Washington State Health Care Authority
Report to the Legislature

Rural Access Study

ESSB 5693; Section 215(110); Chapter 297; Laws of 2022

December 2023

Legislative Summary

$50,000 of the general fund—state appropriation for fiscal year 2023 is provided on a one-time basis solely for the authority to conduct a study and provide data regarding challenges to receiving behavioral health services in rural communities. The study must review timely access to behavioral health services in rural areas including: (a) Designated crisis responder response times; (b) the availability of behavioral health inpatient and outpatient services; (c) wait times for hospital beds; and (d) the availability of adult and youth mobile crisis teams. The study must include recommendations on strategies to improve access to behavioral health services in rural areas in the short-term as the state works to develop and implement the recommendations of the crisis response improvement strategy committee established in chapter 302, Laws of 2021. The authority must submit a report to the office of financial management and the appropriate committees of the legislature with a summary of the data, findings, and recommendations.

Background

In 2021 state funding was provided to study the challenges of receiving behavioral health services in rural communities, including a summary report of data, findings, and recommendations.

The attached report, produced by Mercer, presents the methods, results, and conclusions of the study, as well as recommendations for future crisis system improvements.

Contact

For information about this report please contact Larry Green, Medical Program Specialist or Julie Brown, Crisis Servies Program Administrator, Division of Behavioral Health and Recovery, Health Care at larry.green@hca.wa.gov or Julie.brown@hca.wa.gov.

Division of Behavioral Health and Recovery
626 8th Avenue SE
Olympia, WA 98501
Phone: (844) 461-4436
www.hca.wa.gov

Mercer

Government Human Services Consulting

Rural Access Study

Accessing Behavioral Health Services in Rural Washington State Counties

Health Care Authority

October 12, 2023

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Section 1
Introduction

Under language in ESSB 5693, Chapter 297, Laws of 2022, Section 215, Proviso 110[1], The State of Washington's Health Care Authority (HCA) was tasked by the Washington State Legislature to examine challenges to receiving timely access to behavioral health (BH) services in rural counties. To assist with this study, HCA engaged with Mercer Government Human Services Consulting (Mercer), part of Mercer Health & Benefits LLC, to analyze access to an array of BH services in rural Washington counties, with particular emphasis on the following focus areas:

1. Designated Crisis Responder (DCR) response times
2. Availability of BH inpatient (IP) and outpatient (OP) services
3. Wait times for IP psychiatric hospital beds
4. Availability of adult and youth mobile crisis teams

To arrive at the findings and recommendations included in this report, Mercer:

- Reviewed crisis system utilization data collected by Behavioral Health Administrative Service Organizations (BH-ASOs) and other BH-related reports shared by HCA.
- Reviewed Managed Care Organization (MCO) and BH-ASO network adequacy standards as outlined in the Apple Health and BH-ASO contracts.
- Analyzed survey data and interview responses from select BH providers.
- Analyzed data collected during a tribal listening session.
- Synthesized and reproduced information published in recent legislative reports specific to issues experienced by tribal populations, including recommendations to improve tribal BH service delivery systems.

[1] https://lawfilesext.leg.wa.gov/biennium/2021-22/Pdf/Bills/Session%20Laws/Senate/5693-S.SL.pdf?q=20220413082126

Section 2
Background

Washington State is comprised of 39 counties (nine urban and 30 rural). To define "rural communities," and for this study, Washington utilizes the Washington State Office of Financial Management's definition of a rural county as "a county with a population density less than 100 persons per square mile."[2]

The management of physical and BH care is organized across three systems[3]:

1. The management and delivery of Medicaid services are organized across 10 integrated managed care regions where MCOs are responsible for establishing and maintaining BH networks for individuals enrolled in Washington's Apple Health program. These organizations work to ensure Medicaid recipients have access to appropriate and timely BH services, as well as to manage costs and improve the overall quality of care. Five MCOs are operating in the state — Amerigroup Washington (AMG), Coordinated Care of Washington Community Health Plan of Washington (CHPW), Molina Healthcare of Washington (MHW) and United HealthCare Community Plan (UHC). Four of the five MCOs serve members on a statewide basis, except for UHC which serves 17 of Washington's counties. Most Medicaid recipients are under a managed care arrangement; however, Apple Health offers a fee-for-service BH Services Only plan to individuals who are eligible for Apple Health but do not qualify for management care enrollment.

2. Washington State also utilizes ten regionally-based BH-ASOs whose BH network responsibilities include crisis hotline services, mental health (MH) crisis services such as mobile crisis, short-term substance use disorder (SUD) crisis services, and Involuntary Treatment Act (ITA) assessments and administration of detention petitions. BH-ASOs must provide these services to anyone in their region experiencing a MH or SUD crisis (regardless of insurance and income level.)

   BH-ASOs include:

   - Carelon — Pierce
   - Carelon — North Central
   - Carelon — Southwest
   - Great Rivers
   - Greater Columbia
   - King
   - North Sound

[2] Population density and land area criteria used for rural area assistance and other programs | Office of Financial Management (wa.gov)

[3] Apple Health managed care | Washington State Health Care Authority

- Salish
- Spokane, and
- Thurston-Mason

The study excludes BH-ASOs that serve only urban areas (Carelon — Pierce and King BH-ASOs). Carelon — North Central and Great Rivers serve only rural counties, and the remaining BH-ASOs serve a combination of both rural and urban counties.

3. Last, Washington's Apple Health Foster Care Program provides statewide physical and BH care to youth aged 21 and under in foster care placement, youth aged 21 and under who are receiving adoption support, and youth aged 18–26 years who have transitioned out of the foster care system on or after their 18th birthday. Apple Health Core Connections (Coordinated Care of Washington) administers the Apple Health Foster Care Program.

American Indian/Alaskan Native (AI/AN) Healthcare Programs[4]

Introduction

The Indian Health Care Delivery System and Indian Health Service provides health care in tribal and urban Indian communities in Washington State and includes services funded by the State Medicaid Program. BH services, including OP mental health, OP SUD, and inpatient SUD programs, are provided by over 32 Indian Health Care Providers (IHCPs), Indian Health Service Units, and Urban Indian Health Programs (UIHPs) in Washington State. The tribes, in collaboration with the Urban Indian Health Organizations and HCA, have worked over the past decade to address access to BH crisis services for American Indians and Alaska Natives (AI/AN). In addition, IHCPs participate in the state's Medicaid Transformation Project through Initiative 1[5] and the implementation of other culturally relevant projects. Through this initiative, IHCPs are improving how tribal members receive care from Washington's 29 federally recognized tribes and two UIHPs. IHCPs and UIHPs have provided integrated care for many years and serve as the health home for many AI/AN individuals in Washington state.

In 2021, the Washington State Legislature passed House Bill 1477, establishing the Crisis Response Improvement Strategy (CRIS) Committee and Steering Committee. The Steering Committee is responsible for developing recommendations for an integrated BH crisis response and suicide prevention system. Tribal organizations, tribal health partners, and state and federal partners participate in the Tribal 988 Subcommittee and report through the CRIS Committee structure. The Tribal 988 Subcommittee is facilitated through the Tribal Centric BH Advisory Board and is responsible for identifying recommendations to improve Washington's BH crisis response system for tribal populations.

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[4] Content in this section is synthesized and reproduced from the following publications: *Initial Assessment of the Behavioral Health Crisis Response and Suicide Prevention Services in Washington and Preliminary Funding Recommendations (2021) and the Washington Behavioral Health Crisis Response and Suicide Prevention System: HB 1477 Committee Progress Report and Funding Recommendations for the 988 Line Tax (2022).*

[5] Initiative 1 addresses actions to improve the Apple Health (Medicaid) health care delivery system in Washington State. Within this initiative, Accountable Communities of Health (ACHs) and Indian Health Care Providers (IHCPs) are working to improve the health of the people in their communities and regions.

History

Historically, tribal members have faced many barriers to accessing needed crisis and BH services, including long wait times for mobile crisis response and DCR services. When Washington State transitioned to a managed care system for mental health, Tribes were left without adequate funding to serve their members. Tribes have worked with the state to create plans to improve access to crisis services across the state, with the Tribal Centric BH Advisory Board overseeing the development and implementation of numerous activities, including Tribal DCRs. Beyond the statewide initiatives, the 29 tribes are in different stages of implementing local crisis services: Several have crisis lines that are either available Monday-Friday from 8:00 am – 5:00 pm or are available 24/7; Tribal-designated crisis responders who conduct ITA evaluations and investigations are under development with several Tribes; and mobile crisis response teams and crisis facilities are also being considered.

In 2013, the Tribes, Indian Policy Advisory Committee, and the Department of Social and Health Services developed a report to the legislature that outlined crisis improvement recommendations to improve the Tribal Centric Crisis System. Suggestions included timely and equitable access to crisis services for AI/AN, enhanced connections and ability to have designated crisis responders, notification and coordination by evaluation and treatment facilities when discharging AI/AN patients, legislation to allow tribal courts to issue ITA commitments for tribal citizens, training for non-Tribal DCRs for evaluations of AI/AN individuals, and conduct a feasibility study for one or more evaluation and treatment facilities to serve AI/AN individuals in need of inpatient psychiatric care.

In 2016, Tribal governments requested that the State follow federal law in ensuring that AI/ANs not be required to be covered by a Medicaid-managed care entity and be allowed to receive services through the fee-for-service system. Today, about 55% of AI/AN Medicaid enrollees remain in the fee-for-service Medicaid program instead of managed care.

In carrying out the work of HB 1477, the Steering Committee is engaging with Tribes that recognize the sovereign authorities of Tribal governments and the extensive work led by Tribes and Urban Indian Health Organizations (UIHOs) in Washington for over a decade to address the significant inequities in health and access to BH crisis services experienced by AI/AN individuals in the state.

Current State

Currently, no inpatient mental health services are available through IHCPs, which creates a lack of culturally attuned services. However, tribes are working to develop the capacity to provide inpatient mental health services by IHCPs on tribal lands. These efforts include plans to build a Tribal Evaluation and Treatment/Secure Withdrawal Management Facility. Currently there are individual Tribes looking to stand up their own BH inpatient facilities in addition to the work of the statewide facility.

Each of the 29 federally recognized tribes in the State of Washington structure and deliver unique BH programs and serve as stewards of owner-operated health systems responsive to local priorities and needs. There are significant differences in the experiences of different tribal communities regarding the current crisis response system, and these disparities are wide-ranging and have substantial ramifications for the design of an improved system.

