North Sound Behavioral Health Organization

301 Valley Mall Way, Suite 110, Mount Vernon, WA 98273

ADVISORY BOARD AGENDA

January 2nd, 2018

1:00 p.m. – 3:00 p.m.

CALL TO ORDER & INTRODUCTIONS

REVISIONS TO THE AGENDA

APPROVAL OF MINUTES FROM PREVIOUS MEETING

Approval of December Minutes……...TAB 1

ANNOUNCEMENTS

BRIEF COMMENTS OR QUESTIONS FROM THE PUBLIC

STANDING COMMITTEE REPORTS (Briefs from Each Committee Attached)

- Quality Management Oversight Committee (QMOC)……TAB 2

EXECUTIVE/FINANCE COMMITTEE REPORT

Approval of the December Expenditures…….. ……TAB 3

EXECUTIVE DIRECTOR'S REPORT & ACTION ITEMS

Executive Director's Report Items

- Report from Joe……TAB 4
- Stakeholder Survey Results……TAB 5
- Dennis Regan Medicaid Population Report……TAB 6

Executive Director's Action Items

- Action Items/Memorandum ……TAB 7

OLD BUSINESS

2018 Site Tours and Pre-Meeting Topics……TAB 8

2018 Legislative Advocacy Priorities……TAB 9

2018 Visual Art & Poetry Contest Theme

NEW BUSINESS

Advisory Board Composition on North Sound Behavioral Health Organization Standing Committees

Future Holiday Cards from Advisory Board

AREPORT FROM ADVISORY BOARD MEMBERS

2017 Co-Occurring Disorders & Treatment Conference

REMINDER OF NEXT MEETING

- The next scheduled meeting is February 6th, 2018 in the Conference Room Snohomish

ADJOURN

APPROVED by Advisory Board

North Sound Behavioral Health Organization

301 Valley Mall Way, Suite 110, Mount Vernon, WA 98273

ADVISORY BOARD MINUTES

December 5th, 2017

1:00 p.m. – 3:00 p.m.

ATTENDANCE

Advisory Board Members Present

Island: Candy Trautman, Betty Rogers, Chris Garden
San Juan: Theresa Chemnick (Phone)
Skagit: Duncan West, Joan Lubbe
Snohomish: Marie Jubie, Jack Eckrem, Fred Plappert, Joan Bethel, Carolann Sullivan, Pat O'Maley-Lanphear, Carolyn Hetherwick Goza
Whatcom: David Kincheloe, Mark McDonald, Arlene Feld, Stephen Jackson, Natasha Raming,

Excused Advisory Board Members

Island:
San Juan:
Skagit: Ron Coakley
Snohomish: Jennifer Yuen
Whatcom: Michael Massanari

Absent Advisory Board Members

Island:
San Juan:
Skagit:
Snohomish:
Whatcom:

NSBHO Staff Present

Joe Valentine (Executive Director)
Maria Arreola (Administrative Assistant II)

Guests Present

Boone Sureepisarn – Behavioral Health Ombuds Specialist
Amanda Sloan – Behavioral Health Ombuds Specialist

CALL TO ORDER & INTRODUCTIONS

The Chair called the meeting to order at 1:03 p.m. and introductions were made.

REVISIONS TO THE AGENDA

The Chair inquired regarding revisions to the Agenda. None mentioned.

APPROVAL OF MINUTES FROM PREVIOUS MEETING MINUTES

November minutes were approved by a motion and vote.

APPROVED by Advisory Board

STANDING COMMITTEE REPORTS (Briefs from Each Committee Attached)

- Quality Management Oversight Committee (QMOC) Report (No November Meeting)

EXECUTIVE DIRECTOR'S REPORT & ACTION ITEMS

Executive Director Report

Joe reported on

- Integration Planning
- Opioid Summit Follow Up
- Behavioral Health Facilities Update
- 911 and Regional Crisis Line

2018 Proposed North Sound BHO Budget

Motion was made to approve the 2018 Proposed North Sound BHO Budget. Motion seconded. All in favor.

Action Items

Joe reviewed each of the Action Items with the Advisory Board

- A motion was made to move the Action to the County Authorities Executive Committee for approval. Motion was seconded all in favor.

OLD BUSINESS

Advisory Board Code of Ethics

Discussion took place referrencing to the Bylaws Article II; Section 8, Limitation of Duties.

2018 Chair and Vice-Chair Elections
Vote took place for Chair and Vice-Chair. It was announced Pat O'Maley-Lanphear from Snohomish County will be Chair and Ron Coakley from Skagit County will be Vice-Chair.

2018 Visual Art & Poetry Contest Theme
Members turned in the vote for the theme. Maria will send out notification of the chosen theme. Announcement will take place during the January meeting.

2018 Site Tours and Pre-Meeting Topics
Site tours were determined to be the Lynwood Detox Center and the Swinomish Wellness Center. January and February pre-meetings were determined. Further planning of 2018 months will be determined during the January meeting.

2018 Legislative Advocacy Priorities
Members ranked the top three priorities. Maria will tally the votes to determine the top three. A meeting with Marie will be established to review the top three priorities. Announcement will be made during the January meeting.

2017 Co-Occurring Disorders & Treatment Conference
Tabled until the January meeting.

APPROVED by Advisory Board

NEW BUSINESS

Future Holiday Cards from Advisory Board

Tabled until the January meeting.

ACTION ITEMS

Executive & Finance Committee

The November Expenditures were reviewed and discussed. A motion was made to move the Expenditures to the County Authorities Executive Committee for approval. Motion was approved.

2018 Proposed North Sound BHO Budget

Motion was made to approve the 2018 Proposed North Sound BHO budget; Motion was seconded. All were in favor.

REPORT FROM ADVISORY BOARD MEMBERS

None

BRIEF COMMENTS OR QUESTIONS FROM THE PUBLIC

None

ADJOURNMENT

The Chair adjourned the meeting at 3:10 p.m.

NEXT MEETING

The next **Advisory Board meeting** is January 2nd, 2018 in Conference Room Snohomish

North Sound
Behavioral Health Organization, LLC
301 Valley Mall Way, Suite 110, Mount Vernon, WA 98273
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Quality Management Oversight Committee (QMOC) Brief
December 13, 2017

Policy 1571.00 – Authorization for Payment of Psychiatric Inpatient Services

Michael McAuley, North Sound BHO

The North Sound Behavioral Health Organization (BHO) entered into a Prepaid Inpatient Health Plan (PIHP) contract amendment that changes our Utilization Management (UM) responsibilities for psychiatric inpatient services for individuals who are Medicaid eligible and eligible for publicly funded inpatient mental health who reside within the North Sound BHO region. Policy 1571.00 operational definitions, procedures and timelines have been changed to aligned with the Code of Federal Regulations (CFR) for Public Health (42 CFR), Social Security Act requirements for managed care plans. This policy continues to meet the Department of Behavioral Health and Recovery (DBHR) Medicaid contractual requirements of utilization management of payment of inpatient services. QMOC voted to approve this policy.

Policy 1530.00 – Cross-System Coordination

Val Jones, North Sound BHO

Policy 1530.00 has been updated to include expectations for cross-system coordination at both the North Sound BHO and provider levels. For providers, the expectation is that collaboration with allied systems is ongoing when individuals present with ongoing needs that lie beyond what behavioral health services generally address. Evidence of such collaboration must be included in the Recovery and Resiliency Plan (RRP) and progress notes as appropriate and release of information (ROI) forms must be obtained. The North Sound BHO will both monitor clinical records to ensure collaboration does take place where indicated, and actively develop strong working relationships with allied systems. The policy was also revised to include updated language. QMOC voted to approve this policy.

Policy 1530.00 – Special Populations

Jessie Ellis, North Sound BHO

Several Quality Specialists and managers have attempted to update Policy 1558.00, formerly titled *Mental Health Specialist,* for the last few years. More than once we have had an updated draft ready for committee approval, but discovered at the last minute that the section pertaining to Special Population Consultations was not consistent with the current Washington Administrative Code (WAC) and/or the Prepaid Inpatient Health Plan (PIHP) contract language and/or behavioral health agency (BHA) reports of conflicting interpretation communicated by DBHR auditors during on-site audits, and/or from DBHR staff phone responses to inquiries from the North Sound BHO. Jessie Ellis and Kurt Aemmer will look to see if Policy 1530.00 may be archived and will bring back to QMOC for approval to archive after further research.

Policy 1516.00 – Mental Health Professional Requirements and Exception Requests

Kurt Aemmer, North Sound BHO

Recommendation that Policy 1516.00, Mental Health Professional (MHP) Requirements and Exception Request, and the accompanying MHP Exception Request Form, be archived. In 2016, the item in italic, below, was added to the WAC that defines Mental Health Professional (MHP). The Department of Behavioral Health and Recovery (DBHR) is no longer granting MHP exceptions because clinicians who now meet licensing requirements (per item #2, below) are already considered MHPs, and thus no longer need Exceptions. (*2. A clinician who is licensed by the State of Washington Department of Health (DOH) as a mental health counselor, mental health counselor associate, marriage and family therapist, marriage and family therapist associate.)* QMOC voted to archive this policy.

2017 Discharge Planning Focused Utilization Review Report

Kurt Aemmer, North Sound BHO

Kurt Aemmer provided an overview of the 2017 Discharge Planning Focused Utilization Review (UR) Report. It was noted that this review pertains to mental health (MH) services only. As a region, documentation of the discharge planning aspect of care is exceptional. Clinical staff supervision/training is indicated for two of the behavioral health agencies (BHAs) whose aggregate scores were less than 90%. The North Sound BHO will be folding the nine discharge planning questions into the Routine UR Tool for 2018.

2017 Group Services Focused Utilization Review Report

Kurt Aemmer, North Sound BHO

Kurt Aemmer provided an overview of the 2017 Group Services Focused UR Report. It was noted that this review pertains to mental health (MH) services only. As a Region, documentation of Group Services surpassed the 90% compliance benchmark with an overall aggregate score of 92%. Further clinical staff supervision/training is indicated for the two BHAs whose aggregate scores were less than 90%, and the one other BHA, who in spite of earning an overall compliance rate of more than 90%, scored 90% or higher on only three of five standards. The North Sound BHO will be folding portions of the group services review into the Routine UR Tool for 2018.

2017 Wraparound with Intensive Services (WISe) Chart Review Report

Irene Richards, North Sound BHO

The 2017 Wraparound with Intensive Services (WISe) chart review was conducted by the North Sound BHO Children's Quality team and stretched over the time frame of October 2017 – November 2017. The North Sound BHA WISe providers reviewed were Compass Health and Catholic Community Services (CCS). Overall, the review yielded positive results. Recommendations for 2018 include formalizing a coaching model to prevent drift and offer supplemental training to WISe provider staff.

Open Access MTM Presentation of Results

Alexandra Urban, North Sound BHO

Alexandra Urban provided an overview of MTM's power point of the results of the 'Access Redesign Initiative' with the following providers: Catholic Community Services NW, Evergreen Recovery, Lake Whatcom Center, Sea Mar, Sunrise, and Unity Care. Highlights include: three organizations succeeded in reducing staff time by more than 25%; client wait time was reduced by an average of 45%; project-wide, the average cost reduction was 18% per intake; 100% collaborative documentation; and an average savings per center after implementation= $81,537.87.

Developmental Disabilities Administration (DDA) Assessments

Jessie Ellis, North Sound BHO

Changes to the Development Disabilities Administration (DDA) waiver programs mean that individuals must receive a denial for services from both their BHO and managed care organization (MCO) before receiving approval or re-approval for waiver program services. Providers may see an increase in the numbers of folks seeking assessments to get this denial, or seeking services to replace lost waiver services. In many cases, these individuals will not have a covered diagnosis and will receive a denial. In some cases, they may qualify based on a covered diagnosis – but the services available through our system do not meet the need that would be addressed by the waiver services. If the latter situation comes to the attention of providers, please notify the BHO, who is working with DDA to trouble shoot how we can best support individuals to receive appropriate services.

Services for Individuals who have moved to our Region

Jessie Ellis, North Sound BHO

Jessie reminded BHAs that we are contractually obligated to provide intake assessments to anyone who has a BHO or Fully Integrated Managed Care (FIMC) benefit in Provider One, regardless of whether their benefit reflects the North Sound region. Before providing ongoing services, please confirm that the individual has changed their address in Provider One. If someone shows up and has not yet changed their address, providers could consider assisting them to do so, and then carrying out the scheduled appointment. Jessie Ellis noted that the North Sound BHO will be updating Policy 3045 – Eligibility Verification to reflect these guidelines.

Advisory Board Budget
December 2017

	Total	All Conferences	Board Development	Advisory Board Expenses	Stakeholder Transportation	Legislative Session
		Project # 1	Project # 2	Project # 3	Project # 4	Project # 5
Budget	$ 42,000.00	$ 15,000.00	$ 3,545.00	$ 22,765.00	$ 255.00	$ 435.00
Expense	(31,588.67)	(8,335.67)	(3,507.36)	(19,310.82)		(434.82)
Under / (Over) Budget	$ 10,411.33	$ 6,664.33	$ 37.64	$ 3,454.18	$ 255.00	$ 0.18
		BHC , NAMI, COD, OTHER	BOARDS SUMMIT (RETREAT)	Costs for Board Members (meals mileage, misc.)	Non- Advisory Board Members, to attend meetings and special events	Shuttle, meals, hotel, travel

North Sound
Behavioral Health Organization, LLC.
Warrants Paid
December 2017

	Type	Date	Name	Memo	Amount
Advisory Board					
Supplies	Bill	12/18/2017	Hobby Lobby	Batch # 121620	206.30
	Bill	12/27/2017	Mister T Trophies	Batch # 121751	238.70
Total · Supplies					**445.00**
Travel	Bill	12/04/2017	AA Dispatch	Batch # 121423	393.50
	Bill	12/12/2017	Hetherwick-Goza, Carolyn	Batch # 121541	193.88
	Bill	12/12/2017	Betty Rogers	Batch # 121541	172.18
Total · Travel					**759.56**
Miscellaneous	Bill	12/12/2017	Haggen Inc	Batch # 121541	539.26
Total · Miscellaneous					**539.26**
TOTAL· Advisory Board					**1,743.82**

North Sound BHO Executive Directors Report

For the North Sound BHO Advisory Board

January 2, 2018

Integration Planning

- On December 21, we forwarded to Health Care Authority (HCA) the proposed set of North Sound addendum questions for the February,2018 Integrated Care Request For Proposal (RFP) which HCA will be releasing. The questions incorporated the priority areas identified in the stakeholder survey
- By the end of January, we'll need to identify the county representatives for the RFP review panels.
- We are continuing to negotiate with HCA regarding the terms and conditions of our agreement to become a mid-adopter.
- I've met individually with each of the MCOs to explore more candidly what each may be willing to contract back with the future Behavioral Health – Administrative Services Organization (BH-ASO) for Services and/or Administrative Functions.
- One of the key issues for MCO's to consider when "delegating" functions to another entity is whether that entity meets "NCQA" (National Committee for Quality Assurance) standards and can be certified as such. We're exploring how we could become certified, it looks like we already meet most of these standards.
- We're developing more detailed cost estimates of the funding necessary to carry out both the core Administrative Services Organization (ASO) role as well as to provide enhanced crisis services, and other functions such as care coordination, allied system coordination, and capacity building.
- The 6th meeting of the Interlocal Leadership Structure is scheduled for January 12th. We'll continue to discuss with the MCOs and the Counties the role for the BH-ASO in 2019 and beyond.
- Field trips are still being scheduled for the MCOs to each of the 5 counties to take place during January.

