

Implementation plan to continue the expansion of civil long-term inpatient capacity

Engrossed Substitute Senate Bill 5092; Section 215(66)(h); Chapter 334; Laws of 2021
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Executive summary

This report is in response to section 215 of the 2021 Biennial Operating Budget (ESSB 5092 Chapter 334, Laws of 2021), which directs the Health Care Authority (HCA) to coordinate with the Department of Social and Health Services (DSHS), the Office of the Governor (OG), the Office of Financial Management (OFM), Medicaid Managed Care Organizations (MCOs), Behavioral Health Administrative Service Organizations (BH-ASOs) representative(s), and community providers to develop and implement a plan to continue the expansion of the civil community long-term inpatient beds. HCA is required to produce two reports to the Office of the Governor and the Washington State Legislature, this is the first of those reports.

As required by ESSB 5092, HCA created a work group with representatives from the organizations mentioned above to identify the gaps and barriers as well as potential solutions to support the expansion of long-term civil commitment beds in community-based settings.

As expansion of the 90-day and 180-day inpatient civil commitment beds continues, it has become apparent that some individuals requiring long-term inpatient psychiatric care in community settings have more complex and challenging needs that exceed the capabilities of existing community-based resources. These individuals may be attempting to transition out of a state hospital or may have been directly admitted into existing community inpatient beds.

Work group findings

The work group identified and examined multiple options to reduce barriers and improve outcomes for these complex individuals. The possible improvements include enhanced rates, additional staff training, regulatory changes, new facility types, physical modification of existing facilities, system enhancements, throughput-discharge potentials, and additional contract requirements.

Based on the information and guidance provided by the work group, HCA and DSHS leadership prioritized four strategies for initial implementation.¹

1. Rate enhancement is the first priority. An enhanced rate would open doors for providers to staff settings appropriately.
2. The second priority identified was to provide Advanced Crisis Intervention Training (ACIT) to staff in contracted settings. This training is designed to reduce violent behaviors often expressed by the population that is not currently being served in the current array of HCA contracted beds.
3. The third priority was to create specialized facilities. These facilities would be designed and staffed to accommodate the populations that are currently difficult to serve in community settings, or at the state hospitals.
4. The fourth, and final, identified priority would be to create “no refuse” facilities. These state-owned facilities would also be designed and staffed to accommodate the needs of populations with more complex and challenging needs.

¹ This report is informational and does not confer any rights or additional benefits long-term care civilly committed individuals. The proposals within this report require legislative changes and additional funding mechanisms in order to implement the goals of ESSB 5092.

Background

In 2018, Governor Jay Inslee announced a plan to reshape how and where individuals with mental illness receive treatment in Washington state. Second Substitute House Bill 1394 expanded long-term involuntary mental health treatment options to include willing community hospitals and freestanding evaluation and treatment facilities (E&Ts). This expansion allows individuals on 90-day or 180-day civil commitment orders to receive long-term inpatient psychiatric care in settings closer to their homes that were more integrated into the community.

Current status

As directed by the Legislature, the HCA has worked to contract with willing community hospitals with psychiatric units, E&Ts, and private psychiatric hospitals, to expand and maintain capacity for 90-day or 180-day involuntary inpatient psychiatric treatment. Successful recruitment of new providers has required considerable marketing efforts and the provision of technical assistance to support facilities in this new line of work. The increased number of community beds allows many individuals receiving involuntary inpatient care to remain in their communities, often within the same facility throughout their treatment. Hospitals and E&Ts have slowly begun to contract with HCA to provide long-term involuntary psychiatric care.

In most instances, the payment rate HCA is authorized to pay these facilities is similar for individuals on both long-term and short-term involuntary orders.

There is often sufficient demand for short-term beds and there is little financial incentive for providers to shift from providing short-term to long-term care. Currently, 140 beds are under contract across the state to provide long-term involuntary psychiatric care. Given the voluntary nature of the contractual relationship between HCA and these facilities, these facilities have unfettered discretion when making the clinical determination on whether to admit a particular individual into their facility.

The Health Care Authority (HCA) further recognizes the significant resources the legislature has provided for the expansion of Governor Inslee's plan. This includes the implementation of new initiatives such as Intensive Behavioral Health Treatment Facilities and Intensive Residential Treatment teams, expansion of PACT services, and expanding the spectrum of community-based care for individuals discharging or diverting from the state psychiatric hospitals.

