2018 Behavioral Health Capital Funding Prioritization and Feasibility Study

Prepared for Washington State Office of Financial Management

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1. Executive Summary

Purpose and Scope

The Washington State Office of Financial Management contracted with Public Consulting Group, Inc. to establish a Behavioral Health Statewide Plan, as required by Section 1022 of the 2018 supplemental capital budget (Chapter 298, Laws of 2018). The plan must "inform future grant allocations by assessing and prioritizing facility needs and gaps in the behavioral health continuum of care." The proviso defines the following four key tasks as the major components of the plan:

- Assessment of current continuum of care in each region of the state
- Prioritization of facility type by geographic region
- Distribution method to guide Department of Commerce grant allocations
- Feasibility of establishing state-operated, community-based mental health hospitals

As an end goal of this funding allocation plan, each region of the state should support the full continuum of care for behavioral health consumers.

This report covers all four proviso tasks. Section 8 provides the feasibility study for state-operated, community-based mental health hospitals, which was completed as a separate workstream.

Current and Planned Bed Counts

Based on data obtained from the Washington State Department of Social and Health Services Research and Data Analysis division and confirmed with several stakeholders, Table 1 identifies the current and planned bed count for the ten facility types defined by the budget proviso across all regions.

Key Findings

- Community hospital and residential treatment beds show the widest variation region by region, while freestanding evaluation and treatment beds are more evenly distributed.
- Each region has some form of crisis beds available. However, Greater Columbia is the only region that has more than one type of crisis bed.
- Eastern and western regions of the state are each currently served by one secure withdrawal management and stabilization facility and one enhanced service facility.

Table 1. Current and Planned Bed Count by Region and Category

Region	Community Hospitals	Freestanding Evaluation and Treatment	Enhanced Service Facility	Triage Facility	Crisis Stabilization	Crisis Walk-in	Crisis Respite	Residential Treatment Facility	Supportive Housing	Secure Withdrawal Management and Stabilization	Regional Totals
Great Rivers	22	16	0	0	32	0	18	14	301	24	427
Greater Columbia	56	32	0	24	0	0	16	18	826	1	973
King	449	46	48	0	0	0	39	136	5,767	0	6,485
North Central	0	0	0	16	0	0	10	8	159	0	193
North Sound	204	48	16	21	0	0	0	76	2,133	8	2,506
Pierce	31	48	0	16	32	0	0	135	897	0	1,159
Salish	4	42	0	16	0	0	6	48	417	0	533
Spokane	70	48	24	16	32	0	0	155	808	24	1,177
SW WA	14	11	12	22	16	0	4	28	465	16	588
Thurston-Mason	18	25	0	0	0	0	10	16	139	0	208
Total	868	316	100	131	112	0	103	634	11,912	73	14,249

Stakeholder Perspective

To provide context for the quantitative data described above, Public Consulting Group interviewed providers, advocates, behavioral health organizations, managed care organizations and state agency representatives. The Office of Financial Management worked with the Department of Social and Health Services, Health Care Authority and the Department of Commerce to identify individual contacts within these stakeholder categories.

Key Findings

- Increased property and rent values have exacerbated the need for affordable, supportive housing options. For individuals living with behavioral health conditions, housing is key to stability and continued recovery. However, shelters can be triggering for individuals with serious mental illness, and most do not accept individuals who are current substance users. Many of the individuals we interviewed voiced support for additional Housing First model facilities, which do not require sobriety as a condition of admittance. Additionally, stakeholders pointed to the absence of residential facilities that can provide an intermediate level of care. Such facilities play a critical role in the care continuum, supporting safe discharge from inpatient settings as well as preventing decompensation that leads to inpatient utilization.

- Geriatric and pediatric populations are universally underserved, with respect to both the available workforce and appropriate facilities. For the geropsychiatric population, Medicare coverage does not reimburse for some facility types, which impacts provider sustainability. Stakeholders emphasized the need for residential facilities to care for geropsychiatric cases and individuals with dementia. Although this report focuses on adult facilities, all specialty care for children and adolescents is notably lacking.

- HB 1713, commonly referred to as Ricky's Law, integrates substance use disorders in the Involuntary Treatment Act. As a result, RCW 71.05.153 was modified to allow any designated crisis responder to take a person into emergency custody in a secure detoxification facility or approved substance use disorder treatment program for not more than 72 hours as described in RCW 71.05.180, if a secure detoxification facility or approved substance use disorder treatment program is available and has adequate space for the person." Stakeholders commented that development of the facility types described by Ricky's Law has been slow and urged prioritization of these facilities for capital investment.

- Resources are sparse in the rural and remote areas of the state. Different care models that significantly integrate services, including health and social services, may help maximize the utility of current resources and infrastructure. Stakeholders also suggest that locating services on rural county borders may be an efficient approach to serving areas with few people.

Regional Gap Analysis

Given the limitations in available benchmarks, Public Consulting Group grouped the proviso bed types into five general categories: residential services, crisis services, secure withdrawal management and stabilization, inpatient and supportive housing. Residential services include bed counts from enhanced service facilities and residential treatment facilities. Crisis services include beds from triage

facilities, crisis stabilization, and crisis respite. Inpatient beds were defined as psychiatric beds in community hospitals and freestanding evaluation and treatment facilities. Because secure withdrawal management and stabilization facilities are a legislatively mandated specialty facility, this bed type is addressed independently. Lastly, supportive housing included all units in permanent supportive housing facilities.

Public Consulting Group completed two comparative analyses to determine an appropriate target bed count for the first four bed categories. The first analysis compared per capita inpatient and "residential and other 24-hour services" bed counts reported for Colorado, Illinois, Massachusetts, Minnesota and Oregon to per capita bed counts for Washington.[1] The second analysis compared regions within Washington, distributing the target bed count for the "residential and other 24-hour services" category across residential, crisis and secure withdrawal management and stabilization beds based on their current average distribution across the state. The final analysis applied the U.S. Department of Housing and Urban Development's Homeless Assistance Programs Calculating Unmet Need for Homeless Individuals and Housing.[2] The report provides the methodology to calculate unmet need for permanent supportive housing.

Key Findings

- The average per capita "residential and other 24-hour services" bed count for the states identified above is 13 beds/100,000 population higher than that of Washington. The gap for inpatient beds is slightly smaller at 7 beds/100,000 population.
- Folding in the regional comparison within Washington, the statewide gap to target is relatively uniform across residential, crisis and inpatient bed types, as illustrated in Table 2. King County shows the largest total gap to target, followed by North Sound and Greater Columbia. Spokane shows the smallest total gap to target.
- The housing methodology yielded an unmet need of 228 beds per 100,000 population.

Table 2. Total Gap to Target by Bed Category

	Care Continuum Category	Target Bed Count	Current Bed Count	Gap	Total Need
Statewide	Residential	1,163	734	429	1,538
	Crisis Services	808	346	462	
	Secure Withdrawal Management and Stabilization	197	73	124	
	Inpatient	1,707	1,184	523	

Recommended Allocation Plan

Public Consulting Group conducted an intraregional analysis to prioritize funding need based on:

1. the gap to target for bed counts within each region
2. stakeholder input on community-identified priorities

[1] National Association of State Mental Health Program Directors August 2017 Trend in Psychiatric Inpatient Capacity, United States and Each State, 1970 to 2014 report.
[2] https://www.hudexchange.info/resources/documents/CalculatingUnmetNeed_December2011.pdf

The funding plan organizes these priorities across five years of state funding. These target numbers are intended to provide a baseline understanding of how Washington can fill gaps in its care continuum across the state, bridging regional disparities in access to specific bed types.

Broadly, the plan initiates capacity building for the highest priority areas in year one and lowest priority areas in years four and five. Priorities are scheduled across the five years to add a roughly similar number of beds each year in different regions. Due to the large raw number of permanent supportive housing beds projected across the state, capacity building for housing in several regions is spread across multiple years.

Table 3 illustrates the distribution of capital needs by year, region and bed type. In years four and five, several categories are marked "TBD." These categories were ranked as the lowest priority based on current bed capacity and were not specifically identified by stakeholder as a priority. However, given the significant and varied development efforts targeted for years one through three, the actual need in these categories and regions will likely change over time. To address this uncertainty, we have not indicated zero beds or a negative result in any area of the plan. Those areas are instead marked TBD to indicate that the need should be reevaluated following completion of initial development efforts.

Table 3. Funding Priorities by Calendar Year

	Bed Types	CY19	CY20	CY21	CY22	CY23
Great Rivers	Residential			31		
	Crisis Services					TBD
	Secure Withdrawal Management and Stabilization				TBD	
	Inpatient			27		
	Housing		293			
Greater Columbia	Residential		96			
	Crisis Services				39	
	Secure Withdrawal Management and Stabilization		18			
	Inpatient				79	
	Housing	929				
King	Residential			160		
	Crisis Services		200			
	Secure Withdrawal Management and Stabilization	58				
	Inpatient					10
	Housing			8,728		

	Bed Types	CY19	CY20	CY21	CY22	CY23
North Central	Residential		32			
	Crisis Services				2	
	Secure Withdrawal Management and Stabilization	7				
	Inpatient	59				
	Housing					70
North Sound	Residential			104		
	Crisis Services				115	
	Secure Withdrawal Management and Stabilization		25			
	Inpatient					36
	Housing	3,052				
Pierce	Residential					3
	Crisis Services				48	
	Secure Withdrawal Management and Stabilization	23				
	Inpatient				123	
	Housing				1,313	
Salish	Residential			10		
	Crisis Services			19		
	Secure Withdrawal Management and Stabilization	10				
	Inpatient			40		
	Housing			526		
Spokane	Residential				TBD	
	Crisis Services			18		
	Secure Withdrawal Management and Stabilization					TBD
	Inpatient					21
	Housing				1,110	
SW WA	Residential				40	
	Crisis Services			13		
	Secure Withdrawal Management				TBD	

	Bed Types	CY19	CY20	CY21	CY22	CY23
	and Stabilization					
	Inpatient		92			
	Housing			709		
Thurston-Mason	Residential			38		
	Crisis Services		28			
	Secure Withdrawal Management and Stabilization	9				
	Inpatient				36	
	Housing			155		

Feasibility Study

In addition to the funding allocation plan described above, Public Consulting Group analyzed the feasibility of establishing state-owned, community-based mental health facilities through a two-pronged approach, focusing on the costs of building and operating a facility as well as the administrative and regulatory challenges such facilities must face.

Cost Estimates

Start-up costs were determined using RS Means Data Online, a software tool that provides estimates for materials and labor for the construction of a new hospital facility. To create a size estimate for a facility, Public Consulting Group calculated the average size of nine existing evaluation and treatment centers then added square footage to account for additional office and direct care space for a total estimate of 17,500 square feet. RS Means construction costs for facilities in ten major cities across Washington were averaged to form a baseline cost estimate for a state-owned, community-based facility.

Public Consulting Group then explored multiple methods to determine the costs of operating a 16-bed evaluation and treatment facility. Efforts to determine operational costs included requests to state executive department officials for any operating cost data maintained by the state. As the state does not directly pay for the operations of these facilities, and such cost reporting is not legally mandated, the state does not have data that directly tracks operational costs for these facilities.

Public Consulting Group then engaged the Washington State Council for Behavioral Health to determine if any member organizations would be open to sharing operational cost data in any form. Telecare Behavioral Health and Compass Health agreed to provide summary operational cost estimates for this report.

<u>Key Findings</u>

- Start-up costs averaged $7.2 million for a 16-bed facility, or $414 per square foot.
- The size and location of the facility significantly affects the construction cost. The most expensive location in which to build a 17,500 square-foot facility is Seattle, at $7,584,305. The most affordable location is Spokane at $6,794,331.

- Operating costs for the two facilities available for this analysis range from $3.6 million to $4.9 million annually.
- Operating costs vary based on prevailing wage in the chosen location, scope of services provided, age of the facility and other factors. Thus, the state's actual costs will vary based on location, capital amortization requirements, staffing levels, and type of services provided.

Administration, Operation and Regulation

Public Consulting Group also compared administration and operational requirements of a new facility to serve 90- and 180-day commitments to the current models for state hospitals and evaluation and treatment facility. The new facility will serve the population now served by the state hospitals, but in a smaller community setting that shares similarities to evaluation and treatment facilities. This analysis included reflection on stakeholder input.

Key Findings

- Stakeholders advised that any new facility serving 90 and 180-day commitments must account for the significant physical health needs of this population, many of whom have co-occurring medical conditions. Individuals who are referred to an evaluation and treatment facility today must be medically cleared before admission. This process is typically carried out in an emergency department. For those requiring commitment, receiving clearance in a busy ED, followed by transfer to a separate facility, amplifies the trauma of the commitment process.
- Washington's provider community is concerned about the resources required to manage and staff enough facilities to serve the entire population in need. Some stakeholders noted that the smaller facility is the most appropriate model of care but acknowledged that it will significantly increase the funding required to serve committed individuals.
- Support for state-owned facilities that contract for clinical program operation was widely noted during our interviews. Stakeholders expressed concern that the state hospitals' current challenges would carry over to smaller facilities. For example, team-based care models are not fully supported by the job classifications now used in the state hospitals. Stakeholders also emphasized the advantages of contracting for services, including the use of quality measures and the opportunity to re-procure if clinical and quality standards are not met.

2. Introduction

2.1. Purpose of the Study

The Washington State Office of Financial Management contracted with Public Consulting Group, Inc. to assess the state's adult behavioral health care continuum across various bed and facility types, prioritize behavioral health facility type by geographic region, create a systematic method to distribute resources across geographical regions, and conduct a feasibility assessment for establishing state-operated, community-based mental health facilities as required by Section 1022 of the 2018 supplemental capital budget (Chapter 298, Laws of 2018). This study represents one part of an ongoing, multi-faceted effort to improve community access for patients served by Washington's behavioral health system.

2.2. Purpose of this Report

This report analyzes the current adult community behavioral health capacity in Washington's behavioral health system and provides recommendations for increasing capacity in ten state-defined regions across Washington. Public Consulting Group's analysis of Washington's current capacity combines quantitative facility data with input from stakeholders representing varying needs and perspectives. Stakeholder input, supported by quantitative data, provides a first-hand perspective on the gaps in the continuum of care throughout the State. Data from other states served as a benchmark for comparing community behavioral health capacity in Washington. States with similar infrastructures and populations were chosen to provide context for our evaluation – recognizing commonalities to evaluate strategies for recommended bed counts per region.

The feasibility study portion of this report examines both the baseline cost and other non-financial factors that should be considered in the decision to move forward with community-based facilities for 90- and 180-day civil commitments.

3. Capital Planning Approach

3.1. Summary of Approach

To efficiently process the data sources required for this analysis, our approach required three work streams. Table 4 below summarizes data collection and analysis processes, as well as any applicable limitations, for each work stream.

Table 4. Work Streams for Data Analysis

Work Stream	Process
Quantitative Data Analysis	• Confirmed with the State data points required to accurately describe Washington's current adult community behavioral health facilities and bed types by region. • Reviewed data request with the State on June 21, 2018. • Processed data received and conducted follow up with identified sources as needed. • Incorporated additional data from the following sources into the analysis: o National Association of State Mental Health Program Directors o Substance Abuse and Mental Health Services Administration (SAMHSA) o The Department of Housing and Urban Development o Washington State 2018 Housing Inventory Count from Homelessness Data Exchange
Peer State Analysis	• Identified and confirmed five states for inclusion: Colorado, Illinois, Massachusetts, Minnesota and Oregon. o These states were used in Public Consulting Group's 2016 Initial Findings Report on Washington's Behavioral Health System. o Colorado and Oregon represent similar geographies and populations. o Minnesota offers best practices at a comparable per capita spend. o Massachusetts is a highly ranked state nationally, but also struggles with community resource availability. o Illinois' system is similarly structured around large inpatient hospitals. • These states were used as benchmarks for community bed capacity based on data obtained from the National Association of State Mental Health Program Directors and SAMHSA.
Stakeholder Input	• Conducted stakeholder interviews from July 13 – 27, 2018. • Contacted 35 organizations and agencies to request participation. • Reviewed input, identifying major themes and conflicting views.

Work stream leads circulated their analyses with the entire team and project management staff to foster mutual understanding of the challenges and potential findings across all data sources. Additional information regarding the regions used in this report is provided in Appendix A.

3.2. Limitations, Considerations & Key Assumptions

In its October 2017 report, "Beyond Beds, the Vital Role of a Full Continuum of Psychiatric Care",[3] the National Association of State Mental Health Program Directors discussed the difficulties in determining the "correct" number or type of behavioral health beds in a given geographic region. The report notes that "no government agency publishes a comprehensive national census that includes all categories of available mental health beds – child/adolescent, adult and geriatric, forensic, public and private, crisis and rehabilitation, mental health and substance abuse, and all others that serve patients with behavioral health conditions. No evidence-based target number exists for how many psychiatric beds are needed at each level of care, either in the United States or elsewhere."

Without completing a comprehensive community needs assessment across the state, this lack of an evidence-based target number makes providing a suggested number of beds for Washington challenging.

Thus, the future state totals provided in this report represent targets based on peer state data and the current distribution of beds in Washington with the goals of:

1. Ensuring that the continuum of behavioral health facilities and bed types is accessible in each region of the state.
2. Mitigating regional disparities in the availability of bed and facility types across Washington.

The targets do not represent the specific clinical need for each bed type in each region, but rather provide Washington policy leaders with a framework from which to build their overarching funding strategy.

Also, of note, while all available stakeholders were interviewed during this process, time constraints limited engagement to State-identified interview subjects. Broader public comment was not included in the scope of this report. Additionally, each peer state reports information with degrees of variability. Thus, for some data points included in this report, a simple comparison across states may lead to misinterpretation of the data. In those instances, the report includes a narrative describing the context of the data in each state.

[3] https://www.nasmhpd.org/sites/default/files/TAC.Paper_.1Beyond_Beds.pdf

4. Current Community Behavioral Health Capacity

4.1 Introduction

Washington's prevalence rates for mental health conditions are among the highest in the nation.[4] To support recovery, individuals with mental health and addiction related conditions access services across a spectrum of inpatient, residential, and outpatient settings. This section identifies the current bed counts across a variety of adult behavioral health facilities providing services in Washington.

From the data provided, community hospitals and evaluation and treatment facilities operate 1,099 beds across the state. Enhanced service facilities, triage facilities, crisis stabilization facilities, crisis respite facilities, residential treatment facilities, and secure withdrawal management and stabilization facilities operate an additional 793 beds for a total of 1,892. This total does not include projects currently under construction, projects funded and in the planning stages, or beds in Eastern and Western State Hospitals. Additionally, since this report focuses on behavioral health facilities, other outpatient services – such as counseling, mobile crisis intervention, and care management – are not analyzed herein.

Defined below are the specific facility types explored in more detail throughout this report:

- **Community Hospitals:** Psychiatric units in community hospitals offer an alternative to state hospitalization for some individuals. Community hospitals support individuals for longer lengths of stay and provide acute medical care for those with other physical health needs. More information can be found in WAC 182-550-1050.[5]
- **Freestanding Evaluation and Treatment Facility:** Freestanding Evaluation and Treatment Facilities (Evaluation and Treatment Facilities) are non-hospital, community-based, inpatient psychiatric facilities. They offer a limited alternative to state hospitalization for individuals requiring short term psychiatric treatment absent complex physical health needs. The average length of stay is 14 days for most individuals. However, Evaluation and Treatment Facilities may have longer lengths of stay than the ideal number due to lack of capacity. While Evaluation and Treatment beds are a service type within residential treatment or hospital settings, residential treatment facilities hosting such beds were commonly referred to as "E&T centers or facilities" by stakeholders in the state. References to E&T centers or facilities throughout this report refer to E&T program beds in Department of Health licensed residential treatment facilities. E&T beds in hospitals are referred to as community hospital beds. The definition is also defined in RCW 71.34.020.[6]
- **Enhanced Service Facility:** Enhanced Service Facilities are for people with psychiatric disorders who need a higher level of care and supervision than a residential treatment facility but no longer benefit from inpatient care. Enhanced service facilities are defined in RCW 70.97.010.[7]

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[4] Washington State Institute for Public Policy. February 2015. Inpatient Psychiatric Capacity and Utilization in Washington State. www.wsipp.wa.gov

[5] http://apps.leg.wa.gov/WAC/default.aspx?cite=182-550-1050.%20%20Accessed%203/6/15%20and%208/20/15

[6] http://app.leg.wa.gov/rcw/default.aspx?cite=71.34.020

[7] https://app.leg.wa.gov/rcw/default.aspx?cite=70.97.010

- **Triage Facility:** Triage Facilities direct individuals to an appropriate level of care and may be operated with or without beds. Those facilities equipped with beds may support short term services, such as crisis stabilization and sub-acute withdrawal management. The average length of stay is 5-7 days with no stays longer than 14 days. More information on triage facilities can be found in RCW 71.05.020.[8]
- **Crisis Stabilization:** Crisis Stabilization Facilities aim to avoid unnecessary hospitalization for individual experiencing a behavioral health crisis and is defined at RCW 71.05.020.[8] The average length of stay is 5-7 days with no stays longer than 14 days.
- **Crisis Walk-In:** Crisis Walk-In Facilities offer crisis stabilization and intervention, counseling, peer support and medication management for up to 23 hours.
- **Crisis Respite:** Crisis respite beds are designated beds within a residential treatment facility that focus on de-escalation and may provide an alternative to detention or hospitalization.
- **Residential Facility:** Residential Facilities provide an intermediate level of care. These facilities are focused on maintaining individual stability and safety in a less restrictive environment than an inpatient facility. Information on residential facilities can be found in WAC 246-337.[9]
- **Supportive Housing:** Supportive Housing provides affordable low-income housing units paired with behavioral health treatment and support services. For this report, supportive housing is defined as Permanent Supportive Housing as per the data in Washington State 2018 Housing Inventory Count from Homelessness Data Exchange. More information on supportive housing can be found in RCW 18.330.010.[10]
- **Secure Withdrawal Management and Stabilization:** Secure Withdrawal Management and Stabilization facilities are facilities supporting involuntary treatment for those with substance use disorders, defined at RCW 71.05.020.[8]

4.2 Community Capacity

The remainder of this section provides the total bed counts for the above facilities by region. Regions are based on Health Care Authority purchasing regions and were provided to Public Consulting Group by the Office of Financial Management. This data provides the foundation of the prioritization analysis provided in later sections in this report. It is important to note that single bed certifications are not accounted for in this data and analysis.

State Hospitals

Importantly, in addition to the community-based facilities described in this section, Washington has historically allotted civil beds in Eastern and Western State Hospital to each behavioral health organization. As the State is planning to transition civil patients out of the state hospitals, these bed counts were not included in the assessment of current regional capacity. These beds are, however, critical to understanding the current overall capacity for inpatient care. For reference, Table 5 identifies the number of beds allocated within the State Hospitals for each region.

[8] http://app.leg.wa.gov/RCW/default.aspx?cite=71.05.020
[9] http://app.leg.wa.gov/wac/default.aspx?cite=246-337-001
[10] http://app.leg.wa.gov/rcw/default.aspx?cite=18.330.010

Table 5. Total State Hospital Civil Bed Allocations per Region

Region	Number of Beds Allotted to Western State Hospital	Number of Beds Allotted to Eastern State Hospital
Great Rivers	29	
Greater Columbia		68*
King	210	
North Central		24
North Sound	106	
Pierce	84	
Salish	30	
Spokane		100*
SW WA	37*	
Thurston-Mason	31	
Grand Total	527	192

* Note: Greater Columbia behavioral health organization allocations are assumed for Greater Columbia Region, Spokane Regional County behavioral health organization allocations are assumed for Spokane Region, and Southwest FIMC allocations are assumed for SW WA Region.

