Washington State Health Care Authority

Report to the Legislature

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

Status report

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

October 15, 2022

Washington State Health Care Authority

Division of Behavioral Health and Recovery
P.O. Box 42704
Olympia, WA 98504-2730
Phone: (360) 725-9421
Fax: (360) 763-4702
www.hca.wa.gov

Table of contents

Executive summary 3

Summary of updates 3

Enhanced rate of reimbursement 3

Advanced Crisis Intervention Training (ACIT) 3

Uniform screening tool 4

Acute care hospital capacity 4

Washington's first intensive behavioral health treatment facility 4

Background 4

Progress on prioritized solutions 5

Enhanced rate and specialized units 5

Identified facilities 5

Follow up to key findings as identified in the initial report 6

Advanced Crisis Intervention Training (ACIT) 6

No-refuse facilities 6

Prioritize contracting with acute care hospitals 7

Development of additional community settings to support discharge and facility throughput 7

DSHS' uniform screening tool 7

Conclusion 8

Continuing cross-agency efforts 8

Partnership with DSHS 8

Closing 8

Executive summary

This report is in response to Senate Bill (SB) 5092 (2021), which directs the Health Care Authority (HCA) to coordinate with the Department of Social and Health Services (DSHS); Office of the Governor (GOV); Office of Financial Management (OFM); Medicaid managed care organizations (MCOs); Behavioral health administrative service organizations (BH-ASOs) representative(s); and community providers to develop and implement a plan to continue the expansion of civil community long-term inpatient beds.

SB 5092 requires HCA to produce two reports to GOV and the Washington State Legislature. This report is the second of those reports.

HCA's initial report recommended prioritizing the following strategies:[1]

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

Summary of updates

Enhanced rate of reimbursement

For the first listed priority strategy above, HCA proposes a pilot at a small number of facilities. These pilot sites will serve a specific population, as identified in Identified facilities section of this report. Applying an enhanced rate of reimbursement for these sites will provide sufficient staffing levels and expertise.

HCA will monitor these pilot sites in the areas of admission, successful discharge planning, and readmission rates. We also plan to evaluate the pilot and broaden its scope, if proven successful.

This effort also makes progress toward the third priority strategy (fostering the development of specialized sub-unit)).

Advanced Crisis Intervention Training (ACIT)

HCA is attempting to identify a funding source to be able to contract for the ACIT trainings and provide the training to currently contracted facilities in calendar year 2023. We are confident facilities will take advantage of this training opportunity.

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

Uniform screening tool

As a result of separate but parallel work group activities, both DSHS and HCA identified similar groups of individuals who are struggling to access care in the current array of beds providing care to individuals on 90- or 180-day civil commitment orders.

As we continue to partner on expanding long-term civil capacity in the community, we continue to better identify the needs and existing gaps and are making progress to close them. An example of this DSHS' development of a uniform screening tool, which matches patient needs with treatment locations.

As this tool begins to be piloted, we expect to learn more about the capacity of the state's existing network of providers and treatment settings. This tool will help us better understand whether the state needs to operate facilities that will admit those with the most challenging behaviors and needs.

Acute care hospital capacity

HCA continues to seek additional capacity within acute care hospitals to serve those with more complex medical needs, in addition to their psychiatric treatment. In the last year, 12 additional beds became available in two hospitals. HCA will work to build further capacity for these types of beds in the coming year.

Washington's first intensive behavioral health treatment facility

As 2022 ends, we anticipate the opening of the first-ever intensive behavioral health treatment facility in Olympia. This facility type will help to broaden the spectrum of services available within the community, helping to support a greater variety of needs. We believe that enhancing the kind of community-based services when people need to discharge from involuntary treatment may encourage providers to accept individuals who previously were denied due to lack of discharge options.

Background

SB 5092 requires that HCA create a work group with representatives from DSHS, GOV, OFM, MCOs, BH-ASOs, and community providers to identify the gaps and barriers—as well as potential solutions—to support the expansion of long-term civil commitment beds in community-based settings.

HCA's first report, submitted December 2021, identified a number of barriers to expanding community-based civil long term placements. We also provided potential solutions to reduce barriers and improve outcomes for indviduals with complex medical needs.

The initial report suggested prioritizing the following strategies:

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

Progress on prioritized solutions

The work group identified some potential solutions to the various gaps and barriers that are preventing admissions. During this past calendar year, HCA, in partnership with DSHS, continued to make progress with a number of strategies identified in the previous report, as well as other related efforts.

