PUBLIC CONSULTING GROUP

State of Washington
Department of Social and Health Services
Mental Health Division

Tim Brown, Ph.D., Assistant Secretary, HRSA
Karl Brimner, M.Ed., Director, MHD

Capacity and Demand Study for Inpatient Psychiatric Hospital and Community Residential Beds
Adults & Children

FINAL REPORT

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I. EXECUTIVE SUMMARY

PURPOSE

Public Consulting Group, Inc. (PCG) was engaged by the Mental Health Division (MHD) of the State of Washington's Department of Social and Health Services (DSHS) to complete a scope of work entitled the "Capacity and Demand Study for Inpatient Psychiatric Hospital and Community Residential Beds – Adults and Children." The goal of this project was to update and expand a report completed in September 2002 titled *"Projecting the Need for Inpatient and Residential Behavioral Health Services for Adults Served by the Mental Health Division."* The report expansion in the adult service area includes providing additional definition around the types of adult residential programs currently offered, to provide a regional perspective of existing and proposed inpatient and residential programs, and to update certain peer state analyses from the September 2002 report. In addition, MHD contracted with PCG to conduct a review of the more limited children inpatient and residential services paid for by MHD. The addition of services for children focused on the Children's Long-Term Inpatient Program (CLIP), a review of complementary alternative service programs, and a peer state comparison. The scope of these studies focused on civil beds; no forensic beds were included. While this report does not specifically address outpatient mental health services provided to adults and children, these services are a central component of the continuum of care and are sometimes referenced as part of this report.

METHODOLOGY

As part of the data collection activities of this report, data request documents were developed and submitted to MHD and the Regional Support Networks (RSNs) to collect capacity, utilization, reimbursement and cost data on the residential and inpatient hospital services provides by MHD to Adults and Children. In addition, individual meetings were held with representatives of the community hospitals (including representation from the Washington Hospital Association), the two (2) state psychiatric hospitals (Eastern and Western State Hospitals) and the four (4) CLIP facilities, regarding both capacity and demand for adult and children services covered by the scope of this engagement. These discussions also included the identification and discussion of influencing factors that, if properly and promptly addressed, can result in improved program integration and a better continuum of care. Advancements in this

area will provide a system that better matches demand for services with available capacity – one that attempts to strike a balance between providing the most clinically appropriate service in the most cost effective manner. This will benefit both the consumers of mental health services in the state as well as the taxpayers that fund these services.

It is also important to note that this report was prepared in a condensed time frame and with limited funding. Since the Washington MHD system of residential care is really *fourteen local systems of care*, with a few intensive, high cost services provided statewide, sixty days is a very limited amount of time to complete a detailed statewide analysis. MHD has assisted the process through an extensive review of the data bases used in this report. In addition, due to the funding and time constraints, PCG did not have the opportunity to identify all other residential capacity not funded through MHD but funded through other agencies (e.g. Aging and Disability Services Administration within DSHS) that may serve MHD consumers. It is important that MHD and DSHS track and maintain a database of all capacity and settings where individuals with mental health issues reside in order to continue to gain a better picture of how all MHD consumers are served. This continued monitoring will assist MHD and DSHS efforts to ensure that appropriate services reach these individuals where they reside.

Also, it should be noted that we have been informed of recent interpretative changes made by CMS concerning Washington's 1915(b) waiver that finances the community mental health system. These changes of interpretation present concerns to all administrators and providers we talked to who believe they will have further impact on the community-based residential system. We have not been able to analyze these changes or project their impact on the capacity or demand for adult or child residential care.

SUMMARY OF RECOMMENDATIONS

The following changes in capacity and policy are recommended to better align the supply of adult residential and inpatient services with the demand for mental health services funded by MHD:

#A-1: State spending for adult mental health residential and inpatient services remains significantly below peer state investment for comparable services. ***We estimate the gap in spending to be a minimum of $20 million to meet the spending level of peer states for residential services only.***

This gap includes only residential services under the auspices of the RSNs. We know that this number is low because: a) it does not detail the cost of specific residential services missing from the system; b) it does not factor in the very low capacity of community inpatient beds operated by local hospitals; and c) it does not factor in recent changes in CMS interpretation of the Federal Waiver that finances community services. Additional recommendations address #1(a) and #1(b). It is premature to project the dollar value of #1(c).

Our findings – both analytical and anecdotal -strongly suggest that the existing provider network has insufficient residential and alternative community-based inpatient capacity to meet the current level of demand. This results in the disruption of the smooth patient flow through the entire continuum of care. RSNs spend approximately $31 million, about $6.80 per capita, for residential care in FY2003. Projecting the spending rate of peer states and the national average for residential care since FY2002 (using an inflation rate of 3.5%) suggests that Washington would need to be at about $8 per capita in current dollars, or a total of $51 million to meet peer and national averages. The $20 million would only keep Washington at the spending rate of its peers, *it would not be sufficient to meet the specific needs detailed in this study*.

The lack of residential and alternative community-based inpatient capacity prevents the hospital system from timely discharging patients to more appropriate discharge destinations, resulting in longer lengths of stay, fewer new admissions (exacerbated by state hospital admission waiting lists and admission delays which together imply reduced access to care and higher than necessary treatment costs). This lack of capacity essentially "backs-up" the entire system, forcing the higher cost community and state hospital providers to serve patient populations that they are not best suited to manage or that do not require hospital level of care. This problem also disrupts overall system quality and cost effectiveness through the ineffective alignment of patient care needs with the provider who best can provide the service.

#A-2: Spending for community-based residential and inpatient services should increase by $48.9 million to meet the identified gaps in specific community-based residential and inpatient services detailed in this study.

The following recommendations specify missing adult services by number of beds and RSN or regional location. We estimate the full implementation cost of these services to be approximately $48.9 million, not allowing for receipt of any third party revenues that could lower the state's net cost. The creation of 680 new beds will increase the capacity of the community system by more than one-

third. We have used estimated Washington per diem costs for each program type that is subject to further review. However, this does not take into account recent Federal waiver interpretations which may reduce available spending for certain residential services, requiring additional costs for Washington to maintain its current services. Also, this number does not include additional case management and other outpatient services needed by this population as residential services expand. The beds we have projected by RSN or region conform to a statewide methodology developed for this study. It is recommended that these projections be further reviewed by the RSNs to ensure that they are considered comparatively within the local service system developed by each RSN.

#A-3: The lack of community-based residential and alternative community-based inpatient capacity is particularly apparent with specialty patient populations currently served by the state hospitals. It is estimated that up to 144 patients at Western State Hospital and 5 patients at Eastern State Hospital could be served in the community if specialty community-based programs were developed. These services would cost an estimated $10,877,000 per year.

While all inpatient providers are impacted by this system back-up, the longer term acute hospital programs (the State Hospitals, but predominately Western State Hospital) are impacted by providing care to specialty patient populations that could be best served in the community, more appropriately at lower cost. These 149 patients either do not require hospital level of care or fall outside of the typical acute care psychiatric hospital range of services. Services they need include (a) psychiatric nursing care/adult family homes, (b) specialty residences for persons with developmental disabilities, (c) medical facilities for persons with traumatic brain injury, (d) other residential programs for populations with special or rehabilitative needs. All of these clients will require case management and related outpatient services in a community setting. We are not able to identify the RSNs of origin for these 149 patients. (It should be noted that these clients do not include the PALS residents included in a recent study.)

Locating these patient populations at the state hospitals is also partially influenced by the community protection laws of the state and, in some cases, the resistance of communities to accept programs for persons with special needs. The development of additional community-based capacity to serve these specialty populations will allow the state hospitals to better focus their attention on the psychiatric population (both short and long term) that cannot be taken care of in the community, provide increased state hospital capacity to accept medically necessary and appropriate admissions from community hospitals (thus alleviating one of their discharge barriers to improve access of care), provide the opportunity to reduce any excess state hospital bed capacity and realize cost savings to

be reinvested in community-based services, and provide lower cost programs specifically designed to meet the clinical needs of the patients, while also protecting the community at large.

In our last report we stated that "a significant proportion of the (state hospital) population (18-27%) presented a challenge to state hospital staff in finding residential placements due to their potential threat to public safety because of past behavioral problems, including sexual assault / deviance history, and a lack of capacity in the community." While state hospital beds have been reduced and additional residential capacity has been developed in the community, there still remains a need to develop specialized community-based services for these patients.

#A-4: During the past two years there has not been enough progress to create sufficient capacity to divert admissions from state hospitals or other psychiatric inpatient settings. We recommend (a) expansion of Evaluation and Treatment (E&T) centers to add at least 89 beds to the system, divided between the Eastern Region (33 beds) and the Western Region (56 beds) at a cost of $17,054,625 per year, and (b) increased access to 34 additional hospital diversion beds, at an annual cost of $2,357,900, focused solely on those areas with limited access to hospital diversion care.

In spite of increased pressure on community admissions and continuous pressure on the state hospital for admissions, the community system has not expanded its ability to accept admissions at either E&T centers or community hospitals. Currently, there are eleven RSNs without access to E&T centers and three RSNs without access to crisis intervention services. An additional four RSNs appear to be missing an adequate number of crisis beds for hospital diversion. These shortages create unnecessary and expensive pressure on community hospital emergency rooms and increases the waiting time for state hospital acute admissions. Inevitably they result in unnecessary and costly hospital admissions, either in the community or the state hospital.

