King County

1200 King County Courthouse
516 Third Avenue
Seattle, WA 98104

Meeting Agenda

Health, Housing, and Human Services Committee

Councilmembers:
Teresa Mosqueda, Chair;
Rhonda Lewis, Vice Chair;
Jorge L. Barón, Steffanie Fain

Lead Staff: Olivia Brey (206-263-7913)
Committee Clerk: Angelica Calderon (206-477-0874)

9:30 AM | **Thursday, July 23, 2026** | **Hybrid Meeting**

SPECIAL MEETING

Hybrid Meetings: Attend King County Council committee meetings in person in Council Chambers (Room 1001), 516 3rd Avenue in Seattle, or through remote access. Details on how to attend and/or provide public comment remotely are listed below.

Pursuant to K.C.C. 1.24.035 A. and F., this meeting is also noticed as a meeting of the Metropolitan King County Council, whose agenda is limited to the committee business. In this meeting only the rules and procedures applicable to committees apply and not those applicable to full council meetings.

HOW TO PROVIDE PUBLIC COMMENT: The Health, Housing, and Human Services Committee values community input and looks forward to hearing from you on agenda items.

There are three ways to provide public comment:
1. In person: You may attend the meeting and provide comment in the Council Chambers.
2. By email: You may comment in writing on current agenda items by submitting your email comments to committees@kingcounty.gov. If your email is received by 8:00 a.m. on the day of the meeting, your email comments will be distributed to the committee members and appropriate staff prior to the meeting.
3. Remote attendance at the meeting by phone or computer (see "Connecting to the Webinar" below)

You are not required to sign up in advance. Comments are limited to current agenda items.

Sign language and interpreter services can be arranged given sufficient notice (206-848-0355).
TTY Number - TTY 711.
Council Chambers is equipped with a hearing loop, which provides a wireless signal that is picked up by a hearing aid when it is set to 'T' (Telecoil) setting.

You have the right to language access services at no cost to you. To request these services, please contact Language Access Coordinator, Tera Chea at (206) 477 9259 or email Tera.chea2@kingcounty.gov by 8:00 a.m. at least three business days prior to the meeting.

CONNECTING TO THE WEBINAR:
Webinar ID: 842 7675 9952

By computer using the Zoom application at https://zoom.us/join and the webinar ID above.

Via phone by calling 1 253 215 8782 and using the webinar ID above.

HOW TO WATCH/LISTEN TO THE MEETING REMOTELY: There are several ways to watch or listen in to the meeting:
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To show a PDF of the written materials for an agenda item, click on the agenda item below.

1. **Call to Order**

2. **Roll Call**

3. **Approval of Minutes** p. 5

   Minutes June 2, 2026 meeting.

4. **Public Comment**

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Consent

5. Proposed Ordinance No. 2026-0117 **p. 8**

AN ORDINANCE authorizing the county executive to enter into an interlocal agreement for the provision of autopsy and forensic pathology services by the King County medical examiner's office to Skagit County.

Sponsors: Mosqueda

Olivia Brey, Council staff

Discussion Only

6. Proposed Ordinance No. 2026-0177 **p. 21**

AN ORDINANCE adopting the King County behavioral health bridge implementation plan, required by the 2026-2027 Biennial Budget Ordinance, Ordinance 20023, Section 70, Proviso P1, to govern the expenditure of proceeds from 2028 through 2034 of the behavioral health sales and use tax authorized by RCW 82.14.460 and K.C.C. 4A.500.315.

Sponsors: Mosqueda

Sam Porter, Council staff

7. Proposed Ordinance No. 2026-0174 **p. 176**

AN ORDINANCE renaming and revising the mental illness and drug dependency fund and the mental illness and drug dependency advisory committee; amending Ordinance 16077, Section 4, as amended, and K.C.C. 2.130.010, Ordinance 18217, Section 2, as amended, and K.C.C. 2A.300.510, Ordinance 15955, Section 2, as amended, and K.C.C. 4A.200.430, and Ordinance 16693, Section 3, as amended, and K.C.C 24.22.020, adding a new section to K.C.C. chapter 4A.200, and recodifying K.C.C. 4A.200.430.

Sponsors: Mosqueda

Sam Porter, Council staff

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Discussion and Possible Action

8. Proposed Motion No. 2026-0145 **p. 200**

A MOTION acknowledging receipt of the Harborview Medical Center Long-Range Planning Committee Plan required by the 2026-2027 Biennial Budget Ordinance, Ordinance 20023, Section 17, Proviso P8.

Sponsors: Mosqueda

Sam Porter, Council staff

Briefing

9. Briefing No. 2026-B0089 **p. 231**

Disability Pride Month - 39th Anniversary of the Federal American's With Disability Act; Implementation and Activation at King County.

Darya Farivar, ADA & Disability Equity Specialist, King County Executive Office (KCEO)
Cecelia Black, ADA & Disability Equity Specialist, KCEO
Nate Olsen, ADA & Disability Equity Specialist, KCEO

10. Briefing No. 2026-B0090 **p. 240**

Update on U.S. Continuum of Care Funding

Jeff Simms, Chief Program Officer, King County Regional Homelessness Authority
Daniel Malone, Executive Director, Downtown Emergency Service Center (DESC)
Lindsey Grad, Legislative Director, SEIU Healthcare 1199NW
Regan McBride, Union Representative, PROTEC17
Hogarth Russell, Union Representative, OPEIU Local 8

Adjournment

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Meeting Minutes

Health, Housing, and Human Services Committee

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Rhonda Lewis, Vice Chair;
Jorge L. Barón, Steffanie Fain

Lead Staff: Olivia Brey (206-263-7913)
Committee Clerk: Angelica Calderon (206-477-0874)

9:30 AM | **Tuesday, June 2, 2026** | **Hybrid Meeting**

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1. Call to Order

Chair Mosqueda called the meeting to order at 9:34 a.m.

2. Roll Call

Present: 4 - Barón, Fain, Lewis and Mosqueda

3. Approval of Minutes

Vice Chair Lewis moved approval of May 5, 2026, meeting minutes. There being no objections, the minutes were approved.

4. Public Comment

There was no one to offer public comments.

Briefing

5. Briefing No. 2026-B0073

Public Health Fiscal Outlook

Aaron Rubardt, Budget Director, Executive's Office and Drew Pounds, Executive Analyst, Executive's Office, briefed the Committee via PowerPoint presentation and answered questions from the members.

This matter was Presented

Discussion and Possible Action

6. Proposed Motion No. 2026-0111

A MOTION acknowledging receipt of a report on maintaining Medicaid retention in King County, in accordance with the 2026-2027 Biennial Budget Ordinance, Ordinance 20023, Section 17, Proviso P9.

Sponsors: Mosqueda

Sam Porter, Council staff, briefed the Committee on the legislation and answered questions from members. Daphne Pie, Regional Health Services Administrator for Access and Outreach in Community Health Services, (PHSKC) and Keith Seinfeld, Policy, Programs and Communications Strategist, PHSKC, also briefed and answered questions from the members.

A motion was made by Lewis that this Motion be Recommended Do Pass. The motion carried by the following vote:

Yes: 4 - Barón, Fain, Lewis and Mosqueda

Other Business

There was no other business to come before the Committee.

Adjournment

The meeting was adjourned at 11:27 a.m.

Approved this _____ day of _____

Clerk's Signature

Metropolitan King County Council
Staff Report

Committee:	Health, Housing, and Human Services		
Agenda Item:	5	**Analyst(s):**	Olivia Brey
Proposed No.:	2026-0117	**Meeting Date:**	July 23, 2026

OVERVIEW

TOPIC: An ordinance authorizing the executive to enter an interlocal agreement with Skagit County to provide autopsy and forensic pathology services, as requested, for a five-year period.

LEGISLATION SUMMARY

The proposed ordinance would authorize the executive to enter into an interlocal agreement with Skagit County to allow King County to provide autopsy and forensic pathology services, as requested by Skagit County, for a five-year period. The interlocal agreement notes that the services are contingent upon the King County Medical Examiner's Office (MEO) capacity to provide services when requested by Skagit County.

According to Executive staff, this is the first agreement for the King County MEO with the Skagit County Coroner and Skagit County requires an interlocal agreement as part of their process. State law requires public agencies entering into agreements for cooperative action to be acted upon by ordinance. The transmitted ordinance and attachment appear to meet the requirements of state law.

KEY ISSUES FROM THE ANALYSIS

No issues have been identified.

BACKGROUND & TIMING CONSIDERATIONS

↑ BACK TO TOP

King County Medical Examiner's Office (MEO). The King County MEO investigates sudden, unexpected, and unnatural deaths in King County and works to provide accurate identification of decedents and to notify the next of kin.[1] The MEO is housed organizationally within the Prevention Division of Public Health with over 40 professional staff including medical examiners (medical doctors with forensic pathology specialty),

[1] King County Medical Examiner's Office. https://kingcounty.gov/en/dept/dph/health-safety/medical-examiner

medical investigators, autopsy technicians, Real-Time Drug Surveillance Program staff, and administrative support staff.

Skagit County Coroner's Office. The Skagit County Coroner's Office investigates the circumstances surrounding a person's death independently of any law enforcement agency. Similar to the King County MEO, the coroner is also responsible for identifying decedents, locating and making notification to next-of-kin, safeguarding personal property, collecting evidence, and completion of mandatory records and documents. The Coroner's Office includes the County Coroner and four medicolegal death investigators. [2]

ANALYSIS

↑ BACK TO TOP

Proposed Ordinance 2026-0117 would authorize the executive to enter an interlocal agreement with Skagit County for the King County MEO to provide autopsy and forensic pathology services, as requested, for a period of five years. The transmitted proposed ordinance indicates that Skagit County may refer select cases to the MEO when Skagit County has a need for subspeciality expertise, facility capacity, increased caseload, or staffing constraints.

According to Executive staff, this is the first agreement for the King County MEO with the Skagit County Coroner. The MEO provides services for other jurisdictions using simple contracts, but Skagit County requires an interlocal agreement.

State law (RCW 39.34.030) requires public agencies entering into agreements for cooperative action to be acted upon by ordinance.[3] The transmitted ordinance and attachment appear to meet the requirements of state law. Key provisions of the agreement are described below.

Skagit County Coroner Responsibilities. The interlocal agreement identifies the Skagit County Coroner responsibilities, including, but not limited to:

- Requesting services and coordinating examination details with the MEO;
- Providing investigative reports and other documentation prior to the examination;
- Transportation of the body to and from the MEO;
- Handling communications about the case to family members, law enforcement, media, and other government agencies;
- Identification of the decedent using information collected by the MEO; and

[2] Skagit County Coroner's Office. https://www.skagitcounty.net/Departments/Coroner/main.htm
[3] RCW 34.34.030. https://app.leg.wa.gov/rcw/default.aspx?cite=39.34.030

- Creation of a death record.

King County MEO Responsibilities. The King County MEO responsibilities outlined in the interlocal agreement, include, but are not limited to:

- Coordination with the Skagit County Coroner;
- Performing a postmortem examination and necessary ancillary studies;
- Providing a verbal report of preliminary examination findings as soon as practical after the examination and a final written report and other records within a reasonable time;
- Collection of evidence and release to Skagit County Coroner, as well as release of toxicology samples;
- Maintain records, wet tissue samples, paraffin blocks, and glass slides per the MEO retention policies;
- Storage of bodies at Skagit County coroner's request; and
- Providing testimony and expert opinions in subsequent legal proceedings.

The interlocal agreement notes that the services are contingent upon the MEO's capacity to provide services when requested by Skagit County.

Fee Schedule. A schedule of fees is included attached interlocal agreement for exams, autopsies, and body storage. The fee for testimony and related expenses isn't specified, but fee schedule notes that Skagit County will pay an hourly rate based on the employee's salary and travel expenses. Executive staff stated that the fee amounts reflect the average amount of time taken based on various employees considering the average cost per hour of each employee's classification, as well as equipment costs. The costs are comparable to the amount charged by other independent pathologists and medical examiner offices in the state.

According to Executive staff, no fiscal impact is expected because no specific revenue or expenditures are included at this time and the purpose of this agreement is to allow Skagit County to request the MEO's services when they need them.

ATTACHMENTS

1. Proposed Ordinance 2026-0117 (and its attachment)
2. Transmittal Letter

1200 King County Courthouse
516 Third Avenue
Seattle, WA 98104

KING COUNTY

Signature Report

Ordinance

Proposed No. 2026-0117.1 **Sponsors** Mosqueda

AN ORDINANCE authorizing the county executive to enter into an interlocal agreement for the provision of autopsy and forensic pathology services by the King County medical examiner's office to Skagit County.

STATEMENT OF FACTS:

1. Interjurisdictional collaboration among death investigation agencies is a recognized best practice that promotes consistency in forensic standards, service continuity, and efficient use of public resources.

2. The Skagit County coroner's office is a small jurisdiction with two contracted forensic pathologists and low refrigeration space capacity for cases.

3. The King County medical examiner's office has seven full-time forensic pathologists and high capacity for storage and active examinations.

4. During times of periodic limitations in forensic pathology staffing, subspecialty expertise, or facility capacity, the Skagit county coroner's office would like to refer select cases to the King County medical examiner's office for autopsy and forensic pathology services.

5. Access to the King County medical examiner's office resources will help ensure timely, thorough, and scientifically rigorous examinations for Skagit County cases, particularly during periods of increased caseload or staffing constraints.

6. The provision of requested services is contingent upon the King County medical examiner's office capacity to provide such services.

7. For any services utilized via the attached agreement, the Skagit County coroner's office will reimburse the King County medical examiner's office according to the established fee schedule.

8. The attached interlocal agreement is entered into under the authority of chapter 39.34 RCW, which requires action by ordinance before execution.

BE IT ORDAINED BY THE COUNCIL OF KING COUNTY

SECTION 1. The county executive is hereby authorized to execute an interlocal agreement with Skagit County, in substantially the form of Attachment A to this

ordinance, necessary for the provision of autopsy and forensic pathology services by the King County medical examiner's office to Skagit County.

KING COUNTY COUNCIL
KING COUNTY, WASHINGTON

_____

Sarah Perry, Chair

ATTEST:

_____

Melani Pedroza, Clerk of the Council

APPROVED this _____ day of _____, _____.

_____

Girmay Zahilay, County Executive

Attachments: A. Interlocal Agreement for Autopsy and Forensic Pathology Services between King County and Skagit County

Interlocal Agreement for Autopsy and Forensic Pathology Services Between King County and Skagit County

A. Purpose

Seattle-King County Department of Public Health-Prevention Division, King County Medical Examiner's Office (Medical Examiner), and Skagit County Coroner (Skagit Coroner) agree that Medical Examiner will provide forensic pathology services for Skagit Coroner.

B. Organization and Financing

This Agreement does not create any joint or cooperative undertaking nor any separate legal or administrative entity and does not require any financing other than the payments set forth in it.

C. Responsibilities/Scope of Services and Roles

Upon Skagit Coroner's request, Medical Examiner will perform the following services which will be billed at the rates set forth in the Fee Schedule in Attachment A. The services are contingent upon Medical Examiner's capacity to provide these services at the time Skagit Coroner requests services.

The Skagit Coroner agrees to:

1. Request services and coordinate examination details with the Medical Examiner Investigations Manager (or when they are not available, the Medical Examiner Health Services Administrator);
2. Provide an investigative report, scene photographs, relevant available medical records and history, and the investigating law enforcement agency's contact information *prior to the examination* (information sharing may be facilitated by MDILog);
3. Provide follow up investigation necessary to determine cause of death when the Medical Examiner requests;
4. Transport the body to and from Medical Examiner – due to limited cooler space, a storage fee will be charged if bodies are not removed within a reasonable time (see Fee Schedule);
5. Handle all communications about the case, including but not limited to, death notification, questions from family members and law enforcement, media inquiries, and communications with other local, state, and federal agencies;
6. Identify the decedent – Medical Examiner may collect fingerprints, radiographs, DNA, etc., for identification purposes, however, the Skagit Coroner is ultimately responsible for making the identification;
7. Create death record in WHALES;
8. Pay the fees for services as set forth in the Fee Schedule below; and
9. Submit requests for service under this agreement to consults.meo@kingcounty.gov.

In return for Skagit Coroner meeting the above conditions, Medical Examiner will:

1. Coordinate with the Skagit Coroner for a mutually convenient time for a postmortem examination (such as external exams or routine or complex

autopsies);
2. As Medical Examiner capacity allows, perform a postmortem examination in accordance with Medical Examiner procedures, including necessary ancillary studies;
3. Provide a verbal report of preliminary examination findings as soon as practical after the examination, and a final written report of postmortem examination and other relevant records such as photographs and ancillary reports within a reasonable time;
4. Collect evidence and release it to the Skagit Coroner or appropriate law enforcement agency;
5. Release toxicology samples to the Skagit Coroner – at the Skagit Coroner's request, Medical Examiner will submit appropriate samples to the Washington State Toxicology Laboratory for toxicologic analysis but cannot store the remaining samples on site and will assist Skagit Coroner in transferring such remaining samples to alternative storage;
6. Maintain records, wet tissue samples, paraffin blocks, and glass slides at Medical Examiner per its retention policies;
7. Store bodies at Skagit Coroner's request or as set forth in the fee schedule; and
8. Provide testimony and expert opinions in subsequent legal proceedings.

D. Confidential or Proprietary Materials

If any Medical Examiner professionals performing work under this Agreement are requested to provide testimony, at deposition or otherwise, that person may need to resist a third party's effort to elicit, in connection with that testimony, facts concerning either: (a) proprietary Medical Examiner materials; or (b) other Medical Examiner's clients and/or engagements. Medical Examiner may need to resist such efforts due to: (1) confidentiality agreements or protective orders governing those other engagements; (2) restrictions other Medical Examiner's clients have imposed on disclosure; or (3) other reasons. Medical Examiner has a legitimate interest in maintaining the confidentiality of their proprietary materials and information relating to other clients and engagements. If the Medical Examiner is asked or required to disclose proprietary matters or information relating to other clients or engagements, the Medical Examiner will use their best efforts to protect the Skagit Coroner's interests consistent with their needs to protect their proprietary materials and comply with applicable non-disclosure obligations. If necessary, the Medical Examiner will engage, at their own expense, their own independent counsel to assist them in this effort.

E. Duration

The Agreement is effective from _____ through _____, for a period of five (5) years.

F. Termination

Either party may terminate this Agreement without cause, in whole or in part, at any time, by providing the other party 15 days advance written notice. The Agreement will terminate 15 days after a party gives that notice.

If the Contract is terminated, Medical Examiner agrees to complete any services it began before the termination date. Skagit Coroner will be liable only for payment for services the Medical Examiner began prior to the effective termination date; and the Medical Examiner

shall be released from any obligation to provide further services under this Contract. However, the Medical Examiner and the Skagit Coroner may agree that Medical Examiner will provide additional services including expert opinions and testimony. The Skagit Coroner and the Medical Examiner shall agree in advance on fees to be paid for such services and Skagit Coroner will pay such fees in the same manner as fees were paid under this Agreement.

G. Hold Harmless and Indemnification

Each party assumes liability for its own wrongful and/or negligent acts or omissions or those of their officials, officers, agents, or employees to the fullest extent required by law. Each party shall protect, defend, indemnify, and save harmless the other party, its officers, employees, and agents from any and all costs, claims, judgments, and/or awards of damages made by them or their officers, employees, and/or agents, arising out of, or in any way resulting from, their or their officers, employees, and/or agents' negligent acts or omissions.

For this purpose, by mutual negotiation, the parties expressly waive all immunity and limitation on liability under any industrial insurance act, including Title 51 RCW, other worker's compensation act, disability benefit act, or other employee benefit act of any jurisdiction which would otherwise be applicable in the case of such claim.

H. Insurance

Each party shall maintain its own insurance and/or self-insurance for its liabilities from damage to property and/or injuries to persons arising out of its activities associated with this Agreement as it deems reasonably appropriate and prudent. The maintenance of, or lack thereof of insurance and/or self-insurance shall not limit the liability of the indemnifying party(s). Each party, upon request, shall provide the other with a certificate of insurance or letter of self-insurance annually as the case may be.

I. No Third Party Beneficiaries

There are no third-party beneficiaries to this Agreement, and this Agreement shall not impart any rights enforceable by any person or entity that is not a party.

J. Administration

The following individuals are designated as representatives of the respective parties. The representatives shall administer, coordinate, and monitor performance under this Agreement. If a party changes its representative, it shall notify the other party.

The Skagit Coroner's representative shall be
Hayley L. Thompson, D-ABMDI
Skagit County Coroner
1700 Continental Place
Mount Vernon, WA 98273
(360) 416-1996 (main 24-hour number)
(360) 848-1173 (fax)

Medical Examiner 's representative shall be
Nathan Geerdes, D-ABMDI
Investigations Manager

908 Jefferson Street
Seattle, WA 98104
(206) 731-3232 (main 24-hour number)
Consults.meo@kingcounty.gov

K. Treatment of Assets and Property

The parties will not, under this Agreement, jointly or cooperatively, acquire, hold, use, or dispose of any fixed assets or personal or real property.

L. Changes, Modifications, Amendments, And Waivers

The parties may change, modify, amend, or waive this Agreement only by written agreement. A party's waiver or breach of any term or condition of this Agreement shall not waive any prior or subsequent breach. This Agreement contains all of the parties' agreed terms and conditions. All items incorporated herein by reference are attached. The parties do not have any other binding understandings, oral or otherwise, regarding this Agreement's subject matter.

M. Severability

If any Agreement term, condition, or application to any person or circumstances is invalidated, the Agreement's other terms, conditions, or applications shall remain valid, and any invalid terms and conditions will be severed if possible.

The undersigned agree to the terms and conditions set forth in this Agreement.

Public Health – Seattle & King County	**Skagit County Coroner**
_____	_____
Authorized Signature	Authorized Signature
_____	_____
Name	Name
Director	
_____	_____
Title	Title
_____	_____
Date	Date

Medical Examiner Fee Schedule for Forensic Pathology Services 2026

Note: The Medical Examiner will decide whether an autopsy is routine or complex

The base cost of all procedures include reasonable consultation time with Skagit Coroner (or designee), law enforcement officials, and attorneys. If such demands on Medical Examiner employees' time become excessive, Medical Examiner may charge an hourly rate based on the employee's salary so it does not suffer a loss. The rates listed here are subject to change based on inflationary increases.

External Exam **$900**

This includes: 1) an external examination of the body by a forensic pathologist; 2) body photography; 3) basic radiography; 3) collection and submission of toxicology samples and evaluation of results; 4) review of pertinent records; 5) discussing findings with Skagit Coroner (and/or designee); 6) opinion on cause of death; and 7) a written external exam report.

Autopsy - Routine **$1,900**

This includes: 1) all external exam features; 2) a complete internal examination; 3) a forensic pathologist conducting appropriate ancillary studies; and 4) a written autopsy report.

Autopsy – Complex **$2,500**

This includes: 1) all features of a routine autopsy; 2) additional procedures that may include: a) evidence collection; b) extensive radiography; c) extensive wound documentation; d) subspecialty consultation; e) evaluation of medically complex cases, etc. Cases in this category include, but are not limited to, homicides, suspected homicides, and child deaths.

Body Storage **$50/Day**

Medical Examiner expects that bodies will be removed as soon as is practicable after their examination. Medical Examiner will charge storage fees at the above rate beginning on the fourth business day after the examination concludes. Skagit Coroner may obtain bodies from Medical Examiner between 8 AM and 4:30 PM Monday- Friday, excluding holidays.

Testimony and Related Expenses **Variable**

If Medical Examiner employees spend time away from their office because they are providing testimony in a county other than King at Skagit Coroner's request, Skagit Coroner will pay that employee's hourly rate while they are actively working on the case, and any travel expenses. Travel expenses include travel time, hotel, airfare, mileage, meals, parking, etc. Travel time is portal-to-portal and will be capped at 8 hours per day or actual time spent in transit.

King County | **Office of the Executive**

Executive Girmay Zahilay
Chinook Building, CNK-EX-0800
401 Fifth Avenue, Suite 800
Seattle, WA 98104-2391

May 1, 2026

The Honorable Sarah Perry
Chair, King County Council
Room 1200
C O U R T H O U S E

Dear Councilmember Perry:

This letter transmits a proposed Ordinance authorizing an interlocal agreement for the provision of autopsy and forensic pathology services by the King County Medical Examiner's Office to Skagit County. Pursuant to the Revised Code of Washington 39.34, action by Ordinance is required prior to execution.

Skagit County is seeking to engage the King County Medical Examiner's Office (MEO) to provide backup autopsy and forensic pathology services. MEO provides similar services to other counties. In this instance, Skagit County's policies require an interlocal agreement.

The King County prosecuting attorney's office and the King County office of risk management services have reviewed the interlocal agreement.

Thank you for your consideration of this ordinance. If your staff have questions, please contact Joy Carpine-Cazzanti, Government Relations Manager, Public Health – Seattle & King County, at 206-263-0365.

Sincerely,

for

Girmay Zahilay
King County Executive

Enclosure

cc: King County Councilmembers
ATTN: Stephanie Cirkovich, Chief of Staff, King County Council
Melani Hay, Clerk of the Council
Karan Gill, Deputy Executive, Office of the Executive
Jasmin Weaver, Chief of Staff, Office of the Executive
Hyeok Kim, Chief Operating Officer, Office of the Executive
Sierra Howlett Browne, Director of Government Relations, Office of the Executive
Garrett Holbrook, Council Relations Manager, Office of the Executive
Sandra Valenciano, Director and Health Officer, Public Health – Seattle & King County

Metropolitan King County Council
Staff Report

Committee:	Health, Housing, and Human Services		
Agenda Item:	6	**Analyst(s):**	Sam Porter Miranda Leskinen
Proposed No.:	2026-0177	**Meeting Date:**	July 23, 2026

OVERVIEW

TOPIC: An ordinance adopting the "Behavioral Health Bridge" Implementation Plan.

LEGISLATION SUMMARY: Proposed Ordinance 2026-0177 would adopt the implementation plan for the Behavioral Health Bridge (Bridge) sales tax funded services from 2028 through 2034. The Mental Illness and Drug Dependency (MIDD) sales tax is proposed to be renamed the Behavioral Health Bridge sales tax through Proposed Ordinance 2025-0174.

Starting in 2028, this implementation plan will govern the administration and implementation of the Behavioral Health Bridge sales tax revenue. The existing MIDD II Service Improvement Plan[1], Implementation Plan[2], and the Evaluation Plan[3] will continue to govern investments through 2027 in accordance with an Expenditure Restriction in the County's 2026-2027 Biennial Budget (Ordinance 20023, Section 70, ER 6).

The Executive transmitted Proposed Ordinance 2026-0177 on July 1, 2026. This item is dually referred to the Health, Housing, and Human Services Committee, as a mandatory referral, and to the Regional Policy Committee. Today is the first Council staff briefing to the Health, Housing, and Human Services Committee.

Timing Considerations. While there is no mandated deadline by which the legislation must be adopted, Executive staff have expressed their desire to have the legislation adopted in October. The estimated schedule for the legislation is provided at the end of this staff report.

It is important to note that transmitted in tandem with the implementation plan is Proposed Ordinance 2026-0174, which proposes to rename MIDD the "Behavioral Health Bridge" and update the Advisory Committee. Proposed Ordinance 2026-0174 is a mandatory dual referral to the Regional Policy Committee.

[1] Ordinance 18406
[2] Motion 15093
[3] Motion 15058

Staff analysis of the transmitted legislation is ongoing.

KEY ISSUES FROM THE ANALYSIS

A. **Potential policy issues.** Staff identified seven policy issues with the transmitted implementation plan for the Behavioral Health Bridge which is Attachment A to Proposed Ordinance 2026-0177. These policy issues present policy choices.

1. Proposed new priorities.
2. Performance measurement and evaluation plan.
3. Notification to Council regarding substantial adjustment.
4. Priorities for allocating undesignated fund balance.
5. Permissive language.
6. Reporting requirements.
7. Procurement engagement.

BACKGROUND & TIMING CONSIDERATIONS

MIDD Sales Tax History. In 2005, the Washington State Legislature provided a funding option enabling county legislative authorities to raise the local sales tax by one tenth of one percent to fund behavioral health and therapeutic court programs. By law, funds raised by this tax are to be dedicated to new or expanded behavioral health services and new or expanded therapeutic court programs. Furthermore, RCW 82.14.460(3) requires that every county that authorizes this tax must operate a therapeutic court for dependency proceedings.

The MIDD sales tax was first adopted in King County in 2007 through Ordinance 15949 (MIDD I 2008-2016), renewed in 2016 through Ordinance 18333 (MIDD II 2017-2025), and most recently renewed in 2025 through Ordinance 19976 (MIDD III 2026-2035). In August 2016, the Executive transmitted the MIDD II service improvement plan (SIP) to guide MIDD II investments. The SIP was approved through Ordinance 18406 in November 2016. The MIDD II implementation plan which outlined the programs to be funded through MIDD II was adopted by Motion 15093 in March 2018. The MIDD II evaluation plan was approved by Motion 15058 in February 2018.

From 2017 through 2025, MIDD programs served more than 130,000 unduplicated residents.

MIDD II Implementation Plan. The MIDD II Implementation Plan governed MIDD expenditures from 2017-2025 and included narrative descriptions of every funded initiative and a spending plan for each initiative for the first biennium (2017-2018) of expenditures.

Per an Expenditure Restriction in the County's 2026-2027 Biennial Budget (Ordinance 20023, Section 70, ER 6), the existing MIDD II Service Improvement Plan[4], Implementation Plan[5], and the Evaluation Plan[6] will continue to govern investments through 2027.

MIDD Renewal. The MIDD Sales Tax was renewed in 2025 through Ordinance 19976 and the 1/10th of one penny sales tax is currently projected to generate approximately $998 million over the nine-year collection period. Table 1 identifies current annual projected sales tax revenues based on the March 2026 Office of Economic and Financial Analysis forecast.[7]

Table 1. 2026-2035 MIDD Estimated Collections

Year	Amount
2026	$100,455,043
2027	$103,725,037
2028	$107,552,413
2029	$103,729,828
2030	$108,695,275
2031	$112,916,796
2032	$116,208,071
2033	$120,520,229
2034	$124,178,259

MIDD Expenditure Requirements. Per state law[8], MIDD revenue must be used solely for the purpose of providing for the operation or delivery of new or expanded chemical dependency (also known as substance use disorder) or mental health treatment programs and services and for the operation or delivery of therapeutic court programs and services.

MIDD sales tax revenue may also be used for new construction of facilities and modifications to existing facilities to address health and safety needs necessary for the provision of programs otherwise funded by MIDD revenue. Furthermore, every county that authorizes the MIDD sales tax is required to establish and operate a therapeutic court component for dependency proceedings.

[4] Ordinance 18406
[5] Motion 15093
[6] Motion 15058
[7] The forecast accounts for adjusted tax base expansion under ESSB 5814 and the tax base reduction from 2029 and beyond under ESSB 6346.
[8] RCW 82.14.460

MIDD Advisory Committee. The 37-member King County MIDD Advisory Committee (established by K.C.C. 2.130.010) is composed of separately elected officials, King County agency directors, representatives of behavioral health service providers, managed care organizations operating in King County, and individuals with lived experience. The committee acts as an advisory body to the Council and the Executive.

In accordance with King County Code, the Advisory Committee is tasked with:

- Reviewing and providing written recommendations to the Executive and Council on the implementation and effectiveness of the County's MIDD sales tax-funded programs in meeting the goals;
- Reviewing and reporting to the Executive and the Council on annual evaluation reports for MIDD;
- Reviewing and commenting on emerging and evolving priorities for the use of MIDD sales tax revenue;
- Serving as a forum to promote coordination and collaboration between entities involved with MIDD sales tax programs;
- Educating the public, policymakers, and stakeholders on MIDD sales tax-funded programs; and
- Coordinating and sharing information with other related efforts and groups.

ANALYSIS

Proposed Ordinance 2026-0177. This section provides staff analysis of the transmitted implementation plan as follows:

- Implementation plan overview
    - Primary purpose
    - Five strategies and 13 goals
- Community engagement
- Equity framework
- Advisory Committee
- Phased, competitive procurement and base budget analysis
- Measurement and evaluation
- Reporting
- Financial plan and policies for underspend and deficit
- Inflation rate adjustment policy proviso response
- Potential policy issues
- Next steps and key dates

Staff analysis of the transmitted legislation is ongoing. Of note, MIDD is proposed to be renamed "Behavioral Health Bridge" (the Bridge) per companion legislation (Proposed

Ordinance 2026-0174) that was transmitted in tandem with the proposed 2028-2034 implementation plan.[9]

Implementation plan overview. The transmitted 2028-2034 plan, unlike the MIDD 2 implementation plan, does not identify specific programs that will receive Bridge funding as allowed by RCW 82.14.460.

Primary Purpose and Strategy Areas. The transmitted plan is organized around a primary purpose and five updated strategy areas, which are identified in Table 2. Programs that receive Bridge funding, according to the plan, will advance the primary strategy areas and will be tied to performance measures and outcomes that achieve 13 strategy goals (see Table 2).

The plan states that "Rather than focusing solely on service delivery, the renewed framework seeks to create sustainable system change by aligning investments around measurable outcomes driven by five strategic areas." The plan further indicates this structure allows the Behavioral Health and Recovery Division in the Department of Community and Human Services (DCHS) to make programmatic decisions through procurement.

The plan further states that the intent of the stated primary purpose (see Table 2) is to focus on low-income residents with behavioral health conditions, in particular those "who are marginalized or experience intersectional inequalities" to invest where the need is greatest and where Bridge dollars can make meaningful impact.

[9] For context, the Executive has proposed renaming "MIDD" as the King County Behavioral Health Bridge, or "the Bridge", in response to community and provider feedback.

Table 2. Implementation Plan Primary Purpose, Strategy Areas and Goals

Primary Purpose	To invest in the long-term availability, accessibility, effectiveness, and equity of the county's behavioral health system, especially where people are falling through the cracks of existing systems.
Strategy Area 1	**Care transitions and diversion services:** Enhance navigation and system coordination to ensure people receive timely, appropriate behavioral health services across all levels of care, divert individuals with behavioral health conditions from criminal-legal involvement to support long-term stability, and provide appropriate supportive services for individuals with behavioral health conditions involved in the legal system.
Goal 1	Divert people from criminal-legal involvement, provide supportive services for those involved in the legal system, and support successful community reentry.
Goal 2	Help people with behavioral health conditions achieve and maintain stable housing.
Goal 3	Enhance navigation and system coordination so that people receive timely and appropriate behavioral health services across all levels of care.
Strategy Area 2	**Substance use disorder (SUD) prevention, treatment, and recovery:** Treat SUD by providing effective, low-barrier services that address people's holistic needs and support sustainable paths to long-term recovery.
Goal 1	Drive engagement and retention in SUD care.
Goal 2	Provide effective, low-barrier SUD treatment that meets people's holistic needs.
Goal 3	Support paths to achieve and maintain recovery after treatment.
Strategy Area 3	**Equitable access to behavioral health care:** Decrease barriers to behavioral health services and increase access to culturally and linguistically responsive care.
Goal 1	Provide behavioral health care for low-income people who are ineligible for Medicaid.
Goal 2	Support the wellbeing of diverse communities by providing culturally and linguistically responsive services and removing barriers to care.
Strategy Area 4	**Child, youth, and young adult mental wellbeing:** Address the youth behavioral health crisis by investing in developmentally tailored services and programs that meet youth where they are.
Goal 1	Improve youth access to behavioral health care by providing developmentally appropriate services that meet young people where they are, at school and in community.
Goal 2	Provide behavioral health and therapeutic services to youth involved in the legal system, including diversion from deeper legal system involvement.
Goal 3	Invest in the behavioral health of youth who are marginalized or experience inequities.
Strategy Area 5	**Behavioral health workforce development:** Strengthen and diversify the behavioral health workforce to meet growing community needs.
Goal 1	Strengthen and diversify the behavioral health provider pipeline.
Goal 2	Advance and develop the skills of the current workforce to meet growing community needs.

As previously noted, the transmitted plan is silent on specific programs that would be eligible for funding under the new strategy areas and does not name programs in the plan. After transmittal, Executive staff provided a crosswalk that is attached to this staff report as Attachment 5. The crosswalk compares the 54 former MIDD programs and the corresponding anticipated Bridge activity under which programs may be eligible for funding. Additionally, the phased, competitive procurement and base budget analyses section later in this staff report provides more detail on the new procurement process proposed by the transmitted plan.

Community engagement. The transmitted plan indicates that DCHS solicited feedback from community members from 2024 through 2025. These efforts included 46 in-person and 34 virtual listening sessions, eight community events, and an online survey translated into 21 languages. In total, 2,226 people provided feedback across all regions of King County. Detailed information about the listening sessions and community engagement, including demographic and Council District breakdown of participants appears in Appendix B of the transmitted plan. A crosswalk of strategy areas and community engagement themes appears in Appendix C.

DCHS also conducted a multi-sector, subject matter expert engagement process from April to July 2025 for each proposed strategy area. Membership consisted of more than 100 clinical providers, licensed peers, criminal-legal system representatives, researchers, and more to inform the implementation plan's 13 goals. A detailed crosswalk of the goals presented in the implementation plan and subject matter expert suggestions that informed the activities of each goal appears in Appendix D of the plan.

Equity framework. The plan states that Black, Indigenous, and People of Color, refugee and immigrant, LGBTQIA+, and disability communities are more likely to struggle with behavioral health conditions and less likely to access supportive care than the King County population overall. Therefore, DCHS developed an equity framework for the King County Behavioral Health Bridge to "embed services and outcomes for marginalized communities across all domains of Bridge services, not just the Equitable Access strategy area." The plan states that the framework for the Bridge "describes five pillars of an equitable, anti-racist, multi-cultural King County behavioral health system." The framework states that investments will be designed to advance a behavioral health system that is:

1. Connected and coordinated,
2. Transparent and accountable,
3. Inclusive, collaborative, diverse, and people-focused,
4. Responsive and adaptive to community-identified needs, and
5. Accessible and available.

The plan provides examples for how the equity framework was utilized in the process to develop the implementation plan in Appendix E.

Advisory Committee. Proposed Ordinance 2026-0174 transmitted concurrently with the implementation plan would change the name of the MIDD behavioral health sales tax, update the name of the Advisory Committee, and make additional changes to the committee including removing outdated references in King County Code and updating representative positions. This includes converting a representative of All Home to an entity serving individuals experiencing homelessness in King County, and changing two positions for individuals representing behavioral health consumer interests and representing community interests from the MIDD Consumers and Communities Ad Hoc Work Group to two positions representing behavioral health consumer interests who have lived experience with behavioral health conditions. This legislation is a mandatory dual referral to the Regional Policy Committee. Additional details are provided in the staff report for Proposed Ordinance 2026-0174.

Phased, competitive procurement and base budget analyses. The transmitted plan states that the Executive intends to implement phased, competitive procurements beginning in 2028 for nearly all Bridge-funded programs administered by contracted providers (75% of Bridge investments according to Appendix A). The plan states that the phased timeline will allow for careful design of the procurement process. The plan includes a list of components that are "expected" to be included in the procurement process design, a selection of which includes:

- Analyzing current financial projections, policy updates, performance data, and potential funding sources for each strategy area;
- Completing a review of crosswalk existing programs to strategy areas and identifying alternative funding sources where applicable; and
- Notifying the Council, issuing award letters, and finalizing scopes of work, goals, and outcome measures with awardees.[10]

Executive staff indicate that the procurement process will "follow standard departmental procurement procedures, including new safeguards that DCHS is implementing to respond to the results of the 2025 audit." Additionally, procurements will be guided by the anticipated "activities" that appear with the logic models described in more detail in the performance measurement section of this staff report.

According to the plan, the new procurement process would not always mean that programs would be changed drastically. "In some cases, this might mean that an existing

[10] Behavioral Health Bridge Implementation Plan, page 21.

program is continued with minimal changes. In other cases, existing programs might undergo significant changes, be shifted to another fund source, or be phased out to redirect Behavioral Health Bridge resources to better achieve the County's goals while still providing community members with access to needed services."[11] The plan does not include detail regarding which programs would be phased out or shifted to other fund sources. MIDD 2 initiatives that align with a strategy area will continue until the strategy is reprocured. Attachment 5 to this staff report provides some detail regarding which programs may not be aligned with the activities described in the Bridge implementation plan and would therefore not be eligible for funding under the transmitted plan.

According to the plan, the phased, competitive procurement is intended to improve transparency and accountability, encourage innovation, expand opportunities for provider organizations, align funding with demonstrated outcomes, and ensure investments remain responsive to changing needs. The report also states that the majority of current programming is implemented by providers selected many years ago, and that there are new organizations in the field that have not had the opportunity to apply for behavioral health sales tax funding and this approach would increase those opportunities.

The transmitted plan states that programs operated by County agencies, all Bridge-funded programs that are managed or administered by King County departments and agencies outside of DCHS (25% of Bridge investments according to Appendix A, including those operated by the Courts and Public Health) will receive a base budget analysis. Details about what this base budget analysis will entail are not included in the plan. The plan states that the Executive anticipates initial base budget analysis to be completed ahead of the 2028-2029 budget.

Due to the scale of planning and staffing, the plan states that the procurements and base budget analyses cannot occur all at once and will be done in a phased manner as described in Figure 3[12] in the report depicted in Table 3 below.

Table 3. Timeline of Phased Procurement

Strategy Area	Anticipated launch of programs (reprocured or with new base budget)
SUD Treatment and Recovery (SUD)	Quarter 3 of 2028
Equitable Access to Behavioral Health Care	Quarter 3 of 2028

[11] Behavioral Health Bridge Implementation Plan, page 19.
[12] Behavioral Health Bridge Implementation Plan, page 20.

(EA)	
Care Transitions and Diversion Services (CTD)	Quarter 1 of 2029
Behavioral Health Workforce Development (WF)	Quarter 1 of 2029
Child, Youth, and Young Adult Mental Wellbeing (CYYA)	Quarter 3 of 2029

The plan states that this phased procurement approach will provide an opportunity to coordinate the Children, Youth, and Young Adult Mental Wellbeing strategy with the Best Starts for Kids (BSK) renewal (anticipated in 2027), to ensure the funding streams complement rather than duplicate one another. According to the plan, DCHS plans to announce awards three to six months in advance of program launch dates to provide sufficient ramp down periods for programs or providers that do not receive continued funding. Executive staff provided Table 4 that shows an estimated timeline for phased procurements and non-funded program ramp down periods.

Table 4. Estimated Timeline for Phased Procurements and Non-funded Program Ramp Down

Strategy Area	Procurements Announced	Applications Due & Selection Process	Successful Applicants Announced	Ramp Down for MIDD 2 Programs No Longer Receiving Funding
SUD Treatment and Recovery (SUD)	Start of Q2 2027	Q3 2027	End of Q4 2027	Q1 & 2 2028
Equitable Access to Behavioral Health Care (EA)	Start of Q2 2027	Q3 2027	End of Q4 2027	Q1 & 2 2028
Care Transitions and Diversion Services (CTD)	Start of Q4 2027	End of Q1 2028	End of Q2 2028	Q3 & 4 2028
Behavioral Health Workforce Development (WF)	Start of Q4 2027	End of Q1 2028	End of Q2 2028	Q3 & 4 2028
Child, Youth, and Young Adult Mental Wellbeing (CYYA)	Start of Q2 2028	End of Q3 2028	End of Q4 2028	Q1 & 2 2029

The transmitted plan states that the process to develop and implement procurements is expected to include notifying the Council. Additional details are not included in the plan but in response to Council staff questions Executive staff stated that "the Bridge will continue the standard DCHS practice to notify council of procurements and invite Councilmembers or their staff, to attend panel deliberations." Councilmembers may wish to include additional details in the plan to ensure this practice occurs.

Measurement and evaluation. According to Executive staff, there will not be a companion evaluation plan transmitted for the Bridge (a change from MIDD II). In other words, provisions for measurement and evaluation of Bridge investments are addressed in the transmitted implementation plan (Plan Section VII).

The transmitted implementation plan states that measurement and evaluation for the Bridge, like MIDD II, will utilize the Results Based Accountability (RBA) framework to assess investment results, supplemented with additional evaluation activities.

The RBA framework for evaluation includes performance measurement, population indicators, and in-depth evaluation. This framework, which is used for other human services initiatives like Best Starts for Kids, groups performance measures into three categories:

- How much was done (i.e., service quantity);
- How well was it done (i.e., service quality); and
- Is anyone better off (i.e., participant outcomes).

Performance measures for the Bridge, per the transmitted implementation plan, may be qualitative and/or quantitative and will vary across programs and strategy areas depending on the population served, types of services, and intended outcomes. A couple of example performance measures are provided in Figure 22 of the plan.

RFPs will include the strategy's intended goals and system-wide outcomes and associated performance measures for transparency. DCHS staff will work with service providers during the contracting process to finalize a performance measurement plan. For County-administered programs, agencies will collaborate with DCHS to develop program performance measurement plans.

Strategy Area Logic Models. With the introduction of the primary purpose-strategy area approach for the Bridge, the plan explains that its measurement and evaluation approach builds upon the RBA framework using the logic models contained in Appendices F through J.

Each strategy area's logic model highlights the types of programs or "activities" anticipated for funding and illustrates the envisioned relationship between investments, measures,

and outcomes. Tables 5 through 9 provide a summary of anticipated activities identified in each strategy area's logic model.

Table 5. Care Transitions and Diversion Strategy Area and Goal Activities

Goal 1	**Divert people from criminal-legal involvement, provide supportive services for those involved in the legal system, and support successful community reentry.**
Activity	Diversion from criminal-legal system involvement
Activity	Services for people with behavioral health conditions who have cycled repeatedly through the criminal-legal system
Activity	Supports for people to reenter the community after incarceration
Activity	Behavioral health services and supports for people involved in the legal system, including therapeutic courts.
Goal 2	**Help people with behavioral health conditions achieve and maintain stable housing.**
Activity	Behavioral health services in permanent supportive housing
Activity	High-intensity services for people with behavioral health conditions leaving institutional settings who are experiencing or at risk of homelessness
Goal 3	**Enhance navigation and system coordination so that people receive timely and appropriate behavioral health services across all levels of care.**
Activity	Care navigation, including peer navigation and care coordination
Activity	Technology investments to facilitate care coordination across all levels of care
Activity	Promoting timely access to appropriate care

Table 6. Substance Use Disorder Treatment and Recovery Strategy Area and Goal Activities

Goal 1	**Drive engagement and retention in SUD care.**
Activity	Proactive outreach to people with SUD, especially those experiencing homelessness
Activity	Screening and referrals integrated into multiple settings
Activity	Sobering services
Goal 2	**Provide effective, low-barrier SUD treatment that meets people's holistic needs.**
Activity	Low-barrier access to medications for substance use disorder and medication-first treatment approaches
Activity	Provision of mobile and in-community services
Activity	SUD treatment for incarcerated people
Activity	Alleviating barriers to enter inpatient SUD treatment and withdrawal management
Activity	Culturally and linguistically responsive SUD care
Activity	Overdose prevention and tracking

Goal 3	Support paths to achieve and maintain recovery after treatment.
Activity	Peer recovery services
Activity	Access to housing that supports recovery
Activity	Employment supports

Table 7. Equitable Access to Behavioral Health Care Strategy Area and Goal Activities

Goal 1	Provide behavioral health care for low-income people who are ineligible for Medicaid.
Activity	Non-Medicaid behavioral health services and supports
Goal 2	**Support the wellbeing of diverse communities by providing culturally and linguistically responsive services and removing barriers to care.**
Activity	Community-driven culturally and linguistically responsive services and programs that support behavioral health outside of clinical settings
Activity	Behavioral health treatment services tailored for priority populations

Table 8. Child, Youth, Young Adult Mental Wellbeing Strategy Area and Goal Activities

Goal 1	Improve youth access to behavioral health care by providing developmentally appropriate services that meet young people where they are, at school and in community.
Activity	Youth behavioral health services in schools
Activity	Sober learning environments
Activity	Youth behavioral health services in community
Goal 2	**Provide behavioral health and therapeutic services to youth involved in the legal system, including diversion from deeper legal system involvement**
Activity	Diversion and supportive services for youth involved, or at-risk of involvement, in the criminal-legal system
Goal 3	**Invest in the behavioral health of youth who are marginalized or experience inequities.**
Activity	Tailored supports for youth who are marginalized or experience inequities

Table 9. Behavioral Health Workforce Development Strategy Area and Goal Activities

Goal 1	Strengthen and diversify the behavioral health provider pipeline.
Activity	Building pathways to behavioral health careers
Activity	Supporting high-quality behavioral health clinical internships
Goal 2	**Advance and develop the skills of the current workforce to meet growing community needs.**
Activity	Clinical supervision

Activity	Continuing education for community behavioral health providers

Data Collection. The transmitted report indicates that data collection practices for the Bridge will be outcomes-driven and reflect systems-level objectives for each strategy area as described in the logic models.

Provider performance measurement plans will include key performance measures (balancing tailored and standardized metrics), types of data collection, reporting cycles, and activities to review data and use data to inform continuous improvements. Providers will submit data and relevant information to the County as required by their contract and/or documented in their performance measurement plans.

For direct services investments, the plan indicates that DCHS intends to collect and monitor performance measures about individuals served (where appropriate and legally allowable), nature of provided services, and associated outcomes.

For community infrastructure or systems investments, the plan indicates that DCHS intends to collect and monitor performance measures such as the number of activities conducted or milestones progress.

The plan further notes that DCHS intends to collect system-level data as appropriate, such as changes to the community behavioral health workforces (e.g., retention and turnover rates). Available data systems will also be utilized to measure and assess long-term data and outcomes at the participant level. Additionally, the Bridge evaluation team will monitor key population-level behavioral health indicators (e.g., countywide rate of overdose fatalities), disaggregated by demographic characteristics where data are available.

The ability to conduct in-depth evaluations will be different for each program and strategy, and the plan identifies criteria to guide the evaluation team in prioritizing projects for in-depth evaluation. It's important to note, however, that causality relating to Bridge investments and population-level measures is not likely feasible to study outside of costly randomized controlled trial evaluations.