Issue Impacting Tribal Members

The list below includes recent issues affecting tribal members in Washington State:

- Timely access to BH services
- Extended wait times in emergency rooms and a lack of coordination with IHCPs
- Lack of dedicated tribal BH treatment facilities
- Challenges with recruiting and retaining a sustainable BH workforce
- Honoring tribal court orders and clinical assessments
- Adequate funding to support tribal crisis resources
- Extensive wait times for ITA evaluations and mobile crisis response
- Disagreement with DCR's ITA evaluation of tribal members

Section 3
Methodology

Mercer's approach to assessing the availability of BH services in WA included the following:

- A review of crisis system utilization data collected by BH-ASOs and other applicable tribal and BH reports/data.
- A review of MCO and BH-ASO network adequacy standards.
- An analysis of survey data, interview responses from select BH providers, and perspectives collected during a tribal listening session.

Data Review

Mercer completed a review of BH-ASO annual (2021) and quarterly reports (2020, 2021 and 2022) for each Regional Service Area (RSA). BH-ASOs are required to submit quarterly and yearly crisis system reports for each RSA. Mercer also reviewed other applicable BH reports, such as a Network Adequacy report from September 2022 (pertaining to BH, IP and OP services) and provider network directories. The reports made available to Mercer primarily included data at the RSA level, not at the county level. Because most RSAs include a combination of rural and urban counties (except for North Central and Great River RSAs), data at the RSA level reviewed by Mercer could not be attributed to specific rural counties. As such, Mercer relied heavily on surveys and interviews with BH system stakeholders to conduct the analysis.

To inform the tribal perspective, Mercer reviewed and synthesized information across a variety of legacy reports, as well as more recent publications that depict the unique issues facing tribal members. Mercer summarized recommendations to address the myriad of challenges with accessing needed BH services on tribal lands. The most relevant publications that Mercer analyzed include the following reports:

- *Initial Assessment of the Behavioral Health Crisis Response and Suicide Prevention Services in Washington and Preliminary Funding Recommendations (2021)*
- *Washington Behavioral Health Crisis Response and Suicide Prevention System: HB 1477 Committee Progress Report and Funding Recommendations for the 988 Line Tax (2022)*

Review of Network Standards

Mercer analyzed existing contract requirements for MCOs and BH-ASOs (utilizing the WA Apple Health Integrated MCO Contract and BH-ASO Contract, respectively). The State does not specify unique contractual requirements for rural areas for most network standards. When applicable, Mercer delineates contract standards specific to rural areas.

Surveys

Mercer developed a survey targeting the four focus areas of the study and distributed the survey to over 50 recipients identified by HCA.

Respondents completed 11 survey tools. Responding agency types include:

- BH-ASOs (four completed surveys)
- MCOs (four completed surveys)
- BH providers (two completed surveys)
- A rural hospital (one completed survey)

A summary of the survey results can be found in Section 5 and the survey tool, the *State of Washington Behavioral Health Services Rural Access Study,* is in Appendix A.

Tribal Listening Session and Targeted Interviews

HCA and Mercer facilitated a listening session with tribal elected officials and health leaders on September 27, 2023. The listening session included representation across several Indian Health Care Providers (IHCP) serving urban[6], rural, and frontier tribal lands and staff representing HCA's Tribal Relations.

In addition, Mercer conducted targeted interviews with two BH-ASOs and one MCO. An analysis of survey responses and coordination with HCA helped identify interviewees. See Section 5 for a summary of the interview results. See Appendix B, *Behavioral Health Services Rural Access Study Interview Guide,* to review the questions for each focus area.

[6] Urban areas are included in the study when considering access to services for tribal members as many tribes residing in urban areas lack basic resources and adequate services to meet their behavioral health needs.

Section 4
Summary of Current Network Standards

The Centers for Medicare and Medicaid Services (CMS recently published the *Promoting Access in Medicaid and CHIP Managed Care: Behavioral Health Provider Network Adequacy Toolkit (June 2021),* which includes quantitative network standards and other strategies that states can establish to support and monitor the adequacy of the BH network. Quantitative network standards apply specific metrics or benchmarks to define and monitor access and availability of care. Examples of quantitative standards that states can use include minimum provider-to-enrollee ratios; maximum travel time or distance to providers; a minimum percentage of contracted providers that are accepting new patients; maximum wait times for an appointment; hours of operation requirements (e.g., extended evening or weekend hours); and combinations of these quantitative measures.[7]

The primary intent of establishing quantitative network standards is to promote timely access to BH services. However, the evidence to support improved access to care is limited.[8] Additional research is necessary to understand the degree to which network standards enhance access to and utilization of care, and to identify the standards that are the most effective based on the characteristics of a particular service area (e.g., rural counties, health professional shortage areas).[9]

Other barriers in the BH field limit the ability to study the impact of network adequacy standards, include:

- Lack of consensus in defining and interpreting standards across geographic regions and service area characteristics.[10]
- The impact of workforce shortages on meeting standards.[11]
- The lack of specialty providers can render time and distance standards challenging or impossible to meet.[12]

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[7] Promoting Access in Medicaid and CHIP Managed Care: Behavioral Health Provider Network Adequacy Toolkit, Centers for Medicare and Medicaid Services, June 2021.

[8] Ndumele, C. D., Cohen, M. S., & Cleary, P. D. (2017). Association of state access standards with accessibility to specialists for Medicaid managed care enrollees. *JAMA Internal Medicine, 177*(10), 1445. https://doi.org/10.1001/jamainternmed.2017.3766

[9] Zhu, J. M., Breslau, J., & McConnell, K. J. (2021). Medicaid Managed Care Network Adequacy Standards for Mental Health Care Access. *JAMA Health Forum*, 2(5), e210280. https://doi.org/10.1001/jamahealthforum.2021.0280

[10] Zhu, J. M., Polsky, D., Johnstone, C., & McConnell, K. J. (2022). Variation in network adequacy standards in Medicaid managed care. *The American Journal of Managed Care, 28*(6), 288–292. https://doi.org/10.37765/ajmc.2022.89156

[11] Bradley, K. Wishon, A. Donnelly, A.C. & Lechner, A. (2021). Network adequacy for behavioral health: Existing standards and consideration for designing adequacy standards. U.S. Department of Health and Human Services.

[12] Mattocks, K. M., Elwy, A. R., Yano, E. M., Giovannelli, J., Adelberg, M., Mengeling, M. A., Cunningham, K. J., & Matthews, K. L. (2021). Developing network adequacy standards for VA Community Care. *Health Services Research*, *56*(3), 400–408. https://doi.org/10.1111/1475-6773.13651

- Low reimbursement rates that limit providers' interest in joining networks.[13]
- Challenges maintaining up-to-date directories, and directories that are challenging to navigate.[14]

Mercer reviewed the HCA Apple Health and BH-ASO contracts for quantitative BH network standards to determine one, if the state has adopted a standard and two, if the standard is specific to rural counties. Note — Given this project's scope, Mercer's analysis did not include the state's BH network standards monitoring or a review of the Washington Administrative Code (WAC). Applicable WAC requirements include, but may not be limited to, *WAC 284-170-200, Network Access — General Standards.*

The table below includes a summary of WA's current BH network standards, presented by MCO and BH-ASO standards:

MCO Network Standards

Standard	Requirements (with Apple Health contract citation)	Analysis
Operating Hours	MCOs must have an adequate number of BH provider agencies that offer urgent and non-urgent same-day, evening, and weekend services (6.2.1.8).	HCA has adopted this quantitative standard for all regions within the state.
Maximum Wait Times for Appointments (Appointment Standards)	Transitional healthcare services provided by a home care MH Professional or other BH professional must be provided within seven days of discharge from IP or institutional care for physical or BH care (6.9.2). Non-urgent, symptomatic (i.e., routine care) BH office visits must be available within ten (10) calendar days (6.9.4) and urgent, symptomatic BH visits within 24 hours (6.9.5).	HCA has adopted these quantitative standards for all regions within the state.
Distance to Providers	Distance standards include Urban/non-urban: one provider within 25 miles (6.11.2).	The state has not adopted unique distance standards for rural areas for BH providers, MH Professionals or SUD Professionals.
Maximum Travel Time	For rural areas, drive time to the closest provider is within a 30-minute drive from an enrollee's primary residence (6.11.3).	The state has adopted drive time quantitative network standards specific to rural and large rural geographic areas (population

[13] Bishop, T.F., Press M.J., Keyhani, S,& Pincus, H.A. (2014). Acceptance of insurance by psychiatrists and the implications for access to mental health care. JAMA Psychiatry, 71(2), 176-181. https://doi.org/10. 1001/jamapsychiatry. 2013.2862.

[14] (Goldman, 2022; Haeder et al., 2016; Mattocks et al., 2021; OHSU Center for Health Systems Effectiveness, 2022; Robinson, 2022)

Standard	Requirements (with Apple Health contract citation)	Analysis
	For large rural geographic areas, drive time to the closest provider is a 90-minute drive from a primary residence (6.11.3.3).	density of at least 20 and less than 500 per square mile).
Identification of Providers Not Accepting New Patients	No corresponding requirements.	While this information is collected, the state has not established a minimum percentage of providers that are not accepting new members.
Minimum Provider-to-Enrollee Ratios	No corresponding requirements.	The state does not currently require minimum provider-to-enrollee ratios.

MCO BH Network Exceptions

Sometimes, meeting established quantitative network standards may not be possible, especially in rural or frontier areas where providers may not exist, or vast geographic service areas result in a wide distribution of individuals. HCA recognizes that a full complement of critical provider types may not be available in a service area; therefore, HCA may make exceptions to network adequacy standards to provide coverage for that service area (6.12.6.1.3).

Out-of-Network Providers

HCA's contract with the MCOs includes stipulations regarding the utilization of out-of-network providers when the MCO's contracted BH network cannot accommodate timely access to needed services. The relevant contract provisions include:

"For enrollees residing in rural areas, they may seek care from a Non-Participating Provider when the service or type of provider is not available within the network or when the service or type of provider is available in the network, but an appointment with a participating provider cannot be scheduled within contractually required times (6.17.2), when it is determined that the Enrollee needs related services that would subject the individual to unnecessary risk if received separately (6.17.3), and when the state determines that circumstances warrant out-of-network treatment (6.17.4)."

BH-ASO Network Standards — Crisis Response System

Standard	Requirements (with BH-ASO Contract Citation)	Analysis
Operating Hours	Crisis Services are available 24 hours a day, seven (7) days a week (17.4.1), including crisis call centers (17.4.7).	HCA has adopted this quantitative standard for all regions within the state.
Response Times — Crisis Call Centers	17.4.8 — Crisis call centers' crisis lines must have telephone abandonment rates of five percent or less (17.4.8.1) and response times of at least 90 percent of	HCA has adopted these quantitative standards for all regions within the state.

