Washington State Health Care Authority (HCA) Behavioral Health (BH) Bed Registry and Electronic Referral Tools Project

D4. Needs Assessment Report

Version 4.0

Submitted by:

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*__Please note:__ These are recommendations from a third party and not indicative of steps HCA or Washington state will or plans on taking in full. It is not an exhaustive list of all considerations.

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Table i: Version History

Version	Delivery Date	Version Notes
1.0	August 12, 2024	Draft findings shared with HCA for review
2.0	September 10, 2024	Draft report shared with HCA for review
3.0	October 9, 2024	Final report shared with HCA
4.0	October 25, 2024	Final feedback incorporated and shared with HCA

1 Executive Summary

In Washington (WA), the absence of widespread implementation of a near real-time behavioral health (BH) bed registry limits access to care and follow-up services. This is because providers and clients/patients spend a significant amount of time searching for available beds. Currently, mobile crisis responders, BH providers, emergency room (ER) staff, other providers, and patients (including family members) call multiple hospitals, residential settings, and/or other providers to determine whether there is an appropriate provider to meet an individual's needs and whether the provider has capacity.

In addition, according to interested parties, referrals to and from BH providers are a manual and time-consuming process. Interested parties refer to the individuals/groups that are directly or indirectly affected by decisions related to a BH bed registry and electronic referral tools. A BH bed registry and an electronic referral tool are needed to help HCA and providers understand where individuals are in the process, which will help inform potential improvements necessary to achieve timely end-to-end care.

The Needs Assessment Report for the Health Care Authority's (HCA's) BH Bed Registry and Electronic Referral Tools project examines the current environment related to bed availability and referral in WA and identifies challenges and areas of opportunity. This project also seeks to:

- Compile challenges associated with the manual process providers use to access bed availability
- Understand providers' ability to conduct electronic referrals that result in efficient service delivery for individuals in crisis
- Provide recommendations to HCA for how to work toward addressing identified challenges

This report outlines findings from various data collection methods (e.g., discovery sessions and web surveys) and presents actionable recommendations for HCA to consider while developing and implementing a BH bed registry and electronic referral tools.

The needs assessment yielded 53 findings, as shown in Section 6.2, Table 3. The following list presents a high-level summary of key findings:

- **Technology and Tools**: Manual processes create multiple challenges. Providers across the state invest significant time and effort calling facilities to determine bed availability for individuals' placement using a Microsoft (MS) Excel sheet—or other manual tools—to capture information. With frequent changes in bed availability, some staff spend a significant portion of their day calling multiple facilities for updates. This administrative burden hinders facilities' ability to efficiently care for individuals in crisis—a challenge compounded by staff shortages.
- **Admission Criteria:** Interested parties in multiple discovery sessions noted that if a facility has a bed available, it does not necessarily indicate that the individual will be accepted and receive the bed. Each facility operates with its own admission criteria and

collects different data sets during admission. There is no standard set of admission criteria required for the same type of facilities. These differing admission criteria challenge the referral and admission process. As a result, providers face challenges in gathering the required information about the individual for admission.

- **Resources:** Some facilities in rural areas indicated barriers such as staffing, funding, and internet access to implement and use a BH bed registry and electronic referral tools. In addition, individuals in rural areas often have difficulty accessing services that are farther away due to limited availability of public transportation or a lack of needed services in their area.
- **Processes:** Facilities across the state use multiple electronic health record (EHR) systems, and each system's functionality and processes depend on facility needs. In the absence of a statewide EHR, interested parties highlighted the need for a streamlined process and interoperability among different EHR systems to support provider implementation and utilization of the BH bed registry and electronic referral tools to help bridge the current gap.
- **Cost:** Some facilities struggle with staff shortages, an issue interested parties highlighted as a potential barrier to successfully implementing a BH bed registry and electronic referral tools. In addition, if a new software system is required, some partners might have difficulty budgeting for associated costs due to administrative fee caps.

To help bridge identified gaps and support HCA in implementing a BH bed registry and electronic referral tools, BerryDunn developed nine recommendations, which are listed below in a sequential order:

1. Conduct business process mapping and analysis of new workflow
2. Plan for automation of a BH bed registry and electronic referral tools through broad interoperability with other data sources (e.g., various EHRs)
3. Prioritize functionality and content of a BH bed registry and electronic referral tools
4. Plan for a phase-based implementation approach
5. Implement BH bed registry update cadence based on level of care
6. Create a communication plan to support and continue coordination and partnership with interested parties for effective implementation
7. Develop specialized training plans to support providers' utilization of the BH bed registry and electronic referral tools
8. Create incentives for providers to use and update the BH bed registry and electronic referral tools
9. Create a monitoring tool to track utilization of the BH bed registry and electronic referral tools

These recommendations are for HCA's consideration. HCA's implementation of one or more of these recommendations could be impacted by multiple factors (e.g., the availability of resources, feasibility, changes in future legislation, and changes related to system functionality of the BH bed registry and electronic referral tools.)

BerryDunn identified the following next steps for HCA as it continues to plan for the implementation of a BH bed registry and electronic referral tools. HCA will need to:

- Prioritize recommendations based on feasibility and potential impact
- Refine final Written Communication Materials in the HCA-preferred format and share them with the designated interested parties
- Review key pending decisions included in Section 8 and make informed decisions related to the implementation of the BH bed registry and electronic referral tools

Collectively, these findings and next steps are informed by community partners, persons with lived experience, and HCA staff. The findings and next steps can be used to assist HCA with making progress toward developing and implementing a BH bed registry and electronic referral tools.

2 Introduction

HCA engaged BerryDunn, an independent consulting firm, to help conduct a needs assessment for the successful implementation of a BH bed registry and electronic referral tools. The vision for the Needs Assessment Report for HCA's project is "to prepare for the development and implementation of the BH Integrated Client Referral System [BHICRS] required in House Bill [HB] 1477: inform content of a BH bed registry, increase BH providers' awareness of the benefits of utilizing the BH bed registry and electronic referral tools, and engage persons with lived experience to inform access to needed resources."

Project goals include the following:

- Increasing providers' awareness and future use of a BH bed registry and electronic referral tools, including identifying barriers and opportunities to providers' access and use of tools
- Identifying functionality needed for a BH bed registry in WA and how WA~~'s~~ Healthcare and Emergency and Logistics Tracking Hub (WA HEALTH) infrastructure could be extended to support these needs
- Identifying the type of behavioral health providers and information (e.g., crisis stabilization services, psychiatric inpatient care, substance use disorder [SUD] residential programs) to include in the BH bed registry in addition to those included in HB 1477
- Improving client access to the specific information available in a BH bed registry to help support access to services
- Identifying a communication methodology to share information available in the future BH bed registry with providers and care coordinators
- Supporting the identification of changes to behavioral health providers' workflow in implementing and integrating a BH bed registry and electronic referral tools
- Supporting the identification of future contracting requirements for managed care organizations (MCOs) and Behavioral Health – Administrative Service Organizations (BH-ASOs)

In alignment with these project goals, BerryDunn completed a literature review, conducted web surveys with HCA-identified interested parties, and facilitated a series of discovery sessions. The purpose of this needs assessment is to identify current needs and challenges in accessing BH bed availability and conducting referrals. It also aims to summarize recommendations and strategies shared by interested parties regarding state implementation of a BH bed registry and electronic referral tools.

BerryDunn compiled information gathered from the literature review, discovery sessions, and web surveys to develop this Needs Assessment Report—including recommendations for HCA

to consider—to help support the implementation of a BH bed registry and electronic referral tools.

2.1 Project Background

The National Association of State Mental Health Program Directors (NASMHPD) awarded funds to the HCA Office of Health Information Technology (HIT) to establish same-day/rapid access to BH services for crisis prevention and follow-up care. HCA used NASMHPD funds to engage BerryDunn to gather information from persons with lived experience, crisis responders, tribal partners, MCOs, BH-ASOs, the Washington State Hospital Association (WSHA), the Washington Council for Behavioral Health (WCBH), the Association of Alcoholism and Addictions Programs of Washington (AAP), and state agency staff. These information-gathering activities are supported under Phase A of the project.

BerryDunn also received an award from NASMHPD to gather additional information from community-based behavioral health agencies (BHAs) regarding their current use and potential future use of EHRs for accessing and populating a BH bed registry as well as to understand BH providers' capability to use electronic referral tools, including closed-loop referral tools. These activities are supported under Phase B of the project. Results from both Phase A and B have been incorporated into the needs assessment report.

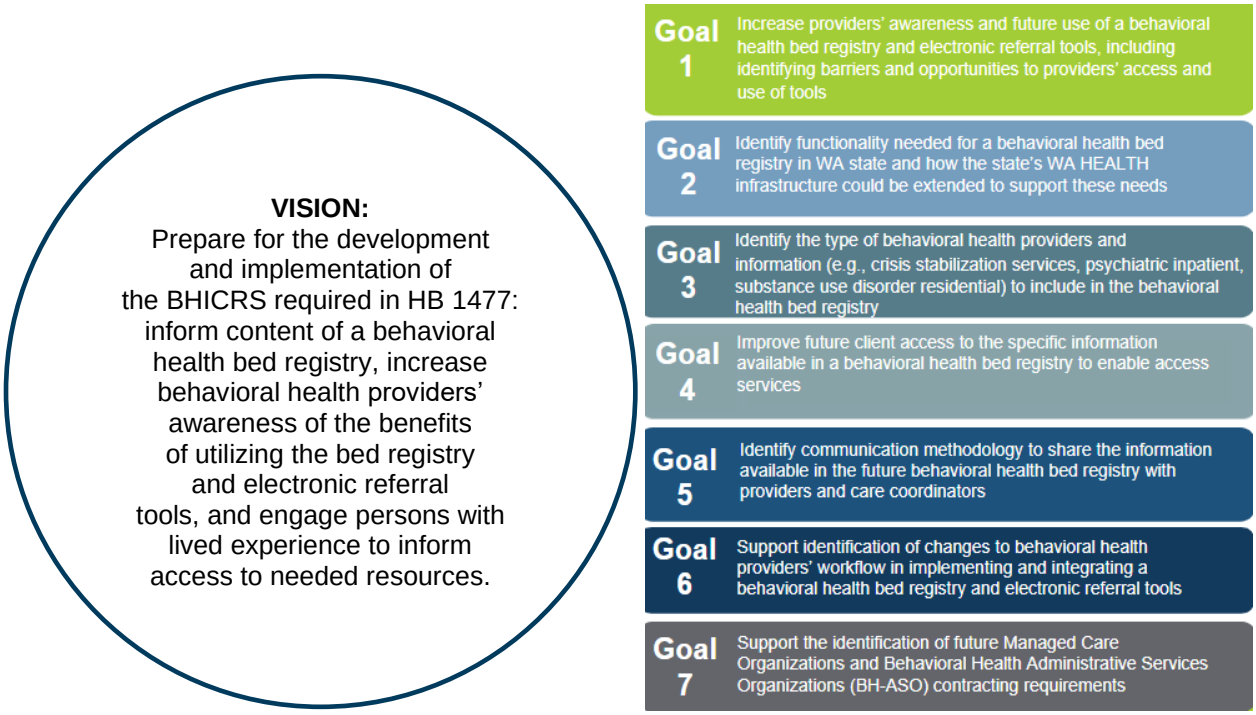
In WA, the absence of widespread implementation of a near real-time BH bed registry and electronic referral tools limits access to care and follow-up services; this is because providers and clients/patients spend a significant amount of time searching for available beds. Currently, mobile crisis responders, BH providers, emergency room (ER) staff, other providers, and patients (including family members) call multiple hospitals, residential settings, and/or other providers to determine whether there is an appropriate provider to meet an individual's needs and whether the provider has capacity. In addition, according to the interested parties, referrals to and from BH providers are currently a manual and time-consuming process.

Implementation of a BH bed registry and electronic referral tools could enable more efficient referral processes, provide timely end-to-end care, save provider time, and improve and enhance access to services for individuals experiencing serious mental illnesses, serious emotional disturbances, and other crises.

2.2 Project Vision and Goal

HCA identified seven goals (Figure 1) consistent with its vision to prepare for the development and implementation of a BH bed registry and electronic referral tools.

Figure 1: Project Vision and Goals



2.3 Work Performed

BerryDunn engaged HCA and other key interested parties to gather and assess information for this report. BerryDunn performed the following key activities between January 29, 2024, and July 18, 2024:

- Conducted a project kickoff meeting with HCA project sponsors and core project team members to discuss project vision/goals and align expectations for project activities.
- Reviewed background documentation provided by the HCA core project team.
- Conducted a web-based literature review to identify existing trends regarding state implementation of the BH bed registry and electronic referral tools.
- Disseminated and analyzed three web surveys for persons with lived experience, MCOs and BH-ASOs, and providers (e.g., crisis responders/providers, tribal providers, WSHA, WCBH, and AAP).
- Conducted meetings with the HCA core project team to identify the approach for discovery sessions.
- Conducted several email follow-ups to identify interested parties for discovery sessions.

- Conducted three planning meetings with the point of contact for HCA tribal partners to plan and prepare for the tribal partners discovery session.
- Met with the point of contact for the Health Management Associates' (HMA's) Crisis Response Improvement Strategy (CRIS) Lived Experience Subcommittee to identify an approach for discovery sessions with persons with lived experience.
- Facilitated 10 discovery sessions for Phase A—HCA NASMHPD contract—with HCA core project team members, Department of Health (DOH) programmatic and technical subject matter experts (SMEs), and other key interested parties between April 24 and July 18, 2024, to learn about area-specific needs and challenges.
- Facilitated seven follow-up discovery sessions for Phase A to collect additional information about future needs and current initiatives underway.
- Facilitated 10 discovery sessions for Phase B—NASMHPD contract with BerryDunn—with BHAs using EHRs to better understand how they currently manage bed capacity and electronic referral tools as well as to explore EHR functionalities.

2.4 Project Influences

Assumptions and constraints are two types of factors that can influence a project. Assumptions are premises about the program or environment that, for the sake of the project, are taken as fact. Constraints are known as facts over which there is limited or no control. Constraints can affect the scope, direction, planning, and implementation of a program, as well as the format and content of a report. Both are considered during an assessment because they can affect project outcomes.

2.4.1 Project Assumptions

The following assumptions could influence this report's findings:

- The needs assessment report is the first step in a multistep process. Assessment findings and recommendations build the foundation for subsequent project activities, including developing and implementing a BH bed registry and electronic referral tools.
- Interested parties' feedback might vary due to diverse perspectives. To inform the assessment, BerryDunn focused on consistent themes across interested parties and attempted to validate feedback to the extent feasible.
- Information provided by interested parties about their needs and challenges is current as of BerryDunn's submission of this report to HCA.
- Additional interested parties—as identified by the organizations' point of contact—have the experience needed to respond to project-related questions.
- BerryDunn issued three web surveys to gather information from a broad group of interested parties; however, it was not possible for BerryDunn to gather information from

each individual. Therefore, for the purposes of this assessment, BerryDunn assumes feedback reflects general perspectives of the respective group they represent.

2.4.2 Project Constraints

The following constraints could influence needs assessment report findings:

- This is a point-in-time assessment based upon information provided to BerryDunn during the project's data collection phase. BerryDunn considers the information gathered for this report as accurate until the time BerryDunn submitted the report.
- HCA and BerryDunn attempted to engage an extensive group of interested parties in data collection activities, including discovery sessions. BerryDunn and HCA made every attempt to engage an extensive list of interested parties to help ensure their voices were heard. These results represent the summation of responses received from those audiences, which may be limited by factors such as lack of response, availability, or other obstacles.
- The terminology "near real-time" has not been defined by the State or by legislation, which the State would defer to.
- BerryDunn issued three separate web surveys to gather information from a broad group of interested parties as described in Section 3.2. HCA disseminated the web surveys to its point of contact from the interested parties listed below; therefore, the total number of individuals that the point of contact sent the web survey is unknown, creating limitations to identify the response rate percentage.
    - Persons with lived experience
    - Crisis responders/providers
    - Tribal partners
    - MCOs
    - BH-ASOs
    - WSHA
    - WCBH
    - AAP

2.5 Report Format

This report includes nine major sections and nine supporting appendices, as follows:

- Section 1 (Executive Summary) provides an overview of key information from other sections in this report.
- Section 2 (Introduction) provides details on the project background, report purpose, work performed to develop the report, project influences—including assumptions and constraints—and the report format.
- Section 3 (Data Collection Methodology) describes the methods, data tools, and resources used to conduct the needs assessment.

- Section 4 (Key Interested Parties) describes key interested parties for this project, including persons with lived experiences in the state and those entities involved in providing services and support to them.
- Section 5 (Current Environment) provides information on current state and federal requirements, MCO and BH-ASO contract requirements, and current processes to track bed availability.
- Section 6 (Assessment Findings) summarizes key strengths, needs, and challenges related to developing and implementing a BH bed registry.
- Section 7 (Recommendations) provides recommendations for HCA to consider while developing and implementing a BH bed registry.
- Section 8 (Key Pending Decisions) provides a list of key pending decisions that HCA must make prior to selecting the future system and implementing recommendations.
- Section 9 (Next Steps) provides next steps based upon the project work plan and associated tasks and deliverables.

The following related appendices provide supporting details pertaining to the report:

- Appendix A (Acronyms and Terms List) lists the acronyms and terms used throughout this report.
- Appendix B (Interested Parties) lists interested parties for Phase A and Phase B.
- Appendix C (Web Survey Questions) lists all web survey questions.
- Appendix D (Discovery Session Questions) lists a set of Phase A and Phase B discovery session questions.
- Appendix E (Discovery Session Summaries) summarizes notes from each discovery session.
- Appendix F (Web Survey Results) summarizes the results of web surveys distributed to HCA-identified interested parties.
- Appendix G (14344 Automated Email Template for Providers) includes DOH's automated draft reminder email message to acute care hospitals that are late in reporting to WA HEALTH.
- Appendix H (DOH Proposed Rule) includes DOH's recent proposed rule announcing the extension of WA HEALTH to include BHAs and facilities.
- Appendix I (DOH Proposal Related to Type of Data) contains DOH's proposal to include bed occupancy data in WA HEALTH for BHAs and facilities.

3 Data Collection Methodology

BerryDunn conducted planning meetings with HCA to identify data collection methodologies and the approach for each methodology. BerryDunn developed an interested party register to identify key individuals and groups that HCA would like to solicit input from during data collection activities, such as web surveys and discovery sessions. Sections 3.1, 3.2, and 3.3 describe BerryDunn's and HCA's planned approach to conduct the literature review, web surveys, and discovery sessions for Phases A and B of the project.

3.1 Literature Review

BerryDunn conducted research using online search engines to identify national and state-level articles related to provider implementation and use of a BH bed registry and electronic tools. BerryDunn focused on the purpose of this project research and used keywords such as "BH bed registry," "bed registry," and "electronic referral tools" to identify relevant articles. BerryDunn reviewed NASMHPD Transformation Transfer Initiative (TTI) website tools and the TTI article "Improving Access to Behavioral Health Crisis Services with Electronic Bed Registries" HCA shared to understand the challenges experienced by states and strategies for overcoming those challenges.[1] In addition, BerryDunn conducted a thorough review of the articles shared by HCA.

BerryDunn analyzed the five articles shared by HCA and organized a summary of findings. The findings focused on provider types; BH bed registry contents, updates, and access based on the availability of such information; and use of electronic referral tools. BerryDunn created an internal MS Excel sheet to track common themes from articles for accuracy and reliability. Based on information in the articles, BerryDunn drafted the literature review for HCA feedback and finalized it by addressing HCA comments and revisions.

3.2 Web Surveys

BerryDunn developed three web surveys using SurveyMonkey to confidentially collect input from a broad group of interested parties. HCA-identified interested parties for web surveys included the following:

- **Persons With Lived Experience**
    - HMA—the organization that manages the CRIS Committee, including the Lived Experience Subcommittee—distributed the survey link to Lived Experience Subcommittee members and invited them to share the survey with affiliated groups to expand input from persons with lived experience. HCA also distributed the survey link to additional groups that included persons with lived experience. The survey closed on June 20, 2024.

[1] National Association of State Mental Health Program Directors (NASMHPD). 2019. "Improving Access to Behavioral Health Crisis Services with Electronic Bed Registries." Accessed March 20, 2024. https://nasmhpd.org/sites/default/files/Bed_Registry_Full_Report.pdf.

- **BH-ASOs and MCOs**
    - BerryDunn designed the web surveys for BH-ASOs and MCOs and shared the link with HCA. HCA distributed the link electronically via the HCA BH-ASO and MCO listservs.
- **Providers (Crisis Responders/Providers, Tribal Partners, Including Providers, WSHA, WCBH, and AAP)**
    - BerryDunn designed and sent the web surveys to the provider associations (WSHA, WCBH, and AAP), and then these provider associations emailed the web surveys to their membership. Surveys were distributed electronically, allowing survey respondents to respond at their convenience.
    - HCA and BerryDunn developed a Dear Tribal Leader Letter (DTLL) to invite input from tribal governments and Indian health care providers (IHCPs) to inform and support the successful implementation of a BH bed registry and electronic referral tools. The DTLL is a formal communication mailed to tribal partners and describes the policy or program under consideration and its anticipated tribal impact. The DTLL requested tribal/IHCP participation in a listening session and feedback via a survey. The DTLL included a link to the survey. HCA and BerryDunn provided an overview of the project to the 988 Tribal Subcommittee and the Tribal Mobile Crisis Workgroup.
    - BerryDunn drafted and shared an email for HCA to distribute the crisis responders web survey with HCA's list of crisis responders/providers.

BerryDunn developed survey questions to collect information on needs, challenges, and opportunities related to the BH bed registry and electronic referral tools from persons with lived experience, crisis responders/providers, tribal partners, MCOs, BH-ASOs, WSHA, WCBH, and AAP. Survey findings helped HCA better understand the current environment related to the BH bed registry and electronic referral tools and how implementation of these tools could be supported, including:

- Content to be prioritized and visible in a BH bed registry
- Frequency of updates to a BH bed registry
- Access to a BH bed registry by providers and care coordinators
- Use of electronic referral tools by providers with existing technology tools (EHR, SharePoint, OpenBeds, and other available resources) and those without
- Processes that could support care coordination needs for persons experiencing crises

To complete the web surveys:

- BerryDunn drafted open-ended and multiple-choice questions based on discussions with HCA, reviewed the questions with HCA, and updated the draft surveys based on feedback. BerryDunn created the surveys using SurveyMonkey.
- BerryDunn shared web survey links with the lead organization for each targeted group of survey respondents (i.e., associations, MCOs and BH-ASOs for their staff and provider networks, tribal partners, and the HMA for the CRIS Lived Experience Subcommittee). These lead organizations were given the opportunity to share the web survey and provide feedback and/or request input.
- BerryDunn drafted two reminder emails and distributed them to the lead organizations for their dissemination.

After gathering responses, BerryDunn leveraged data analysis and visualization tools (e.g., bar graphs) to analyze survey responses and incorporated results into this report. In addition, the web survey analysis informed the development of discovery session questions.

3.3 Discovery Sessions

BerryDunn divided the discovery sessions into two phases—Phase A and Phase B—to distinguish information-gathering activities. Section 2.1: Project Background contains more information about these phases.

Phase A: BerryDunn conducted 10 discovery sessions and seven follow-up sessions[2] to gather information on needs and challenges related to the BH bed registry and electronic referral tools, including information about:

- Content to include in the future BH bed registry, the frequency and method by which to update the BH bed registry, and BH bed registry users
- Recommendations and methods for supporting individuals in crisis/need and understanding the methods for individuals to identify available BH resources
- Electronic referral/closed-loop referral tools, including opportunities and barriers to usage
- Potential contractual requirements and incentives for providers to maintain the BH bed registry and referral data

Participant Selection: HCA selected discovery session participants, which included representatives from each of the following interested party groups:

- Persons with lived experience
- 988 Lifeline crisis call centers

[2] BerryDunn conducted discovery session follow-up when all questions in Appendix D could not be discussed.

- Crisis providers/responders identified by BH-ASOs
- Tribal providers/crisis responders identified by tribal partners
- BH-ASO and MCO representatives
- Providers from WSHA, WCBH, and AAP
- State agency staff, including staff from HCA (i.e., Division of BH and Recovery, Enterprise Technology Service, Medicaid Programs Division staff) and DOH staff

Phase B: BerryDunn conducted 10 discovery sessions for Phase B with BHA providers. HCA used 2022 annual HCA BH Provider Survey data to identify provider organizations that reported primarily using EHR systems. HCA identified:

- Four provider organizations reported using Credible EHR
- Three provider organizations reported using an Epic EHR
- Three provider organizations reported using Netsmart EHR
- Two provider organizations reported using CareLogic EHR
- Two provider organizations reported using Qualifacts EHR

Each discovery session comprised providers in rural or urban areas of the state.

BerryDunn used discovery sessions to gather information from community-based BH providers regarding the following:

- Functionality/version of the EHR that community-based BH providers use as well as technical support needed to use a BH bed registry and electronic referral tools
- Opportunities and barriers to using a BH bed registry and electronic referral tools
- Implementation support, training, and workflow

Facilitation and Structure: BerryDunn used a group of facilitators who are skilled at creating a supportive, inclusive environment to lead discovery sessions. BerryDunn developed questions for each session in advance, which HCA reviewed and provided feedback. BerryDunn followed a structured agenda to cover all relevant topics and meet assessment objectives.

At the beginning of each discovery session, BerryDunn highlighted goals and objectives to provide context and guide discussion. In addition, BerryDunn developed a project overview MS PowerPoint presentation to share with attendees and followed best practices for virtual meetings.

Notetaking and Documentation: Throughout discovery sessions, BerryDunn designated one individual to capture key points, ideas, and suggestions. BerryDunn used these notes to support the development of this report. When possible, for notetaking purposes, BerryDunn recorded sessions.

BerryDunn designed discovery sessions to encourage interactive, collaborative discussion among participants by asking open-ended questions to elicit insights, experiences, and recommendations related to challenges and barriers to providers' access and use of a BH bed registry and electronic referral tools. BerryDunn encouraged participants to share their perspectives, raise concerns, and propose solutions based on their expertise and experiences.

4 Key Interested Parties

This section provides an overview of the key interested parties who were engaged throughout this project. Appendix B includes a complete list of key interested parties for both Phase A and Phase B.

4.1 Persons With Lived Experience

In the state of WA, persons with lived experience refer to those who receive BH services—or support family/friends with obtaining these services—and understand the challenges that impact access and utilization of BH services. In WA, the CRIS Lived Experience Subcommittee is one group that represents persons with lived experience and is vital to state efforts in enhancing its BH crisis response system. Established under HB 1477, this subcommittee includes individuals and family members with firsthand experience of BH challenges. Their primary role is to provide unique insights and recommendations to inform the development of policies and programs as well as to help ensure the BH crisis response system is effective and empathetic to those it serves. Persons with lived experience have been identified as key interested parties due to the subcommittee's advocacy to help ensure past experiences are heard and validated and its commitment to create a more responsive and humane BH crisis system. The subcommittee's input is vital in understanding the needs and perspectives of those directly impacted by BH challenges and crises.

4.2 988 Lifeline Crisis Call Centers

The 988 Lifeline crisis call centers in WA provide a crucial support system for individuals experiencing mental health or substance use crises. DOH leads the State's efforts to help ensure services are accessible in multiple languages and tailored to various cultural needs. The 988 Lifeline crisis call centers can be the first place that people in crisis contact. When someone in crisis speaks to a call center staff member, the staff member listens, documents the individual's needs, and provides an initial recommendation for referrals and next steps. There are three crisis call centers in the state: Volunteers of America (VOA) Western Washington, Frontier Behavioral Health (FBH), and Crisis Connections. The 988 Lifeline includes specific support lines, such as the Veterans Crisis Line and the Native and Strong Lifeline for American Indian and Alaska Native individuals. As an integral component in the state's mental health infrastructure, 988 Lifeline crisis call centers play an important role in identifying the content of the BH bed registry from the user perspective to improve outcomes for those experiencing BH crises.

4.3 Crisis Responders/Providers

Crisis responders and providers in WA are essential in delivering immediate assistance to individuals experiencing BH emergencies. These responders include designated crisis responders (DCRs), mobile crisis teams, crisis stabilization units, and crisis hotlines. Crisis response services are imperative in helping ensure individuals in distress receive timely, appropriate care and are connected to ongoing support and treatment. Crisis responders and providers are identified as interested parties because of the invaluable benefits they might realize through improved accuracy and efficiency of BH services information, increasing the ability to provide timely care and streamlining transitions to continued support and treatment. These providers play a crucial role in identifying services and making referrals. They help inform content that might be needed in the BH bed registry and electronic referral tools and how to support implementation (e.g., through the implementation of new workflows to gather data).

4.4 Tribal Partners, Including Tribal Providers

Tribal partners in WA are important in collaborating with HCA to grow BH services for Native American communities. These partnerships involve developing and implementing programs tailored to address mental health issues/SUDs specific to tribal populations and help ensure culturally appropriate treatment. Additionally, tribal partners contribute to state-level initiatives, such as the CRIS, to improve crisis response and suicide prevention services, helping ensure interventions are culturally sensitive and effective. Tribal partners have been identified as interested parties due to their unique connection and ability to facilitate suitable coordination between tribes and state services, improving overall outcomes for Native American communities facing BH crises. These providers will be directly impacted by the implementation of the BH bed registry and electronic referral tools changing their workflow.

4.5 Managed Care Organizations

MCOs are central to managing several services throughout WA. The five MCOs in the state offer extensive health coverage, including primary care, BH, and preventive services while helping ensure high-quality care standards and efficient resource utilization. HCA oversees these organizations by setting performance targets, conducting audits, and enforcing contractual compliance. The integrated managed care model—promoted by the HCA—aims to address physical and BH needs, treat the whole person, and improve overall health outcomes. MCOs are responsible for enforcing compliance/requirements and are considered a key interested party to regulate compliance among the provider network related to the implementation of a BH bed registry and electronic referral tools.

4.6 Behavioral Health-Administrative Service Organizations

BH-ASOs in WA are vital in managing crisis services and coordinating care for individuals with BH needs. The 10 BH-ASOs oversee and fund various crisis response services, including mobile crisis teams, crisis stabilization facilities, and Involuntary Treatment Act (ITA) services. BH-ASOs work closely with local providers, hospitals, and community organizations to help ensure individuals in crisis receive timely, appropriate care. They also manage the allocation of resources and funding to support these services, aiming to improve care access and outcomes for individuals experiencing BH crises. The efficient utilization and management of the BH bed

registry and electronic referral tools depends on coordination and cooperation from the BH-ASOs network, which makes them a key interested party.

4.7 The Washington State Hospital Association

WSHA represents 107 hospitals and health systems throughout WA. It advocates for policies that improve healthcare access and enhance patient care quality and safety. WSHA's mission is to advocate for and provide value to its members in achieving their goals, focusing on service, integrity, collaboration, innovation, and equity. WSHA has been identified as an interested party because the implementation of the BH bed registry will likely impact the workflow for various hospitals and health systems.

4.8 The Washington Council for Behavioral Health

The WCBH is an organization that represents 38 community-based BHAs across WA. WCBH advocates for high-quality mental health and SUD services, working to ensure individuals and families receive extensive and effective care. WCBH collaborates with policymakers, state agencies, and other interested parties to influence legislation and shape policies that impact BH services. In addition to its advocacy efforts, WCBH provides training, technical assistance, and support to its member organizations, helping them implement best practices and improve service delivery. Through its commitment to advocacy, education, and collaboration, WCBH strives to enhance the BH system and promote well-being in WA. WCBH has been identified as an interested party due to its role in advocating for and supporting BH services. The implementation and sustainability of the BH bed registry and electronic referral tools will depend on the right advocacy and technical support.

4.9 Association of Alcoholism and Addiction Programs of Washington

The AAP is a collaborative dedicated to improving the effectiveness of state-approved alcoholism and addiction treatment programs. AAP advocates to change laws to include thorough assessment and treatment, broadening treatment access for underserved populations, increasing healthcare coverage for SUD, and promoting early detection and treatment for the disease. AAP’s ongoing research and outreach to improve overall quality and accessibility of addiction services in WA will be impacted by the utilization and maintenance of the BH bed registry and electronic referral tools.

4.10 State Agency Staff, Including Health Care Authority and Department of Health

DOH and the HCA work collaboratively to increase BH services and public health initiatives across the state. HCA manages health care programs, including Medicaid and BH services, while DOH oversees public health policies, licensing, and enforcement of health regulations to help ensure safe, competent care. Based on legislative requirements, DOH and HCA staff are leading efforts to implement the BH bed registry and electronic referral tools. In addition, these staff have key knowledge of the intricacies of developing and implementing electronic tools across the state and with diverse partners.

5 Current Environment

This section describes existing federal and state requirements, BH-ASO and MCO contract requirements, the current process for accessing and updating bed information, and information related to current referral tools across providers and other interested parties.

5.1 Overview of Federal and State Requirements

The federal government designated 988 as the telephone number for individuals in crisis to call in order to connect with suicide prevention and mental health services. The federal government passed the National Suicide Hotline Designation Act of 2020, which requires all telephone service providers to route 988 calls to existing National Suicide Prevention Lifelines (NSPLs).

In 2021, the WA State legislature passed the Crisis Call Center and Services Act (HB 1477), which requires the implementation of the national 988 system and the statewide implementation of a technology platform/tools to support the enhanced crisis call and response system by developing additional functionality not included in the national system.

In WA, 988 crisis calls are routed to one of three NSPLs in the state (now referred to as 988 Lifeline crisis call centers) and are part of the Lifeline national network. One of the three 988 Lifeline crisis call centers operates the Native and Strong Lifeline.

HB 1477, as amended by Senate Bill (SB) 1134 and required in the Revised Code of Washington (RCW) 71.24.890,[3] requires DOH to develop an enhanced crisis call and response platform and the HCA to develop a BHICRS. The BHICRS must provide system coordination information to 988 Lifeline crisis call centers and other entities involved in BH care. The BHICRS must provide system coordination information to 988 Lifeline crisis centers and other entities involved in BH care. According to the Third Sector report,[4] a BHICRS capable of timely coordination of crisis response services—with a focus on interoperability and timely data access—is needed for effective crisis management. The required BHICRS comprises several components, including development and use of a BH bed registry and electronic referral tools. RCW 71.24.890 specifies:

> (6) In developing the new technologies under subsection (5) of this section, the department and the authority must coordinate to designate a primary technology system to provide each of the following:
>
> (a) Access to real-time information relevant to the coordination of BH crisis response and suicide prevention services, including:
>
> (i) Real-time bed availability for all BH bed types and recliner chairs, including but not

[3] Washington State Legislature. n.d. "RCW 71.24.890: National 988 System—Designated 988 Contact Hubs—Technology and Platform Development—Agency Collaboration." *Washington State Legislature.* Accessed August 8, 2024. https://app.leg.wa.gov/RCW/default.aspx?cite=71.24.890

[4] Third Sector. October 29, 2021. *Washington State 988 Case Referral and Management System Discovery Report.* Accessed March 20,2024. https://tscp.wpenginepowered.com/wp-content/uploads/2021/12/FINAL-WA-988-Report-Phase-1B-Third-Sector-October-29.pdf

limited to crisis stabilization services, 23-hour crisis relief centers, psychiatric inpatient, SUD inpatient, withdrawal management, peer-run respite centers, and crisis respite services, inclusive of both voluntary and involuntary beds, for use by crisis response workers, first responders, health care providers, emergency departments, and individuals in crisis; and

(ii) Real-time information relevant to the coordination of BH crisis response and suicide prevention services for a person, including the means to access:

(A) Information about any less restrictive alternative treatment orders or mental health advance directives related to the person; and

(B) Information necessary to enable the designated 988 contact hub to actively collaborate with emergency departments, primary care providers and BH providers within MCOs, BH-ASOs, and other health care payers to establish a safety plan for the person in accordance with best practices and provide the next steps for the person's transition to follow-up noncrisis care.

(b) The means to track the outcome of the 988 call to enable appropriate follow-up, cross-system coordination, and accountability, including as appropriate: (i) Any immediate services dispatched and reports generated from the encounter; (ii) the validation of a safety plan established for the caller in accordance with best practices; (iii) the next steps for the caller to follow in transition to noncrisis follow-up care, including a next-day appointment for callers experiencing urgent, symptomatic BH care needs; and (iv) the means to verify and document whether the caller was successful in making the transition to appropriate noncrisis follow-up care indicated in the safety plan for the person, to be completed either by the care coordinator provided through the person's MCO, health plan, or BH-ASO, or if such a care coordinator is not available or does not follow through, by the staff of the designated 988 contact hub;

(c) A means to facilitate actions to verify and document whether the person's transition to follow-up noncrisis care was completed and services offered, to be performed by a care coordinator provided through the person's MCO, health plan, or BH-ASOs, or if such a care coordinator is not available or does not follow through, by the staff of the designated 988 contact hub;

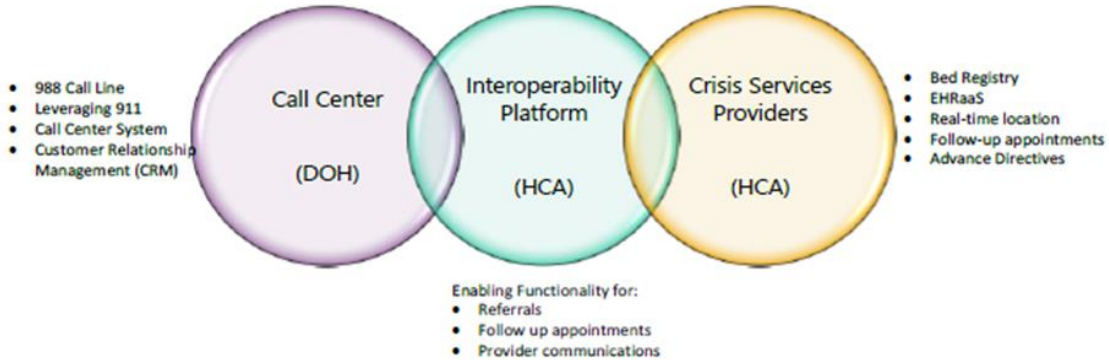
(d) The means to provide geographically, culturally, and linguistically appropriate services to persons who are part of high-risk populations or otherwise have need of specialized services or accommodations, and to document these services or accommodations; and

(e) When appropriate, consultation with tribal governments to help ensure coordinated care in government-to-government relationships, and access to dedicated services to tribal members.

In addition, SB 6259,[5] the "WA Indian BH Act," requires IHCPs be included in any HCA-created bed registry system.

Section 109 of HB 1477[6] requires DOH and HCA to create a technical and operational plan to develop and implement the required technology and platforms to support an enhanced crisis system. The plan recommends a "system of systems" approach in that several systems will be needed to meet HB 1477 requirements. The technical operational plan depicts the technology systems and tools using the infographic referenced in Figure 2 below.[7]

Figure 2: HB 1477 Technology Systems and Tools



WA State Proposed Rules

On January 22, 2024, the DOH Office of Healthcare Analytics, Readiness, and Preparedness filed a proposed rule to amend Washington Administrative Code (WAC) to require acute care/BH facilities and agencies to report critical healthcare and readiness data to WA HEALTH.[8] The proposal extends reporting obligations beyond acute care facilities—as previously mandated during the COVID-19 pandemic—to include BH facilities and agencies. The DOH proposal amends the WAC to require BHAs and providers to submit certain data and indicates that interested parties could contact DOH. Appendix H and I include additional information regarding the proposed rule.

During the COVID-19 public health event, the WA HEALTH program served to make critical information available about the availability of acute care hospital beds and supplies. During the pandemic, acute care facilities struggled with "difficult-to-discharge" situations in which some patients "needed to be discharged to a BH facility rather than home, but the state had no

[5] State of Washington. 2020. "Indian Behavioral Health System—Various Provisions." *State of Washington.* Accessed August 8, 2024. 6259-S.SL.pdf
[6] Washington State Health Care Authority. June 2021. *1477 Overview: E2SHB 1477 Implementation of the National 988 System to Enhance and Expand Behavioral Health Crisis Response and Suicide Prevention Services*. Accessed April 15, 2024. https://www.hca.wa.gov/assets/program/E2SHB%201477.pdf
[7] Washington State Health Care Authority. August 31, 2022. *Final Technical and Operational Plan; National 988 System: Crisis Call Center and Behavioral Health Integrated Referral System.* Accessed April 15, 2024. https://www.hca.wa.gov/assets/program/final-technical-and-operational-plan-988.pdf
[8] Washington State Department of Health. March 7, 2024. *WA-DOH Office of Healthcare Analytics, Readiness, and Preparedness*. Washington State Department of Health. Accessed March 20, 2024. https://content.govdelivery.com/accounts/WADOH/bulletins/38f2e9f

centralized online repository of available beds in BH facilities."[9] WA State regulations require BHAs to "file with the department or the authority upon request, data, statistics, schedules, and information the department or the authority reasonably requires."[10] The DOH believes permanently implementing WA HEALTH would encourage facilities to continue reporting data critical to WA's emergency readiness and would improve patient placement to BH facilities given that such placements are difficult to find in the current environment. Overall, WA HEALTH bolsters awareness of acute care hospital capacity issues and could streamline patient transfers to BH facilities.

5.2 Overview of Behavioral Health-Administrative Service Organizations and Managed Care Organizations Contract Requirements

BH-ASOs and MCO contracts with the State include requirements for client access to services, reporting of service availability, and customer support coordinating services within their provider networks. Each contract undergoes two renewal processes a year when amendments can be negotiated for the next contract year.

The following sections briefly recap what services BH-ASOs and MCOs provide and what sections of their contracts with the State may already guide the sharing of available services and coordination of services between providers.

5.2.1 Behavioral Health-Administrative Service Organizations Contracts

The State contracts with 10 BH-ASOs to provide crisis services across all counties in WA. In turn, BH-ASOs contract with BH crisis service providers in their region to help ensure crisis services are provided to all people—regardless of insurance coverage—for the initial crisis response and sometimes for a follow-up window up to 72 hours (about three days). These services can include mobile crisis services, involuntary services such as DCR investigations, services for people who are underinsured, and regional crisis lines.[11]

Table 1 below identifies sections of the State's contract with BH-ASOs that might regulate care coordination and information-sharing activities across providers in their network. This list is not exclusive, and section numbering may vary based on individual contracts.

[9] Peterson, Kristin. January 22, 2024. "WSR 24-03-126 Preproposal Statement of Inquiry Department of Health." Accessed March 20, 2024. https://lawfilesext.leg.wa.gov/law/wsr/2024/03/24-03-126.htm
[10] Washington State Legislature. n.d. "RCW 71.24.037: Licensed or Certified Behavioral Health Agencies—Minimum Standards—Investigations and Enforcement Actions—Inspections." 2019. *Washington State Legislature.* Accessed March 20, 2024. https://app.leg.wa.gov/RCW/default.aspx?cite=71.24.037
[11] Washington State Health Care Authority ASO Fact Sheet. Accessed July 2024. https://www.hca.wa.gov/billers-providers-partners/program-information-providers/resources

Table 1: BH-ASO Contract Sections

Topic	Contract Sections and Exhibit	BH-ASO – Contract Sections[12] Description
Equal Access	Section 3.3	Equal access for individuals with communication barriers.
Network Capacity	Section 6.2.1	In establishing, maintaining, monitoring, and reporting of its network, the contractor must consider the following: The expected utilization of services, the characteristics and health care needs of the population, the number, and types of providers (training, experience and specialization) able to furnish services, and the geographic location of providers and Individuals (including distance, travel time, means of transportation ordinarily used by individuals, and whether the location is American Disability Act accessible) for all contractor-funded BH programs and services based on available resources.
Customer Service	Section 6.4	The contractor shall have a customer service line, with a single toll-free number for individuals to call regarding services, at its expense, which shall be a separate and distinct number from the contractor's regional crisis toll-free telephone number(s).
Capacity Management	Section 6.6.4	Capacity Management (42 U.S.C. § 300-23 and 42 U.S.C. § 300X 27) The contractor must notify HCA, in writing, when its network of Substance Abuse Block Grant (SABG) providers is at 90% capacity. On a quarterly basis, submit the SABG capacity management report on the last day of the month following the close of the quarter. The capacity management form must identify pregnant and postpartum women and individuals using intravenous drug providers receiving SABG funds, who are at 90% capacity, and what action was taken to address capacity.
Data Use and Security	Exhibit E	Data use, security, and confidentiality, sets out contractor's obligations for compliance with data security and confidentiality terms.
Next-Day Appointment	Section 17.4.3	Contractor shall coordinate with the 988/NSPL provider in their region to help ensure these appointments are accessible to uninsured individual callers who meet the criteria outlined in the next-day appointment assessment tool.
	Section 17.4.3.1	Contractor is encouraged to work with their crisis providers to help ensure they can access next-day appointments for individuals who meet the criteria in the next-day appointment.

[12] Washington State Health Care Authority. "Washington Behavioral Health – Administrative Services Organization Contract, Amendments and Exhibits From July 2023 Through Amendment #2, Effective Date January 1, 2024."

Topic	Contract Sections and Exhibit	BH-ASO – Contract Sections[12] Description
Reporting	Section 7.6	Required reporting for BH supplemental data.

5.2.2 Managed Care Organizations Contracts

The State contracts with five MCOs to create a prepaid and extensive system of medical and health delivery. Services include preventive, primary, specialty, and ancillary health services.[13] The five MCOs connect with approximately 26 providers within their networks.[14]

Table 2 below identifies sections of the State's contract with MCOs that may regulate care coordination and information-sharing activities across providers in their network. This list is not exclusive, and section numbering may vary based on individual contracts.

Table 2: MCO Contract Sections

Topic	Contract Sections and Exhibit	MCO Contract Sections[15] Description
Information Requirements for Enrollees and Potential Enrollees	Section 3.6.3	The HCA will produce, and the contractor shall use, managed care handbook templates (Fully Integrated Managed Care and BH Services Only). HCA-produced templates and HCA-approved contractor handbooks will provide sufficient, accurate, and current written information to assist potential enrollees in making an informed decision about enrollment in accord with the provisions of this Section (SSA 1932[d][2] and 42 Code of Federal Regulations [CFR] § 438.10 and 438.104[b][1][iii]).
	Section 3.6.12	The contractor shall create a link on the front page of its website for providers and enrollees that directs said providers and enrollees to a BH website.
Equal Access	Section 3.7	Equal access for enrollees and potential enrollees with communication barriers.
Network Capacity	Section 6.1.12	The contractor shall maintain an online provider directory with a link on the front page of the contractor's website that immediately directs users to the contractor's searchable online provider directory.
	Section 6.1.13	Contractor's program staff shall provide assistance to enrollees and potential enrollees in conducting provider searches based

[13] The Washington State Health Care Authority. n.d. "Managed Care | Washington State Health Care Authority." Accessed July 2024. https://www.hca.wa.gov/billers-providers-partners/program-information-providers/managed-care
[14] The Washington State Health Care Authority. Apple Health (Medicaid) and Managed Care Reports. *Washington State Health Care Authority.* Accessed July 2024. https://www.hca.wa.gov/about-hca/data-and-reports/apple-health-medicaid-and-managed-care-reports#mcpar
[15] Washington Apple Health Integrated Managed Care Contract, January 2020 through Amendment 19, effective date July 1, 2024.

Topic	Contract Sections and Exhibit	MCO Contract Sections[15] Description
		on office or facility location, clinical specialty, provider discipline, provider capacity, and available languages.
	Section 6.2.2	The contractor, in partnership with essential BH providers, must develop and implement plans for improving access to timely and clinically appropriate treatment for enrollees with BH needs, including individuals with current or prior criminal justice involvement.
Customer Service	Section 6.7	The contractor shall provide adequate staff to provide customer service representation at a minimum from 8 a.m. to 5 p.m., Pacific Time, Monday through Friday, year-round and shall provide customer service on all dates that are recognized as workdays for state employees.
Provider Database	Section 6.10	The contractor shall have, maintain, and provide to HCA upon request an up-to-date database of its provider network. In populating its database, the contractor shall obtain the following information: the identity, location, languages spoken (when this information is supplied by the provider), qualifications, practice restrictions, and availability of all current contracted providers, including specialty providers (42 CFR § 438.242[b][1]).
Data Use and Security	Exhibit G	Data use, security, and confidentiality outline contractor obligations for compliance with data security and confidentiality terms.
Next-Day Appointment	Section 6.7.5.4	Assisting and triaging enrollees who may be in crisis with access to qualified clinicians without placing the enrollee on hold. The qualified clinician shall assess the crisis and warm transfer the call to the BH-ASO or its designated crisis provider(s), call 911, refer the individual for services, refer the individual to their provider, or resolve the crisis over the telephone as appropriate.
	Section 14.18.5.2	Warm handoff: When an enrollee completes or is discharged from an inpatient BHA, the subcontracting agency will have policies and practices in place to provide scheduled immediate appointments with community health care providers to include, but not be limited to, the following: 14.18.5.2.1.1 Intensive Outpatient/Outpatient Services. Documentation of and appointment referral for next level of treatment upon completion of residential services. 14.18.5.2.1.2 Medication-Assisted Treatment. If the enrollee was inducted or continued on Food and Drug Administration (FDA)-approved medications for SUD during their stay in an inpatient BH facility, the agency

Topic	Contract Sections and Exhibit	MCO Contract Sections[15] Description
		will coordinate a same-day appointment with an outpatient provider to coincide with the individual's discharge date. 14.18.5.2.1.3 Peer Support and Recovery-Based Services. The inpatient BH facility will document and provide the enrollee with addresses and phone numbers at discharge for community-based peer support and recovery support resources. 14.18.5.2.1.4 Housing. Enrollee's housing status must be verified through the enrollee or authorized representative and documented within the EHR. When necessary, the BH facility will refer the enrollee to housing and community support services; documentation of any referrals must be placed in the EHR. When the enrollee is prescribed FDA-approved medications for SUD, the provider must document efforts to obtain housing to fit the individual's needs. 14.18.5.2.1.5 Transportation. Arrange for transportation for the individual, as needed, to scheduled appointments and recovery-based housing.
Reporting	Section 6.3	Service Delivery Network. In establishing, maintaining, monitoring, and reporting of its network, the contractor must consider the information in 42 CFR § 438.206(b).

5.3 Access to Bed Information and Use of Referral Tools in the Current Environment

Currently, there is no single way to track bed availability among providers. Due to the lack of widely implemented electronic referral tools, providers have difficulty determining whether a referral resulted in successful access to services for their client. Interested parties across the state are using manual processes such as phone calls, MS Excel sheets, emails, and faxes to identify bed availability and send referrals. This manual process is time-consuming, which creates administrative burden for facilities and long wait times for individuals in crisis. These challenges hinder efficient care delivery for individuals experiencing crises, serious mental illnesses, and serious emotional disturbances. Current practices underscore the need for a more coordinated and streamlined approach to improve BH service access and treatment for those in BH crises.

5.3.1 Persons With Lived Experience

Individuals in crisis currently do not have access to bed availability information. ERs serve as primary access points for crisis-related BH services. Individuals in crisis often rely on the following points of contact to obtain the list of BH providers and referrals:

- Health insurance providers
- Washington DOH
- Peer support
- Connections through organizations (e.g., Veterans Administration, FBH, Passages, the Wraparound with Intensive Services [WISe] program, and the Children's Long-Term Inpatient Program)

Respondents indicated the current process can be cumbersome and involves numerous calls and lengthy assessments before receiving BH services.

5.3.2 988 Lifeline Crisis Call Centers

The current environment for 988 Lifeline crisis call centers including Volunteers of America (VOA) who oversee the Native and Strong Lifeline (NSLL), relies heavily on manual processes to track BH bed availability and capacity. The process involves an individual placement desk and a dedicated person who contacts inpatient facilities twice daily to update an internal bed availability list. This process remains labor-intensive, is prone to human error, and has difficulties exacerbated by staffing shortages. Interested parties mentioned using the OpenBeds platform in some counties, where it may function as a dispatch tool for coordinating with mobile crisis teams.

The current referral process lacks a closed-loop system to understand external referral outcomes. While next-day appointments are contracted through the county with providers for mental health and SUD, there is no system to track the post-admission outcomes. Some 988 Lifeline crisis call center staff currently maintain a list of outpatient providers that accept walk-in appointments and refer callers directly to these resources.

Staff at 988 Lifeline crisis call centers receive initial and ongoing training regarding when to make referrals. However, there is no significant training for staff on intake process differences for mental health and SUD. The inconsistency in the referral process is compounded by the varying processes of each facility, which underscores the importance of knowing exclusionary criteria, especially for co-occurring SUD and mental health conditions.

5.3.3 Crisis Responders/Providers

In the current environment, tracking BH bed availability remains a challenge for crisis providers and responders involved in BH services. Currently, DCRs find placement for individuals on voluntary psychiatric or ITA beds by searching locally within their partnership organizations. If no beds are available locally, they use a printed list of facilities statewide, make phone calls to check bed availability, and provide initial screening information. Many organizations follow a similar practice, relying on a manual process that requires multiple daily updates due to the changing bed availability status.

5.3.4 Tribal Partners, Including Tribal Providers

Based on responses from the listening session, tribal partners rely on MS Excel spreadsheets to track bed availability. Tribal partners wish to monitor various types of BH beds, including those for older adult, dementia, SUD, medically complicated cases, and dual diagnosis patients. However, finding beds for individuals with physical disabilities is particularly difficult because most facilities that accept Medicaid, Medicare, or no insurance cannot provide necessary medical accommodations. This challenge creates a service gap for individuals with physical disabilities. To gain further insight into this challenge, tribal partners are collecting feedback via surveys from tribal members for the Native Resource Hub. The Native Resource Hub serves as an active phone line and information center dedicated to native communities.

5.3.5 Similar to the challenges experienced by other interested parties, tribal partners also face technological challenges that hinder the effectiveness of BH services. Indian Health Clinics face significant obstacles with closed-loop referral systems, mainly when referrals are made to providers who do not use the same EHR. This lack of interoperability complicates the coordination of care. While some case managers are available to assist American Indian and Alaska Native individuals in need of BH services—including crisis services—staffing levels are insufficient. Care coordination services exist for individuals enrolled in specific programs, but there is a lack of support for those not enrolled. Furthermore, care coordination is not easily sustainable. Because care coordination is not a billable service under the current system, there is no current procedural terminology code for fee-for-service IHCPs.Managed Care Organizations

MCOs use various types of manual tools (e.g., multiple MS Excel spreadsheets, SharePoint) to track BH bed availability. MCOs reported there is not one system or registry that all providers use. This decentralized approach makes bed tracking challenging and increases administrative burden on providers, emergency medical services (EMS), and police.

In addition, the process of sending and receiving referrals is manual. Providers use phone calls and emails as a means of communication. Some facilities manually track referral outcomes by requiring notifications within 24 hours of admission, clinical notes for ongoing service utilization, and discharge summaries from receiving facilities. Providers face difficulties placing patients, often needing to call other providers to find open beds and determine if each program meets patient needs.

5.3.6 Behavioral Health-Administrative Service Organizations

In the current environment, facilities use several systems to track BH bed availability, and facilities faced challenges during those system implementations. Regions previously attempted to use a system for electronic referrals but encountered provider resistance during implementation. For example, the King County region has developed a rudimentary SUD

registry using SharePoint, and interested parties said it was helpful; however, the SUD registry required significant administrative support to maintain. The SUD registry is not fully used due to capacity issues and a lack of motivation among residential providers to update bed information.

Some organizations maintain a registry for only involuntary beds and dispatch-designated resident crisis responders. As a result of these challenges, maintaining a BH bed registry remains a manual process that involves calling providers twice daily to update bed availability. There is no formal bed tracking system in some regions. DCRs rely mostly on emails and phone calls to track bed availability.

The referral process is also manual. Providers use fax machines and email to make referrals as opposed to automated systems. Interested parties mentioned using MS Excel sheets and other manual processes to track referral appointments and attendance. However, referring facilities are currently unable to track referral outcomes or services rendered to the individuals in crisis.

5.3.7 The Washington State Hospital Association

WSHA uses multiple systems and platforms such as Aida and the Community Connect version of Epic. The Aida platform helps by:

- Applying a search and filter feature for desired beds and locations
- Enabling referral acceptance or denial checks
- Offering the ability to integrate with the Epic EHR

Facilities can quickly accept or decline referrals using the Aida system, although tracking post-discharge outcomes remains unclear.

The Epic Community Connect system allows users to send and receive referrals. However, there are difficulties connecting this system to other potential EHR systems due to its location in the State of Oregon.

5.3.8 The Washington Council for Behavioral Health

Tracking BH bed availability and managing referrals is a complex, often manual process for interested parties. Internally, organizations within WCBH use various EHR systems (e.g., Epic, Qualifacts, Streamline SmartCare, and Credible) to track bed availability. However, WCBH organizations must manually enter data into the system. These systems include customizable dashboards to track different metrics.

The process for external bed tracking and referrals is manual and requires daily updates from BH hospitals via email and phone.

5.3.9 Association of Alcoholism and Addiction Programs of Washington

Within AAP, inpatient coordinators communicate via phone to confirm bed availability and handle transportation details if a bed is open due to a medical discharge. Beds are usually available because of the dynamic nature of patient turnover. Detox beds operate on a first-

come, first-served basis, and potential patients are screened to help ensure they meet facility admission requirements. While the MS Teams platform is used internally to coordinate bed availability, the overall process relies on phone calls and emails due to the need for person-to-person communication with facilities.

Some AAP providers use systems (e.g., Sigmund Aura) to track bed availability and generate daily reports through Power BI. The Power BI report still requires manual review and updates to help ensure accuracy.

5.3.10 State Agency Staff, Including Health Care Authority and Department of Health

In the current environment, DOH developed WA HEALTH to track certain types of bed information. Currently, WA HEALTH only tracks bed information for acute hospitals—not for emergency departments or inpatient psychiatric hospitals—and is not used in the current 988 environment. Staff can enter data into WA HEALTH manually or via comma-separated values (CSV) uploads, with criteria in place to help ensure data quality. Some organizations choose to update WA HEALTH daily, while others choose to make updates Monday through Friday and not on weekends. DOH currently sends reminders to help ensure compliance with WA HEALTH updates, with an automation process in development for generating additional reminders.

Currently, facilities use manual processes to track bed availability. This involves a low-tech process, where authorization specialists' email and call 21 providers for bed counts twice weekly, and then staff enter data into ServiceNow for report generation. The provider organizations included in this manual process are hospitals, evaluation and treatment facilities, standalone psychiatric hospitals, and acute care hospitals.

HCA does not have specific electronic tools for sending referrals, but it has tools to help find different providers (e.g., provider entry portal for tribal members, BH services delivery guide, and provider directory). However, these tools lack robust search capabilities and timely updates. These available tools allow providers/individuals for resource identification but involves manual processes for contacting the facilities/providers to get updated information. Some interested parties use platform tools—such as Bamboo Health and the Recovery Navigator Line—to search for providers.

6 Assessment Findings

6.1 Summary of Findings

BerryDunn used information gathered from discovery sessions, web survey responses, and background documents to identify provider needs and challenges related to accessing bed availability and conducting referrals. BerryDunn analyzed and cross-referenced discovery session notes, web survey responses, and background documents to conduct a thematic analysis. The analysis identified data patterns to determine themes. The themes are labeled with an alphanumerical identification (ID) tag. Although not exclusive, the following are common themes and key findings:

- **Technology and Tools**: Manual processes create multiple challenges. Providers across the state invest significant time and effort calling facilities to determine bed availability for individuals' placement using a MS Excel sheet—or other manual tools—to capture information. With frequent changes in bed availability, some staff spend a significant portion of their day calling multiple facilities for updates. This administrative burden hinders facilities' ability to efficiently care for individuals in crisis—a challenge compounded by staff shortages.
- **Admission Criteria:** Interested parties in multiple discovery sessions noted that if a facility has a bed available, it does not necessarily indicate that the individual will be accepted and receive the bed. Each facility operates with its own admission criteria and collects different data sets during admission. There is no standard set of admission criteria required for the same type of facilities. These differing admission criteria challenge the referral and admission process. As a result, providers face challenges in gathering the required information about the individual for admission.
- **Resources:** Some facilities in rural areas indicated barriers such as staffing, funding, and internet access to implement and use a BH bed registry and electronic referral tools. In addition, individuals in rural areas often have difficulty accessing services that are farther away due to limited availability of public transportation or a lack of needed services in their area.
- **Processes:** Facilities across the state use multiple electronic health record (EHR) systems, and each system's functionality and processes depend on facility needs. In the absence of a statewide EHR, interested parties highlighted the need for a streamlined process and interoperability among different EHR systems to support provider implementation and utilization of the BH bed registry and electronic referral tools to help bridge the current gap.
- **Cost:** Some facilities struggle with staff shortages, an issue interested parties highlighted as a potential barrier to successfully implementing a BH bed registry and electronic referral tools. In addition, if a new software system is required, some partners might have difficulty budgeting for associated costs due to administrative fee caps.

These findings suggest the need for a streamlined, easy-to-use, and sustainable BH bed registry and electronic referral tools for providers to adopt and implement in their workflow. There is a need for interface and exchange of data among existing systems to reduce duplication of efforts and additional administrative burden on providers. BerryDunn details these findings in Section 6.2.

6.2 Needs and Challenges in the Current Environment

Table 3 below outlines needs and challenges learned through web surveys, discovery sessions with interested parties, and review of background documents. Findings are categorized based on themes heard during data collection activities and are in no specific order. BerryDunn identified the category most relevant for each finding.

Table 3: Needs and Challenges

ID	Categories	Description
F1	Processes	Interested parties use manual processes to track BH bed availability (i.e., MS Excel sheets, phone calls, emails, fax), which is time-consuming. This creates challenges in obtaining accurate bed availability counts due to potential for human error and/or the information is outdated by the time it is updated.
F2	Processes	Resources to search for providers have been developed; however, the tools that are publicly available consist of a long list of resources and do not have robust features to filter and locate a facility/provider that meets the individual's need. There is a need to tie all services into 988 and build a searchable database similar to the vaccine locator tool.
F3	Processes	Even with a screening/admission process in place to assess individuals, identify beds, and place an individual in a facility, there is no incentive for receiving providers to fill beds with high-need/high-risk individuals. This makes it difficult for referring providers to find a place for individuals with more extensive needs.
F4	Processes	Care coordination is not a billable service, and there is limited funding dedicated to increase care coordination staff. Without sufficient funding and resources, it will be a challenge to establish a full care coordination team to support efficient care delivery for individuals in crisis.
F5	Processes	Withdrawal beds are available on a first-come, first-served basis due to a reportedly high frequency of individuals missing the appointment. Interested parties noted that tracking bed availability is a fluid process. Most facilities overbook due to similar events, and/or the bed update might not be valid/reliable because the facility already has a

ID	Categories	Description
		patient waiting for a bed in the ER. Due to this, a bed might appear open when it is not.
F6	Processes	Interested parties do not have the ability to reserve beds. An individual can be given a bed allocation, but if they are unable to arrive at the facility within a few hours, the bed will be reallocated to another individual, even when the first individual is on their way to the facility.
F7	Processes	Interested parties have a medical clearance process that creates system delays by requiring information that only the hospital or BH facility has. This process also requires individuals in crisis to go to the ER for clearance, which may have long wait times or turn away individuals. This creates a challenge for obtaining timely information and placing an individual in the open bed.
F8	Processes	Individuals in crisis often depend upon various organizations and insurance companies to gather the list of BH providers. However, these organizations and insurance companies do not update the lists frequently, which leads to further delays and inefficiencies in accessing BH services.
F9	Processes	The varied accuracy of bed availability information from facility staff is often influenced by the unit's workload. For example, agencies might avoid calling facilities due to the strain it places on staff, opting to send people to facilities that handle voluntary admissions or dispatch a mobile crisis response team.
F10	Processes	In some locations, manually calling multiple facilities requires one full-time employee to call and maintain their bed tracking tools, such as MS Excel spreadsheets, to update bed availability. This compounds the challenges associated with existing staff shortages in the facilities.
F11	Bed Capacity	Interested parties are experiencing a supply and demand challenge for bed capacity. Facilities receive several referrals in a day for a single bed, resulting in long wait times to hear from providers on whether they can take patients.
F12	BH Bed Registry Content	There is a lack of tools to track open beds with criteria such as gender and age.
F13	BH Bed Registry Content	Some interested parties expressed concern over a BH bed registry not working due to manual components (phone call confirmations, emails, etc.) that staff must conduct to verify bed availability and an individual's suitability for admission.

ID	Categories	Description
F14	BH Bed Registry Access	There are mixed responses from interested parties on individuals in crisis having access to the BH bed registry. Interested parties highlighted individuals in crisis—or their friends/family—who are looking for bed availability might walk into a facility without an assessment that helps determine the appropriate treatment setting for that individual. This creates additional confusion and frustration among individuals in crisis, their family/friends, and facility staff.
F15	BH Bed Registry Functionality	Interested parties face challenges placing individuals in crisis into a facility that meets their needs in a timely manner. There is a desire to include exclusionary criteria in the BH bed registry by filtering through demographic and treatment options. This will allow BH staff to place individuals in crisis into an appropriate facility.
F16	Technology and Tools	Most interested parties use an EHR to track information on internal referrals. Currently, interested parties cannot track external referrals through their EHRs, which hinders their ability to electronically capture external referrals and the outcome of an individual once they leave the facility.
F17	Technology and Tools	Interested parties request an automatic update for BH bed availability data from their existing system to the BH bed registry to help ensure real-time reporting for availability. Without automation, staff would face another manual process.
F18	Technology and Tools	Interested parties built individual processes/tools to track bed availability and conduct referrals throughout the state. These processes and tools differ by organization, creating challenges to fully integrate individual systems with EHRs. There is a need for interface and interoperability among existing systems to reduce duplication of efforts for staff to maintain a BH bed registry and electronic referral tools.
F19	Technology and Tools	Interested parties do not currently share all available beds with BHAs due to the common practice of overbooking to help ensure consistent, full capacity, as individuals frequently miss their appointments. This creates a challenge for BH facilities to identify accurate bed availability because facilities might under-report their numbers.
F20	Technology and Tools	If an admission, discharge, and transfer (ADT) system is not used as a source of information for providers using EHRs to feed into the BH bed registry, there will be barriers such as administrative burden for providers to manually input information into the BH bed registry.

ID	Categories	Description
F21	Technology and Tools	Many interested parties use different EHR systems, and there is no way to access referral outcomes electronically if the individual is referred to a facility with a different EHR system. This creates a challenge to manage external referrals electronically. In addition, there is no automated process to receive information about referral outcomes.
F22	Technology and Tools	The current reporting systems that could be used to track available beds at the state level do not provide enough details for a BH bed registry, such as bed levels. If HCA decides to use WA HEALTH for the BH bed registry, there is a need for facilities to provide details on the level of bed/type.
F23	Technology and Tools	Customizing reports in the EHR is difficult for staff. This creates the challenge of using the EHR to run reports for items, such as bed availability and other essential tasks, due to a lack of flexibility.
F24	Technology and Tools	Interested parties mostly use fax or email to make referrals. This introduces the challenge of referrals getting lost and extends wait times to hear back from various facilities.
F25	Technology and Tools	Some interested parties do not track bed availability in a central location and must call facilities every time an individual needs an open bed or referral.
F26	Technology and Tools	Interested parties use software outside of the EHR to run reports (such as Power BI and PowerBuilder) and track bed availability (such as Redstream, XFERALL, and GE Tiles). This is a challenge due to the associated cost and training required for the separate software; moreover, interoperability between software is unknown.
F27	Technology and Tools	If interested parties use the EHR to track BH bed availability, it locks the bed when a referral is pending. This is a challenge because another individual cannot be placed in the bed if the individual does not arrive at the facility within the expected time frame, limiting facilities' capability to reach maximum capacity.
F28	Technology and Tools	Sometimes a bed can be available, but the facility cannot accept new patients due to the unit's level of acuity. There is a challenge with using an electronic system to update a BH bed registry automatically if the system lacks a mechanism to accommodate variabilities like unit acuity/staffing levels.
F29	Technology and Tools	Current BH bed tracking systems do not include all providers. This is a challenge because a location close to an

ID	Categories	Description
		individual may not show in a service directory when searching their current bed tracking system.
F30	Technology and Tools	The electronic bed registry might show beds as available, but facilities cannot admit any individuals due to different circumstances, such as an infectious disease outbreak or high acuity. This creates a challenge for individuals in crisis, as they may not be accepted to a facility even if it has open beds.
F31	Resources	Interested parties throughout the state have a BH staff shortage, creating barriers for timely updates and maintenance of the BH bed registry.
F32	Resources	There are no centralized locations for identifying BH services for persons with lived experience. Most of the time, accessing BH services depends on the relationships and connections that individuals with lived experience have.
F33	Resources	At times, persons with lived experience and care coordinators face challenges using web-based tools, as the tools can be difficult to navigate and/or internet connection issues can occur while trying to identify BH services.
F34	Resources	Transportation in rural areas is challenging (e.g., public and private transportation and ambulances), which creates difficulty in getting individuals to facilities with open beds. In addition, staff assist with providing transportation or working to arrange it, which impacts staff availability to provide consistent treatment. There is a dual burden of administrative tasks on the staff.
F35	Resources	Facilities have waitlists that individuals in crisis can join ahead of time for their treatment; however, individuals in crisis are not aware of the waitlist process. This creates a challenge for individuals in crisis seeking timely treatment.
F36	Resources	There are not enough specialized beds for older adults and individuals with developmental disabilities. Moreover, there is lack of withdrawal management, residential, and medical co-occurring beds, which creates a challenge for individuals in crisis to access services.
F37	Resources	Interested parties in rural areas struggle to find specific beds due to lack of facilities that provide different levels of care.
F38	Implementation	There is no standard process to track beds or conduct referrals, making bed tracking and referrals a time-consuming process.
F39	Implementation	Interested parties cannot currently receive external electronic referrals or their outcomes (e.g., referral resulted

ID	Categories	Description
		in an assessment, etc.). There is an administrative burden to manually receive outcomes about external referrals.
F40	Implementation	Creating a closed-loop electronic referral tool compliant with the Health Insurance Portability and Accountability Act (HIPAA) and 42-CFR is a challenge due to privacy issues.
F41	Care Coordination	Individuals and family members do not know how to navigate BH services to receive timely treatment. In addition, people with neurological disabilities might be unable to conduct their own research online using web-based tools if the tools are not accessible.
F42	Communication	There is a lack of awareness among individuals in crisis about existing tools, available services, providers, and resources that can be used during a crisis due to lack of frequent communications.
F43	Support	Interested parties are not aware if the EHR could be used for electronic referrals and/or the BH bed registry. This is a gap in knowledge and awareness of EHR functionalities.
F44	Requirements	Some facilities might not want their civil conversion beds posted in the BH bed registry. This will create challenges for facilities to identify the number of available long-term civil commitment beds and differentiate the type of beds that can accept individuals on 90- or 180-day holds for specific services.
F45	Requirements	If a requirement is established to update a BH bed registry more than twice per day, and the updates must be entered manually, there is a risk that providers will not adhere to the requirement. This is a challenge with making a real-time BH bed registry as required by HB 1477.
F46	Requirements	All providers and hospitals do not fall under the same authority within a service area. There is a difference between private and public hospitals and which hospitals fall under MCO authority. This makes it difficult for MCOs to implement requirements for all providers to update a BH bed registry.
F47	Cost	If a new system is required for an electronic reporting tools and BH bed registry, the cost may be a challenge for organizations. Specifically, this could be a challenge for nonprofits with limits on administrative and overhead costs, and budgeting for a new system could have long-term impacts.