We have projected the demand for E&T beds by region since they require substantial capital and staff investment to implement and operate and are easily designed to serve multiple RSNs. No special consideration was given E&Ts with more than 16 beds, possibly jeopardizing current or future Medicaid revenues, due to their IMD status. The crisis respite beds are located in nine RSNs.

#A-5: There has not been adequate progress made in developing and locating sufficient community residential beds in most RSNs. Analysis of the supply and utilization data suggests that the state may be in need of as many as 408 new community residential beds, at an annual cost of $18,615,000 to create sufficient local residential resources.

Long-term residential beds are available in all RSNs but their capacity and utilization varies widely. We have projected a need for 408 beds based on increasing the beds in those RSNs where the supply is substantially below the state average and their utilization of current beds is 90% or above. The new beds and expanded programs are in eleven RSNs. We recommend additional investigation of whether these RSNs meet, or could meet, these needs in alternative settings, e.g. PACT teams or nursing homes not reflected in this study, to create a more complete understanding of the local resource requirements before final locations are determined.

#A-6: The state hospital bed capacity has been reduced to 834 staffed beds (as of the July 1, 2004 RSN allocation). Further reductions should be made if MHD is able to continue to receive new funds and shift hospital resources to expand community residential alternatives. MHD should consider a state hospital target of approximately 575 beds if it is able to fully implement the recommendations of this study and the previous PALS study.

During the past two years, the number of staffed state hospital beds has decreased from 981 to 834. This difference of 147 beds (15% of capacity) has occurred as the result of intensive planning and development activities involving MHD, the state hospitals, and the RSNs. It has been accompanied by a substantial increase of residential beds in local communities plus expansion in case management and other supportive services. The state hospital capacity of 12.6 beds per 100,000, comparable to the median of Washington's peer group states, is a reasonable goal for MHD to achieve through the continued reallocation of hospital resources and infusion of new funds. However, it is expected that expansion in community capacity will be developed incrementally, allowing the continuation of incremental reductions in the state hospital population.

#A-7: The existing community psychiatric hospital bed capacity has eroded by 85 beds since Fiscal Year 2000. The capacity should be preserved, with opportunities to expand, to meet the increasing demand of the states population growth and decreasing reliance on state hospital beds. Preservation (and expansion) of the capacity requires a rate structure that fully

reflects the cost of providing services to the consumers referred by the public system who are eligible for Medicaid, other third party coverage, or who have no coverage.

It has been estimated that approximately 32% of persons served in psychiatric beds in community hospitals were publicly funded in FY 2003 (23% of consumers were Medicaid eligible). Shifting community hospital bed capacity will adversely affect these individuals, particularly since the system is under-resourced by an estimated 680 beds. Inpatient psychiatric services provided to adults by the community hospital system is currently reimbursed less than cost. There is an increasing reluctance by the community hospitals to maintain these adult beds when reimbursement rates do not adequately cover the costs of performing the services. This situation can jeopardize the ability of the community hospitals to maintain this bed capacity over the long-term. An evaluation of the rate structure should be made in the near term and a reimbursement adjustment to align more closely with actual costs should be considered to preserve the existing inpatient community bed capacity. This is a difficult objective for the state as financial estimates indicate that this may be an industry wide issue and not just a Medicaid payment rate issue. Also, it is further impacted by uncompensated care provided to the uninsured population by community hospitals.

#A-8: Adult community support services should be reviewed for further expansion to include the development of Program for Assertive Community Treatment (PACT) teams and the expansion of additional support services and treatment for co-occurring disorders. These services are needed in addition to the residential and impatient care recommended in this report.

While not part of this study, community-based services play a vital and cost-efficient role in providing timely treatment without the need to use institution-based services such as community inpatient and state hospital beds. In a study soon to be released of the PALS program, recently conducted for the Mental Health Division, PCG recommended the development of PACT teams, additional support services (such as Supported Housing, Day Rehab, Social Clubs, Vocational, and Specialized Day Programs), specialized treatment (in the areas of substance abuse, neurological / cognitive impairment, forensic involvement and medical issues), and community program enhancements that integrate the treatment of co-occurring disorders (substance abuse / mental illness) through a combination of supported housing, PACT / ACT teams and flexible support services. We also recommended an increased emphasis on promoting recovery and providing community capacity for early intervention in situations of relapse or crisis. A strengthened and effective community-based service system will help to reduce the demand for more expensive hospital beds and evaluation and treatment centers and will help to alleviate the patient flow bottlenecks that now exist in the system.

Additional data regarding supported housing and similar services received during the course of this study and the 2002 Report is included in **APPENDIX K**.

#A-9: A continuous, state-wide MHD planning function should be fully developed to oversee the implementation and management of the recommendations of this report.

Improvements in attaining smooth patient flow through the mental health continuum of care are possible with the addition of the beds recommended in this report, better coordination between the local and state level, and with more consistent practices across the RSNs as they interact with statewide and regional programs. To ensure the optimal use of the limited resources in providing mental health services to its citizens, MHD should establish an ongoing, formal process to monitor the community provider system, identify inefficiencies and deficiencies within the continuum of care, develop action plans to respond to priority areas in need of improvement, and to measure and report performance results. Through this effort, a coordinated annual resource management plan can be developed that has a system-wide emphasis. Such a formal plan will better align and place into context individual decision packages submitted to division and department administration and the legislature to the overall needs of the system. It will eliminate the need for specialized studies (such as this one) to create databases used to analyze and plan the system. Another impact of this approach will be the timely development of biennial budget materials that are supported by documented and current utilization and demand data.

Furthermore, this management function should also be used by MHD and DSHS to track and maintain a database of all capacity and settings where individuals with mental health issues reside in order to continue to gain a better picture of how all MHD consumers are served. This continued monitoring will assist MHD and DSHS efforts to ensure that appropriate services reach these individuals where they reside.

Such a planning and management effort could be conducted within the context of the existing managed care approach used in the state. Funding for new initiatives could be part of the RSN capitation agreement if the contracting and reporting system is redesigned to ensure that local service delivery decisions follow state goals and priorities.

The following changes in capacity and policy are recommended to better align the supply of children's residential and inpatient services with the demand for mental health services funded by MHD:

#C-1: A new therapeutic foster care community model to serve high risk children and adolescents should be developed. We recommend a minimum of three new therapeutic foster care models, two in western Washington and one in Eastern Washington.

Washington should focus on the development of lower cost, proven models of community care including the therapeutic foster care community model to serve children and adolescents. One such model, the Oregon Social Learning Model, provides a good model of care for the western part of the state. It requires a cluster of ten or more foster care homes and would be most appropriate in more dense, urban areas. In eastern Washington and other more rural areas, a different model of community care may need to be developed. (The service models developed by private providers Mentor, Inc. and Pressley Ridge should be considered). We strongly recommend that some of the new therapeutic foster capacity be reserved initially to facilitate timely and therapeutically effective transition from CLIPs. If possible, these new community programs should be "teamed" (recurring referral, joint training) with specific CLIP facilities to facilitate the smooth transfer of patient care responsibilities. As the therapeutic foster care model becomes more widely available across the state, direct access from the community for children and adolescents who may otherwise require a CLIP admission will become a good alternative. This direct access will provide diversion alternatives for individuals who otherwise would be admitted to CLIPs or who have extended stays at community hospitals due to the lack of an appropriate alternative.

#C-2: The Children's Long Term Inpatient Programs (CLIP) plays a critical "safety net" role and should remain in place until the new service is deployed and evaluated. CLIPs should be strengthened by the better alignment of payment levels to service delivery costs. Once the therapeutic foster care model is widely deployed, a reassessment of these two forms of care should be conducted to ensure that the right blend of services, as measured by outcomes and costs, is available statewide.

The current CLIP programs provide an appropriate level of care for children with severe mental illness and behavioral disorders, many of whom have multiple diagnoses. They have developed some evidence based (DBT) and promising (parent family advocates) practices in their treatment approach, though some programs are more highly developed than others. MHD should ensure that these program components are effectively developed in all CLIP settings through standardized expectations and targeted funding.

CLIPs play an important role as a "safety net" in the current system. Virtually all of the children served have experienced failures in one or more community settings. New models will take some time to develop and some children will likely still require CLIP type facilities even after the new programs are in place. To ensure that adequate resources are available for the CLIPs to provide needed services, a detailed review of their costs and reimbursement levels should be conducted to ensure that they have sufficient financial support. This will also protect against a further reduction of CLIP providers and available beds in the mental health system until such time as the new treatment programs are fully functional. There should be an internal review of treatment management to look at the possibility of marginal improvements in the average length of stay to increase current capacity. This review should begin now in anticipation of expanded community resources that will further reduce lengths of stay in the future.

Access to acute care beds for children and adolescents in crisis that requires inpatient level of care should be expanded in a timely way. The current practice of boarding patients in the emergency rooms with 1:1 staffing and certifying admissions to the medical floors, although providing a community safety net, is both costly and ineffective care. The record reviews conducted demonstrated that overall there was an extended length of stay in the community hospital prior to admission to a CLIP bed. Reducing the CLIP length of stay as discussed above will create more available beds for kids currently backed up in community hospitals.

