

Long-Term Behavioral Health Inpatient Involuntary Care Access, Purchasing, and Bidirectional Integration

Engrossed Second Substitute Senate Bill 5432; Section 1003(3);
Chapter 325; Laws of 2019
December 15, 2019



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Acknowledgments

We thank all 123 staff, community partners, and agency representatives who participated in 35 hours of workshop meetings brainstorming ideas, reviewing drafts, and providing input into this report.

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Executive Summary

This report is the result of the 2019 Legislature's directive that the Health Care Authority establish a work group to:

- Recommend how to manage adult and children's access to long-term inpatient involuntary care in the community and at the state hospitals until the risk for such care is fully integrated into HCA's contracts with the managed care organizations (MCOs).
- Provide advice to guide the process to fully integrate risk for long-term inpatient involuntary care into the MCO contracts.
- Recommend how to expand bidirectional integration through increased support of co-occurring disorder services.

The work group has two primary recommendations for managing access to adult long-term involuntary inpatient care. First, Washington should continue to build out community services to reduce the need for long-term involuntary inpatient care and facilitate discharge from such care. Second, assuming a positive feasibility study, Washington should implement a centralized system that will manage access to all short-term and long-term involuntary inpatient care statewide. To manage access to the children's long-term inpatient program, the work group recommends that Washington implement community services that provide a full continuum of care (step-up/step-down options) such as family respite care, partial hospitalizations, and intensive outpatient programs.

Fully integrating risk for long-term inpatient involuntary care into the MCO contracts requires phased data gathering:

- Rate development pre-work - Data on cost and utilization developed to inform actuarial work.
- Initial implementation - HCA to consider risk mitigation arrangements during this initial period.
- Post implementation - HCA to make adjustments to contracts and rates based on experience during the initial implementation period.

In order for the state to expand bidirectional care, it first must have an adequate base of providers who are licensed and certified to provide both physical and behavioral health services. The work group recommends that the Legislature invest state funds to incentivize providers and facilities to obtain the licensure or certifications necessary to expand the workforce. The work group also recommends:

- Comprehensive behavioral health screening
- Increased behavioral health training
- Funding residential treatment facilities with onsite behavioral health professionals



Background

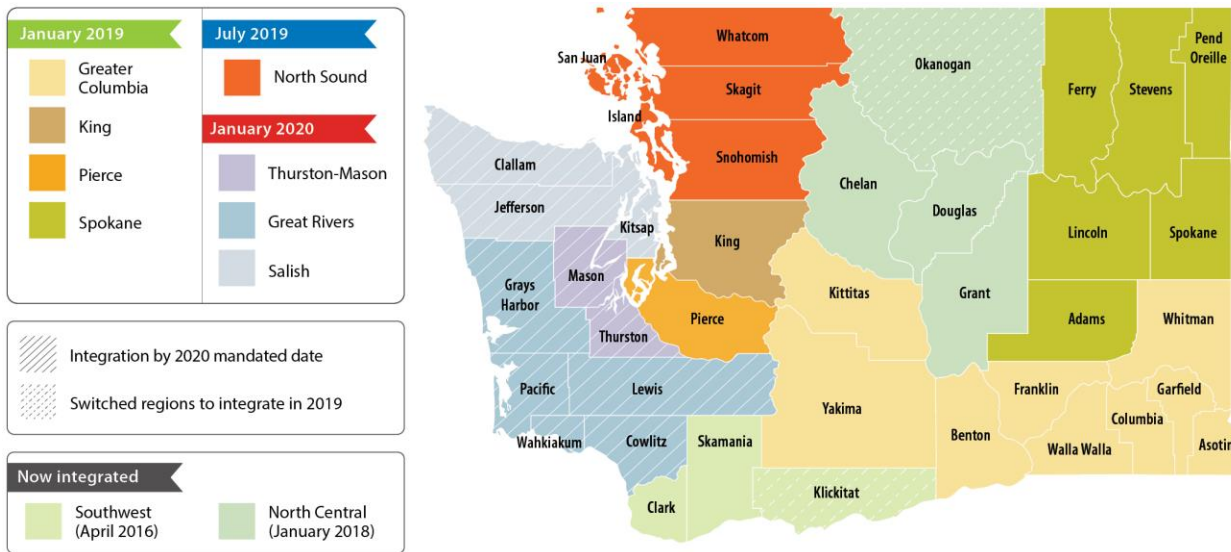
The Health Care Authority (HCA) is responsible for purchasing and oversight of the state's behavioral health system with the goal of whole person care. Based on recent efforts to integrate the provision of physical and behavioral health services, the state must develop the legal, administrative, and operational policies, purchasing strategies, and business processes to provide long-term involuntary inpatient behavioral health care in the community setting. Involuntary care is governed by chapter 71.05 RCW (the Involuntary Treatment Act), which sets strict protections for individuals in Washington who are involuntarily committed for short-term or long-term mental health or substance use disorder treatment. Washington's current involuntary care system is complex and under transformation.

Historically, adults requiring long-term involuntary care for mental health related conditions received care through state-run institutions (Eastern State Hospital and Western State Hospital). The services were accessed by entities known as Behavioral Health Administrative Services Organizations and Managed Care Organizations (prior to that, by Behavioral Health Organizations or Regional Service Networks) through a hospital bed allocation model. The purpose of the psychiatric hospital bed allocation model was to ensure statewide, equitable utilization of long-term involuntary civil beds.

For children, long-term involuntary care is managed through the Children's Long-term Inpatient Program (CLIP). The state contracts with five CLIP programs to provide long-term involuntary care for children, one of which is the state-run Child Study and Treatment Center. All five CLIP programs provide voluntary and long-term involuntary (that is, 180-day Involuntary Treatment Act) care. Unlike the adult system, the children's long-term beds have always had community-based, long-term involuntary beds outside of the state hospital system.



Purchasing Regions and Integration Dates



As of January 1, 2020, all regions will provide integrated physical and behavioral health care through a Medicaid managed care organization (MCO). Individuals who are not eligible for Medicaid may receive behavioral health services through a Behavioral Health Administrative Services Organization (BH-ASO). MCOs will continue to coordinate crisis-related services with the BH-ASO in each region and individuals will continue to receive involuntary short-term and long-term inpatient behavioral health services. The hospital bed allocation model will no longer exist.

In 2019, the Legislature directed HCA to establish a work group to:

- Recommend how to manage adult and children’s access to long-term inpatient involuntary care in the community and at the state hospitals until the risk for such care is fully integrated into HCA’s contracts with the MCOs.
- Provide advice to guide the process to fully integrate risk for long-term inpatient involuntary care into the MCO contracts.
- Recommend how to expand bidirectional integration through increased support of co-occurring disorder services.



Recommendations

Adult Long-Term Involuntary Inpatient Care

The work group has two primary recommendations:

1. Washington should continue to build out community services that provide varying levels of care and behavioral support to reduce the need for long-term involuntary inpatient care and facilitate discharge from such care.
2. Washington should implement a centralized system that will manage access to all short-term and long-term involuntary inpatient care statewide.

