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I. GENERAL AND OVERALL TRANSITION PLAN

A. Transition Planning Process

1. Decision Making Process

a. In April of 2014, the North Sound Mental Health Administration (NSMHA) staff began discussion with its Board of Directors on whether the North Sound Counties should move forward to convert the existing Regional Support Network (RSN) to a Behavioral Health Organization (BHO). At its April 2014 meeting, the Board indicated its interest in actively pursuing converting the existing RSN to a BHO and directed staff to provide individual briefings to each of the five county councils. Individual briefings were subsequently provided and each of the County Councils gave their approval to pursue the BHO option. On June 8, 2015, a formal letter was sent to the Department of Social and Health Services (DSHS) Division of Behavioral Health and Recovery (DBHR) indicating that it was the intent of NSMHA to apply to become a BHO (see Appendix, Section I, 01).

b. NSMHA began working with its attorney on the changes that would need to be made to the existing RSN Interlocal Agreement to create the new BHO entity. After reviewing the changing laws and interpretations related to the "Interlocal Cooperation Act", NSMHA's attorney advised us that we needed to create a more formal legal entity and recommended the formation of a "Limited Liability Corporation" (LLC). The attorney believed that an LLC would provide clearer legal authority to enter into contracts and conduct business on behalf of the five (5) counties. A copy of our correspondence with DBHR regarding this proposal (see Appendix, Section I, 02).

c. In September 2015, a draft of the North Sound BHO (NSBHO) Detailed Plan was reviewed with the County Behavioral Health Coordinators (CBHC), the RSN Planning Committee, Advisory Board and Board of Directors (BOD).

d. The final plan was reviewed with the same groups in October and at the BOD, October 8, 2015, meeting the BOD gave formal approval to submit the detailed plan to the state.

e. At its October 8th meeting, the BOD also approved the proposed new Operating Agreement (see Appendices, Section I, 03-1 and 03-2) and it has been forwarded to the five (5) county councils and their attorneys for review and approval.

2. Stakeholder Engagement

a. From the very beginning of its planning process, NSMHA reached out to CBHC and all regional Behavioral Health Providers to fully engage them in the development of the BHO system design. A formal provider/county regional BHO Planning Workgroup was established and began meeting in October 2014.

b. The existing monthly meetings of NSMHA and the CBHC were expanded to also include the County Chemical Dependency Coordinators (CCDC). Monthly meeting agenda items include: briefings on both mental health (MH) and Substance Use Disorders (SUD) issues, as well as, joint work on BHO design.
c. Orientation meetings were held in June 2014 with all of the regional SUD providers to brief them on the proposed planning process, hear their initial concerns and invite them to actively participate in the planning.
d. Following the June orientation meetings, NSMHA's Director made individual site visits to each SUD outpatient, Detox and Residential Treatment provider to receive an in-depth overview of their existing treatment programs and discuss their concerns and future needs.
e. Two (2) expert consultants were contracted with to facilitate the development of the plan – Dale Jarvis, fiscal consultant, and Dr. Rick Ries from the University of Washington (UW), clinical consultant.
f. A series of formally structured BHO system development meetings were held with the BHO Planning Workgroup to develop the system "vision", identify and discuss key issues and develop the fiscal and clinical models. Below is a summary of these meetings:

October 16, 2014	Overview of proposed planning process and discussion of key issues. Introduction of Provider readiness Survey
March 20, 2015	Overview of the development of the fiscal model and development of the BHO system "vision"
May 1, 2015	Identification of core SUD services and additional services to create an enhanced BHO continuum of services
September 11, 2015	Work on the detailed fiscal model assumptions and review of the overall Detailed Plan

g. Appendices 03-1 through 03-6 are copies of the consultant briefing materials that supported this work.
h. In between the workgroup meetings, readiness and cost surveys were sent to SUD providers to collect baseline data on their current capacity and costs and expansion capacity and associated costs. This data is being used to develop the Fiscal Model (Section VI).
i. NSHMA has developed a "credentialing" process to determine which SUD agencies would qualify to contract with the future BHO. Agencies selected to be part of the initial BHO network will be provided technical assistance and support to prepare them to operate under a Medicaid managed care plan (Section IV.A).

j. Clinical design workgroups will be held with key agency clinical staff, CBHC and NSMHA clinical staff to develop the clinical flow details related to access, assessment, service authorization, utilization management, etc.

B. Behavioral Health Integration Model

1. Working with the BHO Planning Workgroup, NSMHA has developed a model describing what a full continuum of care for SUD services would look like, including, Co-Occurring Disorders (COD) services, better coordination with primary care, prevention and recovery supports (see Appendix, Section I, 04).
2. NSMHA has identified the core SUD services that can be supported within the existing BHO budget and implemented beginning in April of 2016 (Section IV.C). This will serve as "Stage 1" in the implementation of the BHO network.
3. NSMHA has also identified the enhanced services described in the SUD Service Array model that we will work on in "Stage 2". Some of these will require us to seek other sources of funding, such as: County local dollars; Apple Health Managed Care Organizations (MCO); etc. (Section IV.C). This supplemental funding strategy will be driven by the remaining availability of dollars for services that qualify for BHO Medicaid and non-Medicaid support, as well as, on the restrictions for use of those dollars.
4. NSMHA is developing a rate structure that will provide sustainable funding for SUD treatment services, expand capacity to meet the increasing number of Medicaid eligible persons who need treatment and incentivize co-occurring services and coordination with primary care (Section VI).
5. NSMHA will implement a "no-wrong door" approach that will allow a person to contact any Behavioral Health Agency (BHA) directly to request services. The 24 hour Access Line operated by Volunteers of America (VOA) will be expanded to include SUD services also (Section IV.C.1).
6. NSMHA will require all contracted BHAs to use an integrated behavioral health screening protocol to identify both MH and SUD treatment needs.
7. NSMHA will fund extensive cross-training to all BHA staff on how to identify the basic signs of both MH and SUD.

C. BHO Organizational Structure

1. NSMHA is expanding its current administrative structure to include staff with expertise in SUD services, as well as, additional staff for core administrative functions such as: information technology support, contracting specialists, human resources and training specialists, crisis service specialists, quality improvement coordination, accounting and administrative support (Section V.A).
2. The NSBHO would operate under an "LLC" overseen by the five (5) North Sound counties. A copy of the draft Inter-Local agreement and associated Joint Operating Agreement (JOA) are included in Appendix, Section I, 03-2.

3. The existing composition for the Board of Directors would be retained (see Appendix, Section I, 05).
4. NSMHA will be inviting Tribal Authorities to re-appoint representatives to the BHO Board. The Tribes currently share three (3) non-voting seats on the RSN Board.
5. NSMHA will expand the Advisory Board to 26 persons plus 8 seats for each of the North Sound Tribes. NSMHA will target recruitment for the new, expanded seats to focus on persons with lived experience and/or service delivery experience related to Substance Abuse. See the proposed Operating Agreement in Appendix Section I, 03-2 for the distribution of the BHO Advisory Board Seats by County.
6. County authorities will still appoint the representatives to the Advisory Board, but the Advisory Board nominating committee will interview prospective nominees and submit their recommendations to the county.
7. NSMHA will expand the existing County Administration contracts to delegate additional responsibilities to the counties to include coordination with local systems related to SUD services. This would include supporting the existing local Criminal Justice Treatment Account (CJTA) Panels, coordination with Drug Courts, Law Enforcement, Hospitals, Emergency Medical Services (EMS), Advisory Groups, etc.

II. TRANSITION AND COORDINATION OF SERVICES PLAN

A. Transition of Services

1. Before implementation
   Transition of current enrollees from County/State funded Substance Use Disorder (SUD) programs to Behavioral Health Organization (BHO) contracted programs.

   In conjunction with County Alcohol Drug Coordinators (CADC), North Sound Mental Health Administration (NSMHA) will develop an agreement to transition all enrolled clients, to include service provider name, treatment location, services being provided, planned treatment end date, and administrative records. NSMHA will request all regional network providers of SUD services to secure a release of information (ROI) from every individual, enrolled in publicly-funded services under the Division of Behavioral Health and Recovery (DBHR) SUD contract; for their records to be released all ROI must meet criteria of CFR 42 Part 2, Subpart C, 2.31. NSMHA will work with providers to submit electronically all administrative client information prior to March 31, 2016. NSMHA will compare this data to the TARGET data received from DBHR to ensure all enrolled clients are included or reconcile any differences.

2. After Implementation

   a. NSMHA is working with the current Regional Support Networks (RSN) to adapt the current uniform transfer agreement for use by the BHOs.
   b. To ensure a seamless transition for individuals moving from one (1) BHO region to another, a BHO Care Coordinator shall work with the individual's Managed Care Organization (MCO), behavioral and physical healthcare provider(s) and receiving BHO to identify the individual's healthcare needs. This information will be utilized to ensure the development of a plan to transition the individual from current services to services in the new region. BHO Care Coordinators have access to Predictive Risk Intelligence System (PRISM) and the BHO Consumer Information System (CIS) as a starting point to identify potential needs and the providers of the services.
   c. NSMHA is also working with the other RSNs on protocols for use and payment of out-of-region SUD residential treatment services.
   d. NSMHA will work with DBHR, Health Care Alliance (HCA) and other BHOs on transfer procedures with fully integrated regions.
   e. North Sound BHO (NSBHO) will continue SUD service provision according to American Society of Addiction Medicine (ASAM) criteria for all SUD treatment enrollees prior to April 1, 2016, until treatment is complete, or when services are no longer medically necessary according to ASAM criteria, or when a different course of treatment is medically necessary according to ASAM criteria. Involuntary treatment services will continue according to Revised Code of Washington (RCW) 70.96A.140, with length-of-stay determined by ASAM criteria.

3. Discharge from State Hospital and Evaluation and Treatment (E&T) Facilities

    a. NSMHA liaisons to Western State Hospital (WSH) monitor patient progress toward discharge goals throughout their stay at WSH. During the referral and admission process, resources are identified and appropriate contact and communication is initiated during the inpatient stay.
    b. When a patient is identified as ready to discharge by the treatment team, NSMHA's liaison assesses the patient to see if they are in agreement. Per the current WSH/RSN working agreement, the assessment must be done within five (5) working days of the referral. During this assessment, NSMHA's liaison identifies the Level of Care (LOC) that is most appropriate for the patient upon discharge. This assessment identifies previous community resources, current care needs, patient goals and supports that will be most beneficial. Once all parties agree, a Patient Placement Referral (PPR) and RSN/Community Services Office (CSO) form is submitted to Patient Financial Services at WSH so that financial benefits can be assessed and any needed financial applications can be completed.
    c. NSMHA's liaison then begins the referral process, working with a multitude of agencies and service providers to create a plan that will most effectively meet the needs of the patient within the resources available. This includes, but is not limited to, sending referrals to the various resources and community partners, follow up contact regarding the referral, coordinating pre-placement visits and connecting patients to mental health resources for post-discharge follow up.
    d. Housing is often the most significant barrier to discharge for a patient at WSH. The HARPS program provides a vital bridge for patients who transition from inpatient care to independent community living - by making funds available for the short-term transitional resources and peer support necessary to make it to long-term affordable housing.
    e. As part of the discharge process for the inpatient facilities, they will have a plan of treatment using language and terminology that is understandable to the individual and members of his/her support system, is individualized, includes interventions in response to current identified needs, be expected to help the individual achieve their goals and is updated to reflect any changes in the individual's needs. The expectation is there is documentation of the course of treatment, documentation of daily contact with a Mental Health Professional (MHP), documentation of observation of functional behavior, including evaluation of response to treatment, documentation of ongoing assessment of risk and daily evaluation for release from inpatient care.

f. Within the discharge plan the clinical record should include a plan for follow up services and informing the individual of the purpose and reason for follow-up services, informing the individual of follow-up service name, address, phone number, appointment date and contact person, if known, and documentation of inclusion of coordination of community care for discharge which begins at admission.

B. Coordination with Other Systems

1. Coordination with healthcare providers

a. NSMHA contracts with two (2) Federally Qualified Health Centers (FQHC) (Sea Mar and Interfaith Community Health Center) that provide integrated health services. Sea Mar is a certified mental health and SUD provider and NSMHA will work with them to test new strategies for integrating primary care and behavioral health.
b. NSMHA-contracted Behavioral Health Agencies (BHA) have piloted:

i. Co-location of primary care provider at the BHA facility and
ii. Co-location of a behavioral health clinician and psychiatric prescriber at a local primary care clinic (PCC).

c. Implement initiatives with primary care providers (PCP) to ensure identification of mental health and SUD and referral to BHO behavioral health services (e.g., utilization of Screening, Brief Interventions and Referral to Treatment [SBIRT]). NSMHA and The Everett Clinic (TEC) are currently piloting a streamlined referral process for PCPs to BHO providers. NSMHA and TEC have developed a referral process to ensure seamless connection for individuals referred by TEC primary healthcare providers to NSMHA behavioral health services.
d. Establish routine contact by BHO with PCCs that our individuals utilize most – TEC, Community Health Center of Snohomish County, Peace Health and Providence medical groups in order to facilitate improved care coordination processes.
e. NSMHA maintains policies and procedures to ensure coordination across multiple systems including a policy that requires coordination with healthcare providers. To ensure timely communication and coordination of services, NSMHA requires providers to:

i. Inquire about co-morbid conditions at intake and ongoing during an episode of care. Providers obtain healthcare provider names and their contact information for any co-morbid conditions for which the individual is receiving care.
ii. Assist individuals in obtaining a PCP when they do not have one in addition to making referrals and linkages to other external healthcare providers for any co-morbid issues for which the individual is not yet receiving care.

iii. Coordinate care, at a minimum, at key points during the episode of care including initiation of an episode of behavioral health care, when psychotropic medications are initiated or changed, when the individual experiences a change in his/her clinical condition.
iv. NSMHA monitors that this coordination is occurring via our annual reviews of BHA's clinical records.

f. NSMHA is an active participant in the North Sound Accountable Community of Health (NSACH) and is participating in identifying pilot NSACH projects that would promote further integration between behavioral health and primary care.

2. Coordination with Apple Health MCOs

a. NSMHA has Joint Operating Agreements (JOA) with the five (5) MCOs in the North Sound Region with a focus on developing more detailed processes and data sharing to identify shared members in need of follow up services upon discharge from a medical or psychiatric hospitalization and/or those with significant co-morbid psychiatric, substance and/or medical issues (see Appendices, Section II, 01-1 through 01-7).
b. The RSNs and MCOs met on September 23, 2015, and jointly agreed to create workgroups addressing three (3) areas of coordination: co-occurring services to persons with mild mental illness, care coordination to high need persons and expansion of Medication Assisted Treatment (MAT). NSMHA will work with MCOs on expansion of the existing JOAs to incorporate agreed upon joint efforts related to the three (3) areas listed above. However, because the MCOs are not themselves certified BHAs, NSMHA cannot currently enter into a formal "contract" with them. However, NSMHA is proposing to form a Limited Liability Corporation (LLC) as the entity created by the new Inter-Local agreement and this would open up the opportunity for formal contracts.
c. NSMHA Care Coordinators participate in coordination meetings with MCOs or their subcontractors including routine meetings with Amerigroup Care Coordinators; attendance at care coordination meetings for individuals with high Emergency Department (ED) use in Snohomish County. Our Care Coordinators are also available between meeting times for any care coordination issues that arise for shared members with any of the five (5) MCOs.
d. NSMHA contracts with Emergency Department Information Exchange (EDIE) vendor and are developing processes for NSMHA and the BHAs to utilize EDIE to identify and intervene with individuals who are utilizing a significant amount of ED services and would likely benefit from a less restrictive (LR) intervention.

3. Coordination with Jails

    a. NSMHA is developing an agreement with Snohomish County Human Services and Snohomish County Jail whereby Human Services has access to limited NSMHA consumer information and would be able to provide jail medical staff information regarding individual's behavioral health in order to facilitate care while in jail and transition to behavioral health services when released.
    b. NSMHA funds Jail Transition programs in each of the five (5) counties. Jail Transition Services (JTS) funding is provided by the State legislature to provide mental health services for mentally ill offenders while confined in a county or city jail. These services are intended to facilitate access to outpatient mental health programs that offer services upon the mentally ill offender's release from confinement. This includes efforts to expedite applications for new or reinstated Medicaid benefits for the offender. NSMHA does not provide these services directly. Rather, NSMHA contracts with outpatient mental health providers throughout the Region to directly provide these transition services to inmates willing to accept them during their confinement.
    c. NSMHA contracts with Island, San Juan, Skagit, Snohomish and Whatcom Counties for allied system coordination duties, including with local jails. These existing contracts will be expanded to include development and/or expansion of existing county/jail coordination protocols related to SUD services including a Chemical Dependency Specialist (CDS) for Involuntary Commitment Services who will, when notified by the jail, provide a SUD assessment within 72 hours of release from the jail, to an individual returned to the jail from WSH or an E&T, when there is documentation suggesting SUD.

4. Coordination with Local Criminal Justice Treatment Account (CJTA) Plans

    a. NSBHO will contract with the County Health and Human Service agencies to continue to support the development of county specific CJTA plans and the submission to the State CJTA Panel for approval. Funding to local CJTA supported activities such as drug courts and treatment services to drug court clients will be allocated based on the priorities in the local plans and the State CJTA Panel funding allocations for each county.
    b. The BHO and County Agencies will meet with county drug courts to brief them on the BHO system and develop Memorandums of Understanding (MOU) with individual courts for referral and reporting.

5. Coordination with Regional Department of Corrections (DOC)
   NSBHO will develop and issue a bid process for the provision of services to individuals that are Medicaid eligible and involved with DOC. The bid process will be based on the National Institute on Drug Abuse research-based guide *Principles of Drug Abuse Treatment for Criminal Justice Populations* to ensure the regional network includes providers with the specialized expertise based to offer services to this population that is structured, consistent and evidence-based. In the development of the bid document, NSMHA will use as a reference the Washington State DOC document titled *Evidence-Based Addiction Treatment of Offenders in WA State DOC.* North Sound will designate specific staff contacts for the regional DOC offices and in conjunction with these regional management teams determine the need for regular periodic meetings.

6. Coordination with Children's Long-term Inpatient Program (CLIP) and with intensive community services and inpatient/residential services for youth.

   a. CLIP is the most intensive inpatient psychiatric treatment available to all Washington State residents, ages 5-18 years of age. While youth may have Co-Occurring Disorders (COD), historically those have been in the domain of developmental disabilities vs. SUD. As a BHO, NSMHA will continue current CLIP care coordination policies and practices, per contract and per statewide CLIP Improvement Team (CLIP-IT) agreements. Additionally, NSMHA has a full-time Children's Care Coordinator (CCC). This position requires an MHP and Community Mental Health Specialist (CMHS). The person who holds the position will be trained in ASAM if they do not already have such training. The CCC is responsible for processing voluntary CLIP applications; attending CLIP-IT; phoning in to all CLIP treatment plan reviews for North Sound children/youth; community level care coordination when a network provider is not involved; and general CLIP point of contact for CLIP Administration, families and system partners (see Appendices, Section II, 02-1 and 02-2).
   b. The BHO CCC will continue to act as primary point of contact to coordinate care at all levels of care. For mental health inpatient, this function is typically at the discharge end of care but could occur at any point and in conjunction with the network provider. Mental health residential for children/youth is only available via CLIP; NSBHO will follow the process outlined in a. above. For SUD inpatient and residential, care coordination from the BHO can occur prior to admit, during or at discharge and in conjunction with the network provider.

III. COMMUNICATIONS AND STAKEHOLDER PLAN

A. Communications Plan

The North Sound Mental Health Administration (NSMHA) will develop a comprehensive communication plan to notify enrollees, providers, allied systems and other community stakeholders. This will include public information on how Substance Use Disorders (SUD) services can be accessed using NSMHA's existing Access Line and 24-hour Crisis Line. Communication strategies will include a fact sheet to be sent to providers, allied systems, law enforcement, healthcare providers, etc. NSMHA will also use our existing e-newsletter distribution list and post information on our public website. NSMHA will also request to meet with some of the major news media in the region we have worked with in the past. Specific instructions will be provided to our providers for notifying their current enrollees regarding the transition process.

Specific information/materials will be developed to advise individuals of their rights and distributed to all network providers including SUD, County Human Services, Ombuds, local Department of Social and Health Services (DSHS) offices, National Alliance for the Mentally Ill (NAMI) and other community-based organizations. A fact sheet will be developed to be distributed throughout the region, posted on North Sound Behavioral Health Organization (NSBHO) website, provider websites and through our electronic newsletter. Volunteers of America (VOA) will have a script for individuals calling in to access services.

B. Individuals

1. Second Opinion

    a. At any time during an episode of care, a second opinion may be requested regarding any clinical decision, which may include, but not be limited to: medical necessity, recommended interventions and/or medications, diagnosis and plan of care. Individuals are notified of their right to a second opinion, at a minimum, at the time of intake and when they express dissatisfaction with a clinical decision.
    b. Second opinions are conducted by Mental Health Professionals (MHP) qualified to review and treat the mental health condition in question as expeditiously as the individual's mental health condition requires and no later than 30 calendar days from the request.
    c. NSMHA will arrange for a second opinion with an MHP outside of the network when there is not a provider with the appropriate experience available within the network; this is provided at no cost to the consumer.

    While second opinion requests may be directed to either the Behavioral Health Agency (BHA) or NSMHA, NSMHA tracks all second opinion requests. NSMHA staff, BHA staff and Ombuds are available to assist individuals in accessing a timely second opinion.

2. Out-of-Network Services
    a. NSMHA and its contracted BHAs consider the provision of out-of-network services when the BHA and/or NSMHA determine the resources outside of the network are needed to meet the individual's needs or when an individual requests an out-of-network service.
    b. These requests are initially directed to the BHA and evaluated based on whether the request is for services related to treating a covered diagnosis; the services are medically necessary; there is not an appropriate service or provider available within the network.
    c. For medically necessary services, the BHA is responsible for arranging timely access to and coordination of the out-of-network services through subcontracts; NSMHA assists BHAs with arranging these services when needed. Out-of-network services occurring in another State are contracted for by NSMHA. These services are provided at no additional cost to the consumer.
    d. The BHA notifies NSMHA of all out-of-network services at the time services are initiated including providing a copy of the contract. NSMHA conducts an annual review of the clinical record for any individual who received out-of-network services to ensure the provision of out-of-network services were provided in a timely manner and in accordance with clinical standards (e.g., BHA maintained coordination of care, continued other medically necessary services, maintained documentation per standards).

C. Providers

In addition to the overall communication plan described above, NSMHA began meeting with all regional behavioral health providers starting in October 2014 (see this Section A). Through meetings with SUD providers and the County Alcohol Drug Coordinators (CADC), they directly participated in the development of the new model and overall the meetings included: a review of readiness, visioning process, discussion of enhanced continuum of services and new fiscal model. Nonetheless, NSMHA will offer fact sheet materials to all behavioral health providers.

NSMHA will hold a meeting with the county designated Chemical Dependency Specialists (CDS) and Designated Mental Health Professional (DMHP) and County Coordinators to provide fact sheets and discuss the Behavioral Health Organization (BHO) system of services.

NSMHA will work with the other Regional Support Network (RSN)/ BHO to develop a fact sheet for residential providers in the state in addition to process development meetings.

NSMHA will provide fact sheets for county drug courts and will meet with each local Criminal Justice Treatment Account (CJTA) panel and the county coordinator to discuss the continued alliance of the drug court, CJTA model, the county coordinator and the BHO.

NSMHA will work with the CADC to develop materials specific to local jails and local relationships with the jails to ensure that jails are included and have working knowledge of and understand the system change.

NSMHA will provide the fact sheet and service access information to the regional syringe exchange programs.

NSMHA will provide an announcement and fact sheet to the eight (8) regional Community Prevention and Wellness Initiative (CPWI) Coalitions and the four (4) regional Drug Free Communities (DFC) Coalitions, including a specific contact to provide additional information if needed. Through these coalitions' assistance, NSMHA will ensure other interested community coalitions receive our materials.

D. Advisory Board

NSMHA's Advisory Board has been fully involved in the review of the BHO Plan. They also developed the specific recommendations related to the composition of the future BHO Advisory Board and recruitment and selection process for Board members, including the addition of SUD specific representation. As specified in the five (5) county Interlocal Agreements, each respective county will appoint members to the Advisory Board. The Advisory Board will vet the candidate and conduct an informal interview and provide feedback to the county on whether the individual is a good fit for the Board. The board developed criteria for new members at their 2015 retreat. The criteria include, but are not limited to:

1. Committed to Integration of Services
2. Persons with lived experience in both Mental Health and Substance Use
3. Willingness to participate in educational and training opportunities
4. Committed to diverse representation
5. Parents of children with lived experience

The Board has recommended that the Interlocal Agreement for the BHO add an additional member per county to ensure the board has diverse representation. The Board has a budget of $34,000 for transportation, conferences, scholarships, meals and other costs directly related to Advisory Board business and initiatives.

E. Stakeholders

See the description of the overall communication plan in this Section A.

NSMHA will provide fact sheets to CADC that they will provide to their local county behavioral health issues advocacy board as they educate this board on the BHO.

NSMHA will work with the CADC to develop a list of stakeholders in each county to ensure all SUD stakeholders are included in the information sharing. NSMHA will also provide NSMHA contact information to answer further questions from stakeholders. Local health officers and all regional health clinic directors and hospital administrators will be provided notification and fact sheets to ensure they are included in the information exchange.

F. Staff

NSMHA staff is briefed on the status of the BHO plan development at monthly staff meetings and are provided with the same briefing documents as Advisory Board and Board of Director members. A number of NSMHA staff is also participating in the development and writing of the plan.

G. Tribes

Tribal Authorities have been briefed at each stage of the BHO planning process (see Section XI). Regular updates are provided at the bi-monthly "7.01" consultation meetings and at the Regional Tribal Coordinating Council (RTCC) meetings.

At the time NSMHA is notified of acceptance as NSBHO, we will develop an individual letter to each regional Tribal Council in order to formally inform them of the transition of the North Sound Mental Health Administration to the North Sound Behavioral Health Organization, and thanking their tribal members by name who assisted NSMHA in the development and transition.

IV. NETWORK ANALYSIS AND DEVELOPMENT PLAN

A. Network Analysis

Over the years, the North Sound Mental Health Administration (NSMHA) has used a network analysis methodology developed in conjunction with our fiscal consultant, Dale Jarvis. This methodology uses a sophisticated modeling program to compare historical service utilization and penetration, service costs, population dynamics, projected Medicaid population growth and level of care assessments using the "Level of Care Utilization System (LOCUS)" program. The modeling program helps us determine how much Medicaid and non-Medicaid funds to allocate for each service component and for equitable geographic distribution. For areas where there are special challenges to service access, such as the San Juan Islands, additional network "capacity" funding is provided. This model has been fine-tuned and works well to align funding with need. In addition, NSMHA sets aside a Medicaid reserve to reimburse for services where the need has exceeded projections (see Appendix Section IV-01).

For the Behavioral Health Organization (BHO) Mental Health services network, NSMHA will continue to use this methodology but will begin to plan for funding Co-Occurring Disorders (COD) services as part of the network analysis for Substance Use Disorders (SUD) treatment services.

The same general methodology has been used to project service need for SUD services. NSMHA has worked with Mr. Jarvis and Dr. Richard Ries to create a new modeling program that inserts historical service utilization data, service costs, estimated prevalence, projected Medicaid population growth, level of care (LOC) based on American Society of Addiction Medicine (ASAM) and the core network of service components NSMHA will need to have in place upon implementation. The analysis will also include projections to assist in identifying areas for future enhancement (see Appendix Section IV 01-1 and 02).

B. Network Development

1. Mental Health (MH)
   The existing network of certified Behavioral Health Agencies (BHA) will continue and these contracts will be transitioned to the BHO.

2. SUD and Co-Occurring Disorder (COD) Service
   NSMHA plans to develop the SUD and COD network of services in stages. Stage 1 to be implemented April 1, 2016, will include the core SUD services as required to meet medical necessity. Later stages will include enhancements related to Integrated Dual-Disorder Treatment (IDDT), increased local capacity for SUD residential services, expansion of Medication Assisted Treatment (MAT) and increased local capacity of SUD Residential and Co-Occurring residential services using 16 bed facilities.

For Stage 1, NSMHA will be using a Request for Qualifications (RFQ) process to certify which of the existing SUD providers in the region can meet the new state and BHO requirements. NSMHA plans to initially contract with all qualified SUD providers to ensure network adequacy upon implementation. Other providers will also be invited to respond to the RFQ and it is possible NSMHA will be adding new providers to the initial network, subject to responses in the credentialing packet (see Appendix Section IV 03). NSMHA is also working with other Regional Support Network (RSN)/BHO's on inter-BHO agreements that will allow access to some services outside our region.

C. Network Monitoring and Expansion

1. Current monitoring and documenting system

a. Contracts, payment and reports
NSMHA produces a monthly fee-for-service payment report that has the budget to actual information by agency, county, program, child and adult, Medicaid and non-Medicaid services. NSMHA also produces a monthly dashboard report that goes to the Board of Directors (BOD). NSMHA also uses specialty reports that review specific services such as the Western State Hospital (WSH) census report, the crisis services report sent to the Integrated Crisis Response System (ICRS) Committee, Program for Assertive Community Treatment (PACT) services report, Wraparound with Intensive Services (WISe) report and the Evaluation and Treatment (E&T) capacity usage report. These help NSMHA monitor the service demand on our system. The ICRS committee reviews emergency dispatch criteria, locations, time to service encounter, E&T daily census and decline data, triage facility usage and decline data. NSMHA also has a report that measures the time from request of service to first offered appointment and first appointment. Individual feedback – NSMHA has a customer service team in our office that helps individuals with questions or problems. NSMHA tracks their issues and reviews their requests. NSMHA also has local Ombuds that help individuals with customer service issues and provides a detailed report every six (6) months. NSMHA takes comments at our BOD and Advisory Board meetings. Our Quality Management Oversight Committee (QMOC) has a review function that includes RSN, providers, Ombuds and individual input. NSMHA also works with our five (5) counties and takes individual's referrals and complaints from them. Some individuals have gone to the Department of Social and Health Services (DSHS) with service issues. All of these sources of individual feedback are used to help measure individual access to NSMHA services.

b. Additional analysis
NSMHA has a data analyst who works with the clinical and administrative teams that have special data requests. NSMHA has requests for reviews of specialty services, types of individuals and services in graphical areas. These focused data reviews helps NSMHA quantify the individual's feedback information and help management develop solutions to network capacity issues. An example of this process was a provider requested expansion of services in a specific geographical area. Providers said they had a lot of individuals in service and requesting services from a part of the region that did not have a facility. NSMHA cross referenced the individual service data by zip code, individual demographic data by zip code, eligible individual data by zip code and found NSMHA had an urban area that had a lot of individuals and not enough facilities. NSMHA helped a provider expand their facility and services in that zip code.

2. Expansion of the monitoring system to include SUD services

a. Plan of expansion from network analysis and analytical review
Regional Family Youth System Partner Round Tables (FYSPRT) will play a critical role, in informing and advising high-level policy-making, program planning and decision-making and for the implementation of the T.R. Settlement Agreement.
b. Use of out-of-region services
NSMHA plans on adding residential services not in our region by contracting with other BHO's. NSMHA also plans on monitoring those services to help determine additional in region capacity.
c. Planned capacity building and incentive payments to move network
NSMHA will use our capacity estimates from the Dale Jarvis prevalence projections and our experience to determine future capacity needs. So far NSMHA has identified our biggest needs for a male youth residential facility and more Opiate Substitution Treatment (OST) services in our region. NSMHA has an estimate for services and will monitor for additional demand as we develop the SUD system. NSMHA will use similar system capacity monitoring as stated above. NSMHA plans on expanding our incentive payments to move the system to produce better outcomes. NSMHA likes to use standard data measurements for these pay for performance incentive programs because they can be measurable and have a baseline performance. However, NSMHA is open to looking at other ways to move system outcomes in a positive direction.

3. Reporting of capacity and system change

    a. NSMHA plans to report out capacity, change in capacity and additional needed services. Currently, NSMHA requires providers to turn in a capacity report twice a year on clinical personnel and facility capacity, notifies the Division of Behavioral Health and Recovery (DBHR) on any significant changes in our network and sends DBHR a copy of our contracts. Additional service needs that have been met are reported as a significant change in capacity and reported to DBHR along with any new contracts. Additional service need issues are reviewed through our quality management process, the Quality Management Oversight Committee (QMOC), and may also be reviewed by the Planning Committee, before moving forward to the BOD.
    b. Plan to report NSMHA's monitoring of capacity building projects
    As NSMHA develops new capacity for additional services, we will report this information to our BOD. NSMHA will also submit this information to DBHR along with any new contracts for services. NSMHA's semi-annual provider capacity report is also available to DBHR. Additional capacity reports/monitoring tools include: monitoring access timelines, comparing and evaluating projected and budget service utilization to actual utilization, analyzing maximum drive times geographically from each zip code to each physical clinic location, analyzing crisis service maximum peak service demand in four (4) hour increments by county and day of the week and projecting an actuarial value on current received services to determine viability of long-term revenue and funding models.

D. Network Components

1. Access to Care

    NSMHA has designed a "no wrong door" approach for individuals to access services. NSMHA contracts with Volunteers of America (VOA) to operate a centralized access line. Individuals can call this line and find out about the provider options in their area. After a financial eligibility screening and gathering of brief clinical information, the access line staff will connect the individual with the agency of the individual's choice for an intake or crisis services, if a more urgent need is identified. Individuals may also call directly or walk into an agency and they will be assisted in scheduling an intake, if financially eligible. Some of NSMHA's contracted providers have implemented an open access model so individuals may be seen for intake on the same day they request services. This is being developed more broadly across the region as noted below. NSMHA is designing an alternative access system so individuals may also directly contact BHAs to request services.

a. BHAs are expected to meet established timelines with regards to intake and first ongoing appointments. NSMHA monitors the timeliness of these services and strategizes with providers when timelines are not met. Most recently, NSMHA is working on implementation of a same day access model across the region, which is expected to ensure access to services right when the individual needs it (e.g., elimination of no-shows) and improve the efficiency of the service access process for BHAs.
b. BHOs and BHAs have trained staff on the use of the new statewide Access to Care Standards (ACS). Authorizations and denials of services are made by BHO staff knowledgeable of ACS.

2. Service Continuum/Array of Services

a. Outpatient Services
NSMHA contracts for an array of routine and intensive outpatient (IOP) MH services with certified BHAs across our five (5)-county region, which allows for individual choice. Routine services include: Brief Intervention Treatment, Intake Evaluation, Family Treatment, Group Treatment, Individual Treatment, Medication Management, Medication Monitoring, Rehabilitation Case Management, Therapeutic Psychoeducation and Peer Support. Other outpatient services including Day Support, Psychological Assessment and Special Population Evaluation are requested less frequently than those listed previously, but NSMHA and our BHAs provide or arrange for any medically necessary service in the state plan. The BHO also contracts for several intensive service options including: MH Services in a Residential Setting, Wraparound with Intensive Services (WISe), PACT, IDDT and Adult IOP High Intensity Treatment (HIT). As is noted below, not all of these programs are located in every county but NSMHA ensures individuals with intensive needs receive the intensity and type of services necessary to address their needs.
b. Residential Treatment
Residential Treatment is provided at three (3) Residential Treatment Facilities (RTF) located in Snohomish County: Aurora House, Green House and Haven House and one (1) Assisted Living Facility (ALF) in Whatcom County, Lake Whatcom Residential and Treatment Center (LWRTC). The three (3) RTFs are operated by Compass Health and the ALF is operated by Lake Whatcom Center (LWC). The RTFs are designed to support individuals in attaining sufficient independent, Activity of Daily Living (ADL) skills so they are able to enhance their recovery by moving from the RTFs to a more independent level of community-based living. The RTF programs combine case management, medication management and targeted treatment/recovery planning to assist individuals in attaining community placement. The RTF expected length-of-stay is 18 months. Discharge planning for individuals receiving care at RTFs begins upon admission to the RTF. ALF care is similar to RTF care in terms of ADL training, symptom management and individualized recovery planning.

However, there is no 18 month expected length-of-stay for individuals at the ALF. Individuals at the ALF tend to require longer than 18 months attain/regain sufficient independent living skills to move out of the ALF.

c. Wraparound with Intensive Services (WISe)
NSMHA currently contracts with 2 BHA's for WISe; Compass Health in Snohomish County and Catholic Community Services NW (CCSNW) in Skagit and Whatcom Counties. WISe is a child and family team based approach that integrates fidelity-based Wraparound, core Medicaid mental health services and 24/7 crisis response and stabilization. Each WISe professional team includes: Mental Health Therapist (MHT), care coordinator and a youth or parent partner. Current regional capacity is 146 slots with expansion intervals from October 2015-April 2018 that will bring us to a capacity of 385 individuals and programs in 4 of 5 North Sound counties. NSMHA's expansion plan also includes WISe specific for Transition Age Youth (TAY) population.

d. Wraparound
NMSHA contracts with Compass Health in Island County to provide capacity for eight (8) slots of fidelity-based Wraparound similar to that described above. However, this program does not include integrated crisis response and stabilization.

e. Program for Assertive Community Treatment (PACT)
NSMHA contracts with two (2) BHAs to operate PACT teams in our three (3) largest counties. PACT is an evidence-based model for working with individuals with severe and persistent mental illnesses whose needs are not met by traditional MH services. The teams provide most of their services in the community. PACT is an integrated treatment approach and staffing includes: a vocational specialist, Chemical Dependency Specialist (CDS), registered nurses (RN), MHPs and a Peer Counselor. This staff works in treatment teams to provide comprehensive services.

f. Integrated Dual-Disorder Treatment (IDDT)
NSMHA contracts with one (1) BHA to operate IDDT teams in Skagit and Snohomish County. IDDT is an evidence-based model for working with individuals who have both severe and persistent mental illness and SUD. The interdisciplinary teams work to provide integrated MH and SUD treatment that is appropriate to each individual's specific needs. They use a strategy of assertive outreach and provide motivational interventions that are appropriate to the individual's stage of recovery. IDDT provides individual and group treatment, as well as, prescriber services.

g. Adult Intensive Outpatient Program (IOP)
This service is available in all counties except San Juan due to a lack of need for a whole team in that County. NSMHA contracts with 4 providers with 7 teams for IOP. These programs follow the HIT modality and as such, are intended to reinforce safety and promote recovery. The IOP team is available to individuals in the program on a 24/7 basis and provides the array of routine outpatient MH services with a significant number of those services occurring in the community. The staff to individual ratio for IOP is no more than 1:15.

h. Inpatient and Hospital Transition Services

i. The BHO's 24/7 Inpatient Utilization Management function is delegated to VOA. VOA provides authorization for all involuntary inpatient psychiatric admissions, as well as, utilization review of all voluntary inpatient psychiatric admissions and requests for continued stay for individuals currently eligible or applying for Washington Apple Health.
ii. NSMHA has a transitional care team that assists individuals in connecting to outpatient services after discharge from inpatient psychiatric care. They focus on the six (6) inpatient facilities most utilized by the North Sound and make connections with individuals and facilities prior to discharge, in person whenever possible.
iii. A process for discharge planning and proposal for transition to meet the requirement to work with hospitals to develop an individualized discharge plan to meet requirements of new law (see Section II.A.3).

E. SUD Network

1. Service Access

a. North Sound BHO (NSBHO) will expand the capacity of the existing Access Line and 24-hour Crisis Line (see this Section D.1.a.) to include screening and referral for SUD services. However, the "No Wrong Door" community-wide approach will allow for individuals to go directly to BHA SUD treatment agencies for services. The same timelines for intake and assessment that have been established for BHA MH Treatment Agencies will also be established for BHA SUD agencies.
b. All BHA agency intake staff will be trained on the use of a common intake screening tool such as the Global Appraisal of Individual Needs-Short Screener (GAIN-SS). All BHA agency intake staff will also receive introductory training in both the MH ACS and ASAM Patient Placement Criteria (ASAM PPC). Lists of current and projected providers are contained in Appendices 04 and 04-1.

2. Service Continuum/Array of Services

    a. Involuntary Commitment Services
    The BHO will maintain this service through contracts with current Chemical Dependency Specialists (CDS) in each county. Additionally, the contract will require that the CDS will respond to requests for SUD assessments within 72 hours for those individuals released from local jails where they were held and returned from the state hospital or an E&T under Revised Code of Washington (RCW) 71.05.232 when records indicate a possible SUD.

    The BHO will develop data tracking of the Involuntary Treatment Act (ITA) SUD assessments, as well as, the commitments to monitor utilization of this service. Utilization record review of this service will become part of the monitoring strategy. Response times to complete these assessments and commitments will be a component of the monitoring.

    The BHO will ensure a review is conducted of any minor admitted to inpatient treatment under RCW 70.96A.245 to determine medical necessity to continue inpatient treatment within 7-14 days of the minor's admission, adhering to all requirements of RCW 70.96A.097. The BHO will ensure the review is conducted by a Chemical Dependency Professional (CDP) or a physician that is not affiliated with the program providing the treatment and has no financial interest in continued inpatient treatment. Additionally, the Children's Care Coordinator can assist with problem solving, transfers and care coordination.

F. Additional crisis services in our region include:

1. Crisis Outreach Services
    The Crisis Prevention and Intervention Team (CPIT) in Skagit County will be piloting an integrated MH/substance use outreach service. CPIT will pair MHPs with CDPs and Certified Peer Counselors to respond to these calls. These professionals will be able to assess for MH, alcohol and/or drug involvement and make referrals to appropriate resources in the community. CPIT in Skagit County will refer to the Skagit County Crisis Center, if clinically warranted, for further MH and substance use interventions. The teams will provide extended follow up support when needed to improve engagement with outpatient or other community services.
2. Crisis Stabilization Services (Triage Centers)
    There are 3 stabilization/triage centers in this region that can respond to both mental illness and substance use disorders. These 24/7 voluntary programs are designed to provider short-term stabilization. The programs are working closely with regional emergency departments (ED) and law enforcement agencies. They provide a valuable diversion to hospitalization for individuals in the North Sound Region.

a. Skagit County and Whatcom County programs provide state certified subacute detoxification services.
b. Snohomish County Triage Center provides sobering services and works closely with detoxification programs in the region.
c. These centers also provide 24/7 nursing enhancement to better support the care for more acute needs.

G. Coordination with Law Enforcement in Protective Custody of individuals who are intoxicated

NSMHA currently has regular local (county) crisis oversight meetings with law enforcement agencies, hospitals and crisis system representatives to address law enforcement coordination for behavioral health issues to include SUD. Currently, law enforcement has arrangements with local EDs to address medical needs and safety while the individual is in protective custody. The regional crisis system is working closely with law enforcement to work on diverting individuals in behavioral health crisis who are clinically appropriate from jails. The use of the crisis stabilization centers, noted above, is instrumental in supporting those diversions.

H. Withdrawal Management Services

Regionally, there are 4 centers certified by DBHR for subacute, acute detoxification, or withdrawal management services, located in Whatcom, Skagit and Snohomish Counties and all have 16 beds or less. Three centers are subacute and 1 is acute. Two of the subacute are adult-specific and 1 is youth-specific; the acute center is adult-specific. Scheduled to open later this year in Snohomish County is another acute center for adults of 16 beds. All centers work to engage the individual to complete the course of detoxification and withdrawal in the center, reach agreement to treatment placement with entry scheduled prior to leaving the center, or meet a previously scheduled entry date for treatment. The stay is 3-5 days under Medicaid State Plan services. There are also 2 hospitals in the region that provide withdrawal management for pregnant women. The availability and utilization of withdrawal management services will be reviewed by the BHO with the future provider network to determine any alternative implementation methods that may be more cohesive within an integrated system for those using this recovery service.

I. Outpatient Services

There are currently 8 publicly-funded state certified outpatient treatment providers in the region that provide adult and youth outpatient (OP) ASAM Level 1 and IOP ASAM Level 2.1 services, with branches in multiple counties which the BHO will continue (see Section IV, Appendix 04). Sixty-three percent (63%) of the regional SUD providers are currently providers in the NSMHA RSN. SUD provider number by county is: Island – 1 provider; San Juan – 1 provider with 3 branches; Skagit – 5 providers; Snohomish – 6 providers with 12 branches; and Whatcom – 2 providers. One provider is also an OST provider. Within the regional provider network branch sites, there are 31 potential locations to receive youth OP/IOP services; 36 potential locations to receive adult

OP/IOP services; and 6 identified locations to receive Pregnant, Post-Partum, and Parenting Women (PPW) OP/IOP services although current county-contracted adult providers are expected to provide the delineated specific PPW services. NSMHA intends to review the distribution and utilization of these outpatient services to determine the need for additional capacity within the region. The BHO will include in the review the need for youth services including early intervention and school-based services; additional adult services including specific PPW services; childcare and therapeutic childcare services; and review of need for Medicaid service capacity in rural and remote areas of the region. Additionally, a review of SUD services available to older adults in settings responsive to their developmental stage will be implemented by the BHO. In addition to the future provider network in the regional area, there are currently 41 DATA 2000 waiver prescribers (e.g., buprenorphine and naltrexone and the various trademarked combinations) to collaborate with outpatient treatment providers to ensure treatment and recovery services accompany MAT. The BHO will work with the future provider network to review best practices for prescription opioid dependence and system of care. Additionally, the BHO will align with local Primary Care Clinics (PCC) in the use of Screening, Brief Interventions and Referral to Treatment (SBIRT) for youth, adults and PPW with access to treatment within the future provider network for those in their PCC and other community clinics found to be in need of treatment.

Core services in the provider network will be culturally competent, developmentally appropriate and include: assessments completed prior to acceptance into treatment to diagnose according to Diagnostic and Statistical Manual (DSM)-5 and determine ASAM PPC LOC; development of an Individual Service Plan (ISP) with the individual; residential treatment placement as indicated; individual and group education and counseling including family and PPW specific treatment elements; referral to primary care; as well as, other needed community services. Intensity and length-of-time is determined initially based on the ASAM LOC, reviewed at least monthly for the first 3 months, then quarterly for appropriateness of services. OP is a minimum of 60 days with weekly group or individual and IOP is for a total of 72 hours within 12 weeks of treatment, while also including individual need, within the ASAM PPC. Other services in the region for adult and youth include: Driving under the Influence (DUI) assessment, Alcohol and Drug Information System (ADIS) and Deferred Prosecution court ordered treatment.

Specific to PPW with dependent children, these priority access to treatment services also receive the highest admissions preference during pregnancy and doubly so if using drugs intravenously. Treatment services must include prenatal and postpartum care; primary care; pediatric primary care and immunizations; childcare; gender-specific treatment services such as female counselors when requested, trauma and domestic violence care, parenting support and education; therapeutic interventions for their children; sufficient case management; and transportation services. The BHO will continue contracts with these providers and will ensure need is met to avoid wait times. Additional available community resources for PPW include a Safe Babies Safe Moms program in Whatcom County and a Parent Child Assistance Program in Skagit County.

Criminal Justice Treatment Account (CJTA) services are provided to drug court participants in each of the counties through the providers in those local area counties. These providers have programmatic expertise specific to the needs of individuals who experience SUD along with repetitive involvement with the criminal justice system that could be mitigated with recovery. These providers successfully interact with and respond to the local drug courts and ensure the accountability needs are met in the prescribed manner the drug court requires. These service contracts will be maintained by the BHO. As previously described, the BHO will continue the CJTA local county panels and plans and develop a regional plan based on the plans from the local panels to ensure local area needs are met within a regional CJTA plan.

Another specific population to address is those involved with the Department of Corrections (DOC) who are in need of SUD outpatient treatment and are Medicaid eligible. As described in Section II, NSBHO will develop a competitive bid process to procure providers with specialized expertise to serve them, since the DOC currently procures these services. North Sound wants to ensure quality care to assist and support the recovery of this group of individuals is within our provider network.

J. Medication Assisted Treatment (MAT) and Medication Assisted Recovery (MAR)
The BHO intends to maintain within the projected provider network the one (1) currently county-contracted OST provider. There is another OST provider in the region that accepts Medicaid and is not contracted by the county. NSMHA will maintain the alliance with this program. NSMHA plans to develop partnerships and alliances regionally to increase MAT service availability based on the University of Washington (UW) Alcohol and Drug Abuse Institute (ADAI) heroin use and overdose data, the Snohomish County Heroin Report and anecdotal report. According to these reports, there are approximately 300 individuals waiting for availability in OST even after increasing each license to 750. Additionally, within the region as of June 2015, there were 41 DATA 2000 waiver prescribers (e.g., buprenorphine and naltrexone) with just over half of them approved to treat up to 100 patients. However, the extent of utilization of these prescribing rights is not known. The BHO will develop an initial plan to determine regional use of MAT and challenges and successes. Five (5) provider locations are associated with this prescriber group and offer MAT in conjunction with their outpatient treatment services.

As NSMHA develops engagement and care coordination functions, we also intend to work regionally to increase overdose prevention. Of the three (3) syringe exchange programs in the region, one (1) provides overdose prevention education that includes availability of naloxone and another is developing policies for the future availability. All regional counties have at least two (2) pharmacy locations that can provide naloxone to community members. Please note NSMHA does acknowledge that federal Substance Abuse Prevention Treatment (SAPT) block grant cannot be used for syringe exchange services.

K. Residential Services

There are five (5) residential service programs located in the North Sound region that the BHO intends to continue based on a credentialing process. For the publicly-funded beds they are:

1. Pioneer Center North (PCN) – Long-term Residential (LTR); ASAM Level 3.3; adult; 108 beds;
2. Evergreen Manor Unit 1 – Intensive Inpatient (IIP), LTR, Co-Occurring Disorders (COD); ASAM Level 3.5 and 3.3; adult; PPW; 12 women and 6 children;
3. Evergreen Manor Unit 2 – IIP, LTR; ASAM Level 3.5 and 3.3; adult; PPW; 9 women and 9 children;
4. Sea Mar Visions – IIP, Recovery House (RH); youth; girls; Level II; 17 beds; and
5. Skagit Recovery Center – RH; youth; ASAM Level 3.1; 17 beds.

To address the issue of PCN, both Institution for Mental Diseases (IMD) and location, NSMHA has begun work locally to develop a plan to maintain these treatment services for our regional communities, as well as, for the statewide communities in need of this specific service.

L. Recovery Support Services

Individual recovery capital is reviewed initially as part of the SUD assessment and evaluation process, and areas identified to support development are included in the ISP. Groups and individual sessions are also a vehicle to add to individual recovery capital. Recovery supports in regional SUD programs offer access to childcare services; self-care and care of children through primary care, medical and dental; fellowship, affiliation and support group introduction and access; and accessing housing and employment/re-employment guidance and support.

For those experiencing Serious Mental Illness (SMI) and SUD, Peer Counselors have been trained to support individuals with these concomitant life issues. There are three (3) community peer centers in the region that include: Baily Peer Center in Snohomish County, REACH Peer Center in Skagit County and Rainbow Recovery Peer Center in Whatcom County.

The BHO will work with the SUD provider network on the potential system inclusion of Recovery Coaches trained under the Connecticut Community for Addiction Recovery (CCAR) model, as well as, Access to Recovery (ATR) funding. A recovery alliance has recently formed in Skagit County, that includes participation by the Recovery Café Everett, a recovery alliance in Snohomish County. Additionally, the BHO will work with the provider network to determine additional recovery supports needed.

M. Co-Occurring Disorders (COD) Treatment Services

The BHO currently has two (2) IDDT programs in two (2) counties that started under the RSN. For the future provider network, the BHO will expect providers to be dually certified and/or licensed for both SUD and mental health at a future date. The BHO will increase the implementation of COD services within the region, but especially once the Washington Administrative Code (WAC) has been released.

As the foundation to this, the BHO will explore the feasibility of a plan in conjunction with the future provider network to potentially include the administration of the Dual Diagnosis Capability in Addiction Treatment (DDCAT) and Dual Diagnosis Mental Health Team (DDMHT) and utilize the existing expertise of the Addiction Technology Transfer Center (ATTC), UW and other available expertise.

The BHO will work with the future provider network to implement a milieu of trauma-informed care in all service locations.

N. Responding to Emerging SUD Challenges

NSMHA has contracted with Dr. Richard Ries, Director of the Addictions Division at the UW School of Psychiatry, to develop pilot strategies to address the growing Opioid epidemic. This will include testing out some of the approaches that DSHS is developing in conjunction with its new federal grant. NSMHA is also planning to convene a summit of the region's Public Health Departments and Tribes to identify joint strategies that can be undertaken. This may include surveillance strategies, expansion of MAT and new forms of public education and outreach.

V. STAFFING, WORKFORCE ANALYSIS AND DEVELOPMENT PLAN

A. Behavioral Health Organization (BHO) Administrative Structure

The Regional Support Network (RSN) has identified the additional administrative capacity, including positions, non-labor costs and provider training that will be necessary to administer the BHO. The RSN Board of Directors (BOD) has approved the staffing plan and total additional costs will be built into the 2016 Operating Budget request (see Appendices, Section V, 01 and 02).

B. Training System

1. Regional Training Committee (RTC)

    a. NSMHA's training committee is a subcommittee of the Quality Management Oversight Committee (QMOC), a subcommittee of the BOD. The membership is comprised of NSMHA staff, network providers and Advisory Board members. In the fall of 2015, the regional Substance Use Disorders (SUD) providers will be invited to attend the RTC meetings. The charge of this group is to identify training needs in the region, develop a regional training plan, vet trainings and recommend trainings to be sponsored by NSMHA. NSMHA will be surveying all contracted mental health (MH) providers and prospective SUD providers on upcoming training needs for the 2016 integration of services.

    b. The RTC just completed a survey of our current provider network to determine whether the training NSMHA is currently providing is adequate, useful and pertinent to the current system needs. In winter of 2015, it is NSMHA's intention to survey the SUD providers to determine what training they are currently providing and what they see as a need in the future in an integrated behavioral health system. Motivational Interviewing (MI) and Cognitive Behavioral Therapy (CBT) have been identified on both the SUD and MH Evidenced-based Practices (EBP) list. NSMHA has already implemented training in both areas and will expand the provider pool to include SUD providers in the region. NSMHA will continue to assess the training needs of our expanded provider network post April 2016.

2. Relias

    a. NSMHA's online learning system, Relias, was implemented in 2014 as a regional training resource. The vast library is available to all NSMHA contracted providers, which will include the SUD providers in 2016. The library is behavioral health focused with MH and SUD modules that provide introductory and Continuing Education Units (CEU)/Clock Hours. NSMHA has the ability to upload customized trainings, track regional completion/compliance of trainings, assign/recommend trainings to the provider network and expand the library in response to NSMHA and provider needs. The providers have access to the complete library and can assign trainings based on the needs of the individual employees.

b. The Relias system is continually updating its library and adding new and/or revised modules when developed. The completion rate and compliance rate for the system is meeting national standards of use for the online learning system. Sponsored trainings include:

   i. Motivational Interviewing Training (MIT)
   NSMHA has funded over 70 hours of MIT for 390 clinical staff over the last 3 years to promote engagement and treatment of individuals. This EBP has been identified by the RTC as an ongoing need in the region. The BHO will continue promoting MIT post April 2016. This training has been conducted by Addiction Technology Transfer Center (ATTC) Limited Liability Corporation (LLC) affiliated with Oregon Health Sciences. Currently, all of our outpatient SUD providers have implemented this practice across the 5 regional counties.

   ii. Illness Management and Recovery (IMR) Training
   NSMHA has trained six (6) teams in the North Sound Region on IMR over the last two (2) years. Susan Gingerich, one (1) of the developers of IMR, provided this training. Another two (2)-day training is being provided in the winter of 2015.

   iii. Common Elements Treatment Approach (CETA) Training
   NSMHA is scheduling CETA training for early 2016 to include MH and SUD providers. Lucy Berliner, Licensed Clinical Social Worker (LCSW) is associated with Harborview Center for Sexual Assault and Traumatic Stress and University of Washington (UW) School of Medicine, Public Behavior Health and Justice Policy. The training will consist of 2, 2-day live trainings and 6 consultation period post training. NSMHA anticipates training 75-100 individuals in the first round of training. Based on training committee recommendation, NSMHA expects to continue this training in the region.

   iv. Cognitive Behavioral Therapy (CPT+) Training
   NSMHA has scheduled training for fall of 2015. Lucy Berliner, LCSW, and Laura Merchant, LCSW, will be conducting the training. NSMHA anticipates training 50 individuals during the first round of trainings. The training will consist of 2 – 3-day live trainings with a 6 month consultation follow up. Based on training committee recommendation, NSMHA expects to continue this training in the region.

   v. Wraparound
   NSMHA began training workforce in Wraparound in 2007. To date NSMHA has offered basic and advanced training annually. NSMHA has trained approximately 200 staff and supervisors in both the Wraparound process and coaching models. Future Wraparound training will be tied to Wraparound with Intensive Services (WISe) expansion following protocols developed by the Washington State University Training Coalition.

vi. Transition Age Youth (TAY)
Beginning in 2016, NSMHA will explore and select a training model for staff working with TAY that are also enrolled in WISe.

vii. Systems of Care Institute (SOCI) Training
For 4 years, NSMHA has sponsored SOCI training providing professionals in the community, social and human services, education and other related fields with valuable training and education to support professionals serving children, youth and families in our communities. SOCI is based on the principles of interagency collaboration, individualized and strength-based practices, cultural responsiveness, community-based services, accountability and full participation of families and youth at all levels of the system. It is typically attended by 200 individuals from across service domains in Washington, Oregon and Idaho. Family and youth also attend as presenters and attendees. **Target Audience:** Behavioral Health, Tribal Health & Human Services, Child Welfare, Education, Disabilities, Juvenile Justice, Advocacy and other related social service fields. Youth receiving these services and/or their caregivers are also encouraged to attend. **Goals:** Increase access to essential information across systems; promote skills and strategies that support positive outcomes and enrich understanding of different perspectives and common goals in support of North Sound children and families.

The BHO will support training of Behavioral Health Agency (BHA) clinical staff to expand their capacity in care coordination, gain a better understanding of the common physical health problems and capitalize on existing behavior change skills to best assist individuals with co-morbid behavioral health and physical health conditions in navigating the healthcare system (e.g., National Council for Behavioral Health Case to Care Coordination training).

viii. Behavioral Health Cross Training

a) Using the survey of existing providers referenced in Section B.1.b., the BHO will sponsor a series of classroom, webinar and online trainings designed to provide all BHA clinical staff with a basic knowledge of the full range of covered behavioral health diagnoses.
b) A basic introduction to MH and substance abuse intake and assessment tools, including MH Access to Care Standards (ACS), Level of Care Utilization System (LOCUS) and American Society of Addiction Medicine (ASAM) will be provided to all BHA intake staff.

C. Workforce Development

The RSN has begun conversations with local community colleges to develop a "fast track" for Master's level clinicians to obtain Chemical Dependency Professional (CDP) certification. Three colleges in the region are interested in working with NSMHA in establishing the "fast-track" for MHPs in the region. We are awaiting a decision from the Department of Health on the number of hours and credits needed for the certification. NSMHA will also engage the Workforce Development Council in hopes of partnering to provide opportunities for additional training and possible funding collaborations.

These discussions also included updates to course curriculums needed for all CDP certifications so staff are prepared to work within the progressively developing system of behavioral healthcare. Additionally, we are discussing how we can create opportunities for CDPs to continue their education by obtaining an advanced degree for an expanded role an integrated behavior health system.

The BHO will participate in statewide efforts to develop a tuition subsidy program to increase the number of college students pursuing a degree in behavioral health services.

VI. FINANCIAL AND ADMINISTRATIVE PLAN

A. Budget Allocation Plan and Rate Structure

The North Sound Mental Health Administration (NSMHA) developed a budget allocation plan and rate structure that uses a software model developed by our consultant, Mr. Dale Jarvis. This model combines projected Medicaid population growth, estimated level of need for Substance Use Disorder (SUD) services ("prevalence"), estimated new capacity to meet this need and a rate structure that supports sustainability of services. This process identified projected needs and focused allocation of resources in our proposed funding. Appendix, Section VI, 01 is the working document that was used to compare historical service data to prevalence estimates within our region to develop the service demand estimates. NSMHA partnered with SUD providers in the region to identify the current actual cost of services and through a multistep process developed the funding plan. NSMHA's first plan is to increase rates to cover actual costs of services provided. Secondly, NSMHA will expand services based on our demand analyses. For the third step, NSMHA will add crisis outreach, stabilization services and 24 hour crisis hotline services, within funding constraints. In addition to partnering with the SUD providers, NSMHA also partnered with the 5 counties in our region to develop a state general fund and Substance Abuse Prevention Treatment (SAPT) service plan. NSMHA is still working on refining our final Criminal Justice Treatment Account (CJTA) plan with our county partners. In order to meet the expected demand for service, NSMHA allocated additional Medicaid funds from our current mental health (MH) fund balance. These additional funds are needed to start the process; however, they will eventually be depleted. In theory, the additional services will increase the Medicaid rates when the next actuarial study or rebase is performed. It is projected that this funding going forward will pay for these SUD services. A comprehensive service and fiscal model is a good beginning point for this process; however, in the long-term the Behavioral Health Organization (BHO) will need to adjust services and payment based on actual service demand and actual provider operating costs.

B. Payment Mechanisms

The existing array of NSMHA payment mechanisms will be expanded to include SUD services. This includes a combination of fee-for-service, capacity, cost-reimbursement and performance incentives. NSMHA will follow the same process used for mental health services to match type of payments to the type of services (see Appendix, Section VI, 02), additional detail for the North Sound approved cost allocation plan.

C. Substance Use Disorder (SUD) Service Array Model

A continuum of care "BHO SUD Service Array" model (see Appendix, Section VI, 03) has been developed that identifies both services that could be funded with BHO funds, as well as, services that can be funded from other sources. NSMHA will work with the five (5) counties, Managed Care Organizations (MCO) and other system partners to identify investment opportunities for other funds. When the funding model based on the clinical design and proposed funding is completed, NSMHA will be able to further detail how the BHO will fund these services and the required funding from the five (5) counties and other organizations in our region.

D. Current payment mechanisms and planned expansion

1. Current payment system

a. Cost allocation methodology between fund sources. The BHO will use a similar methodology as NSMHA currently has in place. Appendix, Section VI, 02 is the North Sound cost allocation plan updated 3/31/2015.
b. Fee-for-service payments. Fee-for-service payment works well for outpatient service types where the volume determines total payment. The North Sound uses fee-for-service payment as an incentive for providers to perform more services. An increased service directly correlates to increased payment.
c. Capacity payments. These payments work well for emergency services (fire house model) where services are required 24 hours a day 7 days a week and capacity based payment is for capacity based services.
d. Cost reimbursement payments. This type of payment works well for Federal Block Grant (FBG) service and start up contracts. When there is a pilot program, this type of payment service is often employed. Often, it may take a program some time to gain momentum to full productivity and this payment structure pays only for actual costs.
e. Incentive payments. NSMHA contacted the Center for Medicare and Medicaid Services (CMS) in 2014 to gain an understanding as to the acceptable use of Medicaid funds for incentive payments. NSMHA was informed by the San Francisco, California office of CMS that Medicaid funds may be used for incentive type payments. However, NSMHA was advised they could not be used in ways prohibited as illegal by the federal or state government. NSMHA is currently using two (2) pay for performance incentive systems to pay for positive outcomes that move the current system in a prescribed direction.
f. The Program for Assertive Community Treatment (PACT) was not performing as well as NSMHA expected. To improve their fidelity outcomes and utilization, NSMHA developed three (3) bonus measurements, which if met, would pay PACT additional funds that would be passed on to the staff of that program. Performance standards were developed around the average number of contacts per week, percent of outreach services and maintaining the number of active individuals in the program.
g. The second incentive system is for our Inpatient Transition Care Team to improve the amount of individuals that were scheduled for an outpatient visit within 7 days after being discharged from an inpatient episode. Our contract with the team is paid on a cost reimbursement basis with quarterly bonus. In order to receive the bonus, the quarterly outcomes need to increase from the historical data. Historically, our system data showed that 46% of the individuals were seen in an outpatient episode within 7 days of discharge from the hospital. NSMHA's target is to have 75% of the individuals seen in an outpatient episode within 7 days of discharge from the hospital. A bonus payment is based on the percent of the movement from current to our ideal every quarter.

h. County administrative support payments. NSMHA provides the five (5) counties with funding for administrative and support services. The counties assist with regional planning and local coordination, Advisory Board membership, quality management oversite, allied system coordination, community coordination, supportive housing services and resource coordination between the counties and the Regional Support Network (RSN)/BHO.

i. Third party resource requirements. NSMHA's policy requires agencies to identify, pursue and record third party insurance resources as required by their contracts with the RSN. Since Medicaid is the payer of last resort, NSMHA also requires the providers to report their collections every six (6) months to the RSN so NSMHA can report them on the bi-annual quarterly report to the Division of Behavioral Health and Recovery (DBHR). This is in compliance with our encounter data reporting system. NSMHA does not have a claims adjudication system (see Appendix, Section VI, 04)

j. State individual funding. NSMHA distributes the state funds to the mandated services, such as crisis and inpatient, for the non-Medicaid individuals and also non-Medicaid covered state plan services for Medicaid individuals, such as involuntary detention, court costs, Medicaid Personal Care (MPC) and residential room and board. Any unspent funds are then allocated to the outpatient services based on identified priorities. NSMHA's current priorities are individuals discharged from Western State Hospital (WSH) or a Children's Long-term Inpatient Program (CLIP) facility and individuals on less restrictive (LR) order, conditional release (CR) and Medicaid individuals on a spend down. State funding policy and procedures can be found in Appendix, Section VI, 05.

k. Non-Medicaid individuals. These state individuals are divided into two categories: 1) those who meet financial eligibility criteria (Example: adults that have income less than 200% of federal poverty) and 2) those individuals who do not meet state funding criteria (Example: adults that have income more than 200% of federal poverty). Individuals who do meet state funded criteria will not be charged for crisis or outpatient services. In addition, these individuals could also potentially meet 1 of the state exception criteria to obtain an assessment for outpatient services, such as, a recent discharge from WSH, CLIP facility, or NSMHA's Evaluation and Treatment (E&T) facilities. Individuals who do not meet state funding criteria will be charged for their crisis services under the standard third party billing rules. These individuals are not eligible for an outpatient service exception under state funding policy (see Appendix, Section VI, 05).

2. Expansion of the payment system to include SUD services

   a. Securing the SUD network. For start-up and service contracts, NSMHA has begun a credentialing process to assist SUD providers, which will be followed later by a Request for Proposals (RFP) and/or Request for Qualifications (RFQ) process.

b. Federally Qualified Health Center (FQHC) payments and primary healthcare facilities. NSMHA plans on contracting with the FQHC contractors in our region who qualify and apply to provide SUD services.
c. Administrative and support service. NSMHA plans to expand the county administrative and support services to include SUD services. NSMHA plans to allocate funding to the five (5) counties for the development of plans to integrate and expand local and county funded services in partnership with the BHO.
d. Out-of-region agreements and payments. NSMHA will work with the other RSN/BHOs to share residential and other resources not sufficiently provided within the borders of our region. In addition, NSMHA will partner to contract for specialty services for individual needs.
e. Future incentive payments. NSMHA plans to partner with providers, allied systems and healthcare providers to move the system in a direction with better outcomes in the areas of: penetration, program completion, early intervention, community care coordination, Medication Assisted Treatment (MAT) and same day access. NSMHA has been exploring payment of additional funds to providers who improve their SUD outpatient program completion rates. Conversations with Apple Health providers have indicated three (3) areas of mutual interest: 1) individuals with low mental health needs and substance abuse issue, 2) high need mental health individuals who also need care coordination and, 3) addressing the current opioid epidemic and related issues. Preliminary discussions have centered on providing incentives to primary care physicians (PCP) to increase opioid substitution therapy. Since this is a capacity issue, there is a need to increase this capacity at the onset as a BHO, with responsibility for SUD services. NSMHA has identified this issue as a potential opportunity to partner with the Apple Health providers.
f. Third Party Responsibilities. NSMHA will administer individual third party responsibilities similar to our current system as a direct result of the fact that Medicaid is the payer of last resort. NSMHA will expand policy 3044.00 to include SUD services and update state individual funding policy 1574.00 to add SUD services (see Appendices, Section VI, 04 and 05). NSMHA has state service projected demand from our software model, as mentioned previously and also have an estimated amount of non-Medicaid covered services, such as, residential services in an Institution for Mental Diseases (IMD) that may be needed. NSMHA continues work with the counties on drug court funding. On receipt of final state funds and Substance Abuse Prevention (SAP) grant funds, NSMHA will be in a position to complete our funding model and determine the availability of funds for state funded individual services.

3. Fund balance projected usage. NSMHA plans to allocate a portion of our fund balance reserves for SUD network infrastructure and expansion. These funds have been set aside by the North Sound Board of Directors (BOD).

E. Current administration plan with expansion of staff and subcontracts

1. The existing NSMHA administrative structure will be expanded to address the increased administrative workload. This includes expansion of the existing county administrative contracts for allied system coordination and an expanded provider training budget.

2. Current structure with expansion plan.
   a. Additional staffing. NSMHA has in place a BOD approved staffing plan (see Appendix, Section VI, 06 and Appendix, Section V, 02), BHO Organization chart for detail on additional staffing.
   b. Additional subcontracts. The network expansion plan has a two part process. First, to perform a credentialing process and extend administrative and support contracts. Secondly, to perform an RFP and/or RFQ for SUD service contracts based on the final fiscal model developed with consultant, Mr. Dale Jarvis.
   c. Additional County administrative and support service. Arrangements have been put in place with the five (5) county agencies to expand their administrative and support contracts to include assistance with SUD services.
   d. Other delegated functions. Expansion of delegated services, including Crisis and Access lines through Volunteers of America (VOA), Ombuds and Quality Review Team (QRT) have been discussed with the current providers who plan on expanding their services to include SUD services.

3. Conversion of Advisory Board
   The current Advisory Board has developed a design for a revised Advisory Board with 26 members for both mental health and substance use issues.

4. Agency organizational status
   NSMHA plans to move forward with a plan to update the inter-local cooperation agreement, with a view to transition into a Limited Liability Corporation (LLC). The plan is to update the inter-local and form an LLC as of January 1, 2016. The change in entity status from our current default partnership status is required by Revised Code of Washington (RCW) 71.24.380(C) "All counties within a regional service area that includes more than one (1) county, which shall form a responding entity through the adoption of an inter-local agreement. The inter-local agreement must specify the terms by which the responding entity shall serve as the BHO within the regional service area."

VII. UTILIZATION MANAGEMENT PLAN

A. Level of Care (LOC) Guidelines for Outpatient Services

1. Access to Care Standards (ACS) and medical necessity are utilized to determine initial eligibility for behavioral health services (see Appendix, Section VII, 01).
2. Once an individual is determined to be eligible for services, the appropriate LOC for an individual's needs will be determined by the Level of Care Utilization System (LOCUS) and Child and Adolescent Level of Care Utilization System (CALOCUS) for mental health (MH) and the American Society of Addiction Medicine (ASAM) will be used with persons diagnosed with a Substance Use Disorder (SUD). Authorization for continuation of outpatient or residential services will use the same tools to assess medical need for continuation of services.
3. The Behavioral Health Organization (BHO) will review authorizations or denials of SUD services using the same processes used for MH services (see this Section C).
4. Continued Stay Criteria
5. Continues to meet medical necessity and one (1) or more of the following:

    a. Individual is engaged in a transition to discharge plan;
    b. Although the individual's functioning has improved, continued treatment is deemed medically necessary to prevent deterioration as evidenced by previous documented unsuccessful efforts at discharge;
    c. Although the individual's functioning has improved, they have needs which cannot be met by any other system or resource and, if unmet, would result in deterioration of functioning and likely re-admission; or
    d. Individual has a current Less Restrictive (LR) or Conditional Release (CR) in place.

6. American Society of Addiction Medicine (ASAM)
   ASAM criteria will be used for initial authorizations, changes in LOC, continuing stay and discharge for covered SUD diagnosis based on Diagnostic and Statistical Manual (DSM) 5. LOC to be provided by the North Sound BHO (NSBHO) are included in Appendix, Section VII, 02.

B. Authorization for Routine Services

1. Financially eligible individuals receive an integrated intake evaluation. At the completion of the intake, the intake clinician makes a determination whether to recommend authorization or denial of ongoing services. If authorization is being recommended, the Behavioral Health Agency (BHA) submits an authorization request electronically to the BHO. The request is reviewed by qualified, clinical staff and the determination by BHO staff is transmitted electronically back to the BHA. If

the BHO recommends denial of services, the BHA must submit the intake evaluation and any other documentation used to make the recommendation to BHO. The BHO staff will review this information and make a determination. The BHA is notified of the BHO decision via faxed, written notification. Clients are notified by a letter of authorization and denial decisions by the BHO (see this Section C) for additional information of denial of services. This process occurs within required timelines.

a. Authorizations are for all routine outpatient services. Within particular LOCs, there are a few services (intensive service programs including mental health residential services, fidelity programs) that have some additional admission criteria that must be met. Requests for these services are reviewed by the BHA Program Manager. Individuals who meet these additional criteria are admitted to the program. Individuals who the BHA does not think are appropriate for the program/do not meet the additional criteria are reviewed with the BHO and a Notice of Action is sent if denied admission to the program.
b. Any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested is made by a healthcare professional that has appropriate clinical expertise in treating the enrollee's condition or disease.

2. BHAs must submit requests for additional services/reauthorization within the two (2) week period prior to the current authorization expiration. Individuals for whom reauthorization is being requested must meet continued stay criteria as noted above.
3. Denial, reduction, suspension, termination of requested SUD services will be determined by BHO staff that is a professional who meets the requirements of a Chemical Dependency Professional (CDP) and has appropriate clinical expertise.

C. Notice of Adverse Action
As noted previously, BHAs and individuals are notified of both authorization and denial decisions by the BHO (see Section X.D) for additional detail regarding content and format of notices.

D. Authorization for SUD Residential Services

1. The Regional Support Networks (RSN) are currently developing statewide criteria for contracting and paying for SUD residential services. Each BHO will hold the contracts with SUD residential facilities in its geographic region but BHOs can access beds anywhere in the state. The BHO holding the contract will coordinate billing, payment and data reporting between the facility and other BHOs using its beds.
2. Designated SUD outpatient providers will be authorized to do the LOC assessment using ASAM and make a referral for SUD residential services subject to an authorization process developed by the BHO. NSMHA/BHO will engage its regional residential providers in developing specific protocols for this authorization process.

3. Individuals will not be required to relinquish custody of their minor children to access SUD residential services.
4. Authorization for non-Medicaid residential services will be based on the availability of resources and according to the designated priorities under the Substance Abuse Prevention Treatment (SAPT) block grant and the state designated priorities under state general funds.

E. Utilization Management Plan

1. Data review
   NSMHA has provided guidelines regarding the hours and types of service that are most appropriate for each LOC. Data reports are routinely run and reviewed for the hours of service delivered at each LOC as part of the monitoring of over- and under-utilization.
2. Chart review
   The BHO conducts annual reviews of clinical charts at BHAs. Throughout the year several different reviews with different purposes are conducted. Annually, the BHO conducts a Routine Utilization Review that looks at a random sample of outpatient charts to evaluate if services provided are medically necessary and appropriate intensity (whether there is over- or under-utilization) to meet the individual's needs. This review also covers quality of care issues, which will be addressed in Section VIII.

F. Authorizing Treatment for Non-Medicaid populations

1. The BHO routinely evaluates availability of non-Medicaid funding sources to utilize for treatment services and populations of individuals not covered by Medicaid and who are low income (see Section VI.D.1.j and k) for additional information related to state-funding and current policy.
2. Within available resources, the BHO's current non-Medicaid priority populations to serve with MH services include:

   a. Individuals discharging or discharged within the last 30 days from Western State Hospital (WSH) or Children's Long-term Inpatient Program (CLIP);
   b. Individuals on an LR/CR; or
   c. Individuals currently in services who lose Medicaid funding or have a spenddown.

3. Within available resources, the BHO's current non-Medicaid priority populations to serve with substance use services include:

   a. Pregnant or parenting women;
   b. Individuals who use intravenously;
   c. Youth with:

i. Hardship exemption from requirement to purchase healthcare insurance;
ii. No parental involvement;
iii. No healthcare coverage due to parent choice; or
iv. Homeless but not incarcerated.

d. Adults

i. Undocumented;
ii. Hardship exemption; or
iii. Homeless but not incarcerated.

4. Unless specifically indicated otherwise, individuals who meet these criteria are eligible for all medically necessary state plan services. The authorization process for non-Medicaid is the same as Medicaid outlined above.

G. Sub-contractual Relationships and Delegation

The NSBHO will conduct Request for Qualifications (RFQ) every five (5) years for outpatient services and Request for Proposals (RFP) on a regular basis to bring new services on line in the region, as is current practice. Currently, NSMHA is in the process of credentialing the substance use providers not currently in the network. The intention of the credentialing process is to provide the capital to qualified contractors to build the infrastructure needed to become part of the NSBHO provider network in 2016. In January of 2016, NSMHA will credential the remainder of our provider network, of which, approximately 90% are dually certified for SUD services. Once the credentialing process is complete, qualified providers will be eligible to compete for NSBHO RFQ/RFP.

