Implementation and Communication Plan

Washington Mental Health System Assessment

December 21, 2016

PCG Health

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1. Executive Summary

The Washington Office of Financial Management (OFM) contracted Public Consulting Group (PCG) to examine the structure and financing of the adult mental health system, as required by Engrossed Substitute Senate Bill 6656. This document, "Implementation and Communication Plan," represents the third and final deliverable for this assessment. The plan details the major action steps required to implement recommendations defined in the "Final Recommendations Report" as well as two additional recommendations proposed by the Jail Diversion Workgroup.

The report is divided into three major components, as outlined below.

- *Implementation Plan*: describes both the start-up tasks that are a precursor to effectively implementing the recommendations as well as the major action steps required to implement each recommendation.
- *Communication Plan*: identifies communication strategies in the messaging of implementation efforts and the stakeholders who will be impacted.
- *Project Management and Monitoring*: presents methods for overseeing and tracking implementation progress and identifying and addressing challenges as they arise.

Implementation Plan
The implementation plan provided in this report summarizes the major action items required to implement the proposed recommendations during the next three state fiscal years.

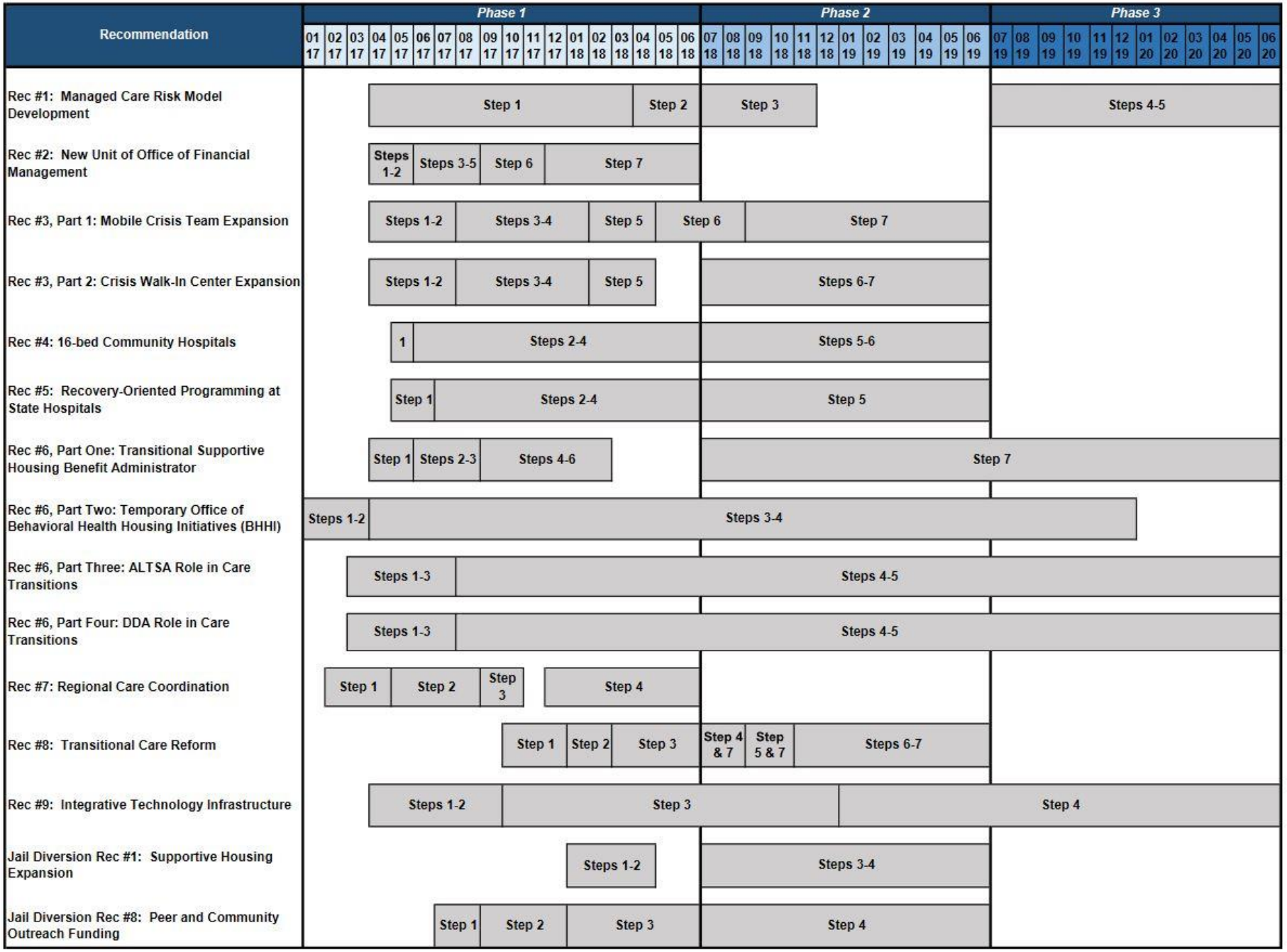
Phase One consists of start-up and planning efforts that should be executed between January 2017 and June 2017, followed by tasks to be completed within the next full fiscal year. Start-up tasks should be the responsibility of the Project Management Office (PMO) for the implementation.

While the majority of the implementation tasks in Phase One will commence after the start-up period ends, some activities may reasonably begin while start-up tasks are preceding. Scheduling early start dates for such activities helps stagger the implementation tasks across the 18-month period to reduce the month over month workload for responsible parties. Leadership on these individual projects should plan to meet regularly with the PMO to ensure alignment with the overall approach.

Implementation tasks in this phase are scheduled with the goal of completing the vast majority of planning activities within the next 18 months.

Phase Two implements the planning activities and decision points of Phase One. The majority of capital outlays estimated for this implementation in the 2017-19 budget will occur in this phase.

Phase Three focuses on operations, monitoring and evaluation activities. While the first wave of implementation will be complete by this time, tasks scheduled during this phase should inform the refinement of these new programs and services. The phased implementation of an integrative technology platform will also impact the evaluation process as new data analytics and data sharing capabilities create the opportunity for process improvements and other efficiencies. The following figure illustrates the overlap and timing of the major action steps by recommendation.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Communications Plan

Throughout the implementation process, effectively communicating ideas, progress, and changes to various stakeholders will be critical to success. General messaging should address why there is a need for change, what the proposed change entails, and how it impacts the system. Specific to Washington, this three-fold approach in messaging would include:

1) Description of the current state of the mental health system and challenges that impact access, delivery, and effectiveness of mental health services.
2) Description of specific changes to the system that directly addresses the current challenges.
3) Description of the future state and expected improvements that will be realized.

Appendix A of this report provides sample messaging for each of the three parts described above.

The stakeholder communication matrix below provides a structure to document stakeholder needs. This matrix will act as a living resource that will be updated and expanded as the project evolves. In the instances where more than one owner has been designated, communication may only be achieved through a fully collaborative effort among the identified parties.

Stakeholder Group	Communication Needs	Owner	Frequency	Communication Format
Governor's Office	**Receive** updates on progress, timelines, milestones, and any risks identified. **Provide** feedback on program direction, budget needs, and alignment with evolving state strategies.	OFM	Bi-monthly, and as needed	Scheduled Meetings
Behavioral Health Clients	**Receive** information on developments and changes in system redesign that impact care delivery. **Provide** input on service needs to inform definitions and program design.	DSHS, MCOs/BHOs, Providers	As needed	Public Website, Documents that may be distributed, and links.
Select Committee on Quality Improvement in State Hospitals	**Receive** updates on implementation efforts as they relate to State Hospital operations. **Provide** feedback on strategic direction and program design.	OFM	Monthly, and as needed in the interim	Scheduled Meetings
Behavioral Health Organizations	**Receive** information on pending changes in delivery system and responsibilities in providing services and care management impacting short term operations. **Provide** feedback on program design and feasibility of program requirements.	DSHS, HCA	Bi-weekly, and as needed	Workgroup Meetings, Emails
Managed Care Organizations	**Receive** information on pending changes in delivery system and responsibilities in providing services and care management impacting both short term and long term operations. **Provide** feedback on program design and feasibility of program requirements.	HCA	Bi-weekly, and interim meetings as needed	Workgroup Meetings, Emails

Stakeholder Group	Communication Needs	Owner	Frequency	Communication Format
Behavioral Health Providers	**Receive** information on changes in the delivery system and responsibilities in providing services at varying levels. **Provide** input to shape program design for new and expanded services, as well as feedback on proposed delivery changes and feasibility of new requirements.	DSHS, MCOs/BHOs	Monthly, and as needed in the interim	Workgroup Meetings, Emails
County Behavioral Health Departments	**Receive** information on changes in the delivery system expected at the state and county level. **Provide** input regarding the feasibility of county level changes and experience in service delivery that may inform program design.	DSHS, MCOs/BHOs	Monthly, and as needed in the interim	Meetings, Email

Project Management and Monitoring

The project management elements recommended in this report ensure that appropriate levels of communication, monitoring and management take place throughout the implementation process. Each element, described briefly below, represents an active process that should be maintained and regularly updated by the appointed project manager for the life of the project.

- Project Organization: includes the key personnel and artifacts that oversee the engagement to aid in providing the appropriate level of communication to all stakeholders. Complete understanding of objectives and directions as well as project progress are also communicated.
- Status Reports: provide additional tracking against the project plan using a simpler structure to clearly and quickly express progress as well as identify and distribute attention to any concerns, risks or required actions.
- Milestone Performance Chart: provides standards of measurement for milestones outline in the work plan. The standards are designed to help project team members maintain fidelity to the work plan dates and activities.
- Issue Escalation Chart: features the process and procedures used to address all identified and unidentified problems. The chart specifies responsible parties as well as the chain of escalation and measures to be implemented in the event of an issue.
- Schedule Management: provides a means of assessing, managing and reporting on interdependencies within the schedule. The schedule will be baselined to increase accountability among the project team members throughout implementation.

The long-term nature and large scope and scale of this implementation plan adds layers of complexity to the project. As such, PCG recommends designating a single entity for managing project responsibilities. The entity and OFM should work together to track progress towards the plan by identifying common implementation phases, completion criteria, affiliated milestones for project management and performance management.

2. Purpose and Structure

This document serves as a roadmap for Washington to advance recommendations proposed in PCG's "Final Recommendations Report" and other identified independent consultant reports. Although this document provides clear direction on specific steps the state should take to reform the behavioral health system, its objective is not to provide an exhaustive list of implementation and communication tasks. Intentionally, this design supplies state agencies and other stakeholders with a path and framework that can be modified and expanded to meet the evolving needs of stakeholders and address changes that may occur over the implementation time period.

The plan that follows is divided into three major components as outlined below. The Communication Plan and Project Management and Monitoring sections support successful completion of the Implementation Plan.

- *Implementation Plan*: details start-up tasks that are a precursor to effectively implementing recommendations and provides a high-level overview of the major steps and considerations necessary to implement each recommendation.
- *Communication Plan*: identifies communication strategies in the messaging of implementation efforts and the stakeholders who will be impacted.
- *Project Management and Monitoring*: presents methods for overseeing and tracking implementation progress and identifying and addressing challenges as they arise.