The “Through-Put” Issue

Effective behavioral health treatment options in the community help make sure patients can be appropriately discharged from the state hospitals and community hospitals and help address behavioral health issues early on, preventing some individuals from needing psychiatric hospitalization in the first place, which in turn reduces the demand on the limited long-term inpatient beds while helping to prevent individuals from experiencing crisis.

The adult subgroup reviewed the importance of developing appropriate resources that will be available to individuals in the community to prevent the need for, and aid the transition from, psychiatric hospitalization. Washington should continue its efforts to expand treatment services, residential programs, housing support, intensive case management, behavioral health workforce development, and its drive for long-term involuntary care in the community-based facilities.¹ These efforts should include:

- Resources for individuals who have significant barriers to placement (risk of fire-starting, sexual offender/predator risk, criminal history, risk of physical violence).
- Special programs/facilities for geropsychiatric, transition-age youth (18-25), and developmentally disabled populations.
- Mental health residential treatment capacity (Adult Residential Treatment Facility) and other step-down options that are not short-term in nature.
- Housing options that are affordable and available to individuals with a behavioral health and co-occurring criminal history.
- Behavioral health system resources to fund personal care assistance and other supportive services such as case management and medication management and oversight that support individuals with psychiatric needs to stay stably housed in the community and avoid inpatient stays, stays in more expensive settings, or homelessness.

The adult subgroup also identified numerous state efforts already underway that the Legislature should support. A non-exhaustive list includes:

- Health Care Authority efforts to increase Program of Assertive Community Treatment (PACT) capacity across the State.

¹ The need for greater community-based behavioral health support has been well documented. See Appendix D; in particular, the December 2018 Governor’s Policy Brief, “Transforming Washington’s Behavioral Health Care System.”

- The University of Washington’s implementation (supported by funding from the Health Care Authority) of a new promising practice – cognitive behavioral therapy for psychosis (CBTp).
- The State’s implementation of the New Journey’s coordinated specialty care teams providing early intervention for first episode psychosis under Section 6 of Second Substitute Senate Bill 5903 (Chapter 360, Laws of 2019).
- New facilities and expansion of the capacity of current provider types in the community as initiated by Second Substitute House Bill 1394 (Chapter 324, Laws of 2019).
- Peer Respite Facilities (recently funded; to be implemented by the Health Care Authority).
- Initiatives of the Department of Social and Health Services’ Aging and Long-Term Support Administration, such as workforce development and provider training and technical assistance that assists providers serving individuals with significant behavioral health needs.
- Recommendations relating to short-term and long-term residential intensive behavioral health and developmental disability services for youth and adults with developmental disabilities and behavioral health needs (forthcoming; as required by Second Substitute House Bill 1394, section 10).
- Workforce development efforts such as:
 - Recommendations to increase access to clinical training and supervised practice for the behavioral health workforce (forthcoming; funding provided by Engrossed Substitute House Bill 1109 section 221(22) for the Department of Health).
 - A recommended action plan to address behavioral health workforce shortages (forthcoming; funding provided by Engrossed Substitute House Bill 1109 section 614(2) for the health workforce council of the State Workforce Training and Education Coordinating Board).

Managing Involuntary Inpatient Placement

With the unavailability of state hospital beds, designated crisis responders across the state must rely on a cumbersome system to place individuals in either: (1) private facilities that are licensed and certified to provide involuntary inpatient mental health care, or (2) medical hospitals using the single bed certification process. This typically involves repeated calling of certified evaluation and treatment facilities for bed availability, starting with those nearby. Frequently, they find a vacant bed at the time of the call, but then discover that the bed is taken when they try to initiate the placement. Facilities may also choose to decline a placement even if a bed is available. Individuals whom community facilities are unable or unwilling to serve are very often detained to hospital emergency rooms or medical/surgical beds using the single bed certification process. Although this process is intended for short-term use, it often results in patients remaining for weeks or longer in facilities not intended for longer term or more intensive mental health treatment.

The State has a centralized mechanism to independently manage access for the children’s population; this is lacking in the adult system. This subgroup recommends that the State develop a centralized system that will manage access to all short-term and long-term involuntary inpatient care statewide for adults. This system would track short-term and long-term bed availability in real-time, manage civil bed placements, and authorize and monitor single bed certifications when necessary. The system would consider a variety of factors to determine the most appropriate placement, including:

- Proximity to the patient’s home, family, and community supports
- Clinical appropriateness considering the patient’s co-morbid conditions
- Age
- Disability
- Continuity of care



- Rare and specialized treatment resources (such as dementia, eating disorders, developmental disabilities, borderline personality disorder, etc.)

This centralized system would also track the reasons provided by involuntary inpatient care facilities for refusing care to individuals awaiting beds and advocate for placement. This subgroup discussed at length that in many areas of the State there are often beds available, but inpatient involuntary care facilities may refuse a patient due to perceived or real behavioral or administrative barriers. There is currently no way to consistently track or effectively challenge these refusals.

The adult subgroup recommends that the Health Care Authority conduct a Request for Information (RFI) to gather input on program design, determine whether any potential vendors are able and interested in performing this function, and better understand the costs associated with the proposed model. Prior to conducting a RFI, the State should also explore other bed tracking efforts that have been attempted over the years in Washington and in other states (both on a voluntary and mandated basis).

The subgroup also recommends that the system incorporate an information technology solution to track real-time placement availability and collect data on bed availability to inform future decisions. Through either a statutory amendment or contracts, the State should require all facilities to use the system to report bed utilization.

The Washington State Hospital Association (WSHA) expressed several concerns with the adult subgroup's recommendations. While many on the workgroup believe a centralized system would alleviate delays in accessing ITA beds, WSHA believes it does not solve gaps in access to services at all levels of crisis care, and does not ensure that individuals will gain treatment in the least restrictive setting possible. Also, WSHA feels that a centralized bed tracking system could redirect critical staff within the hospital to administrative functions and away from patient care.

Additionally, WSHA expressed concerns with requiring all facilities to use this system to report bed utilization, especially if there is not uniform consensus by all facilities (e.g., hospitals and residential evaluation and treatment facilities) who would bear the burden of reporting this information. WSHA believes the State should maintain a directory of facilities that may have psychiatric beds available, along with updated contact information.

The Washington Council for Behavioral Health also expressed concerns regarding a centralized placement system. The Council believes managing access to an inadequate number of beds will not create greater access to treatment. The Council is concerned about the costs of a 24/7 clinical team to manage a bed tracking system, how such a system would handle real-time information and regional differences, and which provider types would have access to it and how they would interact with each other. Most importantly to the Council, the recommendation is not an investment in what the state needs most, that is, early intervention and prevention to help people before their condition escalates to the point of requiring involuntary inpatient care.



