Crisis Triage and Stabilization Center Feasibility Study

PREPARED FOR

GRAYS HARBOR COUNTY
PUBLIC HEALTH

BY

ALLIE FRANKLIN, LICSW
PAUL FLEISSNER
JOHN VOLPE, LCSW
GREG USZAK
NICOLE LEHMAN, MSW
MATT WARD

DECEMBER 20, 2023

Research and Consulting in the Fields of Health and Human Services Policy, Health Economics and finance, Program Evaluation, Data Analysis, and Health System Restructuring.

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Introduction

Grays Harbor engaged with Health Management Associates to conduct an assessment and financial model for options to consider a crisis triage facility in Grays Harbor and to increase the behavioral health crisis triage supports for the community. The analysis was conducted over the course of a four-month period in late 2023 and builds on data and stakeholder work done for the Behavioral Health Gap Analysis. This assessment included stakeholder engagement through key informant interviews with 9 organizations, two provider forums, and analysis of the Medicaid claims database (T-MSIS) for the years 2017-2020. All data analyzed for this project was specific to Grays Harbor residents. Claims data reflect the utilization of Grays Harbor residents regardless of their location within Washington when they received the care. Analysis conducted included learning more about a prior stabilization unit in Grays Harbor, the Crisis Clinic, and some general information about the average census of that unit. The assessment below includes a summary of the background and methodology, themes from providers and considerations for future state.

Executive Summary

Understanding the Need:

Grays Harbor County identified a need for additional behavioral health crisis services through the 2022 Behavioral Health Gap Analysis and the 2022 Community Health Assessment. The 2022 gap analysis found that Grays Harbor consistently uses more crisis services per capita than other counties in the same region. In 2022, Grays Harbor:

- Used more mobile crisis services than any other county in the five-county region.
- As the third largest county in the region, utilization of 41% of the total usage for the region was a significant outlier.
- Despite having a population that is 10% smaller than Lewis County, Grays Harbor regularly uses between 22 and 50% more crisis resources than its slightly larger neighbor.
- Used a comparable amount, and at times more mobile crisis time than its much larger neighbor, Cowlitz County:
    - Cowlitz County's population is 47% larger than Grays Harbor.
    - Throughout 2021 and 2022, Grays Harbor required a mobile crisis team response at the same or higher rate to Cowlitz County.
    - In March of 2022, Grays Harbor's mobile crisis utilization was 17% higher than Cowlitz County's usage.
- Analysis of the trends shows that a high percentage of the responses are to clients who are familiar users of crisis services. This suggests that post crisis interventions could have a significant impact on reducing the overuse of crisis care in the County.

Recommendations:

HMA recommends that Grays Harbor take a multifaceted approach to addressing the complex issues that comprise the behavioral health crisis services needs for the community. **No single facility, approach or solution will solve all of the BH crisis needs to a community.** However, there are several approaches and solutions that may help to address some of the issues that residents, first responders and families face regarding behavioral health crisis needs in Grays Harbor. Based on the analysis conducted, stakeholder engagement and financial feasibility modeling conducted, HMA recommends that Grays

Harbor would be best served by a combination of three models, and a low barrier, high support shelter solution:

- **EmPATH unit** that is co-located at an existing medical facility with an emergency department
- A **Behavioral Health Urgent Care** that is **co-located at an existing medical facility with an emergency department.**
- Establishment of a **multi-agency, cross sector familiar face or high user care coordination team** would increase the level of support that individuals who frequently use emergency department and have frequent contacts with law enforcement for behavioral health symptoms.

Youth Specific Recommendations:

- To support youth experiencing a behavioral health crisis, HMA supports the plans that the community has in place to procure a **youth mobile crisis team**. These have been shown to be effective at helping youth and their families receive support in the community and avoid hospitalization.
- Including **child psychiatry or an Advanced Practice Practitioner** with youth behavioral health expertise in a **BH Urgent Care** program with would be able to serve youth and adults for outpatient, urgent care.

Homelessness and Behavioral Health Support Recommendations

- In order to support the flow of clients out of any crisis stabilization or EmPATH unit that Grays Harbor determines to be the best fit for residents, HMA recommends investing in a low barrier, high support shelter that supports people who need more support than a typical shelter can provide.
- One Washington program that offers this service array is the Pierce County Catholic Community Services Nativity House Program[1].
- The combination of a supportive shelter and behavioral health support models will ensure clients receive the appropriate level of care and utilize available resources appropriately. Clients who are staying at the shelter that need additional behavioral health support could access the EmPATH and/or BH Urgent Care and clients who are discharging from the EmPATH or BH Urgent Care can have an immediate housing option to avoid recidivism.

Results of the Behavioral Health Crisis Tirage and Stabilization Center Feasibility Analysis

Analysis from T-MSIS Data

In the analysis of T-MSIS in Grays Harbor County for 2016- 2019, HMA noted that a high percentage of visits to the emergency department do not result in an inpatient stay. This suggests that there is likely a

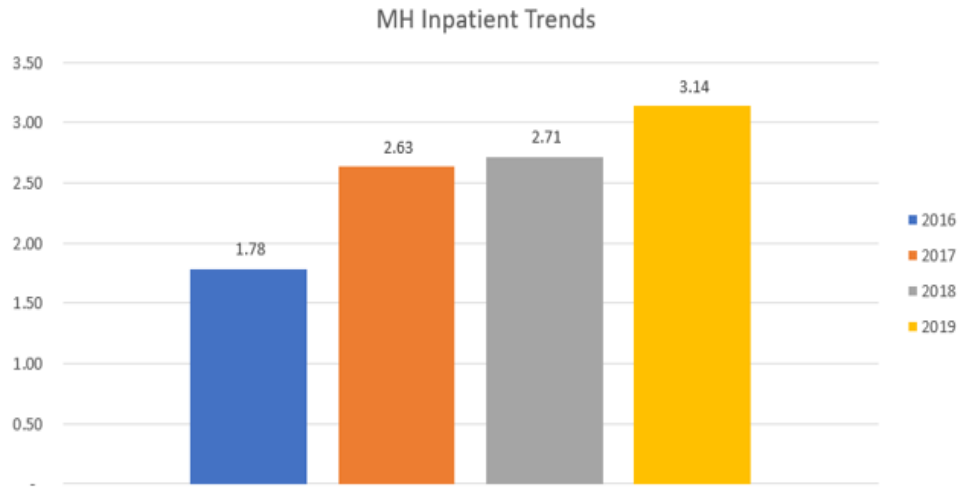
[1] Nativity House Day and Overnight Shelters - Catholic Community Services and Catholic Housing Services of Western Washington (ccsww.org)

significant opportunity to provide care for many of the people who are currently presenting to the emergency department in alternative settings. Specifically, only 11.7% of patients who presented to the emergency department for a mental health chief complaint in 2019 were hospitalized in an acute care inpatient unit. This leaves 88.3% of individuals who presented to the emergency department as the population that could benefit from alternatives to emergency department care. For those Grays Harbor residents who presented to the emergency department with substance use disorder chief complaints, the opportunity to relieve pressure on the emergency department is illustrated by a 4.8% inpatient admission rate, leaving 95.2% of the emergency department visits as the population that could benefit from alternatives to emergency department admissions.