ID	Categories	Description
F48	Cost	Previous efforts to track bed availability were unsustainable because of the time it took to update the tracker and connect with people who were not updating the tracker.
F49	Data	There is a lack of standardized data between hospitals and BH facilities, as they have differing minimum data standards, which hinders some facilities' ability to use an EHR. This delays the referral and placement process because facilities must rescreen the individual or wait for paperwork to be faxed to complete the referral.
F50	Regulations	Interested parties in multiple discovery sessions noted that if a facility has a bed available, it does not necessarily indicate that the individual will be accepted and receive the bed. Facilities have their own assessment criteria to admit individuals in crisis, and if individuals in crisis are to have access to the BH bed registry, it creates additional burden on them and the facilities.
F51	Regulations	Some BH facilities do not have state licenses, creating challenges for states to regulate and inspect these facilities and help ensure adequate treatment for underserved groups.
F52	Regulations	Previous efforts to implement a BH bed registry failed in part due to a lack of contractual requirements for organizations to follow.
F53	Regulations	Interested parties have long wait times because there is no requirement for facilities to make referral decisions within a certain amount of time.

7 Recommendations

7.1 Summary of Recommendations

BerryDunn identified nine recommendations for HCA's consideration based on findings from the literature reviews, web surveys, initial discovery sessions, follow-up discovery sessions, and background documentation. The recommendations are categorized into three focus areas: implementation, technology, and planning and are in sequential order of implementation for HCA's consideration.

These recommendations are for HCA's consideration. HCA's implementation of one or more recommendations could be impacted by multiple factors (e.g., resource availability, feasibility, future legislation changes, and changes related to system functionality of the BH bed registry and electronic referral tools.)

BerryDunn highlighted the future-state goal(s) addressed by each recommendation. Each recommendation is also categorized using the level of effort (LOE) as defined below:

- **High:** Requires substantial time, resources, and expertise, often involving complex tasks
- **Medium:** Requires a moderate amount of time and resources, typically involving tasks of moderate complexity
- **Low:** Requires minimal time and resources, usually involving simple or routine tasks

In addition, BerryDunn identified the estimated timeline of 0 – 6 months, 6 – 12 months, or 12+ months for HCA to complete the recommendations. Some recommendations depend on each other, and BerryDunn has noted these dependencies within recommendations. Table 4 below summarizes recommendations included in Section 7.2.

Table 4: Summary of Recommendations

ID	Recommendations	LOE	Estimated Timeline to Complete
R1	Identify and conduct business process mapping and analysis of new workflow	High	0 – 6 months
R2	Plan for automation of a BH bed registry and electronic referral tools through broad interoperability with other data sources (e.g., various EHRs)	High	6 – 12 months
R3	Prioritize functionality and content of a BH bed registry and electronic referral tools	High	6 – 12 months
R4	Plan for a phase-based implementation approach	Medium	12+ months
R5	Implement BH bed registry update cadence based on level of care	High	12+ months

ID	Recommendations	LOE	Estimated Timeline to Complete
R6	Create a communication plan to support and continue coordination and partnership with interested parties for effective implementation	Low	0 – 6 months
R7	Develop specialized training plans to support providers' utilization of the BH bed registry and electronic referral tools	Medium	6 – 12 months
R8	Create incentives for providers to use and update the BH bed registry and electronic referral tools	High	12+ months
R9	Create a monitoring tool to track utilization of the BH bed registry and electronic referral tools	Medium	12+ months

7.2 Description of Recommendations

7.2.1 Recommendation 1

Table 5: Recommendation Dashboard

Category: Implementation			
Recommendation 1: Conduct business process mapping and analysis of new workflow			
Findings Addressed: F3, F5, F6, F7, F8, F9, F33, F38, F53			
Future-State Goals Addressed	**Estimated LOE**	**Timeline**	**Dependencies**
Goal 6	High	0 – 6 months	Recommendation 2 and 3

Recommendation Description

HCA should continue working with interested parties to develop future business process maps and analyze a fully functional BH bed registry and electronic referral tools workflow. This could help provide HCA with a chance to further:

- Evaluate the content of the BH bed registry
- Identify systems with which to interface and maintain interoperability
- Identify processes that could be standardized
- Identify users of the BH bed registry and electronic referral tools
- Identify upcoming changes in provider workflows
- Identify additional functionalities of the BH bed registry and electronic referral tools
- Evaluate challenges and opportunities to improve the process in the following areas that interested parties expressed concern about:

- **Timeliness of accessing the tools** – The amount of time it takes to access web-based tools and any connectivity challenges
- **Timeliness of locating services** – The amount of time it takes to locate available services
- **Timeliness of obtaining responses to a referral** – The amount of time it takes to receive a response from the initial referral
- **Timeliness of accessing services** – The amount of time it takes to receive services and the feasibility of meeting the next-day appointment criteria with a focus on individuals with more extensive needs

7.2.2 Recommendation 2

Table 6: Recommendation Dashboard

Category: Technology			
Recommendation 2: Plan for automation of a BH bed registry and electronic referral tools through broad interoperability with other data sources (e.g., various EHRs)			
Findings Addressed: F1, F7, F9, F10, F11, F16, F17, F18, F20, F21, F24, F25, F26, F38, F39, F40, F45, F48, F49			
Future-State Goals Addressed	**Estimated LOE**	**Timeline**	**Dependencies**
Goal 1, 2, and 4	High	6 – 12 months	Recommendation 3

Recommendation Description

To help HCA limit staff burden and increase accuracy of the BH bed registry and electronic referral tools, information in the BH bed registry should be automatically uploaded from existing systems into one database. In addition, there is a need for electronic referrals to communicate across the EHRs and the diverse systems used across the facilities. HCA should consider developing an interoperability plan that will support interface functionality between diverse EHRs and reporting systems. To build an interoperability plan, HCA should consider taking the following steps:

- Develop a communication plan to promote the long-term benefits of interoperability across all EHRs and data systems.
- Establish a key interested parties' advisory group to engage vendors and providers and to help ensure consistency in the process to report on available beds across systems and interfaces.
- Compile an inventory of systems and data sets available across BH service providers.
- Develop and maintain an inventory of systems and identify what systems and data sets are needed to meet the needs of the BH bed registry and electronic referral tools.

- Standardize data collection processes across BH facilities to support information-sharing during electronic referral processes.
- Develop minimum standards for BH service providers to track data in their EHR or preferred electronic system.
- Determine HIPAA and 42-CFR rules around privacy to electronically exchange information regarding referrals. Also ensure that Tribal sovereignty as it pertains to tribal data is maintained as established by: (i) The National Congress of American Indians and (ii) are reflected in the "Best Practices for AI/AN Data Collection."
- Facilitate information exchange conversations between service providers and vendors to understand anticipated changes in provider workflows.
- Develop a plan to support interfacing the BH bed registry and electronic referral tools with existing internal and external systems to reduce duplication of efforts for staff. This could include use of ADT as a source of information for providers using EHR to feed into the BH bed registry.

7.2.3 Recommendation 3

Table 7: Recommendation Dashboard

Category: Implementation			
Recommendation 3: Prioritize functionality and content of a BH bed registry and electronic referral tools			
Findings Addressed: F2, F3, F4, F5, F6, F8, F9, F11, F12, F13, F14, F15, F19, F22, F24, F25, F27, F28, F34, F38, F50			
Future-State Goals Addressed	**Estimated LOE**	**Timeline**	**Dependencies**
Goal 2, 3, and 4	High	6 – 12 months	Recommendation 1 and 4

Recommendation Description

To support successful implementation of a BH bed registry and electronic referral tools, HCA should determine the functionality and information that will be included in the BH bed registry. The functionalities and information/content should be largely informed by the needs of the future users of the BH bed registry and electronic referral tools. Below are the functionalities for HCA to consider when planning for the implementation of a BH bed registry and electronic referral tools. These functionalities are not listed in order of priority, and this recommendation is a pending decision for HCA (refer to Section 8 pending Decision 4).

- Easy access to the BH bed registry without multiple login criteria
- Ability to automate data entry and update bed availability as per HCA-determined cadence

- Searchable database that limits access to service providers or could include a public-facing version with ability to sort the beds as per individual's need
- Ability to hold a bed for the individual
- Ability to send an alert to provider(s) when a new bed is available
- Ability to complete referral forms embedded within the BH bed registry and electronic referral tools
- Ability to send electronic referrals
- Ability to send an alert to provider(s) on referral acceptance and patient admissions
- Ability to schedule and coordinate transportation when needed

In addition, HCA should consider the following content/information to be included in the BH bed registry and electronic referral tools:

- Information on provider name, program type/bed type, insurance accepted, and service location
- Exclusionary criteria (such as age, gender, and diagnosis), admission requirements, and information on acuity level of the facilities
- Total number of beds available based on age and gender
- Information about whether providers with available beds have the cultural competency to serve diverse groups
- Providers' licensing status (e.g., licensed, licensure pending)
- Information for care coordinators to use while supporting individuals in crisis
- Timestamp of last BH bed registry update (e.g., last updated August 25, 2024, at 11:32 a.m.)

7.2.4 Recommendation 4

Table 8: Recommendation Dashboard

Category: Implementation			
Recommendation 4: Plan for a phase-based implementation approach			
Findings Addressed: F29, F36, F44			
Future-State Goals Addressed	**Estimated LOE**	**Timeline**	**Dependencies**
Goal 4 and 6	Medium	12+ months	Recommendation 1 and 3

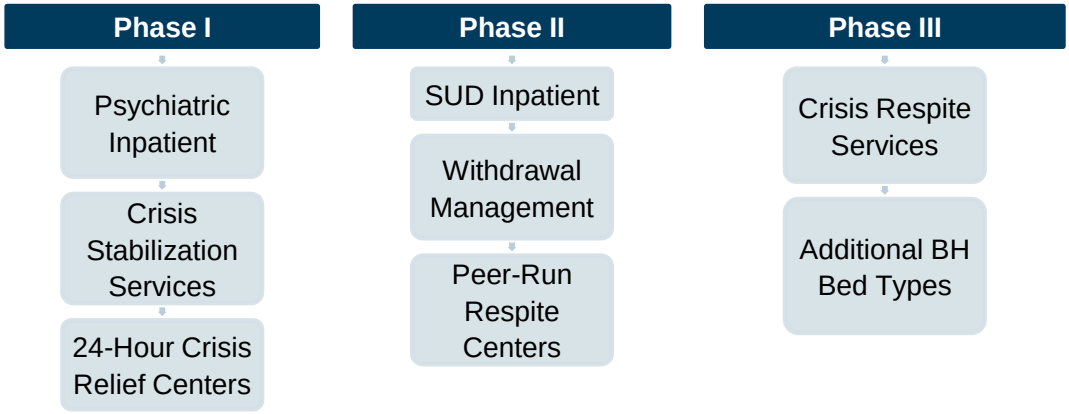
Recommendation Description

HCA should consider implementing the BH bed registry and electronic referral tools in phases to help ensure tool usage is well documented, processes are clearly defined, and procedures account for the differences across levels of care. A phase-based implementation approach could also help HCA ensure the systems are tested, user friendly, and efficiently manage a high volume of information and referrals. A phase-based implementation approach might include the following:

- **Phase I** – Identify vendor/vendors to build a system to host the BH bed registry and electronic referral tools. HCA can then start by selecting one region with established DCRs, robust use of EHRs, and collaboration models that exist across BH providers to roll out the implementation. This phase would include the rollout of BH bed types that were prioritized by the interested parties during discovery sessions.
- **Phase II** – Start incremental implementation for other BH bed types in Phase II when the BH bed registry and electronic referral tools have been tested for BH service types included in Phase I.
- **Phase III** – Focus on implementing crisis respite services and additional BH bed types in Phase III. As HCA continues to build on statewide data interfaces and interoperability across BH facilities, HCA should consider including additional BH service types (e.g., recovery housing, mental health residential treatment beds, diversion beds, single vs. co-occurring beds, pediatric inpatient beds, long-term civil commitment beds).

Figure 3 below demonstrates a potential approach for the phase-based implementation of BH bed types—after identification of a system—for HCA's consideration.

Figure 3: Phase-Based Implementation



7.2.5 Recommendation 5

Table 9: Recommendation Dashboard

Category: Implementation			
Recommendation 5: Implement BH bed registry update cadence based on level of care			
Findings Addressed: F5, F9, F17, F45, F48			
Future-State Goals Addressed	**Estimated LOE**	**Timeline**	**Dependencies**
Goal 6 and 7	High	12+ months	None

Recommendation Description

Having access to real-time bed availability is essential for providing BH services. Due to variability of different bed types, a standard update cadence might not be feasible for all BH bed types. Based on feedback from interested parties during discovery sessions and in web surveys, Table 10 outlines a suggested BH bed registry cadence for updates. The bed types listed below is in no particular order.

Table 10: BH Bed Registry Update Cadence Based on Level of Care

Bed Type	Update Cadence
Crisis Stabilization	Twice a day (during shift change)
Acute Care	Daily
Inpatient Services	Twice a day
Residential Treatment	At admission and discharge
Supportive Housing	At admission and discharge
Outpatient Services	At admission and discharge

To implement the update cadence, HCA should consider:

- Creating reporting requirements in the providers' contract related to the cadence for updating information in the BH bed registry based on level of care.
- Creating an automated email alert to the providers/facilities that are late in reporting the bed availability as per the update cadence.

7.2.6 Recommendation 6

Table 11: Recommendation Dashboard

Category: Planning			
Recommendation 6: Create a communication plan to support and continue coordination and partnership with interested parties for effective implementation			
Findings Addressed: F8, F9, F10, F30, F31, F32, F34, F35, F37, F41, F42, F47			
Future-State Goals Addressed	**Estimated LOE**	**Timeline**	**Dependencies**
Goal 1 and 5	Low	0 – 6 months	None

Recommendation Description

HCA should consider developing a robust communication plan that supports effective coordination and collaboration across service providers, individuals in crisis, vendors, and HCA. When developing the communication plan, HCA could consider the following strategies:

- **Engage change champions** – Establishing change champions from key interested parties can help with the implementation of the BH bed registry and electronic referral tools. Change champions are individuals selected based on their leadership and communication skills to help actively promote initiatives aimed at organizational and/or social change. They can support implementation activities by carrying forward messaging within their networks and advocating for the use of the new BH bed registry and electronic referral tools. Change champions can include hospital administrators, representatives of emergency departments, acute psychiatric inpatient units, mobile crisis responders, DCRs, and consumers.
- **Communicate clear and reliable timelines** – Communicating clear and reliable timelines for implementation activities can help provide clear expectations for:
    - How and when interested parties will be engaged during implementation activities
    - Determination of the phase/activities where the interested parties' participation will be crucial to project success
- **Develop communication materials** – Developing communication materials relevant to the audience can help gain buy-in from interested parties. Communication materials can define how the BH bed registry and electronic referral tools will address the following areas of concern or other questions/concerns that interested parties might raise in the future. HCA can consider including communication materials related to:
    - **Funding** sources that will be available to support implementation early in the process. Communicating information about available funding can help alleviate

concerns of financial burden on service providers (e.g., staffing shortage, transportation issues, lack of beds, new system costs, and ongoing oversight).

- **Staff availability** and how the BH bed registry and electronic referral tools will work to decrease staff time required to locate available services and send or receive referrals.
- **Automation** and streamlining of the business process that might limit administrative burden on staff.
- **User flexibility** including information on manual options to update bed availability if unique acuity or staffing levels are not conducive for admitting new clients.
- **Responsibility** and clearly defined roles for timely updates and ongoing maintenance of the systems.
- **Accessibility** including information on if and how the BH bed registry and electronic referral tools will be accessible to people with lived experience through service providers and/or additional access as determined by HCA.

- **Identify effective communication channels** – Identifying methods to deliver the communication materials can help ensure there is a focus on HCA's intended audience. HCA could conduct webinars, regular meetings, and forums or share the communication materials via DTLL, newsletter, websites, or emails.

7.2.7 Recommendation 7

Table 12: Recommendation Dashboard

Category: Planning			
Recommendation 7: Develop specialized training plans to support providers' utilization of the BH bed registry and electronic referral tools			
Findings Addressed: F23, F26, F38, F43			
Future-State Goals Addressed	**Estimated LOE**	**Timeline**	**Dependencies**
Goal 1 and 6	Medium	6 – 12 months	Recommendation 3 and 5

Recommendation Description

When the BH bed registry and electronic referral tools are established, HCA should consider developing specialized training plans for the providers. To help prepare and account for the diverse use of existing EHRs and reporting systems across providers, HCA should develop the specialized training plans based on the EHR vendors that facilities are currently using. To develop the training plans, HCA should coordinate with the EHR vendors early in the process. Engaging EHR vendors early in the process can provide opportunities for these vendors to educate/train providers on how to use their EHR most effectively and efficiently in the providers'

current environment to communicate with the BH bed registry and electronic referral tools. With EHR vendor input, training plans for EHR providers should support BH providers' understanding of the following items:

- Process for updating the BH bed registry and electronic referral tools based on information from the provider's EHR reports (e.g., a bed occupancy report that can be linked to the BH bed registry)
- Available reports in the EHR to inform the BH bed registry and electronic referral tools
- Submission and tracking of referrals (if available)
- Process to confirm accuracy of data being entered into the BH bed registry and electronic referral tools by the provider
- Process to report and track available beds and referrals in the provider's EHR
- Submission of available grants to support implementation of the BH bed registry and electronic referral tools
- Analysis of ongoing workflows and process redesign

Training plans for non-EHR providers will need to focus on understanding the following items:

- Process to track available BH bed workflows and submitting them into the BH bed registry
- Process to confirm accuracy of data being entered into the BH bed registry and electronic referral tools
- Process to report and track available beds and referrals
- Transition to an EHR in the long term

7.2.8 Recommendation 8

Table 13: Recommendation Dashboard

Category: Implementation			
Recommendation 8: Create incentives for providers to use and update the BH bed registry and electronic referral tools			
Findings Addressed: F5, F19, F52			
Future-State Goals Addressed	**Estimated LOE**	**Timeline**	**Dependencies**
Goal 1 and 6	High	12+ months	Recommendation 5

Recommendation Description

To encourage timely reporting and updates to the BH bed registry and the adoption of electronic referral tools, HCA should create a system of incentives that recognizes and rewards providers who consistently maintain accurate and current data. HCA should consider the following approaches and strategies when building and implementing incentives:

- **Recognition programs** – Publicly acknowledge/promote facilities that excel in timely reporting, which could help encourage other providers to report in a timelier manner. In addition, HCA should consider establishing an annual awards program highlighting top-performing providers, which could help enhance its reputation in the community.
- **Subsidies for technology adoption** – Provide subsidies or grants to facilities that implement the BH bed registry and electronic referral tools. This could help more providers integrate the new tools into their processes by lowering the amount of funding required to spend from the providers'/individual budgets.
- **Performance-based financial incentives** – Offer financial rewards to facilities that consistently update their bed availability and maintain accuracy in the BH bed registry. These incentives could be tied to identified metrics (e.g., the frequency of updates based on level of care).

Incorporating these strategies could lead to a more efficient, reliable BH bed registry update and use of electronic referral tools, which could help improve access to care for individuals in crisis.

7.2.9 Recommendation 9

Table 14: Recommendation Dashboard

Category: Implementation			
Recommendation 9: Create a monitoring tool to track utilization of the BH bed registry and electronic referral tools			
Findings Addressed: F46, F51			
Future-State Goals Addressed	**Estimated LOE**	**Timeline**	**Dependencies**
Goal 1 and 6	Medium	12+ months	Recommendation 5 and 6

Recommendation Description

HCA can consider creating a monitoring tool to track the utilization/implementation of the BH bed registry and electronic referral tools. An effective monitoring tool could include performance measures to help track adoption of the BH bed registry and the electronic referral tools. To limit staff and provider burden, performance measures should be informed by reports pulled from the system. It is important for HCA to standardize definitions and practices on which data to collect. HCA can develop key performance measures in coordination with interested parties. Table 15 below provides example performance measures.

Table 15: Example Performance Measures

ID	Performance Measures
1	Number of facilities using electronic referral tools to accept or decline referral within 24 hours once a referral is received
2	Within the first year of implementation, number of next-day appointments conducted for individuals accepted via an electronic referral
3	Of total facilities, X% updated the BH bed registry per the required BH bed registry and electronic referral tools update cadence
4	X% of facilities used the BH bed registry and electronic referral tools within the first year of implementation

In addition to including performance measures in the monitoring tool, HCA should consider determining the frequency of monitoring activities by creating a risk assessment to identify providers that might need additional support when implementing the BH bed registry and electronic referral tools. The risk assessment could include monitoring criteria for high-, medium-, and low-risk BH providers. Table 16 provides an example for criteria definitions of each risk level and possible cadence of monitoring activities based on these risk levels.

Table 16. Risk Level and Cadence of Monitoring Activities

Risk Level	Monitoring Activities
Low – BH provider has an established EHR, or reporting system, that has tested and confirmed interoperability with the BH bed registry and electronic referral tools.	Quarterly
Medium – BH provider has an established EHR, or reporting system, and is still working to develop/enhance interoperability with the BH bed registry and electronic referral tools.	Monthly
High – BH provider does not have an EHR, or a well-established EHR, and will be responsible for manual updates to the BH bed registry. BH provider has no reporting issues within its systems and/or EHR. Note: An ideal BH bed registry and electronic referral tools will aim to limit the providers who fall into this category.	Biweekly

7.3 Additional Considerations

The recommendations resulting from this assessment primarily address challenges identified by interested parties. Based on the literature review and market research, BerryDunn developed other considerations, as noted in Table 17, to help support HCA during the implementation of a BH bed registry and electronic referral tools.

Table 17: Additional Considerations

ID	Recommendations

AC1	Create a public-facing portal within the BH bed registry and electronic referral tools.
	• Interview the selected vendor to understand system functionality and capability.
	• Include the following information in the public-facing portal:
	  ○ Available services
	  ○ Service type by age
	  ○ Location
	  ○ Contact address
	  ○ Provider name
	  ○ Cultural competency of providers
	  ○ Accepted insurances
	  ○ Admission process/requirements to enroll in the programs
	  ○ Any lawsuits or complaints about the service providers
	  ○ Skill level of providers
	  ○ Additional resources such as information on wraparound services

AC2	Conduct analysis of care coordinator roles and responsibilities to determine the care coordinators' access and future use of the BH bed registry and electronic referral tools. • Conduct interviews and focus group discussions after implementation with existing care coordinators to understand their role in supporting individuals in crisis. Identify opportunities on how care coordinators could play a role in communicating information from the BH bed registry to individuals in crisis and connect them to needed services.
AC3	Identify appropriate requirements for providers to maintain the BH bed registry and electronic referral tools. • Coordinate with BH-ASOs and MCOs during implementation to help identify the appropriate requirements for providers. ○ Conduct in-depth interviews and working sessions with BH-ASOs and MCOs to identify the requirements that will help ensure providers' utilization and maintenance of the BH bed registry and electronic referral tools.

8 Key Pending Decisions

Table 18 below provides a list of key pending decisions that HCA must make prior to selecting the future system and implementing recommendations.

Table 18: Key Pending Decisions

ID	Title	Description
PD1	Utilization of Existing System(s)	HCA needs to determine whether to continue using its existing system or consider releasing a request for proposals (RFP) to solicit bids from other vendors to develop and implement a BH bed registry and electronic referral tools.
PD2	BH Bed Registry and Electronic Referral Tools Access	HCA needs to identify who would have access to the BH bed registry and what information would be available for each user.
PD3	Real-Time Data Availability	HCA needs to determine the cadence to update the BH bed registry (i.e., how often the providers should update the data).
PD4	BH Bed Registry and Electronic Referral Tool Functionality	HCA needs to identify the desired functionality of the BH bed registry (e.g., what information will be included in the BH bed registry, what filters and search options should be incorporated, and how the system will manage data quality and its overall security).

9 Next Steps

Next steps that HCA should consider in its implementation of the BH bed registry and electronic referral tools include:

- Prioritize recommendations based on feasibility and potential impact.
- Refine final Written Communication Materials in the HCA-preferred format and share them with designated interested parties.
- Review key pending decisions included in Section 8 and make informed decisions related to the implementation of the BH bed registry and electronic referral tools.

Appendix A: Acronyms and Terms List

Table A1 lists the acronyms and terms used in the document.

Table A1: Acronyms and Terms List

Acronym/Term	Description
AAP	Association of Alcoholism and Addiction Programs for Washington
ADT	Admit, Discharge, Transfer
BH	Behavioral Health
BHA	Behavioral Health Agency
BH-ASO	Behavioral Health – Administrative Service Organization
BHICRS	Behavioral Health Integrated Client Referral System
CFR	Code of Federal Regulations
CRIS	Crisis Response Improvement Strategy
CSV	Comma-Separated Values
DCR	Designated Crisis Responder
DED	Deliverable Expectation Document
DOH	Department of Health
DTLL	Dear Tribal Leader Letter
EHR	Electronic Health Record
EMS	Emergency Medical Services
ER	Emergency Room
FBH	Frontier Behavioral Health
FDA	Food and Drug Administration
HB	House Bill
HCA	Health Care Authority
HIT	Health Information Technology
HIPAA	Health Insurance Portability and Accountability Act
HMA	Health Management Associates
HSQA	Health Systems Quality Assurance
ID	Identification
IHCP	Indian Health Care Providers
ITA	Involuntary Treatment Act

Acronym/Term	Description
LOE	Level of Effort
MCO	Managed Care Organization
MS	Microsoft
NASMHPD	National Association of State Mental Health Program Directors
NSPL	National Suicide Prevention Lifeline
PDF	Portable Document Format
RCW	Revised Code of Washington
RFP	Request for Proposal
SABG	Substance Abuse Block Grant
SB	Senate Bill
SME	Subject Matter Expert
SUD	Substance Use Disorder
TTI	Transformative Transfer Initiative
WA	Washington
WAC	Washington Administrative Code
WA HEALTH	Washington's Healthcare and Emergency and Logistics Tracking Hub
WCBH	Washington Council for Behavioral Health
WISe	Wraparound with Intensive Services
WSHA	Washington State Hospital Association

Appendix B: Interested Parties

Table B1 lists HCA-identified interested parties engaged in data collection activities.

Table B1: Phase A Interested Parties

#	Interested Party	Organization	Name	Title[16]
1	BH-ASO	HCA	Ruth Leonard (Point of Contact)	MPD/BH-ASO Contract Manager
		Salish BH-ASO	Jolene Kron	Clinical Director
		North Sound ASO	Michael McAuley	Clinical Director
		North Sound ASO	Megan Drake	Clinical Specialist
		Spokane BH-ASO	Jessica Thompson	Integrated Behavioral Healthcare Quality Supervisor
		Spokane BH-ASO	Ashley Magee	Integrated Behavioral Healthcare Manager
		Carelon	Tiffany Villines	Director
		Carelon	Darlene Davies	Clinical Programs Director
		Carelon	Richard VanCleave	Behavioral Health Case Manager II
		Great Rivers	Trinidad Medina	Chief Executive Director
		King County Department of Community and Human Services	Dan Floyd	Care Coordination and Recovery Section Manager
		King County Department of Community and Human Services	Brain Allender	Chief Medical Officer, Behavioral Health and Recovery Division
		King County Department of Community and Human Services	Matthew Goldman	Medical Director, Crisis Care Center Levy Implementation Planning

[16] The titles for some of the interested parties are unknown at this time, as they were not shared with BerryDunn and are not listed online.

#	Interested Party	Organization	Name	Title[16]
		King County Department of Community and Human Services	Titus Chembukha	Information and Data Systems Manager, Special Projects Manager II
2	MCO	HCA	Glory Dole (Point of Contact)	Manager: Medicaid Contracts and Compliance
		HCA	Jessica Diaz (Point of Contact)	Section Manager, Medicaid Managed Care
		Community Health Plan of Washington (CHPW)	Terry Lee	Senior Behavioral Health Medical Director
		CHPW	Justin Fowler	Senior Director of Utilization Management
		UnitedHealthcare	Nicole Jones	Senior Technology Project Manager
		Coordinated Care	Jessica Molberg	Director of Behavioral Health
		Coordinated Care	Katie Ramos	Manager of Behavioral Health
		Molina Healthcare of Washington Inc.	Becca Gregory	Transition of Care Supervisor
		Molina Healthcare of Washington Inc.	Savannah Burts	Behavioral Health Clinical Lead
		Molina Healthcare of Washington Inc.	Dorothy Sivanish	Manager, Transitions of Care
		Wellpoint	Amanda Bieber-Mayberry	Director Behavioral Health Services
		Premera	Robert Small M.D.	Medical Director
3	Washington State Hospital Association	Hospitals/EDs/Inpatient Psychiatric	Darcy Jaffe (Point of Contact)	Senior VP- Safety and Quality
		Hospitals/EDs/Inpatient Psychiatric	Caitlin Safford	Senior Director, Government Affairs

#	Interested Party	Organization	Name	Title[16]
		Administrator of Behavioral Health & Primary Care	Stacey Devenney	Asst. Administrator of Behavioral Health & Primary Care
		Administrator of Behavioral Health & Primary Care	Tim Meeks	Clinical
		Administrator of Behavioral Health & Primary Care	Anna Marti	IT Staff
		Emergency Department Ocean Beach Hospital	Williams Wallace	Clinical Nurse Manager
		Emergency Department Ocean Beach Hospital	James Bruce	Clinician
		Emergency Department Ocean Beach Hospital	Terri Morris	IT
		Behavioral Health Providence Inland Northwest	Tamara Sheehan	Sr. Director
		Behavioral Health Providence Inland Northwest	Debbie Hjortedal	Psych Triage Supervisor and Admission Coordinator
		Behavioral Health Providence Inland Northwest	Sherly Romaniuk	Unknown
		Wellfound Behavioral Health Hospital	Heidi Brown	Unknown
		Wellfound Behavioral Health Hospital	Angela Naylor	CEO
		Wellfound Behavioral Health Hospital	Antonio Soto	Clinical Director
		Wellfound Behavioral Health Hospital	May Johnson	Unknown

#	Interested Party	Organization	Name	Title[16]
		Wellfound Behavioral Health Hospital	Rhiannon Service	Unknown
		Wellfound Behavioral Health Hospital	Aubrey Freeman	Unknown
		Confluence Health in Wenatchee for the Emergency Department	Kelly Allen	CNO
		Confluence Health in Wenatchee for the Emergency Department	Deborah Schlotfeldt	IT Staff
		South Sound Behavioral Health Hospital	Neil Lacanlale	Interim CEO (was CNO)
		South Sound Behavioral Health Hospital	Jessi Winn	Director of Admissions and Referral
		South Sound Behavioral Health Hospital	Shakena Godbolt	Administrative Assistant & Credentialing Coordinator
4	Association of Alcoholism and Addiction Programs of Washington	Association of Alcohol and Addiction Programs of Washington State	Linda Grant	Chief Executive Officer, Evergreen Recovery Centers
		The Center for Alcohol and Drug Treatment	Loretta Stover (Point of Contact)	Executive Director
		Sundown M Ranch	Mark Loes	Director of Operations
		Sundown M Ranch	Scott Munson	CEO
		Sundown M Ranch	Alicia Egan	Clinical
		Sundown M Ranch	Garen Barnett	IT Manager
		Olalla Recovery Centers	Christine Lynch	Executive Director
		Olalla Recovery Centers	Derek Murphy	Director of Clinical Services
		Lifeline Connections	Jennifer Logan	Clinical

#	Interested Party	Organization	Name	Title[16]
		Lifeline Connections	Andrea Brooks	Executive Director
		Lifeline Connections	Linda Burnham	Health Record
		Lifeline Connections	Mavis White	Record-Keeping
5	Washington Council for Behavioral Health	MultiCare Behavioral Health Services	Joan Miller (Point of Contact)	Chief Executive Officer, Washington Council for Behavioral Health
		MultiCare Behavioral Health Services	Silvia Riley	Director of Crisis Services
		MultiCare Behavioral Health Services	Tanya Moe	Manager
		MultiCare Behavioral Health Services	Heather Marsh	Assistant VP BH Outpatient Operations
		MultiCare Behavioral Health Services	Ian Norbeck	Ent App Administrator III
		MultiCare Behavioral Health Services	Eric Krauskopf	Associate Vice President
		Frontier Behavioral Health	Kelli Miller	Interim CEO
		Frontier Behavioral Health	Sara Schumacher	Director
		Frontier Behavioral Health	Karen Thomason	Unknown
		Behavioral Health and Primary Care for Harborview Medical Center	Stacey Devenney	Assistant Administrator, Executive Leadership
		Behavioral Health and Primary Care for Harborview Medical Center	Tim Meeks	Clinical
		Behavioral Health and Primary Care for Harborview Medical Center	Anna Marti	IT Staff

#	Interested Party	Organization	Name	Title[16]
		Compass Health	Amy Pereira-Clevenger	Director of Crisis Response and Stabilization
		Compass Health	Brooklynn Horat	Clinical Director North Outpatient
		Compass Health	Cathryn Catledge	Peer Specialist
		Compass Health	Doreen Yumang-Ros	Director of Inpatient and Health Care Services
		Comprehensive Healthcare	Kim Clemmons	Team Lead for Detox and Crisis Triage
		Comprehensive Healthcare	Brad Beck	Chief Information Officer
		Comprehensive Healthcare	Jodi Daly	CEO
		Kitsap Mental Health Services	Stephanie Lewis	Leadership Role
		Kitsap Mental Health Services	Sarah Hicks	Clinician
		Kitsap Mental Health Services	Gerald “Jerry” McKlosky	IT Staff
6	988 Lifeline Crisis Call Center	DOH	Lonnie Peterson (Point of Contact)	988 Crisis Systems Section Manager
		Volunteers of America Western Washington	Levi Van Dyke	Chief Behavioral Health Officer
		Volunteers of America Western Washington	Rena Fitzgerald	Director of Operations
		Volunteers of America Western Washington	Courtney Colwell	988 Director
		Volunteers of America Western Washington	Reid Johnson	Unknown

#	Interested Party	Organization	Name	Title[16]
		Volunteers of America Western Washington	Caitlynn Fuselier	Unknown
		Frontier Behavioral Health	Jan Tokumoto	COO
		Frontier Behavioral Health	Kelli Miller	Interim CEO
		Crisis Connections	Michelle McDaniels	CEO
		Crisis Connections	Alice Nichols	Senior Director of Clinical Operations
		Crisis Connections	John Fleming	IT
7	State Staff	HCA	Kelly McPherson	State HIT Coordinator/988 Project Director
		HCA	Jennie Harvell	ETS/Senior Federal Project Consultant
		HCA	Madeline Cope	ETS/HIT 988 SME/Management Analyst 5
		HCA	Kara Panek	DBHR/Adult Services/Involuntary Services Section Treatment Manager
		HCA	Matthew Gower	DBHR/Crisis System Team Lead
		HCA	Luke Waggoner	DBHR/Involuntary Treatment and Crisis System Supervisor
		HCA	Sherry Wylie	DBHR
		HCA	Lucy Mendoza	Tribal BH Administrator
		HCA	Samantha Schrader	ETS/IT Business Analyst
		HCA	Cheryl Arenas	ETS/IT Business Analyst

#	Interested Party	Organization	Name	Title[16]
		HCA	Huong Nguyen-Nabors	TS/Enterprise Technical Architect
		HCA	Ruth Leonard	MPD/BH-ASO Contract Manager
		HCA	Michelle Alger	MPD/Contract Manager
		HCA	Jessica Diaz	Section Manager/MPD/ MCO Contracts
		HCA	Doria Maselli	DBHR/988 Comms
		DOH	Kate Shetty	Senior Project Manager
		DOH	Lonnie Peterson	988 Crisis Systems Section Manager
		DOH	Sachin Lande	IT Architecture Expert
		DOH	Elaina Perry	988 Program Supervisor/Health Services Consultant 4
		DOH	Beth Shuurmans	988 Implementation Specialist/Health Services Consultant 3
		DOH	Judy Hall	Performance Officer
		DOH	Michelle Moore	IT Project Manager
		DOH	Bridget Doyle	Change Manager/Management Analyst 5
		DOH	Krystle Edwards	Management Analyst 5
		HCA	McKenzie Olver	HIT Project Coordinator/Management Analyst 4
		HCA	Bill Kinney	HIT Project Manager
		HCA	John Anderson	HIT Project Manager

#	Interested Party	Organization	Name	Title[16]
		HCA	Kyle Wiese	HIT Project Manager
		DOH	Daniel Feeman	Project Manager
		DOH	Brent Hofmman	Project Manager
		DOH	Tyler Nowan	Office Director of Healthcare Analytics, Readiness, and Preparedness
		DOH	Donna Bybee	Database Administrator
		DOH	Ravi Kafle	Senior Informatics Architect
8	CRIS	HMA	Betsy Jones	PM
		HMA	Nicola Pinson	PM
		HMA	Bipasha Mukherjee	Chair, Subcommittee of Persons with Lived Experience
9	Crisis Providers	HCA	Matthew Gower (Point of Contact)	DBHR/Crisis System Team Lead
		HCA	Sherry Wylie	Youth Mobile Crisis Team Administrator
		Comprehensive Healthcare	Jodi Daly	CEO
		Comprehensive Healthcare	Kim Clemmons	Team Lead for Detox and Crisis Triage
		Comprehensive Healthcare	Brad Beck	Chief Information Officer
		Palouse River Counseling	Mike Berney	Executive Director
		Quality Behavioral Health	Danika Gwinn	Behavior Analyst
		Adult Mobile Crisis & DCR	Holly Johnson	Crisis Services Manager, Olympic Health & Recovery Services

#	Interested Party	Organization	Name	Title[16]
		Youth Mobile Crisis	Heidi Knadel, MA, LMHC	Service Director Catholic Community Services Family Behavioral Health
		Clark County - SeaMar Adult MRRCT and DCR Team	Jenni Oneil	Unknown
		Clark County - SeaMar Adult MRRCT and DCR Team	Laura Nichols	BH Program Manager and Diversity Equity and Anti-Racism Committee Co-Chair
		Clark County - SeaMar Adult MRRCT and DCR Team	Laura Cissna	Clinical Supervisor
		Clark County Youth Crisis Team: Catholic Community Services	Theresa Ortiz	Unknown
		Clark County Youth Crisis Team: Catholic Community Services	Julie Bacon	Clinical Supervisor
		Klickitat County- DCR/MRRCT	Tyrone Bryant	Unknown
		Klickitat County- DCR/MRRCT	Chris De Villeneuve	Unknown
		Skamania County- DCR Only	Tamara Cissel	Clinical Supervisor
		Chelan Douglas: Adult/Youth/DCR: Catholic Charities	Steven Hightower	Unknown
		Chelan Douglas: Adult/Youth/DCR: Catholic Charities	Jesus Mendoza	Unknown
		Grant County- Adult/Youth/DCR- Renew	Traci Hunt	Unknown

#	Interested Party	Organization	Name	Title[16]
		Grant County-Adult/Youth/DCR- Renew	Juan Padilla	Unknown
		Okanogan County-Adult/Youth/DCR-Okanogan Behavioral Health	Sarah Claussen	Unknown
		Okanogan County-Adult/Youth/DCR-Okanogan Behavioral Health	Quinn Lontz	Chief Clinical Officer
		Adult/DCR Multicare Behavioral Health	Tanya Moe	Manager
		Adult/DCR Multicare Behavioral Health	Silvia Riley	Director Crisis Services
		Youth MRRCT/MRSS: Catholic Community Services	Nolita Reynolds	Clinical Director
		Youth MRRCT/MRSS: Catholic Community Services	Rhodia Ramirez	Clinical Supervisor
		Youth MRRCT/MRSS: Seneca Family of Agencies	Alex Mehling	Executive Director
		Youth MRRCT/MRSS: Seneca Family of Agencies	Joe Avalos	Unknown
		Youth MRRCT/MRSS: Seneca Family of Agencies	Christy Little	Assistant Director
		Spokane County Regional Behavioral Health	Tara Bates	Unknown
		Spokane County Regional Behavioral Health	David Nielsen	Executive Director

#	Interested Party	Organization	Name	Title[16]
		Spokane County Regional Behavioral Health	Ashley Magee	Integrated Behavioral Healthcare Manager
		Salish BH-ASO	Linton Petersen	Unknown
		Salish BH-ASO	Dana Milagrosa	Unknown
		MRRCT/DCR	Carola Schmid	Manager
		MRRCT/DCR	Brian Austin	Manager
		Compass Health	Amy Pereira-Clevenger	Clinical Director
		MRRCT/DCR	Joanne Norman	Manager
		Spokane County Regional Behavioral Health	Jan Downing	Unknown
		Connections Health Solutions	Sarah Lopez	Vice President Clinical Implementation
10	Tribal	HCA Office of Tribal Affairs	Lucy Mendoza	Tribal Behavioral Health Administrator
11	HCA Leadership	HCA	Kelly McPherson	State HIT Coordinator
		HCA	Teesha Kirschbaum	Acting DBHR Director
		HCA	Jerry Britcher	CIO
		HCA	Jason McGill	Assistant Dir MPD
		HCA	Lonnie Peterson	988 Crisis Systems Section Manager

Table B2: Phase B Interested Parties

#	Interested Party	Organization	Name	Title
1.	BH Providers	Bridgeways	Andrea Duffield	CEO
		Bridgeways	Anthony Serrano	Billing Specialist
		Bridgeways	Willow Babcock	FCS Program Manager

#	Interested Party	Organization	Name	Title
		Center for Human Services	Beratta Gomillion	Executive Director
		Center for Human Services	Katrina Hanawalt	Clinical
		Center for Human Services	Cathy Assata	N/A
		Center for Human Services	M Guich	Record-Keeping/IT Staff
		Cascade Community Healthcare	Leann Reed	COO
		Cascade Community Healthcare	Mindy Greenwood	CIO
		Cascade Community Healthcare	Jason Ong	Manager, Information Systems
		Evergreen Recovery Center	Patrick Evans	CEO
		Evergreen Recovery Center	Elizabeth Gholson	IT
		Evergreen Recovery Center	Brian Bononi	Clinician
		Behavioral Health and Primary Care for Harborview Medical Center	Stacey Devenney	Administrator
		Behavioral Health and Primary Care for Harborview Medical Center	Tim Meeks	Clinical
		Behavioral Health and Primary Care for Harborview Medical Center	Anna Marti	IT Staff
		MultiCare Behavioral Health	Eric Krauskopf	Executive Director
		MultiCare Behavioral Health	Tanya Moe	Manager
		MultiCare Behavioral Health	Silvia Riley	Clinician
		MultiCare Behavioral Health	Angie Riske	IS&T
		Providence Sacred Heart Medical Center - E and T	Tamara Sheehan	Director of Psychiatry

#	Interested Party	Organization	Name	Title
		Providence Sacred Heart Medical Center - E and T	Debbie Hjortedal	Clinical
		Providence Sacred Heart Medical Center - E and T	Beth Peterson	Clinical Informatics
		Olympic Health and Recovery Services	Joe Avalos	OHRS Administrator
		Olympic Health and Recovery Services	Holly Johnson	Clinician
		Olympic Health and Recovery Services	Erica Dennehy	Quality Manager
		Olympic Health and Recovery Services	Chris Foster	Record-Keeping/IT Staff
		Community Integrated Health Services LLC	Marc Bollinger	CEO
		Community Integrated Health Services LLC	Kathy Robertson	Chief Clinical Officer
		Community Integrated Health Services LLC	Ron Lehto	Chief Business Officer
		Community Integrated Health Services LLC	Randy Webster	IT/IS Manager
		Community Integrated Health Services LLC	Veronica Doble	Finance Analyst
		Peer Bridgers and Hospital Liaisons	Ian Callahan	Supervisor
		Peer Bridgers and Hospital Liaisons	Titus Chumbukha	IT Staff
		Olalla Recovery Centers	Christine Lynch	Administrator
		Olalla Recovery Centers	Derek Murphy	Director of Clinical Services
		Spokane Public Schools - District 81	David Crump, Ph.D.	Clinical Director

#	Interested Party	Organization	Name	Title
		Spokane Public Schools - District 81	Marilis Thomas	Clinician
		Spokane Public Schools - District 81	Tracey Schoenrock	Medical Billing/Record-Keeping
		Spokane Public Schools - District 81	Jessica Bumsted	Medical Billing/Record-Keeping
		Lake Whatcom Residential and Treatment Center - Main	Dean Lampman	Quality Management Director
		Lake Whatcom Residential and Treatment Center - Main	Tannis Peura	Director of Operations
		American Behavioral Health Systems, Inc. - Mission	Jessica Helmbrecht	EHR Administrator
		American Behavioral Health Systems, Inc. - Mission	Nicole Gutierrez	Admissions Supervisor
		American Behavioral Health Systems, Inc. - Mission	Craig Zahn	Clinical Director
		American Indian Community Center Goodheart Behavioral Health	Shelley Ethrington	Clinical Manager
		American Indian Community Center Goodheart Behavioral Health	Linda Lauch	Executive Director
		American Indian Community Center Goodheart Behavioral Health	Nora Cornelius	Clinician
		American Indian Community Center Goodheart Behavioral Health	Cassandra Andrews	Record-Keeping

Appendix C: Web Survey Questions

Appendix C includes BH-ASO and MCO, people with lived experience, and provider web survey questions.


BH-ASOs and MCOs Web Survey_FINAL_05


Persons with Lived Experience Web Surve


Providers Web Survey_FINAL_052020

Appendix D: Discovery Session Questions

Appendix D includes Phase A and Phase B discovery session questions.

HCA Bed Registry Phase A Discovery Ses

Phase B_EHR_Paper Provider Discovery Se

Appendix E: Discovery Session Summaries

Appendix E includes summary notes and key themes from discovery sessions with BH-ASOs, MCOs, WCBH, crisis providers, WSHA, people with lived experience, tribes, AAP, 988 Lifeline crisis call centers, Epic users, Netsmart users, CareLogic users, Qualifacts users, and Credible users.

Summary Notes:

BH-ASOs, MCOs

In meeting with the BH-ASOs and MCOs, HCA learned that the BH-ASOs and MCOs are currently tracking bed availability externally with "home-grown" solutions like Excel sheets, phone calls, and SharePoint. BH-ASOs and MCOs also utilize DCRs and the ITA bed registry that VOA hosts. BH-ASOs and MCOs voiced a desire for a singular, interoperable system.

The BH-ASOs and MCOs believe the following features and information would be valuable in a bed registry:

- Information on whether a facility provides specialty care (e.g., geriatric, evidence-based practice, electroconvulsive therapy)
- Licensure
- Measure of level of care (American Society of Addiction Medicine or Level of Care Utilization System)
- Up-to-date contact information for each facility
- Discharge plans
- Exclusionary criteria
- Single versus shared room facilities
- Referral tracking
- Accommodations for special populations (e.g., disabilities, dementia)
- Near-real-time updates on bed availability

The BH-ASOs and MCOs believe participation in this system would likely have to be contractually mandated to ensure it is regularly and consistently updated. Incentives could help ease the burden of being contractually obligated to participate. Financial incentives would be helpful to hire staff, aid in the adoption of an EHR, provide training, and to aid in technology implementation.

The BH-ASOs and MCOs are not against people in crisis having access to the bed registry but believe the view should be limited to program/facility/admission criteria, contact information, and number of beds available.

Associations (WSHA, WCBH, AAP)

In meeting with WCBH, WSHA, and AAP (associations), HCA learned the associations are currently tracking bed availability externally with WA Track, EHRs, Excel sheets and phone calls, Northwest Healthcare Response Network, and OpenBeds. Some voiced concern about how this is not the first attempt at a bed registry and suggested learning from past attempts/coordinating with existing systems to prevent reinventing the wheel with taxpayer money.

The associations believe the following features and information would be valuable in a bed registry:

- Insurance accepted
- Criteria for admission (e.g., age, gender, type of bed, acuity level, history of violence, patient in restraints, mental status, ambulatory status, diagnosis, sex offender status, SUD detention, involuntary vs. voluntary, medical clearance)
- Ability to prioritize client needs
- Standardization
- Single room versus shared room
- The ability to filter in search feature of registry
- Real-time updates for screening, pending admission, discharge, etc.

Like the providers mentioned earlier, the associations believe that forming relationships between facilities is crucial to getting patients the care they need. The associations also noted a concern regarding large hospital systems “cherry-picking” who they will or will not accept. Individuals with complex needs/circumstances are often hard to place and will be turned away for an individual with more “simple” needs.

The associations believe incentives will not be turned down but also wonder about the need for this system. Current methods seem to be working and the system might cause the loss of relationships between facilities.

Crisis Call Centers

In meeting with the crisis call centers, HCA learned that the crisis call centers are currently tracking bed availability externally with OpenBeds, the regional crisis lines ITA placement desk, phone calls, emails, and a shared file. The crisis call centers shared that this is a manual and time-consuming process. The crisis call centers have a dedicated staff member who contacts inpatient facilities twice a day. Manual work is slow and often wrought with error. The crisis call centers also shared that with current methods, the community does not have a way to view beds and they believe that to be a problem.

The crisis call centers believe the following features and information would be valuable in a bed registry:

- Exclusionary criteria
- Filters for searching
- Facility capacity
- Bed type (youth, etc.)
- Plain language and easy to understand
- Resources to find care coordinators, so patients don't get turned away from facilities
- Updated twice daily at the minimum but real time is preferred

Like the associations, the crisis call centers are worried about hospitals "cherry-picking." The crisis call centers want the bed registry to be public facing to give patients agency but worry about hospitals rejecting them. Cherry-picking is the top complaint among outreach teams.

The crisis call centers believe a mandate would force hospitals to comply and stop cherry-picking. The crisis call centers also believe that incentives to hire staff, train staff, and maintain technology would be helpful.

There is no closed-loop referral process unless the visit starts and ends in one facility. The crisis call centers keep lists of outpatient providers who have walk-in availability and refer callers directly to those providers. The crisis call centers shared that a closed-loop referral system would be helpful.

Tribes

In meeting with the tribes, HCA learned the tribes are currently tracking bed availability internally and externally with Excel sheets, phone calls, and through partnering with DCR and VOA. This manual process adds work to already overburdened providers and administrators. The tribes believe the following features and information would be valuable in a bed registry:

- Ability to schedule and coordinate transportation when needed
- Ability to connect the registry to existing hubs such as Native and Strong
- Ability to rate and review facilities
- Treatment center locators with filters
- Ability to connect to EHR
- Ability to filter what insurance is accepted by each facility
- Up-to-date facility licensure
- Whether the facility is culturally competent and trauma informed

- Ability to identify the type of facility (e.g., detox, transitional services, inpatient, involuntary vs. voluntary, youth services)
- Daily updates at least, but near-real-time updates would be preferred
- App and web-based tools

The tribes believe providing incentives would decrease the additional work required to maintain and update the system. Incentives could include funds for hiring care coordinators and case managers, funds for updating bandwidth for rural communities, and public recognition or awards for participating facilities.

RCW 71.24.890 states: Real-time bed availability for all behavioral health bed types and recliner chairs, including but not limited to crisis stabilization services, 23-hour crisis relief centers, psychiatric inpatient, substance use disorder inpatient, withdrawal management, peer-run respite centers, and crisis respite services, inclusive of both voluntary and involuntary beds, for use by crisis response workers, first responders, health care providers, emergency departments, and individuals in crisis. In addition to those listed above, the tribes would like transport services, 2-1-1, VisionLink, FQHCs, Tribal Outpatient Centers, and members of the public to have access to the registry.

Closed-loop referrals are a challenge for the tribes due to EHR interface issues and bandwidth issues. Some facilities are still using fax machines to send and receive referrals. When a referral is sent to a facility with a different EHR vendor, the closed-loop referral is lost entirely.

Lived Experience

In meeting with the Lived Experience Subcommittee, HCA learned they find beds and resources via the following:

- Emergency rooms
- Talk therapy
- Department of Social and Health Services
- 2-1-1
- Insurance referrals
- Peer support
- Inland NW Behavioral Health
- Pediatric Complex Care Association
- Veterans Administration
- Frontier Behavioral Health
- Passages

- The Best Program
- Children's Long-Term Inpatient Program
- Seattle resource guide
- WISe program
- Mobile response and stabilization services
- BH agencies registry

Having a centralized, public-facing, web-based registry would be valuable instead of making multiple phone calls and trying to navigate the disjointed system. Asking small organizations and facilities to manage these processes on their own is not sustainable. The Lived Experience Subcommittee also suggested partnering with parks and recreation organizations to create youth and community centers that can handle crises.

The Lived Experience Subcommittee believes the following features and information would be valuable in a bed registry:

- A bed registry and referral system that law enforcement is not involved with
- Filters for searching
- A system that blocks and/or penalizes ghost networks
- What insurance is accepted
- Gender-affirming care
- Neurodivergent-knowledgeable providers
- Payment and term clarity (including length of coverage for programs)
- Reliable system and web tools

The Lived Experience Subcommittee also stated that having care coordinators to help navigate the system, referrals, and processes would be valuable. The group has/is experiencing difficulties accessing the following services:

- SUD
- Housing
- Shelter
- Inpatient beds
- Respite services for caregivers
- Adequate in-home care from Direct Support Professionals
- Psychosis services

- Care outside business hours
- Chronic illness support
- Post traumatic stress disorder services
- In-person therapy (telehealth is not ideal for everyone)
- Supported living communities for those with complex trauma

The current referral process is not user friendly. The onus is on the help seeker to track down care; it can often be a lengthy process, and they have to know the right questions to ask. Rejection when trying to get placed with a referral is discouraging for individuals, and care coordinators could help with this issue.

EHR Users (CareLogic, Credible, Epic, Netsmart, Qualifacts)

In meeting with urban and rural provider users (providers) of CareLogic, Credible, Epic, Netsmart, and Qualifacts, HCA learned they are currently tracking bed availability internally and externally using nurse boards (whiteboards), phone calls, EHRs, separate bed lists for level of care, partnering with Crisis Connections and DCRs, email registry, SharePoint, King County SUD Residential Bed Tracker, Rezstream, and Xferall for referrals. The providers stated that their EHRs have some ability to track beds internally, but they do not often use this functionality due to lack of reliability (i.e., technical difficulties/system glitches).

The providers believe the following features and information would be valuable in a bed registry:

- Criteria for admission to facility (e.g., age, gender, bed type, specialized beds)
- Screening questions for admittance criteria
- Basic facility information (address, phone number, link to website)
- Bed availability updates at least twice daily
- Automated bed availability updates

The providers believe financial incentives would be a great way to maintain compliance with the bed registry. The bed registry itself could act as an incentive because it means beds are getting filled, but providers would not turn down additional funds to hire staff, maintain technology, and provide training. A contractual mandate could be put in place, but the providers believe that would have a negative impact without financial incentives.

Some of the providers in this group question whether they would use a bed registry. They value the relationships that are built via phone calls to other facilities and do not want to jeopardize that. They also believe their current methods are sustainable for now. This also goes for creating referrals; they prefer to still call for referrals. However, they would be interested in the closed-loop referral aspect, as they struggle with that once a patient leaves their care.

The providers voiced some concerns about whether this will be an all-encompassing system across the crisis continuum or if there would be multiple systems for them to maintain and

update. There were also concerns about the interfacing and interoperability of different EHRs and the proposed system.

Key Themes

During the discovery and listening sessions, several common concerns and preferred system features were identified. These are summarized below.

Future System Features:

- A system with a search bar and filters
    - The filters will filter facility type, bed type, admission/exclusionary criteria, patient preferences (e.g., LGBTQIA+ friendly, single room vs. shared room)
- Clearly defined admission/exclusionary criteria for each facility/program
    - Including age, gender, diagnosis/need, youth services, etc.
- Up-to-date facility information
    - Licensure
    - Address
    - Phone number
    - Email address
    - Insurance accepted
- Resources to find/connect with care coordinators
- Daily or real-time bed availability updates

Concerns:

- Losing the human connection and relationships gained from phone calls and emails when contacting facilities
- System not being updated regularly
- Technical issues
    - Interface/interoperability with EHRs
    - People with poor bandwidth having access issues
- Cherry-picking
- Mandates
    - Some are concerned mandates without incentives will cause unnecessary burden

    - Some are concerned that without mandates, the system will not be useful or complied with
- Burden on providers
- Too many systems, further complicating the crisis care continuum

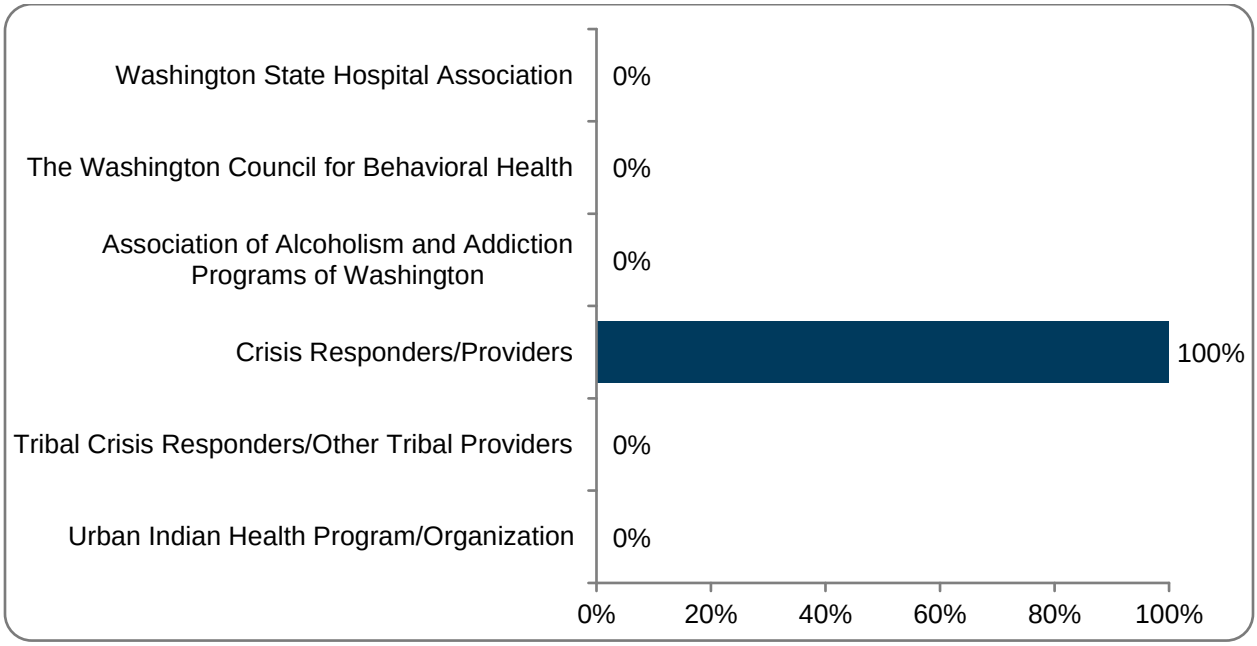
Appendix F: Web Survey Results

Appendix F includes the close-ended web survey responses received from the crisis responders/providers, AAP, BH-ASOs, MCOs, WCBH, WSHA, and the lived experience interested party. HCA disseminated the web surveys to its point of contact from the interested parties listed above, so the total number of individuals that the point of contact sent the web survey is unknown creating limitations to identify the percentage of response rate. BerryDunn and HCA had sent the web survey to tribal partners, however; despite multiple efforts from BerryDunn and HCA, BerryDunn did not receive any responses from tribal partners.

Some of the question numbers are skipped below; BerryDunn did not include responses to open-ended questions due to the high volume of qualitative data received.[17]

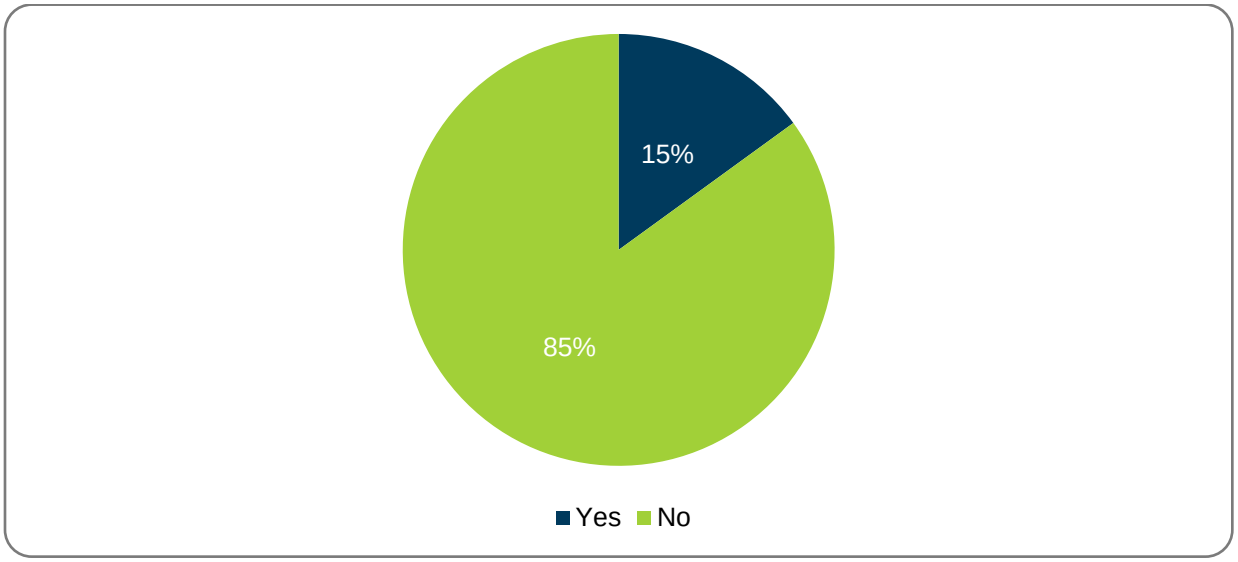
Crisis Responders/Providers Web Survey Results

Q1: Which of the following best describes your organizational affiliation?

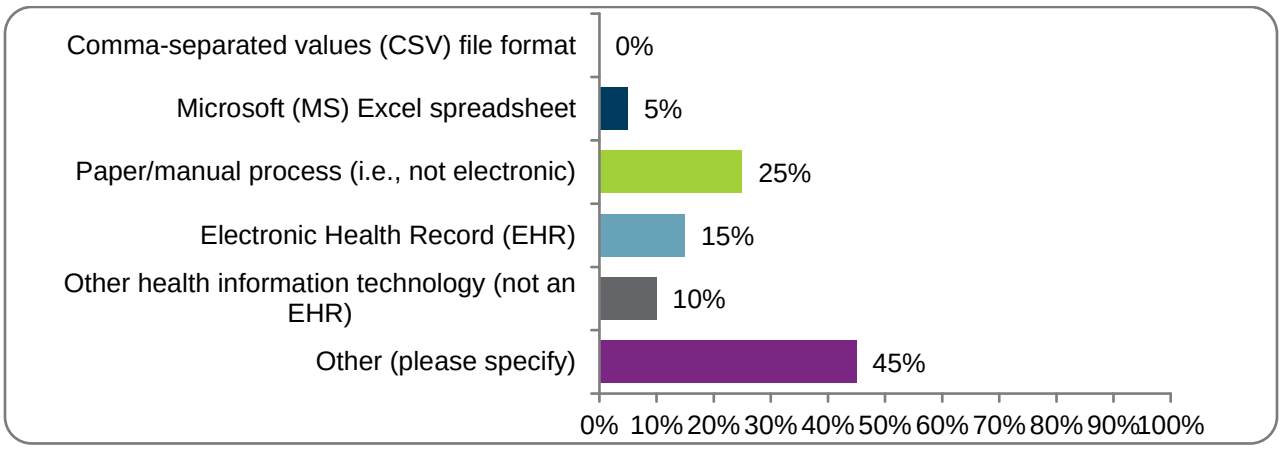


[17] BerryDunn has provided raw web survey responses to HCA, which includes open-ended questions.

Q2: Does your organization/program have system(s) in place to track behavioral health bed availability?

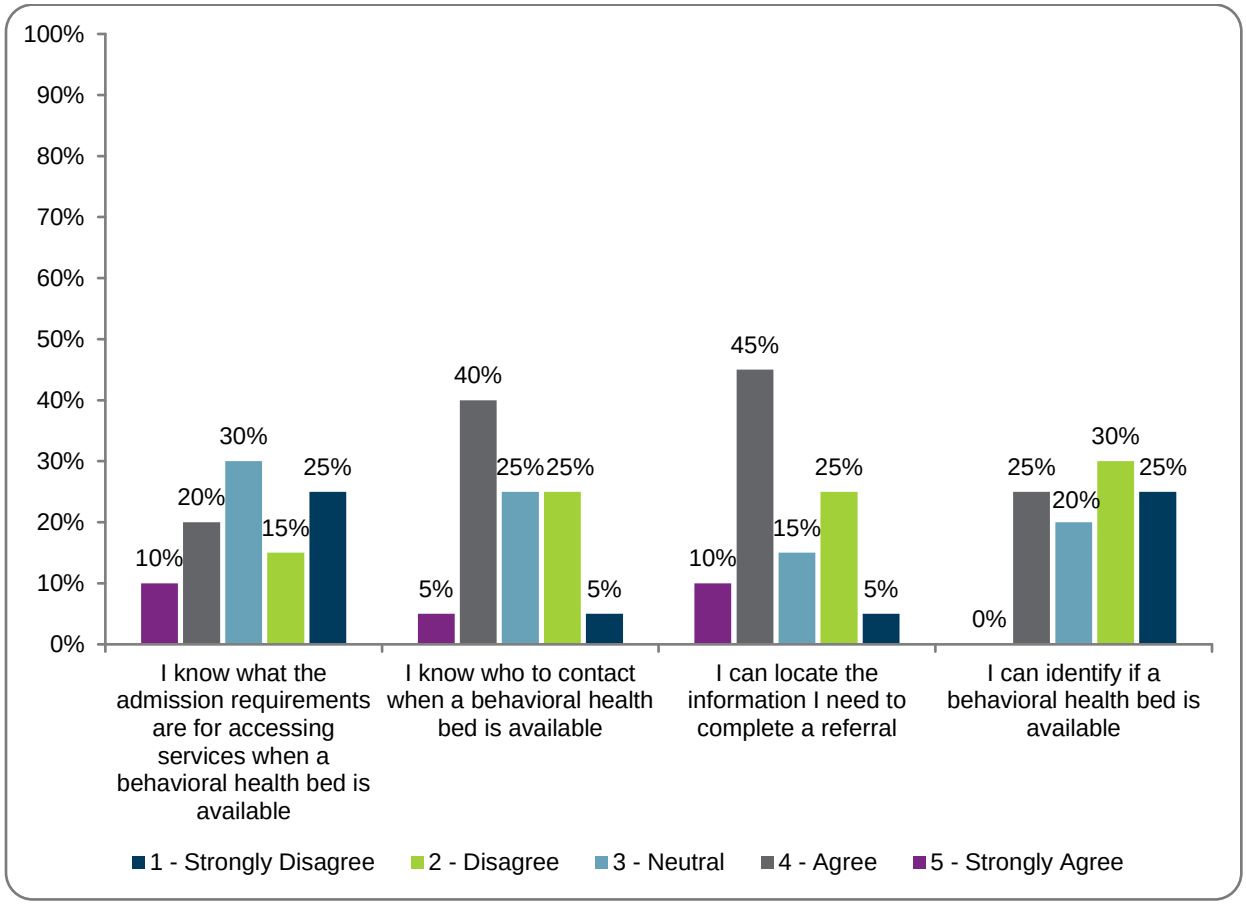


Q5: Which of the following describes how you/your agency currently track behavioral health bed availability in your facility?

