516 Third Avenue, Council Chambers, 10th Floor, Seattle, WA 98104

King County

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 | **Tuesday, September 1, 2026** | **Hybrid 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.

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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 of July 23, 2026 Special meeting.

4. **Public Comment**

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Discussion Only

5. Proposed Ordinance No. 2026-0174 **p. 10**

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

6. Proposed Ordinance No. 2026-0177 **p. 34**

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

Discussion and Possible Action

7. Proposed Motion No. 2026-0159 **p. 222**

A MOTION acknowledging receipt of the 2025 health through housing annual report, in accordance with K.C.C. chapter 24.30.

Sponsors: Mosqueda

Olivia Brey, Council staff

Briefing

8. Briefing No. 2026-B0101 **p. 313**

Rental Fee Transparency

Zach Neumann, Co-Founder and CEO, Community Economic Defense Project
Ariel Nelson, Senior Attorney, National Consumer Law Center

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Other Business

Adjournment

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King County

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Meeting Minutes

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**

DRAFT MINUTES - SPECIAL MEETING

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1. Call to Order

Chair Mosqueda called the meeting to order at 9:30 a.m.

2. Roll Call

Present: 4 - Barón, Fain, Lewis and Mosqueda

3. Approval of Minutes

Vice Chair Lewis moved approval of June 2, 2026, meeting minutes. There being no objections, the minutes were approved.

4. Public Comment

The following people were present to offer public comment.

1. Alex Tzimerman; 2. Sara Dickmeyer; 3. ; Kale Garvey; 4. Thyda Chhom

Consent

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

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

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

Yes: 4 - Barón, Fain, Lewis and Mosqueda

Discussion Only

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

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

This matter was Deferred

Sam Porter and Miranda Leskinen, Council staff, briefed the Committee on the legislation and answered questions from members. Susan Mclaughlin, Director, Community & Human Services Department, (DCHS), Marissa Chavez, Policy County Executive Assistant, King County Executive, Isabel Jones, Interim Division Director, BHRD, DCHS, were present to brief the Committee via PowerPoint presentation and answer questions from the members.

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

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

This matter was Deferred

Sam Porter and Miranda Leskinen, Council staff, briefed the Committee on the legislation and answered questions from members. Susan Mclaughlin, Director, Community & Human Services Department, (DCHS), Marissa Chavez, Policy County Executive Assistant, King County Executive, Isabel Jones, Interim Division Director, BHRD, DCHS, were present to brief the Committee via PowerPoint presentation and answer questions from the members.

Discussion and Possible Action

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

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

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

Yes: 4 - Barón, Fain, Lewis and Mosqueda

Sam Porter and Miranda Leskinen, Council staff, briefed the Committee on the legislation and answered questions from members. Jeff Muhm, Special Advisor to the Executive's Leadership Team, Madeline Grant, Chief Administrative Officer, Harborview Medical Center, commented and answered questions from members.

The following amendments were moved:
Amendment 1 moved by CM Lewis was passed.
Amendment 2 moved by CM Lewis was passed.

Briefing

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

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

This matter was Presented

Darya Farivar, ADA & Disability Equity Specialist, King County Executive Office, (KCEO), Cecelia Black, ADA & Disability Equity Specialist, KCEO and Nate Olsen, ADA & Disability Equity Specialist, KCEO, briefed the Committee via PowerPoint presentation and answered questions from the members.

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

Update on U.S. Continuum of Care Funding

This matter was Presented

Jeff Simms, Chief Program Officer, King County Regional Homelessness Authority, briefed the Committee via PowerPoint presentation and answered questions from the members. Daniel Malone, Executive Director, Downtown Emergency Service Center (DESC), Regan McBride, Union Representative, PROTEC17, Lindsey Grad, Legislative Director, SEIU Healthcare 1199NW and Byram Simpson, Union Representative, OPEIU Local 8, commented to the Committee and answered questions from the members.

Adjournment

The meeting was adjourned at 12:29 p.m.

Approved this _____ day of _____.

Clerk's Signature

Metropolitan King County Council
Staff Report

Committee:	Health, Housing, and Human Services Committee		
Agenda Item:	5	**Analyst(s):**	Sam Porter
Proposed No.:	2026-B0098	**Meeting Date:**	September 1, 2026

OVERVIEW

TOPIC: A proposed 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.

It is important to note that transmitted in tandem with this item is Proposed Ordinance 2026-0177, which would adopt the Behavioral Health Bridge Implementation Plan. Proposed Ordinance 2026-0177 is a mandatory dual referral to the Regional Policy Committee. These ordinances are anticipated to be taken up on the same schedule (refer to Table 12 of the staff report for Proposed Ordinance 2026-0177 for schedule information).

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), 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, 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;

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

- 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

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

[4] Proposed Ordinance 2026-0177, https://mkcclegisearch.kingcounty.gov/LegislationDetail.aspx?ID=8125181&GUID=F7713E11-9782-46B6-9FF7-91FC684D6BB2&Options=Advanced&Search=

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.

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 (Proposed Ordinance 2026-0177) 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 Committee		
Agenda Item:	6	**Analyst(s):**	Sam Porter Miranda Leskinen
Proposed No.:	2026-0177	**Meeting Date:**	September 1, 2026

OVERVIEW

TOPIC: Proposed Ordinance 2026-0177 that would adopt 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 second briefing on this item in the Health, Housing, and Human Services Committee, which received an initial briefing at its July 23, 2026 meeting. Any updates from the previous staff report are noted with red text.

Timing Considerations. There is no mandated deadline by which the legislation must be adopted. Executive staff initially expressed their desire to have the legislation adopted in October but have since agreed to final adoption by the end of 2026. Table 12 of this staff report provides the current anticipated schedule (updated August 19, 2026) and contemplates potential final adoption in November.

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

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. Both ordinances are anticipated to be taken up on the same schedule.

KEY ISSUES FROM THE ANALYSIS

A. **Potential policy issues.** Staff identified nine 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.
8. Implementation plan perspective.
9. Lack of specificity in the plan.

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 $971 million over the nine-year collection period.[7] Table 1 identifies current annual projected sales tax revenues based on the July 2026 Office of Economic and Financial Analysis forecast.[8] Table 1 has been updated from the July 23, HHHS Committee Staff report which was based on the March 2026 OEFA forecast. The July 2026 OEFA forecast projects an overall decrease in revenue for the Bridge during the plan period from 2028-2034 by approximately $26 million.

Table 1. 2026-2034 MIDD Estimated Collections per July 2026 Forecast

Year	Amount
2026	$101,148,041
2027	$102,758,300
2028	$103,569,657
2029	$101,423,239
2030	$105,381,475
2031	$109,101,359
2032	$112,092,438
2033	$116,166,596
2034	$119,770,981

[4] Ordinance 18406
[5] Motion 15093
[6] Motion 15058
[7] This is approximately $27 million less than was projected by the March 2026 OEFA forecast.
[8] The forecast accounts for adjusted tax base expansion under ESSB 5814 and the tax base reduction from 2029 and beyond under ESSB 6346.

MIDD Expenditure Requirements. Per state law,[9] 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.

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

[9] RCW 82.14.460

- 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

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.[10]

Implementation plan overview. 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).

It is important to note that 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. The transmitted 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 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, which notes that 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. Attachment 5 to this staff report contains a crosswalk provided by Executive staff that illustrates MIDD programs and the corresponding anticipated Bridge activity under which programs may be eligible for funding.

[10] 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[11]	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.

[11] The intent of the stated primary purpose 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.

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 of the plan.

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.[12]

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 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."[13] 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

[12] Behavioral Health Bridge Implementation Plan, page 21.
[13] Behavioral Health Bridge Implementation Plan, page 19.

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 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[14] 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 (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

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

[14] Behavioral Health Bridge Implementation Plan, page 20.

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 plan 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 represent policy choices.

Financial policies.

Financial Plan. The transmitted plan includes a financial plan[15] with estimated collections and estimated expenditures. Table 10 shows a summary of the estimated annual revenue from 2028 to 2034, based on the King County OEFA July 2026 forecast and Table 11 shows the estimated expenditures for each strategy area based on the March 2026 OEFA forecast. Staff analysis is ongoing regarding the impact of the July OEFA forecast on the financial plan and estimated expenditures for the Bridge.

[15] Bridge Implementation Plan, p. 50.

Table 10. Bridge Projected Revenue in Millions, 2028-2034[16]

	2028	2029	2030	2031	2032	2033	2034
Projected Sales Tax	$103.6	$101.4	$105.4	$109.1	$112.1	$116.2	$119.8
Projected Interest, est.	$0.7	$0.8	$0.7	$0.6	$0.6	$0.6	$0.7
Total Est. Revenue	**$104.3**	**$102.2**	**$106.1**	**$109.7**	**$112.7**	**$116.8**	**$120.5**

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**

[16] Table 10 has been updated from the July 23, HHHS Committee Staff report which was based on the March 2026 OEFA forecast. The forecast has decreased overall revenue for the Bridge during the plan period from 2028-2034 by approximately $26 million.

**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 present 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, represent 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 biennial report to be transmitted to Council beginning in 2030 along with offering an annual briefing to Council starting in 2028. The biennial 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.

8. Implementation Plan Perspective. The transmitted plan is drafted as if this is the Executive's implementation plan and not that of the County. Throughout the plan, language is used leaving this impression. For example, at page 10 the plan states, "In addition to a new name, and in keeping with the Executive's priorities, the new implementation plan includes other key changes including [...]" It is a policy choice whether to edit these statements so that the implementation plan reflects that it is a King County plan, not just that of the Executive.

9. Lack of Specificity in the Plan. The implementation does not identify specific programs that will receive funding. Based on communications with Executive staff, it appears that they may not have additional details to share at this time regarding programmatic investments, finalized performance measures, or evaluation plans. If Councilmembers wanted additional information about these topics, prior to 2028, the Council could add a new section to Proposed Ordinance 2026-0177 to request that a plan update be transmitted in Q3 of 2027 that provides these details. Language could also be added to the Executive Summary of the Bridge plan attached to PO 2026-0177 reflecting this change.

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 for the proposed ordinance as it was updated on August 19, 2026, including amendment deadlines. This proposed schedule accommodates, if necessary, one rereferral to the Regional Policy Committee.

Table 12. Proposed Ordinance 2026-0177 Anticipated Legislative Schedule
Updated August 19, 2026

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 Only	HHHS	September 1	
Discussion and Possible Action	HHHS	October 6	Striker direction due: 9/22 COB Striker distribution: 9/29 COB Line amendment direction due: 10/2 COB
Discussion Only	RPC	October 14	
Discussion and Possible Action	RPC (special meeting)	Week of November 2-6	Striker direction due: TBD Striker distribution: TBD Line amendment direction due: TBD
Potential Final Action	Full Council	November 17 (Regular)	Line amendment direction due: 11/13 COB
***If* legislation is amended after RPC, then re-referral to RPC would be necessary:**			
Action	RPC (special meeting)	Week of November 30 -December 4	Line amendment direction due: TBD
Final Action	Full Council	December 8 (Expedited)	

Of note, companion legislation (Proposed Ordinance 2026-0174) which proposes to rename the MIDD the "Behavioral Health Bridge" and update the Advisory Committee was transmitted concurrent to Proposed Ordinance 2026-0177. Proposed Ordinance 2026-

0174 is also a mandatory dual referral to the Regional Policy Committee and is discussed in a separate staff report. Both ordinances are anticipated to be taken up on the same schedule.

Previous Committee Questions and Answers. Executive staff provided responses to questions asked by members during the July 23rd meeting of the Health, Housing, and Human Services Committee. These questions and answers are provided in Attachments 6 and 7 to this staff report. Additionally, Attachment 8 provides a reference for the names and associated strategy numbers for current MIDD initiatives as referenced in Attachment 7.

Council's legal counsel has reviewed 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
6. Q&A in response to the July 23rd HHHS Committee meeting
7. Behavioral Health Bridge and MIDD Strategy Financial Crosswalk
8. Current MIDD Initiative Reference for Attachment 7
9. Executive Staff PowerPoint Presentation, August 26, RPC Meeting

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

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

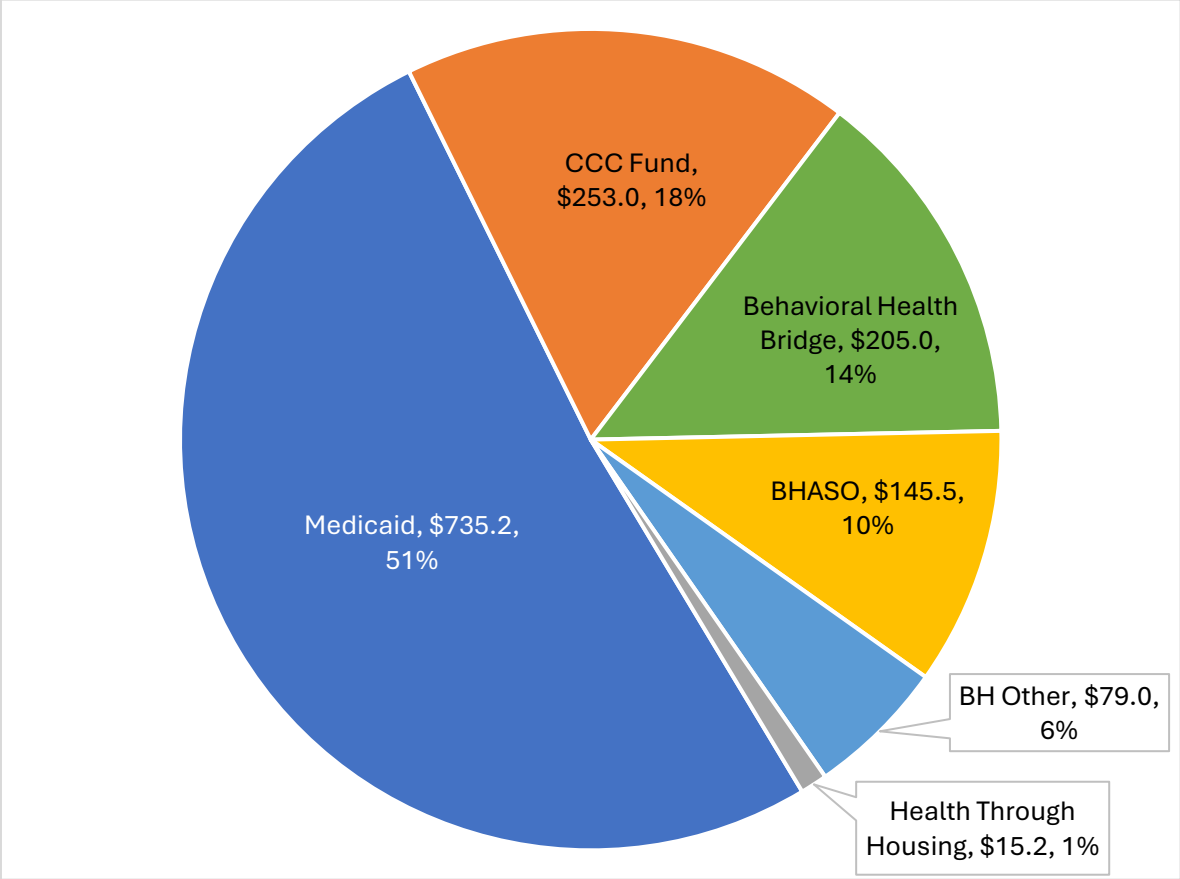
DCHS' Behavioral Health and Recovery Division (BHRD) oversees the public behavioral health system in King County, which includes managing and implementing the Behavioral Health Bridge and the CCC Levy. In addition to the Behavioral Health Bridge and the CCC Levy, BHRD oversees the publicly funded behavioral 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.

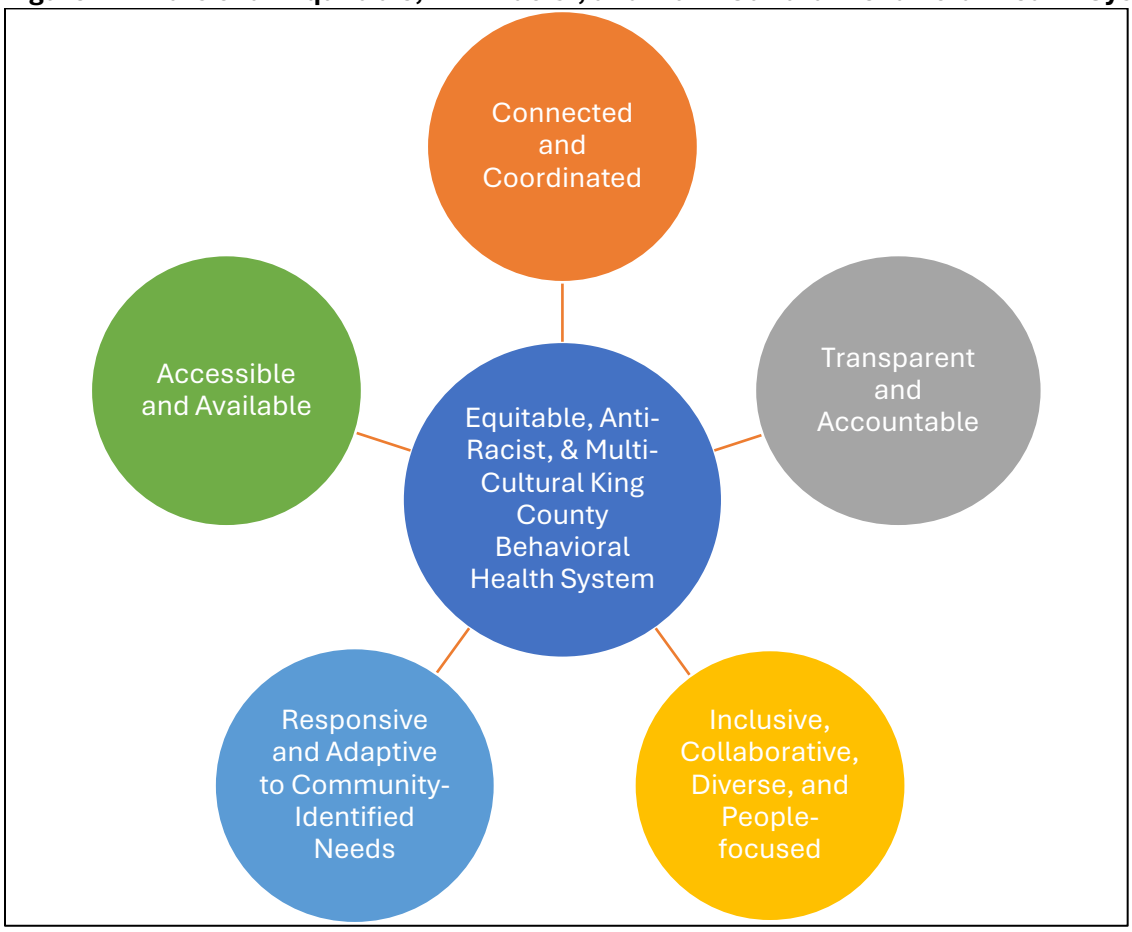
BIPOC, refugee and immigrant, LGBTQIA+ (lesbian, gay, bisexual, transgender, queer, intersex, asexual), and disability communities are more likely to struggle with behavioral health conditions and less likely to access supportive care than the King County population overall (see Subsection IV.B and Subsection 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.

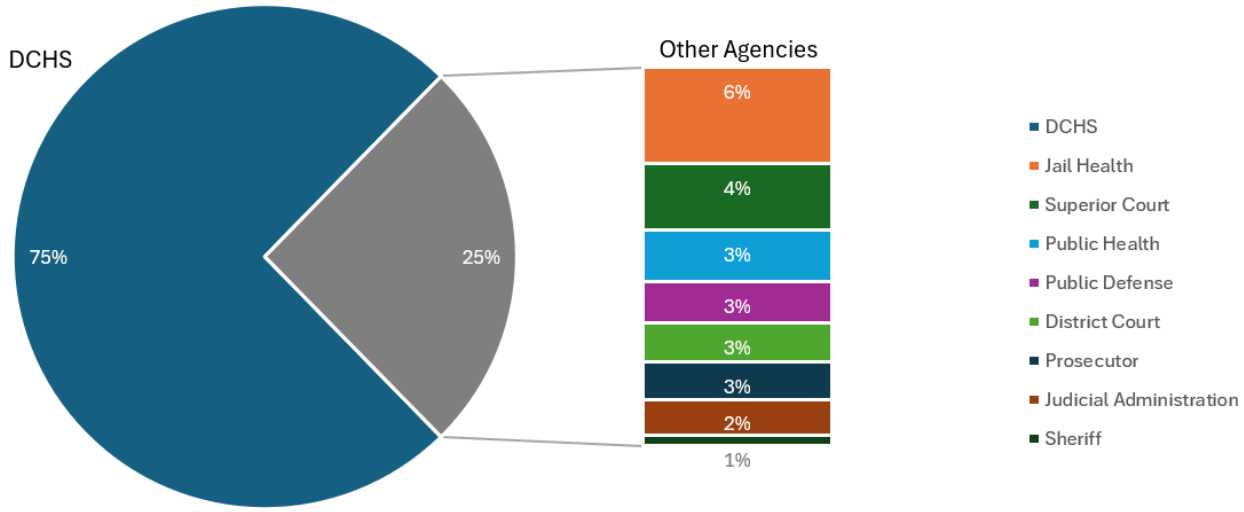
Successful implementation will depend on continued partnership with community-based organizations, behavioral health providers, people with lived experience, and across County agencies. Ongoing evaluation, transparent reporting, and a phased procurement approach will help deliver a smooth transition 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)

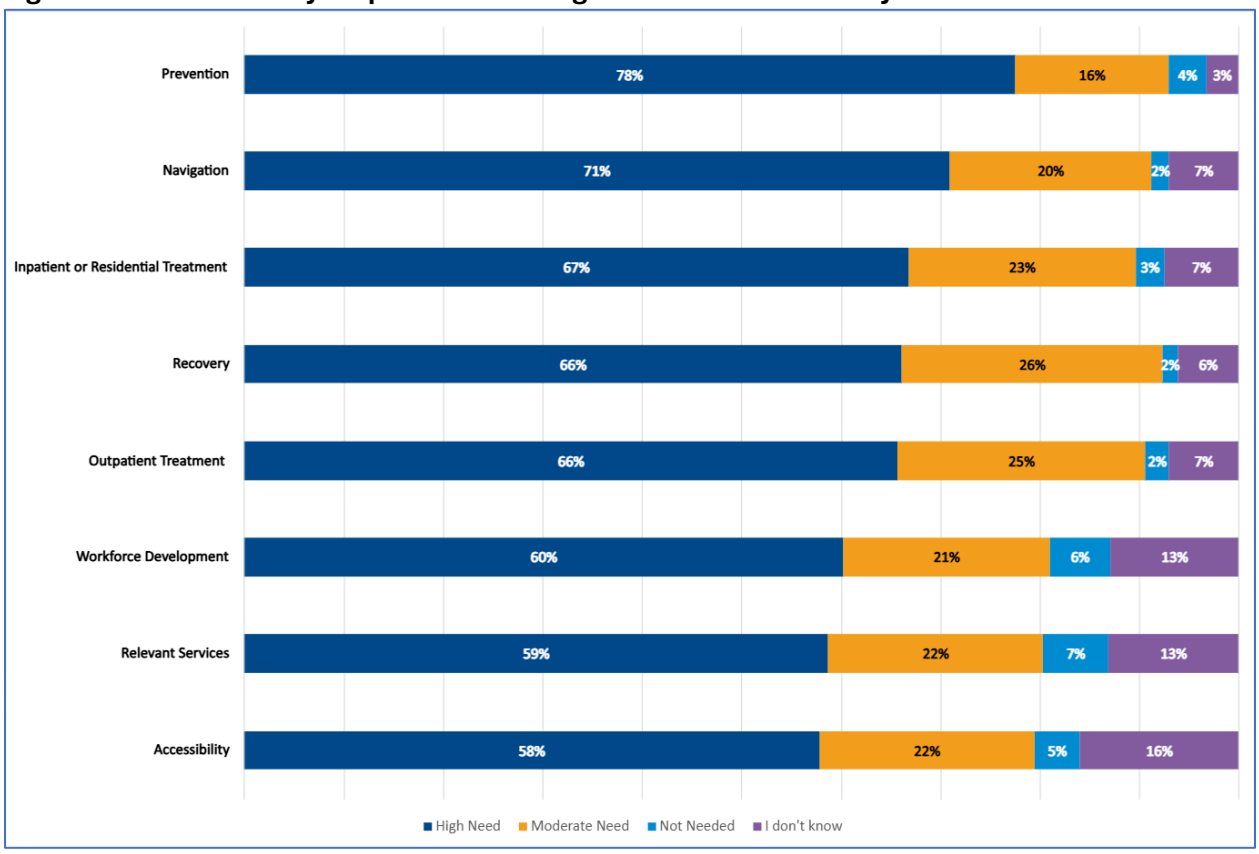
Affiliation or self-identification of attendees	Number of people engaged
LGBTQIA+ community members	23 (3%)
Behavioral health providers	72 (9%)
City government agencies	50 (7%)
Community-based organizations (CBOs)	62 (8%)
Correctional officers	15 (2%)
Incarcerated adults	99 (13%)
Incarcerated youth	27 (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.

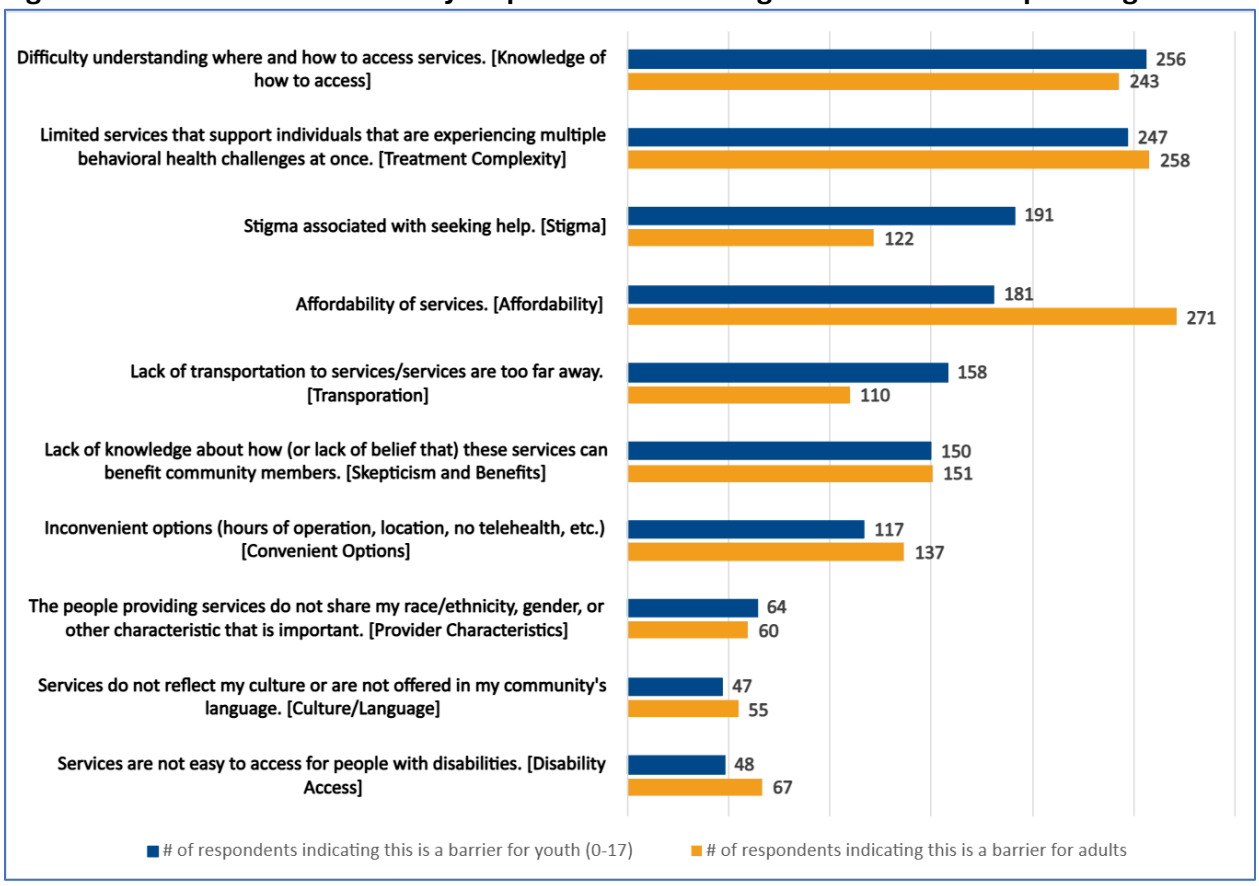
Figure 32: Online survey respondents' rating of behavioral health system barriers



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:

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- Stephanie Lane, Peer Washington
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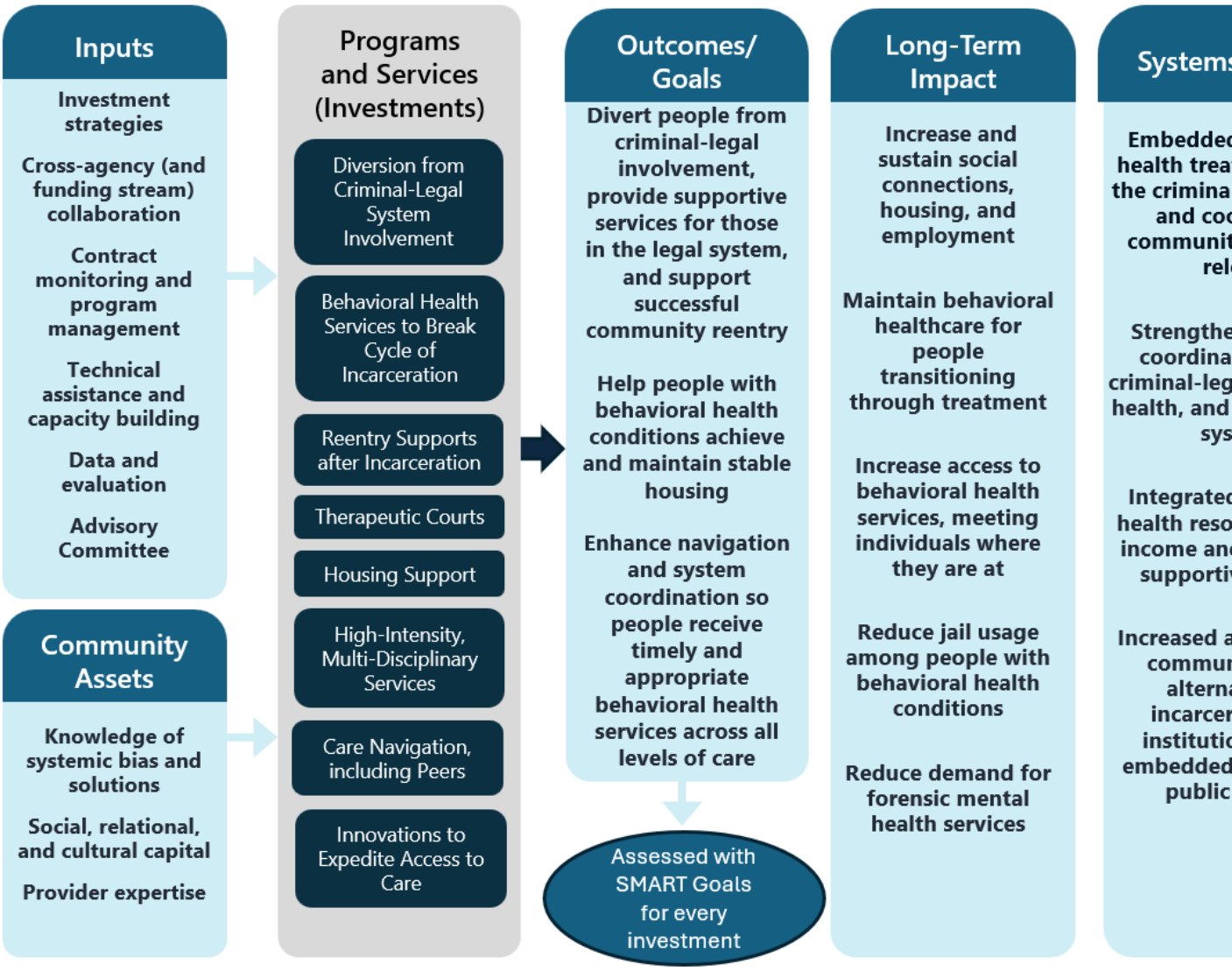
E. Appendix E. Implementation examples of the five equity pillars

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.

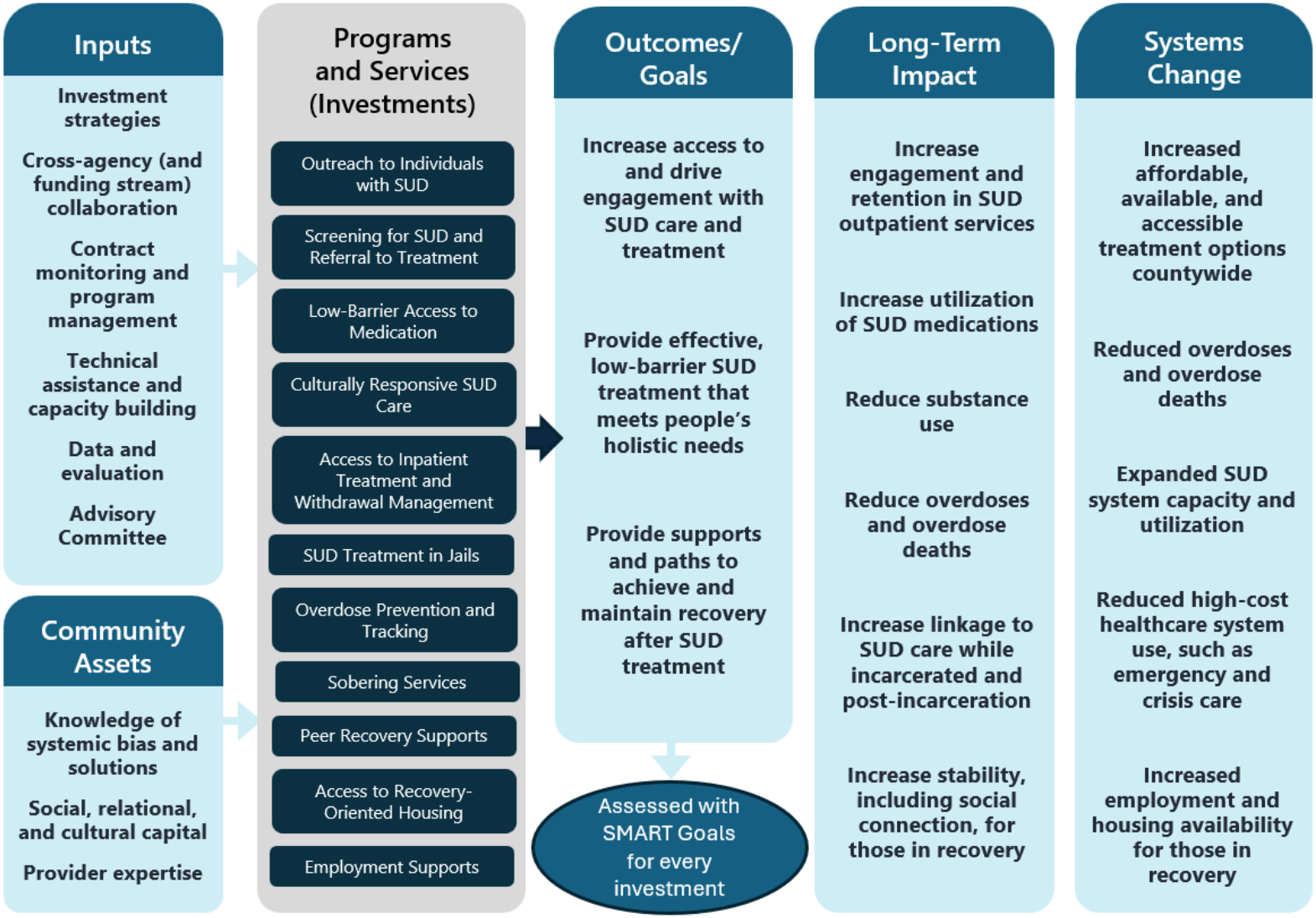
The Executive intends to invest funds under this goal to enhance and build on the CCP after it is launched to make care navigation easier, faster, and more effective by adding features that respond to community-identified needs.

