King County

Harborview Leadership Group Agenda – 5/22/19

MEETING OUTCOMES

- Understand behavioral health facility needs and discuss options for potential inclusion in bond measure
- Discuss supplemental analyses and information regarding Involuntary Treatment Court facility needs
- Review the Leadership Group's community engagement process
- Receive updates on the strategic facilities master planning consultant request for proposal (RFP) and the 2019 legislative session

AGENDA

6:00 pm	Welcome & Meeting Goals – Christina Hulet, Facilitator • Agenda overview • Approval of April meeting minutes
6:10 pm	Public Comment
6:15 pm	Involuntary Treatment Court Additional Analyses – Sub-Committee Team
6:25 pm	Behavioral Health Report – Sub-Committee Team
7:25 pm	Community Engagement Process
7:40 pm	Updates • Strategic facilities master planning consultant RFP • Legislative session
7:55 pm	Wrap-up and Next Steps – Christina Hulet, Facilitator
8:00 pm	Adjourn

King County Harborview Leadership Group Meeting
Wednesday, April 24, 2019
Minutes

COMMITTEE MEMBERS:

ORGANIZATION	MEMBER	PRESENT	MEMBER	PRESENT
King County Executive	Rachel Smith	Yes	Kelli Carroll	Yes
King County Council	Rod Dembowski	Yes	Joe McDermott	Yes
HMC Board of Trustees	Lisa Jensen	No	Lee Ann Prielipp	Yes
Mission Population	Gregory Francis	Yes	Nancy Dow	Yes
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	Cynthia Dold (Designee)	No		
First Hill Community	Sam Russell	Yes		

ADDITIONAL ATTENDEES:

- Christina Hulet, Consultant
- Mark Ellerbrook, King County Community & Human Services
- Brook Buettner, King County Community & Human Services
- Lan Nguyen King County Council
- Kristina Logsdon, King County Council
- Leslie Harper-Miles, King County FMD
- Bailey Bryant, King County Executive
- Kera Dennis, UW Medicine
- Ian Goodhew, UW Medicine via telephone
- Christina Hulet, Consultant
- Ted Klainer, Harborview Medical Center

CALL TO ORDER
Christina Hulet called the meeting to order at 6:05 p.m.

INTRODUCTIONS – Christina Hulet
Introductions were made.

MARCH MEETING MINUTES – Christina Hulet
Motion to read and approve meeting minutes.
Amendment to indicate that Leeann Prielipp was not in attendance at the March meeting.
Amendment to add Lan Nguyen as an additional attendee at the March meeting.
Approved, none opposed, no abstentions.

PUBLIC COMMENT
None.

HOUSING SUBCOMMITTEE PRESENTATION
Leslie Harper-Miles welcomed and introduced presenters for Housing Subcommittee Presentation

- Brook Buettner
- Mark Ellerbrook

Housing Subcommittee presentation and report provided in meeting materials.

FEEDBACK & QUESTIONS ON HOUSING SUBCOMMITTEE PRESENTATION

Regarding Respite
A question was asked as to whether the individuals in respite are released into homelessness.

- Presenters responded affirmatively that sometimes individuals can be released from respite back into homelessness.

A question was asked regarding the cost of respite beds compared to other typical housing costs.

- Presenters responded that the needs that can be met in respite provide a certain level of care that could not necessarily be met in a home alone.

A question was asked regarding the affect that respite has on patient flow in the hospital.

- Presenters responded that respite improves patient flow in the hospital by providing needs at a different location. Discussion followed.

Conversation followed regarding the practice of a layer-cake type structure and its benefits to meeting complex patient needs, including respite.

Regarding Permanent Supportive Housing
A question was posed regarding the guidelines needed to qualify for PSH housing in King County and who the PSH programs targeted populations are – i.e. those coming out of homelessness directly**.**

- Presenters responded that at this time Permanent Supportive Housing is structured around individuals who are coming out of homelessness directly. Conversation followed.

It was noted that Harborview has partnered with Plymouth PSH on 7th and Cherry by aiding in designing units and providing a nurse run clinic.

Regarding Affordable Workforce Housing
A questions was posed regarding the number of cost-burdened employees at Harborview and how the Housing Subcommittee arrived at the presented number.

- Presenters indicated that the number was calculated with help from unions and the university and the affordable housing data for King County.

Regarding Increased Shelter

A question was posed as to how bed allocation occurs once a shelter becomes 24/7.

- Presenters responded that bed allocation varies by shelter.

Additional:

A question was posed as to how these options can integrate with the move towards physical healthcare integration.

Conversation regarding the Behavioral Health Institute followed.

Action Items:

- Further confirmation of workforce affordable housing Harborview employee numbers. More information as to how this proposed option intersects with other agencies who are also focused on this issue.

HARBORVIEW MEDICAL CENTER SUBCOMMITTEE PRESENTATION

Presenters for Harborview Subcommittee Presentation

- Paul Hayes
- Ted Klainer

Harborview subcommittee presentation and report provided in meeting materials

FEEDBACK & QUESTIONS ON HARBORVIEW SUBCOMMITTEE PRESENTATION

A questions was posed to the subcommittee as to whether a proposed option assumes that the hospital would increase its licensed bed capacity.

