King County

REVISED April 1, 2020

Harborview Leadership Group Recommendation Report
Per King County Motion 15183

February 2020

April 1, 2020 Revision Note: **Appendix M Philanthropy Subcommittee Report was added. No changes were made to the narrative.**

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II. Executive Summary

Motion 15183: King County Motion 15183[1] created a planning process for a potential bond to support capital improvement at Harborview Medical Center (HMC). The motion called for the establishment of a leadership group, comprised of representatives from HMC management, HMC Board of Trustees, University of Washington, labor, the First Neighborhood Association, the mission population served by HMC, the King County Council, and Executive's Office, to identify hospital and community needs in the planning for a potential facilities bond for HMC.[2] The Harborview Leadership Group (HLG) was charged with making recommendations on HMC's capital program to the Capital Planning Oversight Group, the HMC Board of Trustees, the County Executive and the County Council.

This report fulfills the requirements of Motion 15183. It serves as the format for the HLG to make recommendations to the Capital Planning Oversight Committee. This report has been reviewed and approved by the HLG.

Background: HMC is a 413-licensed bed hospital owned by King County and operated by University of Washington Medicine (UW Medicine). The hospital is overseen by a 13-member Board of Trustees appointed by King County. HMC is a comprehensive regional health care facility dedicated to providing specialized care for a broad spectrum of patients, the control of illness, and the promotion and restoration of health. Harborview is one of the nation's leading academic medical centers and is the only Level 1 Trauma Center for adults and children serving a four-state region (Alaska, Idaho, Montana, and Washington).

Over time Harborview's medical facilities have expanded and changed to meet the demands of a growing and diverse population, as well as advancements in the fields of patient care, research, medicine, and technology. King County has provided for such facility improvements and expansions through voter-approved financing, generally occurring every 15-20 years. The voters of King County have supported the hospital through a number of bond measures over the years, most recently in the year 2000 with a $193 million bond.

Motion 15183 Charge

The Harborview Leadership group is charged with making recommendations on Harborview's clinical facility master plan, addressing the clinical facility master plan needs of the hospital and include, at a minimum:

1. An evaluation of the size and scope of a potential bond effort;
2. Exploration of the possibility of private philanthropy that could be anticipated were such an effort to go forward;
3. An evaluation of inclusion of the needs of the department of public health;
4. An evaluation of housing needs of the mission population and how the bond could address those needs;
5. An evaluation of how the project could address the needs of those impacted by the Involuntary Treatment Act;
6. An evaluation of how best to address behavioral health needs;
7. Whether bond proceeds should be invested in public health facilities beyond the Harborview campus to better serve residents countywide; and
8. Whether bond funds for other public safety infrastructure needs should be included and, if so, for what needs.

[1] Motion 15183 is attached as Appendix A
[2] List of Harborview Leadership Group members attached as Appendix B

The medical center's facilities are aging and outdated in terms of modern medical best practice standards for infection control and privacy. The hospital operates at almost 100 percent capacity on a daily basis. Facility configuration and capacity constraints significantly impact hospital operations, resulting in virtually no vital surge capacity (ability to house more patients in the event of an emergency), no capacity for growth, and limited flexibility for hospital operations. The older structures on the campus have not been seismically upgraded and pose life safety risks during a major earthquake. In summary, the aging HMC physical plant limits the ability of HMC and King County to provide care and services to the mission population and residents of King County.

New equipment, innovations in medical technology, updated infection control protocols, expanding emergency preparedness needs, growing behavioral health demands, and increasingly complex health needs of the mission populations necessitate planning for regional health facilities improvements. The medical center, and other health related facilities owned by King County, require facility improvements to better serve the mission populations and ensure compliance with infection control protocols, modern privacy standards, and facility seismic requirements.

King County Code 2.42.020

King County maintains Harborview Medical Center as a county hospital, pursuant to state law, for the primary purpose of providing comprehensive health care to the indigent, sick, injured or infirm of King County, and is dedicated to the control of illness and the promotion and restoration of health within the King County area.

Harborview Leadership Group Approach: The HLG met for 13 months between December 2018 and January 2020 to review facility needs as required by Motion 15183. Supported by staff from HMC, UW Medicine, King County Council, and King County Executive, the HLG reviewed data and information to come to its recommendation on size and scope of a potential bond for HMC.[3]

The County, with participation from HMC, engaged the architectural/space planning consulting firm of HDR to assist with options development and cost estimates to inform HLG's consideration of size and scope of a potential bond. A facilitation consultant, Christina Hulet, was contracted to support the HLG in meeting its charge.

A stakeholder engagement process was deployed so that community priorities could be taken into consideration by the HLG in its deliberations. Subcommittees aligning with the specific areas outlined in the motion gathered data, conducted analyses, and developed initial options for the HLG to study, with each subcommittee presenting its findings to the HLG for review and discussion. Subcommittees included an array of subject matter experts, including participation from individuals outside of King County government, UW Medicine, and HMC.

Findings and Recommendations on Harborview Medical Center's Clinical Facility Master Plan: On January 29, 2020, the Leadership Group voted unanimously to approve a recommended size and scope for Harborview's clinical facility master plan. Prior to the vote, the group highlighted the following discussion points:

- Desire to design the very best space feasible;

[3] List of staff included as Appendix C

- New and renovated space should be developed and designed to provide the most flexibility and latitude for operations and services; services and programs should not be constrained by inappropriate space;
- Subject matter experts with expertise in areas such as operations, services, and facilities should be engaged in the planning and development of spaces on the Harborview Campus; and,
- The final location of specific services and programs identified in the HLG recommended package may change due to evolving best practices, program needs, building code requirements, or unforeseen factors.

The table below summarizes the size and scope recommendation approved by the Harborview Leadership Group on January 29, 2020. It includes clarifications endorsed by the Leadership Group, as underlined.

Table 1

Component Name	**Component Description**	**Estimated Cost*** **Subject to modification*
New Tower	Increase bed capacity; expand/modify ED; meet privacy and infection control standards; disaster prep; plant infrastructure	$952M
New Behavioral Health Building	Existing behavioral health services/programs and Behavioral Health Institute services/programs	$79M
Existing Hospital Space Renovations	Expand ITA court in most appropriate location; move/expand gamma knife; lab; Public Health TB, STD, MEO; nutrition, etc.	$178M
Harborview Hall	Seismic upgrades; improve/modify space; create space for up to 150 respite beds; maintain enhanced homeless shelter in most appropriate location	$108M
Center Tower	Seismic upgrades; improve and modify space for offices	$248M
Pioneer Square Clinic	Seismic and code improvements; improve and modify space for medical clinic/office space	$20M
East Clinic	Demolish East Clinic Building	$9M
Site Improvements/Other Costs	Site preparation; 1% for Art; Project Labor Agreement; Project Management	$146M
Total		***$1.74B***

Next Steps: This report and the recommendations of the Harborview Leadership Group will be provided to the Harborview Capital Planning Oversight Committee. The recommendations then proceed to the HMC Board of Trustees, the King County Executive, and King County Council. The Council may choose to vote to place a bond measure on a ballot for consideration by King County Voters. The next general election is November 2020.

III. Background

Overview: Harborview Medical Center (HMC) is a 413-licensed bed hospital owned by King County and operated by University of Washington Medicine (UW Medicine) through a Hospital Services Agreement[4] between King County and the University of Washington. The hospital is overseen by a 13-member Board of Trustees appointed by King County.

HMC is a comprehensive regional health care facility dedicated to providing specialized care for a broad spectrum of patients, the control of illness, and the promotion and restoration of health. Harborview is one of the nation's leading academic medical centers and is the only Level 1 Trauma Center serving a four-state region (Alaska, Idaho, Montana, and Washington).

The medical center is home to a wide range of critical medical and behavioral health services, including state-of-the-art emergency medical services, general medicine and specialty clinics and centers of excellence in burn, neurosciences, ophthalmology, infectious disease, rehab therapy. Harborview's mission ensures that the following patients and programs are given priority care:

- ❑ Persons who are non-English speaking poor
- ❑ Persons who are uninsured or underinsured
- ❑ Persons who experience domestic violence
- ❑ Persons who experience sexual assault
- ❑ Persons incarcerated in King County's Jails
- ❑ Persons with mental illness, particularly those treated involuntarily
- ❑ Persons with substance abuse
- ❑ Persons with sexually transmitted diseases
- ❑ Persons who require specialized emergency care
- ❑ Persons who require trauma care
- ❑ Persons who require burn care

Services Offered at HMC: The Harborview campus facilities house a variety of services provided by UW Medicine and also by King County as highlighted below:

Behavioral Health: A variety of in- and out-patient behavioral health services, including psychiatric emergency services, outpatient clinics, and medication assisted treatment are provided at the HMC campus. In addition, King County's Superior Court operates the Involuntary Treatment Court at Harborview.

Trauma Response: As the only Level I Adult and Pediatric Trauma Center in Washington, HMC provides specialized comprehensive emergency services to patients throughout the region, and

[4] Ordinance 18232.

serves as the disaster preparedness and disaster control hospital for Seattle and King County. It is also the only Level 1 Trauma Center serving a four-state region (Alaska, Idaho, Montana, and Washington).

International Medicine: HMC is unique in its offering of an International Medicine Clinic, providing primary care and mental health care services to adult refugees and immigrants. Staff speak a number of languages in addition to English, including Spanish, Amharic, Cantonese, Chao Jo, Mandarin, Hmong, Khmer, Laotian, Mien, Oromo, Somali, Tigrinya and Vietnamese; interpreter services are also available.

Emergency Management / Disaster Relief: The medical center is the regional emergency management command center during a natural disaster or major crisis event. The hospital is required to have flexible inpatient beds and operating capacity and rapid response systems as needed for a crisis response.

Infection and Infectious Disease Control: HMC is at the forefront of containing and combating infectious diseases. Harborview is required to have clinical facilities and isolation room capacity to respond to emergency infectious disease outbreaks.

King County Clinics and Services: A number of King County's core public health services are located at Harborview, including the Tuberculosis (TB) clinic, STD/HIV clinic, the county's Public Health Lab, the Vital Statistics Office, and the King County Medical Examiner. King County operates a 24/7 homeless shelter at Harborview Hall in partnership with the Salvation Army.

Over time Harborview's medical facilities have expanded and changed to meet the demands of a growing and diverse population, as well as advancements in the fields of patient care, research, medicine, and technology. King County has provided for such facility improvements and expansions through voter-approved financing, generally occurring every 15-20 years.

Harborview Leadership Group: In 2018, the Executive and King County Council agreed to evaluate Harborview's facility needs along with the other related healthcare facilities via Motion 15183. King County Motion 15183[5] created a planning process for a potential bond to support capital improvement at HMC. The motion called for the establishment of a leadership group, comprised of representatives from HMC management, HMC Board of Trustees, University of Washington, labor, the First Neighborhood Association, the mission population served by HMC, the King County Council, and Executive Office, to identify hospital and community needs in the planning for a potential facilities bond for HMC.[6] The Harborview Leadership Group (HLG) was charged with making recommendations on HMC's capital program to the Capital Planning Oversight Group, the HMC Board of Trustees, the County Executive and the County Council.

[5] Motion 15183 is attached as Appendix A
[6] List of Harborview Leadership Group members attached as Appendix B

The HLG met for 13 months between December 2018 and January 2020 to review facility needs as required by Motion 15183. Supported by staff from HMC, UW Medicine, King County Council, and King County Executive, the HLG reviewed data and information to come to its recommendation on size and scope of a potential bond for HMC.[7]

The County, with participation from HMC, engaged the architectural/space planning consulting firm of HDR to assist with options development and cost estimates to inform HLG's consideration of size and scope of a potential bond. A facilitation consultant, Hulet Consulting, was contracted to support the HLG in meeting its charge.

2018 HMC Statistics
Provided by HMC

Licensed beds: 413
Employees: 4,501
Admissions: 16,716
Emergency Department visits: 57,516
Clinical visits: 262,132

A stakeholder engagement process was deployed so that community priorities could be taken into consideration by the HLG in its deliberations. Subcommittees aligning with the specific areas outlined in the motion gathered data, conducted analyses, and developed initial options for the HLG to study, with each subcommittee presenting its findings to the HLG for review and discussion. Subcommittees included an array of subject matter experts, including participation from individuals outside of King County government, UW Medicine, and HMC. Additional information on the stakeholder engagement the subcommittee approaches are described in subsequent sections of this report.

Report Methodology: This report was developed by King County staff, with review and feedback by staff from HMC and the King County Council. The HLG reviewed and made final edits and approved its contents at the January 29th HLG meeting. The information contained in this report is extracted from data, reports, and presentations provided to the HLG, along with data and information provided by HDR.

IV. Motion 15183 Requirements

King County Motion 15183 called for the HLG to address the eight areas identified in the motion and to recommend a size and scope of potential bond for Harborview Medical Center, should a bond proposal be put forward to King County voters for consideration. The following outlines the timeline and processes that the HLG created and followed to comply with the requirements of Motion 15183.

At its first meetings, the HLG established the timeline, processes, and analytical criteria that the HLG would use to determine its recommendations for the capital program. At each HLG meeting, an updated timeline showing deliverables and process dates was provided. The analytical criteria, subcommittee process, and stakeholder engagement approaches are summarized below.

Analytical Criteria: In order to assist the Leadership Group to conduct its options analysis and subcommittees in the development of options, a consistent analytical structure was established and adopted at its initial meetings. The framework was structured with four overarching areas, each with specific impact elements:

Area 1: People Impact

- Mission Population
- Patients and clients
- Labor and employees

[7] Staff list is attached as Appendix C

- Neighbors and community

Area 2: Service/Operational Impact

- Delivery of emergency services
- Addresses facility deficiencies and needs
- Supports innovation, best practices, and/or new models of care

Area 3: Equity and Social Justice

- Service models that promote equity
- Influenced by community priorities
- Addresses Determinants of Equity
- Access to healthcare and improved health outcomes

Area 4: Fiscal/Financial Impact

- The long-term financial position of Harborview and King County
- Existing facilities
- Opportunities for other funding

See Appendix D for the criteria document.

Subcommittees: Subcommittees aligning with the specific areas called out in the motion were established early in 2019 to gather data, conduct analyses, and develop options for the HLG to consider. Following an established template and over the course of 2019, each subcommittee presented their findings to the HLG for review and discussion. The subcommittees for the HLG were:

- ❑ Medical Center Facilities
- ❑ Behavioral Health
- ❑ Housing
- ❑ Involuntary Treatment Court
- ❑ Public Health
- ❑ Pioneer Square Clinic
- ❑ Philanthropy
- ❑ Public Safety

Subcommittees were comprised of subject matter experts from Harborview, UW, and King County along with external experts. A consistent reporting format was deployed for all subcommittee reports, with each subcommittee topic discussed in at least two HLG meetings. The staff workgroup received pre-briefings, reviewed initial drafts of subcommittee reports, and worked with subcommittees to update reports/options as needed. The detailed subcommittee reports are attached to this report as Appendices F-L.

Community Engagement: A community engagement process was deployed to meet with key stakeholder groups reflecting areas such as behavioral health, housing, immigrant and refugee communities, and labor. Several shared themes arose between all groups, with some unique themes articulated by each group, summarized below.

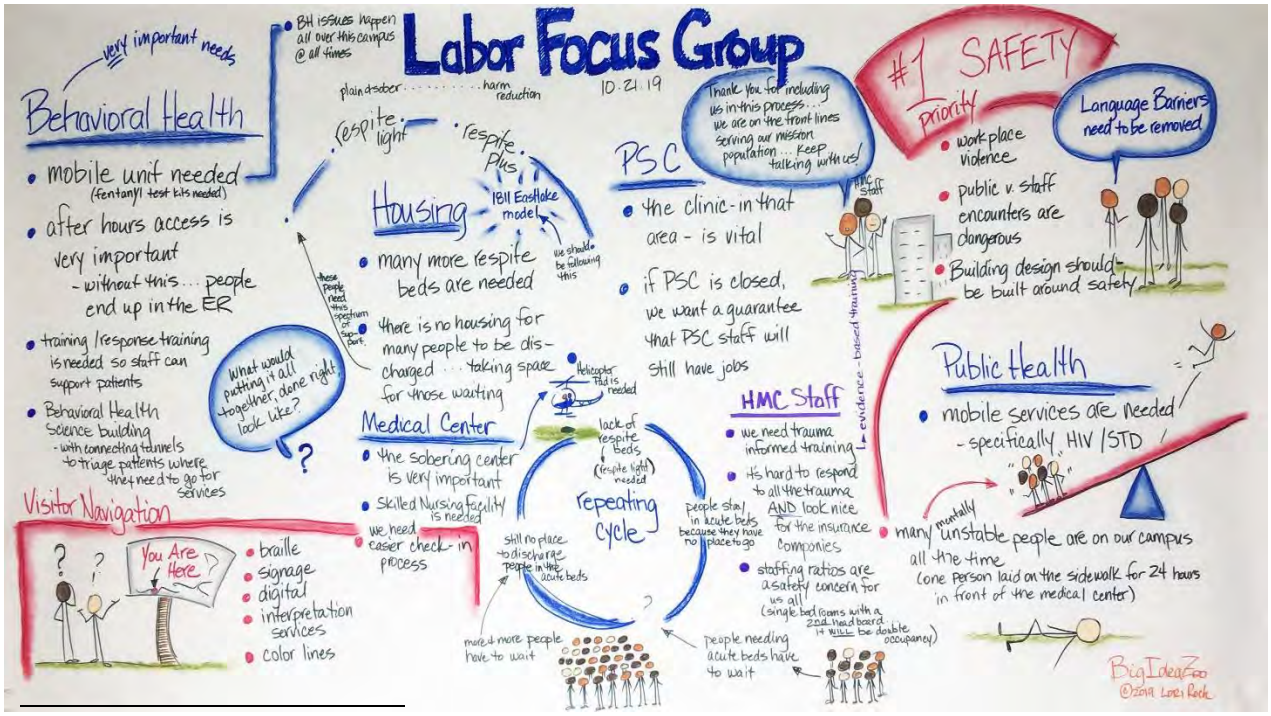
Briefing, feedback sessions, and focus groups were held with existing groups as well as groups assembled solely for providing feedback to the HLG, as noted below.

Briefings and Feedback Sessions	Focus Group Sessions
• Health Care for the Homeless	• Housing Providers Focus Group

• King County Immigrant and Refugee Commission • Behavioral Health Advisory Board • First Hill Neighborhood Association	• Health Care for the Homeless Focus Group • Labor & Employees Focus Group • Immigrant and Refugee Focus Group

Community Engagement: Key Shared Themes	Community Engagement: Key Unique Themes
• Need behavioral health facilities and resources • Need to improve flow and efficiency in hospital to improve access to care • Respite and multi-level respite care beds are important • A sobering center is necessary • More services needed in South King County • Strong support for maintaining and improving Pioneer Square Clinic • Step up/Step down facilities to meet changing needs of patients and population (BH) • Safety and security of patients and employees is essential • Need supportive housing	• New facilities on Harborview's campus on employees • Concern about co-locating all behavioral health facilities to one area • Improve access to care by increasing mobile and satellite services • Need improved accessibility/wayfinding on HMC campus (i.e. signage, maps, arrows, directions, braille) • Immigrant specific focus needed for services • Transportation options needed for accessibility to care • Need options for services outside of Harborview • Behavioral Health Institute/BH facilities and programs must be culturally sensitive and communities of color must be engaged in its development

Example Illustrated Focus Group Notes[8]



[8] Appendix E contains illustrated notes from all engagement sessions

A. Harborview Clinical Masterplan Needs

A summary of Harborview's facilities is included above section, "Overview".

Clinical Facility Need Statement: The medical center's facilities are aging and out of date in terms of modern medical best practice standards for infection control and privacy. Current rooms do not meet best practice standards; existing building infrastructure and floor size prohibits renovating to meet best practice standards. Facility configuration and capacity constraints significantly impact hospital operations.

The hospital operates at almost 100 percent capacity on a daily basis, with at least 50 beds located in double patient rooms that cannot be used because of isolation precautions.[9] The need for isolation precautions requires hospital staff to place patients in areas not initially designed for acute care beds, such as the Emergency Department, Intensive Care Units (ICU), and surgical recovery rooms, creating a "grid locked" operational environment:

- Patients are often boarded in the Emergency Department, resulting in patients with prolonged stays waiting for an acute care bed in an appropriate patient room. While they are waiting, patients are placed in small bays, partitioned by curtains, which are not intended for longer term stays.
- Patients who are boarded in operating room recovery areas result in increased length of stay for surgical patients.
- Patients who no longer meet ICU criteria often remain in ICU when no acute care bed is available. ICU beds are more costly.
- Harborview also cares for at least 30 patients per day who no longer meet inpatient criteria but cannot be discharged for various reasons (such as homelessness) that occupy acute care beds for extended periods of time. Their length of stay can be prolonged for weeks or months depending on the circumstances.

This grid locked operational environment, leaves the hospital with no flexibility for hospital operations and virtually no vital surge capacity.[10] Additionally, this operational imbalance puts extreme financial stress on Harborview's bottom line.

Patient Feedback

"The doctors I saw were fantastic. I had a huge team working on my case and I felt like I was in good hands. I had a great deal of problems with noise. I had a real difficult roommate who yelled a lot."

"I had to listen to my roommate cry and go on and on about her life. Her husband slept in the room. I know everything about her life -even when people came to visit, she never stopped!!! No rest at all. I understand the rooms are small but this was really hectic."

[9] Data provided by Harborview Medical Center, January 29, 2019. See Appendix F.

[10] The US Department of Health and Human Services defines medical surge capacity refers to the ability to evaluate and care for a markedly increased volume of patients exceeding normal operating capacity. The surge needs may extend beyond direct patient care to include such tasks as extensive laboratory studies or epidemiological investigations.

Table 2

Existing Patient Room Analysis			
Harborview Medical Center	**# of Patient Beds on Campus**	**# of Patient Rooms on Campus**	**# of Patient Rooms that Meet Best Practice Standards***
East Hospital	199	133	0
West Hospital	139	106	0
Maleng	75	58	40
Total	**413**	**297**	**40 (20 are Psych ICU)**

Best Practice Standards refer to a patient room that is large enough for current code requirements; dedicated caregiver, patient and family zones; and, a dedicated bathroom with toilet, sink and shower.

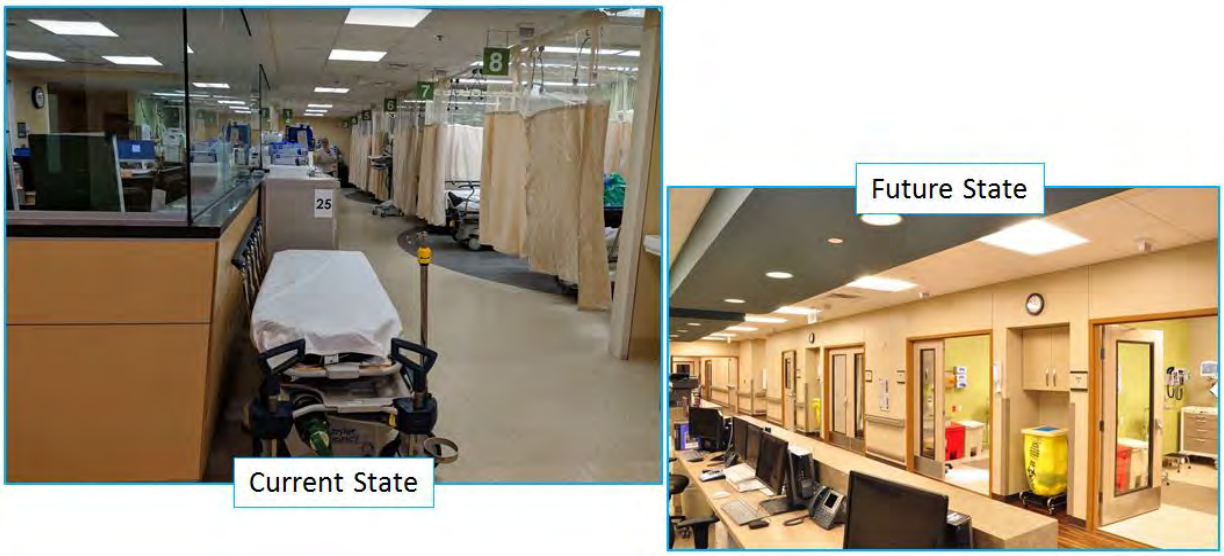
Standard Harborview Acute Care Room

Harborview Medical Center is the only Level 1 Adult and Pediatric Trauma Center in the five state region but its existing Emergency Department is deeply space constrained, further limiting the hospital's ability to manage high volumes of patient admissions caused by basic influenza outbreaks or natural disasters. The existing Emergency Department was last remodeled during the 2000 Bond Project, nearly 20 years ago.

The current configuration uses obsolete small patient bays that are only separated by curtains providing very little privacy for patient and care providers. The Emergency Department needs to be updated, modernized, and expanded to support the high level of patient care. Additionally, trauma patients flown

by helicopter to HMC must be unloaded from the helicopter, loaded into an ambulance, and then driven around the building to the Emergency Department entrance, resulting in a cumbersome and expensive process.

Emergency Department Current and Future State



Seismic Need Statement: The Center Tower and Harborview Hall are older structures on the campus built in the 1930s. Neither building has been seismically upgraded to meet modern building codes. Notably, the Center Tower's façade and platform have landmark status per the City of Seattle.

Without seismic upgrades, these buildings pose a significant life-safety risk to the patients, employees, and visitors to the Harborview campus during a major earthquake. Seattle and King County are located in an area marked by the prevalence of earthquakes.[11]

The East Clinic building, constructed in the 1950s and is a candidate for demolition as it does not meet current seismic standards and is not a designated landmark. It is poorly suited and inefficient for use as a modern day office or clinic space.

Harborview Leadership Group Recommendation: Include funding in a potential bond to:

1. Increase bed capacity and expand ED through erecting new tower on the campus; replace double patient rooms with 360 single patient rooms;
2. Renovate and relocate as necessary spaces in existing campus facilities serving clinical needs such as but not limited to Gamma Knife, and lab;
3. Seismically upgrade Center Tower and Harborview Hall; and,
4. Demolish East Clinic; create open space.

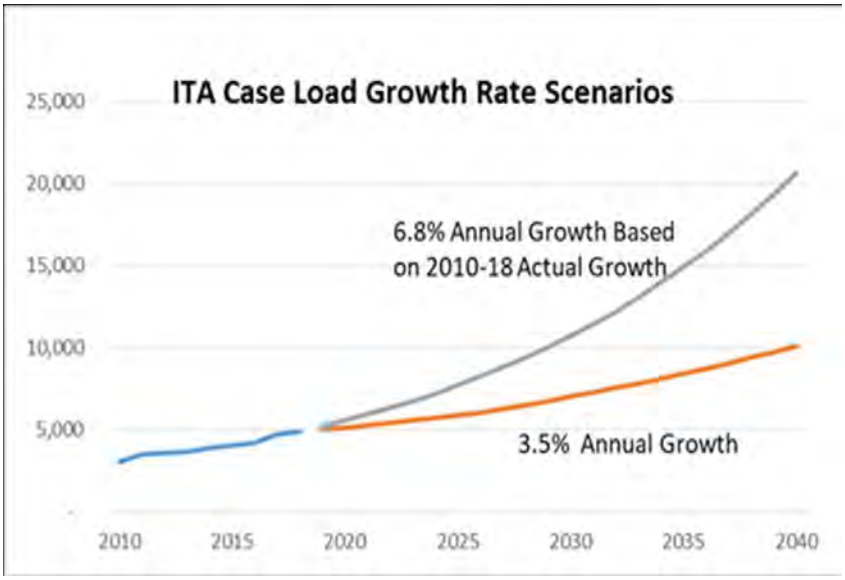
[11] King County Emergency Management-Earthquake

B. Involuntary Treatment Court Needs

Overview: Washington State's Involuntary Treatment Act (ITA) provides a legal basis for the limited term, civil detention and involuntary psychiatric treatment of individuals with significant risks arising from mental health disorders.[12] King County Superior Court operates ITA Court in space located at the Ninth and Jefferson Building (NJB) on the Harborview Campus.

ITA Court conducts civil commitment hearings, which are a judicial process, for persons already admitted to, and being treated in, inpatient units at hospitals or treatment facilities across King County. The Court utilizes in-person and video hearings to conduct the civil commitment hearings. Data provided in the ITA Subcommittee report states that about 80 percent of ITA Court hearings were conducted via video, where patients are located in hospitals or treatment facilities across King County and not on the Harborview Campus; only about 20% of ITA Court cases involve individuals receiving services at Harborview.

Table 3



Need Statement: As identified in the ITA Subcommittee report:[13]

- ITA Court experiences significant space constraints as caseloads continue to increase, as shown in Table 2.
- ITA court officials plan for the continued use of both in-person and video hearings over the next decade.
- The current in-person facilities are inadequate in size and functionality; and video hearings will require ongoing equipment and capital infrastructure support.

Harborview Leadership Group Recommendation: Include funding in a potential bond to:

1. Expand the ITA Court space on the Harborview campus in the most appropriate location.
2. Invest in behavioral health facilities.

C. Behavioral Health Needs

Overview: *Behavioral health disorders* is the umbrella term for both mental health and substance use disorders, such as depression, schizophrenia, alcohol use disorder, and opiate use disorder. People of all

[12] RCW 71.05 and 71.34
[13] See Appendix G

races, socioeconomic classes, ages, and sexes can develop behavioral health disorders; psychiatric illness does not discriminate. The continuum of services for behavioral health conditions ranges from outpatient visits at one end of the spectrum, where people go to a clinic once every few months for short appointments, to involuntary hospitalization, where people are admitted to a psychiatric hospital against their will at the other end of the spectrum.

HMC is a recovery-oriented system and currently provides several behavioral health services, including multiple outpatient clinics, a Psychiatric Emergency Service (PES), and three inpatient psychiatric units. Offerings at the outpatient clinics include services for mental health and substance use disorders, care for geriatric populations, short-term interventions that help link individuals to ongoing services provided in community or at HMC, and support services to help individuals participating in the behavioral health system obtain housing and employment. HMC also offers an outpatient clinic for physicians training to become psychiatrists as well as a new clinic that focuses on Specialized Treatment of Early Psychosis (STEP).

Need Statement: HMC is one of the few hospitals in the state that accepts all individuals who present for care. As a result, the most ill and vulnerable individuals with significant health complexity in the region often come to HMC. All behavioral health clinics at HMC are operating at maximum capacity and, combined, have over 51,000 visits per year. As identified in the Behavioral Health subcommittee report[14] the current facilities do not support a therapeutic environment, are at capacity, and are not operationally efficient.

More types and availability of services can also help save lives. Furthermore, it could reduce pressure on judicial resources at the Involuntary Treatment Act (ITA) court by alleviating caseload growth. There is a need for more avenues for people to access care and treatment before symptoms reach the threshold of hospitalization, particularly involuntary detention.

Harborview Leadership Group Recommendation: Include funding in a potential bond to:
Build a new behavioral health building on the campus that would include space for expanded outpatient clinical space, programs for the developing Behavioral Health Institute, a sobering center, and a step up/step down program.

D. Housing Needs for the Mission Population

Overview: The Housing Subcommittee report included information on the continuum of shelter and housing options for the mission population in its analysis, as summarized below.[15]

- *Respite Beds:* Often, individuals who are homeless or marginally housed stay in the hospital longer than clinically indicated because they have nowhere else to go to receive lower-acuity medical and recuperative care. In all of King County there is a very small number of respite beds (34 medical and 20 Behavioral Health) allocated to HMC, Swedish Medical Center and Valley Medical Center. The small number of respite beds in King County means that need far outstripping the supply. The lack of

[14] See Appendix H
[15] See Appendix I

medical respite beds increases morbidity and mortality among homeless patients, as well as acting as a bottleneck for discharge from Emergency Department and hospital beds.

- *Permanent Supportive Housing:* There is a significant shortfall of permanent supportive housing (PSH) units in King County. At the writing of the subcommittee report, there were about 180 PSH buildings serving adults in King County, with a total of 5,544 adult units.[16] In 2017, there was need for 3,200-3,800 additional PSH units.[17] In King County, PSH is almost exclusively staffed to support individuals with behavioral health challenges. PSH provides on demand services to formerly homeless households who have a disability, behavioral health condition, or both. PSH units cost ~$375,000-425,000 per unit to build. There is a large body of evidence that individuals in PSH have lowered system utilization including emergency department visits and supportive housing reduces ED visits and hospital days.

- *Workforce/Affordable Housing:* There is a significant and growing need for workforce housing in King County. High housing costs negatively impact the ability of the Harborview workforce, particularly those in mid to lower range salary positions, to live reasonably close to their workplace. Income-Restricted Housing is long-term housing for households with a total income less than a particular percentage of Area Median Income (AMI). In King County, the AMI for a household is $103,400. There is a current shortage of about 56,159 units for 30 percent AMI and below, with a projected need of 82,792 units between now and 2030.

- *Shelters:* As of the 2018 Point in Time Count there were 5,792 unsheltered households in King County.[18] Currently, there are about 540 shelter beds within about 6 blocks of the Harborview campus. Additional shelter resources could come in the form of emergency shelter,[19] which provides indoor sleeping space and some services or more robust enhanced shelter capacity,[20] which is generally open 24 hours and offers more flexibility and services. Increased shelter capacity could provide additional alternatives for discharge from hospital. It may also have a public health impact, as unsheltered homelessness leads to increased morbidity and mortality. Additional drop-in center capacity may reduce non-acute emergency department utilization.

[16] HUD 2018 Continuum of Care Homeless Assistance Programs Housing Inventory Count Report.
[17] King County and Seattle Homelessness – Some Facts. McKinsey & Company, December 15, 2017
[18] Seattle/King County Point-In-Time Counts of Persons Experiencing Homelessness, The Economics of Homelessness in Seattle and King County, McKinsey & Company
[19] As defined by King County, emergency shelter is temporary shelter from the elements and unsafe streets for individuals and families experiencing homelessness. Shelter programs are either fixed capacity (facility-based) or flexible capacity (for example, hotel/motel vouchers). Emergency shelters typically address the basic health, food, clothing and personal hygiene needs of the households that they serve and provide information and referrals about supportive services and housing. Emergency shelters are indoors, and range from mats on the floor in a common space to beds in individual units. Some shelters are overnight only, where others operate 24/7.
[20] As defined by King County, enhanced shelters operate 24/7, year round and provide services and housing navigation to help people exit homelessness. Enhanced shelters ensure basic needs, including personal safety, sufficient and safe sleep, hygiene, adequate nutrition, and secure storage for personal belongings.

Need Statement: Unmanaged medical and behavioral health conditions compound the vulnerabilities associated with homelessness, and homelessness can compound the morbidity and mortality of health conditions.

Harborview Leadership Group Recommendation: Include funding in a potential bond to:
1. Provide space for 150 respite beds.
2. Maintain current 24/7 enhanced shelter at Harborview Hall or most appropriate location.

E. Needs of the Department of Public Health/Public Health Facilities Beyond Harborview Campus

Overview: The Public Health Subcommittee report included information on the Public Health programs and locations, summarized below.[21]

Public Health – Seattle & King County (PHSKC) eliminates health inequities and maximizes opportunities for every person to achieve optimal health. Public Health protects its community from the spread of disease, provides primary care and linkages to specialty care, and seeks to address the social determinants of heath.

Historically, King County has contributed to the health safety net by operating the public health system in the county. Public Health services on HMC campus include:
- HIV/STD Clinic
- King County Medical Examiner's Office (KCMEO)
- Tuberculosis (TB) Control Program
- Public Health Laboratory
- Vital Statistics

PHSKC programs *not* located on the HMC campus with a nexus to the work of the Leadership Group include: the Refugee Health Screening Program which provides the legally required health assessment services for newly arrived refugees and asylees and the Downtown Public Health Center which:
- Serves low-income, homeless and refugee populations
- Services include adult health care and Swedish family medicine residency program, dental clinic, travel clinic, Refugee Health Screening, WIC, and Needle Exchange Program

Need Statement: HIV/STD Clinic, KCMEO, TB Control Program benefit from being housed on the HMC campus. Each of these programs anticipate growth and need for additional space:
- HIV/STD Clinic projects caseload increases
- KCMEO projects caseload increases
- TB Control Program projects active TB caseloads to remain level; latent TB infection to become reportable, increasing workload; and additional federal funding necessitating staff increases

In addition, Refugee Health Screening and TB Control would benefit from co-locating on HMC campus. Downtown Public Health needs a permanent home to ensure health and human services for the safety net population in downtown Seattle.

Harborview Leadership Group Recommendation: Include funding in a potential bond to:
Expand and renovate Public Health spaces on the Harborview Campus.

[21] See Appendix J

F. Pioneer Square Clinic

Overview: The Pioneer Square Clinic Subcommittee report included information on the clinical services provided in the Pioneer Square Clinic in its analysis, as summarized below.[22]

The Pioneer Square Clinic (PSC), located at 3rd Avenue and Washington Street in downtown Seattle, was established 45 years ago as a critical part of the health safety net for the county's most vulnerable residents. Services offered include:

- Primary Care Medical Home
- Acute episodic care
- Psychiatry, Social Work, Mental Health
- Podiatry
- Nutrition
- Pharmacy
- Opioid Based Outpatient Treatment (OBOT)

The surrounding neighborhood has 6 homeless shelters, 7 low in-come housing complexes, 3 senior housing complexes, multiple food and survival services and only 1 medical clinic: the Pioneer Square clinic operated by Harborview Medical Center.

Built in 1904, the Pioneer Square Clinic building is a historic landmark and grandfathered in to its code, specifying that any major changes made to the building would require bringing the entirety of the clinic up to current state and local code requirements.

Need Statement: Pioneer Square Clinic is open 50 hours a week Monday – Friday and is turning away patients daily. The clinic has 7 small exam rooms limiting ability to respond to low acuity calls due to scheduled visits and high volume of walk-ins. Pioneer Square does not have a procedure area and must call 911 for transport to HMC emergency department instead of stabilizing lower acuity needs in the clinic but requiring more room that current exam rooms offer. The clinic is need of significant HVAC, plumbing and electrical upgrades to maintain quality care for patients

Harborview Leadership Group Recommendation: Include funding in a potential bond to:
Seismically upgrade and renovate the clinic.

G. Public Safety Infrastructure Needs

The members of the Public Safety Subcommittee met with staff from the office of the sponsoring Councilmember of Motion 15183 in August. Staff discussion on the analytical approach to this area included recognition that the county was engaged in a concurrent planning for its Civic Campus work. The group concurred that the Civic Campus planning timeline impacted HLG subcommittee's ability to pursue recommendations and agreed that because this issue area was expected to be addressed through the separate Civic Campus work, the Public Safety Subcommittee would not pursue options development for this area. The HLG was provided with this update.

[22] See Appendix K

H. Private Philanthropy Opportunities

Overview: An initial Philanthropy Subcommittee report included a broad overview of the committee's planned approach, as summarized below.[23]

Historically, major facility capital expansion and campus development has been publically funded, with annual and targeted fundraising efforts for HMC providing on-going support of capital renovations, equipment and operational expenses.

The Philanthropy Subcommittee engaged a third party consultant to explore how private philanthropy could generate measurable funding needed for facility investments and possibly reduce the amount that would need to be sought from taxpayers. Public/private partnerships in financing major public hospital construction projects of the scale under investigations by the Harborview Leadership Group are rare, with few examples nationally. The subcommittee is in the process of conducting a formal fundraising feasibility study to help determine the level of philanthropic support that could be generated locally for a similar effort.

As of the writing of this report, the assessment of private philanthropy opportunities has not been finalized. The initial finding is that philanthropy can play a part in reducing the cost of the project, though no specific funding amount has been identified.

A report is expected mid-February. It will be provided to the Capital Planning Oversight Group, the Board of Trustees, the King County Executive, and the King County Council as they review the recommendations from the Harborview Leadership Group and consider a legislative package for a potential bond for Harborview facilities.

Harborview Leadership Group Recommendation:
Philanthropy can play a part in reducing the cost of the project, though no specific funding amount is identified.

I. Harborview Leadership Group Recommendation

Findings and Recommendations on Harborview Medical Center's Clinical Facility Master Plan: On January 29, 2020, the Leadership Group voted unanimously to approve a recommended size and scope for Harborview's clinical facility master plan as outlined in Table 4 below.

Prior to the vote, the group highlighted the following discussion points:

- Desire to design the very best space feasible;
- New and renovated space should be developed and designed to provide the most flexibility and latitude for operations and services; services and programs should not be constrained by inappropriate space;
- Subject matter experts with expertise in areas such as operations, services, and facilities should be engaged in the planning and development of spaces on the Harborview Campus; and,

[23] See Appendix L

- The final location of specific services and programs identified in the HLG recommended package may change due to evolving best practices, program needs, building code requirements, or unforeseen factors.

The table below summarizes the size and scope recommendation approved by the Harborview Leadership Group on January 29, 2020. It includes clarifications endorsed by the Leadership Group, as underlined.

Table 4

Component Name	Component Description	Estimated Cost* **Subject to modification*
New Tower	Increase bed capacity; expand/modify ED; meet privacy and infection control standards; disaster prep; plant infrastructure	$952M
New Behavioral Health Building	Existing behavioral health services/programs and Behavioral Health Institute services/programs	$79M
Existing Hospital Space Renovations	Expand ITA court in most appropriate location; move/expand gamma knife; lab; Public Health TB, STD, MEO; nutrition, etc.	$178M
Harborview Hall	Seismic upgrades; improve/modify space; create space for up to 150 respite beds; maintain enhanced homeless shelter in most appropriate location	$108M
Center Tower	Seismic upgrades; improve and modify space for offices	$248M
Pioneer Square Clinic	Seismic and code improvements; improve and modify space for medical clinic/office space	$20M
East Clinic	Demolish East Clinic Building	$9M
Site Improvements/Other Costs	Site preparation; 1% for Art; Project Labor Agreement; Project Management	$146M
Total		***$1.74B***

V. Conclusion and Next Steps

The Harborview Leadership Group has fulfilled its charge, having developed recommendations on Harborview's clinical facility master plan and having conducted assessments of the needs other subject areas for inclusion in a potential bond as required by Motion 15183. The unanimously supported recommendations outlined in this report address the clinical facility master plan needs of the hospital, as well as the needs of Public Health, Involuntary Treatment Court, behavioral health, and housing for the mission population.

As required, this report and the recommendations of the Harborview Leadership Group will be provided to the Harborview Capital Planning Oversight Committee at Harborview. The recommendations then proceed to the HMC Board of Trustees, the King County Executive, and King County Council. The Council

may vote to place a bond measure on a ballot for consideration by King County Voters. The next general election is November 2020.

VI. Appendices

Appendix A	Motion 15183
Appendix B	Harborview Leadership Group Member List
Appendix C	Harborview Leadership Group Staff List
Appendix D	Analytical Criteria for Harborview Leadership Group Recommendation
Appendix E	Community Engagement Illustrated Notes
Appendix F	Harborview Medical Center Subcommittee Report and Presentations
Appendix G	Involuntary Treatment Act (ITA) Court Subcommittee Report and Presentations
Appendix H	Behavioral Health Subcommittee Report and Presentations
Appendix I	Housing Subcommittee Report and Presentations
Appendix J	Public Health Subcommittee Report and Presentations
Appendix K	Pioneer Square Subcommittee Report and Presentations
Appendix L	Philanthropy Subcommittee Report and Presentations
Appendix M	Final Philanthropy Report

King County

KING COUNTY

1200 King County Courthouse
516 Third Avenue
Seattle, WA 98104

Signature Report

July 24, 2018

Motion 15183

Proposed No. 2018-0319.2 **Sponsors** Dembowski

A MOTION creating a planning process for a potential bond to support capital improvement at Harborview Medical Center.

