King County

# Harborview Leadership Group Agenda – 4/24/19

## MEETING OUTCOMES

- Understand housing facility needs and discuss options for potential inclusion in bond measure
- Discuss supplemental analyses and information regarding Harborview's facility needs
- Receive updates on the Leadership Group's community engagement process and recent legislative activity in Olympia

## AGENDA

| | |
|---|---|
| 6:00 pm | Welcome & Meeting Goals – Christina Hulet, Facilitator<br>• Agenda overview<br>• Approval of March meeting minutes |
| 6:10 pm | Public Comment |
| 6:15 pm | Housing Report – Sub-Committee Team |
| 7:00 pm | Harborview Report: Additional Analysis – Paul Hayes, Executive Director, Harborview Medical Center |
| 7:45 pm | Legislative Session Updates |
| 7:55 pm | Wrap-up and Next Steps – Christina Hulet, Facilitator |
| 8:00 pm | Adjourn |

**King County Harborview Leadership Group Meeting**
**Wednesday, March 27, 2019**
**Minutes**

**COMMITTEE MEMBERS:**

| ORGANIZATION | MEMBER | PRESENT | MEMBER | PRESENT |
|---|---|---|---|---|
| King County Executive | Rachel Smith | No | Kelli Carroll | Yes |
| King County Council | Rod Dembowski<br>Kristina Logdson (Designee) | No<br>Yes | Joe McDermott | Yes |
| HMC Board of Trustees | Lisa Jensen | No | Lee Ann Prielipp | Yes |
| Mission Population | Gregory Francis | Yes | Nancy Dow | Yes – via telephone |
| Labor Representatives | Lindsay Grad | No | Rod Palmquist | Yes |
| HMC Executive Director | Paul Hayes, RN | Yes | | |
| HMC Medical Director | Rick Goss, MD | Yes | | |
| UW Medicine CHSO | Lisa Brandenberg<br>Cynthia Dold (Designee) | No<br>Yes | | |
| First Hill Community | Sam Russell | Yes | | |

**ADDITIONAL ATTENDEES:**

- Sid Bender, King County PSB
- Pat Hamacher, King County Council
- Kera Dennis, UW MED
- Ian Goodhew, UW MED via telephone
- Leslie Harper-Miles, King County FMD
- Christina Hulet, Consultant
- Ted Klainer, Harborview Medical Center
- Kristina Logsdon, King County Councilmember Rod Dembowski
- James Rogers, King County Superior Court
- Mary Roberts, King County Superior Court

- Paul Sherfey, King County Superior Court
- Bailey Bryant, King County Executive
- Marshall Ayers, Harborview Medical Center

**CALL TO ORDER**
Christina Hulet called the meeting to order at 4:09 p.m.

**INTRODUCTIONS – Christina Hulet**
Introductions were made.

**JANUARY MEETING MINUTES – Christina Hulet**
Joe McDermott motioned to review and approve minutes from the meeting on January 29, 2019.
Gregory Francis seconded the motion.
Meeting minutes were read and reviewed by Leadership Group.
Rod Palmquist moved to amend minutes to include updated analytical criteria as verbally approved in January 29th meeting.
Approving minutes with amendment of analytical criteria as verbally discussed in January 29th meeting.
Approved, none opposed, no abstentions.

**PUBLIC COMMENT**
None

**GROUNDING GROUP'S WORK – Christina Hulet**
The primary role for this group is to prioritize needs and develop recommendations based on the County council Motion for a possible bond measure to go before voters in 2020. Christina reviewed approved criteria with the group.

**ITA COURT SUBCOMMITTEE PRESENTATION**
**Leslie Harper-Miles** welcomed and introduced presenters for ITA Court Subcommittee Presentation
- James Rogers, Presiding Judge – King County Superior Court
- Mary Roberts ITA Court Judge – King County Superior Court
- Paul Sherfey, CAO – King County Superior Court

ITA Presentation Materials provided in meeting packet

**FEEDBACK & QUESTIONS ON ITA COURT SUBCOMMITEE PRESENTATION**
**Questions Posed to Group:**
*Joe McDermott* – If video testimony was struck down by the Washington State Supreme Court would that fundamentally change the court?
*Judge James Rogers* responded that regardless of the ruling, the court's current facility is limiting. If video testimony, or video hearings, were to be struck down, the court would have a large issue on their hands and, in Judge Roger's opinion, would be unable to process civil cases any longer in order to meet the demand in the current space.

*Rod Palmquist* – Ninth and Jefferson is a fairly newly constructed building. Why should the ITA Court be included in the scope of a possible bond particularly above other facilities when it is one of the newer facilities?

*Judge Rodgers* responded – While it is not the subcommittee or the court's position to indicate to the county and leadership group what its priorities should be, the proposed expansion is modest and much needed with the current trend of case load. *Paul Sherfey* reiterated that the current 6000 sf was not sufficient in 2013, when it was indicated that 12000 sf would be needed. This need was not met then, and since that time, the number of cases has only increased.

*Rod Palmquist* – How many Harborview patients are in ITA Court? Particularly, how much has it increased overtime [comparable to the chart in the presentation showing total over-time increase in ITA Court cases the last 8 years]?
*Judge Mary Roberts* responded - While we do not have that specific statistic, they agree to obtain that information and report back on the numbers to the group.

*Paul Hayes*: Has there been any assessment to increase video hearings? Given the fact that much of it is done remotely, was there an evaluation done to relocate video hearing process FROM Ninth and Jefferson Building?
*Judge Mary Roberts* responded – People in ITA Court that are brought on gurneys are coming from community hospitals. Increasing video hearings would require those hospitals to set up a video courtroom. Setting up a video courtroom would require private rooms, access to patient records, security etc. These needs, while not impossible, make it unlikely for the court to increase video hearing to these hospitals. The statistic of 90% of hearings are conducted via video has been consistent and it will likely stay consistent.