- Presenters responded that there is no plan at this time to increase the licensed bed capacity. The ultimate goal would be to take the double rooms in the East Hospital and move beds to a single room.

A question was posed as to whether Harborview has considered increasing its licensure numbers in the long run.

- Presenters responded that it would be a possibility though it is not immediately on the table.

A question was posed as to whether the presented options accomplish the goal of moving towards single patient rooms for the hospital.

- Presenters responded affirmatively that additional rooms as proposed in options would greatly increase the capacity for single patient rooms in the hospital.

A question was posed as to whether renovation of the Maleng building is contingent on the bond or is able to move forward prior to the bond.

- Presenters responded affirmatively that it is possible to move forward. Discussion followed.

There was a request to further clarify the finances around Maleng renovations and the desire to have the renovations as a part of the bond.

Conversation regarding specific location of proposed tower, details regarding capacity, and available space followed.

LEGISLATIVE SESSION UPDATE – Ian Goodhew

Key budget news and updates on the legislature. Overall budget is still being finalized in the capitol. The hospital has routinely received state support in past years. There has been significant support for the

behavioral health teaching hospital. An initial allocation of $33.5 million has been made in order to begin building. That facility will have 90 day bed capacity to take pressure off of Western State. This hospital will also train and educate the work force and teach them how to handle the most acute and in need members of the population. Additionally, $500,000 of pre-design money will be allocated by the legislature to the BHI.

NEXT STEPS – Christina Hulet

The next Leadership Group meeting is scheduled for May 22nd where the Behavioral Health Subcommittee will be presenting their analysis as well as follow-up presentations from Housing and the ITA court subcommittees.

Action Items:

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

ADJOURNMENT – Christina Hulet

With no further business, the meeting was adjourned at 7:53 p.m.

Involuntary Treatment Court Subcommittee Follow Up

Analysis for the Harborview Leadership Group

MAY 22, 2019

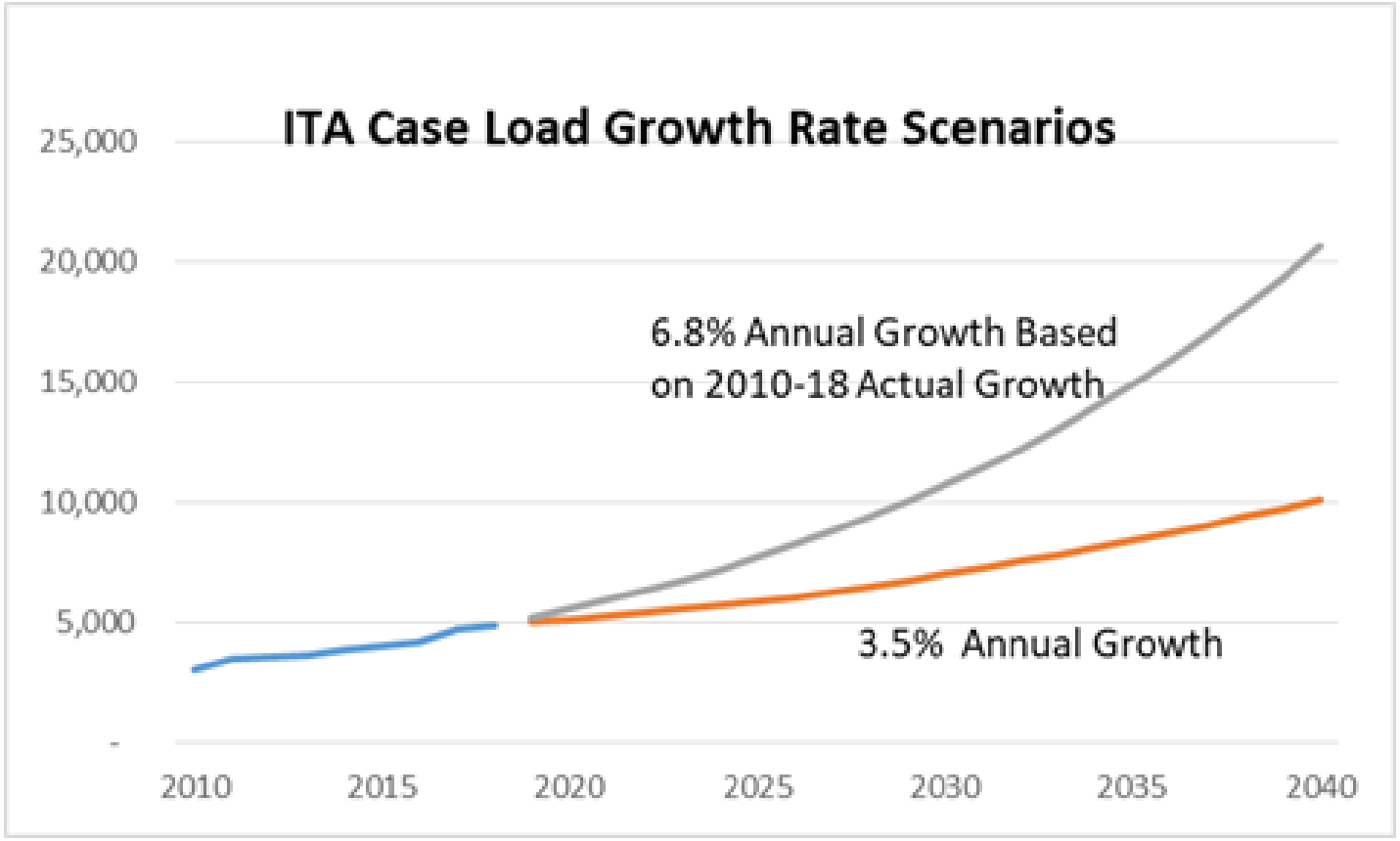
Review of March 24, 2019 ITA Subcommittee Presentation

