**LEGISLATIVE TASK FORCE – SPOKANE MULTI-COUNTY RSN**
**FOR SINGLE BED CERTIFICATION**

1. **What is the magnitude of the psychiatric boarding problem in Spokane RSN?**
   a) Spokane is a multi-county RSN which includes: Adams, Ferry, Grant, Lincoln, Okanogan, Pend Oreille, Spokane, and Stevens counties.
   b) SCRSN uses a "Notification" process instead of the SBC. Patients on "Notification" are considered boarding.
   c) 4 Spokane County facilities that admit involuntary psychiatric patients referred from eastside counties:
      i. PSHMC (2 units with a total of 46 beds. 32 beds for voluntary admissions and 14 beds for involuntary/acute care admissions; 7 beds in their psychiatric triage area in the Emergency Department)),
      ii. 2 Evaluation and Treatment facilities (total of 32 beds); and
      iii. Eastern State Hospital.
   d) Boarding data for 2014
      i. Average of 64 individuals boarded each month;
      ii. 0-15 individuals were boarded on any given day;
      iii. Average length of stay for boarding is 48 hours
      iv. Boarding is higher on weekends and holidays because of lack of discharges that occur during those times.
      v. 75% of boarding occurs at PSHMC where boarding remains at or below 48 hours on average
      vi. Patients are boarded in EDs or medical beds at PSHMC, VA Medical Center, Providence Holy Family Hospital, Deaconess, and Valley hospitals.
   e) Boarding outliers: patients with "special needs " (10-20%) are boarded for 4 days on average and as long as 20 days. "Special needs" patients:
      i. Require a higher level of care (1:1) due to their health status; PSHMC has only 5 beds for "special needs" patients
      ii. Developmentally disabled patients: HMH unit has 12 beds shared among eastside providers
      iii. Level of violence that facility is unable to manage

2. **What settings and conditions, or range of conditions, do patients in Spokane RSN experience when they are boarding, or receive single bed certifications? Are they either in the Ed or on the med floor?**
   a) Majority are boarded in the Emergency Department.
   b) Approximately 10/month (approximately 15%) are either already on a medical floor or moved to a medical floor (social admission) for boarding.
   c) Approximately 90% of boarded patients are in seclusion and/or restraints
   d) DMHPs recommend psychiatric consultation for all boarded individuals.
      i. Psychiatric consultation may be one time only or none at all depending on where the individual is located. Two of the hospitals do not have full time psychiatrist to provide consultation.

3. **What is the RSN and its providers doing differently in response to the court opinion? Have there already been impacts?**
   a) "Special Needs": DMHPs are working with emergency departments to determine if there is an acute psychiatric need versus an individual who needs a placement.


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b) Notification process: Will be replaced with the SBC procedure.
c) Every available bed at ESH will be used to eliminate boarding,
d) Admitting patients across the state

**4. What, in your view, still needs to be done to provide for the long and short term impacts of the court decision? What are the biggest risks going forward?**

a) Extensive work would be needed to determine how we will proceed if criteria for SBC cannot be met at a hospital that is unable to provide psychiatric services.
b) We would like clarification of the time frame allowed for patients to wait/board once provisional acceptance has been provided.
   I. ESH is unable to provide a provision acceptance until the next business day for any admissions after 6 p.m. so the patient will be waiting/boarding until the transport occurs. (RCW 71.05.170 Acceptance of petition: Duty of state hospital. The facility providing seventy-two hour evaluation and treatment must **immediately accept on a provisional basis the petition and the person**.)
   i. Admissions across the state: Process to obtain a bed will decrease availability of DMHPs because of the amount of time taken to secure a bed. Patients will wait/board until the next business day when the transport can occur. Some facilities require in-person testimony from DMHPs and witnesses or they will not accept the admission – this will limit our options.
   ii. Admissions may also be waiting/boarding to accommodate the patient because of age, level of care needed, etc.
c) Boarding Outliers
   i. Additional HMH beds or the ability to admit patients to units other than HMH
   ii. Additional and enhanced drug and alcohol diversion resources and/or implementation of an emergency provision for involuntary CD inpatient treatment are needed to offset admissions
d) Timely ESH discharges when enrolled clients present as discharge ready.
e) Additional psychiatric support at for skilled nursing facilities to successfully manage individuals with dementia who present at risk.

**5. Anything else you would like task force members to know about the issue.**

a) End the RSN penalties for being over census at the state hospital.
b) Standardization of practice does not work well for all RSNs who due to their location may not have similar resources to draw upon.
c) ESH hospital has consistently been understaffed with psychiatrist which limits their ability to utilize all their beds.
d) Inclusion of IMDs will not create more beds in Spokane County because we currently do not have an IMD facility that is equipped to take patients with a high level of acuity. We are not aware of any funding available to cover the capital and staffing costs that position an IMD to serve this acute population.
e) Housing resources, client/family choice regarding discharge placements continue to delay discharges from ESH which then decreases capacity for admissions.
f) Because there are some limitations to the level of acuity that can be managed at the E&Ts, this resource may not be viable for all involuntary patients.