HCA Response to North Sound Mid-Adopter Conditions - Updated

Condition	HCA Response
1. Policy Allowing for Interlocal Leadership Structure	Agreed – stipulated in Governor's Directive 17-11
2. Appropriate Level of Budget appropriation to support BH-ASO role	Agreed in principle to seek necessary level of funding to maintain the existing continuum of care of crisis services We'll need to negotiate what the appropriate funding level is. Also agreed to allow us to retain a portion of un-spent state dollars.

3. Allowing MCOs to contract back with BH-ASO for certain Medicaid Behavioral Health Services, especially during the transition year	Agreed in principle. Will need to negotiate details based on our proposed role for the BH-ASO. HCA provided specific guidance in November 7 memo: "Mid-Adopter Transition Year Options"
4. Allowing for county input into the RFP Addendum	Agreed. BHO and counties will prepare specific questions for an Addendum RFP. See attached November 3 HCA memo on proposed number of MCOs for each region.
5. Stipulation for withdrawal of mid-adopter agreement if majority of counties feel the above conditions have not been met	Agreed but only before May 15

Opioid Summit Follow UP

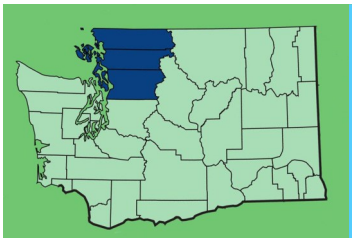
- The two-page summary of the results of the October 25 North Sound Opioid Summit have been distributed to all Summit participants and other stakeholders. This was included in the December County Authorities Executive Committee (CAEC) meeting packet.
- The list of key policy recommendations from the Summit has been forward to all area legislators [attached].
- BHO staff continue to work with County Coordinators and the North Sound ACH to develop and implement a "Post-Summit Workplan" laying out a prioritized list of "next steps" (See attached draft plan).

Behavioral Health Facilities Update

- Work continues on conducting the necessary environmental assessments of the Oak Harbor property which Island County is purchasing for siting the Tri-County Triage Center.
- The City of Oak Harbor has determined that the proposed facility would qualify for a "conditional use" permit under the category of "skilled nursing facility". Cumming will work with BCRA, the architectural firm, on submitting the conditional use permit application.
- The Port of Skagit has agreed to extend the lease for the North Sound E&T by 3-5 years which will give us additional time to secure legislative funding, acquire a site, and build the replacement facility.
- The Port of Skagit and Snohomish and Everett lobbyists are continuing to advocate with the Governor's Office and key legislators to ensure that the money in the proposed 2017 Capitol Budget for the North Sound facilities is secure.
- No additional progress has been made on identifying a suitable parcel in Skagit County for a future Stabilization Campus.

Number of Non-Medicaid Persons currently being served by BHO Services

- Tab 6 is an analysis of the current number of non-Medicaid persons receiving BHO funded services. This gives some sense of the number of persons that might be at risk of losing services depending on the level of non-Medicaid funding that will be allocated for the BH-ASOs.



2017 NORTH SOUND OPIOID SUMMIT

POLICY IMPLICATIONS

Use federal and state dollars to expand capacity to fully address the need:

1. **Increase Medicaid rates for Medication Assisted Treatment (MAT) prescribers** – Current reimbursement rates for physicians and others (e.g. Nurse Practitioners and Physician's Assistants) deter potential buprenorphine prescribers. Persons struggling with Opioid Use Disorder (OUD) can be challenging to work with, especially in the early stages of Medication Assisted Treatment (MAT) while the patient's situation is stabilizing. The lack of available prescribers limits the system's ability to meet the need, but deficient rates create disincentives for prescribers to engage with this population.
2. **Allow the services of Nurse Care Managers (NCMs) to become a Medicaid reimbursable expense** – NCMs expand the health care response to the Opioid Epidemic by expanding the reach of prescribing professionals and linking patients to other services such as counseling.
3. **Invest state funds to expand the network of Care Coordinators, such as Peer Counselors and Community Health Workers** – A dedicated pool of Care Coordinators funded by Managed Care Organizations and federal programs such as the Department of Social and Health Services (DSHS) State Targeted Response (STR) grant (e.g. Spoke Care Navigators) already exists, but it is inadequate given the volume of OUD-affected persons needing help. Accessing treatment is difficult since there are not enough MAT prescribers or available slots in traditional treatment programs. Expanding the Care Coordinator system will help bridge system gaps and connect people with treatment, supportive services and the coaching they need to be successful in their recovery.
4. **Create Housing opportunities for Persons who are receiving MAT through public-private partnerships and capital investments** – Oxford Houses and other Sober living houses are effective for persons with Substance Use Disorder, but typically do not allow persons with Opioid Use Disorder who are receiving Medication Assisted Treatment. The stigma against MAT in the recovery community persists in many settings. A proactive strategy must be implemented to ensure individuals with OUD have the stable housing they need to increase their chances for recovery.
5. **Require Drug Courts receiving state dollars (e.g. Criminal Justice Treatment Account) to allow Medication Assisted Treatment (MAT) for Opioid Use Disorder (OUD)** – In 2015, the National Drug Czar, Michael Botticelli, confirmed MAT as the standard of care for OUD by defunding Drug Courts unwilling to allow medication as a treatment option for their clients. Washington State should follow suit by similarly restricting state funding for Drug Courts.
6. **Require drug manufacturers to fund and operate a drug "take-back" program that offers a safe and secure method for collection and disposal of all medicines, including Schedule 1 drugs** – Current proposed legislation such as HB 1047 has great potential in holding drug manufacturers accountable for the safe disposal of medication. However, 1047 excludes Schedule 1 drugs which are the genesis of the opioid epidemic. Families and communities must have convenient everyday options for their responsible management of unused medications, especially opioids and other drugs vulnerable to misuse.
7. **Support public and professional education to reduce the stigma related to both Opioid Use Disorder (OUD) and the use of Medication Assisted Treatment to address it –** Shame and misunderstanding can cause individuals struggling with opioid use, and their loved ones, to avoid the issue, causing delays in seeking life-saving treatment. Unfortunately, a core of professionals also remains in the OUD treatment system that resists accepting MAT as the Standard of Care in the treatment of OUD. This stigma should be addressed with education to change community and cultural norms that reinforce it. The State Legislature should also lead this effort by removing statements from the Revised Code of Washington that contribute to the stigma, such as "The state of Washington declares that there is no fundamental right to Medication Assisted Treatment for Opioid Use Disorder" (RCW 71.24.585) which contradicts medical Best Practices.

POST-SUMMIT WORKPLAN for 2018

OVERVIEW:

- **Collaborate with County, Tribal, Health Care and other Key Partners to coordinate efforts and delegate strategically.**
- **Hold Quarterly Regional Forums to bring Summit participants and other stakeholders together to develop coordinated strategies based on Summit Recommendations.**
- **Use existing resources strategically when possible to maximize impacts (e.g. local wisdom, trainers, Relias, existing fund sources when possible).**
- **Access new funding streams, especially for capital/one-time investments.**

Category	Summit Recommendation	Corresponding ORP Activity	Next Steps
"Upstream"	**Work closely with schools, youth-serving organizations and other key partners to expand evidence-based prevention, outreach/early intervention and treatment programs for youth.**	1.3.1 - Strengthen and coordinate efforts to leverage supportive services for youth by facilitating collaborations between local stakeholders, including coalitions, schools, ESD 189, child welfare/foster care, juvenile justice and health care. Consider expanding screening practices into existing youth access points to prevent identify OUD.	Convene a Regional Youth Services Forum bringing a wide range of local stakeholders together to consider the full continuum of services available to support youth, identify key gaps, make recommendations for partnering to create solutions and implement new programming.
		2.6.8 - Expand youth intervention, Tx and recovery support capacity in the community, including outreach and/or case management in schools, youth shelters, juvenile court and other venues where youth are found.	
		1.3.2 – Collaborate with the North Sound ACH to conduct a regional assessment and gaps analysis of evidence-based primary prevention services in elementary and middle schools as a first step toward strategically filling the gaps.	
		1.3.3 - Facilitate regional coordination between the BHO, county human services, public health, local schools and other partners to implement services to fill identified primary prevention gaps.	(2018 Regional Prevention Summit later that focuses entirely on Prevention in the region in October?)

	Increase efforts to support parents and families in preventing childhood trauma and accessing services when needed, such as parent education and family-focused care coordination.	1.3.4 - Create intergenerational services for the family members and significant partners of OUD-affected individuals to promote healing and wellness. Start by convening a regional workgroup consisting of key stakeholders with expertise in family programming to develop a workplan.	Convene a Regional Intergen-erational Services Forum bringing a wide range of local stakeholders together to consider a new para-digm for services that address the intergenerational nature of SUD and create solutions to prevent and mitigate ACEs.
	Support community drug "take back" programs and other efforts to keep medications secure.	1.4.1 - Support local efforts to promote safe storage disposal options.	Support regional strategies to disseminate information and resources.
Connections	**Expand Syringe Exchange Programs, and support the growth of connected services such as Outreach, ongoing Care Coordination, Primary Health and Dental Care.**	2.4.1 - Support efforts to establish or enhance care coordination services as part of syringe exchange program services.	Work with the current regional SEP programs to identify what supports regional partners outside their system might provide to expand their efforts. (Regional meeting to start? Public Health lead?)
		2.4.2 - Support efforts to provide services onsite at SEPs, such as treatment outreach, Buprenorphine prescribing, primary care nurses and housing case management.	
	Increase funding to expand access to naloxone for people at risk, such as those leaving jails or detox.	3.2.1 - Partner with Counties, UW, Tribes, housing providers, hospitals, emergency services, syringe exchange programs and other stakeholders to expand the availability and use of naloxone, especially for high risk populations.	Explore regional strategies to increase naloxone availability and identify funding streams to support strategic expansion for high risk individuals.
Treatment	**Provide financial incentives for primary care physicians and other providers to prescribe Buprenorphine.**	2.2.1 - Partner with the ACH and other stakeholders to expand medication-assisted treatment capacity, including offering trainings for "mid-level" health professionals to prescribe Buprenorphine.	Identify fund sources for financial incentives and work with health care partners to develop strategies.
		2.2.6 - Partner with health care community to find resources to	

		subsidize the costs for becoming certified to prescribe Buprenorphine.	
	Address local community concerns related to the siting of MAT clinics.	2.2.3 - Partner with Counties and other stakeholders to expand other treatment capacity, including Opioid Treatment Programs, withdrawal management, residential options and other services, and create system incentives for the colocation of services in centralized locations.	Work with County and Tribal partners to address and support the development of collocated services in centralized locations for easier client/family access.
		2.2.5 - Enhance service system infrastructure to increase prescriber capacity, including the establishment of local "hub and spoke" models.	Continue to support H&S program and identify funds to support SCN expansion to new sites.
	Use mobile vans to increase access to MAT especially in rural areas.	2.2.4 - Create access to MAT and other services by supporting Tx, outreach and case management in a variety of community locations, such as mobile vans.	Research regulatory and program details, and Identify fund sources (local foundations?) for initial investment (vehicle and supplies); create North Sound BHO RFQ for mobile van services.
	Provide MAT to persons who are incarcerated or being released from Jail. Encourage and support Jails in replicating effective pilots such as those in Snohomish Co.	2.3.1 - Support local efforts to provide medication-assisted treatment to individuals impacted by OUD while incarcerated or being released from jail.	Work with County leaders to develop and implement strategies to replicate programs.
		2.3.2 - Facilitate the development of comprehensive transitional services for Department of Corrections parolees and other individuals with OUD being released from jail.	
Recovery Supports (during and post-Tx)	**Actively create Housing opportunities for Persons who are receiving MAT.**	2.6.2 – Participate in collaborative efforts to expand housing for individuals with OUD in all stages of their recovery, including interim, transitional, sober support, per-manent supported recovery housing.	Convene a Regional Recovery Housing Forum to bring a wide range of local stakeholders together to design new innovative models of recovery housing (during and post-Tx). Continue to advocate.
	Expand Recovery Supports, such as Housing, Child Care,	2.6.11 - Expand transportation services for people going into	Convene subsequent Regional ROSC Forum(s) to develop new strategies

	Transportation, Employment, Education, and ongoing Recovery Coaching.	treatment (and working to become stable in their recovery).	that better connect existing services and design new innovative services that take recovery supports to the people who need them.
		2.6.12 - Facilitate conversations between regional stakeholders and supported employment resources to explore the feasibility of offering vocational services and life skills training on-site at treatment facilities and other strategic venues.	
System Improvement	**Expand the Workforce of CDPs, Peer Counselors and Recovery Coaches through tuition subsidies and other supports.**	2.6.3 - Collaborate with stakeholders to develop a more robust workforce of Chemical Dependency Professionals (CDPs), including cross-training for Mental Health Professionals and CDPs to become dually licensed, and promoting educational supports such as tuition waivers and distance learning options.	Convene a Regional Workforce Forum bringing a wide range of local stakeholders together to consider innovative solutions to develop tuition subsidies, college credit for experience, distance learning options and new programs to make MH education requirements and licensure accessible for CDPs.
		2.6.4 - Expand system workforce by including recovery coaches, BH aides, peer counselors and other paraprofessionals, and advocate for their certification to help mitigate workforce shortages.	As part of the Workforce Forum, explore training needs/solutions and funding opportunities for paraprofessionals to expand the OUD workforce.
		2.6.5 – Support efforts to expand access to clinical supervision for CDP trainees to obtain their full CDP credential without delays.	As part of the Workforce Forum, identify new and innovative solutions to address the clinical supervision shortage.
	Continue to address the Stigma around both Opioid Use Disorder and the use of Medication Assisted Treatment to address it.	2.6.6 - Develop and implement strategies to raise awareness of MAT as an essential tool in OUD treatment, including trainings and working with stakeholders from local colleges to integrate this information in their CDP curricula.	Develop and implement a Stigma Reduction Plan that targets specific sectors, starting with the Tx Community and Primary Care Clinics.

