Emergency Rooms at the Epicenter

ADDRESSING THE CRISES OF HOMELESSNESS, MENTAL HEALTH, AND SUBSTANCE USE DISORDER

Recommendations for an Emergency Response

JANUARY 2024

Letter from Challenge Seattle's CEO

"The loss of lives every day due to fentanyl overdoses and mental health breakdowns is the definition of crisis"

When you go to an ER today for yourself or someone else, what are your expectations? I'm sure they are similar to what mine were: a safe and secure place where we would find immediate care in a crisis. My experience this Fall at a local ER totally surprised me. I found an ER crammed full of people suffering from overdoses and mental health crises. As there were concerns by the staff for the safety of patients and visitors, I questioned how we keep these high-quality doctors, nurses, and staff from burning out.

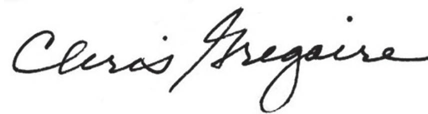
For years, Challenge Seattle has been focusing on chronic homelessness and our housing crisis. In multiple reports, we made a series of recommendations that have been supported by state and local jurisdictions. But my own personal experience revealed another painful impact of the unhoused relying more and more on emergency rooms across our state and not receiving the right care at these facilities. The members of Challenge Seattle agreed this is a statewide crisis needing an emergency response.

We partnered with the Washington State Hospital Association and began our study of best practices across our state and country because we are not alone—it is a national problem. Obviously, housing has become unaffordable for far too many leading too many to homelessness. Mental health challenges are growing in all populations but particularly with those who are unhoused. And while opioids have been an epidemic for the last decade, fentanyl has hit the unhoused with the deadliest impacts of nearly all populations. The consequence of all of this is seen every day in emergency rooms across our state putting "Emergency Rooms at the Epicenter: Addressing the Crisis of Homelessness, Mental Health, and Substance Use Disorder." Make no mistake, the doctors, nurses, and staff in our ERs are doing heroic work.

While there are obviously some visits to the ER by unhoused individuals that are necessary, far too many are not. The ER is generally not the best place to treat and stabilize an individual who is homeless and suffering from a substance use disorder and/or a mental health crisis. While I know we are experiencing crisis fatigue, the loss of lives every day due to fentanyl overdoses and mental health breakdowns is the definition of crisis. There is reason to be hopeful with plans for the future like opening new crisis facilities and housing, but most of these proposals and facilities will take years to build and open.

Our recommendations are intended to focus on an emergency response to the crisis. To execute on these recommendations will require help from the Governor and Legislature in the 2024 session, local governments, hospitals, non-profits, philanthropy, and the private sector.

We met the challenge of the Great Recession and led the nation in recovery. We met the crisis of the COVID-19 pandemic and led the nation with public-private partnerships. We can meet this emergency room, homelessness, mental health, and fentanyl crisis head on and lead again. Please join us.



Chris Gregoire
Challenge Seattle CEO
Former Governor of Washington

Letter from the Washington State Hospital Association

"Much like we did in COVID-19, we need an emergency response now"

Washingtonians hope not to need an emergency room, but when they do, they expect it to be quickly available to care for them or their loved ones. They also expect that other patients who are in the emergency room will also be seeking care for emergency health needs.

However, this is not always the experience. Many emergency rooms in Washington are often at or over capacity. A major factor contributing to emergency room capacity challenges is that emergency rooms have become a primary destination for people whose situations are not medical emergencies but instead have conditions related to substance abuse or mental illness complicated by homelessness—and there is nowhere else for them to go for help. A disproportionate number of homeless individuals experience substance use or mental illness. As homelessness has grown exponentially in our state, and community resources have not kept up or have even decreased in availability, the emergency room has become the default. What was once manageable in our emergency rooms has become a crisis. Much like we did in COVID-19, we need an emergency response now.

Law enforcement and EMS often bring people who are emotionally or mentally impaired to the emergency room because they don't have another place to take them. People who have overdosed and received reversal medications are brought to the emergency room for additional medical care even though they would be better cared for at a quieter, lower acuity setting. People with multiple ED visits are often struggling with unstable housing where minor medical conditions are exacerbated by lack of food, warmth, or appropriate clothing. Everyone needs and deserves safe places to go for help. The emergency room cannot be the only option.

When individuals go to the emergency department federal and state laws require they be screened by health care professionals to determine if they have an emergency medical condition even if it is clear that they do not. Additionally, patients need a safe discharge plan from the emergency room and if there are not appropriate places to send them, it can result in long hours and even days in the emergency department or other areas of the hospital while solutions are sought.

This situation puts real strain on our emergency rooms and is far from good care for anyone. Patient waiting times can be long and patients can become angry and frustrated. A crowded environment is the antithesis of what helps people in crisis. Emergency room staff can feel moral distress by not being able to provide emergency care to the many waiting patients. Managing the complex needs of non-emergency patients can lead to burnout.

The Washington State Hospital Association greatly appreciates the dedication of Challenge Seattle to addressing this problem. Throughout our study of this issue, we found other cities and states who are better serving these populations and more reasonably allocating resources, preserving their emergency rooms for emergency needs. We found examples of programs and approaches in our community that can work if they are properly resourced.

We need other options in our state, including street medicine, 24/7 stabilization sites, more ready access to treatment, and different types of other behavioral health facilities. When Washington gets these services up-and-running, it is essential that ongoing, reasonable funding is provided for both operations and facilities so they can be sustained.

Please join us in creating solutions to this problem. Together, we can serve people who are experiencing behavioral health crisis and housing instability with more dignity and effectiveness—and ensure our emergency rooms have the capacity for true emergency care.

Cassie Sauer
Washington State Hospital Association, President and CEO

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Washington State Hospital Association,Senior Vice President, Safety and Quality

Washington State Hospital Association

Table of Contents & Acknowledgements

Letter from Challenge Seattle CEO 2
Letter from the Washington State Hospital Association 3
Acknowledgments 4
Key Terms 5
Executive Summary 6
Our Emergency Rooms at the Epicenter 8
Recommendations for an Emergency Response 13
Long-Term Housing and Treatment is Foundational 29
Conclusion 30
End Notes 31

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As we embarked upon this project, we partnered with the Washington State Hospital Association (WSHA), which represents all the hospitals and health systems in Washington. WSHA's entire team has been integral to our project with their deep policy and operational expertise. WSHA also distributed a survey to the state's largest hospitals to create the first ever analysis on the intersection of unhoused individuals at ERs.

Recognizing the complexity of the issue, we relied on the experience of more than 100 people whom we joined for interviews, roundtables, and ride-alongs. Across the state, we spoke to many of the people on the frontlines of this crisis: doctors, nurses, first responders, peers, and service providers as well as policymakers, Tribal leaders, and leading experts. As many other cities and states are grappling with this crisis, we spoke to several national organizations and program leaders who provided the case studies that we feature in the report.

In addition, we are grateful for the deep expertise of our advisory group and their designees, who provided input and guidance throughout this project. This group is comprised of exemplary leaders in our state, and we owe a great deal of gratitude for their time.

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Key Terms

Across the report, we utilize the following terms and definitions which are recommended by federal and state health partners:

Behavioral Health. While there is no single definition of behavioral health, our report defines it as emotional, psychological, and social factors of the overall health and well-being of a person, which includes mental health and substance use. Our report also acknowledges that many times in practice behavioral health does not include substance use disorder.

Emergency Medical Services (EMS). EMS providers include emergency medical technicians (EMTs) and paramedics, who are highly trained in advanced life support. As defined by state law, EMS means medical treatment and care which may be rendered at the scene of any medical emergency or while transporting any patient in an ambulance to an appropriate medical facility, including ambulance transportation between medical facilities.

Emergency Room (ER) and Emergency Department (ED). An emergency department or emergency room means the area of a hospital open 24 hours a day and 7 days a week where unscheduled medical or surgical care is provided to patients who need care.

Mental Health Conditions. Mental health conditions are disorders that affect your mood, thinking, and behavior. Some examples of mental health conditions are depression, anxiety, bipolar disorder, schizophrenia, posttraumatic stress disorder, and psychosis. Mental health conditions can have various causes, such as genetics, environment, trauma, or substance use.

Mobile Behavioral Health Teams. Across the report, mobile behavioral health teams refer to all types of mobile teams in a community who are responding to mental health crises or substance use disorder. In many cases, these are mental health professionals who are co-responders with law enforcement, fire, and/or EMS but some mobile behavioral health teams may be deployed through referrals or 988. This includes but is not limited to the state's mobile rapid response crisis team, which is defined by law as professionals who provided community-based intervention and meets standards for response times.

Medications for Opioid Use Disorder (MOUD). Medications for opioid use disorder (MOUD) is an approach to opioid use treatment that combines the use of FDA-approved drugs with counseling and behavioral therapies for people diagnosed with opioid use disorder (OUD). MOUD can include different types of medications, such as methadone, buprenorphine, or naltrexone, depending on the patient's needs and preferences.

Mental Health Professionals (MHP). A mental health professional is a certified or licensed individual whose scope of practice is a psychiatrist, psychologist, psychiatric advanced registered nurse practitioner (ARNP), psychiatric nurse, mental health counselor, social worker, or other professionals as defined by law in Washington.

Opioid treatment program (OTP). Opioid treatment programs are facilities that provide medications and treatment for people with opioid use disorder. These facilities must be certified and comply with federal and state regulations.

Patient. A patient is any recipient of health care services, including behavioral health services, that are performed by health care professionals. Also commonly referred to as a "client" in behavioral health settings.

Peer Services. While different organizations have different definitions, peer services are when an individual has a "shared lived experience" with the community they are serving. These trained individuals are often referred to as "peer support specialists" and serve an important and trusted role in health promotion. Leveraging peer services in behavioral health settings is an effective strategy to increase both access and capacity for treatment services.