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

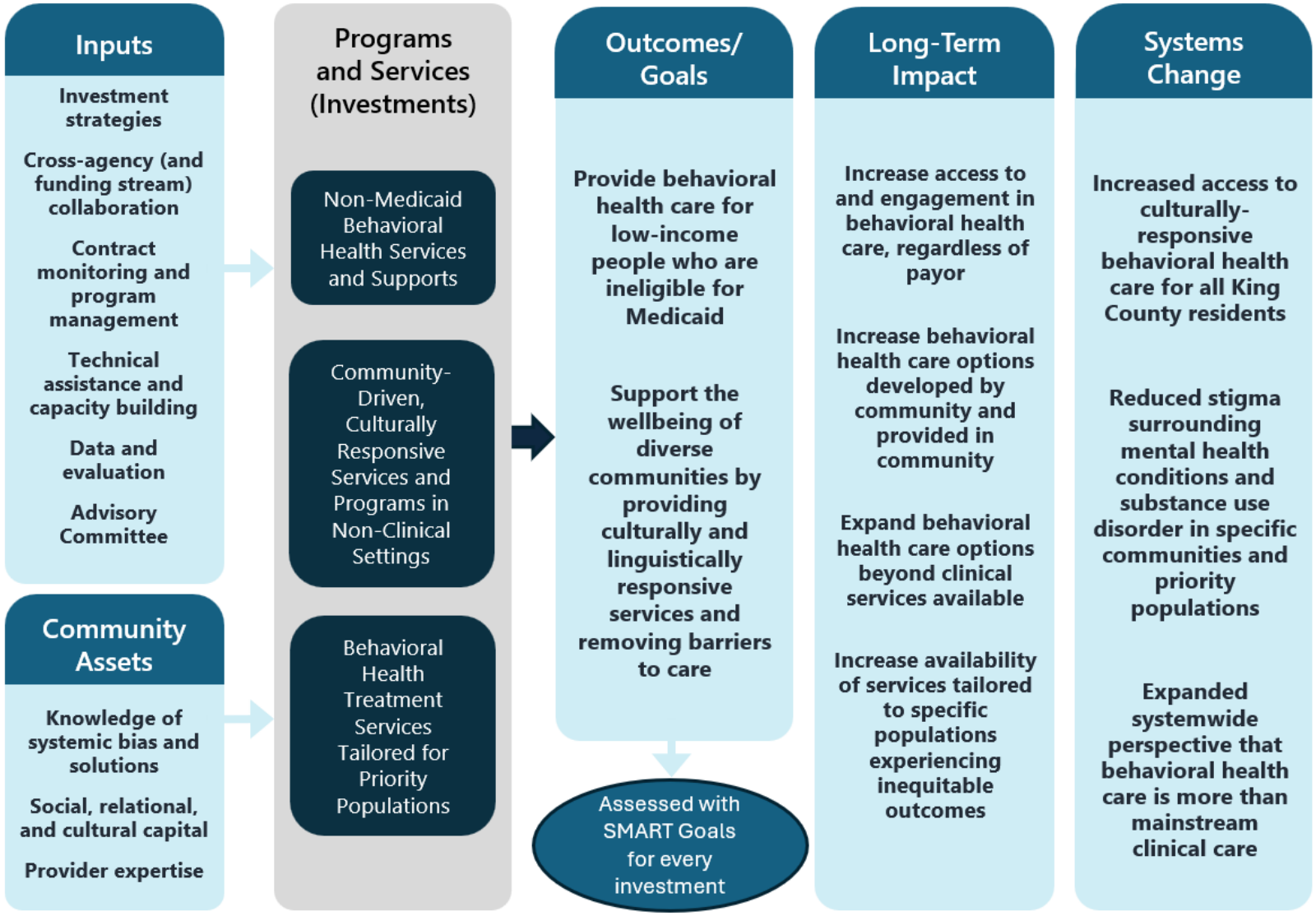
Housing is an important component of long-term recovery. There is a high correlation between housing instability and substance use disorders. The Substance Use and Mental Health Administration (SAMHSA) identifies "Home" as one of the four dimensions of recovery, alongside "Health," "Purpose," and "Community."[191,192] 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:

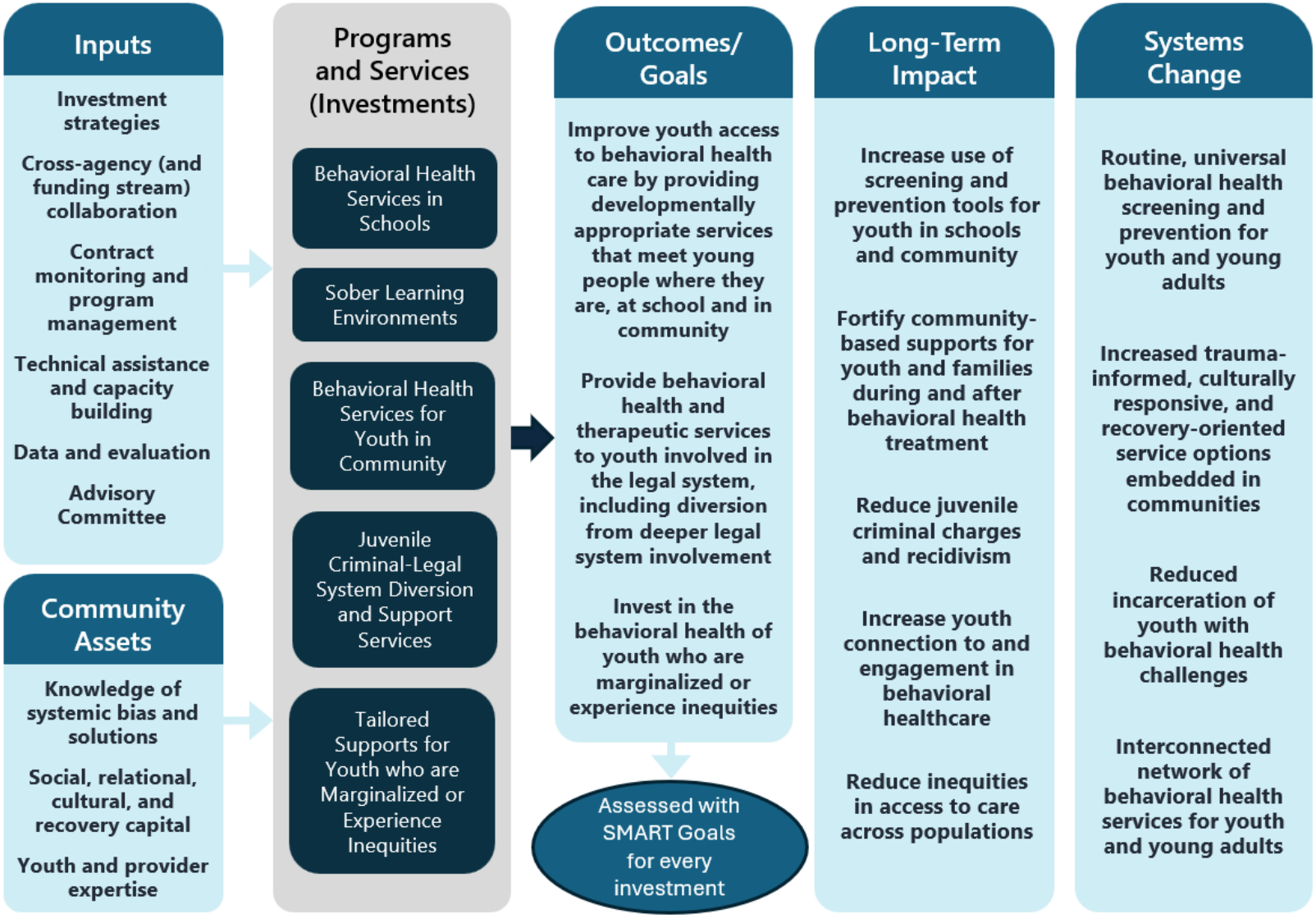
- Identify as Black, Indigenous, or people of color.
- Are immigrants, refugees, or asylees.
- Identify as LGBTQIA+.
- Live in rural areas.
- Are older adults.
- Are survivors of trauma or violence.

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:

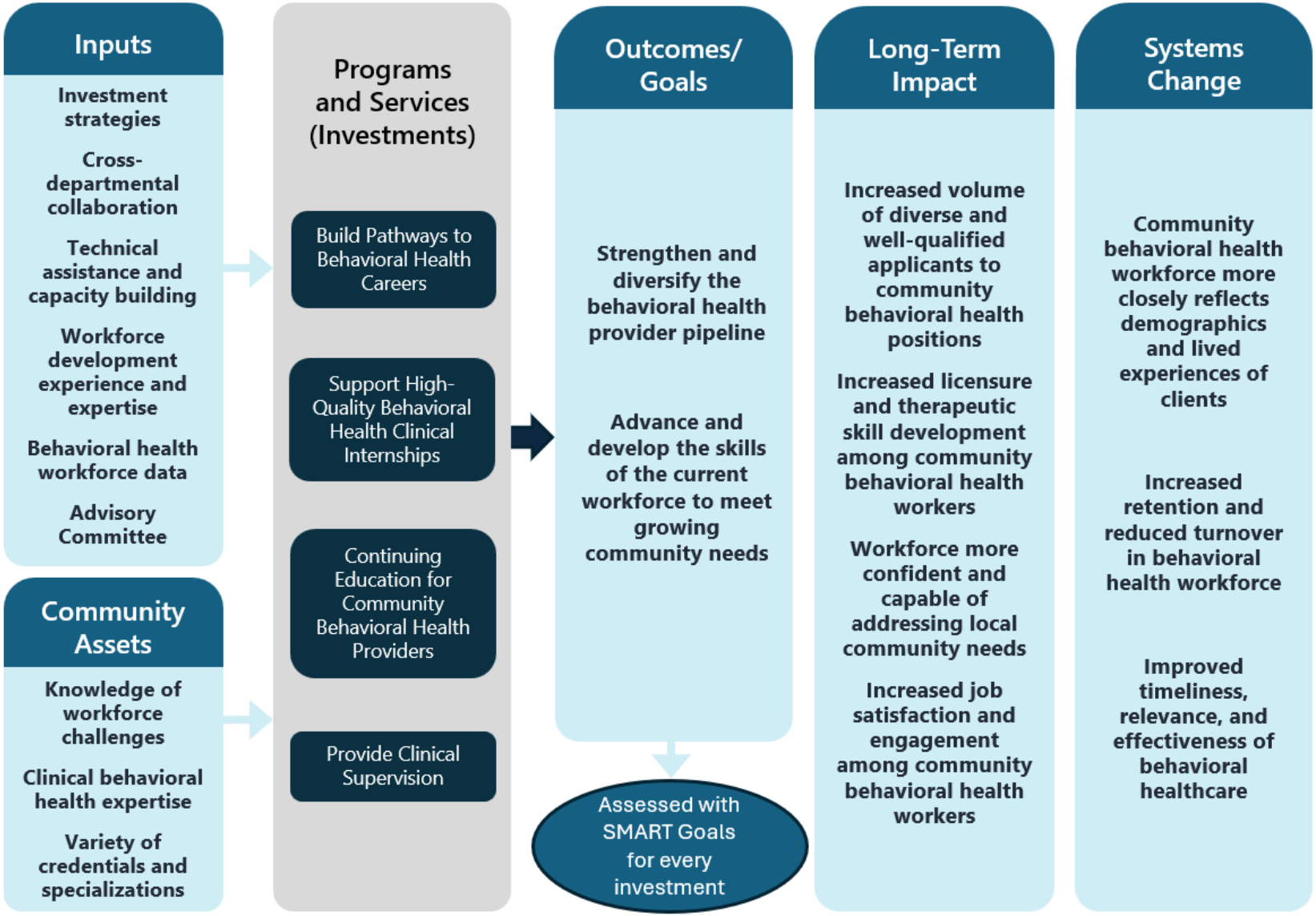
- Suicide prevention approaches designed with and for Black youth.
- Sober community-building and substance use prevention for LGBTQIA+ youth.
- In-language therapy groups for youth who speak a language other than English at home.
- Trauma healing programs for American Indian/Alaska Native youth who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

[26] King County Department of Community and Human Services. (2023, July). *The KCICN Improves Access to Behavioral Health Care for Residents Furthest from Care*. [https://cdn.kingcounty.gov/-/media/king-county/depts/dchs/behavioral-health-recovery/2023-kcicn-legislative-handout.pdf?rev=c5a838bfcbda42a590b5dd1d078bc0d8&hash=DA4ADD564B01D20B4402B3C3D424F07B]

[27] Based on the BHRD financial plan as of January 1, 2026, consistent with projections available at the time of adoption of the 2026-2027 Biennial Budget Ordinance.

[28] Motion 15093. [https://mkcclegisearch.kingcounty.gov/LegislationDetail.aspx?ID=3119993&GUID=ABA47252-DF74-49B5-A4DA-C5391A5F71CD&Options=Advanced&Search=]

[29] King County DCHS. (2023). *The KCICN Improves Access to Behavioral Health Care for Residents Furthest from Care*. [https://cdn.kingcounty.gov/-/media/king-county/depts/dchs/behavioral-health-recovery/2023-kcicn-legislative-handout.pdf?rev=c5a838bfcbda42a590b5dd1d078bc0d8&hash=DA4ADD564B01D20B4402B3C3D424F07B]

[30] King County DCHS. *Crisis Care Centers Initiative*. [https://kingcounty.gov/en/dept/dchs/human-social-services/community-funded-initiatives/crisis-care-centers-levy]

[31] King County DCHS. *Health Through Housing Initiative*. [https://kingcounty.gov/en/dept/dchs/human-social-services/community-funded-initiatives/health-through-housing]

[32] Veterans, Seniors, and Human Services Levy (VSHSL) Implementation Plan for 2024-2029. [https://cdn.kingcounty.gov/-/media/king-county/depts/dchs/asd/2024-2029-vshsl-implementation-plan.pdf?rev=e319cf4d9d2e410c8e4777061315145b&hash=CE5452BA60853FC0B26C240224388DFD]

[33] Washington State Health Care Authority. (2024). *Apple Health Expansion enrollment cap*. [https://www.hca.wa.gov/about-hca/news/announcements/apple-health-expansion-enrollment-cap]

[34] Washington State Health Care Authority. *Medicaid Transformation Project (MTP)*. [https://www.hca.wa.gov/about-hca/programs-and-initiatives/medicaid-transformation-project-mtp]

[35] Brunner, J. and Sowersby, S. (2026). WA budget woes dominate as Ferguson, lawmakers begin 2026 session. *The Seattle Times*. [https://www.seattletimes.com/seattle-news/politics/wa-budget-woes-dominate-as-ferguson-lawmakers-begin-2026-session/]

[36] State budget cuts affected long-term civil commitment beds, the children's long-term inpatient program, he Recovery Navigator Program, and Law Enforcement Assisted Diversion (LEAD).

[37] One Big Beautiful Bill Act, H.R.1, 119th Congress (2025-2026). [https://www.congress.gov/bill/119th-congress/house-bill/1]; Federal legislation requires states to implement work requirements and 6-month reauthorizations for Medicaid enrollment as soon as 2027.

[38] Washington State Health Care Authority. (2026). *Impact of Federal Budget on Medicaid in Washington State*. [https://www.hca.wa.gov/assets/program/medicaid-in-washington-state.pdf]

[39] Westneat, D. (2025). WA is the No. 1 target in the GOP's health care slashing bill. *The Seattle Times*. [https://www.seattletimes.com/seattle-news/politics/wa-is-the-no-1-target-in-the-gops-health-care-slashing-bill/]

[40] Washington State Health Care Authority. (2024). *Follow-Up After ED Visit for Substance Use: 30 Days*. *Healthier Washington Measure Explorer & Trend Dashboard*. [https://hca-tableau.watech.wa.gov/t/51/views/HealthierWashingtonDashboard/Measures?%3AisGuestRedirectFromVizportal=y&%3Aembed=y]

[41] King County DCHS. (2022). *DCHS Data Insights Series: Integrating Data to Better Understand Fatal Overdoses and Service System Engagement*. [https://cdn.kingcounty.gov/-/media/king-county/depts/dchs/department/documents/FINAL_integrated_overdose_brief.ashx?la=en]

[42] King County DCHS. (2022). *DCHS Data Insights Series: Integrating Data to Better Understand Fatal Overdoses and Service System Engagement*. [https://cdn.kingcounty.gov/-/media/king-county/depts/dchs/department/documents/FINAL_integrated_overdose_brief.ashx?la=en]

[43] Public Health – Seattle & King County. *Overdose deaths data dashboard*. [https://kingcounty.gov/en/dept/dph/health-safety/safety-injury-prevention/overdose-prevention-response/data-dashboards/]

[44] Public Health – Seattle & King County. *Overdose deaths data dashboard*. [https://kingcounty.gov/en/dept/dph/health-safety/safety-injury-prevention/overdose-prevention-response/data-dashboards/]; In 2017, there were 16 fatal overdoses per 100,000 people. In 2025, there were 35.2 per 100,000.

[45] Dickson-Gomez J., Spector A., Weeks M., Galletly C., McDonald M., Green Montaque H.D. (2022). You're Not Supposed to be on it Forever: Medications to Treat Opioid Use Disorder (MOUD)

Related Stigma Among Drug Treatment Providers and People who Use Opioids. *Substance Abuse*. 27(16). [https://journals.sagepub.com/doi/10.1177/11782218221103859]

[46] All Home. (2017). *Count Us In: Seattle/King County Point-in-Time Count of Persons Experiencing Homelessnes*s. [https://kcrha.org/wp-content/uploads/2022/05/2017-King-PIT-Count-Comprehensive-Report-FINAL-DRAFT-5.31.17.pdf]

[47] King County Regional Homelessness Authority. (2026). *Seattle/King County Point-in-Time Count 2026*. [https://kcrha.org/community-data/king-county-point-in-time-count/]

[48] Communities Count. *King County Population Dashboard*. [https://www.communitiescount.org/population-dashboard]

[49] Public Health – Seattle & King County. *Community Health Needs Assessment*. [https://kingcounty.gov/en/dept/dph/about-king-county/about-public-health/chna]

[50] Balk, G. (2023) New King County milestone: One-quarter of residents born outside U.S. *The Seattle Times*. [https://www.seattletimes.com/seattle-news/data/new-king-county-milestone-one-quarter-of-residents-born-outside-u-s/]

[51] KFF. (2024). *Racial and Ethnic Disparities in Mental Health Care: Findings from the KFF Survey of Racism, Discrimination and Health*. [https://www.kff.org/racial-equity-and-health-policy/racial-and-ethnic-disparities-in-mental-health-care-findings-from-the-kff-survey-of-racism-discrimination-and-health/]

[52] Public Health – Seattle & King County. *Data to inform King County's overdose response*. [https://kingcounty.gov/en/dept/dph/health-safety/safety-injury-prevention/overdose-prevention-response/data-dashboards/]. 2025 fatal overdose rates per 100,000 people: AI/AN: 211.4; Black: 95.2; White, non-Hispanic: 31.3.

[53] Communities Count. *Frequent Mental Distress*. [https://www.communitiescount.org/frequent-mental-distress]

[54] Chatterjee, R. (2024). We're not 'out of the woods' in the youth mental health crisis, a CDC researcher says. *NPR*. [https://www.npr.org/sections/shots-health-news/2024/08/07/nx-s1-5064406/cdc-youth-risk-behavior-survey-suicide-mental-health-drugs-alcohol]

[55] Friedman, J., Hadland, S. E. (2024). The Overdose Crisis among U.S. Adolescents. *The New England Journal of Medicine*, *390*(2), 97–100. [https://doi.org/10.1056/NEJMp2312084]

[56] Public Health-Seattle & King County. (2024). *Youth Mental Health and Substance Use in King County*. [https://www.communitiescount.org/blog/2025/3/20/from-data-to-action-addressing-youth-mental-health-and-substance-use-in-king-county]

[57] Washington State Healthy Youth Survey. [https://www.askhys.net/SurveyResults/FactSheets]

[58] Youth.GOV. *Behavioral Health*. [https://youth.gov/youth-topics/homelessness-and-housing-instability/behavioral-health]

[59] 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]. The 2017 MIDD 2 Implementation Plan noted that "the behavioral health workforce is in crisis."

[60] The Council of State Governments. (2024). *Mental Health Matters: Addressing Behavioral Health Workforce Shortages*. [https://www.csg.org/2024/10/10/mental-health-matters-addressing-behavioral-health-workforce-shortages/]

[61] King County. KCICN Workforce Survey 2021.

[62] King County. (2024). *2024 MIDD Behavioral Health Sales Tax Fund Annual Summary Report*. [https://cdn.kingcounty.gov/-/media/king-county/depts/dchs/behavioral-health-recovery/midd/midd/reports/2024-midd-annual-summary-report.pdf?rev=edfcfcbcc624444a871b804afc335f66&hash=DC1226BDA3A9431F948BED3D97F42160]

[63] King County. KCICN Workforce Survey 2025.

[64] United States Health Resources & Services Administration. (2025, December). *State of the Behavioral Health Workforce, 2025*. [https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/data-research/Behavioral-Health-Workforce-Brief-2025.pdf]

[65] King County DCHS. (2025). *MIDD Renewal Community Engagement Report*. [https://cdn.kingcounty.gov/-/media/king-county/depts/dchs/behavioral-health-recovery/midd/midd-renewal-community-engagement-report-final-2025.pdf?rev=158a78c33eab4cdda443da39d874f040&hash=3EDD11B4F9CAF6A7C4BDDCB16EAFF1FD]

[66] King County DCHS. (2025). *Be Heard: Community Voices About Mental Health and Wellness Report*. [https://cdn.kingcounty.gov/-/media/king-county/depts/dchs/behavioral-health-recovery/MIDD/Be-Heard-Community-Listening-Report]

[67] MIDD AC Meeting Notes, January 23, 2025. [https://cdn.kingcounty.gov/-/media/king-county/depts/dchs/behavioral-health-recovery/midd/advisory-committee/2025-02-27/item-2-midd-meeting-notes-12325.pdf?rev=9590bfd12154478d93cd3bed1faa80f1&hash=1FE6DAA83E16AD08A8E75EC512C1FA10]

[68] RCW 82.14.460(4). [https://app.leg.wa.gov/rcw/default.aspx?cite=82.14.460]

[70] 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]

[71] Heinz A., Liu S. (2022). Challenges and chances for mental health care in the 21st century. *World Psychiatry* (8;21(3)), 423-424. [https://pmc.ncbi.nlm.nih.gov/articles/PMC9453898/]

[72] Recovery.com. (2024). *Timeline: History of Addiction Treatment*. [https://recovery.org/drug-treatment/history/]

[73] 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]

[74] King County Executive Order, "Better Governance and Financial Management." Document Code ACO-8-33-EO. Section 6. Reviewing and Prioritizing Base Budgets. 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]

[75] Ordinance 16077. [https://mkcclegisearch.kingcounty.gov/LegislationDetail.aspx?ID=555168&GUID=59A067B4-E1D8-4A40-9775-50FA651696E1]

[76] Ordinance 18452. [https://mkcclegisearch.kingcounty.gov/LegislationDetail.aspx?ID=2819659&GUID=43729153-15C2-4825-89CD-C8885F90D04B]

[77] Ordinance 18452. [https://cdn.kingcounty.gov/-/media/king-county/depts/dchs/behavioral-health-recovery/midd/midd/documents/ordinance_18452.pdf?la=en&rev=92633d2b80584444a3af3c7827dda4ae&hash=5C0B38DE9C3143EEC710B1889431B656].

[78] 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]

[79] 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]

[80] King County Regional Homelessness Authority. (2026). *Point-in-Time Count*. [https://kcrha.org/community-data/king-county-point-in-time-count/]

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

[82] 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]

[83] 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]

[84] Center on Budget and Policy Priorities. (2022). *States Can Reduce Medicaid's Administrative Burdens to Advance Health and Racial Equity*. [https://www.cbpp.org/research/health/states-can-reduce-medicaids-administrative-burdens-to-advance-health-and-racial]

[85] King County DCHS. (2026). *Cultivating Connections: Update on King County's Response to the Opioid Overdose Crisis*. [https://dchsblog.com/2026/03/10/update-on-king-countys-response-to-the-opioid-overdose-crisis/]

[86] Substance Abuse and Mental Health Administration. *SAMHSA's Working Definition of Recovery: 10 Guiding Principles of Recovery*. [https://library.samhsa.gov/sites/default/files/pep12-recdef.pdf]

[87] Islam M.F., Guerrero M., Nguyen R.L., Porcaro A., Cummings C., Stevens E., Kang A., Jason L.A. (2023). The Importance of Social Support in Recovery Populations: Toward a Multilevel Understanding. *Alcohol Treat Q*. [https://pmc.ncbi.nlm.nih.gov/articles/PMC10259869/]

[88] Abramo, A. (2020). After leaving addiction treatment, young adults often face homelessness. *Cascade PBS*. [https://www.cascadepbs.org/equity/2020/07/after-leaving-addiction-treatment-young-adults-often-face-homelessness/]

[89] The Agency for Healthcare Research and Quality (AHRQ). *Six Domains of Health Care Quality*. [https://www.ahrq.gov/talkingquality/measures/six-domains.html]

[90] KFF. (2026). *How states verify citizenship and immigration status in Medicaid*. [https://www.kff.org/medicaid/how-states-verify-citizenship-and-immigration-status-in-medicaid/]

[91] Communities Count. *Health Insurance*. [https://www.communitiescount.org/health-insurance]; In King County in 2024, 14.9 percent of non-citizens lacked health insurance, compared to only 5.3 percent of the overall population.

[92] KFF. (2026). *How states verify citizenship and immigration status in Medicaid*. [https://www.kff.org/medicaid/how-states-verify-citizenship-and-immigration-status-in-medicaid/]

[93] Tens of thousands of Washingtonians could soon be in healthcare limbo. (2026). *KOMO News*. [https://komonews.com/news/politics/tens-of-thousands-of-washingtonians-could-soon-be-in-healthcare-limbo]

[94] National Alliance for Mental Illness. *Budget Reconciliation: Impact on People with Mental Health Conditions*. [https://www.nami.org/wp-content/uploads/2025/09/Budget-Reconciliation-Impact-on-People-With-Mental-Health-Conditions-FINAL.pdf]

[95] KFF. (2024). *Racial and Ethnic Disparities in Mental Health Care: Findings from the KFF Survey of Racism, Discrimination and Health*. [https://www.kff.org/racial-equity-and-health-policy/racial-and-ethnic-disparities-in-mental-health-care-findings-from-the-kff-survey-of-racism-discrimination-and-health/]

[96] Masanori, K. (2025). The rising predictive power of LGBT identity in mental health: An analysis of variable importance. *Annals of Epidemiology*, Volume 111. [https://www.sciencedirect.com/science/article/abs/pii/S1047279725002777]

[97] Morales D.A., Barksdale C.L., Beckel-Mitchener A.C. (2020). A call to action to address rural mental health disparities. *J Clin Transl Sci*, 4(5):463-467. [https://pmc.ncbi.nlm.nih.gov/articles/PMC7681156/]

[98] Blatchford, T. (2026). King County's mental health expansion moving too slowly, Zahilay says. *The Seattle Times*. [https://www.seattletimes.com/seattle-news/mental-health/king-countys-mental-health-expansion-moving-way-too-slowly-zahilay-says/]

[99] Best Starts for Kids Implementation Plan: 2022-2027. [https://cdn.kingcounty.gov/-/media/king-county/depts/dchs/best-starts/documents/best_starts_for_kids_implementation_plan_approved_2021.pdf?la=en&rev=982959618c9246df82d2f6a68272c68f&hash=072B4DA6104EBC2E7F728B175898696D]

[100] Blatchford, T. (2026, April). King County's mental health expansion moving too slowly, Zahilay says. *Seattle Times*. [https://www.seattletimes.com/seattle-news/mental-health/king-countys-mental-health-expansion-moving-way-too-slowly-zahilay-says/]

[101] Motion 16966. [https://mkcclegisearch.kingcounty.gov/LegislationDetail.aspx?ID=7760680&GUID=69D1C7DC-BC39-4093-BC56-3B473E58E1B7&Options=Advanced&Search=]

[102] Consistent with all Behavioral Health Bridge investments, services provided by this goal are not intended to replace Medicaid payment for equivalent services.

[103] Piper K., Stielow S., Hines-Wilson M., Van Alstine E., Sheerin K., Modrowski C., Kemp K. (2025). Barriers to Behavioral Health Treatment among Youth and Caregivers Involved in the Juvenile Legal

System. *Evid Based Pract Child Adolesc Ment Health*. [https://pmc.ncbi.nlm.nih.gov/articles/PMC12803726/]

[104] King County Prosecuting Attorney's Office Data Dashboard. [https://kingcounty.gov/en/dept/pao/about-king-county/about-pao/data-reports/dashboard#toc-The-Data-Dashboard]

[105] King County Department of Adult and Juvenile Detention. Detention and Alternatives Report Year 2026.[https://cdn.kingcounty.gov/-/media/king-county/depts/dajd/documents/population-information-pdfs/2026-05-kc-dar-scorecard.pdf?rev=4df996b290e5462487e3be5d6052a39c&hash=A17AFCE0F5EE810290D73181AEB6E711]

[106] Washington State Healthy Youth Survey. [https://www.askhys.net/SurveyResults/FactSheets]

[107] Washington State Healthy Youth Survey. [https://www.askhys.net/SurveyResults/FactSheets]

[108] Rapid Health Information NetwOrk (RHINO). [https://kingcounty.gov/en/dept/dph/about-king-county/about-public-health/data-reports/population-health-data/community-health-indicators/rhino?shortname=Suicidal%20ideation]

[109] Washington State Healthy Youth Survey. [https://www.askhys.net/SurveyResults/FactSheets]

[110] Health Resources and Services Administration. *Behavioral Health Workforce Projections*. [https://data.hrsa.gov/topics/health-workforce/workforce-projections]

[111] King County. KCICN Workforce Survey 2025.

[112] Other DCHS funds also support aspects of the human services workforce. VSHSL focuses on nonprofit staff, the CCC Levy focuses on crisis staff, and the Behavioral Health Bridge is intended to focus on behavioral health workers across the care continuum (beyond crisis services). These fund sources will work in concert, with complementary rather than duplicative investments.

[113] National Center for Health Workforce Analysis. (2025). *State of the Behavioral Health Workforce, 2025*. [https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/data-research/Behavioral-Health-Workforce-Brief-2025.pdf]; Report highlight: "Substantial shortages of addiction counselors, marriage and family therapists, mental health counselors, psychologists, mental health and substance use disorder social workers, adult psychiatrists, child and adolescent psychiatrists, and school counselors are projected in 2038."

[114] Pathman D.E., de Saxe Zerden L., Konrad T.R., Shafer A.B., Harrison J.N., Fannell J., Lombardi B.M. (2025, April). Job assessments and the anticipated retention of behavioral health clinicians working in U.S. Health Professional Shortage Areas. *BMC Health Serv Res*, 25(1):592. [https://pmc.ncbi.nlm.nih.gov/articles/PMC12020279/]

[115] Harrison, J.P. (2020). *Therapist turnover in community mental health: Testing the applicability of job embeddedness and shocks*. [Doctoral dissertation, University of Washington].

[https://digital.lib.washington.edu/server/api/core/bitstreams/a3b23e92-f797-4721-aa76-8d3ed2137be0/content]

[116] King County. KCICN Workforce Survey 2025.

[117] Washington State Department of Health. *Agency-Affiliated Counselor – Frequently Asked Questions*. [https://doh.wa.gov/licenses-permits-and-certificates/professions-new-renew-or-update/agency-affiliated-counselor/frequently-asked-questions]

[118] King County. KCICN Workforce Survey 2025.

[119] King County. KCICN Workforce Survey 2025.

[120] King County. KCICN Workforce Survey 2025.

[121] 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]

[122] MIDD 2 Evaluation Plan. (2018). [https://cdn.kingcounty.gov/-/media/king-county/depts/dchs/behavioral-health-recovery/midd/midd/documents/170804_midd_evaluation_plan.pdf?la=en&rev=85c9a05460084507a190c1ce943d57b1&hash=6E4F1C75BCAC13288FBBB0C57A7E9BF1]

[123] Ordinance 18407. [https://cdn.kingcounty.gov/-/media/king-county/depts/dchs/behavioral-health-recovery/midd/midd/documents/ordinance_18407.pdf?la=en&rev=5867c9491f1344488211221b2fd7fda8&hash=08258AC12F55E0E731E8DB355A154182]

[124] Clear Impact. *What is Results-Based Accountability?* [https://clearimpact.com/results-based-accountability/]

[126] Substance Abuse and Mental Health Services Administration. (2024). *Developing Goals and Measurable Objectives*. [https://www.samhsa.gov/grants/how-to-apply/forms-and-resources/developing-goals-measurable-objectives]

[127] King County DCHS. *MIDD Behavioral Health Sales Tax dashboard, Plans, Reports, and Briefing Papers*. [https://kingcounty.gov/en/dept/dchs/human-social-services/community-funded-initiatives/midd-behavioral-health-tax/midd-behavioral-health-sales-tax-dashboard/past-reports]

[128] WestEd Justice & Prevention Research Center for the Annie E. Casey Foundation. (2019). *Reflections on Applying Principles of Equitable Evaluation*. [https://www.aecf.org/resources/reflections-on-applying-principles-of-equitable-evaluation]

[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.

[130] Clear Impact. *What is Results-Based Accountability?* [https://clearimpact.com/results-based-accountability/].

[131] Motion 15081. [https://mkcclegisearch.kingcounty.gov/LegislationDetail.aspx?ID=3307620&GUID=D5F273E9-C87F-40F1-97FE-C668F5DAA261&Options=Advanced&Search=]. Motion 15081 accepted a report on consolidated human services reporting, as required by Ordinance 18409, Section 66, Proviso P2.

[132] King County DCHS. *Measuring DCHS' Impact*. [https://kingcounty.gov/en/dept/dchs/about-king-county/about-dchs/data-reports]

[133] Motion 15081. [https://mkcclegisearch.kingcounty.gov/LegislationDetail.aspx?ID=3307620&GUID=D5F273E9-C87F-40F1-97FE-C668F5DAA261&Options=Advanced&Search=ht]; Motion 15081 accepted a report on consolidated human services reporting, as required by Ordinance 18409, Section 66, Proviso P2.

[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.

[135] King County DCHS. *Explore the Data*. [https://kingcounty.gov/en/dept/dchs/about-king-county/about-dchs/data-reports/impact-dashboard]

[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]

[142] 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]

[143] One Big Beautiful Bill Act, H.R.1, 119th Congress (2025-2026). [https://www.congress.gov/bill/119th-congress/house-bill/1]; Federal legislation requires states to implement work requirements and 6-month reauthorizations for Medicaid enrollment as soon as 2027.

[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]

[155] King County DCHS. (2024). *Section 6.3 of DCHS Inflation Rate Adjustment Policy for Human Services Contracts*. [https://cdn.kingcounty.gov/-/media/king-county/depts/dchs/ASD/DCHS%20Inflation%20Policy]

[156] 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]

[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]

[158] King County. *King County Budget and Financial Planning Assumptions Dashboard*. [https://app.powerbigov.us/groups/me/reports/b97a6283-2b3f-4a50-8f6d-c5d0d601df05/ReportSection3c4f835a513e65de275e]

[159] King County DCHS. (2024). *Section 6.1 of DCHS Inflation Rate Adjustment Policy for Human Services Contracts*. [https://cdn.kingcounty.gov/-/media/king-county/depts/dchs/ASD/DCHS%20Inflation%20Policy]

[160] King County DCHS. (2025). *MIDD Renewal Community Engagement Report*. [https://cdn.kingcounty.gov/-/media/king-county/depts/dchs/behavioral-health-recovery/midd/midd-renewal-community-engagement-report-final-2025.pdf?rev=158a78c33eab4cdda443da39d874f040&hash=3EDD11B4F9CAF6A7C4BDDCB16EAFF1FD]

[161] Communities Count. *Communities Count Population Dashboard*. [https://www.communitiescount.org/population-dashboard]; As of 2024, 48.2 percent of King County residents identified as BIPOC.

[162] King County DCHS. *Familiar Faces Data Packet*. [https://www.naco.org/sites/default/files/event_attachments/Familiar%20Faces%20Data%20Packet.pdf]; This source provides and internal analysis of jail bookings in King County Correctional Facility, Maleng Regional Justice Center, South Correctional Entity, and municipal jails for the Cities of Enumclaw, Issaquah, Kent, and Kirkland.

[163] Therapeutic court services provided by the Juvenile Response and Accountability Court – Behavioral Health Response (JTRAC-BHR) are addressed under CYYA Goal 2.

[164] U.S. Department of Housing and Urban Development. *Homelessness Management Information System*. [https://www.hudexchange.info/programs/hmis/]

[165] 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]

[166] King County DCHS. (2024). *2023 Health Through Housing Annual Report*. [https://cdn.kingcounty.gov/-/media/king-county/depts/dchs/housing/health-through-housing/annual-reports/2023-health-through-housing-annual-report.pdf?rev=508110dfaa6d4939b9925e2af0f3caf1&hash=6B38F2613B8573DCA8E926227019C3C7]

[167] Kelly E., Fulginiti A., Pahwa R., *et al*. (2014). A Pilot Test of a Peer Navigator Intervention for Improving the Health of Individuals with Serious Mental Illness. *Community Ment Health J* 50, 435–446. [https://link.springer.com/article/10.1007/s10597-013-9616-4]

[168] Anderson E.S., Rusoja E., Luftig J., Ullal M., Shardha R., Schwimmer H., Friedman A., Hailozian C., Herring A.A. (2023). Effectiveness of Substance Use Navigation for Emergency Department Patients with Substance Use Disorders: An Implementation Study. *Annals of Emergency Medicine*, Volume 81, Issue 3. [https://www.sciencedirect.com/science/article/abs/pii/S0196064422011647]

[169] Corrigan P., Sheehan L., Morris S., Larson J.E., Torres A., Lorena Lara J., Paniagua D., Mayes J., Doing S. (2018). The Impact of a Peer Navigator Program in Addressing the Health Needs of Latinos with Serious Mental Illness. *Psychiatric Services*, Volume 69, Issue 4. [https://psychiatryonline.org/doi/full/10.1176/appi.ps.201700241]

[170] Eliacin J., Burgess D., Rollins A.L., Patterson S., Damush T., Bair M.J., Salyers M.P., Spoont M., Chinman M., Slaven J.E., Matthias M.S. (2023). Outcomes of a peer-led navigation program, PARTNER-MH, for racially minoritized Veterans receiving mental health services: a pilot randomized controlled trial to assess feasibility and acceptability, *Translational Behavioral Medicine*, Volume 13, Issue 9. [https://academic.oup.com/tbm/article-abstract/13/9/710/7148295]

[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.

[172] Tommasello A.C., Myers C.P., Gillis L., Treherne L.L., Plumhoff M. (1999). Effectiveness of outreach to homeless substance abusers. *Eval Program Plan*, 22(3):295-303. [https://pubmed.ncbi.nlm.nih.gov/24011449/]

[173] King County DCHS. (2026, April). *Internal analysis of Medicaid claims data, Washington State Health Care Authority*.