		2.6.15 - Offer training opportunities for stakeholders to expand the knowledge base, increase capacity and implement system enhancements.	Incorporate targeted trainings to help reduce Stigma among professionals and other stakeholders (e.g. NA, Oxford Houses, etc.).
	Transition the Treatment paradigm to support Effective Strategies.	2.2.2 - Support the development of treatment on demand for all OUD services and promote a strengths-based culture throughout the system	Continue to expand Open Access for Tx services, and identify strategies to transition Tx culture (e.g. harm reduction, client decision-making, etc.)
		2.6.9 - Work with Counties and treatment providers to expand clinical outpatient Evidence-Based Program options for treating OUD, including EMDR and DBT.	Start building capacity to implement EBPs for treating trauma via COD pilot programs that provide EMDR and DBT services for individuals experiencing OUD.
	Actively partner to fill gaps and "scale up" effective local programs, like MAT in Jails and Behavioral Health Professionals embedded with Law Enforcement.	2.6.10 - Foster regional coordination and cross-county collaborations by establishing a funding mechanism to support such efforts.	Identify funding sources to expand programs, and work with ACH, Tribes, Counties and Public Health to expand programs and create new opportunities that build on existing resources (e.g. cross-county collaborations).
		2.6.15 - Offer training opportunities for stakeholders to expand the knowledge base and implement system enhancements.	Use existing resources (e.g. Relias, etc.) and other opportunities to support trainings for expanding effective models when indicated.
Data	**Support local efforts to address the Opioid crisis as a Public Health problem, including comprehensive strategies to conduct community "Surveillance" on Overdoses and Mortality. . .**	4.3.1 - Partner with local Health Officers and other key stakeholders to create regional capacity to collectively monitor data related to OUD, such as encouraging EMS and law enforcement to provide overdose data to public health.	Work with the ACH and Public Health partners (especially ACH and PH Regional Epidemiologists) to identify key data questions and develop strategies to improve surveillance and outcome-based program evaluations.
		4.3.2 - Discover and utilize multiple data sources to investigate the scope of the opioid epidemic as it manifests in the youth population.	

		4.3.3 - Explore and implement other strategies for regional surveillance of opioid use and related morbidity and mortality.	
	. . . as well as documenting the effectiveness of Treatment and Prevention efforts.	4.4.1 - Utilize BHO (and other) data resources to track the impacts of regional efforts, considering the feasibility of a common data set of 5-10 key indicators.	

Note: For this document "Forum" denotes a meeting of local stakeholders and subject area specialists designed for strategic collaboration and planning for coordination of efforts. "Summit" would follow the goals, tone and perhaps format of our Regional Opioid Summit.

POSSIBLE REGIONAL FORUM 2018 CALENDAR:

Regional Youth Services Forum	**March 2018**
Regional Recovery Housing Forum	**June 2018**
Regional Workforce Forum	**September 2018**
Regional Intergenerational Services Forum	**January 2019**
Regional ROSC Services Forum	**April 2019**

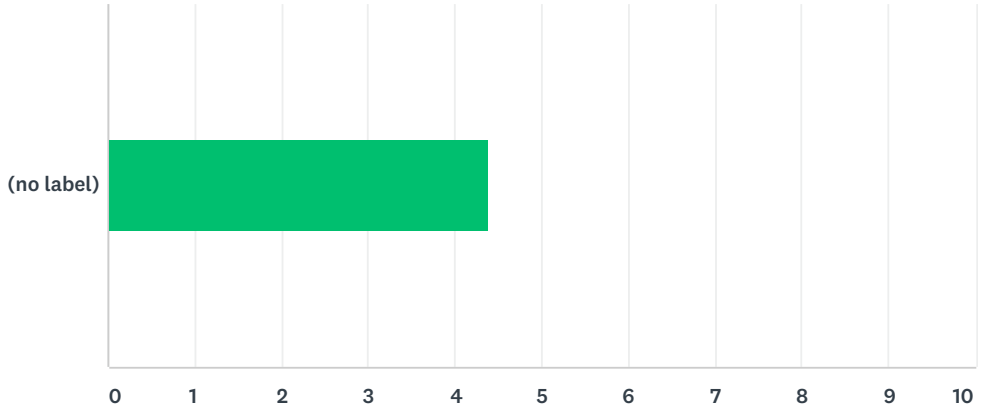
North Sound
Behavioral Health Organization, LLC

▪ Stakeholder Survey Summary ▪

Survey Question #	Topic Area	Weighted Average
5	Coordinating care for individuals involved with multiple agencies and addressing the unique needs of special population groups, such as individuals who are homeless, involved with criminal justice, utilizing high cost services, etc.	4.58
3	Making investments in network capacity such as service expansion, and building behavioral health facilities	4.56
1	Addressing the specific needs of rural and frontier areas in the North Sound Region	4.4
4	Addressing the opioid crisis by providing adequate funding for medication assisted treatment and coordinating with existing county efforts	4.38
2	Collaborate and coordinate with the five (5) Counties and demonstrate the willingness to continue to fund and support allied systems	4.34
16	Standardizing policies and administrative requirements between Managed Care Organizations (MCO)	4.31
7	Ongoing coordination and consultation with the Behavioral Health Administrative Service Organization (BH ASO), currently the BHO, to address regional needs and setting regional priorities	4.27
10	Investments in workforce development, such as tuition subsidies, to increase the number of Chemical Dependency Professionals	4.15
14	Willingness to fund innovative projects/programs that demonstrate outcomes	4.15
11	Investments in training and consultation on Evidence Based Practices	4.08
15	Invest in programs that improve service delivery, such as mobile outreach teams, telepsychiatry, etc.	4.08
9	Willingness to collaborate with partners on pooling de-identified service data and to exchange data for care coordination with other Managed Care Organization (MCO) and the Behavioral Health Administrative Services Organization (BH ASO)	4.05
13	Contracting with smaller specialized/niche providers in the region serving older adults, children and underserved populations	3.98
8	Coordinating with local Tribes to provide services to American Indian/Alaskan Native population who are not served in the fee for service programs	3.87
6	Investing in and encouraging the use of Peer Support and demonstrating recovery oriented systems of care	3.85
12	Identification and description of the Clinical Integration Model to be implemented, specifically in geographically challenged areas	3.82

Q1 Addressing the specific needs of rural and frontier areas in the North Sound Region

Answered: 62 Skipped: 0



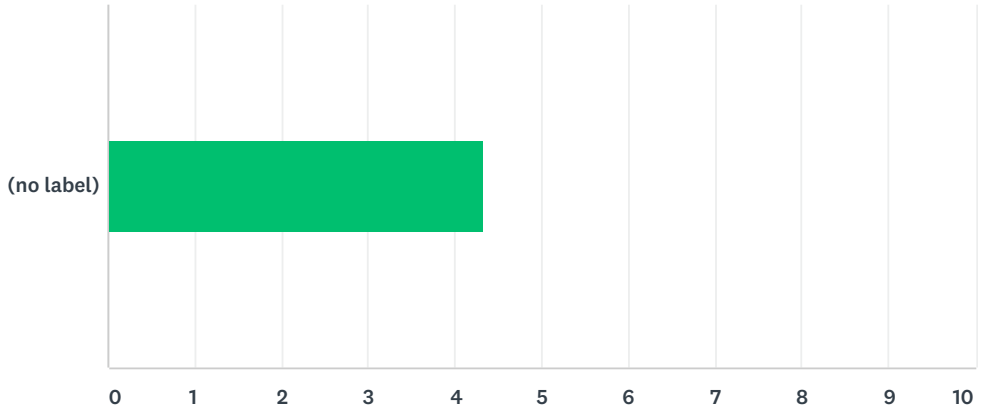
	NOT IMPORTANT	SOMEWHAT IMPORTANT	NEUTRAL	IMPORTANT	VERY IMPORTANT	TOTAL	WEIGHTED AVERAGE
(no label)	0.00% 0	4.84% 3	1.61% 1	41.94% 26	51.61% 32	62	4.40

#	COMMENT/FORMULATE A SPECIFIC QUESTION FOR THIS TOPIC AREA.	DATE
1	access to services and scope of service availbility is significantly different in rual areas - issue is under rated in decision making when addressing gaps	12/10/2017 6:12 PM
2	Since Medicaid does not fund non-direct services, what facilities and funding are available to keep people with serious mental illnesses or substance use disorders in their own communities (rural, urban, suburban) when they have been involuntarily (or voluntarily) hospitalized for treatment? And what funding is there to facilitate transitions back into the community if they cannot be treated there?	12/8/2017 7:42 AM
3	Traditional insurance contracting models will not work in our rural and frontier service areas.	12/4/2017 4:21 PM
4	How can we ensure those areas obtain necessary services?	12/4/2017 9:48 AM
5	How do you propose to pay for capacity to ensure services are availible when needed?	11/30/2017 11:09 AM
6	We have seen strong trend lines for increased need	11/29/2017 6:31 PM
7	Would MCO's have higher outreach rates?	11/29/2017 3:53 PM
8	How will rural clients access services?	11/29/2017 11:51 AM
9	currently high cost and low access	11/29/2017 11:28 AM
10	Will there be any incentives for providers to serve these outlying populations?	11/29/2017 11:17 AM
11	How do you define "network adequacy" for a rural region?	11/29/2017 8:06 AM
12	How will the rural population access services-satellite offices or pay for transportation?	11/28/2017 5:03 PM
13	affordable non biased housing	11/28/2017 3:28 PM
14	While the population base does not lend well to turning a profit, how will you ensure quality services when client numbers + needs hinder profit?	11/28/2017 3:13 PM
15	How to work with marginalized communites that are also geographically remote.	11/28/2017 2:26 PM
16	How will you plan to serve more rural locations?	11/28/2017 2:19 PM
17	Access to care in a primary care office is critical.	11/28/2017 2:05 PM

18	How will you ensure services are located in easily accessible locations and/or clients have access to transportation?	11/28/2017 1:56 PM

Q2 Collaborate and coordinate with the five (5) Counties and demonstrate the willingness to continue to fund and support allied systems

Answered: 62 Skipped: 0



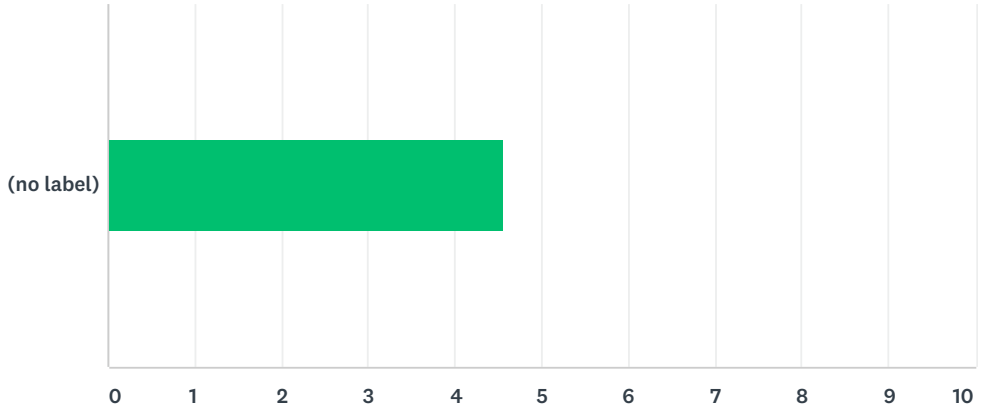
	NOT IMPORTANT	SOMEWHAT IMPORTANT	NEUTRAL	IMPORTANT	VERY IMPORTANT	TOTAL	WEIGHTED AVERAGE
(no label)	0.00% 0	8.06% 5	8.06% 5	25.81% 16	58.06% 36	62	4.34

#	COMMENT/FORMULATE A SPECIFIC QUESTION FOR THIS TOPIC AREA.	DATE
1	Collaboration allows for consitiency; efficent use of resources; fostering adoption of best practice	12/10/2017 6:12 PM
2	People with serious mental illnesses and/or substance use disorders are sometimes highly mobile (crossing county boundaries) and periodically pre-crisis stabilization or (worse-case) crisis-related interventions. The systems in place to provide critical care are not funded by Medicaid. How will the State fund crisis services, and through what organizations?	12/8/2017 7:42 AM
3	Integrated care demands regular coordinating meetings. In addition constant funding is needed.	12/7/2017 8:25 PM
4	Collaboration and coordination across counties is important. We should also be maximizing the amount of funds that go to direct service.	12/4/2017 4:21 PM
5	Could the MCO's invest in a Community Welnnes Fund that could be used to support many non Mediciad services like transportation, childcare, legal services and social services that are essential to archiving long term recovery?	12/4/2017 7:41 AM
6	What is your plan to identify specific region and community needs and priorities?	11/30/2017 5:51 PM
7	What types of services do you see yourself contracting back to Counties to provide? Are you anticipating one-on-one contracts or a large contract with the ASO's that can be sub-contracted out to counties? Explain your view of collaboration and coordination in this scenerio.	11/30/2017 11:09 AM
8	Collaboration is a priority to bend tbecostcueve	11/29/2017 6:31 PM
9	Assuming willingness to individualize county needs and not allocate all resources to only designated areas as has been the case	11/29/2017 11:28 AM
10	How do you intend to meet the unique needs of these 5 counties?	11/28/2017 3:09 PM
11	"Please give some examples of activities and services you are aware of in our region that exemplify allied system coordination - specifically, activities provided by counties on behalf of the BHO - and discuss your intention to or not to contnue supporting and funding those services. Please indicate why you intend to support or not support those continued activites and services."	11/28/2017 2:35 PM

12	What kind of systesm would they bring forth that would be flexible across the 5 counties that are set up differently from each other (the NS counties are each quite unique)? In other words, how would they flex their care availability depending on the sytems set-up of a specific county?	11/28/2017 2:26 PM
13	How will you collaborate and coordinate services through our five county areas?	11/28/2017 2:19 PM
14	Our geographical area often prohibits full 5 county collaboration for services.	11/28/2017 2:05 PM

Q3 Making investments in network capacity such as service expansion, and building behavioral health facilities