#C-3: Community outpatient services should be expanded to support children and adolescents at risk of placement and especially to support reintegration of families when children return home from CLIPs.

The expansion of community based services for children and adolescents is essential to minimize the need for foster care, residential, or inpatient services as well as to promote effective integration back into the community once an individual has left any of these treatment alternatives. A goal of outpatient community-based services (which include intensive case management, "wraparound" care where families participate in the development of individualized care plans focused on individual and families strengths, home-based services, child psychiatric consultation, caregiver respite, and outpatient psychotherapy) is to provide early intervention and on-going treatment in the home or community setting to avoid escalating conditions that can lead to treatment that requires separation from the family home. Community based services can minimize these disruptions and the corresponding risks (e.g. trauma from separation) that may occur with inpatient and residential treatment options while also offering effective outcomes and comparatively lower cost of care.

#C-4: Funding and access to specialized children's services, including CLIPs and new therapeutic foster care, should be planned and managed by Washington MHD in partnership with local RSNs and service providers to ensure effective model implementation reduce waiting time and ensure appropriate access to care.

New models are best developed by a central entity that will design and implement them in line with proven and evidence-based practices and will administer access based on need. There will always be intense local pressure for admissions and increasing pressure on RSNs to find solutions for children with serious and complex needs. However, these specialized, high cost and scarce resources are most likely to meet the needs of the children they are intended to serve if their management continues to be the responsibility of MHD.

As the system expands the community-based services that are available for children and adolescents for transitional care from hospitalization and long term residential care, there should be a parallel reduction in length of stay in the CLIP facilities. MHD should ensure that there is improvement in the flow of patients through the system and a process for system-wide oversight of extended lengths of stay or clinical review of "stuck cases" should be implemented. Within the CLIP Administration there currently exists an extensive system for data capture regarding the CLIP facilities. This system should be expanded to provide direct utilization management. The increase in patient flow will provide more timely access to CLIP beds and therefore increase the capacity of CLIP beds currently available to the system. Such a process can also assist in identifying and resolving specific barriers to community placements in conjunction with the RSNs.

II. PROVIDER SYSTEM OVERVIEW

TOTAL BEDS AVAILABLE AND USED

The adult system, as of June 30 2004, provided total capacity of 3,004 beds of which 2,882 beds (96%) are utilized.

S-1. Summary of Number of Providers, Available Beds, Used Beds (FY 2004) - Adults
2002 Service Type Categories

Services	Number of Providers	Total Available Beds	Total Beds Used	Average Utilization	Avg. Unused Beds
Residential	91	1,680.00	1,595.10	94.9%	84.90
Crisis Respite	28	180.00	156.70	87.1%	23.30
Evaluation and Treatment Centers	4	78.00	76.83	98.5%	1.17
Inpatient Community Hospitals	25	215.16	215.16	100.0%	0.00
State Hospital (Civil and PALS)	2	851.00	838.75	98.6%	12.25
All Services	-	3,004.16	2,882.54	96.0%	121.62

Notes:
1. Residential and Crisis Respite beds come from FY 2004 and may have been supplied by the RSNs as a fiscal year average or bed data as of June 30, 2004.
2. Provider counts for Crisis Respite and Residential categories are not unduplicated.
3. I/Pcommunity Hospital data come from MHD. Data is for the 18 and over population.
4. For the purpose of this analysis, the number of community hospital beds available to each RSN has been indicated using the number of beds used by each RSN. A breakdown of available beds by RSN was not provided.
5. Residential and Crisis Respite data is categorized based on the 2002 Report "Major Residential Categories".
6. This summary does not include children's beds or providers.
7. 'Total Beds Used' for inpatient community hospitals is based on complete year FY 2003 data.
8. To mirror the 2002 Report summary table identical to this one, Inpatient Community Hospitals data includes data for the four E&Ts in the state (81 beds available, 70 beds used, 4 providers).

For consistency with original sources of data, some of the data provided is displayed with two decimal places, while others are displayed as whole numbers.

NUMBER OF AVAILABLE BEDS

Since June 30 2002, the system has reduced state hospital capacity (130 less beds or 13%). Residential capacity has decreased by 44 beds capacity while crisis respite has increased by 58 beds. Residential and crisis respite now account for 62% of total capacity, up from 59% in 2002. RSNs with highest capacity (available beds) are King (919 beds); Pierce (574); and Spokane (373 beds). RSNs with lowest capacity (available beds) are Northeast (18 beds); Grays Harbor (28 beds); and Timberlands (30 beds).

S-2. Summary of Number of Available Beds by RSN (FY 2004) - Adults
2002 Service Type Categories

RSNs	Residential	Crisis Respite	Community Inpatient		State Inpatient	All Services
			Evaluation & Treatment Centers	Community Hospitals (FY 2003)	State Hospitals (Civil and PALS)	
Chelan-Douglas	20.00	5.00	-	1.98	11.00	37.98
Clark	71.00	-	-	7.80	41.00	119.80
Grays Harbor	-	10.00	-	1.45	17.00	28.45
Greater Columbia	158.00	55.00	-	13.21	70.00	296.21
King	583.00	20.00	33.00	64.99	218.00	918.99
North Central	35.00	-	-	4.12	18.00	57.12
North Sound	109.00	47.00	30.00	33.86	93.00	312.86
Northeast	2.00	4.00	-	2.28	10.00	18.28
Peninsula	34.00	4.00	15.00	2.94	42.00	97.94
Pierce	349.00	18.00	-	31.88	175.00	573.88
Southwest	47.00	-	-	6.30	15.00	68.30
Spokane	243.00	8.00	-	33.73	88.00	372.73
Thurston-Mason	23.00	6.00	-	8.79	34.00	71.79
Timberlands	6.00	3.00	-	1.83	19.00	29.83
TOTAL 2004	**1,680.00**	**180.00**	**78.00**	**215.16**	**851.00**	**3,004.16**
Percent of Total	**56%**	**6%**	**3%**	**7%**	**28%**	**100%**
2002 Study	**1,724.00**	**122.00**	**110.00**	**187.00**	**981.00**	**3,124.00**
Percent of Total	**55%**	**4%**	**4%**	**6%**	**31%**	**100%**
VARIANCE	*(44.00)*	*58.00*	*(32.00)*	*28.16*	*(130.00)*	*(119.84)*
% Change	***-2.6%***	***47.5%***	***-29.1%***	***15.1%***	***-13.3%***	***-3.8%***

Notes:
1. Data for inpatient community hospitals is for FY 2003. For the purpose of this analysis, the number of community hospital beds available to each RSN has been indicated using the number of beds used by each RSN. A breakdown of available beds by RSN was

NUMBER OF USED BEDS

Since June 30 2002, the system has reduced use of state hospital beds (149.25 less beds) and residential beds (85.90 less beds) while increasing the use of crisis respite beds by 34.60 beds. Residential and crisis respite account for 60% of beds used, up from 59% in 2002. RSNs with the highest number of beds used are King (895.98 beds); Pierce (551.08 beds); and Spokane (394.55 beds). RSNs with the lowest number of beds used are Northeast (17.54 beds); Timberlands (20.80 beds); and Grays Harbor (25.01 beds).

S-3. Summary of Number of Used Beds by RSN (FY 2004) - Adults
2002 Service Type Categories

RSNs	Residential	Crisis Respite	Community Inpatient		State Inpatient	All Services
			Evaluation & Treatment Centers	Community Hospitals (FY 2003)	State Hospitals (Civil and PALS)	
Chelan-Douglas	20.00	3.00	-	1.98	14.62	39.60
Clark	60.90	-	-	7.80	35.78	104.48
Grays Harbor	-	10.00	-	1.45	13.56	25.01
Greater Columbia	155.00	42.10	-	13.21	47.63	257.94
King	555.00	15.00	33.00	64.99	227.99	895.98
North Central	30.00	-	-	4.12	16.29	50.40
North Sound	109.00	47.00	30.00	33.86	85.87	305.73
Northeast	2.00	4.00	-	2.28	9.27	17.54
Peninsula	32.00	2.40	13.83	2.94	35.12	86.28
Pierce	322.00	18.00	-	31.88	179.19	551.08
Southwest	47.00	-	-	6.30	16.26	69.56
Spokane	243.00	8.00	-	33.73	109.82	394.55
Thurston-Mason	15.00	6.00	-	8.79	33.78	63.57
Timberlands	4.20	1.20	-	1.83	13.57	20.80
TOTAL 2004	**1,595.10**	**156.70**	**76.83**	**215.16**	**838.75**	**2,882.54**
Percent of Total	**55%**	**5%**	**3%**	**7%**	**29%**	**100%**
2002 Study	**1,681.00**	**120.00**	**95.00**	**193.00**	**988.00**	**3,077.00**
Percent of Total	**55%**	**4%**	**3%**	**6%**	**32%**	**100%**
VARIANCE	*(85.90)*	*36.70*	*(18.17)*	*22.16*	*(149.25)*	*(194.46)*
% Change	***-5.1%***	***30.6%***	***-19.1%***	***11.5%***	***-15.1%***	***-6.3%***

Notes:
1. Data for inpatient community hospitals is for FY 2003. For the purpose of this analysis, the number of community hospital beds available to each RSN has been indicated using the number of beds used by each RSN. A breakdown of available beds by RSN was

BED UTILIZATION

Overall utilization has decreased by 2.5% since June 30 2002 from 98.5% to 96.0%, as bed availability slightly outpaced bed demand. The largest impact is found in crisis respite (reduced by 11.3% from 98.4% to 87.1%). State and community hospitals were operating near or above full capacity, while E&T utilization remained constant. RSNs with the highest utilization percentage are Spokane (105.9%); Chelan-Douglas (104.3%); and Southwest (101.8%). RSNs with the lowest utilization percentage are Timberlands (69.7%); Greater Columbia (87.1%); and Clark (87.2%).

