E2SHB 2453 - H AMD **800**
By Representative Jinkins

1 Strike everything after the enacting clause and insert the
2 following:

3 "NEW SECTION. **Sec. 1.** A new section is added to chapter 71.24
4 RCW to read as follows:
5 The legislature finds that the growing demand for state hospital
6 beds has strained the state's capacity to meet the demand while
7 providing for a sufficient workforce to operate the state hospitals
8 safely. It is the intent of the legislature that the executive and
9 legislative branches work collaboratively to maximize access to,
10 safety of, and the therapeutic role of the state hospitals to best
11 serve patients while ensuring the safety of patients and employees.

12 NEW SECTION. **Sec. 2.** A new section is added to chapter 71.24
13 RCW to read as follows:
14 (1) The legislature intends to explore the option of changing the
15 current financing structure and financial incentives for state
16 hospital civil bed utilization by providing behavioral health
17 organizations and full integration entities under RCW 71.24.380 with
18 the state funds necessary to purchase a number of days of care at a
19 state hospital equivalent to the current allocation model, instead of
20 providing state hospital bed allocations under RCW 71.24.310. Such
21 funds would be available to purchase state hospital beds or for
22 alternative uses such as to purchase beds in other locations, to
23 invest in community services, and to invest in diversion from
24 inpatient care. Behavioral health organizations and equivalent
25 entities in full integration regions would be placed at risk for part
26 or all of state hospital civil utilization for patients within their
27 catchment areas, while receiving the means and opportunity to apply
28 any savings resulting from reduced state hospital utilization
29 directly to the service of clients in the community. This policy
30 option is intended to incentivize behavioral health organizations and
31 entities in full integration regions to increase their utilization

management efforts, develop additional capacity for hospital diversion, and increase their capacity to safely serve complex clients in the community.

(2) To further these ends, the department must develop a detailed transition plan in collaboration with its actuarial consultant and the external consultant to examine the current configuration and financing of state hospitals under section 5 of this act and with the regular input of behavioral health organizations, full integration regions, and other stakeholders. The transition plan shall include but not be limited to consideration of the following:

(a) A methodology for division of the current state hospital beds between each of the behavioral health organizations and full integration regions, including the appropriate method of allocation of beds among the behavioral health organizations and full integration regions;

(b) Development of payment rates for state hospital utilization that reflect financing, safety, and accreditation needs under the new system and ensure that necessary access to state hospital beds is maintained for behavioral health organizations and full integration regions;

(c) Maximizing federal participation for treatment and preserving access to funds through the disproportionate share hospital program;

(d) Billing and reimbursement mechanisms;

(e) Discharge planning procedures that must be adapted to account for functional needs assessments upon admission;

(f) Identification of regional differences and challenges for implementation in different regional service areas;

(g) A means of tracking expenditures related to successful reductions of state hospital utilization by regional service areas and means to assure that the funds necessary to safely maintain gains in utilization reduction are protected;

(h) Recommendations regarding smaller-scale fund-shift pilot initiatives through contracts with behavioral health organizations or long-term care providers to provide enhanced behavioral supports to move certain state hospital patients to alternative placements outside of the state hospital, including step-down and transitional placements;

(i) Recommendations for the timing of implementation of smaller-scale pilots and any full-scale transition;

(j) The potential for adverse impacts on safety and a description of available methods to mitigate any risks for patients, behavioral health organizations, full integration regions, and the community; and

(k) In recognition that behavioral health organizations and equivalent entities in full integration regions may not be best positioned to control utilization management for patients whose primary community care needs will be funded by the state long-term care or developmental disability systems, options for shifting the primary financial responsibility for state hospital costs for these patients to the long-term care and developmental disability systems, including an explanation of any benefits or disadvantages associated with these options.

(3) A preliminary draft of the transition plan must be submitted to the relevant committees of the legislature by November 15, 2016, for review by the select committee on quality improvement in state hospitals. The department shall consider the input of the committee and external stakeholders before submitting a final transition plan by December 30, 2016.

NEW SECTION. **Sec. 3.** (1) A select committee on quality improvement in state hospitals is established, composed of the following members:

(a) Four members of the senate, appointed by the president of the senate, consisting of the chairs and ranking members of the committee on health care and the committee on human services, mental health and housing, or their successor committees;

(b) Four members of the house of representatives, appointed by the speaker of the house of representatives, consisting of the chair and ranking members of the committee on health care and wellness and the committee on judiciary, or their successor committees;

(c) One member, appointed by the governor, representing the office of financial management; and

(d) Two nonvoting members, appointed by the governor, consisting of the secretary of the department of social and health services or a designee and the director of the department of labor and industries or a designee.

