

Select Committee on Quality Improvement in the State Hospitals
Matrix of Mental Health Consultant Recommendations
December 20, 2016

Study	Recommendation	Governor's Budget
PCG #1	<p>Require the Director of the Health Care Authority (HCA) to submit a state psychiatric hospital managed care risk model to the Governor and the Legislature by December 31, 2017 to support putting Medicaid managed care organizations at risk for this benefit effective January 1, 2020. The risk model must address the proper role of commercial managed care for forensic as well as civil populations and the legal role of a business entity's duties in managing a civil commitment. It should establish Managed Care Organization (MCO) contract and provider participation requirements, shared risk arrangements, quality and performance metrics and capacity of the state-hospital business model to adapt to commercial funding streams, including any impacts to labor agreements.</p> <p>Key Features:</p> <ul style="list-style-type: none"> • Aligns with Washington's broad goal for full physical and behavioral health integration. • Addresses the absence of an existing risk model for this unique class of providers. • Addresses the need for accountability and risk management for hospital bed use by non-Medicaid populations and Medicaid enrollees not enrolled in managed care. 	<p>\$140,000 GF-S, \$140,000 Other funds for financial risk model analysis by HCA.</p>
PCG #2	<p>Establish a new unit within the Office of Financial Management (OFM) that integrates and coordinates fiscal analysis of all behavioral health services across agencies and units of government.</p> <p>Key Features:</p> <ul style="list-style-type: none"> • Does not replace agency-based fiscal oversight by OFM. • Complements agency-based fiscal oversight by adding an integrated analytical framework to enhance synergies between and among agency initiatives that have a behavioral health impact. 	<p>Agency will implement with no additional funding.</p>
PCG #3	<p>Enhance community support by strengthening acute care episode management and community services to reduce admissions to state psychiatric hospitals. Specifically, this will be done by funding three new mobile crisis teams, two new crisis walk in centers, a 15 percent increase in the number of peer support specialists and the commencement of a grant program to enhance substance use disorder treatment more broadly into mental health care.</p> <p>Key Features:</p> <ul style="list-style-type: none"> • Supports integration of substance use disorder treatment across community outpatient settings. • Requires capital investment to develop new facilities for walk-in crisis patients. 	<p>\$3.7M GF-S, \$1.2M Other funds for mobile crisis teams.</p> <p>\$2.3M GF-S, \$1.3M Other funds, \$3.8M Capital funds for crisis walk-in centers. (also see Diversion #3)</p>

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PCG #4	<p>Establish six new 16-bed community hospitals for civil commitments and transitional acute psychiatric care needs to promote regional care and the potential for an emphasis in specialty care for co-morbid conditions. These conditions may include developmental disabilities, dementia and certain categories of co-occurring substance use disorders.</p> <p>Key Features:</p> <ul style="list-style-type: none"> • Establishes four 16-bed facilities to serve civilly committed patients in the western region of the state and two in the eastern region of the state. • Keeps patients closer to their communities of residence, thereby easing the transition to outpatient placement. • Permits establishment of these facilities for exclusive focus on civil populations with comorbid conditions that are manageable in a smaller and potentially less intensive setting. 	<p>\$2.7M GF-S, \$1.1M Other funds, \$22.5M Capital funds; 333.8 FTE for phase-in of nine 16-bed state-run community behavioral health hospitals to serve civil patients.</p>
PCG #5	<p>Reform state hospital programming to integrate substance use disorder treatment and add inpatient peer support.</p> <p>Key Features:</p> <ul style="list-style-type: none"> • Redesigns treatment protocols to address substance use disorder in the context of mental health conditions for comorbid patients. • Adds peer specialists to the inpatient treatment team for forensic patients. 	<p>\$3.5M GF-S; 21.0 FTE for Integrated substance use disorder treatment at the state hospitals.</p>
PCG #6	<p>Align community mental health placements with identified civil placement discharge needs by (1) establishing a transitional, statewide supportive housing benefit administrator; (2) creating a temporary Office of Behavioral Health Housing Initiatives, charged with facilitating the collaboration of capacity building investment pools, and (3) establishing expanded responsibility for selected state hospital transitions and management practices to Aging and Long-Term Support Administration (AL TSA) and Developmental Disabilities Administration (DDA).</p> <p>Key Features:</p> <ul style="list-style-type: none"> • Builds capacity to assure new supportive housing benefit will be effective for behavioral health. • Creates a coordinating entity to align disparate capacity investment efforts. • Transfers responsibilities for transition management for individuals who are aging or have physical disabilities to the AL TSA. • Transfers responsibility for management for individuals with developmental disabilities to the DDA. 	<p>\$280,000 GF-S; 1.0 FTE for a transitional statewide supportive housing benefit administrator.</p> <p>\$63.1M GF-S, \$36.6M Other funds, \$24.5M Capital funds; 182.8 FTE for 356 enhanced discharge placement option beds.</p> <p>\$2.3M GF-S, \$2.1M Other funds; 21.3 FTE for discharge case managers and financial service specialists at the state hospitals.</p> <p>\$8.2M GF-S, \$16.0M Capitals funds; 1.0 FTE for 320 new permanent supportive housing beds.</p>