S-4. Summary of Bed Utilization by RSN (FY 2004) - Adults
2002 Service Type Categories

RSNs	Residential	Crisis Respite	Community Inpatient		State Inpatient	All Services
			Evaluation & Treatment Centers	Community Hospitals (FY 2003)	State Hospitals (Civil and PALS)	
Chelan-Douglas	100.0%	60.0%	-	100.0%	132.9%	104.3%
Clark	85.8%	-	-	100.0%	87.3%	87.2%
Grays Harbor	-	100.0%	-	100.0%	79.8%	87.9%
Greater Columbia	98.1%	76.5%	-	100.0%	68.0%	87.1%
King	95.2%	75.0%	100.0%	100.0%	104.6%	97.5%
North Central	85.7%	-	-	100.0%	90.5%	88.2%
North Sound	100.0%	100.0%	100.0%	100.0%	92.3%	97.7%
Northeast	100.0%	100.0%	-	100.0%	92.7%	96.0%
Peninsula	94.1%	60.0%	92.2%	100.0%	83.6%	88.1%
Pierce	92.3%	100.0%	-	100.0%	102.4%	96.0%
Southwest	100.0%	-	-	100.0%	108.4%	101.8%
Spokane	100.0%	100.0%	-	100.0%	124.8%	105.9%
Thurston-Mason	65.2%	100.0%	-	100.0%	99.4%	88.6%
Timberlands	70.0%	40.0%	-	100.0%	71.4%	69.7%
TOTAL 2004	**94.9%**	**87.1%**	**98.5%**	**100.0%**	**98.6%**	**96.0%**
2002 Study	**97.5%**	**98.4%**	**86.4%**	**103.2%**	**100.7%**	**98.5%**
% Change	***-2.6%***	***-11.3%***	***12.1%***	***-3.2%***	***-2.2%***	***-2.5%***

NUMBER OF BEDS USED PER 100,000 ADULT GENERAL POPULATION (2004)

Since June 30 2002, overall bed utilization per 100,000 adult general population has decreased by 7.2 beds (10.2%) from 70.5 to 63.3 beds. State and community hospital utilization, respectively, experienced a reduction of 4.8 beds (20.7%) and 0.4 beds (5.9%), while residential utilization also decreased by 2.7 beds (7.2%). Crisis respite utilization increased 0.6 beds (21.4%). RSNs with the highest bed utilization per 100,000 adult general population are Spokane (123.4 beds); Pierce (100.4 beds); and Southwest (98.4 beds). RSNs with the lowest bed utilization per 100,000 adult general population are Timberlands (29.4 beds); Thurston-Mason (32.0 beds); and Northeast (33.8 beds).

Table S-5. Number of Beds Used Per 100,000 Adult General Population (2004 Study)
2002 Service Type Categories

RSNs	Adult Population (18 and Over)	Residential Utilization		Crisis Respite Utilization		Inpatient Community Hospital Utilization		State Hospital Utilization		Total	
		Residential Beds	Per 100,000	Crisis Respite Beds	Per 100,000	ADC	Per 100,000	State Hospital Beds	Per 100,000	All Beds	Per 100,000
Chelan-Douglas	75,823	20.00	26.40	3.00	4.00	1.98	2.60	14.62	19.30	39.60	52.20
Clark	280,705	60.90	21.70	-	-	7.80	2.80	35.78	12.70	104.48	37.20
Grays Harbor	51,267	-	-	10.00	19.50	1.45	2.80	13.56	26.50	25.01	48.80
Greater Columbia	464,338	155.00	33.40	42.10	9.10	13.21	2.80	47.63	10.30	257.94	55.60
King	1,325,363	555.00	41.90	15.00	1.10	97.99	7.40	227.99	17.20	895.98	67.60
North Central	99,525	30.00	30.10	-	-	4.12	4.10	16.29	16.40	50.40	50.60
North Sound	753,513	109.00	14.50	47.00	6.20	63.86	8.50	85.87	11.40	305.73	40.60
Northeast	51,973	2.00	3.80	4.00	7.70	2.28	4.40	9.27	17.80	17.54	33.80
Peninsula	245,710	32.00	13.00	2.40	1.00	16.77	6.80	35.12	14.30	86.28	35.10
Pierce	548,966	322.00	58.70	18.00	3.30	31.88	5.80	179.19	32.60	551.08	100.40
Southwest	70,659	47.00	66.50	-	-	6.30	8.90	16.26	23.00	69.56	98.40
Spokane	319,713	243.00	76.00	8.00	2.50	33.73	10.60	109.82	34.30	394.55	123.40
Thurston-Mason	198,492	15.00	7.60	6.00	3.00	8.79	4.40	33.78	17.00	63.57	32.00
Timberlands	70,808	4.20	5.90	1.20	1.70	1.83	2.60	13.57	19.20	20.80	29.40
TOTAL	**4,556,856**	**1,595.10**	**35.00**	**156.70**	**3.40**	**291.99**	**6.40**	**838.75**	**18.40**	**2,882.54**	**63.30**
2002 Study	4,257,494	1,681.00	37.70	120.00	2.80	288.00	6.80	988.00	23.20	3,077.00	70.50
VARIANCE	*299,362*	*(85.90)*	*(2.70)*	*36.70*	*0.60*	*3.99*	*(0.40)*	*(149.25)*	*(4.80)*	*(194.46)*	*(7.20)*
% Change	***7.0%***	***-5.1%***	***-7.2%***	***30.6%***	***21.4%***	***1.4%***	***-5.9%***	***-15.1%***	***-20.7%***	***-6.3%***	***-10.2%***

HOSPITAL DIVERSION/ALTERNATIVES USED BEDS *(2004 Service Setting Definitions)*

The result was For FY 2004, crisis respite accounts for 129 beds (81.3%) of total hospital diversion/alternative used beds (158.7).

Table S-6. Number of Used Beds by RSN (FY 2004)
Hospital Diversion / Alternatives

RSNs	2004 SERVICE SETTING DEFINITIONS				
	Hospital Diversion / Alternatives				TOTAL
	Crisis Respite	Crisis Triage	Crisis Stabilization	Step Down Beds	
Chelan-Douglas	3.0	-	-	-	3.0
Clark	-	-	-	-	-
Grays Harbor	10.0	-	-	-	10.0
Greater Columbia	39.0	3.1	-	-	42.1
King	15.0	-	-	-	15.0
North Central	-	-	-	-	-
North Sound	47.0	-	-	-	47.0
Northeast	4.0	-	-	-	4.0
Peninsula	-	-	2.4	-	2.4
Pierce	3.0	15.0	-	-	18.0
Southwest	-	-	-	2.0	2.0
Spokane	8.0	-	-	-	8.0
Thurston-Mason	-	-	6.0	-	6.0
Timberlands	-	-	1.2	-	1.2
TOTAL	**129.0**	**18.1**	**9.6**	**2.0**	**158.7**
Percent of Total	**81.3%**	**11.4%**	**6.0%**	**1.3%**	**100%**

RESIDENTIAL SUPERVISED AND SUPPORTED LIVING USED BEDS *(2004 Service Setting Definitions)*

Of the 829.5 intensive residential used beds, 796.3 (96.0%) are for supervised living and 33.2 (4.0%) are for supported living. Of the 763.6 non-intensive residential used beds, 716.6 (93.8%) are for supervised living and 47.0 (6.2%) are for supported living.