(2) The committee shall have two cochairs elected by the membership of the committee.

1 (3) The governor or a designee shall convene the initial meeting
2 of the committee.
3 (4) Meetings of the committee shall be open to the public and
4 shall provide an opportunity for public comment.
5 (5) Primary staff support for the committee must be provided by
6 the office of financial management. Additional staff support may be
7 provided by the office of program research and senate committee
8 services.
9 (6) The committee shall meet, at a minimum, on a quarterly basis
10 beginning April 2016, or as determined necessary by the committee
11 cochairs.
12 (7) State agency representatives shall respond in a timely manner
13 to data requests from the cochairs relating to the work of the
14 committee.
15 (8) Legislative members of the committee must be reimbursed for
16 travel expenses in accordance with RCW 44.04.120. Nonlegislative
17 members are not entitled to be reimbursed for travel expenses if they
18 are elected officials or are participating on behalf of an employer,
19 governmental entity, or other organization. Any reimbursement for
20 other nonlegislative members is subject to chapter 43.03 RCW.
21 (9) The expenses of the committee must be paid jointly by the
22 senate and the house of representatives. Committee expenditures are
23 subject to approval by the senate facilities and operations committee
24 and the house of representatives executive rules committee, or their
25 successor committees.

26 NEW SECTION. **Sec. 4.** The committee shall receive updates,
27 monitor, and make recommendations to the governor, the office of
28 financial management, and the legislature in the following areas,
29 with respect to the state hospitals:
30 (1) Planning related to the appropriate role of the state
31 hospitals in the state's mental health system, as well as state
32 hospital structure, financing, staff composition, and workforce
33 development needs to improve the quality of care, patient outcomes,
34 safety, and operations of the state hospitals;
35 (2) Recommendations for the use of funds from the governor's
36 behavioral health innovation fund created in section 6 of this act,
37 taking into consideration the information and recommendations
38 provided by the consultants identified in section 5 of this act and

the quarterly implementation progress reports provided in section 8 of this act;

(3) Monitoring of process and outcome measures regarding the implementation of policies and appropriations passed by the legislature; and

(4) Reviewing findings by the department of health regarding the results of its survey of the state hospitals and the department of labor and industries concerning the safety of the state hospitals and compliance with follow-up recommendations for corrective action. These agencies shall report to the committee quarterly or as requested by the committee.

NEW SECTION. **Sec. 5.** (1) Long-term planning for the state hospitals and recommendations for the use of funds from the governor's behavioral health innovation fund created in section 6 of this act must be informed by the use of consultants who shall make recommendations to the governor, the legislature, and the committee by October 1, 2016. The committee shall review the selection of consultants and provide input into the prioritization of tasks.

(2) The office of financial management must contract for the services of an external consultant who will examine the current configuration and financing of the state hospital system. This consultant shall:

(a) Work with the department of social and health services to produce the detailed transition plan described in section 2 of this act;

(b) Work with the state hospitals, local governments, community hospitals, mental health providers, substance use disorder treatment providers, other providers, and behavioral health organizations to identify options and make recommendations related to:

(i) Identification of which populations are appropriately served at the state hospitals;

(ii) Identification of barriers to timely admission to the state hospitals of individuals who have been court ordered to ninety or one hundred eighty days of treatment under RCW 71.05.320;

(iii) Utilization of interventions to prevent or reduce psychiatric hospitalization;

(iv) Benefits and costs of developing and implementing step-down and transitional placements for state hospital patients;