Standard	Requirements (with BH-ASO Contract Citation)	Analysis
	calls are answered within thirty (30) seconds (17.4.8.2).	
Response Times — DCRs	Crisis response shall occur within two hours of the referral to an emergent crisis and within 24 hours of referral to an urgent crisis (17.4.1.1).	HCA has adopted these quantitative standards for all regions within the state.
Response Times — Adult and Youth Mobile Crisis	Mobile crisis services provided are available within two hours of contact for emergent, within 24 hours for an urgent crisis, and the best practice is a response within 60 minutes for all call types (17.4.5.4.2.3).	HCA has adopted these quantitative standards for all regions within the state.
Maximum Wait Times for Appointments	BH-ASOs must contract with an adequate number of BH provider agencies that offer next-day appointments for uninsured individuals who meet the definition of an Urgent BH Situation and have a presentation of signs or symptoms of a BH concern (17.4.2). BH-ASOs are encouraged to work with their crisis providers to ensure they can access next-day appointments for Individuals who meet the criteria in the next-day appointment (17.4.3.1).	HCA has adopted this quantitative standard for all regions within the state.
Availability	BH-ASOs must have established new mobile crisis teams, or enhanced existing mobile crisis team staffing, for adult and children, youth and family teams that meet the intention of Engrossed Substitute Senate Bill 5092; Section 215(65); Chapter 334; Laws of 2021. Each BH ASO will have a minimum of one adult mobile crisis outreach team and one child, youth and family mobile crisis team in the region and continue to work on increasing capacity (17.4.5).	HCA has adopted this quantitative standard for all regions within the state.
Team Composition	The goal for each mobile crisis team is to have the capacity to provide services in the community 24 hours per day, seven days per week, 365 days per year with a two-person dyad (peer and clinician). Each mobile crisis Provider must have a minimum of one Mental Health Professional (MHP) supervisor to provide clinical oversight and supervision of all staff, at all times (17.4.5.2).	HCA has adopted these standards for all regions within the state.

Standard	Requirements (with BH-ASO Contract Citation)	Analysis
Provider Qualifications	Each mobile crisis team will require at a minimum, a MHP to provide clinical assessment and a peer trained in Crisis Services, responding jointly. Mental Health Care Providers (MHCPs), with WAC 246-341-0302 exemption, can respond jointly with a peer in place of an MHP, as long as at least one MHP is available 24/7 for any MHCP or peer to contact for consultation, this MHP does not have to be the supervisor (17.4.5.3.2).	HCA has adopted this quantitative standard for all regions within the state.
Out-of-Network Providers	BH-ASOs may provide Contracted Services through Non-Participating Providers if their network of Participating Providers are insufficient to meet the BH needs of Individuals in a manner consistent with the BH-ASO contract (6.1.1.1). BH-ASOs may not contract for Crisis Services (SUD or MH) or ITA-related services out of Washington State (6.1.1.4).	HCA has adopted this quantitative standard for all regions within the state.
Reporting	BH-ASOs must submit a quarterly Mobile Crisis report using the most recent template provided by the HCA. This report will include quarterly data on certified peer counselor services and adult and youth crisis services (17.4.5.1). For each RSA, the BH-ASO must provide crisis system reports to include quarterly and annual reports (17.9.1).	HCA has adopted this quantitative standard for all regions within the state. The reporting requirements do not include county-specific reports.
Satisfaction Surveys	No corresponding requirements.	The state does not currently require BH-ASOs to complete member satisfaction surveys. However, member survey requirements are found in the MCOs contracts and, as such, MCOs administer surveys for all Medicaid services.

Section 5

Survey, Interview, and Tribal Listening Session Findings

Mercer distributed a survey to over 50 recipients identified by HCA and, in response, received 11 completed survey tools. Targeted recipients included key stakeholders in Washington's BH community. Stakeholders serving only urban counties were excluded from the survey as this study focuses on rural access to BH services.

The following entities provided survey responses:

- Four BH-ASOs: Salish, North-South, Spokane, and Greater Columbia.
- Four MCOs: AMG, CHPW, MHW and UHC.
- One hospital: Providence St. Peter Hospital.
- Two BH providers: Northeast Washington Alliance Counseling Services and Wahkiakum County Health and Human Services

Responding BH-ASOs serve 18 out of 30 of Washington's rural counties, responding MCOs serve all 30 rural counties, and the BH providers serve four. The hospital respondent represents Thurston County.

Mercer also facilitated three in-depth interviews with BH-ASOs and MCOs. Interviews included:

- Two BH-ASOs: Carelon (serving seven rural counties) and Great River (serving five rural counties)
- One MCO: Coordinated Care of Washington (serves all 30 rural counties)

Survey and Interview Findings by Focus Area

The following section provides a summary of key survey results per focus area. It is important to note that survey and interview responses represent a portion of Washington's BH operational, management, and direct-service entities and may reflect experiences in some, but not all, rural counties.

Focus Area 1: Designated Crisis Responder (DCR) Response Times

Dedication of DCRs to Rural Counties:

- All responding BH-ASOs dedicate DCRs specifically to rural counties. One BH-ASO utilizes their own employees as well as contracted staff to serve in the DCR role.
- Some DCRs in rural counties hold dual roles as DCRs and mobile crisis outreach providers. One BH-ASO employs 11 DCRs and a supervisor who may provide coverage during high-demand periods.
- One BH-ASO is offering DCRs monetary incentives to help with job retention, bonuses, assistance with re-location, and flexible working schedules. This BH-ASO can deploy a

pool of staff to counties that may lack access to DCRs and may assist traveling DCRs by providing hotel rooms or access to temporary housing,

- Because DCRs must be available seven days a week, 24 hours per day, establishing an efficient staffing schedule can be challenging. BH-ASOs analyze high-volume times of the day and adjust DCR staffing accordingly, but peaks in demand can be unpredictable.

The most common challenges to accessing DCR services or performing DCR responsibilities include:

- Insufficient staff coverage and a perceived lack of funding to recruit additional DCR staff.
- A lack of cellular phone service coverage in remote areas.
- Extensive travel times in remote areas.
- Widespread stigma in some rural communities associated with individuals struggling with mental health (MH) and SUD conditions. This results in some regions citing a lack of resources available to support these individuals and some emergency departments (EDs) being less accommodating to patients experiencing MH or SUD issues.
- Recruitment and retention of DCRs in rural counties is particularly challenging. Often, there is only one DCR per shift, which could delay access to services and burden the DCR to respond. Challenges to DCR employment or retention include finding affordable housing for BH professionals in rural areas and the extensive training required before deploying a DCR. In the state's rural and frontier geographic service areas, the nearest city can be over an hour and a half drive, and travel time can render DCRs unavailable for prolonged periods.
- Requirements to complete medical clearance in EDs before admitting a member to a hospital bed, evaluation and treatment centers, secure withdrawal facilities, or a crisis stabilization unit.
- While some BH-ASOs initially screen calls requesting DCR services through a dedicated crisis line, some requests may not require a response from a DCR (e.g., the member agrees to voluntary treatment). Interviewees expressed that some hospitals request DCRs to backfill hospital social workers or support ED physicians who may want a second opinion from a DCR before determining a patient’s disposition. One BH-ASO believes that DCR functions should be separate and distinct from mobile crisis services and that DCRs should only perform ITA evaluations.
- Once a DCR completes an assessment and determines that the member needs involuntary inpatient services, the DCR must search for an available ITA bed. Interviewees consistently identified limited placement options if a member meets ITA criteria. A centralized statewide ITA bed repository is under development but is not currently available. As such, DCRs must call each available IP facility to ascertain the availability of an ITA hospital bed.
- Transportation is a significant challenge as some transportation vendors refuse to transport members out of the region when hospital beds are unavailable in the member’s County of origin. Interviewees report that some EDs refuse to transport involuntary patients unless the transportation vendor has capabilities for secure transportation. In addition, ambulance payment policies do not reimburse transporters for round trips but

only pay for one-way trips, disincentivizing ambulance providers from participating in the ITA process. Particularly when it is common for individuals to need to travel across the state to access services mostly impacting rural communities with limited access to ITA providers.

DCR Data collection by BH-ASOs:

- All responding BH-ASOs reported they collect "emergent" DCR response times for rural areas, but only two collect for "urgent" DCR response times. (NOTE: HCA defines "emergent" response times as within 2 hours of a referral to a crisis and defines "urgent" response times as within 24 hours for a referral to a crisis).

ITAs:

- The average time DCRs spent on ITAs from start to finish was three-hundred eighty-six minutes.
  - Most BH-ASOs reported that it takes longer to complete the ITA process for individuals in rural areas.
  - Reasons include but are not limited to travel time, limited staffing resources to provide county-wide coverage and address multiple crises simultaneously, and coordination of transportation and placement due to long distances.

The ongoing impact of COVID on DCR Services:

- Exasperation of staffing and ITA hospital bed shortages.
- An increase in the volume of members in crisis and presenting with co-morbidities due to delays in treatment and a lack of resources secondary to the pandemic.
- Increases in demand for BH services for adults and youth.
- Adoption of the use of telehealth to complete the ITA process as opposed to in-person assessments which has improved access and reduced travel time.

Focus Area 2: Access to Inpatient and Outpatient BH Services

Top challenges to offering a wide array of BH services in rural counties:

- A pervasive lack of available BH providers in rural areas, including Spanish-speaking providers.
- Staffing shortages, including attracting and retaining qualified providers to relocate and live in rural areas. Some rural providers experience protracted delays in filling vacant staffing positions, with one provider reporting four key vacant positions for over a year.
- Access to transportation and long distances between available BH providers and individuals seeking care (some individuals must travel over two hours to find an available provider).
- Long wait times to initiate care (it commonly takes several months to secure an initial intake appointment, as reported during interviews with BH-ASO staff).

- Lack of access to broadband services in some remote areas limits the widespread utilization of telehealth.
- Provider reimbursement rates are perceived to be too low to attract and retain providers in rural areas, and the rates may not consider the unique needs of agencies operating in rural areas, including time expended related to transportation, which may not be reimbursable. In addition, some BH providers may opt to contract with commercial carriers as reimbursement rates may be higher than those offered under the Medicaid program.
- Stigma related to BH conditions and reluctance from some individuals to seek care until needs escalate to an acute crisis.
- Some available rural BH providers may choose not to participate in the Medicaid service delivery system, citing administrative burdens related to reporting and billing requirements.

Top BH services with extended delays to access the service:

- Children's Long-Term Inpatient Program (CLIP). Accessing CLIP can take months, and children are often placed out-of-state.
- Non-emergency medical transportation.
- SUD intensive IP residential.
- Involuntary IP psychiatric/MH free-standing evaluation and treatment.
- Medication management services provided by adult and child psychiatrists.