Table S-7. Number of Used Beds by RSN (FY 2004)
Residential Supervised and Supported Living

RSN	Residential Supervised Living		TOTAL	Residential Supported Living		TOTAL	Consolidated--Supervised AND Supported Living		TOTAL
	Intensive	Non-Intensive		Intensive	Non-Intensive		Intensive	Non-Intensive	
Chelan-Douglas	-	20.0	20.0	-	-	-	-	20.0	20.0
Clark	30.3	30.6	60.9	-	-	-	30.3	30.6	60.9
Grays Harbor	-	-	-	-	-	-	-	-	-
Greater Columbia	129.0	26.0	155.0	-	-	-	129.0	26.0	155.0
King	217.0	317.0	534.0	21.0	-	21.0	238.0	317.0	555.0
North Central	-	30.0	30.0	-	-	-	-	30.0	30.0
North Sound	16.0	93.0	109.0	-	-	-	16.0	93.0	109.0
Northeast	-	-	-	-	2.0	2.0	-	2.0	2.0
Peninsula	13.0	19.0	32.0	-	-	-	13.0	19.0	32.0
Pierce	141.0	181.0	322.0	-	-	-	141.0	181.0	322.0
Southwest	-	-	-	-	45.0	45.0	-	45.0	45.0
Spokane	243.0	-	243.0	-	-	-	243.0	-	243.0
Thurston-Mason	7.0	-	7.0	8.0	-	8.0	15.0	-	15.0
Timberlands	-	-	-	4.2	-	4.2	4.2	-	4.2
TOTAL	**796.3**	**716.6**	**1,512.9**	**33.2**	**47.0**	**80.2**	**829.5**	**763.6**	**1,593.1**
Percent of Total	**52.6%**	**47.4%**	**100.0%**	**41.4%**	**58.6%**	**100.0%**	**52.1%**	**47.9%**	**100%**

Additional summary tables can be found in **APPENDIX A** of this report.

III. STAKEHOLDER INTERVIEWS

INTRODUCTION

Interviews with key stakeholders in the MHD service delivery system were conducted to obtain input pertaining to the current demand for adult and children's inpatient and residential services and to assess how the level of demand aligns with current capacity. These interviews focused on the state-operated and community inpatient hospitals, as well as the CLIP facilities for children. Each stakeholder was encouraged to identify areas in need of improvement and to provide a corresponding recommendation. If these identified issues can be addressed, the public health system will operate more effectively and efficiently by delivering medically necessary patient services in the most appropriate and cost effective setting in a timely manner. This section provides a summary of the key themes that emerged during these interviews.

Collectively, the most significant findings from the interviews held with key segments of the Washington public mental health service delivery system are as follows:

1. There is lack of community-based capacity (residential, hospital step-down, and outpatient services capacity, including access to medication) that can provide early intervention services to divert hospital admissions and the necessary post-hospital discharge care that is required to maintain patients in their community without excessive use of inpatient hospital services. This deficiency in community-based services is evidenced by: higher levels of hospital Emergency Room Boarding and Medical Bed certifications for psychiatric care, extended lengths of stay beyond what is required, full utilization of available hospital beds, admission waiting lists, treatment of civil cases on forensic wards at the state hospitals, delays in hospital discharges and timely access to wrap-around services. This situation has created a back-up in the system, due to the inability of care providers to find appropriate residential services for hospital patients. This system back-up negatively impacts the smooth and timely transfer of patient care responsibilities through the continuum of care to the most appropriate clinical care setting that best matches the specific needs of the consumer at the lowest possible cost.

2. Specialized populations are now served by more expensive and restrictive state and acute community hospitals because of a lack in better community-based alternatives. These specialized populations include the developmentally disabled, the geriatric, those with traumatic brain injuries, those with sexually deviant behaviors, those with co-occurring disorders (e.g. mental illness / chemical dependency) and those with medically complex cases (e.g. end stage renal disease).

3. There is an immediate need to at least preserve the existing community hospital beds that currently exist in the system. This may include evaluating funding arrangements to ensure that payment rates come closer (or cover) the actual cost of service delivery.

4. There is a lack of a global resource planning and management function within the state system (including a formal process and central oversight authority) to monitor the overall system effectiveness and develop short and long term plans to adjust the service delivery system to better meet the needs of the consumers on a continuous basis. This central planning and management function should include all state agencies providing related services and integrate all service care settings (inpatient and outpatient) and providers.

5. There is a need to fully assess the potential impact that the new interpretation of the federal waiver will have on the community hospitals and residential capacity provided by the RSNs. The impact on the uninsured population should be a component of this analysis, detailing the impact on each major segment of the service delivery system.

Detailed summaries of the stakeholder interviews and supporting tables are provided for inpatient community hospitals, the state psychiatric hospitals (Western and Eastern State Hospitals), and the Children's Long-Term Inpatient Program (CLIP) in **APPENDIX B** of this report.

IV. DATA ANALYSIS - ADULTS

A. STATE PSYCHIATRIC HOSPITALS

INTRODUCTION

In the State Hospitals section of the report, PCG summarizes the key findings and statistics pertaining to Washington's state hospitals. The supporting analysis for the key findings based on the data obtained from the state's Mental Health Division is included in **APPENDIX C** of this report.

The section is structured as follows:

I. Key Findings
II. Key Statistics
III. Support for Key Findings & Statistics (Appendix B)
    a. Number of Patient Bed Trends
    b. RSN Bed Allocation
    c. Number of Patient Admissions
    d. Average Daily Census
    e. Length of Stay
    f. Utilization per 100,000 Adult Population
    g. Utilization per 100,000 Medicaid Eligibles
    h. Peer State Comparison
    i. Daily Bed Rate Trends

KEY FINDINGS

1. There's been a reduction of 147 state hospital civil and PALS beds, a 15% decrease, from FY 2001 to FY 2005.

2. There's been a re-allocation of the state hospital beds per Regional Support Network (RSN) as derived by the state of Washington's Mental Health Division. Due to the overall decrease in state hospital beds, all RSNs have experienced a reduction in their respective bed allocation from FY 2001 to FY 2005 except for North Central and North Sound.

3. The state hospitals are still maintaining full capacity, which indicates continued high demand for state hospital beds and alternative community based services. Comparing the most current bed allocation (FY 2005) to the average daily census as of June 2004, the combined state hospital civil bed occupancy rate was 101.7% (744 used beds to 731 available beds). This compares to the 102.1% occupancy rate in June of 2002 (988 used beds to 981 available).

4. Comparing FY 2005 allocation to June 2004 average daily census, PALS beds are under capacity by 8 beds or 7.8% (95 used beds to 103 available beds).

5. The two state hospitals continue to indicate a significant percentage (58%) with lengths of stay beyond 90 days in FY 2004. Patients with lengths of stay beyond 180 days accounted for 32% of all civil patient discharges in FY 2004.

6. Washington's FY 2004 18.7 state hospital beds per 100,000 adult population remains the highest when compared to eight peer states surveyed in 2002.

7. Consistent with the reduction in state hospital beds, state hospital admissions has been reduced by 473 from FY 2001 to FY 2004. However, Washington's FY 2004 34.2 state hospital admissions per 100,000 adult population remains the 4th highest when compared to eight peer states surveyed in 2002.

KEY STATISTICS

The state of Washington's two psychiatric inpatient facilities, Eastern State Hospital (ESH) and Western State Hospital (WSH), together, serve civil and forensic patients across the state. The key capacity (July 1, 2004) and utilization (June 30, 2004) statistics for each of these two hospitals are summarized below:

Table SH-1. Capacity & Utilization Statistics

Institution	Type of Commitment	Number of Available Beds	Average Daily Census	Average Length of Stay	Admissions	Discharges	Number of RSNs Using the Facility
Eastern State Hospital	Civil	192	196	168	741	n/a	
	Forensic	83	88	376	199	n/a	
	Total	275	284	n/a	940	1,069	5
Western State Hospital	Civil	539	548	395	678	n/a	
	Forensic	241	224	316	688	n/a	
	PALS	103	95	n/a	140	n/a	
	Total	883	867	n/a	1,506	1,347	9
Combined State Hospitals	Civil	731	744	n/a	1,419	n/a	
	Forensic	324	312	n/a	887	n/a	
	PALS	103	95	n/a	140	n/a	
	Total	1,157	1,151	n/a	2,306	2,416	14

Note:
1. The number of available beds is based on the FY 2005 RSN bed allocation as of July 1, 2004. The average daily census, average length of stay, admissions, and discharges are as of June 30, 2004.
2. MHD is the source for all of the Washington state hospital data.

Support for the key findings and statistics for the state hospitals can be found in **APPENDIX C** of this report.

B. INPATIENT COMMUNITY HOSPITALS

INTRODUCTION

The following section discusses inpatient community hospital beds for adults in the State of Washington. This narrative draws comparisons to PCG's 2002 Report in order to show where Washington is now in terms of the availability and use of community hospital beds. As part of this narrative, we have included descriptive data tables to illustrate key findings for the data analyzed. It is important to note that for this analysis, PCG used FY 2003 inpatient community hospital data supplied by MHD. Data provided for FY 2004 was incomplete given the fiscal year reporting lag of claims and payments. The FY 2003 data was complete and was judged to be a better representation of community hospital usage. It is also important to note that RSNs, in the majority of cases, do not have a specified number of beds available at a particular community hospital. RSNs use available beds as needed and wherever a bed is available at the community hospitals for their consumers.

The section is structured as follows:

Overview of Inpatient Community Hospitals

I. Key Findings
II. Key Statistics – Inpatient Community Hospital Provider Capacity
III. Support for Key Findings
   a. Community Hospital Financial Data

Overview of RSN Usage of Inpatient Psychiatric Community Hospital Bed Capacity

I. Key Findings
II. Key Statistics
III. Support for Key Findings

Support for the key findings and statistics for inpatient community hospitals can be found in **APPENDIX D** of this report.

