



Washington State Behavioral Health Communication Framework

December 2021 Project Summary &
Recommendations

THE WILLIAM D. RUCKELSHAUS CENTER

UNIVERSITY OF WASHINGTON

WA Behavioral Health Communication Framework Workgroup December 2021 Project Summary & Recommendations

The William D. Ruckelshaus Center is a neutral resource for collaborative problem solving in the State of Washington and the Pacific Northwest, dedicated to assisting public, private, tribal, non-profit, and other community leaders in their efforts to build consensus and resolve conflicts around difficult public policy issues. It is a joint effort of Washington State University hosted and administered by WSU Extension and the University of Washington hosted by the Daniel J. Evans School of Public Policy and Governance. For more information, visit: www.ruckelshauscenter.wsu.edu

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This brief summarizes the Washington Behavioral Health Communication Framework Workgroup's progress ('Ruckelshaus Workgroup' or 'Workgroup') throughout 2020 and 2021. As of December 2021, this Workgroup has met together at least monthly since September 2020. The Workgroup included twenty-one members over the course of the facilitations, including County Commissioners and county senior staff, a Washington State Association of Counties ('WSAC') executive, Health Care Authority ('HCA') leadership and one Behavioral Health Administrative Services Organization ('BH-ASO') director.

Prior to these joint meetings, the Ruckelshaus Center ('Center') facilitated five separate county/BH-ASO Workgroup meetings and two separate HCA Workgroup meetings between the summer and fall of 2020.

The Center's facilitation is now complete - the Ruckelshaus Workgroup has achieved their goal of designing a consensus-based Communication Framework to support future team-based problem-solving efforts involving both statewide/systemic and county-specific/regional behavioral health policy design and program implementation issues. The Workgroup expects to begin the launch of their Communication Framework during the first quarter of CY2022.

No written summary can adequately convey the shared personal experience of twenty-one people working together for twenty months towards a common goal. The Workgroup hopes to convey their experience through examples, demonstrations, discussion, trainings and storytelling to other counties, BH-ASOs, HCA staff and partners, and others serving the behavioral health continuum – so that teams might apply the framework in ways that will help them experience similar trust-building through their collaborative work efforts, as they work with the HCA to solve behavioral health integration challenges, and open new communication channels between counties and state agencies.

Brief Historical Context: Mental Health & Substance Use Disorders - Delivery & Financing Changes in Washington State

Washington is transforming the way that Medicaid services are delivered and reimbursed, including integration between physical and behavioral health (mental health and substance use disorder) care delivery¹. Behavioral health integration has been a significant endeavor, involving transformative

¹ Systemic Medicaid transformation in Washington includes four overarching goals: reduce avoidable intensive services and settings; improve population health; accelerate transition from fee-for-service to value-based reimbursement and ensure per capita cost growth is kept below national trends. For further information, please note the WA Health Care Authority's numerous website links on State Innovation Model grants, establishment

change. Partnerships and relationships within and between organizations and sectors have been tested during policy and implementation changes over recent years that have impacted responsibility, accountability, funding flexibility, collaboration, and communication.

The model of mental health and substance use disorder ('SUD') delivery and financing in Washington state has shifted several times in recent years. Prior to 2016, Medicaid enrollees with co-occurring physical, mental health and/or SUD conditions navigated between separate systems to care for their needs. Managed Care Organizations ('MCOs') oversaw their physical care requirements, as well as mild to moderate behavioral healthcare needs. Regional Support Networks ('RSNs') oversaw care (via mental health agencies) for those meeting criteria for serious mental illness, or serious emotional disturbances. County governments managed SUD outpatient services via County Substance Use Coordinators. The Department of Social and Health Services' (DSHS) Division of Behavioral Health and Recovery (DBHR) directly contracted for SUD residential services. In addition to service delivery, administration and funding were also fragmented. The HCA contracted with the MCOs, while DSHS oversaw specialty mental health and SUD services through the RSNs and counties. The RSNs managed both federal and state contracts to deliver care and support for Medicaid and safety-net populations and contracted with community mental health providers to deliver mental health care. SUD services were administered at county levels via grants and fee-for service funding.

This earlier RSN/county model allowed for some flexibility of funding streams, and the counties retained a large share of responsibility and oversight in the system; but care was uncoordinated for those with co-occurring conditions. In addition, lack of information system interoperability between RSNs, counties and MCOs made coordination of care unlikely. Providers were unable to support people 'holistically'. On a systemic basis, Medicaid enrollees and others continued to suffer from chronic problems of access to both mental health and SUD providers.

Washington state began transitioning to a fully integrated care model in 2014. Legislation to advance whole person care included replacing RSNs with Behavioral Health Organizations ('BHOs'). BHOs were meant to be a temporary model to allow regions in Washington to begin integrating the purchase of physical health, mental health, and SUD services between 2016 and 2019. Subsequent legislation advanced clinical integration and mandated access to additional recovery support services. Task force recommendations suggested full implementation of integration statewide by 2020. BHOs replaced RSNs in nearly all counties by April 2016 and began purchasing and administering behavioral health services for Medicaid enrollees under managed care on a regional basis.

BHO Service Examples

Mental Health:

- Intake Evaluation
- Individual Treatment Services
- Crisis Services
- Group Treatment Services
- Brief Intervention/Treatment
- Family Treatment
- Peer Support
- Medication Management/Monitoring

Substance Use Disorders:

- Assessment
- Brief Intervention
- Withdrawal Mgmt (Detoxification)
- Outpatient Treatment
- Inpatient Residential Treatment
- Opiate Substitution Treatment
- Referral to Treatment
- Intensive Outpatient Treatment
- Case Management

Under fully integrated managed care, MCOs coordinate care across the continuum of physical and behavioral health services. Each region contracts with multiple MCOs, based on competitive bid. In the interim, BHOs replaced the existing RSNs, and became financially 'at risk' for both SUD and mental health services. BHO's temporary status was meant to transition management of behavioral health to MCOs.

The transition from RSNs to BHOs significantly changed the way that counties and behavioral health providers operated. BHOs had to expand their provider networks and develop integrated data systems, as they were now financially 'at risk'. SUD providers had to join MCO contracts within regions.

The latest organizational change involved transition from BHOs to fully integrated managed care. Washington's ten designated regions implemented fully integrated managed care on different timelines, which impacted regional/county behavioral health entities. County commissioners determined when to adopt fully integrated managed care within each region. In addition, the state planned for the management of the continuum of crisis services for all statewide residents (not just Medicaid enrollees), including regional crisis hotlines and mobile crisis outreach teams. Originally, the RSNs (and later the transitioned BHOs) received both Medicaid and other public funding to manage and administer these crisis services. As the state moved towards fully integrated managed care, there was recognition that managing crisis functions would require a single regional entity, as splitting funding and functions between MCOs and others within a region would be problematic.

The state ultimately contracted with one BH-ASO per region. The BH-ASOs manage crisis services for everyone, regardless of insurance status; some non-crisis behavioral health services for uninsured populations; regional functions, including ombudsman and community behavioral health advisory boards, and funding from block grants and criminal justice treatment account funds. Fully integrated MCOs are required to contract with the BH-ASOs for crisis services for Medicaid enrollees, including coordination and data-sharing requirements.

In addition, the HCA continues to have direct government-to-government relationships and contracts with Tribal Governments relative to behavioral health.