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PCG #7	<p>Recommendation 7: Develop regional care coordination models to follow rising and high risk patients throughout the care continuum, including those with significant mental health and substance use disorder needs.</p> <p>Key Features:</p> <ul style="list-style-type: none"> • Establishes a new regional model of comprehensive care and case management across the care continuum that helps better organize and focus existing services delivery and management efforts around the whole person. • Builds on existing care and case management requirements for Behavioral Health Organizations (BHOs) and MCOs, including augmentation of existing health home services and potential utilization of delivery system reform incentive payments under the Medicaid Transformation demonstration. 	
PCG #8	<p>Invest in transitional care reform initiatives to add step-up, step-down and Housing and Recovery through Peer Services (HARPS) resources. Specifically, add two new, 10-bed step down facilities in Western Washington and one new 10-bed step down facility in Eastern Washington.</p> <p>Key Features:</p> <ul style="list-style-type: none"> • Develops step-down facilities following the Enhanced Services Facilities model implemented in Vancouver and Spokane and augments HARPS teams to connect discharged patients to available housing. • Develops step-up facilities that allow for both patient walk-in appointments and short term admissions initiated by the patient or caregiver. 	\$2.8M GF-S for two additional HARPS teams.
PCG #9	<p>Create an integrative technology infrastructure to support behavioral health service delivery and transition to integrated care.</p> <p>Key Features:</p> <ul style="list-style-type: none"> • Develops a learning health system to support patient-centered care and monitoring. • Supports transition to full integration while providing unique functionality for behavioral health. 	
Diversion #1	<p>Increase the availability of low- and no-barrier, supportive housing for people with a criminal history, substance use disorder, and/or mental illness.</p> <ul style="list-style-type: none"> • Allocate state funding for local capital projects to increase housing stock. • Provide incentives to landlords to serve this population. • Increase funding for supportive housing services by accessing Medicaid (non-waiver) or general fund dollars. 	<p>\$2.9 million GF-S; \$5.0M Capital funds; 100 beds.</p> <p>\$4.6M GF-S, \$1.5M Capital funds for 60 step-down housing beds.</p>
Diversion #2	<p>Increase capacity across the continuum of mental health treatment delivery, especially with residential treatment.</p> <ul style="list-style-type: none"> • Allocate state funding for regional capital projects for residential behavioral health treatment. • Build or retrofit existing buildings to increase capacity in this area across the state. 	

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Diversion #3	<p>Increase the capacity and accessibility of crisis stabilization and 23-hour observation facilities.</p> <ul style="list-style-type: none"> • Remove access barriers at crisis stabilization centers, such as criteria that exclude people with outstanding warrants or certain types of charges (fire setting or sex offenses, for example). • Establish regional 23-hour crisis observation facilities that are linked to psychiatric beds and residential and outpatient follow-up care. Allocate state funds for regional capital projects for these facilities. The Unity Center for Behavioral Health in Portland, Oregon, includes a 23-hour observation facility slated to open early in 2017; capital costs for the center (to remodel an existing building) were funded from state and local general funds, private donations through a local hospital foundation, and local hospitals. 	<p>\$2.3M GF-S, \$1.3M Other funds, \$3.8M Capital funds for crisis walk-in centers. (also see PCG #3)</p>
Diversion #4	<p>Better identify detainees who have mental illness.</p> <ul style="list-style-type: none"> • Expand the use of formal, evidence-based mental health screening tools at booking. As indicated, follow up with comprehensive assessments by mental health professionals. • In jails that lack onsite mental health professionals, pair the use of an evidence-based screening tool with phone or video consultation (such as via tele psychiatry) with mental health professionals who are available 24/7. 	

