Washington State Health Care Authority

Report to the Legislature

Statewide substance use disorder (SUD) prevalence and cross-sector interactions: inventory of data and reporting capabilities

Final report

Revised Code of Washington 71.24.913(2)(b)

December 1, 2024

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Executive summary

This final inventory report fulfills the requirement outlined in RCW 71.24.913, which directs the Health Care Authority (HCA) to provide a final inventory report to the Governor and the Legislature by December 1, 2024. The inventory catalogues the data sources available to the Health Care Authority that fit the requirements identified in the bill, documents the definitions requiring additional clarification, and contains information on non-HCA data sources as well as recommendations for additional data connections and data share agreements.

RCW 71.24.913 also requires that, beginning in 2026, HCA must include regular assessments of the prevalence of substance use disorder (SUD) and interactions of persons with SUD with service providers, nonprofit service providers, first responders, health care facilities, and law enforcement agencies, as part of an annual report which began in July 2024.

SUD prevalence reporting: inventory of necessary and available data

Background

The Revised Code of Washington (RCW) 71.24.913 requires that, beginning in 2026, HCA includes regular assessments of the prevalence of substance use disorder (SUD) and interactions of persons with SUD with service providers, nonprofit service providers, first responders, health care facilities, and law enforcement agencies, as part of an annual report which began in July 2024.

HCA was directed to provide a final report to the Governor and the Legislature by December 1, 2024, including a comprehensive assessment of the inventory of:

1. Types and sources of data available to HCA.
2. Data necessary but currently unavailable to HCA.
3. Recommendations for new data sources, data connections, data sharing authorities, and developing supportive legislation.

Methodology

Given the broad scope and implications for the potential interactions persons with SUD may have with these entities, for the purposes of this report, this language has been interpreted to be regarding how the interactions relate to or provide outcome data for HCA-administered behavioral health service programs.

The intent of this report is to create a comprehensive list of Washington State's data systems and databases that capture the population affected by SUD that can be potentially served by HCA-administered behavioral health service programs. Where possible, the report identifies methods of sharing aggregated information to limit access to protected health information.

Between May and August 2024, HCA conducted over 100 interviews with behavioral health program managers, nonprofit organizations, researchers, data leaders from 15 state agencies, and university researchers to gather information on data systems that will be necessary for HCA to meet the data reporting requirements specified in RCW 71.24.913.

Table 1: Definitions and descriptions of key terms

Terms	Definitions
Substance use disorder (SUD)	According to RCW 71.24.025, "substance use disorder" means a cluster of cognitive, behavioral, and physiological symptoms indicating an individual continues using the substance despite significant substance-related problems. The diagnosis of a SUD is based on a pathological pattern of behaviors related to the use of substances. See also 42 CFR 2.11 "substance use disorder (SUD)": Part 2 expands on this definition by elaborating on what is considered "significant substance-related problems." It includes "impaired control, social impairment, risky use, and pharmacological tolerance and withdrawal. For the purposes of the regulations in

Terms	Definitions
	this part, this definition does not include tobacco or caffeine use."[1] Based on these definitions, SUD is interpreted as diagnosed and undiagnosed SUD (e.g., self-report or observation) in this report.
Service providers	Those who provide physical and behavioral health services, as well as social services, including housing support, homeless prevention, and other publicly funded services. In the tables of this report, the term "service providers" is used to include both service providers and nonprofit providers.
First responders	RCW 71.24.025(32), first responders includes ambulance, fire, mobile rapid response crisis team, co-responder team, designated crisis responder, fire department mobile integrated health team, community assistance referral and education services program under RCW **35.21.930**, and law enforcement personnel. According to **RCW 70.54.430**, first responders are defined as law enforcement officers, coroners, medical examiners, firefighters, and emergency medical personnel.
Law enforcement	According to **RCW 10.93.020**, general authority Washington law enforcement agency "means any agency, department, or division of a municipal corporation, political subdivision, or other unit of local government of this state, and any agency, department, or division of state government, having as its primary function the detection and apprehension of persons committing infractions or violating the traffic or criminal laws in general, as distinguished from a limited authority Washington law enforcement agency, and any other unit of government expressly designated by statute as a general authority Washington law enforcement agency. The Washington state patrol and the department of fish and wildlife are general authorities of the Washington law enforcement agencies."
2 USC § 290dd-2 and 42 CFR Part 2 (also referred to as Part 2)	42 CFR Part 2 protects SUD records generated by a Part 2 program, which is defined as a federally assisted person or entity that holds itself out as providing, and provides, SUD diagnosis, treatment, or referral for treatment. "Federally assisted" is very broadly construed and includes (but is not limited to) a program accepting patients under any federal programs (such as Medicaid or Medicare), enjoying any tax preferential status (such as being a nonprofit), and having a federal license to administer controlled substances. Part 2 was revised in 2024 to allow patients to sign a single consent to disclose, and redisclose, their information for treatment, payment, and healthcare operations. Part 2 is generally a much stricter law than HIPAA, with fewer exceptions where records can be disclosed without patient consent.