Why is this history important? These significant changes to delivery and financing models evolved over a relatively short period of years. The roles, responsibilities and authority of counties and other participants in Washington's behavioral health system have altered considerably. Prior funding flexibility has been constrained, as entities have fewer funding streams to blend to provide services – to Medicaid enrollees, the uninsured and those with other insurance status. The behavioral health support and care system doesn't operate in a vacuum - interconnected services, including support and funding responsibility for related county-based criminal justice services have changed along with these delivery system transitions, and can end up competing with funding for more traditional behavioral health services. Fewer pots of money are left to fund additional services. The counties' relationships with the HCA (and others) have been strained as these delivery system changes have created additional system stressors.

In addition, many of the state employees that oversaw behavioral health services at DSHS' DBHR consolidated and transitioned to the HCA in 2018, while many of the folks who were in licensing and certification shifted to the Department of Health. Just prior to these organizational changes, DSHS/DBHR streamlined five Washington Administrative Code chapters regulating behavioral health

into one, merging the regulatory framework and language for mental health, SUD and co-occurring treatments. These consolidations were implemented to streamline service delivery and improve care access. During this time, the state also modified the definition of ‘mental health professional’ to allow provider flexibility and improve access to care, eliminate some agency training requirements and allow for certain documentation exemptions while ensuring patient safety standards. Further regulatory changes were enacted after DBHR’s organizational transition to the HCA and DOH, as part of the efforts to integrate physical and behavioral healthcare. These big changes and compounding stress factors within and across Washington’s behavioral health system sometimes intensified communication gaps and challenges to existing relationships between the HCA and counties.

Intergovernmental challenges between counties, state agencies and tribes often emerge when complex policies are designed and implemented. In addition, the nature of public healthcare policy and underlying federal/state and federal/tribal funded partnerships (and tribal/state relationships) involves complex program regulations and rules. These can further confuse different entities’ perceptions of roles, authority, responsibilities, and relationships in the context of care and support delivery within local jurisdictions. Creating time and space to build strong communications pathways often takes a back seat when system transitions and reorganizations occur.

Finally, behavioral health services involve a complex continuum – delivery, federal and state requirements, participant relationships and related nuance are difficult to fully understand, without full time expertise. County commissioners and staff are interested in supporting all their constituents, without regard to type of healthcare insurance. Few elected officials have the time to become experts in behavioral health unless they happen to work within the field. The HCA must navigate between federal program and funding requirements, state oversight responsibilities, regional and local needs and federal and state regulations that may be unaligned. All parties lack adequate staffing capacity, and behavioral health provider shortages are chronic and long-standing. In addition, COVID-19 is increasing the demand and need for behavioral health services well beyond pre-pandemic times, as well as illuminating outcomes disparities – especially negative impacts on marginalized communities.

Engagement Initiation and Purpose

The HCA and WSAC approached the Ruckelshaus Center in Spring 2020 to first assess a subset of county elected officials and staff, ASOs, WSAC representation and HCA leaders, and (if appropriate) design and facilitate an impartial process to help interested parties work towards collaboration and consensus-building. The parties felt that existing communication gaps and related challenges could greatly benefit from an agreed-to Communication Framework to help further integration success, strengthen relationships, and create a partnership structure to jointly tackle behavioral health integration issues – including challenges involving both policy development and program implementation.

The parties recognized the need for a more productive and satisfying path forward, predicated on rebuilding trust and creating a mutual, workable Communication Framework and underlying commitment to each other that has the potential to outlast individual tenure, turnover, election cycles and systems change.

The Center facilitated twenty-one individuals to design a consensus-based Communication Framework to reach these collaborative goals. This Workgroup included county commissioners and staff representation from several geographically and demographically diverse regions, a BH-ASO, the WSAC

executive and a group of HCA leaders with varying behavioral health expertise². The members included county officials and others with diverse stories of relationship challenges with the HCA – varying degrees of behavioral health systems and implementation exposure over time – and from urban, rural and frontier geographies with diverse population needs. Some Workgroup members shifted in or out of the Workgroup over the course of the twenty months. Several people retired and were replaced by others. One elected official lost her re-election bid.

The Workgroup was kept small, to maintain effective progress throughout 100 percent virtual facilitation, as the engagement began soon after the pandemic broke out in the U.S. in early 2020. The most important condition of the group was to work closely together in good faith to develop the relationships and trust to build and test an agreed-to Communication Framework. The intent was (and is) to broadcast the framework statewide after development. In fact, the Workgroup never met ‘live’, but was able to meet the goal of framework completion by the end of 2021. As noted, the Workgroup has begun to implement plans to educate and inform other counties, BH-ASOs and other parties (beginning in the first calendar quarter of 2022) about the benefits of using the Communication Framework to work collaboratively with the HCA on a wide range of behavioral health and related challenges, from proactive systemic issues and change, to regional and county-specific problems.

The Communication Framework is not itself a problem-solving methodology. Rather, it helps create the space and structure to apply agreed-to venues, principles, and attributes to positively change the collaborative process, and allow for a high degree of authentic teamwork to problem-solve. The framework assumes that parties will enter the process in good faith and respect, with the willingness to improve relationships and build trust over time. For newer participants, the framework provides a more streamlined way to learn about the complexities of behavioral health, better serve Washington residents, and be a relevant partner in positive systems change. The twenty months that the Ruckelshaus Workgroup spent together was, in effect, a demonstration of this framework. They took on the iterative work to develop the framework through a series of facilitated meetings, exercises, real time testing and open discussions to learn from each other, change their perspectives, build trust, and achieve collaborative results.

The Communication Framework is flexible and is expected to be improved over time. Ideally, the Workgroup believes that eventual process (and outcomes) success will be measured by the greater goal of a cultural shift in teaming collaboratively to improve systems from a person (citizen)-centered perspective, and not based solely on the structure of any specific framework.

Workgroup Process: Initial Assessment and Emerging Themes

The Center conducted individual assessment interviews of county elected officials and staff, a WSAC executive, and a BH-ASO director during Spring 2020. Similar assessment interviews of HCA leaders were conducted during Summer 2020³.

Individual assessment interviews accomplish multiple goals. First, the interviews allow different parties to identify relevant issues around the engagement theme and vet their diverse perspectives and experience. Second, the interviews encourage people to envision what a successful project outcome might look like, as well as the related benefits – in this case, developing an effective

² A roster of workgroup members is included in Attachment A.

³ Copies of both versions of assessment questions are included in Attachment B.

Communication Framework and its positive impact on behavioral health integration and person-centered outcomes. Third, the interviews allow for a candid discussion of issues and perception of history, as well as relationships between involved parties. Finally, the Center uses the information and opinions heard to assess the potential for collaborative success, as well as to design an effective convening process.

Assessment interview feedback broadly fell into the following themes:

- Organizational and program(s) history and evolution
- Physical and behavioral health integration vision
- Integration experience to-date
- Process history: Strengths and gaps
- Status quo risks
- Systemic impacts and concerns
- Relationships between counties, BH-ASOs and the state (HCA and prior Department of Social and Health Services history)
- Collaborative workgroup expectations and willingness to participate in good faith

In general, the assessment interview responses involved issues embedded in the evolution of behavioral health delivery and payment models over a relatively brief history – from RSNs to BHOs, to the current MCO and BH-ASO model. As noted, this evolution, combined with state agency organizational changes, federal deadlines and other relevant factors involved complicated and complex policy implementation requirements. The changes in delivery models over time and resulting systemic stressors for counties and the HCA are described more fully in the prior section.