When a prospective contractor completes and qualifies on an RFQ/RFP, the NSBHO will begin the negotiating process of contracting. Once contracts are negotiated and in place, the NSBHO will provide technical assistance to the contractor to include, but not limited to: Information System/Information Technology (IS/IT), clinical oversight, policies and procedures and fiscal processes. Our administrative audit team, comprised of contracts manager, compliance officer, fiscal officer and administrative staff conducts an audit at a minimum of once during the contract cycles. The clinical oversight team conducts quarterly clinical and utilization reviews of MH services and in 2016 the reviews will include SUD (see Appendices, Section VII, 03-1 through 03-12) for sample contracts, audit policy, sample audit tools and a sample of audit reports.

NSMHA currently has delegated inpatient utilization, access and the crisis hotline to Volunteers of America (VOA). The NSBHO will institute a hybrid of access for substance use services, accessing through VOA and through the provider agencies. The clinical team reviews the data of inpatient denials, access and crisis calls on a quarterly basis, this will include the SUD administrative services delegated to VOA as well (see Appendices, Section VII, 04-1 through 04-3) for delegation policy and a sample delegation plan.

NSMHA currently delegates aspects of community and allied system collaboration and coordination to the five (5) counties in our region. The delegation of these activities will include SUD collaboration and coordination at the county level as well in 2016. NSMHA currently audits the counties to ensure the funding provided is being utilized to support the delegated activities in their respective contracts; the NSBHO will continue the process as it relates to SUD systems.

VIII. QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT PLAN

A. Overview of Current Quality Assurance Plan

1. The current North Sound Mental Health Administration (NSMHA) "Quality Assurance Plan" is being re-drafted and expanded to include new state requirements and to cover Substance Use Disorders (SUD) services.
2. NSMHA has an Internal Quality Management Committee (IQMC) led by Betsy Kruse, Deputy Director, designated as the Quality Manager. The IQMC is responsible for the development and oversite of Quality Assessment and Performance Improvement (QAPI) activities as outlined in the Quality Management Plan (QMP). This committee ensures the BHO QMP is consistent with and incorporates Division of Behavioral Health and Recovery (DBHR) Quality Strategies.
3. The Quality Management Oversight Committee (QMOC) is a standing advisory committee of NSMHA Board of Directors (BOD). It is responsible for the oversight of quality management systems of NSMHA, reviewing all quality management activities and making recommendations for quality improvement to the BOD. QMOC ensures the gathering and analysis of data and reports to recognize the need for improvement or change (as outlined in the Quality Management Work Plan). QMOC is chaired by a Member of the BOD (or designated alternate). Two (2) Members of the BOD (or designated alternates) appointed by the Board are voting members of QMOC. QMOC membership is comprised of NSMHA staff, county coordinators, contractors and Advisory Board members and advocates. In the BHO, NSMHA will incorporate SUD representation.
4. The BHO will establish a "Quality Review Team (QRT)" per new state contract requirements, to include individuals, family members and advocates in review of contractor performance.
5. The recently hired NSMHA "Quality Improvement Coordinator (QIC)" will be supporting strategies to measure and incentivize performance outcomes.
6. Future "Performance Improvement Projects (PIP)" will include a PIP specific to SUD services.
7. Through the work of the Regional Training Committee (RTC) the BHO will implement Evidence-Based Practices (EBP) for both Mental Health (MH) and SUD services.
8. NSMHA currently monitors and report outcomes and quality and utilization of services through our standing committee structure. NSMHA intends to establish reporting via an annual report card. This report card will be a public document.

B. How the Quality Review Plan will address SUD services

1. Monitoring utilization of services (see Section VII.E).
2. Monitoring quality of care chart review

a. As noted in Section VII.E.2, the BHO conducts annual reviews of clinical charts at Behavioral Health Agencies (BHAs). Throughout the year several different reviews with different purposes are conducted. Annually, the BHO conducts a routine utilization review (UR) that looks at a random sample of outpatient charts to monitor not only utilization of services, but also quality of care including adequacy of the Individual Service Plan (ISP) goals/objectives and services delivered in addressing the individual's needs; use of EBP or clinical guideline practices; progress on ISP goals; ensuring the ISP and services delivered are recovery-oriented; evidence of care coordination activities with healthcare providers and other allied systems (see Appendix, Section VIII, 01).
b. NSMHA also conducts additional reviews that focus on a particular program (e.g., intensive program specific; NSMHA typically reviews all of our intensive programs, such as the Program for Assertive Community Treatment [PACT], annually) or topic (e.g., discharge planning, cultural competence).

3. Monitoring appropriateness of services for persons with special behavioral health needs

a. The BHO identifies persons with special behavioral health needs including:

i. Individuals with covered behavioral health diagnoses for which NSHMA needs to provide out-of-network services to address the identified concerns; and
ii. Individuals who are members of specific populations (e.g., children, geriatric, ethnic minorities, individuals with disabilities) for which special consideration needs to be taken to ensure the services are culturally and age relevant.

b. Monitoring

i. The process for individuals to obtain and how the BHO monitors out-of-network services was previously outlined in Section III.B.2.
ii. The BHO requires cultural and age-related issues relevant to treatment are addressed on the ISP and in the progress notes. If the clinician providing the services is not supervised by a specialist for the specific population, the clinician may obtain consultation from a specialist. The BHO expects that the consultant's recommendations will be documented in the chart and incorporated into treatment as the individual would like. Provision of culturally competent services is monitored annually via clinical chart review.

4. Corrective Action
   NSMHA shall ensure Contractors are accountable for contract compliance. When deficiencies are identified and meet the established criteria for corrective action, NSMHA shall require the Contractor to develop a corrective action plan (CAP).

5. Timeliness of access to services

   a. From the time an individual requests services via phone call, walk in, or written communication to the BHA or our centralized access line at Volunteers of America (VOA), the BHA has 14 calendar days to provide an intake evaluation and 28 calendar days to provide the first ongoing appointment.
   b. These data points are captured in our Consumer Information System (CIS) and a monthly report is generated to track adherence to these timelines. The BHAs are provided the data as well and the report is discussed semi-annually or more frequently, if needed, at NSMHA's QMOC meeting with membership as outlined in this Section, A.3.
   c. Out-of-Network Services (see Section III.B.2).

C. Practice Guidelines
To ensure NSMHA's practice guidelines are based on valid and reliable clinical evidence or generally accepted practice, NSMHA utilizes recognized bodies/organizations in the professional community, such as, American Psychiatric Association (APA). In collaboration with our Medical Director and SUD American Society of Addiction Medicine (ASAM) psychiatric consultant, NSMHA is in the process of identifying the most appropriate guidelines for SUD. NSMHA also works with our stakeholders to identify other practice guidelines to develop and adopt that address the unique needs of our community. NSMHA reviews and secures approval of the practice guidelines via QMOC. At a minimum, the guidelines are reviewed at QMOC every two (2) years.

D. Encounter Data Validation (EDV)
Accuracy of NSMHA's administrative systems and processes is critical to ensure encounter data submissions to the Department of Social and Health Services (DSHS) are complete and accurate reflections of the care provided to Medicaid beneficiaries; instances where the editing process rejects data for data quality deficiencies are minimized; and report templates and quality measures accurately reflect the data is truly comparable across all Regional Support Networks (RSNs). The goal is to design an EDV process that ensures the accuracy, completeness and integrity of encounter data by comparing encounter data with other administrative data. NSMHA will be including SUD services in the EDV process.

E. Performance Improvement Projects (PIP)
1. The BHO will continue to follow the guidelines outlined in NSMHA's Prepaid Inpatient Health Plan (PIHP) contract with DBHR, Section 10.8.

a. There will be at least two (2) PIPs during the agreement period:

   i. One (1) must have a topic that is identified as being clinical in nature, and
   ii. One (1) must have a topic that is identified as being non-clinical in nature.

b. At least one (1) of the two (2) PIPs, clinical or non-clinical, must focus on a measurement pertaining to children.

2. Current process for PIP development and evaluation

   a. The BHO will continue to use provider data and feedback, as well as, an integrated provider and BHO committee to develop PIP topics for study.
   b. PIP topics will be sent to DBHR for approval, as suggested by the External Quality Review Organization (EQRO) vendor.
   c. Once approval is met by the state, the BHO will use the following methods outlined in NSMHA's DBHR PIHP contract Section 10.8.1.2 to ensure project efficacy:

      i. The use of performance measures (PM) that contain objective quality indicators to eliminate research bias;
      ii. The utilization of data to implement reasonable and achievable interventions;
      iii. The evaluation of the effectiveness of each intervention through quantitative and qualitative analysis; and
      iv. The development and implementation of sustainable improvement activities.

   d. The BHO will submit all PIP documentation to the preferred state EQRO vendor for validation and recommendation.
   e. PIPs may be ongoing but will be completed within a reasonable timeframe as stated in NSMHA's DBHR PIHP contract Section 10.8.1.3.

3. The BHO will integrate SUD by incorporating an additional PIP that is solely dedicated to SUD services for a total of three (3) ongoing PIPs.

   The SUD PIP will follow the same procedure for development and evaluation as the clinical and non-clinical PIPs.

F. Performance Measures (PM)
   1. Core PMs
      a. The BHO continues to participate in the state workgroup for HB1519/SB5732.
         iii. Substance Use Treatment Penetration Rate;
         iv. Substance Use Treatment Retention/Engagement Rate;
         v. Mental Health Treatment Penetration Rate; and
         vi. Psychiatric Hospitalization Readmission Rate.
      b. The BHO uses both state and regional data to monitor the Core PMs. The data for these measures is reviewed and discussed at both IQMC and QMOC with the purpose of improving the measures when needed.
      c. The BHO will continue to fund our care transitions team, which provides services as a bridge between inpatient and outpatient to ensure an individual who has been psychiatrically hospitalized gets connected to outpatient behavioral health resources and to reduce the chances of inpatient readmission during the time the individual is establishing connection with outpatient resources.

   2. Regional Performance Measures (PM)
      a. The North Sound BHO (NSBHO) will continue to follow the guidelines outlined in NSMHA's PIHP contract Section 10.8.2, with regard to Regional PMs to include development, calculation, tracking and reporting timelines to DBHR.
      b. The BHO responsibility includes the collection and management of the data necessary to support the Regional PMs activities, including: establishing the baseline, determining demonstrable improvement target(s), tracking change in performance over time and reporting the annual findings to DBHR as outlined in the PIHP.
      c. NSMHA currently has three (3) Regional PMs in place that meets PIHP guidelines and provides interim and annual reports to the BHAs as a part of continuous quality improvement, as well as, meeting reporting timelines to DBHR. NSMHA has met Regional PM targets for the past two (2) cycles.
      d. NSMHA's Regional PMs are chosen based on local relevance, clinical consensus, research evidence and input from the local MH Advisory Board. With the integration of SUD services, NSBHO will develop Regional PMs using the same process and methodology with input from the integrated MH and SUD Advisory Board.
      e. NSBHO will respond to subsequent requests by DSHS to provide explanations for PMs that do not meet the annual regional performance targets. NSBHO will complete a CAP when designated by DBHR.
      f. NSBHO will make the results of the Regional PMs available to the public.

G. Appendix, Section VIII, 02 is a list of current Evidenced-Based Practices (EBP)

IX. Program Integrity Plan

DELETED BY THE DIVISION OF BEHAVIORAL HEALTH AND RECOVERY (DBHR)

X. GRIEVANCE SYSTEM PLAN

A. Grievance System Overview

The following is a comprehensive assessment of North Sound Mental Health Administration's (NSMHA) current compliance with all state and federal grievance system requirements, regulatory and contractual.

This section provides an overview of NSMHA's current system and areas where plans for NSMHA's transition to a Behavioral Health Organization (BHO) are expanding to address Substance Use Disorder (SUD). The SUD system together with the current Mental Health (MH) system will transition to become the behavioral health (BH) system. Some specific contractual and regulatory requirements will be expanded upon below in each section as well.

NSMHA provides a robust grievance system that includes grievance, expedited grievance, Notice of Action (NOA or notice), appeal and expedited appeal processes, as well as, access to state fair hearings. The NOA, appeal and expedited appeal processes are for Medicaid recipients.

NSMHA Quality Specialist staff authorizes outpatient services and sends NOAs for denials based on Access to Care Standards (ACS) to Medicaid enrollees. NSMHA's designee, Volunteers of America (VOA), authorizes inpatient services and sends NOAs for any inpatient denials. All Medicaid recipients with a MH or BH benefit are entitled to an intake/assessment and it is considered a denial if an enrollee does not receive a SUD treatment assessment or a MH intake evaluation upon request.

NSMHA maintains a provider and Prepaid Inpatient Health Plan (PIHP)/Regional Support Network (RSN) level grievance process which encourages resolution of grievances at the lowest possible level. NSMHA requires by contract that each provider identify a grievance system contact where individuals can file provider level grievances. NSMHA also has identified grievance contacts at the RSN level.

Grievances may be initiated at the provider level or PIHP/RSN level, with or without, Ombuds involvement. If individuals are not satisfied with the resolution at the provider level, they may initiate a grievance at the PIHP/RSN level.

NSMHA currently requires that individuals be sent a written response to grievances within 30 days of receipt at the provider level and within 30 days of receipt at the PIHP/RSN level, with a possible extension of 14 days at the PIHP/RSN level.

NSMHA also currently has an expedited grievance process at both the provider and PIHP/RSN level.

NSMHA staff currently processes any enrollee appeals and policies reflect the required timeframe for appeals of 45 calendar days with a possible extension of up to 14 days. For expedited appeals, the required timeframe is 3 business days, with a possible extension of up to 14 days.

NSMHA policy will be updated to require that the grievance or appeal process is exhausted prior to the request for state fair hearing, a new requirement from the Division of Behavioral Health and Recovery (DBHR).

NSMHA maintains a grievance system committee that includes a Mental Health Professional (MHP), the Medical Director, Deputy/Clinical Director, Compliance Officer and other NSMHA staff for their expertise as grievance issues dictate. The grievance system committee hears RSN level grievances and appeals, with the composition of the committee dependent upon the nature of the grievance or appeal. For all inpatient appeals, if the denial is upheld, a psychiatrist must make the decision. In addition, when grievances or appeals concern medication related issues, NSMHA's Medical Director or another psychiatrist is involved, as needed.

NSMHA or provider staff, in the case of provider level grievances, if deciding any of the following, must be MHPs, who have the appropriate clinical expertise:

a. An appeal of a denial that is based on lack of medical necessity;
b. A grievance regarding denial of expedited resolution of an appeal; or
c. A grievance or appeal that involves clinical issues.

NSMHA will revise policy to reflect that these cases must include an MHP or Chemical Dependency Professional (CDP) staff as indicated.

NSMHA will either add CDP, psychiatrist, or physician with addiction specialty to the grievance system committee. Our intention is that NSMHA has the expertise to hear grievance and appeals from individuals that may have MH/SUD, in order to provide an integrated grievance and appeal system.

This requirement will also be extended to provider grievance process. In addition, if a grievance involves an issue of medication, providers will be required to involve the appropriate medical staff.

NSMHA endorses the concept of broad and consistent reporting of grievance, notice and appeal data as important feedback to the systems of care and as an opportunity for continuous quality improvement.

NSMHA developed and implemented a web-based portal system for both provider and PIHP/RSN level grievance reporting. This system allows oversight, tracking and reporting of provider and PIHP/RSN level grievances on an ongoing basis. NSMHA anticipates expanding this web-based portal system to maximize the potential for continuous quality improvement.

NSMHA has grievance system policies for both Medicaid and State funded services that include:

a. Grievance System-General Policy Requirements;
b. Complaint and Grievance Policies – Complaints are from individuals other than the enrollee, who do not have grievance rights. For example, parents of adult children who do not possess a release of information (ROI) or other legal relationship with the enrollee, community members, or other involved parties;
c. Appeal policy;
d. Fair hearing policy; and
e. Notice requirements policy.

NSMHA will update customer services policies to include the DBHR complaint process outlined in Washington Administrative Code (WAC) 388-877-0605.

All contracted providers are required to do the following: "Providers must comply with this policy and may develop individualized implementation guidelines as needed". NSMHA and each provider also have to identify toll free numbers for reporting grievances that includes, but is not limited to: interpreter services and toll-free numbers with adequate Teletypewriter/Telecommunication Devices for the Deaf (TTY/TTD) capability. As indicated, Ombuds services are also offered for assistance during all processes; NSMHA and providers also may assist at all levels of the systems.

NSMHA's policy provides for customer service, complaint, grievance, appeal and fair hearing processes that are age, culturally and linguistically competent. NSMHA, its formal designee and network providers will provide oral or manual interpreter services or written translation free-of-charge in all non-English languages for all steps necessary to file a grievance or appeal and to receive complaints from others.

NSMHA is currently restructuring the quality management processes, implementing a multi-discipline Internal Quality Management Committee (IQMC) to review grievance system information in conjunction with other quality indicators. NSMHA also has a Quality Management Oversight Committee (QMOC) which includes enrollees, providers, Ombuds services, county and NSMHA staff.

NSMHA has plans for the expansion of the grievance system to address the SUD system. Managed care is new to the SUD system and NSMHA plans to provide training to the counties, SUD providers and MH providers. As outlined above, each MH provider is currently required to have a centralized grievance system contact that is trained and in turn trains staff within their organization. This model will also be expanded to include SUD providers. Training in this transition to the BHO will include:

a. Authorization processes, including NOAs;
b. Grievances;
c. Appeals;
d. Access to state fair hearings;
e. Role of Ombuds services;
f. Data collection and reporting for grievance system;
g. Fundamental role of grievance, appeal and fair hearing rights as protection for enrollees and other priority populations in a managed care system; and
h. Use of grievance, appeal and fair hearing information and data as an opportunity for further study and review for continuous quality improvement at all levels of our systems.

1. Identified deficiencies are addressed below with a detailed plan for correction to be completed no later than April 1, 2016.

   NSMHA revised grievance policies in 2014 and they will be updated further in anticipation of transition to a BHO by April 1, 2016. In turn, providers will be required to revise their policies as part of the new BHO contracts, which will now include SUD providers.

   NSMHA will update the policies to include the new due process WAC rules 388-877A-0400 through 0450 and the new PIHP and State Mental Health Contract (SMHC) requirements. In addition, NSMHA anticipates the WAC may change to incorporate the SUD system. In this eventuality, NSMHA policies will change to address these as well.

   NSMHA is aware that a number of proposed changes to Code of Federal Regulation (CFR) may necessitate further changes to WAC, and respectively, in the RSN and subcontractor's policies in the future.

   NSMHA may evaluate current timelines for grievance disposition and notice to affected parties in light of the longer timeframes allowed in WAC and contracts; however, current timelines may be continued that are shorter than the maximum timelines allowed. NSMHA strives to balance the need for timely responses and the need for enough time to attempt to reach satisfactory resolution with the requirements to process grievances.

NSMHA is in the process of revising grievance system policies, reporting and data collection in response to changing DBHR expectations. As outlined previously, NSMHA implemented a web-based portal system that assists in tracking reporting of both provider and RSN level grievances. Providers enter data regarding grievances directly into the web-based system.

Due to priorities and changes to the grievance system, NSMHA continues work to audit providers for the current contract cycle. A part of the audit process is a review of provider policies for the grievance system to ensure they conform to NSMHA's policies.

In addition, NSMHA performs oversight of providers on an ongoing basis by other means including:

a. Review of web-based portal entry of provider level grievances, including the tracking of provider timelines for acknowledgment and resolution;
b. Cross checking Ombuds reports with provider reports;
c. Monthly meetings with Ombuds;
d. Review of provider semi-annual grievance system reports that have providers identify areas of further review or quality improvement (see Appendix, Section X, 01);
e. Review of grievances that come to the PIHP/RSN level; and
f. Review for possible system implications in a monthly grievance system committee meeting, reporting to the IQMC for continuous quality improvement.

2. Ombuds

Plans to provide BHO Ombuds services to meet the needs of those who access both the MH and SUD treatment services include:

a. NSMHA currently has two (2) full time Ombuds funded separately and employed by Community Action of Skagit County (CASC). NSMHA Ombuds are functionally independent from both the RSN and provider agencies in the regional network. Ombuds are either consumers, past consumers, or family members of those in the community mental health system.
b. Ombuds actively assist enrollees/individuals to access the grievance, appeal and fair hearing systems and provide support to them at each level of the process (provider and RSN level).
c. NSMHA is reassessing Ombuds staffing levels in light of anticipation of an increase in grievance/appeals with the addition of SUD services. NSMHA will provide training opportunities to assist Ombuds to work with enrollees and individuals in the SUD system. Ombuds training needs may include:

i. American Society of Addiction Medicine (ASAM) training;
ii. ACS criteria training, which has undergone recent state revision; or
iii. Confidentiality training in light of the stricter requirements for the provision of SUD services.

NSMHA Ombuds regularly participate in QMOC and have access to training provided through NSMHA. Ombuds also regularly attend quarterly DBHR statewide training.

NSMHA's grievance system staff (Grievance System Coordinator, Deputy Director and System Operations Manager) meets monthly with Ombuds to review changes, discuss specific issues, which provide opportunity for increased communication, especially during this time of system change and transition.

Ombuds currently provide quarterly and semi-annual reports to NSMHA committees, including Leadership Team, QMOC, Advisory Board and Board of Directors (BOD). With internal restructuring of quality management, Ombuds will provide reports to NSMHA's IQMC to assist with prioritizing areas for focus review for continuous quality improvement.

B. Grievance System – Action
Actions are decisions made by NSMHA or, in the case of psychiatric inpatient authorization, by designee.

NSMHA will collaborate with DBHR for guidance regarding the disagreement with medication as an action, not currently addressed in the WAC or contract. Policies will be revised in this area as needed following consultation with DBHR. NOAs will be distributed by the BHO.

All Medicaid recipients with a MH or BH benefit are entitled to an intake/assessment. It will be considered a denial if a Medicaid enrollee does not receive a SUD treatment assessment or a MH intake evaluation upon request.

NSMHA will expand the definition of action to include SUD services. ACS is being refined for both MH and SUD services. In addition, ASAM criteria will be incorporated into NSMHA level of care guidelines (see Section VII).

An "Action" is, for Medicaid recipients, in the case of NSMHA or designee:

1. The denial or limited authorization of a requested service, including the type or level of service;
2. The reduction, suspension, or termination of a previously authorized service;
3. The denial, in whole or in part, of payment for a service;
4. The failure to provide services in a timely manner, as defined by the state; or
5. The failure of NSMHA or its contracted BHA to act within the grievance system timeframes as provided in WAC 388-877A-0420 through 388-877A-0450.

Failure to act within the timelines includes 42 CFR 438.408(b) and failure to provide the disposition or resolution of and notice to affected parties of grievances, appeals and expedited appeals, if accepted.

Actions will include situations when a written resolution to a grievance is not sent within 90 calendar days by either a provider or NSMHA, unless extended by NSMHA at the RSN level, written resolution for appeal is not sent by NSMHA within 43 calendar days, unless extended, or in the case of an expedited appeal request, if resolution is accepted, NSMHA sends written resolution within 3 business days, unless extended.

Additionally actions include service authorization decisions not reached within applicable timeframes for either standard or expedited service authorizations as this constitutes a denial.

Denial, suspension, reduction and termination of services are not defined in WAC; however, are defined in PIHP contract and in draft BHO PIHP contract. NSMHA will continue to use contract definitions in policy as this area evolves to include SUD services.

Federal law also includes as an action: For a resident of a rural area with only one (1) Managed Care Organization (MCO), the denial of a Medicaid enrollee's request to exercise his/her right, under § 438.52(b)(2)(ii), to obtain services outside the network. NSMHA understands that this area is waived according to the most recent waiver for the PIHP. This action is also not listed in PIHP contract or the WAC.

NSMHA does include choice of providers and in four (4) out of five (5) counties have at least two (2) provider organizations for MH and SUD services. In all counties individuals would have choice of clinician and can request a change of clinician. Out-of-network services are also an option if medically necessary services are not available within the network.

C. Grievance System – Service Authorization

1. After an intake evaluation, the BHA recommends authorization or denial of services to the BHO. This process is outlined in detail in Section VII.B.1.
2. The BHO delegates authorization and denial of inpatient psychiatric services to VOA. VOA operates on a 24/7 basis and makes a determination on prior authorization requests within twelve (12) hours of the request and requests for extension of a current stay are determined within twenty four (24) hours of the request. Retrospective authorization requests (e.g., those that occur after the stay has occurred), are made within 30 calendar days. All denials for inpatient psychiatric care are issued by a psychiatrist.

D. Grievance System - Notice of Action (NOA or notice)
The BHO provides notification to the requesting provider and gives the enrollee written notice of any decision by the BHO to deny a service authorization request or authorize a service in an amount, duration, or scope that is less than requested.

1. The notice to the enrollee explains:

    a. The action the BHO has taken or intends to take;
    b. The reasons for the action and a citation of the rule(s) being implemented;
    c. The right to appeal and how to appeal, get a second opinion and request a fair hearing;
    d. When and how the individual can get expedited resolution;
    e. When and how services can continue during the resolution process and the circumstances under which the individual may have to pay the costs of these services; and
    f. How to access assistance for navigating resolution processes via the BHO/Ombuds.

2. The notice is provided in a manner that may be easily understood, including being provided in non-English languages. North Sound has made the written notices available in several languages historically; however, NSMHA is required to have the written notice available in Spanish, as this is the prevalent non-English language in this region. North Sound also has the ability to make oral interpretation services available. Information on the availability of the notice in alternate formats (e.g., for individuals with special needs such as those with visual limitations, limited reading proficiency) including oral interpretation and how to access them are included in the notice.

E. Grievance System – Notice of Action – Timeframes – Termination, Suspension, or Reduction of Services

1. For termination, suspension, or reduction of previously authorized services, at least 10 calendar days before the effective date of the action, except if the criteria noted in 42 CFR 431.213 or 431.214 are met:

    a. NSMHA or designee has factual information confirming the death of a recipient;
    b. NSMHA or designee receives a clear written statement signed by a recipient that they no longer wish services or gives information that requires termination or reduction of services and indicates they understand this must be the result of supplying that information;
    c. The recipient has been admitted to an institution where he or she is ineligible under the plan for further services;

d. The recipient's whereabouts are unknown and the post office returns NSMHA or designee's mail directed to the recipient indicating no forwarding address;
e. NSMHA establishes the fact that the recipient has been accepted for Washington Apple Health services by another local jurisdiction, state, territory, or commonwealth;
f. The recipient's physician prescribes a change in the level of medical care. NSMHA has facts indicating the action should be taken because of probable fraud by the recipient and the facts have been verified, if possible, through secondary services;
g. For exceptions, NSMHA may mail the Notice of Action or Adverse Determination (see this Section E.1.a-e) no later than the date of action or adverse determination. In the case of fraud (see this Section E.1.f), NSMHA may mail the NOA five (5) calendar days in advance of the action.

2. Grievance System – Notice of Action – Timeframes – Denial of Payment
This must be done on the date of the action affecting the claim/payment.

3. Grievance System – Notice of Action – Timeframes – Denial of Standard Authorization
As expeditiously as the enrollee's health condition requires and not to exceed 14 calendar days following the receipt of the request for services. This timeframe may be extended up to 14 additional calendar days if the enrollee or provider requests an extension or the BHO justifies a need for additional information and how the extension is in the enrollee's interest.

4. Grievance System – Notice of Action – Timeframes – Denial of Expedited Authorization
As expeditiously as the enrollee's health condition requires and not to exceed 3 working days following the receipt of the request for services. This timeframe may be extended up to 14 additional calendar days if the enrollee or provider requests an extension or the BHO justifies a need for additional information and how the extension is in the enrollee's interest.

5. Grievance System – Notice of Action – Timeframes – Untimely Authorization
Service authorizations not reached within the timeframes specified above for standard and expedited authorizations result in a notice on the date the timeframe expires as this constitutes a denial.

F. Grievance System – Information to Providers and Subcontractors
NSMHA currently states, as a condition of our contracts, the Contractor must implement complaint, grievance, appeal and fair hearing processes that are in conformance with NSMHA's policies and procedures. As indicated by DBHR, complaints are from those other than individuals who can access the grievance process and are not part of the reported grievance system information to DBHR.

NSMHA's current grievance system policy states formal designees, providers and any other contracted individuals and agencies shall comply with all requirements outlined in NSMHA's grievance system policies listed below and in the references cited in the policies, which include 42 CFR 438 Subpart F, 400-424. NSMHA will update polices to add due process WAC to this list of references.

Providers must comply with NSMHA's grievance system policies according to NSMHA/DBHR agreement "Providers must comply with this policy and may develop individualized implementation guidelines as needed":

1. Grievance System-General Policy Requirements;
2. Complaint and Grievance Policy – Complaints are by those who cannot access the Grievance System, for example from parents of adult children, community members or other involved parties without written authorization;
3. Appeal Policy;
4. Fair hearing Policy; and
5. Notice Requirements Policy.

NSMHA policies are designed to cover the federal Information requirements in 438.10 (g)(1) below with the exception of (7). NSMHA does allow inpatient providers to appeal denial of inpatient certification and authorization separate from the enrollee appeal process. NSMHA does not, however, contract directly with these inpatient facilities at this time.

438.10(g)(1) Grievance, appeal, and fair hearing procedures and timeframes, as provided in §§ 438.400 through 438.424, in a state-developed or state-approved description, that must include the following:

1. For State fair hearing:

    a. The right to hearing;
    b. The method for obtaining a hearing; and
    c. The rules that govern representation at the hearing.

2. The right to file grievances and appeals;
3. The requirements and timeframes for filing a grievance or appeal;
4. The availability of assistance in the filing process;
5. The toll-free numbers that the enrollee can use to file a grievance or an appeal by phone; and
6. The fact that, when requested by the enrollee:

    a. Benefits will continue if the enrollee files an appeal or a request for State fair hearing within the timeframes specified for filing; and
    b. The enrollee may be required to pay the cost of services furnished while the appeal is pending, if the final decision is adverse to the enrollee.

7. Any appeal rights that the state chooses to make available to providers to challenge the failure of the organization to cover a service.

   DBHR develops and distributes the Medicaid Mental Health Benefit Booklet for Medicaid enrollees and distributes enrollment notices to enrollees that cover these rules, as well, in state developed descriptions.

   NSMHA's understanding is the Medicaid Mental Health Benefits Booklet and enrollment notices will be updated by DBHR and the "Medicaid Behavioral Health Benefits Booklet" will be the state-produced mechanism to help Medicaid enrollees understand the requirements and benefits of the BHO.

   NSMHA providers are also currently required to offer every Medicaid enrollee a Washington Medicaid Mental Health Benefit Booklet at intake, which includes information on obtaining the booklet in alternative formats. Providers inform enrollees the booklet, is available via the Internet at: http://dshs.wa.gov/dbhr/mhmedicaidbenefit.shtml

   With the transition to a BHO and the integration of MH and SUD, this will become the Medicaid Behavioral Health Benefit Booklet.

   NSMHA will also review grievance policies and incorporate SUD system together with MH system to become BH system.

G. Grievance System – Record Keeping and Reporting

1. Record Keeping

   NSMHA's current policy for record keeping is that NSMHA, providers', formal designees and Ombuds retain full records of complaints, grievance and appeals and materials received or compiled in the course of processing and attempting to resolve grievances for six (6) years after the completion of the grievance process in confidential files separate from clinical records. NSMHA will also retain records of fair hearings for this period.

   These records will not be disclosed without the individual's written authorization, except as necessary to resolve the complaint, grievance, or appeal to the Department of Social and Health Services (DSHS) if a fair hearing is requested or for review as part of the state quality strategy. This is consistent overall with the new WAC 388-877A-0420(6)(g).

NSMHA will incorporate language from the new WAC 388-877A-0420(6)(g), "that full records of all grievances and materials received or compiled in the course of processing and attempting to resolve the grievance are maintained and kept for six (6) years after the completion of the grievance" in the revised policy and require by contract that subcontractors also maintain these materials to ensure this requirement is explicit for all provider record keeping. In addition, NSMHA will include this for appeals and fair hearings.

2. Reporting Requirements
   NSMHA reports provider level and PIHP/RSN level grievances, actions (Notice of Actions (NOA)), enrollee appeals, fair hearings filed and Ombuds involvement on a semi-annual basis as required by DBHR. DBHR recently changed reporting requirements and as a result, NSMHA policy and processes will be reviewed to enact these changes as part of DBHR's Quality Strategy (see Appendix 02).

   As outlined above, NSMHA is also restructuring our quality management process to more effectively integrate grievance system information with other quality indicators to afford greater comprehensive systemic review for continuous quality improvement processes.

   NSMHA has maintained an internal grievance system committee that has evaluated grievance system information for continuous quality improvement. This committee may be evaluated in light of our restructured quality management processes.

   DBHR is changing their reporting periods to quarterly rather than semi-annual basis and NSMHA will change our policies to achieve this objective. DBHR is also revising the data elements to report and reporting instructions.

   NSMHA, as outlined above, has instituted a web-based portal system to collect and track provider and RSN level grievances and related timelines to report to DBHR per their aggregate reporting requirements.

   NSMHA will collaborate to develop a clear understanding of the different grievance reporting categories and evaluate consistent coding of those categories with a view towards enhancing the web-based portal system. This will assist in capturing additional information to assist with analyzing the data for continuous quality improvement or further study and review.

   NSMHA will continue to require each provider submit grievance system narrative reports to self-identify continuous quality improvement as we are committed to using the information at all levels of our system. Ombuds also provide recommendations in narrative reports.

H. Grievance System – Appeal

Appeal Definition – An appeal is a request for review of an action to NSMHA. "Appeal" means an oral or written request by an enrollee, or with the enrollee's written permission, the enrollee's authorized representative for NSMHA to review an action as defined above.

The appeal process is one of the processes that allow individuals (Medicaid) to appeal an action made by NSMHA, or for inpatient authorization, our designee, that is communicated on an NOA.

I. Grievance System – Authority to File

The WAC has recently clarified who can access the grievance system, file a grievance, appeal, or request a fair hearing. An individual applying for, is eligible for, or receives RSN authorized MH services from an agency licensed by DSHS as a BHA may access the grievance system. It is understood that for the purpose of filing a NSMHA appeal, the individual must be a Medicaid recipient.

For the purposes of accessing the grievance system (including the grievance process, appeal process, expedited appeal process, or access to state fair hearing), the WAC further clarifies that if acting on the individual's behalf the following can access the grievance system:

1. In the case of a minor, the individual's parent or, if applicable, the individual's custodial parent;
2. Individual's legal guardian; or
3. Individual's representative, if the individual gives written permission.

NSMHA policy will ensure that a provider acting on behalf of the enrollee and with the enrollee's written consent may file an appeal as is specified in 42 CFR 438.402 (b)(1)(ii).

CFR stipulates that a provider may file a grievance or request a state fair hearing on behalf of an enrollee, if the state permits the provider to act as the enrollee's authorized representative.

As WAC or contract does not prohibit a provider from acting on behalf of an individual for grievance and fair hearing, NSMHA will specify that network providers, with written consent, can act on the individual's behalf (including Medicaid enrollees) to file a grievance with a provider or NSMHA and file a fair hearing.

To summarize

1. Grievance/fair hearing – An individual, their authorized representative (including a network provider with written permission and acting on their behalf) or the individual's legal guardian may file a grievance or fair hearing. In the case of a minor, the individual's parent or, if applicable, their custodial parent may also file the grievance or fair hearing; and

2. Appeal – An individual with Medicaid, their authorized representative (including a network provider with written permission and acting on their behalf), or the individual's legal guardian may file an appeal. In the case of a minor, the individual's parent or (if applicable their custodial parent) may also file the appeal. For the purposes of inpatient authorization, the inpatient provider of services may also be the representative with written consent.

NSMHA will refine policy definitions to ensure they are consistent with the new due process WAC and federal law.

J. Grievance System – Appeal – Timing
NSMHA will update policies to be congruent with new WAC timelines to appeal:

1. For standard (non-expedited) appeals, an appeal may be filed within ninety (90) calendar days of the date on the NOA, if the individual does not ask for services to continue.
2. For expedited appeals, an appeal must be filed within 20 calendar days of the date on the NOA, if the Medicaid covered individual does not request services continue.
3. Service continuation requirements apply in cases where there is a termination, suspension, or reduction of services.
4. For both non-expedited and expedited appeals, in cases where there is a request for service continuation, an appeal may be filed on or before the later of the following:

    a. Within 10 calendar days of the NSMHA mailing of the NOA; or
    b. The intended effective date of NSMHA's proposed action.

NSMHA understands the due process WAC for expedited appeal, the new PIHP contract, or the draft BHO PIHP contract may not include the option of filing within the intended effective date of the proposed action for expedited appeal requests; however, understands it is the intention of federal law, CFR 42 438.420(a)(2) and plans to address in policy unless otherwise instructed.

Appeals may be initiated orally or in writing and unless the person requests expedited resolution must follow an oral filing with a written, signed appeal per CFR. Oral inquires seeking to appeal an action are treated as appeals. This is to establish the earliest possible filing date for the appeal and must be confirmed in writing, unless the enrollee or the provider requests expedited resolution. The CFR and contract indicate that appeals, unless expedition is requested, must be followed up on in writing.

The new due process WAC and PIHP contract outline that if a written NOA was not received, an appeal may still be filed. NSMHA will collaborate with DBHR to understand the intention of this requirement and associated timelines in order that policies reflect the intent of the law. NSMHA understands this requirement is intended to reflect situations where an NOA was not provided within required timeframes.

K. Grievance System – Appeal Process – Procedures

Appeals may be initiated orally or in writing with NSMHA and unless the person requests expedited resolution, must follow an oral filing with a written, signed, appeal. Oral inquires seeking to appeal an action are treated as appeals to establish earliest possible filing date for the appeal and must be confirmed in writing, unless the enrollee or the provider requests expedited resolution.

NSMHA provides written acknowledgment of receipt of all appeals and requests for service continuation within five (5) business days. Any oral conformation of receipt is followed with a written acknowledgment of receipt (see this Section N).

For appeals that involve termination, suspension, or reduction of services that are requested within the required timelines for continuation of services and the individual requests continuation of services, the written acknowledgement will include the request for continued services. The written notice will also contain information to advise individuals that if the ultimate appeal decision is not in the individual's favor, NSMHA may recover the cost of the services provided pending the appeal decision.

If NSMHA cannot determine if the enrollee wishes for services to continue during the appeal process, NSMHA will continue with the appeal process and provide information to the enrollee about their options.

NSMHA staff and Ombuds staff are available to assist enrollees and their representatives with formulating their appeals in writing as needed and to facilitate the appeal process.

NSMHA staff also actively assists individuals to gain Ombuds support during the appeal process regardless of whether they began their appeal with Ombuds involvement.

NSMHA also provides enrollees a reasonable opportunity to present evidence and allegations of fact or law in person, as well as in writing, informing individuals of time limits available for presenting evidence in the case of expedited resolution and for the resolution process in general.

For enrollee appeals that are non-expedited, NSMHA often meets with the individual, Ombuds and others as requested with the NSMHA Grievance System Committee. NSMHA reviews all written and oral information submitted by the individual, Ombuds, or others prior to making a decision on the enrollee's appeal.

The NSMHA Grievance System Committee includes NSMHA staff that must be MHPs and have the appropriate clinical expertise, for:

1. An appeal of a denial that is based on lack of medical necessity; and
2. Any appeal that involves clinical issues.

In addition as noted previously with transition to BHO, NSMHA will need to revise policy to reflect these cases must include MHP and CDP staff, as indicated.

In addition as noted previously, NSMHA's Medical Director or another psychiatrist makes decisions to uphold psychiatric inpatient denials.

NSMHA policies provide Medicaid recipients and authorized representatives the opportunity, before and during the appeals process, to examine the case file including medical records and any other documents and records considered during the appeals process.

NSMHA policies include as parties to the appeal the enrollee, his/her legal representative, or the legal representative of a deceased enrollee's estate.

L. Grievance System – Appeal Process – Resolution and Notification
NSMHA provides for resolution of standard (non-expedited) appeals as expeditiously as the enrollee's MH condition requires not exceeding 45 days, unless an extension of up to 14 days is provided.

NSMHA may extend the timeline for appeals up to 14 calendar days if the enrollee requests the extension or the RSN demonstrates, to the satisfaction of the state agency, upon its request, the need for additional information and the delay is in the enrollee's interest.

For extensions requested by the enrollee, although not required, NSMHA currently provides written notice of the request and related dates. For extensions not requested by the enrollee, NSMHA will provide the enrollee written notice of the reason for the delay.

M. Grievance System - Appeal Process - Format and Content of Resolution Notice.
NSMHA sends a written notice of resolution for all appeals, including expedited appeals (see this Section N) for additional expedited appeal process requirements discussed in more detail.

The written notice of resolution for all appeals includes the results of the appeals process including: the decision, the date of the decision, the reason for the decision, and the right and process to request a fair hearing if the enrollee disagrees with the decision or if the decision is not wholly in their favor. The written notice of resolution will also include the right and process to request to continue to receive benefits while the hearing is pending, if the continuation requirements are met and that the enrollee may be held liable for the cost of those benefits if the hearing decision upholds NSMHA's decision.

Additionally, NSMHA notices of appeal resolution will include the following timeframes to request fair hearing:

1. Within 10 calendar days from the date on the notice of the appeal resolution if the enrollee is asking that services be continued pending the outcome of the hearing; or
2. Within 90 calendar days from the date on the notice of the appeal resolution if the enrollee is not asking for continued benefits.

Also, if an expedited fair hearing is requested, it must be within 10 calendar days of the date on the notice of resolution of the appeal as outlined in the due process WAC.

N. Grievance System – Appeal and State Fair Hearing Process – Effectuation when Services were not Furnished
Current policy states that if NSMHA or the state fair hearing officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, NSMHA must authorize or provide the disputed services promptly and as expeditiously as the enrollee's MH condition requires.

With transition to a BHO, policy will be updated to stipulate the BHO must authorize or provide the disputed services promptly and as expeditiously and enrollee's BH condition requires.

O. Grievance System – Appeal and State Fair Hearing Process – Effectuation when Services were Furnished
If NSMHA or the state fair hearing officer reverses a decision to deny authorization of services and the enrollee received the disputed services while the appeal was pending, NSMHA or the state must pay for those services in accordance with state policy and regulations.

If the administrative hearing decision is not in favor of the individual, NSMHA may recover the cost of MH/BH services furnished to the individual while the hearing was pending to the extent that they were provided solely because of the requirements for service continuation outlined in due process WAC and CFR 42.431.230 (b).

NSMHA shall be bound by the hearing determinations, whether or not the hearing determination upholds NSMHA's decision.

DSHS is responsible for the implementation of the hearing decision, even if the hearing decision is not within the purview of contract agreements with NSMHA. This will be added to NSMHA policy as it is not currently stated.

P. Grievance System – Expedited Appeals Process – General
NSMHA maintains an expedited appeal process that has requirements in addition to or instead of the appeal process discussed above. Enrollees or their representatives may request an expedited appeal if the enrollee/representative or provider believes the standard time for resolution would seriously jeopardize the enrollee's ability to maintain or regain maximum function.

If an expedited appeal is requested, NSMHA will attempt to confirm receipt of the request in person or by telephone.

NSMHA will update its policy to include the new WAC timelines and rules for requesting an expedited appeal. This will include the action on the NOA for a denial of a requested service, suspension, reduction, or termination of previously authorized MH/BH services and the appeal must be filed orally or in writing within:

1. Ten (10) calendar days from the date on NSMHA's written NOA that communicated the action, if the individual is requesting continued benefits; or
2. Twenty (20) calendar days for the date on NSMHA's written NOA that communicated the action if the individual is not requesting continued benefits.

If an expedited appeal is requested and NSMHA or NSMHA's provider of services or inpatient provider determines, in making the request on the enrollee's behalf or supporting the enrollee's request that taking the time for a standard resolution could seriously jeopardize the enrollee's life, health, or ability to attain, maintain, or regain maximum function, NSMHA will meet the additional requirements for expedited appeals below.

If, however, NSMHA denies the request for expedited resolution of the appeal, NSMHA will transfer the appeal to the timeframes for standard appeal resolution discussed above. Additionally, if expedition is denied, NSMHA will make reasonable efforts to give the individual prompt oral notice of the denial of expedition and follow up within two (2) calendar days of the denial of expedition with a written notice.

The written notice will include the individual's right to file a grievance regarding NSMHA's denial of a request for expedition.

Q. Grievance System – Expedited Appeals Process – Authority to File
As noted above, an enrollee, their authorized representative, or network provider, with written permission and acting on their behalf or the enrollee's legal guardian, may file an expedited appeal. In the case of a minor, the enrollee's parent or, if applicable, their custodial parent may also file the expedited appeal. For the purposes of inpatient authorization the inpatient provider of services may also act on the enrollee's behalf with written consent.

NSMHA will refine policy definitions to be consistent with WAC and federal law.

R. Grievance System – Expedited Appeals Process – Procedure
NSMHA will provide the enrollee (and others at their request) a reasonable opportunity to present evidence and allegations of fact or law in person, as well as, in writing and will inform the enrollee of the limited time available for this in the case of a request for expedited resolution.

S. Grievance System – Expedited Appeals Process – Resolution and Notification
NSMHA will make a decision on expedited appeals, if expedition is accepted, and provide written notice of resolution within three (3) working days. NSMHA will also make reasonable efforts to provide oral notice.

NSMHA may extend the three (3) working day timeline for up to fourteen (14) additional calendar days if:

1. The enrollee, provider, or other representative acting on behalf on the enrollee requests the extension; or
2. NSMHA shows to the satisfaction of the state agency, upon its request, that there is the need for additional information and the delay is in the enrollee's interest.

For extensions requested by the enrollee, although not required, NSMHA currently provides written notice of the request and related dates. For extensions not requested by the enrollee, NSMHA will give the enrollee written notice of the reason for the delay.

The written notice of resolution for expedited appeals will include the items listed above under appeal resolution (see this Section M).

T. Grievance System – Expedited Appeals Process – Punitive Action
NSMHA appeal policy specifies assurances be made which outline that retaliation or punitive action is not taken against a Medicaid individual or provider, who requests an expedited resolution or supports an enrollee's appeal.

U. Grievance System – State Fair Hearing Process – Notification of State Procedures
NSMHA previously addressed that providers will receive information, at the time of contract; about the grievance system (see this Section F).

42 CFR 431.200(b) provides that if the state takes action to suspend, reduce, or terminate, services or NSMHA takes action as outlined above (see this Section F) there will be procedures for the opportunity for a fair hearing. As outlined above following an appeal, individuals with Medicaid may request a fair hearing. In addition, both state funded and Medicaid individuals may request fair hearing after the grievance process.

42 CFR 431.220 further indicates that the agency need not grant a hearing if the sole issue is a federal or state law requiring an automatic change adversely affecting some or all beneficiaries. Current policy will be revised to address this requirement, as it is not in current NSMHA fair hearing policy.

NSMHA has maintained a fair hearing policy to assist individuals with:

1. Their understanding of the right to request a fair hearing;
2. Timelines to request fair hearing;
3. Process to request a fair hearing;
4. Service continuation requirements pending hearing decisions; and
5. Available supports with fair hearing process, including Ombuds services.

NSMHA will update policy to reflect recent changes that include stipulation that the individual must first exhaust the grievance *or* appeal processes prior to requesting a fair hearing.

NSMHA fair hearing policy is in process of update to reflect the timelines to request fair hearing and rules for continuation of benefits/services to match due process requirements in WAC.

NSMHA will seek clarification from DBHR where needed to ensure BHO policies are clear and concise. This includes specific clarification as to continuation of benefits rules and their application in differing circumstances and timelines. In particular their application following grievance in which there is a request for a fair hearing if the individual also requests continuation of services following the grievance pending fair hearing. NSMHA will collaborate with DBHR to gain a clear understanding of the intention of the rules in order to meet the intent of the law in policy to continue authorized services for both Medicaid recipients and state funded individuals pending fair hearing.

NSMHA policy will specify, if accepted by DBHR, that individuals and their representatives have the right to request pre-hearing and administrative hearing processes described in WAC Chapter 388-02 (for non- Medicaid) or 182-526 (Medicaid). Individuals may call the Office of Administrative Hearings (OAH) at 1-800-583-8271 to inquire about qualifying for a state fair hearing.

Individuals must first exhaust the grievance process or the appeal process (only Medicaid recipients have an appeal process) prior to requesting fair hearing. Situations when an individual may request a fair hearing include the following:

1. Medicaid recipient does not receive a favorable disposition of an appeal by NSMHA;
2. An individual (including Medicaid recipients) does not receive a favorable disposition of a grievance from NSMHA;

3. NSMHA violates state defined maximum timelines for a provider grievance process 90 days, RSN level grievance process of 90 days unless extended up to 14 additional days, NSMHA violates the timeframe for appeal of 45 days unless extended up to 14 additional days, or NSMHA violates the timeframe for expedited appeal, if NSMHA agrees to expedition, of 3 business days unless extended for up to 14 additional days;
4. Situations also may include when written acknowledgement is not sent within five (5) business days (depending on DBHR direction in this area);
5. Because volition of these grievance system timelines are also circumstances where an NOA should be sent; a person could conceivably appeal first or go directly to fair hearing depending on state direction regarding exhaustion when timelines are not met; and/or
6. Service Authorization.

NSMHA policy will also be revised to reflect new timelines to request a fair hearing as outlined in the Due Process WAC.

If continued services are not requested due to service continuation requirements, a hearing may be requested within 90 calendar days from:

1. The date on the written resolution from the provider or NSMHA at the end of the grievance process; or
2. The date on the written resolution of appeal received from NSMHA at the end of the appeal process.

NSMHA will collaborate with DBHR to gain an understanding of the intention of the WAC for the timeline to file a fair hearing following a grievance if the individual requests continuation of benefits pending fair hearing.

NSMHA's policy currently reflects continuation or reinstatement of previously authorized services during the grievance process, at both provider and RSN levels, through to authorization end date. This assumes the individual is in a current authorization period and it is for currently authorized services. NSMHA will also specify that continued services will be provided, at least through the grievance process, even if authorization ends during the grievance process.

If continued services are requested pending the outcome of the fair hearing per WAC, all of the following apply:

1. The decision of the NOA must be for termination, suspension, or reduction of services and the individual appealed the decision;
2. Individual received written resolution of an appeal that upholds the NOA; and
3. Individual requests an administrative hearing and continued services within 10 calendar days of the written notification of the resolution.

WAC 0420(6)(b) states the individual has the right to have currently authorized MH services continued pending resolution of the grievance and, if applicable, through subsequent steps of the grievance system.

NSMHA will request clarification from DBHR to gain a better understanding of the intention of this requirement. If requested, NSMHA would also continue previously authorized services pending fair hearing following the grievance process if:

1. Services were provided by an authorized BHA;
2. Individual requests a continuation of services;
3. Individual is currently receiving services at the time of the request; and/or
4. Individual requests fair hearing within 10 calendar days of the written notification of the grievance resolution, to mirror the appeal process.

If a written letter of resolution was not received within the state maximum timeframes required for grievances or appeals, the individual can still request a fair hearing.

If an individual requests an expedited fair hearing, the expedited hearing must be requested within 10 calendar days of the notice of resolution of either the grievance or appeal. The same rules apply for service continuation of expedited hearing requests.

When criteria are met for continued services in the fair hearing policy, NSMHA will continue the MH/BH services during the administrative hearing process until one (1) of following occur:

1. Individual withdraws the hearing request;
2. Administrative law judge issues a hearing decision adverse to the individual; or
3. Period covered by the original authorization of MH/BH services has expired.

If an administrative hearing decision is not in favor of the individual, NSMHA may recover the cost of the MH/BH services furnished to the individual while the hearing was pending to the extent they were provided solely because of service continuation requirements.

Currently, policy outlines that if NSMHA or the state fair hearing officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, NSMHA must authorize or provide the disputed services promptly and as expeditiously as the enrollee's MH/BH condition requires.

If NSMHA or the state fair hearing officer reverses a decision to deny authorization of services and the enrollee received the disputed services while the appeal was pending, NSMHA or the state must pay for those services in accordance with state policy and regulations.

If the administrative hearing decision is not in favor of the individual, NSMHA may recover the cost of MH services and in the transition to BHO, BH services, furnished to the individual while the hearing was pending to the extent that they were provided solely because of the requirements for service continuation outlined in due process WAC and CFR 42.431.230(b).

NSMHA shall be bound by the hearing determinations whether or not the hearing determination upholds NSMHA's decision. DSHS is responsible for the implementation of the hearing decision even if the hearing decision is not within the purview of contract agreements with NSMHA. This will be added to NSMHA's policy as it is not currently stated.

NSMHA assumes in anticipation of becoming a BHO, the above rules would be refined to include BH versus MH services to address the SUD system, as well as, MH system.

V. Grievance System – State Fair Hearing Process – Parties
NSMHA will also add to our policies that the parties to the state fair hearing include NSMHA, as well as, the enrollee and his/her representative, or representative of a deceased enrollee's estate.

W. Grievance System – Grievance– Definition
For individuals with Medicaid, grievances are an expression of dissatisfaction about any matter other than an "action" as defined in NSMHA's policy and discussed above.

For state-funded individuals, grievances are an expression of any matter other than initial eligibility of routine services unless NSMHA standards for state funded criteria is met. Potential subjects for grievances include, but are not limited to: the quality of care or services provided and aspects of interpersonal relationships, such as, rudeness of a provider, employee, or failure to respect the enrollee's rights.

NSMHA will collaborate with DBHR to ensure interpretation of grievance for non-Medicaid enrollees meets the intention that non-enrollees cannot grieve the fact they are not provided an assessment for routine ongoing services unless they meet priority state funded criteria. NSMHA has developed standards for SUD service priorities as well.

X. Grievance System – Grievance Process – Procedures and Authority to File
As outlined above, an individual (including Medicaid recipients), their authorized representative, or network provider with written permission and acting on their behalf, or the enrollee's legal guardian may file a grievance. In the case of a minor, the individual's parent or, if applicable, their custodial parent may also file the grievance. For the purposes of inpatient authorization, the inpatient provider of services may also act on the enrollee's behalf with written consent.

An individual can file a grievance with either the provider of services or with NSMHA. Grievances may be filed orally, in person, or in writing. NSMHA is updating policy to include a grievance can also be filed in person as this was not explicitly noted in policy; however, was assumed.

NSMHA encourages the filing of and resolution of grievances at the lowest possible level. NSMHA, Ombuds and provider staff are available to assist individuals to file their grievance at the lowest level first.

Each provider is required to have an identified grievance system contact that can receive grievances and facilitate the process within their organization. In addition, grievances can be initiated with other staff within the provider organization. Also, each provider will have a toll free number to file a grievance. NSMHA also has a toll free number.

NSMHA continues work to ensure consistent application of the grievance process and revised policy will specify that grievances are processed and reported regardless of the ease of resolution.

Other persons (if the individual so chooses), may participate in the grievance process. Additionally, written response is provided and the grievance is resolved even if the individual is no longer receiving MH/BH services.

Individuals who make decisions on grievances are not involved in any previous level of decision-making of the same issue for the same individual.

For grievances that involve clinical issues or medical necessity, qualified MHPs who have the appropriate clinical expertise will make the decision. With the addition of the SUD system, NSMHA policies will specify decisions would be made by a MHP or CDP with the appropriate expertise.

Grievances at the provider or PIHP level may include a meeting with the individual, others of their choice and Ombuds, if involved, to assist with resolution if needed.

Individuals and their representatives (with appropriate release) may examine their enrollee record, including medical records and any other documents/records considered during the grievance process.

If individuals are not satisfied with provider level grievance resolution or if state required timeframes of 90 days are not met, individuals can file a grievance with NSMHA.

NSMHA policy will be updated to reflect once an individual receives a decision on a grievance from NSMHA the individual cannot file the same grievance with the provider.

Y. Grievance System – Grievance Process – Disposition and Notification
NSMHA's current policy states grievances are processed as expeditiously as the person's MH condition requires within 30 days at the provider level and the RSN level. The timeframe of 30 days at the RSN level may be extended up to 14 additional days if the individual requests an extension or NSMHA shows to the satisfaction of DBHR upon its request, there is need for additional information and how the delay is in the individual's interest.

For extensions requested by the individual or authorized representative, although not required, NSMHA currently provides written notice of the request and related dates. For extensions not requested by the enrollee, NSMHA will give the individual or authorized representative written notice of the reason for the delay.

NSMHA currently has an expedited grievance process at the provider and RSN level that requires a response within three (3) business days, if expedition is accepted, unless extended at NSMHA level.

As outlined above, NSMHA may review these timelines as they appear to exceed some of the minimum state established requirements.

Written acknowledgement is required for all grievances within five (5) business days at the provider level and RSN level. The written acknowledgement will also include notice to the individual or representative that previously authorized services will continue or be reinstated during the grievance process at the individual or representative's request and will continue at least through the provider and RSN level grievance process.

During NSMHA or provider grievance process, NSMHA and providers will continue or reinstate individual's previously authorized services at the individual's or their representative's request. NSMHA will also continue or reinstate previously authorized service following a grievance pending fair hearing. These are previously authorized services to continue if the original period covered by the original authorization has not expired.

As indicated above, NSMHA will collaborate with DBHR to gain a clear understanding of the intention of the rules for service continuation in order to meet the intent of the law in policy.

Written response in the form of a written resolution letter to grievances is required for all grievances, including those filed at the provider or RSN level.

The written response for the provider level grievance process includes the decision for the grievance, reason for the decision, results of the resolution process, process and available supports if the individual has any concerns about retaliation. In addition, the written response will also include the right and process to pursue the grievance with NSMHA, right for previously authorized services to continue or be reinstated during the NSMHA grievance process at the individual's or individual's representative's request.

In addition, NSMHA will add to provider level policies that written resolution include the timelines to file a fair hearing, which are within 90 calendar days from the date of written resolution by the RSN, should the individual choose to file an RSN level grievance. Provider level grievance letters, by current policy, also indicate the process to file a grievance with the RSN following the provider level.

Similarly the written response by NSMHA for RSN level grievances currently includes the reason for the decision, results of the resolution process, date it was completed, process and available supports if the enrollee has any concerns about retaliation.

The notice of grievance resolution also includes: right and process to request a fair hearing if the individual is not satisfied with the resolution, right to request a fair hearing at any time if they believe there has been a violation of DSHS rules including the grievance resolution timeframes, right to request continuation of services while the hearing is pending and rules that govern the process. In addition, NSMHA will add to policy that the written resolution will include the timelines to file a fair hearing which is:

1. Within 90 calendar days from the date of the written grievance response by the RSN if continued services are not requested; and
2. As outlined in fair hearing discussion, NSMHA will collaborate with DBHR to gain a clear understanding of the intention of the rules for service continuation and timelines in order to meet the intent of the law in policy. In particular, to clarify in policy with regard to whether all requests for fair hearing following grievance are to be made within 90 days or are there other rules that apply to requesting a hearing if the person requests continuation of authorized services post grievance pending fair hearing.

XI. TRIBAL COMMUNICATION AND COORDINATION AND COMMUNICATION PLAN

A. Inclusion of Tribal Authorities-Revised Code of Washington (RCW) 71.24.300
   1. Tribal Authorities will be invited to update their designated representatives for both the North Sound Behavioral Health Organization (NSBHO) Board of Directors (BOD) and Advisory Board. Each of the eight (8) Tribes will have their own seat on the Advisory Board. The Tribes currently share three (3) seats on the BOD.
   2. The provisions for the inclusion of Tribal Authorities on the BOD and Advisory Board are included in the BHO Joint County Authority and Operating Agreement (see Appendix, Section XI, 01)

B. Implementation of the "American Indian Addendum" [Department of Social and Health Services (DSHS) Division of Behavioral Health and Recovery (DBHR) Exhibit E]
   1. The American Indian Addendum applies special terms and conditions to network provider agreements between tribal health programs and qualified health plans. Currently, the only contract the North Sound Mental Health Administration (NSMHA) holds with a tribal health program is a federal Mental Health Block Grant (MHBG) contract with the Tulalip Tribes for a children's mental health "wraparound" program similar to the Wraparound with Intensive Services (WISe) program. This contract complies with all of the applicable federal and state requirements for MHBG funded programs while at the same time recognizing the sovereignty of the Tulalip Tribal Nation and supports the cultural adaptations the Tulalip behavioral health program has made in implementing this program.
   2. NSHMA has also offered to contract with tribal behavioral health programs to provide Involuntary Treatment Act (ITA) assessment services by designating qualified Tribal Mental Health Professionals (MHP) as "Designated Mental Health Professionals (DMHP)". Several of the North Sound Tribes have expressed interest but are still assessing their capacity to take on this new responsibility.
   3. In planning for the Behavioral Health Organization (BHO) network of services, NSHMA has also offered to work with tribes on future partnership arrangements related to Medication Assisted Treatments (MAT) and Substance User Disorder (SUD) residential services.

C. Ensuring equal access for American Indians/Alaska Natives (AI/AN) to behavioral health services

   NSBHO will continue its existing collaboration with the eight (8) North Sound Tribal Nations to maintain and update a "7.01 Plan" that identifies the goals and activities that will be jointly undertaken to ensure equal access to behavioral health services for AI/AN (see Appendix, Section XI, 02).

   Examples of such activities include:

   1. Incorporating a field in NSBHO's Consumer Information System (CIS) that can be used to identify tribal members (see Appendix, Section XI, 02.2.1).
   2. Setting aside a portion of the BHO's MHBG funds for behavioral health services to tribal members (see Appendix, Section XI, 02.2.2).
   3. Development of written crisis services agreements (see this Section F.2).

4. Maintaining a "Tribal Mental Health Brochure" that provides information on tribal behavioral health programs to assist in the referral of AI/ANs from NSMHA funded programs (see Appendix, Section XI, 02.3.1).
5. Updating the current NSMHA "Cultural Competency Plan" for the future BHO to include updated information related to providing culturally competent services to AI/ANs [3.1] (see Appendix, Section XI, 03).
6. Updating current NSMHA policies and protocols for the BHO related to serving AI/ANs (see Appendix, Section XI, 02.3.4).
7. Expanding the current NSHMA/Tribal Mental Health Workgroup to include representatives of Tribal SUD services (see Appendix, Section XI, 02.4.3).

D. Providing culturally competent services to American Indian/Alaska Native (AI/AN)
   1. The BHO will continue to work with the Tribes on providing training opportunities that increase the cultural sensitivity of Behavioral Health Professionals (BHP) serving AI/AN. This includes hosting the annual Tribal/NSBHO Behavioral Health Conferences (see Appendix, Section XI, 02.4.1 and 4.2). Themes related to incorporating traditional tribal healing practices, suicide prevention and reduction of drug addiction, especially among youth, will continue to be prominent themes in future conferences.
   2. Current NSMHA policies and protocols related to serving AI/ANs will be updated for the BHO (see Appendix, Section XI, 02.3.4).
   3. The current NSMHA "Cultural Competency Plan" for the future BHO to include updated information related to providing culturally competent services to AI/ANs (see Appendix, Section XI, 03).

E. Tribal Involuntary Treatment Act (ITA) Court Orders for Substance Use Disorder (SUD) Treatment Services
   NSMHA is currently gathering data on placements in SUD residential services related to Tribal court orders and will develop Memorandums of Understanding (MOUs) with interested tribes related to BHO payment of services for Medicaid-eligible tribal members.

F. Coordination with Tribal Providers
   1. The current NSMHA/Tribal Mental Health Workgroup will be expanded to include tribal SUD providers. This workgroup implements specific elements of NSMHA's 7.01 Plan that focus on improving clinical coordination between non-tribal behavioral health services and tribal behavioral health programs.
   2. NSHMA is currently implementing the state contract requirement to develop written crisis services agreements with each Tribal authority to increase coordination of mental health crisis services, including psychiatric inpatient discharge planning (see Appendix, Section XI, 04). This plan will also include training of BHO contracted providers and hospitals on the protocols called for in these agreements. Meetings have been held to date with the Tulalip, Upper Skagit, Sauk-Suiattle, Lummi, Nooksack and Stillaguamish Tribes. Tribal representatives are currently reviewing the proposed agreement with their Tribal attorneys and councils. Meetings still need to be scheduled with the Samish and Swinomish Tribes. In September 2014, a "Dear Tribal Leader" letter was sent to all eight (8) Tribes requesting to meet.

XII. Evidence-Based, Research-Based and Promising Practices Analysis and Development

DELETED BY THE DIVISION OF BEHAVIORAL HEALTH AND RECOVERY (DBHR)

XIII. BEHAVIORAL HEALTH DATA CONSOLIDATION PROJECT PLAN

A. Plan and timeline to collect and report on data elements

The North Sound Mental Health Administration (NSMHA) has begun conversations with provider agency staff related to the submission of data. Early conversations were around getting a sense of whether they had existing data systems and if modifications were made in-house or if there was a need to outsource modifications. All the new providers NSMHA met with had existing data systems and mixes of in house/outsource abilities. For those providers who outsource the changes to their data systems, communications have been initiated to make them aware of the upcoming changes and planning to meet the April 1, 2016, deadline.

The timeline for being able to collect and report on the data elements has been driven by the changes that have been identified in the work done by the Behavioral Health Data Consolidation (BHDC) project and the Substance Use Disorder (SUD) Service Encounter Reporting Instructions (SERI) workgroup. The work product created by the BHDC project provides NSMHA with a basis for the data that must be collected to meet state requirements.

NSMHA continues to work to identify the additional data elements that need to be collected to manage the Behavioral Health Organization (BHO) system in the North Sound. Work has been completed to identify what items are included in the BHDC and what items are already collected as a part of the NSMHA Consumer Information System (CIS) Data Dictionary. Part of this work identified the need for certain crosswalks and updates to existing code tables.

Based on initial conversations with SUD providers, the reporting of the encounters will be a similar process to what their systems are already able to perform. There will be some customization that will need to be performed for the BHO-specific reporting requirements.

B. Timeline

Summer 2015 – Meet with SUD providers to discuss their data systems

1. Identify what system used;
2. In-house or outsource changes;
3. Current extract/batch submission;
4. Introduce NSMHA CIS Data Dictionary; and
5. Introduce flow and processing of data files.

September 2015

1. Receive proposed BHDC document from the Division of Behavioral Health and Recovery (DBHR) and
2. Begin distribution to NSMHA staff to identify additional data needs.

October 2015

1. Receive public draft of SUD SERI;
2. Complete crosswalk of elements in BHDC and NSMHA CIS Data Dictionary;
3. Meeting with provider data staff to identify initial data changes;
4. Work on identifying initial gaps in data collection; and
5. Solicit input/feedback on working drafts.

November 2015

1. NSMHA Staff to complete identification of additional data elements and
2. Continue communications with provider data staff of project.

December 2015

1. Publish NSMHA CIS Data Dictionary changes incorporating new data reporting requirements;
2. Prepare NSMHA CIS test system for changes; and
3. Continue communications with provider data staff of project.

January 2016

1. As necessary, continue preparation of NSMHA CIS test system;
2. Make changes as necessary for new transactions to be submitted to BHDC;
3. Make NSMHA CIS test system available for provider test batches; and
4. Continue communications with provider data staff of project.

February 2016

1. Testing, testing, testing – inbound/outbound and
2. Continue communications with provider data staff of project.

March 2016

1. Testing, testing, testing – inbound/outbound;
2. Make NSMHA CIS production system ready for changes; and
3. Continue communications with provider data staff of project.

April 2016

1. Begin receipt of new data and
2. Begin submission of new data to BHDC/ProviderOne.

C. Plan to assess and ensure provider agencies are able to submit client and service data

1. Barriers in meeting the data collection and transmission requirements;
2. Communication of data reporting requirements;
3. Technical assistance/support; and
4. Information Technology (IT) Systems/Electronic Health Records (EHRs) used by provider agencies.

See this Section A. Additionally, NSMHA is currently working to establish contractual requirements to allow for technical assistance and support to prepare provider data systems for the new requirements.

D. Plan to collect client and service data from residential providers throughout the state
NSMHA is part of discussions that are being held with other Regional Support Networks (RSN)/Behavioral Health Organizations (BHOs) in the state as all work towards determining a data collection method that allows data transmission to the appropriate BHO, be reported to the state, while minimizing the reporting burden of residential providers. As of this writing, no plan has yet to be finalized; plan to meet this need.

E. System capacity to collect, store and submit funding source information associated with a person and service in order to meet block grant reporting requirements
As of this writing, the methodology used to identify funding source information is through a combination of:

1. The use of modifiers associated with an encounter that is provided;
2. Specific encounters that are specific to a funding source; and
3. Information contained in the Client Profile and Substance Use sections of the BHDC.

NSMHA's CIS already has the capability to accept and report up to four (4) different modifiers per encounter. The modifiers that have been added to the SUD SERI will easily be able to be accepted into NSMHA's CIS when submitted. Some code tables currently in use are able to provide breakouts for funding sources for the type of encounter that is reported. These code tables will be updated to incorporate additional funding sources as necessary.

The additional information that is part of the Client Profile and Substance Use sections of the BHDC will be incorporated into NSMHA's CIS after NSMHA staff has identified the data requirements that are necessary to manage the BHO system in the region.

F. Plan to ensure encounters submitted within 30 days after the close of the month of service

Currently, NSMHA has contract provisions with provider agencies that require data to be submitted by the 5th calendar day after the close of each calendar month in which an event occurred. This is inclusive of all data reporting that is part of NSMHA's CIS Data Dictionary. This contract provision will be maintained within the new contracts with new agencies. Providers have an incentive to submit their data by the established timelines in order to receive timely payments for services provided.

NSMHA generally submits encounter data on a weekly basis to ProviderOne and non-encounter data to the current, Mental Health Division (MHD)-CIS. The batch processes gather data that has been submitted and accepted into NSMHA's CIS to be submitted upstream to ProviderOne or the MHD-CIS.

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SECTION X

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Appendix	Section XII	Deleted by DBHR

SECTION XIII

Appendix	Section XIII	Contains no appendices

North Sound Mental Health Administration

Regional Support Network for Island, San Juan, Skagit, Snohomish, and Whatcom Counties

Improving the mental health and well being of individuals and families in our communities

117 North First Street, Suite 8 • Mount Vernon, WA 98273

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June 8, 2015

Melena Thompson
Implementation and Policy Manager
Division of Behavior Health and Recovery
PO Box 45320
Olympia, WA 98504

Dear Melena,
This letter is to inform you that the North Sound Regional Support Network, DBA North Sound Mental Health Administration, will be applying to become the Behavior Health Organization for our five (5) county region.

We have received approval from our Board of Directors to move forward with the transition, which will include revising our Interlocal Agreement with Island, San Juan, Skagit, Snohomish and Whatcom counties. We are also in discussion with our attorney to convert our legal status to a Limited Liability Company (LLC).

It is our intention to have the process and paperwork complete and filed with the State prior to March 31, 2016. Please let me know if you have any questions about our intent to become the North Sound Behavior Health Organization.

Sincerely,

Margaret Rojas
Contracts Manager

Responses to 08-19-15 Email from Melena Thompson

Melena:

In an email on August 19 to me, you asked for some additional information concerning the BHO agreement I sent to you on August 18. I hope the following information is helpful.

The adoption of the entity structure is required and it provides many advantages.

1. Compliance with Legislative Mandate. RCW 71.24.380 requires that where multiple counties submit to the Secretary a plan to provide behavioral health services, "the counties ***shall form a responding entity through the adoption of an interlocal agreement***." (emphasis added) The Interlocal Cooperation Act requires that an interlocal agreement state "***the precise organization, composition and nature of any separate legal or administrative entity created thereby*** together with the powers delegated thereto, provided such entity may be legally created" and allows "limited liability companies" to serve as such entities. (emphasis added) RCW 39.34.030. The BHO Operating Agreement we sent to you for review complies with the requirements of RCW 71.24.380 and RCW 39.34.030.

2. Legal Authority. A mere "Joint Operating Board," comprised of a group of county authorities, is not an "entity" as required by RCW 71.24.380 and the legal authority of a joint operating board to enter into legal relationships has been called into question. On the other hand, there is no question that a limited liability company can undertake important operative functions, such as:

    - Enter into contracts with third parties for services;
    - Enter into construction contracts, for such items as tenant improvements to a leased space or public works;
    - Engage and enter into agreements with consultants, such as attorneys and accountants;
    - Purchase and own real property;
    - Lease real property;
    - Borrow and invest funds;
    - Employ workers; and
    - Purchase insurance and have an insurable interest.

3. Adaptation and Termination. RCW 71.24.850 anticipates, based on additional studies, further integration of behavioral health as part of a "managed care health system." This may lead to the termination of behavioral health organizations in 2020. As a limited liability company, NSBHO together with the County Authorities will be able to follow well-understood, predictable procedures to adapt its operations, or terminate and wind up its affairs, should the delivery of integrated medical and behavioral health services starting in 2020 so require.

A single "County Authority," which is a recognized entity, (*i.e.,* a county) may operate a BHO on its own. But when a "*Group* of County Authorities" is formed, just like when a group of people come together to operate any enterprise, the "group" needs to adopt an entity structure to conduct its affairs, both with respect to one another and with third parties.

By forming our Behavioral Health Organization as a limited liability company, we will be able to own property and allow County Authorities to invest capital. This is vitally important in this region as we strive to provide needed facilities for evaluation and treatment of our consumers. It also allows for meaningful involvement of Tribal Authorities and establishes the Tribal Authorities' role. Most importantly, we will be in compliance with state law and in a position to effectively and efficiently provide behavioral health services.

JOINT COUNTY AUTHORITY BHO OPERATING AGREEMENT

OF

NORTH SOUND BEHAVIORAL HEALTH ORGANIZATION, LLC,

a Washington Behavioral Health Organization and Limited Liability Company (LLC)

Dated and Effective

as of

_____, 2016

JOINT COUNTY AUTHORITY BHO OPERATING AGREEMENT OF NORTH SOUND MENTAL HEALTH ORGANIZATION, LLC

THIS JOINT COUNTY AUTHORITY BHO OPERATING AGREEMENT (this "Agreement") is made and entered into effective as of _____ 2016, by and among the following County Authorities: Island County, San Juan County, Skagit County, Snohomish County and Whatcom County (collectively "County Authorities").

RECITALS

A. The County Authorities, as defined below and as provided for in RCW 71.24.025 (12), are entering into this Agreement to jointly provide a community health program and regional system of care, with the collective goal of consolidating administration, reducing administrative layering and reducing administrative costs, consistent with the State of Washington's legislative policy as set forth in RCW 71.24.015.

B. This Agreement is a joint operating agreement entered into by a group of County Authorities responding to a request for a detailed plan and contract with the State of Washington to operate as a regional support network until April 1, 2016, and as a behavioral health administration as of April 1, 2016, as provided for in RCW 71.24.100.

C. This Agreement provides a means for each County Authority to share in the cost of mental and behavioral health services and further provides the means for both payment of services and audit of funds, as provided for in RCW 71.24.100. In addition, this Agreement provides for the joint supervision and operation of services and facilities, as provided for in RCW 71.24.110.

D. This Agreement also serves as an Operating Agreement as provided for in the LLC Act, as defined below.

ARTICLE 1 -- DEFINITIONS

The following terms used in this Agreement shall have the following meanings (unless otherwise expressly provided herein):

1.1 "**BHO Act**" means Chapter 225, Laws of 2014 and those portions of Chapter 71.24 in effect on and after April 1, 2016.

1.2 "**BHO**" means North Sound Behavioral Health Organization, LLC, a joint operating agreement of the five County Authorities. The BHO is a "company" as that term is used in the LLC Act.

1.3 "**Capital Account**" means the capital account determined and maintained for each County Authority pursuant to Section 8.3.

1.4 "**Capital Contribution**" means any contribution to the capital of the BHO in cash or property by a County Authority whenever made.

1.5 "**Certificate of Formation**" means the certificate of formation pursuant to which the BHO was formed as an LLC, as originally filed with the office of the Secretary of State on _____, 2016, and as amended from time to time.

1.6 "**Code**" means the Internal Revenue Code of 1986, as amended, or corresponding provisions of subsequent superseding federal revenue laws.

1.7 "**County Authority**" or "**County Authorities**" shall have the same meaning as used in RCW 71.24.025 (12), as amended and shall include only Island, San Juan, Snohomish Skagit and Whatcom Counties. Each County Authority that signs a counterpart of this Agreement shall be a "member" of the LLC formed hereby as that term is defined in RCW 25.15.005 (8) and as that term is used in RCW 25.15.115, as amended. Each County Authority of the BHO must be a public agency as provided for in RCW 39.34.030(3)(b).

1.8 "**County Authorities Interest**" means all of a County Authority's share in the BHO's assets pursuant to this Agreement and the LLC Act and includes a County Authority's rights to participate in the management and affairs of the BHO, including the right to vote on, consent to or otherwise participate in any decision of the County Authorities.

1.9 "**LLC**" means limited liability company.

1.10 "**LLC Act**" means the Washington Limited Liability Act, RCW Ch. 25.15, as amended.

1.11 "**Majority Interest**" means, at any time, more than fifty percent (50%) of the then outstanding Units held by the County Authorities.

