



Washington State
Hospital Association

2021
Data Report

Washington State Hospital Association

Inpatient Behavioral Health Treatment Data Project:

Summary Report of Key Findings

December 2021

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ACKNOWLEDGEMENTS

We hope the data from this project will begin a community conversation and collaborative effort to improve behavioral health systems and services for people in Washington State. We appreciate the support of Sen. Manka Dhingra (D-45th) in championing the need for a data project like this to inform behavioral health policy efforts in the state. We would also like to thank the Washington Council for Behavioral Health's leadership for mobilizing their members to engage in this work.

This project was a collaborative effort of several organizations. We appreciate the enthusiasm and willingness of hospitals, freestanding evaluation and treatment (E&T) facilities, and secure withdrawal management and stabilization (SWMS) facilities for participating in this data collection effort. These diverse facility types across the state participated in weekly data reporting in the middle of the COVID-19 pandemic, a statewide behavioral health surge and staffing crises.

The Washington State Hospital Association (WSHA) project team is profoundly humbled and grateful to each of the participating facilities.

EXECUTIVE SUMMARY

This report presents results from the *WSHA Inpatient Behavioral Health Treatment Data Project*, a data collection effort completed with inpatient behavioral health treatment facilities across Washington State. Little data exists about inpatient capacity and system needs in Washington. The project's purpose was to collect quantitative and qualitative data about inpatient behavioral health treatment to identify, quantify, and understand treatment gaps and capacity needs, inform policy and funding changes, and support system and quality improvement efforts.

Key Findings

- **Diversity and variation exist across inpatient behavioral health facilities and facility types.** Not all inpatient beds are the same. Facilities vary in their facility design, building and IT infrastructure, treatment capacity and specializations, staffing, and other key facility-level characteristics.
- **Inpatient capacity is not meeting the current treatment demand,** particularly for specialized populations, such as patients with medical complexity; violent, aggressive or complex behaviors; or cognitive impairments/neurodiversity.
- **Patients with specialized treatment needs are often in the hospital longer** and are more difficult to discharge to safe, stable, long-term placements. Community discharge opportunities are limited. Placing patients with specialized and complex needs takes increased time and resources for facilities.
- **Discharge challenges impact and influence inpatient capacity.** When patients are not able to transition back to the community (e.g., stable placements, outpatient services), this affects the facility's capacity and ability to admit other patients.
- **Limited access to outpatient services may impact the need for inpatient treatment.** When patients do not have timely access to outpatient and crisis services, patients often come to inpatient facilities experiencing more acute symptoms and may take additional time/resources to stabilize before discharge.

Policy Opportunities

The findings from the *WSHA Inpatient Behavioral Health Treatment Data Project* suggest important policy opportunities for behavioral health system improvement. Key areas include the following:

- **Increasing inpatient capacity for patients with specialized needs,** including patients with complex and violent behaviors, medical complexity, and neurodiversity (e.g., developmental disabilities, dementia).
- **Building out step-down services and supports for patients leaving inpatient treatment settings.** This may include investments in partial hospitalization, intensive outpatient programs, psychiatric and medical respites, or other resources to facilitate successful discharges and help individuals reintegrate into the community.
- **Strengthening outpatient community behavioral health and crisis diversion resources** to support individuals in the community and prevent unnecessary emergency department visits and behavioral health hospitalizations.
- **Increasing community long-term supports and supportive housing capacity,** particularly for patients with violent behaviors, greater psychiatric acuity and complex medical needs.
- **Continued investment in and support of the behavioral health workforce.**

PROJECT OVERVIEW AND METHODS

This report presents results from the *WSHA Inpatient Behavioral Health Treatment Data Project*, a data collection effort completed with inpatient behavioral health treatment facilities across Washington State. Little data exists about inpatient capacity and system needs in Washington, and the impetus behind this collective data effort was to begin filling in these gaps. The purpose of the project was to collect data about inpatient behavioral health treatment to identify, quantify, and understand treatment gaps and capacity needs, inform policy changes, identify investment opportunities, and support system and quality improvement efforts.

Acute care hospitals with inpatient behavioral health units, freestanding psychiatric hospitals, freestanding evaluation and treatment (E&Ts) facilities, and secure withdrawal management and stabilization (SWMS) facilities from around the state were invited to participate in the project. Approximately 75 percent of hospitals and over 70 percent of freestanding E&T/SWMS facilities that offer inpatient behavioral health treatment participated in one or more of the project components. Data were collected over a four-month period (April – July 2021).

This project employed a mixed-method data approach to better understand the following elements:

- Characteristics of facilities providing inpatient behavioral health care in Washington State
- Numbers and characteristics of patients not finding an inpatient bed and often ending up on a single bed certification (SBC)¹
- Length-of-stay characteristics
- Discharge characteristics and obstacles
- Policy and improvement opportunities

Data collection occurred in four data component areas. The first data component was an online facility-level survey collecting data on facility characteristics (e.g., size, location, number/types of inpatient beds and services, staffing elements, involuntary treatment characteristics). Survey responses were received in April and May 2021. For the second project component, facilities reported weekly declines and deferrals (e.g., no bed available, not meeting admission criteria) between April and July 2021. The third element was a short survey that facilities completed on each patient discharged during the collection timeframe (April – July 2021). The final element was qualitative and involved two focus groups with hospital and freestanding E&T leaders to better understand the quantitative data findings. The focus groups were conducted after each of the quantitative components were completed (August 2021). Each of the quantitative data collection elements were conducted via SurveyMonkey, and the focus groups were done via Zoom.

Tables and charts detailing the main findings in each of the project components are shown and explained throughout this report. Because of the small number of SWMS facilities, most results depict freestanding E&T and SMWS facilities together. All results described in this report are descriptive. Differences shown may not be statistically significant.

¹ [RCW 71.05.745](#) defines “single bed certification” (SBC).

KEY FINDINGS

The findings from the *WSHA Inpatient Behavioral Health Treatment Data Project* highlight the relationship and interconnection between inpatient admission and discharge placement, particularly for patients with complex conditions or behaviors, higher acuity, medical comorbidities and other specialized needs.

Key Findings

- **Diversity and variation exist across inpatient behavioral health facilities and facility types.** Not all inpatient beds are the same. Facilities vary in their facility design, building and IT infrastructure, treatment capacity and specializations, staffing, and other key facility-level characteristics (pp. 7-10).
- **Inpatient capacity is not meeting the current treatment demand,** particularly for specialized populations, such as patients with medical complexity; violent, aggressive or complex behaviors; or cognitive impairments/neurodiversity (pp. 11-17).
- **Patients with specialized treatment needs are often in the hospital longer** and are more difficult to discharge to safe, stable, long-term placements. Community discharge opportunities are limited. Placing patients with specialized and complex needs takes considerable time and resources for facilities (pp. 18-24).
- **Discharge challenges impact and influence inpatient capacity.** When patients are not able to transition back to the community (e.g., stable placements, outpatient services), this affects the facility's capacity and ability to admit other patients (pp. 23-24).
- **Limited access to outpatient services may impact the need for inpatient treatment.** When patients do not have timely access to outpatient and crisis services, patients often come to inpatient facilities experiencing more acute symptoms and may take additional time/resources to stabilize before discharge (pp. 16-17, 23-24).

"We currently have a patient who has been hospitalized for over two years ... for every patient that we have for two years, that's dozens of patients we could have treated in the community."

