

# Care delivery and cost effective treatment for adults on 90- or 180-day civil commitment orders

Second Substitute House Bill 1394; Section 7; Chapter 324; Laws of 2019  
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## Care delivery and cost effective treatment for adults on 90- or 180-day civil commitment orders

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## Executive summary

The Washington State legislature recommended that the Division of Behavioral Health and Recovery (DBHR) create and facilitate a work group that would review current laws and regulations for adults on 90- or 180-day civil commitment orders and then identify necessary changes to address care delivery and cost-effective treatment. Details of the workgroup can be found on page four (4) of the Introduction section.

After careful review of the current Washington Administrative Codes (WACs) for individuals on 90- or 180-day civil commitment orders, the work group determined that while the majority of the current rules and regulations for services within the community are satisfactory, there is room for refinement to better meet the needs of patients in long-term community detention. Rules reviewed are located on page six (6).

The work group recognized that there is nothing prohibitive in the current rules for offering these services in the community. While the regulations do not prohibit care delivery, rates and reimbursement may. The recommendation offered in the Rate Methodology for 90- and 180-Day Civil Commitment Beds report that all costs be analyzed to ensure willing providers was revisited.

It was recognized by the work group that incentivizing facilities by reimbursing for the full costs will be key in continued participation of providing care for individuals on the long term civil commitment orders. Rate methodologies for both community hospitals and freestanding evaluation and treatment facilities (E&Ts) to cover the cost of care must be considered as Medicaid rules can differ based on facility type (e.g., Medicaid does not reimburse freestanding E&Ts for room and board, but they do reimburse hospitals for those costs).

The work group recommends that a review of these rules be revisited in 2023. Western State Hospital will have fully closed their civil side and all of the individuals on these long term orders will have been receiving care in a community setting. It is at that time, there will be a better understanding of the continuum of care and what needs to be adjusted.

## Introduction

Second Substitute House Bill 1394, Chapter 324, section 7 of the bill, provides for the Health Care Authority to produce a one-time report, requiring the following:

“... the Health Care Authority shall confer with the Department of Health, hospitals licensed under chapters 70.41 and 71.12 RCW, and evaluation and treatment facilities licensed or certified under chapter 71.05 RCW to review laws and regulations and identify changes that may be necessary to address care delivery and cost-effective treatment for adults on ninety-day or one hundred eighty-day commitment orders...”.

## Background

Access to the full array of behavioral health treatment options is vital to recovery for individuals experiencing mental illness. A continuum of treatment is imperative to ensure safe, healthy communities, and quality outcomes. As a leader in providing innovative medical and behavioral



health treatment, Washington State invested almost \$20 billion<sup>1</sup> in 2019 at all levels of care. Included in these treatment modalities are inpatient psychiatric care, hospital diversion programs, peer services, crisis stabilization, housing support, and other evidence-based practices to promote recovery for people experiencing mental illness.

Washington State will transition all but individuals who are civilly committed following forensic involvement under [RCW 10.77](#) and individuals needing the most intensive and long-term psychiatric services away from state hospitals. The state was directed by SSB 5883, 2018 to contract with community hospitals and residential evaluation and treatment centers to provide up to 48 long-term inpatient care beds as defined in RCW 71.24.025. This work transferred to the Health Care Authority (HCA) when The Division of Behavioral Health and Recovery (DBHR) transitioned out of the Department of Social and Health Services (DSHS).

As directed by SSB 5883, DBHR collaborated with non-Institutes of Mental Disease (IMD) community hospitals to identify internal evaluation and treatment centers located in both eastern and western Washington. DBHR identified free standing evaluation and treatment centers (E&Ts) in western Washington.

SSHB 1394 provided new direction that removed the language excluding IMDs. This permitted the HCA to also seek out beds in all community hospitals to included IMD's. The workgroup agreed that different-sized facilities should be considered and based on regional or community need. While 16 beds or fewer would allow the state to receive the federal Medicaid match, contracting with larger facilities can provide better economies of scale, a broader range of treatment interventions and facility design, and in many cases can reduce the cost of care.