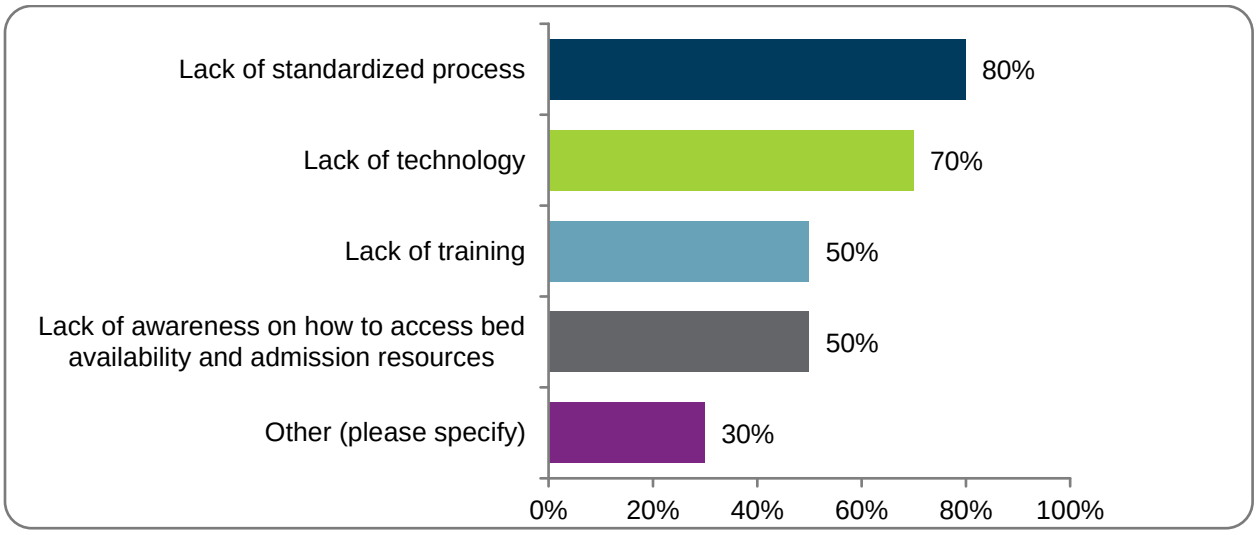


Survey respondents indicated that other methods of tracking behavioral health bed availability include calling behavioral health centers and inpatient facilities, receiving a list of bed availability by the Volunteers of America, or not tracking bed availability at all.

Q6: Please rate each of the following using a scale of 1 to 5 with 1 being strongly disagree and 5 being strongly agree:



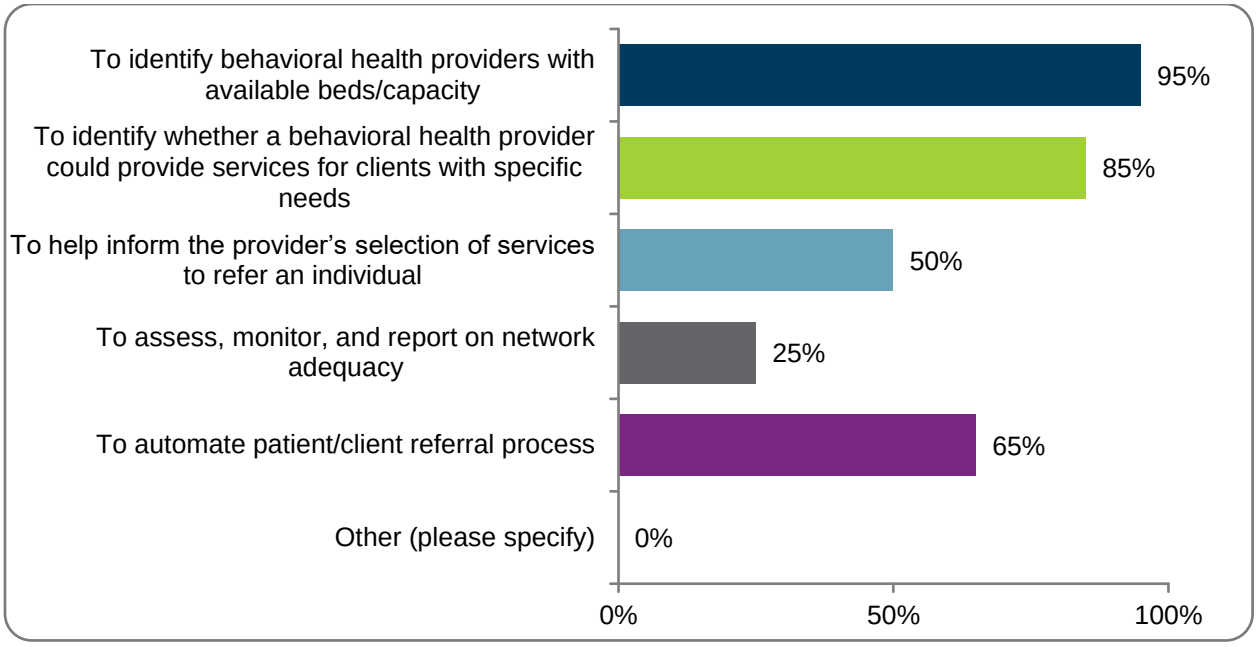
Q7: What are the challenges with the current process (i.e., paper-based or electronic) to identify and access behavioral health bed availability? (Select all that apply*)



*In this question, survey respondents had an option to select more than one response for which the total percentage is over 100.

Survey respondents indicated that other challenges for tracking behavioral health bed availability include lack of knowledge about pending admissions and discharges, lack of consistency for admission criteria, needing to fax each facility paperwork, and a lag in referral and acceptance time.

Q8: Which of the following describes how you/your agency would use a behavioral health bed registry? (Select all that apply*)

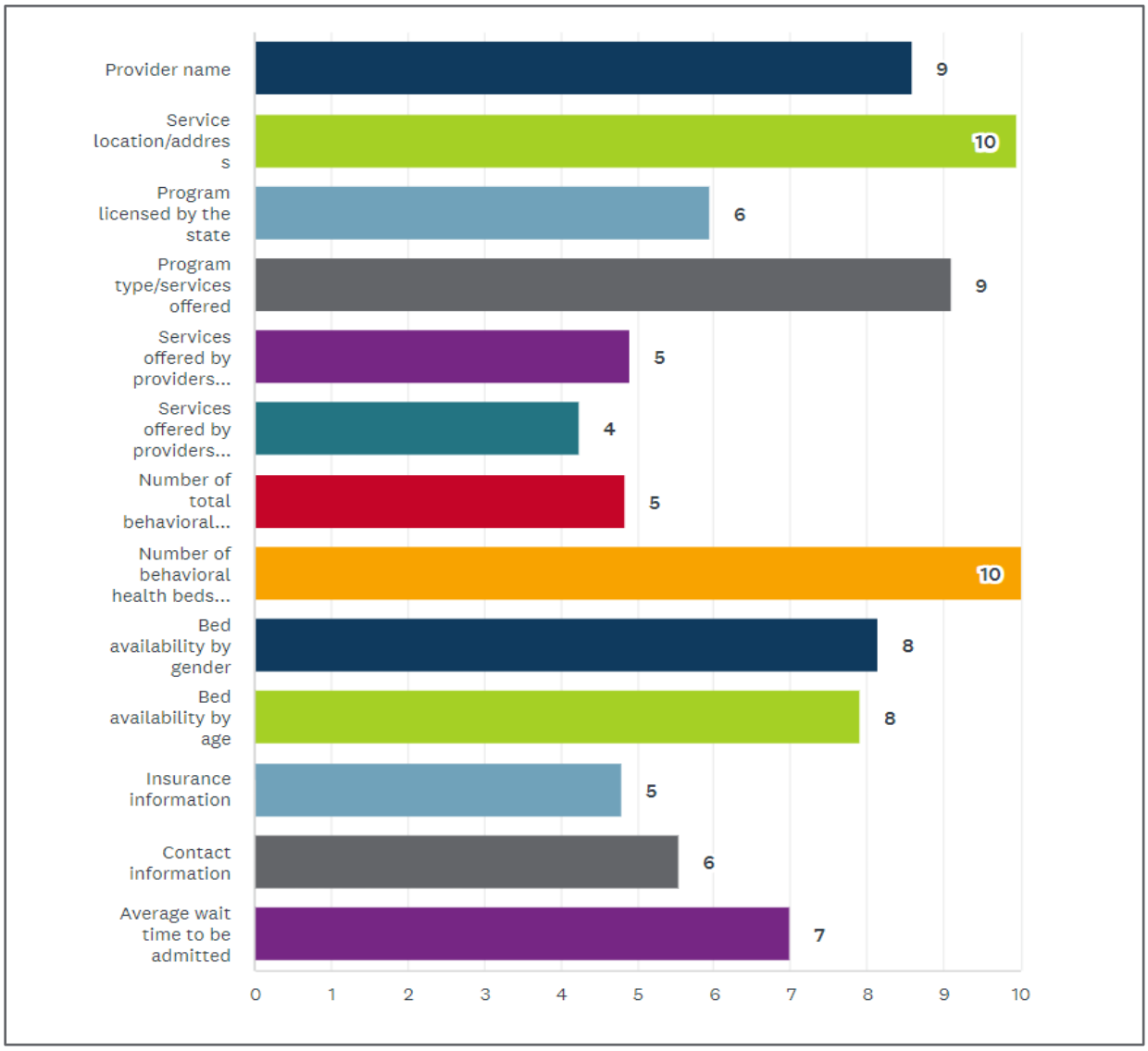


*In this question, survey respondents had an option to select more than one response for which the total percentage is over 100.

Q9: Indicate which of the following information/content is necessary to include in the behavioral health bed registry? (Please rank the options below in order of priority)

Based on the responses, the top-five priority list identified by the interested parties was:

1. Service location/address
2. Number of BH beds available
3. Program type/services offered
4. Provider name
5. Bed availability by gender

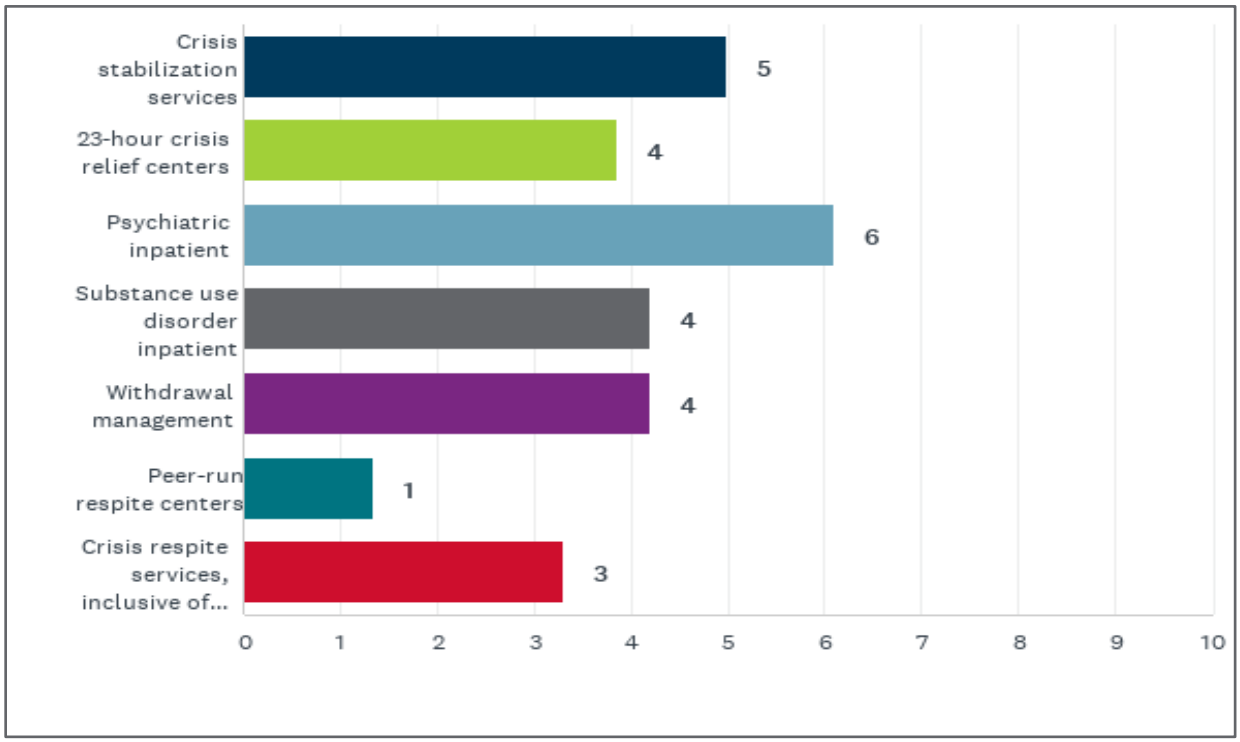


* Graph represented in weighted average

Q10: Which of the following behavioral health bed types should be included in a behavioral health bed registry? (Please rank the options below in order of priority)

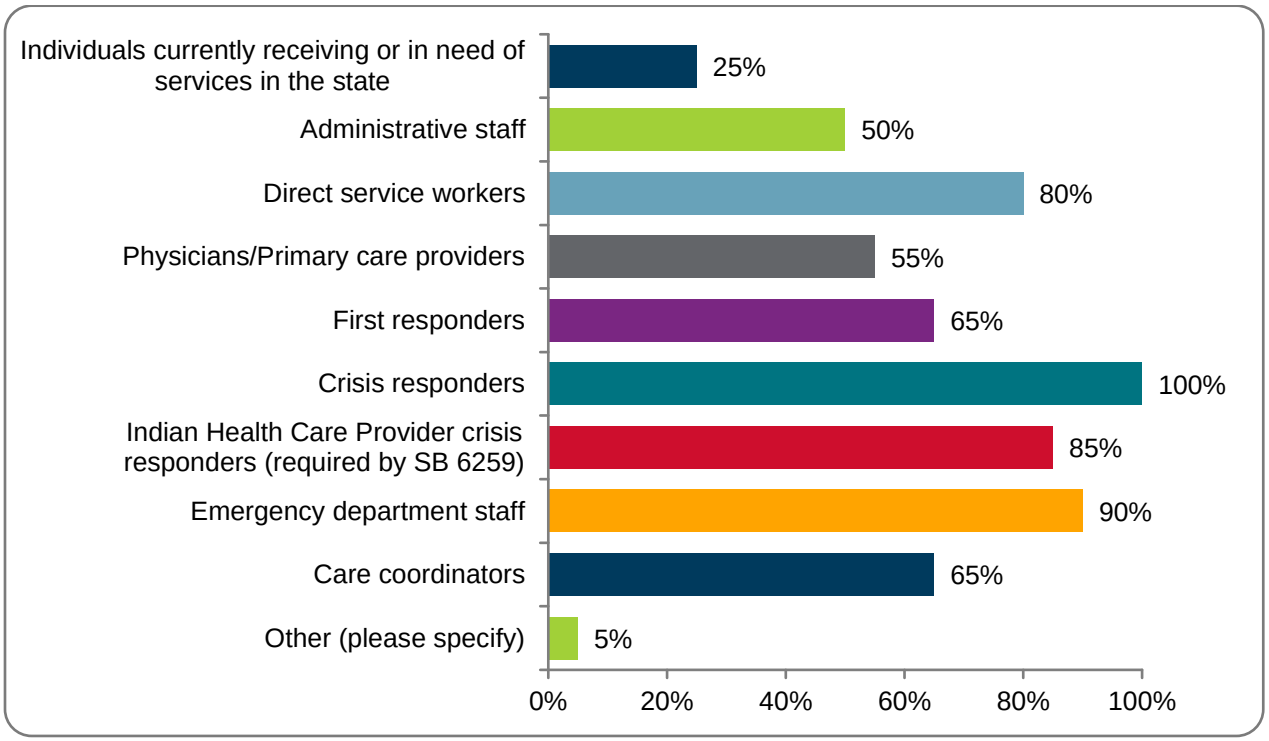
The top five BH bed types identified by the interested parties were:

1. Psychiatric inpatient
2. Crisis stabilization services
3. SUD inpatient
4. Withdrawal management
5. 23-hour crisis relief centers



* Graph represented in weighted average

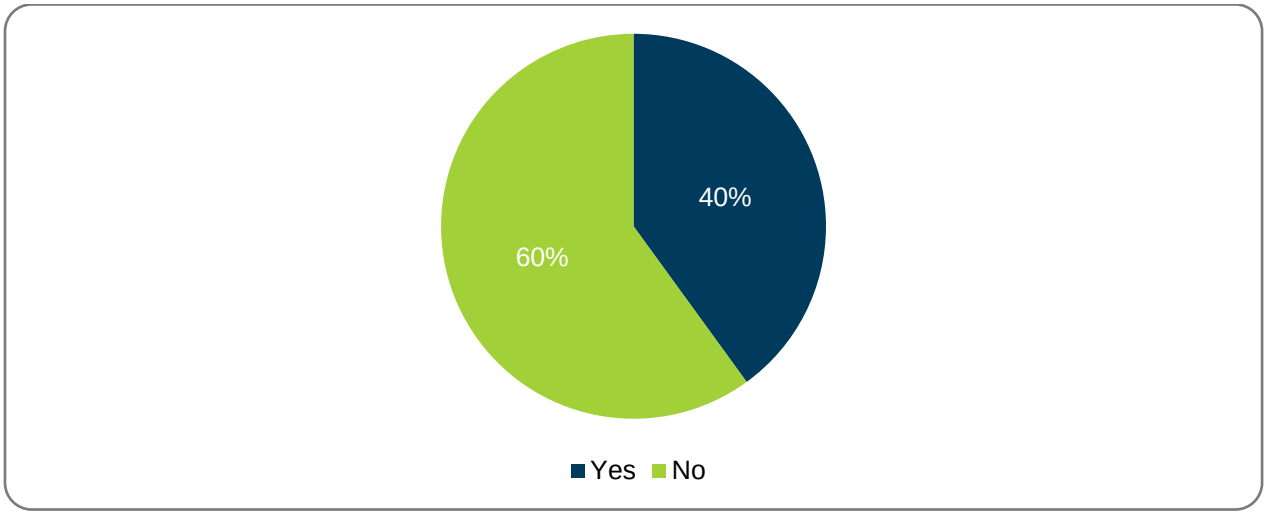
Q12: Who should have access to some or all of the behavioral health bed registry? (Select all that apply*)



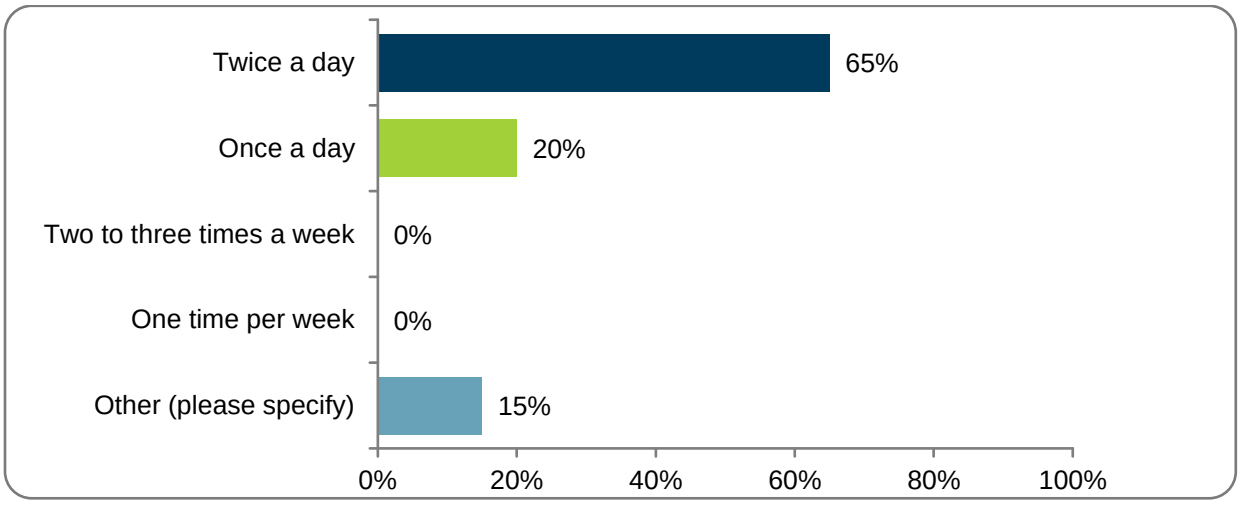
*In this question, survey respondents had an option to select more than one response for which the total percentage is over 100.

Survey respondents indicated that other individuals who should have access to the behavioral health bed registry are case managers and therapists.

Q13: Should individuals in crisis and/or their family members have access to a behavioral health bed registry?

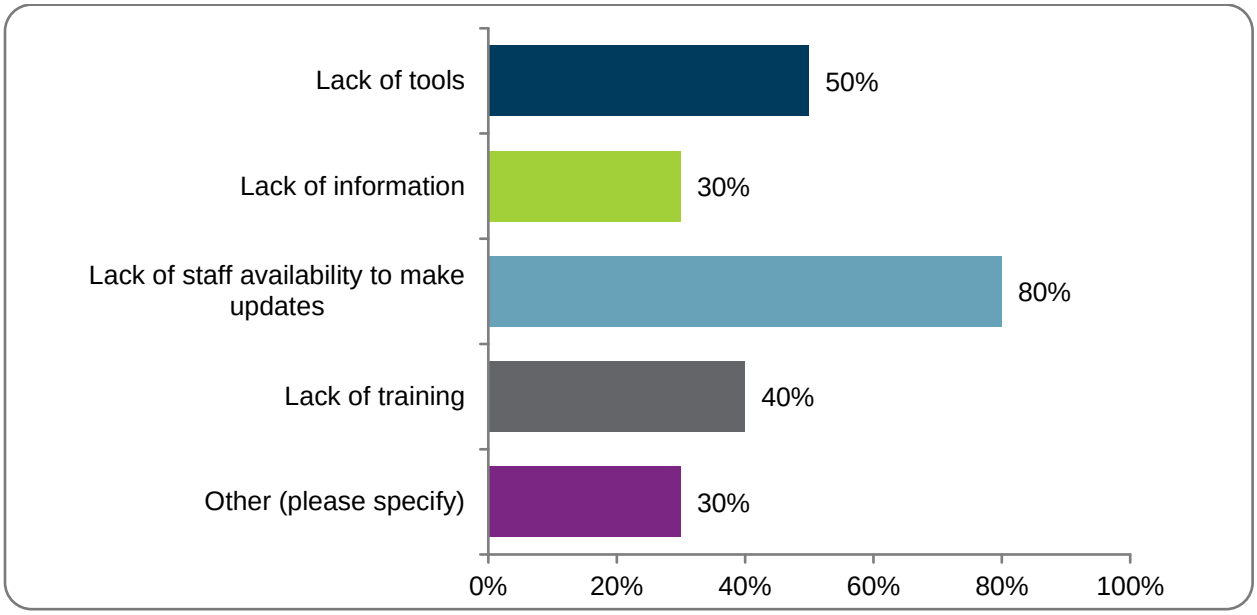


Q15: What is the desired cadence/frequency for providers to update the behavioral health bed registry?



Survey respondents indicated that the desired update cadence could be every time there is a change in bed availability. They mentioned using ADT data to update the BH bed registry automatically.

Q16: What potential barriers do you foresee with providers updating the behavioral health bed registry? (Select all that apply*)



*In this question, survey respondents had an option to select more than one response for which the total percentage is over 100.

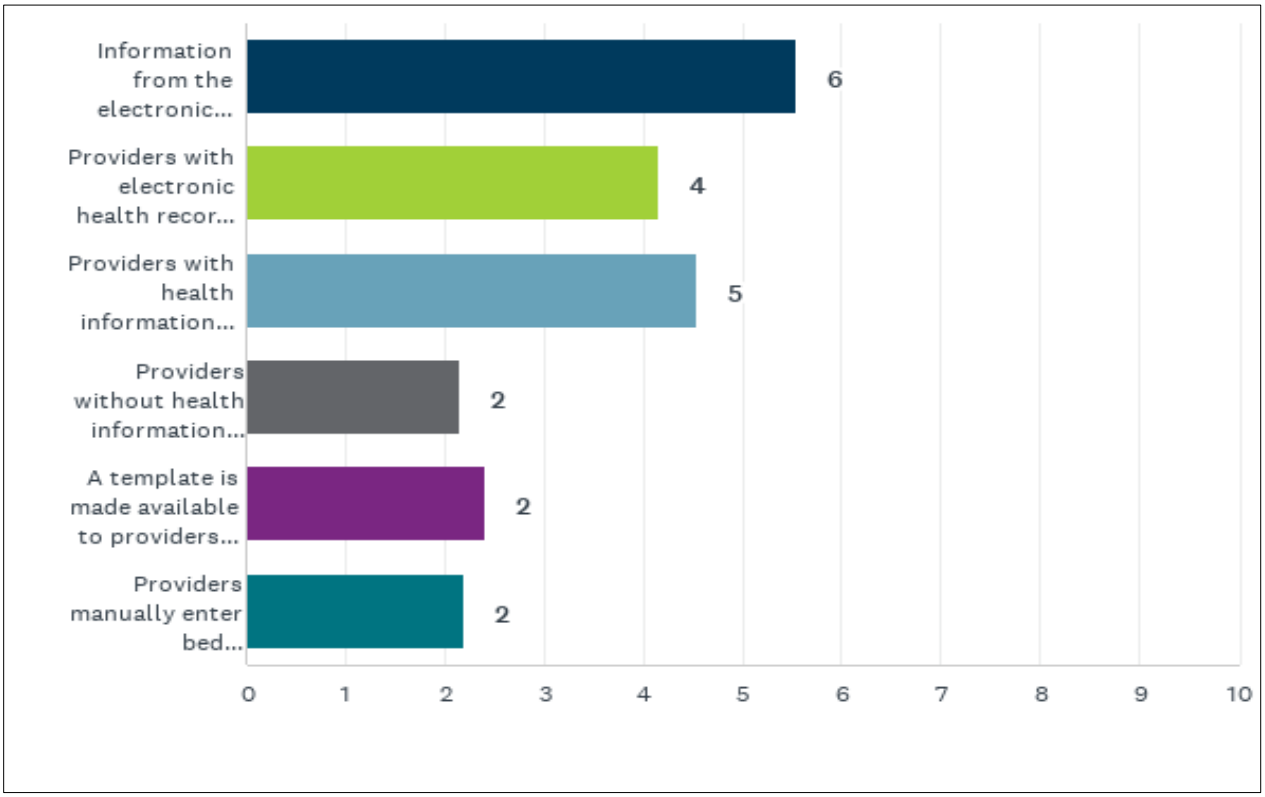
Survey respondents indicated that other potential barriers for providers to update the BH bed registry include resistance to transparency and accuracy, lack of contractual agreements for providers, lack of policy implementation at the state level, and lack of acuity information for inpatient facilities.

Q18: What would be the preferred method(s) for how the information within the behavioral health bed registry would be updated? (Please rank the options below in order of priority)

The top five preferred methods for information within the BH bed registry identified by the interested parties were:

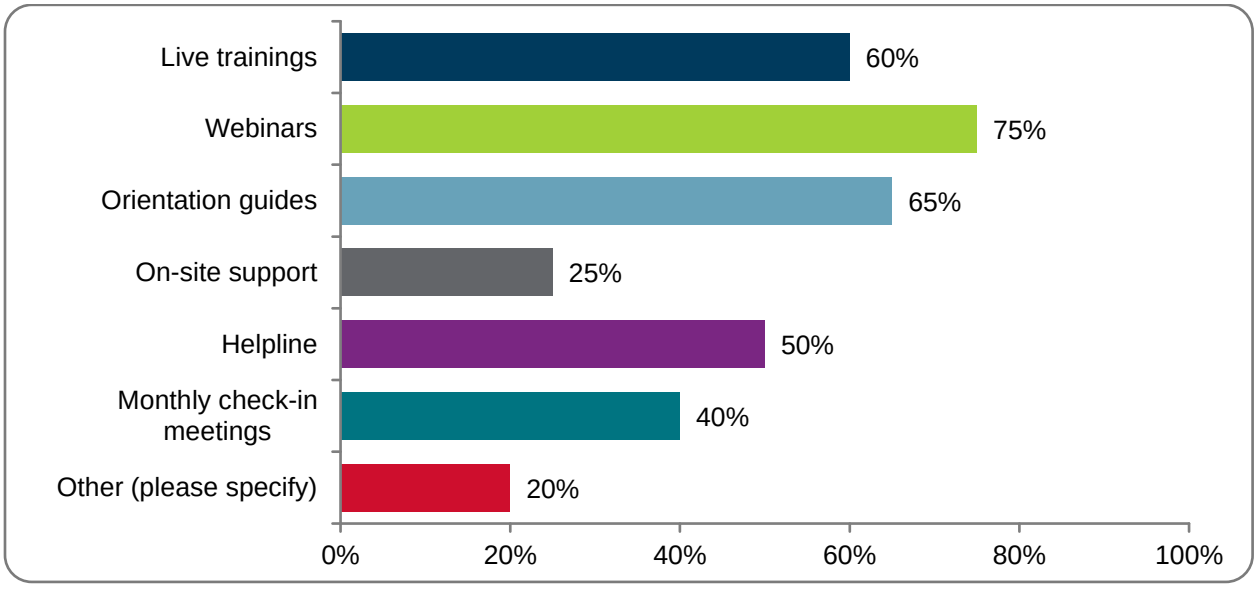
1. Information from the electronic closed-loop referral tool(s) would automatically update a provider's available beds in the behavioral health bed registry when a referral is accepted
2. Providers with health information technology/EHR tools would automatically track and send information about available bed capacity to the behavioral health bed registry
3. Providers with EHRs would create ADT summaries when an individual is admitted, discharged, transferred and the ADT would be shared with the registry to update bed availability
4. A template is made available to providers to update bed availability information

5. Providers without health information technology/EHR tools would use spreadsheets (or CSV files) to track bed availability and send information to the behavioral health bed registry



* Graph represented in weighted average

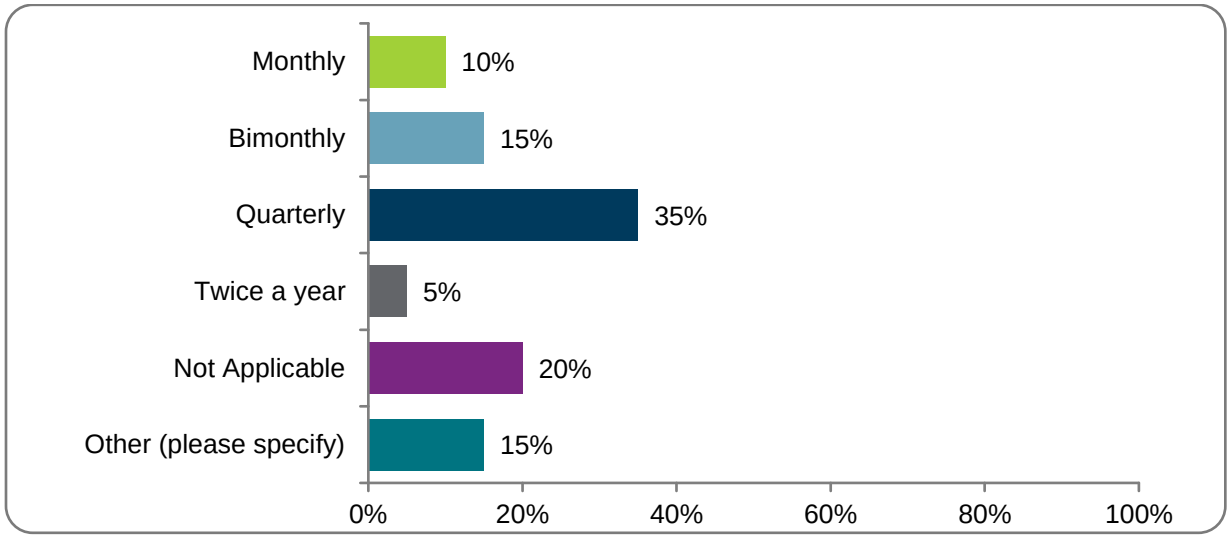
Q19: What support and tools would be helpful for you/your agency to implement a behavioral health bed registry? (Select all that apply*)



*In this question, survey respondents had an option to select more than one response for which the total percentage is over 100.

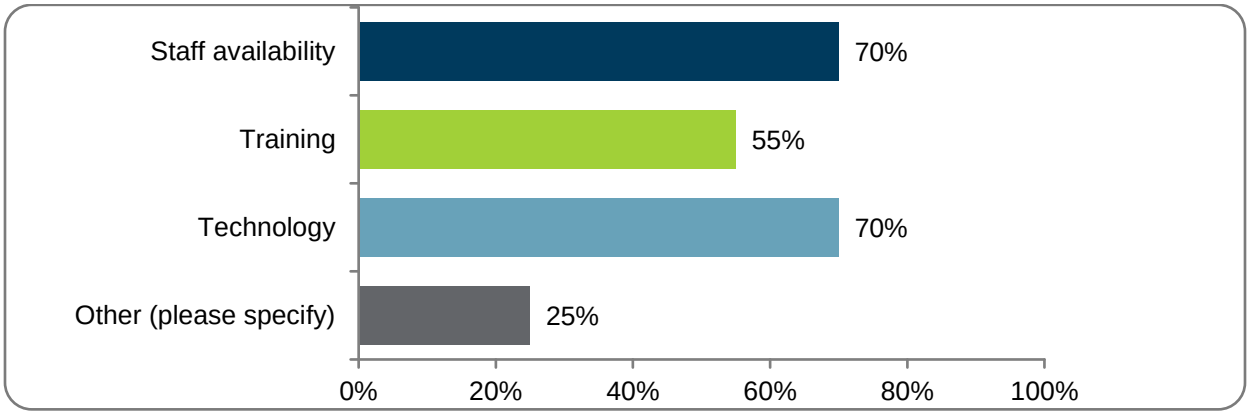
Survey respondents indicated other tools/supports include providing weekend and late-night training sessions, providing separate trainings for technical, clinical, and administrative staff based on their required use of the behavioral health bed registry, conducting quarterly check-ins, and including training in the new staff orientation guide.

Q20: If you selected live trainings on the previous question, how often should the live trainings be offered to support implementation and use of a behavioral health bed registry?



Survey respondents indicated that the live trainings could be provided monthly in the beginning and change the cadence as needed in the future. Survey respondents also recommended having previous trainings available online.

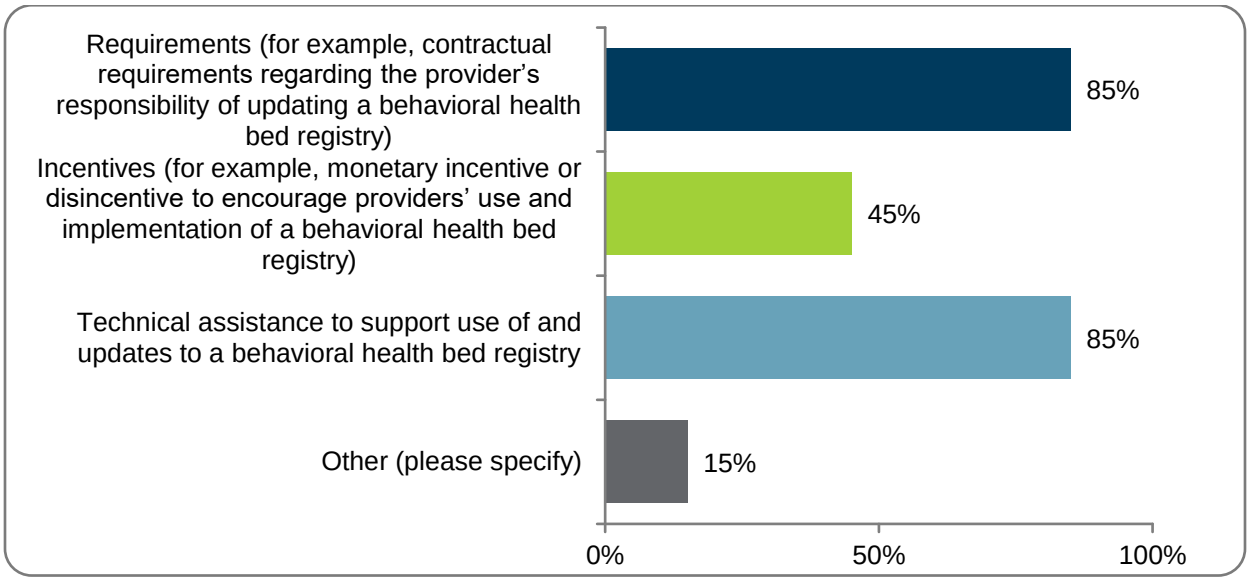
Q21: What barriers do you anticipate regarding the ongoing use and adoption of the behavioral health bed registry? (Select all that apply*)



*In this question, survey respondents had an option to select more than one response for which the total percentage is over 100.

Survey respondents indicated that other anticipated barriers regarding use and adoption of a BH bed registry include institutional buy-in, facilities responding within a designated time frame for referrals, staff absences affecting facility availability, and acuity levels affecting bed availability.

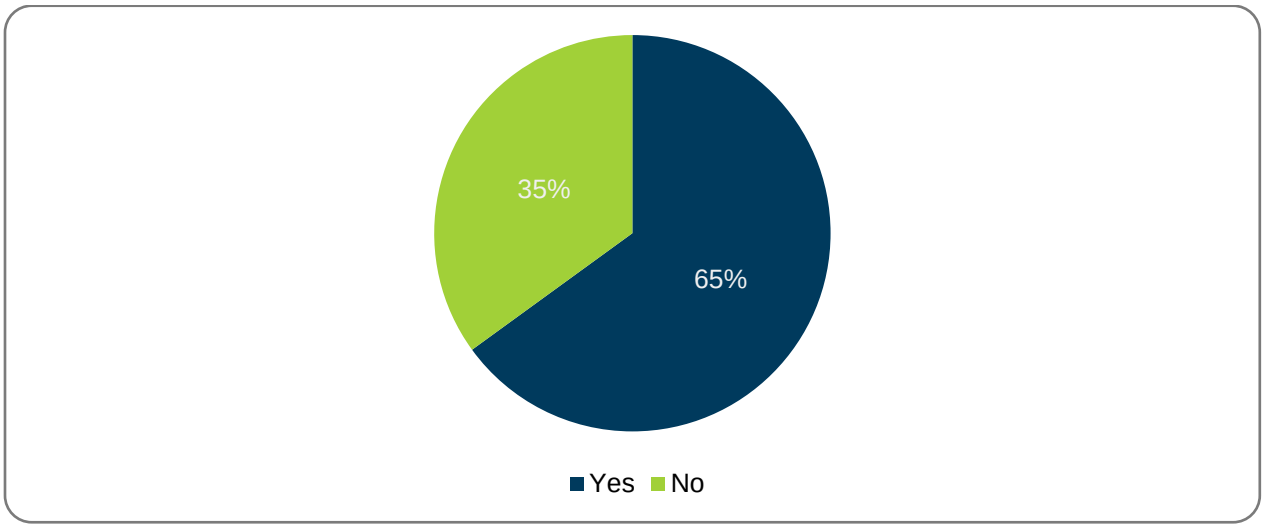
Q22: Which of the following do you think would support the implementation of a behavioral health bed registry? (Select all that apply*)



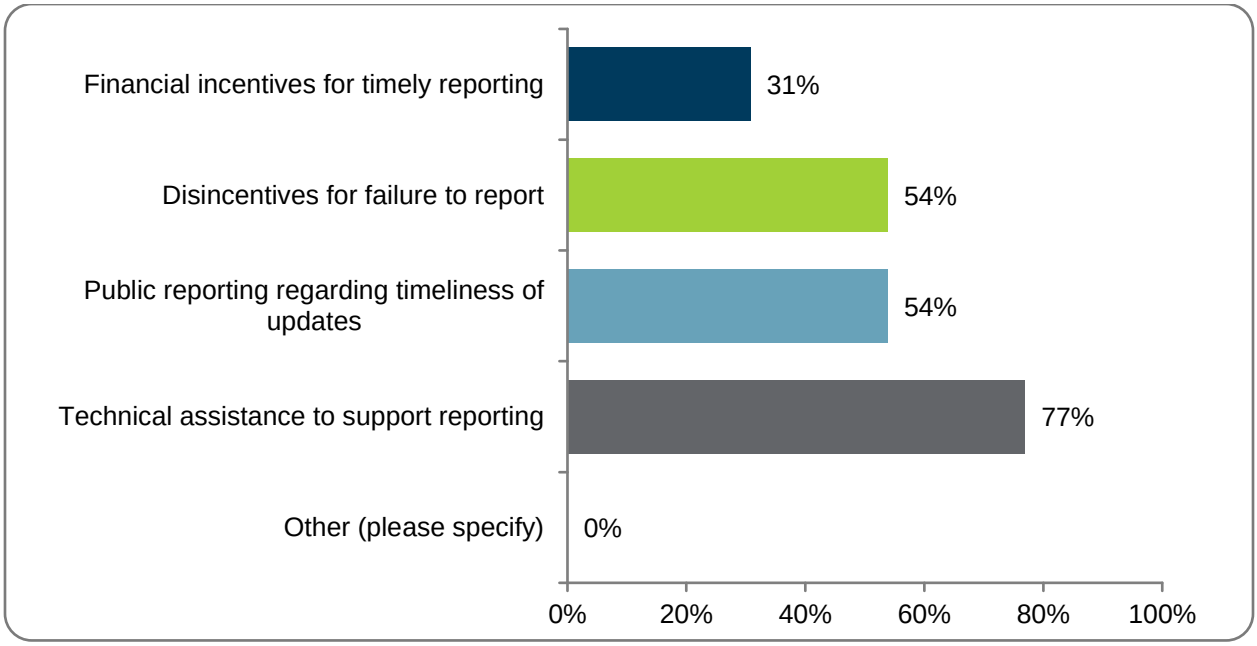
*In this question, survey respondents had an option to select more than one response for which the total percentage is over 100.

Survey respondents indicated that other implementation support could include ASOs and MCOs setting an individual admission response time for each facility and monitoring programs to help ensure facilities are meeting the contractual requirements.

Q25: Is enforcement necessary to help ensure compliance with the contractual or licensing requirements?

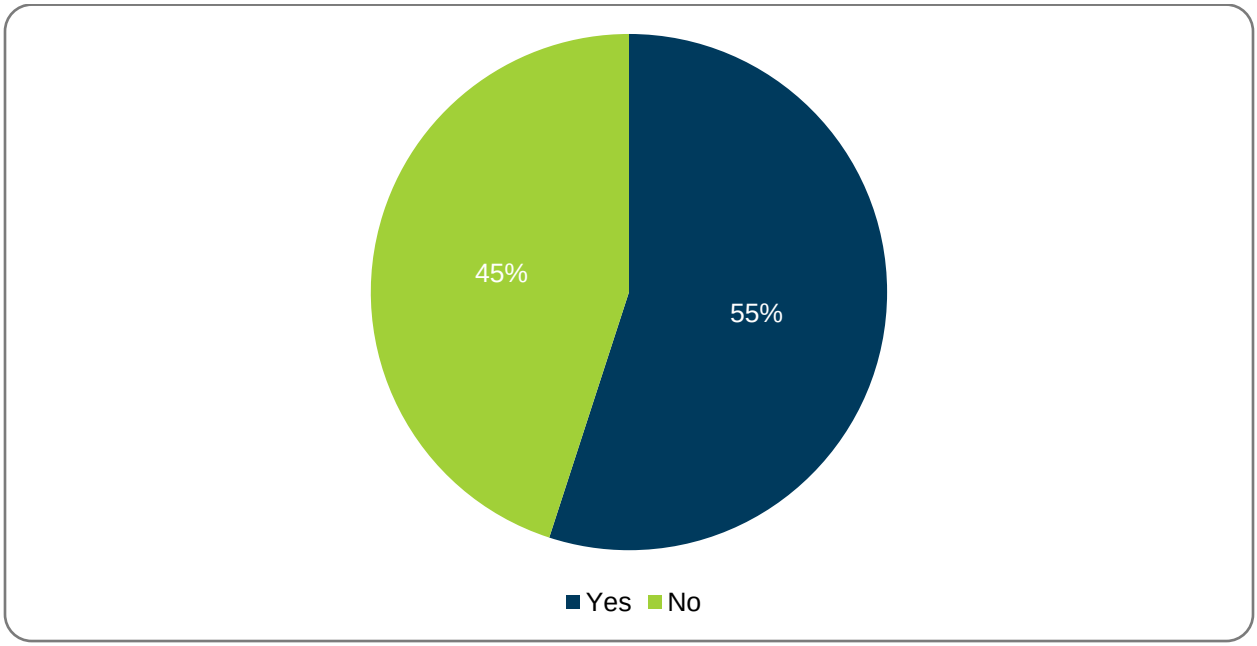


Q26: What types of enforcement would be helpful to support implementation of a behavioral health bed registry? (Select all that apply*)

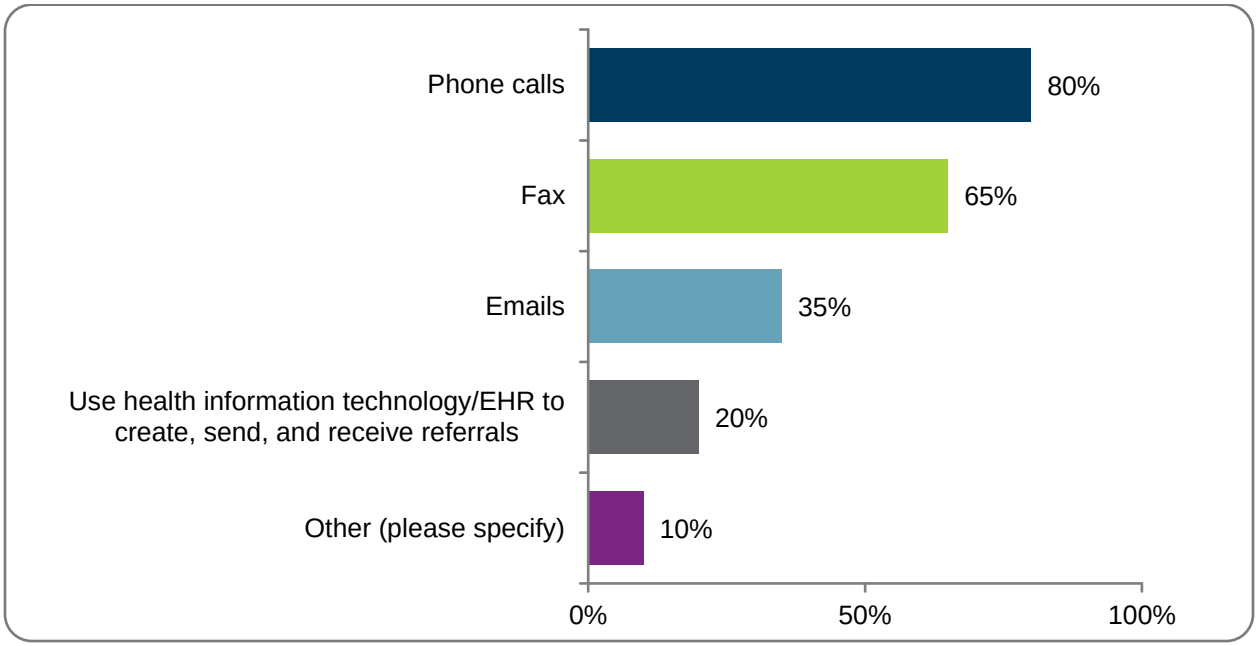


*In this question, survey respondents had an option to select more than one response for which the total percentage is over 100.

Q28: Does your organization/program have system(s) in place to send and receive referrals?



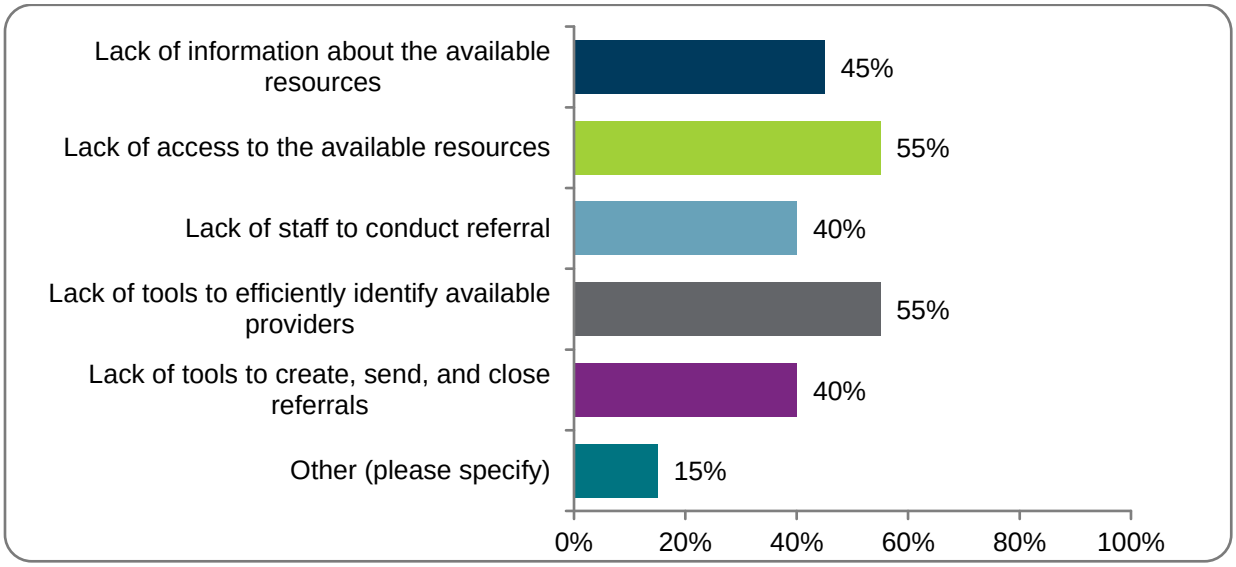
Q30: Which of the following describes how you/your agency makes referrals in the current environment? (Select all that apply*)



*In this question, survey respondents had an option to select more than one response for which the total percentage is over 100.

Survey respondents indicated that other referral methods include using the OpenBeds module to accept referrals from the mobile crisis dispatch and using the police record management system.

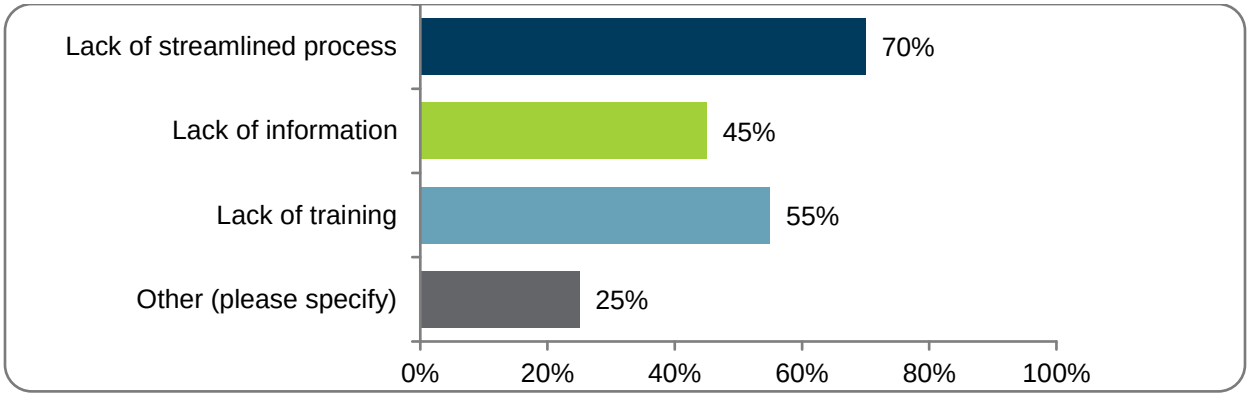
Q31: What are the challenges with the current referral process? (Select all that apply*)



*In this question, survey respondents had an option to select more than one response for which the total percentage is over 100.

Survey respondents indicated that other challenges with the current referral method include inconsistency in admission requirements and the medical clearance process, exclusion of special populations, the time it takes to locate an available bed and to hear a response about the referral, and overall time delays.

Q32: What challenges do you anticipate in the use and adoption of electronic referral tools? (Select all that apply*)

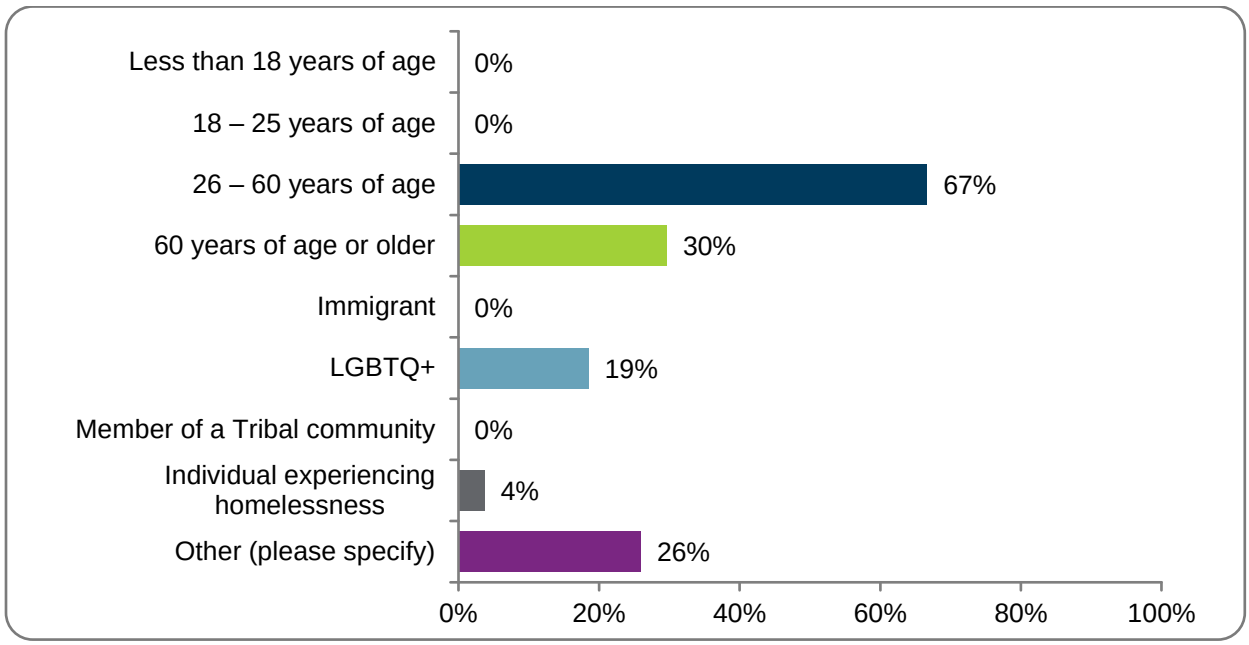


*In this question, survey respondents had an option to select more than one response for which the total percentage is over 100.

Survey respondents indicated that other anticipated challenges for the adoption of electronic referral tools include concerns with HIPAA, an additional system for staff to input data into, lack of internet in rural areas, the time it may take to input all required information for admission, lack of prioritization across all interested parties, and hospital buy-in.

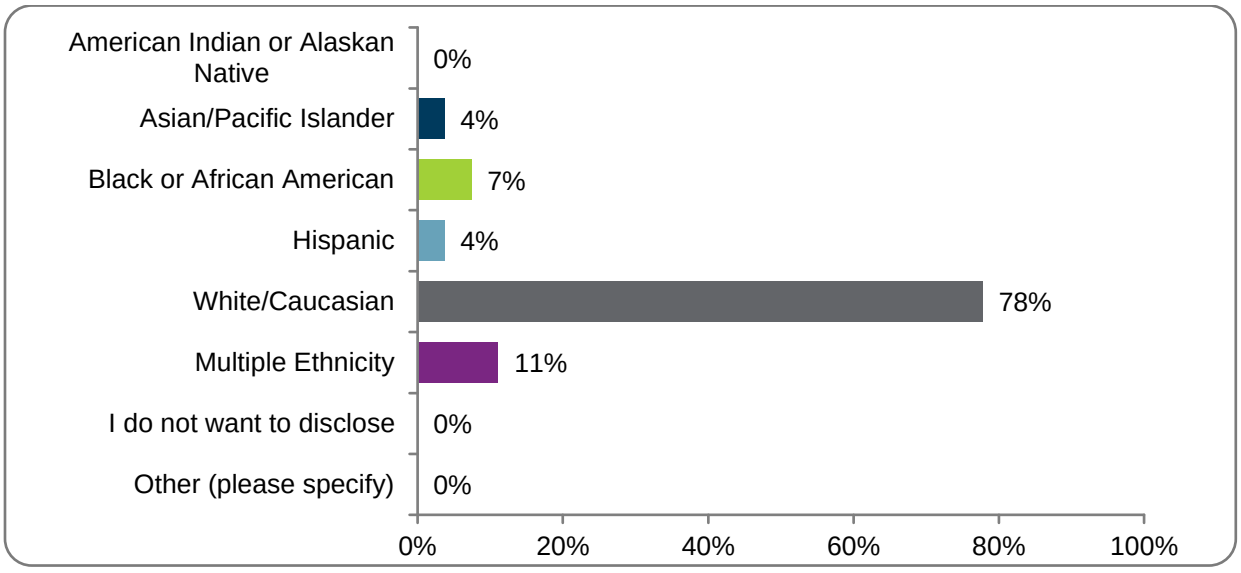
Lived Experience Web Survey Results

Q1: Please identify the demographic that best represents you: (Select all that apply*)



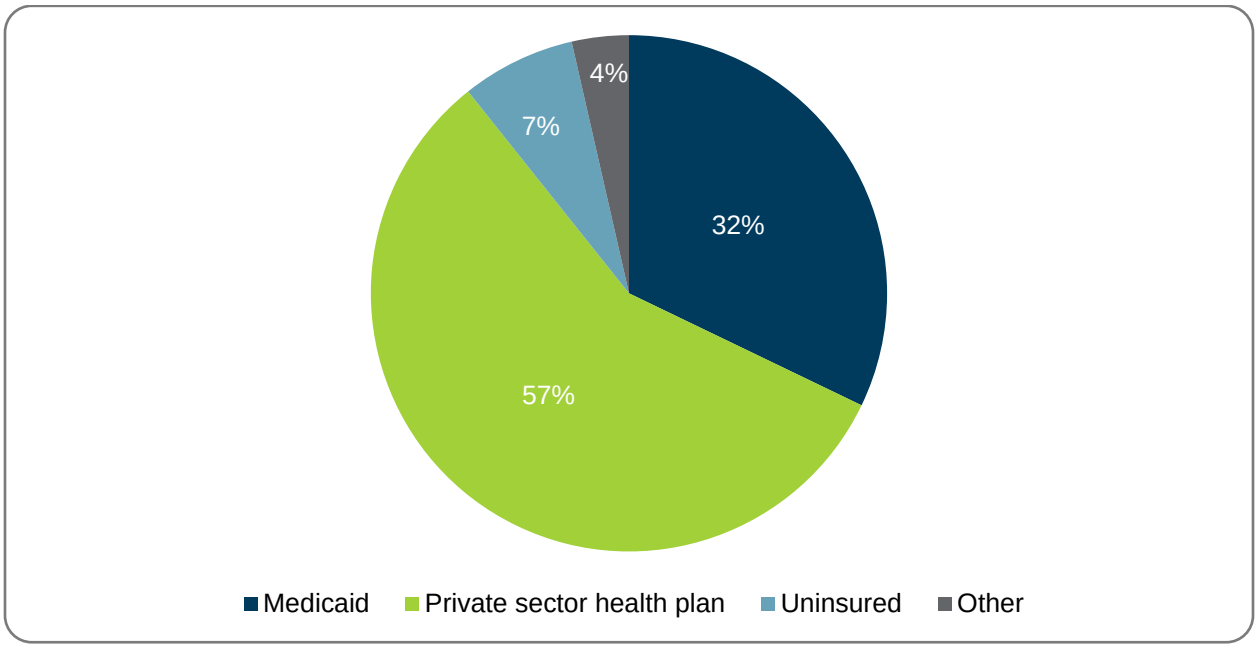
Other demographics of interested parties that responded to the survey include health insurance carrier, medical director, peer support, disabled, neurominority disabled, previously homeless, family member of an individual with dual diagnosis of mental illness and intellectual disability, and family member who lost someone due to behavioral healthcare.

Q2: What racial or ethnic group best describes you? (Select all that apply*)

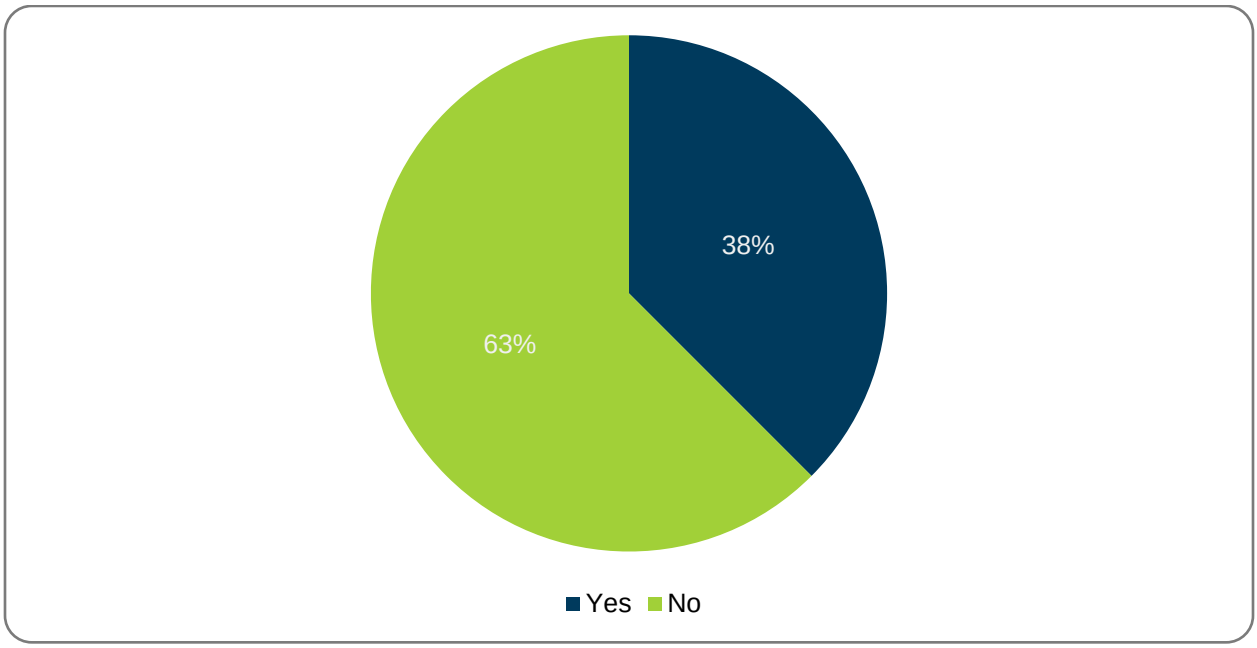


*In this question, survey respondents had an option to select more than one response for which the total percentage is over 100.

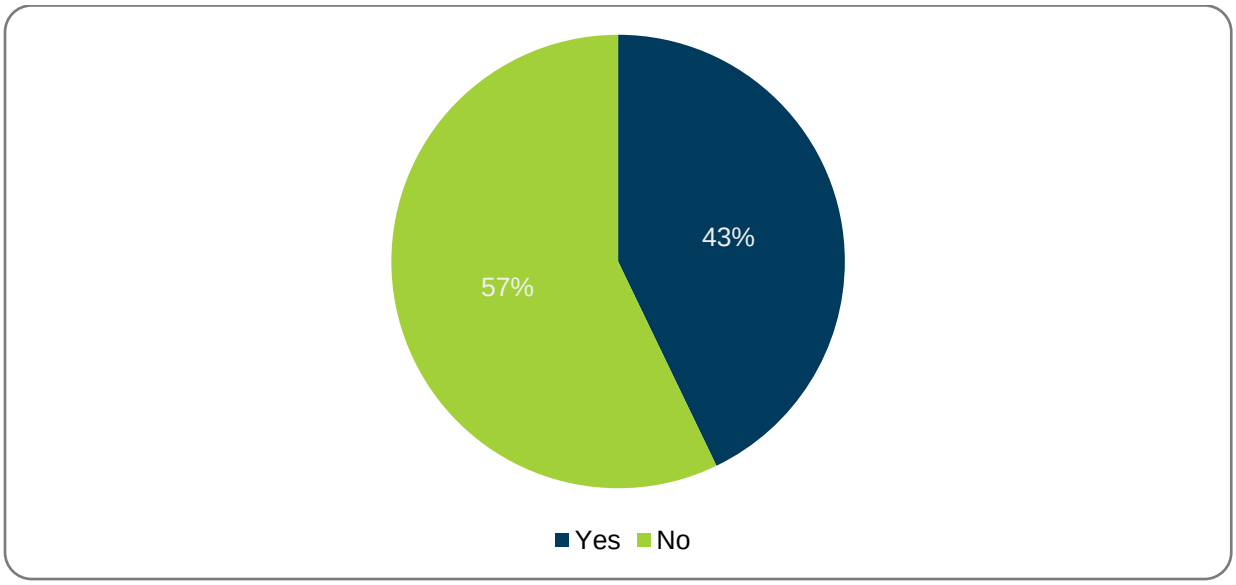
Q3: Are you currently enrolled in:



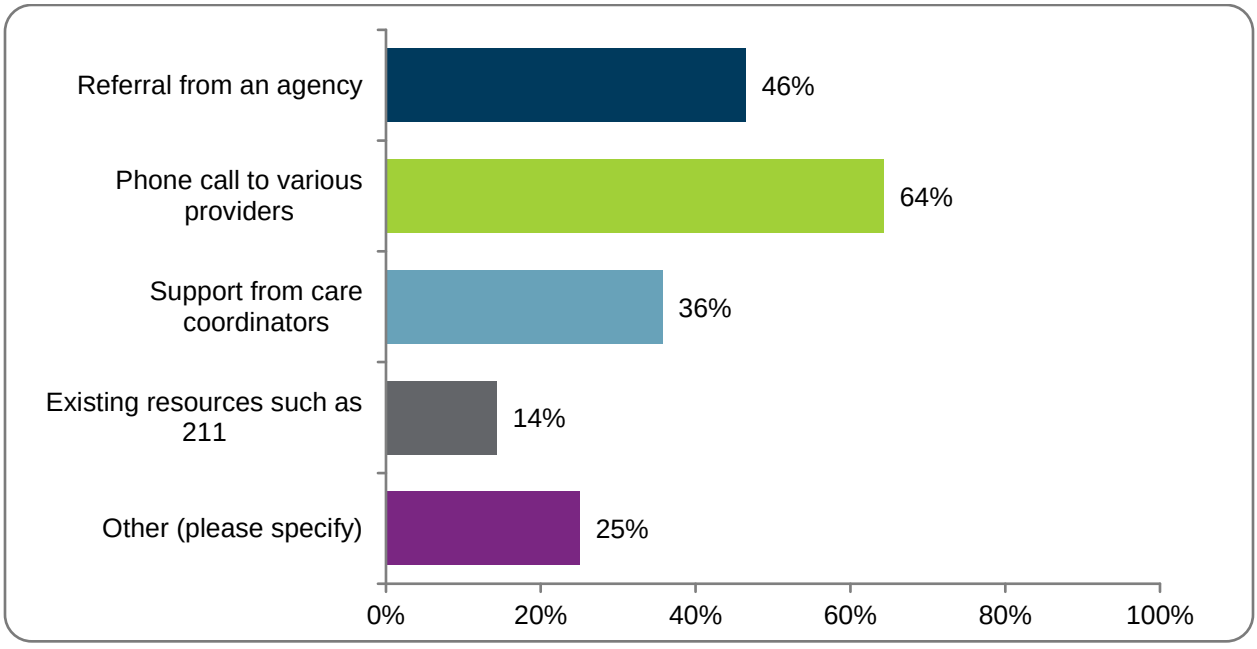
Q4: If you are enrolled in a private sector health plan, does your health plan provide care coordination services that help you access behavioral health services at the time of crisis?