Mental Health Inpatient and Emergency Department Utilization Trends

Utilization patterns show an upward trend for inpatient psychiatric admissions in Grays Harbor from 2016 to 2019 among Medicaid beneficiaries. **Figure 1** shows the inpatient utilization patterns for **Grays Harbor Medicaid beneficiaries** for the years 2016- 2019.

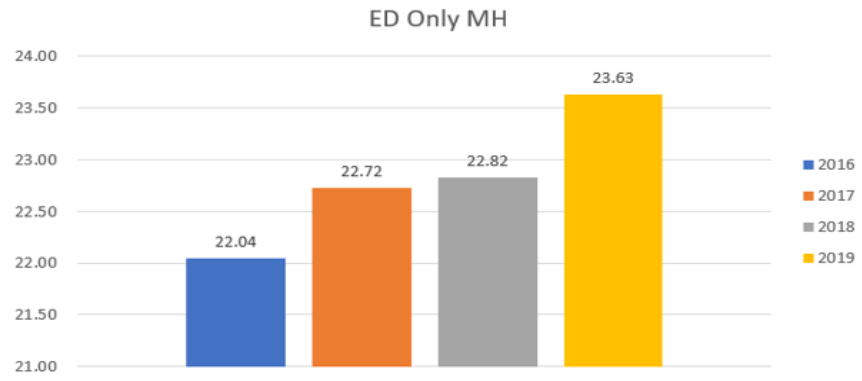
Figure 1 Mental Health Inpatient Treatment Utilization Trends 2016- 2019



	Inpatient stays with MH diagnos	MH Inpatient all ages per 1000
2016	52	**1.78**
2017	78	**2.63**
2018	79	**2.71**
2019	90	**3.14**

During the same timeframe, there was also an increase in the number of Grays Harbor Medicaid beneficiaries who were seen in the emergency department for a mental health chief complaint who were not psychiatrically hospitalized. This is illustrated in **Figure 2.**

Figure 2 Mental Health Emergency Department Treatment Utilization Trends 2016- 2019



	ED only MH	ED Only MH per 1,000
2016	643	**22.04**
2017	673	**22.72**
2018	665	**22.82**
2019	678	**23.63**

This suggests that there is an opportunity to reduce the unnecessary use of emergency departments by creating alternative settings for people to receive mental health crisis support. The T-MSIS data and utilization patterns suggest that demand for a community based low threshold crisis triage or receiving facility could potentially support up to 5 patients per night. This number is based on current emergency department utilization patterns. This analysis aligns with the data for the utilization of the former Crisis Clinic in Grays Harbor which had an average daily census of 4 clients during the period immediately before closure.

Studies regarding crisis triage and EmPATH units show that communities that implement community based low threshold crisis triage or receiving facilities also see a decrease in the number of clients who need psychiatric hospitalization. In 2021, a group of researchers conducted a meta-analysis study that reviewed 12 separate academic studies of crisis stabilization and psychiatric observation units[2]. This study examined the outcomes of over 67,000 patients who were treated in short stay crisis stabilization or EmPATH units. Results showed a reduction in the rates of psychiatric holds (often referred to as detained in Washington State), one study showed a reduction from 49.8% of patients being detained prior to the intervention to a rate of 42% after the unit opened. All of the studies that measured inpatient admissions showed a significant reduction in the rate of both voluntary and involuntary

[2] Anderson, K., Goldsmith, L., Lomani, J., Ali, Z., Clarke, G., Crowe, C., . . . Gillard, S. (2022). Short-stay crisis units for mental health patients on crisis care pathways: Systematic review and meta-analysis. BJPsych Open, 8(4), E144. doi:10.1192/bjo.2022.534

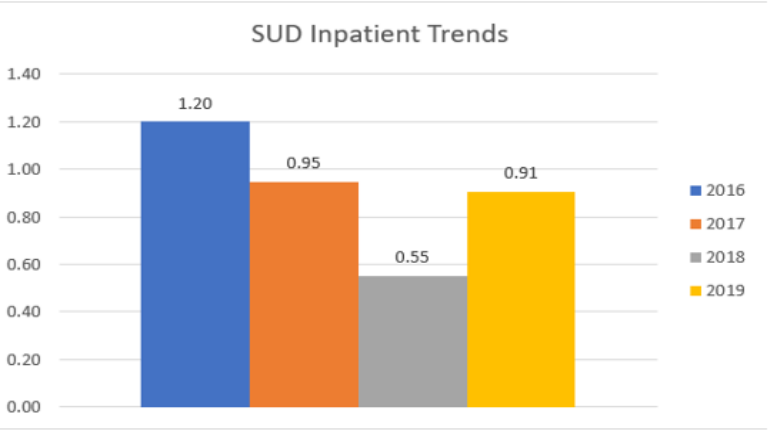
admissions. One study cited showed a reduction from 42% admitted prior to the unit's opening down to 25% post opening[3]. Another study showed a reduction in admissions from 47.9% to 38% [4].

Substance Use Disorder Inpatient Treatment and Emergency Department Utilization Trends Utilization patterns show an overall downward trend for inpatient substance use disorder treatment admissions in Grays Harbor from 2016 to 2019 among Medicaid beneficiaries as illustrated in Figure 3. It is significant to note that there is a 65% increase in inpatient admissions between 2018 and 2019. The 2019 volumes are still below 2016 and 2017 levels. In the same period, there was also an 11% increase in the number of Grays Harbor Medicaid beneficiaries who were seen in the emergency department for a substance use disorder chief complaint who were not hospitalized for an SUD diagnosis. Figure 4 Illustrates the changes in the emergency department utilization. This suggests that there is an opportunity to significantly impact the traffic in the emergency departments by creating alternative settings for people to receive substance use disorder crisis support.