Substance Use Disorder (SUD). Substance use disorder is a treatable disorder that affects a person's brain and behavior, leading to their inability to control their use of substances like legal or illegal drugs, alcohol, or medications. Symptoms can be moderate to severe, with addiction being the most severe form of SUD.

Executive Summary

A crisis impacting all communities across the state

Emergency rooms serve our community 24/7 on some of the worst days possible for patients who are facing heart attacks, strokes, trauma, or injuries from car accidents. But now they have transformed into the epicenter of care for the overlapping crises of homelessness, substance use disorder especially fentanyl, and mental health conditions.

This crisis is impacting our communities at all levels, and in every corner of our state—whether you are in Seattle, Vancouver, Spokane, or other cities in our state. The data shows this is no small crisis:

- While unhoused residents are 1 out of every 275 residents, it is estimated that 1 in 10 ER visits are for individuals who are unhoused.
- Unhoused individuals are estimated to account for 270,000-320,000 ER visits per year since 2021.
- The estimated cost of care in ERs for unhoused patients is $930 million-$1.15 billion per year across the state.
- At the state's largest hospitals, a majority of unhoused residents who are seeking care at an ER have a substance use disorder and/or a mental health condition.

While EDs are acting as a social safety net for unhoused residents, they are not the appropriate place to address housing or shelter needs nor the best places to serve unhoused patients with mental health and/or substance use disorder issues. Our emergency rooms across the state are already crowded, provide the most expensive health care, and are facing workforce shortages due to safety issues and burnout and, like all of health care, are facing workforce shortages.

To address this complex issue, we believe that we need the right people to respond to these crises, the right place for short-term stabilization, and long-term treatment and housing solutions. Housing and community-based treatment are foundational to addressing these issues long-term. And while there have been billions of dollars provided in long-term investments to address these underfunded areas, the siting, new construction, financing, staffing, and permitting takes years—not weeks or months. We are in crisis today with lives at stake crying out for action now.

With the understanding that most of these long-term housing and treatment facilities are expected to open later this decade, Challenge Seattle examined programs and policies that could most quickly be deployed. We reviewed local efforts and programs across the country, received input from the expertise of statewide leaders on our advisory group, participated in ride-alongs and site visits, and in total, interviewed more than 100 doctors, nurses, first responders, national experts, and local officials. As a result, we are recommending ten actions to triage the crisis of unhoused individuals perpetually cycling through our emergency response system and ERs. While some recommendations require bold action to break down barriers, all could and should be implemented within months.

Executive Summary

Two high-priority recommendations are:

- **Creating street medicine teams:** Medical care and mobile treatment to meet people on the street, under bridges, or in encampments to avoid emergency rooms and prevent crises.
- **Establishing 24/7 low-barrier stabilization sites:** Additional facilities to allow individuals up to 72 hours to stabilize from a crisis, with a focus on treatment for substance and opioid use disorders along with mental health conditions.

Eight key foundational actions include:

- **Accelerating behavioral health facilities through retrofitting and rapid acquisition:** To accelerate currently funded projects and create new facilities, rapidly stand up underutilized or vacant facilities to address behavioral health with particular focus on the fentanyl crisis.
- **Utilizing mobile behavioral health teams to respond to overdoses:** As local and state government have created more civilian mobile response teams, ensure they are equipped to respond to substance use disorder.
- **Authorizing EMTs and paramedics to administer opioid treatment:** First responders can treat early withdrawal symptoms and increase the likelihood of long-term recovery with the initial dose of buprenorphine.
- **Removing barriers to opioid treatment like Sublocade:** The injectable medication for the extended release of buprenorphine faces regulatory, financial, and insurance barriers that must be addressed.
- **Increasing coordinated care teams:** Intensive patient navigator teams to address "super utilizers" of ERs focused on unsheltered high-need, high-cost patients accounting for a disproportionately high amount of health care utilization.
- **Implementing real-time data sharing across emergency response:** Removing barriers to share patient care plans safely and securely across hospitals and providers.
- **Expanding peer navigator workforce with entry level training and apprenticeship opportunities:** A trained peer provider who uses his or her lived experience of recovery is key to our workforce shortage and patient success.
- **Creating sustainable funding:** Success of these recommendations requires addressing payment and reimbursement rates for essential services related to behavioral health and crisis care such as first responders, transportation to facilities, and/or payment rates for crisis facilities and staff.

As these recommendations are implemented, we recognize that longer-term solutions like emergency housing, medical respite or recuperative care, detox, residential treatment, state psychiatric facilities, long-term care facilities and supportive housing must continue being built.

As seen in every part of the state, we are not sufficiently serving unhoused individuals who are frequently revolving through our ERs and dying at unprecedented levels, so we have two choices: continue the status quo as we wait for facilities to open or implement an emergency response now to address the crisis.

Our Emergency Rooms at the Epicenter

Across the nation, our cities and states are on the frontline of three crises: homelessness, mental health, and substance use disorder. Each of these crises has been steadily building for years. The safety net and the epicenter where all too often these three crises intersect is our emergency rooms.

"New numbers show increase in Washington homelessness"

12/19/23

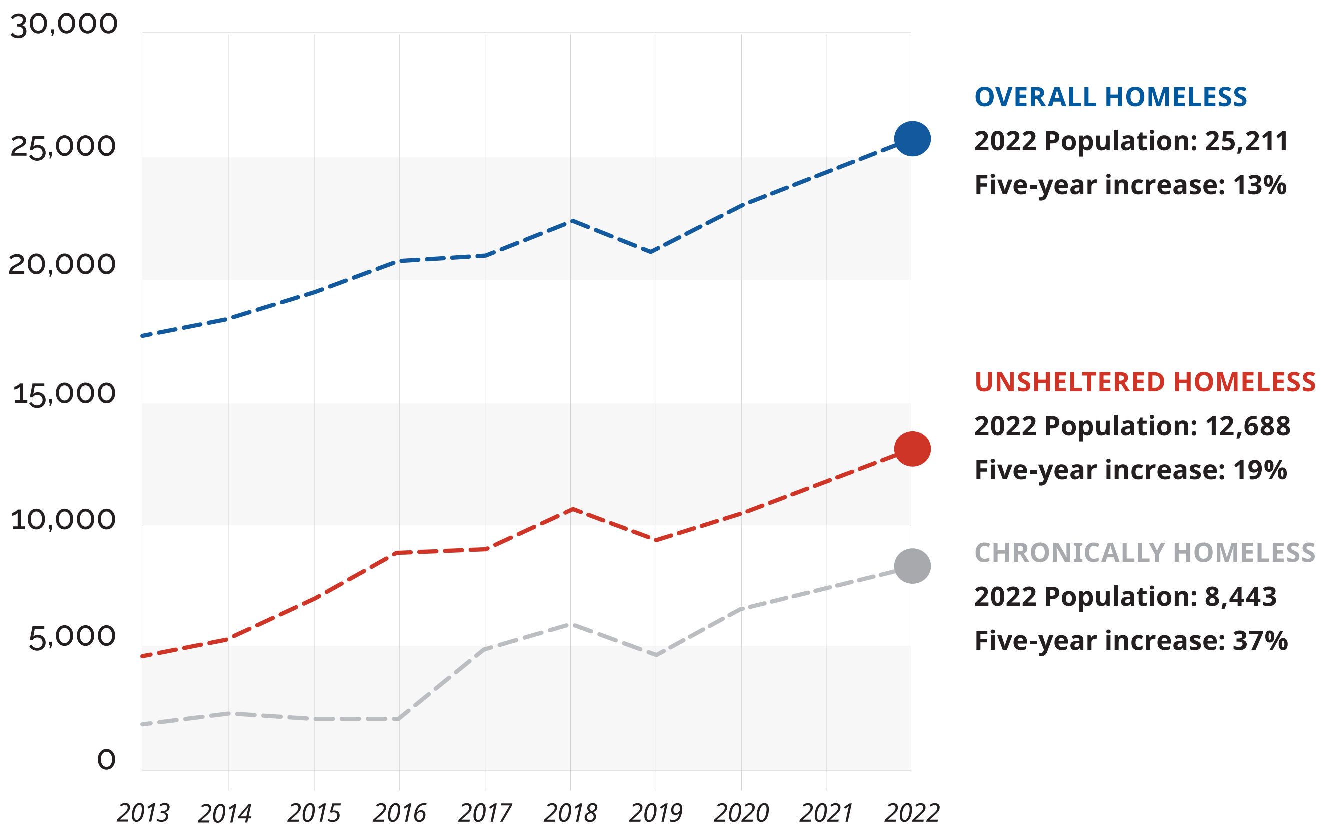
In most of these crises, the ER is not the best place for an unhoused person who needs a prescription filled, someone who is experiencing a mental health crisis, or some individuals who have been revived from an overdose who do not need further medical care. While there are cases in need of ER care, too many avoidable visits to the ER are resulting in: the overcrowding of emergency rooms, delayed care, and increased violence to patients and staff. In many of these cases, unhoused patients seeking care are not getting the best care for them.

The Significant Increase of Chronic Homelessness, Mental Health Crises, and Substance Use Disorder—Especially Fentanyl

The data is clear on the rapid rise in chronic homelessness, mental health crises, and substance use disorder, particularly fentanyl overdoses, in the past few years across the state.