Reporting. The transmitted plan states that DCHS will offer an annual briefing to Council coinciding with the release of annual data dashboard updates to report on Results Based Accountability indicators and planned or implemented improvements to the Behavioral Health Bridge. The plan proposes that the Executive transmit a biennial report to Council detailing programs and services funded by the Bridge transmitted no later than August 31 every other year beginning in 2030. This is a change from the current annual report cadence. The biennial reports would be transmitted with a motion acknowledging receipt

of the report. Executive staff stated that "the proposed transition to biennial narrative reports is intended to redirect Executive branch staff resources to increase continuous improvement and taking action to use information on program performance and outcomes to make adjustments when needed. However, the shift to biennial transmitted reports does not replace annual monitoring or accountability."

Biennial Behavioral Health Bridge reports would include the following:

- An overview of Behavioral Health Bridge accomplishments during the previous two calendar years and a description of continuous improvement changes that have been implemented based on performance results, as well as planned operational adjustments to improve performance when applicable;
- The Behavioral Health Bridge fund's fiscal and performance management during the applicable calendar years;
- The expenditure of Behavioral Health Bridge proceeds by strategy area by ZIP code in King County;
- The number of individuals receiving Behavioral Health Bridge-supported services by strategy area by ZIP code where the individuals reside at the time of service;
- A map or summary describing the Behavioral Health Bridge's geographic distribution; and
- Summaries of findings from in-depth evaluations related to Behavioral Health Bridge programs, and actions taken or planned based on those findings in years where such findings are available.

The transmitted plan states that the Bridge evaluation team will report program and strategy expenditures by ZIP code beginning in 2028. The approach will be aligned with those implemented in 2023 for Best Starts for Kids, 2024 for Veterans, Seniors, and Human Services Levy (VSHSL), and 2025 for the Crisis Care Centers (CCC) Levy and will utilize provider locations and participant residences. The transition to biennial reports and what is included in the report represents policy choices.

Financial policies.

Financial Plan. The transmitted plan includes a financial plan[13] with estimated levy collections and estimated levy expenditures. Table 10 shows a summary of the estimated annual revenue from 2028 to 2034, based on the King County OEFA March 2026 forecast and Table 11 shows the estimated expenditures for each strategy area.

[13] Bridge Implementation Plan, p. 50.

Table 10. Bridge Projected Revenue in Millions, 2028-2034

	2028	2029	2030	2031	2032	2033	2034
Projected Sales Tax	$107.6	$103.7	$108.7	$112.9	$116.2	$120.5	$124.2
Projected Interest	$0.7	$0.8	$0.7	$0.6	$0.6	$0.6	$0.7
Total Revenue	**$108.3**	**$104.5**	**$109.4**	**$113.5**	**$116.8**	**$121.1**	**$124.9**

Table 11. Bridge Strategy Area Estimated Expenditures in Millions, 2028-2034

	2028	2029	2030	2031	2032	2033	2034
Strategy 1: Care Transitions and Diversion							
Goal 1	$25.8*	$24.0	$24.6	$25.1	$25.7	$26.2	$26.8
Goal 2	$5.7*	$5.0	$5.1	$5.3	$5.4	$5.5	$5.7
Goal 3	$5.2*	$3.5	$3.6	$3.7	$3.8	$4.2	$4.5
Total	**$36.7***	**$32.5**	**$33.3**	**$34.1**	**$34.9**	**$35.9**	**$36.9**
Strategy 2: Substance Use Disorder Treatment and Recovery							
Goal 1	$1.7*	$2.2	$2.3	$2.4	$2.4	$2.5	$2.5
Goal 2	$15.6*	$16.3	$16.8	$17.3	$17.7	$18.1	$18.5
Goal 3	$2.1*	$1.6	$1.7	$1.7	$1.8	$2.1	$2.4
Total	**$19.5***	**$20.2**	**$20.8**	**$21.4**	**$21.9**	**$22.6**	**$23.3**
Strategy 3: Equitable Access to Behavioral Health Care							
Goal 1	$12.0	$12.3	$12.7	$13.0	$13.3	$13.6	$13.9
Goal 2	$4.1*	$4.2	$4.3	$4.5	$4.6	$5.0	$5.3
Total	**$16.1***	**$16.5**	**$17.0**	**$17.5**	**$17.9**	**$18.6**	**$19.2**
Strategy 4: Child, Youth, and Young Adult Mental Wellbeing							
Goal 1	$3.5*	$4.0*	$4.5	$4.6	$4.7	$4.9	$5.0
Goal 2	$5.2*	$4.9*	$4.7	$4.8	$5.0	$5.1	$5.2
Goal 3	$2.6*	$2.8*	$3.0	$3.1	$3.1	$3.5	$3.8
Total	**$11.2***	**$11.7***	**$12.2**	**$12.5**	**$12.8**	**$13.4**	**$13.9**
Strategy 5: Behavioral Health Workforce Development							
Goal 1	$0	$2.5	$2.5	$2.6	$2.7	$2.9	$3.0
Goal 2	$1.3*	$4.1	$4.2	$4.4	$4.5	$4.7	$4.9
Total	**$1.3***	**$6.6**	**$6.8**	**$7.0**	**$7.1**	**$7.6**	**$8.0**

**This amount pays for continuing MIDD 2 initiatives, prior to the launch of new and revised WF programs in 2029.*

Executive staff indicate that estimated expenditures are based on engagement with subject matter experts and staff estimates based on the revenue estimates and how much DCHS thinks would be needed to move the needle on each goal. Actual spending will be determined at the time of procurement. The financial plan fully allocates projected Bridge

revenue. If additional goals or strategies were added to the plan by amendment, adjustments to the financial plan would be needed.

Technical assistance and capacity building. The transmitted plan indicates that the Behavioral Health Bridge will set aside 0.5% of revenue for technical assistance and capacity building to support the implementation of the identified goals. This is intended to support organizations with information, tools, and resources to strengthen their infrastructure in the areas of fiscal management, documentation, and reporting, as well as opportunities for areas with service gaps to build capacity.

Administration and compliance. In response to the 2025 audit, the transmitted plan states that the Behavioral Health Bridge will increase the proportion of funds supporting administrative functions in 2028-2034 to enhance fiscal controls and contract management. Executive staff indicate that additional staff will be needed to support procurement, evaluation, program management, compliance, financial management, and reporting.

Reserves. Consistent with the County's Comprehensive Financial Management Policies, the Bridge will maintain a fund reserve equivalent to 60 days of budgeted spending in the current adopted or projected biennial budget under this plan. Additionally, the fund will maintain a Sustainability Reserve starting in 2028 to maintain program commitments despite the projected decrease in sales tax revenue in 2029 due to 2026 changes in state law pertaining to products and services that will be exempt from sales tax beginning in 2029. This Sustainability Reserve will be spent down by 2031.

Behavioral Health Fund transfer. The transmitted plan would formalize the continuation of a transfer of MIDD revenue to the Behavioral Health Fund that has occurred since 2021. The transfer is to support the Behavioral Health and Recovery Division's infrastructure and the King County Integrated Care Network which costs more to operate than is covered by Medicaid. In the 2026-2027 Biennial Budget this transfer is $16.8 million. The transmitted plan's financial plan shows the 2028-2029 biennium transfer as $16.3 million with annual increases of approximately 2.5% thereafter.

Process for adjusting plan investments. The plan states that investment amounts identified in the plan are based on fiscal and programmatic assumptions. A substantial adjustment is defined as a "change or series of changes within the same calendar year to a strategy area's annual funding allocation by ten percent or more." Consistent with Health Through Housing, VSHSL, CCC, and BSK levies, if a substantial adjustment were planned by the Executive to the funding allocations identified in the proposed implementation plan, then the Executive would transmit a notification letter to the Council explaining the rationale

and scope of the planned change, upon which time the Council would have 30 days to pass a motion rejecting the change – otherwise, the change would proceed after the 30 days.

A change is not considered a substantial adjustment if it is due to additional Behavioral Health Bridge sales tax revenue or other funding sources becoming available. In this scenario, the additional sales tax revenue would be allocated according to the priorities described in the next subsection of this staff report and cannot reduce another strategy area's allocation. In addition, Bridge sales tax proceeds that are not spent within a strategy area may be retained within the same strategy area for use in a subsequent year without being considered a substantial adjustment for the purpose of this plan.

Priorities for allocating undesignated fund balance. The transmitted plan would establish priorities for allocating the undesignated fund balance which is new for this revenue stream. The plan states that the Executive intends to apply the following three priorities to allocate undesignated fund balance when the Executive determines that it represents an opportunity for long-term, sustainable investment:

1. In any year where inflation rates have been reduced due to limited funding availability, provide inflationary adjustments to contracted providers up to the amount of CPI-U (Consumer Price Index for All Urban Consumers) Seattle inflation rates.
2. Augment existing investments to mitigate losses of Medicaid coverage to the degree necessary and feasible within available funds. This includes increasing funding to Equitable Access Goal 1, "Provide behavioral health care for low-income people who are ineligible for Medicaid." It may also include increasing investment in other programs negatively affected by growth of the uninsured rate among the Behavioral Health Bridge's service population.
3. Scale high-performing or innovative Behavioral Health Bridge investments to address unmet need. The investments to be augmented shall be selected through a process that includes Behavioral Health Bridge Advisory Committee consultation and is guided by performance and measurement data.

The plan states that when the Executive determines that fund availability is one-time in nature and cannot reasonably support sustained programming, the Executive intends to consider using these funds for one-time investments including capital projects such as building behavioral health facilities or housing for people with behavioral health conditions, or in pilot programs that can later transition to other funding sources such as Medicaid.

Supplantation considerations. The plan states that the strategic investment areas proposed comply with the supplantation restrictions in RCW 82.14.460(4) that are currently in effect.

Ordinance 20023, Section 70, Proviso P1. The 2026-2027 Biennial Budget included a proviso (Ordinance 20023, Section 70, Proviso P1) that withheld $500,000 from the MIDD budget until the Executive transmitted the new MIDD implementation plan including an analysis about the DCHS inflation rate adjustment policy, how it was determined to be applicable to this revenue source, its projected impact on the revenue source, and a process for mitigating negative impacts. The transmitted implementation plan includes the proviso response in Section X and appears to respond to the proviso. Passage of Proposed Ordinance 2026-0177 adopting the Bridge implementation plan would release the $500,000 withheld from the MIDD budget. The proviso language is in italics below.

A. A description of how the inflation rate adjustment policy was determined to be applicable to the mental illness and drug dependency fund given the incompatibility with the requirements of the fund source due to the volatile nature of sales tax revenue;

The inflation rate adjustment policy was determined to be applicable to the MIDD fund because the "policy applies to local funding sources managed by DCHS because these funds are under greater local control." The response states that the inflation rate increase would only be implemented "to the degree possible while maintaining healthy financial reserves consistent with King County Comprehensive Financial Management Policies."

B. An analysis regarding the effect of the inflation rate adjustment policy on the mental illness and drug dependency fund, which is projecting an average future growth rate for mental illness and drug dependency of 2.7 percent per year according to 2025 data from King County's office of economic and financial analysis;

The proviso response states that the "Behavioral Health Bridge fund's projected long-term revenue grows at an average of 2.6 percent per year [...] this growth rate falls below typical King County Budget and Financial Planning Assumptions (BFPA), the policy has a structural impact on the fund's long-range sustainability." Further, "if CPI-U inflation assumptions continue to track near the current range [...] Behavioral Health Bridge expenditure growth would outpace revenue growth." The response states that there are mechanisms in the inflation policy and budget process to identify these trends and mitigate the impacts. This includes the department being able to delay or suspend the increases if appropriate reserves are not achieved and if revenue forecasts project a decline in fund balance compared to revenue. The report indicates that "despite the risks, DCHS is not projecting a structural gap in the Behavioral Health Bridge from 2028 through 2034. However, if inflationary adjustments were included at Consumer Price Index-Urban (CPI-U) Seattle

[King County's Budget and Financial Planning Assumptions] rates every year, the fund would be at risk of not having enough cash to cover expenses after 2028." Consequently, DCHS will take steps to mitigate this risk described in subsections C and D.

C. An exploration of how the inflation rate adjustment policy could result in expenditures outpacing sales tax revenues and whether inflation rate adjustment policy creates a structural gap for the mental illness and drug dependency fund; and *D. Proposed mitigation strategies to address a possible structural gap due to the inflation rate adjustment policy*

The response states that the implementation plan provides inflation adjustments that are lower than CPI-U Seattle to eligible providers with continuing contracts in 2029, this is the year there is a projected 3.55 percent decrease in sales tax revenues as shown in the financial plan. New contracts do not receive an inflation increase, only in the second year of a program and beyond would providers become eligible and are expected to receive this increase. These adjustments are included in the financial plan and are reviewed annually to confirm funding availability. Figure 24 of the implementation plan shows the projected inflation adjustments for contracted providers as compared to the CPI-U inflation factor. The projected inflation adjustment to be provided to Bridge-contracted providers is CPI-U Seattle every year except 2029. The report states that the reduced inflation adjustment in 2029 is "intended to enable the County to continue providing critical Behavioral Health Bridge-funded services without exceeding revenues, despite the inherent volatility of the sales tax."

The response states that if a deficit or reserve shortfall arises in the future DCHS intends to consult with the King County Behavioral Health Bridge Advisory Committee to take one or more of the following actions:

1. Forgo program expansions and investments in new programs.
2. Prohibit or cap future provider inflation rate increases.
3. Propose and implement reductions to Behavioral Health Bridge-funded programs or services.

Implementation plan appendices. There are ten appendices to the implementation plan. Key appendices are:

- Appendix B. Community engagement activities and results
- Appendix C. Crosswalk of strategy areas and community engagement themes
- Appendix F - J. Logic model and anticipated activities for each strategy area

Potential policy issues. Staff have identified some potential policy issues as summarized below. The issues all represent policy choices for the committees to consider.

1. Proposed new priorities. The transmitted plan replaces the MIDD 2 strategies with five new strategies to address care transitions and diversion services; substance use disorder treatment and recovery; equitable access to behavioral health care; child, youth, and young adult mental wellbeing; and behavioral health workforce development. Whether to accept these new strategies in the implementation plan as proposed presents policy choices.

2. Performance measurement and evaluation plan. The transmitted plan does not require transmittal of a companion evaluation plan for the Bridge (a change from MIDD II). The transmitted plan will use the Results Based Accountability framework used in MIDD II to assess investments. The transmitted plan states that performance measures may be qualitative or quantitative and will vary across programs and strategy areas with a couple of examples provided in the plan. The performance measurement plans would be developed with the selected provider for each program. Whether to require more detail about the performance measurement and evaluation plans represents a policy choice.

3. Notification to the Council regarding substantial adjustments. The transmitted plan indicates that a substantial adjustment to the financial plan is a change or series of changes within the same calendar year to a strategy area's annual funding allocation by ten percent or more. The threshold amount for requiring notification to Council presents a policy choice.

4. Priorities for allocating undesignated fund balance. The transmitted plan includes priorities for allocating an undesignated fund balance. Whether to include priorities, or what priorities are included, represents policy choices.

5. Permissive language. The transmitted plan uses permissive language such as "intends", "plans", and "anticipates" throughout the plan with respect to various components of the plan that the Executive may implement. Using these terms allows the Executive the option to not implement components, whereas terms such as "shall" or "will" would require the Executive to follow through on implementation of these components. Whether to change the terminology represents a policy choice.

6. Reporting requirements. The transmitted plan requires a biannual report be transmitted to Council beginning in 2030 along with offering an annual briefing to Council starting in 2028. The biannual report would be transmitted with a motion acknowledging receipt of the report and no legislation or materials would be transmitted for the annual briefing. This change from an annual report presents a policy choice.

7. Procurement Engagement. The transmitted plan states that the process to develop and implement procurements is expected to include notifying the Council. Additional details are not included in the plan but in response to Council staff questions Executive staff stated that "the Bridge will continue the standard DCHS practice to notify council of procurements and invite Councilmembers or their staff to attend panel deliberations." Councilmembers may wish to include additional details in the plan to ensure this practice is implemented.

Next steps and key dates. The Executive transmitted Proposed Ordinance 2026-0177 on July 1, 2026. This item is dually referred to the Health, Housing, and Human Services Committee, as a mandatory referral, and to the Regional Policy Committee.

Table 12 provides the anticipated legislative schedule, including amendment deadlines, for the proposed ordinance. This proposed schedule accommodates, if necessary, one rereferral to the Regional Policy Committee.

Table 12. Proposed Ordinance 2026-0177 Anticipated Legislative Schedule

Action	Committee /Council	Date	Amendment Deadline
Submitted to Clerk		July 1	
Introduction and referral	Full Council	July 7	
Discussion Only	HHHS (special meeting)	July 23	
Briefing *(legislation is in HHHS control)*	RPC (special meeting)	August 26	
Discussion and Possible Action	HHHS	September 1	Striker direction due: 8/13 Striker distribution: 8/19 Line amendment direction due: 8/25 Line amendments issued: 8/28
Discussion and Possible Action	RPC	October 14	Striker direction due: 9/25 Striker issued: 10/1 Line amendment direction due: 10/7 Line amendments issued: 10/12
Potential Final Action	Full Council	October 27 (Regular)	Line amendment direction due: 10/20 Line amendments issued: 10/23
***If* legislation is amended after RPC, then re-referral to RPC would be necessary:**			
Action	RPC	November 11*	Line amendment direction due: 11/4 Line amendments issued: 11/9
Final Action	Full Council	November 17 (Expedited)	

* November 11 is a holiday, a special meeting may be needed.

Of note, companion legislation (Proposed Ordinance 2026-0174) which proposes to rename MIDD the "Behavioral Health Bridge" and update the Advisory Committee was

transmitted concurrent to Proposed Ordinance 2026-0177. Proposed Ordinance 2026-0174 is a mandatory dual referral to the Regional Policy Committee and is discussed in a separate staff report.

Council's legal counsel is reviewing the implementation plan.

INVITED

- Isabel Jones – Interim Director, Behavioral Health and Recovery Division (BHRD), Department of Community and Human Services (DCHS)
- Laura Smith – MIDD Renewal Manager, BHRD, DCHS
- Susan Mclaughlin – Director, DCHS
- Liz Arjun – Behavioral Health Policy Lead, Office of the Executive

ATTACHMENTS

1. Proposed Ordinance 2026-0177 (and its attachment)
2. Transmittal Letter
3. Fiscal Note
4. Financial Plan
5. Behavioral Health Bridge and MIDD Strategy Crosswalk

1200 King County Courthouse
516 Third Avenue
Seattle, WA 98104

KING COUNTY

Signature Report

Ordinance

Proposed No. 2026-0177.1 **Sponsors** Mosqueda

AN ORDINANCE adopting the King County behavioral health bridge implementation plan, required by the 2026-2027 Biennial Budget Ordinance, Ordinance 20023, Section 70, Proviso P1, to govern the expenditure of proceeds from 2028 through 2034 of the behavioral health sales and use tax authorized by RCW 82.14.460 and K.C.C. 4A.500.315.

STATEMENT OF FACTS:

1. In 2005, the state Legislature authorized counties to implement a one-tenth of one percent sales and use tax to support new and expanded behavioral health programs, as described in RCW 82.14.460.

2. The behavioral health sales and use tax, originally enacted in King County in 2007 through Ordinance 15949, was extended in 2016 through Ordinance 18333. Ordinance 19976, Section 2, which is codified as K.C.C. 4A.500.315, provided for the continued collection of the sales and use tax without interruption and at the same rate through January 1, 2035.

3. The tax, originally known in King County by the mental illness and drug dependency ("MIDD") name, is renamed through Ordinance XXXXX (Proposed Ordinance 2026-XXXX), the King County behavioral health bridge ("the bridge").

4. The bridge is projected to generate nearly eight hundred million dollars for behavioral health care in King County between 2028 and 2034.

5. Between 2017 and 2025, participants in relevant sales-tax-funded programs had sixty-two percent fewer engagements with publicly funded crisis services, thirty-eight percent fewer episodes of hospitalization and involuntary detention, fifty-nine percent fewer bookings into King County and municipal jails, and thirty-two percent fewer emergency department visits three years after enrollment.

6. Significant behavioral health need persists in King County, fueling a cycle of homelessness, incarceration, and hospitalization that affects too many people. For example, nearly one thousand four hundred individuals in King County are regularly cycling through County and municipal jails, which means being booked into a correctional facility located in King County four or more times per year in two of the past three years, and ninety-six percent of these individuals have a behavioral health condition or a history of interaction with publicly funded behavioral health or crisis services.

7. The bridge sales tax continues to fill critical gaps in the availability of behavioral health care in King County, including paying for behavioral health care for low-income people not eligible for Medicaid and whose services are not covered by state funding. Bridge-funded programs and services also complement and strengthen the investments of other county funding streams, such as the Crisis Care Centers Levy and Health Through

Housing, by paying for services and programs that those targeted local moneys do not support.

8. The King County Behavioral Health Bridge Implementation Plan 2028-2034 invests where the need is greatest and where dollars can make the most meaningful impact. The plan seeks to break the cycle of behavioral health crises, incarceration, hospitalization, and homelessness by streamlining systems, coordinating across care settings, investing in technology, and paying for essential services that help people achieve and maintain stability. The plan promotes holistic and high-quality behavioral health care for years to come by addressing long-term workforce shortages and the youth behavioral health crisis. The plan invests strategically to improve the availability, accessibility, effectiveness, and equity of behavioral health care in King County across five interconnected strategy areas, which are: care transitions and diversion services; substance use disorder treatment, and recovery; equitable access to behavioral health care; child, youth, and young adult mental well-being; and behavioral health workforce development.

9. The 2026-2027 Biennial Budget Ordinance, Ordinance 20023, Section 70, Expenditure Restriction ER6, restricts nearly all behavioral health sales and use tax revenues in 2026 and 2027 to be expended or encumbered consistent with the processes and practices established in Ordinance 18406 and Motions 15093 and 15058. As a result, the King

County Behavioral Health Bridge Implementation Plan 2028-2034 encompasses the years 2028 through 2034.

10. Ordinance 20023, Section 70, Proviso P1, states that the executive should electronically file the mental illness and drug dependency sales tax implementation plan by July 1, 2026. Consistent with Ordinance XXXXX (Proposed Ordinance 2026-XXXX), the plan called for in the proviso is renamed the King County behavioral health bridge implementation plan.

BE IT ORDAINED BY THE COUNCIL OF KING COUNTY:

SECTION 1. The King County Behavioral Health Bridge Implementation Plan 2028-2034, which is Attachment A to this ordinance, as required by the 2026-2027 Biennial Budget Ordinance, Ordinance 20023, Section 70, Proviso P1, is hereby adopted

to govern the expenditure of behavioral health sales and use tax proceeds as authorized under Ordinance 19976 and K.C.C. 4A.500.315.

KING COUNTY COUNCIL
KING COUNTY, WASHINGTON

_____

Sarah Perry, Chair

ATTEST:

_____

Melani Pedroza, Clerk of the Council

APPROVED this _____ day of _____, _____.

_____

Girmay Zahilay, County Executive

Attachments: A. King County Behavioral Health Bridge Implementation Plan 2028-2034

King County Behavioral Health Bridge Implementation Plan 2028-2034

July 2026

King County

I. Contents

II. Executive Summary

The King County Behavioral Health Bridge ("the Bridge"), formerly known as the MIDD (Mental Illness and Drug Dependency) behavioral health sales tax, currently infuses approximately $100 million per year into the King County community behavioral health system through a countywide 0.1 percent sales tax authorized under RCW 82.14.460 and K.C.C. 4A.500.315.[1,2,3] This implementation plan describes a strategic approach to guide investments for the sales tax revenues from 2028 through 2034 to make behavioral health treatment more available, accessible, effective, and equitable for King County residents.

The primary purpose of the King County Behavioral Health Bridge is to invest in the long-term availability, accessibility, effectiveness, and equity of the county's behavioral health system, especially where people are falling through the cracks of existing systems.

By focusing on low-income residents with mental health conditions and substance use disorders, particularly those who are marginalized or experience intersectional inequities, the Behavioral Health Bridge invests where the need is greatest and where its dollars can make the most meaningful impact.

The Behavioral Health Bridge strengthens publicly funded behavioral health care in King County by investing in prevention, treatment, and recovery services that are often unavailable, inaccessible, or insufficiently resourced. These investments help break cycles of incarceration, hospitalization, homelessness, and crisis by ensuring people receive timely, culturally responsive, and effective care.

A new name

In response to community and provider feedback, as part of this renewal, the Executive proposes to rename MIDD as the King County Behavioral Health Bridge, or "the Bridge." The new name reflects the program's essential role in bridging critical gaps in behavioral health funding left by insufficient federal and state resources. It also helps create a bridge between people experiencing behavioral health conditions and community behavioral health treatment, other systems people interact with including the criminal-legal system, and pathways to recovery.

Context and need

Behavioral health needs in King County have evolved considerably since the 2018 adoption of the MIDD 2 Implementation Plan, which guides investments through 2027.[4,5] King County faces growing uncertainty regarding federal and state behavioral health funding. Anticipated Medicaid eligibility changes and coverage reductions are expected to increase the number of residents who require behavioral health services but lack insurance coverage. As a flexible local funding source, the Behavioral Health Bridge is uniquely positioned to fill service gaps that cannot be addressed through Medicaid or other state and federal funding streams.

Community engagement conducted during development of the renewal reached more than 2,200 residents, service providers, people with lived experience, advocates, and system partners through listening sessions, community events, surveys, and culturally specific outreach efforts. Participants consistently identified five priority needs:

- Increasing access to behavioral health care and reducing barriers to treatment;
- Strengthening culturally relevant and responsive services;
- Improving coordination across fragmented systems;
- Expanding services for children, youth, and young adults; and
- Addressing workforce shortages and improving workforce diversity.

A countywide approach guided by five strategy areas

The proposed Behavioral Health Bridge implementation plan represents a shift from funding a collection of individual programs toward investing in a coordinated, countywide behavioral health system. The plan emphasizes integration across behavioral health, health care, crisis response, homelessness, housing, and criminal-legal systems to improve outcomes and reduce fragmentation. Rather than focusing solely on service delivery, the renewed framework seeks to create sustainable system change by aligning investments around measurable outcomes driven by five strategic areas.

The proposed five strategy areas emerged from deep engagement with community members and subject matter experts, as well as the latest available county-level behavioral health data.

1. **Care Transitions and Diversion Services (CTD):** Enhance navigation and system coordination to ensure people receive timely, appropriate behavioral health services across all levels of care, divert individuals with behavioral health conditions from criminal-legal involvement to support long-term stability, and provide appropriate supportive services for individuals with behavioral health conditions involved in the legal system.
2. **Substance Use Disorder Treatment and Recovery (SUD):** Treat substance use disorders by providing effective, low-barrier services that address people's holistic needs and support sustainable paths to long-term recovery.
3. **Equitable Access to Behavioral Health Care (EA):** Decrease barriers to behavioral health services and increase access to culturally and linguistically responsive care.
4. **Child, Youth, and Young Adult Mental Wellbeing (CYYA):** Address the youth behavioral health crisis by investing in developmentally tailored services and programs that meet youth where they are.
5. **Behavioral Health Workforce Development (WF):** Strengthen and diversify the behavioral health workforce to meet growing community needs.

Phased, competitive procurement and base budget analyses

A significant feature of the renewal is the Executive's intention is to implement competitive procurements for nearly all contracted community-based programs. Many currently funded initiatives were established years ago, and the County seeks to ensure future investments align with contemporary evidence, emerging community needs, and best practices.

Through phased procurements beginning in 2028, the County will create opportunities for both existing and new providers to compete for Behavioral Health Bridge funding. This approach is intended to:

- Improve transparency and accountability;
- Encourage innovation;
- Expand opportunities for community-based organizations;

- Align funding with demonstrated outcomes; and
- Ensure investments remain responsive to changing needs.

Program components directly operated by other County agencies will generally not be procured with requests for proposal (RFPs) competitively. All investments, whether County-run or contracted to external providers, will advance the primary strategy areas for the Behavioral Health Bridge as described in this plan, and will be tied to performance measures and outcomes that achieve 13 goals identified in Section VI. Procurements will be designed to complement and coordinate with Medicaid, the Crisis Care Centers Levy, Best Starts for Kids, and other major behavioral health funding sources. The Executive Office will work alongside DCHS and partner agencies to conduct base budget analyses, align investments with strategic priorities, identify efficiencies, and ensure accountability across agencies.

Measurement and evaluation

In 2028-2034, the King County Behavioral Health Bridge will take a renewed approach to measurement and evaluation focusing on accountability, transparency, actionability, and consistency across all funded programs. Approximately one-quarter of current Behavioral Health Bridge funding supports programs administered outside the Department of Community and Human Services (DCHS), including investments in public health, courts, detention, public defense, and other County agencies. The Bridge renewal framework establishes a more coordinated countywide approach to ensure all investments align with shared goals and measurable outcomes.

While MIDD had substantial collaboration that resulted in extensive data collection, in the coming years the Behavioral Health Bridge can deliver outcomes through shared accountability and data-driven decision-making that crosses agencies with support from the Executive Office. This process will be informed by performance measures, outcome data, and participant experiences.

King County intends to measure and evaluate behavioral health sales tax investments with an evaluation approach that is transparent, outcomes-driven, and equity-focused, utilizing both quantitative and qualitative data. The County will track population-level indicators, implement strategy and program-specific performance measures aligned with the Results Based Accountability framework, and conduct business reviews and in-depth evaluations when appropriate. Results will be published through detailed annual online dashboards, annual briefings, and a biennial report to the King County Council. The Executive Office and DCHS will work together to monitor operations, direct operational continuous improvement, and make investment adjustments to best achieve the Bridge purpose. See Section VII and Section VIII for more information about the Behavioral Health Bridge's evaluation, performance measurement, and reporting in 2028-2034.

Reporting

The Executive will transmit to the Council a King County Behavioral Health Bridge Biennial Report, which includes data on expenditures, services, and outcomes, no later than August 31 every other year beginning in 2030. This report will include an overview of Behavioral Health Bridge accomplishments during the previous two calendar years, fiscal and performance management, expenditure of Behavioral Health Bridge proceeds by strategy area by ZIP code, the number of individuals receiving services by strategy and by ZIP code, and summaries of evaluation findings

when available. The biennial report will include descriptions of specific actions to improve programs based on reporting and evaluation and inform potential investment changes that the Executive may include in budget proposals. The Executive will make the biennial reports available widely to the Council, the Regional Policy Committee, and the community through DCHS' communication channels.[6]

Detailed performance measurements will be available online through interactive dashboards that include data disaggregated by strategy area, as well as historical data that can be used to make year-over-year comparisons of services and outcomes. DCHS staff along with the Executive Office will offer to brief the Council annually with information collected through the dashboards.

Reporting commitments are fully described in Section VIII.

Financial plan and policies

The financial plan includes projected annual revenues and expenditures for the King County Behavioral Health Bridge from 2028 through 2034. This includes the anticipated amounts of annual investment for each of the Behavioral Health Bridge's strategies and annual reserves, though specific investment amounts will depend on fund availability at the time of procurement. This section includes an inflation policy analysis as called for by the King County Council in a proviso in the 2026-2027 biennial budget ordinance. It describes the impact of the DCHS inflation policy on the Behavioral Health Bridge and presents a process to mitigate a potential structural gap between inflationary increases and sales tax revenues. The financial plan and policies are more fully described in Section IX.

Conclusion

The 2028–2034 Behavioral Health Bridge Implementation Plan represents an evolution of King County's behavioral health investment strategy. The proposed framework builds on nearly two decades of local innovation while responding to emerging challenges.

By prioritizing systems integration, equitable access, substance use treatment and recovery, youth behavioral health, workforce development, and outcome-driven investments, the Behavioral Health Bridge seeks to support a more coordinated, effective, and sustainable behavioral health system. The renewal positions King County to address immediate community needs while laying the foundation for long-term improvements in health, recovery, housing stability, and public safety.

III. Background

A. The King County Behavioral Health Bridge

The King County Behavioral Health Bridge ("the Bridge"), formerly known as the MIDD (Mental Illness and Drug Dependency) behavioral health sales tax, currently infuses approximately $100 million per year into the King County community behavioral health system.[7] The Behavioral Health Bridge is a countywide 0.1 percent sales tax that was created by the Legislature in 2005 and authorized under RCW 82.14.460 and K.C.C. 400.5A.315.[8,9] It allows counties in Washington to contribute funding for substance use and mental health treatment and services, including therapeutic courts for county residents.[10] King County passed local legislation to enact the sales tax in this region in 2007 and began collections and programming in 2008.[11] The King County Council renewed the tax for an additional nine years in 2016 and again in 2025.[12,13] Consistent with Ordinance 19976, as of the date of this plan, tax collections will extend to January 1, 2035.[14]

The Bridge is intended to augment longstanding inadequate federal and state investments to make behavioral health treatment more available, accessible, effective, and equitable for King County residents.[15] Between 2017 and 2025, MIDD programs directly served over 130,000 unduplicated King County residents and reached many more through community-wide education and outreach.[16] The MIDD 2 Implementation Plan, which currently guides MIDD program investments, expires at the end of 2027.[17,18]

Behavioral Health Bridge investments improve health and wellness, recovery, and connection to community, especially for people most affected by inequities related to race, income, and access to healthcare and are primarily managed by the Department of Community and Human Services (DCHS) Behavioral Health and Recovery Division (BHRD) within King County.[19] State law requires that counties that implement a behavioral health sales tax under RCW 82.14.460 also maintain a dependency therapeutic treatment court (King County's Family Treatment Court).[20] State law grants counties discretion to direct funding to many different kinds of behavioral health services in different settings, enabling the fund to invest where the need is greatest, at times in agencies outside of DCHS.[21]

The flexibility in state law has allowed King County to invest in programs and services that collectively reduce reliance on jails, emergency rooms, and hospitals, and create engagement in and connections to community-based behavioral health treatment for King County residents most in need. In the 2026-2027 biennium, about 25 percent of Bridge funds are managed by other King County agencies, including the Prosecuting Attorney's Office, Public Health - Seattle & King County, the Department of Judicial Administration, the Department of Adult and Juvenile Detention, the Sheriff's Office, the District Court, the Superior Court, and the Department of Public Defense (see Figure 25 in Appendix A). DCHS also currently manages some community contracts for behavioral health services that are connected to programs primarily operated by other County agencies.

Programs funded by MIDD in 2017-2025 reached over 20,000 people each year through more than 50 initiatives.[22] MIDD programs and initiatives since 2017 were organized under the following strategy areas:

- Recovery and Reentry

- Crisis Diversion
- Prevention and Early Intervention
- Therapeutic Courts
- System Improvement

Behavioral Health Bridge sales tax investments help people achieve recovery and stability. Three years after engagement in relevant MIDD initiatives, participants experienced:

- 62 percent fewer engagements with adult crisis programs.
- 32 percent fewer emergency department visits.
- 59 percent fewer bookings into King County jails.
- 38 percent fewer involuntary psychiatric hospitalizations.[23]

For more information about key outcomes and feedback about past MIDD investments, please view each MIDD Annual Report available on the DCHS website, including interactive data dashboards for each annual report starting in 2020.[24]

B. Primary purpose

The primary purpose of the King County Behavioral Health Bridge is to invest in the long-term availability, accessibility, effectiveness, and equity of the county's behavioral health system, especially where people are falling through the cracks of existing systems.

By focusing on low-income residents with mental health conditions and substance use disorders, particularly those who are marginalized or experience intersectional inequities, the Behavioral Health Bridge invests where the need is greatest and where its dollars can make the most meaningful impact.

The Behavioral Health Bridge strengthens publicly funded behavioral health care in King County by investing in prevention, treatment, and recovery services that are often unavailable, inaccessible, or insufficiently resourced. These investments help break cycles of incarceration, hospitalization, homelessness, and crisis by ensuring people receive timely, culturally responsive, and effective care.

C. A new name and a new process to meet current needs

While MIDD remains a critical source of funding for behavioral health services, its name and the language "mental illness and drug dependency" no longer reflect the values and priorities that guide behavioral health work today. Community engagement and "Being in Community" are central to the Executive's approach to behavioral health. Over the years, the Department of Community and Human Services (DCHS) has consistently heard from behavioral health providers, partners, and community members that the current name contributes to stigma around behavioral health. In response to this feedback, the Executive proposes to rename MIDD as the King County Behavioral Health Bridge, or "the Bridge." Legislation transmitted concurrently with this plan formalizes the name change in King County Code.

The new name reflects the program's essential role in bridging critical gaps in behavioral health funding left by insufficient federal and state resources. Through this support, the Bridge helps ensure that more people can access behavioral health care when they need it most, especially

low-income residents who lack access to care or do not qualify for Medicaid. It also helps create a bridge between people experiencing behavioral health conditions and engagement with community behavioral health treatment and the many other systems people interact with, including the criminal-legal system, and pathways to recovery.

This plan uses the name "MIDD" to refer to investments prior to 2026 and uses "the King County Behavioral Health Bridge" and related terms to refer to current and future investments.

In addition to a new name, and in keeping with the Executive's priorities, the new implementation plan includes other key changes including:

- **A whole-county approach to investing, monitoring and measuring impacts of invested resources.** As noted earlier, in the 2026-2027 biennium, about 25 percent of Bridge funds are managed by King County departments outside of DCHS, including the Prosecuting Attorney's Office, Public Health - Seattle & King County, the Department of Judicial Administration, the Department of Adult and Juvenile Detention, the Sheriff's Office, the District Court, the Superior Court, and the Department of Public Defense. Partnership and coordination between multiple systems can improve health and wellness, support recovery, and forge connection to community for King County residents. Achieving the purpose of the Bridge requires many systems working together towards the same vision and goals through aligned strategies. As such, the Executive Office will coordinate with DCHS and partner agencies in using information from Bridge measurement and evaluation to make informed budget and operational improvements. The Executive Office will play a lead role to support alignment across the County.
- **A procurement process guided by five strategy areas.** For the approximately 75 percent of Behavioral Health Bridge dollars administered directly through DCHS, this plan lays out a public procurement process that will happen in phases over the course of an 18-month period beginning in 2028. The phased timeline is structured to allow for careful design, including alignment and incorporation of base budget assessments of county-provided services being conducted by the Executive Office's Budget Team in collaboration with DCHS, reassignment of programs to other, more appropriate funding sources such as Medicaid and new county funding sources, and recommendations from the Breaking the Cycle Workgroup.[25]

The Behavioral Health Bridge is a countywide funding source that has the potential to be transformative for people who are low-income with behavioral health conditions, especially those who are farthest from access and opportunity. This new implementation plan includes a new framework to guide investments for 2028 through 2034. It maintains core investments while establishing a new process to strategically address the most pressing behavioral health issues in King County as reflected in population health data and in a deep and robust community engagement process. All investments will improve the availability, accessibility, effectiveness, and equity of behavioral health care in King County.

D. Overview of DCHS and community behavioral health services

The Department of Community and Human Services (DCHS)

DCHS' mission is to provide equitable opportunities for King County residents to be healthy, happy, and connected to community. DCHS' five divisions provide human services for adults, including veterans and seniors; behavioral health care across the lifespan; services supporting children, youth, and young adults to thrive; services for people with developmental disabilities; and affordable housing and homelessness prevention. The department manages more than $3 billion per biennium in public funds to support King County residents to access a broad range of services, including the Behavioral Health Bridge.

Community behavioral health services in King County

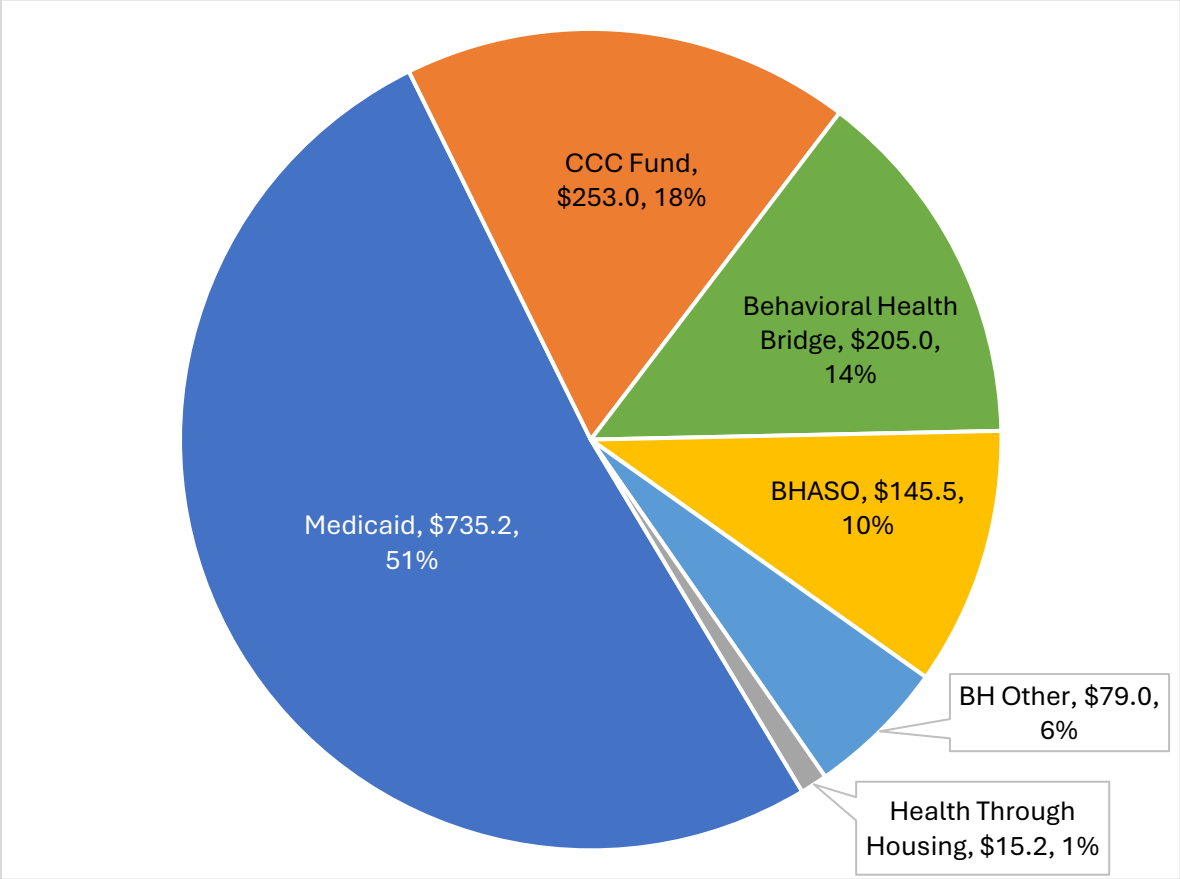
DCHS' Behavioral Health and Recovery Division (BHRD) oversees the public behavioral health system in King County, which includes managing and implementing the Behavioral Health Bridge and the CCC Levy. In addition to the Behavioral Health Bridge and the CCC Levy, BHRD oversees the publicly funded behavioral health system, including the King County Integrated Care Network (KCICN) and the Behavioral Health Administrative Services Organization (BHASO), and braids these distinct funding streams into a coherent continuum of care rather than a collection of siloed programs.

BHRD manages state and federally funded behavioral health services for people with low incomes, including Medicaid services delivered through the KCICN. Created in 2019 as a partnership between BHRD and more than 50 licensed community behavioral health providers, the KCICN represents the county's core behavioral health treatment capacity (outpatient services, residential treatment, case management, and more).[26] It serves approximately 50,000 low-income residents each year, and ensures access to community-based behavioral health treatment regardless of ability to pay.

Through its BHASO role, BHRD also administers the regional crisis system, providing and coordinating 24/7 crisis response, involuntary treatment investigations, and other non-Medicaid programs for all residents, including those who are uninsured or underinsured. Across these roles, BHRD manages all publicly funded behavioral health crisis services in the county, serving roughly 70,000 people each year. While most services are delivered through contracted community behavioral health agencies, BHRD also provides certain statutory functions directly, such as Designated Crisis Responder (DCR) investigations and involuntary commitment processes.

Behavioral Health Bridge sales tax funds comprise 14 percent of BHRD's projected revenues in 2026-27 (Figure 1).

Figure 1: Behavioral Health and Recovery Division projected revenue by fund source according to 2026-2027 financial plans (dollars in millions)[27]



**BH Other includes non-BHASO federal, state, local, and private grants, interfund transfers, and local taxes.*

IV. The process to develop the Behavioral Health Bridge Implementation Plan

The development of the Behavioral Health Bridge Implementation Plan involved a number of components, including a scan of changes to the behavioral health policy and funding landscape and a regional population-level data review coupled with robust community engagement process.

A. Behavioral health policy and funding changes

The behavioral health funding landscape has evolved significantly at the federal, state, and local levels since the MIDD 2 Implementation Plan was adopted in 2018.[28]

- **Local changes**: The creation of the KCICN in 2019, the passage of the Health Through Housing sales tax (2020) and the Crisis Care Centers Levy (2023), and the renewal of the Best Starts for Kids Levy (2021) and Veterans, Seniors, and Human Services Levy (2023).[29, 30, 31, 32]
- **State changes**: Changes to coverage for non-citizen Washingtonians with the introduction of Apple Health Expansion in 2024 and its contraction in 2026, federal approval of Apple Health's Medicaid Transformation Project 2.0 in 2023, and reductions in state funding for non-citizen health care, pre-release services, and several behavioral health programs serving King County as result of a state budget shortfall in the 2025-2027 state fiscal biennium.[33, 34, 35, 36]
- **Federal changes**: The passage of H.R.1 in 2025 which imposes significant changes to Medicaid, including work requirements and more frequent eligibility redeterminations, anticipated to reduce Medicaid enrollment in Washington State by 26 percent starting in 2027.[37, 38, 39]

The presence of new and expanded funding sources for behavioral health, combined with the possibility of losing other sources, creates an opportunity to evaluate and restructure behavioral health sales tax investments. Coordinating and aligning investments will maximize existing revenue and improve the County's ability to meet the increasing behavioral health needs of County residents.

B. Changes in regional behavioral health needs

Since the implementation of MIDD 2, behavioral health challenges in King County have also undergone significant changes, including the fentanyl epidemic and a global pandemic which produced crises in youth behavioral health and in the behavioral health workforce. King County must invest strategically to meet these new challenges head-on. Community input and the most current available local data indicate that the greatest current challenges in King County are:

Complex, siloed systems. As the behavioral health system has grown over the past decade, the connections between parts of the system have not kept pace. For example, among Medicaid enrollees in King County in 2023, 67 percent of people who went to an emergency department for an SUD concern did not have a follow-up outpatient visit within 30 days.[40] In addition, analysis shows that people who died from overdose in King County had engaged with a variety of public services such as jails, emergency departments, homeless services, or mental health care in the

year before their death.[41] However, fewer than half (48 percent) had been receiving publicly funded SUD services during that time.[42] To achieve its goal of an effective behavioral health system, King County must invest in care transitions directly to ensure that all parts of the system work together and people can access timely and appropriate care no matter where they enter the system.

Substance use disorders. In 2017, only nine percent of fatal overdoses involved fentanyl; in 2025, that number was 78 percent.[43] After reaching a peak in 2023, the rate of fatal overdose has begun to decline but it is still twice as high as in 2017.[44] Treatment methods have shifted to adapt to this new form of the opioid crisis. Medications for opioid use disorder (MOUD) have become the standard of care, but are still not available to everyone who needs them.[45] In addition, the proportion of unhoused, unsheltered people with a substance use disorder has increased from 29 percent in 2017 to 41 percent in 2026.[46,47] Innovative strategies that go beyond traditional office-based appointments are needed to help this population access care and move toward recovery.

Behavioral health inequities. As of 2024, 48 percent of King County's population and 62 percent of the population under age 18 were Black, Indigenous, or people of color (BIPOC).[48] Further, one in four County residents is an immigrant, and almost one third report speaking a language other than English at home.[49,50] Decades of research demonstrate racial and ethnic inequities in access to behavioral health care, and King County is no exception.[51] For example, Black/African American and American Indian/Alaska Native residents of King County are much more likely to experience a fatal overdose than their White, non-Hispanic peers.[52] Lesbian, gay, bisexual and transgender adults are two to three times as likely to experience frequent mental distress as their cisgender and heterosexual peers.[53] Targeted investments are needed to address inequities and ensure all King County residents can access and receive high quality, culturally-relevant behavioral health care.

Youth mental health crisis. The COVID-19 pandemic produced a youth mental health crisis that is still creating ripple effects years later.[54] Death by drug overdose or poisoning has become the third leading cause of death for people under 20 years old, with Washington State youth experiencing mortality at nearly twice the national average.[55] In 2023 among King County young people ages 11 to 24, Emergency Medical Services responded to 868 non-fatal opioid overdoses and 53 fatal overdoses.[56] In 2025, approximately one in 12 King County eighth and tenth graders reported considering suicide during the previous year.[57] Young people who do not receive help with their behavioral health are more likely to struggle with substance use, become homeless, or be arrested, whether during adolescence or later in life.[58] These youth and families need additional behavioral health support during the 2028-2034 Behavioral Health Bridge implementation period to keep them from becoming trapped in a cycle of behavioral health crisis, incarceration, and homelessness.

Behavioral health workforce shortage. It takes people to treat people. The behavioral health workforce has been strained for years, but the crisis escalated during the COVID-19 pandemic, which produced a nationwide surge in demand for behavioral health services at the same time that many clinical staff exited the workforce.[59,60] Locally, a 2023 survey of KCICN providers found that vacancies had doubled since 2021, and 65 percent of MIDD initiatives identified problems with staff recruitment and retention as a key factor impacting program reach and performance.[61,62] In 2025, KCICN provider agencies had an overall vacancy rate of nearly 10 percent, equating to 414 open positions.[63] The persistent workforce shortage means that treatment needs go unmet and care is delayed.[64] In addition, community and subject matter expert feedback (detailed in the next subsection) demonstrates a significant need for a behavioral health workforce that better represents the racial, cultural, and linguistic backgrounds of the people being served. Strategic

investments in the behavioral health workforce are expected to reduce treatment delays and gaps, help build a diverse provider pipeline, and promote the skills needed to treat the Behavioral Health Bridge's high-need service population.

C. Community and subject matter expert engagement

Community and subject matter expert engagement included consultation with the MIDD Advisory Committee, analysis of successes and challenges from the past 18 years of MIDD programming, coordination with other County agencies and partners, dialogue with internal workgroups within DCHS, engagement with over 2,200 County residents, and convenings of multi-disciplinary subject matter expert workgroups. The community engagement activities and multi-sector workgroups are broadly described below and further detailed in Appendices A, B, and C.

