SENATE BILL REPORT
2SHB 1394

As Passed Senate - Amended, April 17, 2019

Title: An act relating to community facilities needed to ensure a continuum of care for behavioral health patients.

Brief Description: Concerning community facilities needed to ensure a continuum of care for behavioral health patients.

Sponsors: House Committee on Appropriations (originally sponsored by Representatives Schmick, Cody, Jinkins, Kilduff, Davis, Griffey, Riccelli, Macri, Harris, Robinson, Goodman, Sullivan, Appleton, Bergquist, Thai, Tharinger, Slatter, Doglio, Pollet, Callan, Leavitt and Ormsby; by request of Office of the Governor).

Brief History: Passed House: 3/05/19, 98-0.
Committee Activity: Behavioral Health Subcommittee to Health & Long Term Care: 3/15/19, 3/22/19 [DPA-WM].
Ways & Means: 3/28/19, 4/08/19 [DPA].
Floor Activity:
Passed Senate - Amended: 4/17/19, 48-0.

Brief Summary of Bill
(As Amended by Senate)

- Requires the Health Care Authority (HCA) to assess community capacity to provide long-term inpatient care to involuntary patients and contract for such services to the extent that certified providers are available.
- Suspends the certificate of need requirement relating to construction of psychiatric beds or expansion of psychiatric bed capacity for an additional two years until June 30, 2021.
- Requires the Department of Health (DOH) to license and certify intensive behavioral health treatment facilities, mental health peer respite centers, and to allow an enhanced rate to be paid to nursing homes that convert to assisted living or residential treatment facilities.
- Requires HCA to establish a daytime mental health drop-in center pilot in Yakima until July 1, 2022, and issue a report by December 1, 2021.
- Requires HCA and DOH to consult with hospitals and review laws and regulations relating to long-term inpatient care provided to involuntary

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patients and recommend any changes needed to address care delivery and cost effectiveness by December 15, 2019.

- Requires the Department of Social and Health Services to track information related to clients of the Developmental Disabilities Administration and share the information upon request with specified entities and the public.

SENATE COMMITTEE ON BEHAVIORAL HEALTH SUBCOMMITTEE TO HEALTH & LONG TERM CARE

Majority Report: Do pass as amended and be referred to Committee on Ways & Means.
Signed by Senators Dhingra, Chair; Wagoner, Ranking Member; Darneille and Frockt.

Staff: Kevin Black (786-7747)

SENATE COMMITTEE ON WAYS & MEANS

Majority Report: Do pass as amended.
Signed by Senators Rolfes, Chair; Frockt, Vice Chair, Operating, Capital Lead; Braun, Ranking Member; Brown, Assistant Ranking Member, Operating; Honeyford, Assistant Ranking Member, Capital; Bailey, Becker, Billig, Carlyle, Conway, Darneille, Hasegawa, Hunt, Keiser, Liias, Palumbo, Pedersen, Rivers, Schoesler, Van De Wege, Wagoner and Warnick.

Staff: Travis Sugarman (786-7446)

Background: Long-Term Inpatient Care. Long-term inpatient care is voluntary or involuntary inpatient treatment for a mental disorder or substance use disorder which extends for periods of 90 days or more. Involuntary treatment is provided to persons who are initially detained by designated crisis responders and subsequently court-ordered to receive treatment based on a behavioral health disorder that causes them to present a likelihood of serious harm or to be gravely disabled. Patients committed for involuntary inpatient treatment start by receiving short-term care for 72-hours and then 14 days at community evaluation and treatment facilities (E&Ts) or secure detoxification facilities (secure detoxes) before, if the patient continues to have needs that cannot be met in a less restrictive alternative, becoming eligible for a further period of commitment for up to 90 days and transfer to long-term inpatient care.

Licensure and Certification of Facilities. DOH licenses and certifies residential treatment facilities and other facilities that treat persons with mental health and substance use disorder treatment needs, including E&Ts, secure detoxes, crisis triage facilities, and crisis stabilization units. Residential treatment facilities provide intensive services to adults with behavioral health needs and may include 24-hour supervision, acuity-based staffing, and the ability to use limited egress. The Department of Social and Health Services (DSHS) licenses and certifies enhanced services facilities, skilled nursing facilities, assisted living facilities,

and adult family homes for adults with needs for functional assistance related to activities of daily living.