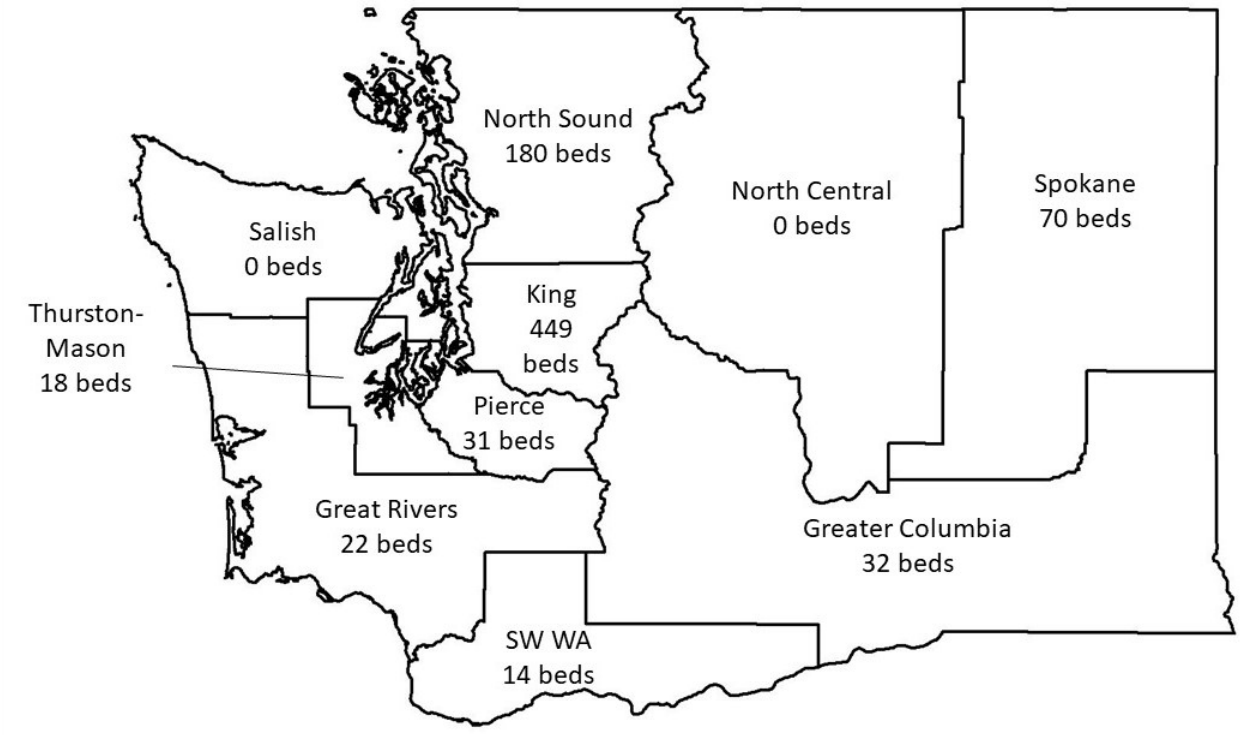
Community Hospitals

Psychiatric units in community hospitals offer an additional resource for inpatient treatment for some individuals. These community hospital beds are used for both involuntary and voluntary commitments. As shown in Table 6, there are currently 816 licensed community hospital beds providing psychiatric care across Washington. King operates the largest number of community hospital beds with 449 in total, while the more remote areas of North Central and Salish have none.

Table 6. Community Hospital Bed Count

Region	Great Rivers	Greater Columbia	King	North Central	North Sound	Pierce	Salish	Spokane	SW WA	Thurston-Mason	Total
Number of Beds	22	32	449	0	180	31	0	70	14	18	816
Beds per 100,000 Population	8	4	21	0	14	4	0	12	3	5	11

Figure 1. Community Hospital Bed Numbers by Region



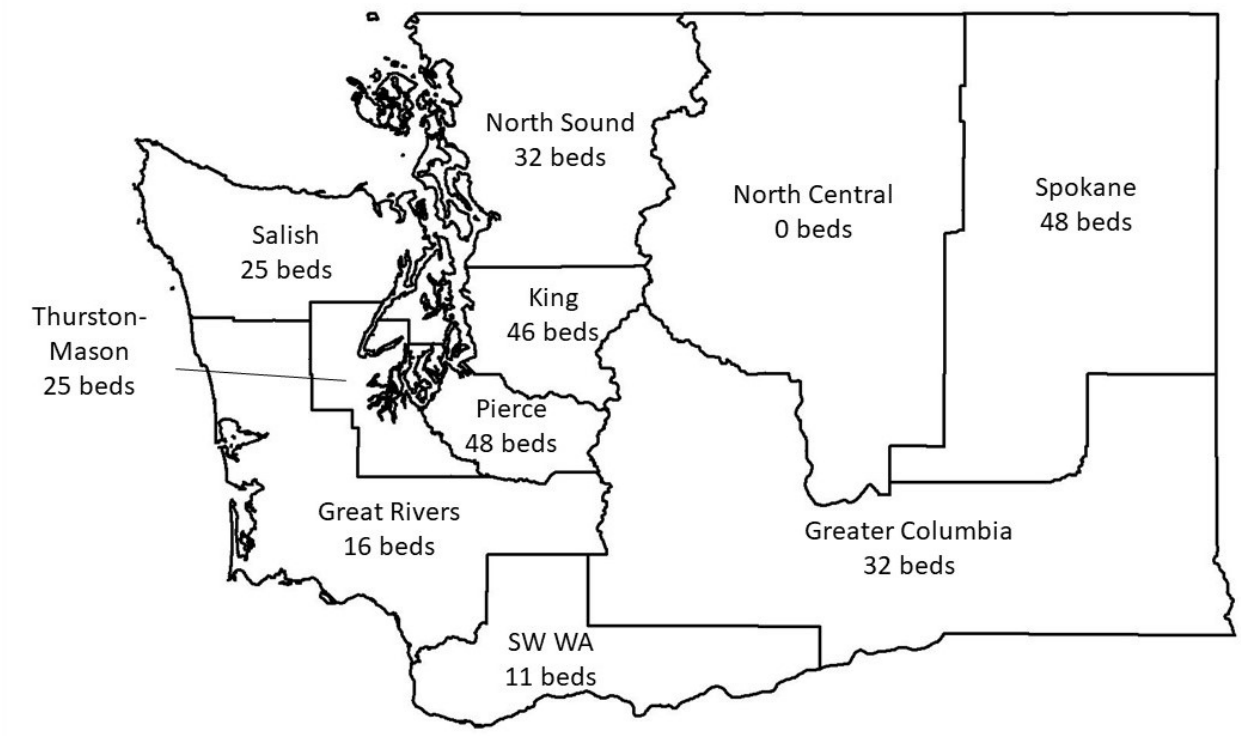
Evaluation and Treatment Facilities

Freestanding evaluation and treatment facilities offer short term psychiatric treatment for high acuity individuals who do not require additional physical health monitoring or treatment. Evaluation and treatment facilities may represent the first phase of inpatient treatment for many individuals. As shown in Table 7, Washington has 283 total evaluation and treatment facility beds throughout the State. Pierce and Spokane have the most freestanding evaluation and treatment beds with 48 total beds each. King is close behind with a total of 46. Compared to community hospital beds, the regional distribution of evaluation and treatment beds is more uniform. Again, however, there were no such beds identified for North Central in the data provided.

Table 7. Evaluation and Treatment Bed Count

Region	Great Rivers	Greater Columbia	King	North Central	North Sound	Pierce	Salish	Spokane	SW WA	Thurston-Mason	Total
Number of Beds	16	32	46	0	32	48	25	48	11	25	283
Beds per 100,000 Population	6	4	2	0	3	5	7	8	2	7	4

Figure 2. Evaluation and Treatment Bed Numbers by Region



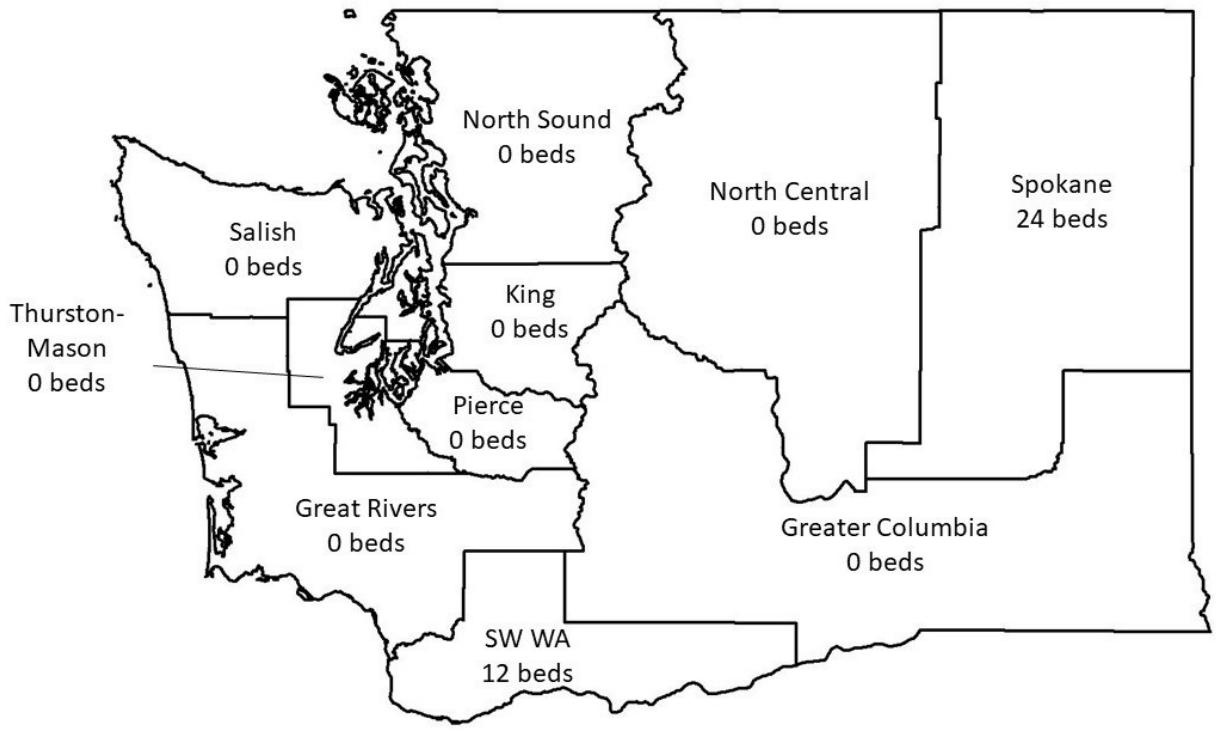
Enhanced Service Facility

Enhanced Service Facilities serve individuals with specialized care needs, such as those with dementia diagnoses. Washington has 36 total enhanced service facility beds. As shown in Table 8, these beds are only available in the regions of Spokane and SW Washington, serving the eastern and western parts of the state, respectively.

Table 8. Enhanced Service Facility Bed Count

Region	Great Rivers	Greater Columbia	King	North Central	North Sound	Pierce	Salish	Spokane	SW WA	Thurston-Mason	Total
Number of Beds	0	0	0	0	0	0	0	24	12	0	36
Beds per 100,000 Population	0	0	0	0	0	0	0	4	2	0	0

Figure 3. Enhanced Service Facility Bed Numbers by Region



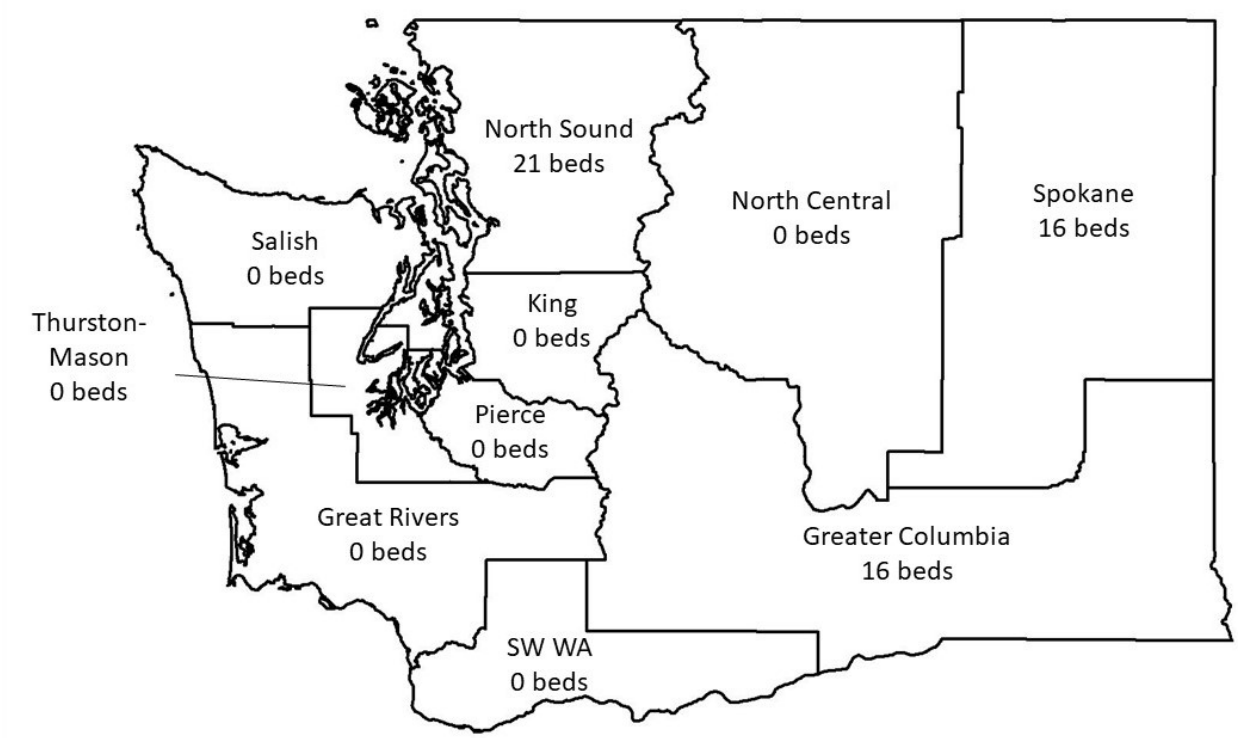
Triage Facility

Triage facilities that operate beds allow individuals to seek stabilization or detox services for a short period of time. Table 9 shows how the 53 total triage beds are distributed, with 21 beds in North Sound Region and 16 beds each in Greater Columbia and Spokane. All other regions lack these types of triage facilities as options for stabilization and sub-acute detoxification.

Table 9. Triage Facility Bed Counts

Region	Great Rivers	Greater Columbia	King	North Central	North Sound	Pierce	Salish	Spokane	SW WA	Thurston-Mason	Total
Number of Beds	0	16	0	0	21	0	0	16	0	0	53
Beds per 100,000 Population	0	2	0	0	2	0	0	3	0	0	1

Figure 4. Triage Facility Bed Numbers by Region



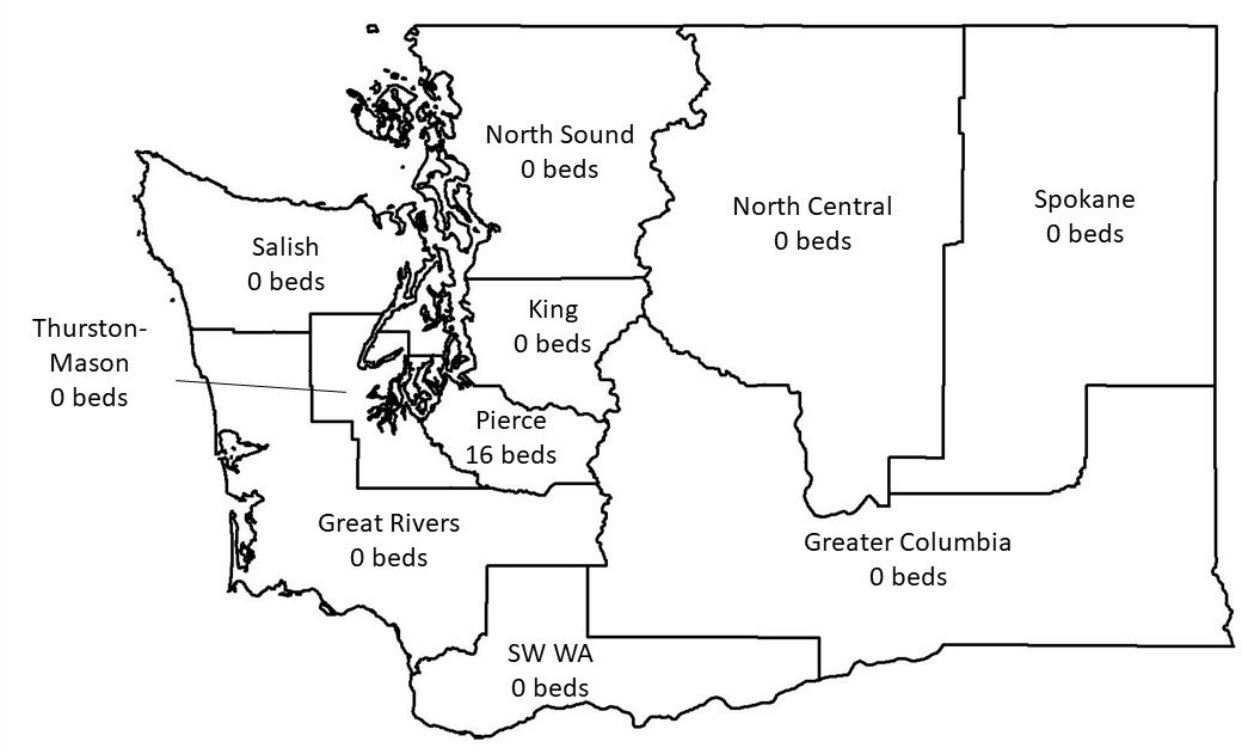
Crisis Stabilization Facility

Crisis stabilization facilities provide a diversion resource to prevent the need for inpatient admission. These facilities offer short term care with average length of stays between 5 and 7 days. As shown by the table and map below, Washington has 16 crisis stabilization beds, all located in Pierce.

Table 10. Crisis Stabilization Facility Bed Count

Region	Great Rivers	Greater Columbia	King	North Central	North Sound	Pierce	Salish	Spokane	SW WA	Thurston-Mason	Total
Number of Beds	0	0	0	0	0	16	0	0	0	0	16
Beds per 100,000 Population	0	0	0	0	0	2	0	0	0	0	0

Figure 5. Crisis Stabilization Facility Bed Numbers by Region



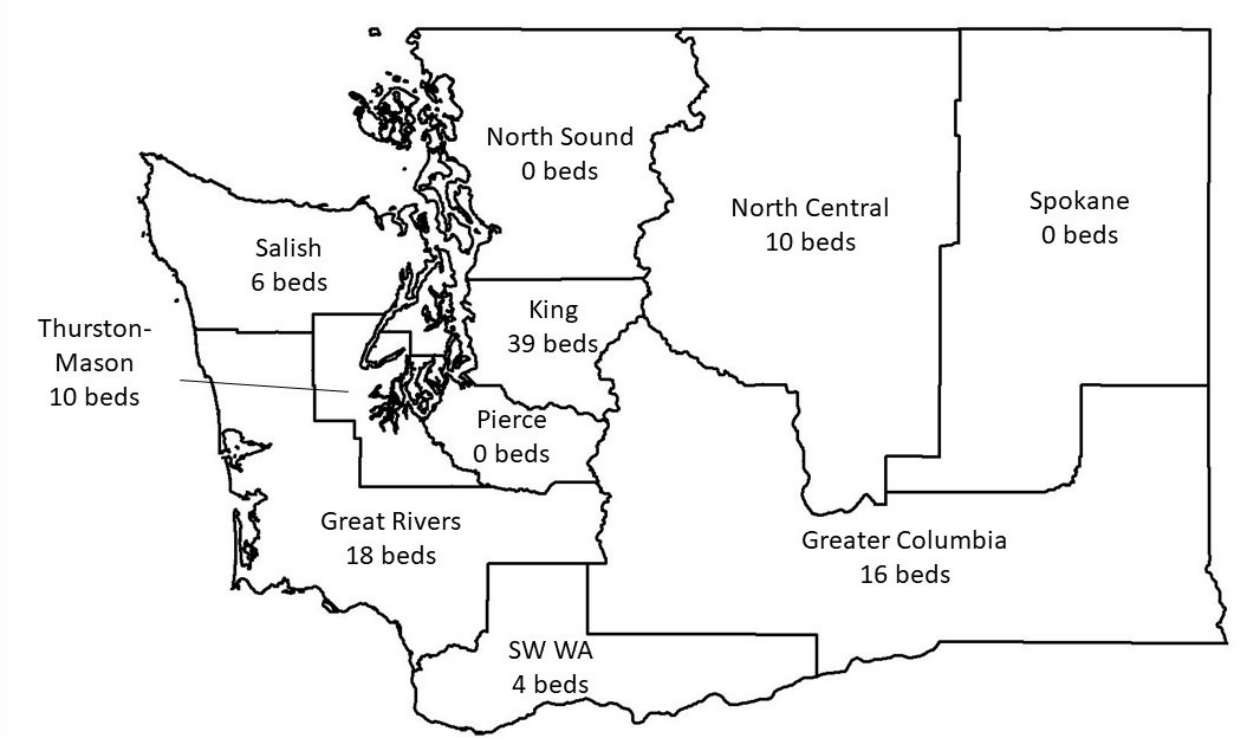
Crisis Respite Facility

Crisis respite beds also offer a less restrictive alternative to inpatient hospitalization or detention. Table 11 shows the geographic distribution of the 103 total beds operated in the state. King has the most crisis respite beds with 39 in total, followed by Great Rivers and Greater Columbia with 18 beds and 16 beds, respectively. Spokane and Pierce do not have crisis respite beds available.

Table 11. Crisis Respite Facility Bed Count

Region	Great Rivers	Greater Columbia	King	North Central	North Sound	Pierce	Salish	Spokane	SW WA	Thurston-Mason	Total
Number of Beds	18	16	39	10	0	0	6	0	4	10	103
Beds per 100,000 Population	6	2	2	4	0	0	2	0	1	3	1

Figure 6. Crisis Respite Facility Bed Numbers by Region



Crisis Walk-In Facility

Crisis walk-in facilities offer a variety of crisis stabilization and intervention services for 23-hour care. The data sets analyzed for this report did not include capacity information for these facilities. Therefore, their contribution to the continuum of crisis services is not evaluated as part of this report.

