Washington State Joint Legislative and Executive Committee on Behavioral Health

Meeting Notes

Monday, Sept. 23, 2024

Attendees		
☐ Rep. Tana Senn	☐ Anna Nepomuceno	☐ Jane Beyer
☐ Amber Leaders	☐ Laura Van Tosh	☐ Kailey Fiedler-Gohlke
☐ Sen. Keith Wagoner	☐ Dr. Brian Waiblinger, MD	☐ Teresa Claycamp (delegate for Teesha Kirshbaum)
☐ Rep. Carolyn Eslick	☐ Sen. Clair Wilson	☐ Rep. Alicia Rule

Absent: Sen. Annette Cleveland, Allison Krutsinger (DCYF), Lacy Fehrenbach (DOH), Vicki Lowe (Washington State American Indian Health Commission)

Meeting Goals:

1. Gain a new understanding of certain behavioral health services and where they lie on the Continuum of Care
2. Start to develop high-level priorities for the 2025 legislative session.

	AGENDA ITEM	Comments, Decisions and Summary of Discussion
1.	Charter and Continuum of Care	**Charter:** • Blend/crosswalk Charter with Continuum of Care (Guiding Principles # 1 -5 are pillars of the Continuum) • Will be important to consider definition of BH used by the CYBHWG/P25 and assess alignment, recognizing that there will be some differences. **Continuum of Care:** • Suggested changes: ○ Add a descriptor for recovery and resilience, aftercare supports to text on the right side – it's missing. ○ Close loop of recovery and resiliency support with promotion of wellbeing (which is ongoing) - connect long term and inpatient/residential care back into outpatient care and integrated care, which is where most people released from involuntary treatment/state hospitals are discharged to. ○ We need some after the end of Long Term and Inpatient Care so it doesn't look like it just drops off there. Maybe dotted lines back into other BH supports. ○ Suggestive of pathways – double sided arrows, dotted lines ○ Community care hubs - where they fit into the continuum of care (ACH, Medicaid transformation)? Connect to ongoing support for patients (perhaps integrate into recovery aftercare supports) ○ Confusion over lines at the bottom between the overarching principles and the CoC – it looks like the line only refers to "needed by all".

	○ Another line to consider refining the needed by all, some and few ○ Remove ongoing/short-term/long term ○ Promotion, prevention and early interventions – add reducing stigma needs to be added to reduce barrier of receiving care. (*Add to text on the right*?)
2. Bed Inventory and Contributing Factors	**Questions and Comments** **Discussion Question: What is most interesting to you as we develop a bed inventory?** – Are we collecting ER services/community hospital beds by region ○ Yes, for the state-funded beds. – Are there people accessing beds as a referral system for BH ○ State funded beds then yes - Reasons why beds stay full is more interesting question than just the numbers. - Committee to consider who is funding the beds - DSHS has bed tracking for state hospitals and state-run community beds. - We (capital budget committee) don't have the data we need to know what to prioritize for beds. We need to know what is not working in order to make decisions. - Need for public database for BH beds. We have to have real time bed tracking, it is frustrating. What are the roadblocks to the registry? - We (HCA) do not have information on real time availability of community beds, or good information on why admissions may not be occurring. We have lots of general beds, but they're not necessarily full. We need to know what are the underlying causes for admissions not occurring – workforce issues? Needs are too complex and don't match the types of beds available? Infrastructure safety issues can result in decreased staffing. - We need to highlight the difference between staffed beds and licensed bed capacity – beds can be open or closed due to staffing and other reasons. ○ This JLEC could recommend something. - If we do early intervention/prevention what do the long-term impacts look like for bed needs? - Having too many beds; over production of beds can set up the providers for financial failure. - Is the plan to accomplish the bed inventory before session in Jan? ○ Yes ○ With prioritization of the committee - What does a public facing bed database look like? - Easily accessible for the providers and public, respect patient confidentiality ○ How do patients check in (by themselves, or referral?) ○ Voluntary care - has to be in crisis, typically admitted through the emergency room, to qualify for insurance coverage. Determined by insurance companies. ▪ Dictated by insurance companies. "Voluntary" means a short-term stay of 3-5 days. • Intensive staffing ○ Community Needs ▪ What facilities and resources are we lacking in the community to get the patient discharged from the hospitals? What is the gap? ▪ Biggest barrier is that we can't discharge until we have an appropriate place to send them.

	▪ Minnesota has a broader array of housing and community beds than WA. California too. ▪ What are we missing? • Staff around the clock o Buying commercial property and having staff to support the patient transition process o Weighing the cost of inpt beds vs. outpatient beds o Education of families on access to care o Does facility take disability and other medical conditions o We need to pay attention to the issue of "medical necessity" versus insurance coverage. It sounds like insurance coverage is taking the place of medical need. ▪ 2025 Bill - Medical necessity (based on medical need not on insurance) o What communities are having a challenge accessing the BH system and why? ▪ Can demographics be captured? • Race, ethnicity, language and disability and sexual orientation/gender identity and income level ▪ We can get service delivery data/utilization for some services that includes demographics. o Needs – different for public and policy makers **The bed inventory can serve two needs:** ▪ 1. Information on the landscape ▪ 2. Setting Policy: How to use it to identify needs and gaps? How is bed inventory moving BH in WA in direction that committee has chosen it to go?
Themes from JLEC Priorities and Recommendations from other Committees	**Overarching Themes Discussion/Exercise** - Suggestions o Add Access Issues with commercial health insurance plans (Rep. Rule) o Parity between what's covered and reimbursement rates of community-based providers (Kailey F-G) o Issues of NIMBY – communities not allowing BH clinics. This needs to be addressed. (Anna N.) o Workforce: Issues of insufficient qualified supervisors (Rep. Rule) Education and training programs to support pathways and positions to increase the BH workforce. (Rep. Senn) o Overlap between the themes of Workforce and Structural issues. Behavioral Health Workforce and case load. Could we combine these themes? (Teresa C.) **Themes ranking by Committee members.** The top 4 will be used to guide upcoming "sprint" teams/workgroups. **1. Community Based Behavioral Health Care (14)** **2. Prevention and Early Intervention (9)** **3. Eliminate Disparities and Inequities (7)** **4. Structural and Administrative Issues (7)** *5. Strengthen Workforce (6) – this could be combined with Structural and Administrative Issues* 6. Address BH cost coverage (6)

	7. Substance use (5) 8. Reform Criminal Justice practices (3) 9. Enhance Community Crisis response (0) 10. Reduce community Crisis response (0)

Action Items		
#	**Action Item**	**Assigned To:**
1.	Revise Continuum of Care	Athena Group
2.	Follow up email to Committee re: Sprint Teams (subcommittees)	Athena Group