SENATE BILL REPORT
SB 5431

As Reported by Senate Committee On:
Behavioral Health Subcommittee to Health & Long Term Care, February 21, 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: Senators Frockt, Rivers, O'Ban, Dhingra, Darneille, Cleveland, Keiser, Wagoner, Das, Van De Wege, Zeiger, Conway, Hunt, Kuderer and Nguyen; by request of Office of the Governor.

Brief History:
Committee Activity: Behavioral Health Subcommittee to Health & Long Term Care: 2/14/19, 2/21/19 [DPS-WM].

Brief Summary of First Substitute Bill

- 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 and behavioral health drop-in centers and allows an enhanced rate to be paid to nursing homes that convert to assisted living or residential treatment facilities.
- Requires HCA and DOH to consult with hospitals and evaluation and treatment facilities to review laws and regulations relating to long-term inpatient care provided to involuntary patients and recommend any changes needed to address care delivery and cost effectiveness by December 15, 2019.

This analysis was prepared by non-partisan legislative staff for the use of legislative members in their deliberations. This analysis is not a part of the legislation nor does it constitute a statement of legislative intent.

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

Majority Report: That Substitute Senate Bill No. 5431 be substituted therefor, and the substitute bill do pass and be referred to Committee on Ways & Means.

Signed by Senators Dhingra, Chair; Wagoner, Ranking Member; Darneille, Frockt and O'Ban.

Staff: Kevin Black (786-7747)

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 Bill (First Substitute): 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.

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;
- 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 Obuds services to residents of IBHTFs.

DOH must license or certify 24-hour, peer-run behavioral health drop-in centers that provide voluntary, short-term, noncrisis services for up to seven days in a month for adults in psychiatric distress referred from emergency rooms, hospitals, or designated crisis responders who do not meet legal criteria for involuntary commitment. Behavioral health drop-in centers must partner with the local crisis system and focus on recovery and wellness.

DOH must provide recommendations to the Governor and Legislature by December 1, 2019, in consultation with DSHS, the Department of Children, Youth and Families, and representatives from providers serving children's inpatient psychiatric needs in Seattle, Spokane, and Tacoma, on youth short-term residential intensive behavioral health and developmental disabilities services that include licensed mental health professionals and developmental disabilities professionals. The recommendations must consider developmental disability-related services needed to support the youth and family in preparation for and after discharge.

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.

HCA must confer with DOH, hospitals, and evaluation and treatment facilities 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.

EFFECT OF CHANGES MADE BY BEHAVIORAL HEALTH SUBCOMMITTEE TO HEALTH & LONG TERM CARE COMMITTEE (First Substitute):

- Amends requirements for intensive behavioral health treatment facilities;
- Amends definition and requirements for behavioral health drop-in centers;
- Requires DOH to lead a stakeholder process to develop and establish resident rights and access to Ombuds services for residents of intensive behavioral health treatment facilities; and
- Requires DOH to consult with inpatient psychiatric providers for children before developing recommendations for youth short-term residential intensive behavioral health and developmental disabilities services.

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 Original Bill: *The committee recommended a different version of the bill than what was heard.* PRO: This is consistent with the capital budget work being done to build out mental health facilities. The extension of certificate of need is necessary and should be followed by an entire overhaul of our antiquated certificate of need process. The new facility types are an important part of the downstream commitments we need to make to make the system workable. We have heard over the years that our behavioral health system is a crisis system, and the only way to get a bed is to be in crisis. There needs to be a continuum, and this is the first step to filling it in on the behavioral health side. Many people in Western State Hospital are ready for discharge but have no place to go. Intensive behavioral health treatment facility capacity is intended to be purchased through managed care organizations unlike the current capacity funded through the Department of Social and Health Services Aging & Long-Term Care Administration. People are looking for a place to go when they do not yet meet detention criteria. There is no voluntary option available. Peer-run mental health drop-in centers are based on a model in New York for fully voluntary peer-run respite for up to seven days. The bill also address a problem related to persons with developmental disabilities who lack discharge options from community hospitals. These options fill a very important gap that exists in the current system. Please adopt an amendment adding E&Ts to the consultation process to amend regulations for long-term involuntary inpatient care and clarifying that drop-in centers are meant to be open 24 hours a day. Community hospitals are prepared to offer 76 beds for long-term involuntary inpatient care in locations around the state. This bill is required to do that, both the authorizing language and the suspension of the certificate of need. Please amend the bill to prevent the conversion of scarce short-term beds to long-term beds to avoid

exacerbating the short-term bed crisis. Please add additional clarity around the population intended to be served by the intensive behavioral health treatment facilities, which seems to overlap with criteria for residential care facilities. Please refine requirements for mental health drop-in centers to preserve the capacity for self-referrals and clarify if they are intended to serve persons with substance use disorder needs. We would like to open 24 beds at Providence, including six beds for long-term inpatient involuntary care. Not suspending the certificate of need process would add a year to the development timeline. We believe creating new facility types will increase capacity by getting people out of inpatient settings, and also improve people's lives by allowing them to be served in community settings with more dignity. Please amend the bill by adding an amendment relating to resident rights. Moving long-term civil commitments out of the state hospitals into the state hospital may make sense, but moving the care away from state workers may not be to the advantage of the patients. Private care services change based on funding. This is half a plan. We need to build the safety net using state-run facilities, especially for patients who are hard to treat and unprofitable for private contractors.

Persons Testifying: PRO: Senator David Frockt, Prime Sponsor; Rashi Gupta, Governor's Policy Office; Kristen Federici, Providence St. Joseph Health; Melanie Smith, NAMI Washington; Andrea Davis, Coordinated Care; Abby Moore, Washington Council for Behavioral Health; Celia Jackson, King County; Matt Zuvich, Washington Federation of State Employees; Len McComb, Community Health Plan of Washington.

Persons Signed In To Testify But Not Testifying: No one.