[1] 42 CFR 2.11. https://www.ecfr.gov/current/title-42/chapter-I/subchapter-A/part-2

Table 2: Definitions of data types[2]

Data Types	Definition
Electronic Health Records (EHR)	EHR data is collected at the point of care at a medical facility, hospital, clinic, or practice using electronic means. EHR data contains clinical information about patients and may include demographic information, diagnosis, treatment, prescription drugs, laboratory tests, physiologic monitoring data, hospitalization, and patient insurance.
Claims	Claims data capture service encounters where the contract provider submits service encounters per their contracted arrangement. The data reflect the billable interactions (insurance claims) between insured patients and the health care delivery system. Claims data can be obtained from government agencies and/or commercial health insurance companies.
Administrative	Administrative data are generated during each interaction with a social or health service system such as a visit to a doctor's office, hospital admission, interactions with care facilities, or providers/nonprofit providers contracted by HCA or other state agencies. In this report, vital statistics such as birth and death records as well as court records are also included.
Survey	Survey data are gathered from a sample of individuals by asking them questions through a structured method such as a questionnaire or interview, and health surveys assess the health of the population and estimate disease prevalence.

Types and sources of data available to HCA

This section includes a list of types and sources of data currently available to HCA (Table 3 and 4) for reporting on required data elements and a summary of available data, including a brief description of each data system/database, its strengths, and limitations.

[2] Adapted from the University of Washington's classification of health care data: https://guides.lib.uw.edu/hsl/data/findclin

Table 3: Data available to HCA by data system and data custodian

Data System	Data custodian	Data type	Prevalence of SUD	Interaction: service providers	Interaction: first responders	Interaction: health care facilities	Interaction: law enforcement
All Payer Claims Data/ProviderOne (Apple Health Claims)	HCA	Claims	X	X	X	X	
Behavioral Health Data System (BHDS) Supplemental Data including Assessment Reports Generation Tool (TARGET)	HCA	Administrative	X	X		X	
All Payer Claims Data/Medicare claims	HCA	Claims	X	X	X	X	
All Payer Claims Data/Private insurance claims data	HCA	Claims	X	X	X	X	
Clinical Data Repository (CDR)	HCA	EHR	X	X		X	
Healthy Youth Survey	HCA	Survey	X				
State Hospitals Data	DSHS	Administrative		X		X	
Arrest (Criminal History) Record	WSP	Administrative					X
Comprehensive Hospital Abstract Reporting System (CHARS)	DOH	Administrative		X		X	
WHALES - Washington Health and Life Event System	DOH	Administrative	X		X		
Unintentional Drug Overdose Data (SUDORS)	DOH	Administrative			X		X
State and regional population estimates	OFM	Survey	X				
National Survey on Drug Use and Health (NSDUH)	SAMHSA	Survey	X				
Behavioral Risk Factor Surveillance System (BRFSS)	CDC	Survey	X				

Summary of findings on data systems currently available to HCA

This section includes a brief description of each data system/data source included in Table 3 with an assessment of data strengths and limitations. Each data source may have additional limitations regarding allowed uses and data completeness.

The Washington State All Payer Claims Database (WA-APCD) is an integrated database, owned by the state of Washington and administered by HCA. WA-APCD contains health care claims data including HCA's ProviderOne (Apple Health/Medicaid), Medicare, and commercial health insurance data. WA-APCD covers 70 percent of the Washington general population,[3] which is suited for reporting interactions with health/behavioral health providers and healthcare facilities in the state. The limitation of WA-APCD data is that SUD related diagnosis and treatment services may be underreported due to varying interpretations of 42 CFR Part 2 among service providers and/or payers. Further, traditionally SUD services have been provided and paid for through non-claims-based payment mechanisms such as through federal or state grants; therefore, WA-APCD does not reflect the entire universe of SUD services utilization or cost in WA. The WA-APCD is actively working to ensure more uniformity around submission and requirements.

Behavioral Health Data System (BHDS) was developed from the Behavioral Health Data Consolidation project that implemented a combined behavioral healthcare model and incorporated integrated behavioral health (mental health and substance abuse) data collection, storage and reporting function into BHDS. This change was driven by federal rules that required the integration of both mental health and SUD into a behavioral healthcare model, and these changes also brought a change from a fee-for-service to a managed care model for SUD treatment services. The BHDS includes data from two legacy systems:

- Treatment and Assessment Reports Generation Tool (TARGET), covering SUD clients and services.
- Mental Health Consumer Information System, covering community mental health clients and services.

BHDS includes two types of data. First, behavioral health supplemental data transactions, which are submitted by contracted providers directly to HCA and ingested into BHDS. These are submitted directly to HCA's Division of Behavioral Health and Recovery (DBHR) by contracted providers per instructions in BHDG and then ingested into BHDS. The second type of data is behavioral health-related claim encounters from ProviderOne. Detailed guidelines for behavioral health encounters are documented in the Service Encounter Reporting Instructions (SERI) guide. Behavioral health encounters are identified in ProviderOne for ingestion into BHDS using several factors including behavioral health diagnostic codes, claim type, provider IDs, and procedure or service codes.[4] Together ProviderOne and BHDS hold over one-third of DBHR program data including mobile crisis data, state funded Hub and Spoke data or data for residential SUD treatment programs. Programs that do not utilize ProviderOne and BHDS as part of their data collection systems are further discussed at the end of this section.

