# Overview

Residential Care Services (RCS) promotes and protects the rights, security and well-being of individuals living in licensed or certified residential settings. The Behavioral Health Support Team (BHST) works to carry out the Mental Health Transformation Initiative in the state of Washington. The goal of the BHST is to assist in the long-term success of individuals with challenging and complex behavioral health needs residing in these settings. To accomplish this, the BHST offers clinical and regulatory expertise to providers who work with this population to help them provide high-quality, person-centered care while remaining in compliance.

The BHST is comprised of a BHST Unit Manager, Behavioral Health (BH) Outcome Improvement Specialists, a Behavioral Health Policy Program Manager (PPM), a Behavioral Health Training Specialist, and Behavioral Health Quality Improvement Consultants (BQIC).

Center for Medicare and Medicaid Services (CMS) uses the term “clients” and “individuals” interchangeably in the State Operations Manual (SOM). In this Standard Operating Procedure (SOP) the term “individuals” is used.

Facility, home, and provider(s) refers to Adult Family Homes (AFH), Assisted Living Facilities (ALF), Certified Community Residential Services and Supports (CCRSS), Enhanced Services Facilities (ESF), Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID), and Nursing Homes (NH). In this SOP the term “provider” is used.

This SOP outlines the process BHST members are required to follow when assisting long-term care (LTC) and community-based settings to meet the needs of individuals with challenging and complex behavioral health needs while simultaneously remaining in compliance with all applicable regulations. Relevant Code of Federal Regulations (CFR), Revised Codes of Washington (RCS) and Washington Administrative Codes (WACs) include:

- 42 C.F.R. § 483.1 through 483.206: Nursing Homes
- Chapter 18.20 RCW Assisted Living Facilities (ALF)
- Chapter 18.51 RCW Nursing Homes (NH)
- Chapter 70.97 RCW Enhanced Services Facilities (ESF)
- Chapter 70.128 RCW Adult Family Homes (AFH)
- Chapter 70.129 RCW Long-Term Care Resident Rights
- Chapter 71.05 RCW Mental Illness
- Chapter 71A.12 RCW Developmental Disabilities State Services
- Chapter 74.34 RCW - Abuse of Vulnerable Adults
- Chapter 74.42 RCW Nursing Homes – Resident Care, Operation Standards
- Chapter 182-538C WAC Crisis and Non-crisis Behavioral Health Services
- Chapter 246-341 WAC Behavioral Health Services Administrative Requirements

- Chapter 388-76 WAC Adult Family Home (AFH)
- Chapter 388-78A WAC Assisted Living Facilities (ALF)
- Chapter 388-97 WAC Nursing Homes (NH)
- Chapter 388-101 WAC Certified Community Residential Services and Supports (CCRSS)
- Chapter 388-101D Requirements For Providers of Residential Services and Supports
- Chapter 388-107 WAC Enhanced Services Facilities (ESF)
- Chapter 388-110 WAC – Contracted Residential Care Services
- Chapter 388-112A WAC - Residential Long-Term Care Services Training
- Chapter 388-113 WAC Disqualifying Crimes and Negative Actions

These procedures are not covered by DSHS Administrative Policies as they are specific to Residential Care Services. These procedures will be reviewed for accuracy and compliance at least every five years.

## Contacts

- Behavioral Health Support Team General Contact, RCSBHST@dshs.wa.gov
- RCS Policy Unit General Contact, RCSPolicy@dshs.wa.gov
- RCS Quality Improvement Unit General Contact, ImproveRCS@dshs.wa.gov

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# Part I: General Guidelines

## A. Behavioral Health Support Team Unit Manager

The BHST Unit Manager is responsible for ensuring the division is continuously working toward meeting the goals of the Governor's Mental Health Transformation Initiative.

