MIDD Briefing Paper

BP 12 Hospital Step Down
BP 105 Hospital Step Down/Step Up Program

Existing MIDD Program/Strategy Review □ MIDD I Strategy Number _____ (Attach MIDD I pages)
New Concept × (Attach New Concept Form)
Type of category: New Concept

SUMMARY: The "step-up" program would divert individuals who are experiencing an escalation in symptoms from a hospital stay and preserve the individual's ability to remain in his/her housing despite experiencing a crisis. The "step-down" program would enhance and improve the system of care by discharging individuals who no longer meet medical necessity for a hospital level of care to a less intensive yet supportive model, thereby opening access to hospital beds for those individuals whose psychiatric needs are most acute. It would assist individuals with transitioning from the psychiatric hospital back to the community.

Collaborators:

Name	Department
Susan Schoeld	DCHS/MHCADSD

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

Name	Role	Organization
Chris Young	Social Work Supervisor and 10.77 evaluator	Harborview Medical Center

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?**

A facility-based hospital stepdown program will provide a temporary placement in a 24-hour/seven day per week supervised living setting for up to 45 days for individuals who no longer meet medical necessity criteria for an involuntary or voluntary psychiatric hospitalization. The program will provide for 16 - 18 beds in a healthy and safe milieu within a harm reduction framework, with a structured day of activity, room and board, facility-based residential case management including peer support staff, and a prescribing Advanced Registered Nurse Practitioner. Services will include group treatment, medication management and monitoring, transportation assistance, assistance with applying for entitlements and

other publicly funded benefits, advocacy and assistance with linkages for ongoing behavioral health care services, and housing and essential needs. In addition to facility-based staff (who generally will only provide services within the facility), the program will be connected to a care management team for out-of-facility services. The team will assist with transportation to appointments and securing essential needs, linkages to behavioral health services and residential/supportive housing resources, assistance with acquiring documents/paperwork necessary to secure long term resources (e.g., entitlements) and ancillary services. In some cases the facility could be used as a step-up program (five to seven beds) for people being served in an outpatient program who are experiencing an escalation of symptoms, in an attempt to stabilize symptoms and divert the person from a hospital stay.

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).

The "step-up" program would divert individuals who are experiencing an escalation in symptoms from a hospital stay and preserve the individual's ability to remain in his/her housing despite experiencing a crisis. The "step-down" program would enhance and improve the system of care by discharging individuals who no longer meet medical necessity for a hospital level of care to a less intensive yet supportive model, thereby opening access to hospital beds for those individuals whose psychiatric needs are most acute. It would assist individuals with transitioning from the psychiatric hospital back to the community.

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.**

Data referenced in a recent (September 2015) conversation between Chris Imhoff of Washington State's Division of Behavioral Health and Recovery (DBHR) and Jim Vollendroff of King County Mental Health, Chemical Abuse and Dependency Services Division (MHCADSD) indicates that King County residents have longer lengths of stay at Western State Hospital (WSH) than residents of any of the other eight Regional Support Network (RSNs) involuntarily detained there (currently averaging over 180 days per stay). [1]As of October 2015, there were a minimum of 60 King County individuals deemed ready for discharge from WSH. On average, there are 55-60 individuals from King County at WSH who no longer meet medical necessity to remain there.[2] State hospital beds cost approximately $600 per day and local psychiatric hospital beds cost upwards of $1000 per day. The daily rate for a facility based program – approximately $190 per day - is a fraction of costs associated with hospital bed use. Most often, barriers to

[1] Meeting held with Department of Behavioral Health and Recovery management and the CEO of Western State Hospital with King County Mental Health Division Director Jim Vollendroff and staff Jeanne Camelio, Septe,ber 11, 2015.