1 (v) Whether discharges of patients take into consideration
2 whether it is appropriate for the patient to return to the patient's
3 original community considering the location of family and other
4 natural supports, the availability of appropriate services, and the
5 desires of the patients. The consultant must report whether the lack
6 of resources in a patient's home community is a significant factor
7 that causes barriers to discharge or frequently results in relocation
8 of patients outside their home communities for posthospital care;
9 (vi) Optimization of continuity of care with community providers,
10 including but not limited to coordination with any community
11 behavioral health provider or evaluation and treatment facility that
12 has treated the patient immediately prior to state hospital
13 admission, and any provider that will serve the patient upon
14 discharge from the state hospital;
15 (vii) Reduction of barriers to discharge, including options to:
16 (A) Ensure discharge planning begins at admission;
17 (B) Offer co-occurring substance use disorder treatment services
18 at the state hospitals;
19 (C) Clarify and hold accountable state hospitals and behavioral
20 health organizations for their respective roles in the discharge
21 planning process, including development of community diversion and
22 transition options;
23 (D) Include contract performance measures related to timely
24 discharge planning in behavioral health organization contracts;
25 (E) Improve state monitoring and oversight of behavioral health
26 organizations in their contracted responsibilities for developing an
27 adequate network to meet the needs of their communities;
28 (F) Incentivize the use of community resources when clinically
29 appropriate; and
30 (G) Expedite discharge for individuals who are the responsibility
31 of the long-term care or developmental disability systems, or who are
32 not covered by medicaid, and assure financial responsibility to
33 appropriate systems, including the potential necessity of other
34 state-run facilities;
35 (viii) Planning for the long-term integration of physical and
36 behavioral health services, including strategies for assessing risk
37 for the utilization of state hospital beds to health plans contracted
38 to provide the full range of physical and behavioral health services;
39 and

(ix) Identification of the potential costs, benefits, and impacts associated with dividing one or both of the state hospitals into discrete hospitals to serve civil and forensic patients in separate facilities.

(3) The department of social and health services shall contract for the services of an academic or independent state hospitals psychiatric clinical care model consultant to examine the clinical role of staffing at the state hospitals.

(a) The consultant's analysis must include an examination of:

(i) The clinical models of care;

(ii) Current staffing models and recommended updates to the staffing model created under section 9(1) of this act;

(iii) Barriers to recruitment and retention of staff;

(iv) Creating a sustainable culture of wellness and recovery;

(v) Increasing responsiveness to patient needs;

(vi) Reducing wards to an appropriate size;

(vii) The use of interdisciplinary health care teams;

(viii) The appropriate staffing model and staffing mix to achieve optimal treatment outcomes considering patient acuity; and

(ix) Recommended practices to increase safety for staff and patients.

(b) To the extent that funding is appropriated for this purpose and necessary modification to labor practices are completed, the consultant shall assist the department of social and health services with implementation of recommended changes.

(4) The consultant services in this section shall be acquired with funds appropriated for this purpose and the contracts are exempt from the competitive solicitation requirements in RCW 39.26.125.

NEW SECTION. **Sec. 6.** The governor's behavioral health innovation fund is hereby created in the state treasury. Moneys in the fund may be spent only after appropriation. Only the director of financial management or the director's designee may authorize expenditures from the fund. Moneys in the fund are provided solely to improve quality of care, patient outcomes, patient and staff safety, and the efficiency of operations at the state hospitals.

NEW SECTION. **Sec. 7.** (1) The department of social and health services may apply to the office of financial management to receive funds from the governor's behavioral health innovation fund.

(2) The application must include proposals to increase the overall function of the state hospital system in one or more of the following categories:

(a) Instituting fund-shift pilot initiatives through contracts with behavioral health organizations or long-term care providers providing enhanced behavioral supports to move certain state hospital patients to alternative placements outside of the state hospital, contingent on federal funding. Proposals must include quality outcome measures and acuity-based staffing models of interdisciplinary teams designed for optimal treatment outcomes;

(b) Developing and utilizing step-down and transitional placements for state hospital patients;

(c) Improving staff retention and recruiting;

(d) Increasing capacity and instituting other measures to reduce backlogs and wait lists in both the civil and forensic systems;

(e) Increasing stability and predictability in the state hospitals' operating costs and budgets;

(f) Making necessary practice and staffing changes, subject to collective bargaining;

(g) Improving safety for patients and staff;

(h) Increasing staff training;

(i) Improving the therapeutic environment; and

(j) Improving the provision of forensic mental health services.

(3) Application proposals must be based on the use of evidence-based practices, promising practices, or approaches that otherwise demonstrate quantifiable, positive results.

(4) Moneys from the governor's behavioral health innovation fund may not be used for salary increases within the state hospitals.

(5) The office of financial management must consider input from the committee when awarding funding.