WHEREAS, The Harborview Medical Center was founded in 1877 as a six-bed county hospital in South Seattle, and

WHEREAS, the hospital relocated to its current location in 1931, and

WHEREAS, the hospital now has four hundred and thirteen beds, seven primary care clinics and forty-nine other specialty clinics, and

WHEREAS, the hospital provides over sixty thousand emergency visits and more than a quarter million clinic visits each year, and

WHEREAS, the hospital is maintained as a public hospital to provide healthcare to those groups of patients and programs that are determined to require priority treatment, and

WHEREAS, the hospital is owned by King County, overseen by the Harborview Medical Center Board of Trustees and operated by the University of Washington, and

WHEREAS, the hospital is the only level one adult and pediatric trauma center serving the states of Washington, Alaska, Montana and Idaho, and the hospital provides specialized comprehensive emergency services to patients and serves as the disaster preparedness and control hospital for Seattle and King County, and

WHEREAS, the voters of King County have supported the hospital with a number of bond measures over the years, most recently in the year 2000 with a $243 million bond, and

WHEREAS, the medical center now needs additional capital funding to improve facilities, better serve the mission population and maintain modern seismic standards, and

WHEREAS, the mission of Harborview Medical Center is: to provide healthcare for the most vulnerable residents of King County; to provide and teach exemplary patient care; to provide care for a broad spectrum of patients from throughout the region; and to develop and maintain leading-edge centers of emphasis, and

WHEREAS, the following populations are given priority for care at Harborview: persons who are non-English-speaking poor, persons who are uninsured or underinsured, persons who experience domestic violence, persons who experience sexual assault, persons incarcerated in King County's jails, persons with mental illness, particularly those treated involuntarily, persons with substance abuse issues, persons with sexually transmitted diseases, persons who require specialized emergency care, persons who require trauma care and persons who require burn care;

NOW, THEREFORE, BE IT MOVED by the Council of King County:

A. The executive, in cooperation with the Harborview Medical Center Board of Trustees and the University of Washington, will convene a Harborview leadership group to identify hospital and community needs should a bond measure go forward. The group shall be appointed by the executive and confirmed by the county council and shall consist, at a minimum of the following members:

1. At least two representatives of the county executive;

2. At least two county councilmembers or designees;

3. Two members of the Harborview Medical Center Board of Trustees;

4. The Harborview Medical Center Executive Director;

5. The UW Medicine Chief Health System Officer or designee;

6. At least two representatives of labor unions representing employees at the Harborview Medical Center;

7. A representative of the First Hill community;

8. At least two representatives of the mission populations served by Harborview; and

9. The Harborview Medical Center Medical Director.

B. The Harborview leadership group is charged with making recommendations on the capital program to the Capital Planning Oversight Committee at Harborview. The recommendations then proceed to the Harborview Medical Center Board of Trustees, the county executive and the county council.

C. The recommendations shall address the clinical facility master plan needs of the hospital and include, at a minimum:

1. An evaluation of the size and scope of a potential bond effort;

2. Exploration of the possibility of private philanthropy that could be anticipated were such an effort to go forward;

3. An evaluation of inclusion of the needs of the department of public health;

4. An evaluation of housing needs of the mission population and how the bond could address those needs;

5. An evaluation of how the project could address the needs of those impacted

by the Involuntary Treatment Act;

6. An evaluation of how best to address behavioral health needs;

7. Whether bond proceeds should be invested in public health facilities beyond the Harborview campus to better serve residents countywide; and

8. Whether bond funds for other public safety infrastructure needs should be included and, if so, for what needs.

D. The county will make resources available to the planning group, pending

appropriation, to fund studies, analyses and other needs to prepare the best set of recommendations.

Motion 15183 was introduced on 7/16/2018 and passed by the Metropolitan King County Council on 7/23/18, by the following vote:

Yes: 9 - Mr. von Reichbauer, Mr. Gossett, Ms. Lambert, Mr. Dunn, Mr. McDermott, Mr. Dembowski, Mr. Upthegrove, Ms. Kohl-Welles and Ms. Balducci
No: 0
Excused: 0

KING COUNTY COUNCIL
KING COUNTY, WASHINGTON

J. Joseph McDermott, Chair

ATTEST:

Melani Pedroza, Clerk of the Council

Attachments: None

Harborview Leadership Group

FACILITATOR

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- Katie Ross

King County Council Staff

- Pat Hamacher
- Kristina Logsdon
- Lan Nguyen
- Samantha Porter

Harborview Medical Center

- Kera Dennis
- Ted Klainer
- Clayton Lewis

UW Medicine

- Ian Goodhew

Public Health – Seattle & King County

- Maria Wood
- TJ Cosgrove

King County Facilities Management Division

- Cristina Gonzalez

King County Department of Community and Human Services

- Mark Ellerbrook
- Maria Yang, MD
- Kelli Nomura

King County Office of the Executive

- Bailey Bryant

Analytical Criteria for Harborview Leadership Group Recommendation – Approved 1.29.19

Introduction: Over the coming months, the Harborview Leadership Group will be presented with a variety of facility options to consider as they develop and prioritize recommendations for a potential capital bond measure to support the county-owned Harborview Medical Center (HMC) pursuant to Motion 15183.

In order to assist the Leadership Group to conduct its options analysis, a consistent analytical structure that can be applied to all proposals has been developed. The framework is structured with four overarching areas, each with specific impact elements.

Each facility proposal/option will be examined using the criteria below.

Area 1: People Impact
- Mission Population
- Patients and clients
- Labor and employees
- Neighbors and community

Area 2: Service/Operational Impact
- Delivery of emergency services
- Addresses facility deficiencies and needs
- Supports innovation, best practices, and/or new models of care

Area 3: Equity and Social Justice
- Service models that promote equity
- Influenced by community priorities
- Addresses Determinants of Equity
- Access to healthcare and improved health outcomes

Area 4: Fiscal/Financial Impact
- The long-term financial position of Harborview and King County
- Existing facilities
- Opportunities for other funding

Area 1: What is the impact to people?

A. How would the proposal impact clients, patients, and the community in the following areas?
    1. Prioritizes the needs of the Mission Population, providing for new or expanded services to address gaps
    2. Increase and/or ease of access
    3. Improves care

B. How would the proposal impact labor and employees in the following areas?
    1. Increases job opportunities
    2. Enhances employee and patient safety
    3. Supports more efficient workflow and productivity
    4. Supports recruitment and retention

C. How would the proposal impact neighbors and surrounding communities in the long-term?
    1. Decreases in traffic and/or noise
    2. Increase in availability and accessibility by community
    3. Improves neighborhood safety
    4. Supported by neighbors and communities
    5. Responsive to changing population patterns and geographic needs of county residents

Area 2: What is the impact to services and operations?

A. How would the proposal impact delivery of emergency services?
    1. Ensures functionality of public resource of Level 1 trauma center
    2. Provides surge capacity during high census periods, natural disasters, or mass casualty events
    3. Stabilizes facility to fulfill regional emergency preparedness role

B. How would the proposal address facility needs/deficiencies?
    1. Provides for seismic upgrades and requirements
    2. Modernizes building systems (e.g. HVAC, elevators, lighting)
    3. Incorporates green building practices
    4. Maximizes use of existing facilities

C. How does the proposal support innovation, best practices, and/or new models of care?
    1. Enables modern infection control standards
    2. Improves safety, effectiveness, and efficiency of patient care
    3. Supports innovative service delivery
    4. Positions the facility to accommodate future growth or service demands

Area 3: What is the equity and social justice impact?

A. Does the proposal advance new service models that promote equity?
B. How has the proposal been influenced by community priorities?
C. What determinants of equity are impacted by the facility proposal? See King County Determinants of Equity
D. How would the proposal promote access to healthcare and improve health outcomes for communities of color, communities where English is not the primary language, and other marginalized communities?

Area 4: What is the fiscal impact?

A. How does the proposal strengthen long-term financial position of Harborview and King County?
B. What opportunities to renovate existing facilities to house the service would be included in the proposal?
C. Does the proposal provide opportunities for philanthropic, federal, state, or other facility funding?

Community Engagement

DATA GATHERING

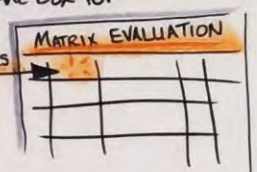
8.9.19

success:

criteria:

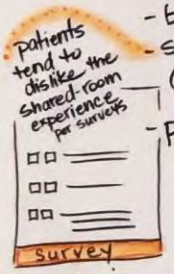
- socio-ecological model
- invite in the community (WHOLE)

- safe, resilient, accessible space (on campus / getting to campus)
- single patient room experience
- infection control (compounded by double rooms)
- consensus by the time final plan is reached
- space - enough of it
- dignity, community ownership
- think outside the box for options (per scores)



- equity & accessibility to patient rooms

- increase:
  - bed capacity
  - single-patient room capacity (staff shuffle this every day)
  - parking capacity / accessibility
    - patient
    - staff
    - non-locals (not likely to use mass transit)

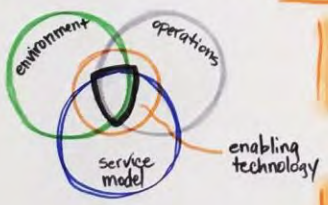


- improve predictability for the voter
- maximize existing facilities

- intuitive way-finding
- walking distances
- non-institutional uses
- noise mitigation
- decanting space (ensure context supports this)
- open space considerations

medical services

- optimize utilization across facilities
- balancing out-patient with acute services for optimization



behavioral health

- research-driven
- patient-driven (their goals)

- community linkages
- safety & security
  - start w/ site design
  - reducing stigma
- stress reduction

7 Flows

these need to be considered as separate flows
- patients
- family/visitors
- staff
- medication
- information
- supplies
- equipment

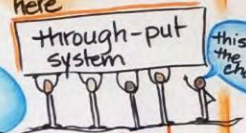
- continuum of care

- layer cake concept for housing

We need a new term!

managing patient complexity ("our patients are highly complex")

we need to visualize the data here



behavioral health puts heavy demands on this system

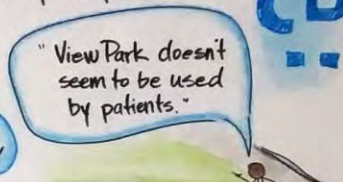
"We need lower acuity beds."

"Often patients have no place to discharge ... We need a bridging location for them."

We need a plan for how this - respite care need - can work

open space:

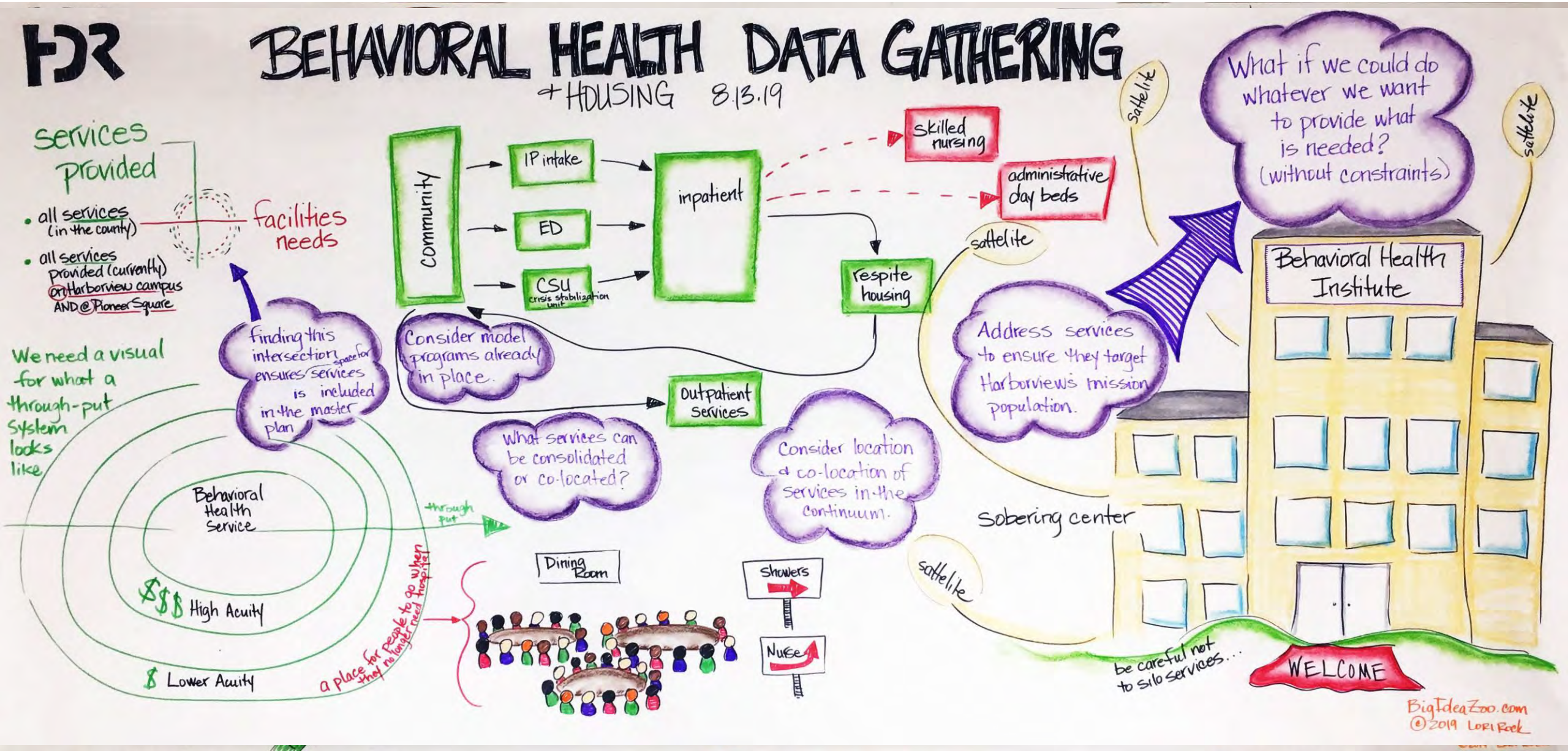
- calming space
- rehabilitation space
- making the outside operate as well as the inside
- understand what counts as open space



- this is a complicated concept
- arrival / departure process is changing:
  - from share-a-ride
  - to autonomous rides

vision:

- community hospital front door
- big picture thinking
- decomplicate the parking
  - especially for non-locals
- make sure there is ENOUGH parking
- decision-making that reflects the mission


HDR
BEHAVIORAL HEALTH DATA GATHERING
+HOUSING 8.13.19
services provided
all services (in the county)
all services provided (currently) @Harborview campus AND @Pioneer Square
facilities needs
finding this intersection ensures space for services is included in the master plan
We need a visual for what a through-put system looks like
Behavioral Health Service
through put
$$$ High Acuity
$ Lower Acuity
a place for people to go when they no longer need hospital
community
IP intake
ED
CSU crisis stabilization unit
inpatient
skilled nursing
administrative day beds
respite housing
outpatient services
Consider model programs already in place.
What services can be consolidated or co-located?
Consider location & co-location of services in the continuum.
Dining Room
showers
Nurse
satellite
satellite
satellite
What if we could do whatever we want to provide what is needed? (without constraints)
Address services to ensure they target Harborview's mission population.
Behavioral Health Institute
sobering center
be careful not to silo services...
WELCOME
BigIdeaZoo.com
©2019 Lori Rock

Housing Provider - Focus Group

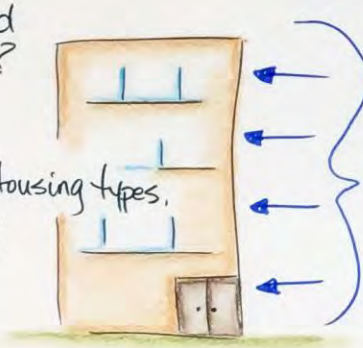
10.15.19

- How do people arrive @ HMC, and get access to care? (No wrong front door)

- How close to HMC campus should Housing be located?
  - And what types?

When ~~supportive~~ respite Housing is located near services, residents tend to stay longer.

- Is there a facility need in South King County?
  - Stratifying
- Layering services/Housing types, complicates funding



stacked

biggest need

- What unit needs must be included and for which types (kitchen, bathroom)
  - shared?
  - SRO (single room occupancy)
- Are we missing perspectives for nonlocal people?

Housing Needs

- chronically-ill, harm reduction (released from hospital, no place to go)
- clustered personal care services (serving people who can perform basic human functions)
- Permanent Supportive Housing (1000's)
- Building with stratified Housing (different levels of sppt.)
- Respite Housing (150 to 200 beds)
- Demographic needs:
  - avg age is increasing
  - end-of-life care (typically younger than average population)
- Shelter Needs
- Workforce Housing

no one @ home to care for them

acuity level is too high

could services help if housing is stabilized?

Harborview Services are top notch! (we need this modeled!)

- Potential to create Housing inside HMC campus buildings as they are upgraded seismically & modernized
- There is(a) South King County facility need(s) - with Harborview's service model.

Services Needed

- Sobering center
- typically, services surrounding/needed for PSH, are included in the Housing scenarios

10.15.19

HEALTH CARE For The Homeless

PRIORITIES

- Housing for pathologies should be separated (in close proximity to HMC)
  - "most vulnerable populations" → definition: the single individual
  - respite care – a critical need to help people get better; and once they're better, may need the next step up
- Safety + Security
- Step Up / Step Down Programs
- Respite Capacity – Medically meeting needs

Programs that meet the changing needs of the Homeless can step up or step down as needed

Who We Are . . . And What Should Be Considered:

- people with chronic health problems
- mental health issues
- smaller scale services that are accessible to the populations that need them
  - mobile services (can help people who don't want to go to a big center)
  - = satellite services (with a continuity of care between sites)
- need to understand the pathology of Homelessness
- huge drug population (a separate pathology)
  - active drug user housing must be on a smaller scale: too large, causes problems

some of us have anxiety

this doesn't work for everyone

A Sense of Community

is needed among residents.

It Should Be A Holistic Approach

through the lens of the person seeking treatment

- ITA – needs to be expanded
  - a new facility is being built in the North
- Need to identify the gaps in the system

Observations:

- The ED isn't the best place for everyone who arrives @ HMC
- What can people handle?
- Consider the interconnectedness & co-location of Housing populations — to mitigate problems
- Respect Differences
- Co-locating services can result in passive biases that follow an individual

- PSC = good for
  - drop off clinic (drop-in center)
  - a separate facility should house medical services
    - a workspace for helping services + organizations & community groups
    - plants, waterfall, healing garden
    - I don't see PSC as a healing environment
  - It could be a place that helps direct those needing services (a concierge)
- Each site could use a receptionist that directs visitors

Labor Focus Group

10.21.19

plain & sober ..... harm reduction

Behavioral Health

very important needs

- mobile unit needed (fentanyl test kits needed)
- after hours access is very important - without this... people end up in the ER
- training / response training is needed so staff can support patients
- Behavioral Health Science building - with connecting tunnels to triage patients where they need to go for services

- BH issues happen all over this campus @ all times

Housing

respite light · respite plus · 1811 Eastlake model

- many more respite beds are needed
- there is no housing for many people to be discharged ... taking space for those waiting

these people need this spectrum of support

we should be following this

What would putting it all together, done right, look like? ?

Medical Center

- the sobering center is very important
- Skilled Nursing Facility is needed
- we need easier check-in process

Helicopter Pad is needed

lack of respite beds (respite light) needed

Visitor Navigation

- braille
- signage
- digital
- interpretation services
- color lines

repeating cycle

still no place to discharge people in the acute beds

more & more people have to wait

people needing acute beds have to wait

people stay in acute beds because they have no place to go

PSC

Thank you for including us in this process... we are on the front lines serving our mission population... keep talking with us!

- the clinic - in that area - is vital
- if PSC is closed, we want a guarantee that PSC staff will still have jobs

HMC Staff

- we need trauma informed training
- it's hard to respond to all the trauma AND look nice for the insurance companies
- staffing ratios are a safety concern for us all (single bed rooms with a 2nd head board. It WILL be double occupancy)

#1 SAFETY priority

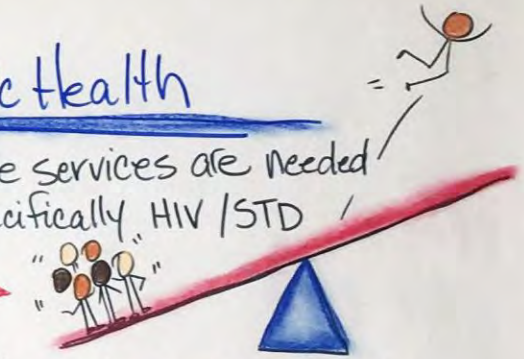
Language Barriers need to be removed

- work place violence
- public v. staff encounters are dangerous
- Building design should be built around safety

→ evidence-based training

Public Health

- mobile services are needed - specifically HIV / STD



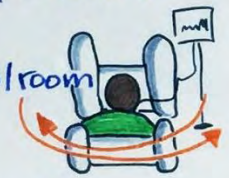
- many mentally unstable people are on our campus all the time (one person laid on the sidewalk for 24 hours in front of the medical center)

Harborview Capital Planning

12.17.19

Medical Center

- Can the Womens Clinic @ Harborview be integrated w/delivery @ UW?
- Patients are overwhelmed w/ room traffic



- Single-patient rooms also will support:
  - room traffic
  - LGBTQ
  - infection control
  - privacy
  - cultural/religious needs

providers really need to knowledgeable & sensitive to this community (in general) on all options

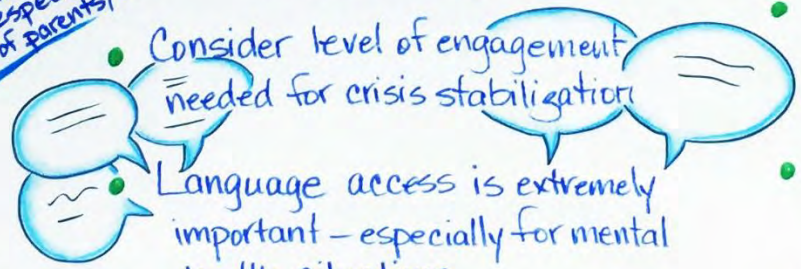
understanding the stigma in ethnic communities (for youth especially under the care of parents/family)

- Does Harborview only need to be located in South Seattle? what about other areas too?
- Transportation options for accessibility to care

- We need to involve Tribal groups in this process

Behavioral Health (and all the options)

- Providing wrap-around services in a single location for survivors of sexual assault or torture
- Immigrant-specific focus needed for these services
  - it needs to be different than it is today
- Consider level of engagement needed for crisis stabilization



- Language access is extremely important – especially for mental health situations
- There is significant stigma in some communities related to mental health
- Bring BHI staff to ethnic community groups
- The current system has many disconnects
  - which creates more pain
- Behavioral Health is not (just) bio-medical.
  - It is spiritual
  - It is about balance
  - It is about many other things

  - Historical trauma
  - ACES inventory
- Youth focused services
  - early intervention
  - substance abuse
- Substance abuse services for the whole immigrant community populations

Housing

- Respite housing . . . Pioneer Square?
- Can an adult family home model be considered?

- Ensure Supportive Housing includes space for families
- Housing for undocumented populations

(the link between medical & other services . . . and housing)

King County

Harborview Leadership Group
Harborview Medical Center
Subcommittee Report
April 24, 2019

Overview

Harborview Medical Center Mission Statement

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The following groups of patients and programs will be given priority for care:

- Persons who are non-English speaking poor
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- Persons who experience domestic violence
- Persons who experience sexual assault
- Persons incarcerated in King County's Jails
- Persons with mental illness, particularly those treated involuntarily
- Persons with substance abuse
- Persons with sexually transmitted diseases
- Persons who require specialized emergency care
- Persons who require trauma care
- Persons who require burn care

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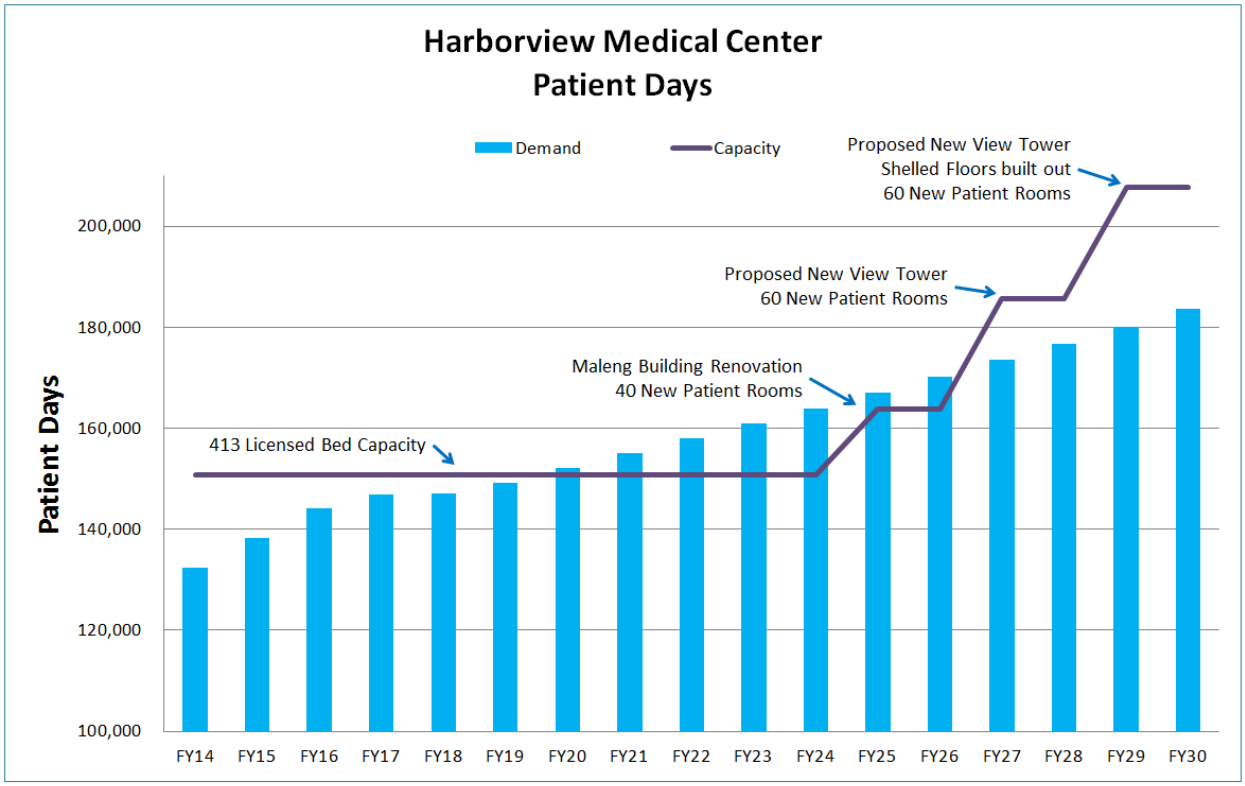
Medical Center Statistics 2018

- Licensed beds - 413
- FTE's - 4,501
- Admissions – 16,716
- Emergency Department visits – 57,516
- Clinic visits – 262,132

Statement of Need

Harborview Medical Center operates at almost 100% capacity on a daily basis. Consequently bed capacity constraints are significantly impacting hospital operations. Below is a graph that reports the actual and projected number of patient days at the hospital from 2014 to 2030. This graph demonstrates that Harborview is at maximum capacity with our current facility configuration:



Demand projections based on Crimson Market Data CAGR of 1.9%

Bed capacity issues can be attributed to an overall increase in the population of King County and increased discharge placement challenges for individuals who require post-acute care, but lack the resources. These challenges include being under insured or uninsured with care needs for skilled nursing facilities or adult family homes. Additionally, many individuals require therapies or assistance with activities of daily living and could benefit from some type of Respite step down or step up unit if there were available beds. Due to the limited nature of available funding offered for post-acute care, these patients frequently remain in the acute inpatient setting for longer than is required.

The current number of licensed beds at HMC is 413. It is common for hospitals to frequently operate a number of licensed beds that is lower than the actual capacity. As such, HMC does not intend to increase the number of licensed beds at this time. Further review and assessment will take place once current bed utilization is optimized.

Space Constraints – Bed Capacity

On a daily basis at least 50 beds located in double patient rooms cannot be used because of isolation precautions. The need for isolation precautions forces hospital staff to place patients in areas that were not initially intended for acute care beds, creating a "grid locked" operational environment. This "grid locked" condition leaves the hospital with no flexibility for hospital operations and virtually no vital surge capacity. Additionally, this operational imbalance puts extreme financial stress on Harborview's bottom line.

Over the years, HMC has deployed numerous tactics to mitigate the impact of bed capacity constraints. These tactics, while effective for patient care, quality and safety, have suboptimal operational impacts. Current tactics to manage bed capacity at Harborview include:

- The hospital regularly goes on "Basic Life Safety Divert", sending lower acuity patients to other hospitals in the area while still admitting higher acuity patients.
- Patients are boarded in Operating Room Recovery areas resulting in increased length of stay for surgical patients.
- Patients are regularly boarded in the Emergency Department which can result in patients waiting more than 24 hours for an acute care bed in a more appropriate patient room. While they are waiting, patients are placed in small bays, partitioned by curtains, which are not intended for longer term stays.
- Acute Care Borders in the ICU – Current ICU bed capacity exceeds ICU bed demand. Patients who no longer meet ICU criteria remain in a higher acuity/higher cost ICU bed, as there is no other location for them to be placed.
- Observation Patients – Currently, HMC has no separate Observation unit. Observation patients are admitted to the hospital and placed in one of the high demand 413 licensed beds. Each day, there are roughly 20 observation patients occupying a licensed bed.
- Administrative Patients with discharge challenges can occupy acute care beds for extended periods of time. These are patients that no longer meet inpatient criteria, but cannot be discharged for various reasons as referenced above. Each day, HMC cares for at least 30 of these patients in hospital beds. Their length of stay can be prolonged for weeks or months depending on the circumstances.

Below is a summary of Harborview's Acute Care bed capacity:

Number of Acute Care Beds in Double Patient Rooms: 201
Number of Acute Care Beds in Single Patient Rooms: 46
This equates to only 18% Acute Care Single Patient Rooms

There are similar bed capacity issues in Harborview's Rehab and Psych bed counts but they are not as extreme and do not have such a direct impact on hospital operations as the Acute Care beds.

Space Constraints – Emergency Department

Harborview Medical Center is the only Level 1 Adult and Pediatric Trauma Center in the WWAMI region (Washington, Wyoming, Alaska, Montana and Idaho). The existing Emergency Department was last remodeled during the 2000 Bond Project, nearly 20 years ago.

The current configuration uses small patient bays that are only separated by curtains. The existing environment provides for very little privacy for patient and care providers. The Emergency Department needs to be updated and modernized to maintain the high quality of patient care Harborview provides for the residents of King County and the WWAMI region.

Facility Options #1: No Change

Harborview is constantly working to improve the hospital's operational efficiency and at the same time provide world class patient care to our mission population and the residents of King County. But no amount of operational improvements can overcome the existing bed capacity constraints that hospital staff have to manage on a daily basis. If there is no increase in patient rooms on the Harborview's campus, King County's population growth all but guarantees that the current bed capacity constraints will continue to be a major issue for decades to come.

Facility Option #2 – Bed Capacity Increase & Emergency Department Modernization

A likely option to increase Harborview's bed capacity is to build new patient rooms on the Harborview campus. While cost estimates and location issues will be addressed by a consultant to be selected in early summer of 2019, a prior consultant has recommended an option to construct a new patient bed tower on the View Park garage location. This option to be vetted during the Harborview Leadership group recommendation process would provide 60 new patient rooms with the advantage of operational efficiency as it can be physically connected to the existing West Hospital inpatient tower. Additional bed capacity can also be achieved in an option to renovate two floors in the Maleng Building to provide 40 new rooms.

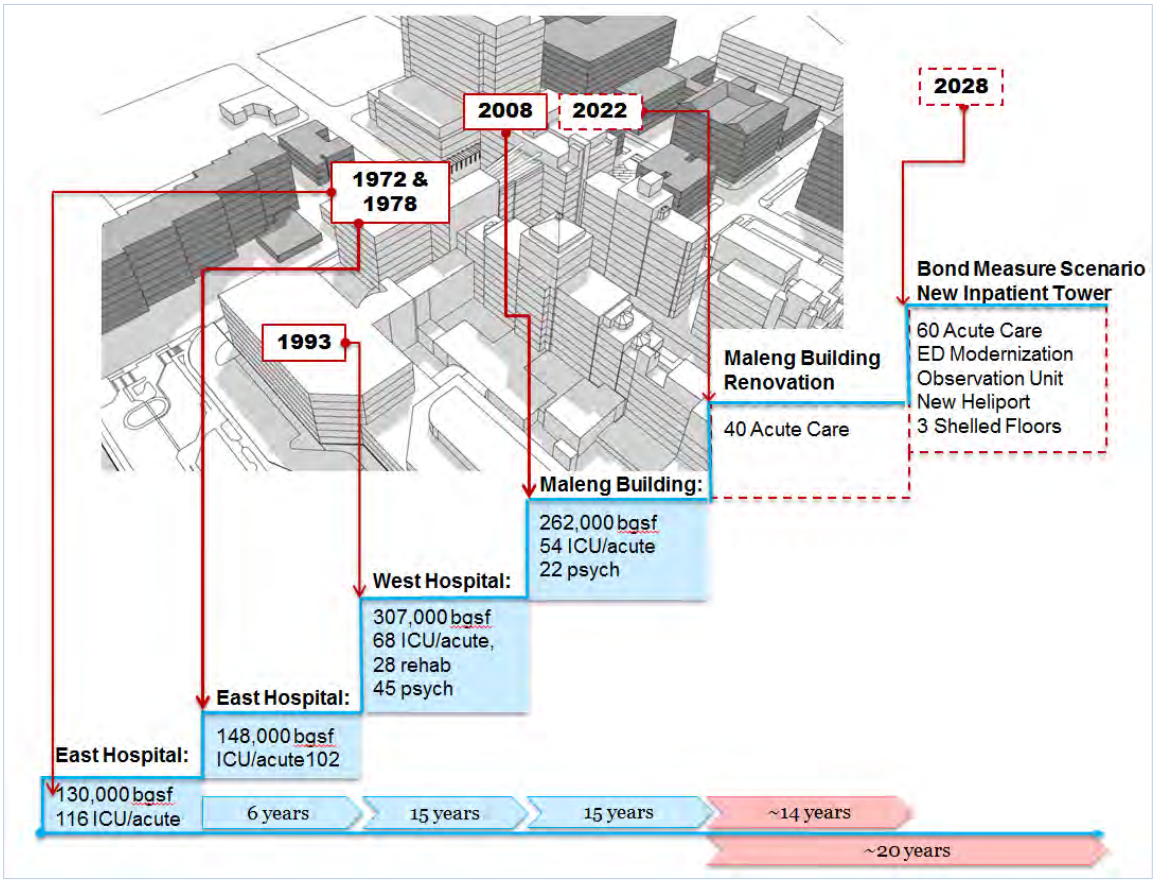
A new inpatient facility and the renovated floors in the Maleng Building will allow the hospital to optimize modern infection control precautions and fully utilize all of its beds. This bed capacity improvement will allow the hospital to continue to provide world class health care and have vital surge capacity in the event of a natural disaster or infectious disease outbreak.

The hospital currently has three helicopter landing pads located on the roof of the P1 Parking Garage. When patients are transported to the hospital via a helicopter they have to be transferred to an ambulance and then driven around the block to entrance of the Emergency Department. A facility solution to this workaround should be developed to allow patients to be brought directly into an emergency room.

The existing Emergency Department needs to be modernized to meet the current and future standards of modern emergency room healthcare. The existing emergency department's 42 ED beds are very constrained, limiting the hospital's ability to manage high volumes of patient admissions caused by basic influenza outbreaks or natural disasters.

See the images below demonstrating the current state versus how new emergency departments are designed and built.

Below is a diagram that describes the age of Harborview's inpatient towers and the durations between construction completion. If a bond measure is approved, a new facility might not be completed until the year 2028, 20 years after the Maleng Building was completed in 2008.



Facility Option #2: Center Tower Seismic Upgrade

The Center Tower building is a 1930s landmarked building. In 2014 a consultant team was hired by King County and Harborview staff to seismically assess the Center Tower. The study found that a seismically

updated Center Tower would need to be reclassified as a Business Occupancy, forcing grandfathered patient care functions like the Pharmacy, Transfusion support and Angiography to be relocated to a new location on campus. A Business Occupancy rating does not allow for inpatient care functions, consequently seismically updated Center Tower could be used as an office building only. Patient transportation can no longer occur in this building once if it is converted to business occupancy status. The assessment did not include abatement, new carpet, lighting, and paint.

Facility Option #3: East Clinic Site

The East Clinic Building is a candidate for demolition as it does not meet current seismic standards and is poorly suited and inefficient for use as a modern day office or clinic space. The East Clinic is also not a landmarked building and is currently occupied. The current occupants would need to be relocated. If the building is demolished, it can potentially be used as a site for a temporary open space or as a site for a new medical office building with a Business Occupancy rating. In terms of inpatient care use, this site is physically separated from the existing inpatient towers and operating rooms. This separation prevents the site from being efficiently integrated with the existing movement of patients and supplies between our existing inpatient towers.

Facility Option #4: Harborview Hall

Harborview Hall is a vacated building that can be renovated and seismically upgraded to either a residential or business occupancy rating. Any renovation of the building is expected to leave the original portion of the building in place, allowing the building to retain its historic character. These original floors can be used as residential or office space but it is likely to be more costly to convert them to traditional outpatient clinical space that typically requires more complex environments that use exam tables, hand washing sinks and clean and soiled utility rooms.

Criteria Matrix:

	1. No Change	2. Bed Capacity & ED Modernization	3. Center Tower	4. East Clinic	5. Harborview Hall
Area 1: People Impact					
Mission Population					
Patients and clients					
Labor and employees					
Neighbors and community					
Area 2: Service/Operational Impact					
Delivery of emergency services					
Addresses facility deficiencies and needs					
Supports innovation, best practices, and/or new models of care					
Area 3: Equity and Social Justice					
Service models that promote equity					
Influenced by community priorities					
Addresses Determinants of Equity					
Access to healthcare and improved health outcomes					
Area 4: Fiscal/Financial Impact					
The long-term financial position of Harborview and King County					
Existing facilities					
Opportunities for other funding					

Meets

Does not meet

Not Applicable

Harborview Leadership Group

Facility Master Plan Overview

Tuesday January 29th, 2019

HARBORVIEW MEDICAL CENTER

UW Medicine King County

Agenda:

- Capacity challenges at Harborview
- Master Planning Work: 2010-2017
- Capital Construction Timeline

HARBORVIEW MEDICAL CENTER
UW Medicine King County

Bed Capacity at Critical Levels

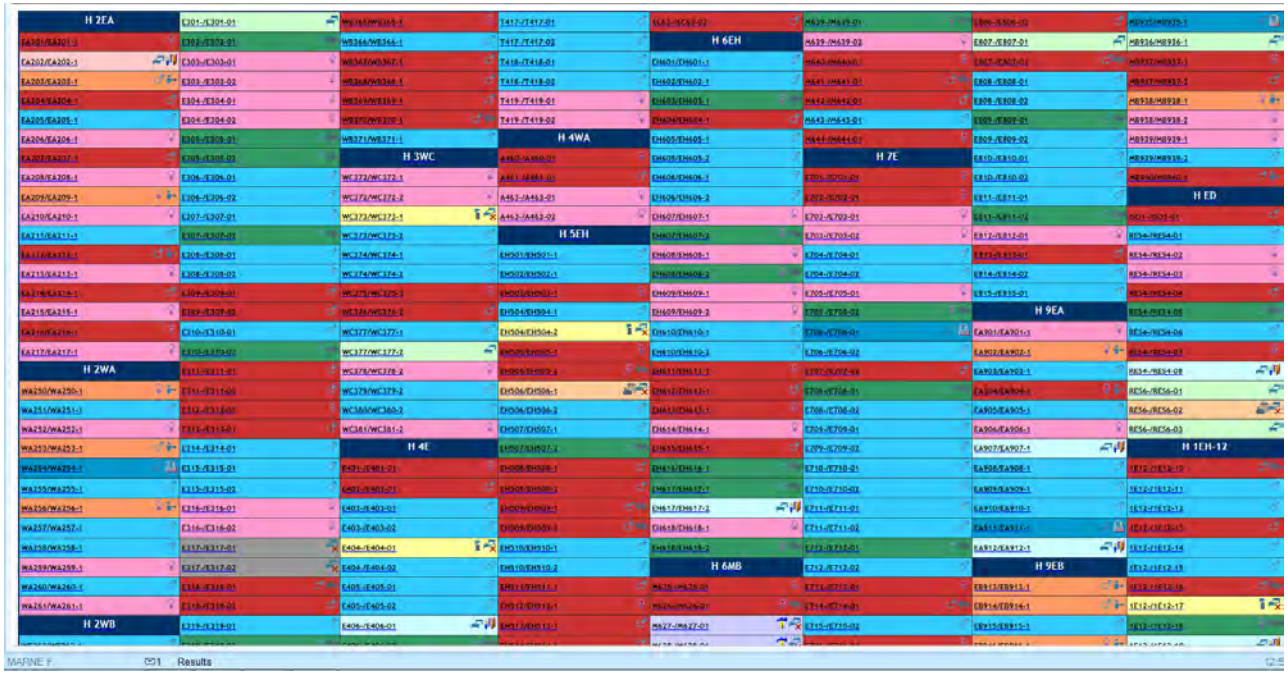
- Harborview Medical Center operates at almost 100% occupancy.
- Facility configuration and capacity constraints are significantly impacting hospital operations.

HARBORVIEW MEDICAL CENTER
UW Medicine King County

Harborview Bed Board

Grid Locked Condition =

Virtually no vital surge capacity.
No capacity for growth.
No flexibility for hospital operations.
Increased operating expense.



