Overview

Residential Care Services (RCS) promotes and protects the rights, security and well-being of individuals living in licensed or certified residential settings. The Behavioral Health Support Team (BHST) works to carry out the Mental Health Transformation Initiative in the state of Washington. The goal of the BHST is to assist in the long-term success of individuals with challenging and complex behavioral health needs residing in these settings. To accomplish this, the BHST offers clinical and regulatory expertise, through education, to providers who work with this population to help them provide high-quality, person-centered care while remaining in compliance.

The BHST is comprised of a BHST Unit Manager, Behavioral Health (BH) Outcome Improvement Specialist, a Behavioral Health Training Specialist, and Behavioral Health Quality Improvement Consultants (BQIC).

Center for Medicare and Medicaid Services (CMS) uses the term “clients” and “individuals” interchangeably in the State Operations Manual (SOM). In this Standard Operating Procedure (SOP) the term “individuals” is used.

Facility, home, and provider(s) refers to Adult Family Homes (AFH), Assisted Living Facilities (ALF), Certified Community Residential Services and Supports (CCRSS), Enhanced Services Facilities (ESF), Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID), and Nursing Homes (NH). In this SOP the term “provider” is used.

This SOP outlines the process BHST members are required to follow when assisting long-term care (LTC) and community-based settings to meet the needs of individuals with challenging and complex behavioral health needs while simultaneously remaining in compliance with all applicable regulations. Relevant Code of Federal Regulations (CFR), Revised Codes of Washington (RCW) and Washington Administrative Codes (WACs) include:

- 42 C.F.R. § 483.1 through 483.206: Nursing Homes
- Chapter 18.20 RCW Assisted Living Facilities (ALF)
- Chapter 18.51 RCW Nursing Homes (NH)
- Chapter 70.97 RCW Enhanced Services Facilities (ESF)
- Chapter 70.128 RCW Adult Family Homes (AFH)
- Chapter 70.129 RCW Long-Term Care Resident Rights
- Chapter 71.05 RCW Mental Illness
- Chapter 71A.12 RCW Developmental Disabilities State Services
- Chapter 74.34 RCW - Abuse of Vulnerable Adults
- Chapter 74.42 RCW Nursing Homes – Resident Care, Operation Standards
- Chapter 182-538C WAC Crisis and Non-crisis Behavioral Health Services
- Chapter 246-341 WAC Behavioral Health Services Administrative Requirements
- Chapter 388-76 WAC Adult Family Home (AFH)
- Chapter 388-78A WAC Assisted Living Facilities (ALF)
- Chapter 388-97 WAC Nursing Homes (NH)

- Chapter 388-101 WAC Certified Community Residential Services and Supports (CCRSS)
- Chapter 388-101D Requirements For Providers of Residential Services and Supports
- Chapter 388-107 WAC Enhanced Services Facilities (ESF)
- Chapter 388-110 WAC – Contracted Residential Care Services
- Chapter 388-112A WAC - Residential Long-Term Care Services Training
- Chapter 388-113 WAC Disqualifying Crimes and Negative Actions

These procedures are in addition to DSHS Administrative Policies, as they are specific to RCS. These procedures will be reviewed for compliance and accuracy at least every five years.

Contacts

- Behavioral Health Support Team General Contact
- RCS Policy Unit General Contact (**internal** RCS use)
- RCSPolicy@dshs.wa.gov (**external** RCS use)
- RCS Quality Improvement Unit General Contact

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Part I: General Guidelines

A. Behavioral Health Support Team Unit Manager

The BHST Unit Manager is responsible for ensuring the division is continuously working toward meeting the goals of the Governor's Mental Health Transformation Initiative.

Some duties of the BHST Unit Manager include but are not limited to:

1. Supervise and provide oversight to BHST staff.
2. Outline staff responsibilities.
3. Ensure processes are being followed.
4. Recruitment and hiring of new staff.
5. Ensure new staff are trained and can demonstrate a working knowledge of BHST policies and procedures.
6. Provide consultation on clinical and non-clinical matters.