Community engagement

Throughout 2024 and 2025, King County DCHS solicited feedback from community members about behavioral health needs through:

- 46 in-person listening sessions,
- 34 virtual listening sessions,
- eight community events, and
- an online survey in 21 languages.[65]

This feedback was complemented with data from the "Be Heard: Community Voices about Mental Health and Wellness Community Listening Project," which gathered information from 543 individuals across 14 culturally centered community-based organizations.[66]

In total, feedback from 2,226 people across all regions of King County informed the direction of the Behavioral Health Bridge renewal. Conversations revealed the following themes:

- Increase access and reduce barriers.
- Strengthen culturally relevant and responsive care.
- Reduce system fragmentation and improve service coordination.
- Strengthen and increase services for children, youth, and young adults.
- Strengthen and expand the behavioral health workforce.
- Strengthen wraparound services that use team-based care and connect people to basic needs.

Combining the recommendations from the community and the behavioral health needs analysis described above, DCHS identified five strategy areas for the next iteration of the sales tax: Care Transitions and Diversion Services; Substance Use Disorder Treatment and Recovery; Equitable Access to Behavioral Health Care; Child, Youth, and Young Adult Mental Wellbeing; and Behavioral Health Workforce Development. The MIDD Advisory Committee reviewed these five strategy areas and collectively agreed they were the highest priority areas for the renewal.[67]

Additional details about methods of engagement, demographics of people engaged, emergent themes, and influences on the implementation plan can be found in Appendices A and B.

Multi-sector subject matter expert workgroups

To explore potential investments within each strategy area, DCHS conducted a multi-sector subject matter expert (SME) engagement process from April to July of 2025. DCHS established a

workgroup of SMEs for each proposed strategy area, with membership consisting of over 100 clinical providers, licensed peers, criminal-legal system representatives, researchers, educators, outreach workers, advocates, nonprofit leaders, members of the MIDD Advisory Committee, King County staff, and people with lived experience. Participant names and a crosswalk of recommendations to plan elements can be found in Appendix D.

SME input aligned closely with the feedback gathered from the broader community around themes like mitigating barriers and improving access, improving coordination across different parts of the behavioral health system, diversifying the behavioral health workforce, ensuring availability of culturally responsive services, enhancing care for youth and young adults, and continuing to support recovery from substance use disorders. Potential recommendations for future investments were intended to bridge gaps, address problems, and build upon existing services to improve behavioral health for County residents.

Strategic approach for King County Behavioral Health Bridge investments

After the conclusion of the workgroups, DCHS evaluated all SME recommendations on a range of factors, including feasibility, cost, equity, and alignment with the County's broader vision for behavioral health. DCHS also examined evaluation data for active MIDD 2 investments. Using this information, the Executive developed a plan that addresses present needs, responds to anticipated federal cuts, and builds capacity for system transformation in the future framed around five strategy areas described in Section VI.

V. A renewed King County Behavioral Health Bridge

The Bridge will fund investment in five areas:

1. **Care Transitions and Diversion Services (CTD):** Enhance navigation and system coordination to ensure people receive timely, appropriate behavioral health services across all levels of care, divert individuals with behavioral health conditions from criminal-legal involvement to support long-term stability, and provide appropriate supportive services for individuals with behavioral health conditions involved in the legal system.
2. **Substance Use Disorder Treatment and Recovery (SUD)**: Treat substance use disorders by providing effective, low-barrier services that address people's holistic needs and support sustainable paths to long-term recovery.
3. **Equitable Access to Behavioral Health Care (EA):** Decrease barriers to behavioral health services and increase access to culturally and linguistically responsive care.
4. **Child, Youth, and Young Adult Mental Wellbeing (CYYA)**: Address the youth behavioral health crisis by investing in developmentally tailored services and programs that meet youth where they are.
5. **Behavioral Health Workforce Development (WF):** Strengthen and diversify the behavioral health workforce to meet growing community needs.

The renewal outlines an approach to future investments that:

- Emphasizes integration of behavioral health, crisis response, criminal legal, health care and homelessness service systems. This countywide approach streamlines fragmented funding streams across many county agencies to maximize resources and seeks to measure and monitor impact for the people being served across systems.
- Seeks to break the cycle of behavioral health crises, incarceration, hospitalization, and homelessness by streamlining systems, coordinating across care settings, investing in technology, and paying for essential services that help people achieve and maintain stability.
- Provides opportunity to build on the strengths of previous investments while strategically tackling the most pressing behavioral health issues in King County communities, including siloed systems, substance use disorders, and inequitable access to care.
- Promotes holistic and high-quality behavioral health care for years to come by addressing long-term workforce shortages and the youth behavioral health crisis.
- Improves the availability, accessibility, effectiveness, and equity of behavioral health care in King County through data-driven decisions, performance measurement across policy areas, continuous improvement, and innovation.

Strategic investment areas in this plan comply with the supplantation restrictions in RCW 82.14.460(4) that were in effect at the time of this plan's drafting.[68] They are also intended to complement other available funding sources for behavioral health treatment and services. For example, the Bridge should not pay for behavioral health treatment for an individual when the same treatment could be provided to the individual under Medicaid coverage or another fund source. Instead, the Bridge is uniquely positioned to fund programs and services beyond the limited scope of federal, state, or other local funding.

A. Equity framework

King County places equity at the heart of its core values, recognizing it is essential to addressing systemic challenges and creating fair opportunities for all residents. By centering equity in actions, policies, and decision making, King County aims to disrupt disparities, promote mental well-being, and foster a community where all individuals and families can thrive.

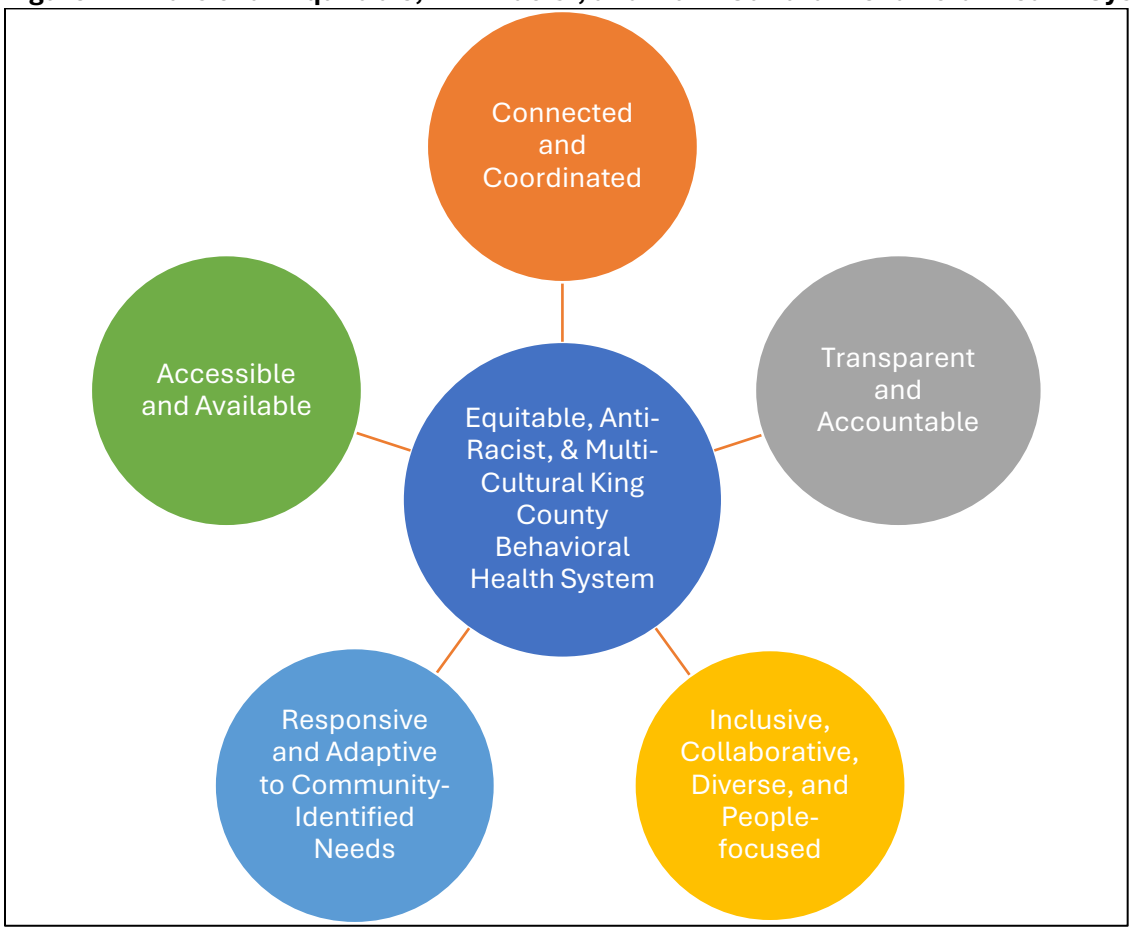
BIPOC, refugee and immigrant, LGBTQIA+ (lesbian, gay, bisexual, transgender, queer, intersex, asexual), and disability communities are more likely to struggle with behavioral health conditions and less likely to access supportive care than the King County population overall (see Subsection IV.B and Subsection VI.C). Direct, intentional policies designed to promote equity and racial justice for all County residents are needed to address these inequities. Through community engagement and collaboration with internal program managers, DCHS developed an equity framework for the King County Behavioral Health Bridge to embed services and outcomes for marginalized communities across all domains of Bridge services, not just the Equitable Access strategy area.

The equity framework for the Bridge describes five pillars of an equitable, anti-racist, multi-cultural King County behavioral health system (Figure 2). Behavioral Health Bridge investments will be designed to advance a behavioral health system that is:

- **Connected and coordinated:** Investing strategically across county systems and partners to strengthen behavioral health coordination; expanding equitable and low-barrier services; aligning with King County's commitment to racial justice; and enhancing continuity of care.
- **Transparent and accountable**: Conducting transparent and equitable procurement processes; embedding equity expectations across provider relationships; and ensuring accountability by tracking outcomes and disparities, supporting providers to improve, and using data to continuously center culturally responsive, equitable services.
- **Inclusive, collaborative, diverse, and people-focused:** Elevating and partnering with people with lived experience through inclusive engagement; centering racial equity and antiracism in funding and program decisions; and resourcing providers to advance equitable, community-driven solutions.
- **Responsive and adaptive to community-identified needs:** Providing community-driven, culturally responsive services that address systemic biases; expanding access for underserved populations; and supporting programs informed and led by the communities most impacted.
- **Accessible and available:** Providing culturally responsive services and seeking to reduce barriers related to cost, wait times, travel, stigma, and physical accessibility.

For examples of how the equity framework was utilized in the process to develop the implementation plan please see Appendix E.

Figure 2: Pillars of an Equitable, Anti-Racist, and Multi-Cultural Behavioral Health System



B. Phased, competitive procurement and base budget analyses

The Executive intends to implement competitive procurements for nearly all Behavioral Health Bridge-funded programs that will be administered by contracted community providers. The intention of new procurements is to ensure that future investments are made to achieve the goals of each strategy area. In some cases, this might mean that an existing program is continued with minimal changes. In other cases, existing programs might undergo significant changes, be shifted to another fund source, or be phased out to redirect Behavioral Health Bridge resources to better achieve the County's goals while still providing community members with access to needed services. These shifts are part of realizing the Executive's priority of Better Government, which "commits King County to operating as a more transparent, effective and accountable organization[69,70]

Competitive procurements will allow King County to evaluate program models and applicants, including new provider organizations and those that have previously received Bridge funding, to identify the most promising, responsive, and effective investments. Behavioral health interventions have continued to evolve and improve as new evidence has emerged over the past 18 years of the

behavioral health sales tax.[71,72] Although many initiatives have evolved through continuous quality improvement since their inception, some are based in program models that are outdated and require a more substantial overhaul to maximize effectiveness. Of the 49 initiatives active in 2026, 27 were continued from MIDD 1 (2008-2016).[73] As a result, the majority of current programming is implemented by providers selected many years ago. Many new organizations have been established in King County but have not had the opportunity to apply for behavioral health sales tax funding. New procurements will provide equitable opportunities for all qualified King County providers to apply for Behavioral Health Bridge funds and are expected to help ensure that funds support the most effective programs.

Due to the scale of programs and services supported by the King County Behavioral Health Bridge, procurements for all strategy areas in this plan and related base budget analyses require significant planning and staffing and cannot all occur at once. Therefore, DCHS plans to phase procurements through the first 18 months of the new implementation period, according to the progression described in Figure 3.

The Executive anticipates initial base budget analysis to be completed ahead of the 2028-2029 budget, but further review and adjustment will align with DCHS strategy area procurement.

Figure 3: Phased introduction of reprocured and revised Behavioral Health Bridge programs

Strategy Area	Anticipated launch of programs (reprocured or with new base budget)
SUD Treatment and Recovery (SUD)	Quarter 3 of 2028
Equitable Access to Behavioral Health Care (EA)	Quarter 3 of 2028
Care Transitions and Diversion Services (CTD)	Quarter 1 of 2029
Behavioral Health Workforce Development (WF)	Quarter 1 of 2029
Child, Youth, and Young Adult Mental Wellbeing (CYYA)	Quarter 3 of 2029

MIDD 2 initiatives that align with each strategy area will generally continue until the area is reprocured. For example, current initiatives that align with the SUD Treatment and Recovery strategy area are expected to continue until programs governed by the activities described in this plan launch in Quarter 3 of 2028. DCHS plans to announce awards three to six months in advance of program launch dates to enable appropriate ramp-down periods for programs or providers that do not receive continued funding. Phased procurements also ensure providers do not have to apply for RFPs in multiple strategy areas simultaneously.

The order of strategy area procurements is strategically designed to facilitate smooth transitions. For example, the complexity of the Care Transitions and Diversion Services area will require significant County staff resources for implementation. Because Behavioral Health Bridge program planning in 2027 will primarily rely on existing DCHS staff, new programs in the CTD area are scheduled to launch in the first quarter of 2029 to ensure enough staff resources are in place to achieve an effective transition in 2028. In addition, the Child, Youth, and Young Adult Mental Wellbeing area will be closely coordinated with Best Starts for Kids (Best Starts) to ensure the funding streams complement rather than duplicate one another. As of the drafting of this plan, if voters approve renewal of the Best Starts for Kids levy, the next implementation plan for Best Starts is expected to be due to King County Council in late 2027, with procurement for new strategies

likely to take place during 2028 and 2029. The Bridge's CYYA strategy area is scheduled for procurement during the same period so that the Behavioral Health Bridge and Best Starts teams can coordinate activities, ensure investments are complimentary and not duplicative, and invest in a continuum of care that best serves youth and families. If the Best Starts levy is not approved by voters, DCHS will reevaluate optimal investments of the Behavioral Health Bridge for children, youth, and young adults to reflect that substantial loss of services for youth and families.

The process to develop and implement procurements is expected to include:

- Analyzing current financial projections, policy updates, performance data, and potential funding sources for each strategy area.
- Conducting base budget analysis of programs directly operated by County agencies.
- Completing a review of crosswalk existing programs to strategy areas and identifying alternative funding sources where applicable.
- Drafting procurement materials for anticipated activities, goals, and preliminary outcome measures.
- Launching competitive procurement with community outreach, information sessions, and technical assistance.
- Recruiting and training review panelists and conducting equitable application scoring.
- Selecting potential awardees and completing all required due diligence steps.
- Notifying the Council, issuing award letters, and finalizing scopes of work, goals, and outcome measures with awardees.
- Supporting providers in transitioning program participants, where applicable.
- Monitoring contract performance and evaluating outcomes to inform future adjustments to contracts and procurements.

Updated landscape and population needs assessment

Prior to procurement of each strategy area, DCHS will review and incorporate the latest information on population needs, policy changes, and updated fiscal information.

Base budget analysis

About 25 percent of the 2026-2027 MIDD funding is transferred to or managed directly by King County agencies other than DCHS. These programs include funding for County employees and community contracts held by other agencies.

Program components directly operated by County agencies will generally not be procured with DCHS-managed requests for proposal (RFPs) as these services are most appropriately or legally required to be implemented by County employees. All investments, whether County-run or contracted to external providers through DCHS or partner County agencies and departments, will advance the primary purpose for the Behavioral Health Bridge as described in this plan, and will be tied to measurable outcomes that achieve the 13 goals identified in Section VI. The Executive Office will coordinate with DCHS on base budget analyses for all Bridge-funded programs that are managed or administered by King County departments and agencies outside DCHS.[74] These analyses will assess investments for alignment with overall Behavioral Health Bridge goals, identify efficiencies, and ensure budget amounts are responsive to current needs.

Review and crosswalk of existing programs and initiatives

As noted earlier, several new funding resources have become available during MIDD 2 including new Medicaid benefits such as the reentry initiative which allows Medicaid reimbursement for transition planning and targeted case management for individuals in carceral settings and new county taxes such as the Crisis Care Centers levy. In developing the procurements, DCHS intends to ensure that the County investments are strategically targeted towards bridging the gaps in the behavioral health service continuum and filling gaps in services for populations that are not eligible for other sources of coverage.

C. Advisory Committee

The King County Behavioral Health Bridge Advisory Committee (AC), known in previous generations of behavioral health sales tax investments as the MIDD AC, is an advisory body to the Executive and Council. AC members are representatives from the health and human services and criminal-legal system communities. The AC ensures that the implementation and evaluation of the strategies and programs funded by the Behavioral Health Bridge sales tax revenue are transparent, accountable, collaborative and effective.

Ordinance 16077 established the committee in 2008, and Ordinance 18452 renamed and revised it for MIDD 2 in 2017.[75,76] Following conversations throughout 2025, the AC agreed that the core functions of the committee as outlined in Ordinance 18452 remain constant.[77] Proposed legislation transmitted concurrently with this plan updates the name of the committee from the King County MIDD Advisory Committee to the King County Behavioral Health Bridge Advisory Committee, consistent with the broader name change discussed in Subsection III.C of this plan. It also makes other limited technical updates to the Advisory Committee code, including to rename or clarify the represented sectors to continue to support effective cross-system engagement.

The King County Behavioral Health Bridge Advisory Committee intends to maintain its strong commitment to centering the expertise and lived experience of its members, engaging them as deeply as possible so they stay well-informed, connected, and meaningfully involved.

VI. Investments across the five strategy areas

This section outlines the identified goals of the five strategy areas for 2028–2034 that form the foundation of this implementation plan. For each of the five strategy areas, this plan outlines:

- the overarching aim of the strategy area; and
- further description of the specific goals within the strategy area that show the desired outcomes for potential investments.

Appendices F - J provide logic models for each of the strategy areas to show how Behavioral Health Bridge investments will drive towards the outcomes and goals for that identified area along with activities that are anticipated to be procured under each goal area.

A. Care Transitions and Diversion Services (CTD)

Enhance navigation and system coordination to ensure people receive timely, appropriate behavioral health services across all levels of care, divert individuals with behavioral health conditions from criminal-legal involvement to support long-term stability, and provide appropriate services for individuals with behavioral health conditions involved in the legal system.

CTD strategy area summary

Behavioral health services in King County include a wide array of treatment types and supports for people across the spectrum of behavioral health needs, and include many services delivered through community agencies as well as some delivered in the criminal legal (including carceral) or hospital settings. The treatment system's size and complexity can create challenges for individuals attempting to navigate between settings, types, and intensities of care. Fragmentation and siloed decision-making across care types and the housing, emergency response, and criminal-legal systems result in inefficiencies, repeated institutional involvement, and preventable harm.[78] Bridge programs combine supports related to behavioral health, housing stabilization, and reentry in order to break cycles of homelessness, crisis, and incarceration or hospitalization.[79]

This strategy area will move the County toward a future state in which progress toward recovery is not undermined by logistical barriers or administrative siloes. Investments in this area will build on existing efforts to help people access lower-acuity services before their behavioral health conditions escalate, divert people from criminal-legal system involvement, support behavioral health services for those involved in the legal system, and support successful community reentry after incarceration. This includes addressing intersecting needs (such as but not limited to mental health conditions, SUD, housing insecurity, and cultural and linguistic barriers) and strengthening linkages between care settings.

King County intends to pursue three goals in the area of Care Transitions and Diversion Services:

- Goal 1: Divert people from criminal-legal involvement, provide supportive services for those involved in the legal system, and support successful community reentry.
- Goal 2: Help people with behavioral health conditions achieve and maintain stable housing.
- Goal 3: Enhance navigation and system coordination so that people receive timely and appropriate behavioral health services across all levels of care.

Figure 4: Estimated expenditures in the Care Transitions and Diversion strategy area, 2028-2034 (millions of dollars)

	2028	2029	2030	2031	2032	2033	2034
Goal 1	$25.8*	$24.0	$24.6	$25.1	$25.7	$26.2	$26.8
Goal 2	$5.7*	$5.0	$5.1	$5.3	$5.4	$5.5	$5.7
Goal 3	$5.2*	$3.5	$3.6	$3.7	$3.8	$4.2	$4.5
Total	**$36.7***	**$32.5**	**$33.3**	**$34.1**	**$34.9**	**$35.9**	**$36.9**

^The complete financial plan for the Bridge can be found in Section IX. Totals may not sum exactly due to rounding.

**This amount pays for continuing MIDD 2 initiatives, prior to the launch of new and revised CTD programs in 2029.*

CTD Goal 1: Divert people from criminal-legal involvement, provide supportive services for those involved in the legal system, and support successful community reentry.

A core aim of the behavioral health sales tax since its inception has been to divert individuals with mental health and substance use conditions from costly settings and systems, such as jails, and to help them successfully re-enter society when leaving institutions. These programs and services remain a high priority, and the King County Behavioral Health Bridge will improve upon existing work by providing services with a focus on coordination and breaking down siloes. Rather than funding programs in isolation, DCHS will strive for care transition services that maintain a cohesive thread of care across diversion, incarceration, and reentry. Rather than intervening separately at discrete moments in a person's journey, programs in this goal area are intended to work together to promote holistic wellbeing and connection to appropriate services, interrupting cycles of incarceration, hospitalization, and crisis.

Population served: Services procured under this goal are intended to serve low-income people with behavioral health conditions who are involved in or at risk of becoming involved in the criminal-legal system.

Anticipated timeline: Reprocured programs are expected to launch in the first quarter of 2029.

Figure 5: Funding estimate for CTD Goal 1 (millions of dollars)

Year	2028	2029	2030	2031	2032	2033	2034
Anticipated Activities	$25.8*	$24.0	$24.6	$25.1	$25.7	$26.2	$26.8

**This amount pays for continuing MIDD 2 initiatives, prior to the launch of new and revised CTD programs in 2029.*

CTD Goal 2: Help people with behavioral health conditions achieve and maintain stable housing.

According to the King County Point in Time Count in 2024, 31 percent of unsheltered people experiencing homelessness have a serious mental illness, and 41 percent have a substance use disorder.[80] Although the Behavioral Health Bridge focuses on behavioral health services, housing that is connected to behavioral health services is a permissible expenditure under RCW 82.14.460(3).[81] Also, the Executive's Breaking the Cycle priority recognizes that homelessness, untreated behavioral health needs, and repeated legal-system involvement are interconnected challenges that require urgent, coordinated solutions.[82] Investments in this goal will align with future recommendations from the Breaking the Cycle Workgroup and will provide services and supports at the intersection of housing instability and behavioral health needs.[83]

Population served: Services procured under this goal are intended to serve low-income people with behavioral health conditions who are experiencing or at risk of experiencing homelessness or housing instability, or who live in King County-funded permanent supportive housing.

Anticipated timeline: Reprocured programs are expected to launch in the first quarter of 2029.

Figure 6: Funding estimate for CTD Goal 2 (millions of dollars)

Year	2028	2029	2030	2031	2032	2033	2034
Anticipated Activities	$5.7*	$5.0	$5.1	$5.3	$5.4	$5.5	$5.7

**This amount pays for continuing MIDD 2 initiatives, prior to the launch of new and revised CTD programs (in 2029.*

CTD Goal 3: Enhance navigation and system coordination so that people receive timely and appropriate behavioral health services across all levels of care.

A significant theme from community engagement that informed this renewal proposal was system fragmentation and service coordination. When services fail to communicate or coordinate with each other, people can fall through the cracks, experience delays in care, or receive duplicative or conflicting support. This not only creates gaps in care but also places additional strain on providers and reduces the overall effectiveness of the system. When services are better connected across clinics, hospitals, community-based organizations, and social service agencies, individuals are more likely to receive comprehensive, continuous, whole-person care. Investments in this goal focus on improving coordination and reducing fragmentation to make care more efficient, easier to access, and more responsive to the needs of the people being served.

Behavioral Health Equity Highlight

CTD Goal 3 supports the behavioral health equity pillar *Connected and Coordinated*. The administrative burdens of navigating public systems and services worsen inequities.[84] By investing in programs that help all eligible people access the care they are entitled to, the Behavioral Health Bridge alleviates barriers and promotes equity.

Population served: Services procured under this goal are intended to serve low-income people with behavioral health conditions and the providers who work with that population.

Anticipated timeline: Reprocured programs are expected to launch in the first quarter of 2029.

Figure 7: Funding estimate for CTD Goal 3 (millions of dollars)

Year	2028	2029	2030	2031	2032	2033	2034
Anticipated Activities	$5.2*	$3.5	$3.6	$3.7	$3.8	$4.2	$4.5

**This amount pays for continuing MIDD 2 initiatives, prior to the launch of new and revised CTD programs in 2029.*

B. Substance Use Disorder Treatment and Recovery (SUD)

Treat substance use disorders by providing effective, low-barrier services that address people's holistic needs and support sustainable paths to long-term recovery.

SUD strategy area summary

King County's vision for SUD treatment in the region is to provide timely access to high quality, evidence-based treatments that support individuals to achieve and sustain recovery. This includes offering peer-based recovery support in tandem with medication, outpatient, inpatient, and residential care. Behavioral Health Bridge sales tax investments will complement and strengthen the existing services of Medicaid, the CCC Levy, and other local and state investments, building upon existing efforts to prevent and treat substance use disorders and help people recover. When procuring services under this strategy area, the County will include people with co-occurring mental health conditions alongside SUD to avoid perpetuating fragmented care.

King County intends to pursue three goals in the area of Substance Use Disorder Treatment and Recovery:

- Goal 1: Drive engagement and retention in SUD care.
- Goal 2: Provide effective, low-barrier SUD treatment that meets people's holistic needs.
- Goal 3: Support paths to achieve and maintain recovery after treatment.

Figure 8: Estimated expenditures in the Substance Use Disorder Treatment and Recovery strategy area, 2028-2034 (millions of dollars)

	2028	2029	2030	2031	2032	2033	2034
Goal 1	$1.7*	$2.2	$2.3	$2.4	$2.4	$2.5	$2.5
Goal 2	$15.6*	$16.3	$16.8	$17.3	$17.7	$18.1	$18.5
Goal 3	$2.1*	$1.6	$1.7	$1.7	$1.8	$2.1	$2.4
Total	**$19.5***	**$20.2**	**$20.8**	**$21.4**	**$21.9**	**$22.6**	**$23.3**

^The complete financial plan for the Bridge can be found in Section IX. Totals may not sum exactly due to rounding.
**A portion of this amount pays for continuing MIDD 2 initiatives, prior to the launch of new and revised SUD programs in mid-2028.*

SUD Goal 1: Drive engagement and retention in SUD care.

In order to break the cycle of substance use, incarceration, and homelessness, people need accessible paths to treatment. Access to treatment for substance use came up repeatedly during community engagement related to the sales tax renewal. Respondents to BHRD's 2024 online survey about the behavioral health system named "difficulty understanding where and how to access services" as the leading barrier to accessing behavioral health services. (See Figure 32 in Appendix B.) At listening sessions, participants noted that the County has made progress in improving access to emergency and on-demand services, improving access across geographic regions, and increasing culturally specific outreach. However, they still described problems finding the SUD services they needed, transportation barriers, and insufficient flexibility in appointment times and locations, as well as a desire for more culturally responsive care.

Consistent with the priorities expressed by community and subject matter experts, the next iteration of the behavioral health sales tax will build on existing programs to help people access care when they are struggling with SUD.

Population served: Services procured under this goal are intended to serve low-income people with SUD who are not currently connected to treatment, especially those experiencing homelessness.

Anticipated timeline: Reprocured programs are expected to launch in the third quarter of 2028.

Figure 9: Funding estimate for SUD Goal 1 (millions of dollars)

Year	2028	2029	2030	2031	2032	2033	2034
Anticipated Activities	$1.7*	$2.2	$2.3	$2.4	$2.4	$2.5	$2.5

**A portion of this amount pays for continuing MIDD 2 initiatives, prior to the launch of new and revised SUD programs in mid-2028.*

SUD Goal 2: Provide effective, low-barrier SUD treatment that meets people's holistic needs.

King County's publicly funded behavioral health treatment system is extensive and funded by a blend of sources, including Medicaid, Medicare, and state and local funds. In 2025, more than 4,400 youth and adults received outpatient SUD services and over 1,750 received residential services for substance use disorder.[85] Over 4,700 people received medication for opioid use disorder (MOUD) from DCHS-contracted providers. The Executive plans to strategically invest Behavioral Health Bridge revenues to ensure SUD services are as effective as possible by sustaining core programs, breaking down barriers to care, and implementing best practices and innovative approaches to treatment.

Population served: Services procured under this goal are intended to serve low-income people with SUD who are ready to initiate or have initiated treatment. This goal is also intended to serve people at risk of overdose through overdose prevention, and the broader community through overdose data collection and tracking.

Anticipated timeline: Reprocured programs are expected to launch in the third quarter of 2028.

Figure 10: Funding estimate for SUD Goal 2 (millions of dollars)

Year	2028	2029	2030	2031	2032	2033	2034
Anticipated Activities	$15.6*	$16.3	$16.8	$17.3	$17.7	$18.1	$18.5

**A portion of this amount pays for continuing MIDD 2 initiatives, prior to the launch of new and revised SUD programs in mid-2028.*

Behavioral Health Equity Highlight

SUD Goal 2 supports the behavioral health equity pillar *Inclusive, collaborative, diverse, and people-focused*. Expanding access to culturally responsive SUD treatment that aligns with individuals' languages, cultures, and lived experiences reduces barriers to care and improves outcomes for historically marginalized communities in King County.

SUD Goal 3: Support paths to achieve and maintain recovery after treatment.

The purpose of treatment is to help people achieve recovery, which is defined by the Substance Abuse and Mental Health Administration as "a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential."[86]

People in recovery need housing, employment, and social supports to maintain the gains they earned during treatment.[87] In the absence of these supports, vulnerable people often have no choice but to return to unstable living situations where they are surrounded by triggers, making it very likely they will fall back into the cycle of SUD and behavioral health crisis.[88] The Bridge will invest in services and supports that help people achieve and maintain stability after treatment for SUD or co-occurring conditions, increasing the likelihood of lasting recovery and long-term wellbeing.

Population served: Services procured under this goal are intended to serve low-income people with SUD who self-identify as being in recovery from SUD, especially those who have recently completed treatment.

Anticipated timeline: Reprocured programs are expected to launch in the third quarter of 2028.

Figure 11: Funding estimate for SUD Goal 3 (millions of dollars)

Year	2028	2029	2030	2031	2032	2033	2034
Anticipated Activities	$2.1*	$1.6	$1.7	$1.7	$1.8	$2.1	$2.4

**A portion of this amount pays for continuing MIDD 2 initiatives, prior to the launch of new and revised SUD programs) in mid-2028.*

C. Equitable Access to Behavioral Health Care (EA)

Decrease barriers to behavioral health services and increase access to culturally and linguistically responsive care.

EA strategy area summary

Equity is a critical dimension of health care quality.[89] To increase the availability, accessibility, and effectiveness of behavioral health care for King County residents, the Executive is prioritizing intentional investments in equitable access for the King County Behavioral Health Bridge's diverse, high-need, low-income service population. This includes providing behavioral health care for people who are uninsured or underinsured. Immigrants are disproportionately affected by lack of insurance because people with certain immigration statuses are not eligible for Medicaid coverage regardless of income, and the passage of federal bill H.R. 1 in 2025 will further restrict Medicaid access for immigrants beginning in October 2026.[90,91,92] In Washington, an estimated 620,000 people, both immigrants and US-born residents, are expected to be affected by the addition of work requirements in Medicaid in 2027, which can result in loss of coverage if a person is unable to prove their eligibility to the State every six months.[93] The administrative tasks required to stay enrolled in Medicaid may be especially difficult for people with behavioral health conditions.[94] In addition, Behavioral Health Bridge investments in this strategy area will directly address access barriers related to racism, immigration status, sexual orientation, gender identity, trauma history, and geographic location through investments in community-based services that meet people where they are.

King County will pursue two goals in the area of equitable access to behavioral health care:

- Goal 1: Provide behavioral health care for low-income people who are ineligible for Medicaid.
- Goal 2: Support the wellbeing of diverse communities by providing culturally and linguistically responsive services and removing barriers to care.

Figure 12: Estimated expenditures in the Equitable Access to Behavioral Health Care strategy area, 2028-2034 (millions of dollars)

	2028	2029	2030	2031	2032	2033	2034
Goal 1	$12.0	$12.3	$12.7	$13.0	$13.3	$13.6	$13.9
Goal 2	$4.1*	$4.2	$4.3	$4.5	$4.6	$5.0	$5.3
Total	**$16.1***	**$16.5**	**$17.0**	**$17.5**	**$17.9**	**$18.6**	**$19.2**

^The complete financial plan for the Bridge can be found in Section IX. Totals may not sum exactly due to rounding.
**A portion of this amount funds continues MIDD 2 initiatives, prior to the launch of new and revised programs in this strategy area in mid-2028.*

EA Goal 1: Provide behavioral health care for low-income people who are ineligible for Medicaid.

Population served: Services procured under this goal are intended to serve low-income people with behavioral health conditions who are ineligible for Medicaid.

Anticipated timeline: Reprocured programs are expected to launch in the first quarter of 2028.

Figure 13: Funding estimate for EA Goal 1 (millions of dollars)

Year	2028	2029	2030	2031	2032	2033	2034
Anticipated Activities	$12.0	$12.3	$12.7	$13.0	$13.3	$13.6	$13.9

Behavioral Health Equity Highlight

EA Goal 1 supports the behavioral health equity pillar *Accessible and Available*. Expanding timely access to services for people without Medicaid helps ensure that individuals and families across King County can receive the care they need when and where they need it.

EA Goal 2: Support the wellbeing of diverse communities by providing culturally and linguistically responsive services and removing barriers to care.

People who are BIPOC, LGBTQIA+, or living in a rural area are vulnerable to behavioral health inequities caused by structural failures to meet their needs.[95,96,97] Culturally centered organizations design and deliver behavioral health supports by and for the communities they serve. Wellbeing is not one-size-fits-all, and healing and recovery are about much more than clinical medical practices. Healing and recovery also include people feeling a sense of connection to their community and culturally competent healing practices. Partnerships with trusted community organizations are critical for people's recovery journeys.[98] Intentional investment under this goal will directly address inequities in behavioral health outcomes related to race, immigration status, sexual orientation, gender identity, trauma history, and geographic access.

Population served: Services procured under this goal are intended to serve low-income people with behavioral health conditions who face behavioral health inequities as demonstrated by service and outcomes data, including those who are BIPOC, immigrants or refugees, LGBTQIA+, rural, older adults, or survivors of trauma or violence.

Anticipated timeline: Reprocured programs are expected to launch in the third quarter of 2028.

Figure 14: Funding estimate for EA Goal 2 (millions of dollars)

Year	2028	2029	2030	2031	2032	2033	2034
Anticipated Activities	$4.1*	$4.2	$4.3	$4.5	$4.6	$5.0	$5.3

**A portion of this amount pays for continuing MIDD 2 initiatives, prior to the launch of new and revised EA programs in mid-2028.*

D. Child, Youth, and Young Adult Mental Wellbeing (CYYA)

Address the youth behavioral health crisis by investing in developmentally tailored services and programs that meet youth where they are.

CYYA strategy area summary

King County is committed to providing equitable opportunities for all children to progress through childhood happy, healthy, safe, and thriving.[99] The need to bolster behavioral health services for children, youth, and young adults emerged as a consistent theme across all community engagement. Long before young people reach a behavioral health crisis, they are feeling lonely, disconnected, or bullied – upstream issues that need to be addressed to prevent behavioral health issues down the line.[100] The King County Behavioral Health Bridge is intentionally designed to invest in areas of unmet need and in services where funding is not currently available or stable, particularly prevention, engagement, early intervention, recovery, and treatment access for individuals who are uninsured or ineligible for Medicaid. By building on family and community strengths, and providing services when youth and families need support, the Bridge will complement other County investments (such as Medicaid, Best Starts, and the CCC Levy) to promote positive behavioral health for King County residents ages zero to 25 and their families.

King County will pursue three goals in the area of child, youth, and young adult mental wellbeing:

- Goal 1: Improve youth access to behavioral health care by providing developmentally appropriate services that meet young people where they are, at school and in community.
- Goal 2: Provide behavioral health and therapeutic services to youth involved in the legal system, including diversion from deeper legal system involvement.
- Goal 3: Invest in the behavioral health of youth who are marginalized or experience inequities.

Figure 15: Estimated expenditures in the Child, Youth, and Young Adult Mental Wellbeing strategy area, 2028-2034 (millions of dollars)

	2028	2029	2030	2031	2032	2033	2034
Goal 1	$3.5*	$4.0*	$4.5	$4.6	$4.7	$4.9	$5.0
Goal 2	$5.2*	$4.9*	$4.7	$4.8	$5.0	$5.1	$5.2
Goal 3	$2.6*	$2.8*	$3.0	$3.1	$3.1	$3.5	$3.8
Total	**$11.2***	**$11.7***	**$12.2**	**$12.5**	**$12.8**	**$13.4**	**$13.9**

^The complete financial plan for the Bridge can be found in Section IX. Totals may not sum exactly due to rounding.
**A portion of this amount funds continuing MIDD 2 initiatives, prior to the launch of new and revised programs in this strategy area.*

CYYA Goal 1: Improve youth access to behavioral health care by providing developmentally appropriate services that meet young people where they are, at school and in community.

The adopted 2025 Youth Action Plan calls for the County to "co-create and embed behavioral health support in youth development programs, schools, and other community-centered organizations."[101] To further this aim, investments under this goal will facilitate access to behavioral health care for young people by placing behavioral health supports in places where youth already spend time, such as schools and community locations.

Population served: Services procured under this goal are intended to serve youth and young adults with behavioral health symptoms or conditions who would benefit from outpatient care, especially those whose families are low-income.[102]

Anticipated timeline: Reprocured programs are expected to launch in the third quarter of 2029.

Figure 16: Funding estimate for CYYA Goal 1 (millions of dollars)

Year	2028	2029	2030	2031	2032	2033	2034
Anticipated Activities	$3.5*	$4.0*	$4.5	$4.6	$4.7	$4.9	$5.0

**A portion of this amount pays for continuing MIDD 2 initiatives, prior to the launch of new and revised CYYA programs in mid-2029.*

CYYA Goal 2: Provide behavioral health and therapeutic services to youth involved in the legal system, including diversion from deeper legal system involvement.

Youth involved with the criminal-legal system are some of the most vulnerable members of King County communities and need additional support to break the cycle of behavioral health issues and incarceration. Nationally, an estimated 50 to 70 percent of youth involved in the juvenile legal system meet criteria for at least one psychiatric disorder.[103] In 2025, 2,095 juvenile cases were referred by law enforcement to the King County Prosecuting Attorney's Office.[104] In the first five months of 2026, an average of 31.2 young people were in secure detention at the Clark Children and Family Justice Center, with another 38.5 assigned to Electronic Home Monitoring.[105] Young people involved in the legal system and their families need additional behavioral health support to keep them from becoming trapped in a cycle of incarceration.

Population served: Services procured under this goal are intended to serve youth with behavioral health conditions who are involved in or at risk of becoming involved in the criminal-legal system.

Anticipated timeline: Reprocured programs are expected to launch in the third quarter of 2029.

Figure 17: Funding estimate for CYYA Goal 2 (millions of dollars)

Year	2028	2029	2030	2031	2032	2033	2034
Anticipated Activities	$5.2*	$4.9*	$4.7	$4.8	$5.0	$5.1	$5.2

**A portion of this amount pays for continuing MIDD 2 initiatives, prior to the launch of new and revised CYYA programs in mid-2029.*

CYYA Goal 3: Invest in the behavioral health of youth who are marginalized or experience inequities.

The youth mental health crisis is widespread across King County communities, but not all youth encounter systems of support in the same way. Due to systemic racism and structural exclusion, some groups of young people are less likely to experience behavioral health services as accessible, affirming, culturally grounded, or responsive to their lived experiences. As a result, King County data show differences in mental health, substance use, and suicidality across youth populations, including among LGBTQIA+ youth, Black youth, Indigenous youth, youth of color, immigrant and refugee youth, and youth with complex behavioral health needs. For example:

- In 2025, Washington eighth graders identifying as American Indian/Alaska Native, Native Hawaiian/Pacific Islander, Hispanic/Latino, or LGBTQ+ were more likely than the statewide average to report depressive feelings.[106] In King County in 2025, about half of LGBTQ+ youth in King County experienced depression.[107]
- The rate of emergency department visits related to suicidal ideation among King County Black youth ages eight to 17 climbed every year from 2020 to 2023. Black youth and youth identifying with multiple races were the only groups without a decline in rates of suicidal ideation-related ED visits between 2022 and 2023.[108]
- In 2025, Washington tenth graders identifying as American Indian/Alaska Native, LGBTQ+, or having a disability were more likely than the Washington average to report using alcohol or vape products within the past 30 days.[109]

These differences highlight the importance of approaches that build on youth strengths, reflect community knowledge, and create more meaningful pathways to support.

Population served: Services procured under this goal are intended to serve youth with behavioral health conditions who face behavioral health inequities as demonstrated by service and outcomes data, including those who are BIPOC, immigrants or refugees, LGBTQIA+, rural, survivors of trauma or violence, or have complex or co-occurring behavioral health conditions.

Anticipated timeline: Reprocured programs are expected to launch in the third quarter of 2029.

Figure 18: Funding estimate for CYYA Goal 3 (millions of dollars)

Year	2028	2029	2030	2031	2032	2033	2034
Anticipated Activities	$2.6*	$2.8*	$3.0	$3.1	$3.1	$3.5	$3.8

**A portion of this amount pays for continuing MIDD 2 initiatives, prior to the launch of new and revised CYYA programs in mid-2029.*

E. Behavioral Health Workforce Development (WF)

Strengthen and diversify the behavioral health workforce to meet growing community needs.

WF strategy area summary

It takes people to treat people. A robust, skilled, and diverse workforce is foundational to delivering quality, timely behavioral health care. Nearly every service supported by the Behavioral Health Bridge relies on qualified behavioral health workers in community agencies, and there is a serious shortage of such professionals.[110] In 2025, the King County Integrated Care Network (KCICN) had an overall vacancy rate of nearly 10 percent, equivalent to 414 open positions.[111] Workforce investments are critical to sustaining services in community behavioral health, but are ineligible for payment by Medicaid. In concert with the activities of the CCC Levy to support the crisis workforce and alongside enhanced data collection to ensure that investments are achieving their intended impact, Bridge sales tax investments will provide a much-needed infusion of resources to help more people start and succeed in careers across the continuum of behavioral health care.[112]

King County will pursue two goals in the area of Behavioral Health Workforce Development:

- Goal 1: Strengthen and diversify the behavioral health provider pipeline.
- Goal 2: Advance and develop the skills of the current workforce to meet growing community needs.

Figure 19: Estimated expenditures in the Behavioral Health Workforce Development strategy area, 2028-2034 (millions of dollars)

	2028	2029	2030	2031	2032	2033	2034
Goal 1	$0	$2.5	$2.5	$2.6	$2.7	$2.9	$3.0
Goal 2	$1.3*	$4.1	$4.2	$4.4	$4.5	$4.7	$4.9
Total	**$1.3***	**$6.6**	**$6.8**	**$7.0**	**$7.1**	**$7.6**	**$8.0**

^The complete financial plan for the Bridge can be found in Section IX. Totals may not sum exactly due to rounding.

**This amount pays for continuing MIDD 2 initiatives, prior to the launch of new and revised WF programs in 2029.*

WF Goal 1: Strengthen and diversify the behavioral health provider pipeline.

Community members and subject matter experts who advised the King County Behavioral Health Bridge renewal reported difficulty accessing care due to a shortage of providers, especially those from diverse linguistic and cultural backgrounds. This echoes national trends: by 2038, behavioral health workforce shortages are projected to create cascading impacts on service access and availability across the country.[113] A national survey of community behavioral health workers found that fewer than half (42 percent) expected to be at their current practice in five years, and a Washington state survey found that community behavioral health organizations lose 25-60 percent of their clinical workforce every year.[114,115] At KCICN agencies in 2025, the highest number of vacancies were among Master's level mental health counselors, followed by non-peer Registered Agency Affiliated Counselors, who are usually Bachelor's-level case managers or student interns practicing under the agency's license.[116,117] SUD Professional trainees (SUDPts) also had a very high vacancy rate of 16 percent.[118]

DCHS plans to use this data to target investments intended to reduce vacancies and thereby increase service access.[119] In addition, KCICN agencies report wanting to diversify their staff, but struggling to pay competitive wages and to find qualified candidates who speak the languages in greatest demand.[120] To address these issues proactively and prevent continued challenges in people's ability to access behavioral health care, Goal 1 will focus on increasing the number of licensed behavioral health workers in King County and building a more representative provider population.

Population served: Services procured under this goal are intended to serve entrants and potential entrants into the behavioral health workforce, as well as people in behavioral health clinical internships, with a focus on increasing the diversity and representativeness of the workforce.

Anticipated timeline: Reprocured programs are expected to launch in the first quarter of 2029.

Figure 20: Funding estimate for WF Goal 1 (millions of dollars)

Year	2028	2029	2030	2031	2032	2033	2034
Anticipated Activities	$0	$2.5	$2.5	$2.6	$2.7	$2.9	$3.0

Behavioral Health Equity Highlight

WF Goal 1 supports the behavioral health equity pillar *Responsive and Adaptive to Community-Identified Needs*. Community members have consistently shared that they feel more comfortable accessing behavioral health care when providers reflect the communities they serve. The Executive is responding to this need by investing in a diverse provider pipeline.

WF Goal 2: Advance and develop the skills of the current workforce to meet growing community needs.

In contrast to private practice, community behavioral health providers are more likely to see patients with complex and co-occurring disorders or high-acuity needs, who may also be low-income, unhoused, uninsured, or have limited English proficiency. Investments from the Bridge will help equip providers with the range of skills necessary to offer high-quality, effective services to this population.

Population served: Services procured under this goal are intended to serve providers in King County's publicly funded community-based behavioral health system.

Anticipated timeline: Reprocured programs are expected to launch in the first quarter of 2029.

Figure 21: Funding estimate for WF Goal 2 (millions of dollars)

Year	2028	2029	2030	2031	2032	2033	2034
Anticipated Activities	$1.3*	$4.1	$4.2	$4.4	$4.5	$4.7	$4.9

**This amount pays for continuing MIDD 2 initiatives, prior to the launch of new and revised WF programs in 2029.*

VII. Measurement and evaluation

This section presents the overarching principles and approaches that will guide the evaluation and performance measurement of the King County Behavioral Health Bridge investments. The performance measurement and evaluation framework for 2028-2034 continues and builds upon the existing framework used by MIDD 2.[121,122,123] Consistent with other King County human services initiatives, measurement and evaluation for the Behavioral Health Bridge will use the Results Based Accountability (RBA) framework, and DCHS plans to work with the Executive Office, other agencies and in partnership with service providers to finalize performance measures.[124]

With the introduction of a new primary purpose and strategy areas in this implementation plan, the measurement and evaluation approach for the Behavioral Health Bridge builds on RBA through the use of logic models in each strategy area that ensure program outcomes are designed to achieve the overall goals of each area, as shown in Section VI of this plan. Further, the use of SMART (specific, measurable, achievable, realistic, time-bound) outcomes for each program and strategy are expected to improve understanding of how each program helps drive the [125] each strategy area.[126]

A. Overarching principles

The King County Behavioral Health Bridge evaluation approach is collaborative, transparent, outcomes-driven, person-centered, equity-focused, and continuously improving. This approach equips the Behavioral Health Bridge with the information needed to understand what works, foster shared accountability, and make data-driven decisions across programs.

Collaborative: Performance measurement and evaluation require DCHS, other County agencies, the Executive Office, and Bridge-funded providers and programs to work together to identify actionable metrics. In partnership with program staff and contracted providers, King County evaluation staff intend to develop performance measures that facilitate strategy-wide impact measurement and capture information meaningful to programs and pertinent to community needs. Each program's performance measures will be finalized in performance measurement plans that align with the Executive's vision and long-term goals for the Behavioral Health Bridge as described in this plan. Where relevant, these performance measurement plans will coincide with other initiatives and countywide strategic plans, such as the Breaking the Cycle Workgroup. For programs that cross multiple County agencies, metrics will be developed collaboratively, with the Executive Office facilitating consistency and coordination across County agencies.

Transparent: To foster public accountability and transparency, King County regularly shares performance measurement and evaluation outcomes, methods, and data sources with the public via annual dashboards and biennial reports, which are described further in Section VIII of this plan.[127] King County evaluation staff will also regularly review data and outcomes with program managers and Bridge-funded providers to ensure that information received by King County is accurate, reliable, and valid.

Outcomes-driven: Assessment and evaluation of data are essential tools for understanding what works, identifying the results of investments, determining whether interventions are effectively addressing relevant issues, and supporting accountability. Behavioral Health Bridge data

collection practices will be outcomes-driven and reflect system-level objectives for each strategy area as described in the logic models throughout this plan. Data collection is expected to incorporate quantitative and qualitative data and will include demographic information to ensure service recipients are reflective of the community. King County staff regularly review data and performance measures to inform program or contract modifications, repurposing of funds, and future procurement of services.

Person-centered: Data influences the narrative about the communities from which it is collected and guides policy decisions and resource distribution. King County seeks to present data in ways that move beyond historical deficit-based portrayals. More importantly, King County intends to regularly share data with community for reflection and to ensure data is person-centered, accurate, and grounded in lived experience. This transparency is essential for strengthening accountability, supporting better government, and reinforcing trust. Whenever possible and feasible, King County staff will continue to center the voices of Behavioral Health Bridge program participants to understand and respond to their experiences of what is working and what is not working. By acknowledging systemic barriers and elevating community strengths, resilience, and stamina, King County aims to ensure the data tells a more complete story that supports equitable decision making.