HARBORVIEW MEDICAL CENTER
UW Medicine King County

On a daily basis at least 50 beds located in double patient rooms cannot be used because of isolation precautions. Current tactics to manage bed capacity include:

- Basic Life Safety Divert
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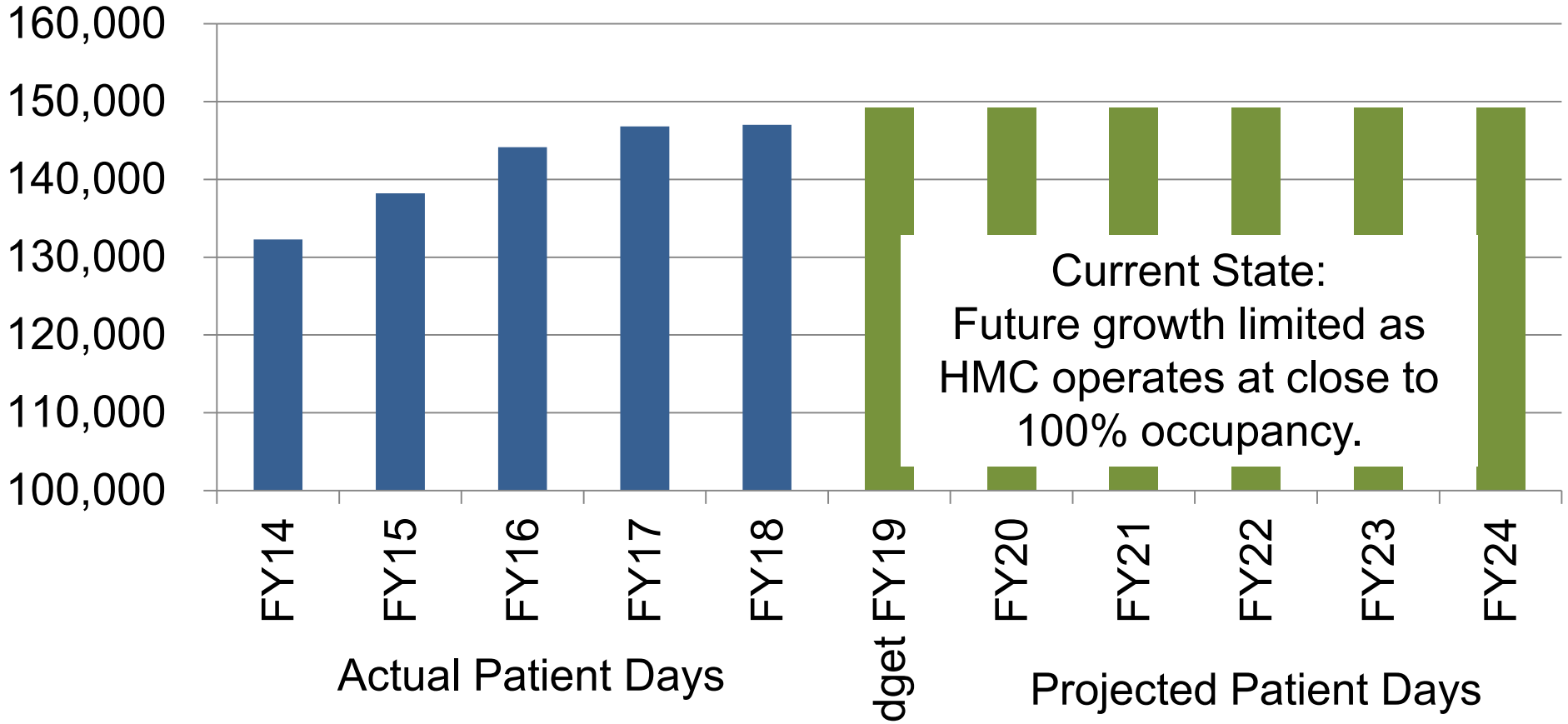
- Patient Boarding in the ED
- Acute Care Borders in the ICU
- Observation Patients are occupying one of coveted 413 licensed beds – average of 20/day
- Administrative Patients with discharge challenges – at least 30/day.

HARBORVIEW MEDICAL CENTER
UW Medicine King County

Long Range Financial Plan
Patient Day Projections



HARBORVIEW MEDICAL CENTER
UW Medicine | King County

Long Range Financial Plan
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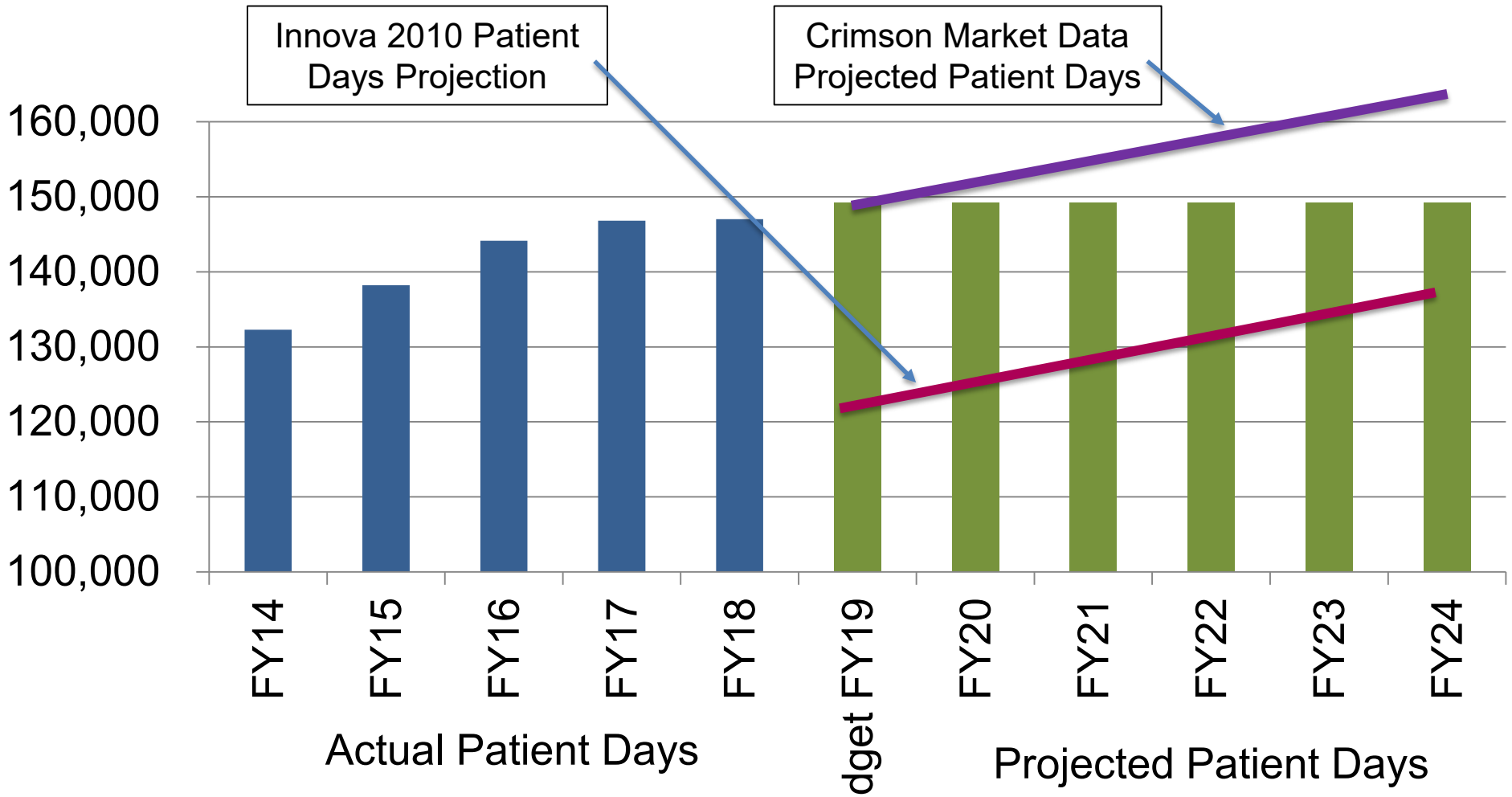


HARBORVIEW MEDICAL CENTER
UW Medicine | King County

2010 Facility Master Plan Update

HMC, King County and Consultant team produced a draft Facility Master Plan.

- View Tower Site identified as the best option for improving inpatient care delivery.
- New Inpatient Tower: 7 floors with garage below, helipad on top (3 floors shelled for future growth)- $800M (2017 estimate – to be updated)

View Park I Site

INNOVA MAGNUSSON KLEMENCIC ASSOCIATES AECOM ELLERBE BECKET AEI Affiliated Engineers

HARBORVIEW MEDICAL CENTER
UW Medicine King County

2014 Seismic Study - Center Tower

HMC, KC & Consultant Team Findings:

Structural Upgrade Option - $268M

Non-structural option - $194M

- Business Occupancy = No Inpatient Care
- Seismic rating similar to an office building.
- Relocated patient care services :

  Pharmacy, Transfusion Services & Angiography
- Relocate essential utilities.
- Center Tower may not be functional after a large earthquake.

HARBORVIEW MEDICAL CENTER
UW Medicine King County

2014 Seismic Study - East Clinic

HMC, KC & Consultant Team Findings:

Structural Upgrade Option - $123M

Non-Structural Upgrade Option - $66M

- Business Occupancy - No Inpatient Care
- Seismic rating similar to an office building.
- East Clinic may not be functional after a large earthquake.

HARBORVIEW MEDICAL CENTER
UW Medicine King County

2017 Maleng Inpatient Bed Capacity Study

Consultant Team Findings:

Renovation Cost for Two Floors- $70M

- Maleng Building originally designed to be a full inpatient tower.
- Building infrastructure and systems designed to handle two new inpatient floors.
- Renovating two floors = 40 new inpatient rooms

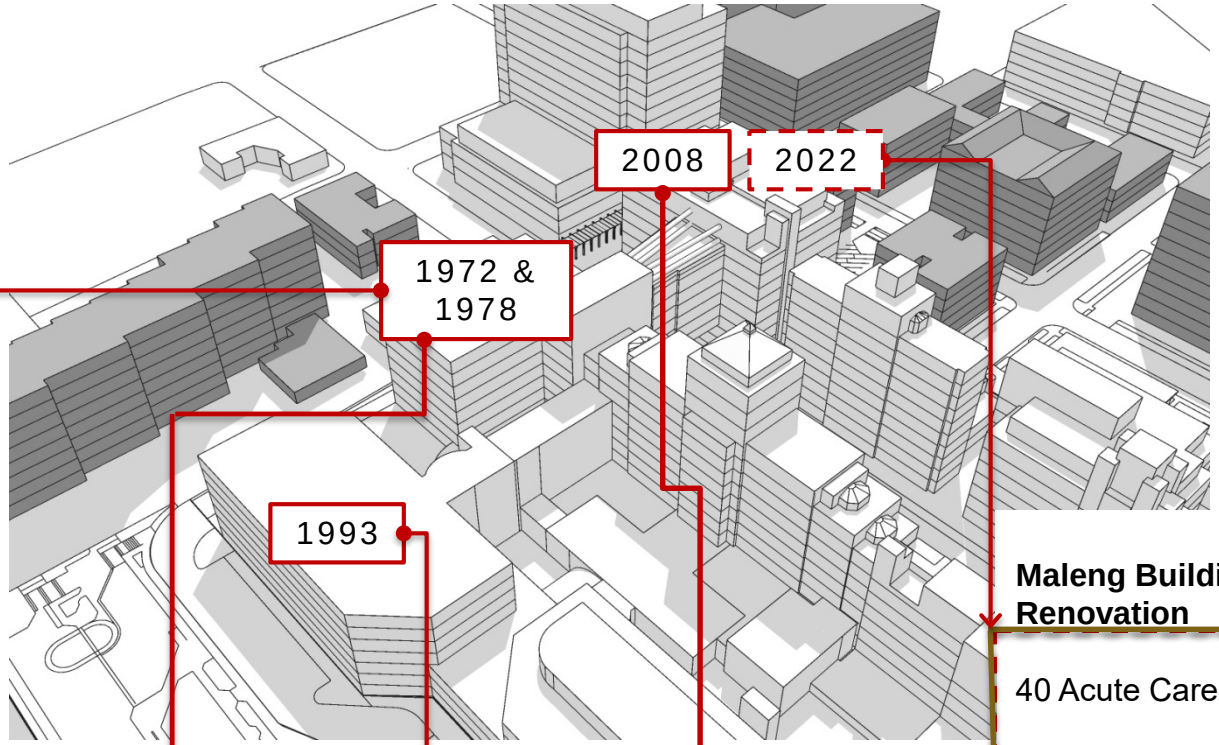
HARBORVIEW MEDICAL CENTER
UW Medicine | King County

2017 Harborview Board of Trustees Strategic Master Plan

Facilitated by Alvarez & Marsal with Public Health and DCHS engagement.

- King County would benefit from additional surge capacity during a disaster, such as a mass casualty incident or natural disaster.
- Facility configuration and age limit the use of acute care and ICU beds.
- Essential services and critical infrastructure systems need to be updated to support patient care.
- Change the lives of those impacted by behavioral health issues through a Behavioral Health Institute.
- Prepare for future facility and operational needs.

HARBORVIEW MEDICAL CENTER
UW Medicine King County



1972 & 1978

1993

2008

2022

2028

East Hospital:
130,000 bgsf
116 ICU/acute

East Hospital:
148,000 bgsf
ICU/acute102

West Hospital:
307,000 bgsf
68 ICU/acute,
28 rehab
45 psych

Maleng Building:
262,000 bgsf
54 ICU/acute
22 psych

Maleng Building Renovation

40 Acute Care

Bond Measure –
New Inpatient Tower
60 Acute Care
ED Expn & Obs beds
New Heliport
4 Shelled Floors

6 years

15 years

15 years

~14 years

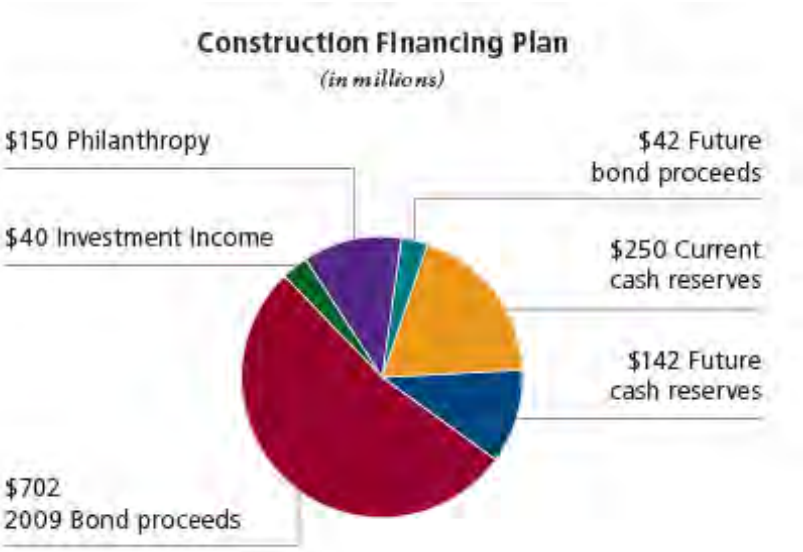
~20 years

Appendix

Comparative Projects

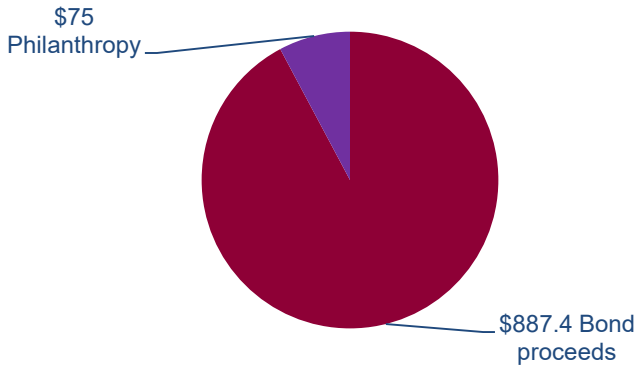
•Parkland Hospital

- 870 beds
- Level I adult trauma
- $1.326b



Zuckerberg San Francisco General Hospital & Trauma Center

- 441 beds
- Level I adult
- $959m



HARBORVIEW MEDICAL CENTER
UW Medicine King County

Harborview Medical Center Subcommittee

Analysis for the Harborview Leadership Group

APRIL 24, 2019

Agenda

- Subcommittee Members
- Overview
- Needs Statement – Space Constraints
- Alternatives/Options
- Questions

Subcommittee Participants

- Kera Dennis, Harborview Medical Center
- Ted Klainer, Harborview Medical Center
- Kelli Carroll, King County
- Patrick Hamacher, King County
- Leslie Harper-Miles, King County
- Sid Bender, King County

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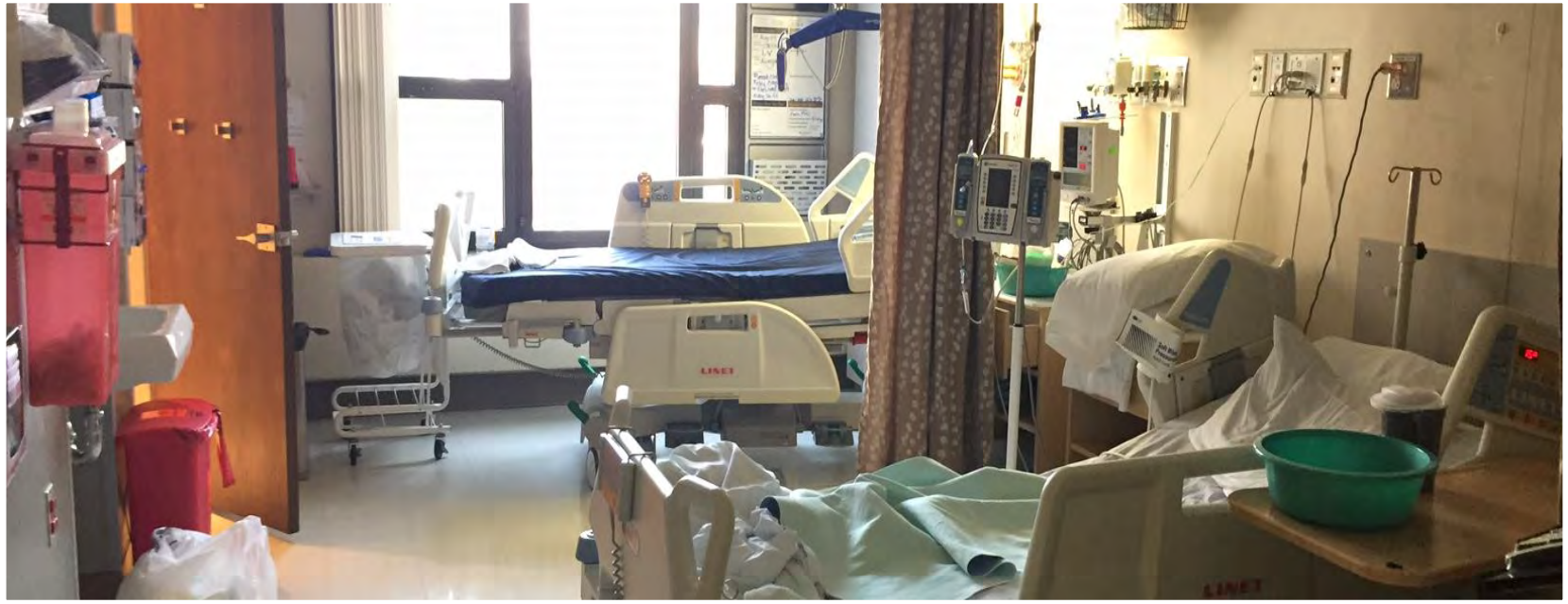

Needs Statement – Space Constraints

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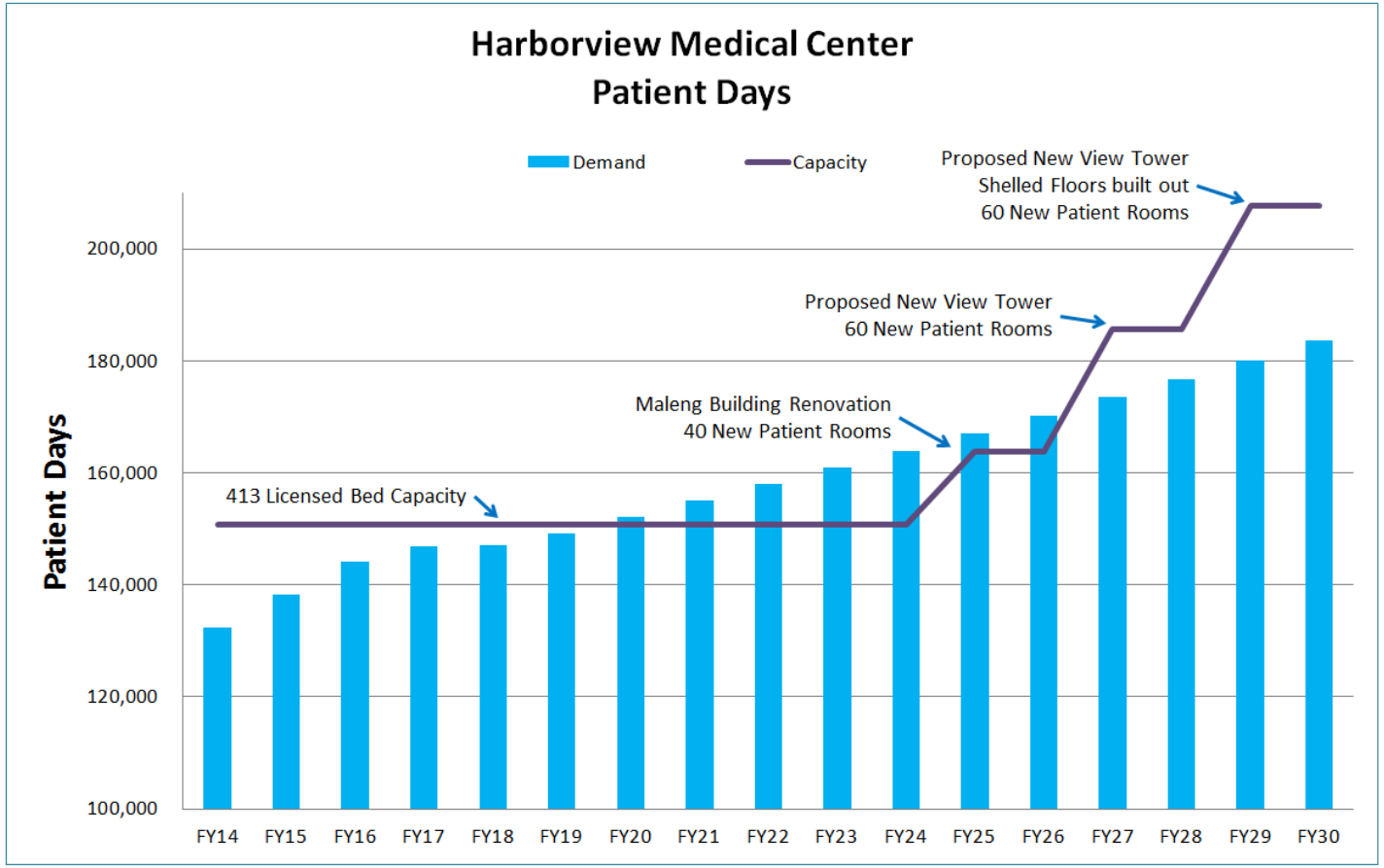
Needs Statement: Patient Beds



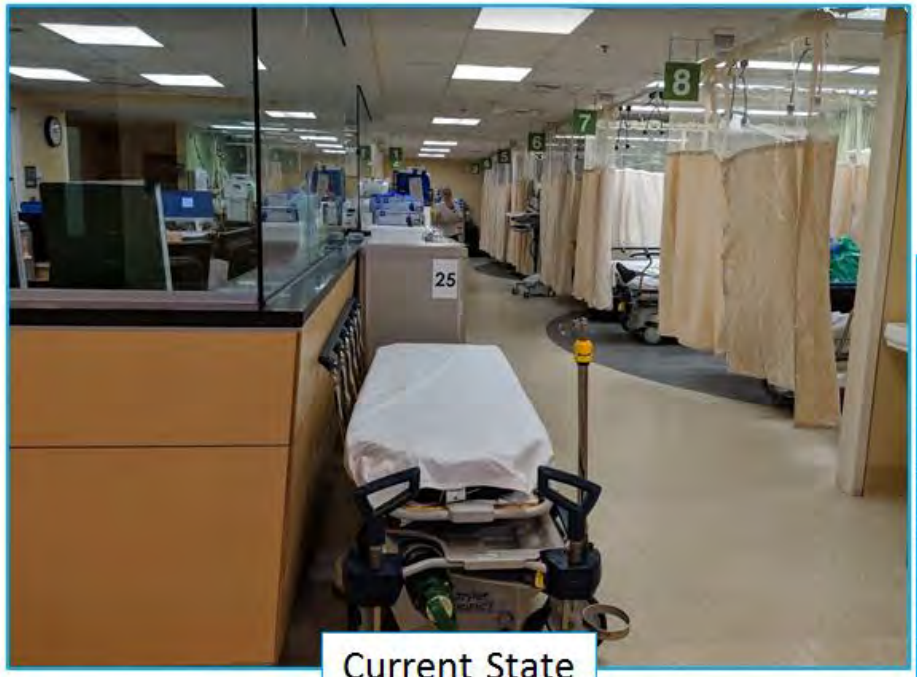
Demand projections based on Crimson Market Data CAGR of 1.9%

Needs Statement – Emergency Department Background and Constraints

- Harborview Medical Center is the only Level 1 Adult and Pediatric Trauma Center in the five state region.
- The existing Emergency Department was last remodeled during the 2000 Bond Project, nearly 20 years ago.
- The current configuration uses obsolete small patient bays that are only separated by curtains providing very little privacy for patient and care providers.
- The Emergency Department needs to be updated and modernized with more square footage to support the high level of patient care.

Emergency Department continued:

- The existing emergency department's 42 ED beds are very constrained, limiting the hospital's ability to manage high volumes of patient admissions caused by basic influenza outbreaks or natural disasters.



Potential Options

- Option #1: No change
- Option #2: Bed Capacity Increase & Emergency Department Modernization
- Option #3: Center Tower Seismic Upgrade
- Option #4: East Clinic Site
- Option #5: Harborview Hall

….Or some combination of these

Option 1: No Change

- No increase in Bed Capacity for Acute Care beds.
- Vital surge capacity will continue to be constrained.
- No Capacity for growth.
- No flexibility for hospital operations.
- Continuing increased operating expenses due to patient placement and inefficiencies.
- Patients continue to leave the ED without being seen.
- Existing infrastructure at end of it’s useful life.

Option 2: Bed Capacity Increase and Emergency Department Improvements

- Bed Capacity
  - New View Tower: 60 acute care beds
  - New View Tower: shelled floors have capacity for 60 more acute care beds
  - Maleng Renovation: 40 acute care beds
- Observation Unit
- Modernized Emergency Department
- Helipad located on roof of building with Emergency Department
- 3 Levels of Parking
- Hybrid Operating Rooms

Option 3: Center Tower Upgrade

- The Center Tower is a 1930's landmarked building.
- A seismically updated Center Tower requires building reclassification which does not allow for inpatient care.
- Inpatient functions like Pharmacy, Transfusion Support and Angiography will need to be relocated.
- If seismic upgrades occur, inpatient transportation can no longer occur in a building with a Business Occupancy rating.

Option 4: East Clinic Site

- The East Clinic Building is a candidate for demolition as it does not meet current seismic standards and is poorly suited for modern day office or clinic space.
- The building site is physically separated from the hospitals existing patient towers and operating rooms.
- Tenants will need to be relocated.

Option 5: Harborview Hall

- Harborview Hall is a building that can be renovated and seismically upgraded to either a residential or business occupancy rating.
- A seismic upgrade will leave the original portion of the building in place using a potential seismic buttress with additional square footage.
- Original floors can be used as residential or office space but difficult to use as a traditional outpatient clinical space.

Criteria

	1. No Change	2. Bed Capacity & ED Modernization	3. Center Tower	4. East Clinic	5. Harborview Hall
Area 1: People Impact					
Mission Population					
Patients and clients					
Labor and employees					
Neighbors and community					
Area 2: Service/Operational Impact					
Delivery of emergency services					
Addresses facility deficiencies and needs					
Supports innovation, best practices, and/or new models of care					
Area 3: Equity and Social Justice					
Service models that promote equity					
Influenced by community priorities					
Addresses Determinants of Equity					
Access to healthcare and improved health outcomes					
Area 4: Fiscal/Financial Impact					
The long-term financial position of Harborview and King County					
Existing facilities					
Opportunities for other funding					

Meets
Does not meet
Not Applicable

Questions?

King County

Harborview Leadership Group

Involuntary Treatment Act (ITA) Court

Draft Subcommittee Report

March 20, 2019

OVERVIEW

Washington's Involuntary Treatment Act (ITA) was implemented in 1973[1] to reform a long history of outdated psychiatric designations, methods, and treatments. Pursuant to RCW chapters 71.05 and 71.34 the ITA provides a legal basis for the limited term, civil detention and involuntary psychiatric treatment of individuals with significant risks arising from mental health disorders. The Involuntary Treatment Act (ITA) Court in King County is operated in conjunction with King County Superior Court, the Behavioral Health and Recovery Division (BHRD) of the Department of Community and Human Services (DCHS), Department of Public Defense (DPD), and the Prosecuting Attorney's Office (PAO), the Department of Judicial Administration (DJA), Facilities Management Division (FMD) and the King County Sheriff's Office.

Operating the ITA Court is a complex judicial process requiring time-sensitive collaboration and coordination between the numerous stakeholders. Mental health professionals make a determination on the appropriate assignment of patients to the court. Superior Court staff must then coordinate interviews with doctors, nurses, evaluators and transportation services. All witnesses, including mental health professionals, family members, or civilian witnesses must also be coordinated with the court calendar. Respondents who are often psychologically and medically fragile may have their cases adjudicated using one of two approaches:

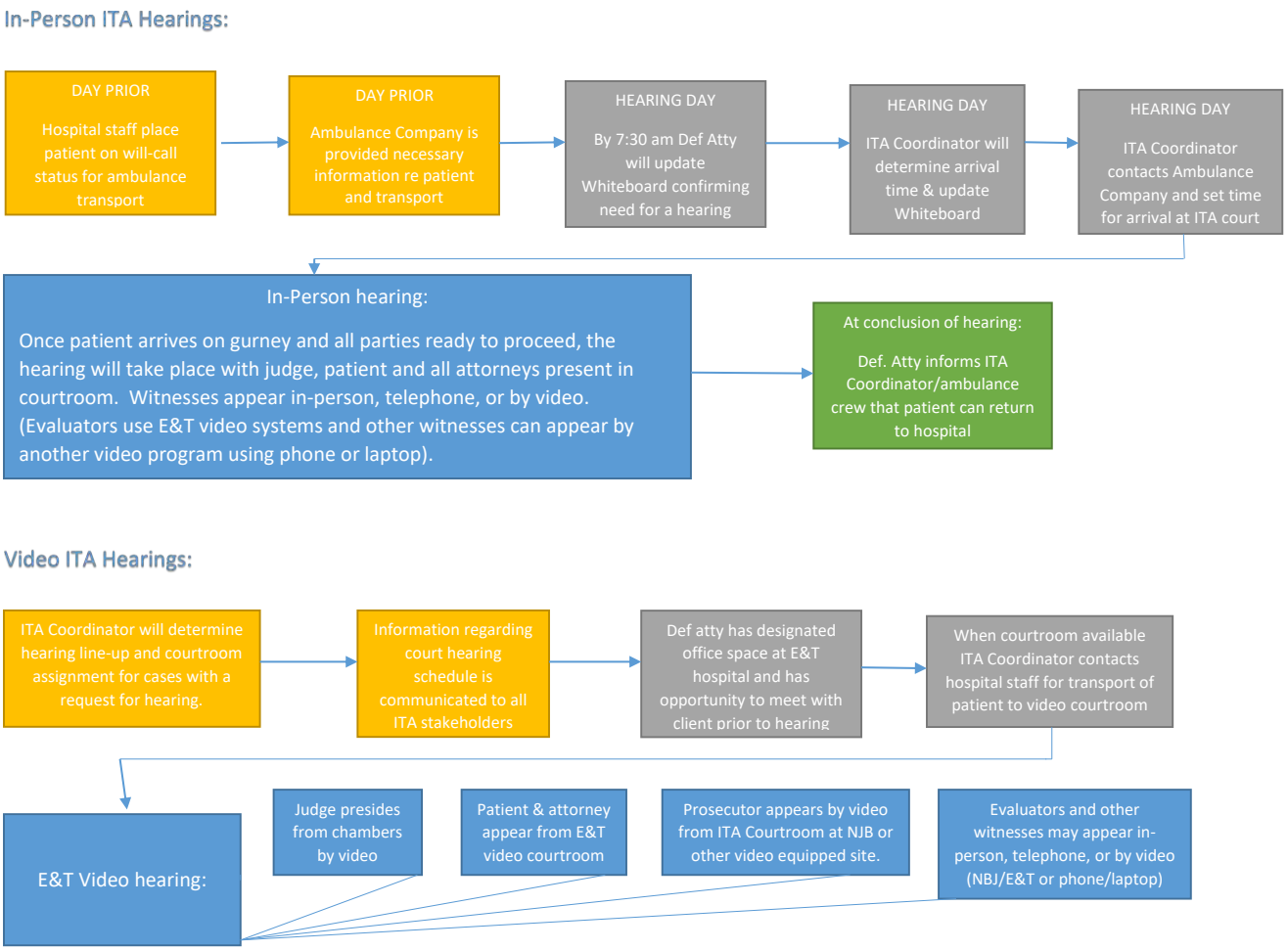
- In-Person ITA Court Hearings at Ninth and Jefferson Building: Those patients who have an in-person ITA hearing at the Ninth and Jefferson Building (NJB) may be transported from area hospitals to the NJB on the Harborview campus. The NJB facility was built with dedicated garage and elevator access for confidential transport of patients directly to the court.
- Video Court Hearings: Patients who are located at Evaluation and Treatment (E&T) facilities[2] may have their cases heard via video hearing. During a video hearing, the patient's case will be heard by a judge through a video connection to the E&T. In this instance, the patient's attorney (public defense) travels to the E&T facility for the court proceeding. Patients are assigned to an E&T based on when they are detained and when the appropriate bed is open. When these facilities are full, individuals may be placed in community hospitals under a single bed certification, per RCW[3].

Regardless of the location, resolving civil commitment cases requires that all parties involved in the case be prepared and present at the same time. If anyone involved with the case is unavailable at the

[1] The ITA law is found in Revised Code of Washington (RCW) chapters 71.05, covering adults, and 71.34, covering youth under age 18.
[2] King County has eight 16-bed E&T facilities where staff provide therapeutic, inpatient evaluation, stabilization, and treatment.
[3] Revised Code of Washington 71.05.745; Washington Administrative Code 388-865-0526

time of a hearing, or unavailable in advance of the hearing for interviews or negotiations, the entire process may be significantly delayed. The court continuously strives to balance due process and individual rights, with access to treatment and community/individual safety.

ITA Case Flow

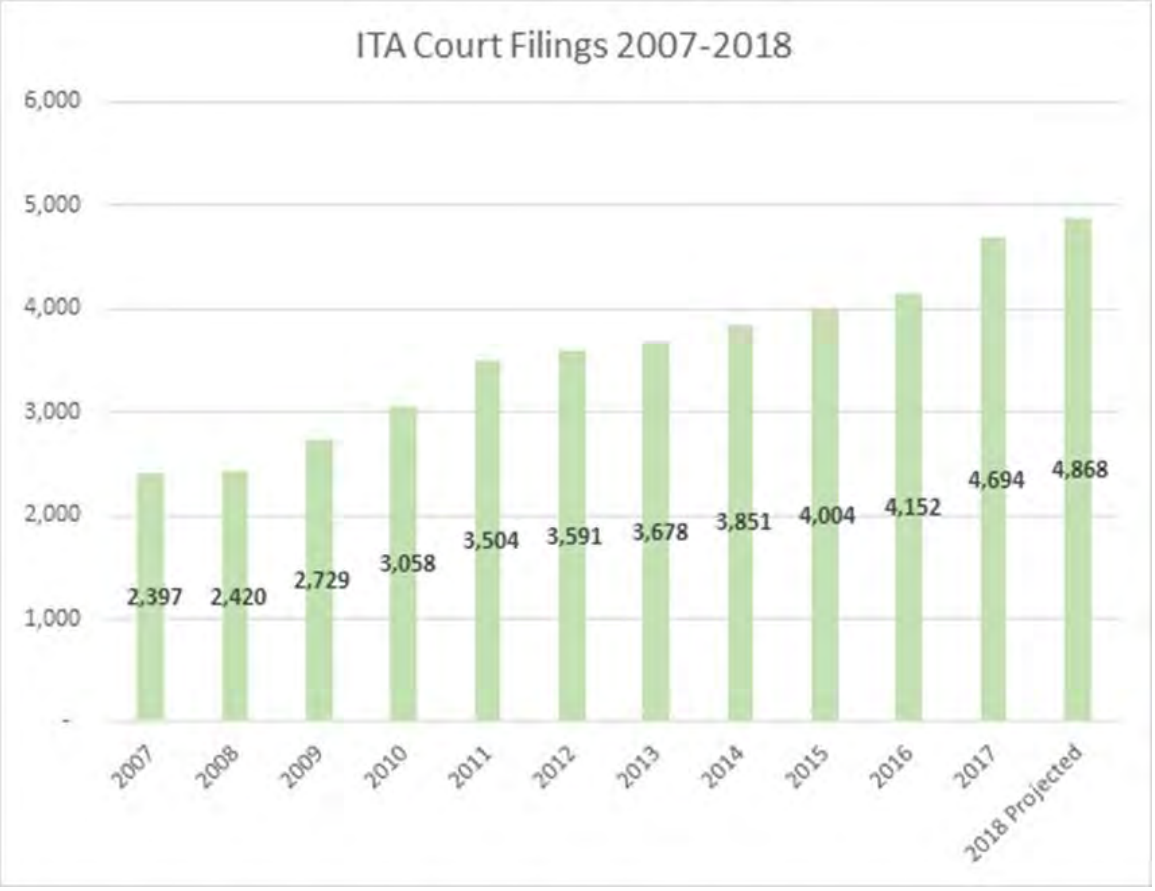


STATEMENT OF NEED

During the past decade, the caseload for King County Superior Court's ITA court has grown faster than any other category of Superior Court cases, going from 2,420 court filings in 2008 to over 4,800 in 2018. Over the years, the statutes governing ITA court have evolved and changed as lawmakers respond to crisis events and treatment access challenges. Recent legislative changes include Ricky's Law[4] which expanded ITA court to include substance use disorder as a criteria, and Joel's Law[5] which allows for families of individuals declined for involuntary detention to appeal the Designated Crisis

[4] https://www.dshs.wa.gov/bha/ricky%E2%80%99s-law-involuntary-treatment-act-substance-use-disorder
[5] https://www.hca.wa.gov/assets/free-or-low-cost/how-to-file-petition-involutary-treatment-joels-law.pdf

Responder's (DCR) decision with the court. Given the multitude of factors contributing to ITA caseload, Superior Court reports that it is particularly difficult to estimate ITA caseload into the out years. In particular, the unpredictability of state law changes that may impact criteria for ITA detention is a significant driver of caseload. Based on population-based projections alone, filings are estimated to increase to 5,577 by 2030 and 6,577 by 2040.

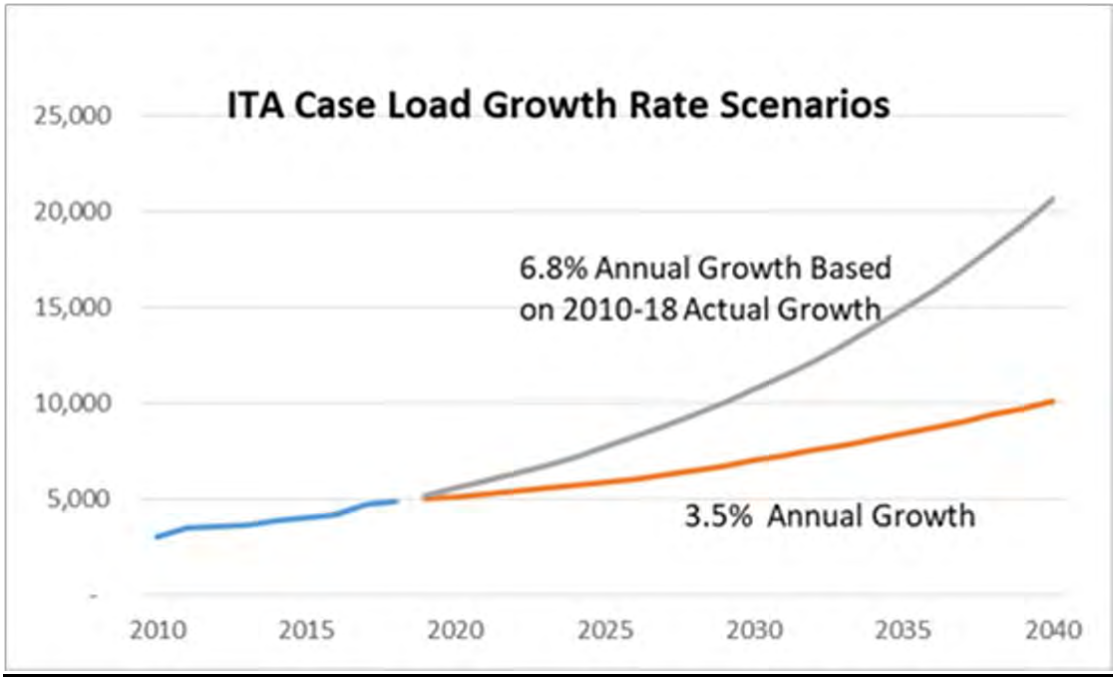


Based on data from the 2016 ITA Court Access Report transmitted to King County Council[6], caseload growth is due to a confluence of factors, including limited community and inpatient mental health resources. The growth in King County's population, along with changing laws, increases the likelihood of involuntary detention growth.[7] Growing use of of ITA Court translates to increased staffing, judicial officers, and space needs.

[6] *Involuntary Treatment Act (ITA) Court Access: Ambulance Transportation and Video Hearings*. Response to 2015/2016 Biennial Budget Ordinance, Ordinance 17941, Section 61, as amended by Ordinance 18178, Section 2, Proviso P1.

[7] These factors, and more detailed background and context regarding the involuntary mental health treatment system including the ITA Court, are described at length in the reports of the Community Alternatives to Boarding Task Force (CABTF): http://kingcounty.gov/~/media/health/MHSA/documents/CABTF_Progress_Report_2.ashx?la=en.

The statutory timeframes to litigate these civil cases are relatively short. Failure to meet expiration dates can result in the premature discharge of individuals who are still at risk of harming themselves or others, or who have a grave disability.



SPACE CONSTRAINTS

All parties involved in ITA Court report that space constraints continue to be a concern. In 2009 ITA Court was relocated from Harborview Hall to new space in the NJB. The NJB's 6,000 SF custom-built space provided one large courtroom with dedicated elevator access from the garage to the court for ambulance patients, and tunnel access to the court for Harborview inpatients. Dedicated family waiting rooms and offices for attorneys, staff and security were also designed into the court based on the patient volumes being experienced at that time.

Since 2009 patient volumes and corresponding staff increases have outpaced the available square footage and resulted in an inadequate court facility at the NJB. The court cannot expand beyond its current footprint due to its location on a densely occupied floor. Over the years, the Facilities Management Division (FMD) has worked with the ITA Court staff and conducted 3 separate interior redesigns to meet the growing demand, providing minimal relief. The redesign work resulted in the loss of interview space, family waiting areas, office spaces and other needed areas. FMD was able to secure leased offices in the nearby Medic One building across the street from the NJB for the DPD attorneys whose numbers have doubled since the court opened in 2009. This temporary approach does not address the Superior Court's long-term functional space needs for the current and growing

ITA court caseload. Superior Court officials have reported on the challenges of working within the current space constraints.

FACILITY OPTION #1: NO CHANGE

The status quo option for the ITA Court would leave the court facility at Harborview unchanged with no potential for growth nor improved functionality.

Due to the continued growth of ITA case filings, the use of video has been instrumental in the court's and stakeholders' ability to meet the statutory requirements for hearing these cases. In February 2014, a Northwest Hospital pilot project established the first E&T video courtroom. Since that time, the use of video to conduct ITA hearings has expanded to all eight King County E&T hospitals. Approximately 3,000 video hearings have occurred since that time.