B. Behavioral Health Outcome Improvement Specialist

The Behavioral Health Outcome Improvement Specialist is responsible for developing, evaluating, and analyzing quality measures. The Behavioral Health Outcome Improvement Specialist assists the BHST in setting benchmarks and goals for continuous improvement and creates programs to measure those goals. RCS relies on the Behavioral Health Outcome Improvement Specialist's experience in program evaluation, utilization of statistically sound and valid data, and report generation which includes outlining program successes and identifying areas requiring additional resources.

Some duties the Behavioral Health Outcome Improvement Specialist will be asked to perform include but are not limited to:

1. Complete program analysis to track and trend outcomes, as well as recommend use of resources, areas for improvement and program gaps, which include identifying intake referral trends by source type, provider, and developing follow up surveys for providers.
2. Identify opportunities for improving and streamlining work such as creating metrics and developing electronic reporting methods for the Unit Manager.
3. Prepare data and reports to be used as a part of the legislative process.
4. Develop an on-going process to maintain quality data. For example, taking over intake processing for weekly case assignment so the BQICs have accurate up-to-date data to assign new referrals.
5. As the Intake Coordinator (IC), create a new folder with an intake number and mark in the tracker as Provider Support or Miscellaneous (see section 'Requests for Information, Provider Support or Open Office Hours').

The RCS Leadership team relies on the Behavioral Health Outcome Improvement Specialist's expertise in the development, implementation and oversight of quality measures, outcomes and improvement processes resulting in positive and measurable impacts on the quality of care for individuals with challenging and complex behavioral health needs residing in LTC and community-based settings.

C. Behavioral Health Training Specialist

Overview

The Behavioral Health Training Specialist is responsible for providing statewide support to help keep RCS staff and providers apprised of, and educated on, current and changing behavioral health standards. This includes consultation, development, and deployment of exclusive training to build proficiencies, understanding, and abilities in working with individuals with challenging and complex behavioral health needs. The Behavioral Health Training Specialist provides technical assistance and education on regulatory requirements as well as best practice training.

The Behavioral Health Training Specialist is the designated expert for behavioral health training across LTC and community-based settings.

Providers such as Enhanced Services Facilitates (ESF) and Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID), who already have behavioral health services on site as a regulatory requirement will not be offered consultations but may attend BHST offered trainings.

Some duties the Behavioral Health Training Specialist will be asked to complete include but are not limited to:

1. Create a curriculum that reflects the most current evidenced-based practice and treatment approaches.
2. Research for proven strategies to address the care needs for individuals with challenging behaviors.
3. Represent RCS by chairing and facilitating both internal and external stakeholder meetings related to behavioral health training and curriculum development.
4. Provide individual and group training sessions.
5. Become a certified continuing education credit trainer.
6. Practice and promote cultural humility in all aspects of service delivery.

Procedure

1. Registration for BHST Trainings:
   The BHST has created a self-registration process for all interested in receiving trainings. Below is the process for locating trainings and registering:
   a. Locate BHST training calendar on BHST providers' page or through BHST staff.
   b. Identify desired training.
   c. Click on 'Click here to register.'
   d. Fill out requested information.
   e. Following submission, a Zoom link will be sent for selected training(s).