Future estimates

The Washington State Department of Commerce has provided significant capital funding to build new facilities and remodel existing facilities, some of which are still under construction or development. These projects often take two to three years before they open. As an example, facilities awarded Department of Commerce funding in 2018 are now a few months from opening these beds. We should note that the pandemic created barriers related to workforce shortages, supply chain disruptions, and lags with permitting that have delayed some of these projects.

Based on current planning estimates, HCA anticipates that an additional 252 beds to be coming online in the next few years. This count includes 75 beds in the University of Washington teaching hospital, 113 beds from Commerce-funded sites, and 64 beds in four facilities that DSHS is standing up. HCA estimates that the process of transitioning from admission to the state hospitals into community settings is now at the halfway point. Much more is known about this work than was understood when the project began.

Key findings

The work group met three times, using its time to identify the gaps and barriers preventing admission for individuals with complex needs and then suggesting potential solutions to resolve these barriers. The work group members recognized this task as a valuable opportunity to make recommendations, adjustments, and enhancements to the work that has already been done to expand the 90-day or 180-day civil commitment beds in the community.

Identified gaps and barriers

Complex conditions

Individuals experiencing an exacerbation of their mental disorder, as defined in RCW 71.05.020 which include Traumatic Brain Injury (TBI), Borderline Intellectual Functioning, Intellectual/Developmental Disability (I/DD), Parkinson's disease, or dementia, often are not accepted for admission in the currently contracted treatment settings. These conditions often lead to the individual exhibiting challenging behaviors that present a danger to themselves or others on the ward or result in significant additional care needs. These complex co-morbid conditions and related challenging behaviors, require specialized treatments and, require more attention and supports than are typically received in the inpatient settings.

The work group identified multiple issues impacting the ability to care for this population. The current reimbursement rate does not provide for staff to patient ratio needed for safety and support. Staff lack specialized training to address unique needs of individuals with cognitive or physical impairment. The currently contracted facilities were not built with these populations, and their resulting needs, in mind. For example, an individual's unique needs could require the need to harden a facility and adjust room size to provide adequate space for medical equipment. Some individuals may require the support of additional therapies such as behavioral therapies, interventions for those with cognitive disorders, physical therapy, and occupational therapy. Lastly, the work group identified that there is a need for specialized facilities to discharge these individuals to that can meet their more unique and complex needs.

Medically complex

The work group identified barriers for individuals who are both psychiatrically acute or high risk due to a cognitive disorder and have a significant medical need that would require medical intervention including the management of medical equipment or need for treatment by medical personnel. These medical needs include catheters, ostomy, dialysis, uncontrolled diabetes, and other issues.

There are currently a small number of contracted sites that can accommodate these needs. Stand-alone E&Ts often cannot serve people with medical equipment that requires medical personnel or creates ligature risk. For example, a group member identified an 8 week wait to access a battery-operated CPAP machine that didn't have wires to pose a ligature risk. Additionally, staff are not trained or equipped to care for individuals with complex medical needs unless the long-term civil beds are in an acute care hospital.

Personal care needs

Some individuals present with personal care needs related to their activities of daily living (ADLs) such as requiring assistance with bathing, dressing, or toileting. The work group reported that assisting with personal care needs often means facilities need additional staff to provide this support. Most facilities are not currently equipped to provide bariatric care as it requires specialized equipment and often additional

staffing for transfer needs. Additionally, these individuals may present as medically complex and may require their mental health treatment to occur in an acute care hospital.

Behaviors

An individual's current or previous behavioral issues may prevent admission. The work group identified challenges admitting those who are physically aggressive or assaultive, have current or historical aggressive sexual behaviors (including registered sex offenders), present with substance use resulting in behavioral issues, or higher risk suicide or self-harm attempts. Sometimes a history of the behavior may be as much as ten years past and yet still prevent admission due to the lack of discharge options for someone with that history. Below we will describe how each kind of behavioral issue creates barriers to admission.