[2] Western State Hospital Ready to Discharge report, November 2015.

moving people out of costly and limited state hospital beds in a timely manner can be attributed to such factors as pending financial applications, long waits for a community resource to become available, transportation delays, long engagement processes by community providers, and waiting for decisions/paperwork/information from family members or providers. For much of 2014 and 2015, King County exceeded its allocation of state hospital beds, resulting in hundreds of thousands of dollars in fines being levied on the County by the Washington State Department of Social and Health Services (DSHS) for being "over census". As of the writing of this paper, King County has another 27 individuals who have received 90- or 180-day court commitment orders waiting in local hospital units for a bed to open at WSH, [3] creating an untenable situation in which County Crisis and Commitment Services staff have few to no local psychiatric inpatient beds available to send individuals on new involuntary treatment orders.

If this new strategy is not implemented, King County will likely continue to be faced with large fines for exceeding state hospital bed allocations; local psychiatric units will continue to have difficulty getting patients transferred to WSH in a timely manner and local hospital beds will not be readily available for those most in need of them; King County Crisis and Commitment Services will continue to experience difficulty accessing local psychiatric hospital beds for newly detained individuals; and individuals who no longer require the most restrictive and most expensive treatment (in a state hospital setting) will continue to remain there far longer than necessary due to lack of immediate resources in the community, which is a violation of those individuals' rights. Most importantly, individuals will continue to languish in inappropriate settings either waiting for a bed to become available at Western State Hospital, or waiting to leave the hospital.

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

A step-down program will free up critical state hospital beds in order to serve those highly acute individuals in our local psychiatric hospital beds who have received 90- and 180-day court commitments. A more efficient flow of individuals from local psychiatric hospital beds to the state hospital allows for those very limited local beds to serve only those in most acute need of psychiatric beds. If the program were able to step-down just half of the individuals who no longer meet medical necessity criteria to remain at the state hospital, it would eliminate the King County waitlist for WSH beds and allow for more timely access to local hospital resources for newly detained individuals. It will also reduce extraordinary lengths of stay (180+ days) for King County residents at WSH. The program would also serve individuals who could safely step-down from a local psychiatric unit. Funds currently being used to pay for lengthy high cost hospitalizations and fines could be repurposed for other services, including those designed to prevent crises requiring hospitalizations from occurring.

For those individuals who are experiencing an escalation in symptoms, this new program would provide a much needed resource in the local continuum of care by providing wrap around services and extra supports during those periods in an individual's life when s/he most needs extra supports. Having the ability to "step into" such a program helps the individual avoid an often traumatic experience in a period of crisis in which s/he is detained against his/her will to an inpatient hospital program.

3. **What EVIDENCE exists that the approach of this New Concept/Existing MIDD Strategy/Program will successfully address the identified need? Please cite published**

[3] Cache report, DSHS Western State Hospital database, 12/10/15.

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.

This approach has not been evaluated to date and is not referenced in the literature. However, returning individuals to their communities of support after periods of hospitalization for medically necessary periods of time is much preferred over keeping people in the most restrictive and expensive resource when they no longer need that type of care. King County averages 60 people at WSH who no longer require that level of care but for whom an immediate community resource is not available to which to discharge them. [4] Having people reside in a short term step down program rather than a local or state hospital bed is a much more cost effective and humane way of working with people who need linkage to a community placement and to ongoing services. In addition, an advisory panel at Harborview Medical Center has identified the period following an inpatient admission as a difficult and vulnerable time for most patients.[5] Patients and families report needing support, structure, and help navigating systems as patients report feeling anxious and fearful about going from the structure of a hospital setting to little support once returned to the community.

4. **Please specify whether 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 approach is an emerging practice. There is anecdotal information that this approach makes fiscal and resource utilization sense, helps to ensure that King County residents receive inpatient psychiatric treatment locally when they most need it, and upholds an individual's rights to be free of a locked setting when s/he no longer needs treatment in such a setting.

