BP 45 Partnerships with Community Hospitals to Serve Psychiatric Patients on Single Bed Certifications (SBCs)

Existing MIDD Program/Strategy Review □ MIDD I Strategy Number _____ (Attach MIDD I pages)
New Concept X (Attach New Concept Form) 45 Serving Emergency Department Psychiatric Patients at Highline Medical Center
Type of category: New Concept

SUMMARY: This concept aims to provide direct support to community hospitals to provide timely and appropriate psychiatric care for individuals who have been involuntarily committed but are temporarily placed in their emergency departments or other non-psychiatric units via single bed certification (SBC) while they are awaiting a certified evaluation and treatment (E&T) bed. The purpose of the service would be to help hospitals manage challenging behaviors that occur in non-psychiatric settings, and to assist with expediting discharge and transition to an E&T bed.

Subject Matter Experts and/or Stakeholders consulted for Briefing Paper preparation. List below.

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The following questions are intended to develop and build on information provided in the New Concept Form or gather information about existing MIDD strategies/programs.

A. Description

1. **Please describe the New Concept or Existing MIDD Strategy/Program: Please be concise, clear, and specific. What is being provided to whom, under what circumstances? What are the New Concept Existing MIDD Strategy/Program goals? For New Concepts, does it relate to an existing MIDD strategy? If so, how?**

This concept aims to provide direct support to community hospitals to provide timely and appropriate psychiatric care for individuals who have been involuntarily committed but are temporarily placed in their emergency departments or other non-psychiatric units via single bed certification (SBC)[1] while they are awaiting a certified evaluation and treatment (E&T)[2] bed. The purpose of the service would be to help hospitals manage challenging behaviors that occur in non-psychiatric settings, and to assist with expediting discharge and transition to an E&T bed.

New partnerships between King County's behavioral health providers and community hospitals serving people with psychiatric needs, including those being treated involuntarily via SBCs, would help community hospitals meet the requirement to provide timely, individualized therapeutic care to individuals in their facilities. This will also promote faster recovery, enabling people to move out of acute care settings more quickly.

Behavioral health agencies that offer services to the same population on an outpatient basis could provide hospital patients with psychiatric assessment, medication assessment and prescription, patient education, peer support services, adjunctive therapy interventions to reduce long-term risk, and environmental outings. In addition, behavioral health agencies could train existing hospital staff on relevant topics such as trauma-informed care and therapeutic de-escalation techniques. Implemented together, such approaches have the potential to reduce patient distress and unmanageable behavior on hospital units while also easing the anxiety of staff and medical patients. Furthermore, this program may have the dual benefit of bringing more coordinated care to SBC patients and community hospitals, driving down the demand for E&T beds by increasing the use of less restrictive alternatives that community hospitals may otherwise be reluctant to pursue due to their relative lack of expertise in acute mental health care. Furthermore, many emergency medical and ambulance costs could be

[1] In 2009, in response to the already-escalating involuntary treatment capacity problem in Washington, a new section 388-865-0526 was added to the Washington Administrative Code (WAC) to institute a single bed certification (SBC) process. This protocol was added to provide temporary certification that allowed individual patients detained under the state's Involuntary Treatment Act to be served in non-E&T hospital settings such as medical units, voluntary psychiatric units, or when necessary, emergency departments. Psychiatric care appropriate to an involuntary patient was often lacking in these settings, with patients sometimes left strapped to gurneys in hallways without being seen often enough by mental health professionals or psychiatrists, or otherwise insufficiently treated for unacceptable periods of time. Though this provision kept people in behavioral health crisis safe when E&T beds were not available, it also became a mechanism by which far too many people were held in settings that did not adequately meet their behavioral health care needs. The initial rule creating SBCs did not articulate any specific requirements for the person's care, making the patient's experience quite variable depending on individual hospitals' capacity and practices. Regulations governing SBCs were revised in response to the 2014 D.W. ruling that invalidated boarding, to require timely and appropriate mental health treatment for all individuals detained in SBC status, creating significant new responsibilities for community hospitals that accept such patients. This revised WAC is discussed in section B1.

[2] Washington State certifies certain programs, called evaluation and treatment (E&T), to provide short-term involuntary inpatient psychiatric treatment as required under the ITA whenever detention standards are met and less restrictive alternative treatment is not appropriate. E&T programs are designed to provide a treatment environment that is specifically suited to the needs of people who cannot maintain safety in the community and are in need of involuntary mental health care. Usually these beds are used for the 72-hour detention and 14-day commitment periods. Many voluntary psychiatric units in community hospitals do not hold this certification for involuntary E&T services. In King County there are five facilities with certified E&T Programs: Fairfax Hospital in Kirkland, serving adolescents and adults; Harborview Medical Center in Seattle, serving adults; Navos in West Seattle, serving primarily adults; Northwest Hospital Geropsychiatric Center in Seattle, serving almost exclusively older adults; and Cascade Behavioral Health in Tukwila, serving adults, which was newly certified in 2015.

reduced if patients could be stabilized and discharged from the "first touch" medical facility rather than later transferred to an E&T.

One community mental health provider (Navos) and a nearby community hospital (Highline) are currently actively exploring this partnership; however, the concept could be scaled to be made available to other mental health agency/hospital partners in King County. Currently all 39 community hospitals are engaged in serving patients on single bed certifications to varying degrees.