[3] Parwani V, Tinloy B, Ulrich A, D'Onofrio G, Goldenberg M, Rothenberg C, et al. Opening of psychiatric observation unit eases boarding crisis. Acad Emerg Med 2018; 25: 456–60

[4] Lester NA, Thompson LR, Herget K, Stephens JA, Campo JV, Adkins EJ, et al. CALM interventions: behavioral health crisis assessment, linkage, and management improve patient care. Am J Med Qual 2018; 33(1): 65–71.

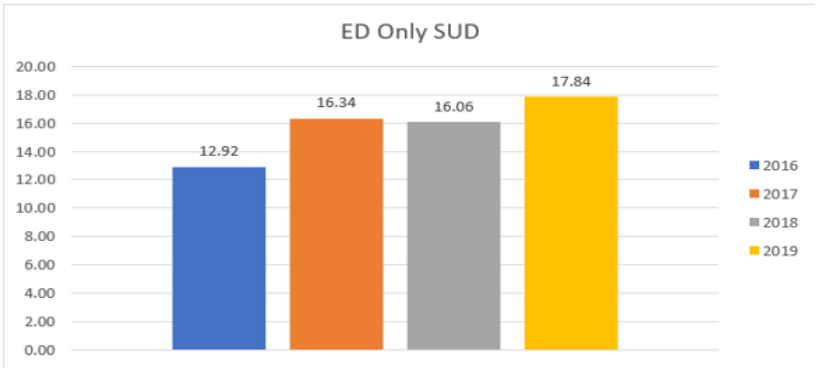
Figure 3 Substance Use Disorder Inpatient Treatment Utilization Trends 2016- 2019



	SUD Inpatient	SUD Inpatient Stays per 1,000
2016	35	**1.20**
2017	28	**0.95**
2018	16	**0.55**
2019	26	**0.91**

*The T-MSIS data and utilization patterns suggest that demand for a community based low threshold crisis triage or receiving facility could potentially support up to **5 patients per night**. This number is based on current emergency department utilization patterns. This analysis aligns with the data for the utilization of the former Crisis Clinic in Grays Harbor which had an average daily census of 4 clients during the period immediately before closure.*

Figure 4 Substance Use Disorder Emergency Department Treatment Utilization Trends 2016- 2019



	ED Only SUD	ED Only SUD per 1,000
2016	377	**12.92**
2017	484	**16.34**
2018	468	**16.06**
2019	512	**17.84**

Themes Shared by Community Providers and Key Informants

Overall, first responders and behavioral health crisis service providers in Grays Harbor reported that they have a strong commitment to supporting residents in the community and avoiding jail bookings or emergency department visits. However, they also noted that some residents who need behavioral health support who don't meet detention or inpatient treatment criteria are seen by law enforcement

or other responders multiple times prior to a crisis that does eventually meet criteria for booking or admission. There were several key themes that emerged from providers, which are described below.

Strengths

Several strengths were noted when conducting the feasibility assessment, including:

- Strong peer support in Grays Harbor, Behavioral Health Urgent Care plans in process with a local medical and behavioral health provider
- Deep commitment from law enforcement and first responders to find alternatives to jail bookings and emergency department admissions for people who are experiencing a behavioral health crisis.
- High level of support for supporting community members in the community and prevent long emergency department stays or jail bookings.
- Strong engagement and commitment to developing solutions for Grays Harbor residents experiencing a behavioral health crisis.
- Promising workforce capacity building with Summit Pacific's integrated walk-in clinic
- CIHS has a new Peer Bridger Program that is quickly building capacity in Grays Harbor. The program was recommended in the 2022 Behavioral Health Gaps Analysis. It is an evidence-based program which can help connect individuals to follow up resources post hospitalization. The program in Grays Harbor will support individuals who are discharging from long term behavioral health treatment facilities such as Western State Hospital.
- The Governor's Opportunity for Supportive Housing (GOSH) program provides supportive housing to individuals who are discharged from Western State Hospital. It has a strong track record of achieving excellent outcomes for the people who are eligible for the services.
- Columbia Wellness operates the Wellness and Recovery Center in Cowlitz County that provides free transportation to and from the center.

Gaps and Opportunities

High Crisis Utilization in Grays Harbor Compared to Other Counties in the Behavioral Health Administrative Organization (BHASO) Region

As addressed in the 2022 Behavioral Health Gap analysis, Grays Harbor uses more Designated Crisis Responder and mobile crisis resources than other counties with similar or more residents. **Appendix D** includes a flow chart that maps the mobile crisis (MCT), designated crisis responder (DCR) and inpatient psychiatric levels of care and their intersections within Grays Harbor County and the Great Rivers Behavioral Health Administrative Services Organization region.

Long Wait Times in the Emergency Department for Patients Needing Medical Clearance prior to an Inpatient Admission

Emergency Departments are designed to provide lifesaving treatment to patients experiencing a life-threatening illness. The physical layout, triage systems and the environments are designed for assessing and treating physical illnesses. They are not designed with psychiatric conditions as their primary focus. As a result, patients with behavioral conditions are triaged behind physically acute conditions in a typical Emergency Department. The requirement for psychiatric patients to be medically cleared prior to

admission into a psychiatric unit further complicates the triage system. This is because the chief complaint of medical clearance is triaged very low, therefore increasing the wait time for a person who needs this clearance to be admitted into a bed. However, if the wait becomes too long and a person who meets medical necessity for an inpatient psychiatric unit decides that they no longer wish to wait, the hospital is faced with the dilemma of needing to determine whether it is safe to allow the patient to leave against medical advice. This can trigger a call to the Designated Crisis Responder (DCR) which extends the time that a patient must wait in the emergency department. During stakeholder interviews and forums, HMA learned that psychiatric patients waiting for medical clearance can wait long periods, at times more than 12 hours for their turn to be evaluated.

High Use Patterns of a Small Number of Individuals

First responders in Grays Harbor note that there are a number of individuals who receive a high number of calls to provide care and intervention. Law enforcement, EMS and other first responders are often called to respond to an individual who is experiencing a behavioral health crisis but who is unwilling to seek help. These individuals end up being transported to the emergency department or booked into jail to wait for a designated crisis responder (DCR) to evaluate them for involuntary commitment. This creates a high demand for the limited DCR resources in the region and when the individuals are not found to meet criteria for detention, they end up being released to the community. Unfortunately, Grays Harbor first responders note that for many residents that have become familiar faces in the process, the cycle repeats until the psychiatric crisis becomes so acute that the person meets criteria and must be hospitalized. First responders in Grays Harbor note that they would prefer to have a place where they could bring and drop off residents who are experiencing a behavioral health crisis to receive intervention, assessment and follow up support.