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2. Additional training requests/inquiries:
   Questions for the Behavioral Health Training Specialist can be submitted by email. Often the Behavioral Health Training Specialist receives inquiries on the following offered supports:
   a. RCS Training: Training for Regional RCS staff on a specific subject matter pertaining to behavioral health and the BHST services.
   b. Providers: Deliver in-service training, support groups, and/or clinics to improve and expand practical and clinical approaches to enhance skills in caring for individuals with complex behavioral health issues.
   c. Stakeholder Training: Trainings for stakeholders to learn about the BHST services.
3. Email, Training tracker, Training calendar, and Continuing education:
   The Behavioral Health Training Specialist will maintain the training email inbox, the training tracker, and the training calendar. The Behavioral Health Training Specialist will provide continuing education credit certificates for trainings that have been approved for continuing education credits.
   a. Training email box:
      1) Monitor training email inbox.
      2) Respond to inquiries, requests, and comments.
      3) Email provider with training intro, links to BHST web page, and the training calendar for self-registration.
   b. BHST Training Calendar:
      1) The BHST training calendar will be curated by the BHST training specialist based on applicable requests and trainings found on the Training Menu. The following will be completed monthly:
         a) Names of trainings, applicable CE's and times will be placed on the BHST training calendar template.
         b) Office Hours for each facility type will be added to the BHST training calendar.
         c) Once finalized, the upcoming BHST training calendar will be shared with BHST staff and placed in appropriate folders for LTC providers.
         d) On (or near) the 15th of each month prior to the upcoming month the BHST training calendar will be posted to the BHST providers page (e.g. on or near September 15th October's training calendar will be posted to the providers page).
   c. Training Tracker:
      1) Maintain training tracker by inputting the following information:
         a) Date of training;
         b) Facility name and setting type;
         c) Provider name and contact information (if different);
         d) Training description;
         e) Training type;
         f) Travel time;
         g) Research, development, and presentation time;
         h) Presentation completion;
         i) Number of participants; and
         j) Presenter name.

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d. Continuing Education Certificates:
   1) During applicable CE approved trainings LTC staff will be instructed on how to submit their information for CE certificates.
   2) BHST training specialist will issue CE certificates per internal process.

D. Behavioral Health Quality Improvement Consultant (BQIC)

Overview

The BQIC Provider Support service offers providers education on a variety of behavioral health and care topics, with a focus on interventions, tools, and resources that fit within the regulatory framework. BQICs research evidence-based interventions, promote regulatory compliance, and create curated approaches to problems and behavioral health needs within outlined topic areas. Providers can then utilize this information from general topic areas to support individuals with challenging behavioral health needs in their current or future placement. BQICs demonstrate a holistic approach to care by considering many aspects which frequently contribute to an individual's needs and/or a person's behavior. This information is weaved into the provider support service to create examples of person-centered support for the provider. BQICs contribute to the department's mission through their work to provide education on topics which are barriers for many providers caring for residents with challenging behaviors. BQICs increase the likelihood of providers understanding mental health, regulatory requirements, decompensation and tangible prevention efforts which result in lower re-hospitalization rates. Work completed by the BHST improves the quality of care in residential settings.

BQIC services are not part of the regulatory process and LTC providers are never compelled to accept technical assistance. All services and support are requested by the facility, no matter the referral source's origin.

BQICs are available on a voluntary basis to Adult Family Homes (AFH), Assisted Living Facilities (ALF), Certified Community Residential Services and Supports (CCRSS), and Nursing Homes (NH). Services are available regardless of the funding source or contract held by the setting.

Providers such as Enhanced Services Facilities (ESF) and Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) who already have behavioral health services on site as a regulatory requirement may be provided with consultation or other support on a case-by-case basis. Consultation with the BHST Unit Manager is required to determine if additional support from the BHST is warranted.

Some duties the BQIC will be asked to complete include but are not limited to:

1. Work with LTC and community-based setting staff, assisting them in understanding regulations relevant to behavioral health concerns and educational topics.
2. Provide suggestions for activities and resources within their local area/ region.
3. Review provider citation history identifying patterns and trends.
4. Provide education on topics selected by the provider, within the scope of the BHST.
5. Assist providers with regulation comprehension as they pertain to the topics discussed with providers. BQICs will consider the following areas: resident rights, resident safety, quality of care, documentation, reporting, medication refusal, restraints, abuse, neglect and exploitation, and others that may apply.

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6. Provide expert-level technical assistance on behavioral health and related regulatory issues within LTC and community-based settings.
7. Collaborate with Home and Community Services (HCS), Developmental Disabilities Administration (DDA), and partner agencies to identify community, recreational, and socialization opportunities, such as clubhouse models in communities for individuals to access on a regular basis for socializing with their peer group or supported employment. Please note, this information will be included generally within appropriate support meetings and education.
8. Comply with state and federal laws to protect and maintain the privacy and security of confidential individual information and ensure use of secure/encrypted email communication.

