12.7.17 1:00 – 3:00PM
Program Council Meeting
Skagit County Commissioners Building
https://zoom.us/j/350744720
Dial: +1 408 638 0968
Meeting ID: 350 744 720

North Sound ACH
BUILDING HEALTHIER COMMUNITIES
in Island, San Juan, Snohomish, Skagit & Whatcom Counties

## Program Council Members:

Greg Arnold
Ryan Blackwell
Siobhan Brown
Federico Cruz-Uribe, MD
Connie Davis, MD
Stephen Gockley, JD
Carol Gipson
Linda Gipson
Bill Henkel
David Jefferson
Jennifer Johnson, Chair
Anji Jorstad
Barbara Juarez
Jeff Ketchel
David Kincheloe, PhD
Barbara LaBrash
Laurel Lee
Linda McCarthy
Chris Phillips, Vice Chair
Glenn Puckett
Caitlin Safford
Tom Sebastian
Janette Schurman
Janet St. Clair
Greg Winter
Laura White

**Staff Members:**
Liz Baxter
Kyle Davidson
Tiffany Edlin
Emily Henke (contractor)
Ross Howell
Heather McGuinness
Hillary Thomsen
Leah Wainman
Nicole Willis

## DRAFT Agenda

| Time | Topic | Purpose | Lead |
|---|---|---|---|
| 1:00 | **1.Welcome and Meeting Agenda**<br>● Introductions<br>● Review November Program Council minutes<br>Attachment A) November 2 meeting minutes | **Action:** Approve August 2017 minutes | Jennifer (Liz) |
| 1:05 | **2. Updates**<br>● **Deliverable**<br>○ Next Steps<br>○ Deadlines<br>Attachment B) Summary of Project Plans Submitted<br>Attachment C) Project Strategy Areas | | Jennifer (Liz) |
| 1:20 | **3. "Regional Health Needs Inventory"**<br>• Please review section one of our deliverable<br>• Come prepared with any questions.<br>Link to section one here. | | Nicole (Liz) |
| 2:00 | **5. Program Council's Role Moving Forward**<br>• Charter Review<br>Attachment D) Program Council Charter | Recommend to the Board | Jennifer (Liz) |
| 2:30 | **6. Other**<br>• Other Updates<br>• 2018 Calendar<br>Attachment E) Diagram_MCO BHO ACH System<br>Attachment F) Graphic Proposed<br>Attachment G) Draft North Sound Proposed 2019 | | Jennifer<br>Greg A.<br>(liz) |
| 2:50 | **7. Public Comment** | | Jennifer |
| 3:00 or sooner | **8. Adjourn** | | Jennifer |

November 2, 2017 1 - 3
Program Council Meeting
Burlington Library

North Sound ACH
BUILDING HEALTHIER COMMUNITIES
in Island, San Juan, Snohomish, Skagit & Whatcom Counties

## Program Council:

- ■ Greg Arnold
- ■ Ryan Blackwell
- ■ Siobhan Brown
- ■ Federico Cruz-Uribe, MD
- ☐ Connie Davis, MD
- ■ Stephen Gockley, JD
- ■ Carol Gipson
- ■ Linda Gipson
- ☐ Bill Henkel
- ■ David Jefferson
- ■ Jennifer Johnson, Chair
- ■ Anji Jorstad
- ☐ Barbara Juarez
- ☐ Jeff Ketchel
- ■ David Kincheloe, PhD
- ☐ Barbara LaBrash
- ☐ Laurel Lee (Jorge Rivera in Laurel's absence)
- ■ Linda McCarthy
- ■ Chris Phillips, Vice Chair
- ■ Glenn Puckett
- ☐ Caitlin Safford
- ■ Tom Sebastian
- ☐ Janette Schurman
- ■ Janet St. Clair
- ■ Greg Winter
- ■ Laura White

**Staff Members:**

- ■ Liz Baxter
- ■ Kyle Davidson
- ■ Tiffany Edlin
- ■ Emily Henke (contractor)
- ■ Ross Howell
- ■ Heather McGuinness
- ■ Hillary Thomsen
- ■ Nicole Willis
- ■ Leah Wainman

## Draft Minutes

### Topic

**1.Welcome and Meeting Agenda**

- Motion: to approve September 7th meeting minutes, by Linda McCarthy; second by Glenn Puckett. All in favor, no oppositions or abstentions. Motion carries with 18 votes.