1.12 "**Executive Committee**" means the governing body of the BHO as further specified in Article 5 of the Agreement. On behalf of the County Authorities, the Executive Committee shall govern the BHO. The Executive Committee shall be comprised of individual representatives from the following County Authorities with each County Authority having the number of representatives noted:

County	Representatives
Island	One
San Juan	One
Skagit	One
Snohomish	Four
Whatcom	Two

1.13 "**Percentage Interest**" means with respect to any County Authority, the percentage determined based upon the ratio that the number of Units held by such County Authority bears to the total number of outstanding Units.

1.14 "**Regulations**" includes proposed, temporary and final Treasury regulations promulgated under the Code and the corresponding sections of any regulations subsequently issued that amend or supersede such regulations.

1.15 "**Reserves**" means, with respect to any fiscal period, funds set aside or amounts allocated during such period to reserves which shall be maintained in amounts deemed sufficient by the Executive Committee for working capital and to pay obligations, expenses and other costs or expenses incident to the ownership or operation of the services provided by the BHO and the BHO's business.

1.16 "**Tribal Authority**" means the federally recognized Indian tribes and the major Indian organizations recognized by the Secretary of the Washington Department of Social and Health Services ("DSHS") that fall within the boundaries of the County Authorities insofar as those tribal organizations do not have a financial relationship with the BHO that would present a conflict of interest.

1.18 "**Tribal Member**" means a Tribal Authority that executes an agreement to become a Tribal Member as set forth in Article 4 below.

1.19 "**Units**" means the Units issued to any County Authority under this Agreement as reflected in attached **Exhibit A**, as amended from time to time.

ARTICLE 2 -- FORMATION OF BHO AS AN LLC

2.1 Formation. The BHO as an LLC was formed on _____, 2016, when the LLC Certificate of Formation was executed and filed with the office of the State of Washington Secretary of State in accordance with and pursuant to the LLC Act. The County Authorities shall promptly execute all amendments to the Certificate of Formation and all other documents needed to enable the County Authorities or Executive Committee, or their respective agents, to accomplish all filing, recording, and other acts necessary and appropriate to comply with all requirements for the formation and operation of the BHO as an LLC under the LLC Act.

2.2 Name. The name of the BHO is North Sound Behavioral Health Organization, LLC.

2.3 Principal Place of Business. The principal place of business of the BHO shall be 301 Valley Mall Way, Suite ____, Mount Vernon, WA 98273. The BHO may locate its places of business at any other place or places as the Executive Committee may from time to time deem advisable.

2.4 Registered Office and Registered Agent. The BHO's initial registered agent and the address of its initial registered office in the State of Washington are as follows:

Name	Address
Bradford E. Furlong	825 Cleveland Avenue, Mount Vernon, WA 98273

The registered office and registered agent may be changed by the County Authorities from time to time by filing an amendment to the Certificate of Formation.

2.5 Term. The term of the BHO shall be perpetual unless the BHO is dissolved in accordance with either Article 11 or the LLC Act.

ARTICLE 3 – AUTHORITY, BUSINESS AND PURPOSE OF BHO

3.1 Authority. As provided for in RCW 71.24.015, it is the policy of the State of Washington to encourage the development of regional mental health services and the availability of treatment components. To this end, RCW 71.24.015 provides for counties to enter into joint operating agreements with one another to form regional systems of care, integrating planning, administration and service delivery duties under RCW Chapters 71.05 and 71.24 in order to consolidate administration and reduce administrative layering and costs. This Agreement is a joint operating agreement between the County Authorities to initially operate as a regional support network. Pursuant to Chapter 225, Laws of 2014 ("BHO Act"), effective April 1, 2016, the BHO, and through the BHO, the County Authorities jointly, will undertake the responsibilities of a behavioral health organization.

The purpose of the County Authorities, in entering into this Agreement, is to present a plan to the Secretary of DSHS to contract for the provision of behavioral health services and upon approval of such plan undertake to contract for the provision of such services within the boundaries of the County Authorities and to take such other and further actions as are required and and/or authorized by the BHO Act. The mutual goal of the County Authorities, in entering into this Agreement, is to work together to provide mental health and behavioral health services to the citizens of each of the County Authorities in an efficient and stream-lined manner.

The State of Washington Interlocal Corporation Act, specifically RCW 39.34.030, provides, in part, that any two or more public agencies may enter into agreements with one another for joint cooperative action. RCW 39.34.030(3)(b) specifically provides that the County Authorities may form a limited liability company under which each County Authority is a public agency, as provided for in Section 1.9, and further provides the BHO's funds are subject to audit, as provided for in Section 9.4. The County Authorities have exercised the authority granted to them under the BHO Act, the LLC Act and the Interlocal Cooperation Act to form this BHO as an LLC to achieve maximum efficiency in the delivery of mental health and behavioral health services and so that their rights and liabilities as to each other and third parties are firmly established and clearly understood.

This Agreement serves as such a joint operating agreement between the County Authorities to operate as a regional support network, as provided for in RCW 71.24.100 and 71.24.110, until April 1, 2016 with:

(a) Each County Authority bearing a share of the cost of mental health services;

(b) The Treasurer of Skagit County serving as the custodian of funds made available for the purposes of such behavioral health services and that the Treasurer may make payments from such funds upon audit by the appropriate auditing officer of Skagit County and shall be responsible to Washington State Department of Social and Health Services ("DSHS") for all debts, obligations, and liabilities owed to DSHS by the BHO upon termination of any contract between the BHO and DSHS, or as a result of remedial action, from BHO funds in its possession;

(c) The Auditor of Skagit County serving as the auditing officer of the BHO's funds and accounts; and

(d) For the joint supervision and operation of services and facilities.

As of April 1, 2016 this Agreement shall serve as a joint operating agreement, as provided for in RCW 71.24.100 and 71.24.110, for a behavioral health organization with:

(a) Each County Authority bearing a share of the cost of behavioral health services;

(b) The Treasurer of Skagit County serving as the custodian of funds made available for the purposes of such mental health services and that the treasurer may make payments from such funds upon audit by the appropriate auditing officer of Skagit County and shall be responsible to DSHS for all debts, obligations, and liabilities owed to DSHS by the BHO upon termination of any contract between the BHO and DSHS, or as a result of remedial action, from BHO funds in its possession;

(c) The Auditor of Skagit County serving as the auditing officer of the BHO's funds and accounts; and

(d) For the joint supervision and operation of services and facilities.

The foregoing notwithstanding, the Executive Committee, as defined in Section 1.12 above and described below in Section 5.1, may by majority vote change the Treasurer and Auditor designation to another Treasurer and Auditor in the same county as any one of the County Authorities.

3.2. Business and Purpose. The business and the purpose of the BHO shall be:

3.2.1 To be recognized and operate as a regional support network to provide regional systems of care for mental health services as provided for in RCW 71.24.016 from the date of formation to March 31, 2016;

3.2.2 To be recognized and operate as a behavioral health organization to provide behavioral health services as provided for in RCW 71.24.016 from April 1, 2016;

3.2.3. To carry out any lawful, services, business or activity that may be conducted by a BHO or LLC as determined by the County Authorities; and

3.2.4 To exercise all other powers necessary to or reasonably connected with the BHO's business and services it provides that may be legally exercised by limited liability companies under the LLC Act.

ARTICLE 4 – NAMES, ADDRESSES AND STATUS OF COUNTY AUTHORITIES

The names and addresses of the County Authorities are set forth in the attached **Exhibit A**, as amended from time to time. Each of the five Counties identified in Section 1.9, once each executes this Agreement, shall be a County Authority of the BHO. A Tribal Authority may become a Tribal Member by executing an agreement in form approved by the Executive Committee. A Tribal Member may appoint one (1) non-voting, *ex officio* representative to the Executive Committee.

ARTICLE 5 -- MANAGEMENT

5.1 Management. The services, business and affairs of the BHO shall be managed by the County Authorities acting through the County Authorities Executive Committee ("Executive Committee"). The Executive Committee in turn shall work with and delegate to the NSBHO Administrator the administration, services, business and affairs of the BHO, as provided for in Section 5.3.5. Each representative serving on the Executive Committee shall devote to the BHO and apply to the accomplishment of the BHO's purposes so much of his or her time and attention as is reasonably necessary to manage the services and business of the BHO. Each Executive Committee representative shall serve at the pleasure of the County Authority that appointed him or her and may be removed or replaced at any time by such County Authority upon written notice to the other County Authorities and the NSBHO Administrator. The County Authorities recognize that from time to time Executive Committee representatives may not be able to attend Executive Committee meetings. Each County Authority, in addition to appointing Executive Committee representatives may also appoint delegates that may attend Executive Committee meetings on behalf of the County Authority and in lieu of the Executive Committee representative, provided the other County Authorities and the NSBHO Administrator are given written notice of the appointment of the delegate together with the delegate's name and contact information, in advance of the meeting. For those County Authorities that have County Administrators, the written notice must come from the County Executive or his or her designee, and for those County Authorities that are governed by a County Council, by the Secretary of the County Council.

Each County Authority shall provide to the other County Authorities and the NSBHO Administrator written notice of the following, together with contact information, including email addresses: 1) Executive Committee representatives and delegates; 2) Advisory Board representatives; and 3) a notice agent designated to receive notice on behalf of the County Authority as provided for in Section 12.1.

Except as otherwise expressly provided in this Agreement, the Executive Committee shall have full, complete and exclusive authority, power and discretion to manage and control the services provided by the BHO and the services, business, affairs and property of the BHO, to make all decisions regarding those matters and to perform any and all other acts or activities customary or incident to the management of the BHO's services and business. Only representatives of the County Authorities, or their approved delegates as provided for in the preceding paragraph, shall have any voting rights on the Executive Committee.

5.2 Decision-Making. The BHO shall make decisions, take actions and incur obligations as determined by the County Authorities acting through the Executive Committee. The Executive Committee shall take action, expend sums and enter into obligations approved by a quorum of the Executive Committee. A quorum of the Executive Committee shall consist of a majority of the County Authorities' Executive Committee representatives.

5.3 Power and Authority. Without limiting the scope and generality of the Executive Committee's actions, the Executive Committee shall have the power and authority, on behalf of the County Authorities, to undertake the following:

5.3.1 Pursuant to RCW 39.34.080, enter into contracts with the DSHS pursuant to the provisions of RCW Chapter 71.24;

5.3.2 Enter into contracts with individuals, public and private organizations, and individual counties, including with other County Authorities to this Agreement, to carry out the purposes of the contract with DSHS and other obligations of the BHO as defined in RCW Chapter 71.24, subject to available funds and to the purpose and goals of the BHO;

5.3.3 Accept and expend funds from the State of Washington, the Federal government, the other County Authorities, and from other public and private sources, including gifts, for activities and purposes related to RCW Chapter 71.24;

5.3.4 Prepare and submit to DSHS appropriate plans, both in length and duration, for mental health services and behavioral health services in accordance with the provisions of RCW Chapter 71.24 and the BHO Act;

5.3.5. Employ or contract for staff and consultants to carry out the responsibilities of this Agreement and the statutory requirements for a regional support network through March 31, 2016, followed by a behavioral health network as of April 1, 2016. In doing so, the Executive Committee shall hire, give authority to, evaluate, give direction to and terminate the BHO's administrator and employees (collectively "NSBHO

Administrator") who shall administer the BHO's operations, services and administration, including all hiring, development, approval and implementation of all policies and procedures, service delivery plans and operating plans. The NSBHO Administrator, and all of its employees and administrators, shall be employees of the BHO and not of individual County Authorities.

The NSBHO Administrator, under the direction of the Executive Committee, shall have the power and authority to:

(i) Prepare, review, modify and present to the Executive Committee for approval the BHO's annual budget;

(ii) Execute contracts for the provision of services and operation of the BHO, including leases for rental of real and personal property;

(iii) Take necessary and appropriate steps on behalf of the Executive Committee to ensure the BHO's compliance with all statutory and funding requirements; and

(iv) Take other actions as directed by the Executive Committee or the County Authorities by their respective resolution or consent.

5.3.6 Spend the capital and revenues of the BHO in the furtherance of the business of the BHO and the services it provides;

5.3.7 Acquire, improve, manage, lease, operate, sell, transfer, exchange, encumber, pledge and dispose of any real or personal property of the BHO;

5.3.8 Purchase such liability, casualty, property and other insurance as the Executive Committee, in its sole discretion, deems advisable to protect the BHO's assets against loss or claims of any nature; *provided*, however, the Executive Committee shall not be liable to the BHO, or to the County Authorities, for failure to purchase any insurance if such coverage should prove inadequate;

5.3.9 Enter into management agreements, service agreements, provider agreements, consultants and professional agreement, maintenance or other service agreements, short-term or long-term rental agreements, together with any other agreements;

5.3.10 As provided for in RCW 71.24.350, as amended, provide for and establish a separately funded mental health Ombuds' office that is:

(i) Independent of the BHO; and

(ii) That maximizes the use of consumer advocates.

5.3.11 Establish risk reserve funds as prudent and as required by its contracts. The NSBHO Administrator shall provide notice to the County Authorities of any need for Capital Contributions to the BHO and as required to fulfill the BHO's obligations and contractual requirements. Upon unanimous vote of the Executive Committee, each County Authority shall make Capital Contributions to the BHO as requested by the NSBHO Administrator and directed by the Executive Committee; *provided*, that such Capital Contributions shall be in proportion to the County Authority's share of Units. In addition, the NSBHO Administrator shall establish additional risk reserves.

5.3.12 Execute instruments and documents, including without limitation, negotiable instruments, documents providing for the acquisition or disposition of the BHO's property, assignments, bills of sale, leases, management agreements, agreements and any other instruments, agreements or documents necessary, in the opinion of the Executive Committee, to the business, and the services, of the BHO;

5.3.13 Employ accountants, legal counsel, independent contractors, managing agents, service providers, management companies or other experts to perform services for the BHO and to compensate them from BHO funds;

5.3.14 Enter into any and all other agreements for any purpose, in such form as the Executive Committee may approve;

5.3.15 Undertake any and all actions and activities authorized by Chapter 70.24 RCW, now or as hereafter amended or otherwise authorized by the laws of the State of Washington; and

5.3.16 To do and perform all other acts as may be necessary or appropriate to the conduct of the BHO's business and services provided.

Unless authorized to do so by this Agreement, or by the Executive Committee, no County Authority, individual representative, or delegate of the Executive Committee, the Advisory Board, any individual representative of the Advisory Board, employee, or other agent of the BHO shall have any power or authority to bind the BHO in any way, to pledge its credit, or to render it liable for any purpose.

5.4 Advisory Board. In addition to the Executive Committee the BHO shall have in place an advisory board of the BHO ("Advisory Board") with representatives from each county. The Advisory Board representatives shall be appointed according to each County Authority's usual and customary method of appointment with terms to be determined by each County Authority, conforming with its respective County Code. Each County Authority shall endeavor to include as part of its appointment representatives from the County Authority's mental health and/or behavioral health advisory board. The Advisory Board shall review and provide comments on plans and policies developed pursuant to RCW Chapter 71.24, provide local oversight regarding the activities of the BHO, and work with the BHO to address and resolve significant concerns regarding service delivery and outcomes. Two of the representatives of the Advisory Board will sit as ex-officio, non-voting representatives on the Executive Committee.

The Advisory Board shall consist of the following twenty-six representatives representing and apportioned to each County Authority as follows:

County Authorities	Representatives
Island	Four
San Juan	Three
Skagit	Four
Snohomish	Nine
Whatcom	Six

In addition to the representatives noted above, each of the Tribal Authorities shall have a representative on the Advisory Board. The Executive Committee shall assure the composition of the Advisory Board is broadly representative of the demographic character of the region and shall include, but not be limited to, representatives of consumers and families, law enforcement and Tribal Authorities.

5.5 Compensation. The BHO will not pay the County Authorities or the representatives of the Executive Committee or representatives of the Advisory Board any fees or other compensation for its services provided except as set forth in this Agreement.

5.6 Limitation on Liability; Indemnification. Neither the Executive Committee nor the Advisory Board, or their respective representatives, officials, County Authorities, managers, employees or agents, shall be liable, responsible or accountable in damages or otherwise to the BHO or the County Authorities for any act or omission performed in good faith pursuant to the authority granted by this Agreement or in accordance with its provisions, and in a manner reasonably believed to be within the scope of the authority granted and in the best interest of the BHO; provided that such act or omission did not constitute fraud, intentional misconduct, or gross negligence. The BHO shall indemnify and hold harmless the Executive Committee and the Advisory Board and any of their respective representatives, officials, County Authorities, managers, employees or agents thereof, against any liability, loss, damage, cost or expense incurred by them on behalf of the BHO or in furtherance of the BHO's interests without relieving any such person of liability for fraud, misconduct, bad faith or negligence. No County Authority or representative of the Executive Committee or the Advisory Board shall have any personal liability with respect to the satisfaction of any required indemnification of the above mentioned persons.

Any indemnification required to be made by the BHO shall be made promptly following the fixing of the liability, loss, damage, cost or expense incurred or suffered by a final judgment of any court, settlement, contract or otherwise. In addition, the BHO shall reimburse a person claiming indemnification under this Section 5.6 for legal expenses and other costs incurred as a result of a legal action brought against such person if: (i) the legal action relates to the performance of duties or services by the person on behalf of the BHO; (ii) the legal action is initiated by a party other than a County Authority; and (iii) such person undertakes to repay the advanced funds to the BHO if it is determined that such person is not entitled to indemnification pursuant to the terms of this Agreement.

5.7 Right to Rely on the Executive Committee. Any person dealing with the BHO may rely (without duty of further inquiry) upon a certificate signed by the Executive Committee as to the identity and authority of any the Executive Committee or other person to act on behalf of the BHO or any County Authority.

ARTICLE 6 -- RIGHTS AND OBLIGATIONS OF COUNTY AUTHORITIES

6.1 Obligations of County Authorities. Each County Authority shall carry out its obligations under this Agreement including appointments of representatives to the Executive Committee and to the Advisory Board. In addition each County Authority shall: (i) designate staff and resources to plan for local behavioral health needs; (ii) monitor local contracts and, upon request, participate in monitoring BHO contracts; (iii) develop local crisis response systems; and (iv) provide local resource coordination.

6.2 Limitation of County Authorities' Liability. No County Authority or County Authority's representative, official County Authority, manager, employee or agent shall be personally liable, merely as a County Authority, for any debts, losses or liabilities of the BHO beyond the County Authority's respective contributions and any obligation of the County Authority hereunder to make contributions, except as otherwise specifically provided by law. No County Authority shall have liability to the BHO or its County Authorities for monetary damages for conduct merely as a County Authority, except for acts or omissions that involve intentional misconduct, fraud, gross negligence, or for any transaction for which the County Authority has personally received a benefit in money, property or services to which the County Authority was not legally entitled. If the Act is hereafter amended to authorize BHO action further eliminating or limiting the personal liability of County Authorities, then the liability of a County Authority shall be eliminated or limited to the full extent permitted by the Act, as so amended. Any repeal or modification of this Section of the Act shall not adversely affect any right or protection of a County Authority of the BHO existing at the time of such repeal or modification for or with respect to an act or omission or such County Authority occurring prior to such repeal or modification. The foregoing notwithstanding, nothing herein shall limit the debts, obligations, and liabilities of County Authorities to DSHS, including, but not limited to, the requirements of County Authorities under chapter 71.24 RCW and any requirements of this Agreement or of any agreement between the BHO and DSHS regarding use of funds, reserves and fund balances.

The BHO shall indemnify and hold harmless the County Authorities and any of their respective representatives, officials, County Authorities, managers, employees or agents thereof, against any liability, loss, damage, cost or expense incurred by them on behalf of the BHO or in furtherance of the BHO's interests without relieving any such person of liability for fraud, misconduct, bad faith or negligence. No County Authority shall have any personal liability with respect to the satisfaction of any required indemnification of the above mentioned persons.

Any indemnification required to be made by the BHO shall be made promptly following the fixing of the liability, loss, damage, cost or expense incurred or suffered by a final judgment of any court, settlement, contract or otherwise. In addition, the BHO shall reimburse a person claiming indemnification under this Section 6.2 for legal expenses and other costs incurred as a result of a legal action brought against such person if: (i) the legal action relates to the performance of duties or services by the person on behalf of the BHO; (ii) the legal action is initiated by a party other than a County Authority; and (iii) such person undertakes to repay the advanced funds to the BHO if it is determined that such person is not entitled to indemnification pursuant to the terms of this Agreement.

6.3 Inspection of Records. Each County Authority shall have the right to inspect and copy at such County Authority's expense, the records required to be maintained by the BHO pursuant to Section 9.7.

6.4 No Priority and Return of Capital. Except as expressly provided in Article 8 or 9, no County Authority shall have priority over any other County Authority, either as to the return of Capital Contributions or as to distributions.

6.5 Withdrawal of County Authority. A County Authority may voluntarily resign or otherwise withdraw as a County Authority; *provided*:

(i) the withdrawing County Authority provides the other County Authorities and the NSBHO Administrator with written notice of withdrawal at least three hundred sixty-five (365) days prior to the expiration of the BHO's current fiscal year; and

(ii) the withdrawing County Authority shall not be entitled to payment or return of Capital Contributions or other monies made to the BHO or held by the BHO whether prior to the date of the notice or between the date of notice and the date of withdrawal.

ARTICLE 7 -- MEETINGS OF EXECUTIVE COMMITTEE

7.1 Meetings. All meetings of the Executive Committee will be held in full compliance with the Washington Open Public Meetings Act, RCW Chapter 42.30. The Executive Committee shall establish a regular business meeting time in compliance with RCW 42.30.070. Special meetings of the Executive Committee, as authorized by RCW 42.30.080, may be called by (i) the presiding officer of the Executive Committee; or by (ii) a majority of the representatives of the Executive Committee.

7.2 Place of Meetings. The party or body calling the meeting as provided for in Section 7.1 may designate any place within a County Authority County as the meeting site. If no designation is made, the place of meeting shall be the principal office of the BHO specified in Section 2.3.

7.3 Notice of Meetings/Agendas. Written notice stating the place, day and hour of the meeting, and in case of a special meeting, the purpose or purposes for which the meeting is called, shall be delivered not less than five (5) nor more than thirty (30) days before the date of the meeting, either personally, by mail or by email, either by or before the date of the meeting by or at the direction of the Executive Committee or the Executive Committee representatives calling the meeting, to each representative of the Executive Committee entitled to vote at such meeting. If mailed, such notice shall be deemed to be delivered three (3) calendar days after being deposited in the United States Mail, addressed to the party as specified herein with postage thereon prepaid. An agenda of every meeting of the Executive Committee shall be posted on the BHO's web site at least twenty-four (24) hours in advance of the meeting.

7.4 Record Date. For the purpose of determining the Executive Committee representatives entitled to notice of or to vote at any meeting of the Executive Committee or any adjournment thereof, the date on which notice of the meeting is mailed or the date on which the resolution declaring such distribution is adopted, as the case may be, shall be the record date for such determination. When a determination of representatives entitled to vote at any meeting of the Executive Committee has been made as provided in this Section, such determination shall apply to any adjournment thereof.

7.5 Quorum. A Majority Interest represented in person shall constitute a quorum at any meeting of the Executive Committee. In the absence of a quorum at any such meeting, the meeting may be adjourned as allowed by and pursuant to RCW 42.30.090. The Executive Committee representatives present at a duly organized meeting may continue to transact business until adjournment, notwithstanding the withdrawal during such meeting of that number of Units whose absence would cause less than a quorum. Any meeting may be continued as allowed by and pursuant to RCW 42.30.100.

7.6 Manner of Acting. If a quorum is present, the affirmative vote of representatives from the Executive Committee holding more than fifty percent (50%) of the Units represented at the meeting in person or by proxy shall be the act of the Executive Committee and of the County Authorities, unless the vote of a greater or lesser percentage is required by this Agreement or the Act.

7.7 Proxies. At all meetings of the Executive Committee a representative may only vote in person in a session of the meeting open to the public; no proxies or secret voting shall be permitted. Notwithstanding the foregoing, as provided for in Section 5.1, Executive Committee representatives may delegate other representatives from their County Authority County to attend Executive Committee meetings.

7.8 No Action by County Authorities Without a Meeting. No action required or permitted to be taken at a meeting of the Executive Committee may be taken without a meeting.

7.9 Waiver of Notice. When any notice is required to be given to a County Authority, a waiver thereof in writing signed by the County Authority entitled to such notice, whether before, at, or after the time stated therein, shall be equivalent to the giving of such notice.

7.10 Failure to Observe Formalities. Pursuant to RCW 25.15.060, notwithstanding anything herein to the contrary, this Agreement does not expressly require the County Authorities to hold any meetings and the failure to observe any formalities requiring the calling or conduct of any meeting shall not be considered a factor tending to establish personal liability of the County Authorities; provided that this provision shall not be construed to permit actions in violation of RCW Chapter 42.30.

ARTICLE 8
CONTRIBUTIONS TO THE BHO AND CAPITAL ACCOUNTS

8.1 County Authorities' Initial Capital Contributions. Each County Authority's initial Capital Contribution shall consist of its respective pro rata share of the assets of North Sound Regional Support Network. All Capital Contributions, if any, shall be made prorata, based on each County Authority's respective Percentage Interest.

8.2 Additional Capital Contributions. Each County Authority shall be required to make such additional Capital Contributions as shall be determined by a unanimous vote of the Executive Committee as necessary to meet the expenses of the BHO. All such Capital Contributions, if any, shall be made prorata, based on each County Authority's respective Percentage Interest.

The Executive Committee shall give written notice to each County Authority of the amount of any required additional Capital Contribution, and each County Authority shall pay to the BHO such additional Capital Contribution no later than thirty (30) days following the date such notice is given. Nothing contained in this Section 8.2 is or shall be deemed to be for the benefit of any Person other than the County Authorities and the BHO, and no such Person shall under any circumstances have any right to compel any actions or payments by the County Authorities.

8.3 Capital Accounts.

8.3.1 Establishment and Maintenance. A separate Capital Account will be maintained for each County Authority throughout the term of the BHO. Each County Authority's Capital Account will be increased by (1) the amount of money contributed by such County Authority to the BHO; and (2) the fair market value of property contributed by such County Authority to the BHO (net of liabilities secured by such contributed property that the BHO is considered to assume.

8.3.2 Compliance with Regulations. The manner in which Capital Accounts are to be maintained pursuant to this Section 8.3 is intended to comply with the requirements of Code Section 704 (b) and the Regulations promulgated thereunder. If in the opinion of the BHO's legal counsel or auditors the manner in which Capital Accounts are to be maintained pursuant to the preceding provisions of this Section 8.3 should be modified in order to comply with Code Section 704 (b) and the Regulations thereunder, then notwithstanding anything to the contrary contained in the preceding provisions of this Section 8.3, the method in which Capital Accounts are maintained shall be so modified; provided, however, that any change in the manner of maintaining Capital Accounts shall not materially alter the economic agreement between or among the County Authorities.

ARTICLE 9 -- ACCOUNTING, BOOKS, AND RECORDS

9.1 Accounting Methods. The BHO's books and records shall be kept, and its financial statements prepared, under such permissible methods of accounting, consistently applied, as the Executive Committee determines is in the best interest of the BHO and its County Authorities and in full compliance with record-keeping and accounting methods required by Washington law and/or the Washington State Auditor and in compliance with the requirements of any state or federal program providing funding or other support for the BHO's programs and services.

9.2 Budget. The NSBHO Administrator shall prepare, and the Executive Committee shall consider and adopt, an annual budget reflecting proposed revenues and expenditures for the next fiscal year no later than December 1, of each preceding fiscal year.

9.3 Disbursements. Funds received by contract from the DSHS shall be disbursed according to the budget as approved. Vouchering and reimbursement procedures shall be developed in accordance with relevant regulations and approved equitable allocation formulas.

9.4 Funds and Audit. Funds provided to the BHO from all sources shall be maintained as a separate fund in the Skagit County Treasury or other County Treasury as designated by the BHO's Executive Committee. Such funds shall be designated as the Operating Fund of the BHO per RCW 39.34.030(4)(b) in the Skagit County Treasury or other County Treasury as determined by the Executive Committee. These monies shall be subject to the same audit and fiscal controls as other funds held by the designated County Treasury. Interest on investment of the BHO's funds shall accrue to the benefit of the BHO.

9.5 Interest on and Return of Capital Contributions. No County Authority shall be entitled to interest on its Capital Contribution or to return of its Capital Contribution, except as otherwise specifically provided for herein.

9.6 Accounting Period. The BHO's fiscal year shall be January 1 through December 31.

9.7 Records, Audits and Reports. At the expense of the BHO, the NSBHO Administrator shall maintain records and accounts of all operations and expenditures of the BHO. All records shall be maintained and be available to the public pursuant to RCW Chapter 42.56, RCW Chapter 70.02, the Health Insurance Portability and Accountability Act ("HIPAA"), PL 104-191, as amended and retained pursuant to retention requirements as set forth in RCW Title 40, WAC 434 and schedules established by the Washington Secretary of State, all as may be amended from time to time. At the minimum the BHO shall keep at its principal place of business the following records:

(a) A current list and past list, setting forth the full name and contact information for each County Authority and each County Authority representative serving on the Executive Committee;

(b) A current list and past list, setting forth the full name and contact information for each representative sitting on the Advisory Board;

(c) A copy of the Certificate of Formation and all amendments thereto;

(d) Copies of this Agreement and all amendments hereto;

(e) Minutes of the County Authority meeting and any written consents obtained from County Authorities for actions taken by County Authorities without a meeting; and

(f) Copies of the BHO's financial statements for the seven (7) most recent years.

ARTICLE 10 -- TRANSFERABILITY

10.1 General. Except as otherwise expressly provided in this Agreement, a County Authority shall not have the right to:

(a) Sell, assign, transfer, exchange or otherwise transfer for consideration, (collectively, "sell" or "sale"); or

(b) Pledge, encumber or otherwise use all or part of its County Authorities Interest in the BHO as security for a loan or other obligation.

ARTICLE 11 -- DISSOLUTION AND TERMINATION

11.1 Dissolution. The BHO shall be dissolved upon the unanimous vote of the County Authorities of the BHO held at the time of the vote.

11.2 Winding Up, Liquidation and Distribution of Assets. Upon dissolution, the Executive Committee shall immediately proceed to wind up the affairs of the BHO. The Executive Committee shall sell or otherwise liquidate all of the BHO's assets as promptly as practicable (except to the extent the Executive Committee may determine to distribute any assets to the County Authorities in kind) and shall apply the proceeds of such sale and the remaining BHO assets in the following order of priority:

11.2.1 Payment of creditors, to the extent otherwise permitted by law, in satisfaction of liabilities of the BHO;

11.2.2 To establish any reserves that the Executive Committee deems reasonably necessary for contingent or unforeseen obligations of the BHO and, at the expiration of such period as the Executive Committee shall deem advisable, the balance then remaining in the manner provided in Section 11.3.3 below;

11.2.3 By the end of the fiscal year in which the liquidation occurs (or, if later, within ninety (90) days after the date of such liquidation), to the County Authorities in proportion to the positive balances of their respective Capital Accounts, as determined after taking into account all Capital Account adjustments for the taxable year during which the liquidation occurs (other than those made pursuant to this Section 11.3.3).

11.3 Termination. The Executive Committee shall comply with any applicable requirements of applicable law pertaining to the winding up of affairs of the BHO and the final distribution of its assets. Upon completion of the winding up, liquidation and distribution of the assets, the BHO shall be deemed terminated.

11.4 Certificate of Cancellation. When all debts, liabilities and obligations have been paid and discharged or adequate provisions have been made therefor and all of the remaining property and assets have been distributed to the County Authorities, the Executive Committee shall file a certificate of cancellation as required by RCW 25.15.080. Upon filing the certificate of cancellation, the existence of the BHO shall cease, except as otherwise provided in the LLC Act.

11.5 Return of Contribution Nonrecourse to Other County Authorities. Except as provided by law or as expressly provided in this Agreement, upon dissolution each County Authority shall look solely to the assets of the BHO for the return of its Capital Contributions, if any. If the property remaining after the payment or discharge of liabilities of the BHO is insufficient to return the contributions to the County Authorities, no County Authority shall have recourse against any other County Authority, the BHO or NSBHO Administrator.

ARTICLE 12 -- MISCELLANEOUS PROVISIONS

12.1 Notices. Any notice, demand, or communication required or permitted under this Agreement shall be deemed to have been duly given if delivered personally to the party to whom directed or, if mailed by registered or certified mail, postage and charges prepaid, addressed: (a) if to a County Authority, to the County Authority's address specified in the attached **Exhibit A**; (b) if to the BHO, to the address specified in Section 2.3; and (c) if to the NSBHO Administrator to the address specified in Section 2.3. Except as otherwise provided herein, any such notice shall be deemed to be given when personally delivered or, if mailed, three (3) business days after the date of mailing. A County Authority, the BHO or the NSBHO Administrator may change its address for the purposes of notices hereunder by giving notice to the others specifying such changed address in the manner specified in this Section 12.1. Notwithstanding the foregoing with respect to ordinary communications between the County Authorities, the Executive Committee representatives and the NSBHO Administrators communication via email is permitted.

12.2 Governing Law. This Agreement shall be construed and enforced in accordance with the laws of the State of Washington.

12.3 Amendments. This Agreement may not be amended except by the written agreement of all the County Authorities holding a County Authorities Interest in the BHO.

12.4 Construction. Whenever the singular number is used in this Agreement and when required by the context, the same shall include the plural and vice versa, and the masculine gender shall include the feminine and neuter genders and vice versa.

12.5 Headings. The headings in this Agreement are inserted for convenience only and shall not affect the interpretations of this Agreement.

12.6 Waivers. The failure to seek redress for violation of or to insist upon the strict performance of any covenant or condition of this Agreement shall not prevent a subsequent act, which would have originally constituted a violation, from having the effect of an original violation.

12.7 Rights and Remedies Cumulative. The rights and remedies provided by this Agreement are cumulative and the use of any one right or remedy shall not preclude or waive the right to use any or all other remedies. Said rights and remedies are given in addition to any other rights the parties may have by law, statute, ordinance or otherwise.

12.8 Severability. If any provision of this Agreement or the application thereof to any Person or circumstance shall be invalid, illegal or unenforceable to any extent, the remainder of this Agreement and the application thereof shall not be affected and shall be enforceable to the fullest extent permitted by law.

12.9 Successors and Assigns. Each of the covenants, terms, provisions and agreements herein contained shall be binding upon and inure to the benefit of the parties hereto and, to the extent permitted by this Agreement, their respective legal representatives, successors and assigns.

12.10 Creditors/Third Parties. None of the provisions of this Agreement shall be for the benefit of or enforceable by any of the creditors of the BHO or any third parties.

12.11 Counterparts. This Agreement may be executed in counterparts, each of which shall be deemed an original and all of which shall constitute one and the same instrument.

12.12 Investment Representations. The Units have not been registered under the Securities Act of 1933, the Securities Act of Washington or any other state securities laws (collectively, the "Securities Acts"). Each County Authority hereby confirms the Units have been acquired for such County Authority's own account, for investment and not with a view to the resale or distribution thereof and may not be offered or sold to anyone unless there is an effective registration or other qualification relating thereto under all applicable Securities Acts.

Executed by the undersigned County Authorities effective as of the date first above written.

COUNTY AUTHORITIES:

ISLAND COUNTY

By: _____
Its: _____

Approved as to form:

By: _____
_____, Prosecuting Attorney

SAN JUAN COUNTY

By: _____
Its: _____

Approved as to form:

By: _____
_____, Prosecuting Attorney

SKAGIT COUNTY

By: _____
Its: _____

Approved as to form:

By: _____
_____, Prosecuting Attorney

SNOHOMISH COUNTY

By: _____
Its: _____

Approved at to form:

By: _____
_____, Prosecuting Attorney

WHATCOM COUNTY

By: _____
Its: _____

Approved as to form:

By: _____
_____, Prosecuting Attorney

EXHIBIT A

COUNTY AUTHORITY INFORMATION

AS OF _____, 2016

Names and Addresses of County Authorities	Units	Percentage Interest
Island County 1 NE 7th St #214 Coupeville, WA 98239	1	11.111111%
San Juan County 55 2nd St N #1 Friday Harbor, WA 98250	1	11.111111%
Skagit County 1800 Continental Pl #100 Mount Vernon, WA 98273	1	11.111111%
Snohomish County 3000 Rockefeller Ave., M/S 609 Everett, WA 98201	4	44.4444444%
Whatcom County 311 Grand Avenue, Suite 105 Bellingham, WA 98225	2	22.222222%

FURLONG ❖ BUTLER
ATTORNEYS

BRADFORD E. FURLONG
EILEEN E. BUTLER
LAURA MINTON BRECKENRIDGE

JENNIFER A. LEE, Legal Assistant
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October 8, 2015

VIA EMAIL ONLY

Royce Buckingham
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Whatcom County
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Jon Cain
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San Juan County
PO Box 760
Friday Harbor, WA 98250

Rebecca Wendling
Deputy Prosecuting Attorney
Snohomish County
3000 Rockefeller, MS 504
Everett, WA 98201

Melinda Miller
Chief Civil Deputy Prosecuting Attorney
Skagit County
700 S 2nd Street, Suite 202
Mount Vernon, WA 98273

RE: North Sound Mental Health Administration
Conversion to Behavioral Health Organization

Greetings:

As was discussed when we met in Mount Vernon on June 30th, during its 2014 Legislative Session, the Washington Legislature passed S.B. 6312, Chapter 225 Laws of 2014, which substantially expanded the scope of services for regional support networks challenging existing RSNs to convert into "behavioral health organizations" ("BHO") charged with the delivery of both mental health and chemical dependency service. North Sound Mental Health Administration has been working towards submitting a plan to DSHS to undertake full BHO services on April 1, 2016.

Since 1996 NSMHA has operated under an interlocal agreement between the five northwest counties. The interlocal did not expressly create NSMHA as any particular type of entity. We believe that NSMHA could very likely be deemed a general partnership, with each county a general partner, were a court to rule on the matter. The interlocal also has certain limitations and omissions. The BHO conversion therefore presents an excellent opportunity to convert NSMHA into a recognizable, commonly accepted entity – a limited liability company.

825 CLEVELAND AVENUE, MOUNT VERNON, WASHINGTON 98273 ❖ TELEPHONE 360.336.6508 FACSIMILE 360.336.3318 ❖ WWW.FURLONGBUTLER.COM

The limited liability company form of entity is specifically authorized for governmental units working together under the Washington Interlocal Cooperation Act by RCW 39.34.030 (3)(b). Additionally, RCW 25.15.417, *et seq*, allows an "organization" such as NSMHA to seamlessly convert to a limited liability company. This conversion will not only provide the member counties a degree of liability insulation for future acts and omissions, it may also provide protection from past acts, pre-dating the conversion. Since approved for use in Washington in 1994, limited liability companies have proven to be an excellent entity choice, providing certainty in the formation, accounting, ownership, operations, governance and winding up for businesses, both privately and publicly owned. Moreover, operating agreements, the foundation of limited liability company organizational documents, are flexible and may be adopted to a variety of uses, including the instant use.

We have prepared the documents needed to convert NSMHA into a limited liability company - "North Sound Behavioral Health Organization, LLC" - effective January 1, 2016. Additionally, we have prepared an Operating Agreement, in which all five counties will be members, for the limited liability company that would replace the interlocal agreement now in place. While we carried over into the new Operating Agreement the basic terms of governance under which NSMHA has operated for nearly twenty years, the new Operating Agreement defines the members of the organization and their rights and responsibilities, provides important tools to allow the organization to meet challenges that lie ahead, assures proper accounting of the organization's assets and the counties' individual interests in the organization and prescribes, if needed, an orderly process to wind up the organization's affairs.

We wrote to you on September 2, 2015, and explained the Division of Behavioral Health and Recovery ("DBHR") had raised questions about the use of a limited liability company to form a BHO. Modifications made to Section 6.2 of the draft Operating Agreement adequately address DBHR's concerns. These changes leave in place the individual counties' financial responsibility to DBHR in the unlikely event the BHO is unable to meet a financial obligation to DBHR under a future agreement. While we would have preferred to eliminate this exposure for the counties, it is likely no different than the counties' existing exposure to DBHR – and, importantly, it should be noted the LLC still will afford insulation to the counties for debts and liabilities of the BHO to other third persons or entities.

In anticipation of the conversion, we have prepared and will file with the Secretary of State documents reserving to NSMHA the future use of the name North Sound Behavioral Health Organization, LLC. The filing of these documents does not commit NSMHA or any county to the conversion process; it simply reserves the name for use if all counties agree to move ahead.

With the foregoing in mind, we have enclosed for your review the following documents:

1. Coversheet for Conversion of Business Entity;
2. Plan of Conversion;
3. Articles of Conversion;
4. Certificate of Formation; and
5. Joint County Authority BHO Operating Agreement.

The NSMHA Board of Directors approved these documents at its meeting on October 8, 2015. Although approval by the NSMHA Board and its decision to recommend conversion to a limited liability company is an important first step on the path to that conversion, each county must ultimately approve and execute these documents. We ask, therefore, that you please review these documents and provide to us your comments, questions or suggestions by October 31, 2015 to allow sufficient time for any changes and approval by each county by December 1, 2015. It remains NSMHA's firm objective to file the conversion documents in December 2015 and to commence operations as a limited liability company on January 1, 2016. When you respond with comments, please provide to us the appropriate form for your county's particular signature block.

In the meantime, should you have any questions or comments, please feel free to call or send an email to either Laura Minton Breckenridge, lmb@furlongbutler.com or Brad Furlong, bef@furlongbutler.com. We will be happy to review any aspect of the conversion process, or these documents, with you.

We appreciate your anticipated cooperation and look forward to working with you on this matter.

FURLONG ✦ BUTLER
ATTORNEYS

Sincerely,

BRADFORD E. FURLONG, WSBA #12924

LAURA MINTON BRECKENRIDGE, WSBA #16140

BEH/smh

cc: Joe Valentine

North Sound RHA
BHO Workgroup
Introduction to Fiscal Planning

DALE JARVIS
& ASSOCIATES, LLC

60 Minutes of Excitement

- What Do We Know About The Current System Clinical/ Financial Modeling
- Overview of the NSMHA Flight Simulator
- Overview of the 3-Step Rate Development Process
- Q&A as we go

Data from the 2014 Gap Analysis

- The Gap Analysis has been completed for the Washington State Legislature and is based on population and enrollment data, served data from the SCOPE system, and need data from the DSHS RDA based on claims and pharmacy data and DUI arrest records.
- The DBHR Report had Skagit has Out of County Residential mixed into the Served and Revenue figures; estimates have been made to adjust these adds out.
- The average PMPM data is from the Mercer Actuarial Study and FY2014 Medicaid Revenue was provided by DBHR.

Data from the 2014 Gap Analysis

North Sound RSA 2014 Substance Use Disorder Gap Analysis

	Island	San Juan	Skagit	Snohomish	Whatcom	North Sound Total
Medicaid Enrollees						
Youth	5,018	1,237	15,615	62,911	19,663	104,444
Adults	8,424	2,142	18,925	90,990	31,303	151,784
Total	13,442	3,379	34,540	153,901	50,966	256,228
Uninsured <200% FPL						
Youth	942	169	2,376	11,693	5,141	20,321
Adults	829	149	1,212	10,862	4,936	17,988
Total	1,771	318	3,588	22,555	10,077	38,309
Total Safety Net	15,213	3,697	38,128	176,456	61,043	294,537

Data from the 2014 Gap Analysis

North Sound RSA 2014 Substance Use Disorder Gap Analysis

	Island	San Juan	Skagit	Snohomish	Whatcom	North Sound Total
Substance Use Disorder Service Need						
Medicaid	1,721	433	4,421	19,699	6,524	32,797
Uninsured <200%	227	41	459	2,887	1,290	4,904
Total	1,947	473	4,880	22,586	7,814	37,701
Number of Persons Receiving Substance Use Disorder Services						
Detox	2	9	491	978	455	1,935
Outpatient	141	67	599	2,481	1,412	4,700
Intensive Outpatient	139	66	953	1,355	237	2,750
Opiate Substitution Tx	0	0	0	1,184	353	1,537
Residential**	2	0	63	102	30	197
Inpatient	15	1	88	199	218	521
Recovery House	0	0	121	1	40	162
Total	299	143	2,315	6,300	2,745	11,802
Penetration Rate	2.2%	4.2%	6.7%	4.1%	5.4%	4.6%
Substance Use Disorder Service Gap						
Unserved	1,648	330	2,565	16,286	5,069	25,899
Percent of Need Met	15%	30%	47%	28%	35%	31%

Data from the 2014 Gap Analysis

Washington State 2014 Substance Use Disorder Revenue Analysis

	Island	San Juan	Skagit	Snohomish	Whatcom	North Sound Total
FY2014 Revenue Analysis						
Medicaid**	$278,811	$111,783	$2,557,254	$10,140,020	$2,657,793	$15,700,000
Non-Medicaid**	$57,452	$29,828	$1,327,429	$1,789,415	$2,647,204	$5,900,000
Total	$336,263	$141,611	$3,884,683	$11,929,435	$5,304,997	$21,600,000
Medicaid %	83%	79%	66%	85%	50%	73%
June 2014 Medicaid Enrollees	13,442	3,379	34,540	153,901	50,966	256,200
Average PMPM, 4/1/2016	$7.94	$7.94	$7.94	$7.94	$7.94	
Medicaid Revenue 4/1/16-3/31/17	$1,280,754	$321,951	$3,290,971	$14,663,687	$4,856,040	$24,400,000
Medicaid Revenue FY2014	$278,811	$111,783	$2,557,254	$10,140,020	$2,657,793	$15,700,000
Increase in CD Medicaid Revenue	$1,001,943	$210,168	$733,717	$4,523,667	$2,198,247	$8,700,000
Percentage Increase	359%	188%	29%	45%	83%	55%

Overview of the NSMHA Flight Simulator

- Shift Over to Excel…

North Sound BHO Planning Flight Simulator
Substance Use Disorder Cost and Utilization Model

Part I. Service Demand Estimates	Preview Scenario Year 1	Year 2	Year 3
Medicaid Enrollees			
Youth	104,444	105,802	107,177
Adults	151,784	153,757	155,756
Total	256,228	259,559	262,933
Substance Use Disorder Prevalence Estimate (based on national prevalence data)			
Youth	2.2%	2.2%	2.2%
Adults	20.1%	20.1%	20.1%
Total	12.8%	12.8%	12.8%
Estimated Medicaid Need			
Youth	2,298	2,328	2,358
Adults	30,509	30,905	31,307
Total	32,806	33,233	33,665
Estimated Medicaid Access Rate			
Youth Access Rate	30%	40%	50%
Adult Access Rate	30%	40%	50%
Youth Admissions	689	931	1,179
Adults Admissions	9,153	12,362	15,653
Total Admissions	9,842	13,293	16,832
Penetration Rate	3.8%	5.1%	6.4%

Overview of the 3-Step Rate Development Process

- Note: The following examples are from the 2013 SWBH Mental Health Rate Study.
- Question 1: What are the Current Costs per Hour?

Line Item	Psychiatrist	Nurse Practitioner	Registered Nurse	Masters Level	Bachelors Level	Peer Counselor	Average
Salary per FTE	$145,731	$84,550	$46,307	$36,689	$31,148	$27,220	$36,969
Salary per Work Hour	$83.51	$48.45	$26.54	$21.03	$17.85	$15.60	$21.19
Benefits %	25.1%	25.1%	25.1%	25.1%	25.1%	25.1%	
Salary/Benefits per Work Hour	$104.48	$60.61	$33.20	$26.30	$22.33	$19.51	$26.50
Contract Cost per Work Hour	$139.99	$78.00	$0.00	$49.15	$20.00	$0.00	
Clinical Comp per Work Hour	$114.30	$61.87	$33.20	$26.57	$22.32	$19.51	$26.50
Other Cost % of Clinical Comp	24%	43%	69%	99%	127%	124%	103.9%
Other Costs per Work Hour	$27.13	$26.79	$23.06	$26.33	$28.34	$24.15	$27.53
Total Cost per Work Hour	$141.43	$88.67	$56.26	$52.91	$50.66	$43.67	$54.04
Productivity	64%	55%	55%	55%	58%	54%	57%
Productive Hours per Year/FTE	1,117	952	960	957	1,017	939	992
Total Cost per Hour	$220.98	$162.57	$102.28	$96.48	$86.88	$81.15	$94.91
Clinician Mix *	2.1%	2.3%	3.4%	33.7%	53.5%	5.0%	100.0%

North Sound BHO Detailed Plan

Overview of the 3-Step Rate Development Process

- Question 2: How do Salaries, Benefits, and Overhead Compare to Market?

Gap Analysis Key Metrics	Provider Network	Market/ Benchmark	Difference	Difference %
Clinician Salaries (per hour)	$21.06	$25.09	-$4.03	-16.1%
Fringe Benefits/Payroll Taxes	23.4%	25.7%	-2.4%	-9.2%
Infrastructure/Overhead % of Clinician Comp	77.1%	108.8%	-31.6%	-29.1%
Clinician Direct Service Hours	912	928	(16)	-1.7%
Months in Working Capital	1.38	3.00	(1.62)	-54.0%

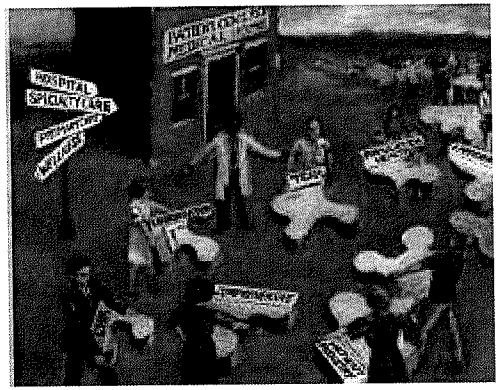
Overview of the 3-Step Rate Development Process

- Question 3: How much of the Gap can we close between Current Rates, Current Costs, and the Market?

Line Item	Psychiatrist	Nurse Practitioner	Registered Nurse	Masters Level	Bachelors Level	Peer Counselor
Variable 1: Salaries						
Current Salary	$145,731	$84,550	$46,307	$36,689	$31,148	$27,220
OR Tri-Co Salary Comparisons	$179,916	$87,151	$66,816	$38,792	$32,884	$27,186
Difference	$34,185	$2,601	$20,510	$2,104	$1,736	-$35
Difference %	23%	3%	44%	6%	6%	0%
Model Change	19%	0%	40%	2%	2%	0%
Revised Salary	$174,087	$84,550	$64,964	$37,325	$31,638	$27,220
Revised Hourly	$83.70	$40.65	$31.23	$17.94	$15.21	$13.09
Assumptions	Used Oregon Tri-County Comparison less 4% Income Tax					

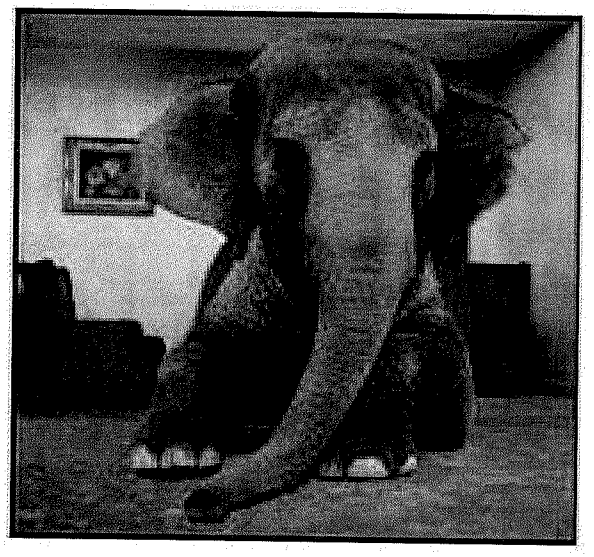
North Sound RHA BHO Workgroup

Session 2, May 1, 2015



Today's Agenda

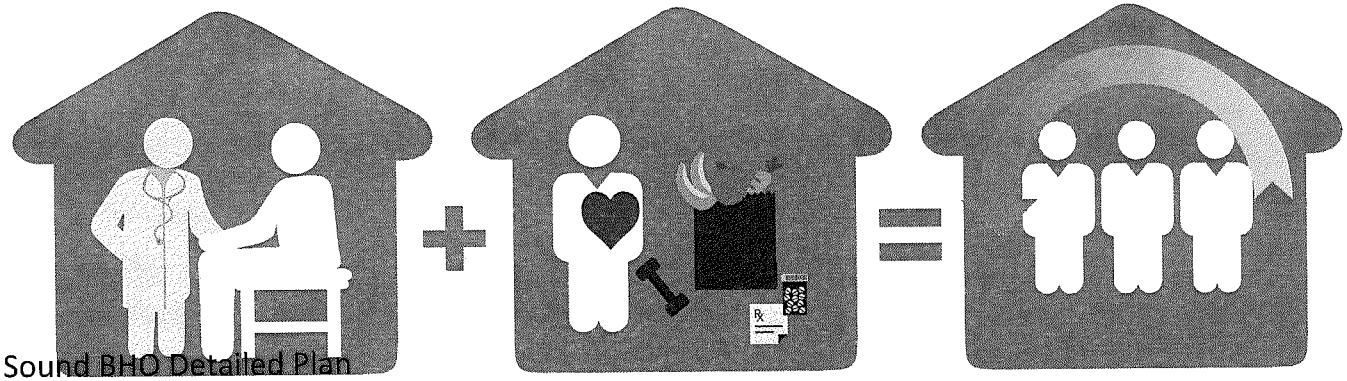
- Overview
- Financial Modeling Quick Review
- BHO Substance Abuse Service Array and Client Flow
- Service Array Discussions, Parts 1 and 2
- What are the "Elephants in the Living Room"?
- System Supports
- Where is the "Change Energy"?
- Next Steps



The Near Future

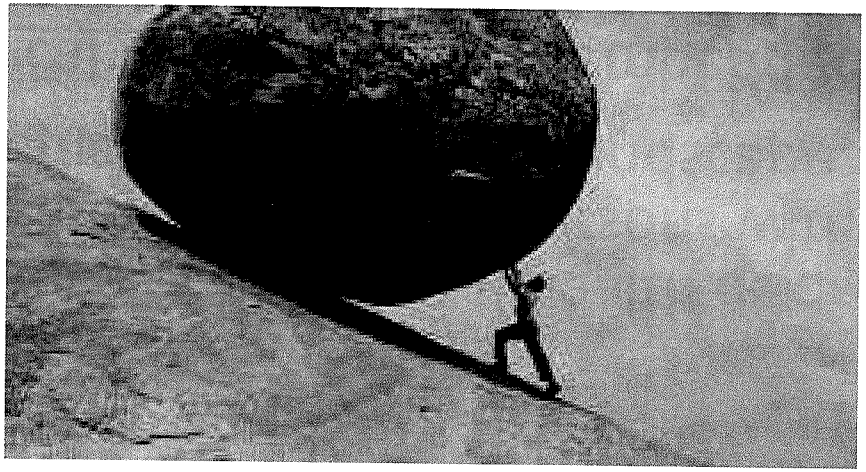
Wide recognition of the prevalence of behavioral health disorders (MH/SUD/COD) and the high healthcare costs of persons with behavioral health disorders is rapidly changing the landscape.

- Behavioral health inside medical homes—deeply embedded in primary care team, prevention and early intervention, addressing behaviors as well as disorders
- Behavioral health specialty centers of excellence, partnering with medical homes to provide high-value, whole-health care to people with complex conditions
- Community-based prevention, early intervention, and treatment services in a variety of settings (schools, supportive housing, youth centers, etc.)



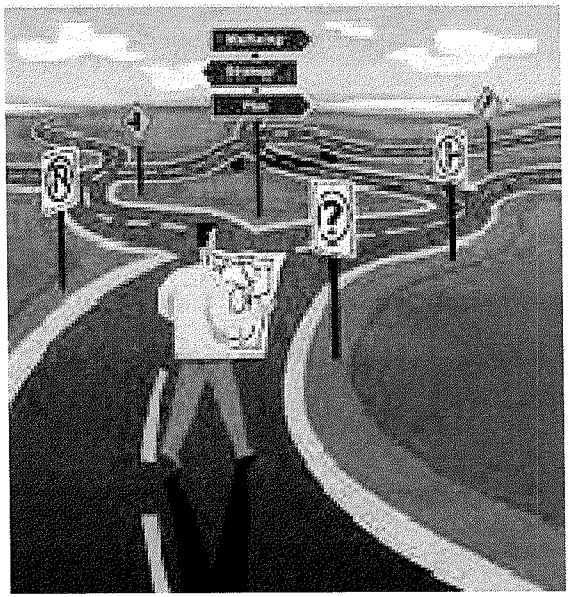
Major Challenges

- Dramatic underfunding
- Acute (versus chronic) orientation
- Denial
- Poor pay
- Poor business infrastructure
- Loss of residential capacity
- Stigma and discrimination
- Abstinence-only approaches
- Lack of services
- Lack of workforce
- Disconnect with trauma



Major Opportunities: Hold These Thoughts Throughout the Day

- Medicaid Expansion + Medicaid Parity = New Money
- Major push: integrated funding + integrated care.
- We need to "hold the vision" while taking one prioritized step at a time.
- Need: simultaneously build Service Capacity + System Supports/Infrastructure



Remember Last Meeting?

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Percentage Increase	359%	188%	29%	45%	83%	55%

The latest CD Revenue Estimates show a further increase of approximately $1,000,000

Remember Last Meeting?

- We're developing a Cost/Utilization Model

North Sound BHO Planning Flight Simulator
Substance Use Disorder Cost and Utilization Model

Preview Scenario

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Remember Last Meeting?

- We're setting new payment rates, taking into consideration what it *should cost* to provide high quality services.

(example from Southwest Behavioral Health RSN)

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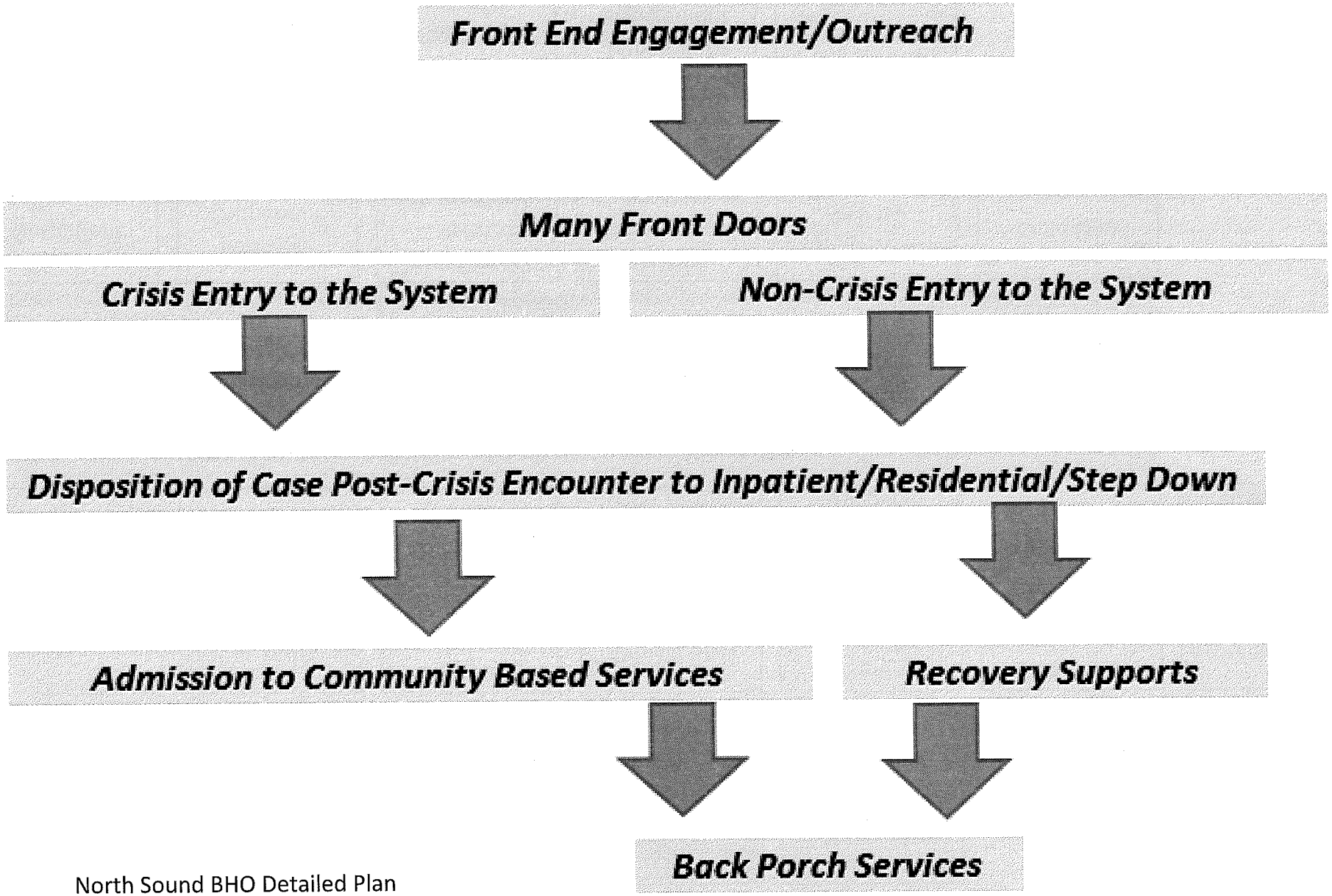
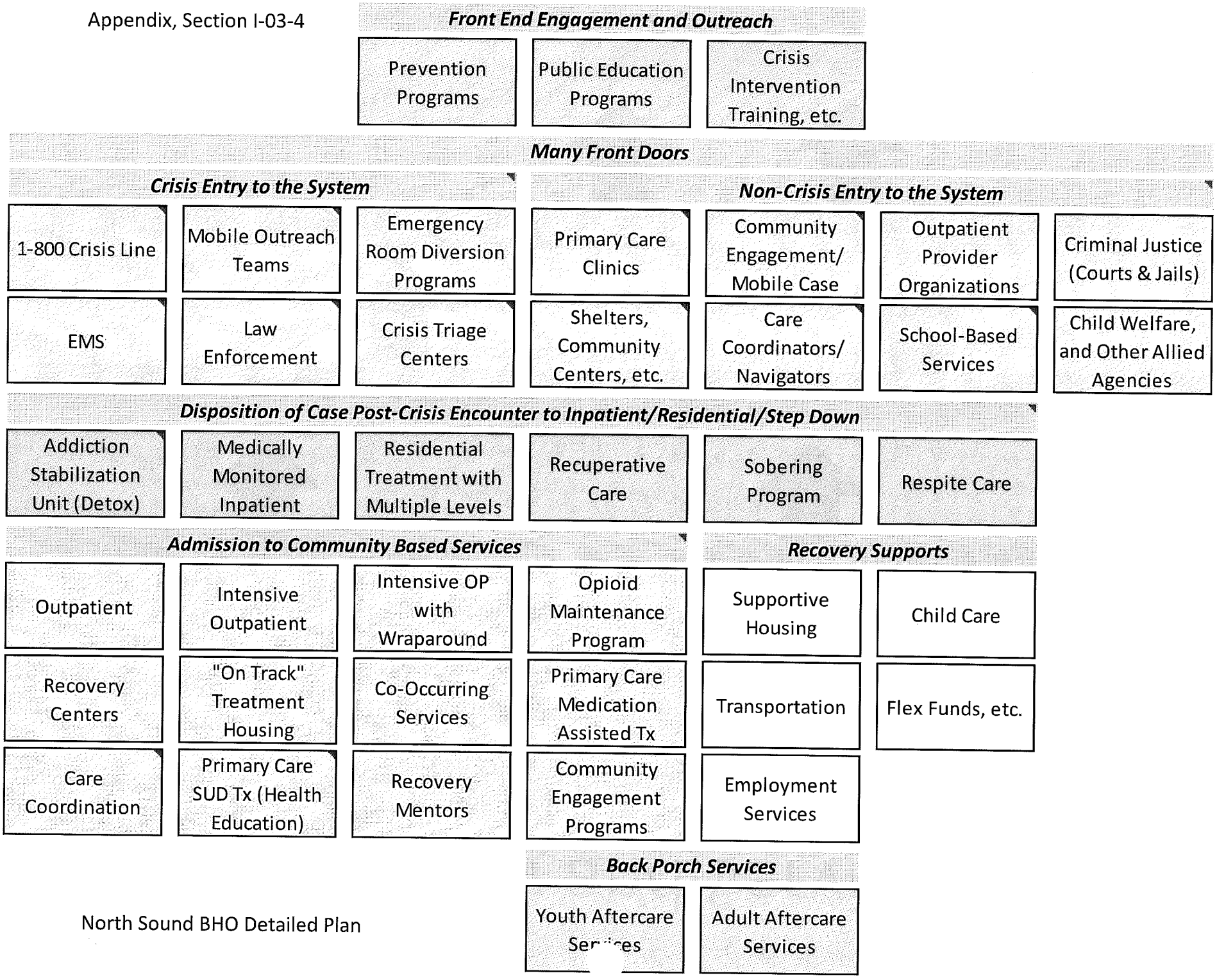
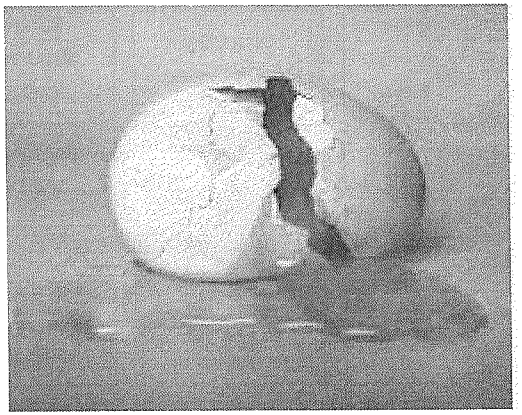
Draft Client Flow and Service Array




Front End Engagement and Outreach
Prevention Programs
Public Education Programs
Crisis Intervention Training, etc.
Many Front Doors
Crisis Entry to the System
Non-Crisis Entry to the System
1-800 Crisis Line
Mobile Outreach Teams
Emergency Room Diversion Programs
Primary Care Clinics
Community Engagement/ Mobile Case
Outpatient Provider Organizations
Criminal Justice (Courts & Jails)
EMS
Law Enforcement
Crisis Triage Centers
Shelters, Community Centers, etc.
Care Coordinators/ Navigators
School-Based Services
Child Welfare, and Other Allied Agencies
Disposition of Case Post-Crisis Encounter to Inpatient/Residential/Step Down
Addiction Stabilization Unit (Detox)
Medically Monitored Inpatient
Residential Treatment with Multiple Levels
Recuperative Care
Sobering Program
Respite Care
Admission to Community Based Services
Recovery Supports
Outpatient
Intensive Outpatient
Intensive OP with Wraparound
Opioid Maintenance Program
Supportive Housing
Child Care
Recovery Centers
"On Track" Treatment Housing
Co-Occurring Services
Primary Care Medication Assisted Tx
Transportation
Flex Funds, etc.
Care Coordination
Primary Care SUD Tx (Health Education)
Recovery Mentors
Community Engagement Programs
Employment Services
Back Porch Services
Youth Aftercare Services
Adult Aftercare Services

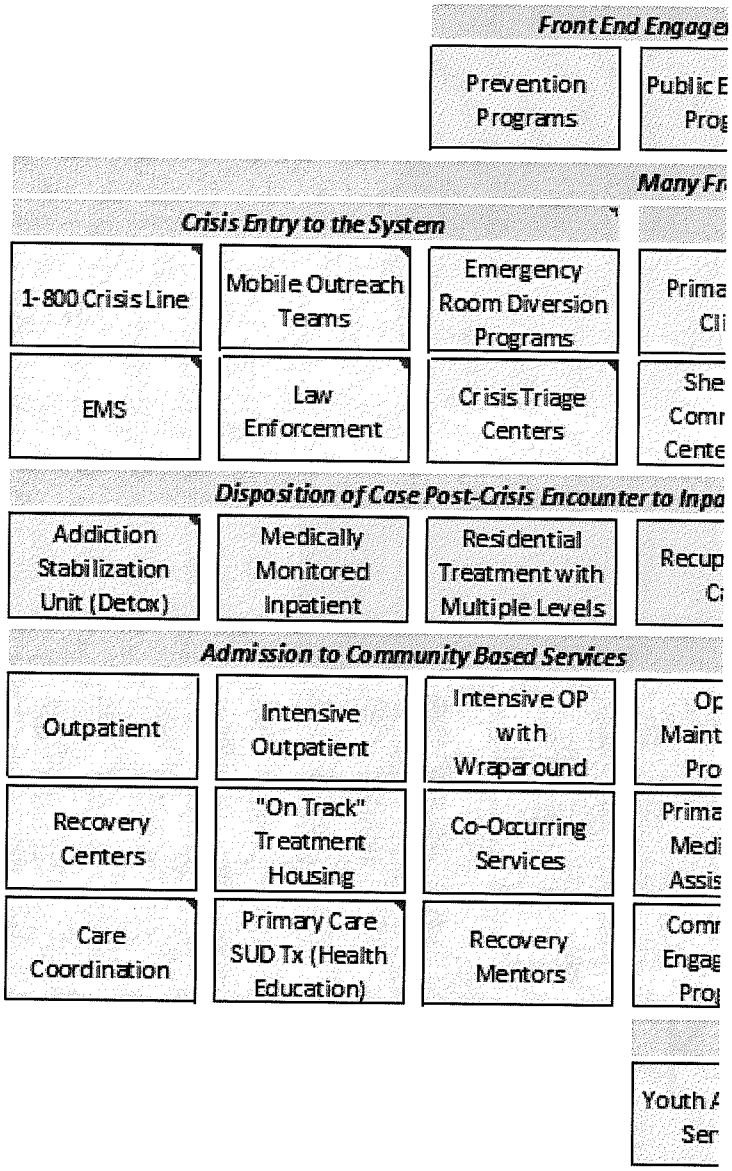
Individual and Small Group Work

- Individual Assignment
  - Take a few minutes to circle the services that aren't familiar to you.
- Small Group
  - Discuss the circled items
  - Write down questions you have about the circled items
- When Finished
  - Take a Break



Service Array Discussion Part 2

- Small Group Work
  1. What are the Services that ought to be in the array?
  2. What are the most important service gaps to address?
  3. What are the BHO-Medicaid funded components that should be prioritized for enhancement/expansion



Service Array Discussion Part 2

BHO Draft SUD Service Array Matrix (Services/ASAM Crosswalk)

Service	Prior ASAM Authorization-ASAM Level	No initial Auth- ASAM authorization for continued services	Other Medical Necessity Criteria	No Prior Auth required-services are reported to BHO	Future Service element-auth to be defined	Non-BHO service
1-800 Crisis Line (24/7)				x		
Mobile Outreach Teams				x		
Crisis Triage Centers		x	x			
Other Emergency Room Diversion Programs					x	
Primary Care & Community-Based SBIRT						x
Community Engagement/Mobile Case Management Teams		x		x	x	
School-Based Services						x
Addiction Stabilization Unit		1WM-2WM	x			
Medically Monitored Intensive Inpatient						?
Clinically Managed Residential	3.1-3.5					
Recuperative Care					x	
Sobering Program		x	x			
Outpatient	1					
Intensive Outpatient	2.1					
Intensive Outpatient with Wraparound	2.1					
[Medication Assisted Treatment]Opioid Maintenance Therapy	OTP L1					
Recovery Mentors					x	
Recovery Centers					x	
Primary Care-Based Outpatient						?
Primary Care-Based Medication Assisted Tx						?
Aftercare Services					x	
Supportive Housing			x			
Transportation, Flex Funds, Child Care, etc.			x			
Engagement Services				x		

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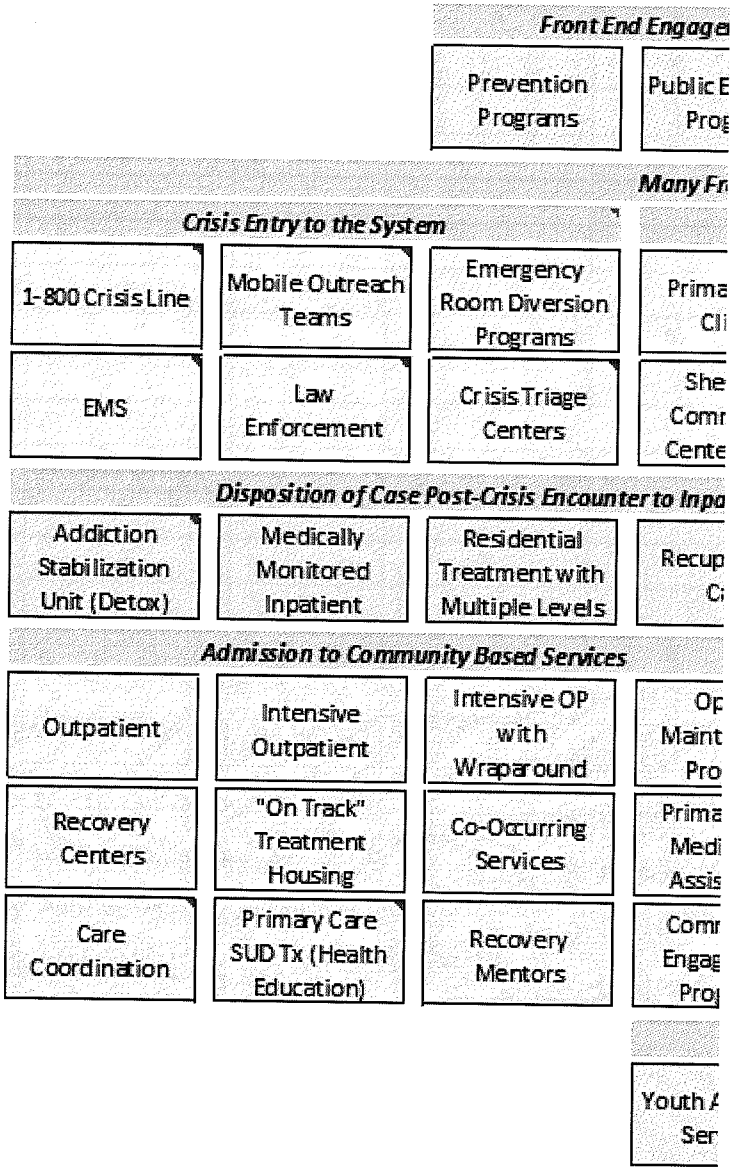
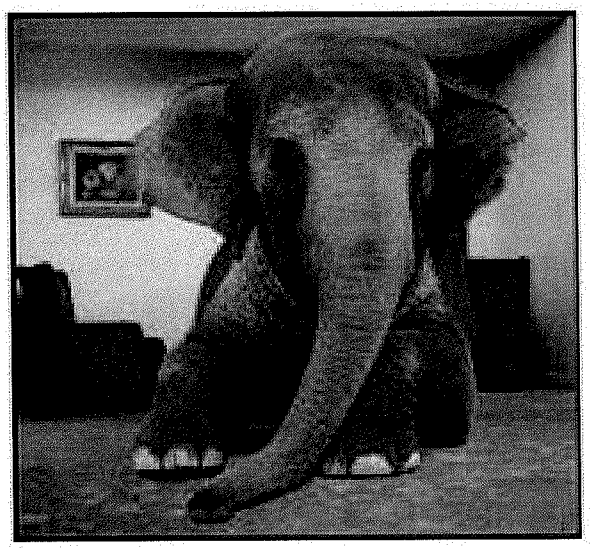


Elephants Discussion

- Small Group Work
  - Identify the major challenges or "elephants in the room" that need to be addressed.
  - Brainstorm possible solutions for the bigger elephants. *(P.s. feel free to look at System Supports on pages 9 and 10 for ideas)*



System Supports Discussion

- Center for Outcomes Based Care
- Coordination with Tribes
- Integrated Care
- Patient Registry Network
- Level of Care System
- Trauma Informed Care
- Business Practices Institute
- Workforce Development Initiative
- Housing First
- Vocational Supports
- Agency Technical Assistance
- Telehealth
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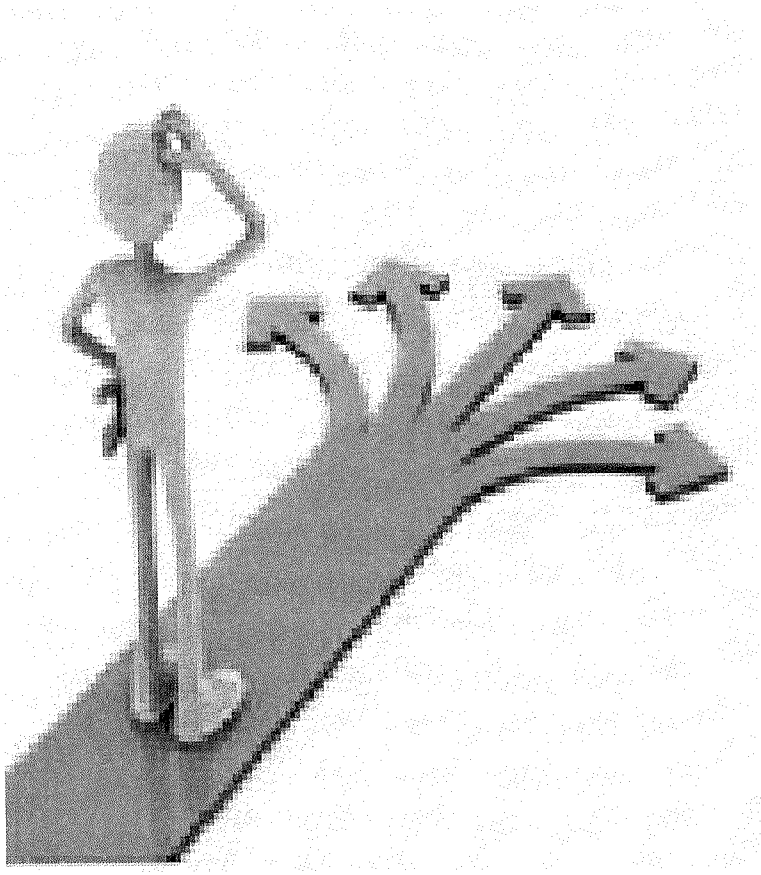
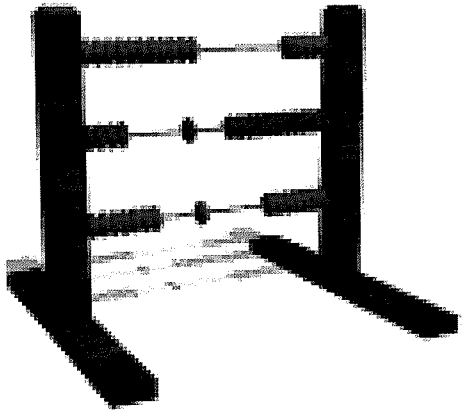
Change Energy – Year 1 Priorities

- Based on the discussion today, what should we prioritize for Year One for service components and funding priorities?