Enhanced rate and specialized units

HCA is currently limited to offering inpatient facilities the published rate for services. An enhanced rate of reimbursement would allow contracted facilities to create higher staffing patterns necessary to provide increased observation, assistance, and intervention to meet the needs of more complex patient populations. An enhanced rate would also help these facilities maintain the safety of all patients and staff.

Some individuals require ongoing 1:1 observation and others may require a 4:1 pattern to provide seclusion and restraint. Additional staff also creates the capacity for these facilities to provide needed training to their staff. When facilities send their staff to trainings, a workforce shortage is created, which results in an all-around hardship. An enhanced rate would incentivize current and future contracted facilities to serve more challenging populations by compensating facilities sufficiently to make the needed staffing and facility adjustments described.

HCA considered several methodologies for developing an enhanced rate. We proposed that the enhanced rate begin with a 20 percent increase to the current reimbursed per diem rate to create the ability for facilities to hire more staff. This increase could be adjusted accordingly, once actual cost data is collected from the participating facilities.

If approved and funded by the Legislature, HCA proposes to introduce an enhanced rate via a pilot where HCA works closely with a few facilities as a trial run. HCA recommends that this pilot be funded with a set amount of money. HCA can then evaluate the effectiveness of the pilot and manage costs. The hope is that HCA could then apply an enhanced rate across the state to further expand community bed usage

Identified facilities

HCA program staff are working with three currently contracted facilities to participate in this pilot. By participating in the pilot, these facilities can accommodate individuals with more complex and challenging needs that exceed the capabilities of existing community-based resources. HCA requested that each site provide a cost analysis, which would identify the costs of treating this population.

Free Standing Evaulation and Treatment Facility (E&T)

Facility one is a contracted facility that wants to provide care for people with intellectual or developmental disabilities (I/DD). Facility one is proposing half of their facility in Pierce County be set up to care for eight individuals on five-day detentions and 14-day civil commitment orders with I/DD care needs.

HCA has an active contract with this site for the other half of their facility to provide eight beds for individuals on 90- and 180-day civil commitment orders. It makes sense for them to care for individuals with the same needs. With enhanced funding, Facility One would swap the use of these eight beds to serve people with I/DD on 90 and 180-day civil commitment orders.

E&T unit in acute care hospital

Facility two is a contracted facility, which is an E&T unit in an acute care hospital serving co-occurring acute phsyciatic and medical conditions. HCA has an active contract with this site to provide 12 beds for individuals on 90- or 180-day civil commitment orders. Facility two is currently caring for individuals with

co-occuring psychiatric/medical needs but are unable to accommodate individuals who have advanced acute psychiatric/acute medical needs that require a higher staff to patient ratio.

Facility two is working to provide HCA with estimated costs for the increased staffing. By offering them a rate that could increase their staffing ratio, they would be able to manage individuals who are currently being denied admittance due to their higher acuity. This facility has also expressed interest in adding electroconvulsive therapy (ECT) treatment, which would increase their ability to serve more people and reduce transfers outside the region.

E&T unit in acute care hospital

Facility three is a contracted facility, an E&T unit in an acute care hospital. As part of their contract with HCA, this facility provides 14 beds for individuals on 90- or 180-day civil commitment orders. They received Department of Commerce (Commerce) capital funds to expand their E&T by adding an additional 14 beds. This facility is interested in providing care for individuals who exhibit physically assaultive and sexually aggressive behaviors.

Individuals showing these behaviors are currently being denied admittance. Facility three would require increased staff to patient ratio as well as specialized de-escalation training for staff. By receiving enhanced funding, all staff would be specially trained in the evidence-based practices to care for the needs of the individuals being cared for.

Follow up to key findings as identified in the initial report

Advanced Crisis Intervention Training (ACIT)

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

Individuals formerly served in the state hospitals are now receiving treatment in these community settings, and the community workforce needs to develop the de-escalation skills the state hospital staff have acquired.

The work group recommended that ACIT developed by DSHS should be made available for all contracted sites. Facility staff need more advanced skills to manage the increased aggression and/or risk of violence by some individuals. ACIT builds upon existing de-escalation and restraint skillsets from MOAB® and other training models. ACIT seeks to reduce the need for seclusion and restraint by teaching staff trauma-informed interventions that can safety guide the individual through a crisis without the use of violence.

HCA program staff met with DSHS to arrange training for the contracted facilities to obtain ACIT. Currently, HCA is attempting to identify a funding source to contract for these trainings. We are confident contracted facilities will take advantage of this training opportunity.