Requests for Information, Provider Support Meetings or Open Office Hours

When collaborating with providers, community partners, and/or agency partners, the BQIC offers technical assistance in the form of Provider Support Meetings, Office Hours and responds to requests for information.

1. Provider Support: For providers who would like a personalized and conversational approach to information on behavioral health and care related topics. BQICs will complete a review of the training needs of the facility to understand topics the provider wishes to learn more about and identify gaps in knowledge, to best support the provider. The BQIC will create personalized provider support materials/ information to meet the identified need of the provider. The BQIC will incorporate relevant and/or potential regulatory compliance information in completed work.
2. Open Office Hours: These are facility setting specific meetings which are open to all providers within that setting who wish to join, ask questions and discuss topics with the BHST and other providers. Generally, each facility setting served by the BHST will have an opportunity to meet monthly. All offerings will be posted on the BHST training calendar found on the website. No PPI will be discussed at these meetings.
3. Miscellaneous – These are questions that can be addressed with minimal effort. Examples may include questions such as “Who do I talk to about contracts? “How do I get an example of a good care plan?” or “It was suggested I talk to the RCS BHST. What is that and what do they do?” Information is generally provided via email.

Procedure

1. Referrals to the BQIC can be made in the following ways:
   - BHST Microsoft Forms Online Intake Form
   - BHST Email: rcsbhst@dshs.wa.gov
   a. BQIC will ensure the provider has requested participation to participate in the provider support process.
   b. As deemed necessary by the BQIC the process outlined below may be altered or changed to meet the needs of the case received (e.g. a provider requires multiple meetings to cover all requested information).

2. Intake Process:
   a. Referral request received.
   b. If referral appears to be a "Miscellaneous" (question or task outside the parameters of a typical consultation) (MISC), the referral is then marked as a MISC in the tracker and assigned to the Unit Manager. The Unit Manager then provides the requested information and adds the required data to the tracker.
   c. If the referral appears to be a provider support request, it is marked in the tracker as "Incomplete provider support" and given an intake number. The IC then creates a new folder with the intake number. A new intake form is started and placed in the folder, along with the original referral message (if available).
   d. The IC will add the following information to the consultation document:
      1) Provider type;
      2) Provider Name and contact information;
      3) License number of provider;
      4) Region and address of provider;
      5) Indicate 'yes' or 'no' for the repeat provider section;
      6) Referent contact information and role/title;
      7) Topics selected by the provider;
      8) Whether there is a request for assistance from the provider (only for intakes submitted on behalf of the provider)
   e. IC checks for duplicate/past provider and makes notations in the tracker accordingly.
   f. Unit Manager or BQIC coordinates tentative data tracker presentation for case assignment.
3. Case Assignment:
   The BHST is not able to provide crisis response services or resident specific consultation. Incoming referrals are not triaged; cases are assigned to BQICs on a first-come, first-served basis.
   a. Cases are assigned based on BQIC availability, and other factors.
   b. Cases are assigned and marked as Incomplete Provider Support.
   c. Updating Tracker:
      a. Update tracker with assigned BQIC name.
4. Initial steps after case assignment:
   a. Intake folder with attached intake form and any associated emails will be moved to the BQIC's personal folder on the shared BHST Q: drive.
   b. Intake information will be reviewed by the BQIC. All relevant research and notes will be documented on the intake form.
   c. Research will be conducted by the BQIC on the facility using the following applications going back a minimum of 12 months:
      1) STARS
      2) ASPEN ACO (if NH)
   d. As applicable, the BQIC will identify questions to ask during the discussion with the LTC facility contact. Questions will be tailored for the provider based on research results and training requests identified in the original intake request.