Services with wait times:

- Many BH services have documented wait times, but the wait times vary depending on the respondent and County.
  - For example, reported wait times for CLIP varied from 30–90 days to 6–9 months.
- No responding BH-ASOs, MCOs, or hospitals track wait times for OP and IP services following an ITA. Only one BH provider that responded to the survey tracks wait times for OP services.

Services offered via telehealth:

- Several respondents reported they started providing some services via telehealth during the pandemic and intend to continue this practice beyond the pandemic. Services include:
  - Hospital-based individual therapy for BH and SUD
  - Community-based BH services, including SUD and eating disorder services
  - Peer support for BH and SUD
  - Medication Management
  - Intensive OP Services

  - Psychiatry Services
  - ITA Investigations

Monitoring:

- Some BH-ASOs and one BH provider reported the use of member satisfaction surveys.
- A few entities monitor availability standards, but most BH-ASOs do not.
- All MCOs and two BH-ASOs monitor time and distance standards.
- Almost all services have no option of two+ providers in the respondents' regions.

Single Case Agreements (SCAs):

- Most MCOs use SCAs to secure out-of-network BH providers when the contracted network cannot meet member needs. MCOs vary in the frequency of SCAs, with some exercising the option 1–4 times weekly and others utilizing SCAs less frequently (1–2 times per year). Some members may be unaware that the use of SCAs is an option to access needed services.

Strategies to Attract and Retain Rural BH Providers:

- MCOs offer rural BH providers value-based purchasing arrangements and incentives for timely follow-up after IP hospitalization. In addition, MCOs have implemented workforce development and retention initiatives. One MCO funds community colleges and universities to offer scholarships incentivizing BH professionals to practice in rural areas.

Focus Area 3: Hospital Bed Wait Times

Bed Volume and Availability:

- Respondents provided differing reports of the number of beds available for youth and adults within their regions and statewide.
  - All respondents reported there are not enough beds for youth (especially children aged 12 and under in which only one facility is available statewide), but most responded there are enough for adults.
  - Some localities cannot access hospital beds and must transport individuals requiring that level of care outside the region. For example, Okanogan County does not currently have access to any MH IP beds within the County.
  - Increased prevalence of children with dual diagnoses (MH/intellectual or developmental disabilities) or autism spectrum disorders results in youth lingering in acute care settings with no intermediate levels of care available. Serving children with co-occurring conditions is more challenging when coordinating discharges and available funding with other child-serving systems (e.g., the Developmental Disabilities Administration).
- Available MH IP beds are reportedly not triaged or prioritized for the most acute patients. Hospitals may deny a patient entry to a facility due to the patient's history of assault or other challenging behaviors.

- Lengths of stay resulting from an ITA can span weeks at a time. During the ITA evaluation period, MCOs may not apply concurrent authorization reviews, leading hospitals to delay discharge planning under these circumstances. Psychiatric patients may occupy a bed at a medical facility via a single-bed certification until an open ITA bed is available. Still, this process can take up to two weeks. In other cases, extended lengths of stay are typical when members need specialized placements, discharge to skilled nursing facilities, or wait for guardianship applications to be processed. In one example, a member required ten days to stabilize in an acute IP setting but waited 75 days before an appropriate discharge could be coordinated.
- Most MCOs and BH-ASOs could not provide an average length of stay for IP beds.
- Some BH-ASOs do not track the average time to obtain an IP bed, and there was significant variability in those who reported wait times (between 12–18 hours, to one day to three weeks).
- There is a lack of geriatric psychiatric beds in the state and challenges finding beds for individuals who are experiencing dementia or organic brain conditions.

Process to Obtain a Bed:

- There does not appear to be a standardized process to identify if an IP, MH or SUD bed is available. BH-ASOs and tribal IHCPs must contact facilities all over the state to search for a bed, initiate single-bed certifications, or try to find less restrictive alternatives. Conversely, the continuum of available ambulatory services, such as the Program for Assertive Community Treatment (PACT), intensive OP services, and medication monitoring services, is insufficient to address current demands or alleviate the needs for IP treatment.

Top Reasons for a No-Bed Report:

- Lack of available beds — particularly for youth aged 12 and under.
- Lack of providers.
- Lack of staffing.
- Level of acuity — medically, BH, SUD needs.
- Lack of facilities able or willing to provide services to individuals with complex needs — co-morbidities and co-occurring disorders (I/DD, dementia, traumatic brain injury, SUD).

Ongoing Impact of COVID-19 on Hospital Bed Wait Times:

- Staffing shortages.
- Time to secure a placement.
- Facility closures (some recent).
- Longer times in EDs due to the length of time to secure placement.

Focus Area 4: Timely Access to Mobile Crisis Teams

- All responding BH-ASOs dedicate mobile crisis teams to rural counties in their region.

Team Composition and Staffing:

- Mobile crisis team size ranges from one to four individuals per team, depending on the county.
- Many mobile crisis team staff members also serve as DCRs.
- Many smaller counties maintain one mobile crisis team per shift due to staffing shortages, and some struggle to maintain 24-hour, seven-day-per-week availability. Current requirements for mobile crisis teams serving youth require 24-hour per day, seven days per week availability. The teams must include at least two staff (irrespective of whether the team operates in an urban or rural geographic service area).
- Some BH-ASOs reported mobile crisis team vacancy rates of ~30%.
- Some counties have a team that can serve adults and children, although the BH-ASO reports that legislation requires mobile crisis teams to serve youth exclusively.
- While challenges exist in recruiting and retaining an adequate workforce, the issue is less pronounced for mobile crisis team staffing as team qualification requirements are less stringent than those required for DCRs. At times, recruitment efforts target staff supporting the wraparound intensive services (WISe) Program, but the strategy can result in the WISe teams lacking appropriate staff.

Mobile Crisis Team Data Collection:

- All BH-ASOs report they track if urgent and emergent mobile crisis team service requests/referrals meet contract standards (for rural counties)
- Most BH-ASOs collect response times for emergent mobile crisis team services requests/referrals at the rural level, except for one BH-ASO.
- Average response time for emergent response is reported to be 46 minutes. The average response time for urgent response is 43 minutes.

Availability:

- Most BH-ASOs report that demand sometimes exceeds staffing capacity, although this is uncommon. One BH-ASO reports meeting two-hour response times 98% of the time.
- Most BH-ASOs reported not having enough member referrals to necessitate additional teams, but it would be beneficial to have more DCRs.
- Interviewees cite a shortage of MH professionals and a lack of peer support specialists.
- In addition to increased funding, consideration for more flexibility with criteria and staffing requirements for mobile crisis teams in rural areas is desired by the BH-ASOs.
- There has not been a concerted or organized effort to promote crisis intervention training with first responders in rural areas. Interviewees reported that law enforcement

involvement is inconsistent and varies by county, with some local first responders opting not to respond to BH crisis events.

Tribal Listening Session Findings

HCA and Mercer facilitated a tribal listening session on September 27, 2023. The listening session included individuals representing IHCPs across urban, rural, and frontier regions in eastern, central, and western Washington. Participants shared current concerns with timely access to IP (including ITA hospital beds), OP mental health and substance use disorder services, and response times for crisis mobile teams and DCR services. Results from the listening session are summarized below. Based on the feedback during the listening session, Mercer categorized the participant responses across the following topics: 1) Availability of providers, programming, and facilities; 2) Workforce challenges; 3) Issues related to characteristics of the geographic service areas; and 4) Other challenges.

The information the listening session participants shared reflects their unique experiences with the healthcare delivery system. Readers should exercise caution when generalizing that the observations reflect the same perceptions of others in the community. However, each participant openly and honestly shared their feelings regarding the discussion topics and those accounts should be honored and respected.

Availability of Providers, Programming, and Facilities

- There is a lack of detoxification centers for youth with substance use disorders in some communities. Members must travel long distances to an out-of-area hospital to receive care. Under these circumstances, the IHCP occasionally funds hotel stays for individuals following discharge due to extensive travel times and transportation challenges related to the person's return to their community.
- There is an absence of transitional housing for youth aging out of the foster care system or needing a temporary, safe placement.
- In some communities, there is a limited number of BH OP providers available to respond to crisis events.
- There is a lack of "back-end" OP BH services following mental health hospital stays.
- One participant reported that the assigned DCR refused to cover some remote areas despite HCA's expectations. In some cases, this has led to adverse outcomes for members. Alternatively, hospital discharges can result in frequent readmissions because a DCR is required to complete the ITA assessment.
- Due to a lack of alternatives, families and police are used to transport members long distances. In one example, a trip to the hospital for an assessment and return can consume 23 hours.
- In one community, the nearest substance abuse detoxification center for adults is three hours away. For youth, the drive time to a substance abuse detoxification facility doubles to six hours.
- There is an issue with communication and coordination between hospitals and tribes. There are few state resources for oversight of hospitals.

- BH inpatient and outpatient services often have long waiting lists failing to meet the needs of those with time sensitive circumstances.
- Misconceptions exist within medical transportation providers that voluntary BH hospital transportation is not covered by Medicaid.
- Mobile crisis response is not available in all communities.

Workforce Challenges

- In some communities, there is a shortage of BH counselors and psychologists to address the needs of youth. The lack of providers results in long delays in completing initial assessments and treatment plans for youth needing support and services.
- Participants reported systemic shortages of health care providers and licensed independent clinical social workers, who must bill Medicare. One representative noted that there are only two licensed clinicians in their area due to its frontier location and there is a need for more housing for healthcare workers.
- A participant noted ongoing challenges in accessing BH medical practitioners to prescribe psychotropic medications.
- Tribes do not feel that DCRs prioritize their requests for community investigations in many areas.

Issues Related to Characteristics of the Geographic Service Areas

- Almost all service areas in Eastern Washington are rural. It is approximately 40 miles from the nearest provider.
- Securing transportation is a significant barrier, and families and IHCPs must rely on tribal police for transport, which is not always possible due to limited resources and competing responsibilities. Tribal law enforcement on the reservation may transport a member to a hospital but must wait until medical professionals can see the person. The availability of mobile crisis teams and DCRs in some counties is limited and the DCRs assigned to some service areas cannot provide immediate responses to persons in need. On average, response times can be one to two hours, which attendees felt is insufficient when persons are in crisis. Family members and IHCPs must weigh who can respond sooner between crisis teams/DCRs or tribal police. Some service areas only have access to a single DCR agency to cover two counties. In some cases, it's closer to travel to a hospital for medical clearance in the neighboring county, resulting in members receiving services outside their communities.
- Internet connectivity and a lack of cellular telephone service can hinder getting care in remote tribal areas.
- Telehealth is an option, but the modality is limited, as many homes in the community do not have access to the internet.