- 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

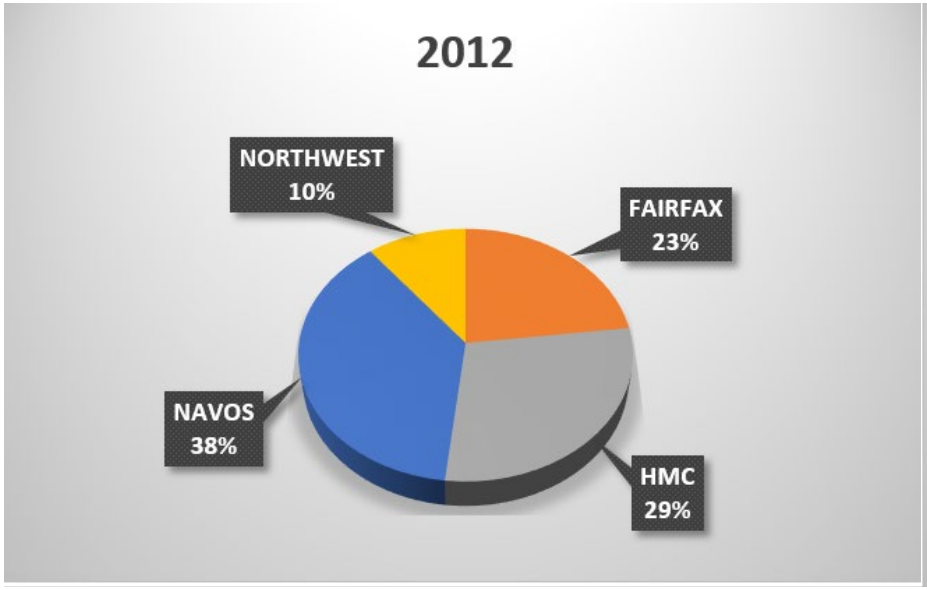
- ITA court officials plan for the continued use of both in-person and video hearings over the next decade.
- The current in-person facilities are inadequate in size and functionality; and video hearings will require ongoing equipment and capital infrastructure support.
- The facility responses presented 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.