Challenges with Non-emergent Transportation

Grays Harbor residents who do need to be hospitalized out of the region face several challenges. There are a limited number of ambulance resources in the region and many of the inpatient units are several hours away. Ambulances are only reimbursed for the part of the trip that has a patient in the vehicle. This means that transporting a patient to a unit in Spokane would involve a 12 + hour drive that an ambulance service would be given reimbursement for 6 hours and the half of the mileage. Stakeholders shared that long waits for ambulances to transport people out of the area have resulted in the patient losing their spot in a facility or have caused patients who started as a voluntary admission to become involuntary due to the long wait times. Another issue that impacts non-emergency transportation is the subject of payment for transporting patients from non-medical facilities to facilities such as evaluation and treatment (E&Ts) centers which are not licensed as hospitals. It may be difficult for ambulance companies to receive reimbursement for trips from a free-standing crisis stabilization center to an E&T should a client need inpatient level care.

Lack of Long-term Supportive Housing Resources

A challenge that stakeholders noted is the lack of housing, shelter, and long-term supportive housing resources. This is important because lack of stable housing has been found to be a key risk factor in

psychiatric inpatient readmission rates[5]. While the GOSH program is a key strength in Grays Harbor, the program has highly restrictive admission criteria and a low rate of reimbursement for providers. As a result, the program has limited slots for people who could also benefit from these supports but who may not qualify for the services. There is an effort underway in Grays Harbor to advocate for expanded entry criteria and increased reimbursement.

Workforce Challenges

A common theme in behavioral health is the shortage of workforce. As identified in the 2022 Grays Harbor Behavioral Health Gap Analysis, Grays Harbor is experiencing critical workforce shortages. One of the leading factors to workforce shortages in behavioral health is clinician burn out. Implementing an innovative program that has proven results for improved client outcomes may serve to bring new clinical staff members to the community. Additionally, many crisis stabilization models leverage peer support specialists as key staff members. This is a workforce that can be cultivated from current community members. An example of innovation bringing new staff into Grays Harbor can be seen at Summit Pacific. This provider has partnered with the Rural Residency Program to bring new team members into Grays Harbor. An innovative program such as a crisis triage, behavioral health urgent care or an EmPATH unit could serve to attract new behavioral health staff to the region.

*Two other factors that arose in the stakeholder interviews for consideration include **non-emergent transportation** and the current culture regarding **medical clearance prior to inpatient psychiatric admissions**. Medical clearance refers to the practice of requiring all patients who are referred to an inpatient psychiatric unit to be evaluated by an emergency department to rule out any health conditions that could impact their inpatient care. These evaluations involve a physical examination, and can include laboratory studies, urine drug screenings and other tests. Several states are working to build alternative pathways for patients that by-pass the need for an emergency department to conduct these screenings. **Until this requirement has been addressed, on a local, statewide, or national level, any referral for inpatient psychiatric treatment will still need to be screened through an emergency department for medical clearance prior to admission.** It is significant to note that this requirement is not a state mandate, it is required by inpatient psychiatric units and free-standing evaluation and treatment centers (E&Ts). Some communities have begun to create multisector collaboratives to consider how to meet the needs for medical screening in other settings such as urgent cares.*

Considerations for Future State

In considering the strengths of the community and the challenges that surfaced during the feasibility study, HMA noted that there are several models of care that the community may choose to consider meeting the community's needs. A few factors presented below should be considered to inform Grays Harbor's ultimate decision.

One factor is the small size of the potential population that would be served. The volumes noted by the T-MSIS claims data suggest that a 16-bed crisis stabilization unit may be too large for the identified

[5] Russolillo, A., Moniruzzaman, A., Carter, M. et al. Association of homelessness and psychiatric hospital readmission—a retrospective cohort study 2016–2020. BMC Psychiatry 23, 459 (2023). https://doi.org/10.1186/s12888-023-04945-z

population most likely to receive services. This would have revenue implications which may negatively impact the program's long-term sustainability. Grays Harbor County experienced this previously with a crisis stabilization unit that closed due to challenges with sustainable funding and the costs of facility maintenance. It is notable that in key informant interviews, HMA learned that another neighboring community recently considered whether to build a free-standing crisis stabilization center and determined that the anticipated volume was not sufficient to meet the operating budget for the proposed facility. A final concern that stakeholders shared about having a free-standing facility the potential for other counites and communities to utilize the facility for their residents. This could be of benefit to Grays Harbor by bringing in needed volume to help sustain the unit. However, stakeholders voiced their concern that utilization by other regions could fill the beds without expanding capacity for Grays Harbor residents.

Two other factors that arose in the stakeholder interviews for consideration include non-emergent transportation and the current culture regarding medical clearance prior to inpatient psychiatric admissions. Medical clearance refers to the practice of requiring all patients who are referred to an inpatient psychiatric unit to be evaluated by an emergency department to rule out any health conditions that could impact their inpatient care. These evaluations involve a physical examination, and can include laboratory studies, urine drug screenings and other tests. Several states are working to build alternative pathways for patients that by-pass the need for an emergency department to conduct these screenings. Until this requirement has been addressed, on a local, statewide, or national level, any referral for inpatient psychiatric treatment will still need to be screened through an emergency department for medical clearance prior to admission. It is significant to note that this requirement is not a state mandate, it is required by inpatient psychiatric units and free-standing evaluation and treatment centers (E&Ts). Some communities have begun to create multisector collaboratives to consider how to meet the needs for medical screening in other settings such as urgent cares.

Options to Consider

	Addresses desire to divert people from the ED/ Jail	Could reduce high use of DCR resource in Grays Harbor	Could reduce/ eliminate long wait times for medical clearance	Addresses transportation reimbursement concerns	Addresses individuals with high use patterns
EmPATH Unit	Yes	Yes	Yes	Yes	Yes
BH urgent care co-located with a hospital	No	Yes	Yes	Yes	Yes
Free-standing crisis stabilization unit	Yes	Yes	No	No	Yes
Free-standing BH urgent care	No	Yes	No	No	Yes
Develop a familiar face/ high use care coordination team	No	Yes	No	No	Yes

EmPATH Unit

Specialized Crisis Stabilization Unit that is designed for people who are experiencing an acute psychiatric crisis to receive assessment and evaluation in a therapeutic and least restrictive setting. EmPATH units are designed to enhance the emergency department, by providing a calm and comforting alternative environment for patients, allowing movement and interaction with both peers and behavioral health team members within the first 24 hours of treatment, something often not available in the emergency department.[6] EmPATH units are located adjacent to the Emergency Department, generally use recliner chairs and a dedicated behavioral health staff trained to support clients who are experiencing a behavioral health crisis.