Certificate of Need. A certificate of need is a requirement for approval from DOH before the provision of health services may be expanded for the purpose of reviewing the potential impact of the expansion on a community's need for the service. The certificate of need requirement to construct a new psychiatric hospital, or to increase the number of psychiatric beds at an existing hospital, was suspended in 2014 to alleviate the need to board psychiatric patients in emergency departments, and remains suspended until June 30, 2019. Different variations of this requirement and suspension until June 30, 2019, exist for acute care hospitals, psychiatric hospitals, psychiatric facilities, and grant-funded psychiatric expansion programs.

Summary of Amended Bill: HCA, managed care organizations, behavioral health services organizations, and, until January 1, 2020, behavioral health organizations must work with willing community hospitals and E&Ts to assess their capacity to become licensed or certified to provide long-term inpatient care to involuntary patients, and enter into contracts and payment arrangements for these services to the extent that licensed or certified facilities are available. Community hospitals and E&Ts are not required to provide long-term inpatient care to involuntary patients.

The suspension of the certificate of need requirement for constructing a new psychiatric hospital or to increase the number of psychiatric beds in a hospital, acute care hospital, psychiatric hospital, or grant-funded psychiatric program is extended for two years until June 30, 2021. An added purpose cited for the suspension is to increase the capacity of hospitals to provide long-term inpatient care to involuntary patients. The certificate of need exemption is expanded to allow a one-time addition of up to 60 psychiatric beds devoted solely to 90-day and 180-day civil commitment patients if the hospital is awarded a grant by the Department of Commerce to increase behavioral health capacity in fiscal year 2019 and commits to maintain a payer mix of at least 50 percent patients funded by Medicare or Medicaid for five consecutive years.

DOH must license or certify intensive behavioral health treatment facilities (IBHTFs) that are specialized residential treatment facilities serve adult clients with behavioral health conditions, including individuals discharging from or diverted from state hospitals, whose care needs cannot be met in other community-based placement settings. IBHTFs must require:

- clearly defined clinical eligibility criteria;
- 24-hour supervision of residents;
- high acuity staffing requirements that include a clinical team and a high staff-to-patient ration;
- minimum standards for providing services to clients with intellectual or developmental disability needs;
- access to regular psychosocial rehabilitation services including, but not limited to, skills training in daily living activities, social interaction, behavioral management, impulse control, and self-management of medications;
- requirements for ability to use limited egress; and
- resident rights that are similar to those of residents in long-term care facilities.

DOH must consult with DSHS, the Department of Commerce, the Long-Term Care Ombuds, and relevant stakeholders to develop recommendations on providing resident rights and access to Ombuds services to residents of IBHTFs.

DOH must certify community behavioral health agencies to provide 24-hour, peer-run mental health peer respite centers that provide voluntary, short-term, noncrisis services for up to seven days in a month for adults in psychiatric distress who do not meet legal criteria for involuntary commitment. Mental health peer respite centers must partner with the local crisis system and focus on recovery and wellness.

HCA must establish a pilot program to provide mental health drop-in center services in Yakima from January 1, 2020 to July 1, 2022. The pilot must involve a peer-focused recovery model during daytime hours through a community-based, therapeutic less-restrictive alternative to psychiatric hospitalization. Clients may refer themselves, be referred by an emergency department, or be brought to the center by their families or by law enforcement. HCA must provide a preliminary report by January 1, 2020, which includes a survey of peer mental health programs operating in the state and a final report by December 1, 2021, describing how clients were served and providing recommendations on how to expand the program statewide.

HCA and DSHS must provide recommendations to the Governor and Legislature by July 1, 2020, on short-term and long-term residential intensive behavioral health and developmental disabilities services for youth and adults who have co-occurring mental health and developmental disability needs and are in danger of experiencing barriers discharging from community hospitals or state hospitals. HCA and DSHS must consult with DOH, DCYF, representatives from hospitals that provide inpatient psychiatric services to children, and developmental disabilities advocacy organizations.

DSHS is authorized to provide an enhanced care rate for a nursing home that provides assisted living and authorized to provide a supplemental add-on residential care rate for a nursing home that provides adult residential care, including but not limited to the purpose of serving individuals with behavioral health treatment needs.

Subject to funding, DSHS must to track and monitor the number of developmental disability clients who are taken to a hospital while receiving Developmental Disabilities Administration (DDA) services, or following termination of DDA services, and whether these clients had a medical need before hospitalization, their length of stay, and what barriers, if any, they experience to discharge after their medical needs are met. For clients who were hospitalized after termination of DDA services, DDA must track the reason for the termination. DDA providers must notify DSHS when a DDA client is taken to the hospital without a medical need and when a DDA client who has been taken to the hospital is unable to discharge back to the same provider. DSHS must provide this information upon request to the Developmental Disabilities Ombuds, the Washington State Hospital Association, the Legislature, and the public.

