Reaching Recovery Housing for Criminal Justice Involved program is available, as resources allow, to eligible individuals for up to 24 months while other housing resources are identified. All attempts are made to establish alternative resources to support long-term housing costs for participants in order to allow new participants access to the Reaching Recovery Housing for Criminal Justice Involved program resources.

Reaching Recovery Housing for Criminal Justice Involved eligible housing costs include the following:

- Rent, including deposits
- Utilities
- Housing related repairs for participant units, as needed

Extension Request

Should a participant's initial 24-month enrollment period be scheduled to end in 6 months or less and the participant has not yet identified an alternative housing plan, the provider may submit an extension request to King County to request that program enrollment is extended up to an additional 12 months, as appropriate and agreeable to the participant. The provider must use the Reaching Recovery Housing for Criminal Justice Involved Extension Request form when submitting the request to King County. All extensions require pre-approval and are determined on a case-by-case basis and are subject to available funding. King County will send all extension request decisions to the provider in writing.

Exit Process

Enrollment in the program may not exceed 3 years.

The provider submits the Reaching Recovery Housing for Criminal Justice Involved Transition Plan Report to King County when a participant is 6 months away from their program end date. In part, this report collects information related to the participant's transition plan, including their housing plan, at the end of the Reaching Recovery Housing for Criminal Justice Involved program.

If a participant's program end date is within 3 months or less and the participant has not yet identified housing and/or will likely not secure housing by this date, an updated Reaching Recovery Housing for Criminal Justice Involved Transition Plan Report must be submitted at this time.

Should a participant be nearing the end of program enrollment, either because an extension request was denied or because the 3-year maximum is approaching, and they still have not identified an alternative housing plan, program enrollment will officially end on either the 2-year or 3-year end date, as applicable to the participant. BHRD will offer an additional, final 6 months of housing and housing support to help with the transition at this time. All program-funded housing and housing support ends after this six-month extension.

Invoice Program Specific Requirements

Method of Payment

- Reimbursement will be made monthly based on actual costs for eligible Reaching Recovery Housing for CJ Involved housing costs.

Reimbursement will be made monthly for administrative costs not to exceed 10% of the month's housing costs. Additional Requirements

- The Provider serves as the pass-through for Reaching Recovery Housing for CJ Involved funds to support participants in maintaining stable housing, and the Provider identifies and collects any client rental responsibility and/or other subsidies/sources of rental assistance prior to utilizing Reaching Recovery Housing for CJ Involved funds.
- Reaching Recovery Housing for CJ Involved funding cannot be used to support vacant units, renovations, maintenance, or office space.

Reaching Recovery Housing for CJ Involved Eligibility Criteria	
Medicaid Status	Yes, unless covered by other identified fund sources
Age Range	Adults Aged 18 Years and Older
Authorization Needed	Yes
Additional Criteria	Eligible participants include individuals who have been incarcerated in the last year or have a significant criminal history or are on probation with the Washington State Department of Corrections (DOC) or a municipal

	jurisdiction in King County; Regional Mental Health Court (RMHC) Project Start participants are a subset of the target populations under this section; and housing for this population must adhere to RMHC requirements and restrictions. Housing supports are tied to a participant's ongoing outpatient treatment benefit. Should an individual lose or discontinue their outpatient benefit, the provider will not continue to support housing costs. Should an individual lose their outpatient benefit, and therefore also their housing benefit, due to being incarcerated or hospitalized, the provider may submit a request for an additional housing benefit that includes the rationale for the request to the County for an additional 24-months of housing supports. The provider may also submit a request to the County for pre-approval of an additional 24- month housing benefit for participants who lose their housing and for whom there is a clinically indicated rationale for supporting an additional benefit. All requests for a second authorization must be pre-approved.

Reaching Recovery Housing for CJ Involved Reporting Requirements	
Monthly Reports	• Reaching Recovery Housing for CJ Involved Monthly Log
Quarterly Reports	• Proviso 86 Quarterly Report ○ The report for January through March is due by April 15 ○ The report for April through June is due by July 15 ○ The report for July through September is due by October 15 ○ The report for October through December is due by January 15
Semiannual Reports	• None
Annual/Other Reports	• Reaching Recovery Housing for CJ Involved Transition Plan Report is due when a participant is 6 months away from the Reaching Recovery Housing for CJ Involved benefit end date. If a participant's Reaching Recovery Housing for CJ Involved benefit end date is within 3 months or less and they have not yet identified housing and/or will likely not secure housing by this date, an updated Reaching Recovery Housing for CJ Involved Transition Plan Report is due at this time. • An extension for up to 12 months to the 24-month Reaching Recovery for CJ Involved benefit can be requested by submitting the Reaching Recovery Housing for CJ Involved Extension Request form. All extensions require pre-approval and are determined on a case-by-case basis and are subject to available funding.
Performance Measurement (PM) Plan	• None

8.8 Recovery High School

Program Overview

King County BHRD partners with Seattle Public Schools to implement a recovery high school program where young people with substance use disorder and other mental health conditions work toward achieving the important developmental milestone of graduating from high school. Hosted through the Interagency Academy network of specialized campuses, the Interagency Recovery Campus (IRC) serves students in grades 9-12 who are actively working toward their academic, career, and recovery

goals. The program is voluntary, and guides students in building sober lifestyles by cultivating connections with peers, engaging in fun prosocial activities, and being a presence in the recovery community.

The 1.0 FTE Student/Family Advocate (SFA) position at IRC is credentialed as a Substance Use Disorder Professional and holds a Master of Social Work (SUDP/MSW). The SFA implements a recovery high school program as described by the Association of Recovery Schools. The SFA is the primary contact for enrolled IRC students and their families/caregivers and consults with Interagency Academy campuses regarding substance use interventions. Examples of job duties include leading daily Recovery Support groups, facilitating admission into behavioral health residential and outpatient treatment programs, supporting and educating parents, and actively informing all students about overdose prevention.

Invoice Program Specific Requirements

Method of Payment

- Reimbursement will be made monthly based on actual costs for 1.0 FTE SFA position.

Additional Requirements

- None

Recovery High School Eligibility Criteria	
Medicaid Status	N/A
Age Range	N/A
Authorization Needed	No
Additional Criteria	None
Recovery High School Reporting Requirements	
Monthly Reports	Recovery High School Expense Report Recovery High School Narrative Report
Quarterly Reports	None
Semiannual Reports	None
Annual/Other Reports	Contribute to other reporting as requested by King County BHRD
Performance Measurement (PM) Plan	None

8.9 Recovery Support Services

Program Overview

This work provides individually directed Substance Use Disorder (SUD) Recovery Support Services (RSS) to eligible individuals who are experiencing and/or have a history with substance use disorder and is funded through the Washington State Health Care Authority's Substance Abuse Block Grant (SABG). SABG RSS is a recovery program and is not meant to supplant or support existing programs experiencing fiscal challenges.

Program Specific Requirements

- Provide client-directed Recovery Support Services (RSS) and community recovery supports to eligible individuals.

- Provider will ensure each eligible individual has access to a Recovery Care Manager (RCM). The RCMs are to provide various social service interventions including managing referrals, assisting with the development and support of recovery care plans, peer services, recovery coaching, occupational and/or life skills development support, and discharge planning.
- Plan, train, and negotiate with community entities for the provision of recovery services as directed by the eligible individual.
- Provided services are culturally relevant to the eligible individual and the community.
- Provide recovery support services and service a minimum of 177 individuals per year. If the provider has an established waiting list, sixty percent (60%) of all eligible individuals enrolled annually should be first time enrollees or individuals that have never been enrolled before.
- Seventy-five percent (75%) of all enrolled eligible individuals should identify with the priority populations as noted in the Additional Requirements section.
- One hundred percent (100%) of eligible individuals must complete a recovery goal plan to be included in their file. Template will be provided by the HCA titled, “SMART Recovery Goal Setting Worksheet.” The complete recovery goal plan must be reviewed and revised as needed by the eligible individual and their RCM every two (2) months at minimum.
- Provided RSS services will include but not be limited to the following:
  - Individual Peer to Peer support
  - Peer-led Support Group
  - Peer-led training on Peer Certification Activity, as approved by the HCA Contract Manager
  - Recovery Housing, including only homes on the HCA Recovery Housing List
  - Recovery Support Service Childcare fee or Family Caregiver fee
  - Recovery Support Transportation fee
  - Recovery Social Support or Social Inclusion Activity, as approved by the HCA Contract Manager, and
  - Other SAMHSA approved recovery support event or activity as approved by the HCA Contract Manager
- Provider will support Recovery Support Barrier Removal Services to include but not be limited to the following:
  - Overdose reversal medications.
  - Harm Reduction supplies.
  - Rental deposits, background checks, and application fees.
  - Hygiene and dental kits.
  - First aid supplies.
  - Utility set-up costs and deposits; and
  - Other one-time requests approved by the BHRD and HCA Contract Managers.
- Provider will 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.

Staff Training and Learning Collaborative Requirements
The Provider must send a minimum of two RCMs to a motivational interview training provided by a qualified organization. The provider will report the training details to the BHRD Contract Manager prior to the start of the training and detail the following:

- Dates of the training.
- Times of the training.
- Training agenda/syllabus.
- Training organization(s), and
- Names of the RCMs who are attending.

The Provider must submit certifications of completion to the BHRD Contract Manager at the end of the training for all RCMs that completed the training. The provider must notify the BHRD Contract Manager via email as soon as possible if the deadline is not met and request in writing a reasonable extension of the deadline.

The Provider must send the program supervisor to the Peer Support Operations and Supervision training provided through HCA. The training must be completed before the end of the contract date and a certification of completion of this training must be provided to the BHRD Contract Manager once completed.

The Provider must designate one representative from the provider's organization to attend the quarterly learning collaborative, along with the BHRD Contract manager, that will be facilitated by the HCA Contract Manager. The provider must provide prior notice to the HCA Contract Manager if they are unable to attend.

The Provider will create and submit a detailed sustainability plan for this program. The plan must include the following information at a minimum:

- Identification of other funding sources to continue the program.
- Challenges and barriers to finding other funding sources.
- Impact of fully funded program and its continuation.
- Impact if program cannot be funded and ends.
- Action steps that will be taken to continue to provide services if funding ends or is decreased.

Data Collection
Ensure that data is collected and submitted on all SUPTRS-BG 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.

Invoice Program Specific Requirements
<u>Method Payment</u>

- Payment will be based upon monthly costs incurred with final approval by the HCA Contract Manager prior to payment.
- A minimum of seventy percent (70%) of the Contract funds are to be used for RSS.
- A maximum of thirty percent (30%) of the Contract funds are to be used for barrier removal services.
- The provider will provide monthly success stories of individuals enrolled in their RSS program. The success stories provided must relate to the goals in the eligible individual's recovery plan, be written

by the eligible individual whenever possible, and not include any identifying information on the eligible individual.

- Reimbursement will be made monthly on cost-per-client expenditures related to recovery support services. Reimbursement is based on rates agreed upon with the HCA.
- The Provider will retain all records and supporting documentation (including receipts) related to the expenses incurred.
- If there is a specific, authorized service, needed to support the individual's recovery, the Provider may request an exemption from the BHRD Project Manager.

Recovery Support Services Eligibility Criteria	
Medicaid Status	N/A
Age Range	16 yrs of age and older
Authorization Needed	No
Additional Criteria	Priority must be given to any individual who identifies as one of the following priority populations: • Houseless • Black, Indigenous, and/or Person of Color (BIPOC) • Other underserved populations; and/or Individuals without access to Medicaid or private insurance
Recovery Support Services Reporting Requirements	
Monthly Reports	• SAMHSA Reporting Matrix • Recovery Support Service Billing Summary • Success Story of an Enrolled Individual • Signed Release Form of Individual Featured in Success Story
Quarterly Reports	• None
Semiannual Reports	• None
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. • Sustainability Plan • Motivational Interviewing Training Report • Peer Support Ops and Supervisor Training Report
Performance Measurement (PM) Plan	• None

8.10 Sobering Services

Program Overview

DCHS/BHRD funds sobering services to strengthen the availability, quality, and coordination of crisis services for people experiencing homelessness. Sobering services are a safe and secure shelter for adults to sleep off the acute effects of intoxication. They also serve as a recovery access point where people receive case management services and assistance to move towards greater self-determination and recovery. The services are contracted out to a community non-profit that employs people trained in medical assessment and response to staff the services.

No eligible individual is refused service (unless temporarily unable to stay onsite for reasons that have been clearly documented and whose status has been communicated in advance to key partners), regardless of capacity. When the center is at capacity and an eligible individual presents for service, an individual in the current census should be discharged and assisted with an alternate placement, if one is available. The Provider coordinates these cases with the King County Emergency Service Patrol (ESP). The Provider maintains a minimum staff to client ratio of 1:15 at all times. The Provider Supervisor or Lead is present during peak admission times (8:00 pm through 2:00 am) to direct staff and assist with client triage and behavior management. Provider staff receive annual training on recovery, substance use disorders (SUD), Motivational Interviewing, skills and strategies for behavior management, and managing acute intoxication.

Sobering services include physician-approved protocols for intake screening and discharge, observations, and regular monitoring, including breathalyzer test, vital signs, head-to-toe physical assessment, and the general health screening interview. The Provider also delivers social services for clients as needed, including but not limited to housing assistance, income support, clothing, and personal hygiene resources. Each client receives discharge planning on completion of services for every admission to determine or update the need for ongoing services and to update information in the database. Each sobering service involvement is seen as a new opportunity to engage the individual in services. The Provider works to enroll individuals who repeatedly use services in withdrawal management services, SUD treatment or case management services, and collects a county High-Utilizer release-of-information (ROI) form for each client.

The King County Yesler Building will provide a temporary home for King County's Sobering Support Shelter. The shelter will operate overnight only, from 5 p.m. to 8 a.m. seven days a week, providing health-supervised shelter for up to 35 people per night. While sited at the Yesler Building, the provider will do the following:

- Accompany clients at all times while entering and exiting the premises.
- Accompany clients to and from the elevator, placing the client securely in the elevator and ensuring they are met by staff when the elevator opens.
- Accompany clients to and from the restroom facilities located on the 3rd floor.
- Ensure clients who exit onto floor 2 are immediately located and returned to the appropriate area.
- Alert the Emergency Dispatch Center (EDC) (206-296-5000) when the 5th Ave door is opened to admit or discharge a client.
- Alert the EDC whenever staff calls 911 for medical or police assistance to the premises.
- Complete sobering services include physician-approved protocols for each intake screening and discharge, observations, and regular monitoring, including breathalyzer test, vital signs, head-to-toe physical assessment, and the general health screening interview.
- Coordinate client handoff with the Emergency Service Patrol.
- Immediately report any damage which constitutes a threat to fire/life/safety to the EDC.
- Report within 3 hours, routine damage or maintenance problems associated with the space to FMD Customer Care during normal business hours – or the EDC after business hours.
- Prevent clients or staff from accessing roped off areas of the 3rd floor.
- Provide custodial care for spaces which are primarily client focused.
- Limit access by clients and staff to non-designated use areas (as indicated on attached building/floor plans).
- Adhere to fire/life/safety training and protocols as provided by Facilities Management Division (FMD).
- Attend to Yesler Sobering Center Trash:
- Daily: Collect, bag, and remove all garbage.
    - All bags are to be tied and secured.

  - Place garbage in bin BOS provided.
  - Take all garbage via alley to the Chinook trash compactor located at the Chinook loading dock.
- Staff to contact the EDC at 206.296.5000 for access to the loading dock if the gate grill is closed.
- Trash is to be placed in the compactor and compacted. (BOS to provide 1 X training and key to Pioneer Staff).
- Bin is to be cleaned and returned to Yesler 3rd floor for next day's use.
- Bin is to be always free of liquid and food to prevent unwanted pests.

Maintenance Requests & After-Hours Emergencies
For maintenance needs from 8AM - 4:30 PM Monday – Friday, contact the FMD Customer Care Services Team at 206-477-9400 or email customercareservices.fmd@kingcounty.gov. When reporting requests, please provide the following information:

- Nature of request (e.g., plugged toilets, lights out)
- Building name (Yesler Building)
- Location within the building (e.g., room numbers, floor, or any other identifiers)
- Pictures and/or videos
- Name of requester, phone number, and e-mail address

For Weekend and Afterhours Emergencies call the Emergency Dispatch Center (EDC) for 24/7 Support 206-296-5000.The Provider agrees to comply with all requirements for reporting Critical Incidents to the County following the standards set out in Section 12.2 Critical Incidents Program and Reporting Requirements.

Invoice Program Specific Requirements
Method of Payment

- Reimbursement will be made in monthly 1/12th payments for the previous month's program operations for Sobering Services.
- Quarterly Reconciliation Reports must be completed regarding actual expenditures and are due on the 15th calendar day following the end of the quarter with the exception of the 4th quarter which is due on the 10th calendar day. Any unexpended funds will be adjusted in the next invoice.

Additional Requirements

- Quarterly reconciliation must be submitted with the February, May and September invoices.
- Duration of this change is dependent upon local conditions and may be updated on a month-to-month basis.

Sobering Services Eligibility Criteria	
Medicaid Status	N/A
Age Range	18 years or older
Authorization Needed	No
Additional Criteria	• Impacted by SUD, • Experiencing homelessness, • Impacted by a co-occurring mental health disorder, • High utilizers of publicly funded crisis services, and/or • Priority Populations: homeless veterans, American Indians, and Alaska Natives
Sobering Services Reporting Requirements	
Monthly Reports	• None
Quarterly Reports	• Sobering Services Fiscal Reconciliation Report

Semiannual Reports	• None
Annual/Other Reports	• If requested by DCHS/BHRD
Performance Measurement (PM) Plan	• None

8.11 Therapeutic Childcare

Program Overview

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 Childcare 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 Childcare services include:
- Therapeutic and behavioral interventions provided with both child and family using individual and group play therapy;
- Parenting education; and
- Parent Skills training.

A discharge and transition plan should be established and implemented 90 days in advance of the completion date. This plan should be provided to the parents' SUD treatment staff and should include the reason for the child and parent exiting from the services, the child's developmental, emotional, behavioral, and medical status, a description of the child and parent progress on the goals and

objectives, and recommended continuation planning and all referrals for the family. If the parent is unexpectedly discharged from SUD treatment for any reason, the child may continue to participate in the services for up to one month to facilitate transition.

Therapeutic Child Care Eligibility Criteria	
Medicaid Status	N/A
Age Range	Birth to 6 years of age
Authorization Needed	No
Additional Criteria	• Children from birth to six years of age not currently involved with Child Protective Services (CPS) who have parents that are actively participating in publicly funded SUD treatment services. • Priority is given to infants and children of pregnant and postpartum women, up to one year postpartum.
Therapeutic Child Care Reporting Requirements	
Monthly Reports	• The Provider completes the report form as provided by the County showing the amount billed to King County BH-ASO and the amount received from King County BH-ASO for each service month. • The Provider reports monthly to the County, in a format provided by the County, the following information: • A daily enrollment with actual dates and hours of attendance by each child for the calendar month including the number of home visits, noting the branch and site location; • The monthly unduplicated number of admissions, enrollments, and discharges; and • The monthly source of referrals of children referred.
Quarterly Reports	• None
Semiannual Reports	• None
Annual/Other Reports	• The Provider submits their current State of Washington Childcare License for each branch site by the month following renewal.
Performance Measurement (PM) Plan	• None

8.12 Tribal Mental Health Services

Program Overview

Programs or services designed to provide outpatient mental health services to children, adults, older adults, and families of tribes in the King County Region. The Provider develops culturally responsive mental health services designed to improve and promote mental health services for Tribal members and include opportunities for mentoring, teaching skills, establishing teamwork, enhancing decision- making, improving self-confidence and self-esteem, and providing services to the community. The Provider ensures the following psychiatric services are available to eligible individuals:

- Assessment,
- Medication evaluation, management, and review; and
- Consultation.

Tribal Mental Health Services Eligibility Criteria	
Medicaid Status	N/A

Age Range	N/A
Authorization Needed	No
Additional Criteria	Eligible individuals are those individuals who are members of, or are related to, members of the contracted Indian Tribe and are in need of mental health services and supports.
Tribal Mental Health Services Reporting Requirements	
Monthly Reports	None
Quarterly Reports	The Provider submits the Mental Health Services Quarterly Report with the BIP in hard copy to the Behavioral Health and Recovery Division (BHRD) Provider Relations/Contract Specialist as follows: • The report for January 1 through March 31 is due by April 15; • The report for April 1 through June 30 is due by July 15; • The report for July 1 through September 30 is due by October 15; • The report for October 1 through December 31 is due by January 15.
Semiannual Reports	None
Annual/Other Reports	None
Performance Measurement (PM) Plan	None

8.13 Tribal Substance Use Disorder Services

Program Overview

Program or services designed to provide outpatient substance use disorder (SUD) services to youth, adults, older adults, and families of tribes in the King County Region. The Provider develops SUD services designed to improve and promote SUD services of Tribal members that are determined to be clinically necessary, culturally appropriate, and improve an individual's ability to maintain recovery and resiliency. Substance Use Disorder Professional's (SUDPs), or Substance Use Disorder Professional Trainee's (SUDPTs) under the supervision of a SUDP assess and assign an ASAM level of care for each of the six dimensions and an overall level-of-care placement recommendation at the following treatment points for all clients receiving SUD services:

- Assessment,
- ISP reviews, and
- Discharge.

Client's ISPs possess the following characteristics:

- Reflects client strengths and needs as identified in the client assessment;
- Establishes individualized, time-limited, measurable, and achievable goals and objectives;
- Documents client involvement in ISP development; and
- Reflects clinical progress or lack thereof.

Tribal SUD Treatment Services Eligibility Criteria	
Medicaid Status	N/A
Age Range	N/A
Authorization Needed	No

Additional Criteria	Eligible individuals are those individuals who are members of, or are related to, members of the contracted Indian Tribe and are in need of mental health services and supports.
Tribal SUD Treatment Services Reporting Requirements	
Monthly Reports	None
Quarterly Reports	The Provider submits the SUD Services Quarterly Report with the BIP in hard copy to the Behavioral Health and Recovery Division (BHRD) Provider Relations/Contract Specialist as follows: • The report for January 1 through March 31 is due by April 15 • The report for April 1 through June 30 is due by July 15 • The report for July 1 through September 30 is due by October 15 • The report for October 1 through December 31 is due by January 15
Semiannual Reports	None
Annual/ Other Reports	None
Performance Measurement (PM) Plan	None

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.

9.1 911 Behavioral Health Crisis Call Diversion Program

Program Overview

The 911 Diversion Behavioral Health Crisis Call Diversion (911 Diversion BHCCD) Program utilizes specially trained counselors to accept warm transfers from King County's Public Safety Answering Points (PSAPs), commonly known as 911 call centers for individuals in behavioral health crisis. These counselors are trained in crisis intervention, de-escalation, and resource information to respond to non-emergency calls placed to PSAPs by or for individuals in crisis. The program streamlines non-emergency 911 calls by referring appropriate calls from PSAPs to behavioral health crisis services.

Callers transferred to behavioral health counselors receive telephonic support as well as access to additional referral resources. Program staff provide interim support for 911 callers while emergency services and/or co-responder teams are enroute; while also maintaining communication with dispatch and response teams to provide updates so emergency responders are prepared to deliver appropriate behavioral health interventions upon arrival.

In addition to individual interventions, the 911 Diversion BHCCD Program is community focused. The program provides public awareness campaigns to educate residents about the program and use of 988 and 211 services and facilitates the expansion of the program into additional King County PSAPs.

911 Behavioral Health Crisis Call Diversion Program Eligibility Criteria	
Medicaid Status	Serves individuals regardless of Medicaid status
Age Range	All ages
Target Population	Callers to the participating Public Safety Answering Points
Authorization Needed	No
Additional Criteria	Any individual experiencing an emotional and/or behavioral disturbance, including substance use/abuse referred by a participating PSAP who meets the following criteria is eligible for services: • Is in emotional or behavioral crisis that would benefit from crisis intervention services; and • Agrees to the call transfer

Goals & Objectives

- Directly connect participating King County PSAPs with behavioral health counselors for appropriate behavioral health crisis calls.
- Ensure that 911 operators are equipped to identify calls that involve a behavioral health crisis and facilitate the transfer of such calls to trained behavioral health crisis counselors.
- Reduce reliance on law enforcement response by diverting appropriate calls to specialized crisis service providers.
- Provide immediate behavioral health support, make referrals, connect individuals to necessary resources, dispatch mobile crisis response teams when needed, and improve outcomes for individuals experiencing a behavioral health crisis.

Program Requirements

Provide staffing to ensure call coverage 24/7/365, including:

- 1 FTE 911 Behavioral Health Crisis Call Diversion Program Director (Mental Health Professional)
  - 2.0 FTE 911 Behavioral Health Crisis Call Diversion Program Clinical Supervisors (Mental Health Professional)
  - 2.8 FTE 911 Crisis Services Clinician MHP
  - 2.8 FTE 911 Call Diversion Specialist under the supervision of an MHP
- Implement a call diversion system that routes non-emergency calls from 911 to behavioral health crisis intervention and community services.
- Ensure seamless integration of the call diversion system with 911 infrastructure and telecommunication networks.
- Train behavioral health crisis diversion specialists to handle diverse non-emergency situations, enabling them to cover behavioral health crisis and community services support.
- Train, or provide training support for training of 911 dispatchers to recognize and reroute calls suited for behavioral health crisis intervention and community services.
- Provide telephonic support and access to additional resources for callers transferred to behavioral health counselors, including:
  - Next Day Appointments
  - Mobile crisis dispatch
  - Walk-in crisis facilities
  - Resource information available through 211 services
  - Other appropriate supports
- Develop and execute a public awareness campaign to educate residents on the use of 988 and 211 services.
- Facilitate warm transfers between 911 and behavioral health crisis responders.
- Provide interim supportive interventions to callers while emergency units are enroute.
- Maintain communication with dispatch to share real-time updates on the situation.
- Monitor referral pathways and volumes to inform quality improvement activities.
- Assess the needs of individual PSAPs and communities to ensure service alignment with the 911 Behavioral Health Crisis Call Diversion program model.
- Develop strategies to expand behavioral health crisis call services and identify expansion opportunities at PSAPs by:
  - identifying community needs;
  - fostering relationships with crisis system partners;
  - supporting the development of strategies for service expansion.

Invoice Program Specific Requirements

Method of Payment

- Reimbursement will be made monthly on an actual cost basis for the 911 Behavioral Health Crisis Call Diversion Program services, including up to 8.6 FTE actuals, and approved program expenditures.

Additional Requirements

- The Provider must retain all records and supporting documentation (including receipts, invoices, timesheets, and copies of checks) related to the expenses incurred for the program described above.
- Non-compliance with evaluation data requirements may result in withholding of payment for all associated contracted services.

- The Provider should notify King County on a monthly basis either via email or verbally during program meetings if BHCCD program-funded positions become vacant and provide a plan on how to fill them.
- Progress towards accomplishments will be communicated in the monthly progress report and monthly check-ins. If provider is unable to meet expected accomplishments, they should contact the King County Program Manager to negotiate an improvement plan. King County reserves the right to reduce or withhold payment until an improvement plan is in place.

911 Behavioral Health Crisis Call Diversion Program Reporting Requirements	
BHRD Information System	Submit Data to the BHRD Information System as outlined in the BHRD Data Dictionary and the Required Transactions Sheet in the ISAC Notebook
Monthly Reports	• BHCCD Actual Monthly Expenditures Report, and Detailed Budget Breakdown for All Program Expenditures • Monthly 911 Diversion Caller Demographics Report • Staffing Reports
Quarterly Reports	None
Semiannual Reports	None
Annual/Other Reports	As requested by the County for Crisis Care Centers Levy annual report Other reports as needed
Performance Measurement (PM) Plan	None

9.2 Behavioral Health Education and Advancement Model (BEAM)

Program Overview

This BEAM scope is available to King County Integrated Care Network (KCICN) providers and Behavioral Health Administrative Service Organizations (BH-ASO) who were awarded projects under the Career and Educational Advancement through Labor-Management Partnerships Option 1 and/or 2 in the Behavioral Health Career Pathways RFP. Career and Educational Advancement through Labor-Management Partnerships projects advance career and educational growth through labor-management collaboration.

The Behavioral Health Education and Advancement Model (BEAM) provides a designated education and training fund administered by SEIU Healthcare 1199NW Multi-Employer Training Fund (HCTF) for non-union employees.

Agencies that have a Collective Bargaining Agreement with the HCTF for union-represented employees are eligible to participate in the Training Trust, which is similar to the BEAM fund. Contributions from this BEAM scope fund provider participation costs in the Training Trust.

Goals and Objectives

- Stabilize the community behavioral health workforce, improve retention rates, increase workforce diversity, and enhance access to behavioral health services.
- Increase diversity and representation of the behavioral health workforce.
- Higher participation in professional development, higher education, and training programs.

Program Requirements
Participation in a BHRD-approved labor-management training fund that provides professional development resources and reimbursements for costs such as tuition assistance, conference attendance and travel, certifications and licenses, and educational resources that support career advancement. Currently approved training funds follow:

	Option 1 (BEAM Non-Union)	Option 2 (Training Trust for Union-Represented Staff)
Target Population	KCICN and BH-ASO agencies that have employees who are non-union.	KCICN and BH-ASO employers who have employees that are SEIU Healthcare 1199NW union represented.
Other Criteria	None	Agency must contribute 1% of their total annual 2026 salaries for Training Trust eligible staff for program benefits.

Invoice Program Specific Requirements
Method of Payment
- Reimbursement will be made monthly on an actual cost basis for Training Trust participation costs, which is 1% of eligible staff payroll (not including benefits), prior to paying the Training Fund.
- The payroll costs for SEIU Healthcare 1199NW union-represented employees and non-union employees should be calculated separately.
- Projected costs are outlined in agencies' approved budgets.

Additional Requirements
- None

Reporting Requirements

Monthly Reports	BEAM and/or Training Trust Monthly Wage Report Training Trust Expenditure Report
Quarterly Reports	None
Semiannual Reports	None
Annual/Other Reports	BEAM and/or Training Trust Annual Report
Performance Measurement (PM) Plan	None

The Monthly Wage Report must contain employee's first name, last name (or an ID number can be substituted for name), job title, percent of FTE, date of hire, gross pay from Box 5 Medicare Wages, 1% of gross pay, and the sum of 1% for all eligible employees.
Data for SEIU Healthcare 1199NW union-represented employees and non-union employees should be calculated separately, for example, on separate tabs of a spreadsheet.

9.3 BH Career Pathways Program

Program Overview
The Behavioral Health Career Pathways Program (BHCP) addresses community behavioral health workforce shortages and the need to grow, sustain, and increase the representativeness of the Behavioral Health Workforce, including the workforce at the region's new CCCs and King County's overall community behavioral health workforce. The BHCP Program is available to awarded King

Target Population	KCICN providers that are licensed behavioral health agencies under contract with King County to serve Medicaid clients.

County Integrated Care Network (KCICN) providers to strengthen the community behavioral health workforce in King County.

The BHCP contains five different project types:

Projects	KCICN
1. Student Internships Stipends and/or Staff Development	X
2. Career and Educational Advancement through Labor-Management Partnerships (Agency-based)	X
3. Clinical Supervision	X
4. Workforce Wellbeing	X
5. YMCA Education Enhancement Program (EEP)	X

All BHCP projects support efforts to expand community behavioral health career pathways, sustaining and expanding labor-management workforce development partnerships, and supporting crisis workforce development, per Ordinance 19572.

Overarching Goals and Objectives

- Stabilization of the community behavioral health workforce, improved retention rates, increased workforce diversity, and enhanced access to behavioral health services.
- Increased diversity and representation of the behavioral health workforce.
- Improved retention rates among providers.
- Higher participation in internships, professional development, and training programs.
- Greater community awareness of and engagement in behavioral health careers.

Individual Project Details and Requirements

1. *Student Internship Stipends and/or Staff Development*

Student Internship Stipends an internships Development projects support various career advancement opportunities through student internship, practicum, or fellowship programs, as well as staff development training or workshops.

Student Internship Stipend and/or Staff Development projects could include:

- Stipend or wages for those participating in an internship, practicum, or fellowship program.
- Salaries/benefits for staff supporting internship, practicum, or fellowship program.
- Supplies, technology, or equipment necessary for internship, practicum, or fellowship program.
- Professional liability insurance required for students participating in an internship, practicum, or fellowship program.
- Partial or full payment of health insurance premiums for those participating in an internship, practicum, or fellowship program.
- Administrative costs associated with internship, practicum, or fellowship program.
- Costs associated with staff participation in training or workshops.
- Supplies, technology, or equipment necessary for training or workshops.

2. *Career and Educational Advancement through Labor-Management Partnerships*

Career and Educational Advancement through Labor-Management Partnerships projects demonstrate a commitment to career and educational growth through labor-management collaboration.

For agencies that are approved for a direct labor-management partnership developed in collaboration between agency management and frontline workers, allowable costs for programs may include:

- Tuition reimbursement
  - Tuition/fees
  - Required books, supplies, or software
- Certifications and licensing
  - Fees for exams and licensure
  - Supports specialty certifications
  - Reimbursement for clinical licensure
  - Conference participation
  - Registration, travel, and accommodation
- Associated costs for supporting a labor committee:
  - In-person travel
  - Supplies
  - Overtime
  - Meals

Agency Labor-Management Partnership	
Target Population	KCICN providers.
Other Criteria	Agency must develop a new labor committee (with over 50% frontline worker representation) to determine how the funds are spent. This committee must meet four (4) times per year and be the decision-making authority for the funds.

3. *Clinical Supervision*

Clinical Supervision projects support efforts to expand or enhance an agency's ability to provide clinical supervision.

Allowable costs for programs may include:

- Salaries/benefits for hiring new licensed clinical supervision staff.
- Costs associated with increasing salaries/benefits for established licensed clinical supervision staff.
- Costs associated with procuring a contract with an outside vendor for clinical supervision support.
- Cost associated with training or workshops for licensed clinical supervision staff.
- Supplies, technology, or equipment necessary to provide clinical supervision.

Target Population	KCICN providers

4. *Workforce Wellbeing*

Workforce Wellbeing projects promote the wellbeing of workers, focusing on activities that support their physical, mental, and emotional health.

Allowable costs for programs may include:

- Staff retreats or teambuilding activities.
- Wellness reimbursement program for staff.
- Staff insurance plan adjustments.
- All staff workshop or training.
- Direct wellness services and supplies for staff.
- Reimbursement to support staff costs incurred through work such as transportation or other vehicle assistance.
- Costs associated with ergonomic office supplies/equipment and space for wellness related activities.

Target Population	KCICN providers

5. *YMCA*

The YMCA has partnered with Heritage University to establish the YMCA Education Enhancement Program (EEP) which provides a free pathway for BH professionals to advance their careers. The program is specifically designed to increase both the number of behavioral health providers throughout King County and the representation of marginalized populations within the pool of providers. The Y+ Heritage Program recruits participants who currently work for a community behavioral health agency and who identify as BIPOC, LGBTQIA+, and/or having a disability. The two-year program is offered at no cost to students and over the course of the program participants earn a master's degree in mental health counseling, complete the requisite internship, and interact with other behavioral health professionals from marginalized communities.

KCICN providers who have students participating in the YMCA EEP are allowed to receive additional reimbursement for student time spent in class throughout the duration of the program. Below is a summary of the number of hours per week for each semester in a one-year period.

- Spring: Students spend approximately five hours in class per week for 16 weeks.
- Summer: Students spend approximately five hours in class per week for 12 weeks.
- Fall: Students spend approximately five hours in class per week for 16 weeks.

Target Population	KCICN providers

Invoice Program Specific Requirements

Projects 1-4:

Method of Payment

- Reimbursement will be made monthly on an actual cost basis for the following Behavioral Health Career Pathways program costs: Student internship stipends, staff development, clinical supervision, workforce wellbeing, and Career and Educational Advancement through Labor-Management Partnerships.

Additional Requirements

- Costs incurred are outlined in the agency's approved budget. Providers will receive approval from King County prior to the purchasing of any items not included in their approved budget.

Project 5:

Reimbursement will be made per semester based on student attendance:

- Spring: Maximum reimbursement of $1,600 per student
- Summer: Maximum reimbursement of $1,200 per student
- Fall: Maximum reimbursement of $1,600 per student

Reporting Requirements (For All Project Types)

Monthly Reports	BH Career Pathways Monthly Invoice Report and Expenditure Report
Quarterly Reports	BH Career Pathways Summary Report
Semiannual Reports	None
Annual/Other Reports	BH Career Pathways Annual Report
Performance Measurement (PM) Plan	None

9.4 Corrections-Based SUD Treatment Services (at the Maleng Regional Justice Center)

Program Overview

The Corrections-Based SUD Treatment Services program provides in-custody SUD treatment services to adult men, who are diagnosed with a SUD and incarcerated at the King County jail. The program aims to expand SUD treatment at the King County jail by providing counselors to deliver SUD services at the Maleng Regional Justice Center (MRJC). The program is provided in accordance with the MIDD Behavioral Health Sales Tax Plan Initiative RR-12 – Jail-based Substance Abuse Treatment as outlined in the MIDD initiative description: RR-12 Description

Corrections-based SUD Treatment Services Eligibility Criteria	
Medicaid Status	N/A
Age Range	Adults Aged 18 Years and Older
Target Population	Adult men who are diagnosed with a SUD and who are incarcerated at, or transferred to, the MRJC.
Authorization Needed	No
Authorization Criteria	None
Other Criteria	To be eligible, individuals: • Must be incarcerated at, or transferred to the MRJC for a period of 14 days or longer; and • Meet the established classifications criteria approved by the King County Department of Adult and Juvenile Detention.

Goals & Objectives

The provider coordinates with the Department of Adult and Juvenile Detention (DAJD) to deliver SUD treatment services that include evidence-based curriculum and modified therapeutic community approach to adult men with varying lengths of stay at the MRJC. The provider also coordinates with Public Health – Seattle & King County Jail Health Services (JHS) when needed to support clients with medication or other health needs while incarcerated.

Program Requirements

- The provider serves up to 36 men at any one time in the Corrections-Based SUD Treatment Services program at the MRJC. Staffing includes 1.0 Full Time Equivalent (FTE) SUDP Clinical Supervisor and 3.0 FTE SUDP/Ts.
- The provider delivers the following services at the MRJC:
  - SUD screening and assessment services.
  - SUD treatment using an evidence-based, cognitive-behavioral curriculum such as Moral Reconation Therapy (MRT) and trauma-informed, modified therapeutic community (TC) approach adapted to the participant's presenting needs and length of stay.
  - Reentry planning and referral to community-based services addressing ongoing SUD treatment needs; and
  - Clinical supervision.
- The provider will coordinate with DAJD and JHS to facilitate referrals to the program and to support ongoing program operations. This includes participating in a monthly operations meeting with DAJD, JHS, and the King County Behavioral Health and Recovery Division (BHRD) to discuss operational issues and ensure effective collaboration.
- The provider will deliver training to corrections and clinical staff supporting continued integration of MTC principles in program operations.
- The provider will ensure data about services and client outcomes as outlined in the MIDD Performance Measurement Plan for initiative RR-12 are submitted to BHRD monthly. Reports will be submitted through the Client Outcome Reporting Engine (CORE) and are due within 15 days following the end of each month.

- The provider will submit an annual narrative progress report to BHRD. This report will cover the activities of the previous year (January – December). The format content guidelines, and submission deadlines will be provided by BHRD.
- Flexible funds may be used for client-specific expenses that help engage, stabilize, or support clients in treatment or with their reentry needs. Program-related expenses that support overall program operations, activities, or needs may be approved on a case-by-case basis with prior county approval. The provider will maintain documentation for all flexible fund expenditures.

Invoice Program Specific Requirements

Method of Payment

- Reimbursement will be made monthly based on actual costs.

Additional Requirements

- Non-compliance with the MIDD evaluation data requirements may result in withholding of payment for all associated contracted services.
- The provider retains all records and supporting documentation (including receipts) related to expenses incurred.

Corrections-Based SUD Treatment Services Reporting Requirements	
BHRD Information System	None
Monthly Reports	MIDD RR-12 CORE Reporting Spreadsheet General Ledger
Quarterly Reports	None
Semiannual Reports	None
Annual/Other Reports	Provide specific information for the MIDD Annual Report as requested by the County. Annual Contract Renewal Budget
Performance Measurement (PM) Plan	Reporting requirements and performance measures are further detailed in an accompanying Performance Measurement plan. See “Performance Measurement (PM) Plans” section on the Provider Manual and specific program PM Plan for more information.

9.5 Community Behavioral Health Rental Assistance (CBRA)

Community Behavioral Health Rental Assistance (CBRA) provides long-term or bridge rental subsidies for individuals with behavioral health conditions and their households. CBRA also offers housing search and placement support for individuals being referred for CBRA funding who have not yet identified housing. When CBRA is partnered with programs offering supportive housing services, those with complex behavioral health needs have opportunities to live independently in the communities of their choice. CBRA delivers services in accordance with Permanent Housing Subsidy rules, Evidenced-based Practice of Permanent Supportive Housing core elements, and Housing First principles.
CBRA is focused on serving the following priority population:

1. First priority will go to referrals meeting eligibility criteria for the program who are discharging or needing to discharge from a State psychiatric hospital or long-term civil commitment bed.
2. Second priority will go to referrals meeting eligibility criteria for the program that are discharging or needing to discharge from a community psychiatric inpatient bed or who have discharged from a State psychiatric hospital or community psychiatric inpatient bed within the past 12 months.

Households that meet CBRA eligibility criteria that are not within this priority population may be served as long as reasonable efforts have been made, including a process to identify and outreach individuals within the priority population, to ensure individuals in the priority population have first access to

available funds. Providers receive CBRA referrals from throughout the community and develop and maintain relationships and regularly coordinate with discharge planners at State psychiatric hospitals and community-based inpatient psychiatric treatment facilities to ensure the priority population is served by CBRA. To cultivate referrals for households that may not fall into the priority population, but are still eligible for the CBRA program, the Providers develop relationships with community behavioral health providers, other treatment institutions, correctional institutions, local coordinated entry-systems, and other providers that serve individuals who meet CBRA eligibility criteria.
The CBRA provider must have a termination and denial policy. This policy must describe the notification process, ensure households are made aware of the grievance and termination procedure, and describe the rights of the participant to appeal complaint and termination decisions, including contact information and timeframes for when appeals must be submitted. The CBRA provider should notify King County prior to terminating a CBRA participant from the program. The termination and denial policy must include the following reasons that a household may be denied subsidies and/or terminated from program participation.

Denial Reasons
- Does not meet CBRA eligibility requirements
- A lack of availability or funding needed to admit a new client into the CBRA program

Termination Reasons
- A confirmed permanent or long-term absence from their unit
- Relocate to a service area where the provider does not provide CBRA subsidy
- Is no longer eligible at recertification
- Requests that subsidies are terminated
- Harmful behaviors that jeopardize the safety of staff or others after all appropriate efforts have been made by staff to resolve the issues. Efforts must be documented and should be reviewed with King County prior to termination
- Evidence of fraud or attempts to commit fraud have been confirmed
- CBRA providers follow the CBRA program guidelines and requirements found within the Program Guidelines document for the current State Fiscal Year, published here: Permanent Housing Subsidy Programs - Washington State Department of Commerce. The WA State Department of Commerce and State of Washington are not liable for claims or damages arising from CBRA provider performance.

Invoice Program Specific Requirements
Method of Payment
- Reimbursement will be made monthly based on cost reimbursement for actual administrative and program operations costs.
- Reimbursement will be made monthly based on cost reimbursement for actual rental assistance costs for households that meet CBRA eligibility criteria.

Community Behavioral Health Rental Assistance (CBRA) Eligibility Criteria	
Medicaid Status	No
Age Range	Adults aged 18 years and older
Authorization Needed	No

Additional Criteria	• Household income is at or below 50% of area median income as defined by HUD; and • At least one adult household member has a documented behavioral health condition; and • The same adult household member is eligible for a long-term support services program; and • The same adult household member has a documented need for long- term housing subsidy with no other suitable resource that can meet the long-term subsidy need.
Community Behavioral Health Rental Assistance (CBRA) Reporting Requirements	
Monthly Reports	• CBRA Monthly Report
Quarterly Reports	• None
Semiannual Reports	• None
Annual/Other Reports	• Upon request, submit accurate and complete information for the Annual County Expenditure Report to the Consolidated Homeless Grant Lead Provider in the communities in which they serve. • Upon request, respond to requests for information by King County and the Washington State Department of Commerce.
Performance Measurement (PM) Plan	• None

9.6 King County Adult Drug Diversion Court (KCDDC)

CJTA is a state-based fund source that may be used, in a limited capacity, to provide substance use disorder (SUD) assessments, residential/inpatient treatment, outpatient and intensive outpatient treatment, engagement, referral, transition planning, and medications for opioid use disorder. This is determined on a case-by-case basis and requirements are defined in Revised Code of Washington (RCW) 71.24.580. This funding stream is dedicated to King County Adult Drug Diversion Court (KCDDC) to offset the costs of supplemental services mandated for providers participating in KCDDC's SUD treatment program.

KCDDC providers incorporate evidence-based practices and All Rise Adult Drug Court Best Practice Standards in collaboration with KCDDC. In addition, KCDDC providers receive orientation to the drug court program and attend ongoing training for continued education in drug court best practices.

Treatment modalities and approaches, including ancillary services, are provided according to prognostic risk level, and criminogenic needs of the participants, as described by Douglas Marlowe, JD, PhD, Chief of Science, Law and Policy for All Rise.

An intake and assessment occurs within three business days of referral by the KCDDC case manager, unless otherwise agreed. The diagnostic results of the SUD assessment and the mental health assessment including the American Society of Addiction Medicine (ASAM) level of care (LOC), and any resulting treatment recommendations will be provided to KCDDC within one week following the assessment. Assessment of LOC should include collateral information received from KCDDC. Treatment will begin within one week of referral by KCDDC case manager, unless otherwise agreed.

Individualized service plans (ISP) are developed per current WAC and ASAM standards and includes participant's Stage of Change, goals, collateral information provided by KCDDC, prognostic risk level, and criminogenic need level as determined by the Risk Assessment and Needs Tool (RANT) administered by KCDDC and/or the Provider.

Input is continually provided to KCDDC case managers and the court via written reports and participation in weekly staff meetings as needed to inform ongoing assessment of the participant's treatment progress, therapeutic responses, and RANT quadrant including any recommended changes.

Appropriate services are provided based on the participant's RANT level.

In addition to the standard provision of outpatient treatment groups, evidence-based and cognitive-behavioral interventions are provided. Cognitive behavioral interventions are manual-based, and providers are trained to deliver the interventions reliably and according to the manual. Fidelity to the treatment model is maintained through continuous refresher training and internal evaluation for consistency. Required cognitive behavioral and evidenced-based intervention services may include:

- Motivational Interviewing
- Stages of Change
- Moral Recognition Therapy (MRT)
- Seeking Safety groups
- Relapse Prevention groups.
- KCDDC providers that conduct drug and alcohol testing ensure that:
- Testing is provided six days per week or as agreed upon by the provider and KCDDC.
- Testing for additional substances and/or more frequent testing is conducted per direction by KCDDC. Testing is random, reliable, observed, and frequency of testing is consistent with KCDDC requirements. When unable to be observed the provider notifies KCDDC for next steps.
- A contract is signed by each participant at intake and maintained in the participant file that clearly identifies the participant's responsibility in providing urinalysis samples to the treatment agency for purposes of drug and alcohol testing.
- Scheduled tests cannot be excused or made up.
- All participants list prescribed medications on a toxicology screening form and provide a prescription drug use form signed by their doctor if applicable. The provider reviews drug-testing reports for consistency and accuracy with prescriptions.

KCDDC providers incorporate additional supports and/or services as directed by KCDDC such as a contingency management program.
Assessments, progress reports, drug and alcohol test results and absences, incident reports and journal notes are submitted in the KCDDC Management Information System (KCDDC MIS), faxed, or emailed within 3 business days prior to the scheduled hearing or as directed by KCDDC and include:

- Progress during the reporting period in the Stages of Change.
- Drug and alcohol test results including missed tests, fake, adulterated, dilute, out-of-range, leaked in transit or insufficient specimen for testing.
- Attendance and absences at individual and group counseling sessions (including dates and reasons for all absences).
- Verification of attendance at the required number of sober support meetings per week (or court-approved alternatives).
- Updated information regarding all aspects of the ISP and other treatment-related observations and/or concerns including behavior, mental health, medication compliance, physical health, and other issues.

- Whenever possible, participants should be made aware of the information contained in the progress report to avoid surprises.

KCDDC staff are notified within 24 hours of a missed drug test, positive drug test, missed dose, failure to report to treatment without calling or display of other concerning behavior or issues.

If a KCDDC participant misses a hearing or fails to serve a sanction, KCDDC may issue a bench warrant. DDCS provides notification of the bench warrant to the Agency, via weekly Hearing Reports and monthly client lists containing bench warrant status. The Agency should notify DDCS if a participant on bench warrant engages with treatment and coordinate with KCDDC on re-engagement. The Agency should direct the participant to contact their drug court case manager, contact their attorney, and/or attend a KCDDC calendar to request that the bench warrant be quashed. KCDDC participants are identified within the KCBH Information System (IS) with an "ADC" program code.

When a participant exits KCDDC the provider will be notified via a Hearings Reports and/or monthly client lists provided by KCDDC, and the provider removes the "ADC" program code within the KCBH IS.

King County Adult Drug Division Court Eligibility Criteria	
Medicaid Status	No
Age Range	Adults aged 18 years and older
Authorization Needed	No
Additional Criteria	Individuals eligible for this service are referred by KCDDC. KCDDC participants between the ages of 18 and 25 who score as High Risk and High Needs per the RANT tool are referred to the Young Adult Track (YAT), which is designed to support progress and stability for this population. The YAT includes SUD treatment, access to MH services, medication management and life skills tailored to the special needs of young adults. The provider accurately identifies the needs of the participant, sets both short and long-term goals, and employs a holistic approach encompassing emotional, spiritual, physical, social, social, and MH issues. Non-Medicaid KCDDC participants who are not enrolled in the King County behavioral health system and who currently reside outside of King County, must have pre-approval from KCDDC. Hardship Insured - third party (Medicare, private insurance) cost sharing obligations (spenddowns, deductibles, copays, and coinsurance) are paid via invoice on an actual basis. Documentation of balance due must be provided along with the invoice.