*Pat Hamacher:* Emphasized the need to evaluate the impact of changing needs of each group over time, including ITA; it is up to the LG to decide what the priority is. Essentially, each group has to make a recommendation based off of their assumption of what the need will be in the future.

**Action Items:**
Leadership Group requested additional information and analyses from the ITA Court Subcommittee when they return in May for their follow-up presentation. Specifically:

- The number of ITA cases that are patients in Harborview compared to other hospitals and how this number changed over time.
- The current square footage need for 2019 to provide an update to the 2013 numbers.
- A detailed breakdown of the current use (office space, court space, waiting areas etc.) including square footage.

## UPDATES:

**LEGISLATIVE UPDATE – Ian Goodhew & Mac Nicholsen**
Legislative handout distributed (attached in minutes)

*Ian:*
In general the state is looking to improve mental health and substance use disorder issues and programing systems by increasing funding and capital expenditures. Investments in these areas directly affect and impact the work that Harborview Medical Center is doing and the decisions that this leadership group has been tasked with making. The legislature is focusing largely on Western State Hospital's lack of ability and the impact that this has on mental health in the state.

With Harborview being the third largest behavioral/mental health hospital in the state, decisions the legislature makes regarding improving mental health outcomes will have a distinct impact on Harborview.

Proposals will be coming out in the coming weeks. State Legislators and the Governor want to create a process to remove long-term civilly committed patients from Western State Hospital ward out into community based hospital beds. In the fall, the Governor proposed a new facility for this purpose – the Behavioral Health Teaching Facility run by the University of Washington – which would take on some of that patient load. This facility is funded up to $33 million in House Capital Budget and $1 million in planning has been allocated from the Senate Capital Budget. The Senate operating budget will come out this Friday and then the House and Senate will work to finalize an official final budget. Discussion followed regarding location of teaching hospital beds.

**STRATEGIC FACILITIES MASTER PLANNING CONSULTANT RFP UPDATE – Leslie Harper-Miles**
RFP will be posted by the end of next week. All necessary documents have been shared where needed and will become available once posted.

**COMMUNITY ENGAGEMENT UPDATE – Kelli Carroll**
Staff provided updates on small planning group meeting. The group, consisting of Kristina Logsden, Lan Nguyen, Pat Hamacher, Leslie Harper-Miles, Katie Ross and Kelli Carroll, drafted initial scope for engagement. Refining of this scope is underway and an outline will be brought to the next meeting.

**SUBCOMMITTEE UPDATE – Leslie Harper-Miles**
The subcommittees have been meeting and working to develop information for presentations and options for the Leadership Group to consider. Many of the groups have recognized the crossover of issues, subjects and needs and have been working together. The housing subcommittee will be presenting next in the April meeting as well as the Harborview subcommittee, who will be returning to give their follow up presentation. Any recommendations for individuals who should participate on the subcommittees are welcome. A question was raised as to whether a subcommittee on Philanthropy has been formulated.

**NEXT STEPS – Christina Hulet**
The next Leadership Group meeting is tentatively scheduled for April 24th where the Harborview Medical Center Subcommittee will be presenting their additional analyses.

**Action Items:**

- Initial Housing Presentation from housing sub-committee
- Community engagement update
- Update on state legislative session

**ADJOURNMENT – Christina Hulet**
With no further business, the meeting was adjourned at 5:44p.m.

# Behavioral Health Budget and Policy Issues of Potential Interest to Harborview – 3/27/19

## Inpatient Treatment

### University of Washington Teaching Hospital

- House budget proposes major capital funding for a 150-bed UW teaching hospital.
    - Mix of long-term inpatient, geriatric psychiatric, medical/surgery psychiatric, and stepdown beds
    - House Bill 1593 supports development of this hospital, as well as various UW Medicine workforce and training interventions, as part of a behavioral health innovation and integration campus

### Long-Term Inpatient Beds in Community Settings

- House budget proposes capital and/or operating funding for:
    - 48-bed mixed-use civil commitment facility (long-term, short-term, stepdown) – capital
    - 16-bed state-operated civil commitment facility (long-term) – capital
    - 66 new community long-term inpatient beds in state FY20, 98 beds in FY21, and 162 new beds by FY23, per House Bill 1394; unclear if beds will be additive vs replace acute care beds – operating
    - 132-138 bed mixed-use psychiatric facility in Auburn (long-term, short-term, crisis stabilization) – capital

### Acute Care: Secure Withdrawal Management (SWM or Secure Detoxification) and Evaluation and Treatment (E&Ts)

- Increases SWM bed rates, and adds capital and operating funding for 2 new SWM facilities in FY20 and FY21
- Provides partial capital funding for additional E&T facilities

## Funding for Core Community-Based Services

### Medicaid Rates

- Budget appears to include funding for certain rate increases for services in primary care settings
- Unclear at this point whether or not any rate increases for community behavioral health are included

### Other Behavioral Health Funding Issues

- Crisis system/non-Medicaid funding (prioritized for crisis, inpatient, and residential care for people without Medicaid) is not increased – community needs significantly exceed the funding level
- Institutions for Mental Disease (IMD) backfill funding (related to a federal rule change that limited the use of Medicaid) is continued – appears insufficient to meet needs
- Behavioral health enhancement funds, a key infusion of additional funding for the community system that started in state FY19, are continued at roughly the same level

## Community Discharge Options

### Assertive Community Treatment

- House budget proposes to add 8 new PACT teams statewide, which offer individualized community-based support to people with severe mental health conditions and high service needs

