1. Call To Order

Committee Chair Anne Deacon called the meeting to order at 2:34 p.m. at the Health Department Lower Level Conference Room, 509 Girard Street, Bellingham.

Members Present: Jill Bernstein, Anne Deacon, Susan Gribbin, Betsy Kruse, Byron Manering, Randy Polidan

Also Present: Stephen Gockley, Forrest Longman, Perry Mowery, Jeff Parks

Members Absent: Julie Finkbonner, Kelli Linville, Greg Winter

Review July 28, 2016 Meeting Summary

There were no changes.

3. Review of Phase 2 Draft Report

The Committee discussed:

- Addressing criminogenic risk factors
- The City of Bellingham law enforcement assisted diversion (LEAD)-like jail diversion program
- Collaboration between the Sheriff and City of Bellingham Police Department
- The level of specificity in the report
- Collaboration among the County Health Department, the City of Bellingham, and housing agencies to address the need for more mental health supportive housing
- First responder database software packages to track mental health calls
- When the committee will discuss prevention and early intervention to reduce adverse childhood experiences.

2. Letter from Sheriff regarding proposed Crisis Intervention Team (CIT)

Jeff Parks, Sheriff's Office, described the Sheriff's additional services request (ASR) for funding for a CIT. The new specialized program includes:

- Three new deputy positions
- A higher level of specialized training for the three deputies
- An ongoing relationship with other community and regional service providers
- Deputies would assist with jail staff to get people out of jail
- Deputies would follow up with residents who need specialized care
- The cost is approximately $300,000 per year, plus approximately $100,000 or $200,000 for startup costs
- It's unlikely the County Executive will fund the program

The committee discussed:

- Whether the Sheriff's Office can create the unit with existing staff
- Whether a better model would be to include a mental health professional on a response team
- Whether the Sheriff and Bellingham Police can collaborate on a program
- Smaller jurisdictions calling on the Sheriff's Office when a specialty situation comes up
- The Task Force's obligation to identify the best program and services options, regardless of a budget process.
- Identifying which projects that work in an integrative and collaborative model
- A software system that combines database information with case management

4. Recovery Support Services

Deacon stated this item is focused on backdoor services at the triage facility, to keep people stable once discharged:

- Supportive housing programs
- Behavioral Health Revenue Advisory Committee (BHRAC) prioritized future sales tax dollars doing to housing
- BHRAC also prioritized pre-arrest diversion activities

The Rainbow Recovery Center will relocate in 2017 to a new location to alleviate problems with predatory people using the program and for the safety of its vulnerable clients. It will shift away from being a homeless drop-in center.

2. Letter from Sheriff regarding proposed Crisis Intervention Team (CIT)

The committee continued discussion of the Sheriff's request:

- The proposed CIT is a step in the right direction
- Law enforcement throughout the county coordinate to the greatest extent possible
- Having a team concept is important
- Include potential outcomes in the information about the CIT
- The CIT should coordinate with the jail

Polidan moved to support the Sheriff's Office effort to create a CIT that can team with local mental health providers. The motion was seconded.

The motion carried unanimously.

Deacon stated it would be important for the Whatcom Police Chiefs to have a discussion about appropriate levels of cooperation and coordination.

5. Prevention & Early Intervention Efforts

The committee did not discuss this item.

6. Transition to commercial managed healthcare in 2020

The committee did not discuss this item.

7. Next Steps: Ideas & Further Information

Deacon stated the next meeting of the committee will be on October 27 at 2:30 p.m.

8. Public Comment

No one spoke.

9. Adjourn

The meeting adjourned at 3:37 p.m.

DRAFT Meeting Summary for October 27, 2016

A quorum of the Committee was not present. An abbreviated meeting summary is below. The meeting was audio recorded. The audio recording is available on the committee's webpage.

1. Call To Order

Committee Chair Anne Deacon called the meeting to order at 3:00 p.m. at the Lummi Administration Building, 2665 Kwina Road, Bellingham.

The meeting attendees introduced themselves and described their backgrounds.

Members Present: Anne Deacon, Julie Finkbonner, Kelli Linville

Task Force Members Also Present: Jill Bernstein, Irene Morgan, Stephen Gockley

Members Absent: Susan Gribbin, Betsy Kruse, Byron Manering, Randy Polidan, Greg Winter

Review September 29, 2016 Meeting Summary

This item was not discussed.