The assessment feedback also identified county and tribal uniqueness with respect to differing population needs, workforce capacities and access to care, partner relationships, and how these and other factors have been impacted by the delivery/financing model and structural changes over time. It was interesting to note the learned experiences relayed about tribal relations and engagement over time. These lessons ultimately served as an important precedent when developing the framework's expected applications and value.

The assessment feedback indicated a strong desire from all parties to improve communication. Most expressed concern about the sizable amount of work ahead to continue to integrate physical and behavioral care. Others relayed stories about the unintended consequences of legislative action that didn't fully include counties in the process of policy deliberation. Many participants spoke of the ripple effects of the changing delivery models on county and BH-ASO funding flexibility, and the resulting burden of constraints that impact capacity to pay for interrelated services – for example, Involuntary Treatment Act court costs and services. Others, from counties, BH-ASOs and the HCA recalled the loss over the years of individual relationships and trust

Examples of Diverse Interview Responses

- County payer-agnostic (all population) vs. HCA Medicaid focus
- Lack of universal vision
- Destigmatizing people/services
- Blending funding streams
- Capacity building
- Matching investments to policy
- COVID telehealth improvements
- Reserve balance issues
- Strong HCA tech assistance history
- Time constraints on sharing local perspectives
- Integration success indicators
- Acute challenges vs. systemic patterns
- HCA turnover
- Lack of county expert knowledge
- Loss of behavioral health providers

that had been built and nurtured, but sidelined due to lack of communication focus, strained timelines, program demands and staff turnover.

Several participants approached the concept of a consensus-based framework with varying degrees of skepticism, based on their experience with the program history - but they recognized the need for improved relationships and communication to feel like they could deal with upcoming challenges related to the complexities of behavioral health integration. Several were concerned with the broader systems interconnections and impacts between behavioral health and other community-based service utilization and access, including county jails and low-income housing.

Although participants had varying images of realistic project success, all expressed a willingness for collaboration to create a consensus-based Communication Framework - to help parties build trust, work through policy and implementation challenges, mitigate future conflict, and fulfill a vision of integration success to improve individual's outcomes in Washington state.

The assessment responses emphasized a genuine desire to 'turn a corner' and leverage some recent examples of positive county/HCA interaction to rebuild trusted relationships. These examples were often rooted in frustration, without a defined process to proceed in a collaborative manner. Their success was often based on individual parties' (sometimes including the state's Medicaid Director) commitments to take personal command over a particular problem, whether local or regional (none of the shared examples were systemic). A significant amount of time and energy went into working through these problems on an acute basis, signaling both the interest in rebuilding relationships, as well the need for a type of framework to help effectively structure these and other important and burdensome issues.

Participants demonstrated both a positive and realistic perspective related to issue complexity, program history, future integration workload, co-learning benefits and the need to shift towards genuine collaboration to further integration goals - to improve holistic care, behavioral health access, capacity and outcomes, and decrease outcomes disparities. Participants were willing during the assessment interviews to commit to the focused time needed to build something significant together.

Workgroup Process: Separate Workgroup Facilitations

The Center began a series of Workgroup facilitations with separate county/BH-ASO and HCA working groups. The assessment interviews revealed an apparent need to begin working separately with these groups, to help them identify the similarities and differences between their principles and values, as well as their desired framework vision. These initial meetings began in Spring 2020 (county/BH-ASO workgroup) and Summer 2020 (HCA workgroup). Five county/BH-ASO meetings and two HCA meetings were held virtually. These meetings were designed to follow a similar pattern with each group:

- Development of Workgroup working structure, virtual facilitation rules of engagement and exploration of participant's needs (including meeting frequency and timing)
- Structured exercises and discussions to explore the group's understanding of the purpose and need for a Communication Framework.
- Collective teamwork to identify and categorize foundational qualities and attributes of a successful Communication Framework.
- Collaborative efforts to begin to convert those qualities and attributes into potential framework principles.

These early meetings produced a separate series of foundational qualities, attributes, and principles to help each of the two working groups define their own versions of successful Communication Framework components. In addition, the structured exercises and discussions helped align each group's foundational components with their initial framework vision, goals, and objectives.

Each working group defined more than 50 foundational qualities and attributes they felt should support a successful Communication Framework. Each group then categorized their attributes for further discussion and storytelling (note sidebar).

Examples of HCA's 50+ identified attributes ranged from 'assume good will', 'present with empathy' and 'use of respectful non-verbal communication skills' in the Positive Working Relationships category; 'honor history/traditions, be future facing for solutions' in the Acknowledge Past category; 'individual/community/tribal focus' in the Mission/Purpose category, and 'no preconceived notions or conclusions', 'follow up on items', 'inquire for clarity' and 'problem solving focus – focus on achievement of goals' in the Productive Meeting Goals category.

Examples of County/BH-ASO's 50+ identified attributes ranged from 'Come prepared to meetings', 'understand issue scope, sequence & priority' and 'when and how to engage knowledgeable staff' in the Foundational Tenets category; 'personal accountability/understanding', 'freedom to push back to learn specifics', 'transparent conversations' and 'celebrate successes' in the Desired Relationship category; 'allow for vulnerability', 'availability', 'learn from each other' and 'communication investment on all sides' in the Relationship Building category; 'respect local value re: systems design & management', 'avoid blindsiding', 'planning when transitioning staff' and 'respect different goals' in the Potential Pitfalls category, and 'a yes instead of a no bias', 'right scope & sequence', and 'building together – not just negotiation' in the Results/Outcomes category.

Many of the attributes that each of the initial working groups independently chose were similar. Common attributes included qualities each group felt were important to rebuild trust and credibility, recognize past failures, work towards better future solutions, maintain a common vision, and generally seek a more humane and collaborative process to team as partners, rather than negotiate as adversaries. In addition, the desire for a person-centered perspective to drive underlying system change and operational problem solving was frequently discussed.

Workgroup Process: Combining the Two Working Groups

The two working groups were combined into one Ruckelshaus Workgroup in September 2020. A series of facilitated, structured exercises helped the group share their foundational ideas, including their model qualities and attributes, as well as reaching agreements on Workgroup focus and engagement responsibilities. From this stage forward, monthly Workgroup sessions made liberal use

CATEGORIES OF ATTRIBUTES

County/BH-ASO Working Group:

- Foundational Tenets
- Desired Engagement
- Relationship Building
- Potential Pitfalls
- Results/Outcomes

HCA Working Group:

- Positive Working Relationships
- Acknowledge Past & Positive Future Direction
- Mission/Purpose
- Productive Meeting Goals

of breakout group discussions and large group debrief formats, to allow for appropriate prompting, participant voice and equity of idea-sharing, and a positive learning environment. The Workgroup decided early to limit their meetings to once a month for only two hours. While this extended the duration of the total engagement, the time in between meetings was often used to engage individually with workgroup members, plan interventions when appropriate, and adjust the planned focus of upcoming meetings. On occasion, other parties were invited to join meetings, to share their lived experience, or provide additional subject matter expertise. This took on significant importance in later testing phases.

The group's sharing of their prior qualities and attributes helped define their core communication principles. These included both value-based and operational components to help design the Communication Framework. A high-level summary of the Workgroup's framework principles is noted in the sidebar graphic⁴.