**2.Updates**

- **Board Decision**
  - At the September Board meeting the Board voted to move forward with all 8 project areas.
- **Health Care Authority News**
  - You would have received a few emails with these updates.
  - The same day as board vote, the HCA informed ACH's that there was going to be a 36% reduction in funds for our year one dollars.
  - They have since updated the reduction in funds to 25% and it may continue to lower.
  - This is due to fund allocation that has changed since the original negotiation of funds with CMS and the State.
  - The HCA has to re-compute the amount of money they have available for this work.
  - Currently, we have a draft deliverable for November 16 complete. We are staying the course and writing to all 8 project areas.
  - After the submission of the deliverable, we will be moving into a planning phase.
  - There is a new mitigation strategy to help counter the decrease in fund allocation.
    - Our submission is no longer binding until January 31st for our project area commitment.
    - There used to be a financial disincentive for regions that did not select at least 6 project areas, that is no longer the case.
    - Your score on your deliverable is associated with the percentage of funds you will earn. They will no longer be rounding down. If you score a 93% on your deliverable you will earn 93% of your year one funding rather than 90% as originally planned.
    - There is a point bonus system for ACHs that select more than 6 project areas.
    - HCA is moving away with the unearned funds pool, moving to an incentive pool for regions that select 6, 7, or 8 project areas.
  - In December we will submit a document that will have a list of partners who will receive funds in year one. We will be able to add to this list as time goes on.
  - Have been working with workgroup leads to help think through the decision of 8 project areas and the

new January 31st binding date.

- Voted to become a mid-adopter region. The funds that we will earn as a mid-adopter, will be looking to the interlocal leadership group to provide recommendations to our finance committee on how to spend funds.

3. Framing
   - Liz reviewed the slides that were presented to the Board in August.
   - It is okay for us to "fail," and still earn some funding. Will be held accountable to region wide percentages.
4. Gathering Perspectives
   - Program Council discussed the non-pie chart in great detail
   - Board made a few recommendations last week, but we would like to hear from you all.
   - No matter how much money we earn, it will not be enough money to support this work, so we will be looking to other funders and partners to leverage money.
   - Want to ensure we scale up workforce to meet our needs down the road. (Trainings!)
   - Some suggestions to remove "equally" from the diagram
   - Would like flexibility on who and when agencies receive funds.
   - Would like to consider communication elements
   - Need to focus on capacity building
   - Moving from provider volume to performance
   - Strong desire from group to keep resiliency fund--support for making it a higher percentage if possible
   - Would like to encourage partnership rather than silos within the split funds portion of the diagram.
5. Next Steps
   - Will plan on reviewing charter at the next meeting
   - Would like to discuss how to optimize our multi-sector table – how do we make a collective impact
   - Would like to leverage shared goals and vision
   - Would like to discuss initiative 3 around supportive housing measures for the future.
6. Public Comment
   - No comment at this time
7. Adjourn at 2:59pm

# Summary of Project Plans submitted November 16 by Accountable Communities of Health (ACHs)

The Medicaid Transformation Demonstration builds incentives for providers who are committed to changing how we deliver care. Each region, through its ACH, will pursue projects that transform the Medicaid delivery system, so that care focuses on the whole person and resources are used more effectively.

- The table below shows the project areas selected by ACHs. You can find the full Project Plans and supplemental workbooks on the Healthier Washington website under Initiative 1.
- **Important:** ACHs have until January 31, 2018 to amend the initial Project Plan submission before final review and approval. Therefore, selected projects in the table below and details within the documents linked above should be viewed as preliminary and subject to change.
- Washington's independent assessor will review and score the Project Plans based on the criteria for project plan assessment. The independent assessor will conclude the assessment process by February 2018.
- At the conclusion of the assessment, the independent assessor will submit its findings to the Health Care Authority for final review and determination of Project Plan approval.
- Approved Project Plans will form the basis of Initiative 1 of Washington's Medicaid Transformation Demonstration.

**Table of ACH projects submitted on November 16, 2017**

| | Better Health Together | Cascade Pacific Action Alliance | Greater Columbia ACH | King County ACH | North Central ACH | North Sound ACH | Olympic Community of Health | Pierce County ACH | Southwest Washington ACH |
|---|---|---|---|---|---|---|---|---|---|
| **Project Areas** | | | | | | | | | |
| Bi-directional integration of physical and behavioral health | √ | √ | √ | √ | √ | √ | √ | √ | √ |
| Community-based care coordination | √ | √ | | | √ | √ | | √ | √ |
| Transitional care | | √ | √ | √ | √ | √ | | | |
| Diversions interventions | | | | | √ | √ | √ | | |
| Addressing the opioid use public health crisis | √ | √ | √ | √ | √ | √ | √ | √ | √ |
| Reproductive and maternal and child health | | √ | | | | √ | √ | | |
| Access to oral health services | | | | | | √ | √ | | |
| Chronic disease prevention and control | √ | √ | √ | √ | √ | √ | √ | √ | √ |