2. **Please identify which of the MIDD II Framework's four Strategy Areas best fits this New Concept/Existing MIDD Strategy/Program area** (Select all that apply):

☒ **Crisis Diversion**	☐ **Prevention and Early Intervention**
☒ **Recovery and Re-entry**	☐ **System Improvements**

Please describe the basis for the determination(s):

By bringing immediate mental health supports to people in crisis in community hospitals, this concept would enable people who are in crisis to get the help they need (Crisis Diversion). By helping people to engage effectively with community alternatives to inpatient care, the concept would empower people to become healthy and safely reintegrate to community after crisis (Recovery and Re-entry).

B. Need; Emerging, Promising, Best, or Evidence Based Practices; Outcomes

1. **Please describe the Community Need, Problem, or Opportunity that the New Concept Existing MIDD Strategy/Program addresses: What unmet mental health/substance use related need for what group or what system/service enhancement will be addressed by this New Concept/Existing MIDD Strategy/Program? What service gap/unmet need will be created for whom if this New Concept Existing MIDD Strategy/Program is *not* implemented? Provide specific examples and supporting data if available.**

"Psychiatric boarding" or "boarding" has become shorthand for the treatment access crisis that resulted when community need for inpatient mental health care – especially involuntary treatment[3] – exceeded appropriate available resources. When appropriate treatment beds were not available, individuals were detained and waiting in less than optimal settings such as emergency departments (EDs) until a psychiatric bed became available. This has been a nationwide problem that had been affecting Washington and King County since at least 2009. The effects, historical context, and gradual onset of this phenomenon are discussed at length in the reports of the Governor and Executive's Community Alternatives to Boarding Task Force (CABTF), available via the link below.[4] Key analysis and conclusions from theses reports are summarized here as context for this concept.

Psychiatric boarding is widely recognized as a major treatment access crisis that hurts patients and drives resources away from community-based and preventive care. Nationally, studies show that prolonged waits in emergency departments for psychiatric patients are associated with lower quality mental health care, as the chaotic emergency department environment increases stress and can worsen

[3] Key terms and processes involved in involuntary treatment in Washington state are defined and summarized in the two progress reports of the Community Alternatives to Boarding Task Force (CABTF), especially the background section of CABTF progress report 1 (June 2015).

[4] CABTF reports are available at www.kingcounty.gov/mhsa, under "What's New." Much of the need analysis and policy context provided in this briefing paper is summarized from those reports.

patients' conditions[5] and due to the fact that needed psychiatric services are often not provided.[6] More and more people are seeking psychiatric care via hospital emergency departments,[7] possibly as a result of the difficulty people experience in accessing community mental health services before they are in crisis, as well as the dramatic reduction in inpatient psychiatric capacity nationally.[8]

The Washington State Supreme Court, in its 2014 *In re the Detention of D.W. et al* decision, prohibited holding involuntary psychiatric patients in non-psychiatric settings solely due to lack of inpatient capacity at certified E&T facilities. The Court found that funding limitations or capacity shortages in certified E&T facilities are invalid reasons for detaining a person while delaying the provision of appropriate mental health care.[9]

Five years prior to the ruling, in response to the already-escalating involuntary treatment capacity problem in Washington, a single bed certification (SBC) process had been created to provide temporary certification that allowed individual patients detained under the state's Involuntary Treatment Act (ITA) to be served in non-E&T hospital settings such as medical units, voluntary psychiatric units, or when necessary, emergency departments. Though this provision kept people in behavioral health crisis safe when E&T beds were not available, it also became a mechanism by which far too many people were held in settings that did not adequately meet their behavioral health care needs. The initial rule creating SBCs did not articulate any specific requirements for the person's care, but since December 2014, SBCs may now only be used to hold a person involuntarily when the hospital is willing and able to provide timely and appropriate mental health treatment to the person. As a result, SBCs now depend on the voluntary participation of a community hospital or other appropriate facility in providing psychiatric services. King County hospitals have been much more receptive than most in the state to the added responsibility that comes with SBC requests since the *D.W.* ruling. There is broad agreement that even the legally allowable use of SBCs to provide "timely and appropriate treatment" to people in crisis is a temporary stopgap, neither a preferred nor a long-term system solution.

In King County and Washington, the psychiatric boarding/single bed certification phenomenon has been driven by a confluence of factors: community and inpatient resources are scarce, while at the same time the treatment need is very high, the population is growing quickly, and laws are changing increasing the likelihood of involuntary detention.

The number of available civil state hospital beds where patients committed under the ITA receive long-term treatment if needed, dropped 25 percent (a loss of 250 beds) between 2006 and 2011. They remain at these historically low levels.[10] Furthermore, the number of community hospital and E&T

[5] Bender, D., Pande, N., Ludwig, M. (2008). *A Literature Review: Psychiatric Boarding: Office of Disability, Aging and Long-Term Care Policy*. Retrieved from **http://aspe.hhs.gov/daltcp/reports/2008/PsyBdLR.pdf**.

[6] American College of Emergency Physicians. ACEP Psychiatric and Substance Abuse Survey (2008), as cited in Abid, Z., Meltzer, A., Lazar, D., Pines, J. (2014). Psychiatric Boarding in U.S. EDs: A Multifactorial Problem that Requires Multidisciplinary Solutions. *Urgent Matters Policy Brief,* 1(2).

[7] Owens P, Mutter R, Stocks C. Mental Health and Substance Abuse-Related Emergency Department Visits among Adults, 2007: Agency for Healthcare Research and Quality (2010), as cited in Abid et al. (2014). Psychiatric Boarding in U.S. EDs: A Multifactorial Problem that Requires Multidisciplinary Solutions. *Urgent Matters Policy Brief,* 1(2).

