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Rural Behavioral Health Access Study

Washington State Health Care Authority

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Rural Behavioral Health Access Study — Overview

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Rural Behavioral Health Access Study

Background

ESSB 5693, Chapter 297, Laws of 2022, Section 215, Proviso 110

The State of Washington's Health Care Authority (HCA) was tasked by the Washington State Legislature to examine challenges to receiving timely access to behavioral health (BH) services in rural counties.

Emphasis on the following focus areas:

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

Rural Counties

- To define rural communities, and for this study, Washington utilizes the Washington State Office of Financial Management's definition of a rural county as a county with a population density less than 100 persons per square mile.

Behavioral Health Administrative Services Organizations (BH-ASOs)

- Washington State utilizes ten regionally based BH-ASOs whose BH network responsibilities include crisis hotline services, mental health (MH) crisis services such as mobile crisis, short-term substance use disorder (SUD) crisis services, and Involuntary Treatment Act (ITA) assessments and administration of detention petitions.

Rural Behavioral Health Access Study

Methodology

Data and Reports	Reviewed crisis system utilization data collected by BH-ASOs and other BH-related reports shared by HCA.
Network Standard Analysis	Reviewed Managed Care Organization (MCO) and BH-ASO network adequacy standards as outlined in the Apple Health and BH-ASO contracts.
Surveys	Analyzed survey data from select BH providers.
Interviews	Mercer facilitated three in-depth interviews with BH-ASOs and MCOs.
Tribal Listening Session	Analyzed data collected during a tribal listening session.
Legislative Reports	Synthesized and reproduced information published in recent legislative reports specific to issues experienced by tribal populations, including recommendations to improve tribal BH service delivery systems.

Focus Area 1: DCR Response Times

Survey and Interview Findings

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

- Insufficient staff coverage and a perceived lack of funding to recruit additional DCR staff.
- A lack of cellular phone service coverage in remote areas.
- Extensive travel times in remote areas.

DCR Data collection by BH-ASOs

All responding BH-ASOs reported they collect emergent DCR response times for rural areas, but only two collect for urgent DCR response times.

ITAs

The average time DCRs spent on ITAs from start to finish was 368 minutes.

Focus Area 2: Access to IP and OP BH Services

Survey and Interview Findings

Top Challenges to Offering a Wide Array of BH Services in Rural Counties

- A pervasive lack of available BH providers in rural areas, including Spanish-speaking providers.
- Staffing shortages, including attracting and retaining qualified providers to relocate and live in rural areas.

Top BH Services with Extended Delays to Access the Service

- Children's Long-Term Inpatient Program (CLIP). Accessing CLIP can take months and children are often placed out-of-state
- Involuntary IP psychiatric/MH free-standing evaluation and treatment.

Services with Wait Times

Many BH services have documented wait times, but the wait times vary depending on the respondent and County.

Focus Area 3: Hospital Bed Wait Times

Survey and Interview Findings

Bed Volume and Availability

All respondents reported there are not enough beds for youth (especially children aged 12 years and under in which only one facility is available statewide), but most responded there are enough for adults.

Process to Obtain a Bed

There does not appear to be a standardized process to identify if an IP, MH, or SUD bed is available.

Top Reasons for a No-Bed Report

- Lack of available beds — particularly for youth aged 12 years and under.
- Lack of providers.
- Lack of staffing.
- Level of acuity — medically, BH, SUD needs

Focus Area 4: Timely Access to Mobile Crisis Teams

Survey and Interview Findings

Team Composition and Staffing

Many smaller counties maintain one mobile crisis team per shift due to staffing shortages, and some struggle to maintain 24/7 availability.

Availability

Most BH-ASOs report that demand sometimes exceeds staffing capacity, although this is uncommon. One BH-ASO reports meeting two-hour response times 98% of the time.

Mobile Crisis Team Data Collection

All BH-ASOs report they track if urgent and emergent mobile crisis team service requests/referrals meet contract standards (for rural counties).

Tribal Listening Session Findings

- Availability of providers, programming, and facilities
- Workforce challenges
- Geographic service area characteristics
- Other challenges

Focus Area Specific Recommendations

DCR Response Times

1

Continue efforts to expand DCR staffing resources and review compensation schedules to assist with the recruitment and retention of DCRs in rural areas.

2

Offer DCR services via telehealth to supplement the ongoing availability of DCRs.

3

Coordinate DCR functions within the existing crisis response continuum to maximize limited staffing resources.

Focus Area Specific Recommendations

Access to IP and OP BH Services

1

- Offer BH professionals, including bilingual Spanish-speaking staff, **relocation assistance and sign-on bonuses** to address staff shortages in rural areas.

2

- Continue efforts to promote **telehealth options** for a variety of OP BH services.

3

- Sponsor and execute a **rural BH provider reimbursement rate study** and, as appropriate, adjust rates to reflect the current market values.

Focus Area Specific Recommendations

Hospital Bed Wait Times

1

Continue efforts to develop and implement a centralized statewide ITA bed repository to assist DCRs and community members to efficiently identify facilities that have available beds.

2

Enhance the continuum of available BH OP services, such as Program of Assertive Community Treatment, intensive OP services, and medication monitoring services to address extended lengths of stay in acute IP settings.

3

Work with the Washington State Hospital Association and local legislators to review and alleviate reported hospital practices related to refusing admission to members perceived to be challenging.

Focus Area Specific Recommendations

Timely Access to Mobile Crisis Teams

Provide, at a minimum, **annual training to support and develop** law enforcement agencies' understanding of BH emergencies and crises; provide and support the delivery of CIT training.

Continue to support the **expansion of mobile crisis teams** including tribal mobile crisis response teams in tribal communities.

Offer flexibility in terms of expectations for mobile crisis teams dedicated to serving youth. Many BH-ASOs have adopted a **hybrid approach** that includes BH staff who are appropriately trained to support adults, adolescents, and children who are experiencing a BH crisis.

Tribal Delivery System Recommendations

Continue efforts to develop the capacity to provide IP MH services by Indian Health Care Providers (IHCPs) on tribal lands, including the development of a culturally appropriate Tribal Evaluation and Treatment/Secure Withdrawal Management Facility.

Adopt legislation to enhance tribes' ability to provide crisis services to their tribal and community members including notification to tribes for ITA investigations of tribal members and American Indians and Alaska Natives with an IHCP as a medical home

Offer funding, training, and technical assistance to tribes and IHCPs on enhancing crisis services, including the development of tribal mobile crisis response, tribal DCR (T-DCR) tribal codes, DCR processes and procedures/T-DCR protocols, operationalization of T-DCR, and tabletop exercise for tribes.

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