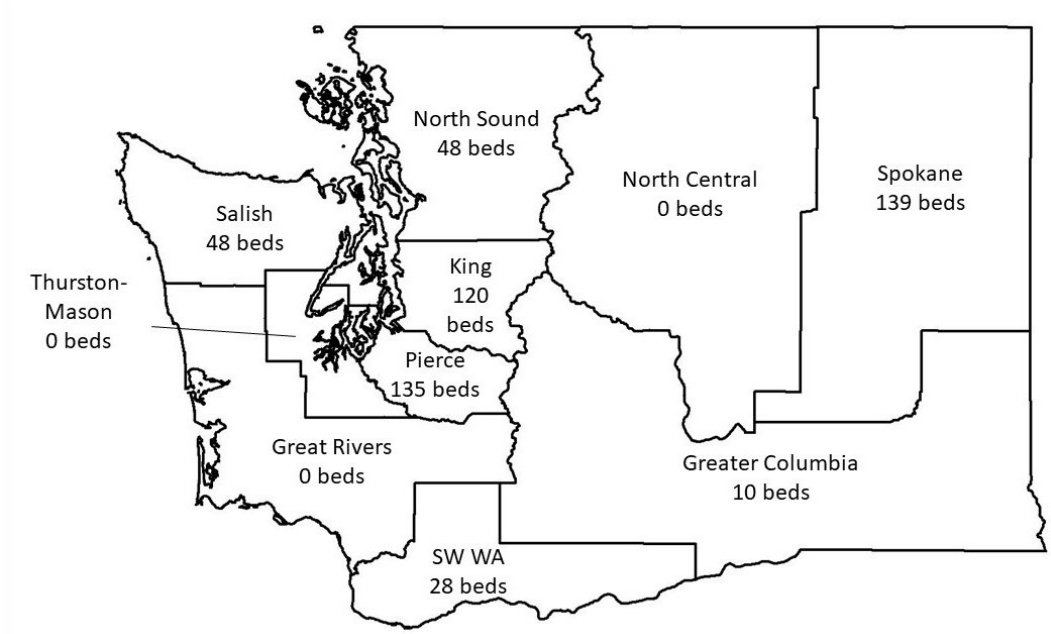
Residential Treatment Facility

Residential treatment facilities serve adults and seniors and focus on stability and safety. Average length of stay for these facilities ranges from 6-18 months. As shown in Table 12, Washington currently operates 528 residential treatment facilities serving adult behavioral health needs. Spokane has the most residential treatment facility beds with 139 in the region. Pierce and King closely follow with 135 beds and 120 beds, respectively. North Central, Thurston-Mason, and Great Rivers do not have any residential treatment facility beds identified in the data set for this study. Individuals in these regions must travel to obtain this level of care.

Table 12. Residential Treatment Facility Bed Count

Region	Great Rivers	Greater Columbia	King	North Central	North Sound	Pierce	Salish	Spokane	SW WA	Thurston-Mason	Total
Number of Beds	0	10	120	0	48	135	48	139	28	0	528
Beds per 100,000 Population	0	1	5	0	4	15	13	23	6	0	7

Figure 7. Residential Treatment Facility Bed Numbers by Region



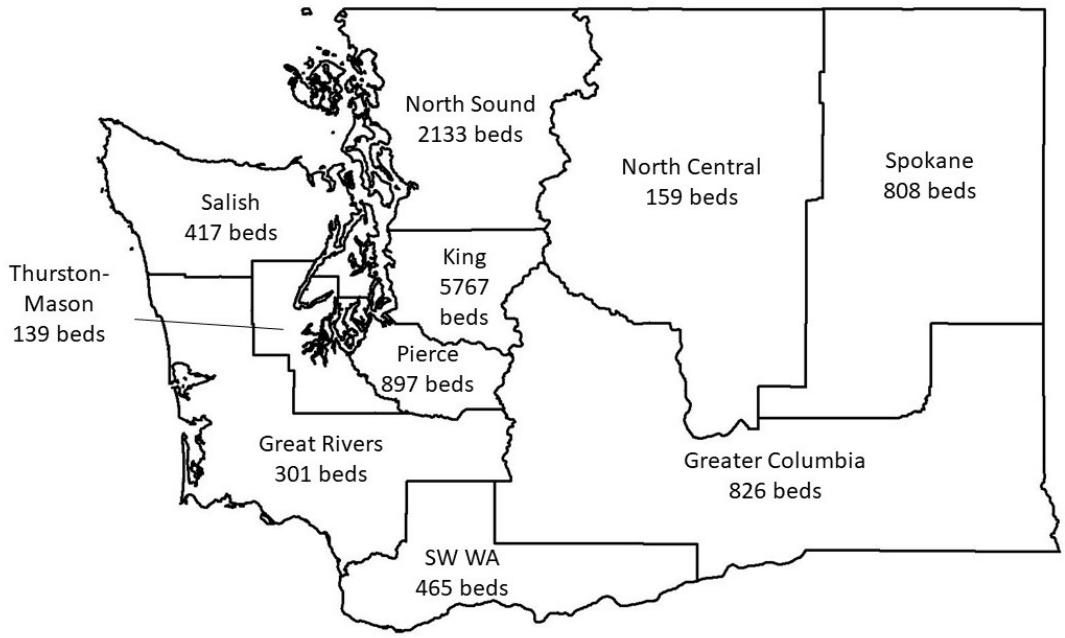
Supportive Housing

Supportive housing provides shelter for low-income individuals paired with behavioral health services and supports. As shown in Table 13, there are 11,912 supportive housing beds located throughout the state. This data was obtained from the Homeless Housing Inventory Count submitted to the US Department of Housing and Urban Development. The counts below represent the 2018 Housing Inventory Count Submission for all Continuums of Care in Washington, which is collected by Washington Department of Commerce. The data is statewide and includes the Snohomish, King, Pierce, Clark, and Spokane County Continuums of Care as well as data from all other regions of the state. King operates the largest number of supportive housing beds with 5,767 in total. North Sound follows with 2,133 supportive housing beds in the region. Pierce, Greater Columbia and Spokane have more than 800 beds each. Thurston-Mason has the fewest beds a total of 139. Supportive Housing is the only facility in the Proviso categories that is currently present in all regions. As discussed in Section 3, however, it is also the only category identified by every stakeholder as a significant unmet need.

Table 13. Supportive Housing Bed Count

Region	Great Rivers	Greater Columbia	King	North Central	North Sound	Pierce	Salish	Spokane	SW WA	Thurston-Mason	Final
Number of Beds	301	826	5,767	159	2,133	897	417	808	465	139	11,912
Beds per 100,000 Population	106	114	263	62	171	102	112	134	92	40	161

Figure 8. Supportive Housing Bed Numbers by Region



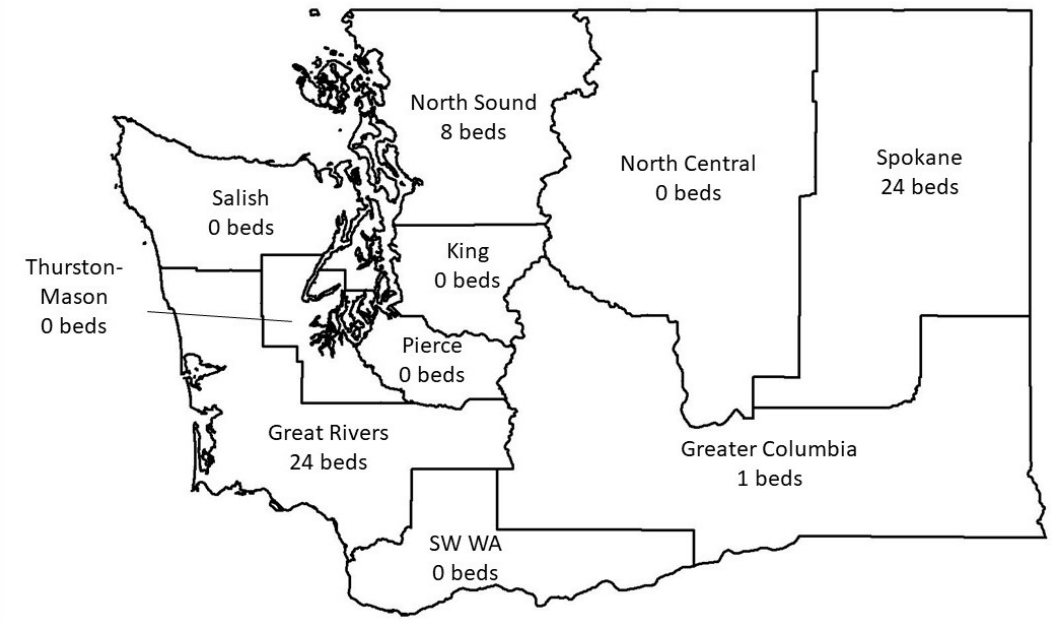
Secure Withdrawal Management and Stabilization Facility

As shown in Table 14, Washington has 57 secure withdrawal management and stabilization beds, the majority of which are located in Spokane and Great Rivers. An additional eight beds were identified in North Sound, with one additional bed in Greater Columbia. This bed type is not currently available in any other region. Stakeholders noted that existing facilities in Great Rivers and Spokane are serving individuals from various parts of the state. In 2016, House Bill 1713 amended Washington's Involuntary Treatment Act for Substance Use Disorders. The law allows designated crisis responder to detain an individual meeting the criteria for involuntary treatment for substance use disorder to a secure withdrawal management and stabilization facility. Section 201 of what is commonly referred to as "Ricky's Law" required the Department of Social and Health Services to establish two secure withdrawal management and stabilization facilities by April 2019, with an additional seven facilities added by 2026 pending available funding. Out of the nine total facilities, seven are targeted for adults and two for children.

Table 14. Secure Withdrawal Management and Stabilization Facility Bed Count

Region	Great Rivers	Greater Columbia	King	North Central	North Sound	Pierce	Salish	Spokane	SW WA	Thurston-Mason	Total
Number of Beds	24	1	0	0	8	0	0	24	0	0	57
Beds per 100,000 Population	8	0	0	0	1	0	0	4	0	0	1

Figure 9. Secure Withdrawal Management and Stabilization Faciilty Bed Numbers by Region



Regional Summary

Table 15 compiles the bed count information for the 10 facility types across all regions. Key points of comparison are noted below:

- North Central currently has just two behavioral health bed types in the region: crisis respite and supportive housing.
- Each region has some form of crisis beds available. However, Greater Columbia is the only region that has more than one type of crisis bed.
- Eastern and western regions of the state are currently served by one secure withdrawal management and stabilization and one enhanced service facility each.
- Community hospital and residential treatment beds show the widest variation region by region, while evaluation and treatment facilities are more evenly distributed.

Table 15. Demonstration Data Display Chart

Region	Community Hospitals	Freestanding Evaluation and Treatment	Enhanced Service Facility	Triage Facility	Crisis Stabilization	Crisis Walk-in	Crisis Respite	Residential Treatment Facility	Supportive Housing	Secure Withdrawal Management and Stabilization	Regional Totals
Great Rivers	22	16	0	0	0	0	18	0	301	24	381
Greater Columbia	32	32	0	16	0	0	16	10	826	1	933
King	449	46	0	0	0	0	39	120	5,767	0	6,421
North Central	0	0	0	0	0	0	10	0	159	0	169
North Sound	180	32	0	21	0	0	0	48	2,133	8	2,422
Pierce	31	48	0	0	16	0	0	135	897	0	1127
Salish	0	25	0	0	0	0	6	48	417	0	496
Spokane	70	48	24	16	0	0	0	139	808	24	1,129
SW WA	14	11	12	0	0	0	4	28	465	0	534
Thurston-Mason	18	25	0	0	0	0	10	0	139	0	192
Total	816	283	36	53	16	0	103	528	11,912	57	13,804

Figures 10 and 11 below illustrate the regional distribution of beds, excluding and including supportive housing beds, respectively. Table 16 shows the total bed numbers without supportive housing beds in each region. Table 17 illustrates total bed numbers by region.

Figure 10. Total Bed Numbers Without Supportive Housing by Region

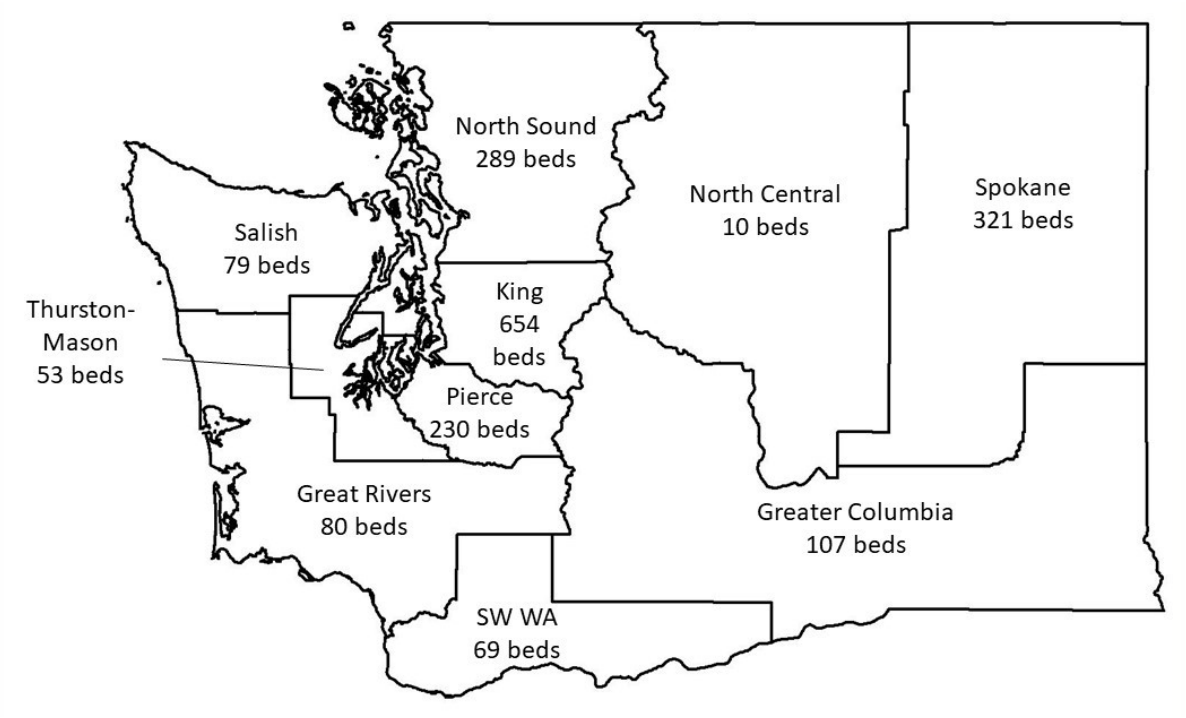


Table 16. Total Bed Numbers Without Supportive Housing by Region

Region	Total Beds Without Supportive Housing
Great Rivers	80
Greater Columbia	107
King	654
North Central	10
North Sound	289
Pierce	230
Salish	79
Spokane	321
SW WA	69
Thurston-Mason	53
Total	1,892

Figure 11. Total Bed Numbers by Region

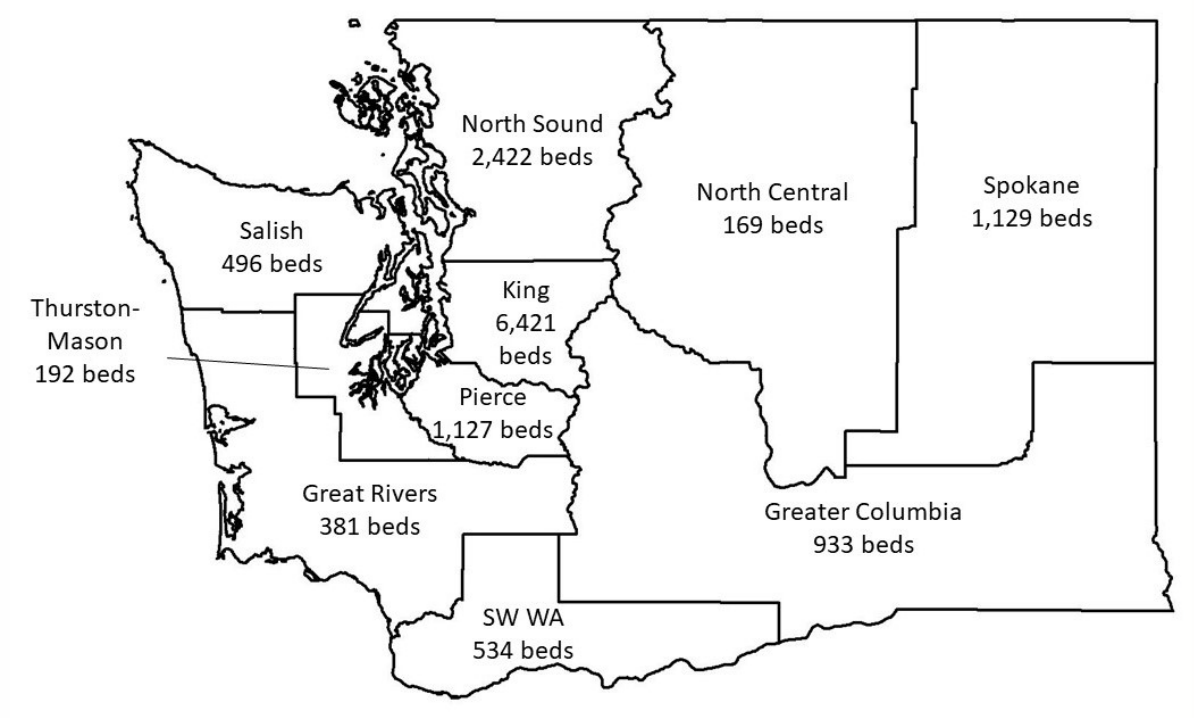


Table 17. Total Bed Numbers by Region

Region	Total Beds
Great Rivers	381
Greater Columbia	933
King	6,421
North Central	169
North Sound	2,422
Pierce	1,127
Salish	496
Spokane	1,129
SW WA	534
Thurston-Mason	192
Total	13,804

4.3. Additional Capacity in Progress

In addition to the current community capacity in Washington, there are several facilities currently in progress that will add to the overall capacity in the State. Table 18 below shows the bed counts for facilities in progress.

Table 18. Demonstration Data Display Chart

Region	Community Hospitals	Freestanding Evaluation and Treatment	Enhanced Service Facility	Triage Facility	Crisis Stabilization	Crisis Walk-in	Crisis Respite	Residential Treatment Facility	Supportive Housing	Secure Withdrawal Management and Stabilization	Regional Totals
Great Rivers	0*	0	0	0	32	0	0	14	0	0	46
Greater Columbia	24*	0	0	8	0	0	0	8	0	0	40
King	0	0	48	0	0	0	0	16	0	0	64
North Central	0	0	0	16	0	0	0	8	0	0	24
North Sound	24	16	16	0	0	0	0	28	0	0	68
Pierce	0	0	0	16	16	0	0	0	0	0	32
Salish	4	17	0	16	0	0	0	0	0	0	37
Spokane	0	0	0	0	32	0	0	16	0	0	48
SW WA	0	0	0	22	16	0	0	0	0	16	54
Thurston-Mason	0	0	0	0	0	0	0	16	0	0	16
Total	52	33	64	78	96	0	0	106	0	16	445

*Total beds pending in this region and category remains to be determined.

For the remainder of this report, we assume the pending beds will be implemented and account for them in our bed counts for analysis. Table 19 shows the total of current and pending bed counts in the state. Figure 12 illustrates total bed count including pending beds in each region and Table 20 shows total bed count including the pending beds in each region.

Table 19. Current and Pending Beds Display Chart

Region	Community Hospitals	Freestanding Evaluation and Treatment	Enhanced Service Facility	Triage Facility	Crisis Stabilization	Crisis Walk-in	Crisis Respite	Residential Treatment Facility	Supportive Housing	Secure Withdrawal Management and Stabilization	Regional Totals
Great Rivers	22	16	0	0	32	0	18	14	301	24	427
Greater Columbia	56	32	0	24	0	0	16	18	826	1	973
King	449	46	48	0	0	0	39	136	5,767	0	6,485
North Central	0	0	0	16	0	0	10	8	159	0	193
North Sound	204	48	16	21	0	0	0	76	2,133	8	2,506
Pierce	31	48	0	16	32	0	0	135	897	0	1,159
Salish	4	42	0	16	0	0	6	48	417	0	533
Spokane	70	48	24	16	32	0	0	155	808	24	1,177
SW WA	14	11	12	22	16	0	4	28	465	16	588
Thurston-Mason	18	25	0	0	0	0	10	16	139	0	208
Total	868	316	100	131	112	0	103	634	11,912	73	14,249

Figure 12. Total Bed Count Including Pending Beds by Region

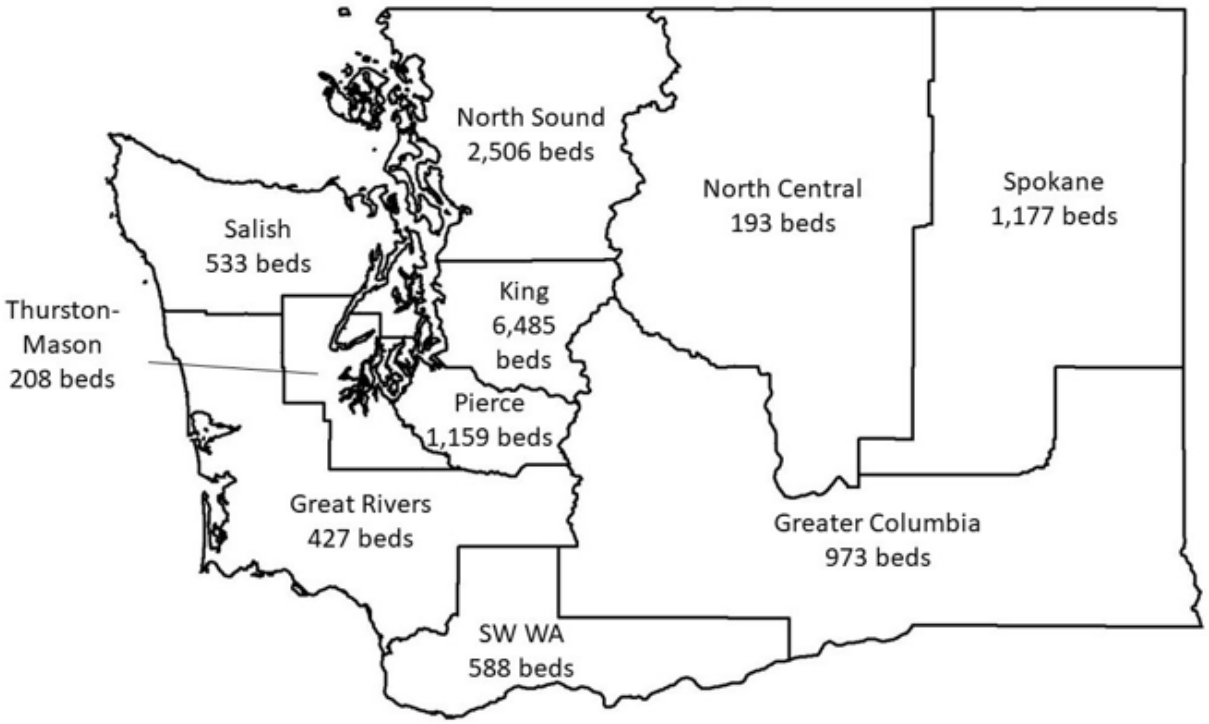


Table 20. Total Bed Count Including Pending Beds by Region

Region	Total Beds Including Pending
Great Rivers	427
Greater Columbia	973
King	6,485
North Central	193
North Sound	2,506
Pierce	1,159
Salish	533
Spokane	1,177
SW WA	588
Thurston-Mason	208
Total	14,249

Care Continuum Category Classifications

Given the limitations in available benchmark discussed in Section 3.2, we grouped the proviso bed categories into "care continuum categories" shown in Table 21. The care continuum categories are residential services, crisis services, secure withdrawal management and stabilization, inpatient, and supportive housing. Residential services include bed counts from enhanced service facilities and residential treatment facilities. Crisis services include beds from triage facilities, crisis stabilization, and crisis respite. Because secure withdrawal management and stabilization facilities are a legislatively mandated specialty facility, this beds type is addressed independently. Inpatient beds were defined as psychiatric beds within community hospitals and evaluation and treatment facilities. Supportive housing included beds at permanent supportive housing facilities.