2. Tour of Lummi Nation Services

Nick Lewis, Lummi Nation, stated the transition center is unavailable for a tour at this time. The Lummi program managers will describe their services and program areas, including a wraparound program to work with families and children to turn their lives around, a tiny home housing program, a free Lummi transit bus, transitional housing, GPS monitoring, and medication and other substance abuse treatment. Challenges includes the influx of non-Tribal homeless people from outside the area who come to them for service, people who aren't under Lummi jurisdiction, and confusion in accessing care.

3. Behavioral Health Revenue Advisory Committee (BHRAC) 2017 Budget

Deacon referenced and read through the annual report in the Committee packet. The Committee discussed mental health court collaboration between the City of Bellingham and the County.

4. Prevention and Early Intervention Efforts

Deacon referenced the information in the Committee packet for the previous agenda item and reported on prevention and early intervention programs that start before children are born and continue with programs with the school districts.

5. Case Management and Database Software for Behavioral Health First Responders

This item was not discussed.

6. Next Steps: Ideas & Further Information

This item was no discussed.

7. Public Comment

No one spoke.

8. Adjourn

The meeting adjourned at 4:30 p.m.

NADCP
National Association of Drug Court Professionals

New Grant Funding Opportunity to Address the Opioid Epidemic

Applications Due: April 25

Applicant Conference: February 25

The Bureau of Justice Assistance, Department of Justice has released a solicitation to fund new grant programs related to the opioid epidemic. These grant programs *do not* replace the Drug Court Discretionary Grant Program or the Veterans Treatment Court Program.

All applications must be submitted by April 25, 2017. Click here to view the application.

The Comprehensive Opioid Abuse Site-Based Grant Program (COAP) consists of six different grant program categories.

Category 3: System-level Diversion and Alternatives to Incarceration Projects
Supports development of county-based approaches to diversion and alternatives to incarceration.
Eligibility: Units of local government and federally recognized Indian tribal governments
Project Period: Up to 36 months
Dollar Amount: No greater than $400,000

Pg. 6: Comprehensive Opioid Abuse Site-based Program was designed to: promote the leveraging of existing resources within a community while maximizing diversion opportunities for individuals who come in contact with the justice system as a result of an opioid use disorder; expand outreach,

treatment, and recovery opportunities to under-served populations; promote cross-system planning and coordination of service delivery; and reduce the incidence of fatal overdoses associated with opioid use.

Pg. 7 – 8: The goals of the Comprehensive Opioid Abuse Site-based Program are twofold. First, the program aims to reduce opioid misuse and the number of overdose fatalities. Second, the program supports the implementation, enhancement, and proactive use of prescription drug monitoring programs to support clinical decision-making and prevent the misuse and diversion of controlled substances.
The objectives of the Comprehensive Opioid Abuse Site-based Program are to:
• Encourage and support comprehensive cross-system planning and collaboration among officials who work in law enforcement, pretrial services, the courts, probation and parole, child welfare, reentry, PDMPs, emergency medical services and health care providers, public health partners, and agencies that provide substance misuse treatment and recovery support services.
• Develop and implement strategies to identify and provide treatment and recovery support services to "high frequency" utilizers of multiple systems (e.g., health care, child welfare, criminal justice, etc.) who have a history of opioid misuse.
• Expand diversion and alternatives to incarceration programs.
• Expand the availability of treatment and recovery support services in rural or tribal communities by expanding the use to technology-assisted treatment and recovery support services.
• Implement and enhance prescription drug monitoring programs.
• Develop multi-disciplinary projects that leverage key data sets (e.g., de-identified PDMP data, naloxone administrations, fatal and non-fatal overdose data, drug arrests, etc.) to create a holistic view of the environment and develop interventions based on this information.
• Objectively assess and/or evaluate the impact of innovative and evidence-based strategies to engage and serve justice-involved individuals with a history of opioid misuse.

Pg. 12 - 14:
Category 3: System-level Diversion and Alternatives to Incarceration Projects
Grantees awarded Category 3 awards will demonstrate a system-level commitment to establishing effective diversion and/or alternatives to incarceration programs for individuals with opioid use disorders. Category 3 applicants should propose initiatives in at least two intercepts within the Sequential Intercept Model (e.g., law enforcement or prosecutor diversion, pretrial diversion, drug courts or other problem-solving courts, community-based supervision, corrections programs, reentry programs, etc.) The population of focus must primarily be justice-involved individuals with a history of opioid misuse as well as individuals who have come in contact with law enforcement but have not been formally charged.
The focus of Category 3 is on developing county-based approaches to diversion and alternatives to incarceration.

