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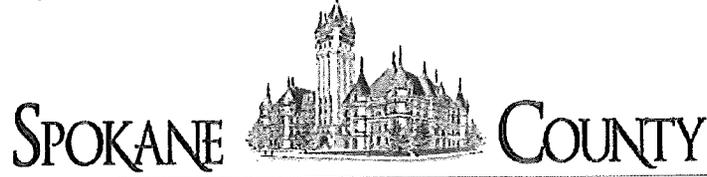
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Spokane County Regional Behavioral Health Organization



COMMUNITY SERVICES, HOUSING, AND COMMUNITY DEVELOPMENT DEPARTMENT
CHRISTINE BARADA, DIRECTOR

October 20, 2015

Melena Thompson
Behavioral Health Organizations Implementation Policy Manager
Department of Social and Health Services
Division of Behavioral Health and Recovery
PO Box 45330
Olympia, WA 98504-5330

RE: Spokane County Regional Behavioral Health Organization's Detailed Plan Submittal

Dear Ms. Thompson:

We are pleased to provide the Spokane County Regional Behavioral Health Organization's (SCRBHO) Detailed Plan in response to the State of Washington, Department of Social and Health Services' (DSHS) Detailed Plan Request from potential Behavioral Health Organizations in accord with 2SSB 6312.

We are enthusiastic about this opportunity and committed to integrating mental health and substance use disorder services within our seven-county Regional Service Area for the contracting period of April 1, 2016 through June 30, 2018. Our enclosed Detailed Plan and Attestations demonstrate the SCRBHO's compliance, with the contractual elements of the act and federal regulations related to Medicaid managed care contracting, as described in Section A., Summary of Project, of DSHS's Amended Behavioral Health Organization Detailed Plan Request. The signatures and initials on the Attestations and Responses spreadsheet, for the Detailed Plan, are provided by the Spokane County Board of Commissioner(s) or designee as approved by Resolution 15-0794.

Thank you very much for your consideration. We look forward to your review and response to the SCRBHO's Detailed Plan submission. Should you have any questions, please contact Suzie McDaniel at (509) 477-4510, smcdaniel@spokanecounty.org or me at (509) 477-7561, cbarada@spokanecounty.org.

Sincerely,

Christine Barada
Director

Encl: 5 Detailed Plans with Attestations

cc: Adams County Commissioners
Ferry County Commissioners
Lincoln County Commissioners
Okanogan County Commissioners
Pend Oreille County Commissioners
Spokane County Commissioners
Steven County Commissioners



Spokane County Regional Behavioral Health Organization

Detailed Plan Request

Behavioral Health Data Consolidation Plan Data Elements, Exhibit A

The Behavioral Health Data Consolidation project has identified the draft set of data elements required for collection from the BHOs. Many of the data elements have standing definitions in current data dictionaries or reporting instructions and this is indicated in the attached Tables. Reporting rules and definitions and values for new elements, will be developed with the RSN/BHO representatives between July 1 – September 11, 2015 either through the SERI workgroup or the BHDC data group.

1. Provide your plan and timeline to collect and report on the data elements contained in Table 1 (Non-Provider One data elements) and Table 2 (Provider One data elements).
SEE PLAN XIII, PAGE 157 FOR RESPONSE

2. Describe your plan to assess and ensure the provider agencies in your network (or subcontractors) are able to submit client and service data that meets the BHO reporting requirements (as specified in table below).
 - a. Describe any barriers your substance use disorder treatment agencies have in meeting the data collection and transmission requirements?
SEE PLAN XIII, PAGES 165 and 166 FOR RESPONSE

 - b. How are you communicating the data reporting requirements?
SEE PLAN XIII, PAGES 165 and 169 FOR RESPONSE

 - c. Describe technical assistance or other support you are providing to substance use disorder treatment agencies?
SEE PLAN XIII, PAGE 170 FOR RESPONSE

 - d. Describe the IT systems/EHRs used by the provider agencies in your network to collect and submit client and services information?
SEE PLAN XIII, PAGE 171 FOR RESPONSE

3. Document your plan to collect client and services data from the substance use residential providers located throughout the state?
SEE PLAN XIII, PAGE 173 FOR RESPONSE

4. Document your systems capacity to collect, store, and submit funding source information associated with a person and service, in order to meet block grant reporting requirements.
SEE PLAN XIII., PAGE 174 FOR RESPONSE

5. Describe how will you ensure that encounters are submitted within 30 days after the close of the month of service?
SEE PLAN XIII, PAGE 175 FOR RESPONSE

Spokane County Regional Behavioral Health Organization

Detailed Plan Request

Behavioral Health Data Consolidation Plan Data Elements, Exhibit A

Table 1 – Data elements not collected through Provider One

Note: Gray items are not collected by the BHO's.

Category	Data Element	Existing Element (Y/N)
Client ID	CLIENT_ALTERNATE_LAST_NAME	Y
Client ID	CLIENT_FIRST_NAME	Y
Client ID	CLIENT_IDENTIFIER	Y
Client ID	CLIENT_LAST_NAME	Y
Client ID	CLIENT_MIDDLE_NAME	Y
Client ID	CLIENT_SOCIAL_SECURITY_NUMBER	Y
Client ID	CLIENT_WA_STATE_DRIVERS_LICENSE	Y
Client ID	DOC_OFFENDER_NUMBER	N
Client Profile/Client	RESADDLINE1	Y
Client Profile/Client	RESIDENCE_CITY	Y
Client Profile/Client	RESIDENCE_COUNTY	Y
Client Profile/Client	RESIDENCE_STATE	Y
Client Profile/Client	RESIDENCE_ZIP_CODE	Y
Client Profile/Client	RESADDLINE2	Y
Client Profile/Education	YEARS_OF_EDUCATION	Y
Client Profile/Family	KIDS_AT_HOME	Y
Client Profile/Family	KIDS_ELSEWHERE	Y
Client Profile/Health Services	EMERGENCY_ROOM_VISITS	Y
Client Profile/Health Services	INPATIENT_ADMISSIONS	Y
Client Profile/Health Status	ACCESS_TO_CARE_DIAGNOSIS	N
Client Profile/Health Status	CLIENT_DIAGNOSIS	Y
Client Profile/Health Status	DISABILITY_TYPE_ID	Y
Client Profile/Health Status	DISCHARGE_TYPE_ID	Y
Client Profile/Health Status	DISPOSITION	Y
Client Profile/Health Status	PREGNANCY_EST_DUE_DATE	Y
Client Profile/Health Status	SELF_HELP_COUNT	Y
Client Profile/Housing	RESIDENCE_TYPE_ID	Y
Client Profile/Income	EMPLOYMENT_ACTIVITY_ID	Y
Client Profile/Income	MONTHLY_PERSONAL_INCOME	Y
Client Profile/Income	PRIMARY_INCOME_SOURCE	Y
Client Profile/Legal	ARREST_TYPE_ID	Y
Client Profile/Legal	ARRESTED_30_DAYS	Y
Client Profile/Legal	CURR_DOMESTIC_VIOLENCE	Y
Client Profile/Legal	LEGAL_ISSUE_TYPE_ID	Y
Client Profile/Legal	LEGAL_STATUS	Y
Client Profile/Legal	PAST_DOMESTIC_VIOLENCE	Y
Client/Profile	BHAS_SCREENING_INDICATOR	Y
Client/Profile	CANS_SCORE	Y
Client/Profile	COD_CODE_TYPE	N
Client/Profile	COD_CODE_VALUE	N
Client/Profile	ENTRY_REFERRAL_ID	Y
Client/Profile	GAINSS_SCORE	Y
Client/Profile	LEGAL_AUTHORITY_CODE	Y
Client/Profile	OP_COD_SCREEN_ID	N
Client/Profile	VETERAN	Y

Spokane County Regional Behavioral Health Organization

Detailed Plan Request

Behavioral Health Data Consolidation Plan Data Elements, Exhibit A

Category	Data Element	Existing Element (Y/N)
Crisis Services	INVESTIGATION REASON	Y
Crisis Services	DETENTION LEGAL REASON	Y
Crisis Services/Outcome	HEARING OUTCOME	Y
Crisis Services/Outcome	INVESTIGATION OUTCOME	Y
Crisis Services/Provider	DETENTION AGENCY NUMBER	Y
Crisis Services/Provider	DETENTION COUNTY	Y
Crisis Services/Provider	DMHP AGENCY NUMBER	Y
Crisis Services/Provider	HEARING COUNTY	Y
Crisis Services/Provider	INVESTIGATION COUNTY	Y
Crisis Services/Provider Info	INVESTIGATION PROVIDER TYPE	Y
Crisis Services/Service Date	DETENTION START DATE	Y
Crisis Services/Service Date	HEARING DATE	Y
Crisis Services/Service Date	INVESTIGATION END DATE	Y
Crisis Services/Service Date	INVESTIGATION START DATE	Y
Demographics	CLIENT BIRTHDATE	Y
Demographics	CLIENT GENDER	Y
Demographics	CLIENT HISPANIC ORIGIN	Y
Demographics	MARITAL STATUS ID	Y
Demographics	PRIMARY LANGUAGE ID	Y
Demographics	RACE ID	Y
Demographics	SEXUAL ORIENTATION ID	Y
Demographics	TRIBE ID	Y
Header	BATCH NUMBER	Y
Header	CLAIMID	Y
Header	MILESTONE TYPE ID	Y
Header	RECEIVED DATE	Y
Services/Amount	ACTIVITY DURATION HOURS	Y
Services/Amount	ACTIVITY DURATION MINUTES	Y
Services/Amount	SERVICE HOURS	Y
Services/Amount	SERVICE MINUTES	Y
Services/Edit	CHANGE UPDATE DATE	Y
Services/Edit	CHANGE USER ID	Y
Services/Gambling	BETTING	Y
Services/Gambling	BINGO	Y
Services/Gambling	BOWL POOL	Y
Services/Gambling	CARDS	Y
Services/Gambling	CASINO	Y
Services/Gambling	CONSEQUENCE	Y
Services/Gambling	DICE	Y
Services/Gambling	DOGS HORSES	Y
Services/Gambling	EPISODES	Y
Services/Gambling	HARM	Y
Services/Gambling	INTERNET	Y
Services/Gambling	LIED	Y
Services/Gambling	LIMIT	Y
Services/Gambling	LOTTERY	Y
Services/Gambling	OTHERGAMBLING	Y
Services/Gambling	SLOTS	Y

Spokane County Regional Behavioral Health Organization

Detailed Plan Request

Behavioral Health Data Consolidation Plan Data Elements, Exhibit A

Category	Data Element	Existing Element (Y/N)
Services/Gambling	SPENT	Y
Services/Gambling	SPORTS	Y
Services/Gambling	STOCKS	Y
Services/Gambling	SUICIDE	Y
Services/Gambling	THINKING	Y
Services/Payment	CONTRACT TYPE ID	Y
Services/Payment	FUNDING TYPE	N
Services/Payment	FUNDING SOURCE ID	Y
Services/Payment	PRIVATE INSURANCE PAYMENT ID	Y
Services/Payment	SERVICE FUNDING DATETIME	Y
Services/Provider	AGENCY NUMBER	Y
Services/Provider	BHO ID	Y
Services/Provider	SERVICE LOCATION	Y
Services/Service Date	AUTH DATE	Y
Services/Service Date	AUTH END DATE	Y
Services/Service Date	AUTH START DATE	Y
Services/Service Date	EFFECTIVE DATETIME	N
Services/Service Date	FIRST_CONTACT_DATETIME (Request for service datetime)	Y
Services/Service Date	INTAKE DATE TIME (Admit Datetime?)	Y
Services/Service Date	PROGRAM END DATETIME	Y
Services/Service Date	PROGRAM START DATETIME	Y
Services/Service Date	SERVICE DENIAL DATE	N
Services/Service Date	SERVICE DENIAL REASON	N
Services/Service Date	SERVICE END DATETIME	Y
Services/Service Date	SERVICE START DATE	Y
Services/Service Date	SERVICES_START_TIME (Admit Datetime?)	Y
Services/Service Date	SUPPORT ACTIVITY DATETIME	Y
Services/Service Date	TREATMENT DATETIME	Y
Services/Service Date	EBP AUTH DATE	Y
Services/Service Date	EBP END DATE	Y
Services/Service Date	EBP START DATE	Y
Services/Type	MODALITY ID	Y
Services/Type	PROCEDURE CODE	Y
Services/Type	PROGRAM ID	Y
Services/Type	RESIDENTIAL ADMIT	N
Services/Type	SERVICE TYPE	Y
Services/Type	SPECIAL ASSESSMENT TYPE ID	Y
Services/Type	TREATMENT ACTIVITY TYPE ID	Y
Substance Use	ASAM LEVEL ID	Y
Substance Use	DATE LAST USED	Y
Substance Use	FIRST USE AGE	Y
Substance Use	FREQUENCY OF USE ID	Y
Substance Use	METHOD ID	Y
Substance Use	NEEDLE USE ID	Y
Substance Use	PEAK USE FREQUENCY ID	Y
Substance Use	RELAPSED	Y

Spokane County Regional Behavioral Health Organization

Detailed Plan Request

Behavioral Health Data Consolidation Plan Data Elements, Exhibit A

Category	Data Element	Existing Element (Y/N)
Substance Use	RELATIVE IMPORTANCE	Y
Substance Use	SMOKING STATUS	N
Substance Use	SUBSTANCE ID	Y
Substance Use	USED NEEDLE RECENTLY	Y

Spokane County Regional Behavioral Health Organization

Detailed Plan Request

Behavioral Health Data Consolidation Plan Data Elements, Exhibit A

Table 2 – Data Elements Collected through Provider One

ProviderOne Data Elements	
ADMISSION SOURCE LKPCD	INDCTR OPTION CODE
ADMISSION SOURCE NAME	INPATIENT SERVICE TYPE
AMOUNT CLAIM CHARGE	ITA INDICATOR
AMT HEADER ALLOWED	LINE ALLOWED AMT
AMT HEADER BILLED	LINE BILLED AMT
AMT HEADER MEDICARE COST AV	LINE BILLED UNITS
AMT HEADER PAID	LINE PAD AMT
AMT HEADER TPL COST AVOIDANCE	LINE TPL COST AVOID AMT
AMT MEDICARE	META GROUP CODE
AMT RECIPIENT	META GROUP DATA VALUE1
AMT REIMBURSEMENT	ORIGINAL EIMBURSED AMT
AMT TOTAL COMPUTED RECIP PMT	PATIENT ACCOUNT NUMBER
AUTH AGENCY NUMBER	PATIENT COMM SRVC OFF LKPCD
AUTH DATE	PATIENT MMIS ID (PIC)
AUTH SERVICE	PATIENT STAUS LKPCD
AUTH SERVICE LEVEL	PAY ORDER DATE
BLNG NATIONAL PRVDR IDNTR	PAY SOURCE
BLNG PRVDR LCTN IDNTR	PROVIDER ID
BLNG PRVDR LEGACY ID	PRVDR COUNTY CODE
CLAIM CHARGE	PRVDR POSTAL CODE
CLAIM ID	RECIPIENT AID CATEGORY (RAC)
CLAIM LINE TCN	REVENUE SOURCE
CLAIM TYPE CID	SERVICE DAYS
CSO REGION	SERVICE LOCATION
CTZNSHP STATUS LKPCD	SERVICE MODIFIER
DATE PAID	SERVICE PROVIDER TYPE
DENIAL REASON CODE 1	SERVICE UNITS
DENIAL REASON CODE 2	TCN DATE
DIAGNOSIS	TCN ORIGINAL
DIAGNOSIS RELATED GROUP (DRG)	TRANSACTION CONTROL NUMBER (TCN)

EXHIBIT B – FUNDING

No response is required.

EXHIBIT C – DRAFT CONTRACTS

No response is required.

EXHIBIT D – SUBSTANCE USE DISORDER SERVICES

No response is required.



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

200 Independence Avenue SW
Washington, DC 20201

Model QHP Addendum for Indian Health Care Providers

1. Purpose of Addendum; Supersession.

The purpose of this Addendum for Indian health care providers is to apply special terms and conditions necessitated by federal law and regulations to the network provider agreement by and between _____ (herein "Qualified Health Plan issuer" and/or "QHP issuer") and _____ (herein "Provider"). To the extent that any provision of the Qualified Health Plan issuer's network provider agreement or any other addendum thereto is inconsistent with any provision of this Addendum, the provisions of this Addendum shall supersede all such other provisions.

2. Definitions.

For purposes of the Qualified Health Plan issuer's agreement, any other addendum thereto, and this Addendum, the following terms and definitions shall apply:

- (a) "Contract health services" has the meaning given in the Indian Health Care Improvement Act (IHCA) Section 4(5), 25 U.S.C. § 1603(5).
- (b) "Indian" has the meaning given in 45 C.F.R. 155.300.
- (c) "Provider" means a health program administered by the Indian Health Service, a tribal health program, an Indian tribe or a tribal organization to which funding is provided pursuant to 25 U.S.C. § 47 (commonly known as the "Buy Indian Act"), or an urban Indian organization that receives funding from the IHS pursuant to Title V of the IHCA (Pub. L. 94-437), as amended, and is identified by name in Section I of this Addendum.
- (d) "Indian Health Service or IHS" means the agency of that name within the U.S. Department of Health and Human Services established by the IHCA Section 601, 25 U.S.C. § 1661.
- (e) "Indian tribe" has the meaning given in the IHCA Section 4(14), 25 U.S.C. § 1603(14).
- (f) "Qualified Health Plan" (QHP) has the meaning given in Section 1301 of the Affordable Care Act, 42 U.S.C. § 18021.
- (g) "Tribal health program" has the meaning given in the IHCA Section 4(25), 25 U.S.C. § 1603(25).
- (h) "Tribal organization" has the meaning given in the IHCA Section 4(26), 25 U.S.C. § 1603(26).
- (i) "Urban Indian organization" has the meaning given in the IHCA Section 4(29), 25 U.S.C. § 1603(29).

3. Description of Provider.

The Provider identified in Section 1 of this Addendum is (check the appropriate box):

The IHS.

An Indian tribe that operates a health program under a contract or compact to carry out programs, services, functions, and activities (or portions thereof) of the IHS pursuant to the ISDEAA, 25 U.S.C. § 450 et seq.

/ / A tribal organization that operates a health program under a contract or compact to carry out programs, services, functions, and activities (or portions thereof) of the IHS pursuant to the ISDEAA, 25 U.S.C. § 450 et seq.

/ / A tribe or tribal organization that operates a health program with funding provided in whole or part pursuant to 25 U.S.C. § 47 (commonly known as the Buy Indian Act).

/ / An urban Indian organization that operates a health program with funds in whole or part provided by IHS under a grant or contract awarded pursuant to Title V of the IHCA.

4. Persons Eligible for Items and Services from Provider.

(a) The parties acknowledge that eligibility for services at the Provider's facilities is determined by federal law, including the IHCA, 25 U.S.C. § 1601, et seq. and/or 42 C.F.R. Part 136. Nothing in this agreement shall be construed to in any way change, reduce, expand, or alter the eligibility requirements for services through the Provider's programs.

(b) No term or condition of the QHP issuer's agreement or any addendum thereto shall be construed to require the Provider to serve individuals who are ineligible under federal law for services from the Provider. The QHP issuer acknowledges that pursuant to 45 C.F.R. 80.3(d), an individual shall not be deemed subjected to discrimination by reason of his/her exclusion from benefits limited by federal law to individuals eligible for services from the Provider. Provider acknowledges that the nondiscrimination provisions of federal law may apply.

5. Applicability of Other Federal Laws.

Federal laws and regulations affecting the Provider, include but are not limited to the following:

(a) The IHS as a Provider:

- (1) Anti-Deficiency Act, 31 U.S.C. § 1341;
- (2) ISDEAA, 25 U.S.C. § 450 et seq.;
- (3) Federal Tort Claims Act ("FTCA"), 28 U.S.C. §§ 2671-2680;
- (4) Federal Medical Care Recovery Act, 42 U.S.C. §§ 2651-2653;
- (5) Federal Privacy Act of 1974 ("Privacy Act"), 5 U.S.C. § 552a, 45 C.F.R. Part 5b;
- (6) Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2;
- (7) Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Parts 160 and 164; and
- (8) IHCA, 25 U.S.C. § 1601 et seq.

(b) An Indian tribe or a Tribal organization that is a Provider:

- (1) ISDEAA, 25 U.S.C. § 450 et seq.;
- (2) IHCA, 25 U.S.C. § 1601 et seq.;
- (3) FTCA, 28 U.S.C. §§ 2671-2680;
- (4) Federal Medical Care Recovery Act, 42 U.S.C. §§ 2651-2653;
- (5) Privacy Act, 5 U.S.C. § 552a, 45 C.F.R. Part 5b; and
- (6) HIPAA, 45 C.F.R. Parts 160 and 164.

(c) An urban Indian organization that is a Provider:

- (1) IHClA, 25 U.S.C. § 1601 et seq. (including without limitation pursuant to the IHClA Section 206(e)(3), 25 U.S.C. § 1621e(e)(3), regarding recovery from tortfeasors);
- (2) Privacy Act, 5 U.S.C. § 552a, 45 C.F.R. Part 5b; and
- (3) HIPAA, 45 C.F.R. Parts 160 and 164.

6. Non-Taxable Entity.

To the extent the Provider is a non-taxable entity, the Provider shall not be required by a QHP issuer to collect or remit any federal, state, or local tax.

7. Insurance and Indemnification.

- (a) *Indian Health Service.* The IHS is covered by the FTCA which obviates the requirement that IHS carry private malpractice insurance as the United States consents to be sued in place of federal employees for any damages to property or for personal injury or death caused by the negligence or wrongful act or omission of federal employees acting within the scope of their employment. 28 U.S.C. §§ 2671-2680. Nothing in the QHP network provider agreement shall be interpreted to authorize or obligate any IHS employee to perform any act outside the scope of his/her employment. The IHS shall not be required to acquire insurance, provide indemnification, or guarantee that the QHP will be held harmless from liability.
- (b) *Indian Tribes and Tribal Organizations.* A Provider which is an Indian tribe, a tribal organization, or employee of a tribe or tribal organization shall not be required to obtain or maintain professional liability insurance to the extent such Provider is covered by the FTCA pursuant to federal law (Public Law 101-512, Title III, § 314, as amended by Public Law 103-138, Title III, § 308 (codified at 25 U.S.C. § 450f note); and 25 C.F.R. Part 900, Subpart M; 25 U.S.C. §458aaa-15(a); and 42 C.F.R. § 137.220). Nothing in the QHP issuer network provider agreement or any addendum thereto shall be interpreted to authorize or obligate such Provider or any employee of such provider to operate outside of the scope of employment of such employee. Such Provider shall not be required to acquire insurance, provide indemnification, or guarantee that the QHP issuer will be held harmless from liability.
- (c) *Urban Indian Organizations.* To the extent a Provider that is an urban Indian organization is covered by the FTCA pursuant to Section 224(g)-(n) of the Public Health Service Act, as amended by the Federally Supported Health Centers Assistance Act, Public Law 104-73, (codified at 42 U.S.C. § 233(g)-(n)), 42 C.F.R. Part 6, such Provider shall not be required to obtain or maintain professional liability insurance. Nothing in the QHP issuer network provider agreement or any addendum thereto shall be interpreted to authorize or obligate such Provider or any employee of such Provider to operate outside of the scope of employment of such employee. Such Provider shall not be required to acquire insurance, provide indemnification, or guarantee that the QHP issuer will be held harmless from liability.

8. Licensure of Health Care Professionals.

- (a) *Indian Health Service.* States may not regulate the activities of IHS-operated health care programs nor require that IHS health care professionals be licensed in the state where they are providing services, whether the IHS employee is working at an IHS-operated facility or has been assigned to a health care program of a tribe, tribal organization, or urban Indian organization. The parties agree that during the term of the QHP issuer's agreement, IHS health care professionals shall hold state licenses in accordance with applicable federal law, and that IHS facilities shall be accredited in accordance with federal statutes and regulations.

- (b) *Indian tribes and tribal organizations.* Section 221 of the IHCA, 25 U.S.C. § 1621t, exempts a health care professional employed by an Indian tribe or tribal organization from the licensing requirements of the state in which such tribe or organization performs services, provided the health care professional is licensed in any state. The parties agree that these federal laws apply to the QHP issuer's agreement and any addenda thereto.
- (c) *Urban Indian organizations.* To the extent that any health care professional of an urban Indian provider is exempt from state regulation, such professional shall be deemed qualified to perform services under the QHP Sponsor's agreement and all addenda thereto, provided such employee is licensed to practice in any state. The parties agree that this federal law applies to the QHP issuer's agreement and any addenda thereto.

9. Licensure of Provider; Eligibility for Payments.

To the extent that the Provider is exempt from state licensing requirements, such Provider shall not be required to hold a state license to receive any payments under the QHP issuer's network provider agreement and any addendum thereto.

10. Dispute Resolution.

In the event of any dispute arising under the QHP issuer's network provider agreement or any addendum thereto, the parties agree to meet and confer in good faith to resolve any such disputes prior to resolution of any disputes through any process identified in the network provider agreement. If the Provider is an IHS provider, the laws of the United States shall apply to any problem or dispute hereunder that cannot be resolved by and between the parties in good faith. Notwithstanding any provision in the provider network agreement, IHS shall not be required to submit any disputes between the parties to binding arbitration.

11. Governing Law.

The QHP issuer's network provider agreement and all addenda thereto shall be governed and construed in accordance with federal law of the United States. In the event of a conflict between such agreement and all addenda thereto and federal law, federal law shall prevail. Nothing in the QHP issuer's network provider agreement or any addendum thereto shall subject an Indian tribe, tribal organization, or urban Indian organization to state law to any greater extent than state law is already applicable.

12. Medical Quality Assurance Requirements.

To the extent the QHP issuer imposes any medical quality assurance requirements on its network providers, any such requirements applicable to the Provider shall be subject to Section 805 of the IHCA, 25 U.S.C. § 1675.

13. Claims Format.

The QHP issuer shall process claims from the Provider in accordance with Section 206(h) of the IHCA, 25 U.S.C. § 1621e(h), which does not permit an issuer to deny a claim submitted by a Provider based on the format in which submitted if the format used complies with that required for submission of claims under Title XVIII of the Social Security Act or recognized under Section 1175 of such Act.

14. Payment of Claims.

The QHP issuer shall pay claims from the Provider in accordance with federal law, including Section 206 of the IHCLA (25 U.S.C. §1621e), and 45 C.F.R., Part 156, Subpart E. The QHP issuer shall be deemed compliant with Section 206 to the extent the QHP issuer and Provider mutually agree to the rates or amounts specified in the QHP issuer agreement as payment in full.

15. Hours and Days of Service.

The hours and days of service of the Provider shall be established by the Provider. Though not required prior to the establishment of such service hours, the QHP issuer and the Provider may negotiate and agree on specific hours and days of service. At the request of the QHP issuer, such Provider shall provide written notification of its hours and days of service.

16. Contract Health Service Referral Requirements

The Provider shall comply with coordination of care and referral obligations of the QHP issuer except only in specific circumstances in which such referrals would conflict with federal law or that referral requirements applicable to Contract Health Services would not be met. The Provider will notify the QHP issuer when such circumstances occur.

17. Sovereign Immunity.

Nothing in the QHP issuer's network provider agreement or in any addendum thereto shall constitute a waiver of federal or tribal sovereign immunity.

18. Endorsement.

An endorsement of a non-federal entity, event, product, service, or enterprise may be neither stated nor implied by the IHS Provider or IHS employees in their official capacities and titles. Such agency names and positions may not be used to suggest official endorsement or preferential treatment of any non-federal entity under this agreement.

APPROVALS

For the Qualified Health Plan Issuer:

For the Provider:

Date _____

Date _____

Spokane County Regional Behavioral Health Organization

Detailed Plan Request Behavioral Health Organization Advisory Board Membership, Exhibit F

The Behavioral Health Organization must maintain an Advisory Board that is broadly representative of the demographic character of the region. Composition of the Advisory Board and the length of terms must be provided to DSHS upon request and meet the following requirements:

- Be representative of the geographic and demographic mix of service population
- Have at least 51% of the membership be persons with lived experience, parents or legal guardians of persons with lived experience and/or self-identified as a person in recovery from a behavioral health disorder.
- Law Enforcement representation
- County representation, when the BHO is not a County operated BHO
- No more than four elected officials
- No employees, managers or other decision makers of subcontracted agencies who have the authority to make policy or fiscal decisions on behalf of the subcontractor.
- Three year term limit, multiple terms may be served, based on rules set by the Advisory Board.

SEE PLAN II., PAGE 36 FOR RESPONSE, AS WELL AS PLAN III., PAGE 53

EXHIBIT G – WISe CAPACITY EXPANSION

No response is required.

I. General and Overall Transition Plan

I. General and Overall Transition Plan

The Spokane County Community Services, Housing, and Community Development Department (CSHCD) is pleased to provide this detailed plan in response to the Behavioral Health Organization Detailed Plan Request. We look forward to partnering with the Department of Social and Health Services (DSHS), Behavioral Health and Service Integration Administration (BHSIA) to integrate publicly-funded mental health and substance use disorder (SUD) treatment through the establishment of the Spokane County Regional Behavioral Health Organization (SCRBHO) as a regional behavioral health organization (BHO).

This initiative is an exciting and important step toward Washington's goal of improved health outcomes through fully-integrated health care delivery. The information contained in this detailed plan reflects over 20 months of regional planning by the CSHCD to assume responsibility for administering and purchasing publicly-funded behavioral health care, including bringing substance use disorder treatment into managed care through our BHO.

The CSHCD is dedicated to strengthening our communities and helping our 7-county region's most disadvantaged residents achieve and maintain safer, healthier, and more independent lives. The CSHCD currently serves as an administrator of both federal and state mental health for 8 counties and administers substance use disorder (SUD) services in Spokane County through its Spokane County Regional Support Network (SCRSN) and the Substance Abuse Division of CSHCD. Since 1993, the SCRSN has been responsible for the full range of community-based mental health services and community inpatient care for eligible individuals. As the Prepaid Inpatient Health Plan (PIHP), Spokane County assumes the risk for all Medicaid eligible in its region, inpatient care, contractual requirements, and performance outcomes. Effective October 1, 2012, the North Central Washington Regional Support Network (NCWRSN), an agency that administered contracts for public mental health services with Adams, Ferry, Grant, Lincoln, Okanogan, Pend Oreille, and Stevens counties, joined with the SCRSN. The SCRSN became a multi-county PIHP administrator for 8 counties' region of care under the governance of the Spokane Board of County Commissioners (BOCC). These 8 counties represent a combined, total population of 696,456 people, residing across 20,033 square miles.¹ Of 39 counties in Washington State, the SCRSN serves both the fourth largest (Spokane County) and the fourth smallest (Ferry County) counties. As you will read throughout this detailed plan, the CSHCD has utilized this BHO application opportunity to move toward integration of its Mental Health (RSN) and Substance Abuse Divisions' administrative responsibilities to achieve the contractual requirements of a BHO.

The current mission of the SCRSN is to ensure that the range of care, resources, and services are person-driven; build on strengths and opportunities; and are available and accessible to individuals and their families seeking to recover from mental illness so they may live safer, healthier, and more independent lives. These resources and services value:

- Safety and health;
- Belief that achieving wellness is a reality, hope, and possibility;
- The dignity of each individual to determine their own path;

¹ 2013 Washington State Department of Financial Management

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- Cultural diversity and sensitivity;
- Promoting a purposeful, satisfying quality of life in one's own community;
- Active partnerships with related services that also assist the individual; and
- Stewardship of public resources to ensure access to quality care for all residents.

As the BHO, the SCRSN will continue this mission while serving as the regional BHO for both mental health and SUD services and lead the adoption of an integrated, culturally-sensitive, and recovery-oriented system of care. The State's initiative supports and enhances Spokane County's long-term vision and aspirations for creating a quality system of care for individuals in the region. Serving as the administrator for both mental health and substance use disorder for many years, Spokane County has witnessed firsthand the complexity of need and the challenges that are created for the individual being served as well as the provider system when mental health and substance use treatment are separated by funding, policy, and regulation. Spokane County, in partnership with the State, has improved the quality of care through technical assistance, pay for performance metrics, and greater adoption of evidence-based practice. One example was Spokane County's embrace of unique funding opportunities for co-occurring mental health and SUD treatment programming. In addition, Spokane County is aware that the sophistication of providers varies across the region and that as a BHO, there is opportunity to further improve evidenced-based-practice delivery and innovation in treating mental health and SUD collaboratively. Spokane County views the current initiative as a way to advance the vision of transforming the delivery system and believes that integration is one of the most central changes required in order for care to be genuinely patient-centered and grounded in the philosophy of recovery.

Because we are committed to the recovery and resiliency of our enrollees, everything from language and communication, preferred practices, Utilization Management (UM) guidelines, and chosen quality measures will align and reinforce this philosophy. This also includes more active participation from individuals and families served in all aspects of the system, including service array, feedback, monitoring, and redesign activities.

While CSHCD has a long and proven history of managing behavioral health benefits under its current contracts with DSHS, transitioning to a BHO requires a significant shift from business practices within our current RSN and SUD administration. The SCRSN has actively participated in state-sponsored meetings throughout the planning process, has utilized guidance from DSHS in providing this comprehensive plan, and looks forward to a collaborative process in addressing any questions regarding the content within this plan. Our preparation efforts included targeted review of current administrative practices and identification of gaps or challenges in meeting new requirements under the pending BHO contract(s) and specific to the 11 key areas of administrative responsibility, outlined in the detailed plans that follow. The following 5 core activities have been central to our planning effort:

- An understanding of DSHS' vision for "Healthier Washington," including the role of BHOs within this larger initiative;
- Ongoing engagement of stakeholders to assist in their understanding of the transition as well as engage them in the planning process;

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- A comprehensive review of the CSHCD's current structure, policies and procedures, and provider network. The review was cross-walked to the BHO requirements to identify gaps between what we do today and the new responsibilities as the SCRBHO; and
- Movement toward full integration of administrative functions of mental health and SUD services.
- Embracing a value-based model that provides for the array of services that is cost effective and ensures quality care.
- Manages risk for a region of care to ensure person-centered recovery and financial success.

In support of these activities, the CSHCD included several transition steps within SCRSN's Quality Management (QM) Plan. In addition to using this QM plan as a tool for monitoring transition activity, the CSHCD created the Behavioral Health Organization Planning Committee. This committee is comprised of 12 to 15 individuals who are key to the transition design, plus community stakeholders, providers, and others as needed.

The role of the committee has been to assimilate information on the BHO transition as it becomes available, identify and implement resulting transition activities, as well as ensure and oversee communication of pertinent BHO transition information to applicable stakeholders. In support of the efforts, the committee was created, continues to monitor, and regularly updates a work plan for the BHO transition. This work plan includes key milestones with associated timelines to support the monitoring of progress. Regularly scheduled committee meetings are utilized to receive and report on these assigned duties in order to maintain accountability for a successful transition. Guided by information provided in meetings with DSHS and BHSIA, the committee identified early key areas of new responsibility and/or significant changes in current administrative structures or processes. These include BHO branding and marketing materials for stakeholder communication, creation of rate-setting methodologies, an enrollee and stakeholder communication plan, Information Technology (IT) enhancements to support data collection and reimbursement, creation of policies and procedures to administer SUD inpatient and residential services, and multiple activities to support the entire provider network throughout and beyond the transition.

While we have made significant progress toward meeting the contractual requirements effective April 1, 2016, this comprehensive plan also outlines outstanding activities to be completed and the timelines associated with those activities. Along with the required attestations, this plan is intended to demonstrate the SCRBHO's commitment to ensure ready access to both mental health and SUD services that are evidenced-based or best practices, as well as monitor and measure the outcomes of those services to confirm their efficacy. A significant step toward becoming a BHO has been the creation of an administrative structure that is built upon the existing strengths and expertise of both the CSHCD leadership and its BHO Planning Committee members. In addition, we have worked to ensure compliance with and throughout our contracting processes with providers, including payment incentives to assist in achieving or exceeding the goals of the contract. Lastly, through our role as a BHO, the SCRBHO recognizes the opportunities to engage consumer and family involvement within the system of care, improve upon current efforts to integrate primary care and behavioral health, and grow and strengthen the behavioral health workforce in both size and quality of care.

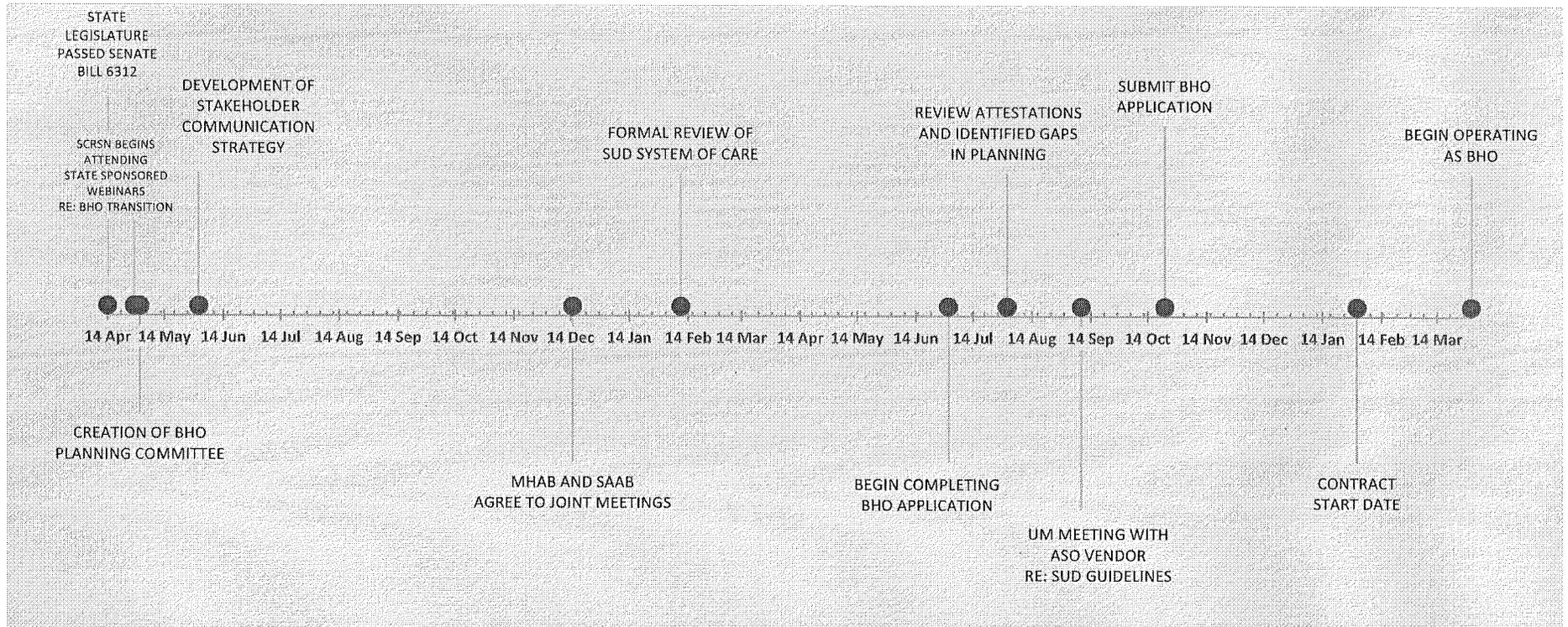
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Formation of the BHO Organizational Structure

In order to truly become an integrated BHO, with equal focus on the administration of mental health and SUD services, the current SCRSN organizational structure will be dissolved. In its place will be a new BHO organizational structure, incorporating the elements necessary for administration of the SUD services that are currently managed under the Substance Abuse Division. Currently, the Spokane BOCC is the governing board of the SCRSN. The SCRSN is advised by community volunteers, who serve on the 2 Mental Health Advisory Boards (MHAB) by appointment of the Spokane BOCC. Most MHAB members have received mental health services or have a family member with mental illness. The MHAB provides feedback and recommended solutions for identified needs and concerns expressed by individuals in treatment, their families, and providers. The MHAB advocates for fiscal stewardship and funding of quality resources to meet the community's mental health priorities. The administration of SUD services is advised by the Substance Abuse Advisory Board (SAAB), which consists of up to 12 members appointed by the Spokane BOCC. Members are chosen for their demonstrated concern for alcoholism and other drug addiction problems and are representative of the community. In preparation for April 2016, the Spokane County MHAB and SAAB have been meeting together for the past 10 months. In April 2016, when the boards merge into one board, individuals from the 7 counties will be solicited to represent their county on behalf of SUD services.

For comparison's sake, we have included the organizational chart for the CSHCD prior to the decision, Attachment 1, to apply as a BHO, as well as the new organizational structure, Attachment 2, which will be necessary to successfully integrate mental health and SUD services and position our BHO to move toward full integration with medical services. As the organizational chart reflects, the mental health and SUD administration are separated, with fewer resources allocated to the administration of chemical dependency benefits. This is due to the size of the state funding allocation, which has been between \$5 million – \$8 million, where the SCRSN is closer to \$85 million – \$100 million. Under the BHO's updated organizational chart provided in Attachment 2, there is integration of mental health and SUD administration under the Integrated Care Services Office. In addition, the SCRBHO allocated extra resources to meet the contractual requirements of the BHO. In addition to organizational structure changes, the existing Mental Health and Substance Abuse Advisory Boards began holding joint meetings, effective January 2015. The CSHCD is working with the Spokane BOCC to formally merge these advisory boards into 1 integrated advisory board, effective April 1, 2016.

Timeline for BHO Transition



- Timeline Acronym Key:**
- ASO (Administrative Service Organization)
 - BHO (Behavioral Health Organization)
 - MHAB (Mental Health Advisory Board)
 - SAAB (Substance Abuse Advisory Board)
 - SCRSN (Spokane County Regional Support Network)
 - SUD (Substance Use Disorder)
 - UM (Utilization Management)

II. Transition and Coordination of Services System

II. Transition and Coordination of Services System

One of the most significant areas of focus for the Spokane County Regional Behavioral Health Organization's (SCR BHO) planning and preparation in developing our Behavioral Health Organization (BHO) structure has been the transition of Substance Use Disorder (SUD) enrollees, providers, and administration of services into managed care. The SCR BHO planning process has included:

- Creating a process to identify the providers expected to become contracted network SUD providers on April 1, 2016;
- Working closely with our partners, including Managed Care Organizations (MCO) and current SUD providers, to ensure protection of the clients' confidential and Protected Health Information (PHI) compliant with Health Insurance Portability and Accountability Act (HIPAA) and Code of Federal Regulations (CFR) 42 Part 2;
- Creating an "Access to Care" process for each transitioning SUD client, to safeguard continuity of care;
- Establishing relationships with residential and inpatient providers to make certain the region is assured provider network adequacy;
- Engaging both existing and new providers in the planning process, including ongoing communication and updates about the transition;
- Updating provider contract language to reflect additional BHO requirements;
- Expanding collaboration with primary care providers and MCOs to initiate improved care coordination; and
- Development of new SUD reimbursement methodology and utilization management processes.

