# Final Alternative Options and Recommendations Report

## Washington Mental Health System Assessment

November 28, 2016

PCG Health

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# Table of Contents

# 1. Executive Summary

The Washington Office of Financial Management contracted Public Consulting Group (PCG) to examine the structure and financing of the adult mental health system, as required by Engrossed Substitute Senate Bill 6656. This report, "Final Alternative Options and Recommendations," is the second in a series of three reports aimed at identifying key challenges in the state's existing mental health system and recommending potential solutions. This report builds from the "Initial Findings Report" as well as subsequent discussions with Washington stakeholders to pose recommendations that address critical challenges to effective behavioral health treatment and prepare the state for a 2020 transition to full integration of physical and behavioral health.

For this phase of the study, options for consideration were developed and vetted working with several key stakeholders. This visioning process confirmed the following key areas of opportunity that the recommendations aim to support:

1. Refine the role of state hospitals to serve the right patients in the right environment.
2. Improve early identification and treatment of behavioral health needs.
3. Increase collaboration and redesign system to achieve patient centered care.
4. Support workforce development efforts and use of best practices to attract and retain staff.
5. Increase focus on outcomes to ensure the system delivers desired results and continuous improvement.
6. Establish a robust continuum of care and support for transitions.

Stakeholder consultation additionally supported the development of five criteria by which all potential recommendations would be judged:

1. Improve efficiency and efficacy of the behavioral health system.
2. Facilitate community supports and refine use of the state hospitals.
3. Focus on patient centered, recovery oriented care.
4. Consider ease of implementation.
5. Consider potential to realize savings to offset cost.

This process culminated in development of the nine recommendations identified below. These recommendations require financial and strategic investments in community-based outpatient and residential care for the civil population to reduce bottlenecks to discharge and prevent hospital admissions and readmissions. They establish that the primary, but not exclusive, focus of Western and Eastern State Hospitals should be forensic care. The recommendations also focus on building the foundations for full integration of physical and behavioral health services in managed care by 2020.

**Recommendation 1**: Require the Director of the Health Care Authority (HCA) to submit a state psychiatric hospital managed care risk model to the Governor and the Legislature by December 31, 2017 to support putting Medicaid managed care organizations at risk for this benefit effective January 1, 2020. The risk model must address the proper role of commercial managed care for forensic as well as civil populations and the legal role of a business entity's duties in managing a civil commitment. It should establish Managed Care Organization (MCO) contract and provider participation requirements, shared risk arrangements, quality and performance metrics and capacity of the state-hospital business model to adapt to commercial funding streams, including any impacts to labor agreements.

Key Features:

- Aligns with Washington's broad goal for full physical and behavioral health integration.
- Addresses the absence of an existing risk model for this unique class of providers.
- Addresses the need for accountability and risk management for hospital bed use by non-Medicaid populations and Medicaid enrollees not enrolled in managed care.

**Recommendation 2**: Establish a new unit within the Office of Financial Management (OFM) that integrates and coordinates fiscal analysis of all behavioral health services across agencies and units of government.

Key Features:

- Does not replace agency-based fiscal oversight by OFM.
- Complements agency-based fiscal oversight by adding an integrated analytical framework to enhance synergies between and among agency initiatives that have a behavioral health impact.

**Recommendation 3**: Enhance community support by strengthening acute care episode management and community services to reduce admissions to state psychiatric hospitals. Specifically, this will be done by funding three new mobile crisis teams, two new crisis walk in centers, a 15 percent increase in the number of peer support specialists and the commencement of a grant program to enhance substance use disorder treatment more broadly into mental health care.

Key Features:

- Supports integration of substance use disorder treatment across community outpatient settings.
- Requires capital investment to develop new facilities for walk-in crisis patients.

**Recommendation 4**: Establish six new 16-bed community hospitals for civil commitments and transitional acute psychiatric care needs to promote regional care and the potential for an emphasis in specialty care for co-morbid conditions. These conditions may include developmental disabilities, dementia and certain categories of co-occurring substance use disorders.

Key Features:

- Establishes four 16-bed facilities to serve civilly committed patients in the western region of the state and two in the eastern region of the state.
- Keeps patients closer to their communities of residence, thereby easing the transition to outpatient placement.
- Permits establishment of these facilities for exclusive focus on civil populations with comorbid conditions that are manageable in a smaller and potentially less intensive setting.

**Recommendation 5**: Reform state hospital programming to integrate substance use disorder treatment and add inpatient peer support.

Key Features:

- Redesigns treatment protocols to address substance use disorder in the context of mental health conditions for comorbid patients.
- Adds peer specialists to the inpatient treatment team for forensic patients.

**Recommendation 6**: Align community mental health placements with identified civil placement discharge needs by (1) establishing a transitional, statewide supportive housing benefit administrator; (2) creating a temporary Office of Behavioral Health Housing Initiatives, charged with facilitating the collaboration of capacity building investment pools, and (3) establishing expanded responsibility for selected state hospital transitions and management practices to Aging and Long-Term Support Administration (ALTSA) and Developmental Disabilities Administration (DDA).

Key Features:

- Builds capacity to assure new supportive housing benefit will be effective for behavioral health.
- Creates a coordinating entity to align disparate capacity investment efforts.
- Transfers responsibilities for transition management for individuals who are aging or have physical disabilities to the ALTSA.
- Transfers responsibility for management for individuals with developmental disabilities to the DDA.

**Recommendation 7**: Develop regional care coordination models to follow rising and high risk patients throughout the care continuum, including those with significant mental health and substance use disorder needs.

Key Features:

- Establishes a new regional model of comprehensive care and case management across the care continuum that helps better organize and focus existing services delivery and management efforts around the whole person.

- Builds on existing care and case management requirements for Behavioral Health Organizations (BHOs) and MCOs, including augmentation of existing health home services and potential utilization of delivery system reform incentive payments under the Medicaid Transformation demonstration.

**Recommendation 8**: Invest in transitional care reform initiatives to add step-up, step-down and Housing and Recovery through Peer Services (HARPS) resources. Specifically, add two new, 10-bed step down facilities in Western Washington and one new 10-bed step down facility in Eastern Washington.

Key Features:

- Develops step-down facilities following the Enhanced Services Facilities model implemented in Vancouver and Spokane and augments HARPS teams to connect discharged patients to available housing.
- Develops step-up facilities that allow for both patient walk-in appointments and short term admissions initiated by the patient or caregiver.

**Recommendation 9**: Create an integrative technology infrastructure to support behavioral health service delivery and transition to integrated care.

Key Features:

- Develops a learning health system to support patient-centered care and monitoring.
- Supports transition to full integration while providing unique functionality for behavioral health.

Many of the above recommendations expand on promising initiatives underway in Washington while addressing challenges posed by the current financial structure and other policy and operational impediments.

Although Washington has made significant progress in behavioral health redesign in recent years, the recommended areas of improvement aim to further align Washington with national best practices and improve both financial efficiency and health outcomes as the state moves toward full care integration.

# 2. Introduction

The Washington Office of Financial Management contracted Public Consulting Group (PCG) to examine the structure and financing of the adult mental health system, as required by Engrossed Substitute Senate Bill 6656. This report, "Final Alternative Options and Recommendations," is the second in a series of three reports aimed at identifying key challenges in the state's existing mental health system and recommending potential solutions. This report builds from the "Initial Findings Report" as well as subsequent discussions with Washington stakeholders to pose recommendations for the state's consideration.

For the recommendations that are selected for further consideration, PCG's third report, "Implementation and Communications Plans," will propose project implementation strategies along with refined budgets and timeframes for completion.

This report is organized to reflect the strategic and financial questions posed by Engrossed Senate Bill 6656. To cohesively address those questions, we begin by briefly discussing the overarching strengths and opportunities in the current system. We then review our approach to identifying and recommending options to address existing opportunities. The recommendations are then presented within the context of the strategic and financial project questions and associated discussion.

Importantly, concurrent work streams in the state are actively developing recommendations focused on workforce development and state hospital staffing. If selected for implementation, many of the recommendations proposed in this report will depend on sufficient workforce availability. Thus implementation planning must consider the timeline and scope of recommendations posed by these workgroups. PCG is actively monitoring the progress of these groups to support alignment.

# 3. Strengths and Opportunities in the Current System

The majority of this report will focus on the challenges facing Washington's adult mental health system. However, during the course of this study, PCG also noted that Washington has continued progress toward effective system redesign in a number of key areas.

For example, despite the higher than average prevalence rates reported in the "Initial Findings Report," only roughly one percent of the state's mental health patient population will be treated by the state's psychiatric hospital system. This statistic demonstrates a commitment to community-based care, which the recommendations in this report will continue to foster. Further, plans to integrate physical and behavioral health demonstrate alignment with national trends and a strong step toward creating a patient-centered, holistic model of care.

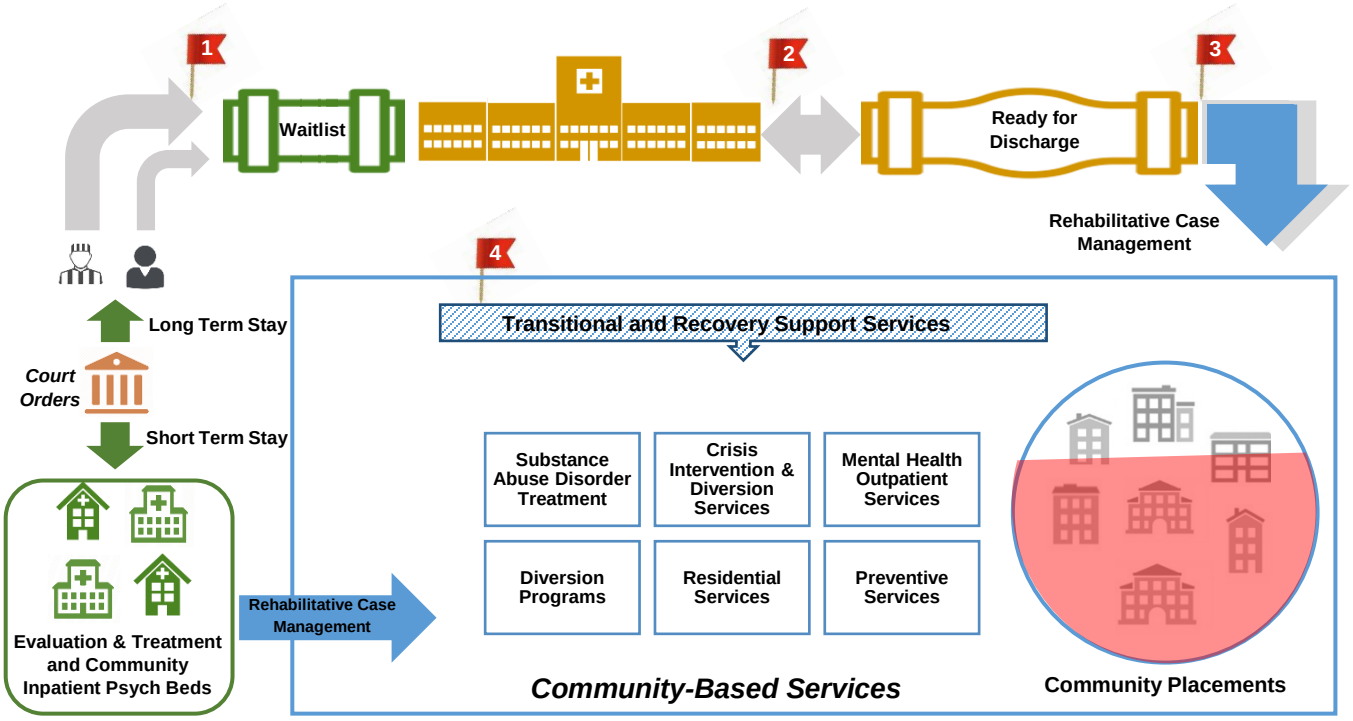
At the provider level, several stakeholders noted the positive effects of recent expansions in community-oriented evidence based practices. Investments in crisis stabilization and trauma informed care strive to prevent patient escalation while expansion of permanent supportive housing prioritizes the patient's basic needs. Recent investments in peer support programs also align with national best practices and represent a necessary movement away from the medical model of care for behavioral health patients.

Lastly, as noted in PCG's previous report, the state is currently funding numerous additional workgroups and analyses to address key issues such as workforce development and jail diversion programs. The recommendations identified in Section 5 of this report aim to expand on the positive efforts already underway in Washington. Many of our recommendations augment or refine the initiatives identified above while proposing alternative solutions to persistent challenges.

Based on the "Initial Findings Report" and stakeholder input, Figure 1 illustrates the current flow of patients through the system, flagging areas of opportunity that significantly impact hospital bed capacity and access to care. The recommendations that follow address issues identified at each stage of the patient pathway, revolving around four key challenges:

- the volume of patients committed to the state hospital and subsequent admission delays
- discharge delays for patients who no longer require state hospitalization
- availability of specialized residential and other community programs
- coordination across the care continuum

**Figure 1. Washington Behavioral Health System: Current State Diagram**



# 4. Approach for Phase II

Building on the information contained in the Initial Findings Report, PCG shifted focus to developing recommendations related to the financing and operation of the state hospital system within the broader continuum of behavioral health care. The process for completion of Phase II involved three major steps:

- visioning sessions and stakeholder interviews
- definition of evaluation criteria
- recommendations development and selection

## 4.1. Visioning Sessions and Stakeholder Interviews

Washington's behavioral health delivery system is already employing many promising practices and in recent years has devoted considerable resources to identifying and implementing ways to improve. To collect firsthand, real time feedback from key stakeholders about actions not yet taken but considered to be important to further system improvement, PCG designed and conducted visioning sessions with several groups involved in the management, operation and decision making related to the state hospitals and community behavioral health system. Participants came together in late September and early October 2016 to answer the following visioning question:

"Imagine that it is 2021 - five years from now and a year after Washington's transition to a fully integrated health system - and Washington has created a highly effective system that meets the (previously identified) goals relative to behavioral health. What happened to realize those goals? What were the most critical action steps taken by the state to achieve this vision for service delivery?"

The visioning question was structured to encourage participants to focus first and foremost on what a highly functioning system looks like by identifying those features or components that they consider indicative of such a system. Second, participants were encouraged to think about the concrete actions required to be taken by various state entities to ensure that those features were in place. In most sessions, the approach to the visioning exercise involved first giving participants time to consider the question and note ideas on their own, followed by consultation and discussion with one or two others in the room, and finally a group exercise involving sharing all ideas and posting them to a board. After all ideas were posted and clarified, participants were asked to collectively group the suggestions and give a name to each grouping that summarized the theme of the suggestions. A full listing of stakeholder suggestions and groupings may be found in Appendix A.

Because not all key stakeholders were available to attend in person visioning sessions, PCG also conducted one-on-one phone interviews with several stakeholders to solicit their feedback. These stakeholders were asked to consider the same visioning question and provide their individual responses. Although these calls did not provide the same forum for collective feedback as the visioning sessions, PCG did ask clarifying questions to garner as much specificity as possible from stakeholders. The action steps identified via stakeholder calls are also included in Appendix A.