Mandatory Project Components for Category 3
All applicants under Category 3 must:
• Establish a team (or utilize a pre-existing team) of stakeholders from across government and the community to engage in the planning process. The appropriate composition of the team may vary based on the proposed project but should generally include representatives from county administration; public health; health care providers; substance use treatment agencies; law enforcement; the local pretrial agency; adult probation and parole; juvenile probation; the trial courts; the adult, juvenile, family, tribal and problem-solving courts; child welfare; corrections administrators; and nonprofit organizations that provide wraparound or recovery support services. Applicants must provide letters of support and/or an

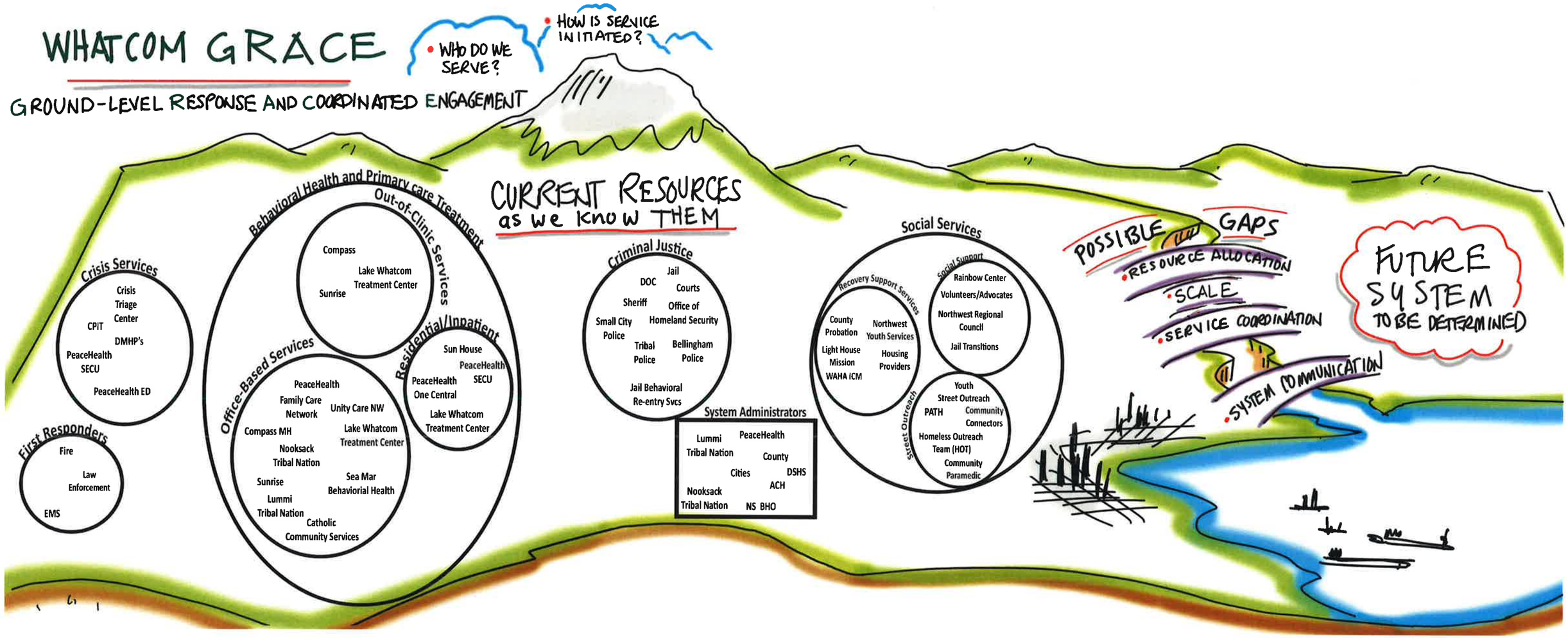
interagency agreement documenting each agency's commitment to participating in the planning and implementation processes. The letters or interagency agreement should clearly articulate the level of involvement each agency will have in the proposed project.
• Complete a structured planning phase before beginning project implementation. Each grant award made under Category 3 will have in place a special condition withholding all but $100,000, which will allow grantees to establish an action plan within 180 days of receiving the award before moving into the implementation phase.
• Document the impact of the opioid epidemic based on local, regional, or state-level data.
• Identify a project coordinator who must have dedicated time set aside beyond their normal job duties to manage the day-to-day operations of the initiative during the planning and implementation phases. No less than 50% of the project coordinator's time should be directed toward the BJA-funded project activities. The project coordinator will work closely with designated BJA Comprehensive Opioid Abuse TTA program providers to:
o Identify the needs of the community, including collecting and analyzing administrative data.
o Work with the project staff to design an appropriate outreach and prevention strategy based on data.
o Convene regular stakeholder discussions surrounding project implementation.
o Respond to requests for data, reports, and information about the proposed initiative.
o Ensure continued project implementation and redirection if needed.
• Agree to work closely with BJA's designated TTA provider(s), which will be selected through a separate solicitation, as well as an evaluator who may conduct site specific evaluations or a cross-site evaluation.
• Track quarterly performance measures. Applicants should fully consider the data collection needed to support the proposed project and budget for these project costs appropriately.
• Budget for travel expenses (airfare, hotel, per diem, and group transportation) for two staff to attend two face-to-face meetings in year 1 of the grant and one face-to-face meeting each year thereafter for the life of the grant. Each meeting should be budgeted for 3 days each in Washington, D.C.