Fall 2021 Workgroup Summary
We'd like a framework that includes/is:

Value-Based Principles

1. Shared goals, shared vision
2. Collectively invested
3. Furthers partnerships & collaboration
4. Allows for vulnerability/forgiveness
5. Population & health-inclusive
6. Recognizes constraints
7. Recognizes diverse perspectives
8. Supports person-centered approach
9. Durable: Survives turnover

Operational Principles

1. Easily understood
2. Efficient
3. Intentional
4. Respectful
5. Realistic
6. Creative (outside the box)
7. Honest/transparent/authentic
8. Includes subject matter experts when needed
9. Results-driven
10. Mission-focused

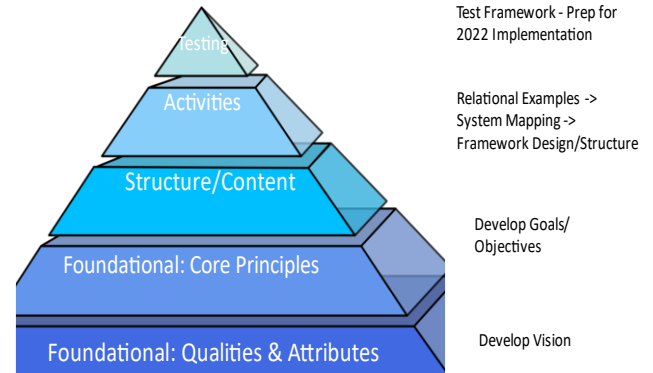
Subsequent Workgroup meetings began to focus on subject matter content (based on lived experience, history of program and systems change, and stratification of past and projected issues into framework categories). This preliminary work helped build and eventually test collective needs, framework structure and integrity. This content was based on the stories and memories that each Workgroup member brought to the collaboration. A series of 'learning' circles' were planned to give Workgroup members the chance to host different issues that would elicit both breadth and depth of discussion to help test the framework needs. For example, one early learning circle focused on the importance of physical/behavioral health integration (from an individual holistic perspective). The ensuing discussion opened a wide diversity of perspectives on systems design, program implementation, unintended consequences, capacity constraints, tribal history and mental health parity.

Another learning circle focused on different perspectives on measuring integration 'success', beyond program metrics. This discussion gave participants a broader understanding of the diversity of program vision, service gaps, different partner/contractor roles and responsibilities, future funding streams, different county needs, the broad scope of the behavioral health continuum, and HCA's role relative to behavioral health and non-Medicaid populations.

⁴ Note that these embedded graphics were originally developed for 'slide' visuals used during Workgroup facilitations and may be difficult to read in this confined report format. Please use your 'View-Zoom' function in Microsoft Word (or similar application) to expand your view to 200%.

Many participants commented that the sharing of different viewpoints within the Workgroup around the history of a specific issue helped them broaden their understanding, empathy, and ability to creatively brainstorm together. These shared learning exercises were one example of the use of facilitated systems thinking tools (mental models) to help the Workgroup progress through both sequential and iterative processes to maintain momentum towards a tested framework design⁵. Continued monthly meetings attempted to balance process and content, with growing emphasis on content as the teamwork progressed.

Ruckelshaus Workgroup: Foundational Pyramid



The Workgroup proceeded on a path to finalizing framework design and moved towards testing. Their momentum was demonstrated on a monthly graphic - a progress 'pyramid' tracked their collaboration and kept them focused on their design efforts and discussion purpose (Note: embedded graphic on the prior page).

Throughout these engagement stages, the Workgroup was simultaneously refining their goals, objectives, and vision, based on their foundational components work (qualities, attributes, and principles). This part of the process was iterative – many discussions looped back to the central points to test the purpose, meaning and intent of the framework. It was often helpful to structure these conversations around the types of issues that might benefit from the framework's use. Those issues were often redefined through 'What'-'Why'-'Who'-'How' conversations:

- 'What' is the real problem or issue?
- 'Why' should this issue be on our collective radar?
- 'Who' will need to be involved to plan for and potentially solve this issue?
- 'How' should the issue be applied to relevant framework model components?

This phase allowed the Workgroup to invest the up-front time to benefit later conversations, when they eventually structured the final framework venues, communication loops and strategic questions to ask. This also began the process of thinking about the types of tools they might need to develop to support the framework.

Communication Framework: Value & Benefits



The Workgroup considered the value and benefits that a new Communication Framework might offer. A version of the existing multi-level tribal/state engagement model helped define the breadth of functions that an effective framework might support. The Workgroup believed that solving the types of issues identified (either county-specific/regional, or systemic) will often require strategic advocacy to build coalitions to approach policy and/or decision makers. The

⁵ Other employed systems-thinking tools included behavior over time graphs, connection circles, causal mapping, components of stock-flow maps and systems archetypes.

framework can be used to help build those collaboratives to seek solutions or systems change. For example:

- If an existing county/regional/tribal operational problem is identified that the HCA has the authority and means to independently correct - the framework can help facilitate that process (for example, correcting the consequences of changes to provider contracting impacting a particular region).
- If the HCA knows that the legislature has appropriated new funding for a portion of the behavioral health continuum (or is leveraging federal funding), the framework can help parties improve preparation for tight implementation deadlines to roll out program improvements – using a much-improved communications process. In this case, the parties can use the framework to proactively plan for and avoid downstream unintended consequences. For example, responding to potential 988 crisis line implementation expectations and associated crisis response system issues; or ripple effects from judicial rulings, such as Washington Supreme court’s Blake decision.
- If an issue is thought to be systemic, the framework helps parties test that assumption, evaluate the issue based on agreed-to principles, prioritize it based on the same principles, and identify the internal or external partners that may be needed to help craft the longer-term solution. The Workgroup agreed that the HCA, as the single-state Medicaid agency would be the logical advisor for this planning. Examples of internal/external partners might include other state agencies (WA Department of Health), the legislature, federal agencies/departments (Centers for Medicare and Medicaid Services; Substance Abuse and Mental Health Services Administration). Such issues could require the proposal of federal Medicaid waivers, new state plan amendments, or new legislation.
- The framework may be used to support collaborative advocacy to evaluate larger systemic issues that are barriers to achieving program and integration vision and outcomes, and propose systems change. Work began to align HCA and WSAC legislative steering committee calendars across session years and to start to build collective legislative strategy.

In April 2021, a smaller sub workgroup was formed with six volunteers: three HCA officials, two county commissioners and one BH-ASO director. The Workgroup had reached a point that required additional meeting time beyond once a month; in particular, to convene a group of detail-minded participants to work through the ‘nuts and bolts’ of finalizing the framework design. This sub workgroup met eleven times between April and November 2021 to work through the many framework details. They relayed their suggestions to the full Workgroup on a regular basis, where discussions led to consensus. During the project’s last several months, this sub workgroup was opened to anyone from the Workgroup who wished to join the meetings. This helped keep the discussions fresh with diverse perspective.

Finally, the Workgroup took the opportunity to ‘pressure test’ the framework in real-time. Examples from Clallam County’s provider contracting process were demonstrated by their regional BH-ASO and County Commissioner – the Workgroup used framework concepts to test for communications gaps and address several external ‘shocks’ that occurred outside of the framework’s boundaries. The test included a Workgroup debrief with corrective action points for both the HCA and county.