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Diversion #5	<p>Create incentives for jails, mental health providers, and health plans to cooperate to ensure that all Medicaid-eligible inmates with mental illness are identified early, enrolled in Medicaid, receive robust assessment and transition services, and access physical and behavioral health services immediately upon release.</p> <ul style="list-style-type: none"> • Automate the suspension and reactivation of Medicaid benefits as people are booked into and released from jail. Washington already is on track to implement suspension (versus termination) of Medicaid benefits upon incarceration, beginning in July 2017. • Use contract provisions with providers and health care plans to mandate the provision of in-jail transition planning and integrate financial disincentives, such as holdbacks, for jail bookings of plan members (similar to emergency department visits or hospital readmissions). For in-jail transition planning, include performance measures such as the following: <ul style="list-style-type: none"> ○ Enroll 100 percent of eligible detainees in Medicaid within 24 hours of booking. ○ Meet with and develop a transition plan for detainees within 72 hours of booking. ○ Connect departing inmates with appropriate physical and behavioral health providers and ensure that they attend appropriate appointments within 72 hours of release. • Develop the infrastructure for an electronic information exchange that alerts health plans when their enrollees are booked in jail. • Encourage providers to use peer support specialists to support people with mental illness who leave jails, to assist with case management; escort people to court, treatment, and initial care appointments; and provide other support services. • Establish statewide guidelines for jail access by providers, including peer support specialists. Currently, screening criteria for providers vary significantly across counties, with some jails excluding peer support specialists who have criminal histories, for example. • Establish statewide standards for the provision of medication to inmates being released from jail. Current practices in Washington vary greatly from jail to jail. 	
Diversion #6	<p>Where practicable, implement a community-based competency restoration process to divert individuals with severe, acute, and chronic mental health issues from jail and unnecessary hospitalization.</p> <ul style="list-style-type: none"> • Model programming, including legal skills education, on existing programs at the state hospital or on other jurisdictions' community-based restoration programs. • Integrate a continuum of residential and treatment options into community-based competency restoration programs to allow for individualized case plans that ensure participants are safely housed, treated, and supervised. 	

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Diversion #7	<p>Modify the competency restoration process to reduce the volume of unnecessary evaluations and jail wait times and more effectively support access to treatment for those who need it.</p> <ul style="list-style-type: none"> • When competency evaluations are requested by the parties to a case, use a competency prescreening tool (administered by a mental health practitioner) to evaluate the need for a competency evaluation. Interviewees for this study reported that approximately 60 percent of competency evaluation orders result in findings of not competent. A competency screening process currently being used in Snohomish County has reduced the number of full evaluations and the wait time for evaluations. Following an order from the court, a mental health professional employed by the jail conducts a competency prescreen and then submits a written report to the prosecutor, public defender, and the court. • Consider eliminating the competency restoration process for misdemeanants and people charged with low-level, non-violent felonies. Instead, prescreen those cases (as described above) and divert people who are possibly not competent to stand trial to community based treatment, or for evaluation through the civil AOT or ITA processes (whichever is the appropriate and less restrictive alternative). This option is only valid if the continuum of community-based treatment capacity is sufficient to treat these individuals. • If eliminating the CST restoration process is not possible, change the CST code (RCW 10.77.088) to exclude people with issues such as traumatic brain injury, dementia, and developmental disabilities from the CST restoration process. 	
Diversion #8	<p>Establish a mechanism to fund street outreach and engagement activities by peer support specialists/community health workers.</p> <ul style="list-style-type: none"> • Explore options for Medicaid funding of outreach and engagement activities or fund with state dollars. 	\$1.7 million GF-S for street outreach and peer support.
Diversion #9	<p>Increase collaborative planning between criminal justice partners and representatives of physical and behavioral health organizations.</p> <ul style="list-style-type: none"> • Require that criminal justice leadership take a seat at the table with the Accountable Communities of Health and on other health integration planning initiatives. • Change Revised Code of Washington (RCW) 72.09.300 to include physical and behavioral health representation on the local law and justice councils. 	
Diversion #10	<p>Identify and prioritize detained high utilizers of multiple systems (HUMS) for robust transition planning and wraparound services upon release.</p> <ul style="list-style-type: none"> • Provide counties with funding and technical assistance to identify HUMS and analyze data about them to better understand the unmet needs that drive their intensive use of jails and crisis resources. (Some counties already have completed this work, although their analyses often focused only on high utilizers of the jail.) • Where practicable, implement a single case manager structure for HUMS, such as the Pathways Community Hub model of community care coordination. • Provide health literacy education to HUMS. 	
Diversion #11	<p>Support the establishment of pretrial release programs statewide.</p> <ul style="list-style-type: none"> • Support the cooperative efforts of the judiciary as they convene a task force focused on pretrial reform. 	