OVERVIEW OF INPATIENT COMMUNITY HOSPITALS

KEY FINDINGS

1. There are a total of 609 inpatient psychiatric beds in the community hospital network.

2. There has been an 85 bed or 12% reduction (from 694 to 609 beds) in the number of available community hospital beds available in the inpatient community hospital setting between FY 2000 and FY 2004.
    - 502 Adult Beds
    - 107 Geriatric Beds

3. A total of 9 beds were planned for closure effective October 1, 2004:
    - The University of Washington Medical Center was scheduled to reduce their beds from 20 to 14 beds (a reduction of 6 beds)
    - Lake Chelan Community Hospital was scheduled to reduce its beds from 13 to 10 (a reduction of 3 beds)
    - However, eight additional beds are planned for Harborview in 2007

4. Hospitals that accept ITA admissions have declined from 18 in 2000 to 16 in 2004 which represents an 11% decrease. The "Total Beds Available for ITA" that is shown on the following table represents the total number of beds for the hospitals that accept ITA admissions and does not represent the actual number of community hospital beds available for ITA patients.

5. Current reimbursement levels are insufficient to cover the costs of inpatient psychiatric services which may lead to further erosion of available inpatient psychiatric bed capacity.

KEY STATISTICS

Inpatient Community Hospital Provider Capacity

Table IA-1. Inpatient Community Hospital Provider Capacity

WASHINGTON STATE COMMUNITY HOSPITAL STAFFED PSYCHIATRIC BEDS

	1994				2000				2001				2002				2003				2004			
	ADULT	GERO	TOTAL	ACCEPT ITA?	ADULT	GERO	TOTAL	ACCEPT ITA?	ADULT	GERO	TOTAL	ACCEPT ITA?	ADULT	GERO	TOTAL	ACCEPT ITA?	ADULT	GERO	TOTAL	ACCEPT ITA?	ADULT	GERO	TOTAL	ACCEPT ITA?
Auburn Regional Medical Center	0	0	0	N	0	20	20	N	0	20	20	N	0	20	20	N	0	20	20	N	0	20	20	N
Central Washington Hospital	19	0	0	Y	0	0	0	-	0	0	0	-	0	0	0	-	0	0	0	-	0	0	0	-
Children's Hospital & Medical Center	0	0	0	Y	0	0	0	Y	0	0	0	Y	0	0	0	Y	0	0	0	Y	0	0	0	Y
Fairfax Hospital	40	0	40	Y	33	0	33	Y	32	0	32	Y	41	0	41	Y	41	0	41	Y	42	0	42	Y
Harborview Medical Center	63	0	63	Y	61	0	61	Y	61	0	61	Y	61	0	61	Y	61	0	61	Y	61	0	61	Y
Harrison Memorial Hospital	17	0	17	N	17	0	17	N	17	0	17	N	17	0	17	N	17	0	17	N	17	0	17	N
Highline Community Hospital	0	20	20	Y	0	20	20	N	0	20	20	N	0	20	20	N	0	20	20	N	0	20	20	N
Lake Chelan Community Hospital	10	0	10	N	10	0	10	N	10	0	10	N	13	0	13	N	13	0	13	N	13	0	13	N
Lourdes Counseling Center	22	0	22	Y	22	0	22	Y	22	0	22	Y	22	0	22	Y	22	0	22	Y	22	0	22	Y
Northwest Hospital	0	15	15	N	0	27	27	Y	0	27	27	Y	0	27	27	Y	0	27	27	Y	0	27	27	Y
Overlake Hospital	16	0	16	N	15	0	15	N	15	0	15	N	15	0	15	N	15	0	15	N	15	0	15	N
Providence St. Peter	26	0	26	Y	26	0	26	Y	20	0	20	Y	18	0	18	Y	18	0	18	Y	15	0	15	N
Puget Sound Behavioral Health	30	0	30	Y	43	0	43	Y	43	0	43	Y	43	0	43	Y	43	0	43	Y	48	0	48	Y
Sacred Heart Medical Center	48	0	48	Y	48	24	72	Y	48	24	72	Y	48	18	66	Y	38	10	48	Y	38	10	48	Y
Skagit Valley Hospital	15	0	15	Y	15	0	15	Y	15	0	15	Y	15	0	15	Y	15	0	15	Y	15	0	15	Y
Snoqualmie Valley Hospital	0	0	0	-	0	0	0	N	0	8	8	N	0	8	8	N	0	8	8	N	0	8	8	N
Southwest Washington Medical Center	16	0	16	Y	16	0	16	Y	16	0	16	Y	16	0	16	Y	16	0	16	Y	16	0	16	Y
St Francis Community Hospital	10	0	10	N	10	0	10	N	10	0	10	N	10	0	10	N	10	0	10	N	10	0	10	N
St John's Medical Center	20	0	20	Y	20	0	20	Y	20	0	20	Y	22	0	22	Y	22	0	22	Y	22	0	22	Y
St. Joseph (Bellingham)	10	0	10	Y	10	0	10	Y	10	0	10	Y	10	0	10	Y	10	0	10	Y	10	0	10	Y
St. Joseph (Tacoma)	18	0	18	N	18	0	18	N	18	0	18	N	18	0	18	N	18	0	18	N	18	0	18	N
St. Mary Medical Center	10	0	0	Y	10	0	10	Y	10	0	10	Y	0	0	0	-	0	0	0	-	0	0	0	-
Stevens Hospital	20	3	23	Y	18	5	23	Y	18	5	23	Y	18	5	23	Y	15	8	23	Y	15	8	23	Y
Swedish Medical Center-Providence	36	0	36	N	36	0	36	N	36	0	36	N	36	0	36	N	23	0	23	N	23	0	23	N
United General	0	0	0	Y	0	10	10	Y	0	10	10	Y	0	10	10	Y	0	10	10	Y	0	0	0	-
University of WA Medical Center	40	0	40	N	20	0	20	N	20	0	20	N	20	0	20	N	20	0	20	N	20	0	20	Y
Valley General Hospital	0	0	0	-	0	12	12	Y	0	12	12	Y	0	12	12	Y	0	14	14	Y	0	14	14	Y
Valley Medical Center	20	0	20	N	20	0	20	N	0	18	18	N	18	0	18	N	16	0	16	N	0	0	0	-
West Seattle Psychiatric Hospital	30	10	40	Y	59	13	72	Y	59	13	72	Y	54	13	67	Y	64	0	64	Y	64	0	64	Y
Yakima Valley Memorial Hospital	0	18	18	Y	18	18	36	Y	18	0	18	Y	18	0	18	Y	18	0	18	Y	18	0	18	Y
TOTAL	**536**	**66**	**573**		**545**	**149**	**694**		**518**	**157**	**675**		**533**	**133**	**666**		**515**	**117**	**632**		**502**	**107**	**609**	
TOTAL BEDS AVAILABLE FOR ITA	**369**	**51**	**391**		**399**	**109**	**508**		**392**	**91**	**483**		**386**	**85**	**471**		**383**	**69**	**452**		**391**	**59**	**450**	

1. Data from Washington Behavioral Health Inpatient Association.

OVERVIEW OF RSN USAGE FOR INPATIENT PSYCHIATRIC COMMUNITY HOSPITAL BED CAPACITY

KEY FINDINGS

1. The data shows that RSNs are using more community hospital beds when compared to FY 2001 data. However, the data also shows that the overall inpatient community hospital system is losing psychiatric beds which reduce the overall availability to the RSN consumers. The 12% decrease in capacity since FY 2000 illustrates a trend that, if not addressed, could result in a possible gap in the mental health services continuum of care.

2. In addition, the data shows that while the number of beds used has increased since FY 2001 by roughly 12%, the number of people served in the inpatient community hospitals has decreased by about 7%. This implies that the length of stay for individuals at this level of care has been increasing and supports the findings that individuals may not be discharged in as timely a manner as possible due to the lack of availability of other system resource capacities.

KEY STATISTICS

Total RSN bed utilization of community hospital inpatient psychiatric beds has increased from an average of 193 beds per day to 215 beds per day (11% increase).

Table IA-2. Inpatient Community Hospitals - Change in Total Available and Used Beds

Bed Type	FY 2001	FY 2003	FY 2001 to FY 2003 Change (Beds)	FY 2001 to FY 2003 Change (Percent)
Beds Available	187	215	28	14.97%
Beds Used	193	215	22	11.40%
Utilization	*103.21%*	*100.00%*	-	*-3.21%*

1. FY 2001: Data come from PCG's 2002 Report. "Beds Available" was collected from the RSNs in the 2002 Report; RSNs stated that beds can only be used when available and are used on an as-needed basis. No contract exists between the RSNs and community hospitals for a specified number of beds. "Beds Used" is MHD's ADC for inpatient community hospital "used beds" data.

2. FY 2003: Data come from MHD. "Beds Available" is given as the number of beds used by each RSN, given that beds are available and used on an as-needed basis. "Beds Used" data was calculated by MHD using te MHD data obtained.