Our goal has been to create a seamless transition for clients and families while administratively becoming a fully integrated BHO. In support of the above activities, Health Management Associates (HMA) was engaged by the Spokane County Community Services, Housing and Development Department (CSHCD) in February 2015 to provide a strategic review and assessment of Spokane County's SUD system of care. Findings and recommendations from this comprehensive system review have been incorporated in the BHO planning and implementation activities as well as this section of our detailed plan.

2.019 Comprehensive Program of Treatment.

(1) Describe your system of care for substance use disorder treatment. Include specifically how it will include a full continuum of care, in accordance with ASAM levels of care as described in the PIHP Draft Contract that includes withdrawal management, residential treatment and outpatient treatment for youth, pregnant and parenting women, and adults.

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The SCRBHO is committed to continuing a robust and competent SUD provider network to ensure access to not only detoxification, residential treatment, and outpatient services but to also continue to offer additional evidenced-based services in the region. As previously stated, HMA was engaged by the CSHCD to provide a strategic review and assessment of Spokane County's SUD system of care. The review included:

- (1) An assessment of the continuum of care including all outpatient and inpatient SUD services;
- (2) A review of both the CSHCD SUD providers currently under contract with the CSHCD as well as inpatient providers currently reimbursed by the State of Washington's Department of Social and Health Services' (DSHS) Division of Behavioral Health and Recovery (DBHR);
- (3) An environmental scan of recent national and Washington state health care policy changes and trends, as well as emerging and best practices in SUD treatment, to provide context for the opportunities and challenges facing the SCRBHO;
- (4) Multiple interviews and site visits with SUD providers to gather information on the current SUD delivery system; and
- (5) A review of multiple documents and data sets provided by the CSHCD and its SUD provider network, as well as other relevant information within the public domain in order to inform and support any recommendation to the transition to a BHO.

The review findings indicated that the current Spokane County network of substance use providers has many strengths. Chief among them is the clear commitment and passion among the providers to serve individuals with substance use disorders. In addition, most providers have been innovative and industrious in their efforts to expand services within a highly restricted reimbursement environment. This demonstrates both a commitment to the population served as well as creativity in business approach to manage resources effectively. These providers have or are gaining additional licensure to provide mental health services and are looking at how to partner with physical health providers and initiate programs such as recovery housing, supported housing, and supported employment programming.

All providers, per a state mandate, utilize the American Society of Addiction Medicine (ASAM) criteria to determine placement and inform level of care, with separate placement criteria for adolescents and adults. Providers routinely reassess individual treatment-need utilizing the ASAM. Because the state supported (and county administered) service array is closely tied to the

ASAM levels, the system of care and services are also closely aligned. However, in some cases, these system driven structures have contributed to challenges individualizing treatment planning and care delivery, including lengths of stay.

The SCRBHO network will continue to provide access to a full continuum of SUD care, with services ranging from social and medical detoxification, traditional outpatient and intensive outpatient services (IOP), and residential/inpatient care. The SCRBHO will continue to provide access to additional specialty treatment including Methadone, Suboxone, and sobering. A full

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array of treatment services currently exists including childcare and transportation. HIP of Spokane County/Community Minded Enterprises (HIP/CME), a currently contracted provider, received a 3-year Access to Recovery (ATR) Substance Abuse and Mental Health Services Administration (SAMHSA) grant to begin providing Recovery Supports in Spokane County and neighboring counties, beginning August of 2015. Examples of recovery supports that HIP/CME will be able to provide to individuals include employment services and job training, sober housing assistance and services, peer-to-peer services, mentoring, and coaching, spiritual and faith-based support, utility, food, and transportation assistance. The table below depicts the current network providers and the SUD services offered. It is important to note that many of these providers offer additional services from those listed, as the table is focused solely on the services of immediate attention for Spokane County's role in administering currently available SUD benefits as a BHO.

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Table X. Overview of Spokane County SUD Service Array by Provider

PROVIDER AGENCY	Outpatient	Intensive Outpatient (IOP)	Co-Occurring (COD)	Detox/ Sobering	Inpatient	Opiate Substitution Treatment	Involuntary Treatment Act	Recovery Housing	Childcare	Transportation	Outreach
ADEPT Assessment Center	X (A)	X (A)						X (A)		X	X
American Behavioral Health Services					X (A)						
Community Detox of Spokane			X (A)	X (A,Y)			X	X (A)		X	X
Community Minded Enterprises									X		X
Daybreak Youth Services	X (Y)				X (Y)					X	X
Excelsior Youth Center	X (Y)	X (Y)	X (Y)		X (Y)					X	X
Healing Lodge					X (Y)						
Frontier Behavioral Health-ICOS			X (A)								
Lakeside Recovery Center	X (A)	X (A)				X (A)				X	X
NATIVE Project	X (Y)	X (Y)	X (Y)							X	X
New Horizon Care Centers	X (A)	X (A)			X (A)					X	X
Northeast Washington Treatment Alternatives (NEWTA)	X (A)	X (A)								X	X
Partners with Families and Children	X (A)	X (A)								X	X
Pioneer Center East	X	X			X (A)		X (A)				
Spokane Addiction Recovery Center (SPARC)	X (A)	X (A)	X (A)		X (A)					X	X
Spokane Public Schools	X (Y)									X	X
Spokane Regional Health District	X					X (A)				X	
YFA Connections	X (A)	X (A)	X (A)							X	X

A=Adults and Y=Youth

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The SCRBHO will have the opportunity to drive appropriate use of the full continuum of care through its Utilization Management (UM) processes. Practice guidelines will be utilized that promote the use of least restrictive, clinically-appropriate interventions prior to use of more intensive and often higher-cost services. Prior authorization requirements will not only screen for previous use of less restrictive intervention, but will also be applied in recommended intervals that ensure appropriate lengths of stay and adjustments to treatment strategies when individuals move (or don't move) along the continuum of recovery.

(3) Describe how you will address emerging substance use disorder challenges, such as new trends in opiate, methamphetamine or marijuana use and treatment.

The SCRBHO will identify and address emerging SUD trends utilizing multiple national and state sponsored resources. Specific examples of monitoring these trends include:

- Review of information gained from SCRBHO data collection and outcome reporting;
- Review of data and information shared through state and local monitoring and reporting by health departments, coroner's offices, DBHR, etc.;
- Results from the National Survey on Drug Use and Health (NSDUH), an annual survey sponsored by SAMHSA as this survey is the primary source of information on the use of illicit drugs, alcohol, and tobacco in the civilian, noninstitutionalized population of the United States aged 12 years old or older; and

In addition, the SCRBHO will use currently operating forums and meetings including Community Partners; Family, Youth, System Partner, Round Table (FYSPRT); and the Behavioral Health Advisory Boards to get stakeholder and community feedback regarding gaps in service delivery. The SCRBHO intends to be as responsive to identified community needs as possible within available funding resources.

In order to meet emerging challenges, Spokane County Regional Support Network (SCRSN) has demonstrated a commitment to Evidence-Based Practice (EBP) and has encouraged providers within the network to adopt specific models of care through training and technical assistance. In its role as BHO, the SCRBHO will evaluate if there are adequate fiscal resources to support identification and training of EBPs for emerging trends in SUD. As part of the previously discussed strategic review and assessment of Spokane County's SUD system of care, our contractor, HMA, provided information on emerging and best practices in SUD treatment. In addition, one of the main goals of requesting the assessment was to determine the degree to which EBP was being successfully implemented across the network. It was an important goal to obtain a baseline on this important factor as well as identify specific areas of growth as we prepared to move towards the BHO model. Our contractor, HMA conducted multiple interviews and site visits with SUD providers to gather information regarding the current use of EBPs in the SUD delivery system. A similar review is scheduled this calendar year (2015) for mental health providers within the proposed BHO mental health provider network. Information from these assessments is assisting the BHO to identify initial EBPs for possible targeted implementation

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within the region. The SCRBHO is currently identifying and developing internal practice guidelines for the utilization management system that promote the use of least restrictive, clinically appropriate interventions prior to use of more intensive, and often higher cost services.

All of the providers indicated use of some EBP models with acknowledgement that most were not using these to fidelity. It did not appear that use of EBPs was foundational for most programs, due to the lack of funding to support a fidelity model; however, EBPs were utilized as an additional tool. The emphasis on EBPs for SUD treatment is a relatively new concept that has been endorsed by the providers, but the absence of adequate funding to successfully implement has hampered the movement toward fidelity. All providers are aware of the need to move in that direction and have demonstrated their commitment by research and incorporating materials on their own. Our hope is that the SCRBHO will have enough available funds to address these issues and the associated cost. It is recognized by the SCRBHO, HMA, and the providers that some of the EBPs in use by the providers are outdated. There are also some programs that stand out as having strong curriculum that is grounded in EBP and had been specifically designed for the population served and the program design of the organization. However, more generally, there is a need for more purposeful engagement of evidence-based practice and training of Chemical Dependency Professionals (CDP) to engage effective treatments, particularly in individual sessions.

The system as a whole (all 7 counties, including any mental health funded co-occurring programs) would benefit from training and education on advancements in substance use treatment approaches as well as treatments and techniques that have been found to be effective.

The following is a grid of the current EBPs and promising practices that the current substance use disorder agencies provide. The grid represents 14 agencies that responded out of 17.

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Evidence-Based Practices in the Treatment of SUD	EBP used by providers; as reported	EBP used by providers; as tallied
12 Step Facilitation	7%	1
Adolescent Assertive Continuing Care	7%	1
Anger Management	7%	1
Anger Replacement Therapy	7%	1
Brief Strategic Family Therapy	7%	1
CBT	50%	7
CBT +	21%	3
Choice Therapy	7%	1
Community Reinforcement and Family Training	7%	1
Cognitive Processing Therapy for PTSD	7%	1
Contingency Management	14%	2
Co-Occurring Integration	7%	1
Crisis Prevention Intervention	7%	1
DBT	43%	6
Interactive Journaling	7%	1
Lifeskills Training	7%	1
Matrix	7%	1
Mental Health First Aid	7%	1
Mindfulness-based CBT	7%	1
Mindfulness-based stress reduction	7%	1
Moral Reconciliation Therapy	29%	4
Motivational Enhancement Therapy	36%	5
Motivational Interviewing	50%	7
MST for Substance Abusing Juvenile Offenders	7%	1
Opioid Treatment Program	7%	1
Parent Management Training	7%	1
Rational Emotive Behavioral Therapy	14%	2
Relapse Prevention	7%	1
Seeking Safety	14%	2
TCU Mapping Enhanced Counseling	14%	2
Therapeutic Community	14%	2
Thinking for Change	7%	1
WRAP	7%	1
Promising Practices Report in the Treatment of SUD	PP used by providers; as reported	PP used by providers; as tallied
Cognitive Relaxation Coping Skills	7%	1
Culture Curriculum-Animal Teachings	7%	1
Opioid Treatment Program	7%	1
Social Decision-Making/Problem-Solving	7%	1

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The SCRBHO plans to initially target the expansion of outpatient SUD EBPs with a goal and focus on improving the quality of outpatient care and reducing the length of stay in inpatient settings. We are pleased that the majority of the SUD providers are dually-licensed for mental health and SUD and many have psychiatric Advanced Registered Nurse Practitioners (ARNP). The SCRBHO will support the identification and training of EBPs if there are financial resources. To date, the mental health and SUD providers have implemented several EBPs with outside resources to obtain training and even fidelity reviews, for example, through DSHS or University of Washington. The provider agencies will be instrumental in identifying possible EBPs and training curriculums that fit with their populations and mission as an agency. The literature associated with EBPs provides direction on target populations or substances for these practices. The SCRBHO recognizes that many EBPs provide curriculum supports and intervention guidelines for use in practice and are available to providers. These tools can be essential in providing structure and quality assurance that were proven to achieving the practice outcomes cited in the evidence base.

The SCRBHO is committed to achieving widespread adoption of EBPs, as well as promising practices. Prior to a discussion of the EBPs that the SCRBHO will promote and support, it is important to acknowledge that EBPs do not exist for every service need or population served. In addition, the SCRBHO recognizes that the level of fidelity to an EBP model, in terms of both population focus and practice implementation, will impact its effectiveness when utilized. The U.S. Department of Health and Human Services' (DHHS) SAMHSA has made a commitment to connecting science to service through the promotion and use of EBPs. The SCRBHO will encourage providers to utilize current and future SAMHSA developed tool kits, including Treatment Improvement Protocols (TIPS), to assist community behavioral health agencies within our network to utilize EBP. SAMHSA has also implemented the National Registry of Evidence-Based Programs and Practices (NREPP), a searchable online registry of mental health and substance abuse interventions that have been reviewed and rated by independent reviewers. The purpose of this registry is to assist the public in identifying scientifically-based approaches to preventing and treating mental and/or SUDs that can be readily disseminated to the field. NREPP is another way that SAMHSA is working to improve access to information on tested interventions and encourage its practical application in the field. The SCRBHO will explore utilizing this resource as an ongoing process for the identification of new EBPs when populations or specific regional needs are identified.

Lastly, the State of Washington, through its Evidence Based Practice Institute & Washington State Institute for Public Policy, has made an investment in inventorying and providing access to a web-based catalogue of EBPs for providers. While the effort to date has been heavily focused on mental health, this initiative has provided technical assistance supports through white papers and the catalogue that we will leverage to support any future the SCRBHO efforts to promote the use of EBPs.

Evidence-Based Practices in the Treatment of SUD

The following treatment approaches are not intended to be a complete listing of EBPs in the treatment of SUDs; however, they represent a list endorsed by The National Institute on Drug Abuse and are taken directly from their *Principles of Drug Addiction Treatment: A Research-Based Guide (Third Edition)*. This guide rightfully points out that effective treatment programs typically incorporate many components, tailored to address the substance of use or abuse and the individual needs of a client. It is further worth noting that the evidence base for each EBP is often specific to a population, treatment for a specific drug class, or even within a particular setting. Achieving the outcomes demonstrated in the research is dependent upon fidelity to the model and linked to these variables. The summaries below represent EBPs being considered by the SCRBHO.

Adults and Older Adults

Cognitive-Behavioral Therapy (Alcohol, Marijuana, Cocaine, Methamphetamine, Nicotine)

Research indicates that the skills individuals learn through cognitive-behavioral approaches are often sustained after completing treatment. Current research focuses on how to produce even more significant effects by combining Cognitive Behavioral Therapy (CBT) with medication assisted therapy as well as with other types of behavioral therapies. A computer-based CBT system has also been developed and has been shown to be effective in helping reduce drug use following standard drug abuse treatment.

Contingency Management Interventions/Motivational Incentives (Alcohol, Stimulants, Opioids, Marijuana, Nicotine)

While controversial among some SUD treatment providers, research has demonstrated the effectiveness of treatment approaches using Contingency Management (CM) methods, which involve providing individuals rewards to reinforce positive behaviors.

Community Reinforcement Approach Plus Vouchers (Alcohol, Cocaine, Opioids)

Community Reinforcement Approach (CRA) Plus Vouchers combines an intensive 24-week outpatient therapy with the use of vouchers for treating individuals with addiction to cocaine and alcohol. Interventions include a range of recreational, familial, social, and vocational reinforcers, along with the vouchers, to demonstrate a how a substance-free lifestyle is not only possible but can be more satisfying than their substance use.

Motivational Enhancement Therapy (Alcohol, Marijuana, Nicotine)

Motivational Enhancement Therapy (MET) is a counseling approach that helps individuals recognize and resolve their ambivalence about engaging in treatment and addressing their substance use. This approach aims to induce rapid and internally motivated change, rather than amore paternalistic, clinician driven approach to the recovery process.

The Matrix Model (Stimulants)

The Matrix Model provides an approach for engaging persons with stimulant (e.g., methamphetamine and cocaine) abuse in treatment as well as assisting them in achieving abstinence. This model blends education about issues associated with addiction and relapse, becoming familiar and utilizing self-help programs, all while receiving direction and support from a trained SUD professional. Patients are also monitored for substance use throughout the course of treatment.

Dialectical Behavioral Therapy

While not included in the NIDA guide, Dialectical Behavior Therapy (DBT) is an evidenced-based treatment developed by Dr. Marsha M. Linehan for individuals with multiple and severe psychosocial disorders, including those who are chronically suicidal. Recognizing that many of these individuals also have co-occurring SUDs, DBT was further developed as an intervention for substance use disorders.

Medication-Assisted Treatment

Medication-Assisted Treatment (MAT) is the use of medications, in combination with counseling and behavioral therapies, to provide a whole-patient approach to the treatment of substance use disorders. Research has demonstrated that when treating SUDs, a combination of these medications and behavioral therapies is most successful. Some medications have shown success in reducing cravings and others are utilized to control withdrawal. There are several medications approved for use for both opioid and alcohol addiction. Medications used for alcohol addiction are Naltrexone (Vivitrol, ReVia), Disulfiram (Antabuse) and Acamprosate Calcium. Methadone, Buprenorphine, and Naltrexone are medications used in medically assisted treatment for opioid addiction.

Integrated Dual Diagnosis Treatment Model

The Integrated Dual Disorder Treatment (IDDT) model is an EBP for individuals with co-occurring severe mental illness and SUDs. As its name suggests, this approach integrates delivery of substance abuse services with mental health services, as opposed to collocating or separating care delivery.

Youth

Family Behavior Therapy

Family Behavior Therapy (FBT) is targeted at addressing not only substance use problems but other co-occurring problems as well. FBT combines behavioral contracting with contingency management and has demonstrated positive results in both adults and adolescents..

Multisystemic Therapy

Multisystemic Therapy (MST) can be utilized effectively to address the factors associated with serious antisocial behavior in children and adolescents who also abuse alcohol and other drugs.

Multidimensional Family Therapy

Multidimensional Family Therapy (MDFT) is rooted in the Multisystemic Family approach and provided in outpatient or partial hospitalization (day treatment) programs for adolescents with substance abuse or co-occurring substance use and mental health disorders, as well as those at high risk for continued substance abuse and other problem behaviors such as conduct disorder and delinquency.

Adolescent Community Reinforcement Approach

The Adolescent Community Reinforcement Approach (A-CRA) is another comprehensive substance abuse treatment intervention that involves both the adolescent and his or her family. It seeks to support the individual's recovery by increasing family, social, and educational/vocational reinforcers.

Dialectical Behavioral Therapy

While not included in the NIDA guide, Dialectical Behavior Therapy (DBT) is an evidenced-based treatment developed by Dr. Marsha M. Linehan for individuals with multiple and severe psychosocial disorders, including those who are chronically suicidal. Recognizing that many of these individuals also have co-occurring SUDs, DBT was further developed as an intervention for substance use disorders.

Medication-Assisted Treatment

Medication-Assisted Treatment (MAT) is the use of medications, in combination with counseling and behavioral therapies, to provide a whole-patient approach to the treatment of SUDs. Research has demonstrated that when treating SUDs, a combination of these medications and behavioral therapies is most successful. Some medications have shown success in reducing cravings and others are utilized to control withdrawal. There are several medications approved for use for both opioid and alcohol addiction. Medications used for alcohol addiction are Naltrexone (Vivitrol, ReVia), Disulfiram (Antabuse) and Acamprosate Calcium. Methadone, Buprenorphine, and Naltrexone are medications used in medically assisted treatment for opioid addiction.

Integrated Dual Diagnosis Treatment Model

The Integrated Dual Disorder Treatment (IDDT) model is an EBP for individuals with co-occurring severe mental illness and substance use disorders. As its name suggests, this approach

integrates delivery of substance abuse services with mental health services, as opposed to collocating or separating care delivery.

Special Considerations in Treatment for Youth

In a joint Center for Medicaid and CHIP Services (CMCS) and SAMHSA letter to states in January 2015, the agencies noted that unlike other populations with behavioral health conditions, there is a lack of guidance regarding the treatment, continuing care and recovery supports needed for youth with SUDs or youth with SUDs and co-occurring mental health disorders. The letter went on to say that because the growing body of research on youth with SUDs had not been systematically collated, reviewed and translated into practice guidelines, SAMHSA convened a technical expert panel comprised of nationally-recognized researchers to review the existing literature and utilize a structured process to identify what the research says about treatment and recovery services for youth with SUDs. The technical expert panel members agreed that practice must be rooted in the emerging neuroscience research in conjunction with the ever-growing psychosocial treatment effectiveness research. The group also stressed that treatment approaches must be developmentally appropriate and incorporate an understanding of the importance of family. The following services represent selected components of a continuum of treatment and recovery services and supports for youth with SUDs.¹

Outpatient (includes partial and intensive outpatient programs): MAT, MAT/CBT, and family-based treatments each have shown effectiveness for treating youth with SUDs. In a recent meta-analysis looking at the effectiveness of youth outpatient treatment for SUD, the results indicated that family therapy programs were found to be more effective than other categories of treatment and that longer treatment duration was associated with smaller improvements.²

Medication-Assisted Treatment: There is evidence that in studies with youth, that MAT has been shown to work best in conjunction with psychosocial treatments and they supported that both counseling and case management should be used to facilitate symptom monitoring and medication adherence in youth with SUDs.³ In addition, the Food and Drug Administration (FDA) has approved buprenorphine for opioid dependent adolescents age 16 and older.

Continuing Care: The SAMHSA technical expert panel members found that continuing care should be provided for all youth who enter treatment for SUDs regardless of treatment completion” and that “continuing care initiation within 2 weeks of leaving treatment improves outcomes for youth with SUDs. The panel further stated that there should be an emphasis on providing youth a choice of continuing care services provided in a variety of settings.^{4 5}

¹ Joint CMCS and SAMHSA Informational Bulletin, January 26, 2015. [Link to Bulletin](#)

² Tanner-Smith, E.E., Wilson, S.J., Lipsey, M.W. (2013). The comparative effectiveness of outpatient treatment for adolescent substance abuse: A Meta-analysis. *Journal of Substance Abuse and Treatment*, 44(2), 145-158.

³ SAMHSA, What does the research tell us, p. 45

⁴ SAMHSA, What does the research tell us, p. 51

⁵ Joint CMCS and SAMHSA Informational Bulletin, January 26, 2015.

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Recovery Services and Supports: Examples include peer support, technology-based supports such as chat rooms and texting, as well as parent and caregiver supports.

Residential Treatment: Most effective for youth who need detox as well as for providing high intensity services for youth with substance use or co-occurring substance use and mental health disorders.

Opiate Substitution Treatment – program certification by department, department duties – definition of opiate substitution treatment. (50)

Describe your use of Medication Assisted Treatment Therapies.

MAT is the use of medications, in combination with counseling and behavioral therapies, to provide a whole-patient approach to the treatment of SUDs. Research has demonstrated that when treating SUDs, a combination of these medications and behavioral therapies is most successful. Some medications have shown success in reducing cravings and others are utilized to control withdrawal. There are several medications approved for use for both opioid and alcohol addiction. Medications used for alcohol addiction are Naltrexone (Vivitrol, ReVia), Disulfiram (Antabuse) and Acamprosate Calcium. Methadone, Buprenorphine, and Naltrexone are medications used in medically assisted treatment for opioid addiction.

The CSHCD currently contracts for 2 MAT Therapies that include Opiate Substitution Treatment (OST) and Buprenorphine (Suboxone) Treatment. The OST program consists of the dosing of Methadone in conjunction with case management, group therapy, and individual therapy for adults aged 18 and older. The Opiate Substitution Treatment program is delivered by the Spokane Regional Health District (SRHD) and has increased from 50 county-funded and Medicaid individuals in 2005 to a current caseload of 519 Medicaid enrolled individuals. The SRHD has an addictions certified physician and has Outpatient Chemical Dependency Licensure to allow them to begin a pilot Suboxone program. The Suboxone program will initially serve individuals who are either private pay or have commercial insurance coverage.

In 2005, Spokane County began a pilot Suboxone program with Lakeside Recovery Center. Lakeside Recovery Center has Memorandums of Understanding with local prescribing physicians who administer the medication, and Lakeside Recovery Center provides case management, group therapy, and individual therapy to the individuals served. The pilot began with 15 county-funded individuals and has now increased to 115. Lakeside Recovery Center has recently hired a physician to increase capacity and provide for better treatment coordination and communication. This program is for adults aged 18 and older.

Within the region, the 6 rural and frontier counties that will be a part of the SCRBHO currently do not have OST or Suboxone programs and will utilize the services offered in Spokane County.

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The 2 agencies currently contracted to provide OST and Suboxone programs have indicated that they intend to acquire mental health licensure and be dually licensed prior to April of 2016. This will allow both programs to further meet the recovery needs of individuals within their programs. The SCRBHO is exploring the possibility of expanding multi-agency treatment within the region if there is available funding and provider capacity to do so.

Evaluation by designated chemical dependency specialist - when required - required notifications. (29)

Describe how you will assure that required evaluations and notifications are performed. Include all agreements and arrangements in-place or planned with all entities with shared responsibility for administration, i.e., CDPs, jails, courts, and Department of Corrections.

In Spokane County, individuals referred to this program are gravely disabled as a result of chemical dependency and are in need of intensive case management and an intensive treatment program with a higher security level than traditional inpatient treatment facilities. Individuals may be referred under several different instances: When an assessment indicates the individual presents a likelihood of serious harm or is gravely disabled as a result of chemical dependency addiction; The individual has been admitted for detoxification, sobering services, or chemical dependency treatment twice or more in the preceding 12 months, pursuant to Revised Code of Washington (RCW) 70.96A.140 and is in need of a more sustained treatment program; or The individual is chemically dependent, has threatened, attempted, or inflicted physical harm on another, and is likely to inflict physical harm on another unless committed. A refusal to go to treatment, by itself, does not constitute evidence of lack of judgment, as to the need for treatment.

Involuntary Treatment Act (ITA) services are provided by staff at Community Detox Services of Spokane, which also administers a social Detox, Sobering, and Co-Occurring program. The ITA specialist is very well versed in community resources and has a good relationship with community partners, including Spokane County Jail and provider agencies.

Services include a referral for financial assistance application for any individual who does not have Medicaid or Medical Care Services medical coverage. A screening to determine if the initial needs of the individual would be better served by placement within the mental health system and appropriate referrals. A chemical dependency assessment is done and arrangements for treatment in an appropriate agency are made. Also, the preparation of a Petition for Involuntary Commitment pursuant to the requirements of RCW 70.96A.140 is done. The contracted provider assures secure transportation to and from treatment for all individuals committed pursuant to RCW 70.96A.140.

Staff who provide ITA services are designated as an ITA Specialist by the CSHCD Human Services Program Manager for the Substance Abuse Treatment Division and the designation

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form is retained in the personnel file of all designated staff. Staff must maintain CDP status in the State of Washington and seek to fulfill annual training requirements that specifically assist in understanding the needs of incapacitated or gravely disabled individuals. The current primary ITA Specialist is dually credentialed and has a Master's degree in mental health.

The ITA Specialist convenes a committee of collaborating agencies and programs serving the individuals who are referred to this program, which meets a minimum of 8 times per year to address the treatment needs of persons who have been admitted for detoxification or treatment 2 or more times in 1 year, pursuant to RCW 70.96A.140, and to initiate involuntary placement for anyone admitted to detoxification 5 or more times in 90 days. The SCRBHO intends to continue the same process, as described above until legislative actions mandate authority revises the system. Attachment 3 is a copy of our current Statement of Work (SOW) with our provider regarding ITAs.

Address advisory board membership in compliance with Exhibit F, BHO Advisory Board Membership. (47)

Since December of 2014, the Mental Health Advisory Board (MHAB) and the Substance Abuse Advisory Board (SAAB) for Spokane County have met together on a combined agenda, with each taking turns as host. This was a decision supported by both of the boards as the SCRSN moves towards BHO implementation in April of 2016. The boards felt that it would give them an opportunity to share and learn from one another and to take on the broader focus of integrated behavioral health.

The current SAAB has individuals who self-identify as being in recovery from SUD and who come from a variety of different backgrounds representing the geographic and demographic population mix of Eastern Washington. Each member brings a belief in recovery and endorses treatment and recovery support options that will help individuals in the community access the services they need to live productive and healthy lives. There are no contracted providers or staff of contracted providers on the board. At this time, each member has expressed an interest in remaining on the board once combined as a single BHO Advisory Board.

Lincoln County is the only county in our Regional Service Area with an active SAAB, and they have indicated that they may continue their local board in addition to the SCRBHO combined board. Pend Oreille County chooses to convene community stakeholder meetings to specifically address substance abuse issues, as needed (e.g., potential closure of the program, Strategic Plan, 1/10th tax, etc.). Otherwise they utilize the Prevention Community Coalitions and more recently, the County Health Coalition to discuss substance abuse needs/issues for the county.

Current board members of both the MHAB and SAAB will be given the opportunity to continue to serve in an advisory position with the new SCRBHO board if they choose to do so. In addition, the SCRBHO plans to recruit from each rural county for representation. The current MHAB has law enforcement and tribal membership and both boards have 3-year term limits,

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therefore, blending of the 2 boards will meet the requirements outlined in Exhibit F of the Detailed Plan Request.

The meeting location will be rotated due to the amount of travel for members in rural counties. Board changes will require a total of 4 resolutions from the Spokane County Board of County Commissioners. A resolution to dissolve the current MHAB, a second resolution to dissolve the current SAAB, a third resolution to form the new BHO board, and a final resolution to form new bi-laws for the newly created SCRBHO Advisory Board. It is not anticipated that these resolutions will meet with any disagreement and will be accomplished prior to April 1, 2016. A list of our current board members and the counties they represent is included below.

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**Spokane County Community Services, Housing,
and Community Development Department
BEHAVIORAL HEALTH ORGANIZATION ADVISORY BOARD**

Sara C.

Spokane County – Mental Health

Craig D.

Spokane County – Mental Health

Floyd L.

Spokane County – Mental Health

Melissa G.

Spokane County – Mental Health

Randi O.

Spokane County – Mental Health

Kari R.

Spokane County – Mental Health

Cindy R.

Spokane County – Mental Health

Bradford T.

Spokane County – Mental Health

Harold W.

Spokane County – Mental Health

Clinton A.

*North Central (Okanogan Co.) –
Mental Health*

Ronald B.

North Central (Ferry Co.) – Mental Health

Ann D.

*North Central (Stevens Co.) –
Mental Health*

Theodore J.

*North Central (Lincoln Co.) – Mental
Health*

Daniel P.

*North Central (At-Large) – Mental
Health*

John W.

*North Central (Pend Oreille Co.) –
Mental Health*

Darrell L.

Spokane County – Substance Abuse

Michael M.

Spokane County – Substance Abuse

Angela M.

Spokane County – Substance Abuse

Robert P.

Spokane County – Substance Abuse

Kurtis R.

Spokane County – Substance Abuse

David S.

Spokane County – Substance Abuse

Kimberley T.

Spokane County – Substance Abuse

Special Funding Streams for SUD

The SCRBHO recognizes the various funding streams supporting SUD services with our region and that these funding streams have specific population focus as well as other funding specific requirements.

Describe how you will ensure substance use disorder treatment services are provided to persons enrolled in substance use disorder treatment under the criminal justice treatment account. Describe how you will develop your local plan in conjunction with the stakeholder groups described in this section and as described in the draft PIHP contract. (48)

The CSHCD Substance Abuse Division, currently facilitates quarterly meetings with the local Criminal Justice Treatment Account (CJTA) Workgroup Panel as outlined in RCW 70.96A.350. In 2013, the CSHCD worked with the local CJTA panel to update the local workgroup plan which was submitted to DBHR and is still being used by the local panel. Since the implementation of Substitute Senate Bill (SSB) 6312 in 2014 CSHCD has been informing and engaging the panel in discussions and planning for the expected changes effective April of 2016. This local panel includes representatives from the state identified parties of interest including CSHCD, Spokane County Behavioral Health Adult Felony Therapeutic Drug Court, prosecuting attorneys, defense attorneys, County Sheriff, and SUD treatment and childcare providers.

The Spokane County Behavioral Health Adult Felony Therapeutic Drug Court currently contracts with an outpatient provider who receives the CJTA and Drug Court funding to serve the individuals involved with Drug Court as well as individuals who meet criteria for CJTA funded treatment funded by Spokane County. As the SCRBHO, and in conjunction with the CJTA Workgroup Panel, we will review reports of the services provided to the target population, monitoring their effectiveness and responsiveness of treatment in meeting the needs of individuals who meet criteria for CJTA funded treatment.

In those instances when the sole provider has indicated a surplus of funding, the CSHCD has asked the local panel for approval to move surplus funding to other Spokane County adult outpatient providers to treat individuals who meet criteria under RCW 70.96A.350. The other 6 counties who will fall under the BHO currently do not have Therapeutic Drug Courts and they are using CJTA funding to treat individuals who meet the criteria under RCW 70.96A.350.

It is the understanding of SCRBHO that CJTA and Drug Court funding will be allocated to the BHO for continuance of Drug Court and CJTA treatment services within the BHO's service area. The SCRBHO will continue to have a presence on the local Spokane County CJTA Workgroup Panel as well as any other Drug Court panels that may be established in the other 6 counties. The funding is categorical and will continue to be used to support individuals in Drug Court and those who meet the eligibility criteria outlined in RCW 70.96A.350. It is also the intent of

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SCRBHO to continue to support the Innovative Project at Geiger Correctional Institution (a CDP stationed at Geiger who performs SUD assessments, referrals, and core coordination for inmates to SUD inpatient and outpatient programs) if the local panels approves.

Transition and Coordination of Services for Youth

In addition to offering access to Wrap-Around with Intensive Services (WISE) Teams, which is discussed further in the plan, the SCR BHO recognizes that there are circumstances for some enrollees that require special consideration and support.

Petition for one hundred eighty-day commitment - hearing - requirements - findings by court - commitment order - release - successive commitments. (231)

(1) Describe how you coordinate with the CLIP Administration

The SCRSN works with the Children's Long Term Inpatient Program (CLIP) Administration from the initiation of a CLIP referral through discharge for both involuntary and voluntary placements. Spokane County has one of the 4 CLIP facilities in their county (only for youth 12-18 years of age). Because of this, and the geographical distance for other youth needing CLIP treatment, the CLIP Coordinator and SCRSN Children's Care Coordinator maintain close communication when looking at placement barriers to placement (e.g., family involvement, transportation, geographical distance) and plan ways around these barriers as to not delay admission.

When the acute care psychiatric hospital has decided that there are no other viable less restrictive options to CLIP and the youth is placed on an involuntary order for CLIP, the SCRSN Children's Care Coordinator alerts the CLIP Coordinator and the outpatient provider to the recommendation for CLIP and works on the best placement option available. The CLIP Coordinator then schedules with the outpatient provider, family, SCRSN Care Coordinator, CLIP provider, and attending hospital a preplacement meeting to work through placement logistics.

For the last 4 years, the SCRSN Children's Care Coordinator has attended the CLIP Improvement Team (CLIP-IT) with other RSN Care Coordinators, the CLIP Administration, and state and local family representatives to work on issues as they relate to CLIP admissions and continued stay and discharge. CLIP IT works collaboratively to eliminating barriers to mental health treatment for youth and involving cross-system leaders across child-serving systems as needed.

(2) Describe the process for identifying alternatives to commitment.

The SCRSN Children's Care Coordinator works with the local acute care psychiatric hospital staff to look at alternatives to CLIP treatment when it is appropriate. Many times alternatives are found with the understanding that if the youth continues to require hospitalization, they would

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then be put on the “inactive list” for CLIP, which allows the youth to maintain on the CLIP list while being discharged to the Least Restrictive Alternative (LRA) as a “safety net” in case the alternative plan does not work to stabilize the youth.

In instances when the community and the hospital are looking for less restrictive resources to divert youth from CLIP, the SCRSN Children’s Care Coordinator will coordinate and facilitate the Children’s Intensive Resource Task Force. This is a committee comprised of cross-system partners who meet with the youth, family, and their outpatient team to look at alternative resources including CLIP when appropriate. This task force serves as the local “CLIP Committee.” However, the group strives to come up with resources to divert placement into CLIP and keep the youth within their natural setting with enhanced resources to help them stabilize in their community.

The SCRBHO will continue to work closely with the CLIP Administration, CLIP Coordinator, acute care psychiatric hospitals, and outpatient providers to ensure that youth who are in need of long-term hospitalization are receiving care at the appropriate time, in the appropriate place, and for the appropriate duration to allow the youth to return to their community with a seamless stepdown plan. For youth who are able to be diverted, the SCRBHO will continue to work with the hospitals and outpatient programs to assist youth with intensive resources to help them stabilize in their community.

Describe how you will coordinate, assess and monitor intensive community services and coordinate with inpatient/residential resources. (234)

The SCRSN and contracted providers assist the community hospital and CLIP with intensive resources that build upon each youth’s strengths and resiliency for treatment in the least restrictive setting possible. Many times when a youth is placed on an LRA, it is recommended that the primary therapist refer to ancillary crisis diversion resources as part of a “stepdown” from the community hospital. Similarly, when a youth is discharged from a CLIP course of treatment, the youth is discharged with intensive resources to help with a comprehensive and strength-based discharge plan.

When the discharge from a community/CLIP hospital requires a higher level of intensity, the hospital, outpatient provider, and/or the family can refer to the Children’s Intensive Resource Task Force. The Spokane County Children’s Intensive Resource Task Force is a community advisory group whose purpose is to provide resource recommendations to help keep children and adolescents in their home community whenever possible. The Task Force provides information, community resource recommendations, and serves as the local approval process for Voluntary CLIP treatment (when appropriate)

The core membership of the Task Force consists of youth, family, natural supports, mental health providers, Psychiatric Center for Children and Adolescents (PCCA)/Providence Sacred

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Heart Medical Center & Children's Hospital, Spokane Public Schools, Children's Administration, the SCRSN, Juvenile Court, and Developmental Disabilities Administration (DDA). Other stakeholders who may attend are the treating inpatient and/or outpatient psychiatric medication manager, youth advocate, law enforcement, primary medical doctor, chemical dependency treatment provider, and state CLIP Coordinator.

The Spokane County Children's Intensive Resource Task Force convenes when a meeting is requested for intensive resources and treatment consultation for youth with complex mental health needs and multi-system involvement, a psychiatrically hospitalized youth's treatment team (community hospital or CLIP) is looking at resources to aid in discharge planning, a cross-system planning is needed for youth and families with complex needs and to support (whenever possible) the youth to continue to be served in their home community or a voluntary CLIP request is made.

The SCRBHO will continue to work with the hospitals and outpatient providers to develop family-centered plans, using our resources to help youth stabilize in their home with enough supports to help them be successful. The Children's Intensive Resource Task Force will continue to meet with youth and families to develop plans to help with discharge planning.

Development and Implementation of WISE Service Programs

Providers and families have been excited to see that the SCRSN was able to provide access to 2 WISE programs in May 2015, and the following section will discuss the implementation and planning for future WISE programs in detail.

Based on the WISE Capacity Expansion document attached as Exhibit G. As of April 1, 2016, what caseload capacity will the BHO have to provide WISE? What is the plan for the BHO to meet the FY16, June 30, 2016 WISE monthly capacity goal? (158)

Currently, the SCRSN has 2 pilot WISE programs in Spokane County that were implemented in May 2015. DBHR was given notice that the SCRSN wanted to implement WISE in July 2017 with plans to pilot the program prior to region-wide implementation. As of July 2015, DBHR included our 2 pilots as a part of our capacity requirements.

While both programs have been responsive to their individual regional needs, including the provision of 24/7 crisis services for their caseloads, maintaining proper staffing has proven a challenge. One team required 6 months to become fully staffed, while another faced challenges with staff turnover.

The SCRSN has encouraged collaboration and provided significant training to support service delivery, data reporting, and troubleshooting challenging cases within this new model of care. Additional teams would require the hiring of another Care Coordinator.

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In early September 2015, DBHR provided the SCRSN with the expected number of teams to implement by April 1, 2016. At that time, the SCRSN notified DBHR of our concerns regarding the cost, implementation challenges, our need to engage in a Request for Proposal (RFP) process with providers to solicit teams, and potential workforce issues. There are issues other than the RFP, a primary one being the lack of funds to provide the services because the Medicaid rates for the SCRSN, under the lower bound, are \$1 Million less per month. On August 27, 2015, DBHR notified the RSNs to expect another significant reduction with specific impact to be shared in October 2015. This impact to the BHO's operating budget will factor into capability for WISE expansion. We know our cost per team is approximately \$400,000 per year. If we do not have enough Medicaid funding and need to cut existing services the Spokane BOCC will decide how that is presented to our community. Due to these challenges, the SCRBHO believes the caseload capacity that will be in place April 1, 2016 will remain at 2 teams.

The SCRSN believes that WISE is an excellent program for those individuals that need the service and that the program would help some of the child/adolescents to avoid inpatient facilities. Today, we have 18 children who could benefit from WISE if other teams were in place. While we have at least one agency that wants to implement WISE, this would require elimination of an existing program that is valuable in addressing the needs of children and families prior to needs escalating to a higher level of care. We have determined that a full review of our agencies mental health programs is needed to assist in making determinations on prioritization of programs and services. This review is expected to occur prior to April 2016. The SCRBHO has engaged HMA, who completed the assessment of our substance abuse system of care, to provide the review and recommendations associated with funding and service priorities. Their review may also assist greatly if we have to discontinue some of our other programs (children or adult) in order to meet the requirements for the number of WISE teams. We expect by June 2016 that we will know how many teams we can expand within the coming months. It will be based on both clinical need and the ability to adequately pay for the teams.

Transition and Coordination of Services with Other Stakeholders

The following responses provide information on how the SCRBHO will manage transitions with other BHOs, coordinate care with courts, city and county jails, and support overall coordination of care between our provider network and primary care, as well as the BHOs.

Discuss how your transfer process to ensure a seamless and safe transition in services, including the sharing of information. Discuss how your transfer process will work with a region that is fully integrated and is not managed by a BHO. (187)

The SCRSN maintains a strong collaborative relationship with the RSNs from across Washington State. The SCRBHO will leverage these relationships to maintain seamless transfers of individuals between BHOs, maintaining continuity of care for enrollees. The RSNs currently have an Inter-RSN Transfer Protocol and transfer form for individuals transferring from or to participating RSNs within the state. The Eastern State Hospital Consortium Agreement has a

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process and a form for transfers between RSNs and that process will be the foundation to determine how transfer will occur for SUD individuals, beginning April 1, 2016. The form and processes will be updated before April 1, 2016 to support BHO to BHO transfers as well as those to the managed care organizations that are involved in the early adopter process. Approximately, 99.9% of the transfers originate from hospital or jail discharges. A person needing outpatient and moving from one RSN to another does not go through the inter-RSN transfer document. Instead, they are dis-enrolled from the current RSN to the new RSN of residence within the state data system and will be paid to the new RSN.