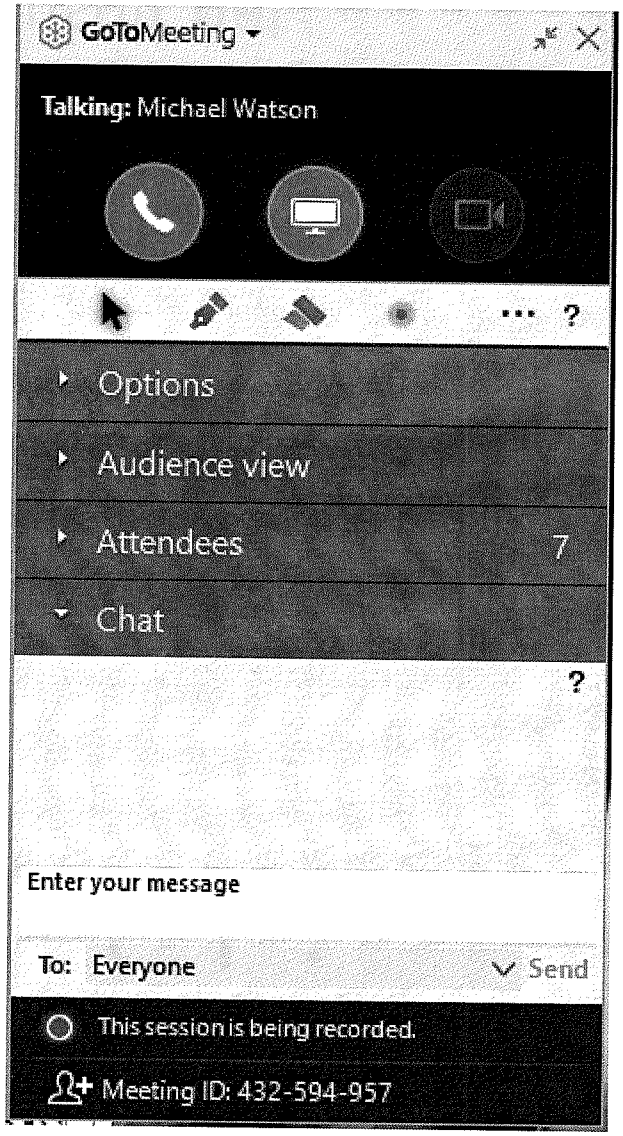


North Sound BHO Fiscal Workshop Webinar



Dale Jarvis, CPA
dale@djconsult.net

- Please feel free to ask questions or type them into the Chat window on your GoToMeeting pane.

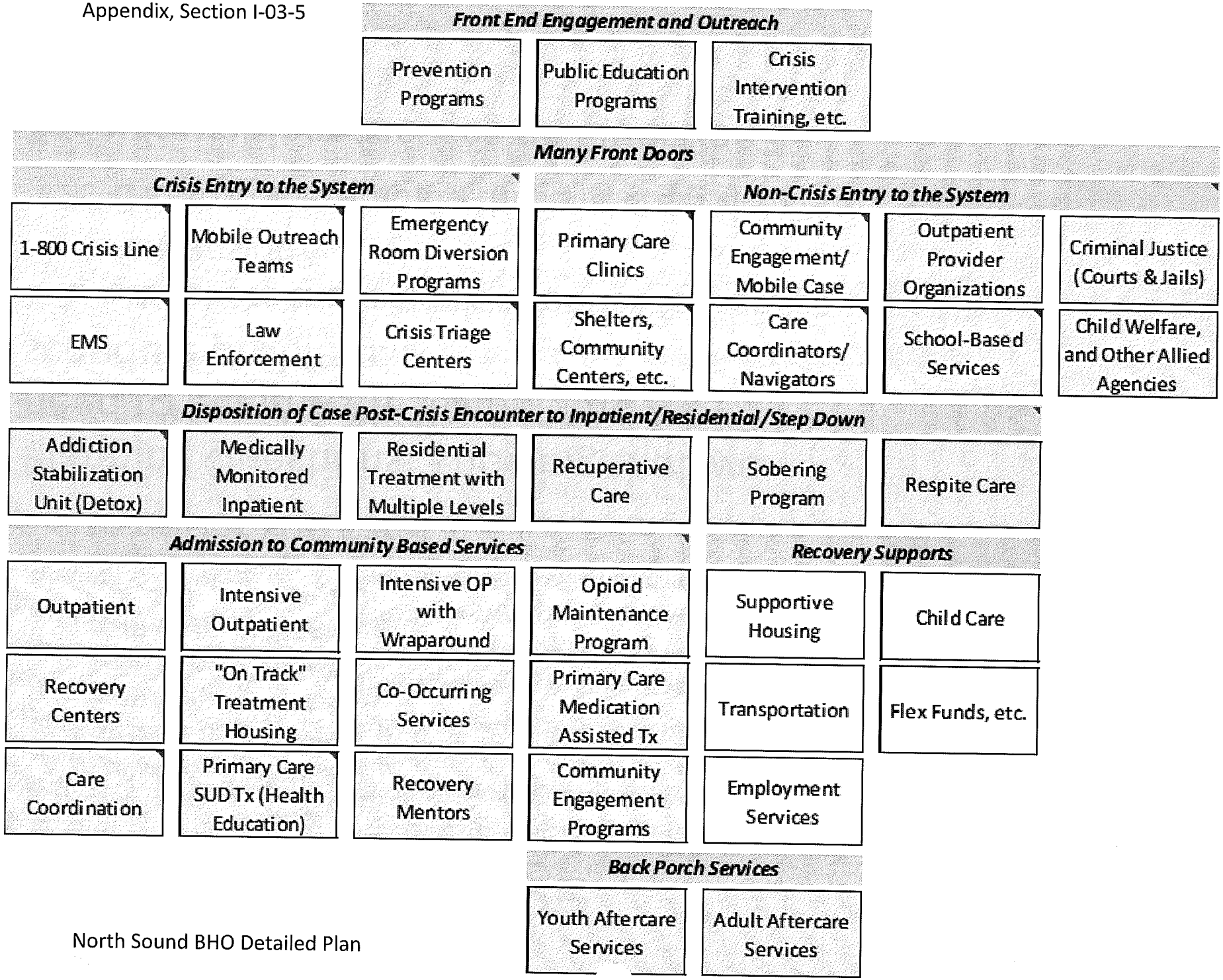


Simple Challenge

- Washington State is aligning the Medicaid Program with the Federal Parity Law
  - More people with Substance Use Disorders quality for Medicaid
  - More money is being pushed out to the BHOs to pay for SUD Care

- Planning Questions: Knowing that we need to begin with "fixing" the fee schedule problem…
  1. What are the region's priorities for service expansion?
  2. How do we ramp up those new services?

- Today's webinar focuses on Question 1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Admission to Community Based Services
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Intensive Outpatient
Intensive OP with Wraparound
Recovery Centers
"On Track" Treatment Housing
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Recovery Mentors
Opioid Maintenance Program
Primary Care Medication Assisted Tx
Community Engagement Programs
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Supportive Housing
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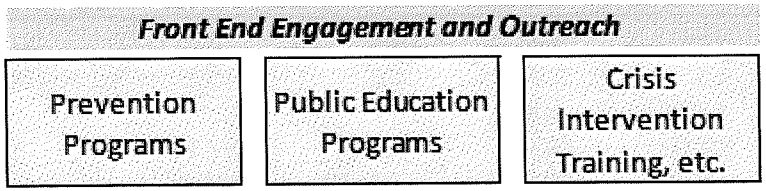
Adult Aftercare Services

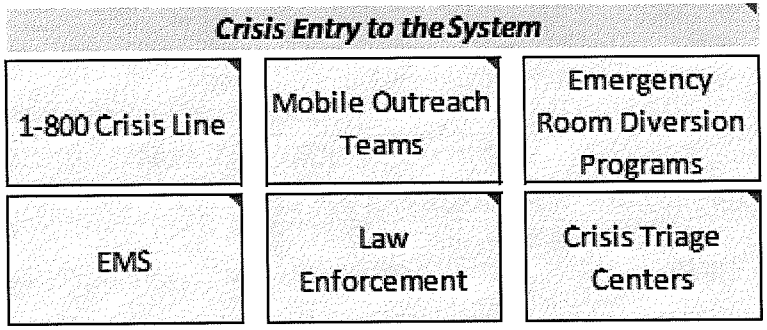
Service Array Descriptions and Examples



Prevention Programs: Prevention programs often fall into three categories: Universal, Selective, and Indicated.

- Universal prevention programs/strategies reach the general population, such as all students in a school or all parents of middle school students.
- Selective prevention programs target groups at risk or subsets of the population, such as children of drug users or poor school achievers.
- Indicated prevention programs identify individuals who are showing early signs of problem behavior(s) and targets them with special programs to prevent further onset of difficulties.

Because of funding restrictions, prevention programs are often grant funded, but as Medicaid moves from "paying for volume" to "paying for value" this is expected to change.



1-800 Crisis Line: The crisis line provides a single number to the community to assist with crises. This includes screening, handling crises on the phone, setting up appointments, triaging to urgent care, and dispatching mobile crisis teams. The service will be expanded to better address calls related to substance use disorders including training all staff on substance use disorders.

Mobile Outreach Teams: Mobile outreach teams ideally should be expanded to include focused treatment on youth and adults experiencing crises that include SUD. One example is the King County Emergency Services Patrol (ESP), which provides direct assistance and transportation of intoxicated/incapacitated individuals to appropriate services and treatment exclusively in the

North Sound BHO Planning: Substance Use Disorder Cost and Utilization Flight Simulator

Baseline

Part I. Enrollment and Revenue

	2014	Year 1	Year 2	Year 3	Comments
Medicaid Enrollees					
Children (0-11)	**91,352**	**91,352**	**92,540**	**93,743**	**Based on current information**
Adolescents (12-17)	**40,130**	**40,130**	**40,652**	**41,180**	"
Adults (18+)	**152,619**	**152,619**	**154,603**	**156,613**	"
Total	284,101	284,101	287,794	291,536	
BHO Revenue					
Average Medicaid Per Member Per Month		**$7.35**	**$7.35**	**$7.35**	**Current PMPM Range: $9.01-$9.77**
Medicaid Revenue		$25,057,708	$25,383,458	$25,713,443	
Total Revenue		$25,057,708	$25,383,458	$25,713,443	

Part II. Service Demand Estimates

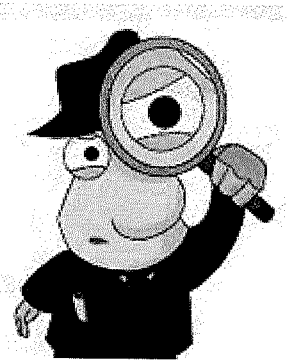
	2014	Year 1	Year 2	Year 3	
Substance Use Disorder Need Estimate (based on DSHS RDA 2014 Analysis)					
Children (0-11)	**0.3%**	**0.3%**	**0.3%**	**0.3%**	**Per DSHS RDA 2014 Analysis**
Adolescents (12-17)	**7.4%**	**7.4%**	**7.4%**	**7.4%**	"
Adults (18+)	**23.8%**	**23.8%**	**23.8%**	**23.8%**	"
Total	13.9%	13.9%	13.9%	13.9%	
Estimated Medicaid Need					
Children (0-11)	274	274	278	281	
Adolescents (12-17)	2,970	2,970	3,008	3,047	
Adults (18+)	36,323	36,323	36,796	37,274	
Total	39,567	39,567	40,081	40,602	
Combined Youth	2.5%	2.5%	2.5%	2.5%	
Estimated Medicaid Access Rate					
Child Access Rate		**23%**	**45%**	**50%**	**Best Guess increases**
Adolescent Access Rate		**40%**	**55%**	**60%**	"
Adult Access Rate		**33%**	**42%**	**45%**	"
Child Admission	**62**	62	125	141	**Based on current information**
Adolescent Admissions	**1,200**	1,200	1,655	1,828	"
Adults Admissions (including 577 DOC Clients)	**12,168**	12,168	15,454	16,773	"
Total Admissions	13,430	13,430	17,234	18,742	
Penetration Rate	4.7%	4.7%	6.0%	6.4%	
Change from Previous Year		-	3,804	1,509	
Change % (Note: DSHS and the Actuaries assume that 7% increase i		0%	28%	9%	
Change compared with 2014		0%	28%	40%	

Part IV. Clients Served Estimates

	Cases 2014	Cases Year 1	Cases Year 2	Cases Year 3	% Un-Duplicated	Comments
Total Child/Adolescent Clients	1,262	1,262	1,779	1,969		Year 1 = 4/2016-3/2017
Total Adult Clients	12,168	12,168	15,454	16,773		
Total Clients	13,430	13,430	17,234	18,742		
Crisis Services, All Ages						
Mobile Outreach Teams	**N/A**	672	1,723	2,811	**25.0%**	**Grow this service**
Crisis Triage Centers	**N/A**	672	1,293	1,687	**25.0%**	"
Detox	**1,950**	672	862	937	**50.0%**	**New capacity coming**
Subacute Detox	**see above**	1,343	1,723	1,874	**35.0%**	"
Sobering Services	**N/A**	-	-	-	**50.0%**	**No capacity in region**
Total Crisis Services		3,359	5,601	7,309		
Brief Intervention & Treatment, All Ages						
All Brief Treatment Settings	**N/A**	672	1,206	1,687	**50.0%**	**Grow this service**
(Mobile Outreach, Emergency Departments, Primary Care Clinics, Crisis Triage Centers, School-Based Services, Jails, Home						
Clients Receiving Ongoing Care - Core Services						
Outpatient						
Child/Adolescents	**1,035**	883	1,246	1,378	**75.0%**	**Grow with population**
Adult	**4,930**	5,111	6,954	7,883	**75.0%**	"
Pregnant and Parenting Women	**40**	122	155	168	**75.0%**	"
Total		6,116	8,355	9,429		
Intensive Outpatient						
Child/Adolescents	**425**	379	534	591	**75.0%**	**Grow with population**
Adult	**3,570**	3,650	4,945	5,871	**75.0%**	"
Pregnant and Parenting Women	**80**	122	155	168	**75.0%**	"
Total		4,151	5,634	6,630		
Opiate Substitution Tx, All Ages	**1,790**	1,813	2,154	2,155	**90.0%**	**New capacity coming**
Medical Services in Additiction Treatment Agencies	**N/A**	269	689	1,125	**90.0%**	**Grow this service**
(Medical treatment, COD psych meds, non-opoid addiction meds, opiod addiction meds, pain management)						
Recovery Supports, All Ages						
All Recovery Support Services	**0**	672	1,723	2,811	**33.0%**	**Grow this Service**
(Recovery Coaches, Recovery Café, Peer Navigators, Recovery Centers)						

We Need Your Help!

- You are closer to the community and what folks need!
- Question 1: How many people do your currently serve per year in each service area below that are paid with Medicaid, federal, state or county funds?
- Question 2: Assuming that you were paid adequate/sustainable/rates (enough to pay living wages and cover overhead), what are the most important services to expand and how many additional clients could you serve?
  - In 2016, 2017 and/or 2018



Switch over to the form

North Sound BHO Substance Use Disorder Provider Capacity Planning

	Agency Name
	Agency Contact and Email Address

Instructions

Assignment: Please complete this form and return to Annette Calder by Wednesday, September 9th at: ***annette_calder@nsmha.org***

Overview: We need your help identifying where the greatest needs exist and where you can help build capacity.

Question 1: How many people do your currently serve per year in each service area below that are paid with Medicaid, state and county funds? (column E) expand and how many additional clients could you serve?, what are the most important services to expand and how many additional clients could you serve?

a. How many more clients could you serve in 2016? (column F)

b. How many more clients could you serve in 2017 (in addition to the 2016 additions)? (column H)

c. How many more clients could you serve in 2018 (in addition to the 2016 and 2017 additions)? (column J)

	2015 Current Capacity	2016 Additions	2016 Total Capacity	2017 Additions	2017 Total Capacity	2018 Additions	2018 Total Capacity	Comments
Crisis Services - Clients								
Mobile Outreach Teams			-		-		-	
Crisis Triage Centers			-		-		-	
Detox			-		-		-	
Subacute Detox			-		-		-	
Sobering Services			-		-		-	
Brief Treatment - Clients								
All Brief Treatment Settings			-		-		-	
(Primary Care Clinics, School-Based Services, Addiction Treatment Centers, Jails, Homeless Shelters, etc.)								
Ongoing Care Clients								
Outpatient								
Adult			-		-		-	
Youth			-		-		-	
Pregnant and Parenting Women			-		-		-	
Intensive Outpatient								
Adult			-		-		-	
Youth			-		-		-	
Pregnant and Parenting Women			-		-		-	

Enhanced Medical Services

	Psych	Addict	Bup
Nurse Practioner	+	+	
Physician Assistant.....	+	+	
Primary Care.....	+	+	+/-
Psychiatrist	+++	+	+/-
Addiction Medicine Doc....	++	++	++/-

MD shortage- how do we attract

- Psychiatrists/ Nurse Practitioners
  - Share with CMHC's?
  - Salary issues ?
  - Benefits?
  - List serve/Support

- Other Docs
  - Evergreen Model
  - MHIP Model
  - Other?

Other Expertise Needed in Addictions sites

- PTSD --- mild / mod / severe
  - Evidence Based Treatments
    - Prolonged Exposure-- **PhDs**
    - CBT **PhDs**
    - SSRI high dose……**MD/Nurse Pract**

Am J Psychiatry. 2010 Jun;167(6):668-75. Epub 2010 Mar 15.

A Double-blind, Placebo-Controlled Trial combining Sertraline and Naltrexone for treating Co-occurring Depression and Alcohol dependence.

Pettinati HM, Oslin DW, Kampman KM, Dundon WD, Xie H, Gallis TL, Dackis CA, O'Brien CP.

METHOD:

A total of 170 depressed alcohol-dependent patients were randomly assigned to receive 14 weeks of treatment with sertraline (200 mg/day [N=40]), naltrexone (100 mg/day [N=49]), the combination of sertraline plus naltrexone (N=42), or double Placebo (N=39) while receiving weekly cognitive-behavioral therapy.

RESULTS: Absitnence and Delay to Relapse

S + N... A= 53.7% D=98 days) ***
N..... A= 21.3% D=29 days)
S.....A= 27.5% D=23 days),
P.....A = 23.1%; D=26 days)

Am J Addict. 2003 Mar-Apr;12(2):137-43

Compliance to Supervised Disulfiram Therapy: a comparison of Voluntary and Court-ordered Patients

. Martin B, Clapp L, Bialkowski D, Bridgeford D, Amponsah A, Lyons L, Beresford TP. Denver

The court ordered group (n=19) was significantly more compliant than the voluntary group (n=22).

Legally mandated subjects attended an average of 87% (+/-21%) of scheduled visits, versus 42% (+/-35%) for the group without court order.

Court mandate roughly doubles the compliance rate of monitored disulfiram therapy, effectively enhancing clinic attendance during the first twelve weeks of treatment.

J Clin Psychopharmacol. 2007 Oct;27(5):507-512.

Efficacy of Extended-Release Naltrexone in Alcohol-Dependent Patients Who Are Abstinent Before Treatment.

O'malley SS, Garbutt JC, Gastfriend DR, Dong Q, Kranzler HR.
*Department of Psychiatry, Yale University

In these patients, all of whom received counseling, the rate of abstinence was severalfold higher for XR-NTX 380 mg compared with placebo:

-median time to first drink was	**41 vs 12 days**	**(P = 0.02)**
-rate of continuous abstinence	**32% vs 11%**	**(P = 0.02)**
-time to first heavy drinking	**>180 vs 20 days**	**(P = 0.04)**
-decreased drinking days/month	**90% 0.7 vs 7.2**	**(P = 0.005)**

Am J Manag Care. 2010;16(12):879-88.

Comparison of Healthcare Utilization among Patients treated with Alcoholism Medications.

Mark TL, Montejano LB, Kranzler HR, Chalk M, Gastfriend DR.

Results

Among 4 medications, the use of **naltrexone XR was associated with fewer inpatient detoxification days** **224 days per 1000 patients) …**
use of oral naltrexone…. **552 days, (P = .001),**
disulfiram **403 days, P = .049),**
acamprosate **525 days, P <.001).**

The group receiving **naltrexone XR also had fewer alcoholism-related inpatient days** than the groups receiving disulfiram or acamprosate.

More patients in the naltrexone XR group had an **outpatient substance abuse visit** compared with patients in the oral alcoholism medication groups.

One year ABSTINENCE (n= 377) was predicted by:

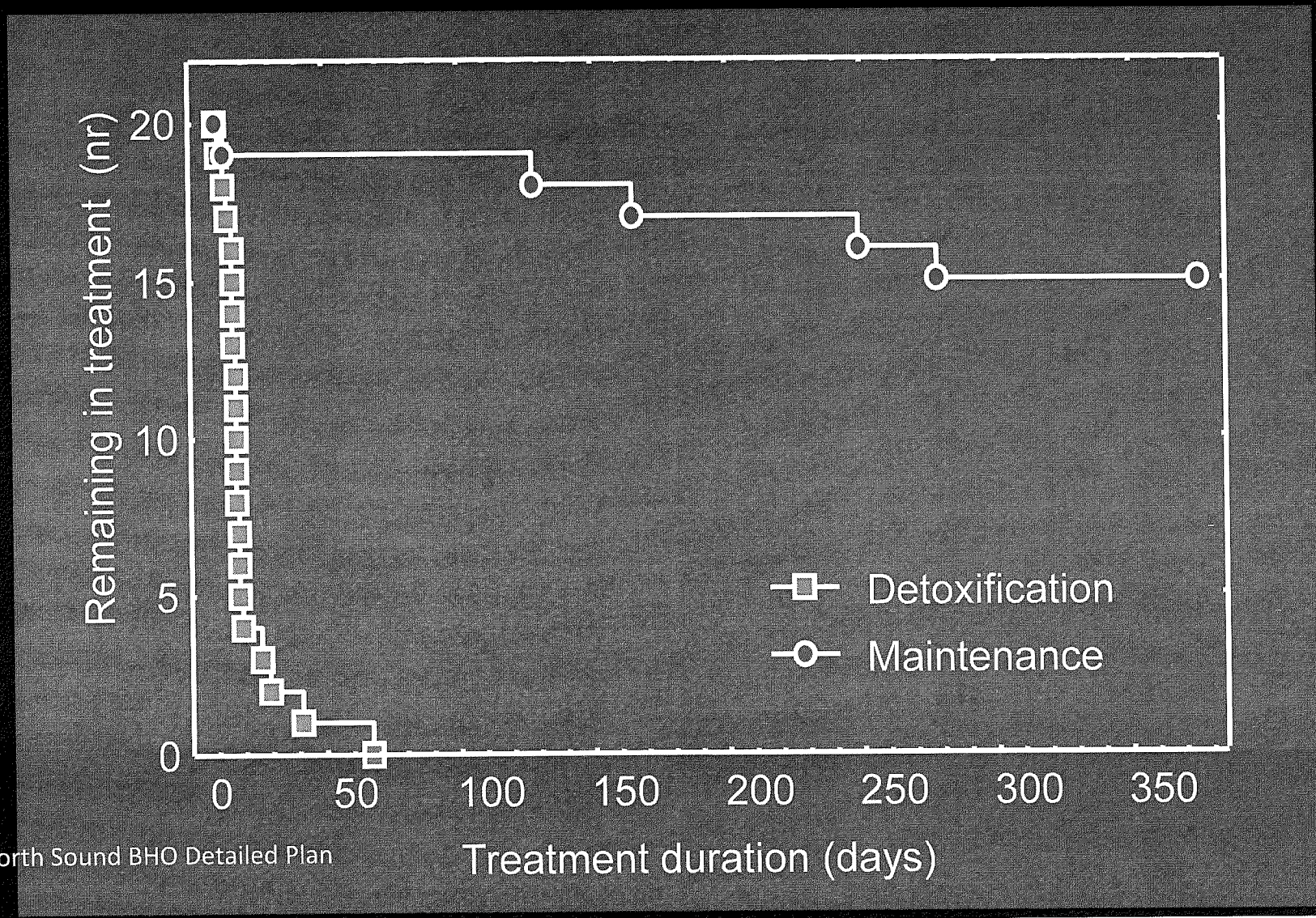
- AA involvement .....**OR = 2.9**
- not having pro-drinking influences in one's network .....**OR = 0.7**
- having support from people met in AA (versus no support); .....**OR = 3.4**

ie support from AA and AA members is a potent predictor

Kaskutas: Addiction 2002

Retention in Opiate treatment with Bup/Naloxone

Heilig, Lancet 2003



Lancet. 2011 Apr 30;377(9776):1506-13.

Injectable extended-release naltrexone for opioid dependence: a double-blind, placebo-controlled, multicentre randomised trial.

Krupitsky E, Nunes EV, Ling W, Illeperuma A, Gastfriend DR, Silverman BL.

FINDINGS:
Between July 3, 2008, and Oct 5, 2009, 250 patients were randomly assigned to XR-NTX (n=126) or placebo (n=124).

The median proportion of weeks of confirmed abstinence was

% weeks abstinent.... 90 versus 35 (p=0·0002)

opioid-free days ..... 99 versus 60 (p=0·0004).

change in craving ..... –10 versus 0·7 (p<0·0001).

Median retention .....168 vs 96 days (p=0·0042).

Two patients in each group discontinued owing to adverse events. No XR-NTX-treated patients died, overdosed, or discontinued owing to severe adverse events.

BMJ. 1999 May 8;318(7193):1235-9.

Suicide within 12 months of contact with mental health services: national clinical survey.

Appleby L, Shaw J, Amos T, McDonnell R, Harris C, McCann K, Kiernan K, Davies S, Bickley H, Parsons R.

RESULTS:

10 040 suicides were notified to the study between April 1996 and March 1998, **Alcohol and drug misuse were common**

--519 (24%; 22% to 26%) suicides occurred within three months of hospital discharge

the highest number occurring in the first week after discharge.

24% to 28%) were non-compliant with medications treatment while
26% to 30%) community patients had lost contact with services.

Most people who committed suicide were thought to have been at no or low immediate risk at the final service contact. Mental health teams believed suicide could have been prevented in 423 (22%; 20% to 24%) cases.

CONCLUSIONS:

Several suicide prevention measures in mental health services are implied by these findings, **including measures to improve compliance and prevent loss of contact with services**. .....

Am J Psychiatry. 2011 Jun;168(6):603-9. Epub 2011 Mar 1.

A nationwide cohort study of oral and depot antipsychotics after first hospitalization for schizophrenia.

Tiihonen J, Haukka J, Taylor M, Haddad PM, Patel MX, Korhonen P.

Abstract

OBJECTIVE:
The authors examined the risk of rehospitalization and drug discontinuation in a nationwide cohort of 2,588 consecutive patients hospitalized for the first time with a diagnosis of schizophrenia between 2000 and 2007 in Finland.

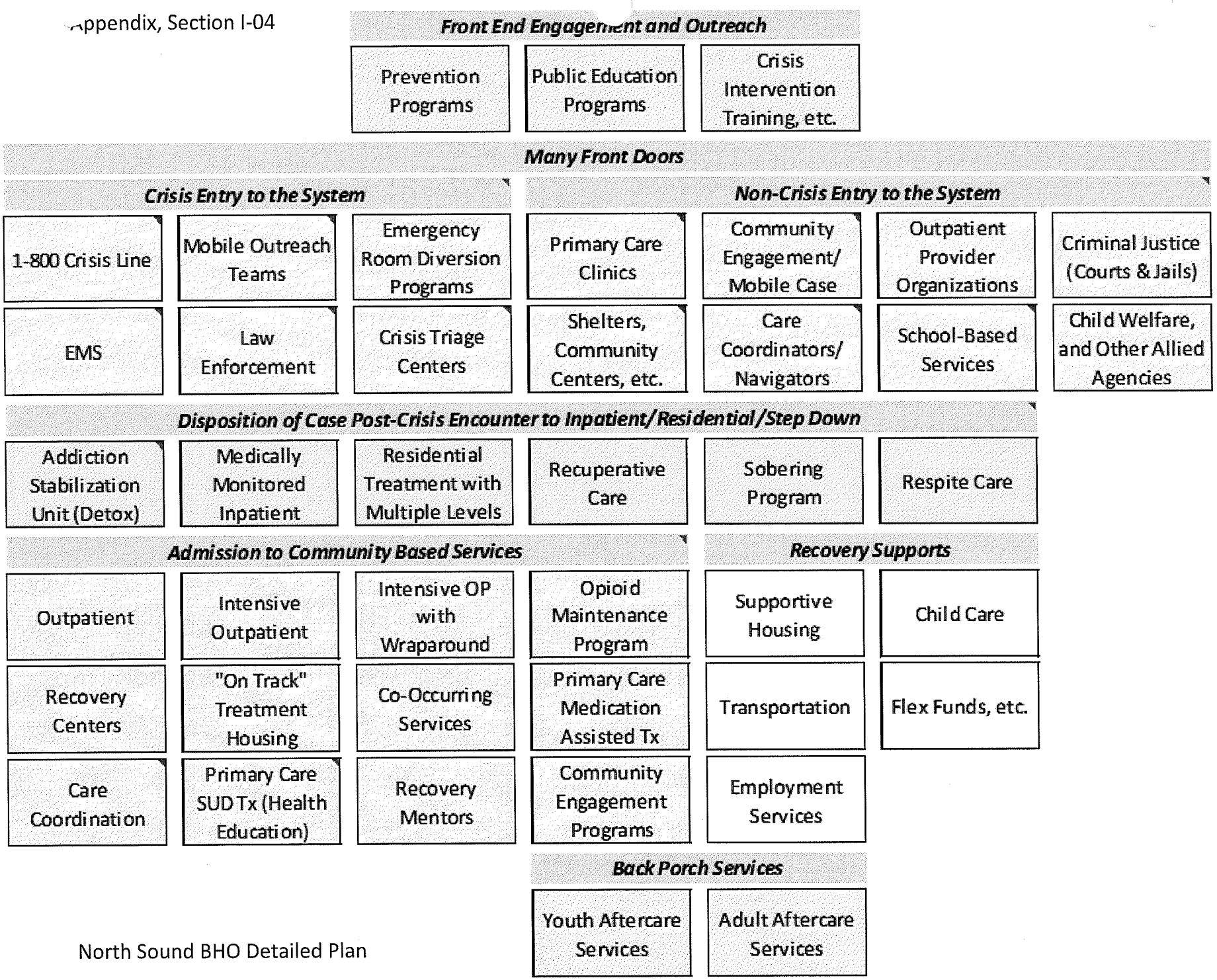
Of 2,588 patients,

58.2% collected a antipsychotoc prescription in first 30 days

45.7continued their initial treatment for 30 days or longer.

risk of rehospitalization
depot medications = one-third of that for oral medications

(adjusted hazard ratio=0.36, 95% CI=0.17-0.75).


Front End Engagement and Outreach
Prevention Programs
Public Education Programs
Crisis Intervention Training, etc.
Many Front Doors
Crisis Entry to the System
1-800 Crisis Line
Mobile Outreach Teams
Emergency Room Diversion Programs
EMS
Law Enforcement
Crisis Triage Centers
Non-Crisis Entry to the System
Primary Care Clinics
Community Engagement/ Mobile Case
Outpatient Provider Organizations
Criminal Justice (Courts & Jails)
Shelters, Community Centers, etc.
Care Coordinators/ Navigators
School-Based Services
Child Welfare, and Other Allied Agencies
Disposition of Case Post-Crisis Encounter to Inpatient/Residential/Step Down
Addiction Stabilization Unit (Detox)
Medically Monitored Inpatient
Residential Treatment with Multiple Levels
Recuperative Care
Sobering Program
Respite Care
Admission to Community Based Services
Outpatient
Intensive Outpatient
Intensive OP with Wraparound
Recovery Centers
"On Track" Treatment Housing
Co-Occurring Services
Care Coordination
Primary Care SUD Tx (Health Education)
Recovery Mentors
Opioid Maintenance Program
Primary Care Medication Assisted Tx
Community Engagement Programs
Recovery Supports
Supportive Housing
Child Care
Transportation
Flex Funds, etc.
Employment Services
Back Porch Services
Youth Aftercare Services
Adult Aftercare Services

NSMHA BOARD OF DIRECTORS – Year 2015

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	ALTERNATE **CAMMY HART-ANDERSON** Human Services 3000 Rockefeller Ave Everett, WA 98201		(425) 388-7233		Cammy.Hart-Anderson@snoco.org Cammy will replace Ken Stark as designee for Lovick April 2015
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	ALTERNATE **REGINA DELAHUNT** Whatcom County Health Dept. Director 509 Girard Street Bellingham, WA 98225	Tammy Axlund X30687	(360) 676-6724	(360) 676-7646	rdelahun@co.whatcom.wa.us taxlund@co.whatcom.wa.us
	KEN MANN Whatcom County Council 311 Grand Avenue, Ste. 105 Bellingham, WA 98225		(360) 676-6690 (360) 483-6020		KMann@co.whatcom.wa.us
	ALTERNATE **ANNE DEACON** Whatcom County Human Services Manager/ County Coordinator 509 Girard Street Bellingham, WA 98225	Vicki McClure x32243	(360) 676-6724 x50877	(360) 738-2490	adeacon@co.whatcom.wa.us vmcclure@whatcomcounty.us
	ALERNATE **JACKIE MITCHELL** Whatcom County Specialist – Substance Abuse Program 509 Girard Street Bellingham, WA 98225		(360) 676-6724 X32017	(360) 676-7646	jmitchel@co.whatcom.wa.us
EX OFFICIO	**MARK MCDONALD** Chair NSMHA Advisory Board 1101 McKenzie Ave. #305 Bellingham, WA 98225		(360) 734-2042	None	arrozo222@yahoo.com
	DAVID KINCHELOE Vice Chair NSMHA Adv Board 1015 Otis St. #110 Bellingham, WA 98225		(360) 961-8611	None	dkincheloe@gmail.com
TRIBAL	**SHERYL FRYBERG** The Tulalip Tribes 6406 Marine Dr. Tulalip, WA 98271	Rebecca Hunter 360-716-4026	(360) 716-4004	(360) 716-0206	sfryberg@tulaliptribes-nsn.gov
	ALTERNATE **SHERRY GUZMAN** The Tulalip Tribes 6406 Marine Drive Tulalip, WA 98271		(360) 651-4715	(360) 651-4368	sguzman@tulaliptribes-nsn.gov

	Vacant **Samish Indian Tribe** 2918 Commercial Ave PO Box 217 Anacortes, WA 98221				
	Vacant **NOOKSACK TRIBE** PO Box 157 Deming, WA 98244				

JOINT OPERATING AGREEMENT

BETWEEN

AMERIGROUP WASHINGTON, INC. MANAGED HEALTH CARE ORGANIZATION

AND

NORTH SOUND MENTAL HEALTH ADMINISTRATION/NORTH SOUND REGIONAL SUPPORT NETWORK

The Operational Agreement is between **Amerigroup Washington Inc.,** a Managed Health Care Organization contracted with the Washington State Health Care Authority to manage Healthy Options and Basic Health Plan(herein after referred to as the **Health Plan**) and the **North Sound Mental Health Administration**, a Regional Support Network (**RSN**) contracted with Washington State Division of Behavior Health and Recovery Services to manage a Prepaid Inpatient Health Plan (PIHP)(herein after referred to as the **RSN**) and serves Island, San Juan, Skagit, Snohomish and Whatcom Counties.

I. PURPOSE

This agreement delineates the roles and responsibilities of the **Health Plan** and the **RSN** related to the provision of mental health benefits for their enrollees who are insured under Washington State Medicaid Healthy Options contract and the Washington State Medicaid PIHP contract.

The agreement also demonstrates a shared commitment by both the **Health Plan** and the **RSN** to coordinate care for persons who are involved in or require services from both systems of care.

This agreement is not intended to identify the operational procedures specific to each Health Plan and each RSN. To ensure that both Health Plan and RSN responsibilities are fully met, details of the local procedures and agreements between each Health Plan and each RSN will be provided in an attachment to this Operating Agreement to be completed by **December 31, 2012** (*Referred to as the Operation Agreement Attachment*).

II. BACKGROUND

A. Health Plan

The **Amerigroup** Washington Inc. Health Plan provides managed health care services to eligible individuals insured under the Healthy Options Plan in Island, San Juan, Skagit, Snohomish and Whatcom Counties.

B. RSN

The **North Sound Mental Health Administration** provides covered mental health services to eligible consumers in Island, San Juan, Skagit, Snohomish and Whatcom Counties.

III. RESPONSIBILITIES AND ROLES

A. Sharing Protected Health Information

The parties agree that information shared under this agreement is shared for the purpose of coordination of treatment and/or health care operations. The parties also agree not to use or disclose protected health information other than as permitted or required by this Agreement, HIPAA and the Health Information Technology for Economic and Clinical Health Act (HITECH). The parties shall use and disclose protected health information only if such use or disclosure, respectively, is in compliance with each applicable requirement of 45 CFR § 164.504(e).

B. Referrals between the Health Plan and the RSN

While both the **Health Plan** and the **RSN** benefit plans cover medically necessary mental health services the scope of the benefits are distinct. The mental health benefit under the **Health Plan** is a limited benefit. The **RSN** mental health benefit has a broad scope and serves individuals with need for higher intensity and/or specialty mental health services. The Washington State Medicaid Program PIHP requires enrollees to meet both medical necessity and Mental Health Access to Care Criteria to define members' qualification for **RSN** mental health services.

Consumer choices, and/ or person centered care, are essential guiding principles of this agreement. Therefore, enrollees covered under Healthy Options may approach either the **Health Plan** or the **RSN** network providers to request mental health services.

Enrollees who choose to access the **Health Plan** may be referred to the **RSN** by the **Health Plan** providers if it appears that they may meet Access to Care criteria. Enrollees who choose to access an RSN network provider will be assessed and either authorized by the RSN into care or referred to the Health Plan based on PIHP criteria.

1. **RSN** Responsibility

   a. The **RSN** has the responsibility to provide a face-to-face assessment for any person enrolled in Medicaid who requests an intake to determine if the individual meets medical necessity and Access to Care criteria for **RSN** mental health services. The **RSN** shall accept a referral from the **Health Plan** for a face-to-face assessment when the **Health Plan** believes the individual may meet Access to Care criteria for the **RSN** mental health benefit.
   b. The **RSN** will authorize and serve any individual who meets medical necessity and the Access to Care criteria and chooses to be served by the **RSN** contracted provider.
   c. The **RSN** will refer individuals to the **Health Plan** for mental health benefits when the individual does not meet Access to Care criteria or medical eligibility, or has graduated from RSN services and/or no longer meets criteria for access to **RSN** services but still may meet medical necessity for the **Health Plan** mental health benefit.

2. **Health Plan** Responsibility

   a. The **Health Plan** has the responsibility to determine if their members meet medical necessity for their mental health benefit or if a referral to the **RSN** for an assessment is warranted. The **Health Plan** is also responsible to provide a mental health benefit for their Healthy Option members who present with medical necessity for mental health services and do not meet the **RSN** PIHP Access to Care criteria.
   b. The **Health Plan** may refer individuals at any time to the **RSN** even if they have been served under the **Health Plan's** mental health benefit to determine if the individual meets Access to Care criteria for **RSN** mental health benefits.

C. Coordination of Care and Care Transitions

The **RSN** and the **Health Plan** have responsibility to assure that enrollees who have multiple needs and make frequent use of the systems of care are provided with quality coordinated care. Specific attention shall also be paid to individuals with co-morbid physical and mental health conditions who are admitted to institutional care for either physical health or mental health conditions. The **RSN** and the **Health Plan** and their respective designees (e.g. care managers, contractors, provider networks) will collaborate on coordination of care for persons who are involved in or require services from both systems of care.

1. **RSN** Responsibility
   a. The **RSN** shall participate in the Care Transitions Performance Improvement Plan pursuant to the requirements in the RSN contract with the state Division of Behavioral Health and Recovery Services (DBHR)
   b. The **RSN** shall provide timely information related to psychiatric hospital admission and discharge for **Health Plan** Healthy Options members.
   c. The **RSN** and its designees will collaborate with **Health Plan** care coordination activities for individuals who are identified through the state PRISM system with high risk scores. During the first year of this agreement the **RSN** will work with the **Health Plan** to develop procedures and/or protocols for their collaboration on care coordination for persons who are identified as high risk.
   d. Additional region specific procedures are provided in the Operational Agreement Attachment.

2. **Health Plan** Responsibility
   a. The **Health Plan** shall participate in the Care Transitions Performance Improvement Plan pursuant to the requirements in the Healthy Options contract with the state Health Care Authority (HCA).
   b. The **Health Plan** shall provide timely information related to medical hospital admission and discharge for **Health Plan** Healthy Options members receiving **RSN** PIHP services.
   c. The **Health Plan** and its designees will collaborate with **RSN** care coordination activities for individuals who are identified through the state PRISM system with high risk scores. During the first

year of this agreement the **Health Plan** will work with the **RSN** to develop procedures and/or protocols for their collaboration on care coordination for persons who are identified as high risk.

d. Additional region specific procedures are provided in the Operational Agreement Attachment.

D. Communications

1. Each **Health Plan** and each **RSN** will provide contact information for functions that will be coordinated between the **Health Plan** and the **RSN**. The individual contacts provided in the Operation Agreement Attachment will include at minimum:
   a. Referrals
   b. Care Coordination and Care Management
   c. Crisis Services Contacts
   d. Data Sharing
   e. Performance Improvement and Quality Management
   f. Dispute Resolution
   g. Critical Incidents

2. The **Health Plan** and the **RSN** agree to participate in further development of additional guidelines and operational procedures that will enhance the bi-directional care coordination between entities. The areas to be addressed may include, but are not limited to the following:
   a. Referral Procedures
   b. Screening Guidelines
   c. Notification of Admissions to Institutional Care
   d. Care Transitions/Discharge Planning from Institutional Care
   e. Continuing Care Transitions
   f. Care Management and Coordination
   g. Performance Measures and Improvement Processes
   h. Notifications of Emergent Care
   i. Data Sharing
   j. Dispute Resolution
   k. Notification of Critical Incidents

IV. Hold Harmless

1. Regardless of any verbal statements made prior to or following signature on this Agreement, nothing in this Agreement is intended to establish a legally binding agreement between the parties.
2. The parties of this agreement will hold one another including their contractors, employees, interns and volunteers harmless for failure to perform any of the roles identified above, including termination of this Agreement with or without advance notice.

3. There shall be no remedy available to one party for failure to perform any role identified above by the other party, or a third party.

V. Dispute Resolution

1. All disputes occurring between the parties of this agreement shall be resolved through informal negotiation between the parties of the Agreement. A guiding principle for resolving disputes is that resolution should be sought at the lowest level and only progress up the hierarchy when satisfactory resolution has not been achieved.
2. Failure to resolve disputes may result in termination of the Agreement.

VI. Term and Termination

1. The effective date of this Agreement will be upon the final signature of the parties to this Agreement and it shall remain in effect until it is terminated in accordance with the terms of this Agreement.
2. Any of the parties to this Agreement may withdraw and terminate their participation from this Agreement for any reason and at any time upon thirty (30) days prior written notice to the other party. Such notice and other correspondence related to this Agreement should be sent to the contacts and addresses listed above.

VII. Amendment

This Agreement may be amended at any time by written agreement and signature of all the parties.

IN WITNESS WHEREOF, the parties hereto have caused this Joint Operating Agreement to be executed by the dates and signatures herein under affixed. The persons signing this Joint Operating Agreement on behalf of the parties represent that each has authority to execute the Joint Operating Agreement on behalf of the party entering this Joint Operating Agreement.

NORTH SOUND MENTAL HEALTH ADMINISTRATION/ NORTH SOUND REGIONAL SUPPORT NETWORK

Joe Valentine
RSN Executive Director

11-15-12
Date

AMERIGROUP WASHINGTON, INC.

Rosa M. Cozad
President and CEO

11/12/2012
Date

BUSINESS ASSOCIATE AGREEMENT

This Business Associate Agreement ("BAA"), effective May 1, 2014 ("Effective Date"), is entered into by and between North Sound Mental Health Administration RSN ("RSN"), and Molina Healthcare of Washington ("Molina") (each a "Party" and collectively the "Parties"). In this BAA, either Party may act in the capacity of a Covered Entity and/or Business Associate of the other Party.

WHEREAS, the Parties have engaged or intend to engage in one or more agreements (each, an "Agreement" and collectively, the "Agreements") which may require the use or disclosure of PHI in performance of services described in such agreement(s) (the "Services") on behalf of Business Associate.

WHEREAS, the Parties are committed to complying with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the Health Information Technology for Economic and Clinical Health ("HITECH") Act and any regulations promulgated thereunder (collectively the "HIPAA Rules").

WHEREAS, this BAA, in conjunction with the HIPAA Rules, sets forth the terms and conditions pursuant to which protected health information (in any format) that is created, received, maintained, or transmitted by, the Business Associate from or on behalf of Covered Entity, will be handled between the Business Associate and Covered Entity and with third parties during the term of the Agreement(s) and after its termination.

NOW THEREFORE, the Parties agree as follows:

1. DEFINITIONS

Unless otherwise provided for in this BAA, terms used in this BAA shall have the same meanings as set forth in HIPAA, the HITECH Act, and the HIPAA Rules including, but not limited to the following: Availability, Confidentiality, Data Aggregation, Designated Record Set, Health Care Operations, Integrity, Minimum Necessary, Notice of Privacy Practices, Required By Law, Secretary, and Subcontractor. Specific definitions are as follows:

"Breach" shall have the same meaning as the term "breach" at 45 CFR 164.402.

"Business Associate" shall have the same meaning as the term "business associate" at 45 CFR 160.103 and in reference to the party to this BAA, shall mean either party listed in the first paragraph of this BAA.

"Compliance Date" shall mean, in each case, the date by which compliance is required under the referenced provision of the HIPAA, the HITECH Act or the HIPAA Rules, as applicable; provided that, in any case for which that date occurs prior to the effective date of this BAA, the Compliance Date shall mean the effective date of this BAA.

"Electronic Protected Health Information" ("Electronic PHI") shall have the same meaning as the term "electronic protected health information" at 45 CFR 160.103.

"HIPAA Rules" shall mean the Privacy, Security, Breach Notification, and Enforcement Rules at 45 CFR Part 160 and Part 164.

"Protected Health Information" ("PHI") shall have the same meaning as the term "protected health information" at 45 CFR 160.103.

"Privacy Rule" means the Standards for Privacy of Individually Identifiable Health Information, set forth at 45 CFR Parts 160 and 164.

"Security Incident" " shall have the same meaning as the term "security incident" at 45 CFR 164.304.

"Security Rule" means the Security Standards for the Protection of Electronic Protected Health Information, set forth at 45 CFR Parts 160 and 164.

"Services" shall mean, to the extent and only to the extent they involve the creation, use or disclosure of PHI, the services provided by Business Associate to Covered Entity under the Agreement(s), including those set forth in this BAA, as amended by written consent of the parties from time to time.

"Unsecured PHI" shall have the same meaning as the term "unsecured protected health information" at 45 CFR 164.402.

2. GENERAL PROVISIONS

2.1 Effect. This BAA supersedes any prior business associate agreement between the Parties and those portions of any Agreement between the Parties that involve the disclosure of PHI by Covered Entity to Business Associate. To the extent any conflict or inconsistency between this BAA and the terms and conditions of any Agreement exists, the terms of this BAA shall prevail.

2.2 Amendment. Covered Entity may amend this BAA to maintain consistency and/or compliance with any state or federal law, policy, directive, regulation, or government sponsored program requirement, upon forty-five (45) business days' notice to Business Associate unless a shorter timeframe is necessary for compliance. Covered Entity may otherwise materially amend this BAA only after forty-five (45) business days prior written notice to Business Associate and only if mutually agreed to by the parties as evidenced by the amendment being executed by each party hereto. If the Parties fail to execute a mutually agreeable amendment within forty-five (45) days of Business Associate's receipt of Covered Entity's written notice to amend this BAA, Covered Entity shall have the right to immediately terminate this BAA and any Agreement(s) between the Parties which may require Business Associate's use or disclosure of PHI in performance of services described in such Agreement(s) on behalf of Covered Entity.

3. SCOPE OF USE AND DISCLOSURE

3.1 Business Associate may use or disclose PHI as required to provide Services and satisfy its obligations under the Agreement, if such use or disclosure of PHI would not violate the Privacy Rule. Unless otherwise limited herein, Business Associate may use or disclose PHI solely:

a. for Business Associate's proper management and administrative services;

b. to carry out the legal responsibilities of Business Associate; and

c. to provide Data Aggregation services relating to the Health Care Operations of
d. Covered Entity if required under the Agreement.

3.2 Business Associate shall not request, use or release more than the Minimum Necessary amount of PHI required to accomplish the purpose of the use or disclosure and shall

comply with 42 U.S.C. § 17935(b) as of its Compliance Date. Business Associate hereby acknowledges that all PHI created or received from, or on behalf of, Covered Entity is, as between the parties, the sole property of Covered Entity.

3.3 Business Associate or its agents or Subcontractors shall not perform any work outside the United States of America that involves access to, use of or disclosure of, PHI without the prior written consent of Covered Entity in each instance.

4. OBLIGATIONS OF BUSINESS ASSOCIATE

Business Associate shall:

4.1 Not use or disclose PHI other than permitted or required by this BAA or as Required by Law.

4.2 Establish and use appropriate safeguards to prevent unauthorized use or disclosure of PHI.

4.3 Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the Confidentiality, Integrity, and Availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf of Covered Entity. Business Associate shall, as of the Compliance Date, comply with the applicable standards at Subpart C of 45 CFR Part 164.

4.4 Promptly report to Covered Entity any unauthorized use or disclosure of PHI, or Security Incident, within no more than five (5) days, after Business Associate becomes aware of the unauthorized use or disclosure of PHI or Security Incident. Business Associate shall take all reasonable steps to mitigate any harmful effects of such Breach or Security Incident. Business Associate shall indemnify Covered Entity against any losses, damages, expenses or other liabilities including reasonable attorney's fees incurred as a result of Business Associate's or its agent's or Subcontractor's unauthorized use or disclosure of PHI or Breach of Unsecured PHI including, but not limited to, the costs of notifying individuals affected by a Breach of Unsecured PHI.

4.5 Business Associate shall, following discovery of a Breach of Unsecured PHI, notify Covered Entity of such Breach as required at 45 CFR 164.410, without unreasonable delay, and in no event more than sixty (60) days after the discovery of the Breach. The notification by the Business Associate to Covered Entity shall include: (1) the identification of each individual whose Unsecured PHI was accessed, acquired, used or disclosed during the Breach; and (2) any other available information that Covered Entity is required to include in its notification to individuals affected by the Breach including, but not limited to, the following:

a. a brief description of what happened, including the date of the Breach and the date of the discovery of the Breach;

b. a description of the types of Unsecured PHI that were involved in the Breach;

c. a brief description of what the Business Associate is doing to investigate the Breach, to mitigate harm to individuals, and to protect against any further Breaches.

4.6 In accordance with 45 CFR 164.502(e)(1)(ii) and 164.308(b)(2), if applicable, ensure that any Subcontractors or agents that create, receive, maintain, or transmit PHI on behalf of the Business Associate agree to the same restrictions, conditions, and requirements that apply to the Business Associate with respect to such information.

4.7 Within ten (10) days of receiving a request, make available PHI in a Designated Record Set to Covered Entity as necessary to satisfy Covered Entity's obligations under 45 CFR 164.524.

4.8 Within fifteen (15) days of receiving a request, make any amendment(s) to PHI in a Designated Record Set as directed or agreed to by Covered Entity pursuant to 45 CFR 164.526.

4.9 Maintain and make available to Covered Entity, within twenty (20) days of receiving a request, the information required to provide an accounting of disclosures to the individual as necessary to satisfy Covered Entity's obligations under 45 CFR 164.528

4.10 Make its internal practices, books and records relating to the use or disclosure of PHI received from or on behalf of Covered Entity available to Covered Entity or the U. S. Secretary of Health and Human Services for purposes of determining compliance with the HIPAA Rules.

4.11 Standard Transactions. To the extent Business Associate conducts Standard Transaction(s) on behalf of Covered Entity, Business Associate shall comply with the HIPAA Regulations, "Administrative Requirements," 45 C.F.R. Part 162, by the applicable compliance date(s) and shall not: (a) Change the definition, data condition or use of a data element or segment in a standard; (b) Add any data elements or segments to the maximum defined data set; (c) Use any code or data elements that are either marked "not used" in the standard's implementation specification or are not in the standard's implementation specification(s); or (d) Change the meaning or intent of the standard's implementation specifications. Business Associate shall comply with any applicable certification and compliance requirements (and provide the Secretary with adequate documentation of such compliance) under subsection (h) of Title 42 U.S.C. Section 1320d-2.

4.12 To the extent the Business Associate is to carry out one or more of Covered Entity's obligation(s) under Subpart E of 45 CFR Part 164, comply with the requirements of Subpart E that apply to Covered Entity in the performance of such obligation(s).

5. MISCELLANEOUS

5.1 Indemnification. In addition to any indemnities set forth in the Agreement(s), each party will indemnify and defend the other party from and against any and all claims, losses, damages, expenses or other liabilities, including reasonable attorney's fees, incurred as a result of any breach by such party of any representation, warranty, covenant, agreement or other obligation expressly contained herein by such party, its employees, agents, Subcontractors or other representatives.

5.2 Interpretation. Any ambiguity in this BAA shall be interpreted to permit compliance with the HIPAA Rules.

5.3 No Third Party Beneficiaries. Nothing express or implied in this BAA is intended to confer, nor shall anything herein confer, upon any person other than the Parties and the respective successors or assigns of the Parties, any rights, remedies, obligations, or liabilities whatsoever.

5.4 Governing Law and Venue. This BAA shall be governed by Washington law notwithstanding any conflicts of law provisions to the contrary. The venue shall be the jurisdiction where the applicable services were received by Covered Entity.

5.5 Notices. Any notices to be given hereunder to a Party shall be made via certified U.S. Mail or express courier to such Party's address given below, and/or (other than for the delivery of fees) via facsimile to the facsimile telephone numbers listed below.

If to Business Associate, to:	**If to Molina, to:**
Joe Valentine	Timothy C. Zevnik, CIPP/US, CIPP/G
117 North 1st Street, Suite 8	200 Oceangate, Suite 100
Mt. Vernon, WA 98273	Long Beach, CA 90802
Attn: Executive Director	Attn: Privacy Official
Fax: 360-416-7017	Fax: 562-499-0789

6. TERM AND TERMINATION OF BAA

6.1 Term. The Term of this BAA shall be effective as of the effective date set forth in the first paragraph of this BAA, and shall terminate on date that the last Agreement remaining in force between the parties is terminated or expires, or on the date Covered Entity terminates for cause as authorized in paragraph 6.2 below, whichever is sooner.

6.2 Termination for Cause. Notwithstanding any other provision of this BAA or the Agreement(s), Covered Entity may terminate this BAA and any or all Agreement(s) upon five (5) days written notice to Business Associate if Covered Entity determines, in its sole discretion, that Business Associate has violated a material term of this BAA.

6.3 Obligations of Business Associate Upon Termination. Upon termination of this BAA for any reason, Business Associate shall return to Covered Entity or, if agreed to by Covered Entity, destroy all PHI received from Covered Entity, or created, maintained, or received by Business Associate on behalf of Covered Entity, that the Business Associate still maintains in any form. If PHI is destroyed, Business Associate agrees to provide Covered Entity with certification of such destruction. Business Associate shall not retain any copies of PHI except as Required By Law. If return or destruction of all PHI, and all copies of PHI, received from Covered Entity, or created, maintained, or received by Business Associate on behalf of Covered Entity, is not feasible, Business Associate shall:

a. Continue to use appropriate safeguards and comply with Subpart C of 45 CFR Part 164 with respect to Electronic PHI to prevent use or disclosure of the PHI, other than as provided for in this Section 6, for as long as Business Associate retains the PHI; and

b. Not use or disclose the PHI retained by Business Associate other than for the purposes for which such PHI was retained and subject to the same conditions set forth in Section 3 above which applied prior to termination.

6.4 Survival. The obligations of Business Associate under this Section shall survive the termination of this BAA and remain in force as long as Business Associate stores or maintains PHI in any form or format (including archival data). Termination of the BAA shall not affect any of the provisions of this BAA that, by wording or nature, are intended to remain effective and to continue in operation.

INTENDING TO BE LEGALLY BOUND, the parties hereto have caused this Agreement to be executed by their duly authorized representatives.

"North Sound Mental Health Administration RSN"

Signature

Joe Valentine
Print Name

Executive Director 7-25-14
Title Date

"Molina"

Signature

Laurel Lee
Print Name

Chief Operating Officer 7/28/14
Title Date

RECEIVED
MAR 05 2013
NSMHA

BUSINESS ASSOCIATE AGREEMENT

This Business Associate Agreement is between Community Health Plan of Washington (CHPW) and North Sound Mental Health Regional Support Network ("Contractor"), and is effective December 13, 2012

Compliance and Privacy and Security Obligations of the Community Health Plan and Contractor.

Each party to this Business Associate Agreement ("BAA"), including its directors, officers, and employees shall take reasonable and necessary actions to safeguard the privacy and security of protected health information in accordance with this BAA. Contractor, including its directors, officers, employees, agents and subcontractors("Business Associate"), will receive or have access to protected health information ("PHI") as defined under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and will use or disclose such PHI in a manner compliant with the requirements of HIPAA, as amended by the Health Information Technology for Economic and Clinical Health Act (the "HITECH Act"), as incorporated in the American Recovery and Reinvestment Act of 2009, along with any guidance and/or regulations issued by Health and Human Services ("HHS"). Business Associate acknowledges that certain provisions of HIPAA, as amended by HITECH, now impose certain obligations directly on Business Associates. The parties acknowledge that certain regulations not yet promulgated pursuant to HITECH, may impose additional obligations on each party, and that further amendment of this BAA may be required to comply with such regulations. As it relates to the use and/or disclosure of protected health information (PHI) under HIPAA, each party shall be subject to the terms of this BAA.

1. Definitions. Terms used, but not otherwise defined, in this BAA shall have the same meaning as set forth in 45 Code of Federal Regulations ("C.F.R.") Parts 160-64 HIPAA, or in the HITECH Act.

1.1. "Business Associate" means Contractor.

1.2 "Covered Entity" means Community Health Plan of Washington.

1.3 "Data Aggregation" has the meaning given such term in 45 CFR § 164.501.

1.4 "Designated Record Set" has the meaning given to such term in 45 CFR § 164.501.

1.5 "Electronic Protected Health Information" ("EPHI") has the meanings set out in 45 CFR. § 160.103.

1.6 "Privacy Rule" means the Standards for Privacy of Individually Identifiable Health Information as 45 CFR part 160 and part 164, subparts A and E.

1.7 "Protected Health Information" ("PHI") has the meaning given to such term in 45 CFR § 160.103, limited to the information created or received by Business Associate from or on behalf of Covered Entity. For purposes of this BAA, PHI encompasses EPHI.

1.8 "Required by Law" has the meaning set out in 45 C.F.R. § 164.103

1.9 "Security Rule" shall mean the Security Standards for the Protection of Electronic Health Information at 45 CFR part 160 and part 164, subparts A and C.

1.10 "Use" means, with respect to PHI, utilization, employment, examination, analysis or application by Business Associate.

2. Permitted Uses and Disclosures. Business Associate is permitted to use and disclose PHI that it creates or receives on Covered Entity's behalf (or from another business associate of Covered Entity) and to request PHI on Covered Entity's behalf (collectively, "Covered Entity's PHI") only as follows:

2.1 Functions and Activities on Covered Entity's Behalf. To perform functions, activities, services on behalf of Covered Entity consistent with the HIPPA and the HITECH Act as specified between the parties.

2.2 Business Associate's Operations. For Business Associate's proper management and administration or to carry out its legal responsibilities, provided that, with respect to such disclosure of Covered Entity's PHI:

15.2.2.1The disclosure is Required by Law; or

2.2.2 Business Associate obtains reasonable assurance, evidenced by written contract or proper authorization, from any person or entity to which Business Associate intends to disclose/will be disclosing Covered Entity's PHI;

2.2.3. The person or entity will hold Covered Entity's PHI in confidence and use or further disclose such PHI only for the purpose for which Business Associate disclosed such PHI to the person or entity or as Required by Law; and will immediately notify Business Associate of any instance in which the confidentiality of Covered Entity's PHI was breached.

2.3 Minimum Necessary and Limited Data Set. Business Associate's use, disclosure or request of Covered Entity's PHI shall utilize a Limited Data Set if practicable. Otherwise, Business Associate will, in its performance of the functions, activities, services, and operations specified in Section 2.2 above, make reasonable efforts to use, to disclose, and to request of Covered Entity only the minimum amount of Covered Entity's PHI reasonably necessary to accomplish the intended purpose of the use, disclosure or request, except that Business Associate will not be obligated to comply with this minimum necessary limitation with respect to:

2.3.1 Disclosure to or request by a health care provider for Treatment;

2.3.2 Use for or disclosure to an individual who is the subject of the Covered Entity's PHI, or that individual's personal representative;

2.3.3 Use or disclosure made pursuant to an authorization compliant with 45 CFR. § 164.508 that is signed by an individual who is the subject of the Covered Entity's PHI to be used or disclosed, or by that individual's personal representative;

2.3.4 Disclosure to HHS in accordance with Section 7.3 of this BAA;

2.3.5 Use or disclosure that is required by Law; or

2.3.6 Any other use or disclosure that is excepted from the minimum necessary limitation as specified in 45 CFR. § 164.502(b)(2).

3. Prohibition on Unauthorized Use or Disclosure. Business Associate will neither use nor disclose Covered Entity's PHI except as permitted or required by this BAA, or in writing by Covered Entity, or as Required by Law. This BAA does not authorize Business Associate to use or disclose Covered Entity's PHI in a manner that will violate the 45 CFR. Part 164, Subpart E "Privacy of Individually Identifiable Health Information" ("Privacy Rule"), except as set forth in Section 2.2 of this BAA.

4. Information Safeguards.

4.1 Privacy of PHI. Business Associate will develop, implement, maintain, and use appropriate administrative, technical, and physical safeguards to protect the privacy of Covered Entity's PHI. The safeguards must reasonably protect Covered Entity's PHI from any intentional or unintentional use or disclosure in violation of the Privacy Rule, 45 CFR. Part 164, Subpart E and this BAA, and limit incidental uses or disclosures made pursuant to a use or disclosure otherwise permitted by this BAA.

4.2 Security of Electronic PHI. Business Associate will develop, implement, maintain, and use administrative, technical, and physical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of Electronic PHI that Business Associate creates, receives, maintains, or transmits on Covered Entity's behalf as required by the Security Rule, 45 CFR. Part 164, Subpart C and as required by the HITECH Act. Business Associate also shall develop and implement policies and procedures and meet the Security Rule documentation requirements as required by the HITECH Act.

4.3 Subcontractors and Agents. Business Associate will require its subcontractors and agents to provide reasonable assurance, evidenced by written contract, that such subcontractor or agent will comply with the same privacy and security safeguard obligations with respect to Covered Entity's PHI that are applicable to Business Associate under this BAA.

5. Individual Rights Related to PHI.

5.1 Access. Business Associate will, within fifteen (15) days following Covered Entity's request, make available to Covered Entity or, at Covered Entity's direction, to an individual (or the individual's personal representative) for inspection and obtaining copies, Covered Entity's PHI about the individual in a designated record set that is in Business Associate's custody or control, so that Covered Entity may meet its access obligations under 45 CFR. § 164.524 and, where applicable, the HITECH Act. Business Associate shall make such information available in an electronic format where directed by Covered Entity.

5.2 Amendment. Business Associate will, upon receipt of written notice from Covered Entity, promptly amend or permit Covered Entity access to amend any portion of Covered Entity's PHI, or a record about the individual in a designated record set for as long as the information is contained in the designated record set, so that Covered Entity may meet its amendment obligations under 45 CFR. § 164.526.

5.3 Disclosure Accounting. So that Covered Entity may meet its disclosure accounting obligations under 45 CFR. § 164.528:

5.3.1 Disclosures Subject to Accounting. Business Associate will record the information specified in Section 5.3.3 below ("Disclosure Information") for each disclosure of Covered Entity's PHI, not excepted from disclosure accounting as specified in Section 5.3.2 below, that Business Associate makes to Covered Entity or to a third party.

5.3.2 Disclosures Not Subject to Accounting. Business Associate will not be obligated to record Disclosure Information or otherwise account for the following disclosures of Covered Entity's PHI:

5.3.2.1 That occurred before April 14, 2003;

5.3.2.2 For Treatment, Payment or Health Care Operations activities (except where such recording or accounting is required by the HITECH Act, and as of the effective dates for this provision of the HITECH Act);

5.3.2.3 To an individual who is the subject of Covered Entity's PHI disclosed, or to that individual's personal representative;

5.3.2.4 Pursuant to an authorization compliant with 45 CFR. § 164.508 that is signed by an individual who is the subject of Covered Entity's PHI disclosed, or by that individual's personal representative;

5.3.2.5 For notification of and to persons involved in the care or payment related to the health care of an individual who is the subject of Covered Entity's PHI disclosed and for disaster relief.

5.3.2.6 To law enforcement officials or correctional institutions in accordance with 45 CFR. § 164.512(k)(5);

5.3.2.7 For national security or intelligence purposes in accordance with 45 CFR. § 164.512(k)(2);

5.3.2.7 Incident to a use or disclosure that Business Associate is otherwise permitted to make by this BAA; and

5.3.2.8 Otherwise excepted from disclosure accounting as specified in 45 CFR. § 164.528.

5.3.3 Disclosure Information. For any disclosure by Business Associate of Covered Entity's PHI that is not excepted from disclosure accounting by Section 5.3.2 above, Business Associate will record the following Disclosure Information as applicable:

5.3.3.1 Disclosure Information Generally. Except for repetitive disclosures of Covered Entity's PHI as specified in Section 5.3.3.2 below, the Disclosure Information that Business Associate must record for each accountable disclosure is (i) the disclosure date, (ii) the name and (if known) address of the entity to which Business Associate made the disclosure, (iii) a brief description of the Covered

Entity's PHI disclosed, and (iv) a brief statement of the purpose of the disclosure. Business Associate further shall provide any additional information to the extent required by the HITECH Act and any accompanying regulations.

5.3.3.2 Disclosure Information for Repetitive Disclosures. For repetitive disclosures of Covered Entity's PHI that Business Associate makes for a single purpose to the same person or entity (including Covered Entity), the Disclosure Information that Business Associate must record is either the Disclosure Information specified in Section 5.3.3.1 above for each accountable disclosure, or (i) the Disclosure Information specified in Section 5.3.3.1 above for the first of the repetitive accountable disclosures, (ii) the frequency, periodicity, or number of the repetitive accountable disclosures, and (iii) the date of the last of the repetitive accountable disclosures.

5.3.3.3 Availability of Disclosure Information. Unless otherwise provided under the HITECH Act, Business Associate will maintain the Disclosure Information for at least 6 years following the date of the accountable disclosure to which the Disclosure Information relates. Business Associate will make the Disclosure Information available to Covered Entity within ten (10) days following a request from Covered Entity for such Disclosure Information to comply with an individual's request for disclosure accounting.

5.3.4 Restriction Agreements and Confidential Communications. Business Associate will comply with any agreement that Covered Entity makes that either (i) restricts use or disclosure of Covered Entity's PHI pursuant to 45 CFR. § 164.522(a), or (ii) requires confidential communication about Covered Entity's PHI pursuant to 45 CFR. § 164.522(b), such obligation shall become effective upon receipt of notice in writing to Business Associate from Covered Entity of the restriction or confidential communication obligations that Business Associate must follow. Covered Entity will promptly notify Business Associate in writing of the termination of any such restriction agreement or confidential communication requirement and, with respect to termination of any such restriction agreement, instruct Business Associate whether any of the Covered Entity's PHI will remain subject to the terms of the restriction agreement.

6. Privacy Obligations, Breach and Security Incidents.

6.1 Reporting.

6.1.1 Privacy Breach. Business Associate will immediately report to Covered Entity, any use or disclosure of Covered Entity's PHI not permitted by this BAA. In addition, Business Associate will report, immediately following discovery, any "Breach" of "Unsecured PHI" as these terms are defined by the HITECH Act and any implementing regulations. Business Associate and Covered Entity shall cooperate in investigating the Breach and in meeting their respective obligations under the HITECH Act and any other security breach notification laws.

6.1.2 Any such report shall include the identification (if known) of each individual whose Unsecured PHI has been, or is reasonably believed by Business Associate to have been, accessed, acquired, or disclosed during such Breach. Business Associate will make the report to Covered Entity's Privacy Officer not more than five (5) business days after Business Associate learns of such non-permitted use or disclosure.

Business Associate's report will at least:

6.1.2.1 Identify the nature of the non-permitted access, use or disclosure, including the date of the Breach and the date of discovery of the Breach;

6.1.2.2 Identify Covered Entity's PHI accessed, used or disclosed as part of the Breach (e.g., full name, social security number, date of birth, etc.);

6.1.2.3 Identify who made the non-permitted access, use or disclosure and who received the non-permitted disclosure;

6.1.2.4 Identify what corrective action Business Associate took and will take, to prevent further non-permitted access, uses or disclosures;

6.1.2.5 Identify what Business Associate did and will do, to mitigate any deleterious effect of the non-permitted access, use or disclosure; and

6.1.2.6 Provide such other information, including a written report, as Covered Entity reasonably requests.

6.1.3 Security Incidents. Business Associate will report to Covered Entity any attempted or successful unauthorized access, use, disclosure, modification, or destruction of Electronic PHI. Business Associate will make this report in accordance with Section 6.1.1 above.

6.2 Termination of BAA.

6.2.1 Right to Terminate for Breach.

6.2.1.1 Covered Entity may terminate this BAA if it determines that Business Associate has breached any provision of this BAA and upon written notice to Business Associate of the breach, Business Associate fails to cure the breach within 30 days after receipt of the notice. Covered Entity may exercise this right to terminate this BAA by providing Business Associate written notice of termination, stating the failure to cure the breach of the BAA that provides the basis for the termination. Any such termination will be effective immediately or at such other date specified in Covered Entity's notice of termination.

If for any reason Covered Entity determines that Business Associate has breached the terms of this BAA and such breach has not been cured, but Covered Entity determines that termination of the BAA is not feasible, Covered Entity may report such breach to HHS.

6.2.1.2 Business Associate may terminate the BAA if it determines that Covered Entity has breached any provision of this BAA and upon written notice to Covered Entity of the breach, Covered Entity fails to cure the breach within 30 days after receipt of the notice. Business Associate may exercise this right to terminate by providing Covered Entity written notice of termination, stating the failure to cure the breach of the BAA that provides the basis for the termination. Any such termination

will be effective immediately or at such other date specified in Business Associate's notice of termination.
If for any reason Business Associate determines that Covered Entity has breached the terms of this BAA and such breach has not been cured, but Business Associate determines that termination of this BAA is not feasible, Business Associate may report such breach to HHS.

6.3 Obligations on Termination.

6.3.1 Return or Destruction of PHI as Feasible. Upon termination or other conclusion of the BAA, Business Associate will, if feasible, return to Covered Entity or destroy all Covered Entity's PHI in whatever form or medium, including all copies thereof and all data, compilations, and other works derived therefrom that allow identification of any individual who is a subject of the PHI. Business Associate will require any subcontractor or agent, to which Business Associate has disclosed Covered Entity's PHI as permitted by Section 4.3 of this BAA, to if feasible return to Business Associate (so that Business Associate may return it to the Covered Entity) or destroy all of Covered Entity's PHI in whatever form or medium received from Business Associate, including all copies thereof and all data, compilations, and other works derived therefrom that allow identification of any individual who is a subject of the PHI, and certify on oath to Business Associate that all such information has been returned or destroyed. Business Associate will complete these obligations as promptly as possible, but not later than thirty (30) days following the effective date of the termination, the last required use of Covered Entity's PHI under the Arrangement, or other conclusion of the Arrangement.

6.3.2 Procedure When Return or Destruction Is Not Feasible. Business Associate will identify any of the Covered Entity's PHI, including any that Business Associate has disclosed to subcontractors or agents as permitted by Section 4.3 of this BAA, that cannot feasibly be returned to Covered Entity or destroyed and explain why return or destruction is infeasible. Where Covered Entity agrees that such return or destruction is infeasible, Business Associate will limit its further use or disclosure of such information to those purposes that make return or destruction of such information infeasible. If Covered Entity does not agree, sub-section 6.3.above shall apply. Business Associate will, by its written contract with any subcontractor or agent to which Business Associate discloses Covered Entity's PHI as permitted by Section 4.3 of this BAA, require such subcontractor or agent to limit its further use or disclosure of the PHI that such subcontractor or agent cannot feasibly return or destroy to those purposes that make the return or destruction of such information infeasible. Business Associate will complete these obligations as promptly as possible, but not later than thirty (30) days following the effective date of the termination, the last required use of Covered Entity's PHI under the Arrangement, or other conclusion of the Arrangement.

6.3.3 Continuing Privacy and Security Obligation. Business Associate's obligation to protect the privacy and safeguard the security of Covered Entity's PHI as specified in this BAA will be continuous and survive termination of this BAA.

6.3.4 Other Obligations and Rights. Business Associate's other obligations and rights and Covered Entity's obligations and rights upon termination or other conclusion of this BAA are those set out in Section 6.3 of the BAA.

7 General Provisions.

7.1 Indemnity. Each party to this BAA agrees to indemnify and hold harmless the other party and any affiliate, officer, director, employee or agent from and against any claim, cause of action, liability, damage, cost or expense, including attorneys' fees and court or proceeding costs, arising out of or in connection with any non-permitted use or disclosure of Covered Entity's PHI or other breach of this BAA by the indemnifying party.

7.2 Remedies. In addition to other rights and responsibilities under the Agreement, Business Associate agrees that monetary damages would be inadequate to compensate Covered Entity for any breach by Business Associate or any sub-Business Associate or agent of Business Associate of the covenants and agreements set forth herein. Accordingly, Business Associate acknowledges and agrees that any such breach or threatened breach will cause irreparable injury to Covered Entity and that, in addition to any other remedies that may be available, in laws, in equity or otherwise, Covered Entity will be entitled to specific performance and injunctive relief as remedies for any such breach. Such remedies will not be deemed to be the exclusive remedies for any breach of this Agreement but will be in addition to all other remedies available at law or in equity to the non-breaching party.

7.3 Inspection of Internal Practices, Books, and Records. Business Associate will make its internal practices, books, and records relating to its use and disclosure of Covered Entity's PHI available to Covered Entity, and to Department of Health and Human Services ("DHHS") to determine Covered Entity's compliance with the Privacy Rule, 45 CFR. Part 164, Subpart E, and the Security Rule and HITECH.

7.4 Amendment to BAA. No provision of this BAA may be modified except by a written document signed by a duly authorized representative of the parties. The parties agree to negotiate in good faith to amend this BAA, as appropriate, to conform to any new or revised legislation, rules and regulations to which either Covered Entity is subject now or in the future including, without limitation, HIPAA, as amended by HITECH. If, within ninety (90) days of either party first providing written notice to the other of the need to amend this BAA to comply with such change in legislation, rules, or regulations, the parties, acting in good faith are i) unable to mutually agree upon and make amendments or alterations to this BAA to meet the requirements in question, or ii) alternatively, the parties determine in good faith that amendments or alterations to the requirements are not feasible, then either party may terminate the BAA upon thirty (30) days written notice.

7.5 Conflicts. The terms and conditions of applicable law will override and control any conflicting term or condition of this BAA. In such event, all non-conflicting terms and conditions of BAA will remain in full force and effect.