Currently up to 90% percent of ITA cases are managed through video court. ITA Video Court functions under the Superior Court policy. The judicial officer presiding over a hearing in which the respondent is present by video must have a full view of all participants. This requires all parties, including witnesses and attorneys to be present via video.

Although video court added another method of adjudicating cases, it faced legal challenges by the Department of Public Defense (DPD). In 2017 The Washington State Court of Appeals in J.N. held that a commitment hearing in which the respondent is prevented from participating in person was contrary to the intent of the legislature for 90 day, 180 day and revocations hearings. Shortly after the ruling in J.N. the legislature amended the statute to expand the definition of being present to include video hearings. It is expected that challenges to the use of video hearings will likely arise again. The possibility of legal limits being placed on the use of video hearings would increase in-person ITA Court hearings and increase pressure on the NJB facility.

The status quo scenario would leave all of the agencies that occupy the current ITA space at NJB (PAO, DPD, Superior Court, DJA, and Sheriff's Office) with inadequate space to serve the number of patients coming to the ITA Court. The limited size and configuration of the ITA Court at Harborview will continue to be a problem even as the number of video conferencing hearings increase.

FACILITY OPTION #2: EXPAND SPACE FOR THE ITA COURT AT HARBORVIEW AND MAKE INVESTMENTS IN VIDEO COURT INFRASTRUCTURE

This option calls for new and/or remodeled space on the Harborview campus or expanded space within the NJB, as well as investments in video hearing equipment and infrastructure at the court and E&Ts.

In 2013 Callison Architects was hired to conduct a space analysis and program for plans to relocate ITA court to Harborview Hall. All ITA Court stakeholders participated in the effort. Data provided in the Callison space analysis continues to be the basis for developing more functional ITA Court space. The analysis indicates that the current 6,000 SF ITA Court would need to double in size to approximately 12,000 SF in order to accommodate the number of staff, judges and cases outlined in the staffing profile.

Space Program Summary

Harborview Hall - ITA Court / Callison Architects / Conceptual Planning / November 21, 2013

Room Description	Square Footage Currently in use 2018	Callison Report Identified Sq.Ft. Needs	Projected Space Growth Beyond 2018
Public Entry	694	1277	TBD
Courtrooms	1870	3170	TBD
Court Administrator	574	1062	TBD
Client	818	1300	TBD
Prosecuting Attorney	1123	1671	TBD
Public Defense	670	3055	TBD
Total	5749	11535	

Redesigning the court space within a 12,000 SF foot print could accommodate all staff in one location with the appropriate separate zones for attorneys and judges. The expanded spaces would be designed to further minimize stress to patients and their families, as well as to provide a flexible design to accommodate both in-person and video hearings. This space analysis assumes that video hearings will continue to occur at the current rate. Space growth beyond 2018 levels have yet to be determined due to numerous unknown factors including the future rate of video hearings.

FACILITY OPTION #3: ITA COURT RELATED BEHAVIORAL HEALTH FACILITIES

ITA Court is part of the larger behavioral health continuum. The behavioral health continuum includes provisions for outpatient clinical facilities, emergency services through post-acute care, and supportive housing. Investment in these complementary facilities may mitigate the increase in psychiatric conditions that lead to ITA Court referrals.

The ITA subcommittee work is synergistic with the work of peer subcommittees focused on Behavioral Health, Harborview Facilities, and Housing. The best way to reduce the use of ITA Court is to reduce number of people who are detained due to behavioral health crises. To achieve this result, greater investment in the outpatient behavioral health system must occur. Greater investments in services

include more outreach to meet people where they are, easy access to services when people want or need them, and expanding the continuum and types of behavioral health services.

There is a consistent correlation between the growth in population and increases in ITA Court caseload. This correlation can be tracked over many years and can be reliably projected over the next decade. However, this simple association does not reveal other variables impacting growth, which will continue to pressure the system over time if not addressed. In that regard the ITA Court would benefit from investments in the following areas of the behavioral health system:

- Behavioral Health clinical facilities targeting early intervention for youth, communities of color, poor and underserved communities
- Modernization of Harborview's emergency department
- Supportive housing along the medical/behavioral health continuum,

This report does not address these options as they are included within the work plans of other subcommittees. However, the ITA subcommittee looks forward to collaborating with other work efforts as we strive collectively to determine the best investments to address the long term behavioral health needs of the community over the next 10-20 years.

SUMMARY CONCLUSIONS

- ✓ The ITA court is governed by State laws and conducts civil commitment hearings according to two separate adjudication approaches: a) in-person hearings, and b) video hearings
- ✓ The number of patients accessing the ITA court has increased significantly over the past decade and is expected to continue over the coming decade.
- ✓ ITA court officials plan for the continued use of both in-person and video hearings over the next decade.
- ✓ The current in-person facilities are inadequate in size and functionality; and video hearings will require ongoing equipment and capital infrastructure support.
- ✓ The facility responses presented herewith are not mutually exclusive and seek to meet the ITA court's needs as follows:
  - Expand the Harborview ITA court's size and improving its functionality; and
  - Expand key facilities along the behavioral health continuum in order to mitigate the growth and recidivism of patients entering the court.

CRITERIA MATRIX

	No Change	Facilities Option 2	Facilities Option 3
Area 1: People Impact			
Mission Population			
Patients and clients			
Labor and employees			
Neighbors and community			
Area 2: Service/Operational Impact			
Delivery of emergency services			
Addresses facility deficiencies and needs			
Supports innovation, best practices, and/or new models of care			
Area 3: Equity and Social Justice			
Service models that promote equity			
Influenced by community priorities			
Addresses Determinants of Equity			
Access to healthcare and improved health outcomes			
Area 4: Fiscal/Financial Impact			
The long-term financial position of Harborview and King County			
Existing facilities			
Opportunities for other funding			

	Meets		Not Applicable
	Does not meet		

Client Demographics
January - December 2018

GENDER	FILED	REVOCATION	UNFILED	TOTAL
Female	1,601	262	1,630	3,493
Male	2,290	424	2,351	5,065
Total	3,891	686	3,981	8,558

AGE	FILED	REVOCATION	UNFILED	TOTAL
<18	67	4	85	156
18-21	305	44	289	638
22-29	851	176	795	1,822
30-39	893	181	1,013	2,087
40-49	610	152	686	1,448
50-54	248	42	288	578
55-59	292	46	307	645
60-64	235	32	238	505
65-69	161	7	117	285
70-74	99	7	86	192
75-79	73	3	56	132
80 and over	102		83	185
unknown	3		9	12
Total	3,939	694	4,052	8,685

RACE	FILED	REVOCATION	UNFILED	TOTAL
African American	501	125	530	1,156
Asian Pacific Island	358	62	291	711
Caucasian	2,340	349	2,455	5,144
Native American	81	11	94	186
Other	201	40	191	432
Two or More	286	90	294	670
Unknown	172	17	195	384
Total	3,939	694	4,050	8,683

HISPANIC INDICATOR	FILED	REVOCATION	UNFILED	TOTAL
No	3,421	628	3,516	
Unknown	147	1	193	
Yes	371	65	343	
Total				

ITA Court Sub-Committee
Harborview Leadership Group (HLG)

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Involuntary Treatment Court Subcommittee

Analysis for the Harborview Leadership Group

MARCH 27, 2019

Agenda

- Charge of the Subcommittee
- Subcommittee Members
- Overview
- Needs Statement
- Alternatives/Options
- Criteria Matrix
- Questions

Charge of Subcommittee

- Conduct an analysis of facility needs and initial options for the Harborview Leadership Group (HLG) to consider for its capital funding recommendations
- Provide a report, and a presentation to the HLG according to their schedule
- Work with staff and consultants to refine the report and support the HLG decision-making process, as requested.

Subcommittee Participants

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Legal Overview

- Washington's Involuntary Treatment Act (ITA) provides a legal basis for the limited term, civil detention and involuntary psychiatric treatment of individuals with significant risks arising from mental health disorders

- Purpose of the Laws
  - ✓ To provide continuity of care
  - ✓ To put an end to inappropriate, indefinite commitments of persons with mental illness
  - ✓ To safeguard individual rights
  - ✓ To encourage the full use of all existing agencies, professional personnel and public funds to prevent duplication of services and unnecessary expenditures
  - ✓ To encourage community based care whenever possible
  - ✓ To protect the public safety

Operating Overview

The Involuntary Treatment Act (ITA) Court in King County is operated in conjunction with

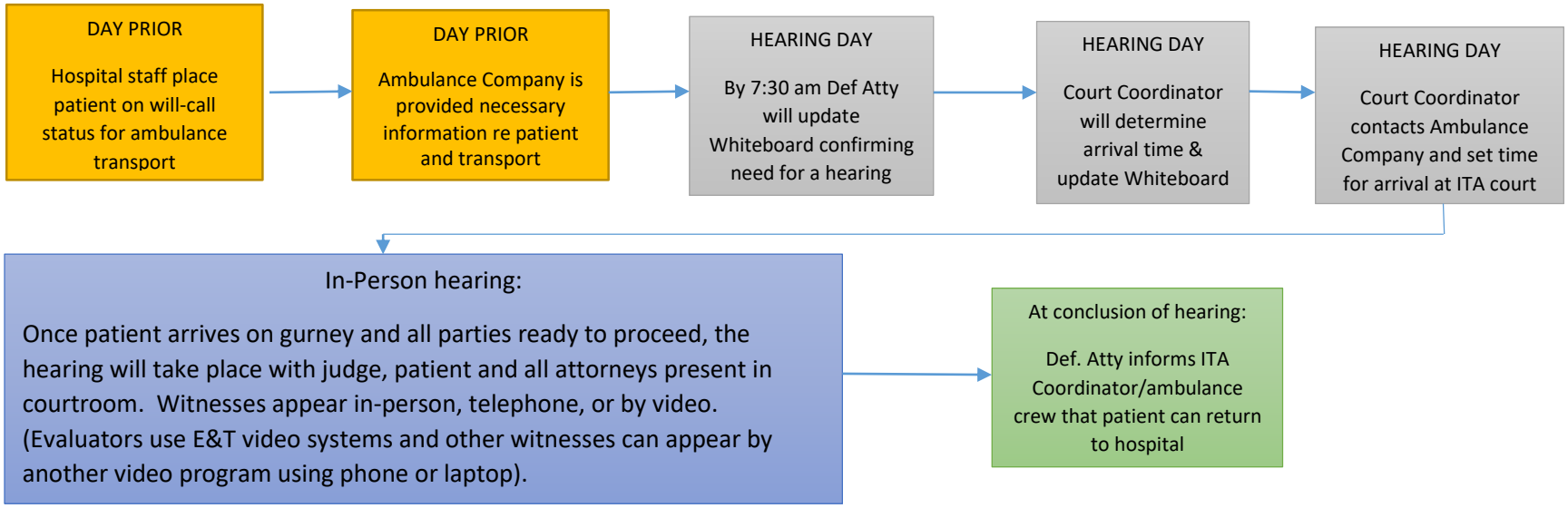
- King County Superior Court
- Behavioral Health and Recovery Division (BHRD)
- Department of Community and Human Services (DCHS)
- Department of Public Defense (DPD)
- Prosecuting Attorney's Office (PAO)
- Department of Judicial Administration (DJA)
- Facilities Management Division (FMD)
- King County Sheriff's Office (KCSO)

ITA Court Facility @ Harborview

- ITA patients may be transported from hospitals to the ITA court located in the Ninth and Jefferson Building (NJB) at Harborview, where court participants convene or appear by video.
- The NJB facility was built with dedicated garage and elevator access for confidential transport of patients directly to the court.
- The facility includes courtrooms, offices, patient waiting rooms and security space.

Case Flow: ITA In-Person Hearings

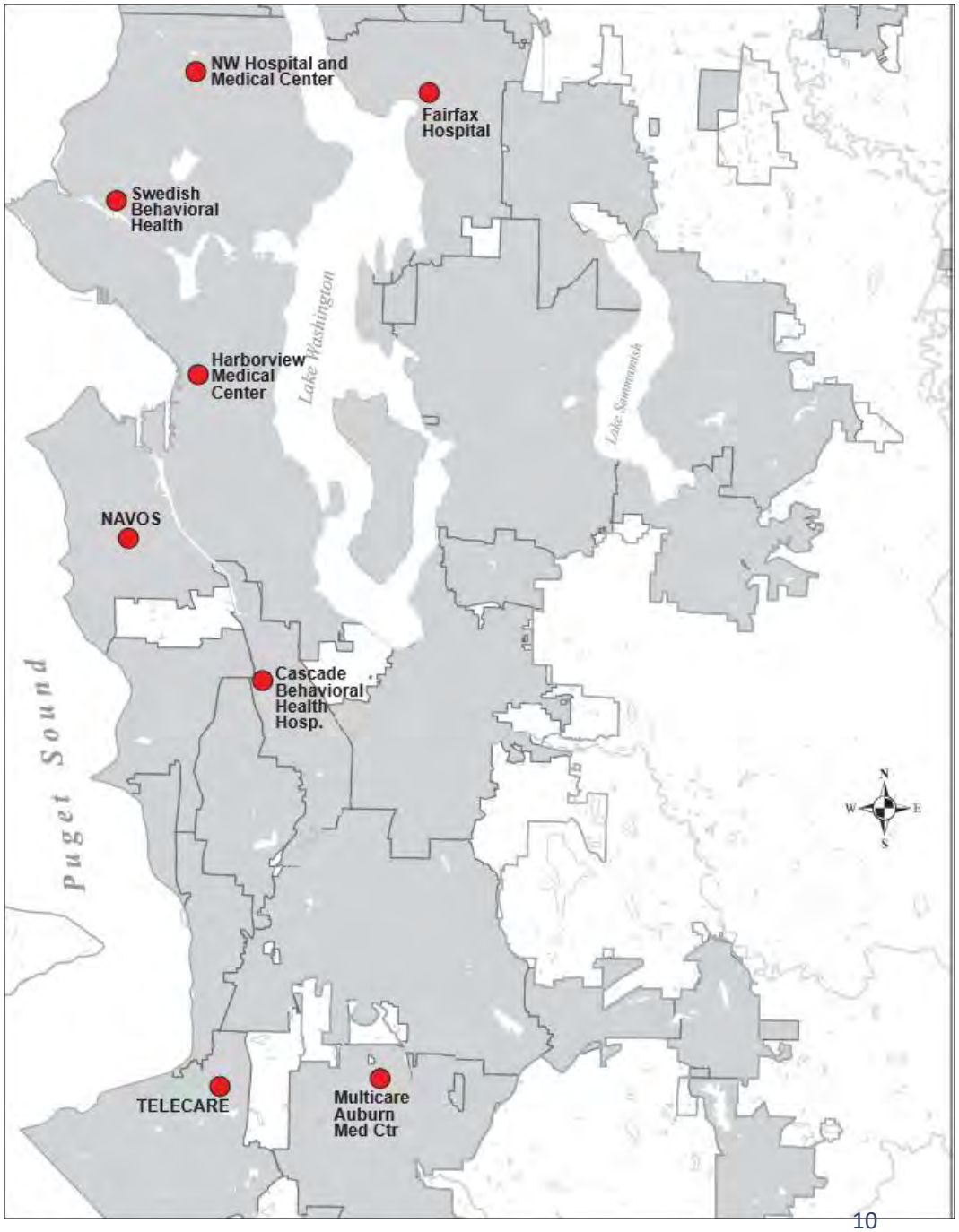
In-Person ITA Hearings:



Evaluation & Treatment Facilities

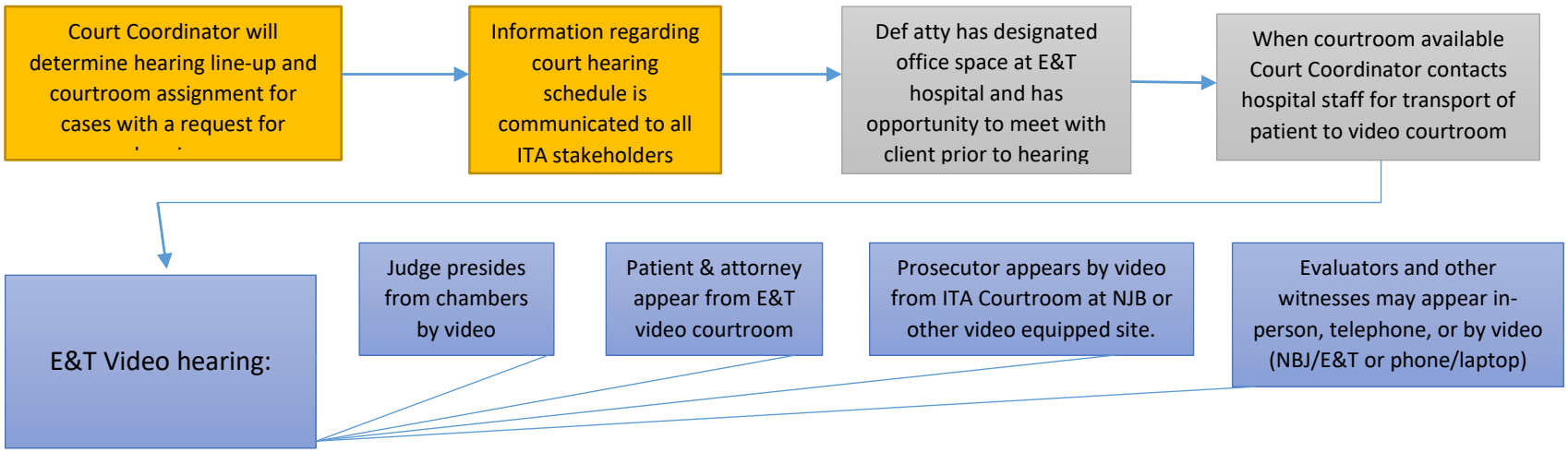
- Evaluation and Treatment Facilities (E&T) are psychiatric hospitals
- Patients are assigned to an Evaluation and Treatment Facility based on when they are detained and when the appropriate bed is open.
- Patients who are located at an E&T may have their cases heard via video hearing.
- When these facilities are full, patients may be located at community hospitals under a single bed certification, where video hearings are not currently held.

Evaluation &Treatment Facilities Locations



Case Flow: Video Hearings

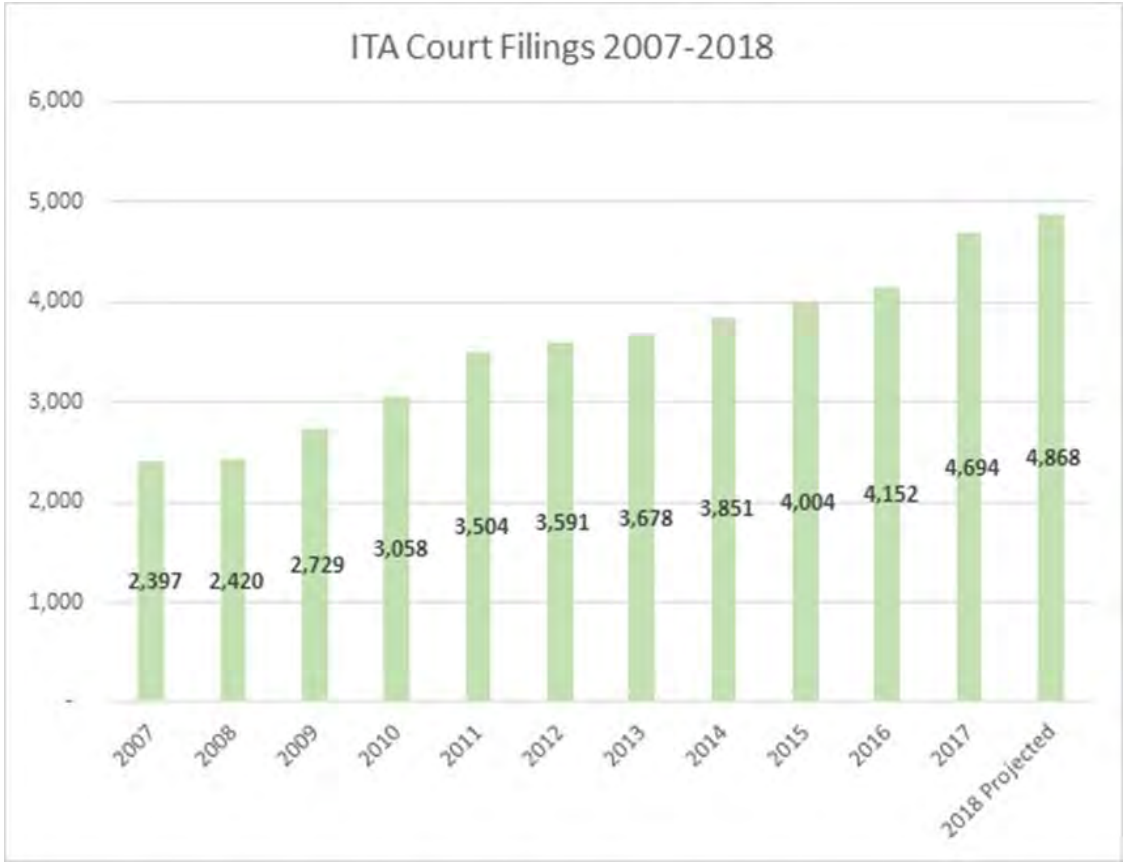
Video ITA Hearings:



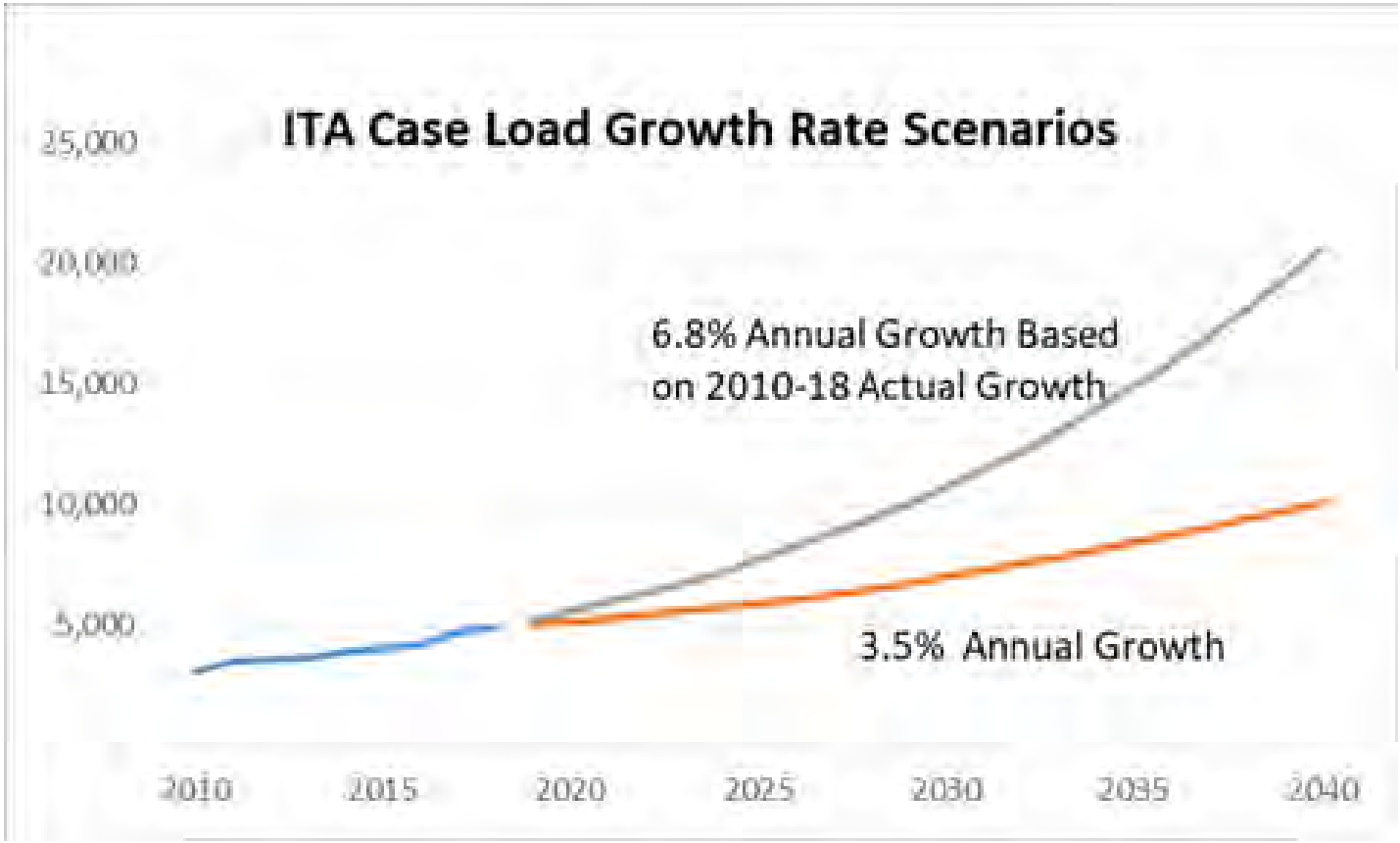
Needs Statement

- During the past decade, the ITA caseload has risen faster than any other category of Superior Court cases, growing from 2,420 in 2008 to over 4800 court filings in 2018.
- Patient volumes and corresponding staff increases have outpaced the available square footage and resulted in an inadequate court facility.
- The ITA court has changed over the years as lawmakers respond to crisis events and treatment access challenges.
- Changes in Laws will continue to broaden access to the ITA Court and increase case volumes.

Impacts: Historical Growth in Patients Served



Impacts: Projected Growth



Impacts: Legal & Legislative Actions

- 2014 Supreme Court decision on Boarding vs. Single Bed Certification (SBC)
- 2017, Ricky's Law adds "substance use disorder" (SUD) to 71.05 and 71.34 as detention criteria
- Joel's Law allows for families of individuals declined for involuntary detention to appeal the Designated Crisis Responder's (DCR) decision with the court.
- 2017 challenge to the use of video hearings: The Washington State Court of Appeals in J.N. Shortly after the ruling in J.N. the legislature amended the statute to expand the definition of being present to include video hearings.
- Pending: SHB 1775/SSB 5744: Creates two certified E&T receiving centers for sexually exploited children.
- Pending: SHB 1907:Broadens definition of "likelihood of serious harm" and creates at additional facilities to be dually licensed as E&T and SWM
- Changes in law have and will continue to increase case volumes

Space Limitations

- The Court currently occupies 6,000 square feet, although a program analysis conducted by Callison Architects in 2013 noted the growth and need, at that point in time, at 12,000 square feet. Since 2013, the filings have increased significantly.
- To make due, FMD has modified the space 3 times since 2009, resulting in the loss of interview space, family waiting area and offices.
- Expanding the current footprint is difficult, given the other tenants on the same floor, including the Pathology Department and the Medical Examiner's Office.
- Among the recent modifications by FMD was securing leased space in the Medic One building across the street from NJB for DPD attorneys, but this requires passing through court security each time they return to court. In addition, long term plans for the Medic One building are uncertain.
- There is currently no other expansion space available on the campus.

Option 1: No Change

- A status quo option for the ITA Court would leave the court facility at Harborview unchanged, and with no potential for growth or improved functionality.
- Since 2009 patient volumes and corresponding staff increases have outpaced the available square footage. The limited size and configuration of the ITA Court at Harborview will continue to be a problem even as the number of video conferencing hearings increases.

Option 2: Enhanced Space for the ITA Court at Harborview

- **The ITA Court is seeking new and/or remodeled space on the Harborview campus or expanded space within the NJB, as well as investments in video hearing equipment and infrastructure at the court and E&Ts.**
- A program analysis conducted in 2013 outlined a space plan that would double the size of the court to approx. 12,000 sq.ft. to meet 2013 demand.
- Much of the data from that analysis is still relevant, except for filing growth projections over the next 10 years, and could become the basis for an updated space program.
- This redesign will use the 90% level of video hearings as the most likely scenario.
- Redesigning the ITA court within a larger foot print could accommodate all staff in one location with the appropriate separate zones for attorneys and judges. The new spaces would be designed to minimize stress to patients, and their families, as well as provide a flexible design to accommodate both in-person and video hearings.

Option 3: Investment in ITA Court Related Behavioral Health Facilities

- The ITA Court is part of the larger behavioral health continuum.
- The continuum includes provisions for outpatient clinical facilities, hospital emergency facilities through post-acute care, and supportive housing.
- The ITA Subcommittee work is synergistic with the work of peer committees that are focused on Behavioral Health, Harborview Facilities, and Housing.
- Investment in these facilities may mitigate the increase in psychiatric conditions that lead to ITA Court referrals.
- In addition to addressing the space expansion needs for the Court, the ITA sub-committee will link with efforts to improve facilities along the behavioral health continuum.

Summary

- The ITA court is governed by State laws and conducts civil commitment hearings according to two separate adjudication approaches:

  a) in-person hearings, and b) video hearings

- The number of patients accessing the ITA court has increased significantly over the past decade and is expected to continue over the coming decade.
- ITA court officials plan for the continued use of both in-person and video hearings over the next decade.
- The current in-person facilities are inadequate in size and functionality; and video hearings will require ongoing equipment and capital infrastructure support.
- The facility responses presented herewith are not mutually exclusive and seek to meet the ITA court's needs as follows:

  (1) expand the Harborview ITA court's size and improving its functionality; and

  (2) expand key facilities along the behavioral health continuum in order to mitigate the growth and recidivism of patients entering the court.

Criteria Matrix

	No Change	Facilities Option 2	Facilities Option 3
Area 1: People Impact			
Mission Population			
Patients and clients			
Labor and employees			
Neighbors and community			
Area 2: Service/Operational Impact			
Delivery of emergency services			
Addresses facility deficiencies and needs			
Supports innovation, best practices, and/or new models of care			
Area 3: Equity and Social Justice			
Service models that promote equity			
Influenced by community priorities			
Addresses Determinants of Equity			
Access to healthcare and improved health outcomes			
Area 4: Fiscal/Financial Impact			
The long-term financial position of Harborview and King County			
Existing facilities			
Opportunities for other funding			

Meets
Does not meet
Not Applicable

Feedback & Questions?

Involuntary Treatment Court Subcommittee Follow Up

Analysis for the Harborview Leadership Group

MAY 22, 2019

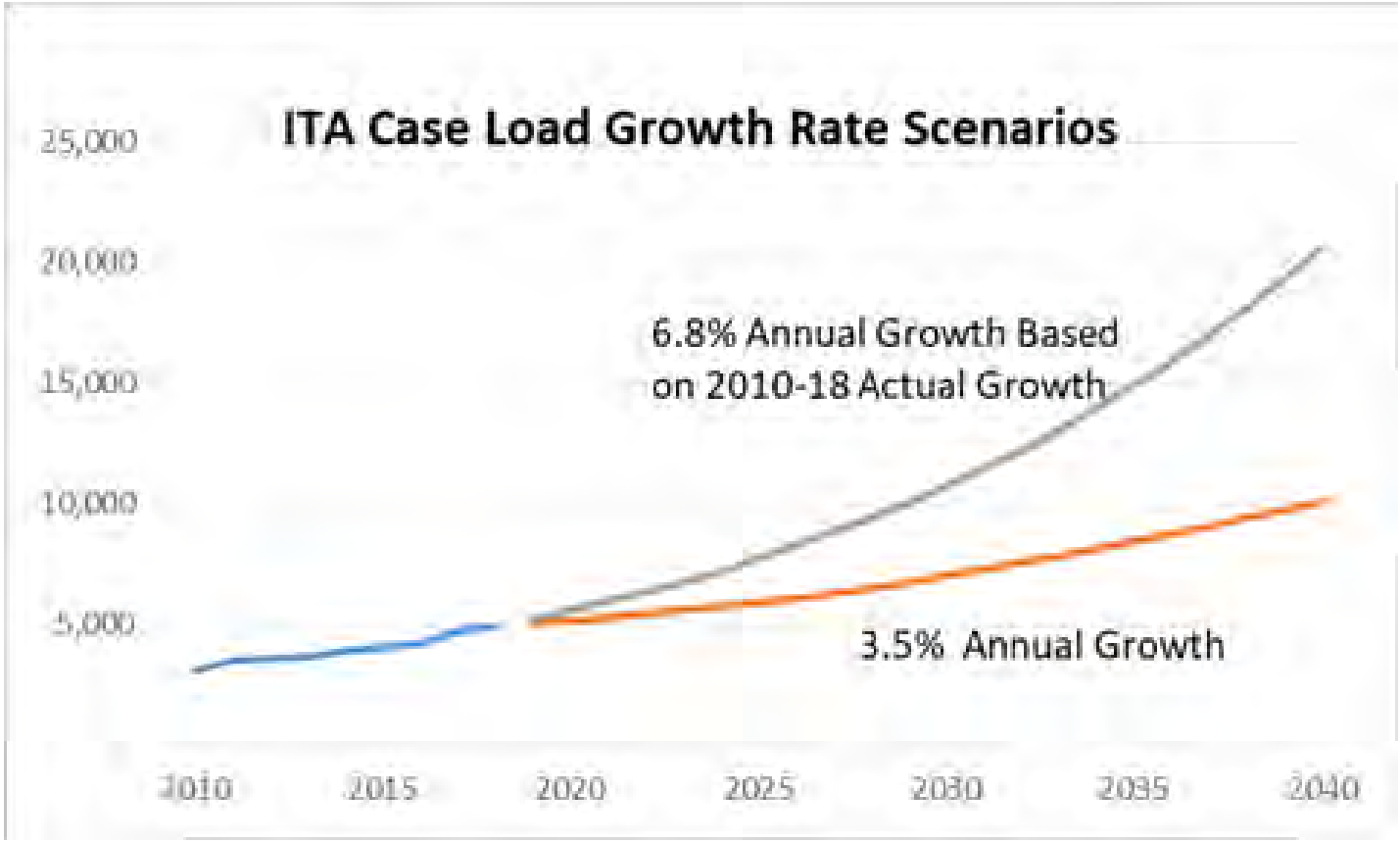
Review of March 24, 2019 ITA Subcommittee Presentation

- The ITA court is governed by State laws and conducts civil commitment hearings according to two separate adjudication approaches:

  a) in-person hearings, and b) video hearings

- During the past decade, the ITA caseload has risen faster than any other category of Superior Court cases, growing from 2,420 in 2008 to over 4800 court filings in 2018.
- The ITA court has changed over the years as lawmakers respond to crisis events and treatment access challenges.
- Changes in laws will continue to broaden access to the ITA Court and increase case volumes.
- Patient volumes and corresponding staff increases have outpaced the available square footage and resulted in an inadequate court facility.

Impacts: Projected Growth



Summary of Options

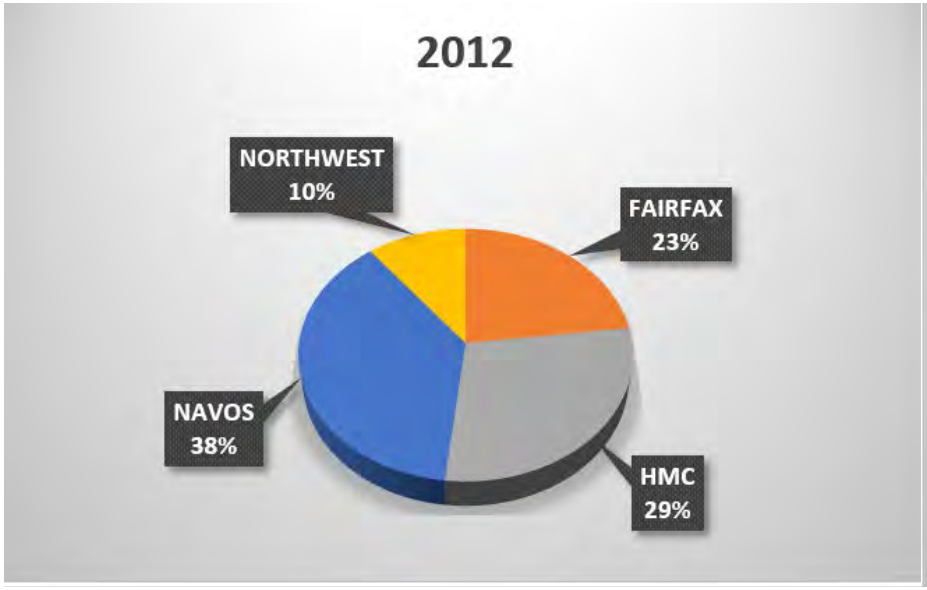
- ITA court officials plan for the continued use of both in-person and video hearings over the next decade.
- The current in-person facilities are inadequate in size and functionality; and video hearings will require ongoing equipment and capital infrastructure support.
- The facility responses presented herewith are not mutually exclusive and seek to meet the ITA court's needs as follows:
  (1) expand the Harborview ITA court's size and improve its functionality;
  (2) expand key facilities along the behavioral health continuum in order to mitigate the growth and recidivism of patients entering the court.

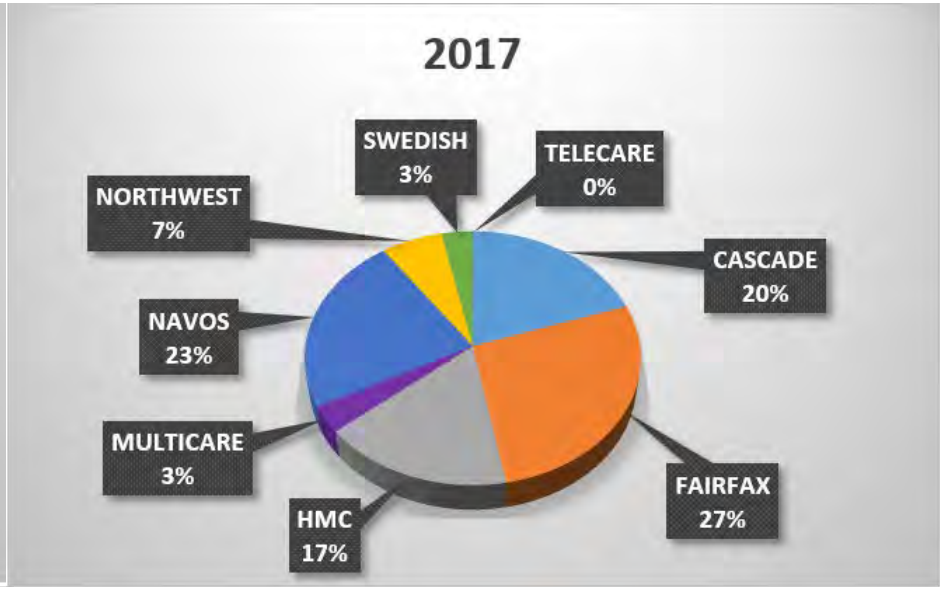
Requests for Additional Information

1. Percentage of ITA patients come from Harborview as compared to other hospitals (and how those numbers have increased or decreased over time).
2. Detailed SF breakdown of current ITA Court space.
3. If the Supreme Court were to overturn video hearings, how would this alter the structure of the court?
4. Why should the ITA Court be included in the scope of the bond process?

1. What Percentage of ITA Patients come from Harborview?

- From 2012 -2018 roughly 20% of the ITA cases were Harborview inpatients.





2. Detailed Square Footage Breakdown of ITA Court Space

Public Defense *
Approximately 444 s/f

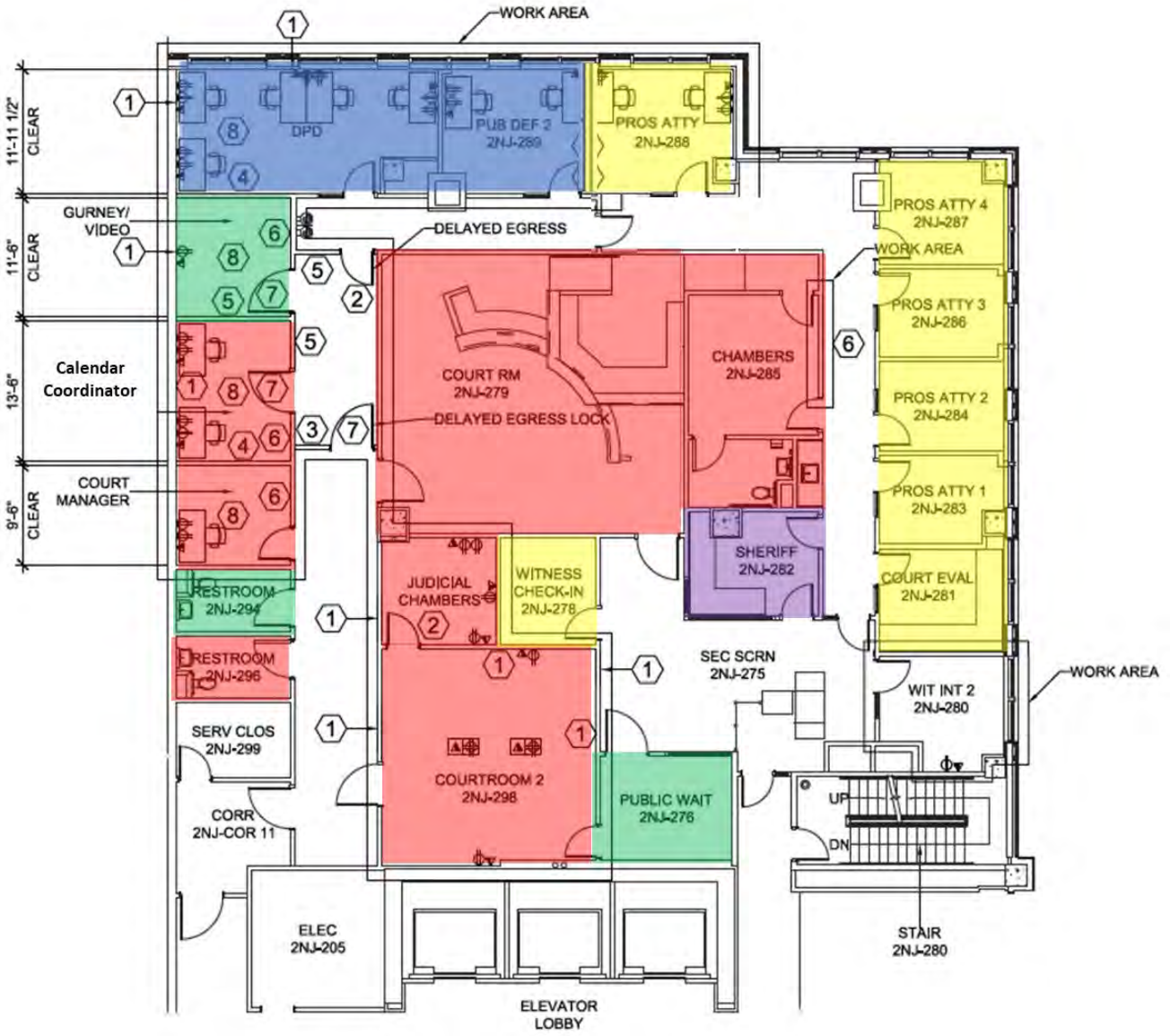
Prosecuting Attorney
Approximately 804 s/f

Common Use
Approximately 416 s/f

Superior Court
Approximately 2,092 s/f

Sheriff CPU
Approximately 125 s/f

* Additional Public Defense office space is located on the Harborview Campus.



3. How would the elimination of video hearings impact the court?

Video hearings occur in approximately 90% of the cases. The impacts of reducing or changing the number of video hearings would challenge the system as follows:

- Additional ambulance operators required
- Significantly more court room space
- Possible interruptions of other superior court calendars to accommodate ITA cases
- Expanding into other courts would limit patient access to mental health services, privacy, and care
- The Court would ultimately be unable to fully meet the needs of ITA patients at the current rate without affecting other court services.