Answered: 61 Skipped: 1



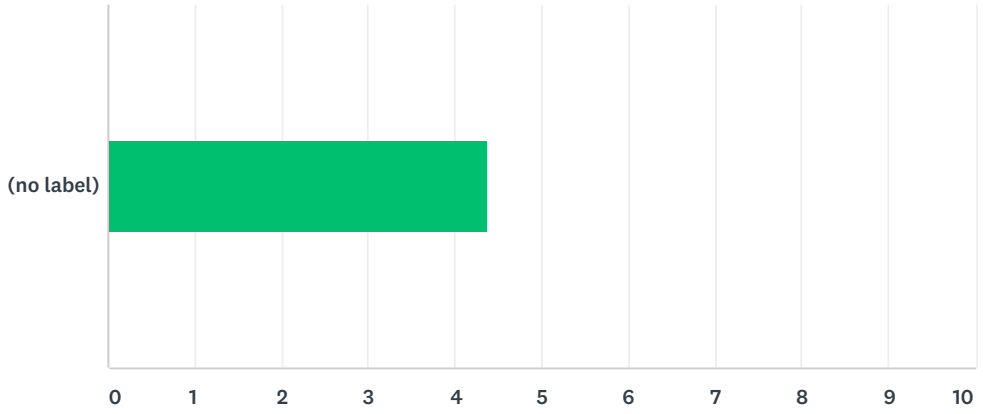
	NOT IMPORTANT	SOMEWHAT IMPORTANT	NEUTRAL	IMPORTANT	VERY IMPORTANT	TOTAL	WEIGHTED AVERAGE
(no label)	0.00% 0	0.00% 0	8.20% 5	27.87% 17	63.93% 39	61	4.56

#	COMMENT/FORMULATE A SPECIFIC QUESTION FOR THIS TOPIC AREA.	DATE
1	Regional approach has greatly expanded scope of services and has enhanced addressing residential service needs that are grosely underserved as well as crisis outreach	12/10/2017 6:12 PM
2	What capital and operational funding has been set aside by the State to build (in the LOCAL communities) highly needed E&T's, Crisis Triage facilities, post-institutional living spaces, housing for the homeless (especially Housing First programs), etc.? In addition, what funding has been allocated for hiring and training staff?	12/8/2017 7:42 AM
3	Behavioral health needs to catch all emergencies by being constantly open and staffed.	12/7/2017 8:25 PM
4	How will MCOs ensure stable funding to Triage and Detox facilities?	12/7/2017 8:54 AM
5	Maximize funding that reaches clients directly.	12/4/2017 4:21 PM
6	What percentage of patients with SUD do you expect to send to residential treatment under ASAM and what is your planned capacity to address that need?	11/30/2017 5:51 PM
7	This is one of the most important questions., both on the behavioral health and physical health side of the equation. How will you make the inecessary investments in service expansion? What will you do if those investments are not being made by existing agencies/providers?	11/30/2017 11:09 AM
8	Access tobehavioral health facilities in our region is a major barrier to improving the overall heath of the populations we serve. Delays in transfers creates bottlenecks and impacts ou ability to serve acute medical care patients in optimal timeframes	11/29/2017 6:31 PM
9	Beyond buildings, things like telemedicine, training and consultation.	11/29/2017 3:53 PM
10	Sevice expansion is more important than building brick and mortar facilities; transportation critical	11/29/2017 11:28 AM
11	Geriatric Mental Health - Dementia facilities	11/29/2017 8:30 AM
12	Critical	11/28/2017 6:10 PM
13	There are no beds for anyone under 18 in Snohomish County. And parents are BEGGING for out-patient facilities that can provide quality, adequate, and accessible care.	11/28/2017 3:09 PM
14	Please indicate your knowledge of current capital projects in our region specific to behavioral health care, and your plan to support or not support the development of those projects.	11/28/2017 2:35 PM

15	Sharp increases in mental health issues with very few resources here - how do they address this?	11/28/2017 2:26 PM
16	Again since our county is isolated and remote, we benefit from a BH facility that serves our patients, that is why our integrated BH program in our primary care office for our patients is best. San Juan County could use a housing and work facility for BH patients to live in while they recover and plan for their future.	11/28/2017 2:05 PM

Q4 Addressing the opioid crisis by providing adequate funding for medication assisted treatment and coordinating with existing county efforts

Answered: 60 Skipped: 2

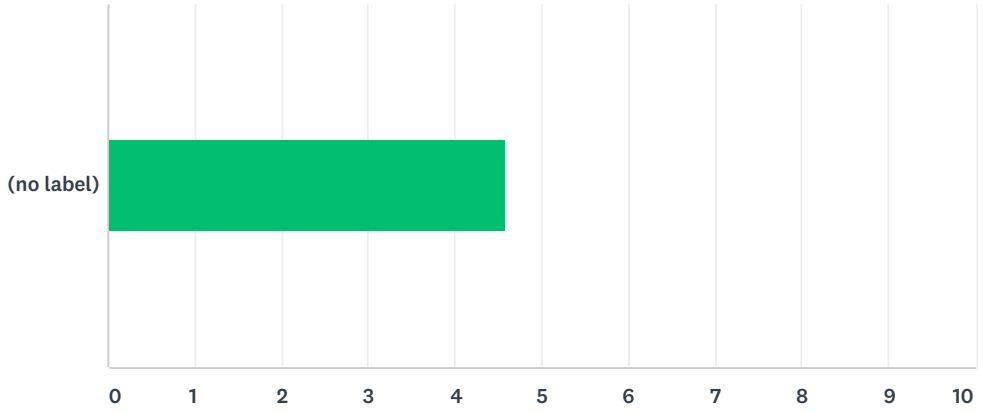


	NOT IMPORTANT	SOMEWHAT IMPORTANT	NEUTRAL	IMPORTANT	VERY IMPORTANT	TOTAL	WEIGHTED AVERAGE
(no label)	0.00% 0	1.67% 1	5.00% 3	46.67% 28	46.67% 28	60	4.38

#	COMMENT/FORMULATE A SPECIFIC QUESTION FOR THIS TOPIC AREA.	DATE
1	We are consistent with national issue playing out in all communities. Detox is not treatment just a first step - we need continum and extensive expansion of services to effective intervene with issue	12/10/2017 6:12 PM
2	Where will the funding come from to train MAT physicians? And nurse practitioners? And PAs? And behavioral health professionals?	12/8/2017 7:42 AM
3	What efforts will your health plan put forth to assure adequate access to MAT?	11/30/2017 5:51 PM
4	I am more intersted in understanding the committment to paying and ensuring a delivering system is in plays for MAT, less so aobut coordinating with existing county efforts. The big issues is will they support treatment and how?	11/30/2017 11:09 AM
5	yes	11/29/2017 6:31 PM
6	not as much demand here than in the more urban counties but increasing access remains important	11/29/2017 11:28 AM
7	I do not feel that coordinating with County efforts has been effective in Whatcom. We need coordination with non-profits that can provide Community Services on this front.	11/28/2017 6:10 PM
8	Will the treatment be uniform through out the region?	11/28/2017 5:03 PM
9	We need MORE in-patient care facilities for YOUTH as well as adults. Also, out-patient accessible care is more than overdue.	11/28/2017 3:09 PM
10	Describe your role in addressing the opioid crisis in our region.	11/28/2017 2:35 PM
11	What are your plans to address our opioid crisis?	11/28/2017 2:19 PM

Q5 Coordinating care for individuals involved with multiple agencies and addressing the unique needs of special population groups, such as individuals who are homeless, involved with criminal justice, utilizing high cost services, etc.

Answered: 62 Skipped: 0



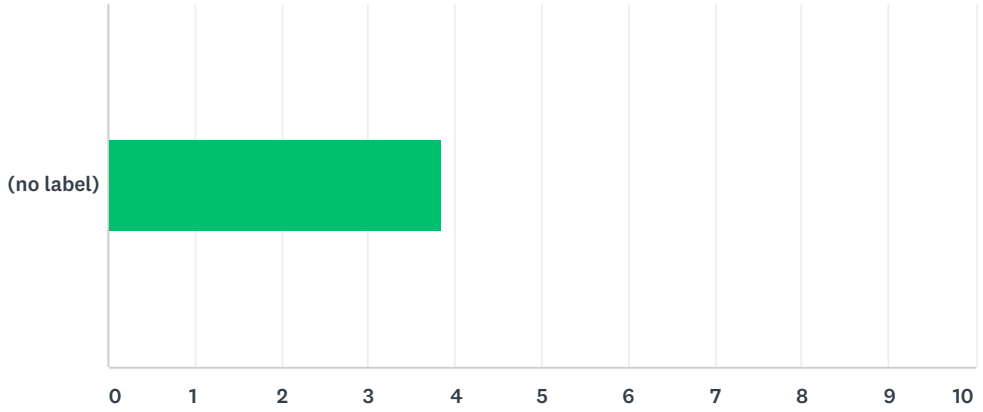
	NOT IMPORTANT	SOMEWHAT IMPORTANT	NEUTRAL	IMPORTANT	VERY IMPORTANT	TOTAL	WEIGHTED AVERAGE
(no label)	0.00% 0	1.61% 1	3.23% 2	30.65% 19	64.52% 40	62	4.58

#	COMMENT/FORMULATE A SPECIFIC QUESTION FOR THIS TOPIC AREA.	DATE
1	concern with multiple plans/carriers have not experience coordinating multiple providers/case management with the same effectiveness of BHO's. If the insurance groups care out the casemanagement, crisis outreach and other services will be one way to effectively blend oversight and service access management.	12/10/2017 6:12 PM
2	Focus on older adults. This is a population often lost in this discussion.	12/8/2017 10:34 AM
3	Which organization (a BHASO?) will coordinate crisis and high-need services and facilities, and where is the funding for these? And, when counting "special populations," are vulnerable senior adults included? And LGBTQ transition-age young adults?	12/8/2017 7:42 AM
4	Wraparound care and assistants for transitions are essential.	12/7/2017 8:25 PM
5	How will MCOs financially support outreach and engagement efforts that connect vulnerable and disenfranchised individuals to Medicaid benefits and services?	12/7/2017 8:54 AM
6	Multi-disciplinary approaches with braided funding and supports should be the focus.	12/4/2017 4:21 PM
7	I think this is the same as the question that asks how they plan to coordinate with counties. I am interested to know what they plans are, and what their committment is to supporting downstream investments that are helpful in stabelizing individuals and keeping them out of cisis.	11/30/2017 11:09 AM
8	MCOs need to demonstrate their understanding of these special pop needs.	11/29/2017 3:53 PM
9	How to keep people enrolled and eligible for benefits	11/29/2017 11:51 AM
10	through the pathways model when adopted through the ACH, not specifically managed by the BHO	11/29/2017 11:28 AM
11	We need a better shelter system in Skagit County	11/29/2017 8:30 AM
12	There are eight American Indian tribes in the North Sound region, what are you doing to understand Tribal needs?	11/29/2017 8:06 AM

13	All of this is important; however, I will again stress coordination with non-profits in Whatcom instead of soley coordinating with the County.	11/28/2017 6:10 PM
14	I would include "on the ground" coordination to this--not just call centers.	11/28/2017 4:23 PM
15	Many of our communities have strategies to support high utilizers and the systems they use. Please describe how you see your MCO interfacing with these multiple models. How do you anticipate addressing the needs of individuals who are considered high-utilizers of emergency rooms, emergency medical servivces, jails, law enforcement, and behavioral health facilities?	11/28/2017 2:35 PM
16	The last thing we need is another silo of care and assistance- any MCO would need to address how they are building bridges and info sharing, not carving things out.	11/28/2017 2:26 PM
17	What steps will you take to braid services of programs serving special populations?	11/28/2017 2:19 PM
18	Again housing and re-hab services in our county is best for our geographical location	11/28/2017 2:05 PM
19	How will you collaborate with other systems serving your clients?	11/28/2017 1:56 PM

Q6 Investing in and encouraging the use of Peer Support and demonstrating recovery oriented systems of care

Answered: 62 Skipped: 0



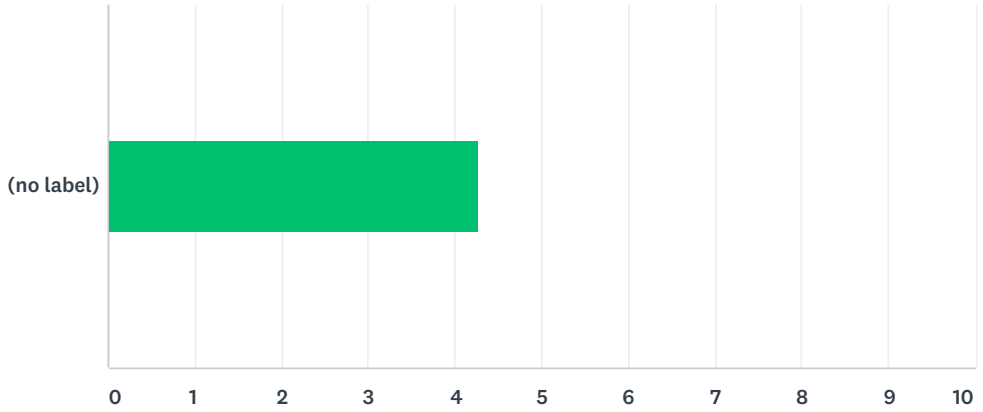
	NOT IMPORTANT	SOMEWHAT IMPORTANT	NEUTRAL	IMPORTANT	VERY IMPORTANT	TOTAL	WEIGHTED AVERAGE
(no label)	1.61% 1	3.23% 2	27.42% 17	43.55% 27	24.19% 15	62	3.85

#	COMMENT/FORMULATE A SPECIFIC QUESTION FOR THIS TOPIC AREA.	DATE
1	Looking at services that are primarly volunteer - the question is how do we instituaionalize successful programs so communities with little resources can capitalize on successful models. This is a community function that can address some of the service limitations. What is 'best practice' in communites where thsi is established and how can those models be duplicated in other communities.	12/10/2017 6:12 PM
2	Peer services and paraprofessional services are useful and imperative, especially in the integration process and using a Pathways model of service coordination. So, why aren't CHWs, CPCs, and Recovery Coaches being trained together or with similar curricula (with speciality training following fundamental training)? And why isn't the Health Department coordinating all of these trainings simultaneously so that the preparatory work is integrated and coordinated?	12/8/2017 7:42 AM
3	Peer support creates as much problems as it solves.	12/7/2017 8:25 PM
4	As long as it using evidenced based practices (ie Clubhouse Model)	12/5/2017 5:57 PM
5	Make sure there's a mechanism to adequately fund Certified Peer Counselors' services.	12/4/2017 4:21 PM
6	Acute care services are the backbone of care needed to stabilize a person but long term continuing care and recovery management are essential to achieve long term recovery. Will the MCO's be willing to pay for Recovery Management services until the client is integrated back into community (3-5) years)?	12/4/2017 7:41 AM
7	How will you utilize peer support in the SUD system where many of the counselors are also peers?	11/30/2017 5:51 PM
8	I am unsure about the peer support piece, I am only really adament about their plans and committments to recovery oriented care systems. How peers fit into that really is only important to me as it relates to higher recover outcomes.	11/30/2017 11:09 AM
9	Important for high needs Medicaid populations - do MCO's understand?	11/29/2017 3:53 PM
10	Are you willing to invest in developing mid-level providers (through the CHAP Program) to provide services to the American Indian/Alaska Native population?	11/29/2017 8:06 AM