Physically assaultive behavior:

- Some sites are not staffed to the level of providing frequent patient restraints or necessary shows of support. When this issue occurs, the site may seek a different placement for individual.
- Staffing shortages sometimes prevent admission of individuals with this behavior.
- The risk to staff and other patients is determined too high for some sites to admit. Smaller E&T units are cautious about creating an environment too dangerous for both admitted individuals and staff.
- Staff report that they do not feel safe and have found that when they have called law enforcement, law enforcement declines to address the behavior even when it is not a result of the behavioral health disorder.
- This behavior places other patients in the facility at risk. The related stress/anxiety can become a barrier to recovery for these patients.

Sexually problematic/aggressive behavior:

- Facilities lack security staffing to manage this behavior.
- Behaviors result in need for additional staff and/or hardening of facility to maintain safety.
- This behavior places other patients in the facility at risk. The related stress/anxiety can become a barrier to recovery for these patients.
- There is no funding stream for sexual offender treatment and no access to it while individual is receiving inpatient care.
- It is difficult to discharge individuals with history of sex offense as there is a lack of post inpatient settings accepting this population.
- There is a lack of workforce trained in working with this population.

Property destruction/vandalism/arson

- Behaviors result in need for additional staff and/or hardening of facility to maintain safety. It is difficult to find settings to discharge people with these behaviors to.
- Damage to facilities can be very expensive due to the specialized requirements (i.e., damage to anti-ligature door handles or other fixtures and holes punched in walls).

Serious self-harm or suicide attempts related to personality disorder symptoms

- Behaviors result in need for additional staff to maintain safety. It is difficult to find settings to discharge people with these behaviors.
- The structure of inpatient settings often creates power struggles where behaviors may escalate to where the patient feels control in the situation – this results in increasingly higher risk behaviors.

- Lack of outpatient services and supports create limited discharge options and little to no diversion options, despite inpatient hospitalization rarely being the necessary level of care.

Workforce shortage

- Individuals displaying the behaviors identified in the above sections often require additional staff. The following barriers were identified by work group participants affecting staff and their ability to care for this population.
- Sites may not be able to take individuals who meet admission criteria due to the current mix of individuals on the ward and current staffing pattern, including:
 - 1:1 staff/patient is often necessary for observation and maintaining safety for all.
 - A 4:1 staff/patient ratio is sometimes necessary when physical restraint is needed.
 - More frequent psychiatric provider intervention is needed and not available on demand.
- A higher level of observation is necessary, and this is too high of a demand on staff time based on staffing pattern and number of other patients.
- Staff need more training to respond to this higher level of acuity and risk.
- Facilities report a statewide workforce shortage(s) in the field of behavioral health and often have difficulty in recruiting/hiring staff. The COVID-19 pandemic has added a layer of complexity to this.
- Increased staffing levels is needed to accommodate increased needs.
- Current milieu is too fragile for additional aggressive behaviors, especially in a smaller E&T settings.
- Increased use of seclusion and restraint requires additional staff which is not available.

Discharge barriers and throughput

Oftentimes a facility will not admit an individual if they are unlikely to find an appropriate discharge setting. The facilities calculate that the individual will be more challenging to discharge and impede throughput for the facility. Individuals with a history of aggressive violent behaviors, individuals with a history of sex offenses, and individuals with a history of arson are often difficult to discharge in the existing system. Residential and other community-based settings shy away from accepting individuals with known histories of violence, aggressive behavior, or arson, fearing for their residents' safety and concerns regarding their facility licensure. If the discharging individual requires more support than can be brought to their own home, there may be no current facility type that is able to accommodate their behavior or level of potential risk.

Adult Family Homes and other residential settings

Many individuals step down from involuntary inpatient care to adult family homes (AFHs) and other residential settings, however barriers may prevent these options. These settings provide services on a voluntary basis and a discharging individual may not wish to go to there. AFHs and other contracted providers are also required to have insurance, and that insurance may be more costly and difficult to obtain for residential providers and/or AFHs that accept higher risk individuals. AFHs and other residential providers are taking on additional risks for safety of the client and other residents when the individual is high risk due to behaviors. If the client's behaviors put the other individuals in the home at risk, it could result in a citation, fine, or even closure of the home, depending on the severity of the incident and the provider's response. To stay in compliance with rules and regulations, or WACs, these facilities are often not willing to take on this risk.