Some duties of the BHST Unit Manager include but are not limited to:
1. Supervise and provide oversight to BHST staff.
2. Outline staff responsibilities.
3. Ensure processes are being followed.
4. Recruitment and hiring of new staff.
5. Ensure new staff are trained and can demonstrate a working knowledge of BHST policies and procedures.
6. Provide consultation on clinical and non-clinical matters.

## B. Behavioral Health Outcome Improvement Specialist

The Behavioral Health Outcome Improvement Specialist is responsible for developing, evaluating, and analyzing quality measures. The Behavioral Health Outcome Improvement Specialist assists the BHST in setting benchmarks and goals for continuous improvement and creates programs to measure those goals. RCS relies on the Behavioral Health Outcome Improvement Specialist's experience in program evaluation, utilization of statistically sound and valid data, and report generation which includes outlining program successes and identifying areas requiring additional resources.

Some duties the Behavioral Health Outcome Improvement Specialist will be asked to perform include but are not limited to:

1. Complete program analysis to track and trend outcomes, as well as recommend use of resources, areas for improvement and program gaps, which include identifying intake referral trends by source type, provider, and developing follow up surveys for providers.
2. Identify opportunities for improving and streamlining work such as creating metrics and developing electronic reporting methods for Unit Manager.
3. Prepare data and reports to be used as a part of the legislative process.
4. Develop an on-going process to maintain quality data. For example, taking over intake processing for weekly case assignment so the BQICs have accurate up-to-date data to assign new referrals.
5. As the Intake Coordinator (IC), create a new folder with an intake number and mark in the tracker as Staffing, Connection Café, Training, Consultation, Preliminary Technical Assistance, or Miscellaneous (see section 'Requests for Information, Staffing, Connection Café, Training and/or Consultation').

The RCS Leadership team relies on the Behavioral Health Outcome Improvement Specialist's expertise in the development, implementation and oversight of quality measures, outcomes and improvement processes resulting in positive and measurable impacts on the quality of care for individuals with challenging and complex behavioral health needs residing in LTC and community-based settings.

# C. Behavioral Health Training Specialist

## Overview

The Behavioral Health Training Specialist is responsible for providing statewide support to help keep RCS staff and providers apprised of, and educated on, current and changing behavioral health standards. This includes consultation, development, and deployment of exclusive training to build proficiencies, understanding, and abilities in working with individuals with challenging and complex behavioral health needs. The Behavioral Health Training Specialist provides technical assistance and education on regulatory requirements as well as best practice training.

The Behavioral Health Training Specialist is the designated expert for behavioral health training across LTC and community-based settings.

Providers such as Enhanced Services Facilitates (ESF) and Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID), who already have behavioral health services on site as a regulatory requirement may be provided behavioral health training or other support on a case-by-case basis. Consultation with the BHST Unit Manager is required to determine if additional support from the BHST is warranted.

Some duties the Behavioral Health Training Specialist will be asked to complete include but are not limited to:

1. Create a curriculum that reflects the most current evidenced-based practice and treatment approaches.
2. Research for proven strategies to address the care needs for individuals with challenging behaviors.
3. Represent RCS by chairing and facilitating both internal and external stakeholder meetings related to behavioral health training and curriculum development.
4. Provide individual and group training sessions.
5. Become a certified continuing education credit trainer.
6. Practice and promote cultural humility in all aspects of service delivery.

## Procedure

1. REFERRALS:
   Referrals to the Behavioral Health Training Specialist can be made by email to ALTSABHSTTraining@dshs.wa.gov. The Behavioral Health Training Specialist offers the following trainings and/or consultation:
   a. RCS Training: Training for Regional RCS staff on a specific subject matter pertaining to behavioral health and the BHST services.

b. Providers: Deliver in-service training, support groups, and/or clinics to improve and expand practical and clinical approaches to enhance skills in caring for individuals with complex behavioral health issues.
c. Stakeholder Training: Trainings for stakeholders to learn about the BHST services.