Specific to requests from one BHO to another for a person to transfer enrollment, the SCRBHO is committed to work together with referring and receiving BHOs to plan for continuity of care. Several different individuals are involved in the transfer planning to ensure a safe and appropriate handoff. Transfer planning actively includes the enrollee and family and focuses primarily on maintaining access to medication, gaining appointments with new providers, sharing of pertinent medical history (with proper releases signed) and review, and updates to the treatment plan. In cases where transfers take place from an inpatient facility, transportation and housing may also be arranged. The SCRBHO, in advance of the proposed discharge or transfer, will contact all parties involved, including but not limited to, the enrollee, social worker or case manager, hospital treatment team, outpatient treatment provider, and care coordinators from the sending and receiving BHO. The discharge plan and/or treatment plan will be reviewed to assist with the transfer. This process will also include contact and enrollment with the appropriate new outpatient provider. Residential placement will be discussed if appropriate.

Provide copies of any agreements with jails or plans for agreements with jails. (174)

Spokane County currently has two agreements in place with local jails:

1. Memorandum of Understanding (MOU) Agreement 0961-68399, which ended June 30, 2014 and is still being negotiated with DSHS, Region I Community Services Division; and,
2. The SCRSN agreement for contracted services by a Behavioral Health Agency that operates within Spokane County Detention Services (Jail) and works with DSHS, Region I Community Services Division on behalf of the inmates. This agreement includes assistance with financial eligibility as the inmate is discharged.

Please see Attachment 4 and 5 for copies of these 2 agreements. The SCRSN does not anticipate there will be other agreements and that these 2 agreements will remain in place.

Describe your current process for discharge planning and describe how you would propose transitioning that process to meet the requirement to work with the hospital to develop an individualized discharge plan and arrange for a transition to the community in accordance with the person's individualized discharge plan within twenty-one days of the determination by July 1, 2018. (124)

The SCRSN works closely with inpatient providers to ensure a seamless transition from inpatient hospitalization to the community. The SCRSN Care Coordinators track enrollees' progress while hospitalized, attend regular discharge planning meetings with the inpatient facility staff, and work closely with facilities and community providers to develop individualized discharge plans.

The SCRSN Care Coordinators review the Eastern State Hospital weekly discharge roster and attend biweekly discharge planning sessions, which allow the SCRSN to understand the progress of individuals in treatment at the hospital and to begin discharge planning for enrollees upon admission. Similarly, the SCRSN Care Coordinators review the daily census and status of individuals with mental health conditions placed at Providence Sacred Heart Medical Center to facilitate discharge planning. They also attend weekly discharge meetings at all Spokane inpatient psychiatric facilities in order to prepare for individual needs, as they transition back into the community. The North Central counties' providers utilize phone calls to appropriate inpatient facilities. Northeast Washington Alliance Counseling Services (NEWACS) has a person stationed in Spokane.

In addition to the facility-specific discharge planning, the SCRSN hosts a weekly meeting with multiple outpatient, residential, and detoxification providers to discuss individual, discharge-planning needs across the system of care. Part of the goal of this meeting is to plan for and set up pre-placement visits in hospital intakes, as well as in hospital face-to-face visits between the discharging entity and the community-based organization to enhance collaboration prior to the individual's transition. Additional community stakeholders are invited to the meeting on a case-by-case basis when individualized needs require other forms of support.

The primary goal of this close care coordination is understanding individual enrollees' symptoms, progress, and response to treatment. This provides a foundation of information to ensure that community-based treatment planning takes advantage of lessons learned in the acute setting and that the next phase of treatment continues care in a stepwise fashion supporting the individual's recovery. As part of the process, enrollees meet with the SCRSN Care Coordinators to articulate their goals in treatment, to ask questions, and to raise concerns about their transition back to the community. The SCRSN Care Coordinator and the enrollee discuss the causes for hospitalization and any specific supports that could prevent this kind of episode in the future, working to create a Wellness Recovery Action Plan (WRAP) outpatient providers can build upon to support and help the individual remain in the least restrictive setting.

The SCRSN Care Coordinators also look at other components of discharge planning that can be individualized to meet the individual's specific needs. These include examination of provider-

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specific programming that is a good fit for the individual's needs, evidenced-based models to recommend, timeframes for specific components of care (such as more frequent psychiatric support if needed), engagement of peer supports, and closer engagement of other social supports such as family, friends, and other natural supports. These supportive factors are particularly important to consider for individuals involuntarily committed in order to build individual engagement in treatment and support a move from involuntary treatment to a more active participation in one's care. Maximizing options and giving individuals choices, in creating the discharge plan, is important for individuals involuntarily committed and can be a key step for them in choosing to engage in treatment.

When individuals are hospitalized outside of the SCRSN region, the SCRSN Care Coordinators coordinate care with local, Spokane primary-providers, family members, and residential providers to ensure a smooth transition. If needed, the SCRSN Care Coordinator works to find a community step-down program such as the Evaluation and Treatment (E&T) facilities, particularly for individuals requiring enrollment and Medicaid application assistance.

As the SCRSN transitions to the BHO, there are 3 primary goals in enhancing individualized discharge planning for individuals with involuntary commitment. The first is to improve capacity and infrastructure to support quality discharge planning regionally and for enrollees who receive services across the state. The SCRBHO will continue to work with local acute and long-term hospitals to guarantee that individuals and their families participate in discharge planning and identify specific treatment components that will support successful re-entry into the community. The SCRBHO believes its Care Coordinators provide an important intermediary role between inpatient settings and the community and can ensure that the central focus remains on individual enrollee needs and goals for recovery. An additional Integrated Care Coordinator is currently being recruited to assist with increasing discharge planning capacity by April 2016.

The other major enhancement for the SCRBHO is to improve integration of mental health and substance use treatment needs within individualized discharge plans. Many enrollees who require inpatient care, particularly involuntary treatment, have co-occurring mental health and substance use conditions. In the past, these conditions were treated separately with the most acute condition receiving the immediate attention. Moving forward, the SCRBHO will support plans that address co-occurring treatment in the design of the discharge plan. In addition, the SCRBHO will facilitate improved provider network collaboration on implementing the discharge plan and coordinating treatment. This may require the SCRBHO to work with providers on being flexible to ensure that the transition process is genuinely individualized.

Lastly, as the SCRBHO focuses on improved adoption of EBPs across the system of care, they will examine and encourage providers to use best practice techniques and other innovations for transitions in care and enhancing individual engagement. For example, peer programming can be incredibly valuable for individuals leaving an inpatient setting and has been shown to assist

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individuals in moving from involuntary treatment to voluntary treatment. The SCRBHO is committed to continual examination of programming and incentivizing providers to use the most effective treatment approaches.

Fully describe how you will coordinate services with the health care system in compliance with this provision, the PIHP contract and good practice. Provide agreements, proposed agreements and policies and procedures. (280)

The SCRSN's support and coordination of physical and mental health care services for Medicaid enrollees has been in place for several years within the provider agencies, the SCRSN Care Coordinators, and the Authorized Service Organizations (ASO) responsibilities. The SCRSN has not been able to fully focus on coordination of primary health care and SUD services for individuals since the contract has been between the counties' Substance Abuse Divisions and DBHR.

The SCRSN has existing Operating Agreements or MOUs with the 5 MCOs that provide services to the Medicaid population in Spokane County. These agreements will be updated to reflect the counties the BHO will represent and to include Medicaid enrollees receiving services for SUDs. Currently, Spokane County has been meeting with the MCOs to discuss the collaboration regarding the enrollees we share and how we can work together successfully. In September 2015, all the RSN Administrators met with all the MCOs for a half a day to ensure health care coordination. Some of the joint activities the SCRBHO has contractually engaged in with MCOs include further development of additional guidelines and operational procedures that will enhance the bi-directional care coordination between entities. The areas to be addressed include but are not limited to the following:

- Confirmation each enrollee has an ongoing source of primary care;
- Referral Procedures;
- Screening Guidelines;
- Notification of Admissions to inpatient or residential care;
- Care Transitions/Discharge Planning from Institutional Care;
- Continuing Care Transitions;
- Care Management and Coordination;
- Performance Measures and Improvement Processes;
- Notifications of Emergent Care;
- Data Sharing;
- Dispute Resolution; and
- Notification of Critical Incidents.

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The April 1, 2016 provider contracts will also include language regarding the coordination of primary and behavioral health care for all enrollees. Contract language currently exists in the mental health provider contracts but not in the current substance abuse contracts. The language will require that Medicaid enrollees are linked to a primary clinician provider. Information regarding assessment of needs and services will be shared through appropriate enrollee release of information. In the other 7 counties, under the SCRSN region of care, both substance abuse and mental health provider agencies are administered under a single Director, further enabling behavioral health coordination. All but one of the rural counties have signed agreements with the managed care companies and report that their collaboration is working well.

In 2015, the SCRSN surveyed the SCRSN mental health and SUD providers in the SCRSN region of care to determine its progress toward integration and collaboration of care. The survey results show excellent movement and efforts to integrate medical with behavioral health and over half of the providers have signed agreements with MCOs for collaboration and services. The SCRBHO will continue to promote the collaboration and coordination of care throughout the system as it moves toward fully-integrated health care. Attachment 6, 7, 8, 9, and 10 are copies of our MOUs with 5 health plans.

The SCRBHO has developed 2 policies specific to coordination of care:

- Provider Linkages and Coordination; and
- Coordination and Continuity of Care.

These policies are monitored and supported through our quality assurance and contract monitoring activities, provider communications, MCO agreements, and the SCRBHO sponsored trainings. Copies of these policies and procedures are included in Attachments 11 and 12.

Provider Linkages and Coordination: The Provider Linkages and Coordination Policy ensures seamless service delivery to individuals enrolled in services throughout the system of care. The policy requires our network providers to coordinate with the SCRBHO, the ancillary service systems, housing and residential providers, substance abuse providers, primary care medical providers, state and local community agencies, criminal justice facilities, homeless services, minority community agencies, schools, third-party payers, Educational Services Districts (ESD), DSHS, DDA, Department of Corrections (DOC), Children's Administration (CA), CLIP, community hospitals, Tribal and Recognized American Indian Organizations (RAIO), Community Detox Services of Spokane, Fire Departments, Hospital Emergency Departments, Regional Health Districts, and any other community agency. Specifically, providers must furnish pertinent information regarding assessments and/or services received or needed at the time of referral or transfer. This may occur through HIPAA compliant electronic transfers, telephonic communication or participation in treatment planning, and discharge or transfer activities. All

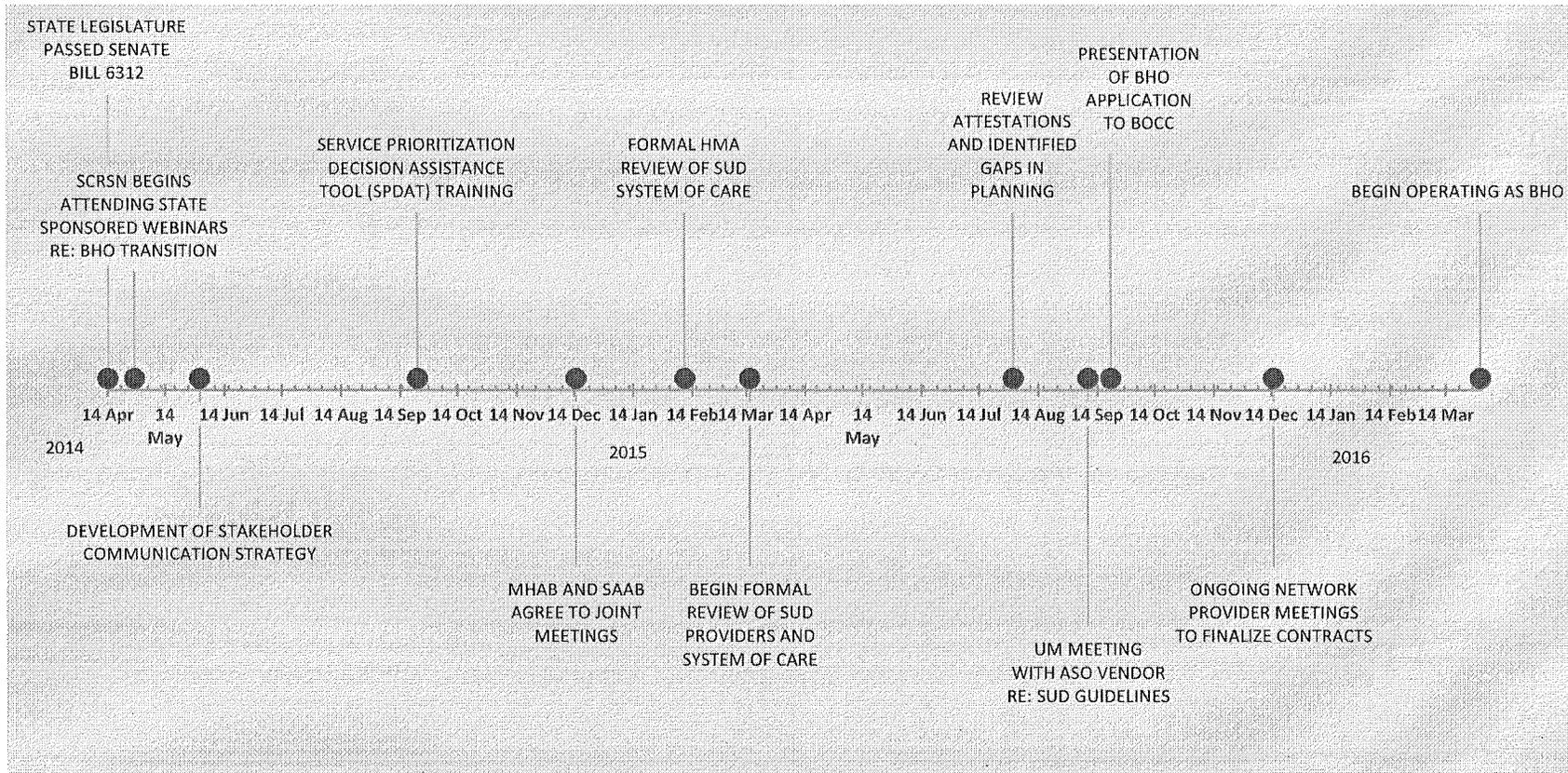
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sharing of information must be compliant with HIPAA, 42 CFR, and other regulatory requirements. Monitoring of these activities will take place during provider and contract monitoring activities.

Coordination and Continuity of Care Policy: The Coordination and Continuity of Care policy addresses the ways in which the SCRBHO will ensure its enrollees have access to primary care and mental health and substance abuse services and supports that are coordinated and integrated along with social services. Providers within its network are contractually required to screen enrollees to ensure they have a primary care provider and if not make referrals to primary care. In addition, as part of the comprehensive assessment and treatment planning process, whole-person health needs must be identified and referrals for needed services made if not provided by the SCRBHO provider. For enrollees with multiple health care providers, our mental health and substance use providers must participate in coordination of care activities with those providers as well as the MCO. Assessment, treatment planning, referral and coordination activities are ongoing throughout the treatment process and not limited to initial intake, including but not limited to required Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program screenings. In addition, youth who have an Individual Education Plan (IEP) or Individualized Family Services Plans (IFSPs) must have this information incorporated into their mental health and/or SUD treatment plans and vice versa. As previously indicated, all sharing of information for referral and coordination purposes is required by provider contract to be compliant with HIPAA, 42 CFR, and other privacy and HIE regulatory requirements.

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Timeline and Milestones for Transition and Coordination of Services Plan



Timeline Acronym Key:

- ASO (Administrative Service Organization)
- BHO (Behavioral Health Organization)
- BoCC (Board of County Commissioners)
- HMA (Health Management Associates)
- MHAB (Mental Health Advisory Board)
- SAAB (Substance Abuse Advisory Board)
- SCRSN (Spokane County Regional Support Network)
- SPDAT (Service Prioritization Decision Assistance Tool)
- SUD (Substance Use Disorder)
- UM (Utilization Management)

III. Communication and Stakeholder Plan

III. Communications and Stakeholder Plan

Describe how you will notify and provide information regarding changes from BHO Integration to enrollees, providers, and allied systems with whom you coordinate care. Timelines in terms of notification. (245)

The Spokane County Regional Behavioral Health Organization (SCRBHO) is committed to ongoing collaboration with our many stakeholders as we make the transition to a Behavioral Health Organization (BHO). We have engaged consumers, families, providers, community stakeholders, and Behavioral Healthcare Options staff throughout the planning process and intend to continuously engage these groups as part of our ongoing administration of a recovery-oriented system of care. The SCRBHO has employed a variety of mechanisms as part of our communication and planning strategies. These include leveraging existing meetings, hosting public meetings and listening sessions, distribution of written materials, and prominently displaying and updating the BHO changes on our website in an easy to read format that is translatable using Google Translate. All meetings are open. The public, family members of individuals in the system of care, and potential and current service providers are encouraged to attend. Written materials may include public notices within the local newspapers, materials that provider staff can share with individuals enrolled in their services, including materials distributed through the Ombudsman office. The SCRBHO also plans to release a series of public service announcements to alert stakeholders and the general public to the transition to a BHO, including the responsibility for managing substance use disorder services.

Enrollees Communication: The Spokane County Regional Support Network (SCRSN) regularly communicates with enrollees through its Ombudsman service, website, Community Partners meetings, contracted network providers, Mental Health Advisory Board (MHAB) meetings, monthly Consumer Consultation Panel (CCP) meetings, Quality Review Team (QRT) activities, and whenever possible at allied system meetings. In addition, the SCRBHO understands its obligation to provide information on:

- Grievance, appeal, and fair hearing procedures and timeframes;
- Advance directives; and
- Information on the structure and operation of the BHO, including contact information, BHO managed benefits, etc.

Detailed information on how the BHO will communicate about grievance, appeal, and fair hearing procedures and timeframes as well as Advance Directives can be found in the Utilization Management Plan section of this document.

Providers: The SCRBHO will continue to communicate with its providers at its Quality Improvement Committee (QIC) meeting for Spokane County providers and North Central

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Quality meetings. In addition, SCRBHO will continue to conduct Directors meetings for its Spokane County provider agencies to gather feedback on BHO initiatives and share pertinent updates.

Allied Systems: The SCRSN communicates with its allied health systems during its Community Partners meetings, which are held monthly. The SCRSN Mental Health Advisory Board and CSHCD Substance Abuse Advisory Board began joint meetings in January 2015 and information regarding the transition has been discussed in this forum as well.

The table below also presents specific communication methods with associated dates throughout our BHO planning process.

Communication	Target Audience	Method	Date
Enrollee information	BHO Enrollees	Letter and DBHR handbook	March 2016-ongoing
Announcement regarding BHO transition	Enrollees, Families, and Provider staff	Posters in Provider Clinics Website postings	March 2016
Announcement of transition of SUD services into managed care	Substance Use Disorder (SUD) Enrollees, MH, SUD, local courts, and allied system agencies	Posters and handouts	March 2016
General BHO Transition information and updates	Enrollees, Families, Providers and General Public	Written materials provided through Ombudsman office	Beginning January 2016
		Local media (newspapers)	February 2016-March 2016
Transition updates	Providers, Allied Health Systems, Better Health Together, Regional Association of Counties Human Services, Drug Court, Family Court, Felony Therapeutic Drug County, Mental Health Therapeutic Court, Priority Spokane, MCOs – Health Plans, Prevention Roundtable, Community Housing and Human Services, Spokane Regional Law & Justice Council, Spokane Regional Health District Prevention Committees, CSHCD Advisory Boards, ALTCEW, Hospitals, NAMI, Board of County Commissioners, Cities and Towns Leadership, Legislators, Tribes & RAIOS	A mix of CSHCD meetings and external meetings	2014 - ongoing

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As indicated throughout the detailed plan, the SCRSN has multiple avenues to engage various stakeholders in the planning for the BHO transition. In many cases, these Boards and groups will also have a continuing role in ongoing operations of the BHO including policy and funding discussions. One such example is our Criminal Justice Treatment Account (CJTA) Workgroup Panel. The Spokane County Community Services, Housing, and Community Development Department (CSHCD), Substance Abuse Division, currently facilitates quarterly meetings with the local CJTA Workgroup Panel as outlined in RCW 70.96A.350. In 2013 CSHCD worked with the local CJTA panel to update the local workgroup plan, which was submitted to the Department of Behavioral Health and Recovery (DBHR) and is still being used by the local panel. Since the implementation of Substitute Senate Bill (SSB) 6312 in 2014, the CSHCD has been informing and engaging the panel in discussions and planning for the expected changes effective April of 2016. This local panel includes representatives from the state-identified parties of interest, including the CSHCD, Spokane County Behavioral Health Adult Felony Therapeutic Drug Court, prosecuting attorneys, defense attorneys, County Sheriff, and treatment and childcare providers.

The following application responses provide additional information specific to communication and collaboration with our advisory boards and consumers and families.

Address advisory board membership in compliance with Exhibit F, BHO Advisory Board Membership. (47)

Since December of 2014, the Mental Health Advisory Board (MHAB) and the Substance Abuse Advisory Board (SAAB) for Spokane County have met together on a combined agenda, with each taking turns as host. This was a decision supported by both of the boards, as the SCRSN moves towards BHO implementation in April of 2016. The boards felt that it would give them an opportunity to share and learn from one another and to take on the broader focus of integrated behavioral health.

The current SAAB has individuals who self-identify as in-recovery from SUDs and who come from a variety of different back grounds, representing the geographic and demographic population mix of Eastern Washington. Each member brings a belief in recovery and endorses treatment and recovery support options that will help individuals in the community access the services they need to live productive and healthy lives. There are no contracted providers or staff of contracted providers on the board. At this time, each member has expressed an interest in remaining on the board once combined as a single BHO Advisory Board.

Lincoln County is the only county in our regional service area with an active SAAB, and they have indicated that they may continue their local board in addition to the SCRBHO combined board. Pend Oreille County chooses to convene community stakeholder meetings as needed to

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specifically address substance abuse issues, e.g., potential closure of the program, Strategic Plan, 1/10th tax, etc. Otherwise, they utilize the Prevention Community Coalitions and more recently, the County Health Coalition to discuss substance abuse needs/issues for the county.

Current board members of both the MHAB and SAAB will be given the opportunity to continue to serve in an advisory position with the new SCRBHO board if they choose to do so. In addition, the SCRBHO plans to recruit from each rural county for representation. The current MHAB has law enforcement and tribal membership and both boards have 3-year term limits, therefore, blending of the two boards will meet the requirements outlined in Exhibit F of the Detailed Plan Request.

The meeting location will rotate, due to the amount of travel for members in rural counties. Board changes will require a total of 4 resolutions from the Spokane Board of County Commissioners. A resolution to dissolve the current MHAB, a second resolution to dissolve the current SAAB, a third resolution to form the new BHO board, and a final resolution to form new bylaws for the newly created SCRBHO Advisory Board. It is not anticipated that these resolutions will meet with any disagreement and will be accomplished prior to April 1, 2016. A list of our current board members and the counties they represent is included below.

Spokane County Regional Behavioral Health Organization

**Spokane County Community Services, Housing,
and Community Development Department
BEHAVIORAL HEALTH ORGANIZATION ADVISORY BOARD**

Sara C.

Spokane County – Mental Health

Craig D.

Spokane County – Mental Health

Floyd L.

Spokane County – Mental Health

Melissa G.

Spokane County – Mental Health

Randi O.

Spokane County – Mental Health

Kari R.

Spokane County – Mental Health

Cindy R.

Spokane County – Mental Health

Bradford T.

Spokane County – Mental Health

Harold W.

Spokane County – Mental Health

Clinton A.

*North Central (Okanogan Co.) –
Mental Health*

Ronald B.

North Central (Ferry Co.) – Mental Health

Ann D.

*North Central (Stevens Co.) –
Mental Health*

Theodore J.

*North Central (Lincoln Co.) – Mental
Health*

Daniel P.

*North Central (At-Large) – Mental
Health*

John W.

*North Central (Pend Oreille Co.) –
Mental Health*

Darrell L.

Spokane County – Substance Abuse

Michael M.

Spokane County – Substance Abuse

Angela M.

Spokane County – Substance Abuse

Robert P.

Spokane County – Substance Abuse

Kurtis R.

Spokane County – Substance Abuse

David S.

Spokane County – Substance Abuse

Kimberley T.

Spokane County – Substance Abuse

Describe how you will involve persons with lived behavioral health experience, their families and advocates in designing and implementing behavioral health services in compliance with this section. (151)

The SCRBHO recognizes the importance of engaging persons with lived experience; including family members, in the planning, implementation, and monitoring of a recovery-oriented behavioral health system. The SCRSN has 5 distinct groups in which persons with mental illness, their family members, and advocates help in designing, implementing, and monitoring services. These groups will continue to meet under SCRBHO and are described below. In addition, SCRBHO plans to continue to support the involvement of peers and families through advocacy and funding for peer/family operated businesses and services and the use of peers within our contracted provider organizations.

The Northeast Family Youth System Partner Roundtable: The SCRSN has supported The Northeast Family Youth System Partner Roundtable (FYSPRT) since its inception. The FYSPRT, which is tri-led by a family representative, youth representative, and a system representative (to which SCRSN holds the position) has had a robust membership of youth and family members from across the region as well as many cross-system partners (juvenile justice, schools, Children's Administration, Developmental Disabilities, etc.) who come together monthly to work on improving the quality of services that are provided to youth and family members. The FYSPRT strives to work through system barriers in a forum where family and youth have equal voice in system changes.

Community Partners Meeting: The SCRSN holds a monthly Community Partners Meeting with adult, youth, and family members with lived experience, mental health agencies (outpatient and inpatient), SUD agencies (outpatient and inpatient), and cross system collaborating agencies (schools, juvenile justice, jail, Eastern State Hospital, Tamarack Center, etc.). The Community Partners' members meet to discuss how to help youth, families, adults, and older individuals from across the mental health and SUD systems to bypass system barriers (such as unnecessary hospitalizations and detentions) and to provide quicker efficiency with utilizing outpatient resources.

Consumer Consultation Panel: The Consumer Consultation Panel (CCP) consists of up to 12 members who are recipients of mental health services. The panel meets monthly to advocate for consumers in the areas of housing, employment, mental health and substance abuse treatment concerns and crisis needs, and to provide the SCRSN with consumer-voice feedback in planning, development, and implementation of behavioral health services. The CCP is responsible for bringing the consumer's voice into SCRSN operations as it pertains to decision-making, planning, implementation, and maintenance of behavioral health services. A CCP member provides a monthly report to the MHAB with concerns and recommendations on behalf of consumers.

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Currently, SCRSN has 2 different MHABs, one serving Spokane County and the other the North Central counties:

The North Central MHAB: The North Central MHAB meets quarterly and is comprised of individuals from the North Central region: Adams, Ferry, Grant, Lincoln, Okanogan, Pend Oreille, and Stevens counties. The members are chosen because they demonstrate concern for mental health and substance abuse issues. They have a passion for representing individuals who live with mental health and substance abuse issues and want to have a voice in how the mental health and substance abuse systems serve these individuals. Many of these members have lived experience with challenges associated with mental health and substance abuse. Other members include an Ombuds representative and a representative from the SCRSN. Members participate in quarterly meetings to solicit input from the North Central counties' citizens, service providers, and consumers regarding needs and priorities for services. They participate in the review of applications for funding that have been submitted to the department. This board is passionate about recovery and look to reduce unnecessary hospitalizations and incarceration by problem solving from a client's perspective. They advocate for services that are recovery-oriented and respect the individual's rights.

Spokane County Combined MHAB and SAAB: The Spokane County combined MHAB/ SAAB meets monthly and is comprised of community members, including those with lived mental health and substance abuse experience. Similar to the North Central MHAB, the Spokane County MHAB/SAAB solicits input from its board regarding needs and priorities for individuals who live in Spokane County.

The BHO will continue to facilitate these forums, working together to promote recovery-oriented, care delivery and eliminate system barriers, unnecessary hospitalizations, and detentions. There are ongoing recruitment efforts for additional youth, family, adult, and older adult members within all of these forums to provide their voice to the needs of our system of care. All of the committees and boards have opportunities to participate in the review and analysis of performance outcomes and other data/reports that are essential to determine if the system of care is performing or requires change for the community.

Advocacy and Funding for Peer/Family Operated Businesses and Services: The SCRSN currently provides funding to the Spokane chapter of the National Alliance on Mental Illness (NAMI). This funding supports local family and peer-led support groups and trainings, including NAMI Peer to Peer, NAMI Connection, NAMI Family to Family, and NAMI Basics. Each of these groups serve to empower individuals with lived experience to better understand mental illness and also to become involved with our local care delivery system. Funding for NAMI Spokane is expected to continue under the BHO. Passages Family Support is a consumer and family-operated, licensed, Community Mental Health Agency that provides outpatient mental health services for adults, youth, and primary caregivers of children and adolescents enrolled in the SCRSN network. Passages Family Support employs Certified Peer Counselors to provide

Spokane County Regional Behavioral Health Organization

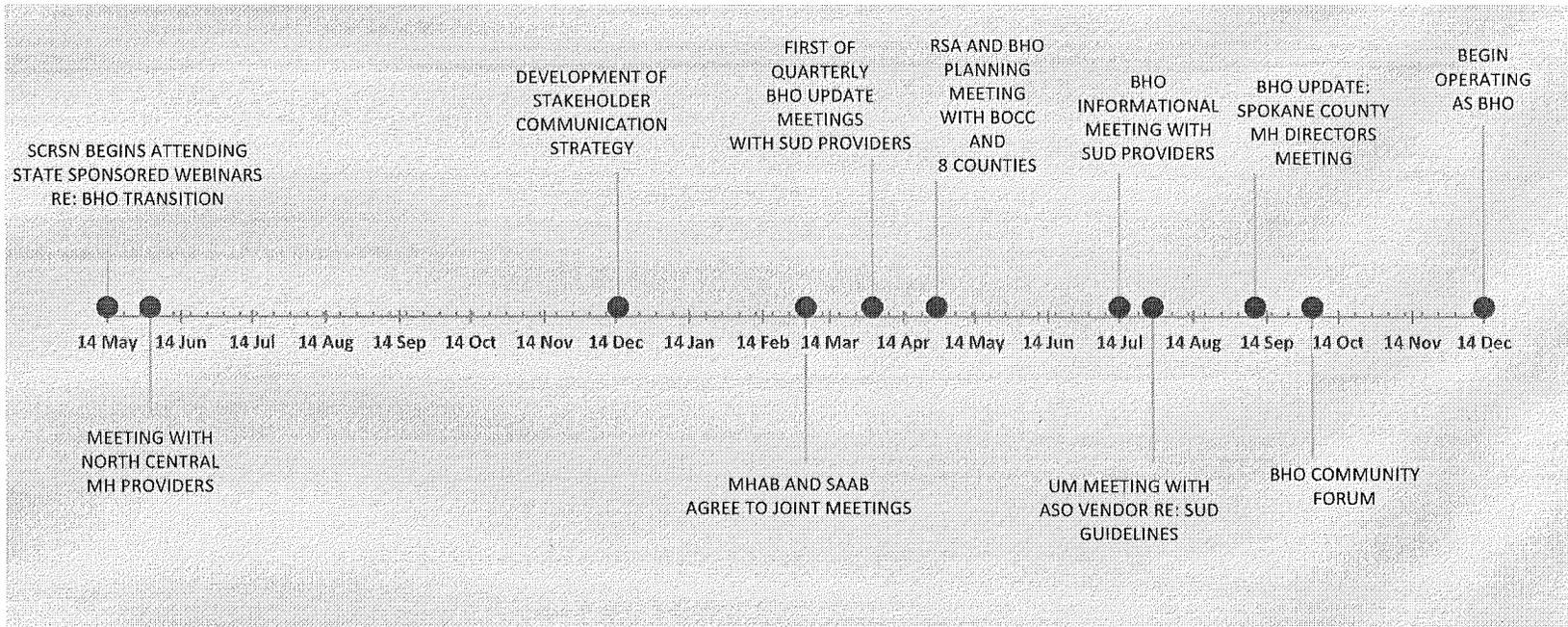
individuals and families with strength-based services that facilitate the recovery process. In addition, their Youth N' Action provides a voice to at-risk young people, ages 14 - 21, including friendship building, trainings, advocacy opportunities, service projects, leadership development, and team building. Additional current RSN and future BHO funded services include:

- Individual Peer Support Services;
- Intensive Case Management;
- Weekly Support Groups;
- Educational Workshops;
- Individual Advocacy;
- In-Home Counseling;
- Facilitation of Wraparound Teams;
- Emergency Financial Support; and
- Wellness Recovery Action Planning (WRAP) Training.

The SCRSN has witnessed firsthand the benefit of engaging peers and families as both advocates and partners within the broader behavioral health system of care. We are committed to continuing with these valuable partnerships and will seek to expand use of peers and families in the administration of substance use disorder services.

Spokane County Regional Behavioral Health Organization

Communications and Stakeholder Plan Timeline and Milestones



Timeline Acronym Key:

- ASO (Administrative Service Organization)
- BHO (Behavioral Health Organization)
- BoCC (Board of County Commissioners)
- MH (Mental Health)
- MHAB (Mental Health Advisory Board)
- RSA (Regional Service Area)
- SAAB (Substance Abuse Advisory Board)
- SCRSN (Spokane County Regional Support Network)
- SUD (Substance Use Disorder)

IV. Network Analysis and Development Plan

IV. Network Analysis and Development Plan

In preparation for the transition and application to be the Behavioral Health Organization (BHO) in this region, the Spokane County Regional Support Network (SCRSN) has placed significant focus and assessment on the network to ensure adequate capacity, breadth of services, and strategic expansion of services to target regional need. In addition, the SCRSN and the Substance Abuse Division have worked in parallel over the last few years advancing the network of providers through new contracts and assessing need for additional services or specialized treatments. Both administrative entities have developed capacity within the system, examined use and location of services, and helped providers diversify types of treatments offered. As the regional convener, the county has also served to bring the network of providers together to share information, improve coordination of services, and to identify as a network what services are needed in terms of additional capacity or new programming.

At this time, the SCRBHO is carefully preparing for integration of mental health and Substance Use Disorder (SUD) providers and has been working to create connectivity among providers that may not have worked together in the past. Similarly, the SCRBHO developed internal capacity and infrastructure to provide a more integrated and coordinated approach to network assessment and capacity monitoring between mental health and substance use programs. The hope and expectation is that by combining these 2 forms of behavioral health treatment, the BHO can assist individuals in the region receive more holistic care and perhaps reduce the duplicity or unnecessary separation of health care needs. A key component of this has been preparing providers within the network to assess for both mental health and substance use and to understand the full capacity of the network in order to coordinate care and connect individuals to the right treatment provider in the right location. The SCRBHO will consist of the counties of Adams, Ferry, Lincoln, Okanogan, Pend Oreille, Spokane, and Stevens; all of which have both SUD treatment services and mental health. The rural counties' providers are all under the county government,

Response to each question identified below. (273)

- 1. Provide a detailed analysis of your delivery network that demonstrates that the network:**
 - a. Is or will be supported by written agreements.**

All contracted provider agencies and facilities (31) will have a contract that consists of standard language that pertains to the expectations of the Division of Behavioral Health and Recovery (DBHR) and SCRBHO, funding terms and conditions, quality, performance, termination, subcontracting, etc. There will be separate exhibits for the funding provided, performance outcomes, and other pertinent areas. A copy of the DBHR contract is provided to the agencies and facilities. All agencies are licensed as Behavioral Health Agencies, and 17 of the agencies are licensed for both mental health and SUD.

- b. Is sufficient to provide adequate access to all services covered under the contracts, and, if it is not sufficient, provides a plan to correct the deficiency. Consider the time and distance standards in the draft PIHP contract attached.**

The SCRBHO has a robust delivery system with a variety of mental health and substance use treatment options that span levels of care from moderate to severe treatment needs and for all ages. Mental health treatment includes 24/7 crisis; assessment; psychiatric medication diagnosis and management; outpatient adult and youth therapy; mental health and SUD co-occurring treatment, case management services; and residential and inpatient care. In addition to these core treatments, the SCRBHO's mental health service array includes Wrap Around with Intensive Services (WISe) programming for children and families; clubhouse functions for adults; parent child interactive therapy; peer programming; jail mental health services; day support programming; school-based health services; engagement and peer support services, and child caregiver respite.

The substance use treatment system is also diverse, spanning from sobering to inpatient services and specifically includes: assessment; stabilization; detoxification; Involuntary Treatment Act (ITA) services; urine analysis testing; outpatient and intensive outpatient services; residential and inpatient; and methadone and other medication assisted treatment options. Other specialty programs include co-occurring mental health and substance use treatment; school-based services; programs focused on population with Human Immunodeficiency Virus (HIV)/Acquired Immune Deficiency Syndrome (AIDS); and programs for pregnant women. Funding is also provided for childcare and transportation.

It is important to note that many of our providers are currently fully or partially integrated with primary medical care. Some of the providers have medical staff within their facilities; other have mental health and/or SUD clinicians at the medical centers. See Response 280 or Plan II Transition and Coordination of Services

The region covered within the SCRBHO is diverse geographically with urban and rural areas. As a result, it has been important to build a system of care that attends to access and availability of services. The majority of the counties are rural, and, in the past, considerable travel was required for members to receive services, often as long as a 30-90 minute drive. In order to improve access, the SCRSN and the Spokane County Substance Abuse Division worked with providers to expand services into satellite locations. For example, in one small county a provider has 20 sites available to improve convenience for individuals seeking treatment. In addition, many of the counties now provide services at several of their school sites. This is an important avenue to improve access for youth and families with behavioral health needs and has the added advantage of reducing transportation challenges and missed hours in school from long transports to specialty service providers.

In Spokane County, service providers have developed sites across the county to ensure convenience and adequate capacity for the need. Some counties, on the border of the SCRBHO region, provide services in multiple BHO regions. Individuals in these counties choose the service providers, based on preference for location and service. Attachments 13 and 14 highlight this information in more detail.

Spokane County Regional Behavioral Health Organization

The following table is an example of network assessment, conducted in September 2015 by Spokane County, to examine network capacity in SUD. This kind of assessment provides valuable input on the way services are being used in the region as well as some of the areas in which capacity may need to be further explored and added. For example, if the finding of a significant wait time is consistent for pregnant women seeking treatment, then this may be an important area for the SCRBHO to consider additional capacity. The SCRBHO has known that adolescent residential services have a long wait time. The SCRBHO will work within the network to create a more comprehensive and effective outpatient continuum for youth to shift the system away from reliance on inpatient or residential services. The SCRBHO will continue to work with the SUD provider system to develop a plan within the next year to reduce the wait list. The SCRBHO believes that the evidence suggests that non-residential services are best practice for youth and residential care should be reserved for those most in need. This transformation in system utilization is in its early phases of discussion but potentially a long-term goal of the SCRBHO given funding and other considerations.

State Funded Spokane Substance Use Disorder Residential/Inpatient Facilities			
<i>Program</i>	<i>Number of State Funded Beds *</i>	<i>Average Wait Time</i>	<i>Average # of Clients Waiting at any one time</i>
American Behavioral Health Services - Adult	76	2 days	Very small
Specialty Services I, LLC - Adult	16	2 days	Very small
Spokane Addiction Recovery Center (SPARC) - Adult	42	3-5 days	1-5
New Horizon Care Center – Sun Ray Court - Adult	28		
New Horizon Care Center – Isabella House – Pregnant and Parenting Women	24	1-2 months	30
Pioneer Center East - Adult	33	24 days	19
The Healing Lodge of the Seven Nations (3 separate units) - Youth	26		
Daybreak of Spokane - Youth	18		
Excelsior Youth - Youth	14	6 wks. to 2 mo.	16
Community Detox – Detox - Youth and Adult	16	1 day	15
Community Detox – Sobering - Adult	14	No wait	n/a

*State-funded services refers to services funded by Medicaid if the facility is 16 beds or less, and non-Medicaid state funds and Federal Block Grant funds if the facility is over 16 beds, based on available funding.

- c. Considers anticipated Medicaid enrollment, expected utilization, provider requirements (number and type), provider capacity, and location and physical access to providers. Include how language and cultural considerations will be addressed.**

The expansion of Medicaid into the SCRBHO region of care is leveling off after 18 months of health care expansion. The SCRSN has tracked the numbers of enrollees each month for the last 10 years and can tell by residence where enrollees predominantly reside. Refer to Attachment 15 for additional detail.

Because understanding the Medicaid population as a whole is only one element of delivery system capacity design and analysis, the SCRSN has utilized other tools to estimate the proportion of the larger Medicaid population that will utilize mental health and substance use services. This separate analysis has allowed the SCRSN to ensure that the region has adequate services in the areas where they are needed most. One such example is analysis of the number of children on free and reduced meals as an indicator of low-income families. As a result of this analysis, the SCRSN has expanded services within school systems to provide more convenient services and to reach individuals and families who may not seek services as well as may need services earlier. Overall, the SCRBHO is well positioned to offer services within the regional communities. Many of the existing services in the region are in community-based settings that offer family and individual preference for where they are seen. For example, providers have expanded services into individuals' homes, churches, or community centers. Services are in over 75 schools currently throughout the counties, and the SCRBHO anticipates more growth in the number of services in community-based settings. The SCRBHO plans to build on existing successes such as a provider agency in a community center that is located in an area with families living in poverty. Services in the community center include mental health, substance use, dental, medical, pharmacy, food bank, childcare, etc. The SCRBHO provider is a partner in the community center and can literally walk the person down the hall to address additional needs such as food acquisition or medical care. The SCRBHO funds mental health and SUD services in Federally Qualified Health Centers (FQHC) as well where people can receive all needed services. This kind of holistic treatment is an important step in advancing the delivery system and meeting enrollee needs in a convenient and whole-person manner.

When new services or additional provider sites are added to the delivery system, a number of key variables are considered for deciding where the service needs to be placed. An essential step is an estimate of the number of individuals expected to be served. This number may be impacted by geographic and demographic data, the number of referrals in that region, and questionnaires or surveys about where individuals prefer to be served. Based on the estimated number of individuals to be served, the provider creates a budget incorporating a plan for the type of services to be added in that location as well as the type and number of staff required for the services (e.g., licensed clinicians and type: MA, BA, Peer, etc.). In Attachment 16, we have identified the contracted agencies that are dually licensed for mental health and SUD services as well as the agency location. The SCRSN has several co-occurring programs for youth and adults. An important priority of the SCRBHO is to continue placing more needed services in the areas where Medicaid individuals reside.

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There are times that the best estimates still do not accurately predict the needs of the region and the specific services desired. When this happens, the SCRSN has worked quickly to revise plans and to assist providers in adapting to enrollee needs. For example, in February of 2015, the SCRSN worked with a provider to place family services on the far west side of Spokane. It turned out that changes in the bus routes, in that area, prevented individuals from easily accessing that service location. The SCRSN and the provider worked with enrollees to find the appropriate and available sites as well as providing services in the home.