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Diversion #12	<p>Modify specialty court policies and practices to better reflect the evidence regarding their effectiveness and to increase participation and efficiency.</p> <ul style="list-style-type: none"> • In counties with high volumes of competency cases, consider establishing competency courts, to more efficiently process these cases. • Use recovery models as the basis for the work of specialty courts, rather than abstinence models. For example, operate courts understanding that relapse is part of the recovery process, and allow for medication-assisted therapy (MAT). MAT is an evidence-based practice that helps people address their substance abuse disorder, stabilize, and be able to take further steps toward recovery. (Presumably MAT will become easier to administer starting in February 2017, when new Department of Health and Human Services policies go into effect that will allow nurse practitioners and physician assistants to prescribe buprenorphine, a medication used to treat opioid addiction. • Change the eligibility requirements for participation in specialty courts to focus on medium- and high-risk offenders, with an emphasis on felony charges. Determine participation based on the results of actuarial risk assessments, rather than solely on charge type, so as to make better use of resources (i.e., focus these specialty court-related resources, which are relatively expensive, on the highest risk offenders). Currently in most specialty courts, eligibility criteria are based on charges and the courts accept only misdemeanants. • Where practicable, establish co-occurring courts, which can more efficiently and comprehensively address the complex needs of the many defendants who have co-occurring mental health and substance use disorders. 	
Diversion #13	<p>Increase understanding locally and at the state level of which services are in place and which are missing at the various points where the criminal justice and mental health systems intersect.</p> <ul style="list-style-type: none"> • Conduct a statewide and regional intercept mapping process with healthcare, behavioral health, law enforcement, and criminal justice stakeholders to clearly identify needs and system gaps at each intercept point and to develop a comprehensive plan to address those gaps at the state and regional levels. 	
Diversion #14	<p>Provide 24/7 telephonic psychiatric consultation to law enforcement in the field, especially in more rural areas.</p> <ul style="list-style-type: none"> • Establish a professionally staffed consultation line (available 24/7 to rural counties) that provides law enforcement officers with immediate, direct access to mental health professionals, for information and consultation regarding people with mental illness who they encounter in the field. 	
Diversion #15	<p>Replicate King County's Law Enforcement-Assisted Diversion (LEAD) program in other large urban areas.</p> <ul style="list-style-type: none"> • Fund replication pilots in larger, more urban jurisdictions across the state. • Direct the Washington State Institute for Public Policy (WSIPP) to conduct a cost/benefit analysis of the LEAD program to inform potential expansion and multi-site replication. LEAD is being replicated in jurisdictions across the country, but not within Washington. 	