Other Challenges

- Due to stigma, some families are reluctant to visit local BH providers in smaller communities and express concern that their health information will not be kept confidential.
- There are challenges in accessing long-term treatment services in some areas, and members must receive care far from their homes and communities. IHCPs and families experience challenges tracking where the member gets treatment once they leave the community. This ambivalence extends to awareness of discharge planning, which participants describe as poorly coordinated, with a need for more communication between the treating facility, the IHCP, and the family.
- Discharge planning from IP settings is poor. Some members are being discharged to the streets or sent back to their home community on a bus with multiple transfers that the member must negotiate. Many treating facilities lack cultural awareness and are not "in tune" with tribal members needing services.
- There are legal restrictions related to completing ITAs through the tribal court system, and memorandums of agreements are not currently in place in courts with jurisdiction over the ITA legal process.
- Jurisdictional issues exist in Tribal Crisis Coordination Planning. Some tribes are within multiple counties and regions creating complexities in planning and the services that are provided sometimes vary in different regions of the state that the tribe engages and needs crisis support from. Plans are outdated and difficult to develop.
- Often, individual cases need to be escalated to higher levels of authority to receive appropriate attention and support in communities.
- DCR agencies state that they will not get paid if they conduct an ITA evaluation that does not result in an ITA.
- There is a lack of coordination with tribe/ICHP for DCR investigations and failing to use available tribal members as collateral information or reliable witnesses for DCR investigations.

Section 6
Recommendations to Improve Access to BH Services in Rural Areas

Establishing and maintaining adequate access to BH services in rural areas is challenging for many states, and Washington is not unique in facing this challenge in its own rural geographical areas. Mercer offers the following recommendations to strengthen contractual network standards, improve network-related reporting requirements, and promote efficient processes to support Washington State's access to BH services in rural communities. This section includes general and focus area-specific recommendations for improving access to crisis and BH services in Washington.

General Recommendations — Establishing Network Standards:

HCA's contracts with MCOs and BH-ASOs include many industry-accepted quantitative network standards, but the standards do not consistently delineate differences between urban and rural geographic service areas. The application of quantitative network standards such as appointment availability and distance standards should account for differences in rural areas (e.g., provider shortages, long distances between enrollees and available providers).

Yet, general distinctions between urban and rural areas may not be sufficient when applying quantitative network standards to Washington State's rural regions. While the state has adopted a definition for rural counties[15], the disbursement of the population and the state's geography includes remote and vast frontier regions where the population density can be as low as five persons or less per square mile[16].

For example, the CMS designates five county types based on population density under the Medicare Advantage Plan - Large Metro, Metro, Micro, Rural, or Counties with Extreme Access Considerations. CMS utilizes these county designations when establishing minimum network standards such as enrollee-to-provider ratios. As such, HCA should consider differentiating urban and rural areas when prescribing quantitative network standards and should consider further delineation of the state's rural regions to account for the extreme challenges related to the availability of and access to BH services.

Recommendations included in this study are directed at specific entities within the care delivery system when applicable, such as MCOs, BH-ASOs, DCRs, and BH direct service providers. In other instances, recommendations may be at a systemic level and will require

[15] According to the Washington State Office of Financial Management (OFM), a "rural county" is defined as "… a county with a population density less than 100 persons per square mile."

[16] https://ofm.wa.gov/washington-data-research/population-demographics/population-estimates/population-density/population-density-county#slideshow-12

the attention and resources of the state legislature, the Washington State Health Care Authority, county representatives, and local officials. It will require a concerted and coordinated effort across all human service agencies and state leaders to address the complex challenges associated with administering critical BH services and supports to meet the needs of the rural citizens in Washington State.

Enhancing Network Standards

Opportunities exist to expand the current array of quantitative network standards that MCOs and BH-ASOs must meet to help ensure the adequacy of the BH network.

Examples Include the Following:

- Set a minimum limit for the percentage of providers that are not accepting new patients at a given point in time. The limit can be specific to an MCO or BH-ASO, the density of the geographic service area (e.g., rural, urban), and/or the practitioner type (e.g., psychiatrist, clinical social worker).
- Require minimum provider-to-enrollee ratios for high-volume BH practitioners.

General Recommendations — Improving Network Reporting Requirements:

Network reporting could be further enhanced by adopting some or all of the following improvements:

- HCA should establish a tracking mechanism (or similar requirement for MCOs and BH-ASOs) to monitor fee-for-service network utilization for individuals who are not participating in managed care.
- Supplement current satisfaction survey questionnaires to include indicators that assess members' perception of accessing timely appointments with practitioners authorized to prescribe psychotropic medications.
- Require contractors to develop and submit a Workforce Development and Retention Plan. The plan helps ensure that the provider network has:
    - Sufficient workforce capacity — An appropriate number of qualified workers is needed to provide service.
    - Required level of workforce capability — Workers who are interpersonally, clinically, culturally, and technically competent in the skills needed to provide services.
    - Connected workplaces — Providers with an internal capacity for developing their workforce and/or are connected to external workforce development resources.
- Enhance the required content of the provider directory. Consider mandating the following elements to the contractor provider directories: 1) If the provider offers telehealth; 2) The provider's hours of operation; 3) Provider specialties (e.g., ABA), including search functions; and 4) Information to assist members in identifying providers that match their cultural, language and race/ethnicity preferences.

- More attention needs to be placed on the programs that are not managed care or BH-ASO programs, including the fee-for-service and behavioral health services only programs to ensure network adequacy and payment parity with managed care. Some of the most vulnerable populations are not enrolled in managed care, and there is a need to assess the fee-for-service network and monitor parity between the programs.

Focus Area-Specific Recommendations

Consistent access to timely BH services (including DCR and mobile crisis team responses) in rural Washington State is a formidable and multifaceted challenge. In addition to national BH provider workforce shortages and an unprecedented demand for BH services following the public health emergency, the state faces critical gaps across the continuum of BH services and the crisis response network in rural areas across the state.

The following focus area-specific recommendations seek to help address some of these challenges and leverage, promote, and further existing strategies to improve access to BH services in rural areas.

Focus Area 1: Designated Crisis Responder (DCR) Response Times

As appropriate, promote and adopt the following strategies across all rural geographic service areas:

- Offer DCR services via telehealth to supplement the ongoing availability of DCRs.
- Continue efforts to expand DCR staffing resources and review compensation schedules to assist with the recruitment and retention of DCRs in rural areas. To the extent possible and based on available funding, offer monetary incentives to help with job retention, bonuses, assistance with re-location, and flexible working schedules.
- Examine current reimbursement policies for ambulance services to assess the feasibility of a bundled payment methodology that would cover the costs for round trips in rural areas.
- Establish standardized call center screening tools to ascertain the appropriateness of deploying a DCR when requested. It was reported that some referrals do not require dispatching a DCR (e.g., the member agrees to voluntary treatment). Provide education to the Washington State Hospital Association and local hospitals regarding the appropriate role of the DCR and available alternatives to respond to members who need BH interventions.
- Explore options to reconfigure the DCR model to address ITA evaluations. For example, integrate DCR functions as part of the crisis response continuum (e.g., crisis line, mobile teams, crisis stabilization units) to consolidate and extend limited staffing resources in rural areas.
- Continue to support tribal DCRs within each region to support culturally attuned investigations and to increase timely responses to tribal members.

Focus Area 2: Access to IP and OP BH Services

As appropriate, promote and adopt the following strategies across all rural geographic service areas:

- Continue efforts to promote telehealth options for a variety of OP BH services. Include training and support for BH agencies to identify technology and infrastructure resources, as well as the appropriate delivery of telehealth when providing BH services.
- Continue efforts to implement value-based purchasing arrangements, the use of incentives, and enhanced rates to attract and retain BH providers in rural areas.
- Offer BH professionals, including bilingual Spanish-speaking staff, relocation assistance and sign-on bonuses to address staff shortages in rural areas.
- Sponsor and execute a rural BH provider reimbursement rate study and, as appropriate, adjust rates to reflect the current market values.
- Host community forums, and educational events, and create a marketing campaign to address and reduce stigma related to BH conditions in rural communities.
- Collaborate with universities and community colleges to develop curriculum and programs to educate and train BH professionals, including opportunities for internships at rural behavioral provider agencies and psychiatric hospitals. Consider student loan forgiveness incentives or waiving tuition fees in exchange for commitments from graduating BH professionals to practice in rural areas for specified periods (e.g., two-year rotations).
- Increase training, improve rates, ensure parity between the fee-for-service and managed care systems, and increase the BH fee-for-service provider network.

Focus Area 3: Hospital Bed Wait Times

As appropriate, promote and adopt the following strategies across all rural geographic service areas:

- Continue efforts to develop and implement a centralized statewide ITA bed repository to assist DCRs and community members to efficiently identify facilities that have available beds.
- Work with the Washington State Hospital Association and local legislators to review and alleviate reported hospital practices related to refusing admission to members perceived to be challenging (e.g., high acuity, dual diagnoses, history of assaultive behavior).
- Enhance the continuum of available BH OP services, such as Assertive Community Treatment (PACT), intensive OP services, and medication monitoring services to address extended lengths of stay in acute IP settings.
- Review or adopt legislative changes to the ITA assessment process that result in extended lengths of stay for IP ITA evaluations. Consider tiered reimbursement rates for hospitals that gradually reduce payments as the member’s length of stay is extended.
- Identify alternatives to using the limited number of acute IP beds for long-term care placements that result in extended lengths of stay and limit the availability of beds for

more acute patients. For example, designate an existing hospital ward to serve individuals who require long-term care and supervision. Other options include re-purposing a portion of state hospital civil beds or developing stand-alone crisis stabilization units that can help reduce the current demand on the inventory of acute IP hospital beds.

- Explore options to perform medical clearance exams for members in need of acute IP care in alternative settings as opposed to local emergency departments. Contingent on state licensing requirements and other applicable regulations, determine if IP psychiatric facilities can perform a history and physical with patients as part of the initial intake and admission process.
- Tribes are looking to conduct medical clearance in their communities and need statewide support regarding these efforts.

Focus Area 4: Timely Access to Mobile Crisis Teams

As appropriate, promote and adopt the following strategies across all rural geographic service areas:

- Offer BH professionals relocation assistance and sign-on bonuses to address current vacancy rates.
- Offer flexibility in terms of expectations for mobile crisis teams dedicated to serving youth. Many BH-ASOs have adopted a hybrid approach that includes BH staff who are appropriately trained to support adults, adolescents, and children who are experiencing a BH crisis.
- Provide, at a minimum, annual training to support and develop law enforcement agencies' understanding of BH emergencies and crises; provide and support the delivery of Crisis Intervention Team (CIT) training.
- Continue to support the expansion of mobile crisis teams including tribal mobile crisis response teams in tribal communities.