The test highlighted several important points:

- If other parties (internal or external) with influence aren't aware of the framework and/or are unwilling to work with the improved communication process, they can negatively impact or delay issue resolution. The Workgroup expects a longer-term effort to educate people about the framework's benefits, and how they can engage in productive and collaborative problem-solving efforts, to reduce the probability of external shocks to the process.
- The framework may not fit all the issues that surface; but it does have the capability of providing useful guard rails that can keep an issue from moving off track from resolution. The framework should be adaptive and improved over time to address as many types of issues as possible.
- Lessons learned from existing conflicts should be quickly evaluated as a team, and improvement steps implemented as soon as possible. For example, assumptions of new policy implementation requirements may cause misinterpretation, especially evident during tight deadlines. A quick contracting checklist, or other universal tool might help all parties quality-control their processes in advance of implementation, to avoid unnecessary misinterpretation.

The Workgroup's expectation is that the framework will need to be demonstrated, taught, and reinforced to pass along important lessons learned throughout the twenty-month collaborative process. Time and patience will help guide other willing county, BH-ASO and HCA participants to experience their own trust and capacity building, as the Communication Framework is used to help structure collaborative problem-solving. As willing legislators, providers, Accountable Communities of Health, MCOs, other state agencies and other behavioral health partners gain exposure to and experience within the framework, partners should experience fewer external shocks. The Workgroup expects that WSAC can provide a significant role with both the educational aspect (exposure to the framework, to inform existing County Commissioners and staff, as well as the large percentage of newer elected officials who are unfamiliar with behavioral health issues), as well as noted legislative strategic efforts.

Workgroup Process: The Two Communication Framework Elements

The two Communication Framework graphics follow in Attachment C. Although these graphics are simple in design, successful application of the Communication Framework will require consistent effort and teamwork from all participants, to develop new meeting and discussion patterns that intentionally break from existing meeting agendas and status quo formats.

County-Specific/Regional Issues Communication Framework:

The county-specific/regional framework is based on a communication flow that deliberately uses (mostly) existing meeting structures; the group wanted to avoid, if possible, unnecessarily adding more meetings to partner's already crowded calendars. The Workgroup looked at a wide range of existing behavioral health-related meetings, to identify those that could potentially match the needs of the framework design, partner and issue requirements for effective collaboration, and participation mix. In some cases, these existing meetings may require agenda and process changes. Other meetings are already semi-structured, allowing for flexibility.

This portion of the framework identifies four existing meetings that can provide the input, expertise, collaboration, brainstorming, and feedback loops needed to identify and test county-specific/regional issues (non-systemic), as well as provide momentum and accountability to team problem-solving functions:

- The **monthly BH-ASO meetings** are key to this part of the framework. In addition to their awareness and knowledge about local behavioral health issues, the BH-ASO directors also serve as a logical ‘collection point’ for issue/problem input from:
 - County ASO directors and Beacon Health (serving as the BH-ASO in three of the ten regions);
 - additional related communication from County Commissioners (who often hear of issues from the public, providers, and others), and
 - the Association of County Human Services (‘ACHS’), an affiliate of WSAC, and co-chaired by one of the Ruckelshaus Workgroup members.

The Workgroup identified certain communication ‘gaps’ when developing this flowchart. The group felt that bringing Beacon Health Options into more conversations would benefit collaborative problem-solving results, as well as tighten relationships between county elected officials, county staff and Beacon in the three regions they serve⁶.

The monthly BH-ASO full-day meetings are an efficient way to identify what may be county-specific or regional issues and bring them to the BH-ASO/HCA meeting the following day.

- The ‘next day’ **BH-ASO/HCA meeting** can serve first as an evaluation point for each raised issue. The team can discuss the context of each issue and determine if it is truly county-specific or regional; if the issue is systemic, the team can move the issue to the framework’s second process. In some cases, issues may include both county-specific/regional and systemic components. The team will need to determine (with or without external guidance) if one or both of the framework’s two processes will fit best. These decisions will likely consider urgency, expected scope of resolution requirements, and resource capacity.

The Workgroup discussed constructing simple scheduling/prioritization tools and lists that can support the maintenance of resolution steps, accountability, and responsibility for these efforts, provide visibility of progress, and generally support the framework principles and attributes developed in the Workgroup facilitations.

The problem-solving process itself is dependent on the scope of the issue, team agreement on context and cause, and evaluation of the pros/cons of potential solutions and downstream consequences. Again, the problem-solving process is embedded within the framework’s communication flow and venues, but not specifically prescribed by the Communication Framework. Some issues can be resolved simply and efficiently with minimal intervention; others require complicated steps involving multiple parties and consensus-building. Regardless, the framework provides the means to raise, evaluate and vet the issues, share diverse opinions and perspectives, and create feedback loops that keep the team informed through resolution to avoid missteps, communication gaps and misunderstandings.

- The **individual BH-ASO/HCA meetings** (county ASOs and Beacon) are relatively new and less structured. The HCA began these meetings as a learning experience, to share information between the parties. The Workgroup felt these would be ideal collaboration spaces to share frank and open discussion to identify both regional opportunities and challenges in a smaller group setting. The meeting frequency will likely need to be adjusted over time, but the

⁶ Beacon serves as BH-ASO in the following regions: Pierce (Pierce County), Southwest (Clark, Klickitat and Skamania Counties), and North Central (Chelan, Douglas, Grant and Okanogan Counties).

content could add valuable input to share at the monthly BH-ASO meetings, and then at the following BH-ASO/HCA meeting.

- The existing every other month **ACHS meetings** (noted above) bring county administrative, planning and service delivery staff together to discuss county implementation around state executive and legislative actions involving behavioral health and intellectual/developmental disabilities services. The HCA has been attending these meetings this past year. The Workgroup felt that this group's 'ground-level' perspective would help provide valuable input to the BH-ASO/HCA next day meeting issue content and perspective. Isabel Jones currently serves as a behavioral health co-chair with ACHS, as well as having participated as one of our framework Workgroup members for the past twenty months.

Workgroup Examples of Emerging and Ongoing Complex Issues

- 988 Crisis Lifeline implementation and changes to WA crisis response system
- Impacts of 1/10th of 1% sales tax and differing county applications
- Impacts from the WA Supreme Court Blake decision
- CMS payment disconnect with WA-defined Eval & Treatment centers
- Behavioral Health Navigator program for student suicide prevention and support
- HB1310: Police use of force
- Quality of crisis response
- Small BH provider capacity and turnover
- Variability of BH treatment & interventions
- Re-org of health boards
- Opportunities include new legislative investments

These four existing meetings make up the 'bones' of the county-specific/regional issue framework. The Workgroup agreed that this portion of the Communications Framework in no way prevents County Commissioners or others from direct contact with the HCA or others – rather, it is intended to provide a logical structure and communication flow that is meant to create more efficient and effective outcomes, avoid communication gaps, and maintain a shared level of visibility and accountability to support a collaborative process. As noted, the meetings' agendas, content and issue resolution processes should remain flexible and adaptable – and changes to the Communication Framework are expected and welcomed over time.

Systemic Issue Communication Framework Steps

The second framework applies if the BH-ASO/HCA meeting team evaluates an issue or opportunity and determines it is systemic in nature. The Workgroup concluded that the existing quarterly **legislatively mandated behavioral health 'coordination' meetings** will be revised to accommodate this systemic work using the framework's collaborative principles. The HCA will work to redesign these meetings to address these systemic opportunities and issues and host the meetings. Meeting frequency may be reconsidered, to

match the intensity and breadth of the expected work.