[174] Carpenter P., Mays S., Sharp J., Little S.H. (2025). Evaluating the Efficacy of Predischarge Referrals in Preventing Emergency Mental Health Hospital Readmissions: A Scoping Review. *Doctor of Nursing Practice Projects,* Paper 100. [http://dx.doi.org/10.21007/con.dnp.2025.0100]

[175] Reed, M.K., Smith, K.R., Ciocco, F. *et al.* (2023). Sorting through life: evaluating patient-important measures of success in a medication for opioid use disorder (MOUD) treatment program. *Substance Abuse Treatment Prevention Policy,* 18, 4. [https://link.springer.com/article/10.1186/s13011-022-00510-1]

[176] Wakeman S.E., Larochelle M.R., Ameli O., et al. (2020). Comparative Effectiveness of Different Treatment Pathways for Opioid Use Disorder. *JAMA Network Open*, 3(2). [https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2760032]

[177] Johns Hopkins Bloomberg School of Public Health. (2023, May). *Fentanyl, Heroin Use Substantially Decline in Patients Receiving Methadone Treatment for Opioid Use Disorder During First Year*. [https://publichealth.jhu.edu/2023/fentanyl-heroin-use-substantially-decline-in-patients-receiving-methadone-treatment-for-opioid-use-disorder-during-first-year]

[178] Kiley, B. (2023, June). Walk the beat with an outreach worker helping people who live on Seattle streets. *The Seattle Times*. [https://www.seattletimes.com/pacific-nw-magazine/walk-the-beat-with-an-outreach-worker-helping-people-who-live-on-seattle-streets/]

[179] University of Washington School of Nursing and Research with Expert Advisors on Drug Use (READU). (2023). *Opioid Settlement Stakeholder Feedback: Recommendations for the use of opioid settlement funds allocated to Seattle & King County*. [https://cdn.kingcounty.gov/-/media/king-county/depts/dph/documents/safety-injury-prevention/overdose-prevention/opioid-settlement-stakeholder-feedback.pdf?rev=a3ec346155a74f509ffc4e8c70005518&hash=2A4DB44D762FAED01ADE3F5791A83B4A]

[180] Addictions, Drug & Alcohol Institute. (2024). *Results from the 2023 WA State Syringe Services Program Health Survey*. [https://adai.uw.edu/wordpress/wp-content/uploads/dlm_uploads/ssp-health-survey-2023.pdf]

[181] Fockele C.E., Duber H.C., Finegood B., Morse S.C., Whiteside L.K. (2021). Improving transitions of care for patients initiated on buprenorphine for opioid use disorder from the emergency departments in King County, Washington. *J Am Coll Emerg Physicians Open,* 23;2(2). [https://pmc.ncbi.nlm.nih.gov/articles/PMC7987236/]

[182] Harborview Injury Prevention & Research Center at the University of Washington. (2024). *NEW Tele-buprenorphine Hotline now serving King County*. [https://hiprc.org/blog/telebup-hotline/]

[183] U.S. Department of Justice Civil Rights Division. ADA.gov: Opioid Use Disorder. [https://www.ada.gov/topics/opioid-use-disorder]

[184] Banks D.E., Brown K., Saraiya T.C. (2023). Culturally Responsive Substance Use Treatment: Contemporary Definitions and Approaches for Minoritized Racial/Ethnic Groups. *Curr Addict Rep*, 10(3):422-431. [https://pmc.ncbi.nlm.nih.gov/articles/PMC12834561/]

[185] Yoon-Hendricks, A. (2023). How Native WA communities are fighting the fentanyl crisis. *The Seattle Times*. [https://www.seattletimes.com/seattle-news/how-native-wa-communities-are-fighting-the-fentanyl-crisis/]

[186] Guerrero E.G., Khachikian T., Kim T., Kong Y., Vega W.A. (2013). Spanish language proficiency among providers and Latino clients' engagement in substance abuse treatment. *Addictive Behaviors*, 38(12):2893-2897. [https://www.sciencedirect.com/science/article/abs/pii/S0306460313002451]

[187] King County DCHS. (2025). *Be Heard: Community Voices About Mental Health and Wellness Report*. [https://cdn.kingcounty.gov/-/media/king-county/depts/dchs/behavioral-health-recovery/MIDD/Be-Heard-Community-Listening-Report]

[188] King County DCHS. (2025). *MIDD Renewal Community Engagement Report*. [https://cdn.kingcounty.gov/-/media/king-county/depts/dchs/behavioral-health-recovery/midd/midd-renewal-community-engagement-report-final-

2025.pdf?rev=158a78c33eab4cdda443da39d874f040&hash=3EDD11B4F9CAF6A7C4BDDCB16EAFF1FD]

[189] Public Health – Seattle & King County. *Data to inform King County's overdose response*. [https://kingcounty.gov/en/dept/dph/health-safety/safety-injury-prevention/overdose-prevention-response/data-dashboards/]

[190] Recovery Research Institute. *What is the evidence for peer recovery support services?* [https://www.recoveryanswers.org/research-post/what-is-the-evidence-for-peer-recovery-support-services/]

[191] Johns Hopkins Bloomberg School of Public Health blog. *How Stable Housing Supports Recovery from Substance Use Disorders*. [https://opioidprinciples.jhsph.edu/how-stable-housing-supports-recovery-from-substance-use-disorders/]

[192] National Academies of Sciences, Engineering, and Medicine. (2016, September). Measuring Recovery from Substance Use or Mental Disorders: Workshop Summary. *National Academies Press (US)*. [https://www.ncbi.nlm.nih.gov/books/NBK390393/]

[193] King County DCHS. (2025, January). *Be Heard: Community Voices About Mental Health and Wellness Report*. [https://cdn.kingcounty.gov/-/media/king-county/depts/dchs/behavioral-health-recovery/MIDD/Be-Heard-Community-Listening-Report]

[194] Morales-Garzón S., Parker L.A., Hernández-Aguado I., González-Moro Tolosana M., Pastor-Valero M., Chilet-Rosell E. (2023, April). Addressing Health Disparities through Community Participation: A Scoping Review of Co-Creation in Public Health. *Healthcare (Basel)*,11(7):1034. [https://pmc.ncbi.nlm.nih.gov/articles/PMC10094395/]

[195] Chen D., Watson R.J., Caputi T.L., Shover C.L. (2021). Proportion of U.S. Clinics Offering LGBT-Tailored Mental Health Services Decreased Over Time: A Panel Study of the National Mental Health Services Survey. *Ann LGBTQ Public Popul Health*. [https://pmc.ncbi.nlm.nih.gov/articles/PMC8659117/]

[196] Seattle Public Schools' Interagency Recovery Campus: Washington's Only Sober Public High School. [https://cdn.kingcounty.gov/-/media/king-county/depts/dchs/behavioral-health-recovery/youth/01-interagency-recovery-campus-enrollment-brochure-06-2025-final.pdf?rev=deeb06b6eedd4d5abac0b65cc15072ad&hash=8E56135EABBF1E42430F890384FDC2A6]

[197] Kohlenberg E., Lucenko B., Mancuso D., He L., Coker L., Liu Q., Felver, B. (2013). *Behavioral Health Needs and School Success: Youth with Mental Health and Substance Abuse Problems are at Risk for Poor High School Performance*. [https://www.dshs.wa.gov/sites/default/files/rda/reports/research-11-194.pdf]

[198] Seattle Public Schools. *Report 2: Student Characteristics and Outcomes*. [https://interagency.seattleschools.org/about/campus-locations/interagencys-recovery-campus/student-characteristics-outcomes/]

[199] Loeb, H., Wyatt, J. G., Sandoval, N. (2025). *Seattle Public Schools' Interagency Recovery Campus Brief Series*. Renton, WA: Puget Sound Education Service District Strategy, Evaluation and Learning Department and Seattle, WA: King County Department of Community and Human Services, Behavioral Health and Recovery Division. [https://cdn.kingcounty.gov/-/media/king-county/depts/dchs/behavioral-health-recovery/youth/2025-interagency-recovery-campus-intro-data-experiences-briefs-combined.pdf?rev=9fb0274d1cfa46dd9e191a90ab64263a&hash=14924D4E89E63B2B07B565551EF8F547]

[200] Hill E., Bond L., Weisz J.R., Patel V. (2025). Addressing the Adolescent Mental Health-Care Gap in the United States. *Journal of Adolescent Health*, 77, 1014-1016. [https://www.jahonline.org/article/S1054-139X(25)00370-2/fulltext]

[201] This number reflects youth served through the following MIDD 2 initiatives: CD-02A: Youth Connection Services, CD-02B: Family Court Services (FCS) Behavioral Health Program, CD-13: Family Intervention Restorative Services (FIRS), and PRI-02: Juvenile Justice Youth Behavioral Health Assessments (JJYBHA).

[202] Ngo V.K., Asarnow J.R., Lange J., Jaycox L.H., Rea M.M., Landon C., Tang L., Miranda J. (2009, October). Outcomes for Youths from Racial-Ethnic Minority Groups in a Quality Improvement Intervention for Depression Treatment. *RAND. Psychiatric Services*, v. 60, no. 10. [https://www.rand.org/pubs/external_publications/EP20091015.html]

[203] Center for the Study of Social Policy. (2025, May). *Using Culture to Promote Youth Mental Health and Well-being: Lessons from Community Providers*. [https://cssp.org/resource/using-culture-to-promote-youth-mental-health-and-well-being/]

[204] Bochicchio, L., Reeder, K., Ivanoff, A., Pope, H., Stefancic, A. (2022). Psychotherapeutic interventions for LGBTQ + youth: a systematic review. *Journal of LGBT Youth*, *19*(2), 152–179. [https://doi.org/10.1080/19361653.2020.1766393]

[205] Washington Council for Behavioral Health. (2024). *Behavioral Health Teaching Clinic Designation and Enhancement Rate Demonstration Project – Stakeholder Report*. [https://www.thewashingtoncouncil.org/wp-content/uploads/2025/01/BH-Teaching-Clinic-Final-Report-Dec.-2024.pdf]

[206] Washington State Department of Health. *Mental Health Counselor – Licensing Requirements*. [https://doh.wa.gov/licenses-permits-and-certificates/professions-new-renew-or-update/mental-health-counselor/licensing-requirements]

[207] Washington Council for Behavioral Health. (2024). *Behavioral Health Teaching Clinic Designation and Enhancement Rate Demonstration Project – Stakeholder Report*.

[https://www.thewashingtoncouncil.org/wp-content/uploads/2025/01/BH-Teaching-Clinic-Final-Report-Dec.-2024.pdf]

[208] King County. KCICN Workforce Survey 2025.

[209] Seattle YMCA. (2026). *The Y + Heritage University Master's in Mental Health Counseling Program* [https://www.seattleymca.org/blog/y-heritage-university-masters-mental-health-counseling-program]

King County | Office of the Executive

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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 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	

ATTACHMENT 6: EXECUTIVE FOLLOW-UP RESPONSES FROM THE JULY 23, 2026, HHHS COMMITTEE MEETING

#	Topic	Committee Question	Executive Response	Policy Staff Comments
1	**Existing Funding Levels**	Please provide a summary of existing funding levels for MIDD II programs and strategies (annual and/or to date).	While the Bridge implementation plan calls for a more strategic and aligned approach to funding priorities, it is anticipated that many of the services currently provided under MIDD 2 initiatives programming will continue through updated procurements. Attachment 7 to the staff report provides an overview of current investments in services aligned with the Bridge strategy areas and shows those investments from 2026-2034. The MIDD 2 to BH Bridge Comparison (Attachment 7 to the staff report) compares funding levels for current 2026-27 services with the planned investments under each Bridge Implementation Plan goal area. Shifts from current funding amounts to planned investment under the Bridge Implementation Plan are summarized below: • **Care Transitions and Diversion:** The slight reduction in Care Transitions and Diversion reflects a planned shift as some existing programs move to other funding streams, specifically CD-06, Crisis Diversion Services, and CD-11, Children's Crisis Outreach and Response System. • **SUD Treatment and Recovery:** Increasing SUD investment is essential because growing overdose risks demand more effective, low-barrier care, including significant added funding to expand legally-mandated access to MOUD for people in custody in King County jails. Increased funding in this strategy area will strengthen early intervention and engagement, expand access to a full continuum of treatment, and enhance long-term recovery supports. • **Equitable Access to BH Care:** A reduction in equitable access funding relative to 2026-2027 reflects a planned shift in the non-Medicaid outpatient benefit payment model and eligibility process while still prioritizing culturally responsive care for communities facing the greatest barriers. These changes are expected to support the non-Medicaid benefit program to support the same amount or more individuals within the proposed budget. • **Children, Youth, and Young Adults:** Increasing investment in children and youth is critical because rising behavioral health needs in this population require earlier, developmentally tailored supports. • **Workforce:** Investment is increasing to address persistent recruitment and retention challenges, stabilize provider capacity, and ensure the behavioral health system can effectively implement and sustain the plan's strategies and services.	While Attachment 7 to the staff report provides more information regarding how much funding is currently allocated to programs that may be eligible for Bridge funding under the new implementation plan, this response is consistent with the plan in that it does not provide specificity or identify programs that will receive funding under the Bridge. Policy issue 9 as identified in the staff report flags that there is a lack of specificity in the transmitted implementation plan and it is a policy choice for members if they want additional information about which programs will receive funding prior to the implementation plan going into effect in 2028.
2	**MIDD 2 Data**	**How did the data from MIDD 2 inform the Bridge plan and process?**	DCHS reviewed data on enrollment patterns, outcomes, spending, and implementation challenges for MIDD 2 programs during the renewal process. DCHS will incorporate this information, along with assessment data for the current behavioral health landscape, along with an analysis of updated population trends and performance indicators and outcome data from MIDD 2 programs, into the procurement development phase. This process will help determine which existing service types and program models are best suited to continue (with updates to align under the Bridge Implementation Plan's strategy areas, goals, and evaluation approach), versus where new or revised models may be procured to meet emerging community needs. DCHS intentionally refrained from asking the multidisciplinary subject matter expert workgroups that supported the Bridge Implementation Plan's program design to begin their process by evaluating current MIDD programming. This approach allowed workgroups to start from a blank slate, generating input based on community identified needs, updated behavioral health data, and the broader system challenges described in the Bridge Implementation Plan, to create a forward-looking investment framework that reflects the needs and priorities of King County residents. Later, during procurement, more recent MIDD program data will be integrated where applicable to align future investments with the proposed Implementation Plan's strategy areas and goals.	This response indicates that DCHS has reviewed MIDD 2 data to inform the renewal process and intends to incorporate this information, along with additional analysis, into the procurement development, "to align future investments with the proposed Implementation Plan's strategy areas and goals." However, DCHS intentionally did not include this information and analysis in their engagement with subject matter experts to "start from a blank slate" and "generate community identified needs [...]to create a forward-looking investment framework that reflects the needs and priorities of King County residents." It is unknown what impact this approach may have had on the Bridge program design.

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3	**MIDD 2 Data and Funding Decisions**	**Please explain how decisions about what does/doesn't get funding are made (e.g., informed by MIDD II data/evaluation or community feedback)?**	Building on the process outlined in the Implementation Plan and in the question above that shaped the design of the Bridge Implementation Plan's strategy areas and goals, DCHS intends to continue to use data and feedback to inform the process of procuring and contracting for Bridge-funded services. Procurement development will integrate updated performance information, population level trends, and outcome data from existing MIDD programs. This analysis will help to determine which existing services and program models are strong candidates to continue as Bridge-funded programs (with updates to align under the Bridge Implementation Plan's strategy areas, goals, and evaluation approach); which may be better aligned with other funding sources such as Medicaid or the Crisis Care Centers Levy; and where new or revised models may be required to meet emerging community needs. The renewed process emphasizes the interconnectedness of the proposed goals, alignment with the broader behavioral health system, and responsiveness to significant changes in the funding landscape. Community feedback also plays a central role in determining funding priorities. Engagement with more than 2,200 residents and providers directly informed the identification of the five strategy areas, the definition of community needs, and the elevation of equity issues across the system. Recommendations from multisector subject matter experts and community participants shaped the strategic direction rather than evaluations of existing services, ensuring that decisions reflect community identified priorities rather than legacy investments. Combined with data analysis, and attention to forthcoming shifts in state and federal funding streams, this ensures that funding decisions remain both evidence informed and responsive to evolving behavioral health needs in King County. Together, community identified needs and subject matter expert insights shaped the Bridge's strategy areas by pinpointing where investments can have the greatest impact in the behavioral health system. As described in the Implementation Plan, Bridge investments will directly impact these areas.	This response from Executive staff provides more declarative statements about what the procurement process will include than described in the implementation plan. As indicated in the staff report, the phased, competitive procurement section (p. 19-21, Bridge plan) of the transmitted implementation plan provides a general overview of what the procurement design would look like but does not use declarative statements regarding what it will entail. Page 21 of the implementation plan includes a list of what, "the process to develop and implement procurements is expected to include". Policy issue number 5 flags that the transmitted plan uses permissive language such as "intends", "plans", and "anticipates" with respect to various components that the Executive may implement. This response from Executive staff states that, "procurement development will integrate updated performance information, population level trends, and outcome data from existing MIDD programs." It is a policy choice for councilmembers whether to change the terminology or include declarative statements that Executive staff provided in the plan.
4	**MIDD Data**	**Please provide available quantitative data that informed policy decisions in transmitted plan, generally speaking (tables, charts etc. that could be shared with providers) by 7/31.**	To inform future investments and strategy areas, DCHS staff conducted an extensive look back at the MIDD 2 implementation and the over 100,000 King County residents who were served since 2017. Staff identified successes and challenges of MIDD implementation, changes to community behavioral health needs over the past decade, and changes in the funding landscape (local, State, and Federal). Staff assessed the number of County residents served by MIDD 2 within each strategy area, demographics characteristics of those served, program costs, geographic reach, and outcome data, all within the context of the current behavioral health landscape. The figure below displays the trends in the number of MIDD participants, organized by MIDD 2 strategy area, from 2017-2025.	This response from Executive staff provides additional information for councilmembers to consider. Of note, the number of individuals served by the Therapeutic Courts strategy area appears to be on a steady decline since 2020. This could be due, at least in part, to a decline in eligible therapeutic court participants due to the Washington State Supreme Court ruling in State v. Blake that deemed unconstitutional Washington's simple possession of a controlled substance statute in 2021. Data provided related to fatal overdose trends in King County was used to inform an increase in funding for substance use disorder treatment in the proposed Bridge

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			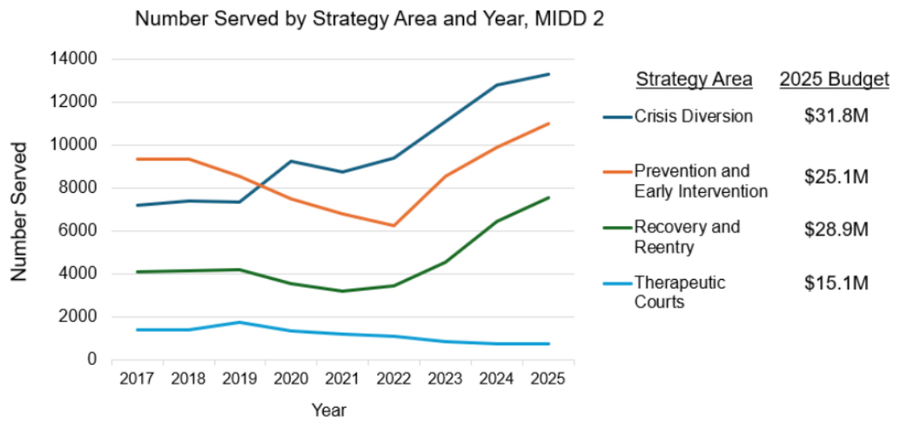 Every year, the MIDD Annual Report Data Dashboard[1] provides detailed information on each initiative that uses sales tax revenue. Long-term outcomes related to crisis episodes, emergency department visits, jail bookings, and psychiatric hospitalizations are displayed on the dashboard and can be filtered to the specific initiatives to which these outcomes pertain. See the example below of jail booking outcome data across the entire MIDD, which shows consistent reductions in jail bookings over the long-term for individuals participating in relevant MIDD programs. These outcomes are assessed over time by cohort (i.e., year) of MIDD 2 program participants. The example to the right illustrates that among individuals enrolled in relevant MIDD programs in 2020; jail bookings went down by 59% by the third year following their participation. Among individuals enrolled in relevant MIDD programs in 2021, jail bookings went down by 36% by the third year following their participation. This information demonstrates a consistent pattern, year-over-year, of the long-term outcomes for individuals participating in MIDD programs. The data is purely descriptive, however, and the new evaluation framework in the Bridge Implementation Plan will add the ability to assess relative impact across programs and the potential to assess program efficacy. DCHS staff used MIDD 2 data like this, at the strategy area and initiative level, to inform the	plan. This proposal for increased funding appears logical, though it may be worth requesting additional information from Executive staff regarding other increases of funding to address fatal overdose trends that have been allocated in recent years through the Crisis Care Centers Levy, opioid settlement funds, and other new revenue sources. Additional information may be needed to ensure local revenue sources are used to enhance and not duplicate services.

[1] MIDD Annual Report Data Dashboard, https://kingcounty.gov/MIDDdashboard

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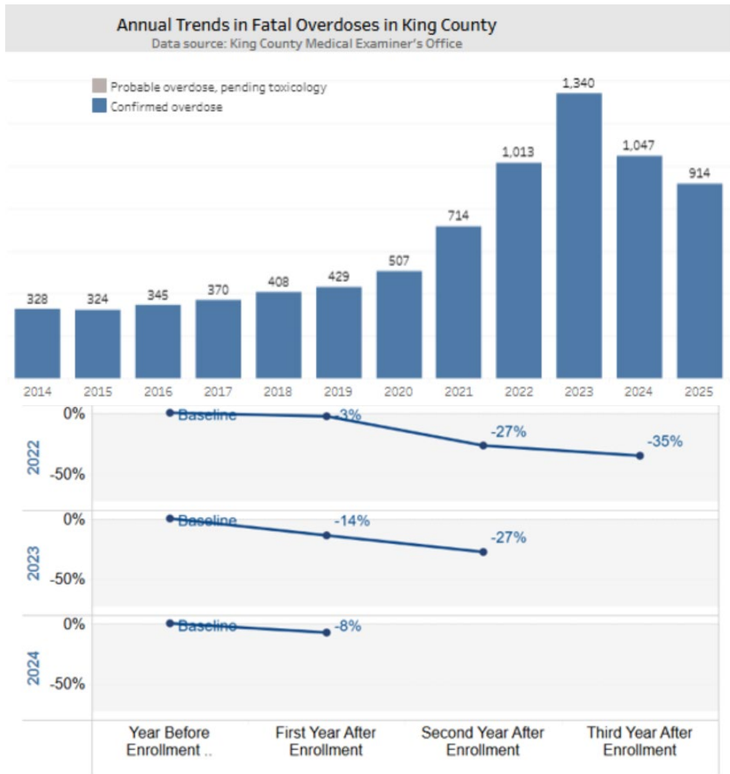
			development of the Bridge Implementation Plan, including its proposed strategy areas and goals and the anticipated activities that DCHS plans to procure. In addition to assessing patterns in outcome data for MIDD 2 programming, DCHS staff also assessed the existing behavioral health landscape using available data from Public Health – Seattle and King County (PHSKC) and other entities. For example, as shown to the right and summarized in the Implementation Plan, fatal overdose rates have increased and remain substantially higher than 2018 levels. This pattern in King County necessitates a renewed focus of behavioral health investments aimed at substance use. Patterns, such as those displayed below, informed the creation of the Substance Use Disorder Treatment and Recovery strategy area and the anticipated activities therein. Further, DCHS staff engaged over 2,200 community members to inform the creation of the Bridge Implementation Plan and identify needs and gaps in the King County behavioral health system (for more detail, see the Phase One Community Engagement Report[2]). This engagement process sought insight into how the Bridge might enhance behavioral health care for community members, reduce substance use risks (including overdose), improve the behavioral health workforce, and support integrated care. Community members who participated represented every King County Council district. The most oft-cited recommendations from community members were collapsed into major themes and summarized as follows: 1. Increase Access & Reduce Barriers 2. Strengthen Culturally Relevant & Responsive Care 3. Reduce System Fragmentation & Improve Service Coordination 4. Strengthen and Increase Services for Children, Youth, and Young Adults 5. Strengthen and Expand the Behavioral Health Workforce 6. Strengthen Wraparound Services  *Source: Overdose deaths data dashboard, Public Health – Seattle & King County. [LINK]*	

[2] Phase One Community Engagement Report, https://cdn.kingcounty.gov/-/media/king-county/depts/dchs/behavioral-health-recovery/midd/midd-renewal-community-engagement-report-final-2025.pdf?rev=158a78c33eab4cdda443da39d874f040&hash=3EDD11B4F9CAF6A7C4BDDCB16EAFF1FD

<table>
<tr><th>#</th><th>Topic</th><th>Committee Question</th><th>Executive Response</th><th>Policy Staff Comments</th></tr>
<tr><td>5</td><td>MIDD 2 Data and Funding Decisions</td><td>What is the proportion of funding going to different strategies under exec's proposed IP?</td><td>The figure to the right shows each strategy area and the total amount of Bridge revenue to be invested in each area during the 2028-34 implementation period.

NOTE: Numbers in the table may not sum exactly due to rounding.

To see a breakdown of the investments by year, please see the Implementation Plan, page 50, Figure 23.

<table><tr><th colspan="2">Behavioral Health Bridge Sales Tax Approximate Allocation by Strategy (2028 - 2034)</th><th>Percentage of funding invested</th></tr><tr><td></td><td>Total (millions)</td><td></td></tr><tr><td>Strategy Area 1: Care Transitions and Diversion Services</td><td>$244.4</td><td>31%</td></tr><tr><td>Strategy Area 2: SUD Treatment and Recovery</td><td>$149.6</td><td>19%</td></tr><tr><td>Strategy Area 3: Equitable Access to Behavioral Health Care</td><td>$122.9</td><td>15%</td></tr><tr><td>Strategy Area 4: Child, Youth, and Young Adult Mental Wellbeing</td><td>$87.8</td><td>11%</td></tr><tr><td>Strategy Area 5: Behavioral Health Workforce Development</td><td>$44.3</td><td>6%</td></tr><tr><td>Technical Assistance & Capacity Building</td><td>$4.0</td><td>1%</td></tr><tr><td>Administration & Compliance</td><td>$64.8</td><td>8%</td></tr><tr><td>Performance Measurement & Evaluation</td><td>$19.0</td><td>2%</td></tr><tr><td>Behavioral Health Fund Transfer:</td><td>$60.9</td><td>8%</td></tr><tr><td>Total Behavioral Health Bridge Sales Tax Costs</td><td>$797.7</td><td></td></tr></table></td><td>No policy staff comment.</td></tr>
<tr><td>6</td><td>Funding Decisions</td><td>What are trade-offs of new funding strategies, what are we potentially not funding; explanation of why we are prioritizing some areas over others.</td><td>The Behavioral Health Bridge Implementation Plan generally organizes the services supported by the fund to align under new strategy areas and goals, without excluding types of services funded under MIDD 2 from eligibility for future funding. Most service types funded under MIDD 2 align with the Behavioral Health Bridge strategy areas and goals. To ensure an equitable and accountable process, most Bridge services will be competitively reprocured starting in 2028, with the exception of services directly operated by King County, such as therapeutic courts and some public health programs.

As described further in the Implementation Plan Section IV, page 13-16 and in the responses to Batch 2 questions 1, 2, and 4[3], the selected strategy areas are prioritized because they emerged from an 18-month, comprehensive process that included a thorough behavioral health landscape assessment, extensive community engagement, and consultation with subject matter experts. This deliberate approach ensured that priorities in the Implementation Plan reflect the most pressing community needs. This process helped identify strategies that are positioned to create meaningful improvement on key issues and needs in behavioral health in King County, given the limited amount of funding available through the Bridge.</td><td>No policy staff comment.</td></tr>
<tr><td>7</td><td>Funding Decisions</td><td>Please provide more information about what programs utilize braided funds (and rationale for</td><td>Historically, services have been structured with braided funding when the County wished to respond to an urgent or newly emerging community need, but no single funding stream had sufficient funding available to fund the requested program or service in its entirety. As the County has added or renewed several local funding streams in human services and behavioral health since the 2017 renewal of the MIDD fund, the Bridge renewal presents an opportunity to start to shift programs to single sources of local funding</td><td>No policy staff comment.</td></tr>
</table>

[3] These are questions 2, 3, and 4 in this attachment, Attachment 6.

<table>
<tr><th>#</th><th>Topic</th><th>Committee Question</th><th>Executive Response</th><th>Policy Staff Comments</th></tr>
<tr><td></td><td></td><td>combined funding approach) and the rationale for ‘unbraiding’ some program funding for the Bridge.</td><td>where possible. This approach is intended to streamline administration and oversight while enhancing transparency and accountability. It also supports the Executive’s priority of shifting from a collection of disparate programs to a thoughtfully planned and integrated system.

The chart below shows the MIDD 2 investments that have associated braided funding in 2026-27, with information about what other funding streams currently support each service.

At this time, DCHS does not have information about the presence or absence of braided funding in programs that receive direct appropriations from Council and are administered by courts or other criminal legal system agencies.

<table>
<tr><th rowspan="2">MIDD Initiative</th><th rowspan="2">Program Title- Official</th><th rowspan="2">Managing Division/ Department</th><th colspan="8">Type of funding</th><th rowspan="2">OTHER - NON STATE, NON LOCAL [includes Juul/Atria settlement, Raikes Foundation, Opioid settlement]</th></tr>
<tr><th>OTHER FEDERAL</th><th>MEDICAID</th><th>BHASO</th><th>OTHER STATE</th><th>CCC</th><th>BSK</th><th>VSHSL</th><th>OTHER LOCAL</th></tr>
<tr><td>TX-ADC</td><td>Adult Drug Court</td><td>BHRD</td><td></td><td></td><td>Yes</td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>RR-02</td><td>Community Center for Alternative Programs (CCAP)</td><td>BHRD</td><td></td><td></td><td></td><td>Yes</td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>CD-10</td><td>Emergency Telephone Services - Regional Crisis Line</td><td>BHRD</td><td></td><td>Yes</td><td>Yes</td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>SP-14 & RR-13</td><td>Familiar Faces Intensive Case Management (VITAL)</td><td>BHRD</td><td></td><td></td><td>Yes</td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>CD-13</td><td>Family Intervention Restorative Services</td><td>BHRD</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td>Yes</td><td></td></tr>
<tr><td>CD-13</td><td>Functional Family Therapy (FFT)</td><td>BHRD</td><td></td><td></td><td></td><td>Yes</td><td></td><td></td><td></td><td>Yes</td><td></td></tr>
<tr><td>RR-12</td><td>Jail SUD Assessment Services</td><td>BHRD</td><td></td><td></td><td>Yes</td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>PRI-02</td><td>Juvenille Justice Youth Behavioral Health Assessments</td><td>BHRD</td><td></td><td></td><td></td><td>Yes</td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>RR-01</td><td>KC Housing and Recovery Through Peer Services (HARPS)</td><td>BHRD</td><td>Yes</td><td></td><td>Yes</td><td>Yes</td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>CD-01</td><td>Law enforcement Diversion (LEAD)</td><td>BHRD</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td>Yes</td><td></td></tr>
<tr><td>TX-SMC</td><td>Legal Intervention & Network of Care (LINC)</td><td>BHRD</td><td></td><td></td><td>Yes</td><td>Yes</td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>CD-13</td><td>Multisystemic Therapy (MST)</td><td>BHRD</td><td></td><td></td><td></td><td>Yes</td><td></td><td></td><td></td><td>Yes</td><td></td></tr>
<tr><td>CD-10</td><td>Next Day Appointments (MH)</td><td>BHRD</td><td></td><td></td><td>Yes</td><td>Yes</td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>PRI-04</td><td>Geriatric Regional Assessment Team</td><td>BHRD</td><td></td><td></td><td></td><td></td><td></td><td></td><td>Yes</td><td></td><td></td></tr>
<tr><td>PRI-11</td><td>Older Adult Substance Use Disorder Services</td><td>BHRD</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td>Yes</td><td></td></tr>
<tr><td>RR-11A</td><td>Peer Bridger</td><td>BHRD</td><td></td><td></td><td></td><td>Yes</td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>SI-03</td><td>Program for Assertive Community Treatment (PACT)</td><td>BHRD</td><td>Yes</td><td></td><td>Yes</td><td>Yes</td><td></td><td></td><td></td><td>Yes</td><td></td></tr>
<tr><td>SP-09</td><td>Recovery High School</td><td>BHRD</td><td></td><td></td><td>Yes</td><td></td><td></td><td>Yes</td><td></td><td></td><td></td></tr>
<tr><td>SP-09</td><td>Recovery Navigator Program</td><td>BHRD</td><td></td><td></td><td>Yes</td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>PRI-11</td><td>RSN Clubhouse Services</td><td>BHRD</td><td></td><td>Yes</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>PRI-05</td><td>School-based SBIRT</td><td>BHRD</td><td></td><td></td><td></td><td></td><td></td><td>Yes</td><td></td><td></td><td></td></tr>
<tr><td>PRI-11</td><td>Sobering Services</td><td>BHRD</td><td>Yes</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>PRI-11</td><td>Standard Supportive Housing</td><td>BHRD</td><td></td><td>Yes</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>CD-11</td><td>Youth Mobile Crisis Team (MRSS)</td><td>BHRD</td><td>Yes</td><td>Yes</td><td>Yes</td><td></td><td>Yes</td><td></td><td></td><td>Yes</td><td></td></tr>
<tr><td>SP-01</td><td>Youth Support Services</td><td>BHRD</td><td></td><td></td><td>Yes</td><td></td><td></td><td></td><td></td><td>Yes</td><td></td></tr>
<tr><td>CD-07H</td><td>Jail-based Methadone Dosing</td><td>PHSKC</td><td></td><td></td><td></td><td>Yes</td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>CD-03</td><td>Healthcare for the Homeless Network (HCHN)</td><td>PHSKC</td><td>Yes</td><td>Yes</td><td></td><td>Yes</td><td></td><td></td><td></td><td>Yes</td><td>Yes</td></tr>
<tr><td>CD-14</td><td>Opioid-Related Surveillance & Evaluation</td><td>PHSKC</td><td>Yes</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td>Yes</td></tr>
<tr><td>CD-07</td><td>Street Medicine Team - Behavioral Health Specialist</td><td>PHSKC</td><td>Yes</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
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</td><td></td></tr>
<tr><td>8</td><td>Funding Decisions</td><td>What's the proportion of administration funding under MIDD II compared to the Bridge proposal?</td><td>The figure below shows the proportion of administration funding reflected in the Bridge Implementation Plan in comparison to MIDD 2026-27 administration funding for MIDD 2 in 2026-27.

<table>
<tr><th></th><th>Time Period</th><th>Approximate Proportion</th><th>Total Amount</th><th>Average Annual Amount</th></tr>
<tr><td>MIDD 2 (current budget)</td><td>2026-27</td><td>6%</td><td>$15M over 2 years</td><td>$7.5M</td></tr>
<tr><td>Bridge (implementation plan)</td><td>2028-34</td><td>8%</td><td>$64.8M over 7 years</td><td>$9.3M</td></tr>
</table>
In 2026-27, MIDD funding for administration is just above 6%, excluding evaluation functions. Under the Bridge Implementation as proposed, administration constitutes just below 8% of total planned expenditures for the 7-year planning period. The new implementation plan increases allocations to ensure the Bridge has sufficient staffing and systems capacity to meet audit aligned standards of oversight, strengthen contract monitoring, and improve data measurement and evaluation consistent with Better</td><td>The proposed amount of funding allocated to administration for the Bridge is comparable to what was allocated for administration in the CCC Levy implementation plan. The CCC Levy averages approximately $8.9 million annually for administration.</td></tr>
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<tr><td></td><td></td><td></td><td>Government priorities. This includes expanding administrative and evaluation infrastructure to support a more rigorous procurement process, enhanced fiscal controls, continuous quality improvement, and expanded cross agency coordination.</td><td></td></tr>
<tr><td>9</td><td>Funding Decisions</td><td>Please provide a comparison between current and proposed workforce investments and corresponding dollar amounts.</td><td>
<table>
<tr><th colspan="4">MIDD/Bridge Workforce Investments Comparison</th></tr>
<tr><th>Initiative/ Funding Stream</th><th>Dollar Amount</th><th>Investment Period</th><th>Investment Description</th></tr>
<tr><td>MIDD Sales Tax</td><td>$6.7M</td><td>2017-2027</td><td>SI-04: Workforce Development
Workforce Development supports providers to receive specialized training in clinical skills, such as Dialectical Behavior Therapy. This initiative also funds the annual umbrella license for SUD youth treatment providers to implement the evidence-based program, Seven Challenges. It also supports Seven Challenges national trainers to work with the agencies by facilitating quarterly meetings and an annual fidelity meeting.</td></tr>
<tr><td>BRIDGE Sales Tax

Proposed</td><td>$36.4M</td><td>2028-2034</td><td>Goal 1: Strengthen and diversify the behavioral health provider pipeline
Activity: Build pathways to behavioral health careers
Activity: Support high-quality behavioral health clinical internships
Goal 2: Advance and develop skills of the current workforce to meet growing community needs
Activity: Clinical supervision
Activity: Continuing education for community behavioral health providers, including expansion of King County Integrated Care Network (KCICN) Training Academy in Evidence-Based Practices and other culturally relevant clinical modalities effective for BHRD population</td></tr>
</table>
</td><td>The proposed Bridge plan would increase funding for workforce strategies by more than five times from MIDD 2. This is the largest increase in funding for a strategy between MIDD 2 and the proposed Bridge fund. It is notable that the Crisis Care Centers Levy also prioritized workforce strategies including funding for behavioral health career pathways and clinical supervision. This indicates the workforce strategies designed for the Bridge are in alignment with the CCC Levy workforce strategies. CCC Levy funded strategies would not be able to pay for Bridge workforce strategies as those are specific to the CCC Levy-funded workforce.</td></tr>
<tr><td>10</td><td>Funding Decisions</td><td>Undesignated fund balance – please provide more information on what the proposal is for dealing with undesignated fund balance and alternative policy options.</td><td>Section IX.C of the Bridge Implementation Plan addresses priorities for allocating undesignated fund balance, including how such allocations remain subject to the County’s budget process. The relevant section of the plan is excerpted below.

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</td><td>This response from Executive staff aligns with the proposal as it appears in the transmitted Bridge plan. As noted in the staff report, Policy Issue 4 flags that whether to include priorities, or what priorities are included in the priorities for allocating the undesignated fund balance, represent policy choices for the members.</td></tr>
</table>

#	Topic	Committee Question	Executive Response	Policy Staff Comments
			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.	
11	**Timeline for Implementation Plan**	**Regarding the timeline for making decisions, is there a need to implement some strategies prior to the 2-year extension?**	The Executive requests that Expenditure Restriction ER6 governing expenditures during 2026-2027 be left in place, and that the Bridge Implementation Plan go into effect at the beginning of 2028 as proposed. As discussed further below, retaining the proposed Implementation Plan time period would enable the Executive branch to begin planning for the renewed Bridge, including its phased procurements, during 2027 ahead of the plan's effective date. The Executive supports any Council consideration timeline for the Bridge Implementation Plan that results in adoption by December 31, 2026, provided staffing for the renewed Bridge that is needed in 2027 to plan for procurements is adopted through the 2nd omnibus supplemental budget that will be transmitted to the Council this fall. To support the procurement strategy that is necessary to carry out the strategies in the Implementation Plan, the Executive anticipates proposing additional staffing for Bridge implementation planning through the 2nd omnibus, to begin in 2027. Section V.B of the plan describes the design of the procurement process, including planned phases and anticipated development and implementation steps. The procurement process will follow standard departmental procurement procedures, including new safeguards that DCHS is implementing to respond to the results of a 2025 KCAO audit of the department. As also described in the response to Batch 2 question 9[4], procurements for each strategy area are anticipated to be publicly announced approximately one year in advance of the launch of new or reprocured programs within that strategy area. This timeline allows time for an application period, review period, transition or ramp-down period where applicable, and the thoughtful transfer of program participants to new providers as necessary.	No policy staff comment.
12	**Provider Engagement**	**Please summarize any providers feedback about changing the procurement process for the Bridge and need for more measurable outcomes.**	Providers played an important role in shaping the planned shift to competitive procurement during the renewal process. Through listening sessions and SME workgroups, providers emphasized that the provider landscape has shifted over the years and that there is a need for transparent and equitable procurement processes and expressed support for revisiting longstanding program models to better reflect current behavioral health needs. Providers also called for using data to determine the services to provide which directly informed the Implementation Plan's strengthened performance measurement approach, including logic models, goals, and outcomes.	No policy staff comment.
13	**Provider Engagement**	**How is the provider community being made aware of the changes proposed by the new implementation plan, such as RFP/procurement approach and transition timing for new/continuing and noncontinuing programs from MIDD II? Please**	The Bridge serves as a hub across the region for behavioral health providers, and throughout the process of extending the MIDD behavioral health sales tax and developing the implementation plan, the planning team has engaged providers in every step of the process. In 2027, DCHS will develop a plan to engage the provider community. The plan is expected to build on measurable outcomes and community engagement strategies that informed the sales tax extension, which include: • Engaging with the MIDD Advisory Board, Behavioral Health Advisory Board, and the King County Integrated Care Network to bring providers along in the planning, procurement process, and forthcoming procurement timelines per the implementation plan. • Partnering with regionally based behavioral health providers and human services coalitions (e.g. King County Human Services Alliance) and partner groups to host planning session on "what to expect" for upcoming procurement opportunities.	No policy staff comment.