On completion of the visioning sessions and stakeholder calls, PCG compiled and analyzed the collective responses and ultimately grouped them according to the following six "Areas of Opportunity" related to the desired future state of Washington's behavioral health system:

1. Refine the role of state hospitals to serve the right patients in the right environment.
2. Improve early identification and treatment of behavioral health needs.
3. Increase collaboration and redesign system to achieve patient centered care.
4. Support workforce development efforts and use of best practices to attract and retain staff.
5. Increase focus on outcomes to ensure the system delivers desired results and continuous improvement.
6. Establish a robust continuum of care and support for transitions.

The complete Areas of Opportunity matrix is found on the following pages. Within each Area of Opportunity are specific suggested outcomes that stakeholders suggested would signify progress toward realization of that opportunity.

**Table 1. Areas of Opportunity and Outcomes/Components**

| Areas of Opportunity | Refine the role of state hospitals to serve the right patients in the right environment | Improve early identification and treatment of behavioral health needs | Increase collaboration and redesign system to achieve patient centered care | Support workforce development efforts and use of best practices to attract and retain staff | Increase focus on outcomes to ensure the system delivers desired results and continuous improvement | Establish a robust continuum of care and support for transitions |
|---|---|---|---|---|---|---|
| **Outcomes** | Population served at state hospitals is well defined – specific focus on forensic and those with the most complex needs and diagnoses | Increased availability of jail and hospital diversion programs across Washington | Recovery oriented care is provided at all levels of the system and is continuous (not episodic) | Better pay and training attracts new talent and encourages retention of staff and continuity in patient care | Standardization of EHR and data systems across hospitals and provider system | Transitional placements in community for individuals with a range of needs (ADL, complex behaviors, dementia care, etc.) |
| | Rightsizing of state hospitals to enable effective management | Crisis intervention training for health and law enforcement professionals | Patient has a voice in care/support decisions and quality of life considerations are addressed | Certified, accredited and professional classification is available to those who work in the behavioral health system | Ready access to patient/client information for providers caring for and preparing to care for patients/clients (seamless transitions) | Greater availability of affordable housing to clients with behavioral health needs |
| | Shorter commitment periods to address patient needs in a timely manner | Widely available crisis hotlines and stabilization resources to provide rapid intervention for individuals at risk of destabilization | Aligned public and private systems for resource development and design | Clear career ladders with opportunities for promotion and increased pay | Use of quality data to track and measure patient outcomes, performance metrics and other key indicators | More widespread use of peers including in state hospital setting |

| Areas of Opportunity | Refine the role of state hospitals to serve the right patients in the right environment | Improve early identification and treatment of behavioral health needs | Increase collaboration and redesign system to achieve patient centered care | Support workforce development efforts and use of best practices to attract and retain staff | Increase focus on outcomes to ensure the system delivers desired results and continuous improvement | Establish a robust continuum of care and support for transitions |
|---|---|---|---|---|---|---|
| **Outcomes** | Fully funded and staffed hospitals | Trauma informed care training for all in the system (providers and policy makers) | Implementation of standardized care models based on best practices | Staff-to-patient ratios are aligned with acuity, behavioral issues and the full range of patient needs | More effective bed management and access to real time data about available resources/ placements | Strong care coordination including targeted support for high utilizers/very complex cases |
| | State hospitals have been designed/ redesigned as modern, state of the art facilities to address patient comfort and staff safety | More widespread use of Assertive Community Treatment to identify and address early warning signs | Integrated care models that address a wider range of patient needs and focus on outcomes | Collaboration with universities to train and place students to work in behavioral health and state hospitals in particular | Effective tracking of patient outcomes and placements after discharge (e.g. re-hospitalization, jail, stay in community) | "Warm handoffs" to community providers on discharge |
| | Hospitals address full range of patient needs (e.g. SUD, individual psychotherapy) | Early screening for behavioral health issues as part of primary care | Patients can access treatment and medication at the place they are most comfortable going | Educational assistance to encourage hospital staff to pursue additional training and certifications | EHR supports system needs previously identified through planning efforts (not vice versa) | Appropriate, safe transportation from hospital at discharge |
| | Uniform discharge planning tools and protocols to ensure consistent, transparent discharge decisions | Behavioral health needs of clients in jail are addressed while they are awaiting evaluation/ placement | Full stakeholder involvement in system design | Better hospital and community connections for staff, patients and outside healthcare and social workers | Increased focus on outcomes (regulatory, administrative, accountability, funding) rather than process | Casework prior to discharge to address benefits coordination |

| Areas of Opportunity | Refine the role of state hospitals to serve the right patients in the right environment | Improve early identification and treatment of behavioral health needs | Increase collaboration and redesign system to achieve patient centered care | Support workforce development efforts and use of best practices to attract and retain staff | Increase focus on outcomes to ensure the system delivers desired results and continuous improvement | Establish a robust continuum of care and support for transitions |
|---|---|---|---|---|---|---|
| **Outcomes** | Limited use of seclusion and restraint | | Decrease stigma through community education | State hospitals are seen as a desirable place to work | Use data to inform management decisions | Effective transition programs for step down and "step up" |
| | Positive, affirming leadership and culture | | Comprehensive cross training and understanding among criminal justice, mental health and legislative systems | Regular psychiatric supervision | Reward innovation and positive outcomes | Smaller caseloads for case managers |
| | Purchasing model for state beds | | Adoption of team/ evidence based practices to support integration and early intervention | | Effective design and enforcement of state contracts | Adjusting reimbursement rates to allow for greater workforce integration |
| | | | Improve training for providers – recovery model and other best practices curriculum | | Performance measures are linked to financial incentives (e.g. reducing/ preventing hospitalization, maintaining client residence in community) | Programs/ services for "familiar faces" e.g. single case manager for high utilizers across systems |
| | | | | | | Solutions tailored to different needs of urban and rural counties |

## 4.2. Definition of Evaluation Criteria

Building on the Areas of Opportunity identified through visioning and stakeholder sessions, PCG developed a set of criteria to evaluate potential recommendations related to the state hospitals and the behavioral health system as a whole. PCG developed the following criteria which were reviewed and accepted by the state:

1. Improve efficiency/effectiveness of behavioral health system.
2. Facilitate community supports and refine use of state hospitals.
3. Focus on patient centered, recovery oriented care.
4. Consider ease of implementation.
5. Consider potential realized savings to offset cost.

The following table summarizes specific considerations related to the selection criteria used by PCG to evaluate recommendations.

**Table 2. Criteria for Recommendations Selection**

| Improve Efficiency/Effectiveness of Behavioral Health System | Facilitate Community Supports and Refine Use of State Hospitals | Focus on Patient Centered, Recovery Oriented Care | Ease of Implementation | Realized Savings to offset Cost |
|---|---|---|---|---|
| • Is the recommendation designed to improve overall efficiency and effectiveness of the behavioral health system?<br>• Is the recommendation likely to result in a seamless experience for patients, clients, providers and caregivers?<br>• Does the recommendation leverage the full range of resources available in the system? | • Does the recommendation encourage the use of state hospitals only when necessary based on specific criteria?<br>• Does the recommendation incentivize use of community treatment resources?<br>• Does the recommendation facilitate a robust system of community supports and services to keep individuals in the community? | • Does the recommendation place the patient at the center of treatment and support decisions?<br>• Does the recommendation emphasize a recovery model as opposed to the institutional setting status quo? | • Can the recommendation be implemented using existing resources?<br>• Can the recommendation be implemented in a clear and reasonable time frame?<br>• Does the State have primary authority for implementation and maintenance?<br>• Is the workload impact of responsible parties likely to be manageable? | • Can responsibility for costs be shared (e.g. by Federal dollars?<br>• Are there any savings offsets likely to be realized by the State?<br>• Will costs be one-time costs or add to on-going base costs? |

## 4.3. Recommendations Development and Selection

Throughout the process of gathering stakeholder feedback, PCG continued to collect and analyze information from various sources and began to formulate proposed recommendations for inclusion in the final report. PCG documented several possible operational changes, initiatives and policies with the potential to effect system change and these recommendations were refined over time based on additional data gathering. On finalization of the evaluation criteria, PCG considered each of these recommendations against the criteria to determine suitability for inclusion in the report.

Recommendation options that met all or most of the criteria were included in the report. Options that did not adhere to most or all of the evaluation criteria were not selected and are listed in the following table. Rows with a "✓" indicate that the option met at least one of the strategies for recommendation, but didn't meet enough to be a priority.

**Table 3. Options Not Recommended**

| Option Description | Improve Efficiency and Effectiveness of BH System | Facilitate Community Supports and Refine Use of State Hospitals | Focus on Patient Centered, Recovery Oriented Care | Ease of Implementation | Realized Savings to offset Cost |
|---|---|---|---|---|---|
| Place BHOs at full risk for state hospital utilization. | | ✓ | ✓ | | |
| Place the Aging and Long-Term Support Administration (ALTSA) at risk for state hospital utilization. | | ✓ | ✓ | | |
| Divide one or both state psychiatric hospitals into discrete hospitals to serve civil and forensic patients separately. | | | ✓ | | |

Although PCG sees long term merit in carving-in state psychiatric hospital benefits into Medicaid managed care, the current lack of an appropriate risk model would prevent any enhancements of efficiency and effectiveness under the BHOs or through ALTSA prior to 2020.

In response to the request to PCG regarding placing the ALTSA at risk for state hospital utilization, we decided against this because:

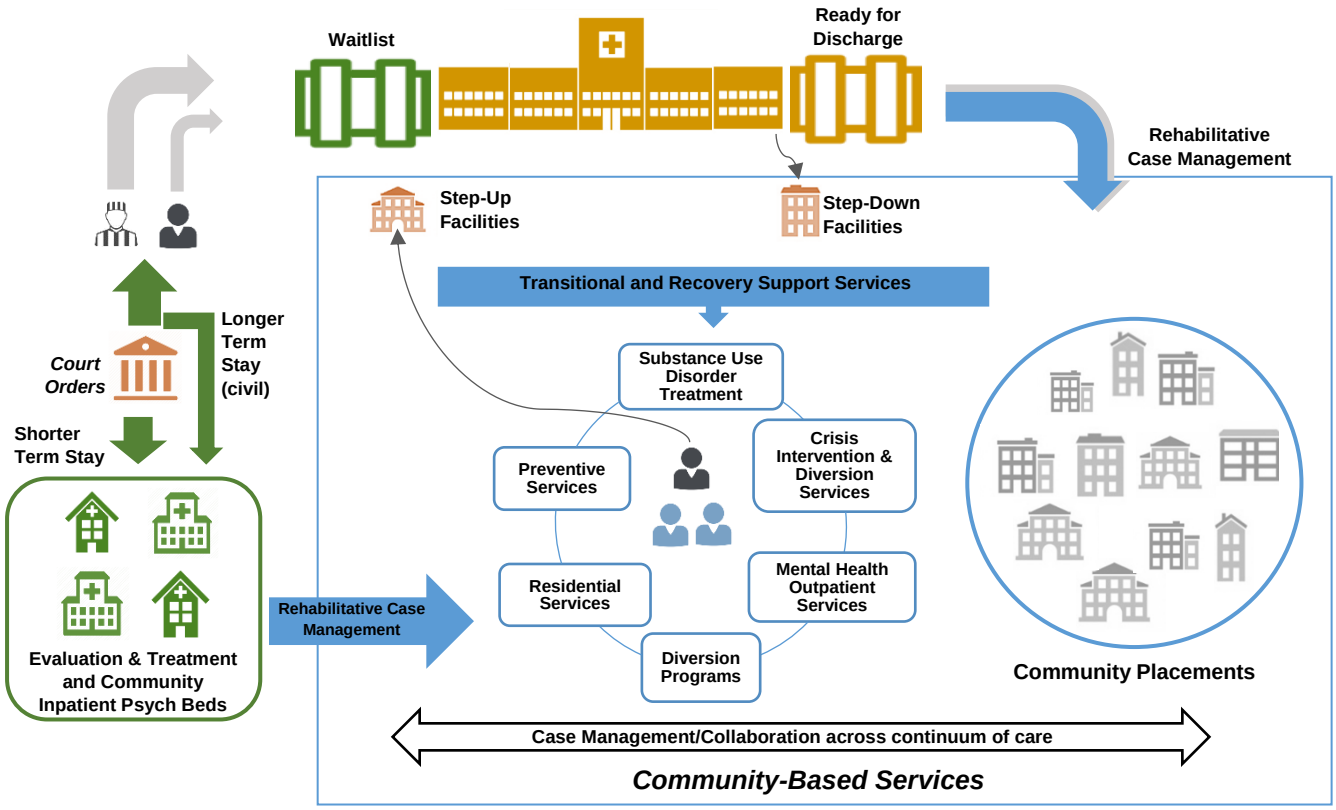
- A capitation approach would leave ALTSA without administrative authority or control over hospital discharge practices but with responsibility for financial outcomes of the discharge practices.
- Stronger recommendations were available that increased the responsibility of DDA for the discharge of state hospital patients with intellectual and developmental disabilities (ID/DD), and ALTSA for individuals aged 65 and older from the geropsychiatric wards.

# 5. Recommendations

The visioning process described in the previous section contributed to the following "To-Be" vision for Washington's mental health system. Recommendations discussed in this section specifically support this vision by:

- increasing diversion and recovery programs
- providing inpatient treatment options outside the state hospitals
- augmenting state hospital treatment programs
- expanding residential and community placements
- fostering collaboration across the continuum of care and supporting care transitions

**Figure 2. Washington Behavioral Health System: Future State Diagram**




The above diagram represents an ideal future state in which civil commitments requiring state hospitalization are minimized and community services function as a robust and coordinated continuum of care. Although the majority of the recommendations posed in this report may be implemented independently, the collection of recommendations builds to this state. Throughout the remainder of this report, our approach aims to provide necessary background information to answer each question posed by Engrossed Senate Bill 6656 and then propose recommendations to address related issues and achieve the above systemic goals.

## 5.1. Financing Recommendations

The following section is responsive to the financial questions posed by Engrossed Senate Bill 6656:

"Should changes be made to the current financing structure and financial incentives for state hospital civil bed utilization by providing behavioral health organizations and full integration entities under RCW 71.24.380 with the state funds necessary to purchase a number of days of care at a state hospital equivalent to the current allocation model, instead of providing state hospital bed allocations under RCW 71.24.310?"

"Should Behavioral Health Organizations and equivalent entities in full integration regions be placed at risk for state hospital civil utilization for patients within their catchment areas, while receiving the means and opportunity to apply any savings resulting from reduced state hospital utilization directly to the service of clients in the community?"

"How can behavioral health organizations in full integration regions be incentivized to increase their utilization management efforts, develop additional capacity for hospital diversion, and increase capacity to safely serve complex clients in the community?"

"If changes are made to the current financing structure, how best can funds be made available to purchase state hospital beds or for alternative uses such as to purchase beds in other locations, to invest in community services, and to invest in diversion from inpatient care?"

To address these interrelated questions, the recommendations outlined in this section propose a shift in the financing structure for Medicaid clients, with a focus on MCOs. As detailed throughout this report, Washington must promote the development of community-based treatment resources throughout the state. Currently, the main incentive for community development rests in the statutory restriction on the number of state hospital beds BHOs may use without financial contribution. Given the planned phase out of the current BHO model, changing this allocation methodology for the existing BHOs will likely create more disruption than benefit. Therefore, recommendations posed in this section call for implementing full risk at the MCO level only, using the next two years to prepare for full capitation across an integrated delivery model.