King County Adult Drug Division Court **Reporting Requirements**	
BHRD Information System	• None
Monthly Reports	• None
Quarterly Reports	• CORE Reporting Spreadsheet ▪ MIDD RR-05, MIDD TX-ADC
Semiannual Reports	• None
Annual Reports	• None
Performance Measurement (PM) Plan	• Reporting requirements and performance measures are further detailed in an accompanying Performance Measurement plan. See

	"Performance Measurement (PM) Plans" section on the Provider Manual and specific program PM Plan for more information

9.6.1 Criminal Justice Treatment Account (CJTA) for Adults Involved with the Criminal Legal System

Medication for Opioid Use Disorder (MOUD) provides pharmacy services when requested directly from the Department of Judicial Administration's King County Drug Diversion Court (KCDDC). KCDDC participants, treatment and housing providers are provided with Naloxone nasal spray and use instructions at intake and throughout the program with a goal of reducing overdose death.
CJTA may also be used for the following:

- To purchase Naloxone and MOUD through a contracted pharmacy.
- Reimbursement for KCDDC urinalysis (UAs).

Invoice Program Specific Requirements

Method of Payment

- Reimbursement will be made for each naloxone nasal spray kit ordered by King County Adult Drug Court.

Additional Requirements

None

Criminal Justice Treatment Account (CJTA) for Adults Involved with the Criminal Legal System **Reporting Requirements**	
Performance Measurement (PM) Plan	• None

9.6.2 Jail-based Medication for Opioid Use Disorder (MOUD) for Persons Transitioning to Inpatient/Residential Services

A coordinated MOUD prescription program operated between Public Health-Jail Health Services, KCDDC, and Harborview Medical Center Long-Term Care Pharmacy for persons who are transitioning from in custody. This program allows for stable access to necessary MOUD prescriptions for persons in custody with an opioid use disorder to support successful treatment. All persons in custody with a substance use disorder are eligible.

Jail-based Medication for Opioid Use Disorder (MOUD) for Persons Transiting to Inpatient/Residential Services **Reporting Requirements**	
Performance Measurement (PM) Plan	• Reporting requirements and performance measures are further detailed in an accompanying Performance Measurement plan. See "Performance Measurement (PM) Plans" section on the Provider Manual and specific program PM Plan for more information

9.7 Crisis Respite Program (CRP)

This program provides temporary shelter and/or residential care for individuals in crisis in need of case management support and connects clients to mental health or substance use disorder treatment and other services as needed. The Provider maintains a Crisis Respite Program with a minimum capacity of 20 crisis respite beds in which length of stay is based on clinical necessity and provides transitional case management services for adults from eligible referral sources. Capacity is managed to ensure appropriate acceptance of referrals between the hours of 7:30 am and 11:30 pm. The Provider

maintains sufficient and qualified staff to ensure care for clients accepted into the crisis respite beds including case managers, residential counselors, a part-time Advanced Registered Nurse Practitioner, and a supervisor who is a Mental Health Professional (MHP). Staffing changes are approved by Behavioral Health and Recovery Division (BHRD). CRP services include shelter or residential services, access to and services of a psychiatrist for consultation, medication evaluation services by an ARNP, case management services, assistance with linkages to more permanent housing and treatment services, and referrals for substance use disorder (SUD) assessment as needed.

Invoice Program Specific Requirements

Method of Payment

- Reimbursement will be made monthly for capacity rates 93% and above for crisis respite services and capacity for eligible individuals in crisis that are referred to the program. For less than a 93% capacity, the monthly amount will be at the daily bed rate.

Additional Requirements

- None

CRP Eligibility Criteria	
Medicaid Status	N/A
Age Range	18 years and older
Authorization Needed	Yes
Additional Criteria	Referred by an approved referral source (with priority for homeless individuals when the CRP is operating at capacity) including: • King County Crisis and Commitment Services; • Involuntary commitment single bed certification patients King County; • Harborview Medical Center (HMC) Psychiatric Emergency Service (PES) or any hospital emergency room within King County (eligibility applies only to referrals of individuals leaving the HMC PES or hospital emergency rooms who are not eligible for the Crisis Solutions Center [CSC]); • Any psychiatric inpatient unit or evaluation and treatment facility in King County; • Adult Inpatient and Residential Liaisons and/or Western State Hospital Staff Social Workers; • The Seattle Municipal Mental Health Court and the King County Regional Mental Health Court; • Any King County Withdrawal Management Service; • The Mobile Crisis Team if not referred to the CSC; • HMC Psychiatric Consultation Services: and • Internal referrals including CDIS, CDF, PACT, mental health outpatient high level of care, HOST, or other extremely vulnerable individuals when there is low census.
CRP Reporting Requirements	
Monthly Reports	• CRP Census Log • CRP Referral Sources • CRP Referral Outcomes
Quarterly Reports	• None
Semiannual Reports	• None

Annual Reports	• CRP Annual Staffing Plan with the January BIP in an electronic format approved by the County.
Performance Measurement (PM) Plan	• None

9.8 DRS Care Coordination

Diversion and Reentry Care Coordination provides Substance Use Disorder assessments for individuals who are currently involved in a Mental Health Court, Drug Court or working with release planners in the jail. The focus is to ensure that adult individuals with behavioral health conditions who have contact with the criminal legal system have access to resources and treatment services that reduce court involvement and future contact with the criminal legal system.

Diversion and Reentry Care Coordination Eligibility Criteria	
Medicaid Status	N/A
Age Range	Adults Aged 18 Years and Older
Authorization Needed	No
Additional Criteria	For the SUD assessment services, individuals opting into or opted into any of the adult specialty courts in King County.
Diversion and Reentry Care Coordination Reporting Requirements	
Monthly Reports	Diversion & Reentry Outreach Log, for SUD services (as provided by the County).
Quarterly Reports	None
Semiannual Reports	None
Annual/Other Reports	None
Performance Measurement (PM) Plan	None

9.9 Housing Resource Navigation

The Housing Resource Navigation program provides housing resource navigation and case management at the time of diversion from criminal prosecution to behavioral health treatment and at the time of discharge from crisis stabilization services. The Housing Resource Navigation program occurs within a high support shelter environment.

Housing Resource Navigation Providers partner with high support shelters to ensure that shelter is available at the time of diversion from criminal prosecution to behavioral health treatment and at the time of discharge from crisis stabilization services and continues to be available for a temporary period of time. The high-support shelter environment includes support staff that are on-site 24 hours a day and 7 days a week (24/7).

Housing resource navigation services are available at the time of initial enrollment in the program and on an on-going basis to support continued planning and progress towards long-term housing solutions. Services are mobile, knowledgeable of community housing resources, and may include assessment of housing needs and goals, community resource navigation, financial resource acquisition support, support obtaining documentation needed to acquire housing, and advocacy with housing operators,

landlords, and other gatekeepers. Housing resource navigation takes into consideration an individual's immediate and long-term needs and ability to achieve and maintain housing stability.
The DESC Housing Resource Navigation program offers a capacity of 10. The Purpose Dignity Action Housing Resource Navigation program offers a program capacity of 15. Each program develops a referral process, including referral prioritization criteria, and accepts community referrals from a variety of sources that support diversion or deferment from criminal prosecution to behavioral health treatment or discharge from crisis stabilization services.

- Examples of community referral sources that support diversion or deferment from criminal prosecution to behavioral health treatment include, but are not limited to, Law Enforcement Assisted Diversion (LEAD), Community Outreach and Advocacy Team (COAT), Legal Intervention and Network of Care (LINC) prosecutorial diversion, REACH Reentry Program, King County Veterans Reentry Program, Community Center for Alternative Programs (CCAP), and Pretrial Assessment and Linkage Services (PALS).
- Examples of community referral sources that support discharge from crisis stabilization services include, but are not limited to, the Mobile Rapid Response Crisis Team, the Crisis Diversion Facility, hospital settings, and Crisis Care Centers.

Invoice Program Specific Requirements

Method of Payment

- Reimbursement will be made monthly on an actual cost basis for Housing Resource Navigation operations costs.

Additional Requirements

None.

Housing Resource Navigation Eligibility Criteria	
Medicaid Status	N/A
Age Range	Adults 18 years of age or older
Authorization Needed	No
Additional Criteria	Homeless and connected to a program that supports diversion or deferment from criminal prosecution to behavioral health treatment or discharging from crisis stabilization into homelessness.
Housing Resource Navigation Reporting Requirements	
Monthly Reports	• Housing Resource Navigation Monthly Log • Housing Resource Navigation monthly spending report, in the agency format approved by BHRD.
Quarterly Reports	• Housing Resource Navigation Quarterly Report ○ The report for January through March is due by April 15 ○ The report for April through June is due by July 15 ○ The report for July through September is due by October 15 ○ The report for October through December is due by January 15
Semiannual Reports	• None
Annual/Other Report	• None
Performance Measurement (PM) Plan	• None

9.10 Homeless Outreach, Stabilization, and Transition - Mental Health (HOST-MH)

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. 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.

For enrollment to HOST-MH, 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 HOST-MH until this investigation is complete; and
- If the individual is determined to be a King County resident, request an authorization with a start date that reflects services already provided by HOST-MH.
- HOST-MH staff ensure the following outreach and engagement services are provided:
- Identification and assessment of clients who are homeless or at imminent risk of being 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-MH 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.

Invoice Program Specific Requirements

Method of Payment

- Payments will be made monthly in 1/12th amounts for outreach, stabilization and transition services provided to eligible individuals.

Additional Requirements

- None.

HOST-MH Eligibility Criteria	
Medicaid Status	N/A
Age Range	Adults Aged 18 Years and Older
Authorization Needed	No
Additional Criteria	An individual meeting all of the following criteria is eligible to participate in the HOST-MH 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-MH Reporting Requirements	
Monthly Reports	• KCMHP Transition Report in an electronic format provided by the County
Quarterly Reports	• HOST Report
Semiannual Reports	• None
Annual/Other Reports	• None
Performance Measurement (PM) Plan	• None

9.11 Homeless Outreach, Stabilization, and Transition – Substance Use Disorder (HOST-SUD)

The HOST SUD program is an outreach-based program that serves individuals who are living with serious SUDs or co-occurring SUDs and behavioral health conditions, are experiencing homelessness, and whose severity of behavioral health symptom acuity level creates a barrier to accessing and receiving conventional behavioral health services and outreach models. Services may include outreach, identification, engagement, re-engagement, stabilization, and transition services. The HOST-SUD Program provides the services and staff; and otherwise do all the things necessary for the implementation of the HOST program.

Definitions

- **"Co-Occurring"** or **"Co-Occurring Serious Mental Illness and Substance use Disorder"** means an Individual's Serious Mental Illness (SMI) and Substance Use Disorder (SUD) can be diagnosed independently of one another.
- **"Contact"** means an interaction between a HOST-funded worker or workers and an Individual who is potentially HOST eligible or enrolled in HOST.
- **"HOST-SUD"** means the program that serves Individuals who are living with serious SUDs or co-**occurring** SUDs and behavioral health conditions, are experiencing homelessness, and whose severity of behavioral health symptom acuity level creates a barrier to accessing and receiving conventional behavioral health services and outreach models.
- **"Homeless"** means homeless or at imminent risk of becoming homeless, lacking fixed, regular, and adequate night-time residence, or having a primary night-time residence that is:
  - A supervised publicly or privately operated shelter designed to provide temporary living accommodations.
  - An institution that provides a temporary residence for individuals; and
  - A public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings.
- **"PDAMS"** means Program Data, Acquisition, Management and Storage. This is a database operated by HCA to collect service data.
- **"Services," in a data entry context** means outreach and engagement activities in locations such as a social service program, such as a drop-in center or shelter where the individual is living the night before contact.
- "**Technical Assistance Provider**" means the organization contracted with the Health Care Authority (HCA) who will be providing technical assistance to agencies and staff around implementing and supporting the HOST program.

Program Specific Requirements

The HOST-SUD Program performs the following services and activities:
Hires and maintains a multidisciplinary team that aligns with the Provider's approved HOST-SUD Project Plan, as demonstrated by a list of current staff and their individual credentials, position titles, and assigned full-time equivalents (FTEs). For each position that remains vacant for more than ninety (90) calendar days, the payment amount may be reduced by up to ten thousand dollars per position until such time as the position is filled.

- Outreaches and engages the most vulnerable individuals into services with the ultimate goals of addressing their behavioral and physical health needs, increasing stability, obtaining housing, and transitioning them into long-term services for their SUDs or co- occurring SUDs and behavioral health conditions.
- Utilizes the HOST principles provided by the HCA, that will best serve intended and eligible populations.

  - Ensures all services and activities provided are designed and delivered in a manner sensitive to the needs of all disadvantaged populations.
  - Initiates actions to ensure or improve access, retention, and cultural relevance of treatment, prevention, or other appropriate services, for disadvantaged populations in need of treatment and prevention services as identified in their needs assessment.
  - Takes the initiative to strengthen working relationships with other agencies serving these populations.
- Participates in training and technical assistance activities as prescribed by HCA and King County.
- Completes an assessment of each HOST-SUD individuals' basic needs, including behavioral health and SUD conditions, medical, housing, benefits, legal, safety and cultural needs, as appropriate.
- Engages eligible individuals, provides intensive case management and stabilization services with a range of treatment options, develops, and maintains linkages to critical resources, and transitions stabilized individuals to long-term behavioral health or other appropriate ongoing services.
- Maintains individual service records for enrolled individuals. Each service record contains at a minimum: Completed assessment, determination of eligibility, service plan that includes individualized goals utilizing person-centered approach, progress notes, and discharge plan. These service records will only be accessed by employees of the HOST-SUD Provider. The HOST-SUD Program provides aggregate data of service records upon request to King County and HCA.

Performance Table

Goal	Task	Due Date	Performance Measure
1	The HOST-SUD Program attend monthly HOST provider meetings, participate in site- monitoring activities at a minimum of once annually, and participate in technical assistance as needed	Due monthly by the 10th of the following month.	Receipt of copy of contract specifying this requirement and list of meetings attended by provider. List of meetings attended will be provided as part of the HOST-SUD Monthly Narrative Report.
2	The HOST-SUD Program must participate in scheduled reviews of the HOST program at a minimum of once per month, or as needed.	Due monthly by the 10th of the following month.	Receipt of list of meetings attended by provider demonstrating a minimum of one meeting per month. This information will be provided as part of the HOST-SUD Monthly Narrative Report.
3	Maintain a multidisciplinary team that aligns with the HOST-SUD Program approved Project Plan. For each position that remains vacant for more than 90 calendar days, the payment amount may be reduced by ten thousand until such time as the position is filled.	Due monthly by the 10th of the following month.	List of current staff and their individual credentials, position titles, and assigned full-time equivalents (FTEs). This information will be provided as part of the HOST-SUD Monthly Narrative Report.
4	Complete monthly HOST-SUD Narrative Reports: To include but not limited to, narrative pertaining to project progress, staffing levels, and meetings attended. Submit completed reports to King County Behavioral Health and Recovery Division's HOST-SUD Program/ Project Manager.	Due monthly by the 10th of the following month.	Receipt of a monthly outcome reporting template.

5	Submit monthly HOST data to HCA's Program Data, Acquisition, Management and Storage (PDAMS) via web portal. Data will include but are not limited to number of outreach contacts, number of enrollments, and a breakdown of the type of behavioral health services received	Due monthly by the 10th of the following month.	Receipt of monthly HOST-SUD service data in PDAMS, de monstrating a variety of service types provided to a minimum of 30 unique individuals per month.

Additional Requirements

- Reports may include, but are not limited to, monthly status reports pertaining to HCA in the approved Project Plan and outreach and engagement services provided by the HOST-SUD Program. Reports to be submitted to King County BHRD by the 10th of the following month and service data uploaded to PDAMS web portal, no later than the 20th of the following month.
- Capital Purchases made for this program are to be utilized for this program explicitly. Assets for this program will be used at the level of 90 percent specifically. De minimis use will be allowed. If the program funding is discontinued, the state of Washington can decide to re-purpose assets for the benefit of this or other programs.
- The HOST-SUD program maintains limited Flexible Funds to be used on resources needed 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.

Program Specific Requirements

For enrollment to HOST-SUD, staff first complete the following steps:

- Briefly investigate whether each potential enrollee has received behavioral health services, including looking the individual up in the relevant county or state database (e.g., ProviderOne)
- Identify that the presenting issues with the individual are SUD and or co-occurring.
- Wait to enroll the individual in HOST-SUD until this investigation is complete.
- If the individual is determined to be a King County resident, request an authorization with a start date that reflects services already provided by HOST-SUD

HOST-SUD staff ensure the following outreach and engagement services are provided:

- Identification and assessment of clients who are homeless or at imminent risk of being homeless to determine eligibility.
- Assessment and development of comprehensive short-term service plans for identified individuals.
- SUD screening and assessment
- Referral and linkage to necessary SUD higher level of care programs, mental health, 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 SUD and mental health services and facilitation of the authorization process
- Crisis intervention during hours of program operation

As needed, intensive case management and stabilization services are provided. Participants 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

- SUD screening and assessment by an SUDP
- 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.
- 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.

Information System Requirements

- HOST-SUD data uploaded via HCA's Program Data, Acquisition, Management and Storage (PDAMS) via web porta monthly.

Invoice Program Specific Requirements

Method of Payment

- Reimbursement will be made monthly in 1/12th payments per deliverable goal for DESC HOST-SUD services for the year.
- A multidisciplinary team that aligns with the approved HOST-SUD project plan must be maintained. For each position that remains vacant for more than ninety (90) calendar days, the payment amount may be reduced by up to $10,000.00 a month per position until such time as the position is filled.
- Receipt of monthly HOST-SUD service data in Program Data, Acquisition, Management and Storage (PDAMS) via web portal, demonstrating a variety of service types provided to a minimum of 30 unique individuals per month, the payment may be reduced by $12,375 per month if service data is not received.

Additional Requirements

- The approved multidisciplinary team must be maintained. For each position that remains vacant for more than ninety (90) calendar days, the payment amount may be reduced by up to $10,000.00 a month per position per until such time as the position is filled, with a maximum reduction of $50,000.00 per month.
- The HOST-SUD service data must be uploaded to HCA's PDAMS no later than 20th of the month or the payment may be reduced up to $12,375 per month.

HOST SUD Eligibility Criteria	
Medicaid Status	N/A
Age Range	Adults Aged 18 Years and Older
Authorization Needed	No

Additional Criteria	An individual meeting all of the following criteria is eligible to participate in the HOST-SUD Project: • The individual must be homeless or at imminent risk of homelessness; • The individual appears to have a serious and persistent SUD and/or Co-occurring mental illness; and • The individual is unable or unwilling to access services through the traditional SUD treatment Providers due to clinical reasons. • An individual who is homeless and currently authorized to a MH outpatient benefit but has not received services for 90 or more days.
HOST SUD Reporting Requirements	
Monthly Reports	• KCMHP Transition Report in an electronic format provided by the County. • HOST-SUD Monthly Status Reports (HOST-SUD)
Quarterly Reports	• Other reports as needed
Semiannual Reports	• None
Annual/Other Reports	• None
Performance Measurement (PM) Plan	• None

9.12 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.

Invoice Program Specific Requirements

Method of Payment

- Reimbursement will be made monthly based on a daily rate for any day when at least one client is served by ITA Transportation (Medical Standby Services).

Additional Requirements

- The Provider will not invoice the County for services paid for by another funder.
- The Provider will not invoice the County for any day that service is not provided to any clients.

ITA Transportation Eligibility Criteria	
Medicaid Status	N/A
Age Range	Ages 13 and Up
Authorization Needed	Yes
Additional Criteria	Individuals coming from community hospitals that utilize the King County Involuntary Commitment Court and Evaluation and Treatment (E&T) facilities
ITA Transportation Reporting Requirements	
Monthly Reports	• ITA Court Times Report
Quarterly Reports	• None
Semiannual Reports	• None
Annual/Other Reports	• None
Performance Measurement (PM) Plan	• None

9.13 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 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.

Invoice Program Specific Requirements

Method of Payment

- Reimbursement will be paid in monthly 1/12th monthly amounts for fund coordination expenses.
- Payments for trainings costs for eligible participants will be paid on an actual cost reimbursement basis upon submission of supporting documentation.

Additional Requirements

None

KC Consumer Training Eligibility Criteria	
Medicaid Status	N/A
Age Range	N/A
Authorization Needed	No
Additional Criteria	• King County resident who is enrolled in BHRD programs, a family member of a person enrolled in BHRD programs, or an advocate for consumers of publicly funded mental health services. • Not Eligible: A Professional in the field of behavioral health or an employee of a community mental health agency
KC Consumer Training Reporting Requirements	
Monthly Reports	• King County Consumer Training Fund Expenditures Report in a format provided by BHRD in hard copy with the invoice.
Quarterly Reports	• None
Semiannual Reports	• King County Consumer Training Fund Status Report in a format provided by the County in hard copy with the June and December BIP.
Annual/Other Reports	• King County Consumer Training Fund Conference and Seminar Approval List Annual Report in a format provided by the County in hard copy with the December BIP. • The Provider complies with the specific requirements for financial audits or alternative as required in the Standard Contract.
Performance Measurement (PM) Plan	• None

9.14 King County Sexual Assault Resource Center (KCSARC) Specialty Services

Program Overview

The KCSARC Specialized Services program allows individuals who are enrolled with another outpatient Provider in the KCICN network (non KCSARC) for mental services, to receive specialty sexual assault services from KCSARC, a certified Community Sexual Assault Program (CSAP), simultaneously while retaining their regular outpatient service benefit. Services provided include intensive, trauma-focused, evidence-based therapy to address sexual assault or childhood sexual abuse.

KCSARC Specialty Services Eligibility Criteria	
Medicaid Status	Yes
Age Range	Children, youth and adults.

Target Population	Individuals must be enrolled with a KCICN MH outpatient benefit Provider agency (non-KCSARC) to be eligible for these add-on services.
Authorization Needed	No
Authorization Criteria	Must meet same medical necessity requirement as a MHOPB.
Other Criteria	No

Goals & Objectives
The goal of this program (code) is to allow clients who are receiving basic mental health outpatient services with a KCICN Provider to access sexual assault/abuse specialty services at KCSARC without the need to terminate the outpatient benefit with the original Provider.

Program Requirements
Services are provided in accordance with WAC 246-341 or its successor for mental health outpatient care and any additional requirements as outlined in the BHRD Provider Manual.

Information System Requirements
Agency must submit authorization data and service encounters for this program using appropriate Current Procedural Terminology (CPT) codes as established in the KCSARC specialty program's fee schedule.

KCSARC Specialty Services Reporting Requirements	
Monthly Reports	None
Quarterly Reports	None
Semiannual Reports	None
Annual/Other Reports	None
Performance Measurement (PM) Plan	None

9.15 Legal Intervention and Network of Care (LINC)

The Legal Intervention and Network of Care (LINC) program provides transitional low barrier behavioral health services, intensive community support, and linkages to resources in order to divert adults with behavioral health conditions from prosecution for misdemeanors and low-level felonies which are likely to result in orders for forensic mental health services such as competency evaluation or restoration. As prosecutorial diversion, cases are dismissed or a prosecutor may decline to file a case at the time of LINC enrollment, following development of an adequate Care Plan with the individual. By providing a behavioral health intervention in lieu of prosecution of a case, LINC reduces court orders for competency services in local criminal courts, prevents people from becoming Trueblood class members, and reduces recidivism in the forensic mental health system.

LINC services typically last 6-12 months and include community-based care coordination and case management, legal coordination, robust individual support, peer support services, and on-demand mental health and co-occurring substance use 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:

- Screening referrals which have been approved by a prosecutor for individuals both in-custody in local jails and out-of-custody in community settings.

- Developing an initial Care Plan with eligible individuals who consent to participate, which is shared with the respective prosecutor, and coordinating charge diversion/dismissal and jail release with criminal legal system partners.
- Transitional, community-based care management for a period of usually 6-12 months.
- Assertive, low barrier engagement and outreach, soliciting motivation to participate in services.
- Assistance accessing basic needs resources, including navigation to shelter and housing resources.
- Peer support services.
- Rapid access to medication management and access to day treatment support.
- Access to respite beds in a staffed behavioral health facility.
- Connection to and coordination with ongoing outpatient behavioral health services.
- Criminal legal coordination by dedicated prosecutor liaisons within Seattle City Attorney's Office and King County Prosecuting Attorney's Office.

Provider Will:

- Provide services in a person-first, recovery-oriented, culturally sensitive, and trauma-informed care paradigm. Providers develop staff awareness of historical trauma and systemic racism which have contributed to racial disproportionality in the population receiving orders for competency services.
- Develop and implement staff training plans to address best practices, safety and compliance, and clinical competencies.
- Utilize safe practices to provide services to individuals who may have histories of violence and trauma.
- Program should aim to enroll at least 70 clients in a twelve-month period.
- Maintain individual service records including:
  - An initial assessment of an individual's needs as relevant to the program service profile.
  - An initial Care Plan and a subsequent individualized service plan which reflects the person's desires and goals and identifies specific strategies and objectives to address needs and goals, with regular revisions to the service plan as goals are met and needs change.
  - Documentation of services provided and progress toward service plan goals.

Invoice Program Specific Requirements

Method of Payment

- Reimbursement will be made in 1/12th monthly amounts for LINC care management services.
- Reimbursement will be made monthly for respite beds calculated on bed day capacity if actual occupancy rate is 80% or greater. When minimum occupancy is not met, reimbursement will be calculated as actual bed days x daily rate.
- Reimbursement will be made monthly for Day Treatment based on actual utilization.
- Reimbursement will be made in monthly 1/12th amounts for the Competency Boundary Spanner (CBS) position and flex funds.
- If this position becomes vacant, full reimbursement may be paid for up to two months for costs related to hiring to refill the position. If the position remains vacant for more than 60 days, payment will be suspended until the position is filled and then pro-rated for that month.

Additional Requirements

- Provider shall submit expenditure reports (preferably a general ledger) on a quarterly basis for reconciliation on 1/12th monthly payments. If the actual costs incurred are less than the payment, the difference will be recovered by King County by reducing or skipping future payments / OR, within the contract period, a provider can submit a plan indicating how it will catch up on underspend and get written approval by the project manager and fiscal.

Legal Intervention and Network of Care Eligibility Criteria	
Medicaid Status	N/A
Age Range	Adults Aged 18 Years and Older

Authorization Needed	Yes
Additional Criteria	• Are a defendant in a current open (pre-disposition) misdemeanor or low-level felony case or a suspect in a pre-filing investigation in any jurisdiction within the King County geographic area. • Identified as eligible for a diversion program by a prosecutor in the jurisdiction within King County in which they have a current open case. • Have a current major mental health disorder diagnosis under the Diagnostic and Statistical Manual of Mental Disorders, Version 5 (DSMV) or ICD-10 or 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 previous court order for competency evaluation or competency restoration services or are likely to receive an order for competency services on the current legal charge(s).
Legal Intervention and Network of Care Reporting Requirements	
Monthly Reports	• Legal Intervention and Network of Care (LINC) Client Narrative • LINC Client Record • LINC Enrollee and Referral Tracking • LINC Monthly Report Log
Quarterly Reports	• Expenditure reports for 1/12th payments
Semiannual Reports	• None
Annual/Other Reports	• Provide information as requested by the county for HCA Trueblood Diversion narrative report or DSHS Office of Forensic Mental Health Services annual report. • Provide information as requested by the county for the MIDD annual report for the Competency Boundary Spanner.
Performance Measurement (PM) Plan	• Reporting requirements and performance measures are further detailed in an accompanying Performance Measurement plan. See "Performance Measurement (PM) Plans" section on the Provider Manual and specific program PM Plan for more information

9.16 Mental Health Sentencing Alternative

Program Overview

The Mental Health Sentencing Alternative (MHSA) is a sentencing option that allows defendants, who are diagnosed with a serious mental illness and convicted of a felony to receive mental health and medication management treatment instead of incarceration. The program aims to provide these defendants with appropriate mental health treatment while they are being supervised in the community by the Department of Corrections. This alternative is available for individuals convicted of a felony that is not a serious violent or sex offense.

Mental Health Sentencing Alternative Eligibility Criteria	
Medicaid Status	
Age Range	Adults Aged 18 Years and Older
Target Population	• Residents of King County - or individuals experiencing homelessness in King County prior to and/or after incarceration - who are eligible for an MHSA (as defined in other criteria below).

Authorization Needed	No
Authorization Criteria	None
Other Criteria	A defendant is eligible for the MHSA if: • The defendant is convicted of a felony that is not a serious violent offense or sex offense; • The defendant is diagnosed with a serious mental illness recognized by the diagnostic manual in use by mental health professionals at the time of sentencing; and • The defendant and the community would benefit from supervision and treatment, as determined by the judge; and • The defendant is willing to participate in the sentencing alternative; and • The defendant is referred for participation in an MHSA by the Department of Public Defense.
Performance Measurement (PM) Plan	None

Goals & Objectives
The provider coordinates with Crisis Connections for MHSA referrals from the King County Department of Public Defense (DPD). The provider also coordinates with Public Health – Seattle & King County Jail Health Services (or other jail health entity) and the Department of Corrections to support release to and completion of the MHSA program.

Program Requirements
The provider will comply with requirements outlined in RCW 9.94A.695. In addition:
- The provider serves up to 5 clients referred for MHSA each month for a maximum total of 60 clients served over a 12-month period.
- Selected clients will be seen the day of or within 24 hours of release for a brief assessment.
- Clients will be referred to psychiatric services for on-going medication management and engage in outpatient services to support ongoing community tenure.
- The provider will deliver mental health services and provide ongoing monitoring of the client's adherence to their treatment plan, including requirements of the client's sentencing alternative.
- The provider will coordinate and communicate with the courts and Department of Corrections, as necessary.

Invoice Program Specific Requirements
Method of Payment
- Reimbursement will be made in monthly 1/12th amounts for capacity to serve Mental Health Sentencing Alternative referrals.

Additional Requirements
- The provider shall include with each monthly invoice a written certification, signed by an authorized representative, confirming that sufficient qualified staff and appropriate facilities were available to serve up to 5 MHSA-referred clients during the invoiced month.

Mental Health Sentencing Alternative Reporting Requirements	
BHRD Information System	• None

Monthly Reports	• Certification of Staffing and Facility Capacity for MHSA Referrals
Quarterly Reports	• MHSA Narrative Report (i.e. summary of clients served, and successes and challenges encountered within the last quarter)
Semiannual Reports	• None
Annual/Other Reports	• None
Performance Measurement (PM) Plan	• None

9.17 PATH

Program Overview

Projects for Assistance in Transition from Homelessness (PATH) provides outreach, engagement, and transitional support services to individuals with serious mental illness or individuals with co-occurring serious mental illness and substance use disorder (SUD) who are homeless or at risk of becoming homeless. The program utilizes outreach case managers to provide outreach, engagement, and/or case management services for individuals experiencing homelessness in King County.

For additional PATH Program requirements, please see Attachment 1, "PATH Statement of Work," below.

Invoice Program Specific Requirements

Method of Payment

- Reimbursement will be made quarterly for actual allowable direct costs as identified in the PATH Report.

Additional Requirements

- None

PATH Eligibility Criteria	
Medicaid Status	N/A
Age Range	Adults Aged 18 Years and Older
Authorization Needed	No
Additional Criteria	Individuals eligible for Project for Assistance in Transition from Homelessness (PATH) services are those who: • Are homeless or at imminent risk of homelessness; • Have a diagnosable and persistent mental or emotional impairment that seriously limits the individual's major life activities and may also have a co-occurring SUD; • Are not receiving other BHRD funded ongoing services. Individuals are not PATH-eligible when: They are enrolled in other BHRD programs and are receiving all necessary services that will transition them from homelessness into psychiatric and medical services, community mental health or co-occurring SUD services, case management services, secure housing, employment services, and/or other services that will assist them in avoiding homelessness.
PATH Reporting Requirements	
Monthly Reports	• None
Quarterly Reports	• PATH HMIS Report
Semiannual Reports	• None
Annual/Other Reports	• PATH Annual Application • PATH Annual Data Exchange (PDX) Report • Any other requested reports by the County. • Client information needs to be entered in the King County data system.

Performance Measurement (PM) Plan	• None

Attachments in this Section:

- Attachment 1: PATH Statement of Work

ATTACHMENT 1: STATEMENT OF WORK

1. Purpose

The Contractor will provide Projects for Assistance in Transition from Homelessness (PATH) services to eligible Participants.

2. Background

PATH is a vital resource in communities as providers, their partners, and stakeholders seek to end homelessness. PATH programs across the country have been instrumental in the development and improvement of effective outreach and engagement methods to people who are experiencing Serious Mental Illnesses/Co-Occurring Disorders (SMI/COD) as well as homelessness or at imminent risk of experiencing homelessness. PATH programs offer initial connection to Continuum of Care (COC) services and referrals to longer term behavioral health support, primary health care, Substance Use Disorder (SUD) treatment services and an array of other survival supports. PATH programs fulfill this role in communities by utilizing the guidance provided by the Substance Abuse and Mental Health Services Administration (SAMHSA) to prioritize PATH program activities service provision to individuals experiencing chronic homelessness, veterans, and other underserved populations, connecting program participants to relevant providers in the COC and continuing to innovate and create improved processes and services.

3. Guiding Principles

3.1. Person-centered services

3.1.1. PATH programs are committed to services that meet the needs and preferences of people who are experiencing homelessness or at imminent risk of experiencing homelessness and who have SMI/COD.

3.1.2. PATH provides services in collaboration, participant-led service plans and subsequent referrals and resources which are effective when needs are identified by the PATH participant.

3.2. Cultural context in PATH services

3.2.1. PATH programs are committed to meeting the needs and preferences of individuals within the context of culture.

3.2.2. For this to happen in a meaningful way, services must be offered in accordance with awareness and sensitivity to the uniquely appropriate language, customs, and cultural norms of individuals.

3.3. Consumer/peer-run services

3.3.1. The history of the PATH program proves the effectiveness of services provided by people who have lived experience.

3.3.2. Individuals who have lived experience serve as powerful examples, and consumer/peer-run services are a strong tool in efforts to address homelessness.

3.4. Commitment to quality

3.4.1. State PATH Contacts (SPCs) are committed to helping providers achieve high quality in all areas of service provision.

3.4.2. Encouragement of evidence-based and exemplary practices within homelessness services and mainstream systems is part of this strategy.

4. Work Expectations

The Contractor will provide the services and staff, and otherwise do all things necessary for or incidental to the performance of work as set forth herein. The Contractor will implement services in accordance with the PATH program and HCA guidelines, including, but not limited to the following:

4.1. Provide Intended Use Plan (IUP) Services

Provide services and activities described in the IUP, in accordance with Attachment 8, Intended Use Plan (IUP), and within the amounts and categories listed in the HCA-approved budget narrative.

4.1.1. The IUP will be the basis of the Contractor's, and any HCA-approved subcontractor's PATH services and activities using PATH funds under this contract.

4.1.2. Use the least intrusive manner possible in locations where PATH-eligible Participants may be contacted and served.

4.1.3. Provide services to the number of people served that is referenced in the IUP.

4.1.4. Achieve or exceed national PATH Government Performance and Results Act (GPRA) performance measures in delivery and costs of services, as referenced in the IUP.

4.1.5. Maintain staffing levels detailed in the IUP.

4.1.6. Any proposed revisions to the IUP, or any HCA-approved successor IUP, must be submitted to the HCA Contract Manager listed on first page of this contract, when proposed revisions reflect substantial changes in PATH services and activities funded under this contract.

4.1.7. Revised IUPs are subject to approval by the HCA Contract Manager prior to implementation.

4.1.7.1. Proposed changes must be submitted to HCA for consideration and approval, at least sixty (60) days before implementation; and

4.1.7.2. Changes to the IUP approved by HCA in writing will be incorporated by reference into this contract and will supersede any previous versions of the IUP.

4.1.8. IUP requirements

4.1.8.1. Annual submission to HCA in the form of an IUP by an HCA-established date, which will be communicated to the Contractor to enable HCA to meet the federal timeline for responding to the annual federal FOA for PATH funds.

4.1.8.2. Each IUP must provide a projected summary of performance in the following outcome measures:

a. Number of individuals experiencing homelessness, over eighteen (18) years old, to be contacted;

b. Number of contacted PATH-eligible individuals who become enrolled in PATH program;

c. Number of PATH Participants who are experiencing homelessness during period of service provision;

d. Number of PATH Participants who will receive community mental health services;

e. Number of PATH Participants referred to and who will attain housing;

f. Number of PATH Participants referred to and who will attain SUD treatment services;

g. Number of PATH-funded staff trained in Supplemental Security Income (SSI) Social Security Disability Insurance (SSDI) Outreach, Access, and Recovery (SOAR); and

h. Detailed budget narrative.

4.1.9. Screen Participants for eligibility benefits

Ensure enrolled PATH Participants are screened for eligibility for all possible benefits, including, but not limited to the following:

4.1.9.1. Services under the Prepaid Inpatient Health Plan (PIHP) or comparable services structures, including but not limited to:

a. Emergency;

b. Psychiatric;

c. Medical;

d. Residential;

e. Employment; and

f. Community support services.

4.1.9.2. Housing services and resources;

4.1.9.3. Veteran services;

4.1.9.4. SSI/SSDI or other disability and financial benefits;

4.1.9.5. Bureau of Indian Affairs (BIA) benefits;

4.1.9.6. Economic services;

4.1.9.7. Medical services;

4.1.9.8. SUD treatment services; and

4.1.9.9. Vocational rehabilitation services.

4.1.10. Target priority populations

4.1.10.1. Give special consideration to services for veterans and strongly encourage subcontractors to work closely with entities that demonstrate effectiveness in serving veterans experiencing homelessness.

4.1.10.2. SAMHSA strongly encourages PATH sites to prioritize services for the individuals who are experiencing chronic homelessness.

4.1.11. The Contractor will not expend more than twenty percent (20%) of PATH funds under this contract, in accordance with current FOA. The Contractor must track the costs in this category with records demonstrating that the twenty percent (20%) cap has not been exceeded, to include, but not limited to, the following:

4.1.11.1. Minor renovation, expansion, and repair of housing;

4.1.11.2. Technical assistance in applying for housing assistance;

4.1.11.3. Improving the coordination of housing services;

4.1.11.4. Security deposits;

4.1.11.5. The costs associated with matching eligible homeless individuals with appropriate housing situations; and

4.1.11.6. One-time rental payments to prevent eviction.

4.1.12. The Contractor will indicate clearly when issuing statements, press releases, requests for proposal, bid solicitations, and other documents describing projects or programs funded in whole or in part with PATH funds as follows:

4.1.12.1. The percentage of the total costs of the program or project financed with PATH funds;

4.1.12.2. The dollar amount of PATH funds for the program or project; and

4.1.12.3. The percentage and dollar amount of the total costs of the program or project that will be financed by non-governmental sources.

4.1.13. Achieve Performance Goals: Achieve or exceed national PATH Government Performance and Results Act (GPRA) performance measures in delivery and costs of services in accordance with Attachment 6, Center for Mental Health Services (CMHS) Government Performance and Results Act (GPRA) Performance Measures.

4.1.14. Provide Alternative Referrals to Religious Services: If a religiously affiliated organization receives PATH funds, the Contractor will ensure that PATH services are separate in either time or location of services that are inherently religious in nature. If a PATH-enrolled individual chooses not to be served by that organization because of their religious affiliation, they must be referred to a different service provider.

4.1.15. In addition to Section 4, General Terms and conditions, the Contractor may subcontract services or activities under this Contract with organizations, as long as they do not have a policy of excluding individuals from mental health services due to the existence or suspicion of SUD and/or mental illness.

4.2. Develop and implement an integrated system of PATH services.

4.2.1. Solicit past and current PATH participant input and recommendations to identify service needs of PATH participants and pathways to improvement and increased relevancy for recipients.

4.2.2. Use information received from feedback and recommendations, PATH program management experience, and other information gained from reliable sources on ending homelessness to develop and implement an integrated system of PATH services, activities, and housing to accommodate local needs and circumstances of individuals experiencing homelessness.

4.3. Work with COC committees

4.3.1. Participate in the planning and collaboration of local COC committees affecting PATH participants.

4.3.2. Strongly encourage subcontractors to participate in the planning and collaboration of local COC committees.

4.4. Create, provide, and maintain documentation

4.4.1. Maintain individual Participant service records for PATH-enrolled individuals, where each Participant service record will contain at minimum:

4.4.1.1. Every contact between PATH-funded staff and any individual who is PATH-eligible or enrolled in PATH is entered into the Homeless Management Information System (HMIS), managed by the Department of Commerce.

4.4.1.2. Statement of goal or need as described by the PATH-enrolled individual.

4.4.1.3. Documentation of homelessness or chronic homelessness either by PATH-enrolled individual self-report or by PATH-funded staff observation.

4.4.1.4. History and/or symptoms or observable behaviors of the SMI experienced by the PATH-enrolled individual, reported and/or observed.

4.4.1.5. Assessment of PATH-enrolled individual's basic needs; including legal, health and safety concerns, cultural needs, SUD-related information or resources, as appropriate.

4.4.1.6. Service plan with regular updated of PATH-enrolled individual's progress toward goals stated on their service plan, including transfer to longer term supportive services:

4.4.1.7. Utilize HMIS data standards and submit PATH service data in accordance with State and Federal requirements.

4.4.1.8. Participate in HMIS data collection activities and submit Participant service data electronically.

4.4.1.9. SAMHSA requires data entry into HMIS in a timely manner to increase favorable health outcomes for participants.

4.4.1.10. Every HMIS administrator has its own policies and procedures regarding timeliness of data entry for end users.

4.5. Comply with

4.5.1. Requirements, conditions, and limitations of PATH funds.

4.5.2. Federal and state Requirements, including employment standards, in accordance with Attachment 5, Funding Opportunity Announcement (FOA) SM-20-F3.

4.5.3. Consistent with Public Law (PL) 101-645 Title V, Subtitle B, relating to PATH eligible Participants, to include, but not limited to, the following:

4.5.3.1. May use funds to supplement, not supplant, existing services to individuals with SMI/COD, and who are experiencing homelessness or at imminent risk of experiencing homelessness.

4.5.3.2. May not use funds, directly or indirectly, to purchase, prescribe, or provide marijuana or treatment using marijuana. Treatment in this context includes the treatment of:

a. SUD;

b. Opioid Use Disorder (OUD); and/or

c. Mental disorders.

4.5.4. Meet requirements for non-federal match contributions

4.5.4.1. Contribute no less than the required minimum of (33.33333%) of non-federal match funds based upon the total PATH award amount;

4.5.4.2. The PATH Award to the Contractor is for PATH services and activities, and for HMIS reporting capability used to participate in PATH data collection activities;

4.5.4.3. The contractual award of PATH funds under this Contract equals the "PATH Award to Contractor" listed in the HCA approved Contractor IUP budget narrative; and

4.5.4.4. Ensure that all non-federal match contributions are in accordance with federally-approved PATH services and activities referenced in FOA # SM-20-F3 and in accordance with the IUP.

5. Reports

5.1. The Contractor will complete reports according to the time schedules designated, and/or communicated by HCA Contract Manager.

5.2. Components may be waived in writing by the HCA Contract Manager for the purpose of this Contract.

5.3. Failure to submit required reports within the time specified may result in one or more of the following:

5.3.1. Withholding of current or future payments;

5.3.2. Withholding of additional awards for a project; and

5.3.3. Suspension or termination of this contract.

5.4. Types of reports

5.4.1. Report 1: HMIS Annual Report

5.4.1.1. Frequency: At least four (4) times, quarterly, and additional instances, as applicable and requested by the HCA Contract Manager.

5.4.1.2. Components:

a. Meet HCA PATH Program Requirements.

b. Submit the report titled "HMIS Annual Report" on a quarterly basis to the HCA Contract Manager via email for written approval, in accordance with the following date ranges and due dates:

#	Date Range	Due Date
Q1	10/1/2025-12/31/2025	1/15/2026
Q2	10/1/2025-3/31/2026	4/15/2026
Q3	10/1/2025-6/30/2026	7/15/2026
Q4	10/1/2025-9/30/2026	With final invoice

c. Direct Service staff are required to attend New Employee Orientation (one time) (offered by HCA quarterly) and attend bi-monthly Learning Collaborative meetings.

d. PATH program managers are required to attend bi-monthly meetings titled "PATH Supervisor Meetings."

e. PATH-funded staff are required to attend the annual HCA PATH and Peer Pathfinder Outreach Academy or online alternative if available.

f. PATH Providers are required to cooperate with requests for remote or in person site visits.

g. PATH Providers are required to cooperate with Annual Application (SAMHSA) requests for data and other information by HCA Contract Manager.

5.4.2. Report 2: IUP and Budget Narrative

5.4.2.1. Frequency: At least one (1), and additional instances, as applicable and requested by the HCA Contract Manager.

5.4.2.2. Components: Report template, provided by the HCA Contract Manager within sixty (60) days after Contract execution, using the object class categories referenced in HCA approved Contractor IUP budget narrative.

5.4.3. Report 3: Annual PATH Data Exchange (PDX) Report

5.4.3.1. Frequency: One (1) time

5.4.3.2. Components:

a. Each PATH provider Supervisor or Lead will submit one PATH Annual Data Report into PATH Data Exchange (PDX).

b. HCA will grant access to the PDX site upon request.

c. Analysis of performance will be based on IUP and factors that have affected local PATH project(s).

d. This report includes measures taken to maintain and improve the integrity of PATH project(s).

e. Submit through SAMHSA-required annual report database (PATH PDX) aggregate

f. Participant service data consistent with the national 'PATH Annual Report Manual,' developed by SAMHSA's Homeless and Housing Resources Network and the CMHS GPRA Performance Measures, in accordance with Attachment 6, Center for Mental Health Services (CMHS) Government Performance and Results Act (GPRA) Performance Measures.

g. If a data check is prompted by the system:

i. Respond to SAMHSA data checks associated with warnings in PATH Data Exchange (PDX).

ii. SAMHSA reviews these data check measures each year and may request additional information to assist in evaluating the PATH program and reason why the GPRA measurement was not met.

iii. A list of current data checks is listed below.

iv. The Data check measurements are as follows:

A. Zero (0) individuals contacted = 0;

B. One hundred percent (100%) of persons contacted through outreach became enrolled in PATH;

C. Percentage of eligible persons contacted who became enrolled in PATH is less than forty-six percent (46%);

D. Number of persons enrolled has decreased by more than fifty percent (50%) since the previous year or increased by more than one hundred percent (100%) since the previous year;

E. Percentage of PATH Participant who received community mental health services is less than fifty-three percent (53%) of the GPRA measure;

F. Number of PATH Participants who are seventeen (17) years old or younger is greater than zero; and

G. Sum of "Client refused" and "Data not collected" categories for each demographic data element ("Unknown" category for field #28f) is greater than ten percent (10%) of the total number of persons enrolled in PATH (field #15).

9.18 Transition Support Program (TSP)

Program Overview

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. Services are intended for individuals that are not connected or are marginally engaged with the publicly funded behavioral health system. TSP provides crisis consultation and support, care management and coordination, medication support, and peer services as well as mental health assessment, treatment, and consultation. Services are temporary with the goal of enrolling clients in clinic-based, behavioral health services and/or other relevant community support within 90 days. 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 450 unduplicated clients annually. TSP is a multi-disciplinary team that consists of the following specialties and capacities.

- Peer Specialists;
- Psychiatric prescriber;
- Physical health assessment, treatment, consultation, and health education; and
- Mental health assessment, treatment, consultation, and support.

The TSP team performs the following duties in a timely manner:

- Attempts initial engagement with referred individuals within 24 hours or the next business workday;
- Provides all 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, it 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.

Invoice Program Specific Requirements

Method of Payment

- Reimbursement will be made in monthly 1/12th amounts for a Transition Support Program team to provide discharge and transition support to eligible individuals.

Additional Requirements

- None.

Transition Support Program Services Eligibility Criteria	
Medicaid Status	N/A
Age Range	18 years of age or older
Authorization Needed	No
Additional Criteria	• Was involuntarily detained and is held at a King County psychiatric hospital or E&T facility; and • Is not enrolled or is marginally engaged in the publicly funded behavioral health system; and • Is willing to participate in TSP. • Priority is given to individuals that are placed on Single Bed Certifications (SBCs) and/or exhibit a history of frequent psychiatric hospital admissions or other high-intensity services.
Transition Support Program Reporting Requirements	
Monthly Reports	• Transition Support Program Staffing Report • Transition Support Program Exit Disposition Report
Quarterly Reports	• None
Semiannual Reports	• None
Annual/Other Reports	• None
Performance Measurement (PM) Plan	• None

9.19 Intensive Care Management/Familiar Faces/Vital

Program Overview

The Vital program delivers comprehensive and integrated services to adults who are experiencing behavioral health challenges and require an intensive level of support and community outreach.

Individuals may also be experiencing homelessness. The multi-disciplinary team consists of a supervisor/team lead, four care manager staff, a behavioral health specialist, an occupational therapist, a registered nurse, a Psychiatric Advanced Registered Nurse Practitioner (ARNP) or Psychiatrist, and a Primary Care ARNP or Medical Doctor who provides physical health care to participants. Services utilize evidence-based or promising practices, such as, Motivational Interviewing, Trauma Informed Care, and operate from a harm reduction approach. The team works closely with dedicated prosecuting attorney staff from the King County Prosecuting Attorney's Office and the Seattle City Attorney's Office in order to divert the filing of charges or collaborate on creative dispositions of criminal court cases that are focused on reducing jail time and ongoing and future criminal legal system involvement.