Children’s Long-Term Involuntary Inpatient Program

The children’s subgroup believes that the State manages access well² for long-term involuntary care in contracted facilities under its CLIP program, governed by chapter 71.34 RCW. It recommends that the state continue this method of managing access. The subgroup provides recommendations on how to improve the continuum of care for children requiring involuntary inpatient behavioral health care services.

An important aspect of managing access to the children’s long-term inpatient program³ is to provide family and community supports that can either prevent children’s issues from escalating to that level of care, or ensure children can return to their families and communities when that level of care is no longer necessary.⁴ The children’s subgroup recommends that Washington implement community services that provide a full continuum of care (step-up/step-down options) such as family respite care, partial hospitalizations, and intensive outpatient programs.

Family Respite Services

It is common for the family to look to the state for long-term inpatient treatment when behaviors escalate. The children’s subgroup recommends respite care services as a method to decrease the use of the children’s long-term inpatient program. This service is currently available today for the developmentally disabled population through a waiver from the federal government of certain federal Medicaid requirements, and for the child welfare population through licensed providers.

Respite care keeps youth as close to their communities as possible when tensions and family interactions reach a point where a temporary break will provide the space and support needed for therapeutic progress towards youth and family goals. Respite care should be driven by the needs of the youth and family and be provided in a variety of settings such as the child’s home or an organization’s facilities. Respite will allow the family to:

- Receive some planned relief from the frequently conflictual relationship between the parent/guardian and youth experiencing the behavioral health challenges.
- Receive crisis respite to support families, stabilize children, and increase opportunities for prevention of out-of-home placement.
- Receive therapeutic interventions by trained professionals providing the respite care and learn how those home-based interventions can be used to mitigate or avoid future behavior escalation and decompensation.

² Although involuntary youth are placed on a waitlist with other youth and access may be delayed due to current capacity of CLIP programs.

³ The subgroup is not recommending that CLIP change its current access management practices. As required by federal law, Washington contracts with an independent authority, the CLIP Administration Office, for all statewide CLIP admissions, including voluntary referrals and adolescents involuntarily committed for up to 180 days of inpatient care (Involuntary Treatment Act orders). The CLIP Administration Office manages admissions and bed utilization of all five CLIP Programs (Child Study and Treatment Center, Lakewood; Sunstone Youth Treatment Center (Navos), Burien; Pearl Street Center, Tacoma; Tamarack Center, Spokane; Two Rivers Landing, Yakima). The CLIP Administration Office conducts medical necessity and recertification reviews on all voluntary referrals and Involuntary Treatment Act youth that have converted to voluntary status. It also provides clinical care coordination support for children and youth experiencing cross-system and other barriers for admission or discharge.

⁴ For example, to treat children with autism accompanied by severe behaviors, the Health Care Authority is designing a system that will provide an inpatient unit, partial hospitalization, community team support, and applied behavior analysis services in the home.

Providing occasional respite care for caregivers as part of a therapeutic treatment plan can reduce the likelihood that the caregivers and youth experience an escalation of conflict resulting in admission to long-term inpatient care. It may also reduce episodes of violence, emergency hospitalization, and homelessness.

The children's subgroup cautions that creating a new benefit under the Medicaid State Plan is complex when such service may cross over with an existing Medicaid waiver service. The subgroup recommends that the Health Care Authority explore the potential implementation of respite care as a State Plan service and only implement such service once it has a sufficient number of respite providers trained and contracted to provide such services as a State Plan benefit. We believe this approach will ensure compliance with federal and state legal obligations.

Other Community Supports to Increase the Continuum of Care

The children's subgroup recommends reducing the use of children's long-term inpatient (CLIP) care by providing care options in the gap between CLIP and services such as the Wraparound with Intensive Services (WISe) program.⁵ The subgroup recommends partial hospitalization programs, intensive outpatient programs, and community facilities as these gap services.

Partial Hospitalization and Intensive Outpatient Programs

The state should adopt evidence-based partial hospitalization programs and intensive outpatient programs as a Medicaid benefit⁶ for children who would benefit from short-term, intensive treatment programs structured around the child's particular needs. For children on Medicaid, these programs would address the continuum of care by being a key tool to avoid some inpatient admissions and help discharge certain patients from inpatient facilities in a more timely manner. Partial hospitalization programs and intensive outpatient programs should focus on giving children effective coping skills to improve self-management of care and enable them to continue treatment in a community setting, surrounded by family and other community-based supports.

The subgroup believes these programs will likely:

- Reduce inpatient care by helping stabilize patients outside of inpatient care settings.
- Ease discharge issues if patients can continue their behavioral health care by transitioning to an intensive outpatient care program once they no longer meet inpatient admissions criteria.
- Help reduce inpatient readmissions, because patients can access medication management and therapies.
- Increase health equity for low-income children.

Other Programs

The subgroup cautions that partial hospitalization programs and intensive outpatient programs will sometimes be insufficient. It recommends supplementing these programs by funding intermediate-level community-based facilities that can meet the needs of youth that are above the WISe but below the CLIP level of care.

⁵ WISe provides home and community based services for youth up to age 21 and their families. WISe works to avoid institutionalized care such as hospitalization, incarceration, and residential care for these youth. WISe is targeted for lower acuity children than those who would benefit from partial hospitalization or intensive outpatient programs.

⁶ These services are covered by most commercial health plans and Medicare. Low-income children on Medicaid should be able to access these same services.

Prior to implementing the above services, the children’s subgroup recommends the Legislature fund a one-year study to explore the eligible population, identify their likely needs and geographic locations, and establish a model that will ensure the availability of facilities and appropriately trained and licensed providers.

Integrating Risk for Long-Term Involuntary Inpatient Care into Managed Care Organization Contracts

The Legislature requested advice to guide the process that will fully integrate the risk for long-term involuntary inpatient care into managed care organization contracts. While these clients have historically been served in Eastern and Western State Hospital, there is growing desire to have them treated in community facilities. Community facilities will have a different cost structure from the State Hospitals. Little data currently exists on how cost will manifest in a community setting. The workgroup highlighted the importance of allowing for enough time to collect data on actual costs before incorporating this service into managed care rates. They identified three phases to this work.

- **Rate development pre-work** - data on cost and utilization developed to inform actuarial work.
- **Initial implementation** - HCA to consider risk mitigation arrangements during this initial period.
- **Post implementation** - HCA to make adjustments to contracts and rates based on experience during the initial implementation period.