### 5.1.1. Financing Behavioral Health Organizations

The following recommendation proposes a transition plan to support the state's move toward fully capitated, integration under an MCO model by 2020.

| Recommendation 1: | **Require the Director of the Health Care Authority to submit a state psychiatric hospital managed care risk model to the Governor and the Legislature by December 31, 2017 to support putting Medicaid managed care organizations at risk for this benefit effective January 1, 2020.** |
|---|---|
| **Benefits** | • Prepare state agencies and managed care organizations to implement full integration<br>• Align financial structure with goal of reducing inpatient utilization |
| **Areas of Opportunity** | • Increase collaboration and redesign system to achieve patient centered care<br>• Refine the role of state hospitals to serve the right patients in the right environment<br>• Support workforce development efforts and use of best practices to attract and retain staff |
| **Time Frame** | Twelve months to design the risk model. In follow up, use 2018 to develop risk model features and 2019 to implement for effective launch 1/1/20. |
| **Key Gaps** | • State psychiatric hospital business model lacks readiness for managed care<br>• Undefined legal role of a business entity in managing a civil commitment<br>• Undeveloped MCO contract provisions and performance metrics that permit the framework of the model to be understood by MCOs and hospitals. |

**What it Does**

This recommendation supports the eventual inclusion of the state hospital inpatient psychiatric benefit into Medicaid managed care in 2020, consistent with the broader integration of physical and behavioral health already planned for roll out in Washington at that time.

However, the recommendation acknowledges that Washington lacks an existing risk model necessary to effect this change. Therefore, PCG recommends deferring a carve-in of state psychiatric hospital inpatient care into the existing BHOs structure prior to 2020. With the BHO structure itself set to sunset in three years, PCG believes this transition time is optimally used to design, develop and implement the appropriate risk model. For 2017, we focus on design of that model, which is our first recommendation.

State psychiatric hospitals are a unique class of healthcare provider. They bridge functions that are oriented to both healthcare and criminal justice administration. They are different from public acute care hospitals both in terms of their relationship to the criminal justice system and their lack of a strong private payer source. Staffing issues require a much different level of direct state involvement over elements such as worker's compensation and collective bargaining.

Extending a traditional healthcare capitation risk model to this provider type is not without its challenges. Traditional risk models typically involve voluntary contracting between payer and provider and capacity of the provider's delivery model to adapt to the requirements of commercial oversight. Although managed care for state inpatient psychiatric facilities has the upside potential of leveraging market incentives to increase care efficiency, the provider class has historically operated far outside the bounds of commercial healthcare.

PCG believes HCA, in coordination with the Department of Social and Health Services (DSHS), must draft a risk model "blueprint" to demonstrate that the concept can successfully be made operational. The blueprint must address key issues that are currently gaps to implementation:

- Will the risk model apply equally to forensic and civil patients?
- If forensics are not included, would "forensic flip" cases also be exempt?
- Will state psychiatric hospitals be legally required to contract with MCOs?
- Would these contracts be wholly distinct from the state's contracts with the same plans to provide Medicaid managed care?
- How can a commercial entity appropriately engage in care decisions that are interrelated with the legal components of a civil commitment?
- What performance metrics are envisioned for the MCOs related to this benefit within the Medicaid managed care contracts?
- May MCOs impose performance benchmarks on the hospitals as conditions of their contracts, and, if so, how might collective bargaining agreements be impacted?

Resolving these issues provides a major step forward to a successful carve-in of state hospital inpatient psychiatric beds to Medicaid managed care in 2020.

As background, in 2014, the Washington State Legislature passed Senate Bill 6312. The bill directed the Department of Social and Health Services to integrate funding and oversight for behavioral health (mental health and substance use) treatment services. The bill laid the foundation for integrated care, and in 2016 the new Behavioral Health Organizations assumed responsibility for managing both mental health services and substance use disorder (SUD) services.

State psychiatric hospital services were not included in the new managed care programs. The result is that an expensive and large component of behavioral health services remains outside of current integrative efforts. PCG recommends bringing this service component into an integrated care framework. Integrating psychiatric hospital services into managed care enhances the Legislature's 2014 vision. Through full capitation, better care coordination and care management can reduce illness and avoid unnecessary costs while focusing care where it will have maximal therapeutic value.

On implementation of this recommendation, individuals referred by the court for involuntary hospital admissions will become the financial responsibility of managed care organizations. Like other transformational changes, this shift of responsibility will have broad impacts on how behavioral health is delivered. Expected impacts are outlined below.

*State Hospitals:*

- Funding to pay for these services will move from hospital accounts to MCO accounts.
- State hospitals will need to change their business model. The hospitals will contract their services to the MCOs and will no longer rely exclusively on the state budget to cover operational costs.
- The hospitals will still be state-operated but will negotiate rates and admissions with payers.

*Managed Care Organizations:*

- To manage risk effectively, the MCOs will need to have oversight responsibility for clinical discharge decisions for individuals receiving care at state hospitals and other hospitals. It is assumed that over time the medical staff and hospital staff will collaborate on patient treatment plans and discharge decisions, and that the MCOs will have responsibility for making payment decisions about the duration and frequency of treatment.

- The MCOs may contract with any provider capable of providing the level of inpatient psychiatric care required under the civil commitment.
- MCOs will provide civil commitment inpatient psychiatric care within a fixed capitation rate and operate at risk for all hospital utilization above their capitation base.
- This changing responsibility will increase the care coordination and care management activities of the MCOs.

*Community Hospitals:*

- Currently, the majority of individuals adjudicated as needing a 90-day involuntary commitment are routinely sent to a state hospital.
- In a transformed system, any hospital or other setting that can provide inpatient psychiatric care to individuals with an involuntary commitment could potentially treat patients.
- Community hospitals could then compete on quality and cost with one another and the state hospitals.

The potential benefits of these changes are broad and deep:

- One entity – the MCO – will be responsible for the physical and behavioral health of an individual, ending confusion in the current system in which multiple agencies own various responsibilities but no organization manages the care of an individual across the continuum.
- Hospitals may compete for patients from the MCOs on the basis of offering the best care with the best outcomes at reasonable prices.
- State hospitals may become smaller over time and more efficient.
- MCOs may be held accountable more effectively through performance outcomes and budget controls.
- Individuals may experience improved care coordination.

**Gaps**

Tasks necessary to accomplish this innovation may include:

- Legislative authorization to place MCOs at risk for state hospital utilization and the MCO's responsibilities for ensuring compliance with court orders.
- A fiscal or actuarial analysis to determine how much of the state hospital budget should be placed in the capitation base.
- MCOs will need to prepare plans identifying how they will determine the medical necessity of admissions to hospital services and discharges from hospitals.
- DSHS and the HCA will need to ensure that their MCO purchasing contracts are consistent with existing legal provisions regarding payment for hospital services, the establishment of quality standards, the adequacy of provider networks and the claiming of federal matching funds.
- State code may need to be updated. For example, changes may be needed to the ninety-day references in RCW 71.05.320. Currently, the language is silent on where persons can be admitted for 90-day stays. Language that encourages multiple treatment venues and eliminates the necessity for administrative approval before an individual can be sent somewhere other than a state hospital is likely required.

### 5.1.2. Maximizing Federal Financial Participation

This subsection specifically addresses the shift in funding sources that will result from treatment changes proposed throughout this report.

| Recommendation 2: | Establish a new unit within the Office of Financial Management (OFM) that integrates and coordinates fiscal analysis of all behavioral health services across agencies and units of government. |
|---|---|
| **Benefits** | • Supplements and does not replace existing agency-based budget oversight<br>• With behavioral health initiatives increasingly stretching across agencies and state and local governments, this unit provides a singular focus on "connecting the dots."<br>• Assures synergies of agency budget initiatives so that each initiative is "greater than the sum of its parts"<br>• Enhances coordination of capacity building efforts with one-time funding sources, such as DSRIP and county level investments<br>• Acknowledges the independence of local government funding initiatives, but helps local communities align with and leverage other state activities |
| **Supports** | • Refine the role of state hospitals to serve the right patients in the right environment<br>• Improve early identification and treatment of behavioral health needs<br>• Increase workforce development and use of best practices to attract and retain staff |
| **Time Frame** | Staff the unit and positions by Spring 2017 |
| **Key Gaps** | Individuals with the knowledge and experience to manage a complex unit/division of state government |

**What it Does**

Washington is investing significantly to change the behavioral health landscape in the state. Multiple initiatives are underway that will impact the state hospitals and the entire behavioral health system. These initiatives include but are not limited to:

- the Governor's Behavioral Health Innovation Fund
- the Medicaid Transformation Waiver, including its Delivery System Reform Incentive Pool (DSRIP)
- the implementation of Value Based Purchasing (VBP) at the HCA
- Local investments such as the 1/10 of 1 percent tax levied by 23 local jurisdictions to fund mental health and chemical dependency services.

With so much change at one time, it is imperative that Washington establish formal methods for financial control to govern, monitor, and report financial outcomes for the state.

PCG recommends that the Governor's Office establish a unit within OFM that provides integrated analysis for statewide behavioral health financing. An estimated six new positions would be required, reflecting the following full time equivalent (FTE) roles: one director, two HCA analysts, one DSHS analyst, and up to two FTEs of additional analyst support.

## Gaps

The unit described above will be responsible for managing five key strategic areas defined below.

*Medicaid Services in Hospital and Community Settings*
Washington must take a thoughtful approach to managing the state behavioral health Medicaid budget through upcoming IMD-DSH reductions and plans for increased community based alternatives. Washington has maximized the IMD-DSH claiming at the state facilities historically. In 2016, the IMD-DSH allotment was $66.3 million (and a total DSH allotment cap of $201.1 million). Washington's regulations stipulate that IMD-DSH is only available to "state owned and operated psychiatric hospitals—Eastern and Western State Hospital" (WAC 182-550-5130: Institution for Mental Diseases DSH (IMD-DSH)). The Patient Protection and Affordable Care Act of 2010 reduced federal DSH allotments nationally - which have averaged $11 billion annually - to account for the decrease in uncompensated care anticipated under health insurance coverage expansion. Left unchanged, Washington would have a maximum IMD-DSH claim of approximately $18M by 2024 (a 70 percent decrease).

As Washington plans for these reductions, PCG has developed offsetting strategies that will maximize state reimbursement. PCG has provided several recommendations in this report that will impact overall Medicaid reimbursement. Our recommendations focus on establishing formal processes to manage these changes over the next several years to maximize financial efficiency for the state.

1. State Hospital Changes – PCG recommends that the state hospitals focus on the forensic and hard-to-serve civil commitments in the future. As this process unfolds, Washington will need to have a strategy to manage the reduction in state expenses and net reimbursement to the state for Medicaid fee-for-service, Medicaid DSH, and other payer sources.

2. Non-State Hospital Alternatives (Inpatient) – Per PCG's recommendation, Washington will potentially be building hospital capacity for services in two (2) or more 16-bed psychiatric hospitals. The major benefit of this model is that the state can claim full federal financial participation (FFP) for the Medicaid eligible population because the individuals are no longer patients in an IMD. Planning for these alternative resources will be important to ensure Washington is maximizing reimbursement.

3. Community Based Alternatives – As the state builds capacity with community services, more Medicaid services will be provided and more claiming opportunities will become available. For example, an individual may be diverted from civil commitment through effective utilization of additional residential treatment services, crisis treatment, supportive housing, and other services in the community. There is no IMD restriction for community based care, so Washington will have access to full FFP for all Medicaid eligible community services. Washington will need to develop detailed budgets based on proposed utilization models and track all financials to accurately reflect the changes from the present model.

*Medicaid Delivery System Reform Incentive Program Planning*
In October 2016, the Centers for Medicare and Medicaid Services (CMS) provided agreement in principle for $1.5 billion investment over the next five years to transform Medicaid in Washington. HCA and CMS will work together in the coming months to finalize terms and conditions, and the waiver will take effect once they reach an agreement. HCA has published information that defined three main domains for delivery system

reform investment as follows: Domain 1 - Health Systems Capacity Building; Domain 2 - Care Delivery Redesign; and Domain 3 - Prevention and Health Promotion. Key highlights of the framework include a project for "Bi-directional Integration of Care" and "Care Transitions" for high needs populations. Although final details of the waiver have not been established, it will be important for Washington to approach the system reform in a coordinated approach as this waiver is one of the most ambitious and transformative of any waiver in Medicaid history for the behavioral health population in Washington and peer states.

*Medicaid Value Based Purchasing Planning*
Washington will need to work with the behavioral health provider community to align behavioral health provider goals with the HCA VBP program. Healthier Washington established a goal of tying 90 percent of state payments to value by 2021. The movement toward a VBP model is critical to the success and sustainability of the DSRIP waiver. States like Arkansas and Tennessee have experienced savings and improved quality of care for behavioral health VBP episodes like attention deficit and hyperactivity disorder, anxiety, and depression. The way payers purchase services in the future under a VBP model will certainly look different than today. Washington's behavioral health leadership must ensure that they are invested in the VBP discussion.

*Non Medicaid DSHS Funding*
The DSHS Behavioral Health Administration (BHA) is responsible for a $1.14 billion budget in the 2015-17 biennium.[1] It is important that lawmakers and state budget managers have a detailed understanding of what these funds finance and how those services relate to other behavioral health and substance abuse spending in the state.

*County Behavioral Health Funding*
Although the state does not have ultimate authority over county budgets, counties fund some behavioral health and substance use services. For example, a countywide 0.1 percent sales tax would be expected to generate over $100 million annually. These funding streams may supplement Medicaid, Federal Block Grant, and state DSHS funds for behavioral health and substance abuse services. Broadly, it is important that the state have a general understanding of the types of services that each county funds with their dollars.

## 5.2. Strategic Recommendations

This section specifically addresses investments in community resources as well as a shift in the structure and function of the state hospital system. The questions and associated recommendations are structured to follow a patient's potential pathway through the mental health care continuum, as follows:

1. focused investment in community services and supports
2. shifting treatment for the civil inpatient population outside of the existing state hospitals
3. augmented state hospital programming to support recovery
4. expansion of residential resources to mitigate barriers to discharge
5. investment in improving transitional care and overall continuity of care

[1]Washington State Department of Social and Health Services: Behavioral Health Administration. https://www.dshs.wa.gov/fsa/budget/behavioral-health-administration

### 5.2.1. Community Services and Supports

Because the goal of an effective mental health system is to promote and support continued community-based treatment and recovery, we begin this section by examining the ways in which various interventions and community supports may successfully keep individuals in the community and prevent psychiatric hospitalization. The following subsection refers to the study question:

"What interventions should be utilized to prevent or reduce psychiatric hospitalization?"

Interventions to prevent or reduce psychiatric hospitalization are positioned along a continuum of care addressing various levels of intensity. At the beginning of the continuum is integrated physical and behavioral health care, typically delivered in a primary care setting, that provides screening and assessment for behavioral health conditions alongside physical health. Washington's planned integration of physical and behavioral health services under managed care contracts – started in the early adopter region in 2016 and expected to be fully realized across the state by 2020 – is expected to have a significant impact on more seamless integration of physical and behavioral healthcare by folding costs for both into a single budget for the managed care entities. This structure creates a financial incentive for effective management of both types of conditions.