[3] Washington State All Payers Claims Database and Lead Organization Biennial Report, 2024.
[4] Behavioral Health Data Guide (BHDG). https://www.hca.wa.gov/assets/billers-and-providers/Behavioral-Health-Data-Guide.pdf

Clinical Data Repository (CDR) is a secure database administered by HCA that enables Medicaid managed care organizations to exchange real-time data from various electronic health record (EHR) systems that their providers use. The CDR includes clinical EHR data not captured by claims data such as WA-APCD. The limitation of CDR is it only contains Medicaid clients with managed care organizations excluding fee-for-services and non-Medicaid population. Currently, only ambulatory services data are available and behavioral health providers were not previously submitting the data to CDR. However, the recent 42 CFR Part 2 revision presents the opportunity for a better integration of SUD treatment data into the EHR systems, which will contribute to the improvement of CDR data on SUD.[5]

State hospital data, owned by the Department of Social and Health Services (DSHS) Behavioral Health Administration (BHA), is an important data source that captures inpatient services provided at state owned hospitals including Eastern and Western State Hospitals and Child Study and Treatment Center.

Washington Health and Life Event System (WHALES) containing birth and death records, are collected and managed by the Department of Health (DOH) and currently available to HCA for individuals enrolled in HCA's programs. Vital records provide critical information for Washington state's population in estimating SUD prevalence. Data on hospital stays in **the Comprehensive Hospital Abstract Reporting System (CHARS)** are available to HCA. Additionally, DOH's **Unintentional Drug Overdose Data (SUDORS)** links DOH death records to toxicology data collected by Washington State Patrol (WSP) and records deaths caused due to drug overdose.

Additional data used for the prevalence of SUD include the Office of Financial Management's (OFM) **population estimates**, and national surveys including the Substance Abuse and Mental Health Services Administration's (SAMHSA) **National Survey on Drug Use and Health (NSDUH)**. This provides national representative data on SUD and the Center for Disease Control's (CDC) **Behavioral Risk Factor Surveillance System (BRFSS),** the nation's premier system of health-related telephone survey. Additionally, HCA's **Healthy Youth Survey** collects information on substance use among students in grades 6, 8, 10, and 12 in Washington state.

WSP's criminal history data are records that capture the interactions with law enforcement and are available to HCA for individuals enrolled in HCA's programs.

Additionally, HCA collects information about clients participating in various programs targeting population impacted by SUD and their service interactions shown in Table 4. The data is collected through various systems, including:

- Program Data Acquisition, Management and Storage (PDAMS)
- The Diversion Data Integration Platform (DDIP), currently being developed by HCA as part of Blake Bill 5536 effort
- Minerva
- Student Assistance Prevention and Intervention Services Program (SAPISP) System

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[5] Tillman, A.R., Bacon, E., Bender, B. *et al.* Using 42 CFR part 2 revisions to integrate substance use disorder treatment information into electronic health records at a safety net health system. *Addict Sci Clin Pract* **19**, 48 (2024). **https://doi.org/10.1186/s13722-024-00477-3**

- Reported and summarized by DSHS's Research and Data Analysis (RDA)
- Julota

Senate Bill (2E2SSB) 5536-related program and outcome data are listed in Table 4, and there are many more DBHR program data that are currently collected, and HCA will consider additional program data for this work in the future. Boxes that are marked with an "x" indicate that the program collects some, if not all, of the following data elements such as SUD diagnosis data, self-reported substance use, service provider/nonprofit service provider regarding services completed, name of service providers, name of facilities and program referrals received from law enforcement officers.

Table 4: Data available to HCA: HCA's behavioral health program data

Behavioral health program data	Data type	Interaction: service providers	Interaction: first responders	Interaction: health care facilities	Interaction: law enforcement
Arrest and Jail Alternatives (AJA) program	Administrative	X			X
Criminal justice treatment account (CJTA) program	Administrative	X			X
Recovery Navigator Programs (RNP) program	Administrative	X			X
The Bridge program*	Administrative	X		X	
Clubhouse and Peer-run Organization program	Administrative	X		X	
Contingency Management program	Administrative	X			
Forensic Housing & Recovery Through Peer Services (FHARPS)	Administrative	X			X
Health Engagement Hubs	Administrative			X	
Homeless Outreach Stabilization and Transition (HOST)	Administrative	X			
Housing & Recovery Through Peer Services (HARPS) program	Administrative	X			
Housing Subsidies 102 program	Administrative	X			
Law Enforcement Assisted Diversion (LEAD) program	Administrative	X			X
Medications for Opioid Use Disorder in Jails	Administrative	X			X
Opioid Treatment Program (OTP)	Administrative	X		X	
Recovery Residences	Administrative	X		X	
State Opioid Response (SOR) grant program	Administrative	X			
Trueblood Diversion Program*	Administrative				X
Peer Pathfinder	Administrative	X			

*Planned for data collection

Data currently unavailable to HCA

Table 5 lists data currently unavailable to HCA by data custodian and required data elements, followed by a brief description of each data system/database, its strengths, and limitations.