Intensive Care Management/Familiar Faces/Vital Eligibility Criteria	
Medicaid Status	Medicaid eligible individuals will be served by VITAL with an outpatient Mental Health Services benefit.
Age Range	Adults Aged 18 Years and Older
Authorization Needed	Yes

Additional Criteria	Individuals meet both of the following criteria: • Four or more bookings in the King County Jail within a rolling 12-month period; and • That occurs twice in a three-year time frame.

Program Requirements

- Maintain individual service records including:
  - A Medicaid-compliant intake assessment conducted at the soonest time possible, however completion of the assessment should not be a barrier to admission, outreach and engagement, and delivery of low-barrier behavioral health care.
  - An individualized service plan which reflects the person's desires and goals and identifies specific strategies and objectives to address needs and goals, with regular revisions to the service plan as goals are met and needs change.
- Documentation of services provided and progress toward service plan goal.

Invoice Program Specific Requirements

Method of Payment

Evergreen Treatment Services Only:

- Reimbursement will be made in monthly 1/12th amounts for providing intensive services for the Familiar Faces population.

Harborview Medical Center Only:

- Reimbursement will be the total program costs minus Medicaid payments for Medicaid eligible services received.

Additional Requirements

- None

Intensive Care Management/Familiar Faces/Vital Reporting Requirements	
Monthly Reports	• Vital Housing Log • General Ledger
Quarterly Reports	• None
Semiannual Reports	• None
Annual/Other Reports	• Ad-hoc reports as required for evaluation. • VSHS Levy Annual Report • MIDD Annual Narrative Report • Provide a minimum of one program case study or participant vignette describing the participant's background, treatment, and outcomes. • Annual Contract Renewal Budget • Any other requested reports by the County.
Performance Measurement (PM) Plan	• Reporting requirements and performance measures are further detailed in an accompanying Performance Measurement plan. See "Performance Measurement (PM) Plans" section on the Provider Manual and specific program PM Plan for more information

9.20 Peer Bridger Program

Program Overview

The Peer Bridger program provides transitional support for adult individuals who have been hospitalized psychiatrically at Navos or Harborview. Services are provided in accordance with the MIDD Behavioral Health Sales Tax Plan Initiative RR-11a - Peer Bridger Program.

Teams of Washington State Certified Peer Counselors (individuals who have lived experience with behavioral health issues) at Harborview and Navos hospitals work in coordination with their inpatient treatment teams to identify individuals in need of this support, and to develop individualized plans to promote successful transition to the community. Peer Bridgers work with program participants for up to 90 days after discharge, focusing on establishing outpatient care and helping to navigate challenges in the community. These post-discharge services include but are not limited to:

- Facilitating connection to outpatient behavioral health services, primary care, and community resources
- Supporting individuals to identify strengths and develop personal goals.
- Assisting in education regarding medications (obtaining, effective use, and coping with side effects)
- Assisting in the development and utilization of natural supports
- Navigating complex social service systems
- Coaching regarding maintaining housing and residential placements
- Connection with recovery communities (12-step, mental health, substance use disorder treatment, etc.)
- Coping skills coaching regarding life changes and recovery principles.
- Practice skills learned while in the hospital.
- Teaching and practicing self-advocacy.

Invoice Program Specific Requirements

Method of Payment

- If any of the positions become vacant, full reimbursement may be paid for up to two months for costs related to hiring to refill the position(s). If the position(s) have remained vacant for more than 60 days, payment will be pro-rated for the vacant FTE(s) as follows:
  - Total actual payroll hours provided for the period divided by total hours that should have been provided equals percent of FTE(s) provided; and
  - Percent of FTE provided multiplied by the monthly increment = Adjusted reimbursement for month.
- Payroll documentation will be submitted to support the billing for each FTE per month.
- Reimbursement will be made monthly for operational expenses (e.g., supplies, utilities, space, and insurance) and essential needs and travel expenses based on actual monthly expenditures.
- Monthly payment will not exceed 1/12th payment of the annual allocated amount.
- **HBHS:** Reimbursement will be made monthly in 1/12th amounts for 4.8 full-time equivalent (FTE) staff (includes 4.2 FTE Peer Bridger Staff and 0.5 FTE Supervisory Staff, and 0.1 Admin Support).
- **NAVOS:** Reimbursement will be made monthly for 5.7 full-time equivalent (FTE) staff (includes 5.0 FTE Peer Bridger Staff and 0.6 FTE Supervisory Staff, and 0.1 Admin support).

Additional Requirements

- Non-compliance with the MIDD evaluation data requirements may result in withholding of payment for all associated contracted services.

Peer Bridger Program Eligibility Criteria	
Medicaid Status	N/A
Age Range	Adults aged 18 years and older
Authorization Needed	No
Additional Criteria	King County resident hospitalized psychiatrically at Navos or Harborview
Peer Bridger Program Reporting Requirements	
Monthly Reports	• Peer Bridger Program FTE Report • Peer Bridger Program Voucher Report
Quarterly Reports	• None

Semiannual Reports	• None
Annual/Other Reports	• None
Performance Measurement (PM) Plan	• Reporting requirements and performance measures are further detailed in an accompanying Performance Measurement plan. See "Performance Measurement (PM) Plans" section on the Provider Manual and specific program PM Plan for more information

9.21 Pioneer Square Client Engagement

Program Overview

The Pioneer Square Client Engagement (PSCE) team proactively addresses the needs of individuals accessing or living outside near, contracted agency Drop In and clinical sites. The PSCE team build rapport with individuals in the service area, providing education, service orientation, resource referral, and de-escalation to address any identified non-emergent needs. The team works closely with other contracted Provider programs, external service providers, nearby businesses, and neighborhood residents to promote individual, clinic, and neighborhood safety. The PSCE team maintains effective working relationships with emergency personnel for improved emergency service utilization, and coordination during emergency situations.

Specific PSCE activities include:

- Referrals
- Support for service connections.
- Safety escort
- De-escalation
- Coordination with First Responders
- Internal consult on neighborhood complaints
- Internal reporting and documentation
- Case consults

Program Specific Requirements

- PSCE Team members maintain an active agency affiliated counselor or superseding credential.
- PSCE Team members are trained on de-escalation, CPR and First Aid.
- Provider meets with King County Contract Monitor at minimum monthly or at a frequency communicated in writing from King County Contract Monitor to contracted Provider.

Funding

Allowable costs: Refer to approved Scope budget. Costs covered include salary and benefits for two (2) FTE Client Engagement Specialist positions. Provider will charge current NICRA rate and provide King County with copy of current NICRA documentation.

Pioneer Square Client Engagement Eligibility Criteria	
Medicaid Status	N/A
Age Range	N/A
Authorization Needed	None
Additional Criteria	None
Pioneer Square Client Engagement Reporting Requirements	
Monthly Reports	• None
Quarterly Reports	• None
Semiannual Reports	Biannual reporting with the following metrics:

	• Number of total individuals served • Number of unique individuals served (deduplicated), if available • Coverage area (ZIP code) • Actual service location (ZIP codes) • Preferred metric (not required): Number of referrals and number of service connection attempts and successes Mid-year data: Due 7/31 (monthly data from January-June period) Annual data: Due 1/31 (monthly data from July-December period)
Annual/Other Reports	• None
Performance Measurement (PM) Plan	• Reporting requirements and performance measures are further detailed in an accompanying Performance Measurement plan. See "Performance Measurement (PM) Plans" section on the Provider Manual and specific program PM Plan for more information

9.22 Housing Services for King County Regional Mental Health Court

Program Overview

Housing services provides 23 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. The program is funded by MIDD Behavioral Health Sales Tax Initiative TX-RMHC – *Regional Mental Health and Veteran's Court.*

Invoice Program Specific Requirements

Method of Payment

- Reimbursement will be monthly on a 1/12th basis for case management and behavioral health assessments.

Additional Requirements:

- None

Housing Services for King County Regional Mental Health Court Eligibility Criteria	
Medicaid Status	N/A
Age Range	Adults Aged 18 years and Older
Authorization Needed	No
Additional Criteria	• For housing services, adult individuals who are opting into or currently participating in Regional Mental Health Court/Regional Veterans Court. • For the SUD assessment services, individuals 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	
BHRD Information System	• None
Monthly Reports	• Housing Data and Status Report • Housing Data Log, as provided by the County
Quarterly Reports	• None

Semiannual Reports	• None
Annual/Other Reports	• MIDD Annual Report • Annual Program Budget
Performance Measurement (PM) Plan	• Reporting requirements and performance measures are further detailed in an accompanying Performance Measurement plan. See "Performance Measurement (PM) Plans" section on the Provider Manual and specific program PM Plan for more information Performance Measurement (PM) Plan

9.23 Recovery Navigator Program

Program Overview

The Recovery Navigator Program (RNP) was developed in response to the endorsed Senate Bill 5476 addressing the State versus Blake decision and in 2023 updated with Senate Bill 5536. This program is a community-based outreach/engagement program that seeks to engage individuals who may benefit from behavioral health treatment and facilitate connections to the behavioral health treatment system. RNP serves Individuals who are at risk of arrest or already have been involved in the criminal legal system. The focus population for the RNP is to serve individuals who intersect with law enforcement because of simple drug possession and/or have frequent contact with the criminal legal system because of unmet behavioral healthcare needs.

The goal of the RNP is to make these services available across our region in areas that are currently not served or underserved, to remove barriers, and create a seamless approach to recovery.

This program assists individuals with a Substance Use Disorder (SUD), or substance use concerns in accessing outreach, treatment, and recovery support services that are low barrier, person centered, informed by people with lived experience, and culturally and linguistically appropriate.

Providers adhere to the following program guidelines as identified by the Health Care Authority's Recovery Navigator Uniform Program Standards Guide 2024-2025 located here: Recovery Navigator Program Uniform Program Standards Guide (82-0643)

RNP Provides

- Rapid response outreach to referrals
- Outreach services as long as needed to engage individual in other services
- Intake and referral services
- Biopsychosocial assessments
- Intensive case management
- Light case management
- Coordination with law enforcement, prosecutors, program staff, medical providers, and community partners
- Warm handoffs to treatment along the continuum of care
- Warm handoffs to recovery support as needed.

Program Specific Requirements

- Provide rapid response outreach/engagement services 30 minutes within urban and suburban areas and one hour to 1.5 hours in rural areas between the hours of 9am and 5pm, 7 days a week.
- Provide outreach and engagements services, case management services, recovery services, and to help navigate individuals to other behavioral health services that may be needed.

- RNP includes staff members who spend most of their time in the field. This will include spending time visiting community-based organizations and settings.
- The outreach and referral staff will be available to respond and engage upon referral.
- Outreach staff will connect with individuals who might need case management or ongoing referrals to external services.
- RNP staff prioritizes responses to law enforcement calls with the long-term goal of being able to respond to any community-based and emergency response referral and coordinate with case management staff to meet the individual needs of new and existing program participants.
- RNP staff also prioritizes court system referrals and other criminal legal system personnel with a credible alternative to further legal system involvement for criminal activity that stems from unmet behavioral health needs or poverty. The programs works to improve community health and safety by reducing individuals' involvement with the criminal legal system through the use of specific human services tools and in coordination with community input.
- Provide ongoing recovery support through RNP outreach workers and, when agreed upon with the individual, longer-term light and intensive case management services which may include: a biopsychosocial assessment, referrals and linkage to access services across the continuum of care.
- Coordinate communication between law enforcement, prosecutors, program staff, medical providers, and community partners.
- Provide behavioral health information and resources to staff and volunteers at local community-based organizations and to individuals living in rural unincorporated areas about the availability of behavioral health services.
- RNP maintains a sufficient number of appropriate personnel, including people with lived experience in SUD to the extent possible, to provide outreach/engagement services, case management services, and supervision/management for all program staff.
- Each zone has staff designated to work to provide services within that service area.
- Outreach services will begin with the first referral and case management services will begin when the individual agrees to services by signing the program Release of Information Form
- The program provides funds for client direct service expense not to exceed 8.9% of the budget and these flexible participant funds may be used to cover a participant’s modest and variable needs within available funding.
- Participating RNPs collect and provide data points related to the individuals referred into the program, and service date(s) on participant they serve within the RNP program.

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

- Outreach and engagement to meet with harder to serve populations.
- To help individuals who need assistance learning how to use technology.
- Paying for staff’s mileage
- Other expenses as approved by your BHRD RNP Program Manager

Invoice Program Specific Requirements

<u>Method of Payment</u>

- Reimbursement is made based on actual costs for eligible expenses outlined above.
- Receipts and payment documents must be submitted with the invoice.
- The amount requested for outreach/coordination should be equal to the staff time spent on that activity multiplied by their hourly salary.
- Reimbursement will be made monthly on a cost reimbursement basis for Recovery Navigator program staffing as outlined in the agency’s approved RFP budget.
    - The agency will not charge the County for personnel costs which are specifically paid for by another source of funds or not provided for the Recovery Navigator Program.

  - The agency will not charge the County for program expenditures under line item "Client Direct Services" for more than 1/12 of 10% of their total budget per month without prior authorization.
- Reimbursement will be made monthly in 1/12th amounts for the Value Based Deliverable (10% of the total budget).

Additional Requirements

- Reimbursement is contingent on available funding. Reimbursement is available for activities conducted and expenses incurred.
- The Provider attests that by submission of this invoice, they have not been reimbursed by any other fund source.
- Any changes to the program staffing should be completed in consultation with and approved by the BHRD Program Manager.
- Total annual reimbursement for the Recovery Navigator Program will not exceed the State HCA awarded funds.
- Supporting documentation related to the expenses incurred (i.e., receipts, payroll documentation etc.) will be retained by the agency and provided upon request.

Recovery Navigator Program Eligibility Criteria	
Medicaid Status	N/A
Age Range	Youth and Adult
Authorization Needed	No
Additional Criteria	None
Recovery Navigator Program Reporting Requirements	
Monthly Reports	RNP Data Collection Tool **due the 10th of the month following the reporting period.** RNP FTE Report, RNP Expenditure Report, general ledger and time sheets
Quarterly Reports	None
Semiannual Reports	None
Annual/Other Reports	Other information as requested by SAMHSA, HCA and/or BHRD.
Performance Measurement (PM) Plan	None

9.24 Recovery Navigator Housing Funds

Recovery Navigator Program has two options for program participants to access housing:

1. Crisis Housing Vouchers
2. Governor's Housing Homeless Initiative

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

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

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

Crisis Housing Vouchers are intended to be utilized at:

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

When a provider utilizes a Crisis Housing Voucher, a referral to a community-based supportive housing program also must occur.
A referral to the community-based supportive housing program Forensic HARPS must occur for individuals who meet the following criteria:

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

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

- Referrals must be made by or within the same day as Crisis Housing Voucher utilization.
- Referrals must be made via secure email, phone call, or fax.

Governor's Housing/Homeless Initiative

Governor's Housing/Homeless Initiative provides housing bridge subsidy to reduce instances where an individual leaves a State-operated behavioral health or private behavioral health facility directly into homelessness.

A Recovery Navigator Program participant is eligible for Governor's Housing/Homeless Initiative funding if they meet the following eligibility criteria.

- The individual is a Recovery Navigator Program participant at Peer WA, and
- Is transitioning out of an inpatient behavioral healthcare setting, such as a State mental health hospital, SUD inpatient setting, 90/180 bed, crisis stabilization setting, or another inpatient mental health setting, and
- Is at risk of homelessness upon discharge from the inpatient setting.

Participants who meet eligibility criteria can access Governor's Housing/Homeless Initiative funding, however Recovery Navigator Program participants who meet eligibility criteria and are being discharged from State operated behavioral health facilities must be prioritized.

Governor's Housing/Homeless Initiative maximum funding per participant is approximately $3000 per person or 2 months of rent per person while securing long-term rental resources, as long as the total is within the contracted amount. Allowable expenses include the following.

- Identification documents
- Applications fees, including background check and credit check fees
- Moving expenses, such as a moving truck and supplies
- Transitional housing fees at an accredited recovery home for up to 2 months
- Move-in costs for permanent housing, such as first and last months' rent, deposit, and fees
- Costs for certain home sustainability items, such as mattresses, appliances, lights, and cleaning supplies
- Barrier removal costs, such as past due utilities, past rental debt, and a short-term hotel while seeking housing
- Prior approval must be requested and approved by King County for any additional requests.

Invoice Program Specific Requirements

Method of Payment

- Reimbursement will be made monthly on an actual cost basis for Crisis Housing Voucher (CHV) funding utilized for Recovery Navigator Program participants who meet CHV eligibility.
  - CHV will cover up to a maximum of 14 days of short-term housing placement at a hotel, motel, or with a family member or friend. At the discretion of the Provider, the CHV may be extended an additional 14 days.
  - Pre-approval must be provided to utilize CHV for any other housing-related expenses.
  - Providers will provide accounting records to King County for end of year reconciliation.
- For Peer WA Only: Reimbursement will be made monthly on an actual cost basis for Governor's Housing/Homeless Initiative funding utilized for Recovery Navigator Program participants who meet eligibility criteria.

Additional Requirements

- Supporting documentation related to the expenses incurred (i.e., receipts, payroll documentation etc.) will be retained by the agency and provided upon request.
- The agency retains all records and supporting documentation related to expenses incurred for the Governor's Housing/Homeless Initiative funding and may be required to provide accounting records to King County.

Recovery Navigator Housing Funds Eligibility Criteria	
Medicaid Status	N/A
Age Range	Adult
Authorization Needed	No
Additional Criteria	None
Recovery Navigator Housing Funds Reporting Requirements	
Monthly Reports	Crisis Housing Voucher Log-due the 5th of the month following the reporting period For RNP Providers Administering Governor's Housing/Homeless Initiative Funding: Governor's Housing/Homeless Initiative Monthly Log
Quarterly Reports	None
Semiannual Reports	None
Annual/Other Reports	None
Other Reports	Other information as requested by SAMHSA, HCA and/or BHRD.
Performance Measurement (PM) Plan	None

Attachments in this Section
Attachment A: Crisis Housing Voucher Exception Request Form

9.25 Trueblood Transitional Supportive Housing

Program Overview
Trueblood Transitional Supportive Housing (TSH) is part of the continuum of care of Trueblood Diversion program: Legal Intervention and Network of Care (LINC), These programs divert individuals who are at risk of receiving forensic mental health services in the criminal legal system to behavioral health services in community settings. This program provides transitional housing and on-site housing support services for 18 participants at any given time.
Transitional Supportive Housing services include:

- Residence in a safe environment which respects the dignity of individuals.
- On-site support services offered 7 days/week.
- Coaching and group activities to support developing of independent living and tenancy skills.
- Coordination with service providers including Trueblood diversion programs, and other behavioral health, healthcare, and social service providers.
- Information and referral to basic needs resources
- Group activities and outings to increase community integration.
- Support in developing community-based support networks.
- Staff work with participants to develop and strengthen activity of daily living skills to build independence, consistent with program services described in the Standard Supportive Housing Program (SSH) section.

Provider will:

- Provide services in a person-first, recovery-oriented, culturally sensitive, and trauma-informed care paradigm. Providers develop staff awareness of historical trauma and systemic racism which have contributed to racial disproportionality in the population receiving orders for competency services and provide culturally responsive care.
- Develop and implement staff training plans to address best practices, safety and compliance, and clinical competencies.
- Utilize safe practices to provide services to individuals who may have histories of violence and trauma.
- Maintain individual service records including:
  - Housing agreements at entry and renewal periods.
  - An assessment of an individual's needs as relevant to the program service profile.
  - An individualized service plan which reflects the person's desires and goals and identifies specific strategies and objectives to address needs and goals, with regular revisions to the service plan as goals are met and needs change.
  - Documentation of services provided and progress toward service plan goals.

Invoice Program Specific Requirements

Method of Payment

- Reimbursement will be made monthly on a cost reimbursement basis for administrative and program operations.
- Flexible funds will be reimbursed for actual costs incurred for participants.

Additional Requirements

- None

Trueblood Transitional Supportive Housing Eligibility Criteria	
Medicaid Status	N/A
Age Range	Adults Aged 18 Years and Older
Authorization Needed	No
Additional Criteria	Currently enrolled in Legal Intervention and Network of Care (LINC).
Trueblood Transitional Supportive Housing Reporting Requirements	
Monthly Reports	• LINC Client Record
Quarterly Reports	• None
Semiannual Reports	• None
Annual/Other Reports	• Quarterly: provide information as requested by the county for HCA Trueblood Diversion narrative report. • Any other requested reports by the County

9.26 Veterans Reentry Services Program

Program Overview

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.

Invoice Program Specific Requirements

Method of Payment

- Reimbursement will be made on a monthly 1/12th amount for Incarcerated Veterans Reintegration Services.
- Reimbursement will be made at a cost reimbursement for flexible funding and training purposes benefitting the Incarcerated Veterans Reintegration Services participant population.

Additional Requirements

- None.

Veterans Reentry Services Program Eligibility Criteria	
Medicaid Status	N/A
Age Range	Adults Aged 18 Years and Older
Authorization Needed	Yes
Additional Criteria	Individuals who meet the above eligibility and will not be transferred to a Washington State Department of Corrections (DOC) facility or out-of-county facility.
Veterans Reentry Services Program Reporting Requirements	
Monthly Reports	• Veterans Flex Fund Expenditure Report • Veterans Staffing Report

Quarterly Reports	• None
Semiannual Reports	• None
Annual/Other Reports	• Minimum of two VRSP case studies or individual vignettes describing the participant's background, treatment and outcomes. • Any other requested reports by the County
Performance Measurement (PM) Plan	• Reporting requirements and performance measures are further detailed in an accompanying Performance Measurement plan. See "Performance Measurement (PM) Plans" section on the Provider Manual and specific program PM Plan for more information

9.27 Workforce Development

Program Overview

Training, technical assistance, learning collaborative and leadership services that assist King County in developing and implementing the King County Workforce Development Plan (KCWDP).
These activities are funded by the MIDD Behavioral Health Sales Tax Plan Initiatives #SI-04 Workforce Development and #PRI-01Screening, 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

- Operate within a trauma-informed, culturally responsive, recovery-oriented framework.
- Manage training logistics including registration, securing venues, catering, and certificates unless other arrangements have been agreed upon by both parties.
- Participate in the development of the KCWDP quarterly training calendar.
- Provide continuing credits for a wide range of clinical staff in the behavioral health and medical fields.
- Engage in quality management activities in collaboration with the Behavioral Health and Recovery Division (BHRD) Program Manager and KCWDP Coordinator. This includes strategies to improve attendance and evaluation feedback if needed, determining future and ongoing workforce development needs, assuring availability of trainings throughout the County, engaging underserved populations, and tailoring training content for a variety of learning styles and audiences utilizing active and receptive instructional activities to effectively teach concepts and skills.
- Coordinate training services with the KCWDP Coordinator.
- Participate in scheduled KCWDP coordination/planning meetings.
- Comply with the MIDD Evaluation Plan and the MIDD and Data Submission Plan:
  - Data are due 15 calendar days after the end of the month for which data are being reported, unless stated otherwise.
  - Non-compliance with evaluation data requirements may result in the withholding of payment for all associated contracted services.

Deliverables are determined on a quarterly, semi-annual or annual basis with input from each KCWDP Provider that includes Provider-specific training, technical assistance, learning collaborative and/or leadership services that are to be provided.

Workforce Development Plan Reporting Requirements	
Monthly Reports	• Training evaluations and sign-in sheets must be submitted within five business days after training is provided. • Workforce Development Professional Support Services Report, if applicable.
Quarterly Reports	• None
Semiannual Reports	• None
Annual/Other	• None
Performance Measurement (PM) Plan	• TBD

9.28 Youth Support Services

Program Overview

Youth Support Services (YSS) clinicians provide outreach and/or engagement services for youth and young adults and linkage to treatment and other recovery support services. The following array of services are provided: brief intervention, motivational interviewing, building community connections and supportive relationships, life skill education, substance use disorder (SUD) and mental health (MH) screening, creating connections to education, healthcare, housing and/or job-seeking opportunities, case management services, engagement services, and assistance with entry into the SUD and/or MH treatment system.

Deliverables

- Establish relationships with eligible youth and young adults.
- Maintain regular contact with these individuals.
- Refer participants to services, including behavioral health supports, as well as housing, employment, and/ or educational supports.
- Assist eligible youth in lowering use of drugs/ alcohol or maintaining sobriety.

Invoice Program Specific Requirements

Method of Payment

- Reimbursement will be made in 1/12th amounts for delivery of outreach and engagement services to eligible youth and young adults.
- Monthly narrative and quarterly reports documenting these services will be required for payment.

Additional Requirements

- Non-compliance with MIDD evaluation data requirements may result in withholding of payment for all associated contracted services

Youth Support Services Eligibility Criteria	
Medicaid Status	N/A
Age Range	Youth ages 12 through 25 years old
Authorization Needed	No

Additional Criteria	• King County Resident
	• The focus of this program are youth and young adults who are:
	  ○ Involved with drugs or alcohol;
	  ○ Involved with risky behaviors; and/or
	  ○ Involved, or at risk for involvement, in the juvenile justice system.

Youth Support Services Reporting Requirements	

Monthly Reports	• Youth Support Services Narrative Report including information on how the program deliverables were met
Quarterly Reports	YSS Excel Report –due the 15th of the month following the last month in the quarter that includes: • The number of youth reached per month, • The number of youth referred to SUD treatment, • The number of youth referred to non-treatment services, and • Information on relationships established with youth.
Semiannual Reports	None
Annual/Other Reports	None
Performance Measurement (PM) Plan	Reporting requirements and performance measures are further detailed in an accompanying Performance Measurement plan. See “Performance Measurement (PM) Plans” section on the Provider Manual and specific program PM Plan for more information

10 MIDD Locally Funded Programs

The following programs receive funding through MIDD Behavioral Health Sales Tax. All programs that have MIDD funding as a funding source provide services in accordance with the associated MIDD Initiative. Additionally, the following programs are not the only MIDD funded programs. Some may be in other sections of this Provider Manual, as they better fit under another section. If a program receives MIDD funding on an agency's "Funding Overview," then the Provider must follow MIDD requirements for that program.

MIDD Service Improvement Plan and MIDD 2 Implementation Plan
Providers implement services and programs as described in MIDD planning documents which includes the *MIDD Service Improvement Plan* and *MIDD 2 Implementation Plan*. Proposed programmatic changes to MIDD initiatives are reviewed and approved by BHRD in advance of any change being made.

MIDD Performance Measurement and Evaluation
Providers participate in MIDD performance measurement and evaluation activities as detailed in Performance Measurement (PM) Plans section of the Provider Manual. Providers work with DCHS Performance Measurement and Evaluation staff and BHRD program managers to co-develop PM Plans, which include program-specific data elements, performance targets and metrics, and data transmission methods.

Providers submit data to DCHS/BHRD in accordance with the agreed-upon methods outlined in PM Plans. This generally includes uploading reporting spreadsheets containing client-level data to the Client Outcomes Reporting Engine (CORE) online data submission system or the BHRD Information System. Data are typically due 15 calendar days after the end of the month for which quarterly/monthly data are being reported unless otherwise specified in PM Plans. DCHS staff review each data submission for completeness and accuracy and work to support Providers if any corrections are required. If submitted data require corrections, data will be corrected and resubmitted within 14 calendar days of notification.

10.1 1811 Intensive Case Management Services

Program Overview
The 1811 Eastlake residential facility is sponsored by the Downtown Emergency Service Center. The facility provides supportive housing for 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.

The 1811 Intensive Case Management Services program assists clients with 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.
- Comply with the MIDD Evaluation Plan and the MIDD Data Submission.

- Plan outings and on-site activities to improve participants' daily living skills and increase the level of meaningful activity in participants' lives.
- Facilitate engagement of participants through creative, resourceful strategies that build trust and confidence.

Invoice Program Specific Requirements

Method of Payment

- Reimbursement will be made for a 1.0 full-time equivalent (FTE) case management staff:
  - Each FTE will have 37.5 payroll hours per week;
  - Total staff payroll hours provided will include actual hours worked, holidays, jury duty, bereavement, and sick and vacation leave up to five consecutive business days; and
  - Payroll documentation will be submitted to support the billing for each FTE per month.
- If the position becomes vacant, full reimbursement may be paid for up to two months for costs related to hiring to refill the position. If the position has remained vacant for more than 60 days, payment will be pro-rated for the vacant FTE as follows:
  - Total actual payroll hours provided for the period divided by total hours that should have been provided equals percent of FTE provided; and
  - Percent of FTE provided multiplied by the monthly allotment equals adjusted reimbursement for the month.

Additional Requirements

- If the position becomes vacant, notification to the County is required in writing within seven business days. Notification should also include a plan for filling the position within 60 days of vacancy.
- Non-compliance with the MIDD evaluation data requirements may result in withholding of payment for all associated contracted services.

1811 Intensive Case Management Services *Eligibility Criteria*	
Medicaid Status	N/A
Age Range	Over 18
Authorization Needed	No
Additional Criteria	• Individuals must be diagnosed as moderate or severe substance use disorder (SUD) and have a history of high utilization of crisis services at the following locations: Sobering Services, Harborview Medical Center (HMC), and/or King County Correctional Facility. • Individuals must meet the standards for low-income client eligibility as described in the King County BH-ASO Policies and Procedures.
1811 Intensive Case Management Services *Reporting Requirements*	
Monthly Reports	• 1811 Intensive Case Management Report
Quarterly Reports	• 1811 Intensive Case Management Quarterly Report
Semiannual Reports	• None
Annual/Other Reports	• None
Performance Measurement (PM) Plan	• Reporting requirements and performance measures are further detailed in an accompanying Performance Measurement plan. See "Performance Measurement (PM) Plans" section on the Provider Manual and specific program PM Plan for more information

10.2 Children's Domestic Violence Response Team (CDVRT)

Program Overview

The CDVRT provides behavioral health and advocacy services to children who have experienced DV, and support, advocacy, and parent education to their non-violent parent. The program is provided in accordance with the MIDD Behavioral Health Sales Tax Plan Initiative CD-08 – Children's Domestic Violence Response Team as outlined in the MIDD initiative description: CD-08 Description

The CDVRT provides services to children ages 0 to 17 years old and their families who are experiencing domestic violence. Services include:

- Screening through a parent and child interview, as well as established standardized screening tools.
- Assessment, therapeutic interventions (using evidenced based practices such as CBT), service coordination, linkage to needed services and supports, advocacy, and supportive services.
- Development of a staff team which includes both children's mental health specialists and children's DV advocates and may include other team members identified by the child and family, including supportive family members, case workers, and teachers.
- Engagement through structured activities (e.g. "Meet and Greets", monthly Family Dinners) designed to support children and families to learn about the program, develop skills and provide a safe space to share experiences with others in similar circumstances.
- Coordination of care with referring sources and across disciplines.

Program Requirements

- Provide monthly data in accordance with established performance targets and outcome measures outlined in the MIDD Evaluation and Data Submission Plan for CD-08.

- Provide CDVRT services for a minimum of 150 unduplicated children/youth annually from 85 unduplicated families.
- Completion of (mutually determined) client outcome measures at baseline and at least one repeated measure during the treatment process.
- Adherence to reporting requirements as noted.

Invoice Program Specific Requirements

Method of Payment

- Reimbursement will be made in monthly 1/12th amounts for team services to child/youth survivors of domestic violence and their families.

Additional Requirements

- Non-compliance with the MIDD evaluation data requirements may result in withholding of payment for all associated contracted services.

CDVRT Eligibility Criteria	
Medicaid Status	N/A
Age Range	Birth to 17
Authorization Needed	No
Additional Criteria	Resident of King County and experiencing domestic violence
CDVRT Reporting Requirements	
BHRD Information System	• None
Monthly Reports	CDVRT Monthly Summary (Agiloft); MIDD CD-08 CORE Reporting Spreadsheet
Quarterly Reports	• None
Semiannual Reports	• None
Annual/Other Reports	• MIDD Annual Narrative Report; Provider Profile Update Report at minimum of annually or when things change.
Performance Measurement (PM) Plan	• Reporting requirements and performance measures are further detailed in an accompanying Performance Measurement plan. See “Performance Measurement (PM) Plans” section on the Provider Manual and specific program PM Plan for more information

10.3Crisis Outreach Response – Young Adults (CORS-YA)

Program Overview

The CORS-YA program provides crisis outreach response services for young adults (ages 18-24) living in King County-identified residential and shelter programs. If an individual is identified to be in need of crisis, the level of de-escalation support will determine the stabilization response to the individual and staff at the residential or shelter program.

Invoice Program Specific Requirements

Method of Payment

- Reimbursement will be made in a monthly allocation for a Mobile Crisis Team to provide prevention and early intervention to young adults living in residential and/or shelter settings in King County.
- Reimbursement will be made in a monthly allocation for capacity of a Respite Bed for short-term respite opportunities identified by the Mobile Crisis Team.

Additional Requirements

- Non-compliance with the MIDD evaluation data requirements may result in withholding of payment for all associated contracted services.

Crisis Outreach Response System-Young Adults (CORS-YA) Eligibility Criteria	
Medicaid Status	N/A
Age Range	18-24 years old
Authorization Needed	No
Additional Criteria	Young adults aged 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 and/or accessing a shelter setting.
Crisis Outreach Response System-Young Adults (CORS-YA) Reporting Requirements	
Monthly Reports	• Young Adult Outreach Response System Summary
Quarterly Reports	• None
Semiannual Reports	• None
Annual/Other Reports	• MIDD Annual Narrative Report
Performance Measurement (PM) Plan	• Reporting requirements and performance measures are further detailed in an accompanying Performance Measurement plan. See "Performance Measurement (PM) Plans" section on the Provider Manual and specific program PM Plan for more information

Goals & Objectives

- Crisis support accessed through Crisis Connections
- Mobile Outreach Response
- Crisis support and stabilization from 8-12 weeks.
- Default response, in person. Call may request a callback for non-emergent needs.
- Provide trauma-informed care: Caller defines the crisis, supported by intake and expertise from Crisis Connections
- Reduce the use of emergency departments (ED), first responders, and emergency shelters due to a behavioral health crisis.
- Support and maintain individuals in their current housing situation/placement (e.g. transitional, independent, etc.) and community environments.
- Assist young adults in accessing ongoing behavioral health and/or substance use services.
- Promote and support overall wellbeing, attainment of individualized goals, and housing stability.

Program Requirements

Staffing

The CORS YA team is comprised of the following staff:

- Mental Health Professionals (MHP, RCW 71-05-020) and Certified Peer Specialist
- Supervisor who, at a minimum, holds a bachelor's degree in human or social service field and are clinically licensed in the state of Washington.
- Substance Use Disorder Professional (SUDP) with experience providing behavioral health crisis support.

- In person response teams are composed of, at minimum, one MHP and CPC.

Outreach & Engagement

- CORS YA staff provide non-emergent outreach to individuals located in King County. Typical response time is within a 60-minute window from referral by Crisis Connections.
- A 60-minute response time, in person or callback, is best practice within the MRSS Best Practice Guidelines.
- CORS YA teams pursue the least restrictive response for individuals seeking support.

Training

- Crisis de-escalation and stabilization
- Trauma-responsive care (HCA training)
- HCA sponsored peer crisis training (CPC's only)

Stabilization & Support

CORS YA teams provide for up to 12 weeks of support stabilization services including, but not limited to:

- Care coordination
- Skill building
- Peer support
- Safety Planning
- In setting/placement education/psychoeducation
- Identification of natural and community support

10.4 Domestic Violence Behavioral Health Services

Program Overview

Domestic Violence Behavioral Health Services program 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 behavioral health treatment, referral and supports for domestic violence survivors served by the agency. The program is provided in accordance with the MIDD Behavioral Health Sales Tax Plan Initiative PRI-10 – *Domestic Violence and Behavioral Health Services and System Coordination* as outlined in the MIDD initiative description: PRI-10 Description

DV-BH Services programs include:

- Minimum staffing of a 1.0 full-time equivalent (FTE) licensed Mental Health Professional (MHP) with expertise in domestic violence and substance abuse. Minimum staffing also includes the positions and FTEs as designated in the agency's proposal to provide expansion program services.
- 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 include:
  - 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 for initiative PRI- 10.
- Adherence to reporting requirements as noted.

Invoice Program Specific Requirements

Method of Payment

- Reimbursement will be made in monthly 1/12th amounts for a 1.0 full-time equivalent (FTE) Mental Health Professional (MHP) staff. For less than 1.0 FTE provided, the monthly amount will be prorated.
- Reimbursement will be made in monthly amounts for FTEs as designated in the agency's proposal to provide expansion program services.
- If during any month an agency does not provide the designated full-time equivalency as noted, the agency should invoice for a prorated amount as described below. If any of the position(s) become vacant, full reimbursement may be paid for up to two months for costs related to hiring to refill the positions. If the position has remained vacant for more than 60 days, payment will be pro-rated for the vacant FTE as follows:
  - Total actual payroll hours provided for the period divided by total hours that should have been provided equals percent of FTE provided; and
  - Percent of FTE provided multiplied by the monthly allotment equals adjusted reimbursement for the month.
- Reimbursement will be made monthly for actual costs related to start-up and hiring for the expansion program.
- Reimbursement will be made monthly for actual costs related to infrastructure supports as outlined in the agency's expansion proposal.
- The agency retains all records and supporting documentation related to the expenses incurred for the position(s) described above.

Additional Requirements

- Notification to the County of changes in staffing is required in writing within seven business days. If the change involves a vacancy notification should also include a plan for filling the position within 60 days of vacancy, as well as a coverage plan for any enrolled clients impacted.
- Non-compliance with the MIDD evaluation data requirements may result in withholding of payment for all associated contracted services.

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.). Must be a resident of King County.
Domestic Violence Behavioral Health (DV-BH) Services Reporting Requirements	

BHRD Information System	• None
Monthly Reports	• DV-BH Services Monthly Summary; DV-BH Services Monthly Staffing Report; MIDD PRI-10 CORE Reporting Spreadsheet
Quarterly Reports	• None
Semiannual Reports	• None
Annual/Other Reports	• MIDD Annual Narrative Report; Provider Profile Update Report at minimum of annually or when things change
Performance Measurement (PM) Plan	• Reporting requirements and performance measures are further detailed in an accompanying Performance Measurement plan. See "Performance Measurement (PM) Plans" section on the Provider Manual and specific program PM Plan for more information.

10.5 Domestic Violence Behavioral Health Services with Culturally Specific Supports

Program Overview

Culturally specific and linguistically appropriate services for domestic violence survivors who are refugees or immigrants and receiving domestic violence (DV) advocacy services at the Refugee Women's Alliance (ReWA). DV Advocates under the supervision of a Mental Health Professional (MHP), provide brief behavioral health treatment, referral and supports for domestic violence survivors in their native language. In addition, this program manages funds for interpreter services for the other domestic violence and sexual assault Provider network agencies to ensure that immigrant and refugee survivors receive services in their language of choice. The program is provided in accordance with the MIDD Behavioral Health Sales Tax Plan Initiative PRI-10 – *Domestic Violence and Behavioral Health Services and System Coordination* as outlined in the MIDD initiative description: PRI-10 Description

DV-BH Services and Culturally Specific Supports program includes:

- Minimum staffing of a 1.0 full-time equivalent (FTE) licensed Mental Health Professional (MHP) consultant with expertise in domestic violence and substance abuse who supervises the work of the DV Advocate staff providing behavioral health services. Minimum staffing also includes the positions and FTEs as designated in the agency's proposal to provide expansion program 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 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: https://www.kingcounty.gov/~/media/depts/community-human-services/MIDD/documents/170804_MIDD_Evaluation_Plan.ashx?la=en for initiative PRI- 10.
- Adherence to reporting requirements as noted.

Invoice Program Specific Requirements

Method of Payment

- Reimbursement will be made in monthly 1/12th amounts for a 1.0 full-time equivalent (FTE) Mental Health Professional (MHP) staff consultant. For less than 1.0 FTE provided, the monthly amount will be prorated.
- Reimbursement will be made in monthly amounts for FTEs as designated in the agency's proposal to provide expansion program services.
- If during any month an agency does not provide the designated full-time equivalency as noted, the agency should invoice for a prorated amount as described below. If any of the position(s) become vacant, full reimbursement may be paid for up to two months for costs related to hiring to refill the positions. If the position has remained vacant for more than 60 days, payment will be pro-rated for the vacant FTE as follows:
  - Total actual payroll hours provided for the period divided by total hours that should have been provided equals percent of FTE provided; and
  - Percent of FTE provided multiplied by the monthly allotment equals adjusted reimbursement for the month.
- Reimbursement will be made monthly on a unit cost basis (internal) or actual cost reimbursement (external) for Interpreter or translation services provided. Receipts for services purchased externally must be submitted with the invoice.
- If applicable, language access funds for other types of BIPOC supports will be paid on a cost reimbursement basis as approved.
- Reimbursement will be made monthly for actual costs related to start-up and hiring for the expansion program.
- Reimbursement will be made monthly for actual costs related to infrastructure supports as outlined in the agency's expansion proposal.
- The agency retains all records and supporting documentation related to the expenses incurred for the position(s) described above.

Additional Requirements

- Notification to the County of changes in staffing is required in writing within seven business days. If the change involves a vacancy notification should also include a plan for filling the position within 60 days of vacancy, as well as a coverage plan for any enrolled clients impacted.
- Non-compliance with the MIDD evaluation data requirements may result in withholding of payment for all associated contracted services.

- Using designated funds for language access is the priority. Use of underspend for other BIPOC support is allowable with approval by the BHRD Program Manager.

Domestic Violence Behavioral Health (DV-BH) Services and Culturally Specific Supports Eligibility Criteria	
Medicaid Status	N/A
Age Range	Youth or adults (no age restrictions) who identify as domestic violence survivors. Primary population served are refugees or immigrants.
Authorization Needed	No
Additional Criteria	Must have no other source of payment for services (i.e. does not have Medicaid, other insurance, etc.). Must be a resident of King County.
Domestic Violence Behavioral Health (DV-BH) Services and Culturally Specific Supports Reporting Requirements	
BHRD Information System	• None
Monthly Reports	• DV-BH Services Monthly Summary; DV-BH Services Monthly Staffing Report; Interpreter Services Summary Report; MIDD PRI-10 CORE Reporting Spreadsheet
Quarterly Reports	• None
Semiannual Reports	• None
Annual/Other Reports	• MIDD Annual Narrative Report; Provider Profile Update Report at minimum of annually or when things change
Performance Measurement (PM) Plan	• Reporting requirements and performance measures are further detailed in an accompanying Performance Measurement plan. See “Performance Measurement (PM) Plans” section on the Provider Manual and specific program PM Plan for more information.

10.6 Domestic Violence/Sexual Assault Behavioral Health Systems Coordination

Program Overview

Provides system coordination and training activities to promote cross training and increased collaboration, policy development, and specialized consultation between behavioral health treatment Providers and agencies providing domestic violence and sexual assault services throughout King County to improve the responsiveness of services to survivors with behavioral health concerns. The program is provided in accordance with the MIDD Behavioral Health Sales Tax Plan Initiative PRI-10 – *Domestic Violence and Behavioral Health Services and System Coordination* as outlined in the MIDD initiative description: PRI-10 Description

DV-SA BH Systems Coordination includes:

- Minimum staffing of a 1.0 full-time equivalent (FTE) System Coordinator/Trainer with expertise in domestic violence and sexual assault and knowledge of behavioral health issues experienced by survivors.
- Developing an Annual Training Plan each year in collaboration with KC BHRD which may include training provided to specific initiative partners, the gender-based violence community network, as well as community behavioral health system Providers.
- Providing specialized cross-system training for a minimum of 200 clinical or advocacy staff from community behavioral health, domestic violence and/or sexual assault agencies each year.
- Regular collaboration with BHRD to address system issues, share information and prepare for quarterly initiative meetings. Meeting follow-up.
- Collaboration and relationship building between the behavioral health, domestic violence, and sexual assault service systems to promote cross-systems training and increased knowledge and

awareness across disciplines. This includes regular collaboration, coordination and relationship building with other initiative contracted Providers.
- Coordination or provision of specialized consultation for or between sexual assault, domestic violence and behavioral health agencies on issues impacting behavioral health treatment for survivors.
- Providing research and practice recommendations to inform the development of policies and procedures to assist domestic violence, sexual assault, and behavioral health providers better serve survivors who are experiencing behavioral health issues.
- Providing monthly reports and data in accordance with established performance targets and outcome measures outlined in the MIDD Evaluation and Data Submission Plan for initiative PRI-10.
- Adherence to reporting requirements as noted.

Invoice Program Specific Requirements

Method of Payment

- Reimbursement will be made in monthly 1/12th amounts for a 1.0 full-time equivalent (FTE) System Coordinator. For less than 1.0 FTE provided, the monthly amount will be prorated.
- If during any month an agency does not provide the designated full-time equivalency as noted, the agency should invoice for a prorated amount as described below. If the position becomes vacant, full reimbursement may be paid for up to two months for costs related to hiring to refill the position. If the position has remained vacant for more than 60 days, payment will be pro-rated for the vacant FTE as follows:
  - Total actual payroll hours provided for the period divided by total hours that should have been provided equals percent of FTE provided; and
  - Percent of FTE provided multiplied by the monthly allotment equals adjusted reimbursement for the month.
- The agency retains all records and supporting documentation related to the expenses incurred for the services and position(s) described above.
- Training and consultation funds will be paid monthly based on actual cost reimbursement.
- The agency retains all records and supporting documentation (including receipts) related to the expenses incurred.

Additional Requirements

- The System Coordinator will coordinate specialized training for a minimum of 160 behavioral health, domestic violence, sexual assault counselors and/or advocates annually.
- If the position becomes vacant, notification to the County is required in writing within seven business days. Notification should also include a plan for filling the position within 60 days of vacancy.
- Non-compliance with the MIDD evaluation data requirements may result in withholding of payment for all associated contracted services.

Domestic Violence-Sexual Assault Behavioral Health Systems Coordination Eligibility Criteria	
Medicaid Status	N/A
Age Range	N/A
Authorization Needed	None
Additional Criteria	Community-based Providers who offer domestic violence, sexual assault or behavioral health services to survivors are eligible for this service.
Domestic Violence-Sexual Assault Behavioral Health Systems Coordination Reporting Requirements	
BHRD Information System	• None

Monthly Reports	• DV-SA System Coordination Staffing, Training and Activity Reports
Quarterly Reports	• None
Semiannual Reports	• None
Annual/Other Reports	• MIDD Annual Narrative Report; Provider Profile Update Report at minimum of annually or when things change
Performance Measurement (PM) Plan	• Reporting requirements and performance measures are further detailed in an accompanying Performance Measurement plan. See "Performance Measurement (PM) Plans" section on the Provider Manual and specific program PM Plan for more information.

10.7 Family Support Organization

Program Overview

Family Support Organization provides resources and support to families in King County, including youth peer and parent/caregiver partner supports. The overall goal of the program is to improve the health and wellness of children and youth living with behavioral health conditions, as well as their caregivers. The program is provided in accordance with the MIDD Behavioral Health Sales Tax Plan Initiative CD-12- Parent Partners Family Assistance as outlined in the MIDD initiative description: CD-12 Description. The Provider, Guided Pathways Support for Youth and Families (GPS), ensures equitable access to services throughout the King County region. This Family Support Organization hires, trains, develops and retains staff that reflect the cultural and ethnic diversity of the children, youth and families engaged in the services.

- Parent/caregiver partners are Washington State Certified Peer counselors or have experience providing or receiving paraprofessional parent/caregiver peer supports. They also have lived experience as a parent/caregiver of youth receiving services from child-serving systems (e.g., mental health treatment system, substance use disorder treatment system, child welfare and juvenile justice system).
- Youth peers are between the age of 18 – 28 with lived experience in utilizing mental health, substance use disorder, juvenile justice or Wraparound services.
- Program staff, including parent/caregiver partners and youth peers, provide: Flexible and accessible parent/caregiver and youth peer support;
- Referrals to the King County Behavioral Health System, the Children's Administration, and other child-serving systems as needed;
- Parents/caregivers with effective advocacy tools for receiving support for these systems;
- Assistance to parents/caregivers in navigating child serving systems;
- Support to parents/caregivers and youth through mentoring and sharing of their own experiences as service recipients in child-serving systems from a recovery-oriented perspective in order to promote hope and self-determination; Culturally relevant supports that are in accordance with the ethnic and cultural values and beliefs of the individual(s) and families served and are customized and flexible to meet the needs and goals of the individual(s) and families served;
- Collaboration and active participation with relevant organizations to include the King County Community Collaborative, the King County Peer Support Network, and King County Community Resource Teams;
- Leadership, training and support related to peer workforce development.
- The Provider provides an annual work plan with budget to King County for review and approval. This plan includes minimum service delivery numbers, and the following activities provided by the Family Support Organization:

- Family-oriented social events to be held regularly throughout the year. Events are located in King County and are open to the public. Volunteers and families receiving services are engaged in the planning and implementation of the family social events, with the support of staff and based on the interests and needs of the participating volunteers and families. These events focus on community building and building family-to-family connections to increase access to and awareness of other families who have a shared experience of receiving services from the child-serving systems. The events may also be educational.
- Parenting education: Occurs in collaboration with other child-serving organizations. The Provider participates in or sponsors parenting education opportunities. The Provider leverages existing parent and family trainings in the community and bases any additional Provider-generated trainings or pilot curriculums on the community needs assessment and related Provider research in order to prevent duplication of services. The Provider sponsorship of trainings includes publicizing the training through the Provider Network and collaborating partnerships, and providing additional supports as needed for the training or to the trainer(s). All trainings are located in King County, are open to the public, and have varying locations in an effort to reach residents in several geographic areas within the County. Training topics may include: Individual Education Plans (IEPs); Finding and selecting specialized childcare; Child-serving systems navigation; Advocacy; Parent-to-parent support; and other topics as identified by the Provider.
- Youth peer support: The Provider selects or develops a support group facilitation model appropriate for youth. The Provider recruits, trains, and supervises volunteer youth peers to provide peer support and youth support groups. Youth peers that are recruited draw upon their own experiences in child-serving systems to support the needs and goals of peers. The Provider provides support in person at their offices, in homes, in the community, over the phone or via the computer. The Provider pilots peer counseling and drop-in programs located in King County schools as identified in the annual work plan.
- Information and referral: The information and referral database and telephone service focuses on the specific areas of expertise related to family and parent supports for families that could benefit from services and/or assistance with linkage to child-serving systems (the service is non-duplicative in nature, providing referrals to 2-1-1 or other referral services for broader supports such as housing and employment). The Provider recruits, trains, and supervises staff or volunteers to provide information and referral services to children, youth, and families by phone. The Provider may also distribute information via a website, newsletter, traditional media and/or social media.