Equity-focused: The Executive intends to deepen the Behavioral Health Bridge's commitment to the principles of equitable evaluation.[128] DCHS intends to ensure data reflect the communities from which they are gathered and help illuminate how needs, strengths, and outcomes vary across populations in ways that inform policy and resource decisions. During the 2028–2034 Bridge implementation period, DCHS intends to specifically expand the visibility of BIPOC communities within data and strengthen their involvement in determining what data are collected and how findings are interpreted. This may include enhancing the ways evaluators disaggregate results by race, ethnicity, and other demographics; developing new data collection methods; continuing to value and report qualitative outcomes; and increasing opportunities for community reflection and feedback on data analysis and results. Together, these approaches are expected to support both stronger accountability to outcomes and a more accurate, community-grounded understanding of what is working.

Continuous improvement:
King County DCHS evaluation staff process data at least quarterly to ensure completeness, accuracy, and timely course correction. Findings are shared with DCHS staff, partner agencies, the Executive Office, and community providers to support evidence-informed decisions that improve program reach, quality, and outcomes. As countywide practices evolve, King County may include Bridge-related metrics in department or cross-department business reviews[129]. The Executive may also establish an Executive-level decision-making forum that reviews data holistically across departments, strengthens measurement practices, and directs coordinated action to improve outcomes and cross-departmental alignment. The Executive Office intends to lead cross-agency routine review and monitoring, including for programs managed by separately elected agencies. Recommendations from the Breaking the Cycle workgroup are expected to influence performance reporting. DCHS evaluation staff, in collaboration with partners, also regularly reexamine measurement and evaluation approaches to improve data sources and methodologies and to remain responsive to emerging evaluation challenges and program implementation needs.

B. Performance measurement and evaluation framework

The Behavioral Health Bridge's performance measurement and evaluation framework is designed to monitor performance, improve quality, generate actionable insights, and inform decision-makers and the public. Measurement and evaluation results give insight into which programs are effective and why, inform operational adjustments, and help hold contracted partners accountable for the activities they are funded to implement. Monitoring and evaluation will also inform DCHS and Executive Office decisions about budget proposals.

The Behavioral Health Bridge's scale and complexity requires an approach that encompasses a range of measurement techniques. The Bridge's measurement and evaluation framework begins with Results Based Accountability (RBA), a method for assessing the results of strategies, and is supplemented with additional evaluation activities.[130] The resulting framework includes:

- **Performance measurement:** Performance measures regularly track program outcomes to assess how well an investment or strategy is performing. In addition to measuring operational and contractual expectations of programs and strategies, such as the number of individuals served or activities conducted with Behavioral Health Bridge resources, performance measures also track whether strategies are achieving intended outcomes, whether outcomes are equitable, and whether program participants are better off. These indicators will inform deliberations about adjustments to contracts, future procurement, operational direction from the Executive Office, and budget decisions.
- **Population indicators:** The Behavioral Health Bridge uses population indicators to identify needs, understand baseline conditions, and track trends. Population indicators are broad measures of community-level conditions (such as rates of homelessness, emergency department usage, or criminal legal involvement) that reflect the overall well-being of a population rather than the performance of any single program. Because many factors influence population indicators over the long term, changes cannot be attributed specifically or exclusively to Bridge investments. However, tracking these indicators is beneficial in understanding whether the combined efforts of initiatives are impacting regional challenges.
- **In-depth evaluation:** Additional evaluation will complement performance measurement to deepen knowledge of what is effective and inform continuous improvement for specific strategies. This may include assessing new pilot programs, designing new measurement and evaluation tools, and conducting studies of program effectiveness. DCHS may contract with one or more independent organizations or engage in public-private partnerships to conduct in-depth evaluations. Results from in-depth evaluation will inform County decision-making by providing evidence on implementation quality, program mechanisms, and contribution to desired outcomes, and will also strengthen the broader evidence base for effective behavioral health interventions that can be applied in other jurisdictions.

These three approaches are described in more detail in the following subsections.

Performance measurement

The Behavioral Health Bridge will measure the performance of individual programs or strategies to assess how the program is being implemented and whether it is successfully driving positive

outcomes for participants (i.e., "performance accountability"). As appropriate, programs will measure each of the three domains defined by RBA:

1. How much did we do?
2. How well did we do it?
3. Is anyone better off?

Performance measures will vary across programs and strategy areas depending on the population served, type of services, and intended outcomes; these measures can be qualitative, quantitative, or both. To measure outcomes across different investments, performance measurement and evaluation will align with the outcomes and goals identified in the logic models in Section VI and Appendices F-J. Aligning performance measures under the logic models enables King County evaluation staff to assess how well investments contribute to the shared goals and intended longer-term impact of the Behavioral Health Bridge strategy areas. Each program will have performance measures that assess progress toward the specific program's intended goals, as well as standard measures that facilitate evaluation of the Behavioral Health Bridge's collective impact across goal areas. Example performance measures for programs within the RBA framework are shown below in Figure 22. The examples of "How well did we do it?" and "Is anyone better off?" performance measurement could also be rolled up into a strategy area's broader goal for long-term impact (such as "reduce overdoses and overdose deaths" or "maintain behavioral healthcare for people transitioning through treatment settings").

Figure 22: Example performance measures

How much did we do?	How well did we do it?	Is anyone better off?
Number of individuals engaged through outreach	Percent of individuals receiving a warm handoff/referral to a treatment provider	Percent of individuals consistently accessing medication for opioid use disorder
Number of individuals assessed for diversion from involuntary commitment	Percent of individuals enrolled with an outpatient treatment provider	Percent of individuals with no involuntary treatment act (ITA) court referrals in the 12 months following program enrollment

Contracted community providers and County partners across all strategies and programs will be expected to regularly submit data and information that form the basis of performance measures. The timeline for finalizing and reporting performance measures is expected to be distinct for each program and will depend on contracting and implementation timelines.

For every strategy that is competitively procured, RFPs will include the strategy's intended goals and system-wide outcomes and associated performance measures. By including this information in RFPs, King County will transparently communicate reporting requirements and expectations based on each investment's intended impact. These expectations provide clear direction on priority outcomes and areas where progress must be demonstrated, while still allowing flexibility for program-specific approaches.

During the contract negotiation process, DCHS staff will engage with funded providers to finalize a performance measurement (PM) plan. The finalized PM plan will capture the unique aspects of

each program's model while also adopting standardized measures that support assessment of the Behavioral Health Bridge's collective impact.

County-run programs in other agencies will similarly collaborate with DCHS to develop performance measurement plans that are aligned with each program's purpose, service model, operational context, and data capacity, with the Executive Office playing a lead role in supporting alignment across County agencies. This coordinated approach is expected to result in specific performance measures and outcomes that track program capacity and outcomes for participants, while also working toward systemic goals across programs with similar functions or intended outcomes. See "Continuous improvement" in the above Overarching principles section for how this data will feed into decision-making and continuous improvement at the program and system levels.

Data collection

King County invests heavily in data systems and infrastructure to responsibly collect, manage, and share information, with the goal of making data widely accessible and informative for direct programming and policy decisions. Data collection and reporting to King County is dependent on the type of strategy or program being measured. The format and reporting mechanisms for collecting data will also adapt to available reporting systems and provider capacity. Data will be collected at different intervals, depending on the program or strategy, although information will typically be received by King County following each month or each quarter. Providers will submit data and relevant information to King County as required by their contract and/or documented in their PM Plans.

Data collection types to be detailed in the PM plan may include:

- **Individual-level data:** Individual-level data is comprised of person-specific demographic information, information about services provided, survey information gathered at regular intervals, program outcomes, and other information.
- **Aggregate-level data:** Aggregate-level data is comprised of high-level summary statistics about program services or participants. This can include counts, totals, and averages reported to King County at regular intervals.
- **Qualitative data:** When appropriate for the program model, qualitative data will be reported by the funded program. Qualitative data may include focus groups, open-ended surveys and questionnaires, and interviews.
- **Narrative reports:** Funded organizations are expected to submit to King County annual or biannual narrative reports comprised of information about operations, client stories, system change efforts, and other program activities as requested.

The Bridge will also leverage administrative data sources to assess participants' use of systems such as jails, psychiatric inpatient hospitals, emergency departments, and crisis services. Data will typically be reported as the change over time in participants' total number of bookings, hospitalizations, emergency department admissions, or crisis episodes in a given period. Long-term outcomes can be measured with administrative data by comparing participant data from a baseline year to the years subsequent to receiving services. As appropriate, outcomes will be assessed by cohort (participants' enrollment year), making it possible to follow a group of participants over time, track consistency in outcomes across cohorts, and increase King County's understanding of the impact of Behavioral Health Bridge programming on participants' interactions

with various publicly funded systems. DCHS also intends to collect system-level data as appropriate, such as changes to the community behavioral health workforce, including job vacancies, retention and turnover rates, and workforce diversity.

Recommendations from the Breaking the Cycle workgroup are expected to inform improvements to data collection, sharing, and reporting.

In addition, PM plans will capture individual program models' unique aspects, while also establishing standardized measures to facilitate measurement of the Behavioral Health Bridge's collective impact across goal areas. This approach aims to minimize the burden of data collection on providers while ensuring that measurement and evaluation reflect programs' and communities' definitions of progress, and that King County and funded entities are aligned on reporting requirements. The approach also promotes strategic learning and accountability through transparency and collaboration with service providers.

PM plans will include key performance measures, types of data collection, reporting cycles, and activities to review the data and support continuous quality improvement. For investments that fund direct behavioral health services to clients, DCHS intends to collect and monitor performance measures about individuals served, the nature of services provided, and associated outcomes. Participant-level data about people receiving services may be disaggregated by race, ethnicity, or other demographic characteristics. For investments that do not provide direct services to individuals, but are instead investing in community infrastructure or systems, DCHS intends to collect and monitor performance measures such as the number of activities conducted or progress toward milestones. For example, King County staff could assess an investment in capital funding for housing sites by monitoring the number of buildings constructed, facilities opened, or beds created. DCHS will work with partner agencies to collect individual level data where appropriate and legally allowable.

Disaggregation by demographic characteristics

To address behavioral health inequities, Behavioral Health Bridge measurement and evaluation methods will measure race, ethnicity, and other demographic characteristics at both the program level and across programs to analyze equity in access, engagement, and outcomes. These analyses will yield critical information to advance the behavioral health equity framework.

Behavioral Health Equity Highlight

Disaggregation by race and ethnicity supports the behavioral health equity pillar *Transparent and Accountable*. Collecting, analyzing, and reporting data by race and ethnicity increases awareness of disparities, strengthens accountability for equitable outcomes, and informs targeted strategies to address inequities experienced by historically and currently marginalized communities in King County.

Measuring the King County Behavioral Health Bridge's collective impact

Whenever possible, each program will include standardized performance measures that are common across all programs with a similar intended outcome within a strategy area. This will make it possible for the County to describe the collective impact of the Behavioral Health Bridge by reporting summarized performance measures for all programs within the same strategy area. The

standardized performance measures will be publicly available as part of the Behavioral Health Bridge biennial reporting described further in Section VIII.

To facilitate measurement across DCHS investments, Behavioral Health Bridge performance measurement and reporting will be aligned with other human services funding initiatives, including the CCC Levy, Best Starts, VSHSL, and Health Through Housing. Behavioral Health Bridge performance measurement and reporting will also continue to be integrated into the DCHS dashboard, and particular outcome measures will be aligned with DCHS-wide performance measures and the Executive Office's performance measurement approach to ensure alignment in reporting. The subsequent subsection "Aligning performance measurement with other dedicated human services initiatives" describes this in further detail.

Where appropriate, the Executive Office will collaborate with DCHS and partner agencies to elevate data and performance measures as part of a whole-county approach to human services investments and align with countywide initiatives such as recommendations from the Executive's Breaking the Cycle Workgroup.

Reporting methodology to show geographic distribution by ZIP code

The ZIP code data on where participants reside has been a staple of behavioral health sales tax reporting to date. During the 2028-2034 implementation period, DCHS intends to expand Behavioral Health Bridge reporting to include expenditures by ZIP code for each program or strategy. ZIP code data will be reported using maps or other visualizations to aid interpretation of the data. All reporting by ZIP code will continue to abide by privacy and confidentiality guidelines to ensure individuals cannot be identified.

Beginning with the online dashboard update that reflects 2028 calendar year data and through the 2028-2034 implementation period, the Behavioral Health Bridge evaluation team will report program and strategy expenditures by ZIP code. The methods and dissemination practices for reporting expenditures by ZIP code will be aligned with the approaches implemented in 2023 for Best Starts, 2024 for VSHSL, and 2025 for the CCC Levy. These approaches utilize provider locations *and* participant residences, recognizing that Behavioral Health Bridge partners provide a mix of virtual, mobile, and in-person programs and services. Reporting by providers' location may not fully capture the reach of services, and alternatively, reporting by participants' residence may not capture the difficulties some participants have in accessing services, including transportation. Many program participants access programs in more than one way. Using this combined methodology to assess expenditures by ZIP code can help deepen understanding of how programs are accessible to people throughout the county.

Collection of program participant ZIP code data may be limited for some programs. The limitations include activities associated with, but not limited to, mobile programs or programs serving people experiencing homelessness, refugees, people experiencing acute behavioral health crisis, or people who are survivors of domestic violence. Geographic information may also not be available or relevant for programs and strategies that invest in systems and environment change and strategies that support systemwide capacity building. ZIP code collection may also not be possible for programs that are required to use an existing data system that DCHS cannot revise, or when a legal framework prevents the sharing of these data. All reporting by ZIP code will continue to abide by privacy and confidentiality guidelines. All data collection for the Behavioral Health Bridge is

grounded in the principle that data collection should never be a barrier to individuals accessing necessary services.

Aligning performance measurement with other dedicated human services initiatives

The health and human services needs of King County residents span the boundaries of federal, state, and local funding. Revenue from the Behavioral Health Bridge, along with VSHSL, Best Starts, the CCC Levy, and HTH constitute a substantial portion of local human services investments. DCHS staff coordinated planning efforts across these initiatives during the development of this implementation plan, as many of these human services funding streams will require renewal during the course of the next Behavioral Health Bridge implementation period. The overlapping funding renewal timelines offer opportunities to innovate and adapt to emerging community needs over the course of Behavioral Health Bridge implementation.

In response to a 2018 budget proviso, DCHS invested heavily in data systems and infrastructure to responsibly collect, manage, and share information, with the goal to make data widely accessible and to direct programming and policy decisions.[131] These investments have made new data products possible, including dashboards, that provide insight on participants in programs and activities and how they access services, as well as how investments and services are geographically distributed. Using these tools, DCHS collaborates with service participants, contracted providers, and internal direct services staff to collect high-quality data, review program performance, and develop and monitor quality improvement initiatives.

In 2022, DCHS released a consolidated dashboard to report data on MIDD, Best Starts, and VSHSL funded services.[132] In 2023, the consolidated dashboard added data for all programs and activities, including those that were federally funded, in the Behavioral Health and Recovery Division and the Developmental Disabilities and Early Childhood Supports Division. In 2025, this dashboard was expanded to include further information from all DCHS divisions. With all of these data sources now represented, the dashboard transparently shares how the department's investments strengthen the communities of King County.

Population indicators

The Behavioral Health Bridge evaluation team will monitor critical population indicators related to behavioral health, disaggregated by demographic characteristics (such as age, race, ethnicity, place, and gender) where data are available. These measures could include countywide metrics such as the size of the adult carceral population with known behavioral health conditions, the rate of overdose fatalities, or the number of behavioral health providers serving youth. King County measurement of population-level indicators is expected to focus on how they change over time in both size and demographic composition. Where relevant, population-level indicators are intended to align with the Executive Office's performance measurement approach.

While the goal is for Behavioral Health Bridge programs and strategies to work in combination to impact population-level outcomes in the long term, multiple factors influence these measures. Therefore, Behavioral Health Bridge evaluation efforts will not attribute changes in population indicators, positive or negative, to Behavioral Health Bridge investments alone. Population accountability may be tracked and monitored for Behavioral Health Bridge strategy areas, though programs and strategies will be measured on performance accountability.

Population-level measures, such as number of people experiencing behavioral health crisis or the number of people booked into jail are influenced by many extenuating factors (such as state policy, criminal-legal system practices, judicial sentencing alternatives, underlying social and economic factors, broader resource constraints, and more). Except for randomized controlled trial evaluations, which can be cost-prohibitive and often present political, operational, and feasibility challenges, Behavioral Health Bridge monitoring and evaluation will not be able to definitively provide causal evidence that intervention led to population-level outcomes. However, these measures provide crucial information on King County residents and can indicate overall areas for further investment or changes in approach.

In-depth evaluation

Behavioral Health Bridge investments include many programs with existing evidence bases, as well as new, innovative programs or adaptations to evidence-based programs. In-depth evaluation provides an opportunity to inform program decision making and ensure that programs are effective through the combination of qualitative and quantitative data with rigorous, tested methodological approaches. The ability to conduct in-depth evaluations will be different for each program and strategy, depending on the availability of reliable data, sufficient and representative enrollment in programs, and the time needed for data collection and analysis.

Behavioral Health Bridge evaluators intend to prioritize projects for in-depth evaluation as capacity allows in collaboration with program staff and the provider community using the following criteria:

- **High interest from partners, including:** the Executive, King County Council, King County Behavioral Health Bridge Advisory Committee, community-based organizations, DCHS leadership, grantees, the public, or program participants.
- **High potential to improve equity** by identifying disproportionalities in service access and engagement or improvement in services for historically underserved communities and communities most in need. This includes evaluating how programs contribute to breaking cycles of addiction, homelessness, and incarceration in communities disproportionately affected by the behavioral health, housing, and criminal-legal systems.
- **New programming or novel implementation** of pilot programs, or existing programs in new settings or among different populations, to expand the evidence base for services and effective program adaptations.
- **High quality data** with sustainable and robust sources of information that enable King County staff to track changes over time.

In-depth evaluation design is expected to be based on what is appropriate for the program's stage of implementation. Design options include, but are not limited to, developmental evaluation, process evaluation, and outcomes evaluation. Examples of in-depth evaluation may include case control or quasi-experimental designs that include resource intensive data collection. To conduct such evaluations for the Behavioral Health Bridge, DCHS may contract with external research partners or engage in public-private partnerships to augment its own data collection, measurement, and evaluation work.

Data and evaluation for decision-making

Data collection and analysis will be used to inform decision-making and continuously improve outcomes. Contracted service providers will be responsible for achieving goals and objectives and

DCHS will monitor results to facilitate operational improvements and make adjustments to contracts over time. DCHS will regularly meet with the Executive Office, leaders, analysts and subject matter experts to review investment performance across the Behavioral Health Bridge portfolio and discuss opportunities for system learning and improvement. Performance measurement and evaluation information will inform Executive budget proposals, alongside program context, community need, and other relevant factors, to strengthen services and the overall approach of the Bridge investments.

VIII. Reporting for continuous improvement and accountability

At the time of the writing of this plan, DCHS is working to capture, share, and evaluate King County Behavioral Health Bridge information through a variety of methods that did not exist when the behavioral health sales tax was last renewed. This includes:

- **Consolidated Reporting via DCHS Dashboard:** In response to a 2018 proviso, DCHS developed the capacity to report across programs and funding streams by analyzing large amounts of data from hundreds of providers without duplicating service participants.[133,134] This effort resulted in the consolidated DCHS Dashboard.[135] While the 2018 proviso asked for reporting on the combined impact of Best Starts, MIDD, and the VSHSL, the DCHS Dashboard also reports on King County residents' participation in services funded by the CCC Levy, the Health Through Housing sales tax, and the KCICN (mostly Medicaid-funded), among other components of the DCHS budget.
- **Behavioral Health Bridge Dashboard:** The Behavioral Health Bridge Dashboard, formerly known as the MIDD Dashboard, portrays data about who participates in Bridge-funded services, where they live and access services, and how those services impact their lives.[136] Offered in an interactive format, the dashboard provides a snapshot across the entire investment portfolio or by strategy area. It also makes it possible for users to focus on the performance of a single program. The dashboard also offers financial information about the Behavioral Health Bridge.
- **Comprehensive Contract Management**: In 2024, DCHS implemented new contract management software, Agiloft, that supports the department's procurement, contracting, and invoicing activities. Agiloft centralizes and standardizes information about DCHS' contracted service providers, including where their brick-and-mortar offices are located. This allows for more complete and consistent reporting of the geographic location of services throughout the region.
- **Enhancements to whole-county monitoring:** Executive Office-led base budget analysis and development of an ongoing monitoring structure in collaboration with DCHS and other County partners will enhance collaboration and a shared understanding of non-contracted programs. County agencies will continue to participate in standard DCHS-led reporting, with the Executive Office playing a lead role in supporting alignment between County agencies. Results from monitoring will inform both operational adjustments and budget decisions to better achieve intended outcomes.

These advancements will allow for action-oriented reporting using recent data to facilitate continuous improvement and operational adjustments. DCHS and the Executive will offer an annual briefing to Council coinciding with the release of annual dashboard updates to report on Results Based Accountability indicators and planned or implemented improvements.

As part of this comprehensive performance data collection, assessment, and reporting, the Executive will transmit a biennial report to Council detailing the programs and services funded by the Behavioral Health Bridge that will be transmitted no later than August 31 every other year. Each report will focus on data from the prior two calendar years. The first report, to be provided by August 31, 2030, will report on data from calendar years 2028 and 2029. Subsequent biennial reports will be provided by August 31, 2032, and August 31, 2034. The Advisory Committee described in this plan will review and provide guidance on the biennial reports. The Executive will

make the reports available widely to the Council, the Regional Policy Committee, and the community through DCHS' communication channels.[137] of this plan will review and provide guidance on the biennial reports. The Executive will make the reports available widely to the Council, the Regional Policy Committee, and the community through DCHS' communication channels.[138]

Biennial reports about the Behavioral Health Bridge will include the following:

- An overview of Behavioral Health Bridge accomplishments during the previous two calendar years, and a description of continuous improvement changes that have been implemented based on performance results, as well as planned operational adjustments to improve performance when applicable;
- The Behavioral Health Bridge fund's fiscal and performance management during the applicable calendar years;
- The expenditure of Behavioral Health Bridge proceeds by strategy area by ZIP code in King County as described in Subsection VII.B;
- The number of individuals receiving Behavioral Health Bridge-supported services by strategy area by ZIP code where the individuals reside at the time of service as described in Subsection VII.B;
- A map or summary describing the Behavioral Health Bridge's geographic distribution; and
- Summaries of findings from in-depth evaluations related to Behavioral Health Bridge programs, and actions taken or planned based on those findings in years where such findings are available.

The Executive will accompany each biennial report with a motion acknowledging receipt of the report. The Executive will be prepared to brief the King County Council or its committees, including the Regional Policy Committee, on the biennial report to inform the Council's consideration of this motion.

IX. Financial plan and policies

A. Overview

This section describes the plans and policies for King County Behavioral Health Bridge revenues and expenditures for the period of 2028 through 2034 based on current available information. The financial plan in this section includes a sustainability reserve to mitigate a projected reduction in 2029 behavioral health sales tax revenues and assumes most economic adjustments for providers are maintained through 2034.

Beginning on January 1, 2029, many products and services will become exempt from sales tax in Washington State, including diapers, hygiene products, over-the-counter medications, information technology services, software, security and safety, temporary staffing services, and live performances, as a result of changes made during the 2026 state legislative session.[139] These reductions in the sales tax base have a direct impact on the Behavioral Health Bridge, decreasing projected sales tax revenue by 3.55 percent between 2028 and 2029.[140] At the same time, as discussed in Section X, DCHS' inflation policy is designed to ensure, whenever possible, that County funding for human services programs keeps up with the rising costs to deliver services.[141]

The financial plan shown in Figure 23 represents the best available estimates of projected revenue and planned expenditures as of the time of the plan's drafting. However, during the next implementation period, multiple factors could potentially drive changes to Bridge spending:

- **The Executive's Breaking the Cycle Workgroup** will provide recommendations that may influence the way collaboration works across and within programs.[142]
- **The competitive procurement process** may identify organizations with different approaches to achieving Bridge goals.
- **A continuous focus on shifting Bridge costs to Medicaid or other county funds such as but not limited to the CCC Levy, Best Starts, or VSHSL that may have closer alignment with the program goal.** This may mean up-front investment of Behavioral Health Bridge funds to sustain services but potential reallocation of funding over time as Medicaid replaces local dollars or funds are shifted between levies.
- **Federal changes to Medicaid** may require the Bridge to shift to support populations and services that are no longer eligible for Medicaid reimbursement.[143]
- **Base budget analyses for all programs** are expected to right-size programs in other departments and agencies and reveal opportunities for better collaboration.[144]
- **Rigorous performance measurement of contracts** is expected to drive future investment decisions.
- **Performance and outcome monitoring systems** will inform decisions about investments with a focus on real results for people, as described in Section VII of this plan.
- As a **sales tax levy,** Behavioral Health Bridge revenues can be volatile and fluctuations in revenue projections may drive budget adjustments. Specific investment amounts will depend on fund availability at the time of procurement.

As a result, this plan includes processes for adapting Behavioral Health Bridge expenditures to these or other changing conditions. Policies relating to the processes for adjusting sales tax allocations, allocating undesignated fund balance, and implementing the DCHS inflation policy can be found in Subsection IX.C and Section X.

B. Financial plan

Figure 23: Anticipated Behavioral Health Bridge Sales Tax Revenues and Expenditures 2028-2034 (in millions)*

	2028	2029	2030	2031	2032	2033	2034	Total
Projected Beginning Fund Balance	$ 19.5	$ 23.4	$ 20.4	$ 19.0	$ 18.8	$ 19.2	$ 19.8	
PROJECTED REVENUE								
Projected Sales Tax Revenue	$ 107.6	$ 103.7	$ 108.7	$ 112.9	$ 116.2	$ 120.5	$ 124.2	$ 793.8
Projected Annual Interest	0.7	0.8	0.7	0.6	0.6	0.6	0.7	4.8
Total Revenue	**$ 108.3**	**$ 104.5**	**$ 109.4**	**$ 113.6**	**$ 116.8**	**$ 121.2**	**$ 124.8**	**$ 798.6**
APPROXIMATE EXPENDITURE ALLOCATION BY STRATEGY								
Strategy Area 1: Care Transitions and Diversion Services	$ 36.7	$ 32.5	$ 33.3	$ 34.1	$ 34.9	$ 35.9	$ 36.9	$ 244.4
Strategy Area 2: SUD Treatment and Recovery	19.5	20.2	20.8	21.4	21.9	22.6	23.4	149.6
Strategy Area 3: Equitable Access to Behavioral Health Care	16.1	16.5	17.0	17.5	17.9	18.6	19.2	122.9
Strategy Area 4: Child, Youth, and Young Adult Mental Wellbeing	11.2	11.7	12.2	12.5	12.8	13.4	13.9	87.8
Strategy Area 5: Behavioral Health Workforce Development	1.3	6.6	6.8	7.0	7.1	7.6	8.0	44.3
Technical Assistance & Capacity Building	0.5	0.5	0.5	0.6	0.6	0.6	0.6	4.0
Administration & Compliance	8.5	8.8	9.0	9.3	9.5	9.7	9.9	64.8
Performance Measurement & Evaluation	2.5	2.6	2.7	2.7	2.8	2.9	2.9	19.0
Behavioral Health Fund Transfer	8.0	8.3	8.5	8.7	9.0	9.2	9.4	60.9
Total Expenditures	**$ 104.4**	**$ 107.5**	**$ 110.8**	**$ 113.8**	**$ 116.5**	**$ 120.5**	**$ 124.2**	**$ 797.7**
ENDING FUND BALANCE AND RESERVES								
Ending Fund Balance	**$ 23.4**	**$ 20.4**	**$ 19.0**	**$ 18.8**	**$ 19.2**	**$ 19.8**	**$ 20.4**	
Rainy Day Reserve (60 Days of Expenditure)	$ 17.2	$ 17.7	$ 18.2	$ 18.7	$ 19.2	$ 19.8	$ 20.4	
Sustainability Reserve	6.3	2.7	0.8	0.1	-	-	-	
Total Reserves	**$ 23.4**	**$ 20.4**	**$ 19.0**	**$ 18.8**	**$ 19.2**	**$ 19.8**	**$ 20.4**	

**Totals may not sum exactly due to rounding.*

Allocations across the five strategy areas

Figure 23 depicts how this plan annually allocates Behavioral Health Bridge revenues across the five strategy areas. Detailed descriptions of goals, intended outcomes and anticipated expenditures within each area can be found in the following subsections:

- VI.A: Care Transitions and Diversion Services and Appendix F
- VI.B: Substance Use Disorder Treatment and Recovery and Appendix G
- VI.C: Equitable Access to Behavioral Health Care and Appendix H
- VI.D: Child, Youth, and Young Adult Mental Wellbeing and Appendix I
- VI.E: Behavioral Health Workforce Development and Appendix J

Figure 23 also reflects changes to funding amounts in 2028 and 2029 due to the phased procurement and base budget analyses scheduled to take place during those years, as described in Subsection V.B. Increases and decreases in strategy area spending in the first two years reflect phased procurement and reprioritization of investments as the Executive works to rebalance the Behavioral Health Bridge portfolio to focus on the most pressing needs for King County's publicly funded behavioral health system. Some reductions also reflect plans to move investments to other fund sources. The estimated expenditures for each strategy area are projections based on current information.

Technical assistance and capacity building

For the first time, beginning in 2028 the Behavioral Health Bridge will provide funding for technical assistance and capacity building activities to support the implementation of the goals described in this plan. Through investments like the Bridge, DCHS strives to partner with organizations that serve, and are led by, their own communities. Community-led organizations are best positioned to implement programs that will have positive impacts on the members of their communities. DCHS recognizes that many organizations, and the communities they serve, have historically experienced barriers to accessing funding opportunities from government agencies such as King County. Technical assistance is intended to meet organizations where they are and to support them in understanding King County's contract requirements and assist them in developing capacity to manage public funds.

The Bridge will provide funding for technical assistance and capacity building activities to support the implementation of the goals described in this plan. After contracts are awarded, technical assistance and capacity building offer provision and co-creation of information, tools, and resources to strengthen the infrastructure of Behavioral Health Bridge-funded organizations, particularly in areas of fiscal management, documentation, and reporting, as well as opportunities for areas with service gaps to build capacity. DCHS will set aside 0.5 percent of revenues toward these activities.

Administration and compliance

The Behavioral Health Bridge will increase the proportion of funds supporting administrative functions in 2028-2034. DCHS is working to enhance its fiscal controls and contract management in response to the results of a 2025 audit.[145,146] This process requires additional staff to ensure enough resources are in place for proper contract monitoring and quality assurance. The level of administrative funding reflected in the financial plan (Figure 23) will better support DCHS to conduct all required contract monitoring and fraud prevention activities for Behavioral Health

Bridge programs, as well as program development, procurements and continuous quality improvement.

Performance measurement and evaluation

The Behavioral Health Bridge increases the proportion of funds allocated to measurement and evaluation in 2028-2034. These investments fund a team of skilled staff, the development and maintenance of robust data systems, assessment and analysis of Behavioral Health Bridge programs, and partnerships with external evaluators and subject matter experts. With this investment, the Executive intends to develop insights that enable providers, communities, and policymakers to make data-informed decisions and engage in continuous quality improvement efforts. More information about the performance measurement and accountability strategies for the next iteration of the Behavioral Health Bridge is in Section VII.

Behavioral Health Fund transfer

The Behavioral Health Bridge maintains a similar level of funding to MIDD 2 for a transfer to the Behavioral Health Fund. King County operates a unique behavioral health delivery system incorporating a public-private partnership for delivering community behavioral health care, a nation-leading crisis care system, and innovative local services to provide access to care regardless of insurance or immigration status. A key component is the Behavioral Health Fund, which collects and redistributes dollars that underwrite King County's ability to administer the complex behavioral health system, which leverages over 140 funding sources to develop and sustain life-saving community-based programs. The behavioral health sales tax has supported the Behavioral Health Fund with a transfer of resources since 2021. This strategic resource supports BHRD's organizational infrastructure and ability to continue administering and monitoring Behavioral Health Bridge programs and the broader behavioral health treatment and support system. It also ensures that King County can continue to deliver on its promise of a diverse and high-quality network that is widely available to meet residents' expectations and needs.

Sustainability reserve

The 2026 changes in state law described earlier in this section require a new mechanism to ensure program stability in the Behavioral Health Bridge. In order to maintain program commitments despite an abrupt decrease in projected sales tax revenue in 2029, the financial plan in Figure 23 includes a sustainability reserve. This sets aside money in 2028 to be spent down slowly through 2031. This is in addition to the rainy-day reserve called for by the County's comprehensive financial management policies and is expected to enable the County to sustain Bridge-funded programs despite volatile revenue.[147] The sustainability reserve is not an undesignated fund balance. Reappropriating it to fund programs and services in the short term would create significant reserve shortfalls for the remaining six years of the 2028-2034 Behavioral Health Bridge planning period.

C. Fiscal policies

This subsection describes policies for making and communicating about substantial adjustments to Behavioral Health Bridge expenditures, and priorities for allocating undesignated fund balance.

Process for making substantial adjustments to the financial plans

This part of this subsection describes the process of communicating and making substantial adjustments to the Bridge's financial plan, which is consistent with the change process for the HTH

sales tax and VSHSL, CCC, and Best Starts levies. A substantial adjustment is a change or series of changes within the same calendar year to a strategy area's annual funding allocation by ten percent or more.[148]

A change is not considered a substantial adjustment if it is due to additional Behavioral Health Bridge sales tax revenue or other funding sources becoming available. In this scenario, the additional sales tax revenue should be allocated according to the priorities described in the next subsection and cannot reduce another strategy area's allocation. In addition, behavioral health sales tax proceeds that are not spent within a strategy area may be retained within the same strategy area for use in a subsequent year without being considered a substantial adjustment for the purpose of this plan.

Substantial adjustments to this plan's financial plan will be communicated according to the process defined in this subsection, and whenever feasible, such modifications shall incorporate briefings to the Behavioral Health Bridge Advisory Committee to allow committee members to review and provide guidance on the changes. If, without Council direction or concurrence, the Executive determines a substantial adjustment to the funding allocations specified in the financial plan is needed, the Executive will transmit a notification letter to Council detailing the scope of and rationale for the changes. The Executive may only send notification letters as frequently as twice per year when needed. The Executive will electronically file the letter with the Clerk of the Council, who will retain an electronic copy and provide an electronic copy to all councilmembers, the Council Chief of Staff, the lead staff for the Health, Housing, and Human Services Committee, or its successor, and the Regional Policy Committee. Unless the Council passes a motion rejecting the contemplated change within 30 days of the Executive's transmittal, the Executive may proceed with the change as set forth in the notification letter.

Priorities for allocating undesignated fund balance

This part of this subsection describes the process for prioritizing allocations of undesignated fund balance. Undesignated fund balance may result from circumstances such as, but not limited to, Behavioral Health Bridge revenue exceeding this plan's revenue projections or Bridge revenue becoming available because other funding sources (including federal, state, or philanthropic sources) are contributing funding toward Bridge strategy areas and goals at a higher level than anticipated. Expenditures of Behavioral Health Bridge revenues allocated through this prioritization remain subject to the appropriation limits authorized through the County's budget process. Any proposals requiring additional appropriation will be proposed by the Executive in budget ordinances and be subject to County Council deliberation and adoption. The Executive will assess whether undesignated fund balance is the result of one-time fund availability or represents an opportunity for long-term, sustainable investment.

The Executive intends to apply the following priorities to allocate undesignated fund balance when the Executive determines that it represents an opportunity for long-term, sustainable investment:

1. In any year where inflation rates have been reduced due to limited funding availability, provide inflationary adjustments to contracted providers up to the amount of CPI-U Seattle inflation rates.
2. Augment existing investments to mitigate losses of Medicaid coverage to the degree necessary and feasible within available funds. This includes increasing funding to EA Goal 1, "Provide behavioral health care for low-income people who are ineligible for Medicaid." It

may also include increasing investment in other programs negatively affected by growth of the uninsured rate among the Behavioral Health Bridge's service population.

3. Scale high-performing or innovative Behavioral Health Bridge investments to address unmet need. The investments to be augmented shall be selected through a process that includes Behavioral Health Bridge Advisory Committee consultation and is guided by performance and measurement data.

When the Executive determines that fund availability is one-time in nature and cannot reasonably support sustained programming, the Executive intends to consider using these funds for one-time investments including capital projects such as building behavioral health facilities or housing for people with behavioral health conditions, or in pilot programs that can later transition to other funding sources such as Medicaid.

Section X below describes strategies that would be applied to the Bridge fund if a deficit or reserve shortfall occurs when planned expenditures exceed available revenue. (See Subsection X.C.)

X. Inflation rate adjustment policy analysis

This section responds to Ordinance 20023, Section 70, Proviso P1. It examines how the DCHS Inflation Rate Adjustment Policy was determined to apply to the Behavioral Health Bridge fund, evaluating the financial impact of applying inflationary adjustments that exceed projected revenue growth, and assessing whether this dynamic contributes to a structural gap in the fund.[149] The parts of this subsection below address each of these questions by describing the policy rationale, analyzing the relationship between expenditure growth and revenue projections, and exploring the long-term implications for fund stability.

A. How the inflation policy was determined to be applicable to the King County Behavioral Health Bridge

DCHS adopted the Inflation Rate Adjustment Policy for Human Services Contracts on September 1, 2024.[150] Developed in response to Council interest expressed in a 2021 budget proviso, the policy's intent is to promote contract payments that increase with the rate of inflation by directing inflation rate adjustments to be applied to all local investments in DCHS human services contracts.[151] The application of this policy across local human services funds is important because when contract payments do not increase amidst growth in operating costs and living expenses, organizations struggle to maintain service levels or to provide living wages to their employees.

The policy directs DCHS to integrate inflation rate adjustments into biennial budget proposals, financial plans, and implementation plans when proposed to the Executive and King County Council. When Council adoption of these plans allows, DCHS intends to implement inflation rate adjustments in relevant and applicable program contracts. However, consistent with the policy, DCHS plans to implement inflation rate increases only to the degree possible while maintaining healthy financial reserves consistent with King County Comprehensive Financial Management Policies.[152]

The policy applies to local funding sources managed by DCHS because these funds are under greater local control. These sources include both more volatile sales tax sources such as, but not limited to, the Behavioral Health Bridge, and less volatile property tax levy sources. As a result, the County can design spending plans through implementation plans and budgets that incorporate appropriate inflationary adjustments that respond to providers' need to maintain services.

B. Analysis of the effect of the inflation rate adjustment policy on the Behavioral Health Bridge and risk of a structural gap

The inflation rate adjustment policy calls for the Behavioral Health Bridge to incorporate inflation factors based on King County's Budget and Financial Planning Assumptions (BFPA).[153] The Behavioral Health Bridge fund's projected long-term revenue grows at an average of 2.6 percent per year, according to 2026 OEFA data.[154] Because this growth rate falls below typical BFPA provider inflation assumptions, the policy has a structural impact on the fund's long-range sustainability.

During the 2028-2034 plan period, the Behavioral Health Bridge is expected to continue reflecting inflation adjustments to contracted behavioral health programs informed by the CPI-U Seattle BFPA inflation rate. If CPI-U inflation assumptions continue to track near the current range (generally between three and four percent), Behavioral Health Bridge expenditure growth would outpace revenue growth. Continuing to provide inflation rate increases at a higher rate than sales

tax revenue creates a risk of a structural operating gap in the outyears of the plan period, independent of one-time factors such as beginning fund balance or temporary underspending. Both the inflation policy and the County budget process provide mechanisms to identify these trends and take mitigating actions through fiscal monitoring and appropriation processes.

The inflation rate policy itself does not appropriate funds. It is instead a vehicle for DCHS to propose inflation rate increases to the Executive and the Council for consideration. While the policy directs DCHS to implement the inflation rate increases once they have been adopted by Council, it also includes administrative provisions allowing for the department to delay or suspend the increases in the following circumstances:

- Inflation rate increases will not be implemented until appropriate reserves have been achieved.[155]
- When revenue forecasts for a fund source project a decline in fund balance compared to the revenue forecasts used in the adopted budget for that fiscal year, inflation rate increases may be suspended or reduced. Adjustments will resume when positive revenue growth is reflected in the revenue forecasts underlying the adopted budget.[156]

A structural gap is based on the relationship between recurring revenues and recurring expenditures, not on whether the fund has enough cash on hand in any given year. Despite the risks, DCHS is not projecting a structural gap in the Behavioral Health Bridge from 2028 through 2034. However, if inflationary adjustments were included at CPI-U Seattle BFPA rates every year, the fund would be at risk of not having enough cash to cover expenses after 2028. As a result, maintaining the 2028 service portfolio through 2034 requires temporary changes regarding inflation adjustments in 2029. The steps DCHS will take to mitigate this risk are described in the following subsection.

C. Process for mitigating fund shortfalls or structural gaps

The financial plan in Figure 23 provides for adequate Behavioral Health Bridge dollars to continue funding critical services throughout the 2028-2034 implementation plan period despite volatility in revenue. To do this while maintaining 60-day operating reserves, the plan provides lower inflation adjustments to eligible providers with continuing contracts in 2029, the same year as a projected 3.55 percent decrease in sales tax revenues (as shown in Figure 24 below). This is consistent with the inflation policy, which allows for inflation rate adjustments when revenue forecasts anticipate a decline in underlying revenues.[157]

Inflation adjustments are not applicable at the start of new contracts, which are calculated as new base budgets, rather than adjusted in comparison to a prior year. Because phased implementation will take place throughout 2028 and 2029, some providers operating existing programs will be eligible for adjustments in 2028 in the final year of their MIDD 2 contracts, while others will be eligible in 2029 in the second year of their new Behavioral Health Bridge contracts. By 2030, new or revised Bridge programs are expected to be in their second or third year, and eligible providers delivering programs across the range of Bridge-funded services are expected to receive an inflation adjustment. These adjustments are included in the expenditures projected in the financial plan (Figure 23 above).

The financial projections included in this and other multi-year implementation plans are likely to change over the course of their planning periods. In order to account for this uncertainty, the DCHS inflation policy calls for the financial outlook of the fund to be reviewed annually to confirm funding

availability. DCHS most recently completed this review for MIDD in 2025 and determined that behavioral health sales tax funds could be made available to continue inflationary adjustments for 2026 and 2027. The inflationary adjustments were reviewed by the Executive Office, included in the 2026-2027 Executive Proposed budget, and adopted by the County Council through the budget. DCHS intends to reevaluate and confirm 2027 inflation adjustments in late 2026 and to continue these annual reviews throughout the 2028-2034 implementation plan period. Each biennial budget process will include an assessment of whether inflationary adjustments can be afforded based on the most recent revenue and expenditure forecasts for the Bridge fund. The budget process provides the Executive Office and Council an opportunity to evaluate, adjust if necessary, and approve any inflationary adjustment budget proposal.

Figure 24: Projected inflation adjustments for Behavioral Health Bridge contracted providers, 2028-2034

Year	Projected CPI-U Seattle BFPA inflation factor[158]	Projected inflation adjustment to be provided to Bridge-contracted providers
2028	3.30%	3.30%
2029	3.11%	2.50%
2030	2.98%	2.98%
2031	2.91%	2.91%
2032	2.34%	2.34%
2033	2.22%	2.22%
2034	2.18%	2.18%

The reduced inflation adjustment in 2029 is intended to enable the County to continue providing critical Behavioral Health Bridge-funded services without exceeding revenues, despite the inherent volatility of the sales tax. Full CPI-U Seattle inflation adjustments will be provided if funds become available, in accordance with the inflation policy and as reflected in the priorities for allocating undesignated fund balance in Subsection IX.C.

Actual revenues and expenditures inevitably deviate from projections. If a deficit or a reserve shortfall arises in the future, DCHS intends to consult with the King County Behavioral Health Bridge Advisory Committee to take one or more of the following actions to the degree necessary:

- **Forgo program expansions and investments in new programs.** Priority will be given to maintaining existing programs and service levels, except for reducing or sunsetting programs for other policy reasons.
- **Prohibit or cap future provider inflation rate increases.** DCHS may suspend or reduce inflation rate adjustments below the rates shown in Figure 24:
    - when revenue forecasts anticipate a decline in fund balance, or
    - if the inflation rate surpasses the rate of growth of the fund's revenue and surpasses the assumed inflation rate in applicable budgets, financial plans, and implementation plans.[159]
- **Propose and implement reductions to Behavioral Health Bridge-funded programs or services.** Reductions to existing programs and service levels are viewed as a last resort. If service cuts are necessary, they would be informed by performance outcomes and reviewed in advance with the Behavioral Health Bridge Advisory Committee for feedback and advice.

XI. Conclusion

The King County Behavioral Health Bridge Implementation Plan 2028-2034 contains an approach to developing an equity-driven set of investments to strengthen King County's behavioral health system in a time of profound community need. Grounded in extensive community engagement, informed by multidisciplinary expertise, and aligned to complement the County's other behavioral health and human services funding sources, this plan sets a direction toward a behavioral health system that is more available, accessible, effective, and equitable.

This plan features investments across five strategy areas: Care Transitions and Diversion Services; Substance Use Disorder Treatment and Recovery; Equitable Access to Behavioral Health Care; Child, Youth, and Young Adult Mental Wellbeing; and Behavioral Health Workforce Development. The investments in this plan are expected to help break the cycle of crisis, homelessness, incarceration, and hospitalization by helping people receive the right treatment and support at the right time. The plan's strategy areas, goal areas, and anticipated activities are designed not only to meet immediate needs but also to strengthen community behavioral health care against potential shifts in funding, workforce capacity, and service demand that are expected in the coming years.

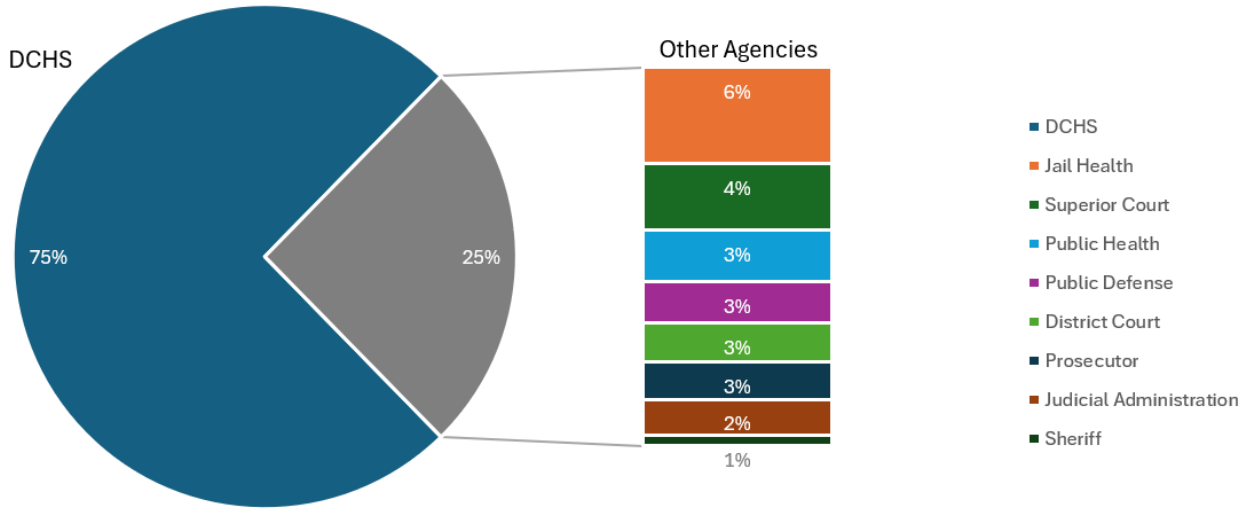
Successful implementation will depend on continued partnership with community-based organizations, behavioral health providers, people with lived experience, and across County agencies. Ongoing evaluation, transparent reporting, and a phased procurement approach will help deliver a smooth transition from the current set of investments to the planned Behavioral Health Bridge investments.

With this plan, King County reaffirms its commitment to enabling all residents, especially those most impacted by inequities, to access effective, high-quality behavioral health care and pursue long term recovery, stability, and wellbeing.

XII. Appendices

A. Appendix A. Behavioral Health Bridge investments in DCHS and other agencies

Figure 25: 2026-2027 adopted Behavioral Health Bridge budget by King County agency



B. Appendix B. Community engagement activities and results[160]

Listening sessions and community-based events

Between Behavioral Health Bridge-focused listening sessions and the Be Heard: Community Voices About Mental Health and Wellness project, BHRD staff conducted 46 in-person listening sessions and 486 interviews about the King County behavioral health system in 2024 and 2025 (Figure 25). Additional efforts to gather in-person feedback included attending community-based events, which engaged 447 community members throughout King County. To ensure representation across the county, BHRD held at least one in-person listening session in each council district.