Allowable Uses of Funds for Category 3 – Planning Phase
Grant funds may be used to support a combination of the allowable use categories below, or be concentrated on one specific area:
• Identify high-frequency utilizers across multiple systems (e.g., those with a high number of contacts with police, ambulance, or emergency departments, child welfare, the courts, the jail, or community supervision). Once these individuals are identified, the planning group should use the planning phase to identify policy options and approaches to engage these individuals in treatment and recovery supports.
• Document the prevalence of individuals with opioid use disorders in the various local intercept points, identify the population's needs, and identify intervention options that reduce the use of incarceration, promote treatment engagement, minimize need for child protective services involvement and/or foster care placement, or reduce the risk of overdose death.
• Engage a research partner to provide skills and assistance in identifying performance measures, providing subject matter expertise and guidance, and/or ensuring performance and outcome evaluations are being considered within the planning phase.

Allowable Uses of Funds for Category 3 – Implementation Phase
Grant funds may be used to support a combination of the allowable use categories below, or be concentrated on one specific area:
• Link high-frequency utilizers with evidence-based treatment and recovery support services with a goal of reducing overreliance on emergency health care and encounters with the criminal justice system.
• Implement a plan to universally screen individuals entering community-based supervision and/or jail for risk of overdose and prioritize services to these individuals.

• Develop and implement a comprehensive plan to reduce the risk of overdose death and enhance treatment and recovery service engagement among the pretrial and post-trial populations leaving local jails or secure residential treatment facilities.
• Implement or expand the system-wide use of recovery support services using peer recovery coaches to help justice-involved individuals enter into and navigate
systems of care, remove barriers to recovery, and stay engaged in the recovery process.
• Expand the use of cognitive-behavioral treatment in combination with medication-assisted treatment to help individuals engage in the treatment process, modify their attitudes and behaviors related to opioid misuse, and increase life skills.
• Implement wraparound services that facilitate meaningful coordination between the justice system and family support agencies, especially child welfare, to safeguard the lives and wellbeing of minor children and family members who experience the impacts of opioid use. These initiatives may focus on improving parental functioning or engaging family members as a natural support system at all points in the justice system. Applicants are highly encouraged to review the National Center on Substance Abuse and Child Welfare (NCSACW) website https://ncsacw.samhsa.gov for additional information and incorporate these concepts into their grant proposals.
• Establish collaborative public health and justice partnerships to address the unique needs of justice-involved women with opioid use disorders, including pregnant women.
• Develop data or information systems to facilitate analyses and help track progress and assist in efforts to report on outcomes.
• Implement other comprehensive approaches that serve individuals within more than one intercept and align with the goals of the Comprehensive Opioid Abuse Site-based Program.
• Support the mandatory project coordinator position.
• Engage a research partner to conduct action research providing skills and assistance in identifying performance measures, tracking measures to assist in the improvement of program implementation and fidelity, providing subject matter expertise and guidance, performing performance evaluations, and/or ensuring outcomes are being evaluated effectively.

Priority Consideration for Category 3
Priority consideration will be given to applicants that:
• Demonstrate that they have been disproportionally impacted by the illegal opioid epidemic as evidenced, in part, by high rates of primary treatment admissions for heroin and other opioids; high rates of overdose deaths from heroin and other opioids; and/or a lack of accessibility to treatment providers and facilities and to emergency medical services.
• Include an action researcher that will assist in the identification of the problem, design of the solution, and evaluation of the proposed initiative.