Stakeholders noted that financial integration does not automatically equate to care integration. To this end, Washington must also ensure the widespread availability of primary care provider training on behavioral health issues and encourage better information sharing among providers to more efficiently address the full range of patient needs. The Accountable Communities of Health (ACH), funded under the Healthier Washington waiver and its DSRIP initiative, will help convene the right sectors and community leadership to support full integration.

For individuals experiencing more advanced behavioral health issues, including those with serious mental illness (SMI), a more robust system of interventions may be required to prevent psychiatric hospitalization. Most notable among these interventions are crisis services such as crisis hotlines and mobile crisis teams. These services may play a critical role in swiftly addressing the urgent behavioral health needs of individuals in crisis, or at risk of being in crisis, and may successfully divert an individual from a psychiatric hospitalization.

Crisis hotlines are often the first point of contact when an individual is either at risk for or is experiencing a behavioral health crisis as they are easily accessible, and staff can often perform triage services to best address the specific needs of each individual. Washington currently has crisis hotlines operating in nearly all counties. Crisis mental health facilities are equipped to address the acute needs of individuals experiencing a mental health crisis and seek to treat and reduce symptoms and avoid the need for psychiatric hospitalization. Crisis mental health services are currently available in all geographic regions of Washington. However, not all facilities are equipped to handle involuntary admissions, which may pose a challenge when the individual in crisis is determined to need inpatient treatment and is unwilling to submit to this voluntarily. Washington made significant investments to increase crisis mental health facility capacity in the 2013-15 state budget, resulting in an additional 41 beds at four facilities.[2]

Mobile crisis services are available on a much more limited basis in Washington and have until recently been offered solely in King County, although additional funding was recently made available through BHO

[2] Washington State Institute for Public Policy. "Inpatient Psychiatric Capacity and Utilization in Washington State." January 2015. www.wsipp.wa.gov.

contracts to introduce teams in the North Central and Thurston Mason BHO regions. Although costly to implement, mobile crisis services offer a highly effective intervention that utilizes a team of professionals that typically includes interdisciplinary mental health professionals (e.g. nurses, social workers, psychiatrist, psychologist, peer support specialist) and meets individuals in crisis in the community. This approach provides a dynamic and adaptable response to crisis situations and has proven effective at mitigating the need for psychiatric hospitalization. In Minnesota, where mobile crisis response teams are available for adults in all counties of the state, only 11 percent of the 5,000 mobile crisis interventions provided in 2009 resulted in hospital emergency or inpatient treatment.[3]

Another effective intervention for individuals with severe mental illness is the Program of Assertive Community Treatment (PACT), which provides highly intensive community-based support to individuals at high risk of psychiatric hospitalization and/or incarceration. Washington is currently funding PACT teams in all regions of the state with some variation in specific service offerings in each community. Stakeholders indicated that operating full PACT teams has been challenged by a lack of qualified providers in some areas and that a modified version of this model may prove more effective when considering expansion. Although not a formal recommendation, PCG encourages Washington to continue to gauge the effectiveness of and demand for the program to determine any required adjustments to the scope and reach of the program.

Expanding on the existing programs and opportunities described above, the remainder of this section details the specific areas of investment recommended.

| **Recommendation 3:** | **Strengthen acute care episode management and community services to reduce admissions to state psychiatric hospitals. Fund three new mobile crisis teams, two new crisis walk in centers, a 15 percent increase in the number of peer support specialists and a grant program to enhance substance use disorder treatment more broadly into community settings.** |
|---|---|
| **Benefits** | • Increases access for consumers at risk of destabilization to receive timely interventions that may negate the need for commitment to inpatient care<br>• Increases the likelihood that consumers will be served by professionals familiar with them and/or their conditions in their own communities<br>• Encourages greater collaboration among mental health professionals in a community<br>• Better addresses the significant need for integrated treatment of mental health and substance use disorder issues for individuals with co-occurring conditions |
| **Supports** | • Improve early identification and treatment of behavioral health needs<br>• Increase collaboration and redesign system to achieve patient centered care<br>• Establish a robust continuum of care and support for transitions<br>• Increase workforce development and use of best practices to attract and retain staff |
| **Time Frame** | One to two years |
| **Key Gaps** | • Communities may struggle to provide the requisite number and type of professionals to adequately staff teams and facilities<br>• In rural areas of the state, timely intervention may be hindered by distance<br>• Crisis walk-in centers do not currently exist in the state |

[3] "Mental Health Mobile Crisis Response Teams." NAMI Minnesota Fact Sheet. nami-mn@nami.org.

**What it Does**

An effective system of community supports and interventions aims to address mental health issues early on and divert individuals from reaching the point where psychiatric hospitalization is required. As with physical health, mental health care is ideally focused first on prevention. Even for individuals with severe and/or chronic behavioral health needs, services in the community can offer timely and effective care that supports them in managing their condition(s) outside of state hospitals. Washington's behavioral health system places heavy emphasis on community-based treatment. Only roughly one percent of the state's behavioral health patient population will be treated by the state's psychiatric hospital system. This experience in delivering and supporting community-based care can be leveraged to decrease the number of individuals on the psychiatric hospital admissions waitlist, which in turn will relieve the pressure on state hospital bed utilization and enable the state hospitals to focus on patients most appropriately served by them. With this solid foundation, Washington's community-based services have the potential to evolve even further toward a model in which best practices are regularly and widely implemented.

This recommendation calls for augmentation of three community support programs in the current system. The result of these initiatives, working together, will promote strong, effective care management, especially for acute care episodes, and sustained support for individuals after acute care or inpatient services are provided.

1. Continue to expand and refine the use of mobile crisis teams in additional regions of the state, regularly assessing impact on reducing psychiatric hospitalizations and diverting from jails.

The addition of mobile crisis teams in more communities throughout Washington will enable more timely and effective response to individuals in crisis for whom relocation to a facility may prevent successful intervention. The model enables behavioral health professionals with different skill sets to work together to address the needs of the individual in crisis and seek to diffuse a crisis situation before it escalates to a point at which the individual may need to be hospitalized or jailed. Because teams generally are available 24 hours per day, seven days per week and have the mobility to meet the individual at the location of the crisis, they offer a unique and valuable service not currently available in most regions of Washington.

A 2014 report by the Substance Abuse and Mental Health Administration (SAMHSA) outlined opportunities and challenges associated with implementation of crisis services compiled over several years of experience at the state level. Suggested opportunities for strengthening and sustaining operations included the use of peers as part of the crisis team and collaboration with entities including hospitals and emergency departments (ED) to reduce ED wait times and develop alternatives to ED utilization. The report also emphasized the importance of data collection on key indicators, such as response time to calls and percentage of individuals diverted from inpatient hospitalization to improve crisis service delivery.

Although the recent funding to BHOs for new mobile crisis teams will improve access to these services, DSHS identified that there is an additional need of nine teams to serve populations across the state. As a frame of reference, DSHS cited Georgia's population of ten million with a geographic area of 59,000 square miles. Washington has a population of more than seven million with a geographic size of just over 71,000 square miles. Other states also follow this approach of providing mobile crisis services in each of their designated planning regions.

PCG's recommendation is that Washington fund an additional three mobile crisis teams in different areas of the state over the next two years while monitoring and tracking the performance of the existing and newly created mobile crisis teams to gauge their effectiveness at diverting patients from inpatient hospitalization or jail and then refine the geography and/or approach of the teams as needed.

2. Implement crisis walk-in centers in high need, urban areas.

In addition to mobile crisis teams, further availability of diversion services will ensure that an individual experiencing a crisis has multiple touch points in the community to address their needs before the episode requires hospitalization. A service unavailable in Washington is a crisis walk-in center, which allows for individuals to stay up to 23 hours under observation. Services in the center generally include crisis stabilization and intervention, individual counseling, peer support, medication management, education, and referral assistance. States with crisis walk-in centers include Colorado, Michigan, Wisconsin, and Tennessee. States vary in the hours of operations of the centers as some are 24 hours, seven days a week and others operate during standard business hours.

In SAMSHA's report on crisis services, crisis walk-in centers or similar programs have been shown to be effective in lowering the rate of hospital admissions.[4] The hypothesis behind lower rates of hospital admissions is that short observation time drives quick decision making and referrals to outpatient programs. Furthermore, the individual in crisis is likely more willing to accept programs that are immediately available and to agree to participate in referred programs or accept treatment services.

PCG recommends that Washington introduce crisis walk-in centers in two high population areas over the next two years, monitor their effectiveness and then consider expansion into more counties. One crisis walk-in center should be located in King County to address the high level of need. This recommendation aligns with a similar recommendation in the Community Alternatives to Boarding Task Force (CABTF) Report. Other BHO areas identified by DSHS as suitable for establishment of a crisis walk-in center are Pierce, Spokane, Clark, Yakima, and Snohomish. Some states have crisis walk-in centers mainly in urban areas, while others choose to have one in each planning region specific to the state. PCG recommends that the identification of areas for placement of crisis walk-in centers and mobile crisis teams be coordinated so as to maximize coverage and avoid potential duplication of crisis services

3. Fully integrate substance use disorder (SUD) and mental health disorder treatment, including increased funding for peer specialists.

The integration of SUD and mental health treatment represents a top priority for the system as a whole. Because individuals with comorbid mental health and substance use disorders present higher risk of destabilization and inpatient hospitalization, each condition must be treated in the context of the other and provided by a care team that understands the effects and impacts of comorbidity. SUD and mental health treatment integration in multiple settings throughout the care continuum increases the likelihood that high risk individuals are treated consistently and continually through a person-centered approach.

[4] Substance Abuse and Mental Health Services Administration. Crisis Services: Effectiveness, Cost-Effectiveness, and Funding Strategies. HHS Publication No. (SMA)-14-4848. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014.

According to BHO staff interviewed by PCG, achieving service integration in Washington has been challenged by state licensing regulations that had maintained the former partition between mental health and SUD as different delivery systems. As of July 2016, changes to the requirements for attaining dual licensure as a mental health professional aim to improve this system.

To address the need for reform toward service integration at the provider level, PCG recommends that Washington implement a grant program focused on SUD integration with mental health services. The grant, available directly to community providers, would support training of existing staff and recruitment of integrated SUD specialists to transform their community practices. By making funding available directly to providers, Washington can match the needs of providers in the process of SUD integration and increase the availability of peer specialists focused specifically on comorbid treatment.

PCG also recommends that Washington further increase funding (through BHO/MCO capitation rate increases) to achieve a 15 percent increase in the number of peer specialists incrementally over the next three years (five percent per year) to reduce caseloads and maximize impact. Peer specialists are a particularly effective addition to SUD integrated treatment teams because of their flexibility in supporting individuals in various treatment settings and at different stages of recovery. Augmenting funding for peer specialists also supports the expansion of PACT teams, as described earlier in this section. BHOs and MCOs are contracted to provide peer support services and recently received additional state funding to expand the peer bridge program for patients transitioning from inpatient psychiatric hospital care. Stakeholders indicated that high peer bridge caseloads in some areas may prohibit evaluation of the program's efficacy. The effect of this recent funding addition on reducing caseloads and improving outcomes should inform future funding allocations in this area.

**Gaps**

The gaps identified below identify specific areas where Washington may encounter challenges and/or require change for the implementation of this recommendation. However, these are manageable gaps and, if addressed, will result in a community support structure that further decreases the number of individuals served in Washington's psychiatric hospitals.

Regarding mobile crisis teams, barriers to implementation typically encountered include geography and securing sufficient personnel to staff teams. A potential option to meet need in rural areas or areas with an insufficient number of qualified professionals is to incorporate a telehealth component to crisis services. A "face-to-face" interaction still occurs with a mental health professional or peer support specialist while other team members are physically present with the individual to offer in-person support and facilitate the interaction.

For crisis walk-in centers, Washington faces an experience gap in that the state has not implemented such a program before and has no known in-state model. However, many states have successfully set up these centers including the nearby states of Oregon, California and Colorado, some of which may serve as a model from which Washington may adapt best practices to fit the needs of its population. Additionally, Washington will need to determine whether an existing facility may be leveraged for this purpose and how it will be operated. The CABTF Report offers some insight and recommendations in this regard.

Regarding the block grant funding for SUD integration, PCG does not recognize any significant gaps to implementation, particularly due to the flexible nature of the funding structure. Peer specialist certification

processes are currently being updated to ease the burden to providers. Implementation of this program will require coordination with these efforts as well as increases in training availability across the state.

### 5.2.2. Inpatient Care Outside of the Existing State Hospital System

Those patients for whom diversion and crisis mitigation are not successful may require inpatient treatment. Two study questions related to inpatient treatment are concurrently addressed in the following section:

"Which populations are most appropriately served at the state psychiatric hospitals?"

"What are the barriers to timely admission to the state hospitals of individuals who have been court ordered to ninety or one hundred eighty days of treatment under RCW 71.05.320?"

Despite much progress in developing community-based alternatives to hospital care, there remains a portion of individuals for whom institutional care is the appropriate treatment at certain times. As noted in Washington's Involuntary Treatment Act, an involuntary treatment detention may be initiated if an individual is determined by a designated official to be gravely disabled or poses a danger to self or others as a result of a mental illness. Within this definition, however, there exists a range of patient demographics and treatment needs.

Individuals deemed appropriate for state hospital care have been determined not appropriate for treatment in a community setting, typically due to behavioral issues and in accordance with the criteria specified above. In many cases, general hospitals with psychiatric units "may be reluctant to admit individuals that pose a serious risk of violence towards others, appear difficult to discharge, or display inappropriate sexual or other problematic behaviors that would place other patients or staff at risk."[5] This small number of hard-to-serve patients reflects the appropriate use of civil beds in the state hospital, aligned with best practices and peer state operations. These patients may require long term psychiatric hospitalization to stabilize, and greater capacity at the state psychiatric hospitals typically means that they are better equipped to accommodate these patients than smaller, community based facilities whose patients generally experience shorter stays.

The other significant – and growing – population served by the state psychiatric hospitals are forensic patients that have been mandated by the courts to undergo evaluation, treatment and/or long term commitment as a result of criminal activity. The state hospitals are well equipped to handle the needs of these patients within designated, secure hospital units. Capacity continues to present challenges, as evidenced by the 2014 Trueblood lawsuit and ensuing actions by Washington to make available additional beds in the state hospitals and open two new facilities to provide competency restoration services. Due to the continued demand for forensic services and the need for secure placements for these individuals, the forensic population should continue to be a primary focus for the state hospitals in terms of populations served. Within that context, it is important to note that forensic patients also present with a wide range of treatment needs. Although forensic patients are typically treated in state hospital settings, there is variation in the structure of forensic facilities nationally. The Whiting Forensic Division of Connecticut Valley Hospital has received praised from advocates for its design and staffing model, which operates physically separate units for misdemeanor and felony

[5] William H. Fisher, Jeffrey L. Geller and John A. Pandiani. "The Changing Role of the State Psychiatric Hospital." *Health Affairs* 28, no. 3 (2009): 676-684.

patients. Whiting's staffing model emphasizes the use of experienced clinical personnel with security staff managing entrances and having minimal direct contact with patients.