Considerations for this option: There are several advantages to co-location with the emergency department. All patients who have psychiatric needs can be assessed, treated, and supported in the EmPATH unit, freeing up the emergency department staff to treat other health conditions. This gives patients who have psychiatric needs a calming, supportive environment, and a completely different triage experience. Emergency Departments are designed primarily to care for people who are experiencing a physical health emergency. Patients who are experiencing a behavioral health emergency are highly likely to be triaged below people who are acutely bleeding, experiencing potential cardiac or neurological emergencies, traumatic physical injuries, etc. Location within the hospital allows ambulances to transport any patients who require an inpatient psychiatric admission and satisfies the requirements for "medical clearance," while also giving patients quick access to initial psychiatric assessment and care. Through the process of continuous reassessment and engagement with peers, technicians and behavioral health staff, the EmPATH unit can reduce hospital admission rates, and wait times in the emergency department. Access to pharmacy supports for all health conditions is a key advantage to co-location. EmPATH units use observation codes to bill for the care that is provided. This provides financial support for ongoing operating expenses. From a financial sustainability perspective, a unit that is part of a hospital can bill for both the services provided and a hospital facility fee. This creates a significant sustainability advantage in that the financial modeling conducted as a part of this assessment forecasts a favorable contribution margin for an EmPATH unit that is connected to a hospital.

BH Urgent Care Co-located with Hospital

Outpatient care center that is designed to provide walk-in support to people who are experiencing a BH crisis. Services include assessment, medical screening, access to appropriate medications, and referrals to community-based providers and other resources for follow up care. A behavioral health urgent care center that is co-located with an emergency department can have a separate entrance and check-in desk. Behavioral health urgent care centers in some communities provide next day, post emergency department follow-up care to support patients in connecting to outpatient treatment and reduce avoidable emergency department visits. BH Urgent cares are typically open during the day and evening

[6] https://www.bwbr.com/empath-units-improving-psychiatric-emergency-care/

hours, from 5- 7 days per week. A sample plan for operating hours might be 10 am – 10 pm, 7 days a week.

Considerations for this option: One significant advantage to co-location with the emergency department is the ability for the units to coordinate bi-directional referrals. If a patient presents to the emergency department for a "medical clearance" the emergency department triage can discharge the patient to the urgent care. Similarly, if a patient arrives at the urgent care but is found to need emergency care, the urgent care can coordinate an immediate transfer to the emergency department. Co-location to the emergency department facilitates post emergency department follow-up care because patients know the location of the hospital and can return for immediate follow-up without an emergency department admission. Co-locating peer support with the facility can help patients connect with peer supports that have been shown to improve clinical outcomes for people with behavioral health conditions.[7] Coordination with peer support organizations, mobile crisis teams, the crisis helpline and outpatient behavioral health units is essential to ensure that the urgent care does not become the primary behavioral health provider for clients. In order for the model to work, the BH Urgent Care will need to work closely with community BH resources to ensure that individuals with BH care plans and intensive care teams who present to the BH Urgent Care receive the care that meets their needs. From a financial feasibility perspective, an Urgent Care that is connected to a hospital may be able to bill hospital facility fees in addition to the procedure fees. This would have a significant impact on the sustainability of a BH Urgent Care.

Free-standing BH Crisis Stabilization Unit

Crisis receiving and stabilization units are designed to offer a no-wrong-door approach to access for mental health and substance use crisis. Units operate similar to hospital emergency departments in that they accept all walk-ins, ambulance, fire and police drop-offs. Units need to be prepared to say yes to mental health crisis referrals, including working with persons of varying ages (as allowed by facility license) and clinical conditions (such as serious emotional disturbance, serious mental illness, intellectual and developmental disabilities), regardless of acuity. Often facilities use chairs or recliners in lieu of beds to maximize their use of space and to support the model of a short stay. One of the hallmarks of this type of unit is its commitment to never reject a first responder or walk-in referral. This ensures that first responders will experience the facility as a true alternative to emergency departments and jail bookings. It is important to note that if an individual's condition is assessed to require medical attention in a hospital or referral to a dedicated withdrawal management (i.e., referred to more commonly and historically as detoxification) program, it is the responsibility of the crisis receiving and stabilization facility to make those arrangements. [8] .

Considerations for this option: Facility gives first responders the option to drop off at crisis stabilization unit and avoid emergency departments or the need for jail bookings. Similar to an EmPATH unit, a crisis stabilization unit can immediately assess and begin to support an individual who is experiencing a

[7] https://www.mhanational.org/sites/default/files/Evidence%20for%20Peer%20Support%20May%202019.pdf
[8] https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-services-executive-summary-02242020.pdf

behavioral health crisis. Some disadvantages to a freestanding facility include lack of access to a wide array of medical care services including an onsite pharmacy for medication management, access to emergency care if needed, and units are not able to complete the current "medical clearance" process for patients who are assessed to need inpatient psychiatric care. This means that a person who arrives at stabilization center and is found to need inpatient psychiatric care, they would have to be transported to the emergency department for "medical clearance" prior to admission. As noted in considerations for future state, the potential demand for this service might be too low or too variable to cover the operational costs of a free-standing unit. If multiple regions wanted to pool resources to develop a unit that would be shared by the regions, the unit may be able to remain at census and meet operating budgets. Sharing presents some issues with first responder drop offs and the regions who are funding the facility would need to develop protocols around priority for limited capacity, managing out of region referrals, etc. A freestanding unit would not be eligible to bill hospital facility fees which could have a significant impact on the financial sustainability of a small facility of this size.

Free-standing BH Urgent Care

Outpatient care center that is designed to provide walk-in support to people who are experiencing a BH crisis. Services include assessment, medical screening, access to appropriate medications, and referrals to community-based providers and other resources for follow up care. Behavioral health urgent care centers in some communities provide next day, post emergency department follow-up care to support patients in connecting to outpatient treatment and reduce avoidable emergency department visits. BH Urgent cares are typically open during the day and evening hours, from 5- 7 days per week. A sample plan for operating hours might be 10 am – 10 pm, 7 days a week.

Considerations for this option: One significant dis-advantage to free standing BH Urgent Care is that the BH Urgent care would not be able to relieve the emergency department of the "medical clearance" process. Similarly, if a patient arrives at the urgent care but is found to need emergency care, the urgent care would need to call an ambulance to transport the patient to the nearest emergency department. Peer support can still be co-located with a freestanding urgent care to help patients connect with peer supports that have been shown to improve clinical outcomes for people with behavioral health conditions.[9] Coordination with peer support organizations, mobile crisis teams, the crisis helpline and outpatient behavioral health units is essential to ensure that the urgent care does not become the primary behavioral health provider for clients. In order for the model to work, the BH Urgent Care will need to work closely with community BH resources to ensure that individuals with BH care plans and intensive care teams who present to the BH Urgent Care receive the care that meets their needs.