C. EVALUATION AND TREATMENT (E&T) CENTERS

INTRODUCTION

The Evaluation and Treatment Center (E&T) is a unique type of mental health care facility that supplies a platform for quick and effective crisis management and stabilization. The primary goal of an E&T is to evaluate, diagnose and stabilize acute psychiatric symptoms within a very short duration of time. Washington State currently maintains four E&T facilities—West Seattle Psychiatric Hospital, Kitsap Mental Health Services, Compass Health Snohomish E&T, and Compass Health North Sound E&T—all of which are located within the Western State Hospital system. PCG's 2002 study for MHD touched upon the demand and utilization of Washington's Evaluation & Treatment facilities. In our conclusion, we made the recommendation to add beds earmarked for E&T use only, which would serve to decrease a number of unnecessary acute patient admissions in state hospitals.

Support for the key findings and statistics for evaluation and treatment centers can be found in **APPENDIX E** of this report.

KEY FINDINGS

1. There are four E&Ts in the State of Washington, serving three RSNs—King, Peninsula, and North Sound. The eleven other RSNs do not have any E&T capacity.

2. At the present time, all four centers are positioned in the domain of Western State Hospital: West Seattle Psychiatric Hospital is located in King County, Kitsap Mental Health Services is situated in Kitsap County, Compass Health Snohomish E&T is located in Snohomish County, and Compass Health North Sound E&T is in Skagit County.

3. There were 78 available E&T beds throughout the State in FY 2004; of these, 76.83 (98.5% occupancy rate) were used. In FY 2003, there were 110 available E&T beds and 95 used beds (86.3% occupancy rate).

KEY STATISTICS

The data below contains the most recent capacity and utilization information pertaining to the four E&T facilities. The available beds and the average daily census reflect FY 2004. The average length of stay, admissions, and discharge data reflect FY 2003 due to the incompleteness of FY 2004 data. The E&T capacity and utilization data was provided by MHD.

Table ETA-1. Summary of Evaluation & Treatment Center Capacity and Utilization

RSN	Institution	Number of Available Beds	Average Daily Census	Average Length of Stay	Admissions	Discharges	Number of RSNs Using the Facility
King	West Seattle Psychiatric Hospital	33	33	14	1,301	1,311	1
Peninsula	Kitsap Mental Health Services	15	13.83	17	490	487	1
North Sound	Compass Health Snohomish and Compass Health North Sound	30	30	12	633	644	1
TOTAL:		**78**	**76.83**	**14**	**2,424**	**2,442**	**3**

D. RESIDENTIAL

INTRODUCTION

The following section of the report reviews the residential and crisis respite bed capacity and utilization data provided by the RSNs. The data collected from the RSNs was limited to residential services given that all community and state hospital data was provided by MHD. This analysis draws comparisons to the 2002 Report by grouping the current data into the 2002 Major Residential Categories formulated by PCG, MHD, and the RSNs during the course of the 2002 study. This review also looks at the data organized into new service setting definitions that were formulated by PCG and MHD with input from various system stakeholders serving as members of the mental health advisory group.

KEY FINDINGS

1. In FY 2004, the RSNs had 1,680 available residential beds situated in 91 residential providers and 180 crisis respite beds situated in 28 crisis respite providers. Comparable data in the 2002 Report indicated 1,724 available residential beds in 87 residential providers and 120 available crisis respite beds in 31 crisis respite providers.

2. In FY 2004, the RSNs utilized 1,595.1 residential beds (94.9% occupancy rate) and 156.7 crisis respite beds (87.1% occupancy rate), leaving 84.9 unused residential beds and 23.3 unused crisis respite beds. The residential occupancy rate in the 2002 study was 97.5% (1,681 used beds to 1,724 available beds). The crisis respite occupancy rate in the 2002 study was 98.4% (120 used beds to 122 available beds).

3. In FY 2004, residential bed utilization per 100,000 adult general population was 35.0, a 4.5% decrease over the 2002 study results of 39.5 beds used per 100,000. Crisis respite utilization per 100,000 in FY 2004 was 3.4, a 22.0% increase over the 2002 study results of 2.8 beds per 100,000.

KEY STATISTICS

The following information summarizes some key RSN statistics for FY 2004.

Table R-1. Residential Services Summary

Provider Type	Number of Providers	Number of Available Beds	Number of Used Beds	Number of Unused Beds	Bed Utilization per 100,000 Adult General Population
Residential	91	1,680	1,595.1	84.9	35.0
Crisis Respite	28	180	156.7	23.3	3.4
Total Residential & Crisis Respite	119	1,860	1,751.8	108.2	38.4

Support for the key findings and statistics can be found in **APPENDIX F** of this report.

E. ADULT PEER STATE COMPARISON STUDY UPDATE

INTRODUCTION

The following section includes PCG's update of the adult peer state comparison study conducted as part of the 2002 Report. While completing a comprehensive update to this component of the last was not under the umbrella of this current report, PCG has provided the Mental Health Division with an analysis Washington's system has changed over the past two years and compare this change to the peer state comparison group comprised in the 2002 Report. We have included three tables containing data collected for the 2002 comparison study that show population and number of staffed state hospital beds, admissions, and average daily census (ADC). PCG included the "Per 100,000" analyses by the adult general population and number of Medicaid eligibles as well.

KEY FINDINGS

1. There have been bed reductions at the state hospitals since release of the 2002 Report. In order to understand whether or not the decrease in available state hospital beds has reduced the reliance on state hospitals in Washington, it is important to look at the relative impact on admissions. To do so, we set up an additional analysis of admissions per available bed. Findings of this analysis are included below.

2. The supporting statistics and tables indicate that although Washington has decreased the number of state hospital beds and the overall utilization rate of these beds, it is still higher than the peer states examined in the 2002 Report. While an updated and comprehensive peer state comparison study was not completed for adults, data from the 2002 Study indicate that several of the peer states had plans to downsize the number of state hospital beds in the system at the time of the survey conducted in 2002.

3. Washington has moved closer to it peers in terms of utilization, but it is assumed that bed reductions have been made by several of the peer states, thus lowering the mean utilization rate. Washington will need to continue to reduce its reliance on the state hospitals and increase utilization of state hospital alternatives if it is to keep pace with its peers and have available bed and utilization rates closer to those of its peers. While the total number of admissions has decreased significantly between the 2002 and 2004 Reports, the number of admissions per available bed has decreased as well. The analysis of admissions per available bed and average length of stay show that while beds have been reduced in the state hospital system consumers are

staying longer. There appears to be less "turn-around" of consumers admitted to the hospital. This results in congestion at the "front door" of state hospitals given that individuals are staying longer with fewer beds in which to stay.

4. An update of the peer state comparison of inpatient psychiatric beds in the community indicates that Washington is significantly below the average (993 beds) and median (503 beds) of its peer states. Consequently, Washington is using 21.8 beds per 100,000 (58.0%) less than the peer state average and 23.8 beds per 100,000 (60.2%) less than the peer state median.

5. The number of inpatient community psychiatric hospital beds available in Washington has decreased by 95 since the 2002 Report. In addition, Washington is using 2.8 beds per 100,000 less since the 2002 Report.

Support for the key findings and statistics can be found in **APPENDIX G** of this report.

V. DATA ANALYSIS - CHILDREN

A. CHILDREN'S LONG-TERM INPATIENT PROGRAM (CLIP)

KEY STATISTICS

In Washington State, the Children's Long Term Inpatient Programs (CLIPs) function as the highest level of care available for emotionally and behaviorally disordered children that range in age from 5 to 17 years old. MHD tends to view these programs, which serve children with severe, complex mental health problems at four facilities with a total of approximately 91 beds, as a 'last resort' placement. In general, children admitted to these facilities—the Child Study and Treatment Center, McGraw Center, Pearl Street Center, and Tamarack Center—have a history of failed treatment attempts, including multiple inpatient admissions at an acute level.

Voluntary applicants are referred to the CLIPs only after scrutiny and approval by regional teams that are facilitated by each RSN. The applicant must adhere to the following: he/she must be a legal resident of Washington State, be less than 18 years of age, and have a severe psychiatric impairment that requires the restrictive setting and concentrated services of CLIPs. Requirements for application are rigorous—records from a child's inpatient and outpatient mental health care, out-of-home placements, schools, and other child serving agencies are mandatory, as is the inclusion of the perspectives of family members and involved professionals. A written synopsis based on this information is drafted and submitted to the CLIP Certification Team, who then ascertains whether the applicant meets Medicaid-necessary criteria. Those children who are approved for admission are placed on the statewide waiting list. At the time of this report, a delay of more than 60 days awaits 45% of children before admission to a CLIP facility can be is granted, 32% wait 30 to 60 days, and 23% wait less than 30 days. Once admitted, patients stay an average of 8 months, though some children receive care for as little as 2 months or as many as 24 months.

In fiscal year 2003, the bed rate at three of the four CLIP facilities was $339.00 per day and $600.90 per day at the Child Study and Treatment Center. Funding issues are paramount for CLIP administrators, who have seen erosion in their operating budgets over the

years. This lack of funding has caused great concern over the preservation of extensive and effective inpatient child services for the community. Recently, one CLIP provider, The Martin Center, was forced to close all 12 of its beds, citing a deficiency in financial support. The hard reality that the CLIPs have had to confront throughout the years is static budgets paired with continually rising operational costs.