Q5: Do either Managed Care Organizations or Behavioral Health-Administrative Service Organizations provide care coordination services that help you access behavioral health services at the time of crisis?



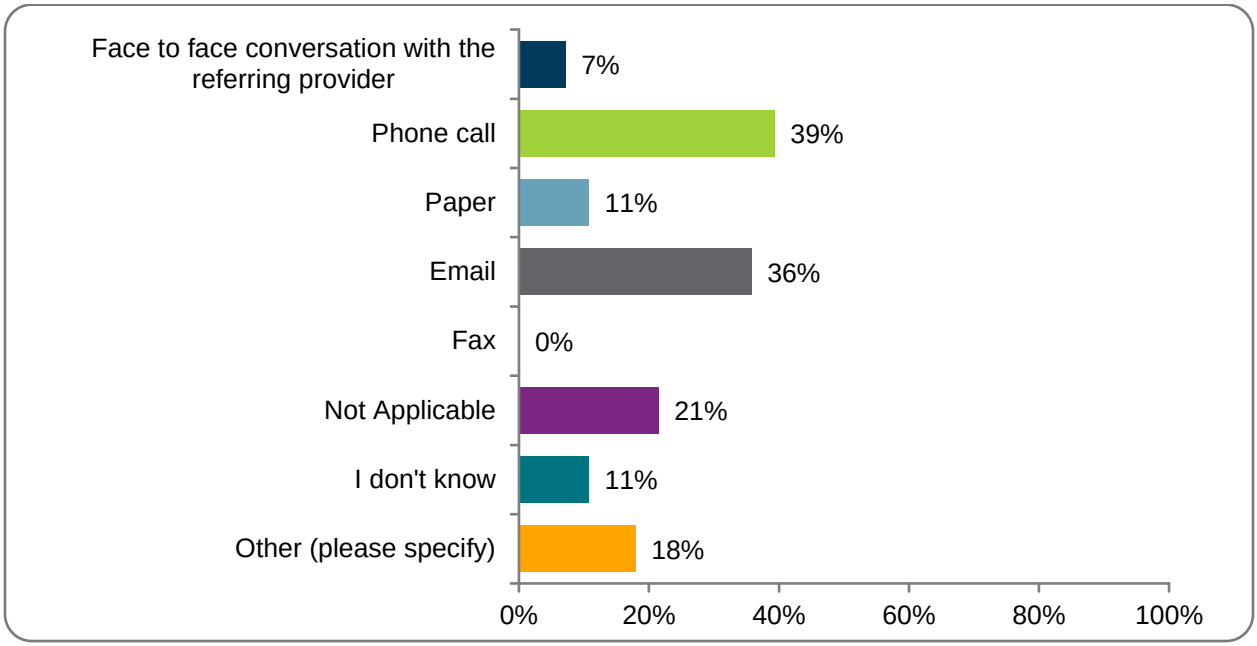
Q8: How do you access behavioral health services? (Select all that apply*)



*In this question, survey respondents had an option to select more than one response for which the total percentage is over 100.

Survey respondents indicated that other access lanes for behavioral healthcare are referral from primary care, making direct call to providers, and information provided by BHAs, Volunteers of America hotline, 988, and WISe teams.

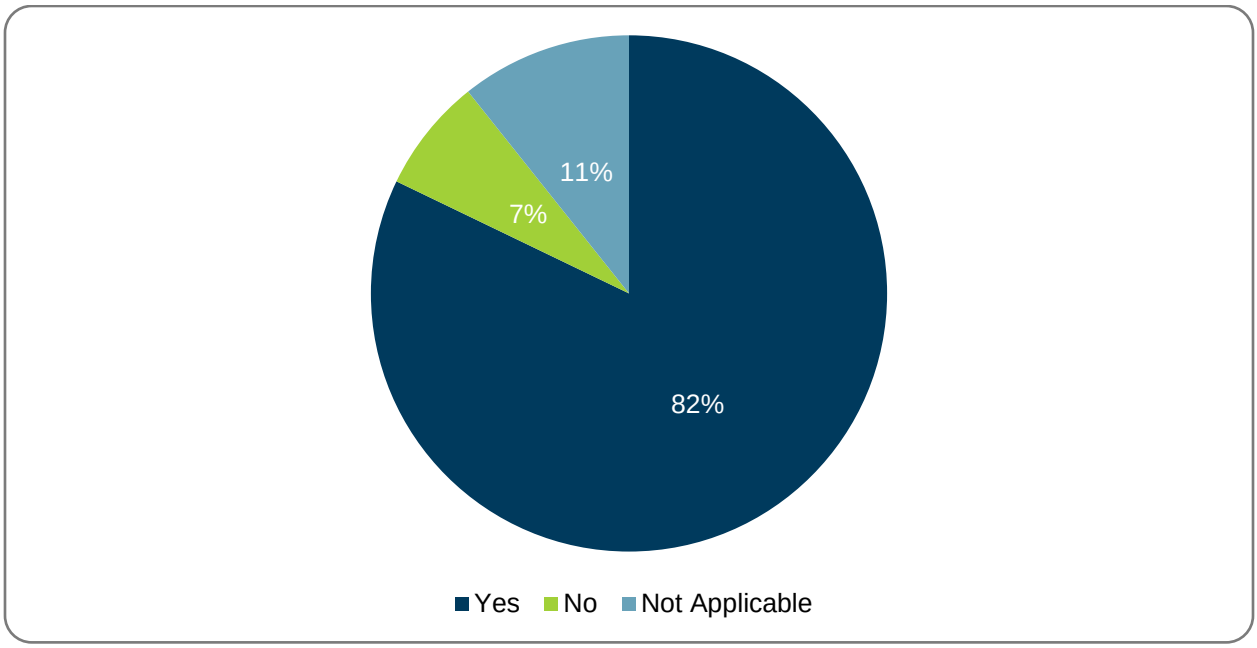
Q9: If you receive a referral from an agency, how do you currently get notifications (e.g., appointments) about your referral? (Select all that apply*)



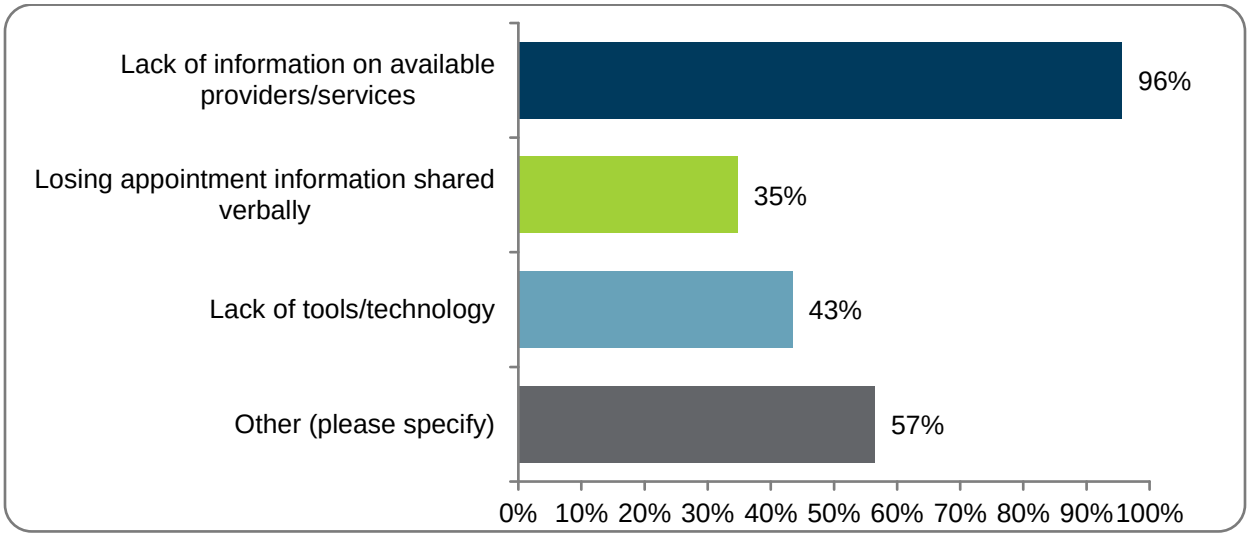
*In this question, survey respondents had an option to select more than one response for which the total percentage is over 100.

Survey respondents indicated that other methods for referral information were received via Zoom, community health centers, and text messages.

Q10: Are there challenges with the current referral process?



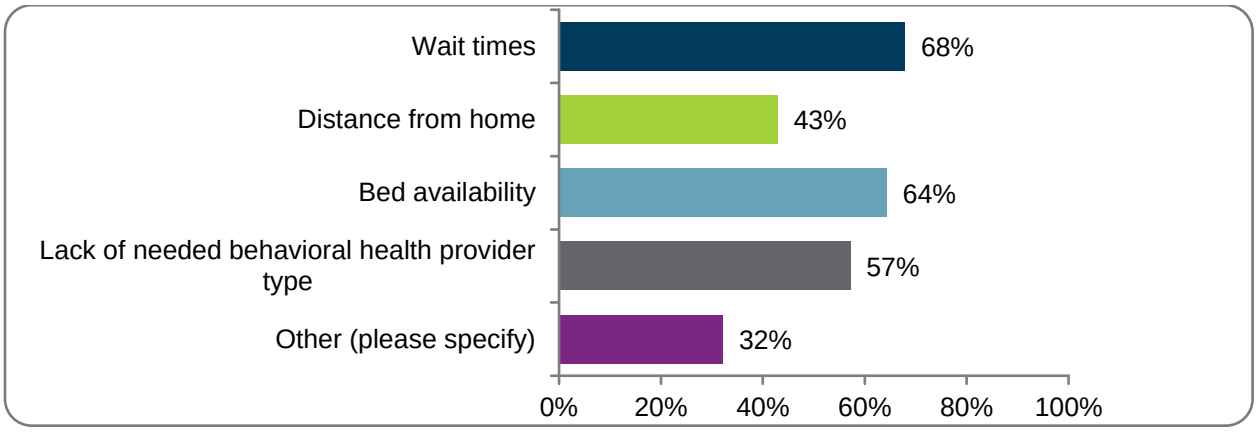
Q11: If yes, what are some challenges with the current referral process? (Select all that apply*)



*In this question, survey respondents had an option to select more than one response for which the total percentage is over 100.

Survey respondents indicated that other challenges with the current referral process include long wait times to see providers, a lack of providers, finding providers who accept Medicaid, state requirement that SUD patients be sober before services, lack of coordination with staff, lack of services, ghost networks, agencies closing at 5 p.m. and their communication methods, bed availability based on insurance, and living in a rural community.

Q12: What challenges do you experience while accessing behavioral health services? (Select all that apply*)

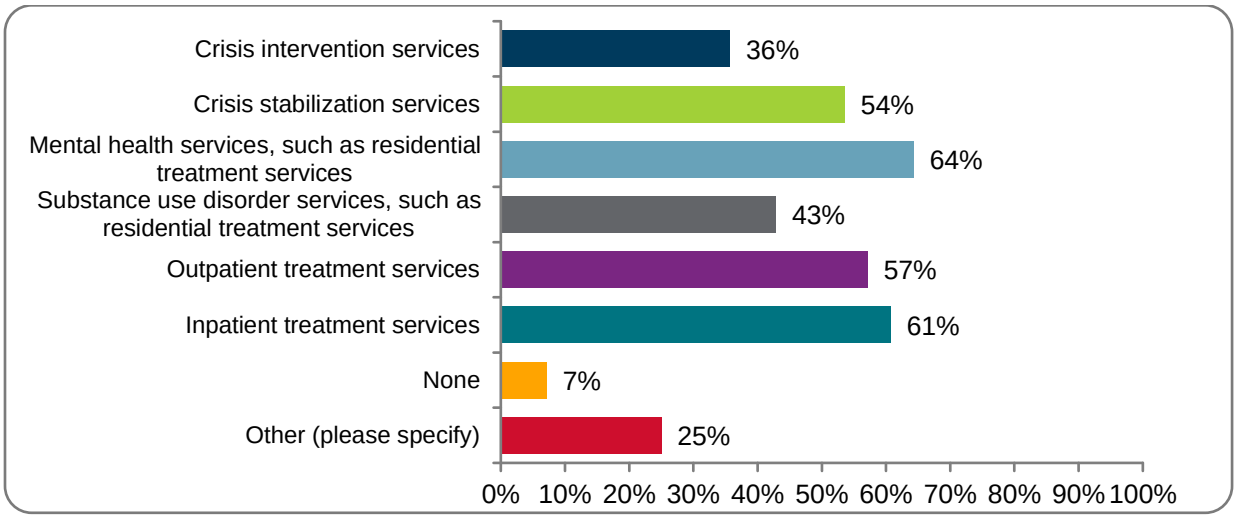


*In this question, survey respondents had an option to select more than one response for which the total percentage is over 100.

Survey respondents indicated that other challenges when accessing behavioral health services include clarity on how services will work, lack of real-time bed availability data, lack of access,

lack of crisis response by DCRs during a crisis, lack of awareness of services, providers not accepting Medicaid, facilities closing before 5 p.m., facilities requiring appointments, and providers not accepting complex patients.

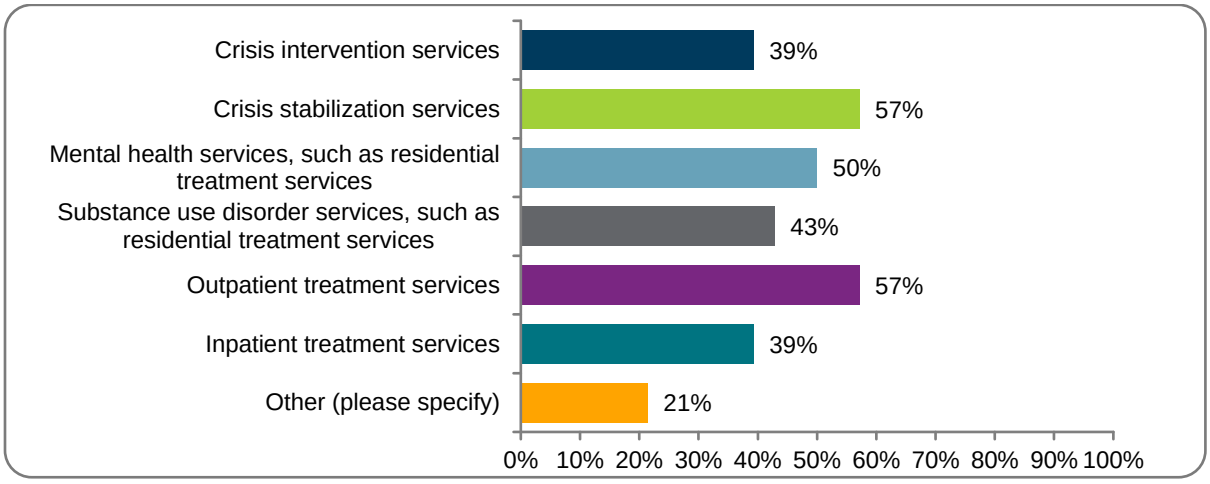
Q13: What behavioral health services do you have a difficult time finding and utilizing? (Select all that apply*)



*In this question, survey respondents had an option to select more than one response for which the total percentage is over 100.

Survey respondents indicated that other behavioral health services that are difficult to find are services for people with co-occurring illnesses, medication specialists and psychiatrists, in-home care/caregiving, ongoing intensive support at home, dentists that offer nitrous/gas/IV sedation and accept Medicaid, involuntary treatment beds, and assisted outpatient treatment services for individuals who do not qualify for the voluntary system.

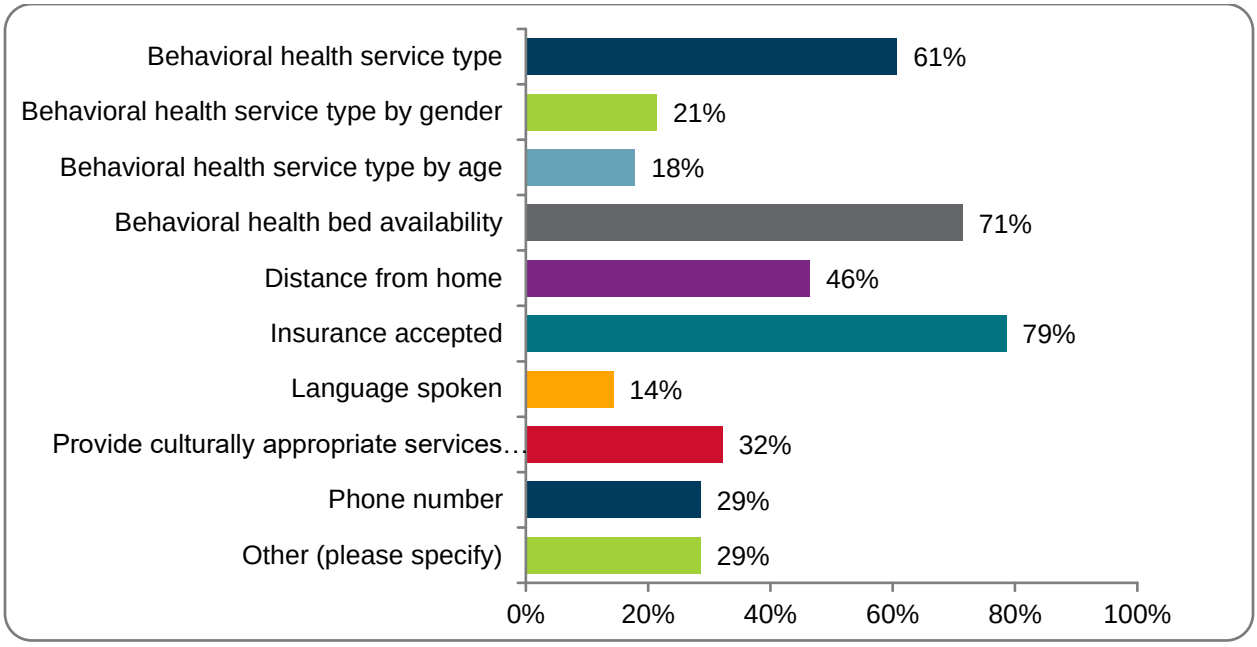
Q14: What behavioral health service type is of high priority for you or your family members? (Select all that apply*)



*In this question, survey respondents had an option to select more than one response for which the total percentage is over 100.

Survey respondents indicated that other high-priority behavioral health services for family members include co-occurring inpatient beds, support for family members, long-term care planning, in-home care and ongoing intensive support at home, ADHD services, and continuity of care.

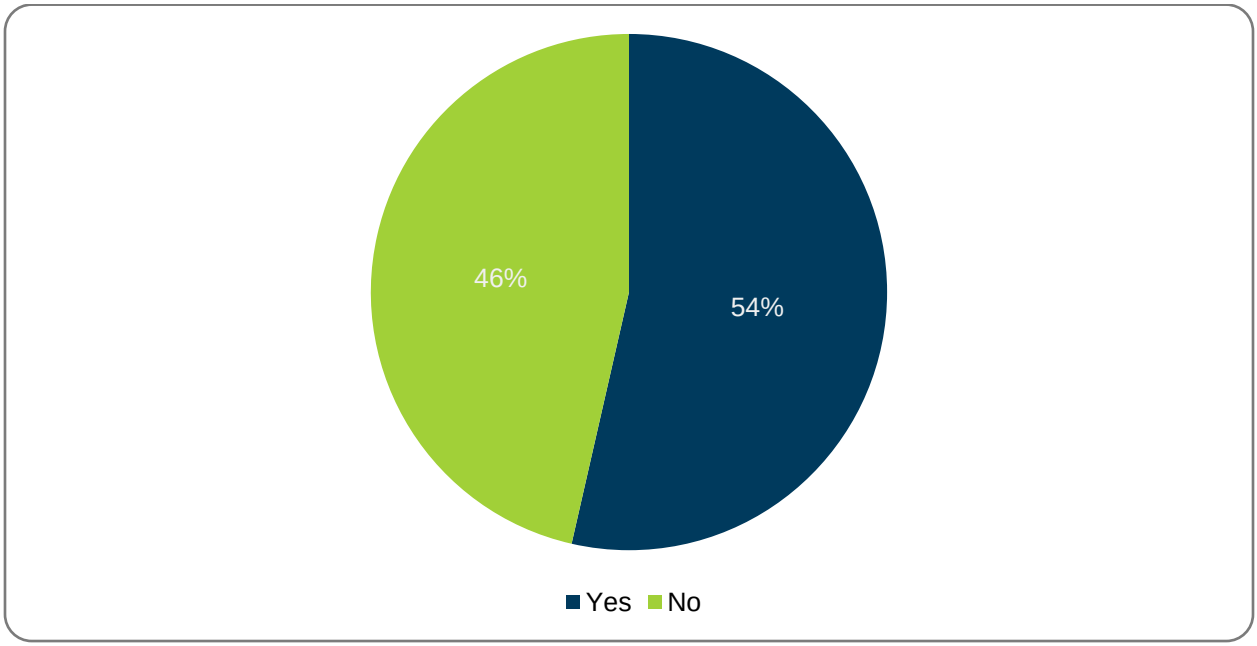
Q15: What information would be helpful to know when you are looking for behavioral health services? (Select all that apply*)



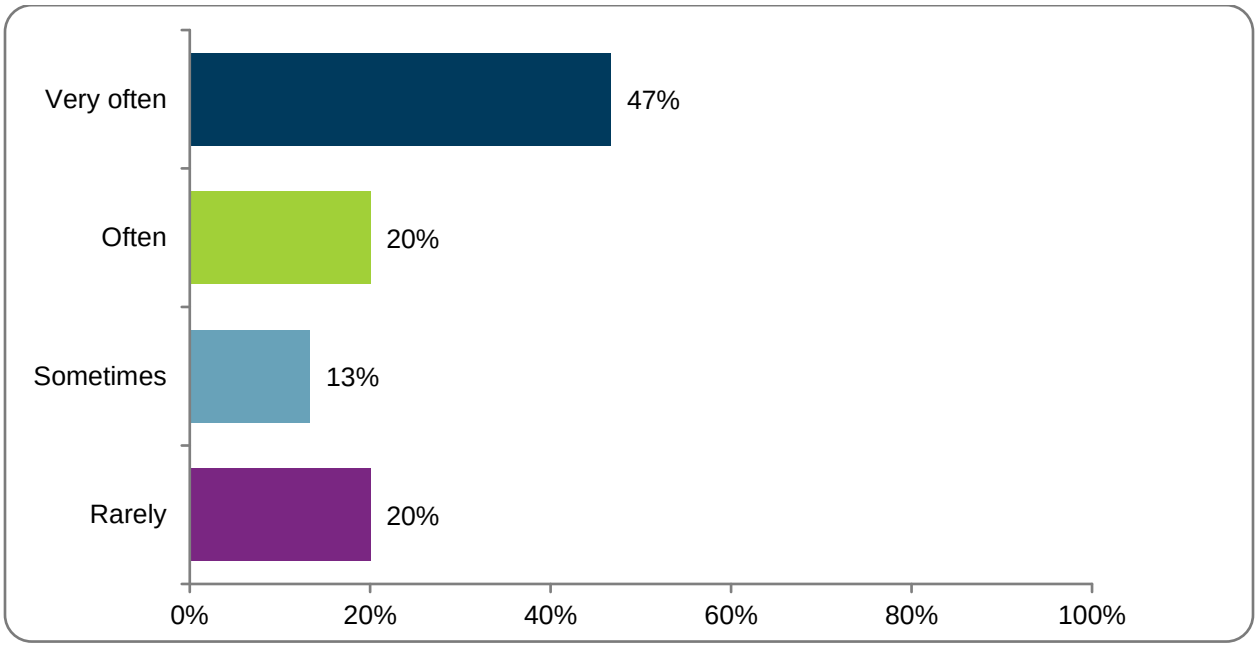
*In this question, survey respondents had an option to select more than one response for which the total percentage is over 100.

Survey respondents indicated that other helpful information includes lawsuits against service providers, admissions information for residential facilities, available wraparound services, listing of providers, provider knowledge on working with special populations (LGBTQ+, neurodiverse individuals, IDD, chronic illnesses), bed availability, programs offered, and program expectations.

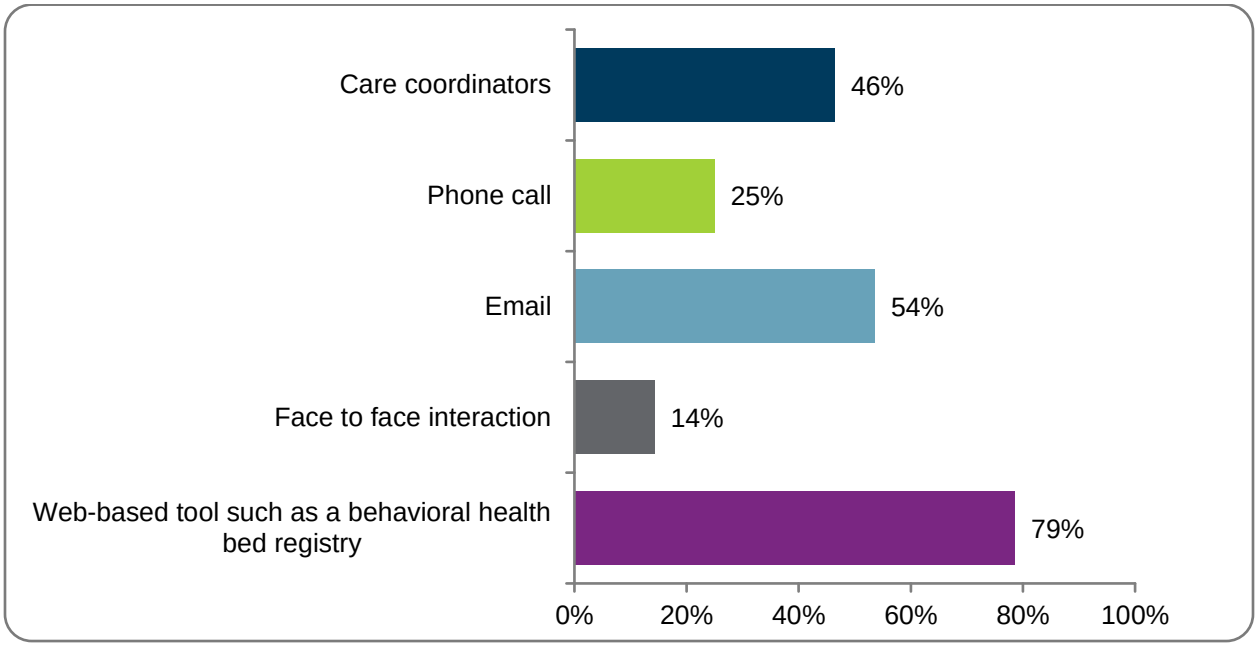
Q16: Do you have access to any information you selected in the previous question in a web-based tool (for example, 211 resources)?



Q18: How often do you use the web-based tool to access the information you need?

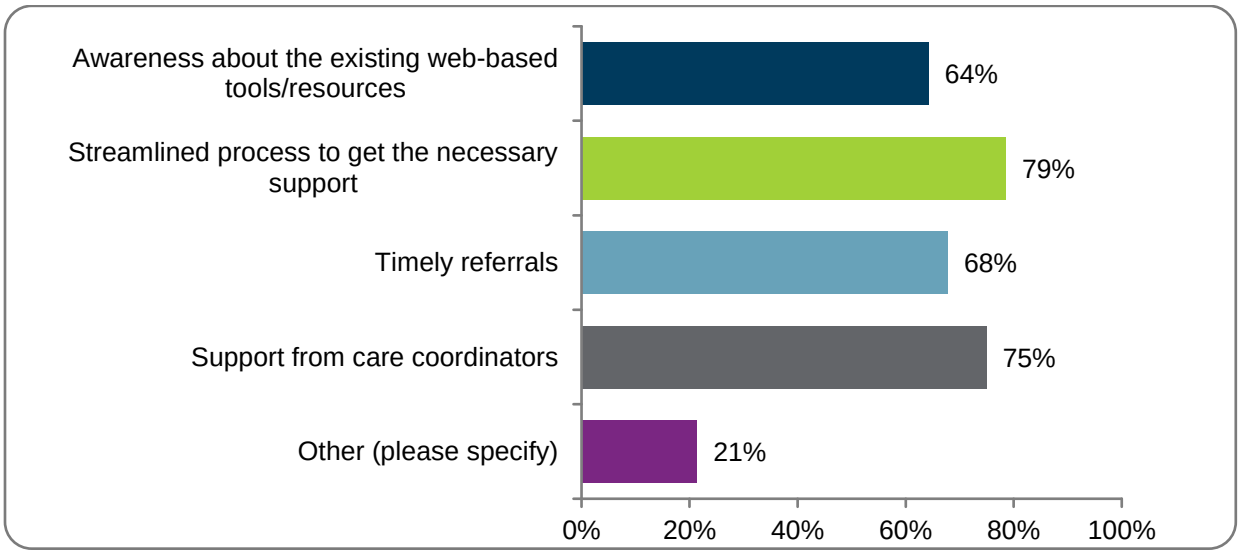


Q19: How would you like to receive information about available providers, services, and bed availability in the future? (Select all that apply*)



*In this question, survey respondents had an option to select more than one response for which the total percentage is over 100.

Q20: What additional support do you need to have easier access to behavioral health services? (Select all that apply*)

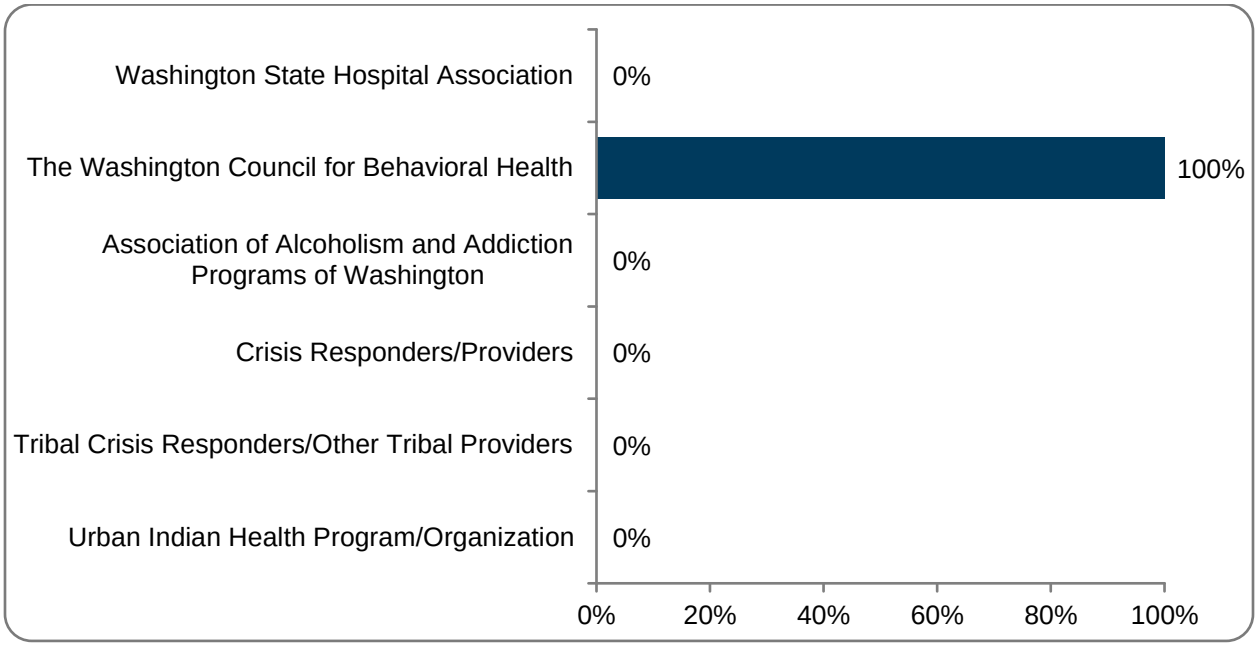


*In this question, survey respondents had an option to select more than one response for which the total percentage is over 100.

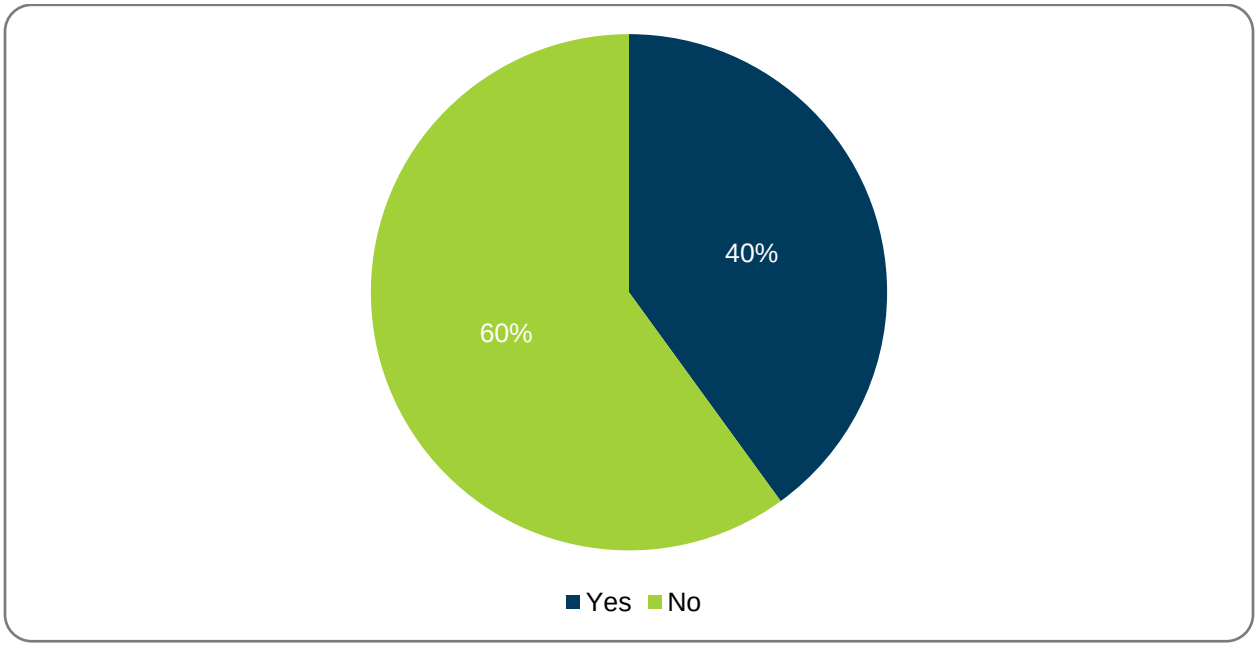
Survey respondents indicated that other support needed to access behavioral health care includes insurance coverage, available referrals, in-home care support, and care coordinators.

The Washington Council for Behavioral Health Web Survey Results

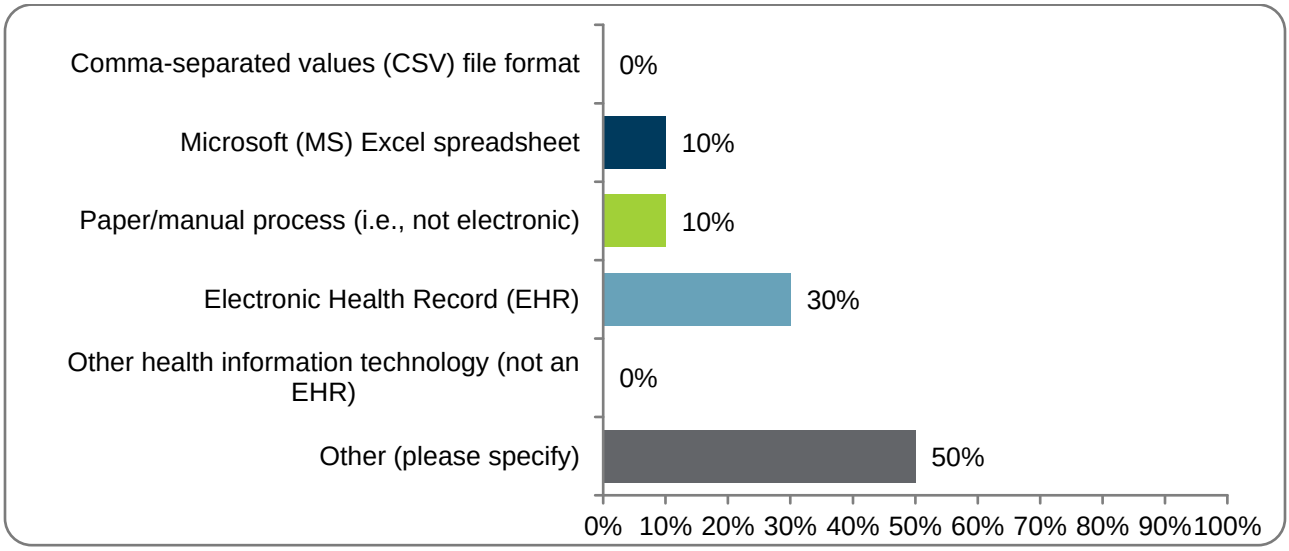
Q1: Which of the following best describes your organizational affiliation?



Q2: Does your organization/program have system(s) in place to track behavioral health bed availability?

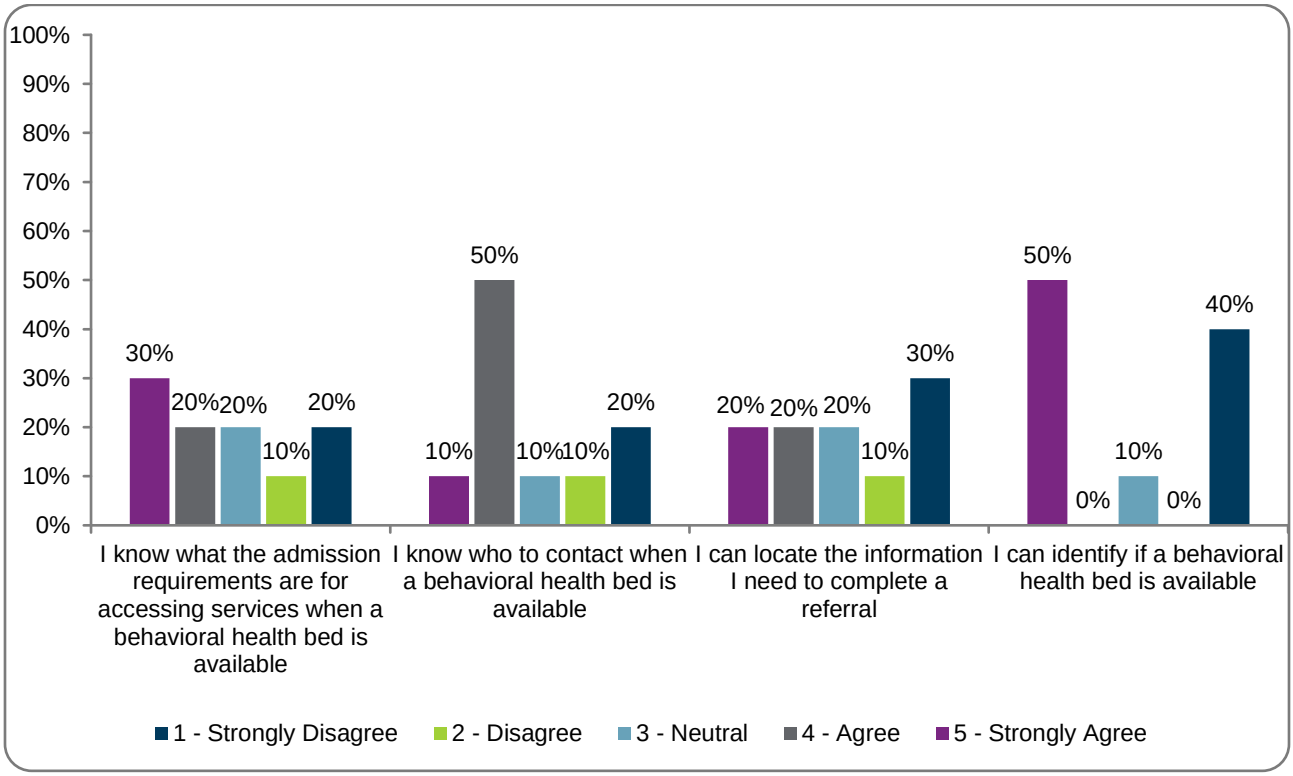


Q5: Which of the following describes how you/your agency currently track behavioral health bed availability in your facility?

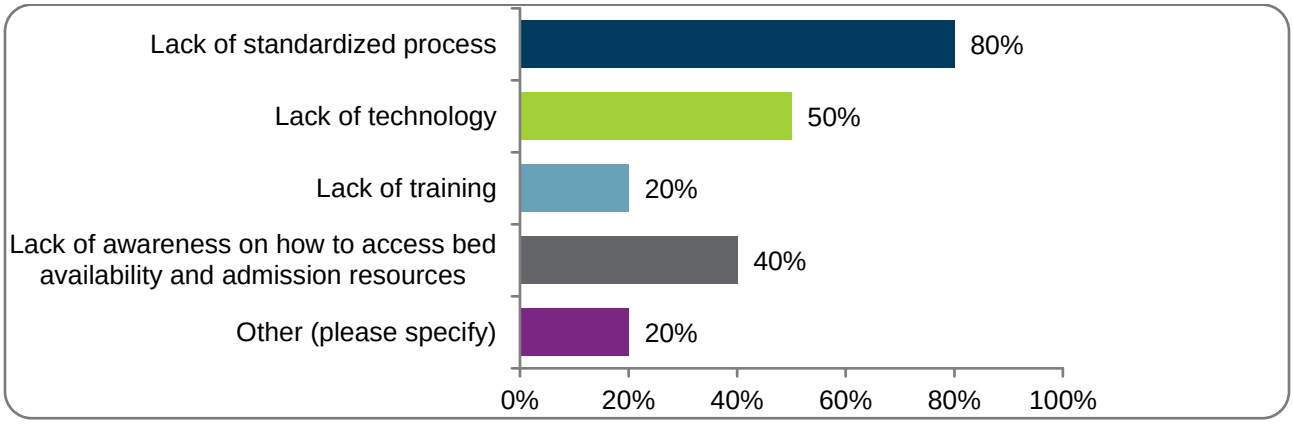


Survey respondents indicated that other bed tracking methods include using Power BI to track caseload capacity and WA Track for psychiatric emergency services.

Q6: Please rate each of the following using a scale of 1 to 5 with 1 being strongly disagree and 5 being strongly agree:



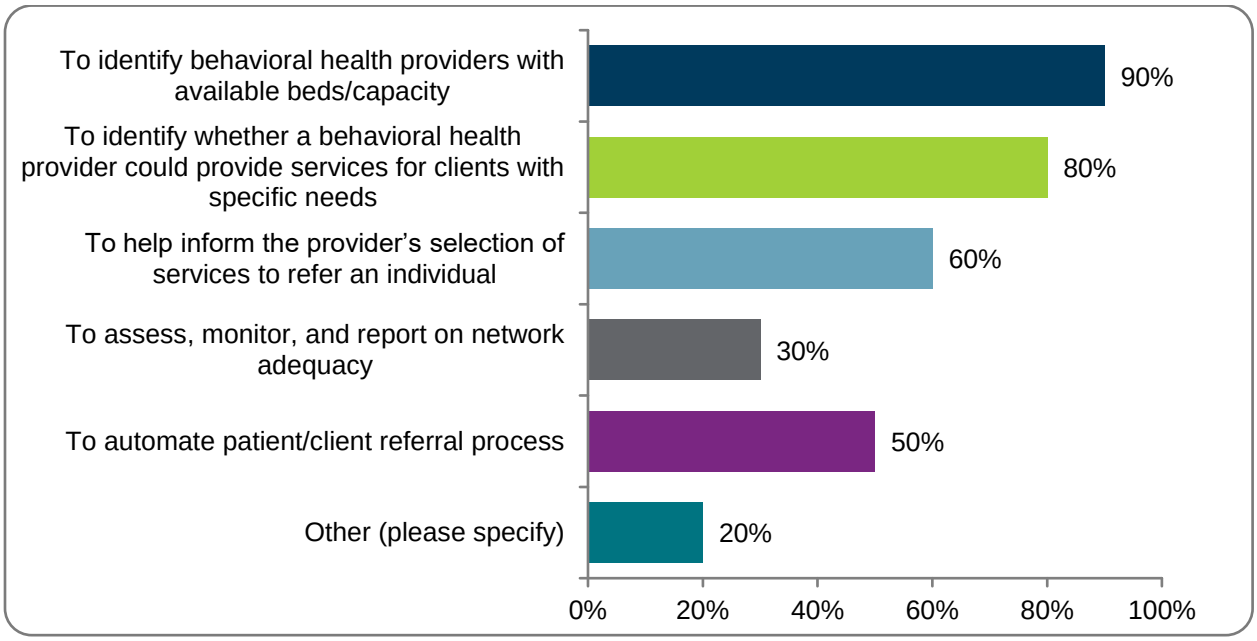
Q7: What are the challenges with the current process (i.e., paper-based or electronic) to identify and access behavioral health bed availability? (Select all that apply*)



*In this question, survey respondents had an option to select more than one response for which the total percentage is over 100.

Survey respondents indicated that other challenges with the current method of tracking bed availability were lack of knowledge of pending admissions/discharges, wait times, competing referrals, and lack of an electronic referral process.

Q8: Which of the following describes how you/your agency would use a behavioral health bed registry? (Select all that apply*)



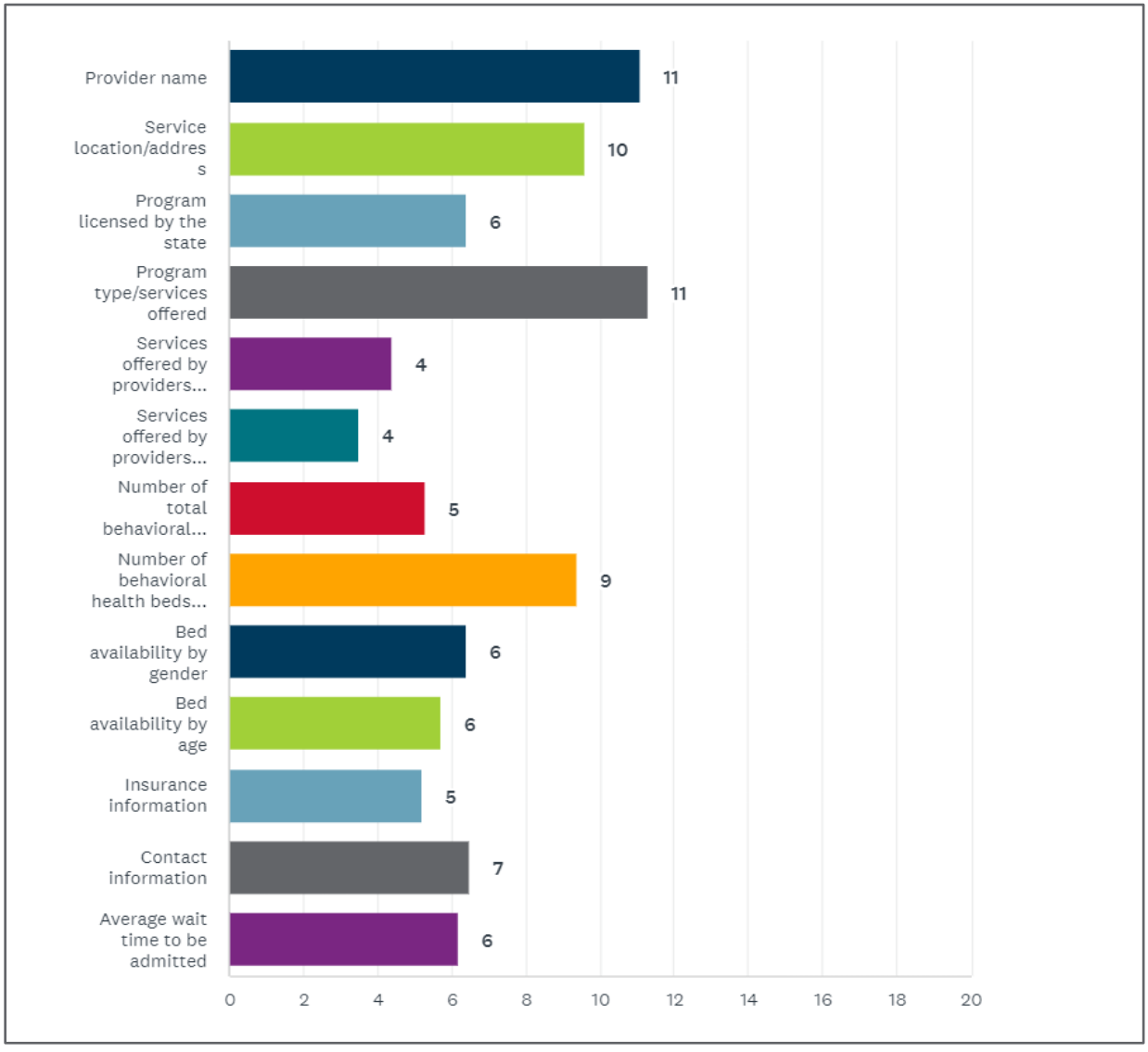
*In this question, survey respondents had an option to select more than one response for which the total percentage is over 100.

Survey respondents indicated that other uses for a behavioral health bed registry were streamlining the referral process and using more extensive technology.

Q9: Indicate which of the following information/content is necessary to include in the behavioral health bed registry? (Please rank the options below in order of priority)

The top-five priority list identified by the interested parties was:

1. Provider name
2. Program type/services offered
3. Number of BH beds available
4. Program licensed by the state
5. Average wait time to be admitted

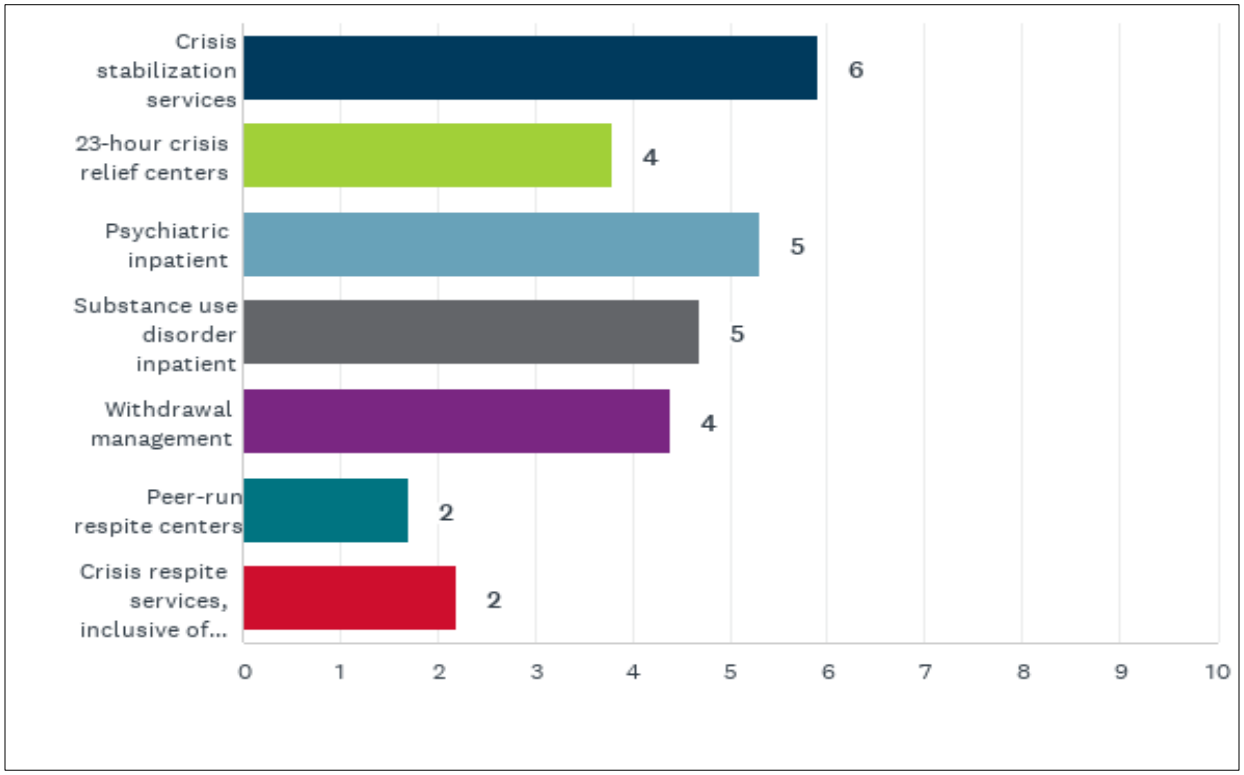


* Graph represented in weighted average

Q10: Which of the following behavioral health bed types should be included in a behavioral health bed registry? (Please rank the options below in order of priority)

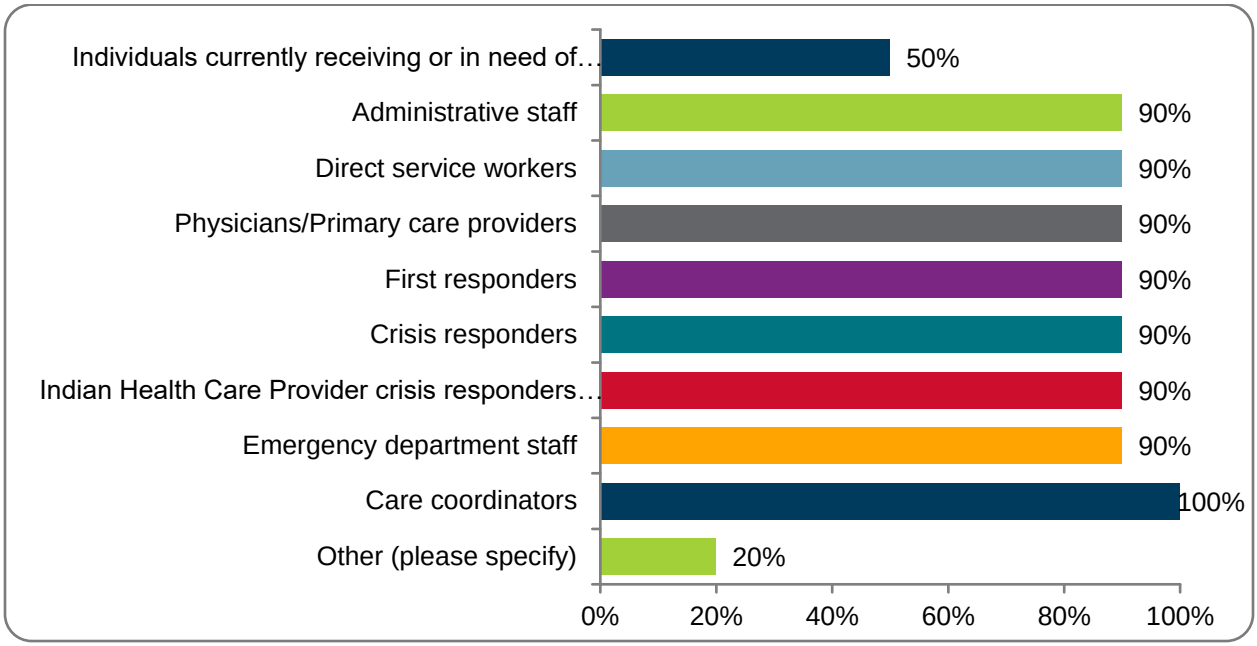
The top five BH bed types identified by the interested parties were:

1. Crisis stabilization services
2. Psychiatric inpatient
3. SUD inpatient
4. Withdrawal management
5. 23-hour crisis relief centers



* Graph represented in weighted average

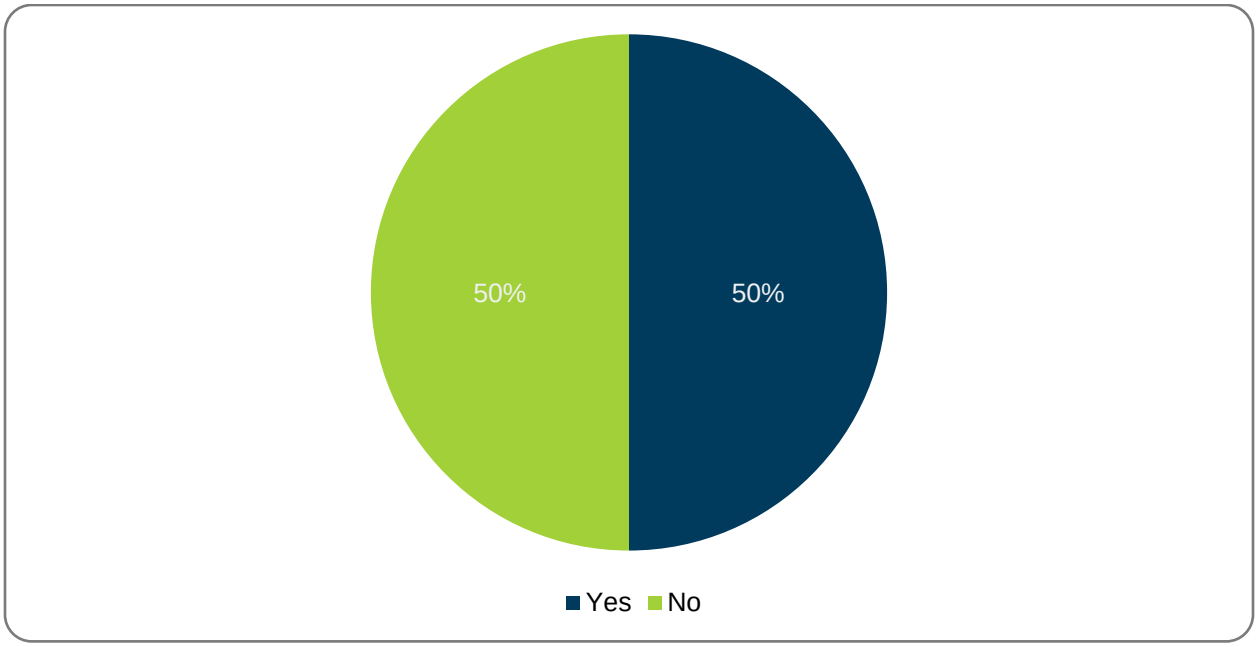
Q12: Who should have access to some or all of the behavioral health bed registry? (Select all that apply*)



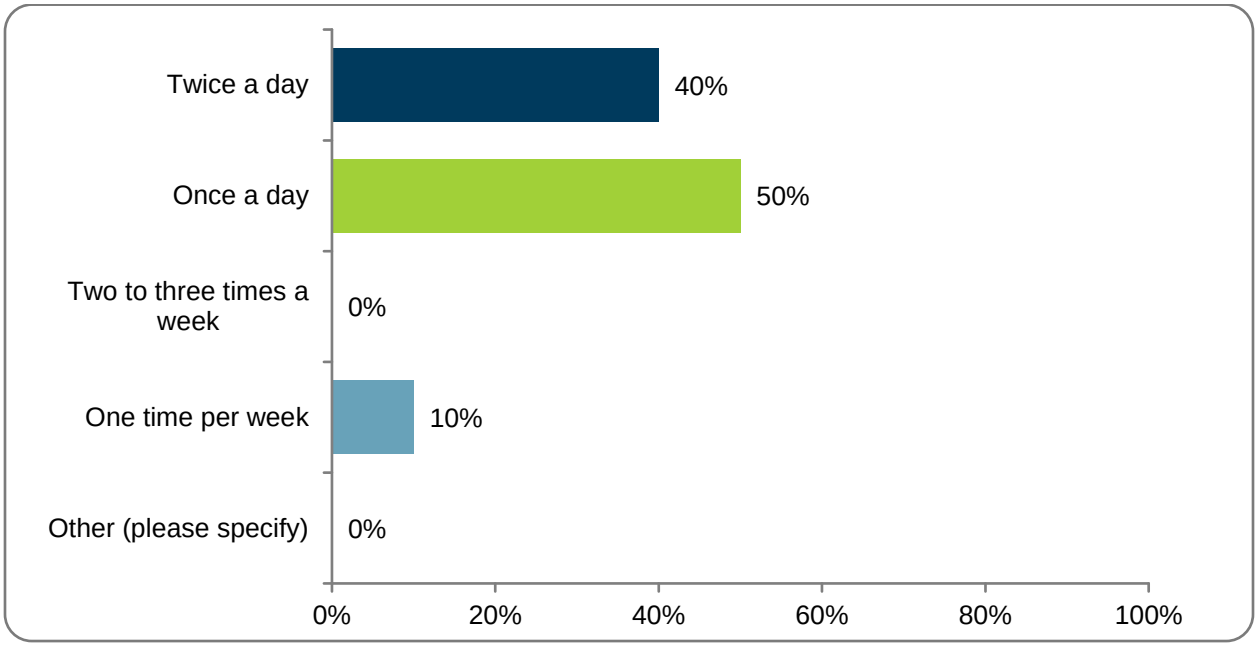
*In this question, survey respondents had an option to select more than one response for which the total percentage is over 100.

Survey responses indicated limiting access to the BH bed registry based on staff member role.

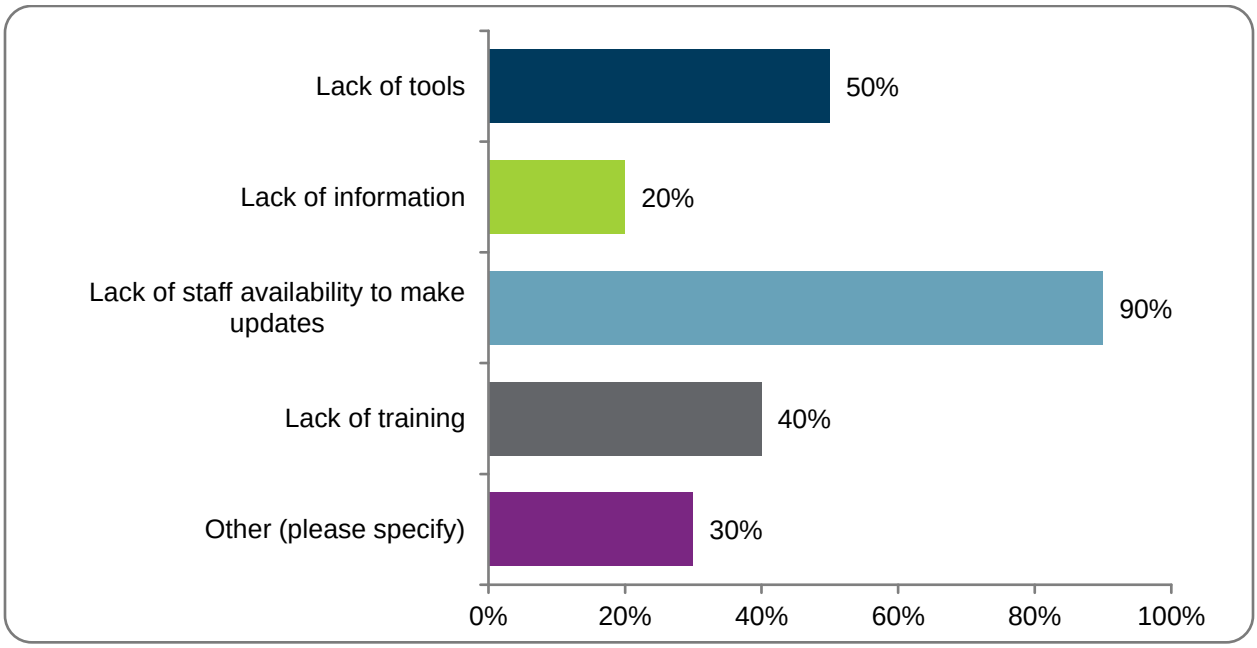
Q13: Should individuals in crisis and/or their family members have access to a behavioral health bed registry?



Q15: What is the desired cadence/frequency for providers to update the behavioral health bed registry?



Q16: What potential barriers do you foresee with providers updating the behavioral health bed registry? (Select all that apply*)



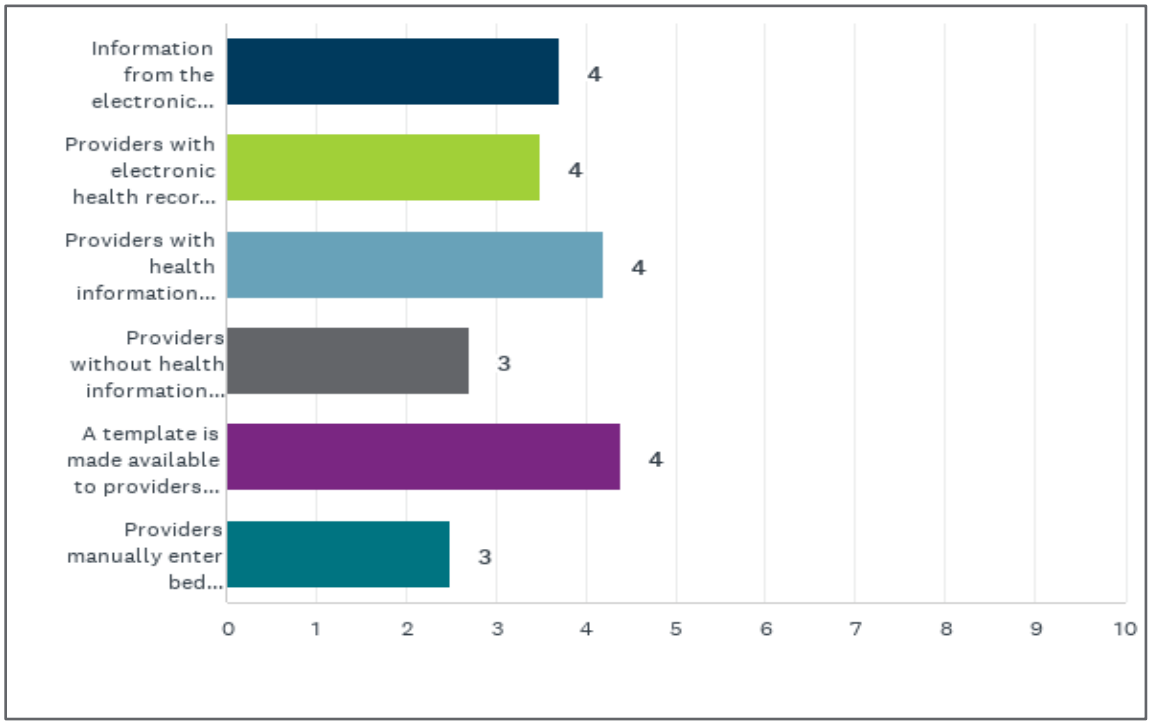
*In this question, survey respondents had an option to select more than one response for which the total percentage is over 100.

Survey respondents indicated that other potential barriers for providers updating the behavioral health registry included lack of staff managing the referrals from the registry and updating the registry.