Structure

The plan is structured to account for the current environment and expected changes that impact Washington's behavioral health system. Most significantly, full integration of physical and behavioral health in the Medicaid program will occur by the year 2020. The recommendations included in the implementation plan address both short term and long term goals with the ultimate objective of supporting this transition. Accordingly, PCG designed the plan with a timeframe of January 2017 through June 2020. The plan is divided into three phases to provide direction that aligns with state fiscal years:

- Phase 1 spans from January 2017 to June 2018
- Phase 2 spans from July 2018 to June 2019
- Phase 3 spans from July 2019 to June 2020

Lastly, both the implementation and communication components in this document recognize the number of state agencies and other stakeholders that will be involved in and impacted by implementation efforts. The implementation plan clearly identifies the responsible groups to complete major tasks for each recommendation and the communication plan addresses communication expectations among various stakeholders.

3. Recommendations Implementation Plan

This section includes three components: (1) a start-up plan; (2) action steps for each recommendation; and (3) a comprehensive implementation matrix.

3.1. Start-Up Plan

The start-up plan defines tasks that should be executed in the first four months to establish a structure for identification and analysis of decision points that will drive implementation. The majority of the identified tasks are expected to be completed prior to taking steps towards implementation of the recommendations. This set of actions ensures that there is a structure in place to effectively guide implementation efforts and document and oversee progress.

The timeline for the start-up plan assumes efforts will commence at the start of calendar year 2017.

Task	Task Description	Start Date	End Date
Establish a governance structure.	A governance structure is required to gather key staff who will be responsible for ultimately steering and overseeing the project. The governance team may take the form of a Work Group or Steering Committee.	1/3/2017	1/13/2017
Hold kick off governance meeting.	The governance team will meet to identify roles, responsibilities, goals, and discuss the implementation strategy.	1/16/2017	1/27/2017
Develop governance charter.	The “governance charter” is a document that details the mission, purpose, and expectations of the governance team.	1/16/2017	2/3/2017
Identify project management process.	The implementation requires project management for performance, schedule, risk, issue and scope, quality, and communications management. Further details are provided in Section 5 of this report.	1/27/2017	2/3/2017
Create initial implementation work plan.	An initial detailed work plan should be developed to layout clear implementation tasks and timelines.	2/6/2017	3/3/2017
Create project monitoring process.	A reporting and status update process should be developed so expectations of responsible parties are clear and to track overall project progress.	3/17/2017	3/31/2017
Identify all stakeholders.	Identify all stakeholders who will be involved in implementation efforts, particularly those who will be responsible for executing any implementation tasks. This list includes different state agencies, behavioral health organizations, and managed care organizations.	2/6/2017	3/3/2017
Hold stakeholder meetings.	Stakeholder meetings will provide a forum to gather input on the implementation work plan that will further define and detail tasks for each recommendation.	3/3/2017	3/17/2017
Confirm consensus on implementation work plan.	Finalize a work plan that provides schedule and accountability for all tasks.	3/17/2017	3/31/2017

3.2. Recommendation Action Steps

Once the start-up structure has been established, the State may begin implementation of the action steps described below. For each recommendation, a summary table provides a high level view of the major action steps as well as the project phase in which the step will be executed. Below the summary table, each action step is expanded to include additional details and considerations to support planning.

Recommendation #1: Require the Director of the Health Care Authority to submit a state psychiatric hospital managed care risk model to the Governor and Legislature by December 31, 2017 to support putting Medicaid managed care organizations (MCOs) at risk for this benefit effective January 1, 2020.

Action Steps	Phase 1	Phase 2	Phase 3	Responsible Parties
1. Develop blue print for MCO risk model.	X			HCA with DSHS review
2. Submit to Governor and Legislature for review.		X		Governor, Legislature
3. Develop revised language for MCO contracts.		X		HCA, MCOs
4. MCOs assume risk for state psychiatric hospital utilization.			X	MCOs

Action Step #1: Develop blue print for MCO risk model, to address the following key decision points:

- Will the risk model apply equally to forensic and civil patients?
- If forensics are not included, would "forensic flip" cases also be exempt?
- Will state psychiatric hospitals be legally required to contract with MCOs?
- Would these contracts be wholly distinct from the state's contracts with the same plans to provide Medicaid managed care?
- How can a commercial entity appropriately engage in care decisions that are interrelated with the legal components of a civil commitment?
- How can the MCOs exercise clinical decision making when an individual is ready to be discharged from a state hospital?
- What performance metrics are envisioned for the MCOs related to this benefit within the Medicaid managed care contracts?
- May MCOs impose performance benchmarks on the hospitals as conditions of their contracts, and, if so, would collective bargaining agreements be impacted?
- What contracting process should the MCOs use with community hospitals?

Action Step #2: Submit to Governor and Legislature for review.

- Provide briefing of key changes and expected outcomes, including the process and reasoning behind recommended changes.
- Discuss major impacts and document feedback.
- Revise blue print accordingly.

Action Step #3: Develop revised language for MCO contracts to address the following requirements:

- An actuarially-sound capitation rate analysis should identify the amount of funds to be added to the capitation rate to cover the cost of the inpatient utilization.
- Capitation rates may require further adjustment based on policy and financial discussions among state agencies and the MCOs.
- Language to implement the relative responsibilities of the MCOs and state hospitals should be discussed and understood by all parties.
- The state and the MCOs will need to analyze whether a bed allocation methodology is still necessary.

Action Step #4: MCOs assume risk for state psychiatric hospital utilization. During this phase, MCOs will:

- Implement risk mitigation strategies to manage inpatient utilization, e.g. hire more case management staff, establish court or hospital liaison positions etc.
- Implement policies and procedures to coordinate with civil commitment procedures.
- Implement clinical arrangements with state and community hospitals.
- Establish performance measures and initiate data collection.

Recommendation #2: Establish a new unit within the Office of Financial Management (OFM) that integrates and coordinates fiscal analysis of all behavioral health services across agencies and units of government.

Action Steps	Phase 1	Phase 2	Phase 3	Responsible Parties
1. Examine state regulations impacting new unit of state government.	X			OFM
2. Define job descriptions for staff.	X			OFM, DSHS, HCA
3. Define salary and benefit bands for employees.	X			OFM
4. Define reporting relationships for staff.	X			OFM, DSHS, HCA
5. Define the major deliverables for the OFM unit.	X			OFM
6. Hire new employees.	X			OFM
7. Implement the plan for the 2017-2019 Biennial Budget Cycle.	X			OFM

Action Step #1: Examine state regulations impacting new unit of state government.

- OFM will need to review existing state regulations and procedures for starting a new unit within an agency. Areas of review may include human resource regulations, funding authority, office space planning, and cost allocation considerations.

Action Step #2: Define job descriptions for staff.

- Up to two (2) FTEs of additional analyst support - A preferred job description would include 1+ years of Washington budget, DSHS, HCA, or other state agency experience. An ideal candidate would

understand the county system of behavioral health funding. The position would require an undergraduate degree, and general proficiency with state agencies and budget process.

Action Step #3: Define salary and benefit bands for employees

- Salaries may vary depending on whether a position is non-represented or union represented. OFM will need to work with human resources to determine whether new positions would be represented and define salary levels.

Action Step #4: Define reporting relationships for staff, both internally and externally.

- Define relationships that support connections with key agency stakeholders in HCA, DSHS and other agencies as well as coordination with current OFM budget staff assigned to HCA and DSHS.
- Develop a policy and procedure manual for reporting and data sharing within OFM and outside OFM. The manual will leverage existing OFM procedures for budget preparation and monitoring.

Action Step #5: Define the major deliverables for the OFM unit.

- The major deliverable will be 2017-2019 Biennial Budget Cycle for the unit. Additional deliverables will support ongoing monitoring and technical assistance with the agencies and OFM.

Action Step #6: Hire the new employees.

- OFM will need to aggressively recruit for the new positions within the agency immediately after funding has been established.

Action Step #7: Implement plan for the 2017-2019 Biennial Budget Cycle.

- The Office of Financial Management (OFM) coordinates the submission of agency budget requests and prepares the Governor's budget recommendation to the Legislature. This team will work closely with OFM and state agency staff to explain and justify planned expenditures.

Recommendation #3: Enhance community support by strengthening acute episode management and community services to reduce admissions to state psychiatric hospitals. Specifically, this recommendation will be accomplished by funding 1) three new mobile crisis teams and 2) two new crisis walk in centers.

Subpart One: Fund three new mobile crisis teams

Action Steps	Phase 1	Phase 2	Phase 3	Responsible Parties
1. Establish strategic planning and implementation committee to collaborate on development and operation of mobile crisis teams.	X			DSHS, HCA, BHO/MCOs
2. Establish and execute plan to conduct regional stakeholder outreach to determine needs and priorities.	X			Multi-agency committee
3. Confirm scope of services the mobile crisis team would provide and associated definitions.	X			Multi-agency committee
4. Confirm workforce requirements for the mobile crisis teams.	X			Multi-agency committee
5. Develop a detailed plan for mobile crisis team implementation.	X			Multi-agency committee
6. Develop performance measure and track performance.		X		Multi-agency committee

Action Step #1: Establish a strategic planning and implementation committee consisting of DSHS, HCA, and BHO/MCO staff to collaborate on the development and operation of additional mobile crisis teams.

- Identify individuals whose participation is deemed critical to successful implementation, including those with access to the necessary information and resources to drive these efforts forward.
- Discuss the roles and responsibilities of the committee and outline desired time frames for implementation of key features associated with the initiative.
- Identify other stakeholders with whom the committee will likely need to coordinate.

Action Step #2: Establish and execute a plan and process for conducting regional stakeholder outreach to determine needs and priorities.

- Identify key stakeholders in target regions and begin conducting outreach to gauge interest and concerns and better understand the regional landscape.
- Conduct data analysis on demographics, hospital utilization and mental health prevalence in different regions to define areas of need that mobile crisis teams may address.
- In collecting stakeholder input and performing data analysis, select the regions where mobile crisis teams will be added.

Action Step #3: Confirm scope of services the mobile crisis team would provide and associated service definitions.

- Review established mobile crisis team programs in the state and peer states to identify proven best practices and lessons learned.
- Analyze the specific needs in the regions where the additional mobile crisis teams will be added.

- Define services to be provided by mobile crisis teams, including expected scope and duration as well as processes for referring individuals to other services and coordinating with the individual's health home as applicable.

Action Step #4: Confirm workforce requirements for the mobile crisis teams.

- Determine types of positions, experience, qualifications and the number of staff for each team.
    - Note that inclusion of peer specialists in crisis teams has been identified as a best practice for mobile crisis services.
- Define job descriptions and additional training requirements.

Action Step #5: Develop a detailed plan and timeline for the establishment of the mobile crisis teams.

- Based on the outcomes of the above action steps, develop a formal plan for how, where and when to employ crisis mobile teams.
    - This initiative is expected to be implemented in a shorter time frame as there are no capital costs. However, to the extent that the final staffing model uses peer specialists, recruitment may delay implementation. Efforts underway in the state to streamline peer training requirements and support workforce development should be addressed within the operations plan.
    - Barring the above dependencies, an estimate of six to nine months is expected to plan for and prepare mobile crisis teams to serve in the community.