Invoice Program Specific Requirements

Method of Payment

- Reimbursement will be made in monthly 1/12th amounts to maintain a Family Support Organization providing resources and supports to families in King County, including youth peer and parent partner supports.

Additional Requirements

- Non-compliance with the MIDD evaluation data requirements may result in withholding of payment for all associated contracted services.
- Unallowable costs are according to the funding source, i.e., MIDD.
- If the Provider claims and the County reimburses for expenditures under this contract that are later found to be claimed in error or to be for unallowable costs, the County will recover those costs, and the Provider will fully cooperate with the recovery.

Family Support Organization Eligibility Criteria	
Medicaid Status	N/A
Age Range	Individuals up to age 21 and their families/caregivers and support system.
Authorization Needed	No

Additional Criteria	Live in King County, would benefit from services, agree to participate in services and are receiving or may benefit from receiving services from any of the following child serving systems: mental health, substance use disorder, child welfare, juvenile justice, developmental disabilities and or special education programs.
Family Support Organization Reporting Requirements	
Monthly Reports	• GPS Progress Report • MIDD Evaluation Data Report/ Reporting into CORE
Quarterly Reports	• None
Semiannual Reports	• None
Annual/Other Reports	• GPS Work Plan and brief year-end summary • MIDD Annual Report.
Performance Measurement (PM) Plan	• Reporting requirements and performance measures are further detailed in an accompanying Performance Measurement plan. See "Performance Measurement (PM) Plans" section on the Provider Manual and specific program PM Plan for more information

10.8 Family Treatment Court (FTC) Wraparound

Program Overview

FTC Wraparound is a recovery-based child welfare court intervention. FTC Wraparound focuses on children's welfare and families' recovery from substance use through evidence-based practices to improve child well-being, family functioning, and parenting skills. Strong agency partnerships enable FTC Wraparound to maintain maximum capacity to serve children in north and south King County.

  - SUDP, and/or any other member(s) of the team as appropriate.
  - Share the individualized Wraparound care plan, 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 care plans 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; and
  - Submit all required reports to FTC.
- The Provider maintains a caseload of 15 to 23 families per year.
- The Provider ensures that the FTC Wraparound staff attends all County-convened MIDD Wraparound trainings.
- The Provider complies with the MIDD Evaluation Plan and the MIDD Data Submission Plan.
- Data are due 15 calendar days after the end of the month for which data are being reported, unless stated otherwise. Data shall be complete and accurate. The King County Behavioral Health and Recovery Division (BHRD) will review each data submission and notify the Provider of any needed corrective action. Data shall be corrected and resubmitted within 14 calendar days of notification.
- Non-compliance with MIDD evaluation data requirements may result in the withholding of payment for all associated contracted services.

Goals and Objectives

Goal

- Reduce the number of people with mental illness and Substance Use Disorder using costly interventions like jail, emergency rooms, and hospitals.
- Divert youth and adults with mental illness and Substance Use Disorder from initial or further justice system involvement.
- Engage and leverage community-based and natural supports for families involved with FTC.
- Implement a family-driven approach to integrating systems of care for families.

Objectives

- Ensure the full involvement and partnership of families in the care of their children.
- Improve outcomes for Division of Children and Family Services (DCFS)-involved families through multi-system planning and coordination.
- Provide information, support, and training to families in order for them to improve their ability to advocate for their own needs.
- Provide linkage to other necessary services.

Invoice Program Specific Requirements

Method of Payment

- Reimbursement will be made in monthly 1/12th amounts for a 1.0 FTE Facilitator staff as follows:
  - FTE will have 40 payroll hours per week;
  - Total staff payroll hours provided will include actual hours worked, holidays, jury duty, bereavement and sick and vacation leave; and
  - Submit payroll documentation to support the billing for the FTE per month.
- Reimbursement will be pro-rated if less than the required FTE hours are provided. The adjusted reimbursement amount will be computed as follows:
  - Total actual payroll hours provided for the period divided by total hours that should have been provided = percent of FTE provided; and
  - Percent of FTE provided multiplied by the monthly amount = adjusted reimbursement for the month.

Additional Requirements

- The Provider shall comply with the MIDD Evaluation Plan and the MIDD Data Submission Plan.
  - Data are due 15 calendar days after the end of the month for which data are being reported, unless stated otherwise. Data shall be complete and accurate. The King County Behavioral Health and Recovery Division (BHRD) will review each data submission and notify the Provider of any needed corrective action. Data shall be corrected and resubmitted within 14 calendar days of notification.
  - Non-compliance with MIDD evaluation data requirements may result in the withholding of payment for all associated contracted services.

Family Treatment Court Wraparound Eligibility Criteria	
Medicaid Status	N/A
Age Range	N/A
Authorization Needed	None
Additional Criteria	Individuals are referred by FTC and are diagnosed with a substance use disorder (SUD) and in need of outpatient SUD services, as assessed by a Substance Use Disorder Professional (SUDP) using an assessment instrument that incorporates American Society of Addiction Medicine (ASAM) Criteria and the American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM_V), or their successors.

Family Treatment Court Wraparound Reporting Requirements	
Monthly Reports	Family Treatment Court Report
Quarterly Reports	None
Semiannual Reports	None
Annual/Other Reports	The Provider provides an Annual Outcome Report which describes the activities, successes and challenges of the program and a summary of the accomplishment of outcomes/goals of the program.
Performance Measurement (PM) Plan	Reporting requirements and performance measures are further detailed in an accompanying Performance Measurement plan. See "Performance Measurement (PM) Plans" section on the Provider Manual and specific program PM Plan for more information

10.9 Forensic Treatment Program at CCAP

Program Overview

Substance use disorder (SUD) treatment and mental health services (including pre-treatment services) are provided to appropriate adult men and women court-ordered to the Community Center for Alternative Programs (CCAP) in Seattle. The services are evidence-based and adapted to serve people of color, utilizing a trauma-informed, modified Therapeutic Community (TC) approach and cognitive behavioral interventions to address criminogenic risk factors. The program is partially funded by MIDD Behavioral Health Sales Tax Initiative RR-02 – *Behavior Modification Classes for Community Center for Alternative Program Clients.*

Invoice Program Specific Requirements

Method of Payment:

- Reimbursement will be monthly on a 1/12th basis for case management and behavioral health assessments.

Additional Requirements:

- None

Forensic Treatment Program at CCAP Eligibility Criteria	
Medicaid Status	Yes and No
Age Range	Adults Aged 18 Years and Older
Authorization Needed	Yes
Additional Criteria	• Pre-Treatment, Screening and Assessment: Adjudicated and pre-trial adults who are ordered by King County District Court or King County Superior Court to report to CCAP; • SUD Outpatient Services: CCAP participants who meet medical necessity for outpatient or intensive outpatient (IOP) treatment services 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.
Forensic Treatment at CCAP Reporting Requirements	

BHRD Information System	• Submit Data to the BHRD Information System as outlined in the BHRD Data Dictionary as requested by DCHS evaluator
Monthly Reports	• As requested by DCHS evaluator CCAP Staffing Report; • Forensic Treatment Flex Fund Expenditures Report; • Forensic Treatment Subsidized Client Report; • Forensic Treatment Services Denial Report
Quarterly Reports	• As requested by DCHS evaluator
Semiannual Reports	• As requested by DCHS evaluator
Annual/Other Reports	• Annual Outcome Report which describes the activities, successes and challenges of the program and a summary of the accomplishment of outcomes/goals of the program. • Participates with the MIDD Evaluation Plan. • Annual Program Budget
Performance Measurement (PM) Plan	• Reporting requirements and performance measures are further detailed in an accompanying Performance Measurement plan. See "Performance Measurement (PM) Plans" section on the Provider Manual and specific program PM Plan for more information

10.10 Juvenile Justice Assessment Team (JJAT)

Program Overview

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.

Program Specific Requirements

- Provide 2.0 FTE SUDP's, 2.0 FTE Mental Health Professionals (MHPs), and 1.0 FTE Treatment Family Liaison to provide KSCS/JJ-related liaison services.
- Ensure that the Juvenile Justice Assessment Team (JJAT) clinical staff are licensed MHPs, SUDPs, or SUPDs.
- Ensure that new JJAT staff participate in onsite job orientation and training over the first six months of hire by the Program Supervisor and/or Program Coordinator.
- Collaborate with other JJAT, DAJD, and Juvenile Court Services (JCS) staff to develop and implement protocols for prioritizing referrals, and transition planning in coordination with the Treatment Family Liaison.
- Provide services as described in the JJAT Referral Process document including contacting the referral source within two business days of the referral assignment to consult on the case and determine if a full assessment is warranted.
- Screen youth for potential trauma issues and refer for services, as needed.
- Provide assessments for referred youth in their community within seven working days from the Referral Confirmation Date using prioritization protocols. In the event of a cancellation or non-appearance for the appointment, every effort should be made to reschedule the appointment within the same week or within three to five business days of the missed appointment.

- Submit a comprehensive assessment summary presented in a standardized report within five working days from the date of the assessment interview or as needed to comply with court requests and to facilitate treatment placement. The report shall include at a minimum:
  - Name of Assessor;
  - Agency Name;
  - Date of Assessment;
  - Youth's name, date of birth, and age;
  - Race/Ethnicity;
  - Gender;
  - Parent/Primary Guardian: Name, relation to youth and contact information;
  - Name and Contact Information for Referral source and Attorney
  - Referral and background information;
  - Other supporting documents used for clinical and diagnostic impressions;
  - Child and Family History;
  - Self-identified Strengths/Goals/Challenges;
  - Clinical Impressions;
  - DSM V Diagnostic Impressions;
  - Service Recommendations; and
  - Identification of at least two collateral contacts.
- At least 75 percent of confirmed referrals shall be completed monthly.
- Contingent upon referrals from JCS a minimum of 12 MH assessments or MH status exams and 15 SUD assessments per FTE shall be completed on a monthly basis.
- Occasionally, in some urgent situations, JJAT staff shall be available to complete assessments on demand, same day as referral.
- Utilizing the Extended Client Lookup System (ECLS) JJAT staff shall determine if a youth is already enrolled in the KCBHO. If so, attempts shall be made with the provider to determine who will be responsible for completing the assessment.
- Participating in therapeutic court and other program staffing's and scheduled case staffing.
- Upon completion of the assessment JJAT staff shall scan and submit the full assessment and assessment summary to the referral source, save it to the JJAT Archived Files folder and pass the file to the Treatment Family Liaison for transition and engagement services if needed.
- Develop and maintain collaborative working relationships with JJ programs/initiatives and youth-serving systems to ensure coordinated and comprehensive services and discharge plans. These include but are not limited to: Multi-systemic Therapy, Functional Family Therapy, Juvenile Drug Court, At-Risk Youth /Truancy, Family Intervention Restorative Services, Children's Administration, and the Department of Social and Human Services.
- Provide documentation of all activities related to youth and family care from the date of initial referral (including demographic data forms, case notes, etc.).
- Once all assessment, referral, engagement, and transition services are completed case files should be purged of court provided documents, organized according to close file standards, and submitted to the Program Coordinator within five days. Any additional notes, reports or case related documents should be scanned into the JJAT Archived Files folder prior to submitting the file to the Program Coordinator.
- Participate in JJAT staff meetings and other meetings pertaining to provision of services.
- Provide 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.
- Ensure that weekly coverage by each JJAT staff is provided at an onsite court location for a minimum of 80% of each FTE allocation and for an average of no more than 4 hours stationed elsewhere unless there is prior approval from the Agency Supervisor and JJAT Program Supervisor.
- JCS staff shall participate in the selection of any new candidates for any of the 5.0 JJAT staff.

Goal and Objective

Goal

- To build service coordination between King County Behavioral Integrated Care Network (KCICN) providers, KCSC, DAJD, and the community.
- To provide multi-disciplinary, culturally specific screening and assessment and short-term intervention services to juvenile justice (JJ) involved youth.
- To increase availability of mental health (MH) and substance use disorder (SUD) assessments for youth who enter the juvenile justice system and to increase access to appropriate care for these youth and therefore produce reduction in health care use and criminal justice involvement.

Objectives

- To evaluate non-enrolled youth for eligibility for KCBHO services.
- To refer preliminarily eligible youth to KCBHO treatment providers for services.
- To build formal service coordination between other systems and KCBHO providers.

Invoice Program Specific Requirements

Method of Payment

- Reimbursement will be made monthly for 2.0 full-time equivalent (FTE) Substance Use Disorder Professionals, 2.0 (FTE) Mental Health Professionals and 1.0 (FTE) Family Partnership Position to provide King County Superior Court/Juvenile Justice-related assessment and liaison services.
  - Each FTE will have 40 payroll hours per week;
  - Total staff payroll hours provided will include actual hours worked, holidays, jury duty, bereavement, and sick and vacation leave up to five consecutive business days; and
  - Submit payroll documentation to support the billing for each FTE per month.
- Payment will be prorated if less than the required FTE hours are provided. The adjusted reimbursement amount will be computed as follows:
  - Total actual payroll hours provided for the period divided by total hours that should have been provided = percent of FTE provided; and
  - Percent FTE provided multiplied by monthly amount = adjusted reimbursement for month.

Additional Requirements

- 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. Data shall be complete and accurate. BHRD will review each data submission and notify the Provider of any needed corrective action. Data shall be corrected and resubmitted within 14 calendar days of notification; and
- Non-compliance with the MIDD evaluation data requirements may result in withholding of payment for all associated contracted services.

Juvenile Justice Assessment Team Eligibility Criteria	
Medicaid Status	N/A
Age Range	12 – 20 years of age
Authorization Needed	Youth involved in juvenile court with an active case and BH concern

Additional Criteria	None
Juvenile Justice Assessment Team Reporting Requirements	
Monthly Reports	Juvenile Justice Assessment Team (JJAT) FTE Report JJAT Outreach and Engagement Expenses Report
Quarterly Reports	None
Semiannual Reports	None
Annual/Other Reports	None
Performance Measurement (PM) Plan	Reporting requirements and performance measures are further detailed in an accompanying Performance Measurement plan. See "Performance Measurement (PM) Plans" section on the Provider Manual and specific program PM Plan for more information

10.11 Involuntary Treatment Triage Program

Program Overview

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

Invoice Program Specific Requirements

Method of Payment

- Reimbursement will be monthly on a 1/12th basis for case management and behavioral health assessments.

Additional Requirements

- None

Involuntary Treatment Triage Program Eligibility Criteria	
Medicaid Status	N/A
Age Range	Adults Aged 18 Years and Older
Authorization Needed	Yes
Additional Criteria	Individuals eligible for this service must be 18 years of age or older and who: • Are incarcerated, having been charged with a serious misdemeanor offense as determined by the Prosecuting Attorney; • Have a mental disorder or a mental disorder cannot be ruled out; and • Are referred by the court after an order for evaluation for a 90-day psychiatric hospitalization.
Involuntary Treatment Triage Program Reporting Requirements	
BHRD Information System	• None

Monthly Reports	• Involuntary Treatment Triage Report
Quarterly Reports	• None
Semiannual Reports	• None
Annual/Other Reports	• An annual report providing a description and analysis of program activities, successes, challenges, and additional funding sources (including in-kind contributions) identified to support program activity. • Annual Program Budget
Performance Measurement (PM) Plan	• Reporting requirements and performance measures are further detailed in an accompanying Performance Measurement plan. See "Performance Measurement (PM) Plans" section on the Provider Manual and specific program PM Plan for more information

10.12 King County Integrated Care Network (KCICN) Training Academy

The following training is available to KCICN agencies that were selected through the Request for Application process.

Dialectical Behavior Therapy (DBT) Training
The Dialectical Behavior Therapy (DBT) training sequence supports community agencies in establishing or improving their DBT training programs: internal, self-sustaining programs including treatment for clients as well as ongoing trainings for new staff at least annually. This training sequence supports DBT programming for varying levels of care within the behavioral health continuum (e.g. residential, community wraparound, high/medium/low levels of care in outpatient) and the provision of ongoing DBT training to new cohorts of clinical staff to support these programs.

Cognitive Behavioral Therapy for psychosis (CBTp) Training
The Cognitive Behavioral Therapy for psychosis (CBTp) training sequence supports community agencies in establishing or improving their CBTp training programs. This training sequence supports CBTp programming for varying levels of care across the behavioral health continuum (e.g. residential, community wraparound, high/medium/low levels of care in outpatient) and the provision of ongoing CBTp training to new cohorts of clinical staff to support these programs.

Program Specific Requirements

DBT Training

Round 1 Training Schedule

Training	# Sessions	Estimated Dates for Phase
Supervisors and Team Leaders Meeting	1	March 12, 2024, 8:30am – 4:30pm
Skill Training 1	4	April 8-11, 2024, 8:30am – 12:30pm
Skill Training 2	4	May 6 – 9, 2024 8:30am – 12:30pm
Individual Therapy in DBT 1 (for Mental Health Professionals [MHPs]) (SUDP optional)	8	June 3-6, 17-18, 20-21 8:30am-12:30pm
Individual Therapy in DBT 2 (for MHPs)	3	September 17 – 19, 2024 8:30am – 12:30pm
Train the Trainer (1+ trainers to be identified)	4	February 18-21, 2025, 8:30am – 4:30pm

Round 2 Training Schedule

Training	# of Sessions	Estimated Dates
Supervisors and Team Leaders Meeting	1	March 5, 2024, 8:30am – 4:30pm
Skills Training 1	4	April 14 – 17, 2025 8:30am – 12:30pm
Skills Training 2	4	May 12 – 15, 2025 8:30am – 12:30pm
Individual Therapy in DBT 1 (for Mental Health Professionals [MHPs]) (SUDP optional)	10	June 9 – 13 & July 14 – 18, 2025 8:30am – 12:30pm
Individual Therapy in DBT 2 (for MHPs)	3	September 9 – 11, 2025 8:30am – 12:30pm
DBT Champions Meeting (1+ Champions to be identified)	4	February 23 – 26, 2026 8:30am – 4:30pm
Attend 75% of TIC Monthly Consultation Meetings (2 meeting times will be offered per month to support participation)	5	August – December 2025

Training Requirements

Agencies who participate in the training sequence must identify at least six team members to be trained in providing the treatment with a subset identified as internal trainers. Three of those team members must be masters-level MHPs; additional team members may have other credentials. One or two of the DBT MHPs will be identified by agency with input from training staff, as DBT Trainers prior to the Train the Trainer sessions.

Agencies and designated staff must commit to providing the following DBT program activities:

- Clearly defined entrance and exit criteria for the DBT program.
- Pretreatment that orients the client to what is being offered and obtains commitment from the client to participate.
- Tracking of progress using the 8-item version of the Difficulties with Emotion Regulation Scale (DERS- 8).
- Formal DBT skills groups (generally 1.5 – 2 hours/week depending on the size of the group), following a standard DBT skills training group schedule (mindfulness, homework review, new teaching, practice, assigning homework for next group).
- Two DBT skills group leaders for any DBT skills group.
- 45–55-minute DBT individual session once a week (for clients in a comprehensive program).
- Defining how out of session problem behavior for DBT clients will be handled – assuming coaching is the first pass (rather than standard crisis response).
- 60 – 90-minute consultation team meeting (depending on the size of the clinical team) once a week or bi-weekly.
- Defining who will lead/manage between-session coaching.
- Commitment to identify and support or two DBT Trainers prior to the Train the Trainer sessions. This includes providing access to recorded therapy sessions for review by the Trainer.
- Commitment to provide at least annual training to new cohorts of clinical staff in the full model.
- At least one staff to meet with BHRD staff monthly for 30-minute virtual check-ins.
- Submit monthly implementation reports by the 5th of each month

DBT Skills Training Requirements for All Participants

- Attend all Skills Training sessions
- Attend 1 - 1.5-hour DBT team meetings (weekly or bi-weekly, minimum of 75%)
- Co-facilitate weekly 1.5 - 2-hour long DBT skills teaching group for King County clients on a rotating basis

- Provide out of session DBT skills coaching via phone within personal limits
- Complete assigned DBT readings and review relevant DBT teaching and learning materials
- Support agency leadership with implementing and sustaining a DBT program

DBT Individual Therapy Training Requirements for MHPs or Licensed SUDPs

- Attend all Individual Therapy Training sessions
- Provide weekly individual DBT therapy to King County clients
- Attend at least 75% of monthly consultations as provided by TIC
- Complete assigned DBT readings in the individual DBT therapy textbook and review relevant DBT teaching and learning materials

Requirements for DBT Champions

- Prior to the DBT Champion's meeting, each agency in collaboration with TIC will select one or two DBT Individual Therapy Participants to support DBT at their agency and become DBT Champions. DBT Champions will have the opportunity to participate, along with TIC, in providing future rounds of training within their agency. Additional requirements for DBT Champions are as follows:
- Submit recordings of individual DBT client sessions (on at least two different DBT clients) to be evaluated by TIC for proficiency
- Submit recordings of at least one DBT skills group to be evaluated by TIC for proficiency
- Submit written DBT case conceptualizations on at least two different DBT clients, to be evaluated by TIC for proficiency
- Participate in a skills coaching role play with TIC, to be evaluated for proficiency
- Attend monthly TIC consult for DBT Champion candidates (replaces Individual Therapy consults)
- Attend DBT Champions Meeting series

CBTp Training

Round 1 Training Schedule

Deliverable	Tasks	Time	Estimated Dates for Phase
	Follow-along consultation	12 hours	12 1-hour biweekly session
Individual CBTp	Asynchronous training and LMS activities	5 hours	On-demand beginning 5/27/2024
	Live, synchronous training	22.5 hours	4.5-hour sessions 1/13/2025, 1/14/2025, 1/15/2025, 1/16/2025, 1/17/2025
	Follow-along consultation and case presentation	15 hours	12 biweekly 1-hour sessions, transitioning to Champion-led
	Asynchronous training CHAMPIONS ONLY	5 hours	On-demand

Round 2 Training Schedule

Training	Task	#Sessions	Estimated Dates
Leadership	Administrator Workshop	1	September 26, 2025 (about 4 hours)
Foundational	Asynchronous Training: Foundational Principals of CBTp	On-going	Available October 1, 2025 (about 3 hours)
	Asynchronous Training: Lyssn	On-going	Available October 1, 2025

	(access provided by BHRD)		(about 5-7 hours)
	Live Skills Lab *Two options are available – one session is required*	1	November 12, 2025 9:00 am – 12:00 PM ***or*** December 3, 2025 1:00 PM – 3:00 PM
Group	Group Intensive Workshop	5	February 2 – 6, 2026 9:00 AM - 12:30 PM
	UW SPIRIT Center Consultation & Case Presentation	6	2x per month (1 hour each) (February - July 2026)
Individual	Individual Intensive Workshop	5	February 9 – 13, 2026 9:00 AM - 12:30 PM
	UW SPIRIT Center Consultation	6	2x per month (1 hour each) (February - July 2026)
Champion	Orientation	1	August 2026 (60-minute session)
	UW SPIRIT Center Training Session	6	September 2026 – January 2027

Training Requirements

Agencies who participate in the training sequence must identify at least six team members to provide two of the three modes of stepped care model of CBTp. At least two Mental Health Professionals (MHP's) must be identified to be trained in group administered CBTp. At least three MHP's must be identified to participate in Introduction to Individual CBTp. MHP's will either participate in the individual or group CBTp training sequences, not both. Additional team members may be peers, SUDP's or other non-MHP staff providing direct client care. One or two MHP's will be identified by each participating agency, with input from UW SPIRIT Lab staff, to be CBTp Champions. Champions will support agency adoption of CBTp and are eligible to participate in the CBTp Train the Trainer program (to come in a later phase of the training initiative).

Requirements for Agency CBTp Programming

Agencies and designated staff must commit to providing the following CBTp program activities:

- Attend one-time Administrator Training to orient leadership to CBTp programing, discuss implementation planning, and review training requirements and expectations.
- Engagement that orients the client to what is being offered and obtains commitment from the client to participate.
- Attend Foundational Training.
- Attend Group and/or Individual Training.
- Implement CBTp Group and/or CBTp Individual:
  - Provide weekly CBTp Therapy Groups (2 group leaders per group at a time, at least 1 MHP).
  - Provide structured CBT-informed individual sessions for psychosis with ongoing support and consultation to build skill proficiency (provided by at least 3 MHPs).
- Track progress of client participants in Individual CBTp using PsychSurveys platform (provided by BHRD) and one self-report measures, the CHOICE-short form (a 12- item recovery measure);
- Commitment to identify and support one or two CBTp Champions in completing Champions training.
- Propose and support, at minimum, one or two CBTp Champions during this phase of the project. Champions may be identified as candidates for Train the Trainer sequence planned as a future phase; and
- Commit to provide at least one annual training to new cohorts of clinical staff in the full model.

- Provide high-level monthly report to BHRD on required program activities (BHRD to provide template).
- Agency leadership meeting with BHRD staff monthly for 30-minute check-ins to discuss training progress, implementation of CBTp program, and other trainee support.
- Provide high-level monthly report to BHRD on required program activities (BHRD to provide template).
- Agency leadership meeting with BHRD staff monthly for 30-minute check-ins to discuss training progress, implementation of CBTp program, and other trainee support.

Foundational Training Requirements for All Participants
All agency staff participating in the CBTp training program must be trained in Foundational CBTp and must meet the following requirements. Additional staff may also participate in Foundational training without moving on to Group or Individual CBTp. No specific credentials are required for participating in this training component and agencies are encouraged to consider participants from a mix of roles (e.g., Peer Support Specialists, Mental Health Care Providers (MHCPs), and SUDP trainees (SUDPTs), MHP interns).

- Complete Asynchronous Training – Foundational Principals of CBTp (ePrimer)
- Complete Asynchronous Training Modules in Lyssn
- Attend one Skills Lab session with UW SPIRIT Center

Group Training Requirements
At minimum four participants must be identified to participate in CBTp Group Therapy training and implementation, two of which must be MHPs. Agencies are encouraged to consider participants from a mix of roles (e.g., Peer Support Specialists, Mental Health Care Providers (MHCPs), SUDP trainees (SUDPTs), and MHP interns). Participants must meet the following requirements.

- Complete Group Intensive Training
- Co-facilitate a weekly 60-90-minute CBTp group (2 group leaders per group at a time, led by at least 1 MHP, participating staff may rotate as group leaders)
- Attend at least 75% of monthly consultation calls as provided by UW SPIRIT Center

Individual Training Requirements
At minimum three participants must be identified to participate in Introduction to Individual CBTp training and implementation. Participants learning Individual CBTp must be MHPs. Preference is given to licensed MHP's with a strong commitment to enhancing access to evidenced-based psychological treatments for serious mental illness. Participants must meet the following requirements.

- Complete Individual Training
- Identify a minimum of three training cases, with whom you will meet weekly during the consultation period
- Track response to treatment using PsychSurveys platform (provided by BHRD) and two self-report measures, the CHOICE-short form (a 12-item recovery measure)
- Attend at least 75% of monthly consultation calls as provided by UW SPIRIT Center

Champion Training Requirements
In collaboration with UW SPIRIT Center, each agency will select one or two MHP's who have completed and met the above the requirements for CBTp Group or CBTp Individual training to support CBTp at their agency and become CBTp Champions. Champions will participate in additional training and have the opportunity to co-facilitate future rounds of training within their agency. Additional requirements for CBTp Champions are as follows:

- Submit session audio for review; demonstrate competence in at least two audio session
- Attend Champion Training Orientation Call

- Attend a minimum of 4 of 6 monthly training sessions provided by UW SPIRIT Center
- Complete asynchronous between session assignments
- Observe / co-facilitate a CBTp training with a UW SPIRIT Center trainer
- Lead an internal CBTp training

Invoice Program Specific Requirements

Method of Payment

- DBT Training: Reimbursement will be made on a one-time basis upon completion of DBT training.
- CBTp Training: Reimbursement will be made on a one-time basis upon completion of CBTp training.

Additional Requirements

DBT Training

- At the completion of the training, the agency will be able to invoice for $2,000 per staff member who successfully complete the training in recognition of the value of their time to the agency.
- DCHS BHRD staff reserves the right, at its sole discretion, to determine whether requirements for reimbursement have been met.

CBTp Training

- At the completion of the training, the agency will be able to invoice for $2,000 per staff member who successfully complete the training in recognition of the value of their time to the agency.
- DCHS BHRD staff reserves the right, at its sole discretion, to determine whether requirements for reimbursement have been met.

10.13 Low-Barrier Buprenorphine Service Expansion

Program Overview

As recommended by the Heroin and Prescription Opiate Task force, Behavioral Health and Recovery Division (BHRD) is partnering with community services Providers to address the region's heroin and opioid epidemic. As a result, Low Barrier Buprenorphine Services Expansion and Coordination was created to provide access to buprenorphine [an opioid partial agonist] for all people in need of services, in low-barrier modalities close to where individuals live. Moreover, individuals experiencing opioid use disorder, who desire opioid agonist pharmacotherapy with buprenorphine, have access to low-barrier treatment on demand. Treatment on demand is defined as the individual meeting with a prescriber immediately, or on day one or day two, to initiate treatment. A low-barrier or "buprenorphine first" model of care aims to use buprenorphine treatment induction and stabilization as the priority health intervention. Individuals who 1) are experiencing homelessness, 2) have limited or no support systems, and/or 3) have complex medical and behavioral health needs may experience difficulty successfully engaging and receiving care at traditional opioid treatment programs. A low barrier model of care is an alternative approach to opioid treatment that is client-centered, focused on harm reduction, and designed to engage a greater number of individuals experiencing opioid use disorder in effective opioid treatment.

Providers deliver and/or facilitate 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. Providers dedicate nurse care managers, care navigators, substance use disorder professionals, physicians, advanced registered nurse practitioners or other medical Providers to engage with potential clients.. When possible, the Provider bills Medicaid through the managed care organizations (MCOs) for reimbursement for prescriber time related to buprenorphine/MAT, those clients with Medicaid prescriptions are filled through pharmacies which have working relationships with

Providers. For those participants without Medicaid, flexible funds built into the program budget are utilized with some flexible funds also utilized to cover Medicare part D copays, in instances when clients lack resources.

When possible, Providers identify 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. Providers 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 can receive individualized treatment and support.

Providers are encouraged to train nurses and clinical staff 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 mental health clinicians, substance use disorder counseling, and linkages to housing, employment, crisis, shelter and nursing programs.

When the provider is responsible for coordinating buprenorphine treatment rather than directly providing the medication, the provider acts as the main centralized access point for those seeking buprenorphine and will do the following:

- Discuss MOUD treatment options with potential clients including how to obtain long-acting injectable forms of medication.
- Facilitate efficient and timely access to buprenorphine services.
- Discuss how naloxone can be used to reverse an opioid overdose and either directly distribute the medication to a client, explain how it can be accessed within a client's community, or facilitate how it can be ordered by mail for those who are uninsured.

With regards to accessing system-wide rapid access to low-barrier treatment for individuals experiencing substance use disorder who call the Recovery Help Line at Crisis Connections, they will be provided education and information about opioid use disorder, effective treatments that are available, and information about where they can go in their community to access those treatment services, including mediations for opioid use disorder. The Recovery Help Line will support low barrier access to MOUD by:

- Dedicating one full-time equivalent (FTE) position identified to manage the King County resources listed in the MOUD Locator and King County Walk In Flyer. Verify those listings for accuracy and update as needed, monthly. These will be online resources made available to the public as well as community partners.
- Within the MOUD Locator resources for King County, make searchable which buprenorphine providers work with specific populations of people, including specific ethnicities and age groups.
- Promoting the MOUD Locator and Walk In Flyer at King County conferences, local community events, and resource fairs, noting participation in the monthly report.
- Identifying which buprenorphine Providers have a low-barrier, harm-reduction approach in delivering services.
- Discussing with callers how naloxone can be used to reverse an opioid overdose and how it can be accessed within a caller's community, or how it can be ordered by mail for those callers who are uninsured.

- Contributing to ongoing data analysis and opioid use trends by submitting a monthly report that captures the number of opioid and MOUD related calls within King County and tracks the total number of MOUD programs that are currently active and accepting new clients/patients.
- Documenting successes as well as barriers in accessing MAT services;
- Conducting follow-up calls Recovery Help Line 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.

Invoice Program Specific Requirements

Method of Payment

- Actual cost reimbursement will be made monthly for FTE actuals and program expenditures.
- If a position becomes vacant, full reimbursement may be paid for up to two months for costs related to hiring to refill the position. If the position has remained vacant for more than 60 days, payment will be pro-rated for the vacant FTE as follows:
- Total actual payroll hours provided for the period divided by total hours that should have been provided equals percent of FTE provided, and
- Percent of FTE provided multiplied by the monthly allotment equals adjusted reimbursement for the month.

HealthPoint

- Reimbursement will be made monthly on an actual cost basis for 3.0 FTEs, prescription delivery and program expenses.

Neighborcare

- Reimbursement will be made monthly on an actual cost basis for 1.7 FTEs, and program expenses.

DESC

- Reimbursement will be made monthly on an actual cost basis for 2.3.0 FTEs..

Additional Requirements

- If a position becomes vacant, notification to the County is required in writing within seven business days. Notification should also include a plan for filling the position within 60 days of vacancy.
- Non-compliance with the MIDD evaluation data requirements may result in withholding of payment for all associated contracted services.

DESC, HealthPoint and Neighborcare

- Modifying the array of personnel (as described in the grant proposal) deployed to deliver low-barrier buprenorphine services is allowable. Notification to and consultation with the County regarding changes to the original staffing plan is required.

Low Barrier Buprenorphine Service* Coordination *Eligibility Criteria	
Medicaid Status	N/A
Age Range	N/A
Authorization Needed	No
Additional Criteria	• Individuals receive priority services as described in the Behavioral Health and Recovery Division (BHRD) Provider Manual • Individuals reside in King County • Individuals meet the medical criteria as identified by the attending physician. • Individuals meet the Provider's program eligibility criteria
Low Barrier Buprenorphine Service Reporting Requirements	

Monthly Reports	• Low Barrier Buprenorphine FTE Report • Low Barrier Buprenorphine Report (Crisis Connections)
Quarterly Reports	• MIDD CD-07b CORE Quarterly Reporting Spreadsheet
Semiannual Reports	• None
Annual/Other Reports	• The Provider participates with the MIDD Evaluation Plan. • Data are due 15 calendar days after the end of the quarter for which data are being reported, unless stated otherwise.
Performance Measurement (PM) Plan	• Reporting requirements and performance measures are further detailed in an accompanying Performance Measurement plan. See "Performance Measurement (PM) Plans" section on the Provider Manual and specific program PM Plan for more information

10.14 Medication-Assisted Treatment Shelters/Encampments

Program Overview

Opioid use disorder is an ongoing problem for many living in our County and providing them with access to evidence-based treatment is critical to promote recovery. Access to treatment is particularly challenging for those people utilizing shelters and encampments throughout the County who cannot or will not travel to clinics or medical offices. Providers provide Medication-Assisted Treatment (MAT) to people utilizing King County shelters and encampments. This program is funded by the MIDD Behavioral Health Sales Tax Initiative CD-07.

Program Specific Requirements

- Find, engage, assess and provide MAT (buprenorphine) in non-traditional settings directly to people utilizing shelters and encampments to allow them to begin the recovery process.
- Serve people residing in shelters and encampments in both Seattle and King County based on data provided by Public Health – Seattle/King County fatal and non-fatal overdose dashboards, other reliable data sources and the provider's knowledge of high need areas of the County. The Provider consults the County and the Public Health Mobile Street Medicine Team about the location of geographical service areas outside of Seattle where there is a high need for MAT services to this population.
- Develop collaborative working relationships with organizations that have credibility with people utilizing shelters and encampments including the Public Health Mobile Street Medicine Team and other behavioral health and primary care Providers serving this population.
- Public Health will use funding to support the Mobile Street Medicine Team's prescriber and behavioral health provider FTE for service provision in South King County, along with the Team's harm reduction, outreach, and medical supply costs.
- Provider keeps informed of changes to federal and state laws and regulations to allow MAT to be provided in the most creative and flexible manner possible to effectively serve this population.
- Whenever possible, provide MAT services to people utilizing shelters and encampments outside of normal business hours.
- Work collaboratively with the County's Performance, Measurement and Evaluation team to develop performance measures related to the required MIDD Sales Tax evaluation process. The Provider collects client enrollment and demographic data in a format that aligns with King County. The format that data is reported to King County depends on the program model and specific service delivered. King County is moving toward client-level data collection for services that work with clients over time. Service and outcome information is collected in a format appropriate to the program model. Information about clients served should be collected continuously by the funded program and is regularly reported via DCHS' online reporting system currently under development. Data is used to

assess the quality of the services that clients receive, and the outcomes related to the program participants. Client-level data elements include client demographics, basic information about services provided, and outcomes of those services. The County works with Providers to determine which client-level data elements are appropriate for the service provision model and for the data collecting process that MAT programs develop.

- Participate with the Department of Community and Human Service Behavioral Health and Recovery program manager to develop periodic narrative reports to share information about milestones, program success or lessons learned, operations, participant stories, system change efforts and other requested information. The frequency and specific content of narrative reports is determined in collaboration with King County during the first few months of the contracting period.

Invoice Program Specific Requirements

Method of Payment

HEP

- Actual cost reimbursement will be made in monthly amounts for 3.45 FTEs to provide Medication-Assisted Treatment (MAT) services in shelters or encampments. Actual cost reimbursement will be made in monthly amounts for program expenditures and supplies, including cash value cards for hepatitis testing services and/or receiving medications for opioid use disorder and for the purchase and distribution of IM naloxone.

RYTHER

- Actual cost reimbursement will be made in monthly amounts for 3.823 FTEs to provide Medication-Assisted Treatment (MAT) services in shelters or encampments.

PUBLIC HEALTH MOBILE STREET MEDICINE TEAM

- Actual cost reimbursement will be made in monthly amounts for a combined 1.0 FTE to provide Medication-Assisted Treatment (MAT) services in shelters or encampments.

ALL

- If the position(s) become vacant, full reimbursement may be paid for up to two months for costs related to hiring to refill the position(s). If the position(s) remain vacant for more than 60 days, payment will be pro-rated for the vacant FTEs as follows:
  - Total actual payroll hours provided for the period divided by total hours that should have been provided equals percent of FTEs provided; and
  - Percent of FTEs provided multiplied by the monthly allotment equals adjusted reimbursement for the month.
- Reimbursement will be made on an actual cost basis for supplies, equipment, travel, training, incentives, printing and other costs related to MIDD-funded MAT.
  - The Provider will retain all records and supporting documentation (including receipts) related to the expenses incurred.

Additional Requirements

- If the position(s) become vacant, notification to the County is required in writing within seven business days. Notification should also include a plan for filling the position within 60 days of vacancy.
- Non-compliance with the MIDD evaluation data requirements may result in withholding of payment for all associated contracted services.
- One-time expenditures should be completed in consultation with and approved by the BHRD Program Manager.

Medication-Assisted Treatment – Shelters/Encampments	
Medicaid Status	N/A
Age Range	Adults and Youth

Authorization Needed	No
Additional Criteria	None
SOR Recovery Support Services Reporting Requirements	
Monthly Reports	MAT – Shelters/Encampments FTE Report
Quarterly Reports	MIDD CD-07CORE Reporting Spreadsheet
Semiannual Reports	None
Annual/Other Reports	Upon request, contribute to the MIDD Behavioral Health Sales Tax annual report.
Performance Measurement (PM) Plan	Reporting requirements and performance measures are further detailed in an accompanying Performance Measurement plan. See "Performance Measurement (PM) Plans" section on the Provider Manual and specific program PM Plan for more information

10.15 Older Adult Substance Use

Program Overview

The Older Adult Substance Use program provides substance use disorder (SUD) services to elderly and disabled adults with SUD needs. Generally, services occur in the individual's natural environment. The program serves people aged 60 or older and/or Medicaid Title XIX Case Management Core clients who are in need of SUD services. The Older Adult Substance Use program provides outreach, engagement, and treatment services which include evaluations, ongoing counseling, and referrals to appropriate resources, treatment, and medical care, and individualized treatment plans. The Older Adult Substance Use program also researches and develops resources, provides case staffing, and provides consultation to mental health staff and professionals from community agencies, including the Aging and Disability Services (ADS) and ADS subcontracted agency case managers, related to substance use issues, assessment, and care planning. Examples of appropriate referrals can include, but are not limited to, the following:

- Reclusive individuals who need, but refuse to access medical, mental health, or substance use disorder services.
- Individuals who, due to substance use problems, suddenly deteriorate or change behaviors which put them at risk of hospitalization.
- Individuals at risk of personal safety, inadequate nutrition, survival, and/or self/neglect
- Individuals of questionable competency unable to manage their own affairs.
- Services are provided during normal office hours Monday through Friday.
- Clients are seen in order of referral unless referent identifies needs as more urgent.
- The Older Adult Substance Use program is required to meet the following performance commitments (PC):
    - PC #1: 42 seniors and disabled clients with substance use challenges receive in-home client evaluation, counseling, and develop treatment plans.
    - PC #2 The Substance Use Disorder Professional (SUDP) provides 35 consultation sessions (each of 6 case management agency locations quarterly and an additional consultation session per case management agency as requested) to professionals and case managers on substance abuse issues, assessment, and care planning.
    - PC #3: 2.0 FTE Substance Use Disorder Professional (SUDP) provides substance use disorder services to people 60 years of age and older and Title XIX ADS & sub-contracted agency case management clients 18 years of age and older for 12 months.

- The Provider notifies Behavioral Health and Recovery Division (BHRD) of all staff changes affecting the program within seven (7) days of the resignation, firing or any other change. A plan for replacing the staff person including a timeline is submitted within fourteen (14) days of the resignation, firing or any other change. This includes the names of the staff involved in and/or impacted by staff changes.
- The Provider maintains timely and accurate records which reflect service levels, participant characteristics, specific actions taken to assist participants, service outcomes, and expenditures.
- The Provider does not require individuals who are eligible for services to participate in other services, activities, or programs as a prerequisite to receiving services, including, but not limited to religious activities.
- The Provider provides information and referral to other appropriate agencies if clients cannot be served by the Provider.
- The Provider identifies the services as funded by the City of Seattle Human Services Department and Aging and Disability Services, the local Area Agency on Aging for Seattle-King County, in all communication with members of the public and recipients of services. The Provider also posts a notice to this effect in a prominent place at each Provider location where such services are provided.
- The Provider develops, implements, and maintains a tool to determine client satisfaction with contract funded services.

Program Personnel Qualifications/Staffing Expectations

- Staffing levels are maintained at 1.0 FTE
- Qualifications for the 1.0 FTE substance use disorder counselor:
  - Certified as a Substance Use Disorder Professional (SUDP)
  - Geriatric experience preferred.
- The Provider conducts comprehensive in-home client evaluations, provides ongoing counseling, refers clients to appropriate community resources and medical care, increases socialization and, in most cases, develops an individually tailored plan for each client. The SUDP uses a variety of approaches to build rapport with clients to place necessary resources in the home. When appropriate, arranges for a psychiatrist to evaluate the client. B. Facilitates case staffing, makes care and treatment recommendations to ADS and sub-contracted agency case managers. C. Provides research and develops substance use resources, provides informal training and consults with professionals from community agencies (including the ADS & subcontracted agency Case Managers) on substance use issues, assessment, and care planning. D. Reviews medications and treatment plans with a psychiatrist and makes recommendations to prescribing physician when appropriate.
- Communication with ADS Case Manager: The substance use disorder counselor communicates or corresponds with the ADS or subcontracted agency Case Manager as follows: a. To confirm receipt of referral within 3 business days. B. When the initial home visit is scheduled or if unable to contact the client after three (3) attempts. C. If the client declines services. D. To provide a six-month individual services plan. E. If any significant events arise with the client. F. When services with the client have been terminated.
- The Provider maintains compliance with all Washington statutory and case law pertaining to adult protective services.
- The Provider operates under the principle of the least restrictive alternative to promote the older person’s control and independence to the greatest extent possible.
- To ensure quality provision and coordination of services, the Provider informs BHRD and ADS of any changes in program service capacity.
- The Provider coordinates regularly with ADS Program Specialist and ADS case management team to ensure effectiveness of services.

Consultant and evaluation services include:

- Outreach, engagement, and treatment services to clients.
- In-Home Evaluations/Counseling: A comprehensive level of functioning and substance use disorder assessment is completed in the residences of the referred adults. Documentation becomes part of the client's permanent, confidential client record. The evaluation should include a narrative summary, diagnostic impression, and therapy goals.
- Referrals to appropriate community resources, treatment, and medical care as needed.
- Care Planning and Consulting: Develop an individual service plan for each client using a variety of approaches to build rapport with clients, provide a variety of resources, and increase socialization. When appropriate, the SUDP arranges for a psychiatrist to evaluate the clients.
- Case Staffing: The SUDP participates in case staffing, make care planning and treatment recommendations to ADS and ADS subcontracted agency case managers, and review medications and treatment plans with the psychiatrist, making recommendations when appropriate. Staffing may occur in person or remotely using Skype or other teleconference technology.
- Development of Substance Use Resources: The SUDP researches substance use resources and provide feedback to professional team members and ADS and subcontracted agency case managers regarding available community services.
- Communicate with the client's physician regarding medical issues and medication review or recommendations.
- Expert consultation regarding SUD and geriatric mental health issues with ADS & ADS subcontracted agency case managers so that case managers within the Area Agency on Aging (AAA) have received a consult opportunity every quarter. Consultations may occur in person or remotely using Skype or other teleconference technology.

Invoice Program Specific Requirements

Method of Payment

- Reimbursement will be made for a 2.0 full-time equivalent (FTE) SUDP staff. For less than 2.0 FTE provided, the monthly amount will be prorated.
- The reimbursement will be pro-rated if less than the required FTE hours are provided. The adjusted reimbursement amount will be computed as follows:
- Total actual payroll hours provided divided by total hours that should have been provided = Percent of FTE provided.
- Percent of FTE provided multiplied by the Monthly increment = Adjusted reimbursement for the month.
- Payroll documentation will be submitted to support the billing for each FTE per month.

Additional Requirements

- Non-compliance with the MIDD evaluation data requirements may result in withholding of payment for all associated contracted services.

Older Adult Substance Use Eligibility Criteria	
Medicaid Status	Yes
Age Range	60 years of age or older or Medicaid Title XIX Case Management Core clients, defined as 18 years of age or older, financially and functionally eligible for Medicaid Personal Care, Community First Choice, COPES, New Freedom, or Roads to Community Living services.
Authorization Needed	Yes
Additional Criteria	Individuals must be in need of substance use disorder services and agree to services. Individuals must reside in King County.
Older Adult Substance Use Reporting Requirements	

Monthly Reports	• Older Adult SUD FTE Report • Older Adult SUD Performance Report
Quarterly Reports	• None
Semiannual Reports	• Older Adult SUD Narrative Report regarding program challenges and successes
Annual/Other Reports	• None
Performance Measurement (PM) Plan	• Reporting requirements and performance measures are further detailed in an accompanying Performance Measurement plan. See "Performance Measurement (PM) Plans" section on the Provider Manual and specific program PM Plan for more information

10.16 Mental Health First Aid

Program Overview

A program designed to increase the number of people in the community trained in Mental Health First Aid (MHFA). The goal of MHFA is to reduce public stigma and increase knowledge of resources and how to support individuals in behavioral health crisis while connecting them to professional support. Intended groups include the public, behavioral health (BH) workforce, and community-based human service organizations (CBOs), especially groups that may benefit the most, such as those that routinely engage with individuals needing BH support. The program is provided in accordance with the MIDD Behavioral Health Sales Tax Plan Initiative PRI-07 as outlined in the MIDD 2 Implementation Plan. The MHFA program is responsible for both delivery of direct trainings and for coordination of trainings provided by independent trainers. Individuals must be over 18 and live or work in King County to be eligible to receive Adult and Youth MHFA, and youth must be 15-18 years old and connected to a sponsoring organization such as a school or CBO to be eligible to receive teen MHFA.

Program Specific Requirements

- Minimum staffing of a 1.0 full-time equivalent (FTE) MHFA Coordinator, and a 1.0 FTE MHFA Specialist.

<u>Coordination Duties</u>

- Outreach, promote, schedule, and manage a combination of direct MHFA trainings, independent trainer-led trainings, and train-the-trainer courses.
- Recruit and maintain an active pool of trained, independent MHFA trainers.
- Provide presentations and trainings to interested parties on the availability of MHFA trainings as needed.
- Ensure that MHFA attendees meet geographic and other eligibility criteria.
- Ensure a minimum of 5 and a maximum of 30 attendees per training, and a monthly average of 8 attendees per training. Reschedule trainings if less than 5 individuals have completed registration and pre-work.
- Provide pre/post support to independent trainers and attendees for training completion/certification.
- Provide independent instructor informational/learning collaboratives as needed to ensure instructors are teaching most current MHFA curriculum.
- Attend monthly meetings with King County and identify areas to strengthen the curriculum, including cultural adaptability and improved inclusiveness.
- Coordinate with existing community efforts and state and local partners to create a sustainable model in King County.
- Monitor the MHFA budget and expenditures from all funding sources (i.e., MIDD) to ensure implementation within allocated budgets.

<u>Training Duties</u>

- The provision of Youth, Adult and Teen MHFA trainings throughout King County including the registration, pre/post work, and certification of attendees.

Equitable Outreach and MHFA Training Delivery

- Provide targeted outreach and cultivate ongoing relationships with populations and the organizations that serve them who may lack awareness or access to behavioral health resources, experience cultural stigma, and/or experience inequities in behavioral health outcomes. Groups include but are not limited to Black, Indigenous, and People of Color (BIPOC), LGBTQ+, refugees and immigrants, non-English speakers, individuals living in rural areas, and youth.
- Proactively offer and support modifications to MHFA trainings to provide them in a culturally and linguistically relevant manner, including the coordination and use of interpreter services and pre/post support as needed by the population(s) served.