Currently, Eastern and Western State Hospitals serve a civil population that extends beyond the hard-to-serve patients described above. In serving large and diverse patient populations, the state hospitals at times lack the capacity and staff to adequately address the full range of treatment needs that may be associated with civilly committed patients. The following recommendation creates an alternative inpatient treatment model that aims to minimize the state hospital civil population.

| **Recommendation 4:** | **Establish six new 16-bed community hospitals for civil commitments and transitional acute psychiatric care needs to promote regional care and the potential for an emphasis in specialty care for co-morbid conditions.** |
|---|---|
| **Benefits** | • Allows the existing state hospitals to focus more on forensic patients and hard to serve civil patients<br>• Enables more patients to be treated close to their home communities and support systems<br>• Creates facilities designed to address the particular needs of a region or particular co-occurring conditions<br>• Allows for capture of Medicaid funding to offset state costs |
| **Supports** | • Refining the role of state hospitals to serve the right patients in the right environment<br>• Increase collaboration and redesign system to achieve patient centered care |
| **Time Frame** | 3-5 years |
| **Key Gaps** | • Need for capital funding and processes to support the design and development of new facilities<br>• Review of existing community capacity and plan to accommodate population<br>• Adjustments to the orders issued by the Involuntary Treatment Act (ITA) Courts to allow greater placement flexibility |

Among other states, approaches to refining or overhauling the state hospital system have taken on different forms. As mentioned above, peer states such as Colorado and Oregon have focused on streamlining state hospital operations into two facilities each with a focus on serving forensic populations and a smaller subset of complex and/or hard-to-place civil patients. In Minnesota, a multi-year effort to reduce the number and size of large state hospital facilities was achieved largely through the development of several smaller, 16-bed community behavioral health hospitals designed to serve as an alternative to the state hospital for civil commitments as well as a transitional facility for patients requiring shorter term acute psychiatric care. The development of these smaller facilities, all of which are certified by the Centers for Medicare and Medicaid Services (CMS), has enabled more regional, specialized care for patients while keeping them closer to their home communities during inpatient treatment. At the same time, the 16-bed size of the facilities means that they are not classified as Institutions for Mental Disease (IMDs) by Medicaid, thereby enabling Minnesota to capture reimbursement dollars for Medicaid patients served in those facilities. PCG recommends that Washington adopt an approach similar to the Minnesota model.

**What It Does**

The development of 16-bed community hospitals will allow Washington to provide acute psychiatric inpatient care in regional settings, thereby addressing the needs of more patients in a setting closer to one's home. Rather than requiring that all civilly committed patients be sent to Western or Eastern State Hospitals for

treatment, this model creates alternative options for patients with less complex needs to be served in a regional facility.

PCG recommends that Washington establish six new regional psychiatric hospitals over the next three years, four in Western Washington and two in Eastern Washington. Similar to the Minnesota model, these 16-bed facilities would be equipped to accept involuntary civil commitments but could also serve as a placement option for step-down care from the existing state hospitals that would enable patients to transition back to their home regions while still receiving acute inpatient care on a short-term basis. In Minnesota, community behavioral health hospitals also accept patients on emergency or judicial hold orders as well as a small number of voluntary admissions, and Washington might also consider using the new facilities for this purpose as deemed necessary and appropriate based on existing community capacity. In stakeholder visioning sessions, the prospect of having beds available for voluntary admissions was mentioned several times as having potential to stabilize individuals in the community and prevent psychiatric crises and/or civil commitments.

The 16-bed community hospitals would be equipped to provide a range of treatment services to individuals with serious mental illness comparable to what is available in the state hospitals, such as assessment of health needs, person centered treatment planning, medication management, nursing care and individualized discharge planning. Additional areas of specialization should be determined through community needs assessments, stakeholder sessions and other data gathering processes. For example, a region heavily affected by substance use disorder issues may indicate a preference specialized services addressing this need to be available within the facility, even for a limited number of beds. Other specialized care might address needs related to particular complex medical conditions, traumatic brain injury and/or dementia care. The community-based nature of the facilities would likely allow for greater collaboration with community service providers to address a broad range of patient needs as well as specialized care for specific conditions.

The expectation is that these smaller facilities would be recovery focused and typically handle shorter lengths of stay, averaging 20 days, although no established cap on the number of days a patient could remain in the facility would exist. During that time, the hospital would provide acute care in conjunction with the patient's needs while preparing the patient to step down to a less acute level of care, whether it be a community placement or return to the patient's home.

On the above point, it is important to clarify that these facilities would not be designed to handle all types of civil commitments. Unlike the existing state hospitals, these facilities would not be equipped to handle the needs of individuals with violent or aggressive behaviors, nor would they be ideal for individuals requiring long lengths of stay (180 days or more). Washington statute currently allows for civil commitment terms of 14, 90 and 180 days. Although the proposed facilities would be primarily designed to address shorter lengths of stay, they would likely be able to handle the needs of certain patients beyond that time frame provided that recovery and/or readiness for community placement is reasonably expected to be achieved within several days or weeks. With this in mind, having an intermediate option between 14 and 90-day commitments would help facilitate civil commitment placements. Hence, as a subcategory of this recommendation, PCG suggests that Washington consider a 45-day commitment term for civil patients who have completed a 14-day stay but require additional inpatient care prior to discharge.

**Gaps**

Constructing, rehabilitating or reconfiguring facilities to create new hospitals is a significant undertaking that will require large scale investment of funds and stakeholder engagement on many levels to implement

successfully. To adequately plan for the proposed facilities and develop the treatment program, the state should implement a robust regional stakeholder input process as soon as possible to begin engaging key community partners and identifying more concrete needs regarding acute inpatient psychiatric care. Information gathered may then be compiled and shared broadly to determine where the greatest need and potential for system transformation exists.

In certain regions, securing adequate staffing for these new facilities may prove challenging so the community needs assessment process should take into consideration workforce demographics in the areas identified for potential placement of a new facility. In addition to staffing the hospital, consideration should be given to the availability of providers and services in the community that could directly or indirectly support hospital operations, including on a contractual and/or as needed basis.

Although the construction or renovation of 16-bed facilities will require significant capital outlays, these costs should be considered relative to capital improvements that would be required to modernize buildings at Western State Hospital as well as to-be-realized savings in operating costs as a result of being able to leverage Medicaid dollars for patients at the new facilities.

### 5.2.3. State Hospital Care

As noted above, a subset of the population will still be served by the current state hospital system, primarily focused on forensic patients with a small civil population composed of hard-to-serve patients. With respect to serving the state hospital population, one study question asked the following:

"What are the potential costs, benefits, and impacts associated with dividing one or both of the state psychiatric hospitals into discrete hospitals to serve civil and forensic patients in separate facilities?"

The concept of organizing the state psychiatric hospitals to discretely serve forensic and civil patients in separate facilities has some precedent nationally. For example, Colorado has two state-operated psychiatric treatment centers. The Colorado Mental Health Institute at Pueblo serves primarily forensic patients and the Colorado Mental Health Institute at Fort Logan Denver serves civil patients. The ability to target staff training and qualifications to one population represents one potential benefit of such a system.

However, based on stakeholder input and the proposed redesign efforts within this report, the benefit of this programmatic change for Washington likely does not outweigh the disruption it would cause to the current system. The recommendations proposed in this report call for systematic reduction of the civil population served by the state hospital system. The volume of the remaining population would not justify separating the state hospitals by civil and forensic status because the vast majority of the population will be forensic. Further, the current system of operating two facilities, one in eastern and one in western Washington, theoretically allows individuals to stay relatively close to home, enabling visitation from family and friends. Switching the institutions to provide care for only one patient type would effectively end the regional care system.

Although there are numerous concurrent efforts to examine specific aspects of hospital operations outside of this study, the recommendation that follows proposes two program enhancements that are pertinent to a largely forensic population.

| Recommendation 5: | Reform state hospital programming to include substance use disorder integration and peer support |
|---|---|
| **Benefits** | • Improved outcomes for comorbid patients<br>• Reduced risk of readmission and recidivism post discharge<br>• Reduced length of stay for inpatient treatment |
| **Supports** | • Increase collaboration and redesign system to achieve patient centered care<br>• Increase workforce development and use of best practices to attract and retain staff |
| **Time Frame** | 18-month implementation and initial evaluation |
| **Key Gaps** | • Expanded multi-disciplinary teams<br>• Staff training<br>• Community placements |

**What it Does**

The above recommendation calls for both integration of substance use disorder (SUD) treatment and the addition of peer supports to the treatment team. With respect to SUD treatment, national data indicate that approximately 24 percent of individuals diagnosed with serious mental illness experience co-occurring substance use disorders.[6] Stakeholders interviewed for this study indicated that this prevalence may be as high as 40 to 60 percent for patients admitted to a state hospital in Washington. For these patients, substance use disorder treatment at the state hospitals was described as largely episodic, managed by outside vendors, and focused on group therapy. The above recommendation intends to align state hospital treatment protocols with a significant body of research supporting consistent and specific integration of substance use disorder and mental health treatment.[7] Integration aims to treat substance use disorder in the context of the patient's mental health and other behavioral disorders, using treatment modalities specifically designed for individuals with conditions such as schizophrenia, bipolar, and major depressive disorders.

The Substance Abuse and Mental Health Services Administration (SAMHSA) identifies improved psychiatric symptoms and functioning, decreased hospitalization, increased housing stability and improved quality of life among the benefits of integrated treatment. Such benefits are pertinent to the forensic population, which is more likely to present with SUD than the civil population. Importantly, the forensic populations of most state hospitals represent a wide range of offenders that may require vastly different lengths of stay. Incorporating SUD treatment can better prepare forensic patients for their eventual reentry into the community. Maximizing such benefits also calls for discharge planning to specifically address the patient's ongoing substance use treatment needs, helping them to maintain recovery through long term community-based treatment. [8] Integration and augmentation of SUD treatment in community services to support continued recovery is addressed in previous sections of this report.

Additionally, PCG recommends that Washington initiate a pilot program placing peers within the state hospitals to support patient needs well before the time of discharge and ideally close to the time of admission. Peer support specialists within the hospitals can serve as an effective role model for patients in that they embody the recovery principles to which state hospital patients can aspire. Peers can also share their hospital discharge and outpatient experiences, helping to prepare patients for what they will experience on reentering

[6] Substance Abuse and Mental Health Services Administration: National Survey on Drug Use and Health. 2015.
[7] Kelly, T. and D. Daley. 2013. Soc Work Public Health. 28(0).
[8] SAMHSA Integrated Treatment for Co-occurring Disorders Evidence Based Practices Kit. Published January 2010.

the community. Their connection to patients through shared experience also provides an important lever with which to encourage patient compliance with treatment and hospital staff in general, potentially reducing the incidence of violence in the hospital. For the initial phase, it is recommended that Washington fund 11 peers at Western State Hospital and four at Eastern State Hospital, serving 15 percent of the current patient population. Metrics related to discharges, community placements and long term placement/readmission data should be evaluated over time to determine the effectiveness of the program.

Although peer support programs within state hospitals are rare, Washington can look next door to Oregon for information about an operational model: as part of its overhaul of the state hospital system over the past decade, Oregon created a Peer Recovery Services Department at its Salem facility. Additionally, in Washington, peer services are currently available to clients in inpatient psychiatric settings at Navos and Harborview hospitals.

**Gaps**

Based on the information gathered during this study, three main gaps must be addressed to implement this recommendation. First, implementing true integration of substance use disorder and mental health treatment will require expansion of multidisciplinary treatment teams to include specialists trained in integrated treatment and peers who have maintained recovery from both substance use disorder and mental health symptoms. The specific makeup of these teams should be determined through coordination with each of the contractors currently reviewing the state hospital's staffing model and workforce development needs. However, a sample staffing structure may include a program director to lead development and oversee implementation and evaluation efforts, a nurse practitioner assigned to each hospital to lead implementation, and integrated substance use counselors and peer specialists to provide treatment. The peer pilot will also require identification and certification of additional peer specialists to incorporate into the treatment team for non-SUD patients.

Second, additional training for all staff members will focus on improving identification, documentation and monitoring of substance use disorder symptoms and treatment efficacy. Stakeholders indicated that the actual prevalence of substance use disorder is likely higher than reported, and thus the benefit of integrated treatment is limited by the ability to successfully diagnosis, treat, and monitor patients with co-occurring conditions. Training during the first two years of the program should be supported by a full time facilitator as well as funding for course materials and conference or other outside educational program attendance.

Third, as addressed in previous sections of this report, implementation will require building community capacity to support continued recovery for comorbid patients. Stakeholders pointed to a lack of substance use disorders programs in many communities, specifically residential placements providing substance use disorder supports. Mitigating the risk of readmission and relapse requires long term commitment to treatment. Investment in community resources, combined with active case management and transition support, will be critical to improving outcomes for these patients.

### 5.2.4. Barriers to Discharge and Community Residential Placements

Regardless of whether the patient is discharged from a 16-bed facility or a state hospital, effective hospital discharge and transition requires a clear and coordinated process to place patients in appropriate community settings. The first study question addressing this area asks:

"How can barriers to discharge be reduced or eliminated?"

Best practices emphasize that discharge planning should begin at admission, working with the patient to identify specific goals and create a clear pathway by which the patient may return to the community. In line with this practice, DSHS psychiatric hospital discharge policies are specific to patient populations, each identifying a timeline for discharge planning. Washington's contracts with the current BHOs also define the role of the BHO Medical Director to include utilization reviews to assure proper use of discharge planning guidelines. Additionally, Western State Hospital and Eastern State Hospital each provided their standard operating procedures requiring discharge planning to being at admission.

However, with respect to how discharge planning is executed, our analysis found significant variation among civil discharge readiness assessments and planning procedures at the state hospitals. Although the civil population is expected to be reduced as a result of implementing system reforms, processes impacting discharge should be reviewed and standardized across the state hospital system to ensure consistent use of best practices.

The most significant barrier to discharge identified during this analysis was a lack of appropriate residential placements accepting publicly funded patients. Two additional study questions address this discharge barrier:

"Does discharge of patients take into consideration whether it is appropriate for the patient to return to the patient's original community considering the location of family and other natural supports, the availability of appropriate services, and the desires of patients?"

"Is a lack of resources in a patient's home community a significant factor that causes barriers to discharge or frequently results in relocation of patients outside their home communities for post-hospital care?"