11	We need more availability of Peer Support training on the Behavioral Health and Substance Use front, this training should focus on co-occuring disorders. We need a peer based Community Health worker initiative. We need those educational opportunities to be available and accessible for people that a representative of the disparate populations in our County (Whatcom).	11/28/2017 6:10 PM
12	Are there going to be funds for SUD Recovery Coaches like there is now for MH Peers?	11/28/2017 5:03 PM
13	how do we get funding through the county and state to fund Peer support in SUD?	11/28/2017 3:28 PM
14	Two unrelated questions make no sense.	11/28/2017 3:20 PM
15	Recovery is a no brainer.	11/28/2017 2:26 PM
16	Yes, we need this in our county. Travel outside our county won't work.	11/28/2017 2:05 PM
17	How will peer support and recovery focused services be integrated into services?	11/28/2017 1:56 PM

Q7 Ongoing coordination and consultation with the Behavioral Health Administrative Service Organization (BH ASO), currently the BHO, to address regional needs and setting regional priorities

Answered: 62 Skipped: 0



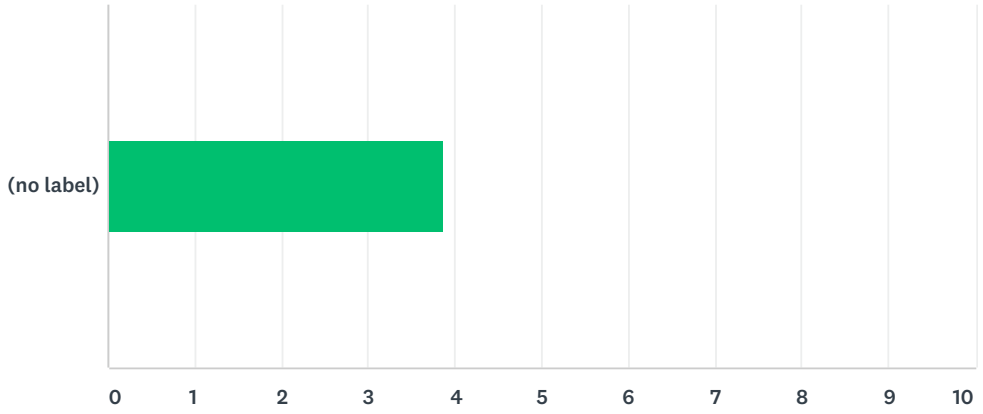
	NOT IMPORTANT	SOMEWHAT IMPORTANT	NEUTRAL	IMPORTANT	VERY IMPORTANT	TOTAL	WEIGHTED AVERAGE
(no label)	0.00% 0	4.84% 3	12.90% 8	32.26% 20	50.00% 31	62	4.27

#	COMMENT/FORMULATE A SPECIFIC QUESTION FOR THIS TOPIC AREA.	DATE
1	The BHO can and should address areas not addressed well by insurance plans ie: crisis teams; case management; regional specific needs. The questionn is how can we formulate contract oversight of providers through the BHO so providers only deal with one set of rules not multiples; BHO works with all programs to get paid to address services not under the plans like crisis teams;provider education etc.	12/10/2017 6:12 PM
2	Not all regions of WA state had highly effective BHOs, but among those that did (e.g., King, North Sound), breaking apart the functions of the BHO that are solely covered by Medicaid funds, and undermining the state funding for allied and ancillary services (e.g., crisis care), seems cavalier. How will the state ensure that adequate, and even increased, funding remains to support all non-Medicaid services that are critical to care access and coordination?	12/8/2017 7:42 AM
3	Needed to keep up with societal changes.	12/7/2017 8:25 PM
4	How will MCOs functionally operate the coordination efforts with BHOs with the intent to be proactive in strategic planning, especially focusing on prevention and intervention efforts?	12/7/2017 8:54 AM
5	So many services rely on regional systems and require significant coordination to work effectively.	12/4/2017 4:21 PM
6	MCO's should present a list of needs the ASO can support	12/1/2017 11:31 AM
7	I want to be careful of creating too many demands on regional priorities. The goal is imporved healthoutcomes, ideally, there will be data that will inform those priorities. i would like to know how they envision sharing information, collaboriting with the BH/ASO on trends and needs we are seeing, etc. I want to ensure that these questions relate to a committment to be in the relationship, but I don't want to ask questions that imply it's out way or no way, our priorities or no priorities, etc.	11/30/2017 11:09 AM
8	How do MCO's see the need for transitioning the system, not jettisoning BH ASO prematurely.	11/29/2017 3:53 PM
9	don't break what is working	11/29/2017 11:51 AM

10	Have not received sufficient support and resources to meet identified needs from the BHO in the past so have limited confidence in their ability to address the needs throughout the region or be responsive	11/29/2017 11:28 AM
11	At this point, YES. The regional BHOs are experts in terms of the needs and unmet needs that are unique to the regions they support.	11/28/2017 6:10 PM
12	This administration has the pulse of what is happening in tjhis region it's fundamental to planning and oprrsyinh	11/28/2017 4:03 PM
13	We do not need to re-invent the wheel when the BHO is doing such a great job.	11/28/2017 3:09 PM
14	The current BHO will be the best resource they have to continue to expand on good work. This would be a must.	11/28/2017 2:26 PM
15	Coordination and consultation with this organization has not been optimal in the past.	11/28/2017 2:05 PM

Q8 Coordinating with local Tribes to provide services to the American Indian/Alaskan Native population who are not served in the fee for service programs

Answered: 61 Skipped: 1

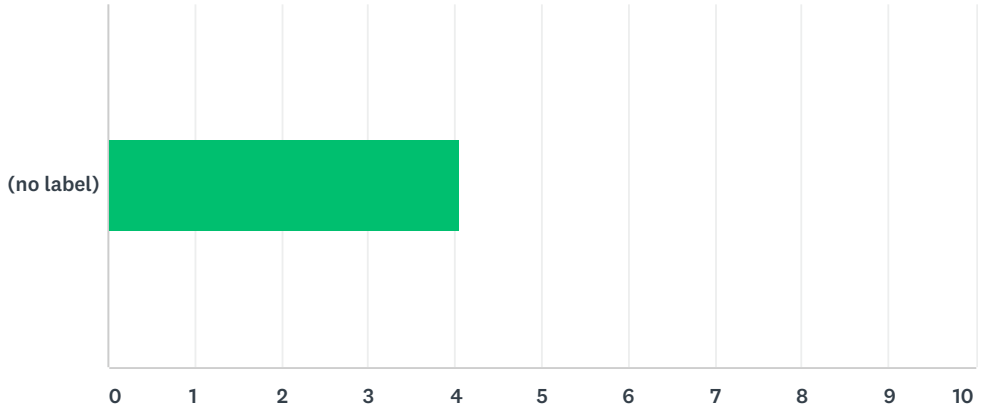


	NOT IMPORTANT	SOMEWHAT IMPORTANT	NEUTRAL	IMPORTANT	VERY IMPORTANT	TOTAL	WEIGHTED AVERAGE
(no label)	3.28% 2	6.56% 4	21.31% 13	37.70% 23	31.15% 19	61	3.87

#	COMMENT/FORMULATE A SPECIFIC QUESTION FOR THIS TOPIC AREA.	DATE
1	We have a rich diversity of individuals served in various regions in WA. Service delivery needs to be provided in relevant manner to differnt communites, so BHO can contract with insurace plans to meet elements not typically provided and if contract for oversight of plans for those carriers, then BHO can mediate between providers and communities and bridge between 'plans' and communities. Question is willingness of plans to use this mechanism to allow for more relevant coverage and state's willingness to back the community leadership model of whtin the BHO's can play an active leadership role.	12/10/2017 6:12 PM
2	Again, this is a role that has been carried out by the BHOs. How will the state fund and authorize coordination of these services?	12/8/2017 7:42 AM
3	How will you address services for AI/AN, especially emergent care such as crisis triage and detox?	11/30/2017 5:51 PM
4	Tribes have their own rules and should not muddy our already cloudy water. I may not fully understand, so my response to this question could be incorrect.	11/30/2017 11:09 AM
5	What is the MCO level of awareness and knowledge about working with Native American tribes.	11/29/2017 3:53 PM
6	The tribes have done a better job of meeting their population's needs than has been accomplished elsewhere	11/29/2017 11:28 AM
7	Anything that can be done to support Native populations in regards to improving Community Health, Crisis Stabilization, Transitions in care, and addressing needs that would otherwise find them in the Criminal Justice Sytstem is an imperative priority. This is a highly vulnerable population that has historically been treated in an inequitable manner, which has in turned increased the frequency of trauma occurring across group members.	11/28/2017 6:10 PM
8	Collaboration and integration portsntbtonthe rrhiom	11/28/2017 4:03 PM
9	How will you reach out to local Tribes?	11/28/2017 2:19 PM
10	Not much volume for this special population in San Juan county	11/28/2017 2:05 PM

Q9 Willingness to collaborate with partners on pooling de-identified service data and to exchange data for care coordination with other Managed Care Organizations (MCO) and the Behavioral Health Administrative Service Organization (BH ASO)

Answered: 61 Skipped: 1



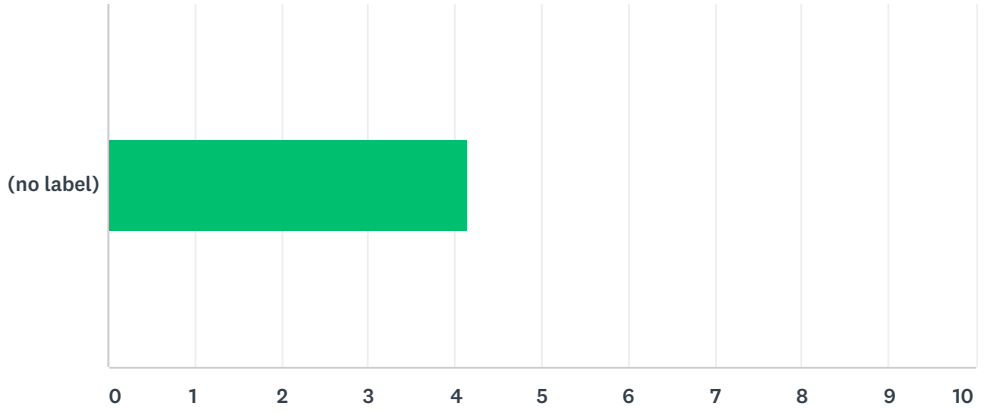
	NOT IMPORTANT	SOMEWHAT IMPORTANT	NEUTRAL	IMPORTANT	VERY IMPORTANT	TOTAL	WEIGHTED AVERAGE
(no label)	1.64% 1	1.64% 1	21.31% 13	40.98% 25	34.43% 21	61	4.05

#	COMMENT/FORMULATE A SPECIFIC QUESTION FOR THIS TOPIC AREA.	DATE
1	Relevance of 'data' gathered has been issue for years. rather than measuring hours of services or other 'wigdit' thinking an opportunity to measure effectiveinss of services is at question. Can carriers define what they find 'best practice' - and based on what source (research based or cost efficiency)? When gaps in service needs identified - what happens (change of plan service incuslion or just remaining unmet)? Most carriers are interested in 'accountability - but that translated to how many services ast whsat cost savings rather than efficay issue.	12/10/2017 6:12 PM
2	Outcome measures, and measures that may indicate pre-critical failure to deliver adequate services to those in need, are imperative. This question, however, is so poorly worded and vague that I'm unclear as to what sort of feedback should be given. Problems that have arisen in the implementation of EHRs at the agency and clinical levels are pervasive. And the capital costs and staffing costs to agencies and clinics are huge. And, the EHRs are clinically awkward, poorly implemented, poorly supported by their vendors, and rarely adaptable/flexible/inter-operable. Yet the State has done next to nothing to facilitate excellent execution/implementation. All this, while Amazon, Google, and Microsoft are three of the key tech players in the state, and could have been contracted by the state to create a truly extraordinary clinical/data system for somatic and behavioral healthcare. What does the state intend to do to facilitate record-keeping, documentation, data collection, inter-operability, and data transmission, all of which are supposed to drive value-based, outcome-oriented, integrated care?	12/8/2017 7:42 AM
3	Data is critical for population health management.	12/4/2017 4:21 PM
4	Important for coordinating care	12/1/2017 11:31 AM
5	What is your plan to collaborate to accomplish pooled regional and state data under the MCOs and how will BH ASO be involved?	11/30/2017 5:51 PM
6	Cooperation and sharing information will be the key to our success, explain how you plan to share and exhange data and information that will ultimately aid in the car for the individuals or improve overall population based health?	11/30/2017 11:09 AM

7	yes	11/29/2017 6:31 PM
8	other HIE solutions are in place that have the potential to do this	11/29/2017 11:28 AM
9	Yes, efforts to improve access, quality, and equity must be data driven; the BH ASO holds key information that will improve Community health.	11/28/2017 6:10 PM
10	Quality of care and awareness of systemwiide needs and goals	11/28/2017 4:03 PM
11	sharing data and learing and adapting services to community needs is hugely important. Data sharing is something many local organizations are trying to tackle, so any incoming MCO would need to partner in this.	11/28/2017 2:26 PM
12	MCO collaboration would be most appropriate for our healthcare organization	11/28/2017 2:05 PM

Q10 Investments in workforce development, such as tuition subsidies to increase the number of Chemical Dependency Professionals