Outcomes

- Per the MIDD Evaluation Plan for PRI- 07
  - Maintain a target of training 1,250 people per year.
  - Report the number of trainings provided per year with no specific number required, but sufficient to achieve the target number of individuals trained yearly.
  - Completed evaluation surveys that indicate the relevance and usefulness of the training.

Invoice Program Specific Requirements

Method of Payment

- Full reimbursement may be paid for up to two months for costs related to hiring to refill position. If position is vacant for more than 60 days, payment will be pro-rated for the vacant FTE as follows:
  - Total actual payroll hours provided for the period divided by total hours that should have been provided equals percent of FTE provided; and
  - Percent FTE provided multiplied by monthly allotment equals adjusted reimbursement.
- To complete the billing invoice process, submit all necessary monthly budget expenditures and programmatic materials per MIDD terms and conditions, including but not limited to receipts for instructor fees, training and marketing materials, attendee “seat” fees, general ledgers, payroll, etc.
- For reimbursement of MHFA Coordinator and Specialist(s) staff time, reimbursement will be made monthly in 1/12th amounts based on staff time allocated to MIDD funded MHFA positions and based on the approved MHFA budget.
- If positions become vacant, full reimbursement may be paid for up to two months of costs related to hiring to refill the position. If the position(s) have remained vacant for more than 60 days, payment will be pro-rated for the vacant FTE(s) as follows:
  - Total actual payroll hours provided for the period divided by total hours that should have been provided equals percent of FTE provided; and
  - Percent FTE provided multiplied by monthly allotment equals adjusted reimbursement.
- Reimbursement will be made monthly for staff time allocated for AP Payment Processing and Marketing based on actual hours worked with no reimbursement for staff vacancies; reimbursement is also based on the specific capped budget amounts for AP Payment Processing and Marketing per the MIDD approved budget.
- Reimbursement will be made monthly for all other expenses (e.g. including new instructor/education enhancement, Instructor fees, and participant fees) and are based on actual cost.
- Retain all records and supporting documentation related to the expenses incurred for the positions and fees (including receipts) described above and include all expenses on the MIDD MHFA Expense Report.

Additional Requirements

- If the position becomes vacant, notification to the County is required in writing within seven business days. Notification includes a plan for filling the position within 60 days of vacancy.

- Non-compliance with the MIDD evaluation data requirements may result in the withholding of payment for all associated contracted services.

Mental Health First Aid Eligibility Criteria	
Medicaid Status	N/A
Age Range	N/A
Authorization Needed	No
Additional Criteria	Live or work in King County to attend DCHS/BHRD MHFA training
Mental Health First Aid Reporting Requirements	
Monthly Reports	• Mental Health First Aid MIDD Expenditures Report • Mental Health First Aid Performance Report
Quarterly Reports	• None
Semiannual Reports	• None
Annual/Other Reports	• None
Performance Measurement (PM) Plan	• Reporting requirements and performance measures are further detailed in an accompanying Performance Measurement plan. See "Performance Measurement (PM) Plans" section on the Provider Manual and specific program PM Plan for more information

10.17 Rapid Re-Housing

Program Overview

The provision of housing services to eligible King County residents. Services are provided in accordance with the MIDD Behavioral Health Sales Tax Plan Initiative RR-04 Rapid Re-housing Oxford House Model. Eligible individuals for this exhibit are homeless King County residents who are applying to live in a King County Oxford House and have not lived in an Oxford House for the previous 12 months. Priority for this work is given to people who are enrolled and participating in an outpatient benefit with a King County contracted Provider and completing substance use disorder residential treatment. Oxford House makes every effort to engage a diverse group of people into Oxford housing.

Oxford House has two full time employees (FTEs) fully dedicated to King County residents and King County Oxford House, ensuring collaboration with Behavioral Health and Recovery Division (BHRD) and ICN partners. One FTE provides engagement to eligible individuals and support while they transition into and live in King County Oxford Houses. This includes determining and communicating a method for Providers to refer people for funding assistance, assuring each individual meets program eligibility criteria, tracking each individual by month to certify they are living in a King County Oxford House and working with individuals to address barriers to housing retention. The second FTE helps increase the housing stock available to individuals served in the Rapid Re-housing program by adding new properties.

Each eligible individual accepted into the program receives up to three months of housing and personal support at $822 per month while actively working on a plan to ensure continued housing and personal expenses are available once the four months ends. Some Oxford House residents may only need one- or two-months assistance before they can secure employment, become financially stable, and phase out their reliance on stipends. Oxford House assures residents needing three full months of housing are evaluated on a case-by-case basis.

Invoice Program Specific Requirements

Method of Payment

- Reimbursement will be made for a 2.0) FTE case managers to provide rapid re-housing services.
  - Each FTE will have 40 payroll hours per week;
  - Total staff payroll hours provided will include actual hours worked, holidays, jury duty, bereavement, and sick and vacation leave up to five consecutive business days; and
  - Submit payroll documentation to support the billing for each FTE per month.
- If the position becomes vacant, full reimbursement may be paid for up to two months for costs related to hiring to refill the position. If the position has remained vacant for more than 60 days, payment will be pro-rated for the vacant FTE as follows:
  - Total actual payroll hours provided for the period divided by total hours that should have been provided equals percent of FTE provided; and
  - Percent of FTE provided multiplied by the monthly allotment equals adjusted reimbursement for the month.
- Unit reimbursement will be made monthly for housing services received by each eligible person residing in a King County Oxford House.

Additional Requirements

- If a position becomes vacant, notification to the County is required in writing within seven business days. Notification should also include a plan for filling the position within 60 days of vacancy.
- Non-compliance with the MIDD evaluation data requirements may result in withholding of payment for all associated contracted services.

Rapid Re-Housing Oxford House Model Eligibility Criteria	
Medicaid Status	N/A
Age Range	N/A
Authorization Needed	No
Additional Criteria	King County resident living in a King County Oxford House
Rapid Re-Housing Oxford House Model Reporting Requirements	
BHRD Information	None
Monthly Reports	• Rapid Re-Housing FTE Report • Rapid Re-Housing Report
Quarterly Reports	None
Semiannual Reports	None
Annual/Other Reports	None
Performance Measurement Plan (PM) Plan	Reporting requirements and performance measures are further detailed in an accompanying performance measurement (PM) plan. See Performance Measurement (PM) Plans" section above

10.18 Recovery Café

Program Overview

Services provided under this scope are provided in accordance with the MIDD Behavioral Health Sales Tax Plan Initiative RR 09 with the goal of improving the health and wellness of individuals living with behavioral health conditions.

In 2020, Recovery Café opened its doors to this new location in the SODO neighborhood of Seattle. The alternative therapeutic model used at Recovery Café provides support, resources, and a community of care along the entire continuum of a person's need for recovery assistance. Whether a

person is in crisis, newer to recovery, in long-term recovery, experiencing a relapse, in a difficult life change, or in a mental health transition, Recovery Café is a refuge of care and evidence-based addiction support.

Recovery Café provides a community in which individuals can stabilize in their mental/physical health, housing, relationships and employment/volunteer service. This community helps individuals fulfill their potential and live meaningful lives. Recovery Café teaches people ways to manage their mental health, maintain sobriety and build a mutually supportive community. Through its work, Recovery Café prevents individuals from potentially lethal crises, avoiding the need for emergency intervention to stabilize that person, and allowing mental health and addiction support professionals to focus on health maintenance and additional harm reduction. Recovery Café's program is designed to help people maintain recovery, reduce relapse and fulfill their potential. Important elements of this work include:

- A healing milieu, including free nutritious meals, activities, computer access and individualized encouragement.
- Accountability groups called Recovery Circles, that are designed to prevent recurrence of substance use by reducing social isolation, providing positive modeling behaviors, and encouraging honest feedback, and increasing emotional support.
- Peer-to-peer member empowerment, enrichment and involvement.
- The School of Recovery, an educational program available to members featuring classes that address the underlying causes of addiction, teach coping skills, develop knowledge, learn new skills and build the resources necessary to begin and maintain recovery from substance use disorders.
- Referral Services to help members navigate the complex social services system to gain and maintain housing, health care, mental health services, legal assistance, and a base of support including positive and consistent relationships with service providers.
- 12-step meetings held in a dedicated space.

Current funding provides for operational costs of the Recovery Café and supports 5 FTEs that sustain recovery support services at this location.

Invoice Program Specific Requirements

Method of Payment

- Reimbursement will be made monthly on an actual cost basis for approved expenditures for the Recovery Cafe.
- Supporting documentation which lists the expenditures and includes the receipts related to costs must be submitted along with the invoice.
- The Provider retains all records related to the expenses incurred.

Additional Requirements

- Non-compliance with the MIDD evaluation data requirements may result in withholding of payment for all associated contracted services.

Recovery Café Eligibility Requirements	
Medicaid Status	N/A
Age Range	N/A
Authorization Needed	No
Additional Criteria	None
Recovery Café Reporting Requirements	
BHRD Information System	• None

Monthly Reports	• Recovery Café Monthly Costs
Quarterly Reports	• None
Semiannual Reports	• None
Annual/Other Reports	• MIDD Evaluation Plan
Performance Measurement (PM) Plan	• Reporting requirements and performance measures are further detailed in an accompanying performance measurement (PM) plan. See Performance Measurement (PM) Plans" section above

10.19 Reentry Case Management Services

Program Overview

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. The program is funded by MIDD Behavioral Health Sales Tax Initiative RR-6A2 –*Reentry Case Management Services*.

Reentry services works with adults who are transitioning out of a suburban jail in South and East King County and/or:

- Are not actively engaged in another behavioral health program;
- Require transitional support to maintain community connections;
- Are experiencing homelessness;
- Are cycling through the jails.

RCMS is an intensive, flexible, community-based team that works to connect individuals to behavioral health treatment, primary health care, and any other services that can assist with skill development.

Services provided will approach center around the participants' self-determination and individual recovery goals. Additionally, RCMS provides ongoing coordination with criminal justice system partners in order to support reentry and reduce incarceration and crisis system utilization.

All Reentry services will work to assist an individual through identified goals for up to 180 days that could include:

- Linkage to all social services including behavioral health and primary care
- Outreach and harm reduction-based care coordination
- Housing and housing stability focus
- Veterans Services (if qualifies)

Invoice Program Specific Requirements

Method of Payment

- Reimbursement will be made monthly on 1/12th basis for case management and behavioral health assessments.

Additional Requirements

- None

Reentry Case Management Services Program Eligibility Criteria	
Medicaid Status	N/A
Age Range	Adults Aged 18 Years and Older
Authorization Needed	Yes
Additional Criteria	Individuals who meet the above eligibility and will not be transferred to a WA State Department of Corrections (DOC) facility or out-of-county facility.
Reentry Case Management Services Program Reporting Requirements	
BHRD Information System	• Submit Data to the BHRD Information System as outlined in the BHRD Data Dictionary as requested by DCHS evaluator
Monthly Reports	• None
Quarterly Reports	• Reentry Case Management Staffing Report
Semiannual Reports	• None
Annual/Other Reports	• Minimum of two case studies or individual vignettes describing the participant's background, treatment and outcomes. • MIDD Annual Report • Annual Program Budget • Any other requested reports by the County.
Performance Measurement (PM) Plan	• Reporting requirements and performance measures are further detailed in an accompanying Performance Measurement plan. See "Performance Measurement (PM) Plans" section on the Provider Manual and specific program PM Plan for more information

10.20 Pretrial Assessment and Linkage Services (PALS)

Program Overview

This scope of work provides the behavioral health (BH) services component of a new court-ordered pretrial services program in South King County. It connects eligible adult felony pretrial defendants with secure linkages to substance use disorder (SUD) and mental health (MH) services, public benefits, and educational and vocational resources incorporating a validated needs-assessment tool. BH services offered through this program are culturally responsive, emphasize harm reduction, and utilize a trauma-informed, modified Therapeutic Community (TC) approach to address criminogenic risk factors. Funding is through the Mental Illness and Drug Dependency (MIDD) Behavioral Health Sales Tax Fund Initiative RR – 15. PALS (Formerly 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 and participants only attend for the services they're assigned to, rather than attendance five days per week at CCAP.

- Services are sited at an outpatient BH facility with trauma-informed, without 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.

Invoice Program Specific Requirements

Method of Payment

- Reimbursement will be made monthly on 1/12th basis for case management and behavioral health assessments.

Additional Requirements:

- None

PreTrial Assessment and Linkage Services (PALS) Eligibility Criteria	
Medicaid Status	Yes and No
Age Range	Adults Aged 18 Years and Older
Authorization Needed	Yes
Additional Criteria	• Pre-Treatment, Screening and Assessment: pre-trial adults who are ordered by King County Superior Court to report to PALS Services. • SUD Outpatient: Meet medical necessity for outpatient or intensive outpatient (IOP) treatment services; and • MH Outpatient: Assessed as appropriate and eligible for a Mental Health Outpatient Benefit as described in the Medicaid State Plan.
PreTrial Assessment and Linkage Services (PALS) Reporting Requirements	
BHRD Information System	Submit Data to the BHRD Information System as outlined in the BHRD Data Dictionary as requested by DCHS evaluator
Monthly Reports	• South KC Pretrial Staffing Report • South KC Pretrial Subsidized Client Report • South KC Pretrial Treatment Services Denial Report
Quarterly Reports	As requested by DCHS Evaluator or PSB Investment Monitor
Semiannual Reports	• None
Annual/Other Reports	• PALS 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 • More as needed for compliance with MIDD Evaluation and PME Plan. • Annual Program Budget

Performance Measurement (PM) Plan	• Reporting requirements and performance measures are further detailed in an accompanying Performance Measurement plan. See "Performance Measurement (PM) Plans" section on the Provider Manual and specific program PM Plan for more information

10.21 Sexual Assault Behavioral Health Services

Program Overview

Mental Health Professional (MHP) staff with expertise in sexual assault and substance abuse are co-located within a Community Sexual Assault Program (CSAP) to provide behavioral health treatment, referral, advocacy and supports for sexual assault survivors served by the organization. The program is provided in accordance with the MIDD Behavioral Health Sales Tax Plan Initiative PRI-09 – Sexual Assault and Behavioral Health Services as outlined in PRI-09 Description.

SA-BH Services programs include:

- Services provided by Mental Health Professional (MHP) staff with expertise in sexual assault and substance abuse. Staffing also includes the positions and FTEs as designated in the agency's proposal to provide expansion program services.
- Clinical supervision for MHP staff to ensure services are in compliance with the Washington Administrative Code (WAC) for behavioral health services and relevant mental health practice standards.
- Initial screening for sexual assault (SA) survivors using a standardized measure to identify potential behavioral health concerns.
- Behavioral health services including:
  - Assessment to identify individual's specific behavioral health needs and the types of interventions to address those needs.
  - Evidence-based trauma-focused therapy for those children, teen, and adult survivors of sexual assault who would benefit from the therapy.
  - Culturally relevant services to sexual assault survivors from immigrant and refugee communities in their own language.
  - Sexual assault-specific advocacy services on behalf of survivors until they are able to act on their own behalf.
  - Referrals to behavioral health treatment providers for individuals who need more intensive services.
- Completion of client outcome measures at baseline and at least one repeated measure during the treatment process.
- Developing collaborative relationships with behavioral health treatment providers to facilitate referrals for individuals who need more intensive treatment services.
- Consultation for community behavioral health or domestic violence agencies to ensure behavioral health treatment that addresses the specific trauma of sexual assault and/or specific consultation on complex cases.
- Collaboration with the System Coordinator to promote cross-systems training among the domestic violence, sexual assault and behavioral health treatment systems including training on evidence-based practices for use with sexual assault survivors who are diagnosed with posttraumatic stress disorder and/or depressive/anxiety disorders.
- Providing monthly data in accordance with established performance targets and outcome measures outlined in the MIDD Evaluation and Data Submission Plan for PRI- 09.
- Adherence to reporting requirements as noted.

Invoice Program Specific Requirements

Method of Payment

- Reimbursement will be made in monthly 1/12th amounts for Mental Health Professional (MHP) behavioral health services provided to sexual assault survivors.
- Reimbursement will be made in monthly amounts for FTEs as designated in the agency's proposal to provide expansion program services.
- If during any month an agency does not provide the designated full-time equivalency as noted, the agency should invoice for a prorated amount as described below. If the expansion position(s) become vacant, full reimbursement may be paid for up to two months for costs related to hiring to refill the position. If the position has remained vacant for more than 60 days, payment will be pro-rated for the vacant FTE as follows:
  - Total actual payroll hours provided for the period divided by total hours that should have been provided equals percent of FTEs provided; and
  - Percent of FTEs provided multiplied by the monthly allotment equals adjusted reimbursement for the month.
- Reimbursement will be made monthly for actual costs related to start-up and hiring for the expansion program.
- Reimbursement will be made monthly for actual costs related to infrastructure supports as outlined in the agency's expansion proposal.
- The agency retains all records and supporting documentation related to the expenses incurred for the services described above.

Additional Requirements

- For the expansion program, notification to the County of changes in staffing is required in writing within seven business days. If the change involves a vacancy notification should also include a plan for filling the position within 60 days of vacancy, as well as a coverage plan for any enrolled clients impacted.
- Trauma-focused therapy and appropriate direct advocacy services will be provided to a minimum of _*_ unduplicated clients. Additional numbers served will be negotiated for the expansion program.
  - 94 - HAAS
  - 128 - KCSARC
- Non-compliance with the MIDD evaluation data requirements may result in withholding of payment for all associated contracted services.

Sexual Assault Behavioral Health (SA-BH) Services Eligibility Criteria	
Medicaid Status	N/A
Age Range	Youth or adults (no age restrictions) who identify as sexual assault survivors
Authorization Needed	No
Additional Criteria	Must have no other source of payment for services (i.e. does not have Medicaid, other insurance, etc.). Must be a resident of King County.
Sexual Assault Behavioral Health (SA-BH) Services Reporting Requirements	
BHRD Information System	None
Monthly Reports	SA-BH Services Monthly Summary; Monthly Staffing Report (expansion staffing); MIDD PRI-09 CORE Reporting Spreadsheet
Quarterly Reports	None
Semiannual Reports	None

Annual/Other Reports	MIDD Annual Narrative Report; Provider Profile Update Report at minimum of annually or when things change.
Performance Measurement (PM) Plan	Reporting requirements and performance measures are further detailed in an accompanying Performance Measurement plan. See "Performance Measurement (PM) Plans" section on the Provider Manual and specific program PM Plan for more information

10.22 Substance Use Disorder Peer Recovery Services

Program Overview

Substance use disorder (SUD) peer recovery services are provided in accordance with the MIDD Behavioral Health Sales Tax Plan Initiative PR-11b– Peer Support. This funding integrates SUD peer recovery services within recovery community organizations that are not certified/licensed to provide SUD treatment services.

Contracted agencies provide 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 recovery coaches refer people to support services in the community as needed. Each individual served has a record established that records items such as screenings, documentation of services and any program agreements such as recovery plans.

Invoice Program Specific Requirements

Method of Payment

- Reimbursement will be made for a 3.0 full-time equivalent (FTE) to SUD Peer Recovery Services.
  - Each FTE will have 40 payroll hours per week;
  - Total staff payroll hours provided will include actual hours worked, holidays, jury duty, bereavement, and sick and vacation leave up to five consecutive business days; and
  - Submit payroll documentation to support the billing for each FTE per month.
- If the position becomes vacant, full reimbursement may be paid for up to two months for costs related to hiring to refill the position. If the position has remained vacant for more than 60 days, payment will be pro-rated for the vacant FTE as follows:
  - Total actual payroll hours provided for the period divided by total hours that should have been provided equals percent of FTE provided; and
  - Percent of FTE provided multiplied by the monthly allotment equals adjusted reimbursement for the month.

Additional Requirements

- If the position becomes vacant, notification to the County is required in writing within seven business days. Notification should also include a plan for filling the position within 60 days of vacancy.
- Non-compliance with the MIDD evaluation data requirements may result in withholding of payment for all associated contracted services.

Substance Use Disorder Peer Recovery Services Eligibility Criteria	
Medicaid Status	N/A
Age Range	18 years or older
Authorization Needed	No
Additional Criteria	• Meet the standards for low-income individual's eligibility. • Individuals are amenable to and requesting peer recovery services.

Substance Use Disorder Peer Recovery Services Reporting Requirements	
BHRD Information System	• None
Monthly Reports	• SUD Peer Recovery Services FTE Report
Quarterly Reports	• None
Semiannual Reports	• None
Annual/Other	• None
Performance Measurement (PM) Plan	• Reporting requirements and performance measures are further detailed in an accompanying performance measurement (PM) plan. See “Performance Measurement (PM) Plans”

10.23 Youth Connection Services

Program Overview

This program provides prevention and behavioral health stabilization support services to youth experiencing homelessness or who, as a result of being disconnected from their families, have come into contact with law enforcement, the juvenile justice system and/or have been identified through at-risk youth or truancy petitions. The program is provided in accordance with the MIDD Behavioral Health Sales Tax Plan Initiative CD-02.

Youth Connection Services (YCS) is a collaborative approach to serving youth and families and diverting them from unnecessary and/or prolonged law enforcement and juvenile justice involvement. Once a referral is made, Crisis Connections determines the level of need and dispatches YCS staff as either an emerging or non-emergent outreach. For an emerging event, the outreach team responds to provide face-to-face stabilization services at the site of concern. The program also ensures that youth receiving a stabilization support response receive continuity of care through connections with relevant community-based and culturally responsive services. For a non-emergent outreach, a youth peer or parent partner is identified to work with the youth and/or the youth’s family to facilitate continued community-based service.

Youth Connection Services Eligibility Criteria	
Medicaid Status	N/A
Age Range	12-18 years old
Authorization Needed	No

Additional Criteria	Non-Emergent Outreach (NEO) Any child or youth ages three through 17, or person acting on their behalf, in King County, who are presenting with high risk factors including but not limited to: • Criminal/At-Risk activity; • Truancy; • Family conflict; • Homelessness or at-risk of homelessness; • Gang involvement/association; or • Substance use or abuse behaviors. Referrals may come from anywhere, but priority is given to youth referred by law enforcement personnel in Auburn, Federal Way and Kent. Service Area encompasses King County geographic areas including the following cities and zip codes **Auburn** (98001, 98002, 98071, 98092), **Federal Way** (98003, 98023, 98063, 98093) and **Kent** (98030, 98031, 98032, 98035, 98042, 98064, 98089).
Youth Connection Services Reporting Requirements	
Monthly Reports	Youth Connection Services Service/System Coordination Summary
Quarterly Reports	None
Semiannual Reports	None
Annual/Other Reports	Youth Connection MIDD Annual Report including: • A description of the activities, successes and challenges of the program • A summary of the accomplishment of outcomes/goals of the program.
Performance Measurement (PM) Plan	Reporting requirements and performance measures are further detailed in an accompanying Performance Measurement plan. See “Performance Measurement (PM) Plans” section on the Provider Manual and specific program PM Plan for more information

Goals & Objectives

- Divert individuals with behavioral health needs from costly interventions, such as jail, emergency rooms, and hospitals.
- Provide mobile response outreach Monday through Friday, 8am-6pm.
- Ongoing support services provided for up to 8 weeks.
- Support and increase the safety of youth who are experiencing crisis resulting from adverse community events and/or engaging in high-risk activities.
- Support and maintain individuals in current living situations and community environment by providing de-escalation, trauma-informed, and culturally appropriate interventions. Serve 100-150 youth annually.
- Act as a mediator with law enforcement and their ability to provide appropriate referrals for services to youth who may benefit from behavioral health treatment, coping skills and support resources.

Program Requirements

Staffing

The YCS team is comprised of the following staff:

- Certified Peer Counselors (CPC, WAC 182-115-0100)
- Program Manager, who, at minimum, holds a bachelor’s degree and has proven experience providing behavioral health, trauma-informed, and public safety support.

- Supervisor, who, at a minimum, holds a master's degree in a human or social services field and are clinically licensed in the state of Washington.

Response & Outreach

- YCS staff provide outreach within 60 minutes of a referral to determine level of acuity and engagement needs.
- YCS teams pursue the least restrictive response for individuals and groups identified as needing support.
- YCS teams are actively engaged in communities to build rapport and trust with individuals who may be hardest to reach and/or are on the fringes of social groups.

Stabilization Support

- Care Coordination
- Skill building
- Peer support
- Safety management
- Identifying and strengthening natural and community supports

Invoice Program Specific Requirements

Method of Payment

- Reimbursement will be made on a monthly allocated basis as outlined in the contract.

Additional Requirements

- Non-compliance with the MIDD evaluation data requirements may result in the withholding of payment for all associated contracted services.

10.24 SBIRT – Emergency Department Services

Program Overview

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 (SUD), 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 (ED), SBIRT Clinicians utilize validated screening measures to quickly screen for severity of substance use, and as indicated, initiate a brief intervention which may or may not be followed by referral to treatment. This scope of work is delivered in accordance with MIDD Behavioral Health Sales Tax Initiative PRI-01 Screening, Brief Intervention, and Referral to Treatment (SBIRT).

Goals

- To reduce the number of people with mental health and substance use disorders using costly interventions like jail, emergency departments, and hospitals.
- To foster the inclusion of briefer forms of drug and alcohol intervention and therapy.
- To reduce the number of individuals with substance use conditions in the hospital ED and increase access and referral to treatment.
- To reduce the incidence and severity of SUD and mental health disorders in youth and adults.

Objectives

- To promote universal SUD screening, brief intervention, and referral to SUD and/or mental health services to eligible patients who present in the ED.
- To provide referrals for assessments, BT, and SUD treatment to patients as indicated and in accordance with the individual's goals, values, and culture.
- To successfully integrate SUD screening and intervention services within selected hospital EDs.

Program Requirements

Components of SBIRT Clinical Practice
SBIRT consists of three components that are delivered according to the spirit, skills, and strategies of Motivational Interviewing. Screening is defined as using a validated tool that quickly gauges the severity of an individual's substance use to guide the level of intervention. Providers are to use the Alcohol Use Disorders Identification Test – Consumption (AUDIT-C) Plus 2. In the event that administering the screening tool is not clinically indicated, the SBIRT Clinician may proceed to the Brief Intervention. An example of this occurs when the individual presents with a clear need for substance use disorder treatment. Deciding not to screen should be a rare occurrence and based on clinical justification.

The next component in SBIRT is conducting the Brief Intervention according to the individual's needs. The general goal of the brief intervention is to guide individuals through considering the impacts of substance use on their physical and behavioral health and motivating behavior change. The essential elements are (a) exploring feedback about substance use, (b) eliciting the individual's thoughts on what they might be willing to change, (c) enhancing self-efficacy, (d) supporting the individual by understanding their perspective and drawing upon natural strengths and supports, and (e) negotiating a change plan. The brief intervention may be focused on harm reduction or treatment options, depending on the individual's goals, values, and culture.

The final component in SBIRT is Referral to Treatment. Based on the individual's needs, the SBIRT Clinician may provide referrals to the continuum of substance use disorder treatment such as withdrawal management, brief therapy, outpatient treatment, medication for substance use disorder, informal or formal peer support, or residential treatment. As mental health conditions often co-occur with alcohol and drug use, an individual may benefit from co-occurring disorder treatment to treat both simultaneously. Referrals to culturally appropriate and trauma-informed community resources are encouraged as there are many pathways to recovery.

Brief Therapy (BT) is available at one site for individuals who may benefit from short-term treatment. Generally limited to 5-12 sessions, BT is a systematic focused process that relies on assessment, patient engagement, and rapid implementation of change strategies. SBIRT Clinicians may provide a "warm handoff" from one provider to another to build on the motivation created during an SBIRT service.

Qualified Personnel
The Provider has one or more SBIRT Clinicians to implement SBIRT in accordance with funding stipulations. SBIRT Clinicians have at least one of the following clinical licensures/certifications as described in the Washington Administrative Code: (a) Substance Use Disorder Professional, (b) Mental Health Counselor, (c) Marriage and Family Therapist, (d) Social Worker. Additionally, they (a) have experience working with individuals who may have mental health and/or substance use disorders (SUD), (b) have completed agency-approved SBIRT training, (c) are able to use validated screening tools such as the Alcohol Use Disorders Identification Test – Consumption (AUDIT-C) Plus 2, and (d) have skills in Motivational Interviewing to facilitate effective brief interventions and referrals to treatment.

The Provider has a SBIRT Implementation Lead in accordance with funding stipulations. The SBIRT Implementation Lead has (a) expertise in hospital operations, systems, and workflow; (b) skills in facilitating change management; and (c) the ability to engage leadership support. Lastly, the Implementation Lead ensures participation by themselves, SBIRT Clinicians, and other identified personnel in quality improvement efforts as scheduled by the County, such as learning collaborative sessions and requests for information.

Information System Requirements
The SBIRT Implementation Lead will ensure client level data is collected and submitted into CORE according to the MIDD Performance, Measurement, and Evaluation (PME) Plan for PRI-01 in a timely

manner. Data is submitted monthly by St. Francis Community Hospital and quarterly by Harborview Medical Center. It is due by the 15th of the month following the end of the service month or quarter.

King County will share quarterly demographic reports from CORE that are specific to each provider. The reports summarize progress toward the annual goal of serving unduplicated individuals as well as demographics and characteristics of individuals served through SBIRT. SBIRT Teams will review the quarterly demographic reports for accuracy and quality assurance and communicate discrepancies between the data and their experience with the King County Program Manager. Annually, one SBIRT-EDS Learning Collaborative will be focused on discussing the prior year's SBIRT data to identify successes and opportunities for further service development.

Invoice Program Specific Requirements

Method of Payment

- Reimbursement will be made monthly for actual expenses.

Additional Requirements

- Non-compliance with the MIDD evaluation data requirements may result in withholding of payment for all associated contracted services.

SBIRT-EDS Eligibility Criteria	
Medicaid Status	N/A
Age Range	As clinically appropriate
Authorization Needed	No
Additional Criteria	Individuals who present to the emergency department for medical attention
SBIRT-EDS Reporting Requirements	
Monthly Reports	• SBIRT-EDS General Ledger or documentation approved by King County
Quarterly Reports	SBIRT-EDS Quarterly Narrative Report (Harborview Medical Center only)
Semiannual Reports	• None
Annual/Other Reports	• Provide specific information about the initiative for the MIDD Annual Report as requested by the County
Performance Measurement (PM) Plan	• Reporting requirements and performance measures are further detailed in an accompanying Performance Measurement plan. See "Performance Measurement (PM) Plans" section on the Provider Manual and specific program PM Plan for more information

10.25 School-Based SBIRT

Program Overview

School-Based Screening and Brief Intervention and Referral To Services (SB-SBIRT) seeks to promote better mental health and prevent substance use among middle and high school students (age 10-24). Schools and their community partners collaborate to offer SB-SBIRT programming during the school day, which assures that the necessary additional supportive adults and services are available to students within the space that they spend much of their time. This screening not only provides a snapshot of students' immediate needs; but also allows the program to focus on prevention through a semi-structured brief intervention model that facilitates access to relevant services and supports which may include treatment and caregiver connections.

In addition to direct student support, SB-SBIRT intentionally invests in systems- and policy-level change, allowing districts to use funds for infrastructure-building efforts such as MTSS implementation, trauma-informed practices, and staff training that strengthen student behavioral health across the

school community. While universal screening occurs at the middle and high school levels, SB-SBIRT-supported systems work may take place at the elementary, middle, and high school levels to promote prevention, early intervention, and sustainable schoolwide impact.

The Provider supports and collaborates with their identified middle and high schools to conduct a universal screening for a specific identified grade level of students using the Check Yourself screening tool, then conducts brief interventions with students through reinforcing existing strengths and helping to identify areas for supports and finally provides students with referrals and follow-up as needed. School staff also engage parents/caregivers to participate in individual/family brief interventions or parent group sessions. Program staff attend and participate in a quarterly learning collaborative that spans the participating King County districts, as well as could take further subject area training.

Key Assumptions of the SB-SBIRT Program

System Level Change:

- A clear, coordinated, and integrated system of Tier 1, Tier 2, and Tier 3 emotional/behavioral supports within SB-SBIRT schools
- Strategic partnerships between districts, schools, and community-based organizations (CBOs) that result in equitable policies and systems to promote student well-being

Student Level Change:

- Increase the connectedness between students, caregivers/trusted adults, and school staff by recognizing and promoting student strengths and protective factors
- Address unmet social, emotional, and mental health needs of youth
- Decrease youth health risk behaviors including delaying the onset of substance use or reducing the prevalence of use

The Provider supports and collaborates with their identified middle and/or high schools to implement the SB-SBIRT Program in these key areas:

Program Administration

- Identify school staff or an outside partner to coordinate SB-SBIRT within each school building participating;
- Set clear expectations including the clarification of roles, responsibilities, and timelines to create a sustainable system; and
- Designate a staff person (or multiple persons) to attend the required grant meetings outlined below.
- Maintain accountability for any services delegated to subcontractors.
- Notify the County of all staff changes affecting the program within five business days of the resignation, termination, or any other change. A plan for replacing the staff person is submitted to the County within seven business days of the resignation, firing, or any other change. This plan includes timelines for replacing the staff person.
- Ensures identified middle and/or high schools are available for onsite visit for the purpose of observing the program and monitoring contract compliance.
- Reviews, develops and/or updates existing school planning, policies, and procedures that address suicide prevention, intervention, and post-intervention consistent with the Washington State Youth Suicide Prevention Plan.
- Provide King County, on an annual basis to be reviewed during the annual site visit, a clear written policy regarding how the school district responds to public records requests for SB-SBIRT data and, specifically, how the policy protects student Personal Identifiable Information as a result of participating in the SB-SBIRT program;

Screening

- Create an SB-SBIRT screening workflow attending to each tiered level of support.

- Complete a universal screen for (at minimum) one full grade as negotiated with the SB-SBIRT Manager using the Check Yourself web-based tool each school year.

Brief Intervention

- Conduct brief interventions with students utilizing the SB-SBIRT model and Motivational Interviewing skills and strategies.
  - Staff are required to follow up with students who screen into Tier 3 (identified safety concerns) within 24 hours of screening.
  - Staff are required to follow up with students who screen into Tier 2 (identified prevention concerns) within two weeks of screening.
- Engage with parents/caregivers to participate in individual/family brief interventions or parent group sessions.
- Ensure and attest that all staff performing SB-SBIRT brief interventions have the required skills to meet the needs of the students and youth as well as fulfill the program aims of SB-SBIRT. This includes appropriate knowledge of:
  - district policies and procedures concerning students who express suicidal thoughts or self-harm behaviors, as well as behaviors that fall under mandated reporter requirements,
  - have at least 12 hours of training in Motivational Interviewing,
  - participate in training around the Brief Intervention Model being used by King County,
  - know how to use the Tickit Health Platform,
  - understand the confidentiality, privacy policies, and procedures of their school district concerning student data and student data protection.
- Provide a full list of school and provider staff who perform the brief intervention at the beginning of each school year and ensure that they complete the training attestation in a timely fashion.
- Complete required documentation of the brief intervention via the “Brief Intervention Report” within the Tickit Health system, which tracks students who screen into the SB-SBIRT program at tier 2 or tier 3 and/or students who were met with after screening.

Referral To

- Map and update a comprehensive referral network;
- Provide students with individualized referrals and follow-up as needed.

The Provider ensures participating middle and/or high school SB-SBIRT practitioners, interventionists and/or school counselors have access, attend, and participate in:

- The annual SB-SBIRT Institute;
- The Brief Intervention Collaborative which happens quarterly, where staff can collaborate and address questions or concerns regarding implementation in the school building and information about the program can be disseminated regularly; and
- Other grant related training such as Motivational Interviewing to support in implementation of the SB-SBIRT model.

The Provider identifies and assigns an SB-SBIRT district lead (or designee) to participate in:

- The annual SB-SBIRT Institute;
- The Evaluation and Implementation Workgroup meetings three times a year to collaborate with participating districts regarding the progress of the evaluation and implementation activities, and
- The Data & Quality Assurance Workgroup to support districts in making sure their data is accurate, does not contain any student identifiable information, and how data can be shared responsibly out with interested communities and partners.

Evaluation Requirements

Best Starts for Kids (BSK) and MIDD Behavioral Health Sales Tax are committed to being able to tell communities and stakeholders what the outcomes are as a result of this funding. The Provider names a person who leads evaluation activities for this contract. The Provider and the BSK/MIDD Evaluation Team work collaboratively to track the strengths and challenges of implementing funded activities. The evaluation protocol and set of performance measures for the activities are co-developed and is intended to give Provider and BSK/MIDD leadership with useful information for decision-making, planning and program management.

- Engage in evaluation activities
- Dedicate 10 percent of the award for evaluation into program staff time;
- Identify and assign an SB-SBIRT district lead (or designee) to participate in scheduled Evaluation and Implementation Workgroup meetings to collaborate with participating districts regarding the progress of the evaluation and implementation activities.
- Establish and maintain data sharing agreement(s) to ensure collaboration and transmittal of data with King County and their provider(s) as needed;
- Participate in activities to support evaluation and learning which may include group meetings to share learning with other providers working on similar strategies, assistance with recruiting teens/parents for their feedback, or administration of surveys for evaluation data collection; and
- Provide additional data or information to King County staff and/or their evaluation provider(s) outside of the regular reporting schedule to respond to specific requests.
- Evaluation Plan

Work in collaboration with King County staff and/or their evaluation provider(s) to refine an Evaluation Plan during the contracting period. The Evaluation Plan uses a format to be supplied by King County or their Provider(s) and includes, at minimum: performance measures and reporting requirements. At least one of each type of performance measure (below) is included in the final Evaluation Plan. When there are multiple Providers working on a related strategy, the Evaluation Plan also includes at least one strategy-level performance measure.

- Quantity of service provided: How much did we do? *For Example:*
  - Percentage of learning collaborative meetings attended.
  - 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 is connected to services.
- Quantity of clients that are better off: Is anyone better off? *For Example:*
  - Percentage of clients with improved health and well-being or with increased skills, knowledge or changed behaviors. For policy, systems, or environment projects, this is usually a narrative description of the change that a Provider has seen as a result of their work.

King County is the final arbiter for the Evaluation Plan and any subsequent revisions. The Evaluation Plan is considered final after email confirmation of acceptance is received by both parties.

Invoice Program Specific Requirements

Method of Payment

- Reimbursement will be made monthly based on actual costs for SB-SBIRT program expenditures.
- The agency retains all records and supporting documentation (including receipts) related to the expenses incurred.

Additional Information

- Non-compliance with the MIDD evaluation data requirements may result in withholding of payment for all associated contracted services.

SB-SBIRT Eligibility Criteria	
Medicaid Status	N/A
Age Range	Ages 10-24
Authorization Needed	No
SB-SBIRT Reporting Requirements	
Monthly Reports	• SB-SBIRT Financial Budget Report
Quarterly	• None
Semiannual Reports	• SB-SBIRT Narrative Report
Annual/Other Reports	• Completion of the "Brief Intervention Report" for each student who was met with and/or who screened into the SB-SBIRT process after screening • Completion of the Annual SB-SBIRT Site Visit
Performance Measurement (PM) Plan	• Reporting requirements and performance measures are further detailed in an accompanying Performance Measurement plan. See "Performance Measurement (PM) Plans" section on the Provider Manual and specific program PM Plan for more information

10.26 Supported Employment Program (SEP)

Program Overview

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 an SEP to assist with job placement activities or to directly perform many aspects of the client's job placement activities such as:
  - Identifying job leads;
  - Conducting job searches;

- Marketing the client to prospective employers;
- Assistance with developing effective resumes;
- Assistance with completing and submitting employment applications;
- Preparing the client for job interviews;
- Arranging for job-related disability accommodation needs; and
- Performing job-creation activities to match a client's skills and abilities to a needed series of tasks as identified by the employer.

In addition to job development, job development logs are completed by Vocational Specialists for all face-to-face employer contacts and submitted to the supervisor on a weekly basis. Logged contacts should be limited to face-to-face contacts about potential employment opportunities with business representatives who have hiring authority. Contacts with secretaries, cashiers, security guards, or other employees at a business may be helpful but do not count for this purpose.
Telephone and email contacts with a hiring manager do not count, nor do follow- along job support contacts with an employer for a person who is currently employed. Supervisors should review logs with employment specialists during supervision to determine the quality of employer contacts and to help specialists plan for next steps.

- **Client preferences guide decisions.** An initial vocational assessment/career profile occurs over two to three sessions and is updated with information from subsequent work or work-related experiences. The vocational assessment is completed by SEP staff. It should include information from the mental health treatment team and, with permission, from family members, friends, and past employers. Information is not gathered to determine employability but to determine the type of job and supports that will be required to help ensure successful employment. At a minimum, the initial work-based vocational assessment includes the following information:
  - Employment goals, preferences, and interests of the client;
  - Client strengths and skills;
  - Client experiences including, but not limited to, work and educational background;
  - Client's current adjustment to the community;
  - Personal contacts; and
  - Supports available and needed.
- **Individualized long-term "follow along" supports are provided.** Also referred to as "Extended Support Services," follow along supports include individualized support services provided to employed clients to help ensure job retention. Follow along supports are individualized for each client based upon the job as well as the participant's preferences, needs, strengths, work history, and other relevant factors. These services may be provided by mental health and/or vocational staff on the job site, in the Provider's office, or in the community. Employer support, such as educational information and job accommodations related to a particular client/employee, are acceptable Extended Support Services. Client assistance may include but is not limited to: individual and group vocational counseling, benefits counseling, on-the-job coaching, off-the-job meetings to talk about work and employer supports, facilitating family meetings to discuss the job, help with training on how to travel to the job site, assistance with grooming, coordinating mental health services and treatment changes with mental health staff as they relate to work performance, and social skills training.
- **Integrated with the treatment team.** Vocational specialists include the behavioral health treatment team in applying strategies to engage and support participants including those individuals in the pre-contemplative, job seeking, and employed stages of employment. The treatment team includes but is not limited to psychiatrists, nurse practitioners, therapists, case/care managers, peers, substance use disorder Providers, housing Providers and Providers from other systems as applicable to the needs of the participant.
- **Benefits counseling is included.** Benefits counseling services include services provided to a client by a benefits specialist familiar with Supplemental Security Income (SSI), Social Security Disability Income (SSDI), Social Security Administration (SSA), Medicaid, and Medicare regulations

and income limits as they relate to client income. Benefits specialists should also be familiar with work incentives, Medicaid spenddowns, Healthcare for Workers with Disabilities (HWD), food stamps, housing subsidies and childcare benefits. Benefits counseling services are provided prior to a client receiving Division of Vocational Rehabilitation (DVR)-funded services. Services result from a written benefits plan that is updated as needed.

- Service activities include vocational assessment and counseling; development of individualized job/career plans that include strengths, abilities, preferences, work history and desired outcomes; job development of competitive, integrated jobs in accordance with the career plan; assistance with resume development, interview skills, workplace "soft"/interpersonal skills, job placement and job retention supports; and internal or referral to external benefits counseling.
- Program design and service delivery should adhere to the IPS fidelity scale located here. Programs should strive to maintain an overall "good fidelity" rating (100-110 points in IPS rating scale) and upon request, demonstrate steps taken to improve IPS adherence if the fidelity rating is below "fair fidelity" (74-99 points in IPS rating scale.)

This program is funded by the MIDD Behavioral Health Sales Tax Plan Initiative RR-10- Behavioral Health Employment Services and Supported Employment. A portion of the total funding for SEP consists of a monthly base reimbursement for services. If specific participant level outcomes are achieved incentives-based funding is provided based on availability of funds and in accordance with the SEP Reimbursement Criteria document and its successors. All Providers must have a current Community Rehabilitation Program contract with the Department of Vocational Rehabilitation (DVR), make a timely request for all DVR services, and document the result of the request in order to be eligible for County reimbursement as DVR is the payer of first choice. DVR services include job placements, ninety-day job retentions, and Intensive Training Services. County funds will not duplicate, replace or supplant DVR funding or any other available employment funding including Medicaid funded supported employment through Foundational Community Supports (FCS) or its successors. Individuals receiving FCS supported employment services for less than six months prior to enrollment are not eligible to enroll in King County funded SE services. Further County reimbursement criteria are detailed in the Specialty Employment Program Reimbursement Criteria document and its successors.

Invoice Program Specific Requirements

Method of Payment

- Reimbursements for SEP base payments will be made in monthly 1/12th payments for SEP services.
- Reimbursements for pre-approved trainings are on an actual cost reimbursement basis.
- Reimbursement will be made quarterly for program outcomes (incentives) as outlined in the Supported Employment Provider Reimbursement Criteria and any successors.

Additional Requirements

- Requests for reimbursements must meet all Supported Employment Provider Reimbursement Criteria requirements and any successors.
- Non-compliance with the MIDD evaluation data requirements may result in the withholding of payment for all associated contracted services.

Supported Employment Program (SEP) Eligibility Criteria	
Medicaid Status	N/A
Age Range	Adults aged 18 Years or Older
Authorization Needed	Yes
Additional Criteria	Refer to IPS model of care fidelity scale here
Supported Employment Program (SEP) Reporting Requirements	
Monthly Reports	None

Quarterly Reports	Supported Employment Program Quarterly Outcomes Report
Semiannual Reports	None
Annual/Other Reports	Provide specific information for the MIDD Annual Report as requested by the County.
Performance Measurement (PM) Plan	Reporting requirements and performance measures are further detailed in an accompanying Performance Measurement plan. See "Performance Measurement (PM) Plans" section on the Provider Manual and specific program PM Plan for more information

10.27 Seven Challenges

Program Overview

Seven Challenges® (the Program) is a proprietary, copyrighted, and trademarked psychological mastery counseling program designed to treat adolescents with drug abuse and dependency problems. The Program consists of reading materials, journals, visual aids, group protocols, posters, group psychological approaches, evaluation instruments and models, counseling techniques, a training regimen, know-how, processes, and other technical and non-technical information.

Seven Challenges is responsible for quality assurance and consulting services to professional and staff personnel covered under the King County Behavioral Health and Recovery Division (BHRD) umbrella license, ("Providers") for the purpose of permitting and allowing such Providers to implement and use Seven Challenges in King County programs.

The Providers are responsible for providing Seven Challenges, at no charge, access to information and resources that permit Seven Challenges to accomplish the support described herein. Providers ensure trained clinicians have their own copy of required Seven Challenges materials to include the latest edition of the book entitled The Seven Challenges, together with the nine-volume journal set, The Seven Challenges Manual, one Seven Challenges poster, and one Working Sessions poster for use during the training and program. Providers participate in quarterly Seven Challenges fidelity and support meetings to include designated Seven Challenges Leaders. The goal of these meetings is to provide ongoing clinical and technical assistance to implement the Seven Challenges model.

Depending on King County funding allocation, the Providers are responsible for ordering required Seven Challenges materials and ensuring relevant staff receive needed Seven Challenges training (Seven Challenges Initial Training, Leader Training, and Refresher Training). Seven Challenges are responsible to coordinate with BHRD staff regarding funding availability then, upon King County approval, will ship Seven Challenges materials to the Providers and deliver the Seven Challenges training sessions.

Invoice Program Specific Requirements

Method of Payment

- Reimbursement will be related to The Seven Challenges annual license fee for the King County Behavioral Health and Recovery Division (BHRD) and selected agencies contracted with BHRD.
- License Fee provides for an annual Support/Fidelity Visit and a minimum of three Support Calls per year. The maximum actual cost reimbursement for the annual license fee is $6,238 total (to be billed out twice a year, usually $3,119.00 in July and $3,119.00 in November).

Seven Challenges Eligibility Criteria

Medicaid Status	N/A
Age Range	N/A
Authorization Needed	Yes
Additional Criteria	Provider personnel covered under the BHRD umbrella license.
Seven Challenges Reporting Requirements	
Monthly Reports	• Seven Challenges Monthly Report (including materials purchased and training sessions provided to the Providers).
Quarterly Reports	• None
Annual/Other Reports	• Annual Fidelity and Support Meeting Summary for The Seven Challenges agencies, complete with recommendations for improved fidelity and supervision.
Performance Measurement (PM) Plan	• Reporting requirements and performance measures are further detailed in an accompanying Performance Measurement plan. See "Performance Measurement (PM) Plans" section on the Provider Manual and specific program PM Plan for more information

10.28 Zero Youth Detention Behavioral Health Pilot Project

Program Overview

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 Care First (formerly Zero Youth Detention), this program 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 (PACT). The activities included in this scope are funded by the MIDD Behavioral Health Sales Tax Plan Initiative CD-02 Youth Detention Prevention Behavioral Health Engagement.

The Provider ensures that FFT, HB, and PACT services are accessible, and meetings are scheduled at times and in locations convenient for enrolled youth and their families/caregivers. Accessibility includes but is not limited to; accommodation of work and school schedules, services provided in homes and/or local communities, and availability of concrete funds to meet basic needs.

The Provider ensures staff operate within a trauma-informed, culturally and racially equitable, and recovery-oriented framework.

Zero Youth Detention Pilot Project Eligibility Criteria	
Medicaid Status	N/A
Age Range	Ages 12-18
Authorization Needed	None
Additional Criteria	Accept referrals solely made by King County Superior Courts Family Court Services

Zero Youth Detention Behavioral Health Pilot Project Reporting Requirements	
Monthly Reports	• IFD Service Report
Quarterly Reports	• None
Annual/Other Reports	• MIDD Annual Narrative
Performance Measurement (PM) Plan	• Reporting requirements and performance measures are further detailed in an accompanying Performance Measurement plan. See "Performance Measurement (PM) Plans" section on the Provider Manual and specific program PM Plan for more information

Goals & Objectives
- Universal access to behavioral health interventions for youth, young adults, and families in King County.
- Ongoing support services provided from up to 12 weeks.
- In person responses are default as identified and outlined by respective interventions
- Support and maintain individuals in current living situation and community setting, reducing risk of housing instability, engagement with the legal system, and/or emergency departments.
- Assist individuals and families by linking to ongoing resources and support to maintain wellbeing and engagement with identified goals.
- Promote and support safe behaviors in home, school, and community environments.