[8] Abid et al. (2014). Psychiatric Boarding in U.S. EDs: A Multifactorial Problem that Requires Multidisciplinary Solutions. *Urgent Matters Policy Brief,* 1(2).

[9] *In re the Detention of D.W., et al.* Case 90110-4. Washington State Supreme Court, retrieved from http://www.courts.wa.gov/opinions/pdf/901104.pdf.

[10] Legislative Evaluation and Accountability Program Committee. Operating Budgets for fiscal years 2007-14, Mental Health Program sections, retrieved from http://leap.leg.wa.gov/leap/budget/index_lbns.asp.

facility beds in Washington certified for involuntary patients also fell by 31 percent (a loss of 194 beds) between 2000 and 2007, as many independent community hospitals closed their certified psychiatric units or reduced the number of available beds. Seventy-six of those beds were gradually restored over the next few years, but this still left a net reduction of 118 beds (19 percent) as recently as 2013.[11] 2014 brought a major increase of 159 involuntary inpatient beds statewide, as the state and local communities have begun to add new resources to address the psychiatric boarding crisis, which has brought the total number of beds statewide back to approximately the same levels as in 2000.[12] However, current capacity needs far exceed what was required 16 years ago.

The dramatic reduction in inpatient resources during the mid-2000s contributed to Washington's overall ranking of 46th among states in per capita short-term mental health facility capacity (including both community hospital beds and E&T beds), according to a 2015 analysis by the Washington State Institute for Public Policy (WSIPP) of data from Substance Abuse and Mental Health Services Administration's (SAMHSA) 2010 National Mental Health Services Survey (N-MHSS).[13]

Major cuts to flexible non-Medicaid mental health funds from the state ($40.9 million statewide, or 34 percent since 2009)[14] have also significantly affected treatment access. These non-Medicaid funds are prioritized for crisis, involuntary commitment, residential, and inpatient services and play an important role in creating and maintaining a comprehensive continuum of community-based care, and also enable King County to facilitate treatment access for individuals who do not have Medicaid. Meanwhile, many Involuntary Treatment Act (ITA) policy changes have been implemented in recent years, most of them designed to make it easier to detain people in crisis involuntarily and/or to extend inpatient stays for these individuals.[15] And finally, the population of King County grew by an estimated 20 percent between 2000 and 2014.[16]

All five E&T facilities in King County have operated at or near capacity on a daily basis for several years, serving a mix of voluntary and involuntary patients. As of May 2015 on average only 209 out of the 341 certified E&T beds (61 percent) were actually occupied by King County ITA patients, with 85 beds serving voluntary patients and 47 used by ITA patients from other counties.[17]

On top of these enduring acute care capacity challenges, access to beds at Western State Hospital (WSH) for individuals who require long-term treatment has been severely curtailed in 2015. As a result of these developments at WSH, movement of patients on long-term 90- and 180-day treatment orders from local

[11] Burley, M., & Scott, A. (2015). *Inpatient psychiatric capacity and utilization in Washington State* (Document Number 15-01-54102). Olympia: Washington State Institute for Public Policy, retrieved from http://www.wsipp.wa.gov/ReportFile/1585/Wsipp_Inpatient-Psychiatric-Capacity-and-Utilization-in-Washington-State_Report.pdf.

[12] Burley, M. & Scott, A. (2015).

[13] Burley, M. & Scott, A. (2015).

[14] Legislative Evaluation and Accountability Program Committee. Enacted Budget Bills, 2008-2015, Mental Health Program sections (204), retrieved from http://leap.leg.wa.gov/leap/budget/index_lbns.asp.

[15] Burley, M. (2011). *How will 2010 changes to Washington's Involuntary Treatment Act impact inpatient treatment capacity?* (Document No. 11-07-3401). Olympia: Washington State Institute for Public Policy, retrieved from http://www.wsipp.wa.gov/ReportFile/1092/Wsipp_Inpatient-Psychiatric-Capacity-in-Washington-State-Assessing-Future-Needs-and-Impacts-Part-One_Full-Report.pdf.

[16] U.S. Census Bureau State and County QuickFacts, retrieved from **http://quickfacts.census.gov/qfd/states/53/53033.html**, and Population for the 15 Largest Counties and Incorporated Places in Washington: 1990 and 2000, retrieved from **https://www.census.gov/census2000/pdf/wa_tab_6.PDF**.

[17] King County Mental Health, Behavioral Health and Recovery Division (BHRD) surveys of evaluation and treatment (E&T) facilities, March 2015 and May 2015.

King County E&T facilities or community hospitals into long-term treatment beds at WSH remain severely limited, thereby leaving fewer acute care beds available for community members who needed them. Due to these evolving conditions at WSH, in November 2015 the independent E&T facilities that serve King County reported that 54 acute care ITA beds – out of the 208 that facilities reported were typically available for King County ITA patients as of November 2015[18] – were occupied by individuals on more restrictive long-term orders. Thus, only about half of the certified beds online at the time of this most recent survey were actually available for involuntary acute care.

E&T facilities consistently reported a trend of increase in late 2015 in the number of patients on long-term more restrictive orders and patients waiting for WSH beds, and some reported a corresponding overall increase in length of stay for their patients, as community resources were likewise less available. As a result of all of these factors, local E&Ts' capacity to admit and treat new King County patients has been significantly reduced. This results in an impact to both the patient who remains in a care setting not designed specifically for his or her needs, and to the individuals who do need that level of care but must wait in another setting, most often being held on an SBC.