4. Why should the ITA Court be included in the bond measure

- The ITA Court is part of the behavioral health continuum of care. The purpose of the laws include
  - ✓ To provide continuity of care
  - ✓ To safeguard individual rights
  - ✓ To encourage the full use of all existing agencies, professional personnel and public funds to prevent duplication of services and unnecessary expenditures
  - ✓ To encourage community based care whenever possible
  - ✓ To protect the public safety
- The proposed options to expand ITA Court are modest, but still rely on the continued use of video court
- Projections for patient annual growth range from 3.5% - 6.8% and translate into hundreds more patients each year over the foreseeable future. The current facilities cannot accommodate that level of growth without expansion and improvement.

Criteria Matrix

	No Change	Facilities Option 2	Facilities Option 3
Area 1: People Impact			
Mission Population			
Patients and clients			
Labor and employees			
Neighbors and community			
Area 2: Service/Operational Impact			
Delivery of emergency services			
Addresses facility deficiencies and needs			
Supports innovation, best practices, and/or new models of care			
Area 3: Equity and Social Justice			
Service models that promote equity			
Influenced by community priorities			
Addresses Determinants of Equity			
Access to healthcare and improved health outcomes			
Area 4: Fiscal/Financial Impact			
The long-term financial position of Harborview and King County			
Existing facilities			
Opportunities for other funding			

Meets
Does not meet
Not Applicable

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Questions?

King County

Harborview Leadership Group

Behavioral Health

Subcommittee Report

May 22, 2019

Behavioral Health Subcommittee

May 22, 2019

Subcommittee Charge

To conduct an analysis of facility needs and initial alternatives (options) for the Leadership Group to consider for its recommendations.

Report Summary

- Harborview Medical Center (HMC) is renowned statewide for its commitment to providing high quality mental health and substance use disorder services to the most ill and vulnerable individuals in the region. However, it offers only two levels of care: Outpatient clinics and inpatient hospitalization. These two services represent a fraction of the entire care continuum. Dozens of people who await admission to psychiatric facilities also occupy beds in the Harborview Psychiatric Emergency Service (PES) and Emergency Department (ED).
- The most effective way to reduce the number of individuals waiting in the PES and ED is to reduce the total number of people who need hospitalization for voluntary or involuntary reasons. To achieve this, there must be more avenues for people to access behavioral health care and treatment, particularly before symptoms reach the threshold of involuntary detention.
- The Subcommittee offers two options to address service gaps: expand existing facilities or add new space for three prioritized programs, and expand existing facilities or add new space for four additional programs.

	No Change/Existing Buildings	Prioritized Programs	Additional Programs
Area 1: People Impact			
Mission Population			
Patients and clients			
Labor and employees			
Neighbors and community			
Area 2: Service/Operational Impact			
Delivery of emergency services			
Addresses facility deficiencies and needs			
Supports innovation, best practices, and/or new models of care			
Area 3: Equity and Social Justice			
Service models that promote equity			
Influenced by community priorities			
Addresses Determinants of Equity			
Access to healthcare and improved health outcomes			
Area 4: Fiscal/Financial Impact			
The long-term financial position of Harborview and King County			

Existing facilities			
Opportunities for other funding			

Meets
Does not meet
Not Applicable

Overview

Behavioral health disorders is the umbrella term for both mental health and substance use disorders, such as depression, schizophrenia, alcohol use disorder, and opiate use disorder. People of all races, socioeconomic classes, ages, and sexes can develop behavioral health disorders; psychiatric illness does not discriminate. The continuum of services for behavioral health conditions ranges from outpatient visits at one end of the spectrum, where people go to a clinic once every few months for short appointments, to involuntary hospitalization, where people are admitted to a psychiatric hospital against their will at the other end of the spectrum. Individuals can and do recover from behavioral health disorders. Recovery is a process of change through which individuals improve their health and wellness, live self-directed lives, and strive to reach their full potential.

Harborview Medical Center (HMC) is a recovery-oriented system and currently provides several behavioral health services, including multiple outpatient clinics, a Psychiatric Emergency Service (PES), and three inpatient psychiatric units.[1] Offerings at the outpatient clinics include services for mental health and substance use disorders, care for geriatric populations, short-term interventions that help link individuals to ongoing services provided in community or at HMC, and support services to help individuals participating in the behavioral health system obtain housing and employment. HMC also offers an outpatient clinic for physicians training to become psychiatrists as well as a new clinic that focuses on Specialized Treatment of Early Psychosis (STEP). All outpatient clinics at HMC are operating at maximum capacity and, combined, have over 51,000 visits per year. The total cost for outpatient services is about $15M per year.[2]

The PES was originally a Crisis Triage Unit to provide "no wrong door" access to individuals experiencing a behavioral health crisis, such as those who are at risk of harming themselves or others. Individuals who are overwhelmed due to internal or external circumstances and need more support are also described as experiencing crisis. The PES is the only psychiatric emergency service in King County. Individuals reporting or demonstrating acute behavioral health crisis receive assessments, interventions, and treatment while in the PES. Over the past 20 years, PES staff have witnessed an increase in the severity and complexity of symptoms that people exhibit. The PES has become, in function, a 10-bed inpatient psychiatric unit for individuals awaiting available hospital beds at either HMC or another psychiatric facility. If individuals do not need further assessment or treatment, they are discharged back to the community. The PES evaluates over 2,500 individuals per year for a total of over 4,100 visits per year.[3]

There are three inpatient psychiatric units with a total of 68 beds across all units at HMC. The services provided in the psychiatric units at Harborview include daily assessments, interventions, and treatment from a multidisciplinary team of nurses, peer counselors, substance use- and mental health-

[1] See Figure 1 in Appendix.
[2] Data from e-mail correspondence from Performance Measurement, UW Medicine Finance.
[3] See Figure 2 in Appendix.

professionals, psychiatrists, and other paraprofessionals. Individuals admitted to these units remain there overnight. HMC has a psychiatric "intensive care unit" (ICU) for involuntarily detained individuals exhibiting severe behavioral health symptoms. The other two units provide services to individuals hospitalized for either voluntary or involuntary reasons. Individuals may move between all three units. The inpatient units serve over 1,000 people per year for a total of over 1,200 admissions. The average length of stay is about 20 days. The total cost for these services is about $23M per year.[4]

Needs Statement

HMC is one of the few hospitals in the state that accepts all individuals who present for care. As a result, the most ill and vulnerable individuals with significant health complexity in the region often come to HMC. Though HMC has a reputation for providing excellent services, it offers only two levels of behavioral health care: outpatient clinics and inpatient hospitalization. These programmatic limitations impact individuals who would benefit from more intensive care than outpatient clinics but who are not (yet) ill enough to warrant hospitalization. Similarly, individuals leaving hospital settings often need extra support when making transitions back to the community. Without enhanced supports, these individuals may return to the ED due to the lack of sufficient support and/or a resurgence of symptoms. The existing PES and ED, however, are not calm, predictable environments that promote recovery. Individuals receiving care and clinical staff observe that psychiatric conditions often get worse in these settings.

The Washington State Supreme Court ruled in August 2014 that "psychiatric boarding" is illegal. The Court ruled that individuals who are detained due to psychiatric reasons cannot wait in emergency departments or medical units without receiving services simply because no psychiatric beds are available. Because HMC has a PES, psychiatrists or nurse practitioners are available every day at all hours. Thus, individuals involuntarily hospitalized in the HMC PES and ED have always received psychiatric services. Thus, while "psychiatric boarding" has never occurred at HMC, the PES and ED staff understandably cannot recreate the treatment teams, programming, and environment of inpatient psychiatric units due to lack of available space and clinical resources. Though it is taxing on staff to provide care to individuals under these circumstances, the people who suffer the most are the detained individuals themselves. These individuals often wait in the noisiest section of the main ED, surrounded by 20 sick and injured people, with one wrist and one ankle each in restraints to prevent them from leaving the gurneys. The wait can last for days. The number of people detained and awaiting available beds has increased with time and has exceeded the number of people who were "psychiatrically boarding" in 2014.[5] Furthermore, there was recent state legislation that could have resulted in an increase the number of individuals who are involuntarily detained. Engrossed 2nd Substitute Senate Bill 5720 included provisions related to the detention of individuals for substance use and extending the length of initial involuntary detentions from three days to five days. This bill did not pass, but could return in the next legislative session.

The most effective way to reduce the number of detained individuals waiting in the PES and ED is to reduce the total number of people who need hospitalization. This also improves the quality and experience of care for the people receiving services. To achieve this, there must be more avenues for people to access care and treatment before symptoms reach the threshold of hospitalization, particularly involuntary detention.[6] This expansion of the continuum of behavioral health services

[4] Ibid and data from e-mail correspondence from Performance Measurement, UW Medicine Finance.
[5] See Figure 3 in Appendix.
[6] See Figure 4 in Appendix.

should help individuals remain with their friends and families in the community while receiving support. More types and availability of services can also help save lives. Furthermore, it could reduce pressure on judicial resources at the Involuntary Treatment Act (ITA) court by alleviating caseload growth.

Lastly, some of the already existing services at Harborview are running out of space. The current outpatient clinic space in the Pat Steele Building is at capacity. HMC leadership reported that the clinic recently had to suspend "same day access" services because it could not accommodate additional people within the existing footprint. The recently launched first episode psychosis program (STEP) currently housed in the East Clinic also needs a more appropriate and accessible space to foster a healing and recovery environment.

Alternatives/Options

The Behavioral Health Subcommittee identified seven specific behavioral health program areas for consideration, each of which would improve the behavioral health system and help address unmet need. Three of the seven programs were prioritized by the Subcommittee with the understanding that funding limitations may exist. The remaining four programs could address other gaps in the behavioral health system to further improve outcomes. Option 1 is no change; Option 2 includes the three prioritized programs: a crisis stabilization unit, which is a new service; a partial hospital program, which is also a new service; and expand existing outpatient clinics. Option 3 includes the remaining four new to Harborview programs identified by the Subcommittee: a forensic inpatient unit, an evidence based practice training center, a sobering center, and telepsychiatry. Each of the seven programs, with the exception of the outpatient clinic, would be new to the Harborview Campus and would require expanded or new space. *Note that the Subcommittee did not address the issue of operating funds for existing and planned new services in new or expanded space.*

The options below provide a description of each clinical program. Note that the Behavioral Health Subcommittee also considered housing options, including behavioral health respite care and residential "step down" housing. This committee supports these options, though they are omitted here because they were folded into the work of the Housing Subcommittee.

Option 1: No Change/Existing Buildings

This option reflects no change from the current status. This option does not meet any of the Leadership Group decision criteria. Furthermore, all of the currently existing buildings are occupied. Thus, in order to place any of the programs listed below into a building, another existing clinical program must leave the building.

Option 2: Expand Existing Facilities or Add New Space for Prioritized Programs

This option provides for renovation of existing buildings or addition of new space to accommodate prioritized new or expanded behavioral health programs and services. This option meets almost all of the Leadership Group decision criteria. Because of stigma associated with behavioral health conditions, the surrounding neighborhood and community may object to additional behavioral health services HMC may offer. However, these individuals are already presenting to HMC for care, and this is an opportunity to improve outcomes for people and the community. The proposed programs are:

Crisis Stabilization Unit (new program)

Individuals, families, and first responders have limited places to turn for assistance when new or urgent and serious behavioral health difficulties arise. The results of this gap are overuse of emergency rooms, incarceration, and inadequate behavioral health care. A crisis stabilization unit (CSU) can serve as a safe place for recovery for individuals experiencing a mental health and/or substance use disorder crisis who need immediate help. These individuals may be intoxicated or in withdrawal, exhibiting worrisome behaviors, or have co-occurring medical conditions.

A CSU would be comprised of a multidisciplinary team of clinical staff to provide immediate assessment, interventions, and referrals to ongoing services, with the goal of providing rapid stabilization for individuals so they may safely return to the community. The environment of a CSU is calm and supportive, which improves clinical outcomes, safety, and satisfaction of individuals receiving care. If hospitalization is indicated, staff will work to facilitate either voluntary or involuntary admission. A specific example of a CSU that provides high-acuity psychiatric treatment is an EmPATH (Emergency Psychiatric Assessment, Treatment and Healing) unit.[7] An EmPATH unit offers opportunities for individuals to talk with and receive support from others in a calm, home-like, supportive environment. Staff and individuals receiving care occupy the same spaces; people sit in recliners, not on gurneys. A CSU could reduce pressure on the ED and provide "surge" capacity for the trauma center, as individuals with less acute medical conditions could move to the CSU for recovery.

Partial Hospital Program: Step Up-Step Down (new program)

A partial hospital program (PHP), sometimes called a "day hospital", offers services that are more frequent and intense compared to an outpatient clinic, but not as intense as a psychiatric hospital. PHP programming involves office visits with no overnight stay, where individuals participate in clinical services with a multidisciplinary team for four or more hours a day, at least several days a week. The course of treatment is usually no more than eight weeks.

These programs can serve as "step up" and "step down" alternatives to inpatient hospitalization. For example, an individual with worsening symptoms may "step up" to PHP services, thus receiving benefits from more assertive support and avoiding the restrictions of a psychiatric unit. Someone who is discharging from a psychiatric unit may "step down" to a PHP to aid the transition back to the community, particularly if outpatient services alone may be insufficient.

Expansion of Outpatient Clinics (existing program)

HMC operates a licensed Behavioral Health Agency located in the first floor of the Pat Steele Building. As noted above, HMC offers a broad array of outpatient services, most of which are operating at their maximum capacity. All outpatient services involve office visits with no overnight stay. Outpatient programs are best suited to provide prevention and early intervention services, which help people remain in their communities and engage in other meaningful activities that support and promote wellness. Increasing the amount of space for outpatient programs will not only allow more people to access services in already existing programs, but can also promote a diversity of programs for different populations (e.g., immigrants and refugees, LGBTQ+ populations, people with both complex medical and psychiatric needs, et al.).

[7] EmPATH units are also called the "Alameda Model": Zeller S, Calma N, Stone A. Effects of a dedicated regional psychiatric emergency service on boarding of psychiatric patients in area emergency departments. West J Emerg Med. 2014;15(1):1-6.

Option 3: Expand Existing Facilities or Add New Space for Additional Programs

As with Option 2, this option meets almost all of the Leadership Group decision criteria. Because of stigma associated with behavioral health conditions, the surrounding neighborhood and community may object to the additional behavioral health services HMC may offer. However, these individuals are already presenting to HMC for care, and this is an opportunity to improve outcomes for people and the community. The proposed additional programs are:

Forensic Inpatient Facility (new program)

Individuals with significant behavioral health conditions are a large and growing population in correctional settings. Psychiatric facilities currently do not allow admission of inmates with any current felony charges, even if the charge is non-violent in nature. These individuals often spend over three months at King County Correctional Facility (KCCF) while awaiting transfer to a forensic inpatient facility (often Western State Hospital).

Incarcerated individuals do receive psychiatric care at KCCF, but it is a jail, not a hospital. While individuals in the most acute units receive several visits from psychiatric staff during the week, the care provided in jail does not include the same types, intensities, or frequencies offered in hospital settings, even though many of these individuals are just as ill. A highly structured, secure hospital unit with 20 to 30 beds that offers consistent treatment in a hospital environment is more likely to generate better health outcomes and promote recovery for this population.

Evidence Based Practice Training Center (new program)

In an effort to support and improve clinical services in community behavioral health clinics, an Evidence Based Practice (EBP) Training Center can provide comprehensive and multidisciplinary clinical training, technical assistance, and evaluation services from experts at the University of Washington. It can also develop curricula, aid in implementing evidence-based practices, and disseminate these models to improve clinical outcomes. The EBP Training Center is also poised to provide accurate information from research and practice to increase the likelihood of evidence-based policy decisions.

Sobering Center (new program)

The sobering center serves as a safe place for people to stay while awaiting the resolution of the acute effects of intoxication (usually alcohol, often with other substances). It also provide the opportunity to connect visitors to treatment services, housing assistance, and other supports. King County already has a sobering center that has been part of the community for more than 20 years. The sobering center is open every day at all hours and serves up to 60 adults at a time. The current sobering center serves chiefly males. When the sobering center is completely full, but others are seeking admission, the emergency medical technician (EMT) staff working there will ask individuals to leave so others may come in.[8] A second sobering center in King County can support more people and help them connect to services. There are opportunities to tailor a second site to serve specific subpopulations (e.g., geriatric populations, LGB populations, transition age youth).

[8] Data from e-mail correspondence from Pioneer Human Services staff supporting the King County Sobering Center.

Telepsychiatry/Telepsychiatric Consult (new program)

There are parts of King County, in both suburban and rural areas, that have few, if any, practicing psychiatrists or psychologists. As a result, individuals in these regions who need or want behavioral health services often must wait for long periods before getting help. Telemedicine is the provision of health care from a distance through technology, usually through videoconferencing.

Telepsychiatry is a subset of telemedicine and allows individuals in underserved areas to speak directly to psychiatrists and other clinicians for a variety of services. Telepsychiatry can also include psychiatrists providing behavioral health education and consultation to primary care providers and EDs. This use of technology allows individuals to access prevention and early intervention services sooner, thus reducing the need for more intensive services in the future.

APPENDIX

Figure 1: Map of Harborview with locations of behavioral health services.

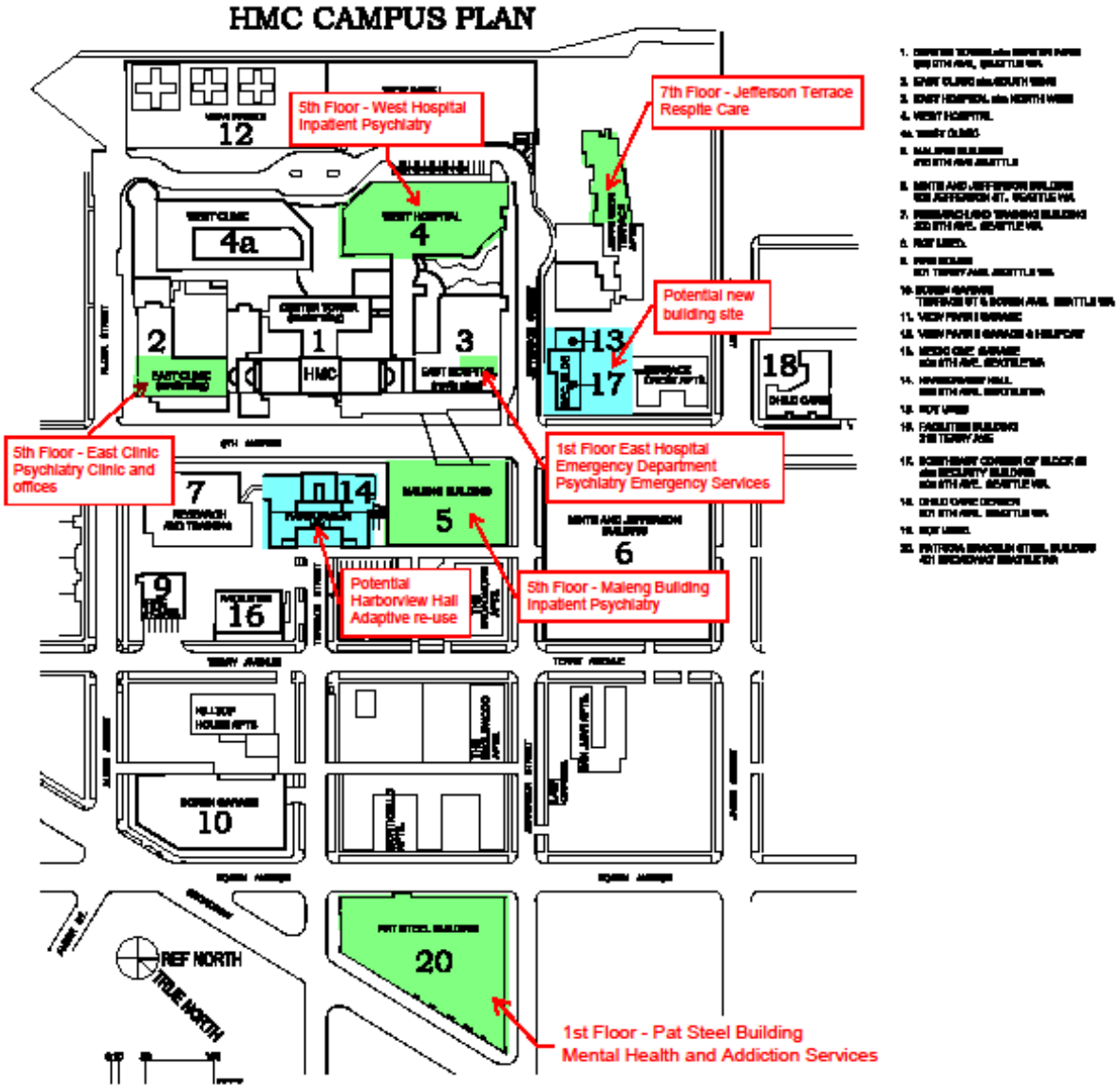


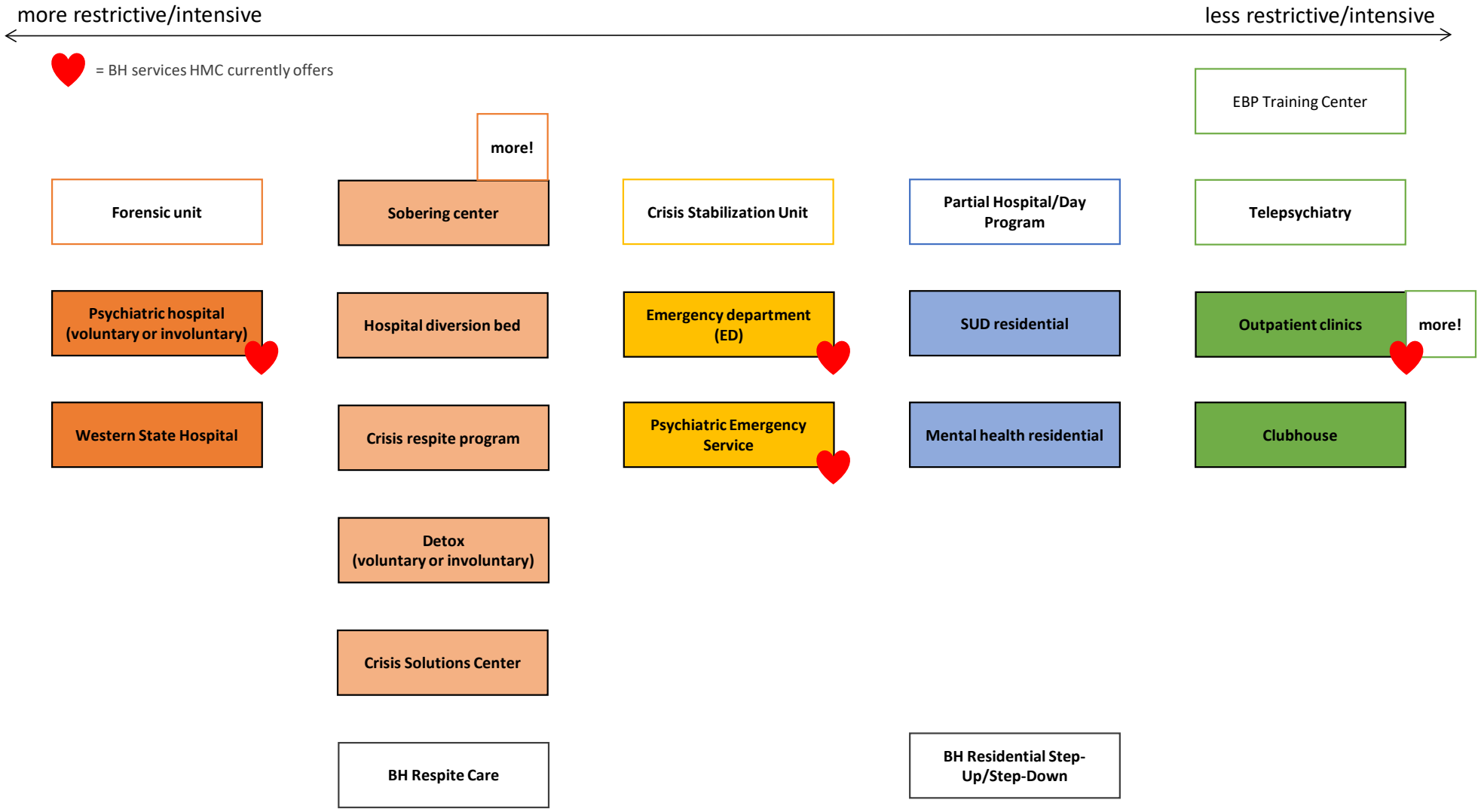
Figure 2: Visits to Harborview Inpatient Psychiatry and Psychiatric Emergency Service.

	HMC Inpatient Psychiatry		HMC Psychiatric Emergency Service (PES)	
	Admissions	Patients	Admissions	Patients
Calendar Year 2018 (Jan 1 – Dec 31)	1,225	1,026	4,127	2,646
Fiscal Year 2018 (Jul 1, 2017 – Jun 30, 2018)	1,296	1,067	4,211	2,730

Figure 3: Single Bed Certification (SBC) data from 2014 to 2018. (SBCs refer to the number of people who have been involuntarily detained due to psychiatric reasons and are awaiting a bed in a psychiatric hospital that has the specific certification to provide involuntary psychiatric treatment.)

Year	2014	2015	2016	2017	2018
Number of people on SBCs	2,614	2,469	3,293	3,812	4,665
Average # Days of SBC	3.42	3.83	3.09	2.94	2.52

Figure 4: A potential continuum of behavioral health services in King County.



Behavioral Health Subcommittee
Analysis for the Harborview Leadership Group

MAY 22, 2019

Subcommittee Members

- Maria Yang, King County (Convener)
- Brigitte Folz, Harborview
- Craig Jaffe, Harborview/King County
- Jim Vollendroff, Harborview/UW
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- Kelli Carroll, King County
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- Nancy Dow, Harborview
- Sam Porter, King County
- Ted Klainer, Harborview

Overview: Behavioral Health Disorders

- **Behavioral health disorders:** mental health and substance use disorders, such as depression, schizophrenia, alcohol use disorder, and opiate use disorder

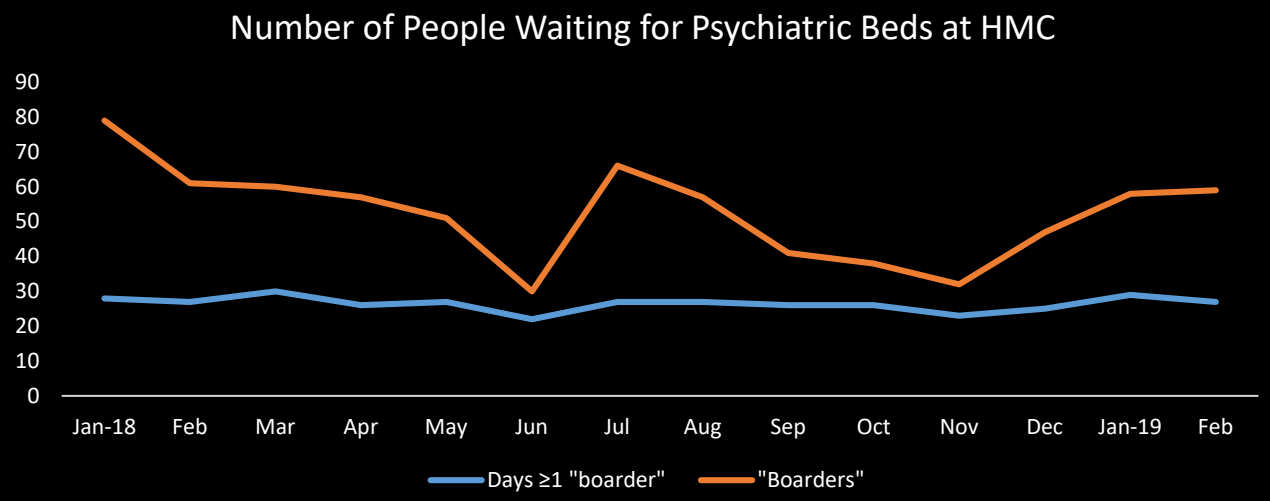
- **Behavioral health disorders do not discriminate**: People of all races, socioeconomic classes, ages, and sexes can develop behavioral health disorders

- **Recovery happens:** people with behavioral health conditions can and do improve their health and wellness, live self-directed lives, and strive to reach their full potential

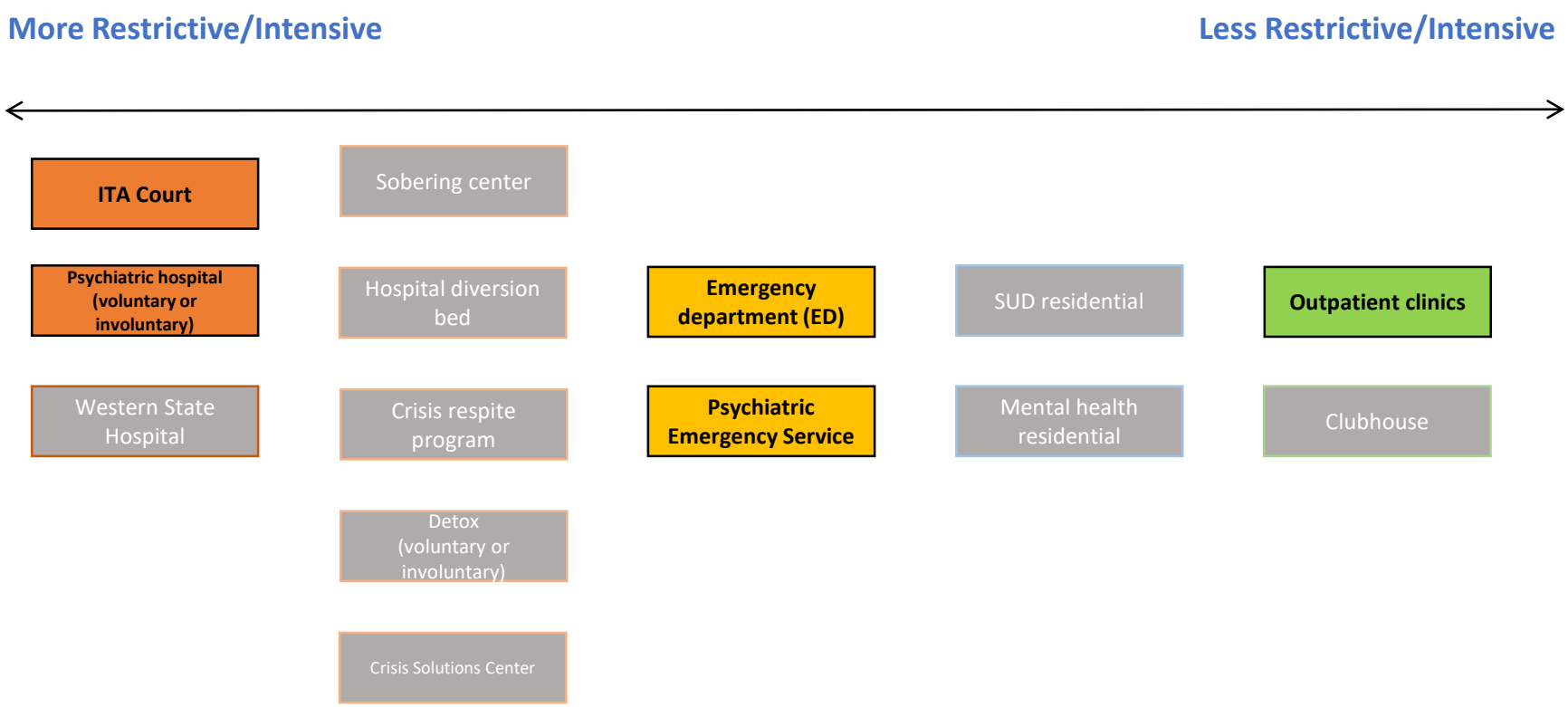
Needs Statement

- Harborview Medical Center (HMC) is renowned for caring for the most ill and vulnerable individuals in the region
- There is a need for more space on the medical center campus to meet the increasing demand for behavioral health services
  - Dozens of people wait in the Psychiatric Emergency Service (PES) and Emergency Department (ED) for crisis treatment
- Unmet behavioral health service needs impact individual and community health and well-being as well as health, human services, and justice continuums
  - Untreated behavioral health conditions can result in increased involvement in the justice system (repeated jail bookings, ITA Court) and homelessness

Overcrowded Psychiatric Emergency Services



Behavioral Health Continuum of Services



Options Overview

The subcommittee considered seven program areas which would have significant improvements to the Behavioral Health system:

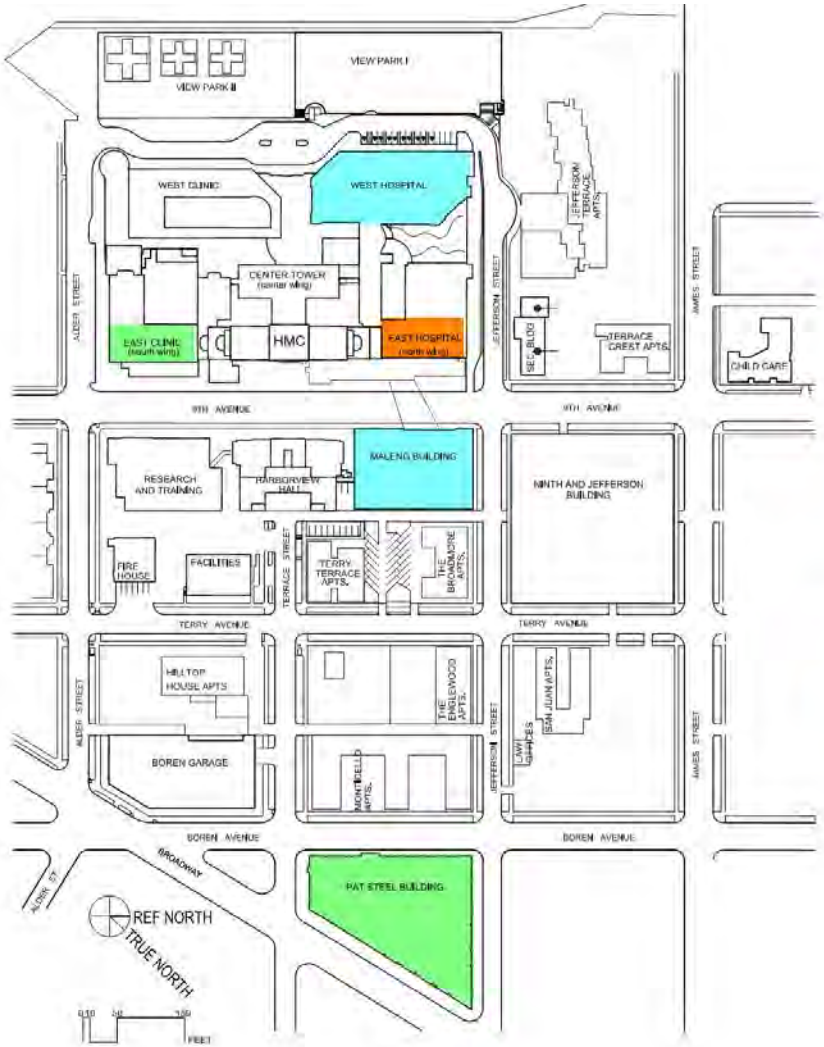
- **Option 1**: No Change/Existing Buildings
- **Option 2:** Expand Existing Facilities or Add New Space for three *Prioritized Programs (two new and one existing program)*
- **Option 3:** Expand Existing Facilities or Add New Space for four *Additional Programs*

…. Or any combination of the programs

Option 1: No Change to Existing Buildings or Services

- Harborview provides behavioral health services across the campus in several different buildings
- All of the existing buildings where services are provided are fully occupied
- In order for a new program to be installed an existing program must exit
- Maintaining the facility status quo does not address unmet need; service gaps continue

Existing Campus Locations of BH Services



Inpatient and Outpatient Psychiatric Services on the Harborview Medical Center Campus

Outpatient Psychiatry
51,611 visits per year
$15M / year

Inpatient Psychiatry
68 beds
1,200 Admits per year
$23M / year

Psychiatric Emergency Services
Emergency Department - 10 beds
4,100 visits per year

Option 2: Expand Existing Facilities or Add New Space for Priority Programs

- The Subcommittee identified seven program areas which would help address unmet needs and offer major improvements to the BH system

- Of those seven, three areas were prioritized by the subcommittee
  - **Crisis Stabilization Unit**
  - **Partial Hospital**
  - **Outpatient Clinics**

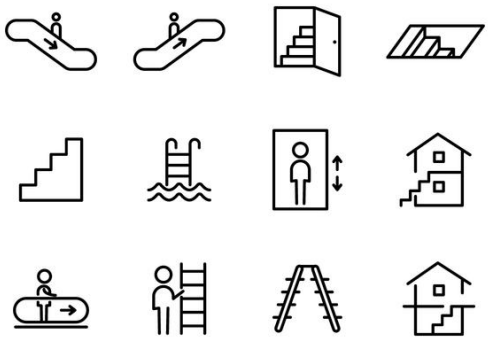
Crisis Stabilization Unit: New Service

- Example: EmPATH Unit
- Provides a safe, calm, supportive space
- promotes rapid stabilization
- Wait times ↓ by hours, ↓ in hospital admissions and readmissions
- ↓ pressure on the ED, ↑ “surge” capacity for the trauma center

Partial Hospital Program (PHP): New Service

- More frequent and intense services than an outpatient clinic, but not as intense as a psychiatric hospital.
- Office visits with a multidisciplinary team with no overnight stay
- The course of treatment is usually no more than eight weeks.

1. Inpatient Hospital > PHP > Outpatient Clinic
2. Option to “step up” and “step down”



Expand Outpatient Clinics: Existing Service

- HMC offers a broad array of outpatient services, most of which are operating at their maximum capacity

- Expanding outpatient clinics would:
  - Increase access to services within existing programs
  - Focus on prevention and early intervention services
  - Promote a diversity of programs for different populations

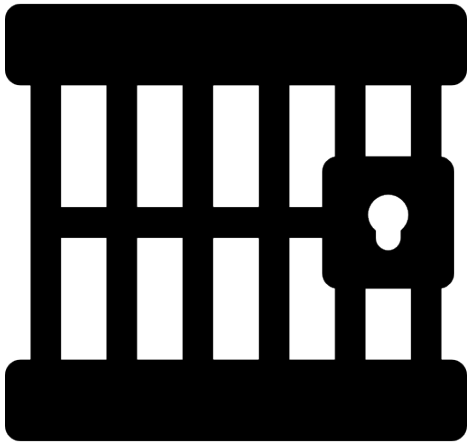
Option 3: Expand Existing Facilities or Add New Space for Additional Programs

In addition to the three priority services, four additional programs were identified by the Subcommittee that could be included in facility planning to improve the continuum of BH services:

- **Forensic Inpatient Unit**
- **Evidence Based Practice Training Center**
- **Sobering Center**
- **Telepsychiatry**

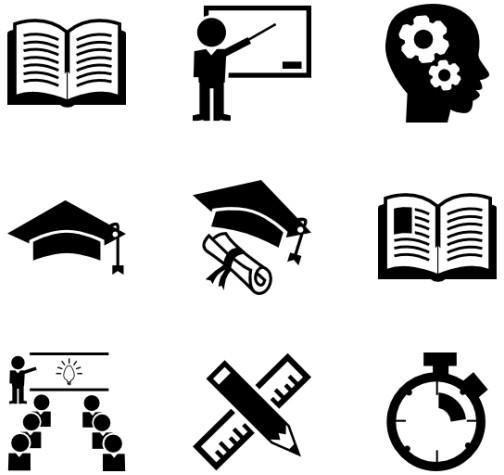
Forensic Inpatient Facility: New Service

- People in jail are often just as ill as people in hospitals
- Psychiatric services are available in jail, and a jail is not a hospital
- A highly structured, secure hospital unit that offers stable and appropriate treatment in a hospital environment fosters better health and lifecourse outcomes



Evidence Based Practice Training Center: New Service

- Multidisciplinary UW educational services
- Implementation and dissemination of evidence-based practices to more stakeholder groups
- Support evidence-based policy decisions

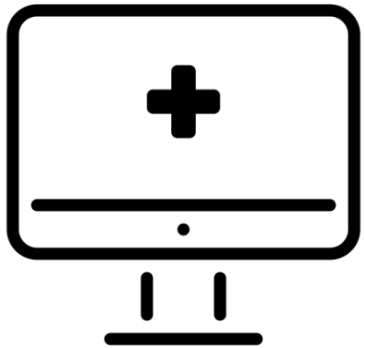


Sobering Center: New Service

- Provides a safe place to stay during resolution of the acute effects of intoxication
- Connects individuals to treatment services, housing assistance, and other supports
- Provides an opportunity to tailor a second site to serve specific populations or more individuals

Telepsychiatry/Telepsychiatric Consult: Expand Existing Service

- Gives people in underserved areas direct access to psychiatrists and other clinicians
- Behavioral health education and consultation to primary care providers and EDs
- Use of technology increases access to prevention and early intervention services sooner



Criteria

	No Change/Existing Buildings	Prioritized Programs	Additional Programs
Area 1: People Impact			
Mission Population			
Patients and clients			
Labor and employees			
Neighbors and community			
Area 2: Service/Operational Impact			
Delivery of emergency services			
Addresses facility deficiencies and needs			
Supports innovation, best practices, and/or new models of care			
Area 3: Equity and Social Justice			
Service models that promote equity			
Influenced by community priorities			
Addresses Determinants of Equity			
Access to healthcare and improved health outcomes			
Area 4: Fiscal/Financial Impact			
The long-term financial position of Harborview and King County			
Existing facilities			
Opportunities for other funding			

Questions?

Harborview Leadership Group
Behavioral Health Follow Up

JUNE 26, 2019

Recap of May 22, 2019 Behavioral Health Subcommittee Presentation

- "Behavioral health disorders" is an umbrella term for both mental health and substance use disorders, such as depression, schizophrenia, alcohol use disorder, and opiate use disorder.

- There is currently a need for more space on the medical center campus to meet the increasing demand for responses to behavioral health conditions:
  - Unmet needs along the behavioral health continuum potentially lead to involuntary treatment and overuse of the criminal legal system
  - Dozens of people wait in the Psychiatric Emergency Service (PES) and Emergency Department (ED) for psychiatric services

Behavioral Health Subcommittee Options Overview

The Subcommittee considered seven program areas which would have significant improvements to the Behavioral Health system.