Develop Familiar Face/ High User Care Coordination Team

A 2023 article by BMC Health Services Research[10] found that a systems level approach to supporting people who use a high number of healthcare services can decrease the utilization patterns. The study found that system components that were the most impactful included strong communication between

[9] https://www.mhanational.org/sites/default/files/Evidence%20for%20Peer%20Support%20May%202019.pdf
[10] Hempel, S., Bolshakova, M., Hochman, M. et al. Caring for high-need patients. BMC Health Serv Res 23, 1289 (2023). https://doi.org/10.1186/s12913-023-10236-w

healthcare professionals to coordinate care, the development of an interdisciplinary team to provide care, and professional skills at addressing the care complexity. In addition, the study noted that professional knowledge about care and system navigation that includes being familiar with resources was rated as important to ensure that patients' needs are met. One model that communities have used to support community members who use high levels of resources across agencies and systems is to consider a community care coordination team. Health plans often convene multidisciplinary and multi sector teams for their members who have high use patterns and cross system involvement. In Washington, the Seattle King County Behavioral Health and Recovery Division has established a more formal program that they call Familiar Faces [11] to address the needs of community members who have 4 or more jail bookings withing 12 months. Familiar Faces works in collaboration with the therapeutic courts for mental health and substance use disorders. Clients are eligible based on their use patterns, the program is for all King County residents who meet the criteria, regardless of insurance status.

Considerations for this option: The King County model involves a highly skilled care coordination team that may not be feasible for Grays Harbor. However, the aspects of convening multidisciplinary, cross sector teams to engage in planning about how to coordinate and support people who are using a high number of crisis services can be applied to Grays Harbor. Ideally, representatives from the BH Urgent Care, EmPATH Unit team, the Crisis Line and Mobile crisis would be standing members of the High Use or Familiar Faces care coordination team. If a member is enrolled with a Medicaid Managed Care Plan, a member of the care management team for that agency would be invited to attend. The care team could select an appropriate cadence to meet, all members sign confidentiality attestations. The goal of the team is to address use patterns across systems and to develop a care approach that may involve referrals to necessary supports, including peer support services. An article from 2021 describes one hospital system's approach to developing high utilizer care plans (HUCP) that include multidisciplinary care teams and engage with the patients directly. The program achieved a 25% reduction in emergency department visits over a 12-month period.[12]

Recommendations

Based on the analysis conducted, stakeholder engagement and financial feasibility modeling conducted, HMA recommends that Grays Harbor take a multifaceted approach to addressing the complex issues that comprise the behavioral health crisis services needs for the community. No single facility, approach or solution will solve all of the BH crisis needs to a community. However, there are several approaches and solutions that may help to address some of the issues that residents, first responders and families face regarding behavioral health crisis needs in Grays Harbor. Based on the analysis and stakeholder engagements that HMA has conducted, we recommend that Grays Harbor County would benefit from a combination of three models listed above. To mitigate the transportation, "medical clearance," and access to pharmacy issues outlined in the **considerations** sections for each, Grays Harbor would benefit

[11] https://kingcounty.gov/en/legacy/depts/community-human-services/mental-health-substance-abuse/diversion-reentry-services/vital-program

[12] https://www.himss.org/resources/high-utilizer-care-plan-project-network-initiative-decrease-inappropriate-healthcare

from both an EmPATH unit and a Behavioral Health Urgent Care that are co-located at existing medical facilities with emergency departments. HMA acknowledges the concern shared by some stakeholders that adding units to hospitals may present challenges regarding space, staffing and cost. It is significant to note that the solutions also present the emergency departments with the opportunity to relieve pressure on their emergency departments by giving people who are experiencing a behavioral health crisis an alternative to the traditional ED. Creating alternatives to ED care can positively impact the throughput for emergency departments, reducing wait times and reducing the incidents of behavioral health boarding. Lastly, the establishment of a multi-agency, cross sector familiar face or high user care coordination team would increase the level of support that individuals who frequently use emergency department and have frequent contacts with law enforcement for behavioral health symptoms. Leveraging this important approach can have a positive impact on the trend in Grays Harbor of a small number of individuals using a high proportion of crisis resources.

To support youth experiencing a behavioral health crisis, HMA supports the plans that the community has in place for a youth mobile crisis team. These have been shown to be effective at helping youth and their families receive support in the community and avoid hospitalization. A BH Urgent Care is able to serve youth and adults for outpatient, urgent care. A freestanding Crisis Stabilization unit would face challenges in meeting the requirements for supporting patients who are over and under the age of 18 in the same unit. Combined age groups in a similar facility require additional staffing resources and site considerations to meet WACs and RCWs that govern the separation of minors from adults in care settings.

During the course of the project, HMA and Grays Harbor County Public Health learned that Mobile Crisis Team provider, Columbia Wellness, is developing a publicly accessible/walk-in option to access their services in Grays Harbor in early 2024. A project of this kind would serve to increase access to crisis response, care planning and connections to follow up care for all Grays Harbor residents.

An important part of the behavioral health crisis care continuum is low barrier, high support shelter for people who are experiencing homelessness and behavioral health conditions. Some people who are living with chronic behavioral health conditions struggle to succeed in typical shelter environments. There are several federal grant programs that are designed to support communities in their efforts to address the intersection of homelessness and behavioral health conditions. **Appendix B** has details on potential funding sources to consider. It is important to note that these fund sources will not pay for all recommended projects. However, they could potentially provide some support to Grays Harbor in the implementation of key recommendations.

In order to support the flow of clients out of any crisis stabilization or EmPATH unit that Grays Harbor determines to be the best fit for residents, HMA recommends investing in a low barrier, high support shelter that supports people who need more support than a typical shelter can provide. One Washington program that offers this service array is the Pierce County Catholic Community Services

Nativity House Program[13]. This shelter provides day support, overnight shelter, mental health assessments, substance use disorder assessments and offers 50 units of supportive housing to support people who have disabilities and have struggled with chronic homelessness. Grays Harbor could choose to integrate peer support into a shelter to support with connecting those residents who use the shelter to appropriate behavioral health services, help with applying for any insurance benefits that they may be eligible to receive and motivational enhancement to help residents take action to follow up with resource connections.