Homelessness

For many years, emergency rooms have emerged as primary health care for individuals experiencing homelessness. With the rise of chronic homelessness across the entire country, ER utilization by homeless patients is three times the US norm and has increased 80% over the last 10 years.[1] People experiencing chronic homelessness often have complex and long-term health conditions, such as substance use disorders and mental health diagnoses. Washington is no exception. Even as Washington has significantly decreased homelessness among veterans and families with children, chronic homelessness has risen by more than 37% over the last 5 years.[2]



Our Emergency Rooms at the Epicenter

Mental Health

Mental health has long been an issue in our state and our country. The COVID-19 pandemic has heightened mental health conditions such as anxiety, depression, sleep disorders, and PTSD. As of 2021, there were over 1.2 million Washingtonians with a mental health condition, nearly a quarter of whom had a serious mental health condition.[3]

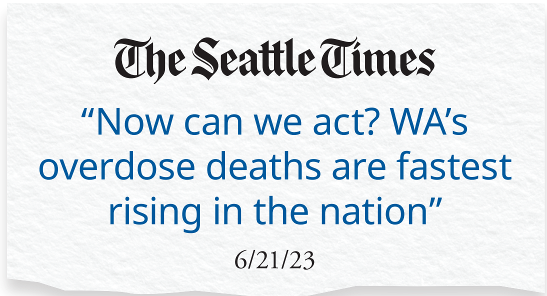
In 2022, Washington launched the 988 Suicide & Crisis Lifeline that connects anyone experiencing a mental health or substance use crisis, or those seeking help for a loved one, with a trained counselor. From July 2022 to June 2023, these crisis centers answered nearly 90,000 calls, texts, or chats, according to the Department of Health. This represents a 75% increase in calls answered since 988 launched, which underlines the need for this service and the importance of the work.[4]

According to the Washington State Hospital Association, approximately one out of three individuals visiting an ER has a primary or secondary mental health condition. In many parts of our state, access to mental health care is limited or inadequate, leaving ERs as one of the only—if not the only—places to turn.

Substance Use Disorder

In Washington, Substance Use Disorder, particularly fentanyl, has reached crisis levels. While opioids have been an epidemic for a decade, the addition of fentanyl—which barely existed in Washington state a few years ago—has overwhelmed our communities.

While many other states were on the forefront of the fentanyl and opioid crisis, the crisis is now here: no state in the U.S. saw a more significant increase in drug overdose deaths year over year than Washington with an increase of 38.5% from July 2022 to July 2023.[5]

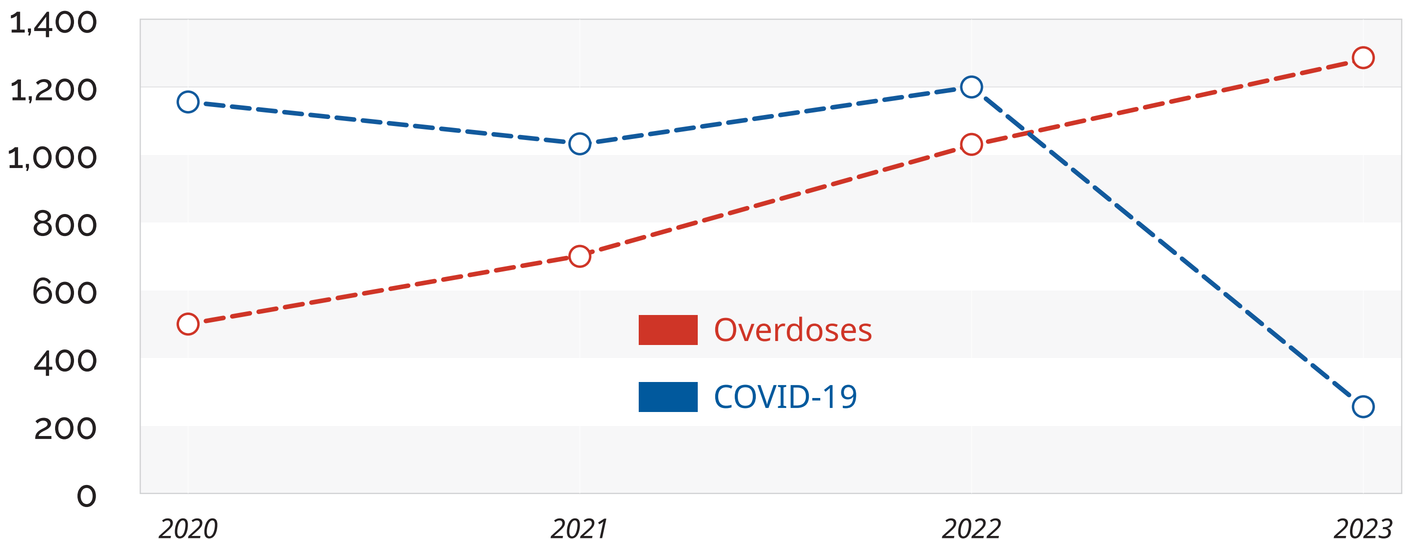

The Seattle Times

"Now can we act? WA's overdose deaths are fastest rising in the nation"

6/21/23

In 2022, the top ten counties in Washington for the rate of opioid deaths per capita did not include King County, but were highest in Mason, Grays Harbor, Clallam, Thurston, Lewis, Chelan, Northeast Tri Counties (Ferry, Pend Oreille, and Stevens), Spokane, Grant, and Pierce. It is a statewide epidemic.[6]

King County has felt the dramatic impacts of the fentanyl crisis. Preliminary data from 2023 shows there have been 8,390 EMS calls in King County for non-fatal overdoses and more than 1,284 fatal overdoses in 2023, surpassing the height of COVID-19 related deaths. In King County, 46% of fatal overdoses were individuals experiencing homelessness or in permanent supportive housing. The current deaths and the trajectory call for an emergency response—overdose deaths have increased 152% since 2020. 2023's record high overdose deaths have surpassed the height of COVID-19.[7]



Our Emergency Rooms at the Epicenter

“Lummi Nation declares state of emergency after uptick in fentanyl overdoses”

9/23/23

Already disproportionately impacted by homelessness, our Tribal communities have been significantly harmed by the fentanyl crisis.

The Centers for Disease Control and Prevention reported that American Indians and Alaska Natives had the highest drug overdose rates in both 2020 and 2021 of any racial or ethnic group in the country.[8] In King County, Indigenous residents died of synthetic overdoses at more than nine times the rate of White residents in 2022.[9] In September 2023, after five tribal members died in a week, the Lummi Nation declared an emergency in order to prioritize its resources to address this crisis.

Each of these issues are impacting emergency rooms; however, the combined impact of all these factors is pushing emergency rooms to the brink.

“In the history of emergency medicine, this has to be one of the most challenging times.”

—ED Physician in Tacoma

“All my partners care and want to help. We are just overwhelmed. It’s reaching a crisis peak. The drug crisis is a large factor.”

—ED Physician in Auburn

The Epicenter: Our Emergency Rooms

In Washington state, unhoused individuals make up one out of every 275 residents in the state yet are one out of every 10 ER visits. Every single day, patients, nurses, and doctors see how emergency rooms cannot continue with the status quo:

- **Care:** ERs are not the best place to serve patients with mental health and/or substance use disorder issues.
- **Cost:** Health care delivery in the emergency departments is the most expensive care.
- **Capacity:** Many ERs are at capacity and others needing care are being displaced.
- **Safety:** Safety issues are increasing for patients and staff.
- **Burnout:** Burnout of ER doctors and nurses is contributing to workforce shortages.

CARE: *ERs are not the best place to serve patients with mental health and/or substance use disorder issues*

Emergency rooms are meant to triage and medically stabilize patients in a relatively short period of time. However, for many patients with substance use disorders or mental health concerns, to truly stabilize a patient and begin treatment it oftentimes takes days.

In 2020, the Substance Abuse and Mental Health Services Administration published new best practices related to crisis care outside of emergency rooms. The report noted that ERs are not well-equipped to address the complex and chronic needs of patients with mental health and/or substance use disorder issues who often require specialized and long-term treatment and support. Unfortunately, all too often when behavioral health patients have difficulty accessing timely and appropriate care in the community, they end up in the ED as a last resort.[10]

In addition, studies have shown that the “chaotic, crowded, noisy, and confined spaces of an ED can be anxiety-provoking, distressing, and may potentially exacerbate psychiatric symptoms.”[11] Moreover, ED staff may lack the training and expertise to effectively assess and manage patients with little experience in psychiatric crisis care. As a result, patients with mental health and/or substance use disorder issues may not receive the best care for them and the experience in an ER can result in long wait times and poor outcomes.

Our Emergency Rooms at the Epicenter

"Emergency rooms were not built, intended, or designed to be crisis centers yet they are operating as such."

—ED Physician in Tacoma

COST: *Health care delivery in the ER is the most expensive care*

Not only is the ER often not the best place for care of these patients, but it is the costliest health care. While the average primary care or urgent care visit costs between $150-$200 a visit, hospital emergency visits are significantly more costly due to facility fees, specialized doctors, and on-demand diagnostics. In Washington, a single night hospital visit can cost $3,806.[12]

While hospitals and local and state governments are currently paying for these services, this has a direct impact on the cost of insurance and the care for individuals visiting hospitals.

Costs of ER Care for Unhoused Patients

$930 million to $1.1 billion

The estimated costs of caring for unhoused patients in our ERs annually

CAPACITY: *Many ERs are over capacity and others needing care are being displaced*

Seeking care at our ERs is not only the costliest, but the infrastructure of our ERs was not built to handle care outside of essential medical emergencies. Our ERs were created to serve patients with serious or life-threatening medical needs: heart attacks, strokes, trauma, or car accidents. When ER beds are not available, this results in longer wait times for care in the ED. In these circumstances, serious and life-threatening medical issues are triaged, rather than receiving timely access to care.

Capacity challenges are being exacerbated by avoidable ER visits. While some patients need medical treatment, patients with a behavioral health diagnosis have significantly longer stays at ERs and are not best served there. At the same time, unhoused patients are continuously cycling through this expensive system. In 2023, at one hospital, 1,375 unhoused individuals accounted for at least 6,450 visits.

"The ER is an ICU level space, yet we are starting to treat heart attack and stroke patients or pregnant women in the waiting room chairs because we don't have capacity in the ED."