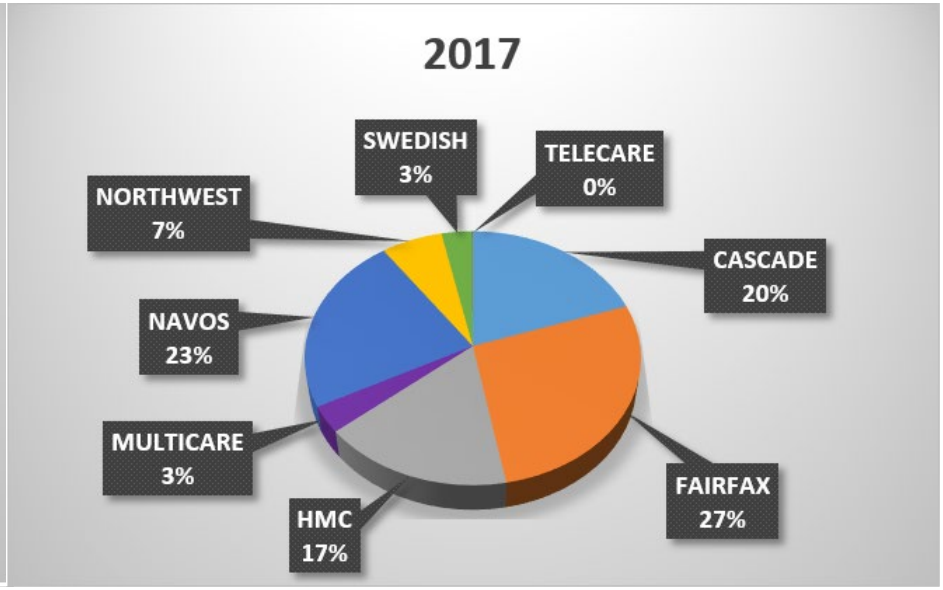
Requests for Additional Information

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

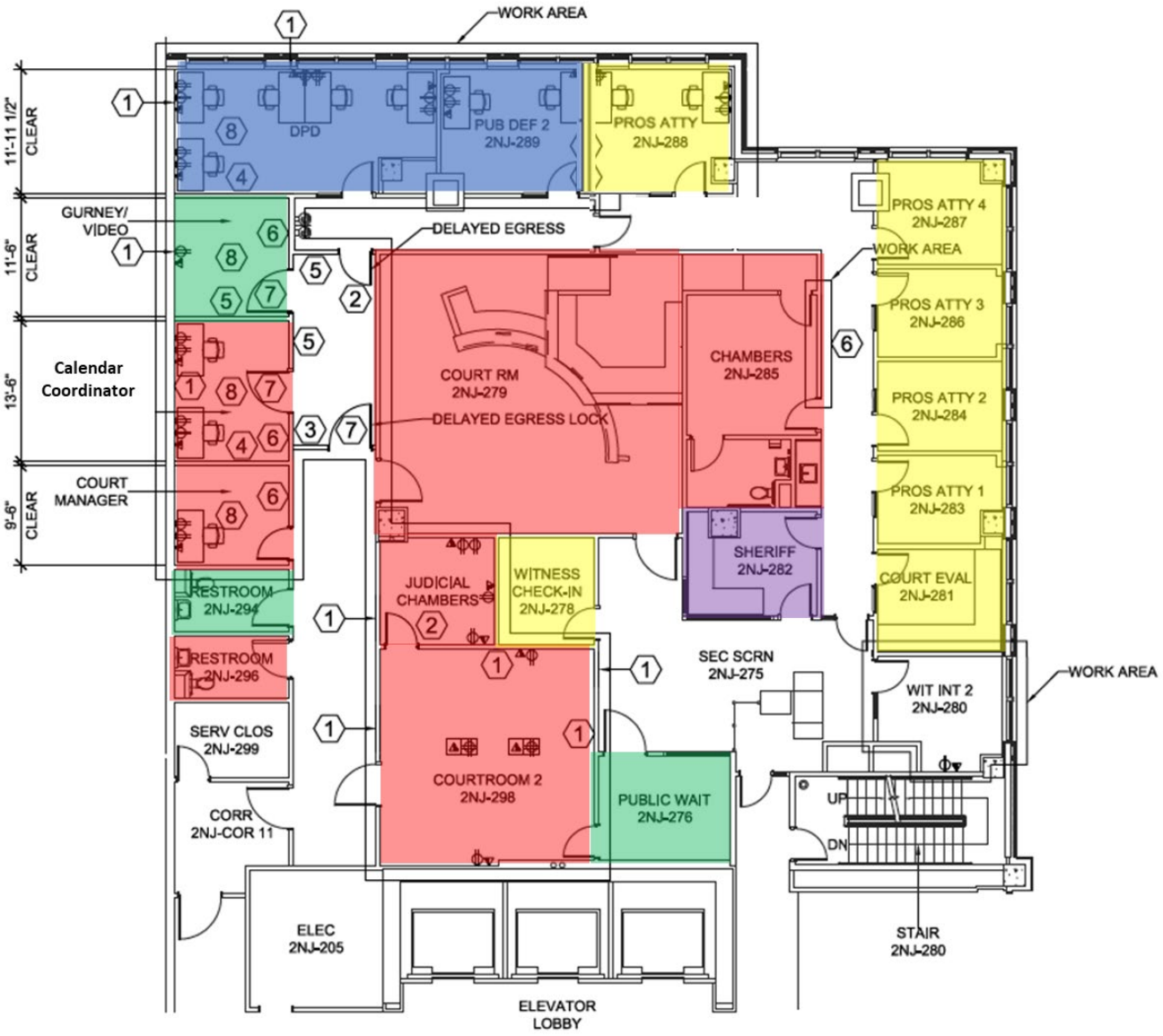
Prosecuting Attorney
Approximately 804 s/f

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

Subcommittee Members

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Questions?

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.