- Acute care hospital participant

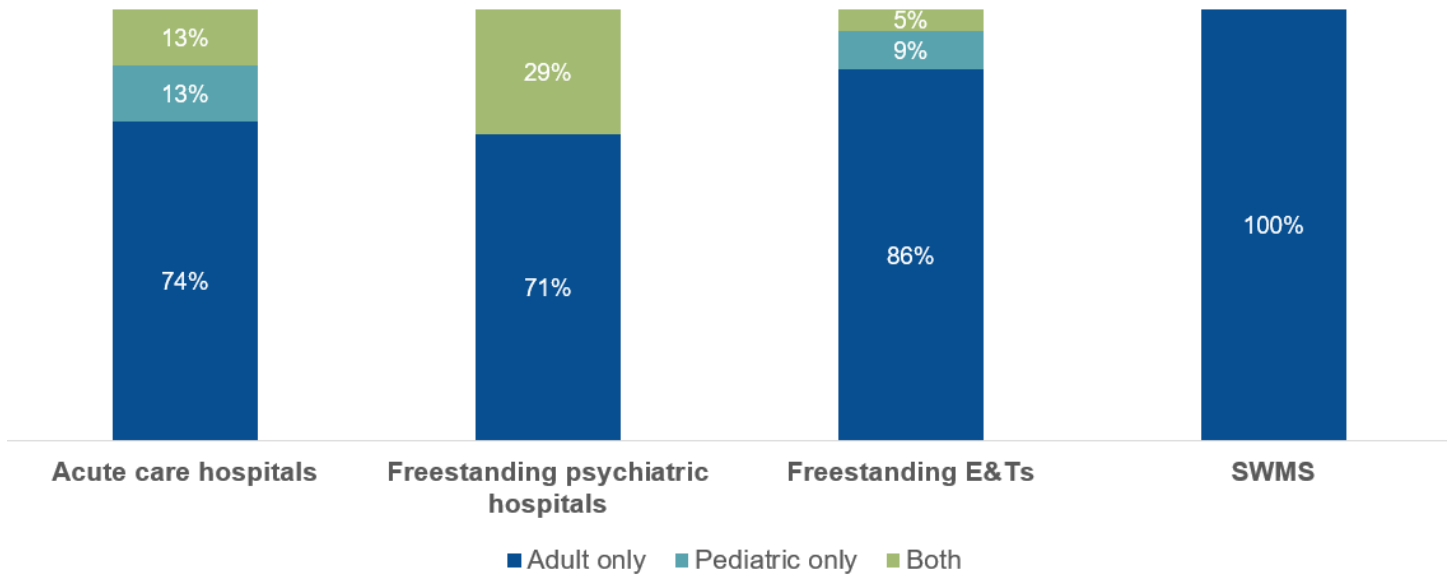
FACILITY CHARACTERISTICS

Inpatient Behavioral Health Facility Types

Acute Care Hospital	Freestanding Psychiatric Hospital	Freestanding Evaluation & Treatment (E&T) Center	Secure Withdrawal Management & Stabilization (SWMS) Facility
<ul style="list-style-type: none"> Hospital setting Medical services onsite Emergency department available Inpatient behavioral health unit(s) onsite Provide short and/or long-term mental health treatment/stabilization Accept SBC for acute or long-term treatment May be able to accept certain specialized populations Greater ability to accept medically complex patients 	<ul style="list-style-type: none"> All beds for behavioral health Limited medical services/staff No emergency department Provide short and/or long-term mental health treatment/stabilization May have voluntary SUD inpatient services Accept SBC for patients needing long-term treatment Limited psychiatric emergency/walk-in services available Limited ability to accept/care for specialized populations Not able to accept/care for medically complex patients 	<ul style="list-style-type: none"> Residential/community setting All beds for behavioral health Very limited medical services/staff No emergency department Provide short and/or long-term mental health treatment/stabilization May have SUD inpatient services onsite Limited ability to accept/care for specialized populations Not able to accept/care for medically complex patients 	<ul style="list-style-type: none"> Residential/community setting Provide medical withdrawal management/SUD treatment Limited medical services/staff Limited psychiatric care/services available Limited ability to accept/care for specialized populations Not able to accept/care for medically complex patients

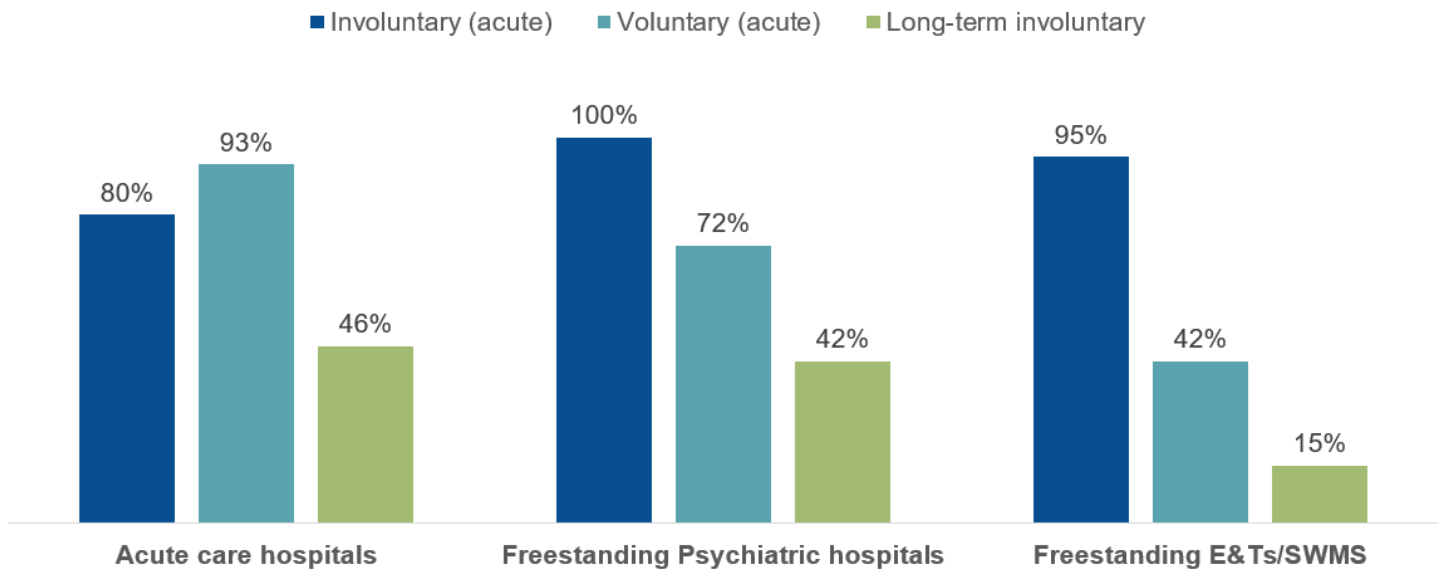
- 43 facilities providing inpatient behavioral health care participated in the facility survey. This included responses from 15 acute care hospitals with inpatient behavioral health units, seven freestanding psychiatric hospitals and 21 freestanding E&T/SWMS facilities.
- Diversity and variation exist across and within inpatient behavioral health facility types. Facilities vary greatly in their facility design, building and IT infrastructure, bed and treatment capacity, staffing availability and roles, and types of specialized patient needs for which they can care.
- Acute care hospital inpatient behavioral health units reported a greater ability to accept medically complex patients, whereas freestanding psychiatric hospitals, freestanding E&Ts, and SWMS facilities reported often not being able to accept or care for patients with complex or specialized medical needs.
- Inpatient behavioral health units in acute care hospitals are the only facility type with medical services and an emergency department onsite.
- Freestanding E&T and SWMS facilities are smaller (i.e., fewer inpatient beds) and based in community/residential settings compared with acute care and freestanding psychiatric hospitals.
- All facility types reported difficulty accepting and caring for patients with specialized needs (e.g., cognitive impairments, complex behaviors). Acute care hospital units reported a greater ability to accept certain specialized populations.