Figure 26: Dates and locations of in-person listening sessions and community-based events

Council District	Date (2024-2025)	Location
District 1	Spring 2024	CHARMD Behavioral Health, Shoreline
District 1	Spring 2024	Korean Community Service Center (KCS), Edmonds
District 2	Spring 2024	Communities of Rooted Brilliance (CRB), Seattle
District 2	Spring 2024	Ethiopian Community in Seattle (ECS), Seattle
District 2	Spring 2024	Filipino Community of Seattle (FCS), Seattle
District 2	Spring 2024	New Americans Alliance for Policy and Research (NAAPR), Seattle
District 2	Spring 2024	Therapy Fund Foundation (TFF), Seattle
District 2	Spring 2024	Vietnamese Health Board (VHB), Seattle
District 5	Spring 2024	Association of Zambians in Seattle (AZS), Kent
District 5	Spring 2024	Congolese Integration Network (CIN), SeaTac
District 6	Spring 2024	Ayan Maternity Health Care Services (AMHS), Kirkland
District 6	Spring 2024	Indian American Community Services (IACS), Bellevue
District 6	Spring 2024	NAMI Eastside (NAMI), Redmond
District 8	Spring 2024	Alimentando al Pueblo, Burien
District 4	July 18, 2024	Interagency School, Seattle
District 8	September 15	Recovery Day Event, Seattle
District 6	September 23	Redmond Community Center at Marymoor Village
District 2	September 24	El Centro de la Raza, Seattle
District 9	September 26	Lake Wilderness Lodge, Maple Valley
District 4	September 30	KEXP, Seattle
District 8	October 1	Hatten Hall, West Seattle Senior Center
District 3	October 3	Riverview School District, Duvall
District 5	October 8	Puget Sound ESD Conference Center, Renton
District 7	October 9	William C Warren Building, Auburn
District 1	October 10	Spartan Recreation Center, Shoreline
District 5	October 31	Consejo Clinica, Renton
District 7	November 11	Todd Beamer High School, Federal Way
District 4	December 4	Behavioral Health Legislature Forum, Seattle
District 2	January 22, 2025	Entre Hermanos, Seattle

Council District	Date (2024-2025)	Location
District 8	March 17,19	King County Correctional Facility (KCCF), Seattle [4 visits]
District 5	March 20, 21	Maleng Regional Justice Center (MRJC), Kent [5 visits]
District 8	March 20	Denny Middle School, Seattle
District 1	April 4	Shoreline Senior Center
District 8	April 4	Chief Sealth High School, Seattle
District 4	April 11	Ballard Senior Center
District 5	April 14, 18	South Correctional Facility (SCORE), Des Moines [4 visits]
District 8	April 15, 16	Clark Children and Family Justice Center (CCFJC), Seattle [6 visits]
District 2	April 17	Fresh Start Housing, Seattle
District 3	April 23	Issaquah Teen Cafe, Issaquah
District 7	June 25	Substance Use Recovery Conference, Auburn
District 3	June 25	Cascade Park Apartments, North Bend
District 3	June 25	Sno-Ridge Apartments, North Bend
District 3	June 30	Sno-Valley Apartment, Carnation
District 3	July 16	Sno-Valley Senior Center, Carnation
District 9	July 17	King County Fair, Enumclaw
District 8	July 18	Reclaiming Wellness Conference
District 9	July 18	King County Fair, Enumclaw
District 9	July 19	King County Fair Enumclaw
District 9	July 20	King County Fair, Enumclaw
District 7	July 31	We are Comunidad, Federal Way
District 3	July 31	Mt. Si Senior Center
District 9	August 4	Maple Valley Community Center, Maple Valley
District 6	August 30	Redmond Pride Event, Redmond
District 3	October 15	Sno-Valley Pride, Carnation

Figure 27: Number of individuals engaged per King County district

District where event occurred	Number of people engaged overall
1	158
2	282
3	108
4	179
5	201
6	326
7	165
8	365
9	135
No District (Virtual listening sessions/participants didn't provide district)	307
Total number of community members engaged	**2226**

In addition, BHRD staff conducted 33 virtual listening sessions from a wide range of King County organizations (Figure 27).

Figure 28: Virtual listening sessions and organizations engaged

Partner Engagement July 2024 – October 2025
Virtual Listening Sessions (2024-2025)
• Behavioral Health Advisory Board [BHAB] Listening Session • Community-based Organization Listening Session (4 sessions) • General Public Listening Session (3 sessions) • HCHN Governance Council Listening Session • King County Alliance for Human Services (KCAHS) Listening Session • King County Employees Listening Session (2 sessions) • King County Rural Behavioral Health Collaborative Listening Session • MIDD Advisory Group Listening Session • MIDD Community Owned Behavioral Health Collaborative Listening Session • MIDD Leads Listening Session • One-on-one Virtual Interview (Consejo Counseling) • One-on-one Virtual Interview (Interagency Schools) • One-on-one Virtual Interview (Kent Youth & Family Services) • One-on-one Virtual Interview (Mental Health Policy Roundtable) • One-on-one Virtual Interview (King County Drug Diversion Court) • Peer Listening Session (3 sessions) • Provider Listening Session (4 sessions) • Rural Community Listening Session (2 sessions) • SB SBIRT Listening Session • Sound Cities Association Listening Session • Vocal-WA Virtual Listening Session

Affiliation of Organizations engaged
• Alimentando al Pueblo (AAP) • Association of Zambians in Seattle (AZS) • Ayan Maternity Health Care Services (AMHS) • Catholic Community Services • CHARMD Behavioral Health (CHARMD) • Children's Crisis Outreach Response System (CCORS) • Choose 180 • City of Bellevue • City of Renton • Comunidad Latino De Vashon • Communities of Rooted Brillance (CRB) • Consejo Counseling and Referral Services • Empower Youth Network • Encompass Northwest • Ethiopian Community in Seattle (ECS) • Filipino Community of Seattle (FCS) • Friends of Youth • Indian American Community Services (IACS) • International Rescue Committee • KCPH Community Navigator • Kent Youth & Family Services (KYFS) • KidVantage • King County (DCHS-ASD, BHRD, CYYAD, HCD & PHS) • Khmer Community Services of Seattle King County (KCSKC) • Korean Community Service Center (KCS) • Peer Washington • Pioneer Human Services • Mental Health Policy Roundtable • NAMI Eastside (NAMI) • Neighborhood House • New Americans Alliance for Policy and Research (NAAPR) • Real Change • Recovery Beyond • Sea Mar • SOUND Behavioral Health • Southwest Youth & Family Services (SWYFS) • The Dove Project • Therapy Fund Foundation (TFF) • Trail Youth • Unkitawa • Urban League • Valley Cities Counseling and Consultation • Vietnamese Health Board (VHB) • Yoga Behind Bars

- YMCA
- Washington Therapy Fund Foundation
- Wagner Pediatrics Speech & Language

Listening sessions engaged people from diverse racial and ethnic backgrounds (Figure 28). At least 55 percent of participants identified as Black, Indigenous, or people of color, closely matching the overall demographics of King County.[161]

Figure 29: Demographic information provided during Behavioral Health Bridge Renewal engagement

Race/Ethnicity	Percentage and Number of people engaged overall
Asian American/Pacific Islander	10% [225]
Black	15% [325]
Latin(a/e/o/x)	14% [320]
Indigenous	1% [30]
Middle Eastern/ North African (MENA)	2% [35]
White	13% [288]
BIPOC/Prefer not to specify*	8% [175]
Race/Ethnicity data not gathered**	37% [828]
Total individuals:	**2226**

* The category "BIPOC/Prefer not to specify" was used by individuals who identified as BIPOC but did not feel comfortable providing more specific information.
** The category of "Race/Ethnicity data not gathered" comes from engagement modalities where race/ethnicity were not requested during the engagement process, such as community-based events, and from participants who did not share their race/ethnicity information.

During behavioral health sales tax renewal engagement efforts in 2024, several groups were identified as communities that often face greater challenges in accessing behavioral healthcare and engagement in feedback processes: LGBTQIA+ people, incarcerated individuals, older adults, people with lived experience, and youth (Figure 29). Based on this information, 2025 engagement efforts related to the renewal focused on reaching these priority populations to ensure their perspectives were fully represented. One highlight of this effort was conducting 19 listening sessions in King County jails, hearing the perspectives of adults and youth who are currently incarcerated. The insights into the challenges these community members face, which often lead to cycling in and out of the detention centers, informed the criminal-legal system elements of this implementation plan.

Figure 30: Priority populations engaged during Behavioral Health Bridge Renewal engagement

Priority population	Number of people engaged
LGBTQIA+	108 (4.8%)
Incarcerated Individuals	126 (5.6%)
Older adults (55+)	362 (16.1%)
Peers (People with lived experience)	356 (13.1%)
Youth (12-25)	209 (9.3%)
Total individuals that were part of a priority population	**1161 (52.1%)**

During in-person and virtual listening sessions, the Behavioral Health Bridge Renewal team asked community members about their affiliations to better understand who was providing feedback. Figure 30 below shows the affiliation of these attendees throughout the years of engagement.

Figure 31: Affiliations of attendees at listening sessions (in-person and virtual)

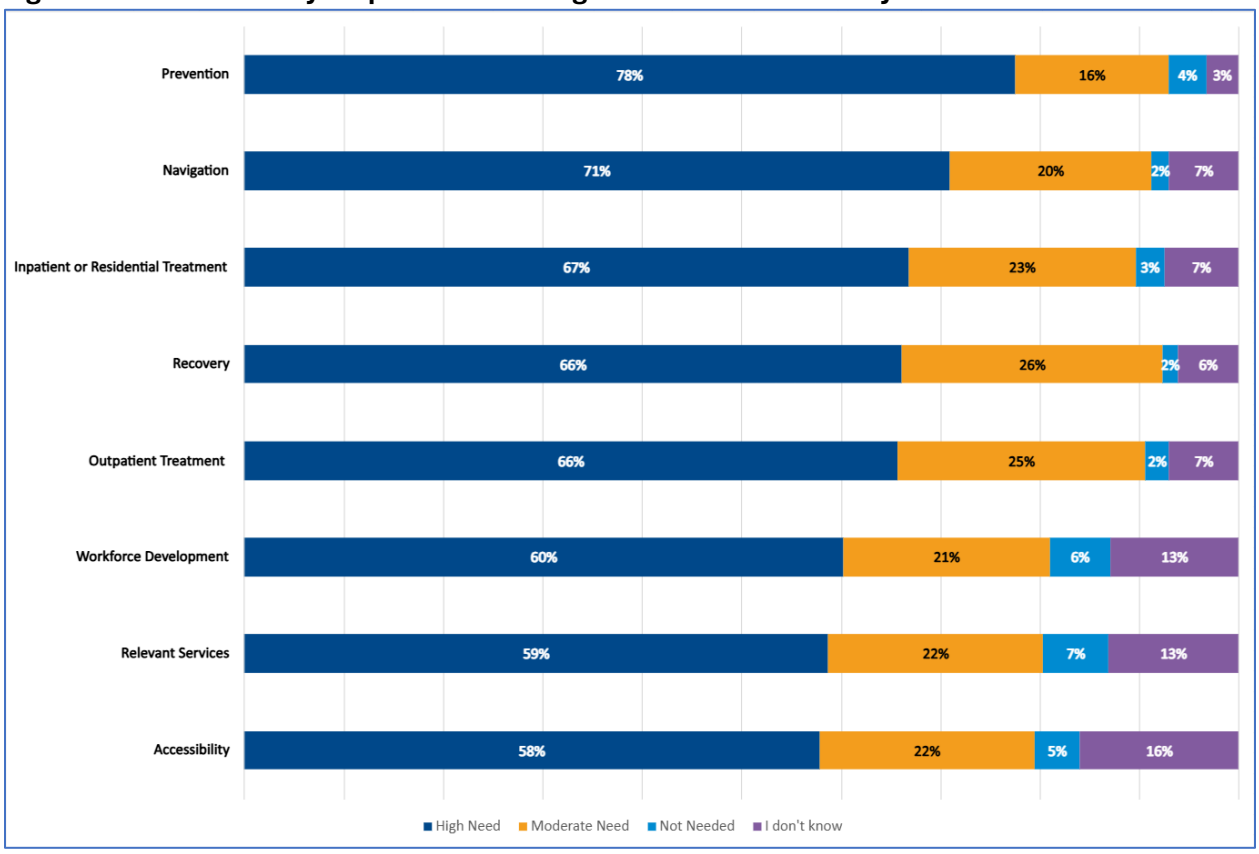
Affiliation or self-identification of attendees	Number of people engaged
LGBTQIA+ community members	23 (3%)
Behavioral health providers	72 (9%)
City government agencies	50 (7%)
Community-based organizations (CBOs)	62 (8%)
Correctional officers	15 (2%)
Incarcerated adults	99 (13%)
Incarcerated youth	27 (4%)
King County community members	27 (4%)
King County employees	47 (6%)
Older adults (55+)	72 (9%)
Older adults with Limited English Proficiency (LEP) (Khmer & Spanish speaking)	27 (4%)
Peers (People with lived/living experience)	61 (8%)
Rural health providers	22 (3%)
School district staff	Δ
Volunteer at non-profit	Δ
Youth (Middle & high schoolers)	142 (19%)
Total individuals who provided affiliation data	**763**

Δ Number of participants is suppressed when less than ten to protect privacy.

Online survey

The Behavioral Health Bridge Renewal team published an online survey to gather feedback from community members who couldn't participate in the other engagement modalities. This survey was available in over 20 languages and was open from August to October 2024 and July to October 2025. 473 respondents to the online survey were asked to identify the greatest barriers to accessing behavioral health services (Figure 31). Every factor was identified as a "high need" by more than half of the respondents, painting a portrait of widespread unmet need.

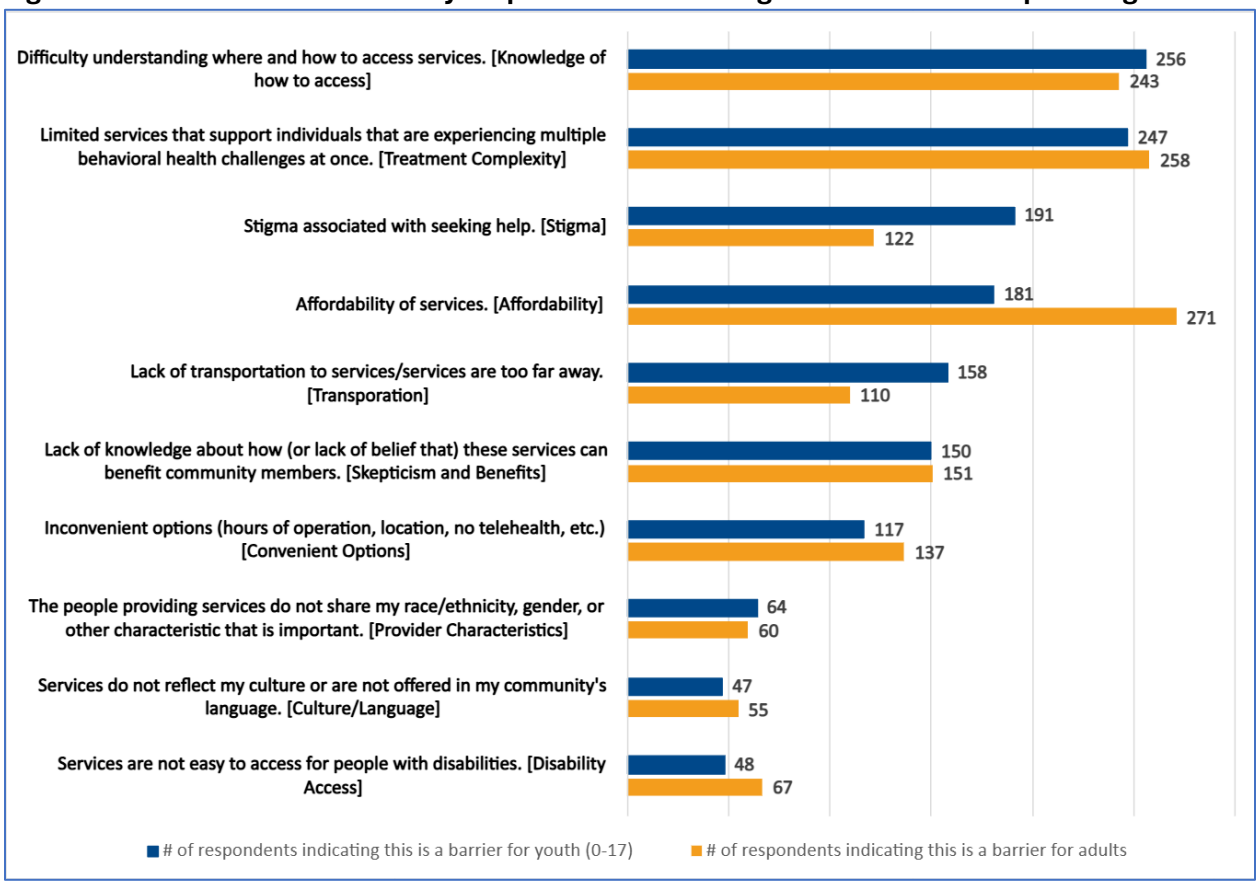
Figure 32: Online survey respondents' rating of behavioral health system barriers



In separate questions about barriers for adults and youth (ages 0-17), respondents were provided with a set of potential barriers and were asked to select the three most pressing (Figure 32). The top two barriers for both adults and youth were "difficulty understanding where and how to access services" and "lack of services for co-occurring conditions, consistent with the themes that emerged from the listening sessions."

On other topics, however, answers differed across age groups. Thirty-six percent of respondents said stigma associated with seeking help was a barrier for youth, while only 25 percent said it was a barrier for adults. Similarly, 42 percent of respondents indicated that affordability of services was a barrier for adults, but only 26 percent said the same for youth.

Figure 33: Percent of online survey respondents indicating a barrier as "most pressing"



All community engagement data was used to inform the strategy areas, goals, and anticipated activities described in this implementation plan. Specific influences are reflected in Appendix C.

C. Appendix C. Crosswalk of strategy areas and community engagement themes

Figure 33 summarizes the relationships between the proposed Behavioral Health Bridge strategy areas and the themes that emerged from renewal-related community engagement. Although all themes will influence all strategy areas to some degree (for example, the theme of "Culturally relevant and responsive care" will be incorporated into all strategy areas), the table displays the themes that are most strongly connected to each strategy area.

Figure 34: Community engagement themes informing each proposed Behavioral Health Bridge strategy area

Proposed strategy area	Most relevant community engagement themes
Care Transitions and Diversion Services	• **Reduce system fragmentation and improve service coordination** (subthemes: struggles with system navigation; transitional service gaps) • **Strengthen wraparound services** (subthemes: crisis diversion and harm reduction; housing crisis; aftercare for those leaving incarceration or inpatient settings)
Substance Use Disorder Treatment and Recovery	• **Reduce system fragmentation and improve service coordination** (subthemes: SUD struggles with system navigation; SUD service gaps) • **Strengthen and expand the behavioral health workforce** (subthemes: SUD peer support models) • **Strengthen wraparound services that use team-based care and connect people to basic needs** (subthemes: crisis diversion and harm reduction; housing crisis; support for community-based organizations to address SUD)
Equitable Access to Behavioral Health Care	• **Increase access and reduce barriers** (subthemes: lack of affordable care; insurance barriers; transportation barriers) • **Strengthen culturally relevant and responsive care** (subthemes: provider diversity and cultural responsiveness; unique trauma and stressors; language access)
Child, Youth, and Young Adult Mental Wellbeing	• **Strengthen and increase services for children, youth, and young adults** (subthemes: support for parents/caregivers; crafting safe spaces; increase awareness and decrease stigma) • **Priority population: LGBTQIA+** (heightened concern for queer and trans youth in current sociopolitical climate) • **Priority population: Youth** (more attention to young people with co-occurring mental health and SUD conditions, as well as those involved in the criminal justice system)
Behavioral Health Workforce Development	• **Strengthen and expand the behavioral health workforce** (subthemes: staffing shortages and high turnover; career development and advancement; peer support models) • **Strengthen culturally relevant and responsive care** (subthemes: provider diversity and cultural responsiveness; language access)

D. Appendix D. Multi-sector subject matter expert process

Recommendations

Figure 34 displays a crosswalk of the goals presented in this implementation plan alongside the SME workgroup suggestions that informed anticipated activities for each goal.

Figure 35: Crosswalk of SME suggestions and proposed investments for a renewed Behavioral Health Bridge

Implementation plan goal	SME suggestions that informed the anticipated activities for each goal
CTD Goal 1. Divert people from criminal-legal involvement, provide supportive services for those involved in the legal system, and support successful community reentry.	From the SUD group: • Scale and strengthen established diversion frameworks that feature a workforce emphasizing those with lived experience, including certified peers. • Medications and other forms of treatment and support for people in jail, both before and after release. • Tailored navigation and wraparound services (transportation, housing) for people with SUD leaving incarceration. • Low-barrier places to stay with behavioral health supports for people leaving incarceration.
CTD Goal 2. Help people with behavioral health conditions achieve and maintain stable housing.	From the CTD group: • More immediate and transitional shelter/housing options for people transitioning out of incarceration, hospitals, treatment facilities, or homelessness, that include a few key 24/7 essential supports. From the SUD group: • Wraparound services connecting people to housing and other supports when accessing SUD care (and vice versa).
CTD Goal 3. Enhance navigation and system coordination so that people receive timely and appropriate behavioral health services across all levels of care.	From the CTD group: • Contract a technology platform that is accessible to all providers that bridges and simplifies communication across existing programs, organizations, and systems, such as behavioral health, criminal-legal, and housing, and others. • Benefit and resource navigators (for people exiting incarceration, among others). • Care navigation programs. • Benefit navigators to help people get food, housing, legal help, medical care, etc. From the SUD group: • Enhance coordination and support services for people moving between withdrawal management and inpatient programs, as well as between inpatient and outpatient providers

Implementation plan goal	SME suggestions that informed the anticipated activities for each goal
	• Technology that allows real-time tracking of available supports, facilitates warm handoffs, and streamlines linkage to care (community information exchange). • Reimagine SUD Next Day Appointments (NDA) for youth and young adults. From the EA group: • Low-barrier case management and robust behavioral health services for people with low incomes who are uninsured, underinsured, or unhoused. From the CYYA group: • Coordinated, high-quality, billable navigation and case management to help families find and coordinate multiple types of services at once • Funding technology to alleviate administrative burdens. From the WF group: • Leverage technology as appropriate to reduce administrative burdens.
SUD Goal 1. Drive engagement and retention in SUD care.	From the SUD group: • Outreach strategies that are delivered in a non-mobile setting, such as emergency departments and primary care.
SUD Goal 2. Provide effective, low-barrier SUD treatment that meets people's holistic needs.	From the SUD group: • Mobile services, such as peer navigation, mobile medication for opioid use disorder (MOUD), and outreach services, that meet people where they are in coordination with available well-designed low-barrier services such as shelter, intensive case management, housing navigation and legal coordination. • Increased access to medication for substance use disorders (MSUD), including through innovative strategies like long-acting injectables • Low-barrier harm reduction services • Medications and other forms of treatment and support for people in jail, both before and after release. • Achieve equitable rates of access to SUD treatment and recovery across races, ethnicities, languages, ages, sexual orientations, gender identities, and parts of the county by bolstering community-based paths to recovery that are tailored to the needs of the people being served.
SUD Goal 3. Support paths to achieve and maintain recovery after treatment.	From the SUD group: • Achieve equitable rates of access to SUD treatment and recovery across races, ethnicities, languages, ages, sexual orientations, gender identities, and parts of the county by bolstering community-based paths to recovery that are tailored to the needs of the people being served.

Implementation plan goal	SME suggestions that informed the anticipated activities for each goal
EA Goal 1. Provide behavioral health care for low-income people who are ineligible for Medicaid.	From the SUD group: • Clinical treatment and case management for people not covered by Medicaid that are tailored to the needs of the people being served. • Medicaid services for non-Medicaid youth, such as outpatient, intensive outpatient, and residential treatment From the EA group: • Language access/Language justice.
EA Goal 2. Support the wellbeing of diverse communities by providing culturally and linguistically responsive services and removing barriers to care.	From the SUD group: • Non-clinical services and supports that are not covered by Medicaid and are tailored to the needs of the people being served From the EA group: • Fund culturally centered organizations to develop and provide community-based programs that address community-identified needs. • Pay for culturally centered organizations to hire peer supporters who can provide relationship-based case management and navigation services, including accompanying people to behavioral health appointments. • Affirming services for LGBTQIA+ communities. • Services by and for rural communities. • Trauma-informed and trauma-responsive care.
CYYA Goal 1. Improve youth access to behavioral health care by providing services that meet young people where they are, at school and in community.	From the SUD group: • School-based SBIRT. • Recovery High Schools for a safe and sober environment where students pursue academic and career goals. • Mobile MSUD and intensive case management for youth and young adults who are experiencing homelessness. • Increased withdrawal management and MOUD treatment options for youth. From the CYYA group: • Universal screenings and tiered response with brief intervention. • School-based health services that include SUD as well as mental health. • Mobile therapy
CYYA Goal 2. Provide behavioral health and therapeutic services to youth involved in the legal system, including	From the CYYA group: • Tailored services, wraparound supports, and partnership programs between the County and community-based organizations (CBOs) to identify and support youth who are involved or at-risk of being involved in the criminal-legal system, including programs serving their families.

Implementation plan goal	SME suggestions that informed the anticipated activities for each goal
diversion from deeper legal system involvement	• Innovative community-based programs that engage youth who are involved or at risk of being involved in the criminal-legal system in healthy activities.
CYYA Goal 3. Invest in the behavioral health of youth who are marginalized or experience inequities.	From the CYYA group: • Ensure that youth with complex needs can have their needs met, regardless of acuity. • Fund culturally centered organizations to incorporate behavioral health supports into existing youth-focused programming. • Targeted, identify-affirming supports for LGBTQIA+ youth.
WF Goal 1. Strengthen and diversify the behavioral health provider pipeline.	From the CTD group: • Grow the non-clinical workforce (peers, CHWs, wellbeing specialists, care navigators, benefit navigators, non-clinical case managers, etc.), which can act as trusted supports. From the SUD group: • Support workforce development for peer and non-clinical providers From the EA group: • Support for behavioral health workforce development activities in community-centered organizations, such as internships and other provider training programs to create a more diverse provider pipeline. From the CYYA group: • Recruitment and retention programs that attract providers from diverse backgrounds and communities, especially multilingual providers. From the WF group: • Fund well-supported internships to bolster a diverse provider pipeline. • Recruitment and training in clinical and non-clinical provider roles, such as peers, mental health care practitioners (MHCPs), etc. • Programs in diverse middle and high schools to increase BH career awareness and pathways among BIPOC youth.
WF Goal 2. Advance and develop the skills of the current workforce to meet growing community needs.	From the CTD group: • Training and development to implement best practices in crisis, navigation, and transition services, such as implementing peer supports and meeting basic needs first • Additional support for supervision and internship with a particular focus on diversifying the workforce. From the CYYA group: • Training and workforce support to ensure there are enough providers who can successfully work with high-acuity youth. • Develop pathways to multi-licensure or team-based care to enable providers to better serve youth with complex needs.

Implementation plan goal	SME suggestions that informed the anticipated activities for each goal
	From the WF group: • Increase support for clinical supervision. • Training curricula that better prepare students for the realities of the job. • Support clinical competency by offering ongoing clinical supervision and support. • Trainings on cultural humility and trauma-informed care, including funding to access trainings and replace lost income from billable activities. • Create training programs in evidence-based practices (EBPs) within community behavioral health settings. • Programs that help mental health practitioners become licensed for SUD, and vice versa. • Training pathways on specialized skills for serving children, youth, and young adults, including those with developmental disabilities.

Participants

The names of participants in the multi-sector subject matter expert workgroups and the organization they represented at the time of their participation are listed below. Workgroup meetings took place between April 21 and July 16, 2025. Each workgroup was overseen by a steering committee, whose members are also listed below.

An asterisk (*) indicates the individual is also a member of the MIDD Advisory Committee.

Care Transitions and Diversion Services (CTD)

Steering committee:

- Amanda Besel, King County DCHS
- Ash Warren, King County DCHS
- Chelsea Baylen, King County DCHS
- Kari Taylor, King County DCHS
- Kayla Rodriguez, King County DCHS
- Sara Tapia, King County DCHS
- Stephanie Moyes, King County DCHS
- Susan Peacey, King County DCHS

Workgroup:

- Amanda Bieber-Mayberry, Wellpoint
- Anthony Hoffer, Crisis Connections
- Bethany O'Neill, Psychologist/Court Evaluator (Options Psychological)
- Brian Allender, King County Chief Medical Officer
- Chloe Gale, ETS/REACH
- Christina Mason, King County Adult Drug Diversion Court (delegate of Catherine Cornwall*)
- Dominique Davis, Community Passageways/Choose 180

- Emily Shapiro, DESC
- Freyton Castillo, King County DCHS
- Jennifer McPherson, Pioneer Human Services
- Jessica Rosado, Valley Cities
- Jim Conroy, King County ASD Veterans Reentry Program
- Jose "Neaners" Garcia, Second Chance Outreach
- Joshua Thorne, King County DCHS
- Kate Anderson, DCYF
- Kate Tramontana, King County District Court – Therapeutic Courts
- Kimberly Hardy, Regional Crisis Response (RCR)
- Kimmy Reedy, Peer Washington
- LaTrecia Smith, King County DCHS
- Lt. Jeff Gepner, SCorE
- Dr. Matthew Goldman, King County DCHS, Crisis Systems Medical Director
- Megan Murphy, King County Jail Health Services
- Owen Riley, Harborview
- Rachel Dryden, King County Department of Public Defense
- Rheanell Roberts, King County DCHS
- Stacey Devenney, Harborview*
- Sue Rash, YMCA Mobile Crisis Team

Substance Use Disorder Treatment and Recovery (SUD)

Steering committee:

- Brad Finegood, Public Health – Seattle & King County*
- Dan Floyd, King County DCHS
- David Perlmutter, King County DCHS
- Dedra Barrow, Public Health – Seattle & King County
- Delton Mosby, King County DCHS
- Ericka Turley, Public Health – Seattle & King County
- Ileana Janovich, King County DCHS
- Jennifer Wyatt, King County DCHS
- Robyn Smith, King County DCHS

Workgroup:

- Angie Thompson, St Frances, St Anne, and St Elizabeth Hospitals
- Apoorva Mallya, Hepatitis Education Project
- Elsa Tamru, Harborview
- Esther Lucero, Seattle Indian Health Board
- Harumi Hashimoto, Asian Counseling and Referral Service (ACRS)
- Hussein Ugas, Rahma Recovery Center
- James Lovell, Chief Seattle Club
- Jessica Levy, Interagency Academy/Recovery High School
- Joe Barsana, King County Drug Diversion Court
- Johnny Ohta, Ryther

- Joshua Wallace, Peer Washington*
- Laura Quinn, King County Community Prevention and Wellness Initiative
- Leslie Enzian, UW Medicine
- Lisa Rogers, Sound
- Malika Lamont – Purpose Dignity Action / LEAD
- Manuela Raunig-Berho, ETS/REACH
- Mark Varela, Coordinated Care Washington
- Mary Hatch – UW Addictions, Drug, and Alcohol Institute
- Monika Whitfield, Washington Recovery Alliance
- Nicole Davis-Westbrook, WA Recovery Helpline and Crisis Connections
- Sabrina de la Fuente, Consejo Counseling and Referral Services
- Scott Reding, Integrative Counseling Services
- Taylor Richards, Recovery Beyond
- Thea Oliphant-Wells, Public Health – Seattle & King County
- Vania Rudolph – Swedish Recovery Services
- Vicki Brinigar – Valley Cities

Equitable Access to Behavioral Health Care (EA)

Steering committee:

- Anne-Marie Bishop, King County DCHS
- Idabelle Fosse, King County DCHS
- Karen Spoelman, King County DCHS
- Makayla Wright, Public Health – Seattle & King County
- Robin Pfohman, King County DCHS
- Tyler Corwin, King County DCHS
- Ziying Hu, King County DCHS

Workgroup:

- Amarinthia Torres, Coalition Ending Gender-Based Violence
- Bonnie Wang, Asian Counseling and Referral Service (ACRS)
- Candace Hunsucker, Community Health Plan of Washington
- Carline Stephens, King County DCHS
- David Bulindah, Wakulima
- David Coffey, Recovery Café
- Eben Pobee, CharmD Behavioral Health
- Fartun Mohamed, Somali Health Board*
- Jade Park, Harborview
- Jams Stuivenga, Sound Generations
- Jessica Knaster Wasse, Public Health – Seattle & King County
- Lea Aromin, Coalition Ending Gender-Based Violence
- Marc Oommen, NAMI Eastside*
- Nimo Abdullahi, Peer Community
- Rashaun Renggli, The DOVE Project
- Rosario Lopez, Super Familia

- Someireh Amirfaiz, New American Alliance for Policy and Research*
- Thyda Chhom, Khmer Community of Seattle – King County
- Wilbur Klein, King County DCHS

Child, Youth, and Young Adult Mental Wellbeing

Steering committee:

- Caress Piña, King County DCHS
- Delaney Knottnerus, King County DCHS
- Fatima Al-Shimari, King County DCHS
- Jim Ott, King County DCHS
- Latonya Rogers, King County DCHS
- Nacoubi Jiles, King County DCHS
- Rebekah Woods, King County DCHS
- Sarah Wilhelm, Public Health – Seattle & King County

Workgroup:

- Anthony Austin, Southeast Youth and Family Services*
- Connie Gonzales, Guided Pathways for Youth and Families
- Dianne Boyd, Children's Crisis Outreach Response (CCORS) for Developmental Disabilities
- Emmy Bell, Vashon Youth & Family Services
- Eric Mayne, Therapeutic Health Services
- Hodan Mohamed, Washington Multicultural Services Link
- Jeni Johnson, Vashon Youth & Family Services*
- Jorene Reiber, Family Court (King County Superior Court)*
- Kashi Arora, Seattle Children's Hospital
- Kate Garvey, King County Sexual Assault Resource Center
- Kristen Prentice, SeaMar
- Letha Fernandez, Sound
- Libby Hein, Molina Healthcare
- M'Liss Moon, Empower Youth Network
- Martha Aguiniga, Mente Counseling and Consulting
- Megan Walsh, Encompass
- Robert Gant, Juvenile Court Services (King County Superior Court)
- Sarah Burdell, International Community Health Services (ICHS)
- Sarah Walker, UW CoLab for Community & Behavioral Health Policy
- Sarah Wilhelm, Best Starts for Kids (Public Health – Seattle & King County)
- William Hairston, Center for Children and Youth Justice

Behavioral Health Workforce Development

Steering committee:

- Brandon Paz, King County DCHS
- David Perlmutter, King County DCHS
- Jessamyn Findlay, King County DCHS
- Karen Manuel, King County DCHS

- Lisa Floyd, King County DCHS
- Margaret Soukup, King County DCHS
- Molly Bauer, King County DCHS
- Sarah Boye, King County DCHS

Workgroup:

- Adrian Lopez Romero, Public Health – Seattle & King County
- Anna Duncan, UW CoLab for Community & Behavioral Health Policy
- Dr. Brian Allender, King County Chief Medical Officer
- Dan Ferguson, Washington State Allied Health Center of Excellence
- Danie Eagleton, Seattle University
- Elizabeth Schaumberg, Crisis Connections
- Erin Lloyd, Valley Cities
- Genell Hennings, YMCA Heritage Masters Program
- Jackie Bui, Youth Eastside Services
- Jasmeet Singh, Crisis Text Line*
- Laura Knapp, Seattle Children's Hospital
- Mario Paredes, Consejo Counseling and Referral Services*
- Melody McKee, SEIU Healthcare Training Fund
- Renee Fullerton, Washington Training & Education Coordinating Board
- Robyn Smith, King County DCHS
- Sachi Horback, United Healthcare
- Shaena Spoor, Deconstructing the Mental Health System
- Stacey Lopez, Sound
- Stephanie Lane, Peer Washington
- Tavish Donahue, Healthier Here

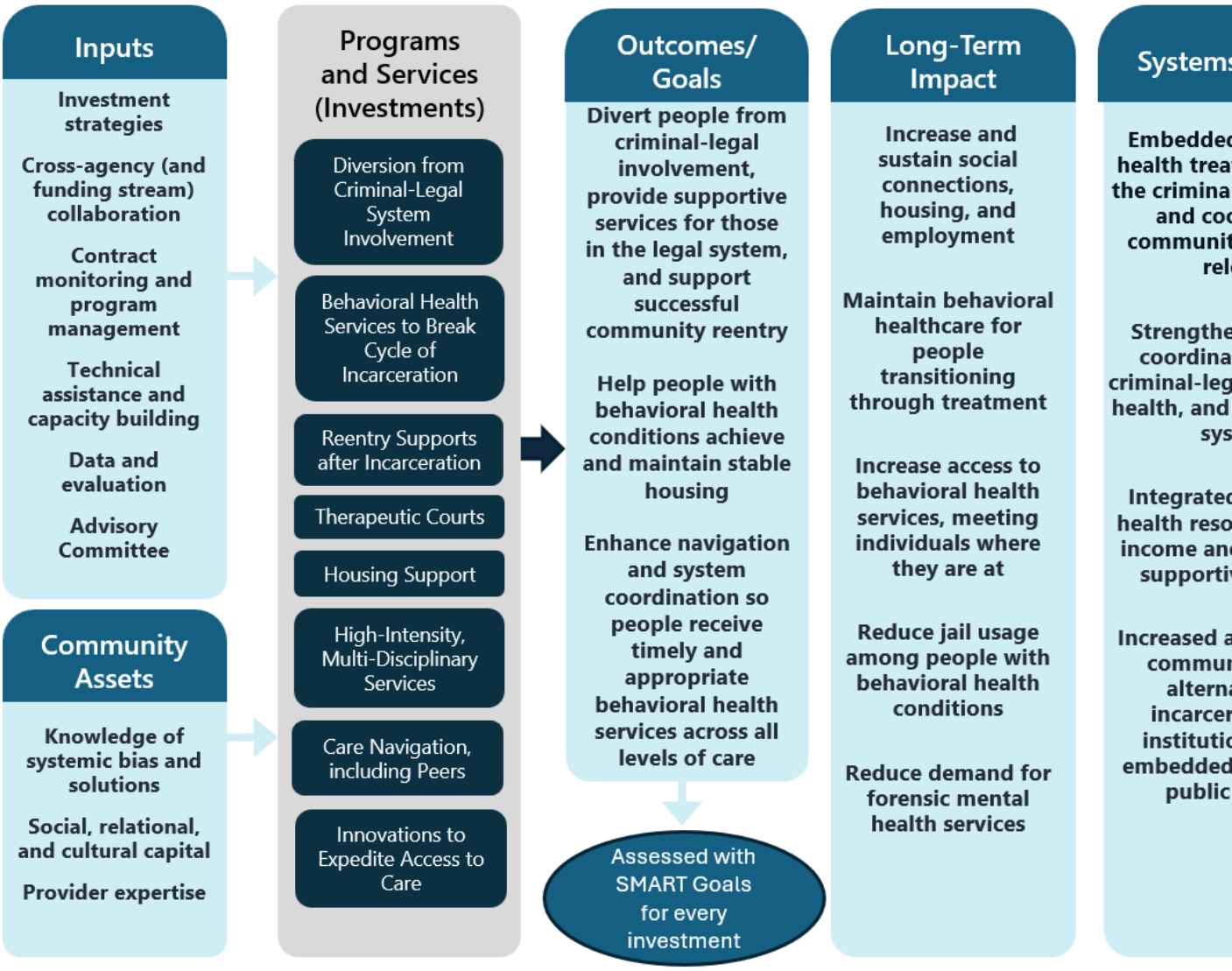
E. Appendix E. Implementation examples of the five equity pillars

Figure 36: Implementation examples of the equity framework pillars

Pillar	Examples of the equity framework in action during the renewal process and in the renewed Behavioral Health Bridge
Connected and coordinated	- Renewal process: Consulted with a wide range of County and non-County partners to understand the behavioral health landscape and identify high-potential investments where the behavioral health sales tax can make the greatest impact. - Behavioral Health Bridge 2028-2034: Goals are interconnected (for example, workforce investments to increase the number and diversity of SUD professionals will also make SUD goals more successful).
Transparent and accountable	- Renewal process: DCHS published community engagement results online in 2024 and 2025. - Behavioral Health Bridge 2028-2034: The implementation plan includes crosswalks showing how community feedback was incorporated into the Plan (see Appendix C and Appendix D). - Behavioral Health Bridge 2028-2034: Robust evaluation will ensure transparency and accountability, including through disaggregation of performance data by race, ethnicity, and language.
Inclusive, collaborative, diverse, and people-focused	- Renewal process: Translated written materials and provided language interpretation at community listening sessions to ensure inclusivity and language access. - Renewal process: Included people with lived experience in the subject matter expert workgroups that developed recommendations for behavioral health sales tax investments. - Behavioral Health Bridge 2028-2034: Outcome evaluation will use participatory and community-based models when appropriate and feasible.
Responsive and adaptive to community-identified needs	- Renewal process: Incorporated community and subject matter expert feedback into the implementation plan. - Behavioral Health Bridge 2028-2034: DCHS will procure programs that support community-identified solutions to behavioral health concerns (EA goal 2 and CYYA goal 3). - Behavioral Health Bridge 2028-2034: Contracted providers will have an opportunity to receive capacity-building and technical assistance to help them become more culturally and linguistically accessible.
Accessible and available	- Behavioral Health Bridge 2028-2034: Investments will make behavioral health care more accessible and available, including through care navigation and timely services (CTD and SUD strategy areas), culturally responsive and developmentally appropriate care (EA and CYYA strategy areas), and by addressing workforce shortages and increasing provider diversity (WF strategy area). - Behavioral Health Bridge 2028-2034: Program evaluation will include monitoring the number of clients being served, and for how long, to alleviate capacity constraints and increase service availability.

F. Appendix F. Logic model and anticipated activities for Care Transitions and Diversion Strategy Area

Figure 37: Logic Model for Care Transitions and Diversion Servies (CTD) Strategy Area



CTD Goal 1: Divert people from criminal-legal involvement, provide supportive services for those involved in the legal system, and support successful community reentry.

Activity: Diversion from criminal-legal system involvement

Criminal-legal system diversion programs direct individuals with behavioral health conditions who commit legal offenses away from more formal or deeper legal system involvement to programs and services that are designed to address their specific needs. The Executive plans to continue services such as: The Executive plans to continue services such as:

- Intensive case management that promotes well-being and independence and helps connect participants to stabilizing services such as housing and employment through a low-barrier, harm reduction approach.
- Services that collaborate with local law enforcement to refer people to appropriate behavioral health supports.
- Peer programs in which people with lived experience guide others on a path toward recovery and stability.
- Training for first responders to best address behavioral health incidents.

Activity: Services for people with behavioral health conditions who have cycled repeatedly through the criminal-legal system

Recent DCHS analysis of jail data reveal that nearly 1,400 individuals in King County are regularly cycling through County and municipal jails, meaning they are being booked into a correctional facility located in King County four or more times per year in two of the past three years.[162] Further analysis reveals that 96 percent of these individuals have interacted with King County's behavioral health or crisis service systems. The Executive intends to fund programs for highly vulnerable people with behavioral health conditions who have cycled repeatedly through the court system and require additional help to maintain stability, such as:

- Prosecutorial resources to help track and, when possible, resolve outstanding warrants and criminal cases for individuals who have high utilization of King County jails.
- Programs to help individuals remain in the community and connect with therapeutic interventions and other resources, such as permanent supportive housing.
- Integrated, community-based approaches to serving people at the intersection of behavioral health and the criminal legal system, promoting recovery, public safety, and harm reduction.

Activity: Supports for people to reenter the community after incarceration

People with behavioral health conditions need support to successfully reenter society after incarceration. The Executive intends to fund services that provide this support, including:

- Reentry care coordination and peer navigation providing linkages to behavioral health treatment, public benefits, and access to basic needs, particularly for unstably housed adults transitioning out of King County jails.
- Timely, complex release planning and coordination of community services for people with behavioral health needs to ensure lifesaving continuity of care at release.
- Programs that provide a supply of medications, culturally appropriate linkages to care, next day appointments for SUD treatment, and re-entry items (identification, phone, clothing, hygiene kits, transportation, Medicaid enrollment, etc.).
- Follow-up support and services, that help individuals link to and attend ongoing treatment visits after release.

Activity: Behavioral health services and supports for people involved in the legal system, including therapeutic courts.
If or when a person with a behavioral health condition is arrested and charged as a result of their condition, services within the legal system often offer a pathway toward treatment and recovery as an alternative to incarceration or deeper legal system involvement. These services provide a treatment plan, points of accountability, and a treatment team, typically made up of legal system staff and therapeutic or case management staff, who support the individual to get the care they need. These services can include therapeutic courts, such as the Regional Mental Health and Veterans Court (RMHC), Seattle Municipal Mental Health Court (SMMHC), Community Court (CC), Adult Drug Court (ADC). Services for individuals with civil legal involvement, such as Family Treatment Court (FTC), are also included.[163]

CTD Goal 2: Help people with behavioral health conditions achieve and maintain stable housing.

Activity: Behavioral health services in permanent supportive housing
As of September 2025, there were 5,953 units of permanent supportive housing (PSH) in King County, and the Executive has committed to continuing to expand supportive housing in the region.[164,165] Permanent supportive housing is an evidence-based approach to chronic homelessness that pairs affordable housing with supportive services like case management, transportation resources and health care services. Many residents of permanent supportive housing have a behavioral health condition. For example, in 2023, more than half (51 percent) of residents in King County's Health Through Housing sites accessed behavioral health care services.[166] Many PSH sites currently provide some limited behavioral health supports, but additional services are needed, especially for people with higher-acuity conditions who need more intensive, hands-on services. On-site services are critical to ensuring PSH sites are safe and sustainable for residents, neighbors, and housing operators, and respite can provide much-needed opportunities for recouperation in a temporary, safe environment outside of the PSH setting. The Executive intends to use the Behavioral Health Bridge to address this need by funding increased behavioral health services at PSH sites and/or in respite settings in order to support residents' long-term stability and keep them from re-entering the cycle of homelessness, incarceration, and hospitalization.

Activity: High-intensity services for people with behavioral health conditions leaving institutional settings who are experiencing or at risk of homelessness
This activity supports programs that facilitate access to affordable and supportive housing for individuals who are experiencing homelessness or discharging from an institutional setting (such as a jail, a local hospital, or Western State Hospital) and would otherwise discharge into homelessness. Once housed, teams can provide support services to assist participants in maintaining housing and increasing independent living and tenancy skills.

CTD Goal 3: Enhance navigation and system coordination so that people receive timely and appropriate behavioral health services across all levels of care.

Activity: Care navigation, including peer navigation and care coordination
One way to help people move through a fragmented system is to fund care navigators or case managers. These professionals help individuals find the services they need and support them to get there. Care navigation has been proven to increase engagement with treatment and reduce reliance on emergency departments.[167,168] Navigation can be especially effective for BIPOC participants when navigators are people with lived experience who come from the same background as the service participant.[169,170] In the next iteration of the Behavioral Health Bridge, the Executive plans to continue to build on existing care navigation services, including services provided by peers and services that are culturally and linguistically responsive.

Activity: Technology investments to facilitate care coordination across all levels of care
In an era of extraordinary technological advances, more can be done to streamline connections between systems and make it easier for people to get the care they need. Subject matter experts requested technology that would allow providers and provider networks to easily see what services a participant is already engaged in, identify available resources that meet their needs, and connect them to care as quickly and seamlessly as possible. There is also a need for technology solutions and support staff that identify when someone has been referred and to ensure that the linkage was made. If the connection does not occur as planned, technology can make it easier to initiate additional outreach and engagement to support successful connections to care for those who may be at risk of falling through the cracks.

Several technology supports designed to facilitate better behavioral health care navigation already exist in King County, such as the BHRD Quality and Care Coordination Resources SharePoint.[171] Subject matter experts who advised on the renewal shared that while these supports each serve important functions, some are only available to a limited group of providers and none offers the full spectrum of information and tools that would be needed to truly streamline care. The forthcoming Crisis Care Coordination Platform (CCP) funded by the CCC Levy is intended to address many provider-identified issues by providing clinicians with real-time information to support critical decision-making during and after behavioral health crisis encounters. However, other features requested by community providers are out of scope for the first phase of the CCP, such as real-time tracking of available beds and services, or a decision support tool to help navigators identify the right services for a client among a range of options.

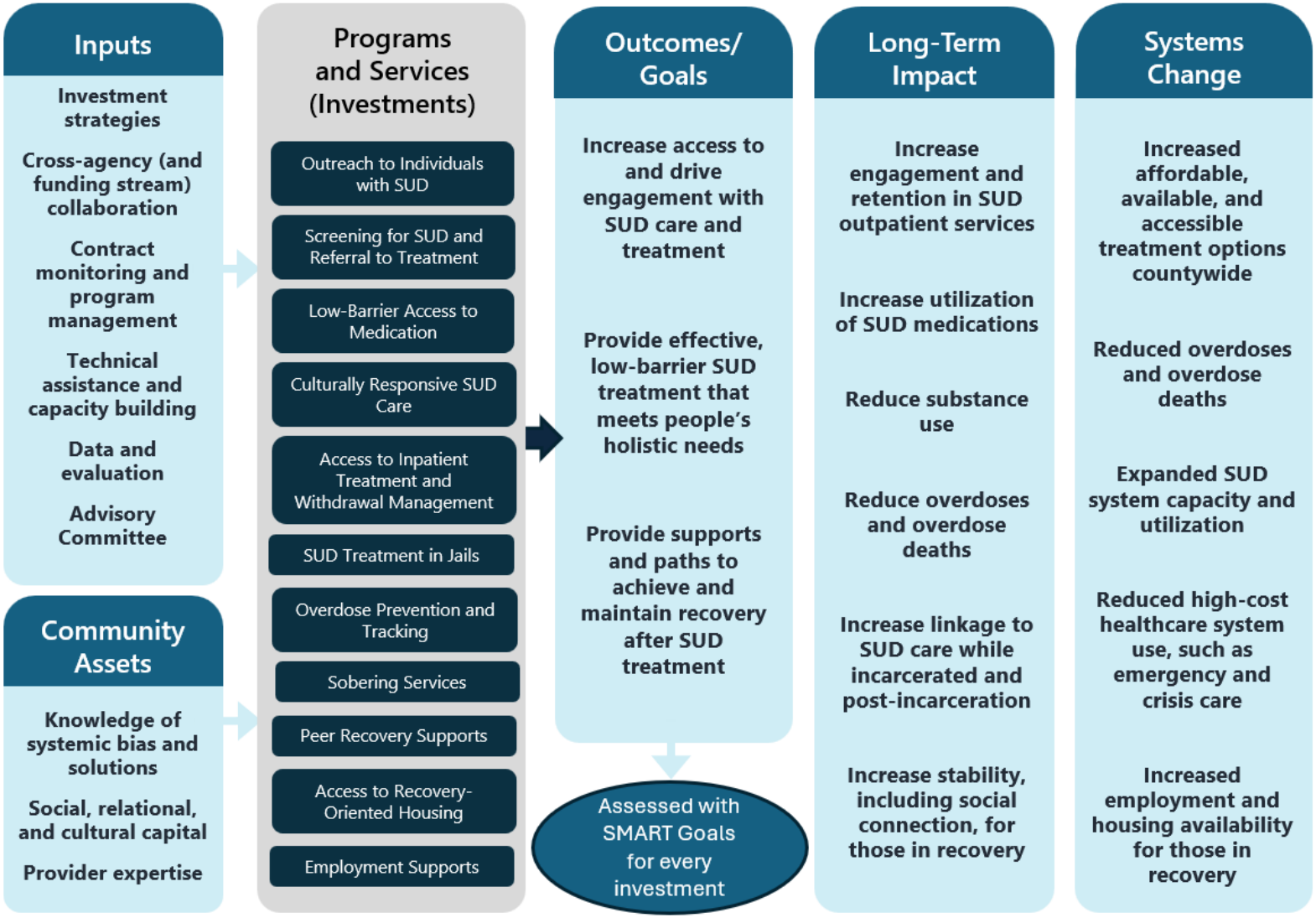
The Executive intends to invest funds under this goal to enhance and build on the CCP after it is launched to make care navigation easier, faster, and more effective by adding features that respond to community-identified needs.