A concerted community effort to respond to the 2014 *D.W.* court ruling that mandated timely and appropriate psychiatric treatment for all involuntary patients, led by King County and the Governor and Executive's jointly convened Community Alternatives to Boarding Task Force (CABTF) along with community partners, had significant immediate impact on SBC use. Between October 2014 and May 2015, an average of 64 percent of involuntarily committed people were placed directly into E&T beds as intended by the ITA. However, these gains have eroded in the months since as SBC use in King County has begun to rise again – despite the fact that there was no change in the detention rate for local DMHPs. As noted above, more individuals have been waiting in King County's E&Ts for beds at WSH even when they have been identified by local inpatient providers and courts as in need of long-term treatment at the State hospital. As a result, there has been less space in E&T facilities to accommodate individuals in the community or in emergency departments who need emergency and acute E&T services.

King County's experience with frequent but relatively brief SBC use is the result of its strong partnerships with community hospitals throughout the County. Even though they do not all have certified E&T beds (or adequate capacity of certified E&T beds), these facilities, including their psychiatric units, medical units, and emergency departments, have opted to join in the collaborative effort to provide timely and appropriate involuntary mental health care to all people who need it.

Community hospitals are independent entities. As a result, they voluntarily participate in this work – by accepting SBCs and bringing psychiatric care to their patients wherever they are. Counting on these partnernerships, King County DMHPs' typical practice is to request SBC authorization whenever a patient cannot be placed into an E&T within three hours, to ensure that timely and appropriate care is provided while an optimal placement is secured. King County actively coordinates with many of these hospitals through a regular task force focused on patient placement, and works to address any concerns quickly when they arise.

As State hospital and intensive community resources continue to be insufficient to meet the need and/or difficult to access, this increases the demands on community hospitals with regard to the number of patients on SBCs that they are asked to accept, including the proportion of people on their units who are in psychiatric crisis. Although as of this writing all community hospitals in King County are still willing to assist with this work, most report that they are feeling overstretched, vulnerable, and

[18] There was some difference in the total number of certified beds available in at King County facilities between these two E&T facility surveys – 341 in spring 2015, as compared to 305 in November 2015. This can be attributed, in part, to Fairfax Hospital's decision to temporarily close one of its units, designed for individuals with more intensive needs, due to concerns about patient acuity and staff safety. In mid-November 2015, Fairfax Hospital reported that it was working strategically to restore these beds by January 2016.

concerned about the safety of their patients and staff. As a result, the shared partnership in serving SBC patients may be at risk. Increased capacity, direct support for hospitals who are serving people on SBCs, and innovations to ease access to alternative placement choices are all critical to hospitals' continued partnership in this effort.

The prevalence of SBC use creates unreimbursed costs for hospitals, patients being served in environments not adequate to meet their psychiatric needs, and staff working to manage behavioral health symptoms beyond what is manageable in that environment without the necessary supports and programming. This creates an environment that can increase psychotic symptomology, agitation, paranoia, and acting out behaviors. The creation of a more nurturing and therapeutic environment of care, along with the appropriate provision of informed psychiatric interventions, are critical for the treatment and recovery of involuntarily detained individuals and their re-entry into a functional lifestyle. Although King County has worked to eliminate the need for psychiatric boarding of involuntarily detained individuals, the system remains overwhelmed and in need of additional ways to address this ongoing need in a way that is both compliant with current laws and therapeutic in its application.

2. **Please describe how the New Concept/Existing MIDD Strategy/Program Addresses the Need outlined above.**

This program would place appropriate staff in community hospitals to address the need for psychiatric and therapeutic care for detained individuals. This would include a psychiatric provider, adjunctive therapists, certified peer specialists (or other qualified staff with lived experience), and trained mental health specialists (to increase opportunities for exercise and a temporary change in environment. Teams consisting of case managers and peer specialists would be embedded in emergency departments, working as part of health care teams. Specially trained peer specialists would act as temporary care managers to engage with patients and identify and act on immediate needs such as funding, insurance, housing, out-patient treatment, and other patient-identified needs as able. Outpatient mental health staff would be available on site in emergency departments daily to identify psychiatric patients, make progress on immediate needs, and engage them needed follow-up treatment, and would assist with brief interventions for other patients exhibiting psychiatric symptoms in emergency departments. Adjunctive therapists would provide a range of therapeutic programming for psychiatric and other crisis patients in the emergency department. These services would occur at different times of the day to provide spaced patient interactions over an extended period of time.

Trainings would also be made available for hospital emergency department staff, including opportunities for observation and consultation. Not only will these interventions be clinically therapeutic, they are also aimed at a reduction in frustration, anxiety and acting out behaviors on the part of the patient. This will likely reduce the anxiety of both hospital staff and other medical patients being treated in the hospital emergency room.

3. **What EVIDENCE exists that the approach of this New Concept/Existing MIDD Strategy/Program will successfully address the identified need? Please cite published research, reports, population feedback, etc. Why would this New Concept/Existing MIDD Strategy/Program be expected to work? If this is an existing MIDD I strategy, please provide evidence of the results from existing MIDD evaluation reports, including who has/has not benefited from this strategy.**

Although there is not a specific evidence base or model for this concept, it does echo several other intervention approaches being used in Washington to reduce single bed certification usage and shorten inpatient stays, some of which have demonstrated successful outcomes.