Q18: What would be the preferred method(s) for how the information within the behavioral health bed registry would be updated? (Please rank the options below in order of priority)

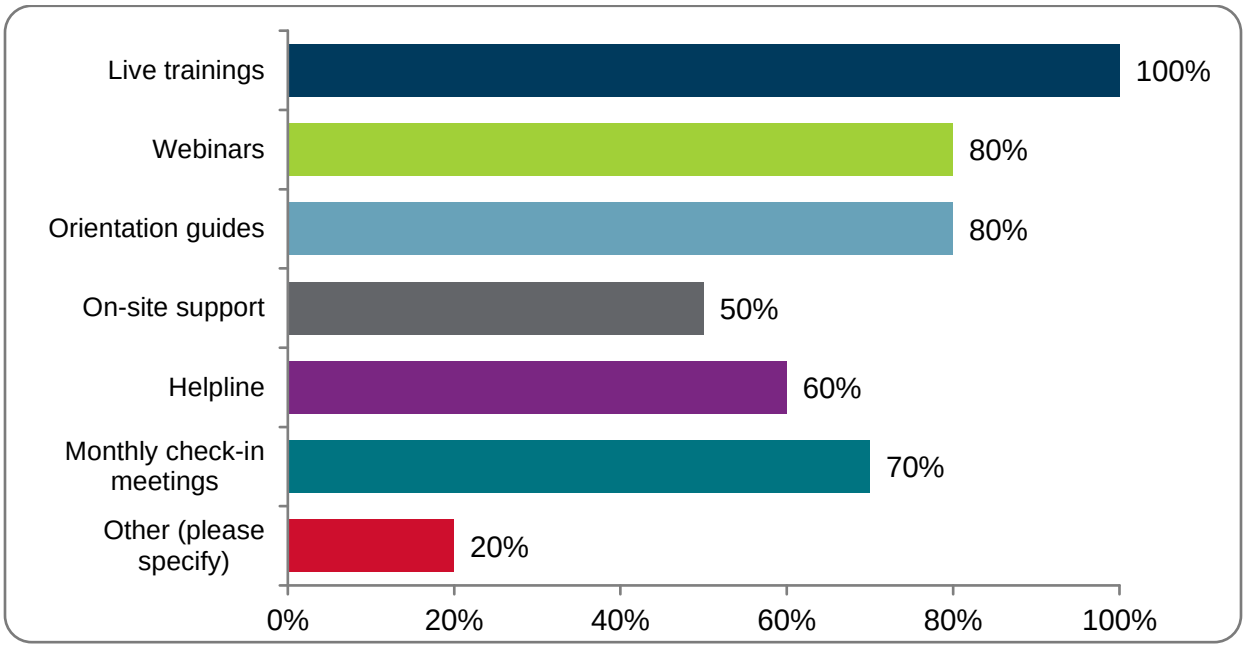
The top five preferred methods for information within the BH bed registry identified by the interested parties were:

1. A template is made available to providers to update bed availability information
2. Providers with health information technology/EHR tools would automatically track and send information about available bed capacity to the behavioral health bed registry
3. Information from the electronic closed-loop referral tool(s) would automatically update a provider's available beds in the behavioral health bed registry when a referral is accepted
4. Providers with EHRs would create ADT summaries when an individual is admitted, discharged, transferred and the ADT would be shared with the registry to update bed availability
5. Providers without health information technology/EHR tools would use spreadsheets (or CSV files) to track bed availability and send information to the behavioral health bed registry



* Graph represented in weighted average

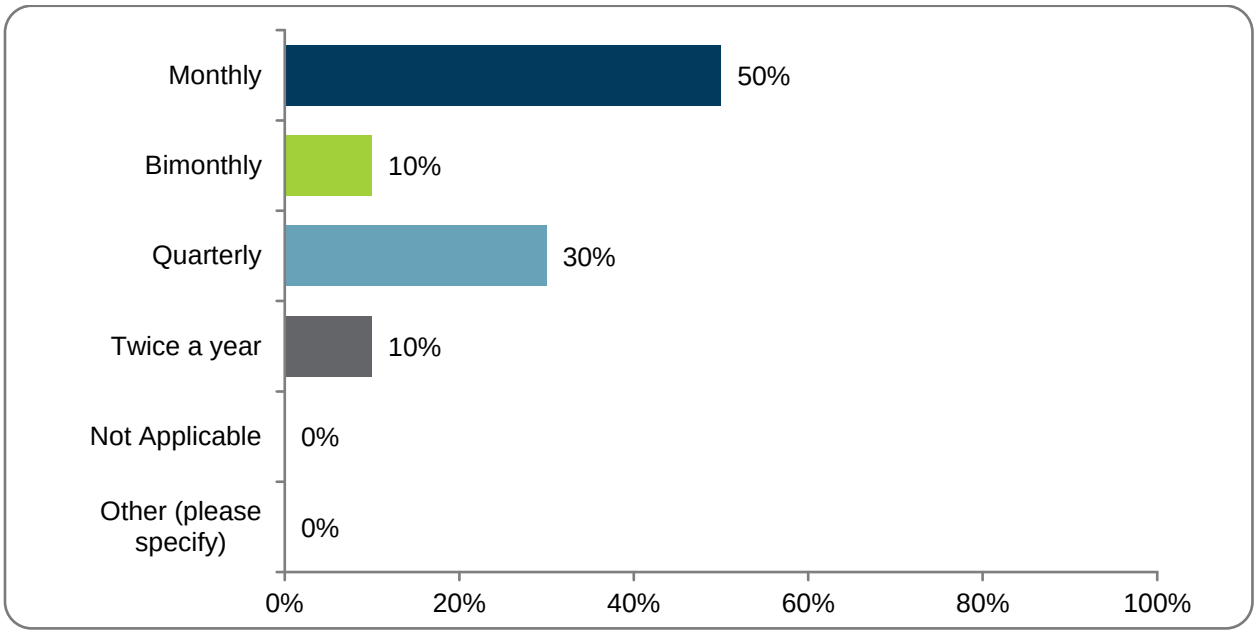
Q19: What support and tools would be helpful for you/your agency to implement a behavioral health bed registry? (Select all that apply*)



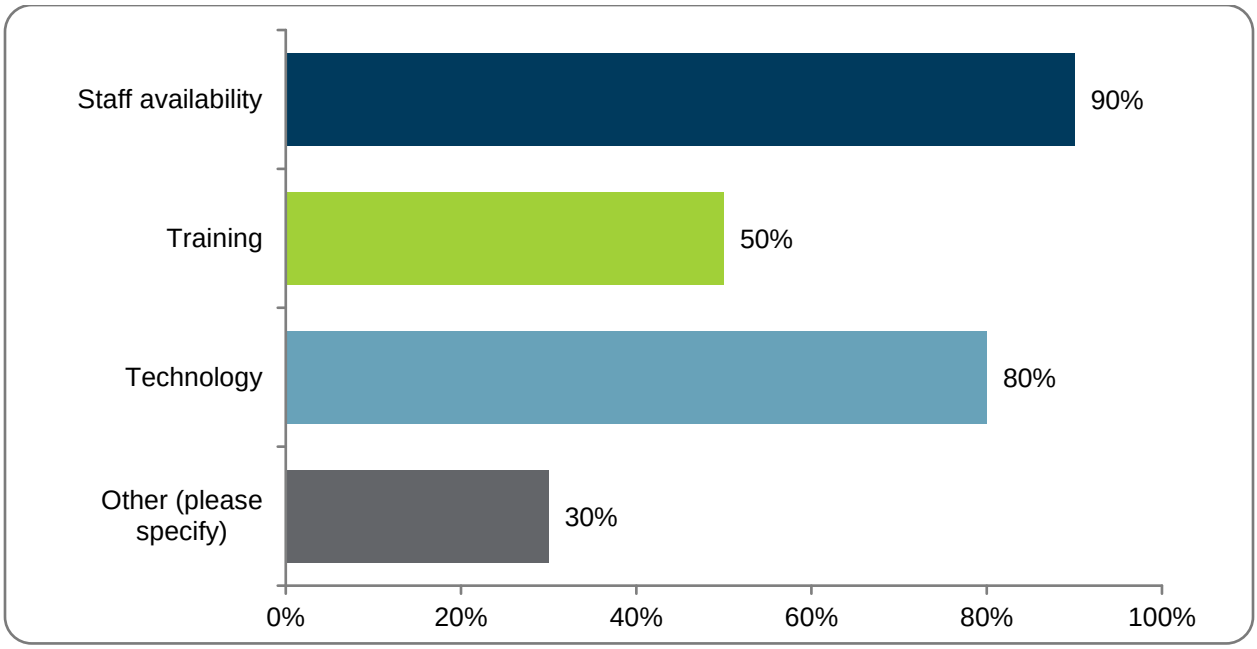
*In this question, survey respondents had an option to select more than one response for which the total percentage is over 100.

Survey respondents indicated that another helpful tool for implementing a behavioral health bed registry would be a 24-hour helpline.

Q20: If you selected live trainings on the previous question, how often should the live trainings be offered to support implementation and use of a behavioral health bed registry?



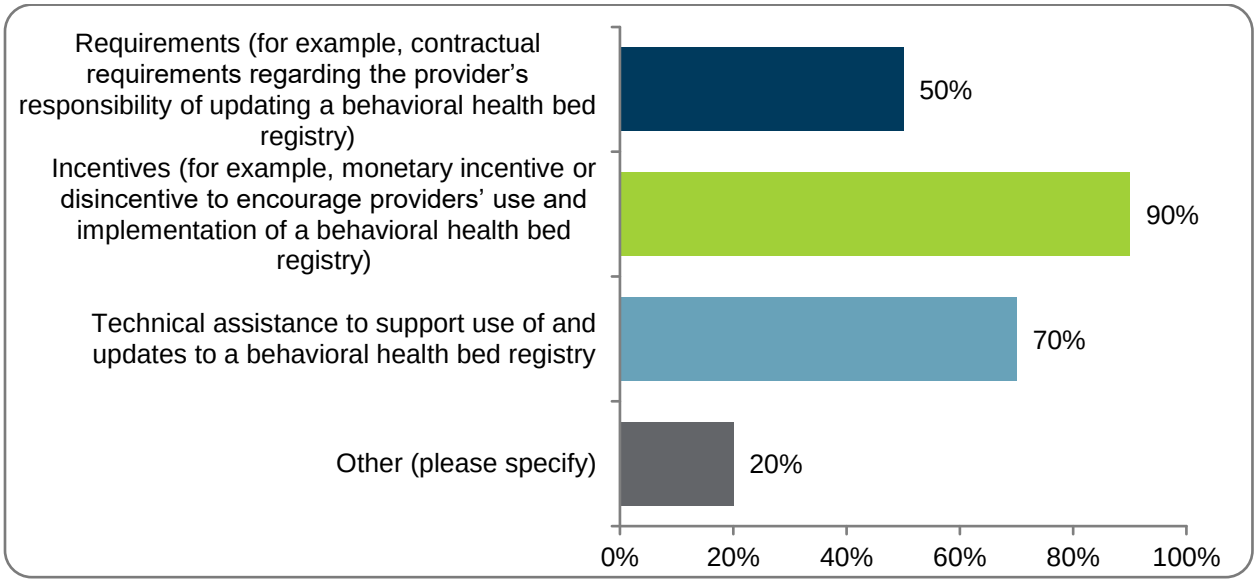
Q21: What barriers do you anticipate regarding the ongoing use and adoption of the behavioral health bed registry? (Select all that apply*)



*In this question, survey respondents had an option to select more than one response for which the total percentage is over 100.

Survey respondents indicated that other anticipated barriers for the use and adoption of the behavioral health bed registry were cost, administrative burden, and the system not reflecting the services being provided.

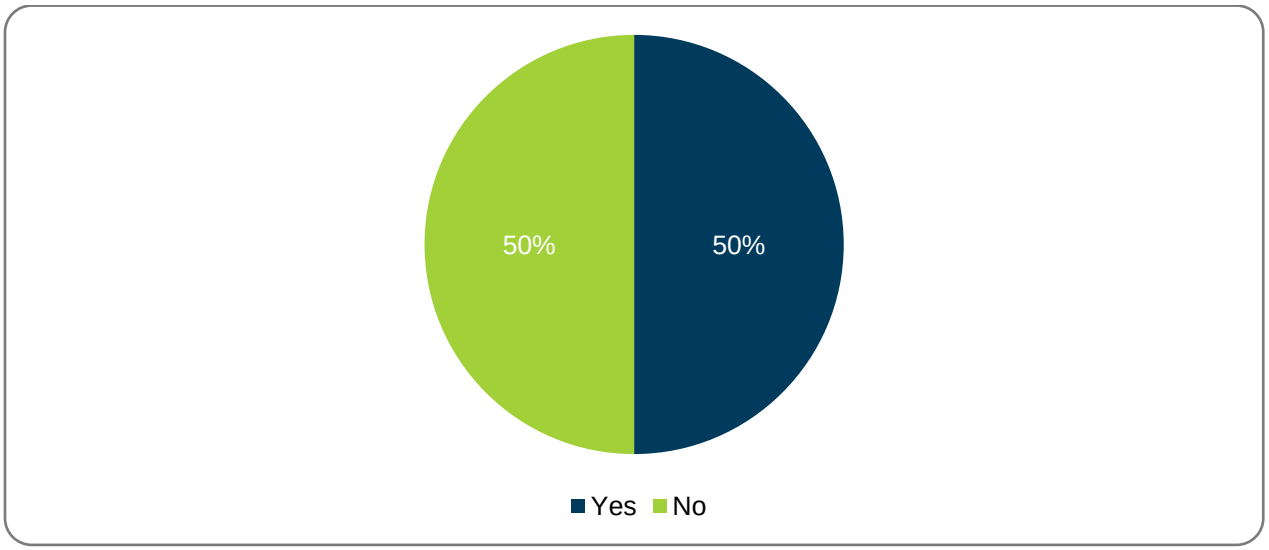
Q22: Which of the following do you think would support the implementation of a behavioral health bed registry? (Select all that apply*)



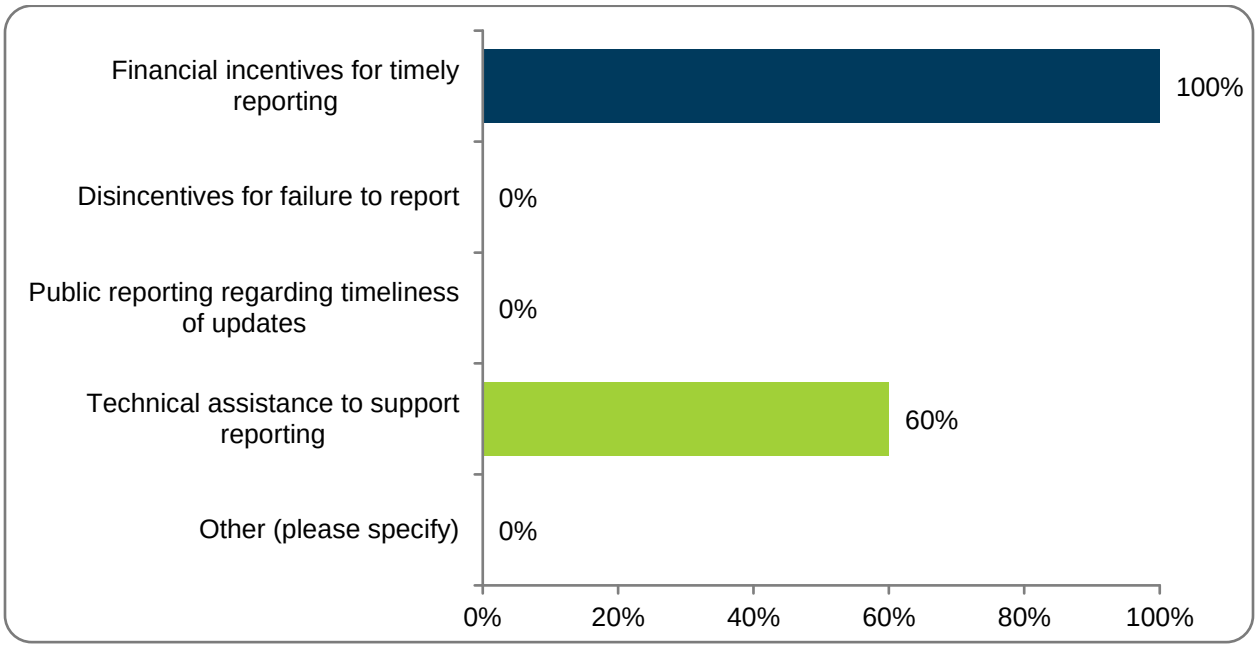
*In this question, survey respondents had an option to select more than one response for which the total percentage is over 100.

Survey respondents indicated that other ways to support implementation of a behavioral health bed registry were to promote incentives instead of a requirement and offer financial support to organizations.

Q25: Is enforcement necessary to help ensure compliance with the contractual or licensing requirements?

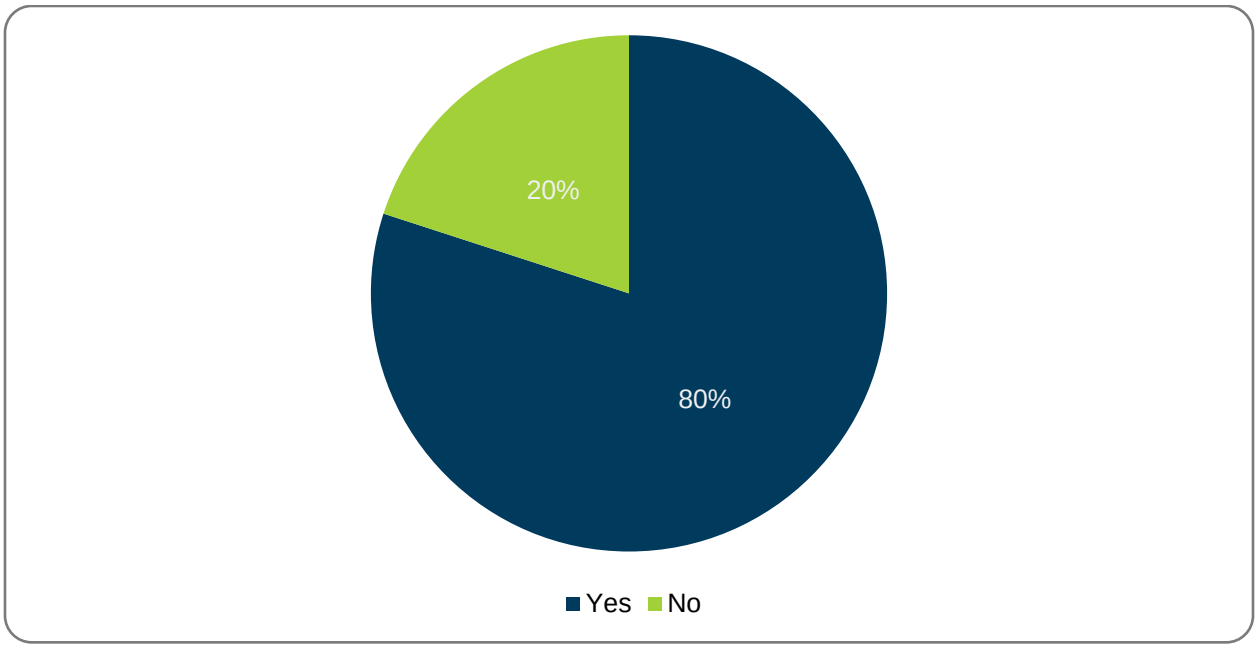


Q26: What types of enforcement would be helpful to support implementation of a behavioral health bed registry? (Select all that apply*)

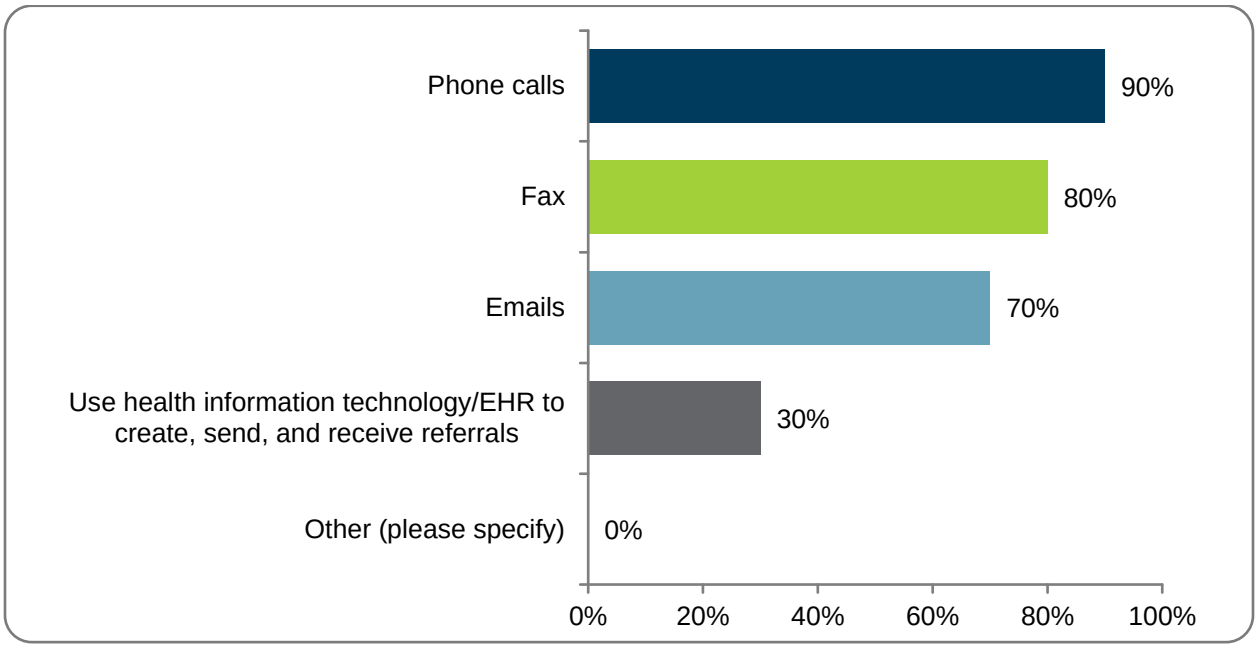


*In this question, survey respondents had an option to select more than one response for which the total percentage is over 100.

Q28: Does your organization/program have system(s) in place to send and receive referrals?

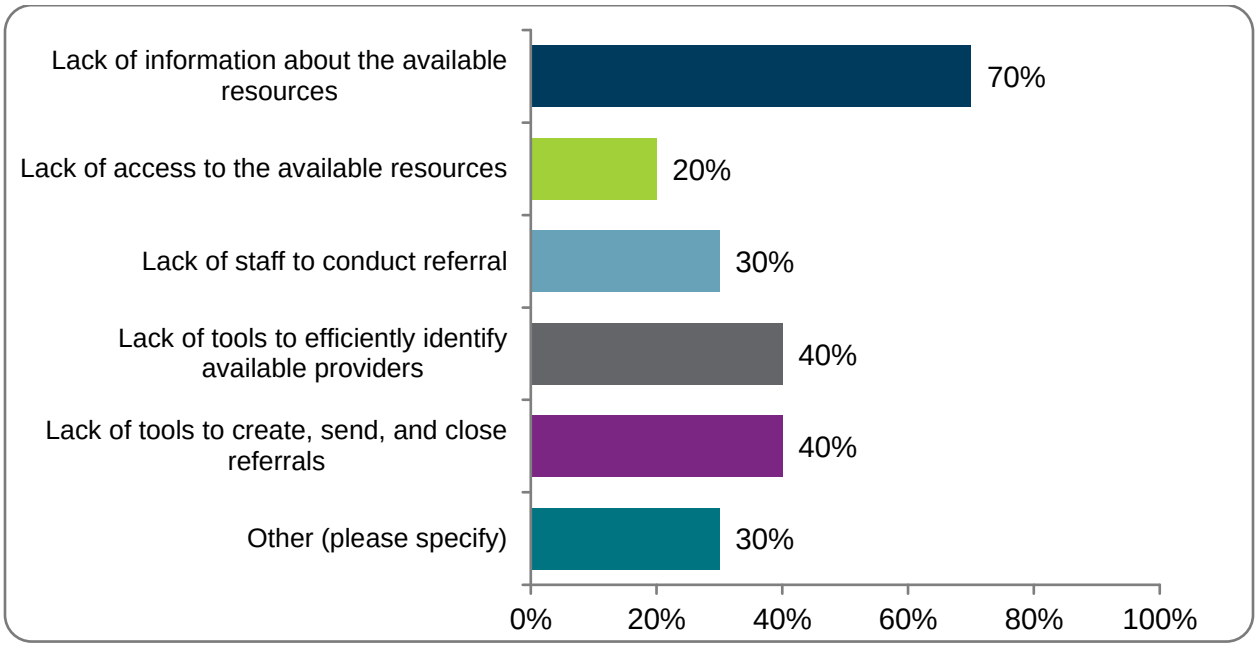


Q30: Which of the following describes how you/your agency makes referrals in the current environment? (Select all that apply*)



*In this question, survey respondents had an option to select more than one response for which the total percentage is over 100.

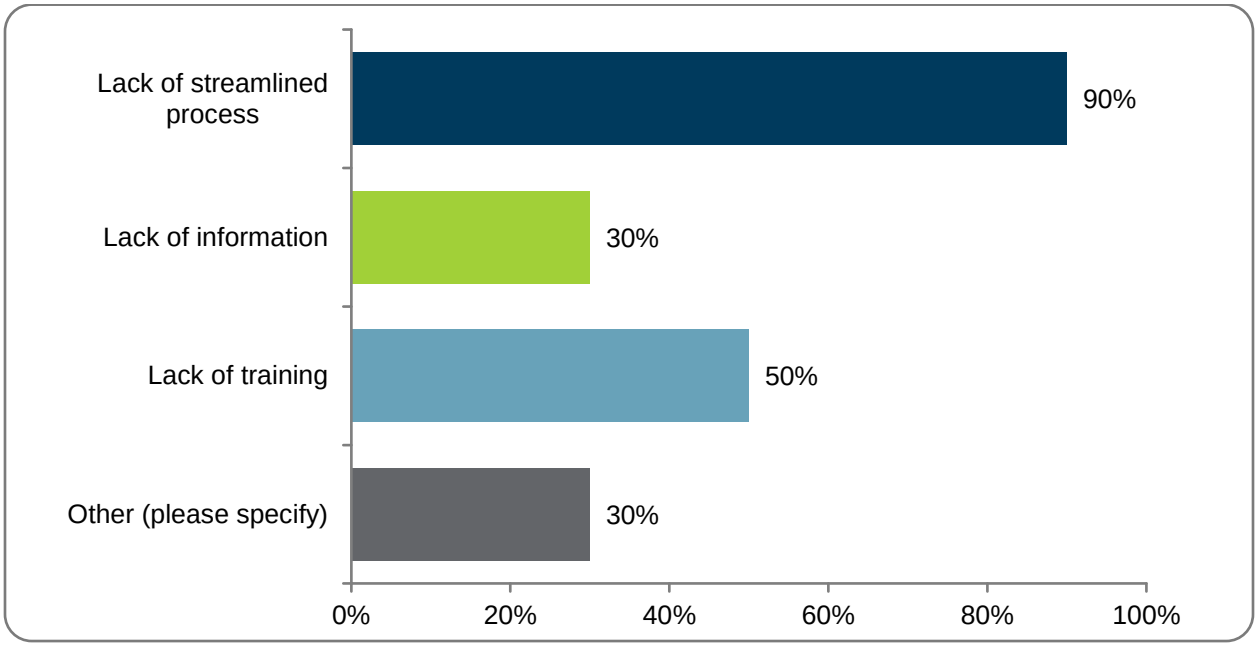
Q31: What are the challenges with the current referral process? (Select all that apply*)



*In this question, survey respondents had an option to select more than one response for which the total percentage is over 100.

Survey respondents indicated that other challenges with the current referral process include lack of knowledge on pending admissions/discharges and DCRs ending the referral before the referral has been “vetted.”

Q32: What challenges do you anticipate in the use and adoption of electronic referral tools? (Select all that apply*)

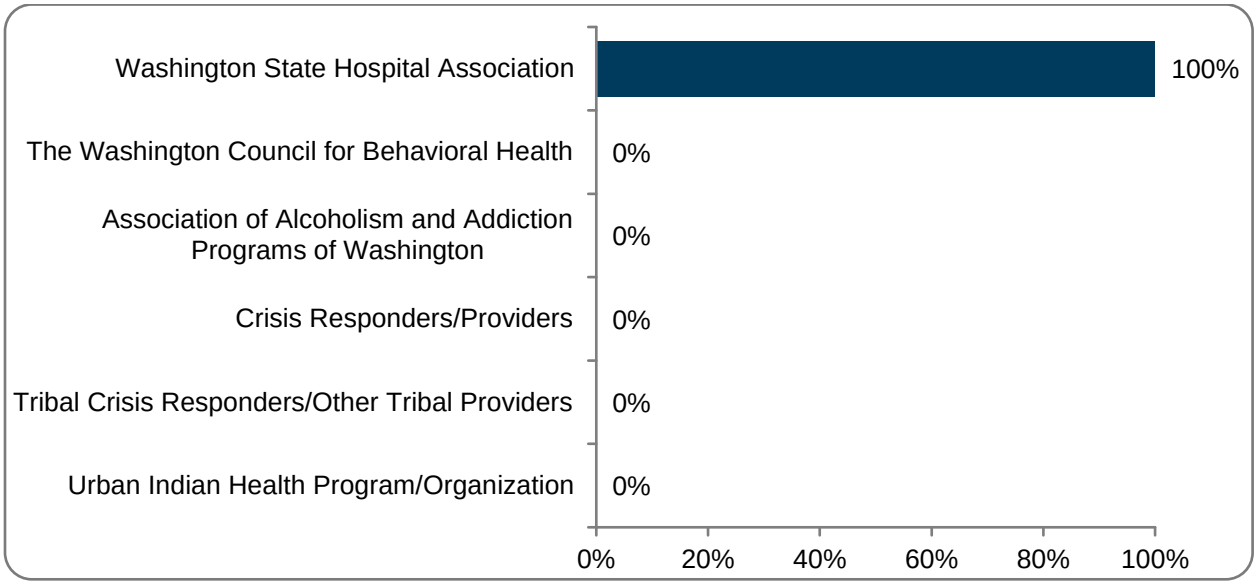


*In this question, survey respondents had an option to select more than one response for which the total percentage is over 100.

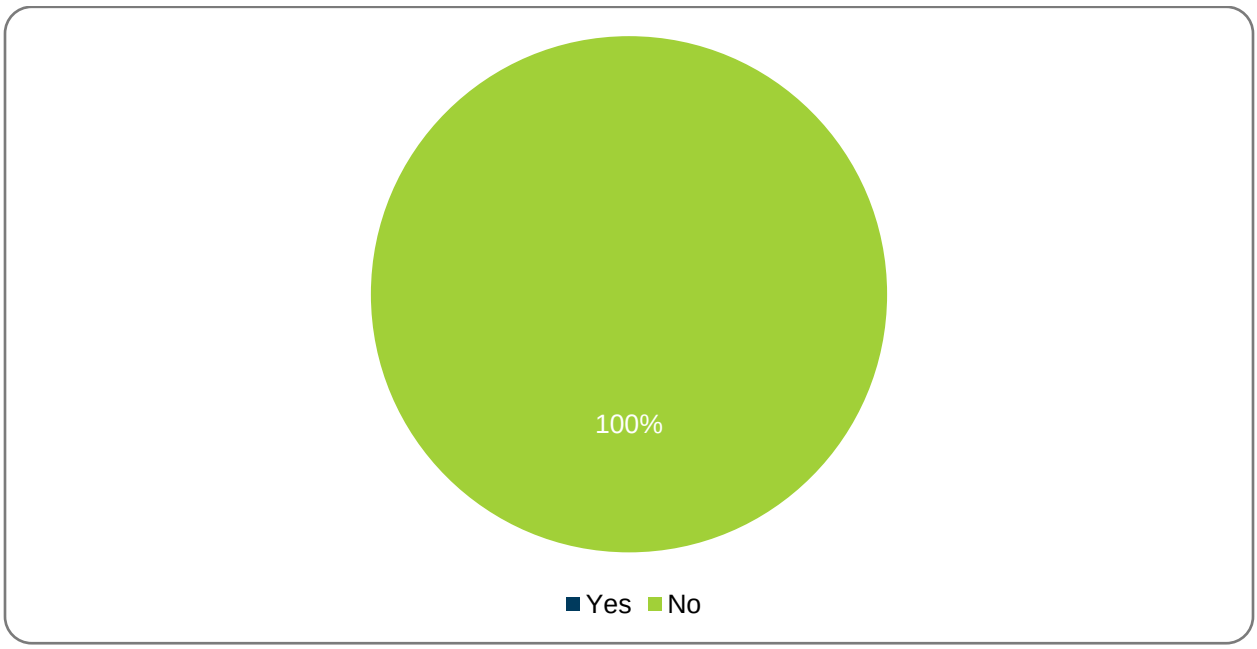
Survey respondents indicated that other anticipated challenges for using electronic referral tools include a lack of statewide participation and the development of another system when one is already available.

The Washington State Hospital Association Web Survey Results

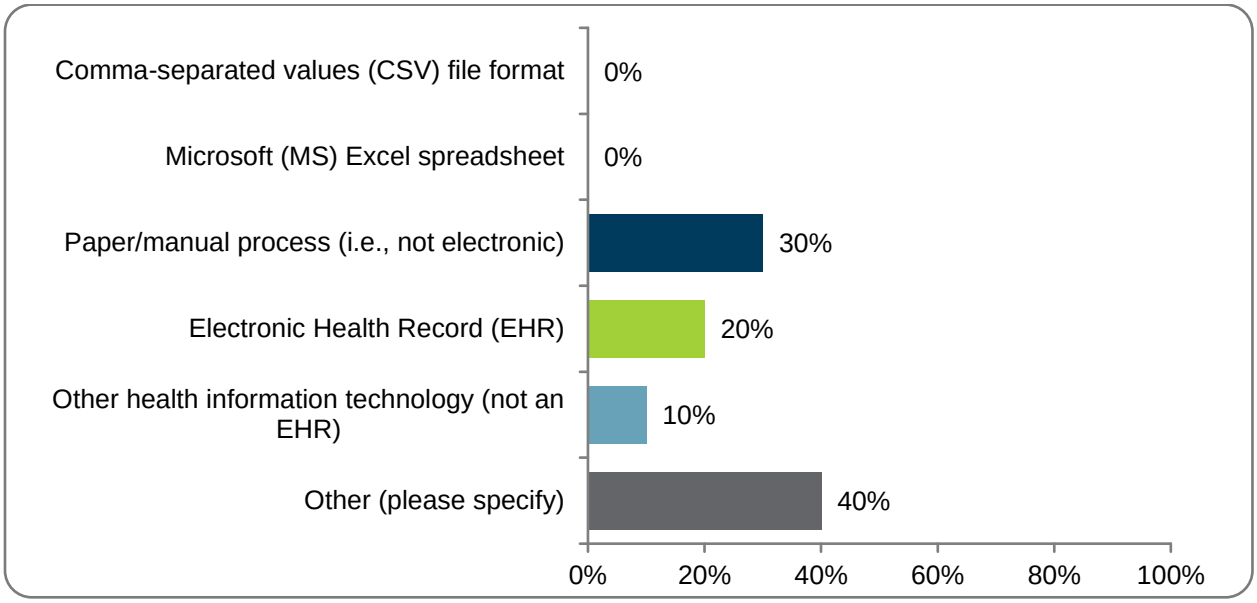
Q1: Which of the following best describes your organizational affiliation?



Q2: Does your organization/program have system(s) in place to track behavioral health bed availability?

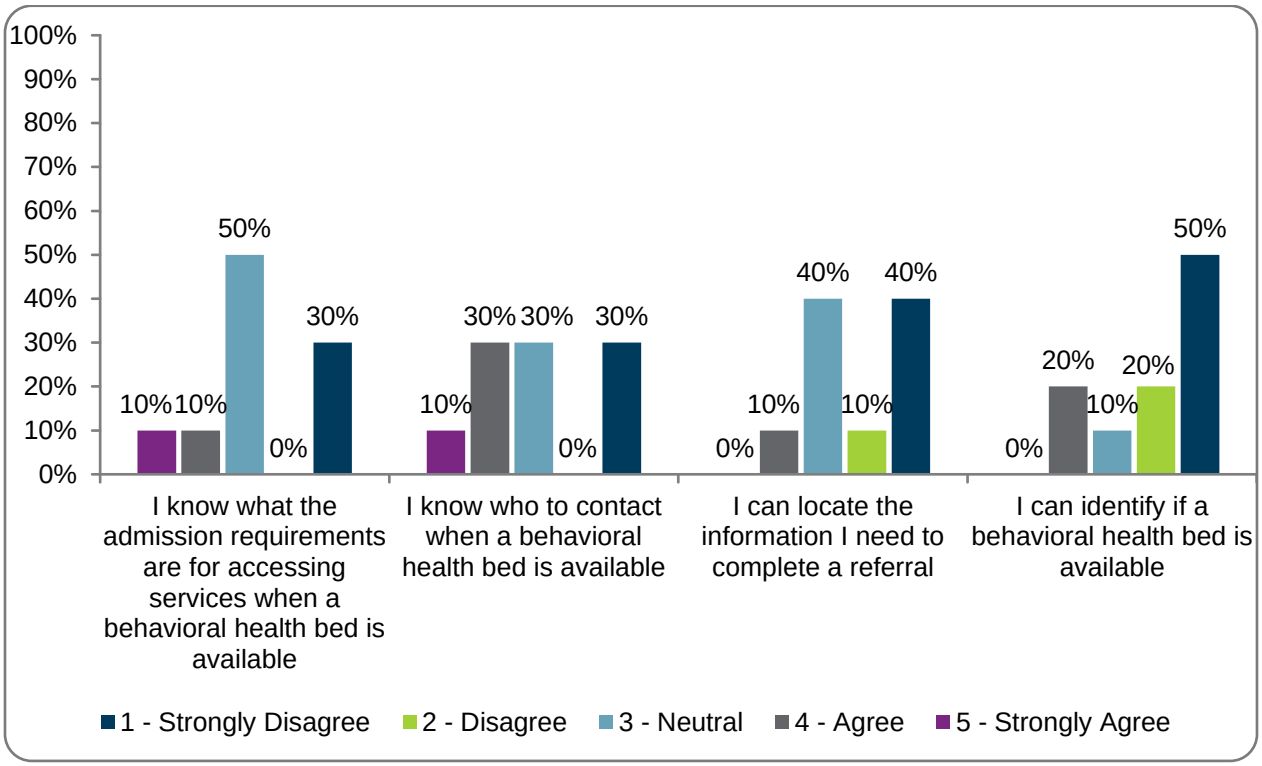


Q5: Which of the following describes how you/your agency currently track behavioral health bed availability in your facility?

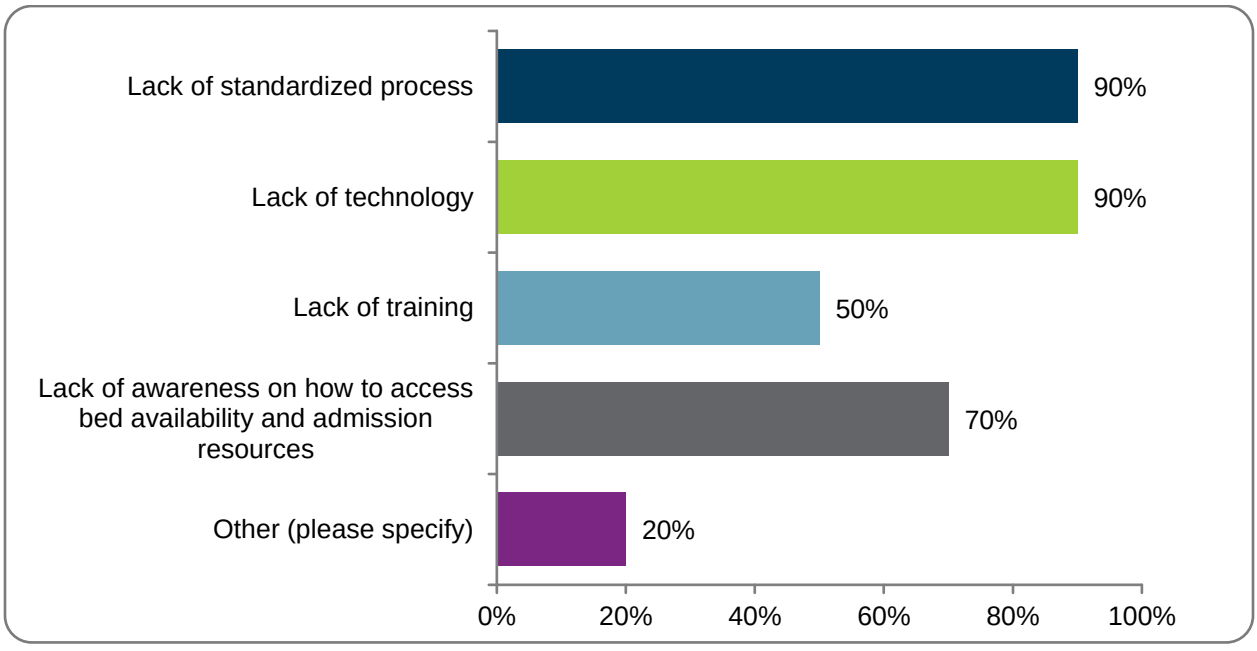


Survey respondents indicated that other methods for tracking behavioral health availability currently include verbally with DCRs, WA Track, and bed meetings twice a day where units report their bed availability.

Q6: Please rate each of the following using a scale of 1 to 5 with 1 being strongly disagree and 5 being strongly agree:



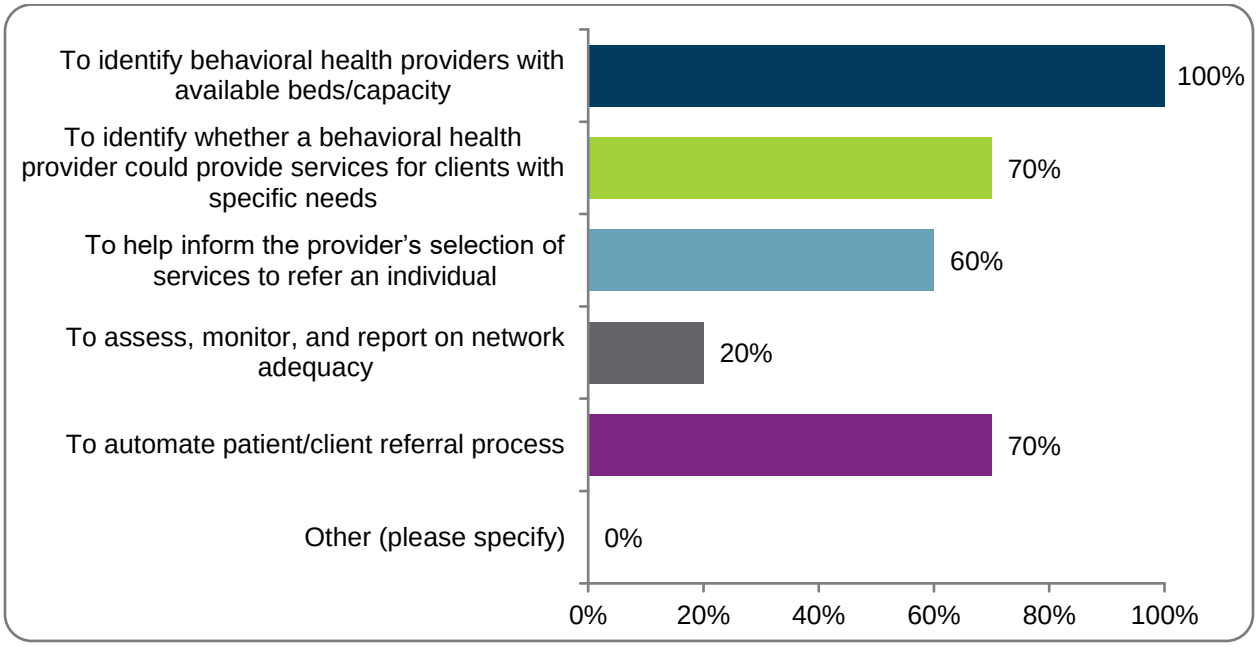
Q7: What are the challenges with the current process (i.e., paper-based or electronic) to identify and access behavioral health bed availability? (Select all that apply*)



*In this question, survey respondents had an option to select more than one response for which the total percentage is over 100.

Survey respondents indicated that another challenge with tracking behavioral health bed availability includes calling individual units for bed availability.

Q8: Which of the following describes how you/your agency would use a behavioral health bed registry? (Select all that apply*)

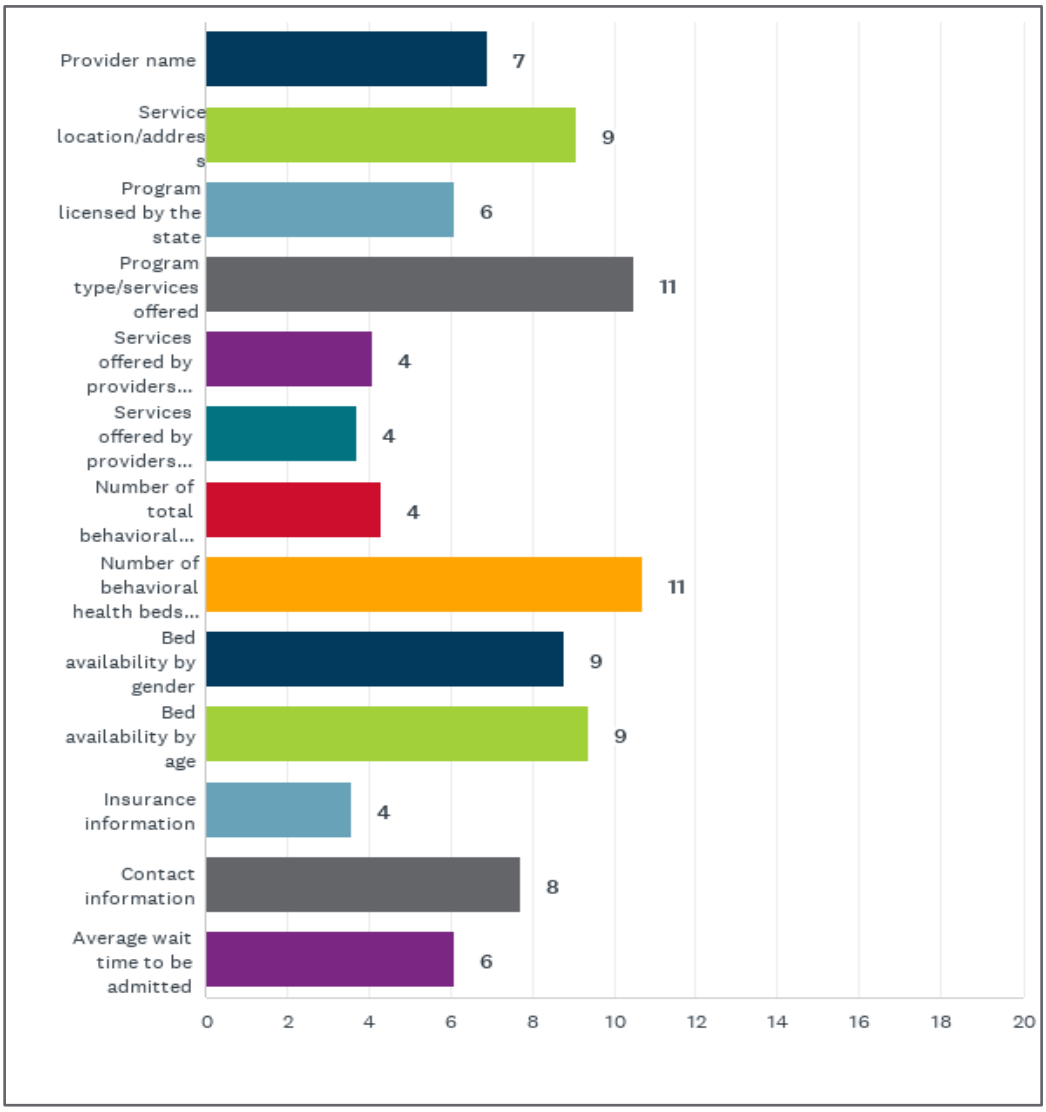


*In this question, survey respondents had an option to select more than one response for which the total percentage is over 100.

Q9: Indicate which of the following information/content is necessary to include in the behavioral health bed registry? (Please rank the options below in order of priority)

The top-five priority list identified by the interested parties was:

1. Program type/services offered
2. Number of BH beds available
3. Service location/address
4. Bed availability by age
5. Bed availability by gender

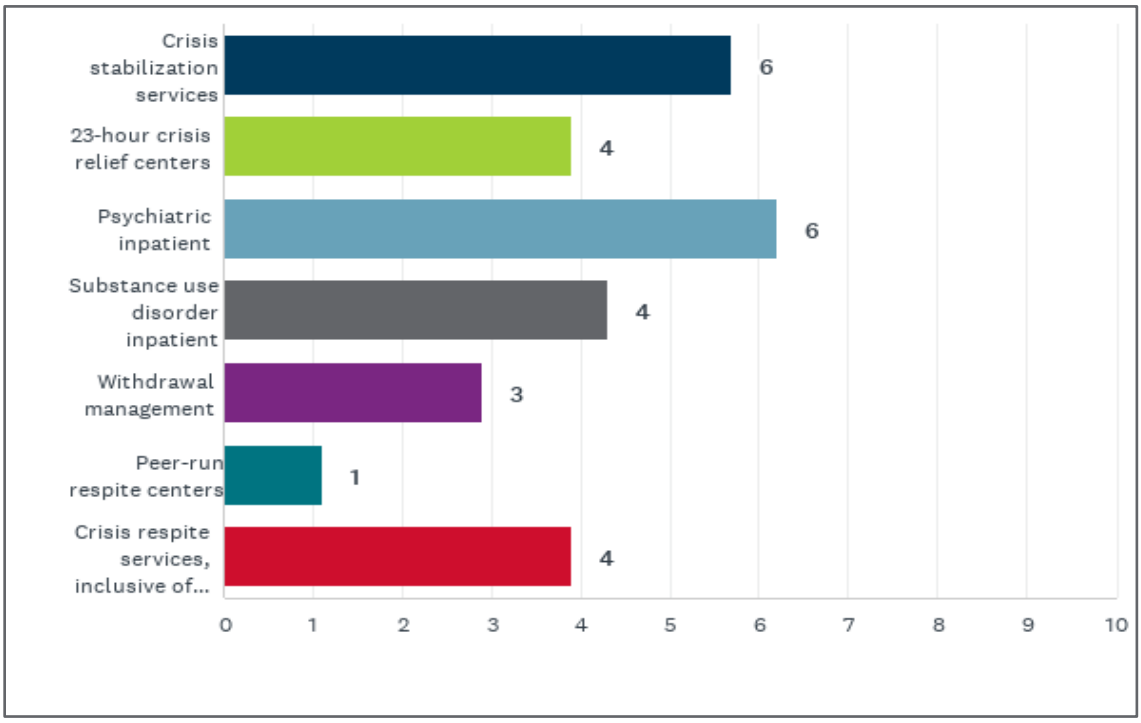


* Graph represented in weighted average

Q10: Which of the following behavioral health bed types should be included in a behavioral health bed registry? (Please rank the options below in order of priority)

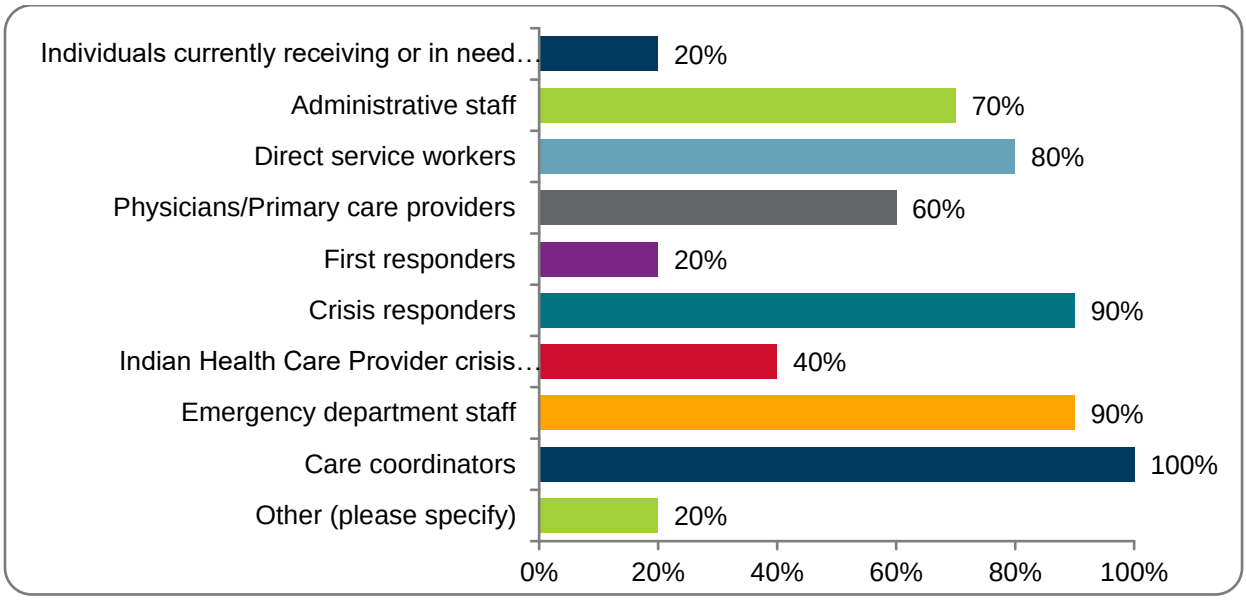
The top five BH bed types identified by the interested parties were:

1. Psychiatric inpatient
2. Crisis stabilization services
3. SUD inpatient
4. 23-hour crisis relief centers
5. Crisis respite services, inclusive of both voluntary and involuntary beds



* Graph represented in weighted average

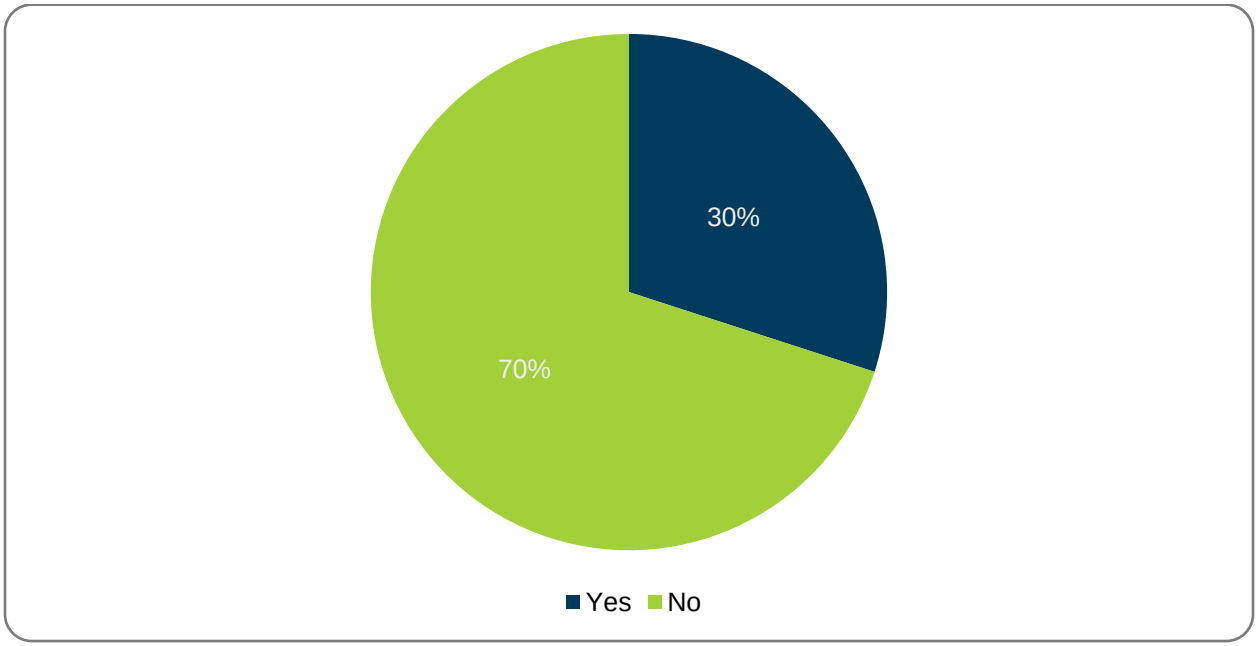
Q12: Who should have access to some or all of the behavioral health bed registry? (Select all that apply*)



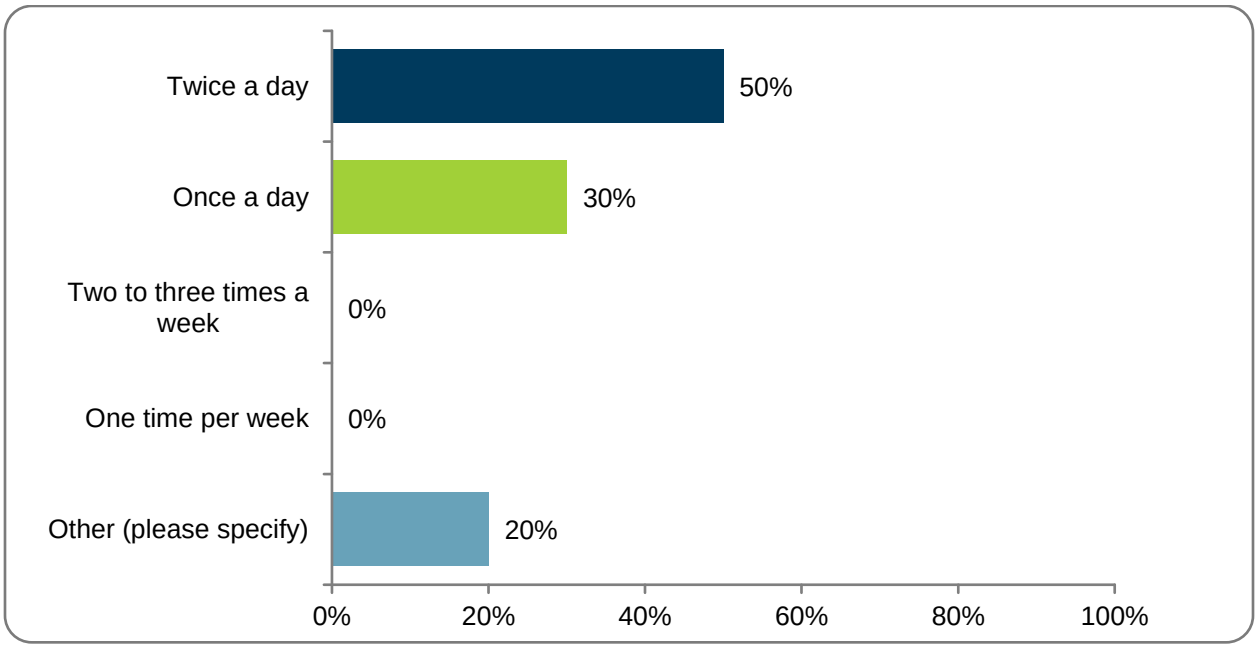
*In this question, survey respondents had an option to select more than one response for which the total percentage is over 100.

Survey respondents indicated that other individuals who should have access to the behavioral health bed registry include all providers and facilities.

Q13: Should Individuals in crisis and/or their family members have access to a behavioral health bed registry?

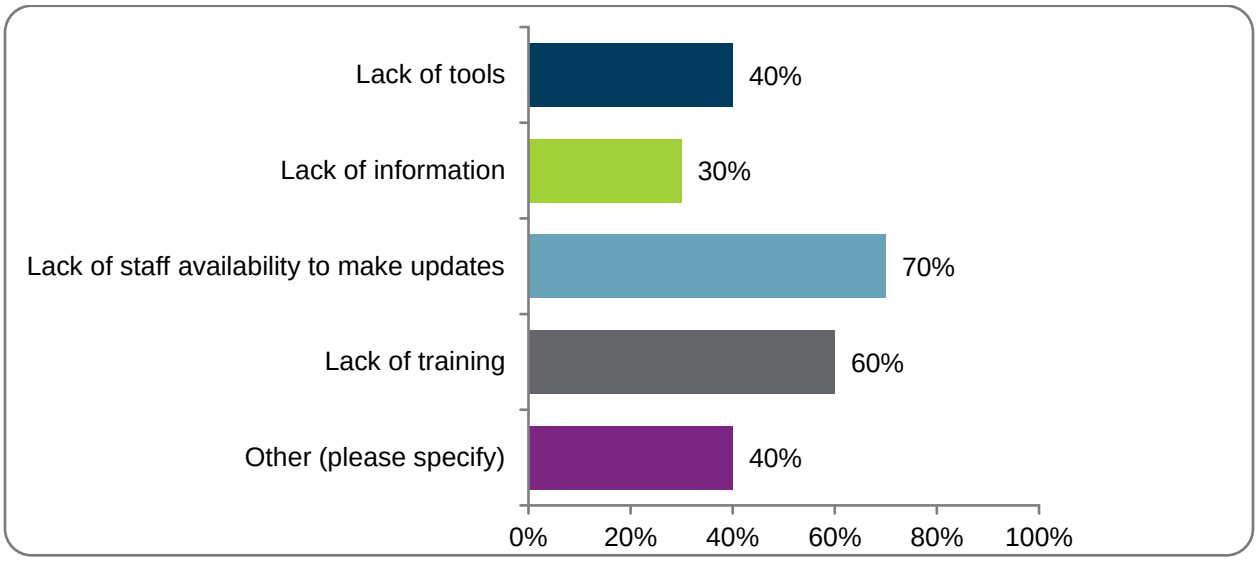


Q15: What is the desired cadence/frequency for providers to update the behavioral health bed registry?



Survey respondents indicated other desired cadences to update the behavioral health bed registry include three to four times a day.

Q16: What potential barriers do you foresee with providers updating the behavioral health bed registry? (Select all that apply*)



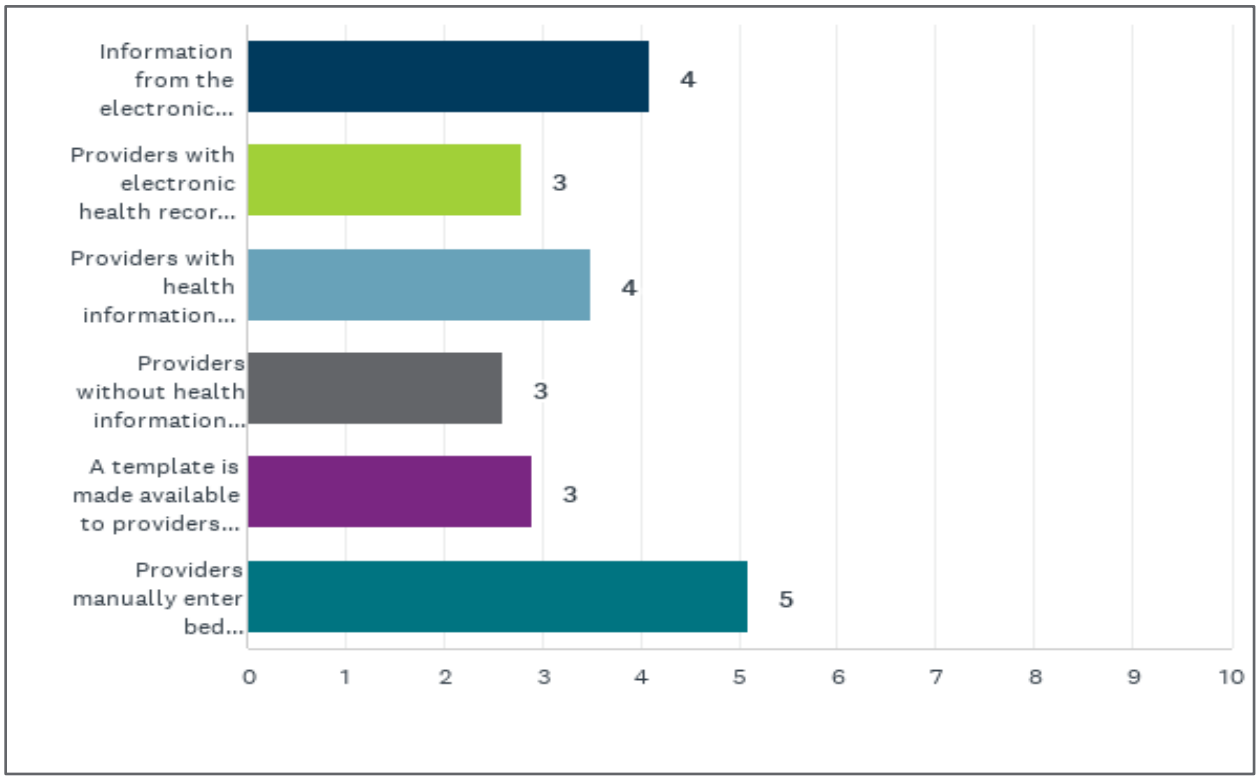
*In this question, survey respondents had an option to select more than one response for which the total percentage is over 100.

Survey respondents indicated that other potential barriers for providers updating the behavioral health bed registry include staff turnover, inappropriate referrals, and the ease to update the BH bed registry.

Q18: What would be the preferred method(s) for how the information within the behavioral health bed registry would be updated? (Please rank the options below in order of priority)

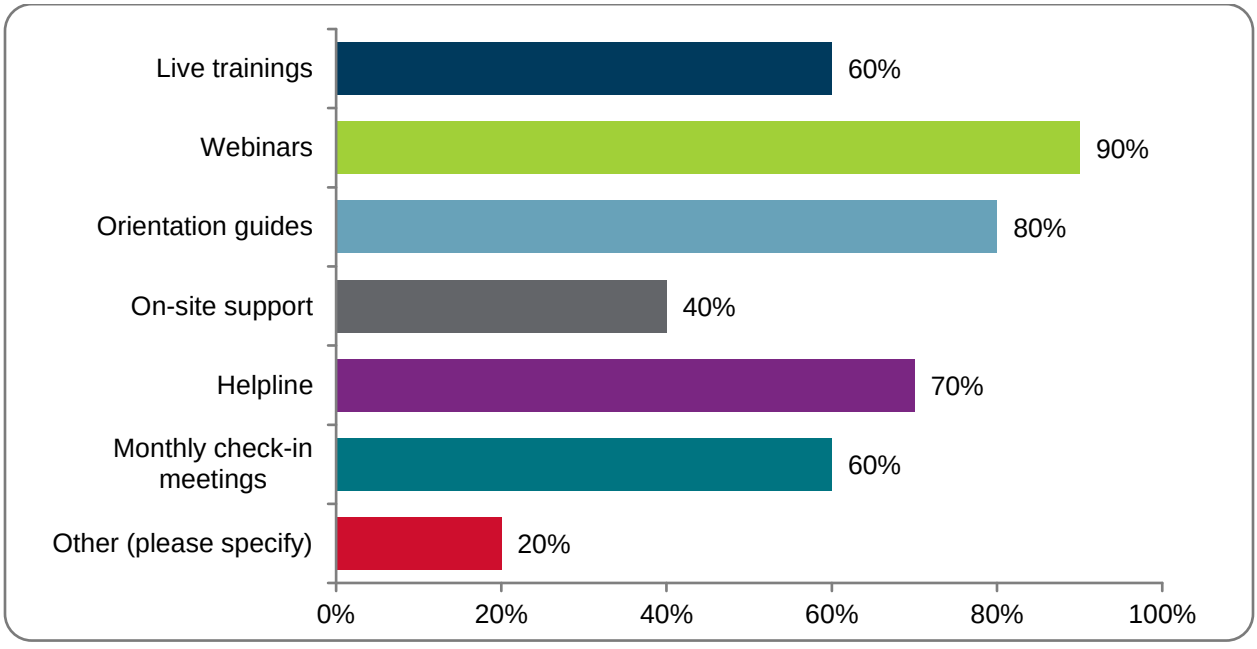
The top five preferred methods for information within the BH bed registry identified by the interested parties were:

1. Providers manually enter bed availability into the web-based behavioral health bed registry at a pre-determined cadence (e.g., once a day)
2. Information from the electronic closed-loop referral tool(s) would automatically update a provider's available beds in the behavioral health bed registry when a referral is accepted
3. Providers with health information technology/EHR tools would automatically track and send information about available bed capacity to the behavioral health bed registry
4. A template is made available to providers to update bed availability information
5. Providers with EHRs would create ADT summaries when an individual is admitted, discharged, transferred and the ADT would be shared with the registry to update bed availability



* Graph represented in weighted average

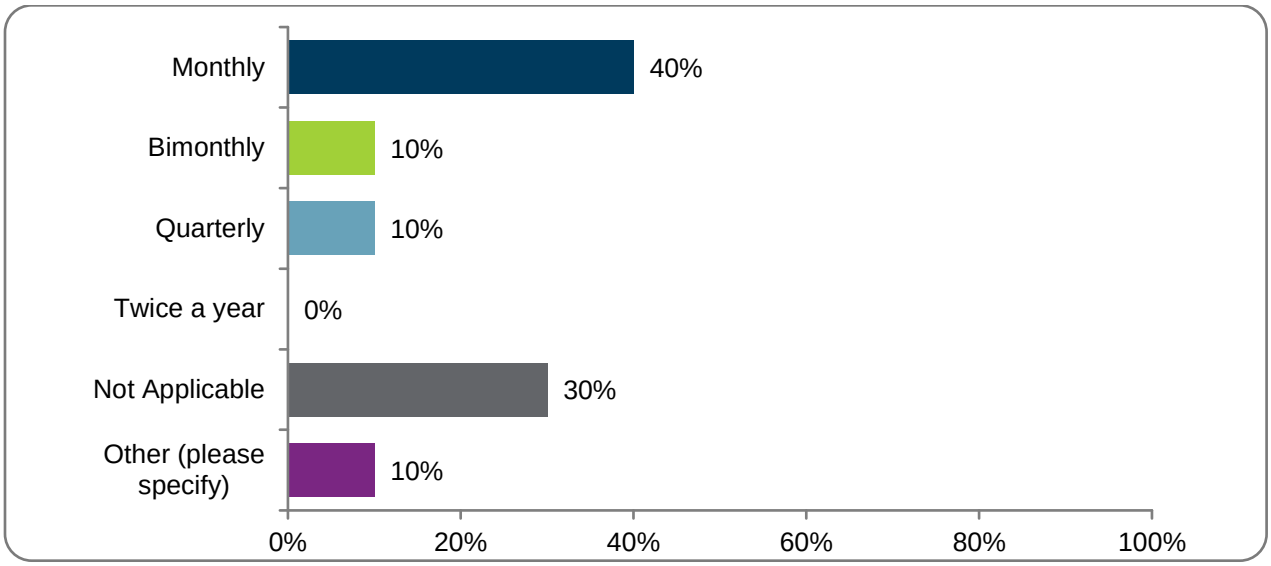
Q19: What support and tools would be helpful for you/your agency to implement a behavioral health bed registry? (Select all that apply*)



*In this question, survey respondents had an option to select more than one response for which the total percentage is over 100.