Table 21. Care Continuum Category Classification Chart

Residential Services	Crisis Services	Secure Withdrawal Management and Stabilization	Inpatient	Supportive Housing
Enhanced Service Facility	Triage Facility	Secure Withdrawal Management and Stabilization	Community Hospitals	Supportive Housing
Residential Treatment Facility	Crisis Stabilization		Evaluation and Treatment	
	Crisis Respite			
	Crisis Walk-in			

Table 22 displays the bed counts and ratios per capita for each care continuum category in the 10 regions examined.

Table 22. Care Continuum Category Bed Counts

Region	Residential and Other 24-Hour Services	Crisis Services	Secure Withdrawal Management and Stabilization	Inpatient	Supportive Housing	Total
Great Rivers Total	14	50	24	38	301	427
Beds per 100,000 Population	5	18	8	13	106	151
Greater Columbia Total	18	40	1	88	826	973
Beds per 100,000 Population	2	6	0	12	114	134
King Total	184	39	0	495	5,767	6,485
Beds per 100,000 Population	8	2	0	23	263	296
North Central Total	8	26	0	0	159	193
Beds per 100,000 Population	3	10	0	0	62	76
North Sound Total	92	21	8	252	2,133	2,506
Beds per 100,000 Population	7	2	1	20	171	201
Pierce Total	135	48	0	79	897	1,159
Beds per 100,000 Population	15	5	0	9	102	132
Salish Total	48	22	0	46	417	533
Beds per 100,000 Population	13	6	0	12	112	143
Spokane Total	179	48	24	118	808	1,177
Beds per 100,000 Population	30	8	4	20	134	196
SW WA Total	40	42	16	25	465	588
Beds per 100,000 Population	8	8	3	5	92	116
Thurston-Mason Total	16	10	0	43	139	208
Beds per 100,000 Population	5	3	0	12	40	60
Statewide Total	826	410	89	1,298	13,069	15,693
Beds per 100,000 Population	11	6	1	18	177	212

5. Stakeholder Feedback

5.1. Overview

To provide context for the quantitative data collected in Section 4, Public Consulting Group interviewed a wide array of providers, advocates, behavioral health organizations, managed care organizations and state agency representatives. The Office of Financial Management worked with Department of Social and Health Services, Health Care Authority and the Department of Commerce to identify individual contacts within these stakeholder categories. Given the abbreviated timeframe available for this study, Public Consulting Group contacted those individuals and conducted telephonic interviews with those who were responsive and available between July 13 and July 27, 2018. Those stakeholders who had previously received a grant from the Department of Commerce were asked additional questions about their experience with the grant process to inform the prioritize process.

5.2. Stakeholder Feedback Summary

Common themes quickly emerged among the interview data collected. While our study aims to identify regional needs for additional behavioral health resources, stakeholders identified several priorities as statewide needs. The first part of this subsection provides a narrative review of those common themes organized by interview topic. The second part provides additional detail in each area organized by region.

Capital Investment Priorities

- **Housing and Residential Options:** With property and rent values soaring, stakeholders stressed the need for affordable, supportive housing options. For individuals living with behavioral health conditions, housing is key to stability and continued recovery. However, shelters can be triggering for individuals with serious mental illness, and most do not accept individuals who are current substance users. Many of the individuals we interviewed voiced support for additional Housing First model facilities, which do not require sobriety as a condition of admittance. Additionally, stakeholders pointed to the absence of residential facilities that can provide an intermediate level of care. Such facilities play a critical role in the care continuum, supporting safe discharge from inpatient settings as well as preventing decompensation that leads to inpatient utilization.
- **Geriatric and Pediatric Specialists:** These populations are universally underserved, with respect to both the available workforce and appropriate facilities. For the geropsychiatric population, Medicare coverage does not reimburse for some facility types, which impacts provide sustainability. Stakeholders emphasized the need for residential facilities to care for geropsychiatric cases and individuals with dementia. Although this report specifically focuses on adult facilities, all specialty care for children and adolescents is notably lacking.
- **Secure Withdrawal Management:** HB 1713, commonly referred to ask Ricky's Law, integrates substance use disorders into the Involuntary Treatment Act. As a result, RCW 71.05.153 was modified to include the following, effective April 1, 2018:

  > "(2) When a designated crisis responder receives information alleging that a person, as the result of substance use disorder, presents an imminent likelihood of serious harm, or is in imminent danger because of being gravely disabled, after investigation and evaluation of the specific facts alleged and of the reliability and credibility of the person or persons providing the information if any, the designated crisis responder may take the person, or cause by oral

> or written order the person to be taken, into emergency custody in a secure detoxification facility or approved substance use disorder treatment program for not more than seventy-two hours as described in RCW 71.05.180, if a secure detoxification facility or approved substance use disorder treatment program is available and has adequate space for the person."

Stakeholders commented that development of the facility types described by Ricky's Law has been slow since the law passed and urged prioritization of these facilities for capital investment.

- **New Models for Rural Communities:** Stakeholders also pointed to the need to explore different care models for rural communities. Resources are sparse in the rural and frontier areas of the state. Models that significantly integrate services, including health and social services, may help maximize the utility of existing resources and infrastructure. Stakeholder also suggest that locating services on rural county borders may be an efficient approach to serving areas with low population densities.

Smaller State Facilities for 90 and 180-day commitments

- **State-Owned, Contract-Operated:** Support for state-owned facilities that contract for clinical program operation was widely noted during our interviews. Stakeholders expressed concern that the state hospitals' current challenges would carry over into smaller facilities. They noted, for example, that team-based care models are not supported by the job classifications used in the state hospitals today. Stakeholders also emphasized the advantages of contracting for services, including the use of quality measures and the opportunity to re-procure if clinical and quality standards are not met.
- **Medical Needs:** Stakeholders advised that any new facility serving 90 and 180-day commitments must account for the significant physical health needs of this population, many of whom have co-occurring medical conditions. Individuals who are referred to an evaluation and treatment facility today must be medically cleared before admission. This process is typically carried out in an emergency department. For those requiring commitment, receiving clearance in a busy emergency department followed by transfer to a separate facility amplifies the trauma of the commitment process.
- **Volume and Expense:** Some stakeholders questioned the cost effectiveness of 16 bed facilities, expressing concern about the resources required to manage and staff enough facilities to serve the entire population in need. Others noted that the smaller facility is the most appropriate model of care but acknowledged that it will significantly increase the funding required to serve committed individuals.

Department of Commerce Grant Process

- **Grant Process:** Among those stakeholders who had previously received Department of Commerce grants, all commented that the application and reporting processes were straight forward and did not require significant resource commitments to complete.
- **Key Challenges:** Though the application process was smooth, stakeholders noted the following challenges in implementing their funded projects:
    - Internal discussions and coordination can be challenging, particularly for larger organizations where many levels of legal review are required.
    - Recipients should plan cash flow carefully as the grant funds are distributed on a reimbursement basis.
    - Siting and community buy-in are at the most pressing challenges for new facilities. Important to work with county and other community organizations early to gain and maintain support.

Table 23 organizes the stakeholder input received by region. The first column identifies recently opened facilities as well as projects that are funded and underway. The second column lists the priorities identified among stakeholders in that region. The remaining two columns provide input on the potential for smaller, state facilities to serve 90 and 180-day commitments as well as any additional input provided.

Table 23. Stakeholder Feedback Summary Chart

Region	Projects Underway	Identified Priorities	Facilities for 90- and 180-day commitments	Any additional information
Greater Columbia*		• Residential treatment • Secure detox • Supportive Housing		
King	• Detox center opening this fall in Valley City. • UW Harborview working with SeaMar to develop floors of Seattle nursing home. • Pilot project for diversion center in Snohomish County currently underway. • Three secure SUD centers coming online in the next 6 months.	• Step down, residential and supportive housing • Geriatric and pediatric placements • Crisis centers • Diversion centers and housing with wraparound services	• Much less traumatic experience for individuals to be treated in the community and increases chances for recovery and success. Great model if staffed and operated appropriately. Siting will likely be an issue. • Work rules from state hospitals should not be duplicated. Staffing requirements at state hospitals make it difficult to run the hospital. Team-based care conflicts with traditional job classifications and division of labor. • Smaller facilities are terrific models of care and also very expensive. • Proliferation of 16 bed facilities cannot be cost effective given staffing and administration requirements. Would be more appropriate to have a facility in King County that is closer to 200 beds.	• Western State Hospital PALS program, the original PACT program, and the original peer-bridger program all represent best practices in program implementation and operation. • Evaluation and treatment facilities used to be used more as a step-down facility for individuals to continue recovery, but in King County, that's not possible anymore. • The original PACT model and peer-bridger model have proved effective in connecting individuals to supports in their communities. • Need to make sure that capital and plans for staffing capacity for all different types of facilities are fully in place before we try to move people out of the hospital into the community.
North Central	N/A	• No facilities in the county. Individuals are always detained outside of the county. • Opioid treatment • Competency restoration	• Support new facilities run through a contract with the state, understanding the needs of the community and connecting with the community. • Funding to build up community infrastructure that surrounds each of these facilities will be critical to success.	

Region	Projects Underway	Identified Priorities	Facilities for 90- and 180-day commitments	Any additional information
North Sound	• Detox and crisis center in Bellingham • Conversion of Everett JD center • Crisis center in Oak Harbor • Crisis detox in Skagit County • One private psychiatric facility with ~100 beds	• Secure detox facility • Recovery houses • Psychiatric beds for 90 and 180-day commitments	• Model makes more sense where there are not sufficient providers in the region • Hybrid model would be better in areas where there are existing BH organizations. • No one model will get us to the goal. State should continue working with existing medical hospitals on converting beds for those they are already serving. Hospitals are nervous about reimbursement, commitment from the state, and managed care organization payment when medically necessary.	• Best strategy for state is a dynamic partnership with the counties. If the state tries to site and operate a facility on its own, it runs into significant problems. • Behavioral health organization has been able to site facilities successfully, requires a lot of conversations at the local level.
Salish	• 5-day, 16 bed crisis triage facility scheduled to open • 30-day, 16 bed SUD unit recently opened • Grant application submitted to renovate existing evaluation and treatment facility • Grant application submitted to add new E&T in Kitsap County.	• Secure detox facilities • Geriatric psych • Long term inpatient beds in lieu of state hospital • Crisis services • Residential facilities and affordable housing	• Similar model was used for DD services in the state. Unclear how such a model would work for rural communities. • Concerned about state operated facilities falling into the same patterns as the state hospitals.	• Workforce development continues to be significant concern. State does not have interstate agreements to transfer licensing, so obtaining license can take 3-6 months.
Pierce	• Two private psychiatric facilities with ~200 beds	• All services are clustered in Tacoma. Need to focus funding on outskirts of regions, on county lines as a hub between two counties.		
Spokane	• One private psychiatric facility with ~100 beds	• Jail diversion and triage facilities • Facilities for chemical dependency	• Need to consider that there will be less need for inpatient services as	• Workforce and funding are concurrent and persistent issues.

Region	Projects Underway	Identified Priorities	Facilities for 90- and 180-day commitments	Any additional information
	• Recently opened a housing complex in Spokane	• Broad need for assisted outpatient treatment, including housing and employment • Improved capacity to integrate physical and behavioral health • Assertive outreach into the community	community moves forward with outreach and outpatient services • Small facilities should plan for more than one restraint room to serve 90 and 180-day commitments • Rural areas will face challenge in building workforce to support population as well as developing supports within community to facilitate safe discharge.	• Rural and native communities are universally underserved
SW WA	Opioid treatment facility recently added to Columbia River. Current program is operating above capacity.	• Evaluation and treatment beds • Crisis stabilization • Competency restoration	• Support the smaller, community-based approach over continuing the state hospital model. • For evaluation and treatment admission, individuals need medical clearance though an ED first, which can be both costly and traumatic. With new facility, we would need to figure out a better process for getting clearance or providing medical clearance onsite. • Also, state should consider logistics around wait lists, local demand, coordination with police, and things like ambulance drop off design.	• Need to sure up financing for the operation of new facilities and programs. Lack of services for the Medicare population right now. Evaluation and treatment isn't allowable under Medicare and that's going to be pretty substantial population for evaluation and treatment facilities and for state hospitals. • In past funding requests, legislature has been very restrictive in how the funding may be used, which hinders its effectiveness.
Thurston-Mason*	• Two private psychiatric facilities with a total of ~200 beds.	• Residential • Crisis • Secure Detox		
Great Rivers	• One new evaluation and treatment facility will open in 1-3 months. Second evaluation and treatment facility recently opened	• Housing under Housing First model • Inpatient substance use disorder facilities • Residential facilities to meet the needs of vulnerable populations	• Agree with more local evaluation and treatment facility model and size, though they are expensive to operate ($3.7M per year). • Should be co-occurring capable and able to address significant	• Encourage state to be creative in how they approach the model for rural communities. • Co-location of services in clinics, schools and other institutions would benefit rural populations and

Region	Projects Underway	Identified Priorities	Facilities for 90- and 180-day commitments	Any additional information
	and includes 6 bed crisis support unit. • Grant for secured detox facility awarded 18 months ago, including a 23-hour bed. • Grant for transitional diversion housing recently awarded will add 33 beds in region. • Grant awarded for detox facility in Grays Harbor. • SUD secure detox facility also recently opened (statewide resource)	• Integrated BH, medical and social services to serve rural population with limited resources • Pediatric services	medical need of Western State Hospital patients • Support model of state-owned and contract-operated, with opportunities to incorporate quality metrics and re-procure as needed. • For 16 people, facility should be staffed with 5-6 recovery specialists, 2 nurses, and a unit manager. The smaller the better to provide one on one care. A 3:1 ratio is generally sufficient to manage everyone effectively.	maximize the utility of public resources. • Would be beneficial to have someone on staff who could support these facilities as they establish policies and procedures, etc., to help guide them through the process.

*Representatives from Thurston-Mason and Greater Columbia were unavailable during the interview timeframe. Individuals with statewide experience offered the identified priorities for those regions.

6. Regional Level Gap Analysis

This section of the report provides guidance regarding the target number of beds per care continuum category for each region. In Section 6.1, we explain the methodology used to determine bed totals by region. Next the report provides suggestions on how many beds, by type, should be added by region. Finally, the determined needs are ranked by priority, using both quantitative data and stakeholder input.

6.1 Methodology

To establish a benchmark for the targeted number of residential and inpatient beds in Washington per capita, we completed a peer state comparison using data from Colorado, Illinois, Massachusetts, Minnesota, and Oregon. Bed data was extracted from a 2017 report from the National Association of State Mental Health Program Directors.[11] While several factors might have since changed, Public Consulting Group used this report as a benchmark for data calculations. The report includes two classifications: "residential and other 24-hour care" and inpatient beds. For comparison purposes, the categories of residential, crisis services, and secure withdrawal management and stabilization beds were grouped under the broader "residential and other 24-hour services" category. For inpatient beds, the cited report provided the total beds per capita inclusive of forensic beds. Source data from the report further indicated that, on average, the percent of inpatient beds that were reserved for forensic programs was 19 percent.[12] Since the data set for Washington excludes forensic beds – and consistent data on the specific number of forensic program beds in other states was unavailable – we reduced the inpatient total from each peer state by 19 percent. We then averaged the peer state ratios to calculate our target beds per 100,000 population as shown in Table 24.

Table 24. Calculating the Peer State Average

	Residential	Inpatient		
State	Residential Beds/100k	Inpatient Beds/100k	% Forensic Beds	Non-Forensic Inpatient Beds/100k
CO	20	23	19%	19
IL	17	34	19%	27
MA	36	37	19%	30
MN	29	25	19%	20
OR	44	24	19%	20
Average	29	28	19%	23

The peer state ratio averages for residential and non-forensic inpatient beds were then multiplied by the population of each region to calculate the target number of beds per region by bed category. The suggested number of beds for each region and bed category can be found in Table 25.

[11] National Association of State Mental Health Program Directors August 2017 Trend in Psychiatric Inpatient Capacity, United States and Each State, 1970 to 2014 report.
[12] The national average number of inpatient forensic beds was determined to be 19% from SAMHSA's National Mental Health Services Survey (N-MHSS): 2014 Data on Mental Health Treatment Facilities.

Table 25. Calculating the Regional Total Suggested Number of Beds

Region	Bed Category	Peer State Beds /100,000	Regional Population	Target Beds by Category	Total Target Beds
Great Rivers	Residential	29	283,697	83	148
	Inpatient	23		65	
Greater Columbia	Residential	29	725,099	212	379
	Inpatient	23		167	
King	Residential	29	2,188,649	641	1,145
	Inpatient	23		505	
North Central	Residential	29	255,378	75	134
	Inpatient	23		59	
North Sound	Residential	29	1,248,530	366	653
	Inpatient	23		288	
Pierce	Residential	29	876,764	257	459
	Inpatient	23		202	
Salish	Residential	29	372,218	109	195
	Inpatient	23		86	
Spokane	Residential	29	601,915	176	315
	Inpatient	23		139	
SW WA	Residential	29	507,520	149	266
	Inpatient	23		117	
Thurston-Mason	Residential	29	344,298	101	180
	Inpatient	23		79	
Total	Residential	29	7,404,068	2,168	3,875
	Inpatient	23		1,707	

As the residential bed category aggregated three care continuum categories, Public Consulting Group de-aggregated the suggested bed counts to determine the suggested number of beds for each care continuum category. The split among these three categories was calculated as the percentage of each bed type based on the current regional bed ratios as shown in Table 26. This calculation resulted in 54 percent of beds for residential and other 24-hour services, 37 percent of beds for crisis services, and 9 percent of beds for secure withdrawal management and stabilization as shown in Table 26.

Table 26. Current Distribution of Residential Beds per 100,000

	Great Rivers	Greater Columbia	King	North Central	North Sound	Pierce	Salish	Spokane	SW WA	Thurston-Mason	Total	Percent
Residential and Other 24-Hour Services	5	2	8	3	7	15	13	30	8	5	97	54%
Crisis Services	18	6	2	10	2	5	6	8	8	3	67	37%
Secure Withdrawal Management and Stabilization	8	0	0	0	1	0	0	4	3	0	16	9%
Total Beds/100k	31	8	10	13	10	21	19	42	19	8	181	100%

The proportions calculated in Table 26 were then multiplied by the target number of residential and inpatient beds to find the target beds by care continuum category, as shown in Table 27.

Table 27. Dividing the Regional Target Number of Beds by Care Continuum Category

Region	Care Continuum Category	Target Beds	Percent Distribution	Target Beds by Care Continuum Category	Total
Great Rivers	Residential	83	54%	45	148
	Crisis Services		37%	31	
	Secure Withdrawal Management and Stabilization		9%	8	
	Inpatient	65		65	
Greater Columbia	Residential	212	54%	114	379
	Crisis Services		37%	79	
	Secure Withdrawal Management and Stabilization		9%	19	
	Inpatient	167		167	
King	Residential	641	54%	344	1,145
	Crisis Services		37%	239	
	Secure Withdrawal Management and Stabilization		9%	58	
	Inpatient	505		505	
North Central	Residential	75	54%	40	134
	Crisis Services		37%	28	
	Secure Withdrawal Management and Stabilization		9%	7	
	Inpatient	59		59	
North Sound	Residential	366	54%	196	653
	Crisis Services		37%	136	
	Secure Withdrawal Management and Stabilization		9%	33	
	Inpatient	288		288	
Pierce	Residential	257	54%	138	459
	Crisis Services		37%	96	
	Secure Withdrawal Management and Stabilization		9%	23	
	Inpatient	202		202	
Salish	Residential	109	54%	58	195
	Crisis Services		37%	41	
	Secure Withdrawal Management and Stabilization		9%	10	
	Inpatient	86		86	
Spokane	Residential	176	54%	95	315
	Crisis Services		37%	66	
	Secure Withdrawal Management and Stabilization		9%	16	
	Inpatient	139		139	
SW WA	Residential	149	54%	80	266
	Crisis Services		37%	55	
	Secure Withdrawal Management and Stabilization		9%	13	
	Inpatient	117		117	
Thurston-Mason	Residential	101	54%	54	180
	Crisis Services		37%	38	
	Secure Withdrawal Management and Stabilization		9%	9	
	Inpatient	79		79	

Total	Residential	2,168	54%	1,163	3,875
	Crisis Services		37%	808	
	Secure Withdrawal Management and Stabilization		9%	197	
	Inpatient	1,707		1,707	

The difference between the target bed count and current bed count was then calculated to identify the beds to be added in each care continuum category and region. These estimates are provided in Table 28. In Section 6.2 below, we provide further explanation and guidance to interpret these targets.

Table 28. Calculating the Number of Beds to Add by Region

Region	Care Continuum Category	Target Bed Count	Current Bed Count	Gap	Total Need
Great Rivers	Residential	45	14	31	22
	Crisis Services	31	50	-19	
	Secure Withdrawal Management and Stabilization	8	24	-16	
	Inpatient	65	38	27	
Greater Columbia	Residential	114	18	96	232
	Crisis Services	79	40	39	
	Secure Withdrawal Management and Stabilization	19	1	18	
	Inpatient	167	88	79	
King	Residential	344	184	160	427
	Crisis Services	239	39	200	
	Secure Withdrawal Management and Stabilization	58	0	58	
	Inpatient	505	495	10	
North Central	Residential	40	8	32	100
	Crisis Services	28	26	2	
	Secure Withdrawal Management and Stabilization	7	0	7	
	Inpatient	59	0	59	
North Sound	Residential	196	92	104	280
	Crisis Services	136	21	115	
	Secure Withdrawal Management and Stabilization	33	8	25	
	Inpatient	288	252	36	
Pierce	Residential	138	135	3	197
	Crisis Services	96	48	48	
	Secure Withdrawal Management and Stabilization	23	0	23	
	Inpatient	202	79	123	
Salish	Residential	58	48	10	79
	Crisis Services	41	22	19	
	Secure Withdrawal Management and Stabilization	10	0	10	
	Inpatient	86	46	40	
Spokane	Residential	95	179	-84	-54
	Crisis Services	66	48	18	
	Secure Withdrawal Management and Stabilization	16	24	-8	
	Inpatient	139	118	21	
SW WA	Residential	80	40	40	143
	Crisis Services	55	42	13	

	Secure Withdrawal Management and Stabilization	13	16	-3	
	Inpatient	117	25	92	
Thurston-Mason	Residential	54	16	38	111
	Crisis Services	38	10	28	
	Secure Withdrawal Management and Stabilization	9	0	9	
	Inpatient	79	43	36	
Total	Residential	1,163	734	429	1,538
	Crisis Services	808	346	462	
	Secure Withdrawal Management and Stabilization	197	73	124	
	Inpatient	1,707	1,184	523	

Supportive Housing

For supportive housing, peer state data that aligned with Washington data was unavailable. Therefore, to determine the number of supportive housing beds required in each region, we applied the United States Department of Housing and Urban Development's Homeless Assistance Programs Calculating Unmet Need for Homeless Individuals and Housing.[13] The report provides the following methodology to calculate unmet need for permanent supportive housing:

Unmet Need for Permanent Supportive Housing =

(The number of unsheltered homeless persons who need Permanent Supportive Housing

+ the number of persons in Emergency Shelter who need Permanent Supportive Housing

+ the number of persons in Transitional Housing who need Permanent Supportive Housing

+ the number of persons in Safe Havens who need Permanent Supportive Housing)

- (Total number of vacant Permanent Supportive Housing beds + Permanent Supportive Housing beds under development)

To calculate the number of unsheltered homeless persons who need permanent supportive housing, we referenced the 2017 Point in Time Counts by State document from the Housing and Urban Development Exchange,[14] as shown in Table 29. The Point in Time count represents the number of homeless people on a given night, sheltered and unsheltered. [15]

[13] https://www.hudexchange.info/resources/documents/CalculatingUnmetNeed_December2011.pdf
[14] https://www.hudexchange.info/resource/3031/pit-and-hic-data-since-2007/
[15] https://endhomelessness.org/resource/what-is-a-point-in-time-count/

Table 29. Number of Unsheltered Homeless Persons Who Need Permanent Supportive Housing

State	Unsheltered Homeless, 2017
Washington	8,591

To calculate the number of persons in emergency shelter, transitional housing and safe havens who need permanent supportive housing, we used the 2017 Housing Inventory Count Counts by State document from the Housing and Urban Development Exchange.[4] Public Consulting Group took the total year-round beds for each bed type and multiplied by the participation rate to calculate the number of people currently using each bed type annually in Table 30.