2. EMAIL, TRAINING TRACKER, TRAINING CALENDAR, AND CONTINUING EDUCATION:
The Behavioral Health Training Specialist will maintain the training email inbox, the training tracker, and the training calendar. The Behavioral Health Training Specialist will provide continuing education credit certificates for trainings that have been approved for continuing education credits.
   a. Training email box:
      i. Monitor training email inbox.
      ii. Respond to inquiries, requests, and comments.
      iii. Document intake in training tracker.
      iv. Email provider with web link to training and any additional information.
   b. Training Tracker:
      i. Maintain training tracker by inputting the following information:
         1) Date of training;
         2) Facility name and setting type;
         3) Provider name and contact information (if different);
         4) Training description;
         5) Training type;
         6) Travel time;
         7) Research, development, and presentation time;
         8) Presentation completion;
         9) Number of participants; and
         10) Presenter name.

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# D. Behavioral Health Quality Improvement Consultant (BQIC)

## Overview

BQIC consultation offers providers interventions, tools, and resources that fit within the regulatory framework. BQICs research evidence-based interventions, promote regulatory compliance, and create unique approaches to problems. Providers can then utilize this information to support individuals with challenging behavioral health needs in their current or future placement. BQICs also demonstrate a holistic approach to care by considering the whole individual throughout their work with providers. BQICs contribute to the department's mission of transforming lives through their work to resolve challenging and complex behavioral health needs. BQICs reduce the risk of decompensation and re-hospitalization, as well as improving the quality of care in residential settings.

BQIC services are not part of the regulatory process and LTC providers are never compelled to accept consultation or technical assistance.

BQICs are available on a voluntary basis to Adult Family Homes (AFH), Assisted Living Facilities (ALF), Certified Community Residential Services and Supports (CCRSS), and Nursing Homes (NH). Services are available regardless of the individual's funding source.

If the individual in the AFH, ALF, CCRSS, or NH already has behavioral supports in place (including but not limited to State Hospital Discharge and Diversion Team (SHDD), Program of All-Inclusive Care for the Elderly (PACE), Expanded Community Services (ECS), Specialized Behavior Support (SBS), Intensive Residential Treatment (IRT), Program of Assertive Community Treatment (PACT), Staff and Family, the BQIC will carefully review the referral to determine if additional support from the BHST is warranted.

Providers such as Enhanced Services Facilitates (ESF) and Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) who already have behavioral health services on site as a regulatory requirement may be provided with consultation or other support on a case-by-case basis. Consultation with the BHST Unit Manager is required to determine if additional support from the BHST is warranted.

Some duties the BQIC will be asked to complete include but are not limited to:

1. Work with LTC and community-based setting staff, assisting them in understanding and complying with regulations relevant to behavioral health concerns.
2. Conduct thorough and comprehensive reviews of individual and provider records, from both a minimum standard and a best practice standard.
3. Evaluate appropriateness of individual activity offerings and provide suggestions for improving person-centeredness.
4. Review provider citation history and individual history (e.g., behavioral issues in prior placements), identifying patterns and trends.

5. Assess current interventions and policies for potential citation risks.
6. Assist providers with regulation comprehension, particularly in the following areas: resident rights, resident safety, quality of care, documentation, reporting, medication refusal, restraints, abuse, neglect and exploitation, and others that may apply.
7. Provide expert-level consultation on behavioral health and related regulatory issues within LTC and community-based settings.
8. Collaborate with Home and Community Services (HCS), Developmental Disabilities Administration (DDA), and partner agencies to identify community, recreational, and socialization opportunities, such as clubhouse models in communities for individuals to access on a regular basis for socializing with their peer group or supported employment.
9. Comply with requirements of Health Information Portability and Accountability ACT (HIPAA).
10. Comply with state and federal laws to protect and maintain the privacy and security of confidential individual information and ensure use of secure/encrypted email communication.

## Requests for Information, Staffing, Connection Café, Training and/or Consultation

When collaborating with providers, community partners, and/or agency partners, the BQIC offers staffing, Connection Café, training, and/or consultation and responds to requests for information.