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?**

If the program design is developed in such a way as to maximize the ability to take the majority of referrals from the state (and local) hospitals and there exists sufficient capacity to serve those individuals, then King County will experience a reduction in lengths of stay for individuals in the state hospital; there will be more efficient flow of patients from local psychiatric beds to WSH beds; and the waitlist for beds at WSH will be drastically reduced thereby freeing up local psychiatric hospital beds. There would also be an increase in the numbers of patients treated in local hospitals. King County will utilize state hospital beds for only those most acutely in need and will likely experience a reduction in the fines levied by DSHS for census overages. King County would provide community based services for individuals as soon as they no longer need a hospital level of care, allowing those individuals to have longer tenure in their communities where they have natural supports and services rather than keeping them in the most restrictive and expensive setting in the continuum of care.

Baseline data for lengths of stay at the state hospital and local psychiatric hospital beds, numbers of individuals deemed ready to discharge from the state hospital, numbers of persons waiting for a state

[4] Western State Hospital Ready to Discharge list for King County, November 2015
[5] Minutes from the Patient and Family Advisory Panel at Harborview Medical Center, 7/16/15.

hospital bed from our local inpatient units, and the amount of fines incurred for census overages could be compared to subsequent data upon implementation of the program. MHCADSD currently has access to much of this data. Cost savings could be demonstrated for each of the data elements. Data can be obtained from DSHS/DBHR and WSH prior to implementing the program and once the program is in place. Data could also be collected on the number of local psychiatric hospitalizations successfully prevented (and relevant cost savings) by providing "step-up" services to enrolled clients experiencing escalating psychiatric symptoms who utilize the program if an appropriate comparison group could be identified.

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.

Adult individuals transitioning from local and state psychiatric hospitals and/or those who need enhanced supports and services for a temporary period of time during an escalation in symptoms.

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**: County-wide

The proposal is for a facility-based program and will be physically located in one particular area of the County, but will have the capacity to serve individuals from any area in King County who are in inpatient units. The care management team can provide services to individuals utilizing the step-down or step-up portions of the program anywhere in King County.

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.**

WSH management and treatment teams, as well as local hospital treatment teams, will be educated on the program and program model; local behavioral health providers will be informed that this resource is an option for their clients who may be experiencing escalating symptoms; Crisis and Commitment services staff will need to understand the model and services provided in order to recommend that a provider who is not aware of the resource makes a referral when appropriate; and collaboration with receiving behavioral health programs and providers will be necessary to ensure continuity of care. Courts overseeing the development of less restrictive outpatient court orders will need to be informed of the program services and length of stay limitations in the step down model. Collaborations with staff who oversee the coordinated entry process for housing will also be necessary for the successful implementation of the program. Collaboration with peer-based and multi-disciplinary hospital transition programs, such as Peer Bridger and the Transitional Support Program (PSB) would be beneficial. Cooperation with local neighborhoods is important to educate and alleviate any community concern about siting this program in or near their neighborhood.

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 state DBHR has expressed concern about the extraordinary lengths of stay that King County residents are experiencing at WSH, and have requested meetings with the MHCADSD Division Director and staff to discuss strategies for reducing lengths of stay.[6] DBHR and WSH are supportive of such a strategy to reduce the numbers of people who are deemed ready for discharge who still remain in state hospital beds. Ongoing census overage fines continue to be assessed against King County for exceeding bed allocations at WSH and now total at least a half million dollars in fines.[7] The continued bed shortage in local Evaluation and Treatment Centers is another factor.

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?

Potential barriers may include the program provider imposing significant restrictions on the clinical profiles of individuals who can be served in either the step-down or step-up portion of the program; significant lack of resources to which to transition individuals from the program; difficulties accessing entitlements in a timely manner; and decompensation of individuals after admission to the program. The County will need to provide clear instructions in the procurement process about accepting a majority of referrals made to the program. There will need to be very close collaborations and partnerships with coordinated entry processes and staff, and skilled clinicians who work within the program, to safely address any clinical or behavioral decompensation of the individuals being served. Close collaboration with Crisis and Commitment staff will be required, when necessary.

This New Concept proposes the use of an existing 35-bed facility in King County, therefore, siting issues would not pertain if this facility remains available and is selected to house the program. In the event

[6] Meeting held with Washington State Division of Behavioral Health and Recovery management and the Western State Hospital Chief Executive Officer on Sept. 11, 2015.