Tribal Delivery System Recommendations[17]

In addition to the Tribal Consultation process, the HB 1477 Tribal 988 Subcommittee, through the work with the Tribal Centric BH Advisory Board, has played an important advisory role to HB 1477 committee work regarding tribal perspectives and the existing tribal efforts to improve the BH crisis response system for tribal members. In 2023, the Tribal 988 Subcommittee will continue to inform the development of HB 1477 recommendations to improve Washington's BH crisis response system. In addition, a Tribal Consultation process

[17] These recommendations were summarized from existing reports and include planned actions to address challenges and issues impacting Washington State's Tribal communities. The information is reproduced here to reflect efforts currently underway to address disparities in care and a lack of resources on tribal lands. Reports referenced include *Initial Assessment of the Behavioral Health Crisis Response and Suicide Prevention Services in Washington and Preliminary Funding Recommendations (2021) and the Washington Behavioral Health Crisis Response and Suicide Prevention System: HB 1477 Committee Progress Report and Funding Recommendations for the 988 Line Tax (2022).*

will be established to review the HB 1477 Committee Final Recommendations due January 1, 2024.

The list below includes recent improvement initiatives and recommendations to help address challenges experienced by tribal members in need of timely mental health and substance abuse treatment services, access to mobile crisis teams, and DCR assessments.

- In November 2022, Washington launched the Native and Strong Lifeline, the first program of its kind in the nation dedicated to serving American Indian and Alaska Native people. As of November 10, 2022, individuals who call the 988 Lifeline from a Washington State area code can press 4 to be connected to a Native and Strong Lifeline counselor who is trained and experienced in working with tribal populations.

- Volunteers of America Western Washington is the 988 Lifeline crisis center that administers the Native and Strong Lifeline. The Native and Strong Lifeline may connect callers with the Native Resources Hub to provide callers with further support and follow-up with their IHCP. The Native Resources Hub was started by the Tribal Centric BH Advisory Board to support IHCPs in helping their patients navigate the complex BH and crisis system and identify bed availability. Continue efforts to establish and maintain the Native Resources Hub to ensure up to date IHCP points of contact to support follow-up care and other resources for AI/AN individuals.

- Plans to integrate BH Aides into the tribal crisis response teams locally and regionally through the Indian BH Hub and Native and Strong Lifeline.

- Continue efforts to develop the capacity to provide IP mental health services by IHCPs on tribal lands, including the development of a culturally appropriate Tribal Evaluation and Treatment/Secure Withdrawal Management Facility.

- Several Tribes have crisis lines available either Monday through Friday from 8:00 am–5:00 pm or on a 24/7 basis. Several tribes are working on establishing Tribal designated crisis responders that will conduct ITA evaluations and investigations through the state system as well as through their tribal court systems. Tribes are also exploring mobile crisis response teams and crisis facilities.

- Leverage technology to maximize opportunities to expand telehealth to support access to care.

- Continue efforts to ensure Cross-System Interfaces that are tailored to tribal populations through the development of the HCA-Tribal Crisis Coordination Protocol. Complete the State/Tribal Crisis Coordination Protocols, ensuring others working in the crisis system are aware of these protocols and the development of the Native and Strong Lifeline and the Indian BH Hub.

- Consider developing formal agreements with neighboring states or Tribes for areas along border regions as people may decide to seek services in another state if they are closer or more convenient for them.

- Include Urban Indian Health Organizations in county and regional crisis response protocol planning.

- Include tribes and IHCPs in the process maps to define referral processes between 911, 988, the Native and Strong Lifeline, Washington Indian BH Hub, Regional Crisis

Lines, IHCPs, Tribal Public Safety, and Tribal First Responders. Identify intake points and processes that identify people with tribal affiliation.

- Partner with local community colleges, including tribal colleges to support staffing needs, especially in rural areas and tribal communities.
- Address disparity of services based on funding (e.g., between Medicaid fee-for-service, Medicaid Managed Care, commercial insurance, uninsured). For example, there are plans to increase fee-for-service rates by 22%, effective January 2024. Moving forward, ensure Tribal partners and systems are included equitably in future funding requests.
- Adopt legislation to enhance tribes' ability to provide crisis services to their tribal and community members including notification to tribes for ITA investigations of tribal members and AI/ANs with an Indian Health Care Provider (IHCP) as a medical home.
- Funding, training, and technical assistance to tribes and IHCPs on enhancing crisis services, including the development of tribal mobile crisis response, T-DCR tribal Codes, DCR processes and procedures/T-DCR protocols, operationalization of T-DCR, and tabletop exercise for tribes.
- Develop and fund tribal DCRs (T-DCR), appointed by the tribe and appointed by HCA for state jurisdiction processes, that can be evaluated anywhere and with anyone in the state.
- Provide training and technical assistance to non-tribal crisis providers and DCRs on working with AI/ANs and tribal communities, including reviewing and providing feedback on the DCR protocols. Continue to promote AI/AN Health Commissioners offering training on effective engagement of tribal members at the DCR Academy.
- Complete the State/Tribe Tribal Crisis Coordination Protocols, ensuring others working in the crisis system are aware of these protocols and the development of the Native and Strong Lifeline and the Indian BH Hub.
- Focus on workforce development strategies in tribal and urban Indian communities.
- Identify and address concerns related to DCRs not providing investigations in rural areas.
- Identify how to address concerns related to individuals being released or not seen in hospital emergency rooms.
- Recommend having a safe place for someone to be and or Involuntary Treatment Stabilization (with medication/management as needed) while waiting for treatment service beds or appointment dates.
- Address issues with mental capacity due to significant substance use such as fentanyl or with opioid use disorder Naloxone interventions.
- Increase communication and education to entities that Medicaid can pay for voluntary transport.

Appendix A
Survey Tool

State of Washington Behavioral Health Services Rural Access Study

Intro

The State of Washington's Health Care Authority (HCA) has been tasked by the state legislature to study challenges to receiving timely access to behavioral health services in rural counties. Under Proviso language in ESSB 5693, Chapter 297, Laws of 2022, Section 215, Proviso 110, HCA will analyze applicable data and submit a report summarizing strategies or recommendations to improve access to behavioral health services in rural areas. One component of studying these challenges is the collection of data and feedback from key behavioral health stakeholders through surveys. You have been selected as a key stakeholder in the state's behavioral health system and we appreciate your time and attention in responding to this survey. **Responses are due no later than July 31, 2023.**

Responses will be submitted directly to Mercer who HCA has contracted with to conduct and analyze survey results. **Please note that this study pertains specifically to rural counties. Please only provide information regarding the delivery of behavioral health services in rural counties and exclude information for urban counties served in your region (if possible).**

If you have questions about the survey, please direct them to Ashleigh Salinski (Ashleigh.Salinski@mercer.com).

Respondent Name	
Respondent Email	
Respondent Phone Number	
Respondent Role	
BH-ASO/MCO/Organization Name	

1

The survey is designed around 4 focus areas identified by HCA. Please limit your responses to questions that pertain to your current employer.

Please select the rural counties your BH-ASO/MCO serves:

☐ Adams	☐ Cowlitz	☐ Grant	☐ Klickitat	☐ Mason	☐ San Juan	☐ Wahki
☐ Asotin	☐ Douglas	☐ Grays Harbor	☐ Kittitas	☐ Okanogan	☐ Skagit	☐ Walla
☐ Chelan	☐ Ferry	☐ Island	☐ Lewis	☐ Pacific	☐ Skamania	☐ Whitm
☐ Clallam	☐ Franklin	☐ Jefferson	☐ Lincoln	☐ Pend Oreille	☐ Stevens	☐ Yakim
☐ Columbia	☐ Garfield					

Focus Area 1

Focus Area 1: Designated Crisis Responder (DCR) response times

Respondents: BH-ASO and DCR representatives

How many DCRs are available in your region?

Do you have any DCRs dedicated solely to the *rural counties* in your region?

- ○ Yes
- ○ No

How many DCRs do you have dedicated solely to the *rural counties* in your region?

Which counties do these DCRs serve?

☐ Adams	☐ Cowlitz	☐ Grant	☐ Klickitat	☐ Mason	☐ San Juan	☐ Wahki
☐ Asotin	☐ Douglas	☐ Grays Harbor	☐ Kittitas	☐ Okanogan	☐ Skagit	☐ Walla
☐ Chelan	☐ Ferry	☐ Island	☐ Lewis	☐ Pacific	☐ Skamania	☐ Whitm
☐ Clallam	☐ Franklin	☐ Jefferson	☐ Lincoln	☐ Pend Oreille	☐ Stevens	☐ Yakim
☐ Columbia	☐ Garfield					

Do any of your DCRs also provide mobile crisis outreach?

○ No

○ Yes (Please list which DCRs also provide mobile crisis outreach)

Describe what strategies and/or activities you have in place that help promote member access to DCR services in *rural counties.*

Identify the current challenges with accessing DCR services for *individuals who reside in rural areas* (e.g., staffing challenges, lack of knowledge of available DCR services, remote regions, insufficient capacity, etc.)

For CY22, what was the average response time for the following responses for *members residing in rural counties*? If you do not collect this information for rural counties, indicate N/A.

	Average Response Time	N/A (Data not Collected)
Emergent Responses		
Urgent Responses		

For CY22, what was the annual number of each of the following data points *for individuals residing in rural counties*?

If you do not have data for CY22, provide the latest available data and indicate the timeframe for this data. If you do not collect this information for rural counties, indicate N/A.

	Annual Total	Data Timeframe (if not CY22)	N/A (Data not Collected)
Involuntary Treatment Act (ITA) Investigations Completed by DCRs			
ITA Investigations Conducted via Telehealth			
Referrals Made to a DCR (List Individually if Multiple in Region)			

For CY22, what is the average time spent on ITA investigations from start to end for *individuals residing in rural counties*? If you do not collect this information for rural counties, indicate N/A.

- ◯ Average time spent on ITA investigations
- ◯ N/A

Does the average time spent on ITA investigations for *individuals residing in rural counties* differ from those in urban counties? If yes, what is the difference in time and cause for the difference in time?

Does average time spent on ITA investigations differ rural/urban counties? (Y/N)

Difference in time

Causes for the difference in time

What is the average wait time for members to obtain an IP psychiatric bed?