### Intensive Behavioral Health Treatment Facilities

- House Bill 1394 creates a new licensing category: "intensive behavioral health treatment facilities"
    - Intended for people with higher levels of behavioral health challenges than existing alternative facilities can accommodate; targets patients taking first steps into the community from long-term inpatient care
    - House budget proposals provide operating and partial capital funding for 2 such facilities

## Other Behavioral Health Policy Legislation of Interest *(still alive as of 3/27/19)*

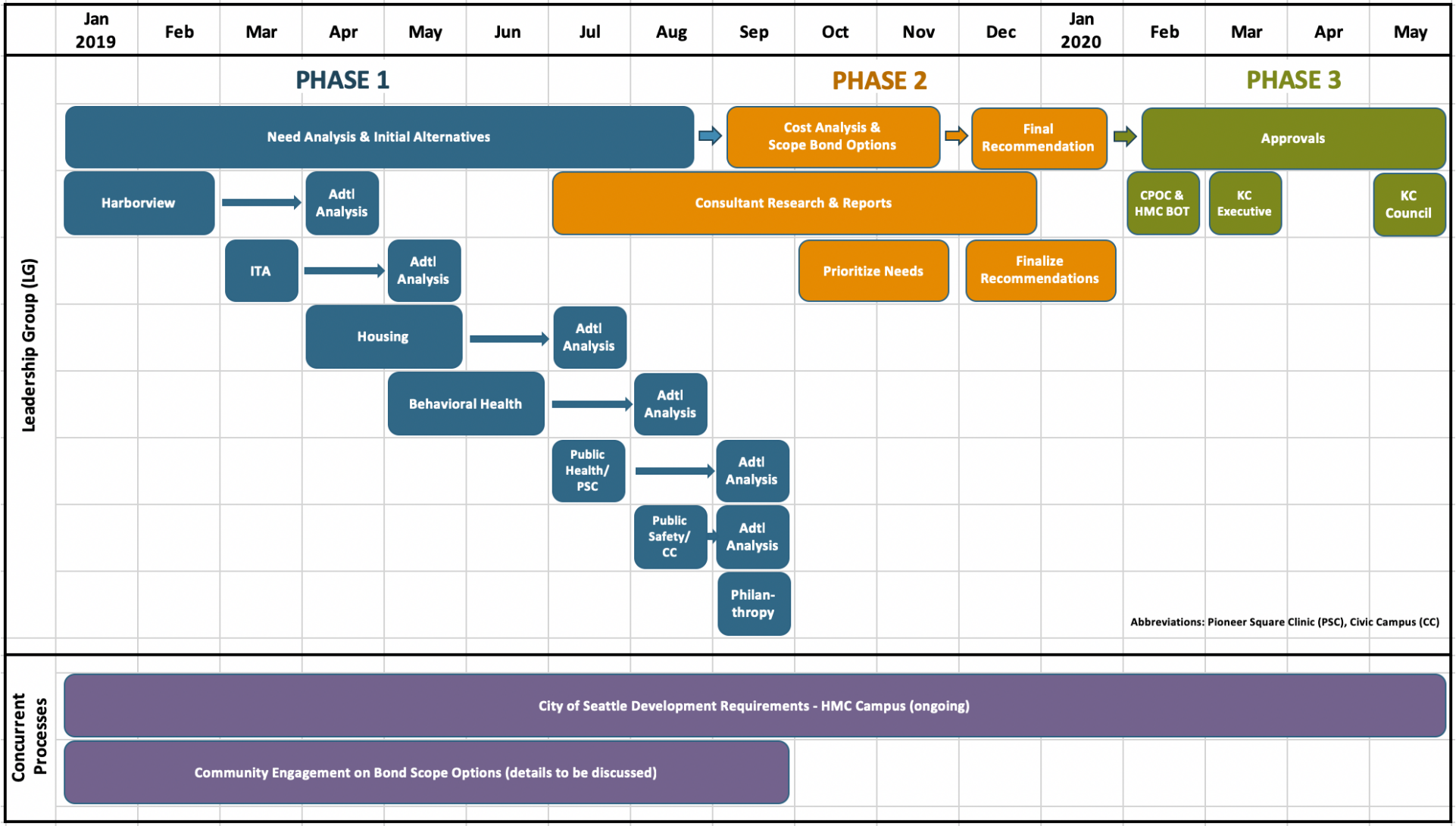
- Senate Bill 5432 addresses behavioral health integration responsibilities, and regional government role
- Senate Bill 5380 modernizes opioid policy and brings to scale opioid work King County has started
    - prevention, medication-assisted treatment, prescription monitoring, and overdose response
- Senate Bill 5444, accompanied by significant funding, implements the *Trueblood* settlement agreement to improve services for those not competent to stand trial; most changes in King County would be in 2021
- Senate Bill 5720 modifies involuntary treatment act initial detention periods and updates detention standards
- Multiple bills aiming to address behavioral health workforce issues and recovery supports

# Harborview Leadership Group Work Plan ~ Approved 1/29/19

Below is the Leadership Group's (LG) draft work plan for review. As a reminder, the LG's charge is to analyze and make recommendations on:

- HMC clinical facility master plan needs
- Public Health Department needs
- Housing needs for the mission population
- Involuntary Treatment Act, client/court needs
- Behavioral health needs
- Public health facilities beyond HMC campus
- Other public safety infrastructure needs
- Private philanthropy opportunities
- Prospective bond size and scope

In order to meet a potential November 2020 general election ballot measure, final recommendations and legislation would need to be transmitted to the King County Council by May 2020 for a July election filing deadline. The chart below provides a high-level overview, followed by a detailed timeline of Leadership Group meetings. Dates may change per the Leadership Group.