Answered: 61 Skipped: 1



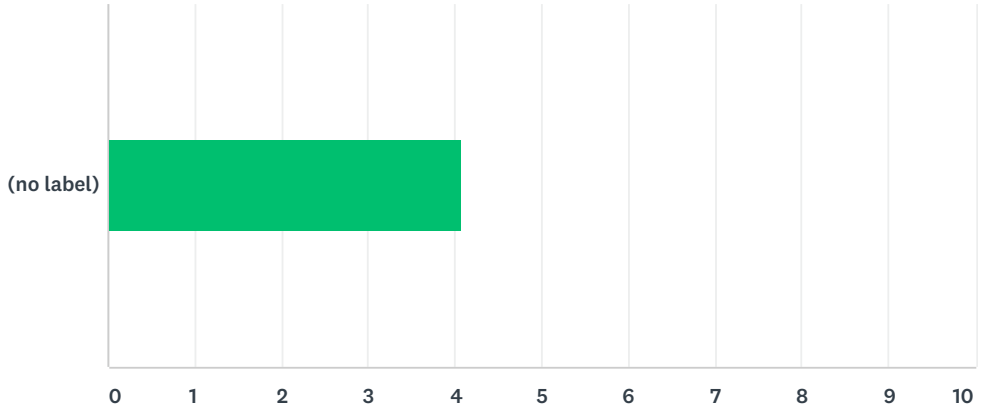
	NOT IMPORTANT	SOMEWHAT IMPORTANT	NEUTRAL	IMPORTANT	VERY IMPORTANT	TOTAL	WEIGHTED AVERAGE
(no label)	1.64% 1	8.20% 5	11.48% 7	31.15% 19	47.54% 29	61	4.15

#	COMMENT/FORMULATE A SPECIFIC QUESTION FOR THIS TOPIC AREA.	DATE
1	With BHO creation gap analyis was done and skilled therapist in both SUD and MH was identified and BHO took on education as investment in future. With change in system to managed care how can we sustain training by BHO for continuing to foster professional growth as we face a crisis of sufficent skill practioners being availble for future service needs.	12/10/2017 6:12 PM
2	Education costs are sky-high and the Feds are currently attempting to remove tax benefits to students, making matters worse. How will the State fund education? And framing education, as this question does, for CDPs is not in line with healthcare integration. There should be no CDPs, nor MHPs, nor NPs, nor MDs, who are not fully cross-trained in many areas of healthcare (somatic, mental, substances, etc.). The funding and curricula should create the integration. As an example, almost no MHPs or CDPs are trained in the evidence-based IDDT treatment protocols? How can integrated treatment occur (except in siloed geo-located agencies) without the professionals being equipped to provide integrated treatment?	12/8/2017 7:42 AM
3	Co-occurring treatment requires cross training.	12/7/2017 8:25 PM
4	Invest to raise the payscale or subsidies for all providers. Many agency treatment staff - with master's degrees, have hourly wages that total low to mid 40s. They can make more working for hospitals, goverment agencies, or private practice.	12/6/2017 10:33 AM
5	Very important and shouldn't be limited to just the CDP program.	12/4/2017 4:21 PM
6	What initiatives will your plan support, including tuition and licensing fee reimbursement, utilize to attract and retain CDPs to meet the need for services?	11/30/2017 5:51 PM
7	I think this issue is extremely important, who pays for it I am nutural on.	11/30/2017 11:09 AM
8	And strategies for increasing the general workforce pool - potential hires.	11/29/2017 3:53 PM
9	The lack of a competent workforce is a huge issue and the best laid plans will fail if we don't have a workforce. Rurla areas are especially vulnerable to this issue.	11/29/2017 3:47 PM
10	HUGE	11/29/2017 11:51 AM

11	Outcomes data needs to be evaluated to determine whether the current CD professionals are having any material impact before further investment is made in that professional group rather than in the PCPs	11/29/2017 11:28 AM
12	dual certified providers seem more important than increasing CDP's	11/29/2017 8:06 AM
13	Yes, however, these should not be opportunities given to a select few individuals. They should be provided to those that have lived experience.	11/28/2017 6:10 PM
14	Describe your track record of tangible investment in your employees:	11/28/2017 3:13 PM
15	Workforce is a tsunami issues - we are on the cusp of a crisis in cargivers, nurses, counselors, etc.	11/28/2017 2:26 PM
16	Again focus on on-line and in county options for workforce development as leaving the county for education is prohibitive.	11/28/2017 2:05 PM

Q11 Investments in training and consultation on Evidence Based Practices

Answered: 62 Skipped: 0

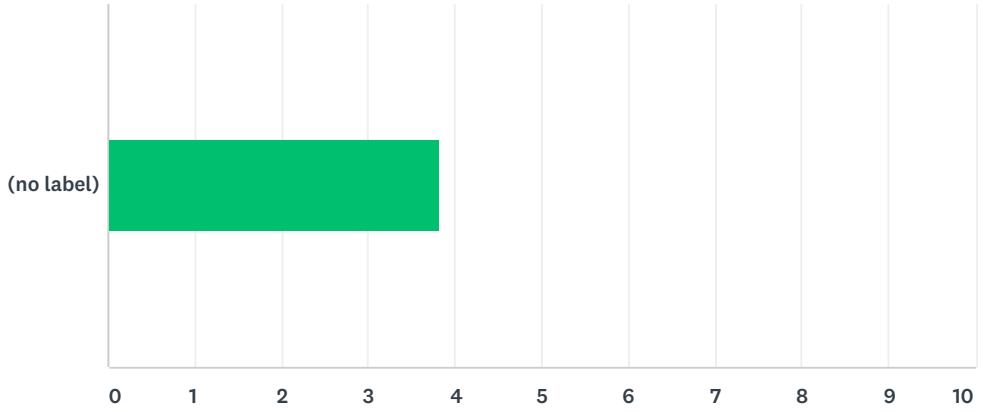


	NOT IMPORTANT	SOMEWHAT IMPORTANT	NEUTRAL	IMPORTANT	VERY IMPORTANT	TOTAL	WEIGHTED AVERAGE
(no label)	0.00% 0	6.45% 4	12.90% 8	46.77% 29	33.87% 21	62	4.08

#	COMMENT/FORMULATE A SPECIFIC QUESTION FOR THIS TOPIC AREA.	DATE
1	Question is not do we invest but how do we accomplish this end as this is another unfunded activity.	12/10/2017 6:12 PM
2	Training dollars are imperative, especially with clinics and agencies already having so little development and administrative money. Some of the BHOs have invested heavily in this area, but where will the funding come from to continue this training? And why does the state authorize trainings that are NOT evidence-based with strong research support for their efficacy?	12/8/2017 7:42 AM
3	Quality of staff more important than a specific style.	12/7/2017 8:25 PM
4	While also allowing flexibility for other services; especially when the "typical" EBPs are not normed for a Medicaid population	12/6/2017 10:33 AM
5	Past support has been very helpful, and continued training will ensure a well-qualified workforce.	12/4/2017 4:21 PM
6	How do they propose to train and invest in these services? What is their committment to evidenced based practices.	11/30/2017 11:09 AM
7	Are MCO's willing to collaborate on a coherent plan that does not give providers multiple and conflicting priorities?	11/29/2017 3:53 PM
8	More confidence in true experts like the AIM at University of Washington than a different approach	11/29/2017 11:28 AM
9	EBP's may not work for tribal populations, consider other options	11/29/2017 8:06 AM
10	How are experts not already aware of evidence based practices? What I do not want to see is money that could be spent on helping people in need of services going to pay for professional continued education. Employers or individuals can fund their own continued education, and should be mandated to do so.	11/28/2017 6:10 PM
11	Proven the more effective methods	11/28/2017 4:03 PM
12	This is always important.	11/28/2017 2:05 PM

Q12 Identification and description of the Clinical Integration Model to be implemented, specifically in geographically challenged areas

Answered: 60 Skipped: 2

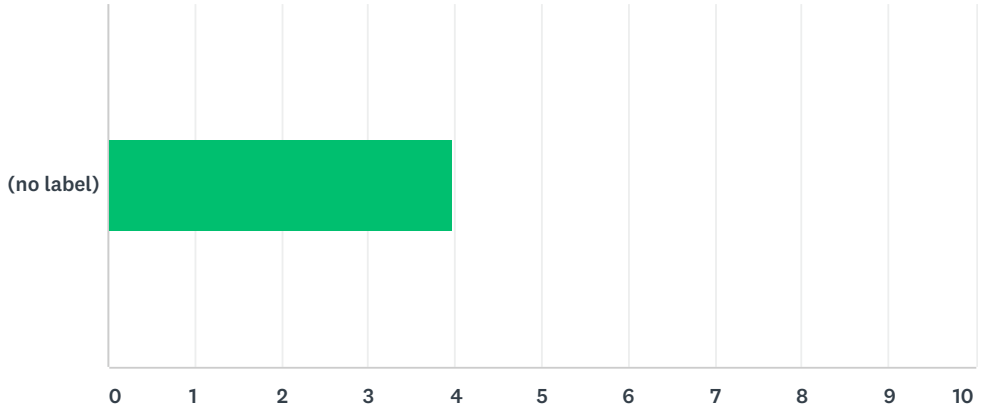


	NOT IMPORTANT	SOMEWHAT IMPORTANT	NEUTRAL	IMPORTANT	VERY IMPORTANT	TOTAL	WEIGHTED AVERAGE
(no label)	1.67% 1	5.00% 3	26.67% 16	43.33% 26	23.33% 14	60	3.82

#	COMMENT/FORMULATE A SPECIFIC QUESTION FOR THIS TOPIC AREA.	DATE
1	Question with multiple carriers in mix is how each carrier is going to address consistency and coordination of service delivery.	12/10/2017 6:12 PM
2	Health information technology (HIT) is supposed to make information-sharing both easier and more affordable, but poor inoperability defeats that, as does the horrible clinical interfaces and inability to use many systems on mobile technologies. Health information exchanges (HIEs) and data aggregation is also poor, digitally and statistically. Yet, the Clinical Integration Model is completely dependent on HIT. Another problem with the Clinical Integration Model is that it is physician-led, requiring all other healthcare providers to work with clients/patients in a hierarchical and less-functional structure that does not, in fact, promote higher quality of care, more cost-efficient care, or better coordinated care across the continua of staff hierarchies, somatic and behavioral disorders, clinical and community settings, and time and distance constraints. So, how will the state fund such processes, educate the workforce, implement HIT systems, and capitalize facilities both at the strictly clinical level and at the community level? Further, what legislative rules have been or will be implemented to promote tele-healthcare delivery that's effective (and not just physician-led)? Further, how will the state fund housing and transportation needs that are integral to health and well-being? And, finally, how will the state fund and promote interventions that address diversity-related challenges?	12/8/2017 7:42 AM
3	This remark is not clear.	12/7/2017 8:25 PM
4	Specific strategy intendification more than specific model.	12/6/2017 10:33 AM
5	Would hope that the MCOs are flexible in developing models for different communities based on need.	12/4/2017 4:21 PM
6	Not sure what is referenced here, specifically.	11/29/2017 3:53 PM
7	Through the ACH to integrate behavioral health into primary care rather than duplication of assets	11/29/2017 11:28 AM
8	Access,resources and quality of care regardless of boundsries	11/28/2017 4:03 PM
9	It is working very well for our primary care providers and their patients.	11/28/2017 2:05 PM

Q13 Contracting with smaller specialized/niche providers in the region serving older adults, children and underserved populations

Answered: 59 Skipped: 3

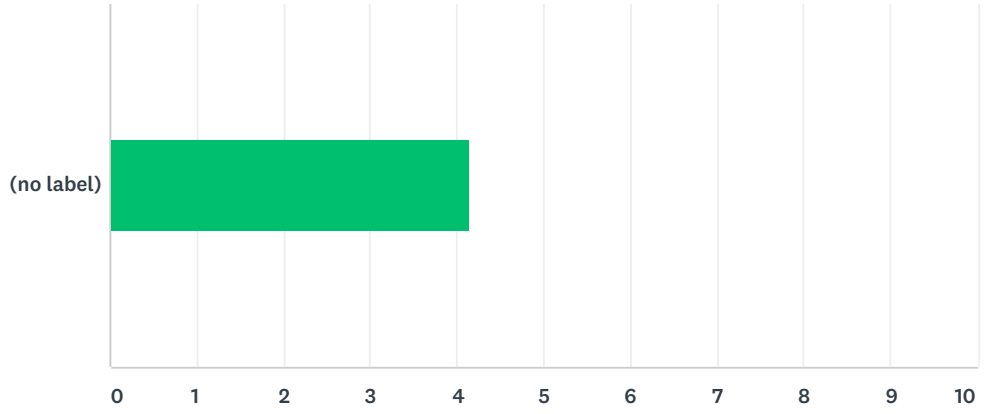


	NOT IMPORTANT	SOMEWHAT IMPORTANT	NEUTRAL	IMPORTANT	VERY IMPORTANT	TOTAL	WEIGHTED AVERAGE
(no label)	0.00% 0	5.08% 3	27.12% 16	32.20% 19	35.59% 21	59	3.98

#	COMMENT/FORMULATE A SPECIFIC QUESTION FOR THIS TOPIC AREA.	DATE
1	These areas are underserved in most of our serv e areas. Are the carriers willing to reimburse BHOs to provide services and outreach?	12/10/2017 6:12 PM
2	There should be NO "smaller niche" providers. They exist precisely because the larger agencies and clinics and institutions FAIL to provide culturally appropriate and geographically well-located healthcare, mostly because the state does not require curricular changes (preparatory), does not adequately fund translation/interpretation, does not promote/reward diversity in academic admissions and hiring, and does not adequately fund culturally appropriate service delivery. So, of course, contracting with such "smaller, niche" providers is absolutely necessary now, but what will the State do to change that necessity (funding, promotion, reward-systems, etc.)?	12/8/2017 7:42 AM
3	Quality trumps size or history.	12/7/2017 8:25 PM
4	How will your plan assure regional access to specialized providers for adults, children and underserved, including PPW?	11/30/2017 5:51 PM
5	and how will those niche services be delivered in rural areas, and what investments can/will be made in transportation to these specialized care providers?	11/30/2017 11:09 AM
6	With outcome criteria identified and without duplication. The investment should be in the primary care practices and not specialized contractors who do not already have a relationship with the patients and have traditionally performed poorly in this setting	11/29/2017 11:28 AM
7	Very important for access and equity. Again, not traditional community non-profits should be involved in providing such services.	11/28/2017 6:10 PM
8	Alternatives that enhance and/or provide needed series otherwise left void	11/28/2017 4:03 PM
9	As a niche provider who will be the only provider serving home-bound people with evidence based therapy, this would be important to continue as there is no other provider doing it. I would believe this would be the same for any provider able to specialize in a necessary population.	11/28/2017 2:26 PM
10	Important if telehealth opportunities were available.	11/28/2017 2:05 PM