Acronyms:

ACH.....Accountable Communities of Health
CPIT.....Crisis Prevention and Intervention Teams
DMHP.....Designated Mental Health Professional
DOC.....Department of Corrections
DSHS.....Washington State Department of Social and Health Services
EMS.....Emergency Medical Service
NS BHO.....North Sound Behavioral Health Organization
PATH.....Project for Assistance in the Transition from Homelessness
SECU.....Specialized Emergency Care Unit (at Peace Health/St. Joseph Hospital)
WAHA ICM.....Whatcom Alliance for Health Advancement Intensive Case Management

Washington State Department of Social & Health Services

Transforming lives

ISSUE DATE: 1/25/2017

DBHR Guidance Document
Frequently Asked Questions
Medicaid Funding for Individuals in an IMD

When a Medicaid individual is receiving SUD residential services in an IMD beyond 14 days:

- **Is it accurate that the payment with other funds is retroactive to day 1 of SUD residential?**

  The final rule is that the state cannot make a monthly capitation payment to an MCO or BHO, or pay for any managed care costs when the individual has stayed in a IMD for more than 15 days in a calendar month. The 2017 Medicaid Managed Care Rate Development Guide states:

  States may make a monthly capitation payment to an MCO or PIHP (in a "risk contract" as defined in 42 CFR 438.2) for an enrollee age 21 to 64 receiving inpatient treatment in an Institution for Mental Diseases (IMD) (as defined in 42 CFR 435.1010) for a short term stay of no more than 15 days during the period of the monthly capitation payment in accordance with 42 CFR 438.6(e). The data used for developing the projected benefit costs for these services must not include:

  i. costs associated with an IMD stay of more than 15 days;
  ii. any other managed care plan costs for services delivered in a month when an enrollee has an IMD stay of more than 15 days; and
  iii. a member month for any month when an enrollee has an IMD stay of more than 15 days.

- **Is the individual's Medicaid canceled or suspended at that time? (canceled=has to reapply for Medicaid when leaves SUD residential treatment; suspended=cannot use Medicaid until the next full month). Do they have to reapply?**

  It is the use of federal funds, not the person's Medicaid eligibility that is the focus of the rule. The State in looking into options on how to operationalize this piece, our goal is to have the person in a suspended status rather than disenrolled. The challenge is that at this time the State has no way to know in real time the status of the person in an IMD. As we get further down the road on the implementation process we will provide more updates.

- **If they are in an IMD more than 15 days in month one, and get released on Day 6 of the next month, is the second month of care Medicaid?**

  In the example given, the first six days of the month would be covered (unless the individual was in an IMD during that same month and the additional days resulted in a total over 15). CMS has stated that the rule applies to the calendar month. An individual could be in and IMD for the last 15 days of one month and the first 15 days of the next month. In that case, the managed care plan would receive payment for both months (assuming those days were the only IMD days for both months).

If you have questions about this guidance please email richard.vancleave@dshs.wa.gov

- **Do they still have access to their Medicaid benefits/entitlements, and it is simply the BHO that must use other funds for residential payment?**
  The CMS rule states that managed care entities may not receive any capitation payment for the month when the individual is in an IMD for more than 15 days. CMS acknowledges that this will result in some cases in a recoupment of capitation payments. They offer the solution that states pay for medically necessary services during those months when a capitation payment is not available (due to a stay in an IMD of greater than 15 days).

  From Page 240 of the final rule:

  "[Comment] A few commenters stated that the preamble indicates that a state will be required to monitor beneficiary IMD lengths of stay on a monthly basis, and if such a stay lasts 15 days or longer in a month, **to seek recoupment of its total capitation payment made to the managed care plan for that month**. Commenters noted that requiring states to recoup capitation payments made to MCOs and PIHPs for an enrollee with an IMD stay that exceeds 15 days will require significant retroactive adjustments and create major financial uncertainty…

  [CMS Response] We acknowledge that this provision requires states to monitor the MCO's or PIHP's use of IMDs as an in lieu of service to ensure that capitation payments were appropriately made and that claims for FFP associated with those capitation payments are filed only when consistent with this rule…We note, however, that states may also pay independently for services provided to patients in IMDs. We emphasize that the statutory exclusion was **designed to assure that states, rather than the federal government, continue to have principal responsibility for funding inpatient psychiatric services."**

List of Acronyms for DBHR Guidance Document

BHO ..... Behavioral Health Organization
CFR ..... Code of Federal Regulations
CMS ..... Centers for Medicare & Medicaid Services
DBHR ..... Division of Behavioral Health and Recovery
FFP ..... Federal Financial Participation
IMD ..... Institution of Mental Diseases
MCO ..... Managed Care Organization
PIHP ..... Prepaid Inpatient Health Plan
SUD ..... Substance Use Disorder