Adult Family Homes and other residential settings are not able to provide mental health treatments and therapies and their staff may lack the expertise to identify and intervene when a resident is decompensating or experiencing the cyclical nature of a condition. The newly developed Intensive Residential Treatment teams support these providers in some regions by bringing a behavioral health treatment team on-site, however this option is not yet statewide.

Other identified gaps and barriers

Other issues impact hospital and E&T's ability to admit some individuals into their settings. In some instances, local zoning or other restrictions are placed on facilities to prevent admission of people charged with felonies or registered sex offenders. In one instance we learned of a hospital that was only granted permission for siting within a city based on such an agreement. Additionally, there is a shortage of guardians, and without a guardian in place to make decisions, some individuals are very difficult to discharge. Facilities may deny admission for an individual when a guardian is clearly needed.

Potential solutions

The work group identified a number of potential solutions to the different gaps and barriers preventing admissions. We have organized these solutions into groupings and recognize that some may fit into more than one category.

Enhanced rate

While currently HCA is limited to only offering inpatient facilities the published rate for services, the program would benefit from being able to offer an enhanced rate. An enhanced rate of funding to these facilities would allow them to create the higher staffing patterns necessary to provide a higher level of observation, assistance, and intervention to meet the needs of this more complex patient population. Some individual require ongoing 1:1 observation and others may require a 4:1 pattern to provide seclusion and restraint. Additional staff also creates the capacity for these facilities to provide needed training to their staff. When facilities send their staff to trainings, a workforce shortage is created which results in an all around hardship. Importantly, an enhanced rate would incentivize current and future contracted facilities to serve more challenging populations by compensating them sufficiently to make the needed staffing and facility adjustments described.

HCA has considered several methodologies for developing an enhanced rate. It was proposed that the enhanced rate begin with a 20% increase to the current reimbursed per diem rate to create the ability for facilities to supply a higher staffing pattern. Another way to introduce an enhanced rate would be to create a pilot project where HCA works closely with one to two facilities and use these facilities as a trial run. It is recommended that this be funded with a set amount of money. With a pilot set up this way, HCA will be able to determine what works, what does not work, and how much it will cost.

Training

The work group identified that clinical staff need additional skills and training in order to meet the needs of more complex individuals. Most of these training needs are not skills or expertise included as part of overall masters level education and need to be accessed post graduation.

The patient population formerly served in the state hospitals are now receiving treatment in these community settings, the community workforce needs to develop the de-escalation skills the state hospital staff have acquired. The work group recommends that the Advanced Crisis Intervention Training (ACIT) developed by the Behavioral Health Administration of DSHS should be made available for all contracted

sites. Facility staff need more advanced skills to manage the increased aggression and/or risk of violence by some individuals previously served at state hospitals. ACIT builds upon existing de-escalation and restraint skillsets from MOAB® and other models of staff training. However ACIT seeks to reduce the need for seclusion and restraint by teaching staff trauma-informed interventions that can safely guide the patient through a crisis without the use of violence.

The work group recommends the promotion of the trauma-informed milieu therapy model as something that may work well with the ACIT model by supporting staff and patients through staff training and supportive protocols. The work group also recommended that rapid response teams be created to provide timely hands-on training and technical assistance to facility staff to improve the management of especially difficult persons. Staff also need greater access to relevant evidence-based practices such as Applied Behavioral Analysis, Dialectical Behavioral Therapy, Acceptance and Commitment Therapy, treatment of eating disorders, anger management, and substance use disorders.

Facilities

Modify the use of physical space in existing facilities

To accommodate the specialized needs of the populations we've discussed, the work group suggested the development of dedicated capacity. A traditional E&T could be modified with sectioned off sub-units such as two distinct wings and served by a common clinical space. These distinct wings could be designed to serve individuals with specialized needs such as I/DD, TBI, dementia, assaultive behavior, with tailored behavioral/habilitative treatment and supports. Facilities or sub-units could be hardened to accommodate individuals who have a propensity for aggressive behaviors to avoid damage and the costs associated with it. Staff would be specially trained in the evidence-based practices to care for the needs of the individuals being cared for.

An enhanced rate of reimbursement may be required to provide sufficient staffing levels and expertise. Capital funding to assist existing facilities to remodel or to spur the creation of new facilities could promote this approach.