- **Option 1**: No Change/Existing Buildings
- **Option 2:** Facilities for New/Expanded Programs
  - 3 prioritized program options
- **Option 3:** Facilities for Additional Programs
  - The remaining 4 programs

…. Or any combination of the seven programs

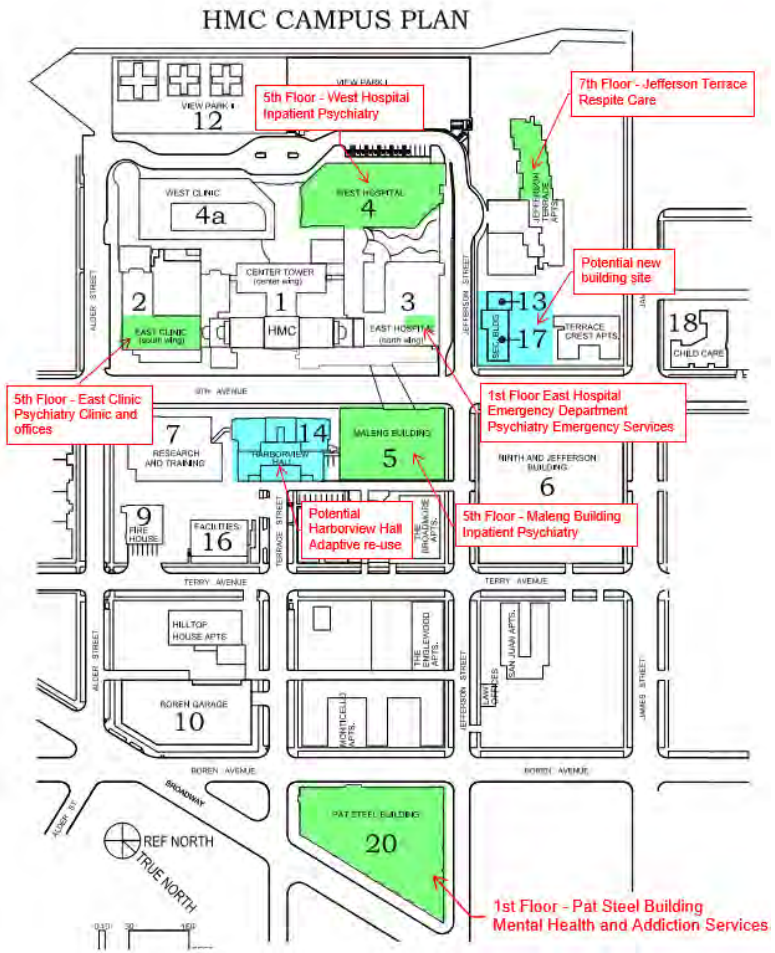
Behavioral Health Program Options Overview

- Prioritized Program Options
  1. Crisis Stabilization Unit
  2. Partial Hospital
  3. Outpatient Clinics

- Additional Programs
  1. Forensic Inpatient Unit
  2. Evidence-Based Practice Training Center
  3. Sobering Center
  4. Telepsychiatry

1. Description of existing outpatient and inpatient Behavioral Health services on the HMC campus.

- There are 15 behavioral health outpatient and inpatient programs and services across the Harborview Campus.
- Additional detailed information and descriptions for each service and its location are provided in the handout.



2. What are the components of the BHI and how will they address the proposals presented?

- HMC has a number of BH related services and programs, but not all fall under the BHI.

- The BHI is envisioned to include four program areas:
  1. First Episode Psychosis Program
  2. Urgent Care Walk In/Crisis Stabilization
  3. Telepsychiatry
  4. Evidence Based Training

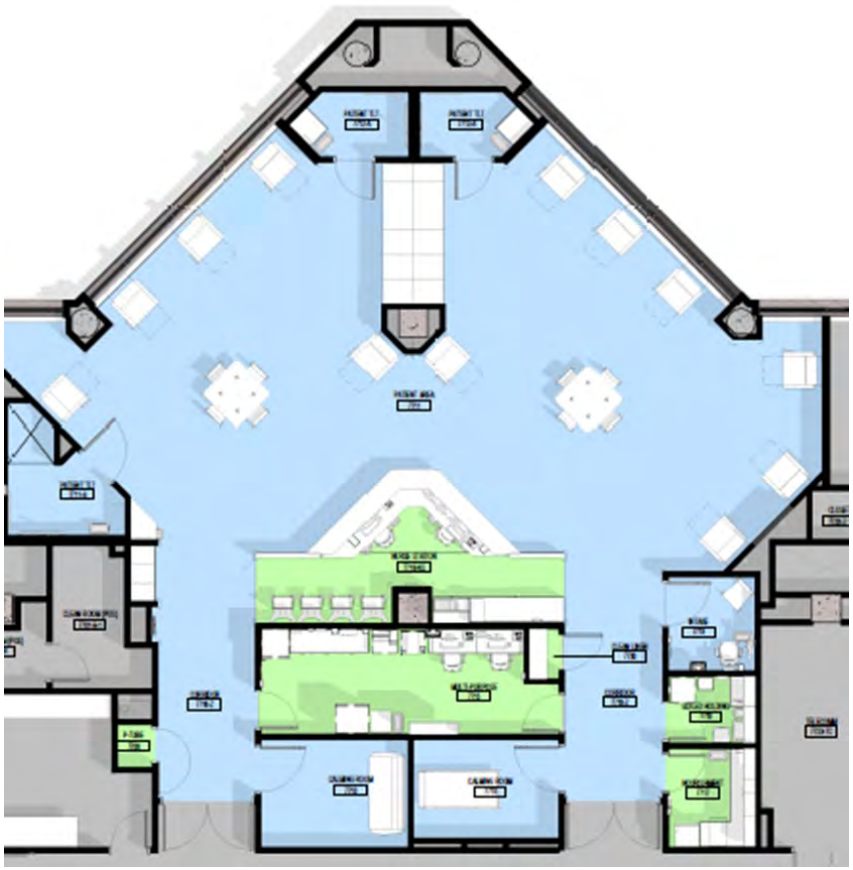
- Other BH related programs could potentially be integrated into the BHI.

3 . Where are other examples of Partial Hospital (PHP) Programs located?

- A partial hospital is not a hospital; it is a day program and no one stays overnight.
- PHP space often looks like clinic space (with perhaps more classroom/group space).

- Currently PHP Units in King County are located at:
  - Fairfax Behavioral Health
  - Overlake Medical Center
  - Northwest Medical Center
  - Cascade Behavioral Health

4. What kind of space is required for an emPATH unit?



- 80 square feet per person is recommended
- Currently there are emPATH units operating in
  - Billings, Montana
  - Alameda, California
  - University Iowa
- Average length of stay is around 16 hours

5. What is the relationship between Housing and Behavioral Health Options?

- People with stable housing experience better treatment outcomes.
- "Layer cake" is a term of art used to describe a multi-use facility that could co-locate levels of services, including behavioral health services, along with housing.
- There is a "layer cake" facility in Portland, OR.
- The topic of housing and behavioral health co-location will be addressed by the Leadership Group as options developed are prioritized.

Criteria Matrix: Behavioral Health

	No Change/Existing Buildings	Prioritized Programs	Additional Programs
Area 1: People Impact			
Mission Population			
Patients and clients			
Labor and employees			
Neighbors and community			
Area 2: Service/Operational Impact			
Delivery of emergency services			
Addresses facility deficiencies and needs			
Supports innovation, best practices, and/or new models of care			
Area 3: Equity and Social Justice			
Service models that promote equity			
Influenced by community priorities			
Addresses Determinants of Equity			
Access to healthcare and improved health outcomes			
Area 4: Fiscal/Financial Impact			
The long-term financial position of Harborview and King County			
Existing facilities			
Opportunities for other funding			

Meets
Does not meet
Not Applicable

Subcommittee Members

- Maria Yang, King County (Convener)
- Brigitte Folz, Harborview
- Craig Jaffe, Harborview/King County
- Jim Vollendroff, Harborview/UW
- Kathleen Murphy, King County
- Kelli Carroll, King County
- Kelli Nomura, King County
- Kera Dennis, Harborview
- Lan Nguyen, King County
- Leslie Harper-Miles, King County
- Maggie Hostnick, DESC
- Nancy Dow, Harborview
- Sam Porter, King County
- Ted Klainer, Harborview

King County

Harborview Leadership Group

Housing

Subcommittee Report

April 24, 2019

Housing Subcommittee

Leadership Group meeting date: April 24, 2019

Subcommittee Charge

To conduct an analysis of facility needs and initial alternatives (options) for the Leadership Group to consider for its recommendations.

Report Summary

Several housing-related capital projects needs related to the Harborview Medical Center (HMC) and its mission population are included in this report. Options for consideration include:

- *Respite Housing (Medical and Behavioral Health)* to increase housing capacity for sub-acute "stepdown" care for individuals living in homelessness;
- *Permanent Supportive Housing* to increase the stock of housing that would meet housing or medical needs of the mission population; and *Shelter* to increase capacity for people living in homelessness.
- Workforce Housing and other low-income housing in support of HMC essential employees and other community members contending with area housing cost increases in excess of income capacity.

	1. No Change	2. Respite	3. PSH	4. Workforce Housing	5. Shelter
Area 1: People Impact					
Mission Population					
Patients and clients					
Labor and employees					
Neighbors and community					
Area 2: Service/Operational Impact					
Delivery of emergency services					
Addresses facility deficiencies and needs					
Supports innovation, best practices, and/or new models of care					
Area 3: Equity and Social Justice					
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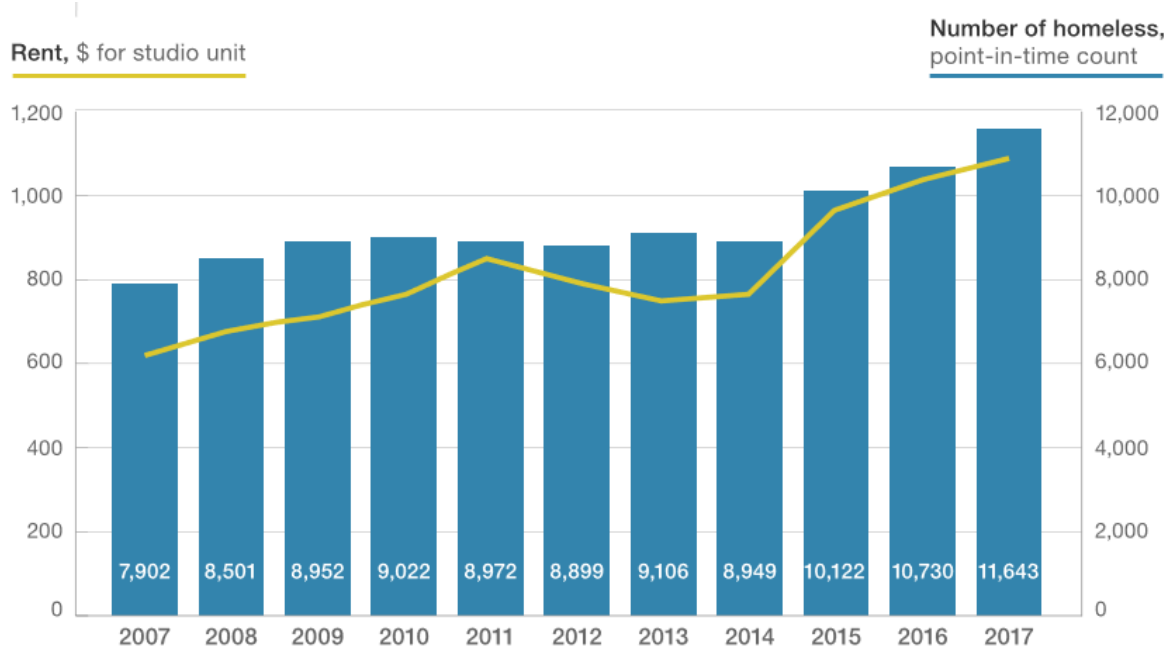
Access to healthcare and improved health outcomes					
Area 4: Fiscal/Financial Impact					
The long-term financial position of Harborview and King County					
Existing facilities					
Opportunities for other funding					

Meets | Not Applicable

Does not meet

Overview



With rising housing costs in King County has also experienced an increase in the number of individuals living homeless or unstably housed. There is also an increasing number of individuals who are rent burdened or cannot afford the cost of housing. In this report, the Housing Subcommittee explores options related to housing issues for the consideration of the Harborview Leadership Group:

1. **No Change/ status quo:** The status quo option for Housing would continue to offer vastly inadequate resources for lower-acuity respite care, supportive housing, shelter, and workforce low-income housing.

2. **Respite capacity, both behavioral health and medical**: Medical and Behavioral Health conditions compound the vulnerability associated with homelessness, and homelessness can compound the morbidity and mortality of health conditions. Often, individuals who are homeless or marginally housed stay in the hospital longer than clinically indicated because they have nowhere else to go to receive lower-acuity medical and recuperative care. In all of King County there is a very small number of respite beds (34 medical and 20 Behavioral Health) allocated to HMC, Swedish Hospital and the UW Hospital. Adding medical and behavioral health respite beds, along with an integrated medical and behavioral health respite program, would increase the community's ability to meet the medical and behavioral health needs of the Harborview mission population. It would also support patient flow – moving people through the hospital and easing discharge bottlenecks, which would allow Harborview to serve more people.

3. **Permanent Supportive Housing**: Permanent Supportive Housing (PSH) is non-time limited affordable housing with long-term high level of services, for households coming out of homelessness and with disabilities or conditions that create barriers to housing stability. In the vast majority of existing PSH buildings, the intensive support is built around behavioral health needs, but there are emerging models for folding in medical care. Such an integrated model would address the needs of a share of the mission

population. PSH has been shown to lower emergency department and hospital utilization and improve outcomes. King County faces a shortfall of an estimated 3,800 PSH units.

4. **Workforce/ Affordable Housing**: There is a significant and growing need for workforce housing in King County. High housing costs negatively impact the ability of the Harborview workforce, particularly those in mid to lower range salary positions, to live reasonably close to their workplace. There are approximately 3,900 unionized staff working at Harborview of which many earn less than 30% of King County's Area Median Income (AMI) as individual households, not counting dependents or other family members. Affordable housing would also benefit the Harborview mission population. Research has shown that providing housing reduces health care costs for homeless individuals with less intensive medical needs.

5. **Increase Shelter Capacity**: There are currently approximately 540 shelter beds operated in the immediate vicinity of the Harborview Campus. Additional shelter resources could come in the form of emergency shelter, which provides indoor sleeping space and some services or more robust enhanced shelter capacity, which is generally open 24 hours and offers more flexibility and services. Development of additional shelter resources would directly benefit Mission Population individuals living in homelessness by providing increased capacity for people to be indoors and accessing services.

Needs Statement

Unmanaged medical and behavioral health conditions compound the vulnerabilities associated with homelessness, and homelessness can compound the morbidity and mortality of health conditions. Unsanitary living conditions, unsafe living environments, and economic hardship predispose persons living homeless to chronic illness, substance use disorder, and infectious disease while diminishing their ability to manage these conditions. The result is a life expectancy that is dramatically lower than the general population. Because of the unique challenges created by the intersection between homelessness and health needs, the average life expectancy for an individual experiencing chronic homelessness is 47 years compared to life expectancy among the general population of 77 years.[1]

There are currently a small number of respite beds in King County, with need far outstripping the supply. The lack of medical respite beds increases morbidity and mortality among homeless patients, as well as acting as a bottleneck for discharge from Emergency Department and hospital beds.

In addition, there is a significant shortfall of Permanent Supportive Housing (PSH) units in King County. There are about 180 PSH buildings serving adults in King County, with a total of 5,544 adult units[2]. In 2017, there was need for 3,200-3,800 additional PSH units[3]. Moreover, with a growing homeless population, 5,792 households were unsheltered last year during the 2018 King County Point in Time count.[4]

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[1] Per HCHN John Gilvar's memo "Unsanitary living conditions, unsafe living environments and economic hardship predispose persons living homeless to chronic illness, substance use disorder, and infectious disease while diminishing their ability to manage these conditions. The result is a life expectancy that is dramatically lower than the general population"
[2] HUD 2018 Continuum of Care Homeless Assistance Programs Housing Inventory Count Report. https://www.hudexchange.info/resource/reportmanagement/published/CoC_HIC_State_WA_2018.PDF
[3] King County and Seattle Homelessness – Some Facts. McKinsey & Company, December 15, 2017
[4] Seattle/King County Point-In-Time Counts of Persons Experiencing Homelessness, The Economics of Homelessness in Seattle and King County, McKinsey & Company

Finally, many Harborview employees are currently rent-burdened and/or unable to live in the city of Seattle near to the Harborview campus. There are approximately 3,900 represented staff working at Harborview. Of the hospital's lower-to-medium skilled unionized staff, between 14% to 86% (or 200-1,280 individuals) earn less than 30% of King County's AMI as individual households, not counting dependents or other family members.

Alternatives/Options

Option I: No Change

With no increase in the number and/or type of housing units, the growing homeless population will continue to face lack of affordable, permanent supportive housing and shelter. There will continue to be vast unmet need for subacute respite services for individuals who are homeless or unstably housed, which often causes a bottleneck in discharges and slows patient flow. Due to the cost of housing on First Hill, many essential employees at area medical facilities will continue to be unable to afford to live there.

Option II: Increase Medical and Behavioral Health Respite Care Facilities

Medical Respite care provides short term housing for homeless or unstably housed individuals who need acute and/or post-acute medical care and who are too ill or frail to recover from a physical illness or injury on the streets but who are not ill enough to be hospitalized. This short-term residential care allows people the opportunity to rest and physically heal in a clean and safe environment while accessing medical care and other supportive services. Such programs are housed in a variety of settings including freestanding facilities, homeless shelters, nursing homes, and transitional housing[5]. There are King County currently 34 medical respite beds, operated by Harborview, which are reserved for only the very highest acuity patients.

Behavioral Health Respite may include a 24 hour behavioral support services, including crisis respite programs as "step up" or "step down" options from other programs and residential "step down" programs from hospitals. Such capacity could form part of a coordinated inpatient care continuum including as a discharge option for inpatient psychiatric units and as an alternative to Psychiatric Emergency Services. A "Crisis Respite Program" is operated by DESC for individuals discharging from psychiatric inpatient units with about a dozen beds. The need far outweighs supply.

This option could take a variety of forms, including: increasing beds under the existing, high acuity medical model; adding lower-acuity medical respite beds; adding behavioral health respite beds, or some combination of services in a **"layer-cake" style building,** possibly with a low-barrier primary care clinic included to leverage of outpatient providers.

Medical Respite has been shown to improve the health of vulnerable populations and reduce homelessness. In 2018 more than 30% of people discharged from Edward Thomas House Medical Respite went to shelters or to the outdoors[6]. Many of them would have benefited from a lower level of care to continue to heal, even when they no longer meet the acuity requirement of daily RN care.

To have supported discharge alternatives for homeless patients would improve patient flow and Harborview's ability to serve mission population patients that are turned away today due to bed

[5] *Medical Respite Care: Financing Approaches June 2017. National Health Care for the Homeless Council. https://www.nhchc.org/wp-content/uploads/2017/07/policy-brief-respite-financing.pdf*
[6] *Harborview Medical Respite Program 2018 Final Dashboard*

availability. Access to beds would allow patients "step down" to less acute care models even before they are ready to discharge to the community, or to shelter. Adding community-based discharge options improves movement through the inpatient system, facilitating faster transition of patients out of acute care settings, resulting in the ability of HMC to accept more high acuity patients.

Behavioral health respite provides short-term housing for individuals who need acute or post-acute psychiatric care. They may still be experiencing or demonstrating symptoms that increases their vulnerability in unsheltered setting, but their symptoms are not acute enough to warrant hospitalizations. Behavioral health respite will provide opportunities for people to recover in a clean and safe environment while receiving psychiatric and supportive services. This makes acute psychiatric beds available for those individuals who need that intensity of care, while also helping individuals make the transition back to community settings with support.

Respite offers significant opportunity for cost savings for HMC. While a hospital bed night costs $1,000-$1,500 or more, a respite bed night at the currently operating, high-acuity Edward Thomas House costs about $400 (which includes the cost of servicing the lease). The National Healthcare for the Homeless Council has shown annual cost savings in the millions for hospitals participating in a Medical Respite program.[7]

Medical respite facilities appropriately staffed can also significantly reduce rates of readmission. Homeless patients who are discharged to a medical respite program experience 50 percent fewer hospital readmissions within 90 days of being discharged than patients who are discharged to their own care.[8] People who receive this intervention also show decrease in Emergency Department visits and increase in outpatient clinic visits post discharge.

In addition, based on data provided by HMC, there are about 30 individuals a day in the hospital who are in "administrative" status or otherwise meet the medical criteria for discharge but for having nowhere to go. Many of these individuals have basic care needs to include their "activities of daily living" (ADLs) which may include transferring from bed to wheelchair, toileting, and basic hygiene. In these cases, a low-level respite with some ADL support may allow for hospital discharge while a longer-term placement, such as Adult Family Home, can be arranged. Each month, at least 300 patients leave the Harborview Emergency Department without being seen because there is not a bed available.

More analysis would be needed to identify ongoing operations cost for any version of respite care.

Option III: Increase Permanent Supportive Housing

Permanent Supported Housing (PSH) is non-time limited affordable housing with a high level of on-site services designed for households who were homeless at time of entry, and have a condition or disability, such as mental illness, substance abuse, chronic health issues, or other chronic conditions that create multiple and serious ongoing barriers to housing stability.[9]

In King County, PSH is almost exclusively staffed to support individuals with behavioral health challenges. In 17 buildings, there are trained nurses (Housing Health Outreach Teams) that provide

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[7] *Medical Respite Care: Demonstrated Cost Savings. http://www.nhchc.org/wp-content/uploads/2011/09/LeftColArt.pdf*
[8] *Kertesz, S. G., Posner, M. A., O'Connell, J. J., Swain, S., Mullins, A. N., Shwartz, M., & Ash, A. S. (2009). Post-hospital medical respite care and hospital readmission of homeless persons. Journal of Prevention & Intervention in the Community, 37(2), 129–142.*
[9] *King County Combined Funders Notice of Funding Availability 2018*

some basic services to residents, but are not sited at the building. There are about 180 PSH buildings serving adults in King County, with a total of 5,544 adult units in 2017, there was need for 3,200-3,800 additional PSH units.[10]

Because of behavioral health or medical conditions, for a portion of the homeless population, permanent supportive housing is the only viable housing alternative. PSH provides on demand services to formerly homeless households who have a disability, behavioral health condition, or both. For many, PSH is their forever home. On average, only 10% of PSH units turnover every year.

PSH has been shown to drives primary care utilization and reduce ED hospital utilization, freeing up hospital resources for individuals with other emergent/ high acuity needs. One 2009 study showed a 24% reduction in ED visits and 29% reduction in hospital days[11].

Many people with behavioral health issues cycle between homelessness and incarceration for months or years at great public expense and with tragic human outcomes. PSH helps end crisis among individuals with complex medical and behavioral health challenges who are the highest users of emergency rooms, jails, shelters, clinics and other costly crisis services. As stated above, people of color are disproportionately represented among individuals living in homelessness.

PSH units cost ~$375,000-425,000 per unit to build. There is a large body of evidence that individuals in PSH have lowered system utilization including emergency department visits and supportive housing reduces ED visits and hospital days. In the case of the 1811 Eastlake Project, which houses Emergency Department high utilizers in a harm-reduction[12] building, significant cost offsets after the first 6 and 12 months of housing were shown. King County Department of Community and Human Services, Homeless Housing and Community Development Division is in the process of analyzing the county's projected need for operations and services in supported housing units over the next 10 years and how that need will be resourced.

Option IV: Increase Workforce/ Affordable Housing

Income-Restricted Housing is long-term housing for households with a total income less than a particular percentage of Area Median Income (AMI). In King County, the AMI for a household is $103,400. There is a current shortage of about 56,159 units for 30% AMI and below, with a projected need of 82,792 units between now and 2030.

In King County, 45% of renters are cost-burdened, meaning they pay 30% or more of their income towards rent. Many of these households are severely cost-burdened, meaning they pay 50% or more of their income towards rent. More than 100,000 households, in King County are severely cost-burdened, with 68% of these households falling between 0-30% of AMI.

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[10] King County and Seattle Homelessness – Some Facts. McKinsey & Company, December 15, 2017

[11] Sadowski LS, Kee RA, VanderWeele TJ, Buchanan D. Effect of a Housing and Case Management Program on Emergency Department Visits and Hospitalizations Among Chronically Ill Homeless Adults: A Randomized Trial. JAMA. 2009;301(17):1771–1778. doi:10.1001/jama.2009.561

[12] According to the Harm Reduction Coalition, "Harm Reduction is a set of practical strategies and ideas aimed at reducing negative consequences associated with drug use. Harm Reduction is also a movement for social justice built on a belief in, and respect for, the rights of people who use drugs." https://harmreduction.org/about-us/principles-of-harm-reduction/

2018 King County 30% AMI (Washington State Housing Finance Commission)

Household Size	**Annual Income**
1 Person Household	$22,470
2 Person Household	$25,680
4 Person Household	$32,100

The greatest housing shortage is for households 30% AMI or below, and these households are disproportionately people of color. The higher household incomes are, the more likely it is for such households to benefit from flexible zoning policies or private development to meet their housing needs, in particular for households that are 80% AMI or higher. The housing needs of King County's lowest income households, 0-30% AMI, will not be met by the private market. Government intervention is needed for these populations' housing security, and without greater investment of public resources into housing targeted at households that are 0-30% AMI, the housing needs for the county's lowest-income residents will never be met.

Affordable Homes Needed to Achieve County-Wide Proportional Need in 2016 and in 2030

	0-30% AMI Units	30-50% AMI Units	50-80% AMI Units
2016	56,159	18,568	7,310
2023 Mid-point	69,476	29,173	13,033
2030	82,792	39,778	18,756

The lack of adequate housing for Harborview's mission population is likely to lead these patients to utilize emergency health care services more frequently. Homeless individuals in their 50s and 60s tend to have the similar health problems as housed individuals in their 70s and 80s, but without housing, it is difficult to manage chronic illness such as diabetes and heart disease. Homeless patients discharged from medical respite care often need permanent housing to prevent their health from deteriorating, or being readmitted to care providers. While some of these individuals would benefit from case management services provided in a permanent supportive housing context, not every low-income person needs this level of support - some just need affordable housing.

Further, skyrocketing housing costs negatively impacts the ability of Harborview staff to live reasonably close to their workplace. There are approximately 3,900 unionized staff working at Harborview. Of the hospital's lower-to-medium skilled unionized staff many earn less than 30% of King County's AMI as individual households, not counting dependents or other family members.

Hospitals throughout the country, including in states like California, Oregon, Illinois, and Florida, have invested in housing for homeless patients. These hospitals have seen drastic reductions in the use of emergency medical care. According to a University of Illinois study of 48 chronically homeless patients, the average health care costs of these individuals was five times higher than other patients, compared to a 50% reduction in costs after chronically homeless patients were able to secure housing.

Research has shown that providing housing reduces health care costs for homeless individuals with less intensive medical needs. In a study of 1,625 individuals in the Portland area, researchers found that living in affordable housing reduced overall Medicaid expenditures by 12%, with an estimated annual savings of $936,000 in health care costs. Individuals were more likely to go to primary care visits after becoming housed, but were less likely to visit the emergency room. There was an 18% decrease in emergency room visits among this population.

Option V: Increase Shelter Resources

As of the 2018 Point in Time Count there were 5,792 unsheltered households in King County[13]. Currently, there are about 540 shelter beds within about 6 blocks of the Harborview campus. Additional shelter resources could come in the form of **emergency shelter**[14], which provides indoor sleeping space and some services or more robust **enhanced shelter**[15] capacity, which is generally open 24 hours and offers more flexibility and services.

	Emergency Shelter	Enhanced Shelter
Definition	• Temporary shelter from the elements and unsafe streets, often only overnight • Basic health, food, clothing and personal hygiene needs • Information and referral, basic Case Management	• 24/7, year round • Basic needs with additional services including storage for personal belongings • Case management services and housing navigation

An additional alternative is to add capacity **Low-barrier 24/7 sleep and hygiene drop-in center** capacity. Many patients self-present to the Emergency Department for inpatient care that could be provided in an outpatient clinic setting if the patients had a safe and supportive place to recuperate after their care is rendered. Having a nearby location for these unsheltered people to go rather than utilize emergency services for non-urgent reasons is greatly needed. Open space with either comfortable chairs or beds/bunks with laundry services, food services, and possibly staff to assist w/housing applications would be needed. This facility should also be able to handle non-urgent reasons patients present to ED triage, such as medication refills, wound care. Other floors could be something like CRP or other short-term vs longer-term housing.

Development of additional shelter resources would directly benefit Mission Population individuals living in homelessness by providing increased capacity for people to be indoors and accessing services. There

[13] *Seattle/King County Point-In-Time Counts of Persons Experiencing Homelessness, The Economics of Homelessness in Seattle and King County, McKinsey & Company*

[14] *"Emergency Shelter is defined as temporary shelter from the elements and unsafe streets for individuals and families experiencing homelessness. Shelter programs are either fixed capacity (facility-based) or flexible capacity (for example, hotel/motel vouchers). Emergency shelters typically address the basic health, food, clothing and personal hygiene needs of the households that they serve and provide information and referrals about supportive services and housing. Emergency shelters are indoors, and range from mats on the floor in a common space to beds in individual units. Some shelters are overnight only, where others operate 24/7." King County Combined Funders Notice of Funding Availability 2018*

[15] *"Enhanced Shelter: Operate 24/7, year round and provide services and housing navigation to help people exit homelessness. Enhanced shelters ensure basic needs, including personal safety, sufficient and safe sleep, hygiene, adequate nutrition, and secure storage for personal belongings." King County Enhanced Shelter Model Description: https://www.kingcounty.gov/~/media/depts/community-human-services/housing/documents/housing-homeless/Enhanced_Shelter_Model_Final.ashx?la=en*

have been significant increases in the homeless population in recent years, (7,902 in 2007 to 12,112 in 2018)[16]. The proportion of individuals living unsheltered has risen disproportionately (47% in 2017 to 52% in 2018), which may point to the need for more emergency shelter that gets people out of the elements and connects them to permanent solutions. Numbers of deaths of people living in homelessness have also risen (from 78 in 2012 to 269 in 2017), and roughly half died outdoors.[17]

Increased shelter capacity in our community could provide additional alternatives for discharge from hospital. It may also have a public health impact, as unsheltered homelessness leads to increased morbidity and mortality. Additional drop-in center capacity may reduce non-acute emergency department utilization.

Homelessness disproportionately impacts communities of color. The 2018 "Count Us In" Point in Time County identified 53% of individuals counted as people of color as compared with 33% of King County general population.[18] Providing additional shelter may provide a location for these populations to come indoors and begin to connect with services. However, as discussed above, access to shelter does not necessarily translate into access to housing. System Performance data from July 2017-June 2018 indicates that 9% of single adult shelter stayers exit to permanent housing[19]. Finally, many individuals with lived experience in homelessness or currently living homeless have expressed through various Advisory Boards that they want more *housing* in our community, not more shelter beds. Agencies who provide outreach services report that many people living unsheltered decline shelter but state that they would accept permanent housing.

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[16] Seattle/King County Point-In-Time Counts of Persons Experiencing Homelessness, The Economics of Homelessness in Seattle and King County, McKinsey & Company

[17] ME Report https://www.kingcounty.gov/depts/health/locations/homeless-health/healthcare-for-the-homeless/~/media/depts/health/homeless-health/healthcare-for-the-homeless/documents/medical-examiner-analysis-homeless-deaths.ashx

[18] 2018 Count Us In Population was 53% persons of color as compared with 33% of King County general population. Seattle/King County Point-In-Time Count of Persons Experiencing Homelessness 2018. http://allhomekc.org/wp-content/uploads/2018/05/FINALDRAFT-COUNTUSIN2018REPORT-5.25.18.pdf

[19] Seattle-King County Continuum of Care system performance data. http://allhomekc.org/system-performance/

Housing Subcommittee
Analysis for the Harborview Leadership Group

APRIL 24, 2019

Agenda

- Subcommittee Members
- Overview
- Needs Statement
- Alternatives/Options
- Questions

Subcommittee Participants

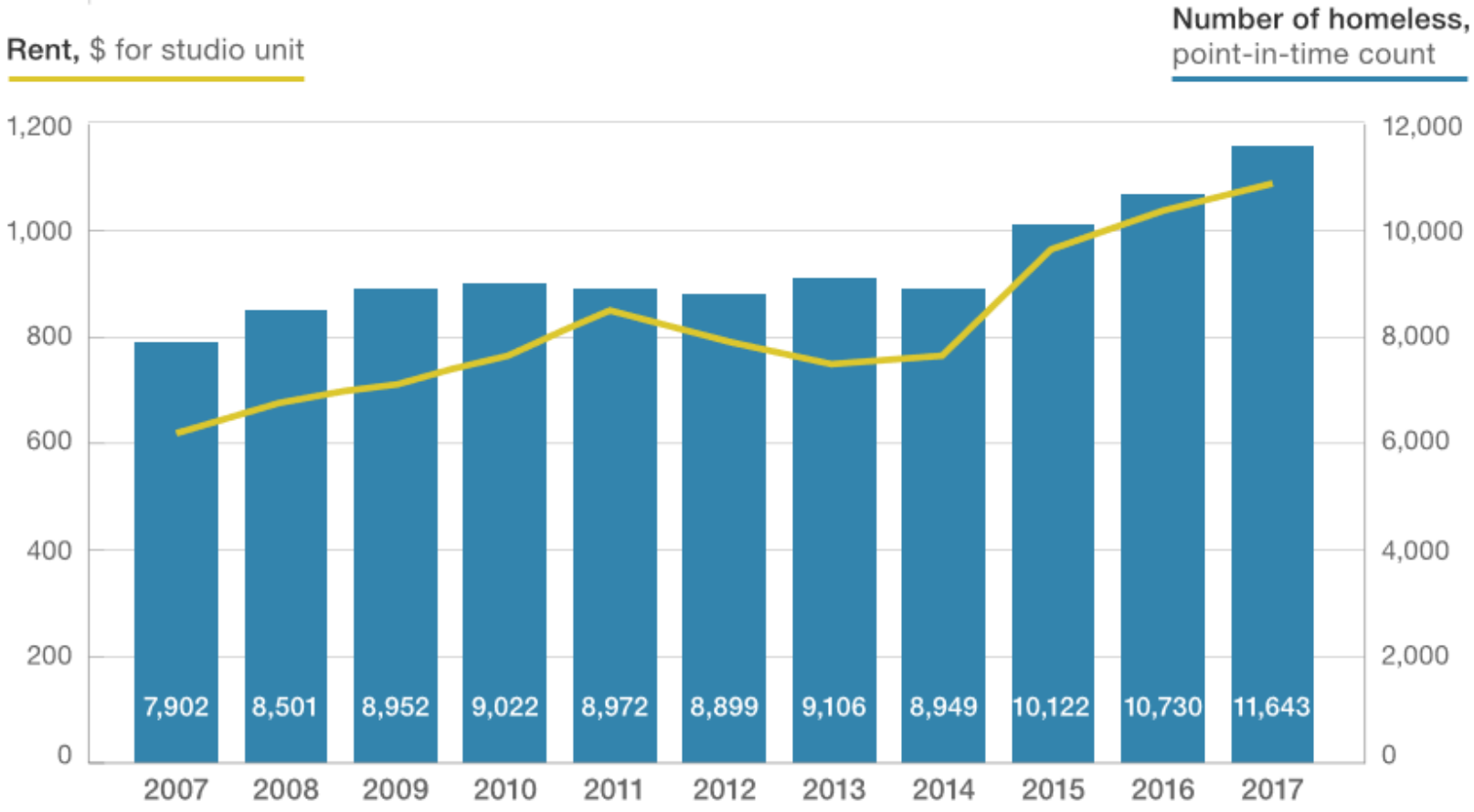
- Sid Bender, KC PSB
- Brook Buettner, KC Community and Human Services
- Kera Dennis, Harborview Medical Center
- Mark Ellerbrook, KC Community and Human Services
- Gregory Francis, Harborview Leadership Group
- Cristina Gonzalez, King County Facilities Management
- Patrick Hamacher, King County Council
- Ted Klainer, Harborview Medical Center
- Kelli Larson, Plymouth Housing
- Kristina Logsdon, King County Council
- Daniel Malone, DESC
- Xochitl Maykovich, Washington Community Action Network
- Leslie Miles, Project Manager
- Rod Palmquist, Washington Federation of State Employees

Overview of Housing-Related Options

- Respite
  Shelter with medical or clinical support
- Permanent Supportive Housing
  Non-time limited affordable housing with long-term high level of services, for households coming out of homelessness and with disabilities or conditions that create barriers to housing stability
- Workforce/ Affordable Housing
  Non-time limited housing for households with total income less than a particular percentage of AMI
- Shelter
  Temporary shelter from the elements and unsafe streets

Housing Subcommittee Needs Statement

King County



McKinsey& Company 2018

Housing Subcommittee Needs Statement

- Need for Respite care far outpaces supply
  - Medical: Currently 35 units shared by multiple hospitals, homeless only
  - Behavioral Health: Currently 20 units
  - Both facilities located in downtown Seattle
- Homeless population growing, need for Affordable Housing, Permanent Supportive Housing and Shelter
- Due to cost of housing on First Hill, many people working in the area are unable to afford to live nearby

Potential Options

- Option #1: No change
- Option #2: Increase Respite Capacity
  (Behavioral Health and Medical)
- Option #3: Increase Permanent Supportive Housing
  (Behavioral Health and Medical)
- Option #4: Increase Workforce/ Affordable Housing
- Option #5: Increase Shelter

….Or some combination of these increases

Option 1:
No Change

- No additional capacity for overstretched Medical and Behavioral Health respite programs
- Continued bottlenecks in discharging individuals with ongoing low-acuity need
- No additional capacity for housing for individuals living in homelessness
- No additional workforce housing near the Harborview campus

Option 2:
Increase Respite Capacity

- Respite is care for people who are homeless or unstably housed who are not sick enough to stay in the hospital but still need some level of care
- Temporary (Average 20 day length of stay in Medical Respite)
- Support patient flow and improve Harborview's ability to serve mission population patients that are turned away due to capacity limits (300/month turned away from ED)
- Jefferson Terrace Medical Respite bed night cost ~$400, compared to $1,000 or more for a hospital bed

Option 2 continued: Increase Respite Capacity

Medical Respite	Behavioral Health Respite
People experiencing homelessness or who are unstably housed, and are too injured to be on the street but not sick enough to stay in the hospital	Individuals who are homeless or unstably housed who are in psychiatric crisis and do not meet the criteria for inpatient hospitalization or detention
Can include daily RN, IV Infusion, wound and infection care, case management, therapies and activities of daily living	Can include behavioral support, case management, housing navigation, mental health care
Integrated "Layer Cake" building	
Medical and behavioral health conditions often co-occurring	
Integrated care allows maximum leveraging of staff and resources	
Step-up/step-down/lateral moves	
Including an outpatient clinic allows respite to leverage outpatient providers	

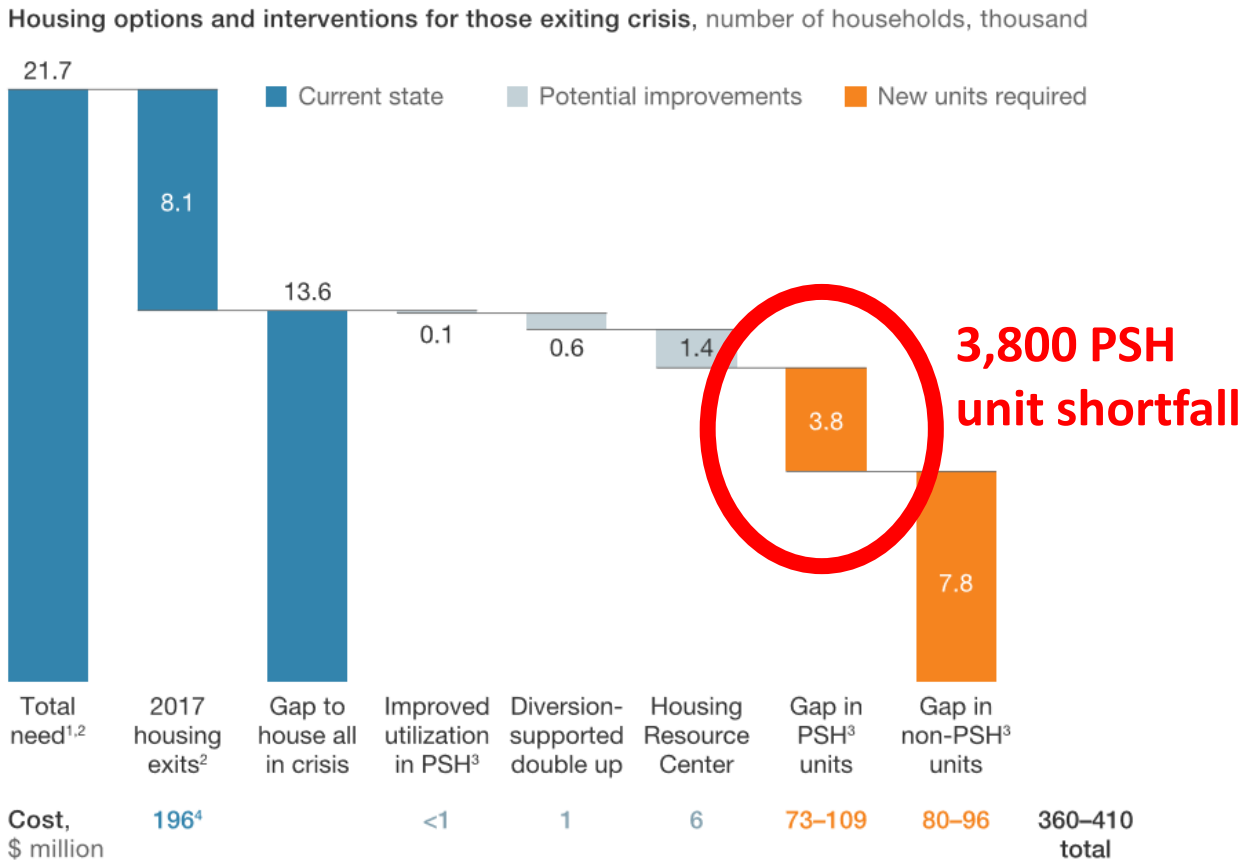
Option 3:
Permanent Supportive Housing

- Permanent Supportive Housing (PSH) =

  Non-time limited affordable housing with long-term high level of services, for households coming out of homelessness and with disabilities or conditions that create barriers to housing stability
- PSH Service Model generally targets behavioral health
- New and emerging work to integrate medical services in PSH buildings
- Need far outpaces supply
- PSH Shown to reduce hospital and ED utilization

Option 3 continued: Permanent Supportive Housing

King County



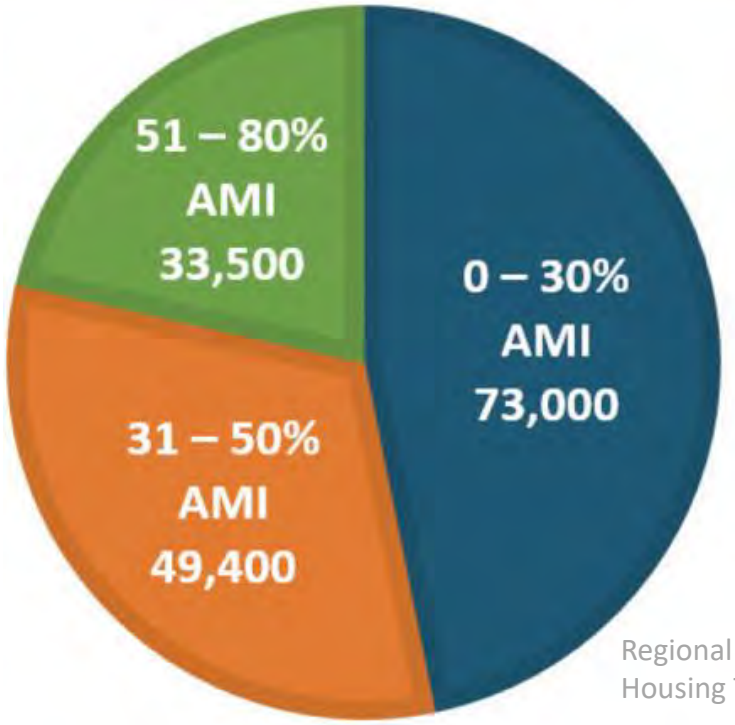
3,800 PSH unit shortfall

McKinsey& Company 2018

Option 4:
Workforce/ Affordable Housing

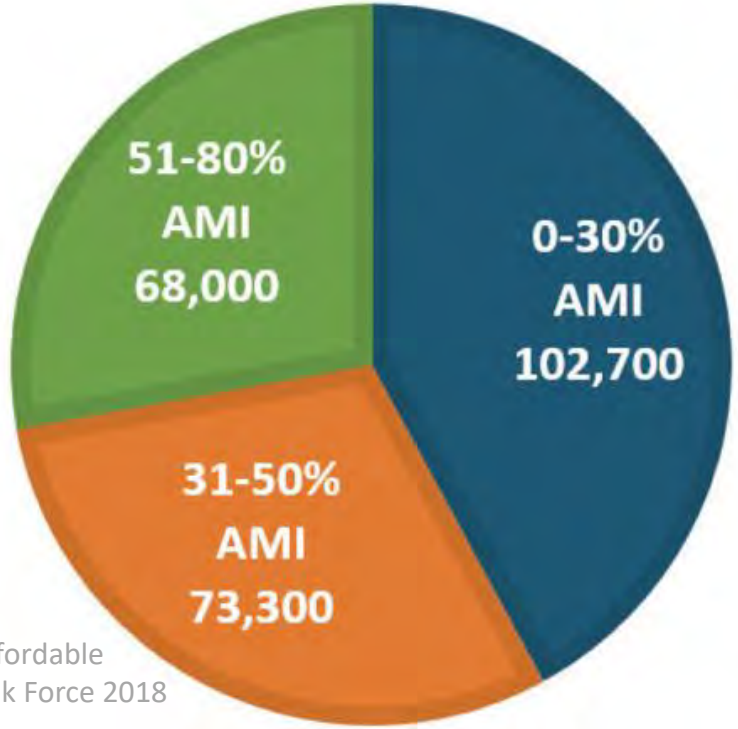
King County

AFFORDABLE HOMES NEEDED TODAY



Regional Affordable Housing Task Force 2018

HOMES NEEDED BY 2040



ANNUAL INCOME AT 30% AMI

1 Person Household	4 Person Household
$22,470	$32,100

Washington State Housing Finance Commission 2018

Option 4 continued: Workforce/ Affordable Housing

- Growing need for affordable housing, especially 0-30% AMI
- Housing can significantly impact access to healthcare
- Affordable housing could benefit Harborview mission population and people working on or near First Hill
- There are up to 1,280 Harborview employee households who would meet the criteria of 30% AMI
- Affordable Housing units would be available to the community at large

Option 5:
Increase Shelter Capacity

Emergency Shelter	Enhanced Shelter
• Temporary shelter from the elements and unsafe streets, often only overnight • Basic health, food, clothing and personal hygiene needs • Information and referral, basic Case Management	• 24/7, year round • Basic needs with additional services including storage for personal belongings • Case management services and housing navigation

Option 5 continued: Increase Shelter Capacity

Background Information Regarding Current Shelter Capacity in the Area

Nearby shelter capacity:

Shelter	Location	Number of beds
Harborview Hall*	9th and Jefferson	100
West Wing	5th and Jefferson	40
Admin Building	5th and Jefferson	50
City Hall Building	4th and James	150
4th and Jefferson	4th and Jefferson	50
DESC	3rd and James	200
Compass @ First Presbyterian*	8th and Spring	100
***operates 24/7**	**Total**	**640**

Harborview Hall Shelter Capacity:

- 100 beds at 9th and Jefferson
- To become an Enhanced Shelter in 2019
- Shelter availability contingent on future Harborview Hall redevelopment plans yet to be determined

Criteria

	1. No Change	2. Respite	3. PSH	4. Workforce Housing	5. Shelter
Area 1: People Impact					
Mission Population					
Patients and clients					
Labor and employees					
Neighbors and community					
Area 2: Service/Operational Impact					
Delivery of emergency services					
Addresses facility deficiencies and needs					
Supports innovation, best practices, and/or new models of care					
Area 3: Equity and Social Justice					
Service models that promote equity					
Influenced by community priorities					
Addresses Determinants of Equity					
Access to healthcare and improved health outcomes					
Area 4: Fiscal/Financial Impact					
The long-term financial position of Harborview and King County					
Existing facilities					
Opportunities for other funding					

Meets
Not Applicable
Does not meet

Questions?