Although the study questions were designed with a focus on state hospitals, any patient who is ready for discharge from an inpatient setting but requires a residential placement will depend on the availability of such beds in their community. The following recommendation aims to address this need.

| **Recommendation 6:** | **Align community placements with civil discharge needs by (1) establishing a transitional supportive housing administrator; (2) creating a temporary Office of Behavioral Health Housing Initiatives to facilitate collaboration of capacity investment pools; and (3) establishing expanded responsibility for selected state hospital transitions and management practices to ALTSA and DDA.** |
|---|---|
| **Benefits** | • Alleviates discharge bottlenecks by aligning community resources with housing<br>• Facilitates the success of supportive housing integration with managed care in 2020<br>• Assures capacity investment funds complement each other<br>• Strengthens responsibilities for transitions from the state hospitals<br>• Strengthens responsibility for management of persons with developmental disabilities |
| **Supports** | • Increase collaboration and redesign system to achieve patient centered care<br>• Establish a robust continuum of care and support for transitions |
| **Time Frame** | • Implement benefit administrator 7/1/17<br>• Create Office of Behavioral Health Housing Initiatives 1/1/17 |

| Recommendation 6: | **Align community placements with civil discharge needs by (1) establishing a transitional supportive housing administrator; (2) creating a temporary Office of Behavioral Health Housing Initiatives to facilitate collaboration of capacity investment pools; and (3) establishing expanded responsibility for selected state hospital transitions and management practices to ALTSA and DDA.** |
|---|---|
| **Key Gaps** | • Bridges gaps in development of supportive housing provider capacity and benefit<br>• Bridges gaps in disparate capacity-building investment funds |

### What it Does

*Transitional, Statewide Supportive Housing Benefit Administration*

The state's recent 1115 waiver contains a supportive housing benefit of five hours per year per individual. When the waiver was developed during 2014-2015 there were approximately 7,500 persons eligible for the waiver's supported housing benefit of which an estimated 3,000 would use the benefit. However, because of the expansion of Medicaid eligibility, 2016 data indicates there are now 15,000 persons eligible for the benefit.[9]

The benefit is intended to provide specialized housing assistance and must be spent efficiently since only five hours per individual are provided. PCG is concerned that behavioral health organizations lack experience with providing housing assistance and may not be the most effective contractors of such services. Moreover, placing the funds for this benefit in the capitation rate of the behavioral health organizations may dilute or dissipate the benefit.

For these reasons, although PCG strongly supports full integration of behavioral health into managed care by 2020, we recommend the state retain a separate, statewide supportive housing care manager to effectively establish and administer the benefit for the first 30 months. Once capacity is built, supportive housing would fully integrate with Medicaid managed care organizations on January 1, 2020. This entity would work with HCA and DSHS to:

- Establish supportive housing provider licensing requirements.
- Recruit providers in alignment with state needs.
- Identify supportive housing provider network adequacy standards.
- Assure that supportive housing benefit dollars are exclusively used for that purpose and are not part of a broader capitation rate during this transitional period.
- Assist Medicaid regional MCOs with the development of their provider networks, contract standards and service agreements to facilitate integration of supportive housing benefits into Medicaid managed care in 2020.
- Provide a single point of reference and information source for capacity building infrastructure initiatives to coordinate with the ongoing supportive housing benefits delivery.

[9] See January 2016 report of the Homeless Management Information System at http://www.commerce.wa.gov/wp-content/uploads/2015/11/hau-hmis-snapshot-homelessness-1-2016.pdf

Although PCG acknowledges that any recommendation cutting against full integration managed care might raise concerns, we believe the temporary assignment of this benefit to a third-party administrator will eventually assure the success of MCO-led supportive housing in 2020.

*Create a Temporary Office of Behavioral Health Housing Initiatives*

This new office would be carefully staffed to work within the authority of HCA or DSHS. The office will function to assure collaboration between the two agencies and the Department of Commerce and be informed by a clear set of objectives from the Governor and Legislature. To accommodate this need, the temporary office would be co-led by the directors of HCA and DSHS and would not require staff or office space independent of the two agencies. Existing staff resources that work on behavioral health housing can be repurposed. However, the office would have a clear set of directives to accomplish through December 31, 2019.

These duties will be aimed at facilitating linkages among disparate behavioral health community bed capacity-building efforts. PCG is already aware of multiple funds that may be considered for use in building this capacity, as discussed in Section 5.1.2. Governance of these funds is established independent of the creation of this office. Governance of Mental Illness and Drug Dependency (MIDD) will reside at the county level and terms for use of the DSRIP fund will be established in special terms and conditions agreed to by HCA and DSHS, and is likely to fund a variety of transformation needs. The creation of this Office of Behavioral Health Housing Initiatives (OBHHI) does not challenge or impede that governance structure. OBHHI's sole aim would be to provide a point of reference and set of benchmarks that permit these separate initiatives to be greater than the sum of their parts through a coordinated development effort.

Duties of the Office would include:

- Providing a statewide perspective on behavioral health capacity building needs for use by Accountable Communities of Health under Initiative One of the Medicaid Transformation Demonstration.
- Mapping DSHS identified needs for state psychiatric hospital discharge residential placements against existing facility types, Medicaid benefits and eligibility categories with particular effort placed on the spectrum of Medicaid residential support benefits across both supportive housing and long term care categories.
- Retaining a statewide inventory of community beds by bed type.

A major finding of PCG's mental health system assessment for Washington was the existence of discharge bottlenecks that prevent residents of state psychiatric facilities from leaving the hospital when they are deemed ready. We believe a highly coordinated effort to establish community bed capacity and help individuals transition from the hospitals provides an effective solution to this problem.

Currently, individuals with intellectual and developmental disabilities (ID/DD), as well as individuals over the age of 65 and persons with a physical disability, who have complex medical and behavioral needs, such as dementia, acute and chronic medical conditions, criminal backgrounds and unstable behaviors, are multi-agency clients. Multiple agencies are involved in their discharge and every agency is dependent on the actions of other agencies. Discharge delays occur as discussions among agencies take place to decide who pays for the community services. Interviews with stakeholders and a review of state hospital discharge documentation indicates that discharge delays for these individuals can extend for weeks to months.

*ALTSA should assume expanded responsibility, but not financial risk, for helping their clients transition from the state hospitals.*

PCG was tasked with considering methodologies that placed ALTSA at risk for the state hospital utilization of individuals who receive ALTSA services. Under this recommendation, ALTSA will assume expanded responsibility for aiding their clients to transition from the state hospitals into the community. This responsibility would begin before hospital staff deem an individual ready for discharge. To the extent possible, this responsibility would specifically include individuals whom the Comprehensive Assessment Reporting Evaluation (CARES) assessment instrument would deem ineligible for Medicaid-paid waiver services because of low activity of daily living (ADL) needs. However, ALTSA should not be placed at financial risk since it is difficult to hold an entity accountable for state hospital utilization when it cannot determine that someone is eligible for state hospital care and does not determine when someone is medically ready for discharge from the hospital.

One factor contributing to discharge delays from the state hospitals is the lack of a single entity responsible for the discharge. For example, successfully placing a patient in an Adult Family Home would involve both state hospital staff and BHO staff to secure the placement while ALTSA staff ensure Medicaid eligibility. Who pays the provider and how much is paid must also be determined among multiple agencies. Additionally, case management, to the extent currently provided, may fall under the purview of a different community mental health provider. This recommendation reassigns primary responsibility to ALTSA to improve the flow of patients through the hospitals and directly address the discharge delays of multiagency clients.

To effectively carry out this responsibility, ALTSA should be allowed to conduct functional assessments of all individuals identified as potential ALTSA clients to understand earlier in the process what the personal care and skilled nursing care needs of the patient will be in the community and what kind of mental health supports the individuals will need. Waiting until the hospital determines someone is eligible for discharge significantly increases the time it takes to find appropriate community placements.

42 CFR §440.180(b)(8) permits states to provide mental health services under a waiver to persons who need such services. The state may wish to consider adding additional mental health services to its 1915(c) waiver operations should the authority be needed temporarily in situations where managed care organizations are not making timely transitions.

The implementation of integrated, person-centered care may require ALTSA to stretch beyond its normal operating philosophies and arrange for modest targeted mental health services to its clients when other sources are not able to provide services needed by its clients.

To carry out its expanded responsibility, ALTSA staff report they may need four case managers to work directly with clients during the transition phase and case manage in the community as well as two additional FTEs dedicated to performing assessments of all potential ALTSA clients when they are admitted to the local geropsychiatric hospital or one of the state hospitals.

There are approximately 138 individuals a year aged 65 and older who are annually transitioned out of the state hospital's geropsychiatric wards. ALTSA staff report that approximately one third of their clients are under the age of 65, implying that there are approximately 70 younger individuals with physical disabilities who require ALTSA's transition support out of other hospital wards. This activity is likely cost effective since the state is unlikely receiving federal match for younger individuals in the state hospitals but can potentially

receive federal match in a community placement. ALTSA should track the cost effectiveness of its efforts in this area.

*The Developmental Disabilities Administration (DDA) should assume expanded responsibility for individuals with intellectual and developmental disabilities (ID/DD) who are in the state hospitals.*

PCG was tasked with considering methodologies that placed DDA at risk for the state hospital utilization of individuals that received DDA services. DDA should have expanded authority to manage transitions from hospitals and review each individual with ID/DD in the state hospitals before the individual is deemed ready for discharge. This recommendation aims to address three main areas of opportunity described below.
First, discharge outcomes for individuals with developmental disabilities can be improved. Interviews with stakeholders and a review of state hospital discharge documentation indicates that discharge delays for these individuals can extend for prolonged periods. The current average length of stay at Western State Hospital for an individual with ID/DD is slightly less than two years, almost twice as long as the average stay for other individuals. At Eastern State Hospital, the average length of stay is four times greater.

An examination of the length of stays of individuals in the geropsychiatric and ID/DD wards reveals that in each hospital, of the ten to 12 individuals in these wards who have stayed in the hospital the longest length of time, approximately half of the individuals have ID/DD even though there are four times as many geropsychiatric beds. There are three persons at Western State Hospital with ID/DD who have been on inpatient status eight to nine years and three who have remained in the hospital 21 to 25 years. One individual with ID/DD had remained at Eastern Hospital for 28 years.

Second, DDA may be able to improve transition outcomes by reviewing each individual with ID/DD in the state hospitals who has stayed longer than two years. There are currently five such individuals at Eastern State Hospital and 15 at Western State Hospital. In general, DDA should have the authority to review the status of individuals with ID/DD before the individual is deemed ready for discharge by hospital staff.

DDA currently provides services to approximately 20,000 individuals in the community.[10] The leadership and experience of DDA staff and a vigorous effort to improve transitions will likely reduce the average length of stay and the number of persons with long lengths of stay. For example, the 83 discharges of individuals with ID/DD at Eastern State Hospital during 2012-2016 were generated by 55 unique patients, implying that approximately 30 persons were discharged more than once. DDA could potentially reduce this turnover were it more closely involved in transition planning.

Third, there may be cost savings from a more efficient operation of the developmental disability wards in the hospitals. There is currently no financial incentive for the hospital to discharge persons with ID/DD from the hospital. Combined, the two hospitals are discharging approximately 35 individuals with ID/DD a year. In fiscal year 2015, the cost for a resident in the habilitative mental health ward was $1,251 per day at Eastern State Hospital and $653 a day at Western State Hospital. To the extent that individuals on these wards are between the ages of 21 and 65, it is possible that no federal match can be claimed on their costs while in a state psychiatric hospital. However, when DDA successfully transitions an individual, a 50 percent federal

[10] http://leg.wa.gov/Senate/Committees/WM/Documents/ICE%20docs/2016%20Briefing%20Book_Final_online.pdf

match may then be claimed for their community treatment costs. DDA should track the cost effectiveness of its efforts in this area.

### Gaps

Creating long-term community residential placements for individuals ready to be released from civil commitment must be a pillar of reform for Washington's mental health system. The need is well documented. DSHS has estimated the following placement need types for the state psychiatric civil population based on discharge categories from July 2016.

**Table 4. Post-Hospitalization Patient Placements and Current Waitlists**

| Placement Need Type | Current Census | Waitlist Census | New Commitments (each month) | Total |
|---|---|---|---|---|
| Total patients | 721 | 83 | 87 | |
| Community or state-run small hospital bed | 36 | 4 | 4 | 45 |
| Enhanced Service Facility | 72 | 8 | 9 | 89 |
| Adult Family Home | 180 | 21 | 22 | 223 |
| Skilled Nursing Facility | 94 | 11 | 11 | 116 |
| Adult Residential Treatment Facility | 151 | 17 | 18 | 187 |
| Shared Supportive Housing | 87 | 10 | 10 | 107 |
| PACT Housing | 7 | 1 | 1 | 9 |
| DD Housing (SOLA) | 43 | 5 | 5 | 53 |
| Sex Offender Housing | 7 | 1 | 1 | 9 |
| Independent (e.g. apartment, family home) | 43 | 5 | 5 | 53 |

Data Source: Washington Department of Social and Health Services

Alleviating discharge bottlenecks requires alignment of outpatient and residential facilities with these identified placement needs. Several capacity building and benefit reform initiatives are already in progress. Based on our research, PCG believes these initiatives are at risk of being implemented in an uncoordinated fashion and will, therefore, miss a historic opportunity to meet community mental health residential placement needs.

Through its Medicaid Transformation Demonstration, Washington will establish a new supportive housing Medicaid benefit - where medically necessary - for specific eligibility groups. This benefit is anticipated to begin mid-2017 and is also anticipated to be administered by Behavioral Health Organizations, Managed Care Organizations and the Aging and Long Term Support Administration.

The supportive housing benefit includes a set of services that help individuals – and most significantly, individuals with behavioral health conditions – establish and maintain residence in the community. This benefit may involve tenancy supports such as assistance in applying for housing, help acquiring furnishings and moving in as well as landlord relationship management. Housing case management supports may include, but not be limited to, independent living skills coaching, coordination with health care providers and transportation to appointments.

Supportive housing parallels similar residential community services under Medicaid for more traditional long term care populations with physical health limitations that require Activities of Daily Living (ADL) support. Indeed, establishing the full spectrum of placement types identified by DSHS reaches across both supportive housing and long term care benefits as well as categories of Medicaid eligibility.

Supported housing, housing in the community, and the expanded roles of ALTSA and DDA need to be addressed in a coordinated and organized manner that captures and controls the complexity of housing-related issues.

### 5.2.5. Supporting Continuity of Care and Transitional Care

Across the entire continuum of care, from initial community treatment through inpatient hospitalization and transition back to community settings, the patient should feel connected to their treatment and supported by a coordinated system of providers. Therefore, this subsection will address the study question:

"How can efforts best optimize continuity of care with community providers, including but not limited to coordination with any community behavioral health provider or evaluation and treatment facility that has treated the patient immediately prior to safe hospital admission, and any provider that will serve the patient on discharge from the state hospital?"

Recovery is seldom achieved through a single episode of care. Treatment, rehabilitation and support services should not be offered through serial episodes of disconnected care offered by different providers. Instead, a carefully crafted system must be established to ensure continuity of the person's most significant therapeutic relationships and supports over time and across episodes and agencies. As discussed in Section 5.2.1., this system includes a strong network of community-based interventions such as crisis outreach and stabilization services in addition to basic needs resources such as housing and transportation, so that patients have a safe and stable place to transition out of the hospital where wraparound and support service providers are available.

The transition period between care settings is the most vulnerable time for patients, especially for those individuals with the highest needs. Fragmentation in the healthcare system often leaves the patient to navigate a complicated system without adequate support. For example, an extended stay at a hospital can terminate a patient's other benefits, such as their financial entitlements, mental health tier for services at an outpatient community provider and even their subsidized permanent housing (which can be terminated after an absence of 90 days). An individual who benefits from a mental health case manager and lives in permanent supportive housing in the community could risk losing both of those resources if he or she stays in the hospital too long. Thus, the system must work to minimize the need for inpatient hospitalization while tracking the patient's ongoing needs and risks over time.