King County's existing peer bridger programs work to provide effective transition support for patients in certain inpatient settings, utilizing peer counselors, to people who are being discharged from inpatient services using the nationally recognized peer bridger model to promote hope, wellness, self-determination, and recovery for participants. Peer bridger programs are intended to connect program participants to mental health and/or SUD treatment, primary care, and other services, based on the strengths, needs, and priorities of the individual. The current program is available at Navos and Harborview only, as part of a two-year grant. It is important to note that this model currently intervenes slightly later in a person's inpatient journey than in the proposed hospital support program, as it is limited to certain E&T facilities and does not serve people who are still on SBCs in community hospitals. The proposed program would be modeled after the peer bridger approach.

The peer bridger program model has been shown to be effective. In a recent outcomes report, it was determined that participants in King County's peer bridger program are achieving significant reductions in hospitalizations and hospital days. The rate of re-hospitalization for individuals in peer bridgers was 10 percent within 30 days of discharge, compared to 14 percent for a comparison group, and the rate of re-hospitalization within 90 days of discharge was 15 percent for peer bridger program participants, compared to 22 percent for the control group. Participants also become enrolled in outpatient mental health services and in Medicaid at a higher rate than the comparison group.[19] The analysis suggests that the peer bridger program is meeting its goals of reducing hospital use and increasing engagement in community-based mental health services.

In addition, a newly developed Mobile Community Assertive Treatment (MCAT) model is being employed in the Spokane area to address single bed certification patients' needs. MCAT consists of a nurse, chemical dependency professional, mental health professional, a peer, and a screener. Team members meet with the attending physician, social worker, and patients, within 24 hours of placement on SBC status, to provide an assessment of stability, contact an appropriate outpatient agency when applicable and engage case managers to assist with evaluation, and coordinate with other resources. The team typically follows patients within the hospital for between four and 14 days although it has the capacity to continue to serve them for up to 60 days. This program has increased community hospitals' willingness to pursue discharge, dropping petitions for 14-day involuntary commitments about half of the time due to their confidence in the less restrictive alternative developed by MCAT.[20]

MCAT has some strong similarities to the existing state-funded Transition Support Program (TSP) implemented in King County in 2014. TSP is also designed to connect individuals involuntarily detained at King County hospitals and E&Ts to behavioral health treatment, engaging them in discharge planning using established models such as Assess Plan Identify Coordinate (APIC) and Care Transitions Intervention (CTI), with the aim of reducing the lengths of their stays in community hospitals or E&Ts.[21] Unlike the facility-based peer bridger programs that are limited to two specific E&Ts, but similar to the MCAT model, TSP has the benefit of being a mobile unit that can be deployed to patients in any setting, and follow patients for up to 90 days. The King County TSP initially played a key role in bringing the County into compliance with the *D.W.* court ruling invalidating psychiatric boarding. However, unlike MCAT, it has not been able to maintain the same level of intensive in-hospital intervention in 2015, generally engaging patients minimally during their hospital stay and working with them mostly after discharge.[22] This reduces the TSP's current effect on psychiatric care provided during SBC stays as well as

[19] King County BHRD Peer Bridger Program Participant and Comparison Group Outcome Analysis, August 2015.

[20] Phone consultation between Jan Dobbs (Frontier Behavioral Health) and Diane Swanberg (King County BHRD), December, 2015.

[21] 2015 Transition Support Program (TSP) contract exhibit.

[22] Phone consultation with David Johnson and Cindy Spanton, December 2015.

the length of those stays. As a result, it has not continued to inspire the confidence of local community hospitals in the same way that the Spokane MCAT unit has. So King County's community hospitals are looking for alternative ways to get the support they need.

4. **This New Concept/Existing MIDD Strategy/Program is a/an: Emerging Practice**
   Please detail the basis for this determination. Please include a citation or reference supporting the selection of practice type.

This innovative partnership would combine practice knowledge gleaned from experienced inpatient psychiatric care providers with service approaches drawn from emerging practices like peer bridgers and applies them in a new setting. Practitioners in this program would use a variety of established approaches when delivering therapy services. As this concept represents a local innovation to address an emerging community need, there is not a specific evidence base for this specific approach.

5. **What OUTCOMES would the County see as a result of investment in this New Concept/Existing MIDD Strategy/Program? Please be as specific as possible. What indicators and data sources could the County use to measure outcomes?**

This program would increase and improve the timely and appropriate mental health care being provided to clients on single bed certifications in non-psychiatric settings, enabling demonstration of continued compliance with the state Supreme Court ruling invalidating psychiatric boarding and associated WAC requirements. Reductions in average length of stay can reasonably be expected, along with discharges to community settings as well as E&T facilities, and increased engagement with community-based treatment. All of these outcomes could be tracked, along with recidivism rates.

C. Populations, Geography, and Collaborations & Partnerships

1. **What Populations might directly benefit from this New Concept/Existing MIDD Strategy/Program:** (Select all that apply):

☐ **All children/youth 18 or under**	☒ **Racial-Ethnic minority (any)**
☐ **Children 0-5**	☒ **Black/African-American**
☐ **Children 6-12**	☒ **Hispanic/Latino**
☐ **Teens 13-18**	☒ **Asian/Pacific Islander**
☒ **Transition age youth 18-25**	☒ **First Nations/American Indian/Native American**
☒ **Adults**	☒ **Immigrant/Refugee**
☒ **Older Adults**	☒ **Veteran/US Military**
☐ **Families**	☒ **Homeless**
☐ **Anyone**	☒ **GLBT**
☒ **Offenders/Ex-offenders/Justice-involved**	☒ **Women**
☐ **Other – Please Specify:**	

Please include details about this population such as: individuals transitioning from psychiatric hospital to community; individuals judged incompetent by the court; children of drug users who are in foster care, etc.