It is important to note that no single solution or facility can solve the complexities of behavioral health crisis and the intersections with homelessness, the criminal justice system and the unique challenges that rural communities face regarding workforce recruitment and retention. However, by building on the strength of Grays Harbor crisis providers, peer support organizations and the high level of interest in finding solutions to improve behavioral health crisis care in Grays Harbor, this multilayered approach offers the best opportunity to have a significant impact on the community. The state of Washington continues to work to address the behavioral health crisis continuum through 9-8-8 and other crisis system redesign efforts. Continued work and advocacy are needed to help address competency restoration work and the wait time for those who need competency evaluations.

Appendix A

Background and Methodology

Overview

A mixed method design was used to gather data about the current resources and gaps, and potential volumes or demand for behavioral health crisis triage services and supports in Grays Harbor County. HMA used the following methods to learn about the services, gaps, and perceptions of the behavioral health crisis system of care in Grays Harbor County. HMA, in collaboration with Grays Harbor Public Health:

- Conducted two provider focus groups with the Grays Harbor Crisis Collaboration
- Conducted nine key informant interviews with local first responders, crisis providers and health care leaders, including representatives from the Aberdeen and Hoquiam Police Departments, the Grays Harbor County Jail, Mark Reed Evaluation & Treatment Center, Olympic Health & Recovery Services, Ride to Wellness, Columbia Wellness, Great Rivers Behavioral Health Administrative Services Organization, Behavioral Health Resources, Catholic Community Services, Destination Hope & Recovery, Coastal Community Action Program, Harbor Regional Health, Summit Pacific Medical Center, and the Grays Harbor County Board of Commissioners.

Additionally, the Health Management Associates team reviewed the following sources:

[13] Nativity House Day and Overnight Shelters - Catholic Community Services and Catholic Housing Services of Western Washington (ccsww.org)

- Reports and data from statewide and county-focused early childhood assessments
- Data that is measured by the Medicaid claims database (T-MSIS) for the years 2017-2020.

HMA examined the behavioral health crisis system of care both quantitatively and qualitatively. There was a strong community and provider engagement in data collection and a general congruence amongst the feedback obtained through key informant interviews and community and provider forums. This gives us a high degree of confidence in the gaps and strengths identified in the report.

Forums and Key Informant Interviews

A diverse set of qualitative data was collected through provider and other stakeholder key informant interviews and forums. Two provider forums were conducted virtually during the Grays Harbor Community Partner Coalition meetings. The forums and interviews were semi-structured and guided by a set of questions developed to understand the current array of behavioral health crisis services and supports in Grays Harbor County and opportunities for change. Detailed interview notes were taken in each interview and forum and subsequently reviewed for themes, which are summarized in the results section below.

Data Analysis of Medicaid Claims for Grays Harbor

HMA examined the data from the Transformed Medicaid Statistical Information System (T-MSIS) database which collects Medicaid and Children's Health Insurance Program (CHIP) data from US states, territories, and the District of Columbia. T-MSIS is the largest national resource of beneficiary information. Currently available T-MSIS data shows claims from the year 2016 through the year 2020. Data for more recent years are not available at this time due to the need for the Center for Medicare and Medicaid Services (CMS) to receive and process all claims prior to releasing data sets. Hospitals have up to 365 days to submit claims, so there is a time lag for data sets that rely on claims. It is important to note that the year 2020 is generally excluded from trend analysis due to the impacts of the COVID-19 pandemic. Emergency Department, inpatient hospitalization and other care utilization were all deeply affected by the pandemic.

All data analyzed for this project was specific to Grays Harbor residents. Claims data reflect the utilization of Grays Harbor residents regardless of their location within Washington when they received the care. Additionally, in order to protect the privacy of individuals, data sharing agreements for this type of data prohibit the release of data that is below a minimum threshold for sharing. When the numbers for a particular population are too small, CMS does not allow the release of that data. In this case, the data on youth utilization of SUD and Mental Health inpatient and ED use for Grays Harbor was below the minimum threshold. As such, the numbers reflected in the data represent adult treatment only. This does not mean that there is not a need for youth behavioral health crisis services in Grays Harbor. It could mean that the chief complaint for the visit did not include a behavioral health condition, or that due to the lack of available resources, few youth were able to find a treatment bed. During stakeholder interviews, HMA learned that there is a request for proposals for an agency to provide

youth mobile crisis services in Grays Harbor. This is in line with recommendations that HMA would make to Grays Harbor to increase support for youth and their families in the community.

Appendix B

Potential funding sources to consider. These fund sources will not pay for all recommended projects, however, could potentially provide some support to Grays Harbor in the implementation of key recommendations.

Projects for Assistance in Transition from Homelessness (PATH)

PATH is a formula grant program that provides financial assistance to states to support services for individuals who are at imminent risk of or experiencing homelessness who have a serious mental illness or co-occurring serious mental illness and substance use disorder. PATH grants are distributed annually to all 50 states, the District of Columbia, Puerto Rico, the Northern Mariana Islands, Guam, American Samoa, and the U.S. Virgin Islands. Each state or territory solicits proposals and awards funds to local public or nonprofit organizations, known as PATH providers. PATH eligible activities include outreach services; screening and diagnostic treatment services; habilitation and rehabilitation services; community mental health services; alcohol or drug treatment services; staff training; case management services; supportive and supervisory services in residential settings; referrals for primary health services, job training, educational services, and relevant housing services; and a prescribed set of housing services.

Grants for the Benefit of Homeless Individuals (GBHI)

GBHI is a competitively awarded grant program that enables communities to expand and strengthen their treatment services for people experiencing homelessness who have substance use disorders or co-occurring mental and substance use disorders. Grants are awarded for up to five years to community-based public or nonprofit entities and funded services include outreach, screening and diagnostic services, treatment, enrollment in mainstream benefit programs, recovery support services, case management, staff training, job training, educational services, and assistance in identification and placement in stable housing.

Treatment for Individuals Experiencing Homelessness (TIEH)

TIEH is a competitively awarded grant program that enables communities to expand access to treatment for people experiencing homelessness who have a serious mental illness (SMI), serious emotional disturbance (SED), or a co-occurring disorder (i.e., a SMI and substance use disorder [SUD] or a SED and SUD). Grants are awarded for up to five years to community-based public or nonprofit entities and funded services include outreach, screening, treatment, peer support, connections to sustainable permanent housing, case management, recovery support services and assistance in enrollment in mainstream benefits.