Below are the recommendations of the workgroup:

1. For risk assumption to work, the capacity needs described in other sections of this report need to be implemented. There are certain indicators that the system would be ready, such as:
 - a. No waitlists for individuals accessing the type of care they need, including E&T facility beds, getting into and out of long-term beds, and into intensive community-based services
 - b. Better investment in the diversion system
2. ITA payment issue: The work group recommends that the Legislature review the issue of tying payment to status for civil commitment. Washington is one of a small number of states to do so.
3. Rate development pre-work:
 - a. HCA should gather data regarding the current utilization of long-term involuntary care, where services are being provided, and the costs
 - b. HCA or some other state agency should update the research done previously by PCG as to whether any other state has shifted risk for long-term involuntary inpatient care into managed care contracts
 - c. HCA should identify any legal or contracting issues that need resolution prior to incorporating services into managed care contracts and rates
 - d. HCA should recognize the degree to which MCOs are able to manage client care for this type of service when developing rates
 - e. When developing the rates, the state should fund the level of services needed (not necessarily the level of services the State provides today)



4. Initial implementation:
 - a. The state should consider development of two-way risk corridors, carve-outs, or other means to ensure fair funding in the initial service years of the contract;
 - b. HCA should use quality measurement mechanisms to monitor implementation of the program by managed care organizations.
5. Post implementation:
 - a. Adjust rates and contracts based on actual experience
 - b. Review needs such as workforce, facilities and crisis and related preventative services

Increasing Support for Co-Occurring Disorder Services to Expand Bidirectional Integration

In order for the state to expand bidirectional integrated care, it first must have an adequate base of providers who are licensed and certified to provide both physical and behavioral health services. Increasing supports for co-occurring service disorders⁷ alone will not create the providers or the facilities needed to provide those services. In addition, the process by which licensed mental health providers become credentialed as Substance Use Disorder (SUD) Providers/Chemical Dependency Providers (CDPs) must be streamlined to highlight the most salient aspects of effective SUD treatment. The same is also true for CDPs seeking mental health certification. This workgroup recommends that the Legislature invest state funds to incentivize providers and facilities to obtain the licensure or certifications necessary to expand the workforce.

Complicating this work is the complexity of the federal laws regulating sharing of information between providers treating physical and behavioral health conditions. The workgroup is unable to solve this problem by establishing new billing rates or creating new service categories; however, the work group does offer three recommendations to enhance whole-person bidirectional care.

Creation of a quad-screening bundle to promote bidirectional integration and whole person care.

The work group's first recommendation is to increase early intervention behavioral health services through comprehensive behavioral health screenings.

Screenings are an early intervention activity that allow care providers to identify issues early, provide prevention services, and avoid more extensive treatment later in life, particularly for children and youth.

Preventive health activities such as annual physicals, sports physicals for youth, and school screenings generally focus on physical health. Including comprehensive behavioral health screenings promotes bidirectional care. The work group identified already available tools it recommends providers combine with their physical health screenings to create one-stop, whole person screening: the patient health questionnaire (PHQ-9); generalized anxiety disorder (GAD-7); child and adolescent trauma screen (CATS); and the screening, brief intervention, and referral to treatment (SBIRT). HCA should explore value-based payment models that encourage the use of these four screens into a bundle and incentivize providers to use this as a quad-screening tool.

⁷ People who have substance use disorders as well as mental health disorders are diagnosed as having co-occurring disorders.

Screenings could take place in a variety of settings, not just schools or during yearly physicals at physicians' offices or health care centers. The work group recommends making screenings available in local community-based behavioral health centers, federally qualified health centers (which provide both behavioral and physical healthcare), and mobile clinics.

The effectiveness of these screens will require providers to have access to the patient's electronic health record as a means to prevent duplicative screenings. Methods for inputting screening results into the electronic health record must be readily available to ensure the primary care provider is able to furnish whole-person care and make informed treatment decisions, including referrals to the appropriate behavioral healthcare, as the screenings may indicate. Payers should compensate those conducting the screenings.

Incentivize and promote behavioral health-related trainings

The second recommendation of the subgroup is to increase access to behavioral health-related training to targeted audiences. The subgroup recommends making behavioral health training, such as mental health first aid and trauma-informed approaches, available to everyone providing health care and social services, such as school employees, first responders, law enforcement, health care professionals, childcare workers, and foster parents.

The subgroup recommends that the Health Care Authority, Department of Health, and behavioral health administrative services organizations use their websites and other outreach methods to increase awareness of these existing trainings. If made known of their availability, various professional associations could include these trainings in conferences and continuing education seminars for professionals. In the longer term, these trainings should be included as part of the regular educational curriculum that individuals must complete to obtain physical health credentials.

The subgroup also recommends that the Legislature explore ways to incentivize these target audiences in receiving behavioral health trainings or provide general state funds.

Residential Treatment Facilities

This subgroup recommends that the Legislature expand funding opportunities for residential treatment facilities with onsite behavioral health professionals. The subgroup believes that the lack of an appropriate place to stay is a social determinant that hinders the ability of those with physical and behavioral health conditions to get and stay well. Providing residential treatment facilities with onsite mental health and substance use disorder treatment providers will allow individuals to maintain their physical health and allow onsite staff to identify individuals who are decompensating. This should reduce admissions to hospital emergency departments and inpatient psychiatric units.



Appendix A: E2SSB 5432, Section 1003(3)

The authority shall establish a work group to determine: (a) How to appropriately manage access to adult long-term inpatient involuntary care and the children's long-term inpatient program in the community and at eastern and western state hospitals, until such a time as the risk for long-term involuntary inpatient care may be fully integrated into managed care organization contracts, and provide advice to guide the integration process; and (b) how to expand bidirectional integration through increased support for co-occurring disorder services, including recommendations related to purchasing and rates. The work group shall include representation from the department of social and health services, the department of health, behavioral health administrative services organizations, at least two managed care organizations, the Washington state association of counties, community behavioral health providers, including providers with experience providing co-occurring disorder services, and the Washington state hospital association. Managed care representation on the work group must include at least one member with financial expertise and at least one member with clinical expertise. The managed care organizations on the work group shall represent the entire managed care sector and shall collaborate with the nonrepresented managed care organizations. The work group shall provide recommendations to the office of financial management and appropriate committees of the legislature by December 15, 2019.



Appendix B: Workgroup Members

Member	Representing
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Appendix C: Work Group Meetings and Activities

July 12, 2019

The work group's first meeting occurred July 12, 2019, in Olympia. Project Lead Annette Schuffenhauer opened the meeting with background information and a project overview. Attendees then split into three groups and rotated among three workshops. The purpose of the workshops was to generate topics and issue lists to start formulation of recommendations for the project's three primary topics. The results of these workshop sessions set the context and work of the project's subgroups. (See Appendix E.) The three workshops asked participants for their thoughts on the following questions:

Managing access to adult long-term involuntary care

- What is the single biggest challenge to managing access to long-term involuntary care in the community setting for the adult population?
- What is the single biggest challenge to managing access in the institutional setting for adults?
- What work (completed or underway) can we leverage off of this summer to provide recommendations on how Washington State should be managing access for long-term involuntary care for adults?

Managing access to children's long-term involuntary care

- What is the single biggest challenge to managing access to long-term involuntary care in the community setting for children?
- What is the single biggest challenge to managing access in the institutional setting?
- What work (completed or underway) can we leverage off of this summer to provide recommendations on how Washington State should be managing access for children's long-term involuntary care?