No-refuse facilities

As HCA and DSHS have continued to identify needs and barriers, we have discussed the need for state-operated sites to serve as "no refuse" facilities. The hope is that as additional facilities open these new

beds will further fill in the gaps that exist today.[2] However, we anticipate there will remain a subset of individuals with extremely challenging needs and/or behavior that will require a state-operated facility; as this work progresses, we will come closer to knowing exactly what this may look like. The DSHS-lead effort to develop a uniform screening and placement tool has helped to refine our understanding of this need and is addressed below.

Prioritize contracting with acute care hospitals

While additional beds are still needed in acute care hospitals, HCA added 12 more contracted beds in the last year. **Providence Everett** and **Yakima Valley Memorial Hospital** both completed their Commerce-funded remodeling and added six new beds (12 total) to each of their facilities. (The beds added for Providence Everett were for the North Sound Region.) HCA will continue to seek out more capacity in acute care hospitals that will meet this important need.

Development of additional community settings to support discharge and facility throughput

Additional facilities and supports are needed in the community to serve populations who often are refused admissions due to difficulty locating a discharge setting. The first Intensive Behavioral Health Treatment Facility in Olympia is scheduled to open in December 2022, with others to follow in the coming year. Other efforts that may greatly assist with this issue include: the behavioral health personal care waiver application, Intensive Residential Treatment team pilots, and the expansion of PACT teams.

DSHS' uniform screening tool

HCA participates in a DSHS-led effort to create a uniform screening tool. This tool will be used to assess the needs of everyone who has been civilly committed to ensure they are admitted to the most appropriate inpatient setting to meet their needs and ensure their success upon discharge. This tool is currently being piloted to further refine the process.

The development of this uniform screening tool has helped us understand the needs of the populations to be served in these different community facility settings. Ultimately, this tool may help the state identify the need for state-run sites to act as no-refuse facilities for those who are the most difficult to place.

HCA is working closely with the contracted facilities and the MCO and BH-ASO representatives to create a uniform discharge process. This will create a more streamlined process and better coordination of the discharge planning process. HCA is also examining contract language to determine if facilities' contracts need to be adjusted to ensure consistent understanding of roles and responsibilities.

Since the inception of the 90- and 180-day program in 2018, the state has increased its capacity for more beds and facilities to help those with complex medical needs. Our state's growth in this area has largely come from Commerce-funded capital grant procurements, state-initiated and/or operated facilities, and inclusion of civil conversion populations.

[2] Additional facilities may open via Commerce-funded facilities, state-initiated facilities that HCA and DSHS stand up, and other new capacity, such as the University of Washington teaching hospital.

HCA is creating an organized workstream of all activities related to making 90- and 180-day civil beds available. We've identified a task list with corresponding action items to move the work forward, which includes efforts to expand our team.

Conclusion

Continuing cross-agency efforts

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

Partnership with DSHS

HCA works closely with the DSHS Behavioral Health Administration (BHA), Aging and Long-Term Support Administration (ALTSA), and Developmental Disabilities Administration (DDA) on staffing options for people with difficulty discharging. These transitions could occur in either an inpatient setting or a setting post-discharge. HCA and ALTSA staff often act as the liaison between the contracted facilities and MCOs to assist in forging those relationships for the best possible outcome for those we serve.

HCA continues to work with DSHS on creating a uniform screening tool to assess the needs of everyone who has been committed on a 90- or 180-day civil order, so they are admitted to the most appropriate inpatient setting to meet their needs and ensure their success upon discharge. The goal is to reduce the number of facilities that are declining the individuals' admittance. This uniform screening tool will also help us gain more information about what levels of care individuals are needing, whether they come from a state hospital or the community.

HCA staff participated in a DSHS/BHA-run work group to identify gaps within the system that are barriers to individuals on a 90- or 180-day civil commitment order receiving inpatient treatment. Identified gaps included:

- Individuals with complex medical issues,
- Individuals with acute aggressive behaviors like those that occur with traumatic brain injuries or neurocognitive disorders, and
- Gaps within the system that enable individuals with these behaviors and/or disorders to discharge from a 90- to 180-day civil commitment bed to the community, addressing the throughput.

Of the items identified as gaps in the system, we determined the following list as a priority. HCA is working on these items for potential funding. If they are not put forward this year, they will remain on the forefront for discussion for future sessions:

- Lack of guardians for state hospital discharges,
- Payment for sex offence treatment in state hospitals and post-discharge, and
- Specialized Traumatic Brain Injury (TBI) facility for individuals with long-term support needs.

Closing

With the support of last year's work group, HCA identified key priorities that will further the expansion of the community-based long term civil capacity. HCA will continue to move forward with this effort, in partnership with DSHS, Commerce, and community providers. As additional capacity comes available, we expect more and more individuals to gain access to contracted beds. We also recognize that without deliberate and careful planning, we will not achieve access for all.