Table 5: Data currently unavailable to HCA by data system and data custodian

Data system/data sources	Data custodian	Data type	Interaction: service providers	Interaction: first responders	Interaction: health care facilities	Interaction: law enforcement
Washington Emergency Medical Services Information System (WEMSIS)	DOH	EHR		X		
The Rapid Health Information NetwOrk (RHINO)	DOH	EHR	X		X	
Syringe Services Program (SSP) data	DOH	Administrative	X			
988 Call Centers/Suicide Crisis Lifeline	DOH	Administrative	X			
Criminal History Database (CHD)	WSIPP	Integrated database				X
Court Case Management System (Enterprise Justice)[6]	AOC	Administrative				X
Automated Client Tracking (ACT) System	DCYF	Administrative				X
Jail Booking and Reporting System (JBRS)	WASPC	Administrative				X
Statewide Child Welfare Information System (FAMLINK)[7]	DCYF	Administrative	X	X	X	
Homeless Management Information System (HMIS)	COM	Administrative	X		X	
Correctional Information Management System (OMNI)	DOC	Administrative	X			X
Correction Institution Pharmacy System (CIPS)	DOC	Administrative	X			X
Automated Client Eligibility System (ACES) Public Benefit Enrollment	DSHS	Administrative	X			
Comprehensive Assessment Reporting Evaluation (CARE) System	DSHS	Administrative	X			
WA State Syringe Services Program Health Survey	UW	Survey	X			
National Incident-Based Reporting System (NIBRS)	WASPC	Administrative				X
Washington State Data Exchange for Public Safety	WASPC	Administrative		X		

[6] The new data system will include Superior Court Management Information System (SCOMIS)/District and Municipal Court Information System (DISCIS)/Juvenile and Corrections System (JCS)/Juvenile Information System (JUVIS)

[7] FAMLIK is not an authoritative source for interactions with first responders or health care facilities but may capture some of service interactions.

Summary of findings on data currently unavailable to HCA

This section includes a brief description of each data system/data source included in Table 5 and an assessment of the strengths and limitations of data.

- HCA currently does not have access to the data collected and owned by DOH that capture interactions with first responders (emergency service personnel) in the **Washington Emergency Medical Services Information System (WEMSIS)** and interactions with emergency department in **the Rapid Health Information NetwOrk** (RHINO) that collects the Rapid Health Information NetwOrk data. The strength of DOH data is the documentation of service interactions for people without insurance and details of services, which are not fully captured in HCA's claims data. The limitation is that DOH data is not integrated into HCA's data. Without linking to HCA's claims data, it is difficult to gauge the overlap of SUD-impacted population presented in WEMIS, RHINO, CHARS, and HCA's claim data.
- DOH captures interactions with nonprofit service providers delivering harm-reduction service in the Syringe Services Program (SSP) data system and interactions with nonprofit service providers captured in 988 Call Centers/Suicide Crisis Lifeline data system. Due to the nature of the SSP program, all SSP data is anonymous; no client-level details, such as insurance status or demographics, are collected.
- HCA does not have access to most data that captures interactions with law enforcement agencies for this reporting purpose. The **Washington State Institute for Public Policy (WSIPP) Criminal History Database (CHD)** synthesizes criminal charge information for individuals by linking data from the Administrative Office of the Courts (AOC), the Department of Corrections (DOC) Correctional Information Management System (OMNI), and the Department of Children, Youth, and Families (DCYF) Juvenile Rehabilitation's Automated Client Tracking (ACT) system. CHD is used by DSHS-RDA as part of its **Integrated Client Database (ICDB).** Through ICDB, HCA has access to WSP's arrest data for other purposes; however, a new data-sharing agreement may be required for this reporting purpose.
- The **Jail Booking and Reporting System (JBRS)** is integrated in HCA's ProviderOne data system and used by HCA to determine Apple Health eligibility; however, the use of JBRS for this work will require a new data-sharing agreement with Washington Association of Sheriffs and Police Chiefs (WASPC), OFM, and separately for King County Department of Adult and Juvenile Detention, which needs an independent data-sharing agreement. JBRS is not part of DSHS-RDA's ICDB and WSIPP's CHD, and HCA will require a separate data-sharing agreement to directly access JBARS data and conduct data linkage to HCA's data systems.
- HCA does not have access to data on service interactions with providers and nonprofit service providers collected by the Department of Commerce's (Commerce) Homeless Management Information System (HMIS) because HCA is not part of HMIS' client consent form, and Commerce does not share data with any entities who are not on the consent form as specified in **RCW 43.185C.180**.
- HCA has limited access to DSHS' **Automated Client Eligibility System (ACES)** Public Benefit Enrollment data, **Comprehensive Assessment Reporting Evaluation (CARE) System**, or DCYF's Statewide Child Welfare Information System (FAMLINK), which are part of DSHS-RDA's ICDB.
- HCA currently does not have access to data that captures interactions with providers of school-based services for youth with SUD in a behavioral health data system managed by the Association

of Educational Service Districts (AESD). Services provided directly by school districts and not supervised by ESDs are not included in this system.