Rather than proceed with another communication flowchart, the Workgroup concluded that a strategic planning framework would best fit communication needs around systemic issues. The Workgroup developed a set of guiding steps within the framework to help structure, evaluate, and prioritize an appropriate strategic approach to address the systemic issue or opportunity:

- Evaluate the issue: Appropriate time will be invested to examine ‘what is the problem/issue/opportunity?’ from diverse team perspectives. Where does the issue fall on the overarching behavioral health continuum? Is the issue proactive or reactive (or both)? Is the issue urgent? If so, to whom? What’s the probable impact(s) on individuals/communities/providers/community partners/budgets and costs?
- Prioritize the issue(s): It’s unlikely that many major systemic issues can be tackled at once. The Workgroup suggests building framework tools that can help prioritize issues and opportunities, based on impact to individuals and communities, collective capacity to invest the time, external partner (e.g., CMS; legislature) interest and support and other relevant factors.
- Who should be at the table? The Workgroup discussed a mix of diverse perspectives, lived experience, subject matter expertise and funding authority, among other considerations. Once again, the Workgroup reminded themselves that re-centering around a person-centered perspective/impact is an important litmus test for collective action.
- Convening partners and parties: Any convening should be consistent with the principles and attributes of successful communication that the Workgroup developed. Consensus-building processes sometimes require a facilitative role – not necessarily a third party, but certainly persons experienced in process design; facilitative methods, structures and exercises, and skilled in conflict resolution/intervention practices. The scope of the issue and breadth of the strategic partnership will help determine the time and effort requirements, as well as the need for differing levels of skills and expertise.
- Solution/agreement seeking: Which parties have the authority to enable the systemic changes proposed? Which partnerships need to be tapped? What are the administrative, legislative, judicial, or other options to move the strategy forward? The Workgroup determined that the HCA would be the lead partner to research potential and likely strategic options⁷, but the HCA may seek guidance from others (e.g., other WA state agencies; other state’s Medicaid agencies; third party experts; federal partners). How will the strategic process be documented to maintain responsibility, accountability, transparency, and other shared communication attributes? How can feedback loops be used to help maintain momentum, collaboration, and trust between team members? Will the process have resilient backup strategies in case external shocks temporarily upset progress? How can team members build in both flexibility and durability to maintain trust and confidence throughout potentially longer-term strategies? What are the best collaborative methods that can be employed to broadcast ‘wins’, admit and manage mistakes, and work with the media? How can the team use lessons learned to augment trainings for policymakers and elected officials, to keep them current and the systemic issues relevant?

The Workgroup believes that this process is not expected to be linear. It should have built-in feedback loops and process checks to help keep a potentially longer-term process on track. A significant amount of dedicated project management may be required but should be consistent with the defined Communication Framework principles and attributes. Many of the concepts and partnerships suggested in the county-specific/regional framework may apply to systemic issues. It will likely make

⁷ The Health Care Authority is the ‘single state agency’ for Medicaid and is the primary point of contact with federal partners such as CMS. Many systemic issues (and program or systems change) require Medicaid state plan amendments, different versions of federal waivers, or other initiatives that are highly dependent on this state/federal relationship.

sense to link the revised legislatively mandated coordination meetings with input from some of the groups identified in the prior framework section.

Workgroup Process: Planning for 2022 Communication Framework Roll-Out

The Workgroup has initiated the planning process for framework implementation. Roll-out is expected to begin in the first calendar quarter of 2022. The Communication Framework was introduced to a group of county-elected officials and staff at WSAC's Annual Statewide County Leader's Conference in Spokane in November 2021. Executive Director Eric Johnson moderated a panel (Commissioner Mark Ozias, Sindi Saunders, and Kevin Harris) who introduced the twenty-month process and the Communication Framework to audience members. Commissioners Jill Johnson and Chris Branch added Workgroup comments and perspective during the subsequent Q&A session. Interest was high.

The Workgroup is in the process of reaching out to introduce the Communication Framework concepts and structure to the five key groups identified in the graphic representations. Key meetings during the first quarter of 2022 have been identified, and Workgroup members are expecting to build a set of discussion and talking points, as well as presentation stories to convey their shared experience to others⁸. WSAC and HCA legislative teams will work on aligning legislative calendars. Workgroup members are enthused and looking forward to sharing their experience and work with counties, BH-ASOs, other HCA staff and others who serve throughout the behavioral health continuum.

Our thanks and gratitude to all Ruckelshaus Workgroup members for their participation, leadership, enthusiasm, and collaboration throughout the past twenty months. We look forward to hearing of your continued Communication Framework progress and success.

Ruckelshaus Center Recommendations

The 2020/2021 Communication Framework Workgroup collectively produced great energy, effort, and results. From a facilitative perspective, the Workgroup maintained a consistent effort throughout a slower, deliberate process. Comments throughout and at the end of the engagement were heartening – team members felt happy with the end results and appreciated the process to help guide them from a prior (and sometimes) contentious program history toward a genuine trusted and credible partner relationship. They have no illusions about the hard work ahead – but look forward to conveying their shared experiences to others, to help embed the collaborative communication principles they worked hard to achieve to improve behavioral health services to Washingtonians, and enact meaningful systems change.

The following Ruckelshaus Center recommendations are suggested to augment the positive progress and results that the Workgroup achieved:

- a. Build a consistent 'de-brief' mechanism into each of the framework's component meetings for quality improvement purposes. While this requires an additional investment in time, it will help the teams remain nimble and adaptive, especially if the de-briefs are scheduled soon after each meeting ends. This may be especially important in the early stages of implementing the framework, as most existing meetings will experience some degree of modification, or a more significant re-design (e.g., current quarterly legislatively mandated meetings).

⁸ For example, the Workgroup suggested versions of the general framework statements in Attachment D.

- b. When facilitating the larger meetings (more than 20 participants), make intentional and frequent use of breakout groups (regardless of virtual or in-person meeting status), as we did during the first half of this workgroup engagement. This will help develop initial trust – most people are more comfortable speaking frankly in smaller groups. As confidence builds and people mix between breakout groups (with time for larger group debriefs to share smaller group work), begin to phase in progressively larger breakout groups, until the value of the full group’s discussion outweighs the value of using breakouts.
- c. Be intentional about improving and adapting the Communication Framework:
 - Calendar ‘tune-up’ meetings with a core workgroup or framework steering committee on a regular basis (perhaps quarterly to begin) to review progress, consider adjustments, celebrate wins, and evaluate bottlenecks and barriers.
 - Continue to ‘pressure-test’ the communication Framework using real-time or recent issues, to identify potential framework gaps or improvements. Implement improvements.
 - Prepare practical examples of ‘wins’ and ‘losses’ to evaluate and brainstorm process improvements, which may include meeting modifications, facilitative improvements, identifying continuing patterns of communication gaps and other lessons learned.
 - Seek diverse opinions on recommended improvements before implementing them.
 - Create a forum to efficiently update everyone on modifications, including ‘why’ and ‘how’ statements. For example, consider a twice a year Communication Framework Bulletin for broad distribution. This could also serve as education updates for newer staff and newly elected officials.
- d. Leverage WSAC’s capacity to build an education plan to update existing County Commissioner’s knowledgeable about behavioral health, less experienced Commissioners, and newly elected officials to promote interest and subject matter context. Teach elected officials how to engage, work with and leverage the framework concepts.
- e. Identify a key set of legislators and staffers who are most knowledgeable of behavioral health systems and issues; present a separate introductory demonstration of the Communication Framework to them for engagement, education, and feedback.
- f. Engage willing tribal support to help add important issue/opportunity evaluation from a tribal/state and tribal/community behavioral health perspective. Tribal mental models and systemic evaluation are compatible in many ways and can add valuable context and diversity of thought to solving systemic issues.
- g. Build framework tools that can be universally used or adapted to meet issue and process requirements. For example:
 - A checklist of communication-based steps for policy implementation rollouts.
 - An issues inventory list for county-specific/regional issues to maintain and document progress, responsibilities and milestones reached.
 - A systems-mapping and/or cause & effect mapping tool to help the team fully evaluate systemic issues. Mapping helps to identify root causes, interdependencies, potential unintended consequences, and possible points of leverage to trigger larger systems impacts. This may also help the team prioritize certain systemic issues, if teamwork invested in one issue has significant impacts on others (see systems-thinking questions in ‘i’ below).
 - A minimum checklist of media or legislative exposure talking points to promote consistency between team members when describing the Communication

Framework. The Workgroup agreed to two general framework statements, noted in Attachment D.