Percent of Facilities with Adult and Pediatric Beds



- Most participating facilities reported providing inpatient behavioral health treatment for adults only, although the percent of facilities differed by facility type.
- Freestanding psychiatric hospitals had the largest percentage of facilities providing inpatient care for both adult and pediatric patients.
- Very few inpatient behavioral health facilities provide care to only pediatric patients.

Percent of Facilities with Involuntary and Voluntary Beds

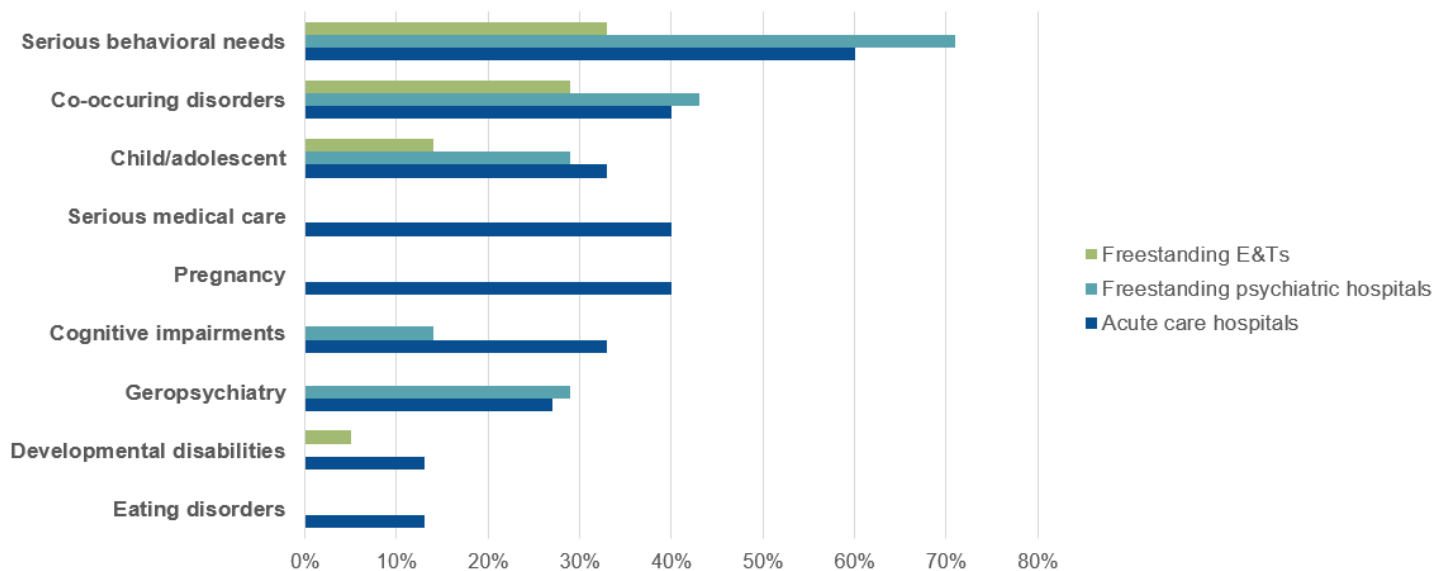


- Inpatient facilities participating in the survey varied in whether they provide involuntary treatment (acute), voluntary treatment and/or long-term involuntary treatment.²
- Most of the acute care hospitals with inpatient behavioral health units provide involuntary treatment (acute) and voluntary treatment. Less than half of these acute care hospitals provide long-term involuntary treatment.
- All freestanding psychiatric hospitals provide involuntary treatment (acute). Additionally, 72% of these facilities also provide voluntary treatment. Less than half of participating freestanding psychiatric hospitals offer long-term involuntary treatment.
- Approximately 95% of freestanding E&T/SWMS facilities offer involuntary treatment (acute). Only 42% of these facilities provide voluntary treatment. A small percentage (15%) of participating freestanding E&T/SWMS facilities reported providing long-term involuntary treatment.

² The percentage of facilities providing long-term involuntary care has changed since this survey was conducted in April 2021. These percentages may not reflect recent changes in the numbers of facilities certified to provide long-term involuntary treatment.

FACILITY CHARACTERISTICS

Percent of Facilities with Inpatient Specializations by Facility Type

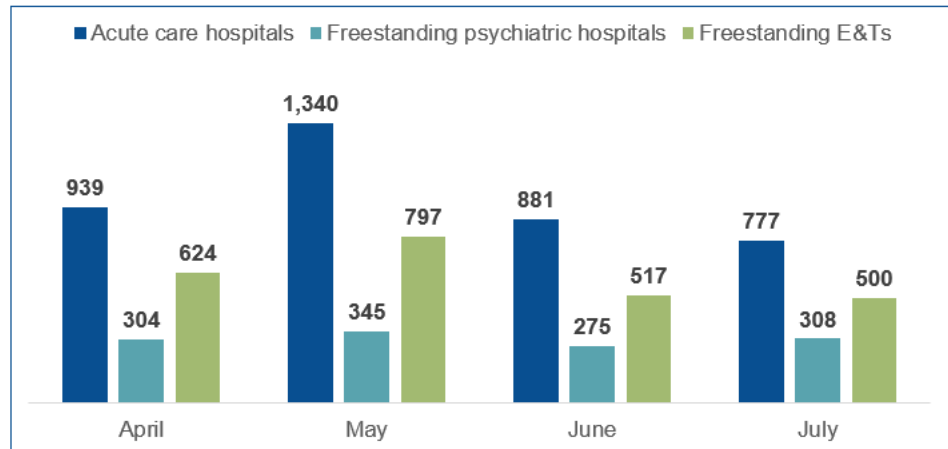


- While all facilities participating in the project reported providing general inpatient behavioral health treatment, many facilities also noted specific inpatient specializations.
- More than half of the acute care hospitals with inpatient behavioral health units and freestanding psychiatric hospitals reported an inpatient specialization for caring for patients with serious behavioral needs, compared with 33% of freestanding E&Ts.
- Around 30% to 40% of facilities in each facility type specialize in offering treatment for individuals with co-occurring disorders (i.e., mental health and substance use disorders).
- Only acute care hospitals reported medical specializations (e.g., caring for patients with serious medical problems, pregnancy, eating disorders). However, these specializations were still not very common, even among acute care hospitals.
- Few facilities reported inpatient specializations related to cognitive impairments, developmental disabilities and/or geropsychiatry.