Harborview Leadership Group
Housing Subcommittee Follow Up

JUNE 26, 2019

Recap of March 24 Housing Presentation

- Need for Respite care far outpaces supply
  - Medical: Currently 35 units shared by multiple hospitals, homeless only
  - Behavioral Health: Currently 20 units
  - Both facilities located in downtown Seattle
- Homeless population growing generating need for Affordable Housing, Permanent Supportive Housing and Shelter
- Due to cost of housing in Seattle, many people working in the area are unable to afford to live nearby HMC

Overview of Housing-Related Options

- Respite
  - *Shelter with medical or clinical support; time limited*
- Permanent Supportive Housing
  - *Non-time limited affordable housing with long-term high level of services, for households coming out of homelessness and with disabilities or conditions that create barriers to housing stability*
- Workforce/ Affordable Housing
  - *Non-time limited housing for households with total income less than a particular percentage of area median income (AMI)*
- Shelter
  - *Temporary overnight shelter*

Housing: Potential Options

- Option #1: No change
- Option #2: Increase Respite Capacity
  - (Behavioral Health and Medical)
- Option #3: Increase Permanent Supportive Housing
  - (Behavioral Health and Medical)
- Option #4: Increase Workforce/ Affordable Housing
- Option #5: Increase Shelter

….Or some combination of these increases

1. What is the cost of respite beds?

*Respite care provides **short term** housing for homeless or unstably housed individuals who need **acute and/or post-acute medical care** and who are too ill or frail to recover from a physical illness or injury on the streets but who are not ill enough to justify hospitalization*

- Jefferson Terrace Medical Respite cost = ~$400/ night or $12,000/month
- Costs include of nursing, pharmacy, care management and 24/7 Security Staff.
- Examples of medical care include: complicated wound care, antibiotic administration, cancer treatment, post operative care, burn care, and other medical care.

2. How does respite affect patient flow in the hospital?

- Provides discharge alternative for homeless patients
- Allows Harborview to serve more people by enabling discharge for homeless patients who would otherwise remain in an acute care bed without a medical need require that level of care.
- Ability to serve more patients currently turned away today due to hospital bed unavailability
- Average length of stay in respite beds: 22 days

3. a. How many cost-burdened employees are at HMC?
b. Where did the figures come from?

a. A refined estimate is under development, though not yet vetted.

b. The estimate of HMC employees eligible for affordable housing based on average median income (AMI) provided in April was based on data provided by one union representing some, but not all, workers at HMC. A wide range was identified in April due to unavailable information regarding average household size.

4. Does a workforce housing option for HMC campus intersect with other agencies focused on workforce housing?

- Seattle Housing Authority (SHA) is leading the efforts to redevelop Yesler Terrace, which will have approximately 4,000 new housing units.
- Of these, 2,000 will be market rate and 1,100 will be for households earning between 60% and 80% of Area Median Income (2 Person household $51,00 - $69,000; 4 person $64,000 to $86,000).
- Considering its proximate location, Harborview could explore a partnership with SHA (and its development partners) to provide access to vacant units (new and at turnover) to qualifying Harborview employees.

5. Which of the housing options offered in April best integrates with the BH Institute?

- The Behavioral Health Institute (BHI) at HMC consists of four programs addressing gaps behavioral health services. The BHI programs focus on:
  - improving care for youth and young adults with early psychosis
  - expanding telepsychiatry for the region
  - strengthening crisis intervention services
  - providing evidence based practice research and training
- Respite housing with behavioral health services for behavior management and therapies to improve activities of daily living could be supported by the expertise of the BHI
- Respite housing could provide discharge options and help prevent psychiatric boarding in Emergency Departments.

6. a. Which housing options align with primary care/behavioral health (e.g. layer cake)?

a. A Respite Care facility could include the following functions:

- Single building with different levels of care (see diagram on next slide)
- Ability to “step up” or “step down” from other programs, facilities, or within the facility
- Consistent with regional shift toward integration of behavioral health and medical care

6. b. What could an integrated Housing and Care Facility Scenario Look Like?

Services include: *Nursing, Pharmacy, Care Management & 24/7 Security Staff*

SAMPLE LAYERCAKE SCENARIO

6 Story Respite and Permanent Supporting Housing Facility Scenario		
6th Floor	Permanent Supportive Housing	15 Studio Units
5th Floor	Respite Care Medical	15 Studio Units
4th Floor	Respite Care Medical	15 Studio Units
3rd Floor	Respite Care Mental Health	12 Studio Units
2nd Floor	Respite Care Daily	15 Studio Units
1st Floor	Small Primary Care and Mental Health Clinic	3 - 6 Exam Rooms

Criteria Matrix: Housing

	1. No Change	2. Respite	3. PSH	4. Workforce Housing	5. Shelter
Area 1: People Impact					
Mission Population					
Patients and clients					
Labor and employees					
Neighbors and community					
Area 2: Service/Operational Impact					
Delivery of emergency services					
Addresses facility deficiencies and needs					
Supports innovation, best practices, and/or new models of care					
Area 3: Equity and Social Justice					
Service models that promote equity					
Influenced by community priorities					
Addresses Determinants of Equity					
Access to healthcare and improved health outcomes					
Area 4: Fiscal/Financial Impact					
The long-term financial position of Harborview and King County					
Existing facilities					
Opportunities for other funding					

Meets
Not Applicable
Does not meet

Subcommittee Members

- Sid Bender, KC PSB
- Brook Buettner, KC Community and Human Services
- Kera Dennis, Harborview Medical Center
- Mark Ellerbrook, KC Community and Human Services
- Gregory Francis, Harborview Leadership Group
- Cristina Gonzalez, King County Facilities Management
- Patrick Hamacher, King County Council
- Ted Klainer, Harborview Medical Center
- Kelli Larson, Plymouth Housing
- Kristina Logsdon, King County Council
- Daniel Malone, DESC
- Xochitl Maykovich, Washington Community Action Network
- Leslie Miles, Project Manager
- Rod Palmquist, Washington Federation of State Employees

King County

Harborview Leadership Group

Public Health

Subcommittee Report

August 28, 2019

Public Health Subcommittee Report

Leadership Group meeting date: August 28, 2019

Subcommittee Charge

The Public Health subcommittee is charged with conducting an analysis of Public Health – Seattle & King County facility needs and initial options for the Leadership Group to consider for its recommendations to the King County Council.

Summary

Several Public Health – Seattle & King County program-related capital project needs associated with the Harborview Medical Center (HMC) and its mission population are included in this report. The HIV/STD Clinic, Medical Examiner's Office, and TB Control Program would like to remain on the HMC campus, with additional square footage to accommodate caseload and staffing increases. Options for consideration include:

- Expand existing facilities on HMC campus to meet projected caseload increases and bring fragmented staff together at the HIV/STD Clinic, Medical Examiner's Office, and the TB Control Program.
- Co-locate Public Health's Refugee Health Screening Program with the TB Control Program.
- Purchase building in downtown Seattle core to ensure safety net access to health and human services.

Overview

Public Health – Seattle & King County (PHSKC) eliminates health inequities and maximizes opportunities for every person to achieve optimal health. Public Health protects its community from the spread of disease, provides primary care and linkages to specialty care, and seeks to address the social determinants of heath.

Historically, King County has contributed to the health safety net by owning the Harborview Medical Center (HMC) and running the public health system in the county. Services located on the HMC campus include: HIV/STD Clinic, King County Medical Examiner's Office, Tuberculosis Control Program, Public Health Laboratory, and Vital Statistics. Public Health has a history of being included in previous HMC bonds. Given the nature of the population Public Health serves, brick and mortar investment *off* of the HMC campus for a health and human services hub in the north end of downtown Seattle will better serve the safety net. Downtown Seattle has a large concentration of people experiencing homelessness which has driven the development of a variety of services to meet their needs, including healthcare, behavioral health and addiction services, and housing.

Public Health - Seattle & King County programs currently on the HMC campus:

- The **HIV/STD Clinic** is a collaboration between the University of Washington's Harborview Medical Center and PHSKC which has been in existence since 1972. The STD Clinic provides comprehensive STD diagnostic and treatment service. The STD Clinic currently shares their space with the MAX Clinic, a service for high-risk HIV patients that is a program of the UW's Madison Clinic. Space options are currently being explored for the MAX Clinic elsewhere on the HMC campus, potentially freeing up space for the HIV/STD Clinic to function at higher capacity.
- The **King County Medical Examiner's Office (KCMEO)** serves the community by investigating sudden, unexpected, violent, suspicious, and unnatural deaths - approximately 17% of all deaths in

King County. The MEO was included in the 2000 Harborview Medical Center bond that provided funding for their current location at the Ninth and Jefferson Building. Vital Statistics is currently co-located with the Medical Examiner's Office. A change to this co-location is currently under consideration to move Vital Statistics away from the HMC campus. This move would free up office space for the KCMEO.

- The **TB Control Program** serves the King County community by managing active cases of pulmonary Tuberculosis, providing oversight for active (contagious) TB cases, conducting contact investigations and providing consultation to community providers and other health facilities. Three quarters of all TB cases in King County are among the foreign-born (See Appendix, Figure 1, for countries of origin). Almost 40 percent of the TB Control Program's clients live in the City of Seattle; the remaining 60 percent living across the county – north, east and south of Seattle.
- The **Public Health Laboratory** is an essential component of Public Health's Prevention and Environmental Health divisions, providing infectious disease – related laboratory services for Public Health clinics, disease control programs, and research projects. Under an agreement with Washington State Department of Health, the lab serves as part of the state public health system. The Laboratory performs 80,000 to 90,000 tests per year. Most of these tests are for HIV, Syphilis, Hepatitis, Gonorrhea, and Chlamydia. Other tests include tests for TB, herpes, and immunity to chickenpox (varicella). About 70% of tests processed by the Public Health Lab come from the STD Clinic, the Gay City partner clinic, and the Downtown Refugee screening program. The remaining 30% come from other Public Health clinics including Community Health Services primary care and family planning, Jail Health, and the TB clinic. The lab's facilities on the HMC campus are satisfactory and do not require any additional square footage.

Public Health Programs on Harborview Medical Center campus with nexus to HMC bond discussion

Program	*Square footage*	*HMC location*	*On campus since*
MEO	34,047	NJB	1983
STD Clinic	13,282	NJB	2009
TB Clinic	4,095	Ground East Clinic	2000

PHSKC programs with a nexus to the HMC bond discussion not located on the HMC campus:

- The **Refugee Health Screening Program** provides the legally required health assessment services that newly arrived refugees and asylees must have, as well as linkage to other needed health and human services. The program currently serves predominantly Afghans and Ukrainians, with small numbers from the Democratic Republic of Congo, Ethiopia, Eritrea, as well as small numbers from Burma, Burundi, Cameroon, El Salvador, Ghana, Iraq, Kenya, Moldova, Nigeria, Russia, Senegal, Somalia, and Sudan.
- The **Downtown Public Health (PH) Center**, located in the Belltown neighborhood, provides critical services to low income, homeless, and refugee populations. Programs sited downtown include the Primary Care Clinic which offers pediatric care, adult health, OB care, services for children with special health care needs, prenatal care; WIC and First Steps; Kids Plus medical case management for homeless families; low barrier Buprenorphine access; Robert Clewis Center needle exchange and its co-located Harborview-run medical clinic; the homeless dental program; and refugee health screening. Together, these programs served over 7,700 unduplicated low income patients in 2018, 36% of whom were homeless, and the needle exchange provided an additional 17,500 encounters, 69% of which were to individuals who were homeless or unstably housed.[1] The downtown PH

[1] Needle exchange does not require registration for exchange services so unduplicated numbers of patients are not available.

Center is the flagship location of the federal Healthcare for the Homeless grant, and houses the PHSKC Needle Exchange. The Needle Exchange provides new, sterile syringes and clean injection equipment in exchange for used, contaminated syringes, and other harm reduction services to people who inject drugs including helping interested drug users find drug treatment and health care. Bupenorphrine Pathways is medication-assisted treatment program, an important intervention endorsed by the King County Heroin & Prescription Opiate Addiction Task Force to create treatment on demand for people who are ready to address their opioid use disorder.

Needs Statement

Benefits of HMC campus location

The HIV/STD Clinic, KCMEO, and TB Control Program all benefit from being housed on the HMC campus.

The **HIV/STD Clinic** location on the Harborview campus is advantageous for STD patients who may need referrals to specialty clinics (primarily due to complications from neurosyphilis - syphilis bacteria in brain or spinal cord - or newly diagnosed HIV). The ability to walk newly diagnosed HIV patients straight to the Madison Clinic directly linking them to HIV care contributes to our high success in HIV care linkage.

KCMEO has been in its new facility since 2009. In 2018, about 15% of cases came to the MEO directly from HMC with transfers between HMC and KCMEO happening efficiently via tunnel and elevator. KCMEO is a 24-hour a day facility, benefitting from HMC's power and security infrastructure. Despite parking, traffic and congestion challenges, KCMEOs central location allow for deployment of staff to deaths that occur across the entire county.

The **TB Control Program's** central location on the HMC campus allows for accessibility of pharmacy and radiology services for patients, and convenient access to HMC International Medicine Clinic. The TB program's medical director and providers regularly consult with Harborview providers and are able to quickly review chest x-rays. The program partners with University of Washington's residency program, and residents rotate through the clinic.

PHSKC's **Refugee Health Screening** program would benefit from co-locating with the TB program on the HMC campus. The program is currently located in Belltown, at the Downtown Public Health Center. Refugee Health Screening clients live primarily in South King County; however, they only visit the clinic one to two times. Sharing space with TB Clinic would allow for efficiencies through shared front office space. More importantly, it would allow for warm hand-offs to the TB Control Program and HMC's International Medicine Clinic (IMC) when indicated. A small number of refugees have class B1 status and require follow up from TB Clinic staff; being co-located with TB Clinic would allow us to coordinate those visits more smoothly. Housing Refugee Health Screening at Harborview would promote greater collaboration between IMC physicians with in-depth knowledge of refugee health and our refugee screening nurse, allowing our nurse to have greater access to the docs and to make immediate referrals. In the case of a serious health condition, the convenience of being able to get them quickly to the ER at HMC would be beneficial. The program sends blood samples to the public health lab at HMC after every clinic; it would be easier, more convenient, and cost effective for staff to deliver the samples directly.

Space Constraints

The HIV/STD Clinic, KCMEO, and TB Control Program project caseload increases and a need for additional space. Also, the Refugee Health Screening Program, if moved to the TB Control Program at HMC, would necessitate additional square footage.

- **HIV/STD Clinic**: The current facility will not meet the needs of the clinic in the long-term due to growing caseloads. In 2018, HIV/STD Clinic conducted 11,439 patient visits. There are currently over 600 persons receiving PrEP, a medication regimen to prevent the transmission of HIV. In 2029, up to 17,000 visits are projected. The continuing rise in STDs throughout King County combined with local and national impetus to get more at risk individuals on PrEP, the current facility will not meet our needs.
- **KCMEO**: Funded in the 2000 Harborview bond, the current space was built to last 25 years. In 2018, there were 14,842 total deaths in King County; the KCMEO assumed jurisdiction of 2,576 cases and performed 1,405 autopsies. By 2029, there will be an estimated 16,089 deaths in King County, with 3,260 cases referred to KCMEO and 1557 autopsies completed. Given population growth, increases in opioid-related and homeless deaths and other complex cases with specific storage needs, KCMEO will need to expand cooler, autopsy and lab space. In addition, KCMEO will need additional space for investigations staff. While a racking system to accommodate additional bodies in the cooler is being explored, this will not solve the need for the long-term. KCMEO anticipates the floor space vacated by Vital Statistics can be reconfigured to accommodate growing staffing needs, but may need to expand its footprint beyond the space freed up by Vital Statistics.
- **TB Control Program**: The current facility is aging and has insufficient space. This will be exacerbated if, as expected, the federal government mandates reporting of latent (non-contagious) TB infection within the next ten years which could result in following up on an additional 10,000 cases annually. See Appendix, Figure 2, for projections based on 5 different scenarios. Additionally, new federal funding will likely be awarded that will require space to accommodate staffing for new programming. The TB Control Program was scheduled to move in 2005 but due to financial constraints the move was delayed.
- The **Refugee Health Screening Program** is seeing about 104 refugees and asylees a month. Washington is fourth in the U.S. for resettlement, so compared to other states, arrivals are high and somewhat consistent. We estimate a continued 100 arrivals a month which is accommodated by operating clinic 2-3 days/week. The TB Control Program would only need minimal additional square footage to accommodate the Refugee Health Screening Program if colocation is pursued.

Downtown Public Health and Human Services Hub

In addition to maintaining its programs on the HMC campus, Public Health would like to maintain a presence in downtown Seattle to ensure health and human services are available in the north end of the downtown core. PHSKC currently offers services in a facility (Downtown Public Health Center at 4th & Blanchard) that is leased from a private landlord which poses uncertainty and risk as well as rising rental costs. A permanent, King County-owned location would ensure continued ability to meet the needs of our County's most vulnerable populations.

The Downtown Public Health Center has been at its current location since the early 1990s and has positive relationships with its commercial and residential neighbors. Many new businesses and hotels have moved in to the surrounding neighborhood without incident. Should the current lease be terminated, re-siting the existing services could be a considerable challenge due to the population served and the nature of the services offered.

Alternatives/Options

Facility Option #1: No change to current facilities

The status quo option for the HIV/STD Clinic, KCMEO, and TB Control Program would leave the three facilities at Harborview unchanged with no potential for growth nor improved functionality. Current facilities at HIV/STD Clinic and KCMEO, while sufficient today, will not meet the needs of increasing caseloads. The TB Control Program is overdue for a facility upgrade, and its current space does not meet program, staff and patient needs. TB Control Program staff are sited throughout East Clinic, fragmenting staff and creating inefficiencies. The inadequate space and configuration of the TB Clinic will only be exacerbated by growth in the coming years.

As the King County population grows, these programs will outgrow their current space at HMC. The status quo scenario would leave HIV/STD Clinic, KCMEO, TB Control Program inadequate space to serve their respective projected caseloads/workloads. With current square footage, there will be a negative impact on most of the HMC Leadership Group decision criteria, including access, workflow efficiency and productivity, and surge capacity.

Facility Option #2: Maintenance of effort for Public Health programs on the HMC campus with enhancements for growth and efficiency

Public Health's HIV/STD Clinic, KCMEO, TB Control program, and Public Health Laboratory would remain on the Harborview campus, allowing for growth of the HIV/STD Clinic, KCMEO, and TB Control program. Expanding the footprint of some of these HMC-located services would accommodate expected caseload growth, allow all staff to be housed together, reduce fragmentation and inefficiencies, and increase program cohesion. In addition, Refugee Health Screening Program would move to the HMC campus, co-located with the TB Control Program.

- **HIV/STD Clinic:** We would like to house all HIV and STD program staff at the same site. The clinic will not be able to handle this increase without additional space. Expanding the HIV/STD Program to a total 20,000 SF foot print could accommodate projected caseload increases and additional staff.
- **KCMEO**: Cooler capacity (cold storage for decedents) must be increased to meet growing demand for short and longer-term storage. This additional space could be adjacent to the current MEO facility, elsewhere on the HMC campus, or new cooler space shared with HMC. KCMEO will need more space for autopsy technicians, an additional pathologist and several additional death investigators as well as a larger cooler to store decedents and expanded space for in-house lab testing of drugs and specimens. Projected caseload growth will drive MEO's need for 15-30% more space within the next 10 years. Additional square footage needs range from 5,000 to 10,000 square feet.
- **TB Control Program**: The TB Clinic has insufficient capacity to house all employees and clinic operations, and the program will soon lose their small conference room. TB Control Program staff are fragmented; the Medical Director, clinic staff and research staff and epidemiologist are located in three different locations. Considering likely changes to federal reporting requirements for latent TB infection, and the expectation of new federal funding and hiring additional staff to take on new bodies of work, the TB program could use double the space they currently have at HMC. Redesigning or relocating the TB Control Program within an 8,200 SF foot print could accommodate all staff in one location with office and clinic space.
- **Refugee Health Screening Program**: The program is using only 3 rooms in its current location, and could be readily integrated into an expanded TB Control Program space.

Facility Option #2 would allow for improved workflow and efficiency, provide for increased surge capacity, allow for improved infection control and patient safety, position facilities for future growth and service demands, and provide ease of access for patients who are seen at both Refugee Screening and the TB Control Program and/or HMC's International Medicine Clinic. There would be the opportunity for physical introductions/hand-offs of patients, and better coordination of care.

Facility Option #3: Purchase building to maintain a County-owned health and human services hub in downtown Seattle

This option provides for purchase of a building in the north end of downtown Seattle to house a health and human services hub that would include adult and pediatric primary care, dental, support for children with special health care needs, maternity support services, WIC, needle exchange, pharmacy, etc. for safety net patients. These services are currently offered at 4th and Blanchard, a rental property. The proposed property acquisition would contribute to reducing disparities by race, place, and income by ensuring access to health and human services for marginalized populations.

The proposed investment would ensure the innovative integration of primary care, dental care, substance use disorder treatment, parent child health services, and harm reduction services under one roof. This approach significantly reduces barriers for individuals who face transportation and other challenges to accessing care. When providers make a warm hand-off to another provider in the Public Health Center, patients are much more likely to follow through on the referral, compared to an appointment scheduled off-site. With all the providers sharing an electronic health record, collaboration and case conferencing are efficient and simple.

The proposed acquisition would better position the County to accommodate future growth and service demands. Buprenorphine Pathways, PHSKC's low barrier opioid treatment program, has had a waiting list since its opening. The demand for dental services continues to outpace the clinic's capacity, and procedures take on average two weeks longer to schedule than at other Public Health dental clinics in the county. To meet the increasing demand for our services, current expansion plans include a remodel of the 4th floor of the current building to quadruple Buprenorphine Pathways capacity as well as the addition of two dental chairs to the homeless dental program in 2020. But as a tenant, PKSKC must expend County funds for these improvements with no guarantee of long term tenancy, and Public Health has had to forgo applying for multiple federal capital improvement grants for the current site due to federal lease requirements that the landlord is unwilling to meet. As demand continues to grow, downtown is the optimal location to site the Familiar Faces[2] vision for a drop-in Campus of Health- a health and human services hub that would include space for additional County programs and community partners. The campus would provide a strategic mix of person-centered services all under one roof while serving as a resource for emergency responders to divert patients away from unnecessary emergency room utilization or incarceration. A property owned by King County would enable Public Health to make long- term infrastructure investments to accommodate this growing need and achieve our future vision without the looming risk of lease termination. The total square footage of the 4th and Blanchard building is 25,497 and Public Health is currently using 21,500.

Facility Option #3 would improve access, allow for improved workflow and efficiency, and positions facilities for future growth and service demands.

[2] The Familiar Faces initiative is a collective impact effort centered on creating a system of integrated care for complex health populations. https://www.kingcounty.gov/elected/executive/health-human-services-transformation/familiar-faces.aspx

Summary Conclusions

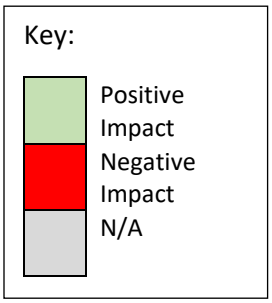
The facility responses presented herewith are not mutually exclusive and seek to meet Public Health's needs as follows:

- TB Control Program facilities are currently inadequate
- Refugee Health Screening and the TB Control program would benefit from co-location
- HIV/STD and KCMEO facilities are adequate now, but will need additional space in the future
- King County and safety net patients would benefit from a permanent health and human services hub in the downtown core

Note: The Public Health Subcommittee supports the expansion of respite care at Harborview, though it is omitted here because it was included in the work of the Housing Subcommittee. Public Health provides significant funding for the current respite program through the Health Care for the Homeless federal grant and the Mental Illness and Drug Dependency (MIDD) fund.

Criteria Matrix

	Option 1: No Change	Option 2: HMC	Option 3: downtown
Area 1: People Impact			
Mission Population			
Patients and clients			
Labor and employees			
Neighbors and community			
Area 2: Service/Operational Impact			
Delivery of emergency services			
Addresses facility deficiencies and needs			
Supports innovation, best practices, and/or new models of care			
Area 3: Equity and Social Justice			
Service models that promote equity			
Influenced by community priorities			
Addresses Determinants of Equity			
Access to healthcare and improved health outcomes			
Area 4: Fiscal/Financial Impact			
The long-term financial position of Harborview and King County			
Existing facilities			
Opportunities for other funding			



Appendix

Figure 1: Country of origin, TB cases in King County, 2017

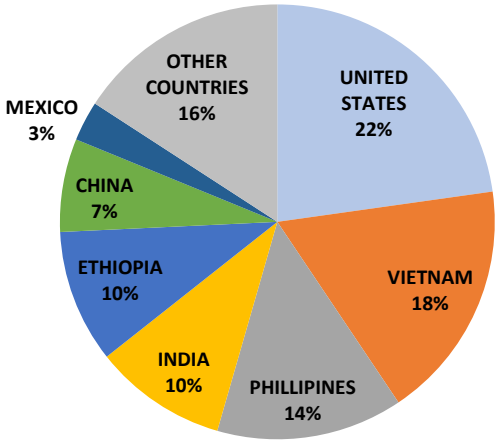
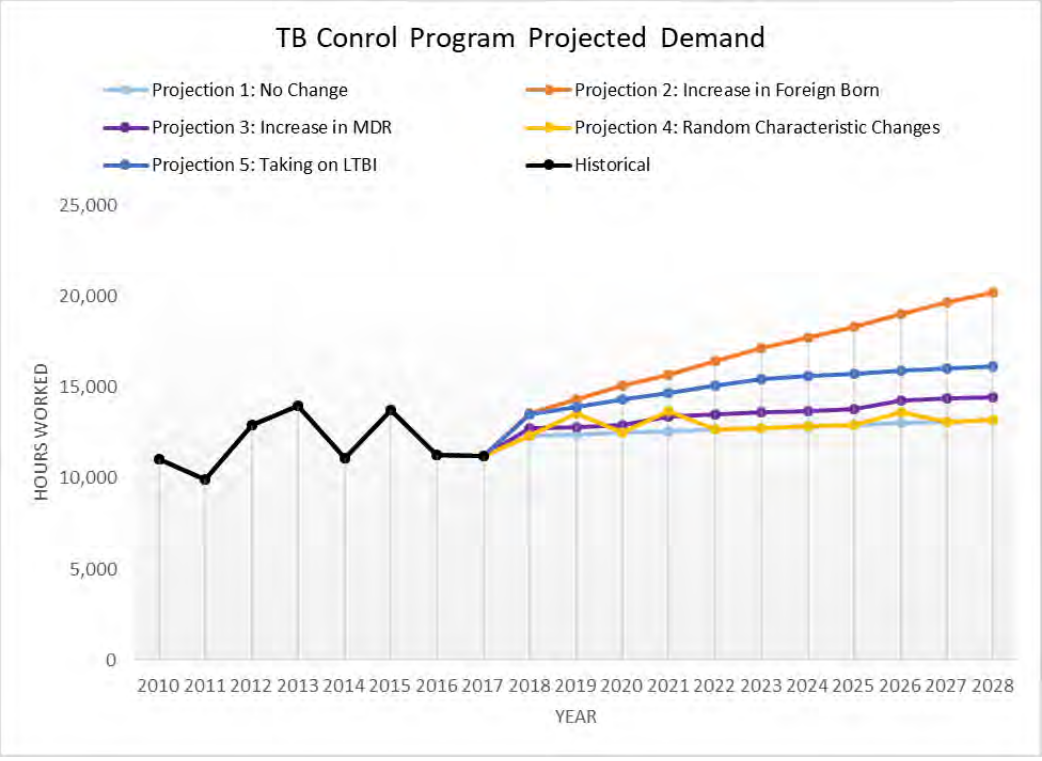


Figure 2: TB Control Program projected demand for TB clinical services under several scenarios



*Note: MDR = Multi=-drug resistant TB

Public Health Subcommittee
Analysis for the Harborview Leadership Group

AUGUST 28, 2019

Subcommittee Members

- Anne Burkland, Public Health – Seattle & King County
- TJ Cosgrove , Public Health – Seattle & King County
- Maria Wood, Public Health – Seattle & King County
- Dennis Worsham, Public Health – Seattle & King County
- Drew Pounds, Office of Performance, Strategy and Budget, King County Executive's Office
- Katie Ross, Office of Performance, Strategy and Budget, King County Executive's Office
- Brigitte Folz, Harborview Medical Center
- Ted Kleiner, Harborview Medical Center
- Lan Nguyen, King County Council
- Sam Porter, King County Council

Overview – Public Health and Safety Net

King County contributes to the health safety net by running the Public Health system and owning Harborview Medical Center (HMC)

- PHSKC eliminates health inequities and maximizes opportunities for every person to achieve optimal health
- PHSKC protects the community from the spread of disease, provides health care and linkages to specialty care, and seeks to address the social determinants of health
- Public Health services on HMC campus include HIV/STD Clinic, King County Medical Examiner's Office (KCMEO), Tuberculosis (TB) Control Program, Public Health Laboratory, and Vital Statistics

Overview – Public Health at HMC

PHSKC programs on the HMC campus with capital needs:

- **HIV/STD Clinic**
  - STD diagnosis and treatment; over half of patients are MSM (men who have sex with men)
  - UW partnership
- **Medical Examiner's Office**
  - Investigates sudden, unexpected, violent, suspicious, and unnatural deaths
  - Included in 2000 HMC bond
- **Tuberculosis Control Program**
  - Manages active cases of pulmonary TB, conducts contact investigations, and provides consultation to community providers
  - 75% cases among foreign-born

Program	Square footage	HMC location	On campus since
MEO	34,047	NJB	1983
STD Clinic	13,282	NJB	2009
TB Clinic	4,095	Ground East Clinic	2000

Overview – PH Programs Downtown

PHSKC programs *not* located on the HMC campus with a nexus to the HMC bond discussion:

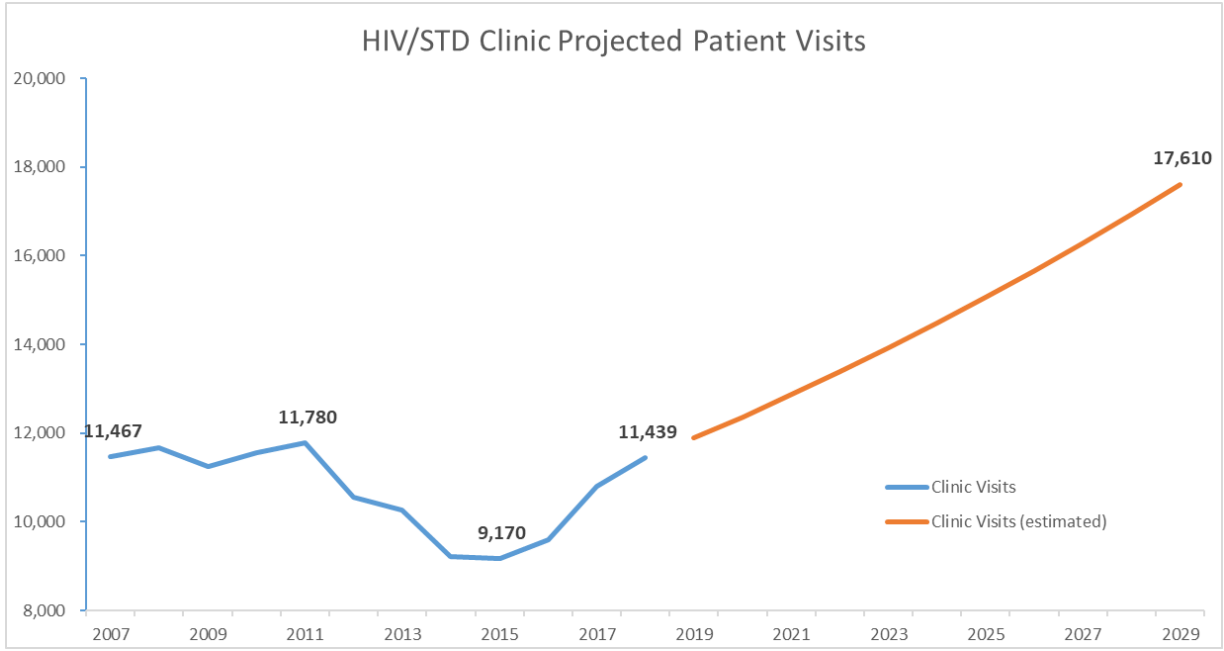
- **Refugee Health Screening Program**
  - Provides the legally required health assessment services for newly arrived refugees and asylees
  - Provides linkage to other needed health and human services
- **Downtown Public Health Center**
  - Serves low-income, homeless and refugee populations
  - Services include adult health care and Swedish family medicine residency program, dental clinic, travel clinic, Refugee Health Screening, WIC, and Needle Exchange Program

Needs Statement

- HIV/STD Clinic, KCMEO, TB Control Program benefit from being housed on the HMC campus
  - All three programs anticipate growth and need for additional space
    - HIV/STD Clinic projects caseload increases
    - KCMEO projects caseload increases
    - TB Control Program projects active TB caseloads to remain level; latent TB infection to become reportable, increasing workload; and additional federal funding necessitating staff increases
    - Refugee Health Screening and TB Control would benefit from co-locating on HMC campus
- Downtown Public Health needs a permanent home to ensure health and human services for the safety net population in downtown Seattle

HIV/STD Clinic Needs

- 2018: STD Clinic conducted 11,439 patient visits
- 2029: Project 17,000 visits
- Ability to refer patients to specialty clinics and/or walk them directly to Madison Clinic important for continuity of care



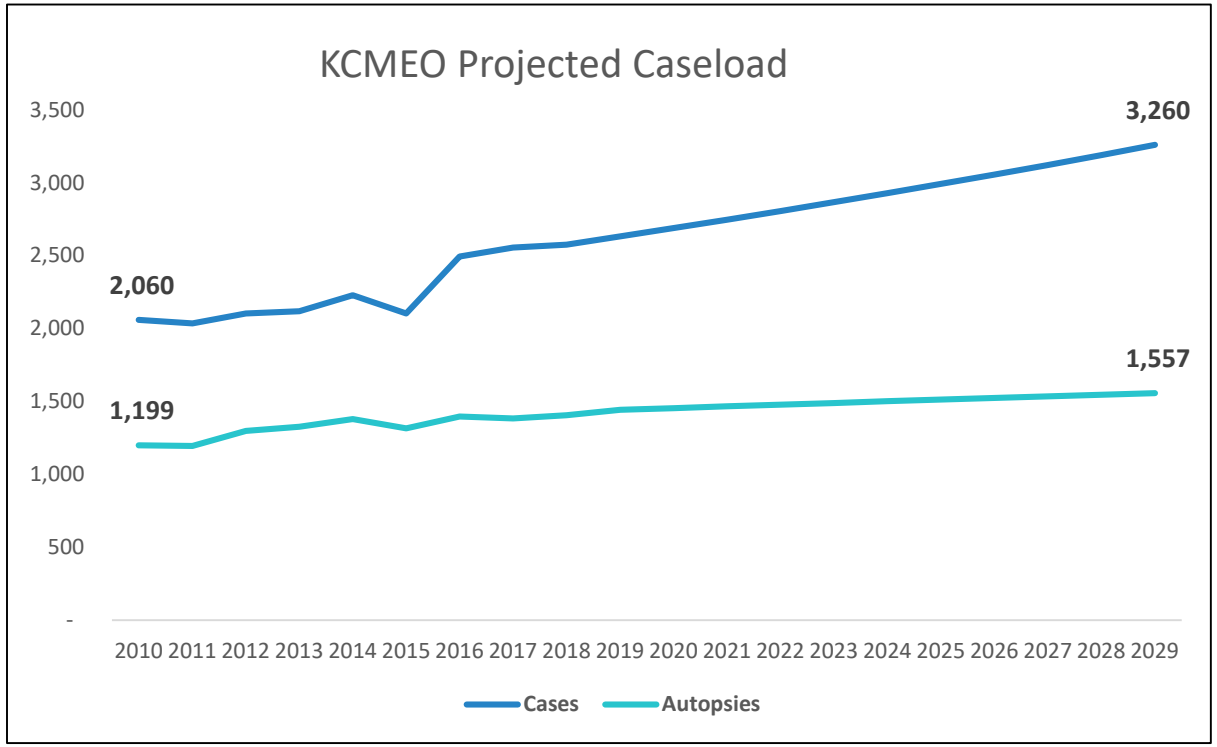
KCMEO Needs

Space needs will increase due to:

- Population growth
- Opioid-related
- Homeless deaths

Additional space needed for:

- Cooler space
- Investigations staff
- Autopsy
- Laboratory

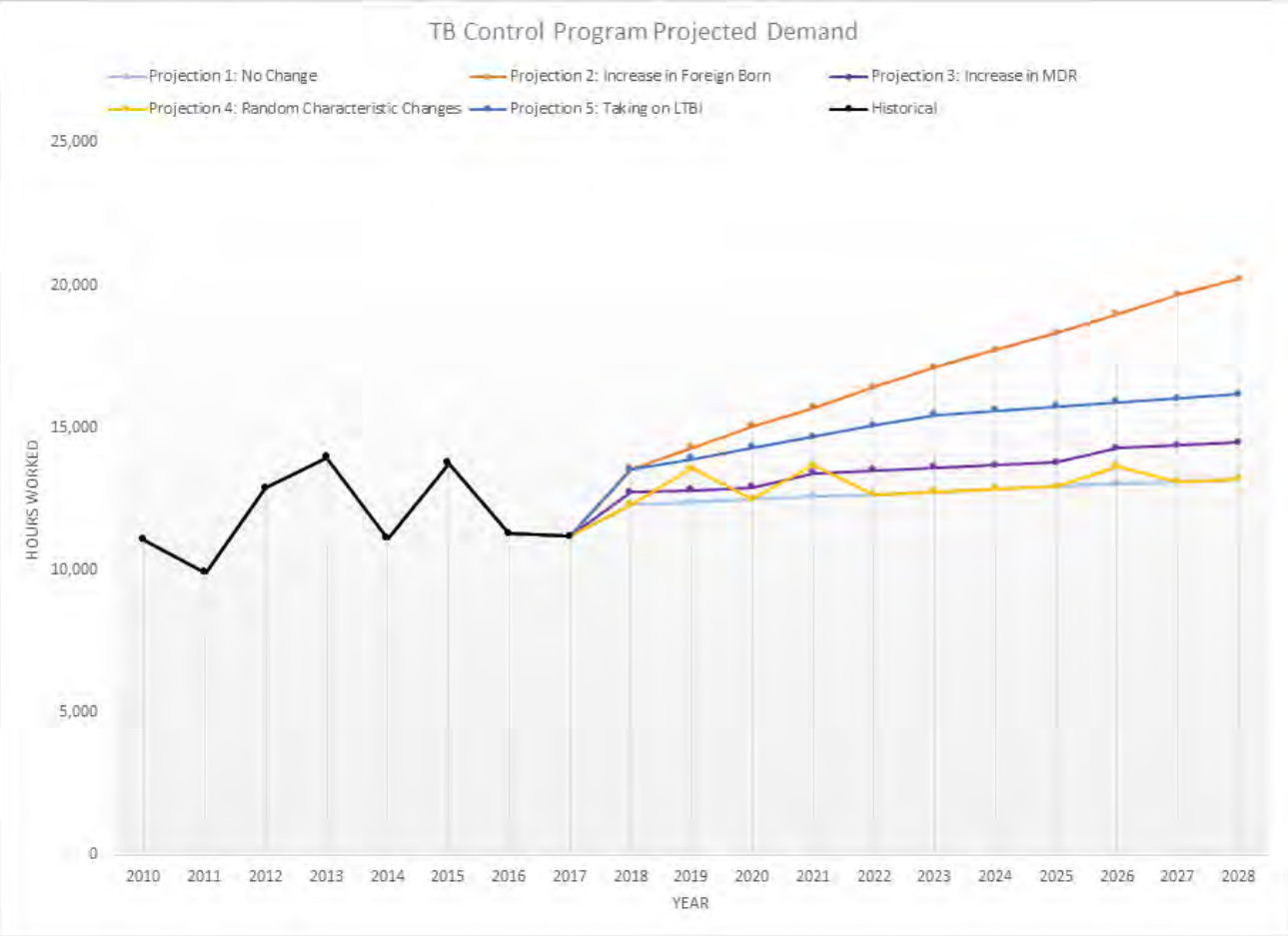


About 15% of 2018 cases came directly from HMC with no need for vehicle transfer

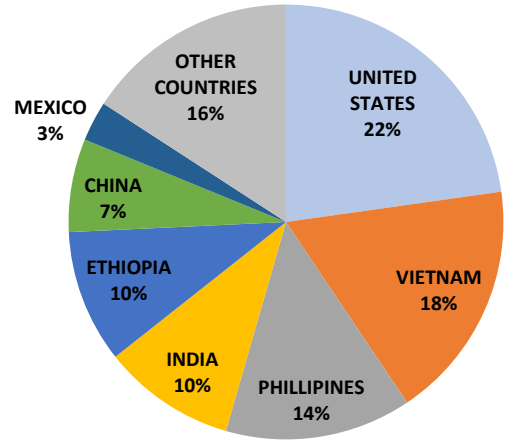
TB Control Program Needs

- Location ideal
  - Access to radiology and pharmacy
  - Proximity to HMC International Medicine Clinic
- Workload
  - Active TB cases likely to remain flat - ~ 100 cases per year
  - Federal government will likely mandate latent TB infection reporting
    - Estimated 100,000 cases of latent TB infection in King County; TB Control Program following up with 10%
- Two sources of CDC funding will likely be awarded
  - Staffing and space increases
- Co-locating Refugee Screening with the TB Control Program would allow for administrative efficiencies and ease of referral to TB and HMC's International Medicine Clinic
  - Refugee Screening estimates 100 arrivals per month, running clinic 2 – 2.5 days/week

TB Control Program Needs



TB Control Program, country of origin of active TB cases, 2017



Downtown Public Health Needs

- Downtown Public Health Center at 4th & Blanchard is leased from a private landlord - poses uncertainty, risk, rising rental costs
- Should the current lease be terminated, re-siting the existing services would pose a considerable challenge for PHSKC due to the population served and the nature of the services offered
- A permanent location will ensure our future ability to meet the needs of our County's most vulnerable populations

Alternatives/Options

- Option 1: No change
- Option 2: Maintenance of effort for Public Health programs on the HMC campus with enhancements for growth and efficiency
- Option 3: Purchase building to maintain a County-owned health and human services hub in downtown Seattle

….Or both 2 and 3

Option 1: No Change

- No change for the HIV/STD Clinic, KCMEO, and TB Control Program would leave the three facilities at Harborview with no potential for growth nor improved functionality
- Current facilities at HIV/STD Clinic and KCMEO, while sufficient today, will not meet the needs of increasing caseloads in the future
- TB Control Program is overdue for an upgrade; it does not meet program and patient needs *currently*

Without increased square footage, there will be a negative impact on most of the HMC Leadership Group decision criteria, including access, workflow efficiency and productivity, and surge capacity.