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Diversion #16	<p>Increase leveraging of Medicaid funding for jail diversion and reentry program components, such as enrollment in Medicaid, assessment, care plan development, service referral, and monitoring.</p> <ul style="list-style-type: none"> • Direct the Washington Health Care Authority (HCA) to more thoroughly explore opportunities to use MAM and TCM in jails, DOC prisons, and community corrections. • As the DOC implements MAM reimbursement for Medicaid enrollment activities, replicate that process in large jails and/or make those services available remotely to jails through DOC. 	
Diversion #17	<p>For people on community supervision who are mentally ill and commit a technical violation of their probation, encourage the use of alternatives to jail as sanctions.</p> <ul style="list-style-type: none"> • Modify swift and certain policies for community supervision to encourage (1) the use of alternative sanctions, such as participation in treatment programs, for individuals with severe mental illness, and (2) increased cooperation and information sharing between community corrections officers and community-based providers. 	
Diversion #18	<p>Require E&Ts and other acute residential facilities to accept jail detainees who have been evaluated and referred by a DMHP.</p> <ul style="list-style-type: none"> • Build incentives to serve clients who have been evaluated and referred by a DMHP into provider and health plan contracts. 	
Diversion #19	<p>Keep people who slap or spit on a nurse, physician, or health care provider who is performing his or her nursing or health care duties from being charged with assault in the third degree (a Class C felony) and instead charge them with assault in the fourth degree (a gross misdemeanor).</p> <ul style="list-style-type: none"> • Change Revised Code of Washington (RCW) 9A.36.031, which defines assault in the third degree as a Class C felony, to eliminate Section (1) (i): "Assaults a nurse, physician, or health care provider who was performing his or her nursing or health care duties at the time of the assault." 	
Diversion #20	<p>Increase mental health, law enforcement, and criminal justice professionals' cross disciplinary understanding of how Washington's criminal justice and behavioral health systems work.</p> <ul style="list-style-type: none"> • Develop and integrate cross-system educational curricula into existing training opportunities, both for new employees and as continuing education requirements. 	
Diversion #21	<p>Support organizational culture change for law enforcement agencies.</p> <ul style="list-style-type: none"> • Fund statewide leadership development training for law enforcement supervisors and managers. 	
Diversion #22	<p>Increase educational opportunities for behavioral health professionals who serve justice involved individuals who have mental illness.</p> <ul style="list-style-type: none"> • For mid-career behavioral health professionals who are serving justice-involved clients, develop and deliver training on the complex needs of these individuals. • Partner with universities to (1) develop certificate programs for behavioral health services for justice-involved populations, and (2) offer practicum opportunities in agencies that serve this population. 	

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Diversion #23	<p>Improve the availability and sharing of electronic medical records (EMRs) in jails and prisons.</p> <ul style="list-style-type: none"> • Purchase EMR systems for DOC and those jails that currently lack them, so that DOC and jails have efficient access to information on inmates' physical and behavioral health histories and can share that information appropriately with other facilities and community-based providers. • Explore the use of SureScripts ePrescribing system as a mechanism to share prescribing information between criminal justice and community-based providers as an interim solution until an electronic health information exchange is established. • Develop the infrastructure for an electronic health information exchange between DOC, jails, and community providers that informs these entities of the types of services and medications that inmates enrolled in Medicaid have accessed in the community. 	
Diversion #24	<p>Analyze existing data to better understand the needs of the justice-involved population—including people with mental illness—and identify current system capacity and service issues.</p> <ul style="list-style-type: none"> • Direct RDA to establish ongoing data use agreements with jails. • Direct RDA to analyze Medicaid, jail, and DSHS data to better understand the impacts of state funding changes and Medicaid expansion on the population of people with mental illness who are being jailed. What percentage of people in jail are eligible for Medicaid, and what percentage of inmates with mental illness are eligible for Medicaid? Are they enrolled? Have they accessed services? Why or why not? Are their wait times longer than those of the non-justice-involved population? What does this say about the availability and effectiveness of behavioral health treatment for the justice-involved population? 	
Workforce 1	<p>Adjust reimbursement rates to better support competitive recruitment and retention of a skilled behavioral health workforce</p> <ul style="list-style-type: none"> • Make the placement of Medicaid rates at the bottom of the rate bands as per ESSB 6052, Sec. 204(1)(q) a one-time response to excess Regional Support Networks reserves, rather than ongoing policy. • Adjust Medicaid capitation rates from the bottom of the rate bands to a level sufficient to positively influence wages. 	
Workforce 2a	<p>Support the use of/expansion of the Healthier Washington Practice Transformation Hub efforts to promote adoption and training of team-based integrated behavioral health and primary care.</p> <ul style="list-style-type: none"> • Examine payment incentives to make sure they are properly aligned to support workforce integration efforts. If the Hub identifies misalignments, there will need to be a state-level discussion about how to shift payments to incentivize integrated behavioral and primary care. • Ensure practice coaches located in each region of the state. • Support training of team-based integrated care in behavioral health as well as in primary care settings. • Create a sustainability plan to support the practice integration support work needed after the conclusion of the Healthier Washington initiative and funding period. 	Healthier WA and 1115 Waiver funded to accomplish some of this work.
Workforce 2b	<p>Consider expanding the list of professions eligible to bill as mental health providers.</p> <ul style="list-style-type: none"> • Policymakers could request that the Department of Health conduct a Sunrise Review of the professions able to bill for mental health services. 	