[7] Census reports published by King County Mental Health, Chemical Abuse and Dependency Services Division staff for the periods of January to March 2014 and October 2014 to February 2015.

that this particular facility could not be used for this purpose, siting another facility may raise issues amongst the neighboring areas; in this case another potential barrier may include possible delays in siting the facility, as is often the case when siting residential programs for individuals with behavioral health conditions. If an alternative building is available and acceptable to the surrounding neighborhood for this purpose, there could be delays and significant unintended costs associated with building renovations in order to meet existing codes and program and staffing needs.

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?**

Unintended consequences could include creating a backlog of individuals at the facility that exceed the intended length of stay, either due to barriers getting funding in place, delays in housing availability, or denials in referrals of individuals to certain providers/programs. Should Medicaid dollars not be captured for the individuals staying in the program, there may be some financial consequences to the program in that event.

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?**

King County is currently experiencing the unintended consequences of not implementing such a model. The unintended consequences include increased lengths of stay at WSH, increased lengths of stays at local psychiatric hospitals for individuals waiting for state hospital beds, and large numbers of people in the most expensive and most restrictive settings without meeting medical necessity criteria for these settings. Moreover, King County is experiencing a lack of hospital resources readily available for those with most acute need, larger numbers of people waiting for inpatient psychiatric treatment in regular hospital settings under single bed certifications that are not able to meet those needs, enormous fines being levied against the County for census overages at WSH, and inability to get individuals admitted to WSH from King County.

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?**

There are no alternative approaches to this New Concept. Currently, individuals are occasionally discharged to the local shelter respite beds when a local community resource is not readily available, but this option must be approved by executive management at WSH and RSN managers, which results in less than positive outcomes for most individuals discharging from the hospital system. The Downtown Emergency Services Center's Crisis Respite Program is often full and thus unavailable, and is not a good option for very vulnerable individuals discharging from the structure of an inpatient hospital.

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 New Concept would provide a level of care that currently does not exist between community-based care and institutional care, and expands the continuum of care for vulnerable adults leaving often lengthy hospital stays and returning to the community. It most closely aligns with Behavioral Health Integration as well as the Health and Human Services Transformation work in that it provides for more flexibility in the way services are provided, and improved health and social outcomes through improved coordination of care. It allows for individuals in the behavioral health system to be served in their communities with the exception of only brief periods of time spent in hospitals, rather than prolonged and unnecessary lengths of stay beyond what is necessary to stabilize a person's symptoms.

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

A patient's rights are violated if they are held in a locked setting once their treatment needs have been met. According to the Washington State statute on Mental Illness, Regional Support Networks are mandated to provide care in the least restrictive environment.[8] It is a more recovery based practice to return individuals to their natural supports and services within their communities, particularly from the state hospital that may be located far away from their families and supports. Many individuals do not see their families and supports when they are hospitalized at the state hospital as it is very challenging for many families to travel there during visiting hours, thus leaving vulnerable individuals separated from important supports. With the building of a new fence around the perimeter of WSH, soon patients will not be allowed to leave the grounds for family visits, which is a very difficult situation for patients trying to recover from a decompensated state. For individuals utilizing the "step-up" portion of the program, preventing an involuntary hospitalization helps build illness management skills. It also promotes insight into the development of escalating symptoms and the need for additional supports without the trauma of entering into a crisis situation in order to get help. Thus, this type of care is both trauma-informed and recovery-oriented.

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

Keeping people in their communities to receive behavioral health care and ensuring that individuals do not remain in locked settings longer than necessary is socially just. It is critical that the program not exclude those individuals who have encountered the criminal justice system during past periods of decompensation who can benefit from a continuum of care via equitable access.