Expanding bidirectional integration through increased support for co-occurring disorder services

- What is the single biggest challenge to expanding directional integration?
- What are some strategies for increasing support for co-occurring disorder services? What aren't we doing that we should be doing?
- What work completed/underway can we leverage off of this summer to provide recommendations on how to expand bidirectional integration through increased support for co-occurring disorder services?
- What are your biggest concerns related to paying/funding this type of service model?

At the end of the meeting, participants were asked to sign up to participate in one or more of the project's subgroups:

- Adult
- Children
- Co-Occurring
- Finance



July 28, 2019

The Health Care Authority hosted adult, children, and co-occurring subgroup meetings. Meeting separately, the subgroups reviewed the information gathered from participants at the July 12 meeting. The subgroups revised and expanded upon that information and engaged in robust discussions regarding their experiences and challenges. Subgroup members then voted on the most important issues that the subgroup should address at remaining meetings in order to develop the recommendations to be included in the final report. (See Appendix E.)

August 2, 2019

The Health Care Authority hosted the adult, children, and co-occurring subgroups in separate meetings to review the three most important issues for which the subgroups will develop recommendations for inclusion in the final report.

August 16, 2019

The Health Care Authority hosted the adult subgroup. Participants worked on: (1) a triage recommendation to manage placement of adults in involuntary inpatient care; (2) a throughput recommendation to ensure timely and appropriate placement of adults in community care following a period of involuntary inpatient care; and (3) advice for the integration of risk for involuntary inpatient care in managed care contracts.

August 22, 2019

The Health Care Authority hosted the finance subgroup. The purpose of the meeting was to begin the process of identifying the financial resources needed to execute the recommendations made by the adult, children, and co-occurring subgroups. This meeting primarily focused on developing the cost of the adult subgroup's triage proposal, which would create a system for centrally managing long-term involuntary inpatient placements. The subgroup assumed financial costs should include HCA's initial manual management of the triage system, and the cost of implementing an information technology solution for the future. The finance subgroup also discussed integrating the risk of long-term involuntary inpatient care into managed care contracts. Finally, the finance subgroup began a discussion of the adult subgroup's second recommendation related to throughput, that is, managing the discharge of patients from long-term involuntary inpatient care to more appropriate settings so that those long-term beds are available for new placements.

August 23, 2019

The Health Care Authority hosted the adult, children, and co-occurring subgroups in separate meetings. The adult subgroup reviewed members' progress on action items assigned at the August 16 meeting. The adult subgroup also reviewed the finance subgroup's request for clarifying information. The children's subgroup worked on further development of its recommendations. The children's subgroup primarily focused on its recommendation to increase bed capacity in the community and provide step-down and diversion programs, including facilities, respite care, and partial hospitalization day treatment. The co-occurring subgroup also worked on further development of its recommendations. The meeting focused on two recommendations: (1) Implementing multiple screening tools that would identify need for multiple behavioral health interventions and promoting mental health first aid training; (2) Providing supported housing as a step-down transitional service through which individuals



would obtain stable housing to address that social determinant of health along with onsite behavioral health services.

August 30, 2019

The Health Care Authority hosted the children and co-occurring subgroups in separate meetings. Both subgroups reviewed and further discussed their recommendations.

September 6, 2019

The Health Care Authority hosted the finance and adult subgroups in separate meetings. The finance team reviewed the adult subgroup's short and long-term placement proposal, resource estimates, and costs. Finance also reviewed a summary of how other states are using technology to track inpatient bed availability. The Finance subgroup considered Beacon's plan to introduce a bed tracker solution in Washington State. The subgroup intends to learn more about the bed tracker solution Beacon uses in Georgia and how Washington might leverage that experience and technology. The adult subgroup reviewed the recommendations the other subgroups are working on. The adult subgroup also reviewed the state of its own recommendations. Regarding the bed management recommendation, the subgroup learned that executive oversight is asking that the subgroup propose conducting a request for information to determine outside organizations' interest in staffing and operating the function rather than have the Health Care Authority do so. The subgroup also discussed the current state of bed availability and placement and the need for throughput solutions to make a bed management solution worthwhile. Finally, the adult subgroup discussed how the state could better manage bed placement effective January 1, 2020.



Appendix D: Prior Reports and Studies

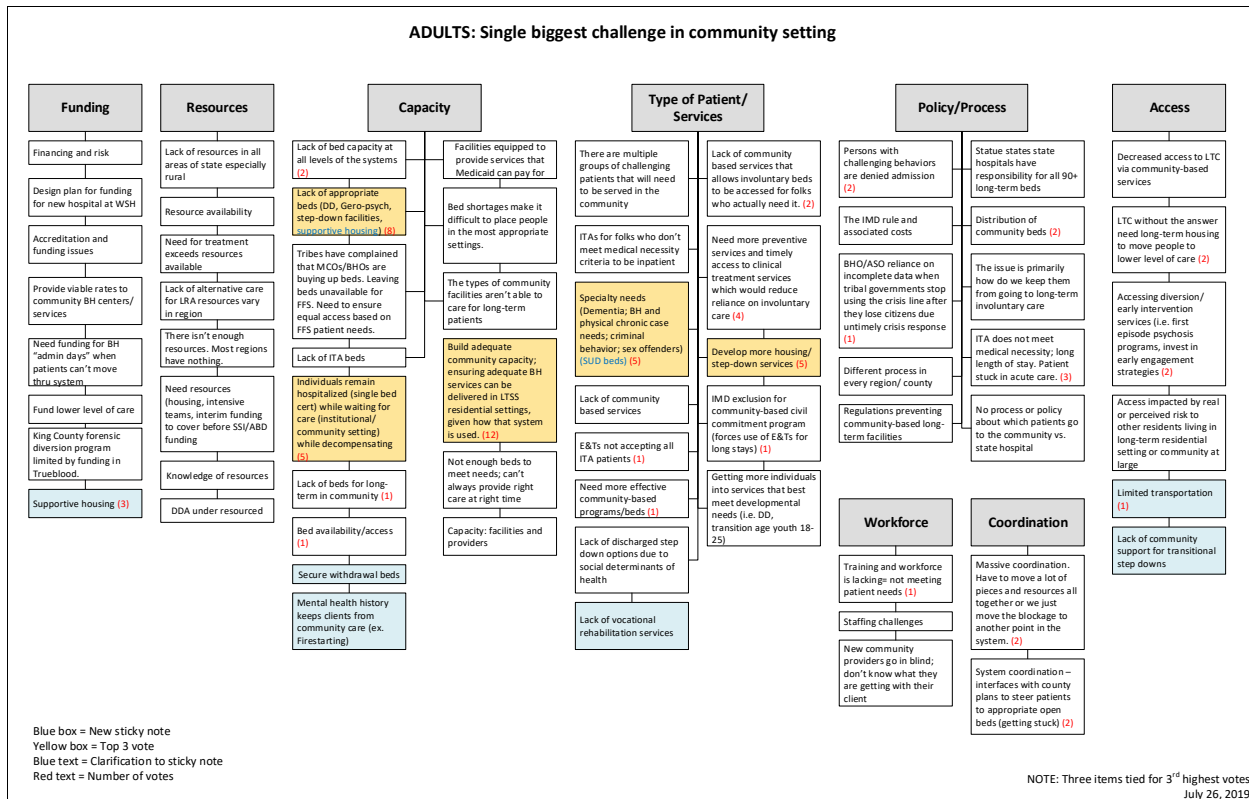
- [Washington State Behavioral Health System Assessment and Final Recommendations](#),” November 22, 2016
- [“Final Alternative Options and Recommendation Report](#),” November 28, 2016
- [“The Children’s Mental Health Work Group Final Report and Recommendations](#),” December 2016
- [“Inpatient Psychiatric Care Risk Model Report](#),” December 28, 2017
- [“Behavioral Health Treatment Needs and Outcomes Among Medicaid Children in Washington State](#),” February 2018
- [“Improve Access to Prevention and Treatment of Opioid Use Disorders](#),” November 30, 2018
- [“Access to Behavioral Health Services for Children](#),” December 1, 2018
- [“Medicaid Funding for Institutions for Mental Disease \(IMD\)](#),” December 1, 2018
- [“Transforming Washington’s Behavioral Health Care System](#),” December 2018
- [“Integrated Managed Care: Legislative Update](#),” December 1, 2018
- [“90-180 Day \(Long-Term\) Civil Commitment Beds](#),” HCA, January 2019
- [“Expand Access to Outpatient Mental Health Services \(Partial Hospitalization and Intensive Outpatient Programs\)](#),” Washington State Hospital Association, 2019 Budget Brief
- [“Adding Behavioral Health Services to the State Plan](#),” March 5, 2019
- [“Washington State Medication Assisted Treatment – Prescription Drug and Opioid Addiction Project](#),” April 2019
- “Children’s Mental Health Work Group – Recommendations Status,” June 26, 2019
- [“Involuntary Treatment Act Court: Reentry and Court Outcomes](#),” King County Auditor’s Office, July 9, 2019
- [“Inpatient Bed Tracking: State Responses to Need for Inpatient Care](#),” HHS, August 6, 2019



