Attendees: Adam York, JHC; Annie Failoni, OPHS; Anna McEnery, JCPH; Apple Martine, JCPH; Dave Fortino, County Jail; Dunia Faulx, JHC; Gabbie Caudill, Believe in Recovery; JD Aldrich, OPHS; Jud Haynes, PTPD Navigator (for Mike Evans); Joe Nole, County Sheriff; Lisa Grundl, Health Facilities Planning & Development; Vicki Kirkpatrick, JCPH; John Nowak, Lori Fleming, and Bernadette Smyth, Grant Team.

Apologies: Brian Richardson, Dove House; Jim Walkowski, EJFR; Jolene Kron, BH-ASO; Matt Ready, JHC; Natalie Gray, DBH; Patrick Johnson, NAMI, Micah Knox, Faith-based member

Not in Attendance: Ford Kessler, Safe Haven; Greg Brotherton, County Commissioner; James Kennedy, County Prosecutor

Notes

Consortium and ad hoc members introduced themselves and were welcomed.

Data Update / Next Steps: Lisa Grundl of Health Facilities Planning and Development (HFPD) made a presentation on Treatment and Recovery Planning for the Consortium, which reviewed licensure options for crisis stabilization/triage, discussed reimbursement landscapes, and updated the group on data/ development of potential volume/average daily census.

While Lisa has collected a lot of information from the group, she hopes to have the remainder of the data needed collected by the November 6th retreat. Lisa met with the Department of Health (DOH), where one of her main questions to DOH was: How do these various licensing categories differ, specifically the crisis stabilization and triage categories? Answer: DOH doesn't really know. There's a lot of gray areas in the program-specific descriptions for crisis stabilization and triage. Lisa then followed up with the Health Care Authority (HCA), who indicated that they treat crisis stabilization and triage the same for reimbursement purposes.

- For all of the service types being considered by the Consortium —crisis stabilization, triage, substance use disorder, evaluation and treatment —the same two licenses are required:
  - A residential treatment facility license
  - A behavioral health agency license
- For each of the service types being considered, they all have to meet the inpatient mental health category within the behavioral health agency license as well.
- Meanwhile, everything is going to be changing.
  - Behavioral health licensing rules are opening up for review and revision by the DOH this spring, which will impact the behavioral health agency licensure requirements, which could be a great thing for this group to weigh in on during the licensing process (e.g., are there different needs in rural areas? Can some of these categories be combined?). This should take 9 months to a year.

- In 2020, Medicaid reimbursement will move to Integrated Managed Care (ICM), using negotiated contracts. Lisa and Jody are working to try to describe the parameters of this for the Consortium's next meeting.
- Licensing for BH facilities moved from WA State Department of Social and Health Services (DSHS) to the DOH in the last year, and DOH is experiencing a challenging learning curve with categories and requirements which are already not very clear.
- Lisa perceives, and is confirming that, while outpatient crisis services will still be paid by the Salish Behavioral Health Organization - Administrative Services (SBH-ASO or just BHO), the inpatient crisis services will fall into the Medicaid managed care plans.
- One rumor the BHC needs to keep an eye on is that under Integrated Managed Care the goal will be to keep as many voluntary services on an outpatient basis as possible. This will, in effect, downsize the number of things MCOs will reimburse for on the inpatient residential side, particularly in mental health.