e. Call provider/referent:
    a. The BQIC will ask curated or general questions during the initial provider call to better understand the need's and goals of the provider support meeting. The BQIC will disclose that resident specific information will not be discussed in this process, but that general questions regarding the training topic are encouraged. Responses will be documented in the intake form.
    b. Schedule the provider support meeting. The BQIC will explain that all support is provided via Teams/Zoom and will provide information on how/ when the invitation will be sent.
    c. Depending on the specific circumstances of the referral, the BQIC will attempt to reach the provider three times, using the phone and/or email contact provided. After the last attempt, the BQIC will notify the provider that the intake will be closed out if no contact is made.
    d. Update intake form with all above information.
f. Additional contact with involved parties. As necessary, the BQIC will curate questions and contact relevant collateral contacts, such as case managers.
g. If the provider declines or there is another reason the provider support meeting does not proceed, the BQIC will complete the intake and email the Behavioral Health Outcome Improvement Specialist. The Behavioral Health Outcome Improvement Specialist will view data and update the tracker. BQIC moves the intake folder to closed folder in the Q: drive.
h. If the provider is unsure if they want assistance, the BQIC may offer to follow up with the provider.

> Example: A BQIC has been assigned a provider support meeting. They call the provider, but the provider is unsure if they would like BHST services because they feel they may want services for the resident. The BQIC can offer to follow up with the provider in (approx.) 2-3 weeks. going and if they need BHST assistance.

5. Visit preparation:
    a. Update Outlook calendar.
    b. Email meeting confirmation to provider, Include link/directions for Zoom or Teams. Update intake form with information describing when this information was sent to the provider.
    c. BQIC will gather all appropriate resources and generate a provider support document, presentation or other training materials (as applicable).. BQIC will update all documentation needed (i.e., best practices, etc.).
    d. Email meeting details to RCS Field Manager (FM). Include RCS Complaint Investigator (CI) if there are open investigations.
    e. Minimally, one day prior to the provider support meeting, email all documents to the provider in PDF format (except for any templates, which should be left in Word format so the provider may modify them).

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6. Provider Support meeting:

a. The BQIC will talk with attendees and provide provider support content, feedback, and resources. Inform provider a link to the survey is included on the provider support documents.
b. Follow up Discussion:
    1) The BQIC will identify if another meeting with the attendees should be scheduled at the conclusion of the meeting to cover additional information. If so, the BQIC will work with the provider to schedule said meeting.
    2) If a follow-up call would be beneficial, the BQIC will explain the follow up process to the LT provider and share they will be calling in approx. 2-3 weeks.
    3) If no additional meeting is needed, the BQIC will explain the closure process to the provider.

7. Post Provider Support Meeting:
    a. On the intake form, BQIC documents the provider support meeting time and date, who attended, and discussions/ impressions.
8. Follow up:
    a. Following the provider support meeting (approximately 14 to 28 days later) the BQIC will complete a follow-up call to the facility. In the call, the BQIC will:
        1) Get updates on the providers understanding of the information, suggestions and/or resources.
        2) The BQIC will identify any questions the provider has about the content shared at the provider support meeting.
        3) Determine if:
            a) a second visit is wanted or needed;
            b) a referral to a trainer is wanted or needed; and if so,
            c) schedule a follow-up meeting or make the appropriate referrals.
    b. BQIC will call those involved before the consultation (i.e., HCS, DDA, etc.) and convey impressions and other necessary information. The BQIC will also explain case closure to HCS, DDA, or others involved. BQIC will send documents to contacts as appropriate.
    c. All information will be documented on the intake form.
9. Case closure:
    a. Email consultation (PDF format) to FM and BHST Supervisor.
    b. Add resources and useful information to OneNote.
    c. Move entire folder to the Closed Folder.
    d. Email Behavioral Health Outcome Improvement Specialist letting them know to close the case.