# NORTH SOUND ACH PROJECT STRATEGY AREAS

## Person-centered Care Coordination

2B: Pathways Community HUB

2B: PreManage Integration

2B: Health Home Coordination

2C: Enhanced Care Transitions Interventions (CTI) Model

2C: Jail Transitions

2C: Inpatient Mental Health Transitions

2D: Community Paramedicine

2D: Care Coordination Collaboratives for Complex Cross-System Cases

3C: Dental Case Finding and Navigation

## Whole Person Care Delivery

2A: Screening (BH/chronic disease)

2A: Brief counseling interventions (BH/chronic disease)

2A: Medication Assisted Therapy (MAT) for depression and opioids

2A: Registry Development

2A: Treat-to-Target

2A: Consultation (medical/psychiatric)

2A: Referral to specialty providers

3A: Screening, Brief Intervention, and Referral to Treatment (SBIRT)

3A: Enhance/expand community recovery services

3A: Mobile treatment and outreach

3A: Improve opioid prescribing practices

3A: Scale up Medication Assisted Therapy (MAT)

3B: One Key Question

3B: Increasing Long-Acting Reversible Contraception (LARC) access

3B: HealthySteps specialists in pediatric practices

3C: Integrating Oral Health in primary care

3C: Dental Health Aide Therapists (DHAT) in Tribal Clinics

3C: ICD-10 coding in oral health

3C: Mobile Hygienists in Community Settings

3C: Silver Diamine Fluoride

3D: Clinical transformation around chronic disease best practices (training, screening, treatment, etc.)

## Upstream Wellness /Prevention Strategies

3A: Social marketing and public awareness

3A: Safe medication storage and disposal

3A: Improve opioid prescribing practices

3A: Prevention education for youth

3A: Increase availability and use of Naloxone

3B: One Key Question

3B: Increasing Long-Acting Reversible Contraception (LARC) access

3D: Asthma home-based environmental intervention

3D: Community-based chronic disease prevention and management programs

# Program Council Charter

DRAFT – 7/17/2017

North Sound ACH
Building Healthier Communities
*In Snohomish, Skagit, Island, San Juan & Whatcom Counties*

**Summary**

The Program Council is chartered by the North Sound ACH Board of Directors to provide oversight for the planning, evaluation and on ongoing improvement of North Sound ACH programming and services. The Program Council carries out this purpose through serving as a brain trust for staff and board, meeting as a Council and providing input to the Board, and chartering workgroups and committees that further the work of the organization.

## Responsibilities

The specific responsibilities of the Program Council include:

- **Recommend programing to the Board** that is consistent with the overall intent and values of the organization, and advances the organizational strategy as set forth by the Board. Most immediately, this involves recommending Medicaid Transformation projects that are aligned with HCA guidelines.
- As the North Sound ACH further develops its portfolio of programs and services in accordance with Board direction, the Provider Council will **anticipate and plan for new programs and partnerships,** particularly those that shift resources from clinical health care to social determinants of health.
- Ensure that the North Sound ACH is regularly using community health assessments and outcome **data to inform and continually improve** North Sound ACH programs and the health of the people living in the North Sound region.
- Ensure that there are opportunities for a broad cross-section of community organizations and people who are affected by North Sound ACH decisions to engage with the ACH and inform its programming and services. One way this is accomplished is through **convening workgroups.**
- Serve as a **community catalyst** for the North Sound ACH and seek avenues for convening cross-sector conversations about emerging topics of interest, (e.g. opportunities to change the balance of power and invest in provider, patient, and family partnership models of care; ways of promoting joy in the workplace; opportunities to return health care savings to other public purposes).

## Resources

The Program Council workgroups and committees will receive technical assistance and staff support from the North Sound ACH staff.

## Membership

Are we configured to fulfill the purpose as outlined above?