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Workforce 2c	<p>Train and deploy entry-level providers in both primary care and behavioral health to support health team efforts in community health settings.</p> <ul style="list-style-type: none"> Assistance with outreach to the behavioral health community to recruit for, and support, staff in the use of the apprenticeship and incumbent worker trainings once they are complete, assist with curriculum review and sharing of expertise to ensure cross-coordination in model dissemination, as well as collaboration with the University of Washington AIMS Center to develop appropriate curriculum. 	
Workforce 3a	<p>Recognize and compensate the function that community-based settings play in training new behavioral health professionals and paraprofessionals in their first year of practice.</p> <ul style="list-style-type: none"> Charter/convene a work group of community mental health agencies and federally qualified health centers to determine which incentives would be useful, and identify the level of funding needed if financial incentives were recommended. Once the work group has concluded its review, the next step would be to work with policymakers to establish and obtain funding for incentives for community mental health agencies and federally qualified health centers with existing training programs. 	
Workforce 3b	<p>Increase the ability of behavioral health clinical training sites to accept students/trainees by incentivizing and supporting clinical training sites.</p> <ul style="list-style-type: none"> Develop and implement a readiness assessment to support clinics in assessing their capacity and ability to implement long-term residency and training programs. Promote increased collaboration between universities/colleges and clinics for clinical training of behavioral health professions. Examine the approach used by Clinical Placements Northwest as a potential model for expanding coordination across the state. Consider legislative and funding support that provides financial incentives for current and potential clinical training sites to make up for time and money lost while training new healthcare workers. Review opportunities to provide additional incentives for clinical training sites to send their preceptors to get training as supervisors 	
Workforce 3c	<p>Encourage payers (MCOs/health plans and BHOs) to contract with licensed community behavioral health agencies, as well as individual licensed clinicians.</p> <ul style="list-style-type: none"> HCA could lead a process to work with payers to update/create contracts with licensed community behavioral health agencies in addition to individual licensed clinicians. Alternately, policymakers could direct HCA to move toward renegotiating the current contracts, and consider requiring future payer contracts to include licensed community behavioral health agencies, in addition to individual licensed clinicians. 	

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Workforce 3d	<p>Increase funding to expand behavioral health education programs and graduate more professionals.</p> <ul style="list-style-type: none"> One suggested approach would be for policymakers to create a grant program for universities with psychiatric ARNP programs in Washington state to apply for and receive funds to pay for faculty positions and preceptorship placement. A pool of \$5 million would allow universities to apply for single or multiple \$400,000 grants for a 2 to 3-year cycle to educate and train additional psychiatric ARNPs. A minimum number of student slots, above previous enrollment, should be identified for grants (for example, eight students per grant award). This proposal would result in an approximately 80 additional psychiatric ARNPs to be educated and clinically trained over the next two to three years. 	
Workforce 4a	<p>Increase primary care providers' (physicians, ARNPs, PAs, pharmacists) confidence to use their full prescriptive authority for psychiatric medications.</p> <ul style="list-style-type: none"> Adjust the Medicare, Medicaid, PEBB, commercial insurance, and other relevant payment models to provide greater support for and sustainability of telepsychiatry and other consultation methods to support primary care providers via tele-consulting services with a psychiatrist. Continue funding beyond 2018 for the University of Washington Integrated Care Training Program (ICTP) and Psychiatry and Addictions Case Conference (PACC), and the University Washington's Project ECHO program that provides weekly didactic education and case consultation to any primary care provider in Washington. Expand MCOs/BHOs providing telepsychiatry networks for contracted provider networks, by supporting options such as the model being developed by North Sound BHO. Consider removing the 100 patient cap for telemedicine. Continue support for psychiatrist training through the UW Integrated Care Training Program (through the UW AIMS Center), and consider expansion of this program to support all psychiatric prescribing providers (e.g., ARNPs), with a plan for ongoing investment in such training beyond 2018. 	
Workforce 4b	<p>Expand telehealth reimbursement to include any site of origination and consultation services.</p> <ul style="list-style-type: none"> Update telemedicine RWCs to allow access and reimbursement from any site of origin. Update telemedicine RCWs to allow reimbursement for consultation services. 	<p>Sec. 212 (y) proviso language included in HCA's budget directing the Authority to evaluate adding a tele psychiatry consultation benefit for Medicaid covered individuals.</p>