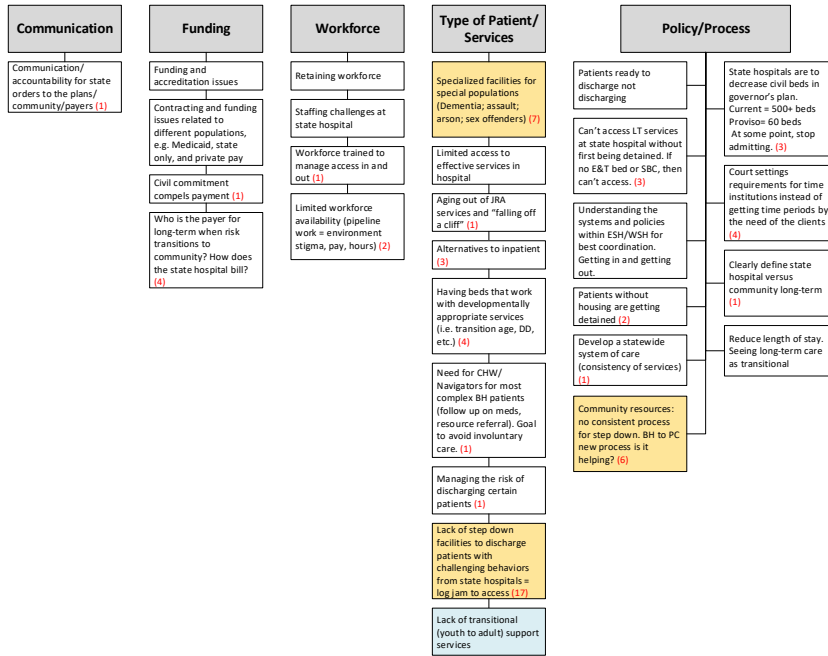
Appendix E: Affinity Diagrams

These affinity diagrams document brainstorming input provided by work group participants at the July 12 and July 28 meetings. They contain the impressions and opinions of individual work group members.

Adult Subgroup



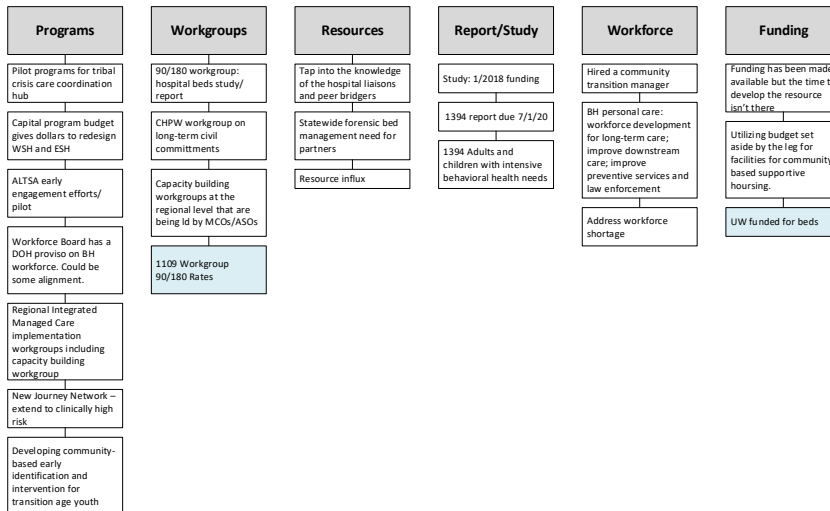
ADULTS: Single biggest challenge in institutional setting



Blue box = New sticky note
 Yellow box = Top 3 vote
 Blue text = Clarification to sticky note
 Red text = Number of votes