- Responding to Vicki's question about what "close to home" will mean in the Governor's downsizing of state hospitals, Lisa said there was a lot we need to understand and respond to:
  - There are currently only five Intensive Inpatient Facilities planned for the state, and the plan is to get people out of state hospitals and closer to their support systems—but what does "close to home" mean when there are only five in the state? Is the plan to expand this to more facilities?
  - There is a question of whether the state will end up with a status quo—meaning, are we going to lose the same number of beds in the hospitals as we gain in the Intensive Inpatient Facilities, which won't address issues of facility space availability for local needs (i.e., is this new capacity or just a status quo?)
- Lisa outlined the high-level requirements for each type of treatment facility (Residential, BH Agency, Intensive Inpatient Mental Health) and the service requirements around staff, administration, licensing, construction review and design, etc. She suggested thinking broadly when designing a facility, to include as many options as possible, so that any future wish to change categories would not be restricted by the physical design.
- Distinctions on licensing:
  - There are a lot of things that can happen under the Behavioral Health Agency license, but once you get it, you can always add categories.
  - For all Inpatient Mental Health Patient Services (including all the categories under review by the Consoritum), the requirements get more specific around staffing and training, security (locked doors, line-of-sight supervision requirements, segregation of violent persons, etc.)

- Combining crisis stabilization and triage might be the best situation for this group, as it would allow a couple of options for both voluntary and involuntary patients (although still need more clarity on the difference):
  - Police could bring people right to a triage facility instead of to hospital, and patients could get both medical and behavioral health screening, and decisions could be made right there.
  - In this scenario we could even have on-call providers who could do medical screenings, but still really focus on that mental health assessment.
  - While there are slight differences in staffing between crisis stabilization and triage, these differences are perceived differently by DOH, the HCA and the BHO. It seems that, for example:
    - Triage requires a medical as well as a social/emotional screening, which implies issues around staffing.
    - For reimbursement, HCA sees crisis stabilization and triage as the same.

    -The BHO sees triage as more "involuntary" and crisis stabilization as voluntary (although in rules it seems clear can do both – although in crisis stabilization it is limited to a much shorter timeframe.
- Discussion with the DOH might address how much flexibility there is here. Slide 14 of the HFPD presentation provided a comparison of the requirements for Crisis Stabilization Unit and Triage Facility, including for involuntary v. voluntary patients.
- Lisa outlined the staffing, etc. requirements for Crisis Stabilization Units versus Triage Facilities, as presented in slide 15 of HFPD's presentation. While some of the requirements are similar, there are many differences in language and requirements for each facility. For example, one major difference is in the assessment timeframe.
  - Crisis Stabilization: Patients who are brought in *involuntarily* by police *to the crisis stabilization* unit have to be evaluated within three hours by a mental health professional.
  - Triage facility: *every* patient has to be evaluated within three hours, and every patient has to have a health screening.
- The assumption may be that, at the Triage facility, most people will be brought in involuntarily by police, which is not the assumption around the Crisis Stabilization unit. Involuntary patients in a Crisis Stabilization Center who convert to "voluntary" could stay longer. Also, certifying as both an Evaluation and/or Intensive Inpatient Facility could allow for longer term stays. When asked, Lisa commented that single bed certs could possibly happen in a Triage center – and noted there are several opportunities for the rules to be cleaned up by the DOH.
- Sheriff Joe Nole commented that, while he is totally sold on this being something that we need, we also need to consider what it would take—funding, reimbursement, staffing, etc.

- Vicki pointed out that, in her experience, these facilities are run by organizations already treating patients and that our facility would probably need to find a home in our medical provider community for mental health and substance use disorder like, for example, DBH, who are the current crisis response in the County.

- Vicki noted one of the questions we need to answer is simply: Will either or both of these licensure options (crisis stabilization or triage) serve our underlying goal, which is to divert people who are in crisis from the Emergency Department or the jail?
  - Lisa responded that one of the goals of the Triage option is that you're not sending them back to the jail—that you're finding a placement for them within 24 hours. With this option, you can do a lot of what the jail and hospital are doing right now in stabilizing patients. But recognizing that 24 hours may not be enough time to find placements, combining a Crisis Stabilization Unit with a Triage facility (or E&T or intensive inpatient) could allow more time/options to stabilize and find placements
  - Lisa is working with BHC members on data—addressing duplication, starting to better understand what the need is for both voluntary and involuntary—and attempting to get arms around reimbursement—and have another meeting set up with HCA and BHO.
- Lisa noted in Spring 2020, some capital dollars for five Intensive Inpatient Facilities, and also some funding for the 90 - 120 day civil commitment patients will become available, and asked if the BHC is interested in more information on this topic. Members indicated yes, once Lisa has met with the HCA and gotten more details.