Table 30. Number of Persons in Emergency Shelter, Transitional Housing, and Safe Havens Who Need Permanent Supportive Housing

Bed Type	Year-Round Beds	Participation Rate	Annual Need
Emergency Shelter	8,428	67.49%	5,688
Transitional Housing	5,815	69.32%	4,031
Safe Havens	45	100%	45

To identify the total number of vacant permanent supportive housing beds as well as the number of beds under development, we referenced Washington State 2018 Housing Inventory Count from the Homelessness Data Exchange document provided by Commerce. To calculate vacancy, the total number of supportive housing beds was subtracted the Point in Time count as shown in Table 31.

Table 31. Total Number of Vacant Permanent Supportive Housing Beds

Total Permanent Supportive Housing Beds	Permanent Supportive Housing PIT Count	Vacant Beds	Total Permanent Supportive Housing Beds Under Construction
11,912	10,557	1,355	115

Inputting the above data points into the Housing and Urban Development methodology estimated the unmet need for permanent supportive housing for Washington at 16,885 beds, or 228 beds per 100,000 population. Table 32 provides the complete calculation.

Table 32. Unmet Need for Permanent Supportive Housing in Washington

Equation Item	Data
# of unsheltered homeless who need Permanent Supportive Housing	8,591
# of people in Emergency Shelter who need Permanent Supportive Housing	5,688
# of people in Transitional Housing who need Permanent Supportive Housing	4,031
# of people in Safe Havens who need Permanent Supportive Housing	45
# of vacant Permanent Supportive Housing beds	1,355
# of Permanent Supportive Housing beds under development	115
Unmet Need of Permanent Supportive Housing	16,885
Unmet Need of Permanent Supportive Housing per 100,000 Population	228

To distribute this total number of additional beds over the ten regions, we calculated the current distribution of bed utilization by region using the Point in Time counts from the Washington State 2018 Housing Inventory Count from Homelessness Data Exchange document. Each regional percentage was then multiplied by the total unmet need of 16,885 permanent supportive housing beds as shown in Table 33.

Table 33. Total Number of Beds to Add to Each Region

Region	Point in Time Counts per Region	Percentage	Additional Bed Need
Great Rivers	183	1.73%	293
Greater Columbia	581	5.50%	929
King	5,457	51.69%	8,728
North Central	44	0.42%	70
North Sound	1,908	18.07%	3,052
Pierce	821	7.78%	1,313
Salish	329	3.12%	526
Spokane	694	6.57%	1,110
SW WA	443	4.20%	709
Thurston-Mason	97	0.92%	155
Total	10,557	100%	16,885

There are limitations with this supportive housing methodology. Distributing the unmet need based on current Point in Time count assumes that the current distribution of housing beds across regions is proportionally accurate. For example, individuals in the King region account for approximately 52 percent of current occupancy. Our distribution assumes that King will continue to account for 52 percent of occupancy when additional beds are added. In addition, any variations in baseline data can have a significant impact on the final calculation.

6.2 Bed Analysis by Region

In the following section, we discuss the results of the above calculation for each region and how the "target" numbers described may be interpreted for planning purposes. As noted in previous sections of this report and reported by stakeholders, housing represents a significant need across all regions.

Great Rivers

For Great Rivers, the methodology suggests that the largest treatment facility gaps occur in residential and inpatient settings. The negative result for crisis service beds denotes that this region's capacity exceeds that of other regions and care continuum categories on a per capita basis. Importantly, Great Rivers is one of only two regions in the state where 24-bed secure withdrawal management and stabilization facilities are currently operated. These facilities are providing services for individuals from multiple regions. Until each region is equipped with secure withdrawal management and stabilization bed capacity, Great River's secure withdrawal management and stabilization beds are a key component to the behavioral health treatment system in Washington.

Table 34. Regional Bed Analysis Chart (Great Rivers)

Care Continuum Category	Current Bed Count	Target Bed Count	Gap
Residential	14	45	31
Crisis Services	50	31	-19
Secure Withdrawal Management and Stabilization	24	8	-16
Inpatient	38	65	27
Supportive Housing	301	594	293
Total	427	742	315

Greater Columbia

Greater Columbia similarly shows the largest gaps in residential and inpatient capacity. Unlike Great Rivers, however, the results for this region suggest that each category is underfunded when compared to other regions on a per capita basis.

Table 35. Regional Bed Analysis Chart (Greater Columbia)

Care Continuum Category	Current Bed Count	Target Bed Count	Gap
Residential and Other 24-Hour Services	18	114	96
Crisis Services	40	79	39
Secure Withdrawal Management and Stabilization	1	19	18
Inpatient	88	167	79
Supportive Housing	826	1,755	929
Total	973	2,135	1,162

King

The methodology suggests that King is lacking in residential and crisis beds compared to other regions. King is one of the few regions where several community hospitals and evaluation and treatment facilities are operated, thus diminishing the gap when compared to other regions on a per capita basis. As noted in Section 6.1, the housing methodology assumes that King will continue to represent approximately 52 percent of supportive housing utilization. Thus, the housing gap represented here is the largest bed count across all regions.

Table 36. Regional Bed Analysis Chart (King)

Care Continuum Category	Current Bed Count	Target Bed Count	Gap
Residential and Other 24-Hour Services	184	344	160
Crisis Services	39	239	200
Secure Withdrawal Management and Stabilization	0	58	58
Inpatient	495	505	10
Supportive Housing	5,767	14,495	8,728
Total	6,485	15,640	9,155

North Central

North Central is a small, rural region with very few facilities across all categories. With no current residential, inpatient or secure detox beds, individuals requiring services in this region must travel outside of their home communities to access these levels of care.

Table 37. Regional Bed Analysis Chart (North Central)

Care Continuum Category	Current Bed Count	Target Bed Count	Gap
Residential and Other 24-Hour Services	8	40	32
Crisis Services	26	28	2
Secure Withdrawal Management and Stabilization	0	7	7
Inpatient	0	59	59
Supportive Housing	159	229	70
Total	193	363	170

North Sound

Residential facilities represent the largest gap for North Sound compared to other regions and categories, followed closely by crisis services. For each of these categories, the target bed count is more than three times the current bed count.

Table 38. Regional Bed Analysis Chart (North Sound)

Care Continuum Category	Current Bed Count	Target Bed Count	Gap
Residential and Other 24-Hour Services	92	196	104
Crisis Services	21	136	115
Secure Withdrawal Management and Stabilization	8	33	25
Inpatient	252	288	36
Supportive Housing	2,133	5,185	3,052
Total	2,506	5,838	3,332

Pierce

In Pierce, the number of residential beds matches the average per capita capacity of other regions. Importantly, the populations served by residential facilities may vary widely across the data set. As with all negative results in this section, the total capacity does not suggest that all clinical needs for the population are appropriately met by the current facilities.

Table 39. Regional Bed Analysis Chart (Pierce)

Care Continuum Category	Current Bed Count	Target Bed Count	Gap
Residential and Other 24-Hour Services	135	138	3
Crisis Services	48	96	48
Secure Withdrawal Management and Stabilization	0	23	23
Inpatient	79	202	123
Supportive Housing	897	2,210	1,313
Total	1,159	2,669	1,510

Salish

Across all categories, Salish showed the smallest gap to target of less than 50 percent for residential, crisis and inpatient services.

Table 40. Regional Bed Analysis Chart (Salish)

Care Continuum Category	Current Bed Count	Target Bed Count	Gap
Residential and Other 24-Hour Services	48	58	10
Crisis Services	22	41	19
Secure Withdrawal Management and Stabilization	0	10	10
Inpatient	46	86	40
Supportive Housing	417	943	526
Total	533	1,138	605

Spokane

Compared to other regions on a per capita basis, Spokane has a higher level of capacity in both residential and secure detox. As noted above, Spokane is one of two regions operating 24-bed secure detox facilities, which currently serve individuals originating from multiple regions across the state. In the residential category, Spokane is also one of only two regions currently operating a large enhanced service facility, which serves populations with specific diagnoses and is also very likely treating individuals from multiple regions in the state.

Table 41. Regional Bed Analysis Chart (Spokane)

Care Continuum Category	Current Bed Count	Target Bed Count	Gap
Residential and Other 24-Hour Services	179	95	-84
Crisis Services	48	66	18
Secure Withdrawal Management and Stabilization	24	16	-8
Inpatient	118	139	21
Supportive Housing	808	1,918	1,110
Total	1,177	2,233	1,056

Southwest Washington

Southwest Washington shows the largest gap in inpatient care, with a target count nearly five times higher than the current count for this population. The gap to target for residential and crisis services is approximately 50 percent or less. A 16-bed secure detox facility is currently planned or Southwest Washington, which satisfies the previous gap against target for this region.

Table 42. Regional Bed Analysis Chart (SW WA)

Care Continuum Category	Current Bed Count	Target Bed Count	Gap
Residential and Other 24-Hour Services	40	80	40
Crisis Services	42	55	13
Secure Withdrawal Management and Stabilization	16	13	-3
Inpatient	25	117	92
Supportive Housing	465	1,174	709
Total	588	1,439	851

Thurston-Mason

Thurston-Mason shows no secure detox beds and just ten crisis beds. The region is supported, however, by both community hospital and evaluation and treatment beds. The 16 residential beds shown under the current bed count represent planned beds for this region. Intermediate care and diversion resources to support ongoing recovery will be key to ongoing development.

Table 43. Regional Bed Analysis Chart (Thurston-Mason)

Care Continuum Category	Current Bed Count	Target Bed Count	Gap
Residential and Other 24-Hour Services	16	54	38
Crisis Services	10	38	28
Secure Withdrawal Management and Stabilization	0	9	9
Inpatient	43	79	36
Supportive Housing	139	294	155
Total	208	474	266

Table 44 summarizes the targeted beds by region and category.

Table 44. Summary of Bed Gaps by Region and Category

Region	Residential	Crisis Services	Secure Withdrawal Management and Stabilization	Inpatient	Supportive Housing	Total
Great Rivers	31	-19	-16	27	293	315
Greater Columbia	96	39	18	79	929	1,162
King	160	200	58	10	8,728	9,155
North Central	32	2	7	59	70	170
North Sound	104	115	25	36	3,052	3,332
Pierce	3	48	23	123	1,313	1,510
Salish	10	19	10	40	526	605
Spokane	-84	18	-8	21	1,110	1,056
SW WA	40	13	-3	92	709	851
Thurston-Mason	38	28	9	36	155	266
Total	429	462	124	523	16,885	18,423

6.3 Prioritization of Bed Needs by Region

Public Consulting Group conducted intraregional analyses to identify which care continuum bed types within each region to prioritize. The analysis ranked need based on the unmet bed need within each region and stakeholder input on community identified priorities.

Unmet need scoring was based on the number of existing beds and gap to target as follows (also shown in Table 45):

- 5: Highest priority, no beds currently operated in the care continuum category
- 4: Gap to target was more than 250 percent of the current bed count for the category
- 3: Gap to target between 51-250 percent of the current bed count for the category
- 2: Gap to target between 1-50 percent of the current bed count for the category
- 1: No gap to target or a negative result based on current bed county for the category

For the community identified priority analysis, we employed a binary scoring system. If a care continuum category was noted as a key priority in Public Consulting Group's community feedback process, a score of 3 was assigned. If a category was not mentioned, no score was assigned, indicated by an asterisk.

Table 45. Unmet Bed Need Classification Key

Score	Unmet Bed Need Criteria	Classification
1	No Bed Increases Suggested	Very Low Priority
2	1-50% Bed Increase	Low Priority
3	51-250% Bed Increase	Moderate Priority
4	> 250% Bed Increase	High Priority
5	No Current Beds	Very High Priority

Great Rivers

Using the above methodology, residential and inpatient beds were identified as the highest priority for Great Rivers. While secure withdrawal management and stabilization beds were identified as a very low priority based on the unmet need analysis, community identification of these beds as a priority resulted in a rank of third. Note here again that the current secure withdrawal management and stabilization beds in Great Rivers serve individuals from multiple regions, which may be contributing to the perception of overall need in this area. Crisis services were the only category not explicitly identified by stakeholders and showing very low priority based on current bed counts per capita.

Table 46. Demonstration Regional Facility Prioritization Ranking Chart - Great Rivers

Rank	Care Continuum Category	Unmet Need	Community Identified Priority	Total
1	Residential	3	3	6
5	Crisis Services	1	*	1
4	Secure Withdrawal Management and Stabilization	1	3	4
1	Inpatient Services	3	3	6
1	Supportive Housing	3	3	6

*Not specifically identified by the community as a priority

Greater Columbia

Residential and secure withdrawal management and stabilization beds were tied as the most pressing care continuum categories to address in Greater Columbia. Public Consulting Group identified both as high priority for unmet need and both were also community identified priorities. The need for residential beds was followed closely by supportive housing. Stakeholders representing the needs of Greater Columbia did not specifically identify crisis or inpatient services for this region. However, all categories showed a moderate to significant gap in services on a per capita basis compared to other regions.

Table 47. Demonstration Regional Facility Prioritization Ranking Chart - Greater Columbia

Rank	Care Continuum Category	Unmet Need	Community Identified Priority	Total
1	Residential and Other 24-Hour Services	4	3	7
4	Crisis Services	3	*	3
1	Secure Withdrawal Management and Stabilization	4	3	7
4	Inpatient Services	3	*	3
3	Supportive Housing	3	3	6

*Not specifically identified by the community as a priority

King

Given its large population and current lack of secure withdrawal management and stabilization beds, secure withdrawal management and stabilization was identified as the top priority for this region, followed by crisis beds and supportive housing. As noted in previous sections of this report, community hospital and evaluation and treatment beds operated in King reduce the need for inpatient beds relative to other regions in the state.

Table 48. Demonstration Regional Facility Prioritization Ranking Chart - King

Rank	Care Continuum Category	Unmet Need	Community Identified Priority	Total
3	Residential and Other 24-Hour Services	3	3	6
2	Crisis Services	4	3	7
1	Secure Withdrawal Management and Stabilization	5	3	8
5	Inpatient Services	2	*	2
3	Supportive Housing	3	3	6

*Not specifically identified by the community as a priority

North Central

As noted above, North Central lacks beds in several categories and stakeholders recognized the broad need for behavioral health facilities across this region.

Table 49. Demonstration Regional Facility Prioritization Ranking Chart - North Central

Rank	Care Continuum Category	Unmet Need	Community Identified Priority	Total
3	Residential and Other 24-Hour Services	4	3	7
4	Crisis Services	2	3	5
1	Secure Withdrawal Management and Stabilization	5	3	8
1	Inpatient Services	5	3	8
5	Supportive Housing	2	*	2

*Not specifically identified by the community as a priority

North Sound

Secure withdrawal management and stabilization was the highest priority category in North Sound. It was as high priority for bed need within the region and was a community identified priority. Second was residential beds with moderate priority for bed need in the region. It was also identified as a community priority. Residential beds are followed closely by supportive housing. Inpatient services were not specifically identified by stakeholders and were ranked low priority based on the gap to target.

Table 50. Demonstration Regional Facility Prioritization Ranking Chart - North Sound

Rank	Care Continuum Category	Unmet Need	Community Identified Priority	Total
2	Residential and Other 24-Hour Services	3	3	6
4	Crisis Services	4	*	4
1	Secure Withdrawal Management and Stabilization	4	3	7
5	Inpatient Services	2	*	2
2	Supportive Housing	3	3	6

*Not specifically identified by the community as a priority

Pierce

In the Pierce region, increasing secure withdrawal management and stabilization beds was identified as the highest priority. Public Consulting Group's unmet need analysis categorized it as a very high priority and it was the only care continuum category that was identified as a community priority. Pierce's geographic location, situated between King and Great Rivers may contribute to the gap between community identified need and unmet need by bed count. Individuals may be able to access services in these neighboring regions more readily than individuals in those regions with similarly low bed counts but more remote locations.

Table 51. Demonstration Regional Facility Prioritization Ranking Chart - Pierce

Rank	Care Continuum Category	Unmet Need	Community Identified Priority	Total
5	Residential and Other 24-Hour Services	2	*	2
2	Crisis Services	3	*	3
1	Secure Withdrawal Management and Stabilization	5	3	8
2	Inpatient Services	3	*	3
2	Supportive Housing	3	*	3

*Not specifically identified by the community as a priority

Salish

All care continuum categories were specifically identified as community priorities in Salish. Therefore, based on the unmet need analysis, Salish has the highest need for increased secure withdrawal management and stabilization beds, followed by inpatient, crisis and supportive housing. While residential services were identified as a low priority based on bed count, community feedback may suggest that the residential beds in this region are not supporting the range of clinical need for its residents.

Table 52. Demonstration Regional Facility Prioritization Ranking Chart - Salish

Rank	Care Continuum Category	Unmet Need	Community Identified Priority	Total
5	Residential and Other 24-Hour Services	2	3	5
2	Crisis Services	3	3	6
1	Secure Withdrawal Management and Stabilization	5	3	8
2	Inpatient Services	3	3	6
2	Supportive Housing	3	3	6

*Not specifically identified by the community as a priority

Spokane

As discussed above, Spokane hosts one of only two enhanced service facility and secure withdrawal management and stabilization facilities currently in operation and serving individuals from other regions. these facilities contribute to the lowest priority ranking by unmet need for residential and secure withdrawal management and stabilization beds. Again, because enhanced service facilities serve specific populations, the existing beds in this region may not meet the clinical needs of region's residents. Stakeholders urged, and the bed counts support, that the key focal areas for development in Spokane are outpatient services, community outreach and care management to effectively deploy resources and help individuals access the care they need.

Table 53. Demonstration Regional Facility Prioritization Ranking Chart - Spokane

Rank	Care Continuum Category	Unmet Need	Community Identified Priority	Total
2	Residential and Other 24-Hour Services	1	3	4
1	Crisis Services	2	3	5
5	Secure Withdrawal Management and Stabilization	1	*	1
4	Inpatient Services	2	*	2
3	Supportive Housing	3	*	3

*Not specifically identified by the community as a priority

Southwest Washington

Increasing inpatient services is the greatest identified need for the Southwest Washington region. Note that these numbers account for a planned 16-bed secure withdrawal management and stabilization facility in this region, which will address the current community identified need for this category. While crisis services were categorized as a low priority in the unmet bed need analysis, the community identified crisis as a priority, particularly with respect to crisis services' role in jail diversion.

Table 54. Demonstration Regional Facility Prioritization Ranking Chart - Southwest Washington

Rank	Care Continuum Category	Unmet Need	Community Identified Priority	Total
4	Residential and Other 24-Hour Services	3	*	3
2	Crisis Services	2	3	5
3	Secure Withdrawal Management and Stabilization	1	3	4
1	Inpatient Services	4	3	7
4	Supportive Housing	3	*	3

*Not specifically identified by the community as a priority

Thurston-Mason

Secure withdrawal management and stabilization and crisis beds are the highest priorities in the Thurston-Mason region. The unmet need analysis classified both as very high priorities and both were identified by the community as priorities. Residential beds were also identified as a community priority for development in this region.

Table 55. Demonstration Regional Facility Prioritization Ranking Chart - Thurston-Mason

Rank	Care Continuum Category	Unmet Need	Community Identified Priority	Total
3	Residential and Other 24-Hour Services	3	3	6
2	Crisis Services	4	3	7
1	Secure Withdrawal Management and Stabilization	5	3	8
4	Inpatient Services	3	*	3
4	Supportive Housing	3	*	3

*Not specifically identified by the community as a priority

7. Funding Recommendations

7.1. Introduction and Methodology

The five-year plan (plan) organizes the priority rankings discussed above across five years of state funding. The plan provides a framework to guide the many decisions, including funding, that will be required on a forward moving basis. It is not expected or suggested that Washington develop the exact number of new beds projected earlier in this report and represented for reference in Section 7.2. Instead, these target numbers aim to provide a baseline understanding of how Washington can fill gaps in its care continuum across the state, bridging regional disparities in access to specific bed types.

Broadly, the plan illustrated in Section 7.2 initiates capacity building for the highest priority areas in year one and lowest priority areas in years four and five. Priorities are scheduled across the five years to add a roughly number of beds each year in different regions. Due to the large raw number of Permanent Supportive Housing beds projected across the state, capacity building for housing in several regions is spread across multiple years. Regions with the highest need in terms of raw numbers are targeted for projects that begin sooner than those with lower projected need.

7.2. Funding Allocation Five Year Plan

Figure 13 below illustrates the distribution of capital needs by year, region and bed type. In years four and five, several categories are marked "TBD." These categories were ranked as the lowest priority based on current bed capacity and were also not specifically identified by stakeholder as a priority. However, given the significant and varied development efforts targeted for years one through three, the actual need in these categories and regions will likely change over time. To address this uncertainty, we have not indicated zero beds or a negative result in any area of the plan. Those areas are instead marked TBD to indicate that the need should be reevaluated following completion of initial development efforts.

We also acknowledge that the distribution of capital funding identified in Figure 13 must directly correspond with aggressive and highly coordinated efforts in workforce development, operational funding and the expansion of community-based outreach and outpatient services. Although the scope of this analysis is limited to the distribution of capital funding, all such workstreams must be coordinated to effectively expand behavioral health care access across the state.

Figure 13. Funding Priorities by Calendar Year

	Bed Types	CY19	CY20	CY21	CY22	CY23
Great Rivers	Residential			31		
	Crisis Services					TBD
	Secure Withdrawal Management and Stabilization				TBD	
	Inpatient			27		
	Housing		293			
Greater Columbia	Residential		96			
	Crisis Services				39	
	Secure Withdrawal Management and Stabilization		18			
	Inpatient				79	
	Housing	929				
King	Residential			160		
	Crisis Services		200			
	Secure Withdrawal Management and Stabilization	58				
	Inpatient					10
	Housing	8,728				
North Central	Residential		32			
	Crisis Services				2	
	Secure Withdrawal Management and Stabilization	7				
	Inpatient	59				
	Housing					70
North Sound	Residential			104		
	Crisis Services				115	
	Secure Withdrawal Management and Stabilization		25			
	Inpatient					36
	Housing	3,052				
Pierce	Residential					3
	Crisis Services				48	

	Bed Types	CY19	CY20	CY21	CY22	CY23
	Secure Withdrawal Management and Stabilization	23				
	Inpatient				123	
	Housing				1,313	
Salish	Residential			10		
	Crisis Services			19		
	Secure Withdrawal Management and Stabilization	10				
	Inpatient			40		
	Housing			526		
Spokane	Residential				TBD	
	Crisis Services			18		
	Secure Withdrawal Management and Stabilization					TBD
	Inpatient					21
	Housing				1,110	
SW WA	Residential				40	
	Crisis Services			13		
	Secure Withdrawal Management and Stabilization				TBD	
	Inpatient		92			
	Housing				709	
Thurston-Mason	Residential			38		
	Crisis Services		28			
	Secure Withdrawal Management and Stabilization	9				
	Inpatient				36	
	Housing			155		

8. Feasibility of State-Operated, Community-Based Mental Health Hospitals

8.1. Overview

Public Consulting Group analyzed the feasibility of state-owned, community-based mental health facilities through a two-pronged approach, focused on the costs of building and operating a facility as well as administrative and regulatory challenges such facilities must face. First, we provide information on our cost analysis and then we discuss the policy environment.