Q14 Willingness to fund innovative projects/programs that demonstrate outcomes

Answered: 62 Skipped: 0

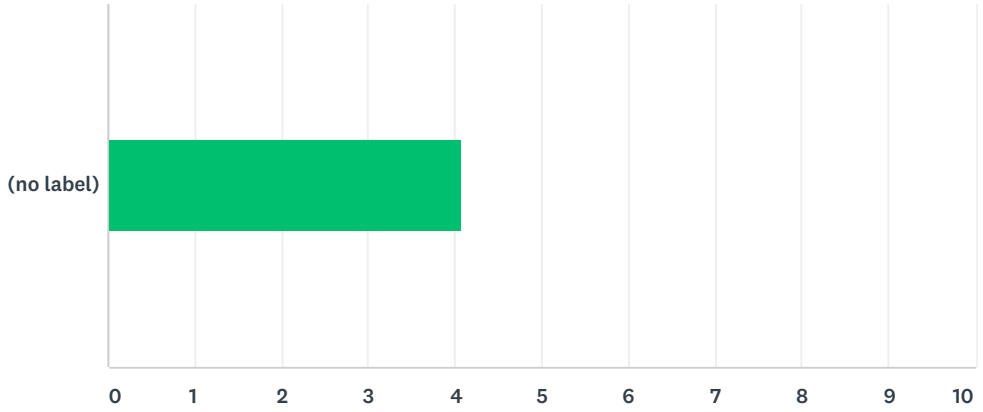


	NOT IMPORTANT	SOMEWHAT IMPORTANT	NEUTRAL	IMPORTANT	VERY IMPORTANT	TOTAL	WEIGHTED AVERAGE
(no label)	1.61% 1	3.23% 2	12.90% 8	43.55% 27	38.71% 24	62	4.15

#	COMMENT/FORMULATE A SPECIFIC QUESTION FOR THIS TOPIC AREA.	DATE
1	SAMSA and NIDA and others have provided best practice models and there continues to be information out. What are carriers willing to pay for to continue to build best practice revisions; will they include measures in their data capture for quality measures and will they differentiate between programs with these measures vs those not using best practices in service delivery?	12/10/2017 6:12 PM
2	Many states and the Feds fund pilot studies that create a research literature that informs which models are effective and which are not. WA state should not be replicating such studies unless it's statistically imperative to do so. Instead, WA state should be funding the implementation of models that have already been demonstrated to be effective, and funding/promoting the scaling up of those models in our state.	12/8/2017 7:42 AM
3	With innovative funding - not FFS. Consider caseload and non-billable supports needed to create better outcomes in difficult to serve populations or geographic areas.	12/6/2017 10:33 AM
4	Clubhouse Model over peer run Recovery Centers	12/5/2017 5:57 PM
5	Would the MCO's be willing to pay for a combination of housing and OP services in lieu of costly inpatient care?	12/4/2017 7:41 AM
6	Only grant programs with qualified personnel, demonstrated ability to provide services with measurable and material outcomes- not just the same recipients who have been granted in the past with marginal improvement in population health outcomes.	11/29/2017 11:28 AM
7	Yes, innovative is the key words and outcomes are a must.	11/28/2017 6:10 PM
8	Necessary to evaluation and planning	11/28/2017 4:03 PM
9	Outcomes for the work is where we are all headed and there would need to be investment in that inevitable future.	11/28/2017 2:26 PM
10	Willing to participate in grant funded projects. No promises on funding them from operations.	11/28/2017 2:05 PM

Q15 Invest in programs that improve service delivery, such as mobile outreach teams, telepsychiatry, etc.

Answered: 62 Skipped: 0

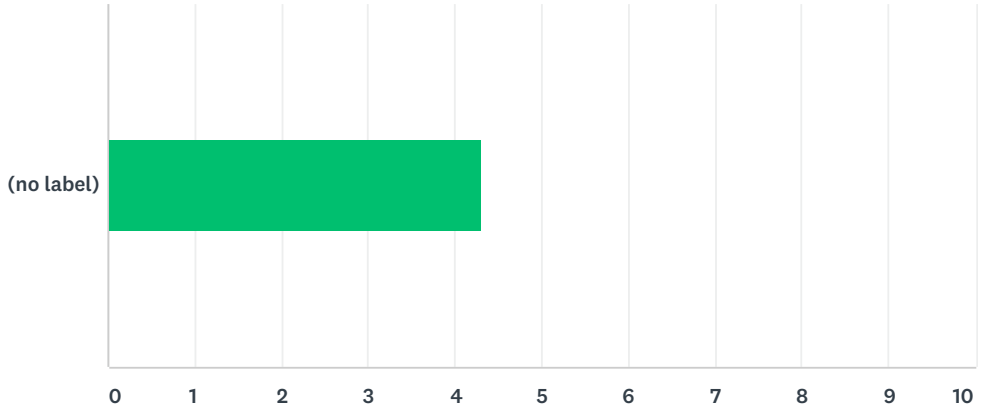


	NOT IMPORTANT	SOMEWHAT IMPORTANT	NEUTRAL	IMPORTANT	VERY IMPORTANT	TOTAL	WEIGHTED AVERAGE
(no label)	3.23% 2	6.45% 4	9.68% 6	40.32% 25	40.32% 25	62	4.08

#	COMMENT/FORMULATE A SPECIFIC QUESTION ON THIS TOPIC AREA.	DATE
1	Given limits of services adn access issue, frequently these outreach services are only service availble to stablize in community. Are carriers going to expand service coverage for these functions or be willing to contract with BHOs to ensure they are contiued /expanded to other communites.	12/10/2017 6:12 PM
2	An aging population, great geo-diversity, homelessness, rurality, island geography, cultural and linguistic diversity, and high client/patient mobility all require an investment of both State and Federal funds in delivery services that are not traditional, such as programs that are NOT physician-led, and technologies/infrastructures such as telehealth/telepsych, mobile outreach, paraprofessional coordination, treatment-based alternatives to incarceration, mobile needle exchange and education, embedding social workers with law enforcement, more local triage centers and E&Ts in lieu of large hospital facilities, housing, and far better and more adaptable EHRs that can be used easily in the field by a clinician or paraprofessional using an iPad, etc. But, almost none of these service alternatives are funded by federal dollars. So, what is the state doing to fund and promote such infrastructural and technological and staffing alternatives?	12/8/2017 7:42 AM
3	Face to face is best.	12/7/2017 8:25 PM
4	Would like to see the MCOs think "outside the box" on traditional approaches.	12/4/2017 4:21 PM
5	good strategy for our geography	11/29/2017 11:51 AM
6	Have already invested in developing these in the absence of support from the BHO	11/29/2017 11:28 AM
7	I would rather see money go into education to reduce our shortage of specialized professional care providers so that they can make house calls, if need be.	11/28/2017 6:10 PM
8	We MUST increase access to QUALITY service providers and mobile would definitely be ideal for reaching our more rural areas, as well as crisis teams like CPIT.	11/28/2017 3:09 PM
9	In our region, we have islands, snowy passes, etc. Being able to present how to create further access to necessary services would be very important.	11/28/2017 2:26 PM
10	Important in San Juan County. Telepsychiatry has been a huge success for us and provides almost better access than in person access on the mainland.	11/28/2017 2:05 PM

Q16 Standardizing policies and administrative requirements between Managed Care Organizations

Answered: 62 Skipped: 0



	NOT IMPORTANT	SOMEWHAT IMPORTANT	NEUTRAL	IMPORTANT	VERY IMPORTANT	TOTAL	WEIGHTED AVERAGE
(no label)	3.23% 2	0.00% 0	11.29% 7	33.87% 21	51.61% 32	62	4.31

#	COMMENT/FORMULATE A SPECIFIC QUESTION FOR THIS TOPIC AREA.	DATE
1	What is teh state willing to do to ensure there is consitnecy in administration and payment structures between the carriers so regardless of carrier the individual not have different coverage and providers are not required to provide services in 4 to 5 ways?	12/10/2017 6:12 PM
2	If agencies and clinics and independent providers are required to submit data and billing information in multiple formats to multiple MCOs, the gross inefficiency will unduly burden those agencies and clinics and independent providers (financially, infrastructurally, digitally, staffing/personnel, documentation time and effort, etc.). Almost NOTHING is more important than requiring all MCOs to use a single set of outcome measures and a single billing function (with identical criteria, matched codes, and a single cloud-based or web-based input location). What requirements has the State established for the MCOs to ease these burdens for providers?	12/8/2017 7:42 AM
3	I suppose it will help.	12/7/2017 8:25 PM
4	Administrative burden takes away from direct client care.	12/4/2017 4:21 PM
5	How will you collaborate with other MCOs to streamline credentialing and administrative requirements common to all providers?	11/30/2017 5:51 PM
6	What type of investments are the MCO's prepared to make in standardizing admistrative requirements.	11/30/2017 11:09 AM
7	This is critical; MCOs need to demonstrate willingness to be part of managing a system, not operating in a vacuum.	11/29/2017 3:53 PM
8	We have better success in individual negotiation of programs and agreed upon quality outcomes. We have a better chance of innovation doing it that way.	11/29/2017 11:28 AM
9	Yes, this would eliminate transaction confusion when it comes to sharing information and increase efficiency.	11/28/2017 6:10 PM
10	Necessary for coordination and vimmunicstion	11/28/2017 4:03 PM
11	Again, silos are the antithesis of real help and outcome driven work with underserved populations.	11/28/2017 2:26 PM
12	Not sure what this means exactly.	11/28/2017 2:05 PM

Q17 Suggestion of other topics.

Answered: 12 Skipped: 50

#	RESPONSES	DATE
1	Child/Adolescent MH and SUD programing and Senior services - both of these areas have very limited services primarly because coverage does not pull out these two unique age groups . Case management across spectrum - Intragrated services between primary health and MH has not adequately been addressed in current service models - so how can we move that forward?	12/10/2017 6:12 PM
2	Be sure co-occurring treaters are trained in both areas.	12/7/2017 8:25 PM
3	Will the MCOs provide flex funds? How will the MCOs ensure interpreter services are readily available and paid for? How do we ensure as a region we continue to have a robust continuum of care with five different payors plus the BHASO?	12/4/2017 4:21 PM
4	In order to stop the revolving door of behavioral health services we need to pay for services that lead to long term care. These include housing, education, legal help, childcare,medical, dental, and employment supports. An MCO will not be expected to pick up all this cost but they should be a key partner in funding a system of care that leads to long term recovery. The MCO's need to be more than funders, they need to be system partners. We need a commitment that recovery rates will continue to rise and the health burden will decrease.	12/4/2017 7:41 AM
5	Expansion to #3: What percentage of your allocation will be dedicated to capacity development through development and start-up of facilities?	11/30/2017 5:51 PM
6	I would like a specific question on jail transition, and jail diversion programs and care.	11/30/2017 11:09 AM
7	Coordination of behavioral health services between community providers and county corrections facilities.	11/29/2017 10:22 AM
8	Fund innovative non-profit approaches to addressing Community health. Approaches that provide opportunities that are appealing to Consumers and produce positive outcomes. County agencies should not be key to the demonstration of Community Health improvement efforts; they should play a role in terms of referral of people in need of services; however, they should not be involved in the provision of such services - Community level non-profit groups and organizations should be providing such services.	11/28/2017 6:10 PM
9	Being the bastion of dignity and respect Keep client focused wants and needs toward Recovery and resilence paramount.	11/28/2017 4:03 PM
10	Oversight of quality of services provided	11/28/2017 3:32 PM
11	PREVENTIVE care rather than always searching for ways to "mop up" lack of services AFTER the fact. Parents have to bear the blunt when not meet criteria for in-patient and many of these parents are not equipped or can deal with these more aggressive youth.	11/28/2017 3:09 PM
12	How will you ensure services and benefits are effectively communicated to clients and partner organizations?	11/28/2017 1:56 PM

MEMORANDUM

DATE: January 2nd, 2018

TO: North Sound BHO Advisory Board

FROM: Joe Valentine, Executive Director

RE: January 11th, 2018 County Authorities Executive Committee Agenda

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Please find for your review the following that will go before the North Sound BHO County Authorities Executive Committee Meeting at the January 11th, 2018 meeting:

For Executive Committee Approval:
Professional Service Contracts

- SVY Consulting (Shelli Young) will continue her work on the regional opioid plan. Tasks include collaborating with regional stakeholders to coordinate efforts, convene quarterly meetings to discuss and develop strategies identified at the Opioid Summit and explore additional resources for continuing the work on the opioid crisis.
- Phoenix Recovery is receiving an additional $30,000 to clean up the data submissions being submitted to the BHO. Previously, Phoenix received $50,000 for their electronic health record implementation.

Motion#
North Sound BHO-SVY Consulting-PSC-16-17 Amendment 3 to extend the contract to continue the work identified in the opioid plan and opioid summit findings. The increase to the contract is $75,000 for a new maximum of $150,000 with the term of the contract being extended from November 14, 2016 through December 31, 2017 to November 14, 2016 through December 31, 2018.

North Sound BHO-Phoenix Recovery Services-PSC-16 Amendment 3 for the purpose of cleaning up their data readying for submission to the BHO and extending the end date of the contract. The additional funding is $30,000 for a new maximum consideration of $80,000 for an extended term from February 15, 2016 through June 30, 2017 to February 15, 2016 through June 30, 2018.

For Executive Committee Ratification:
DBHR Housing Subsidies

- This contract is a pass through for Department of Commerce Housing funds for individuals eligible for Housing and Recovery through Peer Support (HARPS) funding. To be eligible for HARPS funds the individual must be exiting Western State Hospital, community psychiatric hospital or an intensive inpatient substance use disorder facility. The housing subsidies are directed for use by the HARPS Team.

Motion#
DSHS-DBHR-North Sound BHO-BH Housing Subsidy-18 for the purpose of providing additional subsidies to individuals eligible for HARPS services. The maximum consideration on this contract is $165,243 with the term of the contract January 1, 2018 through June 30, 2018.