In the SCRSN region, the communities have seen rapid and massive Medicaid expansion due to intense community efforts and navigator assistance. Approximately, 60,000 individuals became eligible for Medicaid benefits in 2014. Part of the growth and change occurring in the region is a diversification of the population racially and ethnically. The region is currently 95% Caucasian. However, many new residents are moving into the area, and there is an increase in non-native English speakers and as a result a diversity of languages spoken. The language bank used by providers is still catching up with this growth and currently is having challenges finding adequate translation services. World Relief has been offering some assistance working with residents and enrollees—particularly, those from eastern European countries. In addition, the SCRSN has one provider agency that is specializing in refugees.

Our largest ethnic population is Native Americans, and the SCRSN is fortunate to have 2 Recognized American Indian Organizations (RAIO). In Spokane, Native Health of Spokane, a RAIO that is also a FQHC facility, offers medical, dental, mental health, substance abuse, and co-occurring services. They also have Native American clinical specialists on their staff. In addition to being one of the SCRSN providers for behavioral health, Native Health of Spokane staff also sits on the SCRSN Mental Health Advisory Board, representing the Tribes and has often provided cultural insights for other providers working with tribal populations.

The SCRSN has also promoted ongoing training across the region including: the Culture of Poverty; Cultural Needs for Lesbians, Gays, Bisexuals, and Transgendered Adults; Ethnic, Religious, and Political Refugees; Cultural Needs of Ethnic Minorities; and Unique Needs for Families with Criminal and Violent Histories. The SCRSN also encourages and monitors providers to ensure they continue to provide training on diversity and cultural sensitivity within their organizations.

The largest mental health provider in the region has many Multicultural Mental Health Specialists who have received specialized training in cultural competence and treatment across racial and ethnic groups. The other providers in the region utilize this expertise for case consultation and or training.

- d. Includes providers who can meet the needs of pregnant women, as identified in the contracts as a special healthcare need, with a Substance Use Disorder diagnosis.**

The Spokane County Substance Abuse Division currently contracts with New Horizons Care Center, a dually-licensed mental health and substance use treatment agency. New Horizons Care Center is one of 3 inpatient facilities that treat pregnant and parenting women in the state. As a result, they have a strong and well-used service array for women struggling with mental health

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and substance use. The provider has a long history of quality outcomes, and there is a good relationship between the county and New Horizon Care Center to coordinate services in the region. The region has numerous outpatient providers that are licensed as Behavioral Health Agencies that also specialize in treating SUDs and provide services to pregnant and parenting women. We expect these agencies to be contracted with the BHO in April 2016. We understand that DBHR has funding to expand the pregnant and parenting services somewhere in the state, however, we have not heard of any agency in our region that has applied.

- e. Includes providers who can address the needs of individuals who have either been referred through the Department of Corrections, Drug Courts or identified through activities funded by the Criminal Justice Treatment Account.**

The SCRBHO will contract with provider(s) to offer Medicaid outpatient services for individuals who are referred by the Department of Corrections. The SCRBHO will release a Request for Proposal (RFP), in November 2015, for qualified providers to provide these services. The SCRSN has been preparing for this opportunity and has been collaborating with the Department of Corrections to ensure that the SCRBHO can offer a successful program to treat individuals with criminal justice involvement. In addition, the Spokane County Drug Court recently released an RFP for Drug Court Services, working with Spokane County Superior Court. Pioneer Human Services, a SCRSN contracted agency, will be providing the services effective October 1, 2015. Spokane County will contract with Pioneer Human Services, funded by the Criminal Justice Treatment Account, until March 31, 2016 and then the SCRBHO will contract with them beginning in April 2016. The SCRSN also utilizes local funds to support a felony mental health drug court for individuals with chronic mental illness and substance use disorder.

- 2. Provide a list of contracted or anticipated contracted providers and the services they will provide, based on the state plan modalities and state funded priority services as described in the draft contracts and supplemental SUD Service descriptions.**

See Attachments 17 and 18.

- 3. Describe the documentation and provide a sample format that you would be prepared to submit to DSHS on a periodic basis to demonstrate the sufficiency of your network."**

The SCRBHO will provide updated geo mapping of enrollee residence, location of services, and type of services on a periodic basis. In addition, the SCRBHO will provide documentation of the number and type of services utilized across the region, a list of cultural trainings completed in the region, a list of specialists and innovative program offerings, and a list of services offered in different languages. The SCRBHO will also provide documentation of the clinical monitoring of the provider agencies. A list of agency locations changes could also be available. The format for the reports is dependent upon the state's requests and need, and the SCRBHO will be flexible as needed.

Describe the documentation that you would be prepared to submit to DSHS on a periodic basis to demonstrate the sufficiency of your network. (279)

The SCRBHO is prepared to monitor network capacity and report documentation to the state, in a format specified by the state. The SCRSN has been preparing for the added monitoring of the SUD network. In the last year, the SCRSN engaged Health Management Associates (HMA) to conduct an analysis of the SUD provider network adequacy and capacity. This type of analysis provides a solid baseline for the SCRBHO, as it transitions to the BHO. The SCRBHO understands that periodically the state will request documentation demonstrating that the network:

- Offers an appropriate range of services that is adequate for the anticipated number of enrollees for the service area; and
- Maintains a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of enrollees in the service area.

The SCRBHO will be monitoring the network internally by examining the following indicators of service adequacy:

- The number of individuals served;
- Provider capacity and provider census (particularly for residential, inpatient, and detoxification services);
- Provider capacity across geographic regions as well as need by region;
- The number and type of services referred out of network as a result of capacity within the network; and
- Review of stakeholder and advocacy group feedback on the service array and additional desired services.

The SCRBHO will submit documentation specified by the state at the time it enters into a contract or any amendments with the state when there has been a significant change (as defined by the state).

Provide information on how enrollees obtain a second opinion for all behavioral health services. (274)

The SCRSN acknowledges that it is the right of individuals receiving public mental health services to request a second opinion (6.1.1 Washington Administrative Code (WAC) 388-865-0355 and 6.1.2. and Medicaid Rights of members). The SCRSN and its service network provide a second opinion when requested by an individual receiving services or his or her legal representative. There are numerous reasons an individual receiving services may request a second opinion, including wanting more information on the medical necessity of the treatment recommended, diagnostic clarification, denial of services or lack of referral for desired services, and other reasons.

Regardless of the cause for the request for second opinion, the SCRSN ensures the individual receives a second opinion from a qualified mental health provider. Currently, requests for a second opinion are directed to the Administrative Services Organization (ASO) for the SCRSN,

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Behavioral Healthcare Options, Inc. The ASO assists the SCRSN and the provider to make an appropriate and timely referral.

The second opinion may be completed by the initial treating agency if another qualified Mental Health Professional is available, by another agency within the SCRSN network or from a provider outside the SCRSN provider network. Any requests for a second opinion that is outside the initial provider, or when another qualified professional is unavailable, are the responsibility of the SCRSN to make recommendations for an in-network provider or, if needed, a provider out of network. The provider or agency recommended to provide the second opinion must be currently contracted with the SCRSN to deliver publically-funded mental health services.

The SCRSN is responsible for payment for any second opinion provided within or outside its provider network. The SCRSN also monitors the process to ensure that the second opinion is offered to occur within 30 days of the request. The individual requesting the second opinion may decide to delay the second opinion past the 30 days, however, an appropriate and timely referral is guaranteed by the SCRSN. In addition to monitoring the timeframe for referrals, the SCRSN tracks all requests for second opinions to ensure that individuals receive the second opinion within the thirty day timeframe and documents the outcome. The network providers supply the SCRSN with the necessary reporting to track requests.

The SCRSN and its network providers inform individuals of their right to a second opinion and document that the individuals has been informed of this right within the clinical record. In addition, the request for a second opinion, the outcome, and follow up of that second opinion are documented in the clinical record. For situations in which an out-of-network referral is required, the SCRSN documents the second opinion process in a client's file as well as ensures there is documentation in the clinical record of the agency that completes the second opinion.

The SCRBHO will utilize the same policy and procedure as outlined above for both mental health and SUDs.

Provide information on how enrollees can receive medically necessary out-of-network services when those services are not obtainable within your network or not obtainable within the timeframes specified in the contract. (275)

For many years, the SCRSN and its provider network has engaged a process that permits a referral to an appropriate Mental Health Care Provider (MHCP) outside of the SCRSN provider network. Referral to an out-of-network provider is reserved for cases in which there is not a MHCP with appropriate training and experience in the SCRSN provider network to meet the particular medically-necessary mental health service needs of the SCRSN member. As the BHO, the SCRBHO will adopt its mental health policies, process, and procedure for out-of-network services for substance use and chemical dependency services.

In situations where the SCRBHO SUD provider network is unable to provide the medically-necessary services covered under the contract, the SCRBHO will ensure timely access for the medically-necessary covered services through an out-of-network provider. Continuation of these

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services will be paid by the SCRBHO until the services are no longer needed or until the SCRBHO network of providers can offer comparable services. The SCRBHO will work with the out-of-network provider, the individual receiving services, and the new provider to ensure a successful transition and that the transition of care does not disrupt the individual's recovery process.

The out-of-network services will be provided at no cost to the Medicaid enrollee. Instead, the SCRBHO and its ASO will locate a provider that is willing to perform the services and has the required credentials, licensure, insurance, and proven expertise to provide the needed services. The SCRBHO will then negotiate the rate and contractual terms with the provider. Once the contract is complete, then the provider works with the individual to provide the services and to provide the SCRBHO with the appropriate documentation and invoice for payment. Additional circumstances may arise in which a SCRBHO member requires out-of-network services. For example, the member has the need for crisis substance use services, evaluation, stabilization or inpatient care when they are physically out of the SCRBHO service area. In these situations, out-of-network providers will coordinate with SCRBHO in terms of payment and coordination of services when the individual returns to in network providers. The SCRSN has been working with chemical dependency providers across the state for years as the county administrator of state funds and, therefore, has developed relationships across the entire state which will aid in the BHO transition.

The types of services that may be provided out of network for chemical dependency include alcohol/drug screening and brief intervention, inpatient withdrawal management, screening and detoxification, chemical dependency treatment, which includes outpatient treatment in treatment centers and residential treatment facilities with 16 beds or less, laboratory services, and case management services. The SCRBHO will ensure that all service delivery settings meet WAC 388-877B and 246-337 and are delivered by professionals practicing within the scope of their licensure or certification required in the state plan.

The payment structure for out-of-network services is still being determined by the BHOs across the state and with continued input from the State Department of Social and Health Services (DSHS) and DBHR. Currently, there may be times that it makes more sense to change the individual's residency to the local BHO which would include payment structures however this will not always be the case. The RSNs have been working together to determine how best to design the approach as BHOs and, specifically, how to address individuals that are or want to be served outside of the BHO region. One option under consideration is to treat all requests or needs as an out-of-network request. This may mean that there are times the receiving BHO may deny the request due to lack of beds or capacity in their area. In October 2015, there will be greater discussion on how to address out-of-network services for chemical dependency as not all BHOs have the necessary services within their networks. For example, currently individuals outside of Spokane County receive services within Spokane County including detoxification, methadone program, and residential facilities, and sometimes even outpatient treatment. Similarly, it is often the case that Spokane County residents may receive services in other parts of the state, particularly residential or inpatient services. As the BHO, SCRBHO will work closely with the other BHOs and the state to design a system that ensures enrollees receive the services that are medically needed and that out-of-network referrals facilitate quality care.

Describe how you will ensure and monitor timely access to care. Consider the Access standards in the attached draft PIHP contract for Routine, Urgent, and Emergent. (277)

The SCRBHO is committed to timely access to services for all of its enrollees. The SCRSN currently meets contractual requirements in its existing DSHS contracts, for both mental health and chemical dependency services, supported by a variety of monitoring and assurance activities. In preparation for becoming a BHO, the SCRSN has reviewed these existing administrative activities that monitor access to care, including the policies and procedures that outline and support these measures. When possible, administrative functions and policies and procedures for mental health and chemical dependency have been integrated for BHO practice, moving forward.

The SCRSN contracts with Behavioral Healthcare Options, Inc., as an ASO. Under this arrangement, Behavioral Healthcare Options is the delegating entity for the BHO Utilization Management (UM) plan for SUD treatment and mental health services. The SCRSN and the ASO, operating under SCRSN's direction, are collaborating to create an integrated approach to ensuring access and delivery of SUD and mental health services in compliance with all federal and state laws and regulations. The contract with the ASO will clearly maintain the SCRBHO's legal responsibility and authority for ensuring that the BHO's UM plan implementation is consistent with the requirements of Code of Federal Regulation (CFR) 438.206 for timely access and CFR 438.230, which requires an evaluation of the ASO's ability to perform the delegated activities and regular monitoring and reporting of performance of the functions.

The SCRBHO acknowledges the following DBHR contract access-standards and will monitor the processes described below:

- Crisis mental health services will be available 24 hours a day, 7 days per week and may be accessed without full completion of intake evaluations and/or other screening and assessment processes. The SCRBHO has crisis providers within its network to assure this will be met;
- Access to emergent mental health care will occur within 2 hours of a request for mental health services, from any source;
- Access to urgent care will occur within 24 hours of a request for mental health services, from any source;
- Routine, behavioral health intake evaluation or assessment appointments will be available and offered to every enrollee within 14 calendar days of the request, with a possible extension of up to an additional 14 calendar days, unless both of the following conditions are met:
 - An intake evaluation or assessment has been provided in the previous 12 months that establishes medical necessity; and
 - The ASO is able to utilize the previous intake evaluation or assessment as the basis for authorization decisions.
- The time period from the request for behavioral health services to the first, routine service appointment offered must not exceed 28 calendar days; and
- Individuals will receive an outpatient service within 7 calendar days of discharge from a psychiatric inpatient stay.

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The SCRBHO understands that it must address the reason for any delays. This includes documentation when the consumer declines an intake appointment within the first 10 business days following a service request or declines a routine appointment offered within the 28 calendar-day timeframe. Current assurance and monitoring activities include provider education and technical assistance, assurance of standards through provider contract requirements and approval, report generation, monitoring, and follow-up of regional-access performance goals that are approved through the SCRSN quality committees.

Assurances through Provider Contracts: Currently, contracts require providers to comply with the performance measurement of 3 state-designated, core performance goals for outpatient services: (1) A routine outpatient service must be offered to Medicaid clients within 7 working days of discharge from community psychiatric inpatient hospitals and evaluation and treatment facilities, (2) time from the request for service to the routine service shall not exceed 28 calendar days, and (3) time from a service request to an intake service shall not exceed 14 calendar days for outpatients. In addition, providers are contractually required to document when the consumer declines an intake appointment within the first 10 business days following a service request or declines a routine appointment offered within the 28 calendar day timeframe. Provider contracts will be modified to include any changes in access requirements under the BHO contract.

Provider Education and Technical Assistance: The SCRSN provides education to providers through in-person and electronic conference (e.g., Telehealth) meetings, in combination with written materials, to inform providers of access requirements. The SCRSN provides trainings for all new or revised policies and procedures (P&Ps) through a “train the trainer” teaching model, even for minor revisions. A disc of all SCRSN P&Ps is distributed annually to the contracted providers with reminders of access standards. Contract requirements include mandatory reporting on access standards to allow the SCRSN to monitor access by provider, population, or service. Reports are generated and shared with providers. When noncompliance is identified, letters regarding these issues are sent to providers and require a corrective-action-plan response. The SCRSN will continue as the SCRBHO to monitor corrective action plans, working closely with providers to close corrective action plans. In support of these efforts, technical assistance will continue to be offered by both the SCRBHO Information Systems and the Integrated Health Care Coordinators when providers fall out of compliance.

Quality Committee Direction and Oversight: As part of the Regional Support Network Quality Management Plan for 2013-2015, the SCRSN staff review monthly reports, including the *Monthly Access to Care (Standards) Report*, to identify trends and make recommendations at the Quality Improvement Committee (QIC) and North Central Clinical Quality (NCCQ) meetings. This report data will continue to be used to guide leadership decisions that address service gaps, individuals in need of services, and other remarkable trends and patterns. Additional reports used to monitor compliance with access to service include the *Pending Authorization Report* and the *Annual Outpatient (OP) Authorization Timeliness Report*.

SUD Specific Planning: The SCRBHO will expand, extend, and enhance existing processes, systems, communications, and resources to meet the requirements of the transition for individuals enrolled in SUD services. This will be accomplished by cooperating with DSHS and contracted SUD agencies and facilities in the following activities:

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- Identifying all individuals expected to be engaged in SUD treatment on April 1, 2016 and establish these individuals within the SCRBHO Raintree system for collecting and reporting the client demographic and current/ongoing services and treatment information from the SUD contracted provider agencies;
- Authorizing and becoming responsible for continuing services for individuals in a course of treatment, beginning April 1, 2016 and until one of the following:
 - Up to 60 calendars days,
 - Course of treatment is complete,
 - Individual is evaluated, and the determination is that services are no longer necessary, or
 - A determination is made that a different course of treatment is indicated.
- Authorizing and becoming responsible for involuntary treatment services to continue in accordance with Revised Code of Washington (RCW) 70.96A.140, using American Society of Addiction Medicine (ASAM) criteria to determine length of stay; and
- Contracting for, and monitoring of, services to meet contractual requirements including, but not limited to, subcontractor, Health Insurance Portability and Accountability Act (HIPAA), confidentiality, and data security requirements.

The SCRBHO has begun the process of reviewing, editing, and expanding existing policies and procedures to incorporate the administration of SUD services. Special technical assistance will be targeted to SUD providers prior to April 1, 2016 to assist in their understanding and adoption. These efforts have been particularly focused on:

- Criteria for authorization of outpatient, inpatient, residential, and recovery-house services utilizing medical necessity, ASAM, and level of care for initial placement, continuing stay, and discharge;
- Access to care standards for initial authorizations, continuing stay, and discharge criteria for routine and inpatient care;
- For authorizations regarding routine services, determination of eligibility for an initial authorization of services, based on Medical necessity, ASAM, and level of care;
- Denial for authorization requests or authorization approval for services at a lower level than requested; and
- Define revisions and additions needed to match the DBHR contract in the Appointment Standards section for SUD.

Updates to, and development of, additional reports are also currently being evaluated. These include new reports to monitor SUD providers for contract compliance and timeliness of access, including an SUD version of the existing *Monthly Access to Care Report* (reflecting new DSHS Access to Care Standards, e.g., appointment standards) and the *Pending Authorization Report* (consistent with the BHO contract).

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Provide a list of contracted or anticipated contracted providers and the services they will provide (287)

Currently, the CSHCD and the SCRSN have contracts with the following providers:

Provider	Services Provided
Adams County Integrated HealthCare Services	MH – Outpatient Services, 24/7 Crisis, Psychiatric Services, Medication Management
ADEPT	CD - Adult Outpatient Treatment, Adult Treatment, Low Income Treatment, Youth Outpatient Treatment, Youth Treatment, Training, and Outreach
BHR Worldwide	MH – Crisis Answering Service
Catholic Charities	MH – Outpatient Services - Youth & Adult
Children’s Home Society	MH – Outpatient Services - Youth & Adult
Community Colleges of Spokane PACE Services	MH – Supported Education
Community Detox Services of Spokane	MH – Adult Co-Occurring Services, Stabilization, Outpatient; CD - Assessments, Detoxification, ITA Services, and Sobering
Daybreak Youth Services	CD -Youth Offsite Project, Training, Outreach Addition, and Youth Outpatient Treatment
Excelsior Youth Center	MH – Youth Co-Occurring Services, Day Support, Child Caregiver Respite, LifePointe Youth Aging Out; CD - Youth Outpatient Treatment, Youth Off-site Project Outreach, Youth Outreach Project Treatment, Outreach
Frontier Behavioral Health	MH – WISE, ClubHouse, Crisis Services, Psychiatric Services, Medication, Outpatient, Pact, Crisis Stabilization, Adult Co-Occurring, Case Management
Grant Mental Healthcare	MH – Outpatient Services, 24/7 Crisis, Psychiatric Services, Medication Management, and Adult MH Residential
HIP of Spokane County/Community Minded Enterprises (HIP/CME)*	CD - Child Care Referral Services, Outreach
Institute for Family Development	MH – Intensive Outpatient in Home, WISE, PCIT
Kalispel Tribe of Indians	MH – Staff Training
Lakeside Recovery Center	CD - Adult Treatment, UA Testing, Outreach
Lutheran Community Services Northwest	MH – Outpatient, Inpatient Diversion
NATIVE Project	MH - Outpatient Services; CD - Youth Outpatient Treatment, Outreach
New Horizons Care Center	CD - Adult Treatment, HIV/AIDS Outreach Project, HIV/AIDS Project - Low Income, HIV/AIDS Project Treatment, Low Income Treatment, TANF, Adult Outpatient Treatment, Outreach

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Northeast Washington Alliance Counseling Services	MH – Outpatient Services, 24/7 Crisis, Psychiatric Services, Medication Management, Recovery Housing, Crisis Residential/Stabilization
Northeast Washington Treatment Alternatives	CD - Adult Outpatient Treatment, Geiger Outreach Project, CJTA Adult Treatment, Outreach
Okanogan Behavioral Health	MH – Outpatient Services, 24/7 Crisis, Psychiatric Services, Medication Management, Adult Day Treatment
Partners with Families and Children	MH - Outpatient Services - Youth & Adult; CD - Adult Treatment, Low Income Treatment, Outreach
Passages Family Support	MH – Outpatient, Targeted Case Management, and Peer Support
Pend Oreille County Counseling Services	MH – Outpatient Services, 24/7 Crisis, Psychiatric Services, Medication Management
Providence Sacred Heart Medical Center & Children’s Hospital	MH – Day Support Intensive Services (BEST) - Youth
Spokane Addiction Recovery Center	MH – Adult Co-Occurring Services; CD - Adult Treatment, CSO Project, CSO Project Outreach, ESH Project Outreach, Low Income Treatment, SHMC Projects, SHMC Project Outreach, Sunshine Health Facilities Project Treatment, Sunshine Health Facilities Project Outreach, TANF, Adult Outpatient Treatment, Outreach
Spokane County Detention Services	MH – Jail Mental Health Services
Spokane County Juvenile Court	MH – Juvenile Probation and Detention Mental Health Services
Spokane Public Schools	MH - Outpatient Services - Youth, School Based Services; CD - Youth Outpatient Treatment, Youth Outreach
Spokane Regional Health District	CD - Outpatient, Interim Services, Opiate Treatment
Sunshine Health Facilities, Inc.	MH – Mental Health Services to residents of Sunshine
Tamarack Center	MH – Day Support
YFA Connections	MH – Adult Co-Occurring Services, Child Caregiver Respite, School Based Services; CD - Adult Treatment, TANF Treatment, Low Income Treatment, Outreach

The SCRBHO will continue to contract with the aforementioned agencies, with the exception of Grant Mental Healthcare, which will transfer to Chelan Douglas BHO, effective April 1, 2016.

*HIP/CME, a currently contracted provider, employs In-Person Assisters and Navigators that outreach in the community to agencies and individuals to assist in signing people up for health care. This includes not only Apple Health but also commercial insurance plans. HIP/CME’s efforts include educating individuals on their benefits and the community resources that are available to them with their insurance coverage. HIP/CME also provides Medicaid enrollment

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updates and training to other provider agencies to ensure that individuals in services are enrolled with a health care plan and providers are informed of any possible changes that may affect their clients.

In addition, the SCRBHO expects to contract with or expand current services with the following providers:

Adams County Integrated Health Care Services	CD – Information & Referral, Intervention, Evaluation & Assessment, Outpatient, Intensive Outpatient Program, Education, and Prevention
American Behavioral Health Systems, Inc.	CD – Inpatient Chemical Dependency Services
Daybreak Youth Services	CD – Inpatient Chemical Dependency Services
Excelsior Youth Services	CD – Inpatient Chemical Dependency Services
The Healing Lodge of the Seven Nations	CD – Inpatient Chemical Dependency Services
Lincoln County Alcohol/Drug Center	CD – Assessment, Outpatient Treatment, Intensive Outpatient, Deferred Prosecution, Adolescent Treatment, Information/Screening & Referral, DUI Assessment
New Horizons Care Center	CD - Inpatient Chemical Dependency Services
Northeast Washington Alliance Counseling Services	CD – Intensive Outpatient Treatment, Outpatient Treatment
Okanogan Behavioral Health	CD – Evaluations, Outpatient, Intensive Outpatient Services, Deferred Prosecution, Information & Referral, Relapse Prevention & Aftercare, Community Education
Pend Oreille County Counseling Services	CD – Screenings, Assessments, Education, Outpatient Treatment, Intensive Outpatient Treatment, Case Management, and Inpatient Treatment Coordination
Pioneer Center East	CD – Inpatient Chemical Dependency Services
Spokane Addiction Recovery Center	CD – Inpatient Chemical Dependency Services

The SCRBHO will determine whether it will contract with other substance use disorder residential providers throughout the state for services after April 1, 2016.

Based on the WISE Capacity Expansion document attached as Exhibit G. As of April 1, 2016, what caseload capacity will the BHO have to provide WISE? What is the plan for the BHO to meet the FY16 June 30, 2016 WISE monthly capacity goal? (158)

Currently, the SCRSN has 2 pilot WISE programs in Spokane County that were implemented in May 2015. DBHR was given notice that the SCRSN wanted to implement WISE in July 2017 with plans to pilot the program prior to region-wide implementation. As of July 2015, DBHR included our 2 pilots as a part of our capacity requirements.

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While both programs have been responsive to their individual regional needs, including the provision of 24/7 crisis services for their caseloads, maintaining proper staffing has proven a challenge. One team required 6 months to become fully staffed, while another faced challenges with staff turnover. The SCRSN has encouraged collaboration and provided significant training to support service delivery, data reporting, and troubleshooting challenging cases within this new model of care. Additional teams would require the hiring of another Care Coordinator. In early September 2015, the SCRSN was given the expected number of teams by April 1, 2016. At that time, the SCRSN notified DBHR of our concerns regarding the cost, implementation challenges, our need to engage in an RFP process with providers to solicit teams, and potential work force issues. There are issues other than the RFP, primarily, the lack of funds to provide the services because the Medicaid rates for the SCRSN under the lower-bound rates is \$1 Million less per month. On August 27, 2015, DBHR notified the RSNs to expect another significant reduction with specific impact to be shared in October 2015. This impact to the BHO's operating budget will factor into capability for WISE expansion. We know our cost per team is approximately \$400,000 per year. If we do not have enough Medicaid funding and need to cut existing services the Spokane BOCC will decide how that is presented to our community. Due to these challenges, the SCRBHO believes the caseload capacity that will be in place April 1, 2016 will remain 2 teams.

The SCRSN believes that WISE is an excellent program for those individuals who need the service and the program would help some of the child/adolescents to avoid inpatient facilities. Today, we have 18 children who could benefit from WISE if other teams were in place. While we have at least 1 agency that wants to implement WISE, this would require elimination of an existing program that is valuable in addressing the needs of children and families prior to needs escalating to a higher level of care. We have determined that a full review of our agencies' mental health programs is needed to assist in making determinations on prioritization of programs and services. This review is expected to occur prior to April 2016. The SCRBHO has engaged HMA, who completed the assessment of our substance abuse system of care, to provide the review and recommendations associated with funding and service priorities. Their review may also assist greatly if we have to discontinue some of our other programs (children or adult) in order to meet the requirements for the number of WISE teams. We expect by June 2016 that we will know how many teams we can expand within the coming months, which will be based on both clinical need and the ability to adequately pay for the teams.

Describe how you will comply with the requirement to offer contracts to managed health care systems or primary care practice settings to promote access to the services of chemical dependency professionals and mental health professionals for the purposes of integrating such services into primary care settings for individuals with behavioral health and medical comorbidities. Provide a list of existing contracting arrangements and a description of planned efforts to promote clinical integration. (005)

Spokane County has historically understood the importance of integrating behavioral health into primary care and other medical settings and is committed to assisting the network of providers in the region in expanding access to holistic models of care as the BHO. The SCRBHO will encourage, support and provide opportunity for partnerships among providers that facilitate models of integration.

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As the RSN, the SCRSN has worked in collaboration with the local FQHC, Native Project, on numerous model enhancements to support integrated care. For almost 10 years, Native Project has had a contract with SCRSN to provide co-occurring substance use and mental health program for youth and an adult mental health program. Both of these programs are embedded within the Native Project's overall model, which includes medical, pharmacy, and dental in addition to the mental health, SUD, and co-occurring treatment services. In October 2015, the SCRSN funded an Advanced Registered Nurse Practitioner (ARNP) for Native Project to provide psychiatric and medical care throughout the health clinic. The ARNP provides assessment and medication treatment for individuals with mental health and substance use needs while collaborating closely with the medical services providers. This is a way to ensure that the medical providers learn more about the behavioral health needs of the population and it provides a model for treating the whole person, physical and behavioral health needs, within one clinic. The contract is for Medicaid services and is a fixed performance-outcome contract, which includes inpatient reduction, demonstrates person-centered recovery treatment, and requires a level of clients, services, and hours. This contract is the only existing contract with a primary care practice at this time.

We also have collaborated with our network providers who have contracts with Managed Care Organizations (MCO) to provide coordinated care for mental health, substance use, and medical services and support these efforts within their contracts with the SCRSN or our Substance Abuse Division. The managed care organizations currently pay for treatment for mild and moderate mental health needs by contracting with some of those providers. The SCRSN does not hold these specific contracts, however, has been an advocate promoting these types of contracts among its providers to enhance the integration of services. The MCOs are not funded to provide SUD treatment, so our referrals to our SUD contracted providers are based on the relationship between the MCO and the provider.

In 2014 and 2015, the SCRSN had several individual meetings with all of the MCOs and Spokane County CSHCD Leadership to develop relationships and to gain a better understanding of the MCOs' needs and how to facilitate integration and improved models of coordinated medical and behavioral health care. The meetings also highlighted that the MCOs have different initiatives and priorities for development. For example, a plan may be focused on greater expansion of services to include home-based care coordinators for individualized post hospitalization while another is interested in data systems that track individuals across the system of care. The SCRBHO is focused on building relationships with the MCOs to enhance quality care coordination between the MCO and the SCRSN while working to reduce duplication in personnel and functions. The SCRBHO plans to continue building collaborative relationships with the MCOs as well as find opportunities for pilot and demonstration projects within the network that promote the integration of behavioral health and medical treatment. This may include embedding behavioral health providers within primary care settings as well as engaging primary care providers to provide evaluation and treatment for populations in traditional behavioral health settings that do not routinely receive primary care services. Several of the mental health and SUD providers have agreements with MCOs, and we are encouraging all providers to work with them as well as the Community Health Clinics. The SCRBHO realizes that a focus on developing models for individuals with serious mental illness is essential as the population is at risk for significant co-morbid medical problems and, as a result, early mortality.

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Research has shown that individuals with serious mental illness have an average life expectancy of 58.¹ Integrated care is considered an important treatment option for reducing this disparity and improving mortality rates.²

Because the contract SCRSN holds with DBHR limits contracting, we have not pursued additional specific contracts outside of the 5 MCOs that hold the state contract for Medicaid. As the BHO, the SCRBHO understands that currently contracting entities will be required to be Behavioral Health Agencies and, therefore, contracting with primary care or medical settings will not be allowed. The SCRBHO will, however, continue to promote providers within the network work toward integration with medical health providers and support them in creating individual contracts or memorandums of understandings that enhance innovation, integration, and shared services. 18 of the providers have signed agreements with MCOs, 12 providers have behavioral health staff working in medical facilities to provide mental health and/or SUD treatment, and 17 of the providers have external medical providers within their agencies. There are 13 agencies that actually perform full health measurements, including medical assessment within their mental health or substance abuse agencies. All of these efforts are forays into full integration and the provider organizations have made considerable strides in exploring methods for advancing mental health and chemical dependency into medical services. An important part of this has been working collaboratively with MCOs to support the integration of mental health and chemical dependency into medical services.

There are currently important challenges to advancing successful integration as well as important considerations that remain unknown at this time:

- Adequate Medicaid and non-Medicaid funding for an expansion of an innovative model due to the reductions thus far in 2015 to the revenues. The SCRSN has experienced a \$12 Million annual reduction in Medicaid monies that are needed for inpatient diversion, expansion of caseloads, and for higher salaries in order to be a competitive employer in hiring adequate numbers of skilled staff;
- Over time it will be essential for DBHR to change the BHO contract to allow contracting with MCOs. Until then, the BHO will focus on quality care coordination, strong communication, and collaboration with the MCOs;
- There is still uncertainty about whether the MCOs will ultimately contract with BHOs and if they do, the specific nature of that contract remains unclear (e.g., services, specific population(s), funding, and contractual conditions,);
- It would be essential to gather local input and engage the community in decision making regarding the specifics of the system of care;
- It will be important to evaluate whether medical facilities and provider practices would want to hire their own mental health and substance abuse staff rather than integrating with a BHO regional system of care and how to make the business case for working closely with the BHO;

¹ Parks, J, Svendsen, D, Singer, P, and Foti, M. Morbidity and mortality in people with serious mental illness. National Association of State Mental Health Program Directors (NASMHPD) Medical Directors Council.

² Parks, J, Svendsen, D, Singer, P, and Foti, M. Morbidity and mortality in people with serious mental illness. National Association of State Mental Health Program Directors (NASMHPD) Medical Directors Council.

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- The ultimate direction and involvement of the Accountable Communities of Health remains unclear, and this may determine the degree and eventual breadth of support for integration across the system.

2.025 Voluntary Treatment of Individuals with a Substance Use Disorder

Question: *Describe how you will document compliance with these requirements by any organization directly providing services to clients.*

The CSHCD and the Substance Abuse Division have worked with substance use providers across the region to develop a full continuum of services ranging from detoxification to residential and inpatient services as well as a strong network of providers offering outpatient and intensive outpatient services including specialized programming for Medication Assisted Therapy. The vast majority of these services are provided to individuals through voluntary treatment (both for youth and for adults). The provision of RCW 70.96A.110 requires both inpatient and outpatient providers to work closely through referral and coordination of services for individuals needing voluntary treatment. This collaboration occurs as part of routine care and in numerous clinical transitions of care including, but not limited to, when individuals seeking services need an expertise offered by another agency; when individuals would prefer another treatment provider for convenience, fit, etc.; when a program is full or the individual is a poor fit for a specific agency and, thus, refused treatment; and other reasons.

The CSHCD and the Substance Abuse Division holds monthly provider meetings to discuss contract and system issues. However, this meeting also serves as a vital setting for provider agencies to share information, discuss coordination of services and resources, and challenges. Since the passage of SSB6312, local inpatient agencies have also been invited to these meetings to increase collaboration and information sharing. Often this is where providers learn of new programs being offered in other agencies as well as where capacity exists within the system for referral needs. In addition, during this last year, all of the SUD agencies were offered Person Centered Recovery training by Dr. Janis Tondora, which emphasized the importance of agency collaboration to improve engagement and meet individuals' goals.

Early in 2015, Spokane County contracted with HMA, a national consulting firm, who conducted an assessment of the SUD providers in Spokane County. In their final report on the SUD system of care, HMA wrote: "Despite a healthy competition among providers, care coordination for individuals served is strongly valued by all providers. It was impressive that within a system, providers are generally working well together to share information and to provide continuity of care for individuals. There appears to be genuine respect among the provider organizations and a shared goal in providing quality services to individuals—over individual organizational gain. This speaks volumes to the character of the providers."

As part of the transition to the BHO, both inpatient and outpatient providers will be required to notify the SCRBHO of discharges and admissions across the system. This will be a contract requirement, starting in April 2016. There will also be a contractual provision for the inpatient agencies to coordinate services with outpatient providers for better collaboration and person centered recovery. With the BHO providing oversight over both the mental health and substance

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use treatment systems, there will be greater opportunity for assessment of the system's overall capacity to meet individuals' needs and to ensure that individuals seeking voluntary treatment receive appropriate referral, coordination, and collaboration among providers to ensure that treatment needs are addressed. With a central data repository for both mental health and SUD, the BHO will be able to track individual transfers, transitions, and completion of care.

Section 2.026 – Treatment Program and Facilities Admissions-Peace Officer Duties-Protective Custody

Question: *Describe how you will assure compliance with the requirements.*

The SCRSN is currently in compliance with RCW 70.96.120 and will remain compliant under the BHO contract as SCRBHO. The SCRSN currently contracts with providers within Spokane County to ensure access to Evaluation and Treatment (E&T) facilities for the region of care. The SCRSN is planning an E&T facility in Stevens County, which will also operate under an SCRBHO contract that assures adherence to all state requirements. This is an expansion of our provider network, as currently other counties within the region utilize the existing Spokane County E&T facilities. Families of individuals seeking admission through protective custody can access services under the procedures currently followed by Peace Officers and residents of Spokane County. Crisis Intervention training is provided yearly with crisis staff and law enforcement agencies to address safety, policy, and procedural issues. The SCRSN enrollees and their families all have access to a 24 hour, 365 day county crisis lines. Upon enrolling in treatment services, enrollees receive information on utilizing the county crisis line. The county crisis line has direct access to the Designated Mental Health Professionals (DMHP) when evaluation for detention is deemed necessary.

To support ongoing access for both voluntary and involuntary individuals, the SCRSN provides 24 hour a day availability of emergency resources through access to community crisis providers. Individuals who are on hold at a detention facility or who are in the custody of the Police or Sheriff's Department can be admitted to one of 2 E&T facilities in Spokane, only if the patient meets admission criteria. The SCRSN has worked closely with Spokane Police Department to ensure that individuals who are identified as in need of protective custody are located within 8 hours and applicable staff observe the clients on a one-to-one staffing pattern until they arrive, prioritizing the safety of the client, staff, and others. The SCRBHO understands that individuals found to be incapacitated or gravely disabled by alcohol or other drugs at the time of his or her admission or to have become incapacitated or gravely disabled at any time after his or her admission, may not be detained at the facility for more than 72 hours after admission as a patient, unless a petition is filed under RCW 70.96A.140.

Crisis response services include linkage to the SCRSN contracted provider agencies and access to 24-hour, on-call psychiatric/medical services, pursuant to WAC 388 – 865, for medication and support. Crisis providers must be trained in the requirements related to both mental health and substance use disorder related commitments. Crisis providers also provide community-based outreach crisis intervention designed to divert SUD and/or psychiatric hospitalization. Emergency resources also include psychiatric services, referral, and access to food, emergency shelter, domestic violence advocacy, and public assistance for those individuals who may not need inpatient but would benefit from other services.

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An officer may transport an individual to an E&T facility to request admission. A conversation then occurs between the facility staff and law enforcement to determine whether or not the enrollee is amenable to entering the program. The E&T facility is not expected to assume a greater degree of control than can be provided in its customary treatment programs. This confirmation is documented in the chart. Consistent with requirements, our provider contracts specify that no law enforcement officers are posted in the units. Cases are staffed and reviewed by the E&T facility Nurse Manager and Medical Director on an as-needed basis and reviewed for appropriateness and safety. Individuals with substance use disorder(s) receiving treatment in E&T's often also have mental health service needs, and these will be screened for and addressed through our provider contracts. In congruence with the ongoing integration of the administration of substance abuse and mental health services, the SCRBHO will continue to review and integrate its policies, procedures, and contracts to comply with any revised WAC codes.

Describe your program for involuntary commitment, including all agreements and arrangements in-place or planned with all entities with a required role in the involuntary commitment process. (027)

Individuals referred for involuntary commitment are gravely disabled, as a result of chemical dependency and as a result of the severity and high-risk nature of their status, are in need of more intensive services. The inpatient facilities for individuals on involuntary commitment are specialized with intensive case management, a targeted and standardized state-wide treatment program, and heightened facility security.

The SCRSN operates the involuntary commitment program in accordance with the RCW 70.96A.140. As such, the Spokane County CSHCD Human Services Program Manager for the Substance Abuse Treatment Division designates the staff members, who provide ITA services, as ITA Specialists. The ITA Specialists maintain Chemical Dependency Professional (CDP) status with the state and fulfill annual specialized training requirements, enhancing understanding and assessment of grave disability. The CSHCD Substance Abuse Treatment Division's Human Services Program Manager maintains record of the designation form in the personnel file of all designated ITA Specialists. A provider agency employs the ITA Specialist. In Spokane County, the CSHCD Substance Abuse Treatment Division contracts with Community Detox Services of Spokane to employ the ITA specialist.

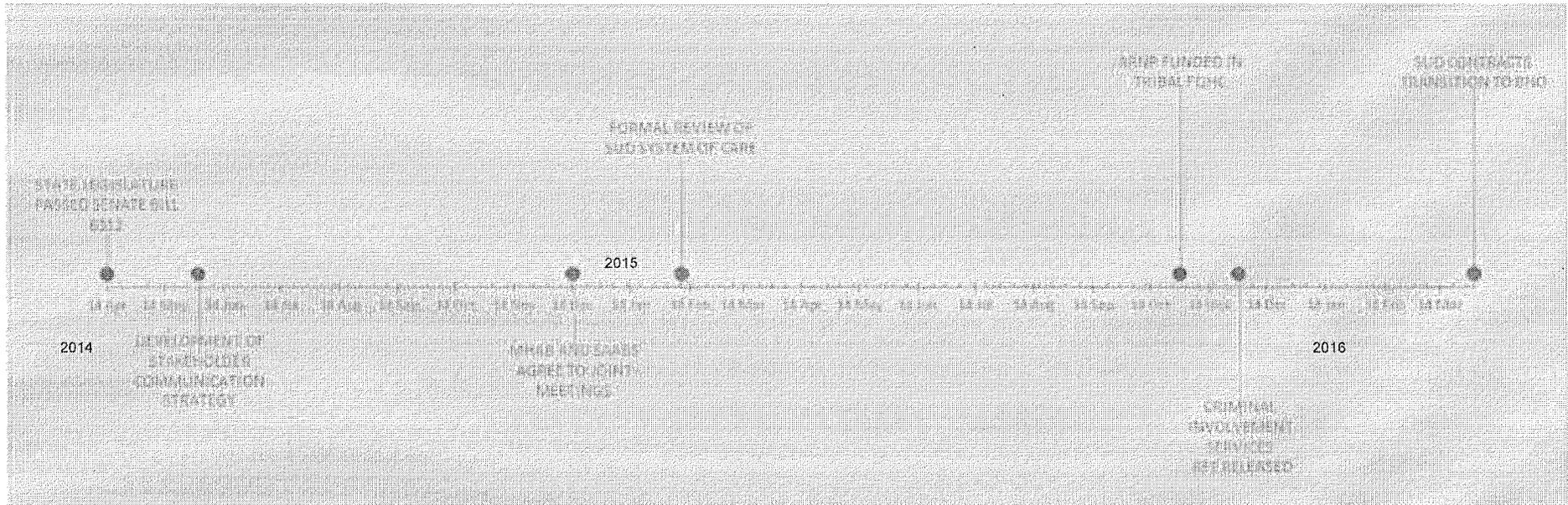
Referrals for assessment for involuntary commitment come from community providers, hospitals, emergency departments, E&T facilities across the state, and other substance use disorder inpatient facilities. Referral to the ITA program is primarily a function of scores on the ASAM assessment, completed by community providers or the discharge planner within inpatient settings. The ITA Specialist convenes a committee of collaborating agencies and programs serving individuals referred to ITA. The committee meets a minimum of 8 times per year to address the treatment needs of persons who have been admitted for detoxification or treatment 2 or more times in 1 year, pursuant to RCW 70.96A.140, and to initiate involuntary placement for anyone admitted to detoxification 5 or more times within 90 days. The referrals are made to one of 2 state-designated ITA facilities, Pioneer Center East and Pioneer Center North.