—ED Physician in Tacoma

"We're reaching capacity, but it's not just capacity in term of beds and space. It's the capacity of health workers to help all their patients with highest level of care. You want to do the most compassionate work—and do the best for each patient."

—ED Registered Nurse

Our Emergency Rooms at the Epicenter

The New York Times

"Stabbed. Kicked. Spit On. Violence in American Hospitals is Out of Control."

10/24/23

SAFETY: *Safety issues are increasing for our patients and staff*

Safety issues are emerging from overcrowded EDs filled with patients facing lengthy wait times and others whose behavioral health crises are escalating while awaiting care. Over and over again in our interviews with our ED doctors and nurses, they discussed the all too routine physical violence and verbal assaults that they face. Every physician and nurse interviewed has experienced or witnessed threats or violent acts, including biting, scratching, spitting, kicking, and punching.

In recent surveys by the American College of Emergency Physicians and the Emergency Nurse Association, two-thirds of emergency physicians reported being assaulted in the past year alone, and 70 percent of emergency nurses reported being hit and kicked while on the job.[13] These attacks can have harmful consequences for the health and well-being of the staff, as well as the quality and safety of patient care.

"Threats have ramped up significantly in the last few years. Knives flashed. Verbal threats. Lockdowns from guns."

—ED Physician in Auburn

"Many times in a shift, we face threats of violence. In any given week, someone will be assaulted. We have broken bones and severe injuries."

—ED Nurse in Seattle

BURNOUT: *Burnout of ER doctors and nurses is contributing to workforce shortages*

The safety issues all too often lead to burnout of staff.

Washington state is facing a severe shortage of nurses and doctors, especially in the ERs, and Washington is on track to have the largest nurse shortage in the country.[14] In 2022, AMA conducted a survey of physicians across the country and found the highest percentages of burnout occurred in emergency medicine due to excessive stress, long hours, and emotional exhaustion.[15] Safety issues and violence against personnel have emerged as significant factors leading nurses, doctors, and staff to leave ERs for other careers or other positions in different settings.

"Our EDs are facing chronic stressors leading to burnout among ED doctors, nurses, techs, and staff—we know there could be a better solution for these patients."

—ED Physician in Seattle

Conclusion

Across the state, residents have seen family members or their communities struggle with the pressing challenges of homelessness, mental health and substance use disorder, especially fentanyl. However, many Washingtonians have not recently visited an emergency room, so they may be unaware of the immense impacts on care, overcrowding, costs, safety, and burnout of staff.

Our emergency rooms are fundamental to our community. Each year there are approximately 2.6 million visits to Washington's emergency rooms—that's millions of residents who rely on this life-saving care.

At every level of government—from local to state to federal and across business, philanthropy, and non-profits—we need more urgency by all of us to address this crisis at hand. The consequences of inaction to address the crisis in the emergency rooms do not just impact doctors and nurses—it impacts every individual and family who is seeking care.

High-priority solutions and foundational actions to more effectively meet community needs

Almost every resident has seen someone in crisis suffering on the side of a highway, in a doorway, or in the middle of a busy intersection. There are deeply complex reasons that led that individual to this crisis moment, but all too often, there is no one to call other than 911, and there is seemingly never the right place for that person to go. When an unhoused individual has an overdose or is in mental health crisis, law enforcement primarily has only two options for that person: jail or an ER.

It is very rare where law enforcement can utilize current behavioral health facilities as there are significant barriers and/or extremely limited beds. In recent years, some new facilities have come online across the state such as the King County Crisis Solutions Center, Snohomish County Diversion Center, Whatcom County Triage Center, or the Crisis Wellness Center in Vancouver. While these facilities have provided additional resources, many are at capacity and cannot meet the current need in the community, especially of the unhoused population suffering from mental health crises and/or substance use disorder.

To further scale these types of facilities and address decades of underfunding in behavioral health, state, local, and Tribal governments have focused on massive new investments and initiatives. These include housing for individuals experiencing homelessness, behavioral health facilities, state psychiatric facilities, long-term care facilities, and treatment options for opioids and substance use. Long-term treatment and housing is critical and needed. Many of these programs and capital investments need to continue to be scaled, but most will not come online until 2026 or beyond.

As we identified the facilities coming online in the years to come, we focused on what we can do while we wait. The ER crisis impacting our state calls for us to act now with solutions implementable in weeks and months as we cannot wait for years. Lives are at stake. Thus, we have focused on policies and actions that can be stood up quickly to answer the crisis with an emergency response.

We reviewed local efforts and programs across the country, examined recommendations proposed as part of the 2023 Washington State Tribal Opioid/Fentanyl Summit,[16] received input from the expertise of statewide leaders on our advisory group, participated in ride-alongs and site visits, and in total, interviewed more than 100 doctors, nurses, first responders, national experts, and local officials. As a result, we are providing 10 recommendations to create an emergency response to the crises of homelessness, mental health and substance use disorder. Our recommendations are focused on a few key principles including rapid deployment in weeks or months, scalability across the state building on current programs, and feasibility of costs and staffing.

Recommendations for an Emergency Response

On the following pages, we recommend two high-priority solutions and several key foundational actions to improve our response and more effectively meet the needs of unhoused residents and the community.

Two high-impact priority recommendations:

- **Creating street medicine teams**
- **Establishing 24/7 low-barrier stabilization sites**

Eight key foundational actions include:

- **Accelerating behavioral health facilities through retrofitting and rapid acquisition**
- **Utilizing mobile behavioral health teams to respond to overdoses**
- **Authorizing EMTs and paramedics to administer opioid treatment**
- **Removing barriers to opioid treatment like Sublocade**
- **Increasing coordinated care teams**
- **Implementing real-time data sharing across emergency response**
- **Expanding peer navigator workforce with entry level training and apprenticeship opportunities**
- **Creating sustainable funding**

As part of each recommendation, we provide an overview, background on relevant Washington initiatives or facilities, suggestions on how each recommendation could be rapidly deployed across the state, and case studies of best practices from across the country.

Working together, these recommendations would work to decrease the number of ER visits while providing better access to care and treatment for unhoused individuals. These recommendations all came from and are supported by experts on the frontline of the crisis. While no city, region, or state has holistically addressed this crisis, each of these initiatives and programs from cities and states across the county are best practices that we can do in our state. We believe that the success of others can be achieved here.

RECOMMENDATION #1:

Creating Street Medicine Teams

On our sidewalks, alleyways, under bridges, or at encampments, street medicine is a proven and cost-effective model to provide medical care and mobile treatment to avoid emergency rooms and prevent crises. From routine medical care to treatment, care outside the walls of the clinic before an emergency occurs is key to avoiding an emergency room.

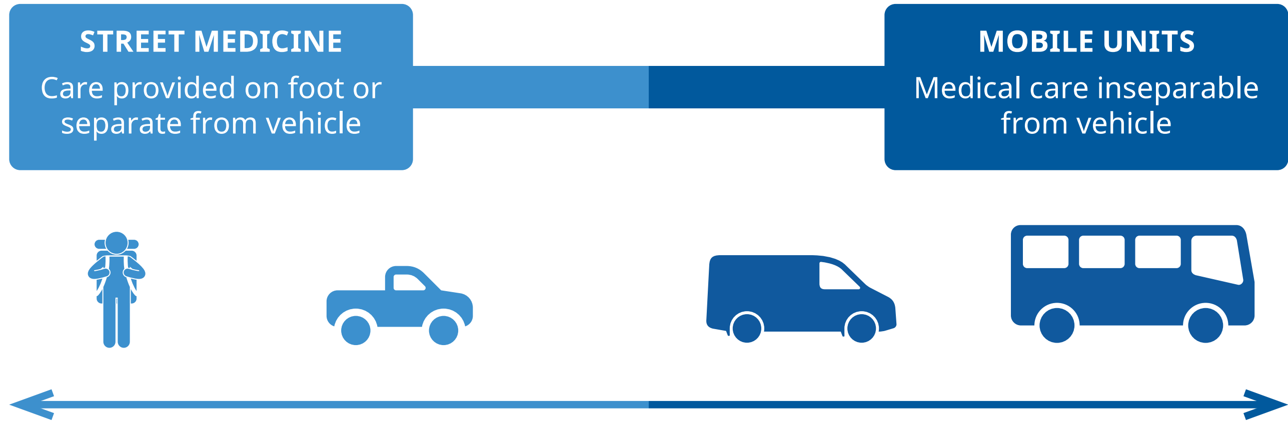
Given the high prevalence and complexity of co-occurring mental health disorders, substance use disorders, and medical needs, street medicine programs have the potential to directly deliver wound and other medical care in the field and administer medications for opioid use disorder such as suboxone and psychiatric care such as long-acting antipsychotics. By operating 7 days a week, street medicine can comprehensively address medical, mental health, and SUD needs, especially if appropriately staffed with peers with lived experience and nurses with access to psychiatrists or physicians. Peers can quickly build trust, which opens the door to care and treatment.

Current WA Programs

Started in 2019, Public Health - Seattle & King County had one small street medicine team operating Monday-Thursday that serves the entire county. In any given month, the team is currently only able to serve a neighborhood once a month with only 5-8 days visiting encampments in Seattle. With a part time advanced registered nurse practitioner, two public health nurses and a care coordinator, the team completed more than 1,000 visits in 2022. There are also small street medicine teams operated by Providence in Olympia and Community Health Association of Spokane.

> "Street Medicine is a promising approach for behavioral health delivery for unsheltered people. As one of our interviewees said: 'the reality of the lives of people experiencing homelessness warrants a specialized approach to health care delivery—that includes mental health, behavioral health, and substance use treatment.'"
>
> Community Mental Health Journal, 8/1/23

Continuum of Medical Outreach



Opportunity to Rapidly Deploy: Street medicine teams can be quickly scaled with funding matched with existing resources and partnerships.