Staffing
- IFD teams are comprised based on the level of clinicians outlined by their organizational policy and the clinical needs of interventionists to facilitate modalities for Parents and Children Together (PACT), Homebuilders, and Functional Family Therapy (FFT).

Outreach & Response
- IFD staff provide services in coordination with Superior Court's Family Court Services and based on intervention availability.
- IFD is expected to outreach referred individuals in the manner in which is identified by the intervention modality and past on organization policy. For extenuating circumstances, IFD will communicate and coordinate alternative plans with FCS.

Invoice Program Specific Requirements

Method of Payment
- Reimbursement will be made on a monthly allocated basis as outlined in the contract.

Additional Requirements
- None

10.29 Wraparound

Program Overview

Wraparound is funded by the MIDD Behavioral Health Sales Tax Plan Initiatives: *CD-15 Wraparound for Youth and Families*.

Wraparound is a team-based planning process for non-Medicaid multi-system involved youth and their families that follows the established guidelines for high fidelity Wraparound. The overall goal of the program is to improve the health and wellness of children and youth living with behavioral health conditions. "Wraparound is commonly described as taking place across four phases of effort: Engagement and team preparation, Initial plan development, Implementation, and Transition. During the Wraparound process, a team of people who are relevant to the life of the child or youth (e.g., family

members, members of the family's social support network, service Providers, and agency representatives) collaboratively develop an individualized plan of care, implement this plan, monitor the efficacy of the plan, and work towards success over time." A hallmark of the Wraparound process is that it is driven by the perspectives of the family and the child or youth. The plan should reflect their goals and their ideas about what sorts of service and support strategies are most likely to be helpful to them in reaching their goals. For more information, please see https://nwi.pdx.edu/

Effective January 1, 2022, there are three (3) agencies contracted to provide this service. Effective July 1, 2025, these three (3) agencies will serve a collective total of thirty-nine (39) non-Medicaid youth and families at any point in time. All referrals will be screened, and total number of enrollees will be monitored, by King County Wraparound Program Manager.

- 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 of 8 children/youth
- Records and reports enrolled and discharged clients on a once per month basis to King County staff.
- Enrolls youth found eligible for MIDD Wraparound by King County ASO in accordance with King County procedures.
- Ensures that encounters are reported correctly and in a timely manner.
- Ensures that pertinent staff attend all County convened trainings, consultations and/or meetings for MIDD Wraparound.
- Assists each Child and Family Team with accessing flex funds, when necessary, in accordance with the King County Wraparound Flex Fund Policy.
- Adheres to the procedures for all CLIP referrals and discharges as defined in the Policies and Procedures of the CLIP Administration.

Invoice Program Specific Requirements

Method of Payment

- Reimbursement will be made monthly with at least 1 billable service at the rate noted per member.
- Reimbursement will be made monthly for flexible funding expenses on an actual cost reimbursement basis upon submission of back-up documentation.

Additional Requirements

- Submission of a list of KCID's for eligible youth for monthly payment.
- Maximum reimbursement for base rate is $734,400.
- Maximum reimbursement for flexible funding is $3,250 annually.
- Total annual amount will not exceed $737,650.
- Non-compliance with the MIDD evaluation data requirements may result in the withholding of payment for all associated contracted services.

MIDD Wraparound Eligibility Criteria (Non-Medicaid)	
Medicaid Status	N/A
Age Range	0-21
Authorization Needed	Yes

Additional Criteria	• King County resident • 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 Community Services) • Agrees to participate in the program
Wraparound Reporting Requirements	
Monthly Reports	• Wraparound Data Outcome Tool and Caregiver Strain Questionnaire to CORE • Wraparound Monthly Invoice to include a list of KCIDs for clients served in each month. • Wraparound Flex Fund Expenditure Report • Wraparound Discharge report due 5th of each month
Quarterly Reports	• None
Annual/Other Reports	• Assist in development of MIDD Annual Narrative Summary
Performance Measurement (PM) Plan	• Reporting requirements and performance measures are further detailed in an accompanying Performance Measurement plan. See “Performance Measurement (PM) Plans” section on the Provider Manual and specific program PM Plan for more information

11 Other Locally Funded Program

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.

Evidence Based Practices Eligibility Criteria	
Medicaid Status	N/A
Age Range	Adults at 18 Years and Older
Authorization Needed	No
Additional Criteria	None
Evidence Based Practices Reporting Requirements	
Monthly Reports	• None
Quarterly Reports	• None
Semiannual Reports	• None
Annual/Other Reports	• A summary of trainings provided with an assessment of Provider understanding and recommendations of next steps.
Performance Measurement (PM) Plan	• None

11.2 Community Outreach and Advocacy Team (COAT)

Program Overview

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 Washington Health Care Authority (HCA) funded Trueblood Diversion 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 competency restoration services (forensic mental health services). Trueblood Diversion programs aim to provide robust community support to prevent people from becoming Trueblood class members and interrupt recidivism for people who have received forensic mental health services. COAT is a behavioral health treatment team available to LEAD-Trueblood participants, it maintains staff to participant ratio of no more than 1:20 and provides core behavioral health services for people unlikely to utilize other outpatient behavioral health services. The team consists of mental health professionals, care coordinators, a psychiatric prescriber, a nurse, an occupational therapist, a Certified Peer Counselor, and a co-occurring disorders specialist who can provide flexible, intensive, and individualized care to enrolled participants.

COAT Services

- Assertive, low barrier engagement and outreach, soliciting motivation to participate in services.
- Community-based behavioral health services and comprehensive care management
- Health care services include wound care, assessment, and coordination of care with medical providers.
- Peer support services

- Psychiatric evaluation and medication management
- Occupational therapy assessment and rehabilitation
- Delivery of evidence-based psychotherapeutic interventions and promising practices such as motivational interviewing, cognitive-behavioral therapy for psychosis, dialectical behavior therapy, psychiatric rehabilitation, trauma informed care, etc.
- Co-occurring disorder treatment from a harm reduction orientation

Provider Obligations

- Provide services in a person-first, recovery-oriented, culturally sensitive, and trauma-informed care paradigm. Providers develop staff awareness of historical trauma and systemic racism which have contributed to racial disproportionality in the population receiving orders for competency services and provide culturally responsive care.
- Develop and implement staff training plans to address best practices, safety and compliance, and clinical competencies.
- Utilize safe practices to provide services to individuals who may have histories of violence and trauma.
- Maintain individual service records including:
  - A Medicaid-compliant intake assessment conducted at the soonest time possible, however completion of the assessment should not be a barrier to admission, outreach and engagement, and delivery of low-barrier behavioral health care.
  - An individualized service plan which reflects the person's desires and goals and identifies specific strategies and objectives to address needs and goals, with regular revisions to the service plan as goals are met and needs change
  - Documentation of services provided and progress toward service plan goals

Invoice Program Specific Requirements

Method of Payment

- Reimbursement will be made monthly on a cost reimbursement basis for administrative and program operations. This reimbursement will be the total program costs minus Medicaid payments for Medicaid eligible services received.
- Flexible funds will be reimbursed for actual costs incurred for participants.

Additional Requirements

None

Community Outreach and Advocacy Team (COAT) Eligibility Criteria	
Medicaid Status	N/A, but Medicaid eligible individuals will be served by COAT with an outpatient Mental Health Services benefit.
Age Range	Adults Aged 18 Years and Older
Authorization Needed	Yes
Additional Criteria	• Have a behavioral health condition and are a current or potential Trueblood class member. • Enrolled or in engagement status with the LEAD-Trueblood program.
Community Outreach and Advocacy Team (COAT) Reporting Requirements	
Monthly Reports	• COAT Monthly Report as provided by the County • COAT Expenditure Report

Quarterly Reports	• Provide information as requested by the county for HCA Trueblood Diversion narrative report.
Semiannual Reports	• None
Annual/Other Reports	• Any other requested reports by the County.
Performance Measurement (PM) Plan	• Reporting requirements and performance measures are further detailed in an accompanying Performance Measurement plan. See "Performance Measurement (PM) Plans" section on the Provider Manual and specific program PM Plan for more information

11.3 Family Intervention and Restorative Services (FIRS)

Program Overview

The Family Intervention and Restorative Services (FIRS) at the Judge Patricia H. Clark Children and Family Justice Center operates a non-secure, 24/7 respite facility, provides 24-hour line of site supervision, provides housing support services, and residential support services for eligible youth residing at the Children and Family Justice Center. The respite facility serves as a safe and temporary respite housing for the youth, while the family gets enrolled in social services. Staying at the respite facility and participating in the FIRS program is voluntary and available as resources allows. King County –Department of Community and Human Services (DCHS), King County Superior Court, and The Provider are collaborating to implement and operationalize a respite facility where eligible youth may stay when the family is experiencing juvenile domestic violence. King County –Department of Adult and Juvenile Detention (DAJD) and Superior Court are providing recently constructed building to be used as the respite facility, computer access, including printer use and internet access, language line access for translation services (as needed), linen, meal service, maintenance and repairs, utilities, and equipment to operate the respite facility safely and effectively. In addition, King County Superior Court is providing services staffed by juvenile probation counselors and Step-Up Social Workers.

Program Requirements

- Operate the seven-bed, 24/7 respite facility located at the Judge Patricia H. Clark Children and Family Justice Center for youth. This facility is non-secure and is a safe place for youth to stay while family intervention and restorative services are considered and arranged.
- Maintain at least two on-site staff at all times per Superior Court requirements.
- Provide at minimum 1,450 hours of housing support services and residential support services, including structured programming, at the respite facility per month.
- Provide 24-hour line of site supervision, housing support services, and residential support services at the respite facility for 7 residents at any given time. Staffing includes 1.0 FTE Program Manager, 8.0 FTE Residential Youth Counselor, 0.33 Director, 0.25 FTE Data Support Specialist, and 1.0 FTE Residential Youth Counselor on-Call.
- Meet annually with KC DCHS to perform a mid-year budget review by no later than July 30.
- Case consults and coordinate with Superior Court's Juvenile Probation Counselors (JPC) and Step-Up Social Workers, where appropriate, surrounding a case management plan.
- Participate in regular meetings with King County Superior Court staff to improve outcomes and indicators for youth referred by juvenile probation counselors.
- Provide culturally appropriate services and operates from a framework that supports recovery.

Invoice Program Specific Requirements

Method of Payment

- Reimbursement will be made monthly for allowable actual costs incurred for Program and Administrative expenditures up to annual maximums noted to provide family intervention restorative services to eligible individuals.
- Expenses will be reconciled monthly against the FIRS approved budget and general ledger.

Additional Requirements

- The Provider retains all records and supporting documentation (including receipts) related to the expenses incurred.

Family Intervention and Restorative Services (FIRS) Eligibility Criteria	
Medicaid Status	N/A
Age Range	12-17
Authorization Needed	N/A
Additional Criteria	Referred by Juvenile Probation Counselors
Family Intervention and Restorative Services (FIRS) Reporting Requirements	
Monthly Reports	• FIRS Expenditure of Actual Administrative and Program Service Report • FIRS State Report
Quarterly Reports	• None
Semiannual Reports	• None
Annual/Other Reports	• FIRS Client Profile Report • FIRS client success stories and photographs as well as more information on housing stability outcomes and project budgets.
Performance Measurement (PM) Plan	• Reporting requirements and performance measures are further detailed in an accompanying Performance Measurement plan. See "Performance Measurement (PM) Plans" section on the Provider Manual and specific program PM Plan for more information

11.4 Family Integrated Transitions

Program Overview

The Family Integrated Transitions (FIT) is a research-based program that provides intensive individual and family services to youth involved in the juvenile justice (JJ) system with mental health (MH) and substance use disorders (SUD). The goals of the FIT program include connecting the family with community supports, improving the MH status of the youth, and increasing prosocial behavior in order to lower the youth's risk of recidivism and use of alcohol and other drugs.

FIT uses the Multisystemic Therapy model with elements of Dialectical Behavior Therapy, Motivational Enhancement Therapy, and Relapse Prevention to serve a minimum of ten youth per clinician annually.

FIT clinicians provide services at a minimum of once weekly in the youth and family's home 24 hours a day, 7 days per week and access to face-to-face crisis response for each youth and their family for the duration of their enrollment in the FIT Program.

FIT services include:

- Assisting the youth participant in defining and identifying family and community;
- Conducting assessment(s) with each youth and family to determine interventions and the unique needs of each family, including what has worked and what has not worked for the youth and family;
- Preparing the family, utilizing education and encouragement strategies to increase trust and address resistance and/or unwillingness to participate;

- Defining and assembling the treatment team and/or community support;
- Developing a service plan with the youth and family that focuses on family strengths and sets goals in collaboration with youth and family members;
- Referring youth to inpatient short-term withdrawal management and psychiatric respite care with cross-discipline support when appropriate and if available;
- Providing referrals for psychiatric evaluation to determine appropriate psychotropic medications, as well as monitoring and counseling to support understanding, acceptance, and adherence to the medication regimen;
- Providing incentives to youth and families as rewards for meeting goals and treatment accomplishments;
- Continuing to work with both the youth and family while youth is on probation revocation status: when a youth goes on absconder, runaway, or escape status, the Provider continues working with the family for 15 days; after 15 days, the case is terminated; and with advance approval of the KCSC, the youth and family may be allowed back in the program;
- Conducting structured graduation ceremonies for youth and family who complete the program; and
- Working with the youth and family to develop long-term linkages in the community to prepare them to transition from the program, including:
- Strategies to transition families to long-term treatment and natural supports,
- Parent-to-parent support strategies, and
- Self-help group linkages.

The FIT Team works collaboratively with the assigned probation staff to develop joint decision-making processes regarding revocations and/or respite care and provides weekly updates either in person or electronically on active cases with to assigned probation staff that includes dates of meetings, current goals and a Case Summary of Supervision and Consultation.
MST-FIT services are provided to youth and families with fidelity to the MST-FIT evidence-based model and MST Goals and Guidelines document.

Family Integrated Traditions (FIT) Eligibility Criteria	
Medicaid Status	N/A
Age Range	11-17.5 years
Authorization Needed	Yes
Additional Criteria	• Qualifying scores from the Risk Needs Assessment developed by the Washington Policy Institute and administered by KCSC, and other criteria established by KCSC; • Referral by staff designated by the KCSC; • Meet the clinical and diagnostic criteria for the FIT Program; and • Have a family stabilization placement.
Family Integrated Transitions (FIT) Reporting Requirements	
Monthly Reports	• MST-FIT FTE Report
Quarterly Reports	• None
Semiannual Reports	• None
Annual/Other Reports	• None
Performance Measurement (PM) Plan	• None

11.5 Functional Family Therapy

Program Overview

Functional Family Therapy (FFT) is an empirically grounded, family-based intervention program for youth who have demonstrated the entire range of maladaptive, acting out behaviors and related syndromes. All FFT services provided comply with the FFT fidelity model and are monitored by Washington State FFT Quality Assurance. The goals of FFT are to decrease involvement in the juvenile justice system by youth receiving services and increase family communication and mutual support.

Services are accessible at times and in locations that are convenient for enrolled youth and their families/guardians. Accessibility includes services accommodating work and school schedules, and services being provided in homes and/or local communities.

FFT helps family members become aware of what they desire from each other, identify possible solutions to family problems, and to develop behavior change strategies.

Services are provided with absolute compliance to all FFT protocols and quality assurance processes.

Each full-time therapist carries a minimum of eight Juvenile Court Services (JCS)-referred families on their caseload at any given time. Each therapist serves no fewer than 32 JCS-referred families per year.

A minimum of 75 percent of the families referred by JCS are engaged (has attended at least one session after intake) into FFT services.

The Provider completes services with a minimum of 75 percent of active (has completed their first session after intake) JCS-referred families per calendar year.

FFT services are terminated after 45 days if the family has not engaged in services.

Minimum numbers served and completed may be adjusted if referral rates or other factors impact the Provider's ability to meet this requirement. The Provider notifies the County if referral rates or other factors that impact the Provider's ability to meet these requirements.

Mechanisms for formal contact with JCS are developed and maintained and includes referral procedures, problem solving related to program operations, and regular meetings with JCS staff involved with specific youth.

The Provider participates in an oversight group comprised of County and service Provider staff and collaborates with the King County Juvenile Justice System, including judges and Juvenile Probation Counselors (JPCs) to assure court orders are followed.

The Provider informs JPCs about the progress of youth on their caseloads who are enrolled in the program.

The Provider participates in all research requirements, including consistent adherence to the FFT model.

The Provider develops and maintains positive interagency relationships, including with at a minimum: mental health, drug/alcohol, child welfare, and schools.

The Provider adheres to all quality assurance processes as defined by the FFT services including, but not limited to participation in:

- Introductory clinical training series in FFT when new therapists are hired;
- Annual booster trainings
- All other trainings required by the JCS Project Manager;
- Weekly meetings including the Provider clinical lead and all therapists to discuss and coordinate cases;
- Bi-weekly case reviews;
- Regular data entry of case notes, client contacts, and other requirements into the FFT Clinical Services System (CSS); and
- Statewide quality assurance activities.

The Provider participates in quality improvement efforts as agreed upon by the Provider, JCS and BHRD:

- The Washington State FFT Quality Assurance monitors all FFT therapists statewide and initiates quality improvement efforts with therapists who are not competent in the FFT model.
- If quality improvement efforts fail, the Provider removes the non-competent FFT therapist from the position and replace the therapist.

FFT staff monitor the following metrics:

- Number of youth with decreased referrals to juvenile court following enrollment in services; or
- Number of youth with fewer days spent in detention following enrollment in services.
- Number of youth and their families exhibiting decreased risk factors or increased protective factors. At exit, families are assessed for their progress toward reducing family risk factors and improving family protective factors such as:
- Adults report increased family management or parenting skills;
- Parents report decreased barriers to being an effective parent; and/or
- Parents report increased positive communication with their child/children.

Functional Family Therapy Eligibility Criteria	
Medicaid Status	N/A
Age Range	11-18
Authorization Needed	Yes

Additional Criteria	• Eligibility is established by scores from the Risk Needs Assessment developed by the Washington State Institute for Public Policy and administered by JCS, and other criteria established by JCS. • Referrals to the FFT Program may only be made by staff designated by the JCS Project Manager. • Criteria whereby a referred youth may be refused or terminated are limited to those described below, and on a case-by-case basis, subject to approval by the JCS Project Manager. These criteria are: • The JPC does not want services and/or does not support the program; • The youth refuses to participate; • The caregiver refuses to participate; • The youth is on the run and/or a warrant is issued; • There is not enough time left in the period of probation; • Youth did not show up for any sessions; • Youth moved or is moving out of state; • Youth is in foster care or other placement less than 90 days or there is a plan for reunification in less than 120 days; • A Diagnostic and Statistical Manual of Mental Disorders-Fifth Edition (DSMV) diagnosis of Schizophrenia or Personality Disorder;
	• Youth in need of crisis stabilization because of active suicidal, homicidal, or psychotic behavior. Once stable, youth who meet the eligibility criteria may be referred into the FFT program; • Youth going into inpatient mental health services; • Youth diagnosed with a moderate or severe substance use disorder by a certified Substance Use Disorder Professional (SUDP); • Chemical Dependency Disposition Alternative (CDDA) youth; • Youth with Intelligent Quotient (IQ) scores of 69 or below; or • Youth participating in the Special Sex Offender Disposition Alternative (SSODA). • It is the responsibility of the Provider to immediately notify the JCS Project Manager and request a waiver if a youth has been referred who fits the exclusionary criteria shown above. • Priority of clients is as follows: • Juvenile offenders and their families as identified through the statewide Risk/Needs Assessment tool. Youth are selected based on risk/needs scores, therapist availability, and other criteria as described in the FFT description.
Functional Family Therapy Reporting Requirements	
Monthly Reports	• FFT Report
Quarterly Reports	• FFT Client Demographic Report • FFT TOM/COM Summary Report
Semiannual Reports	• FFT Data Elements Report
Annual/Other Reports	• None
Performance Measurement (PM) Plan	• Reporting requirements and performance measures are further detailed in an accompanying Performance Measurement plan. See

	"Performance Measurement (PM) Plans" section on the Provider Manual and specific program PM Plan for more information

11.6 Infrastructure Development

Program Overview

Infrastructure Development projects aim to strengthen and expand Behavioral Health and Recovery Division (BHRD's) behavioral health network. These projects may include the acquisition of property, building renovation and remodeling, or other start-up costs to create permanent facilities necessary for operating and providing long-term behavioral health services.

For the purchase of land, buildings and/or remodeling, the Provider:

- Completes the following documents provided by BHRD: Promissory Note, Deed of Trust and Covenant Agreement.
- Submits a plan of activities that outlines the process and steps toward purchasing and/or remodeling the building at BHRD approved site. This plan is submitted by the date requested by BHRD.
- Executes and records a covenant in a form acceptable to the County requiring that behavioral health services specified in this manual is provided at the site for no less than 20 years. The Provider's obligation to provide such services extends beyond the termination date identified, notwithstanding any provision to the contrary, and is enforceable by the County until satisfied.
- Executes a Covenant Agreement (Covenant) and a Promissory Note (Note) in the approved principal amount. The terms and conditions of the Covenant and Note are incorporated into Provider's contract by reference. The Provider also obtains an American Land Title Association (ALTA) extended title insurance policy naming the County as beneficiary.
- Follows sound standard business practices to ensure that public dollars are appropriately spent, including but not limited to the following actions:
- Purchases no property in which a board member or staff person has any financial interest;
- Obtains a Member of Appraisal Institute (MAI), Senior Residential Appraiser (SRA), or Residential Member (RM) appraisal which complies with the Uniform Standards of Professional Appraisal Practices. If the original appraisal exceeds $15,000,000 or involves income property, the Provider obtains a review appraisal, unless the County waives this requirement upon review of the particular circumstances of the acquisition.
- Purchases American Land Title Association (ALTA) extended title insurance naming the County as beneficiary.
- Has the closing documents prepared by an attorney or escrow officer.
- Reviews the Cost Settlement Statement to make sure all costs are eligible. The following costs are eligible: recording fees, transfer taxes, documentation stamps, title certificates, other evidence of title, boundary surveys, penalty costs and charges for repayment of any preexisting recorded mortgage entered into in good faith encumbering the real property, and the pro rata portion of any prepaid real property taxes and other charges such as water, sewer and garbage allocable to the period subsequent to closing or possession, whichever is first.
- Participates in County convened meetings relevant to the purchase of purchase of land, buildings and/or remodeling.

Additional Terms

- The Provider does not assign any portion of its rights or responsibilities under the Contract or transfer or assign any claim arising pursuant to the Contract, without the prior written consent of the County.
- No less than 60 days in advance of a proposed assignment, the Provider delivers to the County its request for consent to any such assignment, which includes information regarding the proposed

assignee's mission, legal status, and qualifications to manage and operate the Premises and to ensure provision of the same level of services.
- Within 15 days after such request for consent assignment, the County may request additional information reasonably available to the Provider about the proposed assignee.
- The County reserves the right to approve the Provider's proposed assignee or to conduct a selection process before approving an assignee. Any assignment without prior written consent by the County will be void.

For other infrastructure or start-up projects:
- Approved expenses are paid on a cost reimbursement basis.
- Refer to invoice for project specific detail.

Invoice Program Specific Requirements
Infrastructure Development - Crisis Stabilization and Walk-In Clinic (Connections)
Method of Payment
- Reimbursement will be made monthly on an actual cost basis for eligible expenses related to building construction as defined in Exhibit I of the contract.
- Supporting documentation which lists the expenditures related to infrastructure development costs must be submitted along with the invoice.
- The agency retains all records and supporting documentation related to the expenses incurred for the program.

Additional Requirements
- The Provider will provide proof of payment to DCHS no later than thirty (30) days from the date the funds were released by DCHS to the Provider.

Infrastructure Development for Cascade Hall
Method of Payment
- Reimbursement will be made monthly on an actual cost basis for capital funds for building improvements and operational start-up for the Cascade Hall Facility.
- Supporting documentation which lists the expenditures and includes the receipts related to infrastructure development costs must be submitted along with the invoice.

Additional Requirements
- None.

Infrastructure Development Reporting Requirements	
Monthly Reports	• As requested by BHRD per specific project
Quarterly Reports	• As requested by BHRD per specific project
Semiannual Reports	• As requested by BHRD per specific project (i.e. status reports in electronic copy that describe the status of the facility purchase)
Annual/Other Reports	As requested BRHD per specific project, such as updated plans and timelines for scheduled activities. • Submit a copy of the appraisal(s) and purchase agreement to King County Housing and Community Development prior to requesting reimbursement for the cost of the real property acquisition. • Submit a copy of the Cost Settlement Statement when requesting funds for real property acquisition.

Performance Measurement (PM) Plan	None

11.7 Facility Renovation

Program Overview

Facility Renovation projects aim to improve the availability and quality of behavioral health services by making necessary capital improvements, repairs, renovations, and/or expansions to behavioral health treatment facilities located in King County.

Facility Requirements

- Provider-owned or Provider-leased
  - If leased, site owner must support all proposed activities and complete Attachment B – Change of Use Restriction and submit it to King County Provider Relations contract lead. See "Behavioral Health and Recovery Division (BHRD) Capital Improvements" Request for Application (RFA) for attachments and additional Q+A.
  - Forms must be submitted and approved prior to incurring expenses.
- Located in King County
- Predominantly serves low-income residents of King County

Program Requirements

Providers assess project feasibility, including:

- Cost estimate
- Timeline
- Design
- Permitting
- Bids
- Zoning

Providers follow procurement procedures as outlined in their internal Procurement Policy and Procedure and within the application submitted to King County for the "Behavioral Health and Recovery Division (BHRD) Capital Improvements" RFA. Sound procurement procedures include:

- Vetting of subcontractors who will be performing work on behalf of Providers.
  - Ensure the most cost effective, qualified subcontractors are selected.
  - Ensure potential subcontractors are licensed/bonded and have a history of conducting the proposed work.
  - Providers may utilize the vendor outlined in the Provider's BHRD Capital Improvements application or utilize an alternate vendor who is able to complete the proposed project.
- Providers maintain all records related to procurement for a minimum of 6 years following the end of the King County contract. Records include written quotes, bids, estimates, or proposals.
- See Section 6 of the contract boilerplate, Maintenance of Records, for more information.
- Providers aim to complete all work prior to the end of the contract year, December 31, 2024.
  - Providers maintain at least monthly communication with their Provider Relations contract lead regarding project implementation and progress, including any delays or barriers to implementation.

- Extensions may be permitted where appropriate for Providers who have maintained regular communication and updates with their Provider Relations contract lead.

Allowable Costs
A 10% contingency allowance was included in all Provider budgets to cover discrepancies in budgeted vs. final expenses, as well as unanticipated costs. Agencies may submit an initial invoice for prepayment of up to 20% of their contract total. Costs incurred should align with the Provider's approved RFA application and budget. Allowable costs may relate the following:

- Architecture and engineering
- Permits, surveys, and tests.
- Construction hard costs, such as General Contractor, Subcontractors, and materials and supplies
- Taxes and fees
- Other costs as outlined in the Provider's approved RFA application.
- Unanticipated costs may arise and should be approved by the Provider's King County Provider Relations contract lead prior to incurring expense.

Unallowable Costs

- Retroactive funding (payment for goods, work or services that were delivered/performed prior to the contract effective date of March 1, 2024)
- Transportation/travel
- Office equipment (laptops, phones)
- Staffing costs or other staff salaries
- Mortgage, rent or utility bills.
- Purchase of new facilities

Facility Renovation Reporting Requirements	
BHRD Information System	• None
Monthly Reports	• Facilities Renovation Monthly Report
Quarterly Reports	• None
Semiannual Reports	• None
Annual/Other Reports	• None
Performance Measurement (PM) Plan	• None

Invoice Program Specific Requirements
Method of Payment

- Reimbursement will be made monthly on a cost-reimbursement basis for Facilities Renovation costs as outlined in the Provider's approved RFA application budget.
- A prepayment of up to 20% of the Providers contracted amount may be invoiced on a one-time basis at the beginning of the contract period to assist with start-up costs.

Additional Requirements

- Supporting documentation related to the expenses incurred (i.e., receipts, Subcontractor agreements, Subcontractor invoices, etc.) will be retained by the agency and provided upon request.

11.8 Start-Up Operations

Start-Up Operations is a period of 1-6 months prior to and immediately following the start of services at the beginning of the contract period. During this time, costs incurred related to staffing, training, consultation, travel, and accommodation may be covered using start-up funding, as outlined in the budget approved by King County. Travel, accommodation and per diems should follow agency internal policy and procedure; in the absence of an established Travel policy, agencies may refer to 2 CFR 200.475 or 5 U.S.C. 5701–11("Travel and Subsistence Expenses; Mileage Allowances") for established rates and guidance. King County can reimburse for pre-approved travel and subsistence expenses up to the maximum amount established by the U.S. General Services Administration: https://www.gsa.gov/travel/plan- book/per-diem-rates. Invoices are paid on a cost-reimbursement basis for pre-approved expenses, unless otherwise specified by the King County Contract Monitor. Expenses related to start-up that are not otherwise included in the contract budget must be approved by King County prior to purchase and/or incurring expense.

11.9 Medication-Assisted Treatment (MAT) Expansion

Program Overview

The Substance Abuse and Mental Health System Administration (SAMHSA) Medication-Assisted Treatment - Prescription Drug and Opioid Addiction (MAT-PDOA) grant funds the Medication-Assisted Treatment Expansion or MAT-EPIC project. MAT is the use of anti-craving medicine such as buprenorphine, in combination with behavioral therapy and support, to treat Opioid Use Disorders (OUD). The lack of prescribers and lack of support for existing prescribers contributes to the underutilization of MAT. The SAMHSA funded project increases Provider capacity to prescribe buprenorphine or naltrexone and during the contract year.

OUD is a chronic relapsing disease that can be effectively treated and managed, but there is no "one size fits all" approach. All practitioners working on the MAT project obtain a data waiver. The SAMHSA grant funds nurse care managers and navigators that allow the sites to serve new clients. The practitioner prescribes the medication while the nurses and other staff manage the care necessary to treat the complex needs of individuals with Opiate Use Disorder.

Program Requirements

- Develop outreach and engagement strategies to increase participation in, and access to treatment for diverse populations;
- Use innovative interventions to reach, engage, and retain clients in MAT-EPIC projects by providing services in locations where individuals with OUD already receive care;
- Refer and link patients for ongoing MAT-EPIC and other needed services, which will be offered at a needle exchange and at an "after hours" community health clinic;
- Screen all individuals with OUD for appropriateness for MAT-EPIC;
- Conduct a detailed clinical assessment to determine if clients meet the diagnostic criteria for OUD relative to MAT-EPIC, including a determination of opioid dependence, a history of opioid use, or a high risk of relapse;
- Conduct screening and assessment for co-occurring substance use and mental disorders and the delivery or coordination of any services determined to be necessary for the individual client to achieve and sustain recovery;
- Ensure all practitioners working on the MAT-EPIC grant obtain a data waiver;

- Check the state, county or local Prescription Drug Monitoring Program (PDMP) for each new client admission in compliance with rules and regulations;
- Provide MAT-EPIC using Food and Drug Administration (FDA) approved medications for the maintenance treatment of OUD in combination with comprehensive psychosocial services;
- Provide education, screening, care coordination, risk reduction interventions, testing and counseling for HIV/AIDS, hepatitis, and other infectious diseases for people with OUD who are receiving treatment;
- Provide support services designed to improve access to and retention in MAT-EPIC and facilitate long-term recovery;
- Build funding mechanisms and service delivery models in order to provide a robust suite of MAT - EPIC and recovery support services that effectively identify, engage and retain individuals in OUD treatment and facilitate long term recovery;
- Establish and implement a plan to mitigate the risk of diversion and ensure the appropriate use/dose of medication by clients.

Medication-Assisted Treatment Expansion Eligibility Criteria	
Medicaid Status	Medicaid and non-Medicaid clients
Age Range	18 years and Older
Authorization Needed	No
Additional Criteria	None
Medication-Assisted Treatment Expansion Reporting Requirements	
Monthly Reports	• Government Performance and Results Act (GPRA) data (twice a month) • MAT Expansion Staffing Report
Quarterly Reports	• None
Semiannual Reports	• None
Annual/Other Reports	• To be determined by SAMHSA-grant evaluator
Performance Measurement (PM) Plan	• TBD

11.10 Multisystemic Therapy

Program Overview

Multisystemic Therapy (MST) is an evidence-based model that provides intensive family- and community-based services in collaboration with KCSC that focuses on addressing all environmental systems that impact youth involved in the juvenile justice (JJ) system. MST clinicians provide services at a minimum of once weekly in the youth and family's home 24 hours a day, 7 days per week and access to face-to-face crisis response for each youth and their family for the duration of their enrollment in the MST Program.

MST services include Serving at least 32 youth either on probation and/or who have completed the Risk Needs Assessment. Each MST therapist maintains an average caseload of four, no more than 6, cases; collaborating with Superior Court to develop and implement mechanisms for formal contact with KCSC; providing accessible services at times and in locations that are convenient to enrolled youth and

their families/guardians and that services are available throughout the County; developing strengths-based, family-focused treatment plans reflective of the family's cultural beliefs and practices and designed to provide sustainable support to families after program termination; providing the Family Preservation Model and other therapeutic models identified during the MST Orientation Training and applying these models in the circumstances described as clinically appropriate; working with existing wraparound and/or family-centered teams that youth may be involved in; maintaining working relationships with the following systems: schools, drug/alcohol, mental health, child welfare, and other agencies or systems with which a youth is involved; identifying drug and alcohol treatment needs in the MST Treatment Plan and, where treatment is indicated, referring to a Substance Use Disorder Professional; participating in transition planning that assists youth and family members to become linked to appropriate service and treatment options in the event a youth and their family are not able to complete a course of MST treatment, at the completion of MST, or at termination from MST; ensuring that at least one MST staff is provided to represent the MST Team at all required meetings and court hearings; and adhering to at least the following quality assurance processes: MST Adherence Measure interviews conducted by an MST Inc. expert with each family enrolled in the program occurring after the second week of treatment and every four weeks thereafter for the duration of enrollment; weekly MST consultation provided by an MST Inc. expert pursuant to MST model adherence procedures; at least weekly clinical supervision and support to each staff providing MST services; and other statewide quality assurance activities, as directed by Behavioral Health and Recovery Division (BHRD) and the KCSC Project Manager.

MST services are provided to youth and families with fidelity to the MST evidence-based model and MST Goals and Guidelines document.

Multisystemic Therapy (MST) Eligibility Criteria	
Medicaid Status	N/A
Age Range	11-17.5 years
Authorization Needed	Yes
Additional Criteria	• Qualifying scores from the Risk Needs Assessment developed by the Washington Policy Institute and administered by KCSC, and other criteria established by KCSC; • Referral by staff designated by the KCSC; and • Have a family stabilization placement • Eligible youth who have referred must not be refused unless they meet the following exclusionary criteria:
	• Youth living independently, or youth for whom a primary caregiver cannot be identified despite extensive efforts to locate all extended family, adult friends, and other potential surrogate caregivers; • Youth in need of crisis stabilization because of active suicidal, homicidal, or psychotic behavior (once stable, youth who meet the eligibility criteria may be referred into the MST program); • Youth participating in the Special Sex Offender Disposition Alternative (SSODA) Program; and Youth with Intelligence Quotient scores of 69 or below.
Multisystemic Therapy (MST) Reporting Requirements	

Monthly Reports	• MST FTE Report • MST City of Seattle Status Report
Quarterly Reports	• None
Semiannual Reports	• None
Annual/Other Reports	• MST City of Seattle Annual Summary Demographic Report
Performance Measurement (PM) Plan	• Reporting requirements and performance measures are further detailed in an accompanying Performance Measurement plan. See "Performance Measurement (PM) Plans" section on the Provider Manual and specific program PM Plan for more information

11.11 Washington Recovery Alliance (WRA)

Program Overview

Washington Recovery Alliance (WRA) is a statewide, grassroots organization comprised of individuals in recovery from addiction and mental health conditions, families impacted by behavioral health conditions, and recovery community organizations driving change in two spheres related to behavioral health recovery: public policy and public understanding. WRA supports the cultivation of a well-organized group of community advocates working on behalf of behavioral health recovery and in partnership with King County. The King County Chapter of the WRA works collaboratively with community sector representatives of the Coalition to organize and train the recovery community and advocates to more effectively address and reduce the stigma often associated with behavioral health disorders and advance the recovery movement in King County.

WRA ensures all services and activities are designed and delivered in a manner sensitive to the needs of all cultural groups and ethnic minorities. WRA initiates actions to ensure or improve access, retention, and cultural relevance of recovery services, for cultural groups and other diverse populations in need of recovery services.

WRA develops a sustainability plan to ensure the continued viability of this body of work.

WRA develops and maintains a social media campaign to improve community understanding of mental health and substance abuse issues and detail any continuing maintenance.

WRA plans and executes a campaign to support individuals to open up around being in recovery from a mental illness or substance use disorder in an effort to reduce social stigma.

WRA works collaboratively with behavioral health Providers and other public entities to host recovery events throughout the year, including during recovery month in September. These campaign efforts document the connections and partnerships developed, the number of individuals participating in recovery events, and an annual summary of recovery events.

WRA creates public events and documents the number of events that have taken place, a description of the events created and the total number of individuals that participate.

WRA is developing a speaker's bureau of individuals in recovery who would receive training and coaching on telling their recovery stories and incorporating it into their social media campaign so that community partners are aware of it.

Washington Recovery Alliance (WRA) Eligibility Criteria	
Medicaid Status	N/A
Age Range	N/A
Authorization Needed	No
Additional Criteria	None
Washington Recovery Alliance (WRA) Reporting Requirements	
Monthly Reports	• None
Quarterly Reports	• None
Semiannual Reports	• None
Annual/Other Reports	• WRA Social Media Campaign Report • WRA Recovery Events Report • WRA Recovery Coalition Sustainability Report
Performance Measurement (PM) Plan	• None

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 works with Behavioral Health and Recovery Division (BHRD) as needed to make adjustments to service methodologies and procedures to ensure quality, performance, and client satisfaction.

The Provider reviews their Quality Management Plan at least annually. Such review incorporates updates and quality initiatives in line with the organization's quality goals. The Provider is responsible for maintaining this documentation internally. A revised date is imprinted on the document, indicating the last date of update. This documentation may be requested by BHRD during identified opportunities for quality review or improvement and during the development of performance plans.

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 is not grounds for an appeal, Administrative Hearing, or a Grievance for the client if similar services are immediately available in the service area.

Clients and Individuals may choose to file a grievance with the funder of their services at any time.

- Non-Medicaid funded individuals and clients may file a grievance at King County Behavioral Health Administrative Services Organization (BH-ASO), and
- Medicaid-funded clients may file grievances at their MCO.
  Providers may resolve complaints directly and are responsible for the following:
- Handling complaints through implementation of their individual policies and procedures.
- Ensuring that non-Medicaid funded individuals and clients are aware of their right to file a grievance with the BH-ASO, and that Medicaid-funded clients are aware of their right to file a grievance with their MCO. MCO and BH-ASO contact information for filing a grievance is included on individual and client rights publications, as well as agency policies and procedures.
- Providing relevant information to Behavioral Health and Recovery Division (BHRD) or MCOs to assist in effectively investigating and resolving grievances filed with the BH-ASO or with an MCO, if requested.
- Participating in evaluating the complaint/grievance system as requested.
  Contact information for individuals or clients to file a grievance:

Organization	Phone number
Amerigroup	1-800-600-4441
Community Health Plan of Washington	1-800-440-1561
Coordinated Care of Washington	1-877-644-4613
Molina Healthcare of Washington, Inc.	1-800-869-7165
United Healthcare Community Plan	1-877-542-8997
King County Behavioral Health and Recovery Division/BH-ASO	1-800-790-8049

12.2 Critical Incidents Program and Reporting Requirements

All Programs establish a Critical Incident Management System consistent with all applicable laws and include policies and procedures for identification of incidents, reporting protocols, oversight responsibilities, and for incorporation into its Quality Management plan.

Critical Incidents and Quality Management

Providers maintain appropriate policies and procedures outlining response and follow-up to Critical Incidents. Providers maintain a Critical Incident Committee consisting of appropriate clinical staff, quality improvement staff, and/or supervisors as necessary for the review and analysis of any causal factors for Critical Incidents.

Providers track critical incidents, identify trends, and address any patterns or trends identified that negatively affect individual and client safety or outcomes.

Providers increase intervention for clients when incident behavior escalates in severity or frequency. Examples of appropriate care and critical incident follow-up include, but are not limited to:

- Regularly scheduled internal reviews at a Critical Incident Committee to identify any contributing factors and/or strategies to prevent future similar occurrences and to direct agency protocol changes.
- Timely follow up and documentation procedures for the incident itself, which could include, but are not limited to referrals to additional services, referral for involuntary treatment, reporting to Law Enforcement, Critical Incident reporting to appropriate funding source(s), APS or CPS notification, and/or a Duty to Warn notification.
- Addressing high risk behaviors in crisis and treatment plans, including individualized strategies to manage risk.
- Ongoing assessment and frequent reassessment of risk, as needed.
- Steps or individual action plan created to minimize future harm.
- Increased frequency of contact based on acuity and risk.
- Increased support around safety planning, SUD support, and relapse prevention, as indicated.
- Increased outreach and contact with collaterals, as indicated.
- Use of clinical supervision and consultation with the treatment team and other partners to strategize how to best support the individual.
- Consistent documentation of all services provided including risk assessment, interventions, contact with collaterals, and outreach and engagement efforts.

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

Providers submit an individual Critical Incident Report to the funder of the services of the reporting program for the following incidents that occur:

- **Incidents that occur <u>to an individual</u>:**
  - **Abuse, neglect, or sexual/financial exploitation perpetrated by staff,** that occurred within a contracted behavioral health facility (inpatient psychiatric, behavioral health agencies), Federally Qualified Health Center (FQHC), or by independent behavioral health Provider.
  - **Physical or sexual assault perpetrated by another client,** that occurred within a contracted behavioral health facility (inpatient psychiatric, behavioral health agencies), or FQHC.
  - **Death*** that occurred within a contracted behavioral health facility (inpatient psychiatric, behavioral health agencies), FQHC, or by independent behavioral health Provider, **OR** Unexpected death where possible relationship with mental illness or substance use, or their treatment cannot be initially ruled out.

- **Incidents that occur 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
- **Other incidents:**
  - Unauthorized leave from a behavioral health facility during an involuntary detention
  - Any event involving an individual that has attracted or is likely to attract media coverage (Provider includes the link to the source of the media, if available)
  - Incidents posing a credible threat to an individual's safety.
  - Suicide and attempted suicide.
  - Poisoning/overdoses unintentional or intention unknown

Please note that reporting requirements are subject to change based on Health Care Authority contract requirements, recommendations from stakeholders, or through Behavioral Health Administrative Services Organization (BH-ASO) quality assurance and improvement process learnings.

Reporting this information to King County BHRD does not discharge the Contractor from completing any mandatory reporting requirements including, but not limited to, notifying DOH, law enforcement, Residential Care Services, and other protective services as necessary.

Reporting Critical Incidents for BH-ASO or Locally Funded Programs
Providers must report Critical Incidents no later than one (1) business day from when the Provider becomes aware of the incident.

Notes:
- If the client is served in PACT, report all unexpected deaths to King County Behavioral Health and Recovery Division (BHRD) regardless of facility or funding/payer status.
- Any media related incidents should be reported to the BH-ASO as soon as possible, and not to exceed one (1) business day.
- If the Provider is a subcontractor, the form should also be sent to the contracting agency.

Organization	Contact/Phone Number	CI Reporting Form
King County Behavioral Health and Recovery Division/BH-ASO	Email: 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. Providers report critical incidents according to the categories listed on the corresponding CI form for submission to that MCO.

Notes:

- If the client is served in PACT, report the critical incident to both the Medicaid Client's MCO, as well as the BH-ASO.
- If the Provider is a subcontractor, the form should also be sent to the contracting agency.
- If the individual has Medicaid and is only enrolled in BH-ASO or Locally Funded services/programs, send the Critical Incident Report to King County BHRD.

Organization	Contact/Phone Number	Link to CI Reporting Form
Wellpoint (P1: WLP)	Email: QMNotification@wellpoint.com Phone: 1-800-600-4441 Fax: 1-855-292-3770	82-0673 Critical Incident Form
Community Health Plan of WA (P1: CHPW)	Email: Critical.Incidents@chpw.org Phone: 1-800-440-1561 Fax: (206) 652-7056	Community Health Plan of Washington, Critical Incident Form
Coordinated Care (P1: CCC)	Email: wa_gocci_reporting@centene.com Phone: 1-877-644-4613 Fax: 1-866-270-1885	82-0673 Critical Incident Form
Molina Healthcare (P1: MHC)	Email: MHW_Critical_Incidents@MolinaHealthcare.com Phone: 1-800-869-7165 Fax: 1-800-767-7188	82-0673 Critical Incident Form
United Healthcare Community Plan (P1: UHC)	Email: wa_criticalinc@uhc.com Phone: 1-877-542-8997 Fax: 1-844-680-9871	Critical incident report form - UnitedHealthcare Community Plan of Washington

Critical Incident (CI) Reporting Criteria for Fee for Service funded individuals or programs billed directly to the HCA for individuals with active Medicaid, but no MCO for BH Services:
Providers must report Critical Incidents no later than one (1) business day from when the Provider becomes aware of the incident for the following incidents that occur:

- Abuse, neglect, or sexual/financial exploitation
- Arson
- Client's death
- Homicide or attempted homicide
- Kidnapping
- Media event where the client has attracted or is likely to attract media attention
- Medical emergency requiring 911 response and/or transport
- Perpetrator assault resulting in serious bodily harm

- Physical assault requiring medical attention
- Sexual assault
- Unauthorized leave from the contracted behavioral health facility during an involuntary detention

Organization	Contact/Phone Number	CI Reporting Form
WA State Health Care Authority	FFSquestions@hca.wa.gov	Critical Incident Form (HCA 82-0673)

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 person(s) involved and the nature and degree of their involvement;
- The individual's location at the time of the report if known (i.e. home, jail, hospital, unknown, etc.) and actions taken by the Provider to locate the individuals or clients if their location is unknown;
- Actions planned or taken by the Provider to minimize harm resulting from the incident; and
- Any legally required notifications made by the Provider.
- In the case of a death of an individual verification from official sources that includes the date, name and title of the sources. When official verification cannot be made, the Provider reports a description of all attempts to retrieve it.

Providers also 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 focus on risk, safety, and quality of services using the BH-ASO Critical Incident Review Guide and take place during annual clinical site visits or at an alternative agreed upon time.

Provider is expected to respond to requests in a timely manner regarding all inquiries related to Critical Incidents. Items flagged as high importance are to be expedited as requested based on timelines stated within the inquiry.

Review Process for Medicaid Funded Programs
The review process may vary depending on the MCO involved. Providers can expect to collaborate with either MCO or BH-ASO staff to review selected critical incidents.

Provider is expected to respond to requests in a timely manner regarding all inquiries related to Critical Incidents. Items flagged as high importance are to be expedited as requested based on timelines stated within the inquiry.

Attachments in this Section:
Attachment A: BHRD Critical Incidents Form

13 Provider Resource Guide

13.1 Behavioral Health Administrative Services Organization (BH-ASO) and King County Integrated Care Network (KCICN) Provider Resource Guide

The purpose of the Provider Resource Guide is to help behavioral health providers and agencies pursue clinical excellence in serving our community. The Provider Resource Guide includes both academic resources and guidelines, as well as quick reference materials and therapeutic tools. BHRD encourages the use of this document to assist provider staff in their day-to-day activities.

The BH-ASO Medial Director works with BHRD clinical staff, as well as provider agencies, to create and regularly review the Provider Resource Guide. Materials in the Provider Resource Guide are based on:

- The needs of clients and families in the communities served by provider agencies,
- Valid and reliable clinical scientific evidence, and
- Principles from the King County Equity and Social Justice Strategic Plan Providers are responsible for:
- Maintaining awareness of the Provider Resource Guide and sharing it with staff when appropriate.

Attachments in this Section:

Attachment A 2023 Provider Resource Guide

14 Behavioral Health Administrative Services Organization (BH-ASO)

This section describes BH-ASO specific guidelines within the King County Regional Service Area. 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 guidelines. Providers can identify which contracted programs fall under the BH-ASO by *Exhibit 5: KCICN BH-ASO Schedule of Services* in their contract package.

14.1 ACCESS TO SERVICES

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. Within available resources, the King County BH-ASO prioritizes services to the populations listed, who meet medical necessity, in the following priority order:

- Pregnant women who inject drugs
- Pregnant women with substance use disorders.
- Women with dependent children
- People who inject drugs

The following are additional priority populations, in no particular order:

- Postpartum Women (up to 1 year, regardless of pregnancy outcome)
- People transitioning from residential care to outpatient care.
- Youth
- People with criminal convictions

For non-crisis behavioral health services funded by General Fund-State, within available resources, priority is given to clients who meet financial eligibility, and meet one of the following criteria:

- Are uninsured;
- Have insurance, but are unable to pay the co-pay or deductible for services;
- Are using excessive Crisis Services due to inability to access non-crisis behavioral health services; and
- 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).

Medicaid Eligibility

- 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:
- As Medicaid eligibility for KCICN is established through managed care organization (MCO) Data provided by the contracted MCOs, if there is a discrepancy between an MCO’s system and ProviderOne, an agency can inform the KCICN, and KCICN staff will work with MCO to correct the inconsistency.

Clients In Foster Care or a Confidential Address Program

- A client in foster care or a confidential address program is considered King County BH-ASO Medicaid-eligible if the Provider indicates that the client is in this type of program and if the client qualifies for BH-ASO coverage in another BH-ASO.

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.