The primary clients who would be served by this program would be emergency department psychiatric patients in SBC status awaiting E&T placement. However, the identification, engagement, and adjunctive therapy aspects of this service would have benefit for other individuals with psychiatric needs who may not be involuntarily detained, and the training component would benefit hospital staff.

2. **Location is an important factor in the availability and delivery of services. Please identify whether this New Concept/Existing MIDD Strategy/Program addresses a specific geographic need in the following area. Please provide additional that discusses the basis for the selection**:

This program model could be made available to community hospital/mental health agency partnerships anywhere in King County. It is most likely to be successful in locations where hospitals and mental health agencies are located near each other.

3. **What types of COLLABORATIONS and/or PARTNERSHIPS may be necessary to implement this New Concept/Existing MIDD Strategy/Program, and with whom (other jurisdictions & cities, law enforcement, first responders, treatment providers, departments within King County, housing, employers, etc.)? Please be specific.**

This program would depend on the establishment of fully collaborative partnerships between community hospitals and community mental health provider agencies, and with the liaison program that screens and places clients who need mental health residential treatment or supported housing to discharge successfully.[23]

If scaled to serve other hospitals, programs such as this one as well as the other approaches discussed in section B2 could serve to strengthen the critical partnership between King County and its community hospitals by offering a concrete program to address these organizations' felt needs for support.

D. Drivers, Barriers, Unintended Consequences, and Alternative Approaches

1. **What FACTORS/DRIVERS, such as health care reform, changes in legislation, etc. might impact the need for or feasibility of this New Concept/Existing MIDD Strategy/Program? How?**

The opening of new E&T facilities, significant expansion of community-based diversion and discharge resources, or expansion of other programs such as TSP or peer bridgers that have the capacity to shorten the stays of individuals on SBCs, could potentially reduce the need for or scope of this program, as any of those changes could result in fewer patients in community hospitals in SBC status.

2. **What potential BARRIERS, if any, might there be to implementation? How might these be overcome? Who would need to be involved in overcoming them?**

Partnerships between community mental health agencies and community hospitals, beyond the one known partnership currently being developed, would need to be established, and mutually workable support approaches would need to be negotiated to fit each hospital setting.

[23] In combination with these other approaches, increased utilization management of residential and supportive housing programs, to ensure that residents continue to medical necessity criteria for these intensive resources or are moved into less restrictive programs, would free up the most intensive community-based beds for those who most need them and reduce pressure on community hospitals and E&Ts seeking to discharge individuals who no longer need inpatient care.

3. **What potential UNINTENDED CONSEQUENCES might exist if this New Concept/Existing MIDD Strategy/Program is implemented? Please be specific---for whom might there be consequences?**

Changing the services provided for involuntarily detained individuals in this way could reduce pressure to establish the full cadre of E&T and state hospital psychiatric beds that are needed to complement innovative community-based less restrictive alternatives that can serve as discharge options. The presence of acute care patients in emergency departments and other non-psychiatric settings may be a deterrent to other individuals seeking help or remaining in the facility for medical reasons, or may be a hindrance to the healing process.

This program's efforts may overlap with the work of the existing Transition Support Program (TSP), especially if the existing TSP program resumes effective and intensive in-reach in hospital settings and regains the confidence of community hospitals.

4. **What potential UNINTENDED CONSEQUENCES might there be if this New Concept/Existing MIDD Strategy/Program is *not* implemented? Please be specific---for whom might there be consequences?**

As noted above, detained individuals could continue to be held in less than optimal settings for longer periods of time than necessary. Community hospitals' willingness to partner in accepting and caring for individuals in SBC status may erode, which would create a compliance crisis as it relates to the *D.W.* ruling. Staff retention at emergency departments serving a high volume of psychiatric patients could continue to be a significant challenge.[24]

5. **What ALTERNATIVE APPROACHES currently exist to address this need apart from this New Concept/Existing MIDD Strategy/Program? At a high level, how does this New Concept/Existing MIDD Strategy/Program compare to those other approaches in terms of cost, feasibility, etc. Could this New Concept/Existing MIDD Strategy/Program be merged with one or more of the alternatives? What are the pros/cons of merging?**

As noted above, the existing Transition Support Program (TSP) and/or an expansion of the peer bridger model to serve SBC patients has the potential to perform many of the functions that would be fulfilled by this program.

E. Countywide Policies and Priorities

1. **How does this New Concept/Existing MIDD Strategy/Program FIT within the CONTINUUM of care, and within other county initiatives such as Behavioral Health Integration, Health and Human Services Transformation, Best Starts for Kids, All Home, the Youth Action Plan, and/or the Vets and Human Services Levy or any other County policy work?**

This proposal links strongly to the work of the Governor and Executive's Community Alternatives to Boarding Task Force (CABTF) to design and recommend system improvements to reduce involuntary treatment demand. In fact, this proposal was featured as a draft recommendation in the CABTF's January 2016 report.

[24] Phone consultation with Mark Benedum and team, Highline Hospital.

This program would serve as a strategically significant example of the promise of physical and behavioral health integration to leverage both behavioral expertise and the medical setting to improve outcomes for patients in crisis.

It supports the individual/family-level goal of the Health and Human Services Transformation Plan to improve access to person-centered, integrated, culturally competent services, where, when, and how people need them.