State Funding Services

Overview of State Funding Services

- What is a State Funded Outpatient Service?
  - State Plan Service to a person without Medicaid Eligibility

  Or

  - State only service to a person regardless of eligibility
    - Crisis Hotline, Investigations, Co-Occurring Disorder Treatment, Engagement and Outreach, Supported Employment and Offender Re-Entry Community Safety Program are some examples

How Many People in 2017 (through 12/15/2017)

- State Only Count - 25,631
  - people receiving State Only services. (not Medicaid eligible or the service wasn't a Medicaid service.)
- Non-Medicaid Count -12,817
  - people receiving a service and were not Medicaid eligible at the time of the service.
- Future Medicaid Count – 3,104
  - people receiving a service with no Medicaid and received at least one service in the following 30 days with Medicaid eligibility.
- Spendown Count - 237
  - people receiving a service with a Medicaid RAC code that indicated Spend Down Program

Demographics

County

Age

Race/Ethnicity

County

Residence	State Only	Non-Medicaid	Future Medicaid	Spendown
Island	992	495	136	14
San Juan	218	125	29	3
Skagit	2,933	1,345	387	25
Snohomish	12,102	5,926	1,532	122
Whatcom	5,029	2,146	559	64
Unknown	3,669	2,162	420	8
Outside Region	688	618	41	1
Grand Total*	25,631	12,817	3,104	237

Age

Age (<18, 60+)	State Only	Non-Medicaid	Future Medicaid	Spendown
child	5,815	1,883	529	0
adult	16,630	8,771	2,281	181
older adult	1,718	1,142	141	54
Grand Total*	24,163	11,796	2,951	235

Race/Ethnicity

Race/Ethnicity	State Only	Non-Medicaid	Future Medicaid	Spendown
African-American	941	457	128	5
Asian/Pacific Islander	631	296	80	4
Hispanic/Latino	1,823	800	250	5
Native American/AN	682	393	101	5
White	14,880	6,848	2,030	171
other	5,118	2,930	357	43
Grand Total*	24,075	11,724	2,946	233

2018 Pre-Meetings, Site Visits, Conferences and Legislative Visits

Date	Pre-Meeting Topics	Note
January	North Sound BHO Website Redesign	Kurt Iverson
February	Managed Care Organizations	
March	Quality Management Oversight Committee (QMOC) 101	Betsy Kruse
April		
May		
June		
July	*Retreat/No Pre-Meeting*	
August		
September		
October		
November		
December	Holiday Potluck - No Pre Meeting	
	Crisis Intervention Team (CIT) Training in 2018	
	SeaMar Co-Occurring Outpatient Treatment	
	Tribal Behavioral Health Programs	
	Certified Peer Specialist Model and Recovery Coach Model	
	Disparities in Behavioral Healthcare	
	Eating Disorders	
	Medication Assisted Treatment	
	Suicide Prevention Policies/Guidelines w/Providers-VOA	

Date	Site Visits	Note
TBD	Swinomish Wellness Center	
TBD	Lynnwood Detox Center	

Date	Advocacy	Note
February 22 - 23	Legislative Session Visit	

Date	Conferences	Location
June 20 - 22	Behavioral Health Conference	Kennewick
TBD	NAMI Conference - The Road to Recovery: Mental Health Matters	
May 16-17	Tribal Conference	Skagit - Bow
TBD	Co-Occurring Disorders Conference	

North Sound BHO Advisory Board 2018 Site Tour

Swinomish Wellness Center
8212 S. March Point Road
Anacortes, WA 98221

Please circle the time and date that best works for you

Thursday, March 15th 10:00 – 11:30

Friday, March 23rd 1:00 – 2:30

Thursday, March 29th 10:00 – 11:30

Friday, March 30th 1:00 – 2:30

North Sound BHO Advisory Board Site Tour

Lynnwood Detox Center
20508 56th Avenue West
Lynwood, WA 98036

Please circle the time and date that best works for you

Friday, January 26, 10:30 – 12:00

Thursday, February 15, 1:00 – 2:30

Monday, March 5, 1:00 – 2:30

Wednesday, June 6, 10:00 – 11:30

NORTH SOUND BEHAVIORAL HEALTH ORGANIZATION
ADVISORY BOARD
2018 LEGISLATIVE PRIORITIES

1. **Support the request of the North Sound BHO and 5 North Sound Counties for capital funding for new Behavioral Health Facilities.**
   These are needed to address the historical lack of treatment facilities in the region; respond to the growing opioid epidemic; and replace the beds that will be lost with the state's lease with Pioneer Center North and the North Sound Evaluation and Treatment Facility expires in June 2018.

2. **Expand prevention and treatment services to reduce Opioid use.**
   Expand funding for Medication Assisted Treatment, including in jails. Expand funding for and encourage the distribution of Naloxone kits to first responders. Support local efforts to promote safe storage and disposal, including a "take-back system" for prescription and over the counter medicines.

3. **Maintain the Behavioral Health Organizations under fully integrated managed care.**
   Provide sufficient dedicated funding to the North Sound Region to support the transition of the Behavioral Health Organization to a "Behavioral Health Administrative Services Organization" (BH-ASO).This funding should be sufficient to maintain the current continuum of care in the North Sound BHO administered Crisis Services and Diversion programs and to preserve the existing systems and historical expertise of the BHO in providing care for persons with serious behavioral health disorders.

North Sound Behavioral Health Organization
Facilities and Recovery System of Care Plan Summary
March 2017

NOTE: Please see reverse side of page for state capital budget request

Overview

Today, there is a growing behavioral health crisis with urgent – and unmet – treatment needs in Snohomish, Skagit, Island, San Juan and Whatcom counties (North Sound Counties). To address this crisis, the North Sound Behavioral Health Organization (BHO) and the North Sound Counties are pioneering an innovative, yet proven, approach to provide small-scale, localized treatment while working collaboratively across the counties to prioritize and maximize resources. Crucial to the success of this approach, the North Sound BHO and the North Sound Counties are requesting state capital budget assistance to ensure the creation of additional and appropriate treatment facilities, specifically to:

- Address the historical lack of substance use disorder residential treatment facilities within the North Sound Region;
- Address the increased demands for services due to population growth and expansion of the Medicaid caseload;
- Provide adequate treatment resources to address the growing opioid epidemic; and,
- Transition services from an outdated treatment model that is not financially sustainable to community based facilities that will serve the North Sound Counties (existing leases ending June 2018).

Behavioral Health Crisis in the North Sound Counties

Persons suffering from behavioral health crises present a growing challenge for the North Sound Counties. It is estimated that ***over half*** of the persons in local jails suffer from a behavioral health disorder. Persons needing psychiatric hospitalization continue to be cared for in local hospitals, which are not equipped to provide this care due to a shortage of state psychiatric hospital beds. The North Sound Counties have been particularly hit hard by the opioid epidemic. Nationally, more people died from drug overdoses in 2014 that in any year on record, and the majority of these drug overdoses involved an opioid. In the State of Washington, approximately 600 persons die each year from an opioid overdose; the largest increase in those deaths are among younger people. 20 percent of all Washington State opioid overdose deaths in 2013 happened in Snohomish County, which comprises only 11 percent of the state population. The other four North Sound Counties have seen a similarly disproportionate increase in opioid overdoses and opioid-related deaths.

Governor Inslee's recently released Executive Order to combat the opioid crisis calls for increased access to treatment. In the North Sound Counties, there are insufficient Substance Use Disorder treatment beds given the size of our population and many persons must travel to Eastern Washington to receive treatment. This increases transportation costs, and makes it harder to keep persons connected with critical community support systems. The default for many persons suffering from an addiction crisis is a hospital emergency department, where the daily cost of care is more expensive than a day of care in a treatment facility.

North Sound Behavioral Health Organization
Facilities and Recovery System of Care Plan Summary
February 2017

Capital Budget Request for 2017-19 Biennium

The North Sound Behavioral Health Organization (BHO), on behalf of and supported by Snohomish, Skagit, Island, San Juan and Whatcom Counties, is requesting financial assistance over the next two biennia in order to phase in the funding and construction of the needed facilities. The capital request equates to about $6 million per county. Ongoing, operational funds for the expanded facilities will be provided from existing North Sound funding sources.

Facility	Estimated Cost (Millions)	Status
Skagit Stabilization Campus - Evaluation and Treatment (E&T) Facility – Skagit County 16 Bed	$6	Location will be in Skagit County. This would replace the existing E&T lease ends in June, 2018. The existing operator has experience in bringing up new E&Ts.
Substance Use Disorder Intensive Inpatient Treatment Facilities - Everett Two 16 Bed Facilities	$6 (16-bed) Facility A $6 (16-bed) Facility B	The proposed location of the two 16-bed facilities is the Denny Youth Center which is a county-owned building on county owned property.
Mental Health Triage - Bellingham 16 Bed	$5	This would be a new facility which would replace the existing smaller Triage facility which is on county-owned land.
Acute Detox - Bellingham 16 Bed	$2	The existing Triage facility would be renovated to serve as the new Acute Detox facility.
Long Term Substance Use Disorder Treatment Facility 16 Bed	$6	Replaces 16 of the 32 beds it is estimated North Sound will need when Pioneer Center North closes in June, 2018. Location to be identified.
Skagit Stabilization Campus - Acute Detox 16 Bed – Skagit County	$6	Locate adjacent to the E&T. Crisis Services and Case Coordination staff would also be located on the same campus.
Triage/Sub-Acute Detox - West Skagit County 8 Bed	$4	Meets the need for access to services for Island, San Juan, and West Skagit County.
2017-19 Biennium Total	$41	
BHO Funds to be Invested	$8.5	
Total Capital Budget Request 2017-19 Biennium	**$32.5**	NOTE: Investment equates to just over $6 million per county.

For 2019-21 biennium, the North Sound BHO is planning on a similar request for an additional $29 million for five additional 16-bed facilities and five recovery houses spread among the five counties.

2017 NORTH SOUND OPIOID SUMMIT REPORT

1,280

Hours Invested by Community Leaders at the 2017 North Sound Opioid Summit

On October 25th, 2017, more than 150 stakeholders convened in Bow, WA, with the goal of expanding the collective efforts that will finally begin to reverse the progression of the opioid epidemic across the North Sound region. Leaders from **Law Enforcement, Drug Courts, Treatment Agencies, Primary Health Care, County Public Health and Human Services, Elected Officials, Tribal Partners and others** gathered to learn the latest research on effective strategies and discover promising local efforts. ***But more importantly, they brought their ideas and skills to help build new partnerships and plan new solutions to fight the Opioid Crisis in the North Sound Region.***

RECOMMENDATIONS

- **Expand "Upstream" efforts**
  - Work closely with schools, youth-serving organizations and other key partners to expand evidence-based prevention, outreach/early intervention and treatment programs for youth
  - Increase efforts to support parents and families in preventing childhood trauma and accessing services when needed, such as parent education and family-focused care coordination
  - Support community drug "take back" programs and other efforts to keep medications secure
  - Increase funding to expand access to naloxone for people at risk, such as those leaving jails or detox
- **Increase community support for, and the availability of, Medication Assisted Treatment (MAT)**
  - Provide financial incentives for primary care physicians and other providers to prescribe Buprenorphine
  - Address local community concerns related to the siting of MAT clinics
  - Use mobile vans to increase access to MAT especially in rural areas
- **Provide MAT to persons who are incarcerated or being released from Jail. Encourage and support Jails in replicating effective pilots such as those in Snohomish County.**
- **Expand Syringe Exchange Programs, and support the growth of connected services such as Outreach, ongoing Care Coordination, Primary Health and Dental Care**
- **Actively create Housing opportunities for Persons who are receiving MAT**
- **Expand the Workforce of CDPs, Peer Counselors and Recovery Coaches through tuition subsidies and other supports**
- **Continue to address the Stigma around both Opioid Use Disorder and the use of Medication Assisted Treatment to address it**
- **Support local efforts to address the Opioid crisis as a Public Health problem, including comprehensive strategies to conduct community "Surveillance" on Overdoses and Mortality, as well as documenting the effectiveness of Treatment and Prevention efforts.**
- **Expand Recovery Supports, such as Housing, Child Care, Transportation, Employment, Education and ongoing Recovery Coaching**
- **Transition the Treatment paradigm to support Effective Strategies**
- **Actively partner to fill gaps and "scale up" effective local programs, like MAT in Jails and Behavioral Health Professionals embedded with Law Enforcement**

2017 NORTH SOUND OPIOID SUMMIT REPORT

A SAMPLE OF PARTICIPANTS' QUESTIONS AND REMARKS

*Prevention in schools? How do we know what's happening and expand what's working?

*How can we expand . . . programs to reach more people? What are the barriers?

*How do we deal with ACEs at the adult level? . . . What is the best medication for Generational ACES?

*Drug take-back programs require involvement by Law Enforcement, but what about . . . requiring drug companies to establish drug take-back programs?

*Could it be legislated that overdoses be reported back to the prescriber . . . so they know the effect of their prescribing practices?

*[What about] Methadone program[s] issuing Narcan to individuals or family when enrolled in OTP?

*How do we promote policy and practice . . . to improve: Collaboration among sectors (Law enforcement, jails, counties, treatment); Resource ($) coordination and optimization (Housing, transportation, Rx . . . .)?

*[We] can't just focus on the "shiny object!" [We] must ensure a full continuum of care!

*If you get someone on MAT how do you guarantee the continuum of care? Care management is essential.

*Need housing for success in recovery

*Given the limited resources, how do we bridge between MAT in criminal justice settings and community providers?

*How do we communicate to community and policy makers to provide additional funding for jail services (workforce for MAT, diversion programs)?

*How do we move from working on our own little piece and instead working on the problem collectively? . . . How can we align our systems to move in the same direction?

*What does it take to educate providers to change course, change philosophy and adopt new Treatment modalities?

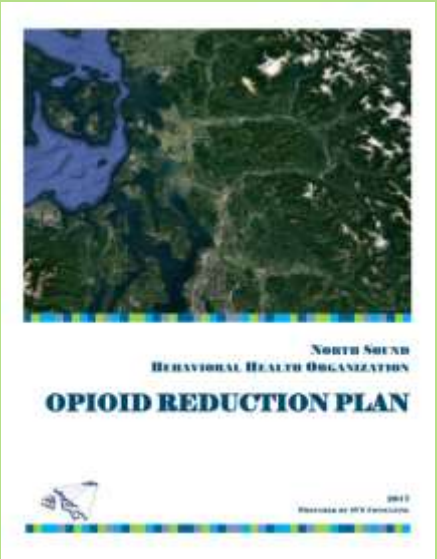
*Detox 90% failure rate increases overdose risk – Why do we do it?

*Withdrawal only is ineffective and unethical

*What can we do to encourage [the] whole community to stop asking "When are you going to get off medicine?". . . . . "When are you gonna get off of that?"

NEXT STEPS

1. **The North Sound BHO will create an electronic distribution list to keep interested persons and organizations informed about ongoing efforts and opportunities to participate.**
2. **Relevant Opioid Summit recommendations will be integrated into the North Sound Opioid Response Plan.**
3. **Individual county human service and public health departments will continue to pursue county-based strategies and provide opportunities for summit participants to become involved.**
4. **The North Sound BHO and the North Sound Accountable Community of Health [ACH] will support local efforts, coordinate regional strategies, and provide opportunities for summit participants to become involved.**
5. **The North Sound BHO, North Sound ACH and Counties will collaborate to increase data collection and monitoring.**
6. **The North Sound BHO, North Sound ACH, Counties and Tribal Partners will collaborate to develop specific legislative proposals for enhancements to policies and funding.**



THE NORTH SOUND
OPIOID REDUCTION PLAN
http://northsoundbho.org/Assets/PDFs/Opioid_Reduction_Plan/