**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?

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:

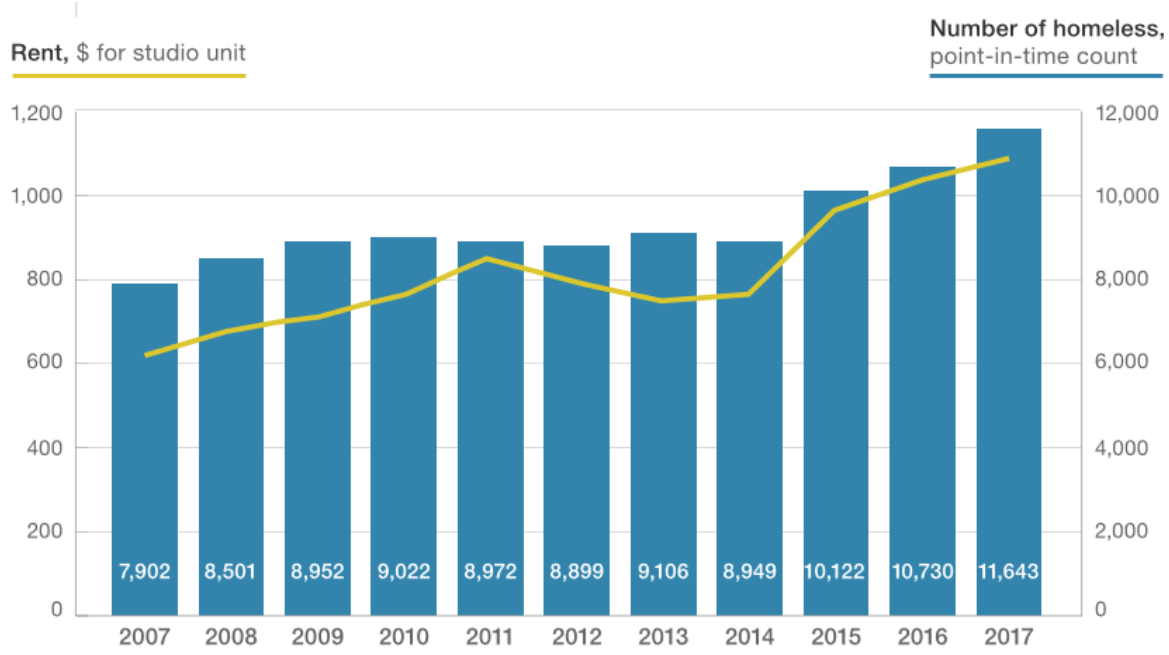
- *Respite Housing (Medical and Behavioral Health)* to increase housing capacity for sub-acute "stepdown" care for individuals living in homelessness;
- *Permanent Supportive Housing* to increase the stock of housing that would meet housing or medical needs of the mission population; and *Shelter* to 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** | | | | | |
| 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

## 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<br>• Basic health, food, clothing and personal hygiene needs<br>• Information and referral, basic Case Management | • 24/7, year round<br>• Basic needs with additional services including storage for personal belongings<br>• 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

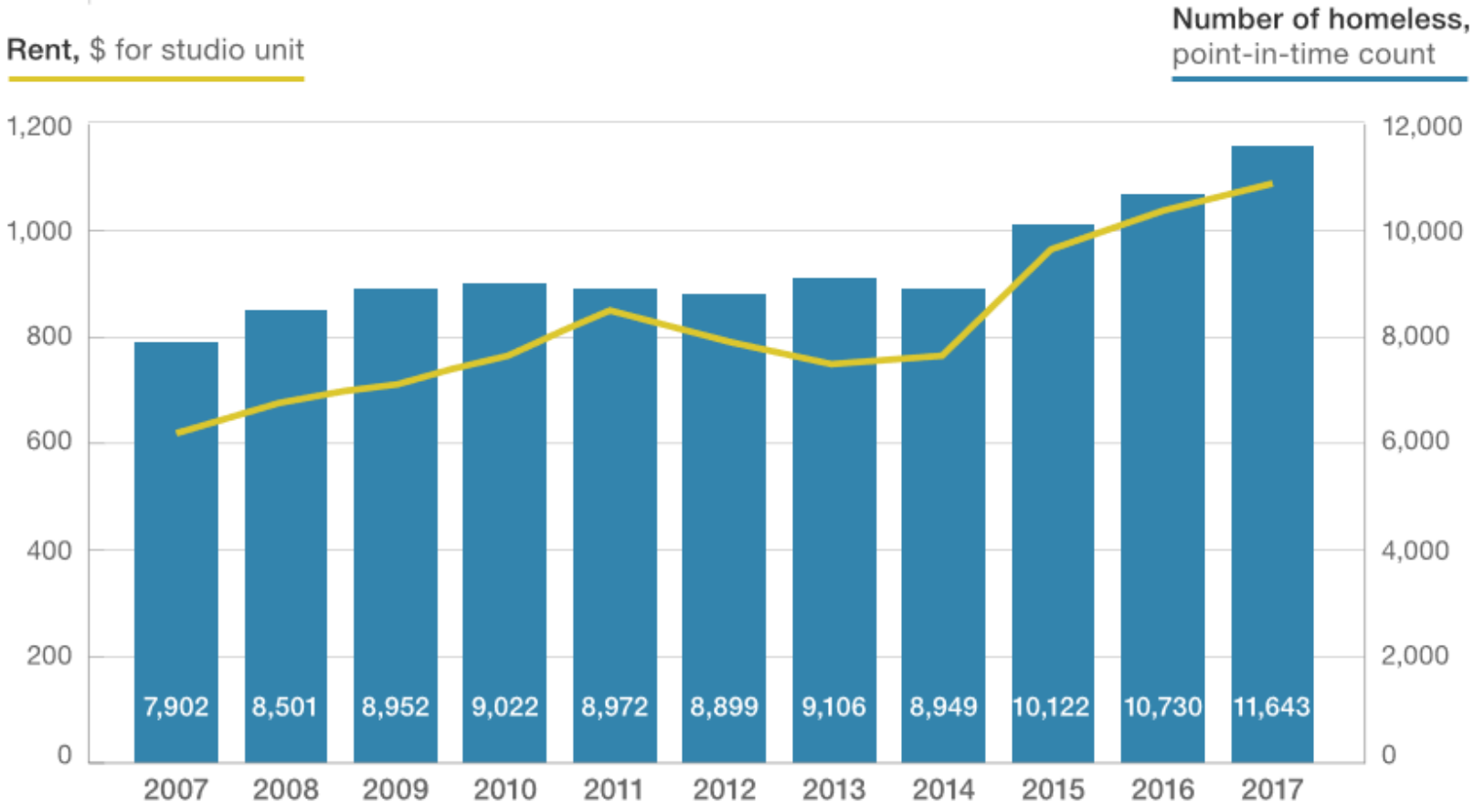
- Sid Bender, KC PSB
- Brook Buettner, KC Community and Human Services
- Kera Dennis, Harborview Medical Center
- Mark Ellerbrook, KC Community and Human Services
- Gregory Francis, Harborview Leadership Group
- Cristina Gonzalez, King County Facilities Management
- Patrick Hamacher, King County Council
- 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 | |

