Jefferson County Behavioral Health Consortium

HRSA Grant Planning Retreat November 6th, 2019

HEALTH FACILITIES PLANNING & DEVELOPMENT

RESEARCH · DATA · ANALYTICS · STRATEGY · IMPLEMENTATION

Retreat Deliverables

Reach preliminary consensus on facility and operational/ programmatic models

Discuss workforce and governance

Consensus on next steps

Grant Vision, Mission & Planning Values

DRAFT VALUES

Making the lives of the residents of Jefferson County better through:

- Community engagement
- Transparency
- Teamwork
- Acknowledging that inclusion, collaboration, respect, and diversity are fundamental in developing needed services and programs
- Integrity
- Placing the needs of the community at the forefront of all of our efforts.

Updates

Jamestown, Clallam, Jefferson Current Planning

- Three entities: Jefferson County PHD No. 2,dba Jefferson Healthcare, Clallam County PHD No. 2, dba Olympic Medical Center and the Jamestown S'klallam Tribe are working together on a multi-phased campus in Sequim.
  - Phase 1- is a Clinic to be owned and operated by the Tribe
  - Phase 2– under analysis now is likely to be an E&T
  - They have defined Phase 3 as a crisis response facility in Jefferson County, and potentially in Port Angeles and Forks as well.

Data Summary

Data Source	Annual Volume	Notes
Jefferson Healthcare	600	BH related ED Visits
Discovery BH	50	Involuntary detentions
	70	Voluntary placements
	140	ITA Investigations
	568	Unduplicated crisis services (includes outpatient)
Jefferson County Jail	892	Mental health related bookings (75% involved alcohol/drug charges)
Jefferson County Sheriff	354	Mental health related incidents
	397	SUD related (44 MH and SUD)
East Jefferson Fire Rescue	29	Incidents of Opioid Overdose
	59	Transports from JH to inpatient BH facility
	100	Total BH responses
Port Townsend Police Department	579	BH related incident (had been drinking)
	353	BH related incident (drugs)
	1,318	BH related incident (mental health)

BHO Data Updates

Our Preliminary Recommendation

2 Phases:

- Phase 1: Community-based programs
- Phase 2: A Residential Treatment Facility (RTF) with several certifications able to accommodate:
  - Voluntary and involuntary
  - Mental health and SUD
  - Number of beds: TBD, but likely to be in the 4-15 bed range (ADC of 2-10).
  - Dependent on ability to operationalize multiple program types in one facility.

Proposed Facility Preliminary Model – RTF and BHA as baseline

RTF Facility Licensure

- **Residential Treatment Facility:** A facility in which twenty-four hour on-site care is provided for the evaluation, stabilization, or treatment of residents for substance use, mental health, co-occurring disorders, or for drug exposed infants.

Behavioral Health Agency Licensure

Inpatient Mental Health Certification

- Crisis Stabilization Unit
- Triage Center
- Evaluation & Treatment
- Withdrawal Management
- Intensive Inpatient Facility

Proposed Facility: Timing, number of beds, staffing, etc.

- There are slight licensing differences between crisis stabilization and triage in the licensing rules (not black and white) – HCA sees them as "redundant". Medicaid state plan focuses on services – not licensing category
- LOS requirements/realities not spelled out - inconsistent/unknown by state agencies
- Medicaid definitions in state plan focus on "stabilization services" not type of certification
- Some services Consortium has considered "stabilization" may fit more into the Medicaid's evaluation and treatment definition.

	Crisis Stabilization Unit	Triage Center	Evaluation &Treatment
Max LOS all patients	14 days	5 days	?
Max involuntary	24 hours	3-5 days	14 days
ALOS all patients	5-10 days	3-5 days	5-10 days

Why do we think we need a Phase 1 solution?

Expect facility "phase 2" option is 3-5 years down the road– due to required advocacy and securing capital

Is a rural inpatient/residential facility feasible? By the end of this planning process, we need to determine if answer is:

No - Absolutely not feasible for county the size of Jefferson	**Maybe** - Feasible (under specific circumstances still being evaluated)	**Yes** – Financially and Operationally Feasible

Why do we think we need a Phase 1 solution?

Currently status is "maybe" – whether move towards "no" or "yes" depends of many factors:

- Can estimated ADC include SUD/MH/involuntary/voluntary
- Upcoming facility licensing changes and timing
- Needed professional licensing changes/exceptions
- Ability to share staff between programs (particularly SUD/MH)
- Other potential "rural" solutions
- Medicaid reimbursement: transitioning from BHOs, contract negotiations, new legislation requiring transparency
- Capital needs
- Governance structure/options
- Other regional approaches/solutions developed
- Options for other "non-clinical" beds/spaces in facility (e.g. respite beds)
- Best practices

Discussion: Facility Model & Need for Phase 1 Solution

Any concerns/comments:

- About the phased approach?
- That the RTF is not the right inpatient/residential model for our County?
- Have we missed anything in our analysis to date?

Potential Phase 1 Solutions—focusing on the 4 A's: Availability, Accessibility, Affordability, and Acceptability

New or expanded services

- Day Program
- Patient Navigators, Community Health Workers, Care Coordination
- LEAD Program
- Community Paramedicine
- Group Housing
- Transportation
- Employment
- Hotline
- Continued integration of physical and behavioral health
- Peer support programs to provide basic treatment or support to individuals with mental illnesses.
- Programs serving special populations targeted interventions to a particular population, such as children or the elderly.
- Tele-mental health
- **And don't forget workforce development!!**

Break Out Session

Phase 1 Programs:

- Concerns/support for the draft list- - what did we miss??
- Focus on identifying multiple options – don't get "stuck" on one
- Operational changes?
- Workforce needs?
- County providers current assets, gaps, priorities?
- Unanswered questions/concerns?

Report Back and Discussion

Review and Discussion Member Readiness Survey

Early Thinking… Governance Options

Option	Pros	Cons
Interlocal Agreement	Easy to put into place.	Only the public entities can participate. And all actions require approval of each entity's board
501(c)(3)	• Allows all community providers to be "at the table" • Generally exempt from tax, able to receive gifts/pursue grants	
LLC	• Allows for partnership/ ownership by for-profit • Easy to establish, and to protect members from liability.	Raising money and grants are challenging
100% owned by existing provider	Easiest to accomplish	Harder to assure all parties have a "place at the table" and ability to influence policy, admission criteria, etc. All burden on 1 party

Facility Model & Need for Phase 1 Solution

Discussion: Do we have consensus, or what else do we need to consider?

Next Steps

- Phase 1 and 2 options:
  - Follow-up data/answers
  - Participation in rulemaking process
  - Interviews/connections with existing providers
  - Continued discussions with state policy makers/agencies
  - Meeting with payors – begin discussions on contracts/reimbursement (United, Molina, Amerigroup)
- Grant Deliverables:
  - Needs Assessment
  - Strategic Plan
- HRSA Grant Pursuit – support development of options