To address the current lack of medical and behavioral health outreach for unsheltered individuals, street medicine teams can be quickly implemented in our state as they can be operated or sponsored by current hospitals, outreach teams, service providers, FQHCs, Public Health departments, or health plans who are already invested in similar work. The Governor's Supplemental Budget included an initial $2 million for street medicine. We recommend that the state legislature, hospitals, philanthropy, health plans, and local governments prioritize funding and/or staff.

Across the country, some efforts have been jumpstarted with volunteers, medical students, or a prioritization of hospital physicians and nurses. Many street medicine programs effectively use telemedicine to create deeper impact. Physicians, psychiatrists, or nurse practitioners are available to remotely assist some of the nurse-led teams in the field with diagnoses or prescriptions.

For example, in Seattle, additional funding could create a team focused on Seattle 5-7 days a week and expand Spokane's team to 7 days a week. These could also be supported through a public-private partnership to support initial startup costs such as equipment and expanded staffing. For the long-term sustainability of programs, street medicine providers can now be reimbursed with federal funds for services due to an official federal change in October 2023.

PHOTO: KECK SCHOOL OF MEDICINE OF USC

In Los Angeles, one of the newer street medicine teams, UCLA Health, is a model in terms of their rapid launch, operating model, and expansion plans (see "Case Study: Street Medicine in Los Angeles" on next page).

Recommendations for an Emergency Response

Case Study: Street Medicine in Los Angeles

In 2022, there were 29 active street medicine teams in California, and in 2023, there are now approximately 50 programs due to an increase in state and local investments.

In a 2023, the USC Keck School of Medicine surveyed current programs and issued recommendations to scale programs more effectively. Like Washington, California street medicine organizations are reporting that the vast majority of their patients have co-occurring disorders including 64% of their patients with mental health diagnoses and 67% with substance use disorders. All but one of the street medicine programs provides some mental health and treatment for substance use disorders, and the vast majority of providers have embraced long-acting antipsychotics for people with severe mental health diagnoses and initiation and continuation of substance use disorder treatment.[17]

One of the newer street medicine teams, UCLA Health, is a model in terms of their rapid launch, operating model, and expansion plans. In January 2022 with philanthropic support, UCLA Health launched two street medicine teams, which consist of a physician or nurse practitioner, nurses, and peers. From idea to inception, UCLA Health launched in months as their team utilized vehicle designs from other street medicine programs, and partnership referrals for primary care or outpatient care. In 2022 with only two teams, UCLA Health had 9,000 patient encounters, 2,300 medical and psychiatric evaluations, and dispensed 1,500 medications. **In the first year, they saw a 32% reduction in repeat ED visits of high-risk patients.**[18]

In 2023, UCLA received additional state and federal grants of $26 million to expand to six teams with vans, equipment, and staff including peer community health workers.

RECOMMENDATION #2:

Establishing 24/7 Low-Barrier Stabilization Sites

After an overdose or while an individual is in mental health crisis, many times the ER is the only facility offering 24/7 care.

With the number of overdoses, a key gap across the state that must be urgently met are low-barrier sites for individuals to receive 24/7 emergency crisis intervention care, which could last up to 72 hours. In many cases, patients do not need extensive detox or medical care after experiencing a crisis such as an overdose; rather, they need a safe, specialized, short-term facility that allows them to be monitored, offered resources to stabilize, address withdrawals, and/or meet with peers or others to explore treatment options.

Based on each community and operators, these facilities can have flexible staffing models that include EMTs, nurses, peers, and/or social workers while having access to prescribers, such as a nurse practitioner or physician. For example, these types of facilities could be integrated into existing locations such as emergency housing or current clinics.

As these types of facilities have opened in Boston, DC, San Francisco, and Portland, they include community access and use by law enforcement, EMS, and hospitals for patients not needing emergency room care. A key aspect is that these facilities are "low-barrier" meaning the requirements for entry are limited or minimal. Barriers to some facilities include medical clearance by a hospital, background checks, costs, and insurance. Some facilities prohibit smoking, vaping, or using tobacco.

Current WA Programs

Overall, there is limited capacity across the very few crisis facilities, residential treatment, or detox facilities that exist, and many of these facilities have restrictions and do not serve individuals with co-occurring mental health and substance use disorder needs.

Recommendations for an Emergency Response

In recent years, there has been a significant increase in funding for community-based behavioral health and outpatient services; many facilities are not expected to open until 2026 and beyond.

Opportunity to Rapidly Deploy: Opening stabilization sites is possible through new statewide funding paired with investments from local governments.

There are a few potential models across hospitals, providers, or local governments that could be deployed to rapidly stand-up stabilization facilities. An emergency response should allow for innovative reprogramming of operations, retrofitting underutilized space, acquisition of properties that could open quickly, or rapid construction such as modular buildings while removing barriers to permitting or financing. To stand up these facilities, there needs to be flexibility regarding staffing models and facility types, and referral processes must be flexible to meet the needs of each community. While facilities are likely to be operated by hospitals and/or behavioral health service providers, there must be a partnership across the public-private-philanthropy sectors to support the success of these sites.

In addition, Health Engagement Hubs could be a model if operations are expanded. As proposed, pilots for Health Engagement Hubs are focused on harm reduction services and supplies, walk-in primary care, low-barrier access to medications for opioid use disorder (MOUD), and case management. The Legislature appropriated $4 million from opioid abatement settlement funds for state fiscal years 2024 to 2025 to implement two pilot sites, one urban and one rural with aim to open by August 2024.

Other potential models could include creating behavioral health urgent care at hospitals which can be done relatively quickly and/or expediting proposed crisis centers that have been funded but have not opened.

Case Study: Boston

From February 2022 to June 2023, Boston Medical Center, the City of Boston, and the state partnered to open an emergency housing and a 24/7 stabilization clinic at a hotel. In less than two months, BMC was able to open this clinic that served thousands of individuals. There was medical, mental health services and SUD treatment, including methadone, and there was significant success in treatment outcomes.

Specifically, the 24/7 site included a low-barrier walk-in clinic and a short-stay stabilization unit that managed over-intoxication, withdrawal, and complications of substance use such as psychosis or abscesses. The clinical programs are staffed 24/7 with a nurse practitioner, two registered nurses, a registration clerk, and a harm reduction specialist.

In the first twelve months of operation, 1,722 patients had 7,468 visits and stayed on average 11.5 hours. Many of these visits would otherwise have been ER visits. Among patients who received clinical services, 84% had opioid use disorder and 61% had co-occurring mental health diagnoses. The clinic primarily relied on methadone to treat withdrawals and begin treatment. 556 unique patients were treated with methadone with more than 90 percent not previously connected to treatment.

However, the site also included 60 beds of transitional housing, which was costly to operate and required substantial resources to support this high-risk patient population, both in terms of staffing and operational intensity. This combined with the limited reimbursement for daily payment rate for these patients led to challenges for sustainability of this model.

Due to the lack of overall sustainable funding, the site closed.[19]

Recommendations for an Emergency Response

Case Study: Washington, D.C.

PHOTO: DUANE LEMPKE PHOTOGRAPHY

On October 31, 2023, DC opened its first 24/7 stabilization center which provides immediate resources for individuals experiencing substance use disorder. The stabilization center features 16 recliners for people staying up to 23 hours, and 6 patient beds for individuals staying for as much as 72 hours, so they can be observed and monitored. Upon arrival, patients will receive a comprehensive medical and psycho-social evaluation by nurse practitioners, RNs, and peer specialists in addition to offering buprenorphine medication on the spot. Operated by a behavioral health provider, the facility is located at a current DC Department of Behavioral Health clinic that was quickly retrofitted.[20]

RECOMMENDATION #3:

Accelerating Behavioral Health Facilities through Retrofitting and Rapid Acquisition

During 2021 and 2022, the state legislature took a successful new approach to rapidly acquire vacant hotels and motels to bring online more housing and emergency shelter for individuals experiencing homelessness. To address the urgency of homelessness, approximately 30 properties were rapidly acquired through a competitive process with many opening within months rather than the 3+ years of new construction of affordable housing.

To immediately address the lack of behavioral health facilities and the fentanyl crisis, this approach can be replicated to rapidly stand up underutilized or vacant facilities to provide mental health and/or substance use disorder treatment. This is essential to creating more 24/7 low-barrier stabilization sites or other sites to serve individuals in crisis.

From co-locating operations at hospitals, detox facilities, or federally qualified health care (FQHC) sites, to partnerships at current shelters, needle exchanges, food pantries or other pre-existing sites offering services, operators could modify facilities to add services more quickly.

New construction or acquisition of new property for a different use offers significantly more challenges as it relates to land use, permitting, financing, construction, and/or community concerns.

Current WA Programs

In recent years, the Department of Commerce has administered a Behavioral Health Facilities grant program to establish new behavioral health service capacity. While this program invests in important community-based care, it has primarily funded the new construction of specialized certified facilities such as 90- and 180-day civil commitment facilities, certified crisis Stabilization Facilities (CSU), Intensive Behavioral Health Treatment Facilities (IBHTF), and Secure Withdrawal Management and Stabilization Facilities (SWMS).

Opportunity to Rapidly Deploy: Creating an innovative new statewide program would allow Tribal governments, providers, hospitals, or local governments to quickly deploy and expedite treatment facilities.

Throughout the state, cities, counties, hospitals, and non-profits have identified facilities that could be used. Governor Inslee's supplemental budget included $8.5 million towards treatment facilities including $3.5 million for a post-overdose facility in Seattle. With additional investments, facilities could be brought online across the state, especially through a similar process as the previous rapid acquisition fund, which conducted a competitive process and funded projects in approximately 60 days.