"No Refuse" facility

Despite the creation of new facilities, programs, and services, some individuals will always be especially difficult to place in contracted settings due to the risk they may pose to other patients, staff, or themselves. The work group identified the need for a state-operated "no refuse" facilities especially equipped to manage the most challenging behavior, similar to how the state psychiatric hospitals have been utilized in the past but on a much smaller scale. These services could also be provided with the state hospitals (depending on which model is most cost effective). This hardened facility would be staffed with personnel trained to respond to difficult to manage behavior. This proposed no refuse facility would likely need to be state run due to challenges related to siting and contracting. Additionally, the census would need to be small (7-10 patients) due to the need for reduced stimulus and increase in staffing rates.

Potential regulatory changes

Some of the barriers identified by the work group could be addressed through regulatory changes. Likely these fixes pose complex challenges and were not fully pursued during the three work group meetings, however they do warrant inclusion into this report.

The Washington State Legislature charged the Department of Commerce with developing a Model Ordinance for cities and counties to utilize for siting community-based behavioral health facilities (ESSB 6168 (2020), Section 127 (27)). BERK Consulting was hired by Commerce and guided by an Advisory

Committee made up of representatives from the Association of Washington Cities (AWC); Department of Health (DOH); Department of Social & Health Services (DSHS); the Governor's Office; Health Care Authority (HCA); housing, health, and human services providers; Tribes and local governments; and the Washington State Association of Counties. Commerce worked collaboratively with the Advisory Group and BERK to provide useful planning guidance so that local governments can readily update policies and codes to allow siting and development of community-based behavioral healthcare projects. More information can be found in the Behavioral Health Model Ordinance Project.

Some individuals with significant behavioral issues pose safety risks to themselves or others if they refuse or forget to take their medication post discharge, leading to few discharge options. The work group identified the need for the creation of a new mid-level facility type with limited egress and able to compel medications. This type of facility is not currently authorized under state law; however it would provide a step-down setting that would allow individuals to move out of involuntary inpatient treatment. As more individuals are served in the community rather than the state hospitals, we see a more complex and acute population seeking support from AL TSA and other providers

New settings and services

Commonly, a facility will not admit an individual if they are unlikely to find an appropriate discharge setting. There are enough instances when discharge options are few and far between. The following information was identified as a possible solution to this throughput barrier.

Post-inpatient facility types or resources: There is a need for additional post-inpatient facility types or resources to support community placement of individuals with histories of assaultive behavior, sexually inappropriate behavior, destructive behaviors such as arson, and those with complex mental disorders including cognitive issues such as TBI, I/DD, or dementia, especially when those are co-occurring with a behavioral health condition

Supervised housing: The work group identified the need for supervised housing that the individuals discharging from 90- or 180-day commitment beds can call home and be under the supervision of personnel qualified to support their complex needs.

Community supervision: There is also a need for some individuals to have 1:1 or 2:1 supervision to ensure the safety of staff or residents of facilities and the community, but this is not Medicaid reimbursable (as it is not a medical need) and cannot be a requirement for an individual.

Guardian shortage: There is a guardian shortage in Washington state. It would be beneficial for Washington state to have the ability to utilize "limited use guardianships" as well as grow a bigger pool of public guardians, either contracted or through creating FTEs for the Office of Public Guardianship. The Office of Public Guardianship has identified a need for marketing and recruitment to increase the current number of contracted public guardians.

Additional factors that may mitigate identified gaps and barriers

Crisis response enhancement: Implementation of enhancement to crisis response with 988 line and more mobile crisis intervention rather than DCR response may de-escalate some individuals, reducing the reliance on involuntary treatment.

Cross-system team staffing: The work group recommended the use of multi-disciplinary/cross-agency complex case staffings to help break through organizational and funding silos.

Partial hospitalization: Increased access to partial hospitalization programs or intensive outpatient programs for people with personality disorders, rather than admit to inpatient programs which may be contraindicated.

Improve system transparency: Develop communication materials that provide greater clarity about facilities' admission criteria and specialization, transportation resources, and case staffing accessibility.