Financing Review and Analysis

Startup Costs

Startup costs were determined using RS Means Data Online, a software tool that provides estimates for materials and labor for the construction of a new hospital facility. The most recent dataset available at the same in RS Means (CY2018 Q2) was utilized. To create a size estimate for a facility, Public Consulting Group reviewed nine existing Evaluation and treatment facilities and found that these facilities averaged 15,688 square feet. Roughly 1,800 square feet were added to this number to account for additional office space and/or space to accommodate medical care, which brought the total square footage for the new facility to 17,500. RS Means includes regional information in its offering, which allows costs for a new 17,500 square foot facility to be calculated in ten different cities throughout Washington. The ten cities that were chosen are the largest cities by population in each region. The construction cost for each facility was averaged to form a baseline cost estimate for the state-owned, community-based facility in Washington.

Operating Costs

Public Consulting Group explored multiple methods to determine the costs of operating a 16-bed evaluation and treatment facility. Efforts to determine operational costs included requests to state executive department officials for any existing data housed by the state regarding operational costs. As the state does not directly pay for the operations of these facilities, and such cost reporting is not legally mandated, the State does not have data that directly tracks to operational costs for these facilities.

At the suggestion of stakeholders, Public Consulting Group explored two other options to determine operational costs. The first option involved reviewing the Mental Health and Substance Use Disorder Services Data Book for Washington to identify actuarial rates as determined by the state's actuarial contractor, Mercer[16]. While this data reflects rates paid to facilities, it was not viewed as providing a full picture of operational costs, and thus was not selected for this analysis. Public Consulting Group also considered information from Behavioral Health Organization reporting. This

[16] https://www.dshs.wa.gov/sites/default/files/BHSIA/dbh/BHO/WA_BHO_Databook_2015.pdf

data was also instructive, but again did not provide a full picture of operational costs for 16-bed evaluation and treatment facilities.

Finally, Public Consulting Group reached out to the Washington State Council for Behavioral Health to determine if any member organizations would be open to sharing operational cost data in any form. Telecare Behavioral Health and Compass Health agreed to provide summary operational cost estimates for Public Consulting Group's use in this report.

Administration, Operation and Regulation

Public Consulting Group also analyzed the feasibility of a new state-owned, community based mental health facility by comparing a new facility to serve 90 and 180-day commitments to the existing models for State Hospitals and evaluation and treatment facilities. The new facility will serve the population currently served by the State Hospitals, but in a smaller community setting that shares similarities to evaluation and treatment facilities. Thus, we examined the ways in which such a facility may align with these existing models of care as well as key differences that will impact policy decisions for this model moving forward.

8.2. Start-up Costs Summary

RS Means Explanation

To provide an accurate estimate of the costs of construction for a new State-owned facility in various regions throughout Washington, Public Consulting Group used RS Means Data Online to provide estimates for materials and labor. RS Means is an internet-based software package that collects and compiles national construction cost data for a wide variety of building types. In addition to providing up-to-date cost per square foot estimates that accounts for the design, materials, and labor costs for a specific building type of a given size, RS Means also publishes a set of city cost indexes that allow for a base cost per square foot to be appropriately modified by locale to adjust for differing costs of living, land value and labor costs. This system incorporates indices to adjust costs to the local market, ensuring an estimate that reflects the costs of doing business in each region, rather than costs that reflect an average figure across the state or country.

The main variable in estimating construction cost with RS Means is the amount of square footage required for the structure. When creating the construction cost estimate, Public Consulting Group, in consultation with the Office of Financial Management, analyzed the square footage of existing evaluation and treatment facilities and found the average amount of square feet per existing evaluation and treatment facility is roughly 16,000 square feet. From there, Public Consulting Group added an additional 1,500 square feet to accommodate medical care, if the State decides to provide this service. To achieve the desired capacity of 16 beds, Public Consulting Group proposes facilities of 17,500 square feet.

Other significant variables that impact construction cost are the type of materials used for the building, and the number of floors. Public Consulting Group has used a two-story brick and concrete building type for this estimate and has not included a basement. If Washington wishes to consider adding a basement to the building for additional storage, it could increase cost estimates by

at least $1-2 million, depending on the total square footage of the building. Appendix B provides a complete listing of all cost entries included in the RS Means cost projection.

Public Consulting Group used RS Means to model the construction costs for a 17,500 square-foot state-owned facility in ten cities throughout Washington. These ten cities were selected as they are the largest metropolitan areas in their respective regions.

Key Limitations

While RS Means provides the ability to estimate construction costs in an array of unique areas across the county, a number of variables are not included in the software or the following figures. One significant unknown is the exact location and cost of land for any new facility. Thus, land will be an additional cost for Washington to consider when building these facilities.

Secondly, RS Means does not consider the cost of anti-ligature construction for the new facilities. This is a special consideration for construction that will be an additional cost for the State. Anti-ligature construction is vital to the safety of individuals, so this type of consideration will be an additional expenditure for the state to absorb. Anti-ligature construction is the process of ensuring that there are no parts of the facility that can be used for self-harm. According to Hipac.com, there are three areas of anti-ligature to focus on when construction a new behavioral health facility. These include load release anti-ligature, fixed anti-ligature, and weaponry deterrent. Release anti-ligature is a magnetic system that will unlatch when too much weight is put on the structure. Fixed anti-ligature is a system of designing structures so a cord cannot be tied around them. Lastly, weaponry deterrent is a method of eliminating items in a facility that could be used to harm oneself or others and designing products to be soft and flexible to reduce potential for harm.[17]

The RS Means costs are modeled on the "hospital" setting in the software.

In addition to the already noted limitations, items not included in these estimates include, but are not limited to, lack of site utilities, parking, landscaping, sales tax, and other variables. Also not included are costs specific to construction undertaken by the state, such as costs due to additional design requirements, prevailing wage, agency project management fees, and similar factors. These items and others will impact the total cost of construction.

Analyzing Existing Facilities

Public Consulting Group analyzed existing evaluation and treatment facilities to determine the square footage projection for the State-owned facility. Public Consulting Group searched public records and used a combination of county public records and search engine results when determining the size of existing evaluation and treatment facilities. Public Consulting Group looked at the living area and the lot size for nine existing evaluation and treatment facilities. Table 56 below provides a summary of the square feet for each existing facility. The facilities averaged 15,688 square feet of living area. Public Consulting Group added about 1,800 square feet to the average facility for medical care and/or additional office space. Public Consulting Group allotted for this

[17] https://www.hipac.com.au/anti-ligature-explained.html

extra space to allow for additional flexibility. For the cost estimation in RS Means, Public Consulting Group used a total of 17,500 square feet for the State-owned facilities. Public Consulting Group recommends this size facility based on existing facility sizes and the need for additional room for medical care or administrative space.

Table 56. Square Footage for Existing Facilities

Evaluation and Treatment Facility	County	Number of Beds	Living Area Square Feet	Lot Size Square Feet
Two Rivers Landing (adolescent)	Yakima	16	30,608[18]	83,363
Cascade Evaluation and Treatment	Lewis	16	19,626[19]	102,366
Telecare Federal Way	King	16	11,158[20]	103,097
Snohomish County Evaluation and Treatment (also called Mukilteo Evaluation and Treatment)	Snohomish	16	8,475[21]	46,609
Greater Lakes Evaluation and Treatment (Pierce County)	Pierce	16	8,471[22]	83,539
MDC Evaluation and Treatment (Metropolitan Development council)	Pierce	16	25,480[23]	18,000
Telecare Pierce County Evaluation and Treatment (community Alternatives Team)	Pierce	16	12,000	N/A
Alliance Evaluation and Treatment (Frontier Behavioral Health/Spokane MH Services)	Stevens	16	9,864[24]	37,600
Spokane Mental Health Calispel Evaluation and Treatment	Spokane	16	16,562[25]	36,917
Spokane Mental Health - Foothills Evaluation and Treatment	Spokane	16	14,636[26]	35,628
		Mean	15,688	60,791

Cost Estimation for Each Region

Public Consulting Group researched total populations for cities in Washington to determine the largest city in each of the ten regions. These cities were used for the cost estimation in RS Means. Public Consulting Group performed a cost estimation for the construction of a 17,500 square-foot brick and concrete two-story facility in each region. Bremerton, Washington and Longview, Washington did not appear in RS Means, so construction costs in Bremerton were assumed to be the same as Tacoma and Longview the same as Vancouver.

Table 57 on the following page provides the city selected for cost modeling in each region.

[18] https://www.spokeo.com/WA/Yakima/504-S-3rd-Ave
[19] http://parcels.lewiscountywa.gov/021902001011
[20] http://blue.kingcounty.com/Assessor/eRealProperty/Dashboard.aspx?ParcelNbr=7681900020
[21] http://www.snoco.org/app2/propsys/PropInfo05StructData.asp?parcel=28042200203700&lrsn=4397152&Ext=C01&StClass=Commercial&Yr=1992&ImpId=C&ImpType=GENOFF&StType=SnoCo
https://www.snoco.org/proptax/(S(c4g4sxgbjzf1thpke0skbsua))/ParcelInfo.aspx?parcel_number=28042200203700
[22] https://epip.co.pierce.wa.us/cfapps/atr/epip/land.cfm?parcel=7130000221
[23] https://epip.co.pierce.wa.us/cfapps/atr/epip/summary.cfm?parcel=2007090021
[24] https://www.spokeo.com/WA/Spokane/107-S-Division-St
[25] https://www.spokeo.com/WA/Spokane/1401-N-Calispel-St
[26] http://cp.spokanecounty.org/SCOUT/propertyinformation/Summary.aspx?PID=35082.4103

Table 57. Largest City in Each Region

City	County	Region
Seattle	King	King
Spokane	Spokane	Spokane
Tacoma	Pierce	Pierce
Vancouver	Clark	SW WA
Everett	Snohomish	North Sound
Yakima	Yakima	Greater Columbia
Olympia	Thurston	Thurston-Mason
Bremerton	Kitsap	Peninsula
Longview	Cowlitz	Timberlands
Wenatchee	Chelan	North Central

Findings

Public Consulting Group determined the total building cost estimate for a new facility in the largest city in each region. Table 58 below summarizes the costs estimations for a 17,500 square foot two-story hospital made from brick and concrete in each of the regions listed. Material and Labor costs, Equipment and Furnishing Costs, Contractor Costs, Architect Costs, and the Total Cost per Square Foot are also included in the summary chart below for each facility in the largest city in each region. Public Consulting Group averaged the above costs and used these averages to form a baseline estimate. The average cost of Materials and Labor for the evaluation and treatment facility is $4,540,213.45 and the average cost for Equipment and Furnishing is $786,581.11. The average Contractor Cost is $1,331,698.66 and the average Architect Cost is $599,264.40. Public Consulting Group determined that the average cost of construction of a new facility is $7,257,757.62 with an average total cost per square foot of $414.73.

The following criteria used in the cost estimation are consistent across every region listed below:

- RS Means building type is a two-story hospital
- Each facility will have 16 beds
- Total square feet for each facility is 17,500

The following caveats should be considered with these findings:

- These estimates do not include the cost of land acquisition.
- These estimated costs do not include permits, site utilities, site development to include parking, sidewalks, landscaping; sales tax or design or construction contingencies.
- Also, not included are costs specific to construction undertaken by the state, such as costs due to additional design requirements, prevailing wage, agency project management fees, and similar factors.
- These estimates do not account for the additional cost for ligature resistant construction.
- Future construction cost estimates should account for escalation to the mid-point of construction.

Table 58 provides details on cost estimation for each region and how Public Consulting Group arrived at the average costs.

Table 58. Cost Estimation for Each Region

Region	Location	Materials and Labor Cost	Equipment and Furnishings Cost	Contractor Cost	Architect Cost	Total Cost	Total Cost per Square Foot
King	Seattle	$4,765,697	$800,766	$1,391,616	$626,227	$7,584,306	$433
Spokane	Spokane	$4,224,367	$762,298	$1,246,666	$561,000	$6,794,331	$388
Pierce	Tacoma	$4,627,142	$795,637	$1,355,695	$610,063	$7,388,536	$422
SW WA	Vancouver	$4,522,177	$784,417	$1,326,649	$596,992	$7,230,235	$413
North Sound	Everett	$4,639,044	$795,637	$1,358,670	$611,402	$7,404,753	$423
Greater Columbia	Yakima	$4,517,340	$794,195	$1,327,884	$597,548	$7,236,966	$414
Thurston-Mason	Olympia	$4,588,754	$795,637	$1,346,098	$605,744	$7,336,233	$419
Peninsula	Bremerton (Assumed same as Tacoma)	$4,627,142	$795,637	$1,355,695	$610,063	$7,388,536	$422
Timberlands	Longview (Assumed same as Vancouver)	$4,522,177	$784,417	$1,326,649	$596,992	$7,230,235	$413
North Central	Wenatchee	$4,368,294	$757,169	$1,281,366	$576,615	$6,983,444	$399
Average		$4,540,213	$786,581	$1,331,699	$599,264	$7,257,758	$415

The ultimate cost will depend on the size and the location of the State-owned facility. Square footage greatly affects the cost of the building, so the State can use the cost per square foot to make assumptions for different size facilities. The cost per square foot for a facility in each region can be multiplied by the desired facility size to determine the total building cost for Washington. Future construction cost estimates should account for escalation to the mid-point of construction and the caveats provided above.

The location also greatly affects the total cost of the proposed facility. The total building costs vary based on the location of the facility. The most expensive city and region to build a 17,500 facility is Seattle, Washington in King County, which is a part of the King region. The total cost for the facility in Seattle is $7,584,306. Conversely, the most affordable place to build a 17,500 facility is in Spokane, Washington. The total cost for the facility in Spokane is $6,794,331. This difference in total cost amounts to $789,975.

A detailed breakdown of the cost information for the King County construction estimate can be found in Appendix B.

Construction Case Study

RS Mean's average estimated construction cost of $7.2M for a 17,500 square foot facility is supported by the recent construction of an evaluation and treatment facility by TeleCare in Pierce County. TeleCare's 12,000 square foot, 16-bed evaluation and treatment facility was built for an approximate total cost of $7,500,000. This equates to $625 per square foot in July 2017 dollars (including land acquisition). Excluding land acquisition, the cost per square foot is $525.

The facility's 16 beds include four semi-private rooms with two beds each, and eight private rooms with one bed each.

Major line items in the construction costs are as follows (approximate numbers provided):

- $1,200,000 for site acquisition,
- $40,000 for legal fees,
- $265,000 for design and administration,
- $5,000,000 for construction costs,
- $500,000 for taxes, $200,000 for fees and
- $300,000 for miscellaneous costs.

These costs include meeting all anti-ligature requirements, however, there are many unknowns about this project and whether these costs are standard for this type and size of facility. Additionally, capital construction for the state will include costs due to additional design requirements, prevailing wage, agency project management fees, art allocation, and similar factors.

Appendix C provides more details on the TeleCare Evaluation and Treatment facility including floor plans and photographs.

8.3. Operational Costs Summary

Telecare Corporation provided Public Consulting Group with operational cost estimates for a 16-bed evaluation and treatment facility using data from their knowledge of the industry and operations in the state. The data in Table 59 represents projected costs based on current Telecare-operated evaluation and treatment facilities in Washington. **Projected operational costs range from $4,900,000 - $5,200,000**. The complete estimate from Telecare can be found in Appendix D.

Table 59. Telecare Operational Cost Estimates (yearly cost estimates)

Expense Category	Estimated Operational Costs without Capital Building Costs	Estimated Operational Costs with Capital Building Costs
Wages	$2,750,000	$2,950,000
Benefits	$675,000	$700,000
Capital Expense	$35,000	$350,000
All Other Expenses	$1,440,000	$1,200,000
Total Projected Operational Expenses	$4,900,000 per year	$5,200,000 per year

Compass Health also provided Public Consulting Group with operational costs for their evaluation and treatment facility for their fiscal year, which started July 1, 2017 and ended June 30, 2018. The values provided in Table 60 are actual costs for fiscal year 2018. Compass Health is a 16-bed facility that provides behavioral health services. Compass Health has nurses on staff 24 hours a day to provide basic medical services. The complete estimate from Compass Health can be found in Appendix E.

Table 60. Compass Health Operational Costs for FY 2017-2018

Expense Category	Estimated Operational Costs without Capital Building Costs
Wages	$2,650,070
Benefits	$723,154
Capital Expense	N/A
All Other Expenses	$296,311
Total Operational Expenses	$3,669,534 per year

The costs to operate an evaluation and treatment facility varies based on prevailing wage in a geographic area, services provided, age of the facility and other factors. Thus, the State's actual costs will vary based on location, capital amortization requirements, staffing levels, and type of services provided. Public Consulting Group would like to thank Telecare and Compass Health for sharing this data.

Public Consulting Group would like to thank Telecare and Compass Health for sharing this data.

8.4. Gap Analysis & Requirement Review

To understand the requirements to which a new State operated facility may be subject, Public Consulting Group completed a gap analysis and requirements review against the evaluation and treatment model and the two existing State Hospitals.

Application of Union Rules and Employment Practices

Public Consulting Group first analyzed the union rules for State Hospitals and community evaluation and treatment facilities. State Hospital employees enter into a Collective Bargaining Agreement that sets wages, working conditions, and benefits. Conversely, evaluation and treatment facilities have the flexibility to negotiate and establish their own employee standards and hiring practices. Should the new State-owned facility be operated directly by the State, the facility would be subject to the Collective Bargaining Agreement as facility staff would be classified as State employees. However, if the State chose to contract operations for the new facility, the employees would not be subject to the terms of existing collective bargaining agreements. Under such a model, the State would have the option of requiring contractors to abide by specific hiring and employment practices through the contract terms and conditions. If the State adopted a model where the work was not completed by state employees, current law requires notification to impacted employees and the employees could ultimately compete to provide the work as a contractor. Additionally, for represented employees, the state would be required to provide notice to labor organizations with impacted employees. Current law and collective bargaining agreements require the state to bargain the decision and the impacts of the decision to contract out work historically completed by bargaining unit employees. Table 61 summarizes the union related requirements of each facility types and options available for a new facility.

Table 61. Application of Union Rules

New State Facility	State Hospital	Community Evaluation and Treatment Facilities
• Option 1: Facility is a State-owned, State-operated model in which employees are covered by the AFSCME Collective Bargaining Agreement[12] • Option 2: Facility is a State-owned, Contract-operated model in which one or more contractors are selected through a competitive process. State has the option to impose employment practice requirements through contracting only.	• The State and the Washington Federation of State Employees are responsible for negotiation of the Collective Bargaining Agreement for State employees. • The Collective Bargaining Agreement establishes pay standards for various levels of employment and employment standards.	• Evaluation and treatment facilities negotiate their own employee standards and hiring practices.

Regulatory and Licensure Requirements

State hospitals are regulated under 42 CFR 482.60. This regulation sets parameters for services that must be provided, the system for maintaining records, and staffing requirements that must be met (42 CFR 482.600). The Centers for Medicare & Medicaid Services contracts with the Department of

Health for oversight of Eastern State Hospital. The Department of Health was also responsible for oversight of Western State Hospital while they were accredited. The Department of Health contracts with Department of Social and Health Services for complaint investigations in Western State Hospital. State Hospitals are not required to file a certificate of need or undergo Construction Review Services; however, residential treatment facilities do require Construction Review Services.

The community-based evaluation and treatment facilities are defined at RCW 71.05.020. These facilities are licensed by the Department of Health. The Department of Health also licenses the Behavioral Health Administrator and certifies the evaluation and treatment services.

Given the hybrid nature of the new facility type under evaluation, additional regulations will likely be required to govern the facility's operational requirements and expectations. The specific regulations required will depend on a number of key decision points, including the operational model, scope of services to be provided and associated staffing needs. Table 62 summarizes the differences in regulatory and licensure authorities among existing facilities.

Table 62. Regulatory and Licensure Authorities

New State Facility	State Hospital	Community Evaluation and Treatment Facilities
• Washington will likely have to adhere to newly developed regulations for the new state-owned facilities. • The regulations will likely be a combination and modification of the rules and requirements for the State Hospitals, behavioral health administration, residential treatment facilities, psychiatric hospitals, and acute care hospital rules. State Hospitals may face Centers for Medicare & Medicaid Services regulation.	• Per 42 CFR 482.60[27]: "A psychiatric hospital must be primarily engaged in providing, by or under the supervision of a doctor or medicine or osteopathy, psychiatric services for the diagnosis and treatment of mentally ill persons; maintain clinical records on all patients, including records sufficient to permit the Centers for Medicare & Medicaid Services to determine the degree and intensity of treatment furnished to Medicare beneficiaries; and meet specified staffing requirements"	• Per RCW 71.05.020[28]RCW: Evaluation and treatment facility is defined as a facility that offers outpatient and inpatient care to those suffering from mental health disorders. • Evaluation and treatment facilities are licensed as residential treatment facilities or hospitals by the Department of Health per 71.34.020[16] • Evaluation and treatment facilities are also certified by the Department of Health.

Safety and Security

The State Hospitals have implemented a Security Management Plan that serves to encourage and maintain safety and security standards throughout the facility. The Security Management Plan intends to keep staff informed and trained on safety procedures in the hospital and provides response strategies for emergency situations. The State Hospitals manage visitor access through a badge system to maintain safety and security for patients and staff.

[27] https://www.law.cornell.edu/cfr/text/42/482.60
[28] http://apps.leg.wa.gov/RCW/default.aspx?cite=71.05.020

Each community evaluation and treatment facility is responsible for developing, implementing and maintaining its own safety and security standards. Given the overlap in populations, the new State facility may more closely model the standards put forth by the State Hospitals but will need to be modified to align with (1) the smaller scale of the new facility, and (2) the absence of forensic cases in the same campus.

Table 63. Safety and Security

New State Facility	State Hospital	Community Evaluation and Treatment facilities
• The new facility will likely require a modified version of the State Hospital security measures. • The safety and security measures must be implemented to ensure the safety of all staff, individuals, and visitors.	• Western State Hospital has implemented a Security Management Plan to promote safety at its facility. • The Security Management Plan establishes a security organization and requires new security technology and equipment, new training for security staff, and implementation of response plans and strategies. • State Hospitals also use visitor badges to maintain safety and security in the facilities.[29] • The Hospitals also has several protocols in place to investigate accidents and injuries and evaluate the hospital following security/safety concerns.[30]	• Each community evaluation and treatment facility is responsible for setting, implementing, and maintaining its own safety and security standards in accordance to requirements in the administrative code.

Provision of Acute Medical Care

The State Hospitals offer both acute medical care and behavioral health care. Many of the individuals committed to the State Hospital have significant, co-occurring medical conditions. A 2012 study notes that an estimated more than half of individuals with schizophrenia also suffer from a chronic medical problem and suggests that co-occurrence of physical medical problems has been associated with poorer outcomes for psychiatric conditions, greater severity of psychiatric symptoms and increased incidence of non-compliance with treatment.[31]

Community evaluation and treatment facilities only offer behavioral health care. Individuals must be medically-cleared before they are admitted to an evaluation and treatment facility, which typically occurs at a nearby Emergency Department. As stakeholders noted, the clearance process can be a source of trauma for individuals at the outset of the commitment process. Table 64 provides a summary of these differences along with three options for the State to consider for a new facility. Each option would bring its own cost implications and staffing considerations.

[29] http://www.governor.wa.gov/sites/default/files/documents/SCQISH_20160630_SafetyUpdate.pdf
[30] https://www.dshs.wa.gov/bha/division-state-hospitals/wsh-safety-office
[31] Douzenis, Athanassios, et al. "Factors Affecting Hospital Stay in Psychiatric Patients: The Role of Active Comorbidity." *BMC Health Services Research*. 2012.