Community Health Plan of Washington	North Sound Mental Health Administration / Contractor
Signature	Signature
By: Abie J Castillo	By:
Title: VP, Network Development	Title: Executive Director
Date: 12/31/12	Date: 12-13-12

RECEIVED
JAN 22 2013
NSMHA

JOINT OPERATING AGREEMENT

BETWEEN

COMMUNITY HEALTH PLAN OF WASHINGTON, MANAGED HEALTH CARE ORGANIZATION

AND

NORTH SOUND MENTAL HEALTH REGIONAL SUPPORT NETWORK

The Operational Agreement is between the Community Health Plan of Washington, a Managed Health Care Organization contracted with the Washington State Health Care Authority to manage Healthy Options and Basic Health Plan(herein after referred to as the **Health Plan**) and North Sound Mental Health RSN, the Regional Support Network (**RSN**) contracted with Washington State Division of Behavior Health and Recovery Services to manage a Prepaid Inpatient Health Plan (PIHP)(herein after referred to as the **RSN**).

I. PURPOSE

This agreement delineates the roles and responsibilities of the **Health Plan** and the **RSN** related to the provision of mental health benefits for their enrollees who are insured under Washington State Medicaid Healthy Options contract and the Washington State Medicaid PIHP contract.

This agreement also demonstrates a shared commitment by both the **Health Plan** and the **RSN** to coordinate care for persons who are involved in or require services from both systems of care.

This agreement is not intended to identify the operational procedures specific to each **Health Plan** and each **RSN**. To ensure that both **Health Plan** and **RSN** responsibilities are fully met, details of the local procedures and agreements between each **Health Plan** and each **RSN** will be developed through ongoing collaborative efforts during the first year of this Operating Agreement.

II. BACKGROUND

A. Health Plan

The **Health Plan** provides managed health care services to eligible individuals insured under the Healthy Options Plan in Washington State.

B. RSN

The **RSN** provides covered mental health services to eligible consumers in Washington State.

III. RESPONSIBILITIES AND ROLES

A. Sharing Protected Health Information

The **Health Plan** and the **RSN** agree that information shared under this agreement is shared for the purpose of coordination of treatment and/or health care operations. The **Health Plan** and the **RSN** also agree not to use or disclose protected health information other than as permitted or required by this Agreement, HIPAA and the Health Information Technology for Economic and Clinical Health Act (HITECH). The parties shall use and disclose protected health information only if such use or disclosure, respectively, is in compliance with each applicable requirement of 45 CFR § 164.504(e).

B. Referrals between the Health Plan and the RSN

While both the **Health Plan** and the **RSN** benefit plans cover medically necessary mental health services the scope of the benefits are distinct. The mental health benefit under the **Health Plan** is a limited benefit. The **RSN** mental health benefit has a broad scope and serves individuals with the need for higher intensity and/or specialty mental health services. The Washington State Medicaid Program PIHP requires enrollees to meet both medical necessity and Mental Health Access to Care Criteria to define members' qualification for **RSN** mental health services.

Consumer choices, and/ or person centered care, are essential guiding principles of this agreement. Therefore, enrollees covered under Healthy Options may approach either the **Health Plan** or the **RSN** network providers to request mental health services.

Enrollees who choose to access the **Health Plan** may be referred to the **RSN** by the **Health Plan** providers if it appears that they may meet Access to Care criteria. Enrollees who choose to access an **RSN** network provider will be assessed and either authorized by the **RSN** into care or referred to the **Health Plan** based on PIHP criteria.

1. **RSN** Responsibility

   a. The **RSN** has the responsibility to provide a face-to-face assessment for any person enrolled in Medicaid who requests an intake to determine if the individual meets medical necessity and Access to Care criteria for **RSN** mental health services. The **RSN** shall accept a referral from the **Health Plan** for a face-to-face assessment when the **Health Plan** believes the individual may meet Access to Care criteria for the **RSN** mental health benefit.
   b. The **RSN** will authorize and serve any individual who meets medical necessity and the Access to Care criteria and chooses to be served by the **RSN** contracted provider.
   c. The **RSN** will refer individuals to the **Health Plan** for mental health benefits when the individual does not meet Access to Care criteria or medical eligibility, or has graduated from **RSN** services and/or no

longer meets criteria for access to **RSN** services but still may meet medical necessity for the **Health Plan** mental health benefit.

2. **Health Plan** Responsibility

   a. The **Health Plan** has the responsibility to determine if their members meet medical necessity for their mental health benefit or if a referral to the **RSN** for an assessment is warranted. The **Health Plan** is also responsible to provide a Covered mental health benefit for their Healthy Option members who present with medical necessity for mental health services and do not meet the **RSN** PIHP Access to Care criteria.
   b. The **Health Plan** may refer individuals at any time to the **RSN** even if they have been served under the **Health Plan's** mental health benefit to determine if the individual meets Access to Care criteria for **RSN** mental health benefits.

C. Coordination of Care and Care Transitions

The **RSN** and the **Health Plan** have responsibility to assure that enrollees who have multiple needs and make frequent use of the systems of care are provided with quality coordinated care. Specific attention shall also be paid to individuals with co-morbid physical and mental health conditions who are admitted to institutional care for either physical health or mental health conditions. The **RSN** and the **Health Plan** and their respective designees (e.g. care managers, contractors and provider networks) will collaborate on coordination of care for persons who are involved in or require services from both systems of care.

1. **RSN** Responsibility
   a. The **RSN** shall participate in the Care Transitions Performance Improvement Plan pursuant to the requirements in the **RSN** contract with the State Division of Behavioral Health and Recovery Services (DBHR)
   b. The **RSN** shall provide timely information to the **Health Plan** related to psychiatric hospital admission and discharge for **Health Plan** Healthy Options members.
   c. The **RSN** and its designees will collaborate with **Health Plan** care coordination activities for individuals who are identified through the state PRISM system with high risk scores. During the first year of this agreement the **RSN** will work with the **Health Plan** to develop procedures and/or protocols for their collaboration on care coordination for persons who are identified as high risk.

2. **Health Plan** Responsibility
   a. The **Health Plan** shall participate in the Care Transitions Performance Improvement Plan pursuant to the requirements in the Healthy Options contract with the State Health Care Authority (HCA).
   b. The **Health Plan** shall provide timely information related to medical hospital admission and discharge for **Health Plan** Healthy Options members receiving **RSN** PIHP services.

c. The **Health Plan** and its designees will collaborate with **RSN** care coordination activities for individuals who are identified through the State PRISM system with high risk scores. During the first year of this agreement the **Health Plan** will work with the **RSN** to develop procedures and/or protocols for their collaboration on care coordination for persons who are identified as high risk.

D. Communications

1. Each **Health Plan** and each **RSN** will provide contact information for functions that will be coordinated between the **Health Plan** and the **RSN**. The individual contacts will include at minimum:
   a. Referrals
   b. Care Coordination and Care Management
   c. Crisis Services Contacts
   d. Data Sharing
   e. Performance Improvement and Quality Management
   f. Dispute Resolution
   g. Critical Incidents

2. The **Health Plan** and the **RSN** agree to participate in further development of additional guidelines and operational procedures that will enhance the bi-directional care coordination between entities. The areas to be addressed may include, but are not limited to the following:
   a. Referral Procedures
   b. Screening Guidelines
   c. Notification of Admissions to Institutional Care
   d. Care Transitions/Discharge Planning from Institutional Care
   e. Continuing Care Transitions
   f. Care Management and Coordination
   g. Performance Measures and Improvement Processes
   h. Notifications of Emergent Care
   i. Data Sharing
   j. Dispute Resolution
   k. Notification of Critical Incidents

IV. Dispute Resolution

1. All disputes occurring between the parties of this agreement shall be resolved through informal negotiation between the parties of the Agreement. A guiding principle for resolving disputes is that resolution should be sought at the lowest level and only progress up the hierarchy when satisfactory resolution has not been achieved.
2. Failure to resolve disputes may result in termination of the Agreement.

V. Term and Termination

1. The effective date of this Agreement will be upon the final signature of the parties to this Agreement and it shall remain in effect until it is terminated in accordance with the terms of this Agreement.
2. Any of the parties to this Agreement may withdraw and terminate their participation from this Agreement for any reason and at any time upon thirty (30) days written notice to the other party. Such notice and other correspondence related to this Agreement should be sent to the contacts and addresses listed below.

VI. Amendment

This Agreement may be amended at any time by written agreement and signature of all the parties.

IN WITNESS WHEREOF, the parties hereto have caused this Operating Agreement to be executed by the dates and signatures herein under affixed. The persons signing this Operating Agreement on behalf of the parties represent that each has authority to execute this Operating Agreement on behalf of the party entering into this Operating Agreement.

By: Joe Valentine

Print Name: Joseph Valentine
RSN Administrator

117 N 1st Street, Suite 8
Address

Mount Vernon, WA 98273
City, State Zip

9/11/2012
Date

By:

Abie Castillo
Vice President, Network Development

720 Olive Way, Ste. 300
Address

Seattle, WA 98101
City, State Zip

10/1/12
Date

RECEIVED
OCT 12 2012
NSRHA

JOINT OPERATING AGREEMENT

BETWEEN

CENPATICO BEHAVIORAL HEALTH, LLC MANAGED HEALTH CARE ORGANIZATION

AND

NORTH SOUND REGIONAL SUPPORT NETWORK

The Operational Agreement ("Agreement") is between the Cenpatico Behavioral Health, LLC a Managed Health Care Organization contracted with the Washington State Health Care Authority to manage Healthy Options and Basic Health Plan(herein after referred to as the Health Plan) and the North Sound Regional Support Network (RSN) contracted with Washington State Division of Behavior Health and Recovery Services to manage a Prepaid Inpatient Health Plan (PIHP)(herein after referred to as the RSN) and serves Whatcom, Skagit, Snohomish, Island and San Juan Counties.

I. PURPOSE

This Agreement delineates the roles and responsibilities of the Health Plan and the RSN related to the provision of mental health benefits for their enrollees who are insured under Washington State Medicaid Healthy Options contract and the Washington State Medicaid PIHP contract.

This Agreement also demonstrates a shared commitment by both the Health Plan and the RSN to coordinate care for persons who are involved in or require services from both systems of care.

This Agreement is not intended to identify the operational procedures specific to each Health Plan and each RSN. To ensure that both Health Plan and RSN responsibilities are fully met, details of the local procedures and agreements between each Health Plan and each RSN will be provided in an attachment to this Agreement to be completed by September 01, 2012 ("Operational Agreement Attachment").

II. BACKGROUND

A. Health Plan

The Health Plan provides managed health care services to eligible individuals insured under the Healthy Options Plan in Whatcom, Skagit, Snohomish, Island and San Juan Counties.

B. RSN

The North Sound Regional Support Network provides covered mental health services to eligible consumers in Whatcom, Skagit, Snohomish, Island and San Juan Counties.

III. RESPONSIBILITIES AND ROLES

A. Sharing Protected Health Information

The parties agree that information shared under this Agreement is shared for the purpose of coordination of treatment and/or health care operations. The parties also agree not to use or disclose protected health information other than as permitted or required by this Agreement, HIPAA and the Health Information Technology for Economic and Clinical Health Act (HITECH). The parties shall use and disclose protected health information only if such use or disclosure, respectively, is in compliance with each applicable requirement of 45 CFR § 164.504(e).

B. Referrals between the Health Plan and the RSN

While both the Health Plan and the RSN benefit plans cover medically necessary mental health services the scope of the benefits are distinct. The mental health benefit under the Health Plan is a limited benefit . The RSN mental health benefit has a broad scope and serves individuals with need for higher intensity and/or specialty mental health services. The Washington State Medicaid Program PIHP requires enrollees to meet both medical necessity and mental health access to care criteria ("Access to Care Criteria") to define members' qualification for RSN mental health services.

Consumer choices, and/ or person centered care, are essential guiding principles of this Agreement. Therefore, enrollees covered under Healthy Options may approach either the Health Plan or the RSN network providers to request mental health services.

Enrollees who choose to access the Health Plan may be referred to the RSN by the Health Plan providers if it appears that they may meet Access to Care Criteria. Enrollees who choose to access an RSN network provider will be assessed and either authorized by the RSN into care or referred to the Health Plan based on PIHP criteria.

1. **RSN Responsibility**

   a. The RSN has the responsibility to provide a face-to-face assessment for any person enrolled in Medicaid who requests an intake to determine if the individual meets medical necessity and Access to Care criteria for RSN mental health services. The RSN shall accept a referral from the Health Plan for a face-to-face assessment when the Health Plan believes the individual may meet Access to Care criteria for the RSN mental health benefit.
   b. The RSN will authorize and serve any individual who meets medical necessity and the Access to Care Criteria and chooses to be served by the RSN contracted provider.
   c. The RSN will refer individuals to the Health Plan for mental health benefits when the individual does not meet Access to Care criteria or medical eligibility, or has graduated from RSN services and/or no longer meets Access to Care Criteria to RSN services but still may meet medical necessity for the Health Plan mental health benefit.

2. **Health Plan Responsibility**

a. The Health Plan has the responsibility to determine if their members meet medical necessity for their mental health benefit or if a referral to the RSN for an assessment is warranted. The Health Plan is also responsible to provide a mental health benefit for their Healthy Option members who present with medical necessity for mental health services and do not meet the RSN PIHP Access to Care Criteria.
b. The Health Plan may refer individuals at any time to the RSN even if they have been served under the Health Plan's mental health benefit to determine if the individual meets Access to Care Criteria for RSN mental health benefits.

C. Coordination of Care and Care Transitions

The RSN and the Health Plan have responsibility to assure that enrollees who have multiple needs and make frequent use of the systems of care are provided with quality coordinated care. Specific attention shall also be paid to individuals with co-morbid physical and mental health conditions who are admitted to institutional care for either physical health or mental health conditions. The RSN and the Health Plan and their respective designees (e.g. care managers, contractors, provider networks) will collaborate on coordination of care for persons who are involved in or require services from both systems of care.

1. **RSN Responsibility**
   a. The RSN shall participate in the Care Transitions Performance Improvement Plan pursuant to the requirements in the RSN contract with the state Division of Behavioral Health and Recovery Services (DBHR).
   b. The RSN shall provide timely information related to psychiatric hospital admission and discharge for Health Plan Healthy Options members.
   c. The RSN and its designees will collaborate with Health Plan care coordination activities for individuals who are identified through the state PRISM system with high risk scores. During the first year of this Agreement the RSN will work with the Health Plan to develop procedures and/or protocols for their collaboration on care coordination for persons who are identified as high risk.
   d. Additional region specific procedures are provided in the Operational Agreement Attachment.

2. **Health Plan Responsibility**
   a. The Health Plan shall participate in the Care Transitions Performance Improvement Plan pursuant to the requirements in the Healthy Options contract with the state Health Care Authority (HCA).
   b. The Health Plan shall provide timely information related to medical hospital admission and discharge for Health Plan Healthy Options members receiving RSN PIHP services.
   c. The Health Plan and its designees will collaborate with RSN care coordination activities for individuals who are identified through the state PRISM system with high risk scores. During the first year of this Agreement the Health Plan will work with the RSN to develop procedures and/or protocols for their collaboration on care coordination for persons who are identified as high risk.
   d. Additional region specific procedures are provided in the Operational Agreement Attachment.

D. Communications

1. Each Health Plan and each RSN will provide contact information for functions that will be coordinated between the Health Plan and the RSN. The individual contacts provided in the Operation Agreement Attachment will include at minimum:
   a. Referrals
   b. Care Coordination and Care Management
   c. Crisis Services Contacts
   d. Data Sharing
   e. Performance Improvement and Quality Management
   f. Dispute Resolution
   g. Critical Incidents

2. The Health Plan and the RSN agree to participate in further development of additional guidelines and operational procedures that will enhance the bi-directional care coordination between entities. The areas to be addressed may include, but are not limited to the following:
   a. Referral Procedures
   b. Screening Guidelines
   c. Notification of Admissions to Institutional Care
   d. Care Transitions/Discharge Planning from Institutional Care
   e. Continuing Care Transitions
   f. Care Management and Coordination
   g. Performance Measures and Improvement Processes
   h. Notifications of Emergent Care
   i. Data Sharing
   j. Dispute Resolution
   k. Notification of Critical Incidents

IV. Hold Harmless

1. Regardless of any verbal statements made prior to or following signature on this Agreement, nothing in this Agreement is intended to establish a legally binding agreement between the parties.
2. The parties of this Agreement will hold one another including their contractors, employees, interns and volunteers harmless for failure to perform any of the roles identified above, including termination of this Agreement with or without advance notice.
3. There shall be no remedy available to one party for failure to perform any role identified above by the other party, or a third party.

V. Dispute Resolution

1. All disputes occurring between the parties of this Agreement shall be resolved through informal negotiation between the parties of the Agreement. A guiding principle for resolving disputes is that resolution should be sought at the lowest level and only progress up the hierarchy when satisfactory resolution has not been achieved.
2. Failure to resolve disputes may result in termination of the Agreement.

VI. Term and Termination

1. The effective date of this Agreement will be upon the final signature of the parties to this Agreement and it shall remain in effect until it is terminated in accordance with the terms of this Agreement.
2. Any of the parties to this Agreement may withdraw and terminate their participation from this Agreement for any reason and at any time. Thirty (30) days written notice is preferred but not required. Such notice and other correspondence related to this Agreement should be sent to the contacts and addresses listed above.

VII. Amendment

This Agreement may be amended at any time by written agreement and signature of all the parties.

IN WITNESS WHEREOF, the parties hereto have caused this Agreement to be executed by the dates and signatures herein under affixed. The persons signing this Agreement on behalf of the parties represent that each has authority to execute the OA on behalf of the party entering this Agreement.

RSN Administrator

7/31/12
Date

~~Executive Director~~ CHIEF OPERATING OFFICER

9/26/12
Date

MOLINA® HEALTHCARE

RECEIVED
OCT 22 2012
NSMHA

October 19, 2012

North Sound Mental Health Administration
ATTN: Joe Valentine
117 North 1st Street, Ste. 8
Mt. Vernon, WA 98273-2858

Dear Provider:

Thank you for completing and returning the Joint Operating Agreement between Molina Healthcare of Washington, Inc. and your organization. Enclosed is one fully executed copy for your records.

I am happy to assist with any other questions and can be reached at (800) 869-7175 Ext. 144013 or by email at Nicole.Dickgieser@molinahealthcare.com. We look forward to working with you.

Sincerely,

Nicole Dickgieser
Provider Contract Specialist

Enclosures

JOINT OPERATING AGREEMENT

BETWEEN

MOLINA HEALTHCARE OF WASHINGTON, MANAGED HEALTH CARE ORGANIZATION

AND

NORTH SOUND MENTAL HEALTH ADMINISTRATION / NORTH SOUND REGIONAL SUPPORT NETWORK

The Joint Operating Agreement is between **Molina Healthcare of Washington**, a Managed Health Care Organization contracted with the Washington State Health Care Authority to manage Healthy Options and Basic Health Plan (herein after referred to as the **Health Plan**) and **North Sound Mental Health Administration**, a Regional Support Network contracted with Washington State Division of Behavior Health and Recovery Services to manage a Prepaid Inpatient Health Plan (PIHP)(herein after referred to as the **RSN**) and serves Island, San Juan, Skagit, Snohomish and Whatcom Counties.

I. PURPOSE

This Agreement delineates the roles and responsibilities of the **Health Plan** and the **RSN** related to the provision of mental health benefits for their enrollees who are insured under Washington State Medicaid Healthy Options contract and the Washington State Medicaid PIHP contract.

The Agreement also demonstrates a shared commitment by both the **Health Plan** and the **RSN** to coordinate care for persons who are involved in or require services from both systems of care.

This Agreement is not intended to identify the operational procedures specific to each Health Plan and each RSN. To ensure that both Health Plan and RSN responsibilities are fully met, details of the local procedures and agreements between each Health Plan and each RSN will be provided in an Attachment to this Joint Operating Agreement (*Referred to as the Joint Operating Agreement Attachment*).

II. BACKGROUND

A. Health Plan

The **Health Plan** provides managed health care services to eligible individuals insured under the Healthy Options Plan in Island, San Juan, Skagit, Snohomish and Whatcom Counties.

B. RSN

The **RSN** provides covered mental health services to eligible consumers in Island, San Juan, Skagit, Snohomish and Whatcom Counties.

III. RESPONSIBILITIES AND ROLES

A. Sharing Protected Health Information

The parties agree that information shared under this Agreement is shared for the purpose of coordination of treatment and/or health care operations. The parties also agree not to use or disclose protected health information other than as permitted or required by this Agreement, HIPAA and the Health Information Technology for Economic and Clinical Health Act (HITECH) and/or other applicable law.

B. Referrals between the Health Plan and the RSN

While both the **Health Plan** and the **RSN** benefit plans cover medically necessary mental health services the scope of the benefits are distinct. The mental health benefit under the **Health Plan** is a limited benefit. The **RSN** mental health benefit has a broad scope and serves individuals with need for higher intensity and/or specialty mental health services. The Washington State Medicaid Program PIHP requires enrollees to meet both medical necessity and Mental Health Access to Care Criteria to define members' qualification for **RSN** mental health services.

Consumer choices, and/ or person centered care, are essential guiding principles of this Agreement. Therefore, enrollees covered under Healthy Options may approach either the **Health Plan** or the **RSN** network providers to request mental health services.

Enrollees who choose to access the **Health Plan** may be referred to the **RSN** by the **Health Plan** providers if it appears that they may meet Access to Care criteria. Enrollees who choose to access an RSN network provider will be assessed and either authorized by the RSN into care or referred to the Health Plan based on PIHP criteria.

1. **RSN** Responsibility

   a. The **RSN** has the responsibility to provide a face-to-face assessment for any person enrolled in Medicaid who requests an intake to determine if the individual meets medical necessity and Access to Care criteria for **RSN** mental health services. The **RSN** shall accept a referral from the **Health Plan** for a face-to-face assessment when the **Health Plan** believes the individual may meet Access to Care criteria for the **RSN** mental health benefit.
   b. The **RSN** will authorize and serve any individual who meets medical necessity and the Access to Care criteria and chooses to be served by the **RSN** contracted provider.
   c. The **RSN** will refer individuals to the **Health Plan** for mental health benefits when the individual does not meet Access to Care criteria or medical eligibility, or has graduated from RSN services and/or no longer meets criteria for access to **RSN** services but still may meet medical necessity for the **Health Plan** mental health benefit.

2. **Health Plan** Responsibility

   a. The **Health Plan** has the responsibility to determine if their members meet medical necessity for their mental health benefit or if a referral to the **RSN** for an assessment is warranted. The **Health Plan** is also responsible to provide a mental health benefit for their Healthy Option members who present with medical necessity for mental health services and do not meet the **RSN** PIHP Access to Care criteria.
   b. The **Health Plan** may refer individuals at any time to the **RSN** even if they have been served under the **Health Plan's** mental health benefit to determine if the individual meets Access to Care criteria for **RSN** mental health benefits.

C. Coordination of Care and Care Transitions

The **RSN** and the **Health Plan** have responsibility to assure that enrollees who have multiple needs and make frequent use of the systems of care are provided with quality coordinated care. Specific attention shall also be paid to individuals with co-morbid physical and mental health conditions who are admitted to institutional care for either physical health or mental health conditions. The **RSN** and the **Health Plan** and their respective designees (e.g. care managers, contractors, provider networks) will collaborate on coordination of care for persons who are involved in or require services from both systems of care.

1. **RSN** Responsibility

   a. The **RSN** shall participate in the Care Transitions Performance Improvement Plan pursuant to the requirements in the RSN contract with the state Division of Behavioral Health and Recovery Services (DBHR)
   b. The **RSN** shall provide timely information related to psychiatric hospital admission and discharge for **Health Plan** Healthy Options members.
   c. The **RSN** and its designees will collaborate with **Health Plan** care coordination activities for individuals who are identified through the state PRISM system with high risk scores. During the first year of this agreement the **RSN** will work with the **Health Plan** to develop procedures and/or protocols for their collaboration on care coordination for persons who are identified as high risk.
   d. Additional region specific procedures are provided in the Joint Operating Agreement Attachment.

2. **Health Plan** Responsibility

   a. The **Health Plan** shall participate in the Care Transitions Performance Improvement Plan pursuant to the requirements in the Healthy Options contract with the state Health Care Authority (HCA).
   b. The **Health Plan** shall provide timely information related to medical hospital admission and discharge for **Health Plan** Healthy Options members receiving **RSN** PIHP services.

c. The **Health Plan** and its designees will collaborate with **RSN** care coordination activities for individuals who are identified through the state PRISM system with high risk scores. During the first year of this Agreement the **Health Plan** will work with the **RSN** to develop procedures and/or protocols for their collaboration on care coordination for persons who are identified as high risk.
d. Additional region specific procedures are provided in the Joint Operating Agreement Attachment.

D. Communications

1. Each **Health Plan** and each **RSN** will provide contact information for functions that will be coordinated between the **Health Plan** and the **RSN**. The individual contacts provided in the Joint Operating Agreement Attachment will include at minimum:
   a. Referrals
   b. Care Coordination and Care Management
   c. Crisis Services Contacts
   d. Data Sharing
   e. Performance Improvement and Quality Management
   f. Dispute Resolution
   g. Critical Incidents

2. The **Health Plan** and the **RSN** agree to participate in further development of additional guidelines and operational procedures that will enhance the bi-directional care coordination between entities. The areas to be addressed may include, but are not limited to the following:
   a. Referral Procedures
   b. Screening Guidelines
   c. Notification of Admissions to Institutional Care
   d. Care Transitions/Discharge Planning from Institutional Care
   e. Continuing Care Transitions
   f. Care Management and Coordination
   g. Performance Measures and Improvement Processes
   h. Notifications of Emergent Care
   i. Data Sharing
   j. Dispute Resolution
   k. Notification of Critical Incidents

IV. Hold Harmless

1. Regardless of any verbal statements made prior to or following signature on this Agreement, nothing in this Agreement is intended to establish a legally binding agreement between the parties.
2. The parties of this Agreement will hold one another including their contractors, employees, interns and volunteers harmless for failure to perform any of the roles identified above, including termination of this Agreement with or without advance notice.
3. There shall be no remedy available to one party for failure to perform any role identified above by the other party, or a third party.

V. Dispute Resolution

1. All disputes occurring between the parties of this Agreement shall be resolved through informal negotiation between the parties of the Agreement. A guiding principle for resolving disputes is that resolution should be sought at the lowest level and only progress up the hierarchy when satisfactory resolution has not been achieved.
2. Failure to resolve disputes may result in termination of the Agreement.

VI. Term and Termination

1. The effective date of this Agreement will be upon the final signature of the parties to this Agreement and it shall remain in effect until it is terminated in accordance with the terms of this Agreement.
2. Any of the parties to this Agreement may withdraw and terminate their participation from this Agreement for any reason and at any time upon thirty (30) days written notice to the other party. Such notice and other correspondence related to this Agreement should be sent to the contacts and addresses listed above.

VII. Amendment

This Agreement may be amended at any time by written agreement and signature of all the parties.

IN WITNESS WHEREOF, the parties hereto have caused this Joint Operating Agreement to be executed by the dates and signatures herein under affixed. The persons signing this Joint Operating Agreement on behalf of the parties represent that each has authority to execute the Joint Operating Agreement on behalf of the party entering this Joint Operating Agreement.

Joe Valentine
RSN Executive Director

9/28/12
Date

Glen H. Bogner
President

10/12/12
Date

ATTACHMENT

Joint Operating Agreement Attachment

This Attachment, as identified in the Joint Operating Agreement between **Molina Healthcare of Washington**, a Managed Care Health Organization and **North Sound Mental Health Administration**, a Regional Support Network, Article I. PURPOSE, details the local procedures and agreements between the Health Plan and RSN.

1. **Coordination of Care/Care Transition**

   A. **RSN Sharing:**
   - Psychiatric Hospital Admissions
   - If receiving services from RSN provider network, the Case Manager name, agency name, and contact information

   B. **Molina Healthcare Sharing:**
   For members who:
   - Meet Access to Care Standards and are currently receiving services from RSN provider network AND
   - Are enrolled in the Molina Case Management Program:
     a. Medical Hospital Admissions
     b. Emergency Department visits

   C. **Collaboration on High Risk Cases**
   The RSN and Molina Healthcare will coordinate and collaborate to assure best patient outcomes for high risk cases.

2. **Communication**

   A. **Contact List**
   i. Referrals: Erin Darrah (back up Christi Sahlin)
   ii. Care Coordination and Care Management: Erin Darrah (back up Christi Sahlin)
   iii. Medical Crisis Services Contacts: 24 hour Molina Nurse Advice Line
      a. English: 1-888-275-8750
      b. Spanish: 1-866-648-3537
      c. TTU: 1-866-735-2929
   iv. Data Sharing: Christi Sahlin (back up Lisa Andrade)
   v. Performance Improvement and Quality Management: Christi Sahlin (back up Lisa Andrade)
   vi. Dispute Resolution: Christi Sahlin (back up Lisa Andrade)
   vii. Critical Incidents: Christi Sahlin (back up Lisa Andrade)

Christi Sahlin, MSW, LICSW
Manager of Integrated Case Management
(425) 424-7103

Erin Darrah, RN, CCM
Supervisor of Integrated Case Management
(425) 424-7171

Lisa Andrade, RN, MSN, MBA
Director of Health Care Services
(425) 424-7172

B. Mechanism for Sharing & Updating Contact List:
Contact list included in Attachment. Updated contact list will be shared as information changes.

C. Other Data Sharing:
Molina Healthcare will share the following information with the RSN for members who are:

- Currently enrolled in Molina Healthcare AND
- Eligible for services from the RSN provider network
    a. Name
    b. Provider One ID#
    c. Address
    d. Phone Number
    e. DOB
    f. PCP
    g. Enrollment Date
    h. Currently enrolled in Case Management Program and if yes – name of assigned Case Manager

Molina Healthcare will share the following information with the RSN for members who are:

- Currently enrolled in Molina Healthcare AND
- Meet Access to Care Standards and are actively receiving services from the RSN provider network
    a. Diagnosis(s): both medical and psychiatric
    b. Physician visits in past 90 days (include both primary care and specialty care visits)
    c. All medications filled in the past 90 days
    d. Currently enrolled in Patient Review and Coordination Program (PRC)

JOINT OPERATING AGREEMENT

BETWEEN

UNITEDHEALTHCARE COMMUNITY PLAN, MANAGED HEALTH CARE ORGANIZATION

AND

NORTH SOUND REGIONAL SUPPORT NETWORK

The Operational Agreement is between the UNITEDHEALTHCARE Community Plan, a Managed Health Care Organization contracted with the Washington State Health Care Authority to manage Healthy Options and Basic Health Plan(herein after referred to as the **Health Plan**) and the North Sound Regional Support Network (RSN) contracted with Washington State Division of Behavior Health and Recovery Services to manage a Prepaid Inpatient Health Plan (PIHP)(herein after referred to as the **RSN**) and serves Island, San Juan, Skagit, Snohomish and Whatcom Counties.

I. PURPOSE

This agreement delineates the roles and responsibilities of the **Health Plan** and the **RSN** related to the provision of mental health benefits for their enrollees who are insured under Washington State Medicaid Healthy Options contract and the Washington State Medicaid PIHP contract.

The agreement also demonstrates a shared commitment by both the **Health Plan** and the **RSN** to coordinate care for persons who are involved in or require services from both systems of care.

This agreement is not intended to identify the operational procedures specific to each Health Plan and each RSN. To ensure that both Health Plan and RSN responsibilities are fully met, details of the local procedures and agreements between each Health Plan and each RSN will be provided in an attachment to this Operating Agreement to be completed by **September 01, 2012** (*Referred to as the Operation Agreement Attachment*).

II. BACKGROUND

A. Health Plan

The UNITEDHEALTHCARE Community Plan Health Plan provides managed health care services to eligible individuals insured under the Healthy Options Plan in Island, San Juan, Skagit, Snohomish and Whatcom Counties.

B. RSN

The North Sound Regional Support Network provides covered mental health services to eligible consumers in Island, San Juan, Skagit, Snohomish and Whatcom Counties.

III. RESPONSI BILITIES AND ROLES

A. Sharing Protected Health Information

The parties agree that information shared under this agreement is shared for the purpose of coordination of treatment and/or health care operations. The parties also agree not to use or disclose protected health information other than as permitted or required by this Agreement, HIPAA and the Health Information Technology for Economic and Clinical Health Act (HITECH). The parties shall use and disclose protected health information only if such use or disclosure, respectively, is in compliance with each applicable requirement of 45 CFR § 164.504(e).

B. Referrals between the Health Plan and the RSN

While both the **Health Plan** and the **RSN** benefit plans cover medically necessary mental health services the scope of the benefits are distinct. The mental health benefit under the **Health Plan** is a limited benefit. The **RSN** mental health benefit has a broad scope and serves individuals with need for higher intensity and/or specialty mental health services. The Washington State Medicaid Program PIHP requires enrollees to meet both medical necessity and Mental Health Access to Care Criteria to define members' qualification for **RSN** mental health services.

Consumer choices, and/ or person centered care, are essential guiding principles of this agreement. Therefore, enrollees covered under Healthy Options may approach either the **Health Plan** or the **RSN** network providers to request mental health services.

Enrollees who choose to access the **Health Plan** may be referred to the **RSN** by the **Health Plan** providers if it appears that they may meet Access to Care criteria. Enrollees who choose to access an RSN network provider will be assessed and either authorized by the RSN into care or referred to the Health Plan based on PIHP criteria.

1. **RSN** Responsibility

   a. The **RSN** has the responsibility to provide a face-to-face assessment for any person enrolled in Medicaid who requests an intake to determine if the individual meets medical necessity and Access to Care criteria for **RSN** mental health services. The **RSN** shall accept a referral from the **Health Plan** for a face-to-face assessment when the **Health Plan** believes the individual may meet Access to Care criteria for the **RSN** mental health benefit.
   b. The **RSN** will authorize and serve any individual who meets medical necessity and the Access to Care criteria and chooses to be served by the **RSN** contracted provider.
   c. The **RSN** will refer individuals to the **Health Plan** for mental health benefits when the individual does not meet Access to Care criteria or medical eligibility, or has graduated from RSN services and/or no

longer meets criteria for access to **RSN** services but still may meet medical necessity for the **Health Plan** mental health benefit.

2. **Health Plan** Responsibility

   a. The **Health Plan** has the responsibility to determine if their members meet medical necessity for their mental health benefit or if a referral to the **RSN** for an assessment is warranted. The **Health Plan** is also responsible to provide a mental health benefit for their Healthy Option members who present with medical necessity for mental health services and do not meet the **RSN** PIHP Access to Care criteria.
   b. The **Health Plan** may refer individuals at any time to the **RSN** even if they have been served under the **Health Plan's** mental health benefit to determine if the individual meets Access to Care criteria for **RSN** mental health benefits.

C. Coordination of Care and Care Transitions

The **RSN** and the **Health Plan** have responsibility to assure that enrollees who have multiple needs and make frequent use of the systems of care are provided with quality coordinated care. Specific attention shall also be paid to individuals with co-morbid physical and mental health conditions who are admitted to institutional care for either physical health or mental health conditions. The **RSN** and the **Health Plan** and their respective designees (e.g. care managers, contractors, provider networks) will collaborate on coordination of care for persons who are involved in or require services from both systems of care.

1. **RSN** Responsibility
   a. The **RSN** shall participate in the Care Transitions Performance Improvement Plan pursuant to the requirements in the RSN contract with the state Division of Behavioral Health and Recovery Services (DBHR).
   b. The **RSN** shall provide timely information related to psychiatric hospital admission and discharge for **Health Plan** Healthy Options members.
   c. The **RSN** and its designees will collaborate with **Health Plan** care coordination activities for individuals who are identified through the state PRISM system with high risk scores. During the first year of this agreement the **RSN** will work with the **Health Plan** to develop procedures and/or protocols for their collaboration on care coordination for persons who are identified as high risk.
   d. Additional region specific procedures are provided in the Operational Agreement Attachment.

2. **Health Plan** Responsibility
   a. The **Health Plan** shall participate in the Care Transitions Performance Improvement Plan pursuant to the requirements in the Healthy Options contract with the state Health Care Authority (HCA).
   b. The **Health Plan** shall provide timely information related to medical hospital admission and discharge for **Health Plan** Healthy Options members receiving **RSN** PIHP services.

c. The **Health Plan** and its designees will collaborate with **RSN** care coordination activities for individuals who are identified through the state PRISM system with high risk scores. During the first year of this agreement the **Health Plan** will work with the **RSN** to develop procedures and/or protocols for their collaboration on care coordination for persons who are identified as high risk.
d. Additional region specific procedures are provided in the Operational Agreement Attachment.

D. Communications

1. Each **Health Plan** and each **RSN** will provide contact information for functions that will be coordinated between the **Health Plan** and the **RSN**. The individual contacts provided in the Operation Agreement Attachment will include at minimum:
   a. Referrals
   b. Care Coordination and Care Management
   c. Crisis Services Contacts
   d. Data Sharing
   e. Performance Improvement and Quality Management
   f. Dispute Resolution
   g. Critical Incidents

2. The **Health Plan** and the **RSN** agree to participate in further development of additional guidelines and operational procedures that will enhance the bi-directional care coordination between entities. The areas to be addressed may include, but are not limited to the following:
   a. Referral Procedures
   b. Screening Guidelines
   c. Notification of Admissions to Institutional Care
   d. Care Transitions/Discharge Planning from Institutional Care
   e. Continuing Care Transitions
   f. Care Management and Coordination
   g. Performance Measures and Improvement Processes
   h. Notifications of Emergent Care
   i. Data Sharing
   j. Dispute Resolution
   k. Notification of Critical Incidents

IV. Hold Harmless

1. Regardless of any verbal statements made prior to or following signature on this Agreement, nothing in this Agreement is intended to establish a legally binding agreement between the parties.

2. The parties of this agreement will hold one another including their contractors, employees, interns and volunteers harmless for failure to perform any of the roles identified above, including termination of this Agreement with or without advance notice.
3. There shall be no remedy available to one party for failure to perform any role identified above by the other party, or a third party.

V. Dispute Resolution

1. All disputes occurring between the parties of this agreement shall be resolved through informal negotiation between the parties of the Agreement. A guiding principle for resolving disputes is that resolution should be sought at the lowest level and only progress up the hierarchy when satisfactory resolution has not been achieved.
2. Failure to resolve disputes may result in termination of the Agreement.

VI. Term and Termination

1. The effective date of this Agreement will be upon the final signature of the parties to this Agreement and it shall remain in effect until it is terminated in accordance with the terms of this Agreement.
2. Any of the parties to this Agreement may withdraw and terminate their participation from this Agreement for any reason and at any time upon thirty (30) days written notice to the other party. Such notice and other correspondence related to this Agreement should be sent to the contacts and addresses listed above.

VII. Amendment

This Agreement may be amended at any time by written agreement and signature of all the parties.

IN WITNESS WHEREOF, the parties hereto have caused this OA to be executed by the dates and signatures herein under affixed. The persons signing this OA on behalf of the parties represent that each has authority to execute the OA on behalf of the party entering this OA.

RSN Administrator	Executive Director
Joe Valentine	Douglas Bowes
Printed Name	Printed Name
7/27/12	8-24-12
Date	Date

Effective Date: 5/21/2008; 9/17/2007; 7/13/2005
Revised Date: 7/13/2010
Review Date: 7/28/2010

North Sound Mental Health Administration

Section 1500 – Clinical: Children's Long-term Inpatient Program (CLIP) Care Coordination

Authorizing Source: PIHP, State Contract, RSN/CLIP Agreement – Appendix A
Cancels:
See Also:
Requires: child- serving agencies to comply with this policy
Responsible Staff: Quality Manager
Approved by: Executive Director
Signature:
Date: 7/29/2010

POLICY #1529.00

SUBJECT: CHILDREN'S LONG-TERM INPATIENT PROGRAM (CLIP) CARE COORDINATION

PURPOSE

To assure appropriate admissions, quality care coordination between North Sound Mental Health Administration (NSMHA), outpatient providers and the Children's Long-Term Inpatient Program (CLIP), and to coordinate appropriate discharges to family or the most normalizing/family-like community settings possible.

POLICY

CLIP is the highest level of treatment for youth who have a severe psychiatric impairment that warrants the restrictions and intensity of the treatment provided by this program. NSMHA and its providers are committed to active care coordination with CLIP to assist with appropriate admissions, high quality and effective inpatient treatment and rapid discharge/return to community from CLIP.

DEFINITIONS

Regional CLIP Committee – A regionally-designated 3-member committee that is responsible for the first level of screening CLIP applications and decision-making regarding whether or not to recommend a CLIP application to CLIP Administration. Recommended applications are then submitted to the Administrative CLIP Committee for final review and certification.

Regional CLIP Coordinator – A member of the Regional CLIP Committee who helps to coordinate the various involved systems, presentation of cases and process for a possible admission to CLIP.

ELIGIBILITY AND ADMISSION CRITERIA

Voluntary and Involuntary

1. Applicants must be under the age of 18 prior to admission to a CLIP program
2. Services are available to both males and females.
3. Services are available to both Medicaid and non-Medicaid youth.
4. Applicants must be legal residents of Washington State defined as being in the custody of Washington State or in the custody of the legal guardian who is a resident of Washington State.
5. Applicants must have a severe psychiatric impairment evidenced by a severe emotional disturbance and corroborated by a clear psychiatric diagnosis which warrants the intensity and restrictions of the treatment provided in a CLIP program.
6. Less Restrictive Treatment Setting: Before applicants are considered for CLIP, the CLIP committee will consider the possibility of a less restrictive setting for treatment, if appropriate and available, prior to recommending the applications which meet the minimum admissions requirement to the CLIP Administration for review. For youth who are currently enrolled in RSN services, it is highly recommended less restrictive care be attempted and documented **prior** to a Regional CLIP screening.

7. Applicants will **not be** excluded from consideration due to intellectual functioning, physical or medical disabilities. **However,** the applicant must meet the minimum admission criteria and demonstrate an ability to benefit from the treatment being provided in the CLIP program.
8. For applicants under the age of 13, the legal guardian must agree to the treatment. If the applicant is 13 years old or older, the client must agree to **voluntary** treatment. CLIP does not have the right to hold a youth against their will unless they have been court ordered to treatment via the Involuntary Treatment Act (ITA).
9. Adolescents (13 years or older) who have been **involuntarily** committed for 180 days of publicly-funded inpatient care are thereby eligible for admission to the CLIP program.

PROCEDURES

NSMHA integrates and coordinates all regional CLIP documentation, assessments and referral activities in the North Sound through the Regional CLIP Committee per the Prepaid Inpatient Health Plan (PIHP)/NSMHA Protocols for CLIP. This Regional Committee and/or CLIP Coordinator has the following functions:

1. Meets twice monthly to hear presentations of CLIP applications and assess the needs of the youth being considered for voluntary admission. Packets must be complete prior to scheduling a regional screening. Packets forwarded to the RSN **incomplete** will be held for a maximum of 60 days while applicant / referent gather the outstanding documents. After 60 days, the application will be considered rescinded and will not be recommend to the CLIP Administration due to lack of information. **Complete** packets can be held by the RSN for up to 6 months prior to an initial regional screening. If the applicant / referent do not respond to the CLIP Coordinators attempts to schedule a screening in that time, the packet will be considered rescinded and shred.

   If approved for referral, a letter will be sent within 10 business days notifying the applicants of the recommendation. The CLIP Coordinator will then coordinate the referrals to the CLIP Administration

2. Assesses the needs of voluntary, and as able upon notification from CLIP Administration, involuntarily committed (ITA) adolescents (180 day restrictive orders) prior to their assignment and admission to a CLIP program.
3. CLIP Coordinator follows the needs and discharge planning of all juveniles transferred for evaluation purposes by Juvenile Rehabilitation Administration (JRA) or adolescents who have been court-ordered for a competency evaluation and/or restoration to competency under Revised Code of Washington (RCW) 10.77 to Child Study and Treatment Center (CSTC).
4. Assures that all required CLIP application materials are submitted prior to CLIP Administration consideration of referrals.

Applications not approved for referral to CLIP Administration:

1. The regional CLIP committee will send a letter within 10 business days, outlining clear reasons why the application was not approved for referral to include recommendations concerning alternative treatment options.
2. Applications can be reconsidered IF new information becomes available within 90 calendar days from the initial regional screening. The new information must be provided to Regional CLIP Committee, who will reconvene to evaluate the new information and make a determination. If the Regional CLIP Committee upholds the original decision, an appeal can be made to CLIP Administration in accordance with the CLIP Administration Policies and Procedures (Appendix A).

3. If there is no new information to present, and applicants disagree with the regional CLIP committee decision, an appeal can be made directly to the CLIP Administration in accordance with the CLIP Administration Policies and Procedures (Appendix A).
4. Appeals to CLIP Administration should be in writing, clearly state the reason the appeal is being made and sent to:

   CLIP Administration Coordinator
   2142 10th Ave W.
   Seattle, WA 98119

All designated members of the child's treatment team, including the regional CLIP Coordinator, will participate in developing a plan of care and implementation for youth accepted into CLIP, including discharge planning.

The North Sound Regional CLIP Coordinator, in conjunction with the CLIP facility case manager, assures that each individual admitted to CLIP is connected with appropriate outpatient / community services, based on identified needs, upon discharge from the program.

A member of the North Sound Regional CLIP Committee and/or Coordinator will participate in concurrent length of stay management and decisions to transfer to another inpatient setting (CLIP or community psychiatric hospital) in accordance with the CLIP Policies and Procedures (Appendix A).

NSMHA will designate a single contact person who will monitor Regional Support Network / Prepaid Inpatient Health Plan (RSN/PIHP) and provider performance in accordance with the terms of this agreement and coordinate with the CLIP Administration as needed and/or required.

ATTACHMENTS

1529.01 – Policies and procedures of the CLIP (Appendix A – RSN/CLIP Agreement)

Effective Date:
Revised Date: 4/2/07
Review Date:

North Sound Mental Health Administration

Section 1500 – Clinical: Care Advocacy

Authorizing Source: Per NSMHA Contract
Cancels:
See Also:
Responsible Staff: Quality Manager
Approved by: Executive Director
Signature:
Date: 7/6/2007

POLICY #1560.00

SUBJECT: CARE ADVOCACY

PURPOSE

Care Advocates engage in coordination of care for consumers throughout the region, in collaboration with providers, to maximize consumer outcomes. While the Care Advocate may on occasion have contact with a consumer, their primary role is to work with provider/stakeholders in coordinating systems issues that directly impact individual consumers or aggregate consumer populations.

POLICY

The Care Advocate performs a variety of clinical management oversight functions to monitor care received by consumers including the following:

High Utilizers of Outpatient Services
The Care Advocate will assist in determining advocacy and appropriate use of services.

High Risk Consumers—The Care Advocate monitors engagement activities for high-risk consumers who are not engaging in outpatient services and for those individuals who are discharging from inpatient mental health treatment into the community.

Frequent Users of Inpatient Psychiatric Services and Crisis Services—The Care Advocate provides oversight of clinical intervention strategies and transitions for consumers frequently using inpatient psychiatric services and/or crisis services.

Coordination of Medical and Psychiatric Care—The Care Advocate monitors for coordination of care between Psychiatric Provider Specialists and Primary Care Providers as necessary and appropriate.

Special Populations—The Care Advocate participates in population level planning and interventions with special populations, as well as oversight of individual cases as needed.

Inpatient and Community Care—The Care Advocate provides oversight of psychiatric inpatient admission and care coordination with CMHA designated contacts, to promote rapid successful reintegration into the community at discharge. The Care Advocate monitors for appropriate discharge planning activities for consumers who qualify for CMHA involvement.

Care Advocates follow the care of a group of consumers in order to identify service gaps and utilization trends. This group of consumers is identified by their presence in reports, monitors and data sources, and those consumers identified by stakeholders. The Care Advocate will also follow those identified as the

highest need consumers on a case-by-case basis to ensure quality care and appropriate utilization of services.

PROCEDURE

The Care Advocate participates in a number of activities including, but not limited to:

1) Monitor the following:

   a. Open Primary Episodes with High Inpatient Counts Report
   b. Top 100 Outpatient Service Utilizers Report
   c. Utilization Management Weekly Reports
   d. Critical Incidents

2) Participation in the following:

   a. Western State Hospital Discharge Planning Meeting
   b. Children's Long Term Inpatient Program Meeting (CLIP)
   c. Hospital Inpatient Meeting
   d. Children's Hospitalization Alternative Program Meeting (CHAP)
   e. Critical Incident Review Committee Meeting
   f. DDD/MH Collaborative Meeting
   g. ADSA/MH Collaborative Meeting
   h. DSHS Meeting (Children's Care Advocate)
   i. DCFS Regional Resource Team Meeting (Children's Care Advocate)
   j. Collaboration with PACT team staff and Advisory Board regarding delivery of services

3) Other:

   a. Targeted Chart Reviews to review clinical interventions and services delivered
   b. Collaboration with Utilization Management clinicians to monitor inpatient utilization
   c. Collaboration with (Federal Block Grant) CMHA clinicians working with inpatient units to engage clients in outpatient care services prior to discharge from inpatient settings
   d. Collaboration with Access clinicians regarding consumer access to CMHA care
   e. Participation in an array of quality assurance and quality improvement activities relating to consumers of RSN services

4) Upon review of consumer records, the Care Advocate may make focused treatment recommendations with required follow up, as necessary.
5) The Care Advocate will make contact regarding client services with provider/stakeholder Quality Managers or the provider/stakeholder assigned designee.
6) In addition, providers may contact the regional Care Advocates for the purpose of informing/consulting with regional staff regarding plan and care of treatment.
7) Providers may request to speak with the Adult or Child Care Advocate.

ATTACHMENTS

None

III. Appendix:
Communications and Stakeholder Plan

CONTAINS NO APPENDICES

North Sound BHO Planning: Substance Use Disorder Cost & Utilization Flight Simulator

3 Year Summary: Baseline + Sustainable Rates + More Clients

Part I. Enrollment	History	Year 1	Year 2	Year 3	3 Year Total
Medicaid Enrollees					
Children (0-11)	**83,326**	**83,326**	**84,409**	**85,507**	253,242
Adolescents (12-17)	**33,155**	**33,155**	**33,586**	**34,023**	100,764
Adults (18+)	**132,713**	**132,713**	**134,438**	**136,186**	403,337
Total	249,194	249,194	252,434	255,715	757,343
Part II. Service Demand Estimates					
Substance Use Disorder Need Estimate (based on DSHS RDA 2014 Analysis)					
Children (0-11)	**0.3%**	**0.3%**	**0.3%**	**0.3%**	**0.3%**
Adolescents (12-17)	**7.4%**	**7.4%**	**7.4%**	**7.4%**	**7.4%**
Adults (18+)	**23.8%**	**23.8%**	**23.8%**	**23.8%**	**23.8%**
Total	13.8%	13.8%	13.8%	13.8%	13.8%
Estimated Medicaid Need					
Children (0-11)	250	250	253	257	760
Adolescents (12-17)	2,453	2,453	2,485	2,518	7,457
Adults (18+)	31,586	31,586	31,996	32,412	95,994
Total	34,289	34,289	34,735	35,186	104,210
Estimated Medicaid Clients					
Child Access Rate		**28%**	**30%**	**32%**	
Adolescent Access Rate		**53%**	**57%**	**61%**	
Adult Access Rate		**31%**	**33%**	**35%**	
Child Clients	**64**	70	76	83	229
Adolescent Clients	**1,176**	1,293	1,410	1,527	4,229
Adults Clients	**8,820**	9,697	10,574	11,450	31,721
Total Medicaid Clients	10,060	11,060	12,060	13,060	36,179
Penetration Rate	4.0%	4.4%	4.8%	5.1%	4.8%
Percent of Need Met	29%	32%	35%	37%	35%
Change from Previous Year		**1,000**	**1,000**	**1,000**	
Change % (Actuaries assume 7% increase in Yr 1)		9.9%	9.0%	8.3%	
Estimated Non-Medicaid Cases in Ongoing Care		221	241	261	724
Total Clients, Medicaid + Non-Medicaid		11,281	12,301	13,321	36,903
Total Episodes (duplicated)		16,429	17,853	19,324	53,606
Part IV. Revenue and Expense Projections					
Medicaid Revenue		$27,297,144	$28,481,567	$29,717,382	$85,496,094
Non-Medicaid Revenue		$9,207,363	$9,391,510	$9,579,340	$28,178,214
Total Revenue		**$36,504,507**	**$37,873,077**	**$39,296,723**	**$113,674,307**
Crisis Services		$6,620,449	$7,041,570	$7,478,914	$21,140,932
Brief Intervention & Treatment		$11,893	$13,244	$14,644	$39,781
Assessments		$2,533,429	$2,826,252	$3,129,648	$8,489,329
Outpatient Services		$3,416,646	$3,811,554	$4,221,625	$11,449,824
Intensive Outpatient		$12,051,801	$13,443,591	$14,886,104	$40,381,495
Opiate Substitution Tx, All Ages		$6,605,375	$7,370,583	$8,159,957	$22,135,915
Medical Services in Addiction Treatment Agencies		$45,269	$50,412	$55,740	$151,421
Recovery Supports		$127,225	$141,931	$157,167	$426,323
Co-Occurring Disorder TX (MH+IOP)		$1,209,536	$1,237,448	$1,390,566	$3,837,550
Homeless Case Management (Cs Mgt & or Outreach)		$291,442	$298,168	$304,894	$894,504
Transportation		$288,839	$337,884	$383,461	$1,010,184
Residential Services		$10,998,046	$10,998,046	$10,998,046	$32,994,138
Administrative and Support Services		$2,431,154	$2,504,089	$2,579,211	$7,514,454
Total Service Cost		**$46,631,102**	**$50,074,771**	**$53,759,976**	**$150,465,850**
Operating Excess (Deficit)		-$10,126,595	-$12,201,694	-$14,463,254	-$36,791,543
Drawdown of Medicaid Reserves		$8,607,606	$10,371,440	$12,293,766	$31,272,811
Reduction in Medicaid Mental Health Expenses		$1,518,989	$1,830,254	$2,169,488	$5,518,731
Medicaid Excess (Deficit)		$0	$0	$0	$0
Non-Medicaid Excess (Deficit)		$0	$0	$0	$0

North Sound BHO Planning: Substance Use Disorder Cost & Utilization Flight Simulator — Year 1: Baseline + Sustainable Rates + More Clients

Part I. Enrollment and Revenue	History	Year 1	Year 2	Year 3	Comments
Medicaid Enrollees					
Children (0-11)	**83,326**	**83,326**	**84,409**	**85,507**	**Based on August 2015 plus 1.3% incr/year**
Adolescents (12-17)	**33,155**	**33,155**	**33,586**	**34,023**	"
Adults (18+)	**132,713**	**132,713**	**134,438**	**136,186**	"
Total	249,194	249,194	252,434	255,715	
BHO Revenue					
Average Medicaid Per Member Per Month		**$9.13**	**$9.40**	**$9.68**	**Based on Rates from 8/2015 plus 3% incr/yr**
Medicaid Revenue		$27,297,144	$28,481,567	$29,717,382	
State General Fund		**$1,758,086**	$1,793,248	$1,829,113	**Based on 2016 budget plus 2% incr/year**
SAPT Funding		**$575,866**	$587,383	$599,131	"
Residential General Fund		**$3,041,598**	$3,102,430	$3,164,479	"
Residential SAPT		**$3,746,544**	$3,820,455	$3,896,864	"
State Drug Court		**$86,269**	$87,994	$89,754	"
Criminal Justice Transfer Account			$0	$0	
Total Revenue		$36,504,507	$37,873,077	$39,296,723	

Part II. Service Demand Estimates	History	Year 1	Year 2	Year 3	
Substance Use Disorder Need Estimate (based on DSHS RDA 2014 Analysis)					
Children (0-11)	**0.3%**	**0.3%**	**0.3%**	**0.3%**	**Per DSHS RDA 2014 Analysis**
Adolescents (12-17)	**7.4%**	**7.4%**	**7.4%**	**7.4%**	"
Adults (18+)	**23.8%**	**23.8%**	**23.8%**	**23.8%**	"
Total	13.8%	13.8%	13.8%	13.8%	
Estimated Medicaid Need					
Children (0-11)	250	250	253	257	
Adolescents (12-17)	2,453	2,453	2,485	2,518	
Adults (18+)	31,586	31,586	31,996	32,412	
Total	34,289	34,289	34,735	35,186	
Combined Youth	2.3%	2.3%	2.3%	2.3%	
Estimated Medicaid Access Rate					
Change in Access Rate		9.94%	7.64%	6.90%	
Child Access Rate	25%	28%	30%	32%	**1,000 Case total growth per year**
Adolescent Access Rate	48%	53%	57%	61%	"
Adult Access Rate	28%	31%	33%	35%	"
Child Clients	**64**	70	76	83	**1,000 Case total growth per year**
Adolescent Clients	**1,176**	1,293	1,410	1,527	"
Adults Clients	**8,820**	9,697	10,574	11,450	"
Total Clients	10,060	11,060	12,060	13,060	
Penetration Rate	4.0%	4.4%	4.8%	5.1%	
Percent of Need Met	29%	32%	35%	37%	
Change from Previous Year		1,000	1,000	1,000	
Change % (Note: DSHS and the Actuaries assume that 7% increase in Year 1)		9.9%	9.0%	8.3%	
Estimated Non-Medicaid Cases in Ongoing Care					
Non-Medicaid as a % of Medicaid		**2.0%**	**2.0%**	**2.0%**	**Estimate**
Non-Medicaid Cases		221	241	261	
Total Clients, Medicaid + Non-Medicaid		11,281	12,301	13,321	

North Sound BHO Planning: Substance Use Disorder Cost & Utilization Flight Simulator — Year 1: Baseline + Sustainable Rates + More Clients

Part III. Clients Served Estimates

	Historical Cases	Current Capacity	Year 1 Case Mix	Cases Year 1	% Un-Duplicated	Comments
						Year 1 = 4/2016-3/2017
Total Child/Adolescent Clients	1,240			1,390		
Total Adult Clients	8,820			9,891		
Total Clients	10,060			11,281		
Crisis Services, All Ages						
Mobile Outreach Teams	N/A	382	10.0%	1,128	50.0%	
Crisis Triage Centers	N/A	840	6.5%	733	50.0%	
Detox	1,950	1,059	12.0%	1,354	50.0%	
Subacute Detox	incl above	1,250	9.5%	1,072	50.0%	
Total Crisis Services			38.0%	4,287		
Brief Intervention & Treatment, All Ages						
All Brief Treatment Settings	N/A	125	1.0%	113	50.0%	
(Mobile Outreach, Emergency Departments, Primary Care Clinics, Crisis Triage Centers, School-Based Services, Jails, Homeless Shelters, etc.)						
Clients Receiving Ongoing Care - Core Services						
Assessments	15,590	N/A	150.0%	16,921	0.0%	
Outpatient						
Child/Adolescents	635	403	50.0%	695	75.4%	
Adult	2,760	2,963	31.0%	3,066	75.4%	
Pregnant and Parenting Women	40	326	1.0%	99	75.4%	
Total				3,860		
Intensive Outpatient						
Child/Adolescents	410	559	34.0%	473	75.4%	
Adult	3,780	4,772	42.0%	4,154	75.4%	
Pregnant and Parenting Women	80	551	1.0%	99	75.4%	
Total				4,726		
Opiate Substitution Tx, All Ages	1,790	2,227	17.5%	1,974	90.0%	
Medical Services in Addiction Treatment Agencies	N/A	255	2.0%	226	90.0%	
(Medical treatment, COD psych meds, non-opoid addiction meds, opiod addiction meds, pain management)						
Recovery Supports, All Ages						
All Recovery Support Services	0	729	5.0%	564	33.0%	
(Recovery Coaches, Recovery Café, Peer Navigators, Recovery Centers)						
Specialized Services, All Ages						
Co-Occurring Disorder TX (MH+IOP)	N/A	596	5.0%	485	100.0%	
Homeless Case Management (Cs Mgt & or Outreach)	N/A		2.0%	194	100.0%	
Total Episodes (duplicated)				**16,429**		
Total Clients (unduplicated estimate)				**11,516**		
Estimated Clients (per above)				**11,281**		

North Sound BHO Planning: Substance Use Disorder Cost & Utilization Flight Simulator — Year 1: Baseline + Sustainable Rates + More Clients

Part IV. Service and Cost Projections — Year 1

Rate Increase	Average Svc. Units	Number of Cases	Completion Rate	Partial Completion Units Used	Total Service Units	Average Cost per Unit	Average Cost per Case	Projected Cost	% BHO Medicaid	Units
						30%				Avg: All Svcs
Crisis Services, All Ages										
Mobile Outreach Teams								$240,000	69%	Fixed Budget
Crisis Phone and Triage								$375,228	69%	Fixed Budget
ITA-CD								$805,000	41%	Fixed Budget
Crisis Triage Centers								$2,588,636	69%	Fixed Budget
Detox	5	1,354	90%	4	6,635	$327.60	$1,605	$2,173,626	91%	Days
Subacute Detox	3	1,072	90%	2	3,109	$140.87	$409	$437,959	91%	Days
Total Crisis Services		2,426			9,744			$6,620,449		
Brief Intervention & Treatment, All Ages										
All Brief Treatment Settings	3	113	50%	1	226	$52.62	$105	$11,893	75%	Clinician Hours
Clients Receiving Ongoing Care - Core Services										
Assessments	1	16,921	100%	1	16,921	$149.72	$150	$2,533,429	98%	Each
Outpatient										
Child/Adolescents	30	695	66%	15	17,306	$41.08	$1,023	$710,930	98%	Mix: Ind & Group
Adult	30	3,066	66%	15	76,343	$34.33	$855	$2,621,084	98%	Mix: Ind & Group
Pregnant and Parenting Women	30	99	66%	15	2,465	$34.33	$855	$84,631	98%	Mix: Ind & Group
Total		3,860			96,114			$3,416,646		
Intensive Outpatient										
Child/Adolescents	80	473	66%	40	31,407	$44.16	$2,932	$1,386,965	98%	Mix: Ind & Group
Adult	80	4,154	66%	40	275,826	$37.77	$2,508	$10,416,569	98%	Mix: Ind & Group
Pregnant and Parenting Women	80	99	66%	40	6,574	$37.77	$2,508	$248,267	98%	Mix: Ind & Group
Total		4,726			313,807			$12,051,801		
Opiate Substitution Tx, All Ages	230	1,974	75%	115	397,268	$16.63	$3,346	$6,605,375	98%	Days
Medical Services in Addiction Treatment Agencies	3	226	50%	1	452	$100.15	$200	$45,269	75%	Visits
Recovery Supports, All Ages										
All Recovery Support Services	12	564	50%	6	5,076	$25.06	$226	$127,225	75%	Client Hours
Specialized Services, All Ages										
Co-Occurring Disorder TX (MH+IOP)	30	485	66%	15	12,077	$100.15	$2,494	$1,209,536	98%	Client Hours
Homeless Case Management (Cs Mgt & or Outreach)	20	194	50%	10	2,910	$100.15	$1,502	$291,442	75%	Client Hours
Transportation								$288,839	60%	Fixed Budget
Total Service Cost (before Residential)								$33,201,902		
Residential Cost Estimate								$10,998,046	40%	per below
County Administrative Costs								$682,430	100%	Fixed Budget
North Sound RSN Operations								$1,748,724	91%	Fixed Budget
Total Service Cost								$46,631,102		
Excess (Deficit)								($10,126,595)		
Medicaid Revenue								$27,297,144		Per above
Medicaid Portion of the Service Cost								$37,423,739		Per above
Medicaid Excess (Deficit)								($10,126,595)		
Non-Medicaid Revenue								9,207,363		Per above
Non-Medicaid Portion of the Service Cost								$9,207,363		Per above
Non-Medicaid Excess (Deficit)								$0		

North Sound BHO Planning: Substance Use Disorder Cost & Utilization Flight Simulator — Year 1: Baseline + Sustainable Rates + More Clients

Residential Estimates	Total Bud	Beds	Occup Rate	Bed Days	Avg Cost	% NSMHA	NSMHA Days	% Medicaid	Mcaid Days	$ Medicaid
Pioneer	**$6,683,476**	**143**	**87%**	45,410	$147.18	**30%**	13,626	**0%**	-	$0
Skagit	**$977,052**	**23**	**85%**	7,136	$136.92	**7%**	514	**0%**	-	$0
Evergreen	**$1,222,324**	**23**	**83%**	6,968	$175.42	**95%**	6,650	**91%**	6,053	$1,061,838
Seamar	**$1,951,477**	**28**	**100%**	10,220	$190.95	**50%**	5,151	**79%**	4,069	$777,018
Subtotal	$10,834,330	217		69,733	$155.37		25,941		10,122	$1,838,857
Beds in Other Places	**$32,676,228**	**1357**	**55%**	272,418	**$155.37**	**16%**	43,587	**38%**	16,503	$2,564,034
Medicaid Total	$43,510,558	1574		342,151			69,528		26,625	$4,402,891

	% Non-Mcaid	NonM Days	$ Non-Mcaid
Pioneer	100%	13,626	$2,005,500
Skagit	100%	514	$70,379
Evergreen	9%	597	$104,728
Seamar	21%	1,082	$206,549
Subtotal		15,819	$2,387,155
Beds in Other Places	62%	27,084	$4,208,000
Non-Medicaid Total		42,903	$6,595,155
Grand Total		69,528	$10,998,046
Medicaid % of Total			40%

North Sound BHO Planning: Substance Use Disorder Cost & Utilization Flight Simulator		Year 2: Baseline + Sustainable Rates + More Clients			
Part I. Enrollment and Revenue	**History**	**Year 1**	**Year 2**	**Year 3**	**Comments**
Medicaid Enrollees					
Children (0-11)	**83,326**	**83,326**	**84,409**	**85,507**	**Based on August 2015 plus 1.3% incr/year**
Adolescents (12-17)	**33,155**	**33,155**	**33,586**	**34,023**	"
Adults (18+)	**132,713**	**132,713**	**134,438**	**136,186**	"
Total	249,194	249,194	252,434	255,715	
BHO Revenue					
Average Medicaid Per Member Per Month		**$9.13**	**$9.40**	**$9.68**	**Based on Rates from 8/2015 plus 3% incr/yr**
Medicaid Revenue		$27,297,144	$28,481,567	$29,717,382	
State General Fund		**$1,758,086**	$1,793,248	$1,829,113	**Based on 2016 budget plus 2% incr/year**
SAPT Funding		**$575,866**	$587,383	$599,131	"
Residential General Fund		**$3,041,598**	$3,102,430	$3,164,479	"
Residential SAPT		**$3,745,544**	$3,820,455	$3,896,864	"
State Drug Court		**$86,269**	$87,994	$89,754	"
Criminal Justice Transfer Account			$0	$0	
Total Revenue		$36,504,507	$37,873,077	$39,296,723	
Part II. Service Demand Estimates	**History**	**Year 1**	**Year 2**	**Year 3**	
Substance Use Disorder Need Estimate (based on DSHS RDA 2014 Analysis)					
Children (0-11)	**0.3%**	**0.3%**	**0.3%**	**0.3%**	**Per DSHS RDA 2014 Analysis**
Adolescents (12-17)	**7.4%**	**7.4%**	**7.4%**	**7.4%**	"
Adults (18+)	**23.8%**	**23.8%**	**23.8%**	**23.8%**	"
Total	13.8%	13.8%	13.8%	13.8%	
Estimated Medicaid Need					
Children (0-11)	250	250	253	257	
Adolescents (12-17)	2,453	2,453	2,485	2,518	
Adults (18+)	31,586	31,586	31,996	32,412	
Total	34,289	34,289	34,735	35,186	
Combined Youth	2.3%	2.3%	2.3%	2.3%	
Estimated Medicaid Access Rate					
Change in Access Rate		**9.94%**	**7.64%**	**6.90%**	
Child Access Rate	25%	28%	30%	32%	**1,000 Case total growth per year**
Adolescent Access Rate	48%	53%	57%	61%	"
Adult Access Rate	28%	31%	33%	35%	"
Child Clients	**64**	70	76	83	**1,000 Case total growth per year**
Adolescent Clients	**1,176**	1,293	1,410	1,527	"
Adults Clients	**8,820**	9,697	10,574	11,450	"
Total Clients	10,060	11,060	12,060	13,060	
Penetration Rate	4.0%	4.4%	4.8%	5.1%	
Percent of Need Met	29%	32%	35%	37%	
Change from Previous Year		1,000	1,000	1,000	
Change % (Note: DSHS and the Actuaries assume that 7% increase in Year 1)		9.9%	9.0%	8.3%	
Estimated Non-Medicaid Cases in Ongoing Care					
Non-Medicaid as a % of Medicaid		**2.0%**	**2.0%**	**2.0%**	**Estimate**
Non-Medicaid Cases		221	241	261	
Total Clients, Medicaid + Non-Medicaid		11,281	12,301	13,321	

North Sound BHO Planning: Substance Use Disorder Cost & Utilization Flight Simulator — Year 2: Baseline + Sustainable Rates + More Clients

Part III. Clients Served Estimates

	Historical Cases	Current Capacity	Year 2 Case Mix	Cases Year 2	% Un-Duplicated	Comments
Total Child/Adolescent Clients	1,240			1,516		Year 1 = 4/2016-3/2017
Total Adult Clients	8,820			10,785		
Total Clients	10,060			12,301		
Crisis Services, All Ages						
Mobile Outreach Teams	N/A	382	10.0%	1,230	50.0%	
Crisis Triage Centers	N/A	840	6.5%	800	50.0%	
Detox	1,950	1,059	12.0%	1,476	50.0%	
Subacute Detox	incl above	1,250	9.5%	1,169	50.0%	
Total Crisis Services			38.0%	4,675		
Brief Intervention & Treatment, All Ages						
All Brief Treatment Settings	N/A	125	1.0%	123	50.0%	
(Mobile Outreach, Emergency Departments, Primary Care Clinics, Crisis Triage Centers, School-Based Services, Jails, Homeless Shelters, etc.)						
Clients Receiving Ongoing Care - Core Services						
Assessments	15,590	N/A	150.0%	18,451	0.0%	
Outpatient						
Child/Adolescents	635	403	50.0%	758	75.4%	
Adult	2,760	2,963	31.0%	3,343	75.4%	
Pregnant and Parenting Women	40	326	1.0%	108	75.4%	
Total				4,209		
Intensive Outpatient						
Child/Adolescents	410	559	34.0%	515	75.4%	
Adult	3,780	4,772	42.0%	4,530	75.4%	
Pregnant and Parenting Women	80	551	1.0%	108	75.4%	
Total				5,153		
Opiate Substitution Tx, All Ages	1,790	2,227	17.5%	2,153	90.0%	
Medical Services in Addiction Treatment Agencies	N/A	255	2.0%	246	90.0%	
(Medical treatment, COD psych meds, non-opoid addiction meds, opiod addiction meds, pain management)						
Recovery Supports, All Ages						
All Recovery Support Services	0	729	5.0%	615	33.0%	
(Recovery Coaches, Recovery Café, Peer Navigators, Recovery Centers)						
Specialized Services, All Ages						
Co-Occurring Disorder TX (MH+IOP)	N/A	596	5.0%	485	100.0%	
Homeless Case Management (Cs Mgt & or Outreach)	N/A		2.0%	194	100.0%	
Total Episodes (duplicated)				**17,853**		
Total Clients (unduplicated estimate)				**12,496**		
Estimated Clients (per above)				**12,301**		

North Sound BHO Planning: Substance Use Disorder Cost & Utilization Flight Simulator — Year 2: Baseline + Sustainable Rates + More Clients

Part IV. Service and Cost Projections — Year 2

Rate Increase	Average Svc. Units	Number of Cases	Completion Rate	Partial Completion Units Used	Total Service Units	Average Cost per Unit	Average Cost per Case	Projected Cost	% BHO Medicaid	Units
						33%				Avg: All Svcs
Crisis Services, All Ages										
Mobile Outreach Teams								**$247,200**	**69%**	**Fixed Budget**
Crisis Phone and Triage								**$386,485**	**69%**	**Fixed Budget**
ITA-CD								**$829,150**	**41%**	**Fixed Budget**
Crisis Triage Centers								**$2,666,295**	**69%**	**Fixed Budget**
Detox	**5**	1,476	**90%**	**4**	7,232	**$335.16**	$1,642	$2,423,877	**91%**	**Days**
Subacute Detox	**3**	1,169	**90%**	**2**	3,390	**$144.12**	$418	$488,563	**91%**	**Days**
Total Crisis Services		2,645			10,622			$7,041,570		
Brief Intervention & Treatment, All Ages										
All Brief Treatment Settings	**3**	123	**50%**	**1**	246	**$53.84**	$108	$13,244	**75%**	**Clinician Hours**
Clients Receiving Ongoing Care - Core Services										
Assessments	**1**	18,451	**100%**	**1**	18,451	**$153.18**	$153	$2,826,252	**98%**	**Each**
Outpatient										
Child/Adolescents	**30**	758	**66%**	**15**	18,874	**$42.03**	$1,046	$793,236	**98%**	**Mix: Ind & Group**
Adult	**30**	3,343	**66%**	**15**	83,241	**$35.13**	$875	$2,923,865	**98%**	**Mix: Ind & Group**
Pregnant and Parenting Women	**30**	108	**66%**	**15**	2,689	**$35.13**	$875	$94,452	**98%**	**Mix: Ind & Group**
Total		4,209			104,804			$3,811,554		
Intensive Outpatient										
Child/Adolescents	**80**	515	**66%**	**40**	34,196	**$45.18**	$3,000	$1,544,979	**98%**	**Mix: Ind & Group**
Adult	**80**	4,530	**66%**	**40**	300,792	**$38.64**	$2,565	$11,621,550	**98%**	**Mix: Ind & Group**
Pregnant and Parenting Women	**80**	108	**66%**	**40**	7,171	**$38.64**	$2,565	$277,062	**98%**	**Mix: Ind & Group**
Total		5,153			342,159			$13,443,591		
Opiate Substitution Tx, All Ages	**230**	2,153	**75%**	**115**	433,291	**$17.01**	$3,423	$7,370,583	**98%**	**Days**
Medical Services in Addiction Treatment Agencies	**3**	246	**50%**	**1**	492	**$102.46**	$205	$50,412	**75%**	**Visits**
Recovery Supports, All Ages										
All Recovery Support Services	**12**	615	**50%**	**6**	5,535	**$25.64**	$231	$141,931	**75%**	**Client Hours**
Specialized Services, All Ages										
Co-Occurring Disorder TX (MH+IOP)	**30**	485	**66%**	**15**	12,077	**$102.46**	$2,551	$1,237,448	**98%**	**Client Hours**
Homeless Case Management (Cs Mgt & or Outreach)	**20**	194	**50%**	**10**	2,910	**$102.46**	$1,537	$298,168	**75%**	**Client Hours**
Transportation								**$337,884**	**53%**	**Fixed Budget**
Total Service Cost (before Residential)								**$36,572,637**		
Residential Cost Estimate								**$10,998,046**	**40%**	**per below**
County Administrative Costs								**$702,903**	**100%**	**Fixed Budget**
North Sound RSN Operations								**$1,801,186**	**91%**	**Fixed Budget**
Total Service Cost								**$50,074,771**		
Excess (Deficit)								**($12,201,694)**		
Medicaid Revenue								**$28,481,567**		**Per above**
Medicaid Portion of the Service Cost								**$40,683,261**		**Per above**
Medicaid Excess (Deficit)								**($12,201,694)**		
Non-Medicaid Revenue								**9,391,510**		**Per above**
Non-Medicaid Portion of the Service Cost								**$9,391,510**		**Per above**
Non-Medicaid Excess (Deficit)								**$0**		

North Sound BHO Planning: Substance Use Disorder Cost & Utilization Flight Simulator — Year 2: Baseline + Sustainable Rates + More Clients

Residential Estimates	Total Bud	Beds	Occup Rate	Bed Days	Avg Cost	% NSMHA	NSMHA Days	% Medicaid	Mcaid Days	$ Medicaid
Rate Increase	3%									
Pioneer	**$6,683,476**	**143**	**87%**	45,410	$147.18	**30%**	13,626	**0%**	-	$0
Skagit	**$977,052**	**23**	**85%**	7,136	$136.92	**7%**	514	**0%**	-	$0
Evergreen	**$1,222,324**	**23**	**83%**	6,968	$175.42	**95%**	6,650	**91%**	6,053	$1,061,838
Seamar	**$1,951,477**	**28**	**100%**	10,220	$190.95	**50%**	5,151	**79%**	4,069	$777,018
Subtotal	$10,834,330	217		69,733	$155.37		25,941		10,122	$1,838,857
Beds in Other Places	**$32,676,228**	**1357**	**55%**	272,418	**$155.37**	**16%**	43,587	**38%**	16,503	$2,564,034
Medicaid Total	$43,510,558	1574		342,151			69,528		26,625	$4,402,891

	% Non-Mcaid	NonM Days	$ Non-Mcaid
Pioneer	100%	13,626	$2,005,500
Skagit	100%	514	$70,379
Evergreen	9%	597	$104,728
Seamar	21%	1,082	$206,549
Subtotal		15,819	$2,387,155
Beds in Other Places	62%	27,084	$4,208,000
Non-Medicaid Total		42,903	$6,595,155
Grand Total		69,528	$10,998,046
Medicaid % of Total			40%