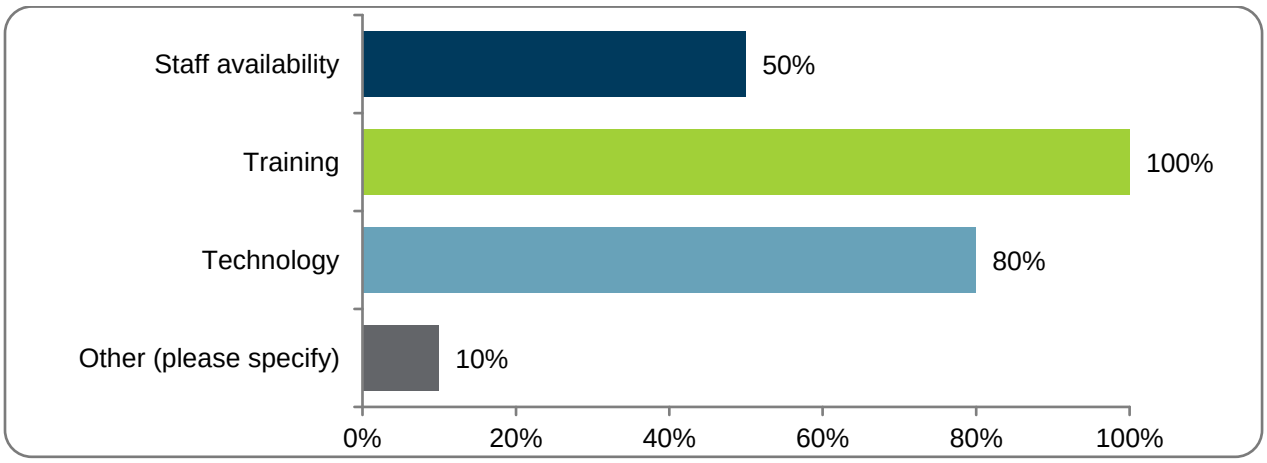
Survey respondents indicated another tool that would help to implement the behavioral health bed registry includes ongoing webinars for new staff.

Q20: If you selected live trainings on the previous question, how often should the live trainings be offered to support implementation and use of a behavioral health bed registry?



Survey respondents indicated that the live trainings should be offered only during the implementation phase.

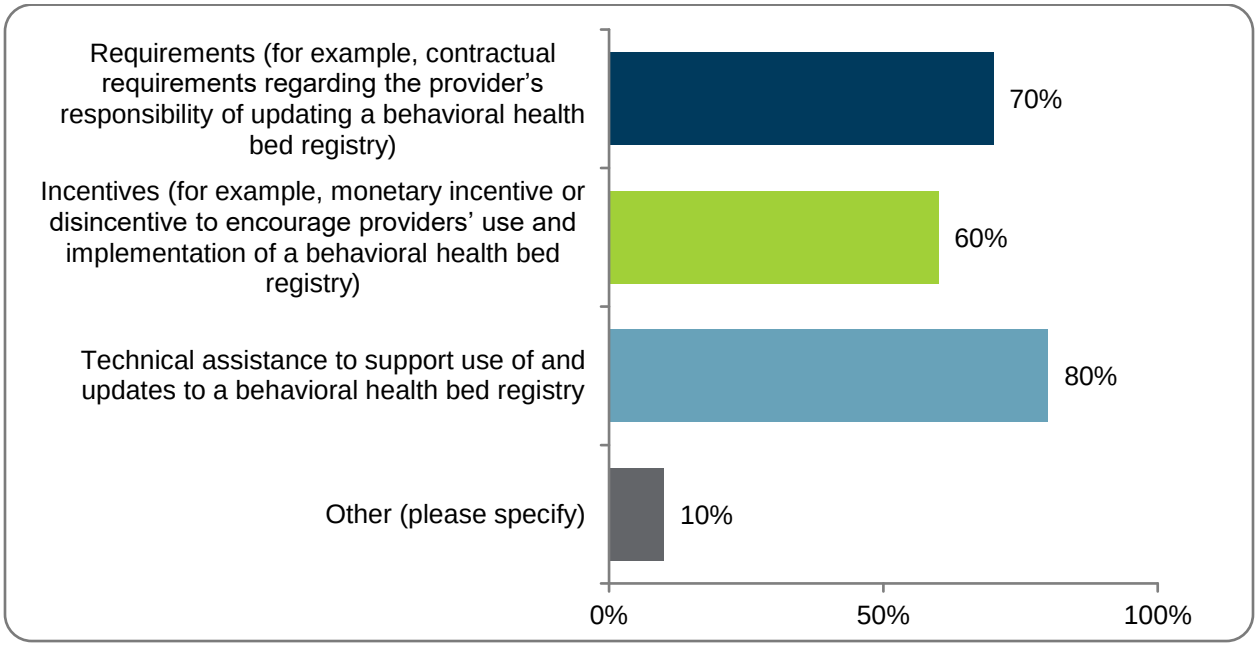
Q21: What barriers do you anticipate regarding the ongoing use and adoption of the behavioral health bed registry? (Select all that apply*)



*In this question, survey respondents had an option to select more than one response for which the total percentage is over 100.

Survey respondents indicated other anticipated barriers for the ongoing use of the behavioral health bed registry include the ease and accessibility of the tool.

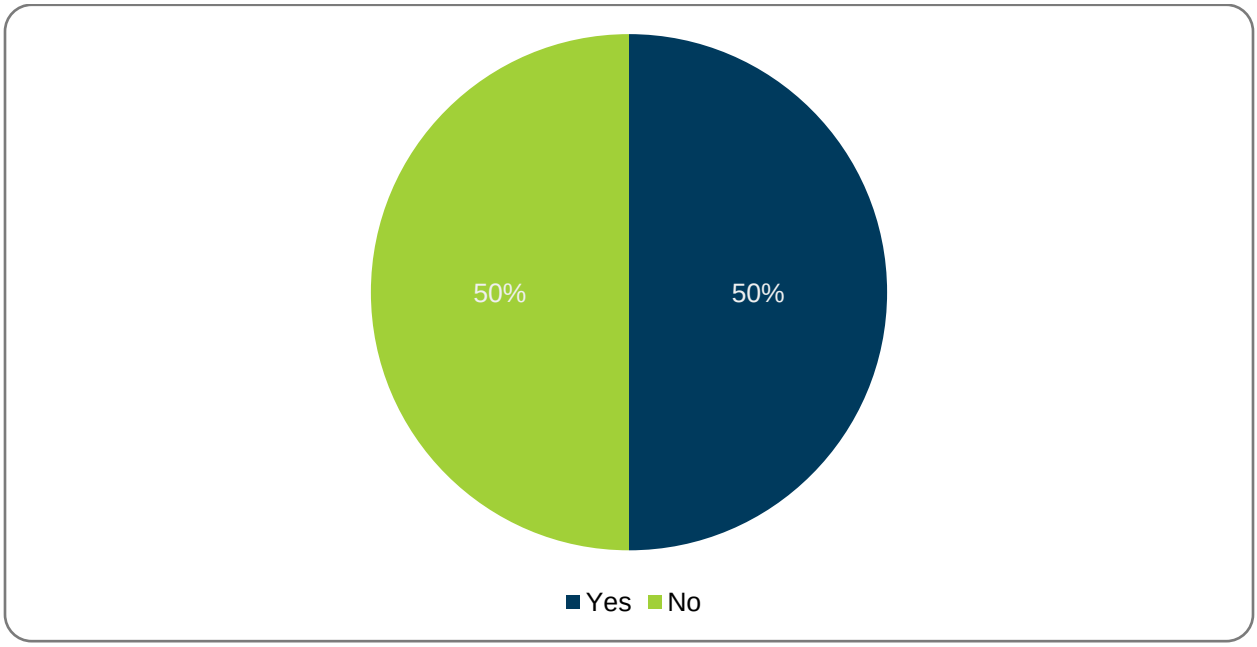
Q22: Which of the following do you think would support the implementation of a behavioral health bed registry? (Select all that apply*)



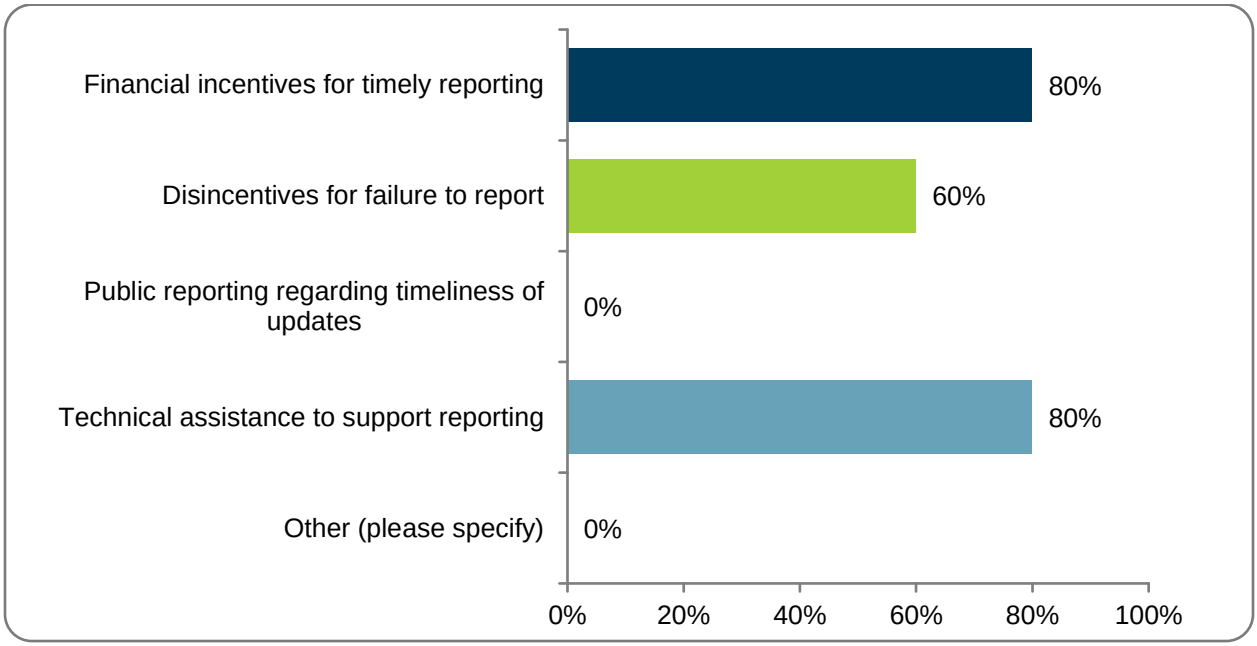
*In this question, survey respondents had an option to select more than one response for which the total percentage is over 100.

Survey respondents indicated other incentives that would support the implementation of the behavioral health bed registry include financial incentives and positive reinforcement.

Q25: Is enforcement necessary to help ensure compliance with the contractual or licensing requirements?

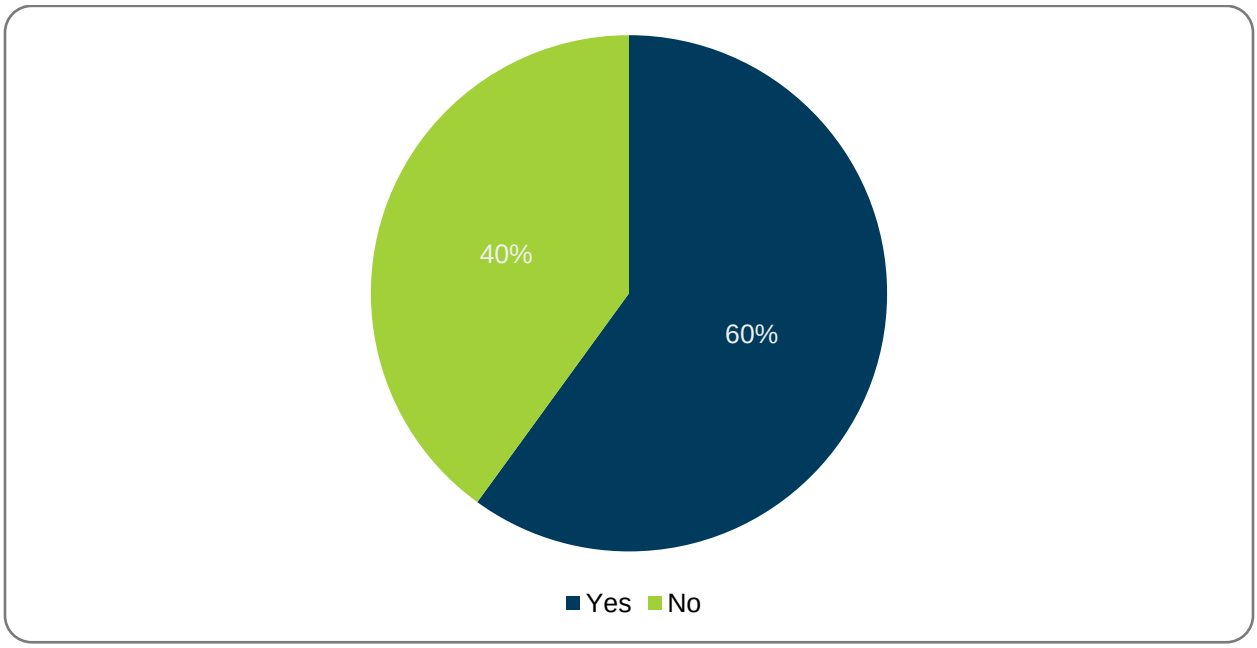


Q26: What types of enforcement would be helpful to support implementation of a behavioral health bed registry? (Select all that apply*)

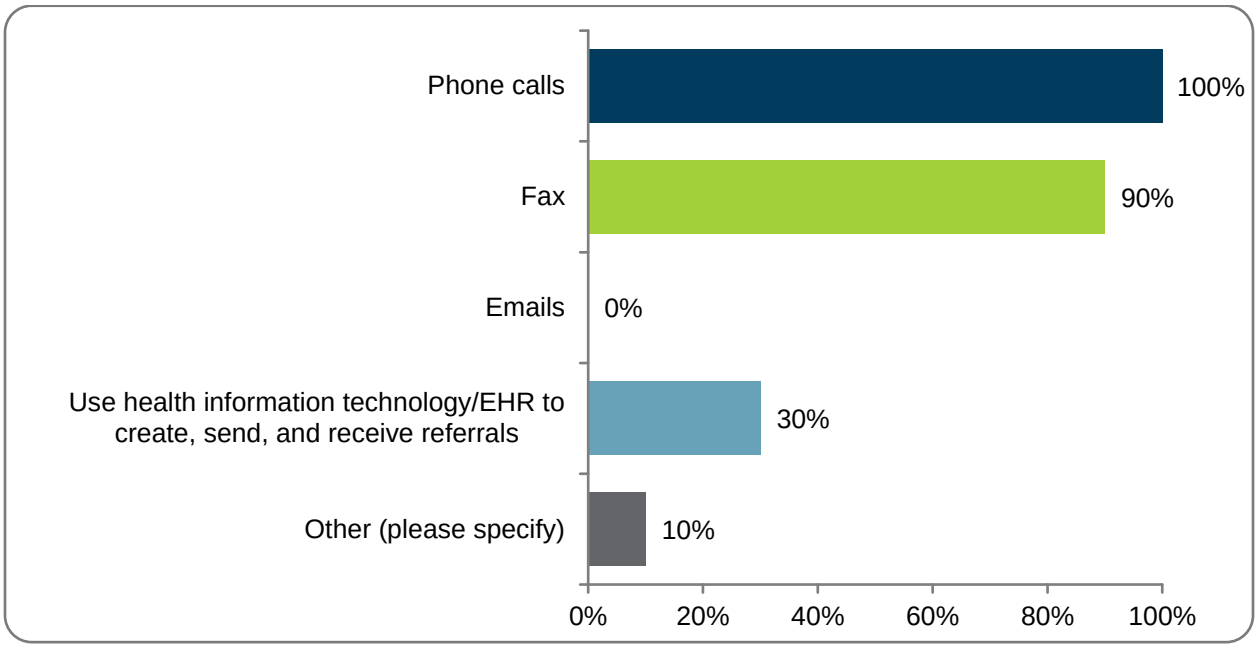


*In this question, survey respondents had an option to select more than one response for which the total percentage is over 100.

Q28: Does your organization/program have system(s) in place to send and receive referrals?

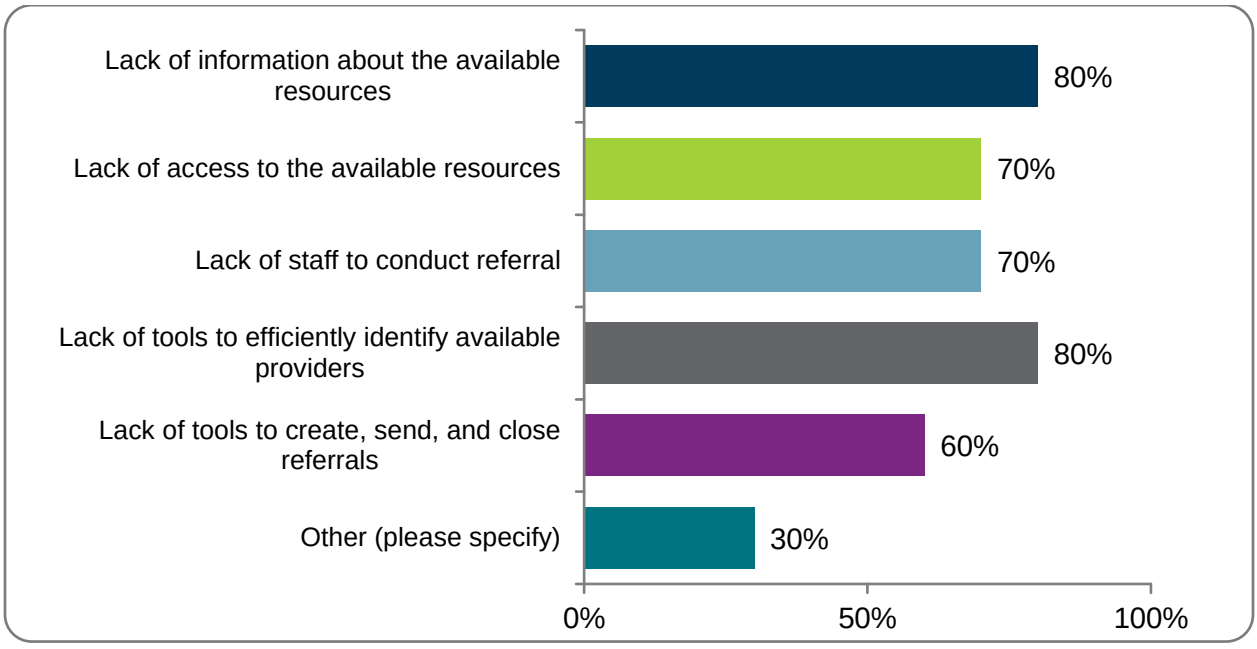


Q30: Which of the following describes how you/your agency makes referrals in the current environment? (Select all that apply*)



*In this question, survey respondents had an option to select more than one response for which the total percentage is over 100.

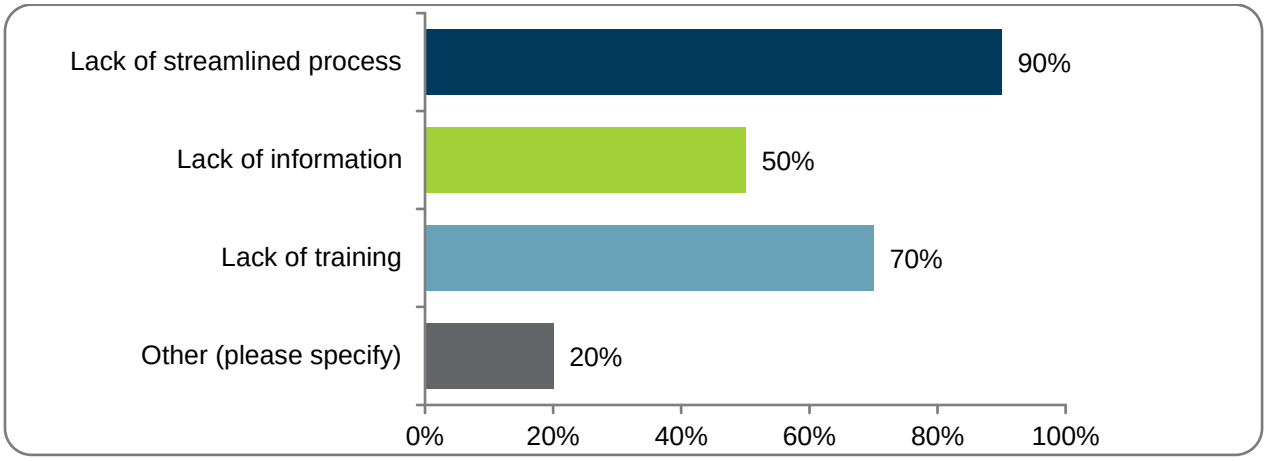
Q31: What are the challenges with the current referral process? (Select all that apply*)



*In this question, survey respondents had an option to select more than one response for which the total percentage is over 100.

Survey respondents indicated other challenges with the current referral process include the lack of standardization for data in referrals and hospitals not using the same tools.

Q32: What challenges do you anticipate in the use and adoption of electronic referral tools? (Select all that apply*)

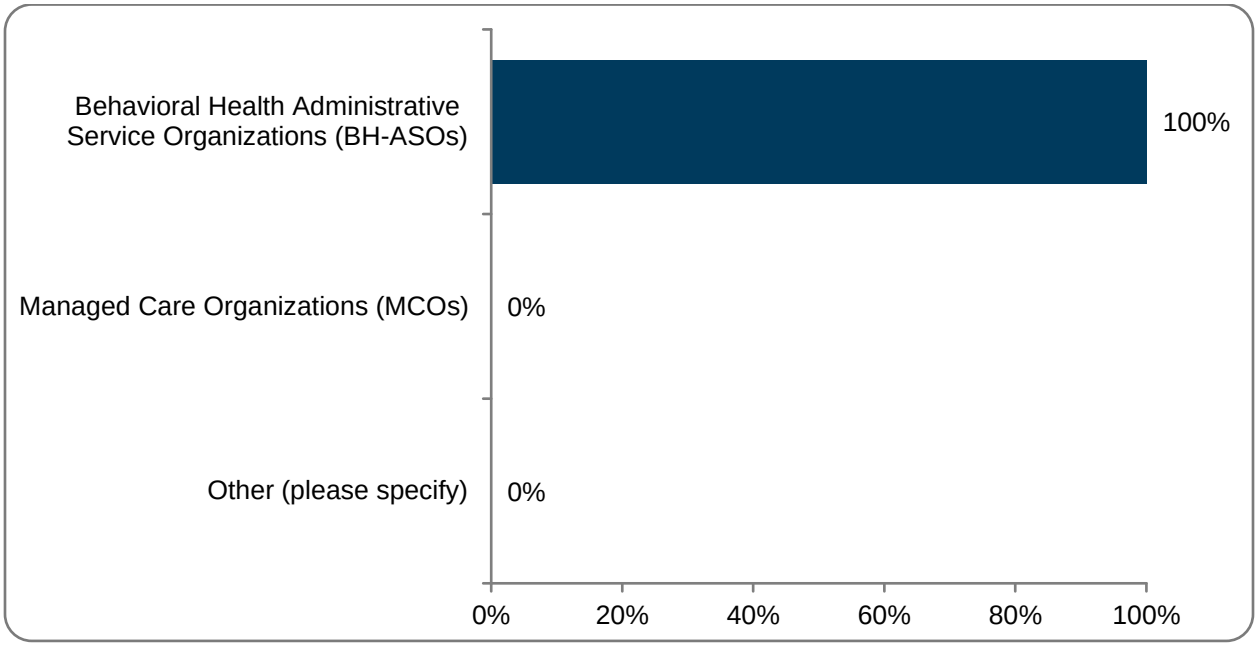


*In this question, survey respondents had an option to select more than one response for which the total percentage is over 100.

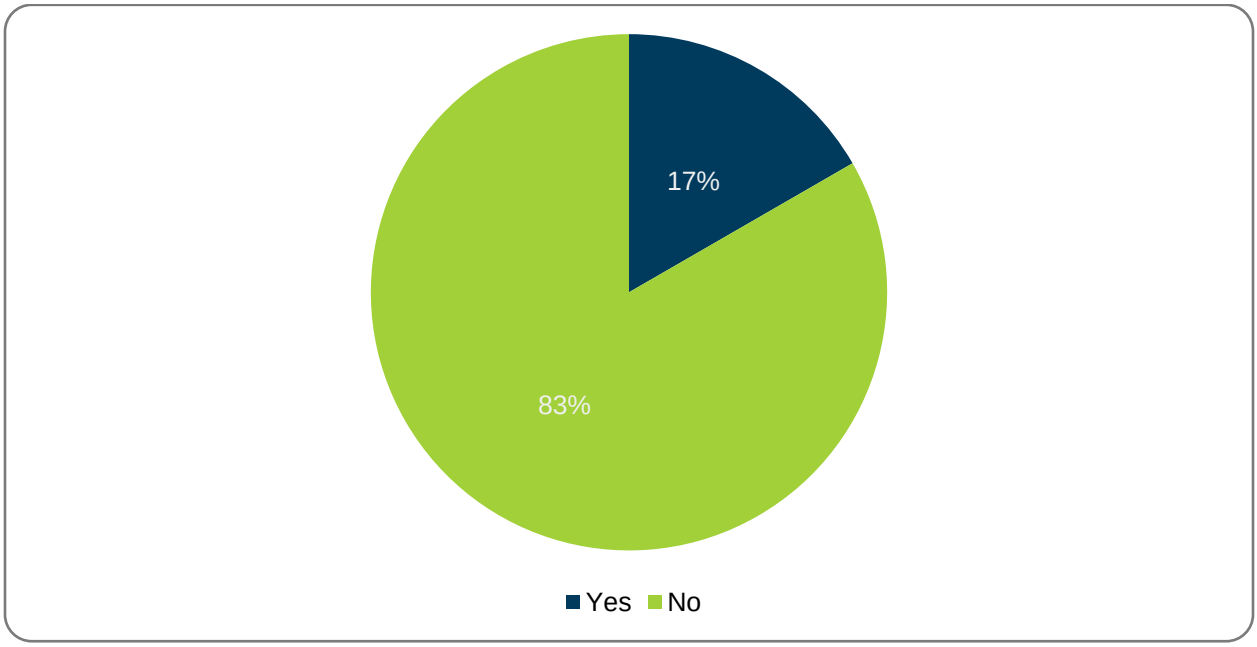
Survey respondents indicated that other anticipated challenges in adopting the electronic referral tool include funding to update the current EHRs to include both the automatic bed tracking and automatic information upload features so the electronic referral tool can integrate with existing systems.

Behavioral Health-Administrative Service Organizations Web Survey Results

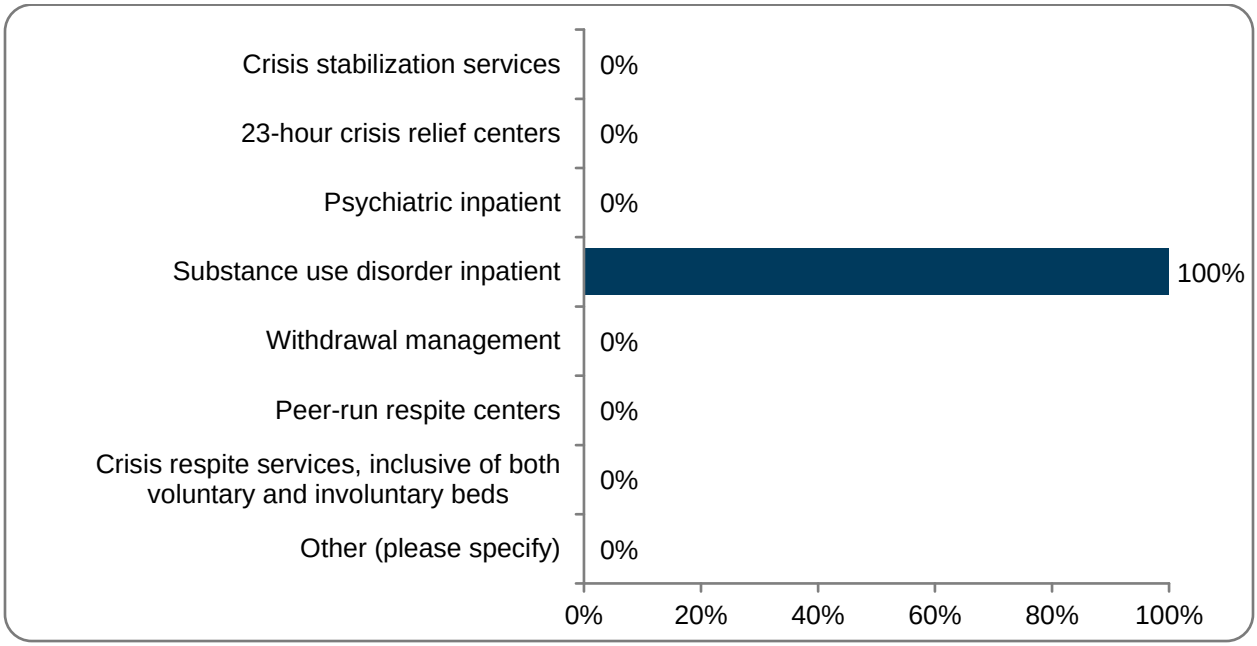
Q1: Which of the following best describes your organizational affiliation?



Q2: Are system(s) in place to track behavioral health bed availability for the providers in your network?

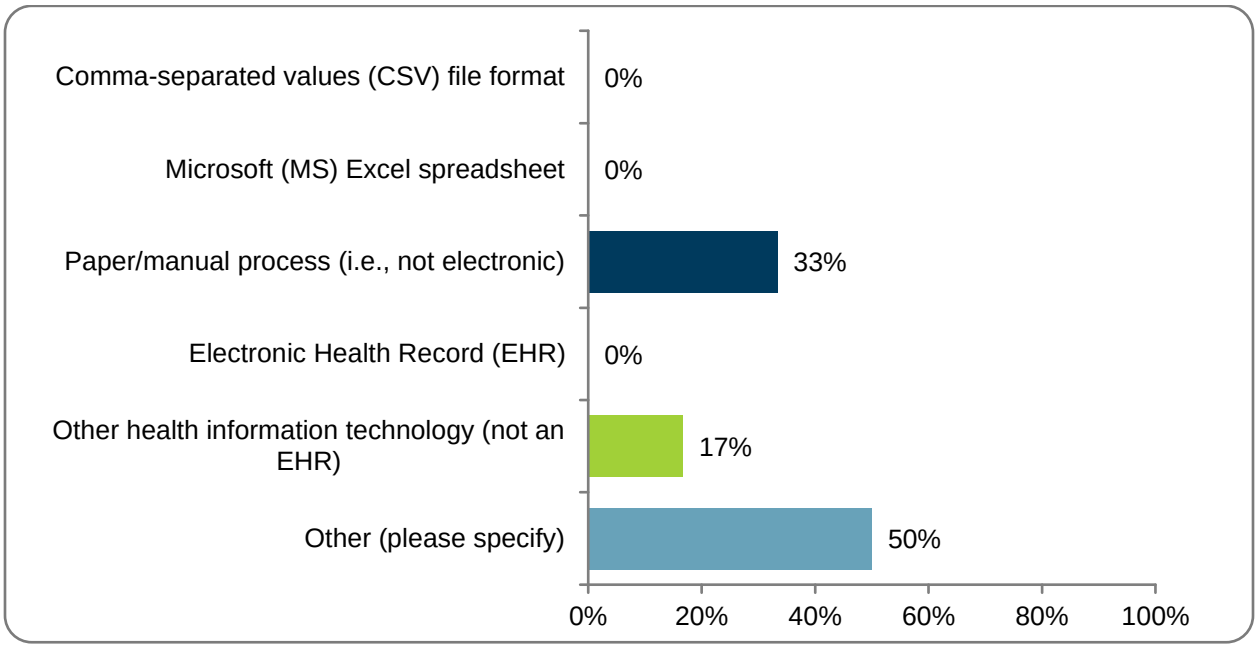


Q4: Which behavioral health provider beds is your organization currently tracking? (Select all that apply*)



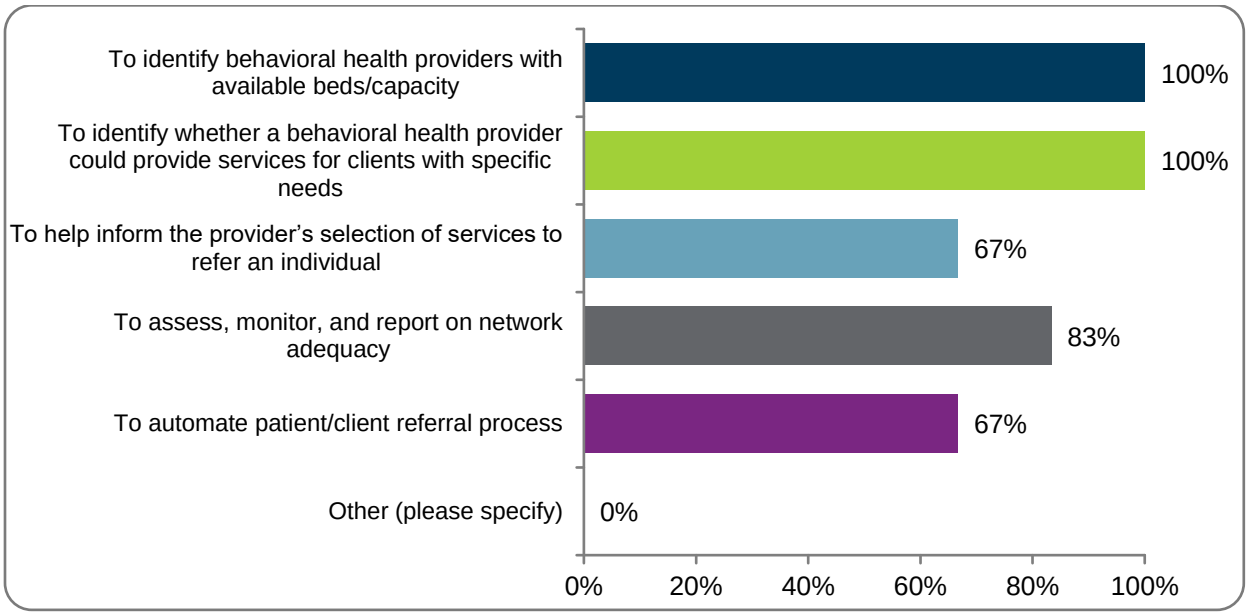
*In this question, survey respondents had an option to select more than one response for which the total percentage is over 100.

Q5: Which of the following describes how you/your organization currently track and update behavioral health bed availability in your behavioral health provider network?



Survey respondents indicated that behavioral health bed availability is also being tracked through other methods, including email updates from providers and a daily list provided by the crisis line.

Q6: Which of the following describes how you/your organization would use a behavioral health bed registry? (Select all that apply*)

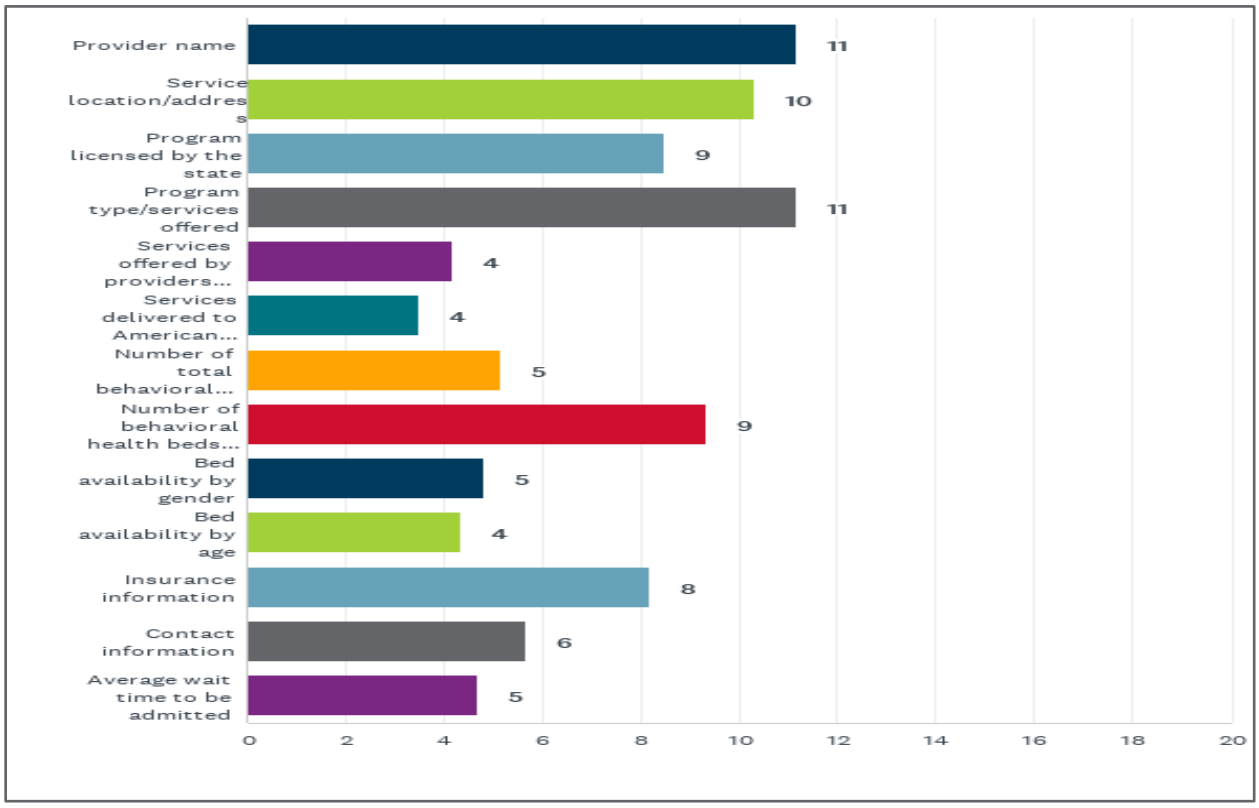


*In this question, survey respondents had an option to select more than one response for which the total percentage is over 100.

Q7: Indicate which of the following information/content is necessary to include in the behavioral health bed registry? (Please rank the options below in order of priority)

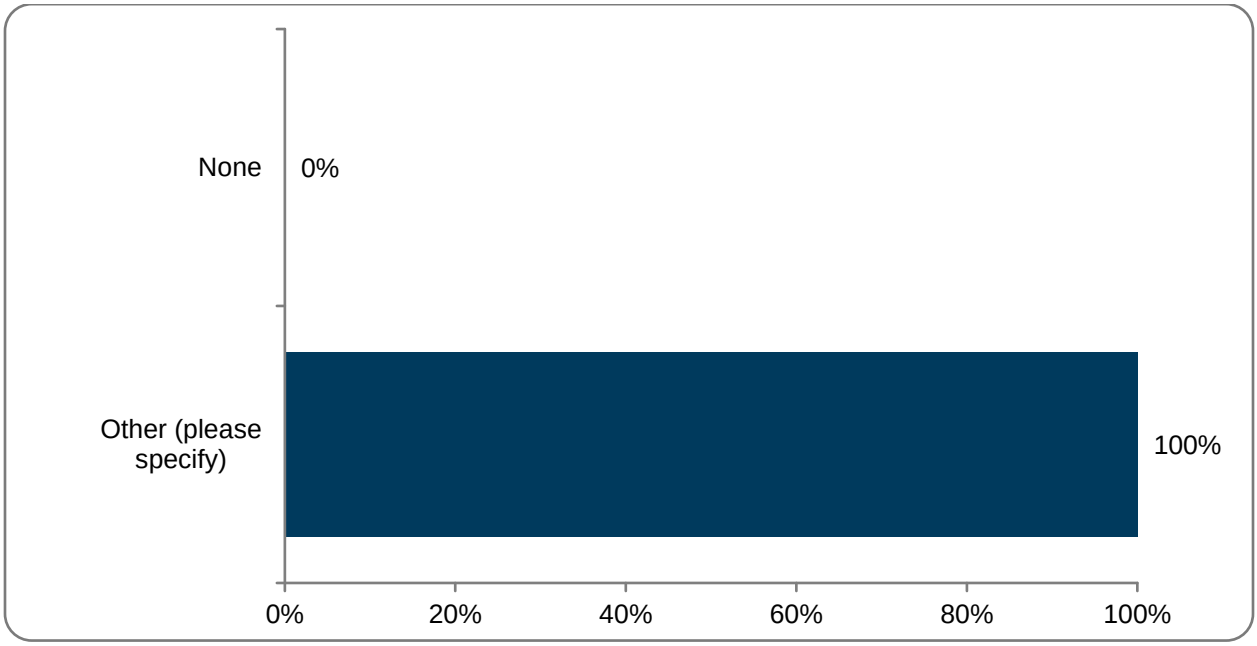
The top-five priority list identified by the interested parties was:

1. Provider name
2. Program type/services offered
3. Service location/address
4. Number of BH beds available
5. Program licensed by the state



* Graph represented in weighted average

Q8: What additional information would be useful to include in a behavioral health bed registry?

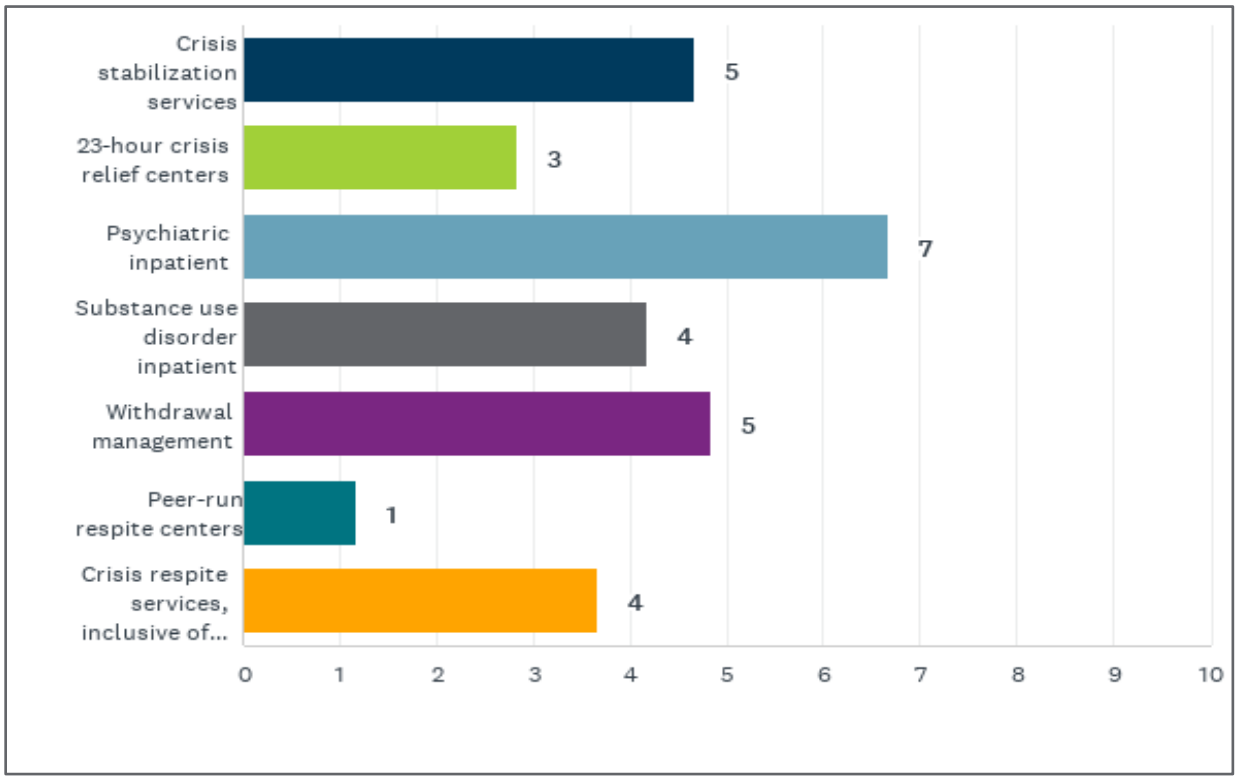


Survey respondents indicated additional information that should be included in the behavioral health bed registry includes travel time, hours referrals are accepted, link to any disqualifying criteria, voluntary versus involuntary, contact for discharge planners, acuity level, special populations served (TBI, IDD, medical acuity/co-morbidity), CLIP beds, and specialty services.

Q9: Which of the following behavioral health bed types should be included in a behavioral health bed registry? (Please rank the options below in order of priority)

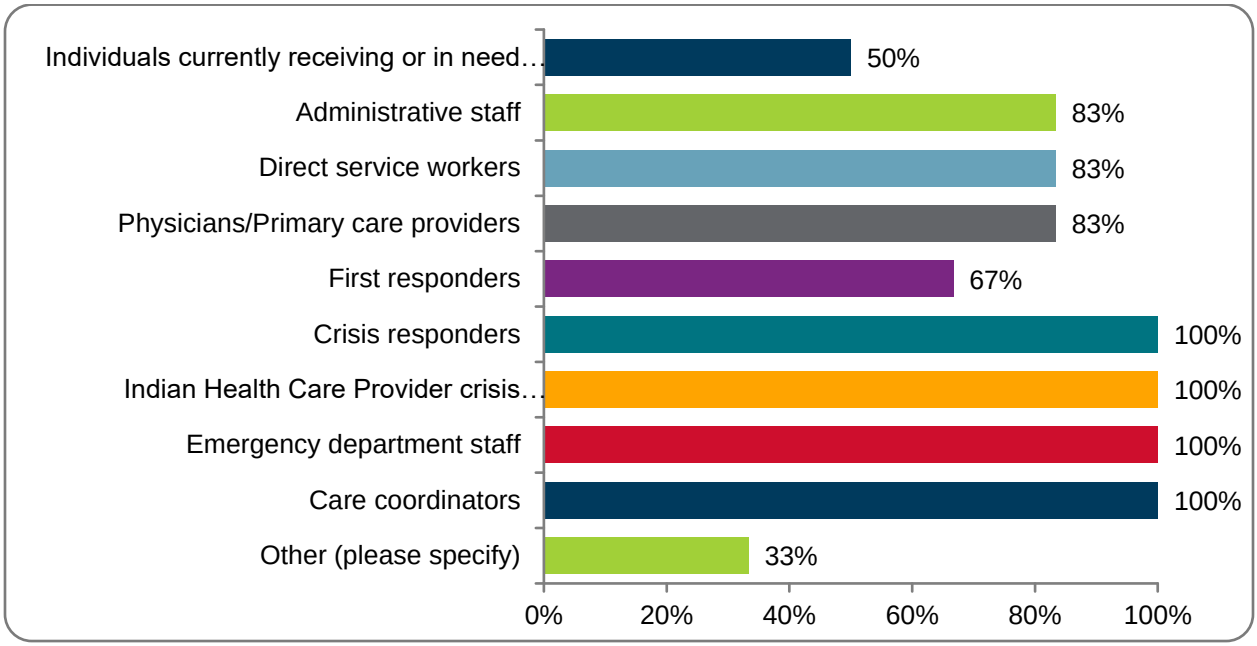
The top five BH bed types identified by the interested parties were:

1. Psychiatric inpatient
2. Withdrawal management
3. Crisis stabilization services
4. Crisis respite services, inclusive of both voluntary and involuntary beds
5. 23-hour crisis relief centers



* Graph represented in weighted average

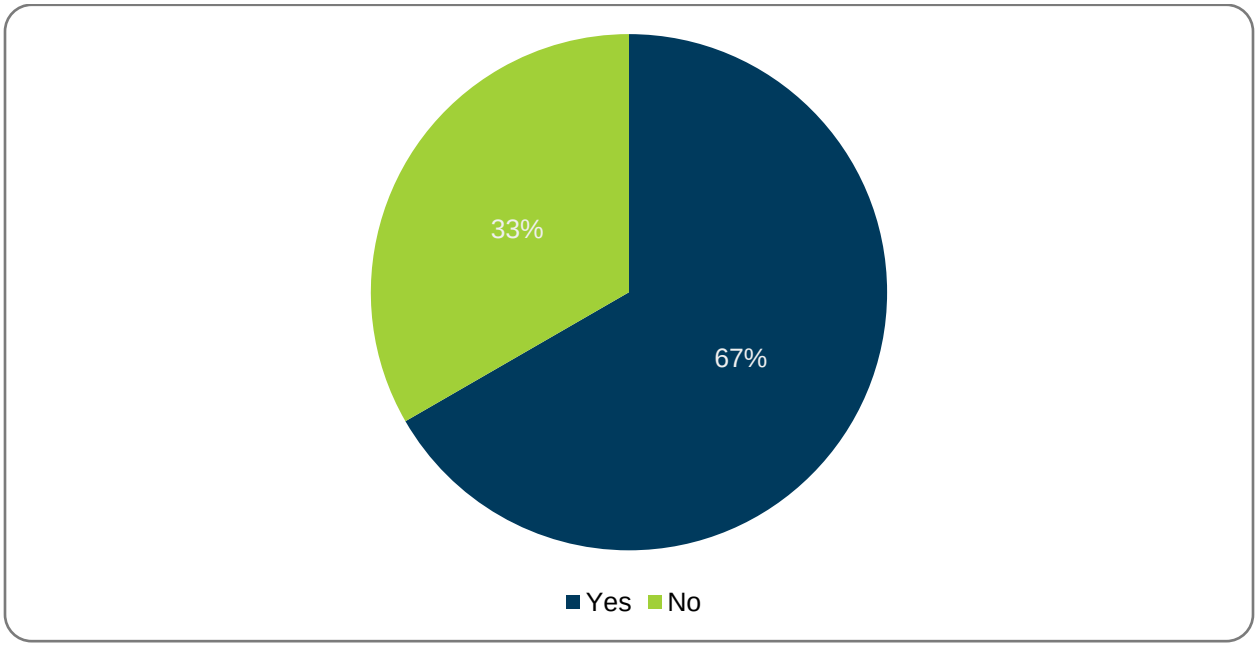
Q11: Who should have access to some or all of the behavioral health bed registry? (Select all that apply*)



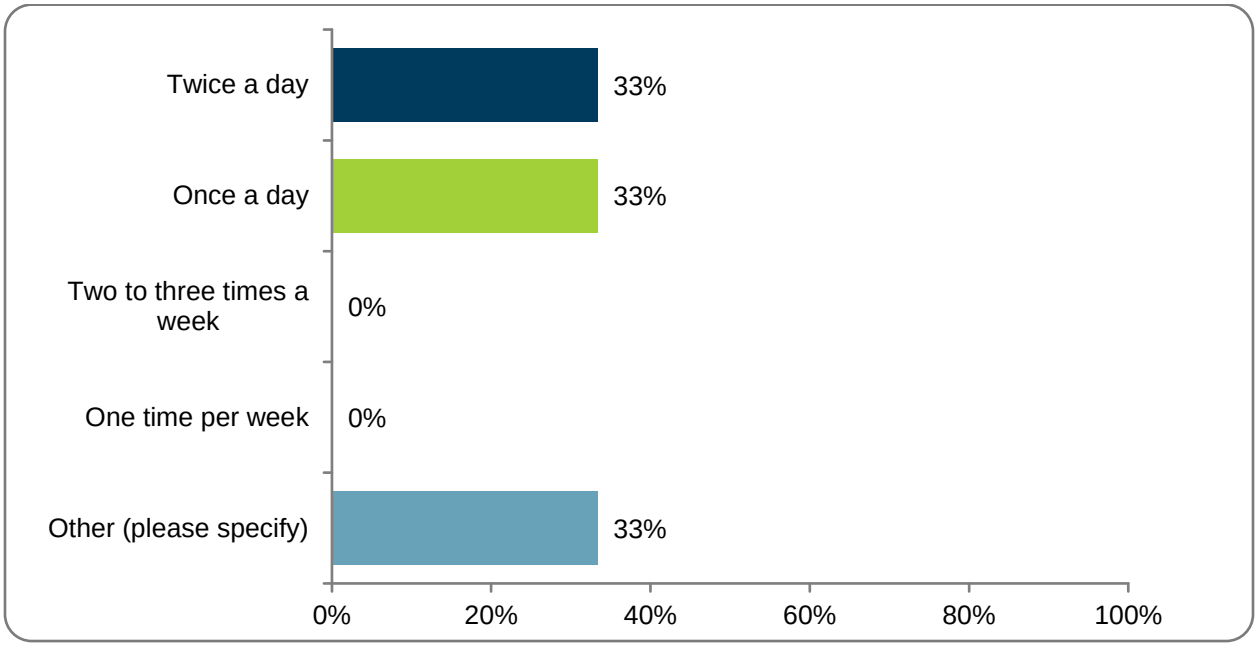
*In this question, survey respondents had an option to select more than one response for which the total percentage is over 100.

Survey respondents indicated BH-ASO and MCO staff should have access to the BH bed registry.

Q12: Should individuals in crisis and/or their family members/loved ones have access to a behavioral health bed registry?

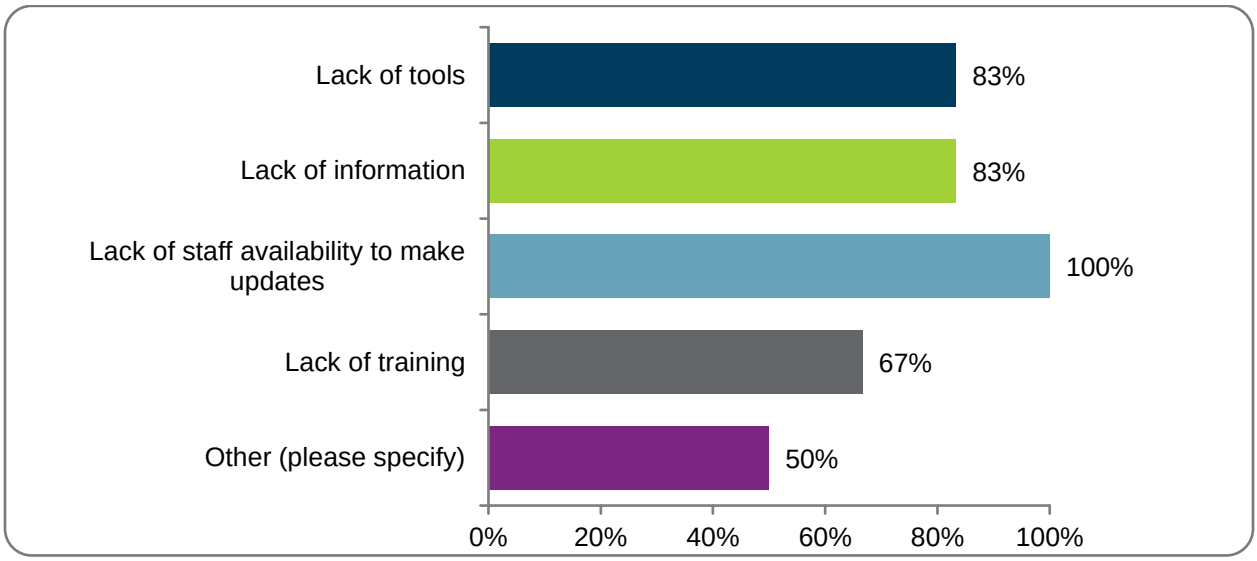


Q14: What is the desired cadence/frequency for providers to update the behavioral health bed registry?



Survey respondents indicated that other cadences the behavioral health bed registry should be updated include real-time, with every admission, and as often as possible.

Q15: What potential barriers do you foresee with providers updating the behavioral health bed registry? (Select all that apply*)



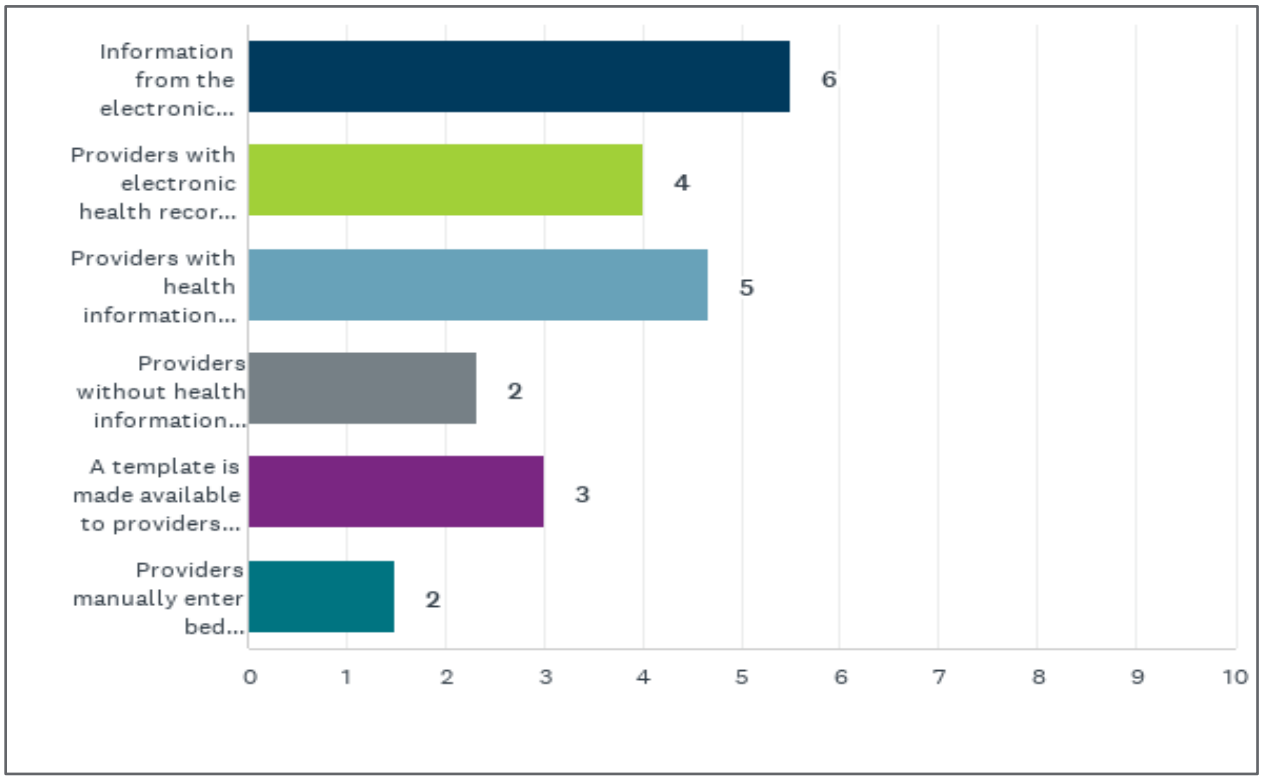
*In this question, survey respondents had an option to select more than one response for which the total percentage is over 100.

Survey respondents indicated other potential barriers for providers to update the behavioral health bed registry include lack of compliance, lack of incentive to participate in updating the registry, and lack of automation.

Q16: What would be the preferred method(s) for how the information within the behavioral health bed registry would be updated? (Please rank the options below in order of priority)

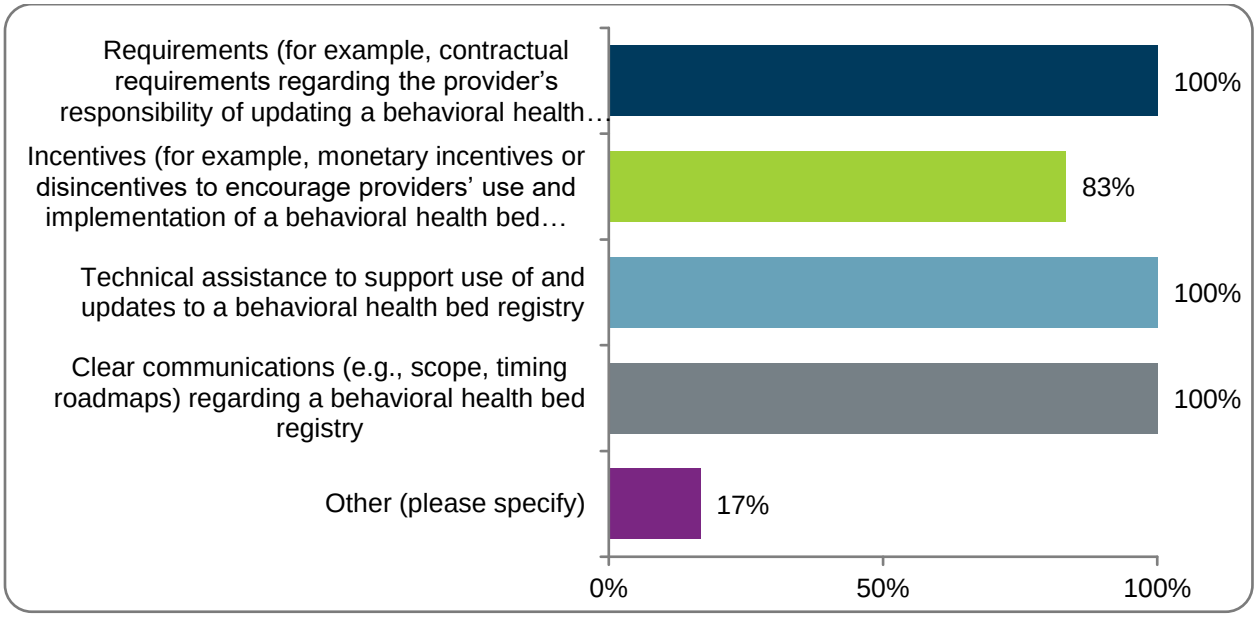
The top five preferred methods for information within the BH bed registry identified by the interested parties were:

1. Information from the electronic closed-loop referral tool(s) would automatically update a provider's available beds in the behavioral health bed registry when a referral is accepted
2. Providers with health information technology/EHR tools would automatically track and send information about available bed capacity to the behavioral health bed registry
3. Providers with EHRs would create ADT summaries when an individual is admitted, discharged, transferred and the ADT would be shared with the registry to update bed availability
4. A template is made available to providers to update bed availability information
5. Providers without health information technology/EHR tools would use spreadsheets (or CSV files) to track bed availability and send information to the behavioral health bed registry



* Graph represented in weighted average

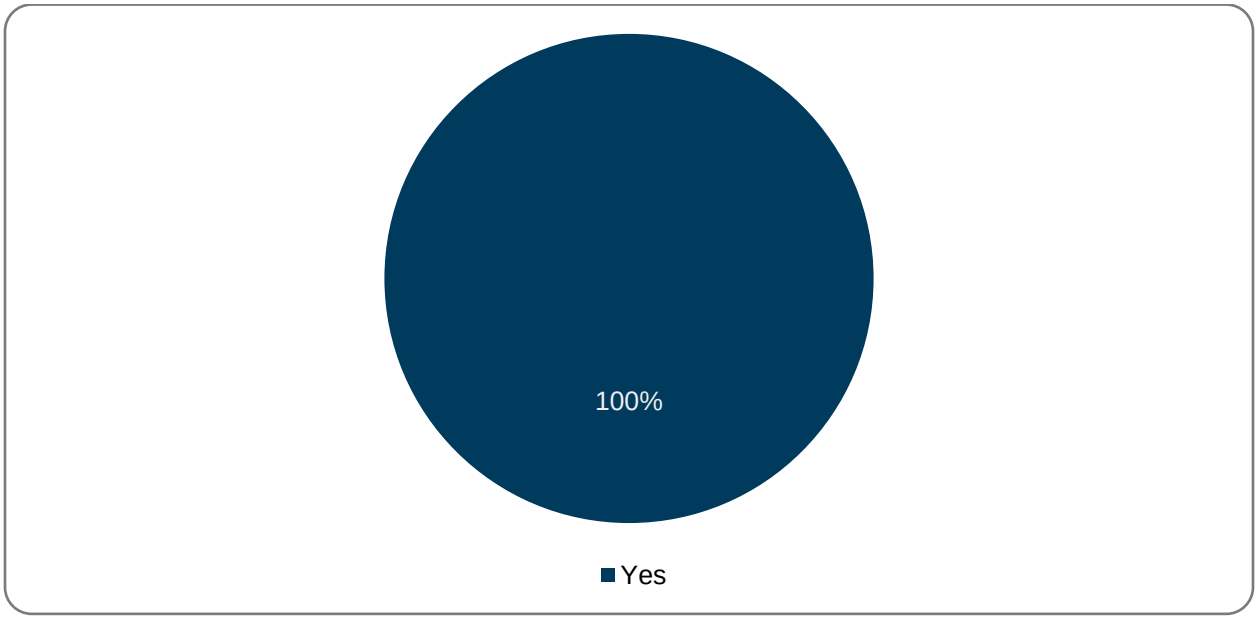
Q17: Which of the following would support the implementation of a behavioral health bed registry? (Select all that apply*)



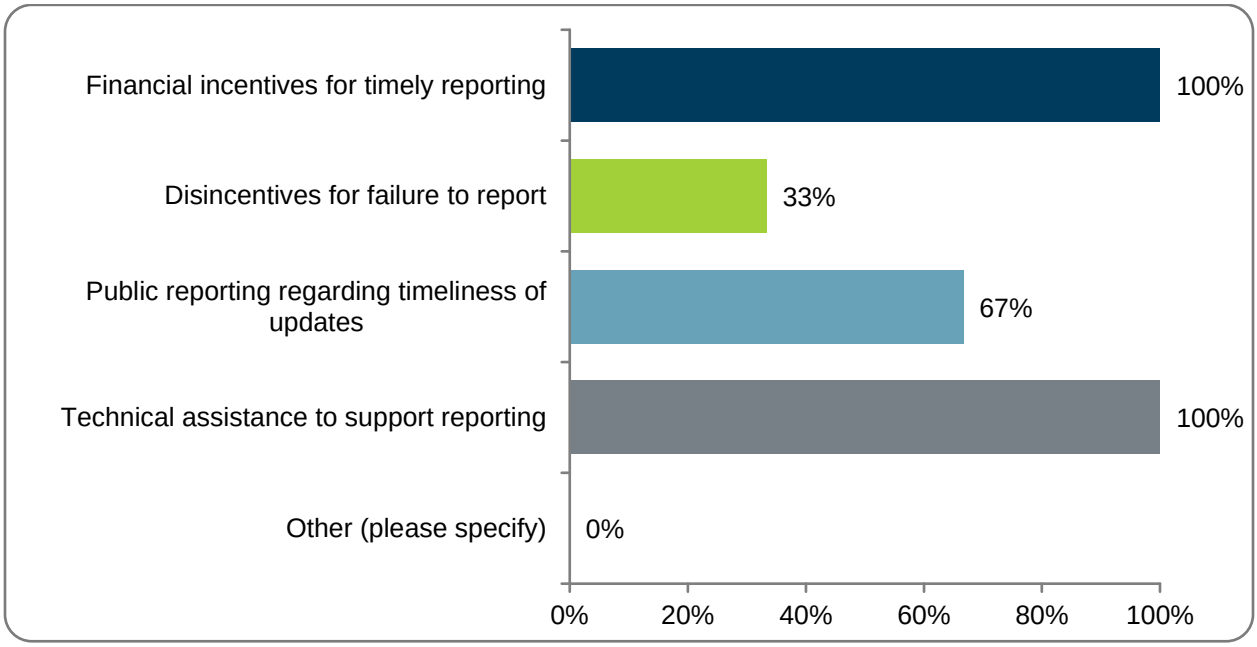
*In this question, survey respondents had an option to select more than one response for which the total percentage is over 100.

Survey respondents indicated other support to implement the behavioral health bed registry includes rule changes and requirements.

Q18: Is enforcement necessary to help ensure compliance with the contractual or licensing requirements?