As of October 2019, these efforts have resulted in 33 beds under contract, to provide bed capacity for individuals on 90 and 180 day civil commitment orders (see table 1). As participation in providing long-term bed capacity is voluntary, additional beds are anticipated by the end of the next biennium but they are yet to be confirmed.

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<sup>1</sup> [https://www.usgovernmentspending.com/spending\\_chart\\_2010\\_2025WAb\\_10t](https://www.usgovernmentspending.com/spending_chart_2010_2025WAb_10t)



**Table 1 - Community hospitals to provide 90- and 180-day civil commitment bed capacity**

<b>Identified community hospitals to provide 90- and 180-day civil commitment bed capacity</b>			
<b>Facility</b>	<b>Location</b>	<b>Number of beds</b>	<b>Online date</b>
Virginia Mason Memorial	Yakima	6	November 2018
Astria Hospital	Toppenish	14	January 2019
PeaceHealth, St. John	Longview	2	May 2019
Cascade Behavioral Health	Tukwila	18	TBD
Fairfax Behavioral Health	Seattle	20	TBD
Navos Behavioral Health	Burien	TBD	TBD
Providence Health & Services	Everett	6	February 2021
Virginia Mason Memorial	Yakima	10	First quarter 2021
UW Medicine Behavioral Health Teaching Hospital	Seattle	50	FY 2023
<b>Identified residential evaluation &amp; treatment centers to provide 90- and 180-day civil commitment bed capacity</b>			
<b>Facility</b>	<b>Location</b>	<b>Number of beds</b>	<b>Online date</b>
Cascade Mental Health Care	Centralia	4	September 2018
Telecare North Sound	Sedro-Woolley	3	October 2018
Kitsap Mental Health Services	Bremerton	4	December 2018
RI International	Olympia	16	Summer 2020
Telecare	Olympia	11	Summer 2020
Telecare	Shelton	16	Summer 2020



## Details of the work group

A work group was formed to review laws and regulations, and identify possible changes to care delivery. Work group representatives included individuals from DBHR, DSHS, the Behavioral Health Administration (BHA), Washington State Hospital Association (WSHA), Department of Health (DOH), the Washington Council for Behavioral Health, representatives from residential evaluation and treatment facilities, peer bridgers, and peers. Work group members met in the months of February and March 2019, then one time per month beginning July 2019 through April 2020. Work group members met two times in May 2020 and two times in June 2020. With most long-term civil commitment beds transitioning from the state hospitals into a variety of community settings, the work group reviewed current laws and regulations to determine what needs to change. It was during these initial meetings that workgroup members agreed to look at current best practices for individuals in a long term inpatient setting. An example of a model identified as incorporating best practices for individuals in an inpatient psychiatric setting is *The Sanctuary Model*. More information on this model is located in the *Best Practices* section.

## Access to outside

It was highly recommended by peer workgroup participants that access to outdoor space be provided. In order to accommodate access to outdoor space(s), the cost to a facility may be substantial if remodeling needs to occur. This is also an important factor to consider when determining the ideal facility size, as greater design flexibility is possible at a cost-effective rate for larger facilities than for 16-bed facilities. Additional funding will need to be provided to accommodate this crucial piece for individuals committed to a facility up to six months or longer.

HCA currently partners with the Department of Commerce's RFP process which if awarded to a facility seeking to provide long term beds, allows the facility to use capital funding to repurpose existing space. However, in order for facilities to be able to respond to Commerce's RFPs, capital funding must be paired with operational funds so these new and repurposed facilities can be properly staffed.