North Sound BHO Planning: Substance Use Disorder Cost & Utilization Flight Simulator — Year 3: Baseline + Sustainable Rates + More Clients

Part I. Enrollment and Revenue	History	Year 1	Year 2	Year 3	Comments
Medicaid Enrollees					
Children (0-11)	**83,326**	**83,326**	**84,409**	**85,507**	**Based on August 2015 plus 1.3% incr/year**
Adolescents (12-17)	**33,155**	**33,155**	**33,586**	**34,023**	"
Adults (18+)	**132,713**	**132,713**	**134,438**	**136,186**	"
Total	249,194	249,194	252,434	255,715	
BHO Revenue					
Average Medicaid Per Member Per Month		**$9.13**	**$9.40**	**$9.68**	**Based on Rates from 8/2015 plus 3% incr/yr**
Medicaid Revenue		$27,297,144	$28,481,567	$29,717,382	
State General Fund		**$1,758,086**	$1,793,248	$1,829,113	**Based on 2016 budget plus 2% incr/year**
SAPT Funding		**$575,866**	$587,383	$599,131	"
Residential General Fund		**$3,041,598**	$3,102,430	$3,164,479	"
Residential SAPT		**$3,745,544**	$3,820,455	$3,896,864	"
State Drug Court		**$86,269**	$87,994	$89,754	"
Criminal Justice Transfer Account			$0	$0	
Total Revenue		$36,504,507	$37,873,077	$39,286,723	

Part II. Service Demand Estimates	History	Year 1	Year 2	Year 3	
Substance Use Disorder Need Estimate (based on DSHS RDA 2014 Analysis)					
Children (0-11)	**0.3%**	**0.3%**	**0.3%**	**0.3%**	**Per DSHS RDA 2014 Analysis**
Adolescents (12-17)	**7.4%**	**7.4%**	**7.4%**	**7.4%**	"
Adults (18+)	**23.8%**	**23.8%**	**23.8%**	**23.8%**	"
Total	13.8%	13.8%	13.8%	13.8%	
Estimated Medicaid Need					
Children (0-11)	250	250	253	257	
Adolescents (12-17)	2,453	2,453	2,485	2,518	
Adults (18+)	31,586	31,586	31,996	32,412	
Total	34,289	34,289	34,735	35,186	
Combined Youth	2.3%	2.3%	2.3%	2.3%	
Estimated Medicaid Access Rate					
Change in Access Rate		9.94%	7.64%	6.90%	
Child Access Rate	25%	28%	30%	32%	**1,000 Case total growth per year**
Adolescent Access Rate	48%	53%	57%	61%	"
Adult Access Rate	28%	31%	33%	35%	"
Child Clients	**64**	70	76	83	**1,000 Case total growth per year**
Adolescent Clients	**1,176**	1,293	1,410	1,527	"
Adults Clients	**8,820**	9,697	10,574	11,450	"
Total Clients	10,060	11,060	12,060	13,060	
Penetration Rate	4.0%	4.4%	4.8%	5.1%	
Percent of Need Met	29%	32%	35%	37%	
Change from Previous Year		1,000	1,000	1,000	
Change % (Note: DSHS and the Actuaries assume that 7% increase in Year 1)		9.9%	9.0%	8.3%	
Estimated Non-Medicaid Cases in Ongoing Care					
Non-Medicaid as a % of Medicaid		**2.0%**	**2.0%**	**2.0%**	**Estimate**
Non-Medicaid Cases		221	241	261	
Total Clients, Medicaid + Non-Medicaid		11,281	12,301	13,321	

North Sound BHO Planning: Substance Use Disorder Cost & Utilization Flight Simulator — Year 3: Baseline + Sustainable Rates + More Clients

Part III. Clients Served Estimates

	Historical Cases	Current Capacity	Year 3 Case Mix	Cases Year 3	% Un-Duplicated	Comments
Total Child/Adolescent Clients	1,240			1,642		Year 1 = 4/2016-3/2017
Total Adult Clients	8,820			11,679		
Total Clients	10,060			13,321		
Crisis Services, All Ages						
Mobile Outreach Teams	N/A	382	10.0%	1,332	50.0%	
Crisis Triage Centers	N/A	840	6.5%	866	50.0%	
Detox	1,950	1,059	12.0%	1,599	50.0%	
Subacute Detox	incl above	1,250	9.5%	1,265	50.0%	
Total Crisis Services			38.0%	5,062		
Brief Intervention & Treatment, All Ages						
All Brief Treatment Settings	N/A	125	1.0%	133	50.0%	
(Mobile Outreach, Emergency Departments, Primary Care Clinics, Crisis Triage Centers, School-Based Services, Jails, Homeless Shelters, etc.)						
Clients Receiving Ongoing Care - Core Services						
Assessments	15,590	N/A	150.0%	19,981	0.0%	
Outpatient						
Child/Adolescents	635	403	50.0%	821	75.4%	
Adult	2,760	2,963	31.0%	3,621	75.4%	
Pregnant and Parenting Women	40	326	1.0%	117	75.4%	
Total				4,559		
Intensive Outpatient						
Child/Adolescents	410	559	34.0%	558	75.4%	
Adult	3,780	4,772	42.0%	4,905	75.4%	
Pregnant and Parenting Women	80	551	1.0%	117	75.4%	
Total				5,580		
Opiate Substitution Tx, All Ages	1,790	2,227	17.5%	2,331	90.0%	
Medical Services in Additiction Treatment Agencies	N/A	255	2.0%	266	90.0%	
(Medical treatment, COD psych meds, non-opoid addiction meds, opiod addiction meds, pain management)						
Recovery Supports, All Ages						
All Recovery Support Services	0	729	5.0%	666	33.0%	
(Recovery Coaches, Recovery Café, Peer Navigators, Recovery Centers)						
Specialized Services, All Ages						
Co-Occurring Disorder TX (MH+IOP)	N/A	596	5.5%	533	100.0%	
Homeless Case Management (Cs Mgt & or Outreach)	N/A		2.0%	194	100.0%	
Total Episodes (duplicated)				**19,324**		
Total Clients (unduplicated estimate)				**13,523**		
Estimated Clients (per above)				**13,321**		

North Sound BHO Planning: Substance Use Disorder Cost & Utilization Flight Simulator — Year 3: Baseline + Sustainable Rates + More Clients

Part IV. Service and Cost Projections — Year 3

Rate Increase	Average Svc. Units	Number of Cases	Completion Rate	Partial Completion Units Used	Total Service Units	Average Cost per Unit	Average Cost per Case	Projected Cost	% BHO Medicaid	Units
						36%				Avg: All Svcs
Crisis Services, All Ages										
Mobile Outreach Teams								$254,616	69%	Fixed Budget
Crisis Phone and Triage								$398,079	69%	Fixed Budget
ITA-CD								$854,025	41%	Fixed Budget
Crisis Triage Centers								$2,746,284	69%	Fixed Budget
Detox	5	1,599	90%	4	7,835	$342.72	$1,679	$2,685,211	91%	Days
Subacute Detox	3	1,265	90%	2	3,669	$147.37	$427	$540,699	91%	Days
Total Crisis Services		2,864			11,504			$7,478,914		
Brief Intervention & Treatment, All Ages										
All Brief Treatment Settings	3	133	50%	1	266	$55.05	$110	$14,644	75%	Clinician Hours
Clients Receiving Ongoing Care - Core Services										
Assessments	1	19,981	100%	1	19,981	$156.63	$157	$3,129,648	98%	Each
Outpatient										
Child/Adolescents	30	821	66%	15	20,443	$42.98	$1,070	$878,558	98%	Mix: Ind & Group
Adult	30	3,621	66%	15	90,163	$35.92	$894	$3,238,439	98%	Mix: Ind & Group
Pregnant and Parenting Women	30	117	66%	15	2,913	$35.92	$894	$104,628	98%	Mix: Ind & Group
Total		4,559			113,519			$4,221,625		
Intensive Outpatient										
Child/Adolescents	80	558	66%	40	37,051	$46.20	$3,068	$1,711,727	98%	Mix: Ind & Group
Adult	80	4,905	66%	40	325,692	$39.51	$2,623	$12,867,440	98%	Mix: Ind & Group
Pregnant and Parenting Women	80	117	66%	40	7,769	$39.51	$2,623	$306,938	98%	Mix: Ind & Group
Total		5,580			370,512			$14,886,104		
Opiate Substitution Tx, All Ages	230	2,331	75%	115	469,114	$17.39	$3,501	$8,159,957	98%	Days
Medical Services in Addiction Treatment Agencies	3	266	50%	1	532	$104.77	$210	$55,740	75%	Visits
Recovery Supports, All Ages										
All Recovery Support Services	12	666	50%	6	5,994	$26.22	$236	$157,167	75%	Client Hours
Specialized Services, All Ages										
Co-Occurring Disorder TX (MH+IOP)	30	533	66%	15	13,272	$104.77	$2,609	$1,390,566	98%	Client Hours
Homeless Case Management (Cs Mgt & or Outreach)	20	194	50%	10	2,910	$104.77	$1,572	$304,894	75%	Client Hours
Transportation								$383,461	48%	Fixed Budget
Total Service Cost (before Residential)								$40,182,719		
Residential Cost Estimate								$10,998,046	40%	per below
County Administrative Costs								$723,990	100%	Fixed Budget
North Sound RSN Operations								$1,855,221	91%	Fixed Budget
Total Service Cost								$53,759,976		
Excess (Deficit)								($14,463,254)		
Medicaid Revenue								$29,717,382		Per above
Medicaid Portion of the Service Cost								$44,180,636		Per above
Medicaid Excess (Deficit)								($14,463,254)		
Non-Medicaid Revenue								9,579,340		Per above
Non-Medicaid Portion of the Service Cost								$9,579,340		Per above
Non-Medicaid Excess (Deficit)								$0		

North Sound BHO Planning: Substance Use Disorder Cost & Utilization Flight Simulator — Year 3: Baseline + Sustainable Rates + More Clients

Residential Estimates	Total Bud	Beds	Occup Rate	Bed Days	Avg Cost	% NSMHA	NSMHA Days	% Medicaid	Mcaid Days	$ Medicaid
Rate Increase	6%									
Pioneer	**$6,683,476**	**143**	**87%**	45,410	$147.18	**30%**	13,626	**0%**	-	$0
Skagit	**$977,052**	**23**	**85%**	7,136	$136.92	**7%**	514	**0%**	-	$0
Evergreen	**$1,222,324**	**23**	**83%**	6,968	$175.42	**95%**	6,650	**91%**	6,053	$1,061,838
Seamar	**$1,951,477**	**28**	**100%**	10,220	$190.95	**50%**	5,151	**79%**	4,069	$777,018
Subtotal	$10,834,330	217		69,733	$155.37		25,941		10,122	$1,838,857
Beds in Other Places	**$32,676,228**	**1357**	**55%**	272,418	**$155.37**	**16%**	43,587	**38%**	16,503	$2,564,034
Medicaid Total	$43,510,558	1574		342,151			69,528		26,625	$4,402,891

	% Non-Mcaid	NonM Days	$ Non-Mcaid
Pioneer	100%	13,626	$2,005,500
Skagit	100%	514	$70,379
Evergreen	9%	597	$104,728
Seamar	21%	1,082	$206,549
Subtotal		15,819	$2,387,155
Beds in Other Places	62%	27,084	$4,208,000
Non-Medicaid Total		42,903	$6,595,155
Grand Total		69,528	$10,998,046
Medicaid % of Total			40%

North Sound BHO Planning: Substance Use Disorder Cost & Utilization Flight Simulator		Baseline			
Part I. Enrollment and Revenue	**History**	**Year 1**	**Year 2**	**Year 3**	**Comments**
Medicaid Enrollees					
Children (0-11)	**83,326**	**83,326**	**84,409**	**85,507**	**Based on August 2015 plus 1.3% incr/year**
Adolescents (12-17)	**33,155**	**33,155**	**33,586**	**34,023**	"
Adults (18+)	**132,713**	**132,713**	**134,438**	**136,186**	"
Total	249,194	249,194	252,434	255,715	
BHO Revenue					
Average Medicaid Per Member Per Month		**$9.13**	**$9.40**	**$9.68**	**Based on Rates from 8/2015 plus 3% incr/yr**
Medicaid Revenue		$27,297,144	$28,481,567	$29,717,382	
State General Fund		**$1,758,086**	$1,793,248	$1,829,113	**Based on 2016 budget plus 2% incr/year**
SAPT Funding		**$575,866**	$587,383	$599,131	"
Residential General Fund		**$3,041,598**	$3,102,430	$3,164,479	"
Residential SAPT		**$3,745,544**	$3,820,455	$3,896,864	"
State Drug Court		**$86,269**	$87,994	$89,754	"
Criminal Justice Transfer Account			$0	$0	
Total Revenue		$36,504,507	$37,873,077	$39,296,723	
Part II. Service Demand Estimates	**History**	**Year 1**	**Year 2**	**Year 3**	
Substance Use Disorder Need Estimate (based on DSHS RDA 2014 Analysis)					
Children (0-11)	**0.3%**	**0.3%**	**0.3%**	**0.3%**	**Per DSHS RDA 2014 Analysis**
Adolescents (12-17)	**7.4%**	**7.4%**	**7.4%**	**7.4%**	"
Adults (18+)	**23.8%**	**23.8%**	**23.8%**	**23.8%**	"
Total	13.8%	13.8%	13.8%	13.8%	
Estimated Medicaid Need					
Children (0-11)	250	250	253	257	
Adolescents (12-17)	2,453	2,453	2,485	2,518	
Adults (18+)	31,586	31,586	31,996	32,412	
Total	34,289	34,289	34,735	35,186	
Combined Youth	2.3%	2.3%	2.3%	2.3%	
Estimated Medicaid Access Rate					
Child Access Rate		**26%**	**26%**	**26%**	**No growth in this Scenario**
Adolescent Access Rate		**48%**	**48%**	**48%**	"
Adult Access Rate		**28%**	**28%**	**28%**	"
Child Clients	**64**	64	65	66	**No growth in this Scenario**
Adolescent Clients	**1,176**	1,176	1,191	1,207	"
Adults Clients	**8,820**	8,820	8,935	9,051	"
Total Clients	10,060	10,060	10,191	10,323	
Penetration Rate	4.0%	4.0%	4.0%	4.0%	
Percent of Need Met	29%	29%	29%	29%	
Change from Previous Year		0	131	132	
Change % (Note: DSHS and the Actuaries assume that 7% increase in Year 1)		0%	1.3%	1.3%	
Estimated Non-Medicaid Cases in Ongoing Care					
Non-Medicaid as a % of Medicaid		**2.0%**	**2.0%**	**2.0%**	**Estimate**
Non-Medicaid Cases		201	204	206	
Total Clients, Medicaid + Non-Medicaid		10,261	10,395	10,530	

North Sound BHO Planning: Substance Use Disorder Cost & Utilization Flight Simulator Baseline

Part III. Clients Served Estimates

	Historical Cases	Current Capacity	Year 1 Case Mix	Cases Year 1	% Un-Duplicated	Comments
Total Child/Adolescent Clients	1,240			1,265		Year 1 = 4/2016-3/2017
Total Adult Clients	8,820			8,996		
Total Clients	10,060			10,261		
Crisis Services, All Ages						
Mobile Outreach Teams	N/A	382	10.0%	1,026	50.0%	
Crisis Triage Centers	N/A	840	6.3%	646	50.0%	
Detox	1,950	1,059	7.9%	811	50.0%	
Subacute Detox	incl above	1,250	9.4%	965	50.0%	
Total Crisis Services			33.6%	3,448		
Brief Intervention & Treatment, All Ages						
All Brief Treatment Settings	N/A	125	1.0%	103	50.0%	
(Mobile Outreach, Emergency Departments, Primary Care Clinics, Crisis Triage Centers, School-Based Services, Jails, Homeless Shelters, etc.)						
Clients Receiving Ongoing Care - Core Services						
Assessments	15,590	N/A	150.0%	15,392	0.0%	
Outpatient						
Child/Adolescents	635	403	50.0%	632	75.4%	
Adult	2,760	2,963	31.0%	2,789	75.4%	
Pregnant and Parenting Women	40	326	1.0%	90	75.4%	
Total				3,511		
Intensive Outpatient						
Child/Adolescents	410	559	34.0%	430	75.4%	
Adult	3,780	4,772	42.0%	3,778	75.4%	
Pregnant and Parenting Women	80	551	1.0%	90	75.4%	
Total				4,298		
Opiate Substitution Tx, All Ages	1,790	2,227	17.5%	1,796	90.0%	
Medical Services in Addiction Treatment Agencies	N/A	255	2.0%	205	90.0%	
(Medical treatment, COD psych meds, non-opoid addiction meds, opiod addiction meds, pain management)						
Recovery Supports, All Ages						
All Recovery Support Services	0	729	5.0%	513	33.0%	
(Recovery Coaches, Recovery Café, Peer Navigators, Recovery Centers)						
Specialized Services, All Ages						
Co-Occurring Disorder TX (MH+IOP)	N/A	596	5.0%	441	100.0%	
Homeless Case Management (Cs Mgt & or Outreach)	N/A		2.0%	176	100.0%	
Total Episodes (duplicated)				**14,491**		
Total Clients (unduplicated estimate)				**10,248**		
Estimated Clients (per above)				**10,261**		

North Sound BHO Planning: Substance Use Disorder Cost & Utilization Flight Simulator Baseline

Part IV. Service and Cost Projections Year 1

Rate Increase	Average Svc. Units	Number of Cases	Completion Rate	Partial Completion Units Used	Total Service Units	Average Cost per Unit	Average Cost per Case	Projected Cost	% BHO Medicaid	Units
						0%				Avg: All Svcs
Crisis Services, All Ages										
Mobile Outreach Teams								$240,000	69%	Fixed Budget
Crisis Phone and Triage								$375,228	69%	Fixed Budget
ITA-CD								$805,000	41%	Fixed Budget
Crisis Triage Centers								$2,588,636	69%	Fixed Budget
Detox	5	811	90%	4	3,974	$252.00	$1,235	$1,001,448	91%	Days
Subacute Detox	3	965	90%	2	2,799	$108.36	$314	$303,300	91%	Days
Total Crisis Services		1,776			6,773			$5,313,612		
Brief Intervention & Treatment, All Ages										
All Brief Treatment Settings	3	103	50%	1	206	$40.48	$81	$8,339	75%	Clinician Hours
Clients Receiving Ongoing Care - Core Services										
Assessments	1	15,392	100%	1	15,392	$115.17	$115	$1,772,697	98%	Each
Outpatient										
Child/Adolescents	30	632	66%	15	15,737	$31.60	$787	$497,289	98%	Mix: Ind & Group
Adult	30	2,789	66%	15	69,446	$26.41	$658	$1,834,069	98%	Mix: Ind & Group
Pregnant and Parenting Women	30	90	66%	15	2,241	$26.41	$658	$59,185	98%	Mix: Ind & Group
Total		3,511			87,424			$2,390,543		
Intensive Outpatient										
Child/Adolescents	80	430	66%	40	28,552	$33.97	$2,256	$969,911	98%	Mix: Ind & Group
Adult	80	3,778	66%	40	250,859	$29.05	$1,929	$7,287,454	98%	Mix: Ind & Group
Pregnant and Parenting Women	80	90	66%	40	5,976	$29.05	$1,929	$173,603	98%	Mix: Ind & Group
Total		4,298			285,387			$8,430,968		
Opiate Substitution Tx, All Ages	230	1,796	75%	115	361,445	$12.79	$2,574	$4,622,882	98%	Days
Medical Services in Addiction Treatment Agencies	3	205	50%	1	410	$77.04	$154	$31,586	75%	Visits
Recovery Supports, All Ages										
All Recovery Support Services	12	513	50%	6	4,617	$19.28	$174	$89,016	75%	Client Hours
Specialized Services, All Ages										
Co-Occurring Disorder TX (MH+IOP)	30	441	66%	15	10,981	$77.04	$1,918	$845,976	98%	Client Hours
Homeless Case Management (Cs Mgt & or Outreach)	20	176	50%	10	2,640	$77.04	$1,156	$203,386	75%	Client Hours
Transportation								$250,000	69%	Fixed Budget
Total Service Cost (before Residential)								$23,959,004		
Residential Cost Estimate								$10,998,046	40%	per below
County Administrative Costs								$682,430	100%	Fixed Budget
North Sound RSN Operations								$1,748,724	91%	Fixed Budget
Total Service Cost								$37,388,204		
Excess (Deficit)								($883,697)		
Medicaid Revenue								$27,297,144		Per above
Medicaid Portion of the Service Cost								$28,528,245		Per above
Medicaid Excess (Deficit)								($1,231,101)		
Non-Medicaid Revenue								9,207,363		Per above
Non-Medicaid Portion of the Service Cost								$8,859,959		Per above
Non-Medicaid Excess (Deficit)								$347,404		

North Sound BHO Planning: Substance Use Disorder Cost & Utilization Flight Simulator Baseline

Residential Estimates	Total Bud	Beds	Occup Rate	Bed Days	Avg Cost	% NSMHA	NSMHA Days	% Medicaid	Mcaid Days	$ Medicaid
Pioneer	**$6,683,476**	**143**	**87%**	45,410	$147.18	**30%**	13,626	**0%**	-	$0
Skagit	**$977,052**	**23**	**85%**	7,136	$136.92	**7%**	514	**0%**	-	$0
Evergreen	**$1,222,324**	**23**	**83%**	6,968	$175.42	**95%**	6,650	**91%**	6,053	$1,061,838
Seamar	**$1,951,477**	**28**	**100%**	10,220	$190.95	**50%**	5,151	**79%**	4,069	$777,018
Subtotal	$10,834,330	217		69,733	$155.37		25,941		10,122	$1,838,857
Beds in Other Places	**$32,676,228**	**1357**	**55%**	272,418	**$155.37**	**16%**	43,587	**38%**	16,503	$2,564,034
Medicaid Total	$43,510,558	1574		342,151			69,528		26,625	$4,402,891

	% Non-Mcaid	NonM Days	$ Non-Mcaid
Pioneer	100%	13,626	$2,005,500
Skagit	100%	514	$70,379
Evergreen	9%	597	$104,728
Seamar	21%	1,082	$206,549
Subtotal		15,819	$2,387,155
Beds in Other Places	62%	27,084	$4,208,000
Non-Medicaid Total		42,903	$6,595,155
Grand Total		69,528	$10,998,046
Medicaid % of Total			40%

North Sound BHO Planning: Substance Use Disorder Cost & Utilization Flight Simulator		Baseline + Sustainable Rates			
Part I. Enrollment and Revenue	**History**	**Year 1**	**Year 2**	**Year 3**	**Comments**
Medicaid Enrollees					
Children (0-11)	**83,326**	**83,326**	**84,409**	**85,507**	**Based on August 2015 plus 1.3% incr/year**
Adolescents (12-17)	**33,155**	**33,155**	**33,586**	**34,023**	"
Adults (18+)	**132,713**	**132,713**	**134,438**	**136,186**	"
Total	249,194	249,194	252,434	255,715	
BHO Revenue					
Average Medicaid Per Member Per Month		**$9.13**	**$9.40**	**$9.68**	**Based on Rates from 8/2015 plus 3% incr/yr**
Medicaid Revenue		$27,297,144	$28,481,567	$29,717,382	
State General Fund		**$1,758,086**	$1,793,248	$1,829,113	**Based on 2016 budget plus 2% incr/year**
SAPT Funding		**$575,866**	$587,383	$599,131	"
Residential General Fund		**$3,041,598**	$3,102,430	$3,164,479	"
Residential SAPT		**$3,745,544**	$3,820,455	$3,896,864	"
State Drug Court		**$86,269**	$87,994	$89,754	"
Criminal Justice Transfer Account			$0	$0	
Total Revenue		$36,504,507	$37,873,077	$39,296,723	
Part II. Service Demand Estimates	**History**	**Year 1**	**Year 2**	**Year 3**	
Substance Use Disorder Need Estimate (based on DSHS RDA 2014 Analysis)					
Children (0-11)	**0.3%**	**0.3%**	**0.3%**	**0.3%**	**Per DSHS RDA 2014 Analysis**
Adolescents (12-17)	**7.4%**	**7.4%**	**7.4%**	**7.4%**	"
Adults (18+)	**23.8%**	**23.8%**	**23.8%**	**23.8%**	"
Total	13.8%	13.8%	13.8%	13.8%	
Estimated Medicaid Need					
Children (0-11)	250	250	253	257	
Adolescents (12-17)	2,453	2,453	2,485	2,518	
Adults (18+)	31,586	31,586	31,996	32,412	
Total	34,289	34,289	34,735	35,186	
Combined Youth	2.3%	2.3%	2.3%	2.3%	
Estimated Medicaid Access Rate					
Child Access Rate		**26%**	**26%**	**26%**	**No growth in this Scenario**
Adolescent Access Rate		**48%**	**48%**	**48%**	"
Adult Access Rate		**28%**	**28%**	**28%**	"
Child Clients	**64**	64	65	66	**No growth in this Scenario**
Adolescent Clients	**1,176**	1,176	1,191	1,207	"
Adults Clients	**8,820**	8,820	8,935	9,051	"
Total Clients	10,060	10,060	10,191	10,323	
Penetration Rate	4.0%	4.0%	4.0%	4.0%	
Percent of Need Met	29%	29%	29%	29%	
Change from Previous Year		0	131	132	
Change % (Note: DSHS and the Actuaries assume that 7% increase in Year 1)		0%	1%	1%	
Estimated Non-Medicaid Cases in Ongoing Care					
Non-Medicaid as a % of Medicaid		**2.0%**	**2.0%**	**2.0%**	**Estimate**
Non-Medicaid Cases		201	204	206	
Total Clients, Medicaid + Non-Medicaid		10,261	10,395	10,530	

North Sound BHO Planning: Substance Use Disorder Cost & Utilization Flight Simulator Baseline + Sustainable Rates

Part III. Clients Served Estimates

	Historical Cases	Current Capacity	Year 1 Case Mix	Cases Year 1	% Un-Duplicated	Comments
Total Child/Adolescent Clients	1,240			1,265		Year 1 = 4/2016-3/2017
Total Adult Clients	8,820			8,996		
Total Clients	10,060			10,261		
Crisis Services, All Ages						
Mobile Outreach Teams	N/A	382	10.0%	1,026	50.0%	
Crisis Triage Centers	N/A	840	6.5%	667	50.0%	
Detox	1,950	1,059	7.5%	770	50.0%	
Subacute Detox	incl above	1,250	9.5%	975	50.0%	
Total Crisis Services			33.5%	3,438		
Brief Intervention & Treatment, All Ages						
All Brief Treatment Settings	N/A	125	1.0%	103	50.0%	
(Mobile Outreach, Emergency Departments, Primary Care Clinics, Crisis Triage Centers, School-Based Services, Jails, Homeless Shelters, etc.)						
Clients Receiving Ongoing Care - Core Services						
Assessments	15,590	N/A	150.0%	15,392	0.0%	
Outpatient						
Child/Adolescents	635	403	50.0%	632	75.4%	
Adult	2,760	2,963	31.0%	2,789	75.4%	
Pregnant and Parenting Women	40	326	1.0%	90	75.4%	
Total				3,511		
Intensive Outpatient						
Child/Adolescents	410	559	34.0%	430	75.4%	
Adult	3,780	4,772	42.0%	3,778	75.4%	
Pregnant and Parenting Women	80	551	1.0%	90	75.4%	
Total				4,298		
Opiate Substitution Tx, All Ages	1,790	2,227	17.5%	1,796	90.0%	
Medical Services in Addiction Treatment Agencies	N/A	255	2.0%	205	90.0%	
(Medical treatment, COD psych meds, non-opoid addiction meds, opiod addiction meds, pain management)						
Recovery Supports, All Ages						
All Recovery Support Services	0	729	5.0%	513	33.0%	
(Recovery Coaches, Recovery Café, Peer Navigators, Recovery Centers)						
Specialized Services, All Ages						
Co-Occurring Disorder TX (MH+IOP)	N/A	596	5.0%	441	100.0%	
Homeless Case Management (Cs Mgt & or Outreach)	N/A		2.0%	176	100.0%	
Total Episodes (duplicated)				14,481		
Total Clients (unduplicated estimate)				10,243		
Estimated Clients (per above)				10,261		

North Sound BHO Planning: Substance Use Disorder Cost & Utilization Flight Simulator Baseline + Sustainable Rates

Part IV. Service and Cost Projections Year 1

	Average Svc. Units	Number of Cases	Completion Rate	Partial Completion Units Used	Total Service Units	Average Cost per Unit	Average Cost per Case	Projected Cost	% BHO Medicaid	Units
Rate Increase						30%				Avg: All Svcs
Crisis Services, All Ages										
Mobile Outreach Teams								**$240,000**	**69%**	**Fixed Budget**
Crisis Phone and Triage								**$375,228**	**69%**	**Fixed Budget**
ITA-CD								**$805,000**	**41%**	**Fixed Budget**
Crisis Triage Centers								**$2,588,636**	**69%**	**Fixed Budget**
Detox	**5**	770	**90%**	**4**	3,773	**$327.60**	$1,605	$1,236,035	**91%**	**Days**
Subacute Detox	**3**	975	**90%**	**2**	2,828	**$140.87**	$409	$398,375	**91%**	**Days**
Total Crisis Services		1,745			6,601			$5,643,274		
Brief Intervention & Treatment, All Ages										
All Brief Treatment Settings	**3**	103	**50%**	**1**	206	**$52.62**	$105	$10,841	**75%**	**Clinician Hours**
Clients Receiving Ongoing Care - Core Services										
Assessments	**1**	15,392	**100%**	**1**	15,392	**$149.72**	$150	$2,304,506	**98%**	**Each**
Outpatient										
Child/Adolescents	**30**	632	**66%**	**15**	15,737	**$41.08**	$1,023	$646,476	**98%**	**Mix: Ind & Group**
Adult	**30**	2,789	**66%**	**15**	69,446	**$34.33**	$855	$2,384,290	**98%**	**Mix: Ind & Group**
Pregnant and Parenting Women	**30**	90	**66%**	**15**	2,241	**$34.33**	$855	$76,940	**98%**	**Mix: Ind & Group**
Total		3,511			87,424			$3,107,706		
Intensive Outpatient										
Child/Adolescents	**80**	430	**66%**	**40**	28,552	**$44.16**	$2,932	$1,260,885	**98%**	**Mix: Ind & Group**
Adult	**80**	3,778	**66%**	**40**	250,859	**$37.77**	$2,508	$9,473,690	**98%**	**Mix: Ind & Group**
Pregnant and Parenting Women	**80**	90	**66%**	**40**	5,976	**$37.77**	$2,508	$225,684	**98%**	**Mix: Ind & Group**
Total		4,298			285,387			$10,960,259		
Opiate Substitution Tx, All Ages	**230**	1,796	**75%**	**115**	361,445	**$16.63**	$3,346	$6,009,746	**98%**	**Days**
Medical Services in Addiction Treatment Agencies	**3**	205	**50%**	**1**	410	**$100.15**	$200	$41,062	**75%**	**Visits**
Recovery Supports, All Ages										
All Recovery Support Services	**12**	513	**50%**	**6**	4,617	**$25.06**	$226	$115,720	**75%**	**Client Hours**
Specialized Services, All Ages										
Co-Occurring Disorder TX (MH+IOP)	**30**	441	**66%**	**15**	10,981	**$100.15**	$2,494	$1,099,769	**98%**	**Client Hours**
Homeless Case Management (Cs Mgt & or Outreach)	**20**	176	**50%**	**10**	2,640	**$100.15**	$1,502	$264,401	**75%**	**Client Hours**
Transportation								**$250,000**	**69%**	**Fixed Budget**
Total Service Cost (before Residential)								**$29,807,283**		
Residential Cost Estimate								**$10,998,046**	**40%**	**per below**
County Administrative Costs								**$682,430**	**100%**	**Fixed Budget**
North Sound RSN Operations								**$1,748,724**	**91%**	**Fixed Budget**
Total Service Cost								**$43,236,483**		
Excess (Deficit)								**($6,731,976)**		
Medicaid Revenue								**$27,297,144**		**Per above**
Medicaid Portion of the Service Cost								**$34,213,552**		**Per above**
Medicaid Excess (Deficit)								**($6,916,408)**		
Non-Medicaid Revenue								**9,207,363**		**Per above**
Non-Medicaid Portion of the Service Cost								**$9,022,931**		**Per above**
Non-Medicaid Excess (Deficit)								**$184,432**		

North Sound BHO Planning: Substance Use Disorder Cost & Utilization Flight Simulator **Baseline + Sustainable Rates**

Residential Estimates	Total Bud	Beds	Occup Rate	Bed Days	Avg Cost	% NSMHA	NSMHA Days	% Medicaid	Mcaid Days	$ Medicaid
Pioneer	**$6,683,476**	**143**	**87%**	45,410	$147.18	**30%**	13,626	**0%**	-	$0
Skagit	**$977,052**	**23**	**85%**	7,136	$136.92	**7%**	514	**0%**	-	$0
Evergreen	**$1,222,324**	**23**	**83%**	6,968	$175.42	**95%**	6,650	**91%**	6,053	$1,061,838
Seamar	**$1,951,477**	**28**	**100%**	10,220	$190.95	**50%**	5,151	**79%**	4,069	$777,018
Subtotal	$10,834,330	217		69,733	$155.37		25,941		10,122	$1,838,857
Beds in Other Places	**$32,676,228**	**1357**	**55%**	272,418	**$155.37**	**16%**	43,587	**38%**	16,503	$2,564,034
Medicaid Total	$43,510,558	1574		342,151			69,528		26,625	$4,402,891

	% Non-Mcaid	NonM Days	$ Non-Mcaid
Pioneer	100%	13,626	$2,005,500
Skagit	100%	514	$70,379
Evergreen	9%	597	$104,728
Seamar	21%	1,082	$206,549
Subtotal		15,819	$2,387,155
Beds in Other Places	62%	27,084	$4,208,000
Non-Medicaid Total		42,903	$6,595,155
Grand Total		69,528	$10,998,046
Medicaid % of Total			40%

Appendix, Section IV-01 North Sound BHO Detailed Plan

	Fund	Program	Medicaid	State Funds	Total			CD Allocate	CD Add	Medicaid	State Funds	SAPT	
		Crisis Outreach											
1	Cap	Snohomish - Compass	1,206,276	541,944	1,748,220	69%/31%			240,000	165,600	37,200	37,200	0.69
2		Detox Evergreen							1,300,000	1,183,000	117,000		0.91
		Detox Evergreen new facility							1,300,000	1,183,000	117,000		
3	Cost	Snohomish - County ITA		2,014,068	2,014,068	100% state							
		All County ITA CD		350,000	350,000				325,000		325,000		0.411428571
4	Cap	Skagit - Compass	1,322,676	594,228	1,916,904	69%/31%			240,000	165,600	74,400		
6	Cap	Whatcom - WCPC	1,206,276	541,944	1,748,220	69%/31%			240,000	165,600	74,400		
8	Cap	Island County - Compass	369,732	166,116	535,848	69%/31%	?						
10	Cap	San Juan - Compass	180,360	81,024	261,384	69%/31%	?						
		Crisis Stabilization -											
11	Cap	Snohomish Stabilization	731,400	328,596	1,059,996	69%/31%			494,000	340,860	153,140		0.69
12	Cost	Snohomish Stabilization - Nursing	667,740	300,000	967,740	69%/31%		483,870		333,870	150,000		
13	Cap	Skagit Stabilization	329,908	148,220	478,128	69%/31%			600,000	414,000	93,000	93,000	
14	Cost	Skagit Stabilization - Nursing	667,740	300,000	967,740	69%/31%		483,870		333,870	150,000		
15	Cap	Whatcom Stabilization	363,564	163,332	526,896	69%/31%			526,896	363,558	81,669	81,669	
16	Cost	Whatcom Stabilization - Nursing	667,740	300,000	967,740	69%/31%		-		-	-	-	
17	FFS	Inpatient Community Hospital	8,500,000	3,000,000	11,500,000	History							
		Evaluation & Treatment											
18	Cap	Mukilteo	2,202,866	1,408,390	3,611,256	61%/39%							
19	Cap	Sedro Woolley	2,804,356	1,792,916	4,597,272	61%/39%							
20	Cost	Sedro Woolley Rent	88,824	56,796	145,620	61%/39%							
21	Cap	VOA Crisis and Triage	863,025	387,736	1,250,761	69%/31%		375,228		258,908	116,321		0.69
						69%/31%				-	-		
22	Cap	Mobile Outreach - Whatcom	-	-	-	69%/31%							
23	Cap	Mobile Outreach - Skagit			-	69%/31%							
24	Mix	Transition Care Services	528,656			100% Med							
25	Cost	Geriatric Outreach	618,840	279,000	897,840	69%/31%							
		Child Outpatient											
26	FFS	Snohomish - CCS	1,079,352	105,816	1,185,168	91%/9%							
27	FFS	Snohomish - Compass	3,134,856	304,980	3,439,836	91%/9%							
28	FFS	Snohomish - Sea Mar	413,232	36,540	449,772	91%/9%							
29	FFS	Snohomish - Center for HS	471,108	55,980	527,088	91%/9%							
30	FFS	Snohomish - Northwest ESD	113,256	6,996	120,252	91%/9%							
31	FFS	Whatcom - CCS	1,310,892	125,964	1,436,856	91%/9%							
32	FFS	Whatcom - WCPC	421,476	34,344	455,820	91%/9%							
33	FFS	Whatcom - Sea Mar	45,132	5,580	50,712	91%/9%							
34	FFS	Whatcom - Northwest ESD	113,256	13,992	127,248	91%/9%							
35	FFS	Skagit - Sea Mar	73,032	9,024	82,056	91%/9%							
36	FFS	Skagit - Compass	428,436	41,016	469,452	91%/9%							
37	FFS	Skagit - CCS	629,868	70,428	700,296	91%/9%							
38	FFS	Skagit - Northwest ESD	129,672	13,992	143,664	91%/9%							
39	FFS	Island - Compass	304,860	37,680	342,540	91%/9%							
40	FFS	Island - Northwest ESD	183,876	6,996	190,872	91%/9%							
41	FFS	Island - Sea Mar	23,160	2,280	25,440	91%/9%							
42	FFS	San Juan - Compass	169,884	13,992	183,876	91%/9%							
		CD Outpatient Services											
		Snohomish									11,000	20,000	
		Skagit									300	1,464	
		Whatcom									5,000	5,000	
		Island									3,000	4,670	
		San Juan									1,500	2,500	54,434
		Children's High Intensity (WISe or Wraparound)											
43	Cap	Snohomish - WRAP - Compass	1,468,800		1,468,800	100% Med							
44	Cap	Whatcom - WRAP - CCS	1,142,400		1,142,400	100% Med							
45	Cap	Skagit - WISe - CCS	979,200		979,200	100% Med							
46	Mix	Island - IWRAP - Compass	122,400		122,400	100% Med							
47	Mix	Island - WRAP - Compass	204,000		204,000	100% Med							
48		WISE - expansion 88 slots	3,590,400			100% Med							
49	Cost	Child Wrap/CHAP Respite Pool		5,000	5,000	100% State							

		Adult Outpatient										
50	FFS	Snohomish - Compass	5,942,064	517,872	6,459,936	91%/9%						
51	FFS	Snohomish - Sunrise	2,773,360	274,608	3,047,988	91%/9%						
52	FFS	Snohomish - Sea Mar	1,135,884	68,448	1,204,332	91%/9%						
53	FFS	Snohomish - Bridgeways	235,572	27,984	263,556	91%/9%						
54	FFS	Whatcom - Interfaith	678,972	50,388	729,360	91%/9%						
55	FFS	Whatcom - WCPC	2,804,496	248,436	3,052,932	91%/9%						
56	FFS	Whatcom - Sea Mar	395,436	38,484	433,920	91%/9%						
57	FFS	Whatcom - Lake Whatcom	986,484	93,360	1,079,844	91%/9%						
58	FFS	Whatcom - Sunrise	339,768	41,976	381,744	91%/9%						
59	FFS	Skagit - Sea Mar	299,100	23,244	322,344	91%/9%						
60	FFS	Skagit - Sunrise	1,679,508	68,160	1,747,668	91%/9%						
61	FFS	Skagit - Compass	1,611,660	190,296	1,801,956	91%/9%						
62	FFS	Skagit - Bridgways	117,792	13,992	131,784	91%/9%						
63	FFS	Island - Compass	884,280	75,180	959,460	91%/9%						
64	FFS	Island - Sunrise	452,988	55,980	508,968	91%/9%						
65	FFS	Island - Sea Mar	92,640	9,180	101,820	91%/9%						
66	FFS	San Juan - Compass	244,152	28,692	272,844	91%/9%						
		Adult IOP	-	-								
67	FFS	Snohomish - Compass	926,220	69,984	996,204	91%/9%						
68	FFS	Snohomish - Sunrise	705,732	69,984	775,716	91%/9%						
69	FFS	Snohomish - SeaMar	298,980	36,948	335,928	91%/9%						
70	FFS	Whatcom - WCPC	378,840	33,456	412,296	91%/9%						
71	FFS	Whatcom - Lake Whatcom	520,404	61,836	582,240	91%/9%						
72	FFS	Skagit - Compass	447,984	50,916	498,900	91%/9%						
73	FFS	Skagit - Sunrise	339,768	41,976	381,744	91%/9%						
74	FFS	Island - Compass	216,300	26,736	243,036	91%/9%						
		IDDT										
75	Cost	Skagit - Sunrise	240,120	107,880	348,000	91%/9%						
76	FFS	Snohomish - Sunrise	450,000		450,000	100% Med						
		Housing Support (Residential)										
77	Cap	Snohomish - Aurora	877,980	219,492	1,097,472	80%/20%						
78	Cap	Snohomish - Haven	470,400	117,600	588,000	80%/20%						
79	Cap	Snohomish - Green	763,956	193,152	957,108	80%/20%						
80	Cap	Whatcom - Lake Whatcom	1,124,148	281,052	1,405,200	80%/20%						
81	Cap	Discharge Housing - Sno Co - CH		31,800	31,800	100% State						
82	Cap	Discharge Housing - Whatcom -LKW		36,000	36,000	100% State						
	Case	Residential CD IMD						6,595,142		2,977,661.90	3,617,480	
	Case	Residential CD Non-IMD						4,099,774	4,099,774.15			
	Cap	Residential Child Care R&B Evergreen						192,000		63,936	128,064	6,787,141.90 10,886,916.05
		PACT										
83	Cost	Snohomish	1,305,648	129,132	1,434,780	91%9%						
	Mix	Snohomish - Incentive	97,923	9,685	107,608	91%9%						
84	Cost	Whatcom	797,160	78,840	876,000	91%9%						
	Mix	Whatcom - Incentive	93,814	9,278	103,092	91%9%						
85	Cost	Skagit	775,320	76,680	852,000	91%9%						
	Mix	Skagit - Incentive	58,149	5,751	63,900	91%9%						
		CD Outpatient Services								8,000	189,072	
		Snohomish								3,500	35,098	
		Skagit								5,000	25,000	
		Whatcom								2,500	19,393	
		Island								1,772	6,000	295,135 this section
		San Juan										349,569 Total incl above
		Peer Centers										
86	Cost	Snohomish - Compass		75,000	75,000	100% State						
87	Cost	Whatcom - WCPC		75,000	75,000	100% State						
88	Cost	Skagit - CVAB		75,000	75,000	100% State						
89	Cap	San Juan Rate Premium Compass	90,516	10,380	100,896	% of fees						
90	Cap	San Juan Subsidy - Compass Health		105,108	105,108	100% State						
91	FFS	Out of Network Services	80,000	-	80,000	100% Med						

92	Cap	Expanded Community Services		187,500	187,500	100% State					
93	Cost	Information Services Subsidy	109,218	10,802	120,020	91%9%					
		CD transportation						117,000		70,000	66,000
		County Administration Funding									
94	Cost	Snohomish	1,025,148		1,025,148	100% Med		366,194	366,194		
95	Cost	Skagit	228,492		228,492	100% Med		81,620	81,620		
96	Cost	Whatcom	275,964		275,964	100% Med		98,578	98,578		
97	Cost	Island	190,416		190,416	100% Med		68,019	68,019		
98	Cost	San Juan	196,214	3,898	200,112	100% Med		68,019	68,019		
99	Cost	Jail Funding		373,104	373,104	100% State					
100	Cost	Interpreter Services	220,800	19,200	240,000	91%9%					
101	Cost	North Sound RSN operations	5,882,129	581,749	6,463,878	91%9%	1,748,724		1,591,339	157,385	
102	Cost	VOA Access Authorization	421,138	41,651	462,789	91%9%					
103	Cost	VOA Inpatient Certification	785,771	77,714	863,485	91%9%					
		Court Costs CD				100% State					
104	Case	Court Costs MH		980,000	980,000	100% State					-
105	Cost	Flex Funds		450,000	450,000	100% State					
106	Cost	Ombuds	154,560	13,440	168,000	91%9%					
107	FFS	Medicaid Personal Care		125,000	125,000	100% State					
108	Cost	PATH Match and Additional Costs		202,851	202,851	100% State					
109	Cost	Additional housing Services		490,440	490,440	100% State					
		Total	$ 81,095,915	$ 21,057,205	$ 98,034,064		3,091,692	16,952,242	11,281,409	4,799,684	4,321,410
										4,799,684	4,321,410
										$ 0	$ -

North Sound BHO Substance Use Disorder Provider Capacity Planning Summary Worksheet

	2014 Served	2015 Current Capacity	2016 Additions	2016 Total Capacity	2016 % Incr	2017 Additions	2017 Total Capacity	2017 % Incr	2018 Additions	2018 Total Capacity	2018 % Incr
Crisis Services - Clients											
Mobile Outreach Teams (including a CDP)		382	1,200	1,582	314%	50	1,632	3%	50	1,682	3%
Crisis Triage Centers (serving SUD needs)		840	60	900	7%	0	900	0%	0	900	0%
Detox	1,000	1,059	80	1,139	8%	25	1,164	2%	0	1,164	0%
Subacute Detox	1,000	1,250	850	2,100	68%	580	2,680	28%	0	2,680	0%
Sobering Services		0	0	-	0%	0	-	0%	0	-	0%
Brief Treatment - Clients											
All Brief Treatment Settings		125	325	450	260%	300	750	67%	350	1,100	47%
(Primary Care Clinics, School-Based Services, Addiction Treatment Centers, Jails, Homeless Shelters, etc.)											
Ongoing Care Clients			2,442			2,593			2,655		
Outpatient											
Adult	4,930	2,963	466	3,429	16%	681	4,110	20%	666	4,776	16%
Youth	1,035	403	160	563	40%	212	775	38%	251	1,026	32%
Pregnant and Parenting Women	40	326	199	525	61%	202	727	38%	221	948	30%
Intensive Outpatient											
Adult	3,570	4,772	1,072	5,844	22%	909	6,753	16%	859	7,612	13%
Youth	425	559	310	869	55%	369	1,238	42%	401	1,639	32%
Pregnant and Parenting Women	80	551	235	786	43%	220	1,006	28%	257	1,263	26%
Opiate Substitution Tx	1,790	2,227	703	2,930	32%	193	3,123	7%	201	3,324	6%
Medical Services in Addiction Treatment Agencies		255	495	750	194%	311	1,061	41%	307	1,368	29%
(Medical treatment, COD psych meds, non-opoid addiction meds, opiod addiction meds, pain management)											
Co-Occurring Disorder Treatment		596	290	886	49%	343	1,229	39%	321	1,550	26%
Recovery Supports		729	75	804	10%	175	979	22%	235	1,214	24%
(Recovery Coaches, Recovery Café, Peer Navigators, Recovery Centers)											
Jail Transition Services		60	30	90	50%	30	120	33%	30	150	25%
Substance Abuse Protective Custody		96	0	96	0%	0	96	0%	0	96	0%
Assessments (DUI, CPS, Court, etc.)		1,956	240	2,196	12%	240	2,436	11%	80	2,516	3%
Juvenile Detention		94	20	114	21%	20	134	18%	20	154	15%
Sultan High School		32	10	42	31%	10	52	24%	10	62	19%
Cocoon House Outreach (Hours)		725	0	725	0%	0	725	0%	0	725	0%
Sultan High School Outreach (Hours)		576	0	576	0%	0	576	0%	0	576	0%
Lincoln High School		29	5	34	17%	10	44	29%	10	54	23%
Weston High School		46	5	51	11%	10	61	20%	10	71	16%
Lincoln High School Outreach (Hours)		217	0	217	0%	0	217	0%	0	217	0%
Weston High School Outreach (Hours)		458	0	458	0%	0	458	0%	0	458	0%
Other		0	0	-	0%	0	-	0%	0	-	0%

SCOPE Data Pull October 2014 - September 2015

	Adult Island	Adult San Juan	Adult Skagit	Adult Snohomish	Adult Whatcom	Adult Totals	% Unduplicate	# Unduplicate
Oct 2014 - Sept 2015 Undup All Age								
Assessments Indicate Depend	490	125	2,340	8,060	2,595	13,610	0%	-
Assessments Indicate Abuse	65	10	265	1,230	410	1,980	0%	-
Total	555	135	2,605	9,290	3,005	15,590	0%	-
Oct 2014 - Sept 2015 All Age								
Detox Admissions	55	5	325	910	680	1,975	0%	-
Undupe Detox Clients	45	5	205	710	350	1,315	50%	658
Oct 2014 - Sept 2015 Undup Adult								
Outpatient	145	50	400	1,060	1,105	2,760	0%	-
IOP	135	115	845	2,360	325	3,780	0%	-
Total	270	155	1,155	3,320	1,395	6,295	100%	6,295
Intensive IP	70	10	105	725	250	1,160	0%	-
Long Term Residential	5	-	435	165	80	685	0%	-
Recovery House	-	-	5	10	5	20	0%	-
Total Residential	75	10	545	900	335	1,865	100%	1,865
Total Adults								8,818
Oct 2014 - Sept 2015 Undup Youth								
Outpatient	5	5	115	325	185	635	0%	-
IOP	15	5	70	285	35	410	0%	-
Total	25	10	170	590	215	1,010	100%	1,010
Youth Level I	-	-	15	25	20	60	0%	-
Youth Level II	10	-	20	60	75	165	0%	-
Youth Recovery House	-	-	10	20	55	85	0%	-
Youth Total	10	-	45	105	150	310	100%	310
Total Youth								1,320

Appendix, Section IV-01 North Sound BHO Detailed Plan

SFY 2014 CD Service Summary

order	modality_id	Payment Source	treatment_activity_type_id	RSA Island	North Sound San_Juan	North Sound Skagit	North Sound Snohomish	North Sound Whatcom	Statewide Totals	Peninsula	North Sound	King
Unduplicate count of clients served (all modalities)	All Services			341	145	2,921	6,842	2,671	70,500	3,778	12,920	16,575
Totals, no assessment, no detox				297	134	2600	5322	2290	60,625	3,505	10,643	14,481
Difference with unduplicated counts				44	11	321	1520	381	9,875	273	2,277	2,094
Estimated total cost of CD services	All Services			$337,953	$142,037	$8,336,972	$11,929,435	$5,294,408	$127,805,603	$5,939,276	$26,040,805	$33,325,426
Distribution of costs into eligibility categories	ADATSA	Medicaid		28%	19%	13%	9.80%	21%				
	DL-U	Medicaid			0.90%	3.90%	1.60%	0.10%				
	DL-X	Medicaid		0.80%	3.50%	2.10%	2.90%	8.30%				
	Medicaid: AGED	Medicaid		0.20%	0.50%	0.10%	0.20%					
	Medicaid: B/D	Medicaid		8.60%	12%	1.80%	9.50%	2.30%				
	Medicaid: Expan	Medicaid		24%	25%	22%	22%	9.60%				
	Medicaid: OTR	Medicaid		5.90%	11%	6.60%	21%	2.60%				
	Medicaid: TANF	Medicaid		15%	6.80%	16%	18%	6.30%				
	non-Medicaid	Non-Medicaid		17%	21%	34%	15%	50%				
	Total			99.50%	99.70%	99.50%	100.00%	100.20%				
Distribution of costs into eligibility categories	ADATSA	Medicaid		$94,627	$26,987	$1,083,806	$1,169,085	$1,111,826	$16,764,086	$875,102	$3,486,331	$5,332,068
	DL-U	Medicaid		$0	$1,278	$325,142	$190,871	$5,294	$2,032,719	$209,652	$522,586	$533,207
	DL-X	Medicaid		$2,704	$4,971	$175,076	$345,954	$439,436	$2,909,920	$60,192	$968,141	$966,437
	Medicaid: AGED	Medicaid		$676	$710	$8,337	$23,859	$0	$448,542	$4,250	$33,582	$33,325
	Medicaid: B/D	Medicaid		$29,064	$17,044	$150,065	$1,133,296	$121,771	$17,626,036	$331,130	$1,451,242	$3,999,051
	Medicaid: Expan	Medicaid		$81,109	$35,509	$1,834,134	$2,624,476	$508,263	$25,018,482	$1,489,429	$5,083,491	$8,331,357
	Medicaid: OTR	Medicaid		$19,939	$15,624	$550,240	$2,505,181	$137,655	$8,926,945	$508,518	$3,228,639	$1,899,549
	Medicaid: TANF	Medicaid		$50,693	$9,659	$1,333,916	$2,147,298	$333,548	$18,592,842	$801,389	$3,875,113	$5,332,068
	non-Medicaid	Non-Medicaid		$57,452	$29,828	$2,834,570	$1,789,415	$2,647,204	$35,236,590	$1,597,340	$7,358,470	$6,665,085
	Total			$336,263	$141,611	$8,295,287	$11,929,435	$5,304,997	$127,556,162	$5,877,002	$26,007,593	$33,092,148
	Medicaid Total			$278,811	$111,783	$5,460,717	$10,140,020	$2,657,793	$92,319,572	$4,279,662	$18,649,124	$26,427,063
	Medicaid %			83%	79%	66%	85%	50%	72%	73%	72%	80%
Costs by Program Area												
	OP	Mcaid elig & included		$73,285	$41,423	$492,620	$3,219,044	$1,229,213	$20,686,330	$1,513,781	$5,055,585	$3,805,708
	IOP	Mcaid elig & included		$152,295	$72,276	$1,000,531	$1,495,696	$158,494	$22,329,621	$2,259,651	$2,879,292	$4,732,168
	OP/IOP Subtotal			$225,580	$113,699	$1,493,151	$4,714,740	$1,387,707	$43,015,951	$3,773,432	$7,934,877	$8,537,876
	Intensive IP			$60,623	$2,705	$228,184	$500,520	$1,763,823	$26,806,955	$1,194,492	$2,555,855	$5,306,314
	Long-Term Res			$11,417	$0	$4,738,016	$1,106,899	$191,199	$14,025,257	$150,864	$6,047,531	$2,455,033
	OST			$0	$0	$0	$3,754,593	$990,993	$25,653,309	$96,553	$4,745,586	$12,771,673
	Recovery House			$0	$0	$719,554	$1,399	$237,984	$1,852,611	$20,528	$958,937	$78,536
	Facility Total			$72,040	$2,705	$5,685,754	$5,363,411	$3,183,999	$68,338,132	$1,462,437	$14,307,909	$20,611,556
	Detox	Mcaid elig		$3,660	$13,331	$873,161	$1,134,972	$436,667	$9,481,197	$313,512	$2,461,791	$2,767,293
	Assessment	Mcaid elig		$24,378	$9,337	$190,119	$517,285	$190,279	$5,118,130	$284,612	$931,398	$1,120,447
	Total			$325,658	$139,072	$8,242,185	$11,730,408	$5,198,652	$125,953,410	$5,833,993	$25,635,975	$33,037,172
	Medicaid Eligible Categories			$253,618	$136,367	$2,556,431	$6,366,997	$2,014,653	$57,615,278	$4,371,556	$11,328,066	$12,425,616
	Medicaid Included Total			$225,580	$113,699	$1,493,151	$4,714,740	$1,387,707	$43,015,951	$3,773,432	$7,934,877	$8,537,876
	Medicaid Included %			89%	83%	58%	74%	69%	75%	86%	70%	69%
	Medicaid Included $			$247,988	$93,202	$3,189,476	$7,508,651	$1,830,706	$67,308,969	$3,688,305	$12,870,022	$18,158,535
	Medicaid Not Included $			$30,823	$18,581	$2,271,241	$2,631,369	$827,087	$25,010,602	$591,356	$5,779,101	$8,268,528
Unduplicate count of clients served	Detox			2	9	491	978	455	9,138	409	1,935	2,578
	Intensive IP			15	1	88	199	218	8,701	515	521	1,746
	IOP			139	66	953	1,355	237	18,185	1,541	2,750	3,859
	Long-Term Res			2		839	102	30	2,127	26	973	408
	OST						1,184	353	7,988	25	1,537	3,759
	OP			141	67	599	2,481	1,412	22,993	1,388	4,700	4,663
	Recovery House					121	1	40	631	10	162	46
	ADATSA Assessment			26	1	167	528	146	4,908	383	868	949

	Assessment			166	75	1,204	3,533	1,317	34,338	1,765	6,295	7,715	
	Skagit Residential Adjust												
	Average LTR Clients % of Total Clients			0.6%	0.0%	28.7%	1.5%	1.1%	3.0%				
	Average Cost per LTR Client			$5,709	$0	$5,647	$10,852	$6,373	$6,594				
	Estimated Revised Skagit Clients					63							
	Change					(776)							
	Revenue Change					-$4,382,241							
	Revenue Change					-53.17%							
Outpatient Units-of-Service (hours)	IOP		Individ	320	202	4,088	4,050	308				North Sound	Mix
	IOP		Group	4,037	1,827	31,002	46,750	5,482				8,968	8.8%
	IOP		Conjoint			1	19	3				89,098	87.7%
	IOP		Family			1	3	5				23	0.0%
	IOP		Case Management	62	24	540	2,905	7				9	0.0%
												3,538	3.5%
	OP		Individ	277	203	3,051	8,206	3,644				101,636	100.0%
	OP		Group	1,806	796	10,685	81,514	37,192				15,381	9.7%
	OP		Conjoint				9	4				131,993	83.1%
	OP		Family				8	3				13	0.0%
	OP		Case Management	43	17	419	10,203	775				11	0.0%
												11,457	7.2%
Outpatient costs	IOP		Individ	$28,780	$16,750	$326,602	$318,676	$24,552				158,855	100.0%
	IOP		Group	$120,928	$54,536	$650,907	$1,056,063	$133,026					
	IOP		Conjoint			$39	$1,456	$193					Units/Client
	IOP		Family			$77	$250	$437				OP	33.80
	IOP		Case Management	$2,587	$990	$22,906	$119,251	$286				IOP	36.96
	OP		Individ	$22,582	$16,468	$243,558	$662,252	$290,165					
	OP		Group	$48,902	$24,228	$231,032	$2,124,536	$906,265					
	OP		Conjoint				$711	$327					
	OP		Family				$622	$212					
	OP		Case Management	$1,801	$727	$18,030	$430,923	$32,244					
Per-diem units of service (days w service)	Detox			11	87	5,392	5,661	3,157					
	Intensive IP			514	30	2,065	4,827	11,068					
	Long-Term Res			89		41,710	8,624	1,544					
	OST						287,011	72,592				359,603	
	Recovery House					5,604	34	1,952					
Estimated Per-diem costs	Detox			$3,660	$13,331	$873,161	$1,134,972	$436,667					
	Intensive IP			$60,623	$2,705	$228,184	$500,520	$1,763,823					
	Long-Term Res			$11,417		$4,738,016	$1,106,899	$191,199				6,047,531	
	OST						$3,754,593	$990,993		OST $		4,745,586	
	Recovery House					$719,554	$1,399	$237,984		OST Cl		1,537	
										$ per		3,087.56	
Assessments (# conducted)	ADATSA Assessment			26	1	169	531	146		Rate		12.79	
	Assessment			171	77	1,302	3,740	1,395		Units/cl		241.40	
Assessment costs	ADATSA Assessment			$4,290	$175	$30,082	$63,943	$23,798					
	Assessment			$20,088	$9,162	$160,037	$453,342	$166,481					
Total Costs													

Pierce	Thurston-Mason	Timberlands	Greater Columbia	North Central	SW WA	Spokane	Statewide Totals	Average
6,893	3,037	3,941	8,846	2,820	4,631	7,059	70,500	
5,967	2,623	3,617	7,006	2,290	3,799	6,694	60,625	
926	414	324	1,840	530	832	365	9,875	
$12,208,994	$5,083,647	$6,087,030	$13,474,518	$2,784,320	$7,519,706	$15,341,881	$127,805,603	
$622,659	$216,252	$1,086,322	$302,342	$500,907	$1,223,708	$3,118,395	$16,764,086	
$73,254	$39,271	$75,803	$50,444	$73,117	$121,835	$333,550	$2,032,719	
$158,717	$56,838	$196,014	$90,088	$93,076	$88,147	$232,270	$2,909,920	
$158,717	$3,234	$9,875	$2,065	$5,101	$21,603	$176,790	$448,542	
$512,778	$127,870	$515,701	$8,191,950	$256,507	$828,634	$1,411,173	$17,626,036	
$2,197,619	$821,468	$1,084,976	$823,435	$728,671	$1,843,941	$2,614,095	$25,018,482	
$415,106	$346,511	$371,960	$380,655	$235,718	$889,151	$651,138	$8,926,945	
$329,643	$1,328,740	$992,282	$1,894,552	$374,190	$1,203,135	$2,461,730	$18,592,842	
$7,691,666	$2,153,631	$1,772,182	$1,787,626	$517,377	$1,365,760	$4,327,453	$35,236,590	
$12,160,158	$5,093,814	$6,105,116	$13,523,157	$2,784,663	$7,585,915	$15,326,595	$127,556,162	
$4,468,492	$2,940,183	$4,332,934	$11,735,531	$2,267,286	$6,220,155	$10,999,142	$92,319,572	
37%	58%	71%	87%	81%	82%	72%	72%	
$1,960,348	$1,393,013	$1,222,180	$1,761,297	$664,183	$1,306,665	$2,003,570	$20,686,330	
$1,841,795	$1,119,659	$2,009,400	$2,981,214	$650,683	$1,272,158	$2,583,601	$22,329,621	
$3,802,143	$2,512,672	$3,231,580	$4,742,511	$1,314,866	$2,578,823	$4,587,171	$43,015,951	
$3,531,123	$434,486	$1,086,507	$4,225,881	$801,839	$1,917,691	$5,752,767	$26,806,955	
$307,026	$205,108	$641,518	$2,137,211	$121,030	$330,340	$1,629,596	$14,025,257	
$3,165,574	$1,249,285	$510,509	$635,658	$0	$1,082,206	$1,396,265	$25,653,309	
$25,219	$10,532	$89,211	$119,357	$0	$5,389	$544,902	$1,852,611	
$7,028,942	$1,899,411	$2,327,745	$7,118,107	$922,869	$3,335,626	$9,323,530	$68,338,132	
$771,081	$338,395	$85,262	$722,252	$297,249	$1,132,904	$591,458	$9,481,197	
$427,226	$240,895	$308,994	$634,397	$200,203	$375,120	$594,838	$5,118,130	
$12,029,392	$4,991,373	$5,953,581	$13,217,267	$2,735,187	$7,422,473	$15,096,997	$125,953,410	
$5,000,450	$3,091,962	$3,625,836	$6,099,160	$1,812,318	$4,086,847	$5,773,467	$57,615,278	
$3,802,143	$2,512,672	$3,231,580	$4,742,511	$1,314,866	$2,578,823	$4,587,171	$43,015,951	
76%	81%	89%	78%	73%	63%	79%	75%	
$3,397,663	$2,387,046	$3,802,349	$8,897,337	$1,579,153	$3,838,422	$8,690,136	$67,308,969	
$1,070,829	$553,137	$530,584	$2,838,194	$688,134	$2,381,733	$2,309,006	$25,010,602	
892	255	92	1,060	430	1,008	479	9,138	
1,150	161	420	1,744	335	690	1,419	8,701	
1,623	933	1,492	2,288	506	1,127	2,066	18,185	
95	30	90	213	25	46	221	2,127	
958	464	192	205	-	331	517	7,988	
2,125	1,027	1,274	2,514	1,424	1,602	2,276	22,993	
16	8	149	42	-	3	195	631	
432	220	338	393	270	511	544	4,908	

2,988	1,611	2,113	4,479	1,133	2,457	3,782	34,338

Ind	Grp
8.8%	
	87.7%
0.0%	
0.0%	
3.5%	
12.3%	87.7%
9.7%	
	83.1%
0.0%	
0.0%	
7.2%	
16.9%	83.1%

Hours/Client
8.45
9.24

Behavioral Health Need - North Sound RSA

MI and AOD Risk factors	Non-Disabled Child (age <12) Enrollees	Disabled Child (age <12) Enrollees	Non-Disabled Adolescent (age12-17) Enrollees	Disabled Adolescent (age12-17) Enrollees	Non-Disabled Adult Enrollees	Disabled Adult Enrollees	Elder Enrollees	Total Enrollees
Total with AOD Treatment Need, FY 2012-2013	219	11	1,639	63	7,914	5,465	6	15,317
Total with MI Need, FY 2012-2013	7,574	519	7,401	522	13,892	13,319	129	43,356
Total with COD, FY 2012-2013	43	4	913	53	4,587	4,638	2	10,240
Total Diagnosed with MI (P1 or CARE) FY 2012-2013	5,814	355	5,719	382	11,250	11,387	84	34,991
Psychotic Disorder	58	6	221	27	853	2,461	18	3,644
Mania & Bipolar Disorder	253	33	682	88	2,464	4,373	20	7,913
Depression Disorder	680	48	2,914	144	7,596	7,412	45	18,839
Anxiety Disorder	2,998	172	2,988	215	6,521	6,477	34	19,405
ADHD	2,098	208	1,051	144	214	435	2	4,152
Adjustment & Stress Disorder	1,389	63	910	39	563	446	2	3,412
Total Filling Psychotropic Rx, FY 2012-2013	3,098	363	4,089	408	10,406	11,554	111	30,029
Antipsychotic	179	81	469	130	1,628	4,132	18	6,637
Antimania	7	2	49	11	345	661	2	1,077
Antidepressants	405	91	1,764	185	7,890	8,889	84	19,308
Antianxiety	836	82	888	113	5,273	6,447	50	13,689
ADHD	2,112	253	2,273	241	1,006	889	0	6,774
Total Enrollees:	**79,399**	**1,571**	**30,607**	**973**	**36,416**	**19,302**	**462**	**168,730**
Mental Health Need %:	**9.5%**	**33.0%**	**24.2%**	**53.6%**	**38.1%**	**69.0%**	**27.9%**	**25.7%**
Substance Use Disorder Need %:	**0.3%**	**0.7%**	**5.4%**	**6.5%**	**21.7%**	**28.3%**	**1.3%**	**9.1%**

Total Adult Elder	Non-Disabled Adult %
22,721	7.3%
3,332	0.1%
6,857	0.3%
15,053	0.9%
13,032	3.8%
651	2.6%
1,011	1.7%
22,071	3.9%
5,778	0.2%
1,008	0.0%
16,863	0.5%
11,770	1.1%
1,895	2.7%

Non-Disabled Child (age <12) Pcnt	Disabled Child (age <12) Pcnt	Non-Disabled Adolescent (age12-17) Pcnt	Disabled Adolescent (age12-17) Pcnt	Non-Disabled Adult Pcnt	Disabled Adult Pcnt	Elder Pcnt
0.3%	0.7%	5.4%	6.5%	21.7%	28.3%	1.3%
9.5%	33.0%	24.2%	53.6%	38.1%	69.0%	27.9%
7.3%	22.6%	18.7%	39.3%	30.9%	59.0%	18.2%
0.1%	0.4%	0.7%	2.8%	2.3%	12.7%	3.9%
0.3%	2.1%	2.2%	9.0%	6.8%	22.7%	4.3%
0.9%	3.1%	9.5%	14.8%	20.9%	38.4%	9.7%
3.8%	10.9%	9.8%	22.1%	17.9%	33.6%	7.4%
2.6%	13.2%	3.4%	14.8%	0.6%	2.3%	0.4%
1.7%	4.0%	3.0%	4.0%	1.5%	2.3%	0.4%
3.9%	23.1%	13.4%	41.9%	28.6%	59.9%	24.0%
0.2%	5.2%	1.5%	13.4%	4.5%	21.4%	3.9%
0.0%	0.1%	0.2%	1.1%	0.9%	3.4%	0.4%
0.5%	5.8%	5.8%	19.0%	21.7%	46.1%	18.2%
1.1%	5.2%	2.9%	11.6%	14.5%	33.4%	10.8%
2.7%	16.1%	7.4%	24.8%	2.8%	4.6%	0.0%

NSMHA Unit Cost Analysis

	Nurse Practitioners/ Physicians Assistants	Supervising Clinician	Therapist/ CDPT	Counselor/ CDP	Case Manager	CDPT	Totals
Section 1 FTEs							
Center for Human Services	0.03			6.50			6.53
Compass Health				2.00			2.00
Evergreen Manor		4.17	4.50	13.90	4.30	4.50	31.37
Sunrise Services	0.25	1.00		1.25	0.25		2.75
Catholic Community Svcs				29.00			29.00
Totals	0.28	5.17	4.50	52.65	4.55	4.50	71.65
Section 2 Total Expenses							
Center for Human Services	$9,235			$813,884			$823,119
Compass Health				$316,794			$316,794
Evergreen Manor		$458,051	$345,799	$1,276,636	$360,530	$345,799	$2,786,815
Sunrise Services	$53,446	$83,095		$95,900	$15,594		$248,035
Catholic Community Svcs				$3,252,014			$3,252,014
Totals	$62,681	$541,146	$345,799	$5,755,229	$376,124	$345,799	$7,426,778
Section 3 Work Hours							
Center for Human Services	62			11,804			11,866
Compass Health				3,250			3,250
Evergreen Manor		8,173	8,820	27,244	8,428	8,820	61,485
Sunrise Services	466	1,864		2,330	466		5,126
Catholic Community Svcs				45,131			45,131
Totals	528	10,037	8,820	89,759	8,894	8,820	126,858
Section 4 Direct Client Hrs							
Center for Human Services	53			4,722			4,775
Compass Health				2,323			2,323
Evergreen Manor		3,269	4,410	20,161	5,310	4,410	37,560
Sunrise Services	280	932		1,398	280		2,890
Catholic Community Svcs				22,566			22,566
Totals	333	4,201	4,410	51,170	5,590	4,410	70,114
Average Hours/FTE/Yr	1,189	813	980	972	1,229	980	979
Section 5 Cost per Clin Hr							
Center for Human Services	$174.25	-	-	$172.36	-	-	$172.38
Compass Health	-	-	-	$136.37	-	-	$136.37
Evergreen Manor	-	$140.12	$78.41	$63.32	$67.90	$78.41	$74.20
Sunrise Services	$190.88	$89.16	-	$68.60	$55.69	-	$85.83
Catholic Community Svcs	-	-	-	$144.11	-	-	$144.11
Totals	$188.23	$128.81	$78.41	$112.47	$67.29	$78.41	$105.92
Fully Loaded Cost/FTE	$223,861	$104,670	$76,844	$109,311	$82,665	$76,844	$103,654
Section 6 Avg Grp Length							
Center for Human Services				60			
Compass Health				180			
Evergreen Manor		120	120	120	60		
Sunrise Services		120		120			
Catholic Community Svcs				120			
Totals							
Section 7 Avg Clients/Grp							
Center for Human Services				10			
Compass Health				12			
Evergreen Manor		12	12	12	12		
Sunrise Services		12		12			
Catholic Community Svcs				12			
Totals							

Missing: Phoenix and SeaMar

Appendix, Section IV-01 North Sound BHO Detailed Plan

Section 8 Avg Clin/Grp							
Center for Human Services				1			
Compass Health				1			
Evergreen Manor		1	1	1	1		
Sunrise Services		1		1			
Catholic Community Svcs				1			
Totals							
Section 9 Avg Cost/Group							
Center for Human Services	-	-	-	$17.24	-	-	-
Compass Health	-	-	-	$34.09	-	-	-
Evergreen Manor	-	$23.35	$13.07	$10.55	$5.66	-	-
Sunrise Services	-	$14.86	-	$11.43	-	-	-
Catholic Community Svcs	-	-	-	$24.02	-	-	-
Totals	-	-	-	-	-	-	**$18.51**
Section 10 Grp FTEs							
Center for Human Services				6.50			6.50
Compass Health				2.00			2.00
Evergreen Manor		4.17	4.50	13.90	4.30		26.87
Sunrise Services		1.00		1.25			2.25
Catholic Community Svcs				29.00			29.00
Totals	-	5.17	4.50	52.65	4.30	-	66.62
Section 10 Grp FTE Weight							
Center for Human Services	-	-	-	0.10	-	-	0.10
Compass Health	-	-	-	0.03	-	-	0.03
Evergreen Manor	-	0.06	0.07	0.21	0.06	-	0.40
Sunrise Services	-	0.02	-	0.02	-	-	0.03
Catholic Community Svcs	-	-	-	0.44	-	-	0.44
Totals	-	0.08	0.07	0.79	0.06	-	1.00

DBHR Residential Bed Rates/Per day Per Client 2013-15 (Includes R & B @ $11.64)	
Adult Intensive Inpatient (IIP)	$ 90.18
Adult IIP Expanded Medical	$ 188.68
Adult IIP COD Pilot	$ 155.00
Adult IIP Deaf and Hard of Hearing	$ 139.20
Adult IIP Non-IMD Pilot (Ended 1/23/14)	$ 126.45
Adult IIP Non-IMD Rate	$150.00
Adult Long Term	$ 53.52
Adult Recovery House	$ 41.14
Adult Involuntary Tx - East	$ 128.28
Adult Involuntary Tx - North	$ 113.28
Housing Support Services	$13.79
Pregnant and Parenting Women (PPW) w/child(ren)	$ 126.45
PPW without child(ren)	$ 106.30
PPW w/child(ren) COD	$ 175.15
PPW w/o child(ren) COD	$ 155.00
Therapeutic Childcare (5 days per week max)	$ 49.60
Safe Babies Safe Moms (Per client/per month)	$ 511.00
PCAP (Per client/per month)	$ 356.00-516.00
Youth Level 1	$ 150.00
Youth Level 2	$ 188.68
Youth Recovery House	$ 128.40
Youth Acute Detox	$ 235.49
Youth Sub Acute Detox	$ 172.44
Youth Crisis Stablilization	$ 189.68

* Denotes Medicaid Rate

** Denotes Low Income Rate of Medicaid + 15%

Non-IMD's: 6 PPW Programs, 9 Youth Programs, 8 Adult IIP Programs

Adult Detox Rates (paid thru county contracted services) by County

Updated 6/30/14 DRAFT

DBHR Oupatient Rates 2013-15	Medicaid	**Low Income	County Specific	Unit Type
Intervention and Referral			30.00-85.00	Per Hour
Alcohol/Drug Information School			31.00-155.00	Per Hour
Opiate Dependency/HIV Services			26.00-75.00	Per Hour
Interim Services			15.00-85.00	Per Hour
Outreach			18.00-75.00	Per Hour
Brief Intervention			7.50-55.00	Per Hour
Crisis Services			22.00-55.00	Per Hour
Acute Detoxification Services	$ 252.00	$ 289.80	170.61-400.00	Per Day
Sub-Acute Detoxification Services	$ 108.36	$ 124.61	124.61-170.61	Per Day
Sobering Services (King, Spokane, Clark) 6/30/14			2.32-7.00 per hr	Per Hour
Involuntary Commitment				
Outpatient Treatment Adult-Group	$ 4.82	$ 5.54	6.00/9.00/12.00	Per 15 Min
Intensive Outpatient Tx Adult-Group	$ 4.82	$ 5.54	6.00/9.00/12.00	Per 15 Min
Outpatient Treatment Adult-Individual	$ 19.26	$ 22.14		Per 15 Min
Intensive Outpatient Tx Adult-Individual	$ 19.26	$ 22.14		Per 15 Min
Outpatient Treatment PPW-Group	$ 4.82	$ 5.54	6.00/9.00/12.00	Per 15 Min
Intensive Outpatient Tx PPW-Group	$ 4.82	$ 7.25	6.00/9.00/12.00	Per 15 Min
Outpatient Treatment PPW-Individual	$ 19.26	$ 22.15		Per 15 Min
Intensive Outpatient Tx PPW-Individual	$ 19.26	$ 22.15		Per 15 Min
Outpatient Treatment Youth-Group	$ 6.30	$ 7.25	7.00/10.00/13.00	Per 15 Min
Intensive Outpatient Tx Youth-Group	$ 6.30	$ 11.64	7.00/10.00/13.00	Per 15 Min
Outpatient Treatment Youth-Individual	$ 19.26	$ 22.15		Per 15 Min
Intensive Outpatient Tx Youth-Individual	$ 19.26	$ 22.15		Per 15 Min
Opiate Substitution Treatment	$ 12.79	$ 14.71		Per Day
Therapeutic Childcare Services	$ 49.60	$ 57.04		Per Day (5 Max)
Transportation			Actual Costs	Actual Costs
Case Management - Adult	$ 10.12	$ 11.64		Per 15 Min
Case Management - PPW	$ 10.12	$ 11.64		Per 15 Min
Case Management - Youth	$ 10.12	$ 11.64		Per 15 Min
Childcare Services		$ -		Per 15 Min
Assessment - Adult	$ 115.17	$ 132.45		Per Assesement
Assessment - PPW	$ 115.17	$ 132.45		Per Assesement
Assessment - Youth	$ 115.17	$ 132.45		Per Assesement
Assessment - DUI	$ 115.17	$ 132.45		Per Assesement
Brief Therapy	$ 53.52	$ 61.55		Per Hour
Screening Tests and Urinary Analysis	$ 8.74	$ 10.05		Per UA
Expanded Assessment	$ 177.69	$ 204.34		Per Assesement
TB Skin Tests	$ 5.01	$ 5.76		Per Test