Washington is already taking steps toward providing a fully integrated healthcare system that offers a comprehensive array of health services by 2020. Building a robust behavioral health continuum that guides and tracks patients over time, and through services that span all levels and intensity of care, aligns with this goal. This subsection proposes three recommendations that aim to jump start this reform across the system and support transitions between treatment settings.

| Recommendation 7: | Develop new, regional care coordination models to follow rising and high risk patients throughout the care continuum, including those with significant mental health and substance use disorder needs. |
|---|---|
| **Benefits** | • Supports and monitors higher risk patients to promote compliance with the treatment plan and prevent escalation.<br>• Reduces length of stay in inpatient settings for higher risk populations.<br>• Serves patients in their communities in a coordinated and cost effective manner |
| **Supports** | • Establish a robust continuum of care and support for transitions<br>• Increase collaboration and redesign system to achieve patient centered care |
| **Time Frame** | All components of the recommendation implemented within 18 months |
| **Key Gaps** | • A system to accurately track target individuals in real time will be required<br>• BHO contract language must be updated<br>• Responsibilities of two state entities (ALTSA and DDA) must be adjusted |

### What it Does

This recommendation establishes a new regional model of comprehensive care and case management across the care continuum, organizing existing service delivery and management through a person-centered approach. As described by stakeholders during this study, the current "rehabilitation case management" BHO benefit focuses on supporting transitions among inpatient and outpatient care providers. This service is contracted out to local community providers. Although valuable, transition management represents only one component of successful case management for higher risk patients.

This recommendation builds on existing care and case management requirements for BHOs and MCOs, augmenting existing health home services for the same high risk population and potentially utilizing delivery system reform incentive payments under the Medicaid Transformation Demonstration. At the heart of the continuum of care for these patients is a dedicated, designated case manager capable of coordination and oversight. Regular client check-ins and interaction with family and caregivers will be required to determine current status, verify adherence to the treatment plan and address unmet needs to prevent destabilization of the individual. Ready access to client information reinforces these efforts and will require the BHOs to provide data in support of the program. In return, contracted providers will be required to track and report patient progress to the BHOs as well as other providers involved in the patient's treatment plan.

Recognizing that the BHO model will be phased out in three years, implementing a "light" health home model intends to lay the foundation for transition to full integration under Medicaid managed care. The program will seek to establish stronger communication protocols among multiple providers as well as data tracking and reporting procedures to inform all entities of the patient's progress and needs. These competencies and associated lessons learned can both inform MCO implementation and support successful operation. By empowering behavioral health providers to manage patient needs ahead of integration, this program also aims to promote a clear and prominent role for behavioral health providers in the transition to full integration, helping to avoid the pitfall of attempting to apply a medical model to meet behavioral health needs.

This program is intentionally limited to the BHO population because this population should already include patients who would be stratified into higher risk categories of care. The ultimate design and volume of patients

served by this program should be determined by each BHO based on the reserve funding available and the makeup of the patient population in their region.

**Gaps**

Implementation of a regional program for both rising risk and high risk patients as described above will require identification of which patients are receiving similar services today and assessment of how existing management models coalesce under a broader program. The recommendation will also require the BHOs to identify and contract with community providers to participate in this program.

Beyond the care management program described above, intensive transitional programs such as step-up and step-down programs represent one specific opportunity to reduce length of stay and risk of readmission for patients with significant behavioral or medical needs. The second recommendation in this subsection refers to the study question:

"What are the benefits and costs of developing and implementing step-down and transitional placements for state hospital patients?"

| **Recommendation 8:** | **Invest in transitional care reform initiatives to add step-up, step-down and HARPS resources. Specifically, add two new, 10-bed step down facilities in Western Washington and one new 10-bed step down facility in Eastern Washington.** |
|---|---|
| **Benefits** | • Prevents initial hospitalization<br>• Prevents readmission<br>• Allows individuals no longer requiring hospital level of care to be moved to a community-based residential placement<br>• Makes state hospital beds available for individuals in need of inpatient psychiatric care awaiting placement |
| **Supports** | • Improve early identification and treatment of behavioral health needs<br>• Increase collaboration and redesign system to achieve patient centered care |
| **Time Frame** | Two years to build facilities and implement programs |
| **Key Gaps** | • Statutory limitations on voluntary admission<br>• Voluntary bed capacity<br>• Treatment protocols<br>• Will require extension of Residential Support Waiver to continue receiving federal match beyond 2019<br>• Dependent on identification of suitable providers through Request for Proposal process |

**What it Does**

Investments in transitional care are designed to address both "front door" and "back door" issues related to improving access to the state hospitals and more broadly to the "right care, right place, right time" for individuals needing acute psychiatric care. Step-up and step-down programs and placements ensure a more seamless continuum of care that enables access to the state hospitals for those needing the most acute level of psychiatric care while assuring other, less restrictive options for those in need of a less acute level of care who are not ready to either be discharged to (step-down) or remain in (step-up) the community.

The 2013 Legislature approved funds for Enhanced Services Facilities (ESF) in an effort to address the needs of individuals being discharged from state hospitals who require long-term care but are challenged to find placement options due to complex behavior, medical, chemical dependency and/or mental health needs. These facilities may also serve as an alternative to hospitalization for individuals with traumatic brain injury (TBI.) As of the writing of this report, ESFs have been developed in two locations: a 12-bed facility in Vancouver and an 8-bed facility in Spokane. The ESF model presents a desirable and effective alternative to inpatient hospitalization for otherwise difficult-to-place state hospital patients who have been deemed ready for discharge. The ESF is intended to provide a homelike residential setting while offering 24-hour access to nursing care and daily access to a mental health professional as well as staff trained in specialty care for dementia and mental health.

According to data received from DSHS regarding patient census in the geriatric wards at Western and Eastern State Hospitals as of September 2016, there were 102 patients at Western State Hospital and 31 at Eastern State Hospital who had been at the hospital for 180 days or longer. Additionally, the discharge "wait list" for Western State Hospital dated July 14, 2016 noted that 92 patients awaiting discharge required long term care housing. Although not all of these patients are likely to be appropriate for ESF placement, it is reasonable to assume that a significant portion would be and that the current 20-bed capacity across the state is insufficient to meet the need. Additionally, ALTSA leadership has indicated that expansion of ESF capacity is a priority for them to better address the needs of patients with complex behavioral health needs. Thus, PCG believes there is sufficient evidence to support a recommendation to build additional "step-down" facilities similar to those recently build in Vancouver and Spokane. As additional construction and expanded capacity are ongoing, a duplicate funding structure that decreases overtime is likely to be required.

Washington can adapt the model used to develop ESF facilities to also develop step-down capacity geared toward addressing the needs of other types of patients. Also, as noted in the CABTF Report for King County, Washington can determine whether other step-down services may be attached to an existing service facility such as a residential treatment facility or freestanding E&T, and should seek to pair these services with existing resources whenever possible for transition support.

This recommendation also includes a step-up program component through which patients may seek short-term inpatient care, mitigating the potential for escalation and preventing commitment. The program would act as a safe treatment location where an individual may seek a walk-in appointment or self-admit for a short stay of three to four days and then return to the community. Transition out of the step-up program would be supported by a "warm hand off" to a community provider to ensure continued treatment. Step-up facilities would be required to work with the homeless to secure placement into a shelter or similar location to ensure the facility does not become a de-facto homeless shelter or discharge individuals to an unstable situation. Step-up programs should be targeted primarily toward the urban core of the western region of the state.

The recommendation envisions the use of voluntary commitment beds in community hospitals in addition to new construction. Because this form of treatment would require changes to the statutory limitations on voluntary commitment and potential changes to the treatment teams and protocols for voluntary beds, PCG recommends employing a process similar to the strategy used in implementing step-down programs, building two program locations employing a 24-hour staffing model that includes both nursing and rehabilitative therapy.

Lastly, a key program that serves individuals discharged from psychiatric and substance abuse inpatient facility is the Housing and Recovery through Peer Services (HARPS) program. HARPS served approximately 1,000 individuals in fiscal years 2014 and 2015. Three support teams consisting of peer counselors were funded to help individuals with housing needs. HARPS is effective in that guidance is delivered by a peer who assists not only in securing housing for an individual but also provides strategies on maintaining housing and referrals for other needed services. Recently, four BHOs have contracts for establishing a HARPS team: Spokane County, Pierce/Optum, Salish, and King County. The four teams are expected to serve 22 people in a year. Washington should continue to incrementally increase the number of HARPS teams each year so an additional 100 individuals may be assisted through the program and obtain needed housing and support.

**Gaps**

Finding willing providers may be a significant challenge. However, if state allocated funding can be made available and qualified providers found via an RFP or similar procurement process, ramp-up and implementation of additional step-down facilities is expected to be relatively straightforward. Because the ESF program is currently authorized under a Residential Support Waiver set to expire on July 31, 2019, continued operation of such facilities would require an extension of the waiver beyond this period. Other step-down facilities dependent on waivers would face similar considerations and requirements.

Step-up facilities will exist in a different legal environment than step-down facilities. The current statute governing voluntary commitment requires that patients pose a risk to themselves or others prior to commitment. Using voluntary commitment beds for a step-up program would require a change to these utilization requirements such that the patient may admit themselves or be referred for admission from a community provider without meeting current commitment criteria.

Expansion of a successful step-up program will require investment in additional beds for this purpose. Lastly, treatment in voluntary beds is currently guided by the voluntary commitment protocols established in the state. As noted above, existing staffing and practices will need to be reviewed and revised to accommodate the purpose of the step-up program and needs of the patients.

The third and final recommendation to support continuity of care requires a significant redesign of the data infrastructure supporting the behavioral health system. Although the scope and benefits addressed in this recommendation largely focus on behavioral health, this recommendation intends to establish a foundation for broader, compatible data sharing under the future integrated care model.

| **Recommendation 9:** | **Create an integrative technology infrastructure to support behavioral health service delivery** |
|---|---|
| **Benefits** | • Links key agencies, caregivers, and patients to a common information platform<br>• Increases the volume and accuracy of information exchanges among behavioral health providers<br>• Provides the technology environment to support a Learning Health system |
| **Supports** | • Early identification and treatment of behavioral health needs<br>• Effective tracking and use of data for system improvement |
| **Time Frame** | After a 6 to 12-month period of creating specifications, programming a system generally takes 2-3 years as capabilities are sequentially added in tiers. |
| **Key Gaps** | • Knowledge gap amongst providers and state staff as they are not universally familiar with using a similar IT system |

| Recommendation 9: | Create an integrative technology infrastructure to support behavioral health service delivery |
|---|---|
| | • Lack of current system means there isn't much background from which to draw for system design elements |

**What it Does**

This recommendation consists of two main parts. First, the recommendation encourages the state to establish a technology platform that links state agencies and behavioral health providers. Washington has already developed excellent data systems such as the Integrated Client Database (ICDB), the Homeless Management Information System (HMIS), the Comprehensive Hospital Abstract Reporting System (CHARS) and DSHS Client Service reports. Absent from the current system is a platform specifically linking agencies and staff.

Multiple states have developed technology platforms linking major service delivery programs, and PCG recommends that Washington follow best practices from these systems. Such platforms exhibit the following key common characteristics as identified by PCG:

- When individuals contact gateway providers, a record is created (with permission).
- Eligibility agencies are linked to the system, and if eligibility for a program needs to be established, eligibility staff are notified. Following notification, a determination is performed and the eligibility determination is added to the record.
- Assessment tools are added to the record, making this information available to care planners and providers.
- Treatment and service utilization is tracked for each patient and available to all authorized providers to edit and augment.
- Specific treatment plans for all or high risk patients are also added to the record.
- Information access is tightly controlled, using "role-based" security to create appropriate levels of permissions for different providers and administrators.

These platforms provide the "electronic glue" linking together care coordination, care transitions across providers, and treatment monitoring. For example, such a system can flag individuals who requires follow up after an emergency room visit or crisis center call.

Examples of such platforms implemented by other states include the following:

- *Minnesota* operates an integrated communications strategy linking long-term care service recipients with the Department of Veterans Affairs and transportation providers. Approximately 5,000 persons across different agencies use a software program called "Link-Live" to communicate with one another and securely share documents. State staff report that the system has fundamentally changed how agencies and departments interact with state residents and with one another.[11]

- *Maryland* implemented a computer system in which the service plans and records of all persons using Home and Community Based Services (HCBS) are stored in a single system, which may be accessed by HCBS providers and state staff. Clients enter the system through multiple agencies and records are created at entry. The record is augmented by Medicaid eligibility and other offices, evolving into a case

[11] Information obtained from Minnesota DHS staff, November 2016.

record and service plan tool for providers. Maryland currently has 129,000 clients on the system and approximately 4,000 users.[12]

- *Mississippi* uses integrative technology to coordinate staff across multiple agencies and speed the flow of program information. The state uses an eLTSS system that begins when individuals contact agencies for information or services and continues through eligibility and service planning decisions. Currently, Mississippi has approximately 60,000 clients on its system and 1,000 users.[13]

These systems represent powerful integrative efforts spanning thousands of staff and tens of thousands of client records. Implementing a similar platform in Washington will significantly improve the state's capability to operate effective programs. Simply put, when you operate effective technology, it is much easier to operate effective programs.

The second part of this recommendation encourages expedited implementation of improved technology at the state hospitals. Aided by substantive payments from the state's electronic health records (EHR) incentive program, many hospitals in Washington have implemented EHR systems while the state hospitals still operate in a paper-based system. In 2015, a contract was signed to begin work on EHR implementation, but conversations with state staff indicated that the project has experienced numerous delays. At the state hospital level, the development of an EHR is an essential part of the information ecosystem described in this recommendation. The state should build a learning health system that uses health information to drive decision making and increase effective health care practices.

Another missing component in Washington's state hospital system is a behavioral health assessment tool like the Comprehensive Assessment Reporting Evaluation tool used by the Aging and Long-Term Support Administration. The development of an acuity assessment tool at the state hospital level was recommended by the 2009 Geller report and is again recommended in this report.[14] The development of an integrative platform would provide the impetus to develop such a tool and incorporate it into the technology.

The integrative effort described above must be aligned with the Medicaid Information Technology Architecture (MITA) project that the State is undertaking. In August 2016, the State awarded a contract to a data processing consulting firm to undertake a self -assessment of the State's Medicaid technology. The technology innovation suggested in this recommendation is consistent with levels three and above of the "MITA Medicaid Maturity Model," which envisions a level of maturation in which state agencies share business processes and data, improve health care, and empower beneficiaries and stakeholders.[15] The innovation suggested here can also be constructed in such a way that it is compatible with CMS' seven standards and conditions to which states must agree on receipt of 90/10 federal matching money from a CMS advanced planning document.

[12] Information obtained from project staff, November 2016.
[13] Information obtained from project staff, November 2016.
[14] See https://www.dshs.wa.gov/sites/default/files/SESA/legislative/documents/StateHospitalSizes.pdf
[15] See description of MITA at
https://www.medicaid.gov/medicaid/financing-and-reimbursement/state-expenditure-reporting/expenditure-reports/index.html

**Gaps**

There are no precedents for similar technology in Washington's behavioral health care system. Therefore, there is likely a gap in the experience of state staff in how to best use a system once it is implemented. Significant training will be required to maximize its usage. Noted experience in other states can help define priorities and appropriate implementation timeframes. Administrative leadership is also necessary to sponsor and oversee the multiyear implementation required.