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Workforce 5a	<p>Improve behavioral health literacy as a foundation for healthcare careers.</p> <ul style="list-style-type: none"> • Policymakers could enhance funding for mental/behavioral health literacy education; using models such as the programs listed in the report, and emphasize support for programs which include training and resources for educators. • The Professional Educator Standards Board, OSPI, and selected teacher preparation programs could provide mental health literacy for pre-service instructors in teacher preparation programs, as well as in-service mental health literacy training for teachers and school staff. • Policymakers could consider funding a program manager for mental health literacy efforts at OSPI. • The OSPI Health Science Program Supervisor, Workforce Board, Educational Services Districts, and local districts, in collaboration with OSPI content specialists and the Health Science Program Supervisor could create and implement a Behavioral Health career pathway curriculum, based on promising practices in Washington, Nevada, Alaska and Nebraska and others, especially in areas that include rural, underserved, and diverse populations. • Policymakers could increase emphasis in state funding for Washington AHECs to continue and expand their health career pathway programs, particularly those focused on behavioral health careers. 	
Workforce 5b	<p>Increase the use of peers and other community-based workers in behavioral health settings.</p> <ul style="list-style-type: none"> • Division of Behavioral Health and Recovery (DBHR) would need to increase the number of training sessions throughout the year, and could consider use of video or virtual training and examination to increase access to the certification. 	
Workforce 5c	<p>Expand use of the I-BEST model, and encourage additional programs that include behavioral health occupations.</p> <ul style="list-style-type: none"> • Increased funding support of policymakers for the I-BEST program. The State Board for Community and Technical Colleges has a funding request that would increase access to I-BEST programs for an additional 900 FTE, which includes healthcare programs. 	
Workforce 5d	<p>Reduce care worker turnover and improve diversity by creating career pathways and opportunities for certification of behavioral health and other paraprofessional roles.</p> <ul style="list-style-type: none"> • The Workforce Board, with funding from the state budget to support 1.5 FTE, could work with the Health Workforce Council to establish a Care Worker Task Force and develop a care worker career lattice over the next 18-24 months. 	
Workforce 5e	<p>Support continued funding for the state's health professionals loan repayment program, and consider strategies to expand the program and its applicability to behavioral health occupations.</p> <ul style="list-style-type: none"> • The Student Achievement Council (WSAC), which administers the program, could be encouraged to increase outreach to sites and graduates to access the program. • Expansion of loan repayment awards would require policymakers to increase the program's appropriation. • The Department of Health could consider convening a workgroup or task force to explore a new direct incentive 	Budget continues funding.
Workforce 5f	<p>Expand the state Work Study program.</p> <ul style="list-style-type: none"> • Policymakers would need to appropriate additional funding to the program. 	
Clinical 1	<p>Reorganize the management model on the wards to include a Ward Program Administrator (WPA) responsible for 24/7 ward operations. This would clarify the chain of command and provide a continuity of authority and communication relevant to the wards.</p>	