Action Step #6: Develop performance monitoring measures to gauge the effectiveness of mobile crisis teams in diverting patients from inpatient hospitalization or jail.

- Require mobile crisis teams to report on measures including, but not limited to:
    - the number of individuals assisted
    - demographics of individuals assisted
    - outcome of incidents (hospitalization, jail)
    - average number of contacts with individuals
    - correlated reduction in inpatient hospital utilization
    - individual experience of care
- Survey health home providers, criminal justice entities and hospital administrators to collect qualitative feedback on mobile crisis efficacy.
- Refine the geography and/or approach of the teams as needed based on data from performance monitoring reports.

Subpart Two: Fund two new crisis walk in centers.

Action Steps	Phase 1	Phase 2	Phase 3	Responsible Parties
1. Establish a strategic planning and implementation committee consisting of DSHS, HCA, and BHO/MCO staff to collaborate on the development and operation of additional mobile crisis teams	X			DSHS, HCA, BHO/MCOs
2. Establish and execute a plan and process for conducting regional stakeholder outreach to determine needs and priorities	X			Multi-agency committee
3. Develop a detailed analysis of current and projected future need short term stay crisis beds and related services	X			Multi-agency committee
4. Confirm scope of services the crisis walk in center will provide to individuals.	X			Multi-agency committee
5. Confirm workforce requirements for the crisis walk in centers.	X			Multi-agency committee
6. Develop a detailed plan and timeline for the establishment of crisis walk in centers.		X		Multi-agency committee

Action Step #1: Establish a strategic planning and implementation committee consisting of DSHS, HCA, and BHO/MCO staff to collaborate on the development and operation of crisis walk in centers.

- Identify individuals whose participation is deemed critical to successful implementation, including those with access to the necessary information and resources to drive these efforts forward.
- Discuss the roles and responsibilities of the committee and outline desired time frames for implementation of key features associated with the initiative.
- Identify other stakeholders with whom the committee will likely need to coordinate with moving forward.
- Importantly, the development of walk-in crisis centers must be coordinated with the mobile crisis process described above to eliminate unnecessary duplication of services and effectively monitor program outcomes.

Action Step #2: Establish and execute a plan and process for conducting regional stakeholder outreach to determine needs and priorities.

- Identify key stakeholders in target regions and begin conducting outreach to gauge interest and concerns and better understand the regional landscape.

Action Step #3: Develop a detailed analysis of current and projected future need short term stay crisis beds and related services. The following elements are appropriate for inclusion in the analysis:

- Current and historic patient census data including diagnoses, demographics, treatments and medications and length of stay
- Prevalence data for serious mental illness and substance use disorder, delineated by region

- Community needs assessments created by facilities in identified regions to better understand community demographics, available resources and identified needs.
- Other available information about regional and statewide population demographics, prevalence rates, health needs and other considerations to help direct the planning related to facility design and offerings
- Select the regions where crisis walk in centers will be established using data collected. Selection must consider the location and experience of similar programs currently operating in the state.

Action Step #4: Confirm the scope of services the crisis walk in center will provide to individuals and associated service definitions.

- Review experience of similar, stationary crisis centers in Washington and other states that have deployed successful models.
    - Services in such centers generally include crisis stabilization and intervention, individual counseling, peer support, medication management, education, and referral assistance.
    - Other states with crisis walk-in centers include Colorado, Michigan, Wisconsin, and Tennessee. States vary in the hours of operations of the centers as some are 24 hours, seven days a week and others operate during standard business hours.
- Define scope and duration of services, expected availability, and processes to support patient navigation and escalation protocols.

Action Step #5: Determine the workforce requirements for the crisis walk in centers.

- Based on expected utilization and service definitions, define staffing requirements, FTE counts, qualifications, and experience.
- Define additional training and ongoing professional development requirements.
- Define administrative and facilities operation positions and FTE counts.
- Develop job descriptions and recruitment strategies.

Action Step #6: Develop a detailed plan and timeline for the establishment of crisis walk in centers.

- Based on the outcomes of the above action steps, develop the formal plan for development and operation of walk-in crisis centers.
    - Consider the time needed to procure a contractor to build the facilities and the goal of having crisis walk-in centers operational in state fiscal year 2020.
- Identify a plan and process for gauging utilization, quality of care and other trends throughout the development process to incorporate lessons learned in real time and enable necessary course corrections or strategic updates as appropriate.

Recommendation #4: Establish six new 16-bed community hospitals for civil commitments and transitional acute psychiatric care needs to promote regional care and the potential for an emphasis in specialty care for co-morbid conditions. These conditions may include developmental disabilities, dementia and certain categories of co-occurring substance use disorders.

Action Steps	Phase 1	Phase 2	Phase 3	Responsible Parties
1. Establish a strategic planning and implementation committee consisting of DSHS and HCA staff, hospital administrators and BHO/MCO staff to coordinate efforts related to the development of the new facilities.	X			DSHS, HCA, BHO/MCOs
2. Engage with the Centers for Medicare and Medicaid Services to discuss licensing and reimbursement considerations relative to the new facilities.	X	X		DSHS
3. Establish and execute a plan and process for conducting regional stakeholder outreach to determine needs and priorities.	X	X		Multi-agency committee
4. Develop a detailed analysis of current and projected future need for psychiatric beds including unmet need.	X			Multi-agency committee
5. Conduct regional assessments of existing facilities to determine potential locations for new or renovated hospitals.		X		Multi-agency committee
6. Develop a detailed plan and timeline for the establishment of the new 16-bed facilities and commence construction and development.		X		DSHS

Action Step #1: Establish a strategic planning and implementation committee consisting of DSHS and HCA staff, hospital administrators and BHO/MCO staff to coordinate efforts related to the development of the new facilities.

- Identify individuals whose participation is deemed critical to successful implementation, including those with access to the necessary information and resources to drive these efforts forward.
- Discuss the roles and responsibilities of the committee and outline desired time frames for implementation of key features associated with the initiative.
- Identify other stakeholders with whom the committee will likely need to coordinate moving forward. This may include stakeholders from peer states including those (such as Minnesota) where similar efforts have been undertaken in recent years.

Action Step #2: Engage with the Centers for Medicare and Medicaid Services to discuss licensing and reimbursement considerations relative to the new facilities.

- Early engagement with CMS will help to identify critical considerations that may help or hinder the efficiency and overall success of the initiative.

- Because funding and reimbursement considerations are a vital component of these efforts, pertinent requirements and expectations should be clarified and considered as soon as possible.

Action Step #3: Establish and execute a plan and process for conducting regional stakeholder outreach to determine needs and priorities.

- Identify key stakeholders in target regions and begin conducting outreach to gauge interest and concerns and better understand the regional landscape.
- Schedule one-on-one interviews followed by larger public stakeholder sessions to solicit broad feedback on the design and implementation of the initiative.

Action Step #4: Develop a detailed analysis of current and projected future need for psychiatric beds including unmet need. The following elements are appropriate for inclusion in the analysis:

- Current and historic patient census data including diagnoses, demographics, treatments and medications and length of stay
- Prevalence data for Serious Mental Illness and Substance Use Disorder, broken out by region
- Community needs assessments created by facilities in identified regions to better understand community demographics, available resources and identified needs
- Other available information about regional and statewide population demographics, prevalence rates, health needs and other considerations to help direct the planning related to facility design and offerings

Action Step #5: Conduct regional assessments of existing facilities to determine potential locations for new or renovated hospitals.

- Using information provided by state or regional stakeholders, licensing departments, hospital associations or other sources, identify facilities and/or sites that may be appropriate for use or re-use as a psychiatric hospital facility.
- Develop criteria to assess the feasibility and pros/cons of developing specific sites.
- Based on the results of assessments conducted according to the established criteria, identify facilities for more extensive feasibility, cost and construction analyses and generate detailed studies for each potential site, leveraging work completed previously to the extent possible.

Action Step #6: Develop a detailed plan and timeline for the establishment of the new 16-bed facilities and commence construction and development.

- Based on the outcomes of other action steps, develop the formal plan for how, where and when to establish the new facilities.
- Stage development to support controlled implementation.
- Identify a plan and process for gauging utilization quality of care and other trends throughout the development process to incorporate lessons learned in real time and enable necessary course corrections or strategic updates as appropriate.

Recommendation #5: Reform state hospital programming to include substance use disorder (SUD) integration and peer support

Action Steps	Phase 1	Phase 2	Phase 3	Responsible Parties
1. Review hospital residents to identify individuals with SUD treatment needs	X			State Hospitals and DSHS
2. Create plan to implement substance abuse treatment programs within the hospitals	X			State Hospitals and DSHS
3. Develop plan to continue treatment in the community	X			State Hospitals, DSHS, BHOs/MCOs
4. Implement SUD Integration Plan	X	X	X	State Hospitals and DSHS
5. Hire Peer Counselors	X			DSHS, contracted providers

Action Step #1: Review hospital residents to identify individuals with SUD treatment needs.

- Conduct records review to determine scope and prevalence of documented comorbid SUD conditions.
- Interview hospital residents to understand potential level of undocumented need among current residents.

Action Step #2: Create an SUD program integration plan. The plan should include the following considerations:

- Best practices for program integration in an inpatient setting, delineated by comorbid behavioral health conditions
- Existing staff qualifications and gaps to be filled by SUD integration specialists
- Staff training needs and new staff recruitment planning
- Processes to standardize SUD treatment needs identification at intake
- Role of peer specialists and recruitment strategies
- Non-staff resources required to implement treatment programs
- Monitoring and performance measurement plan

Action Step #3: Develop plan to expand availability of SUD integrated treatment in community settings.

- Initiate collaborative process among state hospitals, DSHS, BHOs/MCOs and community providers to develop strategic plan.
- Identify best practices for integrated treatment, including care transition and follow-up protocols.
- Estimate funding requirements and potential sources.
- Secure funding and begin program implementation.

Action Step #4: Implement Plan

- Complete staff onboarding and training.

- Phase in program integration by unit and patient population.
- Document and aggregate treatment data for analysis.
- Monitor treatment outcomes and evaluate program success.

Action Step #5: Hire Peer Counselors

- Identify the current number of peer specialists and scope of services provided on an inpatient basis.
- Define gaps in services provided and optimum caseload to be achieved.
- Hire additional peer specialist FTEs according to identified need.

Recommendation #6 Align community mental health placements with identified civil placement discharge needs by 1) Establishing a transitional, statewide supportive housing benefit administrator; and 2) Creating a temporary Office of Behavioral Health Housing Initiatives, charged with facilitating the collaboration of capacity building investment pools; and 3) Establishing expanded responsibility for selected state hospital transitions and management practices to ALTSA and DDA. This recommendation has four subparts:

Subpart One: Establish a transitional, statewide supportive housing benefit administrator

Action Steps	Phase 1	Phase 2	Phase 3	Responsible Parties
1. Conduct meetings to establish business requirements for a supportive housing benefit administrator.	X			DSHS, HCA
2. Consult with CMS to determine if supporting housing benefit administrator is consistent with Special Terms and Conditions of the Transformation 1115 Waiver and to secure CMS approval.	X			Governor, Legislature
3. Issue Request for Information (RFI) to identify potential supportive housing vendors and how they would approach administering the benefit.	X			HCA,
4. Draft contract.	X			HCA
5. Issue Request for Proposals (RFP) to obtain bids and work plans of potential vendors.	X			HCA and DSHS
6. Select vendor.	X			HCA and DSHS
7. Monitor vendor progress and associated performance measures.	X	X	X	HCA and DSHS

Action Step #1: Conduct series of meetings to establish the business requirements for a supportive housing benefit administrator.