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Because these two facilities can have wait lists for up to 2 months, the ITA Specialist, with the collaborating agencies, refers the individual to a community-based provider who can maintain the individual in an appropriate level of care until admission to an ITA facility. These settings often include group homes, the inpatient program at the Spokane Community Detox Services, E&T facilities, or other community-based providers (if that is a safe option). Once the individual is accepted into the ITA-specific facility, the ITA Specialist provides transportation for admission and, once again, at discharge. Upon completion of programming or discharge for other reasons, the ITA Specialist and primary enrolled provider will coordinate care and discharge back, to the community, to an appropriate level of care.

As the BHO, the SCRBHO will continue to closely monitor changes in the ITA program at the state in order to evaluate the need for changes in the program. For example, Washington State House Bill 1713 proposed legislation combining the services of the Designated Mental Health Professional and the substance abuse ITA Specialist under one entity. Although this did not pass, the SCRBHO assumes that continued efforts will be made at the state level to enhance integration of substance use and mental health treatment, and this will ultimately impact the ITA program. Until changes are made at the state level, the SCRBHO plans to maintain the current structure for ITA programs. However, in order to support integration within the region, the SCRBHO, as the BHO, will assist community-based providers with coordinating substance use treatment and mental health treatment-needs prior to the need for an ITA admission and after ITA inpatient discharge. There are several groups or committees that are a cross section of the community stakeholders who meet regularly to address hard to serve individuals in our community, and we are well represented in those meetings. Some of the groups are a multi-agency treatment meeting for SUD, an Eastern State Hospital meeting with providers, the SCRSN, and residential facilities, a Hot Spotters group for hard to serve - facilitated by Empire Health Foundation, and Children's Task Force meeting for families and youth. The SCRBHO believes that more collaborative treatment planning in the community may prevent some individuals from decompensating to the point of grave disability and then requiring ITA treatment. The goal of the SCRBHO is to always integrate care to the highest degree possible and to provide the care needed to keep individuals in the community in the least restrictive setting.

Transition to BHO Timeline



Timeline Acronym Key:

- ARNP (Advanced Registered Nurse Practitioner)
- BHO (Behavioral Health Organization)
- FQHC (Federally Qualified Healthcare Center)
- MHAB (Mental Health Advisory Board)
- SAAB (Substance Abuse Advisory Board)
- RFP (Request for Proposal)
- SUD (Substance Use Disorder)

V. Staffing and Workforce Analysis and Development Plan

V. Staffing and Workforce Analysis and Development Plan

Key in the staffing and workforce development of the Spokane County Regional Behavioral Health Organization (SCRBHO) as a newly organized Behavioral Health Organization (BHO) has been the support and guidance of our various governing and advisory boards. Currently, the Spokane Board of County Commissioners (BOCC) is the governing board of the SCRSN. The SCRSN is advised by community volunteers, who serve on the 2 Mental Health Advisory Boards (MHAB) by appointment of the BOCC. Most MHAB members have received mental health services or have a family member with mental illness. The MHAB provides feedback and recommended solutions for identified needs and concerns expressed by individuals in treatment, their families, and providers. The MHAB advocates for fiscal stewardship and funding of quality resources to meet the community's mental health priorities. The administration of Substance Use Disorder (SUD) services is currently governed by the Substance Abuse Advisory Board (SAAB), which consists of up to 12 members appointed by the Spokane BOCC. Members are chosen for their demonstrated concern for alcoholism and other drug addiction problems and are representative of the community. Other stakeholders have been key to the development of the BHO such as the Community Partners meeting that is held once a month and consists of the SCRSN staff and providers, the SUD providers, consumers and families, Children's Administration, Juvenile Rehabilitation Administration, Spokane County Detention Services, Juvenile Detention and Probation, hospital staff, and other agencies or facilities interested in the needs in the region.

Under the BHO's updated organizational chart there is integration of mental health and substance abuse administration, entitled Integrated Care Services Division. To support these reorganization efforts, the existing Mental Health and Substance Abuse advisory boards began holding joint meetings, effective January 2015. The Community Services, Housing, and Community Development (CSHCD) Department is working with the Spokane County BOCC to formally merge these advisory boards into 1 integrated advisory board, effective April 1, 2016. The SCRSN, the Spokane County Substance Abuse Division, CSHCD leadership, and the additional counties in the SCRSN, including their Substance Abuse Management began planning for the BHO in the middle of 2014 on a regular basis.

SCRBHO Personnel and Other Internal Resources

In preparation for the BHO transition, the SCRSN requested and was allocated extra resources to meet the contractual requirements of the BHO by the BOCC. These funds were utilized to assist in the following ways:

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- Enhancements to the current information system (required by Department of Social and Health Services (DSHS)) to collect and report data to the state, including data analysis capability;
- Development of a data warehouse and business intelligence equipment and software; and
- Additional staff including:
 - a. 8 additional Information System staff, capable of business data analysis and programming;
 - b. An Integrated Behavioral Healthcare Manager to manage the BHO, and to collaborate with health plans, counties, state Health Care Authority (HCA), DSHS, etc.;
 - c. 2 additional Care Coordinators to assist with the integration of the SUD providers, quality monitoring, and planning for new services;
 - d. An Integrated Behavioral Healthcare Project Coordinator to perform special projects under the BHO; and
 - e. 3 licensed Chemical Dependency Treatment staff under the Authorized Services Organization (ASO) to authorize SUD services and provide utilization management.

The CSHCD engaged 2 sets of national consultants to provide technical assistance in several areas including the organizational structure, possible rate structures, best practices, and structure for Substance Abuse service delivery (inpatient and outpatient). The CSHCD staff was involved in these activities as a way to engage them in their new roles and facilitate ownership of the goals associated with the BHO. Planning activities covered all aspects of the Detailed Plan document, including but not limited to review and assessment of provider network gaps and strengths, rate setting activities, policy discussions related to utilization management strategies, development of external communication, quality assurance activities, provider training, and the writing of this Detailed Plan.

Enhancements to ASO Arrangement (see also 24)

The SCRBHO will continue an established delegation agreement with Behavioral Healthcare Options, Inc., a contracted ASO. The SCRBHO delegates responsibilities and functions to the ASO in compliance with DSHS, Division of Behavioral Health and Recovery (DBHR) contract. The contract with the delegated entity will clearly identify that the legal responsibility, for all functions, remains with the SCRBHO.

The SCRBHO will contract with Behavioral Healthcare Options, Inc., to include responsibility for implementing a Utilization Management (UM) Plan that is inclusive of SUD services as well as the current arrangement for mental health services, which was expanded in October 2015. The SCRBHO is developing a written contract that is consistent with the requirements of 42 CFR 438.230 and provides for an evaluation of the subcontractor's ability to perform the delegated activities. The contract will specify the activities and reporting, delegated to the ASO, and

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provide for revoking the delegation or imposing other sanctions if the ASO's performance is inadequate.

The ASO UM program operates in a clearly defined organizational structure. The UM is supported by trained, qualified, clinical and non-clinical staff, and resources to perform this function effectively under the supervision of a qualified UM Program Manager. The ASO Medical Director provides clinical oversight of the UM function, supervises all clinical decisions, and is responsible for quality improvement and quality assurance activities. Additionally, full-time analysts and the SCRBHO leadership routinely work closely with the UM operations.

The ASO's Senior Care Advocates (SCA) are licensed Registered Nurses (RNs) (unrestricted licenses in the State of Washington and/or Nevada), Licensed Clinical Social Workers, Licensed Mental Health Professionals, or Licensed Marriage and Family Therapists (unrestricted in the state of Washington) with 3 years of clinical experience. They are up to date with continuing education, fully oriented to the ASO's clinical criteria, and trained in utilization management processes. They use the SCRSN's established criteria to define medical necessity, length of stay, and intensity of service with focus on high risk, high-resource usage, and high-cost diagnosis and/or procedures.

Physicians are required to maintain board certification in their specialty areas and are re-credentialed every 3 years. Registered Nurses, Licensed, Clinical Social Workers, Licensed Mental Health Professionals, or Marriage and Family Therapists are required to maintain valid and current unrestricted licensure. In preparation for their role in providing UM for SUD services, the updated SCRBHO contract with the ASO will include the requirement of certified Chemical Dependency Professionals (CDPs) as part of the UM team.

Training

In preparation for operating as a recovery-oriented BHO, CSHCD sponsored trainings for county division staff, network providers, tribes, advisory boards, and allied community agencies on current topics relevant to best practices, workforce development, and system initiatives such as:

- Person Centered Recovery Oriented Planning - Janis Tondora, Psy.D.;
- Golden Thread Documentation for Recovery Oriented Care - Mary Thornton, BSRN, MBA;
- Cultural Sensitivity and Responsive Practices - Roberta Wilburn, MA, Ed.D, Th.D.; and
- Assessing and Managing Suicide Risk - Sue Eastgard, MSW.

In addition, the SCRBHO staff actively participates in state sponsored trainings, workgroups, and informational meetings specific to their respective job responsibilities, all of which have been an imperative preparation to serve as a BHO. The table below summarizes these activities but does not represent an exhaustive listing.

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SCRBHO Staff	State Workgroup, Meeting, or Training on Behalf of BHO Preparation in Late 2014 & 2015
Suzie McDaniel	State Performance Measures HMA, all RSN Administrator and DBHR RSN Meetings, SUD Mercer Rate Meeting, Managed Care Organization Meetings, RSN Directors Meeting, RSN Quality Meetings, System of Care Meetings for SUD,
Kathleen Torella & Staff	State Performance Measures, Service Code Reporting for SUD, ICD10 for MH & SUD, Mercer Rates Meeting, HMA meetings, RSN Quality Meetings, System of Care Meetings for SUD
Laura Schultz	Residential SUD Meetings on UM, HMA meetings, BARS Accounting for SUD, Mercer Rate Setting
Charisse Pope	HMA, Service Codes for SUD, ICD10, all RSN Administrator and DBHR RSN Meetings, SUD Mercer Rate Meeting, Managed Care Organization Meetings, RSN Quality Meetings, System of Care Meetings for SUD
Gail Kogle	Grievance & Ombuds Training, Community Partners
Fred Buckles	PATH, Community Partners, Consumer Consultation Panel meetings
Brian Nichols	SAMHSA Best Training for Supportive Employment
Joe Beckett	Service Codes for SUD, ICD10, Competency Evaluations, Single Bed Certification, Joel's Laws, HMA meetings, SUD Monthly Meetings, Community Partners
Robert Miller	Competency Evaluations, Single Bed Certifications, Joel's Law, SUD Monthly Meetings, Community Partners, Joel's Laws, ICD10, HMA meetings
Liz Perez	Wise, ICD10, Competency Evaluations, Single Bed Certifications, Joel's Law, SUD Monthly Meetings, Community Partners, HMA meetings
Robert Brandon, ASO	Managed Care Organization Meetings, RSN Quality Meetings, System of Care Meetings for SUD, UM Meetings
Christine Barada	All RSN Administrator and DBHR RSN Meetings, SUD Mercer Rate Meeting, Managed Care Organization Meetings, ACH Community Meetings, Regional Health District Meetings, Governor's Task Force Meeting on BHO, ABHTS State Committee on SB 6312 for Integration, Other Community Meetings to Train on BHO
Danielle Cannon	All WISE Meetings, ICD10, Children's Long Term Inpatient Meetings, Community Meetings on Children's needs, MH Children Coordinators Meetings, SUD Meetings, Community Partners

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Describe plans to provide behavioral health ombuds services that will meet the needs of those who access both the mental health and substance use disorder treatment services. (175)

The SCRSN currently contracts with 2 separate Ombuds services: one Ombuds provides services to Spokane County only; the second Ombuds provides services to Adams, Ferry, Grant, Lincoln, Okanogan, Pend Oreille, and Stevens counties. As required, Ombuds services operate as distinct, independent of and separate services from SCRSN, and our commitment is to support the maximum use of consumer advocates through the Ombuds Office and is compliant with WAC 388-865-0250.

The Ombuds Office assists individuals receiving SCRSN-funded services with grievances, appeals, and state fair-hearings, and, whenever possible, it works to resolve grievances at the lowest possible level. Ombuds involves others at the individual's request and the Ombuds services provide advocacy, education, outreach, and inform allied systems about Ombuds services available for individuals who are SCRSN funded. The services also assist the SCRSN in efforts to educate the community about the process for filing grievances, appeals, and state fair-hearings.

The SCRSN requires and monitors that Ombuds contractors attend state-funded training as mandated by the state and the SCRSN contract. The SCRSN also identifies they must have knowledge of and understand the process of dispute resolution and must follow confidentiality standards under the Health Insurance Portability and Accountability Act (HIPAA) and state statutes for RCW chapters 70.02, 71.05, and 71.24.

The Office of Ombuds advocates for individuals' rights, as identified in state and federal requirements, and provide individuals, family members, and stakeholders with information about the DBHR published rights. They offer Medicaid enrollees the Benefits Booklet in the preferred language of the individual when requested.

In compliance with the state and the SCRSN contract, Ombuds services offer assistance inclusive of but not limited to accessibility and responsiveness; information regarding rights; procedures and requirements for grievances, appeals, and state fair-hearings; advocacy; investigation, and mediation of grievances; availability and support for fair hearings; and eventual resolution and disposition of grievances, appeals, and fair hearings. The Ombuds Office has no authority to recommend or affect the resolution or disposition of a grievance or appeal.

As required by contract, Ombuds services maintain a numerical tracking system and assign a numerical file to each individual case. The Ombuds Office maintains records for a period of 6 years and access to records is secured with limited access. Ombuds services document all activities, including maintaining a telephone log of incoming and outgoing phone calls and voice messages. The SCRSN monitors reports submitted monthly that the Ombuds services are

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compliant with contractual requirement and follows up with the Ombuds Office on all questions or issues identified. Should a corrective action plan or additional information be required, the SCRSN pursues the necessary follow up.

As required, the Ombuds operates a toll-free phone number identified on all published materials, letterheads, brochures, and business cards. Additionally, to fulfill its responsibilities Ombuds distributes posters and brochures to the SCRSN system of care including providers and programs, individual advocacy groups and allied systems regarding accessibility to Ombuds services. In addition, the SCRSN provides information about Ombuds services on its website.

The Ombuds requests access to the SCRSN provider agencies and residential facilities, community and state hospitals, and individuals' records, with the appropriate releases, to obtain necessary information and conduct outreach to individuals, offering needed assistance to resolve grievances.

In working with individuals, Ombuds services are cognizant of the importance that individuals experience no retaliation and educate individuals about their rights and protection and freedom from retaliation. They monitor the process and assist individuals, family members, and other interested parties for any occurrence or appearance of retaliation taken against them. They report to the SCRSN any appearance of retaliation, and if it occurs, the retaliation by the SCRSN is reported to DBHR.

The Ombuds provides monthly activity reports to the SCRSN that include all provider outreach and training, allied systems outreach, type and number of contacts such as information and referral, dignity and respect, and rights violations. Reports are also provided to the MHAB and the SCRSN Provider Director meetings for their review. If there are any questions or concerns, follow up is discussed with a clear plan for next steps. The Ombuds attends all Quality Improvement Committee (QIC) meetings and Community Partners meetings as active participants and reports on overall issues they identify through the Ombuds Office. The QIC meetings include representatives of consumer and family advocate organizations, and they participate actively with the SCRSN, as we review the terms of the agreement and compliance with the requirements. We are also aware of the requirement that Ombuds members must be current consumers of the mental health system, past consumers, or family members.

The Ombuds Office is available to individuals, families, and stakeholders Monday through Friday during business hours. The state and the SCRSN contract clearly states Ombuds are aware and will meet the requirement that the location of the face-to-face contact with the individual, family, or advocate complies with confidentiality expectations. Response to phone messages, faxes, and written requests are acknowledged within one business day. Voicemail message will reference 911 and crisis hotline numbers. The SCRSN monitors Ombuds' phone logs as part of its overall annual review of services when doing onsite reviews, or more often if there is a need a more frequent review.

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In transitioning to the SCRBHO, Ombuds services will be provided to all the counties in the Regional Service Area for both mental health and SUD. The SCRBHO intends to continue Ombuds services with 2 separate providers. The SCRBHO will establish and monitor clearly-stated requirements that Ombuds will acquire additional training and understanding about the nature of SUD services and the individuals accessing those services, including those in outpatient and residential/inpatient settings. The DBHR provided the first training in September 2015, and the SCRSN staff, Ombuds, and some of the Quality Review Team attended. This training included the uniqueness of SUD services, information about the additional levels of confidentiality required, including that separate recordkeeping of its SUD grievance files should it be required. Other DBHR trainings are planned, and the SCRBHO may request SUD providers to offer additional trainings before April 2016. Training will include material about co-occurring disorders and its relevance to fulfilling the responsibilities of the Ombuds Office's services.

The SCRBHO has apprised SUD providers of the role of the Ombuds Office, effective April 1, 2016. We will also inform individuals being served in the SCRBHO system of care, who are receiving substance use disorder services, about Ombuds services and the grievance system at the time of enrollment or at any time this information is requested or would be useful to provide. All SUD provider agencies received training about the grievance system, including appeals and fair hearings, on October 1, 2015. The training included information about individuals' rights, grievance reporting, Ombuds services and the associated assistance available to individuals, family members, and advocates involved in SUD services to obtain access to the SCRBHO grievance system. The Ombudsman also shared the role they can provide to SUD providers and their clientele at the meeting.

The Ombuds assistance to SUD providers will include but not be limited to accessibility and responsiveness; information regarding rights; procedures and requirements for grievances, appeals, and state fair-hearings; advocacy; investigation and mediation of grievances; availability and support for fair hearings; and eventual resolution and disposition of grievances, appeals, and fair hearings. The Ombuds Office will have no authority to recommend or affect the resolution or disposition of a grievance or appeal.

As we modify the SCRBHO material to provide consistent information compliant with state established standards, the SCRBHO will incorporate state-sponsored training for Ombuds services and the grievance system.

As part of the larger notification process, the SCRBHO will provide information about the Ombuds Office and services and the grievance system to SUD allied system providers and track and monitor outreach to these entities. The progress of the activities will be reported to the SCRBHO and SCRBHO advisory boards, all quality and director meetings, and community partners meetings. As described above, our meetings include the required consumer and family

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member participation and will be extended to be inclusive of the same processes as it applies to SUD services. The Ombuds service will document the number and frequency of provider training and outreach activities in its monthly activity reports that it is required to submit to the SCRBHO. The SCRBHO will work with each Ombuds service to develop training and outreach schedules to ensure that each provider agency has the benefit of staff being trained directly by the Ombuds. The SCRBHO will develop and monitor a tracking mechanism related to Ombuds, which will be used to verify how this training occurs. Through the SCRBHO and its contracts with providers, we will identify the requirement that all provider agencies and evaluation and treatment facilities must post Ombuds services information in their waiting rooms. The SCRBHO will monitor compliance annually through our regularly scheduled visits to the provider and/or request confirmation annually from the providers that they are compliant with this requirement.

Provider Workforce Capacity

Both the SCRSN and the Substance Abuse Division of CSHCD provide ongoing dialog with providers regarding their ability to maintain and expand the workforce needed to provide responsive access to requests for services and routine services after the initial assessment/intake. The CSHCD has known for several years that psychiatrists and Advanced Registered Nurse Practitioners (ARNPs) are difficult to recruit and retain in mental health and SUD. Experience has proven that it takes approximately a year and a half to hire a psychiatrist in our region of care and approximately 9 months for an ARNP. Spokane County has universities that regularly graduate master's degree individuals willing to work in the mental health field, but time has proven that we are a training ground for hospitals, state departments, and insurance or managed care companies because they pay higher wages and often the work is not as stressful. Licensed Chemical Dependency Professional (CDP) are the most difficult to find in our region and our providers often "steal" from one another.

The Adult Behavioral Health Treatment Strategies' state committee as well as other legislators and state officials have been addressing this issue, to work with universities, suggesting that tuitions be waived and recruit nationally; however, no solid plan has been set into place yet.

Based on waitlists and reports that the SCRBHO monitors for adequate staffing (timely access to care, routine services, and no shows percentages), we are able to determine which providers have a shortage of staff. In 2015, the SCRSN provided an increase in providers' compensation to assist in recruitment and retention of qualified staff. This resulted in some success but still took months to fill the positions. Native Health of Spokane was funded with an additional ARNP that begins in October 2016, which took over 1 year to find. The rural counties in the region of care are utilizing Telemedicine for psychiatrists. However, they still must contract with a psychiatrist

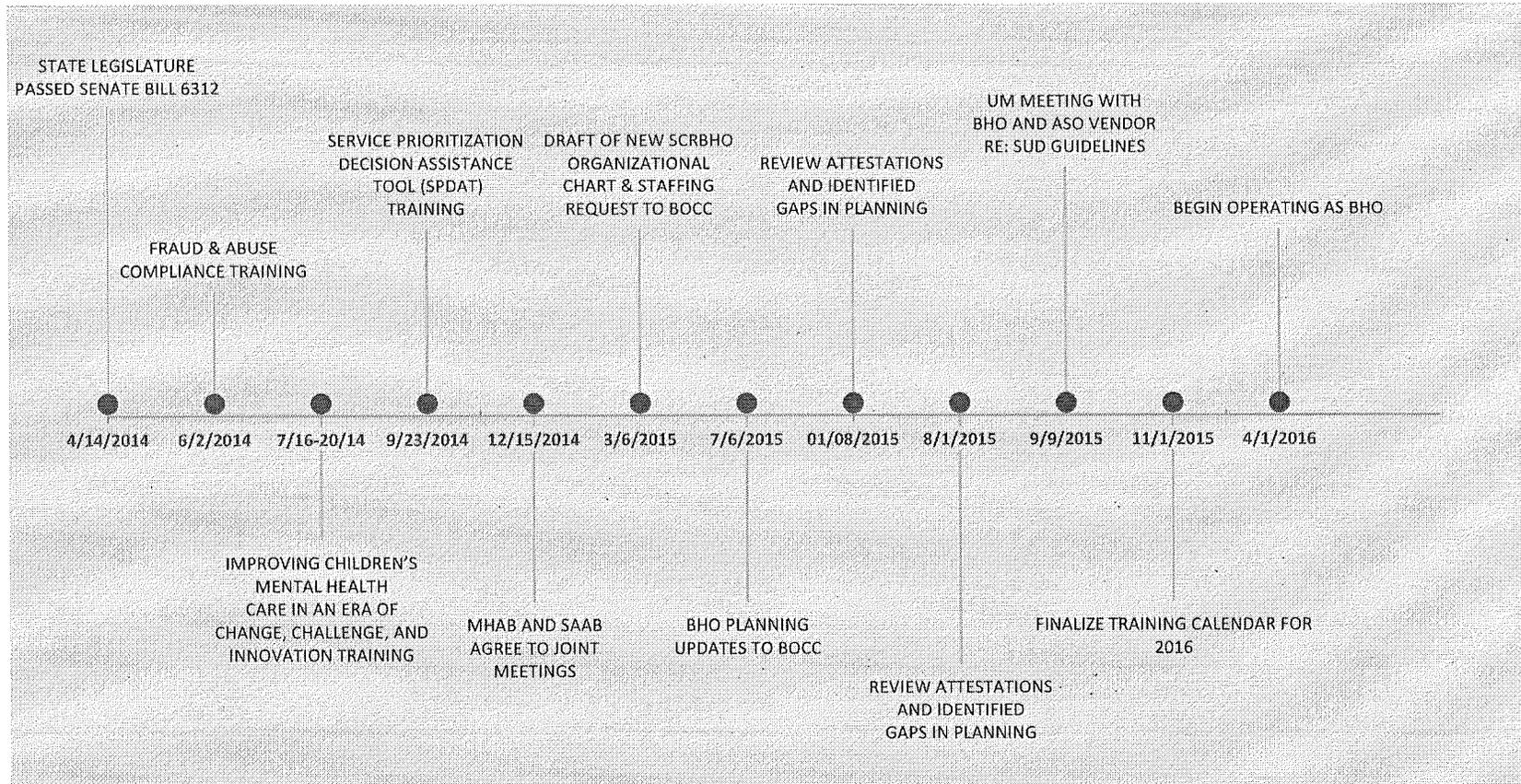
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willing to do evaluations and medication adjustments when they are not face to face with the individual. SUD providers are currently paid on a fee-for-service basis, and their funding has all been allocated to March 31, 2016; therefore, SUD providers are unable to hire additional staff as needed. They augment their expenses by providing services to individuals who have third-party insurance or by other non-county contracts.

When the SCRBHO is operational, we will be able to better address the waitlist for SUD outpatient and inpatient/residential services. We plan to address attracting additional CDPs by providing additional compensation to the providers, so they are more competitive with salaries and/or benefits.

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Timeline with Milestones for Staffing and Workforce Development



- Timeline Acronym Key:**
- ASO (Administrative Service Organization)
 - BHO (Behavioral Health Organization)
 - BoCC (Board of County Commissioners)
 - MHAB (Mental Health Advisory Board)
 - SAAB (Substance Abuse Advisory Board)
 - SPDAT (Service Prioritization Decision Assistance Tool)
 - SUD (Substance Use Disorder)
 - UM (Utilization Management)

VI. Financial and Administrative Plan

VI. Financial and Administrative Plan

The Spokane County Regional Behavioral Health Organization (SCRBHO) has a long history as a contractor with the Department of Social and Health Services (DSHS), and is building on our experience serving the diverse and unique needs of the 8 counties. We are well positioned as an administrator and manager of mental health and Substance Use Disorder (SUD) services and will comply with the statutorily required elements within our contract as a Behavioral Health Organization (BHO). We understand the objective of leveraging reimbursement methods to incentivize the overall desired performance improvements in client outcomes, integration of behavioral and primary care services at the clinical level, and improved care coordination for individuals with complex care needs.

Our commitment is unwavering as we build on the resiliency of all individuals (adults and children, youth and families) and support their recovery and fulfill the responsibilities, defined by statute, in ensuring our provider network offers a continuum of services to priority populations, consistent with medical necessity criteria and accepted practices.

Our goal is to leverage the effective partnerships we have established with our contracted community network, supporting expansion of their competencies in meeting the diverse behavioral health needs of the priority populations. We recognize that many individuals have complex needs and are actively supporting initiatives of the hospitals, primary care providers, and behavioral health providers joining together to improve the integration and coordination of care through co-location and stronger collaboration. We also have contracts with 5 Apple Health Managed Care Organizations (MCO) and are working to realize improved health outcomes for enrollees.

The Spokane County Regional Support Network (SCRSN) directs funding to our network providers to support them in their ability to offer assistance to individuals as they apply for insurance coverage. We are also committed to providing access to SUD services for individuals that meet medical necessity and demonstrate financial need. With the support of funding from state and Federal Block Grant resources, we recognize we must develop a safety net for individuals to receive SUD treatment resources and ameliorate the fiscal impact on providers.

As indicated in the July 1, 2015 SUD provider contracts, agencies that receive Criminal Justice Treatment Alternative (CJTA) funding allocations will be able to use the funding to cover treatment expenses for individuals who are enrolled in Drug Court, have a commercial insurance plan, and fall under the 220% of federal poverty level. In addition, SUD treatment providers are allocated state Grant in-Aid (GIA) and Federal Block Grant funding, to offer services to individuals who are not Medicaid eligible and fall below the 220% of poverty.

The SCRBO understands the importance of overseeing subcontracting and delegation functions and has established effective mechanisms to provide for the delegation of specific responsibilities to subcontractors. As a Prepaid Inpatient Health Plan (PIHP), we maintain authority and oversight for delegated activities, assuring that all required standards are met. We ensure that our providers are competent, licensed, and credentialed to provide the services

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needed. At contract renewal time, the SCRBHO will continue the process of requiring each provider to submit current licensure, insurance (including general liability, professional liability, medical malpractice, and automobile), current policies for records retention and fraud and abuse, copies of all subcontracts that are related to the SCRBHO funding, and a list of ownership, board of directors, and/or controlling members.

The responses below provide more detail about the SCRBHO's financial and administrative plan. The SCRBHO is a comprehensive plan supported by policies and procedures; contractually implemented; and inclusive of financial incentives established to improve system performance, and monitored through our Quality Management committee of the SCRBHO and its leadership. We are pleased to partner with the state and confident that our evolving responsibilities will support the service delivery transformation the state of Washington intends to support, as we work together to improve the overall health of residents of Washington.

2.019 Comprehensive Program of Treatment

(2) Describe how you will fund the services and incorporate and coordinate with public and private resources. Describe how you will fund the services and incorporate and coordinate with public and private resources.

The current system of care payment structure for SUD providers, for both outpatient and residential/inpatient, is based on a Division of Behavioral Health and Recovery (DBHR) fee for service or facility bed rate, per type of service. The Spokane County Regional Support Network (SCRSN) and the Spokane County Substance Abuse Division of the Spokane County Community Services, Housing, and Community Development Department (CSHCD) have been meeting for several months with the SUD providers to discuss funding, rates, the Mercer actuarial rate study for Medicaid, billing, and payment. This is in preparation for the BHO, effective April 1, 2016. Attachments 19 and 20 are 2 examples of worksheets that providers and the county staff have been compiling to assist with a reasonable analysis of how to adequately fund the rates to ensure that provider agencies are sustainable and solvent.

The RSN Administrators across the state have also formed workgroups to collaborate and determine a reasonable solution for contracting, rates, billing, payments, and service reporting on behalf of all the services provided; given that SUD is a statewide system of care rather than a regional system of care. The Spokane County staff has been key players in developing processes to determine costing/rates, billing, payments, and service reporting. The CSHCD leadership, of mental health and SUD treatment systems, has been participating in the state Chemical Dependency workgroup and the state Adult Behavioral Health Systems Task Force to learn more about integration. Our involvement has assisted Spokane County in problem solving to determine the best approach and methods for successfully merging 2 very different systems of care.

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Operating as a BHO, the SCRBHO will provide reimbursement for all required services within the contract, including those services targeting priority populations such as Intravenous (IV) drug users and pregnant and parenting women. At a minimum, we plan to contract with all current county-funded SUD outpatient providers and all the SUD inpatient, residential, recovery-house providers in each of the counties in our region for the April 1, 2016 through June 30, 2017 contract period. The state-wide RSN Administrators continue to discuss the possibilities for the SUD inpatient/residential providers including:

1. Contracting directly across the state with the BHOs of their choice;
2. BHOs contracting only with plans in their region; or
3. BHOs contracting with all the providers in the state or selective providers.

Conversations continue on a monthly basis, and, as these issues are surfaced, we are sharing that information with our providers for their input. The plans we outlined below are subject to change as we learn about our providers and also receive advice from a national consultant on cost and payment alternatives.

Agencies will be encouraged to continue seeking other contracts and third-party reimbursements to augment their costs.

Outpatient Service Providers (which includes Drug Court Assessment, Individual, Family, and Groups, Urinalysis, and Medication Assisted Therapy for Suboxone): The SCRBHO plans to establish a baseline for the revenue and expense for outpatient service providers from the last annual budget period (July 2014 – June 2015). The goal is to determine the actual cost of providing these services, regardless of payer. It is essential to ensure that agencies will be able to cover their cost of doing business with the BHO, and we believe a clearer understanding of a historical baseline is an important foundation. With this foundational analysis, we are exploring whether the new per member per month (PMPM) rates for Medicaid are sufficient. If the funding is sufficient, an increase will be added on to a provider's contract to allow for growth and expansion. It may be paid as an incentive if the providers meet or exceed performance expectations. We plan for a capitated dollar amount for the total contract and the providers will be paid on a 1/15th of a maximum contract amount each month. The contract will be for 15 months, April 1, 2016 through June 30, 2017. There will be an expectation, however, that the contract will be based on successful performance outcomes for the funding provided and the time period.

Building upon our experience with performance-based contracting with mental health, the SCRBHO plans to initiate a similar reimbursement process for our SUD outpatient providers. It will be a monthly payment of a portion of the contracted capitation contract, while measuring the performance outcomes that go hand in hand with the funding.

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We continue to meet with SUD providers to determine possible metrics for the performance outcomes. We have settled on the following:

- 1) Number of clients, 2) services, 3) hours, and 4) a % of charts reviewed that clearly demonstrate person centered recovery. We are still deciding if we want to include a reduction in inpatient readmissions. In addition to the SCRBHO performance outcomes, DBHR will also be including penetration and retention in treatment. The performance expectations will begin as a baseline that will be measured monthly and shared with the providers in year one. We will have some data for comparison in year 2, which may result in revising or utilizing different performance outcomes. See Attachment 21 labeled "Sample Performance Expectations for Mental Health."

Detox, Sobering, and Medication Assisted Therapy (Methadone): These 3 programs are currently reimbursed utilizing hourly or per diem rates. The SCRBHO plans to continue use of this reimbursement method moving forward the first year. Rates will be established with the involvement of providers. The current Methadone rate consists of a bundled rate per day that includes individual, group, and/or case management services. As a BHO, we would like to know how many individuals receive services in addition to the medication and the frequency. At this time, our preference would be a rate per day, augmented with funding for the extra services provided, such as the individual, case managements, or groups. In year 2 or 3, detox and sobering performance-based contracting will also be reviewed for a different method of performance-outcome contracting that includes client engagement in the community and referrals to recovery supports. The ratio of non-Medicaid funds paid to each provider over the prior annual period will be utilized as a baseline to allocate these funds. Moving forward, we will also use our knowledge of the number of non-Medicaid individuals who need and seek services under the BHO.

Inpatient, Residential, Recovery House, and Pregnant Parenting Women: The CSHCD leadership has spent time with the agencies that provide these services to better understand the complexity of both service delivery and the special populations served. We are working on rates together with the providers and have determined that one concept would be to contract with the agencies through a general purchase contract and through a daily per diem rate. We will pay the agencies for all authorized beds occupied, regardless of where the person resides in the state. Under this scenario the rate would be based on a cost of a bed-day, per type of agency for specific services, such as pregnant parenting women with and without children. Non-Medicaid (state GIA) and Federal Block Grant funds are limited and many of the agencies are Institute for Mental Diseases (IMD), as such, the revenue provided each month must be closely monitored to ensure that we have adequate funding for the contract period. The authorization criteria and utilization management of the SUD residential/inpatient services will require that the SCRBHO's Authorizing Service Organization (ASO) also understands which funding source is paying for each bed.

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Attachment 19 and 20 are sample templates that our providers are using to gather information to demonstrate the actual annual cost for the agency to provide the services. It will be used to inform rate setting. The cost for each type of service, inpatient, residential, etc., is listed on a separate report. The number of clients served per day has been requested to assist in addressing the providers' assertion that the rate the state has been paying the agency is not sufficient. In several cases, the current rate has been found to be adequate.

Drug Court Services: In addition to CJTA funds, local sales tax is currently utilized to support drug court related services and SUD treatment in the Spokane County Detention/Jail. A couple of the rural counties in our region utilize their local funds to support their drug courts as well.

Some of our network SUD provider agencies currently have contracts with Department of Corrections, other agencies, or other third party payers for SUD services. We encourage and support their use of non-BHO funding to address the needs of individuals who need services.

We will expect and require that all providers incorporate private resources to help support their organizations.

Address each requirement of these provisions. Specifically, describe how you will use provider reimbursement methods that incentivize improved performance with contractually required client outcomes, integration of behavioral and primary care services at the clinical level, and improved care coordination for individuals with complex care needs (address Apple Health coordination.) (003)

The SCRBHO recognizes there are several statutorily required elements to our contract as a BHO. These key elements are discussed in detail across and/or within sections of this detailed plan. In many cases, these elements are also reinforced and assured through our provider network contracts. The SCRBHO is building upon our experience serving the sometimes diverse and unique needs of 7 counties, with special attention to the needs of underserved populations, in complying with the requirements of Revised Code of Washington (RCW) 43.20A.894.

Our long contracting history with DSHS, as an administrator of both mental health and SUD services, has prepared the SCRBHO to successfully ensure access to effective services to eligible individuals. Consistent with state and federal managed care requirements, key components of our future BHO include:

1. *Focus on Core Populations:* The SCRBHO is committed to providing a recovery-oriented system of care that serves and builds upon the resiliency of adults with serious mental illness, children with mental health needs, and individuals in need of SUD treatment. Services to these populations are consistent with the priorities defined by statute and include a full continuum of interventions to address individual level-of-care needs, identified as medically necessary through broadly accepted practice guidelines. The SCRBHO continuum of care also includes services tailored to meet the needs of individuals with co-occurring mental health and SUDs. The SCRBHO recognizes our obligation to identify and serve individuals eligible for services, both clinically and financially, under the BHO contract.

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- 2. Competent Provider Network:* The SCRBHO recognizes that strong relationships with our behavioral health providers are essential in meeting the needs of our enrollees. The SCRBHO has well-established communication and collaboration pathways in working with providers. This has led to successes in the areas of establishing performance measures, adopting new and promising practices, and filling identified service gaps within local communities. Our contracts are intended to ensure network adequacy, incentivize best practices, and engage providers in our quality assurance efforts. The SCRBHO plans to incorporate the state outcome performance requirements in our provider contracts that were developed by the Adult Behavioral Health System Task Force (mental health penetration, hospital readmission reductions, and SUD retention and penetration). The SCRSN has also focused on local priorities to increase access to employment services for transitional youth prior to leaving high school and housing to assist individuals with mental illness in finding housing and offer community integration services in the community after hospitalization. Recently, two Wrap Around with Intensive Services (WISE) teams have served families in the home to prevent crisis, emergency room visits, and to support the family and child/youth, based on their needs.

Lastly, special attention has been given to our SUD providers to support their transition into a managed care program. These efforts, as well as more detail on our provider network activities, are detailed in the *Transition and Coordination of Services Plan (Plan II.)*, as well as the *Network Analysis and Development Plan (Plan IV.)*.

- 3. Financing of Services:* The SCRBHO recognizes the necessity of our own solvency requirements and other financial integrity standards as a BHO. As a BHO, we assume a great responsibility as stewards of public funds intended to meet the needs of our region's most vulnerable populations. We have experience managing risk for the individuals we serve and with the funding provided. The CSHCD accounting and program staff implemented a strong financial structure to budget, cost, and monitor actual versus contracted revenues and expenses on a monthly basis. This ensures that our financial data is correct and provides information to the program staff on a regular basis. The program staff is responsible to review the financial data, including projections, and determine if adjustments of contractual funding are needed for the types of services expected.

Providers' outcomes are monitored monthly and annually, with the level of reimbursement potentially impacted if providers do not meet established outcome thresholds. Continued challenges in meeting contract expectations may prompt review of outcome requirements or terms of the contract, and/or termination of the contract. As required, provider contracts also include provisions stating that public funds, appropriated by the legislature, may not be used to promote or deter, encourage, or discourage employees from exercising their rights under Title 29, chapter 7, subchapter II, United States Code or chapter 41.56 RCW.

The SCRBHO has experience with performance contracting and recognizes the opportunity to incentivize the use of evidence-based practices through performance-based

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contracting and will be planning for this possibility sometime in 2016-2017 for the SUD providers.

4. *Utilization Management:* The SCRBHO partners with Behavioral Healthcare Options to serve as our Administrative Service Organization (ASO). The SCRBHO operates with the belief that Utilization Management (UM) is a process that can reinforce best practice and individualized treatment approaches, rather than a mechanism to reduce care or purely limit expenditures. The SCRBHO encourages strong relationships between our ASO and provider network, including hosting joint meetings to address challenges and concerns. These meetings also allows stakeholder input in the adoption of practice guidelines and monitoring processes that are intended to improve outcomes through strong clinical practice. This effort is intended to maintain the decision-making independence of designated mental health professionals and designated chemical dependency specialists. More complete information on the utilization management of the BHO can be found in the *Utilization Management Plan (Plan VII)*.
5. *Emphasis on Quality Assurance:* Quality assurance is pursued through both the promotion and support of evidenced-based practices and monitoring of the effectiveness of those and other clinical approaches. This includes identification and collection of meaningful outcome measures. Specific elements of the SCRBHO quality assurance program can be found in the *Quality Assurance Plan (Plan VIII)*.
6. *Integration of Behavioral and Primary Care Services at the Clinical Level:* The SCRSN encourages our network providers to partner with primary care providers, including co-location of services within both settings. Contracts have been utilized to incentivize these activities. There are many network providers that have also established relationships with the managed care organizations. We are also pleased to report that our primary hospitals in the Spokane area are inviting mental health and SUD provider staff into their Emergency Department (ED) and crisis triage area to assist in the reduction of ED admissions. One hospital is paying Community Detox of Spokane to come to the hospital seven days a week, 8:00 a.m. to 11:00 p.m. to move adult individuals from the ED to an SUD detox, sobering, or residential facility. In the most recent month, they moved 80 individuals out of the ED. In another instance, an SUD youth residential provider is taking youth who are in the ED and waiting or able to titrate down, into their residential facility. The following table demonstrates the current status of integration efforts between our network providers and primary care.

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Mental Health and Co-Occurring and Substance Use Disorder Service
 Providers in the Spokane County Regional Behavioral Health Organization Region (33 providers)

	Signed agreements with MCO?	Staff work at medical facility to provide MH or SUD svc?	Employ anyone who performs physical health measurements?	External medical staff provide services at facility?	How is organization involved with housing?	Involved in helping find employment?
Total YES	18 or 56%	12 or 38%	13 or 41%	17 or 53%		11 or 34%
Total NO	14 or 44%	20 or 62%	19 or 59%	15 or 47%		21 or 66%
				Housing totals:		
				not involved	3 or 9%	
				provide and place	2 or 6%	
				refer	16 or 50%	
				refer and place	4 or 13%	
				refer and provide	2 or 6%	
				refer, provide, and place	5 or 16%	

7. *Coordination with Apple Health:* The SCRBHO understands one of the state’s primary health goals is improved care coordination for individuals with complex care needs. The SCRBHO currently has partnerships and contracts with 5 of the Apple Health MCOs: Cenpatico Behavioral Health LLC, UnitedHealthcare Community Plan, Molina Healthcare of Washington, Amerigroup Washington Inc., and Community Health Plan of Washington. These contracts formalize agreements for data exchange, sharing of information, and transfer of enrollees for treatment. Effective April 1, 2016, provider contracts will also include language regarding the coordination of health care for all enrollees for primary, mental, and SUD healthcare. Currently, the RSN Administrators are working with these five MCOs to do better care coordination of individuals that are admitted into hospitals for psychiatric or medical needs. The MCOs are evaluating whether they will contract with the BHOs to provide services to individuals that have mild and moderate mental illness but also have a substance use disorder.