Table 64. Provision of Acute Medical Care

New State Facility	State Hospital	Community Evaluation and Treatment Facilities
• Option 1: Provide acute medical care at the level maintained by the State Hospital. • Option 2: Implement an evaluation and treatment like model which requires medical clearance. • Option 3: Develop hybrid model providing initial clearance as well as limited medical coverage onsite and hospital transfers.	• The State Hospitals offer acute medical care as well as behavioral health care.	• Community evaluation and treatment facilities offer behavioral health care and do not offer acute medical care. • Individuals must be medically cleared prior to admission.

Staffing

The State Hospitals provide staffing for both medical care and behavioral health care. In 2016, Western State Hospital employed 1,899 staff members and Eastern State Hospital employed 716 staff numbers. For adult, civil psychiatric beds, Western State Hospital operated a "direct care staff to bed" ratio of 1.18, while Eastern State Hospital was slightly higher at 1.42. While flexibility is necessary to respond to the changing needs of inpatient population, these ratios are slightly lower than those observed in other states. As one example, two state psychiatric facilities operated in Massachusetts staff their adult beds at 2.32 and 1.77 mental health care direct staff per bed, respectively. In addition to mental health providers, these facilities also staff other direct medical care at 0.28 and 0.25 staff per bed.

Evaluation and treatment facilities today are focused on providing inpatient level mental health care for shorter lengths of stay. Compass Health[32] reports that their team consists of "psychiatric prescribers, registered nurses, clinicians, technicians, and peer counselors who work as a multidisciplinary team to deliver clinical services within a medical model." Staff to bed ratios were not available at the time of this report. Broadly, however, smaller facilities will lose economies of scale with respect to administrative and non-clinical service staffing. Table 65 provides a summary of the differences in staffing to consider across these models.

Table 65. Staffing Considerations

New State Facility	State Hospital	Community Evaluation and Treatment facilities
• Staffing will directly depend on the decision to provide acute medical care. • A larger number of smaller facilities will require additional facilities administration and non-clinical staff. • The level of staffing currently employed at the State Hospitals may be insufficient.	• State hospitals are staffed with direct mental health and medical care staff. • Larger facilities capture economies of scale with respect to administration and flex staffing.	• No acute medical care is provided. • Administrative costs are typically higher than larger facilities serving similar populations.

[32] https://www.compasshealth.org/services/evaluation-treatment-facility/

Facility Siting

New community evaluation and treatment facilities and other types of community-based behavioral health facilities often face resistance from communities when they are first established. A recent evaluation and treatment facility constructed in King County prompted community members to attempt to block the build, fearing loss of property values and safety concerns. The project required more than two years of obtain approval for the 16-bed facility.[33] As the State considers moving 90 and 180-day commitments into the community, stakeholders emphasized the need for local government involvement to help obtain buy-in from the community. The size of the facilities to be built will naturally determine how many are required and the level of effort required to implement with respect to siting.

Table 66. Facility Siting

New State Facility	State Hospital	Community Evaluation and Treatment Facilities
• The new facilities will likely face the same opposition as the community-owned evaluation and treatment facilities. • 16-bed facilities will require a larger number of sites to serve the entire civilly committed population. • Stakeholders urged State to work directly with local governments to build support for these facilities.	• The State Hospitals are established, high occupancy facilities with large campuses.	• Community evaluation and treatment facilities have faced some opposition from neighbors in some communities. • While serving individuals in their home communities is the ideal treatment model, implementation requires a carefully coordinated communication and engagement campaign with the communities that host such facilities.

Community Transitional and Support Services

Lastly, it is critically important to recognize that this model will require new facilities to be integrated into a behavioral health continuum of care that is also changing and restructuring. Medicaid is a major payer for behavioral health services. Alongside Medicaid payment integration and the inclusion of inpatient psychiatric commitment in the Medicaid risk model, the proposed model will require additional resource commitment and coordination within each sited community.

Several stakeholders pointed to the availability of resources in the geographic areas surrounding the current State Hospitals. These resources were built over time to support care transitions and mitigate the risk of decompensation once individuals were discharged to the community. Existing evaluation and treatment facilities have also established connections to important resources and wrap around services for the individuals they serve, who typically have shorter lengths of stay and fewer medical complications. Evaluation and treatment facilities have also historically fallen into the behavioral health organization coverage network, which provides additional care management and transition coordination for Medicaid members.

[33] https://komonews.com/news/local/not-in-my-backyard-neighbors-protest-methadone-clinic

As the State plans for a new community-based facility model, it must simultaneously plan for the additional community resources and infrastructure to support individuals who have just completed 90 to 180 days of inpatient commitment. Transition management, housing and social services, appropriate outpatient, residential and step-down options as well as trauma-informed medical care and addiction resources will be critical to successful implementation of this model.

Appendix A

Region Definitions

Services in the communities in Washington are administered by behavioral health organizations for Medicaid clients. Behavioral health organizations are responsible for coordinating care for individuals requiring behavioral health and/or substance use disorder treatment. Prior to the establishment of behavioral health organization s in April of 2016, the funding and oversight of behavioral health and substance use services were separate and managed by Regional Support Networks.[34] Washington is in the process of moving towards fully integrated care, which will occur by 2019 and integrate physical health and behavioral health services.[35]

Currently, there are 8 behavioral health organizations in the state and 2 fully integrated management care networks contracted to provide crisis and treatment services. The map below shows how the counties are broken down into regions and behavioral health organizations. Great Rivers behavioral health organization is made up of Cowlitz, Grays Harbor, Lewis, Pacific, and Wahkiakum counties. Together they make up Great Rivers Behavioral Health Organization, which will administer and fund mental health initiatives in the region.[36] Asotin, Benton, Columbia, Franklin, Garfield, Kittitas, Walla Walla, Whitman, and Yakima counties make up Greater Columbia behavioral health organization. Greater Columbia Behavioral Health oversees the agencies throughout these counties and is dedicated to bringing behavioral health services to people in the community.[37] King County behavioral health organization, made up of only King County, in committed to bringing behavioral health services to those in need.[38] North Central behavioral health organization serves residents with behavioral health needs in Chelan, Douglas, and Grant counties and will serve those in Okanogan County by January 1, 2020.[39] North Sound behavioral health organization includes Island, San Juan, Skagit, Snohomish, and Whatcom counties and provides resources to those with behavioral health needs in those counties.[40] Pierce behavioral health organization provides services and programs for those in the public behavioral health system in Pierce County.[41] Salish behavioral health organization provides services to residents in Kitsap, Clallam, and Jefferson counties.[42] Spokane behavioral health organization provides services to Spokane, Pend Oreille, Ferry, Adams, Lincoln, and Stevens counties in Washington.[43] SW WA FIMC is currently serving residents in Clark and Skamania counties with behavioral health needs.[44] Lastly, Thurston-Mason behavioral health organization

[34] https://www.hca.wa.gov/assets/billers-and-providers/behavioral-health-organization-bho-fact-sheet-partners.pdf
[35] https://www.hca.wa.gov/assets/program/fimc.nationalreview.pdf
[36] http://greatriversbho.org/about/
[37] https://www.gcbh.org/
[38] https://www.kingcounty.gov/depts/community-human-services/mental-health-substance-abuse/for-providers/bho-network.aspx
[39] http://www.mydocvault.us/uploads/7/5/8/6/7586208/04.24.18_okanogan_county_fimc_meeting_materials.pdf
[40] http://www.northsoundbho.org/About
[41] https://www.optumpiercebho.com/
[42] https://www.kitsapgov.com/hs/Pages/SBHO-Get-Behaviroal-Health-Services.aspx
[43] https://www.spokanecounty.org/2905/About-Behavioral-Health-Organizations
[44] https://www.hca.wa.gov/assets/program/FIMC-preliminary-first-year-findings.pdf

covers residents of Thurston and Mason counties with mental health, substance use disorder, and behavioral health needs.[45]

Below is a map that displays the regions and the counties in Washington.

Appendix Figure 1. Counties in Each Region

[45]https://www.resourcehouse.info/win211/Providers/ThurstonMason_Behavioral_Health_Organization_TMBHO/Behavioral_Health_Organization/1?returnUrl=%2Fwin211%2FSpecialTopics%2FFamilies%2FFamily_Preservation_and_Unification_Assistance%3F

Appendix B

King County Detailed Construction Estimate

King County - Seattle				
A	Substructure	3.13%	$9.95	$174,194.66
A1010	Standard Foundations		$6.61	$115,721.21
	Foundation wall, CIP, 4' wall height, direct chute, .148 CY/LF, 7.2 PLF, 12" thick		$3.24	$56,679.24
	Strip footing, concrete, reinforced, load 11.1 KLF, soil bearing capacity 6 KSF, 12" deep x 24" wide		$1.69	$29,661.54
	Spread footings, 3000 PSI concrete, load 400K, soil bearing capacity 6 KSF, 8' - 6" square x 27" deep		$0.77	$13,497.75
	Spread footings, 3000 PSI concrete, load 600K, soil bearing capacity 6 KSF, 10' - 6" square x 33" deep		$0.91	$15,882.68
A1030	Slab on Grade		$3.24	$56,753.55
	Slab on grade, 4" thick, non-industrial, reinforced		$3.24	$56,753.55
A2010	Basement Excavation		$0.10	$1,719.90
	Excavate and fill, 30,000 SF, 4' deep, sand, gravel, or common earth, on site storage		$0.10	$1,719.90
B	Shell	18.89%	$60.07	$1,051,297.91
B1010	Floor Construction		$14.63	$256,044.29
	Cast-in-place concrete column, 20" square, tied, 500K load, 12' story height, 394 lbs/LF, 4000PSI		$3.04	$53,140.10
	Cast-in-place concrete beam and slab, 8" slab, one way, 18" column, 30'x35' bay, 75 PSF superimposed load, 196 PSF total load		$11.59	$202,904.19
B1020	Roof Construction		$11.11	$194,466.56
	Roof, concrete, beam and slab, 30'x35' bay, 40 PSF superimposed load, 16" deep beam, 8" slab, 158 PSF total load		$11.11	$194,466.56
B2010	Exterior Walls		$25.11	$439,404.03
	Brick wall, composite double wythe, standard face/CMU back-up, 8" thick, perlite core fill		$25.11	$439,404.03
B2020	Exterior Windows		$4.19	$73,252.61
	Windows, aluminum, awning, insulated glass, 4'-5" x 5'-3"		$4.19	$73,252.61
B2030	Exterior Doors		$0.53	$9,241.87
	Door, aluminum & glass, with transom, narrow stile, double door, hardware, 6'-0" x 10'-0" opening		$0.29	$5,015.50

	Door, steel 18 gauge, hollow metal, 1 door with frame, no label, 3'-6" x 7'-0" opening		$0.24	$4,226.37
B3010	Roof Coverings		$4.49	$78,489.22
	Roofing, asphalt flood coat, gravel, base sheet, 3 plies 15# asphalt felt, mopped		$1.71	$29,913.63
	Insulation, rigid, roof deck, composite with 2" EPS, 1" perlite		$1.17	$20,448.66
	Roof edges, aluminum, duranodic, .050" thick, 6" face		$0.98	$17,206.54
	Flashing, aluminum, no backing sides, .019"		$0.20	$3,446.02
	Gravel stop, aluminum, extruded, 4", mill finish, .050" thick		$0.43	$7,474.37
B3020	Roof Openings		$0.02	$399.34
	Roof hatch, with curb, 1" fiberglass insulation, 2'-6" x 3'-0", galvanized steel, 165 lbs		$0.02	$399.34
C	Interiors	18.50%	$58.85	$1,029,831.14
C1010	Partitions		$12.53	$219,307.64
	Concrete block (CMU) partition, light weight, hollow, 6" thick, no finish		$1.22	$21,353.50
	Wood partition, 5/8" fire rated gypsum board face, 1/4"sound deadening gypsum board, 2x4 @ 16" OC framing, same opposite face, sound attenuation insul		$9.27	$162,276.98
	Gypsum board, 1 face only, exterior sheathing, fire resistant, 5/8"		$0.67	$11,759.40
	Gypsum board, 1 face only, 5/8" with 1/16" lead		$0.93	$16,346.05
	Add for the following: taping and finishing		$0.43	$7,571.72
C1020	Interior Doors		$15.33	$268,326.33
	Door, single leaf, kd steel frame, hollow metal, commercial quality, flush, 3'-0" x 7'-0" x 1-3/8"		$11.82	$206,803.33
	Door, single leaf, kd steel frame, metal fire, commercial quality, 3'-0" x 7'-0" x 1-3/8"		$3.52	$61,523.00
C1030	Fittings		$4.10	$71,801.41
	Partitions, hospital curtain, ceiling hung, poly oxford cloth		$4.10	$71,801.41
C2010	Stair Construction		$1.38	$24,234.38
	Stairs, CIP concrete, w/landing, 20 risers, with nosing		$1.38	$24,234.38
C3010	Wall Finishes		$8.39	$146,785.90
	Painting, interior on plaster and drywall, walls & ceilings, roller work, primer & 2 coats		$1.12	$19,649.07
	Painting, interior on plaster and drywall, walls & ceilings, roller work, primer & 2 coats		$0.58	$10,168.11
	Ceramic tile, thin set, 4-1/4" x 4-1/4"		$6.68	$116,968.72
C3020	Floor Finishes		$10.30	$180,173.18

	Composition flooring, epoxy terrazzo, recycled porcelain		$1.06	$18,501.13
	Terrazzo, maximum		$4.69	$82,083.09
	Vinyl, composition tile, maximum		$1.98	$34,605.90
	Tile, ceramic natural clay		$2.57	$44,983.05
C3030	Ceiling Finishes		$6.81	$119,202.30
	Acoustic ceilings, 3/4" fiberglass board, 24" x 48" tile, tee grid, suspended support		$6.81	$119,202.30
D	Services	45.10%	$143.45	$2,510,373.09
D1010	Elevators and Lifts		$5.14	$89,970.11
	Hydraulic hospital elevator, 4000 lb., 3 floors, 12 FT story height, 125 FPM		$5.14	$89,970.11
D2010	Plumbing Fixtures		$8.70	$152,165.86
	Water closet, vitreous china, bowl only with flush valve, wall hung		$2.77	$48,395.07
	Urinal, vitreous china, wall hung		$0.42	$7,266.17
	Lavatory w/trim, wall hung, PE on CI, 19" x 17"		$1.53	$26,698.67
	Kitchen sink w/trim, raised deck, PE on CI, 42" x 21" dual level, triple bowl		$0.32	$5,613.11
	Laundry sink w/trim, PE on CI, black iron frame, 48" x 21" double compartment		$0.25	$4,408.05
	Service sink w/trim, PE on CI,wall hung w/rim guard, 22" x 18"		$0.44	$7,739.26
	Bathtub, recessed, PE on CI, mat bottom, 5'-6" long		$1.52	$26,646.31
	Shower, stall, baked enamel, terrazzo receptor, 36" square		$1.30	$22,667.63
	Water cooler, electric, wall hung, wheelchair type, 7.5 GPH		$0.16	$2,731.59
D2020	Domestic Water Distribution		$19.75	$345,687.16
	Electric water heater, commercial, 100< F rise, 350 gal, 180 KW 738 GPH		$19.75	$345,687.16
D3010	Energy Supply		$5.60	$98,036.05
	Hot water reheat system for 55,000 SF hospital		$5.60	$98,036.05
D3020	Heat Generating Systems		$3.99	$69,808.69
	Boiler, cast iron, gas, hot water, 200 MBH		$0.34	$6,026.98
	Boiler, cast iron, gas, hot water, 2856 MBH		$1.66	$29,035.55
	Pump, base mounted with motor, end-suction, 4" size, 7-1/2 HP, to 350 GPM		$1.99	$34,746.15
D3030	Cooling Generating Systems		$7.13	$124,705.76
	Chiller, reciprocating, water cooled, standard controls, 60 ton		$2.42	$42,403.84
	Chiller, reciprocating, water cooled, standard controls, 150 ton		$2.30	$40,324.84

	Cooling tower, galvanized steel, packaged unit, draw thru, 60 ton		$0.67	$11,684.53
	Cooling tower, galvanized steel, packaged unit, draw thru, 110 ton		$1.73	$30,292.56
D3090	Other HVAC Systems/Equip		$47.21	$826,256.49
	Ductwork for 55,000 SF Surgery center		$18.35	$321,179.25
	AHU, rooftop, cool/heat coils, VAV, filters, 5,000 CFM		$0.98	$17,197.92
	AHU, rooftop, cool/heat coils, VAV, filters, 10,000 CFM		$3.63	$63,610.91
	AHU, rooftop, cool/heat coils, VAV, filters, 20,000 CFM		$13.42	$234,776.44
	VAV terminal, cooling, hot water reheat, with actuator / controls, 200 CFM		$6.62	$115,866.63
	Roof vent. system, centrifugal, aluminum, galvanized curb, back draft damper, 500 CFM		$0.08	$1,426.03
	Roof vent. system, power, centrifugal, aluminum, galvanized curb, back draft damper, 1500 CFM		$0.20	$3,556.24
	Roof vent. system, power, centrifugal, aluminum, galvanized curb, back draft damper, 2750 CFM		$1.25	$21,888.30
	Roof vent. system, power, centrifugal, aluminum, galvanized curb, back draft damper, 5000 CFM		$1.14	$20,009.12
	Plate heat exchanger, 400 GPM		$1.53	$26,745.66
D4010	Sprinklers		$3.56	$62,289.28
	Wet pipe sprinkler systems, steel, light hazard, 1 floor, 10,000 SF		$1.37	$24,009.22
	Wet pipe sprinkler systems, steel, light hazard, each additional floor, 10,000 SF		$2.08	$36,366.73
	Standard High Rise Accessory Package 3 story		$0.11	$1,913.34
D4020	Standpipes		$0.95	$16,541.05
	Wet standpipe risers, class III, steel, black, sch 40, 4" diam pipe, 1 floor		$0.45	$7,846.29
	Wet standpipe risers, class III, steel, black, sch 40, 4" diam pipe, additional floors		$0.22	$3,920.05
	Cabs, hose rack assembly, & extinguisher, 2-1/2" x 1-1/2" valve & hose, steel door & frame		$0.07	$1,201.73
	Alarm, electric pressure switch (circuit closer)		$0.03	$581.37
	Escutcheon plate, for angle valves, polished brass, 2-1/2"			$54.39
	Siamese, with plugs & chains, polished brass, sidewalk, 4" x 2-1/2" x 2-1/2"		$0.05	$909.94
	Valves, angle, wheel handle, 300 lb, 2-1/2"		$0.09	$1,573.39
	Cabinet assembly, includes. adapter, rack, hose, and nozzle		$0.03	$453.89
D5010	Electrical Service/Distribution		$9.50	$166,332.35

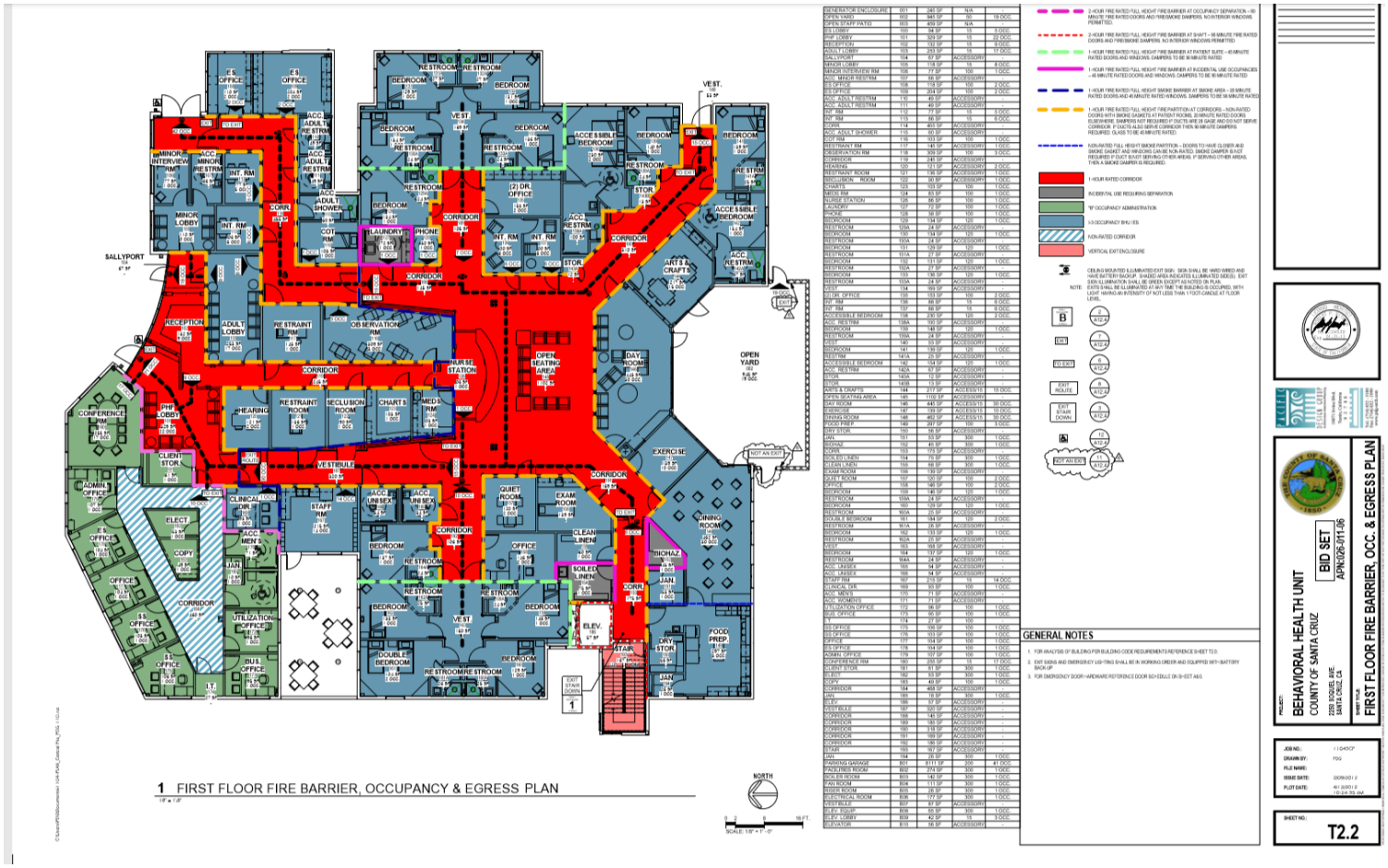
	Underground service installation, includes excavation, backfill, and compaction, 100' length, 4' depth, 3 phase, 4 wire, 277/480 volts, 800 A		$3.60	$63,061.65
	Feeder installation 600 V, including RGS conduit and XHHW wire, 800 A		$2.49	$43,505.00
	Switchgear installation, incl switchboard, panels & circuit breaker, 277/480 V, 800 A		$3.42	$59,765.70
D5020	Lighting and Branch Wiring		$21.67	$379,157.50
	Receptacles incl plate, box, conduit, wire, 20 per 1000 SF,2.4 W per SF, with transformer		$9.48	$165,975.34
	Wall switches, 5.0 per 1000 SF		$2.21	$38,687.78
	Miscellaneous power, 1.2 watts		$0.60	$10,420.46
	Central air conditioning power, 4 watts		$0.90	$15,767.73
	Motor installation, three phase, 460 V, 15 HP motor size		$1.70	$29,791.40
	Motor feeder systems, three phase, feed to 200 V 5 HP, 230 V 7.5 HP, 460 V 15 HP, 575 V 20 HP		$0.37	$6,448.30
	Fluorescent fixtures recess mounted in ceiling, 0.8 watt per SF, 20 FC, 5 fixtures @32 watt per 1000 SF		$6.40	$112,066.50
D5030	Communications and Security		$7.04	$123,145.40
	Communication and alarm systems, fire detection, addressable, 100 detectors, includes outlets, boxes, conduit and wire		$2.43	$42,575.78
	Fire alarm command center, addressable with voice, excl. wire & conduit		$0.26	$4,524.76
	Communication and alarm systems, includes outlets, boxes, conduit and wire, intercom systems, 50 stations		$2.28	$39,879.89
	Communication and alarm systems, includes outlets, boxes, conduit and wire, master TV antenna systems, 30 outlets		$0.96	$16,795.41
	Internet wiring, 8 data/voice outlets per 1000 S.F.		$1.11	$19,369.56
D5090	Other Electrical Systems		$3.22	$56,277.38
	Generator sets, w/battery, charger, muffler and transfer switch, diesel engine with fuel tank, 200 kW		$3.21	$56,230.88
	Uninterruptible power supply with standard battery pack, 15 kVA/12.75 kW			$46.50
E	Equipment & Furnishings	14.39%	$45.76	$800,766.07
E1020	Institutional Equipment		$42.24	$739,243.07
	Architectural equipment, laboratory equipment glassware washer, distilled water, economy		$0.31	$5,375.72
	Architectural equipment, sink, epoxy resin, 25" x 16" x 10"		$0.02	$417.10