## Operating principles:

"True North" statement

# NSACH "True North" (approved at July Board meeting)

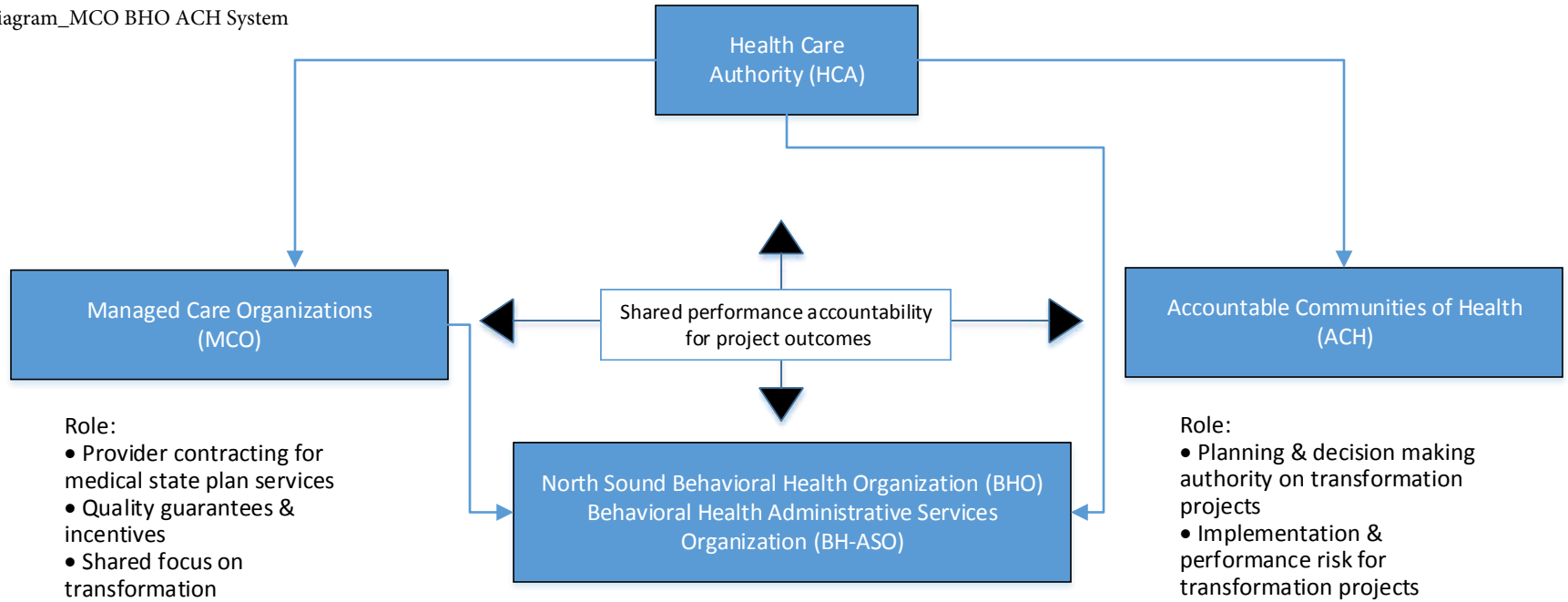
To improve health of the people who live in Island, San Juan, Snohomish, Skagit and Whatcom counties.

To achieve this goal, the North Sound ACH will:

- Work with private and public sector partners to create innovative and sustainable community-led solutions.
- Embed an equity lens, using strategies that advance equity and reduce disparities in operations, decisions and governance.
- Look upstream, midstream and downstream to identify solutions that include, and go beyond, traditional healthcare approaches.
- Embed the perspectives of clients, patients, and community members in operations, decisions and governance.
- Use ACH funds to leverage other opportunities for federal, state investments
- Operate in a lean, efficient manner that optimizes the ability of our partners to carry out the work toward transformation.

**The North Sound ACH uses the WHO definition of health, which states that health is "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity."**

Attachment E) Diagram_MCO BHO ACH System




Role:
- Provider contracting for medical state plan services
- Quality guarantees & incentives
- Shared focus on transformation
- Incentives to attain VBP goals

Revised Rate Setting

- % premium for provider incentives tied to quality
- % premium at risk for performance

Administer Crisis and Non-Medicaid Services
Coordinate regional planning for behavioral health services

Role:
- Maintain services that require blended funding, especially Medicaid, Non-Medicaid, and Local Funds
- Administer specialized behavioral health services that are more efficiently managed as part of a single system, e.g., PACT, WISe, Behavioral Health Residential Treatment facilities
- Coordinate with local government, hospital, EMS, court and jail systems to ensure responsiveness to local community needs and concerns
- Program utilization/oversite for services that directly impact WSH discharge, local systems
- Coordinate care for high needs/cost members that frequently move between MCOs and/or move between hospital, jail and the community - possibly as a "Behavioral Health Home"
- Identify & coordinate BH system improvements and workforce training, including increasing local capacity for crisis stabilization and residential treatment facilities
- Work with the MCOs to develop and implement value based payments for behavioral health services

Role:
- Planning & decision making authority on transformation projects
- Implementation & performance risk for transformation projects
- Incentives for quality improvement & VBP targets