November 6th BHC Retreat (Chimacum Fire Station, 1-5pm): John and Lori outlined some of the things that will be carried out at this half-day retreat in November.

- Lisa/Jody will give a presentation
- Lori/Berni/John will address upcoming HRSA deliverables:
- GAP Analysis / Needs/ Readiness Assessment, due Dec. 1. (See HRSA's Assessment Guidance)
- Strategic Plan, due Jan. 1. (See HRSA's Strategic Plan Guidance)
  - The Strategic Plan topic will be a high-level discussion—including topics like, do we want to try for Crisis Stabilization? Do we want to explore capital funding? Are we going to prop up Navigators?, etc.

GAP Analysis Draft: Berni described the context for this document and briefly went over the GAP Analysis Outcomes document, which includes all comments made or amended by people about the use and acceptance of the CDC's 10 Evidenced-Based Strategies for Preventing Opioid Overdose in Jefferson County. Some commonalities in member feedback below suggests an opportunity to provide targeted communication and education around the validity of the 10 strategies to facilitate understanding and support for their use in our community.

- members strongly understood and supported the strategy
- members perceived that their organizations understood and supported the strategy, but not as strongly as individual members did
- members' perception was that the community was less supportive or understanding of most of the strategies.
- The two exceptions of strategy awareness were Academic Detailing, which drew a lot of "no idea" comments, and Navigators, which members felt had support from everyone, including the community at large. Members also identified the scope and type of gaps and barriers they perceive existing in the various strategies.

MOU Update: MOU has been signed, submitted to HRSA, and emailed out to members. This HRSA grant deliverable is now complete.

Upcoming CHA Community Conversations: All members were given copies of a poster advertising the upcoming CHIP/CHA community conversations in November and December in Port Townsend, Port Hadlock, and Quilcene, and asked to post and distribute them. The poster will be forwarded as a PDF to members and the wider community. John outlined that the community conversations will consist of a high-level presentation of the data collected and what trends emerged, and how the Stakeholder group will use/used that data to adjust or amend CHIP health priorities. There will be a question and answer session at the end. The meetings are scheduled as follows:

Port Townsend: Cotton Building, 607 Water Street, Port Townsend
Wednesday, 20 November 2019. 1:00pm – 2:30 pm

Port Hadlock: Jefferson County Library, 620 Cedar Avenue, Port Hadlock
Thursday, 21 November 2019. 6:00 pm – 7:30 pm

Quilcene: Quilcene Community Center, 294952 US 101, Quilcene
Wednesday, 4 December 2019. 5:30 pm – 7:00 pm

Change of meeting time consideration: Members were asked to think about a suggestion to change the meeting time from 3:00pm to 4:00pm, in order to facilitate DBH attending, as Natalie currently attends the Washington Council for Behavior Health board meetings in Seattle until 2/2:30pm the same day as BHC meets each month.

CHIP Website: CHIP has a new website, which is currently being populated with information, including digital copies of all BHC meeting agendas and handouts. The web address is www.behealthyjefferson.com

Data group: While Lisa said she was happy to talk with anyone who had time, she had already been in touch with people individually. It was decided Lisa would continue to contact people individually.

Actions: HFPD to send the group a link to the DOH survey info, sent to providers and community members, that will be used to kic-off the DOH licensure process.

https://www.doh.wa.gov/LicensesPermitsandCertificates/FacilitiesNewReneworUpdate/BehavioralHealthAgencies

Next Meeting: Half Day Retreat, Wednesday, November 6th, 2019 1:00pm-5:00pm
Chimacum EJFR Firehouse Training Room, 9193 Rhody Drive, Chimacum