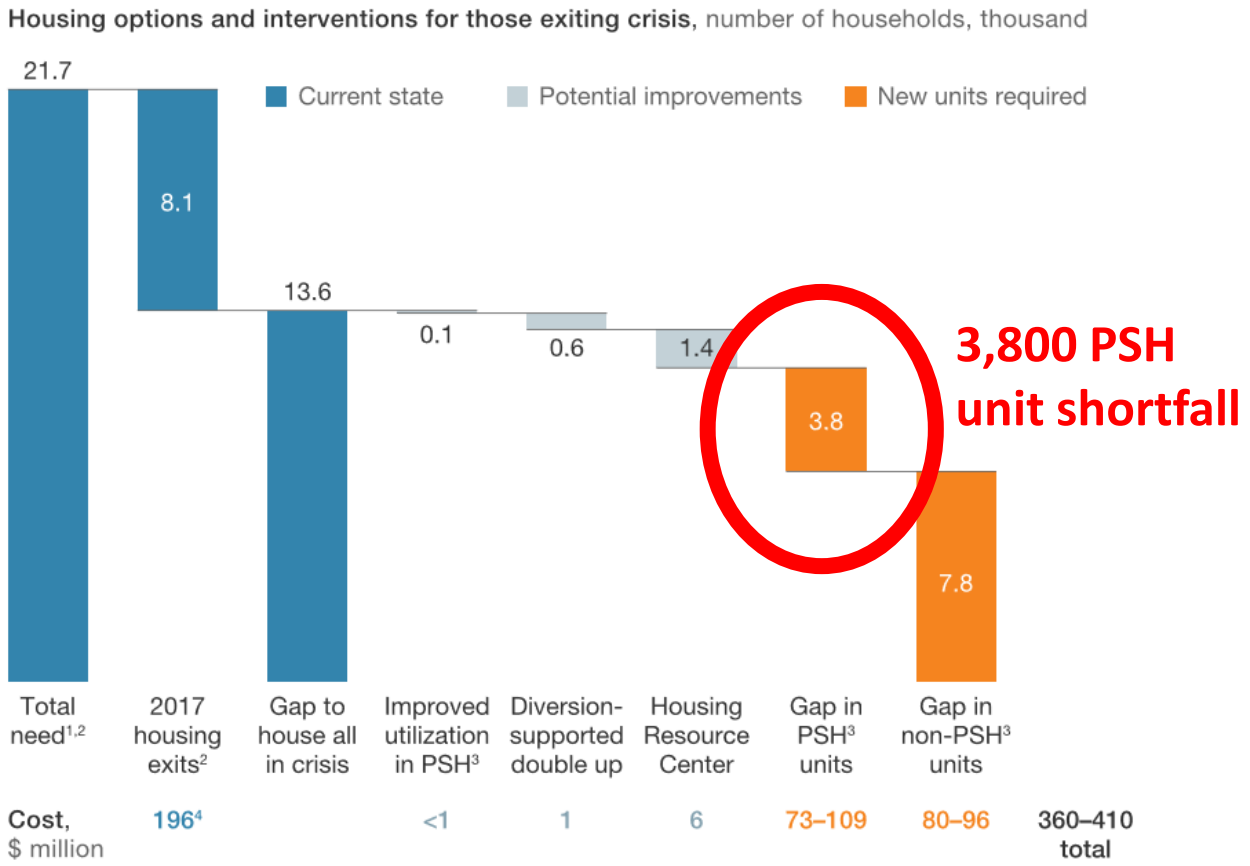
# Option 3:
# Permanent Supportive Housing