[4] This is question 14 in Attachment 6.

#	Topic	Committee Question	Executive Response	Policy Staff Comments
		provide information about your communications plan.	• Facilitating workgroups, which may consist of providers, County staff, and Councilmembers on specific topics to help inform upcoming procurements and inform the provider community about the rounds of procurements by quarter as outlined in the implementation plan. • Sharing data with KCICN providers (who are also Bridge providers) to illustrate the needs and impacts of Bridge investments across the strategy areas. • Conducting surveys to ensure provider voices are incorporated throughout the procurement process • Providers will be informed about changes through DCHS' communication channels, which include, but are not limited to, the Cultivating Connections department blog, department social media accounts, and email lists specific to MIDD renewal community engagement and MIDD renewal updates.	
14	**Provider Engagement**	**Will providers know in advance if their work was going to continue under the Bridge?**	In preparing for the transition to the Behavioral Health Bridge, DCHS will continue sharing information about the strategy areas, goals, and anticipated activities. This information will help providers understand what goal areas are most relevant to the work they do and when those procurement processes open. When procurements are announced for each strategy area, current providers will be able to evaluate whether their current services are a good fit for the planned RFPs or not. DCHS intends to fund the availability of technical assistance to all potential applicants for Bridge funds, to help providers understand the scope of the procurement and any differences from the services they currently provide. In cases where current programs are not a strong match to a Bridge procurement, providers may choose to apply with modified programming approaches, parameters, or focus populations, or they may opt to seek funding elsewhere. DCHS intends to announce Bridge procurements a year in advance of planned program launch, so that providers who choose not to apply or who are not selected in the Bridge procurement have enough time to identify other funding or prepare to ramp down their programs if needed.	Table 4 in the staff report provides the estimated timeline for phased procurements and the estimated ramp down timeframe for programs that will no longer receive funding through the Bridge.
15	**Reporting**	**Please provide the rationale for switching from an annual to a biennial reporting cadence.**	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. The proposed implementation plan continues the same frequency of accountability and transparency by complementing transmitted reports with annual dashboard updates accompanied by Council briefings each year.	As indicated in the staff report, the shift from an annual to a biennial report (with annual briefings to Council) is a policy choice for members to consider.
16	**Technical Question**	**How many contracts does MIDD currently have and how many contracts is the Bridge aiming to have?**	In 2025, MIDD's 52 initiatives involved 312 contracts across 166 different partners. DCHS anticipates conducting an average of 2-3 procurements per Bridge goal in 2028-2029, using the phased procurement approach outlined in the Implementation Plan. The number of applicants, the number of provider partners necessary to deliver a sufficient scope and range of services, and the amounts that applicants request will all be factors in determining the number of Bridge contracts in 2028-34.	No policy staff comment.
17	**Technical Question**	**Can you confirm that it is the intention of the Exec to align the procurement process with the anticipated activities in the logic models?**	Yes, this is the Executive branch's intention. Procurements will align with the plan's strategy areas, goals, and anticipated activities, as outlined in the logic models. In some cases, a single procurement may encompass multiple related activities to best support the goals of the strategy area.	No policy staff comment.
18	**Technical Question**	**Are there Bridge programs that are operated by DCHS? If so, are they not planned to receive a base budget analysis?**	DCHS staff do not provide direct services in any current MIDD programs. All County agencies, including DCHS, are expected to participate in the Executive Office's base budget analysis process described in Executive Order "Better Governance and Financial Management" from March 4, 2026. The program level base-budget analyses planned for non-DCHS managed MIDD/Bridge programs are also responsive to the Executive Order but will provide more specialized and detailed analysis.	No policy staff comment.

			2026-2027 Budget Period		2028-2034 Behavioral Health Bridge Implementation Plan Period						
Strategy Area	**Goal**	**MIDD 2 Initiatives currently aligned with anticipated activities**	**2026**	**2027**	**2028**	**2029**	**2030**	**2031**	**2032**	**2033**	**2034**
Care Transitions and Diversion Services (CTD)	CTD 1. Divert people from criminal-legal involvement, provide supportive services for those involved in the legal system, and support successful community reentry.	CD-01, CD-14, CD-18A, CD-18B , RR-06A, RR-06B, RR-13, PRI-08, TX-ADC (including RR-05), TX-SMHC, TX-RMHC, TX-FTC, TX-CC	$26.8	$21.1	$25.8	$24.0	$24.6	$25.1	$25.7	$26.2	$26.8
	CTD 2. Help people with behavioral health conditions achieve and maintain stable housing.	RR-01, RR-03	$5.9	$6.1	$5.7	$5.0	$5.1	$5.3	$5.4	$5.5	$5.7
	CTD 3. Enhance navigation and system coordination so that people receive timely and appropriate behavioral health services across all levels of care.	RR-11A, RR-08, CD-10, SI-03	$6.8	$3.4	$5.2	$3.5	$3.6	$3.7	$3.8	$4.2	$4.5
	CTD Total		$39.4	$30.5	$36.7	$32.5	$33.3	$34.1	$34.9	$35.9	$36.9
SUD Treatment and Recovery (SUD) Strategy Area	SUD 1. Drive engagement and retention in SUD care.	PRI-01, CD-03	$1.3	$1.4	$1.7	$2.2	$2.3	$2.4	$2.4	$2.5	$2.5
	SUD 2. Provide effective, low-barrier SUD treatment that meets people's holistic needs.	CD-07, RR-12	$7.9	$8.1	$15.6	$16.3	$16.8	$17.3	$17.7	$18.1	$18.5
	SUD 3. Support paths to achieve and maintain recovery after treatment.	RR-04, RR-09, RR-10, RR-11B	$2.8	$2.9	$2.1	$1.6	$1.7	$1.7	$1.8	$2.1	$2.4
	SUD Total		$12.0	$12.3	$19.5	$20.2	$20.8	$21.4	$21.9	$22.6	$23.4
Equitable Access to Behavioral Health Care (EA) Strategy Area	EA 1. Provide behavioral health care for low-income people who are ineligible for Medicaid.	PRI-11	$16.0	$16.6	$12.0	$12.3	$12.7	$13.0	$13.3	$13.6	$13.9
	EA 2. Support the wellbeing of diverse communities by providing culturally and linguistically responsive services and removing barriers to care.	SI-01, SI-02, PRI-07, PRI-09, PRI-10	$4.2	$4.4	$4.1	$4.2	$4.3	$4.5	$4.6	$5.0	$5.3
	EA Total		$20.3	$21.0	$16.1	$16.5	$17.0	$17.5	$17.9	$18.6	$19.2
Child, Youth, and Young Adult Mental Wellbeing (CYYA) Strategy Area	CYYA 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	PRI-05, CD-17	$3.6	$3.7	$3.5	$4.0	$4.5	$4.6	$4.7	$4.9	$5.0
	CYYA 2. Provide behavioral health and therapeutic services to youth involved in the legal system, including diversion from deeper legal system involvement.	CD-02A, CD-02B, CD-13, PRI-02, TX-JTRAC-BHR	$5.3	$5.5	$5.2	$4.9	$4.7	$4.8	$5.0	$5.1	$5.2
	CYYA 3. Invest in the behavioral health of youth who are marginalized or experience inequities.	CD-08, CD-12, CD-15	$2.9	$2.7	$2.6	$2.8	$3.0	$3.1	$3.1	$3.5	$3.8
	CYYA Total		$11.8	$9.2	$11.2	$11.7	$12.2	$12.5	$12.8	$13.4	$13.9
Behavioral Health Workforce Development (WF) Strategy Area	WF 1. Strengthen and diversify the behavioral health provider pipeline.		$0.0	$0.0	$0.0	$2.5	$2.5	$2.6	$2.7	$2.9	$3.0
	WF 2. Advance and develop the skills of the current workforce to meet growing community needs.	SI-04	$1.4	$1.4	$1.3	$4.1	$4.2	$4.4	$4.5	$4.7	$4.9
	WF Total		$1.4	$1.4	$1.3	$6.6	$6.8	$7.0	$7.1	$7.6	$8.0

Consistent with the King County Behavioral Health Bridge Implementation Plan, amounts in this table are in millions.

ATTACHMENT 8: MIDD 2 INITIATIVE REFERENCE FOR ATTACHMENT 7

This attachment provides a list of MIDD 2 initiatives as a reference to the information provided in Attachment 7. Initiatives that are aligned with anticipated Bridge activities as indicated in Attachment 7 are indicated with an asterisk. Initiatives that are not listed as aligned with Bridge activities in Attachment 7 are indicated with a light gray highlight. Attachment 5 to the staff report provides additional information in the right column regarding why the programs highlighted in gray in Attachment 8 are not anticipated to be eligible for Bridge funding.

Prevention and Early Intervention Initiatives

PRI-01: Screening, Brief Intervention and Referral to Treatment*

PRI-02: Juvenile Justice Youth Behavioral Health Assessments*

PRI-03: Prevention and Early Intervention Behavioral Health for Adults Over 50

PRI-04: Older Adult Crisis Intervention/Geriatric Regional Assessment Team

PRI-05: Collaborative School Based Behavioral Health Services: Middle and High School Students*

PRI-06: Zero Suicide Initiative Pilot

PRI-07: Mental Health First Aid*

PRI-08: Crisis Intervention Training – First Responders*

PRI-09: Sexual Assault Behavioral Health Services*

PRI-10: Domestic Violence Behavioral Health Services and System Coordination*

PRI-11: Community Behavioral Health Treatment*

Crisis Diversion Initiatives

CD-01: Law Enforcement Assisted Diversion*

CD-02A: Youth Connection Services*

CD-02B: Family Court Services Behavioral Health Program*

CD-03: Outreach and In Reach System of Care*

CD-04: South County Crisis Diversion Services/Center

CD-05: High Utilizer Care Teams

CD-06: Adult Crisis Diversion Center, Respite Beds, and Mobile Behavioral Health Crisis Team

CD-07: Multipronged Opioid Strategies*

CD-08: Children's Domestic Violence Response Team*

CD-09: Behavioral Health Urgent Care Walk-In Clinic

CD-10: Next-Day Crisis Appointments*

CD-11: Children's Crisis Outreach Response System

CD-12: Parent Partners Family Assistance*

CD-13: Family Interventions Restorative Services*

CD-14: Involuntary Treatment Triage*

CD-15: Wraparound Services for Youth*

CD-16: Youth Behavioral Health Alternatives to Secure Detention

CD-17: Young Adult Crisis Facility*

CD-18A: Regional Crisis Response*

CD-18B: Therapeutic Response Unit*

Recovery and Reentry Initiatives

RR-01: Housing Supportive Services*

RR-02: Behavior Modification Classes at Community Center for Alternative Programs

RR-03: Housing Capital and Rental*

RR-04: Rapid Rehousing Oxford House Model*

RR-05: Housing – Adult Drug Court*

RR-06A: Jail Reentry System of Care*

RR-06B: Jail Coordinated Discharge*

RR-07: Behavioral Health Risk Assessment Tool for Adult Detention

RR-08: Hospital Reentry Respite Beds*

RR-09: Recovery Café*

RR-10: Behavioral Health Employment Services and Supported Employment*

RR-11A: Peer Bridger Programs*

RR-11B: Substance Use Disorder Peer Support*

RR-11C: Peer Respite

RR-12: Jail-Based Substance Abuse Treatment*

RR-13: Deputy Prosecuting Attorney for Familiar Faces*

RR-14: Shelter Navigation Services

RR-15: Pretrial Assessment and Linkage Services (PALS)

System Improvement Initiatives

SI-01: Community-Driven Behavioral Health Grants for Cultural and Ethnic Communities*

SI-02: Behavioral Health Services in Rural King County*

SI-03: Quality Coordinated Outpatient Care*

SI-04: Workforce Development*

SI-05: Emerging Issues

Therapeutic Court Initiatives

TX-ADC: Adult Drug Court*

TX-FTC: Family Treatment Court*

TX-JTRAC-BHR: Juvenile Therapeutic Response and Accountability Court - Behavioral Health Response*

TX-RMHC: Regional Mental Health Court*

TX-SMC: Seattle Mental Health Municipal Court*

TX-CC: Community Courts*

Behavioral Health Bridge Briefing

Liz Arjun, Behavioral & Public Health Policy Advisor, King County Executive Office
Susan McLaughlin, Director, DCHS
Isabel Jones, Acting Director, Behavioral Health and Recovery Division, DCHS

Regional Policy Committee

August 26, 2026

King County
DCHS
Department of Community and Human Services

Agenda

- Development of the Implementation Plan
  - Community engagement behind the plan
- What's Different
  - Updated 5 strategy areas
  - Procurement for DCHS
  - One County Approach to Outcomes, Measures, and Accountability
- Procurement Timeline and Process
- Inflation Analysis

Implementation Plan Development Steps

Behavioral Health Landscape Assessment
Identified successes, gaps, and areas of concern

Multi-Sector Subject Matter Expert Workgroups
Explored potential investments and provided recommendations

Executive Office Alignment
Developed a package of anticipated investments that sustains past successes and meets current and future community needs

Community Engagement
Identified themes related to community members' concerns over 18 months (June 2024-November 2025.)

DCHS Subject Matter Expert Workgroups
Evaluated recommendations to assess feasibility, cost, equity, and alignment with the County's broader vision for behavioral health

MIDD Advisory Committee Engagement Throughout

King County DCHS Department of Community and Human Services

Community and Subject Matter Expert Engagement

King County

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Department of Community and Human Services

Community Engagement Overview

- Over 2200 people engaged over 18 months through listening sessions, community events, and an online survey in 21 languages.
- Half of people engaged were BIPOC, including Black, Latinx, AAPI, Middle Eastern, and Native/Indigenous.
- Significant engagement from youth, elders, LGBTQIA+ people, people with lived experience, and people who are incarcerated.

Engagement took place across all 9 districts of King County from June 2024 to November 2025.

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Engaging Subject Matter Experts

Multi-sector subject matter expert (SME) workgroups

- One workgroup for each strategy area, consisting of **over 100 subject matter experts.**
- They produced a set of **preliminary goals and investment ideas** to improve behavioral health for King County residents.
- Staff at DCHS, Public Health, and the Executive Office **evaluated and refined** the results.

The result: An implementation plan with 13 goals and a set of anticipated activities that respond to the most pressing needs in King County's behavioral health system.

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Executive Office Alignment & Priorities

- **Implement a countywide approach with an emphasis on integration** of behavioral health services and crisis response systems, as well as services for people who are incarcerated, hospitalized, or unhoused.
- **Promote overall accountability across county investments** that will respond to behavioral health needs across different systems, through competitive procurements and other accountability mechanisms.
- **Make stronger investments with data-driven decisions** that have clear performance goals across multiple systems, including the criminal-legal system.

What's New

King County

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BH Bridge Investment Considerations

- Investments respond to changing fiscal projections throughout implementation in 2028-2034.
- Introduction of a reserve to create flexibility during anticipated sales tax volatility.
- Strengthen monitoring and compliance by right-sizing staffing to support the investment of $100M per year.

BH Bridge Strategy Areas

1. Care Transitions & Diversion Services
2. Substance Use Disorder Treatment and Recovery
3. Equitable Access to Behavioral Health Care
4. Child, Youth, and Young Adult Mental Wellbeing
5. Behavioral Health Workforce Development

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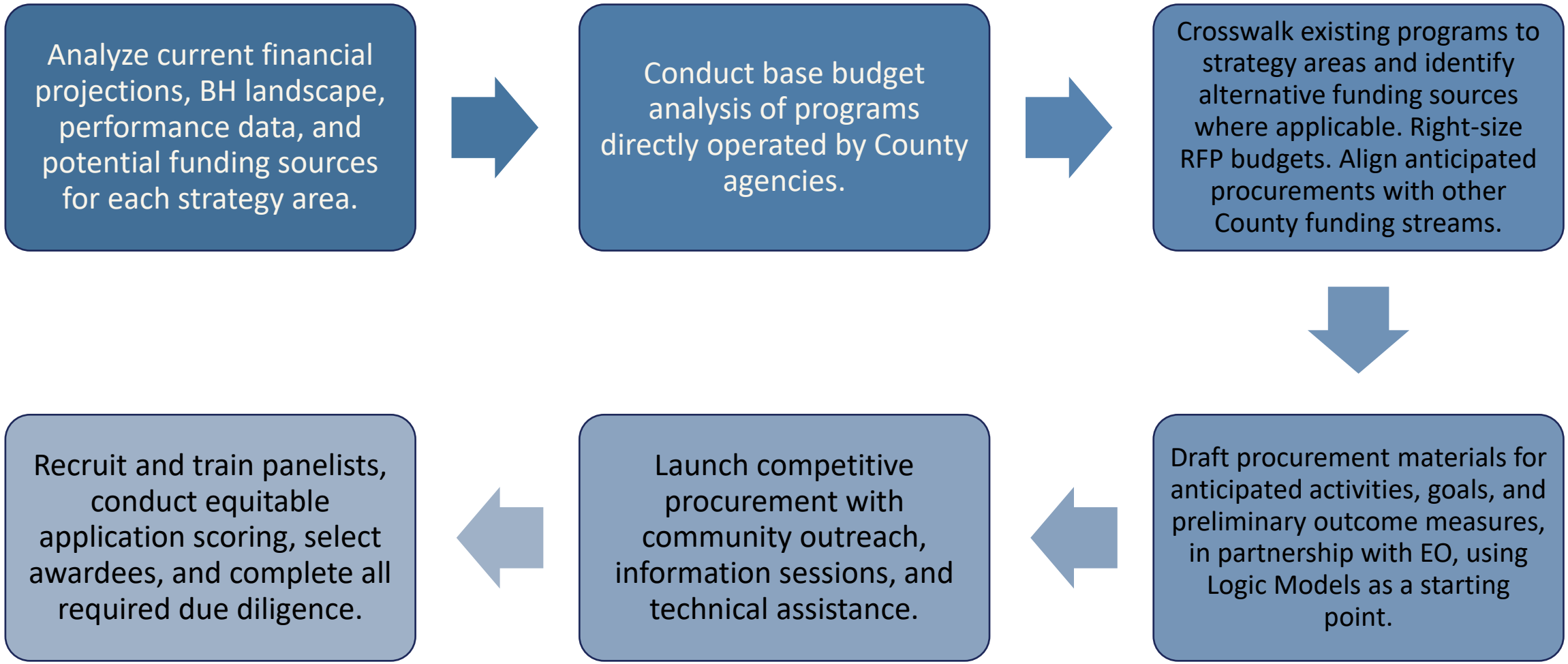
Countywide Approach to Accountability and Outcomes

- Five strategy areas with specific goals and identified measures.
- Competitive procurement process for DCHS programs.
- One County approach with Executive Office to measure, monitor and support accountability.

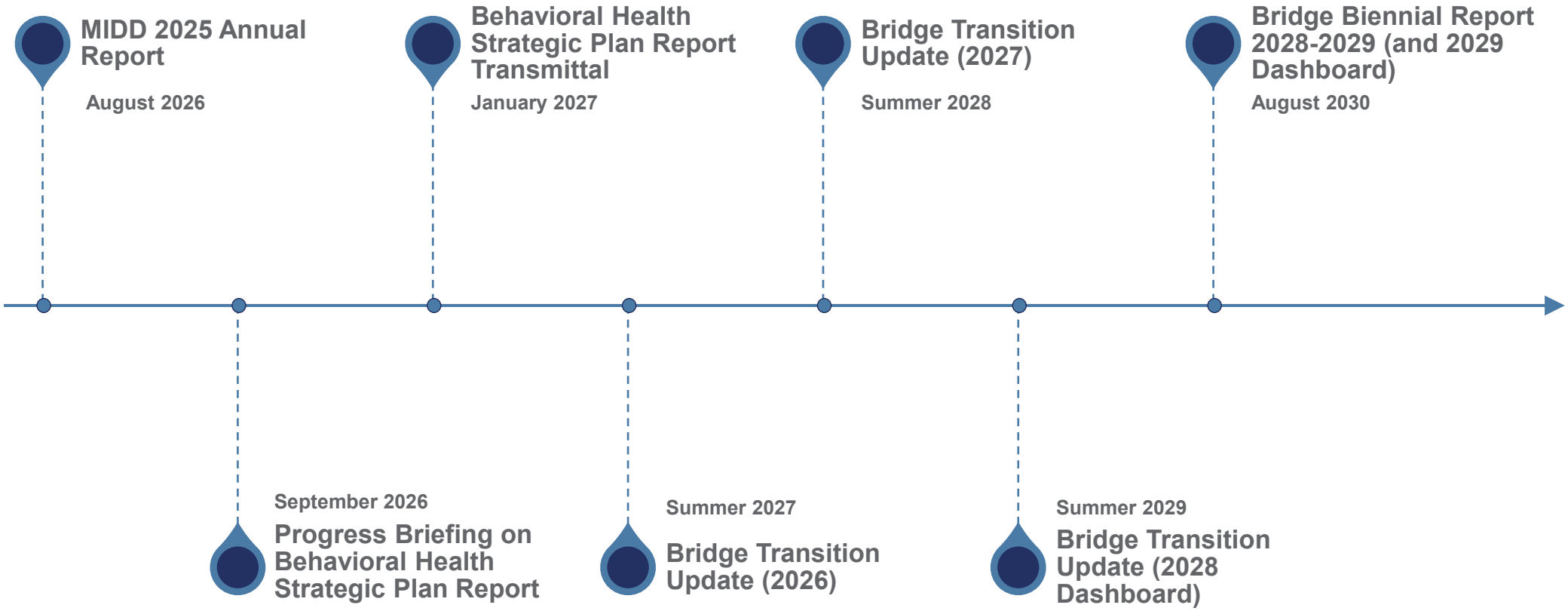
Anticipated Steps to Procurement



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	Anticipated launch of programs (reprocured or with new base budget)
SUD Treatment and Recovery (SUD)	Q2 2027	Q3 2027	End of Q4 2027	Q 1& 2 of 2028	Q3 of 2028
Equitable Access to Behavioral Health Care (EA)	Q2 2027	Q3 2027	End of Q4 2027	Q 1& 2 of 2028	Q3 of 2028
Care Transitions and Diversion Services (CTD)	Q4 2027	End of Q1 2028	End of Q2 2028	Q 3 & 4 of 2028	Q1 of 2029
Behavioral Health Workforce Development (WF)	Q4 2027	End of Q1 2028	End of Q2 2028	Q 3 & 4 of 2028	Q1 of 2029
Child, Youth, and Young Adult Mental Wellbeing (CYYA)	Q2 2028	End of Q3 2028	End of Q4 2028	Q 1 & 2 of 2029	Q3 of 2029

Upcoming Reports and Briefings



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Inflation Analysis

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Inflation Analysis in this Plan

Responsive to Council Budget Proviso

- DCHS integrates provider inflation rate adjustments into implementation plans and budget proposals for local funds to:
  - Support human services providers to maintain service levels/retain workers.
- Expenditure growth is predicted to outpace revenue growth.
- Implementation plan establishes sustainable Bridge spending for 2028-34 by:
  - Planning expenditures to fit within anticipated 7-year revenue total
  - Reducing inflation adjustments when a revenue drop is anticipated (2029) but maintaining them otherwise.

Frequently Asked Questions

King County

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Frequently Asked Questions

- **Will the Bridge invest equitably across the County?**
  - Future Bridge investments are expected to maintain or improve behavioral health service availability across the County through countywide services and targeted investments in both urban and rural areas.
- **Why shift from annual to biennial narrative reports?**
  - The proposed IP continues annual dashboard updates accompanied by Council briefings each year. The proposed transition to biennial narrative reports is intended to redirect Executive branch staff resources to increase continuous improvement.

Questions?

King County

DCHS

Department of Community and Human Services

King County

Metropolitan King County Council
Staff Report

Committee:	Health, Housing, and Human Services Committee		
Agenda Item:	7	**Analyst(s):**	Olivia Brey
Proposed No.:	2026-0159	**Meeting Date:**	September 1, 2026

OVERVIEW

TOPIC: A motion acknowledging receipt of the 2025 Health Through Housing Annual Report, the fourth annual report for this program.

LEGISLATION SUMMARY

In October 2020, Council passed Ordinance 19179, imposing the Health Through Housing (HtH) sales tax. The Council passed Ordinance 19236 in February 2021, requiring the development of an implementation plan with the paramount goal of the creation and ongoing operation of 1,600 units of affordable housing with housing-related services. The HtH Implementation Plan and Ordinance 19366 requires the Advisory Committee to report annually to the Council on expenditures, accomplishments, and effectiveness of the HtH initiative through an online HtH dashboard and to transmit a motion acknowledging receipt of the report.

The Annual Report includes a summary of accomplishments, progress on HtH goals, financial information, information on the HtH Advisory Committee, and a conclusion and next actions. Highlighted metrics include a portfolio of 1,423 units at the end of 2025, 1,380 HtH residents accessed at least one type of onsite health service, and 98 percent of residents reported existing ties to the communities where their HtH site is located.

Proposed Motion 2025-0175 and its attached report appear to comply with the requirements of Ordinance 19366.

KEY ISSUES FROM THE ANALYSIS

A. **Pause on Securing Additional Units.** The Annual Report reiterates DCHS' intention to pause efforts to secure additional HtH units, as previously noted in a letter regarding reallocating funds, dated October 29, 2025. The Annual Report cites uncertainty in HtH projected revenue and significant, unexpected, and costly repair work required for HtH buildings as the reason for the pause.

BACKGROUND

↑ BACK TO TOP

Health Through Housing Sales Tax.

House Bill 1590 and RCW 82.14.530. During the 2020 legislative session, the legislature passed House Bill 1590,[1] which amended RCW 82.14.530 to provide an option for a housing sales tax to be councilmanic. Previously, this housing sales tax was required to go to the ballot for authorization from voters before enactment. In 2021, the legislature amended the law again through Engrossed Substitute House Bill 1070, clarifying that acquiring units of new affordable housing is an eligible use of proceeds.[2]

Counties were given until September 30, 2020, to impose the tax countywide. After that date, cities could impose the tax (either by ballot or councilmanic). According to the statute, if a county imposes the tax after one or more cities have already done so, the county must provide a credit to those cities for the full amount collected within each jurisdiction.

State statute specifies the activities and services for which the tax may be used. Table 1 below provides an overview of the statute's spending requirements.

Table 1. Overview of Spending Allocation Requirements

Allocation	Requirements
At least 60 percent of proceeds	1) Constructing or acquiring affordable housing – including new units within an existing structure and facilities providing housing-related services; 2) Constructing or acquiring mental and behavioral health-related facilities; 3) Funding operations and maintenance of new affordable housing and facilities where housing-related programs are provided, or newly constructed evaluation and treatment centers
Remaining funds	Used for the operation, delivery, or evaluation of mental and behavioral health treatment programs and services or housing-related services

Only the following population groups at or below 60 percent median income for King County may be provided affordable housing and facilities providing housing-related programs using housing sales tax revenue:

1. Persons with behavioral health disabilities;

[1] House Bill 1590. https://app.leg.wa.gov/billsummary/?BillNumber=1590&Year=2019&Initiative=false
[2] Engrossed Substitute House Bill 1070. https://app.leg.wa.gov/billsummary/?BillNumber=1070&Year=2021&Initiative=false

2. Veterans;
3. Senior citizens;
4. Persons who are homeless or at risk of being homeless, including families with children;
5. Unaccompanied homeless youth or young adults;
6. Persons with disabilities; or
7. Domestic violence survivors.

Counties that impose the tax must consult with cities when siting facilities within their jurisdictional boundaries. Additionally, the county must spend at least 30 percent of revenue collected within any city with a population over 60,000 within that jurisdiction. At the time the ordinance was adopted, the following cities had populations over 60,000: Seattle, Bellevue, Kent, Renton, Federal Way, Kirkland, Auburn, Redmond, and Sammamish.

State statute allows the county to issue general obligation or revenue bonds and pledge up to 50 percent of the monies collected for bond repayment. Bonded revenue may finance provision or construction of affordable housing, facilities where housing-related programs are provided, or evaluation and treatment centers.

The county is directed to provide an opportunity for at least 15 percent of units in each facility to be occupied by individuals who live in or near the city where the facility is located, or have other ties to the community, as long as there are enough individuals within the city that need services and meet the rest of the criteria.

Ordinance 19179 and Ordinance 19180. On October 13th, 2020, the King County Council adopted Ordinance 19179[3] imposing a sales and use tax of 1/10th of 1 percent for housing and related services, as authorized in RCW 82.14.530. Proceeds from the tax are deposited into the Health through Housing (HtH) fund, which was established through Ordinance 19180.[4]

Ordinance 19179 directs that fund proceeds are required to be spent on the uses outlined in state statute, as described above, prioritizing those within the population groups in RCW 82.14.520(2)(b) and whose income does not exceed 30 percent of the King County area

[3] Ordinance 19179. https://mkcclegisearch.kingcounty.gov/LegislationDetail.aspx?ID=4652676&GUID=8A31F2EE-23AF-4BA3-9306-CD87CD8B40A0&Options=Advanced&Search=
[4] Ordinance 19180. https://mkcclegisearch.kingcounty.gov/LegislationDetail.aspx?ID=4648545&GUID=5375B2B2-FED6-43E4-9394-15E081218D29&Options=Advanced&Search=

median income. Additionally, proceeds are required to be allocated with the objective of reducing racial and ethnic disproportionality among those experiencing chronic homelessness.

The ordinance also provides the County with the authority to issue bonds and use up to 50 percent of the monies collected for repayment of those bonds.

Ordinance 19236. Adopted in February 2021, Ordinance 19236[5] outlined the content and development approach for the HtH Implementation Plan and defines how revenues are to be spent. Per Ordinance 19236, the Executive is required to develop the implementation plan in consultation with the Affordable Housing Committee and the Chief Executive Officer of the King County Regional Homelessness Authority and transmit the Plan to the King County Council, along with legislation to establish the HtH Advisory Committee, no later than June 30, 2021.

Ordinance 19236 required that the implementation plan include goals, strategies, performance measures, reporting requirements, a process for siting HtH-funded affordable housing and behavioral health facilities, and a detailed annual spending plan for the first eight years of the tax. The paramount goal required to be included in the implementation plan was the creation and ongoing operation of 1,600 units of affordable housing with housing-related services. Additional required goals to be included in the implementation plan were:

- An annual reduction of racial and ethnic demographic disproportionality among persons experiencing chronic homelessness in King County; and
- The creation and operation of a mobile behavioral health intervention program with access for its clients to be created, operated, or otherwise funded by proceeds.

Ordinance 19236 required that legislation establishing the HtH Advisory Committee be transmitted with the implementation plan. The Committee would be tasked with providing advice to the Executive and Council and producing an annual report on the accomplishments and effectiveness of HtH sales tax expenditures. The Committee's responsibilities were to be described in the implementation plan and the membership would be required to include representatives of the following demographics:

- Individuals who have experienced homelessness;
- Racial and ethnic communities that are demographically disproportionately represented among people experiencing chronic homelessness in King County;

[5] Ordinance 19236. https://mkcclegisearch.kingcounty.gov/LegislationDetail.aspx?ID=4652907&GUID=5E5E8D61-6B3B-46EC-937C-6FD39E8CB6F0&Options=Advanced&Search=

- Residents of cities with populations greater than sixty thousand;
- Residents of the unincorporated areas of King County; and
- Representatives from other county, city, and subregional boards, commissions, or committees pertaining to King County human services investments.

2021 HtH Activities. In 2021, the County undertook HtH activities to design key aspects of the initiative and acquired HtH sites. King County acquired a total of 9 buildings in 2021 across Seattle, Renton, Redmond, Auburn, and Federal Way. Additionally, the County established a memorandum of agreement with the City of Seattle to permanently add 350 operations-only units[6] to the HtH portfolio. Lastly, the County opened and moved residents into the Mary Pilgrim Inn, a 100-unit building in North Seattle.

Initial Health Through Housing Implementation Plan. On December 7, 2021, the King County Council adopted Ordinance 19366,[7] adopting the Initial Health Through Housing Implementation Plan (Plan), which governs the expenditure of HtH sales and use tax proceeds from 2022 through 2028. The ordinance also created the HtH Advisory Committee.

The Plan established supporting goals to the paramount goal to be delivered by the end of the initial Implementation Plan's term in 2028, which are:

- Supporting Goal 1: Annually reduce racial and ethnic disproportionality among persons experiencing chronic homelessness in King County (required by K.C.C. 24.30.030.A.1[8]).
- Supporting Goal 2: Create and operate a mobile behavioral health intervention program with access for its clients to housing created, operated, or otherwise funded by HtH proceeds (required by K.C.C. 24.30.030.A.5[9]).
- Supporting Goal 3: Increase HtH resident health by providing health care system enrollment and access on-demand to integrated healthcare for all HtH property residents while they reside in a HtH housing unit.

[6] Operations-only units were created or acquired through capital funds other than HtH, but these have been permanently added to the HtH portfolio via service contracts. Nonprofit organizations retain the ownership of the units while HtH funds the operations and service costs.
[7] Ordinance 19366. https://mkcclegisearch.kingcounty.gov/LegislationDetail.aspx?ID=5121460&GUID=7DC46271-C6B3-4D90-B6DE-DEF37CD0A7D5&Options=Advanced&Search=
[8] K.C.C. 24.30.030.A.1. https://aqua.kingcounty.gov/council/clerk/code/33_Title_24.htm#_Toc65058358
[9] K.C.C. 24.30.030.A.5. https://aqua.kingcounty.gov/council/clerk/code/33_Title_24.htm#_Toc65058358

- Supporting Goal 4: Convert (through rehabilitation or "rehab") into permanent supportive housing by December 31, 2028, at least 50 percent of HtH units that enter the portfolio as emergency housing.
- Supporting Goal 5: Increase the number of organizations who can operate emergency, supportive, or other affordable housing who also specialize in serving a demographically overrepresented population or community among King County's chronically homeless population.
- Supporting Goal 6: Establish and maintain an online, publicly reviewable "dashboard" depicting current and historical performance data and information about the HtH initiative.
- Supporting Goal 7: Publish by December 31, 2026, an in-depth evaluation of the HtH initiative's effectiveness.

The Plan identified the following implementation strategies intended to accomplish the paramount and supporting goals, including:

- Strategy 1: Capital Financing and Improvements for HtH Sites
- Strategy 2: Emergency and Permanent Supportive Housing Operations
- Strategy 3: Behavioral Health Services Outside of HtH Sites
- Strategy 4: Capacity Building Collaborative
- Strategy 5: Evaluation and Performance Measurement
- Strategy 6: Future Acquisition of Additional Properties

Further, the Plan defined an Annual Expenditure Plan, including revenues and expenditures allocated to each strategy.

Annual Reporting Requirements. The Plan required the Advisory Committee to report annually no later than June 15th to the Council on expenditures, accomplishments, and effectiveness of the HtH initiative through an online HtH dashboard.[10]

The dashboard is required to be updated by June 15 each year starting in 2023 and would include, at a minimum:

- A list of HtH Advisory Committee members;
- A map of locations of sites constructed or acquired, and locations and numbers of housing units;

[10] Health Through Housing Dashboard. https://kingcounty.gov/en/dept/dchs/human-social-services/community-funded-initiatives/health-through-housing/health-through-housing-dashboard#rooted

- Demographic data of population residing in HtH-funded housing, including race and ethnicity;
- The number of households receiving service through the mobile behavioral health intervention program;
- The number of households who were living in or near the city in which the site is located;
- HtH initiative financial information, including annual revenue, allocation of proceeds for housing and operations to jurisdictions with HtH sites, and actual expenditures of previous year's proceeds among expenditure categories; and
- Data on how HtH performs on various population-level and program performance measures.

Further, code changes in Ordinance 19366 require the annual report to be transmitted to the Council, with a motion acknowledging receipt of the report. Ordinance 19366 also required reporting on the allocation of proceeds by jurisdiction. For additional information on the Plan, please reference the staff report for Ordinance 19366.[11]

2024 Annual Report. Motion 16910[12] was passed in December 2025 acknowledging the receipt of the third annual report. By the end of 2024, the HtH portfolio included a total of 1,434 units, with 954 units open. A total of 1,281 people were served during the 2024 reporting period and 97 percent of residents had existed ties to the city in which their HtH building is located. Additionally, after one year, HtH residents' total number of days in inpatient hospital care decreased by 33 percent, and their total number of emergency department visits dropped by 17 percent.

Reallocation Letters. The Executive has transmitted four reallocation letters to increase funding for building acquisitions and capital improvements to continue to progress toward the HtH initiative's 1,600-unit goal.[13]

Most recently, in October 2025, the Executive reallocated $7.25 million from Strategy 2 Emergency and Permanent Supportive Housing Operations to $2.45 million for bond

[11] Ordinance 19366. https://mkcclegisearch.kingcounty.gov/LegislationDetail.aspx?ID=5121460&GUID=7DC46271-C6B3-4D90-B6DE-DEF37CD0A7D5&Options=Advanced&Search=&FullText=1

[12] Motion 16910. https://mkcclegisearch.kingcounty.gov/LegislationDetail.aspx?ID=7436417&GUID=8060B529-777E-496A-82D9-08BB39E4C2CE&Options=Advanced&Search=

[13] The first three reallocation letters are summarized in staff reports for previous annual reports.

financing costs and $4.8 million in the HtH Reserve.[14] The funding for bond financing costs was intended to repay bond debt for 2025 capital costs, resulting from high interest rates and capital rehabilitation costs that were larger and required sooner than initially anticipated. The higher bond financing costs also required an increase to the HtH reserve to meet the policy for six months of debt service in the reserve, which necessitated the $4.8 million reallocation. As discussed in previous annual reports, the balance of Strategy 2 had grown each year due to underspend resulting from delayed building openings and less operating funds needed.

The October 2025 reallocation letter also expressed the Executive's intent to pause efforts to secure additional units, despite not yet achieving the paramount goal of creating and operating 1,600 new units of supportive housing. The letter notes that changes in financial conditions impacting the cost of acquiring new properties and maintaining existing HtH buildings, as well as uncertainty in future construction costs and potential reductions in HtH sales tax revenue has led to the pause on expansion efforts.

Frank Chopp Health Through Housing Advisory Committee and Fund. On November 18th, 2025, the King County Council adopted Ordinance 19997,[15] which renamed the Health Through Housing program in honor of former Representative Frank Chopp. Representative Chopp advocated for affordable housing owned by the public or nonprofits so it would be permanently available to support low-income people. Ordinance 19997 made amendments to King County Code to rename the advisory committee and the name of the fund.