- Agencies assign staff to attend meetings.
- First draft of business requirements assigned to key staff for development.
- Larger staff group reviews business requirements and finalizes them.

Action Step #2: Consult with CMS to determine if the business requirements for the supportive housing benefit administrator are consistent with the Special Terms and Conditions of the 1115 waiver and to secure CMS approval.

- Share concept paper outlining Supportive Housing Benefit Administrator proposal with CMS.
- Schedule call to review and discuss parameters.
- Determine framework for approval (STC amendment, email approval, etc.).

Action Step #3: Issue RFI to identify potential supportive housing vendors and how they would approach administering the benefit.

- Draft and release RFI.
- Gather responses and synthesize information provided.

Action Step #4: HCA to draft contract

- Use information collected through RFI process to inform contract draft.
- Assign staff to author specific sections.
- Share draft with key stakeholders for feedback, including CMS.

Action Step #5: Issue RFP to obtain bids and work plans of potential vendors.

- Draft RFP based on above contract requirements and RFI data.
- Assign staff to author specific sections.
- Share draft with key stakeholders for feedback, including CMS.

Action Step #6: Select housing vendor.

- Develop proposal evaluation plan and select evaluation committee.
- Provide training to evaluation committee members on requirements and keys to success.
- Select vendor and issue intent to award.

Action Step #7: Monitor vendor progress against deliverables and key performance metrics.

- HCA assigns staff to perform contract compliance.
- Contractor aids state in establishing licensing requirements for types of housing assistance providers.
- Contractor recruits providers to establish an adequate network.
- Work of housing support vendor is evaluated by agency staff.

Subpart Two: Create a temporary Office of Behavioral Health Housing Initiatives, charged with facilitating the collaboration of capacity building investment pools.

Action Steps	Phase 1	Phase 2	Phase 3	Responsible Parties
1. Assign existing agency staff to support BHHI within the scope of their existing job duties	X			HCA and DSHS
2. Map identified need for state psychiatric hospital discharge residential placements against existing facility types	X			BHHI Staff
3. Create and maintain a statewide inventory of community beds by bed type	X			BHHI Staff
4. Prepare White Paper identifying current and planned state and local behavioral health housing initiatives. Include analysis suggesting coordination	X	X	X	BHHI Staff

Action Step #1: Assign existing agency staff to support BHHI within the scope of their existing job duties.

- Define staff roles, responsibilities and reporting structure.
- Establish BHHI mission.
- Define tenure of office for each position.

Action Step #2: Map identified need for state psychiatric hospital discharge residential placements against existing facility types.

- Gather data from state and local agencies to map identified need, such as demographics, condition prevalence and populations identified as requiring activities of daily living supports.
- Gather data from state and local agencies necessary to map existing facility types, such as populations currently served, proportion of beds available to publicly funded patients and existing care transition support and specialty programming within each facility.
- Overlay needs and existing resources to identify gaps.

Action Step #3: Create and maintain a statewide inventory of community beds by bed type

- Gather baseline information from state and local sources.
- Develop process to collect and update bed inventory allowing for multiple users and controlled entry. The inventory should be housed in a dynamic, electronic database that allows for regular updates with degrees of automation.
- Create data visualization tools and methods for users to access information.

Action Step #4: Prepare white paper identifying current and planned state and local behavioral health housing initiatives and include analysis that suggests coordination among initiatives.

- Gather information from state and local sources.
- Complete initial draft of paper.
- Circulate to stakeholders to assure accuracy of information.

Subpart Three: Establish expanded responsibility for selected state hospital transitions and management practices to ALTSA.

Action Steps	Phase 1	Phase 2	Phase 3	Responsible Parties
1. Identify possible ALTSA responsibilities and coordination needed from state hospital staff	X			ALTSA, state hospital staff
2. Establish policies and procedures identifying the scope of its new responsibilities	X			ALTSA
3. Prepare implementation plan.	X			ALTSA, state hospital staff
4. Assess individuals and contributes to care management plan.	X			ALTSA
5. Implement transition plan for each individual	X	X	X	ALTSA and community providers

Action Step #1: Identify possible ALTSA responsibilities and the coordination needed from state hospital staff.

- Assign ALTSA staff to participate in initiative.
- Set goals and objectives for the increased responsibilities for ALTSA.
- Draft framework for operational coordination among ALTSA and state hospital staff.

Action Step #2: Establish policies and procedures identifying the scope of its new responsibilities including:

- How ALTSA will systematically identify individuals in need
- Projections of the number of individuals to be impacted by change
- Augmentation of case management and other staff required
- Level of effort required of hospitals and other agencies to work with patients before the hospital staff deems them ready for discharge
- Budgetary impacts and cost effectiveness expectations and metrics

Action Step #3: Prepare implementation plan.

- Identify staff or contractors with specific implementation roles.
- Map new responsibilities into overall client care management plan.
- Communicate new responsibilities to external stakeholders.

Action Step #4: Assess individuals and contribute to care management plan.

- Establish protocol for assessments.
- Establish protocol for integration with larger care management plan.
- Create procedures for ongoing role in client care management.

Action Step #5: Implement transition plan for each individual.

- Create transition plan template.
- Establish procedures for use of template.
- Establish protocol for housing information and sharing with care managers.

Subpart Four: Establish expanded responsibility for selected state hospital transitions and management practices to DDA.

Action Steps	Phase 1	Phase 2	Phase 3	Responsible Parties
1. Identify possible DDA responsibilities and coordination needed from state hospital staff.	X			DDA and state hospital staff
2. Establish policies and procedures identifying the scope of its new responsibilities.	X			DDA
3. Develop procedures to transfer ID/DD individuals with prolonged stays out of hospital.	X			
4. Prepare transition plans in conjunction with families and relevant others.	X	X	X	DDA
5. Monitor placement of individuals in the community to track readmissions and remedies for readmissions.	X	X	X	DDA and community providers

Action Step #1: Identify possible DDA responsibilities and the coordination needed from state hospital staff

- Assign DDA staff to initiative.
- Set goals and objectives for the increased responsibilities of DDA.
- Draft framework for coordination with state hospital staff.

Action Step #2: Establish policies and procedures identifying the scope of new responsibilities including:

- Projection of number of ID/DD individuals to be impacted
- Root cause analysis for ID/DD individuals with outlier lengths of stay at state hospitals
- Augmentation of case management and other staff required
- Level of effort required from hospitals and other agencies
- Funding required for DDA to develop additional community placements
- Budgetary impacts and cost effectiveness expectations and metrics

Action Step #3: Develop procedures to transfer ID/DD individuals with prolonged stays out of hospital

- Identify staff or contractors responsible for operations.
- Map new responsibilities into overall client care management plan.
- Communicate new responsibilities to external stakeholders.

Action Step #4: Prepare transition plan for patients in conjunction with their families and caregivers.

- Create transition plan template.
- Establish procedures for use of template.
- Establish protocol for housing information and sharing with care managers.

Action Step #5: Monitor placement of individuals in the community to track readmissions and remedies for readmissions.

- Identify staff responsible for tracking and data analysis.
- Establish database for tracking information.
- Create data visualization tools and user interfaces.

Recommendation #7: Develop regional care coordination models to follow rising and high risk patients throughout the care continuum, including those with significant mental health and substance use disorder needs.

Action Steps	Phase 1	Phase 2	Phase 3	Responsible Parties
1. Conduct "As Is" assessment of their current transition management system.	X			DSHS, HCA
2. Design "To Be" regional care coordination model.	X			DSHS, HCA, BHOs/MCOs
3. Update BHO contract language to require more robust care coordination and case management for high risk patients.	X			DSHS
4. Implement coordinated management program.	X			BHOs

Action Step #1: Conduct "As Is" assessment of current transition management system to address the following key considerations:

- Process for identifying available providers across continuum of care
- Data systems currently in place to facilitate secure sharing of client information
- Current care and case management practices, protocols, and populations impacted across care providers and agencies
- Inclusion of SUD treatment and integrated SUD practices in current care coordination systems
- Size and credentials of current care and case management workforce

Action Step #2: Design "To Be" regional care coordination model, including the following considerations:

- What is the appropriate stratification methodology to determine level of intensity?
- What processes or technologies should be implemented to improve data sharing?
- What policies and procedures must be implemented to unify care coordination efforts across various entities?
- What processes can be implemented to augment inclusion of SUD treatment?
- What are the workforce requirements for the new program? How will new staff be recruited?

Action Step #3: Update BHO contract language to require more robust care coordination and case management for high risk patients to include, at minimum, the following elements:

- Populations served and processes for determining level of intensity
- Client assessment requirements
- Scope, frequency and duration expectations for each level of intensity

- Data analytics and client tracking
- Potential impacts to capitation rates and administrative expense
- Performance metrics and evaluation processes

Action Step #4: Implement coordinated management program.

- Maintain active workgroup to monitor success of BHO program and ongoing alignment with other programs in the state, including initiatives resulting from the 1115 transformation waiver.
- Based on results, develop plan for expansion to coordinate with full managed care integration.

Recommendation #8: Invest in transitional care reform initiatives to add step-up, step-down and HARPS resources. Specifically, add two new, 10-bed step down facilities in Western Washington and one new 10-bed step down facility in Eastern Washington.

Action Steps	Phase 1	Phase 2	Phase 3	Responsible Parties
1. Analyze discharge wait list for services required by those needing long term care housing on discharge.	X			
2. Review funding structure for building ESF facilities in Vancouver and Spokane and determine required changes (if any).	X			
3. Determine exact services to be provided at new facilities, based on current and future patient needs.	X			
4. Update voluntarily commitment process.	X	X		
5. Create "warn hand off" process for those leaving facilities.		X		
6. Create process and plan for increasing number of HARPS teams.		X		
7. Develop a detailed plan and timeline for the establishment of the new facilities and commence construction and development.		X		

Action Step #1: Analyze discharge wait list for services required by those needing long term care housing post discharge, including:

- Scope and level of intensity of services needed
- Populations impacted
- Gaps between services currently offered at Spokane and Vancouver facilities and those required by individuals on the discharge wait list

Action Step #2: Review funding structure for ESF facilities in Spokane and Vancouver and determine required changes (if any).

- This review should address the following key questions:
    - How did the state fund the construction of the Spokane and Vancouver facilities?

  - Is a similar process feasible for new construction?
  - Are funds available or will they require a budget request from the legislature?

Action Step #3: Determine scope of services to be provided at new facilities and associated definitions.