Describe how you will administer patient financial responsibility for non-Medicaid services. (037)

The CSHCD Substance Abuse Division allocates outreach funding to all providers to assist in the efforts to enroll individuals with health care coverage. While the intent is to enroll as many eligible individuals as possible with health care coverage, SCRBHO understands that some individuals may not be eligible for Washington Apple Health, and some services within the desired continuum of services are not reimbursable under Medicaid. The SCRBHO is committed to providing access to SUD services to individuals who meet medical necessity and demonstrate financial need with the support of funding from state and Federal Block Grant resources. This will ensure a safety net for individuals to receive SUD treatment resources and ameliorate the fiscal impact individuals or providers.

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As indicated in the July 1, 2015 SUD provider contracts, agencies that receive Criminal Justice Treatment Alternative (CJTA) funding allocations will be able to use the funding to cover treatment expenses for individuals who are enrolled in Drug Court, have a commercial insurance plan, and fall under the 220% of federal poverty level. In addition, the SCRBHO's contracted SUD treatment providers are allocated state GIA funding. The funding is flexible and allows providers to cover treatment costs for those individuals who are not Medicaid eligible and fall below the 220% of federal poverty level.

Providers are required to verify an individual's financial eligibility upon enrollment into services and continued eligibility on a monthly basis, per contract. Providers utilize OneHealthPort to verify enrollment in Apple Health. If an individual is not eligible for Apple Health, providers have been instructed by Spokane County Regional Support Network (SCRSN) and the Spokane County Substance Abuse Division to verify financial eligibility, including collecting documentation to support need. Documentation may include paycheck stubs, letters from unemployment office, etc. Providers utilize a sliding-fee schedule in determining the fees for low-income eligible services. If a provider determines that charging a low-income individual a fee would stop the individual from continuing treatment, the fee requirement may be waived by the provider. Specific to CJTA funding, an individual must attest that they are unable to meet the co-pays and deductible of their insurance plan.

The SCRBHO is hopeful there will be adequate state GIA and Federal Block Grant funding to allow providers to cover the treatment costs for those individuals who are not Medicaid eligible and fall below the 220% of federal poverty level. If there is adequate state GIA funding; the SCRBHO would like to continue to support providers with their enrollment efforts to link individuals with health care coverage.

Describe how you will ensure substance use disorder treatment services are provided to persons enrolled in substance use disorder treatment under the criminal justice treatment account. Describe how you will develop your local plan in conjunction with the stakeholder groups described in this section and as described in the draft PIHP contract. (048)

The CSHCD, Substance Abuse Division, currently facilitates quarterly meetings with the local Criminal Justice Treatment Account (CJTA) Workgroup Panel as outlined in RCW 70.96A.350. In 2013 CSHCD worked with the local CJTA panel to update the local workgroup plan which was submitted to the Department of Behavioral Health and Recovery and is still being used by the local panel. Since the implementation of Substitute Senate Bill (SSB) 6312 in 2014 CSHCD has been informing and engaging the panel in discussions and planning for the expected changes, effective April of 2016. This local panel includes representatives from the state identified parties of interest including CSHCD, Spokane County Behavioral Health Adult Felony Therapeutic Drug Court, prosecuting attorneys, defense attorneys, County Sheriff, and treatment and childcare providers.

The Spokane County Behavioral Health Adult Felony Therapeutic Drug Court currently contracts with an outpatient provider who receives the CJTA and Drug Court funding to serve the individuals involved with Drug Court, as well as individuals who meet criteria for CJTA funded treatment or funded by Spokane County. As the SCRBHO and in conjunction with the

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CJTA Workgroup Panel, we will review reports of the services provided to the target population, monitoring their effectiveness and responsiveness of treatment in meeting the needs of individuals who meet criteria for CJTA funded treatment. In those instances when the sole provider has indicated a surplus of funding, the CSHCD has asked the local panel for approval to move surplus funding to other Spokane County adult outpatient providers to treat individuals who meet the criteria under RCW 70.96A.350. Some of the other 6 counties who will join the BHO will not have Therapeutic Drug Courts but will use CJTA funding to treat individuals who meet the criteria under RCW 70.96A.350.

It is the understanding of SCRBHO that CJTA and Drug Court funding will be allocated to the BHO's for continuance of Drug Court and CJTA treatment services within the BHO's service area. The SCRBHO will continue to have a presence on the local Spokane County CJTA Workgroup panel, as well as any other Drug Court panels that may be established in the other 6 counties. The funding is categorical and will continue to be used to support individuals in Drug Court and those who meet the eligibility criteria outlined in RCW 70.96A.350. It is also the intent of the SCRBHO to continue to support the Innovative Project at Geiger Correctional Institution (a Chemical Dependency Professional (CDP) stationed at Geiger does SUD assessments, referrals, and core coordination for inmates to SUD inpatient and outpatient programs) if there is adequate funding to do so.

Provide sample subcontracts and/or delegation agreements. Provide policies and procedures for subcontracting and delegation that address these regulatory requirements and specifically address how subcontracted/delegated entities are evaluated and monitored. Provide the most recent monitoring reports for three entities. Describe in detail your current and planned subcontracting/delegation activities for substance use disorder treatment services. (290)

The SCRSN has a delegation plan and has established effective mechanisms to provide for the delegation of specific responsibilities to subcontractors. As a PIHP, the SCRSN maintains authority and oversight for its delegated activities, ensuring that all required standards are met. Providers' proven abilities and licensure are reviewed prior to the SCRSN offering a contract. Providers must submit credentialing information prior to any initial delegation or contract renewal.

At contract renewal, the SCRSN and the Spokane County Substance Abuse Division requires each of the providers to submit current licensure, insurance (including general liability, professional liability, medical malpractice, and automobile); current policies for records retention and fraud and abuse; copies of all subcontracts that are related to their funding; and a list of ownership/ board of directors/controlling members.

As a part of the contracts with agencies, we verify the agency for exclusion through Office of the Inspector General (OIG) and System for Award Maintenance (SAM). Monthly, thereafter, the CSHCD staff compares the list of newly excluded individuals to the list of active contracts. Annually, each agency is checked through Office of Inspector General (OIG). Each provider certifies in signing the contract that they run annual and monthly debarment verification. Agency providers submit a monthly report stating they have performed an OIG excluded provider check.

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Annually, the CSHCD conducts detailed credentialing reviews of its contracted provider's behavioral health clinicians, case managers, Chemical Dependency Professionals (CDP), and medical personnel as a component of its contract compliance review. We verify staff name, degree, current licensure, staff certification or specialties, staff hire, staff training, agency current licensure, and staff signature at each provider agency. The SCRSN Administrator approves each request for Designated Mental Health Professional (DMHP), based on approved backup that justifies the request documentation and a request from the provider.

During an onsite visit for a personnel file review, the CSHCD verifies that each agency performs the monthly exclusion checks prior to hire and monthly thereafter, using OIG and SAM databases. The CSHCD also reviews the physical location of providers for accessibility, posting requirements in public areas, and ease of enrollee access on an annual basis.

The SCRSN does an annual review of contracts, changes in clinical processes, and financial reviews. These may be based on performance or financial reports, by request of provider to discuss options or changes in clinical programs, or to request changes in funding. Other ad hoc reviews are performed as needed to determine if the agency is appropriately providing the required contractual elements and the delegation of any function or duties. The Substance abuse providers also receive financial, clinical, and encounter validation reviews on an annual basis, and the CSHCD staff work with agencies to ensure they understand and meet their contractual obligations.

The SCRSN has policy and procedure requirements for excluded provider, staff qualifications, compliance with state and federal laws, and related policies that providers incorporate into their own policies. The SCRSN verifies that these policies contain all the required elements on an annual basis. New policies are regularly presented at Quality Management and System of Care meetings to ensure providers understand policy requirements.

The SCRSN and the CSHCD Substance Abuse Division review performance data for each provider on a regular basis.

The SCRSN Quality Management Committee meets regularly and includes both the SCRSN and contracted provider staff. The SCRSN reviews quality across the range of business processes, including clinical care, finance, and information systems.

The SCRSN has added representatives of the chemical dependency treatment system to the Quality Management Committee to begin the process of integrating quality management activities across the behavioral health spectrum.

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CURRENT DELEGATION FOR MENTAL HEALTH:

Activity:	Delegated To:
Request levels of need and request authorization for services.	Contracted Providers
Authorization and re-authorization for inpatient, outpatient treatment services, Levels of Need outpatient, and residential placement services	Administrative Service Organization (ASO) Contractor
Assessments of consumers prior to determination of appropriateness of inpatient, outpatient, or residential services	Contracted Providers
Adverse Determinations (Denials)	ASO Contractor
EPSDT – Initial intake review	Contracted Providers
Care Management: <ul style="list-style-type: none"> • Assessment and Re-Assessment <ul style="list-style-type: none"> • Care Planning and Implementation • Collaboration in authorizations required for discharge and transfer needs 	ASO Contractor in Collaboration with Providers
Inpatient, Outpatient, and Residential Services	Contracted Providers
Appeals – 1 st and 2 nd level inpatient; 1 st level outpatient	ASO Manager
Appeals – 2 nd level outpatient	State Office of Administrative Hearings
Communication with consumers - Provide the Division of Behavioral Health and Recovery (DBHR) Benefits Booklet, etc.	Contracted Providers
Communication with consumer members – negative action	ASO Contractor
Telephonic communication with consumers re: NOD/NOA	ASO Contractor
Communication with consumers and providers	Quality Review Team (QRT) Contractor and Ombuds Service Contractors
Staff credentialing, re-credentialing, training review and licensure including MHP, DMHP and MH Specialist	Contracted Providers and ASO Contractor, monitoring oversight by SCRSN clinical staff

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Activity:	Delegated To:
Monitoring a Least Restrictive Alternative (LRA) or a Conditional Release.	Contracted Psychiatric Provider and Contracted Providers
Coordination of outside MD for LRA	Contracted Providers
Ombuds Services	Ombuds Service Contractors
Data Submission to ProviderOne	Raintree
Maintenance of hardware and network	Spokane County ISD and Raintree
SCRSN software	Raintree
Crisis Hotlines	Contracted Crisis Provider Agencies
After hours customer services – authorizations	ASO Contractor
Department Counsel	Spokane County Prosecutor’s Office
Special Population Consult	Contracted Provider Agencies
Interpreter Services	Contracted Providers for their internal communication or connection to external entities for interpreter/translation needs
Coordination of Care	Contracted Providers and ASO Contractor
Safeguarding Protected Health Information (PHI) and Health Insurance Portability and Accountability Act (HIPAA) Breaches of Confidentiality to SCRBHO	Contracted Provider Agencies
Incident Reporting to SCRSN	Contracted Providers
Media Reporting to SCRRSN	Contracted Providers

The SCRBHO will have a comprehensive delegation plan in place and expand its established mechanisms to provide for the delegation of specific responsibilities as a BHO. The SCRBHO maintains authority and oversight for its delegated activities, ensuring that all required standards are met.

Provider credentials are reviewed prior to the SCRBHO offering a contract. Providers must submit credentialing information prior to any contract renewal.

At contract renewal, the SCRBHO will require both mental health and SUD providers to submit current licensure, insurance (including general liability, professional liability, medical malpractice, and automobile), current policies for records retention and fraud and abuse, copies

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of all subcontracts that are related to the SCRBHO funding, and a list of ownership/ board of directors/controlling members.

Prior to contracting, the SCRBHO will verify the contractor for exclusion through the OIG and SAM. Monthly thereafter the BHO compares the list of newly excluded individuals to the list of active contracts. Annually, each agency is again run through OIG. Each provider will certify in signing the contract that they run annual and monthly debarment verification. In addition, providers submit a monthly report stating they have performed an OIG excluded-provider check.

Annually, the SCRBHO will conduct detailed credentialing reviews of its contracted provider's behavioral health clinicians, case managers, CDPs, and medical personnel as a component of its contract compliance review. The SCRBHO will verify staff name, degree, current licensure, staff certification or specialties, staff hire, staff training, agency current licensure, and staff signature at each provider agency. The SCRBHO approves each request for a Designated Mental Health Professional, based on submitted documentation and request from the provider.

During this onsite personnel file review, the SCRBHO will verify that each agency performs the monthly exclusion checks prior to hire and monthly thereafter, using OIG and SAM databases. The SCRBHO will review the physical location of providers for accessibility, posting requirements in public areas, and ease of enrollee access on an annual basis

In addition to the annual site review, the SCRBHO may request other reviews of contracts, changes in clinical processes, and/or financial reviews. These may be based on performance or financial reports, by request of provider to discuss options or changes in clinical programs, or to request changes in funding.

The SCRBHO will monitor and assure that all Corrective Actions a contracted provider agency receives, as a result of a state audit, are corrected in the timeline and manner prescribed by the audit requirement.

The SCRBHO has policy and procedure requirements for excluded providers, staff qualifications, compliance with state and federal laws, and related policies that providers incorporate into their own policies. The SCRBHO will verify that these policies contain all the required elements on an annual basis. New policies are regularly presented at Quality Management meetings and System of Care meetings to ensure providers understand policy requirements.

The SCRBHO will review performance data for each provider on a regular basis.

The SCRBHO Quality Management Committee will meet regularly and includes both SCRBHO and contracted provider staff. The SCRBHO will review quality across the range of business processes, including clinical care, finance, and information systems.

Prior to becoming a BHO, the SCRBHO added representatives of the chemical dependency treatment system to the Quality Management Committee to begin the process of integrating quality management activities across the behavioral health spectrum.

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SCRBHO DELEGATION PLAN

Activity:	Delegated To:
Request authorization of mental health services based on medical necessity and Access to Care; request authorization for substance use disorder services based on ASAM and other factors	Contracted Treatment Providers
Authorization and re-authorization for inpatient, outpatient treatment services, Levels of Need outpatient, residential placement services, and Medicaid Personal Care	Administrative Service Organization (ASO) Contractor
Assessments of individuals prior to determination of appropriateness of inpatient, outpatient, or residential services	Contracted Treatment Providers
Adverse Determinations (Denials)	ASO Contractor
EPSDT – Initial intake review	Contracted Providers
<p>Care Management:</p> <ul style="list-style-type: none"> • Assessment and Re-Assessment • Care Planning and Implementation • Collaboration in authorizations required for discharge and transfer needs 	ASO Contractor in Collaboration with Providers and SCRBHOO Behavioral Health Care Coordinators
Inpatient, Outpatient, Residential Services, and Substance Use Disorder Recovery Services	Contracted Providers
Appeals – 1 st and 2 nd level inpatient; 1 st level outpatient	ASO Manager
Appeals – 2 nd level outpatient	Office of Administrative Hearings
Communication with individuals - Provide the Division of Behavioral Health and Recovery (DBHR) Benefits Booklet, etc.	Contracted Providers
Communication with individuals – negative action	ASO Contractor
Communication regarding Medicaid and non-Medicaid Rights	Contracted Providers Ombuds Services Contractors
Telephonic communication with individuals re: notice of action (NOA)	ASO Contractor
Communication with individuals and providers	QRT and Ombuds Service Contractors
Staff credentialing and licensure including MHP, MH Specialist, CDP, Physician NPI	Contracted Providers and ASO Contractor, oversight by SCRBHOO clinical staff

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Activity:	Delegated To:
Monitoring a Least Restrictive Alternative (LRA) or a Conditional Release.	Contracted Psychiatric Provider or Contracted Treatment Providers via MOU between Psychiatric Lead Agency and Contracted Providers
Coordination of outside MD for LRA	Contracted Treatment Providers
Ombuds and Quality Review Team Services	Ombuds and QRT Service Contractors
Data Submission to ProviderOne	Raintree
Maintenance of hardware and network	Spokane County ISD, Raintree, and Radiance
SCRSN Software	Raintree
Crisis Hotlines	Contracted Crisis Provider Agencies
After hours customer services – authorizations	ASO Contractor
Department Counsel	Spokane County Prosecutor’s Office
Special Population Consultation	Contracted Provider Lead Agency in conjunction with Contracted Providers
Interpreter Services	Contracted Providers
Coordination of Care	Contracted Providers and ASO Contractor in collaboration with SCRBHO Care Coordinators
Safeguarding Protected Health Information (PHI) and Health Insurance Portability and Accountability Act (HIPAA) Breaches of Confidentiality to SCRBHO	Contracted Provider Agencies
Incident Reporting to SCRBHO	Contracted Providers
Media Reporting to SCRBHO	Contracted Providers

As requested, the most recent monitoring reports for three entities can be found in Attachments 22, 23, and 24.

If the proposed Behavioral Health Organization involves more than one county, provide a copy of the required agreement that meets the requirement of this section. (160)

As required by Chapters 71.24 RCW (Community Mental Health Services Act) and 39.34 RCW (the Interlocal Cooperation Act), the Spokane County Regional Support Network (SCRSN) maintains a current interlocal agreement with Adams, Ferry, Grant, Lincoln, Okanogan, Pend Oreille, Stevens, and Spokane counties through March 31, 2016.

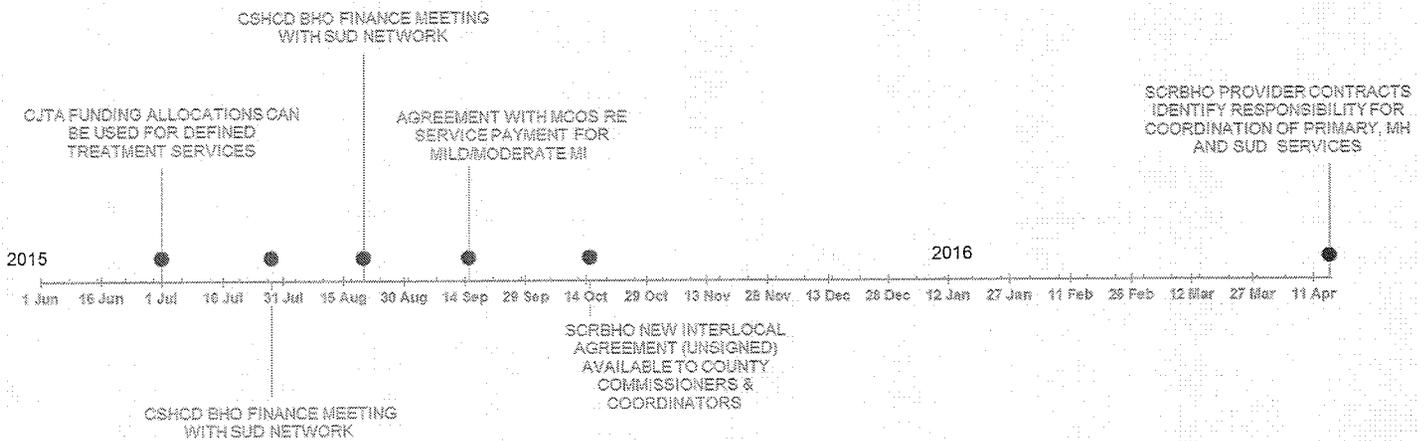
Effective April 1, 2016, a new interlocal agreement under the SCRBHO, will include the aforementioned counties but will exclude Grant. Although the new interlocal agreement is not yet signed, it has been made available to all county coordinators, and in November 2015, will be reviewed with the Spokane BOCC and can be found in Attachment 25.

Spokane County Regional Behavioral Health Organization

If the proposed Behavioral Health Organization involves more than one county, provide a copy of the required agreement that meets the requirement of this section. (161)

The Spokane County Regional Support Network (SCRSN) maintains a current interlocal agreement with Adams, Ferry, Grant, Lincoln, Okanogan, Pend Oreille, Stevens, and Spokane counties through March 31, 2016. Effective April 1, 2016, a new interlocal agreement under the BHO, the SCR BHO will include the aforementioned counties but will exclude Grant. The new interlocal agreement is not yet signed but has been made available to all county commissioners and county coordinators and can be found in Attachment 25.

The SCR BHO is confident our evolution to functioning as an effective, responsive, and fiscally responsible BHO will occur smoothly, and we will fulfil our responsibilities as mandated by the state. We will comply with federal and state statute and regulations, hold relevant contracts and agreements, and in collaboration with providers, MCOs, and sister agencies, support the state of Washington's transformation of its health care system in its goal to improve the health outcomes of its residents and its communities.



Timeline Acronym Key:

- BHO (Behavioral Health Organization)
- CJTA (Criminal Justice Treatment Account)
- CSHCD (Community Services, Housing, and Community Development)
- MCO (Managed Care Organization)
- MI (Mental Illness)
- MH (Mental Health)
- SCR BHO (Spokane County Regional Behavioral Health Organization)
- SUD (Substance Use Disorder)

VII. Utilization Management Plan

VII. Utilization Management Plan

The Spokane County Regional Behavioral Health Organization (SCRBHO) is committed to providing Substance Use Disorder (SUD) treatment services to Medicaid enrollees for whom services are medically necessary as well as other priority populations, as determined by the state. A significant area of focus for the SCRBHO planning and preparation in developing our BHO structure has been the transition of SUD enrollees, providers, and administration of services into managed care.

Building on the approach similar to our Mental Health Utilization Management Plan (UM) the SUD UM Plan will establish a service delivery, based on network care standards of nationally accepted criteria for medical necessity and the varying levels of care, as developed by the American Society of Addiction Medicine (ASAM). The UM Plan is anchored in accomplishing the objectives of improving enrollees' outcomes, achieved within a framework of individualized, strengths-based and person-centered planning, and interdisciplinary team collaboration. Additionally, the SCRBHO is committed to serving the enrollees with an effective and responsive delivery system that continually assesses how to meet enrollee needs, incorporates evolving practices, and supports delivery changes as it identifies, monitors, and addresses emerging SUD challenges.

How will you assure an independent review occurs for minors admitted under the provisions of 70.96A.245 that meets these requirements? This requirement will be delegated to the BHO by the Department. (23)

As described in more detail below, the SCRBHO will extend the current contract the SCRSN holds with the Administrative Services Organization (ASO) and will include within the Delegation Agreement responsibility for completing an independent review for a minor admitted to inpatient treatment, under Revised Code of Washington (RCW) 70.96A.245. As required by the state, this review will be conducted by a physician or Chemical Dependency Professional (CDP) who is employed by the ASO and is in compliance with the SCRBHO contract with the Department of Social and Health Services (DSHS). The ASO will not have a financial interest in continued inpatient treatment of the minor, nor be affiliated with the program providing the treatment. The physician or CDP will conduct the review not less than 7 nor more than 14 days following the date the minor was brought to the facility, under RCW 70.96A.245(1), to determine whether it is a medical necessity to continue the minor's treatment on an inpatient basis.

As part of the determination, the physician or CDP will consider whether it is a medical necessity to release the minor from inpatient treatment and will consider the opinion of the treatment provider, the safety of the minor, the likelihood the minor's chemical dependency recovery will deteriorate if released from inpatient treatment, and the wishes of the parents.

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If the physician or the chemical dependency counselor determines it is no longer a medical necessity for a minor to receive inpatient treatment, the ASO staff is responsible for immediately notifying the professional person in charge, who will then immediately notify the parents. The professional person in charge shall release the minor to the parents within 24 hours of receiving notice. If the professional person in charge and the parent believe that it is a medical necessity for the minor to remain in inpatient treatment, the minor shall be released to the parent on the second judicial day following the determination, to allow the parent time to file an at-risk-youth petition, under chapter 13.32A RCW. If it is determined it is a medical necessity for the minor to receive outpatient treatment and the minor declines to obtain such treatment, such refusal shall be grounds for the parent to file an at-risk-youth petition. In accordance with RCW 70.96A.097, the SCRBHO contractor will continue to recommend at-risk-youth petitions for those minors who decline medically necessary inpatient or outpatient chemical dependency treatment.

As the SCRBHO, the UM Plan will facilitate the improvement of access to SUD services to eligible individuals throughout the continuum of services and,

- Deliver services based on network care standards of nationally accepted criteria for medical necessity and the varying levels of care, developed by ASAM;
- Collaborate with network providers to offer high-quality services, anchored in evidence-based practices and within an integrated behavioral health approach;
- Strengthen enrollees' outcomes, achieved within a framework of individualized, person-centered planning, and interdisciplinary team collaboration;
- Establish a process for identifying when and how much treatment is offered to other non-Medicaid populations, based on the state's priorities; and
- Delineate the approach to address emerging substance use disorder challenges.

Delegation Agreement (see also 290)

As demonstrated through the sample subcontracts and/or delegation agreements and discussed in VI. Financial and Administrative Plan, the SCRSN is responsible to meet all standards under federal and state statutes and regulations and Washington Administrative Code (WAC) and, as the SCRBHO, will fulfill state-identified responsibilities. The SCRBHO will continue an established delegation agreement with Behavioral Healthcare Options, a contracted ASO. We will delegate responsibilities and functions to the ASO that are clinically sound and compliant with the DSHS/Division of Behavioral Health and Recovery (DBHR) contract. The contract with the delegated entity will clearly identify that the legal responsibility, for all functions, remains with the SCRBHO.

Describe your Utilization Management System and how you will ensure substance use disorder treatment services are provided to Medicaid enrollees for whom they are medically necessary. Include a process for determining when and how much treatment is offered for other non-Medicaid populations based on the state's priorities. (24)

The SCRBHO will contract with Behavioral Healthcare Options to include responsibility for implementing a UM Plan that is inclusive of SUD services as well as mental health services. The SCRBHO will develop a written contract that is consistent with the requirements of 42 CFR 438.230 and provides for an evaluation of the subcontractor's ability to perform the delegated activities. The contract will specify the activities and reporting, delegated to the ASO, and provide for revoking the delegation or imposing other sanctions if the ASO's performance is inadequate. Currently, the performance of the ASO is reviewed and monitored as part of the SCRSN Quality Management Plan for 2013-2015. The SCRSN staff reviews monthly reports, including the *Appointment Standards through the Monthly Access to Care Standards Report*, as well as reports which collect information on the number of individuals being served, to identify trends and make recommendations at the Quality Improvement Committee (QIC) meetings. Data will continue to be used as one tool to guide leadership decisions that address service gaps, individuals in need of services, and compliance with the UM Plan standards, and any other remarkable trends and patterns. Additional reports used to monitor compliance with access to service include the *Pending Authorization Report* and *Annual Outpatient (OP) Authorization Timeliness Report*.

Service through the SCRBHO will be available 24 hours a day, 7 days a week for individuals, youth, and families seeking access to care or requiring information about specific providers, diagnosis, benefits, eligibility, or educational resources. Under the direction of the ASO's medical director, qualified and licensed clinical staff will be available to respond to all SUD service requests for authorization; including inpatient withdrawal management, determine resource availability, and make appropriate referrals as necessary.

Requests for Service are directed to the ASO and the ASO authorizes the services based on medical necessity, International Statistical Classification of Diseases and Related Health Problems (ICD)-10 diagnosis, and ASAM level for anyone needing SUD services. The SCRBHO will monitor the denials by the ASO to ensure that we are not turning individuals away that need to be served. Denial reports are a part of not just utilization management but are reviewed by the Quality Teams to ensure SCRBHO is serving individuals who need the services. The other report the Quality Team reviews is the monthly Service Denial Report from each provider that lists each person denied and why. In the past we discovered in mental health that people were being turned away or sent to other agencies because there was not enough staffing to handle the volume of requests. When that occurs we make adjustments in the system which may mean more staffing to a provider, and perhaps less to another who is below volume; or we reorganize how referrals flow so that the number of requests are spread out. In the SCRSN processes are interconnected so that utilization management issues may be addressed by Quality

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Teams, financial, leadership, or information systems staff. If it is determined that there are issues or concerns that need to be addressed by providers then one of the regular quality group meetings are utilized to address and resolve the issues or needed changes.

Clients who are not on Medicaid will be offered services if they meet the same criteria for treatment as Medicaid clients. The requests for services come to the provider organizations and they request authorization from the ASO if the provider has State Grant-in-Aid (GIA) or Federal Block Grant funding available, if they do not they may refer through warm handout to another agency that has those funds available. The SCRBHO will ensure that 5% of the Federal Block Grant is dedicated to the pregnant parenting women who do not have Medicaid and will track those clients and funding expended. Once the State GIA and federal block grant funds are totally exhausted then the person requesting services will be referred to other organizations in the community.

Describe your utilization management system and how it will be modified to provide all utilization management activities, including authorization of services for substance use disorder services. (284)

As discussed above, the SCRSN delegates the authorization of services to an ASO, Behavioral Healthcare Options. The ASO UM operates in a clearly defined organizational structure. UM is supported by trained, qualified, clinical and non-clinical staff and resources to perform this function effectively under the supervision of a qualified UM Program Manager. The ASO Medical Director provides clinical oversight of the UM function, supervises all clinical decisions and is responsible for quality improvement and quality assurance activities. Additionally, full-time analysts and the SCRBHO leadership routinely work closely with the UM operations.

The ASO uses specific guidelines for the utilization of each level of care. These criteria are reviewed and address the clinical thresholds for when a service is appropriate; what initial assessment guidelines should be used by the reviewers; what concurrent review guidelines should be applied; when a referral is indicated for a physician review; when a review is not indicated; and, what discharge criteria are applicable.

For certification of any level of care, the following conditions must be met: 1) an appropriate evaluation has been performed to establish the presence of a treatable psychiatric condition; 2) the enrollee can be expected to benefit from appropriate treatment; 3) any level of treatment should be based on necessity, not convenience, and cannot be safely or effectively provided in a less acute setting, 4) if inpatient psychiatric care is secondary to a physical condition putting the patient at risk, the care should be managed in a medical setting; and (5) enrollees receive initial and extended service by adherence to appropriate treatment recommendations including but not limited to medication regimens, participation in therapeutic groups and individual sessions, treatment and discharge planning.

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The UM Program uses standardized, objective and clinically valid criteria to approve requested services/care in conjunction with the SCRSN Level of Care, and State of Washington guidelines for Access to Care and medical necessity. These guidelines are compatible with established principals of healthcare and flexible enough to allow deviations. Screening criteria is applied in a flexible manner based on currently accepted medical or healthcare practices, enrollees with specialized needs, including but not limited to: members with disabilities, acute conditions or life-threatening illness, and an assessment of the local delivery system.

The ASO's Senior Care Advocates (SCA) are licensed Registered Nurses (RNs) (unrestricted licenses in the State of Washington and/or Nevada), Licensed Clinical Social Workers, Licensed Mental Health Professionals (MHP), or Licensed Marriage and Family Therapists (unrestricted in the state of Washington) with 3 years of clinical experience. They are up to date with continuing education, fully oriented to the ASO's clinical criteria, and trained in UM processes. They use the SCRSN's established criteria to define medical necessity, length of stay, and intensity of service with focus on high risk, high-resource usage, and high-cost diagnosis and/or procedures.

Physicians are required to maintain board certification in their specialty areas and are re-credentialed every 3 years. Registered Nurses, Licensed, Clinical Social Workers, Licensed MHPs, or Marriage and Family Therapists are required to maintain valid and current unrestricted licensure.

As part of our monitoring the use and pattern of extensions and implementing corrective action where necessary, we will regularly review reports, as described in our SCRSN Quality Management Plan, and committee structure to ensure compliance. Policies will also state that authorization decisions must be expedited to no longer than 3 business days after receipt of the request for services if either of the following is true:

- The enrollee's presenting mental health condition affects his or her ability to maintain or regain maximum functioning; or
- Enrollee presents a potential risk of harm to self of others.

In the event that information received does not sufficiently meet admission or continued stay criteria, or the proposed care is ambiguous, the Senior Care Advocate refers all information to the ASO's Medical Director. This review is to be completed within 24 hours of receipt.

As the result of the peer review, one of the following will occur:

- A determination that medical necessity has been established. The written decision is returned to the Senior Care Advocate for documentation into computer system, same day verbal notification is given to provider.
- Determination that medical necessity does not exist. The ASO Medical Director signs the decision-review form. The physician returns the form to the Senior Care Advocate

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who notifies the provider of the decision. The Senior Care Advocate prepares and sends the written notification to the provider, facility, and patient, per established timeframes.

If the determination requires additional information to make a decision and if the provider fails to provide necessary or adequate information to determine if medical necessity exists, the physician or peer advisor calls the attending physician or provider to obtain necessary information. The physician or peer advisor still must make a decision within 24 hours of receipt of request. If no response is received from the treating provider, the determination is based on the clinical information available.

Inpatient denials are only made by Medical Doctors (MDs) or Doctors of Osteopathic medicine (DOs). Adverse determinations issued for urgent and non-urgent care have an indicated clinical and/or administrative reason based upon the criteria, specific delegated criteria, benefit coverage, knowledge of local healthcare delivery systems, and available practitioner-to-practitioner communication.

Adverse determination based on clinical criteria may occur in the following instances: 1) The treatment setting requested is not consistent with the diagnosis, severity, or complexity of symptoms, and the treatment proposed can safely be completed in an alternative care setting; 2) The proposed treatment provider is not licensed or qualified to provide the requested service(s). In these situations, the ASO would recommend referral to a qualified provider; 3) The treatment modality is not consistent with the diagnosis, severity, and/or complexity of the case; 4) the information provided fails to meet the medical necessity criteria for the requested care; 5) the proposed treatment fails to hold reasonable probability of rapid stabilization and/or improvement by the patient; or 6) There is lack of timely treatment processes to include for example, family sessions, a psychiatrist visit, necessary treatment planning, and/or there are non-clinical discharge delays, and lack of medication adjustments where indicated to support clinical progress.

If the SCRBHO denies payment of any portion of a psychiatric inpatient stay and the inpatient facility has a dispute, we will follow the dispute process provided in the Health Care Authority's (HCA's) Inpatient Hospital Services Medicaid Provider Guide, under "Provider Services," "Provider Information," "Claims and Billing."

In the event that a community hospital becomes insolvent, the SCRBHO will continue authorized, community-psychiatric, inpatient services for the remainder of the period for which payment has been made, as well as inpatient admissions until discharge.

In situations where any of the above occurs, the ASO's Senior Care Advocate notifies the ASO's appropriately-credentialed provider for a determination. A decision regarding urgent care must be made within 24 hours. Recommendations for adverse determinations, based on administrative issues, may occur at any time during the clinical review process and include these circumstances: The request is for treating a benefit plan diagnostic or service exclusion, benefit termination, and untimely submissions.

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The process for administrative or benefit denials is done by the Senior Care Advocate who notifies the provider verbally and sends written notification to patient, provider, and facility to contact the ASO for information regarding the grievance process for administrative/benefit denials.

It is the ASO's goal to make available a peer-to-peer conversation with the attending physician, or other ordering provider, before an adverse determination is rendered. When a determination has been made to issue a non-certification decision and no peer-to-peer conversation has occurred during the review process, the ASO provides, within 1 business day of a request by the attending physician, the opportunity to discuss the non-certification decision with the clinical peer reviewer making the initial determination or with a different clinical peer if the original clinical peer reviewer cannot be available within 1 business day. If the peer-to-peer conversation or review of additional information does not result in a certification, the ASO informs the provider and enrollee of the adverse decision, the right to initiate an appeal, and the procedure to do so.

Requests for authorization of various outpatient services, including residential treatment or specialty services are reviewed each business day.

The ASO UM Coordinators obtain printed daily reports from the SCRSN Information System (IS) and review for Access to Care Standards, Title XIX Medicaid eligibility and Level of Care status. They enter approvals if all aforementioned items meet criteria. The Senior Care Advocate with a Child Mental Health designation from the State of Washington reviews outpatient requests for authorization for children 20 years and younger. All authorizations are issued based on sound clinical judgment with reasonable expectation of improvement from the proposed care, within the guidelines of the benefit coverage.

Service Authorization Substance Use Disorder Services

Although the UM services for SUD will follow the same policies, procedures, processes, and guidelines (as outlined above), they will be modified to meet the uniqueness of SUD services. The ASO will recruit, hire, and train qualified individuals with CDP licenses, and the UM decisions for admission, continuing stay, and discharge will be made utilizing ASAM criteria, medical necessity, and Level of Care guidelines.

The UM Program will operate within an established structure in which policies for authorization include ASAM criteria and written Level of Care Guidelines for continuing stay. The clinical team will use the policies to make decisions about scope, duration, intensity, and continuation of services. The Level of Care Guidelines will include criteria for authorization of routine services including outpatient and residential treatment programs. The ASAM criteria will be inclusive for initial authorizations, continuing stay, and discharge.

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As determined by the state, the ASAM levels of care provided will include:

- Level 1 Outpatient Services
- Level 2.1 Intensive Outpatient Services
- Level 3.1 Clinically-Managed, Low-Intensity Residential Services
- Level 3.3 Clinically-Managed, Population-Specific, High-Intensity Residential Services. (This level of care is not designated for adolescent populations)
- Level 3.5 Clinically-Managed, Medium-Intensity Residential Services

Additionally, the state has determined that ASAM levels of care for Withdrawal Management (WM: Detoxification Services) will include the following:

- Level 1 WM Ambulatory withdrawal management without extended onsite monitoring.
- Level 3.2 WM Clinically-managed Residential Withdrawal Management (Acute and Sub-Acute Certification).

The UM Plan will establish processes and procedures to drive appropriate use of the full continuum of care through its processes. Practice guidelines that promote the use of least-restrictive, clinically-appropriate interventions prior to use of more intensive and often higher-cost services will be the foundation of the UM Plan. Prior authorization requirements will screen for previous use of less-restrictive interventions and will be applied in recommended intervals that ensure appropriate lengths of stay and adjustments to treatment strategies when individuals move (or don't move) along the continuum of recovery. Providers in Washington State use the ASAM criteria to determine placement and level of care (with separate placement criteria for adolescents and adults). The SCRBHO will monitor that the providers' documentation of assessment aligns with the placement level assigned and subsequent services rendered.

The UM Plan policies will clearly state that enrollees are not required to relinquish custody of minor children in order to access residential SUD treatment services. Any decision to deny a service authorization request or authorize a service in an amount, duration, or scope that is less than requested must be determined by a professional who meets or exceeds the requirements of a CDP with the appropriate clinical expertise.

Non-Medicaid Priority Populations

The SCRBHO policy will include the priority populations that are eligible to access behavioral health services, within available resources. The populations will include:

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- Individuals who have an income level of no more than 220% of the federal poverty level;
- Individuals who are not Medicaid eligible;
- Individuals who are uninsured, pregnant and/or parenting, or intravenous drug users; and
- Individuals who have insurance and are unable to meet the co-pay or deductible for the services.

The SCRBHO's approach to fulfilling the state's objective of access to behavioral health services for individuals who are not eligible for Medicaid but meet medical necessity will be prioritized as follows:

- Specific populations the state identifies throughout the period of the contract;
- Individuals who have high-intensity needs and are in a crisis; and
- Women who are pregnant and meet the income level specified by the state.

The SCRBHO will partner with the ASO to collect information on the number of individuals being served monthly by tracking their utilization. We will use the first year to establish a benchmark, from which to anticipate the number of individuals requesting services, type of service needs, and length of treatment. From the benchmark, the SCRBHO will further refine its process for responding to the need within the available resources and the state's priorities.

Authorization for Withdrawal Management Services

The UM Plan will be supported by the ASO's clinical staff members (3 licensed CDP Full-Time Equivalents (FTEs)) who will be available to respond to requests for authorization for inpatient withdrawal management and determine resource availability during normal business hours. Outside of normal business hours, the ASO will provide a toll-free number and staff to accept calls regarding UM issues. The ASO staff retrieves and triages or responds to all messages no later than the next business day. The CDPs will make appropriate referrals as necessary. Working with the SCRBHO network, all services will be delivered in settings that meet the requirements of Washington Administrative Code (WAC 388-877B) for individuals who have met the screening criteria. The policy will clearly state services will be based on a written recommendation for SUD treatment from a licensed, health-care practitioner functioning within his or her scope of practice under state law.

The UM Plan will not be structured in any way as to provide incentives to individuals or entities to deny, limit, or discontinue medically necessary services. Decisions are based on medical necessity criteria and level of care guidelines of ASAM, interpreted by trained and experienced clinicians who are qualified in their knowledge of SUD services and authorization procedures and policies.

The ASO's medical director will provide guidance, leadership, oversight, and utilization and quality assurance for the behavioral health programs within the UM Plan. Although the activities included below may be carried out in conjunction with the administrative staff or other clinical

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staff within the organization, the medical director's responsibility, supported by the policies and procedures, is to oversee that the utilization reviews and will address the following components:

- Services requested in comparison to services identified as medically necessary;
- A review of youth receiving medication without accompanying behavioral or therapeutic intervention;
- Level of Care authorized for SUD treatment services, based on ASAM in comparison to treatment services provided;
- A review of which goals identified in the Individual Service Plan have been met, have been discontinued, or have continued need;
- Patterns of denials; and
- Use of evidence-based and other identified practice guidelines.

The UM Plan's policies will state that the ASO's clinical team will make a determination of eligibility for an initial authorization of routine services within 14 days, based on medical necessity in conjunction with treatment services, based on the presence of a Diagnostic and Statistical Manual of Mental Disorders (DSM) 5 substance related diagnosis and application of the ASAM criteria following an assessment. An extension of up to 14 additional calendar days, to make the authorization decision, is possible upon request by the enrollee or the Behavioral Health Agencies (BHA) or the contractor justifies (to DSHS upon request) a need for additional information and how the extension is in the enrollee's interest. Such an extension is included in written policies and procedures to ensure consistent application of extensions within the service area.

The UM Plan and its policies and procedures will establish discharge planning guidelines to implement the clinicians and the physicians in their efforts to support and effect timely discharges that are responsive to the individuals' needs and contained within the treatment plan. Additionally, the UM Plan and policy and procedures recognize the importance of supporting the individuals with SUD in their transition from more intensive levels of care and helping them sustain their recovery within the community.

In preparation for UM services to be provided for SUDs, the SCRSN and the ASO staff consulted with the ASO medical director as well as Health Management Associates (HMA) to develop initial criteria for UM for SUD services. The SCRSN and ASO will continue meeting with community providers to work together to define and outline processes. Below the SUD Service Authorization Schedule reflects the initial steps decided with the ASO medical director and Health Management Associates in designing a UM Plan for SUD services.