1. STAFFING – These are questions or queries that do not rise to the level of requiring consultation but involve some time and research. For example, a provider may need assistance understanding how resident rights regulations apply to a particular situation. They may be struggling with a unique delusion or symptom despite having extensive experience working with challenging behaviors. Or they may have questions about their responsibilities regarding an individual who always threatens to discharge from the provider's care against medical advice (AMA). Support is generally provided via brief phone call and/or email. Staffing may also be provided to a provider that has other behavioral health resources available (i.e., ECS or SBS) where a full consultation is not indicated and may duplicate other services.
2. CONNECTION CAFÉ – These are meetings scheduled between a BQIC and a provider and are less formal than a consultation. The Cafés provide an open forum for staff to ask questions about regulations and other topics that may not be individual specific. These meetings may be used to also answer general questions about many individuals residing in the facility.
3. TRAINING – These are a specialized list of trainings provided by BQICs that may be useful to the provider based on individual behaviors and/or staffing needs.
4. CONSULTATION – For providers who have an individual currently residing in their home or facility with challenging behaviors, BQICs will complete a thorough and comprehensive consultation to address the specific needs of an individual and/or the setting itself. Extensive research about the setting and individual becomes the foundation from which the BQIC develops tailored intervention ideas and regulatory guidance. Work is done to identify possible resources and forms of support for the individual and provider staff alike. A written summary is given to the provider and is also discussed during one or two meetings with staff.

5. PRELIMINARY TECHNICAL ASSISTANCE (PTA) – For providers who are considering admitting an individual with known challenging behaviors from a medical hospital or another long-term care/community-based placement but are not sure about the admission or would like assistance with preparing for the arrival, BQICs will be available to support providers ahead of the admission. Like consultations, PTAs involve more extensive research and writing. They also involve one or two meetings with the provider.
6. MISCELLANEOUS – These are questions that can be addressed with minimal effort. Examples may include questions such as “What is an ECS contract?” “How do I get an example of a good care plan?” or “It was suggested I talk to the RCS BHST. What is that and what do they do?” Information is generally provided via email.

## Procedure

1. Referrals to the BQIC can be made in the following ways:
   BHST Email: rcsbhst@dshs.wa.gov
   BHST Referral Message Line: 360-725-3445

   BQIC will ensure the provider has approved participation with the consultation process.
2. Intake Process:
   a. Referral request received.
   b. If referral appears to be a “Miscellaneous” (question or task outside the parameters of a typical consultation) (MISC), the referral is then marked as a MISC in the tracker and assigned to the Unit Manager. The Unit Manager then provides the requested information and adds required data to the tracker.
   c. If the referral appears to be a Connection Café request, it is marked in the tracker as “Incomplete Connection Café” and given an intake number. The Intake Coordinator (IC) then creates a new folder with the intake number. A new intake form is started and placed in the folder, along with the original referral message (if available).
   d. If the referral appears to be a Training request, it is marked in the tracker as “Incomplete Training” and given an intake number. The IC then creates a new folder with the intake number. A new intake form is started and placed in the folder, along with the original referral message (if available).
   e. If the referral appears to be a consult or PTA request, it is marked in the tracker as either “Incomplete Consult” or “PTA Incomplete” and given an intake number. The IC then creates a new folder with the intake number. A new intake form is started and placed in the folder, along with the original referral message (if available).
   f. The IC will add the following information to the consultation document:
      i. Individual name;
      ii. Individual date of birth (DOB) and age;
      iii. Provider type;
      iv. Name and license number of provider;

v. Region and address of provider;
vi. Indicate 'yes' or 'no' for the repeat provider section;
vii. Referent contact information and role/title;
viii. Details of the referral request;
ix. Number of residents; and
x. Whether there is provider approval.
xi. If the consultation is a PTA, provider contact person and contact information, note from contact with the provider.

g. IC checks for duplicate/past provider/individual and makes notations in the tracker accordingly.
h. Back up BQIC coordinates tentative data tracker presentation for case assignment.