- 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**

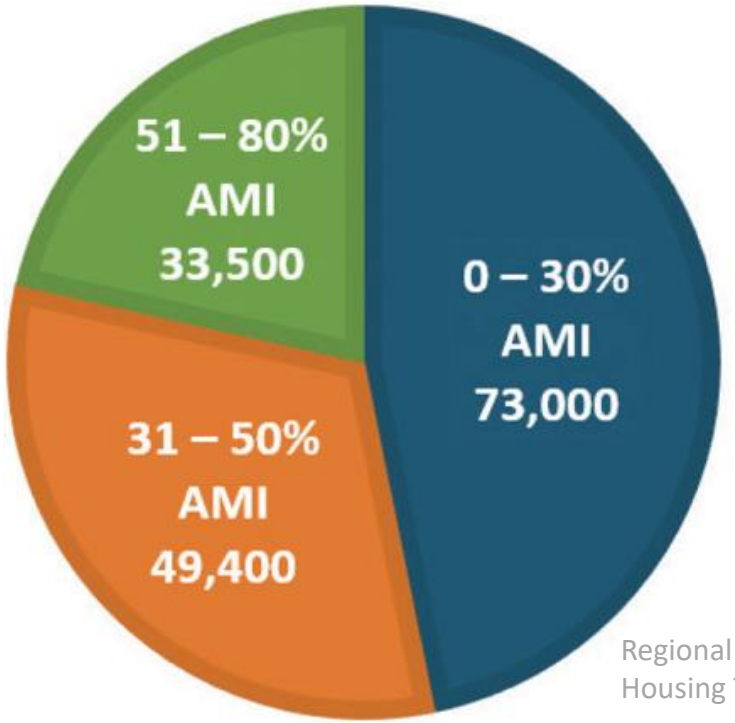



McKinsey& Company 2018

# Option 4:
# Workforce/ Affordable Housing

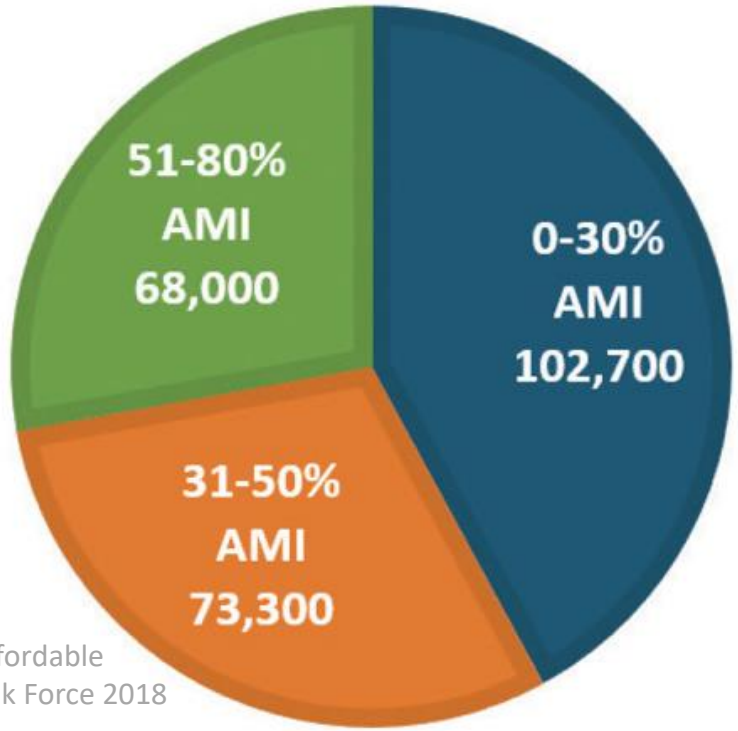
**King County**

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<br>• Basic health, food, clothing and personal hygiene needs<br>• Information and referral, basic Case Management | • 24/7, year round<br>• Basic needs with additional services including storage for personal belongings<br>• 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?

King County

# Harborview Leadership Group

# Harborview Medical Center

# Subcommittee Report

# April 24, 2019

## Overview

### *Harborview Medical Center Mission Statement*

Harborview Medical Center is owned by King County, governed by the Harborview Board of Trustees, and managed under contract by the University of Washington.

Harborview Medical Center is a comprehensive healthcare facility dedicated to the control of illness and the promotion and restoration of health. Its primary mission 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. As the only Level I Adult and Pediatric Trauma Center in Washington, Harborview Medical Center Provides specialized comprehensive emergency services to patients throughout the region, and serves as the disaster preparedness and disaster control hospital for Seattle and King County.

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

Harborview's patient care mission is accomplished by assuming and maintaining a strong leadership position in the Pacific Northwest and the local community. This leadership role is nurtured through the delivery of health services of the highest quality to all of its patients and through effective use of its resources as determined by the Harborview Board of Trustees.

Harborview, in cooperation with UW Medicine, plans and coordinates with Public Health Seattle and King County, other County agencies, community providers, and area hospitals, to provide programs and services.