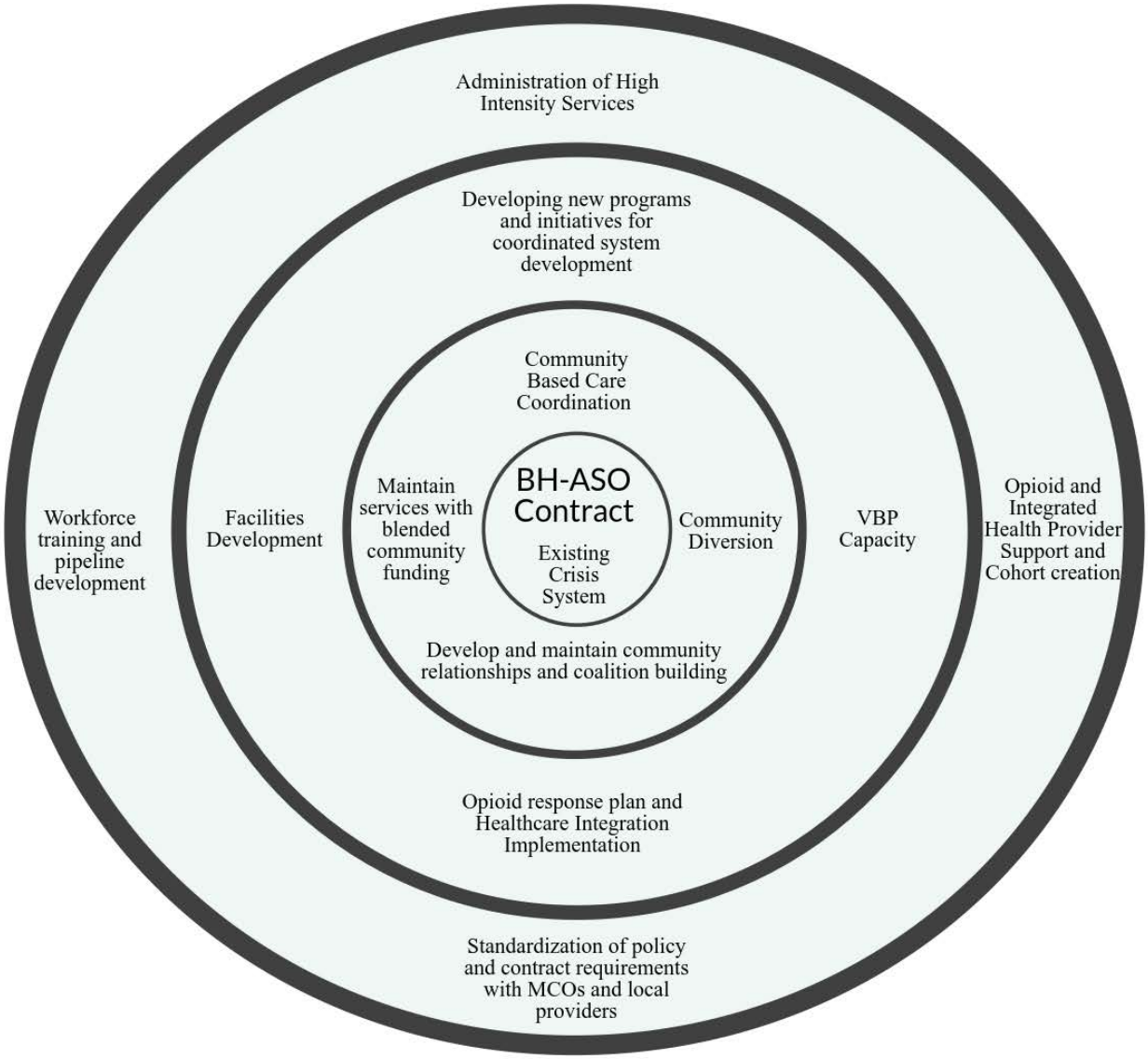
- Not responsible for state plan services

North Sound Behavioral Health Organization, LLC
301 Valley Mall Way, Suite 110, Mount Vernon, WA 98273
http://northsoundbho.org • 360.416.7013 • 800.684.3555 • F 360.416.7017

Attachment F) Graphic Proposed

# Proposed North Sound BH-ASO

## Local Community Embedded Partner




1st Circle - Crisis Continuum of Care

2nd Circle - Community and Local Allied System Connections

3rd Circle - Community Capacity Building

4th Circle - Provider and Stakeholder Support

# North Sound Proposed 2019
# Behavioral Health – Administrative Services Organization

## 1. Crisis Continuum of Care

**BH-ASO contracted crisis and non-Medicaid funded services**

- Crisis Triage and Intervention Telephone line
- Mental Health and Substance Use Disorder Involuntary Treatment
- Designated Mental Health Professionals
- Court for Involuntary Treatment Act (ITA)
- Mobile Crisis teams – Crisis Prevention and Response Teams (CPIT)
- Crisis Stabilization Services (up to 14 days) for MH and SUD
- Peer to Peer "Warm line"
- Criminal Justice Treatment Account (CJTA)
- Substance Abuse Prevention and Treatment (SAPT) Block Grant
- General Fund State (GFS) services
- Mental Health Block Grant (MHBG)
- Jail Transition and Pre-release Services
- Outreach to Individuals Using Intravenous Drugs
- Crisis line connection to 911
- Regional Ombuds Services