HCA must confer with DOH and hospitals to identify changes that may be necessary in laws and regulations to address care delivery and cost-effective treatment for adults in long-term

involuntary inpatient care. HCA must report its findings to the Governor and the Legislature by December 15, 2019.

The definition of "recovery" under chapter 71.24 RCW is amended to mean a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

Appropriation: None.

Fiscal Note: Available.

Creates Committee/Commission/Task Force that includes Legislative members: No.

Effective Date: Ninety days after adjournment of session in which bill is passed.

Staff Summary of Public Testimony on Second Substitute House Bill (Behavioral Health Subcommittee to Health & Long Term Care): *The committee recommended a different version of the bill than what was heard.* PRO: As we figure out how to handle mental health, we need to put rules in place. The peer drop-in program in New York has had good results. This is a work in progress. Peer respite drop-in centers are voluntary, short-term overnight programs, in a home-like setting. This will help people not have to go to emergency rooms when that is not the appropriate place. The Hospital Association has been in discussions about providing community beds for long-term involuntary hospitalization and is prepared to provide up to 200 beds. The certificate of need exemptions are needed to do this in a timely manner. Please amend the bill to allow an up-to-60 bed expansion of psychiatric beds in King County. Siting state-run, small facilities is an important part of the Governor's plan. State employees are needed to provide mental health services. My son has a severe mental illness. He is currently hospitalized three hours from our home. I support increasing system capacity and improving the continuum of care. Negative outcomes are avoidable when patients can get care in their own community. The burden and stress is lessened for families when treatment is close to home. We look forward to developing resident rights for clients in these facilities, who should be served by the long-term care ombuds program.

CON: I have experienced over 50 psychiatric hospitalizations, shock treatment, and involuntary treatment. Please make amendments to this bill which I am providing in writing. Please add persons with direct, lived experience to the work group. Drop-in centers are distinct from peer respite. Both models are entirely voluntary and must not include a law enforcement drop off. Professionals and experts have not been doing a good job for people like me. Quality of treatment has not been sufficient to maintain facility certifications at Western State Hospital or Rainier School. We need a quality assurance program for the operation of all state facilities. More effort must be made to talk to peers about what their actual needs are. Please listen to us and incorporate our input into your policy-making.

OTHER: In general we support this effort. Please make the same amendment to the definition of intensive behavioral health treatment facility which you made on the Senate bill. Please include the previous language relating to mental health peer respite centers. We are concerned about losing short-term involuntary treatment capacity in the shift towards

providing community long-term beds. Please ensure that residents in intensive behavioral health facilities have statutorily protected rights, and that these facilities are only used for voluntary services which allow residents to come and go. More space for community input is needed.

Persons Testifying (Behavioral Health Subcommittee to Health & Long Term Care): PRO: Representative Joe Schmick, Prime Sponsor; Rashi Gupta, Governor's Policy Office; Matt Zuvich, Washington Federation of State Employees; Len McComb, Washington State Hospital Association; Melanie Smith, NAMI Washington; Patricia Egbert, citizen.

CON: Tim Field, citizen; Laura Van Tosh, citizen.

OTHER: David Foster, King County; Rebecca Faust, citizen.

Persons Signed In To Testify But Not Testifying (Behavioral Health Subcommittee to Health & Long Term Care): No one.

Staff Summary of Public Testimony on Bill as Amended by Behavioral Health Subcommittee to Health & Long Term Care (Ways & Means): PRO: This is the first step to fill the continuum of care with more options for individuals in crisis that may not meet the criteria for commitment, but need intensive supports. These two types of facilities would provide opportunities for these services in places other than the state hospitals. I have been working on some language so that we can use the intensive behavioral health facilities for individuals with developmental disabilities. The drop in center pilot for Yakima is not slated for the Yakima Valley School and does not have a designated facility yet. The peer respite centers do not allow for law enforcement drop offs. This pilot would allow for that. The certificate of need exemption is important to the hospital that wants to provide 90/180 day beds for the system. Individuals with developmental disabilities should be allowed to be housed in the intensive behavioral health facilities because there is currently not any place that can take them from the state hospitals.

OTHER: I do appreciate there are alternatives and support peer respites. Peer respite centers need to stay true to the model and you should not allow for anything other than self-referrals.

Persons Testifying (Ways & Means): PRO: Len McComb, Washington State Hospital Association; Rashi Gupta, Governor's Policy Office; Donna Patrick, Developmental Disabilities Council.

OTHER: David Culp, Community Peer Respite Planning Council; Rebecca Faust, citizen.

Persons Signed In To Testify But Not Testifying (Ways & Means): No one.