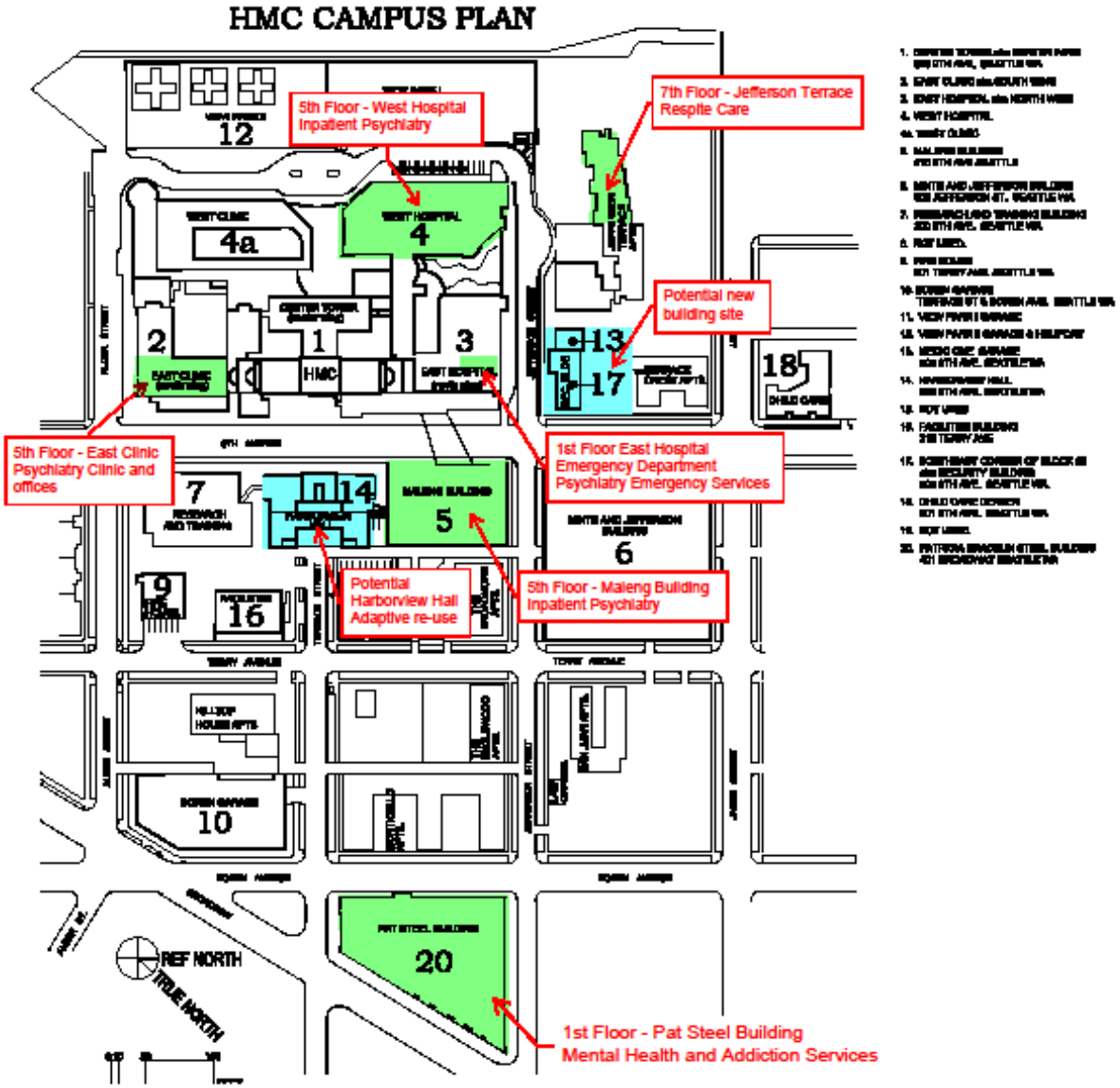


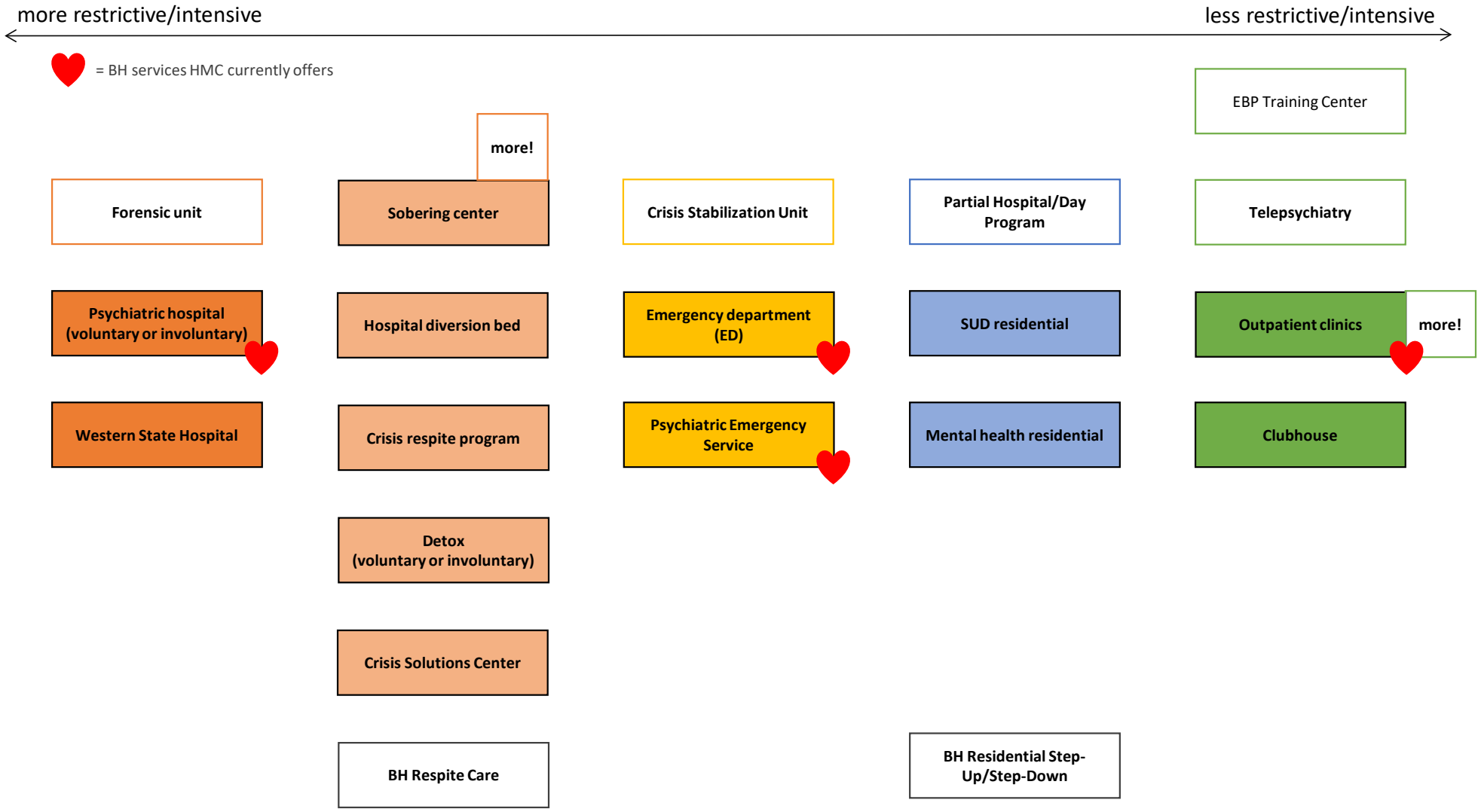
Figure 2: Visits to Harborview Inpatient Psychiatry and Psychiatric Emergency Service.