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 facility is needed to implement the program, requiring capital outlays. The program will need the ability to collect data about utilization and report such data to the County. It is important that clinical staff persons are trained to provide compassionate care within the program. Staffing would consist of

[8] Chapter 71.05 on Mental Illness, Revised Code of Washington.

peer support clinicians, a prescriber, and mental health professionals. If the facility is limited to 16 beds or the federal Insitutions of Mental Diseases (IMD) exclusion[9] is modified or waived via a Medicaid Transformation Waiver[10], the facility could potentially draw down Medicaid resources as a means of partial on-going financial support for serving those who are Medicaid eligible. If the facility is larger than 16 beds and the regulations are not changed or waived, additional local dollars will be needed to support on-going daily operations. An increased bed capacity will make a bigger difference alleviating the problem.

2. **Estimated ANNUAL COST. $2,500,001-$5 million Provide unit or other specific costs if known.**

The estimated annual cost is $2.5 million to lease a 35-bed facility and serve 250 individuals per year. Additional funds are requested to cover 2.0 FTE mental health professionals (care management team), in the amount of $170,000 per year, and flex funds (to support the purchase of bus passes, emergency medications, personal hygiene items, clothes, and other essential items) in the amount of $30,000 per year. Total annual costs are estimated at $2.7 million to operate a 35-bed facility. Costs would be prorated accordingly if the facility operated with a capacity of less than 35 beds.

Additional one-time only costs may be incurred if facility renovations are necessary to meet existing building and operational codes.

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

Depending on the size of the program, Title XIX Medicaid may be drawn down for some of the program's services to fund a portion of the care management component of the program. Providers are currently unable to bill Medicaid for treatment in psychiatric facilities with more than 16 beds due to the IMD exclusion. Repeal of, or waiver exemptions for, the IMD exclusion by Congress, is being sought by advocates across the United States. Fortunately, "the IMD exclusion is finally being seen by some political leaders as a ridiculously outmoded provision that leaves psychiatric patients with nowhere to go if they need inpatient care."[11]

4. **TIME to implementation: 6 months to a year from award**
    a. **What are the factors in the time to implementation assessment?**

    Factors include securing of the facility and modification for the use of this program (secure medication room, nursing station, etc.). There is currently a 35-bed facility contracted through DSHS Home and Community Services with services provided by Community House Mental Health Agency that could potentially be used to provide this hospital step down (step-up) program. If so, the implementation timeline would be much shorter.

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

    Steps would include issuing a Request for Proposals (RFP) for the program, including a facility and staffing the care management team, executing associated contracts, and working with local and state hospitals and other collaborators prior to starting the program.

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

[9] Cited from http://www.behavioral.net/article/medicaid-considering-imd-exclusion-alternatives on 12/18/15.
[10] http://www.hca.wa.gov/hw/Pages/medicaid_transformation.aspx. Accessed 12/30/15.
[11] Ibid, http://www.behavioral.net/article/medicaid-considering-imd-exclusion-alternatives. Accessed 12/18/15.

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?

It is critical that the program provider not impose restrictive exclusions for accepting individuals into the step-down or step-up portions of the program. This type of model was attempted several years ago in one of the County's long term rehabilitation settings and was underutilized and subsequently closed because the program would not accept many referrals received due to restrictive exclusionary criteria. It is proposed that the "step-down" portion of the program have a capacity of 16-28 beds; and the "step-up" portion of the program have a capacity of five to seven beds. In addition, this facility could be used to provide 24/7 competency restoration/stabilization services (ten beds), as described in briefing paper #124 Local Competency Restoration Services.

New Concept Submission Form

Please review the preceding pages before completing this form.

Please be specific. Be sure to describe how the concept addresses mental health or substance abuse needs in King County. All programs funded by MIDD II must be implemented in King County.

#12 Working Title of Concept: Step Down, Step Up

Name of Person Submitting Concept: Jean Robertson, Retired
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Email: jean.robertson@kingcounty.gov (Retired)
Mailing Address: 401 5th Ave. Suite 400, Seattle 98104

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.

A new adult mental health step-down program to reduce length of stay at Western State Hospital. Community hospitals could also refer to the program but the primary focus would be to bring King County residents back to the community from the state hospital. In some cases the facility could be used as a step-up program for people being served in an outpatient program, who are experiencing an escalation of symptoms, and a short stay in a more structured supportive setting would help avoid hospitalization.