Activity: Promoting timely access to appropriate care
The behavioral health system is most effective when people can get the type of care they need when they need it. The Executive intends to invest the next iteration of the behavioral health sales tax in programs that support timely and appropriate care, such as:

- Same-day or next-day initiation of outpatient treatment for youth and adults.
- Support for people with the highest levels of need to get to safe settings.
- Step-down or respite care for people with behavioral health conditions to continue healing after a crisis or acute care episode.

G. Appendix G. Logic model and anticipated activities for Substance Use Disorder Treatment and Recovery Strategy Area

Figure 38: Logic model for the Substance Use Disorder Treatment and Recovery (SUD) strategy area



SUD Goal 1: Drive engagement and retention in SUD care.

Activity: Proactive outreach to people with SUD, especially those experiencing homelessness
Decades of research, as well as feedback from community members and subject matter experts, show that outreach is a key part of connecting people to care, especially for people with substance use disorders who are experiencing homelessness.[172] The Executive expects that the behavioral health sales tax will pay for community-based and behavioral health organizations to provide evidence-based practices that support engagement in treatment, such as:

- Engaging individuals experiencing homelessness through regular, consistent outreach that builds rapport and trust.
- Conducting basic needs and safety assessments to identify immediate risks, service needs, and eligibility for SUD treatment or other supports.
- Providing information on SUD treatment options, including low-barrier programs, medications, inpatient and residential, outpatient, and withdrawal management services.
- Offering harm reduction supplies and education, such as naloxone distribution, overdose prevention information, and safer-use strategies.
- Facilitating warm handoffs to treatment providers, behavioral health agencies, medical partners, or crisis services, including accompanying clients when appropriate.

Activity: Screening and referrals integrated into multiple settings
Another way to connect people to the care they need is to intervene in key moments, such as when a person goes to a housing site, community center, school, medical appointment, or emergency department. For example, an average of 3,800 King County Medicaid members visit an emergency department multiple times per year with a behavioral health condition as the primary diagnosis.[173] Many of these individuals are served by Behavioral Health Bridge programs, and still more individuals who do not have Medicaid repeatedly visit emergency departments due to behavioral health diagnoses. Providing screenings and appropriate referrals at a moment when someone is already in contact with a care provider reduces the risk that the individual will end up back in the emergency department again for the same issue.[174] It also provides a path to treatment that does not require the person to escalate to the point of criminal-legal system involvement in order for their conditions to be addressed. The Executive anticipates funding programs that screen people for SUD across service settings, provide individualized needs assessments, and refer them to treatment as well as other services.

Activity: Sobering services
Sobering services are a safe and secure shelter for adults to sleep off the acute effects of intoxication under the supervision of staff trained in medical assessment and response. They also serve as a recovery access point where people receive case management services and assistance to move towards greater self-determination and recovery. The Executive anticipates that the Bridge can support this important linkage pathway for people with SUD in need of treatment and other services.

SUD Goal 2: Provide effective, low-barrier SUD treatment that meets people's holistic needs.

Activity: Low-barrier access to medications for substance use disorder and medication-first treatment approaches

Low-barrier access to medications for substance use disorder is a critical aspect of SUD treatment. In particular, medications for opioid use disorder (MOUD) have become the standard of care for treating opioid use disorder regardless of the specific opiate being used, and is associated with longer retention in treatment, decreased opioid use, and reduced mortality from overdose.[175,176] The increased prevalence of fentanyl means that access to MOUD is more important than ever, as fentanyl is metabolized so quickly that even an hour without the drug can make people sick from withdrawal.[177,178] Utilizing a medication-first approach provides a level of stabilization that can often enable enrollment in ongoing treatment services. However, because medications for substance use disorders are not available through all SUD treatment providers, King County's SUD system is not yet optimized to provide access to these lifesaving medications.[179,180,181] Successes like the launch of the Tele-buprenorphine Hotline in 2024, which is partially funded by the Behavioral Health Bridge and provides low-barrier MOUD support, are making progress in this area.[182] However, more work remains to increase the availability of medications in outpatient and residential treatment programming across the County.

The Executive intends to leverage King County Behavioral Health Bridge investments to improve the availability of MOUD and other medications to help people recover from substance use disorders. Behavioral Health Bridge funds can support medication-first treatment approaches in formal treatment settings and in community, such as the buprenorphine line, MOUD in shelters and encampments, and mobile medication access. These on-demand services help people initiate treatment when and where they are ready. The Executive is also considering investing Behavioral Health Bridge funds to increase access to medications within SUD treatment and care by supporting partnerships between treatment providers and pharmacies, adding medical staff to an agency's care team, covering of co-pays, or employing other strategies to help people access medications on demand.

Activity: Provision of mobile and in-community services

In addition to medication, the Executive anticipates supporting the broader provision of SUD services in the community. This means offering treatment, support, and medications in settings where people already are, such as shelters, outreach sites, and other community-based locations, rather than relying primarily on traditional office-based models of care. By paying for services that meet individuals in their own environments, the Behavioral Health Bridge can reduce barriers, build trust, and ensure that services are accessible to those who may not otherwise engage in treatment.

Activity: SUD treatment for incarcerated people

Another area of focus for the Bridge is SUD treatment for people in County jail. This population is vulnerable to repeatedly cycling through the criminal-legal system, with a high cost in human potential as well as taxpayer dollars. Services that help people continue or initiate SUD treatment while in jail can help break this cycle and move people toward long-term recovery and stability. During community engagement around the Behavioral Health Bridge renewal, listening sessions held in King County jails indicated that many people have a desire to engage in treatment while incarcerated, and would benefit from services to connect them to treatment, including counseling and access to MOUD. The Behavioral Health Bridge will build on current efforts to continue providing SUD treatment to people who are incarcerated. Bridge investments are expected to

include, but are not limited to, expanding access to MOUD for people in custody in King County jails through medications, contracts, and additional County staff, to comply with the Americans with Disabilities Act (ADA).[183]

Activity: Alleviating barriers to enter inpatient SUD treatment and withdrawal management
Some people have complex medical needs that must be addressed alongside behavioral health conditions, such as open wounds or uncontrolled diabetes. This is common among people who are living unsheltered, as well as older adults who need continuous medical monitoring. Many behavioral health facilities are not equipped to treat these medical concerns, which effectively prevents these individuals from receiving withdrawal management and other inpatient behavioral health treatment. The Executive anticipates that Behavioral Health Bridge investments can address this barrier to treatment so that the County's most vulnerable residents can get the SUD care they need.

Activity: Culturally and linguistically responsive SUD care
A one-size-fits-all approach to SUD treatment will not meet the needs of King County's diverse communities. For treatment to be effective and equitable, people must be able to access services in their preferred language, from providers who understand and respect their unique backgrounds. Culturally responsive SUD care is proven to improve outcomes for marginalized communities, especially when developed and provided by people from the relevant culture in participants' preferred language.[184,185,186] Participants in the Be Heard: Community Voices About Mental Health and Wellness project and renewal-focused community engagement noted that current treatment options often do not provide care that resonates with their culture or worldview, leaving them feeling alienated and unsure where to turn for help.[187,188] Increasing culturally responsive options for people with SUD is a key way to address inequitable outcomes across King County communities.

The Executive intends for Behavioral Health Bridge dollars to pay for treatment and supports that address the unique needs of people from diverse backgrounds, spiritual traditions, family structures, and cultural approaches to behavioral health by helping existing providers become more culturally responsive and expanding Behavioral Health Bridge services to more culturally grounded providers.

Activity: Overdose prevention and tracking
King County has a robust overdose surveillance program, administered by Public Health – Seattle & King County and partially funded by the behavioral health sales tax. In addition to prevention activities such as naloxone distribution, this program produces the Opioid Overdose Deaths Data Dashboard, a key source for understanding the landscape and impact of opioid use in King County.[189] Maintaining this resource is critical to understanding and evaluating the effectiveness of interventions designed to curb overdose. It also aligns with the Executive's priority of Better Government, ensuring transparency and accountability in the outcomes of County investments related to overdose. The Executive intends to continue funding these important tracking activities in the renewal period.

SUD Goal 3: Support paths to achieve and maintain recovery after treatment.

Activity: Peer recovery services
Throughout community engagement and the multi-sector subject matter expert process, participants were adamant that peer services are critical to successful recovery. Research shows

that peer services improve relationships with treatment and social service providers, reduce rates of relapse, and increase retention in treatment.[190] The Executive intends to continue to invest in peer-based supports, including services that:

- Offer support, mentorship, and practical advice based on personal recovery experiences.
- Provide system navigation through treatment options, housing, transportation, and other community resources.
- Work in community settings, including emergency rooms and encampments, to connect at-risk individuals to care.
- Assist in developing, refining, and implementing self-defined recovery plans.
- Teach coping mechanisms, social skills, and strategies for managing daily life.

Activity: Access to housing that supports recovery

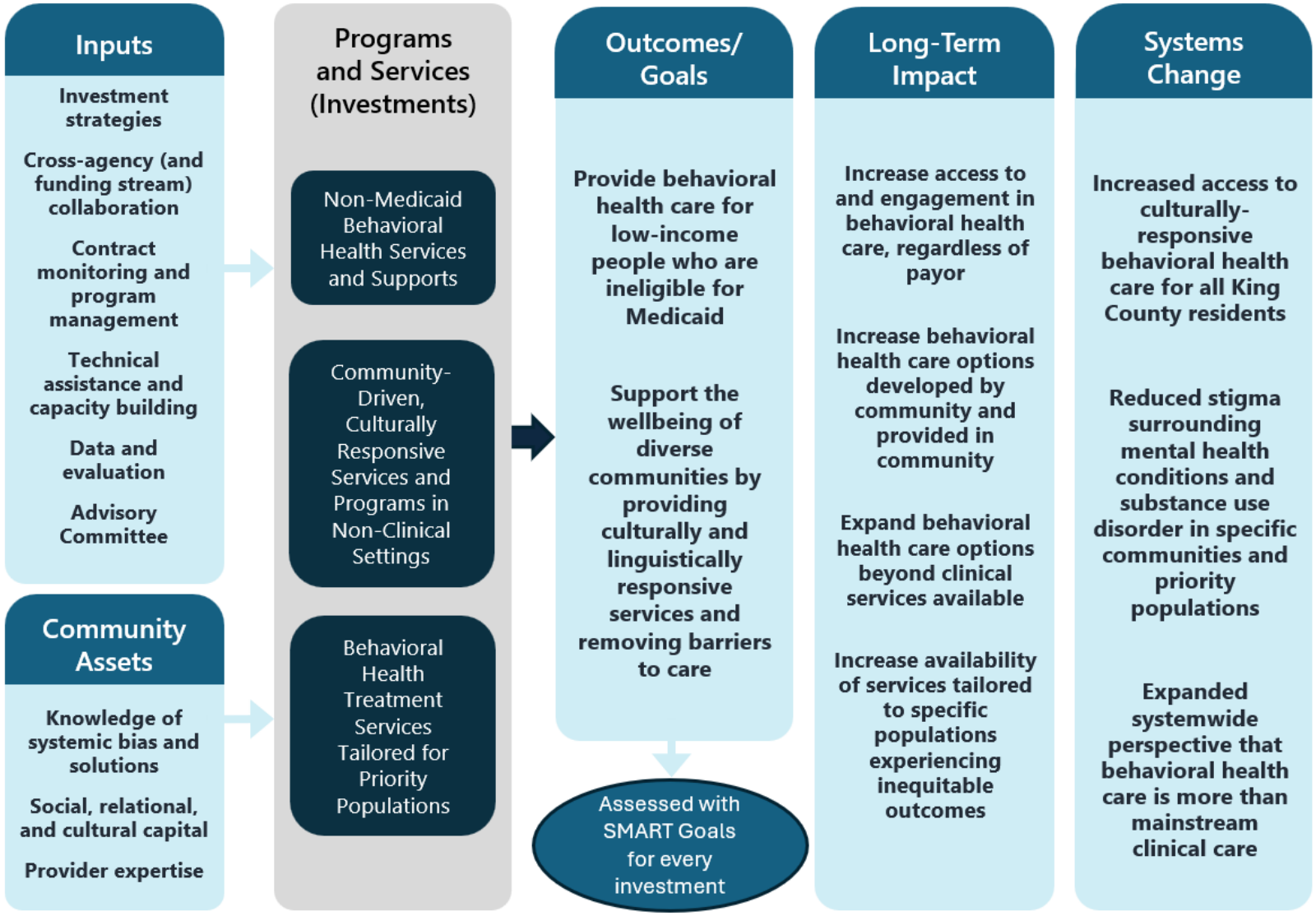
Housing is an important component of long-term recovery. There is a high correlation between housing instability and substance use disorders. The Substance Use and Mental Health Administration (SAMHSA) identifies "Home" as one of the four dimensions of recovery, alongside "Health," "Purpose," and "Community."[191,192] People need safe places to live after treatment in order to maintain recovery, through program models such as rapid rehousing, housing vouchers, or permanent supportive housing. The Executive anticipates that the Bridge can continue to support these important pathways to stability for people in recovery from SUDs.

Activity: Employment supports

Since 2008, the behavioral health sales tax has paid for a supported employment program that helps people with severe mental illnesses achieve self-sufficiency and improve non-vocational outcomes such as improved self-esteem, sense of purpose, decreased isolation, and participation in meaningful activities. Program participation is correlated with decreases in hospitalization and jail utilization. In the 2028-2034 implementation period, the Executive is considering broadening eligibility for this program to include individuals in recovery from SUDs, so they too can have access to support to get and maintain jobs and contribute to their communities.

H. Appendix H. Logic model and anticipated activities for Equitable Access to Behavioral Health Care Strategy Area

Figure 39: Logic model for the Equitable Access to Behavioral Health Care strategy area



EA Goal 1: Provide behavioral health care for low-income people who are ineligible for Medicaid.

Activity: Non-Medicaid behavioral health services and supports
In its next iteration, the behavioral health sales tax will continue to pay for behavioral health services for low-income uninsured or underinsured King County residents who are ineligible for Medicaid coverage.

Since its inception, the behavioral health sales tax has provided access to behavioral health treatment services for uninsured low-income people. Every year since 2008, this program has served between 3,000 and 4,000 uninsured people with outpatient mental health and substance use treatment services, including immigrants and refugees, people on Medicare, and people who are pending Medicaid coverage. This funding addresses inequities for these populations by enabling them to access safety-net behavioral health treatment that would otherwise be out of reach. Supporting access to low-barrier, preventative treatment services helps keep people from delaying needed treatment and accessing higher levels of care at a later time. The King County Behavioral Health Bridge will sustain this important program in 2028-2034 to continue supporting treatment equity between people with insurance coverage and those who lack access due to coverage gaps, income, immigration status or other barriers to care (such as transportation or language). In addition, the Executive plans to use the Bridge to pay for translation and interpretation services for people receiving outpatient treatment through this program who speak a language other than English.

EA Goal 2: Support the wellbeing of diverse communities by providing culturally and linguistically responsive services and removing barriers to care.

Activity: Community-driven culturally and linguistically responsive services and programs that support behavioral health outside of clinical settings
Community engagement participants and subject matter experts were clear that community-based organizations are better positioned to address the needs of their communities than well-intentioned outsiders. Services procured under this goal can directly fund community-based organizations to increase access to culturally and linguistically appropriate prevention, early intervention, care navigation, and recovery supports for BIPOC, immigrant or refugee, LGBTQIA+, and rural King County residents. By working with communities to design and implement service approaches that meet their needs, this goal directly addresses race- and place- based inequities and promotes King County's commitment to equity as a core value.

DCHS intends to release one or more RFPs to identify organizations that can provide tailored supports to populations that experience behavioral health inequities, such as those who:

- Identify as Black, Indigenous, or people of color.
- Are immigrants, refugees, or asylees.
- Identify as LGBTQIA+.
- Live in rural areas.

Examples of the types of programs that could be procured to further this goal include:

- Behavioral health education paired with culturally responsive programming such as sweat lodges or art therapy.

- Community conversations focused on de-stigmatization and healing, including cross-generational programming.
- Queer-affirming suicide prevention provided by an LGBTQIA+ organization.
- Wellness programs in safe spaces that build strong community connections.
- Mental health awareness and education, in preferred languages by trusted organizations.

Activity: Behavioral health treatment services tailored for priority populations
Participants in the Be Heard: Community Voices About Mental Health and Wellness project shared that culture, beliefs, values, race, language, and personal identity affect perspectives on mental health and substance use.[193] The same report found that people are less likely to seek help when the only available treatments do not resonate with their cultural background or the lens through which they see the world. Community members stressed the need for culturally responsive services that are developed by and for their community and provided by individuals from similar backgrounds. Research also shows that culturally adapted clinical care, particularly options co-created by the communities intended to benefit from them, significantly improve outcomes across a range of health conditions.[194,195]

Services procured under this goal will focus on making the publicly funded behavioral health system, such as the King County Integrated Care Network of Medicaid providers, more welcoming and responsive to King County's diverse populations by removing barriers to treatment and providing culturally responsive treatment.

DCHS intends to release one or more RFPs to identify organizations that can support low-income populations experiencing inequitable behavioral health outcomes, such as people who:

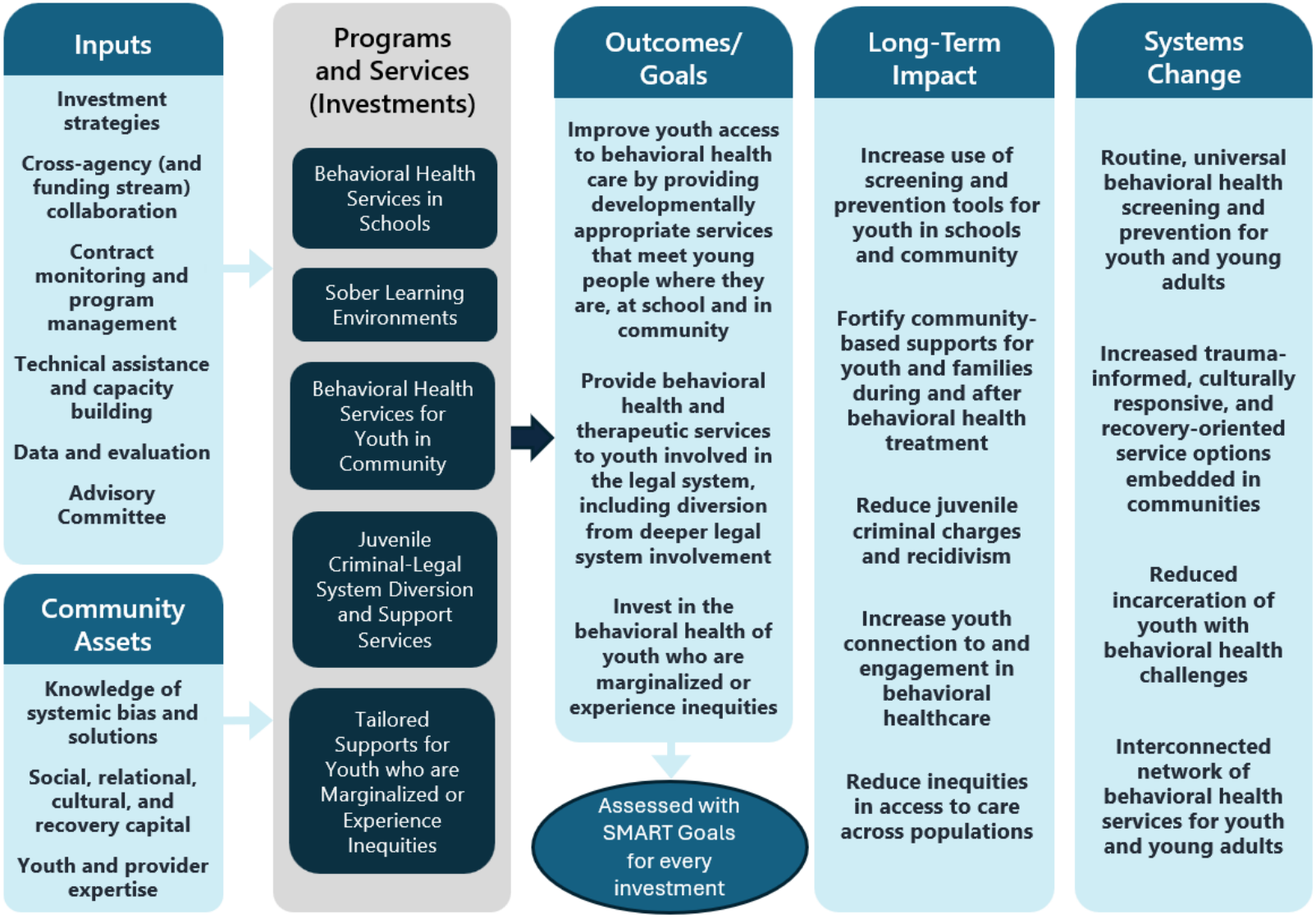
- Identify as Black, Indigenous, or people of color.
- Are immigrants, refugees, or asylees.
- Identify as LGBTQIA+.
- Live in rural areas.
- Are older adults.
- Are survivors of trauma or violence.

Examples of the types of programs that could be procured to further this goal include:

- Tailored therapies for LGBTQIA+ people facing behavioral health challenges.
- Behavioral health treatment and enhanced care navigation for survivors of domestic or sexual violence.
- Behavioral health treatment and supports for people living in rural or unincorporated Community Service Areas.
- Culturally specific, responsive, and trauma informed behavioral health treatment and supports for Black, Indigenous, and immigrant and refugee communities.
- Behavioral health treatment services for older adults with mental health and/or substance use conditions.

I. Appendix I. Logic model and anticipated activities for Child, Youth, Young Adult Mental Wellbeing Strategy Area

Figure 40: Logic model for the Child, Youth, and Young Adult Mental Wellbeing (CYYA) strategy area



CYYA Goal 1: Improve youth access to behavioral health care by providing developmentally appropriate services that meet young people where they are, at school and in community.

Activity: Youth behavioral health services in schools

Locating services in schools is an effective way to facilitate access to care and reduce stigma for young people in need of behavioral health support. Since 2018, the behavioral health sales tax (alongside braided funding from Best Starts) has supported school-based Screening, Brief Intervention, and Referral to Treatment (SB-SBIRT), which screens over 13,000 King County middle and high schoolers across 13 districts each year and helps connect them to needed services. After participating in screening, the students who indicate areas of potential need meet with trained staff to discuss their goals, areas of growth, and connections to needed services.

These programs are most effective when students can be referred to brief treatment (defined as 8 or fewer sessions) on campus, alleviating the need to make a separate appointment, find transportation, or navigate an unfamiliar clinical environment. On-campus services are currently available in some schools, but not all, resulting in inconsistent access. Services offered on campus are also exclusive to mental health concerns and do not include supports for students struggling with substance use. Through the Bridge's investments in 2028-2034, the Executive intends to build on existing School-Based SBIRT programs to allow more schools to offer brief on-campus behavioral health care, including substance use counseling in addition to mental health services. These brief services also support youth and families' transition to care in the community, if they need ongoing or higher-level care.

Activity: Sober learning environments

There are few youth-centered recovery resources, and young people who have experienced substance use disorders need safer and sober environments in which to continue their education while working on their recovery. Since 2014, King County has partnered with Seattle Public Schools Interagency Academy to operate the only public sober high school in Washington. The Interagency Recovery Campus (IRC), known colloquially as Recovery High School, provides a safe and sober environment where young people in recovery from substance use disorder and other behavioral health conditions can pursue their academic and career goals.[196] In 2013, only 25 percent of young people who received publicly funded substance use disorder treatment graduated from high school. For students with co-occurring mental health conditions, the number dropped to 17 percent.[197] At the Recovery High School, however, 67 percent of students earned or are working toward a high school diploma.[198] After enrolling in the program, 53 percent of IRC students have more than one year of recovery.[199] This activity would make it possible for the Bridge to support this valuable educational model.

Activity: Youth behavioral health services in community

During community engagement for the Bridge renewal, survey respondents rated "difficulty understanding where and how to access services" as the primary barrier to accessing behavioral health care for young people, as shown in Appendix B. Adolescents are often dependent on their caregivers' motivation, knowledge, and resources to help them identify when behavioral health care is needed, find a provider, make appointments, and travel to care. Young people often forego care when their caregivers cannot provide this support, or when youth do not want their caregivers to know they are struggling. One effective way to overcome this barrier is to bring care to locations where youth already spend time.[200] This activity enhances access to care in other community locations (beyond schools) where young people already spend time and have relationships with

trusted adults. The Bridge is anticipated to support programs that make behavioral health care more accessible, and therefore more effective, for youth and families, such as:

- Mobile screenings, brief interventions, MOUD, or young adult crisis response services that travel to shelters, community centers, and other youth-serving locations.
- Behavioral health staff in non-clinical youth-serving spaces like community centers, homeless shelters, summer camps, or community-based sports or arts programs.

CYYA Goal 2: Provide behavioral health and therapeutic services to youth involved in the legal system, including diversion from deeper legal system involvement

Activity: Diversion and supportive services for youth involved, or at-risk of involvement, in the criminal-legal system

Since 2017, the behavioral health sales tax has supported 3,443 young people who were involved with the criminal-legal system and have a behavioral health need.[201] These supportive services included risk and needs assessments, community-based behavioral health support and system navigation, youth and family counseling, mental health and SUD services, and referrals to ongoing treatment.

In its next iteration, the King County Behavioral Health Bridge will continue to provide critical services to help young people avoid long-term involvement in the criminal-legal system, such as:

- Behavioral health screenings and assessments,
- System navigation and warm handoff referrals to behavioral health care,
- Parent and family supports,
- De-escalation counseling,
- Mental health services,
- Substance use services,
- Diversion services, and
- Trauma informed, behavioral health focused services for youth with Court involvement, such as those provided by the Juvenile Response and Accountability Court – Behavioral Health Response (JTRAC-BHR).

These programs help young people who have contact with the criminal-legal system get their lives back on track. This prevents them from languishing in detention while waiting for behavioral health care, or falling deeper into a cycle of behavioral health conditions, criminalization, and homelessness.

CYYA Goal 3: Invest in the behavioral health of youth who are marginalized or experience inequities.

Activities: Tailored supports for youth who are marginalized or experience inequities

DCHS intends to release one or more RFPs to identify organizations that can provide tailored, culturally responsive, and affirming supports to youth and families from communities that have been historically underserved or marginalized by behavioral health systems. Among these are young people and families who:

- Identify as LGBTQIA+.
- Identify as Black, Indigenous, or people of color.
- Are immigrants, refugees, asylees, or the children of immigrants, refugees, and asylees.

- Have complex and co-occurring behavioral health conditions, or behavioral health conditions with neurodivergence or intellectual or developmental disabilities.
- Have witnessed or experienced violence, including domestic violence or gun violence.

Tailored interventions have been proven more effective than standard interventions at improving outcomes among LGBTQIA+ youth and youth of color.[202,203,204] Examples of the types of programs that the Executive intends to procure include:

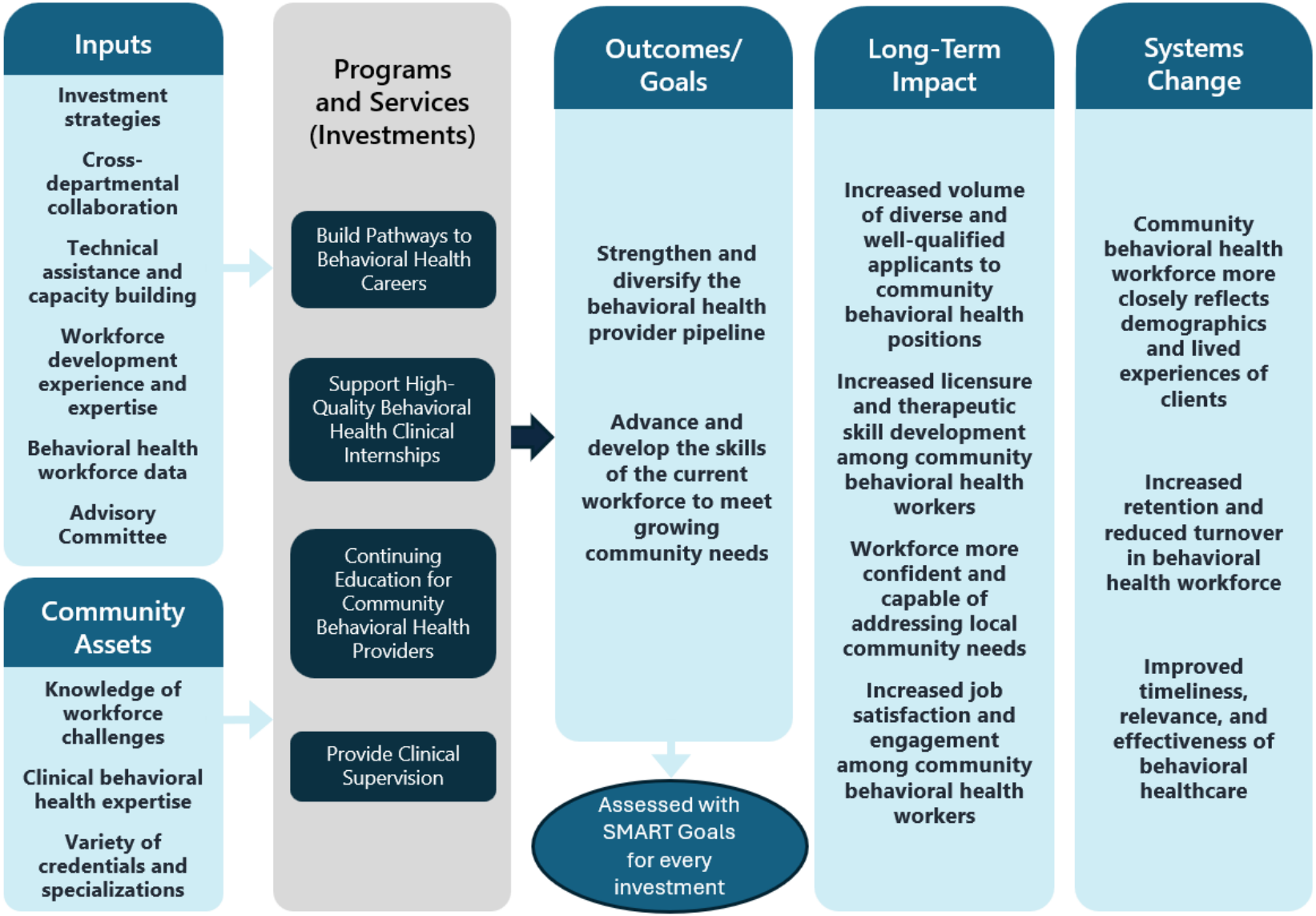
- Suicide prevention approaches designed with and for Black youth.
- Sober community-building and substance use prevention for LGBTQIA+ youth.
- In-language therapy groups for youth who speak a language other than English at home.
- Trauma healing programs for American Indian/Alaska Native youth who have witnessed or experienced violence.

During the procurement process, King County plans to evaluate proposals from community organizations that are already known and respected by the families this goal is intended to serve, which may include KCICN providers. Bridge-funded programs will focus on early intervention, treatment (especially for uninsured youth), and recovery. Services will complement rather than duplicate investments from other funding sources and will streamline connections to the publicly funded behavioral health system for participating youth and families.

This investment creates an opportunity to strengthen culturally responsive, community-rooted pathways into care so that youth can access support earlier and in ways that better meet their needs.

J. Appendix J. Logic model and anticipated activities for the Behavioral Health Workforce Development Strategy Area

Figure 41: Logic model for the Behavioral Health Workforce Development (WF) strategy area



WF Goal 1: Strengthen and diversify the behavioral health provider pipeline.

Activity: Building pathways to behavioral health careers

The Executive intends for the Behavioral Health Bridge to fund programs and activities that bring people into the provider pipeline, with a focus on recruiting a representative workforce, including by raising awareness of behavioral health career opportunities, preparing people for jobs in the field, and connecting people to careers in behavioral health. The Executive plans to invest in activities such as:

- Educating under-resourced communities on non-clinical and clinical career pathways and ways to access free or no-cost trainings.
- Delivering programs in diverse middle and high schools to increase behavioral health career awareness among BIPOC youth.
- Building "connection to industry" through hands-on learning, job shadowing, career tours, and clinical simulations.
- Sponsoring Behavioral Health Career Pathways Fairs in collaboration with community-based organizations that serve underrepresented populations, including youth.
- Continuing summer programs for youth interested in pursuing behavioral health careers.
- Expanding existing relationships with technical colleges and skills centers.
- Targeted outreach to individuals enrolled in higher education behavioral health programs, highlighting benefits of working in community behavioral health, diversity of careers available, and opportunities for career growth within the behavioral health system.

Activity: Supporting high-quality behavioral health clinical internships

Ensuring the availability of well-supported clinical internships in community behavioral health will not only increase the number of new providers entering the workforce, it will also help improve the representativeness of the workforce. Clinical internships provide on-the-job learning experience and are a required component of graduate degree programs to become a behavioral health provider. These internships are typically unpaid and take place while a person is in school pursuing a Master of Social Work or other degree requirement. This step in the training process is cost-prohibitive for many people who cannot afford to work without pay. This barrier is particularly difficult for people from lower-income backgrounds, who are often more representative of the population being served in community behavioral health settings. Additionally, an individual's experience during internship can shape whether they choose to continue to work in community behavioral health settings after they obtain their degree. Clinical interns continue to be the primary pipeline for developing community behavioral health workers, especially those with advanced degrees, including diverse workers.[205]

The Executive intends to invest in activities to support high-quality behavioral health clinical internships, such as:

- Providing financial support for paid internships, building on the work of the CCC Levy's career pathways (CP) funding, which is effective but does not have enough funds to fully meet the needs.
- Developing supervisor training and support initiatives that assist community behavioral health supervisors in providing training and coaching in best practices and culturally relevant core competencies for interns and clinical trainees.

- Developing internship programs to treat people with co-occurring substance use disorders and mental health conditions. No similar internship programs exist as of the time of this plan's drafting, despite the prevalence of co-occurring disorders.
- Supporting training around clinical best practices and ensuring interns have the competencies needed to serve the complex needs seen in community behavioral health.

WF Goal 2: Advance and develop the skills of the current workforce to meet growing community needs.

Activity: Clinical supervision

To promote an adequate supply of behavioral health workers prepared to treat the low-income, high-need population served by community behavioral health, DCHS intends to work to alleviate the barriers around clinical supervision that currently limit the number of new providers who can begin their careers in community behavioral health.

After graduation from a Master's program, new clinicians must complete 1,000 to 3,000 hours of clinical supervision to become a fully licensed behavioral health worker, depending on the license type.[206] The cost of paying to receive clinical supervision is a barrier for providers' career advancement and disproportionately affects low-income and BIPOC individuals.[207] Historically, community behavioral health agencies have offered free clinical supervision as a key benefit and recruitment tool for clinical staff, but clinical supervision itself is not reimbursable by insurance or Medicaid. The hours the supervisor spends supporting a new colleague are unpaid and compete with time they could spend providing services to clients and generating revenue for their agency. As a result, community behavioral health agencies are limited in how many new clinicians they can supervise, which in turn limits the number of new clinicians who can enter community behavioral health. Across 47 KCICN agencies surveyed in 2025, the main reported barrier to hosting clinical trainees was lack of supervisor availability.[208] This creates a bottleneck preventing new clinicians from entering the community behavioral health.

The Executive intends to leverage the Behavioral Health Bridge to pay for clinical supervision through methods such as:

- Funding the provision of clinical supervision within a community behavioral health agency.
- Developing a centralized clinical supervision model for the King County Integrated Care Network that leverages opportunities for shared clinical supervision across multiple behavioral health provider agencies.
- Developing a centralized model for virtual clinical supervision, that could be widely available to community behavioral health agencies to augment and supplement existing agency-provided clinical supervision.

Activity: Continuing education for community behavioral health providers

The Executive intends to sustain and expand the workforce investments that began in MIDD 2 through continuing Bridge investments. Since 2025, the behavioral health sales tax has supported KCICN providers to receive specialized training through avenues like:

- KCICN Training Academy, which provides evidence-based practice (EBP) trainings in Dialectical Behavioral Therapy and Cognitive Behavioral Therapy for Psychosis with continuing education units (CEUs) and follow-up consultation.
- Access to a learning management system, such as Relias.
- Access to EBP training software, such as Lyssn.

- Access to an umbrella license and coverage of training costs for certain training programs, such as the Seven Challenges program for youth SUD treatment.

The Bridge will enable KCICN providers to continue to access training software, along with new high-demand trainings such as but not limited to motivational interviewing, racial socialization and addressing racial trauma, LGBTQIA+ affirming and responsive treatment, family-based interventions for disruptive behavior, parent-child interaction therapy. These additions will support providers in offering the highest quality of care through King County's publicly funded behavioral health system.

The Executive also intends to continue or expand support for partnerships with technical colleges and higher education institutions to create affordable pathways for individuals who already hold credentials in mental health to earn credentials in SUD treatment, and vice versa. For example, the Y+Heritage Master's Program allows current KCICN clinical staff from underrepresented communities to pursue master's degrees in mental health counseling.[209] With support from the Behavioral Health Bridge, the Executive intends to expand this or similar programs to provide pathways for existing students to obtain licensure as Substance Use Disorder Professionals (SUDPs) to be able to treat people with co-occurring conditions.

XIII. Endnotes

[1] Office of Economic and Financial Analysis. *March 2026 King County Economic and Revenue Forecast*. [https://cdn.kingcounty.gov/-/media/king-county/independent/governance-and-leadership/government-oversight/forecasting/documents/march2026_pdfadopted.pdf?rev=6cdf6650ea2d492abfc50bb439636bf8&hash=A27D47D6291478774123E825A1084F99]

[2] RCW 82.14.460. [https://app.leg.wa.gov/rcw/default.aspx?cite=82.14.460]

[3] K.C.C. 4A.500.315: Sales and use tax - for behavioral health programs and services, and therapeutic courts programs and services. [https://aqua.kingcounty.gov/council/clerk/code/07_Title_4A.htm#_Toc54697846]

[4] 2026-2027 King County Biennial Budget Ordinance 20023, Section 70, Expenditure Restriction ER6. [https://mkcclegisearch.kingcounty.gov/LegislationDetail.aspx?ID=7680373&GUID=B4E9E09C-A982-4A8C-A0DA-6CC195D69EE0&Options=Advanced&Search=&FullText=1]

[5] MIDD 2 Implementation Plan (2018). [https://cdn.kingcounty.gov/-/media/king-county/depts/dchs/behavioral-health-recovery/midd/midd/documents/170804_midd_implementation_plan.pdf?la=en&rev=620583891f9244ddb76dfb7e5c4b1f6f&hash=BFE0B56EA0AFE73E42032C2876738B72]

[6] DCHS' communication channels include, but are not limited to, the Cultivating Connections department blog and department social media accounts.

[7] Office of Economic and Financial Analysis. *March 2026 King County Economic and Revenue Forecast*. [https://cdn.kingcounty.gov/-/media/king-county/independent/governance-and-leadership/government-oversight/forecasting/documents/march2026_pdfadopted.pdf?rev=6cdf6650ea2d492abfc50bb439636bf8&hash=A27D47D6291478774123E825A1084F99]

[8] RCW 82.14.460. [https://app.leg.wa.gov/rcw/default.aspx?cite=82.14.460]

[9] K.C.C. 4A.500.315. [https://aqua.kingcounty.gov/council/clerk/code/07_Title_4A.htm#_Toc54697846]

[10] RCW 82.14.460. [https://app.leg.wa.gov/rcw/default.aspx?cite=82.14.460]

[11] Ordinance 15949 (2007). [https://mkcclegisearch.kingcounty.gov/LegislationDetail.aspx?ID=554785&GUID=D03F4D6D-19CA-4973-AB42-558B5BAC250E&Options=Advanced&Search=&FullText=1]

[12] Ordinance 18333 (2016). [https://mkcclegisearch.kingcounty.gov/LegislationDetail.aspx?ID=2745995&GUID=70E5373E-EAD8-4E04-8470-ADF157652B25&Options=Advanced&Search=&FullText=1]

[13] Ordinance 19976 (2025). [https://mkcclegisearch.kingcounty.gov/LegislationDetail.aspx?ID=7477276&GUID=C9F88779-E410-4BF9-9D6C-1E5CF80E02DE&Options=Advanced&Search=&FullText=1]

[14] Ordinance 19976 (2025). [https://mkcclegisearch.kingcounty.gov/LegislationDetail.aspx?ID=7477276&GUID=C9F88779-E410-4BF9-9D6C-1E5CF80E02DE&Options=Advanced&Search=&FullText=1]

[15] Greenstone, S. (August 2023). *Washington counties sue state for 'refusing' to provide mental health services* [KNKX Public Radio]. [https://www.knkx.org/law/2023-08-23/washington-state-counties-lawsuit-mental-health-services]; Archibald, A. (August 2022). Investing in health | Missing money. *Real Change* [https://www.realchangenews.org/news/2022/08/17/investing-health-missing-money]

[16] King County DCHS. *MIDD Behavioral Health Sales Tax dashboard*. [https://kingcounty.gov/en/dept/dchs/human-social-services/community-funded-initiatives/midd-behavioral-health-tax/midd-behavioral-health-sales-tax-dashboard]

[17] MIDD 2 Implementation Plan (2018). [https://cdn.kingcounty.gov/-/media/king-county/depts/dchs/behavioral-health-recovery/midd/midd/documents/170804_midd_implementation_plan.pdf?la=en&rev=620583891f9244ddb76dfb7e5c4b1f6f&hash=BFE0B56EA0AFE73E42032C2876738B72]

[18] 2026-2027 King County Biennial Budget Ordinance 20023, Section 70, Expenditure Restriction ER6. https://mkcclegisearch.kingcounty.gov/LegislationDetail.aspx?ID=7680373&GUID=B4E9E09C-A982-4A8C-A0DA-6CC195D69EE0&Options=Advanced&Search=&FullText=1]

[19] MIDD 2 Implementation Plan (2018). [https://cdn.kingcounty.gov/-/media/king-county/depts/dchs/behavioral-health-recovery/midd/midd/documents/170804_midd_implementation_plan.pdf?la=en&rev=620583891f9244ddb76dfb7e5c4b1f6f&hash=BFE0B56EA0AFE73E42032C2876738B72]

[20] RCW 82.14.460. [https://app.leg.wa.gov/rcw/default.aspx?cite=82.14.460]

[21] RCW 82.14.460. [https://app.leg.wa.gov/rcw/default.aspx?cite=82.14.460]

[22] MIDD 2 Initiative Descriptions. [https://kingcounty.gov/en/dept/dchs/human-social-services/community-funded-initiatives/midd-behavioral-health-tax/initiatives]

[23] These outcomes describe the experiences of individuals enrolled in relevant MIDD initiatives between 2017 and 2022, three years following program participation.

[24] King County DCHS. *MIDD Behavioral Health Sales Tax dashboard*. [https://kingcounty.gov/en/dept/dchs/human-social-services/community-funded-initiatives/midd-

behavioral-health-tax/midd-behavioral-health-sales-tax-dashboard]; Click on "Plans, Reports, and Briefing Papers" on the right sidebar to see reports prior to 2024.

[25] King County Executive Order, "Breaking the Cycle." Document Code ACO-8-34-EO. March 31, 2026. [https://content.govdelivery.com/attachments/WAKING/2026/03/31/file_attachments/3602521/Breaking%20the%20Cycle%20Executive%20Order%20Final.pdf]

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[129] Implementation of a revised approach to performance metrics has begun in 2026. After reviewing best practices across many Departments, work has begun to start integrating

performance metrics into the DNA of how the County does business. The Executive Office is standardizing an approach that will be extended across all Departments and will also be working on additional best practices with the Departments who are doing these processes today to continue with operational excellence work. This approach will eventually include monthly business reviews for every department and quarterly business reviews with the Executive Office.

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[134] Multiple data system improvements support this data collection and reporting, including investments in data systems and infrastructure, performance measurement and evaluation staff to manage and analyze large amounts of data from hundreds of providers. DCHS partnered with PHSKC and KCIT to build an Integrated Data Hub that deduplicates service participants across a wide variety of programs and supports cross-systems analysis. DCHS also developed and implemented a first-of-its kind data system, known as the Client Outcomes Reporting Engine (CORE), to efficiently manage large volumes of data submissions from providers that enables consistent measures and transparent reporting.

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[136] King County DCHS. *MIDD Behavioral Health Sales Tax dashboard*. [https://kingcounty.gov/en/dept/dchs/human-social-services/community-funded-initiatives/midd-behavioral-health-tax/midd-behavioral-health-sales-tax-dashboard].

[138] DCHS' communication channels include, but are not limited to, the Cultivating Connections department blog, and department social media accounts.

[139] State of Washington. (2026). *ESSB 6346*. [https://app.leg.wa.gov/BillSummary/?BillNumber=6346&Year=2025]

[140] Office of Economic and Financial Analysis. *March 2026 King County Economic and Revenue Forecast*. [https://cdn.kingcounty.gov/-/media/king-county/independent/governance-and-leadership/government-oversight/forecasting/documents/march2026_pdfadopted.pdf?rev=6cdf6650ea2d492abfc50bb439636bf8&hash=A27D47D6291478774123E825A1084F99]

[141] King County DCHS. (2024). *DCHS Inflation Rate Adjustment Policy for Human Services Contracts*. [https://cdn.kingcounty.gov/-/media/king-county/depts/dchs/ASD/DCHS%20Inflation%20Policy]

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[144] Section 6. Reviewing and Prioritizing Base Budgets. King County Executive Order, "Better Governance and Financial Management." Document Code ACO-8-33-EO. March 4, 2026. [https://cdn.kingcounty.gov/-/media/king-county/depts/executive-services/policies/documents/aco-8-33-eo-03-04-2026.pdf?rev=f11305dd68fd4c29af2a8ca8e60145a5&hash=95EA94BF839EAEDF42E3EDA908D8368F]

[145] King County DCHS. (2025). *An Update: Responding to the Audit. DCHS Blog: Cultivating Connections*. [https://dchsblog.com/2025/12/11/an-update-responding-to-the-audit/]

[146] Motion 16975. (2026). [https://mkcclegisearch.kingcounty.gov/LegislationDetail.aspx?ID=7965836&GUID=74EC9640-4DB4-4562-BF46-E39FCCC6E8AE&Options=Advanced&Search=] Motion 16975 accepts the Report on the Status of Activities Related to Contract Management and Compliance Reporting Protocols.

[147] King County. *King County Comprehensive Financial Management Policies*. [https://mkcclegisearch.kingcounty.gov/LegislationDetail.aspx?ID=5122778&GUID=EA35F767-889C-4ADA-A720-6342044F7413&Options=Advanced&Search=]

[148] The 10 percent threshold for notification letters will be applied to the annual allocation for the strategy area, as adjusted through any prior changes if applicable. Prior changes may include substantive changes that have been summarized in past notification letters to the Council like those described in this section; proceeds not spent within a strategy area in the originally planned year but retained within the same strategy area for use in a subsequent year; other non-substantive

adjustments that do not meet the notification threshold; or changes that may have been initiated by the Council through a budget ordinance.

[149] 2026-2027 King County Biennial Budget. November 18, 2025. [https://mkcclegisearch.kingcounty.gov/LegislationDetail.aspx?ID=7680373&GUID=B4E9E09C-A982-4A8C-A0DA-6CC195D69EE0&Options=Advanced&Search=&FullText=1]

[150] King County DCHS. DCHS Inflation Rate Adjustment Policy for Human Services Contracts. (2024). [https://cdn.kingcounty.gov/-/media/king-county/depts/dchs/ASD/DCHS%20Inflation%20Policy]

[151] Ordinance 19364, Section 44, Proviso P3. [https://mkcclegisearch.kingcounty.gov/LegislationDetail.aspx?ID=5153492&GUID=83A03492-A721-4832-BA46-BCD9D2951C3D&Options=Advanced&Search=&FullText=1]; This proviso language was later amended to remove the report requirement.

[152] King County DCHS. (2024). *DCHS Inflation Rate Adjustment Policy for Human Services Contracts*. [https://cdn.kingcounty.gov/-/media/king-county/depts/dchs/ASD/DCHS%20Inflation%20Policy]

[153] King County. *King County Budget and Financial Planning Assumptions Dashboard*. [https://app.powerbigov.us/groups/me/reports/b97a6283-2b3f-4a50-8f6d-c5d0d601df05/ReportSection3c4f835a513e65de275e]

[154] Office of Economic and Financial Analysis. *March 2026 King County Economic and Revenue Forecast*. [https://cdn.kingcounty.gov/-/media/king-county/independent/governance-and-leadership/government-oversight/forecasting/documents/march2026_pdfadopted.pdf?rev=6cdf6650ea2d492abfc50bb439636bf8&hash=A27D47D6291478774123E825A1084F99]

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[157] King County DCHS. (2024). *Section 6.7 of DCHS Inflation Rate Adjustment Policy for Human Services Contracts*. [https://cdn.kingcounty.gov/-/media/king-county/depts/dchs/ASD/DCHS%20Inflation%20Policy]

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[171] PointClickCare is an external platform that BHRD contracts with on behalf of KCICN members. Providers can see emergency department and hospitalization encounters for their enrolled clients. However, psychiatric inpatient encounters for some psychiatric hospitals (such as Fairfax and the VA) are not included. The Extended Client Lookup System is a BHRD platform where providers can see a client's Medicaid status and the BHRD-funded services the individual was historically or currently enrolled in, but it does not include services a person engaged in outside of BHRD. The BHRD Quality and Care Coordination Resources SharePoint contains many resources, including a Care Coordination Contact List, which lists the most appropriate contacts for care coordination purposes at various agencies.