This concept also reflects the Veterans and Human Services Levy goals of reducing homelessness; reducing unnecessary emergency medical system involvement; and improving health through the integration of medical and behavioral health services.

The individualized assistance provided to address SBC patients' felt needs would in some cases support the goal of All Home to make homelessness brief and one-time by addressing crises as quickly as possible and assessing, diverting, prioritizing, and matching people with housing and supports.

2. **How is this New Concept/Existing MIDD Strategy/Program rooted in principles of recovery, resiliency, and/or trauma-informed care?**

To ensure a recovery-focused approach, behavioral health staff involved in this program would use Trauma Informed Care (TIC) and Engagement Model approaches and motivational interviewing approach, all of which put the needs, experiences, and preferences of clients at the forefront of care. Furthermore, this program would disseminate recovery-focused practices by teaching TIC approaches and de-escalation to community hospital staff, thereby providing a more recovery-friendly environment in emergency rooms and other non-psychiatric settings.

3. **How does this New Concept/Existing MIDD Strategy/Program enact and further the County's EQUITY and SOCIAL JUSTICE work?**

This concept directly addresses two key determinants of equity identified as part of the County's equity and social justice (ESJ) work. It would improve access to health and human services for individuals who are in crisis and would otherwise often receive only the minimally required care in a non-optimal setting while they are waiting for an E&T placement. The ESJ aim of providing affordable, safe, quality housing would be fulfilled in cases when this program establishes stable community placement for individuals who lack an appropriate home but have become stable enough to avoid an E&T stay altogether as a result of early intervention provided in the emergency department by this team.

F. Implementation Factors

1. **What types of RESOURCES will be needed to implement this New Concept/Existing MIDD Strategy/Program** (staff, physical space, training, UA kits, etc.)**?**

A typical partnership would require a 0.5 FTE advanced registered nurse practitioner (ARNP), a 0.5 FTE adjunctive therapist, a full-time mental health specialist (who could be a specially trained peer), and a 0.4 FTE peer specialist. Supplies may need to be acquired to support adjunctive therapy services.

In addition, training funds and flexible funding should be added to provide one-time assistance to patients to help them discharge effectively. The program could be launched with any amount of funds in

this category, but more flexible patient assistance funding may make the program more effective in arranging less restrictive alternatives and expediting discharge, perhaps avoiding the need for E&T placement.

2. **Estimated ANNUAL COST.** $100,001-500,000 per community hospital/mental health agency partnership
   Provide unit or other specific costs if known.

Unit costs would be variable depending on the compensation rate for the various positions involved in the interdisciplinary team. This funding range provides an appropriate estimate of the cost per hospital/agency partnership.

Although any team that was launched would likely provide significant assistance to its partner hospital, the impact of the approach in this paper would need to be scaled up to include multiple hospital/agency partnerships before it would have a significant system wide impact.

3. **Are there revenue sources other than MIDD that could or currently fund this work? Clarify response, citing revenue sources.**

Some but not all hospitals accepting SBCs may be in a position to absorb some of these costs. Flexible state non-Medicaid funding could also potentially be used, although as noted in B1 above, such dollars are scarce and almost always fully programmed. Given the significant overlap with Veterans and Human Services Levy goals, this service may potentially be eligible for funding by the VHSL as well. Traditional funding sources such as Medicaid do not fit this innovative, flexible, outreach-oriented program model.

4. **TIME to implementation: Less than 6 months from award**

   a. **What are the factors in the time to implementation assessment?**

As noted above, establishment and negotiation of partnerships between community hospitals and mental health agencies would be the main factor in implementation. For the one partnership that is already being developed, implementation could be quicker. Beyond that, the time required to secure qualified staff and train them for this unique assignment would be another factor in implementation timing.

   b. **What are the steps needed for implementation?**

Establishment of partnerships, negotiation of mutually agreeable supports, and staff hiring and training are the main steps involved.

   c. **Does this need an RFP?**

Depending on the approach determined, an RFP may be required. The County may wish to identify potential hospitals based on criteria such as geography, and numbers of SBCs and connect them with appropriate agency partners. Another funding strategy would be to invest in any organically developing partnerships such as the one between Navos and Highline. Most likely, funding may be allocated according to a mix of both approaches. .

G. Any OTHER INFORMATION that would assist reviewers with making recommendations about this New Concept/Existing MIDD Strategy/Program? (optional). Do you have suggestions regarding this New Concept/Existing MIDD Strategy/Program?

This paper links with briefing paper 131 Increase Evaluation and Treatment Center Capacity, which contains much of the same need analysis information because it is addressing the same problem of inpatient psychiatric care access and quality, but at a different point in the care continuum. As noted above, new E&T capacity would reduce SBC use and thus may reduce the need for this program. It also relates to briefing paper 12 105 Hospital Step-Down Step-Up Program, another CABTF-endorsed strategy to reduce hospital lengths of stay.

New Concept Submission Form

#45

Working Title of Concept: Serving Emergency Department Psychiatric Patients at Highline Medical Center

Name of Person Submitting Concept: David M. Johnson, Ed.D, LMHC
Organization(s), if any: Navos
Phone: 206-933-7225
Email: david.johnson@navos.org
Mailing Address: 2600 SW Holden Street, Seattle, WA 98126

Please note that county staff may contact the person shown on this form if additional information or clarification is needed.

Please share whatever you know, to the best of your ability.
*Concepts must be submitted via email to MIDDconcept@kingcounty.gov by **October 31, 2015**.*

1. Describe the concept.
Please be specific, and describe new or expanded mental health or substance abuse-related services specifically.