ANALYSIS

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Proposed Motion 2025-0159 was transmitted on June 16, 2026, and the attached 2025 Health Through Housing Annual Report appears to meet the requirements of Ordinance 19366 to report on the expenditures, accomplishments, and effectiveness of the HtH initiative. More detailed information and infographics can be found on the online HtH Dashboard, maintained by DCHS.[16]

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[14] Notification of Reallocation of HtH Revenue, October 29, 2025. https://mkcclegisearch.kingcounty.gov/View.ashx?M=F&ID=14897488&GUID=B56716B0-86CF-457E-A92C-5646C5F33B6F

[15] Ordinance 19997. https://mkcclegisearch.kingcounty.gov/LegislationDetail.aspx?ID=7711662&GUID=5131AEF4-8473-4147-8092-F4A89BE21A88&Options=Advanced&Search=

[16] Health Through Housing Dashboard. https://kingcounty.gov/en/dept/dchs/human-social-services/community-funded-initiatives/health-through-housing/health-through-housing-dashboard#rooted

Performance Overview: Accomplishments and Effectiveness in 2025. The transmitted report states that 2025 activities were focused on rehabilitating and opening buildings, bringing people inside, and connecting residents with health care and other supports.

HtH's portfolio included a total of 1,423 units at the end of 2025, which is roughly 89 percent of the paramount goal of creating and operating 1,600 units of affordable housing with housing-related services. Eight units were removed from the total housing count due to repurposing units for temporary relocation units at multiple sites. Table 2 summarizes the annual progress toward the HtH initiative's paramount goal.

Table 2. Progress Towards the Paramount Goal

Year End	In Progress or Paused			Open & Operational			TOTAL
	Owned	Operations-Only	Subtotal	Owned	Operations-Only	Subtotal	
2022[17]	413	150	563	603	200	803	**1,366**
2023	419	215	634	462	262	724	**1,358**
2024	396	84	480	474	477	951	**1,431**
2025	317	52	369	545	509	1,054	**1,423**

HtH opened 109 new units for occupancy across four buildings in 2025 including Sweetgrass Flats, The Booker House, Sharyn Grayson House, and Haven Heights in Honor of Bruce Thomas. 77 of the 109 new units are County-owned and 32 are operations-only units. Construction was also completed at another location, Sheila Stanton Place, but since residents didn't begin moving in until 2026, those units will be noted as open in the 2026 reporting period.

The Bob G. is a County-owned building with 80 units which has been closed since June 2023 due to unsafe building conditions. As of the drafting of the Annual Report, the building is in the process of being sold. Additionally, the Annual Report notes that the Argyle, a County-owned, 10-unit building, is not a suitable option for investing in the conversion into permanent supportive housing. The Annual Report notes that the small size, which has made it challenging to find an operator to cost-effectively provide services, a large crack in the basement foundation, and the potential for Sound Transit to site a light rail station where the property is located has contributed to this decision.

> **Key Issue A. Pause on Securing Additional Units.** The Annual Report reiterates DCHS' intention to pause efforts to secure additional HtH units, as previously noted in the October 2025 Reallocation Letter. The Annual Report cites uncertainty in HtH

[17] 2022 reporting was based on total units obtained, irrespective of use (administrative space, community rooms, etc.)

projected revenue and significant, unexpected, and costly repair work required for HtH buildings as the reason for the pause. In 2025, the Facilities Management Division (FMD) discovered over $6.9 million in unanticipated capital costs and additional costs are expected in 2026. According to the Annual Report, "HTH plans to secure additional operations-only units when the initiative's budget forecast projects HTH will generate sufficient revenue to cover total expenditures through 2041, when the first bond will mature."

The Annual Report provides an update on the supporting goal to convert at least 50 percent of units that entered the portfolio as emergency housing into permanent supportive housing. Renovations to convert units in two buildings began in 2025 and will continue through 2026. A third building, which is needed to meet the goal, is in the renovation scoping phase and a site condition assessment will be completed in 2026.

The following highlights were also featured:

- HtH provided a broad range of services and supports to residents with 1,380 HtH residents accessing at least one type of onsite health service. 43 percent of residents received physical health care and 60 percent of residents accessed behavioral health care services.
- HtH continued to achieve positive health outcome for residents. After two years, HTH residents' total number of inpatient hospital stays decreased by 41 percent, and their total number of emergency department visits dropped by 39 percent.
- With regard to housing stability among permanent supportive housing residents, 93 percent of residents maintained their housing or moved to another permanent housing destination.
- HtH began analyzing criminal legal system outcomes and noted that HtH residents experienced reduced engagement with the criminal legal system, with residents experiencing a 24 percent decrease in jail bookings two years after enrollment.
- HtH achieved continued success housing individuals with ties to the city in which their HtH building is located, with 98 percent of residents reporting existing ties.
- HtH sites maintained high occupancy rates in 2025, with buildings ending the year with an average occupancy rate of 92 percent, with some buildings having over 100 percent occupancy rates and others lower due to closures for maintenance, resident turnover, or opening units midyear.

The Annual Report states that progress was made on the primary supporting goal of annually reducing the racial-ethnic disproportionality among persons experiencing chronic

homelessness. Table 3 provides an overview of the race/ethnicity of HtH residents, chronically homeless individuals in King County, and the overall King County population in 2024 and 2025.

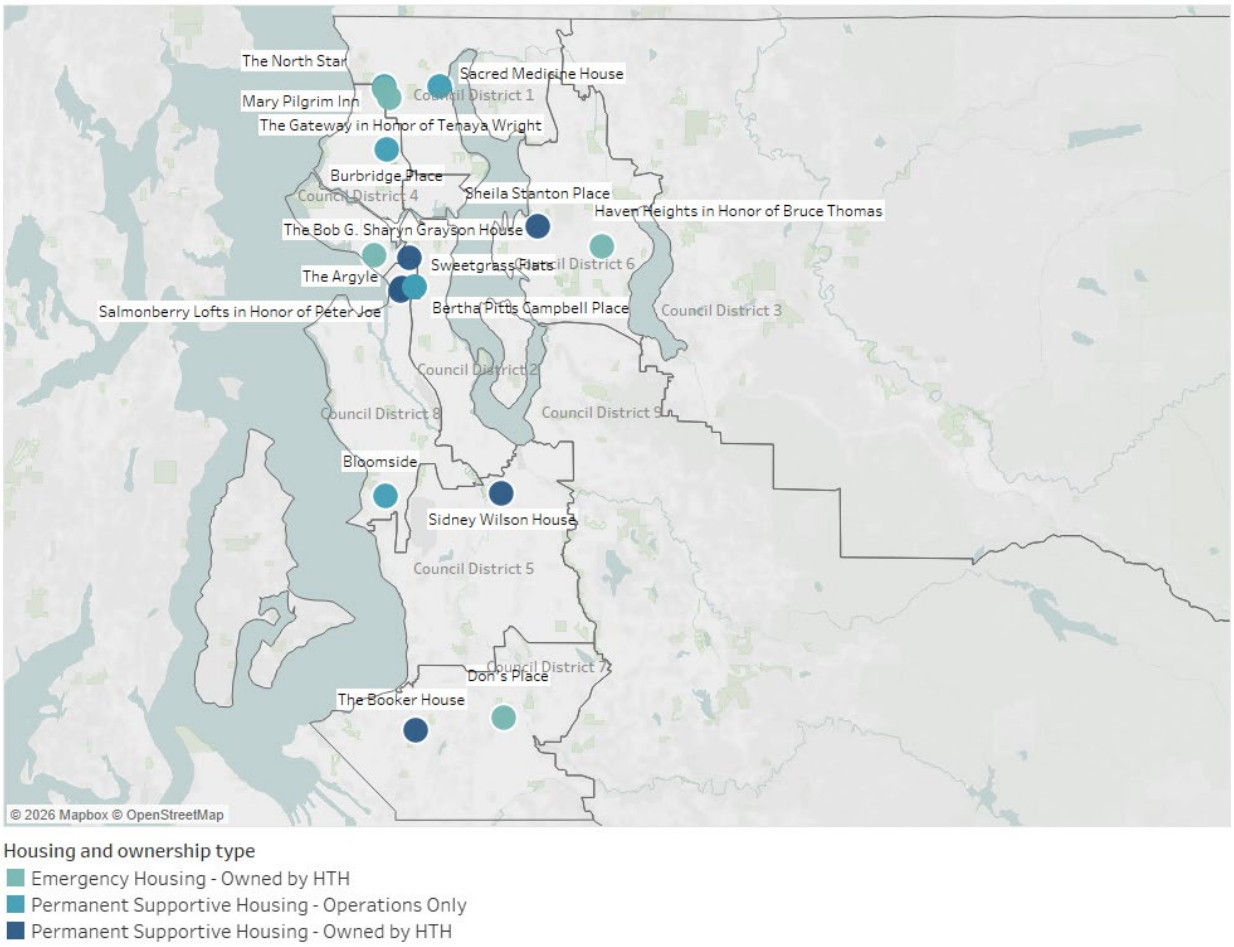
Table 3. Race/Ethnicity of HtH Residents, Chronically Homeless People, and the Overall Population in King County

Race/Ethnicity	HTH Residents		People in King County experiencing chronic homelessness		King County population	
	2024	2025	2024	2025	2024	2025
American Indian, Alaska Native, or Indigenous	16%	18%	5%	5%	<1%	<1%
Asian or Asian America	2%	2%	2%	2%	21%	22%
Black, African American, or African	21%	19%	24%	24%	7%	7%
Hispanic/Latin(a)(o)(x)	3%	3%	3%	4%	8%	8%
Multiracial	11%	12%	15%	14%	10%	10%
Native Hawaiian or Pacific Islander	2%	2%	2%	2%	1%	1%
Unknown/unreported	4%	4%	2%	3%	N/A	N/A
White	41%	40%	46%	47%	52%	52%

The number of American Indian, Alaska Native, or Indigenous residents has continued to increase, which the HtH program attributes to the opening of three buildings run by the Chief Seattle Club, a Native-led human services agency. The percentage of Black, African American, or African (BAAA) residents has decreased, but the number of BAAA residents has remained stable according to the transmitted report.

Site Locations and Other Geographic Information. The number of HtH sites remains unchanged compared to last year and includes 17 sites (11 County-owned and six operations-only buildings). Map 1 shows the location of each HtH building by type.

Map 1. HtH Site Locations



According to the transmitted report, HtH continues to be consistent with the requirement in RCW 82.14.530 that the county provide an opportunity for at least 15 percent of units in each facility to be occupied by individuals who live in or near the city where the facility is located or have other ties to the community. In 2025, 98 percent of residents reported existing ties to the communities where their HtH site is located.

Financial Information. In 2025, HtH revenue totaled $84.6 million, including $73.5 million in tax revenue, which was $2.7 million higher than in 2024. The total revenue was higher than the Implementation Plan projected, as shown in Table 4, largely due to interest received on capital and operating balances. Executive staff noted that interest earnings are put towards the same programming that the principal balance goes toward.

Table 4. 2025 HtH Revenue (in millions)

	Projected in IP	Actual 2025 Revenues (rounded)	Change between IP and Actual 2024
Tax Revenue	$73.3	$73.5	0.3%
Annual Interest	$0.2	$11.0	5400.2%
Annual Bond Proceeds	$0.0	$0.0	0.0%
Commercial Rent	$0.0	$0.1	N/A
Total Revenue	$73.5	$84.6	15.1%

HtH spent $106.2 million in 2025, which was approximately $37 million more than in 2024 and $12.4 million more than what was projected in the Implementation Plan. The Annual Report notes that the higher expenditures were primarily due to opening more buildings than previous years, as well as the rehabilitation work required to open and maintain buildings. A comparison of expenditures by strategy is shown in Table 5.

Table 5. 2025 HtH Expenditures by Strategy (in millions)

Strategy	Projected Expenditure in IP	Actual 2025 Expenditures (rounded)	Change between IP and Actual 2024
Strategy 1 **Capital Financing and Improvements for HtH Sites**	$17.1	$33.2	94.3%
Strategy 2 **Emergency and Permanent Supportive Housing Operations**	$43.3	$36.8	(15.0%)
Strategy 3 **Behavioral Health Services Outside HtH Sites**	$9.5	$9.4	(0.6%)
Strategy 4 **Capacity Building Collaborative**	$0.4	$1.0	160.9%
Strategy 5 **Evaluation and Performance Measurement**	$0.6	$0.2	(62.5%)
Strategy 6 **Future Acquisition of Additional Facilities**	$0.0	$0.0	0.0%
Initiative Administration	$2.2	$2.3	3.4%

Strategy	Projected Expenditure in IP	Actual 2025 Expenditures (rounded)	Change between IP and Actual 2024
Bond Financing Cost	$20.6	$23.2	12.6%
TOTAL EXPENDITURES	$93.8	$106.2	13.3%

As noted in prior staff reports for HtH annual reports, expenditures within Strategy 2 were lower than initially projected due to later building openings and supportive housing funds not being spent as quickly as expected. According to Executive staff, the balance of Strategy 2 funds, after the October reallocation, was approximately $75 million. The funding is planned to be used for covering increased operations and service costs.

Strategy 4 expenditures were higher than projected in the Implementation Plan. The Annual Report noted that HTH provided ongoing one-on-one technical support to operators and facilitated peer learning between organizations, including educating operators on resources available in the community.

Table 6 shows a summary of 2025 expenditures by jurisdiction.[18] Additional details, including costs from acquisition, building rehabilitation, facility maintenance, program operations, and bond financing is shown in Figure 18 of the transmitted report's Attachment A.

Table 6. Allocation of Expenditures by Jurisdiction (in millions)

HtH Host Jurisdiction	2025 Expenditures
Auburn	$5.7
Burien	$1.7
Federal Way	$11.2
Kirkland	$16.2
Redmond	$12.0
Renton	$10.2
Seattle	$36.2
Total	$106.2

[18] The following cities passed legislation in 2020 to keep the tax revenue generated under RCW 82.14.530: Bellevue, Covington, Issaquah, Kent, Maple Valley, North Bend, Renton, and Snoqualmie.

RCW 82.14.530 requires that King County spend at least 30 percent of revenue collected from cities with populations greater than 60,000 within that jurisdiction. Sammamish is the only city that meets this population threshold and doesn't have a HTH site. The Annual Report noted that Executive staff meet regularly with the City of Sammamish to continue collaboration. The other larger jurisdictions have an HTH site, including Federal Way, Kirkland, Redmond, and Seattle, and have exceeded the state law requirement.

Frank Chopp HtH Advisory Committee Membership and Certification of Dashboard. The Frank Chopp HtH Advisory Committee consisted of 15 members, as of December 2025 including: Lana Bostic, Lena Bernal, Indigo Brown, Avon Curtis, Tulika Dugar, Gloria Ramirez Santiago, Patti Yates-Starns, Marissa Fitzgerald, MJ Kiser, Krystal Marx, Sarah Stewart, Da'mont Vann, Barbara Walker, Donnell Olebar, and Andrea Paine. In 2025, DCHS appointed a HtH resident to the Committee. Ordinance 19366 requires the Executive to file an annual report and accompanying motion on behalf of the HtH Advisory Committee. The transmittal letter states that the HtH Advisory Committee certified the transmitted report and online dashboard on May 21, 2026.

Conclusion/Next Actions. The Conclusion/Next Actions section notes that steady progress has been made securing and opening supportive housing across the County. The Executive intends to focus 2026 on finishing rehabilitation of unopened units, moving individuals inside, and providing supportive services to residents.

An evaluation of the HtH initiative is being completed and, according to Executive staff, will be published by December 31, 2026. A formal transmittal to Council is not required.

INVITED

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- Jelani Jackson, Acting Director, Housing and Community Development Division, Department of Community and Human Services (DCHS)
- Shanna Clinton, Acting Manager, Health Through Housing Initiative, DCHS

ATTACHMENTS

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1. Proposed Motion 2026-0159 (and its attachment)
2. Transmittal Letter

1200 King County Courthouse
516 Third Avenue
Seattle, WA 98104

KING COUNTY

Signature Report

Motion

Proposed No. 2026-0159.1 **Sponsors** Mosqueda

A MOTION acknowledging receipt of the 2025 health through housing annual report, in accordance with K.C.C. chapter 24.30.

WHEREAS, in 2020, consistent with the authority and eligible uses set out in Substitute House Bill 1590, which became Chapter 222, Laws of Washington 2020, K.C.C. 4A.503.020 authorized the collection and expenditure of an additional sales and use tax of one-tenth of one percent, and identified priorities for the use of these funds in King County, and

WHEREAS, K.C.C. chapter 24.30, providing for the creation of a health through housing implementation plan, was enacted in February 2021, and

WHEREAS, on August 30, 2021, in accordance with K.C.C. 24.30.020, the executive transmitted to the council for review and adoption an initial implementation plan that described the goals, strategies, performance measures, reporting requirements and annual expenditure plan to direct use of the proceeds from 2022 through 2028 as authorized by K.C.C 4A.503.040, and

WHEREAS, Ordinance 19366, Section 1, adopted the initial implementation plan in December 2021, and

WHEREAS, K.C.C. 2A.300.200 requires the executive to electronically file an annual report on the accomplishments and effectiveness of the expenditure of sales and

use tax proceeds as authorized by K.C.C. chapter 4A.503 and RCW 82.14.530, and including information on the allocation by jurisdiction of sales tax proceeds as authorized by K.C.C. chapter 4A.503 and RCW 82.14.530, by June 15 of each year, and

WHEREAS, the fourth annual report, entitled 2025 Health Through Housing Annual Report, which is Attachment A to this motion, is submitted by the executive;

NOW, THEREFORE, BE IT MOVED by the Council of King County:

The receipt of the fourth annual report on the Health Through Housing initiative,

entitled 2025 Health Through Housing Annual Report, Attachment A to this motion, in accordance with K.C.C. 24.30.020, 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. 2025 Health Through Housing Annual Report

2025 Health Through Housing Annual Report

June 2026

King County

Summary

King County's Health Through Housing (HTH) initiative is an innovative, regional approach that accelerates the County's ability to address chronic homelessness. HTH is focused on creating and operating affordable housing with services, referred to as supportive housing, for households in King County that are at risk of or experiencing chronic homelessness.[1] The HTH initiative is also designed to reduce racial and ethnic disproportionality among persons experiencing chronic homelessness in King County.[2, 3, 4]

HTH's 2025 activities reflect a continued focus on rehabilitating and opening buildings, bringing people inside, and connecting residents with supports. Since its inception, HTH has secured 1,423 housing units, of which 1,054 units were open across 14 sites as of the end of 2025. HTH opened three sites to residents in 2025 (Sweetgrass Flats, The Booker House, and Sharyn Grayson House). It also opened newly renovated units at Haven Heights in Honor of Bruce Thomas in accordance with its phased opening approach. Lastly, HTH finished major construction work at its Kirkland site, Sheila Stanton Place, which started moving in residents in January 2026. Of these newly opened buildings, the Kirkland and Federal Way sites each represent one of the first PSH buildings to open in their respective cities, illustrating the initiative's success using a regional approach to reduce chronic homelessness.

2025 highlights include:

- HTH made significant progress renovating and opening new emergency housing (EH) and Permanent Supportive Housing units (PSH), with 1,054 homes open across 14 sites at the end of 2025, including 109 units that opened for occupancy in 2025.
- HTH continued providing a broad range of services and supports to residents, with almost all 1,380 HTH residents served in 2025 having access to at least one type of onsite health service.
- HTH made progress addressing racial and ethnic disproportionality among the homeless population, including opening three sites that are operated by organizations run by and for BIPOC communities.
- HTH achieved positive health outcomes for residents, including reducing reliance on costly emergency healthcare services. After two years, HTH residents' total number of inpatient hospital stays decreased by 41 percent, and their total number of emergency department visits dropped by 39 percent.
- HTH achieved positive housing stability outcomes among its PSH residents, with 93 percent of PSH residents maintaining their housing or moving to another permanent housing destination.
- HTH residents experienced reduced engagement with the criminal legal system, with residents experiencing a 24 percent decrease in jail bookings two years after enrollment.

- HTH achieved continued success housing individuals with ties to the city in which their HTH building is located, with 98 percent of HTH residents reporting existing ties to the communities where they reside at move in.
- HTH sites maintained high occupancy rates in 2025, with buildings ending the year with an average occupancy rate of 92 percent, with some buildings having over 100 percent occupancy rates and others lower due to closures for maintenance, resident turnover, or opening units midyear.
- HTH provided increased capacity building and technical assistance to its housing operators through monthly Community of Practice sessions and individual consultations with operators.

Background

King County's Health Through Housing initiative (HTH) is focused on creating and sustaining affordable, supportive housing for those in King County experiencing or at risk of chronic homelessness.[5] The initiative takes a regional approach to both accelerate King County's ability to reduce chronic homelessness countywide and dismantle the racial and ethnic disproportionality prevalent among the homeless population in King County.[6] See Appendix D for more information on the historical context of the HTH initiative.

HTH focuses on expanding the supply of both emergency housing (EH) and permanent supportive housing (PSH) and operating the homes it creates consistent with the Housing First model.[7,8,9,,10] After four full years of operation, the HTH initiative has ended homelessness for over 1,400 King County residents, improved the health and wellbeing of residents, and reduced the use of local emergency departments, hospitals, and jails – creating additional cost savings for the County. Recent analysis by DCHS shows that after two years of living in a HTH unit, residents' total number of inpatient hospital care stays decreases by 41 percent, their total number of emergency department visits drops by 39 percent, and residents experience a 24 percent decrease in jail bookings.

From 2020 to 2025, HTH secured 17 sites containing 1,423 units for use as PSH and EH across seven cities.[11] In addition to 11 County-owned buildings where HTH funds the cost of development and operations, the sites include six "operations-only" buildings for which HTH funds the cost of operations. HTH opened 14 of its 17 sites as of December 2025 and finished construction on its 15th site in January 2026.

Since 2020, HTH has opened buildings more quickly than traditionally funded projects, highlighting the strength of the HTH model of housing development. Even as the HTH initiative proceeds quicker than other emergency and supportive housing developments, it has faced challenges securing and opening all 1,600 units envisioned in the Plan. Work has progressed slower than initially projected due to extensive permitting, construction, and community engagement

timelines, staffing limitations, funding constraints, escalating costs, and poor building conditions. For example, across HTH sites, navigating jurisdictional approval has extended the time necessary to open HTH buildings. For example, in Federal Way, HTH purchased the building in 2021, but it did not formally open until 2025. On average, it takes HTH nearly a year to compile all the documentation required for a permit application and receive city approval.

Report Requirements

This annual report summarizes the activities of the HTH initiative through the end of 2025 and fulfills the reporting requirements in KCC 2A.300.200.A. Specifically, this document includes summaries of the accomplishments and effectiveness of the expenditure of HTH sales tax proceeds in 2025 as well as financial information including, but not limited to, the allocation of proceeds by jurisdiction.[12]

This report also summarizes the significant additional annual data reporting provided by HTH's 2025 online dashboard, as called for by the Health Through Housing Implementation Plan as adopted by Ordinance 19366.[13, 14, 15] Finally, this report provides information about the Frank Chopp Health Through Housing Advisory Committee and confirms that the Committee has certified that the online dashboard is current and updated with 2025 data and ready for review, as directed by the Plan.[16, 17] Appendix A of this report shows legislative and Plan language that sets out reporting elements and provides both the location of summary information in this report and tabs of the HTH dashboard that contain further information and opportunities to explore data. Appendix E of this report describes the HTH initiative's legislative history and initiative's goals.

A. Performance Overview: Accomplishments and Effectiveness in 2025

The HTH initiative transformed an emergency response strategy to the COVID-19 pandemic into an innovative, long-term effort to significantly address the region's homelessness crisis. By acquiring and repurposing hotels and apartments throughout the County and providing vital operations funding to providers, HTH has increased housing capacity for residents who are experiencing or at risk of chronic homelessness. In 2025, HTH ended the year with 1,423 housing units secured, of which 1,054 units were open across 14 sites.[18] See Appendix F for more information on the HTH buildings that opened in 2025.

2025 Highlights

HTH's 2025 activities reflect a continued focus on rehabilitating and opening buildings, bringing people inside, and connecting residents with health care and other supports. HTH opened three sites to residents in 2025 (Sweetgrass Flats, The Booker House, and Sharyn Grayson House). It also opened newly renovated units at Haven Heights in Honor of Bruce Thomas in accordance with its phased opening approach.[19] Lastly, HTH finished major construction work at its Kirkland site,

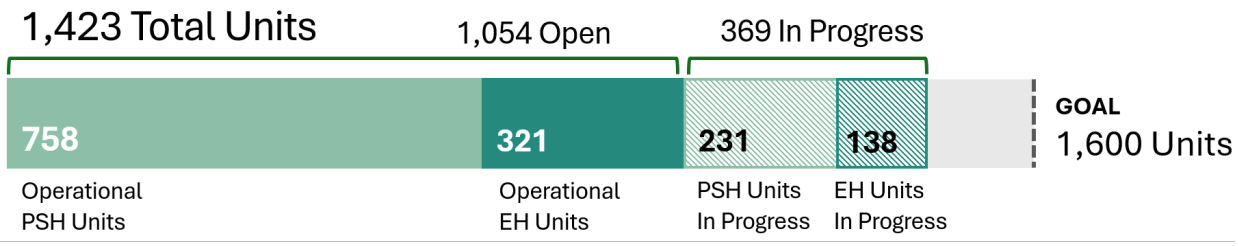
Sheila Stanton Place, which started moving in residents in January 2026. Of these newly opened buildings, the Kirkland and Federal Way sites each represent one of the first PSH buildings to open in their respective cities. The progress made in the last year illustrates the initiative's success using a regional approach to reduce chronic homelessness.

The following subsections describe the initiative's 2025 activities in depth and provide performance data at the program and population level.

Number of Secured and Open Housing Units by Year-End 2025

HTH has made significant progress developing and opening new EH and PSH units. As shown in Figure 1, the initiative had 1,423 housing units secured, of which 1,054 were open by the end of 2025 (compared to 954 open at the end of 2024).[20] In 2025, HTH opened 109 new units for occupancy across four buildings, including 32 at Sweetgrass Flats, 18 at The Booker House, 32 at Sharyn Grayson House, and 27 at Haven Heights in Honor of Bruce Thomas. In 2025, HTH also finished major construction work at its Kirkland site, Sheila Stanton Place, which started moving in residents during January 2026.

Figure 1: Cumulative Number of HTH Housing Units, 2025[21]



As of December 2025, HTH had opened 14 of the 17 buildings secured by the initiative. Of these 14 sites, three are undergoing phased openings (Haven Heights in Honor of Bruce Thomas, Sweetgrass Flats, and The Booker House) and, accordingly, collectively contain 178 unopened units as of December 2025. The 15th site, Sheila Stanton Place, which contains 101 units, opened in January 2026. The remaining 90 unopened units are located at The Bob G. and the Argyle.

As of the drafting of this report, the Executive is in the process of selling the Bob G. Originally named the Inn at Queen Anne, the Bob G. was a critical component of King County's response to the COVID-19 pandemic, having been originally leased as part of shelter deintensification efforts. The HTH initiative purchased this 80-unit building in May 2021. After acquisition, building

deficiencies were identified that had not been evident in the original property condition report.[22,23] A 2024 analysis by FMD indicated that addressing these deficiencies would cost at least $19 million. In early 2026, HTH staff met with a representative of the Seattle City Council, and they were not aware of any Seattle funding source that could support redevelopment. Given the condition of the building, the Executive determined it would be more cost-effective to transfer the building to another owner rather than conduct a major renovation of the building.

King County has also faced challenges with the Argyle, a 10-unit building located in downtown Seattle. Because of the building's small size, it has been challenging to identify an operator who can cost effectively provide 24/7 services to such a small number of residents. Further, in 2025, HTH identified a large crack in the basement foundation that makes the building unsafe for habitation without expensive repairs. In addition, Sound Transit is now considering locating the future Midtown light rail station along 4th Avenue, where the Argyle is located.[24] Given the structural issues with the building, its small size, and the uncertainty around Sound Transit's plans for this and adjacent properties, the building is not a suitable option for investing in the conversion to PSH.

While HTH has not yet reached its paramount goal of securing and opening 1,600 units, financial conditions have changed dramatically since the Plan's adoption, creating new barriers to expanding the HTH portfolio.[25] Recent economic changes have significantly impacted both the cost of acquiring new properties and the cost of renovating and maintaining existing HTH buildings. Additionally, emerging shifts in global trade policy and tariff measures create significant uncertainty regarding future construction costs, and are expected to reduce HTH sales tax revenue. Over the last year, King County Office of Economic and Financial Analysis (OEFA) projections of the amount of tax revenue that the HTH initiative will generate through 2028 have fluctuated significantly due to this uncertainty.[26]

Additionally, in 2025, the King County Facilities Management Division (FMD) determined that many of its acquired HTH buildings required significant, unexpected, and costly repair work.[27] For instance, over the course of 2025, FMD identified five HTH sites where the building envelope had failed and water intrusion had occurred. In total, across the HTH portfolio, FMD discovered more than $6.9 million in unexpected capital costs in 2025, with additional unforeseen capital costs expected in 2026.

- At Haven Heights, FMD identified over $1,000,000 in unanticipated costs, including nearly $540,000 for a total plumbing replacement due to the presence of deteriorating CPVC pipe.
- At Sharyn Grayson House, FMD identified over $540,000 in unanticipated costs, including nearly $300,000 in exterior envelope repairs.
- At Sheila Stanton Place, FMD identified over $2,600,000 in unanticipated costs, including over $600,000 in electrical repairs and over $700,000 for site and fencing revisions.
- At the Booker House, FMD identified over $880,000 in unanticipated costs, including over $184,000 in floor prep costs.

- At Sidney Wilson House, FMD identified over $1,800,000 in unanticipated costs, including nearly $306,000 to replace the roof.

Because HTH is facing both higher-than-expected costs and significant uncertainty regarding future revenue, DCHS has paused efforts to secure additional HTH units. This adjustment reflects DCHS' efforts to prudently manage HTH's limited resources not only to create new housing units, but also to operate those units on an ongoing basis with housing-related services, consistent with the initiative's paramount goal as articulated in Ordinance 19236 and the Plan. The significant increase in construction costs and uncertainty regarding future revenue have made it unclear whether or when the HTH sales tax will raise sufficient revenue to cover the long-term costs of maintaining 1,600 units.[28] Further, the increases in rehabilitation costs, interest costs, and real estate costs mean that HTH would have to pay significantly more to acquire, rehabilitate, and open new buildings purchased under current economic conditions.

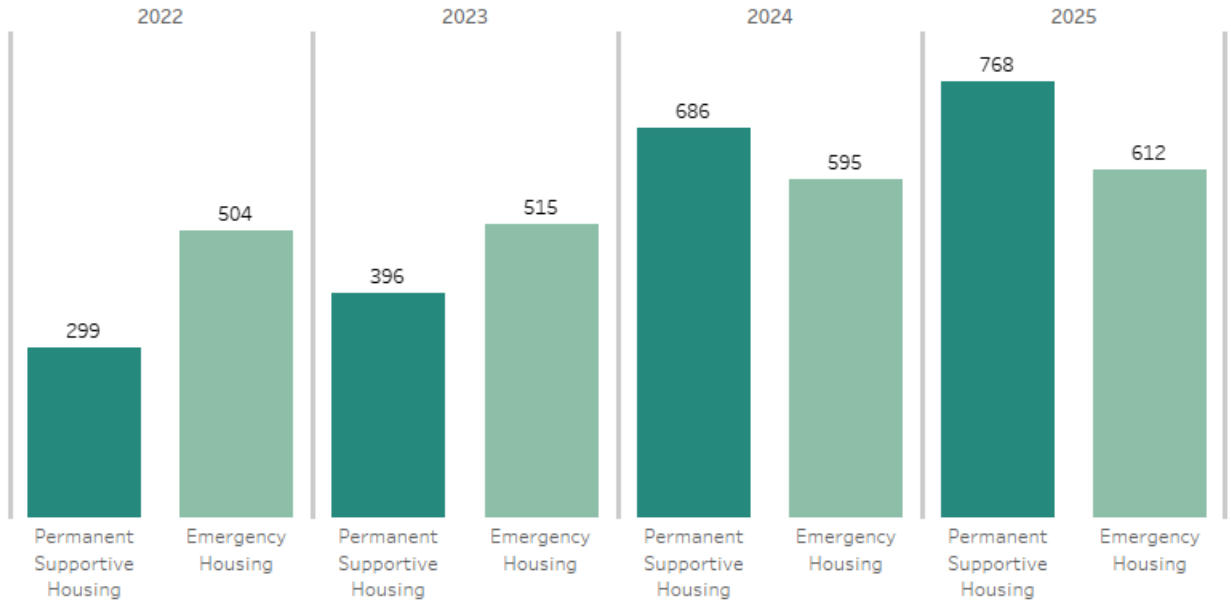
DCHS intends to continue to closely monitor these trends and will secure additional units once financial conditions permit. If financial conditions shift, HTH plans to secure additional operations-only units when the initiative's budget forecast projects HTH will generate sufficient revenue to cover total expenditures through 2041, when the first bond will mature. To ensure that its forecasts accurately project future costs, especially in light of the unexpected repair needs identified in 2025, HTH is working with FMD to comprehensively assess long-term maintenance and capital improvements needed across its current portfolio. HTH expects this assessment to be completed in early 2027. This assessment, and HTH's connected efforts to maintain its acquired buildings, will extend the life of the HTH portfolio and ensure that HTH continues to provide high-quality, safe housing to its residents.

DCHS also plans to work closely with the Executive regarding the future of the HTH initiative, including transfers of ownership of HTH sites or other housing investments using HTH revenue, in anticipation of the Executive's transmittal of a proposed updated implementation plan for HTH in 2027.

Number of People Housed in Health Through Housing Sites

In 2025, HTH permanently or temporarily housed a total of 1,380 people (compared to 1,281 people in 2024).[29] As of December 31, 2025, HTH operated ten sites as PSH and four as Emergency Housing (EH). In 2025, HTH's PSH sites housed a total of 768 residents and HTH's EH sites housed a total of 612 individuals, as shown in Figure 2. This represents a net increase of 99 residents in 2025 as compared to 2024. This increase is due to more residents continuing to move into Haven Heights in Honor of Bruce Thomas, as well as the opening of Sweetgrass Flats, The Booker House, and Sharyn Grayson House in 2025.[30]

Figure 2: People Housed in HTH Emergency Housing or Permanent Supportive Housing, 2022-2025[31]



Source: Seattle-King County Homeless Management Information System (HMIS) Data as of 3/1/2026.

Progress Converting EH to PSH

To open a site as PSH, a developer must obtain special use permits, ensure compliance with local zoning laws, and often undertake significant renovations to meet the long-term living standards required for PSH. This process can take two to five years. Generally, city building codes require EH sites to meet basic health and safety standards without the extensive renovations often required for PSH, allowing EH sites to open faster. In alignment with the Implementation Plan, HTH opened many newly acquired sites as EH in order to immediately provide housing to chronically homeless King County residents. The Implementation Plan includes as a supporting goal converting 50 percent of the units that enter the portfolio as EH to PSH by 2028. HTH aims to meet this goal through the conversion of EH units to PSH at Haven Heights in Honor of Bruce Thomas and Sheila Stanton Place, as shown in Figure 3. In 2025, HTH started renovations to convert units at Haven Heights in Honor of Bruce Thomas and Sheila Stanton Place into PSH; renovations are continuing on the remaining unopened units in 2026. The HTH initiative is also currently exploring conversion design and cost for The Gateway in Honor of Tenaya Wright. In September 2025, HTH received a change of use permit from the City of Seattle to convert the Gateway into PSH. The initiative is now scoping the renovation project, and will conduct a site condition assessment in 2026.

Figure 3: Progress Towards 50 Percent Conversion Goal

Total Units Secured as EH[32]	557
Goal: 50% of units → PSH	279

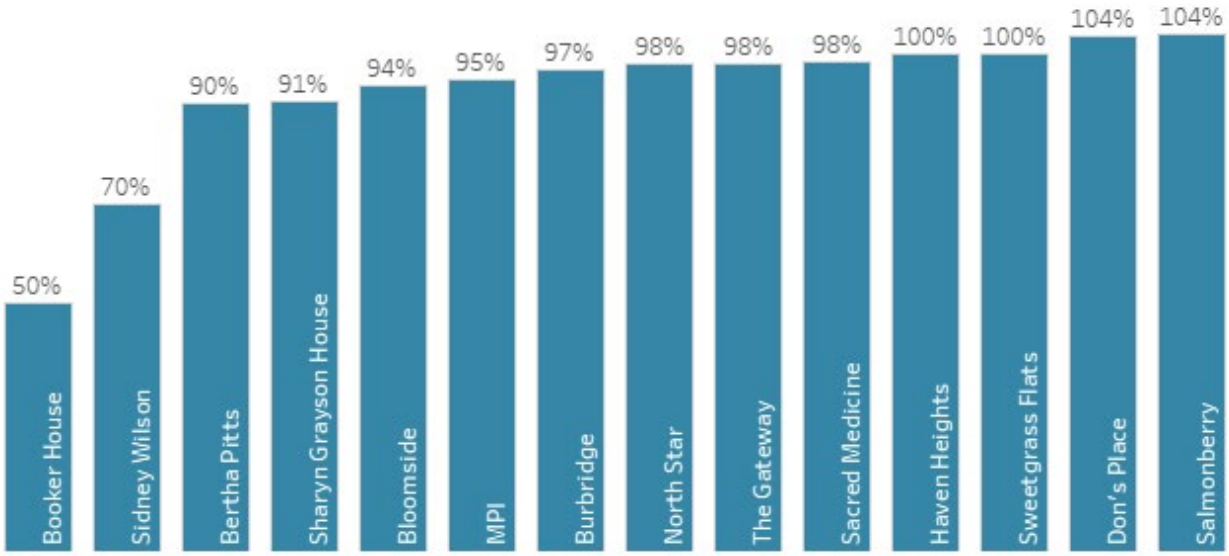
Buildings to be Converted	**Units**
The Gateway in Honor of Tenaya Wright	113
Haven Heights in Honor of Bruce Thomas	100
Sheila Stanton Place	101
Total	314

Percent of Housing Units that Are Occupied

Across the portfolio, HTH sites maintained high occupancy rates in 2025, with buildings ending the year with an average occupancy rate of 92 percent. As of December 31, 2025, Don's Place and Salmonberry Lofts in Honor of Peter Joe achieved the highest occupancy rates (104 percent), as shown in Figure 4.[33] The Booker House ended the year with the lowest occupancy rate (50 percent) due to having opened in December 2025. Building occupancy rates sometimes drop below 100 percent if residents move out and their unit has not yet been filled; rooms are offline due to required maintenance; or a building has just opened and is in its initial lease-up phase,

Sidney Wilson House ended the year with an occupancy rate of 70 percent due in part to a fire event that resulted in 13 units being taken offline for extensive repairs. After this initial fire event, additional rooms were added to the repair project due to newly discovered resident damage and water intrusion caused by building envelope failure. King County procured a general contractor in 2025 that worked to repair a total of 33 units, which have been returned to the operator as of May 2026.