## Identified best practices

- The [Sanctuary Model](#) was developed from 1985-1991 and founded on the realization that most individuals being treated in both outpatient and inpatient settings had survived overwhelmingly stressful and often traumatic experiences, typically beginning in childhood. This model represents a “theory based, trauma informed, and evidence supported whole culture approach that has a clear and structured methodology for creating or changing an organization culture”<sup>2</sup>.
  - Within this model, the Sanctuary Commitments provide the anchoring values and are tied directly to developmentally grounded, trauma informed treatment goals as well as the overall health of the organization culture.
- In the technical report [The Vital Role of State Psychiatric Hospitals](#) published by the National Association of State Mental Health Program Directors Medical Directors Council, it is recommended that the environment and culture of inpatient care be recovery oriented, trauma informed, culturally and linguistically competent, transparent, hopeful, respectful, holistic, and driven by meeting the needs of people serviced while addressing the safety of

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<sup>2</sup> <http://www.sanctuaryweb.com/Home.aspx>

service recipients, staff and the community. Discussion on the aforementioned themes begins on page 26.

- An example of an evidence based practice designed for use by institutions providing mental health treatment to adults in an inpatient setting is the *Six Core Strategies to Prevent Conflict and Violence*. This program works to change the way care is provided in inpatient settings by placing focus on the prevention of conflict and violence, reducing the use of seclusion and restrains and implementing trauma informed care principles, and including the individual to the fullest extent possible in their inpatient care.
- The [Short Term Assessment of Risk and Treatability \(START\)](#) is a brief clinical guide used to assist with planning around identified risks and to assess discharge readiness from a risk perspective. The tool focuses not only on an individual's vulnerabilities but also their strengths and assists in tracking changes of functioning.

## Rules and regulations reviewed

The table below represents the WACs reviewed. It is recognized that only the Department of Health (DOH) WACs were reviewed. Historically, DOH has been the agency to govern rules and regulations for the facilities that provide care to individuals on long term civil commitment orders. The Health Care Authority does not currently have WACs in place that direct care to individuals in an inpatient setting receiving psychiatric care.

Chapter 71.05 RCW and Chapter 71.24 RCW were also considered.

## WACs reviewed

The workgroup reviewed the below WACs for potential change however it did not come up with a firm recommendation for change. One point of discussion was to revise the definition of a Mental Health Professional in WAC 246-341-0200 however a change like this would create a hardship for community behavioral health agencies as this is a foundational role in the community behavioral health system and an essential component of the workforce. The workgroup agreed that this definition should not be changed in the behavioral health agency WACs. Similar hardships would follow if other WAC language is modified and given that the existing WACs governing care in these long term settings are not prohibitive, it is recommended that any potential modifications be revisited in 2023 with a workgroup continuing to meet quarterly to review how the transition from the state hospital to community settings is going.



**Table 2 – WACs reviewed by facility type**

<b>Facility type</b>	General acute care hospital regulations (DOH)	Freestanding psychiatric hospital licensing regulations (DOH)	All E&T facility regulations (DOH) psych, acute care and RTFs – does not apply to state hospitals	Residential treatment facilities (to include free standing E&T)
<b>Regulation(s)</b>	WAC 246-320: Hospital Licensing Regulations	WAC 246-322: Private Psychiatric & Alcoholism Hospitals	WAC 246-341: Behavioral Health Services Administrative Requirements	WAC 246-337 WAC 246-341-0515 WAC 246-341-0200

**Table 3 – WAC review discussion**

<b>Concept</b>	<b>Identified WAC(s) for Revision</b>	<b>Reviewed for potential change</b>
Definition of Mental Health Professional	WAC 246-322-010(23) WAC 246-337	Match Behavioral Health Agency 71.05.020(38) RCW definition of: "Mental health professional" means a psychiatrist, psychologist, physician assistant working with a supervising psychiatrist, psychiatric advanced registered nurse practitioner, psychiatric nurse, or social worker, and such other mental health professionals as may be defined by rules adopted by the secretary pursuant to the provisions of this chapter
Time for physical exam and medical history	WAC 246-322-170(2)(d)	WAC language to be consistent with statute language in RCW 71.34.720(1)
Time for treatment plan	WAC 246-341-1126(6)(c) and (9)	Create timeframe that is consistent with the time frame for initial exams (physical and psychiatric) since treatment plan should include both physical and behavioral health components
Mandatory psychiatric services staffing	WAC 246-320-271 WAC 246-320-226 WAC 246-341 WAC 246-337	Create consistency between all facility types since all will be providing E&T/90- or 180-day services. Align WACs in column 2 with WAC 246-322-170(3)(a) and WAC 246-322-170(3)(b)