Conclusion

Identified priorities

The Authority reviewed the work group recommendations and recommends prioritizing the following potential solutions:

1. **Develop** an enhanced rate to contracted providers serving more complex needs,
2. **Make** ACIT training available to contracted facilities,
3. **Foster** the development of specialized sub-units dedicated to serving individuals with co-morbid cognitive impairments and/or challenging behavior,
4. **Prioritize** contracting with additional acute care hospitals with psychiatric units to enhance the number of beds that can serve those with medical complexity
5. **Consider** the development of a limited number of “no refuse” state-operated facilities.
6. **Develop** additional community resources and services to support individuals with the highest level of complex needs in the outpatient and residential setting.

Next steps for continuing cross-agency efforts

HCA recognizes that expanding community long term civil capacity requires partnerships across state agencies and with stakeholders to resolve the barriers we’ve described in this report. We will continue to build on existing collaborations and develop processes to implement proposed solutions.

Long Term Civil Commitment (LTCC) work group

Currently, a cross-agency executive level work group and set of subgroups meet to address the very issues discussed in this report. It is expected that these groups would oversee and ensure the implementation of approved and/or funded strategies. Additionally, the HCA and DSHS team will pull in representation from the Developmental Disabilities Administration of DSHS as well as the Office of Public Guardianship for partnership on relevant lines of work.

LTCC Transitions of Care/Discharge from Adult Civil to the Community subgroup

Areas of focus of this LTCC subgroup include identifying barriers to discharging patients from long term inpatient settings, strategies for addressing complex cases in community-based settings, identifying gaps within the system of care that are related to these barriers, and developing solutions.

All members of the LTCC subgroup were members of the work group that met to develop this legislative report. After hearing additional stakeholder feedback and using the experience of the HCA and DSHS work group membership, this team, with the support of the executive sponsor, are developing a proposal that includes current decision packages and new proposal ideas (including the recommended priorities above) to address gaps in the system and allow for civil commitments to be successfully transitioned to the community.

Workforce shortage will continue to be a factor when proposals include new programs and increased staffing. The group recommends prioritization of the suggestions brought forward by HCA’s Workforce Development work group.

Washington State Department of Commerce

The Health Care Authority (HCA) works closely with the Washington State Department of Commerce (Commerce) on their Behavioral Health Facilities Program. This program aims to support community

providers in expanding and establishing new capacity for behavioral health services in communities. HCA provides subject matter experts to assist Commerce with their Request for Proposal questions, scoring matrix, and reviewing proposals submitted by potential facilities to ensure that the facilities being funded are in line with Governor Inslee's behavioral health expansion plan.

Department of Social and Health Services

HCA also works closely with the Department of Social and Health Services Behavioral Health Administration (DSHS/BHA) and Aging and Long-Term Support Administration (DSHS/AL TSA) and Developmental Disabilities Administration (DSHS/DDA) on staffing the more difficult to place individuals. These placements could occur in either in an inpatient setting or a setting post discharge. HCA and AL TSA staff often act as the liaison between the contracted facilities and MCOs to assist in forging those relationships to work together for the best possible outcome for the individuals we serve.