SUD Service Authorization Schedule

ASAM	INITIAL AUTH	RE-AUTH AND AUTH CRITERIA
Outpatient	After Assessment (6 months)	Resubmit request (6 months)
IOP Level 11.1	After Assessment (9 months)	Resubmit (9 months)
PHP Level 11.5	No Service in SCRBHO	No Service in SCRBHO
Recovery House Level 111	Prior to admission (30 days)	Resubmit 30
Inter-Residential Level 111.3	LTR:ITA (30 days) Prior Admission (90 day PPW)	Resubmit LTR:ITA 30 (90-day PPW)
Short-term Residential Level 111.5 Inpatient	Start 15 days Prior Authorization	Resubmit 15

There will be follow-up meetings with the providers for SUD inpatient and outpatient services prior to contracting for services to allow them the opportunity to offer input and be a part of the decision process. As a part of the consultation with HMA in September, a work list was identified in order to flush out further details for the authorization process and decision points. One suggestion was to explore the Mihalik Group's Medical Necessity Manual for Behavioral Health as continuing stay criteria in inpatient/residential facilities. Once approved, flow charts and documentation of the authorization processes, for in and outpatient, will be written up.. Our Information Systems staff will work with the ASO, the SCRSN Care Coordinators, and management to determine how best to enter and store the authorization requests and approvals in the SCRSN Information System (IS), as SCRBHO transitions the IS to include the necessary mapping associated with the management of SUD services.

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To fulfill the responsibilities, as the SCRBHO, we identified below some of the major areas that will be addressed, including:

- Authorization/reauthorization forms (ASO);
- Develop the form provider's will submit authorization/continuing care (ASO);
- Criteria for social detox (initial authorization and continuing stay) (ASO);
- Follow up with Community Detox to justify confirmed stay-days (SCRBHO);
- Sobering: Confirm registration process with IS/Raintree (SCRBHO / ASO);
- Provide write-ups of medical/BH collaboration (e.g., Case ex.) (SCRBHO);
- Collaboration write-ups regarding Eastern State Hospital and providers out-of-network (ASO);
- Single bed certification follow up – identified hospital and patient (ASO);
- Explanation/description of Mahalik MNC (ASO);
- Information write-up on SUD "Refresh" (SCRBHO);
- Flow write-up of authorization of OP & IP (ASO);
- Meeting with IS staff for authorization screens (SCRBHO / ASO);
- Review providers (SUD: residential) and confirm level operating at statewide (SCRBHO) – 3.1:3.5; and
- Credentialing of SUD providers – determine when, what, how – SCRBHO.

The UM Plan identifies the state's requirement that the time period from request of behavioral health services to the first Routine Service appointment offered must not exceed 28 calendar days. If there are any delays in meeting this standard, staff will document the reason for any delays. This includes documentation when the individual declines an intake appointment within the first 10 business days following a request or declines a Routine appointment offered within the 28, calendar-day timeframe. The Quality Improvement Committee will be responsible for reviewing and monitoring reports submitted by the ASO to evaluate the frequency of Routine appointments that occur after 28 calendar days for patterns and apply corrective action where needed.

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The UM Plan will also include an established process in which the CDPs will review requests for additional services to determine a re-authorization following the exhaustion of previously authorized services by the enrollee. The process will include an evaluation of the effectiveness of services provided during the benefit period and recommendations for changes in methods or intensity of services being provided and a method for determining if an enrollee has met discharge criteria.

Notice of Adverse Action

As part of the UM Plan, the SCRBHO will expand its existing established processes to comply with all requirements related to the Notice of Adverse Action (NOA) procedure. Within the NOA procedure, staff will follow clearly-identified steps by which all necessary information related to Medicaid eligibility, Medical necessity, and documented acuity of the client is entered in the Information System (IS). As with all NOAs, information is entered into IS, which generates the necessary NOA letter. Based on event timing, the IS program has established decision-mapping to maintain compliance with all rules including, for example: definitions of events, the type of letter related to the reason for NOA, and the timeframe for response. The NOA will notify the requesting provider and give the enrollee written notice of any decision to deny a service-authorization request or to authorize a service in an amount, duration, or scope that is less than requested.

The SCRBHO, through its Quality Management Plan (QMP) structure as described below, is responsible for identifying emerging trends and challenges within the delivery of SUD services. As the committee reviews monthly and quarterly reports, we will discuss the data and information to understand gaps in services, service needs, and provider capacity. The Community Partners meetings are held monthly and participants discuss national, state, and regional trends in areas of opiate, methamphetamine, or marijuana use and treatment; or other mental health and substance use disorder trends; or new programs. In partnership with the state, we will offer to share our findings and discuss with the state officials their priorities and understanding of activities and trends statewide. The SCRBHO is committed to serving its enrollees, meeting member needs, incorporating evolving practices, and supporting delivery changes.

Utilization Management Plan Oversight and Evaluation

Behavioral Health Integrated Utilization Management Plan (see also 292)

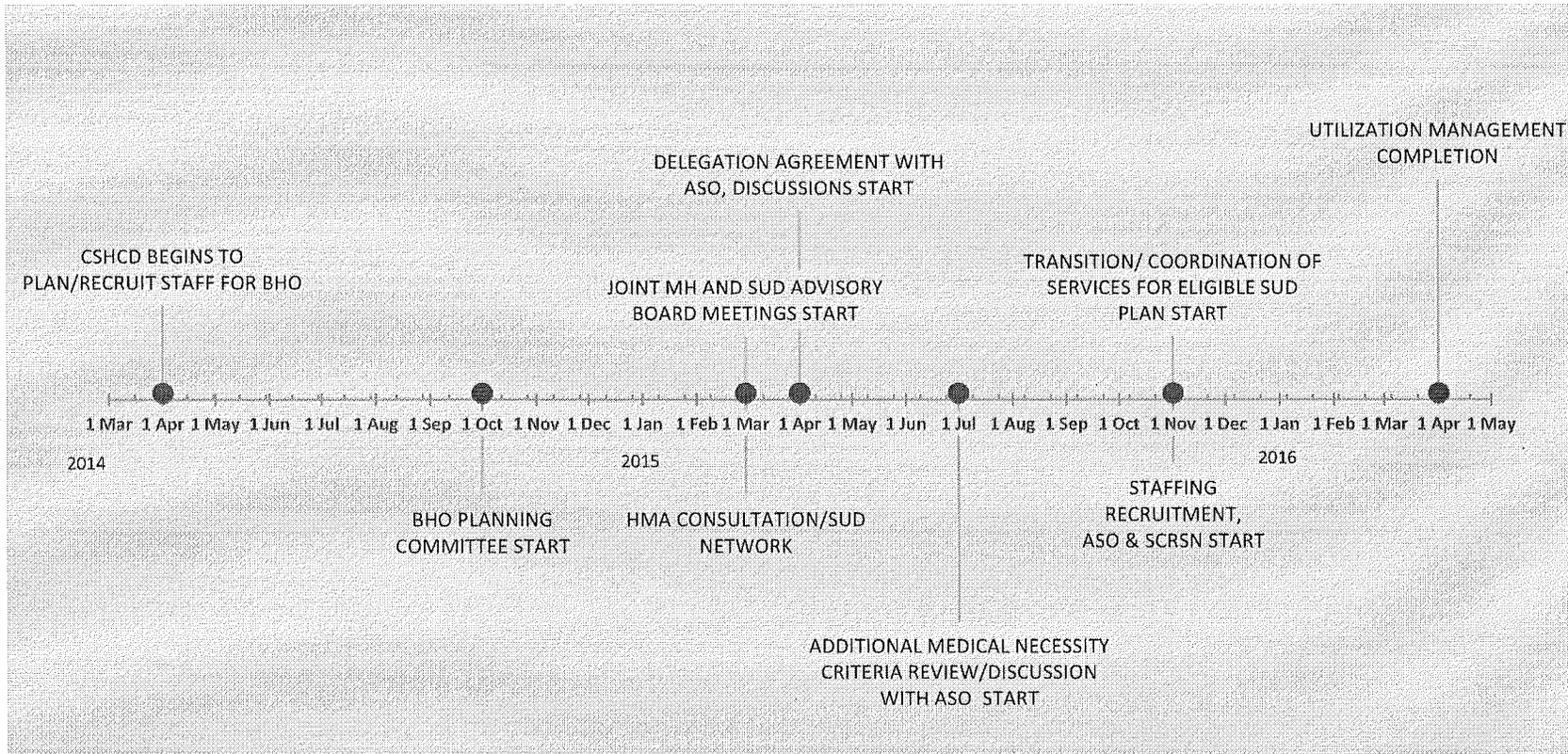
As part of the Quality Management Committee Plan, the SCRSN established a Behavioral Health Organization (BHO) Planning Committee, which meets as needed. The attendees include SCRSN leadership, Integrated Care Coordinators, Mental Health Planners, Integrated Project Coordinator, Fiscal Operations Manager, Quality and Data Systems Manager, and the ASO Program Manager. This committee is responsible for establishing and overseeing critical areas of development related to the SCRSN transforming the organization into the responsible and

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compliant SCRBHO. Currently, the role of the committee is planning efforts for the operational integration of MH and SUD services. Although full integration in 2020 is an agenda item that is discussed, the priority focus is to plan activities associated with accomplishing full readiness of the BHO in meeting its responsibilities, effective April 1, 2016.

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TIMELINE FOR UTILIZATION MANAGEMENT PLAN



Timeline Acronym Key:

- ASO (Administrative Service Organization)
- BHO (Behavioral Health Organization)
- CSHCD (Community Services, Housing, & Community Development)
- HMA (Health Management Associates)
- MH (Mental Health)
- SCRSN (Spokane County Regional Support Network)
- SUD (Substance Use Disorder)

VIII. Quality Assurance Plan

VIII. Quality Assurance Plan

The Spokane County Regional Behavioral Health Organization (SCRBHO) believes that quality assurance is foundational to ensuring the system of care provides clinically effective care in an efficient and cost effective manner. Strong performance standards, contractual requirements, quality monitoring, and improvement efforts are essential for both assessment of current quality as well as ensuring that the system is continually evolving towards a higher standard. The SCRBHO has worked closely with the Division of Behavioral Health and Recovery (DBHR) to make informed decisions about current and future performance metrics as well as providing valuable data about the quality of services within the region. The SCRBHO will continue to partner with DBHR on additional quality improvement initiatives in design, implementation, and reporting to ensure the state maintains a clear understanding of the quality of care in the Spokane County Behavioral Health Organization (BHO) region.

In the recent past and in the near future, a primary focus of quality improvement for the SCRBHO region has been further development of Evidence-Based Practice (EBP) among providers. Assisting providers to learn the importance of expanding existing practice to include general (e.g., Motivational Interviewing) and specialty evidence-based treatment (e.g., Dialectical Behavioral Therapy or Medication Assisted Therapy) has been important to shifting the system of care towards more effective services. In preparation for the transition to a BHO, SCRBHO has furthered evidence-based practice through a number of avenues including: training of providers, contractual expectations for evidence-based and best practices, auditing and monitoring, and outside assessment of provider services and capacity. This focus will remain central to the quality assurance plan.

2.292 Quality assessment and performance improvement program.

(I) Describe your plan for quality assessment and a performance improvement program that will assess the implementation of substance use disorder treatment services that meets the standards in the attached contracts. Include the quality structure and planned measurements and activities.

The Spokane County Regional Support Network (SCRSN) has a comprehensive management plan that currently addresses quality assessment and performance improvement for mental health, which will be expanded to include Substance Use Disorder (SUD) providers and their services. The SCRSN has three quality planning meetings a months and the current SUD providers and SUD residential/inpatient providers have standing invitations to all meetings. This has proven over time to be an important avenue for provider improvement, as we discuss performances, contracts, data requirements, and outcome expectations. We will continue to use these meetings to formulate the integration of SUD into the mental health Quality Management Plan (QMP).

The goal of the quality management plan is to outline the program by which the SCRBHO establishes, deploys, monitors, and improves services provided under agreements with the DBHR, in accord with Revised Code of Washington (RCW) Chapters 71.05 and 71.24 and

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applicable Washington Administrative Code (WAC), and Code of Federal Regulations (CFRs), and any other applicable applications.

As the administrator of SUD services in Spokane County and soon in the region, Spokane County Substance Use Division has been working with SUD providers on quality assessment and quality improvement for years. This has included training, monitoring, and meeting with providers to gain feedback on what is working well and where challenges exist within the system of care. Improvement of the services offered has been a long-standing commitment and will continue to evolve as the region integrates mental health and substance use into a BHO.

Upon approval from DBHR that the SCRBHO is accepted as a BHO, we will begin to address a SUD performance-improvement project to assist our region in determining where we need to improve our quality, what the best indicators of quality include, the tools to determine the effectiveness of the interventions chosen, and the activities to initially increase and then sustain improvement. The performance improvement project will be chosen in consultation with SUD providers to ensure that the data collection and reporting would be consistent and obtainable for ease of measurement. Within the planned contract for SUD providers, the SCRBHO already plans to include additional performance metrics such as required numbers of individuals served, services, and client hours including a maximum number of appointment no shows/cancellations. In addition, there will be an expectation that the clinical charts reflect person-centered recovery.

Spokane County has been preparing for the shift to a BHO administration, and in the last year, completed an assessment of the SUD providers, including examination of quality of services to ensure a baseline understanding of the SUD system of care. Spokane County engaged Health Management Associates (HMA) to conduct an assessment, and they have already met individually with the SUD providers and outlined recommendations for quality improvement and long-term, quality-assurance planning. The recommendations address the same general themes outlined in state contract requirements such as evidence based practice monitoring and assessment of under and over utilization of services. Samples of recommendations the SCRBHO will consider include:

- Improvement of EBP Delivery;
- Monitoring of utilization of services; particularly inpatient services for youth to ensure individuals are receiving the best care in the least restrictive setting. The Utilization Management (UM) Plan has specifically been designed to improve assessment and monitoring in this area of SUD services;
- Routine auditing of providers on their use of American Society of Addiction Medicine (ASAM) criteria and ensuring criteria are applied consistently and appropriately. This may include independent assessments of ASAM criteria as a comparison. Additional training may also be a quality improvement approach in this area;
- Consideration of additional outcome metrics to evaluate quality and improvement efforts.

Examples of these metrics include:

- The number of inpatient placements per individual;
- Symptom reduction measures (baseline and post treatment);
- Increased skill mastery and measure of obtained skill;
- Client satisfaction; and

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- Increased quality of life metrics:
 - Quality of life measures;
 - Stable Housing;
 - Stable Employment; and
 - Stable Relationships.

The SCRBHO is continuing to explore the specific metrics it will employ in a quality assurance plan. However the SCRBHO believes that it has a solid foundation for identifying both strengths of the existing system of care as well as priorities for improvement. See Attachment 26 for the Quality Management Plan.

(2) Provide a plan to correct any deficiencies identified.

The SCRBHO will also seek input, feedback, and participation from a broad range of stakeholder groups that include allied systems, community partners, and individuals and family members with lived experience of substance use and who have received treatment services in the community. The SCRBHO will expand the QMP to ensure SUD providers' adherence to our mission, contracts, and responsibilities within the community.

The Spokane County staff is also attending the DBHR meetings to ensure that the BHO understands and is prepared to develop processes to be accountable to meet additional identified goals. These include DBHR performance-improvement projects such as access to timely care, routing service requirements, penetration rates for Medicaid eligible individuals in the regional service areas, SUD retention, and mental health psychiatric hospitalization.

Each month our internal, information system reports will be generated for all the performances that involve data standards. The reports will be reviewed by the SCRBHO staff involved with quality and contract expectations and shared with providers for their review and input. We will receive state reports on retention, penetration, and hospital readmission on a schedule to be provided by DBHR and will need to work with providers and DBHR if our expectations are low. Person-centered recovery compliance will be determined through client medical-chart reviews.

A quality review also includes the ability to understand what drives the performance expectations and what causes low performance factors, such as agencies having staffing shortages, inappropriately high benchmarks, poor performance or lack of attentiveness to the requirement, etc. The SCRBHO believes that discussion with the provider agency helps to identify why the performance was deficient. This also provides an opportunity for SCRBHO to offer solutions and to engage in problem solving with the providers. An agreed upon corrective action plan would be required of the provider organization, with approval, and would include a specific timeline to become compliant from the SCRBHO. Adjustments in data or financial compensation may be made if needed or warranted.

(3) Provide the name of the quality manager.

Suzie McDaniel is the Quality Manager and Charisse Pope is the backup; however, we have many individuals who work toward the same quality goal within the agency.

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Address the requirement of these provisions. Specifically, describe how you will address performance improvement in compliance with the PIHP Contract for those measures included in that contract. (004)

The SCRSN and the Spokane County Substance Use Division have a long-standing commitment to improving the quality of services within the region. As the RSN for mental health services, advancement of EBPs has been a long-term project. Similarly, in preparation for the transition to a BHO, Spokane County invested in an assessment of Spokane County substance use providers with a focus on their current treatment approaches and capacity to offer evidence-based services. As the SCRBHO, Spokane plans to conduct a similar assessment on mental health provider capacity for advancing evidence-based practice. The assessments provide recommendations for the BHO in increasing quality expectations and sophistication among the providers in both treatment approach and quality measurement.

A quarterly Adult Behavioral Health Task Force, established by the Governor and legislation, includes a Spokane County Commissioner as one of the key members who represents the Washington State Association of Counties (WSAC). The Director of the Spokane County Community Services, Housing, and Community Development Department (CSHCD) is also a stakeholder representing the Spokane region of care, which is currently 8 counties. Both members provide information and input into the larger, task force committee in order for the committee to make meaningful decisions regarding improvement in many areas as identified by RCW 43.20a.895. The general stakeholders are made of local government, representatives of county coordinators, tribal representatives, behavioral health service providers including chemical dependency providers and psychiatric advanced registered nurse practitioners, Medicaid managed-care plan representatives, the Washington State Hospital Association; and the Washington State Medical Association.

Several of the areas that are being addressed are:

- EBPs;
- A quality management system including outcome reporting and development of baseline and improvement targets for each outcome (performance measures and outcomes);
- Effective methods for promotion of workforce capacity and stability; and
- Plan and attention to the financial ramifications to improve the behavioral health system including exploration of private and public financing. For example, the group will closely track the State's announcements related to the Center for Medicare and Medicaid Services letter on 1115 demonstration projects for transforming the substance use treatment system.

The committee met in 2015 and developed 2 performance measures for mental health (penetration and psychiatric hospitalization readmissions) and 2 for substance use treatment (penetration and retention), effective with the BHO contract in April 2016. A small sub-committee was established by DBHR and the Health Care Authority (HCA) that included RSNs, county substance abuse coordinators, substance abuse providers, DBHR, HCA, and other DSHS staff. The committee was created to determine the criteria for the performance measures, the process for how to measure these metrics, and a plan for reporting. The

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CSHCD leadership has participated in these meetings, which has been very helpful to understand what criteria and measurements would be used and applied to the BHO.

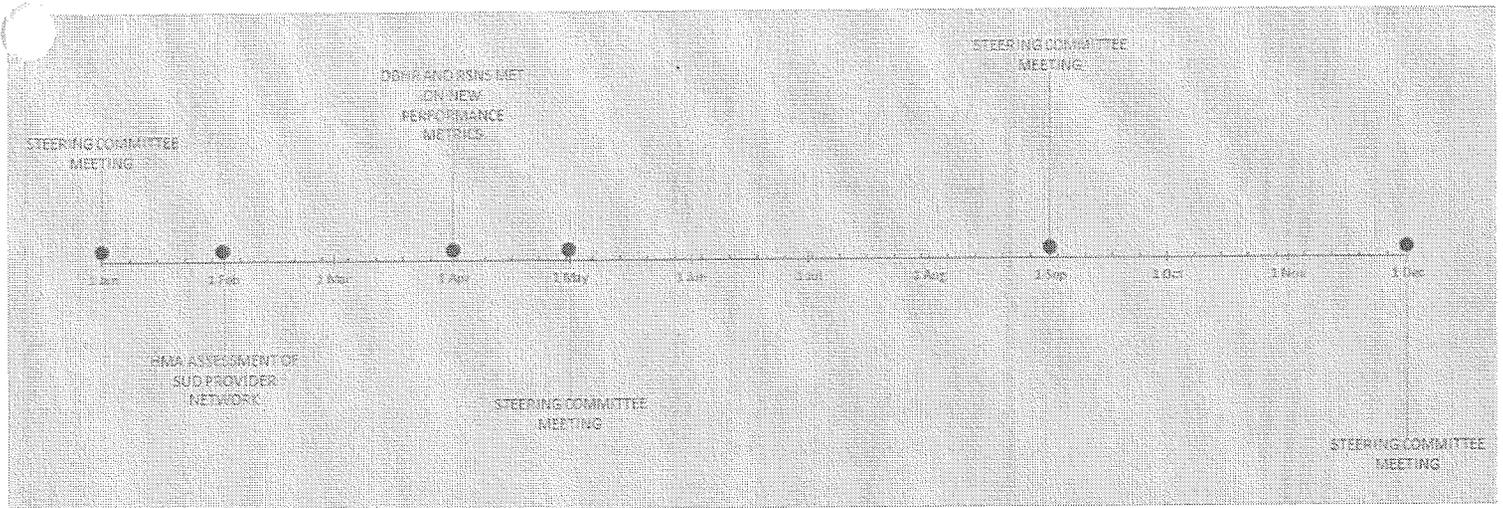
Based on these meetings, RSNs and SUD providers have received some example reports, which inform us of how the mental health data would be extracted and sorted by all RSNs and by each RSN. We have not received any reports yet on the substance use treatment performance metrics, as the criteria and reporting for these measures is still being determined. The SCRBHO is encouraged with the process and development and looks forward to continuing to advance this approach as the BHO.

Although the SCRBHO will not be able to fully replicate the retention, penetration, and psychiatric hospitalization readmission performance results from the BHO's internal health Information Systems, the BHO will be able to use the system to replicate and mirror DBHR's reports as much as possible. It is a clear priority for the BHO to report performance metrics for the region on a timely and actionable basis. The reason that SCRBHO cannot fully recreate the DBHR reports is a result of the broad target population contained in the criteria of the denominator for all 4 measures, which would require that the BHO be able to access and integrate external data from other source systems (e.g., Medicare, treatment need, etc.) into the internal health information systems.

The SCRBHO will also receive DBHR's performance reports for these performances (those that cannot be fully replicated) for evaluating and making improvements in our BHO's results.

The SCRBHO will embrace the performance measures that have been chosen and will work with the state and the providers, so the BHO can meet or improve the readmission and retention rates. With regard to penetration, it is a challenge as we do not really know how many individuals on Medicaid are actually in need of mental health and substance use disorder services. We can measure those that request treatment, follow those that drop from treatment, and those that we don't have adequate programs for their needs. However, if Medicaid individuals do not make a request, we have no knowledge or way to know of their treatment need.

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Timeline Acronym Key:

- HMA (Health Management Associates)
- SUD (Substance Use Providers)
- DBHR (Division of Behavioral Health & Recovery)
- RSN (Regional Support Networks)

IX. Program Integrity Plan

This Plan was deleted by DSHS on October 2, 2015.

X. Grievance System Plan

X. Grievance System

Provide a comprehensive assessment of your current compliance with all State and Federal Grievance System requirements, regulatory and contractual. For any deficiencies identified, provide a detailed work plan to correct the deficiencies to be completed no later than April 1, 2016. (296)

Integral to the Spokane County Regional Support Network's (SCRSN) transition to a Behavioral Health Organization (BHO) will be the enrichment of our current grievance system, including updating policies and procedures and subcontracts with provider agencies. We began training Substance Use Disorder (SUD) providers, on October 1, 2015, on all requirements associated with the provision of an effective and responsive grievance system that includes SUD as well as mental health services within the BHO's responsibilities.

Our approach is person centered and strengths-based, supporting an individual's recovery and giving voice to the rights of enrollees and their authorized representatives to grieve their dissatisfaction with services.

At this time, the SCRSN uses its Information System (IS) to generate reports for the number and type of Notice of Action (NOA) letters sent to enrollees. This report is broken down by NOAs sent to adults, age 21 and older, and children, up to age 20, as defined by the Code of Federal Regulations (CFR). With the new grievance reporting requirements being implemented by DBHR, the SCRSN will be devising mechanisms whereby provider agencies will enter grievance information into the Information System (IS) system in order to generate the reports that will be required for tracking grievances, actions, appeals, and fair hearings.

Grievance System - General Requirements (296)

The SCRSN currently has developed an effective and comprehensive Grievance System that includes a grievance process, an appeals process, and a process for individuals to access the state's fair-hearing process, associated with the delivery of mental health services. As the Spokane County Regional Behavioral Health Organization (SCRBHO) we will be responsible for educating our providers and monitoring their compliance through our annual monitoring process or more often as required. We will begin training providers, in October 2015, to provide the necessary information regarding the inclusion of SUD services within the grievance system, anchored in the expansion of the associated and revised policies and contracts with the BHO and our network providers. Training will be inclusive of identifying processes associated with the delivery of SUD services for enrollees and their authorized representatives. The SCRSN requires each agency utilizes its process for tracking, reporting, and resolving grievances. Currently, the SCRSN contracts with the Ombuds Service to assist enrollees and their authorized representatives about our grievance system and how to access the grievance process. The

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Ombuds contracts will be expanded to include SUD services. Training will include the same process for enrollees receiving SUD services, similar to the process as it exists for mental health services and the related grievance process within our quality framework of continuous improvement.

In SCRSN's transition to the SCRBHO, we and our providers will continue to inform individuals of the right to file a grievance without fear of reprisal. Individuals are provided with written information about how to file a grievance at intake or at any time the individual would benefit from receiving this information. Our approach is to make available necessary information about grievances to potential users of the system of care and their advocates. The SCRSN and its providers are aware that Medicaid enrollees receive this information in the form of the Washington Public Mental Health System Benefits Booklet. In addition, the SCRSN requires its providers to have the Benefits Booklet available in the 8 prevalent languages should it be requested.

The SCRSN has established a tracking, monitoring, and reporting system in which the providers report grievances received at their agencies. This report includes the number and type of grievances, timeliness of responses provided to the individual or their representative, types of resolution, and any grievances that are outstanding for the reporting period. In the coming months, the SCRSN will initiate grievance reporting components in the IS system that will enable the generation of the reports according to the new requirements being implemented by DBHR. The SCRSN and network providers offer information about the grievance process in a manner and language that is understandable to the individual receiving it, presenting the information in age appropriate and culturally competent language, including for those who have sensory impairments. The SCRBHO will incorporate into the IS system's tracking, monitoring, and reporting capabilities associated with the inclusion of SUD services.

As part of its quality management program, the SCRSN reviews grievances for any trends or other events that warrant closer scrutiny or for areas where performance improvement is needed. If necessary, the SCRSN applies corrective actions and monitors the implementation and results of those actions. These same processes will be established in the delivery of SUD services for enrollees and their authorized representatives regarding their rights to utilize the grievance system to grieve their concerns and any aspects of dissatisfaction.

Answer as part of the response to the requirement with the description: Grievance System-general requirements. Provide a specific reference here to where this specific requirement is addressed in your response. (297)

The SCRSN makes known to its provider network, enrollees and their advocates, and allied system partners how it acknowledges and handles actions. Our information incorporates and follows the established definitions including: 1) An action is the denial or limited authorization of a requested service, including the type and duration and any service denial based on Access to

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Care, including the reduction, suspension, or termination of a previously authorized; the denial or failure to provide services in a timely manner; and the failure of the provider network to act within the timeframes provided in 42 CFR 408(b); 2) A denial is a decision by the SCRSN or its designee not to authorize a covered Medicaid mental health service, which will expand to encompass Medicaid SUD services and the benefit requested by a provider on behalf of an eligible Medicaid enrolled individual; 3) It is also a denial if an intake is not provided on request by a Medicaid enrollee; 4) An appeal is a request for a review of an action as the action is defined above; and 5) The fair hearing means a hearing before the Washington State Office of Administrative Hearings.

The SCRSN identifies requirements with which the providers must comply through its contractual process and policies, and through its contracted Ombuds services. When we transition to the SCRBHO we will implement a process inclusive of the SUD services and identify the condition within the provider network contract stating that all providers and subcontractors will abide by all grievance and administrative hearings decisions.

The SCRSN delegates the administering of its notices of adverse action, or NOA, to its contracted Administrative Services Organization (ASO) and will continue the delegation when we become the SCRBHO. The reporting of the associated information and generation of the NOA sent to the Medicaid enrollee occurs via an 'exit reason code' included in the Information System which prepares the NOA. A copy is provided to the agency for the Medicaid enrollee file and the SCRSN monitors that the NOAs are sent within the required timeframe. Only Medicaid eligible individuals receive an NOA. As stated before, this same process will be applied to the delivery of SUD services.

Answer as part of the response to the requirement with the description: Grievance System-general requirements. Provide a specific reference here to where this specific requirement is addressed in your response. Grievance System - Service Authorization (298)

As part of the overall Grievance System, the SCRSN has identified a clear process to track all requests for service even if no service occurs. Provider agencies submit a monthly, service-denial tracking log that includes all denied requests for service and the reason(s) services were denied. The SCRSN utilizes this report as one way to monitor capacity in its system of care. An Access to Care Report, generated by the IS, is also reported monthly. The Access to Care Report records all requests for services, intakes within 10 working days, and the first routine services provided within 30 calendar days. If the intake or first routine service occurs outside the required timeframes, providers must record the reason why. This report is made available to each provider agency on a monthly basis and regularly reviewed at the SCRSN's Quality meetings. The SCRSN also utilizes this report as a way to monitor system capacity. Although the current process applies to enrollees of mental health services, in preparation to becoming the SCRBHO, we will expand the process to include service authorizations related to authorization of SUD services.

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The SCRSN established the Quality Improvement Committee (QIC) as the responsible body for overseeing and monitoring compliance of its grievance system. The QIC reviews the monthly Access to Care Reports for any patterns of concern associated with service authorizations, monitoring for trends or patterns that require additional review. The QIC determines any corrective action steps necessary for follow up, identifying the timeframe required to complete the corrective actions. As noted above, the SCRBHO will build on the current grievance processes and quality monitoring for mental health service authorizations to encompass enrollees who access the SUD service system within the service authorization grievance process.

Answer as part of the response to the requirement with the description: Grievance System-general requirements. Provide a specific reference here to where this specific requirement is addressed in your response. Grievance System - Service Authorization Process (299)

As identified in the SCRSN Grievance System and its Service Authorization policy, applicable to authorizing mental health services, any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, must be determined by a professional who meets or exceeds the requirements of a Mental Health Professional (MHP), with the appropriate clinical expertise to make that decision.

In the contract with its designated ASO for the delivery of mental health services, the SCRSN will expand the responsibilities to include the SUD Utilization Management (UM). As the SCRBHO, we expect to continue delegating authorization responsibilities to the ASO. The ASO will ensure that decisions are clinically sound and in compliance with the Department of Social and Health Services (DSHS)/Division of Behavioral Health and Recovery (DBHR) contract and current Access to Care Standards. The contract language will clearly identify that the legal responsibility, for all functions, remains with the SCRBHO. The contract will mandate that the ASO must hire and maintain a sufficient number of licensed clinical professionals. In addition to MHPs, the ASO will hire Chemical Dependency Professionals (CDPs) to review, approve, or determine the need to deny a service authorization request within the required state timeframe, as related to SUD services.

As part of the SCRSN's monitoring of delegated activities, it regularly reviews the ASO's compliance with all contractual requirements, including requirements that the ASO staff holds, at a minimum, applicable credentials and expertise to maintain timely responsiveness to requests for service authorizations. The SCRSN monitors any issues or concerns related to timely service authorizations, including the need for any corrective actions and the timeframe for correction. The expanded the SCRBHO contract with the ASO will reflect the requirements to hire appropriately credentialed and licensed staff to authorize SUD services. The SCRBHO will continue to annually monitor ASO staff authorizations of requested behavioral health and SUD services. Opportunities for improvement and corrective action plans will be identified as necessary.

Answer as part of the response to the requirement with the description: Grievance System-general requirements. Provide a specific reference here to where this specific requirement is addressed in your response. Grievance System - Notice of Action (300)

The SCRSN has an established process, and formalized in policy, that the staff follows as part of the NOA procedure. The process includes a definition of what an action means in the context of Prepaid Inpatient Health Plan (PIHP) services as well as the other definitions and timeframe requirements, as provided in section 42 CFR 408(b). The Action policy clearly states the NOA must be in writing and meet the language and format requirements for an individual's ease of understanding. Notices sent to individuals contain the following:

- The reason for the notice;
- Definitions of reduction, termination, suspension, and denial;
- How to appeal;
- Information about the right to request a state fair-hearing if they do not agree with the appeal decision;
- That they can access the Ombuds for assistance;
- That they can ask for someone they designate to assist or represent them with their written consent;
- That the individual has the right to request to have benefits continue pending resolution of the appeal;
- How to request the benefits to continue;
- How to request an expedited appeal; and
- That the individual may be required to pay the cost of services if the appeal is denied.

Notices are sent to the individual according to language and format requirements. As identified in SCRSN policy, Notices must be available in alternate formats, provided through audio or video recording in the primary language, read by an interpreter in the individual's primary language, or provided in an alternative format that is acceptable to the individual. Similarly, Notices associated with SUD services under the BHO will be in language and format requirements, as determined by the state, and make the Notices available in alternative formats acceptable to the individual.

The SCRSN mails copies of Notices to any legal representative at the Children's Administration when either an intake is denied or services beyond the intake have not been authorized. The NOA process and policy will be expanded to include SCRBHO's approach to including the SUD service system within the grievance process, to inform any legal representative at the Children's Administration.

Answer as part of the response to the requirement with the description: Grievance System-general requirements. Provide a specific reference here to where this specific requirement is addressed in your response. Grievance System - Notice of Action - Timeframes - Termination, Suspension or Reduction of Services (301)

Within the Grievance System, if an authorization request is denied, the contracted ASO documents the denial in the SCRSN IS. The IS triggers the generation of a NOA, which prints and is mailed to the individual at the last known address on file.

Reductions: The SCRSN does not authorize the maximum number of hours of service that an individual can receive. Instead, the SCRSN authorizes valid services meeting medical necessity criteria for a given time period. For example, authorization for routine outpatient services may be for 6 months. Because of this, the SCRSN would not make reductions because we do not identify the maximum number of hours of services the enrollee may receive. As such, there is no need to generate an NOA.

Suspensions: As noted in the discussion of reductions, the SCRSN does not authorize the types or modalities of service that an individual can receive. Instead, the SCRSN authorizes valid services for a given time period, such as authorization for 6 months. Therefore, SCRSN would not issue an NOA for suspension of services requiring.

Terminations: The provider agency is responsible for documenting information related to the termination in its IS. Once a provider agency enters an Exit Code into the SCRSN IS, an NOA is generated based on the exit code in the Service Encounter Reporting Instructions (SERI). The SCRSN reviews the NOA report, generated from the IS, and will begin review of the NOAs quarterly, instead of monthly, beginning November 2015.

As the SCRBHO, our intention for SUD services is to establish a similar process for authorization of services, authorizing valid services for routine outpatient services for a period of time, dependent upon the clinical needs of the individual. Because of the approach taken within the authorization process, at this time and as with mental health services, we would not be making reductions because we do not identify the maximum number of hours the enrollee may receive. Similarly, there will not be suspensions for SUD services because we will not authorize types or modalities of services.

Terminations will be handled by the provider agency, as they will be responsible for documenting the termination as they do with mental health services. The IS will be programmed to generate the NOA based on the exit code in the SERI, and we will incorporate a similar process for reviewing the NOAs, again, to monitor how the providers and implementation of the SUD services system is progressing as part of the BHO QIC and identify any patterns or trends that are unexpected or require follow-up information and research and/or corrective action.

Answer as part of the response to the requirement with the description: Grievance System-general requirements. Provide a specific reference here to where this specific requirement is addressed in your response. Grievance System - Notice of Action - Timeframes - Denial of Payment (302)

Medicaid enrollees do not receive an NOA for denial of payment to a provider for services that were previously authorized.

Answer as part of the response to the requirement with the description: Grievance System-general requirements. Provide a specific reference here to where this specific requirement is addressed in your response. Grievance System - Notice of Action - Timeframes - Denial of Standard Authorization (303)

As written in the SCRSN policy and compliant with the state requirements, notices of adverse action are sent to the individual within 14 days of the decision to deny a standard authorization, with a possible extension if the individual or the provider requests an additional 14 days and it is to the benefit of the individual. The SCRSN can also extend an additional 14 days if it is for the benefit of the individual and the SCRSN can justify this to the state. In either case, an NOA is generated and sent to the individual to explain the reason for the extension.

The SCRSN's contracted ASO tracks all requests for services that are not authorized on a monthly basis and makes this information available for SCRSN review. The SCRSN reviews the information to understand the reasons the requests for services are not authorized with the objective of determining if there are patterns or trends that require follow up with the provider and/or the ASO as it fulfills its responsibilities on behalf of SCRSN. As is our process in many monitoring activities, the QIC will follow up if additional information is needed and a corrective action plan is required, with identified timeframes for action. We also review the reports to understand if there are implications for any system redesign should a number of providers demonstrate similar patterns.

The SCRBHO intends to implement a similar policy that will be compliant with the requirements of the Notices of Adverse Actions (NOAA) as applicable to SUD services and the timeframes, including any 14 day extensions within which decisions will be made regarding all denials of a standard authorization. As noted previously, we will monitor the requests, as reported by the ASO, to understand the reasons for services not being authorized with the objective of determining if there are patterns or trends that require follow up with the provider and/or the ASO as it fulfills its responsibilities on behalf of SCRBHO.

Answer as part of the response to the requirement with the description: Grievance System-general requirements. Provide a specific reference here to where this specific requirement is addressed in your response. Grievance System - Notice of Action - Timeframes - Denial of Expedited Authorization (304)

The SCRSN has a written policy that denials of expedited authorizations must be made within 3 business days or as expeditiously as the individual's health condition requires. SCRSN monitors compliance with this policy and in 2014, SCRSN's contracted ASO completed authorization decisions within 3 business days 93% of the time.

During the recent Qualis review, it was noted that the SCRSN does not have a mechanism in place to track whether an authorization decision is standard or expedited. Qualis stated that the SCRSN mitigates not having a method to identify if it is a standard or expedited authorization decision by the process that the SCRSN does not require the contracted providers wait for an authorization decision prior to the provision of care. As a result, Qualis did not issue a recommendation or finding. However, the SCRSN is in process of determining how to implement a method by which to track whether a request for authorization is standard or expedited; we anticipate identifying a solution within the next several months.

As is our approach throughout the grievance process, the SCRBHO intends to apply a written policy defining our process for standard and expedited authorizations associated with SUD services. The policy will identify that expedited authorizations will be made within the 3 business days or as expeditiously as the individual's health condition requires. We will monitor compliance with meeting the timeframe for SUD services as we do for mental health services. Our expectation is that the ASO will complete the authorization decisions within the required timeframe at a percentage rate comparable to their 93% in 2014 for authorizations related to mental health services. Once we have developed a method by which to track whether a request for authorization is standard or expedited, we will apply the same method to monitoring SUD requests for authorizations.

Answer as part of the response to the requirement with the description: Grievance System-general requirements. Provide a specific reference here to where this specific requirement is addressed in your response. Grievance System - Notice of Action - Timeframes - Untimely Authorization (305)

The SCRSN has written in policy the standards by which NOA is provided and within what timeframe, as relates to untimely authorization. If the Notice is not mailed in a timely manner as required, the individual is provided information about how to follow the grievance process and how to file an appeal with the state. Additionally the individual is provided information on how to contact the Ombuds Service for assistance with filing the appeal. The SCRBHO will establish the same process to NOA for SUD services as we have established for mental health services.

Answer as part of the response to the requirement with the description: Grievance System-general requirements. Provide a specific reference here to where this specific requirement is addressed in your response. Grievance System - Information to Providers and Subcontractors (306)

The SCRSN includes in all of its contracts with its providers information and requirements about its Grievance System. This information includes grievances, appeals, denials, and state fair-hearings. The SCRSN provides training about the grievance system periodically or as any new process or procedure is implemented. We also identify in our contract with Ombuds that the Ombuds service is required to provide outreach to each contracted provider annually to provide training and information about grievances and rights. Ombuds provides evidence of its outreach and training activities to the SCRSN in the form of monthly activity reports, which are reviewed for compliance with expected outreach and training activities. Should there be any discrepancies in performance against requirements, the SCRSN would follow up with the Ombuds services and request a corrective action plan within an identified timeframe. As the SCRBHO, we will include language in the contracts with the SUD providers the applicable information for the providers and subcontracts describing the information and requirements associated with SUD services and the Grievance System process including grievances, appeals, denials and state fair hearings. We also will provide training about the Grievance System as it applies to SUD services, as although it will not be a new process, it is an expanded process and applicable to enrollees and providers of SUD services.

Answer as part of the response to the requirement with the description: Grievance System-general requirements. Provide a specific reference here to where this specific requirement is addressed in your response. Grievance System - Record Keeping and Reporting (307)

The SCRSN developed and implemented a specific format and requires that all providers and Ombuds use the same grievance reporting log for consistency. The log records grievance number, name or other identifying information, date the grievance was received by the agency, date the grievance was acknowledged in writing, description of grievance, any extension requests, resolution status at time of report, age and Medicaid status of the grievant, and if the Ombuds was involved. These grievance report logs are due to the SCRSN no later than April 30 and October 31 of each year. The SCRSN reviews each provider grievance log to monitor that all required notifications were met, content of the grievance and response, and whether the grievance was resolved satisfactorily. Should there be any need for corrective action, the SCRSN follows up with the provider and Ombuds to conduct the needed improvements.

The SCRBHO will require a similar process for record keeping and reporting, using the specific format and grievance reporting log for providers and Ombuds as it relates to SUD services. The record logs will contain the identified components as noted for mental health services and the grievances. The SCRBHO will review each provider grievance log related to SUD services twice a year, monitoring that all required notifications were met, the content of the grievance response, and whether the grievance was resolved satisfactorily.

Answer as part of the response to the requirement with the description: Grievance System-general requirements. Provide a specific reference here to where this specific requirement is addressed in your response. Grievance System – Appeal (308)

The SCRSN supports the understanding written in its provider and ASO contracts and the associated policy, specifying the responsibility that the SCRSN ASO and the SCRSN network providers must inform individuals of their right to appeal a denial of authorization for services. The SCRSN monitors compliance with this contract requirement on an ongoing basis and follows up on any corrective actions needed, within a specified timeframe to maintain compliance. As the SCRBHO, we will include in the contracts with the ASO and the SCRBHO SUD network providers, the continued expectation that they must inform individuals of their right to appeal a denial of authorization for SUD services. We will monitor the ASO and network providers for their compliance with this requirement and require corrective action plans as needed to address any deficiencies.

Answer as part of the response to the requirement with the description: Grievance System-general requirements. Provide a specific reference here to where this specific requirement is addressed in your response. Grievance System - Authority to File (309)

The SCRSN understands the requirements associated with who has the authority to file an appeal. Written as part of the Grievance System Policy, the SCRSN defines the procedures that staff completes for identifying, and as included in the information contained in the NOA (noted in response 300 above), the individual, his or her legal representative or other designated representative, or the contracted provider acting on behalf of an individual, with the individual's written consent in writing, may file an appeal with the SCRSN. This approach and the associated policy will incorporate information related to the authority to file for enrollees requesting SUD services as the authority to file, which includes the individual, his or her legal representative or other designated representative, or the contracted provider acting on behalf of an individual with the individual's written consent.