Mandatory nurse staffing	WAC 246-341	Create clear consistent standard for 24/7 nursing in all facility types providing 90- and 180-day services
Mandatory social work services	WAC 246-320-271 WAC 246-341 WAC 246-337	Consider standard requirement for all facility types providing E&T/90- or 180-day services to have a social worker
Mandatory therapy services	WAC 246-320 WAC 346-341 WAC 346-337	Consider having consistent therapy services requirements for all facility types providing E&T/90- or 180-day services
Seclusion & Restraint	WAC 246-320-271(7), WAC 246-320-226(3)(f) WAC 246-322-180 WAC 246-341-1158 WAC 246-341-1126(3)	Consider updating language to be consistent with federal requirements. Should be similar to the language in RTF rules WAC 246-337-110(5-12).
Patient Living Areas	WAC 246-320-321 WAC 246-341-1126 WAC 246-341	Consider requirements for facilities providing E&T/90- or 180-day services to have rooms for social, educational, and recreational activities  Consider requiring secure outdoor spaces

## Quality performance

HCA is moving toward a goal of paying for value to achieve better health, better care, and lower costs. This effort includes shifting health care payments away from a system that pays for volume to one that recognizes quality and outcomes. As this work progresses, the workgroup encourages HCA and the Legislature to recognize that long-term, involuntarily civil commitment patients are a high-acuity population, usually with co-morbidities and significant social needs.

The workgroup recommends that further data collection and analysis be done to better understand the gaps in the continuum of care, and how community hospitals, residential E&T facilities, HCA, community behavioral health agencies and the Legislature can address these gaps and improve outcomes for long-term psychiatric patients, with an emphasis on ensuring earlier identification and intervention, expanded community-based treatment capacity and reduced hospitalization and incarceration. This is not an easy problem to address and it has not been solved by the current mental health infrastructure due in part to inadequate access and capacity.

Community hospitals and residential E&T facilities will not be able to improve long-term commitment treatment and care transition models without better data and information. The first step in this will involve collecting and analyzing data from Western and Eastern State Hospitals; this will provide a baseline. As we have more experience with this vulnerable patient population in community settings, data on certain key metrics (as compared to baseline information from the state psychiatric hospitals) may help us understand where community hospitals, residential E&T



facilities, community behavioral health agencies, HCA, and the Legislature can make changes or investments to both define and achieve quality measures.

## Other considerations

### Committed budget

Numerous discussions occurred that unless facilities providing care for individuals on 90- or 180-day civil commitment orders are provided with a committed budget in which to operate from, facilities will remain hesitant to provide care for this vulnerable population. There was consensus that community hospitals and residential E&Ts should be reimbursed at a rate sufficient to cover 100% of cost and incentivize these facilities to provide services for 90- and 180-day civil commitment patients. It is especially important that HCA work with E&T providers on this cost methodology development to ensure incorporation of unique aspects of the historical financing models in these settings.

It is recommended that a financial analysis be conducted to ensure that all costs are taken into consideration.

### Continued work

Due to the complexity of the identified population, it is recommended that a work group continue to meet regularly to continue to review the current rules and regulations and it is thought there will be a better understanding of the continuum of care and what needs to be adjusted once the number of beds continues to grow and reaches the target number.

An area of consideration is ensuring that individual on 90- or 180-day civil commitment orders receive some type of escorted access to community to support whole person health. The topic of civil passes needs to be explored to include access to specialized medical care as well as to assist in assimilating into the community by way of visiting the residence or supported environment they will be discharge

After a search for best and promising practices, an example of a model identified as incorporating best practices for individuals in an inpatient psychiatric setting is *The Sanctuary Model*. More information on this model is located in the *Best Practices* section.