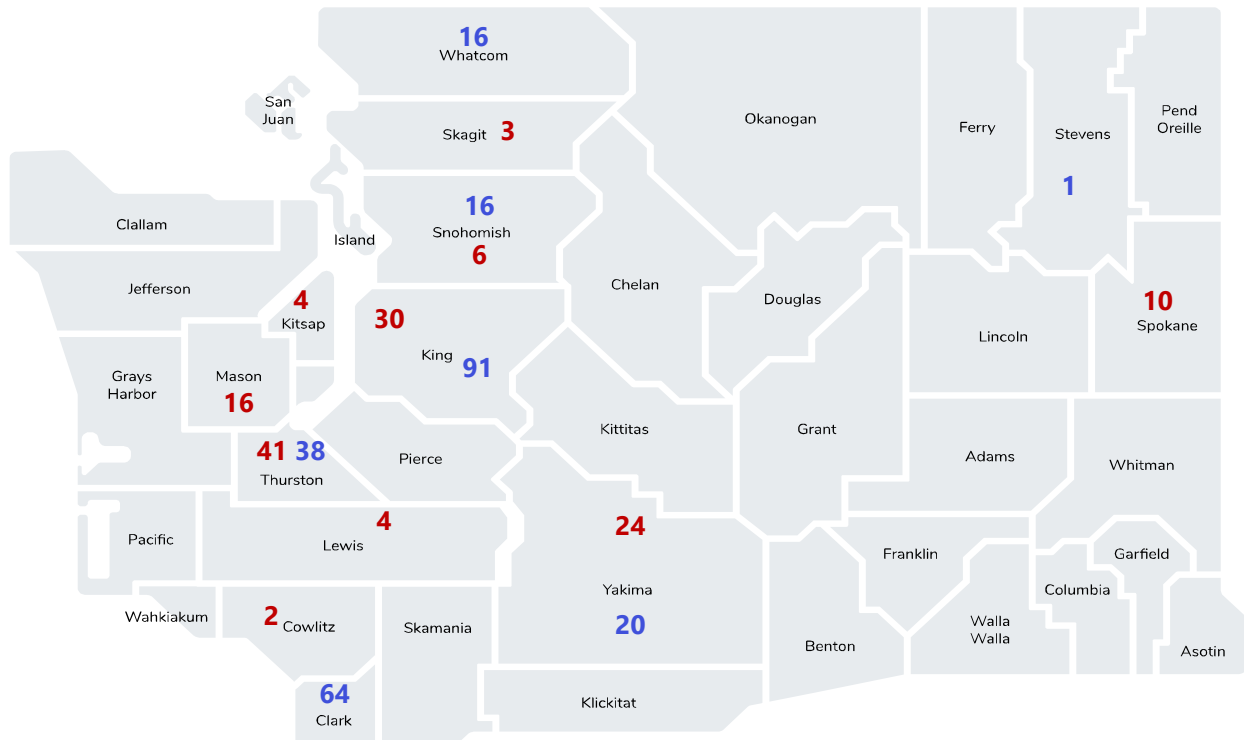
Appendix A: Work group participants

Table 1: work group participants

Holly Borso (Telecare)	Jessica Molberg (Coordinated Care)	Marshall Glass (Coordinated Care)
Misty Queen (Molina)	Ashley Nelson (Molina)	Terri Brazalton (Anthem)
Maribeth Capen (Anthem)	Stacey Lopez (Molina)	Emily Reddick (United Health Care)
Mark Freedman (Thurston Mason BH-ASO)	Michael Reading (King County)	Melanie Brock (King County)
Andrew Busz (WSHA)	Len McComb (WSHA)	Brooke Evans (WSHA)
Dr. Don Christman (Frontier Behavioral Health)	Vivian McGee (Frontier Behavioral Health)	Richard Stride (Cascade Community Healthcare)
Matt Patten (Cascade Community Healthcare)	Jodi Daly (Comprehensive Healthcare)	Sharon McMillan (CHPW)
Joan Miller (WA Council)	Dawn Myre (Fairfax)	Natalia Martinez-Kohler (MultiCare)
Jenise Gogan (DSHS/BHA)	Kevin Bovenkamp (DSHS/BHA)	Jacqueline Cobbs (DSHS/AL TSA)
Bea Rector (DSHS/AL TSA)	Amber Leaders (Gov)	Bryan Way (OFM)
Richard Pannkuk (DSHS/FFA)	Devon Nichols (DSHS/FFA)	Phil Diaz (DSHS/DDA)
Michele Wilsie (HCA)	Catrina Lucero (HCA)	Sarah Cook (HCA)
Abby Frazier-Cole (HCA)	Kara Panek (HCA)	Margo Miller (HCA)
Julie Brown (HCA)	Teesha Kirschbaum (HCA)	Jessica Diaz-Bayne (HCA)
Megan Oczkewicz (HCA)	Gary Hanson (HCA)	Blake Ellison (HCA)

Appendix B: Long-term civil commitment bed capacity map

Image 1: Map of current and anticipated community-based long-term civil commitment bed capacity



Estimations based on available data as of 12/07/2021:

- Current beds under contract 2017- present: **140 beds**
- Funded projects with beds coming online soon: **246 beds**
 - New capacity funded via Commerce grants anticipated coming online FY 2022
 - DSHS creation of three 16 bed facilities in Vancouver, WA
 - DSHS site with 16 bed facility in Ground Mound
 - 75 beds at UW Teaching Hospital

Continue recruitment efforts to expand bed capacity

Current projected total: 386 beds