Option 2: Maintenance of effort of Public Health programs on HMC campus; enhancements for growth and efficiency

Public Health's HIV/STD Clinic, KCMEO, TB Control program, and Public Health Laboratory remain on HMC campus

- Expand the footprint of the HIV/STD Clinic, KCMEO, and TB Control program
- Co-locate Refugee Health Screening Program with the TB Control Program

Additional space needs:

- HIV/STD add about 6,700 additional SF
- KCMEO add 5,000 – 10,000 additional SF
- TB Control Program add about 4,200 SF

Facility Option #2 improves access, workflow, efficiency, surge capacity, infection control, and patient safety, and positions facilities for future growth and service demands.

Option 3: Purchase building to ensure the long-term presence of a downtown health and human services hub

Purchase building in downtown Seattle for health and human services hub for safety net patients, including adult and pediatric primary care, dental, support for children with special health care needs, maternity support services, WIC, expanded buprenorphine program, needle exchange, and pharmacy

- Reduce disparities by race, place, and income by ensuring access to health and human services for marginalized populations
- Ensure innovative integration of primary care, dental care, substance use disorder treatment, parent child health services, and harm reduction services all under one roof
- Significantly reduce barriers for individuals who face transportation and other challenges to accessing care

Facility Option #3 would improve access, allow for improved workflow and efficiency, and positions facilities for future growth and service demands.

Summary Conclusions

The facility responses presented are not mutually exclusive and seek to meet Public Health's needs as follows:

- TB Control Program facilities are currently inadequate
- Refugee Health Screening and the TB Control program would benefit from co-location
- HIV/STD and KCMEO facilities are adequate now, but will need additional space in the future
- King County and safety net patients would benefit from a permanent health and human services home in the downtown core

Criteria

	Option 1: No Change	Option 2: HMC	Option 3: downtown
Area 1: People Impact			
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Labor and employees			
Neighbors and community			
Area 2: Service/Operational Impact			
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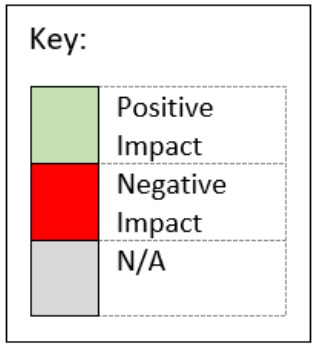
Area 4: Fiscal/Financial Impact			
The long-term financial position of Harborview and King County			
Existing facilities			
Opportunities for other funding			



Questions?

King County

Harborview Leadership Group

Pioneer Square Clinic

Subcommittee Report

August 28, 2019

Pioneer Square Clinic Subcommittee

August 28, 2019

Summary

- Pioneer Square Clinic, operated by Harborview Medical Center, is at capacity and in need of significant upgrades to improve healthcare quality and availability for underserved residents of King County
- The extent of renovations will be considered within the context of operating and program decisions.
- The clinic meets a unique need for comprehensive and low barrier health care in King County, the demand for which is increasing.

	No Change	Remodel	Move to new building	Close clinic and move to Hobson	Downsize and move to Hobson
Area 1: People Impact					
Mission Population					
Patients and clients					
Labor and employees					
Neighbors and community					
Area 2: Service/Operational Impact					
Delivery of emergency services					
Addresses facility deficiencies and needs					
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Addresses Determinants of Equity					
Access to healthcare and improved health outcomes					
Area 4: Fiscal/Financial Impact					
The long-term financial position of Harborview and King County					
Existing facilities					
Opportunities for other funding					

Positive Impact
Negative Impact
N/A

Overview

Harborview Medical Center (HMC) was founded in 1877 as a six bed hospital for people living in poverty in Seattle. Since that time, it has evolved into a comprehensive health care facility dedicated to the control of illness and promotion and restoration of health for King County residents. Prominent in HMC's primary mission is the provision of exemplary, comprehensive healthcare for the most vulnerable residents of King County including people who are uninsured or underinsured, have limited English proficiency living below the poverty level, and those who experience mental illness and substance use issues, regardless of their ability to pay. HMC, as part of the University of Washington, is in the unique position to provide cutting edge medical care within a public hospital that over many years has developed and refined an extensive safety net for homeless patients.

One example of service that exemplifies Harborview's mission is the Pioneer Square Clinic. The Pioneer Square Clinic was established 45 years ago in its location at the base of the county's original Skid Road. The clinic is a critical part of the health safety net and coordinates closely with hospital, shelters, housing, and transportation services in order to provide patients with a full range of care and resources during their visits. In addition to primary care, the services offered include acute episodic care; psychiatry; social work and pharmacy. As part of the Harborview Medical Center's family of services, the clinic is operated by Harborview's physicians and administrators and is also host to a highly sought after residency training program for medical students The concentration of people in this area experiencing addiction, mental illness, or homelessness and poverty have made it an essential location to provide care to some of the county's most vulnerable patients. Over the years the clinic has developed a multi-disciplinary approach to patient care with primary and urgent care provided alongside social work, pharmacy, podiatry, nutrition and psychiatry.

This "one-stop shopping" model has made it easier for patients to have a true health home without the hindrance of having multiple appointments at multiple sites on different days. Pioneer Square Clinic remains one of the few sites in downtown Seattle that offers open access to walk-in appointments for acute medical and mental health care alongside scheduled primary care appointments. Pioneer Square Clinic was developed to serve people using the shelters in the area and making frequent emergency room visits. The design of low barrier with both walk-in and scheduled appointments near other survival services is in response to the communities concerns about undertreated and served people. These clinics support the city and counties goals by addressing both the medical needs and social determinates of health.

Pioneer Square Clinic services a diverse patient group: 40% are people of color, 12% primary language is not English and 44.5 – 65% are unhoused, 96.92% are on publically supported insurance or uninsured. During the last bond process 20 years ago, Pioneer Square Clinic received no upgrades.

Needs Statement

Pioneer Square Clinic is operating at capacity. Despite being open 50 hours a week Monday through Friday, it turns away patients daily. The clinic currently has 7 exam rooms and 4 rooms for supportive services, and saw approximately 8,500 patients in FY 19, with the majority using Medicaid (50%) or Medicare (33%). While there is limited space for procedures and monitoring of patients in the Pioneer Square Clinic, the need for outpatient, lower acuity care in the area is evident. First Responders in the Pioneer Square neighborhood reported that, in 2018, they received roughly 5,200 calls. 50% of these calls were lower acuity, but 1000 of these lower acuity patients were transported to Harborview Medical Center's Emergency Department. Many of these patients could be better served by an outpatient clinic, such as PSC, rather than being transported to an emergency department. Expanding the Pioneer Square clinic could help to prevent Emergency Department visits such as these and overcrowding at Harborview Medical Center. Providing comprehensive low barrier integrated care in the community increases access to medical services, reducing the expensive emergency room or inpatient hospitalization. This allows the hospital to remain focused on people who need emergency care with access to both the emergency room and inpatient beds. It also allows access for planned procedures ensuring efficient patient flow by having a primary care provider established for follow-up and chronic disease management.

Beyond improving efficiency and access to care at Harborview's main campus, improvements to the Pioneer Square Clinic also serve to improve care to some of the county's most vulnerable residents. Updates to Pioneer Square Clinic would provide up to date and fully functioning clinical care in an improved setting for a diverse range of people, many of whom are unhoused or low income. In addition to a growing demand for services due to increases in homelessness within King County, the clinic also requires enhanced chemical dependency care and Behavioral Health integration on site to better serve its patients.

Despite space constraints and setbacks in the current building, the location itself plays a vital role in patient care. The building is in close proximity to four homeless shelters and several low income and Housing First complexes. The clinic's close proximity to these locations benefits patients who have difficulty traveling distances in order to make appointments and are often concentrated in areas that serve their needs. However, the building itself is a 1904 Historic Landmark that requires extensive renovations in order to fully utilize its capacity. Pioneer Square Clinic is currently grandfathered in to its building code meaning any renovations made to the space would require bringing the entire clinic up to current Department of Health code and its Historic Landmark status limit any exterior changes. Additionally, increasing demands for care in other parts of King County, such as south of the downtown area, indicate that there is a need for quality health care for unhoused and low-income individuals beyond the many people currently being served in Pioneer Square alone.

Alternatives/Options

Facility Option 1: No Change

Maintaining the current facility as it operates now limits the ability of Harborview to serve individuals in the Pioneer Square area. The pictures below demonstrate the space constraints currently faced by the clinic. Additionally, increased need for lower acuity services, behavioral health and substance use for homeless or sheltered individuals in the area will remain unmet as the clinic continues to turn away patients due to limited resources and space. Some of the examples below illustrate space issues such as; the hallways are not large enough for passage when patients are at the service desk requiring patients to move away from the desk in order to allow another person to move down the hallway to the bathroom or supportive services; the pharmacy window is in the middle of a walkway to the nursing triage desk and exam rooms; and exam rooms are not large enough for procedures or full access to the patient with inadequate space for supplies to be stored. The building currently requires significant HVAC, plumbing and electrical upgrades. Water pipes often burst and flood exam rooms, leaving them unavailable to serve patients. Leaving Pioneer Square Clinic with no upgrades or changes leaves a significant gap in quality and availability of health care services to Harborview's mission population. In conjunction, Harborview's main campus emergency room will continue to see increases in lower acuity patients and inefficient patient flow if Pioneer Square Clinic remains without any upgrades or improvements.

Option 2: Remodel Existing Pioneer Square Clinic

Ideally, a remodeled building would have a clinic on the first two floors, administrative services on the third and community-based partnerships, such as outreach teams and local police departments, on the fourth. The basement can be used for storage of medical supplies and equipment. An upgraded clinic would improve access for patients to quality health care and potentially lower the patient volume entering Harborview's Emergency Room.

As stated earlier, any minor renovations made to the interior of the building would trigger a full renovation of the clinic, allowing it to finally meet the current code requirements. For example, current codes will require larger exam rooms and a standard ceiling height. The existing clinic has very small exam rooms and a very low ceiling. A consultant team will need to evaluate the viability of remodeling the clinic in its current constrained location. Additionally, a renovation of the clinic would also require relocating services to a temporary space while renovations took place.

Option 3: Move Clinic to New Location in the Pioneer Square Area

An additional option explored by this subcommittee was the potential of purchasing or leasing a new space in Pioneer Square. While the option to move the clinic to a new location eliminates the need to find a temporary space to serve patients during any potential renovations, King County does not currently own any available property in the Pioneer Square Area. Purchasing or leasing a new building or property would require a more focused, intentional exploration of available property and a significant investment.

Option 4: Close clinic and move operations to the 22nd and Rainier clinic (Hobson Place)

Harborview Medical Center and DESC have proposed plans to open an integrated primary care clinic on 22nd and Rainier Avenue. The new 22nd and Rainer clinic site is recognition of the homeless and vulnerably housed population increasing south of the downtown corridor. The proposed clinic would offer two permanent supportive housing buildings with 85 and 90 housing units opening in Fall 2020 and 2021, respectively. This location has proximity to 175 units of permanent supportive housing, 3 shelters and numerous encampments in the area that are underserved in their medical care. Additionally, the clinic would have about 28,000 square feet of clinical space for integrated primary care, behavioral health and a pharmacy. The plans include a gurney bay area to receive low acuity patients from SFD and 2 procedure rooms allowing for people to be cared for in the most appropriate setting and increasing access in HMC emergency room and hospital. Additionally the clinic will have capacity for telemedicine support to nursing and mental health providers in shelters and Housing First complexes. Relocating the services currently provided at Pioneer Square Clinic would leave an unmet need for individuals in the area, but offers the potential of a more diverse range of services for other patients. Leaving an unmet need in the Pioneer Square area could result in an increase in lower acuity emergency department visits at Harborview. Harborview is currently exploring ways to fund this mission critical initiative. Early estimates indicate that the clinic will cost $5M/year.

Option 5: Move the main clinic to Hobson Place and leave a downsized function in PSC with residency with minor renovations

Harborview Medical Center would move part of the current staff to Hobson place at 22nd and Rainer to provide primary care to patients who can transition to a new medical site and people who have unmet medical needs in the area. The clinic in Pioneer Square would undergo some minor renovations to improve functionality, but the hours of operations would be reduced.

Pioneer Square Clinic would then focus on training medical residents in becoming primary care physicians to people with complex medical needs that are greatly influenced by social determinants of health. Both sites will function as a medical home and provide daily walk-in appointments. Retaining both locations would ensure services are available in both areas where needs are evident. Both the Pioneer Square Clinic and Hobson Place are located in areas with access to a number of different transportation options for patients to utilize. Harborview is still determining the fiscal impacts of operating the two clinics at this time.

Pioneer Square Clinic Subcommittee
Analysis for the Harborview Leadership Group

AUGUST 28, 2019

Subcommittee Members

- Tricia Madden, Harborview Medical Center
- Ted Klainer, Harborview Medical Center
- Katie Ross, King County PSB
- Lan Nguyen, King County Council
- Bailey Bryant, King County Office of the Executive
- Leslie Harper-Miles, King County FMD

Overview

- Pioneer Square Clinic was established 45 years ago as a critical part of the health safety net for the county's most vulnerable residents
- Services offered:
  - Primary Care Medical Home
  - Acute episodic care
  - Psychiatry, Social Work, Mental Health
  - Podiatry
  - Nutrition
  - Pharmacy
  - Opioid Based Outpatient Treatment (OBOT)
- Built in 1904, Pioneer Square Clinic is a historic landmark and currently grandfathered in to its clinic code – any major changes made to it would require bringing the entirety of the clinic up to current Department of Health and City standards
- Neighborhood has 6 homeless shelters, 7 low in-come housing complexes, 3 senior housing complexes, multiple food and survival services and only 1 medical clinic (PSQ Clinic)

Needs Statement

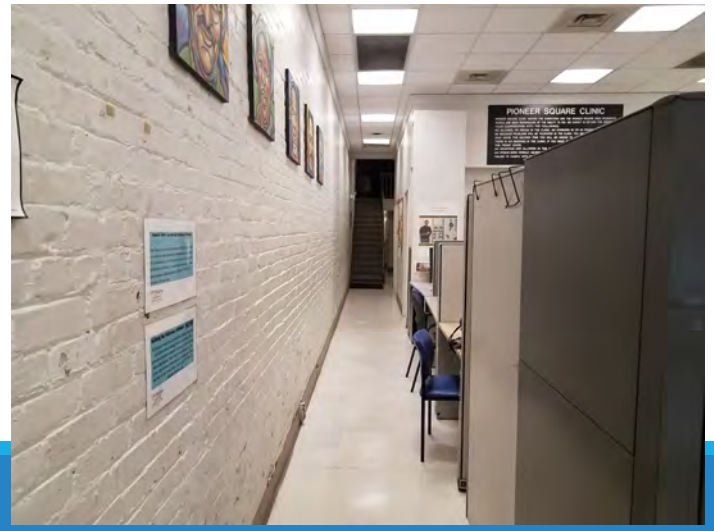
- Pioneer Square Clinic is open 50 hours a week Monday – Friday and is turning away patients daily
- The clinic is need of significant HVAC, plumbing and electrical upgrades to maintain quality care for patients
- Pioneer Square does not have a procedure area and must call 911 for transport to HMC emergency department instead of stabilizing lower acuity needs in the clinic but requiring more room that current exam rooms offer
- Clinic has only 7 exam rooms limiting ability to respond to low acuity calls due to scheduled visits and volume of walk-ins
- Pioneer Square Area had 5,200 low acuity calls in 2018
  - 50% could have been diverted to a clinic, instead about 1000 went to HMC Emergency Room

Alternatives/Options

- Option #1 – No Change
- Option #2 – Remodel Existing Pioneer Square Clinic
- Option #3 – Move clinic operation to new location in Pioneer Square Area
- Option #4 – Close clinic and move operations to the 22nd and Rainier Clinic (Hobson Place)
- Option #5 – Move the main clinic to Hobson and leave a downsized function in PSQ clinic with medical residency

Option 1: No Change

- Pioneer Square Clinic is facing severe space constraints that negatively impact the ability to provide up-to-date and quality health care services
- No changes to the current structure will likely result in needs remaining unmet and an increase in lower acuity emergency department visits at Harborview Medical Center's main campus
- Capacity is reduced when facility repairs are performed in clinical space increasing unmet care and increased demand on HMC ED



Option 2: Remodel Existing Pioneer Square Clinic

- Pioneer Square Clinic is grandfathered in to its code standards, any adjustments made will require bringing the entire clinic up to current code
- Ideally, a remodel would allow for the first two floors to be clinic space, the third floor for administrative services and the fourth floor for community partnerships.
- This upgrade could potentially aid in lowering patient volume at HMC's Emergency Department by allowing for a procedure area and more clinical capacity
- This would require temporarily relocating services to another location while renovations took place.

Option 3: Move Clinic to New Location in the Pioneer Square Area

- The option to purchase or lease a new space entirely in the Pioneer Square Area would require a more intentional exploration of available property.
- King County does not currently own any available space

Option 4: Move Operations to the 22nd and Rainier Clinic (Hobson Place)

- Harborview and DESC have proposed plans to open an integrated primary care clinic on 22nd and Rainier called Hobson Place
- Increases in the homeless population south of the downtown corridor present a need for additional care
- The clinic would have permanent supportive housing and is also in close proximity to other housing 1st complexes, shelters and encampments
- Closing the clinic in Pioneer Square would leave a significant need unmet for individuals who receive care there and do not travel well
- Low acuity calls in 1st 4 months of 2019 in zip code were 215 that could have been sent to a clinic for management so would decrease load on HMC emergency department

Option 5: Move Clinic to Hobson and Leave Downsized Function in PSC With Upgrades

- Downsizing the clinic in Pioneer Square, but allowing for minor upgrades will improve quality of care and maintain service for that area
- Both sites will provide daily walk-in service with two neighborhoods offering a medical home for vulnerable people expanding the safety nets survival services
- Pioneer Square Clinic would focus on training medical residents in becoming primary care physicians
- Majority of operations would move to Hobson place, allowing for a greater number of people to receive care overall
- Both clinics would have capacity to receive low acuity SFD calls reducing demand on HMC emergency department

Criteria

	No Change	Remodel	Move to new building	Close clinic and move to Hobson	Downsize and move to Hobson
Area 1: People Impact					
Mission Population					
Patients and clients					
Labor and employees					
Neighbors and community					
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Addresses Determinants of Equity					
Access to healthcare and improved health outcomes					
Area 4: Fiscal/Financial Impact					
The long-term financial position of Harborview and King County					
Existing facilities					
Opportunities for other funding					

Positive Impact
Negative Impact
N/A

Questions?

King County

Harborview Leadership Group

Philanthropy

Subcommittee Report

September, 2019

OVERVIEW

The University of Washington Advancement Office has long provided support in annual and targeted fundraising efforts for Harborview Medical Center (HMC). To date, a large-scale fundraising effort targeted at capital expansion has not been undertaken. In general, private philanthropy levels in support of capital (renovations and equipment) and operational expenses have been relatively minor, typically raising between $1.5M and $3M annually.

A major facility capital expansion provides an important opportunity, over a designated timeframe, to significantly increase this level of support. Working with the UW Medicine Advancement office, the subcommittee has been exploring how private philanthropy could generate measureable funding for needed facility investments and possibly reduce the amount that would need to be sought from the voters.

Public/private partnerships in financing major public hospital construction projects of the scale under investigation by the Harborview Leadership Group (HLG) are rare, with very few examples nationally. A thoughtful analysis of an equivalent fundraising effort (i.e., Parkland Health & Hospital System in Dallas, TX) and completion of a formal fundraising feasibility study will be important next steps to determine the level of philanthropic support that should be targeted.

STATEMENT OF NEED

There are three key advantages to aligning with a significant private philanthropic effort to help fund facility expansion and/or programming at Harborview:

1. Significant private philanthropy could measurably reduce the amount that the voters would be asked to contribute and/or provide necessary financial operating support of new programs and services made possible by an approved bond effort.
2. Significant private philanthropy would highlight community support and demonstrate a thoughtful approach to financing.
3. Significant philanthropy would have an additive effect of demonstrating HMC's philanthropic worthiness to King County residents and other prospective constituents beyond King County, thus enhancing HMC's opportunity to increase dramatically annual and large-gift fundraising in the years after the new tower is completed.

ALTERNATIVES/OPTIONS: PHILANTHROPY FOR CAPITAL EXPANSION OR ONGOING FUTURE EXPENSES

As has been discussed in several of the other subcommittee reports, one of the key risks to long-term success is over-expenditure on the capital side to construct new facilities and not having the long-term financial wherewithal to fund the ongoing operations. Additionally, it has been identified that many

private foundations and funders limit allocations to programs and services, but do not allocate resources to capital expansion.

The subcommittee reviewed two options:

- **Option 1** – targeting broad fundraising effort to generate funds for both capital expansion and program costs for new services (recommended).
- **Option 2** – limiting fundraising efforts to capital expansion costs to maximize the reduction in funds requested from the voters.

Option 1 - Both Capital and Operating Costs of New Services

Impact to people:
This option will maximize the opportunity to raise private philanthropy by being open to both operating funds for new programs and services, and capital needed to fund equipment and facility expansion. Being flexible in this sense is good for both the mission population and the employees at the hospital campus.

Impact to services and operations:
The biggest impact to services and operations from the philanthropy efforts in Option 1 is that it will improve the long-term outlook of the hospital and help ensure the success in delivery of services that would be promised to the community. It is possible that some of the services may be related to capital facilities built by public and private funding, but not operated by HMC, so the ultimate impact on operations to HMC is likely to be neutral or positive, but cannot be known until future efforts have been completed. Capital and programmatic expansions are expected to implement best practices both in terms of services and facility operations. Hence, the philanthropic efforts, to the extent they make those changes easier to implement, will have positive impacts.

Equity and Social Justice Impacts:
Philanthropy efforts are likely to positively affect equity and social justice concerns in at least two different ways. First, expansion of services provided to the mission population afforded by increased space (which virtually all contemplated changes include). Second, should philanthropy reduce the amount of an initiative forwarded to the voters, a smaller the portion of the total cost that will be paid by those who can least afford it. The property tax is not the most regressive tax used in Washington State as it is only paid by property owners; however, at least a portion of any tax increase is likely to be passed on to renters. Private philanthropy reduces this portion of the project from ever entering that equation.

Option 2 – Limited Philanthropy Targeted at Capital Costs

Impact to people:
As with Option 1, ultimately money raised through private philanthropy is not money asked of the voters of King County. Targeting the efforts at raising capital funds to maximize the amount that can be removed from the bond proposal puts emphasis on reducing the overall size of the bond effort. It would also put the focus on other efforts to fund the longer-term operating costs of any new services.

Impact to service and operations:
Focusing on only capital philanthropy will potentially have the impact of increasing the likelihood that new capital facilities can be constructed. It may also increase the likelihood that long-term funding options for those new services are harder to fund. However, there is a lack of clarity around what new services will be offered and what operating dollars will be available for those services, so this outcome is currently an unknown. Again, any capital and programmatic expansions are expected to implement best practices both in terms of services and facility operations. The philanthropic efforts, to the extent they make those changes easier to implement, will have positive impacts.

Equity and Social Justice Impacts:
Philanthropy efforts are likely to positively affect equity and social justice concerns in at least two different ways. First, expansion of services provided to the mission population afforded by increased space (which virtually all contemplated changes include). Second, should philanthropy reduce the amount of an initiative forwarded to the voters, a smaller the portion of the total cost that will be paid by those who can least afford it. The property tax is not the most regressive tax used in Washington State as it is only paid by property owners; however, at least a portion of any tax increase is likely to be passed on to renters. Private philanthropy reduces this portion of the project from ever entering that equation To the extent that Option 2 focuses on capital philanthropy, this option is likely to further reduce burdens on the taxpayers and therefore have a slightly lower impact on the populations least able to pay.

LEVEL OF PRIVATE SUPPORT: FUNDRAISING FEASIBILITY STUDY

Completion of a formal fundraising feasibility study will be an essential step to help determine the level of philanthropic support that should be targeted. This study should be considered in conjunction with other studies also identified in Council Motion 15182.

The core of a feasibility study effort will be personal interviews with approximately 25-35 top prospective donors (TPDs), and King County, HMC and UW Medicine opinion leaders. Feasibility study questions will be designed to elicit from interviewees' responses to key areas of inquiry: interest in HMC's vision for the future of its healthcare delivery and emergency preparedness capabilities, interest in a fundraising effort in conjunction with a bond measure, interest in contributing significantly to HMC, willingness to work on behalf of the HMC and King County's goals and objectives, willingness to assume fundraising leadership roles, and satisfaction with institutional leadership. The study also

provides a first level of cultivation for the interviewees and informs them of fundraising priorities and goals, as well as HMC's timetable for implementing its vision.

The measures of potential fundraising success, then, are more than just a barometer to calibrate potential level of support. If properly conducted with the right constituents, the feasibility study will also achieve the following results:

- It identifies the attitudes and interests of key constituents who are integral to fundraising success.
- It reliably summarizes responses to the five main areas of inquiry: attitude toward fundraising priorities, approval of effort, willingness to work as a volunteer, willingness to contribute, and degree of interest in supporting HMC in comparison to other fundraising efforts currently underway or being planned to which top prospective donors may be asked to contribute.
- It uncovers any potential major challenges relating to HMC, UW Medicine or their stated goals and vision for capital and programmatic improvements.
- It tests the proposed effort's goal credibility and chances for success, and identifies steps necessary to determine the final goal.
- Feasibility study interviews serve as an introduction to HMC's vision and, as such, represent an important cultivation step with the top prospects within the community.

Feasibility Study Specifics

Before scheduling the feasibility interviews, a visionary case statement/prospectus (to be completed) would be sent to those who will be asked to participate in the study. Every effort will be made to secure interviews with the most prominent philanthropic leaders within our community. After the interviews have been completed and after all appropriate data have been analyzed, a comprehensive report of findings and recommendations will be presented to the HLG. The report should include, but not necessarily be limited to, the following:

- A discussion of the preparation to be undertaken by HMC leadership to achieve further success in the "silent" and "public" phases of the fundraising effort.
- An analysis of HMC's fundraising potential and preliminary goals.
- An evaluation of the constituents' willingness to involve themselves in a fundraising effort as volunteer leaders and donors.
- A determination of the constituents' feelings about HMC's direction, leadership, and role in the infrastructural fabric of King County, Washington, and the Pacific Northwest.
- An assessment of HMC's featured objectives as viewed by the constituents interviewed.
- A tentative fundraising schedule.
- A scale of needed gifts and goal setting for HMC's top priorities.
- Specific recommendations for organizing, staffing, and conducting the fundraising effort.

UW Medicine Advancement has identified a highly-qualified third party consultant unaffiliated with UW Foundation's retainer consultant (Grenzebach Glier and Associates) in order to present an unbiased opinion to the HLG. This consultant selected is uniquely qualified to deliver a feasibility study with access to data from one of the nation's few comparable efforts (Parkland), has the caliber of experience and reputation to engage top prospective donors, and has confirmed ability to deliver the study within the HLG's time constraints. Completion of the feasibility study requires 6-8 weeks from the date of the first interview.

SUMMARY

Option review:

- The philanthropy subcommittee looked at various options for undertaking a major fundraising effort to support the capital and programmatic needs of HMC in looking at a major capital and programmatic expansion.
- The two options considered and contained in this report were to target philanthropy at both capital and operational costs of new services at HMC or to limit the targeted philanthropy just at the capital expansion of the hospital.

Conclusion:

- The subcommittee is recommending that any philanthropic effort be broad enough to allow donors to fund facility expansion, equipment and programmatic needs to encourage wider participation from the philanthropic community (Option 1).
- The subcommittee is recommending completion of a fundraising feasibility study by a third party consultant to help better determine the level of participation from private funders.

	No Change	Option 1	Option 2
Mission Population			
Patients and clients			
Labor and employees			
Neighbors and community			
Delivery of emergency services			
Addresses facility deficiencies and needs			
Supports innovation, best practices, and/or new models of care			
Service models that promote equity			
Influenced by community priorities			
Addresses Determinants of Equity			
Access to healthcare and improved health outcomes			
The long-term financial position of Harborview and King County			
Existing facilities			
Opportunities for other funding			

Positive Impact
Negative Impact
N/A

Philanthropy Subcommittee

Report for the Harborview Leadership Group

SEPTEMBER 25, 2019

Agenda

- Subcommittee Members
- Overview
- Statement of Need
- Funding Options for Philanthropy
- Funding Level for Philanthropy - Fundraising Feasibility Study – Fundraising Conversations
- Questions

Philanthropy Subcommittee Members

- Paul Hayes, Harborview Medical Center
- Kelli Carroll, King County
- Patrick Hamacher, King County
- Leslie Harper-Miles, King County
- Sid Bender, King County
- Ian Goodhew, UW Medicine
- Clint Burwell, UW Medicine Advancement

Overview

Annual and targeted fundraising efforts for Harborview Medical Center (HMC) have provided on-going support of capital renovations, equipment and operational expenses. Historically, major facility capital expansion and campus development has been publically funded. The Philanthropy Subcommittee has been exploring how private philanthropy could generate measurable funding needed for facility investments and possibly reduce the amount that would need to be sought from the voters. Public/private partnerships in financing major public hospital construction projects of the scale under investigations by the Harborview Leadership Group are rare, with few examples nationally. We are in the process of conducting a formal fundraising feasibility study to help determine the level of philanthropic support that we could generate locally for a similar effort.

Needs Statement

There are three key advantages to exploring a significant private philanthropic effort to help fund facility expansion and/or programing at Harborview:

1. Significant philanthropy could measurably reduce the amount that voters would be asked to contribute and/or provide necessary operating support of programs made possible by an approved bond effort
2. Significant philanthropy would highlight community support of Harborview and demonstrate a thoughtful approach to financing
3. Significant philanthropy would have an additive effect of demonstrating HMC's philanthropic worthiness to King County residents and other prospective constituents beyond King County, thus enhancing HMC's opportunity to increase dramatically annual and large-gift fundraising in the years after the new tower is completed.

Funding Options for Philanthropy

- **Option 1** – targeting broad fundraising effort to generate funds for both capital expansion and program costs for new services
- **Option 2** – limiting fundraising efforts to capital expansion costs to maximize the reduction in funds requested from the voters

Subcommittee is recommending that any philanthropic effort be broad enough to allow donors to fund facility expansion, equipment and programmatic needs to encourage wider participation from the philanthropic community (Option 1)

Funding Level for Philanthropy

Completion of a formal **fundraising feasibility study** will be an essential step to help determine the level of philanthropy support that should be targeted:

- Personal interviews with 25-35 top prospective donors and other community opinion leaders
- Institutional meetings – September 2019
- TPD meetings – October/November 2019
- Study findings – November 2019
- Interviewer/fundraising consultant: Chuck Sizemore

Pillars of Fundraising Success

Needs:

Specific capital improvements
Specific programmatic improvements or additions

Communication/Branding:

Constituency:

Individuals
Corporations
Foundations

ENGINES----------->NEEDS----------->CONSTITUENCY

Engines:

Governing board(s)
Fundraising Steering Committee—volunteer leadership
CEO
Dean
Physicians/Program Heads
Other Committed Volunteers
UW Medicine Fundraising Staff

Key Feasibility Study Results

- Key constituents' attitudes toward HMC
- Identification of new TPD's
- Level of constituents' participation—philanthropic, volunteer, and community activist
- Resonance with HMC's BHAGs, vision, and role in the King County community and beyond
- Resonance with HMC leadership—CEO, chiefs of medical disciplines, physicians, nursing staff, and other allied health professionals
- Issues requiring remediation or deeper examination
- Explanation of the fundraising effort's components/goals, so as to begin a level of constituent gift cultivation

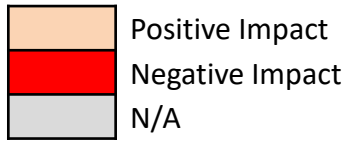
Key Feasibility Study Deliverables

- Fundraising potential and fundraising goal verification
- Fundraising effort's timing and length, as well as a "road map" for executing all of the effort's components
- Identification of a sequence for gift requests and pairing of TPDs with featured fundraising priorities—perhaps occasioned by potential for transformational giving
- Identification of potential volunteers among the interviewees, especially those who could influence larger gifts and greater participation from the community
- Evaluation of the fundraising effort's featured objectives and their resonance with TPDs
- Donor/community communication strategies and content

Questions?

Criteria

	No Change	Option 1	Option 2
Mission Population			
Patients and clients			
Labor and employees			
Neighbors and community			
Delivery of emergency services			
Addresses facility deficiencies and needs			
Supports innovation, best practices, and/or new models of care			
Service models that promote equity			
Influenced by community priorities			
Addresses Determinants of Equity			
Access to healthcare and improved health outcomes			
The long-term financial position of Harborview and King County			
Existing facilities			
Opportunities for other funding			



King County

Harborview Leadership Group

Philanthropy

Report

March 2020

OVERVIEW

The UW Medicine Advancement Office has long provided support in annual and targeted fundraising efforts for Harborview Medical Center (HMC). However, to date no large-scale fundraising effort targeted at capital expansion has been undertaken. Major capital improvements have been either publicly funded and/or funded by HMC reserves. Historically, private philanthropy support for HMC has been used for smaller scale capital improvements, equipment purchases, and general operating support. These gifts and have been at modest levels, typically between $1.5M and $3M raised annually.

A major capital facility expansion provides an opportunity, over a designated timeframe, to potentially increase philanthropy support for HMC. Working with the UW Medicine Advancement office, a subject matter expert was contracted to explore and share findings with the subcommittee on how private philanthropy could generate measurable funding for facility investments and possibly reduce the amount that would need to be sought from the voters.

Data reviewed for this report finds that public-philanthropic partnerships financing for major public hospital construction projects of the scale recommended by the Harborview Leadership Group (HLG) are rare, with very few examples nationally. To better understand and assess philanthropic opportunities, UW Medicine Advancement retained philanthropy consultant, Charles W. Sizemore. The consultant conducted interviews with local philanthropists and others as well as analyzing those successful public-private partnerships mounted over the last 10-15 years at peer, large county hospitals. Comparable projects were identified, such as Parkland Hospital (Dallas), Zuckerberg San Francisco General Hospital, and Grady Memorial Hospital (Atlanta), each of which combined revenue from public bond measures with private philanthropy.

This report provides a summary of the consultant's findings and assessment in undertaking a similar effort for HMC.

STATEMENT OF NEED

It is recognized that significant levels of philanthropic giving could either measurably reduce the amount that the voters would be asked to contribute and/or provide necessary financial operating support of new programs and services made possible by an approved bond effort. Securing private philanthropy demonstrates a thoughtful approach to financing, potentially positively impacting county taxpayers if the accumulated gifts were sizable enough.

METHODOLOGY

Completion of a formal fundraising feasibility study by a highly qualified, third party consultant unaffiliated with UW Foundation's retainer consultant (Grenzebach, Glier and Associates) was an

essential step to present an unbiased opinion to the HLG. In September 2019, UW Medicine Advancement retained Charles W. Sizemore (consultant), who was identified as uniquely qualified to deliver a feasibility study with direct access to data from other comparable fundraising efforts, who had the caliber of experience and reputation to engage top prospective donors, and the ability to deliver the study within the HLG's time constraints.

Pertinent to the assessment called for in Motion 15183, the consultant conducted interviews with approximately 30 top philanthropists, as well as a number of King County, HMC and UW Medicine leaders and supporters. Interview questions were designed to understand knowledge and interest in HMC's future of healthcare delivery, emergency preparedness capabilities, and potential fundraising efforts, as well as introduce the general scope and scale of a potential a bond totaling in the range of $1-$1.7 billion for the construction of a new multi-floor medical tower, as well as renovate other facilities within the HMC complex.

The consultant study identified peer organizations that have successfully undertaken such endeavors. These organizations included Parkland Hospital (Dallas), Zuckerburg San Francisco General Hospital, and Grady Memorial Hospital/Grady Health (Atlanta). The consultant determined that several commonalities exist among the peer endeavors, including:

- Well established, longstanding fundraising operations and track record of securing sizable major gifts;
- A full complement of foundation fundraising staff;
- A culture of philanthropy existed in the symbiosis between each foundation and hospital—i.e. fundraising was an expected and often celebrated norm;
- Strong volunteer leadership composed of individuals who had high philanthropic capacity, visibility in their communities, and fundraising experience;
- Huge lead commitments - $250M from the Woodruff Foundation in Atlanta, $75M from the Zuckerberg family in San Francisco, and $50M from the Simmons Foundation in Dallas - stimulated strong, subsequent giving (Parkland and Grady also received separate $25M commitments) and public awareness. The time to secure these lead gift commitments in advance of public efforts took a minimum of three years; and
- Both before fundraising efforts were formally announced to the public, and throughout the fundraising periods, the hospitals benefited from parallel public relations campaigns, led by professional firms, to posit initially and remind prospective donors repeatedly of the institution's needs and integral roles in their communities.

KEY FINDINGS

- All interviewees knew and respected the role HMC plays in the area's healthcare mosaic.
- Most did not have any personal experience with HMC, either as a patient or as a patients' family member or friend, but all professed a basic understanding and appreciation of the work performed there daily.
- Individuals or family members who had a personal experience at HMC received care in the ER/Trauma Center and within one of HMC's areas of specialization (specifically noted: burn,

plastic/reconstructive surgery, neurology, ophthalmology and rehabilitation). Interviewees were effusive in their praise of HMC's quality of care, as well as the UW Medicine physicians, nursing staff and allied healthcare professionals who had treated them, their friends, or family members.

- Several participants disclosed that they had longstanding healthcare relationships with other providers, but due to the critical or unique nature of their or their loved ones' conditions, HMC became their only choice and is now their preferred choice. They concluded that HMC had either saved their or their loved ones' lives or provided them with a level of critical and ongoing care they could not have received anywhere else in the region.
- Participants who were not familiar with HMC said their main frame of HMC reference was the nightly television news stories highlighting critically injured individuals who had been taken by ambulance or, if they were from more remote locations, helicopter to HMC's trauma center. While these participants expressed a high-level of civic pride in HMC, they viewed HMC akin to a public utility – unseen except in times of crisis, yet always ready and extremely able to serve.
- A lack of understanding about how HMC is funded, as well as no knowledge of its governance, organizational or medical leadership, areas of specialization, or strategic plans for the future was noted by several participants.
- With no previous local models of a private philanthropic partnership with a public funding initiative at the prospective level presented ($1B+), participants were wary, despite overall positive opinions of HMC.
- Though the course of the study, no participant committed to nor indicated the level of a possible leadership gift commitment to HMC. Several agreed, though, that if the area's notable philanthropic leaders were early adapters and provided significant, private philanthropic support for a public-private partnership, other area philanthropists, foundations, and corporations would likely re-evaluate.

ASSESSMENT AND RECOMMENDATION

Greater Seattle is home to some very generous and sophisticated philanthropists, whose gift-making or grant-making foci are varied and, in some cases, include healthcare. While gifts and grants from these individuals and their families have markedly improved the operations of many King County, national, and international non-profits, HMC has not yet benefitted significantly from gift or grants from these noted philanthropists. The consultant concluded that increased philanthropic gifts to HMC could be possible over time with further, focused communication efforts aimed at shaping the constituency's impressions of HMC, in addition to progressive steps toward the fundraising preparedness indicators modeled by the peer organizations detailed above. At the time of writing this report, it was not possible for the consultant to identify or recommend an assumed dollar amount of private philanthropy that could affect the overall amount that the voters would be asked to contribute toward a possible bond, including how many and which philanthropists would be interested in giving, or the level of combined and individual giving.