NEW SECTION. **Sec. 8.** The department of social and health services must provide quarterly implementation progress reports to the committee and the office of financial management that include at a minimum:

(1) The status of completing key activities, critical milestones, and deliverables over the prior period;

(2) Identification of specific barriers to completion of key activities, critical milestones, and deliverables and strategies that will be used for addressing these challenges;

(3) The most recent quarterly data on all performance measures and outcomes for which data is currently being collected, as well as any additional data requested by the committee; and

(4) The status of the adoption and implementation of the policies identified in section 9 of this act.

NEW SECTION. **Sec. 9.** The department of social and health services must assure that the state hospitals adopt and implement the following policies, subject to the availability of appropriated funding, and shall include information regarding the status of the adoption and implementation of these policies in its quarterly reports required under section 8 of this act:

(1) A standardized acuity-based staffing model employed at both facilities that recognizes the staffing level required based upon the type of patients served, the differences and constraints of the physical plant across hospitals and wards, and the full scope of practice of all credentialed health care providers, and that identifies the incorporation of these health care providers practicing to the maximum extent of their credential in interdisciplinary teams. The model shall recognize a role for advanced registered nurse practitioners and physician assistants to utilize the full scope of their practice as provided under section 12 of this act;

(2) A strategy with measurable, articulated steps for reducing the unnecessary utilization of state hospital beds and minimizing readmissions to evaluation and treatment facilities for state hospital patients;

(3) A program of appropriate safety training for state hospital staff;

(4) A plan to fully use appropriated funding for enhanced service facilities and other specialized community resources for placement of state hospital patients with conditions such as dementia, traumatic brain injury, or complex medical and physical needs requiring placement in a facility which offers significant assistance with activities of daily living; and

(5) A process for appeal to the secretary of the department of social and health services or the secretary's designee within fourteen days in cases where a behavioral health organization, other entities under RCW 71.24.380, or the state agency division responsible for the community care needs of the patient and the state

hospital treatment team are unable to reach a mutually agreed upon discharge plan for patients who are considered by either party to be ready for discharge. This process shall ensure consideration of risk factors for readmission.

NEW SECTION. **Sec. 10.** For purposes of this chapter:

(1) "Behavioral health organization" has the same meaning as in RCW 71.24.025 and includes any managed care organization that has contracted with the state to provide fully integrated behavioral health and physical health services for medicaid clients.

(2) "Committee" means the select committee on quality improvement in state hospitals created in section 3 of this act.

(3) "State hospitals" include western state hospital and eastern state hospital as designated in RCW 72.23.020.

NEW SECTION. **Sec. 11.** (1) The legislature finds that there are currently patients with long-term care needs at western state hospital who are ready for discharge and could safely be served in community settings if alternative placements are made available.

(2) The department of social and health services must identify discharge and diversion opportunities for patients needing long-term care to reduce the demand for thirty beds currently being used for this population. A twenty bed reduction must be realized by July 1, 2016, with a utilization reduction of ten additional beds by January 1, 2017. The resources being used to serve these beds must be reinvested within the state hospital budget in order to achieve patient and staff safety improvement goals.

(3) The department of social and health services must provide a progress report to the governor and relevant committees of the legislature by December 1, 2016, and a final report by August 1, 2017, describing outcomes for these patients through June 30, 2017.

NEW SECTION. **Sec. 12.** (1) The legislature finds that the potential uses of psychiatric advanced registered nurse practitioners and physician assistants in institutional settings at the top of their scope of practice are currently being underutilized by the state hospitals.

(2) The office of financial management must create a job class series for psychiatric advanced registered nurse practitioners and a job class series for physician assistants that allows these

professionals to practice at the top of their scope of practice at state hospitals. In conjunction and conformance with the staffing analysis described in section 9(1) of this act, the state hospitals shall increase the employment of professionals operating under these new classifications in a manner that allows the state hospitals to reduce their reliance on psychiatrist positions, which the state hospitals are currently unable to fill. The state hospitals must consider the role of these professionals in supervising or directing the work of other treatment team members.

(3) Nothing in this section should be construed to require the state to violate any collective bargaining agreements in place prior to the effective date of this section. Agreements negotiated or renegotiated after the effective date of this section must be consistent with the expanded use of advanced registered nurse practitioners and physician assistants required by this section.

<u>NEW SECTION.</u> **Sec. 13.** To the extent that any of the timelines in this act are not achievable due to conflicts with other hospital improvement timelines set by federal or state regulatory bodies, the department of social and health services may seek a reasonable extension from the select committee.