July 26, 2019

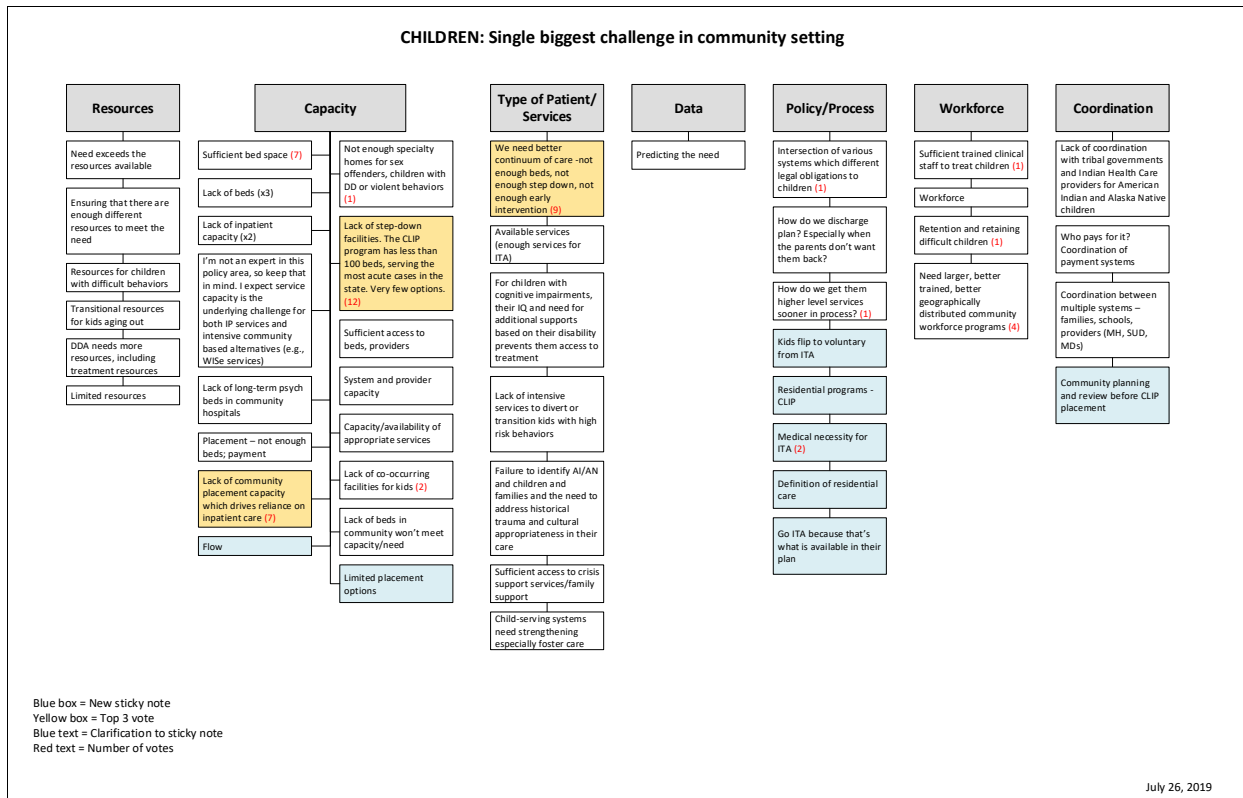
ADULTS: Leverage work completed or underway



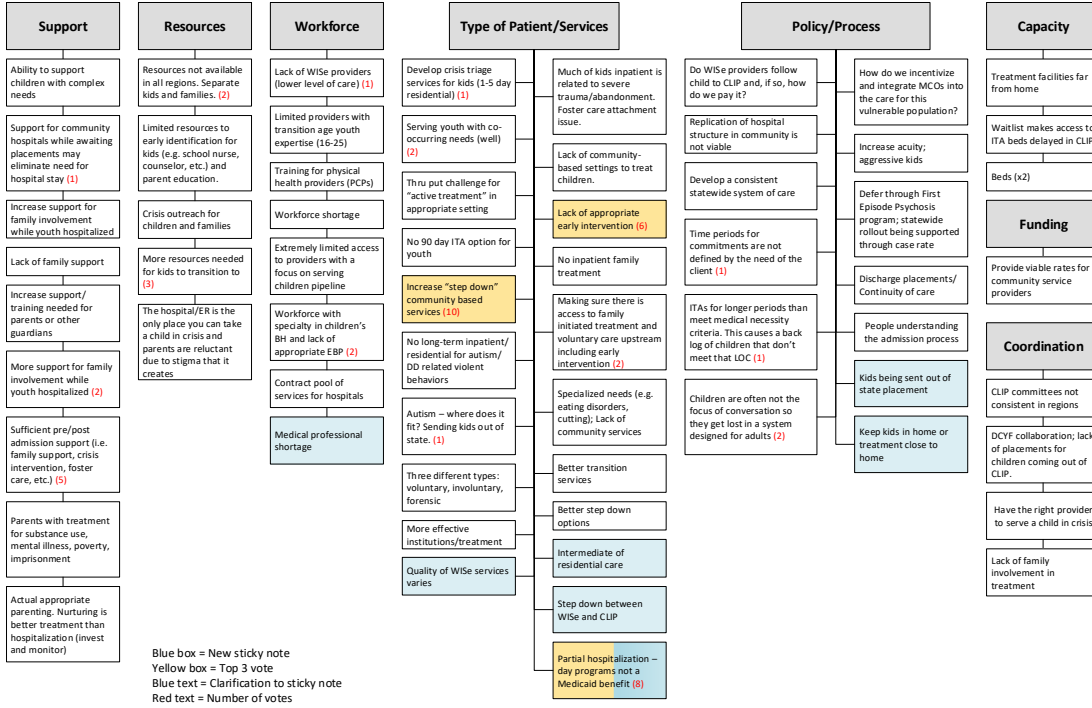
Blue box = New sticky note
 Blue text = Clarification to sticky note
 Red text = Number of votes