- The data that captures interactions with local health jurisdictions and nonprofit providers that offer harm reduction services, such as SSP, are currently limited. Services are often provided anonymously, and no individual identifiers are collected. This makes it not possible to determine the SUD status of individuals who are receiving services. The University of Washington (UW) conducts the **Washington State SSP Health Survey** every two years among participants of SSPs to learn about substance use patterns, health behaviors, service utilization, and health care needs.
- Other data currently unavailable to HCA include interactions with law enforcement reported in WASPC's **National Incident-Based Reporting System (NIBRS)** and **Washington State Data Exchange for Public Safety**, managed by Washington State University (WSU). NIBRS has restrictions on sharing client-level data. HCA will need further investigation to determine the quality of information captured regarding the status of SUD in collaboration with WSU and WASPC.
- HCA also does not have access to the information about how individuals affected by SUD in the criminal justice system are channeled through the courts system. Currently, the information about how individuals affected by SUD in the criminal justice system are going through the courts system is not consistently tracked as superior, district and municipal courts do not always utilize court codes when a SUD screening is ordered, and treatment is recommended following the screening. How a case moves to a therapeutic courts and individuals are connected to behavioral health and recovery services are also affected by the lack in consistency in the use of court codes.
- HCA also does not have access to the data on referrals made by prosecutors to SUD/recovery services, diversion programs, and therapeutic courts and why some of the eligible cases did not receive referrals to diversion programs. Such information is currently not tracked, which is critical for better understanding the mechanism of the diversion process and identifying potential barriers for people affected by SUD in seeking and receiving the care they need. During the passage of SB 5536, there were attempts to require prosecutors to collect detailed information from defendants; however, prosecutors do not believe that they are in the best place to gather such information and share. Prosecutors currently do not have access to a statewide system to enter defendant data.
- EHRs, which contain medical history, are generally unavailable to the HCA, except for information within the Clinical Data Repository. EHRs may provide valuable information including referrals, laboratory results, and health outcomes.
- As the result of transition from TARGET to BHDS and the licensing function moved to DOH, HCA has limited provider data. It is difficult to reconcile provider information in HCA claims and encounter data with DOH provider agency data.

Recommendations

Recommendations for meeting existing legislative reporting requirements

Establishing new data connections, new data-sharing authority, and sources of data

To enable HCA to provide assessments of SUD prevalence and interactions of persons with SUD with service providers, nonprofit service providers, first responders, health care facilities, and law enforcement agencies as mandated RCW 71.24.913, HCA may need to:

- Develop a new data-sharing agreement with WASPC, OFM, and King County Department of Adult and Juvenile Detention,[8] to obtain access to JBRS and conduct data linkage to HCA data systems to identify interactions of individuals with SUD with law enforcement agencies not captured by WSIPP's CHD.
- Increase the monitoring of the accuracy of SUD data in HCA's administrative data systems such as ProviderOne, BHDS, or CDR.
- Improve the useability of the Clinical Data Repository by using United States Core Data for Interoperability (USCDI) standards and strengthened data collection.
- Consider proposing a new question to the state Behavioral Risk Factor Surveillance System survey to assess Washingtonians' current use of alcohol and/or drugs, attempts to stop, and self-identified addiction to those substances.
- Work with DOH to have all certified Behavioral Health Agency (BHA) report their associated national provider identifiers by business site and treatment types[9] and develop a complete behavioral health providers directory that can reliably link national provider identifiers with DOH-certified BHA.

Establishing supportive legislation

To meet legislative reporting requirements from RCW 71.24.913, HCA may need to determine if access to aggregate or patient-level data in the following data systems and data sources is necessary. Starting in 2026, HCA will request aggregated data from each of the following agencies to determine which data systems should be linked to HCA's data systems to identify clients served by 2E2SSB 5536. HCA will assess its data quality and availability for patient-level data that allows data linkage and develop recommendations for additional supportive legislation in the coming years.

- DOH
    - Data on interactions of individuals with SUD with first responders reported in WEMSIS
    - Data on interactions of individuals with SUD with service providers/nonprofit service providers reported in the following data systems:
        - The Rapid Health Information NetwOrk (RHINO) Data
        - 988 Call Centers/Suicide Crisis Lifeline data
- Commerce
    - Data on interactions of individuals with SUD with service providers/nonprofit providers reported in HMIS. HCA will explore how to best obtain the data through collaboration with DSHS-RDA, who currently receives data access.

[8] WASPC is prohibited to share King County Department of Adult and Juvenile Detention Data without a separate data sharing agreement.
[9] DOH maintains agency licensure and certification data, exported weekly in an Excel workbook to HCA/Enterprise Technology Services. The dataset includes the legacy ALCS Agency ID numbers, Secretary of State Numbers, credential information, facility address, but not HIPAA-required NPIs.

- DSHS-RDA
    - Data on interactions of individuals with SUD with service providers, nonprofit providers and health care facilities and law enforcement agencies by program types/setting captured in the following data systems through ICDB such as:
        - ACES/public benefits programs (economic services that involve interactions with service providers and nonprofit providers)
        - CARE (long-term care and disability services)
        - DBHR, grant-funded program data summarized and reported by RDA
        - FAMLINK (child welfare services)
        - ACT (juvenile rehabilitation services)
        - WSIPP's CHD (law enforcement agencies)
- DCYF
    - Data on interactions with service providers, nonprofit providers and health care facilities of individuals who are identified as having SUD-related challenges based on DCYF's assessment or program data that are not part of ICDB
    - FAMLINK (child-welfare services)
    - ACT (juvenile rehabilitation services)
- DOC
    - Data on service interactions of individuals with SUD in prisons (those with diagnoses and those who are receiving SUD recovery services), as DOC stated that the agency will not be able to share client-level data with HCA due to 42 CFR Part 2
- UW
    - Data on interactions of individuals with SUD with nonprofit service providers receiving harm reduction services through the Washington State SSP Health Survey[10]
- WSU
    - Data on interactions of individuals with law enforcement involved substance use/abuse reported in the Washington State Data Exchange for Public Safety
- WASPC
    - Data on SUD-related interactions of individuals with law enforcement captured in NIBRS
- DBHR-contracted service providers' client-level data not submitted to HCA

[10] DOH will share aggregated SSP data with HCA to further supplement this information. SSP data plays an important role in understanding substance use in Washington State and HCA will further investigate potential collaboration with DOH regarding the use of SSP data for this work while respecting the anonymous nature of SSP services and data privacy.