Clients Moving To King County Mid-Month

- This exception applies to new authorization requests that are on hold (in unauthorized "UA" status) due to a discrepancy between agency and ProviderOne Medicaid eligibility data.
- The BH-ASO will receive full 834 eligibility tables to King County monthly with the 834 "adds" and "deletions" coming to the ASO daily. The BH-ASO will track 834 eligibility table the "adds" and "deletions" to assure that information about changes in MCO enrollment occurring midmonth is recorded in the data system and utilized to avoid any gaps in service. This information is available to the Providers through the Extended Client Look-up System (ECLS). Providers are informed of this process and the need to utilize the ECLS for mid-month eligibility changes through KC's Information System Advisory Committee (ISAC). KC intends to provide daily updates to the Providers on all mid-month eligibility changes through the KC IT system in 2019 which will eliminate the need for Providers to use ECLS for this purpose.
- When an authorization request is received, King County BH-ASO and KCICN will compare the agency-supplied Medicaid coverage data with the MCO-supplied Medicaid coverage data. If there is a discrepancy, the authorization will not be approved and will be placed on hold. While the authorization is on hold, the discrepancy will be re-evaluated each time BHRD receives updated MCO data (typically on a daily basis). If the discrepancy is resolved; the authorization will be approved. If the discrepancy remains through the end of the month following the month of the authorization start date, the authorization will be cancelled.
- If a client moves to King County mid-month, that month will never show King County as the BH-ASO in the ProviderOne system. To address this, BHRD will apply the following month's BH-ASO coverage to the previous (partial) month. In order for this to happen:
  - The agency must indicate that the client lived in King County in the partial month;
  - There must be King County BH-ASO coverage for the first full month; and
  - There must be non-King County BH-ASO coverage for the partial month.

Effect of Change in Medicaid Coverage or Circumstances

- Continuity of Care due to change in Medicaid Coverage or Circumstance
  - 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.
- Authorizations that started as Medicaid-funded

  - 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.
  - Gain of Medicaid coverage: Payments for months that are now covered, but were previously suspended, are reinstated (resulting in a positive adjustment).
- Authorizations That Started As Non-Medicaid Funded
  - Loss of Medicaid coverage: There is no effect on payments.
  - 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.
  - The Provider will verify and document the individual's Medicaid eligibility when accepted into services and at every service thereafter. An individual receiving both Medicaid and Medicare will be eligible for King County BH-ASO or KCICN services as a Medicaid client who has a third-party resource.

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.

Non-Medicaid Eligibility
An individual not covered by Medicaid who is a resident of King County may be eligible for an outpatient benefit.

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

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

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.

Financial Eligibility Documenting and Reporting Requirements

- Client diagnosis must meet state and federal regulations, and justification for all diagnoses must be maintained in the agency records.
- 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.
- 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.
- See the Data Dictionary on Diagnoses for additional detail on the reporting of diagnoses information to BHRD Information System (IS).

- 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.
- Priorities for individuals who do not have Medicaid ("non-Medicaid") and will be funded by local funding.
- Must be a resident of King County.
  - 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.
  - The individual may not be covered by any other health insurance, aside from Medicare in some instances where their income is such that they may not be reasonably expected to meet their spenddown.

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

Criteria	First Priority for MH Benefits	Second Priority MH
State Hospital Discharge	• Being discharged from Western State Hospital (WSH) or HCA Long-term Civil Commitment Facility 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.	

Housing	Individual is residing in Standard Supportive Housing or Intensive Supportive Housing program or Shelter-Plus Care; and Will lose housing if MH services are not continued; Individual is residing in Long Term Rehabilitation or Supervised Living facility; and is stepping down to the SSH program.	
Community Inpatient Hospital Discharge (includes E&Ts)	Individual is being discharged within next 30 days or was discharged within last 30 days from inpatient stay.	Individual is being discharged within next 30 days; A Medicaid application is pending; and Hospital discharge social worker has received pre-approval from BHRD clinical specialist prior to discharge. Or see below on Frequent Admissions/ Detentions/Incarcerations.
Chronically Homeless		Individual is experiencing chronic homelessness (see Definitions); and LOCUS/CALOCUS score of at least 14- 16
Discharge from PACT	Individual is being discharged from PACT within the next 60 days; and Has received prior approval by the BHRD PACT Committee. A second year of benefits may be authorized, totaling two years of benefits since discharged from PACT.	
High Level of Care, All Ages		CALOCUS score is 17-19; LOCUS score is 17-19
Medium Level of Care, Children and Older Adults		Children (ages 10-17); or Older adults (over 60)
King County Residents without Medicaid or other insurance		Individuals without Medicaid or other insurance; Children of Individuals without Medicaid or other insurance; and LOCUS/CALOCUS score at least 14-16.

Medicare Qualifiers		Qualified Medicare Beneficiary (QMB); Specified Low-Income Medicare Beneficiary (SLMB); Qualified Individual (QI-1) Medicaid benefit; and LOCUS/CALOCUS score is at least 14-16
Current Non-Medicaid Benefit with Medicaid Application Pending		Currently enrolled in a non-Medicaid benefit; Not enrolled in a non-Medicaid benefit prior to current benefit; Does not meet other non-Medicaid eligibility conditions; and Has a Medicaid application submitted but not yet approved.
Frequent Admissions/ Detentions/ Incarcerations		Individual has had at least two admissions to any single facility or two admissions to any combination of the facilities below within the year previous to the referral date: • Any psychiatric stay. • Jail/youth detention – any stay that is recorded in a KC Department of Adult and Juvenile Detention database. LOCUS/CALOCUS score is at least 14- 16. Referrals from Youth Detention must be made by the children's justice liaison. Referrals from the KC Correctional Facility must be made by the MH Court Liaison.
		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

The following table describes the enhanced criteria for second priority populations for a mental health non-Medicaid outpatient benefit. These enhanced criteria are reviewed on an ongoing basis and contingent upon available funding.

Criteria	Enhanced Second Priority
Single Admission/ Detention/ Incarceration	Individual has been admitted to psychiatric inpatient services or jail or youth detention; LOCUS/CALOCUS score of at least 14-16; Admission occurred in the 12 months prior to the authorization request date.
Medium level of care for all Ages	Individual meets the criteria for a mental health outpatient medium level of care.

Homeless	Individual is homeless according to the BHRD data dictionary definition of homeless under the residential arrangement code; LOCUS/CALOCUS score of at least 14-16.

The following table describes first priority populations for the use of non-Medicaid resources for routine SUD outpatient benefits. Second priority populations for SUD outpatient benefits mirror the standard ones for MH however in place of the LOCUS/CALOCUS score the ASAM level needs to be 1.0 or 2.1.

Criteria	First Priority for *SUD Outpatient benefits
People leaving SUD residential treatment service including secure withdrawal management	Admission to residential treatment occurred within six months of request for authorization; and has an ASAM level of 1.0 or 2.1.
Pregnant or Post-Partum Women	Has an ASAM level of 1.0 or 2.1.
IV drug users	Is diagnosed with an opioid use disorder; is identified as an IV drug user; and has an ASAM level of 1.0 or 2.1.
People who have high utilization of sobering, Detox, EDs, jail and/or a history of multiple DUIs	Individual has had at least two admissions to any single facility or two admissions to any combination of the facilities below within the year previous to the referral date: 1. Detox, Sobering, or Emergency Departments (EDs); 2. Jail/youth detention – any stay that is recorded in a KC Department of Adult and Juvenile Detention database; 3. Drug Court involvement where CJTA is the payer; Has an ASAM level of 1.0 or 2.1.
People who are military veterans	Has an ASAM level of 1.0 or 2.1. Reports participation in military service.
Criteria	**Second Priority for *SUD Outpatient benefits**
Homeless	Continually homeless for a year or at least 4 episodes of homelessness in the past 3 years; ASAM level of 1.0 or 2.1
High Level of Care	ASAM level of 2.1
Medium Level of Care	Youth (10-17) or Older Adult (60 or over)
No Medicaid or Other Insurance	ASAM level of 1.0 or 2.1
Medicare	QMB, SLMB, or QI-1 Medicaid Benefit; LOCUS/CALOCUS score is at least 14-16 or ASAM level of 1.0 or 2.1
Current Non-Medicaid benefit with Medicaid application pending	Not enrolled in a non-Medicaid benefit prior to current benefit or does not meet other non-Medicaid eligibility conditions; has Medicaid application submitted but not yet approved
Frequent Admissions/ Detentions/ Incarcerations	Individual has had at least two admissions to any single facility or two admissions to any combination of the facilities below within the year previous to the referral date: • Any psychiatric stay. • Jail/youth detention – any stay that is recorded in a KC Department of Adult and Juvenile Detention database.

	ASAM level of 1.0 or 2.1

***Second priority SUD Outpatient benefits are funded as resources permit.**

- For mental health agencies that get a quarterly allocation, first priority benefits can be funded using the allocation or using the BHRD Clinical Specialist's non-Medicaid fund source, at the discretion of the agency. The Non-Medicaid Outpatient Benefit Request Form must be submitted.
- The allocation takes into account the expenditures for non-Medicaid benefits year to date, to account for any benefits authorized through the exception procedure or due to spenddown status.
- For mental health agencies without a quarterly allocation, both first and second priority benefits are drawn from the BHRD Clinical Specialist's non-Medicaid fund source. The Non-Medicaid Outpatient Benefit Request Form must be submitted.
- For SUD agencies, first priority and second priority benefits are drawn from the BHRD Clinical Specialist's non-Medicaid fund source. Non-Medicaid Outpatient Benefit Request Form must be submitted for all non-Medicaid SUD benefit requests.

Termination of Outpatient Services

- Termination of a benefit occurs when an authorization for services is ended prior to the original expiration date.
- A terminated benefit is payable to the date of termination.
- For the required terminations below, the date of the termination is the date of the event, unless otherwise specified.
- 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.
- A Provider must submit to the Behavioral Health and Recovery Division (BHRD) Information System (IS) a request to terminate a benefit under the following circumstances:
  - The client dies;
  - The client moves out of the County;
  - 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;
  - 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
  - The client is enrolled in the Program of All-inclusive Care for the Elderly (PACE).
  - 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:
  - Successful completion of the ISP where treatment goals have been met;
  - Inability to provide services to a client where factors other than those under the control of the Provider make the provision of care impossible;

- 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
- The client gains enough resources during the benefit to be treated as a private-pay client.
- 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.

Extraordinary Treatment Plan (ETP) Approval Requests
When a client has treatment needs that exceed the most service-intensive benefit within the BHRD outpatient or residential levels of care, an ETP funding request may be made to BHRD. ETP funds are provided only as resources permit. Requests for ETP funding will be submitted in accord with the Exception to Rule (ETR) / Extraordinary Treatment Plan (ETP) / Overlap of Service Request and Decision For Authorization Form. See attachment below.

Attachments in this Section:
Attachment A: Non-Medicaid Outpatient Benefit Request Form
Attachment B: ETR-ETP Overlap Request Form

14.2 OUTPATIENT SERVICES

For all age groups, regardless of funding source, the state plan modalities are available as described in the State Plan Modalities.

Coordination Of Care With Primary Care Providers And Other Treatment Providers
For individuals receiving outpatient services, the following information must be requested from the individual and the responses documented:

- The name of any current primary medical care Provider;
- Any current physical health concerns; and
- Current medications and any related concerns.

For individuals receiving Substance Use Disorder (SUD) services, release of information must be compliant with 42 CFR, part 2.

- Behavioral Health and Recovery Division (BHRD) Provider agencies ensure that each client's primary care Provider and other treatment Provider (if any) are informed of the name of the BHRD Provider agency and how best to contact the client's behavioral health care Provider and psychiatrist or psychiatric ARNP. Specific staff names need not be mentioned.
- Should the client change primary care or other treatment Providers, the new Providers is contacted by the BHRD Provider Agency with the contact information as above.

Providers need not provide the above information when:

- The client requests the information not be sent and the BHRD Provider Agency concurs with this request, or
- 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).

For individuals without a primary care Provider, the BHRD Provider Agency documents efforts to assist the individual in establishing care with one.

Other Available Services

- Interpreter services, including sign language interpretation and other services for clients who are sensory-impaired (see Client Rights section of the Provider Manual and HCA Interpreter Service Program here
- Health screen referrals;
- All authorized clients who have physical health needs must be referred to a qualified professional for a health screen if they have not been screened within the past year. For individuals over the age of 60, a referral for screening are made if the individual has not been screened within the past 90 days. These referrals must be recorded in the client's chart;
- 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;
- Residential and housing services for adults, according to WAC 246-341-0722 or its successor;
- Co-Occurring Disorder Screening (see Attachment J);
- Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) screenings for children and youth.

Intake Evaluation Requirements

- 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 include
- Current substance use including any SUD diagnoses and treatment status (Global Appraisal of Individual Needs Short Screener [GAIN-SS]);
- An identification of risk of harm to self and/or others, including suicide/homicide;
- (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.)
- Whether the individual is under the supervision of the Department of Corrections (DOC); and
- A recommendation of a course of treatment that:
- Addresses the presenting problem(s); and
- Identifies the use of one or more state plan modalities.

An intake evaluation is not required prior to the provision of:

- Crisis services;
- Withdrawal management services;
- Stabilization services; or
- Rehabilitation case management services.

Individual Service Plan (ISP) Development and Review

Development of the ISP must:

- Meet WAC 246-341-0640 requirements;
- ISP must be in place by the end of the first session (individual or group) following the assessment/intake.
- Be client-driven and strengths-based;
- Meet the individual's unique behavioral health needs; and
- Be developed in collaboration with the individual or with the individual's parent or other legal representative if applicable.

Updates must reflect:

- Any changes in the individual's treatment needs or as requested by the individual, or their parent or other legal representative if applicable;
- An assessment of current strengths and needs; and
- Input from other health, education, social service, and justice agencies, as appropriate and consistent with privacy requirements;
- 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;
- Coordinate with any systems or organizations the individual identifies as being relevant to the individual's treatment; and
- Coordinate with any individualized family service plan (IFSP) when serving children under three years of age.

Clinical Record Content
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, including:
- Documentation that any mandatory reporting of abuse, neglect, or exploitation consistent with Chapters 26.44 and 74.34 RCW has occurred;
- 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.

The following information must be requested from the individual and the responses documented:
- History of any substance use/misuse and treatment, including tobacco use;
- Any disabilities or special needs:
- When intellectual disabilities are identified in children and youth, include goals that focus on restoration to typical functioning;
- Previous history of use of inpatient or outpatient services and/or medications to treat a mental health (MH) condition; and
- Information about past or current trauma and abuse.
- If the Provider believes the client has a clinical need that the individual does not wish to address, this is documented and available for ISP revision.

Crisis Services For Clients Receiving Any Behavioral Health Outpatient Benefit
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.)

All behavioral health outpatient Providers must ensure crisis services 24 hours a day, 365 days a year to all clients authorized to a behavioral health outpatient level of care. This includes clients assigned to a Provider, regardless of whether the Provider has previously provided services to the client. Services include:
- Phone crisis services. This service is always considered emergent. Requirements for these services include:
  - If the Provider has a voice mail system or answering machine, the first information conveyed must be how to access emergency assistance;
  - Providing clients access to qualified clinicians without placing the client on hold or having to call another number;
  - There is immediate access to interpreter services and to individuals who are proficient in the use of TDD or alternate languages to serve individuals who are deaf or hard of hearing; and

  - 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.
- Other crisis services to be provided by all agencies contracted to provide behavioral health outpatient services. This includes clients assigned to a Provider, regardless of whether the Provider has previously provided services to the client:
  - Outreach and stabilization services in clients' homes or other appropriate places in the community.
  - Service coordination and discharge planning with the staff of the hospital diversion or crisis stabilization placements, for clients placed in those beds.
  - Medication Consultation
  - Procedures to coordinate with the regular treatment staff by the next working day if the crisis service is provided outside regular business hours.
  - Access to the client's crisis plan and advance directive, if applicable.
- If a client has a Wellness Recovery Action Plan (WRAP) and has requested a copy be available to crisis services staff, there is access to the client's WRAP.

Crisis Intervention Staff Qualifications

- 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;
- A minimum of a bachelor's degree in a related field or an equivalent combination of education and experience;
- Mental Health Professional (MHP) credential or supervised by an MHP (or a child MH specialist when appropriate);
- Documented receipt of annual violence prevention training on the safety and violence prevention topics described in RCW 49.19.030 (or its successors)
- Knowledgeable about community resources and utilization of natural supports;
- Proficient in assisting callers to identify and utilize their natural supports; and
- Skilled in assisting people to problem-solve and use their own strengths, resiliencies, and coping skills to reduce distress.

Additional Provider Requirements

- 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.
- 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.
- Providers educate clients and/or individuals who have legal responsibility for the client about when and how to use the designated crisis number. Providers provide this same information to families and/or other natural supports as appropriate.
- Providers supply their clients with necessary crisis information. This information is also posted at the Provider's clinical site(s).
- Providers educate clients about how to access psychiatric inpatient services, should such services be necessary.

- Providers partner with clients in the development of their Crisis Plan (see Attachment H Crisis Plan Form). Where appropriate, family members, significant others, behavioral health specialists, and/or other relevant parties and/or cultural consultants are also involved in the Crisis Plan development.
    - All Crisis Plans are in the standardized format provided in Attachment H. If desired, providers can utilize other formats; other formats must include all data elements found in Attachment H and be approved by King County.

Services For An Individual In A Hospital ED
Providers respond to all hospital EDs for any individual:

- Enrolled with the Provider, regardless of whether the Provider has previously provided services to the client; or
- Assigned to the Provider and on an LRO. (See Section 4.1.8).

- Upon the request of hospital ED staff, the Provider gives a telephone response as soon as possible and within two hours of the request;
- Providers give all information that might assist ED staff in resolving the emergency without a hospitalization. This information includes:
    - Any crisis plan, advance directive, and/or WRAP plan;
    - Information on how the individual may obtain crisis outpatient services, including medication services, on the next business day; and
    - Other interventions and resources that can support diversion from hospitalization (such as daily contacts, use of a diversion bed, medication adjustments and/or implementation of the individuals WRAP plan)
- Phone contact with the ED includes the option for the Provider to speak directly with the individual to develop a plan for resolving the emergency without hospitalization.
- If the above activities do not resolve the emergency, the Provider continues efforts as follows:
- Hospital ED and Provider review all diversion options prior to recommending any hospitalization. Least restrictive options that allow individuals to remain in the community and connected to their support networks are preferred.
- If both the ED and Provider staff recommend admission, no outreach is needed, and the hospital will proceed with the admission.
- 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.
- 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.
- If the Provider recommends an admission but the ED does not, Provider goes to the ED and provide input to the ED to pursue the admission.
- If more data is needed to determine whether hospitalization is indicated, or if the ED or Provider need more information about the individual's clinical status and trajectory, the Provider evaluates the individual directly in the ED to help clarify the next clinical steps.
- If at any time, the ED refers the client for an evaluation for a civil commitment, the Provider goes to the ED, if not already there.
- If the Provider recommends the commitment, before leaving the ED, the Provider staff calls the Designated Crisis Responders (DCRs) to offer assistance with declarations and any other activities to support CCS staff.
- If the Provider does not recommend the commitment, the Provider staff need not complete a declaration for the detention.

- Whenever outreach to the ED is given, the Provider documents the assessment, recommendations, and all other activities. If the hospital does not allow the Provider to enter documentation on the hospital's forms, the written documentation is given to the ED on Provider letterhead.

Services For A Client Prior To And Following A Hospitalization

For clients authorized to the behavioral health outpatient level of care, Providers are responsible for:

- 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;
- Identifying and referring individuals in need of hospitalization;
- Coordinating with the hospital as follows:
  - Active involvement of Provider staff is expected to take place during a hospital admission process.
  - 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;
  - 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;
  - If not done during the admission process, the Provider makes contact with the inpatient team within 24 hours of notification of admission (including weekends) to provide any needed clinical information;
  - If the client has been admitted or transferred to WSH, in addition to providing the above information to the hospital, the same information is provided to the adult inpatient and residential liaison;
  - If clinically indicated, the Provider has a face-to-face contact with the client within three working days;
  - The Provider contacts the inpatient team within three working days to discuss treatment planning;
  - The Provider notifies the client's outpatient psychiatrist or psychiatric Advanced Registered Nurse Practitioner (ARNP), if any, so that individual may contact the inpatient team to discuss treatment planning;
  - The Provider has ongoing face-to-face or telephone contact with the client and inpatient team while the client is hospitalized; and
  - The Provider actively assists in discharge planning, including helping the inpatient team determine the appropriate discharge date and updating the ISP and crisis plan. When appropriate, the Provider (and/or liaisons) assists in the development of a less restrictive court order (LRO) in order to enable the client to return to the community.
- 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.
- For referred individuals who are not yet authorized to a mental health outpatient level of care, but who are eligible for BHRD services, BHRD Providers are responsible for:
- Providing timely assessment, enrollment, and care on discharge which includes, at a minimum, providing a face-to-face direct service within seven calendar days following discharge, and, for clients on psychiatric medications, scheduling prior to the client's discharge a medication management appointment to occur within the time frame negotiated with the hospital;
- In addition to the above, for clients referred from WSH;
  - At the request of the adult inpatient and residential liaison, enrolling the referred client prior to discharge and actively participating in discharge planning; or

  - 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.
- 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.

Medication Evaluation Services

- Each Provider agency ensures 24-hours-per-day access to a psychiatrist, physician, physician assistant, or ARNP (all of whom have at least one (1) years' experience in the direct treatment of individuals who have a mental or emotional disorder) for consultation to the client's assigned clinician or on-call Provider staff.
- All clients authorized for an outpatient benefit has access to a psychiatrist or psychiatric ARNP for a face-to-face evaluation within 24 hours of an urgent clinical need.

Early and Periodic Screening, Diagnosis and Treatment (EPSDT)

- The federal and state requirements of EPSDT for the Medicaid children's population is met through the provision of outpatient services.
- Providers ensure face-to-face intake evaluations are completed for all children newly authorized to BHRD outpatient services.
- Each EPSDT child referred by a health Provider is contacted to confirm whether services are being requested by the individual or the individual authorized to consent to treatment for that individual.
- The Provider maintains documentation of its efforts to confirm whether the individual or individual authorized to consent to treatment for the individual requests, declines, or does not respond to efforts within 10 working days to confirm whether these services are being requested.
- 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.
- If circumstances occur that prevent the completion of the behavioral health intake evaluation within this time period, a written description is placed in the clinical record documenting the problem(s) encountered, the remedial action(s) to be taken, and a specific timeline to ensure completion of the assessment.
- For children covered by Medicaid, Providers are required to respond to referrals from primary medical care Providers. This includes:
- A written notice replying to the Physician, ARNP, Physician Assistant, trained public health nurse, or RN who made the EPSDT referral. This notice includes at least the date of the intake and diagnosis; and
- If the child or family does not identify a medical care Provider, the Provider informs the family of the EPSDT rights.
- If the child or family does not identify a medical care Provider, the Provider informs the family of the EPSDT rights.

Vocational Services Provider Requirements

- Either provide employment services, refer clients for employment services, and/or support clients in maintaining employment.
- 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.
- 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.
- Coordinate outpatient treatment services with vocational services provided by the Provider's employment program or the SEP.
- Document coordination of outpatient services with employment services, including progress towards goals for all clients referred or engaged in an employment program.

Documentation Requirements For Outpatient Encounters
All clinical services must be recorded in the clinical record with the:
- Date of service;
- Service description consistent with procedure code (i.e., CPT or HCPCS) and modifier (if applicable) submitted to BHRD IS;
- Service location;
- Service duration and/or unit;
- Primary diagnosis clinician is treating during encounter;
- Clinician taxonomy number;
- Clinician's individual National Provider Identifier (NPI) number;
- Signature of the clinician providing the service, verifiable against a printed name (name or signature may be generated by the electronic medical record); and
- Clinician's credentials.
- Documentation occurs for each unit of service provided.
- The entry must provide enough information to justify the service code.
- The entry must be legible to someone other than the writer.
- Progress notes reference client's current clinical status and response to the ISP.

Documentation Of Crisis Services
- 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.
- Documentation must demonstrate that emergent crisis services are provided within two hours of the request for such services.
- Documentation must demonstrate that urgent crisis services are provided within 24 hours of the request for such services.

Management of Service Utilization
- Providers have a comprehensive utilization management process that identifies patterns of service utilization by all clients and includes strategies to ensure that the right services are provided at the right time in the right place (e.g., type, duration, intensity, and frequency).
- Providers review the agency-specific outpatient service utilization reports provided by BHRD to identify service utilization patterns for all behavioral health outpatient benefits. Providers determine if the services or the benefit level should be changed to reflect the increased or decreased needs of the individual client.
- Providers develop and implement protocols for the utilization management of their clients who are frequently served by other costly systems, such as residential services, emergency room utilization, inpatient psychiatric care or jail.
- BHRD tracks these clients and work with Providers to decrease subsequent need for these services, such as developing and implementing relapse prevention plans, client- centered crisis plans, and to mitigate crisis service utilization. This may include joint Providers; managed care organizations, and BHRD care conferences. Such care conferences must include the client and

informal and/or formal supports as appropriate. If the participation of the client is believed to be clinically contraindicated, the justification for this must be documented.

- BHRD produces a regular High Utilizer Report of individuals who have had three or more BHRD-authorized psychiatric hospitalizations or residential SUD admissions in the preceding 12 months.
- The report includes the client's outpatient Provider.
- Individuals who are not authorized with an outpatient Provider are identified on the report separately.
- Provider-specific client lists are shared quarterly with each Provider's clinical director.

Other Requirements

- Providers participate in BHRD approved quality improvement initiatives.
- Provider agencies use Collective Ambulatory (formerly PreManage) to conduct emergency department (ED) and hospital utilization management for all clients in ongoing outpatient or specialty mental health and SUD programs.

APPENDIX A: Delegation Agreement for Contracted Crisis Services

King County Behavioral Health Administrative Services Organization (BH-ASO) delegates to specific agencies certain activities or services necessary to support and facilitate the provision of behavioral health, recovery, or crisis services to residents of King County and surrounding areas. In addition, the BH-ASO recognizes the importance in maintaining responsibility and appropriate structures and mechanisms to oversee delegated activities. The following content serves as a reference and resource for King County BH-ASO delegate: Crisis Connections.

Monitoring and Oversight of Delegated Activities

BH-ASO delegates to contracted agencies specific activities and/or services necessary to support and facilitate the provision of behavioral health, recovery, or crisis services to residents of King County and surrounding areas. BH-ASO partners with their delegated agencies to review and analyze the performance of delegated entities. This allows BH-ASO to track and monitor the quality of services being performed by the delegated entity, as well as the effectiveness of any interventions or corrective actions.

Pre-Delegation Evaluation:

- BHRD evaluates the delegate's capacity to meet any National Committee for Quality Assurance (NCQA) or Washington Administrative Code (WAC) requirements within the prescribed look-back period prior to implementing delegation.
- Examples of pre-delegation evaluation can include but are not limited to site visit, telephone consultation, documentation review, committee meetings, and virtual review.

Ongoing Review and Evaluation of Delegated Activities:

- Annually, BH-ASO reviews its delegate's policies and procedures related to delegated activities or functions.
- Annually, BH-ASO audits delegate files against NCQA or WAC quality and client safety standards for each year that delegation has been in effect.
- Annually, BH-ASO evaluates delegate performance against NCQA or WAC standards for delegated activities.
- Semi-annually, BH-ASO evaluates regular reports applicable to delegated activities.

Corrective Action Plans:

- For delegation agreements that have been in effect for more than 12 months, at least once in each of the past 2 years, BHRD follows up on opportunities for improvement.
- BH-ASO uses information from its delegation evaluation, ongoing reports, and/or annual evaluation to identify areas of improvement.
- If a delegate fails to meet any of its responsibilities outlined in the Delegation Agreement, including NCQA accreditation or WAC standards, BH-ASO works with the delegate to create a corrective action plan to identify areas of improvement and actions plans to ensure compliance with all elements and categories. If delegate does not take corrective action, or fails to meet improvement goals, BH-ASO reserves the right to revise the contract or delegation agreement and scope or revoke the contract or delegation agreement altogether.

Delegation Agreement/Delegation Grid

The purpose of the following grid is to specify the responsibilities of the King County Integrated Care Network Provider, Crisis Connections ("Delegate") with respect to the specific activities that are

Delegated: Utilization Management, Quality Improvement, WACs. The grid also describes the semi-annual reporting requirements, which are in addition to any applicable reporting requirements stated in the Contract. The grid below applies to the delegation of Behavioral Health Utilization Management, Quality Improvement, and WACs for Crisis Services by King County BH-ASO to Delegate.

The delegation grid may be amended from time to time during the term of the Agreement by King County BH-ASO to reflect changes in delegation standards; delegation status; performance measures; reporting requirements; and other provisions.

The sections that follow describe the process by which King County BH-ASO evaluates Delegate's performance and the remedies available to King County BH-ASO if Delegate does not fulfill its obligations.

Process of Evaluating Delegate's Performance:
King County BH-ASO requires routine reports and documentation as listed in the delegation grid and uses this documentation to evaluate Delegate performance on an ongoing basis. In addition, King County BH-ASO will:

- Conduct an annual audit to ensure all Delegated activities comply with applicable Compliance Requirements,
- Provide written feedback on the results of the annual audit, and
- Require Delegate to implement corrective action plans if the Delegate does not fully meet Compliance Requirements.

If King County BH-ASO determines that Delegate has failed to adequately perform the Delegated activities, King County BH-ASO may:

- Change or revoke the scope of delegation if corrective action is not adequate; and/or
- Discontinue contracting with Delegate.

Ongoing performance of accredited Delegate is evaluated through the semi-annual and routine monitoring of reports. King County BH-ASO reserves the right to conduct annual and ad hoc audits of documentation, processes and files in order to ensure service levels, quality and compliance with regulatory requirements.

Corrective Action Plans:
If Delegate fails to meet any of its responsibilities, including contracted responsibilities and NCQA accreditation or certification standards, King County BH-ASO works with Delegate to create a corrective action plan to identify areas of improvement and actions plans to ensure compliance with all elements and categories. If Delegate does not take corrective action, or fails to meet improvement goals, King County BH-ASO reserves the right to revise the delegation agreement and scope or revoke the delegation agreement altogether.

UTILIZATION MANAGEMENT (UM) DELEGATION GRID			
Function	**Sub-Delegate Activities**	**Reporting: Data, Frequency, & Submission**	**King County BH-ASO Activities**

UM program applies objective and evidence- based criteria and takes individual circumstances and local delivery system into account when determining the medical appropriateness of health care services, makes criteria available, and is consistent in the application of criteria. [UM 2]	• Uses written decision-making criteria that are objective and based on medical evidence [UM 2.A.1] • Has policies for applying the criteria based on individual needs. [UM 2.A.2] • States in writing how practitioners can obtain UM criteria and makes them available upon request [UM 2.B.1, 2.B.2] • Evaluates consistency with which health care professionals involved in UM apply criteria in decision-making and acts on opportunities to improve consistency. [UM 2.C.1, 2.C.2]	Reports Inter-Rater Reliability (IRR) scores to Manager of Delegation on an annual basis. The report can be submitted electronically or hardcopy.	Manager of Delegation receives and reviews the IRR scores.
Members and practitioners can access staff to discuss UM issues *[UM 3]*	• Staff are available at least eight hours a day during normal business hours for inbound collect or toll-free calls regarding UM issues. *[UM 3.A.1]* • Staff can receive inbound communication regarding UM issues after normal business hours. *[UM 3.A.2]* • Staff are identified by name, title and organization name when initiating or returning calls regarding UM issues. *[UM 3.A.3]* • TDD/TTY services for members who need them. *[UM 3.A.4]* • Language assistance for members to discuss UM issues. *[UM 3.A.5]*	None.	Manager of Delegation oversees services to ensure they meet standards during annual audit.

UM decisions are made by qualified health professionals. *[UM 4]*	• Has appropriately licensed professionals supervise all medical necessity decisions and specifies type of UM personnel responsible for each level of UM decision making. *[UM 4.A.1 and 4.A.2]* • Has professionals with required education, training or professional experience in medical or clinical practice with current active licenses who review denials of care based on medical necessity. *[UM 4.B.1, 4.B.2]* • Has physician or appropriate behavioral healthcare practitioner review any behavioral healthcare denial of care based on medical necessity. *[UM 4.D, ASO contract, 11.1.7]* • Has written procedures for using board-certified consultants and provides evidence of use of board-certified for medical necessity review. *[UM 4.F.1 and 4.F.2]*	None.	Manager of Delegation oversees services meet standards during annual audit.
UM decisions are made in a timely manner to minimize any disruption in the provision of healthcare. *[UM 5]* *[ASO contract, 11.4.3.3]*	• For urgent concurrent review, the organization acknowledges receipt for services within two (2) hours and provides a decision and notification within twelve (12) hours of receipt of request. *[ASO contract, 11.4.3.3]* • For post-service decisions, the organization makes decisions within 30 calendar days of receipt of the request and gives electronic or written notification of the decision to practitioners and members within 2 calendar days of the decision. *[ASO contract, 11.4.3.3]*	Reports timeliness of behavioral health decision making to Manager of Delegation on a semi- annual basis. The report can be submitted electronically or hardcopy.	Manager of Delegation receives and reviews compliance during the annual file review.

CRISIS LINE TELEPHONE ACCESS DELEGATION GRID			
Function	**Sub-Delegate Activities**	**Reporting: Data, Frequency, & Submission**	**King County BH-ASO Activities**

Behavioral Health Telephone Access *[ASO Contract, Exhibit E*]	Shows a telephone abandonment rate within 5 percent.	Submission to King County BH-ASO a monthly summary report. Reports provided in electronic or hard copy.	Manager of Delegation receives and reviews monthly reports for performance review.
Behavioral Health Telephone Access *[ASO Contract, Exhibit E*]	Shows that telephones are answered by a live voice within 30 seconds.	Submission to King County BH-ASO a monthly summary report. Reports provided in electronic or hard copy.	Manager of Delegation receives and reviews monthly reports for performance review.
Call Center Reports *[ASO Contract, Exhibit E]*	Crisis Line Call Center Reports to include: Caller demographics	Submission to King County BH-ASO staff monthly.	The BH-ASO analyzes information to assist in improving the crisis response system.
Call Center Reports *[ASO Contract, Exhibit E]*	Crisis Line Call Center Reports to include: • Analysis of calls, callers, dispositions, origin of call (e.g. home, emergency room, community, Provider), referral sources and other relevant information to make recommendations and assist in improving the crisis response system.	Submission to King County BH-ASO staff daily.	The BH-ASO analyzes information to assist in improving the crisis response system.
WAC 246-341-0670 Crisis telephone support services — Service standards.	Crisis telephone support services are services provided as a means of first contact for an individual in crisis or in need of assistance. These services may include de-escalation and referral. (1) A behavioral health agency providing crisis telephone support services must: (a) Have services	Applicable policies and procedures and protocols. Monthly Summary Call logs Annual delegation oversight audit.	Manager of Delegation receives and reviews the policies and procedures, protocols, documentation and reports including
	available 24 hours per day, seven days per week; (b) Assure communication and coordination		monthly summary call logs and

	with the individual's mental health or substance use treatment provider, if indicated and appropriate; (c) Remain on the phone with an individual in crisis in order to provide stabilization and support until the crisis is resolved or referral to another service is accomplished; (d) As appropriate, refer individuals to voluntary or involuntary treatment facilities for admission on a seven day a week, 24 hour a day basis, including arrangements for contacting the designated crisis responder; and; (e) Develop and implement policies and procedures for training staff to identify and assist individuals in crisis before assigning the staff member to unsupervised duties. (2) Documentation of a crisis telephone support service must include the following: (a) A brief summary of each service encounter, including the date, time, and duration of the encounter; (b) The names of the participants; (c) A follow-up plan or disposition, including any referrals for services, including emergency medical services; (d) Whether an individual has a crisis plan and any request to obtain the crisis plan; and (e) The name and credential, if applicable, of the staff person providing the service. (3) A behavioral health agency providing crisis telephone services for substance use disorder must ensure a professional appropriately credentialed to provide substance use disorder treatment is available or on staff 24 hours a day, seven days a week.		annual delegation oversight audit.

Definitions

Action	The denial or limited authorization of a contracted service based on medical necessity.
Acute Withdrawal Management	Services provided to an individual to assist in the process of withdrawal from psychoactive substance in a safe and effective manner. Medically monitored withdrawal management provides medical care and physician supervision for withdrawal from alcohol or other drugs.
Addiction	Addiction is a treatable, chronic medical disease involving complex interactions among brain circuits, genetics, the environment, and an individual's life experiences. People with addiction use substances or engage in behaviors that become compulsive and often continue despite harmful consequences. Prevention efforts and treatment approaches for addiction are generally as successful as those for other chronic diseases.
Administrative Hearing	An adjudicative proceeding before an Administrative Law Judge or a Presiding Officer that is governed by Chapter 34.05 RCW or the Agency's hearings rules found in Chapter 182 WAC.
Adjustment	A process whereby changes to Provider payments are made as a result of policy decision.
Adult	A person who is 18 years of age or older.
Adult Crisis Services	Specialized adult crisis services for adults 18 or older who are not enrolled in the King County Integrated Care Network (KCICN) or Behavioral Health Administrative Services Organization (BH-ASO) outpatient or residential services. The service provides next day appointments (NDAs) and follow- up care, both in and out of facility, until the crisis has stabilized.
Advance Directive	A written instruction, such as a living will or durable power of attorney for health care, relating to the provision of health care, when the individual is incapacitated (WAC 182-501-0125).
Advocacy Service	A service for clients and family members primarily staffed by current or former family members who provide assistance with questions, complaints, and/or grievances.
Agency	For purposes of the King County Integrated Care Network (KCICN) and Behavioral Health-Administrative Service Organization (BH-ASO), this refers to licensed community behavioral health centers credentialed to provide behavioral health services to KCICN and/or BH-ASO clients and families; also called a Provider.
Agreement	The King County Integrated Care Network (KCICN) Base Provider Agreement entered into between Behavioral Health and Recovery Division (BHRD) and Provider, including all attachments and incorporated documents or materials.

Alcohol and Other Drug (AOD) Screen	A process designed to identify people who have or who are at risk of having a substance use disorder (SUD). The process evaluates substance use, which contributes to illness, injury, or other long-term morbidity and/or mortality.
Allied System	An organization in close relationship to the behavioral health system responsible for the provision of services (that are not classified as behavioral health services) to clients and families.
Allied System Provider	An agency or person representing an allied system that provides direct services to clients and their families.
American Society of Addiction Medicine (ASAM)	A professional medical society dedicated to increasing access and improving the quality of addiction treatment.
American Society of Addiction Medicine (ASAM) Criteria	Admission, continued stay, transfer and discharge criteria for individuals with addiction and co-occurring conditions as published by ASAM.
Appeal	A request for review of an action.
Appeal Process	The Provider's procedures for reviewing an action.
Assertive Engagement	Regular outreach and engagement efforts intended to connect with and keep individuals engaged in services. Examples of this include, but are not limited to letters, phone calls, offering flexible appointment times, community outreach, home visits, etc.
Authorization	The activity by the King County Integrated Care Network (KCICN) and Behavioral Health-Administrative Services Organization (BH-ASO) in which a level of care or a specific service is determined to be medically necessary.
Available Resources	Funds appropriated for the purpose of providing behavioral health programs. This includes federal funds, except those provided according to Title XIX of the Social Security Act, and state funds appropriated by the Legislature.
Bed Day	Any day in residence at a residential behavioral health treatment program, excluding the day of discharge.
Behavioral Health Administrative Services Organization (BH-ASO)	An entity designated by the Health Care Authority (HCA) to administer behavioral health services and programs, including crisis services for residents in a defined Regional Services Area. The BH-ASO administers crisis services for all residents in its defined service area, regardless of ability to pay, including Medicaid eligible clients. Behavioral Health and Recovery Division (BHRD) has been designated to serve as the BH-ASO for the King County Regional Service Area.
Behavioral Health	Mental health and substance use disorder (SUD) conditions and related services.

Behavioral Health Crisis Services (Crisis Services)	Providing evaluation and short-term treatment and other services to individuals with an emergent mental health condition or are intoxicated or incapacitated due to substance use and when there is an immediate threat to the individual's health or safety.
Behavioral Health and Recovery Division (BHRD)	A division within King County's Department of Community and Human Services (DCHS) responsible for oversight and provision of behavioral healthcare services encompassing Behavioral Health-Administrative Services Organization (BH-ASO) and King County Integrated Care Network (KCICN). KCICN and BH-ASO are referred to as "BHRD" in this document where the requirements are relative to both entities.
Behavioral Health and Recovery Division (BHRD) Information System (IS)	The Behavioral Health Information System (BHIS) refers to the total electronic information system and network used by the state, King County Integrated Care Network (KCICN) and Behavioral Health Administrative Services Organization (BH-ASO), and contract Providers to collect, store, and disseminate information concerning client participation in behavioral health services.
Breach	The acquisition, access, use, or disclosure of Protected Health Information (PHI) in a manner not permitted under the HIPAA Privacy Rule which compromises the security or privacy of PHI, with the exclusions and exceptions listed in 45 C.F.R. § 164.402.
Brief Intervention	A time limited, structured behavioral intervention using techniques such as evidence-based motivational interviewing, and referral to treatment services when indicated. Services may be provided at sites exterior to treatment facilities such as hospitals, medical clinics, schools or other non-traditional settings.
Business Hours	8:00 am to 5:00 pm Pacific Time, Monday through Friday.
Capacity Management	A system for identifying treatment capacity for individuals who cannot be admitted and a mechanism for matching individuals to treatment programs with sufficient capacity.
Care Coordination	A process-oriented activity to facilitate ongoing communication and collaboration to address the multiple needs of an individual to achieve optimal health and wellness outcomes. Care coordination includes facilitating communication between the family, natural supports, community resources, and involved Providers and agencies, organizing, facilitating and participating in team meetings, and providing for continuity of care by creating linkages to and managing transitions between levels of care.
Case Management	Services provided to assist clients in gaining access to needed medical, social, education, and other services. Does not include direct treatment services in this sub element. This covers case planning, case consultation and referral services, and other support services for the purpose of engaging and retaining clients in treatment or maintaining clients in treatment. This does not include treatment planning activities. See SERI Encounter Reporting Instructions (SERI) for encountering requirements.

Case Rate	A payment level approved for each person authorized for an outpatient or residential benefit payable to a Provider. Rates are based on a medical necessity assessment that determines a service intensity level. Rates are further adjusted based on age group (child or adult) and for cultural and language differentials.
Center for Medicare and Medicaid Services (CMS)	An administrative agency of the United States government, responsible for administering the Medicare program.
Certified Peer Counselor (CPC)	An individual that identifies as a consumer of behavioral health services or a parent or legal guardian of a child who has received behavioral health services that has met the Division of Behavioral Health and Recovery's (DBHR) training and testing requirements. When employed in a Medicaid funded agency, CPCs also hold an agency affiliated counselor credential from the Department of Health (DOH). CPCs draw upon their lived experiences to help their peers find hope and make progress toward accomplishing their recovery goals.
Certified Peer Support Specialist (CPSS)	A person certified under RCW 18.420.010 to engage in the practice of peer support services.
Certified Peer Support Specialist Trainee (CPSST)	An individual working toward the supervised experience and written examination requirements to become a certified peer support specialist under RCW 18.420.010.
Chemical Dependency Disposition Alternative (CDDA)	Juvenile alternative sentencing program offering substance use disorder (SUD) treatment in lieu of more restrictive detention alternatives.
Child and Family Team	A group chosen by the child, youth, and/or family who will support them to meet their needs across life domains. The team is comprised of members who continue to support the family when professionals are no longer involved.
Child/Adolescent	An individual less than 18 years of age, also known as adolescent, juvenile, or minor.
Child and Family Team (CFT)	A group of people – chosen with the family and connected to them through natural, community, and formal support relationships – who develop and implement the family's care plan, address unmet needs, and work toward the family's vision and team mission.
Children's Long-Term Inpatient Program (CLIP)	A medically based treatment approach, available to all Washington State residents, ages 5 to 18 years of age, providing 24-hour psychiatric treatment in a highly structured setting designed to assess, treat, and stabilize youth diagnosed with psychiatric and behavioral disorders.
Children's Program	A behavioral health program that can serve people up to 21 years of age.

Chronically Homeless	A person who has either been continually homeless for a year or has had at least four episodes of homelessness in the past three years.
Client	A person who has been determined to meet both financial eligibility and medical necessity criteria and has been authorized for any Behavioral Health and Recovery Division (BHRD) funded services.
Client Services	A King County Integrated Care Network (KCICN) and Behavioral Health Administrative Services Organization (BH-ASO) staff unit that accepts calls and correspondence from clients, potential clients, and family members; answers questions regarding benefits, eligibility, access to care; and receives and attempts to resolve complaints and grievances.
Clinical Indicators	Include, but are not limited to, inability to maintain abstinence from alcohol or other non-prescribed drugs, positive drug screens, individual report of a subsequent alcohol/drug arrest, individual leaves program against program advice, unexcused absences from treatment, lack of participation in self- help groups, and lack of individual progress in any part of the treatment plan.
Clinical Review	Review of services provided to a client in order to evaluate the quality of care and the impact on the outcome of treatment and/or to verify medical necessity.
Code of Federal Regulations (CFR)	The codification of the general and permanent rules and Regulations, sometimes called administrative law, published in the Federal Register by the executive departments and agencies of the federal government of the United States.
Community Mental Health Agency (CMHA)	A behavioral health agency that is licensed by the state of Washington and certified to provide mental health services
Community Outreach, Intervention and Referral Services	Providing individuals, the general public and community organizations with information on substance use disorders (SUDs), the impact of SUDs on families, treatment of SUDs, and treatment resources that may be available, including responding to telephonic inquiries and other information activities. Also includes referral to assessment, treatment, interim services, and other appropriate support services.
Community-Based	Service and support strategies that take place in the most inclusive, most responsive, most accessible, and least restrictive settings possible and that safely promote client and family integration into home and community life.
Complaint	Any client expression of dissatisfaction that is resolved to the client's satisfaction through simple, first-level dialog. If not resolved to the client's satisfaction, the client has the option to escalate to the level of a formal Grievance with the funder of the services.
Confidentiality	An ethical principle, codified by state and federal statutes, that a behavioral health professional may not reveal any information disclosed in the course of behavioral health treatment, including the fact of providing treatment, unless authorized by law.

Conjoint Counseling	A planned therapeutic or counseling activity specific to substance use disorder provided by a Substance Use Disorder Professional (SUDP) or SUD Trainee (SUDPT) under the supervision of a SUDP to a client and one or more of his/her family by one or more therapists.
Continued Stay Criteria	The minimum criteria to receive an additional authorization for a specific level of care.
Continuity of Care	The provision of continuous care for chronic or acute medical and behavioral health conditions to maintain care that has started or been authorized in one (1) setting as the individual transitions between: facility to home; facility to facility; Providers or service areas; managed care Contractors; and Medicaid fee-for-service and managed care arrangements. Continuity of care occurs in a manner that prevents secondary illness, health care complications or re-hospitalization and promotes optimum health recovery. Transitions of significant importance include but are not limited to: from acute care settings, such as inpatient physical health or behavioral (mental health/substance use) health care settings or emergency departments, to home or other health care settings such as outpatient settings; from hospital to skilled nursing facility; from skilled nursing to home or community-based settings; from one primary care practice to another; and from substance use care to primary and/or mental health care.
Contract	A written agreement between Behavioral Health and Recovery Division (BHRD), including the King County Integrated Care Network (KCICN) or Behavioral Health-Administrative Services Organization (BH-ASO), and a contracted Provider agency. This includes any exhibits, documents, and materials incorporated by reference.
Contractor	The individual or entity performing services pursuant to a contract and includes the Contractor's owners, officers, directors, partners, employees, and/or agents, unless otherwise stated in this Contract. For purposes of any permitted Subcontract, "Contractor" includes any Subcontractor and its owners, officers, directors, partners, employees, and/or agents
Contracted Services	Services that are to be provided by the Contractor under the terms of a Contract within Available Resources.
Co-Occurring Disorder (COD)	A condition in which an individual has a simultaneous major mental disorder, and a coexisting substance use disorder (SUD).
Corrective Action Plan (CAP)	A written plan, specifying Provider requirements to correct identified deficiencies, the plan may include a timeline for such action and consequences of lack of action.
Covered Services	Health care services that are medically necessary are within the normal scope of practice and licensure of Provider and are covered under contract exhibits between King County Integrated Care Network (KCICN), Behavioral Health Administrative Services Organization (BH-ASO) and Providers.
Criminal Justice Treatment Account (CJTA)	An account created by the state for expenditure on substance use disorder (SUD) treatment and treatment support services for offenders with a SUD that, if not treated, would result in addiction, against whom charges are filed by a prosecuting attorney in Washington State; b) the

	provision of drug and alcohol treatment services and treatment support services for nonviolent offenders within a drug court program (RCW 71.24.580).
Crisis Response	Interventions provided to stabilize an individual to reduce behavioral health crisis.
Crisis Service	A response to urgent and emergent behavioral health needs of persons in the community. The goal of this service is to stabilize the individual and family in the least restrictive setting appropriate to their needs, considering strengths, resources, and choice. Interventions are age and developmentally appropriate and contribute to and support the individual's innate resiliency and recovery.
Crisis Services with Next Day Appointment (NDA) Services	Providing emergency interventions for alcohol or drug related crisis to include, on a short-term basis, general assessment of the individual's condition and/or an interview for diagnostic or therapeutic purposes which may or may not lead to ongoing treatment. Also includes referral to assessment, treatment, interim services, and other appropriate support services. Does not include the costs of ongoing therapeutic services.
Crisis Stabilization Placement	Short-term intervention to help children, youth, and families not otherwise enrolled in King County Integrated Care Network (KCICN) or Behavioral Health Administrative Services Organization (BH-ASO) services, through a crisis. Interventions include beds that are available for children requiring immediate out-of-home placements who lack family or natural resources to safely rely upon. See Inpatient Diversion Beds.
Critical Incident	A situation or occurrence that places a client at risk for potential harm or causes harm to a client. Examples include homicide (attempted or completed), suicide (attempted or completed), the unexpected death of a client, or the abuse, neglect, or exploitation of a client by an employee or volunteer.
Cultural Competence	The ability to recognize and respond to health-related beliefs and cultural values, disease incidence and prevalence, and treatment efficacy. Examples of cultural competent care include striving to overcome cultural, language, and communications barriers, providing an environment in which individuals from diverse cultural backgrounds feel comfortable discussing their cultural health beliefs and practices in the context of negotiating treatment options, encouraging individuals to express their spiritual beliefs and cultural practices, and being familiar with and respectful of various traditional healing systems and beliefs and, where appropriate, integrating these approaches into treatment plans. See Washington Administrative Code (WAC) Chapter 246-341-0200.
Cultural Differential	An adjustment in the case rate for each outpatient benefit to support services to clients who are ethnic minorities, sexual minorities, deaf or hard of hearing or non-facility-based medically compromised homebound individuals. The cultural differential payment rate is based on being a member of any one or more of these groups; the payment is not additive if the client belongs to more than one group.