DECLINES AND DEFERRALS RESULTS

Total Declines or Deferrals Reported by Month and Facility Type

Facility Type	N
Acute care hospital	3,937
Freestanding psychiatric hospital	1,232
Freestanding E&T	2,438
Total	7,607



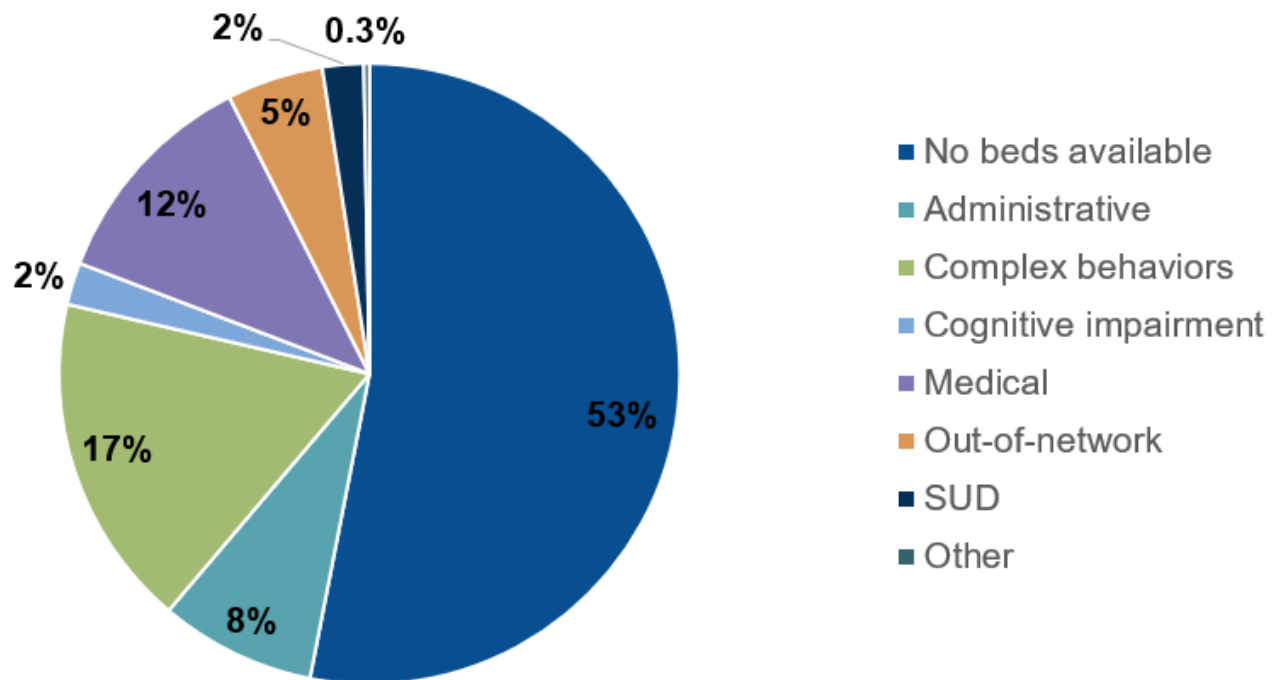
Participating facilities were asked to report their total number of weekly declines or deferrals (e.g., acute care facilities utilizing a wait list approach for their emergency department) for this project component. Data was collected from April to July 2021. For each decline or deferral reported, the facility was asked to select the “primary” reason (e.g., no bed available, not meeting criteria for admission) that the patient could not be admitted to the facility. The data collection tool included 30 prepopulated decline/deferral reasons and an “other” response where facilities could note a reason that was not already included.

Each of the decline/deferral responses fell into one of the following broad categories:

- No bed available in the facility
- Administrative (e.g., no involuntary bed available, staffing constraints, other placement found)
- Complex behaviors (e.g., current violence, disruptive behaviors, history of violence, patient in restraints)
- Medical
- Cognitive impairments/neurodiversity
- Substance use disorder
- Other (reason provided by facility)

The total number of declines/deferrals reported by month and facility type during the study period are depicted in the above charts.

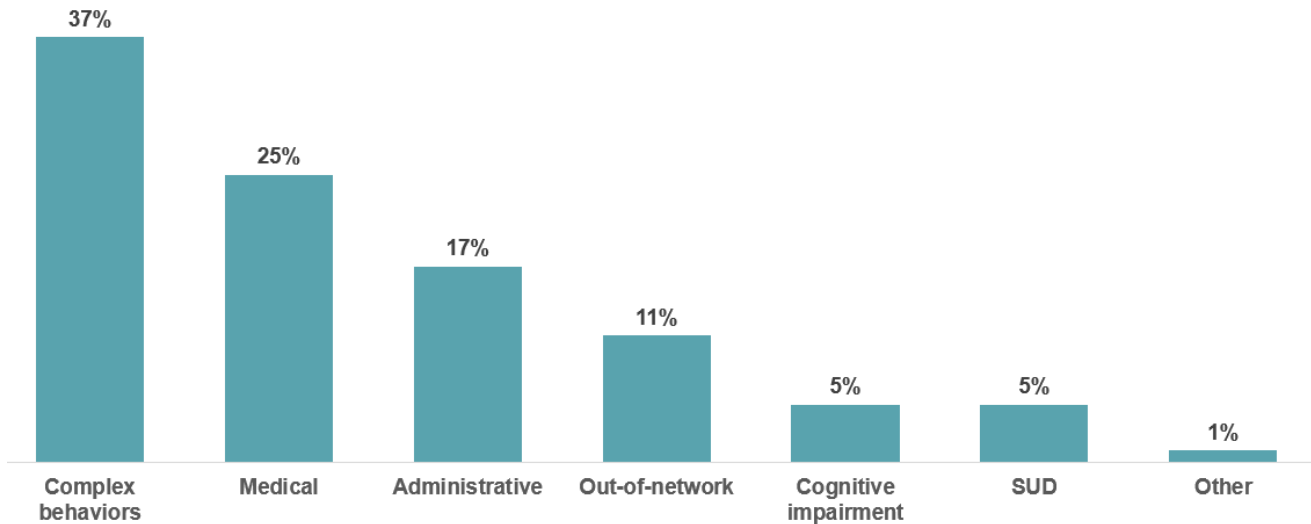
Percent Declines or Deferrals Across All Facilities



- More than half of the declines/deferrals reported were because the facility was full and there were no beds available.
- The complex behaviors (17%), medical (12%) and administrative (8%) categories were the next largest overall decline reasons.

DECLINES AND DEFERRALS RESULTS

Percent Declines by Category Across All Facilities with “No Beds” Removed



- This chart depicts the percentage of decline categories after removing the “no beds available” response (to better drill into decline reasons). Complex behaviors (37%) were the largest decline category. The primary decline reasons making up this category (ranked most to least frequent) included the following:
 1. Patient acuity (e.g., disruptive behaviors)
 2. Does not need inpatient-level care (e.g., will not benefit from psychiatric treatment)
 3. Currently in restraints
 4. Patient history of violence/assault
 5. Patient currently violent
 6. Sex offender history
- The medical category (25%) was the next largest decline group. Declines in this category involved the following responses (ranked most to least frequent):
 1. Serious medical comorbidities (not otherwise specified)
 2. No activities of daily living (ADL) independence (e.g., needs complete assistance bathing/eating)
 3. COVID-19 positive
 4. Needs 1:1 support
 5. Refusal to eat
 6. Needs two-person assist (e.g., for mobility, to transfer from bed or chair)
 7. Continuous positive airway pressure (CPAP) therapy needed
 8. Pregnancy
 9. Refusing labs
 10. Overweight/bariatric