- A tool that helps the group screen issues for urgency, based on agreed-to concepts. The Workgroup had several discussions about a simple 'red-yellow light' tool that elevates urgent (red light) issues and prepares the group for issues of upcoming concern (yellow light). Developing consensus-based rules can support agreement about re-prioritizing issues when necessary.
- h. For those issues that may not 'fit' the framework, consider use of a conflict-resolution process or steps that can help parties test their willingness to collaborate (or at least come to an acceptable joint resolution over the issue). This may also be helpful when interventions are sometimes required during longer-term processes.
- i. Use systems-thinking tools and habits to help expand the systemic framework team's thorough evaluation of an issue, to identify root causes and interconnectivity to gain productive team momentum, refine prioritization competencies and broaden options for lasting solutions. For example, questions to consider include:
- How are differing attitudes and beliefs advancing or hindering efforts to achieve desired results?
 - Has the issue been considered fully? Have we resisted the urge to come to a quick conclusion? Are we all aligned in seeing the 'big picture'? Have we openly tested our theories and shared assumptions with others, to improve performance?
 - Have we identified the many parts of our behavioral health system and structure to understand the whole, and how our system's relationships affect behavior?
 - Have we considered the unintended consequences of a proposed action, and the trade-offs to consider? What are the short and long-term consequences, and are we willing to accept short-term pain for long-term gain?
 - Do we understand the circular nature of complex cause and effect relationships?
 - What indicators should we expect to see as we look for progress? Are we pausing enough to assess the effects of our current plan and work together?
 - Are we identifying how elements of our system have changed over time? How quickly are they changing, and what patterns or trends have emerged?
 - How have our own perspectives changed over time? How has that influenced our decision-making?
 - How can we use what we know about our behavioral health system to identify possible leverage actions? Where might a small change have a long-lasting and desired effect?
- j. When it's appropriate to use either an internal or external facilitator for systemic issue evaluation and prioritization, seek out people who are skilled in facilitating strategic planning efforts.
- k. Consider developing a team member agreement that includes commitment to the Communication Framework's principles and process. For example, other workgroups have developed Declarations of Cooperation, or Memoranda of Collaborative Intent. This is not intended to add a legally binding component to the process, but to instead solicit further commitment of 'buy-in' from engaged parties. In addition, this could represent a creative tool to further framework durability.
- l. Add Communication Framework training for all new state and county staff (and elected officials) involved in behavioral health issues. Add this to a 'checklist' for all outgoing staff, to prompt coaching and education of replacement personnel.

Attachment A – Roster of WA Behavioral Health Communication Framework Team Members (including retired)

| <u>Team Member</u> | <u>Organization</u> |
|---------------------------|--|
| Jessica Blose | Health Care Authority/WA State Opioid Treatment Authority |
| Chris Branch | Okanogan County Commissioner |
| Teresa Claycamp | Health Care Authority/Division of Behavioral Health and Recovery |
| Diana Cockrell | Health Care Authority/Division of Behavioral Health and Recovery |
| Jessie Dean | Health Care Authority/Office of Tribal Affairs |
| Dr. Charissa Fotinos | Health Care Authority/Interim Medicaid Director |
| Edna Fund | Lewis County Commissioner |
| Eric Johnson | Washington State Association of Counties |
| Jill Johnson | Island County Commissioner |
| Isabel Jones | King County/Behavioral Health and Recovery Division |
| Michael Langer | Health Care Authority/Division of Behavioral Health and Recovery |
| Ruth Leonard | Health Care Authority/Medicaid Programs Division |
| Alice Lind | Health Care Authority/Medicaid Programs Division |
| MaryAnne Lindeblad | Health Care Authority/Medicaid Director |
| Sarah Mariani | Health Care Authority/Division of Behavioral Health and Recovery |
| Jason McGill | Health Care Authority/Medicaid Program's Division |
| Mark Ozias | Clallam County Commissioner |
| Melodie Pazolt | Health Care Authority/Division of Behavioral Health and Recovery |
| David Reed | Health Care Authority/Division of Behavioral Health and Recovery |
| Sindi Saunders | Greater Columbia BH-ASO |
| Keri Waterland | Health Care Authority/Division of Behavioral Health and Recovery |

Attachment B

WASHINGTON STATE UNIVERSITY

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WA Behavioral Health Communication Framework Questions: Counties and BH-ASOs

1. *Please describe your position, professional background and organization/constituents as they relate to physical/behavioral health integration in your community. What are your (organization's) most important responsibilities relative to integration goals?*
2. *Imagine your community's ideal health status beyond the finite Demonstration timeline and existing barriers. What would integration success look like from your perspective in 5-10 years? How would you gauge that success?*
3. *How would you describe your current relationship with the Health Care Authority, and with other stakeholders? What specific past events led to any change in those relationships?*
4. *What are some positive examples of behavioral health integration to-date (in either your community or others)?*
5. *Which key components/processes have been missing in building relationships and trust between parties throughout this process?*
6. *What are you most concerned about right now relative to integration issues? What are the risks of remaining 'status quo'?*
7. *Has your own thinking around integration issues and the need for collaboration evolved since the 1115 Waiver began? How?*
8. *What expectations do you have about entering a collaborative process? What do you hope to achieve? What concerns do you have?*
9. *Who else should I speak to with respect to these issues, if and when this initial group expands? Why?*
10. *Are there other questions I should have asked? Do you have any additional questions for me?*