<u>NEW SECTION.</u> **Sec. 14.** This chapter expires July 1, 2019.

Sec. 15. RCW 71.05.365 and 2014 c 225 s 85 are each amended to read as follows:

When a person has been involuntarily committed for treatment to a hospital for a period of ninety or one hundred eighty days, and the superintendent or professional person in charge of the hospital determines that the person no longer requires active psychiatric treatment at an inpatient level of care, the behavioral health organization<u>, full integration entity under RCW 71.24.380, or agency providing oversight of long-term care or developmental disability services that is</u> responsible for resource management services for the person must work with the hospital to develop an individualized discharge plan and arrange for a transition to the community in accordance with the person's individualized discharge plan within ((~~twenty-one~~)) <u>fourteen</u> days of the determination.

1 <u>NEW SECTION.</u> **Sec. 16.** Section 15 of this act takes effect July
2 1, 2018.

3 <u>NEW SECTION.</u> **Sec. 17.** Sections 3 through 14 of this act
4 constitute a new chapter in Title 72 RCW.

5 <u>NEW SECTION.</u> **Sec. 18.** (1) Sections 3 through 8 and 10 of this
6 act are necessary for the immediate preservation of the public peace,
7 health, or safety, or support of the state government and its
8 existing public institutions, and take effect immediately.
9 (2) Section 9 of this act takes effect July 1, 2016."

10 Correct the title.

<u>EFFECT:</u> (1) Requires Department of Social and Health Services (DSHS) to develop a transition plan for changing the structure and financial incentives for state hospital civil bed utilization by providing behavioral health organizations and full integration entities with the state funds necessary for purchase of hospital beds or alternative community beds, instead of providing state hospital bed allocations.

(2) Amends the composition and membership of the Select Committee on Quality Improvement in State Hospitals (select committee) in the following ways: (a) Specifies that representatives of the DSHS and the Department of Labor and Industries (L&I) are nonvoting members; (b) eliminates representatives of the Department of Health (DOH), the Health Care Authority, and the Governor's Office as members of the select committee; (c) removes staffing responsibilities for the select committee from the DSHS, DOH, and L&I; and (d) provides that both cochairs are elected by the membership, rather than having an executive branch cochair selected by the Governor and a legislative cochair selected by the membership.

(3) Adds to the responsibilities of the select committee to review findings by DOH regarding the results of its survey of state hospitals and findings by L&I concerning safety and compliance with corrective action recommendations.

(4) Eliminates the state hospital performance consultant, and adds that consultant's assignment to the assignment to the state hospitals psychiatric clinical care model consultant's assignment, along with additional responsibilities to recommend updates to the staffing model that the DSHS is required to create and make safety practice recommendations, as well as examine barriers to recruitment and retention of staff.

(5) Adds to the configuration and financing consultant's assignment to: (a) Assist with the transition plan for changing the structure and financial incentives for state hospital bed utilization; and (b) examine whether discharges take into consideration the appropriateness of returning patients to their communities of origin, as well as the relationship between lack of resources in a patient's home community and barriers to discharge or discharge outside of the patient's home community.

(6) Amends the requirement that the DSHS discharge patients needing long-term care from Western State Hospital, reducing the need

for thirty beds, to: (a) Require that a twenty bed reduction must occur by July 1, 2016, and an additional ten bed reduction by January 1, 2017 (rather than requiring the reduction of all thirty beds by July 1, 2016); and (b) require DSHS to provide reports to the Governor and the Legislature at specified dates describing outcomes for these patients.

(7) Adds requirements related to expanded utilization of advanced registered nurse practitioners (ARNPs) and physician assistants at the state hospitals: The Office of Financial Management must create a job class series for psychiatric ARNPs and for physician assistants, allowing practice at the top of scope of practice at the state hospitals. State hospitals must increase employment under the new classifications in a manner that reduces reliance on currently unfillable psychiatrist positions.

(8) Reduces a statutory timeline, from twenty-one days to fourteen days, for transition to the community of persons ready for discharge from a state hospital, and includes full integration entities and agencies providing oversight of long-term care or developmental disability services in the list of resource management services that may be responsible for working with the hospital to facilitate discharge. This provision is effective July 1, 2018.

(9) Makes other minor wording and technical corrections.

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