Navos and Highline Medical Center would expand their collaboration to serve psychiatric patients and other crisis patients in Highline's Emergency Department. This concept includes training for Highline Medical Center providers by Navos' behavioral health care providers, behavioral health care staff on-site at Highline Medical Center, and/or engagement and referral of psychiatric and crisis patients to Navos' inpatient and outpatient programs.

2. What community need, problem, or opportunity does your concept address?
Please be specific, and describe how the need relates to mental health or substance abuse.

The Emergency Department at Highline Medical Center, in Burien, is challenged with psychiatric and crisis patients. Highline Medical Center experienced a brief relief from the demands of psychiatric boarding patients following several interventions at the beginning of 2015 to end psychiatric boarding in Washington. That relief did not last, however, and the Emergency Department is now busier than ever serving this population. On an average day, Highline Medical Center's Emergency Department has 5-7 detox patients and 2-3 single bed certifications (SBC) for psychiatric patients. One day, Highline had 8 SBCs. The Emergency Department is not designed or staffed for this extraordinary demand. Highline has asked Navos for assistance with psychiatric and other crisis patients using the Emergency Department.

3. How would your concept address the need?
Please be specific.

Expanded collaboration between Navos and Highline Medical Center would help to serve psychiatric and crisis patients in Highline's Emergency Department. The continuum of services could include one or more of the following:

-Training: 1) Highline nurses will visit Navos' Inpatient Services psychiatric hospital to observe and learn how Navos manages the acuity of the milieu. This training recently began on a limited basis. 2) Navos' Clinical Educator and Therapist Martin Reinsel, MA, LMHC, would observe the Highline Emergency Department and SBC beds and units. He would develop and provide training specific to this setting on managing crisis behaviors in psychiatric patients.

-On-site behavioral health care staff: 1) Navos' Adult Outpatient staff would be on-site in the Emergency Department for one to two hours a day. Navos' outpatient staff would identify and engage psychiatric and crisis patients, and encourage them to enroll in Navos' Adult Outpatient Services. Outpatient staff would also assist with brief interventions for other patients exhibiting psychiatric symptoms in the Emergency Department. 2) A Navos team, consisting of a case manager and a peer support specialist, would be embedded in the Highline Emergency Department, working as part of a team of health care providers. 3) Navos' adjunctive therapists would provide art therapy and other programming during the day for psychiatric and crisis patients in the Emergency Department.

-Engagement and referral: 1) Navos' Peer Bridgers would serve SBC patients in Highline's Emergency Department, helping them to transfer to Navos' Inpatient Services or enroll in Navos' Adult Outpatient Services. 2) Navos' Court Evaluator and Care Plan team would provide services for psychiatric patients in SBCs at Highline.

4. Who would benefit? Please describe potential program participants.

This concept would benefit patients in Highline Medical Center's Emergency Department who are exhibiting psychiatric symptoms or who are in crisis, and who are waiting for transfer to a facility or unit where they can receive psychiatric treatment, or for discharge and referral to outpatient psychiatric treatment.

5. What would be the results of successful implementation of program?
Include outcomes that could be measured and evaluated. Please indicate whether this data is currently collected in some fashion, and in what form.

Outcomes that could be measured include:
-Reduction in use of Emergency Departments for psychiatric crises
-Decreased length of crisis events
-Improved access to inpatient services
-Increased use of appropriate treatment services
-Reduced barriers to services

Measures could include:
-Number of ED visits, and length of stay
-Rate of re-hospitalization
-Number of peer services used
-Number of patients continuing with appropriate treatment

6. Which of the MIDD II Framework's four strategy areas best fits your concept? (you may identify more than one)

☐ **Prevention and Early Intervention:** Keep people healthy by stopping problems before they start and preventing problems from escalating.

☒ **Crisis Diversion:** Assist people who are in crisis or at risk of crisis to get the help they need.

☒ **Recovery and Reentry:** Empower people to become healthy and safely reintegrate into community after crisis.

☐ **System Improvements:** Strengthen the behavioral health system to become more accessible and deliver on outcomes.

7. How does your concept fit within the MIDD II Objective – to improve health, social, and justice outcomes for people living with, or at risk of, mental illness and substance use disorders?

Psychiatric and crisis patients in Highline Medical Center's Emergency Department would receive care from providers trained in trauma-informed care, therapeutic communication, and managing crisis behaviors. Patients would be engaged by behavioral health care providers in their own treatment before discharge from the Emergency Department, and would be referred to appropriate psychiatric treatment.

8. What types of organizations and/or partnerships are necessary for this concept to be successful? Examples: first responders, mental health or substance abuse providers, courts, jails, schools, employers, etc.

This concept would involve Highline Medical Center and Navos, and other health care providers.

9. If you are able to provide estimate(s), how much funding per year do you think would be necessary to implement this concept, and how many people would be served?

Pilot/Small-Scale Implementation: **$ 25,000 per year, serving 150 people per year**
Partial Implementation: **$** # of dollars here **per year, serving** # of people here **people per year**
Full Implementation: **$** # of dollars here **per year, serving** # of people here **people per year**

Once you have completed whatever information you are able to provide about your concept, please send this form to *MIDDConcept@kingcounty.gov*, no later than 5:00 PM on October 31, 2015.

If at any time you have questions about the MIDD new concept process, please contact MIDD staff at *MIDDConcept@kingcounty.gov*.