Culture	An integrated pattern of human behavior, which includes and is not limited to: thought, communication, languages, beliefs, values, practices, customs, courtesies, rituals, manners of interacting, roles, relationships, and the expected behaviors of a racial, ethnic, religious, social, or political group; the ability to transmit the above to succeeding generations; and dynamic in nature.
Cost Reimbursement	The contractor is reimbursed for actual costs up to the maximum consideration allowed in the contract.
Day Support	An intensive rehabilitative program which provides a range of integrated and varied life skills training (e.g., health, hygiene, nutritional issues, money management, maintaining living arrangement, symptom management) for Individuals to promote improved functioning or restoration to a previous higher level of functioning
Deaf	A hearing impairment of such severity that the individual must depend primarily upon visual communication such as writing, lip reading, manual communication, and gestures.
Department of Children, Youth and Families (DCYF)	The Washington State agency responsible for keeping Washington children safe, strengthening families and supporting foster children in their communities.
Department of Community and Human Services (DCHS)	A King County Department that manages a range of programs and services to help King County's most vulnerable residents and strengthen the communities. DCHS includes 5 divisions: • Adult Services • Behavioral Health and Recovery • Children Youth and Young Adults, • Developmental Disabilities and Early Childhood Supports • Housing, Homelessness and Community Development
Department of Social and Health Services (DSHS)	The Washington State agency responsible for providing a broad array of health care and social services.
Developmental Disabilities Administration (DDA)	Washington State agency that is responsible for providing a safe, high-quality, array of home, community and facility-based residential services and employment support for Washington citizens with disabilities.
Designated Crisis Responder (DCR)	A person designated by the county or other authority authorized in rule, to perform the civil commitment duties described in Chapters 71.05 RCW and 71.34 RCW.
Division of Behavioral Health and Recovery (DBHR)	The Health Care Authority (HCA) behavioral health division that administers state only, federal grants, and Medicaid funded behavioral health programs in community settings.
Diverted Juvenile Offender	Any alleged juvenile offender who has entered into a diversion agreement with a superior court diversion unit and who is still under the supervision of such unit. This term also includes a juvenile over 18 years of age who entered into an agreement prior to the 18th birthday as provided in Revised Code of Washington (RCW) 13.04.080 (12).

Dose Day	A Medication-Assisted Treatment (MAT) all-inclusive rate for face-to-face bundled services which include drug/alcohol assessment, daily methadone dose, urinalysis testing, vocational rehabilitation services, individual counseling, group counseling, family therapy, family planning session, counseling and education for pregnant patients, Human Immunodeficiency Virus (HIV) screening, counseling, and testing referral, and case- management. Only one billing per day per client is allowable. Missed doses or days without any of the listed activity are not billable as actual dose days.
Drug Court	A specialty court that has judicially supervised court dockets that handle the cases of non-violent substance abusing offenders under the adult, juvenile, family and tribal justice systems. Drug Courts operate under a specialized model in which the judiciary, prosecution, defense bar, probation, law enforcement, mental health, social service, and treatment communities work together to help non-violent offenders find restoration in recovery and become productive citizens.
Dually Certified Staff	Staff that are licensed as both mental health and substance use disorder (SUD) professionals.
Early Periodic Screening, Diagnosis and Treatment (EPSDT)	The federally mandated program for Medicaid children under age 21 which directs that all children at or below the poverty level be screened for health problems (including mental health) and provided with appropriate services to treat any identified medical issues.
Electroconvulsive therapy (ECT)	A medical procedure used for severe mental health disorders that involves a brief electrical stimulation of the brain while the patient is under anesthesia.
Elope/Elopement	An unauthorized departure of a client from a 24-hour care setting.
Emergent Care	Emergent care are those services that, if not provided, would likely result in the need for crisis intervention or hospitalization due to imminent concerns about potential danger to self, others, or grave disability. Emergency crisis services must be initiated within two hours of the initial request from any source. Examples include phone crisis services, Crisis and Commitment Services (CCS), **Mobile Response and Stabilization Services (MRSS)**, inpatient diversion beds, and crisis stabilization services.
Emergency Services	Inpatient and outpatient contracted services furnished by a Provider qualified to furnish the services needed to evaluate or stabilize an Emergency Medical Condition.
Enrollee	A Medicaid or non-Medicaid recipient.
Ethnic minority	For the purpose of qualifying for the cultural differential case rate, ethnic minority means a person who self identifies as any of the following: African American/Other Black; Asian American/Pacific Islander; Native American; Hispanic; or Other/Mixed Race.
Evaluation and Treatment	Services provided for individuals who pose an actual or imminent danger to self, others, or property due to a mental illness, or who have experienced a marked decline in their ability to care for self-due to the onset or exacerbation of a psychiatric disorder. Services are provided in freestanding inpatient residential (non-hospital/non-Institution for Mental Disease (IMD) facilities) licensed and certified by Department of Health

	(DOH) to provide medically necessary evaluation and treatment to the Individual who would otherwise meet hospital admission criteria. At a minimum, services include evaluation, stabilization and treatment provided by or under the direction of licensed psychiatrists, nurses, and other Mental Health Professionals, and discharge planning to ensure continuity of mental health care. Treatment may include nursing care, individual and family therapy, milieu therapy, psycho-educational groups and pharmacology. The individual is discharged as soon as a less-restrictive plan for treatment can be safely implemented. This service is provided for individuals who pose an actual or imminent danger to self, others, or property due to a mental illness, or who have experienced a marked decline in their ability to care for self-due to the onset or exacerbation of a psychiatric or co-occurring substance use disorder. The severity of symptoms, intensity of treatment needs or lack of necessary support for the individual does not allow them to be managed at a lesser level of care. This service does not include cost for Room and Board. The Health Care Authority (HCA) authorizes exceptions for involuntary length of stay beyond a fourteen (14) day commitment.
Evaluation and Treatment (E&T) Facility	Any facility which can provide directly, or by direct arrangement with other public or private agencies, emergency evaluation and treatment, outpatient care, and timely and appropriate inpatient care to persons suffering from a mental health diagnosis r, and which is licensed or certified as such by the department". (RCW 71.05.020)
Evidenced-Based Practices	A program or practice that has been tested where the weight of the evidence from review demonstrates sustained improvements in at least one outcome. "Evidence-based" also means a program or practice that can be implemented with a set of procedures to allow successful replication in Washington and, when possible, is determined to be cost-beneficial.
Excluded Individuals or Entities	Individuals or entities that have been placed in non-eligible participant status under Medicare, Medicaid, and other federal or state health care programs. Exclusions may occur due to Office of Inspector General sanctions, failure to renew license or certification registration, revocation of professional license or certification, or termination by the state Medicaid agency.
Expanded Substance Use Disorder (SUD) Assessment	A comprehensive interview with the parent, and a minimum of two collateral contacts, resulting in a standardized written report that includes, at a minimum: the presenting problem, a basic psychosocial history including past and present drug/alcohol use (type, frequency, and duration of use), life effects of usage, substance abuse diagnosis, specific treatment recommendations and estimated time frames for completion, other services needed to initiate, establish, or maintain recovery such as mental health or domestic violence services, diagnostic instruments used in the assessment process, and the results of the assessment urinalysis (UA). A minimum of two collateral contacts are made and included.
Extended Client Lookup System (ECLS)	The Behavioral Health and Recovery Division (BHRD) Information System (IS) application that allows authorized users to access information on individuals to determine if they are receiving services

	from King County Integrated Care Network (KCICN) and Behavioral Health Administrative Services Organization (BH-ASO) Providers.
Extraordinary Treatment Plan (ETP)	A plan for services when a client has treatment needs that exceed the most service-intensive benefit within the King County Integrated Care Network (KCICN) or Behavioral Health–Administrative Services Organization (BH- ASO) outpatient or residential levels of care.
Facility	"Facility" means but is not limited to a hospital, an inpatient rehabilitation center, Long-Term and Acute Care (LTAC) center, behavioral health facility, skilled nursing facility, and nursing home.
Fair Hearing	A hearing before the Washington State Office of Administrative Hearings.
Family	A group of individuals who support the client emotionally, physically, and/or financially. A family is defined by its members, and each family defines itself. A family can include individuals of various ages who are biologically related, related by marriage, or not related at all but who provide a significant level of support to the youth or primary caregiver.
Family-Centered	The principle that promotes the family voice is heard and integrated throughout policy, program development, and service delivery. Services have moved from family-as-client to family-as-partner. Services are "done with" the family, rather than "done to" the family.
Family Integrated Transitions Program (FIT)	Two programs, one funded through the State Juvenile Rehabilitation Administration (JRA) is for youth transitioning from incarceration at a JRA facility to the community; the other is funded through Superior Court for youth transitioning from the local detention facility to the community.
Family Partnership	Contributing to a joint venture with the child and family-usually sharing its risks and benefits. Requires joint decision-making power and the shared distribution of benefits or losses.
Family Preservation Model	A service delivery model that incorporates service provision to the family, services targeted to families with children at risk for out-of-home placement and/or incarceration, services flexibly tailored to meet the needs of families within the context of their culture, and staff carrying small caseloads in order to provide highly intense, time-limited services.
Family Support	In the substance use context, information, education, intervention, and other supportive services, provided in a group or individual setting, to individuals who have significant individual relationships (e.g. sibling, child, parent or spouse) with a person with a substance use disorder not currently in treatment. Does not include services to significant others of an individual currently in treatment.
Family Treatment	Behavioral health counseling provided by or under the supervision of a Mental Health Professional for the direct benefit of an Individual. Service is provided with family members and/or other relevant persons in attendance as active participants.

Federally Qualified Health Center (FQHC):	A community-based organization that provides comprehensive primary care and preventive care, including health, dental, and behavioral health services to people of all ages, regardless of their ability to pay or health insurance status.
Financial Exploitation	The illegal or improper use of the property, income, resources, or trust funds of a vulnerable adult by any person for any person's profit or advantage per state statute.
First Responders	Police, sheriff, fire, emergency, medical and hospital emergency rooms, and 911 call centers.
Flag	An indicator that identifies client-centered circumstances or situations that have implications for utilization management or financial management. Flags could: 1. Include indicators that trigger the payment of the cultural differential case rate; 2. Identify individuals who are high users of inpatient or crisis services; or 3. Identify individuals who have an unusual service pattern.
Fraud, Waste and Abuse	• Fraud: An intentional deception or misrepresentation made by a person (individual or entity) with the knowledge that the deception could result in some unauthorized benefit to themself or some other person. It includes any act that constitutes fraud under applicable federal or state law. • Waste: The expenditure or allocation of resources or provision of services significantly in excess of need. Waste need not necessarily involve an element of private use or of individual gain but invariably signifies poor management resulting in the misuse of resources. • Abuse: Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. Abuse also includes beneficiary practices that result in unnecessary cost to the King County Integrated Care Network (KCICN) and Behavioral Health Administrative Service Organization (BH-ASO). Fraud, Waste, and Abuse can include but not be limited to: • Billing for or reporting of services not performed. • Phantom individuals • Double-billing or reporting • Unnecessary services • Kickbacks • Upcoding (in a fee-for-service payment model) • Unbundling (in a fee-for-service payment model) • Falsification of health care Provider credentials • Falsification of Provider financial solvency • Intentional improper billing • Related party contracting • Incentives that limit services or referral

	• Embezzlement and theft • Billing Medicaid enrollees for Medicaid covered services. • Using an inefficient or improperly trained coder whose inefficiency creates errors such as upcoding or double billing. • Neglecting to properly examine service records and as a result claiming a service or services when the individual was not seen by the Provider. • Incurring unnecessary costs as a result of inefficient or ineffective practices, systems, or controls • Continuing to provide a service when the individual is no longer benefiting from the service.
Frequent Use	A criterion for a non-Medicaid benefit, meaning at least two uses of any single resource or two uses of any combination of resources within the year previous to the referral date.
Community Relations Plan	A plan created by a treatment Provider to document community relations efforts and community contacts, evaluate these efforts and contacts over time, and address outstanding problems and deficiencies (WAC 246-341- 1005).
Grievance	An expression of dissatisfaction about any matter other than an action. Possible subjects for grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a Provider or employee, or failure to respect the Individual's rights.
Grievance System	The overall system that includes Grievances and Appeals handled by BHRD BH-ASO or the MCOs and access to the Administrative Hearing Processes
Guidelines	A set of statements used to determine a course of action. A guideline streamlines utilization management decision-making processes according to a set routine or sound evidence-based clinical practice. Guidelines are not binding and are not enforced.
Habilitation and Rehabilitation	Teaching individual's new skills or assisting individuals to relearn skills they once had but lost as the result of a disease.
Hard of Hearing	A hearing impairment resulting in a functional loss, but not to the extent the individual must depend primarily upon visual or tactile communication. The hearing loss should be a significant factor in the symptoms of the behavioral health issue (e.g., increasing anxiety, suspiciousness, or isolation), in the person's level of functioning, or in the provision of treatment.
Health Care Authority (HCA)	The Washington State Health Care Authority, any division, section, office, unit or other entity of HCA or any of the officers or other officials lawfully representing HCA.
Health Care Professional	A physician or any of the following acting within their scope of practice; an applied behavior analyst, certified registered dietician, naturopath, podiatrist, optometrist, optician, osteopath, chiropractor, psychologist, dentist, physician assistant, physical or occupational therapist, therapist assistant, speech language pathologist, audiologist, registered or practical nurse (including nurse practitioner or clinical nurse specialist, certified registered nurse anesthetist, and certified nurse midwife),

	licensed midwife, licensed clinical social worker, licensed mental health counselor, licensed marriage and family therapist, registered respiratory therapist, pharmacist, and certified respiratory therapy technician.
Health Care Provider (HCP)	A Primary Care Provider, Mental Health Professional or Substance Use Disorder Professional.
Health Plan	A plan that undertakes to arrange for the provision of healthcare services to subscribers or enrollees, or to pay for or to reimburse for any part of the cost for those services, in return for a prepaid or periodic charge paid by for or on behalf subscribers or enrollees.
High Intensity Treatment	Intensive levels of service provided to individuals who require a multi-disciplinary treatment team in the community that is available upon demand twenty-four hours per day, seven days per week.
Homeless	Persons who lack a fixed, regular, and adequate night-time residence or have a primary nighttime residence that is: 1. A supervised publicly or privately-operated shelter designed to provide temporary living accommodations (including welfare hotels, congregate shelter and transitional housing for the mentally ill); 2. An institution that provides temporary residence for individuals; or 3. A public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings.
Homeless Outreach, Stabilization and Transition (HOST) Project	A project that provides outreach and engagement, intensive stabilization, transition to ongoing services, and reengagement into services for persons who are mentally ill and homeless.
Housing Services	Minor renovation, expansion, and repair of housing, planning of housing, technical assistance in applying for housing assistance, improving the coordination of housing services, security deposits – the costs associated with matching eligible homeless individuals with appropriate housing situations, and one-time rental payment to prevent eviction.
Individual	Any person in the regional service area (RSA) regardless of income, ability to pay, insurance status, or county of residence; in regard to non-crisis services, it is understood to mean a person who has applied for, is eligible for, or has received General Funds State/ Federal Block Grant (GFS)/FBG services funded by Behavioral Health and Recovery Division (BHRD).
Individual Service Plan (ISP)	An action plan mutually developed by the Provider with the client and others providing supports to the client that describes the services and supports (per Washington Administrative Code (WAC) 246-341-0425 with client goals and steps to achieve recovery.
Individuals with Intellectual or Developmental Disability (I/DD)	People with a disability characterized by significant limitations in both intellectual functioning and in adaptive behavior, which covers many everyday social and practical skills.

Initial Crisis Outreach	A crisis service provided by the Designated Crisis Responders (DCR)s 24 hours a day, 7 days a week. These are one-time-only contacts, provided face-to-face in community-based settings for persons in crisis for whom a mental health diagnosis cannot be ruled out.
Inpatient	Publicly funded behavioral health services in an inpatient facility, including evaluation and treatment (E&T) facilities.
Inpatient Diversion Beds	A short-stay crisis bed in a residential facility that provides 24-hour staff supervision. The goal is to avert immediate voluntary or involuntary hospitalization for those persons who need very short-term supervision during times of emotional crisis in order to ensure their safety or the safety of others.
Involuntary Treatment Act (ITA)	State laws that allow for individuals to be committed by court order to a Facility for a limited period of time. Involuntary civil commitments are meant to provide for the evaluation and treatment of individuals with a behavioral health disorder and who may be either gravely disabled or pose a danger to themselves or others, and who refuse or are unable to enter treatment on their own. An initial commitment may last up to 120 hours, but, if necessary, individuals can be committed for additional periods of fourteen (14), ninety (90), and one hundred eighty (180) calendar days of inpatient involuntary treatment or outpatient involuntary treatment (RCW 71.05.180, RCW 71.05.230 and RCW 71.05.290).
Involuntary Treatment/ Commitment	Evaluation and action ordered by a Designated Crisis Responder (DCR) and/or a Superior Court Judge for persons with a behavioral health disorder who have demonstrated behavior that is dangerous to self or others; or have substantially harmed someone else's property; or are so gravely disabled that they are unable to provide for basic needs and are not receiving essential care for health and safety.
ITA Detained Person	Any person seen face-to-face under the provision of the Involuntary Treatment Act (ITA), Chapters 71.05 or 71.34 Revised Code of Washington (RCW), and subsequently detained for inpatient psychiatric treatment.
Juvenile Drug Court	A specific juvenile court docket, dedicated to a heightened and intensified emphasis on therapy and accountability, as described by the U.S. Department of Justice, Bureau of Justice Assistance in the monograph, Juvenile Drug Courts: Strategies in Practice, March 2003.
Juvenile Offender	Any offender under the jurisdiction of juvenile court who is under the chronological age of eighteen years and who has not been previously transferred to adult court.
King County Family Treatment Court (FTC)	A post-adjudication program established to address issues related to a child’s dependency status due to parental substance abuse.
King County Integrated Care Network (KCICN)	Alliance formed by participating Providers and Behavioral Health and Recovery Division (BHRD) to operate a clinically integrated behavioral health network that provides the full range of Medicaid State Plan Services and contract with the Washington State Health Care Authority (HCA) designated Medicaid managed care organizations (MCOs) for the

	King County Regional Service Area. KCICN is a reference to the entities entering into this Agreement, and neither this Agreement nor any other understanding among participants is intended to create a separate legal entity.
Levels of Care	The organization of services into groups that reflect differences in the intensity of client need and the best way to deliver services that respond to that need. A set of guidelines for placement, continued stay and transfer or discharge of individuals with behavioral health conditions.
Locally Funded Programs	County and City Funded Services which include: All MIDD Behavioral Health Sales Tax program, Supported Employment Services (SEP), and Education and Workforce Development.
Long-Term Care Residential Substance Use Disorder (SUD) Services	The care and treatment of chronically impaired Individuals diagnosed with substance use disorder (SUD) who also have impaired self-maintenance capabilities who reside in a twenty-four (24) hour-a-day, supervised facility in accordance with Chapter 246- 341 WAC (The service as described satisfies the level of intensity in ASAM Level 3.3).
Long-Term Rehabilitation (LTR)	A 24-hour supervised residential treatment program for adults who: 1. Require 24-hour supervision; 2. Do not require extensive medical care; 3. Have a severe functional or behavioral impairment as a result of a psychiatric disorder; and/or do not follow or do not have effective medications.
Low-Income Individual	An individual greater than 18 years old whose gross household monthly income does not exceed the monthly income determined by 220% of the Federal Poverty Guidelines as eligible for low-income services. These individuals are eligible to receive services partially supported by County Community Services. An individual younger than 18 years old who has a family income of less than 300% of the federal poverty level.
Managed Care	An integrated system managing access and intensity and duration of care through defined standards, expected outcomes, quality indicators, and planned expenditures. A prepaid, comprehensive system of medical and behavioral health care delivery including preventive, primary, specialty, and ancillary health services.
Managed Care Organization (MCO)	An organization having a certificate of authority or certificate of registration from the Washington State Office of Insurance Commissioner that contract with Health Care Authority (HCA) under a comprehensive risk contract to provide prepaid health care services to eligible HCA individuals under HCA managed care programs
Managed Care Organization (MCO) Policy and Procedures	The MCO's compilation of operating policies, standards, and procedures for Participating Providers including, but not limited to, MCO's requirements for claims submission and payment, credentialing/re-credentialing, utilization review/management, case management, quality assurance/improvement, advance directives, Client rights, grievances and appeals
Managed Care Organization	The purpose of the Managed Care Policy Manual is to provide a reference for the administration of the Medicaid managed care program

(MCO) Provider Manual	and to provide direction to the MCOs and other entities providing service under managed care
Materials	Any promotional activity or communication with an Individual that is intended to "brand" a Provider's name or organization. Materials include written, oral, in-person (telephonic or face-to-face) or electronic methods of communication, including email, text messaging, and social media (i.e. Facebook, Instagram, and Twitter).
Medicaid Apple (Medicaid Expanded)	An individual who has become eligible and is receiving Title XIX benefits after the open enrollment date of October 1, 2013.
Medicaid Classic	An individual who has become eligible and is receiving Title XIX benefits prior to the open enrollment date of October 1, 2013.
Medicaid Recipient	An individual who is currently enrolled in the Medicaid program.
Medically Necessary/Medical Necessity	A requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate, or prevent the worsening of conditions in the recipient that endanger life, cause suffering or pain, result in illness or infirmity, threaten to cause or aggravate a handicap, or cause physical deformity or malfunction, and there is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the person requesting service. For the purpose of this section, "course of treatment" may include mere observation or, where appropriate, no treatment at all (WAC 182-500-0070).
Medication-Assisted Treatment (MAT)	Provision of treatment services and medication management (methadone, etc.) to individuals addicted to opiates. Treatment is defined as follows: 1. Assessment; 2. Treatment services to individuals with an opioid use disorder; 3. Prescribing and dispensing of methadone or other Department of Social and Health Services (DSHS) Division of Behavioral Health (DBHR)-approved substitute drug in opiate substitute programs approved in accordance with Washington Administrative Code (WAC) 246-341 or its successor. Both withdrawal management and maintenance are included. Physical exams, clinical evaluations, individual or group therapy for the primary individual and their family or significant others, guidance counseling, and educational and vocational information. MAT is also referred to as Opioid Treatment Program (OTP).
Medication Management	The prescribing and/or administering and reviewing of medications and their side effects. This service is rendered face-to-face by a person licensed to perform such services. This service may be provided in consultation with primary therapists, and/or case managers, but includes only minimal psychotherapy.
Medication Monitoring	Face-to-face, one-on-one cueing, observing, and encouraging an Individual to take medications as prescribed. This activity may take place at any location and for as long as it is clinically necessary.

Mental Health Advance Directive	A written document in which the Individual makes a declaration of instructions, or preferences, or appoints an agent to make decisions on behalf of the Individual regarding the Individual's mental health treatment that is consistent with Chapter 71.32 RCW.
Mental Health Block Grant (MHBG)	Funds granted by the Secretary of the Department of Health and Human Services (DHHS), through the Center for Mental Health Services (CMHS), Substance Abuse and Mental Health Services Administration (SAMHSA), to states to establish or expand an organized community-based system for providing mental health services for adults with Serious Mental Illness (SMI) and children who are seriously emotionally disturbed (SED).
Mental Health Court	A specialized court for misdemeanor defendants with mental illness. Defendants work with a team of specialists, including a judge, prosecutor, defender, court monitor, treatment Provider and probation officer, to receive court-ordered treatment as a diversion from prosecution or as a sentencing alternative.
Mental Health Professional	A psychiatrist, psychologist, psychiatric nurse, psychiatric nurse practitioner, physician assistant supervised by a psychiatrist, or social worker as defined in Chapters 71.05 and 71.34 RCW; A person with a master's degree or further advanced degree in counseling or one of the social sciences from an accredited college or university. Such persons have, in addition, at least two (2) years of experience in direct treatment of persons with mental illness or emotional disturbance, such experience gained under the supervision of a Mental Health Professional; A person who meets the waiver criteria of RCW 71.24.260, which was granted before 1986; A person who is licensed by DOH as a mental health counselor, mental health counselor associate, marriage and family therapist, or marriage and family therapist associate. A person who has an approved exception to perform the duties of a Mental Health Professional; or A person who has been granted a time-limited waiver of the minimum requirements of a Mental Health Professional.
MIDD Behavioral Health Sales Tax	A Behavioral Health Sales Tax Fund. King County's MIDD is a countywide 0.1% sales tax generating an about $134 million per two-year biennium, specifically for programs and services for people living with or at risk of behavioral health conditions. King County's MIDD is managed and operated by the King County Department of Community and Human Services' Behavioral Health and Recovery Division.
Mobile Response and Stabilization Services (MRSS)	King County's MRSS provides in person crisis services to all children, youth and families in King County along with stabilization services for up to 8 weeks. MRSS builds on the family's and youth's strengths to provide creative and flexible solutions that focus on teaching and modeling parenting and problem- solving skills to manage behavior and avoid out of home placement. MRSS helps families achieve stability, helps prevent future crises, and helps children remain in their home.
Moral Reconation Therapy (MRT)	A systematic treatment strategy that seeks to decrease recidivism among adult criminal offenders by increasing moral reasoning. This cognitive- behavioral approach combines elements from a variety of psychological traditions to progressively address ego, social, moral, and

	positive behavioral growth. MRT takes the form of group and individual counseling using structured group exercises and prescribed homework assignments.
Multi-System Involved	Any person who is receiving services from or is formally involved with more than one service system. Typically, individuals would be involved with the behavioral health system and at least one other system like the criminal justice system and/or the child welfare system.
Multisystemic Therapy (MST)	MST is an empirically proven program that provides intensive family-based treatment addressing the known determinants of serious antisocial behavior in adolescents and their families. Only staff designated by the King County Superior Court Project Manager may make referrals to the MST Program.
The National Committee for Quality Assurance (NCQA)	An independent 501(c)(3) nonprofit organization in the United States that works to improve health care quality through the administration of evidence-based standards, measures, programs, and accreditation.
Natural Supports	Any person or organization contributing to positive outcomes that is not a formal treatment or intervention service, or any support provided by individuals or organizations in the family's own community, kinship, social, or spiritual networks.
Medically Compromised Client	A person considered to be "medically compromised homebound" has a chronic medical condition, physical or psychiatric, which causes significant disability such that the individual is (1) unable to leave home, or (2) if leaving home is possible, this occurs infrequently, is usually for the purpose of receiving medical care, and requires considerable effort, supervision, or assistance. Because of this difficulty or inability to leave home, the medically compromised homebound individual is unable to utilize services if provided only in a clinic.
Non-Medicaid	A type of funding that can include state, county, federal funds, etc.). Non- Medicaid behavioral health services are available as resources permit.
Notice of Action (NOA)	A written notice that must be provided to Individuals to inform them that a requested Contracted Service was denied or received only a limited authorization based on medical necessity.
Notice of Determination (NOD)	A written statement sent to a Medicaid or non-Medicaid client and his/her requesting Provider when outpatient or residential behavioral health services have been authorized by the King County Integrated Care Network (KCICN) or Behavioral Health Administrative Services Organization (BH-ASO) for the client. Additionally, NODs are sent to non-Medicaid clients in all the instances in which a Medicaid client would get an NOA. The content of the NODs mirrors the content of the NOA except for those instances where non-Medicaid clients have different rights.
Older Adult	A person 60 years of age or older.
Opiate Substitution Treatment Services (OST) (BARS 566.59)	Provision of treatment services and medication management (methadone, etc.) to individuals addicted to opiates. Treatment is defined as follows: 1. Assessment; 2. Treatment services to opiate dependent individuals;

	3. Prescribing and dispensing of methadone or other Department of Social and Health Services (DSHS) Division of Behavioral Health (DBHR)-approved substitute drug in opiate substitute programs approved in accordance with Washington Administrative Code (WAC) 246-341 or its successor. Both withdrawal management and maintenance are included; Physical exams, clinical evaluations, individual or group therapy for the primary individual and their family or significant others, guidance counseling, and educational and vocational information. For the purposes of King County, OST is also referred to as Opioid Treatment Program (OTP).
Opiate Substitution Treatment	Assessment and treatment to opiate dependent patients. Services include prescribing and dispensing of an approved medication, as specified in 21 C.F.R. Part 291, for opiate substitution services in accordance with WAC 246-341 (The service as described satisfies the level of intensity in ASAM Level 1).
Opioid Treatment Program (OTP)	A designated program that dispenses approved medication as specified in 21 C.F.R. Part 291 for opioid treatment in accordance with WAC 246-341- 0100.
Outpatient Treatment Services	Services that provide non-domiciliary/non-residential behavioral health assessment and treatment to individuals.
Outcome Measure(s)	Specific information that demonstrates what happens to individuals as a result of the behavioral health care they receive. Individual outcomes for behavioral health care under the King County Integrated Care Network (KCICN) and Behavioral Health Administrative Services Organization (BH- ASO) are specifically defined for each client depending on age and the level of care they will receive.
Outreach and Engagement	Identification of hard-to-reach individuals with a possible behavioral health condition and engagement of these individuals in assessment and ongoing treatment services as necessary.
Payor	The entity (including company where applicable) that bears direct financial responsibility for paying from its own funds, without reimbursement from another entity, the cost of covered services rendered to clients.
Peer Bridger	A trained Peer Support specialist who offers Peer Support services to participants in state hospitals prior to discharge and after their return to their communities. The Peer Bridger must be an employee of an agency licensed by Department of Health (DOH) that provides recovery services.
Peer Support	Services provided by peer counselors to individuals under the consultation, facilitation, or supervision of a Mental Health Professional.
Person-Centered Care	Integrated services delivered in a setting and manner that is responsive to individuals and their goals, values and preferences, in a system that supports good provider–client communication and empowers individuals receiving care and providers to make effective care plans together.
Personal Information	Information identifiable to any person including but not limited to information that relates to a person's name, health, finances, education, business, use or receipt of governmental services or other activities,

	addresses, telephone numbers, Social Security Numbers, driver license numbers, other identifying numbers, and any financial identifiers.
Pregnant/Postpartum and Parenting Women (PPW)	This term is anticipated to transition to more inclusive language by removing "women" and replacing it with "individual." Women who are pregnant; (ii) women who are postpartum during the first year after pregnancy completion regardless of the outcome of the pregnancy or placement of children; or (iii) women who are parenting children, including those attempting to gain custody of children supervised by Department of Children Youth and Families (DCYF).
Prepaid Inpatient Health Plan (PIHP)	An entity, under contract with the state and funded by prepaid capitation payments, that provides, arranges for, or otherwise has responsibility for the provision of any inpatient or institutional services for its enrollees and does not have a comprehensive (i.e. primary health care) contract.
Prevalent Languages	The Department of Social and Health Services (DSHS) prevalent languages are: Cambodian, Chinese, English, Korean, Laotian, Russian, Somali, Spanish, and Vietnamese.
Prevocational Services	Services based on individual need that prepare a person to seek work. Such services principally include improving skills in resume preparation, application writing, interviewing, and specific work-site-related behaviors such as punctuality, employer-employee relations, and hygiene.
Program for All-Inclusive Care of the Elderly (PACE)	A Medicare/Medicaid program for older adults offered through Providence Elder Care. This program allows frail elderly people who would qualify medically for a nursing home placement to live in their communities. A person enrolled in this program is not eligible for concurrent outpatient benefits.
Program for Assertive Community Treatment (PACT)	An evidence-based service delivery model for providing comprehensive community-based treatment to persons with the most serious and persistent mental illnesses that have not benefited from traditional outpatient programs. Key component elements include team approach, small caseload, individualized treatment, fixed point of responsibility, in-vivo assistance, time-unlimited services, and 24/7 crisis response.
Progress Notes	Permanent record, entered into an individual's clinical record, of ongoing assessments of an individual's participation in and response to treatment, and progress in recovery. Progress notes include the date of treatment service duration, location, Provider credentials, diagnosis, modality and Current Procedural Terminology (CPT) code. See SERI Encounter Reporting Instructions (SERI) for encountering requirements.
Provider	The behavioral health care person(s) or agency including all physicians, clinicians, allied health professionals, and staff persons who provide health care services to clients.
Provider Profile	A compilation of information about a contracted Provider of King County Integrated Care Network (KCICN) or Behavioral Health Administrative Services Organization (BH-ASO) outpatient services. The profile includes populations served, clinical practice information, and clinical outcomes.
ProviderOne	The Health Care Authority's (HCA's) Medicaid Management Information Payment Processing System, or any superseding platform as may be designated by HCA

Psychiatric Emergency Services (PES)	Facility and staff at Harborview Medical Center (HMC) providing the full array of crisis triage services, 24 hours a day, 365 days a year.
Psychological Assessment	All psychometric services provided for evaluating, diagnostic, or therapeutic purposes by or under the supervision of a licensed psychologist
Psychotherapy	The client-centered treatment of emotional, behavioral, personality and psychiatric disorders based primarily upon verbal or non-verbal communication with the client in contrast to treatments utilizing chemical or physical measures. See Service Encounter Reporting Instructions (SERI) for encountering requirements
Quality Assurance (QA)	A focus on compliance with minimum standards (e.g., rules, regulations, contract terms) as well as reasonably expected levels of performance, quality, and practice.
Quality Improvement (QI)	A focus on activities to improve performance above minimum standards, reasonably expected levels of performance, quality, and practice.
Quality Management (QM)	A system and/or process whereby quality assurance and quality improvement activities are incorporated and infused into all aspects of an organization's or system's operations.
Recovery	Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.
Recovery House Residential Treatment	A program of care and treatment with social, vocational, and recreational activities designed to aid individuals diagnosed with substance use disorder (SUD) in the adjustment to abstinence and to aid in job training, reentry to employment, or other types of community activities, excluding Room and Board in a twenty-four (24) hour-a-day supervised facility in accordance with WAC 246-341 (The service as described satisfies the level of intensity in ASAM Level 3.1).
Recovery-Oriented System of Care (ROSC)	A diverse and dynamic community with a healthy economy and environment where all people and businesses have an opportunity to thrive and where wellness and recovery from substance use disorders (SUDs) and mental illness is expected, honored, and celebrated.
Recovery Support Services	A broad range of non-clinical services that assist individuals and families to initiate, stabilize, and maintain long-term recovery from behavioral health disorders. Services may include: peer delivered motivational interviewing; peer wellness coaching; peer-run respite services; person-center planning; self-care and wellness approaches; Wellness Recovery Action Plan (WRAP); supported employment; peer health navigators; supportive housing; recovery community centers; whole health action management; wellness-based community campaign; mutual aid groups for individuals with co-occurring disorders; recovery coaching; shared decision-making; telephone checkups; warm lines; and peer-run crisis diversion services.
Regulation	Any federal, State, Local or King County Behavioral Health and Recovery Division (BHRD) regulation or ordinance
Rehabilitation Case Management	A range of activities by the outpatient community mental health agency's liaison conducted in or with a facility for the direct benefit of an Individual in the public mental health system. To be eligible, the individual must be

	in need of case management in order to ensure timely and appropriate treatment and care coordination.

Residential Treatment Services	Services to provide substance use disorder (SUD) treatment for individuals and include room and board in a 24-hour-a-day supervised facility in accordance with State administrative regulations WAC 246-341 or its successors and as described by the American Society of Addiction Medicine (ASAM). The following levels of care may be provided in residential treatment:
	• ASAM Level 3.1 Clinically Managed Low Intensity Residential Treatment
	  ○ Recovery house treatment services
	  ○ Long-term residential treatment services
	• ASAM Level 3.3 Clinically Managed Population-Specific High Intensity Residential
	• ASAM Level 3.5 Clinically Managed High Intensity Residential
	  ○ Intensive inpatient
	  ○ Co-occurring residential
	• ASAM Level 3.7 Medically Monitored Intensive Inpatient Services
	  ○ Withdrawal management
	• ASAM Level 4 Medically Managed Intensive Inpatient Services
	  ○ Withdrawal management
	Youth residential services include ASAM Levels 3.1, 3.5, 3.7.
	Pregnant and parenting women (PPW) include ASAM Levels 3.3, 3.5.
	Medication-Assisted treatment for Opioid Use Disorder (OUD) includes all residential treatment ASAM Levels.

Resiliency	The personal and community qualities that enable individuals to rebound from adversity, trauma, tragedy, threats, or other stresses and to live productive lives (Revised Code of Washington [RCW] 71.24.025).
Revised Code of Washington (RCW)	The laws of the state of Washington.
Room and Board	Provision for services in a twenty-four (24) hour-a-day setting including accessible, clean and well-maintained sleeping quarters with sufficient space, light and comfortable furnishings for sleeping and personal activities along with nutritionally adequate meals provided three (3) times a day at regular intervals. Room and Board must be provided consistently with the requirements for Residential Treatment Facility Licensing through Department of Health (DOH) (Chapter 246-337 WAC).
Routine Care	Services intended to stabilize, sustain, and facilitate client recovery within their living situation. These services do not meet the definition of urgent or emergent care.
Screening	The process by which Provider evaluates persons who present for service and determines the appropriate referral.
Screening, Brief Intervention, and Referral to Treatment (SBIRT)	SBIRT is a comprehensive and integrated public health approach for early intervention and treatment of persons with, or at risk for developing, SUD. Screening using a validated tool quickly assesses the presence and severity of SUD. Brief intervention guides individuals through considering the physical and behavioral health impacts of drug and alcohol use and motivates behavior change. Referral to treatment

	connects individuals to the continuum of mental health and substance use disorder services, recovery supports, harm reduction education, and culturally appropriate community resources.
Secure Detox Facility	A facility operated by either a public or private agency, as defined in RCW 71.05.020, that provides involuntary treatment to individuals detained for substance use disorder (SUD) Involuntary Treatment Act (ITA) up to ASAM withdrawal management level 3.7.
Seriously Emotionally Disturbed; Severe Emotional Disturbance (SED)	An infant or child from birth to age eighteen who has been determined to be experiencing a mental disorder as defined in Chapter 71.34 Revised Code of Washington (RCW), including those mental disorders that result in a behavioral or conduct disorder, that is clearly interfering with the child's functioning in family or school or with peers, and who meets at least one of the following criteria: 1. Has undergone inpatient treatment or placement outside of the home related to a mental disorder within the last two years; 2. Has undergone involuntary treatment under Chapter 71.34 RCW within the last two years; 3. Is currently served by at least one of the following child serving systems: juvenile justice, child-protection/welfare, special education, or developmental disabilities; 4. Is at risk of escalating maladjustment due to: a. Chronic family dysfunction involving a mentally ill or inadequate caretaker; b. Changes in custodial adult; c. Going to, residing in, or returning from any placement outside of the home, for example, psychiatric hospital, short-term inpatient or residential treatment, group or foster home, or a correctional facility.
Serious Mental Illness (SMI):	Persons aged eighteen (18) and over who currently, or at any time during the past year, have a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within the current Diagnostic and Statistical Manual of Mental Disorders (DSM) that has resulted in functional impairment which substantially limits one (1) or more major life activities such as employment, school, social relationships, etc.
Sexual Minority	A person who self-identifies as LGBTQI: 1. Lesbian; 2. Gay; 3. Bi-sexual; 4. Transgender; 5. Queer; or 6. Intersex
Single Case Agreement (SCA)	A contract between Behavioral Health and Recovery Division (BHRD) and an out-of-network Provider for a specific client, so that the client can see that Provider using their in-network benefits. The fees per session and duration of service are negotiated by BHRD and the Provider as part of the SCA.
Sobering Services	Shelter services designed to provide short-term (12 hours or less) emergency shelter, screening, and referral services to individuals who

	need to sleep off the effects of alcohol or drugs. Services include medical screening, observation, and referral to continued treatment and other services as appropriate.
Special Population Evaluation	An evaluation by a child, geriatric, disabled, or ethnic minority specialist that considers age and cultural variables specific to the individual being evaluated and other culturally and age competent evaluation methods.
Spenddown	Spenddown refers to the amount of medical expense for which the client is responsible. Spenddown occurs when the client's income and resources are above the limits set by the state for receiving Medicaid coverage.
Stabilization Services	Services provided to Individuals who are experiencing a mental health crisis. These services are provided in the person's home, or another home-like setting, or a setting which provides safety for the individual and the Mental Health Professional. Stabilization Services include short-term (less than two (2) weeks per episode) face-to-face assistance with life skills training and understanding of medication effects. This service includes a) follow-up to Crisis Services; and b) other individuals determined by a Mental Health Professional to need additional Stabilization Services. Stabilization Services may be provided prior to an Intake Evaluation for mental health services.
Standard Supportive Housing (SSH)	SSH services are for individuals who may require regular staff contact and the availability of staff 24 hours a day, 7 days a week, but who do not need the physical safety and structure of a residential facility. Individuals may be housed in cluster or independent settings.
Stigma	Attitudes within most communities that view symptoms of mental illness or substance use disorder (SUD) as threatening and uncomfortable and frequently foster negative attitudes and discrimination towards people experiencing behavioral health problems. Such reactions are common when people are willing to admit they have a behavioral health problem, and they can often lead to various forms of exclusion or discrimination – either within social circles or within the workplace. Social stigma is characterized by prejudicial attitudes and discriminating behavior directed towards individuals with behavioral health problems as a result of the label they have been given. Perceived stigma or self-stigma is the internalizing by the behavioral health sufferer of their perceptions of discrimination and can significantly affect feelings of shame and lead to poorer treatment outcomes.
Subcontract	Any separate agreement or contract between the Contractor and an individual or entity ("Subcontractor") to perform all or a portion of the duties and obligations that the Contractor is obligated to perform pursuant to the contract.
Substance Abuse	A recurring pattern of alcohol or other drug use that substantially impairs an individual's functioning in one or more important life areas, such as familial, vocational, psychological, physical, or social.
Substance Use Disorder (SUD)	A problematic pattern of use of alcohol and/or drugs that causes a clinically and functionally significant impairment. This includes use in situations in which it is physically hazardous, social or interpersonal problems related to use, failure to meet responsibilities at work school or home because of use, tolerance, withdrawal, using in larger amounts or

	for longer amounts of time, repeated attempts to control use or quit, much time spent using and physical or psychological problems related to use.
Substance Use Disorder (SUD) Assessment	A therapeutic process provided by a Substance Use Disorder Professional (SUDP) or SUDP Trainee (SUDPT) under the supervision of a SUDP designed to evaluate an individual to determine if the individual has a substance use disorder and determine placement in accordance with the ASAM Criteria (WAC 246-341-0610).
Substance Use Disorder Professional (SUDP)	An individual who is certified by the Washington State Department of Health (DOH) according to RCW 18.205.020 and the certification requirements of Washington Administrative Code (WAC) 246-811-030 to provide SUD services.
Substance Use Disorder Professional Trainee (SUDPT)	An individual working toward the education and experience requirements for certification as a substance use disorder professional, and who has been credentialed as a SUDPT.
Substance Use Disorder (SUD) Treatment Services	A broad range of emergency, withdrawal management, residential, and outpatient services and care. Treatment services include diagnostic evaluation, substance use disorder (SUD) education, individual and group counseling, medical, psychiatric, psychological, and social services, vocational rehabilitation and career counseling that may be extended to alcoholics and other drug addicts and their families, individuals incapacitated by alcohol or other drugs, and intoxicated individuals.
Substance Use Disorder Outpatient Treatment	Services provided in a non-residential substance use disorder (SUD) treatment facility. Outpatient treatment services must meet the criteria in chapter 246-341 WAC (The service as described satisfies the level of intensity in ASAM Level 1).
Substance Abuse	A recurring pattern of alcohol or other drug use that substantially impairs an individual's functioning in one or more important life areas, such as familial, vocational, psychological, physical, or social.
Substance Use Prevention, Treatment, and Recovery Services Block Grant (SUPTRS BG)	The Federal Substance Abuse Block Grant Program authorized by Section 1921 of Title XIX, Part B, Subpart II and III of the Public Health Service Act.
Supervised Living (SL)	Any residential service program including but not necessarily limited to an Adult Family Home (AFH) or Congregate Care Facility (see separate definitions) in which staff provide 24-hour on-site supervision. Additional treatment services may be provided in this setting as part of the outpatient authorized benefit.
Supported Employment (SE)	An evidence-based practice that assists persons diagnosed with serious and persistent mental illness obtains and maintains community-integrated employment that pays at least minimum wage. The practice focuses on defining a participant's circumstances, capabilities, and level of motivation, then adds the supports to assist the participant in finding and retaining an appropriate job.
Supportive Housing Services	Includes eligibility screening, monitoring harm reduction activities, providing housing stabilization, crisis management, and case

	consultation and referral services for the purpose of linking individuals to support services. Services do not include direct treatment services.
System Collaboration	The organization and coordination of resources available through federal, state, and local human service systems responsible for serving individuals and their families. Strategic planning, consolidation of funding streams, and policy formation are examples of tools that promote system collaboration and integration.
System of Care	A comprehensive spectrum of behavioral health and other necessary services which are organized into a coordinated network to meet the multiple and changing needs of children and their families.
Therapeutic Psychoeducation	Informational and experiential services designed to aid Individuals, their family members (e.g., spouse, parents, siblings) and other individuals identified by the Individual as a primary support in the management of psychiatric conditions.
Tier Benefit	See Case Rate.
Transitional Age Youth (TAY)	An individual between the ages of fifteen (15) and twenty- five (25) years who present unique service challenges because they are too old for pediatric services but are often not ready or eligible for adult services.
Trauma-Informed	A program, organization, or system that realizes the widespread impact of trauma and understands potential paths for recovery; recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system; and responds by fully integrating knowledge about trauma into policies, procedures, and practices, and seeks to actively resist re-traumatization.
Trauma-Informed Care (TIC)	TIC is a strengths-based framework that is grounded in an understanding of and responsiveness to the impact of trauma, that emphasizes physical, psychological, and emotional safety for both Providers and survivors, and that creates opportunities for survivors to rebuild a sense of control and empowerment.
TTY or TDD	Teletypewriter (TTY) or Telecommunications Device for the Deaf (TDD). Both acronyms refer to a device that allows deaf individuals to make a telephone call directly, without the use of another person to interpret.
Urgent Care	Urgent care services are those services that, if not provided, would result in decomposition to the point that emergency care is necessary. Urgent crisis services must be initiated within 24 hours of the initial request from any source. Examples include Crisis and Commitment Services (CCS), **Mobile Response and Stabilization Services (MRSS)**services, inpatient diversion beds, and crisis stabilization services.
Urinalysis (UA)	Analysis of an individual's urine sample for the presence of alcohol or controlled substances by a licensed laboratory or a Provider who is exempted from licensure by the department of health: 1. Negative urine: a urine sample in which the lab does not detect specific levels of alcohol or other specified drugs; and 2. Positive urine: a urine sample in which the lab confirms specific levels of alcohol or other specified drugs.
Utilization Review (UR)	The process of evaluating the use of Provider services, procedures, and facilities by comparison with pre-established criteria.

Vocational Services	Services based on individual needs which support a person to gain and retain employment. Such services principally include vocational assessment, job development, job placement, and job coaching. Vocational services may also include medical diagnostics, training, transportation, and provision of tools, equipment and uniforms or work clothes.
Vulnerable Adult	An individual who lacks the functional, mental, or physical ability to care for oneself.
Wait List	A list of individuals for whom a later date for services has been scheduled due to lack of capacity. A person will be selected from the list to fill an opening based on the required order of precedence identified in the appropriate contract.
Waiting List Interim Services (WLIS)	Services offered to an individual denied or delayed admission to a treatment program on the basis of the lack of capacity of the program to admit the individual.
Waiver	The document by which Department of Social and Health Services (DSHS) requests sections of the Social Security Act be waived in order to operate a capitated managed care system to provide services to enrolled recipients.
Washington Administrative Code (WAC)	Regulations of executive branch agencies are issued by authority of statutes. Like legislation and the Constitution, regulations are a source of primary law in Washington State.
Washington Apple Health- Fully Integrated Managed Care (AH-FIMC)	The program under which a managed care organization (MCO) provides General Funds State (GFS) services and Medicaid-funded physical and behavioral health services.
Washington State Risk Needs Assessment	A tool that evaluates the level of risk, treatment needs, and protective factors across a number of domains for adjudicated juvenile offenders. This tool is used statewide by juvenile courts.
WATrac: Washington System for Tracking Resources, Alerts, and Communication	A web-based application serving the Washington Healthcare system by providing two distinct functions: 1) daily tracking of facility or organizational status and bed availability and, 2) incident management and situational awareness during disaster planning and response.
Wellness Recovery Action Plan (WRAP)	A self-management and structured recovery system designed to decrease and prevent intrusive or troubling feelings and behaviors, increase personal empowerment, improve quality of life, and assist persons in achieving their own life goals.
Wraparound	A model of needs-driven and strengths-based planning through a facilitated team process. The client and family are supported by a team of people that includes natural/community support and professionals, eventually evolving to a team of community supports.
Young Adult	A person who is 18, 19 or 20 years old.

Youth	A person from age 10 through 17 years old.
Youth Outpatient Treatment	Services that provide non-domiciliary/non-residential substance use disorder (SUD) assessment and treatment to youth and young adults ages 10 through 20.