3. Case Assignment:
The BHST is not able to provide crisis response services. Incoming referrals are not triaged; cases are assigned to BQICs on a first-come, first-served basis.
   a. Cases are assigned based on BQIC availability, region, and other factors.
   b. Cases assigned and marked as Incomplete Connection Café, Incomplete Training, Preliminary Technical Assistance (PTA Incomplete) or Consultation Incomplete.
   c. Updating Tracker:
      i. Update tracker with assigned BQIC name.
4. Initial steps after case assignment:
   a. Intake folder with attached intake form and any associated emails or voicemails will be moved to the BQIC's personal folder on the Q: drive.
   b. Intake information will be reviewed by the BQIC. All relevant research will be documented on the intake form.
   c. Research will be conducted by the BQIC on the provider using the following applications:
      i. FMS
      ii. TIVA
      iii. TIVA2
      iv. STARS
      v. ASPEN ACO (if NH)
   d. Research will be conducted by the BQIC on the individual using the following applications:
      i. TIVA
      ii. TIVA2
      iii. STARS
      iv. CARE
      v. ASPEN ACO MDS (if NH)
   e. Questions will be tailored for the provider based on research results.
   f. Call provider/referent:
      i. BQIC will ask curated questions of provider contact. Responses will be documented in the intake form.

ii. Schedule the consultation. While it is preferable to hold the meeting in-person at the provider, there may be extenuating circumstances, and the BQIC will use their discretion to determine whether Teams/Zoom may be a more appropriate format.
iii. Request that the provider send the individual's care plan and any other relevant documentation (i.e., behavioral tracking logs, progress notes, provider policies, crisis plan, etc.) if available and voluntarily given by the provider.
iv. Depending on the specific circumstances of the referral, the BQIC will attempt to reach the provider three times, using the phone and/or email contact provided. After the last attempt, the BQIC will notify the provider that the intake will be closed out if no contact is made.
v. Update intake form with all above information.

g. Additional contact with involved parties. As necessary, the BQIC will curate questions and make contact with relevant collateral contacts, such as case managers.
h. If the provider declines, the individual no longer resides under the provider's care, or there is another reason the consultation does not proceed, the BQIC will complete the intake and email the Behavioral Health Outcome Improvement Specialist. The Behavioral Health Outcome Improvement Specialist will view data and update the tracker. BQIC moves the intake folder to closed folder in the Q: drive.
i. If the provider is unsure if they want assistance, the BQIC may offer to follow up with the provider.
Example: A BQIC has been assigned a PTA. They call the provider, but the provider is unsure if they would like BHST services because they feel they need to meet the individual before making that decision. The BQIC can offer to follow up with the provider in 4-6 weeks to see how the placement is going and if they need BHST assistance.

5. Visit preparation:
   a. Update Outlook calendar. If traveling, include travel time.
   b. Email meeting confirmation to provider. If scheduling a web-based meeting, include link/directions for Zoom or Teams. Update intake form with information describing when this information was sent to the provider.
   c. BQIC will gather all appropriate resources and generate a consultation document for each individual. BQIC will update all documentation needed (i.e., best practices, etc.).
   d. Email meeting details to RCS Field Manager (FM). Include RCS Complaint Investigator (CI) if there is open investigations or visits with the provider.
   e. If documentation (e.g., care plan) is received from the provider, create a PDF, and provide comments/feedback as applicable.
   f. One day prior to the consultation meeting, email all documents to the provider in PDF format (except for any templates, which should be left in Word format so the provider may modify them).
6. Consultation meeting:
   a. If consultation is onsite, observe/talk with the individual and staff. If care plan/documentation was not received prior to consultation, review while onsite. Meet with provider or facility

contact and offer consult, feedback, and resources. Inform provider they will receive a survey via email.

b. If consultation is digital, talk with leadership and provide consult, feedback, and resources. Inform provider they will receive a survey via email.