Youth beds (17 years and under)

Adult beds (18 years and older)

Describe the process to determine IP psychiatric bed availability and to obtain a bed.

Youth beds (17 years and under)

Adult beds (18 years and older)

Are there enough IP psychiatric beds available to meet the demand? If no, describe the reasons for the lack of appropriate availability?

Yes No

	Yes	No
Youth beds (17 years and under) [If no, describe reasons for lack of availability]	○	○
Adult beds (18 years and older) [If no, describe reasons for lack of availability]	○	○

List the top 5 reasons leading to a no IP psychiatric bed report (e.g., Transportation, facility full, staffing shortages, COVID-19, behavioral health acuity, medical acuity). If other, describe.

Reason #1	
Reason #2	
Reason #3	
Reason #4	
Reason #5	
Other	

Describe how the COVID-19 pandemic impacted access to DCR services (e.g., utilization, staffing, etc.).

What strategies did you put into place to address the impact of COVID-19 on DCR services?

Describe the current status of DCR services, considering the impact of COVID-19.

Focus Area 2

Focus Area 2:Availability of Behavioral Health (BH) Inpatient (IP) and Outpatient (OP) Services

Respondents: MCO, BH-ASO, and providers of IP and OP BH services

Name the top 3 challenges related to offering a wide array of covered BH services *in rural counties* (e.g., Provider staffing shortages, transportation, reimbursement rates, lack of available providers, remote service areas.)

Challenge #1

Challenge #2

Challenge #3

Do *members residing in rural counties* experience extended delays with accessing any of these BH services? Of these services, identify the five most difficult BH services to *access in rural counties*.

	BH service experiences extended delays accessing	Top five most difficult BH services to access in rural counties
Mental health crisis services (E.g., Next day appointments, 23-hour recliners)	☐	☐
Mobile Response and Stabilization Services (MRSS)	☐	☐
Adult Mobile Crisis Response (MCR)	☐	☐
Involuntary inpatient psychiatric/Mental health free-standing evaluation and treatment services (provided in free-standing inpatient residential)	☐	☐
Program of Assertive Community Treatment (PACT)	☐	☐
Wraparound with Intensive Services (WISe)	☐	☐
Children's Long Term Inpatient Program (CLIP)	☐	☐
Mental health intake evaluation	☐	☐
Medication management	☐	☐
Psychological assessment	☐	☐
Mental health stabilization services (facilities and in home)	☐	☐
SUD assessment services	☐	☐
SUD outpatient treatment	☐	☐
SUD intensive inpatient residential services	☐	☐
Withdrawal management	☐	☐
Secure detox	☐	☐
Involuntary SUD ITA/Secure Withdrawal Management Services (SWMS) facilities	☐	☐
Non-Emergency Medical Transportation (NEMT)	☐	☐

Does your plan maintain an interest list of wait time list for any of these BH services? If yes, what is the average wait time (days/hours) to access each service ?

	Wait time list maintained? (Y/N)	Average wait time (days/hours) to access service
Mental health crisis services (E.g., Next day appointments, 23-hour recliners)		
Mobile Response and Stabilization Services (MRSS)		
Adult Mobile Crisis Response (MCR)		
Involuntary inpatient psychiatric/Mental health free-standing evaluation and treatment services (provided in free-standing inpatient residential)		
Program of Assertive Community Treatment (PACT)		
Wraparound with Intensive Services (WISe)		
Children's Long Term Inpatient Program (CLIP)		
Mental health intake evaluation		
Medication management		
Psychological assessment		
Mental health stabilization services (facilities and in home)		
SUD assessment services		
SUD outpatient treatment		
SUD intensive inpatient residential services		
Withdrawal management		
Secure detox		

	Wait time list maintained? (Y/N)	Average wait time (days/hours) to access service
Involuntary SUD ITA/Secure Withdrawal Management Services (SWMS) facilities		
Non-Emergency Medical Transportation (NEMT)		

Does your plan track wait times for outpatient treatment for *members residing in rural areas* when an individual is referred following an ITA investigation that did not meet detention criteria? If so, what is the average wait time?

- No
- Yes (Please include average wait time below in days/hours)

Does your plan track wait times for voluntary inpatient treatment for *members residing in rural areas* when an individual is referred following an ITA investigation that did not meet detention criteria? If so, what is the average wait time?

- No
- Yes (list average wait time)

Describe what strategies and/or activities (e.g., care coordination) you have in place that help promote member access to BH services *in rural counties*?

Does your plan utilize telehealth, e-visits or other technologies when providing covered BH services?

- No
- Yes

If yes, what services are currently being provided via telehealth, e-visits, or other technologies? Also, please indicate which of these services were NOT provided in these formats prior to the COVID-19 pandemic and whether or not plan intends to continue to offer these services in these formats following the COVID-19 pandemic.

	Name of service currently provided	Service provided prior to the COVID-19 pandemic (Y/N)	Service continuing following the COVID-19 pandemic (Y/N)
Service 1			
Service 2			
Service 3			
Service 4			
Service 5			
Service 6			
Service 7			
Service 8			

Does your plan utilize enrollee satisfaction survey data to monitor access to BH services *in rural counties*? If yes, what accessibility issues have been identified through these surveys?

- No
- Yes (Please list accessibility issues identified)

Does your plan monitor state and contract availability requirements for non-urgent, and urgent BH appointments for *members residing in rural counties*? If yes, what accessibility issues have been identified through this monitoring effort?

- ○ No
- ○ Yes (Please list accessibility issues identified)

Does your plan monitor state and contract distance standards for *members residing in rural counties*. If yes, what accessibility issues have been identified through this monitoring effort?

- ○ No
- ○ Yes (Please list accessibility issues identified)

Does your plan exceed the state and contract time and distance standards for *members residing in rural areas* (if applicable)? If yes, identify the services for which the standards are not met.

- ○ No
- ○ Yes (Please list services for which standards are not met)

How do you ensure that *members residing in rural counties* have a selection of providers within a BH service?

For the BH services listed below, identify any services and/or provider types where there is not an option of two providers or more.

	Service/provider type does NOT have 2+ provider option for youth (17 years and under)	Service/provider type does NOT have 2+ provider option for adults (18 years and older)
Mental health crisis services (E.g., Next day appointments, 23-hour recliners)	☐	☐
Mobile Response and Stabilization Services (MRSS)	☐	☐
Adult Mobile Crisis Response (MCR)	☐	☐
Involuntary inpatient psychiatric/Mental health free-standing evaluation and treatment services (provided in free-standing inpatient residential)	☐	☐
Program of Assertive Community Treatment (PACT)	☐	☐
Wraparound with Intensive Services (WISe)	☐	☐
Children's Long Term Inpatient Program (CLIP)	☐	☐
Mental health intake evaluation	☐	☐
Medication management	☐	☐
Psychological assessment	☐	☐
Mental health stabilization services (facilities and in home)	☐	☐
SUD assessment services	☐	☐

	Service/provider type does NOT have 2+ provider option for youth (17 years and under)	Service/provider type does NOT have 2+ provider option for adults (18 years and older)
SUD outpatient treatment	☐	☐
SUD intensive inpatient residential services	☐	☐
Withdrawal management	☐	☐
Secure detox	☐	☐
Involuntary SUD ITA/Secure Withdrawal Management Services (SWMS) facilities	☐	☐
Non-Emergency Medical Transportation (NEMT)	☐	☐

Under what circumstances and how often do you utilize single case agreements (SCAs)?

Circumstances SCAs utilized

Frequency SCAs are utilized

What are the most prevalent provider types utilized under SCAs?

Do you offer any incentives and/or enhanced rates to attract providers to the network? If yes, describe these incentives and/or enhanced rates.

○ No

○ Yes (Please describe)

What are the top three most common reasons for providers declining to contract (e.g., Low anticipated referral rates, burdensome contracting, documentation and oversight requirements, reimbursement rates, etc.)?

Reason #1

Reason #2

Reason #3

Describe any workforce development and retention initiatives.

Describe how the COVID-19 pandemic impacted access to IP and OP BH services (e.g., utilization, staffing, etc.).

What strategies did you put into place to address the impact of the COVID-19 pandemic on access to IP and OP BH services *in rural counties*?

Describe the status of access to IP and OP BH services *in rural counties*, considering the impact of COVID-19.

Focus Area 3

Focus Area 3: Wait Times for IP Psychiatric Hospital Beds

Respondents: Medical Hospitals, MCO, BH-ASO representatives

How many IP psychiatric hospital beds are available in your region?

Youth beds (17 years and under)

Adult beds (18 years and older)

Are any of the IP psychiatric hospital beds *located in a rural county* within your region?

Youth beds (17 years and under)

Adult beds (18 years and older)

How many IP psychiatric beds are available across all psychiatric hospitals in WA?

Youth beds (17 years and under)

Adult beds (18 years and older)

What are the following averages related to IP psychiatric beds at your hospitals?

	Youth beds (17 years and under)	Adult beds (18 years and older)
Average annual occupancy rates for IP psychiatric beds		
Average wait time (in days) for members to obtain an IP psychiatric bed		
Average length of stay for IP psychiatric hospital beds		

Are there enough IP psychiatric beds available to meet the demand? If no, describe the reasons for the lack of appropriate availability.

Youth beds (17 years and under) [If no, describe the reasons for the lack of appropriate availability]

Adult beds (18 years and older) [If no, describe the reasons for the lack of appropriate availability]

Describe the most common issues to achieving appropriate discharge from an IP psychiatric bed for both youth beds (17 years and under) and adult beds (18 years and older).

Youth beds (17 years and under)

Adult beds (18 years and older)

List the top 5 reasons leading to a no IP psychiatric bed report (e.g., Transportation, facility full, staffing shortages, COVID-19, behavioral health acuity, medical acuity) for both youth beds (17 years and under) and adult beds (18 years and older).

	Youth beds (17 years and under)	Adult beds (18 years and older)
Reason #1		
Reason #2		
Reason #3		
Reason #4		
Reason #5		

Once an IP psychiatric bed is secured what is the average wait time in days/hours for medical transportation to arrive to transport to the admitting facility?

Youth beds (17 years and under)	
Adult beds (18 years and older)	

Describe the process to determine IP psychiatric bed availability and to obtain a bed for both youth beds (17 years and under) and adult beds (18 years and older).

Youth beds (17 years and under)	
Adult beds (18 years and older)	

Describe how the COVID-19 pandemic impacted access to IP psychiatric hospital beds for *members residing in rural areas* (e.g., utilization, staffing, etc.).

What strategies did you put into place to address the impact of the COVID-19 pandemic on access to IP psychiatric hospital beds for *members residing in rural areas*?

Describe the status of access to IP psychiatric hospital beds, considering the impact of COVID-19.