DECLINES AND DEFERRALS RESULTS

- Administrative (17%) reasons were the next largest number of declines. These included individuals that were declined for any of the following reasons (ranked most to least frequent):
 1. Unit acuity/milieu
 2. Another placement found
 3. No involuntary acute beds available
 4. Staffing
 5. No long-term involuntary beds available
 6. No voluntary beds available
 7. Voluntary patient – not willing to participate in programming
 8. Age
 9. Gender
- 11% of patients were declined because their health insurance was out-of-network for the facility.
- Patients were also declined when a facility could not care for specialized needs related to cognitive impairments/neurodiversity (5%). This involved declines related to the following (in order of most to least frequent):
 1. Dementia
 2. Developmental disabilities
 3. Traumatic brain injury/neurocognitive disorders
 4. Autism spectrum disorder
- Declines related to substance use disorders (5%) primarily involved declines related to the following (in order of most to least frequent):
 1. Primary treatment need identified is substance use disorder (e.g., individual does not need psychiatric stabilization)
 2. Behavioral needs related to substance use that the facility cannot manage
 3. Methadone treatment needs that cannot be managed by facility

Unit Acuity and Milieu Management

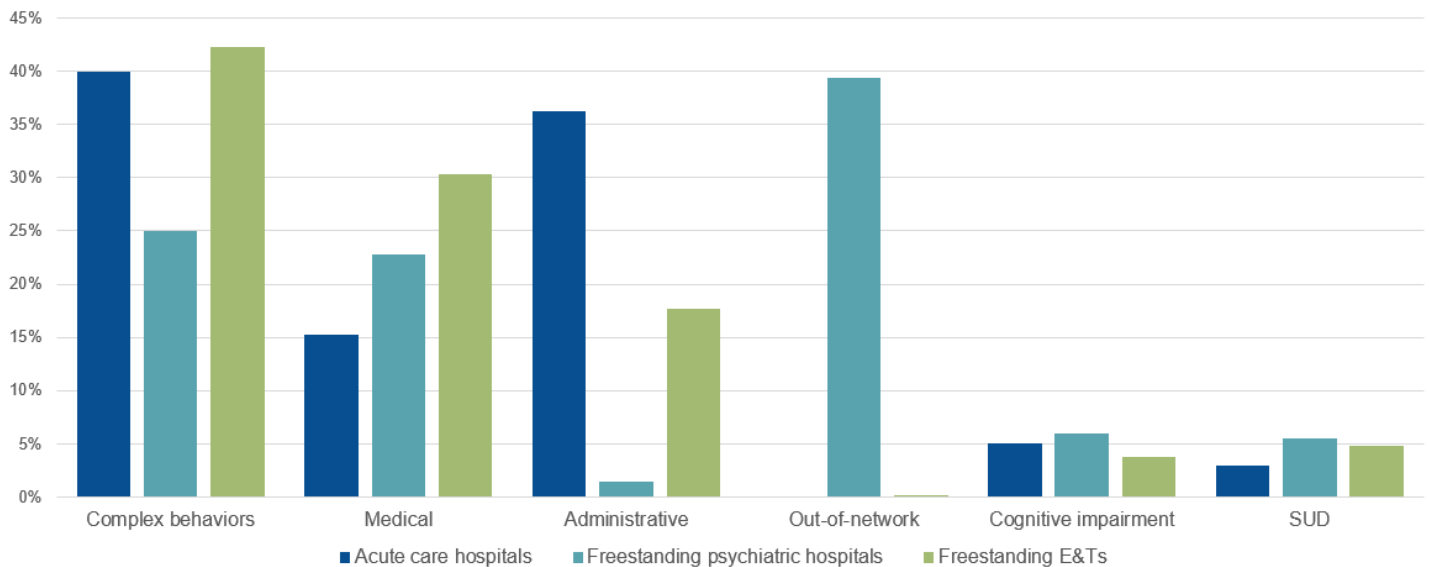
A primary treatment component in behavioral health inpatient care settings involves the unit milieu (e.g., mix of patients in the unit at any given time). It is important for facilities to manage the needs of patients across the unit, including acuity and complex behaviors. This may mean that if a facility already has multiple patients with higher acuity or complexity, the staff may not be able to admit additional higher acuity patients, even if there are available beds.

A volatile milieu can lead to a dangerous environment for an inpatient facility in that violence risk may increase for other patients and/or staff. This is problematic because patients often decompensate in an unstable milieu. Additionally, increased staffing may be needed as patient acuity rises, and not all facilities have adequate staffing models to accommodate this.

Milieu:
a person's social environment

DECLINES AND DEFERRALS RESULTS

Percent Declines by Category and Facility Type (“No Beds” Removed)



- The percent of declines, by category, differed by facility type.
- Nearly 40% of acute care hospital declines and over 40% of freestanding E&T declines were due to complex behaviors, compared with only a quarter of freestanding psychiatric hospital declines.
- Approximately 15% of acute care hospital declines were related to medical, compared with 30% of freestanding E&T declines and 23% of freestanding psychiatric hospital declines.
- Freestanding psychiatric hospitals had a smaller percentage of administrative declines, but more out-of-network declines.
- Each of the facility types had similar percentages of declines related to cognitive impairments/neurodiversity and substance use disorders.

What circumstances or patient presentations limit or disrupt your ability to admit or treat patients in your inpatient unit(s)?

During the focus groups, facility leader participants reported a variety of challenges that disrupt their ability to treat patients in inpatient behavioral health settings. Many of these elements overlap and intersect with each other and are related to facility design, staffing limitations or other system-level constraints. The major themes from the focus group data are represented below.

Theme 1: Present violence/aggressive behavior

- Facilities with already complex milieus reported challenges with admitting patients with present violence. Often this was related to staffing challenges (e.g., availability of staff, staff burnout and injury), safety concerns for other patients in a mixed milieu, the inability to adequately manage violent behaviors without appropriate resources and patients exhibiting forensic behaviors.
- Participants noted that accepting actively violent patients often necessitated the need for additional resources (e.g., staffing), which meant they were often not able to take any new patients.

Theme 2: Medical complexity

- Medical complexity was noted as a barrier to patients being admitted to inpatient behavioral health settings, although this differed somewhat by facility type. Acute care hospital participants noted more difficulty caring for certain types of medical conditions (e.g., eating disorders) that they felt could be better cared for in other hospital inpatient settings.
- Freestanding E&T participants reported not being able to admit patients with complex or specialized medical needs due to a lack of appropriate medical support (e.g., medical staff, building design) in the facility, along with liability concerns.

“[Medical complexity] is the number one reason we are not admitting someone ...”

- Freestanding E&T participant

Theme 3: Cognitive impairments/neurodiversity

- Safety challenges and concerns related to caring for patients in a mixed milieu were the primary barriers to admitting neurodiverse patients into inpatient behavioral health settings.
- Participants noted that caring for patients with cognitive impairments/neurodiversity involves specialty facility design, staff training and availability, and other care needs that are often not available in the facility. Even in facilities where there are design and/or staffing elements to address the needs of patients with these challenges, there is often such a high volume of patients in need that these programs cannot accommodate everyone.

“We need specialized units designed to care for [neurodiverse] patients ... with staff trained in this type of clinical care.”

- Acute care hospital participant

FOCUS GROUP RESPONSES

"...We end up with a mix of patient populations in the same unit that you wouldn't normally put on a mixed unit."

- Acute care hospital participant

Theme 4: Facility capacity and milieu management

- Facilities reported constraints with caring for patients with specialized treatment needs often due to facility capacity and milieu management. Admitting patients with higher acuity and/or treatment needs often limited the facility's ability to admit additional patients. Further, participants noted that safety concerns for patients and staff are a key consideration with milieu management.
- Facility capacity and milieu management are interconnected with other admission challenges noted by participants (e.g., patient violence, complex behaviors, staffing).