	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
- 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

Overview: Behavioral Health Disorders

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

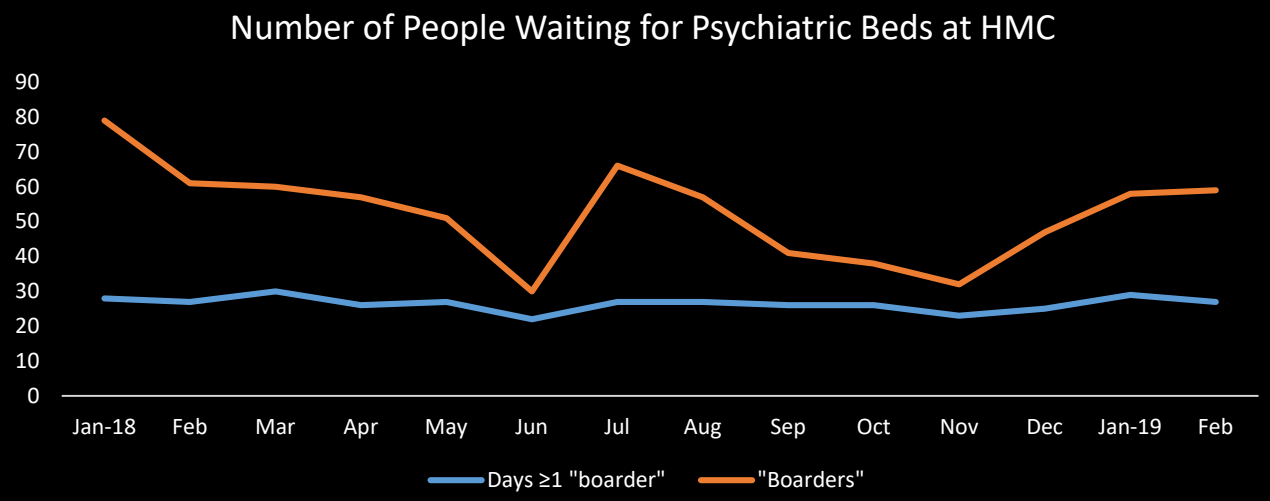
- **Behavioral health disorders do not discriminate**: People of all races, socioeconomic classes, ages, and sexes can develop behavioral health disorders