- Data on interactions of individuals with SUD with service providers including individual characteristics and service locations/regions

Recommendations for meeting Substance Use Recovery Services Advisory Committee (SURSAC) recommendation regarding diversion program outcomes

To meet SURSAC's recommendations, HCA would need to:

- Develop a new data-sharing agreement with AOC and WSIPP to access CHD data.
- Work with WSIPP in consultation with DSHS-RDA to explore the linkage of CHD to HCA's data systems as CHD data currently does not contain information that can accurately measure SUD.
- Develop a data sharing agreement with DOH for HCA to access WEMSIS. HCA will collaborate with DOH to explore data linkage between HCA's data systems and WEMSIS to better understand the overlaps of interactions of individuals with SUD in both systems and assess the added value of integrating WEMSIS into HCA's analytic dataset for the future reporting, which allows HCA to track the use of emergency services by individuals with SUD.
- Develop a data sharing agreement with Commerce that allows HCA to access HMIS data of clients who consented to release their information to HCA.
- Develop new reporting mechanism for AOC requiring superior, district, and municipal courts to utilize court codes when a SUD screening is ordered, treatment is recommended following the screening, and a case moves to a therapeutic court. AOC will share aggregated data on the results on SUD screening and cases on therapeutic courts with HCA.
- Work with AOC and prosecutors' offices to adapt and/or develop a data collection process that can effectively track referrals made to SUD/recovery services, diversion programs, and therapeutic courts, SUD related charges that did not receive referrals and reasons for not providing referrals to eligible cases in HCA's Diversion Data Integration Platform (DDIP).

Limitations of the report

To obtain the information for this report, HCA conducted over 100 interviews with behavioral health program managers, nonprofit organizations, researchers, and data leaders from nine state agencies, and university researchers. The inventory and contents are limited by the staff time availability, access to data source subject matter experts, as well as the interpretation of the scope and definitions for the legislative requirements. Other potential limitations include unidentified data sources, differing interpretations of data restrictions, and information reliability from subject matter experts. There may be additional data sources not included in this report, such as those not well documented or maintained by private sector entities.

Further considerations

Data limitation related to determining the prevalence of individuals with SUD

One of the considerations is to adjust the population focus from **individuals with SUD** to **individuals who use substances** for this work. According to RCW 71.24.025, "Substance use disorder" means a cluster of cognitive, behavioral, and physiological symptoms indicating that an individual continues using the substance despite significant substance-related problems," and the definition seems to be broader

than having a diagnosed SUD. However, an undiagnosed SUD is not well defined. Additionally, a criminal charge related to substance use does not equate with SUD and data on SUD screening and referrals made by courts are not consistently collected to determine SUD status of individuals in the criminal justice system.

For HCA's new reporting requirement, individuals with SUD may include individuals who use substances. This consideration stems from the fact that **2E2SSB 5536** focuses on individuals who use controlled substance and a more inclusive reference of the population affected by substance use could better guide HCA to meet the future reporting requirements specified in RCW 71.24.913 and will bring a better alignment with the overall goal of 2E2SSB 5536.

The prevalence of SUD will need to be determined using multiple data sources to triangulate an estimate range. Reliance solely on administrative claims or surveys is unlikely to appropriately assess unmet treatment need. Recent research (2022) discusses the limitation of a national survey and the underestimation of SUD prevalence because the survey sample may not include major population groups including individuals who are homeless, experiencing housing instability, or being institutionalized.[11]

Claims data analysis alone may result in an undercount due to exclusion of uninsured populations, inconsistent report of diagnosis in claims, and lack of access or initiation of health care services. This underestimation may be compounded in certain subpopulations due to disparities of access and utilization. Development of a standardized statewide method of defining and estimating prevalence and identifying service interactions that involve substance-impacted population may best be designed in collaboration with other state agencies and university researchers, with community member engagement.

Establishing a data-sharing process

As illustrated in the data-systems mapping included in Appendix B, individuals with SUD are widely captured in the different data systems. Recent research based on APCD data linked to other administrative data in Massachusetts shows one-third of people with opioid use disorders are more likely to experience change in insurance status, and insurance instability is higher among the Medicaid population.[12] DOH's data systems play an important role in capturing population uninsured and not part of publicly funded insurance program even when they may be eligible. DOH data systems are currently stand-alone data and not included in existing data systems, such as APCD or ICDB, and further data integration can advance the state's capacity to identify and serve this population affected by SUD. Part 2 restricts sharing certain data on individuals with SUD and may present challenges for data-integration efforts.

Establishing and operationalizing a data sharing agreement with an external agency requires significant staff time and resources as it involves technical staff, contract office, data governance, and

[11] Mojtabai R. Estimating the Prevalence of Substance use disorder in the US Using the Benchmark Multiplier Method. JAMA Psychiatry. 2022 Nov 1;79(11):1074-1080. doi: 10.1001/jamapsychiatry.2022.2756. Erratum in: JAMA Psychiatry. 2023 Jan 1;80(1):96. doi: 10.1001/jamapsychiatry.2022.3947.