NOTE: No multi-vote
 July 26, 2019

Children Subgroup

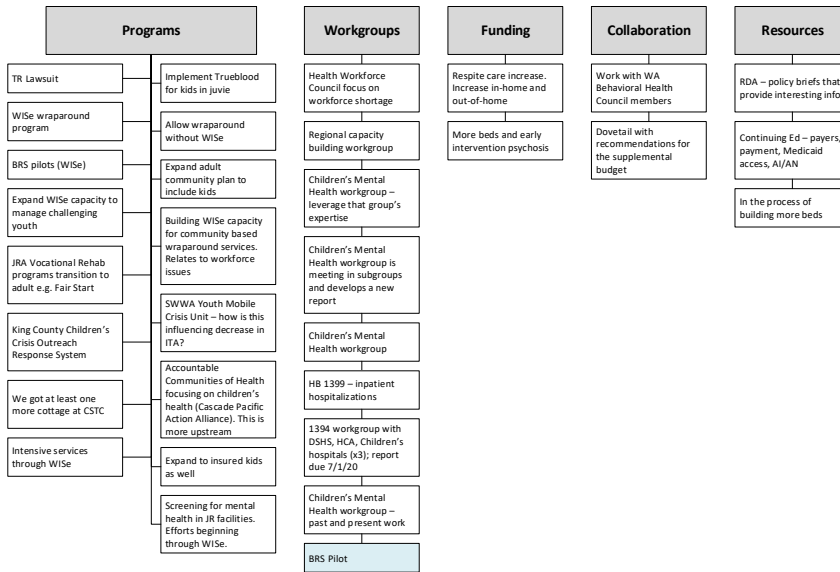


CHILDREN: Single biggest challenge in institutional setting



July 26, 2019

CHILDREN: Leverage work completed or underway

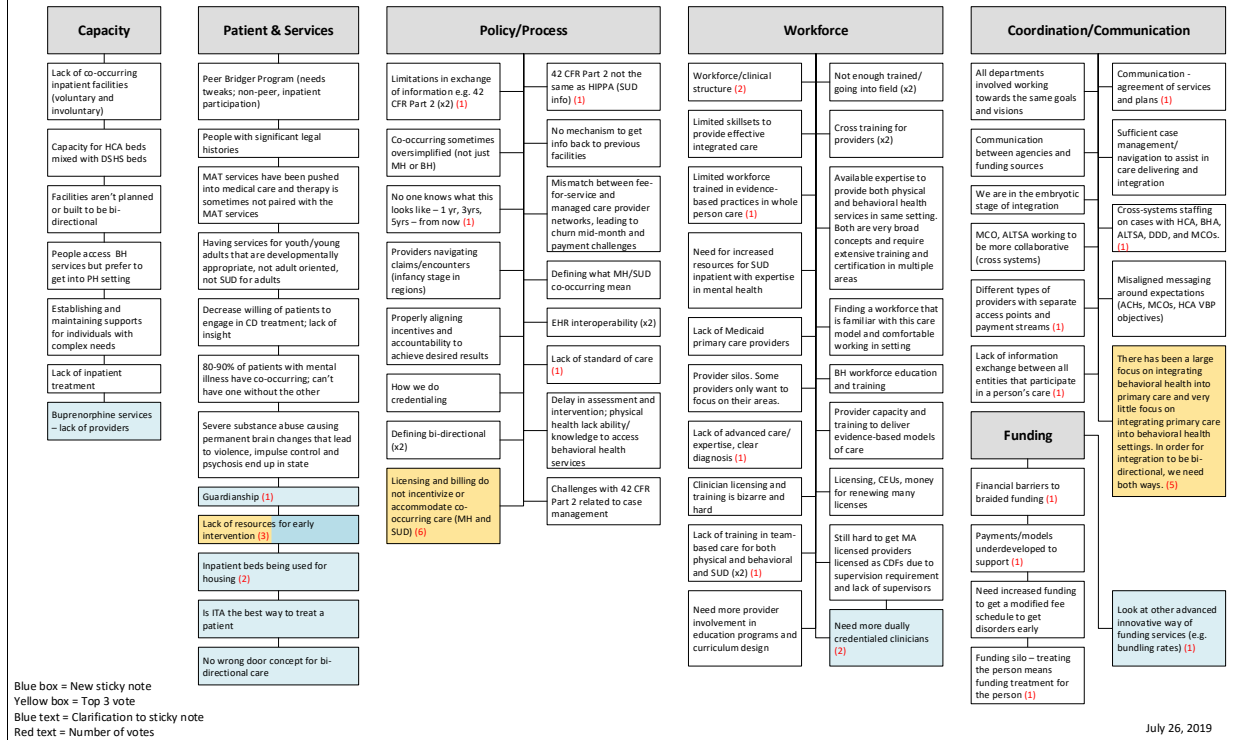


NOTE: No multi-voting

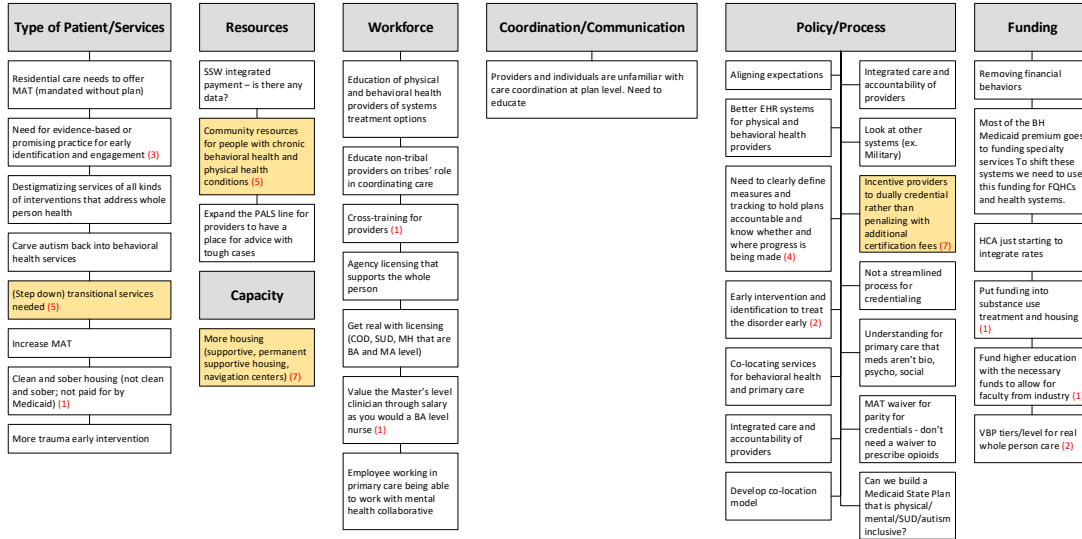
July 26, 2019

Co-Occurring Subgroup

CO-OCCURRING: Single biggest challenge in community setting



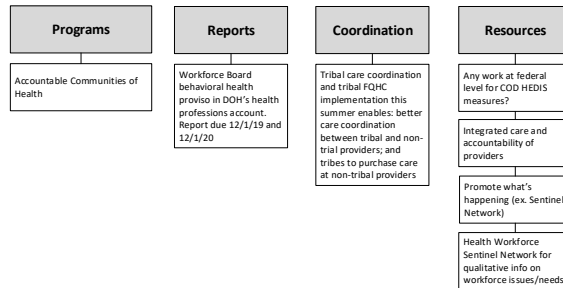
CO-OCCURRING: Strategies for increasing co-occurring disorder services



Blue box = New sticky note
 Yellow box = Top 3 vote
 Blue text = Clarification to sticky note
 Red text = Number of votes

NOTE: Two items tied for 3rd highest votes
 July 26, 2019

CO-OCCURRING: Leverage work completed or underway

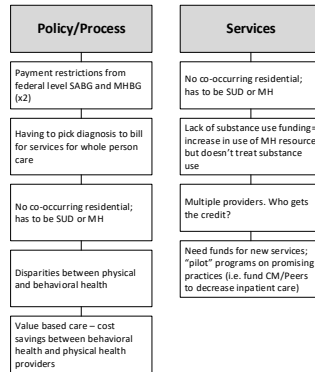


7/12/19: Not all sessions were able to use sticky notes due to time constraint. See notes for details on conversations.

7/26/19: No multi-voting.

July 26, 2019

CO-OCCURRING: Concerns related to paying/funding this type of service model



7/12/19: Not all sessions were able to use sticky notes due to time constraint. See notes for details on conversations.

7/26/19: No multi-voting

July 26, 2019



Appendix F: Meeting Summaries

Meeting minutes and workgroup notes are available upon request.