- **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

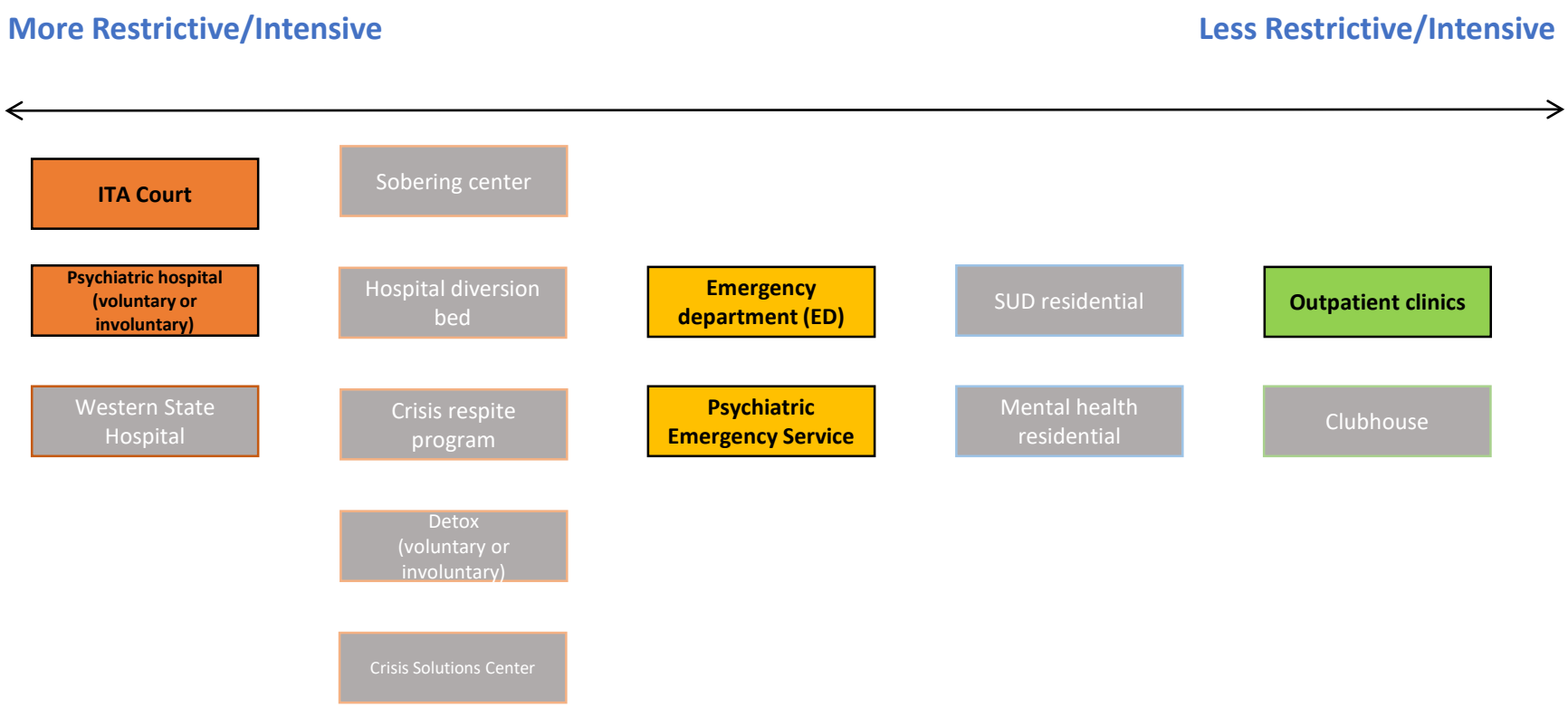
Needs Statement

- 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:

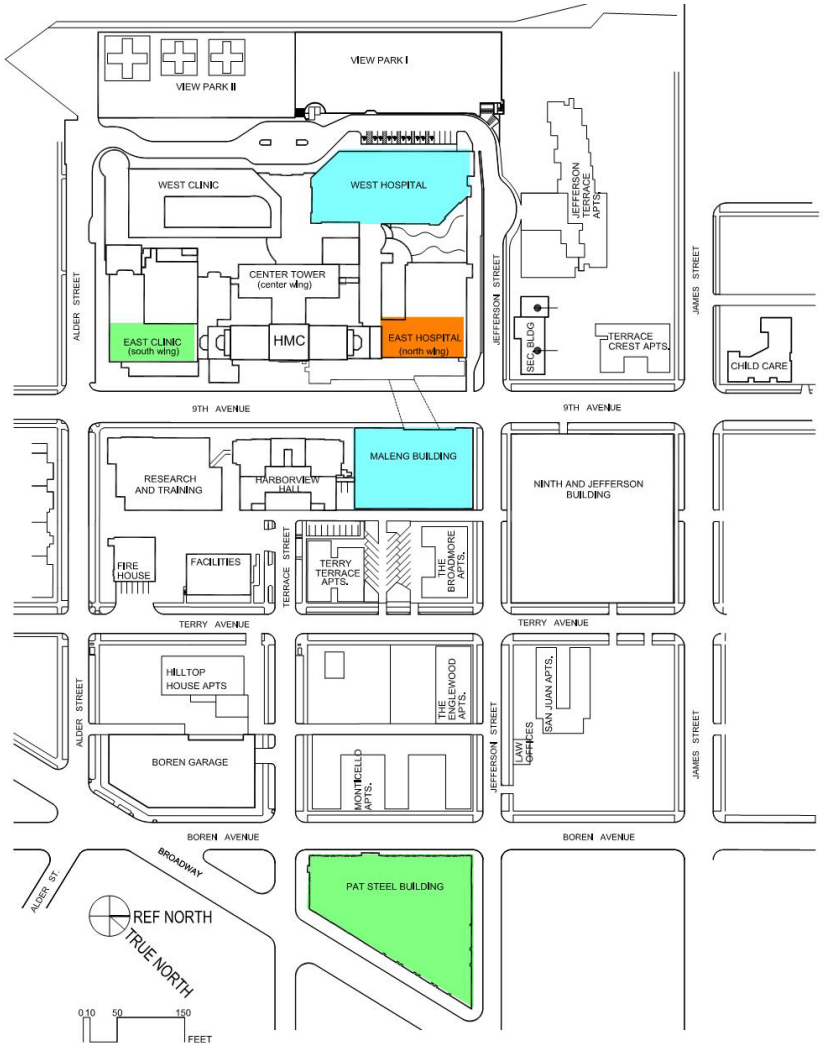
- **Option 1**: No Change/Existing Buildings
- **Option 2:** Expand Existing Facilities or Add New Space for three *Prioritized Programs (two new and one existing program)*
- **Option 3:** Expand Existing Facilities or Add New Space for four *Additional Programs*