Theme 5: Staffing constraints and obstacles

- Facility leaders described staffing as a significant challenge to admitting and treating patients in inpatient behavioral health settings. Staffing barriers and obstacles differed by facility type, region and size of facility.
- Key staffing obstacles included turnover and difficulty retaining staff. Participants noted that this was often related to staff being assaulted by patients, facilities not being able to pay competitive wages, staff burnout and compassion fatigue, and moral injury.
- Staffing constraints can lead to reduced facility capacity, according to focus group participants. For example, a facility may have to take beds off-line if they do not have enough staff.

"We don't have staff who are specially trained in caring for these patients [e.g., patients with cognitive impairments]. We don't have an environment designed for patients who are sensitive to stimuli. So, it's in many ways not conducive to their healing, and yet we cannot place them."

- Acute care hospital participant

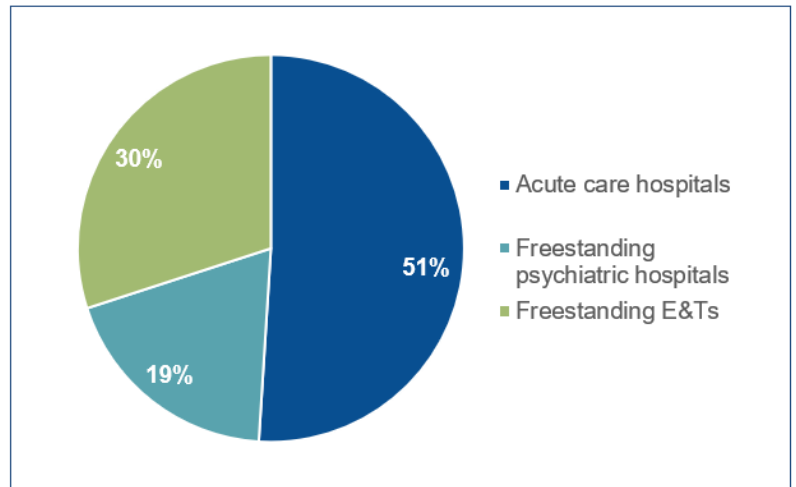
Theme 6: Psychiatric complexity increasing

- Facility leaders reported that psychiatric complexity—higher acuity patients and milieus—often plays a role in whether they can admit a patient at any given time. All focus group participants discussed how patient acuity and severity of symptoms has increased across their patient populations. They noted that it may be, in part, due to decreased outpatient services/supports.
- Psychiatric complexity, according to participants, impacts a facility's ability to admit new patients. It was also discussed as a barrier to discharge.

DISCHARGE AND LENGTH OF STAY RESULTS

Discharge Data Records by Month and Facility Type

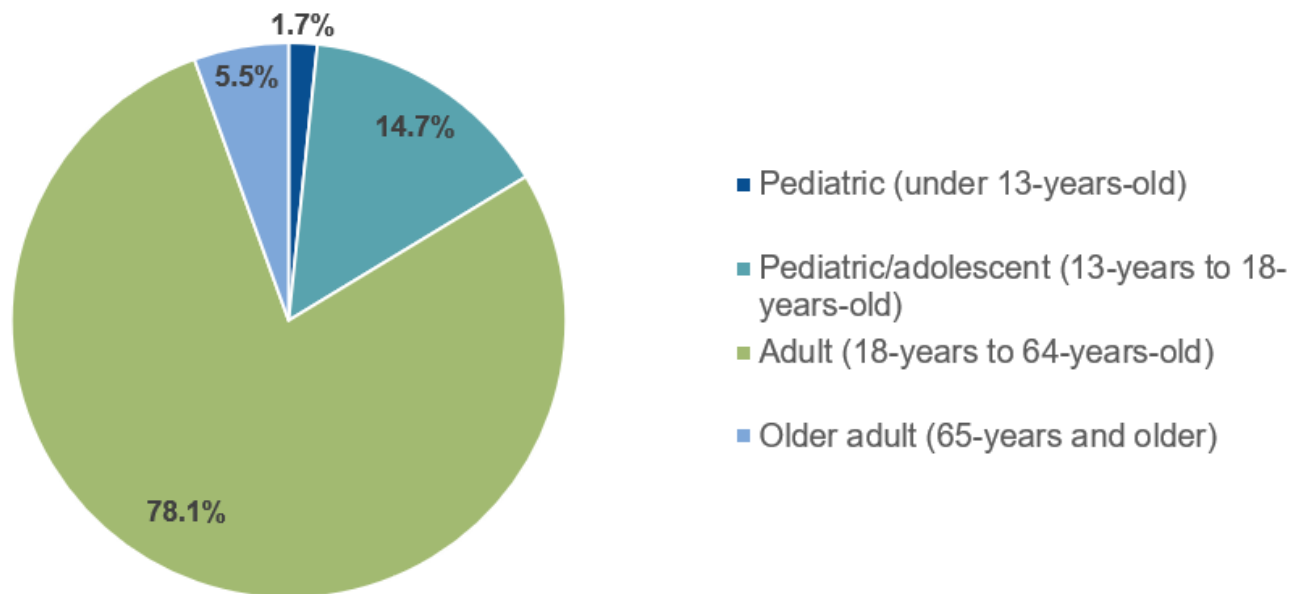
Discharge Month	# Discharges Reported
April	870
May	1,055
June	1,116
July	656



Participating facilities were asked to complete a short survey for each patient discharged from their facility during the data collection period (April-July 2021). Questions addressed the following patient characteristics: discharge date, length of stay, age range, legal status, discharge location, and any obstacles or barriers encountered during discharge.

- More than 3,600 patient discharges are included in the analysis.
- More than half of the records were acute care hospital discharges. Freestanding E&T facilities and freestanding psychiatric hospitals comprised the other half of discharge records.

Percent of Patients Discharged by Age Range

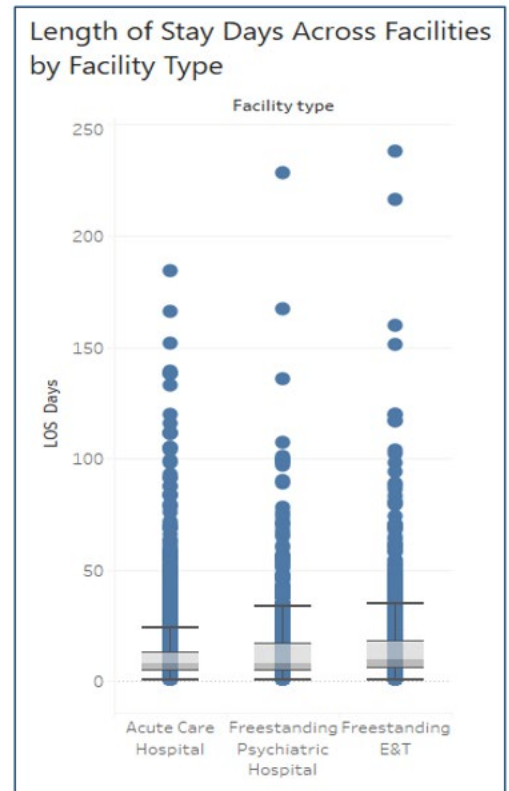


- A majority of discharges were adult patients (18-years to 64-years-old).
- Nearly 15% of discharges were pediatric/adolescent patients (13-years to 18-years old). Only 2% of records were pediatric (under 13-years-old).
- Older adult discharges represent 6% of records.