**Existing continuum of care for regional crisis services**

- Detox (Acute and Subacute)
- Triage Centers
- Engagement with local CHronic-Utilizer Alternative Response Team (CHART) and Ground level Response And Coordinated Engagement (GRACE)
- Local Evaluation and Treatment Center
- Crisis Chat
- San Juan Crisis Engagement

## 2. Community and Local Allied System Connections

**Develop and maintain community relationships and coalition building**

- County Allied System Coordination
- Community planning liaison, including the following (please see Appendix A for a sample list of meetings):
  - Engagement with Home and Community Services (HCS)
  - Developmental Disabilities Administration (DDA)
  - Area Agency on Aging (AAA)
  - Accountable Community of Health (ACH)
  - County Public Health systems
  - Children's Administration
  - City Government
  - Law enforcement agencies
  - Department of Corrections(DOC)
  - Jail systems
  - Tribes
  - Hospital system and Emergency Room

- Emergency Medical Service regarding system interactions and community needs.

**Services that require blended funding to maintain: County 1/10th, Medicaid, Non-Medicaid**

- Integrated Dual Disorder Treatment (IDDT)
- School Based Services
- Geriatric Transition Program (GTP)
- Residential Housing Support
- Jail Transitions
- Treatment Services in the Jails
- Hospital Care Transitions
- Medicaid Personal Care (MPC)
- Coordinated Disaster Response
- Programs funded in part by Dedicated Marijuana Account dollars
- Residential SUD treatment
- Tribal programs

**Diversion and Care Coordination**

- Children's Long-term Inpatient Program (CLIP) screening and diversion
- Western State Hospital screening and diversion
- Western State Hospital discharge into the local community liaison
- Western State Hospital peer bridgers
- Drug court diversions
- Jail discharge coordination
- Coordinating homeless services in the region
- Hospital Care Transitions
- Geriatric Transition Program

**Community based Care Coordination Model [see FIMC contract sections 9.15.6.2 and all of section 14]**

Three Care Coordination Vignettes are available in Appendix B of this document.

Care Coordination promotes behavioral health recovery by identifying and addressing issues that create barriers and interfere with care. Care coordinators organize care activities and share information with service teams in alignment with the needs and preferences of those individuals receiving services to the greatest possible degree. Interventions are performed at both the individual and the system level, and assume a community-based focus on the social determinants of health. Care coordinators' activities include:

1. Participation in meetings with allied systems, including collaboration on projects intended to address barriers which interfere with recovery efforts;
2. Data gathering, including review of treatment records and contact with members of service teams;
3. Consultation with North Sound BHO clinical staff and subject matter experts outside of North Sound BHO;
4. Providing service recommendations;
5. Requiring follow-up from BHAs; and

6. Providing quality improvement information to drive system expansion, enhancement, or improvement (e.g. new programs and quality improvement initiatives)

# 3. Community Capacity Building

**Identified needs for future system development**

- First episode psychosis program
- Transitional aged youth specialty services
- Substance use disorder crisis services
- Evidence based practice support on Dialectical Behavior Therapy (DBT) for personality disorders
- Cognitive Behavioral Therapy (CBT) for psychosis
- Increased Peer workforce and integration
- Older adult specialty services capacity
- Developmental Disability comorbid treatment capacity
- Refine youth medication prescribing protocols/standards for the region
- Expansion of School Based Behavioral Health Services
- Increasing capacity for health screenings, health counseling in behavioral health
- Use of Premanage/Emergency Department Information Exchange in behavioral health clinics
- Facility development for individuals with behavioral health disorders, including Recovery Houses for persons discharging from SUD residential treatment facilities
- Secure detox facilities
- Step down beds to reduce hospitalization length and use of Western State Hospital beds
- Further development of behavioral health resources in geographically difficult areas
- Co-occurring workforce expansion
- Wraparound with Intensive Services (WISe) expansion
- Opioid plan implementation
- SUD Residential expansion
- Regional crisis facility expansion
- Provider IT/IS system development and support
- Central grievance review for system improvement
- Central data clearinghouse, standardized format and transmission of data for the region
- Develop a recovery oriented system of care

**Local BHA support and coordination to improve value based purchasing capacity**

- Engage BHA providers in the implementation of screeners and measurement tools for VBP
- Partner in the creating of data systems and operational capacity to collect and submit quality data
- Craft VBP contract language for regional/statewide use by the MCOs

Capacity building for community disaster response

# 4. Provider and Stakeholder Support: Local provider connection, standardization between MCOs, and community linkage

**Opioid and Integrated Health Provider Support and Cohort creation**

- Coordinating provider response with community development
- Operations support to BHAs and physical health providers