SSI/SSDI Outreach, Access, and Recovery (SOAR)

The SOAR program increases access to Social Security disability benefits for eligible children and adults

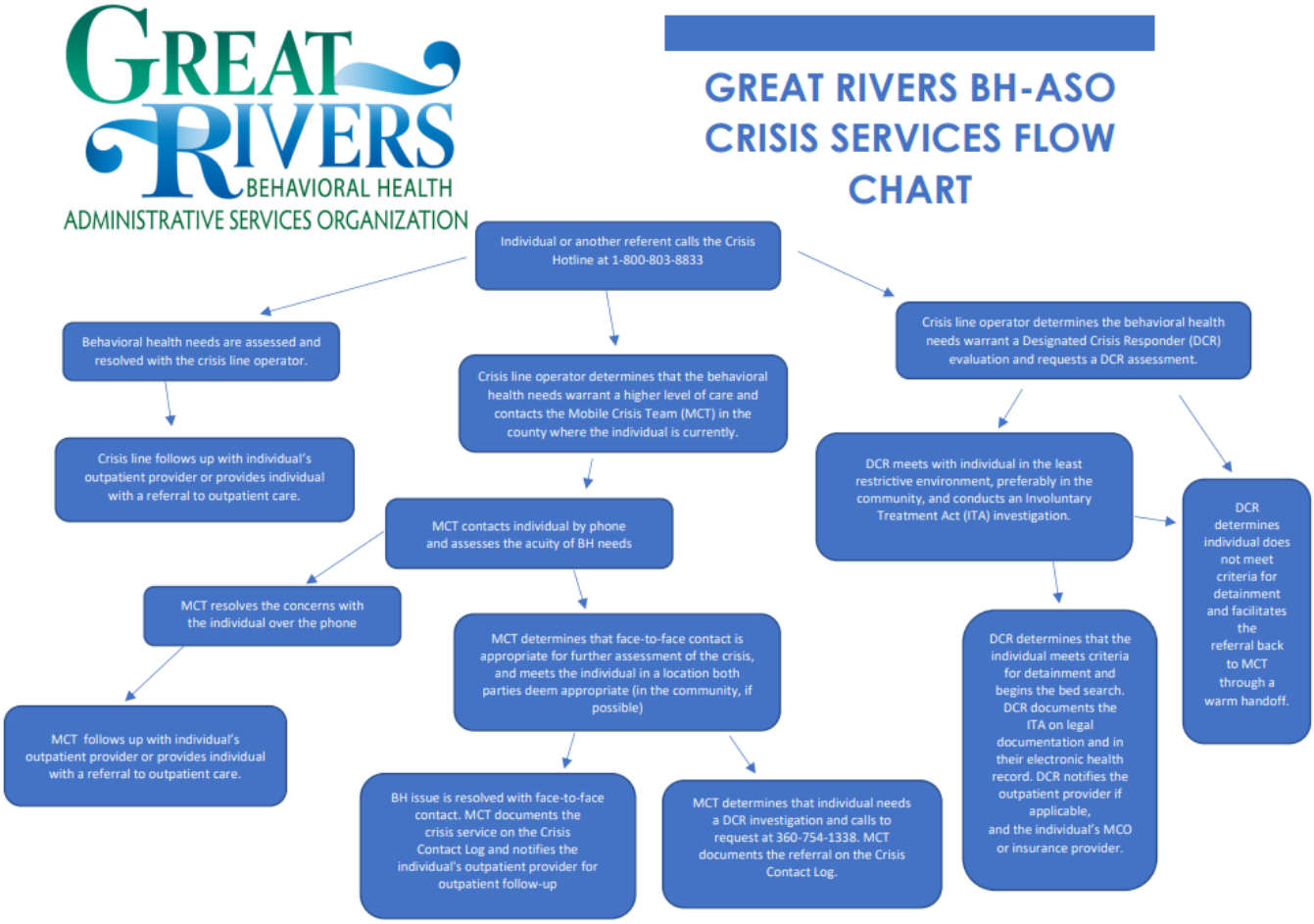
who are experiencing or at risk of homelessness and have a serious mental illness, medical impairment, and/or co-occurring substance use disorder.

Appendix C

Links to Learn More About Innovative Approaches To Address Shelter

- The Springboard Collaborative, Georgetown, DE: The Springboard Collaborative (the-springboard.org)
- The Way Station, Whatcom County, WA: Crisis Respite Bellingham, WA | Bellingham Social Services (unitycarenw.org)
- The Dwellings, Tallahassee, FL: Home - The Dwellings
- U.S. Interagency Council on Homelessness: https://www.usich.gov/ The United States Interagency Council on Homelessness (USICH) is to coordinate the Federal response to homelessness and to create a national partnership at every level of government and with the private sector to reduce and end homelessness in the nation while maximizing the effectiveness of the Federal Government in contributing to the end of homelessness.
- A Primer on Using Medicaid for People Experiencing Chronic Homelessness and Tenants in Permanent Supportive Housing: https://aspe.hhs.gov/reports/primer-using-medicaid-people-experiencing-chronic-homelessness-tenants-permanent-supportive-housing-0 This report provides a "how-to" guide on the various ways that Medicaid can cover services for individuals experiencing chronic homelessness, including the Medicaid authorities and new options provided under the Affordable Care Act.

Appendix D


GREAT RIVERS
BEHAVIORAL HEALTH
ADMINISTRATIVE SERVICES ORGANIZATION
GREAT RIVERS BH-ASO CRISIS SERVICES FLOW CHART
Individual or another referent calls the Crisis Hotline at 1-800-803-8833
Behavioral health needs are assessed and resolved with the crisis line operator.
Crisis line follows up with individual's outpatient provider or provides individual with a referral to outpatient care.
Crisis line operator determines that the behavioral health needs warrant a higher level of care and contacts the Mobile Crisis Team (MCT) in the county where the individual is currently.
MCT contacts individual by phone and assesses the acuity of BH needs
MCT resolves the concerns with the individual over the phone
MCT follows up with individual's outpatient provider or provides individual with a referral to outpatient care.
MCT determines that face-to-face contact is appropriate for further assessment of the crisis, and meets the individual in a location both parties deem appropriate (in the community, if possible)
BH issue is resolved with face-to-face contact. MCT documents the crisis service on the Crisis Contact Log and notifies the individual's outpatient provider for outpatient follow-up
MCT determines that individual needs a DCR investigation and calls to request at 360-754-1338. MCT documents the referral on the Crisis Contact Log.
Crisis line operator determines the behavioral health needs warrant a Designated Crisis Responder (DCR) evaluation and requests a DCR assessment.
DCR meets with individual in the least restrictive environment, preferably in the community, and conducts an Involuntary Treatment Act (ITA) investigation.
DCR determines individual does not meet criteria for detainment and facilitates the referral back to MCT through a warm handoff.
DCR determines that the individual meets criteria for detainment and begins the bed search. DCR documents the ITA on legal documentation and in their electronic health record. DCR notifies the outpatient provider if applicable, and the individual's MCO or insurance provider.