DISCHARGE AND LENGTH OF STAY RESULTS

Average Length of Stay by Facility Type

Facility Type	# of Discharges	Average LOS
Acute care hospitals	1,866	14
Freestanding psychiatric hospitals	719	15
Freestanding E&Ts	1,112	15



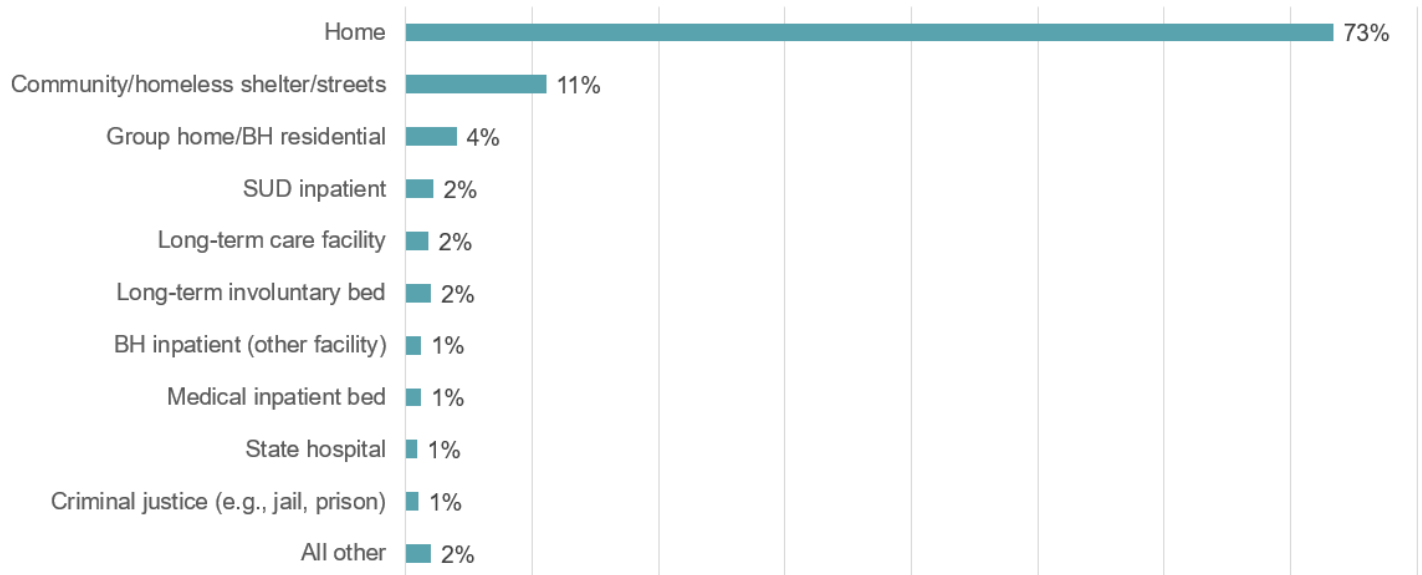
- The average length of stay (“LOS”) for acute care hospitals in the analysis was 14 days. The freestanding psychiatric hospital and freestanding E&T facility average length of stay was 15 days. Considerable variation was evident for individual patient length of stay days, however, with many patients—across all three facility types—having a length of stay well beyond 14-15 days.³
- A majority of acute care hospital patients had a length of stay between 1-100 days, although there were a handful of patients with lengths of stay between 100-200 days.
- Most discharges from freestanding psychiatric hospitals in this analysis were between 1-80 days, although some patients had much longer lengths of stay, between 100-225 days.
- Variation was also present in freestanding E&T discharges. Most patients had a LOS between 1-120 days, but there were also outlier patient length of stay days, stretching to almost 250.⁴

³ Numbers represented in the charts include a small percentage (approximately 2% of records) of patients on long-term involuntary holds (typically 90 or 180-days).

⁴ Six patients with a length of stay beyond 250 days were trimmed from the chart represented here.

DISCHARGE AND LENGTH OF STAY RESULTS

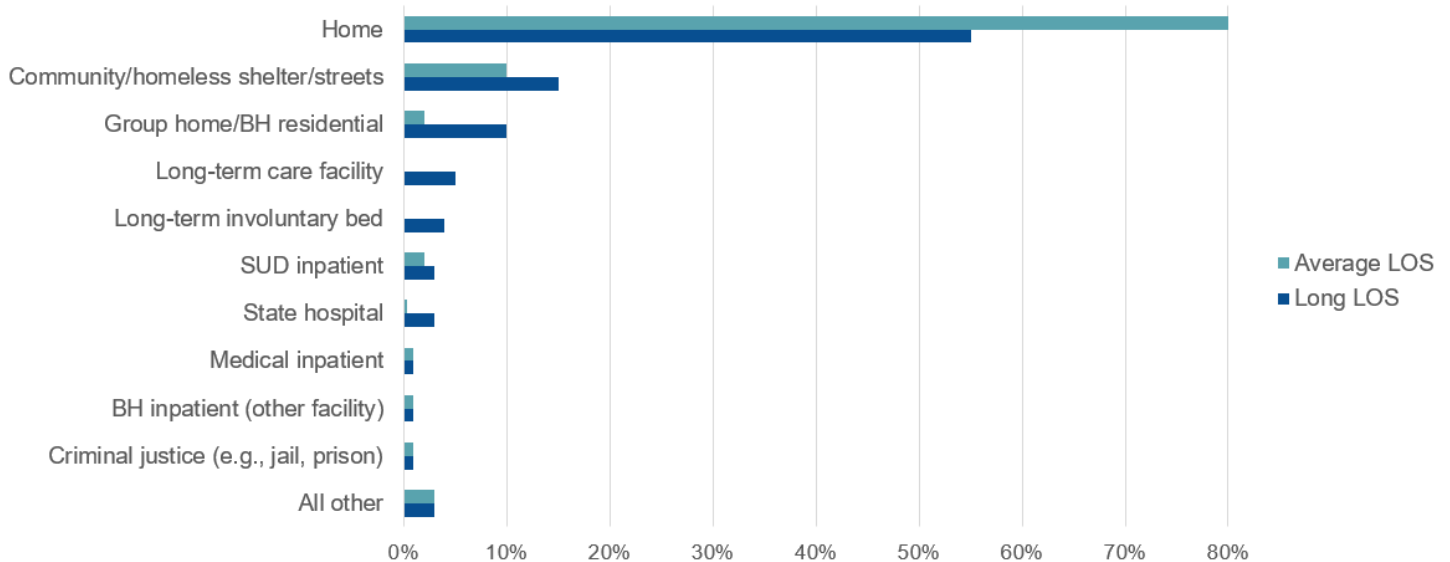
Percent of Discharges by Location Across All Facilities



- A majority of patients were discharged to home (includes discharges to a family member or friend).
- Approximately 11% of discharges were to homelessness (includes homeless shelters).
- About 4% of patients were discharged to a residential treatment facility (e.g., group home).
- All other discharge locations, including “other” (e.g., another state, Children’s Long-term Inpatient Program, Department of Children, Youth, and Families) comprised approximately 1-2% of patient records for each category.