Part II: Appendices

A. Glossary of Terms

Adult Family Home (AFH) – State licensed residential homes to care for two to eight vulnerable adults who may have mental health, dementia, and/or developmental disability/special needs. The homes are private businesses providing each person with a room, meals, laundry, supervision, assistance with activities of daily living, and personal care. Some provide nursing or other special care and services.
Agency – State agency.
Aspen (Automated Survey Process Environment) – a suite of software applications designed to help State Agencies collect and manage healthcare provider data.
Assisted Living Facility (ALF) – State licensed facilities providing basic services assuming general responsibility for the safety and well-being of vulnerable adults. ALFs allow the vulnerable adults to live an independent lifestyle in a community setting while receiving necessary services from a qualified workforce. ALFs can vary in size and ownership from a family-operated 7-bed facility to a corporation-based facility with 150+ beds. ALFs may provide intermittent nursing services or serve vulnerable adults with mental health needs, developmental disabilities, or dementia.
Certified Community Residential Services and Supports (CCRSS) – Includes Supported Living (SL), Group Homes (GH), and Group Training Homes (GTH). These are residential services provided to individuals who are eligible clients of the Developmental Disabilities Administration (DDA). Supported living clients are vulnerable adults living in their own homes in the community. The client or legal representative owns, rents, or leases the home.
Code of Federal Regulation (CFR) – The Departments and Agencies of the Federal Government providing codification of the general and permanent rules published in the Federal Register.
Crisis diversion – Crisis diversion services are provided by trained specialists and are available to individuals determined by DDA to be at risk of institutionalization. Crisis diversion support services are provided in the client's own home. Crisis diversion bed services are provided in a residence maintained by the service provider.
Crisis Diversion Services – DDA offers these services to clients who show a serious decline in mental functioning which may place them at risk of psychiatric hospitalization.
Dementia care – means a therapeutic modality or modalities designed specifically for the care of persons with dementia.
Department – This term refers to the Washington state Department of Social and Health Services (DSHS).
Enhanced Services Facilities (ESF) – means a facility that provides support and services to persons for whom acute inpatient treatment is not medically necessary. RCW 70.97.010.
Facility – as defined in RCW 74.34.020.
Home – A generic term used to describe an adult family home in the State of Washington.
Medically fragile – means a chronic and complex physical condition which results in prolonged dependency on specialized medical care that requires frequent daily skilled nursing interventions. If these medically necessary interventions are interrupted or denied, the resident may experience irreversible damage or death. Examples of specialized medical care and treatment for medically

fragile residents include but are not limited to: IV therapies requiring monitoring of vital signs and dose titration dependent on lab values; wound care requiring external vacuum or other mechanical devices for debridement; complicated wound care requiring other specialized or extensive interventions and treatment; ventilator or other respiratory device dependence and monitoring; dependence on licensed staff for complex respiratory support; and peritoneal or hemodialysis (on-site).

Mental disorder – means any organic, mental, or emotional impairment that has substantial adverse effects on an individual's cognitive or volitional functions.

Mental health professional (MHP) – any person qualified and licensed to provide assessments, diagnosis, and therapy for mental health conditions.

Minimum Data Set (MDS) – a core set of screening, clinical assessment, and functional status elements, including common definitions and coding categories that form the foundation of the comprehensive assessment for all residents of long-term care facilities certified to participate in Medicare and Medicaid and for patients receiving SNF services in non-critical access hospitals with a swing bed agreement.

Nursing facility (NF) – a nursing home, or any portion of a hospital, veterans' home, or residential habilitation center, that is certified to provide nursing services to Medicaid recipients under section 1919(a) of the federal Social Security Act. All beds in a nursing facility are certified to provide Medicaid services, even though one or more of the beds are also certified to provide Medicare skilled nursing facility services.

Nursing home (NH) – A term that can include both 24-hour Skilled Nursing Facilities (SNF) and Nursing Facilities (NF). SNFs are those that participate in both Medicare and Medicaid. NFs are those that participate in Medicaid only.