Figure 4: Occupancy of HTH Buildings as of December 31, 2025

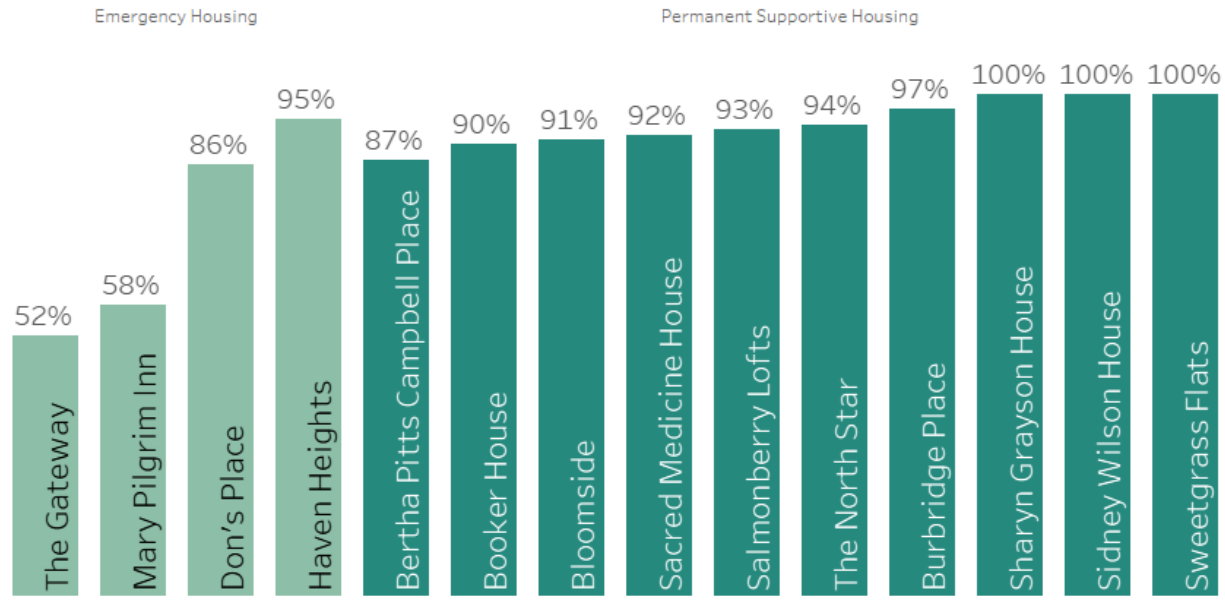


Source: Seattle-King County Homeless Management Information System (HMIS) Data as of 3/1/2026.
Notes: The occupancy rates for Haven Heights in Honor of Bruce Thomas, Sweetgrass Flats, and The Booker House are calculated based on the number of units that were available for occupancy as of December 31, 2025, rather than the number of total units that will be available for occupancy once rehabilitation work ends.

Percent of HTH Residents who Maintain Housing in HTH or Exit to Permanent Housing

Permanent Supportive Housing
In 2025, residents maintained their housing at similar rates across HTH's PSH buildings, as shown in Figure 5. HTH's 93 percent overall rate of maintaining PSH housing or moving on to other permanent destinations is on par with the regional PSH housing stability average (93 percent).[34]

Figure 5: Percent of Residents who Maintained HTH Housing or Exited to Other Permanent Housing, 2025



Source: Seattle-King County Homeless Management Information System (HMIS) Data as of 3/1/2026.

Emergency Housing

Over the last year, HTH's PSH sites continued to perform stronger than EH sites in helping people maintain their housing or move to stable housing elsewhere. While 93 percent of HTH residents in PSH buildings maintained permanent housing, 63 percent of HTH EH residents maintained their housing or moved to another permanent housing destination in 2025. This represents an increase compared to 2024, during which 58 percent of EH residents maintained their housing or moved to another permanent destination.

While the HTH initiative seeks to help all residents maintain their housing long-term, the 63 percent overall rate of maintaining HTH EH housing or moving on to other permanent destinations is above regional EH housing stability averages.[35,36]

At all HTH sites, HTH operators engage residents in case management and other services to promote housing stability. However, not all residents choose to stay in EH buildings. Among the remaining 37 percent of EH residents who did not stay in their HTH unit or move to another permanent destination, 18 percent moved to shelters and other homeless situations. Another six percent moved on to institutional situations (which could include jails, hospitals, long-term care facilities, or nursing homes) and two percent moved on to temporary housing.[37]

The rate of residents who maintained their housing or exited to permanent housing at The Gateway in Honor of Tenaya Wright and Mary Pilgrim Inn remained lower than rates at other EH buildings. The lower rates of housing stability at The Gateway in Honor of Tenaya Wright and Mary Pilgrim Inn, compared to other HTH EH sites, may be a product of the extreme vulnerability of those housed at these two sites.

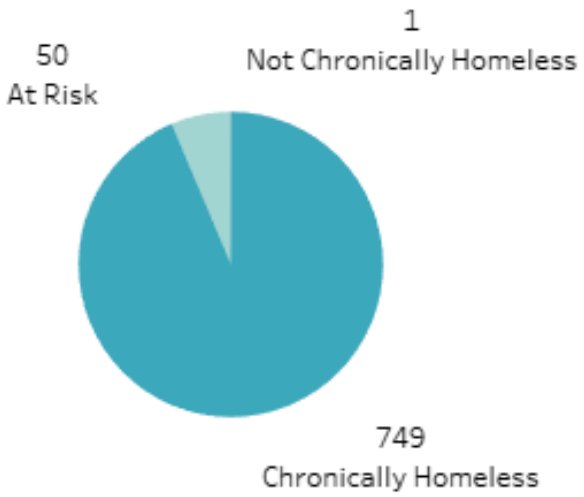
In 2025, DCHS worked with DESC to assess the lower rates of housing stability at its EH sites and to explore adaptations to support residents effectively. As a result of these conversations, Mary Pilgrim Inn updated its internal policies and procedures with the goal of reducing resident exits. Specifically, staff have introduced new policies that are designed to incentivize adherence to program rules, which has likely led to a reduction in the number of residents who were asked to leave due to rule violations in 2025. As a result of these changes, the percent of Mary Pilgrim Inn residents who maintained their housing or moved to permanent housing increased in 2025, and the average length of stay (discussed on page 13) increased from 165 days in 2024 to 208 days in 2025. In 2026, DCHS plans to continue to review EH exit data with DESC staff semiannually and explore additional policy changes that could further promote resident stability.

Further, in the third quarter of 2025, HTH implemented a new customized exit assessment that HTH operators can use to gather more specific data about resident exits. This new assessment allows HTH to differentiate between resident- versus operator-initiated exits and provides more detail on the reason for exit (which HMIS does not collect). As more data is collected and analyzed, it will allow HTH and site operators to better understand why individuals are exiting and identify tailored strategies for promoting housing stability.

Number of People Moved from Chronic Homelessness to Permanent Housing

HTH PSH and EH residents sometimes move to other permanent housing destinations. In EH buildings, HTH operators regularly look for openings in PSH buildings (including HTH PSH buildings) that EH residents can move into permanently. In PSH buildings, residents may decide to move to other permanent destinations that better align with their personal preferences and needs, such as being closer to family. Accordingly, the total number of people that move from chronic homelessness to permanent housing with the help of the HTH initiative is higher than the total number of HTH PSH units open at any point in time. As shown in Figure 6, throughout 2025, 800 individuals were permanently housed in HTH PSH units or moved on to permanent housing elsewhere with the help of HTH resources. Of those 800 individuals, 749 were chronically homeless.[38]

Figure 6: Number of People Moved from Chronic Homelessness to Permanent Housing, 2025



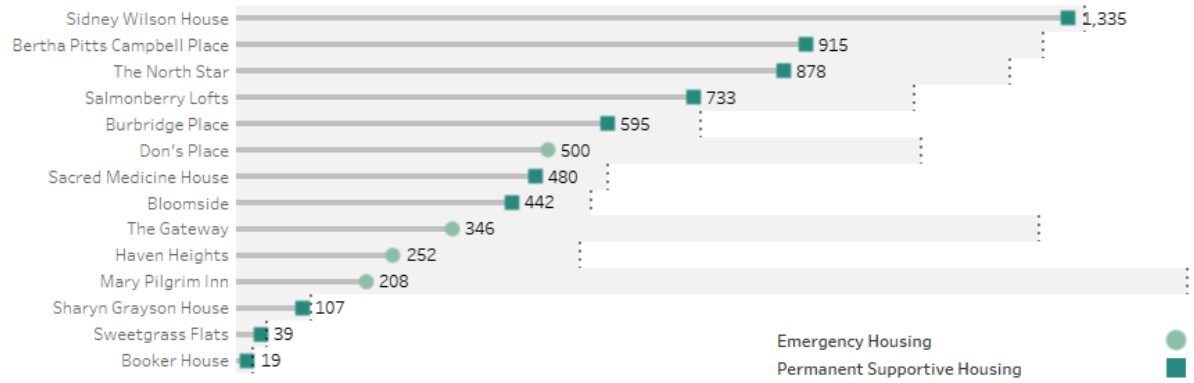
Source: Seattle-King County Homeless Management Information System (HMIS) Data as of 3/1/2026.
Notes on Figure 6: KCC 24.30.010.B defines "at risk of chronic homelessness" as a household that: (1) includes an adult with a developmental, physical or behavioral health disability; (2) is currently experiencing homelessness for only 10 to 12 months in the previous three years, or has experienced homelessness for a cumulative total of 12 months within the last five years; and (3) includes one adult that has been incarcerated within the previous five years in a jail or prison, includes one adult that has been detained or involuntarily committed under chapter 71.05 RCW, or identifies as a member of a population that is demographically overrepresented among persons experiencing homelessness in King County.[39]

Average Length of Stay

HTH residents sustained stable, long-term housing in 2025, as shown in Figure 7. Because the various HTH buildings that were operational in 2025 became available to residents at different times, length of stay statistics vary dramatically. HTH sites that have opened recently have shorter lengths of stay on average than sites that have been established for longer periods of time.

Among all HTH sites, Sidney Wilson House in Renton averaged the longest length of stay, with residents staying in the building for an average of 1,335 days (approximately 3.6 years). The HTH sites that opened in 2025 showed the shortest lengths of stay, with residents staying at Sharyn Grayson House for 107 days, followed by Sweetgrass Flats (39 days), and The Booker House (19 days). Overall, the average length of stay at HTH's EH sites demonstrates that the sites provide immediate relief from unsheltered homelessness in a manner that offers a greater level of resident stability and support services than can be found in the traditional congregate shelter model. Specifically, the average length of stay at HTH's EH sites is 327 days of continuous residence, which is longer than the average amount of time single adults stay in emergency shelters in King County (201 days in 2025).[40,41]

Figure 7: Average Length of Stay for HTH Sites, 2025



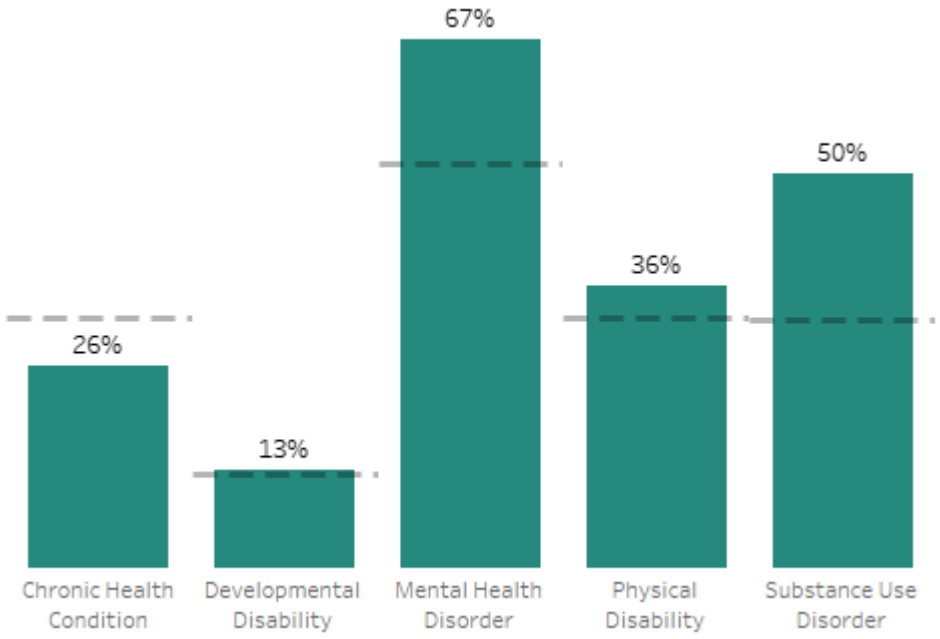
Source: Seattle-King County Homeless Management Information System (HMIS) Data as of 3/1/2026.

HTH Residents' Health Challenges

People experiencing homelessness die on average 12 years sooner than the general U.S. population.[42] Research shows that homelessness both causes and exacerbates illness and chronic mental and physical health conditions in people experiencing homelessness.[43] Lack of housing creates barriers to accessing health care and following health care directives, such as adhering to mental health and prescription medication routines.[44] Because homelessness is linked to physical and mental health conditions, HTH services are designed to support residents with a wide range of health challenges. As one client stated, "Before getting to [the Gateway], I used to think that I'd die on the streets, but [the Gateway] gave me a second chance in life."

In 2025, HTH residents reported the following health challenges at move-in: mental health disorder (67 percent), substance use disorder (50 percent), physical disability (36 percent), chronic health condition (26 percent), and developmental disability (13 percent), as shown in Figure 8. Further, 59 percent of residents reported multiple health conditions. Because the HTH initiative serves individuals experiencing chronic homelessness who typically have higher needs, HTH residents generally report more health conditions at move-in than other homeless adults tracked in Homeless Management Information System (HMIS). For instance, 15 percent more HTH residents report a mental health condition compared to the adult homeless population; 4 percent more report physical disabilities, and 18 percent more report substance use disorders.[45]

Figure 8: Percent of HTH Residents Reporting Health Conditions at Move-in, 2025



Dotted line represents conditions reported by all adults experiencing homelessness in HMIS.
Source: Seattle-King County Homeless Management Information System (HMIS) Data as of 3/1/2026.

Health and Wellbeing Supports

HTH sites are operated by knowledgeable staff who are experts in evidence-based, Housing First practices and are equipped to offer high-quality, wraparound support to their residents.[46] Every HTH site is staffed 24/7 with individuals trained to respond to crises. All HTH residents are assigned a case manager at move-in who helps each resident develop individualized treatment plans based on their specific needs and preferences. HTH site staff meet regularly to plan and review services for program participants and develop strategies for supporting residents who are not meeting their goals. See Appendix C for more information on the eight service providers that operate HTH buildings.

In 2025, HTH continued providing a range of services at its 14 open sites, ensuring all residents had access to services targeting health and wellness, employment, food, transportation, and crisis services, including through partnerships with King County Metro transportation services and DCHS' Employment Resource Program (ERP). As shown in Figure 9, almost all HTH buildings offer at least one type of healthcare service on site (whether physical health, mental health, or substance use disorder treatment). Many HTH buildings have on-site medical rooms that visiting nurses and physicians use to deliver highly accessible care to HTH residents. HTH operators also

help residents enroll in health insurance and get connected to low-barrier community-based organizations that deliver care in the community. During 2025, HTH sites also had access to a Mobile Response Team (MRT) to resolve mental health crises. In interviews, residents emphasize how critical these services are. One resident stated, “It's great I can access medical care on site. It is immensely important and super beneficial. The clinic, the nurses, the doctors—they are super people.”

Figure 9: Presence of Health and Crisis Services Across Sites

Building	Physical Health Care	Mental Health Care	Substance Use Treatment	Crisis Services
Bertha Pitts Campbell Place				●
Bloomside			●	●
Booker House*	●			
Burbridge Place		●	●	●
Don’s Place	●	●	●	●
The Gateway	●	●		●
Haven Heights		●	●	●
Mary Pilgrim Inn	●	●	●	●
The North Star		●	●	●
Sacred Medicine House		●	●	●
Salmonberry Lofts	●	●	●	●
Sharyn Grayson House*				
Sidney Wilson House	●	●	●	●
Sweetgrass Flats*	●	●	●	

* The Booker House, Sharyn Grayson House, and Sweetgrass Flats opened in late 2025 and were still in the process of establishing an MOU with the MRT at the end of 2025.

Note: Bertha Pitts Campbell Place has a medical room that is intended to house onsite nursing services. However, Plymouth has not been able to identify a healthcare provider that has the capacity to provide services at the site (given that many providers have either eliminated community-based positions or left them vacant). Plymouth hired a new VP of Quality, Innovation, & Health in March 2025 who has been working to identify a healthcare provider to serve the site.

The remainder of this section addresses 2025 developments in HTH's health and wellness services. Appendix H contains a comprehensive overview of health and wellness services available to HTH residents.

Behavioral Health Services

In 2025, the MRT managed by DESC continued offering crisis response and other behavioral health services at HTH sites. The MRT helped address the behavioral health needs of residents in 2025 by delivering crisis response and de-escalation, case management, navigation to behavioral health services, and individual and group peer support services. If HTH sites identified that a resident was in crisis or needed a higher level of support than staff had the capacity to provide, sites could call the MRT. In response, the MRT would send a team of professionals (which may have included a case manager, peer support specialist, nurse, or substance use disorder counselor) to address the immediate crisis, as well as provide ongoing case management until the individual is stabilized. Additionally, routine peer engagement and groups proactively identified unmet behavioral health needs among residents. In 2025, the MRT continued offering services at 11 HTH sites. The MRT established memoranda of understanding (MOUs) to serve the three sites that opened in late 2025 (Sweetgrass Flats, The Booker House, and Sharyn Grayson House) in the first quarter of 2026.

In 2025, the MRT served 166 HTH clients in total, including by resolving 157 crises and referring 58 percent of crisis calls to other services, including long term case management, mental health care, medical care, substance use treatment, and peer support services. The MRT also conducted 75 peer support groups at HTH sites. The immediate crisis response offered by the MRT is a critical service for residents requiring low barrier, immediate behavioral health support. Staff at Salmonberry Lofts in Honor of Peter Joe noted that the support MRT provided was "amazing" and was critical to helping residents that need enhanced support.[47] See Appendix G for more information on the geographic location of MRT services provided in 2025.

In addition to responding to immediate crises, HTH operators have continued to establish community partnerships with organizations that offer ongoing mental health services and substance use treatment on site to help residents achieve longer term stability. For instance, in 2025, Haven Heights in Honor of Bruce Thomas established a new partnership with IKRON to bring a psychotherapist specializing in mental health and substance use disorder treatment on site at least one day a week. Case managers at all HTH sites also work diligently to connect residents to a wide range of low-barrier, community-based behavioral health services that supplement those offered on site. For instance, many HTH operators connect residents to Program of Assertive Community Treatment (PACT), a Medicaid-funded program which provides community-based intensive services for people with high behavioral health needs, including on site at HTH buildings.[48]

Overdose Prevention Services

In 2025, HTH providers continued to face challenges with the proliferation of fentanyl, which the human services sector is encountering broadly.[49] In response, all HTH sites have staff trained to administer opioid antagonists, such as naloxone, which can reverse an overdose from opioids. HTH has also continued to facilitate a partnership with Public Health – Seattle & King County (PHSKC) to support HTH operators in overdose prevention and response. In 2025, six HTH operators received training and technical assistance from PHSKC, and several HTH sites (Sacred Medicine, Haven Heights in Honor of Bruce Thomas, North Star, and Sidney Wilson House) participated in a naloxone distribution pilot that PHSKC's Overdose Prevention and Response team designed to increase anonymous access through boxes on every floor of housing programs. Finally, Catholic Community Services, in partnership with PHSKC, is providing Medications for Opioid Disorder (MOUD) care using a mobile, nursing-led model within their emergency shelter and PSH sites, including at Sidney Wilson House. The program offers on-site prescribing and administration of buprenorphine, particularly sublocade and brixadi.

Physical Health Services

In addition to behavioral health care, HTH operators continue to connect residents to a range of low-barrier physical health services that are located both on site and in the community. The configuration of health services offered at HTH sites varies by location and is designed to meet the specific needs of that building's residents as determined by its operator. For instance, in 2025, The Booker House established a new partnership with HealthPoint, who sends a nurse to the site for a minimum of one day each week to provide general primary care consultation and referrals to offsite health providers. In addition to onsite physical health services, case managers at all HTH sites aid residents in accessing low-barrier, community-based health resources. For instance, many residents are connected to health centers that are designed to serve low-income individuals, including Hobson Clinic (run by Harborview in partnership with DESC), 45th Street Clinic, Sea Mar, and Navos. Additionally, in 2025, Sharyn Grayson House established new partnerships with the Tubman Center for Health and Freedom and QueerDoc Telemedicine, which provide medical services to residents at their office or online.

In 2025, HTH also partnered with the Hepatitis Education Project (HEP) to expand residents' access to hepatis C treatment, which is especially prevalent among the homeless population.[50] In August, HEP staff presented at the HTH Community of Practice to educate sites on the need for hepatitis C testing and the role that case managers can play in connecting residents to treatment. Following the session, HEP staff met individually with each site to discuss how HEP could help them facilitate access to testing. In 2025, HEP hosted trainings for over 50 staff at four HTH sites and provided onsite testing at The Booker House.

Metrics for Physical and Behavioral Health Care Access

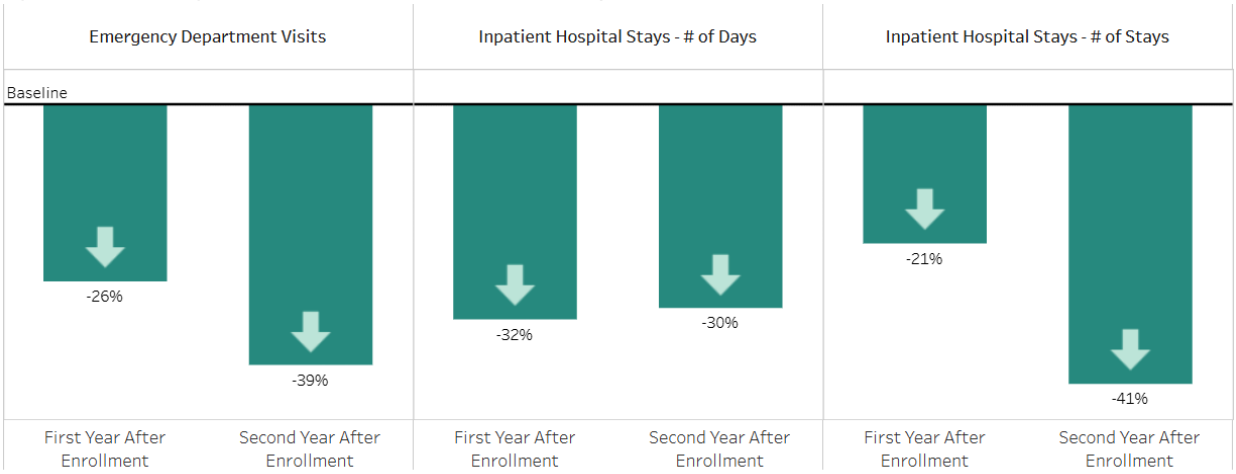
Overall, the services offered above likely have contributed to an increase in the number of HTH residents that access physical and behavioral health care. In 2025:

- 43 percent of residents received physical health care from Health Care for the Homeless Network (HCHN), Public Health – Seattle & King County facilities, and other health care providers who bill to Medicaid.[51]
- 60 percent of residents accessed behavioral health care services provided through King County's publicly funded behavioral health service system, Health Care for the Homeless Network, Public Health – Seattle & King County facilities, and other health care providers who bill to Medicaid.[52,53]
- 95 percent of residents had health insurance, mostly through Medicaid.[54]

HTH operator staff report that the increased housing stability HTH provides to residents contributes to an increase in resident access to health care. The longer a resident lives in a building, the more likely they will have consistent engagement with providers of physical and behavioral health care.

DCHS analysis of Medicaid claims data and emergency department admission data suggests that the increased access to physical and behavioral health care that HTH facilitates is leading to a decrease in the use of emergency health care services. As shown in Figure 10, one year after move in, the total number of emergency department visits by HTH residents decreased by 26 percent, and after two years residents' emergency department visits decreased by 39 percent. After one year, the total number of inpatient hospital stays by HTH residents decreased by 21 percent, and the total number of days HTH residents spent in inpatient hospital care dropped by 32percent. After two years, the total number of inpatient hospital stays by HTH residents was 41 percent lower in total, with a 30 percent reduction in the total number of days HTH residents spent in inpatient hospital care. [55] This is in line with research demonstrating that the housing first model helps shift care from institutions and crisis-related services to more appropriate planned visits and regular follow-up with community-based services.[56,57]

Figure 10: Change in Healthcare Utilization Compared to the Year Prior to Enrollment in HTH



Sources: Sources: Medicaid Claims Data; PointClickCare Emergency Department Data.

Other Supportive Services at HTH Sites in 2025

Mobility Supports: In 2025, DCHS continued supporting the partnership between King County Metro transportation services and HTH sites. By year end, Metro was offering services on site at 12 HTH sites.[58] King County Metro provides a suite of mobility and transportation programs that improve residents' access to essential services. Services available across the HTH initiative included:

- subsidized mobility passes via the ORCA Passport and Easy Trip Programs;
- on-site Community Transportation Navigators with lived experience of homelessness;
- access to the Essential Trip Assistance Program funded by King County Metro, which covers taxi rides to essential appointments, and
- a wheelchair accessible van provided by Metro at each HTH site that specifically serves residents of that site.

During the middle of 2025, Metro decided to wind down the ORCA Passport Program and switch to a new program called Easy Trip. The Easy Trip program is informed by universal basic mobility principles and provides residents with more choice in how they travel. Through this program, HTH residents receive industry-coded debit cards loaded with $50 per month to pay for transportation needs. The funds can be rolled over each month, allowing recipients to spend their money as they best see fit, including on public transit, ferries, long distance buses and trains, app-based rides including rideshare, scooters, and bicycles, and at participating bike shops. The transition to Easy Trip accompanied enrollment in Metro reduced fare passes for which HTH residents are eligible, including ORCA Lift and subsidized annual passes, which is a more cost effective approach to supporting HTH residents in utilizing public transit resources.

The transportation services provided by King County Metro greatly improved residents' access to essential services.

Culturally Responsive Food: DCHS continues to work with the Emergency Feeding Program to provide healthy and culturally responsive food distribution services to HTH sites.[59] In 2025, the Emergency Feeding Program expanded services to eight HTH sites (up from five in 2024). In 2025, deliveries shifted from individual food boxes to larger pallet deliveries to better match site needs and resident populations, resulting in a significant increase in the total volume of food delivered. This initiative-wide service supplements the meal provision that each operator provides through their own partnerships with organizations like Fare Start and Food Lifeline.

Employment Resource Program: In 2025, DCHS continued to provide its Employment Resource Program (ERP) services at HTH sites. ERP offers weekly drop-in services on site to support HTH residents in their professional skill development. ERP services include support:

- Enrolling in educational programs, including trade schools and GED programs;
- Finding internships and opportunities for on-the-job training;
- Finding part-time, full-time, or seasonal employment, and
- Identifying volunteer opportunities at community-based organizations.

In 2025, 57 participants enrolled in the ERP across 10 HTH sites. Upon entering the program, participants chose service areas to access. In 2025, 47 chose to pursue employment and entrepreneurship training and 13 chose to pursue educational development.[60] In 2025, ERP also partnered with Evergreen Goodwill to bring their Digital Equity Bus (DEB) to HTH sites. DEB is a Smart Board-equipped mobile classroom with laptops for people to use for starting their job search. The DEB physically takes the classroom to the HTH sites, where the Employment Resource Program staff can assist residents with resume writing, job training program applications, volunteering opportunities, and other employment resources. Additionally, DCHS is currently working with an external evaluation partner to better understand overall changes in residents' income and employment.

Demographic Data and Progress toward Reducing Disproportionality

Consistent with Ordinance 19179, HTH is dedicated to enhancing equity in housing access, addressing the root causes of chronic homelessness, and housing historically marginalized communities that are more likely to experience chronic homelessness.[61] Accordingly, HTH's primary supporting goal is to annually reduce the racial-ethnic disproportionately among persons experiencing chronic homelessness.[62]

HTH has made progress addressing racial and ethnic disproportionality among the homeless population, especially among the American Indian, Alaska Native, or Indigenous community (AIAN). Figure 11 shows that as of December 2025, 18 percent of HTH residents identified as AIAN,

compared to five percent of the chronically homeless population. Since 2022, the percentage of HTH residents from AIAN communities has increased from three percent to 18 percent. This is largely due to the opening of three buildings run by Chief Seattle Club, a Native-led housing and human services agency specializing in the needs of American Indian and Alaska Native people.

In 2025, the HTH initiative also continued serving a stable number of Black, African American, or African (BAAA) residents.[63, 64, 65] While the percentage of BAAA residents decreased from 25 percent in 2023 to 19 percent in 2025, the total number of BAAA residents stayed stable.[66, 67, 68] The percentage decrease in BAAA residents housed is partly due to the relative increase in the number of AIAN residents housed. Further, DCHS expects the number of BAAA residents HTH houses to increase in 2026 as residents continue to move into The Booker House, which is operated by the Urban League of Metropolitan Seattle (ULMS), which specializes in serving the BAAA population.

In 2025, the HTH initiative also continued serving a stable number of Asian or Asian Americans. While the percentage of Asian or Asian American residents decreased slightly from three percent in 2023 to two percent in 2025, the number of Asian or Asian American residents served remained relatively stable.[69, 70, 71] Further, the Asian or Asian American makeup of the HTH population remains proportionate to their makeup of King County's chronically homeless population (two percent).

Figure 11: Race/Ethnicity of HTH Residents Compared to Chronically Homeless Population and Overall Population in King County, 2025

Race/Ethnicity	Percent of Race/Ethnicity of HTH Residents	Percent of Race/ Ethnicity of People in King County Experiencing Chronic Homelessness	Percent of Race/Ethnicity of Total King County Population
American Indian, Alaska Native, or Indigenous	18%	5%	<1%
Asian or Asian American	2%	2%	22%
Black, African American, or African	19%	24%	7%
Hispanic/Latina/e/o	3%	4%	8%
Multiracial	12%	14%	10%
Native Hawaiian or Pacific Islander	2%	2%	1%
Unknown/Unreported	4%	3%	N/A
White	40%	47%	52%

Sources: Seattle-King County HMIS Data as of 3/1/2025. Washington State Office of Financial Management Population Interim Estimates (PIE), April 2025.

In 2025, HTH continued to work toward reducing the racial and ethnic disparities in homelessness through strategic partnerships with organizations that are run by and for communities that have disproportionately experienced homelessness. By collaborating with these organizations, HTH ensures culturally appropriate services are accessible to historically marginalized communities.

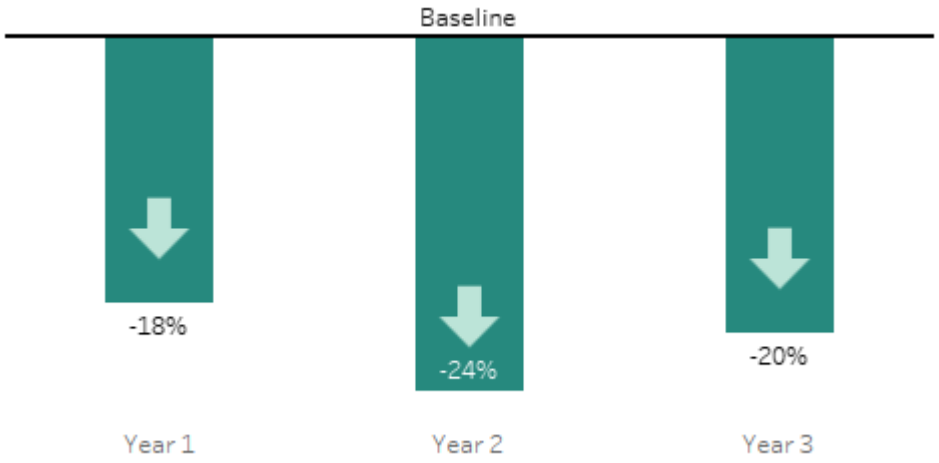
For instance, in 2025 at the newly opened Sweetgrass Flats, Chief Seattle Club began to offer residents a range of services rooted in Indigenous culture. At The Booker House, ULMS initiated services specifically targeted to address the needs of African Americans and other underserved communities. For instance, ULMS is connecting residents to its Criminal Records Expungement Program that helps individuals vacate criminal records, which can limit opportunities for employment and housing.

At the newly opened Sharyn Grayson House, Lavender Rights Project implemented programming that is specifically designed to meet the needs of the Queer, Transgender, Two-spirit, Black, Indigenous, and People of Color (QT2BIPOC) community.

Metrics for Criminal-Legal System Involvement

New analysis by DCHS shows that residents experience a decrease in engagement with the criminal-legal system after enrolling in HTH. While the QT2BIPOC community faces stark disparities in the criminal justice system, living outside also increases the likelihood of interaction with law enforcement. Those that are homeless are at higher risk of receiving citations or being arrested for low-level offenses like loitering or sleeping in parks.[72,73] However, according to new analysis by DCHS, after enrollment in HTH, residents experience a significant decrease in jail bookings, demonstrating the initiative's success in breaking the cycle of homelessness, addiction, trauma, and incarceration. As shown in Figure 12, compared to the year before HTH enrollment, HTH residents experienced decreases in jail bookings of 18 percent in the first year, 24 percent in the second year, and 20 percent in the third year. BAAA and AIAN individuals have experienced the most pronounced decreases in jail bookings after one year (26 percent and 27 percent respectively). This analysis reiterates the profound impact that having access to housing has on HTH residents and on the community more broadly, both by improving resident outcomes and reducing the costs associated with operating jails.

Figure 12: Change in Total Jail Bookings Among All HTH Residents



Source: King County Adult Jail Bookings.

Training and Capacity Building for HTH Providers

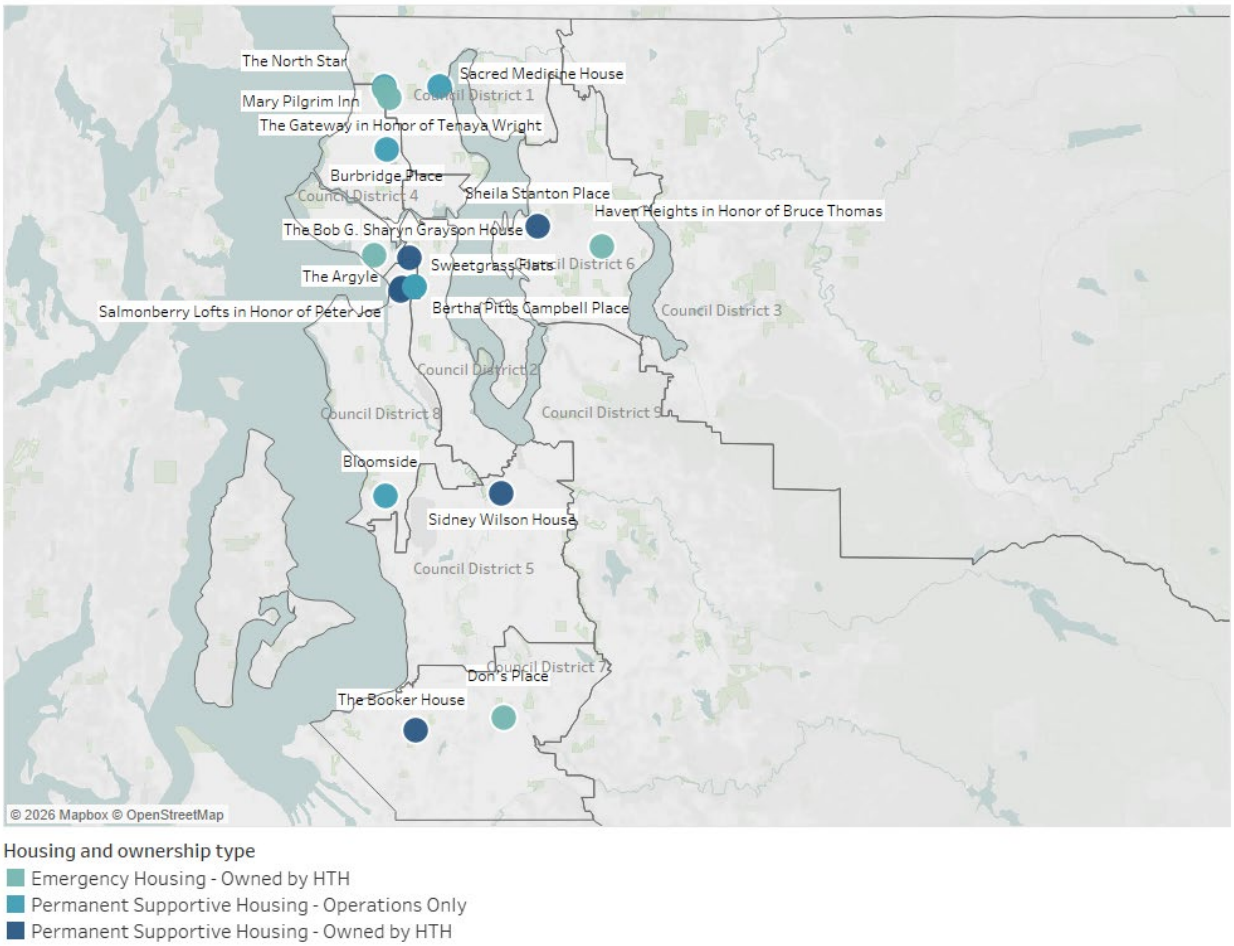
HTH has continued providing significant capacity building and technical assistance to its housing operators. In 2025, HTH provided ongoing one-on-one technical support to operators and continued running the HTH Community of Practice, which facilitates peer to peer learning between organizations. Over the year, HTH program staff met biweekly with each site to provide technical

support on program operations, and HTH fiscal staff met monthly to review invoices and discuss allowable expenses. HTH staff also provided property management support and technical assistance on maintaining data quality within the HMIS system. The HTH Community of Practice met 12 times in 2025 and covered topics such as how to operate resident councils, how to assertively engage residents in services, how to promote good neighbor behaviors, and how to support older adults aging in place. The HTH Community of Practice also brought in experts to educate operators on resources available in the community, such as caregiving resources available through the Washington State Department of Social and Health Services. A particular asset of the Community of Practice is the diversity of culturally specific and supportive housing expertise among operators. The Community of Practice is helping to build relationships between HTH organizations that enhance their ability to provide welcoming, affirming, and culturally responsive services.