- Review experience of similar, existing facilities in Washington and other states that have deployed successful models.
- Define scope and duration of services, expected availability, and processes to support patient navigation and escalation protocols.

Action Step #4: Update voluntary commitment process.

- Define process for accepting a voluntary commitment, including the factors for determining if an individual is accepted for treatment.
- Develop and submit policy briefing to the Governor and legislature.

Action Step #5: Create "warn hand off" process for transitions out of facilities.

- Define transfer and follow-up protocols, including frequency and communication channels to be leveraged.
- Define network of providers with success in accepting step-down patients.
- Include providers in planning process to ensure process feasibility.

Action Step #6: Create process and plan for increasing number of Housing and Recovery through Peer Services (HARPS) teams

- Identify gaps among current HARPS teams and client service needs.
- Map regions experiencing gaps.
- Design plan to augment service availability and utilization and estimate program costs.
- Implement plan.

Action Step #7: Develop a detailed plan and timeline for the establishment of the new facilities and commence construction and development.

- Based on the outcomes of other action steps, develop the formal plan for how, where and when to establish the new facilities.
- Stage development to support controlled implementation.
- Commence construction and development.

Recommendation #9: Create an integrative technology infrastructure to support behavioral health service delivery.

Action Steps	Phase 1	Phase 2	Phase 3	Responsible Parties
1. Visit states that use agency linking software platforms.	X			DSHS, HCA
2. Identify vendors to provide demonstrations of potential agency linking software solutions	X			HCA, DSHS and OCIO
3. Procure technology vendor.	X	X		Governor, Legislature HCA, DSHS and OCIO
4. Phase in platform over three years.		X	X	HCA, DSHS and OCIO

Action Step #1: Visit states that use agency linking software platforms.

- Identify and reach out to states that have experienced success in operating similar platforms.
    - Suggested states are Minnesota and Maryland.
- Arrange for onsite observation of system operations as well as a debrief with appropriate state staff to document lessons learned.

Action Step #2: Identify vendors to provide demonstrations of potential agency linking software solutions.

- Issue Request for Qualifications to identify potential companies and their technology capabilities.
- Identify three to four vendors to provide demonstrations of potential solutions to agency staff.
- Document best practices and potential requirements.

Action Step #3: Procure technology vendor.

- Discuss with CMS, SAMHSA and Office of National Coordinator (ONC) ways the new system could be underwritten with federal funds
- Based on information collected in previous steps, draft RFP for technology vendor.
- Issue RFP to select a contractor capable of creating a system that integrates state and county agencies, MCOs, and behavioral health providers.
- Select vendor.

Action Step #4: Phase in technology over three-year period.

- Integration platforms are typically implanted in modules, bringing in sets of agencies in phases.
- All agencies to be added to the system are identified and a phase in schedule is established.
- Each agency works with vendor to identify records to be captured and staff to be trained.

Jail Diversion Recommendation #1: Increase the availability of low- and no-barrier, supportive housing for people with a criminal history, substance use disorder, and/or mental illness.

Action Steps	Phase 1	Phase 2	Phase 3	Responsible Parties
1. Establish stakeholder group to oversee implementation of recommendation since implementation spans multiple agencies.	X			DOC and DSHS
2. Prepare plan to implement recommendation.	X			Stakeholder group
3. Secure Funding.	X	X		DOC and DSHS
4. Implement housing program.		X		DOC and DSHS

Action Step #1: Establish stakeholder group to oversee implementation of recommendation since implementation spans multiple agencies. The stakeholder group should consist of the following:

- Governor's Office representation
- Legislative representation
- Housing Finance Commission
- Department of Correction
- Department of Social and Health Services
- Department of Commerce
- Health Care Authority
- Representatives from the Association of Washington Housing Authorities
- Office of Behavioral Health Housing Initiatives
- Representatives of Western State Hospital

Action Step #2: Prepare plan to implement recommendation, addressing the following key questions:

- How many individuals will potentially use such a program?
- How will individuals be selected to participate in the program?
- How many beds/placements are needed?
    - Although the Jail Diversion study did not propose a number, state budget documents contain reference to 100 beds.
- What are the funding options to create housing?
- What administrative authority should oversee the program?
- How can the the housing component be linked to supportive services available under the 1115 waiver?
- Is federal match for operating expenses available if 16-bed step down programs were utilized?
- What will differentiate the proposed PALS-like program from the original PALS program?
- How will outcomes be measured?

Action Step #3: Secure Funding.

- Finalize budget requirements.

    - State budget documents indicate that 100 beds may be funded through a combination of $2.9 million in state general fund and $5 million from bonds. Budget documents further indicate that a step-down unit such as the units used in the previous PALS project could be implemented on the campus of Western State Hospital. The PALS-like program would have space for 60 persons, require 72 staff and require $9.1 million in general funds and $1.5 million in state construction funds.
- Identify potential funding sources, which may include:
    - One or more of Washington's 36 Housing Authorities
    - Bonds and tax credits from the State Housing Finance Commission
    - Other bond revenues such as those in the 057 State Building Construction Account
    - State subsidies to landlords and housing developers
    - Federal funding from the state Department of Commerce

Action Step #4: Implement housing program

- Develop contracting vehicle to obtain housing
- Negotiate with providers and developers
- Construct and/or purchase housing
- Prepare transition plans for individuals
- Match housing needs to individuals
- Assign housing coordinator to each individual
- Establish individuals in housing
- Coordinate supportive housing services for individuals
- Ensure mental health and/or substance abuse treatment is received when necessary
- Monitor and report on results of program

Jail Diversion Recommendation #8: Establish a mechanism to fund street outreach and engagement activities by peer support specialists and community health workers.

Action Steps	Phase 1	Phase 2	Phase 3	Responsible Parties
1. Prepare policy analysis	X			DSHS
2. Establish funding and program level of effort.	X			Legislature, DSHS
3. Hire and train peer staff.	X			DSHS, DOC and HCA
4. Implement program.		X		DSHS, DOC and HCA

Action Step #1: Prepare a policy analysis, including the following elements:

- Policy justification of the program
- Targeting and selection process for participants
- Scope of service and qualifications for peer specialists
- Program level of effort
- Performance measurement and evaluation processes

Action Step #2: Establish funding and program level of effort.

- Refine budget estimates for program.
    - State budget documents indicate that approximately $1.6 million in state general funds could support this activity. The recently funded Peer Bridger program budgeted $80,000 per peer specialist indicating that $1.6 million could fund approximately 20 peer specialists.
- Work with the legislature to obtain funding for the program.
- Work with the Washington State Sheriffs' Association, the Washington Association of Sheriffs and Police Chiefs and other potentially interested parties to remove restrictions made by some jails on letting peer support specialists with criminal history work in the jail.
- Draft and discuss statewide jail policy regarding use of peer support specialists.

Action Step #3: Hire and train peer staff. DOC and DSHS will:

- Identify qualifications of staff to be hired for peer support positions.
- Establish relationships with local jails.
- Decide how and who will manage the program.
- Prepare training requirements and materials.
- Hire and train staff.
- Prepare periodic retraining during course of first year.

Action Step #4 Implement program

- Identify low-risk individuals in the target population.
- Match peer specialist and program participants to the extent feasible.
- Peer specialists develop support plans for participants.
- Measure program success by amount and frequency of contact with individual, entrance into treatment, reduction in substance abuse, reduction in facility violence and reduction in recidivism.

3.3 Implementation Matrix

The following matrices organize the action steps described in the previous section by project phase.

Phase One consists of start-up and planning efforts that should be executed in the remaining six months of the current state fiscal year, followed by tasks to be completed within the first full fiscal year. Start-up tasks will be the responsibility of the Project Management Office (PMO) for the implementation.

Recommendation	Action Step	Start Date	End Date	Responsible Parties
Phase One – Start Up		**1/3/2017**	**3/31/2017**	
Create infrastructure to support reform implementation.	1. Establish a governance structure.	1/3/2017	1/13/2017	PMO
	2. Hold kick off governance meeting.	1/16/2017	1/27/2017	PMO
	3. Develop governance charter.	1/16/2017	2/3/2017	PMO
	4. Identify project management process.	1/27/2017	2/3/2017	PMO
	5. Create initial implementation work plan.	2/6/2017	3/3/2017	PMO
	6. Create project monitoring process.	3/17/2017	3/31/2017	PMO
	7. Identify all stakeholders.	2/6/2017	3/3/2017	PMO
	8. Hold stakeholder meetings.	3/3/2017	3/17/2017	PMO
	9. Confirm consensus on implementation work plan.	3/17/2017	3/31/2017	PMO

While the majority of the implementation tasks in Phase One below will commence after the start-up period ends, some activities may reasonably begin while start-up tasks are preceding. Scheduling early start dates for such activities help stagger the implementation tasks across the 18-month period to reduce the month over month workload for responsible parties. Leadership on these individual projects should plan to meet regularly with the PMO to ensure alignment with the overall approach.

Phase One implementation tasks are scheduled with the goal of completing the vast majority of planning activities within the next 18 months.

Recommendation	Action Step	Start Date	End Date	Responsible Parties
Phase One - Implementation		**1/3/2017**	**6/30/2018**	
Rec #1: Managed Care Risk Model Development	1. Develop blue print for MCO risk model	4/1/2017	3/31/2018	HCA with DSHS
	2. Submit plan to Governor and Legislature for review.	4/1/2018	6/30/2018	Governor, Legislature
Rec #2: New Unit of Office of Financial Management	1. Examine state regulations.	4/1/2017	4/30/2017	OFM
	2. Define the major deliverables for the OFM unit.	5/1/2017	6/30/2017	OFM
	3. Define job descriptions for staff.	7/1/2017	8/31/2017	OFM, DSHS, HCA
	4. Define salary and benefit bands for employees.	8/1/2017	8/31/2017	OFM
	5. Define reporting relationships for staff.	8/1/2017	8/31/2017	OFM, DSHS, HCA
	6. Hire new employees.	9/1/2017	11/30/2017	OFM
	7. Implement the plan for the 2017-2019 budget cycle.	12/1/2017	6/30/2018	OFM
Rec #3, Part 1: Mobile Crisis Team Expansion	1. Establish strategic planning and implementation committee.	4/1/2017	4/30/2017	DSHS/HCA/BHO/MCOs
	2. Establish and execute stakeholder outreach plan.	5/1/2017	7/31/2017	Assigned Committee
	3. Confirm scope of services and definitions.	8/1/2017	11/30/2017	Assigned Committee
	4. Confirm workforce requirements for the mobile crisis teams.	11/1/2017	1/31/2018	Assigned Committee
	5. Develop operations timeline.	2/1/2018	4/30/2018	Assigned Committee
Rec #3, Part 2: Crisis Walk-In Center Expansion	1. Establish strategic planning and implementation committee.	4/1/2017	4/30/2017	DSHS/HCA/BHO/MCOs
	2. Establish and execute stakeholder outreach plan.	4/30/2017	7/31/2017	Assigned Committee
	3. Develop needs assessment for walk-in services.	8/1/2017	11/30/2017	Assigned Committee
	4. Confirm scope of services and definitions.	11/1/2017	1/31/2018	Assigned Committee
	5. Confirm workforce requirements for walk-in centers.	2/1/2018	4/30/2018	Assigned Committee
	6. Develop construction plan.	5/1/2018	6/30/2018	Assigned Committee
Rec #4: 16-Bed Community Hospitals	1. Establish strategic planning and implementation committee.	5/1/2017	5/30/2017	DSHS/HCA/BHO/MCOs
	2. Engage Centers for Medicare and Medicaid Services	6/1/2017	6/30/2018	DSHS
	3. Establish and execute stakeholder outreach plan.	6/1/2017	6/30/2018	Assigned Committee
	4. Develop needs assessment for psychiatric beds.	10/1/2017	3/30/2018	Assigned Committee
Rec #5: Recovery-Oriented Hospital Programming	1. Identify state hospital patients requiring SUD treatment.	5/1/2017	6/30/2017	State Hospitals/DSHS
	2. Develop integrated inpatient SUD treatment program.	7/1/2017	3/30/2018	State Hospitals/DSHS
	3. Develop plan to continue SUD treatment in community.	11/1/2017	6/30/2018	State Hospitals, DSHS, BHOs/MCOs
	5. Hire Peer Counselors.	7/1/2017	12/1/2017	DSHS/providers
Rec #6, Part 1: Transitional Supportive Housing Benefit	1. Establish business requirements for administrator.	4/1/2017	5/30/2017	DSHS, HCA
	2. Consult CMS to secure approval.	5/30/2017	6/30/2017	HCA/Governor/Legislature
	3. Issue Request for Information.	7/1//2017	8/31/2017	HCA, DSHS
	4. Draft contract.	9/1/2017	9/30/2017	HCA
	5. Issue Request for Proposals.	11/1/2017	12/30/2017	HCA and DSHS