…. 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**

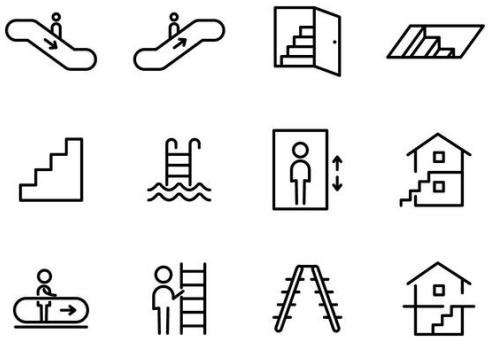
Crisis Stabilization Unit: New Service

- 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

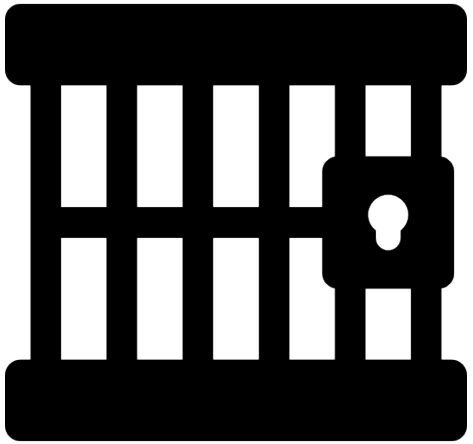
Option 3: Expand Existing Facilities or Add New Space for Additional Programs

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**

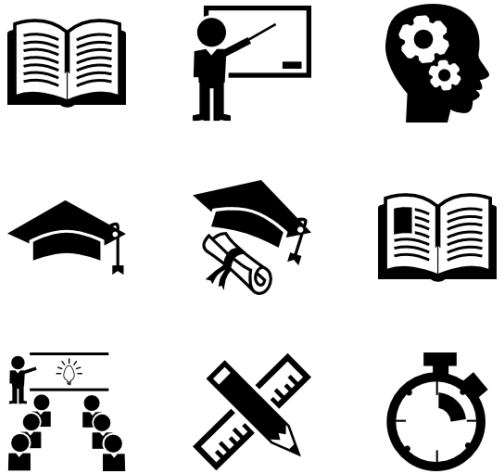
Forensic Inpatient Facility: New Service

- 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

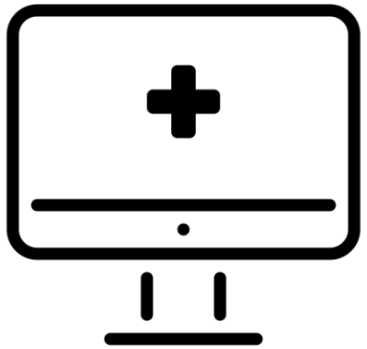


Sobering Center: New Service

- 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?

Community Engagement Goal: Provide for meaningful community participation in the planning and development of HLG recommendations so that community priorities can inform a potential regional health capital bond.

Engagement Guiding Principles

Equitable: multiple strategies/opportunities for people to provide input & weigh in, particularly those historically excluded, under-represented, and/or under-resourced
Transparent: information is clear and understandable, as well as type of feedback being sought, and how information will be used
Authentic: meaningful, not perfunctory "check the box"; all feedback is recorded and provided to HLG
Accessible: physically, linguistically, and culturally welcoming; information uniformly available
Broad: expansive as possible as resources (staff, consulting, and time, etc.) allow

Approach & Timeframe

A. Stand up Engagement Subcommittee: refine engagement activities, develop materials
B. Conduct two rounds of HLG capital planning specific outreach
    1. Inform and shape options that HLG will consider – September/October
    2. Review and comment on draft HLG recommendations - January/February
C. HLG information sharing and Q & A – ongoing
D. Ongoing project outreach - post HLG

Potential Engagement Methodologies

1. **Hold larger scale, geographically focused "community conversations"** (3-5)
   Ex: regions of King County (N, E, S, City of Seattle)
2. **Conduct specific demographic, issue, and/or stakeholder "focus groups"** (10-12)
   Ex: First Hill neighborhood, HMC workforce, mission populations, behavioral health,
3. **Attend existing groups & forums** (as possible)
   Ex: First Hill Neighborhood Association, Immigrant and Refugee Commission, Children and Youth Advisory Board, Board of Health
4. **Digital feedback mechanisms**
   Ex: Via electronic formats/surveys

Initial Stakeholder Outreach List

1. Immigrant and refugee communities
2. Neighborhood(s) residents
3. HMC workforce
4. Hospital users
5. Service providers
6. Physical and behavioral health stakeholders
7. Housing and homelessness stakeholders
8. Businesses
9. Other hospitals