Additionally, leading into full integration, the platform developed should allow for interoperability with systems currently used by physical health providers while maintaining the unique functionality that behavioral health requires.

# Appendix A: Stakeholder Visioning Session Feedback

### Department of Social and Health Services

| Grouping | Adequate Funding | Admissions | System Design | Workforce | Patient Centered Care | Community Care |
|---|---|---|---|---|---|---|
| Outcomes | Fully fund and staff hospitals. Maximize federal funding | Doctors are the only professionals to admit patients to state psychiatric hospitals (need agreement between MD and psychiatrist) | Bringing together public and private behavioral health systems for resource development and design | Create a certified, accredited and professional classification to work in the BH system (Ensure competency, remove stigma) | Provide recovery support that is not episodic | Secured discharge environments – SOLAs/vendor provided – also opportunity to refuse |
| | Resourced correctly full continuum of care | | Purpose of the state hospital is clear, articulate and funded appropriately | Educate and market integration plan across executive, legislative, providers | Care is built with lifelong maintenance/recognition of chronic conditions | Most people with mental illness are treated in community settings |
| | | | The BH system has a well-defined, funded purpose | | "Nothing about them, without them" – patient at center | Effective transition programs – stepdown / step up |
| | | | Institute clear standardized outcome measures | | Early identification of individual MH needs | |
| | | | Funding and implementing systemic data to support effective care delivery | | Measuring quality of life (ask patients what they think/need) | |
| | | | | | Partnering with universities to design the highest quality of evidence-based care (forensic training is a good start) | |

## Health Care Authority

| Grouping | Integrated Care | Sustained, Aligned, Active Leadership | Provide Operational Infrastructure | Right Care, Right Place | Create Workforce Development and Capacity | Adequate Investment and Sustained Funding | Patient Centered System of Care with Aligned Financial Incentives |
|---|---|---|---|---|---|---|---|
| Outcomes | Significant investment in delivery system (DSRIP) | Governor/ Legislative/ local leadership, and direction. | Performance management and monitoring | Develop MH court diversion system | Attract and recruit talent | Adequate funding – from state, local, feds. For core infrastructure | Include patients in design of system |
| | Active medical management of SUD | Concrete vision and goals - operationalize the vision | Data systems established | Jail diversion – pre/post booking, MCO incentives | Training of provider community | Financial integration – move funds across continuum | Early identification of MH needs |
| | Key stakeholders engaged/ community support | Regulatory alignment among MH, SUD etc. | Manage with data | Rightsizing of state hospitals | Practice transformation support and assistance | Buy-in from counties and Legislature | Patient centered/consumer at center of design |
| | Incentives designed for whole system accountability | Administrative integration and alignment | Purchasing model for state hospital beds implemented | Master plan to transition state hospitals | Provider training | Matching systems to demand | Culture of recovery model – needs to cross BH and medical systems |
| | Develop cross discipline, whole person incentives | Strong and aligned leadership | | Only most severe mentally ill patients at state hospitals | | Build provider capacity | Credit for cross-sector savings |
| | Coordinate across agencies and government | | | Increased dementia care capacity/ALTSA contracts | | | |
| | Acquire and share data seamlessly | | | | | | |
| | BH focus in Medicaid, using common language | | | | | | |

### OTB Solutions

| Grouping | Staffing | EHR/Technology | Facilities | Process | Other |
|---|---|---|---|---|---|
| Outcomes | Incorporate/increase BH rotations in medical/nursing/other school curriculum | 42.2 CFR harmonized to HIPAA and state law (to enable more efficient and useful info sharing) | Completely refurbish existing hospitals and/or build new facilities | Involve providers in planning, especially from BH side | Fix issue of insufficient community placement alternatives |
| | Address salary/benefit issues | Utilize technology to assist with placements | State hospitals are modern, state of the art facilities | Allow Lean improvements to be implemented | Politics don't matter – focus on patients instead |
| | Advertise successes (to help decrease stigma) | Fully electronic records – bed management, quality measures and clinical care. HITECH funds/CDR. | | | |
| | Cohesive compensation model for BHA/hospitals | State consolidates data requests/access to reports to decrease redundancies | | | |
| | Staff want to work at the state hospitals – no stigma attached to being employed there | Enterprise Data Warehouse for hospitals (at least) to be able to collect and analyze data around patients, care, staffing and outcomes | | | |
| | Psychiatrists are plentiful | Network connecting hospitals to BHOs/RSNs for efficient/effective patient movement | | | |
| | | EHR implement at hospitals | | | |
| | | Connecting jails with health system to enable better tracking of patients. Could enable better coordination with Medicaid. | | | |

### Service Employees International Union

| Grouping | Process | People | Funding | Other |
|---|---|---|---|---|
| Outcomes | Adequate housing stock at all levels | Grow BH workforce pipeline, career ladders and address recruitment and retention | Invest in long term success | State hospitals have become center of psychiatric excellence |
| | Robust community care network | Highly trained, professional, committed workforce | Adequate funding | Shared priority of all Washingtonians and stakeholders having shared identity and stake in the full continuum |
| | Warm handoff including clear pathways and process (at various levels of the system e.g. ER, crisis intervention line) | Safe staffing and decreased assaults in all BH care environments | | Housing |
| | Standardized care models based on best practices | Good labor management partnership and workforce voice | | Decriminalize/ destigmatize (links to issues of access, adequate funding, workforce – seeing MH as a desirable placement) |
| | Caseloads decreased | Crisis intervention training for all health and law enforcement | | Closing unmet need gap – including SUD |
| | Access (to providers) | Career pathways and ladders within BH | | |
| | Early identification | Genuine WF stabilization and growth | | |
| | | Substance use disorder – process and people | | |

### Washington Federation of State Employees

| Grouping | Working Conditions and Safety | Workforce Retention and Development | Transitions of Care | Other |
|---|---|---|---|---|
| Outcomes | Staff-to-patient ratios accurately reflect acuity | Recruit and maintain quality staff | Invest in residential community services | Management structure that recognizes state agency and medical considerations |
| | Stable and consistent staffing within wards | Agreements with universities to offer training and internships in the hospitals in real time | Availability of transitional placements in community (prefer state-operated SOLAs/ETFs) | Judges in courts understand limits of system (via education) and system understands vision of judge |
| | Effective, consistent system of transition/communication time between shifts | State educational assistance with student loans to remain in service | Staff performing more outreach in community to forge connections and better understand resources | More mental health diversion programs available |
| | Sufficient staffing to enable time for vacations, breaks, trainings | Support continuing education needs (money and time) | Community based rapid intervention for individuals at risk of destabilizing | Legislature and citizenry willing to pay cost of world class care |
| | Use of on-call staff only for its true purpose, not regular staffing | Career ladders for staff at the lower end of earning – custodial, food aides | Appropriate, safe transportation from hospital at discharge | Management structure recognizes agency and medical considerations |
| | Available staffing at all levels and appropriate movement between levels | Rate of pay to various classes will encourage long term employment | Point of contact in community to receive patients being discharged | |
| | Employee access to full rights and necessary assistance when assaulted | Policy personnel focused on issues who understand current practices | Casework prior to discharge addresses benefits coordination | |
| | Provision of security services above and beyond current and adequately paid | Labor relations | Systems integration to coordinate benefits | |
| | | | Treatment not delayed due to inefficiencies in system | |

## Joplin Consulting

| Grouping | Collaboration | Robust Continuum of Care | Education | Measurement |
|---|---|---|---|---|
| | Data available across systems to inform care (and across providers). | Robust continuum of care – complete & includes supportive services (housing, employment, etc.) | Decrease stigma through community ed at all levels (elem. school) to normalize conversation. | Increased focus on outcomes (regulatory, admin, accountability, funding) rather than process. |
| | Systems of care are seamless to the client – including integration of jail and provider services. | Adjust reimbursement rates to allow for greater workforce integration (tele-health, internships) to improve competency, morale and reduce turnover. | Comprehensive cross training and understanding between LE/CJ/MH. | Performance measures are linked to financial incentives. |
| | Improve collaborative effort across continuum of care. | Programs/services for "frequent fliers" (not just low hanging fruit). | Adoption of team/evidence based practices to support integration and early intervention. | Reward innovation and positive outcomes (vs. managing by risk/fear). |
| Outcomes | Data available across systems to inform care (and across providers). | Single case manager for high utilizer across systems (examples: HUB and Golden Thread (from King County)). | Improve training for providers – recovery model and other best practices, curriculum. | Use data to inform management decisions. |
| | Primary care and behavioral health under one roof. | Provide/increase adequate resources for basic needs – housing, transportation, indirect services supportive/transitional. | | |
| | Easier access to services (next day appts, volunteer inpatient stays). | Solutions tailored to different needs of urban and rural counties. | | |
| | | Decrease/shorten hospital stays – focus on services in community, least restrictive settings. | | |

### Union of Physicians of Washington

Note: due to scheduling difficulties this session was more conversational in nature and participants did not group responses into categories. For ease of comprehension, PCG has sought to cluster the suggested options into groupings but has not assigned names to each.

| | | | |
|---|---|---|---|
| Culture of safety, trauma informed care | Patient access to psychotherapy and all necessary treatments | Access to data about patients after discharge for tracking outcomes | Orders for involuntary treatment in the community for adult population |
| Focus on quality to reduce length of stay and recidivism | Liaison assigned to handle difficult cases | Standardization of discharge processes | Address mental health needs while clients are waiting in jails |
| Increase in psychiatric supervision | Enhancements to outpatient services | Define system needs and implement EHR that addresses them | Refer complex medical or agitated patients to state hospital |
| Leadership culture is encouraging | Decreased case manager loads | Coordinate with community based prescribers/providers | |
| Consider smaller, discrete units | Provide addictionologists and invest in SUD treatment services in hospitals | Conditional release program with early warning system and “teeth” to enforce compliance | |
| Provide patients with the structure and guidance to succeed | Enhanced geriatric services in hospitals | Consider re-initiating the severe personality disorder voluntary readmission program | |
| Increased focus on admissions process including coordination and shared decision making among parties | Track and address patients that have been at the hospitals for years | | |
| Update the state system of determining salary increases | Better placement options for ID/DD patients | | |
| Standardize available resources and services but allow for creativity in the process | | | |

## Stakeholder One-on-One Discussions

As noted previously in this report, one-on-one calls with stakeholders did not follow the same format and did not result in groupings of recommendations but rather a collection of recommendations from several discrete individuals. The one-on-one calls were held with representatives from two groups: community providers and legislators. Below are the consolidated responses from each group, listed in no particular order.

**Legislators (Members of Select Committee on Quality Improvement in State Hospitals)**

| | |
|---|---|
| 1 | Long term idealistic goal is that virtually no one in Washington that suffers from MI because we have done the prevention, early intervention. |
| 2 | State hospitals would not open any more beds except for forensic beds. |
| 3 | Need to integrate primary and behavioral health. BH is under diagnosed. We need to do more around early screening of BH. BH is also linked to other illnesses. |
| 4 | Primary care providers need a lot more support if they are going to prescribe MH drugs. |
| 5 | Need more early intervention and then outpatient services. Data from New York shows housing has more impact on a person's mental health than drugs. |
| 6 | Consider having more regional beds with 30, 60 or 90-day stays. |
| 7 | More investment in WSH and in MH treatment generally. |
| 8 | WSH management needs to exert itself. |
| 9 | Focus on being functional at WSH before aiming to be center of excellence. |
| 10 | Much more investment in mental health system and equipping primary care providers to be "QBs" on team that also incorporates mental health. PCP must be the key in care delivery system, whether through ACO or other model. |
| 11 | Lower standard for involuntary commitments from imminent harm to substantial likelihood to give more individuals access to system for initial stabilization. |
| 12 | Need to use APRNs as practitioners - can't afford to pay psychiatrists at WSH what they can get paid in private practice. |
| 13 | DMHP system needs to be overhauled – single biggest deterrent to effective program. |
| 14 | Community needs to be assured that it will be safe from people coming out of hospitals. |
| 15 | Security of facilities needs to be assured so that patients are not "walking away." |
| 16 | Employees need to be kept safe to the greatest extent possible. |
| 17 | Need to retain employees and address turnover, not meeting goals. Increase pay or other address through other avenues. |
| 18 | More robust system of wraparound care |
| 19 | Data collection to measure effectiveness |
| 20 | Better integration of data gathering with community responses to homelessness in general. Two populations are not the same but not entirely different, ensure better understanding among them. |
| 21 | Better education about trauma induced circumstances/issues and how they can cause intergenerational impacts |

## Community Providers

| | |
|---|---|
| 1 | A statewide network of support and recovery that enables individuals to live in the community. |
| 2 | Divert individuals from institutions and jail and support the I their transitions back to the community. |
| 3 | Need true bi-directional integration options with smooth handoffs to and from primary care. Wherever you come into contact with the system you need to have smooth transitions. |
| 4 | Need specialized settings that can provide this care are necessary. Need cooperation between residential programs and service providers. |
| 5 | Need more permanent supportive housing. Need low income housing and services. Services you can get but housing is a problem. |
| 6 | Need a culture change that welcomes peers as valuable clinical team members. |
| 7 | Need expanded community outpatient treatment capacity. A lot of capacity problems are tied to workforce availability and low reimbursement. Currently we turn people away because they are not sick enough. |
| 8 | Five years from now competitive wage rates would be grounded in actual costs and providers would be paid their costs. State hospitals have had to raise wages by $10,000 to $15,000 but not community wages. |
| 9 | Five years from now we will have value-based payment models between managed care and providers. Payment models will also focus on evidence based practices. |
| 10 | System will support solutions at lowest possible level so providers and community members will solve problems. Most successful models happen when local folks solve together. |
| 11 | Everyone in the system (provider, policy, etc) would have undergone trauma informed care training |
| 12 | Much greater use of peers, peer support specialists and peer bridgers, especially in hospitals |
| 13 | Divert funds away from state hospitals and give to community providers |
| 14 | Union job security cannot be a consideration in making decisions about system design. |
| 15 | Community treatment providers would have more contact with each client (ex. PACT team) so that early signs of decompensation could be caught and addressed much quicker and prior to inpatient treatment. Caseloads, turnover prevent this now. May require additional resources to keep case managers longer in field (e.g. pay, career path) |
| 16 | Housing is #1 issue to give clients stability. Treatment providers can find them and treat them. May boil down to funding. Ideal funding would equate to transitional resources. |
| 17 | Crisis solution centers are effective at diverting from system and keeping people in community. Would like to have much more of those around state to provide short term care for someone going through acute episode so they can get back to the community. |
| 18 | State has to get more clear about what they are buying through contracts. What does the scope of services in a region look like that meets minimum requirements? Set of services must be described in enough clarity that each region meets the minimum criteria. Contracts must be effectively enforced. |
| 19 | Make contracts that incentivize good behavior. What are goals of the system? Currently defined by each entity. Could include: keep out of hospitals, keep at home, allow clients to work, etc. Contracted entities should then be incentivized to go above and beyond. |
| 20 | Break up state hospitals – need to be smaller so can be managed. Should be responsible and at risk. State hospitals should be held accountable as vendor so that people can go somewhere else. Believe WSH is far too large to be effectively run. |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