[12] Christine, P. J., Goldman, A. L., Morgan, J. R., Yan, S., Chatterjee, A., Bettano, A. L., ... & LaRochelle, M. R. (2024, July). Insurance Instability for Patients With Opioid Use Disorder in the Year After Diagnosis. In JAMA Health Forum (Vol. 5, No. 7, pp. e242014-e242014). American Medical Association.

privacy officers. HCA will need to plan on how to best gather necessary data unavailable to HCA. HCA will also need to determine the method of data transfer and data ingestion with each organization for each data reporting requirement. The data integration platform mandated in RCW 71.24.908 may provide opportunities for collecting and maintaining some of the data sources identified in the inventory in section 2. Further, any transmission of data to HCA from other agencies may result in an increased workload for that agency and, potentially, need additional resources. In effort to use resources efficiently, HCA will also consider identifying alignments with other data integration efforts as needed.

Conclusion

This final report fulfills the requirement outlined in Section 38(2)(b) of 2E2SSB 5536, codified as RCW 71.24.913, to provide a final inventory report to the Governor and the Legislature by December 1, 2024. This inventory catalogues the data sources currently available to HCA and identifies data that may be necessary for reporting and is currently unavailable to the authority. Recommendations for additional data connections and data share agreements are included.

Appendices

Appendix A: Organizations that contributed information to the report

- Administrative Office of Courts
- Department of Children, Youth and Families
- Department of Commerce
- Department of Corrections
- Department of Health
- Department of Social and Health Services
- Department of Social and Health Services-Research and Data Analysis
- Educational School District 113
- Office of Financial Management
- University of Washington
- Washington Alliance for Quality Recovery Residence
- Washington Association of Sheriffs & Police Chiefs
- Washington State Institute for Public Policy
- Washington State University

Appendix B: Final inventory of data systems and sources

Data system/data sources	Data custodian	HCA can access	Data type	Prevalence of SUD	Interaction: service providers	Interaction: first responders	Interaction: health care facilities	Interaction: law enforcement
988 Call Centers/Suicide Crisis Lifeline	DOH	No	Administrative		X			
All Payer Claims Data/Medicare claims	HCA	Yes	Claims	X	X	X	X	
All Payer Claims Data/Private Insurance	HCA	Yes	Claims	X	X	X	X	
All Payer Claims Data/ProviderOne	HCA	Yes	Claims	X	X	X		
Arrest (Criminal History) Record	WSP	Yes	Administrative					X
Arrest and Jail Alternatives Program	HCA	Yes	Administrative		X			X
Automated Client Eligibility System Public Benefit Enrollment	DSHS	No	Administrative		X			
Automated Client Tracking System	DCYF	No	Administrative					X
Behavioral Health Data System	HCA	Yes	Administrative	X	X		X	
Bridge Program	HCA	Yes	Administrative		X		X	
Clinical Data Repository	HCA	Yes	Electronic Health Record	X	X		X	
Clubhouse and Peer-run Organization Program	HCA	Yes	Administrative		X		X	
Comprehensive Assessment Reporting Evaluation System	DSHS	No	Administrative		X			
Comprehensive Hospital Abstract Reporting System	DOH	Yes	Electronic Health Record	X	X		X	
Contingency Management Program	HCA	Yes	Administrative		X			

Data system/data sources	Data custodian	HCA can access	Data type	Prevalence of SUD	Interaction: service providers	Interaction: first responders	Interaction: health care facilities	Interaction: law enforcement
Correctional Information Management System	DOC	No	Administrative		X			X
Court Case Management System-Enterprise Justice	AOC	No	Administrative					X
Criminal Justice Treatment Account	HCA	Yes	Administrative		X			X
Forensic Housing & Recovery Through Peer Services	HCA	Yes	Administrative		X			X
Health Engagement Hubs Program	HCA	Yes	Administrative				X	
Healthy Youth Survey	HCA	Yes	Survey	X				
Homeless Management Information System	COM	No	Administrative		X		X	
Homeless Outreach Stabilization and Transition	HCA	Yes	Administrative		X			
Housing & Recovery Through Peer Services	HCA	Yes	Administrative		X			
Housing Subsidies 102	HCA	Yes	Administrative		X			
Jail Booking and Reporting System	WASPC	No	Administrative					X
Law Enforcement Assisted Diversion	HCA	Yes	Administrative		X			X
Medications for Opioid Use Disorder in Jails	HCA	Yes	Administrative		X			X
National Incident-Based Reporting System	WASPC	No	Administrative					X
National Survey on Drug Use and Health	SAMHSA	Yes	Survey	X	X			
Opioid Treatment Program	HCA	Yes	Administrative		X		X	