B. Site Locations and Other Geographic Information

HTH had secured a total of 17 sites by the end of 2025, including 11 acquired buildings and six operations-only buildings, in seven cities and in seven of the nine County Council districts. This is shown in Figure 13. A detailed description of each site within the HTH portfolio can be found in Appendix B of this report and the Location Map tab of the HTH dashboard.[74]

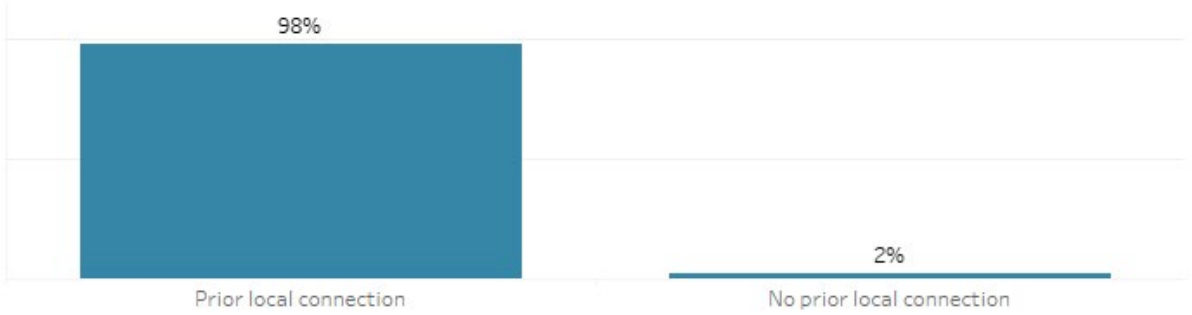
Figure 13: Map of HTH Site Locations, 2025



Individuals Served with Local Community Ties

In 2025, HTH achieved continued success housing individuals with ties to the city in which their HTH building is located. HTH continues to provide referral pathways for people who live in or near the city in which the site is located or have ties to that community, consistent with RCW 82.14.530 and the Implementation Plan.[75, 76] As a result of these efforts, 98 percent of residents reported existing ties to the communities where their HTH site is located, as shown in Figure 14.

Figure 14: HTH Residents with Local Connections to their Host Jurisdiction, 2025



Source: Seattle-King County Homeless Management Information System (HMIS) Data as of 3/1/2026.

C. Financial Information

The HTH initiative is funded by a 0.1 percent sales and use tax imposed by King County in 2020 through Ordinance 19179, codified as King County Code 4A.503.[77] The County leverages anticipated tax revenue to be collected in future years to issue bonds that finance the immediate costs of capital acquisition and rehabilitation. This section of the report summarizes total revenue, actual expenditures, and allocation of debt service in 2025 and provides information about the distribution of proceeds across HTH host jurisdictions.

Annual Revenue

As shown in Figure 15, Health Through Housing's total 2025 revenue totaled $84.6 million, including $73.5 million in tax revenue, $11.0 million in interest, and less than $0.1 million in commercial rent. Tax revenue collections in 2025 were $2.8 million higher than in 2024. Total 2025 revenue was $11.1 million higher than projected in the Plan, primarily due to the interest received on capital and operating balances that are needed to support HTH's future expenditures.

Figure 15: Annual Revenue, 2025

Health Through Housing Revenue in 2025	
Tax Revenue	$73,518,261
Bond Proceeds	$0
Interest	$11,000,712
Rent	$76,277
Total 2024 Revenue	***$84,595,249***

Actual Expenditures

In 2025, as shown in Figure 16, HTH spent $106.2 million, which was approximately $37.1 million more than it spent in 2024. This included $33.2 million on capital expenditures, $49.8 million on operating expenditures, and $23.2 million on bond financing costs. The increase in expenditure compared to 2024 is primarily due to HTH operating more buildings than in previous years, as well as the significant rehabilitation work HTH has funded to open and maintain buildings.

In 2025, HTH spent less on *Strategy 2: Emergency and Permanent Supportive Housing Operations* than was originally projected. Because some buildings opened later than previously projected, supportive housing operating funds were not spent as quickly as expected. However, the funding from 2025 will be allocated to the same operations strategy in future years to cover increased costs for operations and services as HTH operates more of its sites, consistent with provisions for such adjustments in the Implementation Plan.

Figure 16: Expenditures by HTH Strategy, 2025

Health Through Housing Expenditures in 2025	
Strategy 1 Capital Financing and Improvements for HTH Sites *(Rehabilitation)*	$33,226,359
Strategy 2 Emergency and Permanent Supportive Housing Operations	$36,822,131
Facility Maintenance	*$4,102,850*
Program Operations	*$32,719,281*
Strategy 3 Behavioral Health Services Outside HTH Sites	$9,445,112[78]
Strategy 4 Capacity Building Collaborative	$1,043,710
Strategy 5 Evaluation and Performance Measurement	$225,117
Strategy 6 Future Acquisition of Additional Properties *(Acquisitions after 2021)*	$0
Initiative Administration	$2,275,713
Bond Financing Cost (Debt Service)	$23,205,611
Total 2025 Expenditures	***$106,243,752***

Allocation of Expenditures by Jurisdiction

For HTH, King County receives 0.1 percent sales and use tax revenue from each jurisdiction within the region except Bellevue, Covington, Issaquah, Kent, Maple Valley, North Bend, Renton, and Snoqualmie. These jurisdictions passed municipal legislation in 2020 to keep the tax revenue generated through RCW 82.14.530 under city control.[79, 80, 81, 82, 83, 84, 85, 86] RCW 82.14.530 requires King County to plan to spend at least 30 percent of the revenue collected from cities with a population greater than 60,000 within that jurisdiction.

The cities in King County that meet this population threshold but did not pass their own city-level sales tax are Federal Way, Kirkland, Redmond, Sammamish, and Seattle. Among these cities, King County has purchased HTH facilities in Federal Way, Kirkland, Redmond, and Seattle. Executive staff also meet regularly with the City of Sammamish as provided for in the HTH Implementation Plan.[87] At the end of 2025, King County and the City of Sammamish coordinated to convene a meeting, which occurred in early 2026, consistent with the Plan's commitment to continued collaboration. As shown in Figure 17, since 2021, HTH has spent more than 30 percent of the total revenue collected from Federal Way, Kirkland, Redmond, and Seattle within that jurisdiction.

Figure 17: Comparison of All Time HTH Revenue to Expenditures for Larger Jurisdictions, 2025

Jurisdiction	All Time HTH Revenue	All Time HTH Expenditures	Percent
Federal Way	$8,695,771	$45,570,993	524%
Kirkland	$14,452,127	$59,582,446	412%
Redmond	$22,088,181	$56,969,565	258%
Sammamish	$3,327,191	$0	0%
Seattle	$133,248,351	$248,197,652	186%

As shown in Figure 18, in 2025, HTH spent approximately $5.7 million in Auburn, $1.7 million in Burien, $11.2 million in Federal Way, $16.2 million in Kirkland, $12.0 million in Redmond, $10.2 million in Renton, and $36.2 million in Seattle. Higher spending occurred in cities containing multiple HTH sites as well as sites which underwent building rehabilitation in 2025, while lower spending occurred in jurisdictions where HTH only funded operations. HTH had the highest expenditures in Seattle because it has approved acquisition of six HTH sites, more than any other jurisdiction. Expenditures for HTH strategies 3, 4, 5, and initiative administration cannot be readily allocated to specific jurisdictions.[88]

Figure 18: Allocation of Expenditures by Jurisdiction, 2025

HTH Partner Jurisdiction	Expenditure Category	2025 Amount
Auburn	Building Rehabilitation	$990,876
	Facility Maintenance	$230,454
	Program Operations	$3,200,181
	Bond Financing Cost	$1,283,116
	Total	***$5,704,627***
Burien	Program Operations	$1,667,462
	Total	***$1,667,462***
Federal Way	Building Rehabilitation	$6,014,815
	Facility Maintenance	$564,189
	Program Operations	$2,201,709
	Bond Financing Cost	$2,428,661
	Total	***$11,209,375***
Kirkland	Building Rehabilitation	$11,812,456
	Facility Maintenance	$585,316
	Program Operations	$336,712
	Bond Financing Cost	$3,469,577
	Total	***$16,204,061***
Redmond	Building Rehabilitation	$6,187,571
	Facility Maintenance	$405,992
	Program Operations	$2,459,243
	Bond Financing Cost	$2,958,326
	Total	***$12,011,133***
Renton	Building Rehabilitation	$4,285,986
	Facility Maintenance	$474,583
	Program Operations	$2,592,418
	Bond Financing Cost	$2,874,326
	Total	***$10,227,313***
Seattle	Building Rehabilitation	$3,934,655
	Facility Maintenance	$1,842,315
	Program Operations	$20,261,556
	Bond Financing Cost	$10,191,605
	Total	***$36,230,131***
Total Expenditures Allocated by Jurisdiction		***$106,243,752***

Average Per-Unit Costs by Site

The cost per unit for each HTH site varies based on the circumstances of each acquisition, development process, and timing, as well as each site's initial configuration, physical condition, and time for which a given site has been operational.

Figure 19 identifies one-time per-unit acquisition costs, and life-to-date per-unit rehabilitation costs. Figure 20 identifies annual operational costs per unit, including services provided by housing operators and contracted partners and administrative support from King County's Facilities Management Division; and annual facility maintenance costs per unit, including site work outside of major rehabilitation or PSH conversion.

Among properties that HTH acquired, the average per-unit costs for capital were $327,964. In 2025, the average annual per-unit cost of operating HTH properties (which includes program operations and building maintenance) was $40,783.[89]

Figure 19: Life To Date Acquisition/Rehabilitation Cost Per Unit for Each HTH Site

HTH Facility	Expenditure	Life To Date Cost Per Unit
Don's Place	Acquisition	$148,498
	Rehabilitation	$44,486
	Total Cost Per Unit	***$192,984***
Haven Heights	Acquisition	$280,763
	Rehabilitation	$79,638
	Total Cost Per Unit	***$360,401***
Sharyn Grayson House	Acquisition	$363,611
	Rehabilitation	$103,068
	Total Cost Per Unit	***$466,679***
The Booker House	Acquisition	$270,381
	Rehabilitation	$73,659
	Total Cost Per Unit	***$344,040***
Sheila Stanton Place	Acquisition	$283,707
	Rehabilitation	$134,793
	Total Cost Per Unit	***$418,500***
Mary Pilgrim Inn	Acquisition	$214,483
	Rehabilitation	$22,150
	Total Cost Per Unit	***$236,633***
Salmonberry Lofts in Honor of Peter Joe	Acquisition	$323,317
	Rehabilitation	$47,142
	Total Cost Per Unit	***$370,459***
Sidney Wilson House	Acquisition	$277,788
	Rehabilitation	$62,181
	Total Cost Per Unit	***$339,969***
The Argyle	Acquisition	$305,240
	Rehabilitation	$10,559
	Total Cost Per Unit	***$315,799***
The Bob G.	Acquisition	$206,408
	Rehabilitation	$0
	Total Cost Per Unit	***$206,408***
The Gateway in Honor of Tenaya Wright	Acquisition	$362,643
	Rehabilitation	$15,570
	Total Cost Per Unit	***$378,213***

Figure 20: 2025 Operations and Maintenance Cost Per Unit for Each HTH Site

HTH Facility	Expenditure	2025 Cost Per Unit
Bertha Pitts Campbell Place	Maintenance	$0
	Operations	$33,726
	Total Cost Per Unit	***$33,726***
Bloomside	Maintenance	$0
	Operations	*$17,552*
	Total Cost Per Unit	***$17,552***
Burbridge Place	Maintenance	$0
	Operations	$22,292
	Total Cost Per Unit	***$22,292***
Don's Place	Maintenance	$2,845
	Operations	$39,508
	Total Cost Per Unit	***$42,353***
Haven Heights	Maintenance	$4,060
	Operations	$24,592
	Total Cost Per Unit	***$28,652***
Sharyn Grayson House*	Maintenance	$8,335
	Operations	$332
	Total Cost Per Unit	***$8,667***
The Booker House*	Maintenance	$6,560
	Operations	$25,601
	Total Cost Per Unit	***$32,161***
Sheila Stanton Place**	Maintenance	$5,795
	Operations	$3,334
	Total Cost Per Unit	***$9,129***
Mary Pilgrim Inn	Maintenance	$4,017
	Operations	$44,548
	Total Cost Per Unit	***$48,565***
Sacred Medicine House	Maintenance	$0
	Operations	$30,264
	Total Cost Per Unit	***$30,264***
Sweetgrass Flats*	Maintenance	$0
	Operations	$3,308
	Total Cost Per Unit	***$3,308***

HTH Facility	Expenditure	2025 Cost Per Unit
Salmonberry Lofts in Honor of Peter Joe	Maintenance	$4,018
	Operations	$30,953
	Total Cost Per Unit	***$34,971***
Sidney Wilson House	Maintenance	$4,608
	Operations	$25,169
	Total Cost Per Unit	***$29,777***
The Argyle**	Maintenance	$6,067
	Operations	$672
	Total Cost Per Unit	***$6,739***
The Bob G.**	Maintenance (2024)	$4,951
	Operations (2024)	$332
	Total Cost Per Unit	***$5,283***
The Gateway in Honor of Tenaya Wright	Maintenance	$4,355
	Operations	$21,273
	Total Cost Per Unit	***$25,628***
The North Star	Maintenance	$0
	Operations	$32,059
	Total Cost Per Unit	***$32,059***

** 2025 costs per unit are lower at this site because it opened mid-year.*

*** 2025 costs per unit are lower at this site because it was not open for occupancy in 2025.*

D. Frank Chopp HTH Advisory Committee Certification of Dashboard

The Frank Chopp HTH Advisory Committee is a 12- to 16-member group advising the King County Executive and King County Council on current and future implementation of the HTH initiative. In 2025, the Committee convened quarterly and received presentations from HTH staff regarding the HTH model, the initiative's performance, and the final evaluation plan. On May 21, 2026, the Frank Chopp HTH Advisory Committee reviewed and unanimously certified this report and the HTH Dashboard, including certifying that that the dashboard is updated with 2025 calendar year data.[90]

E. Additional Information Available in the HTH Dashboard

Additional information about the HTH initiative is in the online HTH dashboard available here.[91] The dashboard includes:

- Additional data specific to each of HTH's sites;
- Additional context and discussion of initiative activities and performance in 2025;
- Customizable views of HTH data;
- Greater background on disproportionality;
- More information about how HTH and its partners are working to support the health of residents; and
- More information about Advisory Committee members.

Conclusion/Next Actions

In 2025, the HTH initiative's fourth full year of operation, the initiative continued to focus on rehabilitating and opening buildings, moving people inside, connecting residents with health care and other supports, and building the capacity of service providers. HTH ended the year with 1,423 housing units secured and 1,054 units opened at 14 sites, reflecting the initiative's commitment to expanding the availability of supportive housing across the region. While HTH has faced significant challenges that have impacted the pace at which the initiative is achieving its paramount goal of securing and opening 1,600 units, HTH has made steady progress securing and opening supportive housing across King County.

As of December 2025, the HTH initiative has ended homelessness for over 1,400 King County Residents, improved the health and wellbeing of residents, and reduced the use of local emergency departments, hospitals, and jails – creating additional cost savings for the County. According to analysis by DCHS, after two years of living in a HTH unit, residents' total number of inpatient hospital care stays decreases by 41 percent, their total number of emergency department visits dropped by 39 percent, and residents experienced a 24 percent decrease in jail bookings. As HTH residents stay housed year after year, the comprehensive services offered at HTH sites help break the cycle of homelessness, addiction, trauma, and incarceration. As one resident said, "You don't become homeless overnight, and you don't recover overnight either. But with help, you can get there."

In 2026, HTH will focus on finishing the rehabilitation of unopened units, moving individuals inside, and continuing to provide a broad range of supportive services to residents. As external evaluators and DCHS's Performance, Measurement, and Evaluation team wrap up their in-depth evaluation of the HTH initiative, DCHS will reflect on lessons learned during the initiative's first five years and continue building the capacity of operators to refine services and supports. HTH is a powerful part

of King County's regional strategy to address the entwined crises of affordable housing and chronic homelessness by increasing access to dignified supportive housing where people with disabilities can improve their health and their lives.

Appendix A: Reporting Elements Table and HTH Dashboard Guide

Reporting Element Language	Source	See Section(s) of This Report	See Also HTH Dashboard Tab(s)[92]
King County Code 2A.300.200.A			
The Frank Chopp health through housing advisory committee is created to provide advice to the executive and council and report annually to the council and community on the accomplishments and effectiveness of the expenditure of sales and tax proceeds as authorized by KCC chapter 4A.503 and RCW 82.14.530. Annual reporting to the council and the community shall include information on the allocation by jurisdiction of sales and use tax proceeds as authorized by KCC. chapter 4A.503 and RCW 82.14.530. …	KCC 2A.300.200.A	• Report Requirements Subsection A: Performance Overview: Accomplishments and Effectiveness in 2025 • Report Requirements Subsection C: Financial Information • Appendix G: MRT Services by Geographic Area	• Full HTH Dashboard
No later than June 15 of each year, beginning with the first report to be filed by June 15, 2023, on behalf of the advisory committee, the executive shall electronically file the annual report and a motion that should acknowledge receipt of the report with the clerk of the council, who shall retain an electronic copy to all councilmembers, the council chief and member and alternates of the regional policy committee, or its successor. The clerk of the council shall retain an electronic copy and provide an electronic copy to all councilmembers, the council chief of staff and the lead staff for the committee of the whole, or its successor.	KCC 2A.300.200.A	N/A	N/A

Reporting Element Language	Source	See Section(s) of This Report	See Also HTH Dashboard Tab(s)[92]
King County Code 24.30.030.A			
... The implementation plan shall also describe responsibilities of the Frank Chopp health through housing advisory committee, which is to provide advice to the executive and council and to report annually to the council and the community on the accomplishments and effectiveness of the expenditure of proceeds and name the persons to the committee. Annual reporting provided to the council and the community shall include information on the allocation of the proceeds by jurisdiction.	KCC 24.30.030.A	• Report Requirements Subsection A: Performance Overview: Accomplishments and Effectiveness in 2025 • Report Requirements Subsection D: Frank Chopp HTH Advisory Committee Certification of Dashboard • Report Requirements Subsection C: Financial Information • Appendix I: Frank Chopp HTH Advisory Committee Membership	• Full HTH Dashboard

Reporting Element Language	Source	See Section(s) of This Report	See Also HTH Dashboard Tab(s)[92]
HTH Implementation Plan			
The HTH Advisory Committee will annually report to the Council and public on the expenditures, accomplishments, and effectiveness of the HTH initiative through an online HTH dashboard. The purposes of reporting by online dashboard are to increase community access to reporting, to take advantage of an online platform's ability to present interactive data, to allow for faster data updates as data are available within the annual reporting period, and to reduce the environmental impact of printing paper reports.	HTH Implementation Plan, page 64	• Report Requirements Subsection A: Performance Overview: Accomplishments and Effectiveness in 2025 • Report Requirements Subsection B: Site Locations and Other Geographic Information • Report Requirements Subsection C: Financial Information • Report Requirements Subsection E: Performance Overview: Additional Information Available in the HTH Dashboard • Appendix G: MRT Services by Geographic Area	• Full HTH Dashboard

Reporting Element Language	Source	See Section(s) of This Report	See Also HTH Dashboard Tab(s)[92]
DCHS will prepare and maintain the online dashboard. No later than June 15 of each year starting in 2023, the online dashboard will be updated with the prior calendar year's data reporting and an overview of the HTH initiative's performance during the year. The online dashboard will include performance measures that are consistent with this plan's section on Performance Measurement and Evaluation.	HTH Implementation Plan, page 64	• Report Requirements Subsection A: Performance Overview: Accomplishments and Effectiveness in 2025 • Report Requirements Subsection B: Site Locations and Other Geographic Information • Report Requirements Subsection E: Performance Overview: Additional Information Available in the HTH Dashboard • Appendix G: MRT Services by Geographic Area	• Full HTH Dashboard
A list of the members of the HTH Advisory Committee	HTH Implementation Plan, page 65	• Appendix I: Frank Chopp HTH Advisory Committee Membership	• Advisory Committee
A map depicting the locations of sites constructed or acquired with Health through Housing proceeds and depicting the locations and numbers of operational-only housing units supported by HTH	HTH Implementation Plan, page 65	• Report Requirements Subsection B: Site Locations and Other Geographic Information	• Location Map

Reporting Element Language	Source	See Section(s) of This Report	See Also HTH Dashboard Tab(s)[92]
Demographic data describing the population residing in Health through Housing-funded housing, including race and ethnicity. The dashboard will track progress towards reducing racial-ethnic disproportionality by comparing HTH demographic data to the population experiencing chronic homelessness in King County and the general King County population	HTH Implementation Plan, page 65	• Report Requirements Subsection A: Performance Overview: Accomplishments and Effectiveness in 2025 – Demographic Data and Progress toward Reducing Disproportionality	• Who We Serve
Number of households receiving a service through the mobile behavioral health intervention program by geographic area	HTH Implementation Plan, page 65	• Appendix G: MRT Services by Geographic Area	• Mobile Response Team
Number of households, who, at the time of enrollment, were living in or near the city in which the site is located, or have ties to that community	HTH Implementation Plan, page 65	• Report Requirements Subsection B: Site Locations and Other Geographic Information – Individuals Served with Local Community Ties	• Who We Serve
Health Through Housing initiative financial information, including,			
• The program's annual revenue	HTH Implementation Plan, page 65	• Report Requirements Subsection C: Financial Information	• Revenue and Expenditures
• Allocation of proceeds for housing and operations to jurisdictions that host Health through Housing sites	HTH Implementation Plan, page 65	• Report Requirements Subsection C: Financial Information	• Revenue and Expenditures

Reporting Element Language	Source	See Section(s) of This Report	See Also HTH Dashboard Tab(s)[92]
• Actual expenditures of the previous year's proceeds amongst the categories of expenditure required or allowed by KCC chapter 24.30	HTH Implementation Plan, page 65	• Report Requirements Subsection C: Financial Information	• Revenue and Expenditures
• Including the average per-unit cost of acquisition, conversion and operation by site	HTH Implementation Plan, page 65	• Report Requirements Subsection C: Financial Information	• Revenue and Expenditures
Data that describe how the Health through Housing initiative performs on at least the following population-level and program performance measures:			
• Cumulative number of people who moved from chronic homelessness into permanent housing via HTH;	HTH Implementation Plan, page 65	• Report Requirements Subsection A: Performance Overview: Accomplishments and Effectiveness in 2025 - Number of People Moved from Chronic Homelessness to Permanent Housing	• Housing Performance
• Progress on reducing disproportionality in the experience of chronic homelessness;	HTH Implementation Plan, page 65	• Report Requirements Subsection A: Performance Overview: Accomplishments and Effectiveness in 2025 - Demographic Data and Progress toward Reducing Disproportionality	• Who We Sere

Reporting Element Language	Source	See Section(s) of This Report	See Also HTH Dashboard Tab(s)[92]
• Percentage of residents who maintain their housing in HTH or exit to permanent housing from HTH-funded emergency or PSH;	HTH Implementation Plan, page 65	• Report Requirements Subsection A: Performance Overview: Accomplishments and Effectiveness in 2025 – Percent of HTH Residents who Maintain Housing in HTH or Exit to Permanent Housing	• Housing Performance
• Average length of stay of residents in HTH-funded emergency or PSH;	HTH Implementation Plan, page 65	• Report Requirements Subsection A: Performance Overview: Accomplishments and Effectiveness in 2025 – Average Length of Stay	• Occupancy and Length of Stay
• Percentage of residents who receive physical or behavioral health care supports or care while residing in a HTH unit; and	HTH Implementation Plan, page 65	• Report Requirements Subsection A: Performance Overview: Accomplishments and Effectiveness in 2025 – Health and Wellbeing Supports	• Healthcare Access

Reporting Element Language	Source	See Section(s) of This Report	See Also HTH Dashboard Tab(s)[92]
• Additional measures of improvements in health or well-being, as data are available	HTH Implementation Plan, page 65	• Report Requirements Subsection A: Performance Overview: Accomplishments and Effectiveness in 2025 – Health and Wellbeing Supports • Report Requirements Subsection A: Performance Overview: Accomplishments and Effective in 2025 – Metrics for Criminal-Legal System Involvement • Appendix H: Overview of HTH Health and Wellbeing Services	• Healthcare Outcomes • Criminal-Legal Outcomes • Mobile Response Team • Transportation and Mobility Supports • Employment Resource Program • Emergency Feeding Program
Beginning in 2023, the HTH Advisory Committee will annually certify by June 15 that the online dashboard is updated with the previous year's data and ready for review.	HTH Implementation Plan, page 65	• Report Requirements Subsection D: Frank Chopp HTH Advisory Committee Certification of Dashboard	• Advisory Committee

Reporting Element Language	Source	See Section(s) of This Report	See Also HTH Dashboard Tab(s)[92]
On behalf of the Committee, the Executive will electronically file the annual report and a motion that should acknowledge receipt of the report with the clerk of the council, who will retain an electronic copy and provide an electronic copy to all councilmembers, the council chief and members and alternates of the regional policy committee, or its successor. Passage of the motion acknowledging receipt of the report will satisfy 'TH's annual reporting requirement. DCHS will be prepared upon invitation to present an overview of the annual report to the Council or one of its committees and to the Regional Policy Committee.	HTH Implementation Plan, page 65	N/A	N/A

[1] HTH Dashboard. [https://www.kingcounty.gov/hthdashboard]

Appendix B: HTH Investments (Acquisitions and Operations-only Partnerships)
Cumulative to Year End 2025

Investment Type	Service Provider	Building Name	Initial Housing Type	Total Units	Housing Units	City	Council District	Status as of December 2025
Acquisition	Compass Housing Alliance	Don's Place	EH	102	81	Auburn	7	Open and occupied
Acquisition	Lavender Rights Project	Sharyn Grayson House	PSH	37	32	Seattle	2	Open and occupied
Acquisition	The Urban League	The Booker House	PSH	101	86	Federal Way	7	Open and occupied
Acquisition	Plymouth Housing	Sheila Stanton Place	PSH	124	101	Kirkland	6	Pre-occupancy
Acquisition	Salvation Army	Haven Heights in Honor of Bruce Thomas	EH	144	100	Redmond	6	Open and occupied
Acquisition	DESC	Mary Pilgrim Inn	EH	100	82	Seattle	4	Open and occupied
Acquisition	Chief Seattle Club	Salmonberry Lofts in Honor of Peter Joe	PSH	80	74	Seattle	8	Open and occupied
Acquisition	Catholic Community Services	Sidney Wilson House	PSH	110	103	Renton	5	Open and occupied
Acquisition	TBD	The Argyle	PSH	12	10	Seattle	8	Project scoping
Acquisition	Catholic Community Services	The Bob G.	EH	80	80	Seattle	4	Listed for sale

Investment Type	Service Provider	Building Name	Initial Housing Type	Total Units	Housing Units	City	Council District	Status as of December 2025
Acquisition	DESC	The Gateway in Honor of Tenaya Wright	EH	131	113	Seattle	1	Open and occupied
Operations-only	Plymouth Housing	Bertha Pitts Campbell Place	PSH	100	100	Seattle	8	Open and occupied
Operations-only	DESC	Burbridge Place	PSH	62	62	Seattle	4	Open and occupied
Operations-only	DESC	Bloomside	PSH	95	95	Burien	8	Open and occupied
Operations-only	Chief Seattle Club	Sacred Medicine House	PSH	120	120	Seattle	1	Open and occupied
Operations-only	Chief Seattle Club	Sweetgrass Flats	PSH	84	84	Seattle	8	Open and occupied
Operations-only	DESC	The North Star	PSH	100	100	Seattle	4	Open and occupied
			Total	**1,582**	**1,423**			

Appendix C: HTH Service Providers

HTH is partnering with eight service providers to operate HTH's sites, as shown in Figure 1, with the goal of expanding and diversifying the region's capacity to deliver this critical housing. Catholic Community Services, Compass Housing Alliance, DESC, Plymouth Housing, and The Salvation Army are longstanding regional providers of emergency shelter and PSH.[93, 94, 95, 96, 97] Chief Seattle Club, Lavender Rights Project, and the Urban League are deeply embedded in and have rich experience serving communities and populations most disproportionately experiencing homelessness. Chief Seattle Club is a Native-led housing and human services agency that serves American Indian and Alaska Native people.[98] Lavender Rights Project is a Black trans-led and founded organization centered in the values of social justice for trans and queer low-income people.[99] The Urban League of Metropolitan Seattle is an organization dedicated to improving the lives of communities of color. [100]

Figure 1: HTH Service Providers at HTH Sites, 2025

Service Provider	HTH Site Name	Jurisdiction
Catholic Community Services (CCS)	Sidney Wilson House	Renton
	The Bob G.[101]	Queen Anne, Seattle
Chief Seattle Club	Salmonberry Lofts in Honor of Peter Joe	Pioneer Square, Seattle
	Sacred Medicine House *(operations-only)*	Lake City, Seattle
	Sweetgrass Flats *(operations-only)*	Central District, Seattle
Compass Housing Alliance	Don's Place	Auburn
Downtown Emergency Service Center (DESC)	The Mary Pilgrim	Bitter Lake, Seattle
	The Gateway in Honor of Tenaya Wright	Haller Lake, Seattle
	Burbridge Place *(operations-only)*	Green Lake, Seattle
	The North Star *(operations-only)*	Bitter Lake, Seattle
	Bloomside *(operations-only)*	Burien
Lavender Rights Project (LRP)/Chief Seattle Club	Sharyn Grayson House	Capitol Hill, Seattle
Plymouth Housing	Bertha Pitts Campbell Place *(operations-only)*	Central District, Seattle
	Sheila Stanton Place	Kirkland
The Salvation Army	Haven Heights in Honor of Bruce Thomas	Redmond
The Urban League of Metropolitan Seattle	The Booker House	Federal Way

Note: HTH's 17th site, known as the Argyle, is not listed in this table because DCHS has not identified a service provider to operate the building.

These partnerships are vital to providing high quality services and creating inclusive environments that respect and celebrate the cultural backgrounds and lived experience of all residents and staff, thereby promoting a sense of belonging and support for marginalized individuals.

Appendix D: Key Historical Context and Current Conditions

King County launched HTH in 2020 at the height of the COVID-19 pandemic. The pandemic amplified the region's pre-existing housing and homelessness crises, forcing tens of thousands of King County households to fall behind on rent in an expensive housing market.[102, 103] Social distancing requirements implemented during the pandemic further reduced overall shelter capacity while the rate of unsheltered homelessness climbed.[104]

The COVID-19 pandemic demonstrated that single-room settings are more supportive of a person's stability, health, and ability to maintain housing compared to congregate shelters.[105] Integrating this lesson, King County acquired existing buildings across the region, allowing for residents to live in separate bedrooms with the revenue created by the one tenth of a cent sales tax which was authorized by the Washington State Legislature in 2020 exclusively for housing use.[106]

The economic circumstances of the pandemic made hotels and apartments available for purchase at lower rates, allowing HTH to grow the region's stock of affordable homes quickly and at lower cost.[107] The HTH initiative took advantage of these economic circumstances to buy relatively new or recently updated hotels and apartments, many of which included kitchen facilities, to substantially grow the region's stock of affordable homes quickly. Four years into the Plan, HTH has transformed these buildings into EH and PSH with comprehensive wraparound services including case management, behavioral health support, health care, employment support, and crisis intervention for residents experiencing chronic homelessness.

The initiative established partnerships with cities across King County to site and operate EH and PSH at a speed and scale not previously possible. This coordinated strategy recognizes that to reduce chronic homelessness in King County, communities, cities, and the County must act boldly together to increase housing that is available to, and supportive of, residents who have been living outside.

As the world moves beyond the COVID-19 pandemic, the ongoing issues of homelessness, housing affordability, and racial inequity continue to be central concerns for King County. In 2024, the King County Regional Homelessness Authority found that 16,385 individuals were experiencing homelessness, a 39 percent increase from the 2020 Annual Point in Time (PIT) count of 11,751 individuals.[108]

Furthermore, communities do not experience homelessness at the same rate. Black, Hispanic/Latin(a)(o)(x), American Indian, Alaska Native, or Indigenous, and Native Hawaiian or Pacific Islander individuals are overrepresented among those experiencing homelessness compared to King County's overall demographics.[109] Veterans are also an overrepresented group among those who received homelessness services countywide.[110]

This growing rate of homelessness has occurred concurrently with a drastic increase in housing costs. Between 2016 and 2024, the median gross rent in King County increased from $1,418 to $2,110, marking a 49 percent increase.[111] This significant growth in housing costs has been partially driven by rapid population growth in the region. Between 2010 and 2024, the King County population increased 21 percent, increasing demand for housing and putting upward pressure on housing costs.[112, 113] Now, nearly half of households (46 percent) in King County are cost-burdened, meaning they pay more than 30 percent of their income in rent.[114] Over 84 percent of extremely low-income households are severely cost burdened in King County, meaning they pay more than 50 percent of their income in rent.[115] These households are at high risk of homelessness and often do not have safe, affordable options in the private housing market. HTH plays a critical role in meeting the housing needs of extremely low income residents, especially those who have intersecting disabilities and experiences of homelessness.

Appendix E: Legislative History, Initiative Goals, and Annual Reporting Requirements

In 2020, King County implemented the HTH sales tax through the adoption of Ordinance 19179, codified as King County Code (KCC) Chapter 4A.503.[116, 117] After establishing the revenue for the initiative, King County adopted Ordinance 19236 in 2021, which detailed the implementation planning for the HTH initiative.[118] This ordinance established the initiative's paramount goal through 2028 of creating and maintaining the ongoing operations of 1,600 units of affordable, supportive housing for individuals experiencing or at risk of chronic homelessness.[119] HTH is mandated to enhance access to health care, develop a mobile behavioral health intervention program, and address demographic disproportionality in homelessness.[120]

In 2021, King County adopted Ordinance 19366, which adopted the Initial Health Through Housing Implementation Plan, outlined the process to establish an advisory committee for HTH, and set forth annual reporting requirements.[121, 122] The plan outlines the processes for acquiring and operating supportive housing, engaging community stakeholders, and measuring the initiative's impact on chronic homelessness.[123] It also delineates the roles and responsibilities of the advisory committee, setting forth comprehensive annual reporting requirements to maintain transparency and accountability.[124]

Appendix F: Additional Information on Open HTH Buildings

As summarized in the Performance Overview subsection of this report, the HTH initiative opened 109 additional units in 2025. Figure 1 provides details on the buildings where these units opened, including address, initial housing type, and number of units, as well as photos of each property. HTH considers a unit open when it becomes ready for resident occupancy. HTH opens a unit after completing renovations and contracting with a service provider who ensures the facility can function as intended, providing safe and supportive housing.

Figure 1: HTH Units Opened, 2025

1 | Sweetgrass Flats, 157 12th Ave., Seattle, 98122
Property Details
Service Provider: Chief Seattle Club Initial Housing Type: Permanent Supportive Housing Total HTH Units: 84 (32 opened in 2025)
Building Photos


2 | The Booker House, 1400 S 320th St., Federal Way, 98003

Property Details

Service Provider: The Urban League of Metropolitan Seattle
Initial Housing Type: Permanent Supportive Housing
Total HTH Units: 86 (18 opened in 2025)

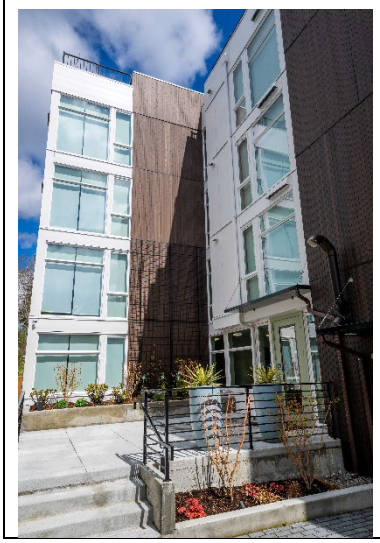
Building Photos

3 | Sharyn Grayson House

Property Details

Service Provider: Lavender Rights Project & Chief Seattle Club
Initial Housing Type: Permanent Supportive Housing
Total HTH Units: 32

Building Photos



4 | Haven Heights in Honor of Bruce Thomas, 2122 152nd Ave. NE, Redmond, 98052

Property Details

Service Provider: The Salvation Army
Initial Housing Type: Emergency Housing
Total HTH Units: 100 (15 opened in 2024, 27 opened in 2025)

Building Photos



Appendix G: MRT Services by Geographic Area

Figure 1: Number of Health Through Housing (HTH) Clients Receiving Mobile Response Team (MRT) Services by Geographic Area[125]

Jurisdiction	Zip Code	Number of Clients Served
Auburn	98001	<10
Burien	98166	<10
Redmond	98052	<10
Renton	98057	12
Seattle	98103	42
	98104	<10
	98122	12
	98125	<10
	98133	75

Notes on Figure 1: Due to some residents moving between sites, the total number of clients served by zip code adds up to more than the total distinct clients served across the entire HTH MRT portfolio.

Appendix H: Overview of HTH Health and Wellness Services

Behavioral Health Services
HTH operators have continued to establish community partnerships with organizations that offer ongoing mental health services and substance use treatment on site to help residents achieve longer term stability. For instance, in 2025:

- Haven Heights in Honor of Bruce Thomas established a new partnership with IKRON to bring a psychotherapist specializing in mental health and substance use disorder treatment on site at least one day a week.

- Burbridge Place and The North Start continued partnering with DESC's outpatient behavioral health service, SAGE (Support, Advocacy, Growth, and Employment), to bring a behavioral health case manager on site 40 hours a week to support residents' recovery.

- Burbridge Place, The North Star, and Bloomside all have staff from DESC's Substance Use Disorder Program on site at least one day a week.

- Sacred Medicine House, Salmonberry Lofts in Honor of Peter Joe, and Sweetgrass Flats host a Traditional Health and Wellness Team that works individually and in group settings to engage residents in trauma-informed healing and wellness modalities that are centered in ancestral Indigenous knowledge. The Traditional Health and Wellness staff are on site for 40 hours a week at each site. All three sites also offer weekly Wellbriety meetings, a culturally based program that supports recovery from alcohol, substance abuse, and intergenerational trauma.

- Catholic Community Services' Counseling, Recovery and Wellness Program (CReW) offered mental health and SUD counseling on site at Sidney Wilson House for 40 hours a week.

- Don's Place continued to partner with HealthPoint medical staff, who are on site 4 hours a week to prescribe psychiatric medications and substance use disorder treatments to residents. Don's Place is also in the process of establishing a new relationship with Lutheran Community Services Northwest, which will offer onsite behavioral health services in future years.

- Mary Pilgrim Inn and the Gateway partner with Harborview to bring a psychiatrist on site for up to two days a week.