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King County | Office of the Executive

Executive Girmay Zahilay
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Seattle, WA 98104-2391

July 1, 2026

The Honorable Sarah Perry
Chair, King County Council
Room 1200
C O U R T H O U S E

Dear Councilmember Perry:

This letter transmits the King County Behavioral Health Bridge Implementation Plan 2028-2034, which responds to Ordinance 20023, Section 70, Proviso P1, and a proposed Ordinance that would, if enacted, adopt the implementation plan. Adoption of this proposed legislation would reaffirm the County's commitment to high-quality, accessible , effective, and equitable behavioral health care in King County.

The "King County Behavioral Health Bridge" ("the Bridge") represents a new name for this plan and its programs, reflected in a separate proposed Ordinance, to replace the "Mental Illness and Drug Dependency" (MIDD) name that has been used for this fund and its programs and advisory committee since 2007. Responsive to community feedback, the King County Behavioral Health Bridge name emphasizes the role of sales tax-funded programs in creating a bridge between people experiencing behavioral health conditions and community behavioral health treatment, other systems people interact with including the criminal-legal system, and pathways to recovery.

Under its former name MIDD, this fund supported programs that served over 130,000 unduplicated King County residents between 2017 and 2025. These investments make programs possible that improve health and wellness, recovery, and connection to community, especially for people most affected by inequities related to race, income, housing status, and access to health care.

The King County Behavioral Health Bridge is projected to generate nearly $800 million for behavioral health care in King County between 2028 and 2034. The proposed King County Behavioral Health Bridge Implementation Plan 2028-2034 invests strategically to break the cycle

and prevent incarceration, hospitalization, homelessness, and crisis for low-income people with mental health and substance use conditions. The plan builds on past successes while strategically tackling the most pressing behavioral health issues in King County communities through investments in five interconnected strategy areas:

- Care transitions and diversion services.
- Substance use disorder prevention, treatment, and recovery.
- Equitable access to behavioral health care.
- Child, youth, and young adult mental wellbeing.
- Behavioral health workforce development.

The proposed plan invests where the need is greatest and where dollars can make the most meaningful impact. It describes the forecasted expenditure of revenues in the five strategy areas to achieve the King County Behavioral Health Bridge's identified goals. It includes activities in which the County anticipates investing to reduce behavioral health system fragmentation, improve service availability, and align with other funding sources such as Medicaid and local funds. The plan also describes a performance measurement and evaluation framework to assess and report on how well Bridge investments are achieving desired results, and describes plans for regular reporting to the Council and community.

This plan and its five strategy areas are the product of an intensive engagement process that began in June 2024 and concluded in March 2026. The strategy areas, goals, and activities were informed by community engagement with over 2,200 King County residents, an extensive multi-sector process involving over 100 subject matter experts, and the most current available county-level data on needs and outcomes. Community engagement activities included participation from behavioral health agencies, people with lived experience of behavioral health, incarcerated people with behavioral health conditions, scholars, advocates, representatives of the legal system, the MIDD Advisory Committee, elected officials, and other community partners. Feedback from these diverse individuals significantly informed the investments described in this plan, and will inform future procurement and operational phases of the Behavioral Health Bridge.

The King County Behavioral Health Bridge Implementation Plan 2028-2034 and its programs will enable the County to continue to break cycles of incarceration, hospitalization, and homelessness and build toward a future of available, accessible, effective, and equitable behavioral health care. I look forward to working with the Council to provide access to high-quality behavioral health care that enables residents to pursue long term recovery, stability, and wellbeing. Thank you for your consideration of this important Plan and proposed Ordinance.

If your staff have any questions, please contact Dr. Susan McLaughlin, director of the Department of Community and Human Services, at 206-477-9309.

Sincerely,

for

Girmay Zahilay
King County Executive

Enclosure

cc: King County Councilmembers
ATTN: Stephanie Cirkovich, Chief of Staff
Melani Hay, Clerk of the Council
Karan Gill, Deputy Executive, Office of the Executive
Jasmin Weaver, Chief of Staff, Office of the Executive
Hyeok Kim, Chief Operating Officer, Office of the Executive
Sierra Howlett Browne, Director of Government Relations, Office of the Executive
Garrett Holbrook, Council Relations Manager, Office of the Executive
Dr. Susan McLaughlin, Acting Director, Department of Community and Human Services

2026 FISCAL NOTE

Ordinance/Motion:	Ordinance
Title:	An ordinance adopting the King County behavioral health bridge implementation plan, required by the 2026-2027 Biennial Budget Ordinance, Ordinance 20023, Section 70, Proviso P1, to govern the expenditure of proceeds from 2028 through 2034 of the behavioral health sales and use tax authorized by RCW 82.14.460 and K.C.C. 4A.500.315.
Affected Agency and/or Agencies:	DCHS
Note Prepared By:	Scott Miller
Date Prepared:	6/3/2026
Note Reviewed By:	Kevin Lo
Date Reviewed:	6/3/2026

Description of request:

The proposed ordinance would adopt the King County Behavioral Health Bridge Implementation Plan 2028-2034 to govern the expenditure of proceeds from 2028 through 2034 of the behavioral health sales and use tax authorized by RCW 82.14.460 and K.C.C. 4A.500.315.

Revenue to:

Agency	Fund Code	Revenue Source	2028-2029	2030-2031	2032-2033
DCHS	1135	Sales Tax	211,280,000	221,610,000	236,730,000
DCHS	1135	Interest Earnings	1,510,000	1,330,000	1,270,000
TOTAL			**212,790,000**	**222,940,000**	**238,000,000**

Expenditures from:

Agency	Fund Code	Department	2028-2029	2030-2031	2032-2033
DCHS	1135	BHRD	211,910,000	224,580,000	236,990,000
TOTAL			**211,910,000**	**224,580,000**	**236,990,000**

Expenditures by Categories

	2028-2029	2030-2031	2032-2033
Strategy Area 1: Care Transitions and Diversion Services	69,180,000	67,460,000	70,810,000
Strategy Area 2: SUD Treatment and Recovery	39,650,000	42,120,000	44,510,000
Strategy Area 3: Equitable Access to Behavioral Health Care	32,630,000	34,520,000	36,530,000
Strategy Area 4: Child, Youth, and Young Adult Mental Wellbeing	22,910,000	24,750,000	26,250,000
Strategy Area 5: Behavioral Health Workforce Development	7,870,000	13,730,000	14,700,000
Technical Assistance & Capacity Building	1,060,000	1,110,000	1,180,000
Administration	17,270,000	18,290,000	19,240,000
Performance Measurement & Evaluation	5,080,000	5,380,000	5,660,000
Behavioral Health Fund Transfer	16,260,000	17,220,000	18,110,000
TOTAL	**211,910,000**	**224,580,000**	**236,990,000**

Does this legislation require a budget supplemental? No. Fiscal impacts begin in the 2028-29 budgetary biennium.

Notes and Assumptions:

Biennial amounts are rounded to nearest $10,000.

Behavioral health provider contract budgets assume inflationary increases based on BFPA rates (Seattle Consumer Price Index).

Financial Plan - King County Behavioral Health Bridge Implementation Plan 2028-2034
Behavioral Health Bridge / 1135

Category	2028-2029 Projected	2030-2031 Projected	2032-2033 Projected	2034 Projected
Beginning Fund Balance	**$ 19,550,000**	**$ 20,430,000**	**$ 18,790,000**	**$ 19,800,000**
Revenues				
Local Sales Tax	211,280,000	221,610,000	236,730,000	124,180,000
Other/Interest	1,510,000	1,330,000	1,270,000	660,000
Total Revenues	**$ 212,790,000**	**$ 222,940,000**	**$ 238,000,000**	**$ 124,840,000**
Expenditures				
Strategy Area 1: Care Transitions and Diversion Services	69,180,000	67,460,000	70,810,000	36,900,000
Strategy Area 2: SUD Treatment and Recovery	39,650,000	42,120,000	44,510,000	23,350,000
Strategy Area 3: Equitable Access to Behavioral Health Care	32,630,000	34,520,000	36,530,000	19,230,000
Strategy Area 4: Child, Youth, and Young Adult Mental Wellbeing	22,910,000	24,750,000	26,250,000	13,920,000
Strategy Area 5: Behavioral Health Workforce Development	7,870,000	13,730,000	14,700,000	7,960,000
Technical Assistance & Capacity Building	1,060,000	1,110,000	1,180,000	620,000
Administration	17,270,000	18,290,000	19,240,000	9,950,000
Performance Measurement & Evaluation	5,080,000	5,380,000	5,660,000	2,930,000
Behavioral Health Fund Transfer	16,260,000	17,220,000	18,110,000	9,360,000
Total Expenditures	**$ 211,910,000**	**$ 224,580,000**	**$ 236,990,000**	**$ 124,220,000**
Estimated Under expenditures	-	-	-	-
Other Fund Transactions	-	-	-	-
Total Other Fund Transactions	**$ -**	**$ -**	**$ -**	**$ -**
Ending Fund Balance	**$ 20,430,000**	**$ 18,790,000**	**$ 19,800,000**	**$ 20,420,000**
Reserves				
Rainy Day Reserve	17,420,000	18,460,000	19,480,000	20,420,000
Sustainability Reserve	3,010,000	330,000	320,000	-
Total Reserves	**$ 20,430,000**	**$ 18,790,000**	**$ 19,800,000**	**$ 20,420,000**
Reserve Shortfall	-	-	-	-
Ending Undesignated Fund Balance	**$ -**	**$ -**	**$ -**	**$ -**

Financial Plan Notes

All financial plans have the following assumptions, unless otherwise noted in below rows:
- Outyear projections columns: revenue and expenditure inflation assumptions are consistent with figures provided by the Executive Budget Team's BFPA guidance and the agency's internal assumptions and methodology.
- Biennial amounts are rounded to nearest $10,000.
- Beginning fund balance for 2028 is based on projections from the MIDD Fund Q1 2026 Financial Monitoring plan from March 2026.

Revenue Notes:

- Revenue amounts are based on March 2026 economic forecast for sales tax, and updated planning assumptions for interest earned.

Expenditure Notes:

- Projected amounts assume the King County Behavioral Health Bridge will implement the King County Behavioral Health Bridge Implementation Plan 2028-2034 as proposed, with expenditures grouped into the categories shown in this table and aligned to expected revenues for the plan period.

Reserve Notes:

- 2028-2034 Rainy Day reserves are based on 60 days of expenditures.

Former MIDD Program and Number	Aligned "Bridge" Anticipated Activity	Notes
PRI-01 Screening, Brief Intervention and Referral to Treatment-SBIRT	SUD Goal 1 - activity: Screening and referrals integrated into multiple settings	
PRI-02 Juvenile Justice Youth Behavioral Health Assessments	CYYA Goal 2 - activity: Diversion and supportive services for youth involved, or at-risk of involvement, in the criminal-legal system	
PRI-03: Prevention and Early Intervention Behavioral Health for Adults Over 50	n/a	Funding ending 12/31/26 per Council-adopted biennial budget
PRI-04 older Adult Crisis Intervention/Geriatric Regional Assessment Team	n/a	Funded by VSHSL-only in 2027
PRI-05 Collaborative School Based Behavioral Health Services: Middle and High School Students	CYYA Goal 1: Youth behavioral health services in schools	
PRI-06: Zero Suicide Initiative Pilot	n/a	Already ended (before 2026-2027 biennium)
PRI-07: Mental Health First Aid	EA Goal 2: activity: Community-driven culturally and linguistically responsive services and programs that support behavioral health outside of clinical settings	
PRI-08: Crisis Intervention Training – First Responders	CTD Goal 1 - activity: Diversion from criminal-legal system involvement	
PRI-09: Sexual Assault Behavioral Health Services	EA Goal 2: activity: BH treatment services tailored for priority populations	
PRI-10: Domestic Violence Behavioral Health Services and System Coordination	EA Goal 2: activity: BH treatment services tailored for priority populations	
PRI-11: Community Behavioral Health Treatment	EA Goal 1: activity: Non-Medicaid behavioral health services and supports	
CD-01: Law Enforcement Assisted Diversion	CTD Goal 1 - activity: Diversion from criminal-legal system involvement	
CD-02: Youth and Young Adult Homelessness Services	CYYA Goal 2 - activity: Diversion and supportive services for youth involved, or at-risk of involvement, in the criminal-legal system	
CD-03: Outreach and In Reach System of Care	SUD Goal 1 - activity: Proactive outreach to people with SUD, especially those experiencing homelessness	
CD-04: South County Crisis Diversion Services/Center	n/a	Rolled into CD-06 several years ago
CD-05: High Utilizer Care Teams	n/a	No longer MIDD-funded (was moved to Harborview bond before 2026-2027 biennium)
CD-06: Adult Crisis Diversion Center, Respite Beds, and Mobile Behavioral Health Crisis Team	n/a	Intended to shift to CCC before 2028
CD-07: Multipronged Opioid Strategies	SUD Goal 2 - activity: Low-barrier access to medications for substance use disorder and medication-first treatment approachesSUD Goal 2 - activity: SUD treatment for incarcerated peopleSUD Goal 2 - activity: overdose prevention and tracking	Current activities of CD-07 align with multiple anticipated future activities within SUD Goal 2

Former MIDD Program and Number	Aligned "Bridge" Anticipated Activity	Notes
CD-08: Children's Domestic Violence Response Team	CYYA Goal 3 - activity: Tailored supports for youth who are marginalized or experience inequities	
CD-09: Behavioral Health Urgent Care Walk-In Clinic	n/a	Already ended (before 2026-2027 biennium)
CD-10: Next-Day Crisis Appointments	CTD Goal 3 - activity: Promoting timely access to appropriate care	
CD-11: Children's Crisis Outreach Response System	n/a	Intended to shift to CCC before 2028
CD-12: Parent Partners Family Assistance	CYYA Goal 3 - activity: Tailored supports for youth who are marginalized or experience inequities	
CD-13: Family Interventions Restorative Services	CYYA Goal 2 - activity: Diversion and supportive services for youth involved, or at-risk of involvement, in the criminal-legal system	
CD-14: Involuntary Treatment Triage	CTD Goal 1 - activity: Services for people with behavioral health conditions who have cycled repeatedly through the criminal-legal system	
CD-15: Wraparound Services for Youth	CYYA Goal 3 - activity: Tailored supports for youth who are marginalized or experience inequities	
CD-16: Youth Behavioral Health Alternatives to Secure Detention	n/a	Already ended (before 2026-2027 biennium)
CD-17: Young Adult Crisis Facility	CYYA Goal 1: Youth behavioral health services in community	
CD-18: RCR/TRU	CTD Goal 1 - activity: Diversion from criminal-legal system involvement	
RR-01: Housing Supportive Services	CTD Goal 2 - activity: Behavioral health services in permanent supportive housing	
RR-02: Behavior Modification Classes at Community Center for Alternative Programs	n/a	Intended to shift to General Fund before 2028
RR-03: Housing Capital and Rental	n/a	The Bridge IP reflects DCHS' plans to cease this transfer to HCD at the time that the CTD area is reprocured (2029)
RR-04: Rapid Rehousing Oxford House Model	SUD Goal 3 - activity: Access to housing that supports recovery	
RR-05: Housing – Adult Drug Court	n/a	Modeled as part of Adult Drug Court beginning in 2028 (continuing, but not as a standalone program)
RR-06: Jail Reentry System of Care	CTD Goal 1 - activity: Supports for people to reenter the community after incarceration	
RR-07: Behavioral Health Risk Assessment Tool for Adult Detention	n/a	Already ended (before 2026-2027 biennium)
RR-08: Hospital Reentry Respite Beds	CTD Goal 3 - activity: Promoting timely access to appropriate care	
RR-09: Recovery Café	SUD Goal 3 - activity: Peer recovery services	
RR-10: Behavioral Health Employment Services and Supported Employment	SUD Goal 3 - activity: Employment supports	
RR-11: Peer Bridgers and Peer Support Pilot	CTD Goal 3 - activity: Care navigation, including peer navigation and care coordination SUD Goal 3 - activity: Peer recovery services	Peer Bridgers (RR-11A) fits under CTD Goal 3 and SUD Peer Support (RR-11B) fits under SUD Goal 3

Former MIDD Program and Number	Aligned "Bridge" Anticipated Activity	Notes
RR-12: Jail-Based Substance Abuse Treatment	SUD Goal 2 - activity: SUD treatment for incarcerated people	
RR-13: Deputy Prosecuting Attorney for Familiar Faces	CTD Goal 1 - activity: Services for people with behavioral health conditions who have cycled repeatedly through the criminal-legal system	
RR-14: Shelter Navigation Services	n/a	Already ended (before 2026-2027 biennium)
RR-15: PreTrial Assessment and Linkage Services (PALS)	n/a	Intended to shift to General Fund before 2028
SI-01: Community-Driven Behavioral Health Grants for Cultural and Ethnic Communities	EA Goal 2: activity: Community-driven culturally and linguistically responsive services and programs that support behavioral health outside of clinical settings EA Goal 2: activity: BH treatment services tailored for priority populations	Current activities of SI-01 that are more upstream in nature would fall under the first activity ("outside of clinical settings"), while treatment services would fall under the second activity.
SI-02: Behavioral Health Services in Rural King County	EA Goal 2: activity: Community-driven culturally and linguistically responsive services and programs that support behavioral health outside of clinical settings EA Goal 2: activity: BH treatment services tailored for priority populations	Current activities of SI-02 that are more upstream in nature would fall under the first activity ("outside of clinical settings"), while treatment services would fall under the second activity.
SI-03: Quality Coordinated Outpatient Care	CTD Goal 3 - activity: Technology investments to facilitate care coordination across all levels of care	
SI-04: Workforce Development	WF Goal 2 - activity: continuing education for community behavioral health providers	
TX-ADC: Adult Drug Court	CTD Goal 1 - activity: Behavioral health services and supports for people involved in the legal system, including therapeutic courts	
TX-FTC: Family Treatment Court	CTD Goal 1 - activity: Behavioral health services and supports for people involved in the legal system, including therapeutic courts	
TX-JTRAC-BHR: Juvenile Therapeutic Response and Accountability Court - Behavioral Health Response	CYYA Goal 2 - activity: Diversion and supportive services for youth involved, or at-risk of involvement, in the criminal-legal system	
TX-RMHC: Regional Mental Health Court	CTD Goal 1 - activity: Behavioral health services and supports for people involved in the legal system, including therapeutic courts	
TX-SMC: Seattle Mental Health Municipal Court	CTD Goal 1 - activity: Behavioral health services and supports for people involved in the legal system, including therapeutic courts	
TX-CCPL: Community Court Planning	CTD Goal 1 - activity: Behavioral health services and supports for people involved in the legal system, including therapeutic courts	

Metropolitan King County Council
Staff Report

Committee:	Health, Housing, and Human Services		
Agenda Item:	7	**Analyst(s):**	Sam Porter
Proposed No.:	2026-0174	**Meeting Date:**	July 23, 2026

OVERVIEW

TOPIC: An ordinance to rename the Mental Illness and Drug Dependency behavioral health sales tax fund and Advisory Committee the "Behavioral Health Bridge" and making additional changes to the Advisory Committee.

LEGISLATION SUMMARY

Proposed Ordinance 2026-0174 would rename and revise the Mental Illness and Drug Dependency (MIDD) fund and Advisory Committee to the Behavioral Health Bridge fund and Advisory Committee and make additional changes to the Advisory Committee. This legislation is a mandatory dual referral to Health, Housing, and Human Services Committee, then the Regional Policy Committee.

KEY ISSUES FROM THE ANALYSIS

A. Duty Changes. Proposed Ordinance 2026-0174 would change the duties of the Advisory Committee from "review and report to the Executive and Council" to "review and provide guidance on Behavioral Health Bridge annual reports."

B. Membership Changes. Proposed Ordinance 2026-0174 would change two representatives of behavioral health consumer interests and community interests to two positions representing behavioral health consumer interests who have lived experience with behavioral health conditions.

C. Reserve Change. Proposed Ordinance 2026-0174 would remove the New Strategy Reserve because it was not included in the transmitted implementation plan and is no longer funded. Removing the New Strategy Reserve is a policy choice.

BACKGROUND & TIMING CONSIDERATIONS

MIDD Sales Tax History. In 2005, the Washington State Legislature provided a funding option enabling county legislative authorities to raise the local sales tax by one tenth of one percent to fund behavioral health and therapeutic court programs. By law, funds raised by this tax are to be dedicated to new or expanded behavioral health services and new or expanded therapeutic court programs. Furthermore, RCW 82.14.460(3) requires that every

county that authorizes this tax must operate a therapeutic court for dependency proceedings.

The MIDD sales tax was first adopted in 2007 through Ordinance 15949 (MIDD I 2008-2016), and renewed again in 2016 through Ordinance 18333 (MIDD II 2017-2025) and most recently in 2025 through Ordinance 19976 (MIDD III 2026-2035). In August 2016, the Executive transmitted the MIDD II service improvement plan (SIP) to guide MIDD II investments. The SIP was approved through Ordinance 18406 in November 2016, and notes that stakeholder feedback indicated concern that the name of the sales tax is outdated and recommends a plan to select a new name for the tax.

In accordance with the 2026-2027 Biennial Budget Ordinance 20023, Expenditure Restriction 6 on the MIDD appropriation unit, MIDD expenditures shall remain consistent with the MIDD II SIP[1], Implementation Plan[2], and the Evaluation Plan[3].

From 2017 through 2025, MIDD programs served more than 130,000 unduplicated residents.

MIDD Advisory Committee. The 37-member King County MIDD Advisory Committee (K.C.C. 2.130.010) is composed of separately elected officials, King County agency directors, representatives of behavioral health service providers, managed care organizations operating in King County, and individuals with lived experience. The committee acts as an advisory body to the Council and the Executive.

In accordance with King County Code, the Advisory Committee is tasked with:

- Reviewing and providing written recommendations to the Executive and Council on the implementation and effectiveness of the county's MIDD sales tax-funded programs in meeting the goals;
- Reviewing and reporting to the Executive and the Council on annual evaluation reports for MIDD;
- Reviewing and commenting on emerging and evolving priorities for the use of MIDD sales tax revenue;
- Serving as a forum to promote coordination and collaboration between entities involved with MIDD sales tax programs;
- Educating the public, policymakers, and stakeholders on MIDD sales tax-funded programs; and
- Coordinating and sharing information with other related efforts and groups.

[1] Ordinance 18406
[2] Motion 15093
[3] Motion 15058

ANALYSIS

Transmitted in tandem with the Behavioral Health Bridge sales tax implementation plan,[4]Proposed Ordinance 2026-0174 would change the name of the sales tax from Mental Illness and Drug Dependency to Behavioral Health Bridge. The term "behavioral health" encompasses both mental illness and drug dependency, also referred to as substance use disorders. The transmittal states this proposed change is because the terms "mental illness and drug dependency" no longer reflect the values and priorities that guide behavioral health work today and that the terms contribute to stigma. Executive staff indicate that the new name is responsive to community feedback, and the proposed title of "Behavioral Health Bridge" was selected because the programs and services funded through the tax, "bridge critical gaps in behavioral health funding left by insufficient federal and state resources, and help create a bridge between people experiencing mental health or substance use disorder-related needs, community behavioral health treatment services, other systems people interact with including the criminal legal system, and pathways to recovery."

Section 1. Advisory Committee Changes. Section 1 of the proposed ordinance makes changes to the Advisory Committee. In addition to revising the name to Behavioral Health Bridge Advisory Committee, the proposed ordinance updates reference to expired portions of King County Code, and references to groups such as All Home, the Regional Human Services Levy Citizen Oversight Board, and the Adult and Juvenile Justice Operational Master Plan Advisory Groups which no longer exist.

> **Key Issue A. Advisory Committee Duty Changes.** The proposed ordinance changes the activities the Advisory Committee is tasked with, from "review and report to the Executive and Council" to "review and provide guidance on Behavioral Health Bridge annual reports." Executive staff state that this change is intended to, "better reflect the MIDD Advisory Committee's current role and engagement regarding the annual report process. The Advisory Committee, which includes representatives from the Executive and the Council, reviews, provides feedback, and approves the annual report that the Behavioral Health and Recovery Division drafts but the Advisory Committee has not historically reported directly to the Executive or Council." The proposed change in Advisory Committee duties reflects a policy choice.

[4] Proposed Ordinance 2026-0177, https://mkcclegisearch.kingcounty.gov/LegislationDetail.aspx?ID=8125181&GUID=F7713E11-9782-46B6-9FF7-91FC684D6BB2&Options=Advanced&Search=

Section 1 also changes the representative on the Advisory Committee for All Home to an entity serving individuals experiencing homelessness in King County. All Home, which no longer exists, served individuals experiencing homelessness in King County.

> **Key Issue B. Advisory Committee Membership Changes.** Additionally, the proposed ordinance replaces positions for an individual representing behavioral health consumer interests and an individual representing community interests from the MIDD Consumers and Communities Ad Hoc Work Group with two positions representing behavioral health consumer interests who have lived experience with behavioral health conditions. Executive staff state that "During the renewal process, the MIDD Advisory Committee advised adding additional members with lived experience. Changing the seats to focus on individuals with lived experience allows the Advisory Committee to draw from a broader pool of prospective members while fulfilling the same goals of having community and consumer representation." The proposed change from these positions as representatives of behavioral health consumer interests and community interests to two positions representing behavioral health consumer interests who have lived experience with behavioral health conditions represents a policy choice. Executive staff indicate that there are additional positions on the MIDD AC that unofficially represent consumer and community interests.

Section 2. Updated Outdated References. Section 2 would update an outdated reference to the MIDD Oversight Board to the Behavioral Health Bridge Advisory Committee as it pertains to coordinating with other county boards and groups regarding the Youth Action Plan. This section would also remove outdated reference to the Regional Human Services Levy Citizen Oversight Board which no longer exists.

Section 3. Recodify Code Section. Section 3 would recodify the revised Behavioral Health Bridge fund in a new section of K.C.C. chapter 4A.200 as recommended by the Code Reviser.

Section 4. Fund Name Change. Section 4 would update the name of the MIDD fund to the Behavioral Health Bridge fund.

> **Key Issue C. New Strategy Reserve Fund Change.** Section 4 would also remove the New Strategy Reserve fund from King County Code. According to Executive staff, the MIDD 2 initiative SI-05: Emerging Issues in Behavioral Health was launched in the 2023-2024 biennium through a partnership with the MIDD Advisory Committee and served the purpose of the New Strategy Reserve fund. Executive staff state that during the 2023-2024 biennium, "SI-05 funded four time-limited projects, including Seattle Public Schools creation of a substance use reduction workgroup,

virtual parent education sessions, standardized training evaluations, and tools to support classroom education implementation. It also funded the Y+ Master's in Mental Health Counseling Program and the development of culturally congruent behavioral health models with the Tubman Center for Health & Freedom, as well as a project by Lutheran Family Services focused on Muslim Trauma Healing. The Council-approved biennial budgets for 2025 and 2026-2027 allocated $0 to SI-05." The removal of the New Strategy Reserve fund is proposed because the strategy SI-05 is no longer funded and Executive staff state it "has historically been challenging to administer under short timelines and in response to new and emerging needs." Executive staff indicate that "DCHS hopes that innovative and best practice programs will be funded in the future through the Bridge and the [implementation] plan supports the ability for that to occur in any of the strategy or goal areas."

In addition to the standard reserves, the transmitted implementation plan does include a sustainability reserve from 2028 through 2031 to mitigate the projected decrease in sales tax revenues due to 2026 changes to state law allowing many products and services to be exempt from sales tax in Washington State starting in 2029.

Removing the New Strategy Reserve fund from King County Code is a policy choice. The New Strategy Reserve fund was not included in the transmitted implementation plan's financial plan and the strategy associated with it is no longer funded. If the new strategy reserve is retained an amendment may be needed to the implementation plan's financial plan to include the fund.

Section 5. Update Name in Housing and Community Development Fund. Section 5 would update the name of MIDD housing services moneys in the Housing and Community Development fund to the Behavioral Health Bridge housing services moneys.

There is no fiscal impact of the proposed ordinance according to the fiscal note.

Council's legal counsel has reviewed the proposed ordinance.

INVITED

- Isabel Jones – Interim Director, BHRD
- Laura Smith – MIDD Renewal Manager, BHRD
- Susan Mclaughlin – Director, DCHS
- Liz Arjun – Behavioral Health Policy Lead, Office of the Executive

ATTACHMENTS

1. Proposed Ordinance 2026-0174
2. Transmittal Letter
3. Fiscal Note

1200 King County Courthouse
516 Third Avenue
Seattle, WA 98104

KING COUNTY

Signature Report

Ordinance

Proposed No. 2026-0174.1 **Sponsors** Mosqueda

AN ORDINANCE renaming and revising the mental illness and drug dependency fund and the mental illness and drug dependency advisory committee; amending Ordinance 16077, Section 4, as amended, and K.C.C. 2.130.010, Ordinance 18217, Section 2, as amended, and K.C.C. 2A.300.510, Ordinance 15955, Section 2, as amended, and K.C.C. 4A.200.430, and Ordinance 16693, Section 3, as amended, and K.C.C 24.22.020, adding a new section to K.C.C. chapter 4A.200, and recodifying K.C.C. 4A.200.430.

STATEMENT OF FACTS:

1. The one-tenth of one percent sales and use tax supporting behavioral health programs and services and therapeutic court programs and services authorized by RCW 82.14.460 and K.C.C. 4A.500.315, which has been known in King County as the mental illness and drug dependency ("MIDD") sales and use tax, generates significant local revenue each year to support behavioral health care in the county.

2. For more than eighteen years, this tax has helped make behavioral health treatment and related services more available, accessible, and effective for King County residents.

3. While the tax remains a critical source of funding for the region's behavioral health services, the "mental illness and drug dependency" name no longer reflects the values and priorities that guide behavioral health work today. Behavioral health providers, partners, and community members have shared that the "mental illness and drug dependency" name contributes to stigma around behavioral health.

4. The programs and services supported by the tax bridge critical gaps in behavioral health funding left by insufficient federal and state resources, and help create a bridge between people experiencing mental health or substance use disorder-related needs, community behavioral health treatment services, other systems people interact with including the criminal legal system, and pathways to recovery. As a result, it is appropriate to rename the tax, fund, advisory committee, and associated plans, programs, and services that have used the "MIDD" and "mental illness and drug dependency" name since 2007 to recognize their collective role as the King County "behavioral health bridge."

5. The proposed purpose, role, and activities of the behavioral health bridge advisory committee remain consistent with the established purpose, role, and activities of the committee.

6. The proposed King County behavioral health bridge implementation plan includes a financial plan that no longer contains a new strategy reserve, but instead includes a sustainability reserve to ensure program stability despite volatile revenue.

BE IT ORDAINED BY THE COUNCIL OF KING COUNTY:

SECTION 1. Ordinance 16077, Section 4, as amended, and K.C.C. 2.130.010 are hereby amended to read as follows:

A. There is hereby established a King County ((~~mental illness and drug dependency~~)) behavioral health bridge advisory committee.

B.1. The advisory committee shall act as an advisory body to the county executive and council. The advisory committee shall conduct reviews, provide comment on and make recommendations on the ((~~mental illness and drug dependency~~)) behavioral health bridge tax-funded initiatives, services, and programs ((~~and policy goals outlined in Ordinance 15949, Section 3, as amended, and K.C.C. 4A.500.340 and consistent with the mental illness and drug dependency service improvement plan that is approved in accordance with Ordinance 17998~~)). The advisory committee shall provide ongoing review, comments and recommendations on ((~~mental illness and drug dependency~~)) behavioral health bridge tax-funded programs until all sales tax revenues have been expended and the final evaluation of the ((~~mental illness and drug dependency~~)) behavioral health bridge programs and services has been submitted to the council.

2. The advisory committee shall:

a. review and provide written recommendations to the executive and the council on the implementation and effectiveness of the county's sales tax funded

programs in meeting the ((~~goals~~)) purpose established in ((~~Ordinance 15949, Section 3, as amended, and K.C.C. 4A.500.300 through 4A.500.340~~)) K.C.C. 4A.500.315 and the goals described in implementation plans that guide the uses of the behavioral health bridge fund;

b. review and ((~~report to the executive and the council~~)) provide guidance on behavioral health bridge annual ((~~evaluation~~)) reports ((~~as required by Ordinance 15949, Section 3, as amended, and K.C.C. 4A.500.300 through 4A.500.340~~));

c. review and make comment on emerging and evolving priorities for the use of the ((~~mental illness and drug dependency~~)) behavioral health bridge sales tax revenue;

d. serve as a forum to promote coordination and collaboration between entities involved with sales tax programs;

e. educate the public, policymakers and stakeholders on ((~~mental illness and drug dependency~~)) the behavioral health bridge sales tax funded programs; and

f. coordinate and share information with other related efforts and groups.

C. The advisory committee shall be composed of one representative from each of the following:

1. The council;

2. The executive;

3. The superior court;

4. The district court;

5. The prosecuting attorney's office;

6. The sheriff's office;

7. The department of public health;

8. The department of judicial administration;

9. The department of adult and juvenile detention;

10. The department of community and human services;

11. A provider of both mental health and chemical dependency services in King County;

12. A provider of culturally specific mental health services in King County;

13. A provider of culturally specific chemical dependency services in King County;

14. A representative of an organization with expertise in helping individuals with behavioral health needs in King County get jobs and live independent lives;

15. A provider of domestic violence prevention services in King County;

16. A provider of sexual assault victim services in King County;

17. An agency providing mental health and chemical dependency services to youth;

18. Harborview Medical Center;

19. ((~~All Home~~)) An entity serving individuals experiencing homelessness in King County;

20. King County systems integration initiative, which is an ongoing work group established by the executive for addressing juvenile justice matters;

21. The Community Health Council;

22. The Washington State Hospital Association, representing King County hospitals;

23. The Sound Cities Association;

24. The city of Seattle;

25. The city of Bellevue;

26. Labor representing a bona fide labor organization;

27. The office of the public defender;

28. The National Alliance on Mental Illness;

29. Puget Sound educational services district;

30. A representative of a philanthropic organization;

31. The King County behavioral health advisory board;

32. A representative of an organization with expertise in recovery;

33. A representative of the five managed care organizations operating in King County;

34. ((~~An~~)) Two individuals representing behavioral health consumer interests ((~~from the mental illness and drug dependency advisory committee's consumers and communities ad hoc work group;~~

~~35. An individual representing community interests from the mental illness and drug dependency advisory committee's consumers and communities ad hoc work group~~)) who have lived experience with behavioral health conditions;

((~~36.~~)) 35. A representative of a grassroots organization serving a cultural population or cultural populations; and

((37.)) 36. A representative of unincorporated King County.

D.1. Separately elected officials and King County agency directors or their designees are not required to be appointed or confirmed.

2. A member of the advisory committee who has been confirmed to serve on another county board or commission is not required to be confirmed to serve on the advisory committee.

3. All other members of the advisory committee are subject to appointment by the county executive and confirmation by the county council.

4. The executive shall appoint advisory committee members to staggered terms in accordance with K.C.C. 2.28.010.C.

E.1. The advisory committee shall adopt rules governing its operations at its first meeting.

2. The committee shall elect a chair or cochairs.

3. Subcommittees and workgroups may be formed at the discretion of the advisory committee.

4. At each meeting of the advisory committee, the advisory committee shall provide an open comment period.

F. The advisory committee shall coordinate with other county groups including, but not limited to, ((~~the All Home coordinating board, the regional human services levy citizen oversight board,~~)) the veterans, seniors, and human services levy citizen ((~~oversight~~)) board, the children and youth advisory board, the behavioral health advisory ((~~and recovery~~)) board, and the board of health ((~~and the adult and juvenile justice operational master plan advisory groups~~)), or their successors, to ensure that information is shared and, when appropriate, efforts are coordinated and not duplicated.

G. The behavioral health and recovery division of the department of community and human services shall provide staffing of the advisory committee.

H. Members of the advisory committee who are not full-time county employees may be reimbursed for parking expenses in the King County parking garage when attending meetings of the committee.

SECTION 2. Ordinance 18217, Section 2, as amended, and K.C.C. 2A.300.510 is hereby amended to read as follows:

A. For the purposes of this section:

1. "Best Starts for Kids children and youth strategies" means those strategies that are eligible expenditures as defined in Ordinance 19267, Section 4.C.1. and 2., Section 4.D. and Section 4.E.;

2. "Collective impact" means a process for achieving meaningful and sustainable progress on complex social issues that involves convening stakeholders across sectors and communities, who share a common vision and a shared agenda for assuring accountability and measuring results; and

3. "Youth Action Plan" means the Youth Action Plan approved under Motion 14378.

B. As recommended in the Youth Action Plan and as required by Ordinance 18088 and 19267, the King County children and youth advisory board is created to act in an advisory capacity to the executive and council to:

1. Assist King County policy makers as they consider outcomes, policies and investments for children and families and youth and young adults; and

2. Serve as the Best Starts for Kids children and youth strategies oversight and advisory body, including making recommendations on and monitoring the distributions

of levy proceeds described in Ordinance 19267, Section 4.C.1. and 2., Section 4.D. and Section 4.E..

C. The goal of the board is to improve the health and well-being of children and youth by utilizing a collective impact model to implement strategies that focus on prevention and early intervention.

D.1. The board shall make recommendations to the executive and county council regarding children and youth services, consistent with the recommendations in the Youth Action Plan.

2. The board shall receive and review King County outcomes and data, recommending improvements and modifications to achieve outcomes and support strong data collection and indicator protocols.

3. The board shall assist the executive and the council with the comprehensive review and analysis of King County government's programs, services and outcomes for children, families, youth and young adults for alignment with other initiatives and coalitions that have outcomes identified for children, families, youth and young adults.

4. The board shall recommend policy, budget, and other findings to the executive and the council, ensuring alignment with other initiatives and coalitions that have outcomes identified for children, families, youth and young adults.

5. The board shall participate with, track and report on efforts of partnerships, coalitions and networks throughout the region to inform the development of an aligned, region wide response that leads to improved outcomes.

6. The board shall be a forum for discussion and exchange of ideas in response to emergent needs, promising practices, and continuous improvement.

E. The board shall provide oversight for the Best Starts for Kids children and youth strategies outlined in the Best Starts for Kids implementation plan. The board shall:

1. Advise on development of indicators and targets for Best Starts for Kids children and youth strategies;

2. Monitor the distribution of best starts for kids levy proceeds;

3. Work in collaboration with executive staff on any recommended changes to the children and youth strategies in the Best Starts for Kids implementation plan; and

4. Consult on and review annual reports to the council and community that demonstrate transparency regarding the expenditure of levy proceeds and the effectiveness of the best starts for kids children and youth strategies in meeting the goals and outcomes established in Ordinance 19267.

F. The board may establish standing and ad hoc work groups focusing on specific components of children and youth services and Best Starts for Kids strategies. Individuals or representative from entities whose work is closely related to children and youth prevention and early intervention strategies may be invited to participate in work groups as nonvoting members.

G. Consistent with a collective impact model, the board shall:

1. Review and advise the executive and council on emerging and evolving best and promising practices to improve the health and well-being of children and youth;

2. Coordinate with other county boards and groups including, but not limited to, the steering committee to address juvenile justice disproportionality, the ((~~mental illness and drug dependency oversight board~~)) behavioral health bridge advisory committee, ((~~the regional human services levy citizen oversight board,~~)) and the veterans, seniors,

and human services levy advisory ((~~citizen oversight~~)) board, to maximize the impact of the county's children and youth services;

3. Serve as a forum to promote coordination and collaboration between entities involved in improving the health and well-being of children and youth; and

4. Coordinate and share information with other related external efforts and groups.

H. The board shall adopt rules governing its operations at its first meeting, which may be revised in subsequent meetings.

I.1. The board shall be composed of not more than forty members, at least five of whom shall be youth age twenty-four or under.

2. As required by Ordinance 18088, the board shall be comprised of a wide array of King County residents and stakeholders with geographically and culturally diverse perspectives.

3. Members of the advisory board shall be appointed by the executive and confirmed by the council.

J. Terms for members of the board shall be for three years.

K. In accordance with K.C.C. 2.28.006, youth members aged twenty-four years old and younger of the board who are neither employees of King County nor employees of other municipal governments shall receive compensation. The initial compensation shall be one hundred twenty-five dollars per meeting and shall not exceed one hundred twenty-five dollars per month before December 31, 2022. Beginning January 1, 2023, the compensation amount per meeting and the maximum compensation amount per month shall be automatically adjusted annually, and every year thereafter, at the rate

equivalent to the twelve-month change in the U.S. Department of Labor, Bureau of Labor Statistics Consumer Price Index for All Urban Consumers for the Seattle-Tacoma-Bellevue Statistical Metropolitan Area, which is known as "the CPI-U." However, if the twelve-month change in the CPI-U is negative, there shall not be an adjustment.

L. The board shall provide support to enable youth board members aged twenty-four years old and younger to earn service-learning hours and community service hours for their participation on the board, where participation so qualifies.

SECTION 3. K.C.C. 4A.200.430, as amended by this ordinance, is recodified as a new section in K.C.C. chapter 4A.200.

SECTION 4. Ordinance 15955, Section 2, as amended, and K.C.C. 4A.200.430 is hereby amended to read as follows:

A. There is hereby created the ((~~mental illness and drug dependency~~)) behavioral health bridge fund.

B. The fund shall be a first tier fund. It is a special revenue fund.

C. The director of the department of community and human services shall be the manager of the fund.

D. The fund shall account for the proceeds of an additional one-tenth of one percent sales tax imposed by the county as authorized in RCW 82.14.460.

E.((~~1. In accordance with K.C.C. chapter 4.33, t~~))The proceeds of the sales tax shall be used solely for the purpose of providing new or expanded chemical dependency or mental health treatment services and for the operation of new or expanded therapeutic court programs and shall not be used to supplant existing funding for these purposes, except as authorized in RCW 82.14.460(4).

((~~2.a. In order to reserve funds for new strategies not currently specified in the implementation plan, a new strategy reserve is hereby created in the mental illness and drug dependency fund. The purpose of the reserve is to fund new strategies and programs that meet the county's policy goals established in K.C.C. 4.33.010.~~

~~b. Mental illness and drug dependency programs or strategies that are financed from the new strategy reserve shall receive financing from the reserve. A project or strategy funded from the new strategy reserve shall not utilize more than twenty percent of the total annual new strategy reserve amount. The annual new strategy reserve amount is based on the later of either the annual mental illness and drug dependency fund financial plan as transmitted by the executive with the proposed annual county budget or as amended by ordinance. Funding new strategies from the new strategy reserve shall commence when the ordinance approving the new strategy is enacted. These programs and strategies shall be reviewed as part of the annual mental illness and drug dependency evaluation cycles.~~

~~c. The new strategy reserve shall be limited to five million dollars.~~

~~d. All unencumbered funds in the new strategy reserve shall be transferred to the undesignated fund balance.~~

~~e. In 2011 and thereafter, the new strategy reserve shall be replenished each year by allocating up to one half of the mental illness and drug dependency fund's previous ending year's undesignated fund balance less the target fund balance to the reserve until the five-million-dollar limit is reached.~~))

SECTION 5. Ordinance 16693, Section 3, as amended, and K.C.C. 24.22.020 is hereby amended to read as follows:

The interim loan program will add to the stock of housing for low-income and special needs residents of King County by facilitating acquisition of low-income housing using homeless housing and services program moneys and ((~~mental illness and drug dependency~~)) behavioral health bridge housing services moneys in the housing and community development fund. These funding sources are collected and awarded to projects annually but are spent down in a manner that creates a fund balance that is carried over from year to year. The interim loan program will allow the county to loan moneys from these low-cost fund balances to experienced housing developers on a short-term, interim basis to acquire property for affordable and homeless housing for households at or below fifty percent of area median income for King County. Interim loans will be awarded only when the project sponsor can provide satisfactory assurances of project feasibility such that permanent funding for the project is highly likely to be secured and the interim loan amount will be repaid within a reasonable ((~~period of~~)) time,

not to exceed five years. No more than fifteen million dollars shall be made available for interim loans at any time.

KING COUNTY COUNCIL
KING COUNTY, WASHINGTON

_____

Sarah Perry, Chair

ATTEST:

_____

Melani Pedroza, Clerk of the Council

APPROVED this _____ day of _____, _____.

_____

Girmay Zahilay, County Executive

Attachments: None

King County | Office of the Executive

Executive Girmay Zahilay
Chinook Building, CNK-EX-0800
401 Fifth Avenue, Suite 800
Seattle, WA 98104-2391

July 1, 2026

The Honorable Sarah Perry
Chair, King County Council
Room 1200
C O U R T H O U S E

Dear Councilmember Perry:

This letter transmits a proposed Ordinance that would, if adopted, rename and revise the Mental Illness and Drug Dependency ("MIDD") fund and the MIDD Advisory Committee, updating the King County Code to establish the new name King County Behavioral Health Bridge ("the Bridge") for the fund and advisory committee.

Responsive to community feedback, the proposed new "King County Behavioral Health Bridge" name replaces the outdated language in the phrase "mental illness and drug dependency" that no longer reflects the values and priorities that guide behavioral health work today and contributes to stigma around behavioral health. The new name emphasizes the role of sales tax-funded programs in creating a bridge between people experiencing behavioral health conditions and community behavioral health treatment, other systems people interact with including the criminal-legal system, and pathways to recovery.

Investments through this fund support programs that improve health and wellness, recovery, and connection to community, especially for people most affected by inequities related to race, income, housing status, and access to care. From 2017 through 2025, these programs served over 130,000 unduplicated King County residents.

The King County Behavioral Health Bridge is projected to generate nearly $800 million for behavioral health care in King County between 2028 and 2034. The King County Behavioral Health Bridge Implementation Plan for 2028-2034, which I am proposing for Council adoption through a separate concurrent transmittal, invests strategically to break the cycle and prevent incarceration, hospitalization, homelessness, and crisis for low-income people with mental health and

substance use conditions. The proposed Plan reflects and further describes the name change in this proposed Ordinance.

I look forward to working with the Council to provide access to high-quality behavioral health care for King County residents. Thank you for considering this important proposed Ordinance to ensure that the updated name for this fund and advisory committee, as well as associated plans, programs, and services, likewise reflects their role as a bridge to long term recovery, stability, and wellbeing.

If your staff have any questions, please contact Dr. Susan McLaughlin, Director of the Department of Community and Human Services, at 206-477-9309.

Sincerely,

for

Girmay Zahilay
King County Executive

Enclosure

cc: King County Councilmembers
ATTN: Stephanie Cirkovich, Chief of Staff
Melani Hay, Clerk of the Council
Karan Gill, Deputy Executive, Office of the Executive
Jasmin Weaver, Chief of Staff, Office of the Executive
Hyeok Kim, Chief Operating Officer, Office of the Executive
Sierra Howlett Browne, Director of Government Relations, Office of the Executive
Garrett Holbrook, Council Relations Manager, Office of the Executive
Dr. Susan McLaughlin, Director, Department of Community and Human Services

2026 FISCAL NOTE

Ordinance/Motion:	Ordinance
Title:	An ordinance renaming and revising the mental illness and drug dependency fund and the mental illness and drug dependency advisory committee; amending Ordinance 16077, Section 4, as amended, and K.C.C. 2.130.010, Ordinance 18217, Section 2, as amended, and K.C.C. 2A.300.510, Ordinance 15955, Section 2, as amended, and K.C.C. 4A.200.430, and Ordinance 16693, Section 3, as amended, and K.C.C 24.22.020, adding a new section to K.C.C. chapter 4A.200, and recodifying K.C.C. 4A.200.430.
Affected Agency and/or Agencies:	DCHS
Note Prepared By:	Scott Miller
Date Prepared:	6/3/2026
Note Reviewed By:	Kevin Lo
Date Reviewed:	6/3/2026

Description of request:

This proposed ordinance would rename and revise the Mental Illness and Drug Dependency (MIDD) fund and advisory committee to reflect the new name King County Behavioral Health Bridge. It includes other technical changes and updates related to the fund and advisory committee.

Revenue to:

Agency	Fund Code	Revenue Source	2026-2027	2028-2029	2030-2031
TOTAL			**0**	**0**	**0**

Expenditures from:

Agency	Fund Code	Department	2026-2027	2028-2029	2030-2031
TOTAL			**0**	**0**	**0**

Expenditures by Categories

	2026-2027	2028-2029	2030-2031
TOTAL	**0**	**0**	**0**

Does this legislation require a budget supplemental? No.

Notes and Assumptions:

Metropolitan King County Council
Staff Report

Committee:	Health, Housing, and Human Services		
Agenda Item:	8	**Analyst:**	Sam Porter
Proposed No.:	2026-0145	**Meeting Date:**	July 23, 2026

OVERVIEW

TOPIC: A proposed motion to acknowledge receipt of a plan to establish a Harborview Medical Center long-range planning committee.

LEGISLATION SUMMARY
Harborview Medical Center has entered a period of significant investment with capital and major maintenance projects. In response, the Council included a proviso on the 2026-2027 Biennial Budget that withholds $100,000 from the Office of Performance Strategy and Budget (PSB) budget until the Executive transmits a plan to establish a Harborview Medical Center long-range planning committee ("Committee") as described in Section 6.2 of the Harborview Hospital Services Agreement, and a motion approving the letter is passed by the Council.

Proposed Motion 2026-0145 would acknowledge receipt of the Plan (Attachment A, Harborview Long-Range Planning Committee Plan), which was transmitted on June 1, 2026. The transmittal letter and Attachment A to Proposed Motion 2026-0145, attempt to address the requirements of the proviso, however the transmitted Plan in Attachment A does not include names of appointed committee members as required by the proviso.

Council passage of the proposed motion would acknowledge receipt of the Plan and release the withheld $100,000 in appropriation authority.

KEY ISSUES FROM THE ANALYSIS

A. **Proviso Response.** The proviso requires that the Executive provide a Plan to establish a Harborview Medical Center long-range planning committee that includes the following:

A. The names of appointed committee members representing the county executive, the county council, the Harborview Medical Center board of trustees and UW Medicine;

B. A description of how the committee will facilitate long-range planning and coordination in pursuit of opportunities to respond to the evolving healthcare industry, improve population health, and have Harborview Medical Center become the provider of choice for county and state residents;

C. A description of shared goals, clear criteria for when the committee has completed its charge, and clear criteria for when a subsequent committee should be constituted, established by the committee;

D. A description of committee processes which will ensure the governance structures, accountabilities, and collective bargaining commitments of each committee member's respective organization will be respected; and

E. The frequency in which the committee shall meet in order to facilitate strong coordination and the identification and monitoring of the goals established among committee members. The committee should recommend the length of time that the committee shall meet.