Recommendation	Action Step	Start Date	End Date	Responsible Parties
	6. Select vendor.	1/3/2018	2/28/2018	HCA and DSHS
Rec #6, Part 2: Temporary Office of Behavioral Health Housing Initiatives (BHHI)	1. Assign existing staff to support BHHI.	1/9/2017	1/20/2017	HCA/DSHS/Legislature
	2. Map identified need for residential placements.	1/23/2017	3/30/2017	BHHI Staff
	3. Create and maintain a statewide inventory of beds.	4/1/2017	12/31/2019	BHHI Staff
	4. Prepare white paper.	5/1/2017	6/30/2017	BHHI Staff
Rec #6, Part 3: ALTSA Role in Care Transitions	1. Identify ALTSA responsibilities and coordination needs.	3/1/2017	5/31/2017	ALTSA, State Hospitals
	2. Establish related policies and procedures.	5/1/2017	7/28/2017	ALTSA
	3. Prepare implementation plan.	5/1/2017	7/28/2017	ALTSA, State Hospitals
	4. Assess individuals.	7/31/2017	12/30/2019	ALTSA
	5. Implement transition plan for each individual.	7/31/2017	12/30/2019	ALTSA / providers
Rec #6, Part 4: DDA Role in Care Transitions	1. Identify DDA responsibilities and coordination needs.	3/1/2017	5/31/2017	DDA, State Hospitals
	2. Establish related policies and procedures.	5/1/2017	7/28/2017	DDA
	3. Develop procedures to transfer ID/DD individuals.	5/1/2017	7/28/2017	DDA and State Hospitals
	4. Work with each individual to prepare a transition plan.	7/31/2017	12/30/2019	DDA
	5. Monitor placement of individuals in the community.	7/31/2017	12/30/2019	DDA / providers
Rec #7: Regional Care Coordination	1. Conduct "As Is" assessment.	2/1/2017	4/30/2017	DSHS, HCA
	2. Develop "To Be" program description for BHOs.	5/1/2017	8/31/2017	DSHS/HCA/BHOs/ MCOs
	3. Update BHO contract language.	9/1/2017	10/31/2017	DSHS
	4. Implement coordinated case management.	12/1/2017	6/30/2018	BHOs
Rec #8: Transitional Care Reform	1. Analyze discharge wait lists.	10/1/2017	12/30/2017	DSHS, State Hospitals
	2. Review funding structure for existing ESF facilities.	1/2/2018	2/28/2018	DSHS, ALTSA
	3. Define services to be provided at new facilities.	3/1/2018	6/30/2018	DSHS
Rec #9: Integrative Technology Infrastructure	1. Conduct state visits to view existing software systems.	4/1/2017	4/28/2017	DSHS, HCA
	2. Identify at least three vendors to demonstrate solutions.	5/1/2017	9/30/2017	HCA, DSHS and OCIO
	3. Procure technology vendor.	10/1/2017	6/30/2018	Governor, Legislature HCA, DSHS and OCIO
Jail Diversion Rec #1: Supportive Housing Expansion	1. Establish multi-agency stakeholder group.	1/3/2018	1/31/2018	DOC and DSHS
	2. Prepare plan for implementing recommendation.	2/1/2018	4/30/2018	Assigned Committee
Jail Diversion Rec #8: Peer and Community Outreach	1. Prepare policy analysis.	7/1/2017	8/31/2017	DSHS
	2. Define funding and program level of effort.	9/1/2017	12/30/2017	Legislature, DSHS
	3. Hire and train peer staff.	1/2/2018	6/30/2018	DSHS, DOC and HCA

Phase Two implements the planning activities and decision points of Phase One. The majority of capital outlays estimated for this implementation in the 2017-19 budget will occur in this phase.

Recommendation	Action Step	Start Date	End Date	Responsible Parties
Phase Two		**7/1/2018**	**6/30/2019**	
Rec #1: Managed Care Risk Model Development	3. Develop revised language for MCO contacts.	7/1/2018	11/30/2018	HCA, MCOs
Rec #3, Part 1: Mobile Crisis Team Expansion	6. Develop performance measures and track performance.	7/1/2018	6/30/2019	HCA
Rec #3, Part 2: Crisis Walk-In Center Expansion	6. Develop construction plan.	7/1/2018	7/30/2018	DSHS/HCA/BHO/MCOs
	7. Construct centers and begin operations.	8/1/2018	6/30/2019	DSHS, vendors
Rec #4: 16-Bed Community Hospitals	2. Engage Centers for Medicare and Medicaid Services	7/1/2018	6/30/2019	DSHS
	3. Establish and execute stakeholder outreach plan.	7/1/2018	6/30/2019	Assigned Committee
	5. Determine potential locations for hospitals.	7/1/2018	8/30/2018	Assigned Committee
	6. Commence construction and development.	9/1/2018	6/30/2019	DSHS
Rec #5: Recovery-Oriented Hospital Programming	4. Implement SUD integration program.	7/1/2018	6/30/2019	State Hospitals and DSHS
Rec #6, Part 1: Transitional Supportive Housing Benefit	7. Monitor vendor activity and outcomes.	7/1/2018	6/30/2019	HCA and DSHA
Rec #6, Part 3: ALTSA Role in Care Transitions	5. Implement transition plan for each individual.	7/1/2018	6/30/2019	ALTSA and community providers
Rec #6, Part 4: DDA Role in Care Transitions	4. Work with each individual to prepare a transition plan.	7/1/2018	6/30/2019	DDA
	5. Monitor placement of individuals in the community	7/1/2018	6/30/2019	DDA and community providers
Rec #8: Transitional Care Reform	4. Update voluntarily commitment process.	7/1/2018	8/30/2018	DSHS, Legislature
	5. Create “warm hand off” process for those leaving facilities.	9/1/2018	10/30/2018	DSHS
	6. Create plan for increasing number of HARPS teams.	11/1/2019	6/30/2019	DSHS
	7. Construct facilities and enroll patients.	7/1/2018	6/30/2019	DSHS, vendors
Rec #9: Integrative Technology Infrastructure	3. Procure technology vendor.	7/1/2018	12/30/2018	Governor, Legislature HCA, DSHS, OCIO
	4. Phase implementation over three years.	1/2/2019	6/30/2019	HCA, DSHS, OCIO
Jail Diversion Rec #1: Supportive Housing Expansion	3. Secure funding.	7/1/2018	7/31/2018	DOC and DSHS
	4. Implement housing program.	8/1/2018	6/30/2019	DOC and DSHS
Jail Diversion Rec #8: Peer and Community Outreach	4. Implement program.	7/1/2018	6/30/2019	DSHS, DOC and HCA

Phase Three focuses on operations, monitoring and evaluation activities. While the first wave of implementation will be complete by this time, tasks schedule during this phase should inform the refinement of these new programs and services. The phased implementation of an integrative technology platform will also impact the evaluation process as new data analytics and data sharing capabilities create the opportunity for process improvements and other efficiencies.

Recommendation	Action Step	Start Date	End Date	Responsible Parties
Phase Three		**7/1/2019**	**6/30/2020**	
Rec #1: Managed Care Risk Model Development	4. Implement risk model to align with MCO expansion.	7/1/2019	6/30/2020	MCOs
	5. Develop performance measure and track performance.	7/1/2019	6/30/2020	HCA
Rec #6, Part 1: Transitional Supportive Housing Benefit	7. Monitor vendor activity and outcomes.	7/1/2019	6/30/2020	HCA and DSHS
Rec #6, Part 3: ALTSA Role in Care Transitions	5. Implement transition plan for each individual	7/1/2019	6/30/2020	ALTSA/community providers
Rec #6, Part 4: DDA Role in Care Transitions	4. Work with each individual to prepare a transition plan.	7/1/2019	6/30/2020	DDA
	5. Monitor placement of individuals in the community.	7/1/2019	6/30/2020	DDA/community providers
Rec #9: Integrative Technology Infrastructure	4. Phase implementation over three years.	7/1/2019	6/30/2020	HCA, DSHS, OCIO

4. Communications Plan

4.1 Objectives and Messaging

The following Communications Plan aims to provide structure and considerations to communicate the state's progress in reforming the behavioral health system. This reform is ambitious and significant and, therefore, will involve and impact many stakeholder groups. From the start of implementation throughout the life the project, effectively communicate progress and changes to various stakeholders across the state is critical to success. The Communication Plan laid out in this report provides strategies to manage communications that can be applied to different stakeholder groups as needs are identified.

Messaging
Effective messaging supports the kind of transparency and credibility that earn stakeholder buy-in. Providing appropriate context for the implementation phase will be a critical component to clearly communicating system reform. Broadly, messaging should address why there is a need for change, what the proposed change entails, and how it impacts the system. Specific to Washington, this three-fold approach would include:

4) Description of the current state of the mental health system and challenges that impact access, delivery, and effectiveness of mental health services.
5) Description of specific changes to the system that directly addresses the current challenges.
6) Description of the future state and expected improvements that will be realized.

For reference and as a starting point, Appendix A includes three communication pieces that address these points, which includes an Initial Findings Summary, Recommendations Summary, and Future State Summary.

To support the "Final Recommendations Report" preceding this document, stakeholders participated in visioning sessions to identify areas of opportunity that, if effectively addressed, can contribute to an ideal system. The six identified areas of opportunity are key points for messaging, representing stakeholder consensus and clearly identifying the goals of the project.