Case managers at all HTH sites work diligently to connect residents to a wide range of low-barrier, community-based behavioral health services that supplement those offered on site. For instance,

many HTH operators connect residents to Program of Assertive Community Treatment (PACT), a Medicaid-funded program which provides community-based intensive services for people with high behavioral health needs. PACT teams consists of a psychiatrist, nurse, mental health counselors, substance use disorder professionals, case managers, vocational specialists, and peer specialists who provide services throughout the community, including on site at HTH buildings. Many HTH operators also connect residents to Evergreen Treatment Services, which runs several clinics that offer medication-assisted treatment for adults with opioid disorders, and a mobile REACH team made up of case managers, social workers, chemical dependency specialists, and nurses who provide services at HTH locations. Several sites connect residents to We Care Daily Clinics, a mobile opioid treatment provider based in Auburn and Seattle. HTH residents in behavioral health crisis can also be connected to Connections Kirkland, a County-funded crisis care center that is open 24/7 to provide walk-in behavioral health urgent care as well as more intensive crisis services when needed.[126]

As such, HTH residents continue to have access to behavioral health services funded by Public Health – Seattle & King County's Health Care for the Homeless Network (such as Evergreen Treatment Services, and REACH, HealthPoint, and Harborview) as well as the network of community behavioral health providers administered by the King County DCHS Behavioral Health and Recovery Division (BHRD) that are funded through Medicaid, state dollars, and MIDD behavioral health sales tax funds (such as IKRON and Lutheran Community Services Northwest).

Physical Health Services

In addition to behavioral health care, HTH operators continue to connect residents to a range of low-barrier physical health services that are located both on site and in the community. The configuration of health services offered at HTH sites varies by location and is designed to meet the specific needs of that building's residents as determined by its operator. This subsection describes the unique health care supports provided at various HTH sites:

- The Booker House: The Booker House established a new partnership with HealthPoint in 2025. A HealthPoint nurse is on site for a minimum of one day each week to provide general primary care consultation and referrals to offsite health providers.

- Sidney Wilson House: Sidney Wilson House has a nurse from HealthPoint on site on a weekly basis for up to 24 hours. This nurse offers general primary care consultation, wound care, overdose prevention, and over the counter pain remedies. In addition, the nurse performs vital care coordination services such as making referrals to the appropriate level of care including hospitals, inpatient clinics, or specialized care, and connecting residents to other health supportive services that are tailored to the individual's needs.

- Don's Place: In 2025, Don's Place continued to partner with HealthPoint to offer both nursing and physician care through its on-site medical exam room. One day a week,

medical staff provide a wide array of health services including wound care, foot care, primary care consults, and referrals to specialized medical services.

- Mary Pilgrim Inn and The Gateway in Honor of Tenaya Wright: Residents at the Mary Pilgrim Inn and The Gateway in Honor of Tenaya Wright benefit from an innovative on-site partnership with Harborview Medical Center's Adult Medicine Clinic. In 2025, Harborview continued medical clinic operations at the Mary Pilgrim Inn and The Gateway in Honor of Tenaya Wright, which is staffed by a physician and nurse. This partnership supports chronic disease management, particularly diabetes management, and supports monitoring of medically fragile residents. Further, DESC employs a nurse that is on site at both The Gateway in Honor of Tenaya Wright and Mary Pilgrim Inn approximately 15 hours a week. Residents also receive on-site medication management services. In interviews, residents speak highly of the care team at these two sites, with one resident saying, "I'm impressed with the medical team. They treat me with compassion, provide follow-up as promised, and are very generous with medical supplies. I'm grateful to be staying at MPI."

- Salmonberry Lofts in Honor of Peter Joe and Sweetgrass Flats: In 2025, Seattle Indian Health Board and Chief Seattle Club continued offering on-site nursing services at Salmonberry Lofts in Honor of Peter Joe, and launched on-site services at Sweetgrass Flats. Nurse care includes medication management, wound care, wellness checkups, consultation and referrals to nearby Seattle Indian Health Board health centers. The Seattle Indian Health Board also runs nearby community health centers that provide medical, dental, behavioral health, and substance use services to its patients, while specializing in the care of Native people.

- The North Star, Burbridge Place, and Bloomside: Residents at Burbridge Place, The North Star, and Bloomside all receive on-site medication management services.

In addition to onsite physical health services, case managers at all HTH sites aid residents in accessing low-barrier, community-based health resources. For instance, some residents are connected to HOST (Homeless Outreach Stabilization and Transition), a multi-disciplinary team of health, substance use disorder, and medical professionals that offer coordinated case management on site. Other sites connect residents to low-barrier, community-based health centers that are designed to serve low-income individuals, including Hobson Clinic (run by Harborview in partnership with DESC), 45th Street Clinic, Sea Mar, and Navos. Burbridge Place connects residents to the Aurora Commons Walk Up Clinic, which is run in partnership with Harborview and available to anyone living or working on Aurora Avenue. In 2025, Sharyn Grayson House established new partnerships with the Tubman Center for Health and Freedom and QueerDoc Telemedicine, which provide medical services to residents at their office or online.

Appendix I: Frank Chopp HTH Advisory Committee Membership

KCC 2A.300.200 and KCC 24.30.020 call for an advisory committee for the HTH initiative.[127, 128] As shown in Figure 1, the Frank Chopp HTH Advisory Committee is a 12- to 16-member group advising the King County Executive and King County Council on current and future implementation of the HTH initiative. In addition to providing guidance, the committee is responsible for:

- Reviewing the initiative's performance data;
- Providing annual certification of the HTH Dashboard; and
- Reporting annually to the King County Council and the community at large on the expenditures, accomplishments, and effectiveness of the HTH initiative.

In 2025, King County adopted Ordinance 19997 to rename the HTH Advisory Committee in honor of Frank Chopp, a longtime Speaker of the Washington State House of Representatives who helped fund the development of affordable housing across the region and championed the state legislation that made the HTH initiative possible. The committee's official name is now the Frank Chopp Health Through Housing Advisory Committee.[129,130]

As of December 2025, the Frank Chopp HTH Advisory Committee consisted of 15 people, including representatives from local communities, non-profit organizations, health care providers, housing experts, and HTH residents.[131] The Committee's purpose is to provide oversight, guidance, and expertise to ensure the initiative's objectives are met effectively and equitably.[132] The Frank Chopp HTH Advisory Committee is intended to serve as a bridge between HTH and the communities it serves, ensuring that the voices and needs of those most affected by housing instability are heard and addressed.[133]

As part of the initiative's commitment to equity and social justice and consistent with the Plan, the Frank Chopp HTH Advisory Committee centers individuals with lived experience and communities that have been historically overrepresented in the region's homelessness crisis. In line with this commitment to equity, DCHS appointed a HTH resident to the Frank Chopp HTH Advisory Committee for the first time in 2025. As of December 2025, committee members include the following 15 King County residents. For more information about the members, visit the Advisory Committee tab of the HTH Dashboard.[134]

Figure 1: Frank Chopp Health Through Housing Advisory Committee Members, 2025

Frank Chopp Health Through Housing Advisory Committee Members		
Lana Bostic	Lena Bernal	Indigo Brown
Avon Curtis	Tulika Dugar	Gloria Ramirez Santiago
Patti Yates-Starns	Marissa Fitzgerald	MJ Kiser
Krystal Marx	Sarah Stewart	Da'mont Vann
Barbara Walker	Donnell Olebar	Andrea Paine

Endnotes

[1] King County Code 24.30.030.A.3. [https://mkcclegisearch.kingcounty.gov/LegislationDetail.aspx?ID=4652907&GUID=5E5E8D61-6B3B-46EC-937C-6FD39E8CB6F0&Options=Advanced&Search=]
[2] King County Code 4A.503.040.B. [https://aqua.kingcounty.gov/council/clerk/code/07_Title_4A.htm#_Toc54697848]
[3] King County Code 24.30.030.A.1. [https://mkcclegisearch.kingcounty.gov/LegislationDetail.aspx?ID=4652907&GUID=5E5E8D61-6B3B-46EC-937C-6FD39E8CB6F0&Options=Advanced&Search=]
[4] Initial Health Through Housing Implementation Plan. [https://mkcclegisearch.kingcounty.gov/View.ashx?M=F&ID=9959294&GUID=718EA25C-9032-448C-8C98-060B2C97B5E8]
[5] Ordinance 19236 [https://mkcclegisearch.kingcounty.gov/LegislationDetail.aspx?ID=4652907&GUID=5E5E8D61-6B3B-46EC-937C-6FD39E8CB6F0&Options=Advanced&Search=]
[6] Ordinance 19236 [https://mkcclegisearch.kingcounty.gov/LegislationDetail.aspx?ID=4652907&GUID=5E5E8D61-6B3B-46EC-937C-6FD39E8CB6F0&Options=Advanced&Search=]
[7] A robust body of research has demonstrated that the Housing First approach effectively ends homelessness, especially for people experiencing chronic homelessness who have higher service needs. The Housing First approach encompasses a broad range of strategies for supporting previously homeless individuals that are reflected in the Housing First fidelity model and PSH quality standards.
[8] Paula Goering, Scott Veldhuizen, Aimee Watson, Carol Adair, Brianna Kopp, Eric Latimer, Geoff Nelson, Eric MacNaughton, David Streiner & Tim Aubry. National At Home/Chez Soi Final Report. Mental Health Commission of Canada. (2014). [https://www.mentalhealthcommission.ca/resource/national-at-home-chez-soi-final-report/]
[9] Housing First in Permanent Supportive Housing. April 15, 2025. [https://files.hudexchange.info/resources/documents/Housing-First-Permanent-Supportive-Housing-Brief.pdf]
[10] CSH Quality Supportive Housing Standards. Corporation for Supportive Housing. October 2025. [https://www.csh.org/wp-content/uploads/CSH-Quality-Supportive-Housing-Standards-CSH-October-2025.pdf]
[11] HTH removed 11 units from its housing unit count in 2025 due to the following: of the 103 residential units at Sheila Stanton Place, Plymouth determined that two are needed for use as temporary relocation units (which residents can move into if their unit undergoes maintenance). Of the 107 residential units at Sidney Wilson House, Catholic Community Services determined four are needed for use as temporary relocation units. Salmonberry Lofts in Honor of Peter Joe determined that one unit was needed for temporary relocations and one for use as a manager unit. Mary Pilgrim Inn confirmed that the site had 82 rather than 85 residential units.
[12] KCC 2A.300.200.A. [https://aqua.kingcounty.gov/council/clerk/code/05_Title_2A.htm#_Toc473536140]

[13] Ordinance 19366. [https://mkcclegisearch.kingcounty.gov/LegislationDetail.aspx?ID=5121460&GUID=7DC46271-C6B3-4D90-B6DE-DEF37CD0A7D5&Options=Advanced&Search=]
[14] Initial Health Through Housing Implementation Plan. [https://mkcclegisearch.kingcounty.gov/View.ashx?M=F&ID=9959294&GUID=718EA25C-9032-448C-8C98-060B2C97B5E8]
[15] Health Through Housing Dashboard. [https://www.kingcounty.gov/hthdashboard]
[16] Initial Health Through Housing Implementation Plan. [https://mkcclegisearch.kingcounty.gov/View.ashx?M=F&ID=9959294&GUID=718EA25C-9032-448C-8C98-060B2C97B5E8]
[17] Health Through Housing Dashboard. [https://www.kingcounty.gov/hthdashboard]
[18] HTH considers a unit opened when it becomes ready for resident occupancy. HTH opens a unit after completing renovations and contracting with a service provider who ensures the facility can function as intended, providing safe and supportive housing.
[19] Haven Heights in Honor of Bruce Thomas is using a phased move in approach while rehabilitation continues to take place on the building. The site first opened for occupancy in June 2024, with 15 residents moving into the building by year end. During 2025, an additional 27 residents moved in, bringing the total number of occupied units to 42. Once rehabilitation work is complete the building will have 100 housing units.
[20] The increase from 954 open units at the end of 2024 to 1,054 at the end of 2025 reflects both the addition of 109 newly opened units in 2025 and updated operational inventory counts at several existing HTH sites. Compared to the 2024 Annual Report, reported open units decreased at Mary Pilgrim Inn (85 to 82 units), Sidney Wilson House (107 to 103 units), and Salmonberry Lofts in Honor of Peter Joe (76 to 74 units). These changes reflect units being used for respite and manager lodging, rather than resident occupancy.
[21] The measure for tracking progress towards HTH's 1,600 unit paramount goal is the cumulative number of *housing units*, which refers specifically to units that will be used for residential purposes. Thus, this figure shows only housing units. By contrast, the 2022 annual report showed the total universe of units obtained irrespective of use (e.g. administrative space, community rooms), or municipal limits on occupancy.
[22] Falkin Associates. Property Condition Assessment. (May 13, 2021).
[23] Rolluda Architects. King County FMD, Inn at Queen Anne Building Assessment. (February 22, 2022).
[24] Sound Transit. Ballard Link Extension Scoping Summary Report. (February 2025). [https://www.soundtransit.org/sites/default/files/documents/BLE-NEPA-Scoping-Summary-Report-02132025.pdf]
[25] Braddock, Shannon. "Notification of Reallocation of Health through Housing Revenue to Fund Bond Financing Costs" October, 29, 2025. [https://mkcclegisearch.kingcounty.gov/LegislationDetail.aspx?ID=7718540&GUID=5BF7C132-117C-4C14-AA59-9BB0FE5560D8&Options=Advanced&Search=]
[26] The Office of Economic and Financial Analysis Revenue Forecasts. July 2025 and March 2026. [https://kingcounty.gov/en/independents/governance-and-leadership/economic-financial-analysis]
[27] FMD works closely with DCHS to support the acquisition, maintenance, building security, and building operations of County-owned HTH properties.

[28] Notification of Reallocation of Health through Housing Revenue to Fund Bond Financing Costs. October 29, 2025. [https://mkcclegisearch.kingcounty.gov/LegislationDetail.aspx?ID=7718540&GUID=5BF7C132-117C-4C14-AA59-9BB0FE5560D8&Options=Advanced&Search=]
[29] Because HTH residents sometimes move throughout the year, the number of people who are housed at any one point in time is lower than the total number of people housed in HTH buildings throughout the entire year. Accordingly, on December 31, 2025 the HTH initiative was housing 989 people, compared to 897 residents on December 31, 2024.
[30] Haven Heights in Honor of Bruce Thomas is using a phased move in approach while rehabilitation continues to take place on the building. The site first opened for occupancy in June 2024, with 15 residents moving into the building by year end. During 2025, an additional 27 residents moved in, bringing the total number of occupied units to 42. Once rehabilitation work is complete the building will have 100 housing units.
[31] In prior annual reports, the counts of People Housed in Health Through Housing (HTH) EH and PSH represented the total number of unique individuals served within each housing type, regardless of movement between them. This resulted in a small number of individuals being counted in both EH and PSH if they transitioned between programs. Beginning in 2024, individuals who moved from EH into PSH were counted only in PSH, so that the EH and PSH counts sum to the total number of distinct individuals housed by HTH. This change results in slightly lower counts for earlier housing types when compared across years.
[32] The Total Units Secured as EH decreased by 15 from prior reports due to the following changes: 10 Argyle units were reclassified as PSH because they contain kitchens, three units were removed from Mary Pilgrim Inn's unit count, and two units at Sheila Stanton Place were reclassified as relocation units.
[33] There are several reasons why HTH buildings have occupancy rates above 100 percent. Occupancy is calculated by dividing the number of residents housed by the number of units available for occupancy, which means the occupancy rate will be above 100 percent if multiple residents are living in one room. HTH sites place multiple residents in a single room for a few reasons: HTH provides housing for couples who live together, and, in some sites, residents at high risk of overdosing are given roommates to reduce the risk of overdose.
[34] King County Regional Homelessness Authority (KCRHA) System Performance Dashboard, Homeless Management Information System (HMIS) data as of 12/2/2025. [https://kcrha.org/community-data/system-performance/]
[35] Seattle-King County Homeless Management Information System (HMIS) Data as of 3/1/2025.
[36] Across King County in 2025, 59 percent of residents of other, non-HTH enhanced non-congregate and hotel shelters maintained their housing or exited to permanent destinations.
[37] For the remaining 10 percent of residents, HTH does not have data on where the resident went after exiting the site. The absence of data for some residents may reflect the resident opting not to report or data not being collected at exit, among other reasons. An additional 10 individuals passed away while enrolled with HTH. Seattle-King County Homeless Management Information System (HMIS) Data as of 3/1/2025.
[38] 50 residents were at risk of chronic homelessness prior to HTH's intervention, as defined by KCC 4A.503. One client's referral paperwork indicated they were chronically homeless. However, upon arrival at the HTH site, staff found that the client was homeless, but did not meet the chronic or at risk definition. To promote this individual's housing stability, the client was enrolled for a short stay before exiting to permanent housing.

[39] Initial Health Through Housing Implementation Plan. [https://mkcclegisearch.kingcounty.gov/View.ashx?M=F&ID=9959294&GUID=718EA25C-9032-448C-8C98-060B2C97B5E8]
[40] KCHRA System Performance Dashboard. March 17, 2026. [https://kcrha.org/community-data/system-performance/]
[41] Colburn, G., Fyall, R., McHugh, C., Moraras, P., Ewing, V., Thompson, S., Dean, T., & Argodale, S. Hotels as Noncongregate Emergency Shelters: An Analysis of Investments in Hotels as Emergency Shelter in King County, Washington During the COVID-19 Pandemic. Housing Policy Debate. 2022; 32(6): 853–875. [https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10586465/]
[42] National Health Care for the Homeless Council. Homelessness and Health: What's the Connection? (February 2019). [https://nhchc.org/wp-content/uploads/2019/08/homelessness-and-health.pdf]
[43] National Health Care for the Homeless Council. Homelessness and Health: What's the Connection? (February 2019). [https://nhchc.org/wp-content/uploads/2019/08/homelessness-and-health.pdf]
[44] National Health Care for the Homeless Council. Homelessness and Health: What's the Connection? (February 2019). [https://nhchc.org/wp-content/uploads/2019/08/homelessness-and-health.pdf]
[45] Seattle-King County Homeless Management Information System (HMIS) Data as of 3/1/2025.
[46] Housing First in Permanent Supportive Housing. April 15, 2025. [https://files.hudexchange.info/resources/documents/Housing-First-Permanent-Supportive-Housing-Brief.pdf]
[47] Interview with HTH site staff. December 20, 2024.
[48] PACT teams consist of a psychiatrist, nurse, mental health counselors, substance use disorder professionals, case managers, vocational specialists, and peer specialists who provide services throughout the community.
[49] King County Department of Community and Human Services. New Actions to Stop the Surge of Fentanyl Overdoses and Expand Behavioral Health Treatment in King County. (March 6, 2024). [https://dchsblog.com/2024/03/06/]
[50] Viral Hepatitis Among People Experiencing Homelessness. CDC. [https://www.cdc.gov/hepatitis/hcp/populations-settings/peh.html]
[51] Health Through Housing Dashboard, *Health Supports* tab. [https://www.kingcounty.gov/hthdashboard]
[52] Health Through Housing Dashboard, *Health Supports* tab. [https://www.kingcounty.gov/hthdashboard]
[53] In the 2022 report, interactions with the behavioral health system, such as authorizations for care during a resident's stay in HTH, were documented using the PHP96 behavioral health system database that DCHS administers. In 2023, the methodology was updated to include authorizations that began before a resident's stay and continued into it. Additionally, new programs introduced in 2023 were included. In the 2024 report, the methodology was again updated to include both authorizations for care documented in the PHP96 behavioral health system database and authorizations for care documented in the Medicaid claims database. This data improvement gives the HTH initiative to a more holistic view of residents' health care access.
[54] Some onsite physical health care services, such as those provided by HealthPoint, are paid for with grant funds secured by the health care provider. Accordingly, a resident may not need to have insurance to access health care services.

[55] These outcomes are assessed for HTH residents who have consented to sharing their identifying information in HMIS. They are calculated for all such residents of HTH, including those who have exited, regardless of how long they remained enrolled in the program.
[56] Paula Goering, Scott Veldhuizen, Aimee Watson, Carol Adair, Brianna Kopp, Eric Latimer, Geoff Nelson, Eric MacNaughton, David Streiner and Tim Aubry. National At Home/Chez Soi Final Report. Mental Health Commission of Canada. (2014). [https://www.mentalhealthcommission.ca/resource/national-at-home-chez-soi-final-report/]
[57] The data in this subsection only reflects the health care data available to the HTH initiative. As a result, it does not include health care that HTH residents access from the U.S. Department of Veterans Affairs, charity care, private insurance, or out-of-pocket payment, some of which is offered on site through HTH programs. HTH will continue to monitor health outcomes and access and will update its dashboard and other reporting to reflect additional data on care access as it becomes available. Additionally, DCHS is currently working with an external evaluation partner to better understand residents' health and wellbeing, and is planning to release a final report by the end of 2026.
[58] Metro started serving two sites that opened in late 2025 in the first quarter of 2026.
[59] The food boxes include dry and canned goods, fresh produce, and meats. Close coordination with staff at each site addresses dietary restrictions, culturally specific food preferences, and delivery timing to meet residents' needs.
[60] HTH residents can choose to pursue multiple service areas.
[61] Ordinance 19179. [https://mkcclegisearch.kingcounty.gov/Legislation.aspx]
[62] Initial Health Through Housing Implementation Plan. [https://mkcclegisearch.kingcounty.gov/View.ashx?M=F&ID=9959294&GUID=718EA25C-9032-448C-8C98-060B2C97B5E8]
[63] Seattle-King County HMIS Data as of 3/1/2025.
[64] Washington State Office of Financial Management Population Interim Estimates (PIE), April 2025.
[65] 2022 Health Through Housing Annual Report. [https://mkcclegisearch.kingcounty.gov/LegislationDetail.aspx?ID=6262252&GUID=12B235F6-F229-411C-9293-B498A6821F87&Options=&Search=]
[66] Seattle-King County HMIS Data as of 3/1/2025.
[67] Washington State Office of Financial Management Population Interim Estimates (PIE), April 2025.
[68] 2022 Health Through Housing Annual Report. [https://mkcclegisearch.kingcounty.gov/LegislationDetail.aspx?ID=6262252&GUID=12B235F6-F229-411C-9293-B498A6821F87&Options=&Search=]
[69] Seattle-King County HMIS Data as of 3/1/2025.
[70] Washington State Office of Financial Management Population Interim Estimates (PIE), April 2025.
[71] 2022 Health Through Housing Annual Report. [https://mkcclegisearch.kingcounty.gov/LegislationDetail.aspx?ID=6262252&GUID=12B235F6-F229-411C-9293-B498A6821F87&Options=&Search=]
[72] Five Charts That Explain the Homelessness-Jail Cycle-and How to Break It. The Urban Institute. 2020. [https://www.urban.org/features/five-charts-explain-homelessness-jail-cycle-and-how-break-it]
[73] Overall, 45 percent of HTH residents experienced a jail booking at some point in the five years prior to their enrollment. Among HTH residents, jail booking rates were highest among the BAAA residents (52 percent) and Native Hawaiian or Pacific Islander residents (52 percent).

[74] HTH Dashboard, *Location Map* tab. [https://www.kingcounty.gov/hthdashboard]
[75] Initial Health Through Housing Implementation Plan. [https://mkcclegisearch.kingcounty.gov/LegislationDetail.aspx?ID=5121460&GUID=7DC46271-C6B3-4D90-B6DE-DEF37CD0A7D5&Options=Advanced&Search=&FullText=1]
[76] RCW 82.14.530(3)(b) requires counties to provide an opportunity for 15% of units at a facility to be provided to individuals who are living in or near the city in which the facility is located, or have ties to that community.
[77] King County Code 4A.503. [https://aqua.kingcounty.gov/council/clerk/code/07_Title_4A.htm#_Toc54697848]
[78] HTH's allocation of Strategy 3 revenues in 2025 amounted to 12.85 percent of total HTH sales tax revenues, as allowed in the Implementation Plan.
[79] City of Bellevue Resolution 9826. [https://bellevue.municipal.codes/enactments/Res9826]
[80] City of Covington Ordinance 14-20. [https://covington.municipal.codes/enactments/Ord14-20]
[81] City of Issaquah Ordinance 2922. [https://issaquah.civicweb.net/document/127758/]
[82] City of Kent City Code 3.16.035 Additional Sales or Use Tax for Housing. [https://www.codepublishing.com/WA/Kent/]
[83] City of Maple Valley Ordinance No. O-20-708. [https://cms3.revize.com/revize/maplevalleywa/Documents/Government/Ordinances/2020/Ord708%20Additional%20Sales%20and%20Use%20Tax%20for%20Housing%20and%20Related%20Services.pdf]
[84] City of North Bend Code 3.10.010. [https://www.codepublishing.com/WA/NorthBend/#!/html/NorthBend03/NorthBend0310.html]
[85] City of Renton Ordinance 5983. [https://edocs.rentonwa.gov/Documents/DocView.aspx?id=8226729&dbid=1&repo=CityofRenton&cr=1]
[86] City of Snoqualmie Resolution 1557. [https://portal.laserfiche.com/Portal/DocView.aspx?id=1946&repo=r-d06bc528]
[87] The plan notes that the County and the city of Sammamish agreed in 2021 that the County would not pursue HTH acquisition in Sammamish but would meet annually to discuss HTH and opportunities for partnership.
[88] In 2025, $12,989,652 in HTH revenue could not be allocated to a specific jurisdiction.
[89] HTH sites that had opened earlier than 2023 received inflationary adjustments to their contracts during 2023 that contributed to increased costs that year and in subsequent years.
[90] Initial Health Through Housing Implementation Plan. [https://mkcclegisearch.kingcounty.gov/LegislationDetail.aspx?ID=5121460&GUID=7DC46271-C6B3-4D90-B6DE-DEF37CD0A7D5&Options=Advanced&Search=&FullText=1]
[91] Health Through Housing Dashboard. [https://www.kingcounty.gov/hthdashboard]
[92] HTH Dashboard. [https://www.kingcounty.gov/hthdashboard]
[93] Catholic Community Services [https://ccsww.org/]
[94] Compass Housing Alliance [https://www.compasshousingalliance.org/]
[95] Downtown Emergency Services Center (DESC) [https://www.desc.org/]
[96] Plymouth Housing Group [https://plymouthhousing.org/]
[97] The Salvation Army [https://seattle.salvationarmy.org/]
[98] Chief Seattle Club [https://www.chiefseattleclub.org/]
[99] Lavender Rights Project [https://www.lavenderrightsproject.org/]
[100] The Urban League of Metropolitan Seattle [https://urbanleague.org/]

[101] CCS operated The Bob G. between April 2020 and June 2023, at which point the building was closed due to unsafe building conditions.
[102] King 5. King County Accepting Applications for Rental Assistance before Eviction Moratorium Expires. [https://www.king5.com/article/news/health/coronavirus/king-county-accepting-applications-for-rental-assistance-before-eviction-moratorium-expires/281-0f3962e9-3abe-451d-8563-ebb4200e97d5]
[103] Zillow King County Market Overview, data through July 31, 2021. [https://www.zillow.com/king-county-wa/home-values/]
[104] King County Homelessness Response System Data Review: Q1 2021 Release. [https://kcrha.org/wp-content/uploads/2022/05/KC-Homeless-Response-System_Data-Review_Q12021.pdf].
[105] University of Washington and King County DCHS: Impact of Hotels as Non-Congregate Emergency Shelters. (2020). [https://kcrha.org/wp-content/uploads/2020/11/Impact-of-Hotels-as-ES-Study_Full-Report_Final-11302020.pdf.]
[106] RCW 82.14.530 as reflected in ESHB 1070 from 2021. [http://lawfilesext.leg.wa.gov/biennium/2021-22/Pdf/Bills/Session%20Laws/House/1070-S.SL.pdf?q=20210815073813]
[107] King County Department of Community and Human Services. Health Through Housing: A Regional Approach to Address Chronic Homelessness. (2024). [https://kingcounty.gov/en/legacy/depts/community-human-services/initiatives/health-through-housing]
[108] King County Regional Homelessness Authority. 2024 Point in Time Count. [https://kcrha.org/community-data/king-county-point-in-time-count/]
[109] King County Department of Community and Human Services, Performance Measurement and Evaluation Division. Integrating Data to Better Measure Homelessness. (December 2021). [https://cdn.kingcounty.gov/-/media/king-county/depts/dchs/department/documents/KC_DCHS_Cross_Systems_Homelessness_Analysis_Brief_12_16_2021_FINAL.ashx?la=en]
[110] King County Department of Community and Human Services, Performance Measurement and Evaluation Division. Integrating Data to Better Measure Homelessness. (December 2021). [https://cdn.kingcounty.gov/-/media/king-county/depts/dchs/department/documents/KC_DCHS_Cross_Systems_Homelessness_Analysis_Brief_12_16_2021_FINAL.ashx?la=en]
[111] U.S. Census Bureau, "American Community Survey 1-Year Estimates: Selected Housing Characteristics," 2016 and 2024. [https://data.census.gov/table/ACSDP1Y2016.DP04] and [https://data.census.gov/table/ACSDP1Y2024.DP04]
[112] U.S. Census Bureau, "American Community Survey 1-Year Estimates: ACS Demographics and Housing Estimates," 2010 and 2024. [https://data.census.gov/table/ACSDP1Y2010.DP05] and [https://data.census.gov/table/ACSDP1Y2024.DP05]
[113] Alexandrov, A. Place the Blame Where It Belongs: Lack of Housing Supply is Largely Responsible for High Home Prices and Rents. The Urban Institute. (January 2024). [https://www.urban.org/sites/default/files/2024-01/Place%20the%20Blame%20Where%20it%20Belongs.pdf]
[114] U.S. Census Bureau, "American Community Survey 1-Year Estimates: Selected Housing Characteristics," 2024. [https://data.census.gov/table/ACSDP1Y2023.DP04]

[115] U.S. Census Bureau, "American Community Survey 5-Year Estimates: Public Use Microdata Sample," 2019-2024 [https://www.census.gov/programs-surveys/acs/microdata/access.2022.html#list-tab-735824205]
[116] Ordinance 19179 [https://mkcclegisearch.kingcounty.gov/LegislationDetail.aspx?ID=4652676&GUID=8A31F2EE-23AF-4BA3-9306-CD87CD8B40A0&Options=&Search=&FullText=1]
[117] King County Code 4A.503 [https://aqua.kingcounty.gov/council/clerk/code/07_Title_4A.htm#_Toc54697848]
[118] Ordinance 19236 [https://mkcclegisearch.kingcounty.gov/LegislationDetail.aspx?ID=4652907&GUID=5E5E8D61-6B3B-46EC-937C-6FD39E8CB6F0&Options=&Search=&FullText=1]
[119] Ordinance 19236 [https://mkcclegisearch.kingcounty.gov/LegislationDetail.aspx?ID=4652907&GUID=5E5E8D61-6B3B-46EC-937C-6FD39E8CB6F0&Options=&Search=&FullText=1]
[120] Ordinance 19236 [https://mkcclegisearch.kingcounty.gov/LegislationDetail.aspx?ID=4652907&GUID=5E5E8D61-6B3B-46EC-937C-6FD39E8CB6F0&Options=&Search=&FullText=1]
[121] Ordinance 19366. [https://mkcclegisearch.kingcounty.gov/LegislationDetail.aspx?ID=5121460&GUID=7DC46271-C6B3-4D90-B6DE-DEF37CD0A7D5&Options=Advanced&Search=&FullText=1]
[122] King County Code 2A.300.200. [https://kingcounty.gov/council/legislation/kc_code/33_Title_24.aspx]
[123] Ordinance 19366. [https://mkcclegisearch.kingcounty.gov/LegislationDetail.aspx?ID=5121460&GUID=7DC46271-C6B3-4D90-B6DE-DEF37CD0A7D5&Options=Advanced&Search=&FullText=1]
[124] Ordinance 19366. [https://mkcclegisearch.kingcounty.gov/LegislationDetail.aspx?ID=5121460&GUID=7DC46271-C6B3-4D90-B6DE-DEF37CD0A7D5&Options=Advanced&Search=&FullText=1]
[125] All the individuals served by MRT in 2025 were in single-person households, so the number of individuals served is equal to the number of households served.
[126] Crisis Care Centers Initiative. King County. [https://kingcounty.gov/en/dept/dchs/human-social-services/community-funded-initiatives/crisis-care-centers-levy]
[127] KCC 2A.300.200. [https://aqua.kingcounty.gov/council/clerk/code/05_Title_2A.htm#_Toc473536140]
[128] KCC 24.30.020. [https://aqua.kingcounty.gov/council/clerk/code/33_Title_24.htm#_Toc65058358]
[129] "King County Health through Housing program renamed to honor Frank Chopp." Capitol Hill Seattle Blog. November 19, 2025. [King County Health through Housing program renamed to honor Frank Chopp | CHS Capitol Hill Seattle News]
[130] Ordinance 19997. [https://mkcclegisearch.kingcounty.gov/LegislationDetail.aspx?ID=7711662&GUID=5131AEF4-8473-4147-8092-F4A89BE21A88&Options=Advanced&Search=]
[131] King County Department of Community and Human Services. (n.d.) Health Through Housing Advisory Committee. [https://kingcounty.gov/en/legacy/depts/community-human-services/initiatives/health-through-housing/advisory-committee]

[132] Ordinance 19366. [https://mkcclegisearch.kingcounty.gov/LegislationDetail.aspx?ID=5121460&GUID=7DC46271-C6B3-4D90-B6DE-DEF37CD0A7D5&Options=Advanced&Search=&FullText=1]
[133] Ordinance 19366. [https://mkcclegisearch.kingcounty.gov/LegislationDetail.aspx?ID=5121460&GUID=7DC46271-C6B3-4D90-B6DE-DEF37CD0A7D5&Options=Advanced&Search=&FullText=1]
[134] Health Through Housing Dashboard. [https://www.kingcounty.gov/hthdashboard]

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June 15, 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 2025 Health Through Housing Annual Report, as required by King County Code 2A.300.200, and an accompanying proposed Motion that would, if enacted, acknowledge receipt of the report.

This annual report summarizes the activities of the Health Through Housing (HTH) initiative through the end of 2025 and fulfills the initiative's annual reporting requirements. Specifically, it includes summaries of the accomplishments and effectiveness of the expenditure of HTH sales tax proceeds in 2025 as well as financial information including but not limited to the allocation of proceeds by jurisdiction. On May 21, 2026, the HTH Advisory Committee reviewed and certified this report and the HTH Dashboard, including certifying that the dashboard is updated with 2025 calendar year data.

This report also summarizes the significant additional annual data reporting provided in HTH's online dashboard, as called for by the Initial Health Through Housing Implementation Plan 2022-2028 as adopted by Ordinance 19366. This tool, which also adds context about HTH's process, outcomes, and community-wide impact, enables community members and policymakers to learn more about HTH locations that are open and the other properties that are at various stages of preparation for operations. County staff and residents can visit the online HTH dashboard at www.kingcounty.gov/hthdashboard for additional information about the HTH initiative.

HTH increases housing capacity for residents with the highest needs, who are experiencing or at risk of chronic homelessness, by repurposing hotels and apartments and expediting financing of other newly constructed buildings throughout the County. HTH ended the year with 1,423 housing units secured and 1,054 units open across 14 sites. In 2025, HTH opened three sites to residents and finished major construction work at its Kirkland site, which started moving in residents in January 2026.

Of these newly opened buildings, the Kirkland and Federal Way sites each represent one of the first PSH buildings to open in their respective cities, illustrating the initiative's success using a regional approach to

reduce chronic homelessness. While HTH has faced significant challenges that have impacted the pace at which the initiative is achieving its paramount goal of securing and opening 1,600 units, HTH has made steady progress securing and opening supportive housing across King County.

After four years of operation, the HTH initiative has ended homelessness for over 1,400 King County residents, improved the health and wellbeing of residents, and reduced the use of local emergency departments, hospitals, and jails.

Recent analysis by DCHS shows that after two years of living in a HTH unit:

- residents' total number of inpatient hospital care stays decreases by 41 percent,
- their total number of emergency department visits drops by 39 percent, and
- residents experience a 24 percent decrease in jail bookings.

Other 2025 highlights include:

- HTH continued providing a broad range of services and supports to residents, with almost all 1,380 HTH residents served in 2025 having access to at least one type of onsite health service.
- HTH made progress addressing racial and ethnic disproportionality among the homeless population, including opening three sites that are operated by organizations run by and for BIPOC communities.
- HTH achieved positive housing stability outcomes among its PSH residents, with 93 percent of PSH residents maintaining their housing or moving to another permanent housing destination.
- HTH achieved continued success housing individuals with ties to the city in which their HTH building is located, with 98 percent of HTH residents reporting existing ties to the communities where they reside at move in.
- HTH sites maintained high occupancy rates in 2025, with buildings ending the year with an average occupancy rate of 92 percent.

While HTH has not yet reached its paramount goal of securing and opening 1,600 units, financial conditions have changed dramatically since the Plan's adoption, creating new barriers to expanding the HTH portfolio. Recent economic changes have significantly impacted both the cost of acquiring new properties and the cost of renovating and maintaining existing HTH buildings. Additionally, emerging shifts in global trade policy and tariff measures create significant uncertainty regarding future construction costs and future HTH sales tax revenue.

Additionally, in 2025, the King County Facilities Management Division (FMD) determined that many of its acquired HTH buildings required significant, unexpected, and costly repair work. Because HTH is facing both higher-than-expected costs and significant uncertainty regarding future revenue, DCHS has paused efforts to secure additional HTH units. This adjustment reflects DCHS' efforts to prudently manage HTH's limited resources not only to create new housing units, but also to operate those units on an ongoing basis with housing-related services, consistent with the initiative's paramount goal as articulated in Ordinance 19236 and the Plan.

DCHS intends to continue to closely monitor these trends and will secure additional units once financial conditions permit. HTH is also working with FMD to comprehensively assess long-term maintenance and capital improvements needed across its current portfolio, enable HTH to continue to provide high-quality, safe housing to its residents.

Despite these challenges, the HTH initiative is the fastest and most regional expansion of supportive housing that King County has ever implemented. It is a powerful component of our regional strategy to break the cycle of homelessness, addiction, and trauma. I look forward to continuing to report on the initiative's progress, and my staff will keep working to overcome these challenges as they bring more people inside.

I am grateful to the cities, providers, neighbors, and other community partners that have worked alongside King County and the HTH initiative to welcome these new homes for people experiencing chronic homelessness. We can turn the tide on this regional crisis by taking unified action across the county through smart, sustainable, evidence-based strategies that will serve thousands of people over decades.

If your staff have any questions, please contact Dr. Susan McLaughlin, Director, 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, 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
Dr. Susan McLaughlin, Director, Department of Community and Human Services

King County

Health, Housing, and Human Services Committee

September 1, 2026 Meeting

Agenda Item No. 8

Briefing No. 2026-B0101

Rental Fee Transparency

Materials for this item will be available before the meeting.