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Clinical 2	Use Center/Unit-based permanent float pools that include full time and part time positions. This would increase the quality and continuity of care for patients, and improve overall safety in the workplace.	
Clinical 3	Use ARNP, P-ARNP and PA-C to ease constraints created by lack of qualified psychiatrists in the workforce, physician unavailability and recruitment delays.	
Clinical 4	Invest in leadership programs that train both experienced and new supervisors on how to monitor, evaluate, and promote clinical competence directly and objectively.	
Clinical 5	Create an organizational work structure that supports both administrative and clinical functions, encouraging appropriate time and focus on patient care and active treatment by clinical staff, with non-clinical activities carried out by administrative and other support services.	
Clinical 6	Address staffing shortages in non-clinical disciplines such as housekeeping, transportation, dietary and food services, which distract nursing staff from their core responsibility of patient care.	
Clinical 7	Conduct thorough facility assessments at both hospitals to evaluate the functional facility design from the perspective of safety, security, privacy and staff working conditions and remediate issues found. This will go a long a way in creating environments in which patients and staff are safe and trauma-informed.	
Clinical 8	Adopt and enforce the use of industry accepted assessment tools and criteria for treatment planning. Treatment standards, process measures, and clinical outcomes that are specific and individualized to the complex populations of patients will drive faster throughput and recovery times.	
Clinical 9	Engage a Public Relations firm to help share what is good about the state hospitals, and share success stories. Appropriate HIPAA authorizations and other releases can also be obtained to share patient stories, as appropriate.	
Clinical 10	<p>Develop a uniform discharge planning process across both state hospitals with responsibility falling to social workers. Elements of a successful discharge planning protocol should include the following:</p> <ul style="list-style-type: none"> • Cultivate a culture of discharge planning beginning at admission. • Adopt a proven and predictable discharge planning screening tool so that information is not solely drawn from chart notes. • Formulate standardized screening tools around prediction rules; for example, a symptom checklist. • Train social workers and discharge planners related to the special needs of the homeless. • Co-develop a discharge readiness assessment tool with the Behavioral Health Organizations (BHO's). Such a tool would be used to evaluate patients for re-entry in the community, including level and type of placement. 	
Clinical 11	Invest in "Lean" efficiency work flow exercises to specifically identify areas of opportunity to maximize nursing/clinical staff time on direct patient care and reduce bottlenecks. This would empower the leadership to take definitive actions and decisions to optimize productivity and staffing levels. Several ideas for Lean exercises are suggested earlier in the document.	
Clinical 12	Develop management reporting metrics. Examples would be a monthly scorecard depicting fill rates and annualized turnover rates for clinical staff positions reported to hospital leadership (this report would demonstrate the effect of actions being taken to enhance recruitment and retention). Supporting this, develop another report used to monitor number of contractors including locum tenens deployed to cover for staffing inadequacies.	

Study	Recommendation	Governor's Budget
Clinical 13	When adverse or unusual occurrence events take place, consistently enforce a thorough analysis of these events. There should be rigorous debriefing to form a comprehensive analysis of circumstances, and how the event can be prevented or avoided in the future. Included in the debrief should be questions covering: what happened, what was missed, what led up to this event, what could have been done differently, what practices precipitated this event, and what can be changed.	
Clinical 14	Establish and reinforce a philosophy of a recovery-centric culture, and extend to the community the hospitals' consultative expertise, access, and training related to the diagnosis and treatment of people with complex conditions who may be at risk of harm to self or others. Provisioning this expertise will help legislators, courts, community providers, families, and others understand the role of the state psychiatric hospitals in the context of recovery and the public health care system. Such actions also provide opportunities to strengthen linkages with the community, develop staff skills, and recruit and retain high quality staff.	
Clinical 15	Reinstitute a formal mentoring program for clinical staff before these staff are assigned to direct patient care. The current "preceptor" program may be insufficient in training nurses and other caregivers on practical everyday challenges in the wards. Avoid assigning staff to float pools until they have fully completed the mentor program and are signed off by the Center/Unit leader.	
Clinical 16	Re-introduce programs (e.g., PALS) to support community engagement and reintegration for patients who have experienced long state psychiatric hospital lengths of stay. Transition services would include skills training to manage patients' illness, health, daily activities, and living environment as well as care coordination, peer support services, and community consultation and liaison.	
Clinical 17	Reestablish strong linkages with medical schools and other academic institutions for education, training, and research to enhance recruitment and retention of workforce.	
Clinical 18	Implement a floating pool of instructional aides within rehab to permit licensed rehabilitation therapists to use their skills more effectively and be more actively involved in treatment.	
Clinical 19	Encourage and enable staff to pursue continuing education within or outside of the workplace, with particular emphasis on evidence-based practices, cultural competence and services designed to manage special sub-populations of patients.	
Clinical 20	Embrace and promote the use of modern health information technologies in daily operations. Hospital leadership should strongly advocate expedient deployment of a fully functioning Electronic Health Record system, and explore the use of telemedicine for specialty consultation.	
Clinical 21	Standardize care planning teams across all hospitals; identify best practice and/or evidence-based practices to include collaboration with peer support specialists. Inclusion in treatment planning wherever practical and feasible is a key component of staff satisfaction, and will go a long way in instilling a sense of belonging and work fulfillment for staff.	
Clinical 22	Launch a formal employee referral program with bonuses tied to hiring and retention. Accelerate recruiting by providing a forum for on-call nurses/staff who may be interested in exploring full time or predictable part time opportunities.	