**Local workforce training and development**

- Management of Aggressive Behavior (MOAB) training
- Provider Privacy, Compliance and IT training
- Training medical staff on behavioral health conditions to decrease stigma in primary care settings
- Training BHAs in implementation of Integrated Healthcare
- Evidence Based Practice trainings
- Relias online training system
- Co-Occurring workforce support – existing community college fast-track program
- Workforce pipeline development – Partnering with local colleges and high schools
- WISe training staff development
- County trainings provided to community partners

**Administration of local high intensity services**

- Program for Assertive Community Treatment (PACT)
- Wraparound with Intensive Services (WISe)
- Mental Health Residential Services
- Substance Abuse Residential Services
- Integrated Dual Disorder Treatment (IDDT)
- Programs to Aid in the Transition from Homelessness (PATH)
- Community Outreach and Recovery Support (CORS)

# Other Information

Programs have multiple components:

1. Creation of the contract
2. Agreed rates and payment
3. Oversite of services (audits)
4. Quality improvement
5. Data processing
6. Coordination of Community supports to program

# North Sound Proposed
# Behavioral Health – Administrative Services Organization
## Appendix 1

| Meeting | Frequency |
|---|---|
| Advisory Board | monthly |
| Aging and Long-Term Support Administration (ALTSA)/Area Agency on Aging (AAA)/Development Disabilities Administration (DDA)/North Sound BHO | quarterly |
| BHO Grievance & Appeals System meeting with Ombuds | monthly |
| Child and Adolescent Needs and Strengths (CANS) Coaching, with PRAED | monthly |
| Children's Administration | quarterly |
| Children's Care Coordination (CCC) and Center for Mental Health Services | quarterly |
| Children's Long-term Inpatient Program (CLIP) Screening Committee | monthly |
| Children's Wellness Committee (Snohomish County) | monthly |
| Consumer Information System (CIS) Provider Workgroup | quarterly |
| County Authorities Executive Committee (CAEC) | monthly |
| County Coordinators | monthly |
| Department of Corrections (DOC)/Mental Health (MH) Collaboration | quarterly |
| Developmental Disabilities Administrationg (DDA) | quarterly |
| Division of Vocational Rehabilitation | to be determined |
| DMHP court work Snoh county | quarterly |
| Family, Youth, System Partner Roundtable (FYSPRT) | 3x per month |
| Grace project Whatcom | monthly |
| Integrated Provider Meeting | quarterly |
| Island County 1/10th Committee | varies, from monthly to bimonthly |
| LE-911 meeting with all counties | varies/monthly |
| Medicaid Quality Management (MQM) Forum with DBHR and EQR vendor | varies, quarterly to semi-annually |
| Medical Directors | to be determined |
| North Sound Accountable Community of Health (NSACH) Board of Directors | monthly |
| North Sound Accountable Community of Health (NSACH) Executive Committee | monthly |
| North Sound Accountable Community of Health (NSACH) Finance Committee | monthly |
| North Sound Accountable Community of Health (NSACH) Program Council | bi-weekly |
| North Sound Youth and Family Coalition (YFC) | monthly |
| Ombuds | monthly |

| | |
|---|---|
| Planning Committee | temporarily suspended |

| Meeting | Frequency |
|---|---|
| PRAED | weekly |
| Quality Management Oversight Committee (QMOC) | monthly |
| Regional Integrated Crisis Response System (ICRS) | bimonthly |
| Regional Integrated Crisis Response System (ICRS) Legal/Policy Workgroup | bimonthly |
| Regional local crisis meetings/oversight San Juan, Island Whatcom, Skagit and Snohomish counties( ED/LE/jail community participation) | varies, from bimonthly to quarterly |
| Regional Pysch Utilizatiom Management (UM) Workgroup | to be determined |
| Regional Training Committee | quarterly |
| San Juan Services | quarterly |
| School Based Coaching (Skagit) | 2x per month |
| Skagit County 1/10th Committee | quarterly |
| Skagit County Housing Affordability Leadership Group | biannually |
| Skagit County Law & Justice Council | monthly |
| Skagit County Permanent Supportive Housing subcommittee | quarterly |
| Skagit County Population Health Trust | monthly |
| Skagit Executive Committee | quarterly |
| Snohomish County Triage Oversight | bimonthly |
| Substance Use Disorder (SUD) Providers | monthly |
| Tribal Meeting | bimonthly |
| Western State Hospital (WSH) Discharge Planning | quarterly |
| Whatcom incarceration task force | monthly |
| Whatcom incarceration task force triage workgroup | monthly |
| Wrap Around with Intensive Services (WISe) Coaching with Washington State University (WSU) | monthly |
| Wrap Around with Intensive Services (WISe) Leadership | monthly |
| Wrap Around with Intensive Services (WISe) Quality Improvement with DBHR and PRAED | monthly |