Resident [ALF] – means an individual who:

1) Chooses to reside in an ALF, including an individual receiving respite care;
2) Is not related by blood or marriage to the operator of the ALF;
3) Receives basic services; and
4) Receives one or more of the services listed in the definition of "general responsibility for the safety and well-being of the resident," and may receive domiciliary care or respite care provided directly, or indirectly, by the assisted living facility. Whereas a nonresident individual may receive services that are permitted under WAC 388-78A-2032.

Revised Code of Washington (RCW) – The compilation of all permanent laws now in force. It is a collection of Session Laws (enacted by the Legislature, and signed by the Governor, or enacted via the initiative process), arranged by topic, with amendments added and repealed laws removed. It does not include temporary laws such as appropriation acts.

Scope and severity (S/S) [NH] – The effect of the deficient practice on resident outcome (severity level) and the number of residents potentially or actually affected (scope level), using the decision matrix grid guidance provided by CMS.

Skilled nursing facility (SNF) – a nursing home, a portion of a nursing home, or a long-term care wing or unit of a hospital that has been certified to provide nursing services to Medicare recipients under section 1819(a) of the federal Social Security Act.

State agency (SA) – A permanent or semi-permanent organization in government that is responsible for the oversight and administration of specific functions.

Supplemental residents – expanded sample or informal interviews to validate or invalidate issues.
Washington Administrative Code (WAC) – Regulations of executive branch agencies issued by authority of statutes. Similar to legislation and the Constitution, regulations are a source of primary law in Washington State. The WAC codifies the regulations arranging them by subject or agency.
Working days (business days) – defined as Monday through Friday, excluding federal and state holidays.

B. Acronym List

AA	Administrative Assistant
ACO	Aspen Central Office
ACTS	ASPEN Complaints/Incidents Tracking System
AFH	Adult Family Home
ALF	Assisted Living Facility
ALTSA	Aging and Long-Term Support Administration (now HCLA)
AMA	Against Medical Advice
ASPEN	Automated Survey Processing Environment System
BH	Behavioral Health
BHO	Behavioral Health Organization
BHST	Behavioral Health Support Team
BQIC	Behavioral Health Quality Improvement Consultant
CARE	Comprehensive Assessment and Reporting Evaluation System
CC	Carbon Copy (in emails)
CCRSS	Certified Community Residential Services and Supports
CFR	Code of Federal Regulations
CI	Complaint Investigator/Investigations
CMS	Centers for Medicare and Medicaid Services
DDA	Developmental Disabilities Administration
DOB	Date of Birth
DSHS	Department of Social and Health Services
eCFR	Electronic Code of Federal Regulation
ECS	Expanded Community Services
ESF	Enhanced Services Facilities
FM	Field Manager
HCLA	Home and Community Living Administration
HCS	Home and Community Services
HIPAA	Health Insurance Portability and Accountability Act
HQ	Headquarters
IC	Intake Coordinator
ICF/IID	Intermediate Care Facilities for Individuals with Intellectual Disabilities
IO	Intake Only
IRT	Intensive Residential Treatment
LTC	Long-Term Care
MISC	Miscellaneous
NF	Nursing Facility
NH	Nursing Homes
PACE	Program of All-Inclusive Care for the Elderly
PACT	Program of Assertive Community Treatment
PDF	Portable Document Format

PTA	Preliminary Technical Assistance
RCS	Residential Care Services
RCW	Revised Code of Washington
SBS	Specialized Behavior Support
SHDD	State Hospital Discharge and Diversion Team
SOM	State Operations Manual
SOP	Standard Operating Procedures
SUD	Substance Use Disorders
T	Tentative
WAC	Washington Administrative Code
WD	Working Day

C. Change Log

Eff. Date	Chapter/ Section #	Description of Change	Reason for Change	Communication and Training Plan
06/26/2025	Entire Chapter	Update to process	Updates comply with new requirements	MB R25-068
01/17/2025	Entire Chapter	Formatting updates	Comply with new DSHS branding	N/A
06/14/2023	Full Chapter	Updates to requirements, transition to new format	Updated Expectations	MB R23-056
10/14/2022	Full Chapter	Establishment of chapter	Establishment of chapter	MB R22-078

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