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.

Data indicates that King County residents have longer lengths of stay at the state hospital than other RSNs. King County continues to have high utilization of single bed certifications, in part due to the back log of people waiting for admission to the state hospital occupying acute care beds. This would also be an opportunity to improve the outcome measure of reducing re-hospitalization rates.

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

Moving people from the state hospital at earlier points in time would reduce length of stay, allow for better flow-through, allowing people in need of the state hospital to be admitted, which would then open up acute care community hospital beds, and potentially reduce the need for Single Bed Certifications.

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

People who no longer need an inpatient level of care but are still in need of structure and clinical supports until they are ready to move into an available residential option such as supported housing, or a longer term residential setting but are awaiting an opening in one of those facilities.

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.

Shortened length of stay at the state hospital; data source- WSH length of stay data. Diversion from inpatient care for persons enrolled in outpatient services; data source- inpatient admissions data. Reduction in SBCs; data source- MHCADSD/ CCS data and/ or DBHR data.

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?

This is a recovery-oriented approach to move people back into the community faster, but humanely, supporting them in their transition into the community with a greater chance of success. As a step-up program, it can provide an alternative to hospitalization, again improving the chance of successful diversion. While living in the community housing options can be pursued, more effective engagement into programs such as Program of Assertive Community Treatment (PACT), and stabilization/skill building for transition into Supportive Housing.

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.

Hospitals, particularly the state hospital and hospital liaison staff, but referrals could come from community hospitals, as well. As a transitional program partnerships would be needed with community outpatient providers, residential providers, PACT teams.

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:	**$ 481,800 per year, serving 50 people per year**
Partial Implementation:	**$ 963, 600 per year, serving 100 people per year**
Full Implementation:	**$ 1,445,400 per year, serving 150 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*.

New Concept Submission Form

Please review the preceding pages before completing this form.

Please be specific. Be sure to describe how the concept addresses mental health or substance abuse needs in King County. All programs funded by MIDD II must be implemented in King County.

#105

Working Title of Concept: Hospital Stepdown Program

Name of Person Submitting Concept: Jeanne Camelio
Organization(s), if any: DCHS/MHCADSD/Diversion and Reentry Services Section
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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.

A facility based hospital stepdown program would provide a temporary placement in a 24 hour/seven days a week supervised living setting for up to 45 days for individuals who no longer meet medical necessity for a involuntary or voluntary psychiatric hospitalization. The program would provide a healthy and safe milieu (within a harm reduction framework) with a structured day, room and board, facility based residential case managers to include peer staff, and a prescribing ARNP. Services would include group treatment, medication management and monitoring, transportation assistance, advocacy and assistance with linkages for ongoing behavioral health care services, housing, and essential needs. In addition to facility based staff, the program would be connected to a care management team for out of facility services, such as transportation assistance to appointments and to secure essential needs, linkages to behavioral health services, and residential/supported housing resources, assistance with acquiring documents/paperwork necessary to secure long term resources/entitlements and other services. The care management team would have access to flexible funds to provide for unmet needs for individuals in the stepdown program; and rapid access to and effective relationships with other entities (Community Services Offices, Social Security Administration staff, transitional and permanent housing providers, low cost legal resources, courts etc.). The program design would necessarily allow for modifications once successful outcomes with this population (individuals discharging from hospitals) have been shown, such that other populations identified as needing a transitional structured milieu (those needing competency restoration services, certain individuals releasing from jails, for example) could access the program for services while waiting for availability of an identified housing option or outpatient program. Once the program is operationalized, the care management team associated with a stepdown system of care may have capacity to serve individuals needing transition and linkage assistance from the state hospital but for whom a facility based stepdown program is not the best option.

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.