Focus Area 4

Focus Area 4: Availability of Adult and Child Mobile Crisis Teams

Respondents: BH-ASO, Outpatient BH providers, mobile crisis responders and DCR representatives

Please provide the number of mobile crisis teams available to your *region's rural counties* and indicate if these mobile crisis teams serve both rural and urban counties.

	Number of mobile crisis teams available in rural counties	Do mobile crisis teams serve both rural and urban counties? (Y/N)
Adult mobile crisis teams		
Youth mobile crisis teams		
Hybrid (adult and youth) mobile crisis teams		

What is the average staff vacancy rate for your mobile crisis teams?

	Average Staff Vacancy Rate
Adult	
Youth	
Hybrid	

How many individual staff does your team include? Of those individuals, how many are DCRs?

Total number of individual staff on team	
Number of individuals on team that are DCRs	

What is the required team composition for mobile crisis teams that serve *rural counties*?

For CY22, what was the total number of mobile crisis outreach services provided to *individuals residing in rural counties* (excluding Involuntary Treatment Investigations)? If you do not collect this information for rural counties, indicate N/A.

	Members under age 18 years	Members 18 years and older	#Conjoint, Total#
Total number of mobile crisis outreach services provided (If data not collected, indicate N/A below)	0	0	0

For CY22, what were the following percentages/averages for *individuals residing in rural counties*? If you do not collect this information for rural counties, indicate N/A.

	CY22 Data for Individuals Residing in Rural Counties	N/A (Data not collected for rural counties)
Percentage of urgent mobile crisis outreach service requests/referrals responded to within 24 hours		
Average response time for urgent responses		
Percentage of emergent mobile crisis outreach service requests/referrals responded to within 2 hours		
Average response time for emergent responses		

Is there sufficient capacity of mobile crisis teams to meet the demand *in rural counties*? If no, identify the reasons for the insufficient capacity.

- Yes
- No (Please describe)

Identify the current challenges with accessing mobile crisis services for *individuals who reside in rural areas* (e.g., distance, staffing shortages, remote areas, etc.

Describe what strategies and/or activities you have in place that help promote member access to mobile crisis services *in rural counties*?

Identify the most common dispositions for *members residing in rural counties* following a mobile crisis event (e.g., voluntary and involuntary psychiatric hospitalization, referral to community resources, stabilization in home, crisis stabilization centers, etc.)

- ☐ Voluntary psychiatric hospitalization
- ☐ Involuntary psychiatric hospitalization
- ☐ Referral to community resources
- ☐ Stabilization in home
- ☐ Crisis stabilization centers
- ☐ Other: Please list

Describe how the COVID-19 pandemic impacted access to mobile crisis services (e.g., utilization, staffing, etc.).

What strategies did you put into place to address the impact of the COVID-19 pandemic on mobile crisis services *in rural counties*?

Describe the status of mobile crisis services *in rural counties*, considering the impact of COVID-19.

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Appendix B

BH Services Rural Access Study Interview Guide

The State of Washington's Health Care Authority (HCA) has been tasked by the state legislature to study challenges to receiving timely access to BH services in rural counties. Under Proviso language in ESSB 5693, Chapter 297, Laws of 2022, Section 215, Proviso 110, HCA will analyze applicable data and submit a report summarizing strategies or recommendations to improve access to BH services in rural areas.

One component of studying these challenges is the collection of data and feedback from community members through interviews. You have been selected as an important partner in the state's BH system and we appreciate your willingness to participate in the interview process.

(Note to Interviewers: Explain that there are four focus areas with accompanying questions — not all focus areas may be applicable to your role in the BH system. The study is focusing on access in rural areas, so please direct your responses towards the rural perspective, unless there are relevant comparisons to apply from urban areas (e.g., issues are unique, more pronounced, or extensive in rural areas compared to urban areas).

Prior to starting the interview, please collect the following information from the interviewee:	
Name	
Agency Affiliation	
Agency Type (e.g., BH-ASO, MCO, provider, hospital, etc.)	*Select Agency Type*
Years of experience with Washington State BH system	*Enter number*
Rural areas served (region or specific counties)	

A. Focus Area 1: Designated Crisis Responder Services

#	Interview Question	Interviewee Response
A.1.	**In your role, do you interact directly or indirectly with DCRs? If no, skip this section. If yes, proceed to the next question.**	☐ No (If no, skip to the next section [B. Focus Area 2: Access to OP and IP BH Services (including SUD services)]) ☐ Yes (Proceed to the next question)
A.2.	**Which rural counties do you work with in conjunction with DCRs?**	
A.3.	**How many DCRs are available in your region?**	*Enter number*
A.4.	**In your opinion, are there enough DCRs in your region to meet the demand for these services?**	☐ No ☐ Yes
A.5.	**What are the most prominent challenges to accessing timely responses from DCRs in rural areas (workforce, capacity, etc.)?**	
A.6.	**How did/has COVID-19 impacted timely access to DCRs?**	
A.7.	**What recommendations do you have to improve access to and responsiveness of DCRs in rural areas?**	
A.7.1	**— Are resources available to improve access?**	
A.8.	**What other information about DCR services in rural areas would you like to share?**	

B. Focus Area 2: Access to OP and IP BH Services (including SUD services)

Note to Interviewer: Please reference Attachment 1: BH Services Supplemental Checklist located at the end of this document to prompt interviewees to provide specific responses when responding to questions.

#	Interview Question	Interviewee Response
B.1.	**Is access to timely outpatient BH services a challenge in your service area?**	☐ No ☐ Yes
B.1.1	**— If yes, which outpatient BH services are most difficult to access?**	
B.2.	**Are you aware of any outpatient BH services that currently have wait lists?**	☐ No ☐ Yes
B.2.1	**— If yes, which outpatient BH services are impacted?**	
B.3.	**What are the most common challenges with accessing timely outpatient BH services (workforce, lack of capacity, transportation, etc.)?**	
B.4.	**Is access to timely IP BH services a challenge in your service area? If yes, please describe.**	☐ No ☐ Yes
B.5.	**Are you aware of any strategies or activities that have proven to help with timely access to outpatient BH services?**	☐ No ☐ Yes
B.5.1	**— If yes, please describe.**	
B.6.	**Are BH outpatient services available via telehealth in your region?**	☐ No ☐ Yes
B.6.1	**— If yes, is telehealth used extensively, moderately, or only occasionally?**	*Select*

#	Interview Question	Interviewee Response
	— Has the use of telehealth decreased since the remission of COVID or has utilization generally remained the same when compared to the COVID era?	*Select*
B.7.	Do members in your region have a choice of more than one provider when accessing outpatient BH services? Please specify the types of BH services that do not have a choice of providers in your region.	☐ No ☐ Yes
B.8.	Do you know why available outpatient and IP BH providers may refuse to participate in the HCA delivery system?	☐ No ☐ Yes
B.8.1	— What are some of the reasons BH providers refuse to contract with the BH-ASOs and/or MCOs?	
B. 9.	Do wait lists exist for any IP BH services?	☐ No ☐ Yes (Describe below)
B.9.1	— If yes, please describe.	
B.10.	What other information about accessing outpatient and IP BH services in rural areas would you like to share?	

C. Focus Area 3: Wait Times for Hospital Beds

#	Interview Question	Interviewee Response
C.1.	**On average, how long does it take to access an IP involuntary treatment act (ITA) bed when needed?**	*Enter number*
C.2.	**When needed, how do you determine if an ITA IP bed is available?**	
C.3.	**In your opinion, are there enough ITA IP beds available to meet the demand?**	☐ No ☐ Yes
C.4.	**Are hospital ITA bed shortages more pronounced for certain conditions (e.g., ASAM Levels of Care for SUD) or age groups (e.g., children 12 and younger)?**	☐ No ☐ Yes
C.5.	**Do you have any recommendations to help community members know the real-time availability of ITA hospital beds?**	☐ No ☐ Yes
C.6.	**Are there enough ITA facilities/ITA hospital beds to address the needs of complex, special populations (e.g., members with co-occurring MH and IDD conditions, members with ASD, etc.)?**	☐ No ☐ Yes
C.7.	**What other information about accessing ITA hospital beds in rural areas would you like to share?**	

D. Focus Area 4: Access to Mobile Crisis Teams

	Interview Question	Interviewee Response
D.1.	Do you have dedicated mobile crisis teams in your region?	☐ No ☐ Yes
D.1.1	— If yes, how many teams are currently available?	*Enter number*
D.2.	Please describe the composition of the available mobile crisis teams – do they consist of one or more BH professionals?	
D.3.	How do the mobile crisis teams in your region coordinate with first responders (e.g., police, fire, EMTs)?	
D.4.	Are there available mobile crisis teams in your region capable of serving adults and youth?	☐ No ☐ Yes
D.5.	Are you aware of any issues impacting the availability of mobile crisis teams in your region (e.g., staffing vacancies)?	☐ No ☐ Yes
D.6.	On average, is the response time for mobile crisis teams reasonable and appropriate to effectively meet the needs of the community?	*Enter number*
D.7.	Is there a high demand for mobile crisis teams in your region and is there sufficient capacity to consistently meet the needs?	☐ No ☐ Yes
D.8.	What recommendations do you have to improve access to and responsiveness of mobile crisis teams in rural areas?	
D.9.	What other information about mobile crisis team services in rural areas would you like to share?	

Attachment 1: BH Services Supplemental Checklist

BH Services Checklist	
☐	(i) Mental Health Crisis Services (e.g., Next day appointments, 23-hour recliners)
☐	(ii) Mobile Response and Stabilization Services (MRSS)
☐	(iii) Adult Mobile Crisis Response (MCR)
☐	(iv) Involuntary IP Psychiatric/Mental Health Free-Standing Evaluation and Treatment Services (provided in free-standing IP residential)
☐	(v) Program of Assertive Community Treatment (PACT)
☐	(vi) Wraparound with Intensive Services (WISe)
☐	(vii) Children's Long Term Inpatient Program (CLIP)
☐	(viii) Mental Health Intake Evaluation
☐	(ix) Medication Management
☐	(x) Psychological Assessment
☐	(xi) Mental Health Stabilization Services (facilities and in home)
☐	(xii) SUD Assessment Services
☐	(xiii) SUD OP Treatment
☐	(xiv) SUD Intensive IP Residential Services
☐	(xv) Withdrawal Management
☐	(xvi) Secure detox
☐	(xvii) Involuntary SUD ITA/Secure Withdrawal Management Services (SWMS) Facilities

Mercer Health & Benefits LLC
2325 East Camelback Road, Suite 600
Phoenix, AZ 85016
www.mercer-government.mercer.com

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