Intensive Outpatient Average	Mix	Ad Rate	Yth Rate
Indiv	16.91%	$77.04	$77.04
Group	83.09%	$19.28	$25.20
Wtg Avg		$29.05	$33.97

Outpatient Average	Mix	Ad Rate	Yth Rate
Indiv	12.34%	$77.04	$77.04
Group	87.66%	$19.28	$25.20
Wtg Avg		$26.41	$31.60

Revised Figures, Scenario 1	New Mix	2015 Cst	2016 Cst
Indiv	20%	$105.92	$109.63
Group	80%	$18.51	$19.16
Wtg Avg		$35.99	**$37.25**

Revised Figures, Scenario 2	New Mix	2015 Cst	2016 Cst
Indiv	30%	$105.92	$109.63
Group	70%	$18.51	$19.16
Wtg Avg		$44.73	**$46.30**

Revised Figures, Scenario 3	New Mix	2015 Cst	2016 Cst
Indiv	40%	$105.92	$109.63
Group	60%	$18.51	$19.16
Wtg Avg		$53.47	**$55.35**

Admission versus Caseload Numbers: August 2014 - July 2015

	Snohomish Admissions	Snohomish Caseload	Admit % of Caseload
Adult OP	350	740	47%
Adult IOP	1,250	1,715	73%
Total Adult	1,575	2,385	66%
Youth OP	170	250	68%
Youth IOP	165	230	72%
Total Youth	330	460	72%
Total Outpatient	1,900	2,840	67%

CCS Funded Outpatient Admissions Retention Analysis - Sept. 2014 - April 2015
Percent with Three Consequtive Months of Activities

	Adult Island	Adult San Juan	Adult Skagit	Adult Snohomish	Adult Whatcom	Adult Totals
September 2014	71.2%	75.6%	54.7%	79.5%	67.5%	
October	72.3%	82.8%	55.6%	81.0%	71.4%	
November	75.0%	78.6%	58.2%	81.6%	71.9%	
December	74.3%	74.1%	59.1%	83.3%	70.9%	
January 2015	77.3%	84.6%	59.5%	83.8%	73.2%	
February	73.2%	82.6%	58.8%	82.3%	75.1%	
March	70.5%	73.1%	57.8%	80.0%	77.7%	
April	72.8%	74.1%	60.4%	77.7%	78.8%	
Average	73.3%	78.2%	58.0%	81.2%	73.3%	
12 Month Admissions	146	56	768	1,606	655	3,231
County Mix	4.5%	1.7%	23.8%	49.7%	20.3%	
Weighted Retention	3.31%	1.36%	13.79%	40.34%	14.86%	73.66%
Agencies						
ACRS				1		1
CCS			55	518	511	1,084
Compass		56			44	100
Evergreen				800		800
Harborview				1		1
Phoenix			529			529
Sea Mar	145		67	216	100	528
St Peter			2			2
Stillaguamish				7		7
Sunrise	1		115			116
THS				63		63

	Youth Island	Youth San Juan	Youth Skagit	Youth Snohomish	Youth Whatcom	Youth Totals
September 2014	72.7%	33.3%	54.3%	71.9%	71.6%	
October	54.5%	0.0%	60.0%	77.4%	71.6%	
November	42.9%		62.2%	85.0%	71.0%	
December	42.9%	0.0%	66.2%	86.3%	71.2%	
January 2015	44.4%	0.0%	65.8%	86.4%	71.8%	
February	42.9%	0.0%	68.0%	86.7%	73.7%	
March	42.9%	0.0%	71.1%	88.2%	75.0%	
April	40.0%	0.0%	69.8%	86.7%	78.4%	
Average	47.9%	4.8%	64.7%	83.6%	73.0%	
12 Month Admissions	16	4	138	379	155	692
County Mix	2.3%	0.6%	19.9%	54.8%	22.4%	
Weighted Retention	1.11%	0.03%	12.90%	45.77%	16.36%	76.17%
Agencies						
CCS			69	221	155	445
Center for Human Services				25		25
Compass		4				4
Evergreen				2		2
NorthShore Youth & Family				1		1
Northwest ESD			23			23
Phoenix			25			25
Sea Mar	16		21	68		105
THS				62		62

Funding Source Analysis for the 12 Months Ended 7/31/2015 - Snohomish County Residence

	CCS	Sales Tx	Ag Fund	DOC	Fed Dir	St Dir	St DSHS	St NoDSHS	Tribal	Other	Private	Total
Outpatient												
Child/Adolescents	250	15	0	0	10	0	0	0	10	20	60	365
Adult	715	50	0	350	40	35	0	0	70	55	290	1605
Pregnant and Parenting Women	25	0	0	0	0	0	0	0	10	0	5	40
Total	990	65	0	350	50	35	0	0	90	75	355	2010
Intensive Outpatient												
Child/Adolescents	225	30	0	0	15	0	0	0	10	20	15	315
Adult	1670	215	0	800	70	0	0	0	335	15	80	3185
Pregnant and Parenting Women	45	5	0	0	0	0	0	0	10	0	0	60
Total	1940	250	0	800	85	0	0	0	355	35	95	3560
Totals	2930	315	0	1150	135	35	0	0	445	110	450	5570
Total Unduplicated	2840	310	0	1005	135	35	0	0	420	100	450	5295
% Duplication	3.2%	1.6%		14.4%	0.0%	0.0%			6.0%	10.0%	0.0%	5.2%
Unduplicated Ratios	54%	6%	0%	19%	3%	1%	0%	0%	8%	2%	8%	100%
Include for Calc	2,840	310			135	35						3320
Unduplicated Ratios	86%	9%			4%	1%						

DBHR SUD Funding Sheet 2013-2015 Biennium

General Fund - State (GFS, Gambling, Crim Just)	$153,526,000
General Fund - Federal (Medicaid, SAPT, Grants	$280,568,000
Local	$16,301,000
	$450,395,000

State Budget FY2016, FY2017 SUD

State GF FY2016	$64,766,000
State FG FY2017	$64,894,000
GF Federal Appropriation	$432,441,000
GF Private/Local Appropriation	$20,211,000
Crim Justice Tx Fund	$11,978,000
Problem Gambling	$1,453,000
Marijuana Account FY16	$10,736,000
Marijuana Account FY17	$24,802,000
Total	$631,281,000

FOR THE DEPARTMENT OF SOCIAL AND HEALTH SERVICES—ALCOHOL AND SUBSTANCE ABUSE PROGRAM

CD Rates

CD Target Rate

First Iteration

	CD rate	people	Total $'s Monthly	Annual $'s
non-disabled children	$ 2.67	103,275	275,744	3,308,931
disabled children	$ 9.26	7,199	66,663	799,953
non-disabled adult	$ 12.51	32,607	407,914	4,894,963
disabled adult	$ 10.98	17,157	188,384	2,260,606
newly eligible	$ 14.36	71,277	1,023,538	12,282,453
	$ 8.48	231,515	1,962,242	23,546,906

Latest Iteration

	CD rate	people	Total $'s Monthly	Annual $'s	Change

CD Lower Bound

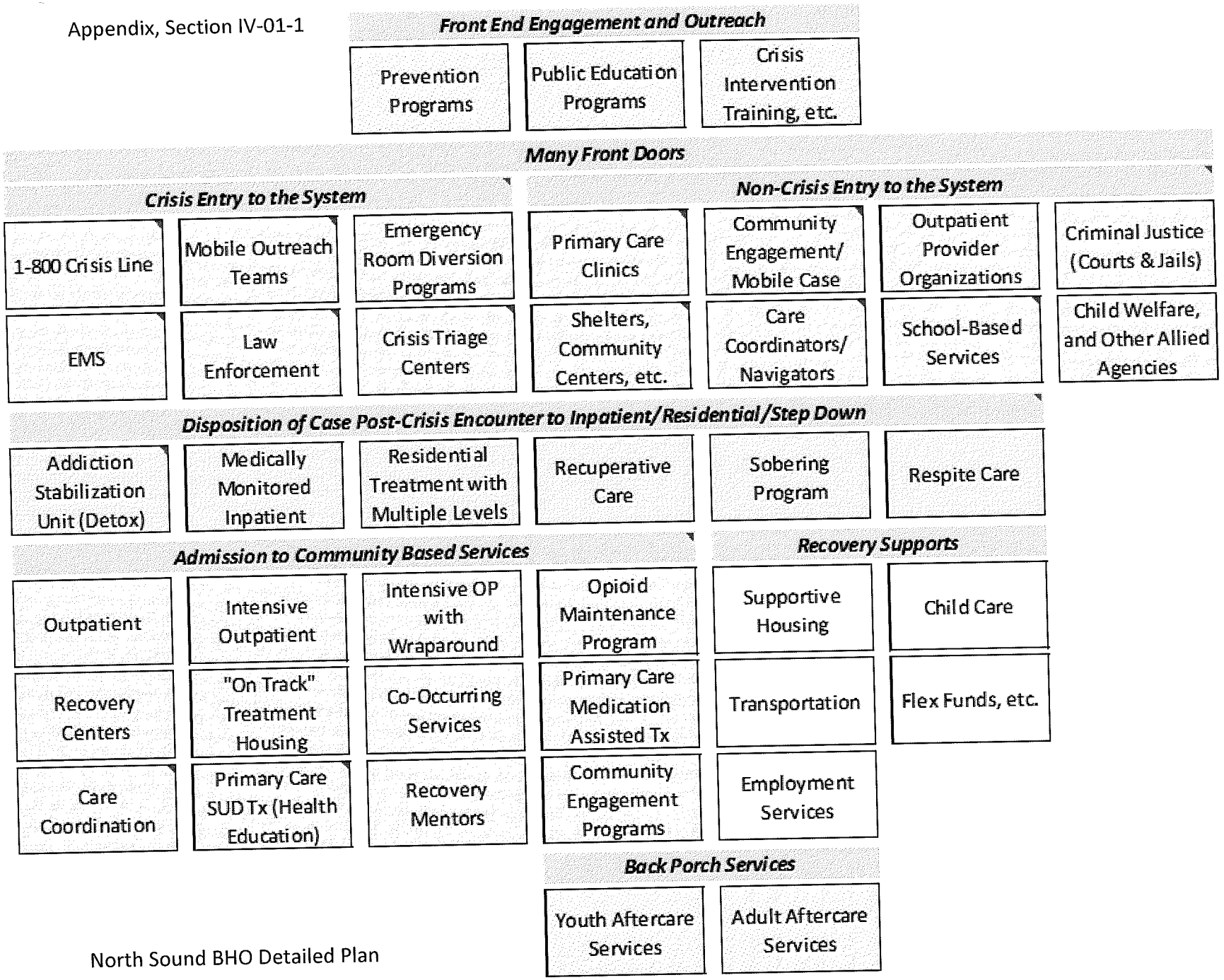
	CD rate	people	Total $'s Monthly	Annual $'s
non-disabled children	$ 2.59	103,275	267,482	3,209,787
disabled children	$ 8.99	7,199	64,719	776,628
non-disabled adult	$ 12.13	32,607	395,523	4,746,275
disabled adult	$ 10.63	17,157	182,379	2,188,547
newly eligible	$ 13.91	71,277	991,463	11,897,557
	$ 8.21	231,515	1,901,566	22,818,794

	CD rate	people	Total $'s Monthly	Annual $'s	Change
non-disabled children	$ 2.94	103,275	303,629	3,643,542	13.5%
disabled children	$ 10.68	7,199	76,885	922,624	18.8%
non-disabled adult	$ 13.04	32,607	425,195	5,102,343	7.5%
disabled adult	$ 13.82	17,157	237,110	2,845,317	30.0%
newly eligible	$ 14.65	71,277	1,044,208	12,530,497	5.3%
	$ 9.01	231,515	2,087,027	25,044,323	9.7%

CD Upper Bound

	CD rate	people	Total $'s Monthly	Annual $'s
non-disabled children	$ 2.80	103,275	289,170	3,470,040
disabled children	$ 9.66	7,199	69,542	834,508
non-disabled adult	$ 13.11	32,607	427,478	5,129,733
disabled adult	$ 11.51	17,157	197,477	2,369,725
newly eligible	$ 15.06	71,277	1,073,432	12,881,179
	$ 8.89	231,515	2,057,099	24,685,186

		people	Total $'s Monthly	Annual $'s	Change
	$ 3.18	103,275	328,415	3,940,974	13.6%
	$ 11.57	7,199	83,292	999,509	19.8%
	$ 14.11	32,607	460,085	5,521,017	7.6%
	$ 15.10	17,157	259,071	3,108,848	31.2%
	$ 15.86	71,277	1,130,453	13,565,439	5.3%
	$ 9.77	231,515	2,261,316	27,135,787	9.9%


Front End Engagement and Outreach
Prevention Programs
Public Education Programs
Crisis Intervention Training, etc.
Many Front Doors
Crisis Entry to the System
1-800 Crisis Line
Mobile Outreach Teams
Emergency Room Diversion Programs
EMS
Law Enforcement
Crisis Triage Centers
Non-Crisis Entry to the System
Primary Care Clinics
Community Engagement/ Mobile Case
Outpatient Provider Organizations
Criminal Justice (Courts & Jails)
Shelters, Community Centers, etc.
Care Coordinators/ Navigators
School-Based Services
Child Welfare, and Other Allied Agencies
Disposition of Case Post-Crisis Encounter to Inpatient/Residential/Step Down
Addiction Stabilization Unit (Detox)
Medically Monitored Inpatient
Residential Treatment with Multiple Levels
Recuperative Care
Sobering Program
Respite Care
Admission to Community Based Services
Outpatient
Intensive Outpatient
Intensive OP with Wraparound
Recovery Centers
"On Track" Treatment Housing
Co-Occurring Services
Care Coordination
Primary Care SUD Tx (Health Education)
Recovery Mentors
Opioid Maintenance Program
Primary Care Medication Assisted Tx
Community Engagement Programs
Recovery Supports
Supportive Housing
Child Care
Transportation
Flex Funds, etc.
Employment Services
Back Porch Services
Youth Aftercare Services
Adult Aftercare Services

North Sound BHO
ASAM Levels of Care

LEVEL	LEVEL OF CARE PLACEMENT	DBHR SERVICE NAME
Level 0.5	Early Intervention	Early Intervention
Level 1	Outpatient Services	Outpatient Treatment
		Brief Outpatient Treatment
		Opiate Substitution Treatment
		Case Management
Level 2.1	Intensive Outpatient Services	Intensive Outpatient Treatment
		Case Management
Level 3.1	Clinically Managed Low Intensity Residential Services	Recovery House Residential Treatment
Level 3.2WM	Clinically Managed Residential Withdrawal Management	Sub-Acute Detoxification
Level 3.3	Clinically Managed Population Specific, High Intensity Residential Services	Long Term Care Residential Treatment
Level 3.5	Clinically Managed Medium Intensity Residential Services	Intensive Inpatient Residential Treatment
Level 3.7WM	Medically Monitored Residential Withdrawal Management	Acute Detoxification

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September 1, 2015

SUD Provider

Dear ,
Your organization is receiving this correspondence because you have indicated a desire to become a contracted provider with the North Sound Mental Health Administration (NSMHA). To prepare to join our network of providers your organization will need to complete the Credentialing Packet accompanying this letter. This process of credentialing will ensure NSMHA you have the business qualifications needed to provide Substance Use Disorder (SUD) Services in our region.

The infrastructure needed to provide services under NSMHA auspices is extensive and complicated. It is the intention of NSMHA to assist qualifying agencies build their organization's infrastructure to meet the requirements of data submission, workforce development and clinical service. We will accomplish this by entering into contracts with qualifying organizations to provide the technical assistance and other support needed to prepare for Substance Use Disorder Services beginning on April 1, 2016.

We ask that you complete the accompanying packet and return to NSMHA by close of business on October 5, 2015. If you have any questions feel free to contact myself or Sharon Toquinto at 360.416.7013, Margaret_rojas@nsmha.org / sharon_toquinto@nsmha.org

Sincerely,

Margaret Rojas
Contracts Manager

North Sound Mental Health Administration

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Enter Contractor Name Here
2015 Contractor Credentialing Application
Instructions and Checklist

One complete Credentialing Application Package should be submitted for your organization. Until all information is received, the Credentialing Application Package is incomplete. If applications are incomplete or not fully responsive, the Contractor will be requested to submit additional supporting information prior to acceptance.

Please complete all documents checked below:

☐ **Credentialing Application** *(signed, in PDF format)*

☐ **Contractor Profile Table** *(in Excel format)*

☐ **Staff Roster** *(in Excel format)*

☐ **Debarment Certification Form** *(signed PDF)*

☐ **Practitioner Attestation Questions and Professional Liability Action Detail**
(do not submit, but retain on file if completed by staff)

☐ **All required attachments or explanations**
(each attachment as separate document, format may vary)

Please submit all required documents via the medium checked below:

☐ **Email to:** deliverables@nsmha.org

Please do not change the name of the documents when submitted.

Please submit hard copies/signed PDF copies of signature pages only via regular mail/email.

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2015 Credentialing Application

I. CONTRACTOR PROFILE

A. Contractor Information

- Contractor Name: _____
- Contractor Federal Tax Identification #: _____

B. Contractor Status (Please check the status that applies to your organization. If Other is checked, add additional information.)

The Contractor is a: ☐ Public Entity

☐ Non-Profit 501(c)(3) Organization

☐ Other (describe): _____

C. Governing Board/Board of Trustees/Ownership

Provide a list of Governing Board/Board of Trustees members that includes all of the following:

1. Identification of the Chair and function of other Board members (e.g., President/Chair, Vice President/Vice Chair and Treasurer);
2. Full names of Board members, as well as their city of residence, a direct phone number, and at least one of the following: an email address, a mailing address, or a fax number; and
3. If the Contractor is neither a public entity nor a non-profit 501(c)(3) organization, provide the same contact information as requested in I.C.1 and I.C.2 for all individuals who have direct or indirect ownership of 5% or more.
4. If substance use disorder (SUD) services are part of a larger organization (e.g., hospital, university, healthcare organization), identify by title and provide the same contact information as requested in I.C.1 and I.C.2 for the staff who actually manage the SUD services, including the Administrator, Director, General Manager, and Business Manager, as applicable, as well as any individuals occupying substantively similar roles.

D. Complete the attached Contractor Profile Table and submit it electronically in Excel format.

II. DISCIPLINARY INFORMATION AND DEBARMENT

If any item in section II Disciplinary Information and Debarment is NOT **initialed by the signer**, please attach an explanation.

A. _____ I confirm that within the past five years, the Contractor has not been subject to any State licensing investigations or actions.

B. _____ I confirm that within the past five years, the Contractor has not been named as a party in any malpractice suits which are pending, have gone to trial, and/or resulted in payment made to any plaintiffs.

C. _____ I confirm that within the past five years, the Contractor has not had a debarment or suspension by Medicaid or Medicare.

D. _____ I confirm that within the past five years, no staff member (including Subcontractor staff) has had a debarment or suspension by Medicaid or Medicare.

E. _____ I confirm that within the past five years, no member of the Contractor's Board of Directors has had a debarment or suspension by Medicaid or Medicare.

F. _____ I confirm that the Contractor consults a NSMHA-approved database at least annually, to confirm that none of the following entities and individuals have been debarred or suspended:

1. The Contractor,
2. Members of the Governing Board/Board of Directors

NSMHA-approved databases include:

1. Federal System for Award Management (SAM), formerly EPLS
2. Office of Inspector General (OIG)

G. Debarment Certification
Please attach the NSMHA Debarment Certification Form for your organization. Signature by the Contractor's Executive Director/Chief Executive Officer on the Debarment Certification Form indicates that the Contractor, staff, Board of Directors, and Subcontractors are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this contract.

H. Criminal History Background Checks

1. _____ I confirm that the Contractor has Policies and Procedures for conducting criminal background checks, and conducts such criminal background checks, as a routine condition of hire for new employees, consistent with WAC 388-805-200(2) and RCW 43.43.830.

2. I confirm that the Contractor either:

_____ Conducts annual criminal background checks on employees of the Contractor after the initial criminal background check, OR

_____ requires completion of the *Practitioner Attestation Questions* annually of each employee of the Contractor after the initial criminal background check.

III. TOBACCO-FREE BUILDINGS AND GROUNDS

If the item below is NOT **initialed by the signer**, please attach an explanation.

_____ I confirm that the Contractor provides and promotes tobacco-free buildings and grounds. Tobacco-free grounds are defined as tobacco-free private property or, if the agency is located in a public space, enforcement of the law requiring no smoking within 25 feet (RCW 70.160.075).

IV. LICENSING AND REGULATORY REVIEW

If any item in section IV Licensing and Regulatory Review is NOT **initialed by the signer**, please attach an explanation.

A. _____ I confirm that the Contractor solicits primary verification for all licensed or certified staff, including contracted staff.

B. _____ I confirm that the Contractor checks with the Washington Department of Health at least annually to assure that Contractor staff possess and have maintained a license or certification in good standing.

C. Please complete the Staff Roster in the attached Excel format, including all Contractor clinical staff as well as any individual subcontractors/consultants who provide direct services. Special population consultants do not need to be included.

D. Please provide the additional documentation noted below.

1. For each M.D., whether consulting or employed, provide a current copy of the DEA Certificate and Board Certificate or documentation of board eligibility. The current status of each M.D.'s state license will also be verified, although documentation need not be submitted.

2. For each Advanced Registered Nurse Practitioner (ARNP), whether consulting or employed, provide a current copy of the DEA Certificate. The current status of each ARNP's state license will also be verified, although documentation need not be submitted.

E. Please respond to the items below by initialing, or noting "N/A" if your organization does not have any individual subcontractors/consultants who provide direct services.

If the item is applicable but not initialed, please attach an explanation.

1. _____ I confirm that each individual subcontractor/consultant holds a relevant current license or certificate with the Washington Department of Health, commensurate with his or her scope of practice.

2. _____ I confirm that the Contractor performs verification of licenses for individual subcontractors/consultants according to the same frequency as it does for other direct service staff, in accordance with the guidelines in sections IV.A. and IV.B. above.

3. _____ I confirm that for each individual subcontractor/consultant who provides direct service, the Contractor provides clinical supervision and other monitoring that is equivalent to the level of supervision provided to clinical providers who are staff of the organization, in accordance with all applicable laws and guidelines for clinical supervision.

V. REQUIREMENTS FOR INFORMING CLIENTS OF CONTRACTOR'S MORAL OR RELIGIOUS OBJECTIONS/RESTRICTIONS

Contractors are required to inform clients at orientation of any moral or religious objections or restrictions regarding care provided (e.g. abortions, end of life counseling). The Contractor is additionally required to provide NSMHA with copies of pertinent language and materials used at orientation to communicate these objections.

If the item below is NOT **initialed by the signer**, please attach relevant orientation materials.

_____ I confirm that the Contractor does not have any moral or religious objections or restrictions regarding care. Documentation about objections is not applicable to this organization.

VI. NOTICE OF FUTURE REQUIREMENT

At the time of the NSMHA implementation on April 1, 2016, all organizations of the provider network will be required to hold dual certification and/or licensing for both SUD and MH, or be actively working toward obtaining it.

Has your organization begun the process? Yes No

Please briefly describe the steps that have been taken or the plan to obtain MH licensing:

_____

VII. CERTIFICATE OF INSURANCE AND ENDORSEMENT

All Contractors that contract with NSMHA must submit an annual certificate of insurance and an endorsement on a separate page. The endorsement language must list as additional parties covered "NSMHA, its officers, officials, employees, and agents."

Insurance levels must meet the levels specified in the Standard Contract (Boilerplate). Insurance agencies utilized by providers must have a minimum Bests' rating of no less than A. Insurance certificates and endorsements may carry over from one contract period to another. If the certificate of insurance indicates that the policies expire during the contract period, the Contractor shall provide an up to date certificate of insurance and endorsement for the contract at the time of the expiration of the policies.

Public Entities (municipal corporations, school districts, universities, hospital districts, educational services districts, or other public entities) may self-insure.

Initial the statement that describes the status of the Contractor's insurance documentation.

_____ A current certificate of insurance, with an endorsement naming "NSMHA, its officers, officials, employees, and agents" on a separate page, is attached.

_____ I confirm that the Contractor is a public entity and self-insures, and a current self-insurance letter is attached.

Please complete and return the Certification and Signature on the following page.

VIII. CREDENTIALING APPLICATION CERTIFICATION AND SIGNATURE

Note: The signature of an authorized representative, such as the Chief Executive Officer or equivalent, is required to complete this Credentialing Application Form. Stamped signatures are not acceptable.

Signature: _____

(Authorized Representative)

Print name: _____

Title: _____

Contractor: _____

Date: _____

Submission Instructions: Submit the signed signature page electronically as part of a PDF version of this document.

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DEBARMENT CERTIFICATION

Contractor is prohibited from paying with funds received under this Contract for goods and services furnished, ordered, or prescribed by excluded individuals and entities (Social Security Act (SSA) section 1903(i)(2) of the Act; 42 CFR 455.104, 455.106, and 1001.1901(b)). Contractor shall:

a. Monitor for excluded individuals and entities as outlined in the Credentialing Application and by:
b. Screening Contractor and subcontractor's employees and individuals and entities with an ownership or control interest for excluded individuals and entities prior to entering into a contractual or other relationship where the individual or entity would benefit directly or indirectly from funds received under this Contract.
c. Screening monthly newly added Contractor and subcontractor's employees and individuals and entities with an ownership or control interest for excluded individuals and entities that would benefit directly or indirectly from funds received under this Contract.
d. Screening monthly Contractor and subcontractor's employees and individuals and entities with an ownership or control interest that would benefit from funds received under this Contract for newly added excluded individuals and entities.

Report to NSMHA:

a. Any excluded individuals and entities discovered in the screening within 10 business days.
b. Any payments made by Contractor that directly or indirectly benefit excluded individuals and entities and the recovery of such payments.
c. Any actions taken by Contractor to terminate relationships with Contractor and subcontractor's employees and individuals with an ownership or control interest discovered in the screening.
d. Any Contractor and subcontractor's employees and individuals with an ownership or control interest convicted of any criminal or civil offense described in SSA section 1128 within 10 business days of Contractor becoming aware of the conviction.
e. Any subcontractor terminated for cause within 10 business days of the effective date of termination to include full details of the reason for termination.
f. Any Contractor and subcontractor's individuals and entities with an ownership or control interest.

Contractor must provide a list with details of ownership and control interest with credential submission in comport with Attachment I herein incorporated by reference. Contractor shall keep the list up-to-date thereafter.

Contractor will not make any payments for goods or services that directly or indirectly benefit any excluded individual or entity. Contractor will immediately recover any payments for goods and services that benefit excluded individuals and entities that it discovers.

Contractor will immediately terminate any employment, contractual and control relationships with an excluded individual and entity that it discovers.

Civil monetary penalties may be imposed against Contractor if it employs or enters into a contract with an excluded individual or entity to provide goods or services to enrollees (SSA section 1128A(a)(6) and 42 CFR 1003.102(a)(2)).

An individual or entity is considered to have an ownership or control interest if they have direct or indirect ownership of five (5) percent or more, or are a managing employee (i.e., a general manager, business manager, administrator, or director) who exercises operational or managerial control or who directly or indirectly conducts day-to-day operations (SSA section 1126(b), 42 CFR 455.104(a), and 1001.1001(a)(1)).

In addition, if NSMHA and /or DSHS notifies Contractor that an individual or entity is excluded from participation by DSHS in RSN's, Contractor shall terminate all beneficial, employment, contractual and control relationships with the excluded individual or entity immediately (WAC 388-502-0030 and 388-877-0500).

The list of excluded individuals will be found at: http://exclusions.oig.hhs.gov/

SSA section 1128 will be found at: http://www.ssa.gov/OP_Home/ssact/title11/1128.htm

Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion – Lower Tier Covered Transactions

(1) The prospective participant certifies, by submission of this packet, that neither it nor its principals is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any Federal department or agency.
(2) Where the prospective participant is unable to certify to any of the statements in this certification, such prospective participant shall attach an explanation to this proposal.

_____

Signature **Date**

_____

Print Name and Title

ATTACHMENT I

DISCLOSURE OF OR CHANGE IN OWNERSHIP AND CONTROL INTEREST

Completion and submission of this form is a condition of participation and full and accurate disclosure of ownership and financial interest is required. A failure to submit the requested information may result in a refusal by North Sound Mental Health Administration (NSMHA) to enter into an agreement or contract with the individual and/or entity or in termination of any existing agreements.

Please answer all questions as of the current date. If additional space is needed, please use an attached sheet. Federal statutes and regulations clearly prohibit NSMHA from paying for items or services furnished, ordered, or prescribed by excluded persons. NSMHA is required to search the exclusions database not only by the name of an entity seeking to participate in the program, but also by the name of any owner or managing employee.

I. Identifying Information	
OWNER TYPE (check one) ☐ Individual Ownership ☐ Organization Ownership	FEDERAL TAX ID/SSN
DOING BUSINESS AS	MINORITY WOMEN OWNED BUSINESS ENTERPRISE (MWOBE):
ORGANIZATION NAME	

II. Ownership and Control Information

List each officer and/or individual, organization, corporation, or entity that has direct or indirect ownership or controlling interest, separately or in combination, amounting to an ownership interest of 5% or more of the provider entity. Attach additional pages as necessary. If there are no individuals or entities with 5% or more ownership/control interest, complete for managing employee.

FIRST NAME	LAST NAME	SSN/TIN	DOB
ADDRESS			
FIRST NAME	LAST NAME	SSN/TIN	DOB
ADDRESS			
FIRST NAME	LAST NAME	SSN/TIN	DOB
ADDRESS			
FIRST NAME	LAST NAME	SSN/TIN	DOB
ADDRESS			

List those persons named that are related to each other (spouse, parent, child, or sibling)

NAME	RELATIONSHIP	DOB

ATTACHMENT I

Does any owner of the disclosing entity also have an ownership or controlling interest of 5% or more in any other entity?		
NAME AND TITLE	SSN/TIN	DOB
ADDRESS		PERCENTAGE
NAME AND TITLE	SSN/TIN	DOB
ADDRESS		PERCENTAGE

III. Subcontractor Information

NAME AND TITLE	SSN/TIN	DOB
ADDRESS		PERCENTAGE
NAME AND TITLE	SSN/TIN	DOB
ADDRESS		PERCENTAGE

IV. Criminal Offenses

List each officer and/or individual who has ownership or control interest in the disclosing entity, or is an agent or managing employee of the disclosing entity and has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or Title XVIII, XIX, or XX, since the inception of those programs. Attach additional pages as necessary.

NAME AND TITLE	SSN/TIN	DOB
ADDRESS		PERCENTAGE
NAME AND TITLE	SSN/TIN	DOB
ADDRESS		PERCENTAGE

V. Suspension or Debarment

Have you, any of your employees, or any individual who has an ownership or controlling interest in the disclosing entity ever been placed on the federal Office of the Inspector General (OIG), Health and Human Services (HHS) exclusions list or otherwise been suspended or debarred from participation in Medicare, Medicaid, or Title XVIII, XIX, or XX services programs. If yes, list each person below. Attach additional pages as necessary. The current lists of excluded individuals can be found at: http://exclusions.oig.hhs.gov/search.aspx and https://www.sam.gov/.

NAME AND TITLE	SSN/TIN	DOB
ADDRESS		PERCENTAGE
NAME AND TITLE	SSN/TIN	DOB
ADDRESS		PERCENTAGE

ATTACHMENT I

VI. Status Changes	
Is a change of ownership anticipated within the next year?	☐ Yes ☐ No
If yes, list date of change in operations: _____	
Is this facility operated by a management company or leased in whole or part by another organization?	☐ Yes ☐ No
Has there been a past bankruptcy or do you anticipate filing for bankruptcy within the next year?	☐ Yes ☐ No
If yes, when? _____	
Whoever knowingly and willfully makes or causes to be made a false statement or representation of this statement, may be prosecuted under applicable federal or state laws. In addition, knowingly and willfully failing to fully and accurately disclose the information requested may result in denial of a request to participate or where the entity already participates, a termination of its agreement or contract with Plan/Network. By signature, I certify that the information provided within, is true and correct and I fully understand the consequences as explained above.	
NAME, SIGNATURE AND TITLE OF INDIVIDUAL COMPLETING THIS FORM	DATE

SUBMISSION INFORMATION

Please submit completed forms by mail, email, or by fax to the below:

North Sound Mental Health Administration (NSMHA)
ATTN: Contracts Manager
117 N. 1st Street, Suite 8
Mount Vernon, WA 98273
Fax: 360-416-7017
Email: margaret_rojas@nsmha.org

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(For information only, this form does not need to be completed and submitted)

WASHINGTON PRACTITIONER ATTESTATION QUESTIONS – *To be completed by the practitioner*

Please answer all of the following questions. If your answer to any of the following questions is 'Yes', provide details as specified on a separate sheet. *If you attach additional sheets, sign and date each sheet.*

A.	**PROFESSIONAL SANCTIONS**			
1.	Have you ever been, or are you now in the process of being denied, revoked, terminated, suspended, restricted, reduced, limited, sanctioned, placed on probation, monitored, or not renewed for any of the following? Or have you voluntarily or involuntarily relinquished, withdrawn, or failed to proceed with an application for any of the following in order to avoid an adverse action or to preclude an investigation or while under investigation relating to professional competence or conduct?			
	a.	License to practice any profession in any jurisdiction	YES ☐	NO ☐
	b.	Other professional registration or certification in any jurisdiction	YES ☐	NO ☐
	c.	Specialty or subspecialty board certification	YES ☐	NO ☐
	d.	Membership on any hospital medical staff	YES ☐	NO ☐
	e.	Clinical privileges at any facility, including hospitals, ambulatory surgical centers, skilled nursing facilities, etc.	YES ☐	NO ☐
	f.	Medicare, Medicaid, FDA, NIH (Office of Human Research Protection), governmental, national or international regulatory agency or any public program	YES ☐	NO ☐
	g.	Professional society membership or fellowship	YES ☐	NO ☐
	h.	Participation/membership in an HMO, PPO, IPS, PHO or other entity	YES ☐	NO ☐
	i.	Academic Appointment	YES ☐	NO ☐
	j.	Authority to prescribe controlled substances (DEA or other authority)	YES ☐	NO ☐
2.	Have you ever been subject to review, challenges, and/or disciplinary action, formal or informal, by an ethics committee, licensing board, medical disciplinary board, professional association or education/training institution?		YES ☐	NO ☐
3.	Have you been found by a state professional disciplinary board to have committed unprofessional conduct as defined in applicable state provisions?		YES ☐	NO ☐
4.	Have you ever been the subject of any reports to a state, federal, national data bank, or state licensing or disciplinary entity?		YES ☐	NO ☐
B.	**CRIMINAL HISTORY**			
1.	Have you ever been charged with a criminal violation (felony or misdemeanor) resulting in either a plea bargain, conviction on the original or lesser charge, or payment of a fine, suspended sentence, community service or other obligation?		YES ☐	NO ☐
	a.	Do you have notice of any such anticipated charges?	YES ☐	NO ☐
	b.	Are you currently under governmental investigation?	YES ☐	NO ☐

C.	**LITIGATION AND MALPRACTICE COVERAGE HISTORY (If you answer "Yes" to any of the questions in this section,** please document in the PROFESSIONAL LIABILITY ACTION DETAIL form.)		
1.	Have allegations or claims of professional negligence been made against you at any time, whether or not you were individually named in the claim or lawsuit?	YES ☐	NO ☐
2.	Have you or your insurance carrier(s) ever paid any money on your behalf to settle/resolve a professional malpractice claim (not necessarily a lawsuit) and/or to satisfy a judgment (court-ordered damage award) in a professional lawsuit?	YES ☐	NO ☐
3.	Are there any such claims being asserted against you now?	YES ☐	NO ☐
4.	Have you ever been denied professional liability coverage or has your coverage ever been terminated, not renewed, restricted, or modified (e.g. reduced limits, restricted coverage, surcharged)?	YES ☐	NO ☐
5.	Are any of the privileges that you are requesting <u>not</u> covered by your current malpractice coverage?	YES ☐	NO ☐

I warrant that all the statements made on this form and on any attached information sheets are complete, accurate, and current. I understand that any material misstatements in, or omissions from, this statement constitute cause for denial of membership or cause for summary dismissal from the entity to which this statement has been submitted.

Applicant's Signature: _____ Date: _____

Type or Print name here: _____

Contractor Profile Table

Agency Name:

	Name	Address	Email	Telephone Number
Executive Director/CEO :				
Chief Financial Officer:				
Chief Operations Officer:				
HIPAA Privacy Officer:				
Compliance Officer:				
Disaster Response Lead:				

Primary and Branch Sites

Primary Site

Street Address (enter below)	Zip Code	Main Phone #	Main Fax #	TDY	Hours of Operation	Website	Total Capacity At This Site (estimated number of clients that could be served)	Population(s) Served At This Site (C=Children/ Youth, A=Adult, OA=Older Adult)	Service Type(s) At This Site (SUD= Substance Use Disorders, MH=Mental Health, P=Prevention)	Level(s) of Care At This Site (OP=Outpatient, IOP=Intensive Oupatient, OST=Opiate Substitution Treatment, MAT=Medication Assisted Treatment, D=Detoxification, R=Residential, S=Specialty Programs/Other)

On-Site Management (Please include names & titles)

Main Contact: Phone #:
Back-Up: Phone #:
Back-Up: Phone #:

Secondary Site(s) (if applicable)

#1 - Street Address (enter below)	Zip Code	Main Phone #	Main Fax #	TDY	Hours of Operation	Website	Total Capacity At This Site (estimated number of clients that could be served)	Population(s) Served At This Site (C=Children/ Youth, A=Adult, OA=Older Adult)	Service Type(s) At This Site (SUD= Substance Use Disorders, MH=Mental Health, P=Prevention)	Level(s) of Care At This Site (OP=Outpatient, IOP=Intensive Oupatient, OST=Opiate Substitution Treatment, MAT=Medication Assisted Treatment, D=Detoxification, R=Residential, S=Specialty Programs/Other)

On-Site Management (Please include names & titles)

Main Contact: Phone #:

Back-Up: Phone #:

Back-Up: Phone #:

Secondary Site(s) (if applicable)										
#2 - Street Address (enter below)	Zip Code	Main Phone #	Main Fax #	TDY	Hours of Operation	Website	Total Capacity At This Site (estimated number of clients that could be served)	Population(s) Served At This Site (C=Children/ Youth, A=Adult, OA=Older Adult)	Service Type(s) At This Site (SUD= Substance Use Disorders, MH=Mental Health, P=Prevention)	Level(s) of Care At This Site (OP=Outpatient, IOP=Intensive Oupatient, OST=Opiate Substitution Treatment, MAT=Medication Assisted Treatment, D=Detoxification, R=Residential, S=Specialty Programs/Other)

On-Site Management (Please include names & titles)

Main Contact: Phone #:

Back-Up: Phone #:

Back-Up: Phone #:

Secondary Site(s) (if applicable)										
#3 - Street Address (enter below)	Zip Code	Main Phone #	Main Fax #	TDY	Hours of Operation	Website	Total Capacity At This Site (estimated number of clients that could be served)	Population(s) Served At This Site (C=Children/ Youth, A=Adult, OA=Older Adult)	Service Type(s) At This Site (SUD= Substance Use Disorders, MH=Mental Health, P=Prevention)	Level(s) of Care At This Site (OP=Outpatient, IOP=Intensive Oupatient, OST=Opiate Substitution Treatment, MAT=Medication Assisted Treatment, D=Detoxification, R=Residential, S=Specialty Programs/Other)

On-Site Management (Please include names & titles)

Main Contact: Phone #:

Back-Up: Phone #:

Back-Up: Phone #:

Secondary Site(s) (if applicable)

#4 - Street Address (enter below)	Zip Code	Main Phone #	Main Fax #	TDY	Hours of Operation	Website	Total Capacity At This Site (estimated number of clients that could be served)	Population(s) Served At This Site (C=Children/ Youth, A=Adult, OA=Older Adult)	Service Type(s) At This Site (SUD= Substance Use Disorders, MH=Mental Health, P=Prevention)	Level(s) of Care At This Site (OP=Outpatient, IOP=Intensive Oupatient, OST=Opiate Substitution Treatment, MAT=Medication Assisted Treatment, D=Detoxification, R=Residential, S=Specialty Programs/Other)

On-Site Management (Please include names & titles)

Main Contact: Phone #:

Back-Up: Phone #:

Back-Up: Phone #:

Secondary Site(s) (if applicable)

#5 - Street Address (enter below)	Zip Code	Main Phone #	Main Fax #	TDY	Hours of Operation	Website	Total Capacity At This Site (estimated number of clients that could be served)	Population(s) Served At This Site (C=Children/ Youth, A=Adult, OA=Older Adult)	Service Type(s) At This Site (SUD= Substance Use Disorders, MH=Mental Health, P=Prevention)	Level(s) of Care At This Site (OP=Outpatient, IOP=Intensive Oupatient, OST=Opiate Substitution Treatment, MAT=Medication Assisted Treatment, D=Detoxification, R=Residential, S=Specialty Programs/Other)

License/Certification

Enclose a current copy of the Contractor's DBHR Certification for each site, and DOH License, if applicable. These documents must clearly show the levels of care that the Contractor is approved to provide.

Agency Name:

Please list the Division of Behavioral Health and Recovery (DBHR) Certification # for each site:

Main Facility: _____

DBHR Certification #: _____ Expiration Date: _____

Certified for: _____ NPI # _____

Branch: _____

DBHR Certification #: _____ Expiration Date: _____

Certified for: _____ NPI # _____

Branch: _____

DBHR Certification #: _____ Expiration Date: _____

Certified for: _____ NPI # _____

Department of Health (DOH) License (if applicable):

License # _____

Expiration Date: _____

Drug Enforcement Administration (DEA)/Federal Drug Administration (FDA) (if applicable)

Methadone License #: _____

Expiration Date: _____

Closure Dates

Agency:

Common Contractor Holiday Closure Dates		
Holiday	2015 Observed	Closed yes/no
New Year's Day	January 1	
MLK Jr Birthday	January 19	
President's Day	February 16	
Emanicipation Day	April 16	
Memorial Day	May 25	
Independence Day	July 4	
Labor Day	September 7	
Columbus Day / Native American Day	October 12	
Veterans Day	November 11	
Thanksgiving Day	November 26	
Day After Thanksgiving	November 27	
Christmas Eve	December 24	
Christmas Day	December 25	
New Year's Eve	December 31	

Other Contractor Closure Dates (if any)	
Event	2015 Date

School Closure Dates (if applicable)	
Event	2015 Date
First Day of School	
Last Day of School	
Closure Dates:	

2015 Staff Roster

This document is intended to serve as a complete, current roster of Contractor clinical staff as well as any individual subcontractors/consultants who provide direct services. Please include any consulting prescribers (psychiatrists or advanced registered nurse practitioners (ARNPs)), and any other subcontracted individual practitioners (therapists, case managers) who provide direct services. Please note that certain additional information is needed only for individuals who have prescription authority.

** CDP = Chemical Dependency Professional. CDPT = Chemical Dependency Professional Trainee. MHP = Mental Health Professional. CPP = Certified Prevention Professional.*
*** Note that either the DEA (Drug Enforcement Administration) or NPI (National Provider Identifier) number is required. It is not necessary to provide both.*

REQUIRED FOR ALL DIRECT SERVICE PROVIDERS										REQUIRED ONLY FOR INDIVIDUALS WITH PRESCRIPTION AUTHORITY			
Staff Name		Status (*Staff, Subcontractor, Consultant*)	Title/Function	Assigned Site/Branch	Washington State Professional License Number	Washington State License Expiration Date	Degree	Specialization(s) (*CDP, CDPT, MHP, Board Certifications, CPP*) *	Language(s) Spoken by the Person	Contact Information Shown on Prescriptions Written by this Person		Drug Enforcement Administration (DEA) Number **	National Provider Identifier (NPI) Number **
Last	First									Address	Phone Number *111-222-3333 format*		

PROJECTED PROVIDER NETWORK FOR SUD SERVICES

OUTPATIENT SERVICES

Compass Health - San Juan County
Catholic Community Services - Skagit County; Snohomish County; Whatcom County
Center for Human Services - Snohomish County
Evergreen Recovery Services - Snohomish County
Sea Mar - Island County; Skagit County; Snohomish County; Whatcom County
Sunrise Recovery Services – Skagit County
Therapeutic Health Services – Snohomish County
Phoenix Recovery – Skagit County

OPIATE SUBSTITUTION TREATMENT

Therapeutic Health Services – Snohomish County

WITHDRAWAL MANAGEMENT SERVICES

Pioneer Human Services – Skagit County; Whatcom County
Evergreen Manor – Snohomish County

INVOLUNTARY COMMITMENT SERVICES

Island County
Compass Health – San Juan County
Evergreen Manor – Snohomish County
Pioneer Human Services – Skagit County; Whatcom County
Phoenix Recovery Services – Skagit County

RESIDENTIAL SERVICES

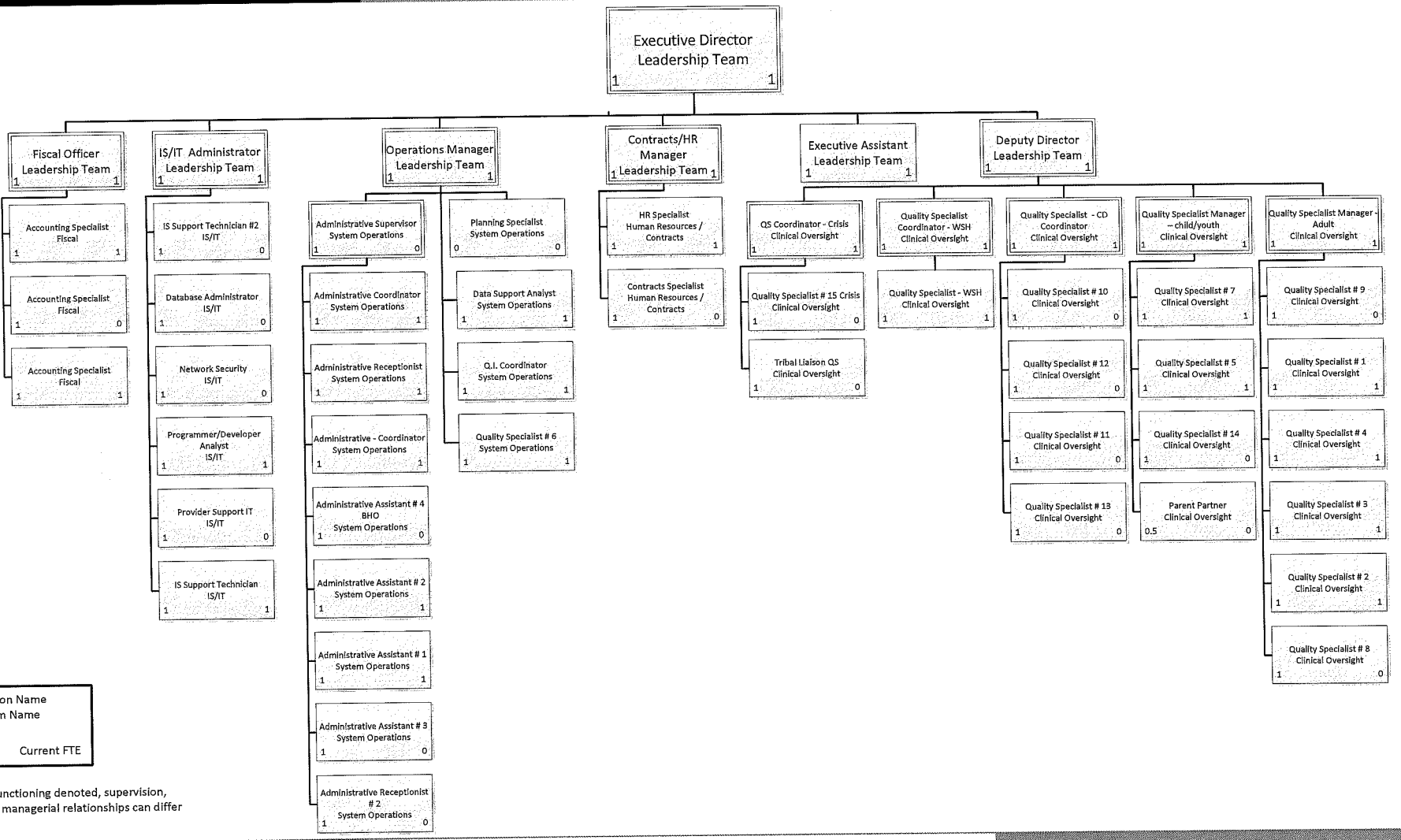
Evergreen Manor – Snohomish County
Pioneer Center North – Skagit County
Skagit Recovery Center – Skagit County
Sea Mar Visions – Whatcom County

Appendix, Section IV-04-1
North Sound Mental Health Administration
Mental Health Provider Network

Provider	Service Provision	County
Bridgeways	Adult-Employment Services	Snohomish
Compass Health (dually certified)	Adult & Child-Outpatient, Intensive Outpatient, WISe, Crisis Services PACT, HARPS, Care Transition Team, Residential	Island, San Juan, Skagit, Snohomish, Whatcom
Catholic Community Services NW (dually certified)	Child/Youth services only: Outpatient, WISe	Skagit, Whatcom
Lake Whatcom Center (dually certified)	Adult-Outpatient, Intensive Outpatient, PACT, Residential	Whatcom
Pioneer Human Services (dually certified)	Crisis Triage	Skagit
Sea Mar (dually certified)	Adult & Child-Outpatient, Intensive Outpatient	Skagit, Snohomish, Whatcom
Snohomish County	ITA, Jail Services	Snohomish
Sunrise Services (dually certified)	Adult-Outpatient, Intensive Outpatient, IDDT, Supported Employment	Island, Skagit, Snohomish, Whatcom
Unity Care NW	Adult Outpatient	Whatcom

September 28, 2015

North Sound BHO Organization Chart



Position Name
Team Name

Budget FTE Current FTE

Operational functioning denoted, supervision, reporting and managerial relationships can differ

Appendix, Section V-02

TEAM	ACTION	POSITION	FTE	PROPOSED CY HIRE	RECRUITMENT MONTH	TEAM LT_ADVISOR PRIORITY FOR HIRE BY CY	TEAM LT_ADMISOR PROPOSED DATE TO HIRE BY	SUMMARY OF BUSINESS NEED	SALARY RANGE
CO TEAM	New Hire	Quality Specialist - Children's	1	2015	Jul-15	1	September 1, 2015	Includes Wraparound with Intensive Services (WISe) expansion (mandate), specialized programs (Intensive Outpatient (IOP) x2, Transition Age Youth (TAY) (contract), Evidence Based Practices (EBP) (House Bill 2536)]. Could also include role as WISe trainer per expected contract amendment. Preferable to have dual Chemical Dependency/Mental Health Professional (CDP/MHP) as youth Chemical Dependency (CD) has different standards than adult. Consider pay differential for dual certification.	Range 22 ($54,599-$66,405)
CO TEAM	New Hire	Quality Specialist - Adult	1	2015	Jul-15	1	September 1, 2015	Piloting Co-Occurring projects in 2015. Need additional staff for oversight and BHO planning	Range 22 ($54,599-$66,405)
CO TEAM	New Hire	Tribal Liaison	1	2015	Jul-15	1	August 1, 2015	Tribal/RSN Crisis System (mandate) and outpatient Least Restrictive Orders (LROs) increasing from .5 FTE (frozen) to 1 FTE	Range 22 ($54,599-$66,405)
HR TEAM	New Hire	HR Specialist	1	2015	Jul-15	1	August 1, 2015	This position is needed due to the increase of 20+ staff, Relias online learning and live trainings/conferences. Due to our growth, systematic and formal processes need to be developed and implemented at NSMHA. This position will work with the HR manager to develop and implement the processes.	Range 24 ($49,326-$59,992)
HR TEAM	New Hire	Contract Specialist	1	2015	Aug-15	2	October 1, 2015	The number of contracts have increased, at any one time we have # 10-15 Professional Service Contracts for consultation/training; Currently we have approximately 76 contracts-all of which need to be written, monitored and amended at various times throughout their cycle. Monitoring of the contracts is becoming a heavier workload, this does not account for the 2016 SU contracting that will almost double our current contracts.	Range 24 ($49,326-$59,992)
IS/IT TEAM	New Hire	IT Tech Support	1	2015	Jul-15	2	October 1, 2015	Increased number of staff and business processes to support. This support need is currently insufficient for the IT needs of the organization and will grow as the organization does.	Range 25 ($46,690-$56,786)
IS/IT TEAM	New Hire	Network/Data Security Analyst	1	2015	Sep-15 (HOLD)	1	Nov-15 (HOLD)	Having someone who can devote the time necessary to conduct audits, monitor the security of the network, perform risk analysis, and other steps necessary to ensure the sensitive data we have continues to be protected.	Range 18 ($68,104-$82,831)
SO TEAM	New Hire	Administrative Support/Receptionist	1	2015	Jul-15	2	September 1, 2015	Increased volume and frequency of work assigned to the current Receptionist in all facets of position responsibilities to the point of doubling as a result of Medicaid expansion. In particular, call volume, which requires informed customer service, not merely call routing.	Range 30 ($35,133-$42,729)
SO TEAM	New Hire	Administrative Support /Assistant	1	2015	Oct-15	3	December 1, 2015	Increased volume and frequency of work assigned to the current Administrative Assistants in all facets of position responsibilities and increase in as a result of Medicaid expansion as well as increasing support for prepatory work related to the transition to the Behavioral Health Organization (BHO)	Range 29 ($37,444-$45,541)
TOTAL 2015			9						
FISCAL TEAM	New Hire	Fiscal Accountant	1	2016	Jan-16	2	1-16-16 to 5-16-16	The BHO will have new extensive inter RSN/BHO billing for all services not provided in the region. Additional CD contract payments, tracking and auditing.	Range 24 ($49,326-59,992)
SO TEAM	New Hire	Administrative Support/Supervisor	1	2016	Jan-16	1	March 1, 2016	This position is needed due to the increase of 20+ staff, including a significant increase in the need for administrative support for those Staff, requiring a working Supervisor. As a direct result of the organizations growth, systematic and formal processes need to be developed, documented and implemented at NSMHA. This position will work with the Operations Manager to develop and implement the efficient and effective work flow processes to support both Medicaid and BHO expansion, and be the direct support for the 2 Managers and 1 Coordinator in the Clinical Oversight Team.	Range 24 ($49,326-$59,992)
CO TEAM	New Hire	Quality Specialist	4	2016	Mar-16	1		Absorb new responsibilities due to BHO transition. Authorizations, denials, utilization review, quality oversight, care coordination, critical incidents etc.	Range 22 ($54,599-$66,405)
CO TEAM	New Hire	Quality Specialist - Crisis	1	2016	Mar-16	1	Hire earlier than 3- 20167	Expect increased volume in utilization and oversight due to BHO implementation	Range 22 ($54,599-$66,405)

Appendix, Section V-02

TEAM	ACTION	POSITION	FTE	PROPOSED CY HIRE	RECRUITMENT MONTH	TEAM LT_ADVISOR PRIORITY FOR HIRE BY CY	TEAM LT_ADMISOR PROPOSED DATE TO HIRE BY	SUMMARY OF BUSINESS NEED	SALARY RANGE
SO TEAM	New Hire	Administrative Support for BHO	1	2016	Mar-16	2	April 1, 2016	This position is needed due to the increase of 20+ staff, including a significant increase in the need for administrative support for those Staff and the significant expansion of program support required as a result of the transition to a BHO.	Range 29 ($37,444-$45,541)
TOTAL 2016			8						
SO TEAM	Reclass	Reclassification-Admin Asst to Admin Coord-J Williams		2015	Jul-15	1	August 1, 2015	This position requires reclassification as a direct result in the increase in scope and independence exercised in providing support for the Systems of Care Institute conference/Children's Policy Executive Team and Advisory Board. This position will assume complete responsibility for the Advisory Board, taking the NSMHA administrative lead responsibilities currently held by Human Resource Manager, whose duties have also expanded. In the move to the BHO, the Advisory Board composition will require change to include CD and the complexity of coordination is expected to expand accordingly.	Range 26 ($44,379-$53,975)
TOTAL PROJECTED NEW HIRE 2015 & 2016			17.00						

North Sound BHO Planning: Substance Use Disorder Cost & Utilization Flight Simulator

3 Year Summary: Baseline + Sustainable Rates + More Clients

Part I. Enrollment	History	Year 1	Year 2	Year 3	3 Year Total
Medicaid Enrollees					
Children (0-11)	**83,326**	**83,326**	**84,409**	**85,507**	253,242
Adolescents (12-17)	**33,155**	**33,155**	**33,586**	**34,023**	100,764
Adults (18+)	**132,713**	**132,713**	**134,438**	**136,186**	403,337
Total	249,194	249,194	252,434	255,715	757,343
Part II. Service Demand Estimates					
Substance Use Disorder Need Estimate (based on DSHS RDA 2014 Analysis)					
Children (0-11)	**0.3%**	**0.3%**	**0.3%**	**0.3%**	**0.3%**
Adolescents (12-17)	**7.4%**	**7.4%**	**7.4%**	**7.4%**	**7.4%**
Adults (18+)	**23.8%**	**23.8%**	**23.8%**	**23.8%**	**23.8%**
Total	13.8%	13.8%	13.8%	13.8%	13.8%
Estimated Medicaid Need					
Children (0-11)	250	250	253	257	760
Adolescents (12-17)	2,453	2,453	2,485	2,518	7,457
Adults (18+)	31,586	31,586	31,996	32,412	95,994
Total	34,289	34,289	34,735	35,186	104,210
Estimated Medicaid Clients					
Child Access Rate		**28%**	**30%**	**32%**	
Adolescent Access Rate		**53%**	**57%**	**61%**	
Adult Access Rate		**31%**	**33%**	**35%**	
Child Clients	**64**	70	76	83	229
Adolescent Clients	**1,176**	1,293	1,410	1,527	4,229
Adults Clients	**8,820**	9,697	10,574	11,450	31,721
Total Medicaid Clients	10,060	11,060	12,060	13,060	36,179
Penetration Rate	4.0%	4.4%	4.8%	5.1%	4.8%
Percent of Need Met	29%	32%	35%	37%	35%
Change from Previous Year		**1,000**	**1,000**	**1,000**	
Change % (Actuaries assume 7% increase in Yr 1)		9.9%	9.0%	8.3%	
Estimated Non-Medicaid Cases in Ongoing Care		221	241	261	724
Total Clients, Medicaid + Non-Medicaid		11,281	12,301	13,321	36,903
Total Episodes (duplicated)		16,429	17,853	19,324	53,606
Part IV. Revenue and Expense Projections					
Medicaid Revenue		$27,297,144	$28,481,567	$29,717,382	$85,496,094
Non-Medicaid Revenue		$9,207,363	$9,391,510	$9,579,340	$28,178,214
Total Revenue		**$36,504,507**	**$37,873,077**	**$39,296,723**	**$113,674,307**
Crisis Services		$6,620,449	$7,041,570	$7,478,914	$21,140,932
Brief Intervention & Treatment		$11,893	$13,244	$14,644	$39,781
Assessments		$2,533,429	$2,826,252	$3,129,648	$8,489,329
Outpatient Services		$3,416,646	$3,811,554	$4,221,625	$11,449,824
Intensive Outpatient		$12,051,801	$13,443,591	$14,886,104	$40,381,495
Opiate Substitution Tx, All Ages		$6,605,375	$7,370,583	$8,159,957	$22,135,915
Medical Services in Addiction Treatment Agencies		$45,269	$50,412	$55,740	$151,421
Recovery Supports		$127,225	$141,931	$157,167	$426,323
Co-Occurring Disorder TX (MH+IOP)		$1,209,536	$1,237,448	$1,390,566	$3,837,550
Homeless Case Management (Cs Mgt & or Outreach)		$291,442	$298,168	$304,894	$894,504
Transportation		$288,839	$337,884	$383,461	$1,010,184
Residential Services		$10,998,046	$10,998,046	$10,998,046	$32,994,138
Administrative and Support Services		$2,431,154	$2,504,089	$2,579,211	$7,514,454
Total Service Cost		**$46,631,102**	**$50,074,771**	**$53,759,976**	**$150,465,850**
Operating Excess (Deficit)		-$10,126,595	-$12,201,694	-$14,463,254	-$36,791,543
Drawdown of Medicaid Reserves		$8,607,606	$10,371,440	$12,293,766	$31,272,811
Reduction in Medicaid Mental Health Expenses		$1,518,989	$1,830,254	$2,169,488	$5,518,731
Medicaid Excess (Deficit)		$0	$0	$0	$0
Non-Medicaid Excess (Deficit)		$0	$0	$0	$0

North Sound BHO Planning: Substance Use Disorder Cost & Utilization Flight Simulator

Year 1: Baseline + Sustainable Rates + More Clients

Part I. Enrollment and Revenue

	History	Year 1	Year 2	Year 3	Comments
Medicaid Enrollees					
Children (0-11)	**83,326**	**83,326**	**84,409**	**85,507**	**Based on August 2015 plus 1.3% incr/year**
Adolescents (12-17)	**33,155**	**33,155**	**33,586**	**34,023**	"
Adults (18+)	**132,713**	**132,713**	**134,438**	**136,186**	"
Total	249,194	249,194	252,434	255,715	
BHO Revenue					
Average Medicaid Per Member Per Month		**$9.13**	**$9.40**	**$9.68**	**Based on Rates from 8/2015 plus 3% incr/yr**
Medicaid Revenue		$27,297,144	$28,481,567	$29,717,382	
State General Fund		**$1,758,086**	$1,793,248	$1,829,113	**Based on 2016 budget plus 2% incr/year**
SAPT Funding		**$575,866**	$587,383	$599,131	"
Residential General Fund		**$3,041,598**	$3,102,430	$3,164,479	"
Residential SAPT		**$3,745,544**	$3,820,455	$3,896,864	"
State Drug Court		**$86,269**	$87,994	$89,754	"
Criminal Justice Transfer Account			$0	$0	
Total Revenue		$36,504,507	$37,873,077	$39,296,723	

Part II. Service Demand Estimates

	History	Year 1	Year 2	Year 3	
Substance Use Disorder Need Estimate (based on DSHS RDA 2014 Analysis)					
Children (0-11)	**0.3%**	**0.3%**	**0.3%**	**0.3%**	**Per DSHS RDA 2014 Analysis**
Adolescents (12-17)	**7.4%**	**7.4%**	**7.4%**	**7.4%**	"
Adults (18+)	**23.8%**	**23.8%**	**23.8%**	**23.8%**	"
Total	13.8%	13.8%	13.8%	13.8%	
Estimated Medicaid Need					
Children (0-11)	250	250	253	257	
Adolescents (12-17)	2,453	2,453	2,485	2,518	
Adults (18+)	31,586	31,586	31,996	32,412	
Total	34,289	34,289	34,735	35,186	
Combined Youth	2.3%	2.3%	2.3%	2.3%	
Estimated Medicaid Access Rate					
Change in Access Rate		9.94%	7.64%	6.90%	
Child Access Rate	25%	28%	30%	32%	**1,000 Case total growth per year**
Adolescent Access Rate	48%	53%	57%	61%	"
Adult Access Rate	28%	31%	33%	35%	"
Child Clients	**64**	70	76	83	**1,000 Case total growth per year**
Adolescent Clients	**1,176**	1,293	1,410	1,527	"
Adults Clients	**8,820**	9,697	10,574	11,450	"
Total Clients	10,060	11,060	12,060	13,060	
Penetration Rate	4.0%	4.4%	4.8%	5.1%	
Percent of Need Met	29%	32%	35%	37%	
Change from Previous Year		1,000	1,000	1,000	
Change % (Note: DSHS and the Actuaries assume that 7% increase in Year 1)		9.9%	9.0%	8.3%	
Estimated Non-Medicaid Cases in Ongoing Care					
Non-Medicaid as a % of Medicaid		**2.0%**	**2.0%**	**2.0%**	**Estimate**
Non-Medicaid Cases		221	241	261	
Total Clients, Medicaid + Non-Medicaid		11,281	12,301	13,321	

North Sound BHO Planning: Substance Use Disorder Cost & Utilization Flight Simulator — Year 1: Baseline + Sustainable Rates + More Clients

Part III. Clients Served Estimates

	Historical Cases	Current Capacity	Year 1 Case Mix	Cases Year 1	% Un-Duplicated	Comments
						Year 1 = 4/2016-3/2017
Total Child/Adolescent Clients	1,240			1,390		
Total Adult Clients	8,820			9,891		
Total Clients	10,060			11,281		
Crisis Services, All Ages						
Mobile Outreach Teams	N/A	382	10.0%	1,128	50.0%	
Crisis Triage Centers	N/A	840	6.5%	733	50.0%	
Detox	1,950	1,059	12.0%	1,354	50.0%	
Subacute Detox	incl above	1,250	9.5%	1,072	50.0%	
Total Crisis Services			38.0%	4,287		
Brief Intervention & Treatment, All Ages						
All Brief Treatment Settings	N/A	125	1.0%	113	50.0%	
(Mobile Outreach, Emergency Departments, Primary Care Clinics, Crisis Triage Centers, School-Based Services, Jails, Homeless Shelters, etc.)						
Clients Receiving Ongoing Care - Core Services						
Assessments	15,590	N/A	150.0%	16,921	0.0%	
Outpatient						
Child/Adolescents	635	403	50.0%	695	75.4%	
Adult	2,760	2,963	31.0%	3,066	75.4%	
Pregnant and Parenting Women	40	326	1.0%	99	75.4%	
Total				3,860		
Intensive Outpatient						
Child/Adolescents	410	559	34.0%	473	75.4%	
Adult	3,780	4,772	42.0%	4,154	75.4%	
Pregnant and Parenting Women	80	551	1.0%	99	75.4%	
Total				4,726		
Opiate Substitution Tx, All Ages	1,790	2,227	17.5%	1,974	90.0%	
Medical Services in Addiction Treatment Agencies	N/A	255	2.0%	226	90.0%	
(Medical treatment, COD psych meds, non-opoid addiction meds, opiod addiction meds, pain management)						
Recovery Supports, All Ages	0	729	5.0%	564	33.0%	
All Recovery Support Services						
(Recovery Coaches, Recovery Café, Peer Navigators, Recovery Centers)						
Specialized Services, All Ages						
Co-Occurring Disorder TX (MH+IOP)	N/A	596	5.0%	485	100.0%	
Homeless Case Management (Cs Mgt & or Outreach)	N/A		2.0%	194	100.0%	
				16,429		
Total Episodes (duplicated)				11,516		
Total Clients (unduplicated estimate)				11,281		
Estimated Clients (per above)						

North Sound BHO Planning: Substance Use Disorder Cost & Utilization Flight Simulator — Year 1: Baseline + Sustainable Rates + More Clients

Part IV. Service and Cost Projections — Year 1

Rate Increase	Average Svc. Units	Number of Cases	Completion Rate	Partial Completion Units Used	Total Service Units	Average Cost per Unit	Average Cost per Case	Projected Cost	% BHO Medicaid	Units
						30%				Avg: All Svcs
Crisis Services, All Ages										
Mobile Outreach Teams								$240,000	69%	Fixed Budget
Crisis Phone and Triage								$375,228	69%	Fixed Budget
ITA-CD								$805,000	41%	Fixed Budget
Crisis Triage Centers								$2,588,636	69%	Fixed Budget
Detox	5	1,354	90%	4	6,635	$327.60	$1,605	$2,173,626	91%	Days
Subacute Detox	3	1,072	90%	2	3,109	$140.87	$409	$437,959	91%	Days
Total Crisis Services		2,426			9,744			$6,620,449		
Brief Intervention & Treatment, All Ages										
All Brief Treatment Settings	3	113	50%	1	226	$52.62	$105	$11,893	75%	Clinician Hours
Clients Receiving Ongoing Care - Core Services										
Assessments	1	16,921	100%	1	16,921	$149.72	$150	$2,533,429	98%	Each
Outpatient										
Child/Adolescents	30	695	66%	15	17,306	$41.08	$1,023	$710,930	98%	Mix: Ind & Group
Adult	30	3,066	66%	15	76,343	$34.33	$855	$2,621,084	98%	Mix: Ind & Group
Pregnant and Parenting Women	30	99	66%	15	2,465	$34.33	$855	$84,631	98%	Mix: Ind & Group
Total		3,860			96,114			$3,416,646		
Intensive Outpatient										
Child/Adolescents	80	473	66%	40	31,407	$44.16	$2,932	$1,386,965	98%	Mix: Ind & Group
Adult	80	4,154	66%	40	275,826	$37.77	$2,508	$10,416,569	98%	Mix: Ind & Group
Pregnant and Parenting Women	80	99	66%	40	6,574	$37.77	$2,508	$248,267	98%	Mix: Ind & Group
Total		4,726			313,807			$12,051,801		
Opiate Substitution Tx, All Ages	230	1,974	75%	115	397,268	$16.63	$3,346	$6,605,375	98%	Days
Medical Services in Addiction Treatment Agencies	3	226	50%	1	452	$100.15	$200	$45,269	75%	Visits
Recovery Supports, All Ages										
All Recovery Support Services	12	564	50%	6	5,076	$25.06	$226	$127,225	75%	Client Hours
Specialized Services, All Ages										
Co-Occurring Disorder TX (MH+IOP)	30	485	66%	15	12,077	$100.15	$2,494	$1,209,536	98%	Client Hours
Homeless Case Management (Cs Mgt & or Outreach)	20	194	50%	10	2,910	$100.15	$1,502	$291,442	75%	Client Hours
Transportation								$288,839	60%	Fixed Budget
Total Service Cost (before Residential)								$33,201,902		
Residential Cost Estimate								$10,998,046	40%	per below
County Administrative Costs								$682,430	100%	Fixed Budget
North Sound RSN Operations								$1,748,724	91%	Fixed Budget
Total Service Cost								$46,631,102		
Excess (Deficit)								($10,126,595)		
Medicaid Revenue								$27,297,144		Per above
Medicaid Portion of the Service Cost								$37,423,739		Per above
Medicaid Excess (Deficit)								($10,126,595)		
Non-Medicaid Revenue								9,207,363		Per above
Non-Medicaid Portion of the Service Cost								$9,207,363		Per above
Non-Medicaid Excess (Deficit)								$0		

North Sound BHO Planning: Substance Use Disorder Cost & Utilization Flight Simulator — Year 1: Baseline + Sustainable Rates + More Clients

	Total Bud	Beds	Occup Rate	Bed Days	Avg Cost	% NSMHA	NSMHA Days	% Medicaid	Mcaid Days	$ Medicaid
Residential Estimates										
Pioneer	**$6,683,476**	**143**	**87%**	45,410	$147.18	**30%**	13,626	**0%**	-	$0
Skagit	**$977,052**	**23**	**85%**	7,136	$136.92	**7%**	514	**0%**	-	$0
Evergreen	**$1,222,324**	**23**	**83%**	6,968	$175.42	**95%**	6,650	**91%**	6,053	$1,061,838
Seamar	**$1,951,477**	**28**	**100%**	10,220	$190.95	**50%**	5,151	**79%**	4,069	$777,018
Subtotal	$10,834,330	217		69,733	$155.37		25,941		10,122	$1,838,857
Beds in Other Places	**$32,676,228**	**1357**	**55%**	272,418	**$155.37**	**16%**	43,587	**38%**	16,503	$2,564,034
Medicaid Total	$43,510,558	1574		342,151			69,528		26,625	$4,402,891

	% Non-Mcaid	NonM Days	$ Non-Mcaid
Pioneer	100%	13,626	$2,005,500
Skagit	100%	514	$70,379
Evergreen	9%	597	$104,728
Seamar	21%	1,082	$206,549
Subtotal		15,819	$2,387,155
Beds in Other Places	62%	27,084	$4,208,000
Non-Medicaid Total		42,903	$6,595,155
Grand Total		69,528	$10,998,046
Medicaid % of Total			40%

North Sound BHO Planning: Substance Use Disorder Cost & Utilization Flight Simulator		Year 2: Baseline + Sustainable Rates + More Clients			
Part I. Enrollment and Revenue					
Medicaid Enrollees	**History**	**Year 1**	**Year 2**	**Year 3**	**Comments**
Children (0-11)					
Adolescents (12-17)	**83,326**	**83,326**	**84,409**	**85,507**	**Based on August 2015 plus 1.3% incr/year**
Adults (18+)	**33,155**	**33,155**	**33,586**	**34,023**	"
Total	**132,713**	**132,713**	**134,438**	**136,186**	"
	249,194	249,194	252,434	255,715	
BHO Revenue					
Average Medicaid Per Member Per Month		**$9.13**	**$9.40**	**$9.68**	**Based on Rates from 8/2015 plus 3% incr/yr**
Medicaid Revenue		$27,297,144	$28,481,567	$29,717,382	
State General Fund		**$1,758,086**	$1,793,248	$1,829,113	**Based on 2016 budget plus 2% incr/year**
SAPT Funding		**$575,866**	$587,383	$599,131	"
Residential General Fund		**$3,041,598**	$3,102,430	$3,164,479	"
Residential SAPT		**$3,745,544**	$3,820,455	$3,896,864	"
State Drug Court		**$86,269**	$87,994	$89,754	"
Criminal Justice Transfer Account			$0	$0	
Total Revenue		$36,504,507	$37,873,077	$39,296,723	
Part II. Service Demand Estimates					
Substance Use Disorder Need Estimate (based on DSHS RDA 2014 Analysis)	**History**	**Year 1**	**Year 2**	**Year 3**	
Children (0-11)					
Adolescents (12-17)	**0.3%**	**0.3%**	**0.3%**	**0.3%**	**Per DSHS RDA 2014 Analysis**
Adults (18+)	**7.4%**	**7.4%**	**7.4%**	**7.4%**	"
Total	**23.8%**	**23.8%**	**23.8%**	**23.8%**	"
	13.8%	13.8%	13.8%	13.8%	
Estimated Medicaid Need					
Children (0-11)					
Adolescents (12-17)	250	250	253	257	
Adults (18+)	2,453	2,453	2,485	2,518	
Total	31,586	31,586	31,996	32,412	
Combined Youth	34,289	34,289	34,735	35,186	
Estimated Medicaid Access Rate	2.3%	2.3%	2.3%	2.3%	
Change in Access Rate					
Child Access Rate		9.94%	7.64%	6.90%	
Adolescent Access Rate	25%	28%	30%	32%	**1,000 Case total growth per year**
Adult Access Rate	48%	53%	57%	61%	"
Child Clients	28%	31%	33%	35%	"
Adolescent Clients	**64**	70	76	83	**1,000 Case total growth per year**
Adults Clients	**1,176**	1,293	1,410	1,527	"
Total Clients	**8,820**	9,697	10,574	11,450	"
Penetration Rate	10,060	11,060	12,060	13,060	
Percent of Need Met	4.0%	4.4%	4.8%	5.1%	
Change from Previous Year	29%	32%	35%	37%	
Change % (Note: DSHS and the Actuaries assume that 7% increase in Year 1)		1,000	1,000	1,000	
Estimated Non-Medicaid Cases in Ongoing Care		9.9%	9.0%	8.3%	
Non-Medicaid as a % of Medicaid					
Non-Medicaid Cases		**2.0%**	**2.0%**	**2.0%**	**Estimate**
Total Clients, Medicaid + Non-Medicaid		221	241	261	
		11,281	12,301	13,321	

North Sound BHO Planning: Substance Use Disorder Cost & Utilization Flight Simulator — Year 2: Baseline + Sustainable Rates + More Clients