Data provided by DBHR (for 2014) indicates that King County residents have the longest lengths of stay at Western State Hospital (WSH) than residents of any of the other eight Regional Support Networks (RSNs) involuntarily detained there. As of October 2015, there were a minimum of 60 King County individuals deemed ready for discharge from WSH. Most often, barriers to moving people out of costly state hospital beds in a timely manner can be attributed to such factors as pending financial applications, waiting for a community resource to become available, transportation delays, long engagement processes by community providers, and waiting for decisions/paperwork/information from family members or providers. For much of 2014 and 2015, King County exceeded its allocation of state hospital beds, resulting in hundreds of thousands of dollars in fines being levied by DSHS for being "over census". Currently, King County has another 27 individuals who have received 90 or even 180 day court commitment orders waiting in local hospital units for a bed to open at WSH, creating an untenable situation in which County Crisis and Commitment Services staff have few to no local psychiatric inpatient beds to which to send individuals on new involuntary treatment orders.

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

A hospital stepdown program would provide a safe therapeutic environment to which to discharge individuals remaining in inpatient psychiatric hospital beds while other identified local community resources are being secured. On average, King County has 60 individuals residing at the state hospital who are ready for discharge to the community, and the provision of a short term discharge option for a portion of those individuals would enable hospital beds to be made available for the many individuals who are waiting for a state hospital bed on a 90 or 180 day more restrictive order. In turn, local psychiatric hospital beds, which are a limited resource, would become available for those individuals who are in acute need of involuntary psychiatric hospitalization. This hospital stepdown program would be accessible to King County individuals in local and state hospital beds, allowing for an increased flow of individuals through the hospital system and ensuring that inpatient psychiatric beds are being utilized primarily for those individuals in acute need of intensive psychiatric inpatient beds.

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

There are many benefits to a stepdown model, both for the community and for individuals served in the behavioral health system. On a larger systems level, there would be dramatic cost savings associated with such a program – state hospital beds cost approximately $600 per day and local psychiatric hospital beds cost upwards of $1000 per day. The daily rate for a facility based program – approximately $190 per day - is a fraction of costs associated with hospital bed use. With more rapid access to a viable discharge option for individuals hospitalized at WSH, fines and damages levied against King County by DSHS for being over allocated beds ("over census") could be reduced. Costly inpatient psychiatric beds (local and state) would increasingly be used only for those who are in acute need of that resource, rather than those who remain in beds for "social service" reasons. On an individual level, an option allowing for more timely discharge to a less restrictive setting in an individual's home community allows that individual to be reconnected with their supports, engaged with services that meet their needs, and able to enjoy the benefits and responsibilities of being back in their familiar community environments.

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.

Successful implementation of a stepdown model would be demonstrated by a reduction in lengths of stay for certain individuals residing in state and local hospital beds (primarily those for whom a behavioral health setting is most appropriate versus individuals requiring Developmental Disability Administration or Home and Community Services settings). According to data kept by DSHS, King County's average length of stay at WSH in 2014 was approximately 181 days for all patients, and ongoing data provided by DSHS with regard to length of stay and daily census would be monitored to measure success of the program. Local psychiatric hospitals and Evaluation and Treatment facilities also report data on lengths of stay and King County staff could monitor and evaluate that data on an ongoing basis upon implementation of this model. A facility has been identified that could potentially be used for this model with a bed capacity of 35 beds; and with ongoing monitoring of utilization of beds, analyses of outcomes and challenges to use of the program, and continuous improvement to best meet the needs of individuals discharging from inpatient psychiatric beds may allow for a certain number of those beds to be designed for varying lengths of stay, for a particular population, or for an enhancement to services provided in the program (i.e., short term personal care services or competency restoration programs, stepdown from jail settings), for example. In addition, waiver programs and funds available for individuals leaving hospital/institutional beds, such as Roads to Community Living funds or Olmstead funds could potentially be leveraged to provide for rent deposits, essential household items etc. for individuals without the means to set up their household units.

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?