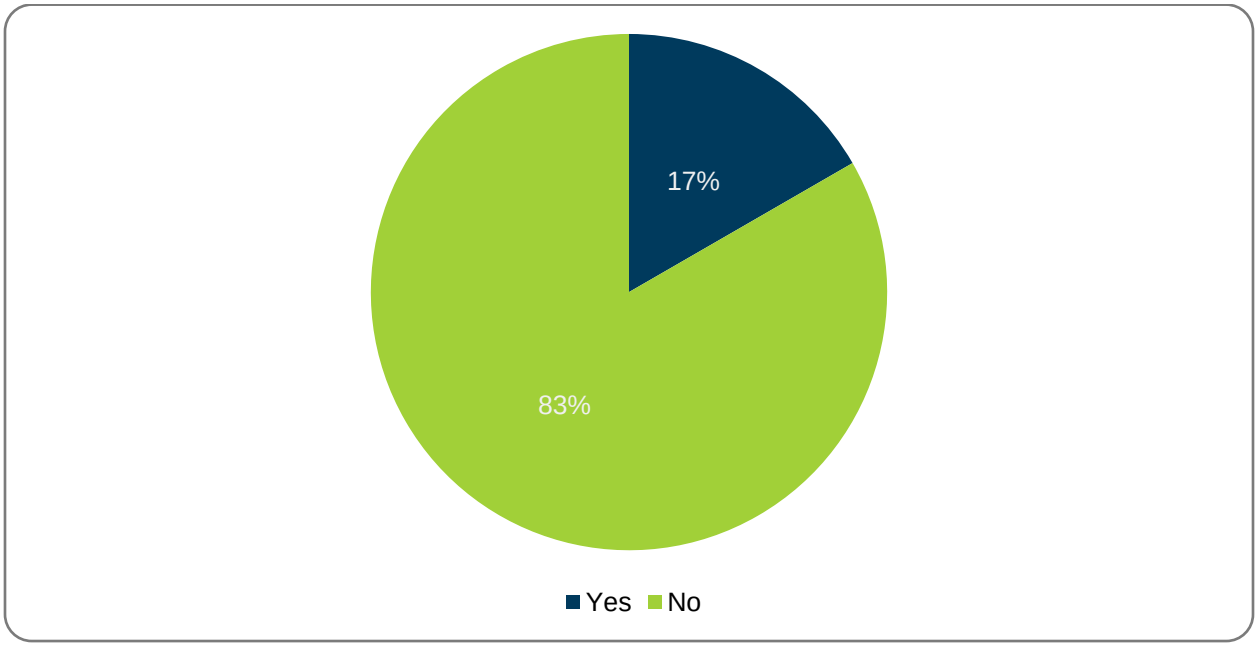


Q19: What type of enforcement would be helpful to support implementation of a behavioral health bed registry? (Select all that apply*)

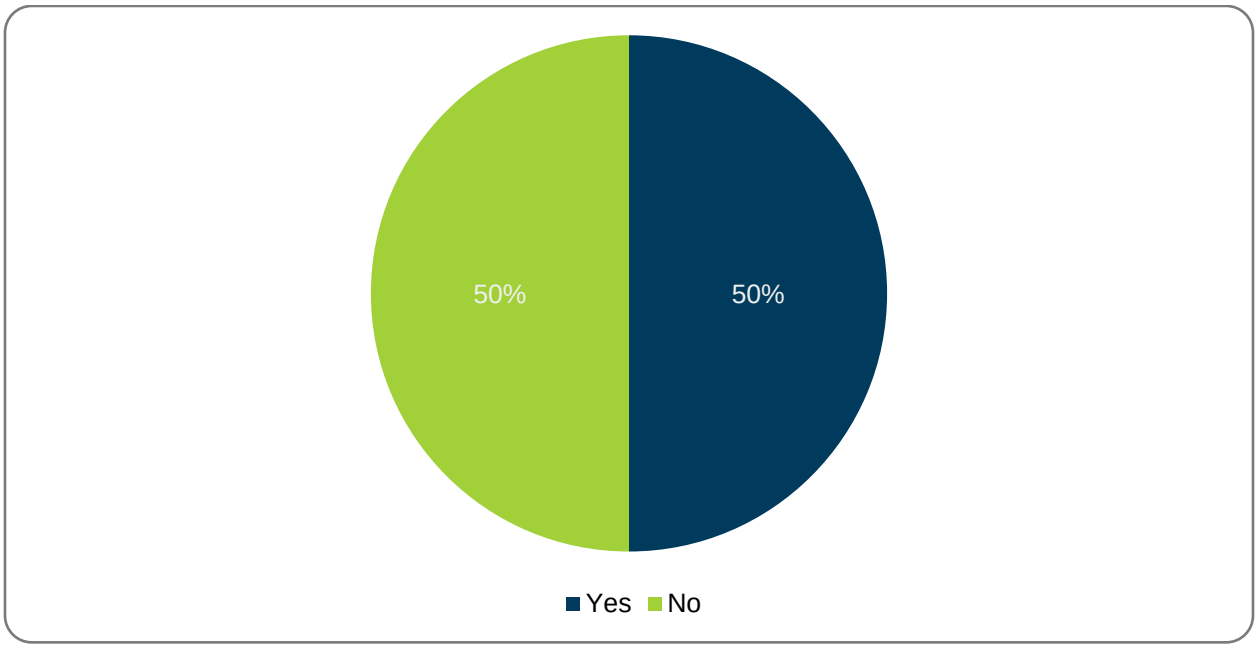


*In this question, survey respondents had an option to select more than one response for which the total percentage is over 100.

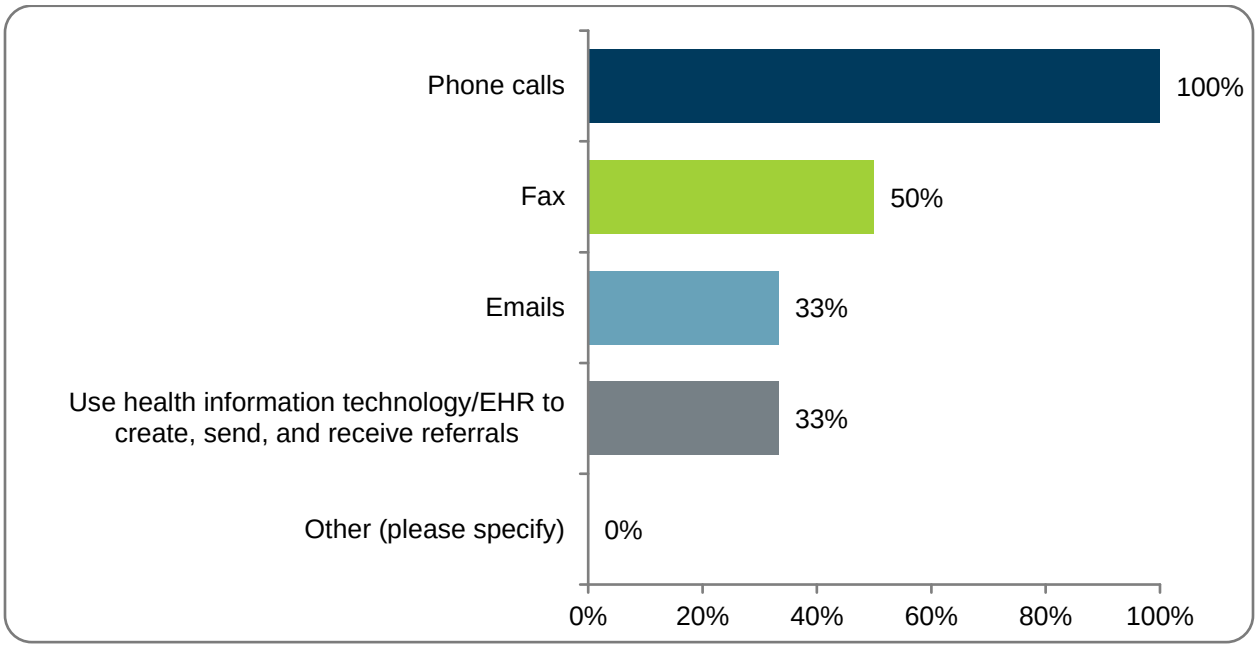
Q21: Are there existing contractual requirements for behavioral health providers to update their capacity?



Q23: Are you aware of system(s) that are in place to send/receive referrals within your behavioral health provider network?

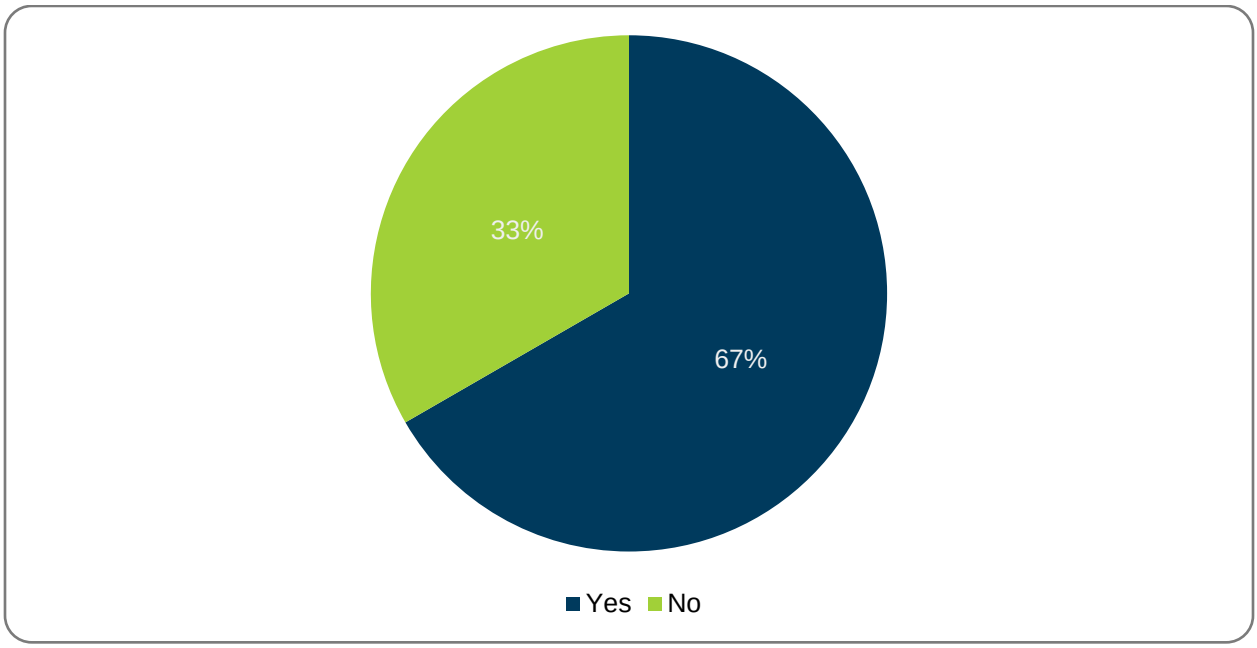


Q25: In your experience, how do provider(s) in your behavioral health provider network currently make referrals? (Select all that apply*)

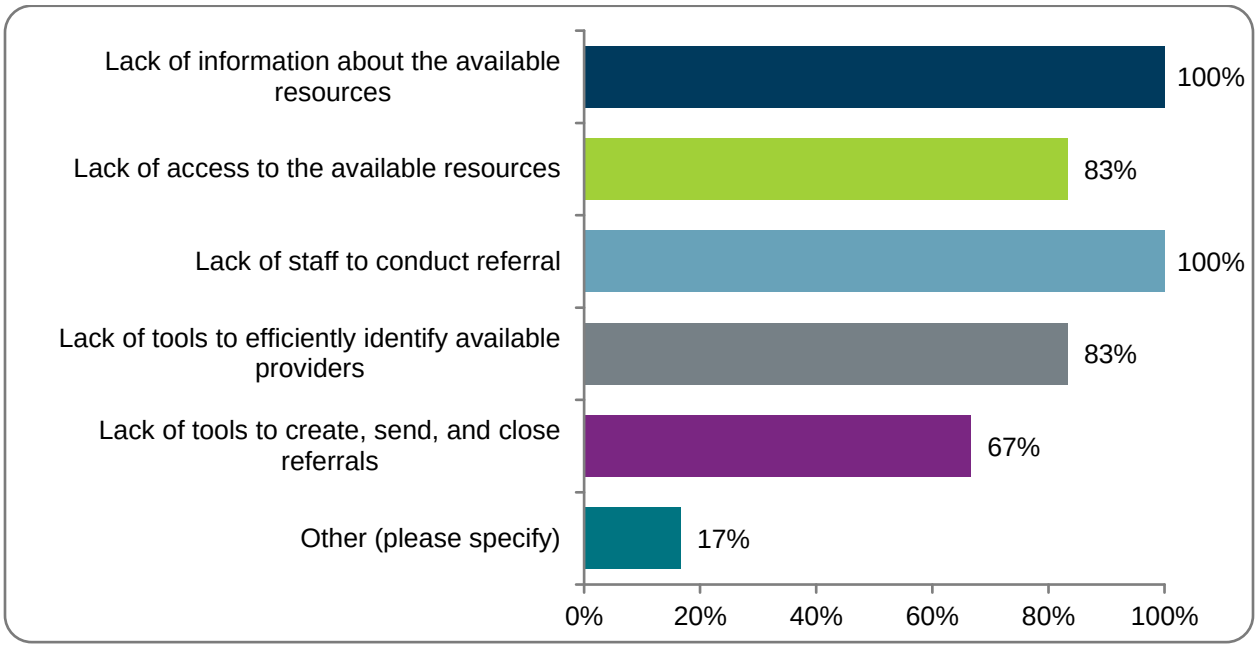


*In this question, survey respondents had an option to select more than one response for which the total percentage is over 100.

Q26: Are there existing contractual requirements for behavioral health providers to share information about referrals to and/or from the crisis continuum of care?



Q28: In your experience, what are the challenges with the current referral process? (Select all that apply*)

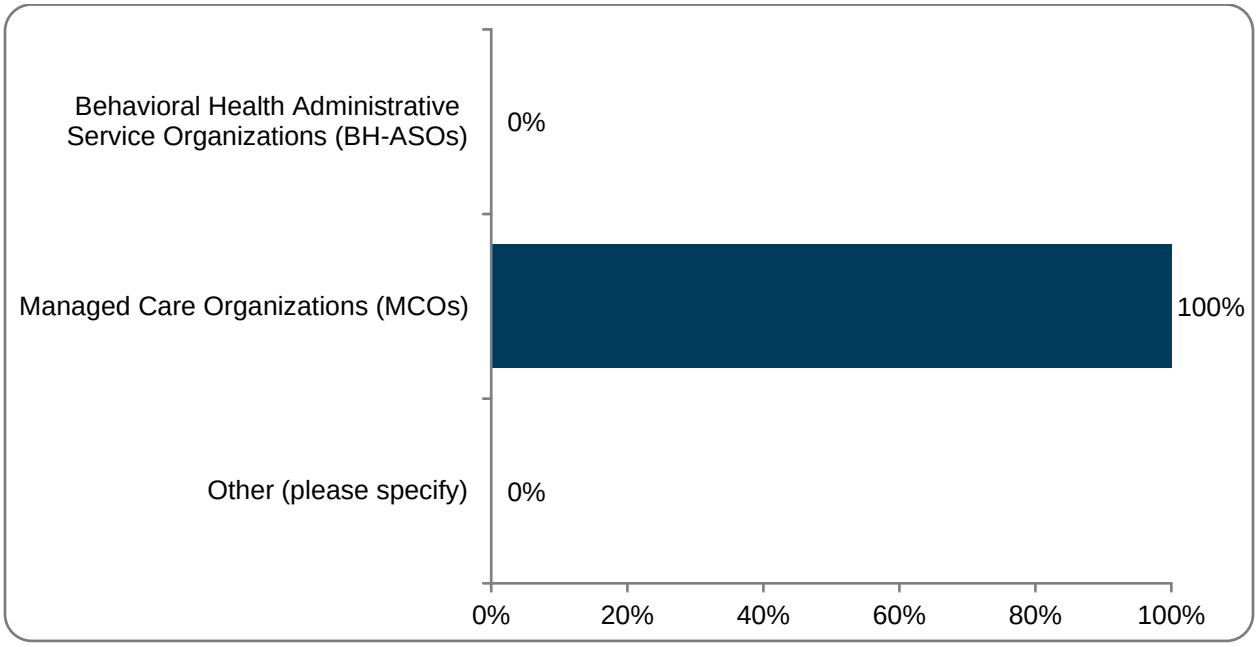


*In this question, survey respondents had an option to select more than one response for which the total percentage is over 100.

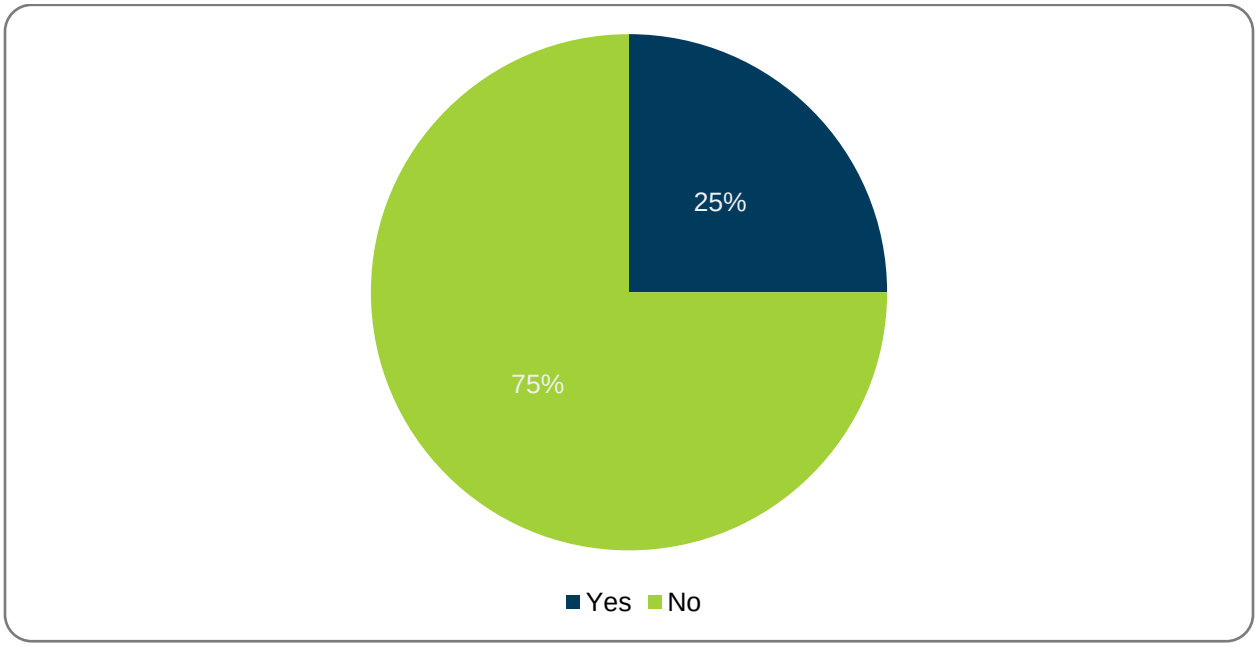
Survey respondents indicated other challenges with the current referral process include available beds but a lack of staff to care for them and lack of facilities accepting overnight admissions.

Managed Care Organizations Web Survey Results

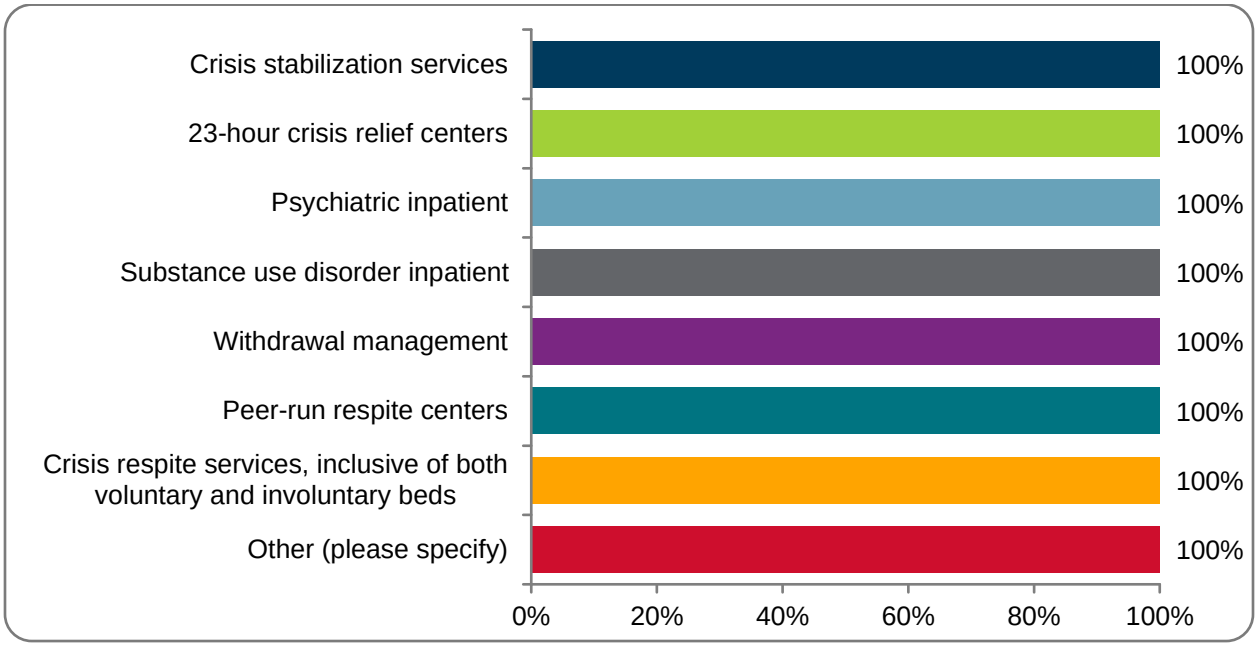
Q1: Which of the following best describes your organizational affiliation?



Q2: Are system(s) in place to track behavioral health bed availability for the providers in your network?



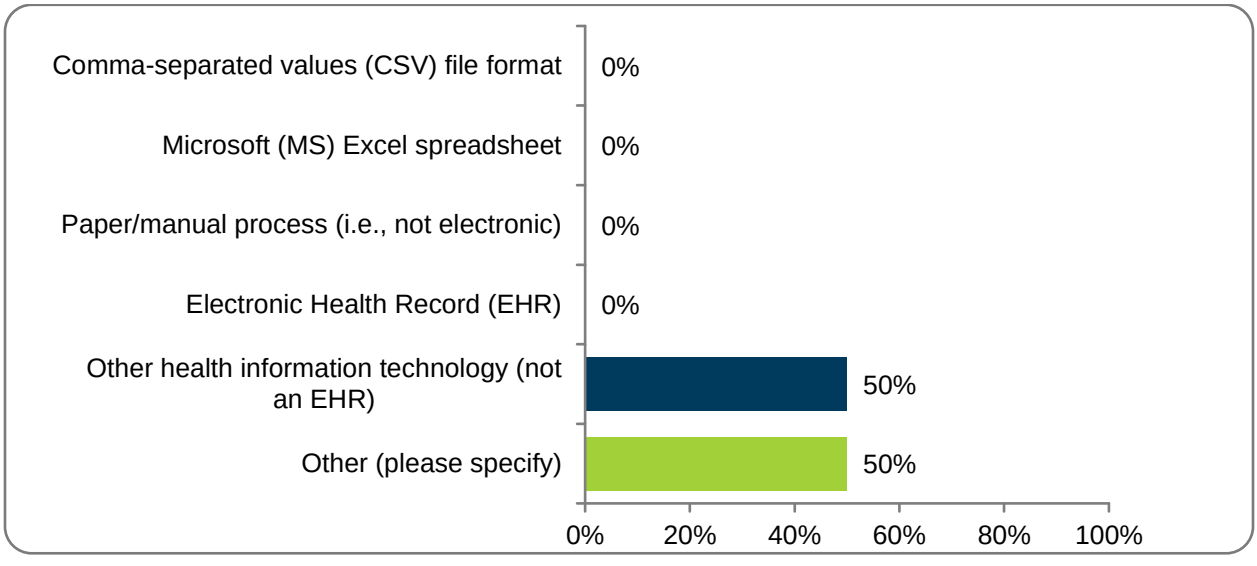
Q4: Which behavioral health provider beds is your organization currently tracking? (Select all that apply*)



*In this question, survey respondents had an option to select more than one response for which the total percentage is over 100.

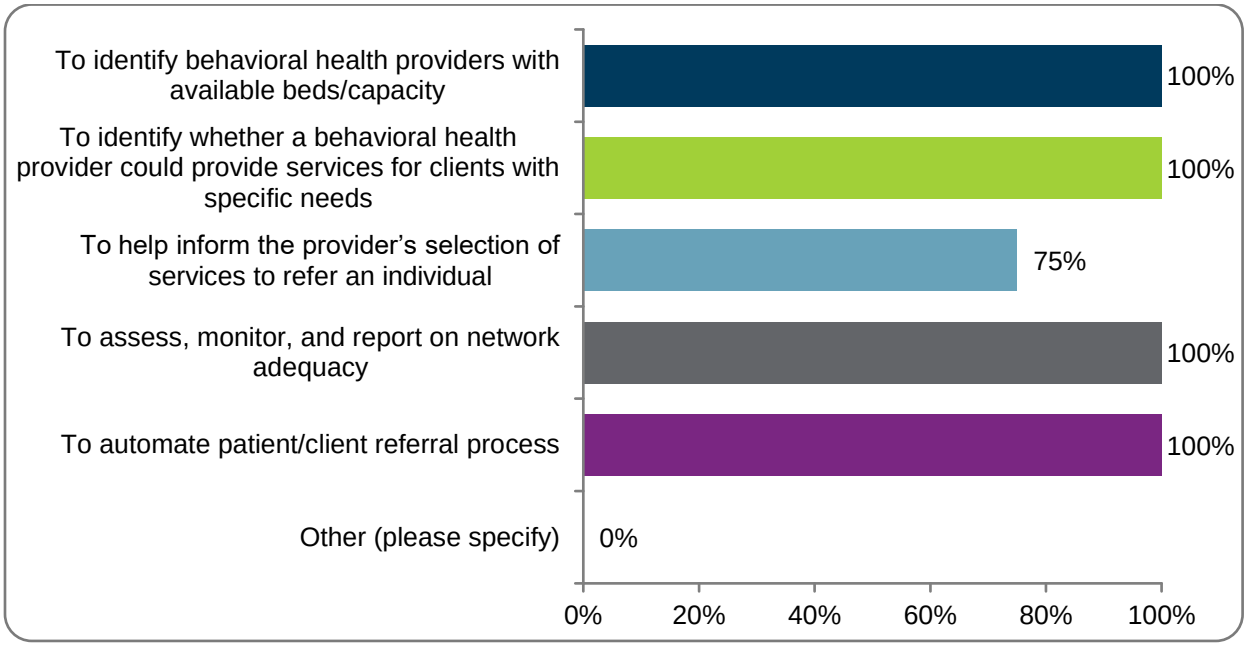
Survey respondents indicated other behavioral health beds currently being tracked include any level of care beds for MCO members.

Q5: Which of the following describes how you/your organization currently track and update behavioral health bed availability in your behavioral health provider network?



Survey respondents indicated other methods currently being used to track behavioral health bed availability include calling behavioral health providers.

Q6: Which of the following describes how you/your organization would use a behavioral health bed registry? (Select all that apply*)

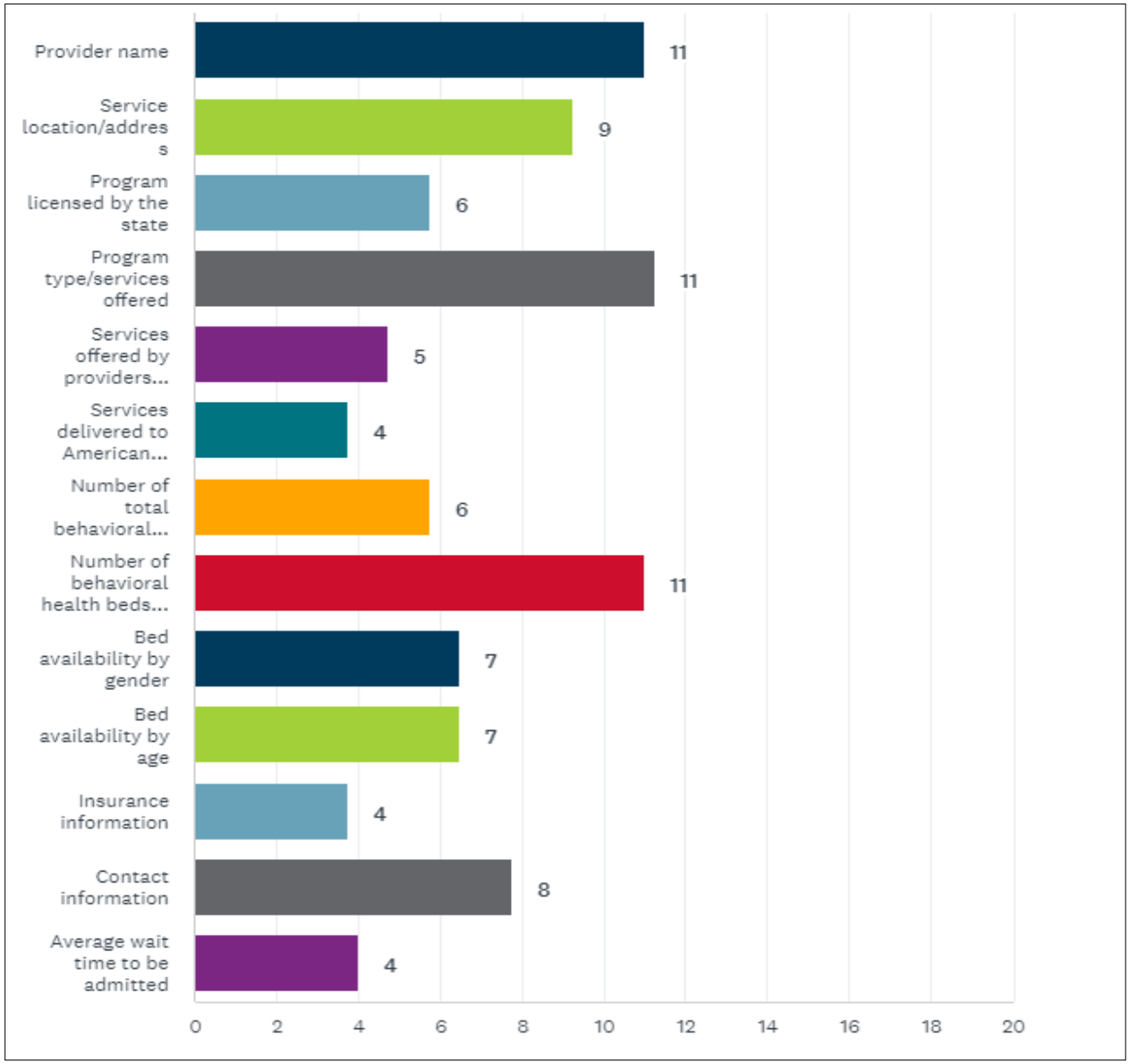


*In this question, survey respondents had an option to select more than one response for which the total percentage is over 100.

Q7: Indicate which of the following information/content is necessary to include in the behavioral health bed registry? (Please rank the options below in order of priority)

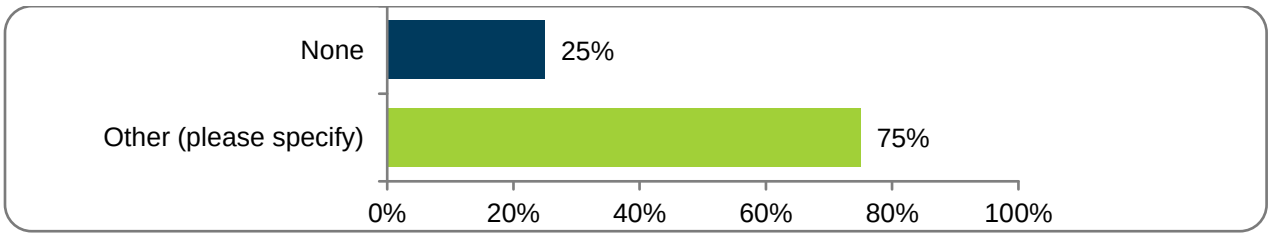
The top-five priority list identified by the interested parties were:

1. Provider name
2. Program type/services offered
3. Number of BH beds available
4. Service location/address
5. Contact information



* Graph represented in weighted average

Q8: What additional information would be useful to include in a behavioral health bed registry?



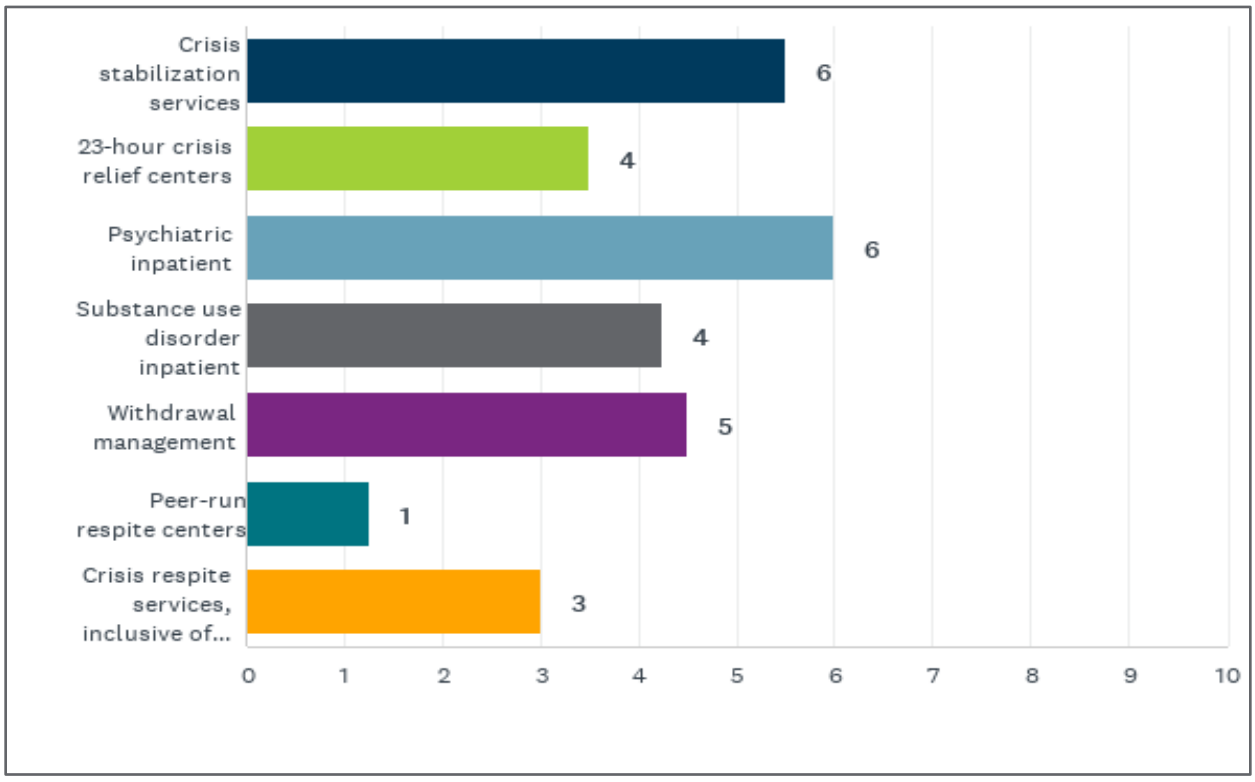
Survey respondents indicated other information that should be included in the behavioral health bed registry includes exclusionary admission criteria, the time the registry was last updated by

the facility, single/double rooms, if involuntary admissions are accepted, and experience with IDD, DD, and dementia.

Q9: Which of the following behavioral health bed types should be included in a behavioral health bed registry? (Please rank the options below in order of priority)

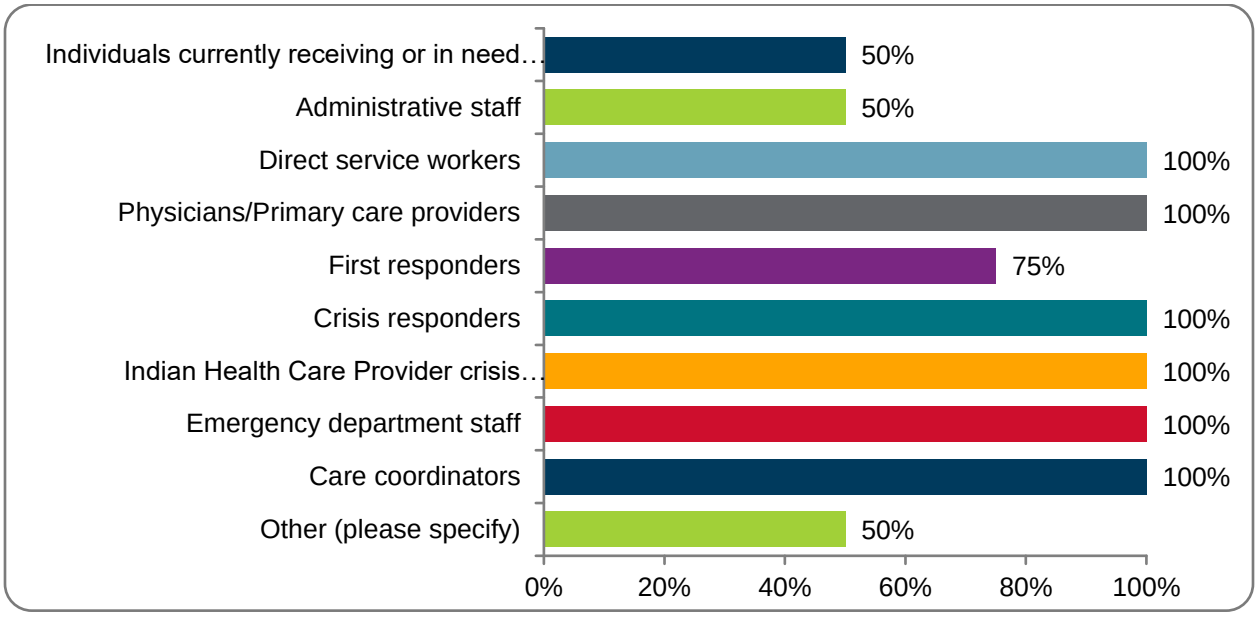
The top five BH bed types identified by the interested parties were:

1. Psychiatric inpatient
2. Crisis stabilization services
3. Withdrawal management
4. SUD inpatient
5. 23-hour crisis relief centers



* Graph represented in weighted average

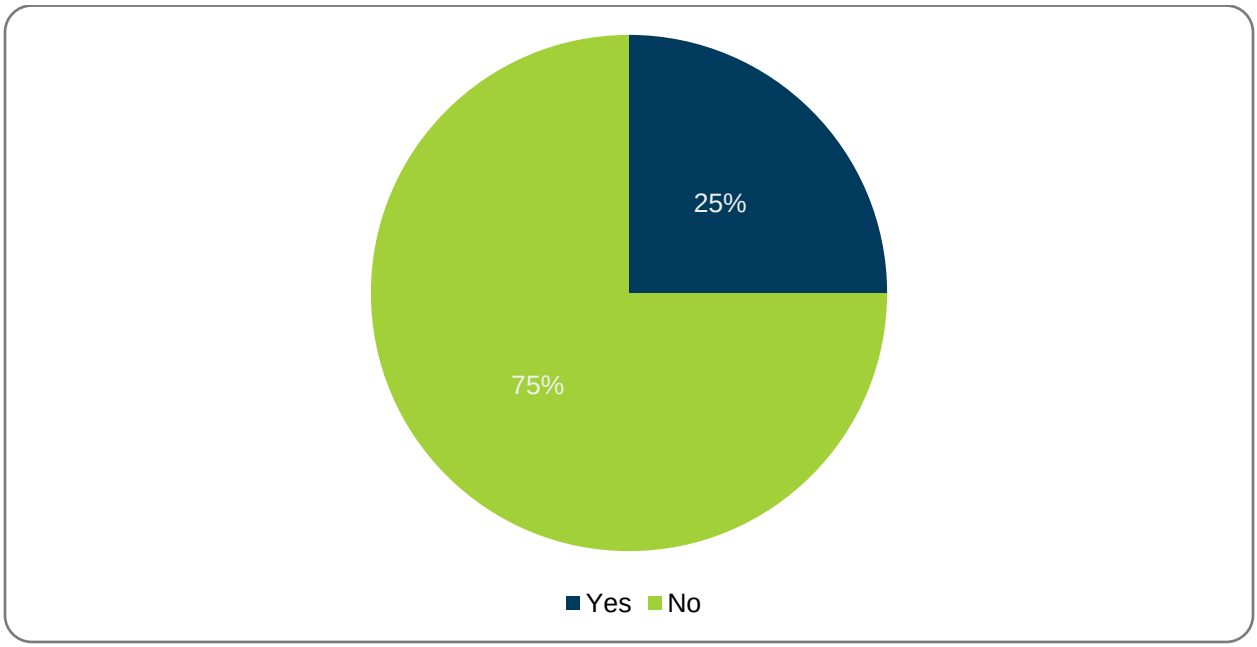
Q11: Who should have access to some or all of the behavioral health bed registry? (Select all that apply*)



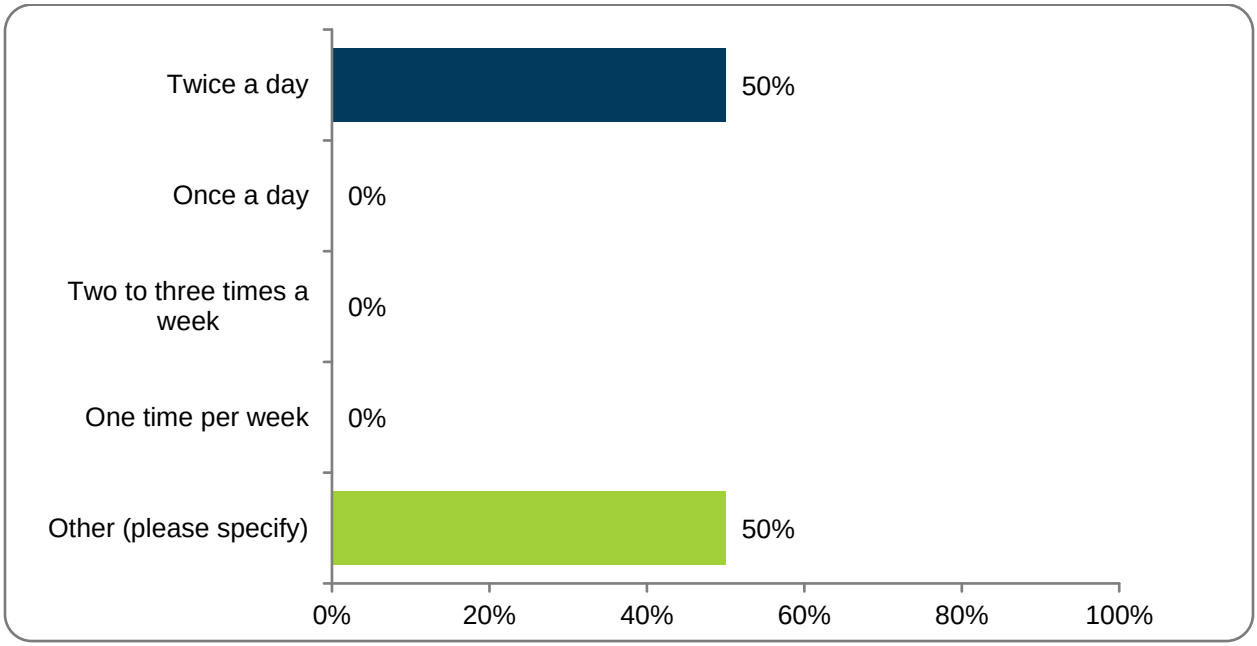
*In this question, survey respondents had an option to select more than one response for which the total percentage is over 100.

Survey respondents indicated other individuals who should have access to the behavioral health bed registry include families and individuals experiencing a mental health crisis, payers, hospital social workers, DCRs, and crisis facilities.

Q12: Should individuals in crisis and/or their family members/loved ones have access to a behavioral health bed registry?

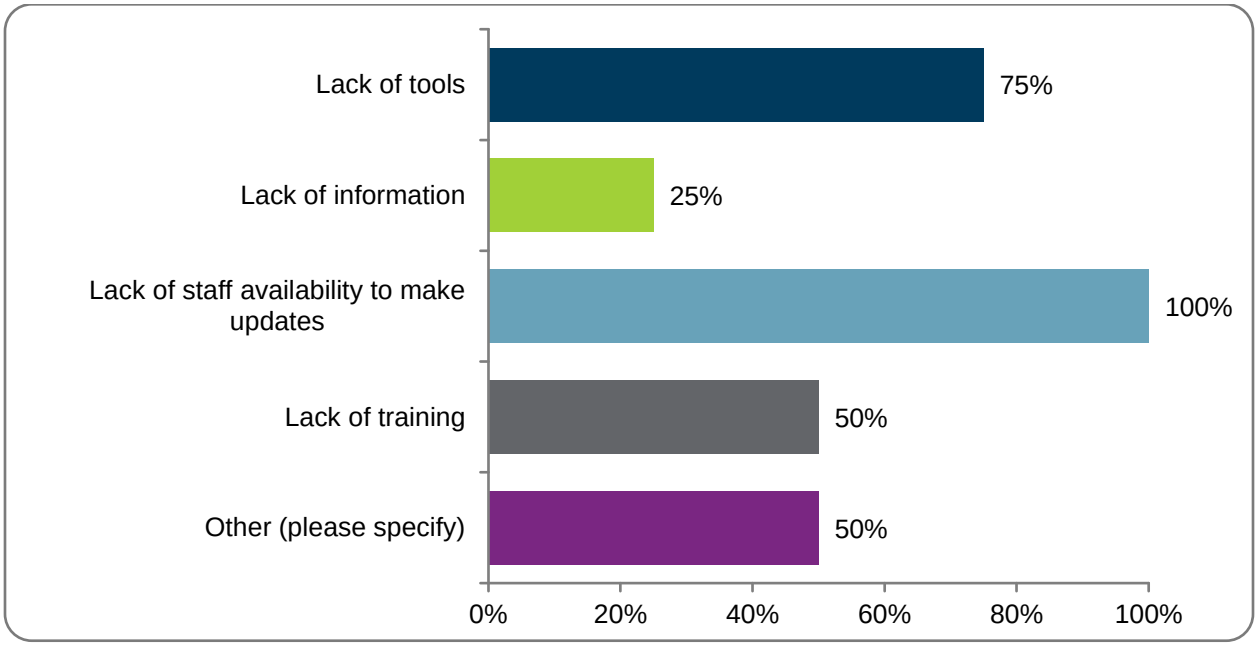


Q14: What is the desired cadence/frequency for providers to update the behavioral health bed registry?



Survey respondents indicated other frequencies at which providers should update the behavioral health bed registry include updates every eight hours and updates based on the level of care.

Q15: What potential barriers do you foresee with providers updating the behavioral health bed registry? (Select all that apply*)



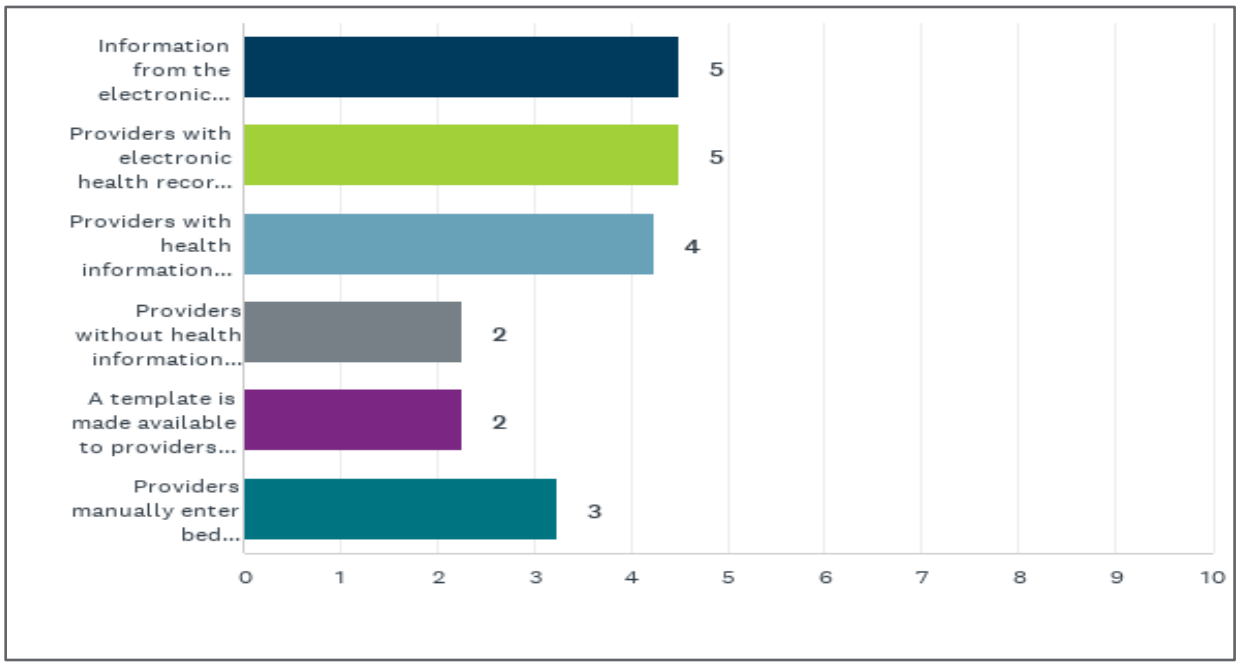
*In this question, survey respondents had an option to select more than one response for which the total percentage is over 100.

Survey respondents indicated other potential barriers for providers to update the behavioral health bed registry include staff turnover, lack of login knowledge, and providers under-reporting.

Q16: What would be the preferred method(s) for how the information within the behavioral health bed registry would be updated? (Please rank the options below in order of priority)

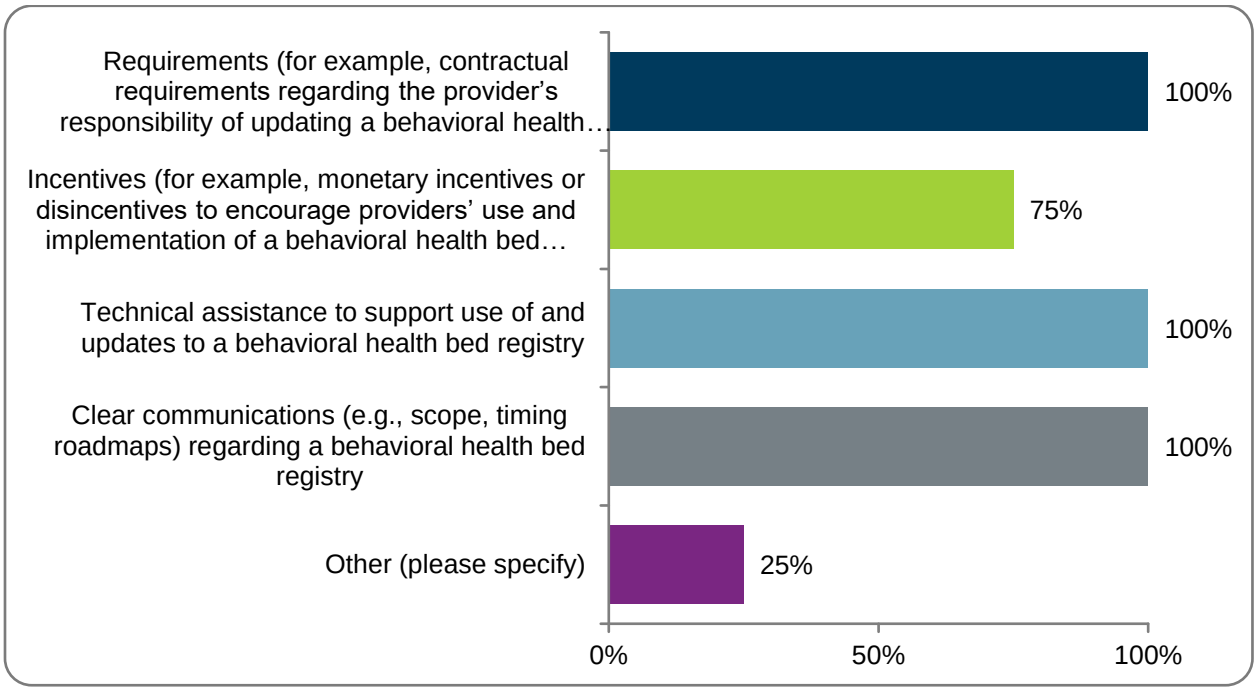
The top five preferred methods for information within the BH bed registry identified by the interested parties were:

1. Information from the electronic closed-loop referral tool(s) would automatically update a provider's available beds in the behavioral health bed registry when a referral is accepted
2. Providers with EHRs would create ADT summaries when an individual is admitted, discharged, transferred and the ADT would be shared with the registry to update bed availability
3. Providers with health information technology/EHR tools would automatically track and send information about available bed capacity to the behavioral health bed registry
4. Providers manually enter bed availability into the web-based behavioral health bed registry at a pre-determined cadence (e.g., once a day)
5. A template is made available to providers to update bed availability information



* Graph represented in weighted average

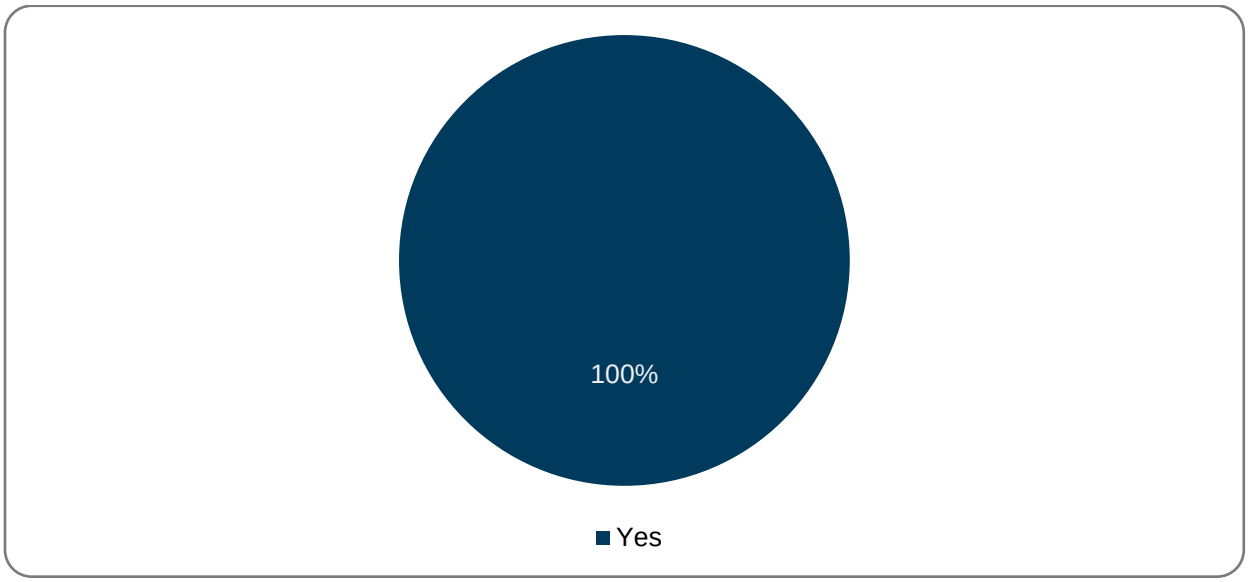
Q17: Which of the following would support the implementation of a behavioral health bed registry? (Select all that apply*)



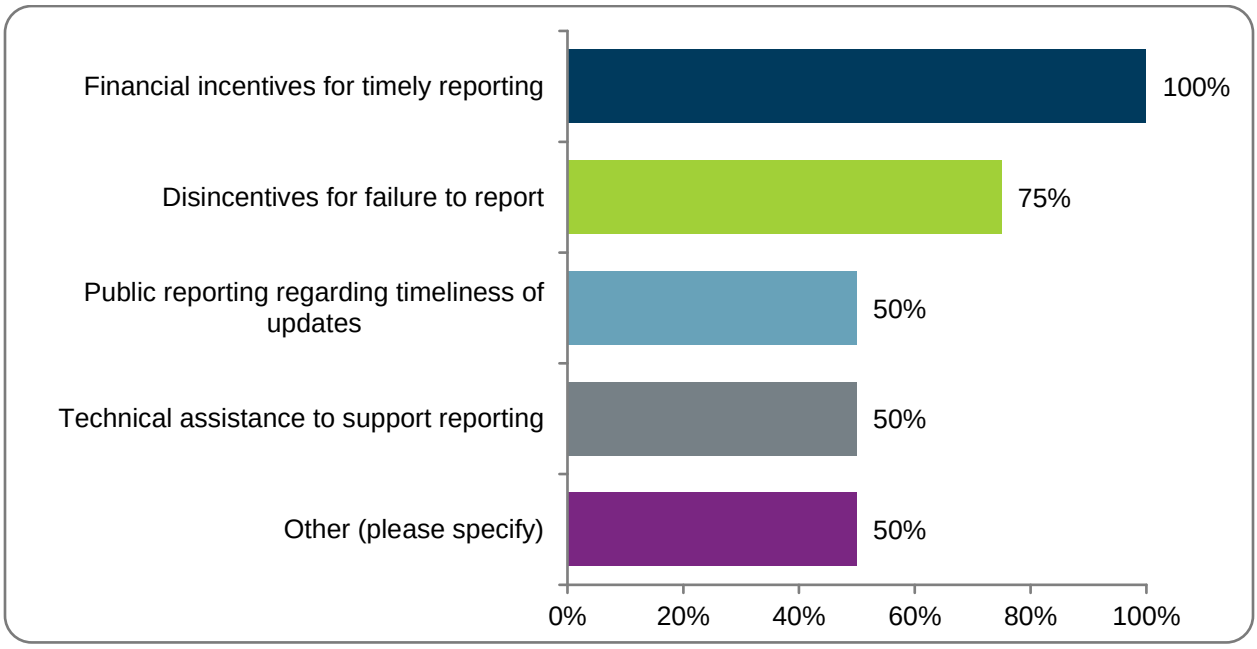
*In this question, survey respondents had an option to select more than one response for which the total percentage is over 100.

Survey respondents indicated that other support for updating the behavioral health bed registry includes updating the information systems and the EHR, improving the accuracy of reporting, and enforcing the registry.

Q18: Is enforcement necessary to help ensure compliance with the contractual or licensing requirements?

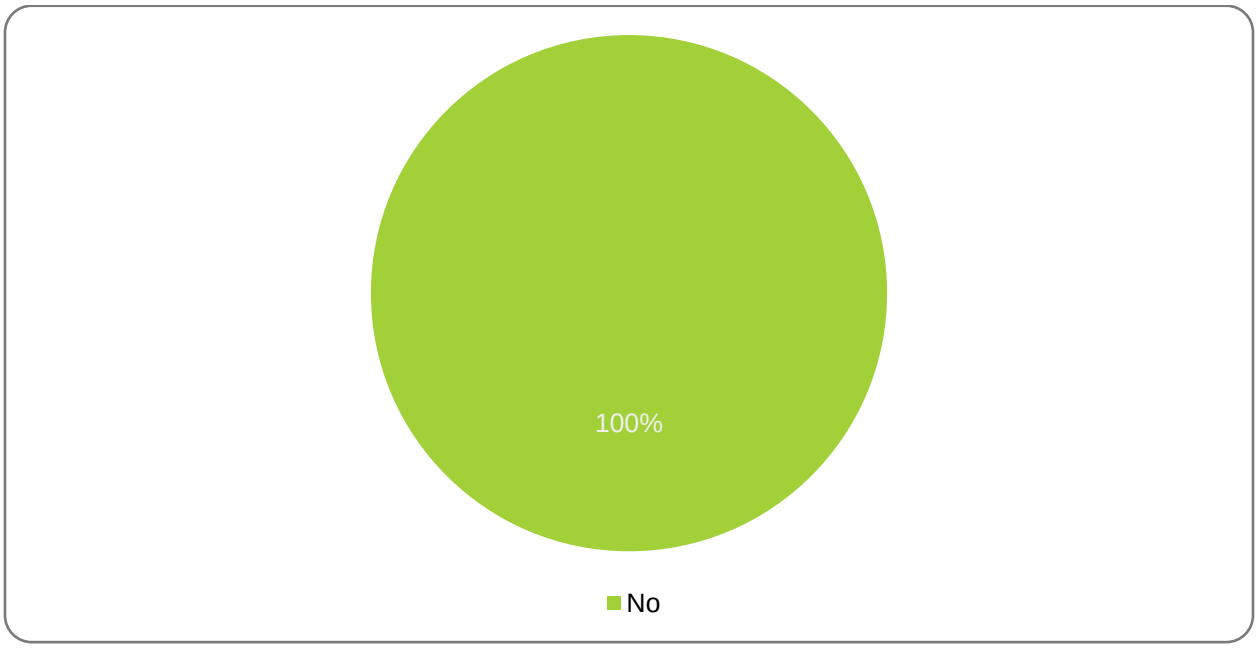


Q19: What type of enforcement would be helpful to support implementation of a behavioral health bed registry? (Select all that apply*)

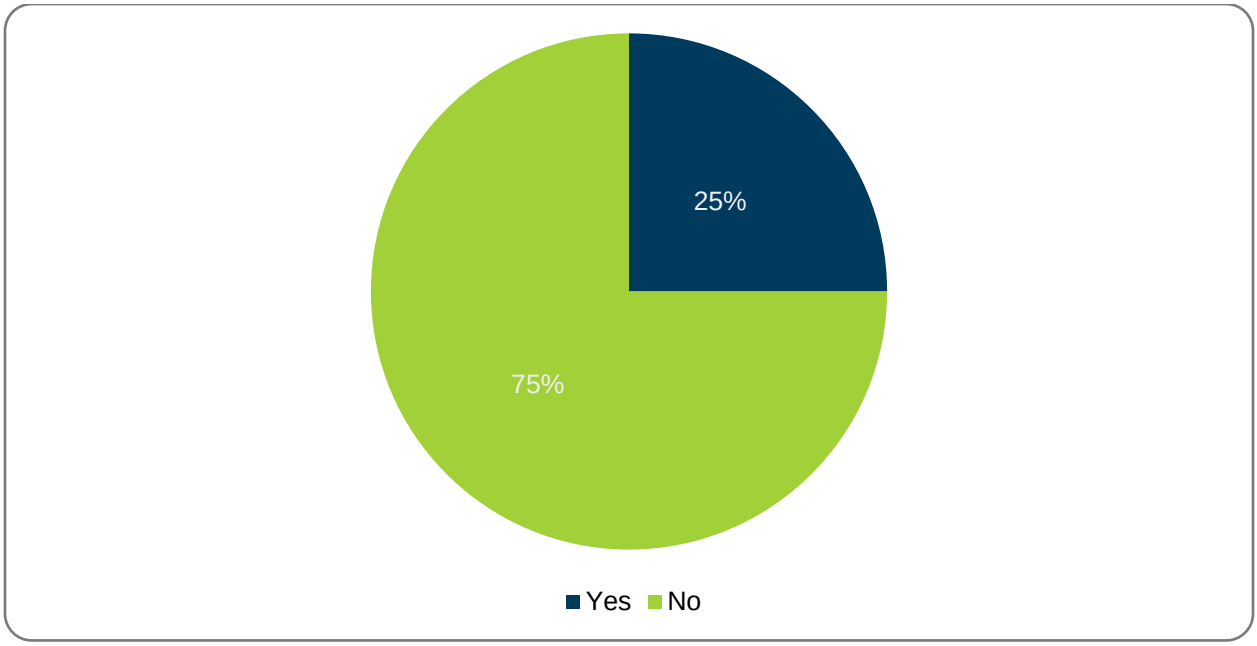


*In this question, survey respondents had an option to select more than one response for which the total percentage is over 100.

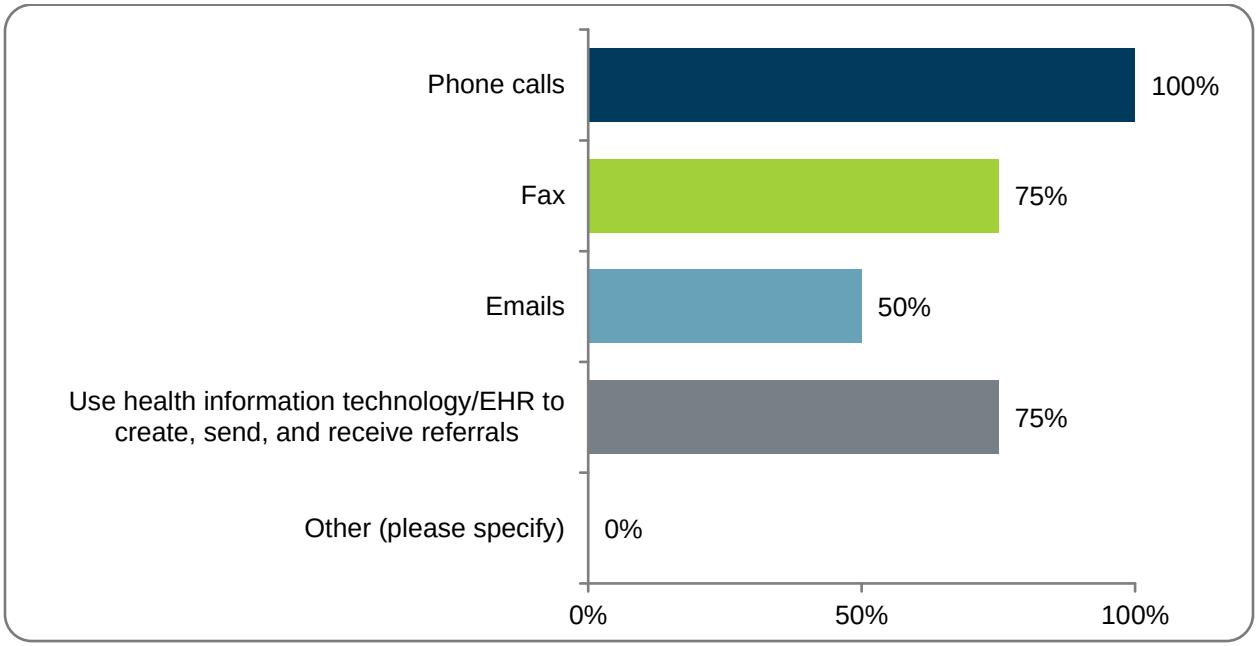
Q21: Are there existing contractual requirements for behavioral health providers to update their capacity?



Q23: Are you aware of system(s) that are in place to send/receive referrals within your behavioral health provider network?

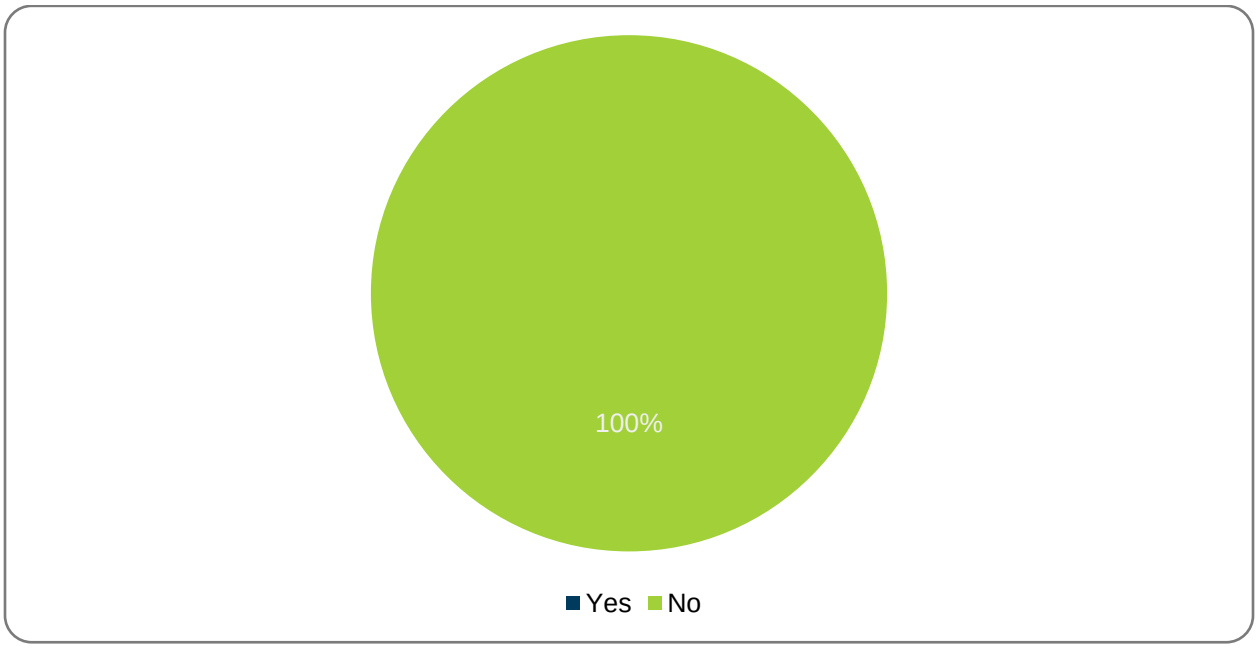


Q25: In your experience, how do provider(s) in your behavioral health provider network currently make referrals? (Select all that apply*)

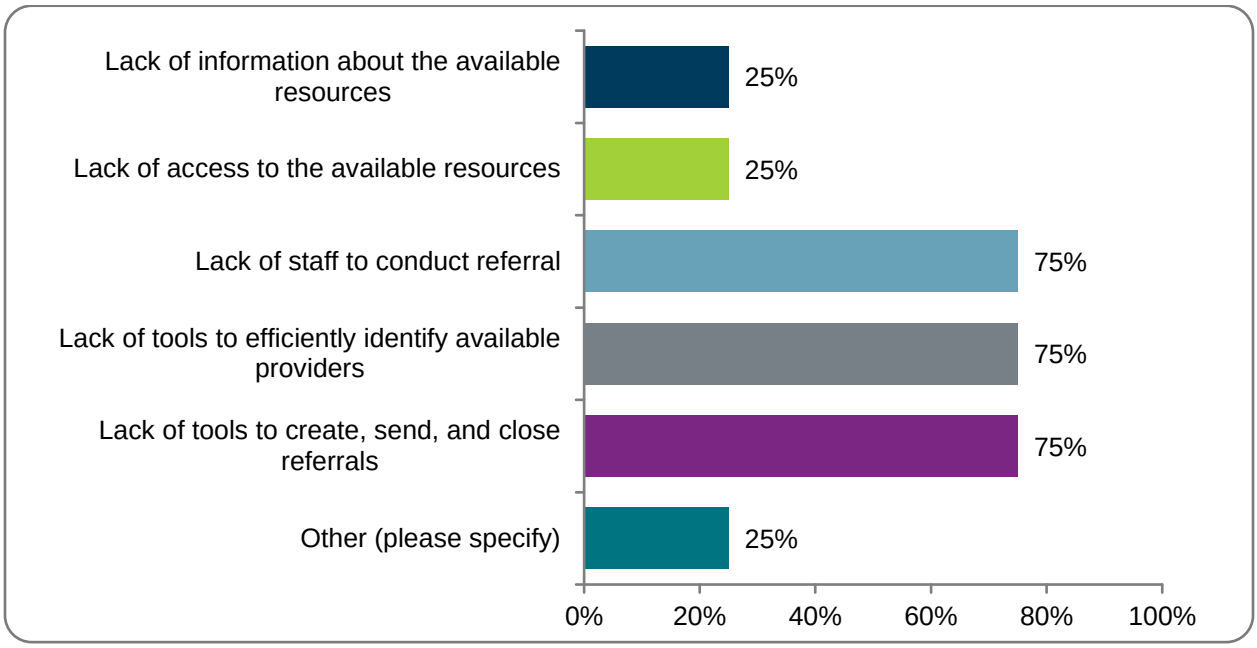


*In this question, survey respondents had an option to select more than one response for which the total percentage is over 100.