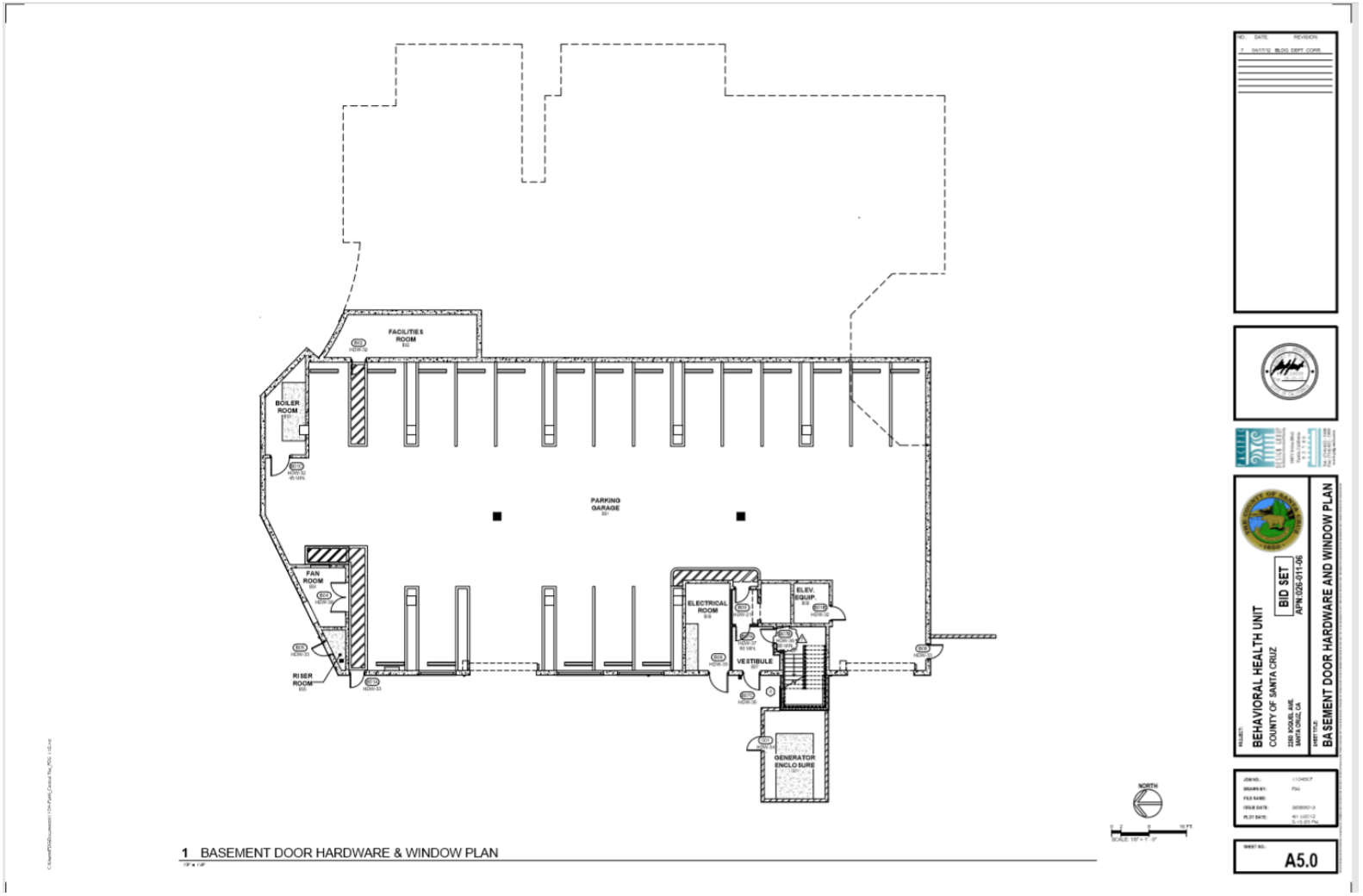
	Architectural equipment, laboratory equipment eye wash, hand held		$0.03	$449.08
	Fume hood, complex, including fixtures and ductwork		$2.06	$35,987.45
	Architectural equipment, medical equipment sterilizers, floor loading, double door, 28"x67"x52"		$4.62	$80,934.00
	Architectural equipment, medical equipment, X-ray, stationary, deluxe		$11.41	$199,703.00
	Architectural equipment, medical equipment, medical gas system for small hospital		$18.95	$331,620.45
	Architectural equipment, kitchen equipment, commercial dish washer, semiautomatic, 50 racks/hr		$0.33	$5,736.99
	Architectural equipment, kitchen equipment, food warmer, counter, 1.65 KW		$0.12	$2,079.28
	Architectural equipment, kitchen equipment, kettles, steam jacketed, 20 gallons		$0.74	$12,997.39
	Architectural equipment, kitchen equipment, range, restaurant type, burners, 2 ovens & 24" griddle		$0.46	$8,033.04
	Architectural equipment, kitchen equipment, range hood, including CO2 system, economy		$0.20	$3,465.38
	Special construction, refrigerators, prefabricated, walk-in, 7'-6" high, 6' x 6'		$3.00	$52,444.18
E1090	Other Equipment			
E2020	Moveable Furnishings		$3.52	$61,523.00
	Furnishings, hospital furniture, patient wall system, no utilities, deluxe, per room		$3.52	$61,523.00
F	Special Construction	0%		
G	Building Sitework	0%		

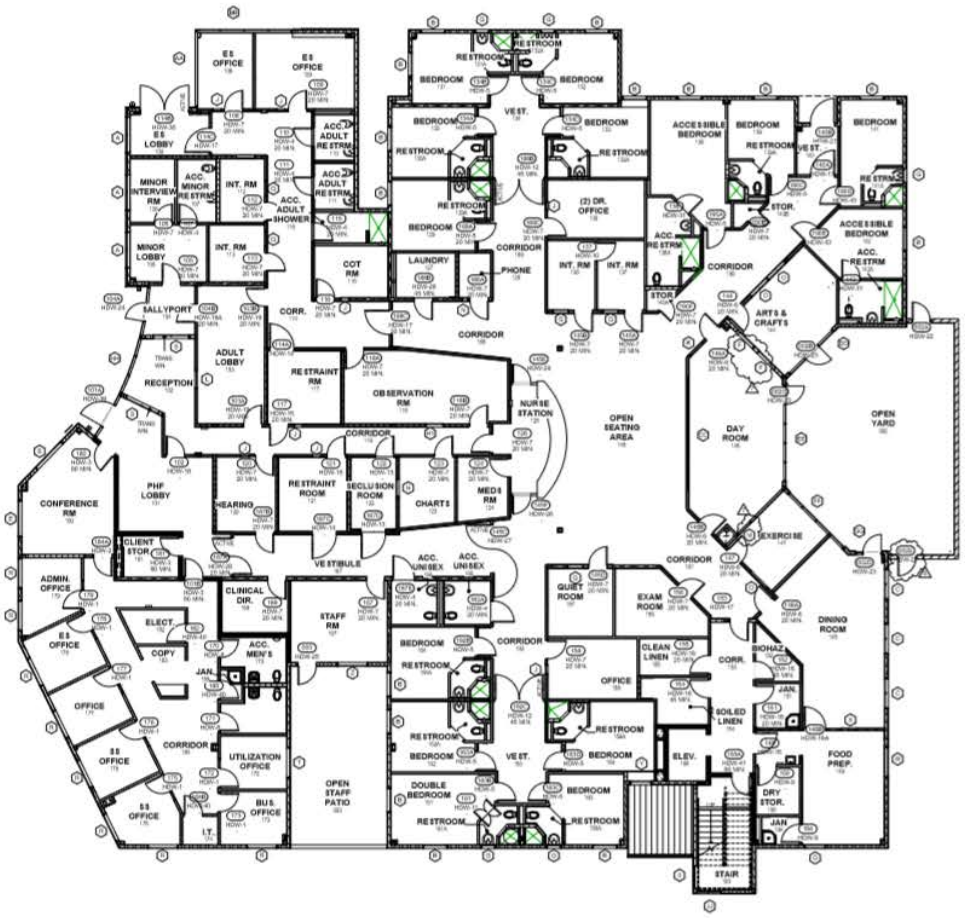
Subtotal	100%	$318.08	$5,566,462.87
Contractor Fees (GC,Overhead,Profit)	25.00%	$79.52	$1,391,615.72
Architectural Fees	9.00%	$35.78	$626,227.07
User Fees	0.00%	$0.00	$0.00
Total Building Cost		$433.39	$7,584,305.66

Appendix C

C.1 Santa Cruz Floorplan

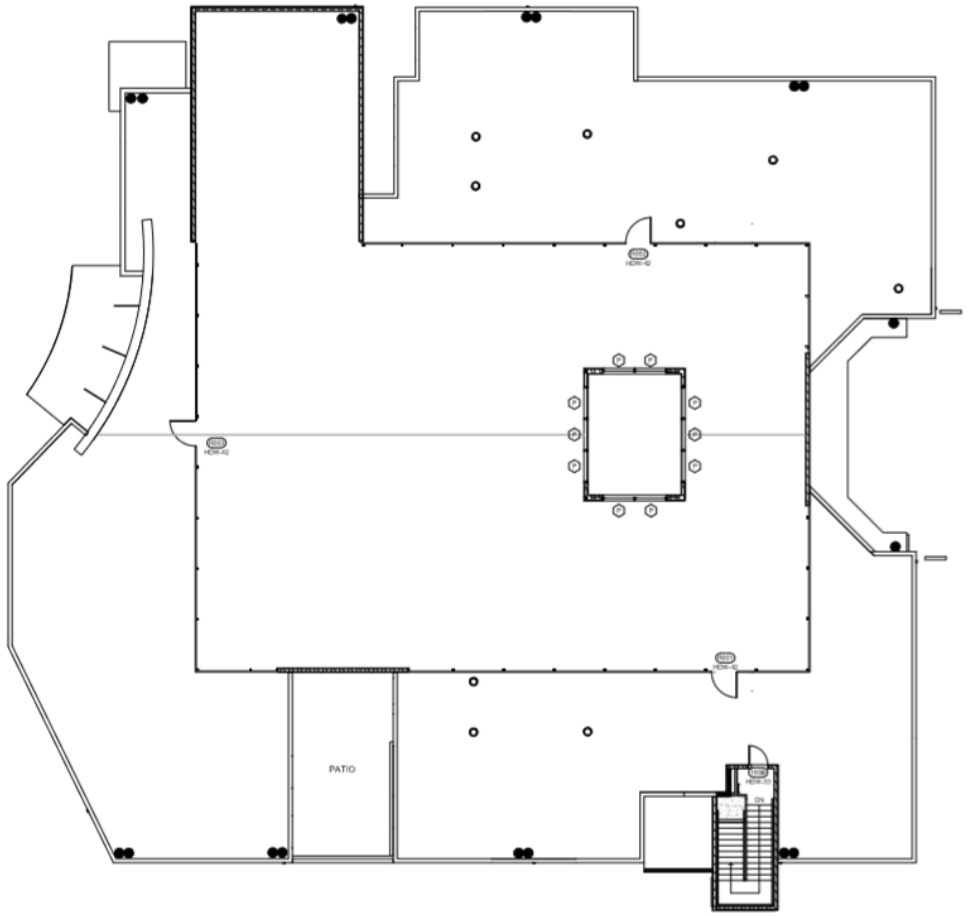



FACILITIES ROOM
BOILER ROOM
PARKING GARAGE
FAN ROOM
RISER ROOM
ELECTRICAL ROOM
ELEV. EQUIP
VESTIBULE
GENERATOR ENCLOSURE
NORTH
1 BASEMENT DOOR HARDWARE & WINDOW PLAN
BEHAVIORAL HEALTH UNIT
COUNTY OF SANTA CRUZ
BID SET
APN: 026-011-06
BASEMENT DOOR HARDWARE AND WINDOW PLAN
A5.0



1 FIRST FLOOR DOOR HARDWARE & WINDOW PLAN

BEHAVIORAL HEALTH UNIT
COUNTY OF SANTA CRUZ
BID SET
APN: 026-011-06
FIRST FLOOR DOOR HARDWARE & WINDOW PLAN
A5.1



1 CLERESTORY DOOR HARDWARE & WINDOW PLAN

NO. DATE REVISION

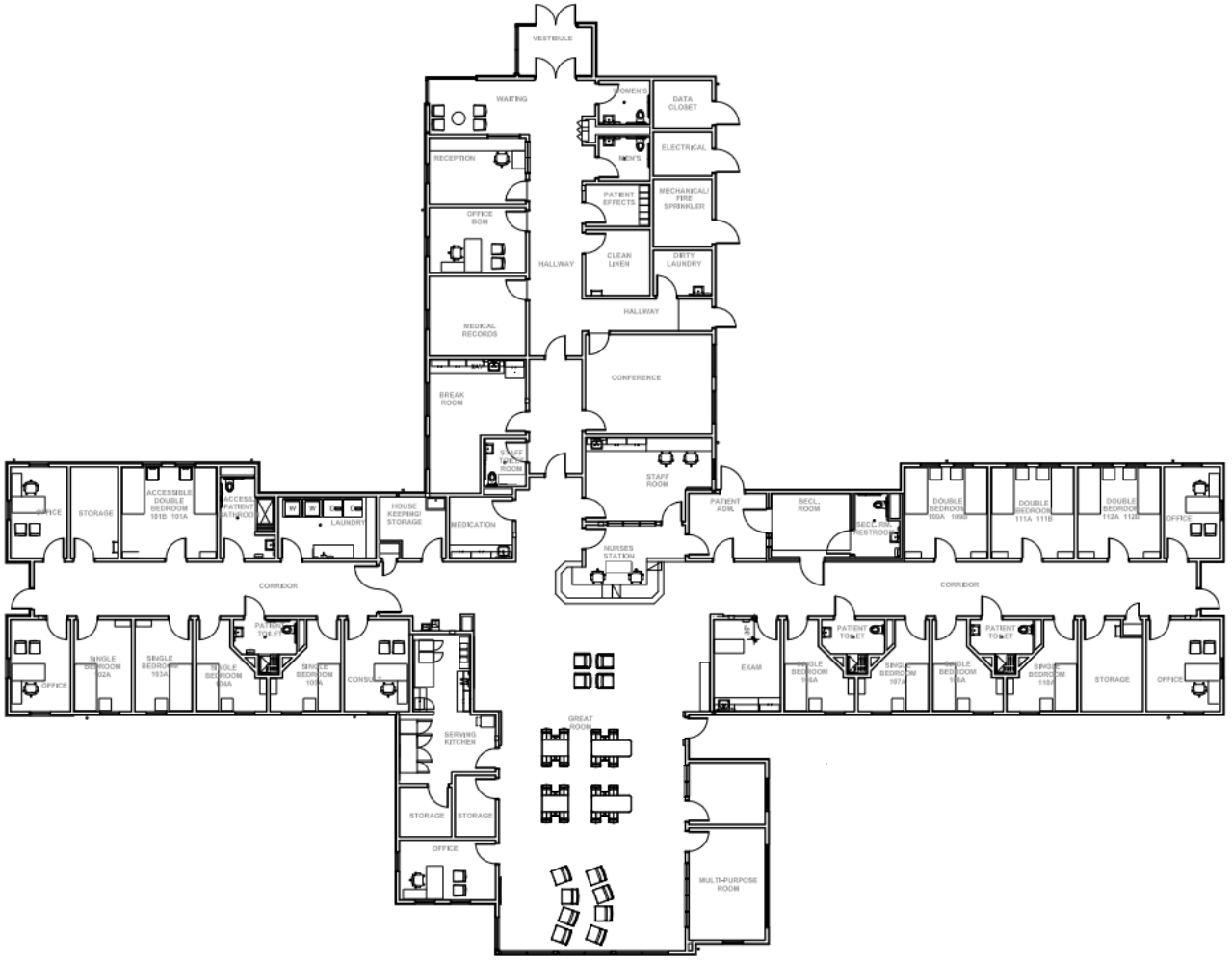
BEHAVIORAL HEALTH UNIT
COUNTY OF SANTA CRUZ
2960 ROBERT AVE
SANTA CRUZ, CA

BID SET
APN: 026-011-06

CLERESTORY DOOR HARDWARE & WINDOW PLAN

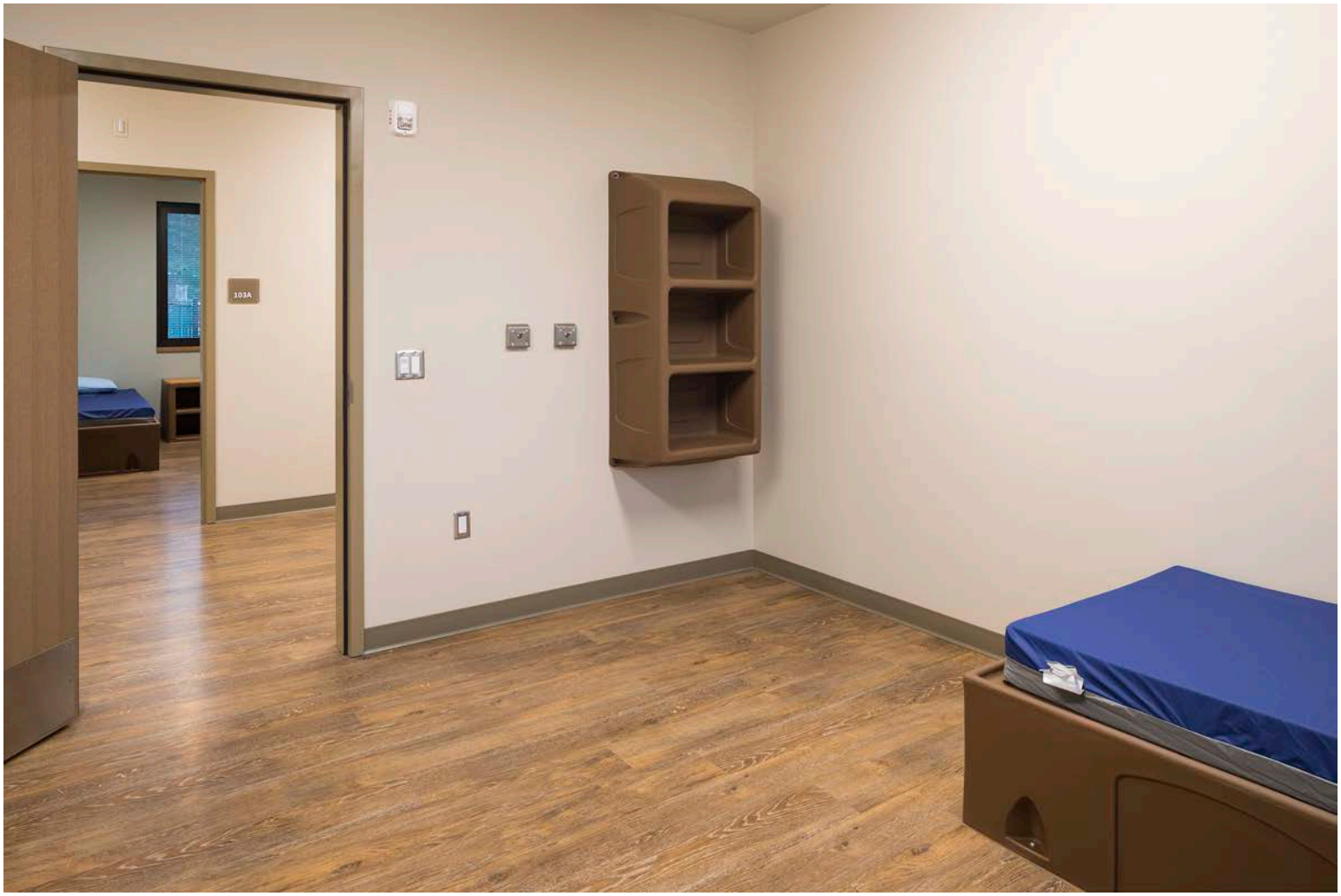
A5.2

C.2 King County Floor Plan



C.3 TeleCare King County Photographs


Recovery
life, for we are special
appy is the person who finds peace


103A

Appendix D

TeleCare Corporation Operational Costs

TELECARE CORPORATION

PROJECTED 16-BED E&T COST

CAPITAL BUILDING COST VS. NO BUILDING COSTS

Expense Category	16-Bed E&T w/o Capital Building Costs	16-Bed E&T w/ Capital Building Costs
Estimated Costs:		
Wage Expenses:	2,750,000	2,950,000
Benefits Expenses:	675,000	700,000
Capital Expenses:	35,000	350,000
All Other Expenses:	1,440,000	1,200,000
Total Projected Costs:	4,900,000	5,200,000

The above cost estimates compare the operating costs of a 16-bed E&T programs with and without capital building costs. These estimates are based on Telecare's experience operating 16-bed E&T programs in the state of Washington. In instances where there are no capital building costs, the primary customer has provided the space necessary to operate the 16-bed E&T and does not charge a facility cost to Telecare. As the staffing requirements are consistent for the 16-bed facilities, the primary variation for salary costs would be related to geographic wage difference and competition for staff. Additionally, in some instances Telecare is required to provide the maintenance for the facility and therefore must employ additional staff to perform this function.

Capital costs are subjected to variation based on the cost to obtain capital funds and contributions from the primary customer (e.g. grant funding to assist with building costs). It is possible the actual capital costs could be higher than stated above.

These estimates are not intended to be a guarantee of the actual funds need to operate a 16-bed E&T in the state of Washington as each project has its own unique cost structure based on numerous factors.

Appendix E

Compass Health Operational Costs

Compass Health **E&T Facility** **FY17-18 Statement of Expenses** **Fiscal year 7/1 to 6/30**	
Personnel Expenses	
Salaries and Wages	2,650,070
Payroll Taxes/Benefits	723,154
Total Personnel Expenses	3,373,223
Direct Expenses:	
Professional Fees	64,479
Supplies	140,843
Travel	2,032
Communications	5,121
Equipment	9,343
Client Assistance	23,140
Other	21,385
Occupancy	186,387
Professional Liability Insurance	35,590
Other Assigned Expenses	74,334
Total Other Expenses	296,311
Total Expenses	3,669,534
Number of beds	16
Annual cost per bed	229,346
Monthly cost per bed	19,112
Daily cost per bed	628

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