Answer as part of the response to the requirement with the description: Grievance System-general requirements. Provide a specific reference here to where this specific requirement is addressed in your response. Grievance System – Timing (310)

Standard Appeal: The individual or their legal representative, or person of their choosing, or the contract provider acting on behalf of the individual must file an appeal within 45 days of when the NOA was mailed. The appeal must first be filed with the SCRSN. The SCRSN can extend this up to 14 days if the individual requests the extension, or if the SCRSN extends the date, it must be for the benefit of the individual. The SCRBHO will establish a similar policy and procedure as described for mental health services to comply with the standard appeal procedure as applies to SUD services and the individual or his or her legal representative or person of his or her choosing or the contract provider acting on behalf of the individual, to meet the identified

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timeliness for filing an appeal with the SCRBHO. The SCRBHO will also extend by 14 days if the individual requests the extension, or if the SCRBHO extends the date, it must be for the benefit of the individual.

Answer as part of the response to the requirement with the description: Grievance System-general requirements. Provide a specific reference here to where this specific requirement is addressed in your response. Grievance System - Appeal Process – Procedures (311)

The SCRSN complies with the requirement that the appeal can be filed orally or in writing unless an expedited appeal is being requested. If the appeal is filed orally staff record the oral appeal to document it also in writing. The SCRSN treats oral appeals the same as written appeals to establish the earliest possible filing date. The appeal will be acknowledged in writing unless expedited resolution is requested.

Expedited appeals can be filed if the individual's life, health, or major ability to function could be seriously harmed by waiting for a standard appeal. Expedited appeals are accepted orally and will be resolved within 3 business days. If the Mental Health Care Provider (MHCP) requests the expedited appeal, the SCRSN will automatically expedite the request for appeal. If the request for an expedited appeal is not accompanied by an MHCP request, the SCRSN will decide if it is clinically required. If the SCRSN does not agree, the appeal will be decided within 45 days.

Individuals are given information about how to contact the Ombuds Service in their region (Spokane County or North Central counties) to obtain their assistance in filing appeals.

Every NOA generated and sent always lists the contracted ASO's toll free number and information informing the enrollee of the right to an appeal and the process for submitting the appeal orally or to request more information related to making an appeal, the steps within the process, and available avenues for submission, response, and in what timeframes.

The SCRBHO will establish a compliant and similar process and policy for its appeals procedures as they apply to SUD services. Individuals may appeal orally and in writing, to establish the earliest filing date except as it pertains to expedited resolutions. The appeal will be acknowledged in writing unless expedited resolution is requested. Expedited appeals can be filed if the individual's life, health, or major ability to function could be seriously harmed by waiting for a standard appeal. Expedited appeals are accepted orally and will be resolved within 3 business days. If the SUD provider requests the expedited appeal, the SCRBHO will automatically expedite the request for appeal. If the request for an expedited appeal is not accompanied by an SUD Provider request, the SCRSN will decide if it is clinically required. If SCRBHO does not agree, the appeal will be decided within 45 days.

Individuals are given information about how to contact the Ombuds Service in their region (Spokane County or North Central counties) to obtain their assistance in filing appeals.

Every NOA generated and sent lists the contracted ASO's toll free number and information informing the enrollee of the right to an appeal and the process for submitting the appeal orally

or to request more information related to making an appeal, the steps within the process, and available avenues for submission, response, and in what timeframes.

Answer as part of the response to the requirement with the description: Grievance System-general requirements. Provide a specific reference here to where this specific requirement is addressed in your response. Grievance System - Appeal Process - Resolution and Notification (312)

The SCRSN disposes of each grievance and appeal as expeditiously as the individual's health condition requires. Appeals are decided within 45 days and no later than 60 days. Expedited appeals are decided within 3 business days. The SCRSN monitors its compliance with the stated timeframes and if the SCRSN finds it is not meeting the expected timeframes, researches the trends or patterns for root causes and develops the needed plans of correction.

The SCRBHO will expand its approach within the grievance system for the appeal process, disposing of each grievance and appeal as expeditiously as the individual's health condition requires. The SCRBHO policy will state the requirements related to the complete resolution and notification, as they pertain to SUD services, in deciding appeals within 45 days and no later than 60 days. The Quality Management Committee (QMC) will review reports for adherence to the procedures and requirements for mental health and SUD services and the associated grievance and appeal process.

Answer as part of the response to the requirement with the description: Grievance System-general requirements. Provide a specific reference here to where this specific requirement is addressed in your response. Grievance System - Appeal Process - Format and Content of Resolution Notice (313)

Currently, the SCRSN provides all appeal decisions in writing. Although expedited appeal decisions are provided orally, they are also provided in writing.

The written notice includes the result of the process and the date it was completed. For a decision that is not wholly in favor of the individual or if the individual disagrees with the decision, information is provided about the right to file a state fair-hearing and how to do so. Information is also provided about how to request that services continue while the hearing is pending, and that the individual may be held liable for the costs of the continued services if the state fair-hearing upholds the SCRSN decision. As the SCRBHO, the same process will be extended and followed as pertains to the delivery of SUD services and the appeal process providing appeal decisions in writing as well as orally for expedited appeals. All the information, as listed above, will be included such as the result of the process and date completed. For a decision that is not wholly in favor of the individual or if the individual disagrees with the decision, information is provided about the right to file a state fair-hearing and how to do so will be included following the above described process.

Answer as part of the response to the requirement with the description: Grievance System-general requirements. Provide a specific reference here to where this specific requirement is addressed in your response. Grievance System - Appeal and State Fair Hearing Process - Continuation of Benefits (314)

The SCRSN policy requires that benefits will be continued if the individual or the provider submits the appeal within 10 days, and if the appeal involves termination, suspension, or reduction of a previously authorized service that was requested by a network provider, as long as the authorization has not expired. The benefits must continue unless the individual withdraws the request for appeal or has requested a state fair-hearing. Authorized services continue until a fair hearing decision is reached. The SCRSN may choose to recover the costs of the services from the individual if the state upholds the SCRSN decision. As the SCRBHO, we will continue the grievance system, as described above, to expand and encompass SUD services and other applicable procedures, as described above, and associated with compliance of the appeal and state fair-hearing process.

Answer as part of the response to the requirement with the description: Grievance System-general requirements. Provide a specific reference here to where this specific requirement is addressed in your response. Grievance System - Appeal and State Fair Hearing Process - Effectuation When Services Were Not Furnished (315)

Per its policy and by provider contract, if the SCRSN or the state reverses a decision that denied, limited or delayed services, the SCRSN must authorize and pay for the disputed services promptly or as expeditiously as the health of the individual requires. The SCRSN monitors compliance with this process as with other requirements. As the SCRBHO, we will expand our policy and provider contracts to be inclusive of the requirement, that if the state reverses a decision that denied limited or delayed services, the SCRBHO will authorize and pay for the disputed services promptly or as expeditiously as the health of the individual requires the SUD services. Similarly, the SCRBHO will monitor compliance with this requirement.

Answer as part of the response to the requirement with the description: Grievance System-general requirements. Provide a specific reference here to where this specific requirement is addressed in your response. Grievance system - Appeal and State Fair Hearing Process - Effectuation When Services Were Furnished (316)

The SCRSN pays for any disputed services should it or the state reverse a decision to deny services. Beginning April 1, 2016, the SCRBHO will pay for any disputed services should it or the state reverse a decision to deny services for individuals receiving SUD and/or mental health services.

Answer as part of the response to the requirement with the description: Grievance System-general requirements. Provide a specific reference here to where this specific requirement is addressed in your response. Grievance System - Expedited Appeals Process – General (317)

Contractually, the SCRSN requires the ASO to offer the expedited appeals process and developed policy and procedures to maintain the process in which individuals or their provider requesting an expedited appeal process, are provided an appeal decision within 3 working days. The SCRSN receives and reviews regular reports from the ASO, documenting compliance with the 3-day expedited appeals process timeframe. Should the ASO not maintain the expected standard, the ASO would provide SCRSN with a corrective action plan and resolution within a defined timeframe. The SCRBHO will expand its contract with the ASO to include the process for offering the expedited appeal process related to SUD services within 3 working days. Similarly compliance will be reviewed, monitored, and reported to assure performance as required.

Answer as part of the response to the requirement with the description: Grievance System-general requirements. Provide a specific reference here to where this specific requirement is addressed in your response. Grievance System - Expedited Appeals Process – Authority to File (318)

The SCRSN understands and complies with the requirement through its grievance process that individuals may file an appeal orally or in writing and are required to follow up with an oral request to file an appeal in writing. This requirement currently applies to MH services and will be expanded by the SCRBHO to comply with the requirement, following the associated policy expanded to be inclusive of SUD services.

Answer as part of the response to the requirement with the description: Grievance System-general requirements. Provide a specific reference here to where this specific requirement is addressed in your response. Grievance System - Expedited Appeals Process – Procedures (319)

Within the Grievance policy, the SCRSN has included the requirement that individuals are provided a reasonable opportunity to present evidence and allegations of fact or law, in person as well as in writing. As this is currently in place for appeals related to mental health services, the policy will be expanded as well as the contract with the ASO to include the requirement and its application to appeals related to SUD services under the SCRBHO.

Answer as part of the response to the requirement with the description: Grievance System-general requirements. Provide a specific reference here to where this specific requirement is addressed in your response. Grievance System - Expedited Appeals Process - Resolution and Notification (320)

The SCRSN requires that all appeals be resolved in an expedited fashion when it determines, or a provider indicates, that taking time for a Standard Appeal Process could jeopardize the

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individual's life, health, or ability to attain, maintain, or regain maximum function. The SCRSN does this within 3 working days and provides notice to the individual and provider of its decision. The SCRSN's policy includes this requirement and monitors compliance.

Extension of timeframes: Per policy, the SCRSN may extend the timeframes, as stated above, up to 14 calendar days if the individual requests the extension, the SCRSN shows to the satisfaction of the state that there is a need for the additional information and that it will benefit the individual, and if it does so, must provide the reason for the extension to the individual in writing.

For notice of expedited resolutions, the SCRSN must also make reasonable efforts to provide oral notice to the individual and the provider.

The SCRBHO will develop the same expedited appeals process, formalized in policy to expand and comply with the process described above and associated with the inclusion of SUD services.

Answer as part of the response to the requirement with the description: Grievance System-general requirements. Provide a specific reference here to where this specific requirement is addressed in your response. Grievance System - Expedited Appeal Process - Punitive Action (321)

Per SCRSN policy, neither enrolled individuals, anyone who assists them, nor the provider shall be retaliated against for assisting the individual in an expedited appeal. The SCRBHO will implement the same expectation and policy applicable to mental health services and the process for SUD services, e.g., that neither enrollees, anyone assisting them, nor the provider will be retaliated against for assisting the individual in an expedited appeal and the SCRBHO will monitor compliance with the policy.

Answer as part of the response to the requirement with the description: Grievance System-general requirements. Provide a specific reference here to where this specific requirement is addressed in your response. Grievance System - State Fair Hearing Process - Notification of State Procedures (322)

The Grievance Policy and language within its subcontracts with providers documents the obligation that the SCRSN will provide information about the grievance system to all providers. The SCRSN provides information about the grievance system to all providers at the time of entering into a contract agreement.

The information provided includes:

- Information about procedures and the right to request a fair hearing when SCRSN initiates an action providing that the enrollee has exhausted all appeals at the lowest level;
- The right to file a grievance;
- The rules about representation at the hearing;

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- The availability of assistance by others, by the individual of their choosing including asking the Ombuds Services for assistance; and
- Clarity regarding the continuance of benefits during the time a grievance or appeals has been filed if it is filed while services are authorized, and that the provider or the individual can appeal to the SCRSN if it decides not to provide a requested service, if that service is a covered benefit as defined by the state.

The SCRSN reports and monitors its compliance in providing this information.

As the SCRBHO, we will expand the policy and include in our contracts language that clearly reflects the policy and information as described above and currently pertinent to mental health services and the application of the expanded policy and contracts to SUD services and the associated monitoring of compliance.

Answer as part of the response to the requirement with the description: Grievance System-general requirements. Provide a specific reference here to where this specific requirement is addressed in your response. Grievance System - State Fair Hearing – Parties (323)

The SCRSN provides information in its mailed Notices that individual's may request a fair hearing from the state within 20 days of receiving the SCRSN's decision about the appeal, if they disagree with the decision. The process and policy currently applies to enrollees accessing mental health services and the process and compliance will be incorporated under the SCRBHO and enrollees will be provided information in the mailed notices sent to enrollees of SUD services.

Answer as part of the response to the requirement with the description: Grievance System-general requirements. Provide a specific reference here to where this specific requirement is addressed in your response. Grievance System - Grievance – Definition (324)

The SCRSN defines grievance as an expression of dissatisfaction about any matter other than an action. Possible subjects for grievances include, but are not limited to, the quality of care or services provide and aspects of interpersonal relationships such as rudeness of a provider, employee, or failure to respect the rights of the individual.

The SCRSN has established grievance procedures that provide for the individual, their legal representative, a person of their choosing with written consent, or a provider agency can challenge the denial of coverage.

In addition to the above, in its policy and its subcontracts with its provider agencies, the SCRSN defines the following:

- Action is the denial or limited authorization of a requested service, including the type and duration and any service denial based on Access to Care, the reduction, suspension, or termination of a previously authorized service, or enrollee disagreement with the treatment plan, or the denial or failure to provide services in a timely manner, and the failure of the SCRSN or network provider to act within the required timeframes;

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- Denial is the decision by the SCRSN or its ASO not to authorize a covered Medicaid mental health service that has been requested by a provider on behalf of an eligible Medicaid enrolled individual. It is also a denial if an intake is not provided upon request by an individual enrolled in Medicaid;
- Appeal is a request for review of an action as defined above; and
- Fair hearing means a hearing before the Washington State Office of Administrative Hearings.

As the SCRBHO transitions its operations and grievance processes to comply with the requirements associated with the delivery of SUD services, it will include these definitions, formalized in policy and procedures to assure compliance, both in the mental health and SUD delivery system.

Answer as part of the response to the requirement with the description: Grievance System-general requirements. Provide a specific reference here to where this specific requirement is addressed in your response. Grievance System - Grievance Process - Procedures and Authority to File (325)

The SCRSN includes within its grievance process and policy the requirement that individuals may file a grievance orally or in writing either with the SCRSN contracted provider agency or the SCRSN directly. Provider agencies, legal representative of the individual, or a person designated by them in writing, including the Ombuds Service, may assist the individual in filing the grievance.

Per policy, the SCRSN provides that an enrollee may file a grievance or an appeal with the SCRSN and may request a fair hearing after exhausting all lower level appeals. The SCRSN and network providers must ensure that the individuals who make decision on grievances are individuals who were not involved in any previous review or decision-making.

Per policy, the SCRSN and its network providers shall ask and encourage individuals to make and resolve grievances at the lowest level possible. Ombuds can assist at any level. The SCRSN monitors compliance through receipt of required reports, and if issues arise, investigates the issue and requests a corrective action as needed.

As noted previously, the SCRBHO intends to incorporate in our existing policies and procedures expansion to encompass the mandated requirements applicable to SUD services and the individuals accessing those services. The SCRBHO will monitor, continue to review and monitor compliance, and take appropriate corrective action as required.

Answer as part of the response to the requirement with the description: Grievance System-general requirements. Provide a specific reference here to where this specific requirement is addressed in your response. Grievance System - Grievance Process - Disposition and Notification (326)

The SCRSN requires that it and its contracted provider agencies provide disposition of grievances within 30 days whenever possible and no later than 90 days or it becomes an Action.

Disposition is provided to the individual in writing. If the individual disagrees with a provider agency's response to the grievance, they may file the grievance with the SCRSN in accordance with its written policies and procedures.

Provider agencies track grievance disposition on a designated grievance reporting log. The log is submitted to SCRSN no later than 30 days after the end of the reporting period. The log tracks the grievance number, type, and date of initial acknowledgement of the grievance in writing if any extensions were requested and if Ombuds services were involved.

As the SCRBHO, we will expand the current grievance process applicable to mental health service delivery to encompass and comply with the inclusion of the process and requirements to the delivery of SUD services and the procedures associated with disposition and notification, as described above.

Transition from SCRSN to SCRBHO

As described in the individual questions, the SCRSN has established a robust and compliant Grievance System process, formalized in policies, that meets federal and state requirements. As we transition to the SCRBHO, we intend to build from our current grievance process as the foundation and continue to meet and comply with the requirements associated with responsibility for SUD services.

To effectuate a responsive and ready system, the SCRBHO began training the SUD provider agencies that we will contract with under the BHO, on October 1, 2015, about its Grievance System, beginning in October 2015. The training will consist of the following:

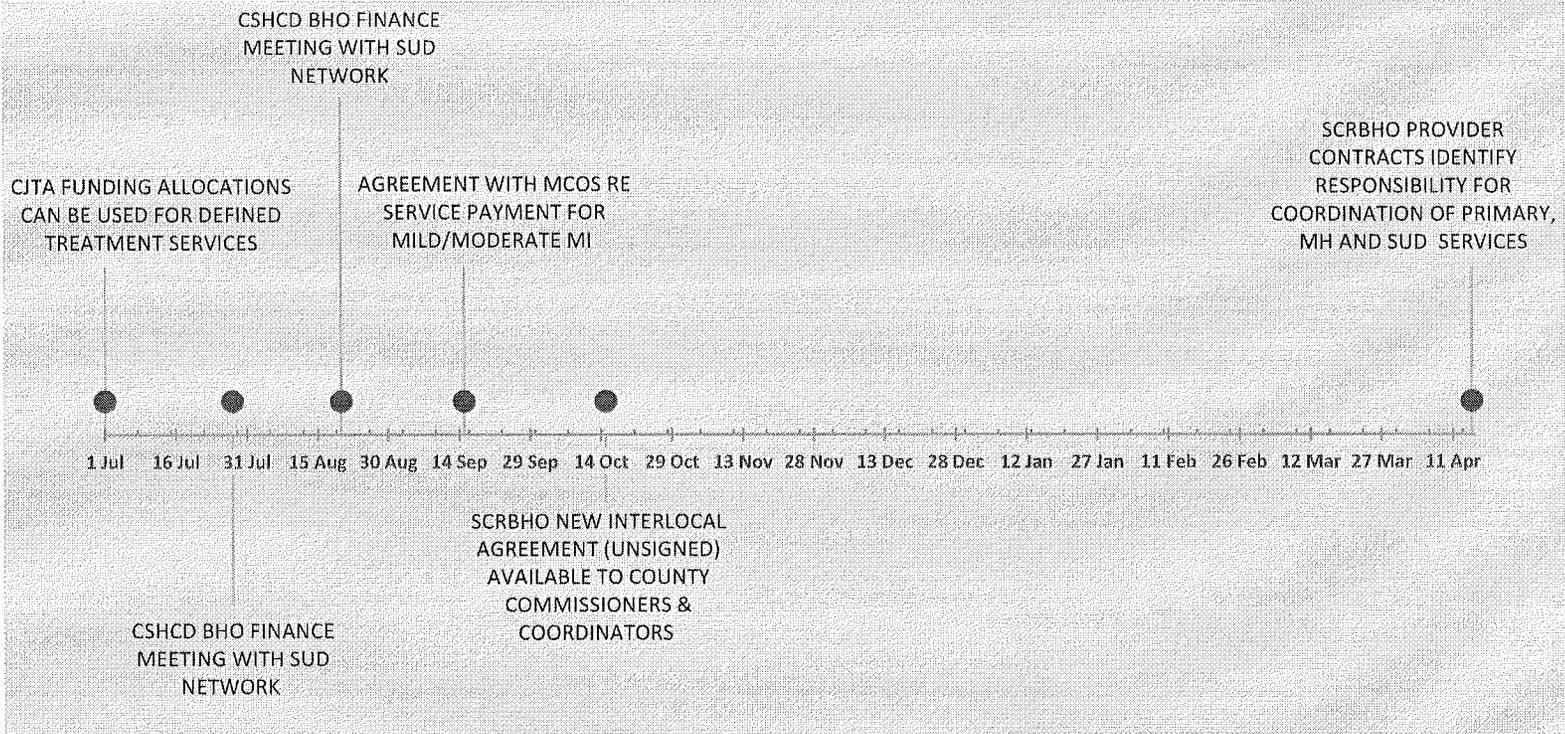
- Overview of the grievance system and the definitions of grievance, appeals, actions, denials, and fair hearings;
- How SCRBHO tracks grievances, appeals, denials, and fair hearings;
- How to provide information to individuals and potential users of the SCRBHO grievance system;
- That SCRBHO incorporates results of grievances, appeals, and fair hearings into its quality management plan and will address any trends;
- That individuals are encouraged to make and resolve grievances at the lowest level and that Ombuds can assist at any level;

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- That individuals are required to exhaust all levels of the appeals process prior to filing a request for a fair hearing;
- That customer service staff must be trained to distinguish between a benefit inquiry, third party insurance issue, and how to route these inquiries internally;
- That providers shall provide assistance with filing a grievance or appeals;
- How to acknowledge and track a grievance and that this is required within 5 business days;
- That SCR BHO and its providers will investigate and resolve all grievances as expeditiously as the individual's health condition requires;
- How a NOA is generated from the SCR BHO Information System and the reasons for the Notice;
- What record-keeping is required;
- How to use the SCR BHO provided grievance reporting log to track and report all grievances; and
- And that final resolution about grievance resolution is the decision of the SCR BHO.

Additionally, the SCR BHO will utilize the Ombuds Service to assist with the training and as a way for the Ombuds to gain understanding of each SUD provider agency and SUD services. The SCR BHO will participate in state-sponsored training about the Grievance System and will convey this training to each provider agency.

Grievance System Plan Timeline



XI. Tribal Communication and Coordination and Communication Plan

XI. Tribal Communication and Coordination and Communication Plan

2.169 Behavioral Health Organization – inclusion of tribal authorization - roles and responsibilities

(1) How will the BHO allow for the inclusion of the tribal authority to be represented as a party to the behavioral health organization?

As a new Behavioral Health Organization (BHO), there is an opportunity to further collaborate with the Kalispel, Spokane, and Colville Tribes, Native Health of Spokane, and the American Indian Community Center who are all within the Spokane County Regional Behavioral Health Organization (SCRBHO) region of care. Over the past year, the Spokane County Regional Support Network (SCRSN) and the Substance Abuse County Coordinator has met several times with the tribes and often including mental health or substance use providers to discuss advisory board membership opportunities, crisis and involuntary services, placement of individuals under detentions, and other relevant issues. The Mental Health Advisory Board (MHAB) and the Substance Abuse Advisory Board (SAAB) each have a current member of a tribe on the board (Kalispel) who fully participate and bring insights to our board members regarding tribal needs or other issues that pertain to delivery of behavioral health services. The SCRSN has a Recognized American Indian Organization (RAIO), Native Health of Spokane, and the Spokane Tribe on the mental health board as well. As the advisory boards merge, all existing members will be asked to become members of the new board for a term of 3 years. The Colville Tribe does not currently have representation on either of the boards, but in the past, have indicated an interested to be involved. The SCRBHO will extend an invitation to the Colville Tribe to designate a representative. We understand that travel and meals can be expensive, as the Tribal members live in rural or frontier areas. We will be offering to pay for travel and meals for all members of the board that live in those areas. These funds come from local sources, rather than Medicaid.

In Spokane County, there are 2 RAIOS, Native Health of Spokane and the American Indian Center. Both the SCRSN and the Spokane County Substance Abuse Division have good working relationships with the organizations and often refer Tribal members to their agencies if they do not want to be served on Tribal lands. Native Health of Spokane is a Federally Qualified Health Center (FQHC) that includes medical, psychiatric evaluation and medication, mental health and substance use disorder treatment, dental, and pharmacy. Native Health of Spokane contracts with the SCRSN and Substance Abuse Division for mental health, Substance Use Disorder (SUD), and co-occurring services. American Indian Health Center has recently had staff turnover, but we have a good working relationship with them. They provide employment counseling, a food and clothing bank, children services, etc. The Healing Lodge is native

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operated and accepts native individuals across the state. Their staff attends our SUD and SCRSN meetings.

In July and August 2015, during the substantial fire storms on the Colville Reservation, the tribes requested that Okanogan Behavioral Healthcare provide crisis assistance during the heavy times of stress. A possible outcome from this help was that Okanogan Behavioral Healthcare may provide the Colville Tribe with assistance at one of their schools in Nespelem, Washington.

In 2014, the SCRSN funded the Kalispel Tribe with Federal Block Grant money to broaden the education of their staff to improve access to SUD treatment for their Tribal members and families. All 3 tribes and RAIOS were contacted to apply for the Federal Block Grant funds, but due to a change in SAMHSA's requirements to serve the seriously mentally ill and seriously emotionally disturbed individuals not on Medicaid, report the data, and maintain accurate clinical charts, it was difficult for them to develop the administration processes for the amount of funding they would receive. Of the 3 tribes, only the Kalispel Tribe was interested.

As agreed upon several years ago, the local Evaluation and Treatment (E&T) facilities notify and coordinate discharge planning for the tribes.

The SCRSN and the Substance Abuse Division have been very invested in collaborating with the tribes and RAIOS and believe there are further opportunities to improve our BHO system of care together.

(2) Provide a work plan for the implementation of the American Indian Addendum, Exhibit E to the DPR.

Exhibit E is applicable to contracts between Qualified Health Plans and tribes. Currently, the only contract that SCRSN holds with a tribal health program is specific to a Federal Block Grant for staff training in SUD treatment for the Kalispel Tribe. The current contract complies with all of the applicable federal and state requirements for Federal Block Grant funded programs and will be amended to include a signed and executed agreement within the Exhibit E attachment.

(3) Address how you will assure that AI/AN enrollees have equal access to behavioral health services.

Any Medicaid tribal member or relative that chooses to receive Regional Support Network (RSN) or SUD services may do so as long as they meet the Division of Behavioral Health and Recovery (DBHR) contractual criteria. All of the 7 counties under the BHO have a long history of working alongside with the tribes and continue to address historical, socio-cultural, economic, religious, and linguistic characteristics of the tribal people who live in our region of care. The SCRSN recognizes that there is much to learn to fully understand the familial beliefs, values, and customs of the tribes: however, access to care and individualized person-centered care, self-direction, and empowerment are all a part of recovery that we all champion.

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Requests for services may come from any client or family member if the person is a child, and the request may go to any provider, whether it is for SUD, mental health, or co-occurring services. Spokane County providers are listed on the Spokane County website for mental health and co-occurring treatment and services. The providers in the North Central counties have information on each of their county websites.

Providers take individuals on a first-come basis, regardless of ethnic background. When service needs are related to SUD, the priority populations are pregnant parenting women, Intravenous (IV) drug users, and individuals on Medicaid. Mental health providers engage enrollees, who meet access to care for mental health, are seriously mental ill or seriously emotionally disturbed, and are on Medicaid. There are some funds to treat non-Medicaid individuals, and both SUD and mental health programs accept as many individuals as they have funding to serve. All individuals receive crisis services, Involuntary Treatment Act (ITA) services, and inpatient services when needed. The SCRSN has worked with each tribe and RAIO to update the crisis plan (3 of which are signed), see Attachments 27, 28, 29, 30, and 31. Signed copies of the plan include Spokane Tribe and both of the RAIOs. Currently, the SCRSN monitors the number of individuals being served by ethnic background. Several of the provider organizations have Native Americans on staff, and the SCRSN also has tribal staff.

- (4) Describe how you will provide culturally competent services to AI/AN, and***
(5) How will the BHO provide for a continuation and/or transition of this practice to assure access to these services by tribal members?

One way to help ensure equal access to service is by the types of trainings that clinicians attend. One of the best trainings is sponsored by the Kalispel Tribe and was originally developed in tandem with the SCRSN. The Tree of Healing Conference is held annually in Spokane and occurred in October of this year. This training is one of the best attended in Spokane and is normally full to capacity. We have sponsored other cultural trainings, but the Tree of Healing has been the most appreciated and recognized for tribal communities. It is a great introduction for Non-Native American Counselors. Another training that was provided this year in January was Culturally Sensitive and Responsive Practices, by Dr. Robert J. Wilburn. This training was well received, but one of the tribes stated that trainings need to be detailed to the specific tribe, as they each have their own cultures. We have not been successful finding specific tribe training, and in Spokane, Native Health of Spokane serves approximately 200 different tribes. We will continue to work on providing training opportunities that increase the cultural sensitivity of behavioral health professionals serving Native Americans and will continue to encourage providers to allow their staff to attend behavioral health conferences that are sponsored by tribes.

(6) Address coordination with Tribal providers and provide any written agreements.

In June 2014, the SCRSN assigned a Care Coordinator to each of the tribes as a liaison to help with communication and collaboration, technical assistance with inpatient or outpatient placements, or issues with the SCRSN or its provider agencies. This practice has worked well and will continue under the BHO. Tribes and RAIOS are invited to all meetings held by the SCRSN and the Substance Abuse Division.

Committees and workgroups all include invitations to tribes and RAIOS. The meetings are often attended by 1 or more of the tribes and RAIOS. The SCRSN liaison job description will be revised under the BHO to include SUD services for tribal communication. The SCRSN currently has written Crisis Service Agreements that have been prepared with input and/or direction from the tribes and RAIOS, and 3 of those are signed and attached.

**XII. Evidenced Based, Researched Based and Promoting Practice
Analysis and Development Plan**

This Plan was deleted by DSHS on August 31, 2015.

XIII. Behavioral Health Data Consolidation Project Plan

XIII. Behavioral Health Data Consolidation Project Plan

Exhibit A.1: Provide your plan and timeline to collect and report on the data elements contained in Table 1 (Non-Provider One data elements) and Table 2 (Provider One data elements). (295)

I. Overview of Management Information Systems and Data Management

a. Management Information System:

The Spokane County Regional Support Network's (SCRSN) primary health information system or Management Information System (MIS) is called "Raintree." The Raintree system is a hosted environment through an Application Service Provider (ASP) agreement that was developed and is supported by Raintree Systems, Inc. The Raintree system is currently utilized by SCRSN to collect, analyze, integrate, transmit, and report mental health outpatient and inpatient data for achieving the objectives of the SCRSN as required in contract, including but not limited to; state required client demographics, service encounters, utilization management, and disenrollment for other than loss of Medicaid eligibility.

The SCRSN's current grievances and appeals processes are manual and information is stored external to the SCRSN's Raintree health information systems.

The Raintree health information system, reporting database, and annual provider monitoring application (tool) and database, which comprise the SCRSN's Health Information Systems (HIS), will be extended, expanded, and enhanced by Spokane County Regional Behavioral Health Organization (SCRBHO) to continue to meet the mental health contract requirements, as well as to collect, store, and report new and changing requirements associated with the Behavioral Health Organization (BHO) contract and data elements contained in Table 1 (Non-Provider One data elements) and Table 2 (Provider One data elements) of Exhibit A, or updated and finalized versions of Exhibit A, by April 1, 2016, to meet the SUD requirements. Data will be collected, stored, and submitted from the following subcontracted entities: Substance Use Disorder (SUD) outpatient provider agencies (hereafter referred to as SUD agencies), SUD residential and inpatient facilities (hereafter referred to as SUD facilities), mental health outpatient provider agencies (hereafter referred to as mental health agencies), and mental health inpatient providers.

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b. Data Management:

The Quality and Data Systems leadership and staff consists of 14 professionals, with expertise in Information Systems (IS) and Data Management, and over 200 collective years of experience in; Data and IS security, software development life cycle, systems implementation and support, data management, quality control, project management, data integration, data conversion, data reconciliation, report writing, data analytics, training, vendor management, Health Insurance Portability and Accountability Act (HIPAA) compliance, contract monitoring, documenting MIS policies, and implementing MIS procedures.

In addition to managing the MIS and the quality of the data collected, stored, integrated and transmitted, the Quality and Data Systems team generates operational reports from the Raintree system for internal use, and for external use for 25 MH agencies in 8 counties.

Additionally, the Quality and Data Systems team generates administrative, financial, performance, and monitoring reports from their Structured Query Language (SQL) server database, which is an operational data store, called the Reporting Database. The SCRSN is in the process of implementing a conformed data warehouse and business intelligence system in a hosted environment; this system is estimated to go-live with reporting and data analytics capabilities in June 2016.

The purpose of this system will be to accelerate and expand current capabilities of the SCRBHO to produce reports more rapidly for business stakeholders and expose decision-makers more readily to relevant data, business trends and anomalies, and to perform predictive analytics.

The SCRSN Quality and Data Systems leadership and staff will transform the systems and services they currently provide to serve the SCRBHO business needs. This transformation will provide a fluid and seamless transition for consumers, SUD and mental health agencies, SUD facilities, and the public in a fully-integrated behavioral health system of care.

These services include overseeing and managing the MIS environment, while supporting the business environment in the following areas, and as depicted in the subsequent diagram:

a. IS Contract Compliance (lower right quadrant of diagram, brown circles)

- i. MIS Policies and Procedures
- ii. Business Continuity and Disaster Recovery Plans
- iii. Annual Provider Monitoring and Reporting
- iv. Contract Compliance

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- v. HIPAA Compliance
- vi. Engagement and Participation with Department of Social and Health Services (DSHS)/Division of Behavioral Health and Recovery (DBHR) on Business and Data Initiatives and Changes

b. Data Information Systems Management (upper right quadrant of diagram, red circles)

- i. IS Security and Access
- ii. Data Security
- iii. Data Collection, Processing, Storage
- iv. State Data Reporting
- v. Electronic Data Interchange (EDI) inbound and outbound, Data Submissions, Data Transmissions
- vi. Systems Availability, Interoperability, Scalability, Extensibility, Expandability
- vii. System Performance Monitoring
- viii. Project Management
- ix. Systems Implementation (requirements, design, development, testing, training, deployment)
- x. Information Systems Support and Maintenance
- xi. Data Sharing

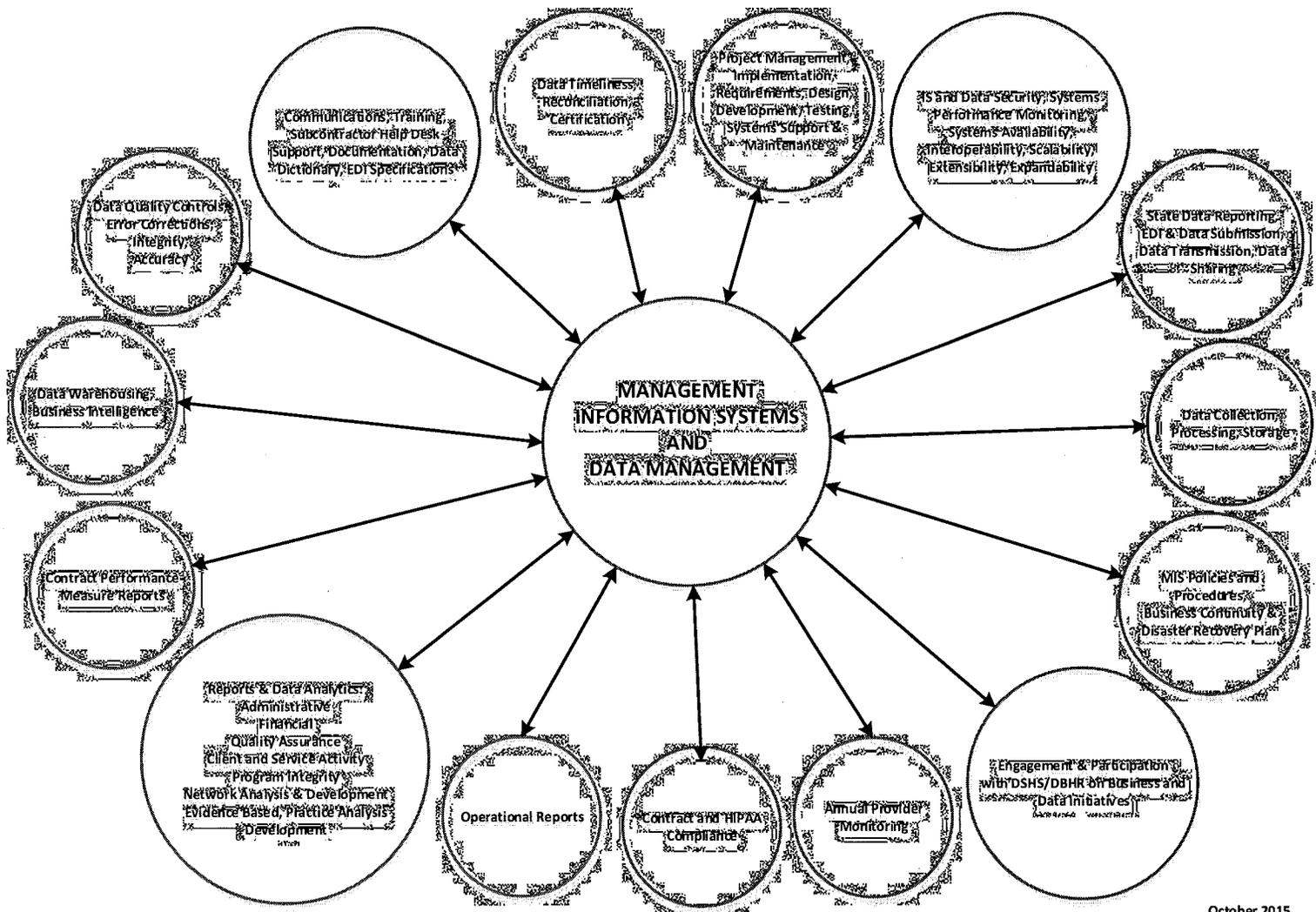
c. Data Quality and Timeliness (upper left quadrant of diagram, blue circles)

- i. Data Quality Control
- ii. Error Corrections
- iii. Data Integrity and Data Accuracy
- iv. Data Timeliness
- v. Data Reconciliation
- vi. Monthly Data Certifications
- vii. Communications/Alerts/Notices
- viii. Training (initial and ongoing)
- ix. Subcontractor Help Desk Support for Business Rule and Data Related Questions
- x. Data Related Documentation (Data Dictionary, EDI Specifications, Training Materials, User Manuals)

d. Reporting and Data Analytics (lower left quadrant of diagram, green circles)

- i. Contract Performance Measures Reports
- ii. Operational Reports
- iii. Reports and Data Analytics for All Business Areas of the SCRBHO

SPOKANE COUNTY REGIONAL BEHAVIORAL HEALTH ORGANIZATION (SCRBHO) BEHAVIORAL HEALTH DATA CONSOLIDATION PROJECT PLAN



October 2015

II. Project Implementation Plan

a. Project Plan and Timeline:

The SCRBHO Quality and Data Systems leadership and staff will leverage their collective knowledge and experience with multiple counties and merged RSNs, as well as the supporting MIS platform and infrastructure for doing so, to integrate SUD and mental health into a behavioral health system of care with a single MIS environment and a common set of processes, for meeting the milestones and deliverables of the SCRBHO Behavioral Health Data Consolidation Project Plan, as explained below:

Per 42 CFR 438.242 (b), the Raintree system will specifically:

1. Collect data on enrollee and provider characteristics as specified by the state, and on services furnished to enrollees through the Raintree encounter data system, and transmitted to the state via 837P and 837I Electronic Data Interchange (EDI) standard formats, as well as native file formatted transactions.
2. Ensure that data received from providers is accurate, timely, and complete by:
 - a. Verifying the accuracy and timeliness of reported data through front end system edit checks to the data prior to saving or processing the data into the Raintree system on a real-time basis for accuracy and on a monthly basis for timeliness;
 - b. Screening the data for completeness, logic, and consistency via front end system edits and back-end system edits across the SCRBHO system of care on a real-time basis for direct data entry users and on a daily basis for agencies transmitting to the SCRBHO via EDI processing; and
 - c. Collecting service information in the HIPAA 5010 EDI 837 Health Care Claim X12 Transaction Set standardized format to the extent feasible and appropriate as specified by the state on a daily basis.
3. Make all collected data available to the state on a weekly basis, and upon request to CMS, as required.

The SCRBHO will leverage existing mechanisms to ensure compliance, data quality, and timeliness with all SUD and MH agencies and SUD facilities. These mechanisms include: policies and procedures, reports, training methods and materials, communications, technical support, and monitoring. These mechanisms will be

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replicated and extended to the SUD agencies and facilities. Existing mechanisms for mental health agencies will be enhanced as required to meet any new or modified contract requirements.¹

The SCRBHO's Behavioral Health Consolidation Project plan, involving the MIS and HIS systems and data, is divided among several phases. As is typical, the project phases will overlap with each other. During this same time period, the SCRBHO will be implementing a Data Warehouse and Business Intelligence Project that is being implemented in order to enhance the SCRBHO's ability to provide more robust reports and business analytics for decision-making, process and program improvement, tracking and trending, performance improvement, and benchmarking outcomes. Both projects will be implemented in parallel with the majority of the work for both concluding in April 2016. Despite this complexity, all critical phases of the Behavioral Health Data Consolidation Project will be completed by April 15, 2016. The phases of the 2 projects are listed below, and a high level project schedule diagram depicting the estimated completion dates for the phases and milestones follows.²

1. Behavioral Health Data Consolidation Project
 - a. Business and Data Requirements Phase
 - b. Design Phase
 - c. Development Phase
 - d. Testing Phase
 - e. Final Documentation Phase
 - f. Training Phase
 - g. Go Live Preparation Phase
 - h. Go Live Phase
 - i. SCRBHO Standard Reports Phase
 - j. EDI Implementation Phase
2. Data Warehouse and Business Intelligence Project – Phase 1
 - a. Planning Phase
 - b. Requirements Phase
 - c. Network/Hardware/Software Installation Phase
 - d. Design Phase
 - i. Data Model

¹ Refer to specifics on the policies, reports, and processes in Appendix A at the end of this document.

² Refer to Appendix B - BHDC Project Plan – HIS Schedule at the end of this document for a more detailed project implementation schedule. This schedule is a “living” project schedule and will be updated regularly throughout the project.

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- e. Development Phase
 - i. Extraction, Transformation, Loading
 - ii. Data Cubes
 - iii. Standard Reports
 - iv. Data Analytics
 - v. Ad Hoc Reports
- f. Testing Phase
- g. Produce and Systems Certification Phase
- h. End User Documentation, Training Plan, and Training Phase
- i. Go Live Preparation Phase
- j. Go Live Phase

**SPOKANE COUNTY REGIONAL BEHAVIORAL HEALTH ORGANIZATION (SCRBHO)
 BEHAVIORAL HEALTH DATA CONSOLIDATION PROJECT PLAN
 Management Information Systems (Health Information Systems) Project
 Schedule Overview**