Case Study: Providence Behavioral Health Urgent Care in Everett

From idea to opening, the behavioral health urgent care took approximately nine months to complete in 2019. Located at the same campus as Providence Medical Center, the urgent care was created in underutilized office space for approximately $150,000 through a philanthropic grant.

The facility operates on Monday-Friday and had 2,280 visits in 2023—a direct reduction in ED visits. Staffed with a mental health professional and nurse with access to a physician, this effective model costs approximately $615,000 a year to operate.

Case Studies: Sacramento and Anchorage

Both Anchorage and Sacramento were able to create walk-in crisis facilities through public-private partnerships and utilizing adjacent land at these hospitals.

In Sacramento, Dignity Health Mercy San Juan created a 24/7 behavioral health urgent care in 2019 that can serve 12 individuals with psychiatrists, behavioral health RNs, peer navigators, and social workers. The facility is co-located outside the emergency department, which experiences a significant volume of psychiatric crises. The custom modular unit took 13 months to design, construct, install plumbing/electric, and permit with approximately $2 million in one-time capital costs. Serving a sizable number of individuals experiencing homelessness, this facility has reduced readmissions and more quickly served individuals in crisis in a calming environment. Compared to the previous average time to receive care of 33 hours in ED, individuals seeking care now receive the appropriate care, counseling, or treatment in less than 4 hours.[21]

Similarly, at Providence Anchorage, officials began construction this Fall on a pre-existing wing of the hospital to create a new behavioral health crisis center expected to open next year, demonstrating the time benefit of both co-location and utilizing an existing space The center will have space for 24 people who need mental health or substance-use stabilization and was funded by the city, state, the Alaska Mental Health Trust Authority, and federal grants.[22]

RECOMMENDATION #4:

Utilizing Mobile Behavioral Health Teams to Respond to Overdoses

Far too many of the current mobile teams do not have the capacity to respond to substance use disorder, but they should. Unlike street medicine, various mobile teams from across the state are deployed to respond to 911 or 988 calls, specifically when an individual is in a behavioral health crisis. In recent years, these teams have been created as a best practice to reduce dependence on law enforcement, fire, EMS, and ERs and to match mental health professions and peers who are better equipped to de-escalate these crises and provide connections to appropriate treatment. Because many of these teams were envisioned and created before the rise of the fentanyl crisis, not all are fully equipped to address substance use disorder or overdoses. However, in many circumstances, these teams could be utilized to help individuals with co-occurring disorders in crisis or to respond to substance use disorder crises.

How a city or county utilizes current or planned mobile teams could vary across a community. In some communities, co-responders are embedded in law enforcement or EMS while others have created mobile integrated health teams at fire departments or mobile crisis teams that are dispatched from 988 or a crisis line.

Recommendations for an Emergency Response

Case Study: Seattle Fire Health 99

In July 2023, Seattle Fire Department began utilizing one of its mobile integrated health teams to respond to overdoses. Currently, Seattle Fire is responding to approximately 12 overdoses a day across the city or more than 4,200 across 2023. While EMTs or paramedics are dispatched initially to overdoses to provide emergency medical care, Health 99 is added to these responses as available. After EMTs depart, Health 99 can focus on treatment options and specializes in connecting patients to detox centers or other resources.

Staffed with a firefighter/EMT and a case worker, the team typically operates Monday through Thursday from 9 a.m. to 7 p.m. The team typically responds to 3-5 overdoses a shift and provides follow-up care.

In recent studies by the National Institutes of Health, researchers concluded that "buprenorphine is a safe and effective option." One study found that "paramedic-initiated buprenorphine in the setting of data sharing and linkage with treatment appears to be a safe intervention with a high rate of ongoing outpatient treatment for risk of fatal opioid overdoses."

The key condition for success is that these teams are equipped with the right expertise to deploy to non-fatal overdoses and conduct post-overdose follow-up. For example, in Maine, each county incorporated specialists for substance use disorder such as mental health and rehabilitation technicians, licensed or certified alcohol drug counselors, or licensed clinical social workers. With such training and expertise, these individuals play a critical role during and after an overdose, navigating the complexity of treatment resources including next day appointments for methadone and buprenorphine, referrals to detox facilities, inpatient treatment facilities, and outpatient treatment programs.

Current WA Programs

Across the state, each community has separate resources, funding, and models for mobile teams. In 2023, the Washington Legislature passed House Bill (HB) 1134 which formalized additional mobile rapid response crisis teams and created a grant program.

Opportunity to Rapidly Deploy: Local governments should evaluate their planned or current mobile teams in order to deploy additional training and/or personnel who may be able to specialize in either overdose response or post-overdose response.

No matter its structure, mobile teams should exist in every community as these resources are key to reducing reliance on law enforcement or EMS as well as ERs. All mobile teams should be equipped with training and resources to address co-occurring disorders with an emphasis on the appropriate treatment for individuals with substance use disorder.

RECOMMENDATION #5:

Authorizing EMTs and Paramedics to Administer Opioid Treatment

Treatment must be foundational and more accessible than fentanyl. When a patient is at risk of overdosing or has overdosed on opioids, many times their first point of contact is with EMS or 911 responding paramedics. After an individual is revived by naloxone, many individuals do not need further medical care in an ER or decline transport to emergency rooms. In a few places across the country—including Camden, New Jersey; Pittsburgh, Pennsylvania; San Francisco, California; Durham County, North Carolina; Hennepin County, Minnesota; and Contra Costa County, California—paramedics or EMTs responding to overdoses are engaging patients to start treatment immediately by

administering buprenorphine (Suboxone). Administering Suboxone is key to reduce the initial severity of withdrawals and increases the likelihood that an individual may seek further treatment. Patients seen by a buprenorphine-equipped ambulance were at least six times more likely than patients seen by a non-buprenorphine equipped ambulance to visit an addiction treatment clinic at least once within 30 days of their ambulance encounter.[23] Key to launching a program is appropriate training and a clear connection to treatment including an initial prescription to buprenorphine, an appointment and access to outpatient treatment, and/or transportation to a detox or stabilization facility.

Current WA Programs

Currently, EMTs or paramedics are not approved in WA to administer buprenorphine.

Opportunity to Rapidly Deploy: In partnership with the Department of Health, Washington's fire departments and emergency medical services providers should launch pilot programs to administer buprenorphine. To further connect individuals with treatment, we recommend that the state legislature approve a standing order to allow the prescribing of buprenorphine statewide.

As of January 2024, the Department of Health is prepared to approve pilot programs to allow paramedics and EMTs to administer buprenorphine. We recommend that local departments get ready to rapidly launch pilot programs. Training can be expedited and replicated from existing programs and resources, while including localized treatment referral resources. We recommend a statewide basic training on overall treatment guidelines, dosage protocols, motivational techniques, and overall background on opioid addiction.

In addition, there must be an overall approach to connect individuals with continued treatment after the initial dose. Even as additional stabilization or treatment facilities are created, there must be access to providers who can prescribe buprenorphine or other medications for opioid use disorder. We recommend that the state legislature support legislation to allow the Secretary of Health to issue a standing order on buprenorphine, similar to the standing order for naloxone or "Narcan." Local public health officials could also create standing orders to prescribe buprenorphine if allowed by local code or launch 24/7 helplines to prescribe buprenorphine—an initiative that King County is launching in early 2024.

Case Study: Camden, New Jersey

Camden had one of the highest overdose and drug-related fatality rates in the state. In 2019, of the 44,466 EMS responses in Camden, 25% were to patients with suspected overdoses. While first responders would administer the life-saving medication of Naloxone, or "Narcan," which would reverse an overdose, they were not able to directly offer treatment.

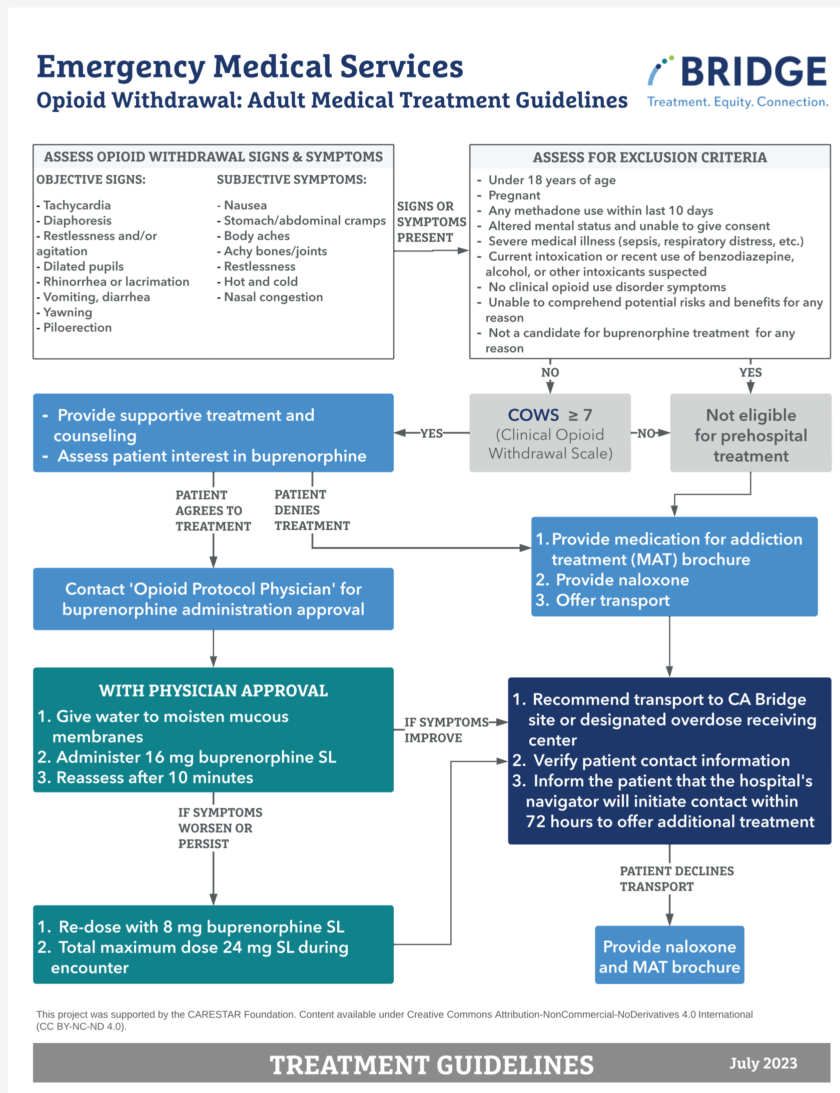
In 2019, EMTs and paramedics in Camden became the first in the country to administer buprenorphine or a single dose of "Suboxone" through their "Bupe First" pilot. The focus was on individuals who had never had access to treatment previously. In 2023, after four years of operating the program, Camden EMS reports that about one in ten of overdose patients accept the first dose of buprenorphine, and of those, 30-40% are in treatment 30 days later.