It appears that the Plan discusses, but does not fully address, the information required in Section A, C, or D of the proviso. Council may wish to amend the Plan to address these items.

AMENDMENTS

- **Amendment 1** would replace transmitted Attachment A with a new Attachment A dated July 2026 that makes multiple substantive and technical changes to the Proviso report as detailed in the Amendment Section of this staff report.

BACKGROUND & TIMING CONSIDERATIONS

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Harborview Medical Center. Harborview serves as the Level 1 trauma center in the four-state region of Washington, Alaska, Idaho, and Montana. Harborview prioritizes serving the "mission population" including the non-English speaking poor, uninsured or underinsured, people who experience domestic violence, sexual assault, or are incarcerated in King County's jails, among others. Harborview is owned by King County, governed by a 13-member County-appointed Board of Trustees, and operated by the University of Washington.

2026-2027 Budget Proviso. Ordinance 20023, Section 17, Proviso P8, restricting $100,000 until a plan is transmitted is as follows:

"P8 PROVIDED FURTHER THAT:

Of this appropriation, $100,000 shall not be expended or encumbered until the executive transmits a plan to establish a Harborview Medical Center

long-range planning committee as described at Section 6.2 of the hospital services agreement and a motion that should acknowledge receipt of the plan, and a motion acknowledging receipt of the plan is passed by the council. The motion should reference the subject matter, the proviso's ordinance, ordinance section, and proviso number in both the title and body of the motion.

The plan shall include, but not be limited to:

A. The names of appointed committee members representing the county executive, the county council, the Harborview Medical Center board of trustees and UW Medicine;

B. A description of how the committee will facilitate long-range planning and coordination in pursuit of opportunities to respond to the evolving healthcare industry, improve population health, and have Harborview Medical Center become the provider of choice for county and state residents;

C. A description of shared goals, clear criteria for when the committee has completed its charge, and clear criteria for when a subsequent committee should be constituted, established by the committee;

D. A description of committee processes which will ensure the governance structures, accountabilities, and collective bargaining commitments of each committee member's respective organization will be respected; and

E. The frequency in which the committee shall meet in order to facilitate strong coordination and the identification and monitoring of the goals established among committee members. The committee should recommend the length of time that the committee shall meet.

The executive should electronically file the plan and a motion required by this proviso by June 1, 2026, with the clerk of the council, who shall retain an electronic copy and provide an electronic copy to all councilmembers, the council chief of staff, and the lead staff for the health, housing, and human services committee or its successor."

Harborview Hospital Services Agreement. The Hospital Services Agreement (HSA) Section 6.2 proposes a long-range planning committee as a system reform opportunity. The HSA states:

> *"The Parties shall coordinate in the pursuit of opportunities to respond to the evolving healthcare industry, improve population health and have the Medical Center become the provider of choice for County and state*

residents, including supporting the Medical Center's status as a major teaching hospital, the continuation and expansion of Research at the Medical Center. To facilitate long-range planning for success in achieving the goals of the County, the Board and UW Medicine, the Parties will establish a committee appointed with representatives from the County, the Board and UW Medicine to focus on long-range planning. The committee will meet as necessary and desirable to facilitate strong coordination and the identification and monitoring of goals established among the Parties. The committee will respect the governance structures, accountabilities and collective bargaining commitments of each Party."

Timing Considerations. Executive staff have indicated that they plan to convene the new committee after adoption of the Proposed Motion acknowledging receipt of the Plan. Executive staff state they could convene the new committee in September or sooner depending upon passage of the Proposed Motion.

ANALYSIS

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Key Issue A. Proviso Response. The proviso requires that the Executive provide a Plan to establish a Harborview Medical Center long-range planning committee as described in Section 6.2 of the Hospital Services Agreement. Proposed Motion 2026-0145 was transmitted on June 1, 2026, in response to Section 17, Proviso P8, in the 2026-2027 Biennial Budget. In addition to acknowledging receipt of the Plan, Council passage of the Proposed Motion would release the $100,000 in restricted appropriation on the Office of Performance, Strategy, and Budget.

Executive staff state that the Plan in Attachment A was developed by the Executive's Office in coordination with the King County Council, Harborview Board of Trustees, and UW Medicine.

A. The names of appointed committee members representing the county Executive, the county Council, the Harborview Medical Center Board of Trustees and UW Medicine;

The Plan does not provide names of appointed committee members as required by the proviso, but it does provide a breakdown of the membership structure among the participating entities including:

- The King County Council,
- The King County Executive's Office,
- The Harborview Board of Trustees (BoT),
- and UW Medicine.

Each participating entity would have 2 regular and 1 alternate members. Executive staff indicate that "the Plan respects the autonomy and independence of each individual entity and identified positions for each entity to choose how it feels fit" and therefore did not name individuals to serve in each position.

B. A description of how the committee will facilitate long-range planning and coordination in pursuit of opportunities to respond to the evolving healthcare industry, improve population health, and have Harborview Medical Center become the provider of choice for county and state residents;

The report states that the Committee would serve as a forum for the participating entities on matters affecting Harborview Medical Center, "including operating and capital needs, financial planning, health policy, and responsible stewardship of public resources." The report states that the Committee would "identify opportunities, risks, trade-offs, evaluate strategic options, and develop recommendations for consideration by the participating entities," and that the Committee would be advisory only and would not bind the participating entities. The report states that the Committee would serve as a forum to support a coordinated, forward-looking, and transparent approach to planning by discussing such topics as:

- Long-range and financial planning approved by the BoT's Finance Committee
- Reviewing Harborview's operating budget and long-term fiscal needs
- Harborview's clinical strategic plan as recommended by the Board's Strategic Planning Committee and the BoT
- Healthcare market analyses and related strategic assessments considered by the BoT's Strategic Planning Committee
- Capital planning and progress updates
- County tax and revenue forecasts, and
- Other relevant planning documents.

C. A description of shared goals, clear criteria for when the committee has completed its charge, and clear criteria for when a subsequent committee should be constituted, established by the committee;

The Plan states that the Committee will develop a charter within the first six months of convening which will include "shared goals, milestones, and benchmarks related to reviewing and making recommendations on the long-term sustainability of Harborview." The Plan states that the Committee will be advisory only, with a goal of "fostering transparent, deliberative, and open dialogue to identify opportunities, risks, trade-offs, and recommendations to the County, UW Medicine, and the Board."

The Plan states that in addition to the charter, the initial work product will be to develop and review an integrated financial plan for Harborview. The Committee will serve as a forum for discussing the integrated financial plan among the participating entities to "share efforts and priorities within their respective authorities under County Code, the Hospital Services Agreement, and other applicable laws and contracts." The integrated financial plan is intended to be "dynamic" such that it will allow the Committee to "evaluate scenarios to support operational and capital financing needs—including strategic investments, tax levy considerations, debt capacity and bond planning, reserve and asset allocation, and capital asset stewardship—and their impact on Harborview's mission." The integrated financial plan will address both short and long-term needs for operations and capital projects.

The Plan states that the Committee will share the results of this work six months after convening. The Council may wish to amend the Plan to clarify how the results of this work will be shared and with whom.

The Plan states that the Committee has completed its initial charge once the charter and integrated financial plan are in place. The Plan has conflicting language pertaining to the duration of the Committee. In one provision in Section C, it states that it is up to the Committee to identify the need for ongoing work, including regular review of the financial plan. However, Section C also states that the Committee shall remain operative throughout the remainder of the term of the current Hospital Services Agreement (unless otherwise decided by consensus of the Committee). The Council may wish to amend the plan to clarify the duration of the Committee or establish clearer criteria for when a subsequent committee should be constituted.

D. A description of committee processes which will ensure the governance structures, accountabilities, and collective bargaining commitments of each committee member's respective organization will be respected; and

The Plan states in Section D that, "the Committee shall be an advisory body, operated by consensus, and facilitating discussion between the County, UW Medicine, and the Harborview Board of Trustees," and be jointly chaired by the County and the CEO of Harborview. The Summary section at the start of the Plan states that the joint chairs would be between a representative from the County Executive and representative from the Harborview CEO. Executive staff stated it was their intent to have the County co-Chair be a representative from the Executive's Office. The Council may wish to amend the plan to clarify that the County's co-Chair would be a representative from the Executive's Office.

The Plan states that the Committee would develop a charter in the first six months of operating that includes operating principles and processes and will ensure that the Committee does not "supplant or duplicate" the responsibilities of the participating entities or the Hospital Services Agreement, and respects the collective bargaining commitment of each Committee member's respective organization.

E. The frequency in which the committee shall meet in order to facilitate strong coordination and the identification and monitoring of the goals established among committee members. The committee should recommend the length of time that the committee shall meet.

The Plan states that the Committee will meet twice per month initially to finalize its charter which is estimated to be completed in the first six months. Once the charter is completed, the Committee will determine how frequently it will continue to meet to complete its initial charge within one year. Executive staff indicate that they intend the committee to commence meeting beginning in September 2026 to allow time for the Council to pass the proviso.

Next steps. Council action on the transmitted Harborview Long-Range Planning Committee Plan (Proposed Motion 2026-0145) would acknowledge receipt of the report and release $100,000 that the budget ordinance encumbered from PSB's budget. As noted above, the transmitted report attempts to satisfy the requirements in the budget proviso but does not include the names of the members representing the participating entities. It is a policy choice for the Council whether the transmitted Plan and the additional information provided in this staff report is sufficient to release the encumbered appropriation authority.

Council's legal counsel has reviewed the proposed ordinance.

AMENDMENTS

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There is one amendment to the Proposed Ordinance as described in the table below. A compare document is attached to this staff report showing the changes from the transmitted proviso to the proviso dated July 26 that would be attached by Amendment 1.

Amendment	Sponsor	Effect Statement
1	Mosqueda	Replace transmitted Attachment A with a new Attachment A dated July 2026 that makes the following changes: • Would make the Chairs of the Health, Housing, and Human Services Committee, and the Committee of

Amendment	Sponsor	Effect Statement
		the Whole, the two regular members representing the King County Council. • Would add one alternate to each of the participating entities thereby creating four representatives for each. • Changes the Executive's Office representatives to being from the Executive Branch. • Clarifies that one of the regular members representing the Executive Branch would be designated co-Chair. • Clarifies that one of the regular members representing UW Medicine would be designated co-Chair. This is a change from the co-Chair representing the HMC CEO. • Adds language in Section B stating the responsibilities of the Harborview Board of Trustees as described in RCW 36.62.180. • Adds language in Section C encouraging the Committee to provide interim reports before the six-month deadline when doing so would support time-sensitive decisions; and identify anticipated external deadlines and incorporating those into its work plan. The Committee would transmit interim reports and final report to the Council Clerk to share with all Councilmembers. • Section C adds language stating, "it is expected that the Council will acknowledge receipt of the transmitted integrated financial plan by motion." • Requires that the Committee finalize its charter within two months and the final report within the first six months. This is a change from finalizing the charter within six months and the final report within a year. • Makes additional clarifying and technical changes as recommended by legal counsel.

INVITED

- Jeff Muhm, Special Advisor to the Executive's Leadership Team, King County Executive's Office
- Ian Goodhew, Chief External Affairs Officer, UW Medicine
- Madeline Grant, Chief Administrative Officer, Harborview Medical Center

ATTACHMENTS

1. Proposed Motion 2026-0145 (and its attachment)
2. Amendment 1 (and its attachment)
3. Amendment 1 Proviso Report Compare Document
4. Transmittal Letter

1200 King County Courthouse
516 Third Avenue
Seattle, WA 98104

KING COUNTY

Signature Report

Motion

Proposed No. 2026-0145.1 **Sponsors** Mosqueda

A MOTION acknowledging receipt of the Harborview Medical Center Long-Range Planning Committee Plan required by the 2026-2027 Biennial Budget Ordinance, Ordinance 20023, Section 17, Proviso P8.

WHEREAS, the 2026-2027 Biennial Budget Ordinance, Ordinance 20023, Section 17, Proviso P8, requires the executive to transmit a plan to establish a Harborview Medical Center long-range planning committee as described at Section 6.2 of the hospital services agreement, and

WHEREAS, Ordinance 20023, Section 17, Proviso P8, further requires the executive to submit a motion that acknowledges receipt of the Harborview Medical Center Long-Range Planning Committee Plan;

NOW, THEREFORE, BE IT MOVED by the Council of King County:

The receipt of the Harborview Medical Center Long-Range Planning Committee

Plan, which is Attachment A to this motion, in compliance with Ordinance 20023, Section 17, Proviso P8, is hereby acknowledged.

KING COUNTY COUNCIL
KING COUNTY, WASHINGTON

_____

Sarah Perry, Chair

ATTEST:

_____

Melani Pedroza, Clerk of the Council

APPROVED this _____ day of _____, _____.

_____

Girmay Zahilay, County Executive

Attachments: A. Harborview Medical Center Long-Range Planning Committee Plan

Harborview Medical Center Long-Range Planning Committee Plan

June 2026

King County

Summary
King County Ordinance 20023 requests that the Executive transmit a plan to establish a Harborview Medical Center long-range planning committee (Committee) as described in section 6.2 of the hospital services agreement.

Under the transmitted plan, the Committee will be comprised of the following participants:

- Three representatives from the King County Council, consisting of two regular members and one alternate
- Three representatives from the King County Executive's Office, consisting of two regular members and one alternate
- Three representatives of Harborview Board of Trustees, consisting of two regular members and one alternate
- Three representatives of UW Medicine, consisting of two regular members and one alternate.

The Committee will be jointly chaired by a representative from the King County Executive's office and a representative from the CEO of the Harborview Medical Center. The Committee will draft a charter and focus its work on understanding the long-term, financial, operational and capital needs of Harborview Medical Center (HMC) with the goal of making recommendations to the King County Executive, King County Council, Harborview Medical Center Board of Trustees and UW Medicine on strategies to meet those needs.

The Committee will work on a consensus basis and any recommendations by the Committee will be advisory in nature and will not bind or replace the independent decision-making authority or responsibilities of the participating entities.

Committee Establishment Plan

A. The names of appointed committee members representing the county executive, the county council, the Harborview Medical Center board of trustees and UW Medicine

The Long-Range Planning Committee (Committee) will include representatives from UW Medicine, Harborview Medical Center (HMC) Board of Trustees (BoT), the King County Council, and the King County Executive, as follows:

- Three representatives from the King County Council, consisting of two regular members and one alternate
- Three representatives from the King County Executive's Office, consisting of two regular members and one alternate
- Three representatives of Harborview Board of Trustees, consisting of two regular members and one alternate
- Three representatives of UW Medicine, consisting of two regular members and one alternate

B. *A description of how the committee will facilitate long-range planning and coordination in pursuit of opportunities to respond to the evolving healthcare industry, improve population health, and have Harborview Medical Center become the provider of choice for county and state residents;*

The Committee will facilitate long-range planning and coordination by serving as a forum for UW Medicine, King County, and the Harborview Board of Trustees on matters affecting Harborview Medical Center, including operating and capital needs, financial planning, health policy, and responsible stewardship of public resources. The Committee will identify opportunities, risks, trade-offs, evaluate strategic options, and develop recommendations for consideration by the participating entities. Recommendations by the Committee are advisory in nature and will not bind or replace the independent decision-making authority or responsibilities of the participating entities.

Consistent with the authorities established in the Hospital Services Agreement, UW Medicine manages the clinical and business operations of the Medical Center, the Board of Trustees oversees Harborview, and the County provides and maintains the facilities and is responsible for issuing bonds, collecting property taxes, and allocating those revenues. The Committee will operate within this framework to promote alignment without altering these distinct roles.

The Committee will also serve as a forum for synthesizing key planning inputs, exchanging and discussing planning information related to Harborview Medical Center. This may include:

- Long-range and financial planning approved by the Board's Finance Committee and the Board of Trustees

- Reviewing Harborview's operating budget and long-term fiscal needs
- Harborview's clinical strategic plan as recommended by the Board's Strategic Planning Committee and the Board of Trustees
- Healthcare market analyses and related strategic assessments considered by the Board's Strategic Planning Committee
- Capital planning and progress updates
- County tax and revenue forecasts, and
- Other relevant planning documents.

By bringing these inputs together, the Committee will support a coordinated, forward-looking, and transparent approach to planning that supports Harborview's long-term sustainability and viability.

C. A description of shared goals, clear criteria for when the committee has completed its charge, and clear criteria for when a subsequent committee should be constituted, established by the committee;

The Committee will have a clearly defined charter consistent with section 6.2 of the Hospital Services Agreement, including establishing shared goals, milestones, and benchmarks related to reviewing and making recommendations on the long-term sustainability of Harborview. These efforts may consider, but not be limited to, priorities of each entity, including: meeting the medical needs of the mission population; completing the hospital capital bond project as approved by voters; maintaining the infrastructure of HMC; ensuring sustainable operations; and long-term capital asset management planning. This work to produce the charter shall be completed within six months of the initial convening.

The Committee's initial work will also include developing and reviewing an integrated financial plan for Harborview, providing a forum for discussion among the Harborview Board, County Council, Executive's Office, and UW Medicine clinical leadership to share efforts and priorities within their respective authorities under County Code, the Hospital Services Agreement, and other applicable laws and contracts. The plan will be dynamic, enabling the committee to evaluate scenarios to support operational and capital financing needs —including strategic investments, tax levy considerations, debt capacity and bond planning, reserve and asset allocation, and capital asset stewardship—and their impact on Harborview's mission. It will address both short- and long-term needs for operations and capital projects, and integrate funding sources including Harborview's operating revenues, the 2020 bond program (and any successor bonds), the County Hospital Tax levy, and other relevant revenue sources. The Committee shall share the results of this work six months after convening.

Once this initial charge is complete, the Committee shall identify the need for ongoing work, including regular review of the integrated financial plan. If further work is needed, the committee may be reconvened at agreed upon intervals, but no more frequently than twice

per year, unless participating entities jointly determine that additional meetings are necessary.

The Committee will be advisory in nature, with a goal of fostering transparent, deliberative, and open dialogue to identify opportunities, risks, trade-offs, and recommendations to the County, UW Medicine, and the Board. The Committee can evaluate scenarios that require coordination across the entities and may vote to make consensus-based, non-binding recommendations to relevant parties. This committee shall remain operative throughout the remainder of the term of the current Hospital Services Agreement, unless otherwise decided by consensus of the Committee.

D. A description of committee processes which will ensure the governance structures, accountabilities, and collective bargaining commitments of each committee member's respective organization will be respected; and

The Committee shall be an advisory body, operated by consensus, and facilitating discussion between the County, UW Medicine, and the Harborview Board of Trustees. The committee will be jointly Chaired by a representative from the County and the CEO of Harborview Medical Center.

Upon convening, the Committee will develop a charter that includes operating principles and processes. The charter shall ensure that the Committee does not supplant or duplicate the responsibilities of the King County Council, the Harborview Board of Trustees, or the County or University of Washington under the Hospital Services Agreement, and respects the collective bargaining commitments of each committee member's respective organization. At its first meeting, the Committee will adopt a meeting schedule. The Committee shall have the authority to establish working groups to fill its charge.

E. The frequency in which the committee shall meet to facilitate strong coordination and the identification and monitoring of the goals established among committee members. The committee should recommend the length of time that the committee shall meet.

The Committee shall initially meet twice per month in order to finalize its charter. Upon completion of the charter, the Committee shall determine the appropriate cadence for subsequent meetings to complete its charge within one year. If Committee members agree to a different cadence, they may adjust the schedule by mutual consensus.

1

July 2, 2026
Replace Attachment A

[S. Porter]

Sponsor: Mosqueda

Proposed No.: 2026-0145

AMENDMENT TO PROPOSED ORDINANCE 2026-0145, VERSION 1

Strike Attachment A, Harborview Medical Center Long-Range Planning Committee Plan, June 2026, and insert Attachment A, Harborview Medical Center Long-Range Planning Committee Plan, July 2026

EFFECT prepared by *S. Porter*: *This amendment would replace the transmitted Attachment A with a new Attachment A dated July 2026 that does the following:*

- ***Would make the Chairs of the Health, Housing, and Human Services Committee, and the Committee of the Whole, the two regular members representing the King County Council.***
- ***Would add one alternate to each of the participating entities thereby creating four representatives for each.***
- ***Changes the Executive's Office representatives to being from the Executive Branch.***
- ***Clarifies that one of the regular members representing the Executive Branch would be designated co-Chair.***
- ***Changes the other co-Chair to representing UW Medicine instead of representing the Harborview CEO.***

- ***Adds language in Section B stating the responsibilitis of the Harborview Board of Trustees as described in RCW 36.62.180.***
- ***Adds language in Section C encouraging the Committee to provide interim reports before the six-month deadline when doing so would support time-sensitive decisions; and identify anticipated external deadlines and incorporating those into its work plan. The Committee would transmit interim reports and final report to the Council Clerk to share with all Councilmembers.***
- ***Section C adds language stating, "it is expected that the Council will acknowledge receipt of the transmitted integrated financial plan by motion."***
- ***Requires that the Committee finalize its charter within two months and the final report within the first six months.***
- ***Makes additional clarifying and technical changes as recommended by legal counsel.***

Harborview Medical Center Long-Range Planning Committee Plan

July 2026

King County

Summary
Proviso 8 to Section 17 of King County Ordinance 20023 directs the Executive to transmit a plan to establish a Harborview Medical Center long-range planning committee (Committee) as described in section 6.2 of the Hospital Services Agreement.

The Committee will draft a charter and focus its work on understanding the long-term, financial, operational and capital needs of Harborview Medical Center (HMC) with the goal of making recommendations to the King County Executive, King County Council, Harborview Medical Center Board of Trustees, and UW Medicine (collectively referred to as participating entities), on strategies to meet those needs.

The Committee will work on a consensus basis and any recommendations by the Committee will be advisory in nature and will not bind or replace the independent decision-making authority or responsibilities of the participating entities.

Required Elements

A. The names of appointed committee members representing the county executive, the county council, the Harborview Medical Center board of trustees and UW Medicine

The names of the Committee members are not yet available. However, the Committee will include representatives from UW Medicine, Harborview Medical Center (Harborview) Board of Trustees (Board), the King County Council, and the King County Executive, as follows:

- Four representatives from the King County Council, consisting of two regular members and two alternates. The Chair of the Health, Housing, and Human Services Committee, and the Chair of the Committee of the Whole shall be the two regular members.
- Four representatives from the King County Executive branch, consisting of two regular members and two alternates. The Executive shall designate one of the Executive branch two regular members as one of the Committee's co-chair.
- Four representatives of Harborview Board of Trustees, consisting of two regular members and two alternates.
- Four representatives of UW Medicine, consisting of two regular members and two alternates. UW Medicine shall designate one of its two regular members as one of the Committee's co-chair.

B. *A description of how the committee will facilitate long-range planning and coordination in pursuit of opportunities to respond to the evolving healthcare industry, improve*

population health, and have Harborview Medical Center become the provider of choice for county and state residents.

The Committee will facilitate long-range planning and coordination by serving as a forum for UW Medicine, King County, and the Harborview Board of Trustees on matters affecting Harborview Medical Center, including operating and capital needs, financial planning, health policy, and responsible stewardship of public resources. The Committee will identify opportunities, risks, trade-offs, evaluate strategic options, and develop recommendations for consideration by the participating entities. Recommendations by the Committee are advisory in nature and will not bind or replace the independent decision-making authority or responsibilities of the participating entities.

Consistent with the authorities established in the Hospital Services Agreement, UW Medicine manages the clinical and business operations of the Medical Center, the Board of Trustees has general supervision and care of Harborview Medical Center within the limits of approved budgets and authorized appropriations, and the County provides and maintains the facilities and is responsible for issuing bonds, collecting property taxes, and appropriating those revenues. The Committee will operate within this framework to promote alignment without altering these distinct roles.

The Committee will also serve as a forum for synthesizing key planning inputs, exchanging and discussing planning information related to Harborview Medical Center. This may include:

- Long-range and financial planning approved by the Board's Finance Committee and the Board of Trustees
- Reviewing Harborview's operating budget and long-term fiscal needs
- Harborview's clinical strategic plan as recommended by the Board's Strategic Planning Committee and the Board of Trustees
- Healthcare market analyses and related strategic assessments considered by the Board's Strategic Planning Committee
- Capital planning and progress updates
- County tax and revenue forecasts, and
- Other relevant planning documents.

By bringing these inputs together, the Committee will support a coordinated, forward-looking, and transparent approach to planning that supports Harborview's long-term sustainability and viability.

C. A description of shared goals, clear criteria for when the committee has completed its charge, and clear criteria for when a subsequent committee should be constituted, established by the committee

The Committee will establish a clearly defined charter consistent with section 6.2 of the Hospital Services Agreement, including establishing shared goals, milestones, and

benchmarks related to reviewing and making recommendations on the long-term sustainability of Harborview. These efforts may consider, but not be limited to, priorities of each entity, including: meeting the medical needs of the mission population; completing the hospital capital bond project as approved by voters; maintaining the infrastructure of Harborview; ensuring sustainable operations; and long-term capital asset management planning.

The Committee's initial work will also include developing and reviewing an integrated financial plan for Harborview, providing a forum for discussion among the Board, County Council, Executive's Office, and UW Medicine clinical leadership to share efforts and priorities within their respective participating entities under the King County Code, the Hospital Services Agreement, and other applicable laws and contracts. The integrated financial plan will be dynamic, enabling the Committee to evaluate scenarios to support operational and capital financing needs —including strategic investments, tax levy considerations, debt capacity and bond planning, reserve and asset allocation, and capital asset stewardship—and their impact on Harborview's mission. It will address both short- and long-term needs for operations and capital projects, and integrate funding sources including Harborview's operating revenues, the 2020 bond program (and any successor bonds), the County Hospital Tax levy, and other relevant revenue sources. The Committee shall produce a final report including the integrated financial plan and any consensus recommendations within six months of convening.

The Committee is encouraged to provide interim reports by consensus before the six-month deadline when doing so would support time-sensitive decisions and share the same with the participating entities.

The Committee should identify anticipated external deadlines in consultation with relevant stakeholders and incorporate those timelines into its work plan.

For the Council, the Committee shall electronically transmit reports to the clerk of the Council for further electronic dissemination by the clerk to all Councilmembers, the Council Chief of Staff and the lead staff for the Committee of the Whole, or its successor. To foster transparency and public awareness, it is expected that the Council will acknowledge receipt of the transmitted the final report by motion.

The Committee shall remain operative throughout the remainder of the term of the current Hospital Services Agreement, unless otherwise decided by consensus of the Committee and upon 90 days prior notice to the respective participating entities. The Committee shall assess the need for ongoing work, including regular review of the integrated financial plan. After transmission of the final report and as will be further developed in the charter, the Committee may be reconvened at agreed upon intervals, but no more frequently than two times per year, unless otherwise decided by consensus of the Committee that additional meetings are necessary.

The Committee will be advisory in nature, with a goal of fostering transparent, deliberative, and open dialogue to identify opportunities, risks, trade-offs, and recommendations to the County, UW Medicine, and the Board. The Committee can evaluate scenarios that require coordination across the entities and may vote to make consensus-based, non-binding recommendations to relevant parties.

D. A description of committee processes which will ensure the governance structures, accountabilities, and collective bargaining commitments of each committee member's respective organization will be respected; and

The Committee's charter will include its operating principles and processes. The charter shall ensure that the Committee does not supplant or duplicate the responsibilities of the King County Council, the Harborview Board of Trustees, or the County or University of Washington under the Hospital Services Agreement, and respects the collective bargaining commitments of each Committee member's respective organization. At its first meeting, the Committee will adopt a meeting schedule. The Committee shall have the authority to establish working groups to fulfill its charge.

In developing its charter, the Committee should identify anticipated external deadlines in consultation with relevant stakeholders and incorporate those timelines into its work plan.

E. The frequency in which the Committee shall meet to facilitate strong coordination and the identification and monitoring of the goals established among committee members. The committee should recommend the length of time that the committee shall meet.

The Committee shall initially meet twice per month in order to finalize its charter within two months of its first meeting. Upon completion of the charter, the Committee shall determine the appropriate cadence for subsequent meetings to complete its additional charge of producing a final report including the integrated financial plan and any consensus recommendations within the first six months. If Committee members agree to a different cadence, they may adjust the schedule by mutual consensus.

Harborview Medical Center Long-Range Planning Committee Plan

~~June~~July 2026

King County

Summary

Proviso 8 to Section 17 of King County Ordinance 20023 ~~requests that~~directs the Executive to transmit a plan to establish a Harborview Medical Center long-range planning committee (Committee) as described in section 6.2 of the ~~hospital services agreement~~Hospital Services Agreement.

~~Under the transmitted plan, the Committee will be comprised of the following participants:~~

- ~~Three representatives from the King County Council, consisting of two regular members and one alternate~~
- ~~Three representatives from the King County Executive's Office, consisting of two regular members and one alternate~~
- ~~Three representatives of Harborview Board of Trustees, consisting of two regular members and one alternate~~
- ~~Three representatives of UW Medicine, consisting of two regular members and one alternate.~~

~~The Committee will be jointly chaired by a representative from the King County Executive's office and a representative from the CEO of the Harborview Medical Center.~~ The Committee will draft a charter and focus its work on understanding the long-term, financial, operational and capital needs of Harborview Medical Center (HMC) with the goal of making recommendations to the King County Executive, King County Council, Harborview Medical Center Board of Trustees, and UW Medicine (collectively referred to as participating entities), on strategies to meet those needs.

The Committee will work on a consensus basis and any recommendations by the Committee will be advisory in nature and will not bind or replace the independent decision-making authority or responsibilities of the participating entities.

~~**Committee Establishment Plan**~~
Required Elements

A. The names of appointed committee members representing the county executive, the county council, the Harborview Medical Center board of trustees and UW Medicine

The ~~Long-Range Planning~~ names of the Committee ~~(~~members are not yet available. However, the Committee~~)~~ will include representatives from UW Medicine, Harborview Medical Center (~~HMC~~Harborview) Board of Trustees (~~BoT~~Board), the King County Council, and the King County Executive, as follows:

- ~~Three~~Four representatives from the King County Council, consisting of two regular members and ~~one alternate~~two alternates. The Chair of the Health, Housing, and Human Services Committee, and the Chair of the Committee of the Whole shall be the two regular members.
- ~~Three~~Four representatives from the King County ~~Executive's Office~~Executive branch, consisting of two regular members and two alternates. The Executive shall designate one of the Executive branch two regular members as one ~~alternate~~of the Committee's co-chair.
- ~~Three~~Four representatives of Harborview Board of Trustees, consisting of two regular members and ~~one alternate~~two alternates.
- ~~Three~~Four representatives of UW Medicine, consisting of two regular members and ~~one alternate~~two alternates. UW Medicine shall designate one of its two regular members as one of the Committee's co-chair.

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B. *A description of how the committee will facilitate long-range planning and coordination in pursuit of opportunities to respond to the evolving healthcare industry, improve population health, and have Harborview Medical Center become the provider of choice for county and state residents~~;~~.*

The Committee will facilitate long-range planning and coordination by serving as a forum for UW Medicine, King County, and the Harborview Board of Trustees on matters affecting Harborview Medical Center, including operating and capital needs, financial planning, health policy, and responsible stewardship of public resources. The Committee will identify opportunities, risks, trade-offs, evaluate strategic options, and develop recommendations for consideration by the participating entities. Recommendations by the Committee are advisory in nature and will not bind or replace the independent decision-making authority or responsibilities of the participating entities.

Consistent with the authorities established in the Hospital Services Agreement, UW Medicine manages the clinical and business operations of the Medical Center, the Board of Trustees ~~oversees Harborview~~has general supervision and care of Harborview Medical Center within the limits of approved budgets and authorized appropriations, and the County provides and maintains the facilities and is responsible for issuing bonds,

collecting property taxes, and ~~allocating~~appropriating those revenues. The Committee will operate within this framework to promote alignment without altering these distinct roles.

The Committee will also serve as a forum for synthesizing key planning inputs, exchanging and discussing planning information related to Harborview Medical Center. This may include:

- Long-range and financial planning approved by the Board's Finance Committee and the Board of Trustees
- Reviewing Harborview's operating budget and long-term fiscal needs
- Harborview's clinical strategic plan as recommended by the Board's Strategic Planning Committee and the Board of Trustees
- Healthcare market analyses and related strategic assessments considered by the Board's Strategic Planning Committee
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By bringing these inputs together, the Committee will support a coordinated, forward-looking, and transparent approach to planning that supports Harborview's long-term sustainability and viability.

C. A description of shared goals, clear criteria for when the committee has completed its charge, and clear criteria for when a subsequent committee should be constituted, established by the committee~~:~~

The Committee will ~~have~~establish a clearly defined charter consistent with section 6.2 of the Hospital Services Agreement, including establishing shared goals, milestones, and benchmarks related to reviewing and making recommendations on the long-term sustainability of Harborview. These efforts may consider, but not be limited to, priorities of each entity, including: meeting the medical needs of the mission population; completing the hospital capital bond project as approved by voters; maintaining the infrastructure of ~~HMC~~Harborview; ensuring sustainable operations; and long-term capital asset management planning. ~~This work to produce the charter shall be completed within six months of the initial convening.~~

The Committee's initial work will also include developing and reviewing an integrated financial plan for Harborview, providing a forum for discussion among the ~~Harborview~~ Board, County Council, Executive's Office, and UW Medicine clinical leadership to share efforts and priorities within their respective ~~authorities~~participating entities under the King County Code, the Hospital Services Agreement, and other applicable laws and contracts. The integrated financial plan will be dynamic, enabling the ~~committee~~Committee to evaluate scenarios to support operational and capital financing needs —including strategic investments, tax levy considerations, debt capacity and bond planning, reserve

and asset allocation, and capital asset stewardship—and their impact on Harborview's mission. It will address both short- and long-term needs for operations and capital projects, and integrate funding sources including Harborview's operating revenues, the 2020 bond program (and any successor bonds), the County Hospital Tax levy, and other relevant revenue sources. The Committee shall ~~share~~produce a final report including the ~~results of this work~~integrated financial plan and any consensus recommendations within six months ~~after~~of convening.

~~Once this initial charge~~ The Committee is ~~complete~~encouraged to provide interim reports by consensus before the six-month deadline when doing so would support time-sensitive decisions and share the same with the participating entities.

The Committee should identify anticipated external deadlines in consultation with relevant stakeholders and incorporate those timelines into its work plan.

For the Council, the Committee shall ~~identify~~ electronically transmit reports to the clerk of the Council for further electronic dissemination by the clerk to all Councilmembers, the Council Chief of Staff and the lead staff for the Committee of the Whole, or its successor. To foster transparency and public awareness, it is expected that the Council will acknowledge receipt of the transmitted the final report by motion.

The Committee shall remain operative throughout the remainder of the term of the current Hospital Services Agreement, unless otherwise decided by consensus of the Committee and upon 90 days prior notice to the respective participating entities. The Committee shall assess the need for ongoing work, including regular review of the integrated financial plan. ~~If further work is needed, the committee~~ After transmission of the final report and as will be further developed in the charter, the Committee may be reconvened at agreed upon intervals, but no more frequently than ~~twice~~two times per year, unless ~~participating entities jointly determine~~otherwise decided by consensus of the Committee that additional meetings are necessary.

The Committee will be advisory in nature, with a goal of fostering transparent, deliberative, and open dialogue to identify opportunities, risks, trade-offs, and recommendations to the County, UW Medicine, and the Board. The Committee can evaluate scenarios that require coordination across the entities and may vote to make consensus-based, non-binding recommendations to relevant parties. ~~This committee shall remain operative throughout the remainder of the term of the current Hospital Services Agreement, unless otherwise decided by consensus of the Committee.~~

D. A description of committee processes which will ensure the governance structures, accountabilities, and collective bargaining commitments of each committee member's respective organization will be respected; and

~~The Committee shall be an advisory body, operated by consensus, and facilitating discussion between the County, UW Medicine, and the Harborview Board of Trustees. The~~

~~committee will be jointly Chaired by a representative from the County and the CEO of Harborview Medical Center.~~

~~Upon convening, the Committee will develop a charter that includes~~ The Committee's charter will include its operating principles and processes. The charter shall ensure that the Committee does not supplant or duplicate the responsibilities of the King County Council, the Harborview Board of Trustees, or the County or University of Washington under the Hospital Services Agreement, and respects the collective bargaining commitments of each ~~committee~~Committee member's respective organization. At its first meeting, the Committee will adopt a meeting schedule. The Committee shall have the authority to establish working groups to ~~fill~~fulfill its charge.

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The Committee shall initially meet twice per month in order to finalize its charter~~.~~ within two months of its first meeting. Upon completion of the charter, the Committee shall determine the appropriate cadence for subsequent meetings to complete its ~~charge within one year.~~additional charge of producing a final report including the integrated financial plan and any consensus recommendations within the first six months. If Committee members agree to a different cadence, they may adjust the schedule by mutual consensus.

King County | Office of the Executive

Executive Girmay Zahilay
Chinook Building, CNK-EX-0800
401 Fifth Avenue, Suite 800
Seattle, WA 98104-2391

June 1, 2026

The Honorable Sarah Perry
Chair, King County Council
Room 1200
C O U R T H O U S E

Dear Councilmember Perry:

This letter transmits the plan to establish the Harborview Medical Center long-range planning committee, in response to Ordinance 20023, Section 17, Proviso P8.

As required, the enclosed plan is consistent with Section 6.2 of the hospital services agreement. The plan outlines elements including the proposed committee's membership, planning and coordination activities, shared goals and processes, and meeting cadence.

In developing this plan, King County's Office of the Executive engaged Harborview Medical Center and UW Medicine staff and leadership to ensure partnership and successful future implementation. The establishment of a long-range planning committee will facilitate strong coordination and the identification and monitoring of goals established among its members.

Thank you for your consideration of this proposed plan. The long-range planning committee will serve as an important forum for University of Washington Medicine, King County, and the Harborview Board of Trustees to exchange and discuss planning information related to Harborview Medical Center and to support Harborview's long-term sustainability and viability.

If your staff have questions, please contact Jeff Muhm, Special Advisor to the Executive's Leadership Team, at 206- 263-4601

Sincerely,

for

Girmay Zahilay
King County Executive

Enclosure

cc: King County Councilmembers
ATTN: Stephanie Cirkovich, Chief of Staff, King County Council
Melani Hay, Clerk of the Council
Karan Gill, Deputy Executive, Office of the Executive
Jasmin Weaver, Chief of Staff, Office of the Executive
Hyeok Kim, Chief Operating Officer, Office of the Executive
Sierra Howlett Browne, Director of Government Relations, Office of the Executive
Garrett Holbrook, Council Relations Manager, Office of the Executive
Jeff Muhm, Special Advisor to the Executive's Leadership Team, Office of the Executive

Americans with Disabilities Act Compliance & Disability Equity in King County

Darya Farivar, Cecelia Black, and Nate Olsen

ADA and Disability Equity Specialists

King County | Office of the Executive

About Us

- Develop Countywide accessibility plans and policies;
- Provide guidance and support to departments trying to achieve or maintain ADA compliance;
- Help members of the public seeking accommodations connect with the appropriate individual;
- Centralize compliance and equity resources;
- Assist the King County Executive in identifying challenges, adapting systems, and establis hing evaluation and accountability mechanisms.

Disability Data Summarized

From Communities Count 2018-2022 data

- **20% of adults in King County have a disability**
- 22% Female, 20% Male, **47% Transgender**
- **42% AI/AN**, 29% NHPI, 27% Hispanic, 26% Black, 21% White, 12% Asian
- 33% Veterans, 20% non-veteran
- **52% <$20,000 household income**
- 23% South, 20% North, 19% Seattle, 17% East

Guiding Laws and Regulations

- Americans with Disabilities Act Title I & II
  - Requirements to be accessible for members of the public
- Web Content Accessibility Guidelines 2.1 A/AA
  - Requirements to be digitally accessible
- KCC 2.16.025 County executive
  - Support departments in ADA compliance

Current State of ADA Compliance

- Expired Title II policy from Exec. Sims (year)
- Title I process improvements
- Completed Transition Plans
  - Metro
  - DLS Roads Division
- In Progress Transition Plans
  - RALS
  - DNRP WTD and Parks Division
  - Elections
  - DAJD

Departments who have an established process/coordinator

- DPD (coordinator)
- DAJD (both)
- DJA (both)
- KCSC (both)
- PHSKC (both)
- Metro (both)
- DHR (both)
- DLS (coordinator)

Current State of ADA Digital Compliance

- ADA Title II requires King County's digital content to be accessible
- Web Content Accessibility Guidelines (WCAG 2.1 A/AA) deadline April 26, 2027
- No audit to understand state of digital compliance
- Compliance is inconsistent across the County
- KCIT has updated Kingcounty.gov platform to comply with WCAG 2.1
- King County has digital accessibility champions in most departments

Current ADA Digital Compliance Projects

- KCIT Digital Compliance Remediation Capitol Project
- Department leaders: DNRP & Metro
- DLS and WTD have created WCAG workgroups
- The Executive is working on a digital accessibility policy to set compliance standard and outline department roles and responsibilities

2026 Projects

- Host Disability Pride Month festivities – Thank you for joining us! :)
- Establish a Disability Equity Commission (update KCC 2.55)
- Establish a digital accessibility policy
- Update our Title II public accommodation process
- Support King County Disability Equity Network modifications to the reasonable accommodation process

Thank you &
happy Disability Pride Month!

Contact Darya, Nate, and Cecelia
at: KCADA@kingcounty.gov

King County | Office of the Executive

KCRHA
King County Regional Homelessness Authority

Federal Continuum of Care Funding

July 16, 2026

Jeff Simms, Chief Program Officer

Current FY25 Award Breakdown

Considered Permanent Housing by HUD

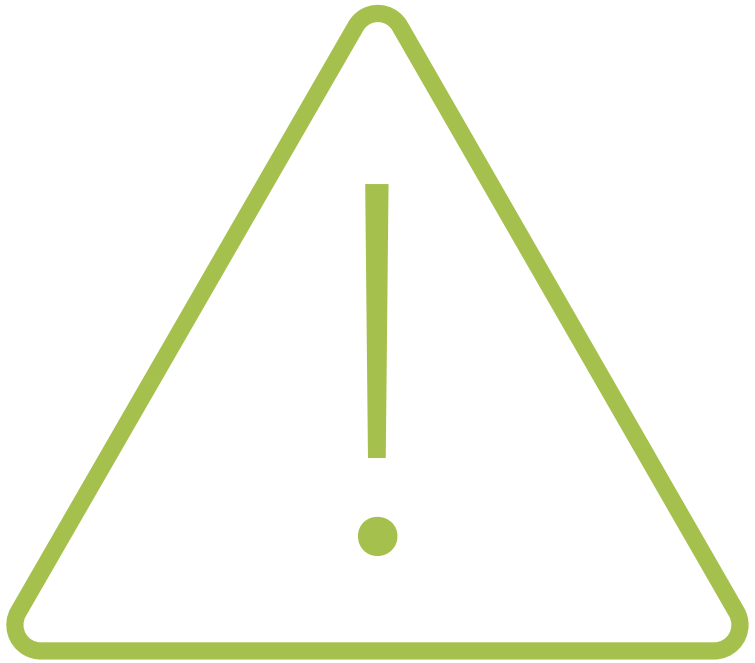
$60,729,627
92% of Total

Program Types	Current Amount
Permanent Supportive Housing (PSH)	$43,389,863
Rapid Re-Housing (RRH)	$12,855,842
Joint Component (JC)	$4,483,922
Transitional Housing	$1,691,356
Safe Haven	$849,156
Supportive Services Only	$109,452
Coordinated Entry	$2,444,037
HMIS	$459,390
Total	**$66,283,018**

Note: CoC Planning Grants ($1,500,000) are not included in the annual renewal demand.

Significant Changes

- Limit “Tier 1” to 60% award amount
- Funds new transitional housing and support services instead of permanent housing renewals
- Not advance “housing first”
- Reinterpretation of "self-sufficiency“
- Sex binary of humans
- Cooperate with Federal immigration enforcement
- Executive Order compliance
- Participation requirements
- Not distribute drug paraphernalia as harm reduction



Expected Local Impact

	Program Types	Current Amount
	Likely Renewed (Tier 1)	$39,769,811
Tier 2	Voluntary Changes or Efficiencies	$4,500,000*
Tier 2	Unfunded Existing Projects	$22,013,207
	Total	$66,283,018

* Estimate as of July 6, 2026. Amounts to be finalized over coming days.
Note: CoC Planning Grants ($1,500,000) are not included in the annual renewal demand.

FY26 CoC NOFO Timeline

KCRHA
King County Regional Homelessness Authority

Scan this QR code to sign up for KCRHA emails →

@KingCoRHA

@KCRHA

DESC

INNOVATION IN HOMELESSNESS THROUGH WORKING CAPITAL

A WAY TO ACCELERATE RESPONSE TO CHRONIC HOMELESSNESS

King County Needs

*According to King County Regional Homelessness Authority 5 year plan

DESC Provides

357 Shelter and Emergency Housing Beds

2,195 Permanent Supportive Housing (PSH) & Scattered Site Apartments

6,569 Total Clients supported in 2025

DESC is growing more quickly than we historically have because of a rapid escalation of people experiencing chronic homelessness and behavioral health crisis events associated with higher severity of mental illness.

A Funding Structure Problem

The reimbursement model requires that we "float" the cost of a program, then submit invoices for payment after services are delivered. In general, we expect reimbursement around 2 months after we provide services.

DESC is using $15 million of its own cash, to front expenses while waiting for reimbursement.

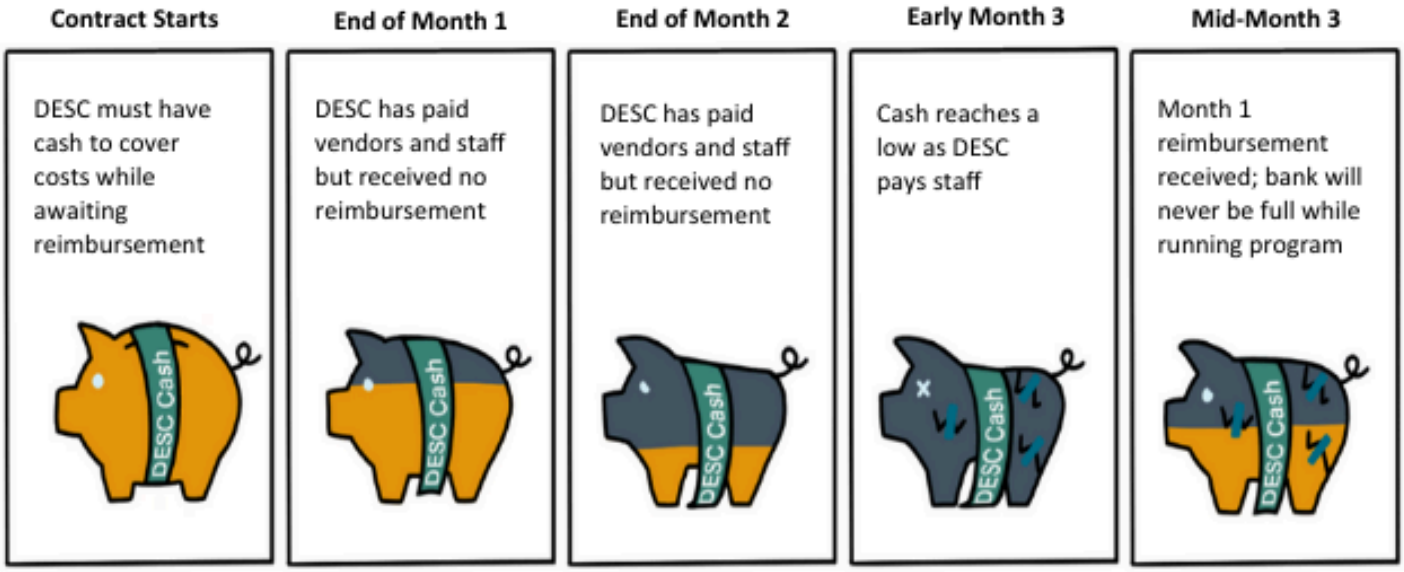
We lose 689k annually in unrealized interest because of these delayed payments

RECENT GROWTH

- Wage equity sector leader
- Fentanyl response scaling
- Overdose Response, Care, and Access Center development
- Scaled emergency crisis response teams
- 596 PSH apartments opened in 5 years
- 440 new apartments opening in 2025-2027

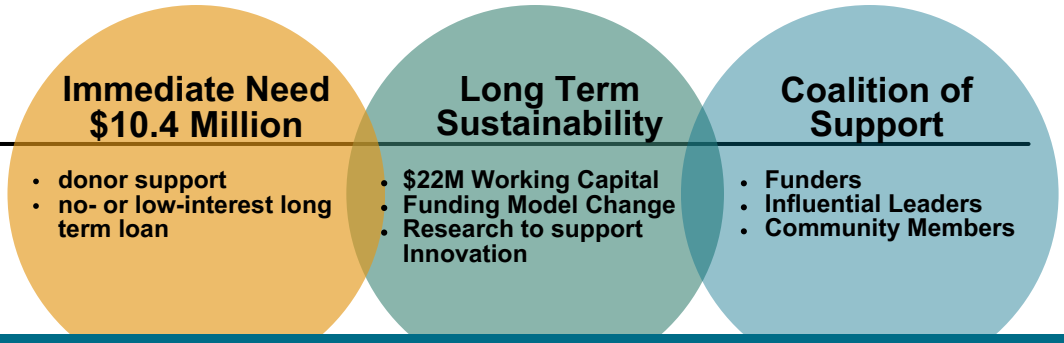
Even a "Fully Funded" program isn't necessarily a financially viable program

The Shrinking Piggy Bank



We are at a point where we may not be able to grow and further innovate to meet the immense needs because the cost burden severely restricts our ability to invest in growth.

The Solution



Foundations	• Fund working capital with restriction • fund advocacy work to change funding models • Provide no- or low-interest long term loans
Influential Leaders	• Review contracts you oversee to determine if there are ways to reduce the burden on non-profits to be able to provide their services
DESC Ambassadors	• Help us identify people we need to talk to to raise money and/or advocate for change • Be a champion in your communities on why it's ALL of our responsibility to care for our most vulnerable neighbors • Help others understand why unrestricted giving is the most impactful way to make a difference in ending homelessness.

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