Data system/data sources	Data custodian	HCA can access	Data type	Prevalence of SUD	Interaction: service providers	Interaction: first responders	Interaction: health care facilities	Interaction: law enforcement
Prescription Monitoring Data	DOH	No	Administrative		X			X
Recovery Navigators	HCA	Yes	Administrative		X			X
Recovery Residences	WAQRR	Yes	Administrative		X		X	
State and Regional Population Estimates	OFM	Yes	Survey	X				
State Hospitals	DSHS	Yes	Administrative		X		X	
State Opioid Response Grant	DSHS	Yes	Administrative		X			
Statewide Child Welfare Information System	DCYF	No	Administrative		X	X	X	
The Behavioral Risk Factor Surveillance System	CDC	Yes	Survey	X				
The Rapid Health Information Network	DOH	No	Electronic Health Record		X		X	
Unintentional Drug Overdose Data	DOH	Yes	Administrative			X		X
Washington State Syringe Services Program Health Survey	UW	No	Survey					
Washington Emergency Medical Services Information System	DOH	No	Administrative			X		
Washington Health and Life Event System	DOH	Yes	Administrative			X		
Washington State Data Exchange for Public Safety	WSU	No	Administrative			X		

Appendix C: Data systems summary

Inventory of data systems (RCW 71.24.913)

HCA access

- HCA has access
- HCA needs further consideration for access to client-level data
- HCA needs access via new legal/institutional agreement
- HCA needs access via new data reporting requirements and new legal/institutional agreement

Interaction with

- First Responders
- Law Enforcement
- Service Providers/Health Care Facilities/ Non-Profit Providers
- SUD Prevalence

* To be added to Diversion Data Integration Platform

Data custodians	Data systems		
AOC	Enterprise Justice (DISCIS, JCS, SCOMIS)*	Data on referrals to: SUD/Recovery Services, Diversion Programs, and Therapeutic Courts	
Commerce	HMIS		
WASPC	JBRS*	NIBRS	WADEPS
DOC	CIPS	OMNI	
DSHS	ACES/Benefit Data	CARE	State Hospitals
DCYF	ACT	FAMLINK	
Crisis Connections	Recovery Helpline		
ESD 113	AESD BH Assistance Program		
UW	WA Syringe Services Program Health Survey		
DOH	PMD SUDOR WHALES	WEMSIS CHARS	RHINO 988 Call Centers/ Suicide Crisis Lifeline
WSP	WSP Criminal History Data*	Toxicology	
OFM	State and Regional Population Estimates		
SAMHSA CDC	BRFSS	NSDUH	
HCA	BHDS/TARGET CDR Commercial Insurance	Healthy Youth Survey Medicare	ProviderOne/Apple Health SEBB/PEBB
	DBHR Program Data AJA* CJTA Clubhouse and peer-run organization programs Contingency management FHARPS Health Engagement Hubs	HARPS HOST Housing Subsidies 102 LEAD* MOUD in Jails OTP Peer Pathfinders	Recovery Residencies Regional Crisis Line Data RNP* SOR STR The Bridge Trueblood*

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Appendix D: List of acronyms

Acronym	Full name
2E2SSB 5536	Second Engrossed Second Substitute Senate Bill 5536
ACES	Automated Client Eligibility System
ACT	Automated Client Tracking
AESD	Association of Educational Service Districts
AJA	Arrest and Jail Alternatives
AOC	Administrative Office of Courts
APCD	All Payer Claims Data
BH	Behavioral Health
BHDS	Behavioral Health Data System
BRFSS	The Behavioral Risk Factor Surveillance System
CARE	Comprehensive Assessment Reporting Evaluation
CDC	Center for Disease Control
CDR	Clinical Data Repository
CHARS	Comprehensive Hospital Abstract Reporting System
CHD	Criminal History Database
CJTA	Criminal justice treatment account
Commerce	Department of Commerce
DBHR	Division of Behavioral Health and Recovery
DCYF	Department of Children, Youth and Families
DDIP	The Diversion Data Integration Platform
DOC	Department of Corrections
DOH	Department of Health
DSHS	Department of Social and Health Services
EHR	Electronic Health Records
ESD	Educational School District
FAMLINK	Statewide Child Welfare Information System
FHARPS	Forensic Housing & Recovery Through Peer Services

Acronym	Full name
HARPS	Housing & Recovery Through Peer Services
HMIS	Homeless Management Information System
HOST	Homeless Outreach Stabilization and Transition
ICDB	Integrated Client Database
JBRS	Jail Booking and Reporting System
LEAD	Law Enforcement Assisted Diversion
MOUD	Medications for Opioid Use Disorder (MOUD)
NIBRS	National Incident-Based Reporting System
NSDUH	National Survey on Drug Use and Health
OFM	Office of Financial Management
OMNI	Correctional Information Management System
OTP	Opioid Treatment Program
PDAMS	Program Data Acquisition, Management and Storage
PMD	Prescription Monitoring Data
RCW	Revised Code of Washington
RDA	Research and Data Analysis
RHINO	The Rapid Health Information NetwOrk
RNP	Recovery Navigator Programs
SAMHSA	Substance Abuse and Mental Health Service Administration
SAPISP	Student Assistance Prevention and Intervention Services Program
SOR	State Opioid Response
SSP	Syringe Services Program
SUD	Substance use disorder
SUDORS	Unintentional Drug Overdose Data
SURSAC	Substance Use Recovery Services Advisory Committee
TARGET	Assessment Reports Generation Tool
UW	University of Washington
WADEPS	Washington State Data Exchange for Public Safety

Acronym	Full name
WAQRR	Washington Alliance for Quality Recovery Residence
WASPC	Washington Association of Sheriffs & Police Chiefs
WEMSIS	Washington Emergency Medical Services Information System
WHALES	Washington Health and Life Event System
WSIPP	Washington State Institute for Public Policy
WSP	Washington State Patrol
WSU	Washington State University