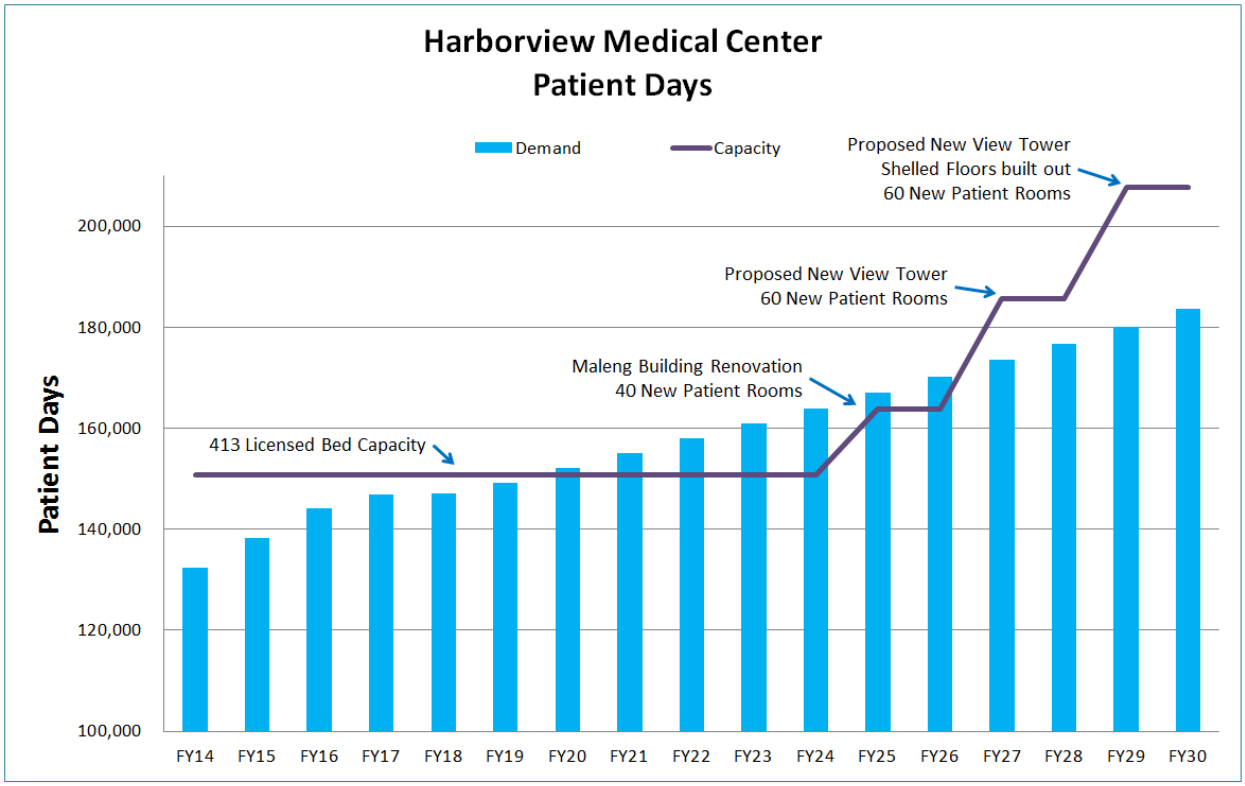
Harborview fulfills its educational mission through commitment to the support of undergraduate, graduate, post-graduate and continuing education programs of the health professions of the University of Washington and other educational institutions, as well as programs relating to patient education. Harborview recognizes that the delivery of the highest quality of healthcare is enhanced by a strong commitment to teaching, community service and research.

### *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.

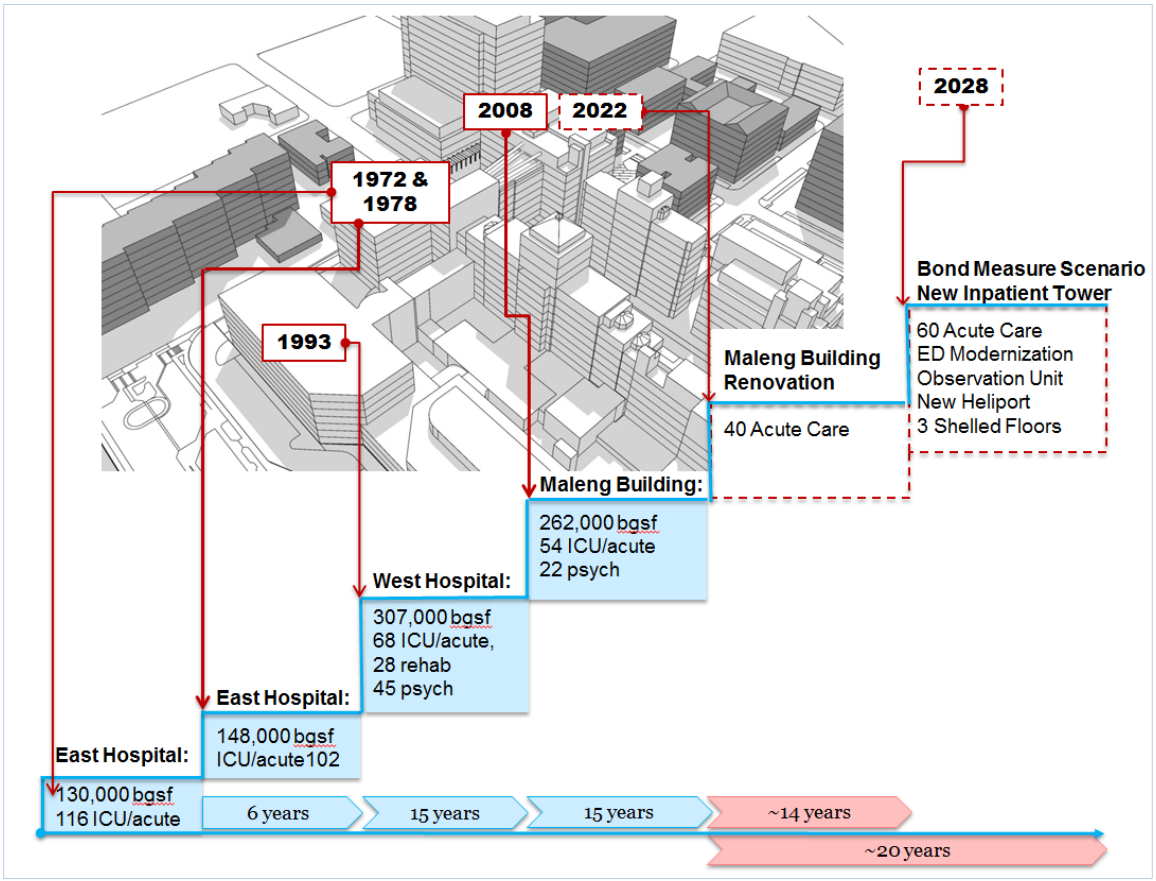
The hospital currently has three helicopter landing pads located on the roof of the P1 Parking Garage. When patients are transported to the hospital via a helicopter they have to be transferred to an ambulance and then driven around the block to entrance of the Emergency Department. A facility solution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

**Harborview Mission Statement**

Harborview Medical Center is owned by King County, governed by the Harborview Board of Trustees, and managed under contract by the University of Washington.