THE
WILLIAM D. RUCKELSHAUS CENTER

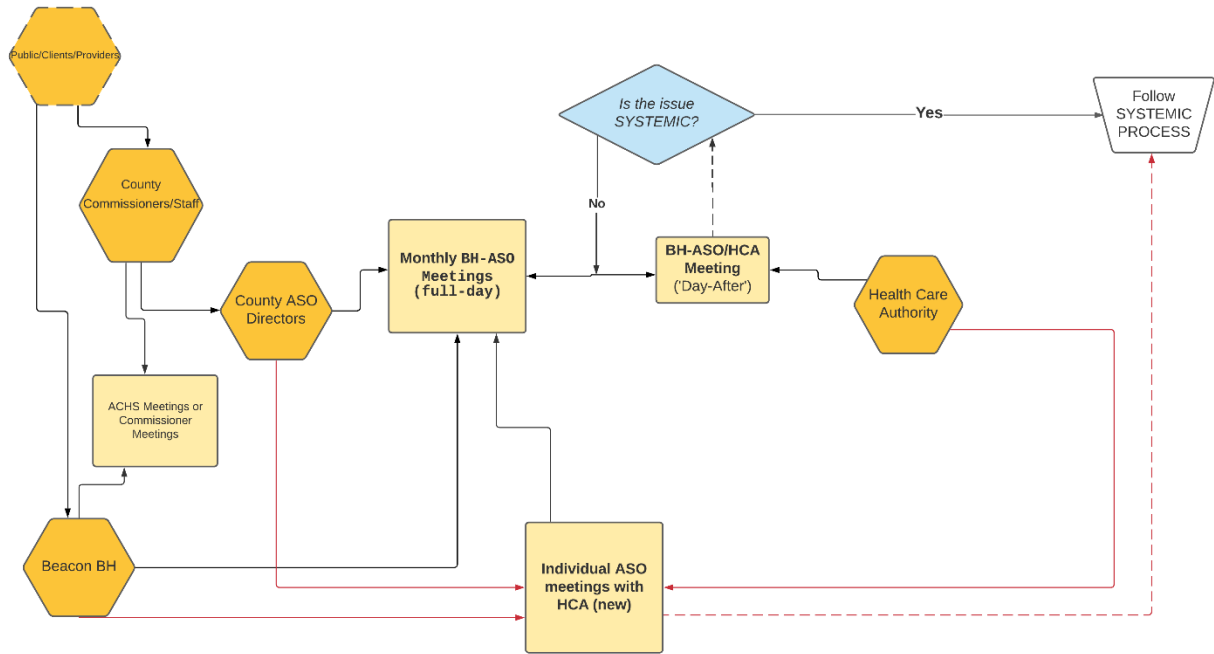
UNIVERSITY OF WASHINGTON

WA Behavioral Health Communication Framework
Questions: Health Care Authority

1. *Please describe your position, professional background and organization/constituents as they relate to physical/behavioral health integration. What are your (organization's/team's) most important responsibilities relative to integration goals?*
2. *Imagine our state's and communities' ideal health status beyond the finite Demonstration timeline and existing barriers. What would integration success look like from your perspective in 5-10 years? How would you gauge that success?*
3. *How would you describe your current relationship with counties, and with other stakeholders, including the MCOs, ACHs and relevant legislators? What specific past events led to any change in those relationships?*
4. *What are some positive examples of behavioral health integration to-date (either statewide or within specific communities)?*
5. *Which key components/processes have been missing in building relationships and trust between parties throughout this process?*
6. *What are you most concerned about right now relative to integration issues? What are the risks of remaining 'status quo'?*
7. *Has your own thinking around integration issues and the need for collaboration evolved since the 1115 Waiver began? How?*
8. *What expectations do you have about entering a collaborative process? What do you hope to achieve? What concerns do you have?*
9. *Who else should I speak to with respect to these issues, if and when this initial group expands? Why?*
10. *Are there other questions I should have asked? Do you have any additional questions for me?*

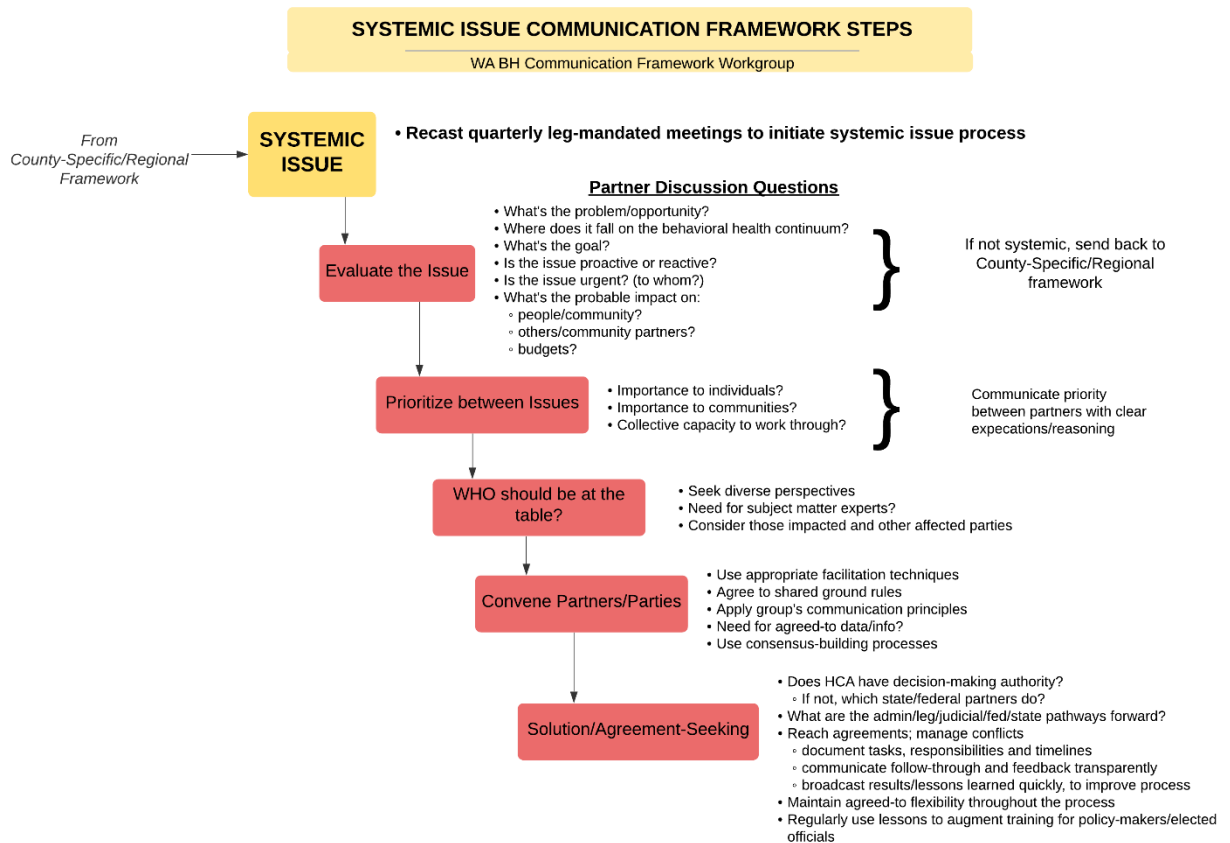
Attachment C

County-Specific/Regional Issue Communication Framework



- Individual ASO meetings to maintain unstructured 'open discussion space'
- Helps to identify regional/systemic issues and share opportunities
- Allows breathing room to listen, plan, align and problem-solve collaboratively

Final Workgroup Version
as of 12/31/221



Final Workgroup Version as of 12/31/21

Attachment D

General Framework Statement Draft: What it is

The behavioral health communication framework creates a collaborative structure to help counties, BH-ASOs and the Health Care Authority to:

- *Work collaboratively and flexibly to help solve county-specific, regional and statewide (systemic) behavioral health integration issues that require teamwork.*
- *Help build and expand trusted relationships that outlast leadership, management and elected official turnover.*
- *Grow into a long-standing partnership culture that is inclusive, transparent and accountable.*
- *Change and improve behavioral health status and systems for the benefit of all Washingtonians.*

General Framework Statement Draft: What it is **not**

The behavioral health communication framework is not:

- *A problem-solving process (it is a communications framework that enables problem-solving)*
- *Meant to address 100% of all behavioral health problems in our state*
- *A guarantee for 100% successful resolution, or a process to always avoid conflict*
- *A means to play 'gotcha'*