7. Post consult/follow-up
   a. On the intake form, BQIC documents consult time and date, who attended, and observations/impressions.
   b. BQIC will complete a follow-up call or email to all who were contacted before the consultation (i.e., HCS, DDA, FM). Send them a copy of the consultation in PDF format. Explain the follow-up process.
   c. BQIC will create questions for the provider based on the information discussed during the consultation. These questions will guide the conversation during the follow-up call.
   d. Following the consultation (approximately 14 to 28 days later) the BQIC will complete a follow-up call to provider.
      i. Get update on how things are going.
      ii. Check if there is any difficulty interpreting consult suggestions or use of resources.
      iii. Is a second visit wanted/needed? Is a referral to trainer wanted/needed? If so, schedule follow-up meeting or make appropriate referrals.
   e. BQIC will call those involved before the consultation (i.e., HCS, DDA, etc.) and convey impressions and other necessary information. The BQIC will also explain case closure to HCS, DDA, or others involved.
   f. All information will be documented on the intake form.
8. Case closure:
   a. Email consultation (PDF format) to FM and BHST Supervisor.
   b. Add resources and useful information to OneNote.
   c. Move entire folder to the Closed Folder.
   d. Email Behavioral Health Outcome Improvement Specialist letting them know to close the case.

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# Part II: Appendices

## A. Acronym List

| | |
|---|---|
| ACO | Aspen Central Office |
| ACTS | ASPEN Complaints/Incidents Tracking System |
| AFH | Adult Family Homes |
| ALF | Assisted Living Facilities |
| ALTSA | Aging and Long-Term Support Administration |
| AMA | Against Medical Advice |
| ASPEN | Automated Survey Processing Environment System |
| BHST | Behavioral Health Support Team |
| BQIC | Behavioral Health Quality Improvement Consultant |
| CARE | Comprehensive Assessment and Reporting Evaluation System |
| CC | Carbon Copy (in emails) |
| CCRSS | Certified Community Residential Services and Supports |
| CFR | Code of Federal Regulations |
| CI | Complaint Investigator |
| CMS | Center for Medicare and Medicaid Services |
| DDA | Developmental Disabilities Administration/Administrator |
| DOB | Date of birth |
| DSHS | Department of Social and Health Services |
| ECS | Expanded Community Services |
| ESF | Enhanced Services Facilities |
| FM | Field Manager |
| HCS | Home and Community Services |
| HIPPA | Health Insurance Portability and Accountability Act |
| HQ | Headquarters |
| IC | Intake Coordinator |
| ICF/IID | Intermediate Care Facilities for Individuals with Intellectual Disabilities |
| IO | Intake Only |
| IRT | Intensive Residential Treatment |
| MISC | Miscellaneous |
| NH | Nursing Homes |
| PACE | Program of All-Inclusive Care for the Elderly |
| PACT | Program of Assertive Community Treatment |
| PDF | Portable Document Format |
| PPM | Policy Program Manager |
| PTA | Preliminary Technical Assistance |

| | |
|---|---|
| RCS | Residential Care Services |
| RCW | Revised Code of Washington |
| SBS | Specialized Behavior Support |
| SHDD | State Hospital Discharge and Diversion Team |
| SOM | State Operations Manual |
| SOP | Standard Operating Procedures |
| T | Tentative |
| WAC | Washington Administrative Code |
| WD | Working Day |

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## B. Change Log

| Eff. Date | Chapter/ Section # | Description of Change | Reason for Change | Communication and Training Plan |
|---|---|---|---|---|
| 06/14/2023 | Full Chapter | Updates to requirements, transition to new format | Updated Expectations | MB R23-056 |
| 10/14/2022 | Full Chapter | Establishment of chapter | Establishment of chapter | MB R22-078 |

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