The involuntary civil commitment law, which allows for the detention of acutely mentally ill individuals who pose a danger to themselves or others, is intended to to be used to provide inpatient psychiatric treatment when a less restrictive setting is not available or appropriate. Hospitalizing individuals, often against their will, for the purposes of providing treatment is not to be taken lightly. When an individual is involuntarily detained in a psychiatric hospital, s/he loses his/her civil rights, freedom, autonomy, and ability to make choices. Hospitalized individuals are often separated from their communities of support, experience disruptions in their ability to receive wages or entitlements, and subsequently lose housing, belongings, and important supports. For the vast majority of individuals, inpatient psychiatric treatment is beneficial and necessary only for a discrete period of time; once the individual has been determined by treatment staff to no longer need intensive hospital based services, s/he must be discharged to a less restrictive level of care/service. Often, the reality of an underfunded behavioral health system of care and lack of resources to which individuals can safely discharge from hospitals in an expeditious manner places undue burden on those very individuals by increasing their lengths of stay in involuntary units. Justice, social, and health outcomes for involuntarily held individuals will be improved when they are not held on a locked psychiatric unit while waiting for an identification card, paperwork to be submitted, or a bed in an identified program to become available.

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.

Partnerships with local and state hospital psychiatric inpatient treatment teams, behavioral health outpatient providers, behavioral health residential and supported housing programs, local community services offices would be necessary for successful implementation of this model. Most providers in the behavioral health services system, including the psychiatric hospitals and evaluation and treatment facilities, recognize the need for viable stepdown options for individuals no longer requiring hospital levels of care. Further development of the program model, including eligibility criteria would be developed with County staff along with a group of community stakeholders. A facility potentially available for this model has been identified with bed capacity for 35 beds.

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: $ per year, serving people per year
Partial Implementation: $ 2.5 million per year, serving 250 people per year
Full Implementation: $ per year, serving 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*.

Working Title of Concept: Step Down, Step Up

Name of Person Submitting Concept: Jean Robertson
Organization(s), if any: MHCADSD
Phone: 206-263-8904
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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.

A new adult mental health step-down program to reduce length of stay at Western State Hospital. Community hospitals could also refer to the program but the primary focus would be to bring King County residents back to the community from the state hospital. In some cases the facility could be used as a step-up program for people being served in an outpatient program, who are experiencing an escalation of symptoms, and a short stay in a more structured supportive setting would help avoid hospitalization.

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.

Data indicates that King County residents have longer lengths of stay at the state hospital than other RSNs. King County continues to have high utilization of single bed certifications, in part due to the back log of people waiting for admission to the state hospital occupying acute care beds. This would also be an opportunity to improve the outcome measure of reducing re-hospitalization rates.

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

Moving people from the state hospital at earlier points in time would reduce length of stay, allow for better flow-through, allowing people in need of the state hospital to be admitted, which would then open up acute care community hospital beds, and potentially reduce the need for Single Bed Certifications.

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

People who no longer need an inpatient level of care but are still in need of structure and clinical supports until they are ready to move into an available residential option such as supported housing, or a longer term residential setting but are awaiting an opening in one of those facilities.

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.

Shortened length of stay at the state hospital. Data source- WSH length of stay data
Diversion from inpatient care for persons enrolled in outpatient services. Data source- inpatient admissions data
Reduction in SBCs. Data source- MHCADSD/ CCS data and/ or DBHR data

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?

This is a recovery-oriented approach to move people back into the community faster, but humanely, supporting them in their transition into the community with a greater chance of success. As a step-up program, it can provide an alternative to hospitalization, again improving the chance of successful diversion. While living in the community housing options can be pursued, more effective engagement into programs such as Program of Assertive Community Treatment (PACT), and stabilization/skill building for transition into Supportive Housing

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.

Hospitals, particularly the state hospital and hospital liaison staff, but referrals could come from community hospitals, as well. As a transitional program partnerships would be needed with community outpatient providers, residential providers, PACT teams.

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:	**$ 481,800 per year, serving 50 people per year**
Partial Implementation:	**$ 963, 600 per year, serving 100 people per year**
Full Implementation:	**$ 1,445,400 per year, serving 150 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.

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