Q26: Are there existing contractual requirements for behavioral health providers to share information about referrals to and/or from the crisis continuum of care?



Q28: In your experience, what are the challenges with the current referral process? (Select all that apply*)

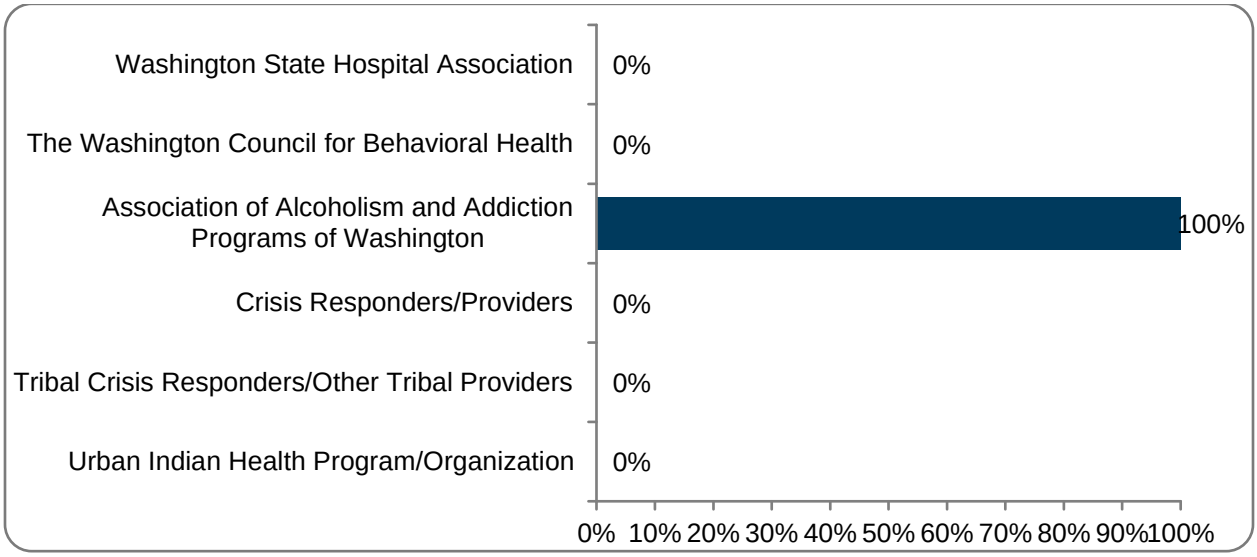


*In this question, survey respondents had an option to select more than one response for which the total percentage is over 100.

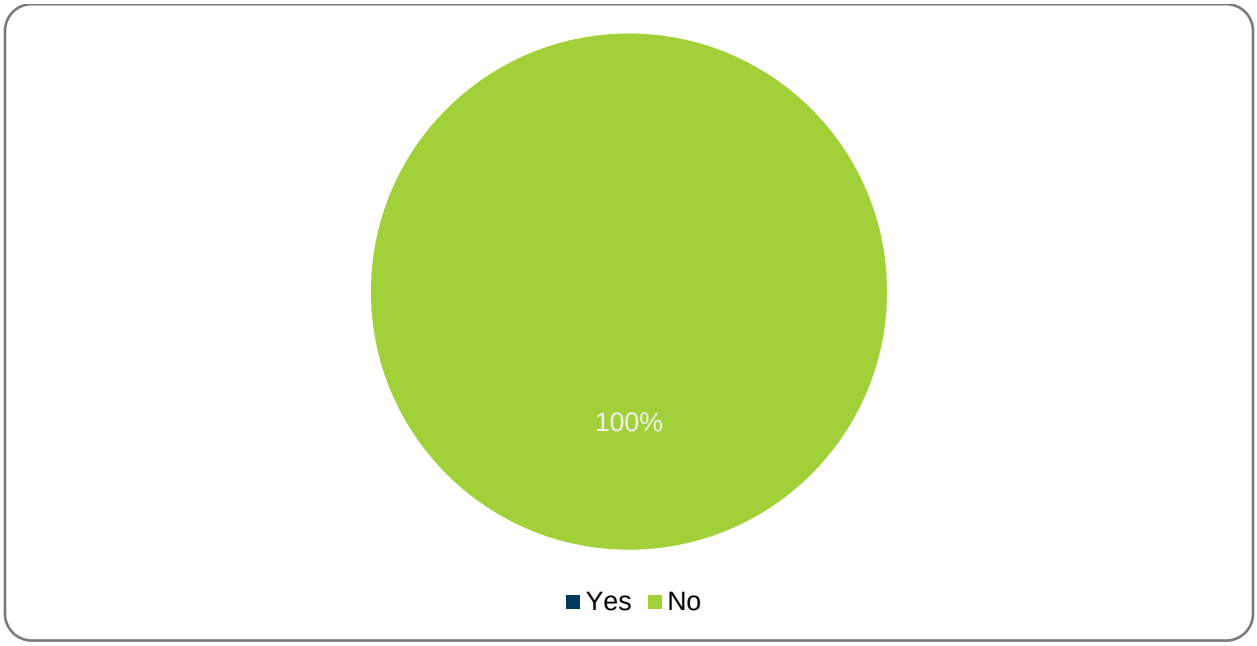
Survey respondents indicated another challenge with the current electronic referral process included behavioral health agencies not reporting bed availability.

Association of Alcoholism and Addiction Programs of Washington Web Survey Results

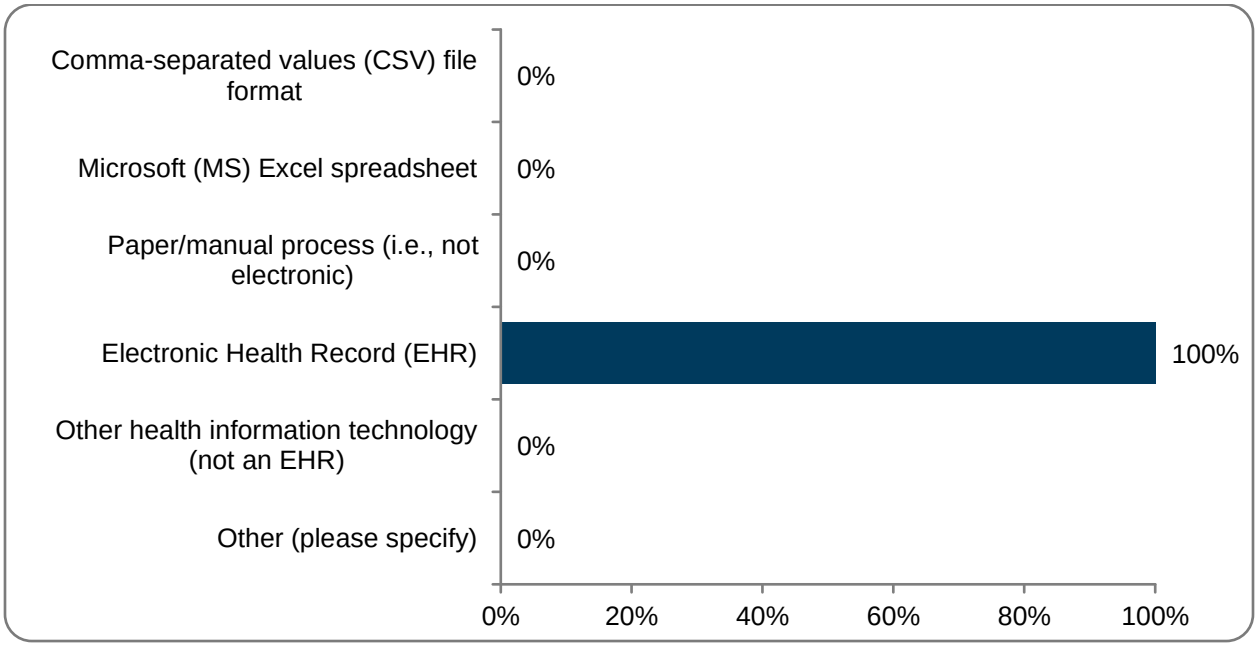
Q1: Which of the following best describes your organizational affiliation?



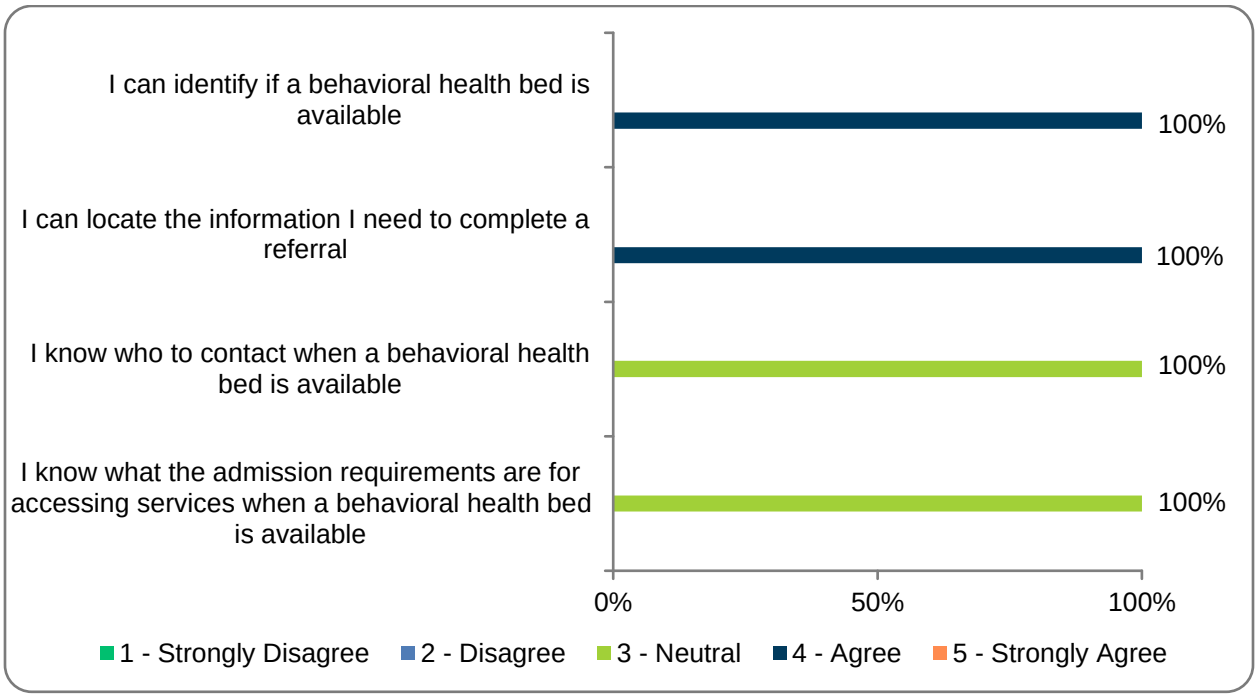
Q2: Does your organization/program have system(s) in place to track behavioral health bed availability?



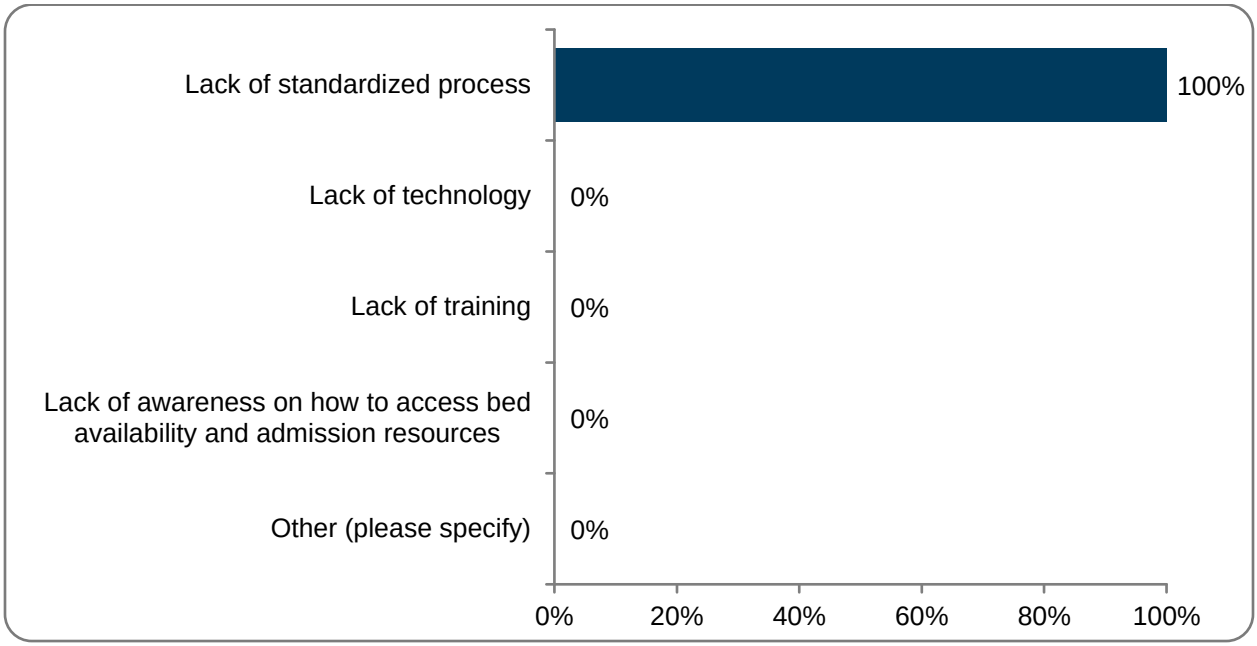
Q5: Which of the following describes how you/your agency currently track behavioral health bed availability in your facility?



Q6: Please rate each of the following using a scale of 1 to 5 with 1 being strongly disagree and 5 being strongly agree:

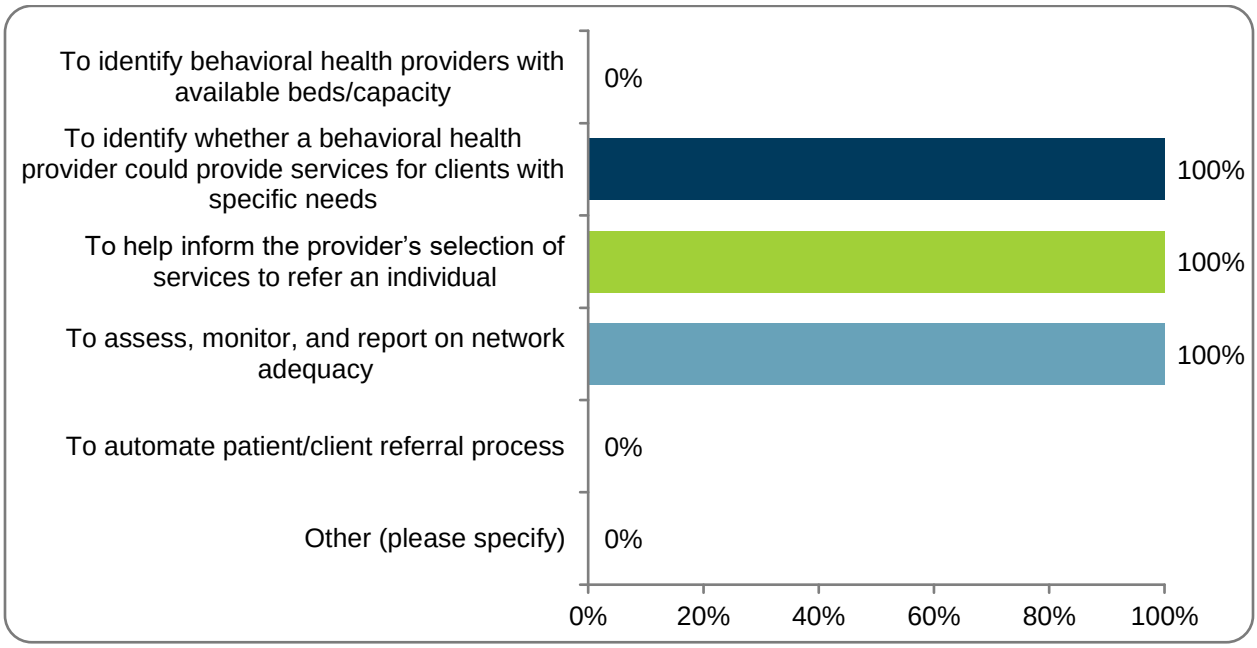


Q7: What are the challenges with the current process (i.e., paper-based or electronic) to identify and access behavioral health bed availability? (Select all that apply*)



*In this question, survey respondents had an option to select more than one response for which the total percentage is over 100.

Q8: Which of the following describes how you/your agency would use a behavioral health bed registry? (Select all that apply*)

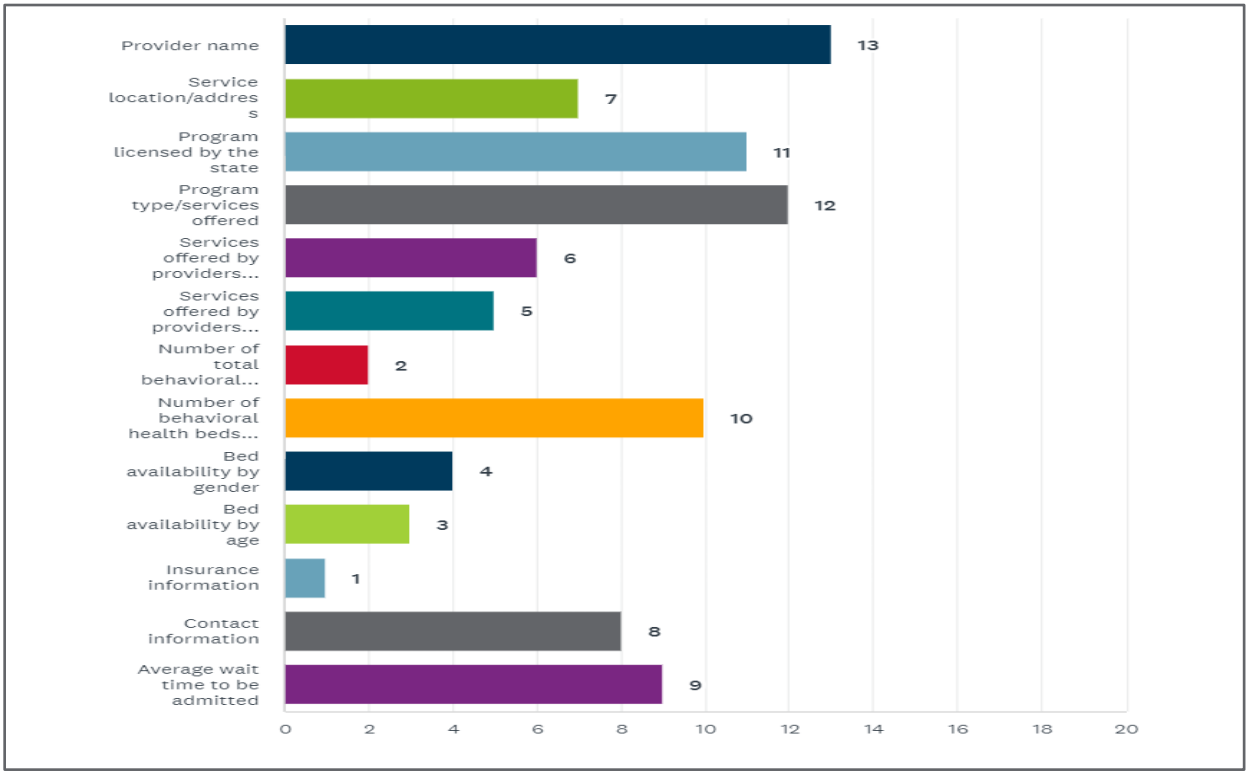


*In this question, survey respondents had an option to select more than one response for which the total percentage is over 100.

Q9: Indicate which of the following information/content is necessary to include in the behavioral health bed registry? (Please rank the options below in order of priority)

The top-five priority list identified by the interested parties was:

1. Provider name
2. Program type/services offered
3. Program licensed by the state
4. Number of BH beds available
5. Average wait time to be admitted



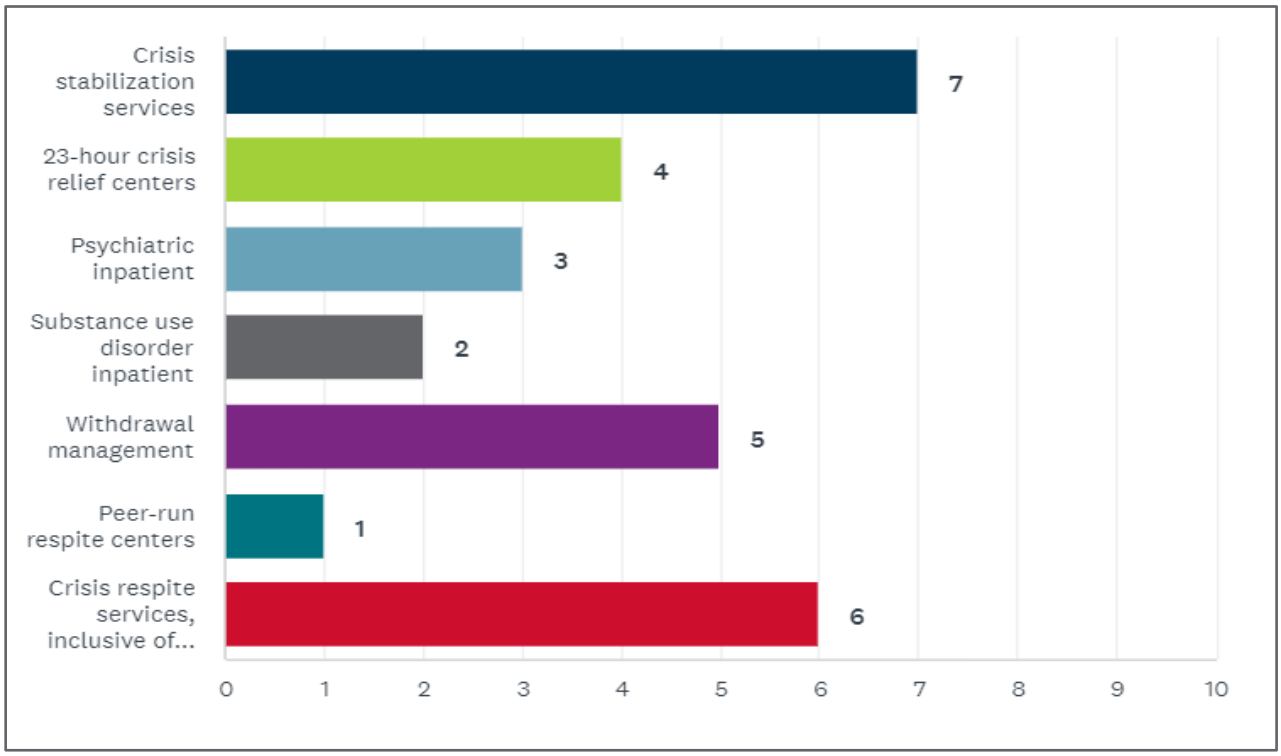
* Graph represented in weighted average

Q10: Which of the following behavioral health bed types should be included in a behavioral health bed registry? (Please rank the options below in order of priority)

The top five BH bed types identified by the interested parties were:

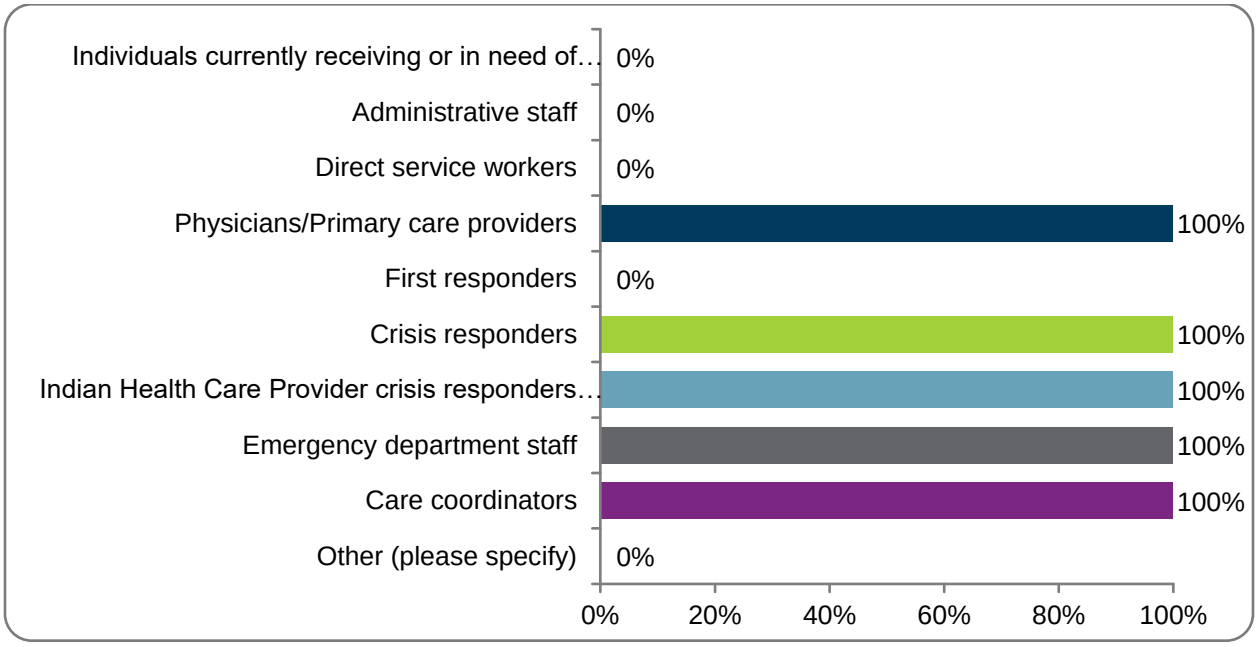
1. Crisis stabilization services
2. Crisis respite services, inclusive of both voluntary and involuntary beds
3. Withdrawal management
4. 23-hour crisis relief centers

5. Psychiatric inpatient



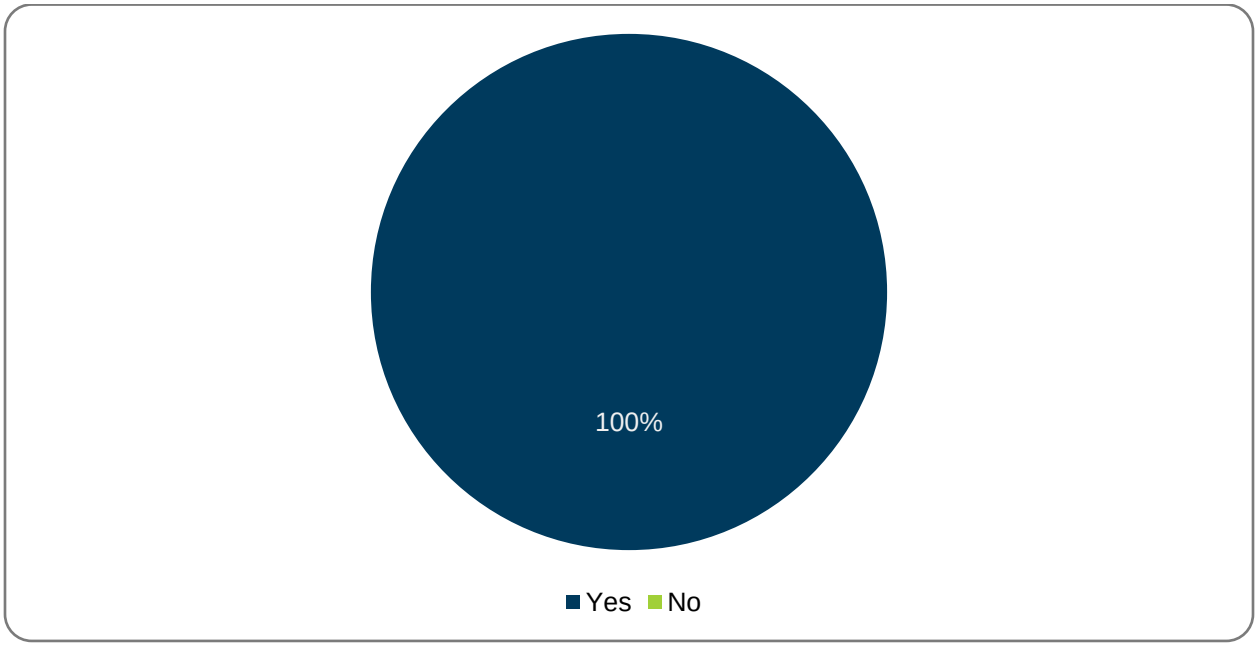
* Graph represented in weighted average

Q12: Who should have access to some or all of the behavioral health bed registry? (Select all that apply)

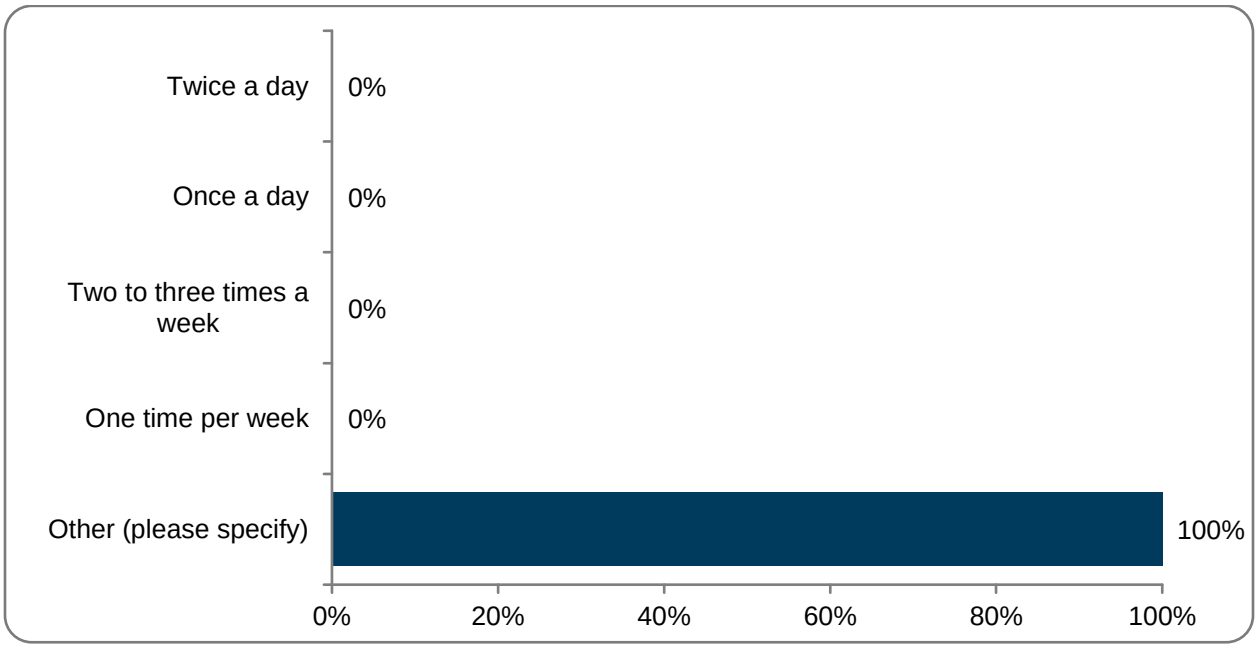


*In this question, survey respondents had an option to select more than one response for which the total percentage is over 100.

Q13: Should individuals in crisis and/or their family members have access to a behavioral health bed registry?

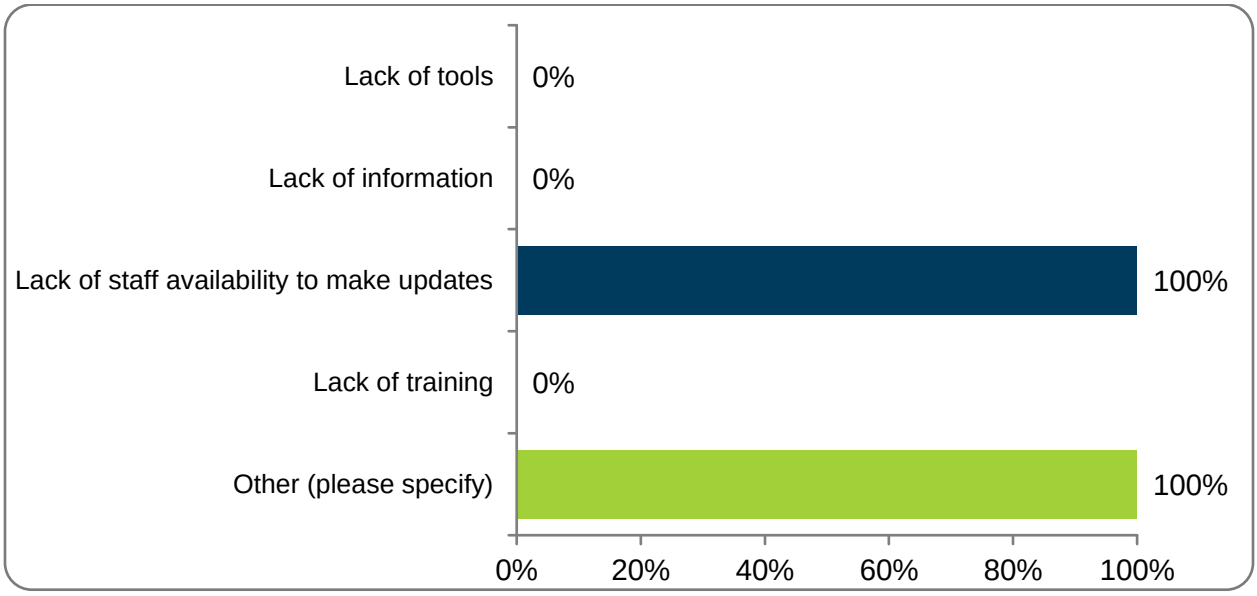


Q15: What is the desired cadence/frequency for providers to update the behavioral health bed registry?



Survey respondents indicated another frequency for providers to update the behavioral health registry is as needed.

Q16: What potential barriers do you foresee with providers updating the behavioral health bed registry? (Select all that apply*)



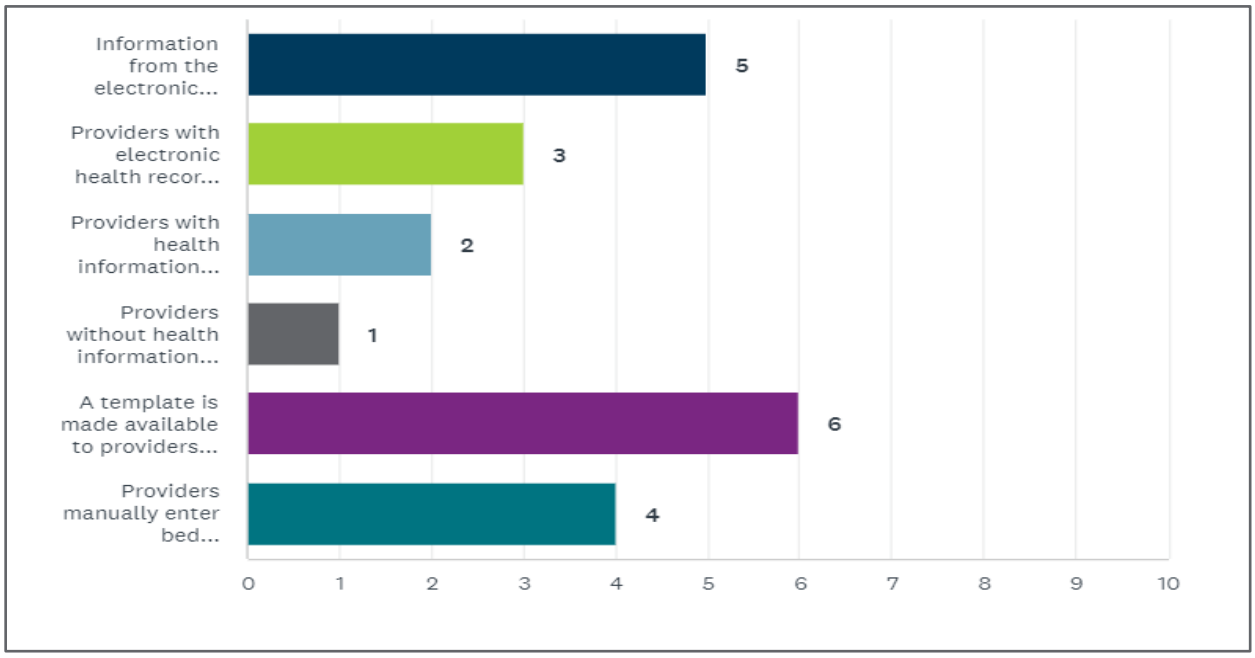
*In this question, survey respondents had an option to select more than one response for which the total percentage is over 100.

Survey respondents indicated another potential barrier for providers to update the behavioral health registry is the variability of bed availability.

Q18: What would be the preferred method(s) for how the information within the behavioral health bed registry would be updated? (Please rank the options below in order of priority)

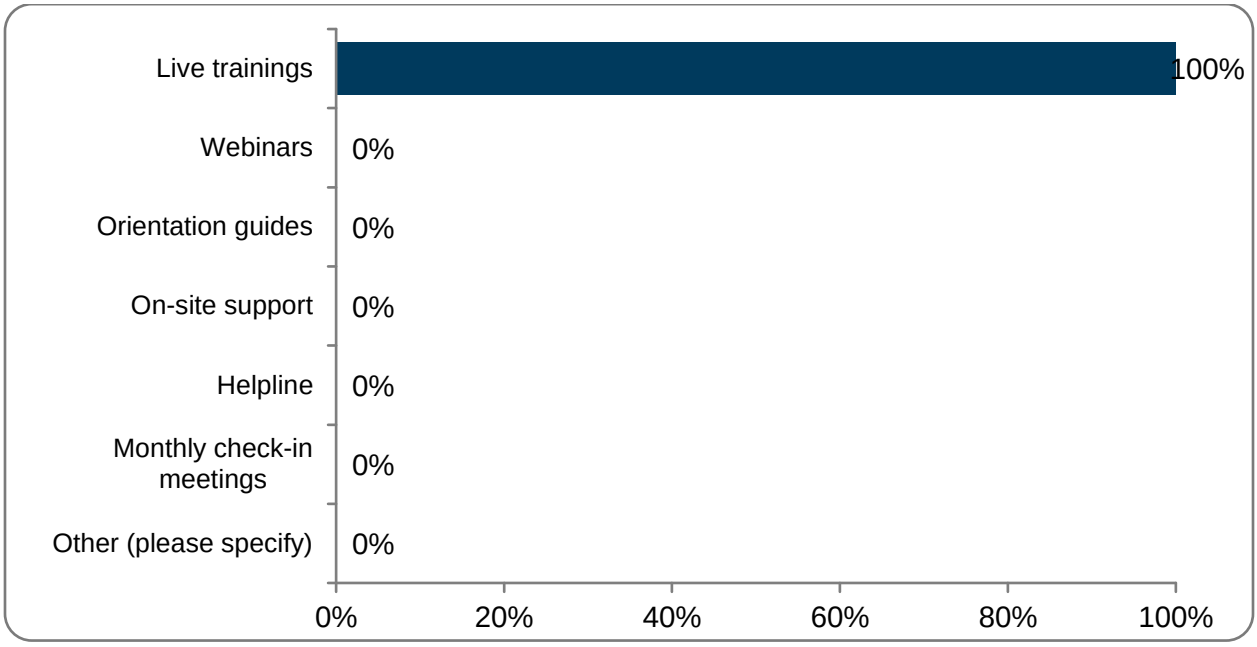
The top five preferred methods for information within the BH bed registry identified by the interested parties were:

1. A template is made available to providers to update bed availability information
2. Information from the electronic closed-loop referral tool(s) would automatically update a provider's available beds in the behavioral health bed registry when a referral is accepted
3. Providers manually enter bed availability into the web-based behavioral health bed registry at a pre-determined cadence (e.g., once a day)
4. Providers with EHRs would create ADT summaries when an individual is admitted, discharged, transferred and the ADT would be shared with the registry to update bed availability
5. Providers with health information technology/EHR tools would automatically track and send information about available bed capacity to the behavioral health bed registry



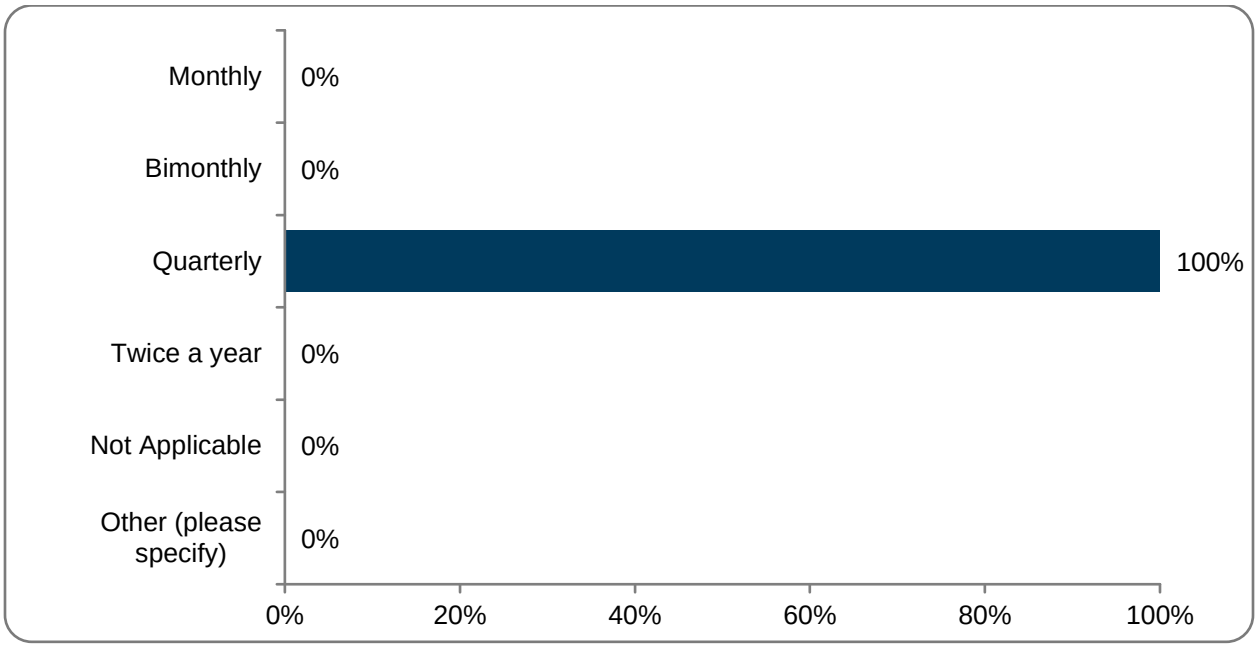
* Graph represented in weighted average

Q19: What support and tools would be helpful for you/your agency to implement a behavioral health bed registry? (Select all that apply*)

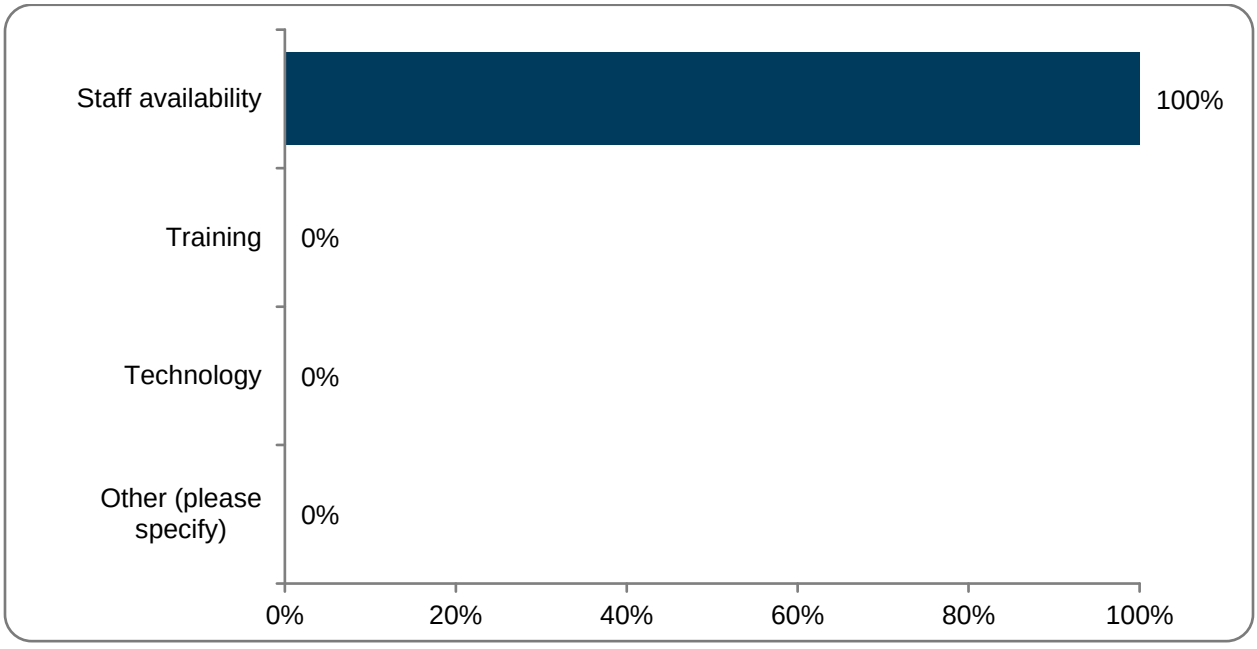


*In this question, survey respondents had an option to select more than one response for which the total percentage is over 100.

Q20: If you selected live trainings on the previous question, how often should the live trainings be offered to support implementation and use of a behavioral health bed registry?

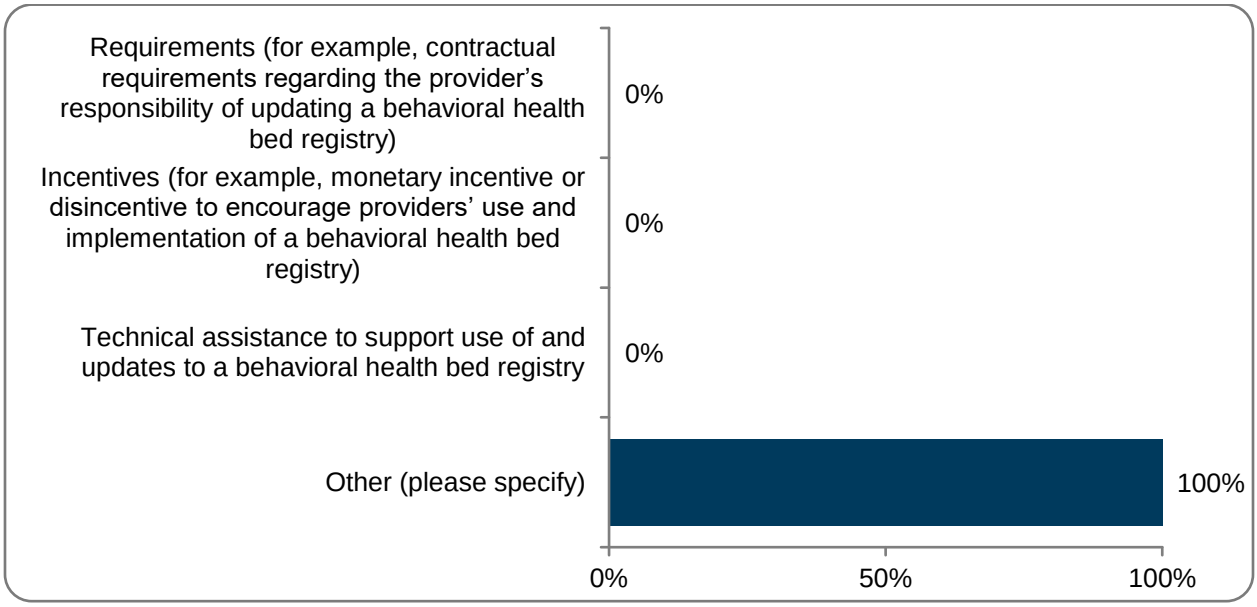


Q21: What barriers do you anticipate regarding the ongoing use and adoption of the behavioral health bed registry? (Select all that apply*)



*In this question, survey respondents had an option to select more than one response for which the total percentage is over 100.

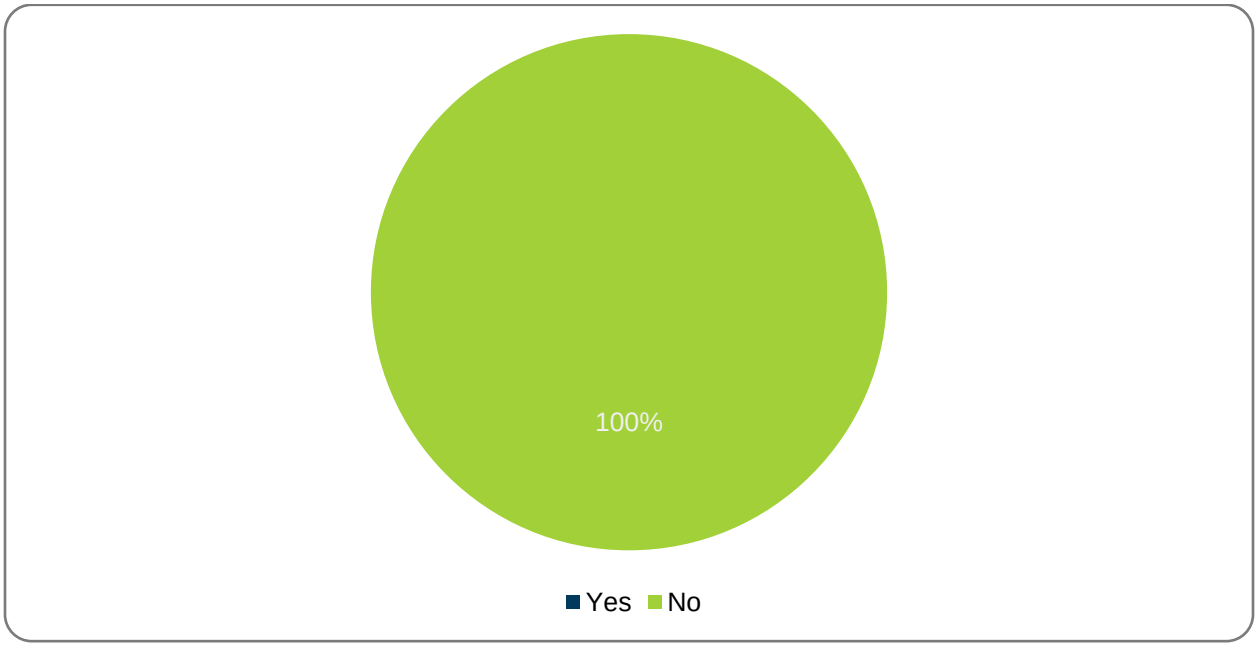
Q22: Which of the following do you think would support the implementation of a behavioral health bed registry? (Select all that apply*)



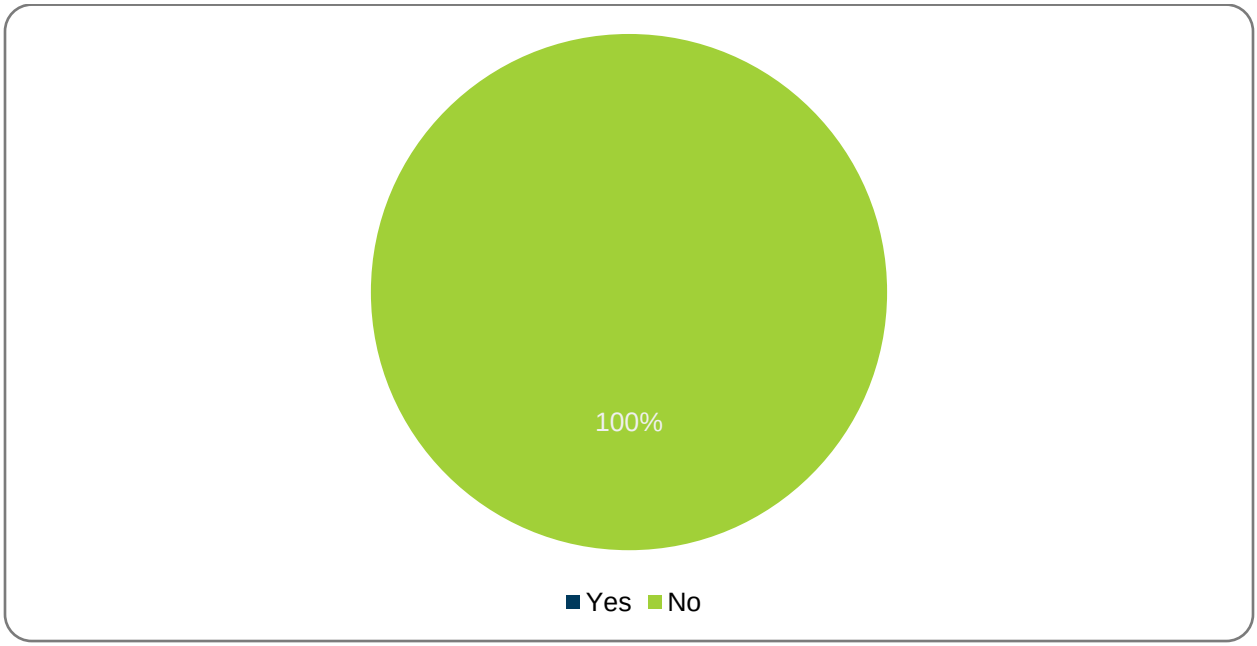
*In this question, survey respondents had an option to select more than one response for which the total percentage is over 100.

Survey respondents indicated another support for the implementation of a behavioral health bed registry is making it voluntary.

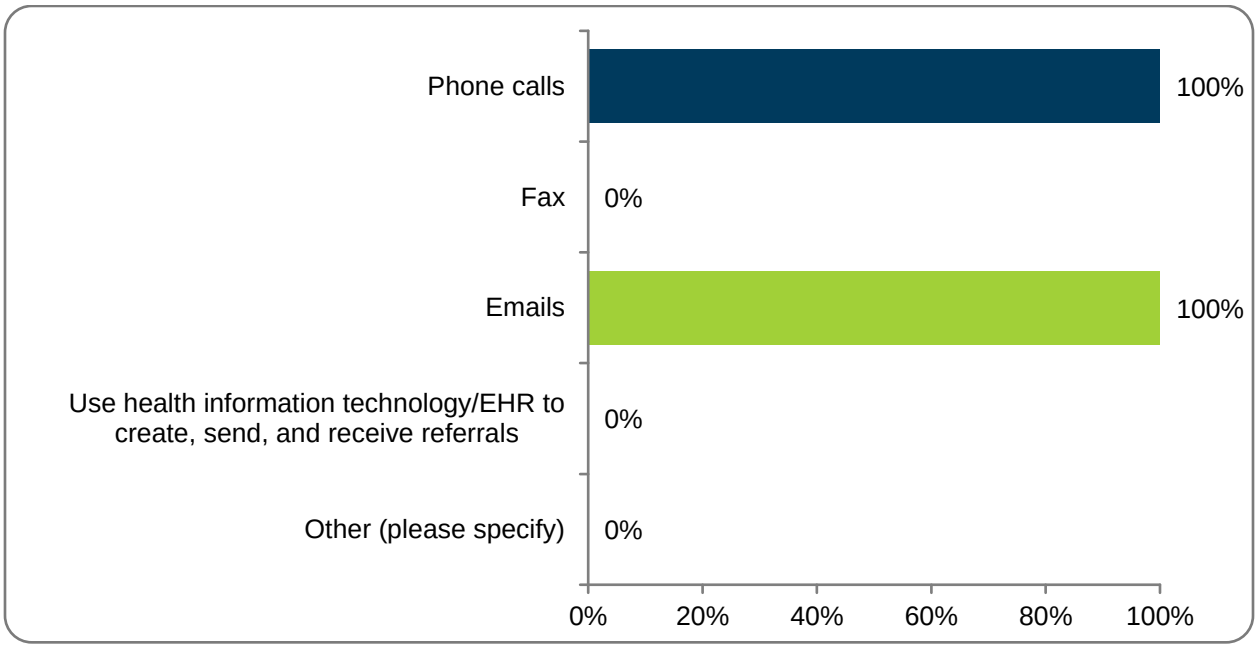
Q25: Is enforcement necessary to help ensure compliance with the contractual or licensing requirements?



Q28: Does your organization/program have system(s) in place to send and receive referrals?

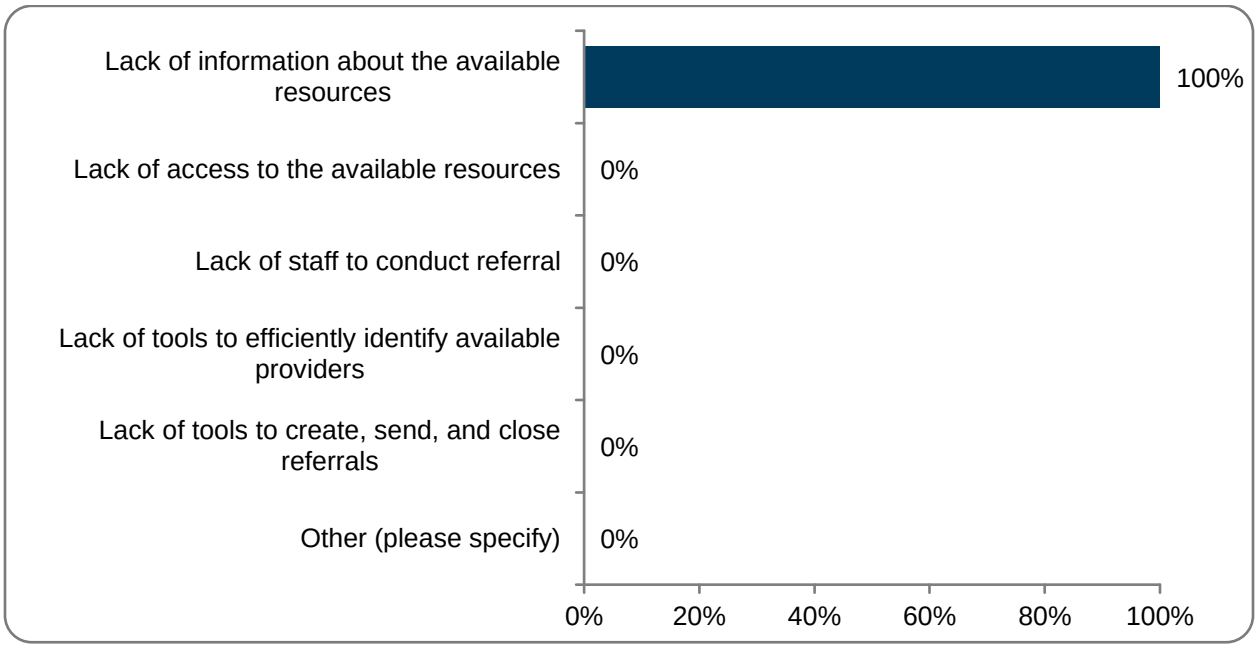


Q30: Which of the following describes how you/your agency makes referrals in the current environment? (Select all that apply*)



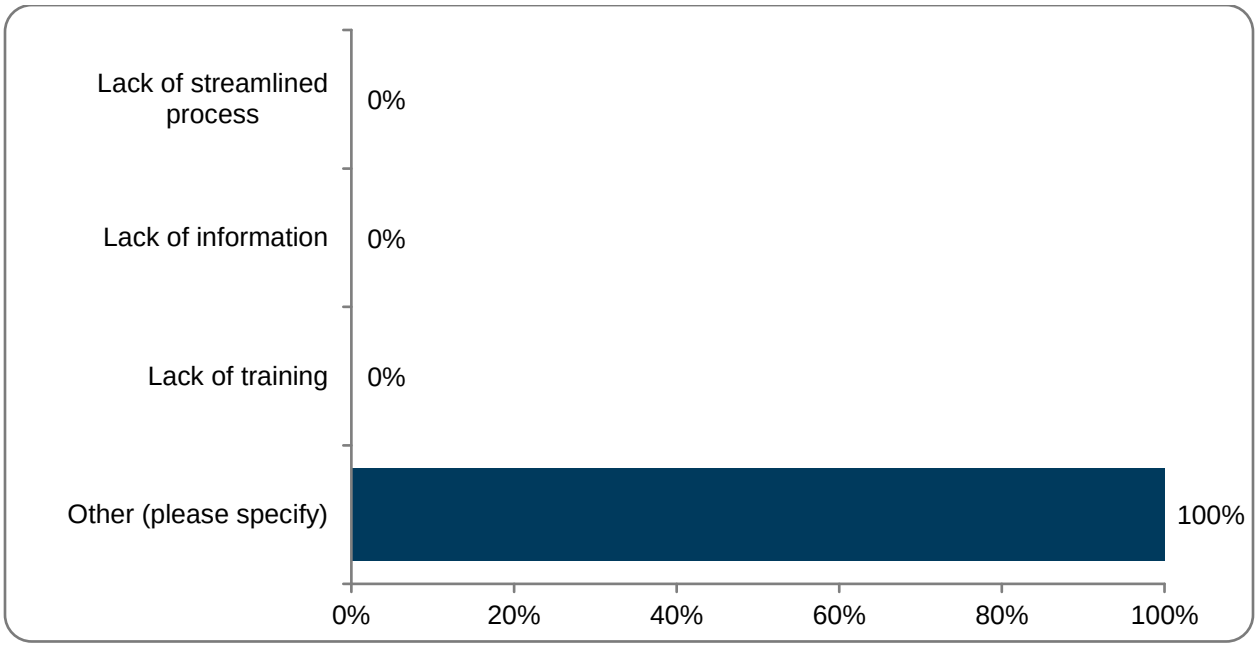
*In this question, survey respondents had an option to select more than one response for which the total percentage is over 100.

Q31: What are the challenges with the current referral process? (Select all that apply*)



*In this question, survey respondents had an option to select more than one response for which the total percentage is over 100.

Q32: What challenges do you anticipate in the use and adoption of electronic referral tools? (Select all that apply*)



*In this question, survey respondents had an option to select more than one response for which the total percentage is over 100.

Survey respondents indicated another challenge for the adoption of an electronic referral tool is 42 CFR part 2.

Appendix G: 14344 Automated Email Template for Providers

HCA created a 14344 automated email for its providers as shown below to send when data is missing from a required report email for WA HEALTH.

Data Upload-Create Automated Email to be Generated for Missing Data

When the Acute Care Facility is late or fails to report data to WA Health, an email should be sent automatically to all Organization Care Workers. The email should specify the missing data requirements and inform them that they must submit them.

Parameters for missing data:

- Please ensure that the email is delivered by 5 am.
- Monday morning – Email will be issued for missing required elements from the previous week.
- Tuesday -Friday morning – Email will be issued if the user is missing any previous third and second days and/or is out of the backdating window for required elements.
- Emails will not be sent on State Holidays.
- Please follow the Reporting Cadence as mentioned in the Admin App for necessary reporting.

Emails:

- **Monday morning** – Email will be issued for facilities missing required elements outside of the backdating 3-day window.

  Good morning,

  This is a reminder that your facility is missing WA HEALTH data outside of the 3-day backdating window for (*Insert Date*). Please contact the WA HEALTH team at wahealth@doh.wa.gov for assistance in submitting the required data.

  Thank you!

  Your WA HEALTH Team

- **Tuesday -Friday morning** - Email will be issued for facilities missing required elements outside of the backdating 3-day window.

  Good morning,

  This is a reminder that your facility is missing WA HEALTH data outside of the 3-day backdating window for (*Insert Date*). Please contact the WA HEALTH team at wahealth@doh.wa.gov for assistance in submitting the required data.

  Thank you!

Your WA HEALTH Team

- **Tuesday -Friday morning** - Email will be issued for facilities missing required elements from "3 days prior" and also "2 days prior."

  Good morning,

  This is a reminder that your facility is missing WA HEALTH data for (*Insert Date*). You still have time to report as you are within the 3-day backdating window for WA HEALTH.

  Thank you for your cooperation, and please let us know if you require any assistance.

  Thank you!

  Your WA HEALTH Team

Appendix H: Department of Health Proposed Rule

DOH proposed rule states:

WAC 246-530-001 Purpose and authority. RCW 43.70.040 (1) The purpose behind WA HEALTH is to bridge the relationship between the department and healthcare facilities to allow for a statewide common operating picture of resource availability. It is essential for the department, facilities, and people seeking healthcare in Washington state to have a state-level situational awareness and monitoring of timely and accurate data about patient volumes, capacities, and resource constraints in Washington's healthcare ecosystem to help ensure continued health system readiness and to mitigate the impact of current and emerging public health threats and associated surges. The purpose of this section is to outline each hospital's responsibility for reporting to the department data pertaining to the maintenance and operation of the hospital in support of health system readiness.

WAC 246-530-010 Definitions. (1) "Department" means the department of health.

(2) "WA HEALTH" means Washington Healthcare Emergency and Logistics Tracking Hub.

(3) "WA HEALTH User Guide" means the written instructions issued by the department for reporting to the department hospital readiness and operation data pertaining to health system readiness. Copies of the WA HEALTH User Guide may be obtained on the department's website (https://doh.wa.gov/public-health-provider-resources/wa-health) or by contacting the department.

WAC 246-530-020 Designation of qualifying facilities. (1) Acute care hospitals and facilities in Washington state, licensed under chapter RCW 70.41, must report critical healthcare, readiness, and operation data to the department through WA HEALTH in accordance with the WA HEALTH User Guide. (2) Behavioral health agencies and facilities in Washington state, licensed under chapter RCW 71.24.037 must report critical healthcare, readiness, and operation data to the department through WA HEALTH in accordance with the WA HEALTH User Guide.

[Statutory Authority: RCW 43.70.040, 70.41.030, 71.24.035(7), and 71.24.015(3).]

Appendix I: Department of Health Proposal Related to Type of Data

Below is the information related to the type of data in DOH's proposed rule:

WAC 246-530-030 Reporting data set information. (1) Facilities must report data to the department in accordance with the WA HEALTH User Guide, including any amended versions thereof issued by the department.

(2) The categories of data required to be reported to WA HEALTH for acute care hospitals and facilities include:

(a) Bed occupancy

(b) Communicable disease

(3) The categories of data required to be reported to WA HEALTH for behavioral health agencies and facilities include:

(a) Bed occupancy

(4) The department may require additional data components to be reported to WA HEALTH according to the WA HEALTH User Guide.

WAC 246-530-040 DOH compliance monitoring. The department may deny, suspend, modify, or revoke a license under RCW 70.41 when it finds an applicant or hospital has failed or refused to comply with WAC 246-320.