In addition, EMS was able to create a standard protocol to efficiently utilize the time on site. The average on-scene time increased by only ten minutes for patients enrolled in Bupe FIRST EMS, an acceptable time increase given the potential benefits of treatment.[24]

Case Study: California

In California, the Public Health Institute/CA Bridge has created a program to provide materials, training, and technical assistance to EMS agencies and personnel for the treatment of opioid use disorder. Supported by philanthropy and the California Department of Public Health, the organization developed a toolkit which is available online that includes protocols for administering buprenorphine and patient materials.

While one county was approved in the initial pilot in 2020, the technical assistance has worked to expand programs to 13 counties in California. Last year, the organization had trained over 200 paramedics in three counties: Contra Costa, Alameda, and San Francisco. Paramedics are provided with robust training that includes the history of opioids in the U.S., pharmacology of buprenorphine, motivational interviewing, and buprenorphine administration in the field. In addition to lectures, EMS providers practice real-case scenarios to prepare them to implement the buprenorphine protocol.[25]



Source: https://bridgetotreatment.org/wp-content/uploads/BRIDGE-PROTOCOL-EMS-Opioid-Withdrawal-Treatment-Guidelines-July-2023.pdf

RECOMMENDATION #6:

Removing Barriers to Opioid Treatment Like Sublocade

Fentanyl is a powerful synthetic opioid that is similar to morphine but is 50 to 100 times more potent. At a cost of 50 cents, it can be fatal in amounts as small as a few grains of sand. Opioid use disorder is treatable with medication. Decades of evidence have proven the effectiveness of buprenorphine and methadone, recognizing patients have different needs of these medications during recovery.

Methadone treatment is highly regulated. Due to strict federal regulations, Opioid Treatment Providers are the only outpatient facilities authorized to administer methadone. Patients need to visit OTPs nearly every day to receive methadone as it is tailored for each patient and often readjusted frequently.

Buprenorphine, known also under the brand name "Suboxone," is also a daily medication that can be administered by an Opioid Treatment Provider. Most notably, other medical providers can prescribe buprenorphine or "Suboxone" that patients can fill at any neighborhood pharmacy. With Congressional action in December of 2022, there is no longer a federal requirement for practitioners to apply for a special waiver prior to prescribing buprenorphine, which has increased access to this treatment.

Another treatment option emerging is Sublocade, a once-monthly injectable buprenorphine. Approved by the FDA in 2017, this continuously releases buprenorphine all month at sustained levels. While Sublocade appears promising to address the barriers to treatment for unsheltered individuals, there are regulatory, financial, and insurance barriers that must be addressed to allow more individuals to access this promising medication. For example, while Sublocade is covered by Medicaid and Medicare, some commercial insurances do not cover and the current Medicaid reimbursement rate leads to losses for all providers. Unlike many states, Medicaid in Washington does not require pre-approval but most commercial insurances do. This has led to delays in treatment for individuals for weeks. In addition, Sublocade is only available at specialty pharmacies and in many cases, some specialty pharmacies require advanced prior consent notices prior to delivery. All of these barriers have led to very few providers utilizing this treatment option.

Current WA Programs

Across the state, there has been a rise in opioid treatment providers and an increase in mobile treatment. Sublocade is used by some providers.

Opportunity to Rapidly Deploy: State agencies and the legislature should support expanding treatment and remove the financial and insurance barriers to Sublocade to allow hospitals, Opioid Treatment Programs, street medicine teams, and providers to provide monthly treatment.

Governor Inslee's budget includes $5 million to expand Opioid Treatment Programs (OTPs) in Tribal and rural areas, as well as across most of central and eastern Washington, as often the challenge of geographical accessibility hinders people accessing methadone treatment. Throughout the state, cities, counties, hospitals, and non-profits have identified facilities that could be used. There is funding to allocate 2,300 doses of Sublocade, prioritizing smaller providers and certain uninsured individuals.

"Can a monthly injection be the key to curbing addiction? These experts say yes"

"Addiction experts say administering a month's worth of anti-addiction medication holds great potential, particularly for people without housing or who struggle with other forms of instability."

5/11/22

Case Study: New Jersey

In August of 2023, the Camden Coalition—a non-profit consortium of health systems, primary care providers, academic institutions, and other providers—created a toolkit with an overview of best practices for New Jersey providers looking to secure patient access to Sublocade. The initial data revealed that it would take patients between 4-6 weeks to receive Sublocade, and many patients also had their prescription canceled due to the pharmacy being unable to gain verbal consent from the patient within the required 28 days. Their goal was to reduce clinic staff time and ease patient burden by eliminating barriers like monthly patient verbal consent, documenting the various managed care organization requirements such as specific forms and consent, and outlining best practices for coordinating with specialty pharmacies. Initially, they collaborated with Cooper University Health Care System, one of the largest hospitals in New Jersey, and the managed care organizations (MCOs) to map and analyze the current process of connecting patients to Sublocade across affiliated and independent specialty pharmacies. They proposed process improvements to the NJ Medicaid's Office of Behavioral Health and the MCOs and worked to implement recommendations of these partners. The toolkit documents a process overview, requirements of insurance and pharmacies including sample forms, best practices for coordinating with specialty pharmacies, and detailed contact information of all specialty pharmacies contracted by each insurance company.[26]

RECOMMENDATION #7:

Implementing Real-time Data Sharing across Emergency Response

While HIPAA generally does not limit disclosures of personal health information between health care providers for treatment, case management, and care coordination, patient information is siloed across health systems and hospitals, HMIS, and homelessness response. There are significant barriers to integration across technology platforms and into other key care coordination systems.

To offer better clinical care across hospitals and providers, timely electronic notifications of critical events such as a hospitalization or case management information should be available across systems. This would allow providers to better address frequent patients as clinical care plans could be shared and case managers notified of major occurrences such as an ER visit.

Current WA Programs

In Washington, there is no consistent technology platform as hospitals, service providers, and government utilize technology.

Opportunity to Rapidly Deploy: Implement data sharing agreements through consistent release of information forms while expediting long-term efforts across technology platforms.

The lack of real-time data shared amongst the highest utilizers can be addressed by implementing data sharing agreements through consistent release of information forms, similar to Oregon and programs like King County High Utilizer Program. Public-private partnerships can expedite implementation of current efforts to create a platform to share patient medical records among public and private health care providers and payers. For example, Healthier Here and organizations in King County have been working with the Connect2 Community Network to create unified community information exchange (CIE) to enable care coordination between health, behavioral health, tribal, community and social service organizations. This would enable organizations to send, receive and follow up on electronic referrals, increase access to resources via a shared directory, and provide visibility of other organizations providing care.

At the same time, the Washington Department of Health has been building out a statewide network of Health Information Exchanges (HIE), which would allow health care professionals, providers, health systems and public health to securely exchange clinical or business information in standardized messages.

Case Study: Washington County, Oregon

In 2022, two health care companies— Kaiser Permanente and Providence—collaborated with Washington County towards a data sharing agreement for patients experiencing homelessness with unmet medical needs. Like most places across the country, there are differing technology platforms across hospitals, government agencies, and service providers. Years in the making, this custom agreement with the County homelessness management information system (HMIS) allows for shared review of homelessness data to allow for case conferencing of patients

Joint meetings were established to share better information on housing and clinical plans for patients across navigators and case managers. In recent months, the agreement is being expanded between the Oregon Health Plan (servicing Medicaid members) and CareOregon, which manages behavioral health benefits. With an approved framework by local government, hospitals, and managed care organizations, they are hoping to expand to other governments and hospitals in the tri-county region around Portland.[27]

RECOMMENDATION #8:

Expanding Workforce through Training and Apprenticeship Opportunities for Entry Level Peers

Across street medicine teams, emergency rooms, outreach teams, behavioral health providers, or crisis responders, peers are necessary for effective outreach, care of patients, and expanding our strained workforce. These peer recovery coaches, outreach workers, or navigators have personal experience with homelessness, substance use or mental health. Therefore, we need to expand and utilize entry level training and/or apprenticeship programs across the state.

Peer support workers are individuals who have been successful in their own recovery process and help others experiencing similar situations. They can better build the much-needed trust of the patients to address the crisis and treatment. Through shared understanding, peer support workers are effective to engage and start the recovery process and reduce the likelihood of relapse.

As the state is facing a workforce shortage across all of health care, human services, and behavioral health, adding entry level opportunities for peers can successfully expand the workforce. To help ensure career advancement, the Department of Health is creating additional certification programs for peers that would allow career progression as well as Medicaid reimbursement rates for some eligible positions.

Current WA Programs

There are some current training programs that offer education and apprenticeship opportunities to peers such as Health Care Apprenticeship Consortium, which is a model for peer apprenticeship programs. While primarily utilized by hospitals and behavioral health providers in Puget Sound, this apprenticeship is open to most employers across Washington. The program offers 250 hours of classroom training, 2,000 hours of the on-the-job training, and financially supports both employers and apprentices.