Harborview Medical Center is a comprehensive healthcare facility dedicated to the control of illness and the promotion and restoration of health. Its primary mission 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. As the only Level I Adult and Pediatric Trauma Center in Washington, Harborview Medical Center Provides specialized comprehensive emergency services to patients throughout the region, and serves as the disaster preparedness and disaster control hospital for Seattle and King County.

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

Harborview's patient care mission is accomplished by assuming and maintaining a strong leadership position in the Pacific Northwest and the local community. This leadership role is nurtured through the delivery of health services of the highest quality to all of its patients and through effective use of its resources as determined by the Harborview Board of Trustees.

Harborview, in cooperation with UW Medicine, plans and coordinates with Public Health Seattle and King County, other County agencies, community providers, and area hospitals, to provide programs and services.

Harborview fulfills its educational mission through commitment to the support of undergraduate, graduate, post-graduate and continuing education programs of the health professions of the University of Washington and other educational institutions, as well as programs relating to patient education.

Harborview recognizes that the delivery of the highest quality of healthcare is enhanced by a strong commitment to teaching, community service and research.

# Overview

***Medical Center Statistics 2018***

Licensed beds - 413

FTE's - 4,501

Admissions – 16,716

Emergency Department visits – 57,516

Clinic visits – 262,132

# Needs Statement – Patient Bed Capacity

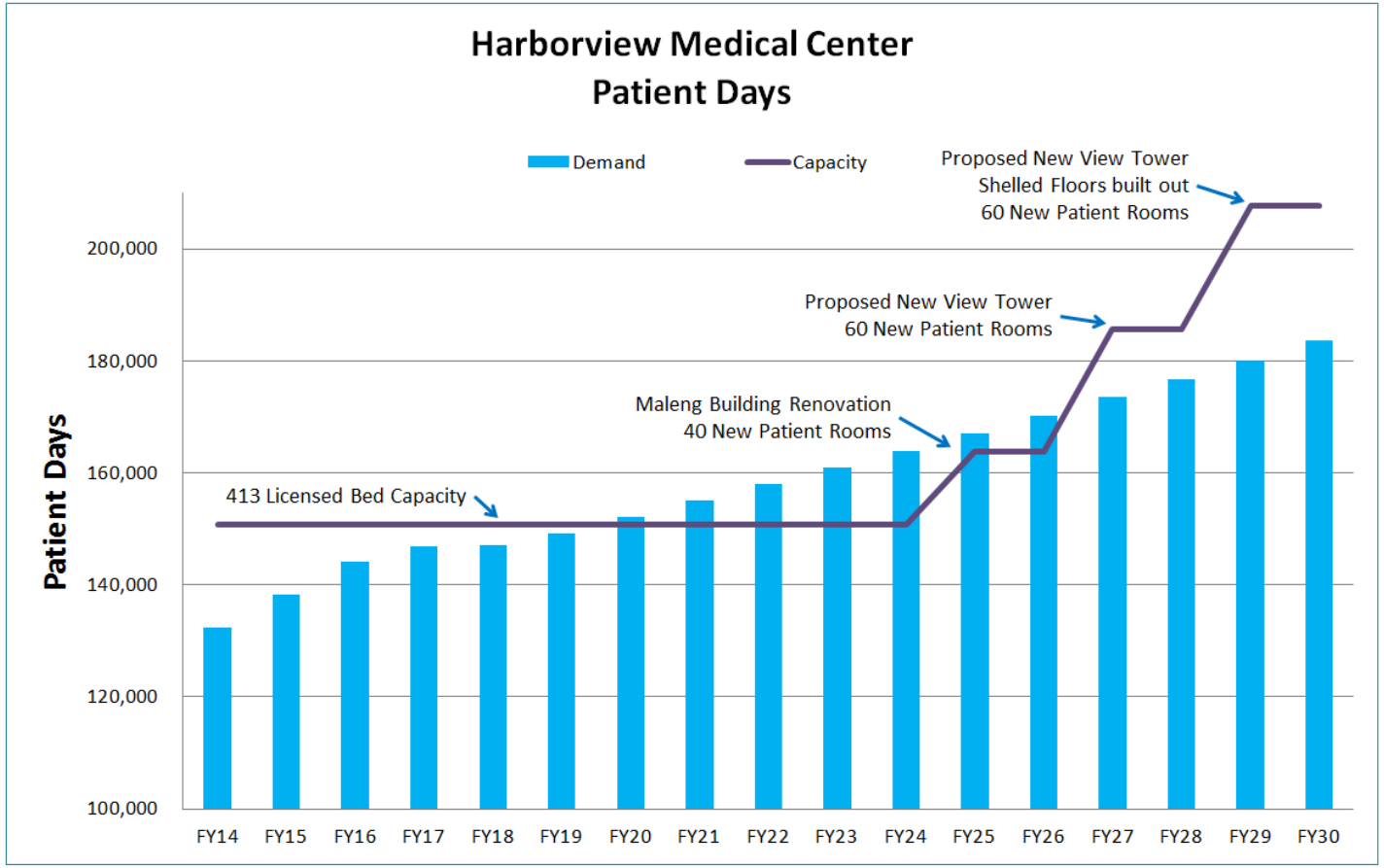
- Harborview Medical Center operates at 100% occupancy.
- Facility configuration and capacity constraints are significantly impacting hospital operations.

# Needs Statement – Space Constraints

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
- Patient Boarding in the Operating Room recovery area.
- Patient Boarding in the Emergency Department
- Acute Care Borders in the Intensive Care Unit
- Observation Patients are occupying one of coveted 413 licensed beds, averaging of 20/day
- Administrative Patients with discharge challenges – at least 30/day.

# 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 | | | | | |
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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 | | | | | |

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# Questions?