Part III. Clients Served Estimates

	Historical Cases	Current Capacity	Year 2 Case Mix	Cases Year 2	% Un-Duplicated	Comments
	1,240			1,516		Year 1 = 4/2016-3/2017
Total Child/Adolescent Clients	8,820			10,785		
Total Adult Clients	10,060			12,301		
Total Clients						
Crisis Services, All Ages						
Mobile Outreach Teams	N/A	382	10.0%	1,230	50.0%	
Crisis Triage Centers	N/A	840	6.5%	800	50.0%	
Detox	1,950	1,059	12.0%	1,476	50.0%	
Subacute Detox	incl above	1,250	9.5%	1,169	50.0%	
Total Crisis Services			38.0%	4,675		
Brief Intervention & Treatment, All Ages						
All Brief Treatment Settings	N/A	125	1.0%	123	50.0%	
(Mobile Outreach, Emergency Departments, Primary Care Clinics, Crisis Triage Centers, School-Based Services, Jails, Homeless Shelters, etc.)						
Clients Receiving Ongoing Care - Core Services						
Assessments	15,590	N/A	150.0%	18,451	0.0%	
Outpatient						
Child/Adolescents	635	403	50.0%	758	75.4%	
Adult	2,760	2,963	31.0%	3,343	75.4%	
Pregnant and Parenting Women	40	326	1.0%	108	75.4%	
Total				4,209		
Intensive Outpatient						
Child/Adolescents	410	559	34.0%	515	75.4%	
Adult	3,780	4,772	42.0%	4,530	75.4%	
Pregnant and Parenting Women	80	551	1.0%	108	75.4%	
Total				5,153		
Opiate Substitution Tx, All Ages	1,790	2,227	17.5%	2,153	90.0%	
Medical Services in Addiction Treatment Agencies	N/A	255	2.0%	246	90.0%	
(Medical treatment, COD psych meds, non-opoid addiction meds, opiod addiction meds, pain management)						
Recovery Supports, All Ages						
All Recovery Support Services	0	729	5.0%	615	33.0%	
(Recovery Coaches, Recovery Café, Peer Navigators, Recovery Centers)						
Specialized Services, All Ages						
Co-Occurring Disorder TX (MH+IOP)	N/A	596	5.0%	485	100.0%	
Homeless Case Management (Cs Mgt & or Outreach)	N/A		2.0%	194	100.0%	
				17,853		
Total Episodes (duplicated)				**12,496**		
Total Clients (unduplicated estimate)				**12,301**		
Estimated Clients (per above)						

North Sound BHO Planning: Substance Use Disorder Cost & Utilization Flight Simulator — Year 2: Baseline + Sustainable Rates + More Clients

Part IV. Service and Cost Projections — Year 2

Rate Increase	Average Svc. Units	Number of Cases	Completion Rate	Partial Completion Units Used	Total Service Units	Average Cost per Unit	Average Cost per Case	Projected Cost	% BHO Medicaid	Units
Crisis Services, All Ages						33%				Avg: All Svcs
Mobile Outreach Teams								$247,200	69%	Fixed Budget
Crisis Phone and Triage								$386,485	69%	Fixed Budget
ITA-CD								$829,150	41%	Fixed Budget
Crisis Triage Centers								$2,666,295	69%	Fixed Budget
Detox	5	1,476	90%	4	7,232	$335.16	$1,642	$2,423,877	91%	Days
Subacute Detox	3	1,169	90%	2	3,390	$144.12	$418	$488,563	91%	Days
Total Crisis Services		2,645			10,622			$7,041,570		
Brief Intervention & Treatment, All Ages										
All Brief Treatment Settings	3	123	50%	1	246	$53.84	$108	$13,244	75%	Clinician Hours
Clients Receiving Ongoing Care - Core Services										
Assessments	1	18,451	100%	1	18,451	$153.18	$153	$2,826,252	98%	Each
Outpatient										
Child/Adolescents	30	758	66%	15	18,874	$42.03	$1,046	$793,236	98%	Mix: Ind & Group
Adult	30	3,343	66%	15	83,241	$35.13	$875	$2,923,865	98%	Mix: Ind & Group
Pregnant and Parenting Women	30	108	66%	15	2,689	$35.13	$875	$94,452	98%	Mix: Ind & Group
Total		4,209			104,804			$3,811,554		
Intensive Outpatient										
Child/Adolescents	80	515	66%	40	34,196	$45.18	$3,000	$1,544,979	98%	Mix: Ind & Group
Adult	80	4,530	66%	40	300,792	$38.64	$2,565	$11,621,550	98%	Mix: Ind & Group
Pregnant and Parenting Women	80	108	66%	40	7,171	$38.64	$2,565	$277,062	98%	Mix: Ind & Group
Total		5,153			342,159			$13,443,591		
Opiate Substitution Tx, All Ages	230	2,153	75%	115	433,291	$17.01	$3,423	$7,370,583	98%	Days
Medical Services in Addiction Treatment Agencies	3	246	50%	1	492	$102.46	$205	$50,412	75%	Visits
Recovery Supports, All Ages										
All Recovery Support Services	12	615	50%	6	5,535	$25.64	$231	$141,931	75%	Client Hours
Specialized Services, All Ages										
Co-Occurring Disorder TX (MH+IOP)	30	485	66%	15	12,077	$102.46	$2,551	$1,237,448	98%	Client Hours
Homeless Case Management (Cs Mgt & or Outreach)	20	194	50%	10	2,910	$102.46	$1,537	$298,168	75%	Client Hours
Transportation								$337,884	53%	Fixed Budget
Total Service Cost (before Residential)								$36,572,637		
Residential Cost Estimate								$10,998,046	40%	per below
County Administrative Costs								$702,903	100%	Fixed Budget
North Sound RSN Operations								$1,801,186	91%	Fixed Budget
Total Service Cost								$50,074,771		
Excess (Deficit)								($12,201,694)		
Medicaid Revenue								$28,481,567		Per above
Medicaid Portion of the Service Cost								$40,683,261		Per above
Medicaid Excess (Deficit)								($12,201,694)		
Non-Medicaid Revenue								9,391,510		Per above
Non-Medicaid Portion of the Service Cost								$9,391,510		Per above
Non-Medicaid Excess (Deficit)								$0		

North Sound BHO Planning: Substance Use Disorder Cost & Utilization Flight Simulator — Year 2: Baseline + Sustainable Rates + More Clients

Residential Estimates	Total Bud	Beds	Occup Rate	Bed Days	Avg Cost	% NSMHA	NSMHA Days	% Medicaid	Mcaid Days	$ Medicaid
Rate Increase	3%									
Pioneer	**$6,683,476**	**143**	**87%**	45,410	$147.18	**30%**	13,626	**0%**	-	$0
Skagit	**$977,052**	**23**	**85%**	7,136	$136.92	**7%**	514	**0%**	-	$0
Evergreen	**$1,222,324**	**23**	**83%**	6,968	$175.42	**95%**	6,650	**91%**	6,053	$1,061,838
Seamar	**$1,951,477**	**28**	**100%**	10,220	$190.95	**50%**	5,151	**79%**	4,069	$777,018
Subtotal	$10,834,330	217		69,733	$155.37		25,941		10,122	$1,838,857
Beds in Other Places	**$32,676,228**	**1357**	**55%**	272,418	**$155.37**	**16%**	43,587	**38%**	16,503	$2,564,034
Medicaid Total	$43,510,558	1574		342,151			69,528		26,625	$4,402,891

	% Non-Mcaid	NonM Days	$ Non-Mcaid
Pioneer	100%	13,626	$2,005,500
Skagit	100%	514	$70,379
Evergreen	9%	597	$104,728
Seamar	21%	1,082	$206,549
Subtotal		15,819	$2,387,155
Beds in Other Places	62%	27,084	$4,208,000
Non-Medicaid Total		42,903	$6,595,155
Grand Total		69,528	$10,998,046
Medicaid % of Total			40%

North Sound BHO Planning: Substance Use Disorder Cost & Utilization Flight Simulator

Year 3: Baseline + Sustainable Rates + More Clients

Part I. Enrollment and Revenue

	History	Year 1	Year 2	Year 3	Comments
Medicaid Enrollees					
Children (0-11)	**83,326**	**83,326**	**84,409**	**85,507**	**Based on August 2015 plus 1.3% incr/year**
Adolescents (12-17)	**33,155**	**33,155**	**33,586**	**34,023**	"
Adults (18+)	**132,713**	**132,713**	**134,438**	**136,186**	"
Total	249,194	249,194	252,434	255,715	
BHO Revenue					
Average Medicaid Per Member Per Month		**$9.13**	**$9.40**	**$9.68**	**Based on Rates from 8/2015 plus 3% incr/yr**
Medicaid Revenue		$27,297,144	$28,481,567	$29,717,382	
State General Fund		**$1,758,086**	$1,793,248	$1,829,113	**Based on 2016 budget plus 2% incr/year**
SAPT Funding		**$575,866**	$587,383	$599,131	"
Residential General Fund		**$3,041,598**	$3,102,430	$3,164,479	"
Residential SAPT		**$3,745,544**	$3,820,455	$3,896,864	"
State Drug Court		**$86,269**	$87,994	$89,754	"
Criminal Justice Transfer Account			$0	$0	
Total Revenue		$36,504,507	$37,873,077	$39,296,723	

Part II. Service Demand Estimates

	History	Year 1	Year 2	Year 3	
Substance Use Disorder Need Estimate (based on DSHS RDA 2014 Analysis)					
Children (0-11)	**0.3%**	**0.3%**	**0.3%**	**0.3%**	**Per DSHS RDA 2014 Analysis**
Adolescents (12-17)	**7.4%**	**7.4%**	**7.4%**	**7.4%**	"
Adults (18+)	**23.8%**	**23.8%**	**23.8%**	**23.8%**	"
Total	13.8%	13.8%	13.8%	13.8%	
Estimated Medicaid Need					
Children (0-11)	250	250	253	257	
Adolescents (12-17)	2,453	2,453	2,485	2,518	
Adults (18+)	31,586	31,586	31,996	32,412	
Total	34,289	34,289	34,735	35,186	
Combined Youth	2.3%	2.3%	2.3%	2.3%	
Estimated Medicaid Access Rate					
Change in Access Rate		9.94%	7.64%	6.90%	
Child Access Rate	25%	28%	30%	32%	**1,000 Case total growth per year**
Adolescent Access Rate	48%	53%	57%	61%	"
Adult Access Rate	28%	31%	33%	35%	"
Child Clients	**64**	70	76	83	**1,000 Case total growth per year**
Adolescent Clients	**1,176**	1,293	1,410	1,527	"
Adults Clients	**8,820**	9,697	10,574	11,450	"
Total Clients	10,060	11,060	12,060	13,060	
Penetration Rate	4.0%	4.4%	4.8%	5.1%	
Percent of Need Met	29%	32%	35%	37%	
Change from Previous Year		1,000	1,000	1,000	
Change % (Note: DSHS and the Actuaries assume that 7% increase in Year 1)		9.9%	9.0%	8.3%	
Estimated Non-Medicaid Cases in Ongoing Care					
Non-Medicaid as a % of Medicaid		**2.0%**	**2.0%**	**2.0%**	**Estimate**
Non-Medicaid Cases		221	241	261	
Total Clients, Medicaid + Non-Medicaid		11,281	12,301	13,321	

North Sound BHO Planning: Substance Use Disorder Cost & Utilization Flight Simulator — Year 3: Baseline + Sustainable Rates + More Clients

Part III. Clients Served Estimates

	Historical Cases	Current Capacity	Year 3 Case Mix	Cases Year 3	% Un-Duplicated	Comments
						Year 1 = 4/2016-3/2017
Total Child/Adolescent Clients	1,240			1,642		
Total Adult Clients	8,820			11,679		
Total Clients	10,060			13,321		
Crisis Services, All Ages						
Mobile Outreach Teams	N/A	382	10.0%	1,332	50.0%	
Crisis Triage Centers	N/A	840	6.5%	866	50.0%	
Detox	1,950	1,059	12.0%	1,599	50.0%	
Subacute Detox	incl above	1,250	9.5%	1,265	50.0%	
Total Crisis Services			38.0%	5,062		
Brief Intervention & Treatment, All Ages						
All Brief Treatment Settings	N/A	125	1.0%	133	50.0%	
(Mobile Outreach, Emergency Departments, Primary Care Clinics, Crisis Triage Centers, School-Based Services, Jails, Homeless Shelters, etc.)						
Clients Receiving Ongoing Care - Core Services						
Assessments	15,590	N/A	150.0%	19,981	0.0%	
Outpatient						
Child/Adolescents	635	403	50.0%	821	75.4%	
Adult	2,760	2,963	31.0%	3,621	75.4%	
Pregnant and Parenting Women	40	326	1.0%	117	75.4%	
Total				4,559		
Intensive Outpatient						
Child/Adolescents	410	559	34.0%	558	75.4%	
Adult	3,780	4,772	42.0%	4,905	75.4%	
Pregnant and Parenting Women	80	551	1.0%	117	75.4%	
Total				5,580		
Opiate Substitution Tx, All Ages	1,790	2,227	17.5%	2,331	90.0%	
Medical Services in Addiction Treatment Agencies	N/A	255	2.0%	266	90.0%	
(Medical treatment, COD psych meds, non-opoid addiction meds, opiod addiction meds, pain management)						
Recovery Supports, All Ages						
All Recovery Support Services	0	729	5.0%	666	33.0%	
(Recovery Coaches, Recovery Café, Peer Navigators, Recovery Centers)						
Specialized Services, All Ages						
Co-Occurring Disorder TX (MH+IOP)	N/A	596	5.5%	533	100.0%	
Homeless Case Management (Cs Mgt & or Outreach)	N/A		2.0%	194	100.0%	
				19,324		
Total Episodes (duplicated)				13,523		
Total Clients (unduplicated estimate)				13,321		
Estimated Clients (per above)						

North Sound BHO Planning: Substance Use Disorder Cost & Utilization Flight Simulator — Year 3: Baseline + Sustainable Rates + More Clients

Part IV. Service and Cost Projections — Year 3

Rate Increase	Average Svc. Units	Number of Cases	Completion Rate	Partial Completion Units Used	Total Service Units	Average Cost per Unit	Average Cost per Case	Projected Cost	% BHO Medicaid	Units
						36%				Avg: All Svcs
Crisis Services, All Ages										
Mobile Outreach Teams								$254,616	69%	Fixed Budget
Crisis Phone and Triage								$398,079	69%	Fixed Budget
ITA-CD								$854,025	41%	Fixed Budget
Crisis Triage Centers								$2,746,284	69%	Fixed Budget
Detox	5	1,599	90%	4	7,835	$342.72	$1,679	$2,685,211	91%	Days
Subacute Detox	3	1,265	90%	2	3,669	$147.37	$427	$540,699	91%	Days
Total Crisis Services		2,864			11,504			$7,478,914		
Brief Intervention & Treatment, All Ages										
All Brief Treatment Settings	3	133	50%	1	266	$55.05	$110	$14,644	75%	Clinician Hours
Clients Receiving Ongoing Care - Core Services										
Assessments	1	19,981	100%	1	19,981	$156.63	$157	$3,129,648	98%	Each
Outpatient										
Child/Adolescents	30	821	66%	15	20,443	$42.98	$1,070	$878,558	98%	Mix: Ind & Group
Adult	30	3,621	66%	15	90,163	$35.92	$894	$3,238,439	98%	Mix: Ind & Group
Pregnant and Parenting Women	30	117	66%	15	2,913	$35.92	$894	$104,628	98%	Mix: Ind & Group
Total		4,559			113,519			$4,221,625		
Intensive Outpatient										
Child/Adolescents	80	558	66%	40	37,051	$46.20	$3,068	$1,711,727	98%	Mix: Ind & Group
Adult	80	4,905	66%	40	325,692	$39.51	$2,623	$12,867,440	98%	Mix: Ind & Group
Pregnant and Parenting Women	80	117	66%	40	7,769	$39.51	$2,623	$306,938	98%	Mix: Ind & Group
Total		5,580			370,512			$14,886,104		
Opiate Substitution Tx, All Ages	230	2,331	75%	115	469,114	$17.39	$3,501	$8,159,957	98%	Days
Medical Services in Addiction Treatment Agencies	3	266	50%	1	532	$104.77	$210	$55,740	75%	Visits
Recovery Supports, All Ages										
All Recovery Support Services	12	666	50%	6	5,994	$26.22	$236	$157,167	75%	Client Hours
Specialized Services, All Ages										
Co-Occurring Disorder TX (MH+IOP)	30	533	66%	15	13,272	$104.77	$2,609	$1,390,566	98%	Client Hours
Homeless Case Management (Cs Mgt & or Outreach)	20	194	50%	10	2,910	$104.77	$1,572	$304,894	75%	Client Hours
Transportation								$383,461	48%	Fixed Budget
Total Service Cost (before Residential)								$40,182,719		
Residential Cost Estimate								$10,998,046	40%	per below
County Administrative Costs								$723,990	100%	Fixed Budget
North Sound RSN Operations								$1,855,221	91%	Fixed Budget
Total Service Cost								$53,759,976		
Excess (Deficit)								($14,463,254)		
Medicaid Revenue								$29,717,382		Per above
Medicaid Portion of the Service Cost								$44,180,636		Per above
Medicaid Excess (Deficit)								($14,463,254)		
Non-Medicaid Revenue								9,579,340		Per above
Non-Medicaid Portion of the Service Cost								$9,579,340		Per above
Non-Medicaid Excess (Deficit)								$0		

North Sound BHO Planning: Substance Use Disorder Cost & Utilization Flight Simulator — Year 3: Baseline + Sustainable Rates + More Clients

Residential Estimates	Total Bud	Beds	Occup Rate	Bed Days	Avg Cost	% NSMHA	NSMHA Days	% Medicaid	Mcaid Days	$ Medicaid
Rate Increase	6%									
Pioneer	**$6,683,476**	**143**	**87%**	45,410	$147.18	**30%**	13,626	**0%**	-	$0
Skagit	**$977,052**	**23**	**85%**	7,136	$136.92	**7%**	514	**0%**	-	$0
Evergreen	**$1,222,324**	**23**	**83%**	6,968	$175.42	**95%**	6,650	**91%**	6,053	$1,061,838
Seamar	**$1,951,477**	**28**	**100%**	10,220	$190.95	**50%**	5,151	**79%**	4,069	$777,018
Subtotal	$10,834,330	217		69,733	$155.37		25,941		10,122	$1,838,857
Beds in Other Places	**$32,676,228**	**1357**	**55%**	272,418	**$155.37**	**16%**	43,587	**38%**	16,503	$2,564,034
Medicaid Total	$43,510,558	1574		342,151			69,528		26,625	$4,402,891

	% Non-Mcaid	NonM Days	$ Non-Mcaid
Pioneer	100%	13,626	$2,005,500
Skagit	100%	514	$70,379
Evergreen	9%	597	$104,728
Seamar	21%	1,082	$206,549
Subtotal		15,819	$2,387,155
Beds in Other Places	62%	27,084	$4,208,000
Non-Medicaid Total		42,903	$6,595,155
Grand Total		69,528	$10,998,046
Medicaid % of Total			40%

North Sound BHO Planning: Substance Use Disorder Cost & Utilization Flight Simulator

Baseline

Part I. Enrollment and Revenue	History	Year 1	Year 2	Year 3	Comments
Medicaid Enrollees					
Children (0-11)	**83,326**	**83,326**	**84,409**	**85,507**	**Based on August 2015 plus 1.3% incr/year**
Adolescents (12-17)	**33,155**	**33,155**	**33,586**	**34,023**	"
Adults (18+)	**132,713**	**132,713**	**134,438**	**136,186**	"
Total	249,194	249,194	252,434	255,715	
BHO Revenue					
Average Medicaid Per Member Per Month		**$9.13**	**$9.40**	**$9.68**	**Based on Rates from 8/2015 plus 3% incr/yr**
Medicaid Revenue		$27,297,144	$28,481,567	$29,717,382	
State General Fund		**$1,758,086**	$1,793,248	$1,829,113	**Based on 2016 budget plus 2% incr/year**
SAPT Funding		**$575,866**	$587,383	$599,131	"
Residential General Fund		**$3,041,598**	$3,102,430	$3,164,479	"
Residential SAPT		**$3,745,544**	$3,820,455	$3,896,864	"
State Drug Court		**$86,269**	$87,994	$89,754	"
Criminal Justice Transfer Account			$0	$0	
Total Revenue		$36,504,507	$37,873,077	$39,296,723	

Part II. Service Demand Estimates	History	Year 1	Year 2	Year 3	
Substance Use Disorder Need Estimate (based on DSHS RDA 2014 Analysis)					
Children (0-11)	**0.3%**	**0.3%**	**0.3%**	**0.3%**	**Per DSHS RDA 2014 Analysis**
Adolescents (12-17)	**7.4%**	**7.4%**	**7.4%**	**7.4%**	"
Adults (18+)	**23.8%**	**23.8%**	**23.8%**	**23.8%**	"
Total	13.8%	13.8%	13.8%	13.8%	
Estimated Medicaid Need					
Children (0-11)	250	250	253	257	
Adolescents (12-17)	2,453	2,453	2,485	2,518	
Adults (18+)	31,586	31,586	31,996	32,412	
Total	34,289	34,289	34,735	35,186	
Combined Youth	2.3%	2.3%	2.3%	2.3%	
Estimated Medicaid Access Rate					
Child Access Rate		**26%**	**26%**	**26%**	**No growth in this Scenario**
Adolescent Access Rate		**48%**	**48%**	**48%**	"
Adult Access Rate		**28%**	**28%**	**28%**	"
Child Clients	**64**	64	65	66	**No growth in this Scenario**
Adolescent Clients	**1,176**	1,176	1,191	1,207	"
Adults Clients	**8,820**	8,820	8,935	9,051	"
Total Clients	10,060	10,060	10,191	10,323	
Penetration Rate	4.0%	4.0%	4.0%	4.0%	
Percent of Need Met	29%	29%	29%	29%	
Change from Previous Year		0	131	132	
Change % (Note: DSHS and the Actuaries assume that 7% increase in Year 1)		0%	1.3%	1.3%	
Estimated Non-Medicaid Cases in Ongoing Care					
Non-Medicaid as a % of Medicaid		**2.0%**	**2.0%**	**2.0%**	**Estimate**
Non-Medicaid Cases		201	204	206	
Total Clients, Medicaid + Non-Medicaid		10,261	10,395	10,530	

North Sound BHO Planning: Substance Use Disorder Cost & Utilization Flight Simulator Baseline

Part III. Clients Served Estimates

	Historical Cases	Current Capacity	Year 1 Case Mix	Cases Year 1	% Un-Duplicated	Comments
						Year 1 = 4/2016-3/2017
Total Child/Adolescent Clients	1,240			1,265		
Total Adult Clients	8,820			8,996		
Total Clients	10,060			10,261		
Crisis Services, All Ages						
Mobile Outreach Teams	N/A	382	10.0%	1,026	50.0%	
Crisis Triage Centers	N/A	840	6.3%	646	50.0%	
Detox	1,950	1,059	7.9%	811	50.0%	
Subacute Detox	incl above	1,250	9.4%	965	50.0%	
Total Crisis Services			33.6%	3,448		
Brief Intervention & Treatment, All Ages						
All Brief Treatment Settings	N/A	125	1.0%	103	50.0%	
(Mobile Outreach, Emergency Departments, Primary Care Clinics, Crisis Triage Centers, School-Based Services, Jails, Homeless Shelters, etc.)						
Clients Receiving Ongoing Care - Core Services						
Assessments	15,590	N/A	150.0%	15,392	0.0%	
Outpatient						
Child/Adolescents	635	403	50.0%	632	75.4%	
Adult	2,760	2,963	31.0%	2,789	75.4%	
Pregnant and Parenting Women	40	326	1.0%	90	75.4%	
Total				3,511		
Intensive Outpatient						
Child/Adolescents	410	559	34.0%	430	75.4%	
Adult	3,780	4,772	42.0%	3,778	75.4%	
Pregnant and Parenting Women	80	551	1.0%	90	75.4%	
Total				4,298		
Opiate Substitution Tx, All Ages	1,790	2,227	17.5%	1,796	90.0%	
Medical Services in Addiction Treatment Agencies	N/A	255	2.0%	205	90.0%	
(Medical treatment, COD psych meds, non-opoid addiction meds, opiod addiction meds, pain management)						
Recovery Supports, All Ages						
All Recovery Support Services	0	729	5.0%	513	33.0%	
(Recovery Coaches, Recovery Café, Peer Navigators, Recovery Centers)						
Specialized Services, All Ages						
Co-Occurring Disorder TX (MH+IOP)	N/A	596	5.0%	441	100.0%	
Homeless Case Management (Cs Mgt & or Outreach)	N/A		2.0%	176	100.0%	
				14,491		
Total Episodes (duplicated)				10,248		
Total Clients (unduplicated estimate)				10,261		
Estimated Clients (per above)						

North Sound BHO Planning: Substance Use Disorder Cost & Utilization Flight Simulator Baseline

Part IV. Service and Cost Projections Year 1

Rate Increase	Average Svc. Units	Number of Cases	Completion Rate	Partial Completion Units Used	Total Service Units	Average Cost per Unit	Average Cost per Case	Projected Cost	% BHO Medicaid	Units
						0%				Avg: All Svcs
Crisis Services, All Ages										
Mobile Outreach Teams								$240,000	69%	Fixed Budget
Crisis Phone and Triage								$375,228	69%	Fixed Budget
ITA-CD								$805,000	41%	Fixed Budget
Crisis Triage Centers								$2,588,636	69%	Fixed Budget
Detox	5	811	90%	4	3,974	$252.00	$1,235	$1,001,448	91%	Days
Subacute Detox	3	965	90%	2	2,799	$108.36	$314	$303,300	91%	Days
Total Crisis Services		1,776			6,773			$5,313,612		
Brief Intervention & Treatment, All Ages										
All Brief Treatment Settings	3	103	50%	1	206	$40.48	$81	$8,339	75%	Clinician Hours
Clients Receiving Ongoing Care - Core Services										
Assessments	1	15,392	100%	1	15,392	$115.17	$115	$1,772,697	98%	Each
Outpatient										
Child/Adolescents	30	632	66%	15	15,737	$31.60	$787	$497,289	98%	Mix: Ind & Group
Adult	30	2,789	66%	15	69,446	$26.41	$658	$1,834,069	98%	Mix: Ind & Group
Pregnant and Parenting Women	30	90	66%	15	2,241	$26.41	$658	$59,185	98%	Mix: Ind & Group
Total		3,511			87,424			$2,390,543		
Intensive Outpatient										
Child/Adolescents	80	430	66%	40	28,552	$33.97	$2,256	$969,911	98%	Mix: Ind & Group
Adult	80	3,778	66%	40	250,859	$29.05	$1,929	$7,287,454	98%	Mix: Ind & Group
Pregnant and Parenting Women	80	90	66%	40	5,976	$29.05	$1,929	$173,603	98%	Mix: Ind & Group
Total		4,298			285,387			$8,430,968		
Opiate Substitution Tx, All Ages	230	1,796	75%	115	361,445	$12.79	$2,574	$4,622,882	98%	Days
Medical Services in Addiction Treatment Agencies	3	205	50%	1	410	$77.04	$154	$31,586	75%	Visits
Recovery Supports, All Ages										
All Recovery Support Services	12	513	50%	6	4,617	$19.28	$174	$89,016	75%	Client Hours
Specialized Services, All Ages										
Co-Occurring Disorder TX (MH+IOP)	30	441	66%	15	10,981	$77.04	$1,918	$845,976	98%	Client Hours
Homeless Case Management (Cs Mgt & or Outreach)	20	176	50%	10	2,640	$77.04	$1,156	$203,386	75%	Client Hours
Transportation								$250,000	69%	Fixed Budget
Total Service Cost (before Residential)								$23,959,004		
Residential Cost Estimate								$10,998,046	40%	per below
County Administrative Costs								$682,430	100%	Fixed Budget
North Sound RSN Operations								$1,748,724	91%	Fixed Budget
Total Service Cost								$37,388,204		
Excess (Deficit)								($883,697)		
Medicaid Revenue								$27,297,144		Per above
Medicaid Portion of the Service Cost								$28,528,245		Per above
Medicaid Excess (Deficit)								($1,231,101)		
Non-Medicaid Revenue								9,207,363		Per above
Non-Medicaid Portion of the Service Cost								$8,859,959		Per above
Non-Medicaid Excess (Deficit)								$347,404		

North Sound BHO Planning: Substance Use Disorder Cost & Utilization Flight Simulator **Baseline**

Residential Estimates	Total Bud	Beds	Occup Rate	Bed Days	Avg Cost	% NSMHA	NSMHA Days	% Medicaid	Mcaid Days	$ Medicaid
Pioneer	**$6,683,476**	**143**	**87%**	45,410	$147.18	**30%**	13,626	**0%**	-	$0
Skagit	**$977,052**	**23**	**85%**	7,136	$136.92	**7%**	514	**0%**	-	$0
Evergreen	**$1,222,324**	**23**	**83%**	6,968	$175.42	**95%**	6,650	**91%**	6,053	$1,061,838
Seamar	**$1,951,477**	**28**	**100%**	10,220	$190.95	**50%**	5,151	**79%**	4,069	$777,018
Subtotal	$10,834,330	217		69,733	$155.37		25,941		10,122	$1,838,857
Beds in Other Places	**$32,676,228**	**1357**	**55%**	272,418	**$155.37**	**16%**	43,587	**38%**	16,503	$2,564,034
Medicaid Total	$43,510,558	1574		342,151			69,528		26,625	$4,402,891

	% Non-Mcaid	NonM Days	$ Non-Mcaid
Pioneer	100%	13,626	$2,005,500
Skagit	100%	514	$70,379
Evergreen	9%	597	$104,728
Seamar	21%	1,082	$206,549
Subtotal		15,819	$2,387,155
Beds in Other Places	62%	27,084	$4,208,000
Non-Medicaid Total		42,903	$6,595,155
Grand Total		69,528	$10,998,046
Medicaid % of Total			40%

North Sound BHO Planning: Substance Use Disorder Cost & Utilization Flight Simulator

Baseline + Sustainable Rates

Part I. Enrollment and Revenue

	History	Year 1	Year 2	Year 3	Comments
Medicaid Enrollees					
Children (0-11)					
Adolescents (12-17)	83,326	83,326	84,409	85,507	Based on August 2015 plus 1.3% incr/year
Adults (18+)	33,155	33,155	33,586	34,023	"
Total	132,713	132,713	134,438	136,186	"
	249,194	249,194	252,434	255,715	
BHO Revenue					
Average Medicaid Per Member Per Month		$9.13	$9.40	$9.68	Based on Rates from 8/2015 plus 3% incr/yr
Medicaid Revenue		$27,297,144	$28,481,567	$29,717,382	
State General Fund		$1,758,086	$1,793,248	$1,829,113	Based on 2016 budget plus 2% incr/year
SAPT Funding		$575,866	$587,383	$599,131	"
Residential General Fund		$3,041,598	$3,102,430	$3,164,479	"
Residential SAPT		$3,745,544	$3,820,455	$3,896,864	"
State Drug Court		$86,269	$87,994	$89,754	"
Criminal Justice Transfer Account			$0	$0	
Total Revenue		$36,504,507	$37,873,077	$39,296,723	

Part II. Service Demand Estimates

	History	Year 1	Year 2	Year 3	
Substance Use Disorder Need Estimate (based on DSHS RDA 2014 Analysis)					
Children (0-11)	0.3%	0.3%	0.3%	0.3%	Per DSHS RDA 2014 Analysis
Adolescents (12-17)	7.4%	7.4%	7.4%	7.4%	"
Adults (18+)	23.8%	23.8%	23.8%	23.8%	"
Total	13.8%	13.8%	13.8%	13.8%	
Estimated Medicaid Need					
Children (0-11)	250	250	253	257	
Adolescents (12-17)	2,453	2,453	2,485	2,518	
Adults (18+)	31,586	31,586	31,996	32,412	
Total	34,289	34,289	34,735	35,166	
Combined Youth	2.3%	2.3%	2.3%	2.3%	
Estimated Medicaid Access Rate					
Child Access Rate		26%	26%	26%	No growth in this Scenario
Adolescent Access Rate		48%	48%	48%	"
Adult Access Rate		28%	28%	28%	"
Child Clients	64	64	65	66	No growth in this Scenario
Adolescent Clients	1,176	1,176	1,191	1,207	"
Adults Clients	8,820	8,820	8,935	9,051	"
Total Clients	10,060	10,060	10,191	10,323	
Penetration Rate	4.0%	4.0%	4.0%	4.0%	
Percent of Need Met	29%	29%	29%	29%	
Change from Previous Year		0	131	132	
Change % (Note: DSHS and the Actuaries assume that 7% increase in Year 1)		0%	1%	1%	
Estimated Non-Medicaid Cases in Ongoing Care					
Non-Medicaid as a % of Medicaid		2.0%	2.0%	2.0%	Estimate
Non-Medicaid Cases		201	204	206	
Total Clients, Medicaid + Non-Medicaid		10,261	10,395	10,530	

North Sound BHO Planning: Substance Use Disorder Cost & Utilization Flight Simulator — Baseline + Sustainable Rates

Part III. Clients Served Estimates

	Historical Cases	Current Capacity	Year 1 Case Mix	Cases Year 1	% Un-Duplicated	Comments
Total Child/Adolescent Clients	1,240			1,265		Year 1 = 4/2016-3/2017
Total Adult Clients	8,820			8,996		
Total Clients	10,060			10,261		
Crisis Services, All Ages						
Mobile Outreach Teams	N/A	382	10.0%	1,026	50.0%	
Crisis Triage Centers	N/A	840	6.5%	667	50.0%	
Detox	1,950	1,059	7.5%	770	50.0%	
Subacute Detox	incl above	1,250	9.5%	975	50.0%	
Total Crisis Services			33.5%	3,438		
Brief Intervention & Treatment, All Ages						
All Brief Treatment Settings	N/A	125	1.0%	103	50.0%	
(Mobile Outreach, Emergency Departments, Primary Care Clinics, Crisis Triage Centers, School-Based Services, Jails, Homeless Shelters, etc.)						
Clients Receiving Ongoing Care - Core Services						
Assessments	15,590	N/A	150.0%	15,392	0.0%	
Outpatient						
Child/Adolescents	635	403	50.0%	632	75.4%	
Adult	2,760	2,963	31.0%	2,789	75.4%	
Pregnant and Parenting Women	40	326	1.0%	90	75.4%	
Total				3,511		
Intensive Outpatient						
Child/Adolescents	410	559	34.0%	430	75.4%	
Adult	3,780	4,772	42.0%	3,778	75.4%	
Pregnant and Parenting Women	80	551	1.0%	90	75.4%	
Total				4,298		
Opiate Substitution Tx, All Ages	1,790	2,227	17.5%	1,796	90.0%	
Medical Services in Addiction Treatment Agencies	N/A	255	2.0%	205	90.0%	
(Medical treatment, COD psych meds, non-opoid addiction meds, opiod addiction meds, pain management)						
Recovery Supports, All Ages						
All Recovery Support Services	0	729	5.0%	513	33.0%	
(Recovery Coaches, Recovery Café, Peer Navigators, Recovery Centers)						
Specialized Services, All Ages						
Co-Occurring Disorder TX (MH+IOP)	N/A	596	5.0%	441	100.0%	
Homeless Case Management (Cs Mgt & or Outreach)	N/A		2.0%	176	100.0%	
Total Episodes (duplicated)				**14,481**		
Total Clients (unduplicated estimate)				**10,243**		
Estimated Clients (per above)				**10,261**		

North Sound BHO Planning: Substance Use Disorder Cost & Utilization Flight Simulator — Baseline + Sustainable Rates

Part IV. Service and Cost Projections — Year 1

Rate Increase	Average Svc. Units	Number of Cases	Completion Rate	Partial Completion Units Used	Total Service Units	Average Cost per Unit	Average Cost per Case	Projected Cost	% BHO Medicaid	Units
						30%				Avg: All Svcs
Crisis Services, All Ages										
Mobile Outreach Teams								$240,000	69%	Fixed Budget
Crisis Phone and Triage								$375,228	69%	Fixed Budget
ITA-CD								$805,000	41%	Fixed Budget
Crisis Triage Centers								$2,588,636	69%	Fixed Budget
Detox	5	770	90%	4	3,773	$327.60	$1,605	$1,236,035	91%	Days
Subacute Detox	3	975	90%	2	2,828	$140.87	$409	$398,375	91%	Days
Total Crisis Services		1,745			6,601			$5,643,274		
Brief Intervention & Treatment, All Ages										
All Brief Treatment Settings	3	103	50%	1	206	$52.62	$105	$10,841	75%	Clinician Hours
Clients Receiving Ongoing Care - Core Services										
Assessments	1	15,392	100%	1	15,392	$149.72	$150	$2,304,506	98%	Each
Outpatient										
Child/Adolescents	30	632	66%	15	15,737	$41.08	$1,023	$646,476	98%	Mix: Ind & Group
Adult	30	2,789	66%	15	69,446	$34.33	$855	$2,384,290	98%	Mix: Ind & Group
Pregnant and Parenting Women	30	90	66%	15	2,241	$34.33	$855	$76,940	98%	Mix: Ind & Group
Total		3,511			87,424			$3,107,706		
Intensive Outpatient										
Child/Adolescents	80	430	66%	40	28,552	$44.16	$2,932	$1,260,885	98%	Mix: Ind & Group
Adult	80	3,778	66%	40	250,859	$37.77	$2,508	$9,473,690	98%	Mix: Ind & Group
Pregnant and Parenting Women	80	90	66%	40	5,976	$37.77	$2,508	$225,684	98%	Mix: Ind & Group
Total		4,298			285,387			$10,960,259		
Opiate Substitution Tx, All Ages	230	1,796	75%	115	361,445	$16.63	$3,346	$6,009,746	98%	Days
Medical Services in Addiction Treatment Agencies	3	205	50%	1	410	$100.15	$200	$41,062	75%	Visits
Recovery Supports, All Ages										
All Recovery Support Services	12	513	50%	6	4,617	$25.06	$226	$115,720	75%	Client Hours
Specialized Services, All Ages										
Co-Occurring Disorder TX (MH+IOP)	30	441	66%	15	10,981	$100.15	$2,494	$1,099,769	98%	Client Hours
Homeless Case Management (Cs Mgt & or Outreach)	20	176	50%	10	2,640	$100.15	$1,502	$264,401	75%	Client Hours
Transportation								$250,000	69%	Fixed Budget
Total Service Cost (before Residential)								$29,807,283		
Residential Cost Estimate								$10,998,046	40%	per below
County Administrative Costs								$682,430	100%	Fixed Budget
North Sound RSN Operations								$1,748,724	91%	Fixed Budget
Total Service Cost								$43,236,483		
Excess (Deficit)								($6,731,976)		
Medicaid Revenue								$27,297,144		Per above
Medicaid Portion of the Service Cost								$34,213,552		Per above
Medicaid Excess (Deficit)								($6,916,408)		
Non-Medicaid Revenue								9,207,363		Per above
Non-Medicaid Portion of the Service Cost								$9,022,931		Per above
Non-Medicaid Excess (Deficit)								$184,432		

North Sound BHO Planning: Substance Use Disorder Cost & Utilization Flight Simulator **Baseline + Sustainable Rates**

Residential Estimates	Total Bud	Beds	Occup Rate	Bed Days	Avg Cost	% NSMHA	NSMHA Days	% Medicaid	Mcaid Days	$ Medicaid
Pioneer	**$6,683,476**	**143**	**87%**	45,410	$147.18	**30%**	13,626	**0%**	-	$0
Skagit	**$977,052**	**23**	**85%**	7,136	$136.92	**7%**	514	**0%**	-	$0
Evergreen	**$1,222,324**	**23**	**83%**	6,968	$175.42	**95%**	6,650	**91%**	6,053	$1,061,838
Seamar	**$1,951,477**	**28**	**100%**	10,220	$190.95	**50%**	5,151	**79%**	4,069	$777,018
Subtotal	$10,834,330	217		69,733	$155.37		25,941		10,122	$1,838,857
Beds in Other Places	**$32,676,228**	**1357**	**55%**	272,418	**$155.37**	**16%**	43,587	**38%**	16,503	$2,564,034
Medicaid Total	$43,510,558	1574		342,151			69,528		26,625	$4,402,891

	% Non-Mcaid	NonM Days	$ Non-Mcaid
Pioneer	100%	13,626	$2,005,500
Skagit	100%	514	$70,379
Evergreen	9%	597	$104,728
Seamar	21%	1,082	$206,549
Subtotal		15,819	$2,387,155
Beds in Other Places	62%	27,084	$4,208,000
Non-Medicaid Total		42,903	$6,595,155
Grand Total		69,528	$10,998,046
Medicaid % of Total			40%

Appendix, Section VI-01 North Sound BHO Detailed Plan

	Fund	Program	Medicaid	State Funds	Total		CD Allocate	CD Add	Medicaid	State Funds	SAPT	
		Crisis Outreach										
1	Cap	Snohomish - Compass	1,206,276	541,944	1,748,220	69%/31%		240,000	165,600	37,200	37,200	0.69
2		Detox Evergreen						1,300,000	1,183,000	117,000		0.91
		Detox Evergreen new facility						1,300,000	1,183,000	117,000		
3	Cost	Snohomish - County ITA		2,014,068	2,014,068	100% state						
		All County ITA CD		350,000	350,000			325,000		325,000		0.411428571
4	Cap	Skagit - Compass	1,322,676	594,228	1,916,904	69%/31%		240,000	165,600	74,400		
6	Cap	Whatcom - WCPC	1,206,276	541,944	1,748,220	69%/31%		240,000	165,600	74,400		
8	Cap	Island County - Compass	369,732	166,116	535,848	69%/31% ?						
10	Cap	San Juan - Compass	180,360	81,024	261,384	69%/31% ?						
		Crisis Stabilization -										
11	Cap	Snohomish Stabilization	731,400	328,596	1,059,996	69%/31%		494,000	340,860	153,140		0.69
12	Cost	Snohomish Stabilization - Nursing	667,740	300,000	967,740	69%/31%	483,870		333,870	150,000		
13	Cap	Skagit Stabilization	329,908	148,220	478,128	69%/31%		600,000	414,000	93,000	93,000	
14	Cost	Skagit Stabilization - Nursing	667,740	300,000	967,740	69%/31%	483,870		333,870	150,000		
15	Cap	Whatcom Stabilization	363,564	163,332	526,896	69%/31%		526,896	363,558	81,669	81,669	
16	Cost	Whatcom Stabilization - Nursing	667,740	300,000	967,740	69%/31%	-		-	-	-	
17	FFS	Inpatient Community Hospital	8,500,000	3,000,000	11,500,000	History						
		Evaluation & Treatment										
18	Cap	Mukilteo	2,202,866	1,408,390	3,611,256	61%/39%						
19	Cap	Sedro Woolley	2,804,356	1,792,916	4,597,272	61%/39%						
20	Cost	Sedro Woolley Rent	88,824	56,796	145,620	61%/39%						
21	Cap	VOA Crisis and Triage	863,025	387,736	1,250,761	69%/31%	375,228		258,908	116,321		0.69
						69%/31%			-	-		
22	Cap	Mobile Outreach - Whatcom	-	-	-	69%/31%						
23	Cap	Mobile Outreach - Skagit			-	69%/31%						
24	Mix	Transition Care Services	528,656			100% Med						
25	Cost	Geriatric Outreach	618,840	279,000	897,840	69%/31%						
		Child Outpatient										
26	FFS	Snohomish - CCS	1,079,352	105,816	1,185,168	91%/9%						
27	FFS	Snohomish - Compass	3,134,856	304,980	3,439,836	91%/9%						
28	FFS	Snohomish - Sea Mar	413,232	36,540	449,772	91%/9%						
29	FFS	Snohomish - Center for HS	471,108	55,980	527,088	91%/9%						
30	FFS	Snohomish - Northwest ESD	113,256	6,996	120,252	91%/9%						
31	FFS	Whatcom - CCS	1,310,892	125,964	1,436,856	91%/9%						
32	FFS	Whatcom - WCPC	421,476	34,344	455,820	91%/9%						
33	FFS	Whatcom - Sea Mar	45,132	5,580	50,712	91%/9%						
34	FFS	Whatcom - Northwest ESD	113,256	13,992	127,248	91%/9%						
35	FFS	Skagit - Sea Mar	73,032	9,024	82,056	91%/9%						
36	FFS	Skagit - Compass	428,436	41,016	469,452	91%/9%						
37	FFS	Skagit - CCS	629,868	70,428	700,296	91%/9%						
38	FFS	Skagit - Northwest ESD	129,672	13,992	143,664	91%/9%						
39	FFS	Island - Compass	304,860	37,680	342,540	91%/9%						
40	FFS	Island - Northwest ESD	183,876	6,996	190,872	91%/9%						
41	FFS	Island - Sea Mar	23,160	2,280	25,440	91%/9%						
42	FFS	San Juan - Compass	169,884	13,992	183,876	91%/9%						
		CD Outpatient Services										
		Snohomish								11,000	20,000	
		Skagit								300	1,464	
		Whatcom								5,000	5,000	
		Island								3,000	4,670	
		San Juan								1,500	2,500	54,434
		Children's High Intensity (WISe or Wraparound)										
43	Cap	Snohomish - WRAP - Compass	1,468,800		1,468,800	100% Med						
44	Cap	Whatcom - WRAP - CCS	1,142,400		1,142,400	100% Med						
45	Cap	Skagit - WISe - CCS	979,200		979,200	100% Med						
46	Mix	Island - IWRAP - Compass	122,400		122,400	100% Med						
47	Mix	Island - WRAP - Compass	204,000		204,000	100% Med						
48		WISE - expansion 88 slots	3,590,400			100% Med						
49	Cost	Child Wrap/CHAP Respite Pool		5,000	5,000	100% State						

		Adult Outpatient											
50	FFS	Snohomish - Compass	5,942,064	517,872	6,459,936	91%/9%							
51	FFS	Snohomish - Sunrise	2,773,380	274,608	3,047,988	91%/9%							
52	FFS	Snohomish - Sea Mar	1,135,884	68,448	1,204,332	91%/9%							
53	FFS	Snohomish - Bridgeways	235,572	27,984	263,556	91%/9%							
54	FFS	Whatcom - Interfaith	678,972	50,388	729,360	91%/9%							
55	FFS	Whatcom - WCPC	2,804,496	248,436	3,052,932	91%/9%							
56	FFS	Whatcom - Sea Mar	395,436	38,484	433,920	91%/9%							
57	FFS	Whatcom - Lake Whatcom	986,484	93,360	1,079,844	91%/9%							
58	FFS	Whatcom - Sunrise	339,768	41,976	381,744	91%/9%							
59	FFS	Skagit - Sea Mar	299,100	23,244	322,344	91%/9%							
60	FFS	Skagit - Sunrise	1,679,508	68,160	1,747,668	91%/9%							
61	FFS	Skagit - Compass	1,611,660	190,296	1,801,956	91%/9%							
62	FFS	Skagit - Bridgways	117,792	13,992	131,784	91%/9%							
63	FFS	Island - Compass	884,280	75,180	959,460	91%/9%							
64	FFS	Island - Sunrise	452,988	55,980	508,968	91%/9%							
65	FFS	Island - Sea Mar	92,640	9,180	101,820	91%/9%							
66	FFS	San Juan - Compass	244,152	28,692	272,844	91%/9%							
		Adult IOP	-	-									
67	FFS	Snohomish - Compass	926,220	69,984	996,204	91%/9%							
68	FFS	Snohomish - Sunrise	705,732	69,984	775,716	91%/9%							
69	FFS	Snohomish - SeaMar	298,980	36,948	335,928	91%/9%							
70	FFS	Whatcom - WCPC	378,840	33,456	412,296	91%/9%							
71	FFS	Whatcom - Lake Whatcom	520,404	61,836	582,240	91%/9%							
72	FFS	Skagit - Compass	447,984	50,916	498,900	91%/9%							
73	FFS	Skagit - Sunrise	339,768	41,976	381,744	91%/9%							
74	FFS	Island - Compass	216,300	26,736	243,036	91%/9%							
		IDDT											
75	Cost	Skagit - Sunrise	240,120	107,880	348,000	91%/9%							
76	FFS	Snohomish - Sunrise	450,000		450,000	100% Med							
		Housing Support (Residential)											
77	Cap	Snohomish - Aurora	877,980	219,492	1,097,472	80%/20%							
78	Cap	Snohomish - Haven	470,400	117,600	588,000	80%/20%							
79	Cap	Snohomish - Green	763,956	193,152	957,108	80%/20%							
80	Cap	Whatcom - Lake Whatcom	1,124,148	281,052	1,405,200	80%/20%							
81	Cap	Discharge Housing - Sno Co - CH		31,800	31,800	100% State							
82	Cap	Discharge Housing - Whatcom -LKW		36,000	36,000	100% State							
	Case	Residential CD IMD						6,595,142		2,977,661.90	3,617,480		
	Case	Residential CD Non-IMD						4,099,774	4,099,774.15				
	Cap	Residential Child Care R&B Evergreen						192,000		63,936	128,064	6,787,141.90	10,886,916.05
		PACT											
83	Cost	Snohomish	1,305,648	129,132	1,434,780	91%9%							
	Mix	Snohomish - Incentive	97,923	9,685	107,608	91%9%							
84	Cost	Whatcom	797,160	78,840	876,000	91%9%							
	Mix	Whatcom - Incentive	93,814	9,278	103,092	91%9%							
85	Cost	Skagit	775,320	76,680	852,000	91%9%							
	Mix	Skagit - Incentive	58,149	5,751	63,900	91%9%							
		CD Outpatient Services											
		Snohomish								8,000	189,072		
		Skagit								3,500	35,898		
		Whatcom								5,000	25,000		
		Island								2,500	19,393		
		San Juan								1,772	5,000	295,135	this section
		Peer Centers										349,569	Total incl above
86	Cost	Snohomish - Compass		75,000	75,000	100% State							
87	Cost	Whatcom - WCPC		75,000	75,000	100% State							
88	Cost	Skagit - CVAB		75,000	75,000	100% State							
89	Cap	San Juan Rate Premium Compass	90,516	10,380	100,896	% of fees							
90	Cap	San Juan Subsidy - Compass Health		105,108	105,108	100% State							
91	FFS	Out of Network Services	80,000	-	80,000	100% Med							

92	Cap	Expanded Community Services		187,500	187,500	100% State					
93	Cost	Information Services Subsidy	109,218	10,802	120,020	91%9%					
		CD transportation						117,000		70,000	56,000
		County Administration Funding									
94	Cost	Snohomish	1,025,148		1,025,148	100% Med		366,194	366,194		
95	Cost	Skagit	228,492		228,492	100% Med		81,620	81,620		
96	Cost	Whatcom	275,964		275,964	100% Med		98,578	98,578		
97	Cost	Island	190,416		190,416	100% Med		68,019	68,019		
98	Cost	San Juan	196,214	3,898	200,112	100% Med		68,019	68,019		
99	Cost	Jail Funding		373,104	373,104	100% State					
100	Cost	Interpreter Services	220,800	19,200	240,000	91%9%					
101	Cost	North Sound RSN operations	5,882,129	581,749	6,463,878	91%9%	1,748,724		1,591,339	157,385	
102	Cost	VOA Access Authorization	421,138	41,651	462,789	91%9%					
103	Cost	VOA Inpatient Certification	785,771	77,714	863,485	91%9%					
		Court Costs CD				100% State					
104	Case	Court Costs MH		980,000	980,000	100% State					
105	Cost	Flex Funds		450,000	450,000	100% State					
106	Cost	Ombuds	154,560	13,440	168,000	91%9%					
107	FFS	Medicaid Personal Care		125,000	125,000	100% State					
108	Cost	PATH Match and Additional Costs		202,851	202,851	100% State					
109	Cost	Additional housing Services		490,440	490,440	100% State					
		Total	$ 81,095,915	$ 21,057,205	$ 98,034,064		3,091,692	16,952,242	11,281,409	4,799,684	4,321,410
										4,799,684	4,321,410
										$ 0	$ -

North Sound BHO Substance Use Disorder Provider Capacity Planning Summary Worksheet

	2014 Served	2015 Current Capacity	2016 Additions	2016 Total Capacity	2016 % Incr	2017 Additions	2017 Total Capacity	2017 % Incr	2018 Additions	2018 Total Capacity	2018 % Incr
Crisis Services - Clients											
Mobile Outreach Teams (including a CDP)		382	1,200	1,582	314%	50	1,632	3%	50	1,682	3%
Crisis Triage Centers (serving SUD needs)		840	60	900	7%	0	900	0%	0	900	0%
Detox	1,000	1,059	80	1,139	8%	25	1,164	2%	0	1,164	0%
Subacute Detox	1,000	1,250	850	2,100	68%	580	2,680	28%	0	2,680	0%
Sobering Services		0	0	-	0%	0	-	0%	0	-	0%
Brief Treatment - Clients											
All Brief Treatment Settings		125	325	450	260%	300	750	67%	350	1,100	47%
(Primary Care Clinics, School-Based Services, Addiction Treatment Centers, Jails, Homeless Shelters, etc.)											
			2,442			2,593			2,655		
Ongoing Care Clients											
Outpatient											
Adult	4,930	2,963	466	3,429	16%	681	4,110	20%	666	4,776	16%
Youth	1,035	403	160	563	40%	212	775	38%	251	1,026	32%
Pregnant and Parenting Women	40	326	199	525	61%	202	727	38%	221	948	30%
Intensive Outpatient											
Adult	3,570	4,772	1,072	5,844	22%	909	6,753	16%	859	7,612	13%
Youth	425	559	310	869	55%	369	1,238	42%	401	1,639	32%
Pregnant and Parenting Women	80	551	235	786	43%	220	1,006	28%	257	1,263	26%
Opiate Substitution Tx	1,790	2,227	703	2,930	32%	193	3,123	7%	201	3,324	6%
Medical Services in Addiction Treatment Agencies		255	495	750	194%	311	1,061	41%	307	1,368	29%
(Medical treatment, COD psych meds, non-opoid addiction meds, opiod addiction meds, pain management)											
Co-Occurring Disorder Treatment		596	290	886	49%	343	1,229	39%	321	1,550	26%
Recovery Supports		729	75	804	10%	175	979	22%	235	1,214	24%
(Recovery Coaches, Recovery Café, Peer Navigators, Recovery Centers)											
Jail Transition Services		60	30	90	50%	30	120	33%	30	150	25%
Substance Abuse Protective Custody		96	0	96	0%	0	96	0%	0	96	0%
Assessments (DUI, CPS, Court, etc.)		1,956	240	2,196	12%	240	2,436	11%	80	2,516	3%
Juvenile Detention		94	20	114	21%	20	134	18%	20	154	15%
Sultan High School		32	10	42	31%	10	52	24%	10	62	19%
Cocoon House Outreach (Hours)		725	0	725	0%	0	725	0%	0	725	0%
Sultan High School Outreach (Hours)		576	0	576	0%	0	576	0%	0	576	0%
Lincoln High School		29	5	34	17%	10	44	29%	10	54	23%
Weston High School		46	5	51	11%	10	61	20%	10	71	16%
Lincoln High School Outreach (Hours)		217	0	217	0%	0	217	0%	0	217	0%
Weston High School Outreach (Hours)		458	0	458	0%	0	458	0%	0	458	0%
Other		0	0	-	0%	0	-	0%	0	-	0%

SCOPE Data Pull October 2014 - September 2015

	Adult Island	Adult San Juan	Adult Skagit	Adult Snohomish	Adult Whatcom	Adult Totals	% Unduplicate	# Unduplicate
Oct 2014 - Sept 2015 Undup All Age								
Assessments Indicate Depend	490	125	2,340	8,060	2,595	13,610	0%	-
Assessments Indicate Abuse	65	10	265	1,230	410	1,980	0%	-
Total	555	135	2,605	9,290	3,005	15,590	0%	-
Oct 2014 - Sept 2015 All Age								
Detox Admissions	55	5	325	910	680	1,975	0%	-
Undupe Detox Clients	45	5	205	710	350	1,315	50%	658
Oct 2014 - Sept 2015 Undup Adult								
Outpatient	145	50	400	1,060	1,105	2,760	0%	-
IOP	135	115	845	2,360	325	3,780	0%	-
Total	270	155	1,155	3,320	1,395	6,295	100%	6,295
Intensive IP	70	10	105	725	250	1,160	0%	-
Long Term Residential	5	-	435	165	80	685	0%	-
Recovery House	-	-	5	10	5	20	0%	-
Total Residential	75	10	545	900	335	1,865	100%	1,865
Total Adults								8,818
Oct 2014 - Sept 2015 Undup Youth								
Outpatient	5	5	115	325	185	635	0%	-
IOP	15	5	70	285	35	410	0%	-
Total	25	10	170	590	215	1,010	100%	1,010
Youth Level I	-	-	15	25	20	60	0%	-
Youth Level II	10	-	20	60	75	165	0%	-
Youth Recovery House	-	-	10	20	55	85	0%	-
Youth Total	10	-	45	105	150	310	100%	310
Total Youth								1,320

Appendix, Section VI-01 North Sound BHO Detailed Plan

SFY 2014 CD Service Summary

order	modality_id	Payment Source	treatment_activity_type_id	RSA Island	North Sound San_Juan	North Sound Skagit	North Sound Snohomish	North Sound Whatcom	Statewide Totals	Peninsula	North Sound	King
Unduplicate count of clients served (all modalities)	All Services			341	145	2,921	6,842	2,671	70,500	3,778	12,920	16,575
Totals, no assessment, no detox				297	134	2600	5322	2290	60,625	3,505	10,643	14,481
Difference with unduplicated counts				44	11	321	1520	381	9,875	273	2,277	2,094
Estimated total cost of CD services	All Services			$337,953	$142,037	$8,336,972	$11,929,435	$5,294,408	$127,805,603	$5,939,276	$26,040,805	$33,325,426
Distribution of costs into eligibility categories	ADATSA	Medicaid		28%	19%	13%	9.80%	21%				
	DL-U	Medicaid			0.90%	3.90%	1.60%	0.10%				
	DL-X	Medicaid		0.80%	3.50%	2.10%	2.90%	8.30%				
	Medicaid: AGED	Medicaid		0.20%	0.50%	0.10%	0.20%					
	Medicaid: B/D	Medicaid		8.60%	12%	1.80%	9.50%	2.30%				
	Medicaid: Expan	Medicaid		24%	25%	22%	22%	9.60%				
	Medicaid: OTR	Medicaid		5.90%	11%	6.60%	21%	2.60%				
	Medicaid: TANF	Medicaid		15%	6.80%	16%	18%	6.30%				
	non-Medicaid	Non-Medicaid		17%	21%	34%	15%	50%				
	Total			99.50%	99.70%	99.50%	100.00%	100.20%				
Distribution of costs into eligibility categories	ADATSA	Medicaid		$94,627	$26,987	$1,083,806	$1,169,085	$1,111,826	$16,764,086	$875,102	$3,486,331	$5,332,068
	DL-U	Medicaid		$0	$1,278	$325,142	$190,871	$5,294	$2,032,719	$209,652	$522,586	$533,207
	DL-X	Medicaid		$2,704	$4,971	$175,076	$345,954	$439,436	$2,909,920	$60,192	$968,141	$966,437
	Medicaid: AGED	Medicaid		$676	$710	$8,337	$23,859	$0	$448,542	$4,250	$33,582	$33,325
	Medicaid: B/D	Medicaid		$29,064	$17,044	$150,065	$1,133,296	$121,771	$17,626,036	$331,130	$1,451,242	$3,999,051
	Medicaid: Expan	Medicaid		$81,109	$35,509	$1,834,134	$2,624,476	$508,263	$25,018,482	$1,489,429	$5,083,491	$8,331,357
	Medicaid: OTR	Medicaid		$19,939	$15,624	$550,240	$2,505,181	$137,655	$8,926,945	$508,518	$3,228,639	$1,899,549
	Medicaid: TANF	Medicaid		$50,693	$9,659	$1,333,916	$2,147,298	$333,548	$18,592,842	$801,389	$3,875,113	$5,332,068
	non-Medicaid	Non-Medicaid		$57,452	$29,828	$2,834,570	$1,789,415	$2,647,204	$35,236,590	$1,597,340	$7,358,470	$6,665,085
	Total			$336,263	$141,611	$8,295,287	$11,929,435	$5,304,997	$127,556,162	$5,877,002	$26,007,593	$33,092,148
	Medicaid Total			$278,811	$111,783	$5,460,717	$10,140,020	$2,657,793	$92,319,572	$4,279,662	$18,649,124	$26,427,063
	Medicaid %			83%	79%	66%	85%	50%	72%	73%	72%	80%
Costs by Program Area												
	OP	Mcaid elig & included		$73,285	$41,423	$492,620	$3,219,044	$1,229,213	$20,686,330	$1,513,781	$5,055,585	$3,805,708
	IOP	Mcaid elig & included		$152,295	$72,276	$1,000,531	$1,495,696	$158,494	$22,329,621	$2,259,651	$2,879,292	$4,732,168
	OP/IOP Subtotal			$225,580	$113,699	$1,493,151	$4,714,740	$1,387,707	$43,015,951	$3,773,432	$7,934,877	$8,537,876
	Intensive IP			$60,623	$2,705	$228,184	$500,520	$1,763,823	$26,806,955	$1,194,492	$2,555,855	$5,306,314
	Long-Term Res			$11,417	$0	$4,738,016	$1,106,899	$191,199	$14,025,257	$150,864	$6,047,531	$2,455,033
	OST			$0	$0	$0	$3,754,593	$990,993	$25,653,309	$96,553	$4,745,586	$12,771,673
	Recovery House			$0	$0	$719,554	$1,399	$237,984	$1,852,611	$20,528	$958,937	$78,536
	Facility Total			$72,040	$2,705	$5,685,754	$5,363,411	$3,183,999	$68,338,132	$1,462,437	$14,307,909	$20,611,556
	Detox	Mcaid elig		$3,660	$13,331	$873,161	$1,134,972	$436,667	$9,481,197	$313,512	$2,461,791	$2,767,293
	Assessment	Mcaid elig		$24,378	$9,337	$190,119	$517,285	$190,279	$5,118,130	$284,612	$931,398	$1,120,447
	Total			$325,658	$139,072	$8,242,185	$11,730,408	$5,198,652	$125,953,410	$5,833,993	$25,635,975	$33,037,172
	Medicaid Eligible Categories			$253,618	$136,367	$2,556,431	$6,366,997	$2,014,653	$57,615,278	$4,371,556	$11,328,066	$12,425,616
	Medicaid Included Total			$225,580	$113,699	$1,493,151	$4,714,740	$1,387,707	$43,015,951	$3,773,432	$7,934,877	$8,537,876
	Medicaid Included %			89%	83%	58%	74%	69%	75%	86%	70%	69%
	Medicaid Included $			$247,988	$93,202	$3,189,476	$7,508,651	$1,830,706	$67,308,969	$3,688,305	$12,870,022	$18,158,535
	Medicaid Not Included $			$30,823	$18,581	$2,271,241	$2,631,369	$827,087	$25,010,602	$591,356	$5,779,101	$8,268,528
Unduplicate count of clients served	Detox			2	9	491	978	455	9,138	409	1,935	2,578
	Intensive IP			15	1	88	199	218	8,701	515	521	1,746
	IOP			139	66	953	1,355	237	18,185	1,541	2,750	3,859
	Long-Term Res			2		839	102	30	2,127	26	973	408
	OST						1,184	353	7,988	25	1,537	3,759
	OP			141	67	599	2,481	1,412	22,993	1,388	4,700	4,663
	Recovery House					121	1	40	631	10	162	46
	ADATSA Assessment			26	1	167	528	146	4,908	383	868	949

	Assessment			166	75	1,204	3,533	1,317	34,338	1,765	6,295	7,715	
	Skagit Residential Adjust												
	Average LTR Clients % of Total Clients			0.6%	0.0%	28.7%	1.5%	1.1%	3.0%				
	Average Cost per LTR Client			$5,709	$0	$5,647	$10,852	$6,373	$6,594				
	Estimated Revised Skagit Clients					63							
	Change					(776)							
	Revenue Change					-$4,382,241							
	Revenue Change					-53.17%							
Outpatient Units-of-Service (hours)	IOP		Individ	320	202	4,088	4,050	308			North Sound	Mix	
	IOP		Group	4,037	1,827	31,002	46,750	5,482			8,968	8.8%	
	IOP		Conjoint			1	19	3			89,098	87.7%	
	IOP		Family			1	3	5			23	0.0%	
	IOP		Case Management	62	24	540	2,905	7			9	0.0%	
											3,538	3.5%	
	OP		Individ	277	203	3,051	8,206	3,644			101,636	100.0%	
	OP		Group	1,806	796	10,685	81,514	37,192			15,381	9.7%	
	OP		Conjoint				9	4			131,993	83.1%	
	OP		Family				8	3			13	0.0%	
	OP		Case Management	43	17	419	10,203	775			11	0.0%	
											11,457	7.2%	
Outpatient costs	IOP		Individ	$28,780	$16,750	$326,602	$318,676	$24,552			158,855	100.0%	
	IOP		Group	$120,928	$54,536	$650,907	$1,056,063	$133,026					
	IOP		Conjoint			$39	$1,456	$193				Units/Client	
	IOP		Family			$77	$250	$437			OP	33.80	
	IOP		Case Management	$2,587	$990	$22,906	$119,251	$286			IOP	36.96	
	OP		Individ	$22,582	$16,468	$243,558	$662,252	$290,165					
	OP		Group	$48,902	$24,228	$231,032	$2,124,536	$906,265					
	OP		Conjoint				$711	$327					
	OP		Family				$622	$212					
	OP		Case Management	$1,801	$727	$18,030	$430,923	$32,244					
Per-diem units of service (days w service)	Detox			11	87	5,392	5,661	3,157					
	Intensive IP			514	30	2,065	4,827	11,068					
	Long-Term Res			89		41,710	8,624	1,544					
	OST						287,011	72,592			359,603		
	Recovery House					5,604	34	1,952					
Estimated Per-diem costs	Detox			$3,660	$13,331	$873,161	$1,134,972	$436,667					
	Intensive IP			$60,623	$2,705	$228,184	$500,520	$1,763,823					
	Long-Term Res			$11,417		$4,738,016	$1,106,899	$191,199			6,047,531		
	OST						$3,754,593	$990,993		OST $	4,745,586		
	Recovery House					$719,554	$1,399	$237,984		OST Cl	1,537		
										$ per	3,087.56		
Assessments (# conducted)	ADATSA Assessment			26	1	169	531	146		Rate	12.79		
	Assessment			171	77	1,302	3,740	1,395		Units/cl	241.40		
Assessment costs	ADATSA Assessment			$4,290	$175	$30,082	$63,943	$23,798					
	Assessment			$20,088	$9,162	$160,037	$453,342	$166,481					
Total Costs													

Pierce	Thurston-Mason	Timberlands	Greater Columbia	North Central	SW WA	Spokane	Statewide Totals	Average
6,893	3,037	3,941	8,846	2,820	4,631	7,059	70,500	
5,967	2,623	3,617	7,006	2,290	3,799	6,694	60,625	
926	414	324	1,840	530	832	365	9,875	
$12,208,994	$5,083,647	$6,087,030	$13,474,518	$2,784,320	$7,519,706	$15,341,881	$127,805,603	
$622,659	$216,252	$1,086,322	$302,342	$500,907	$1,223,708	$3,118,395	$16,764,086	
$73,254	$39,271	$75,803	$50,444	$73,117	$121,835	$333,550	$2,032,719	
$158,717	$56,838	$196,014	$90,088	$93,076	$88,147	$232,270	$2,909,920	
$158,717	$3,234	$9,875	$2,065	$5,101	$21,603	$176,790	$448,542	
$512,778	$127,870	$515,701	$8,191,950	$256,507	$828,634	$1,411,173	$17,626,036	
$2,197,619	$821,468	$1,084,976	$823,435	$728,671	$1,843,941	$2,614,095	$25,018,482	
$415,106	$346,511	$371,960	$380,655	$235,718	$889,151	$651,138	$8,926,945	
$329,643	$1,328,740	$992,282	$1,894,552	$374,190	$1,203,135	$2,461,730	$18,592,842	
$7,691,666	$2,153,631	$1,772,182	$1,787,626	$517,377	$1,365,760	$4,327,453	$35,236,590	
$12,160,158	$5,093,814	$6,105,116	$13,523,157	$2,784,663	$7,585,915	$15,326,595	$127,556,162	
$4,468,492	$2,940,183	$4,332,934	$11,735,531	$2,267,286	$6,220,155	$10,999,142	$92,319,572	
37%	58%	71%	87%	81%	82%	72%	72%	
$1,960,348	$1,393,013	$1,222,180	$1,761,297	$664,183	$1,306,665	$2,003,570	$20,686,330	
$1,841,795	$1,119,659	$2,009,400	$2,981,214	$650,683	$1,272,158	$2,583,601	$22,329,621	
$3,802,143	$2,512,672	$3,231,580	$4,742,511	$1,314,866	$2,578,823	$4,587,171	$43,015,951	
$3,531,123	$434,486	$1,086,507	$4,225,881	$801,839	$1,917,691	$5,752,767	$26,806,955	
$307,026	$205,108	$641,518	$2,137,211	$121,030	$330,340	$1,629,596	$14,025,257	
$3,165,574	$1,249,285	$510,509	$635,658	$0	$1,082,206	$1,396,265	$25,653,309	
$25,219	$10,532	$89,211	$119,357	$0	$5,389	$544,902	$1,852,611	
$7,028,942	$1,899,411	$2,327,745	$7,118,107	$922,869	$3,335,626	$9,323,530	$68,338,132	
$771,081	$338,395	$85,262	$722,252	$297,249	$1,132,904	$591,458	$9,481,197	
$427,226	$240,895	$308,994	$634,397	$200,203	$375,120	$594,838	$5,118,130	
$12,029,392	$4,991,373	$5,953,581	$13,217,267	$2,735,187	$7,422,473	$15,096,997	$125,953,410	
$5,000,450	$3,091,962	$3,625,836	$6,099,160	$1,812,318	$4,086,847	$5,773,467	$57,615,278	
$3,802,143	$2,512,672	$3,231,580	$4,742,511	$1,314,866	$2,578,823	$4,587,171	$43,015,951	
76%	81%	89%	78%	73%	63%	79%	75%	
$3,397,663	$2,387,046	$3,802,349	$8,897,337	$1,579,153	$3,838,422	$8,690,136	$67,308,969	
$1,070,829	$553,137	$530,584	$2,838,194	$688,134	$2,381,733	$2,309,006	$25,010,602	
892	255	92	1,060	430	1,008	479	9,138	
1,150	161	420	1,744	335	690	1,419	8,701	
1,623	933	1,492	2,288	506	1,127	2,066	18,185	
95	30	90	213	25	46	221	2,127	
958	464	192	205	-	331	517	7,988	
2,125	1,027	1,274	2,514	1,424	1,602	2,276	22,993	
16	8	149	42	-	3	195	631	
432	220	338	393	270	511	544	4,908	

2,988	1,611	2,113	4,479	1,133	2,457	3,782	34,338

Ind	Grp
8.8%	
	87.7%
0.0%	
0.0%	
3.5%	
12.3%	87.7%
9.7%	
	83.1%
0.0%	
0.0%	
7.2%	
16.9%	83.1%

Hours/Client
8.45
9.24

Behavioral Health Need - North Sound RSA MI and AOD Risk factors	Non-Disabled Child (age <12) Enrollees	Disabled Child (age <12) Enrollees	Non-Disabled Adolescent (age12-17) Enrollees	Disabled Adolescent (age12-17) Enrollees	Non-Disabled Adult Enrollees	Disabled Adult Enrollees	Elder Enrollees	Total Enrollees	Total Adult Elder	Non-Disabled Adult %
Total with AOD Treatment Need, FY 2012-2013	219	11	1,639	63	7,914	5,465	6	15,317		
Total with MI Need, FY 2012-2013	7,574	519	7,401	522	13,892	13,319	129	43,356		
Total with COD, FY 2012-2013	43	4	913	53	4,587	4,638	2	10,240		
Total Diagnosed with MI (P1 or CARE) FY 2012-2013	5,814	355	5,719	382	11,250	11,387	84	34,991	22,721	
Psychotic Disorder	58	6	221	27	853	2,461	18	3,644	3,332	
Mania & Bipolar Disorder	253	33	682	88	2,464	4,373	20	7,913	6,857	
Depression Disorder	680	48	2,914	144	7,596	7,412	45	18,839	15,053	
Anxiety Disorder	2,998	172	2,988	215	6,521	6,477	34	19,405	13,032	
ADHD	2,098	208	1,051	144	214	435	2	4,152	651	
Adjustment & Stress Disorder	1,389	63	910	39	563	446	2	3,412	1,011	
Total Filling Psychotropic Rx, FY 2012-2013	3,098	363	4,089	408	10,406	11,554	111	30,029	22,071	
Antipsychotic	179	81	469	130	1,628	4,132	18	6,637	5,778	
Antimania	7	2	49	11	345	661	2	1,077	1,008	
Antidepressants	405	91	1,764	185	7,890	8,889	84	19,308	16,863	
Antianxiety	836	82	888	113	5,273	6,447	50	13,689	11,770	
ADHD	2,112	253	2,273	241	1,006	889	0	6,774	1,895	
Total Enrollees:	**79,399**	**1,571**	**30,607**	**973**	**36,416**	**19,302**	**462**	**168,730**		
Mental Health Need %:	**9.5%**	**33.0%**	**24.2%**	**53.6%**	**38.1%**	**69.0%**	**27.9%**	**25.7%**		
Substance Use Disorder Need %:	**0.3%**	**0.7%**	**5.4%**	**6.5%**	**21.7%**	**28.3%**	**1.3%**	**9.1%**		

Non-Disabled Child (age <12) Pcnt	Disabled Child (age <12) Pcnt	Non-Disabled Adolescent (age12-17) Pcnt	Disabled Adolescent (age12-17) Pcnt	Non-Disabled Adult Pcnt	Disabled Adult Pcnt	Elder Pcnt
0.3%	0.7%	5.4%	6.5%	21.7%	28.3%	1.3%
9.5%	33.0%	24.2%	53.6%	38.1%	69.0%	27.9%
7.3%	22.6%	18.7%	39.3%	30.9%	59.0%	18.2%
0.1%	0.4%	0.7%	2.8%	2.3%	12.7%	3.9%
0.3%	2.1%	2.2%	9.0%	6.8%	22.7%	4.3%
0.9%	3.1%	9.5%	14.8%	20.9%	38.4%	9.7%
3.8%	10.9%	9.8%	22.1%	17.9%	33.6%	7.4%
2.6%	13.2%	3.4%	14.8%	0.6%	2.3%	0.4%
1.7%	4.0%	3.0%	4.0%	1.5%	2.3%	0.4%
3.9%	23.1%	13.4%	41.9%	28.6%	59.9%	24.0%
0.2%	5.2%	1.5%	13.4%	4.5%	21.4%	3.9%
0.0%	0.1%	0.2%	1.1%	0.9%	3.4%	0.4%
0.5%	5.8%	5.8%	19.0%	21.7%	46.1%	18.2%
1.1%	5.2%	2.9%	11.6%	14.5%	33.4%	10.8%
2.7%	16.1%	7.4%	24.8%	2.8%	4.6%	0.0%

NSMHA Unit Cost Analysis

	Nurse Practitioners/ Physicians Assistants	Supervising Clinician	Therapist/ CDPT	Counselor/ CDP	Case Manager	CDPT	Totals
Section 1 FTEs							
Center for Human Services	0.03			6.50			6.53
Compass Health				2.00			2.00
Evergreen Manor		4.17	4.50	13.90	4.30	4.50	31.37
Sunrise Services	0.25	1.00		1.25	0.25		2.75
Catholic Community Svcs				29.00			29.00
Totals	0.28	5.17	4.50	52.65	4.55	4.50	71.65
Section 2 Total Expenses							
Center for Human Services	$9,235			$813,884			$823,119
Compass Health				$316,794			$316,794
Evergreen Manor		$458,051	$345,799	$1,276,636	$360,530	$345,799	$2,786,815
Sunrise Services	$53,446	$83,095		$95,900	$15,594		$248,035
Catholic Community Svcs				$3,252,014			$3,252,014
Totals	$62,681	$541,146	$345,799	$5,755,229	$376,124	$345,799	$7,426,778
Section 3 Work Hours							
Center for Human Services	62			11,804			11,866
Compass Health				3,250			3,250
Evergreen Manor		8,173	8,820	27,244	8,428	8,820	61,485
Sunrise Services	466	1,864		2,330	466		5,126
Catholic Community Svcs				45,131			45,131
Totals	528	10,037	8,820	89,759	8,894	8,820	126,858
Section 4 Direct Client Hrs							
Center for Human Services	53			4,722			4,775
Compass Health				2,323			2,323
Evergreen Manor		3,269	4,410	20,161	5,310	4,410	37,560
Sunrise Services	280	932		1,398	280		2,890
Catholic Community Svcs				22,566			22,566
Totals	333	4,201	4,410	51,170	5,590	4,410	70,114
Average Hours/FTE/Yr	1,189	813	980	972	1,229	980	979
Section 5 Cost per Clin Hr							
Center for Human Services	$174.25	-	-	$172.36	-	-	$172.38
Compass Health	-	-	-	$136.37	-	-	$136.37
Evergreen Manor	-	$140.12	$78.41	$63.32	$67.90	$78.41	$74.20
Sunrise Services	$190.88	$89.16	-	$68.60	$55.69	-	$85.83
Catholic Community Svcs	-	-	-	$144.11	-	-	$144.11
Totals	$188.23	$128.81	$78.41	$112.47	$67.29	$78.41	$105.92
Fully Loaded Cost/FTE	$223,861	$104,670	$76,844	$109,311	$82,665	$76,844	$103,654
Section 6 Avg Grp Length							
Center for Human Services				60			
Compass Health				180			
Evergreen Manor		120	120	120	60		
Sunrise Services		120		120			
Catholic Community Svcs				120			
Totals							
Section 7 Avg Clients/Grp							
Center for Human Services				10			
Compass Health				12			
Evergreen Manor		12	12	12	12		
Sunrise Services		12		12			
Catholic Community Svcs				12			
Totals							

Missing: Phoenix and SeaMar