Opportunity to Rapidly Deploy: Community colleges, hospitals, providers, and labor should explore opportunities to further utilize peer training and apprenticeship opportunities.

With access to state and federal workforce grants and ongoing programs, there could be additional opportunities to further expand peer training and apprenticeship opportunities to more communities. While some providers and students may pursue apprenticeship opportunities like the Health Care Apprenticeship Consortium, training at community colleges could also be available across the state.

Many peers may be eligible for financial aid as Washington offers one of the nation's most generous financial aid programs across certificate programs or apprenticeships.

Case Study: Honolulu, Hawaii

PHOTO: ARDENTARBITRATION

Kapi'olani Community College in Honolulu, HI received a $1 million federal grant to provide a free comprehensive training program focused on care coordination in partnership with local employers. These students are enrolled in a free one-year program and receive a certificate after an initial in-person training, flexible online work, and practical experience. Specifically, the training focuses on providing basic health screening services, making referrals to appropriate health care providers or agencies, and following up on referrals. The training was also made available across the state and included participants from the islands of Lāna'i, Maui, Hawai'i, and Kaua'i.

For example, Queens Medical Center had all the navigators of their coordinated care teams certified through this program. Not only has that increased staff retention but also helped create valued outcomes for their case management as they are managing intense patient services for 30-90 days. In one evaluation of their program, their team helped reduce ED visits by their highest utilizers by 53%.[28]

RECOMMENDATION #9:

Utilizing Coordinated Care Teams

Nationally, a few hospitals have set up intensive patient navigator systems to address "super utilizers" of their emergency departments. These programs focus on unsheltered high-need, high-cost patients who account for a disproportionately high amount of health care utilization. While each hospital defines frequent patients differently, hospitals routinely have individuals who are seeking care 3+ times in a year, up to dozens of times a year.

Understanding that there are patients who are most likely to continue to visit the ER, hospitals and programs have been created to better serve these patients who are likely to need care again within days, weeks, or months.

With intensive case management ratios (usually one case worker to every ten patients), these teams are comprised of navigators/case managers, Licensed Clinical Social Worker (LCSW), and/or a physician. Navigators provide referrals across the system to: coordinated entry, primary care, outpatient therapy, psychiatric services, end of life care, shelter, and legal aid. To coordinate across other homelessness and community-based providers, these teams meet on a regular, usually weekly, basis and develop an intensive case management plan for these complex high-risk individuals.

Current WA Programs

While most hospitals have social worker programs to address the broad needs of patients, there is at least one high utilizer program at Harborview Medical Center, which has limited resources. The state also has created and expanded the Program of Assertive Community Treatment (PACT) teams. This program is case management for people with severe mental health disorders, who frequently need care in a psychiatric hospital or other crisis service.

Opportunity to Rapidly Deploy: Creating or prioritizing coordinated care teams at hospitals with dedicated staffing and funding will lead to better outcomes for the highest utilizers.

Working across managed care organizations and the state, there is an opportunity to utilize current social work programs at current hospitals and/or the PACT teams to better focus on this distinct patient population. There are various models that hospitals have deployed in terms of staffing and connections to resources in a community.

Case Study: Connecticut

Connecticut has worked to create nearly 20 community care teams (CCT) across the state. While the teams are unique to every city and hospitals, each team aims to reduce emergency department utilization and improve patient outcomes. Two examples are the Waterbury CCT and the Middlesex CCT that are structured differently for the needs of that community. However, both programs rely on a project leader that holds responsibility for relationships, data-sharing agreements and data tracking, care team convening, leadership development, and communications.

In Middlesex, the program was launched in 2010 by Middlesex Hospital and now has expanded to 16 other behavioral health and community service providers. All patients must sign a release of information to all providers, which allows the hospital's electronic health record to automatically alert providers on key events, such as an ER visit. Overall, the program monitors approximately 700 patients, and the partners meet weekly to review information about patients who were recently in the ED (approximately 10-15 of the highest priority patients), update their plans as needed, and develop strategies to ensure they get necessary services. One study of their patients found a 34.6% decrease in visits in the 6 months after signing up for the program.[29]

In Waterbury, a dedicated team was created at a non-profit, the Greater Waterbury Health Partnership, that works with the hospitals and other service providers in the region. In a study of 23 patients served that meet the criteria of having pre and post data, the Waterbury CCT team reduced at least $1.7 million in hospital charges and 128 hospital visits.[30]

RECOMMENDATION #10:
Creating Sustainable Funding

Success of these recommendations requires addressing payment and Medicaid reimbursement rates for essential services related to behavioral health and crisis care.

Medicaid reimbursement rates are the amounts that Medicaid pays to health care providers for the services they provide to Medicaid enrollees. These rates matter because they affect the access, quality, and cost of health care, and if rates are set too low for providers, they can discontinue offering services.

In recent years, we have created new facilities outside of an emergency room to address mental health conditions or substance use disorders. However, in many cases, operations at these facilities are not reimbursable yet. For example, ambulance transport to a non-ER facility such as a behavioral health facility is not reimbursable, so ambulances all too often must take individuals to an emergency room. Other examples include the lack of reimbursement for a mental health professional responding to a 911 call or the operation of facilities like 24/7 stabilization clinics or crisis facilities.

In our state, there is a troubling pattern of starting programs strong with capital funding and initial investments, but then failing to provide adequate funding for ongoing services. For programs and services focused primarily on people with Medicaid or no health insurance, there must be sufficient funding for operations as costs cannot be shifted to commercial payers. All too often Medicaid reimbursement rates do not cover many services or the actual costs of programs.

The patient population who will be served through these initiatives deserves an appropriate degree of professionalism from the staff serving them. Further, the people delivering the services—many of whom may have lived experience of homelessness, substance use disorder, or recovery—deserve to be paid adequately and receive benefits to support them.

Current WA Programs

As passed by the legislature in 2023, there are some increases to reimbursement rates for some behavioral health services in 2024.

Opportunity to Rapidly Deploy: State and local governments should set a contract and/or reimbursement rate quickly that fully covers ongoing operations, accounts for inflation, and creates reliable sustainability for essential services for behavioral health and crisis care.

We recommend that the state legislature address payment and reimbursement rates for essential services such as behavioral health first responders and transportation to behavioral health facilities. Currently, the Department of Health and Health Care Authority are undergoing the third phase to develop behavioral health rates for the future. Over time, rates must be reviewed and adjusted for the long-term sustainability of these programs.

Note: There is no case study for this recommendation.

PHOTO: JOE MABEL

Despite recent innovative action, our state lacks resources, treatment options, housing, and services to address this crisis

While our recommendations focus on immediate actions to triage the crisis in the ERs, interim and long-term treatment and housing solutions are foundational to long-term success in our ERs and with patients. Even as our recommendations have the potential to reduce tens of thousands of ER visits and provide better care for people cycling through the ERs, we recognize that a number of unhoused patients will need interim housing to continue to stabilize, receive treatment, and pursue recovery.

For unhoused individuals, there must be interim options available in communities to begin recovery such as respite care, emergency shelter, crisis facilities, or residential treatment. For shorter or time restricted stays, there are different models that could be pursued such as the Crisis Solutions Center in Seattle, the Snohomish County Diversion Center in Everett, or expanding treatment at current emergency housing locations. By offering interim options with a recovery focus, these programs can help homeless individuals overcome the barriers and challenges they face and empower them to achieve recovery and independence.

In both the current budget and proposed supplemental budget, there are opportunities to pursue interim facilities that could meet the interim needs and more—specifically the behavioral health facilities program at the Department of Commerce and the proposed additional funding for the rapid capital housing acquisition fund to allow state agencies and local partners to quickly open new shelter and housing units.

Clearly, our state does not have the resources to provide long-term treatment or permanent housing for all individuals experiencing homelessness. There is a statewide shortage of treatment options for all residents with limited availability of detox, residential treatment, crisis facilities or longer inpatient care at state facilities. We also do not have the number of housing units for all individuals experiencing homelessness, nor the services needed to help stabilize them and keep them housed.

Significant funding has been appropriated to invest in a new University of Washington Center for Behavioral Health and Learning, a new forensic hospital in 2028, crisis stabilization facilities, intensive behavioral health treatment facilities, outpatient treatment, and other behavioral health facilities. In communities across the state, we must continue to invest and build long-term treatment facilities.

We also must continue our focus on long-term permanent housing. In recent years, there has been innovative action to create more housing: from King County's Health Through Housing to the state's rapid acquisition fund to historic investments at the local and state level with the Housing Trust Fund and the Seattle Housing Levy. All of these are key to the future of housing in Puget Sound and across the state, especially for individuals experiencing homelessness.

While there is hope for the future for our investments in housing and treatment, we know there is more that must be done to create additional housing in communities across the state and meet the complex needs of unsheltered individuals cycling through our emergency systems.

Let's answer the call now

With our emergency rooms at the epicenter of the homelessness, mental health, and opioid crises, it is time for an emergency response.

These crises impact all of us directly if we visit an emergency room ourselves or indirectly by the loss of life, the human suffering we see on our streets, the burnout impact on doctors, nurses and staff, and the skyrocketing medical costs at these emergency rooms.

We do have reason to be optimistic about projects that will be available in the coming years. And we must continue our steadfast commitment to longer term housing and treatment. However, we cannot wait for years. Lives are at stake.

It is time for action now with an emergency response much like what we did during COVID. The 10 recommendations we provide have been tested and serve as best practices. They are ready for implementation.

We must answer this call to action by joining together and everyone doing their part including state and local government, non-profits, philanthropy, hospitals, the private sector, and YOU.

In a crisis, we answer the call to action. That's who we are. We are problem solvers, compassionate and action oriented. Let's answer the call now.

End Notes

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