1) Refine the role of state hospitals to serve the right patients in the right environment.
2) Improve early identification and treatment of behavioral health needs.
3) Increase collaboration and redesign system to achieve patient centered care.
4) Support workforce development efforts and use of best practices to attract and retain staff
5) Increase focus on outcomes to ensure the system delivers desired results and continuous improvement.
6) Establish a robust continuum of care and support for transitions.

Further, all communications developed for messaging purposes should adhere to the following principles:

- Clear: Ideas should be presented as simply as possible without comprising the integrity of the content.
- Succinct: Ideas should be conveyed concisely as to provide sufficient details that the audience is able to quickly comprehend.
- Digestible: Ideas should be organized and focused so the audience may easily follow and grasp the content.

- Targeted: The communication should consider the audience and be appropriately tailored. This may include changing amount of information, format, and/or length of the communication piece.

4.2 Communication Matrix

In managing communications, it will be important to identify all internal and external stakeholders involved and anticipate their communication needs. The stakeholder communication matrix below provides a structure to document stakeholder needs. It is expected that the matrix will be a living resource that will be updated and expanded as the project evolves.

The initial stakeholder communication matrix below identifies the stakeholder group, a description of communication needs, the anticipated communication frequency for the group, and the mode in which communication will be provided. In the instances where more than one owner has been designated, communication may only be achieved through a fully collaborative effort among the identified parties.

Further development and management of a comprehensive list is an expected task of project management.

Stakeholder Group	Communication Needs	Owner	Frequency	Communication Format
Governor's Office	**Receive** updates on progress, timelines, milestones, and any risks identified. **Provide** feedback on program direction, budget needs, and alignment with evolving state strategies.	OFM	Bi-monthly, and as needed	Scheduled Meetings
Behavioral Health Clients	**Receive** information on developments and changes in system redesign that impact care delivery. **Provide** input on service needs to inform definitions and program design.	DSHS, MCOs/BHOs, Providers	As needed	Public Website with relevant information, documents that may be distributed, and links.
Select Committee on Quality Improvement in State Hospitals	**Receive** updates on implementation efforts as they relate to State Hospital operations. **Provide** feedback on strategic direction and program design.	OFM	Monthly, and as needed in the interim	Scheduled Meetings
Behavioral Health Organizations	**Receive** information on pending changes in delivery system and responsibilities in providing services and care management impacting short term operations. **Provide** feedback on program design and feasibility of program requirements.	DSHS, HCA	Bi-weekly, and as needed	Workgroup Meetings, Emails

Stakeholder Group	Communication Needs	Owner	Frequency	Communication Format
Managed Care Organizations	**Receive** information on pending changes in delivery system and responsibilities in providing services and care management impacting both short term and long term operations. **Provide** feedback on program design and feasibility of program requirements.	HCA	Bi-weekly, and interim meetings as needed	Workgroup Meetings, Emails
Behavioral Health Providers	**Receive** information on changes in the delivery system and responsibilities in providing services at varying levels. **Provide** input to shape program design for new and expanded services, as well as feedback on proposed delivery changes and feasibility of new requirements.	DSHS, MCOs/BHOs	Monthly, and as needed in the interim	Workgroup Meetings, Emails
County Behavioral Health Departments	**Receive** information on changes in the delivery system expected at the state and county level. **Provide** input regarding the feasibility of county level changes and experience in service delivery that may inform program design.	DSHS, MCOs/BHOs	Monthly, and as needed in the interim	Meetings, Email

5. Project Management and Monitoring

5.1 Key Elements to Manage and Monitor Project Implementation

The project management elements recommended and described in this section will ensure that an appropriate level of communication, monitoring and management takes place throughout the implementation process. The suggested instruments were carefully curated and are intended to ensure that all resources are properly allocated and managed. They are intended to cover the complete implementation and control all processes and procedures for each major deliverable. The tools should be maintained and updated by the appointed project manager for the life of the project.

The following elements are suggested: Project Organization, Project Management Lead Project charter, Project Plan, Risk Log, Status Reports, Milestone Performance Chart, Issue Escalation chart and Schedule Management. Each are listed and described below.

Project Organization
Project Organization includes the key personnel who oversee the engagement as well as associated artifacts to aid in providing the appropriate level of communication to all stakeholders. Complete understanding of objectives and directions as well as project progress are also communicated.

- Project Management Lead – This position is the single point of control throughout the implementation.
- Project Charter—The Project Charter states the objectives and details the goals of the implementation as well as roles and responsibilities. This document also identifies the main stakeholders and level of authority of the project manager.
- Project Plan—This is a formal document used to guide execution and control of the project. Outlines task durations, interdependencies, and assigned resources.
- Risk Log—Important in identifying and mitigating risks, this tool tracks issues and helps address problems if they arise.
- Document repository—The document repository serves as a communication channel for all members of the project team

Status Reports
Status reports provide additional tracking against the project plan using a simpler structure to clearly and quickly document progress as well as draw attention to any concerns, risks or required actions.

- Monthly Project Status Report Meetings—Conducted monthly, these meetings bring together all members of the project team along with all control documents aggregated to form a detailed report covering all project activities during the period. Recommend a comprehensive status report for the sates review and approval prior to the end of the first reporting period.
- Weekly Dashboards—Produced by the project manager, weekly dashboards provide a high level of surveillance for the project team members. The document is designed to keep pressure on the team to keep progress moving forward. The consolidated view of materials allows for quick and easy reference.

Milestone Performance Chart
This tool provides standards of measurement for milestones outlined in the work plan. The standards are designed to help project team members maintain fidelity of the work plan dates and activities. At large, the performance chart indicates which items are delayed as well as the impact of delays on other activities or milestones. More specific metrics can be negotiated and tracked.

Scope Management
The wide range of activities, objectives and goals detailed in the implementation plan lends itself to scope management practices. The scope should be observed on two different levels to ensure effective adherence:

- Overall Implementation
  - Aligns each implementation plan with overall goals
  - Validates that recommendations and accompanying activities do not create duplicative processes unnecessarily
  - Verifies adherence to management procedures across the project team

- Individual Recommendation Level
  - Establishes firm understanding of individual scope
  - Protects against scope expansion

Issue Escalation Chart
The issue escalation chart features the process and procedures used to address all identified and unidentified issues. The chart specifies responsible parties as well as the chain of escalation and measures to be implemented in the event of an issue.

- Risks—At the beginning of implementation, risks to the project are identified along with mitigation strategies.
- Other issues (e.g. delays)—Other potential issues are also necessary to identify.

Schedule Management
Using the project plan, which details milestones and necessary tasks for completion, schedule management is a means of assessing, managing and reporting on interdependencies within the schedule. The schedule will be baselined to increase accountability among the project team members throughout implementation. This plan should also be reviewed at monthly meetings as well as any ad hoc project management meetings that are held to discuss performance or any variances that occur so proper action can be taken to correct, if needed.

5.2 Project Management

The long-term nature and large scope and scale of this implementation plan adds layers of complexity to the project. As such, PCG recommends a single entity for project management responsibilities. The entity and OFM should work together to track progress by identifying common implementation phases, completion criteria, affiliated milestones for project management and performance management.

Appendix A.1 Initial Findings Summary

Washington State Mental Health System Assessment

The growing demand for state psychiatric hospital beds has strained Washington's capacity to meet that demand while ensuring the safety of patients and staff. Consequently, Washington has been seeking solutions to improve operations and quality of care at the state hospitals and strengthen the community mental health system to better address the needs of consumers at all levels of interaction with the system. To that end, Washington recently undertook a comprehensive study composed of an Initial Findings Report and Final Recommendations Report. Key information from the Initial Findings Report from is outlined below.

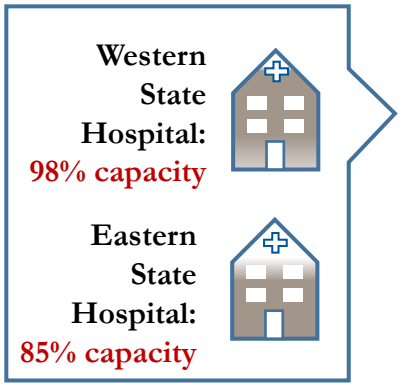
Mental Health Prevalence in Washington

Nearly 1 in 4 adults in the state experience a diagnosable mental health condition

Washington ranks 2nd in the nation on the percent of adults who meet criteria for serious mental illness

Source: Washington State Institute for Public Policy. February 2015. Inpatient Psychiatric Capacity and Utilization in Washington State. www.wsipp.wa.gov

Overview of Initial Findings

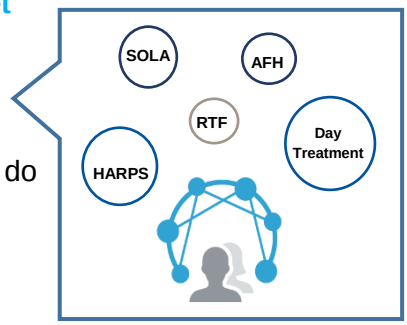


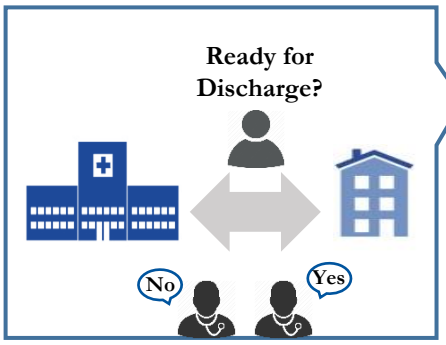
1. State hospital utilization and operations face a number of challenges.

- High occupancy rates
- Lack of alternative settings for complex patients
- Lean staffing models
- Organizational silos and a lack of recovery-oriented programming
- Broad mix of civil and forensic patients

2. Community based resources exist in a complex, disparate set of systems that does not effectively support complex patient needs.

- Insufficient community resources exist to support patients who, although having complex medical, social and behavioral needs, do not require state hospitalization
- Available services may not be fully utilized as they are not reported or organized on a system-wide basis



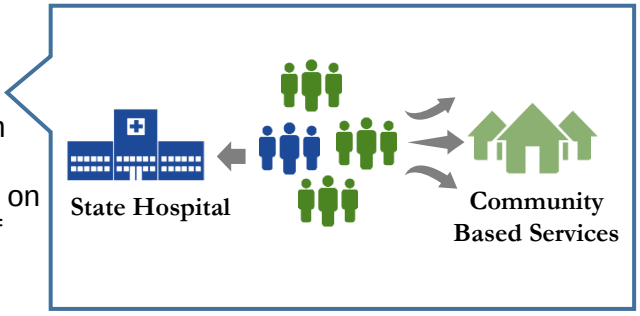


3. Ambiguity and lack of system-wide standardization weakens the ability of providers, BHOs, and patients alike to effectively use the system.

- Admission and discharge readiness assessments vary significantly across the state hospital system and within facilities
- Ambiguity around these processes creates skepticism among stakeholders regarding the appropriateness of patient care

4. Best practices for mental health funding are incentivizing reduced institutionalization and increased outcomes-oriented community care.