# North Sound Proposed
# Behavioral Health – Administrative Services Organization
## Appendix 2

**Care Coordination Vignette #1**

Beth is a 26 year old woman with diagnoses of Borderline Personality Disorder, Anorexia Nervosa, and Major Depressive Disorder. She has self-injurious behaviors and a history of trauma that began in early adolescence. Beth went through periods where she would jump out of moving vehicles on the freeway or fill her pockets with stones and walk into Puget Sound in crowded areas. Once, she called her outpatient provider and told them she was on a train track where she planned to allow herself to be hit by a train. Since the provider did not know where she was, the entire system was shut down until she was located. Beth often presented at the emergency department requesting inpatient psychiatric admission. Mental health professionals working on her case agreed that being in the inpatient environment has the effect of amplifying her distress and subsequent behaviors. When a bed could not be located for her, Beth would escalate in the emergency department by threatening to jump out into traffic or, once, by assaulting hospital staff. Designated mental health professionals felt they had no choice but to detain her. The BHO became involved after Beth was involuntarily hospitalized and placed on a 90 MR.

Despite agreement between the BHO and Western State Hospital that the WSH environment was not appropriate for Beth, the local inpatient unit would not agree to discharge her to the community. The BHO facilitated conversation between the inpatient unit, Western State Hospital, and the outpatient provider. The inpatient unit continued to be unwilling to discharge, insisting on transfer to WSH. The BHO was able to develop a plan in which Beth would be transferred for a very short stay at WSH, and developed an agreement with the outpatient provider that Beth could have a bed at a Residential Treatment Facility on a temporary basis as the agency worked with her to get her into Dialectical Behavioral Therapy, contract with an outpatient eating disorder provider as those services were not available within the BHO network, and work with Beth to help her reach her goals of independent living.

The BHO followed the case for the next 2 years, assisting the outpatient provider in educating professionals in other systems (DMHPs, hospitals, EMTs, Firefighters, etc.) on how to respond to Beth's self-harm in a way that didn't amplify it. The BHO assisted the outpatient provider in obtaining out of network eating disorder treatment, pausing the treatment when her behaviors became so pronounced that she was nearly always medically hospitalized, and then resuming eating disorder treatment when she was able. Beth was ultimately able to move into independent housing. Throughout this period in her treatment, the BHO helped coordinate and educate providers; maintain accountability within the system; trouble-shoot provider disagreements; and work through obstacles related to service availability. The BHO emphasized Beth's involvement in the process, and focused on her recovery and independence.

**Care Coordination Vignette #2**

Ryan is a 41 year old man with diagnoses of schizophrenia and intellectual disability. He has a criminal history as a level 2 sex offender and has been arrested several times for assault. He was not interested in mental health treatment, and his case had been closed with his most recent provider. He has no family support. When homeless, he spends time with a group of people that give him drugs. He is enrolled with the Developmental Disabilities Administration (DDA) and qualifies for residential treatment. They do not know when a bed will be available. Ryan is frequently in and out of both the hospital and jail.

The BHO worked with the jail, DDA, and an outpatient provider to create and effect a plan to maintain community safety while supporting Ryan's ability to access the least restrictive treatment. The BHO had an outpatient provider go to the jail to conduct an intake and plan for discharge to a motel with intensive supports. He was released from jail, but then arrested again after he punched an employee at the motel he was staying at. Pressure was mounting from

the jail to find a disposition as it was clear Ryan would not be found competent due to his intellectual disability. He did not present with any signs of psychosis, however. Fortunately, DDA was able to find a bed shortly thereafter, and the BHO worked with the BHO in the region he was moving to in order to ensure continuity of his mental health services.

**Care Coordination Vignette #3**

The BHO identified that our contracted mental health residential treatment facilities were not serving as a resource for Western State Hospital discharges. There were rarely beds available, and when they were, the providers were often unwilling to accept individuals with such complex, intensive needs. The BHO began a process of more closely managing the RTF utilization, which included care coordination assistance for many of the members.

The BHO helped to coordinate discharges – for example, helping one long term resident who only spoke Russian to locate a culturally-appropriate adult family home placement, and ensuring that the established rate and other parameters were conducive to a long-term placement. BHO also worked to coordinate admissions into the RTF, ensuring that necessary supports were in place to allow the RTF to successfully treat individuals with complex needs. This included facilitating collaboration with the crisis system; mental health providers with specialty expertise; local law enforcement; local hospitals; and health care providers.

After a year and a half of intensive oversight and many care coordination efforts, the RTFs established a reasonable discharge rate, and developed their ability to serve complex individuals. They were able to resume independently managing their census, and now serve as an excellent resource for WSH discharges and other individuals with intensive needs. The BHO continues to provide care coordination on an as-needed basis.