DISCHARGE AND LENGTH OF STAY RESULTS

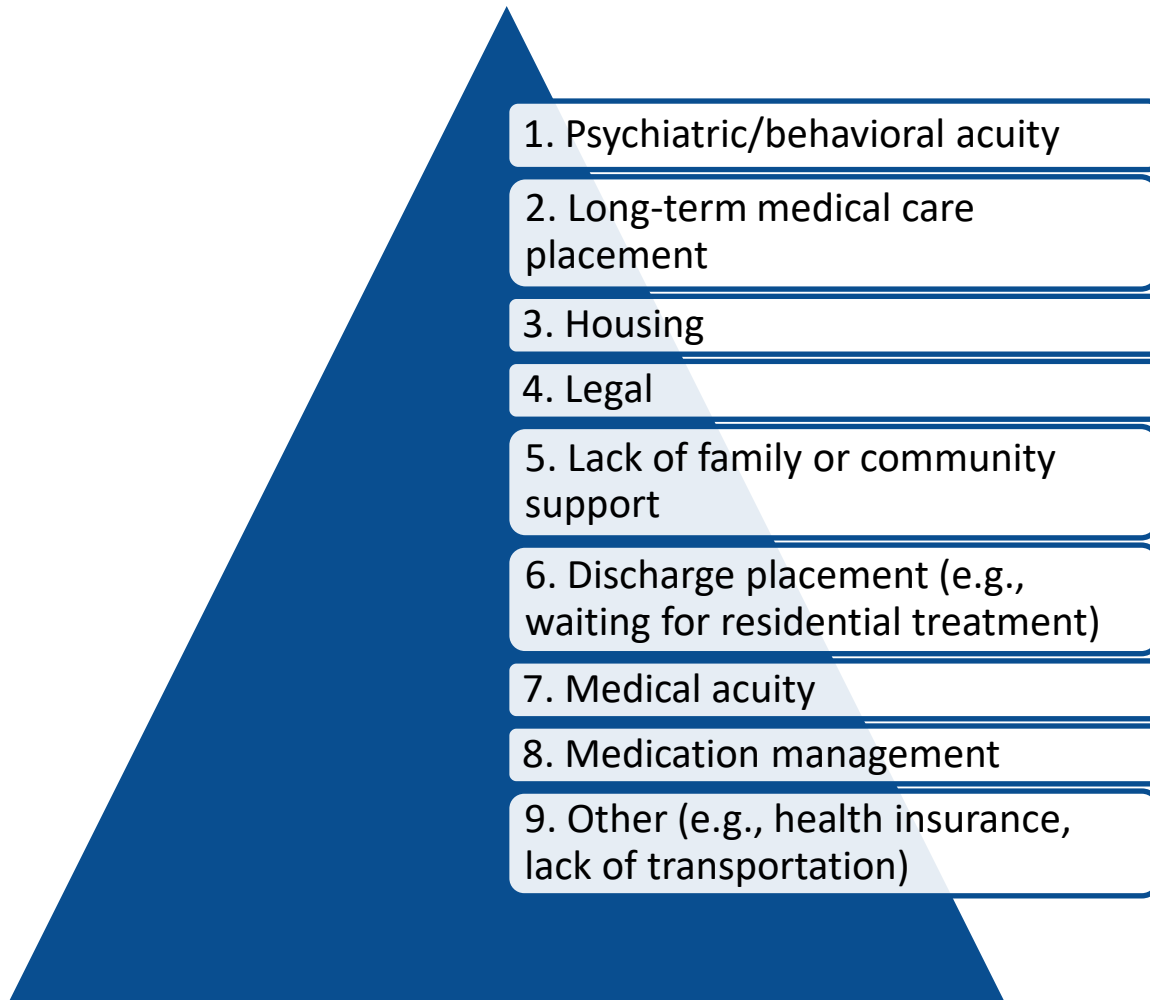
Percent of Discharges Across All Facilities, Including Long Length of Stay



To better understand the relationship between discharge location and length of stay, a “long LOS” variable was created. The “long LOS” variable included patient length of stays beyond expected treatment range/duration for different admission types (e.g., acute LOS > 28 days; long-term involuntary > 90 or 180 days). This was compared to other patient records with lower-to-average LOS days.

- A majority of patients with “average LOS” and “long LOS” were discharged to home (includes discharges to a family member or friend). However, 25% fewer patients with a long length of stay were discharged to home.
- More patients with a long length of stay were discharged to homelessness, suggesting that facilities experienced challenges or barriers with locating stable, long-term housing, and this was the only discharge option due to patient, court or other constraints.
- A higher percentage of patients discharged to residential treatment facilities, like behavioral health group homes, experienced a long length of stay. Similarly, a greater percentage of patients with a long length of stay were discharged to a substance use treatment facility.
- Patients discharged to long-term care services (e.g., medical long-term care facility, long-term involuntary bed, state hospital) were almost universally patients with a long length of stay.
- Other discharge categories, like medical inpatient, behavioral health facility transfer, criminal justice involvement, and all other, comprised similar percent discharges by length of stay.

Discharge Obstacles Among Patients with a Long Length of Stay (in rank order)



Inpatient facilities encountered multiple obstacles in securing appropriate discharge placements for patients. This figure highlights the most common obstacles that facilities experienced in placing patients with a longer length of stay. Common obstacles involved barriers related to:

- Specific patient characteristics (e.g., psychiatric/behavioral acuity, medical acuity) or needs (e.g., medication management, legal).
- Limited supportive housing resources, particularly those involving specialized facility placements (e.g., long-term medical care placement, waiting for a residential treatment bed).
- Other challenges included fewer outpatient and step-down services/supports available in the community, health insurance and transportation barriers, and limited family involvement.

What obstacles does your facility experience surrounding discharge placement and length of stay?

In the focus groups, inpatient facility leaders described a broad range of obstacles they experience surrounding discharge transitions. They discussed limited step-down behavioral health services and supports available in the community to assist patients after they have been discharged. Participants noted insufficient community placements for patients needing supportive housing or long-term treatment and long wait times, administrative barriers, and other constraints accessing available resources. They also discussed payer and transportation needs. The participants described unique challenges associated with discharging patients with specialized needs (e.g., medical complexity, psychiatric acuity, cognitive impairments).

"[The process to place patients in adult family homes] currently takes weeks or months, where it used to be much less than that...so that has created a huge barrier for us."

- Acute care hospital participant

"Many of our patients need to go to some sort of assisted living facility, a group home, something like that, for which they need Home and Community Service involvement [i.e., long waits]."

- Freestanding E&T participant

"We have nine patients who are waiting for residential treatment and have been on our unit for more than three weeks."

- Acute care hospital participant

"From a regulatory standpoint we are caught between a rock and a hard place because we are admonished to provide a safe discharge plan, and yet often there is not a match that would be a safe discharge plan...they may not need further hospitalization but [the] level of next steps are often not available."

- Freestanding E&T participant

POLICY AREAS OF OPPORTUNITY

The findings from the *WSHA Inpatient Behavioral Health Treatment Data Project* suggest important policy opportunities for behavioral health system improvement. Key areas include the following:

- Increasing **inpatient capacity for patients with specialized needs**, including patients with complex and violent behaviors, medical complexity and neurodiversity (e.g., developmental disabilities, dementia).
- Building out **step-down services and supports for patients leaving inpatient treatment settings**. This may include investments in partial hospitalization, intensive outpatient programs, psychiatric and medical respites, or other resources to facilitate successful discharges and help individuals reintegrate into the community.
- Strengthening **outpatient community behavioral health and crisis diversion resources** to support individuals in the community and prevent unnecessary emergency department visits and behavioral health hospitalizations.
- Increasing **community long-term supports and supportive housing capacity**, particularly for patients with violent behaviors, greater psychiatric acuity and complex medical needs.
- Continued investment in and support of the **behavioral health workforce**.

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