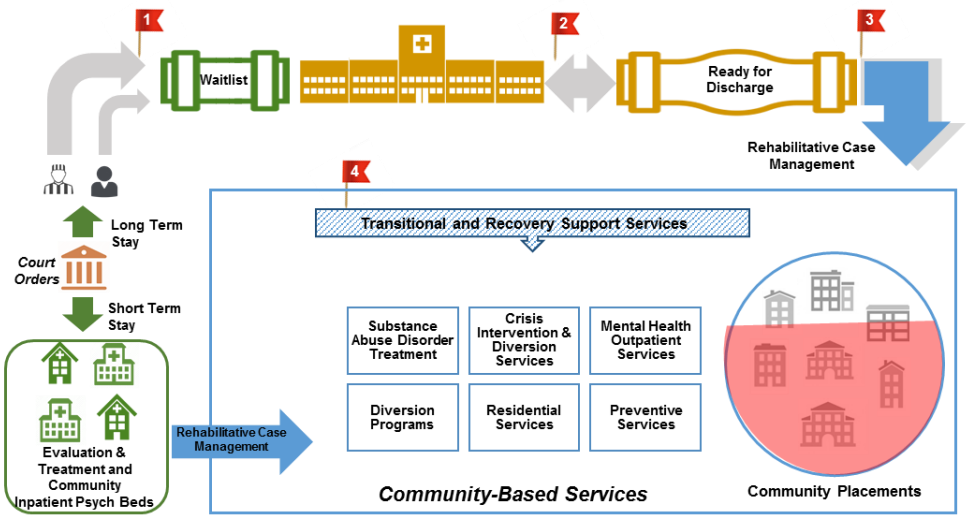
- Reductions in federal funding for state hospitals are occurring concurrent with increased funding for delivery system reform and value-based purchasing
- Effective transition requires significant focus on improving the availability and accessibility of community resources



Key Challenges

Challenges related to access to timely and comprehensive mental health services:

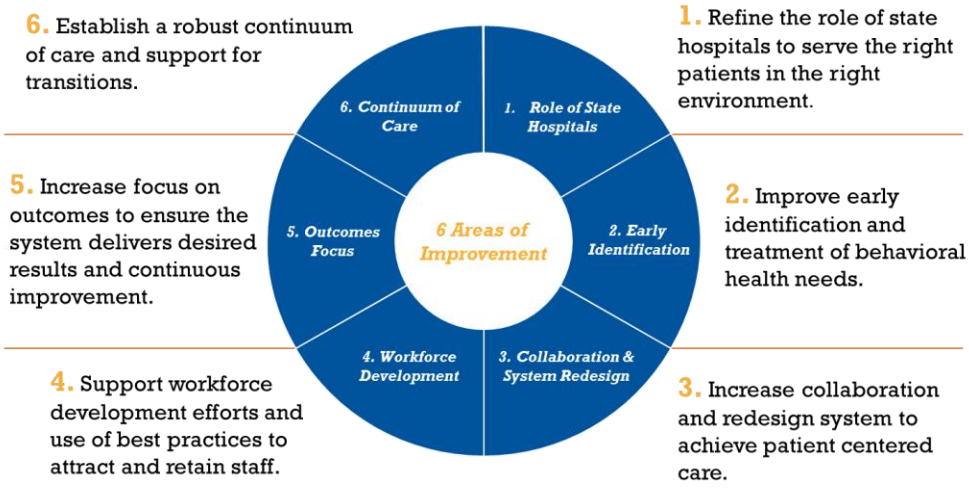
1. Volume of patients committed to the state hospital and subsequent admission delays
2. Discharge delays for patients who no longer require state hospitalization
3. Availability of specialized residential and other community programs, particularly for publicly funded patients
4. Coordination across the care continuum



Appendix A.2 Recommendations Summary
Washington State Mental Health System Assessment

Final Options and Recommendations
Washington recently undertook a comprehensive study to examine the state's mental health system and identify opportunities for innovation and improvement. That report generated several recommendations geared toward strengthening the mental health system, which are described below.

Areas of Opportunity Identified by Stakeholders



Final Recommendations

Recommendation	Areas of Opportunity Addressed
Recommendation 1: **Require the Director of the Health Care Authority to submit a state psychiatric hospital managed care risk model** to the Legislature by December 31, 2017 to support putting Medicaid managed care organizations at risk for this benefit effective January 1, 2020.	✓ Collaboration and system redesign ✓ Role of state hospitals ✓ Workforce development
Recommendation 2: Establish a **new unit within the Office of Financial Management (OFM) that integrates and coordinates fiscal analysis of all behavioral health services** across agencies and units of government.	✓ Collaboration and system redesign ✓ Role of state hospitals
Recommendation 3: Enhance community support by strengthening acute care episode management and community services to reduce admissions to state psychiatric hospitals. Specifically, this will be done by **funding 3 new mobile crisis teams, 2 new crisis walk in centers, a 15 percent increase in the number of peer support specialists** and the commencement of a grant program to enhance substance use disorder treatment more broadly into mental health care.	✓ Early identification ✓ Collaboration and system redesign ✓ Continuum of care ✓ Workforce development

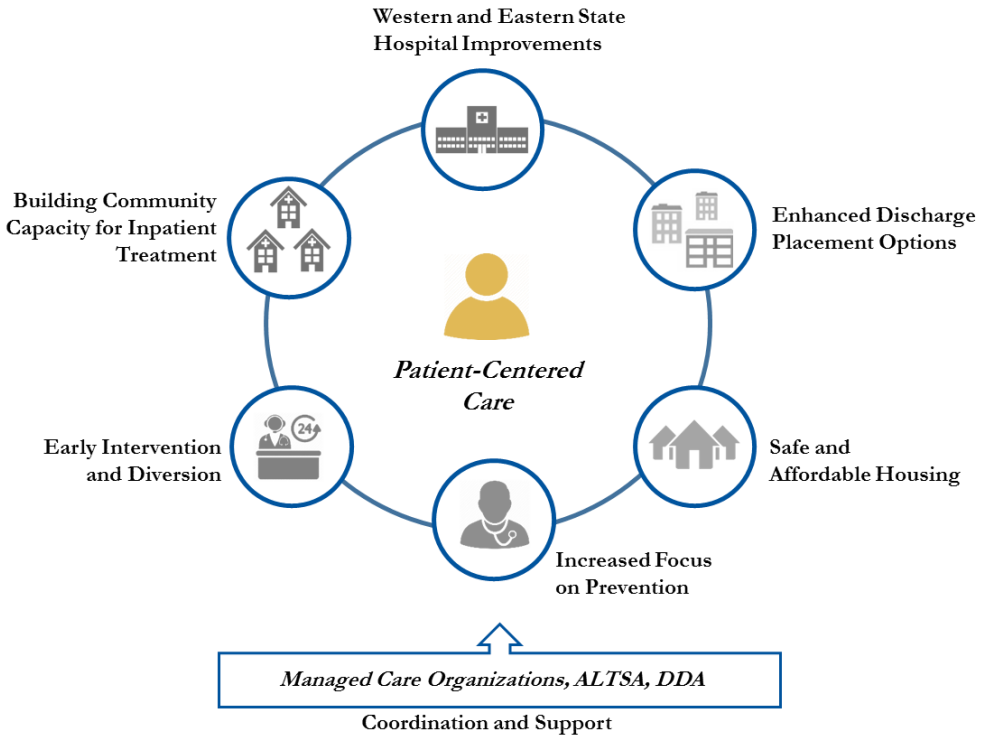
Recommendation	Areas of Opportunity Addressed
Recommendation 4: Establish **6 new 16-bed community hospitals for civil commitments and transitional acute psychiatric care needs** to promote regional care and the potential for an emphasis in specialty care for co-morbid conditions. These conditions may include developmental disabilities, dementia and certain categories of co-occurring substance use disorders.	✓ Role of state hospitals ✓ Collaboration and system redesign ✓ Continuum of care
Recommendation 5: Reform **state hospital programming to integrate substance use disorder treatment and add inpatient peer support**.	✓ Collaboration and system redesign ✓ Workforce development
Recommendation 6: Align community mental health placements with identified civil placement discharge needs by (1) **establishing a transitional, statewide supportive housing benefit administrator**; (2) creating a **temporary Office of Behavioral Health Housing Initiatives**, charged with facilitating the collaboration of capacity building investment pools, and (3) establishing **expanded responsibility for selected state hospital transitions and management practices to ALTSA and DDA**.	✓ Collaboration and system redesign ✓ Care continuum ✓ Outcomes Focus
Recommendation 7: Develop regional care coordination models to **follow rising and high risk patients throughout the care continuum**, including those with significant mental health and substance use disorder needs.	✓ Care continuum ✓ Collaboration and system redesign
Recommendation 8: Invest in transitional care reform initiatives to **add step-up, step-down and HARPS resources.** Specifically, add two new, 10-bed step down facilities in Western Washington and one new 10-bed step down facility in Eastern Washington.	✓ Early identification ✓ Collaboration and system redesign ✓ Care continuum
Recommendation 9: **Create an integrative technology infrastructure** to support behavioral health service delivery and transition to integrated care.	✓ Early identification ✓ Outcomes Focus ✓ Collaboration and system redesign

Appendix A.3 Future State Summary

Washington State Mental Health System Assessment

The Future State

Through informed investments across the continuum of care, the most vulnerable of Washington's residents will have improved access to quality behavioral health services and support.



System Redesign and Coordination

In alignment with the transition to Fully Integrated Health Care in 2020 the **Medicaid Managed Care Organizations will be at financial risk for the state psychiatric hospital benefit**; managing contracts and provider participation requirements as well as quality and performance metrics of the state hospital business model. A **Transitional Statewide Supportive Housing Benefit Administrator** will assure dollars to fund this new Medicaid benefit will be used for that purpose

Enhanced Discharge Placement Options

When a patient with complex needs is ready to leave the hospital, there are **safe and clinically appropriate placements available** that they cannot be turned away from. This will include an **expanded variety of facilities**, such as Enhanced Service Facilities, Adult Family Homes, Skilled Nursing Facilities, Shared Supportive Housing, Assisted Living Facilities, State Operated Living Facilities (ALTSA) and State Operated Living Alternatives (DDA).

Safe and Affordable Housing

For individuals who are able to live more independently with behavioral health services and support, there will be safe and affordable housing resources available in which to smoothly transition out of the hospital as well as to maintain stability and prevent hospitalization or jail time. This will include an **increased number of units of Low and No-barrier Case-managed Housing, Permanent Supportive Housing, Stepdown Housing (PALs) and HARPS Teams**.

Increased Focus on Prevention

Fully integrated health care will create **earlier opportunities for providers to screen and identify behavioral health needs.**

Early Intervention and Diversion

Strengthening acute care services will allow for individuals to get support earlier and possibly prevent hospitalization or jail time. **Mobile Crisis Teams** are able to respond to the location an individual is experiencing a crisis. **Street Outreach** providers engage and connect individuals to support services or treatment before their situation escalates into a crisis. **Crisis Walk-in Centers** serve as an alternative to hospital emergency departments and provide streamlined options for services in the least restrictive environments.

Building Community Capacity for Inpatient Treatment

When an individual requires the safety and stability of an inpatient hospital stay, they will have options closer to where they and their support network are located due to **new State Community Behavioral Health Hospitals**.

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