When PCG was asked to evaluate the current status of CLIPs by the Mental Health Division in the State of Washington, three distinct questions arose:

1. Does the State maintain enough CLIP beds?
2. Are the CLIPs providing high quality service to their consumers?
3. What else can be done to provide effective care for multi-challenged children in community rather than institutional settings?

These questions served to springboard PCG's research into the utilization and effectiveness of the CLIPs, and their replies provided us with a clear framework in which to arrange our recommendations for the future of the program.

KEY FINDINGS

Average Length of Stay

In order to accurately analyze the current situation of the CLIPs and define recommendations for its future, the aspect of Average Length of Stay must take on a primary role. By assessing whether or not the Average Length of Stay (ALOS) within the four CLIPs can be reduced, we are in fact describing the bed use efficiency in the facilities, which in turn satisfies the notion of adding or removing CLIP beds or introducing another type of implementation to the system.

PCG research indicates that in Fiscal Year 2003, the Average Length of Stay for CLIP patients was 8 months, with the range falling between 2 and 24 months after removing outliers from the data set (See Table CL-1.) These figures are significant when the following is considered: a reduction in length of stay of just one week per bed in a 91-bed system with an ALOS of 6 months would increase

capacity by 182 weeks or 3.5 beds per year. Since current figures show that CLIP ALOS is a slightly higher 8 months, the gain in treatment capacity would be somewhat less, but still substantial.

Bed Use Efficiency

Bed use efficiency is closely connected to Average Length of Stay statistics: it is an essential element in deciding whether to add or deduct from a facility's bed allotment, and clarifies the need or lack of it for a new plan of action for the system. In classifying the ALOS at the four CLIP facilities as optimal or not—'optimal' being defined as no more time than is necessary to achieve enough clinical progress so that children can remain in a community setting following discharge—we concluded that while the number of beds allotted to the CLIPs, ninety-one, is appropriate and that the geographic sprawl of the facilities (two in Tacoma, one in Seattle, one in Spokane) is sufficient, the CLIP ALOS of 8 months is unnecessarily high. Certainly it is important that the multi-challenged children served by the CLIPs spend enough time in the treatment environment to settle in, experience stability and structure, achieve behavioral change, and prepare for life in the community. However, a basic expectation of four to six months for this transformation—with some outliers—is a more efficient time frame than the CLIP facilities' current ALOS.

Funding

Because the combination of services that the CLIPs offer is not available in any other area of the Mental Health Division, it is critical that the State of Washington retain this program. Looking at the total Fiscal Year expenditures of the facilities highlights the funding issue that the CLIP Administration is getting tangled in: expenditures for Fiscal Year 2004 totaled $14,170,261, then skyrocketed to an estimated $15,935,191 in Fiscal Year 2005 (see Table CL-4).

Because the basic fundamental of the CLIP system of care is an offering of specialized services, it is evident that significant MHD funding is required. With the average daily bed rate at these four facilities continuing to rise, increasing from $339.00 in Fiscal Year 2003 ($600.90 for the Child Study and Treatment Center, See Table CL-1), to $423.00 projected for Fiscal Year 2005 ($653.25 for the Child Study and Treatment Center, see Table CL-4), the fear that this important program could shut down is becoming more and more of a possibility.

DATA ANALYSIS

Adding a New Model of Care

Through in-depth analysis of Length of Stay and utilization of bed capacity data within the CLIPs (See Table CL-1), PCG suggests that the four facilities implement a new program of care into the current CLIPs structure to reduce ALOS while maintaining the combined bed allocation. Integration of a model such as Therapeutic Foster Care (described in an upcoming section of this report) would address this need while adhering to the stress that CLIP administrators place on the availability of additional community programming.

Table CL-2 details CLIP Administration research into the types of admissions at the four CLIP facilities from years 1991-2003. This research indicates that the two most common primary diagnoses upon admission to the four children's facilities were: 1) attention-deficit, disruptive, and impulse control disorders; and 2) mood disorders. Additional diagnoses included: schizophrenia and other psychotic disorders; adjustment disorders; anxiety disorders; personality disorders; and pervasive developmental disorders. The category of "other" included: delirium, eating disorders, gender identity disorders, other disorder of infancy, childhood or adolescence, psychological factors affecting medical condition, tic disorder, and substance abuse-related disorders. Through the addition of a new program model, such as therapeutic foster care, select children falling under these types of admission categories could receive the same level and type of treatment found in the CLIPs, but in a setting that is not inpatient and under the supervision of a foster family instead of hospital clinicians. The upshot of introducing a program like therapeutic foster care is less strain on CLIP resources, both financially and physically, and for less acute children, those who can receive services outside of admission to CLIPs, a more community-based approach to treatment.

Research by the CLIP Administration also shows that approximately 67% of clients were discharged from the CLIPs because treatment was completed. Of the remaining 33%, the three most common reasons for discharge were: treatment discontinued at consumer's or parent's request, transfer to another children's inpatient unit, and child's failure to return / runaway. Another notable reason for discharge was the remanding of children to court, juvenile justice, or detention centers (see Table CL-3). These grounds for discharge highlight yet another area of the CLIPs that could be aided through the integration of Therapeutic Foster Care. Some outcomes of the Therapeutic Foster Care model that have proven successful are: continued support and therapy after completion of the

more structured program treatment, reduced number of clients who are shifted from one treatment program to another, a low incidence of runaway behavior, and a decrease in juvenile justice intervention.

Additional Funding

The cost per day required to operate these specialized beds has been on the rise for several years now, which over time, has created a generous gap between the funding given to the four CLIP facilities by MHD and the total cost of operating the facilities. According to an MHD briefing on February 27, 2004, the cost of providing care has risen due to the following factors:

- The increase in costs to recruit and retain qualified staff, including psychiatrists, nurses, master's level professionals, & therapists
- The rising costs of employee salaries and benefits
- Costs of liability insurance (e.g. increase from $104,994 to $249,622 over the last year at one of the CLIP facilities)
- Additional costs associated with CMS rules regarding use of seclusion and restraint
- New Department Of Health licensing requirement for 24 hour nursing
- Costs of maintaining JCAHO accreditation (including ORYX requirement)
- The price of capital improvements
- The expensive nature of one-to-one staffing costs for extremely hard to manage residents

After careful review and consideration of the CLIPs current status, their critical data (average length of stay, average bed rate, number served, resources provided, customer satisfaction, etc.) and projections for the future, PCG recommends to MHD that the funding allocated to the CLIPs be substantially increased.

This enhancement is imperative so that the CLIPs can perform consistently, at a rate that provides each and every child or youth admitted to the program with a comprehensive treatment agenda, imparts each customer with a high level of satisfaction upon completion of his or her treatment, affords the parent(s) and/or guardian(s) of the customer generous information on the description of each step of the long-term inpatient program and the status of their child's health and wellbeing while in the program, introduces an offshoot Therapeutic Foster Care program as an option for those children who are on the waitlist for admission to a facility, and reflects the Mental Health Division's understanding of the cost required to deliver this unique, all-inclusive system of care. The failure to increase the allocation of CLIP funds could result in the devastating closure of the program. Without this program, the State of Washington risks:

- Severely limiting the access that needy children have to intensive services;
- Creating an abundance of children that are: relegated to juvenile detention and JRA institutions, homeless, truant, in inappropriate educational settings, emergency room reoccurrences, unnecessarily hospitalized in costly acute psychiatric settings for extended periods of time, given out-of-home placements through the Department of Children's and Family Services, without appropriate services or supports;
- Reducing the full range of mental health services available for children;
- Losing federal matching funds; and
- A drop in the number of long-term inpatient Evaluation and Treatment beds set aside for youth.

The CLIPs have proven to be a vital component of the MHD system of care because of their focused patient population and combination of services; in turn, these programs have also proven themselves to be deserving of an increased expenditure allowance. The CLIPs simply do not operate at their most effective level when funding cuts are made.

B. INPATIENT COMMUNITY HOSPITALS

INTRODUCTION

The following section discusses inpatient community hospital beds for children in the State of Washington. Unlike the analysis of inpatient community hospitals serving adults, no comparisons can be drawn to the 2002 Report given that no children's study was conducted at that time. Therefore, this narrative reviews recent data around inpatient community hospitals serving children in the State of Washington. It is important to note that for this analysis PCG used FY 2003 inpatient community hospital data supplied by MHD. Data provided for FY 2004 was incomplete given the fiscal year reporting lag of claims and payments. The FY 2003 data was complete and was judged to be a better representation of community hospital usage.

KEY FINDINGS

Children have been losing access to inpatient community hospital beds. There has been a 12% decrease in the number of children's beds in the community hospital system. There has been a 14% reduction in the number of beds available for ITA use amongst the community hospital beds available to children. MHD data show that the need for community hospital level of care is in high demand amongst the children population. In order to ensure the need of the children's population is met year after year, more community hospital beds or community alternative will need to be developed.

Specific to the need for an alternative in the community, data indicate that there are significant discharge delays at the community hospital level. The FY 2003 delay data reviewed by PCG show that nearly 53% of the days spent in hospital settings were due to discharge delays. This suggests that there is a shortage of long-term beds in the community which, if in place, could help alleviate the delay in discharging children for hospital settings or divert some admissions to community hospitals altogether.

KEY STATISTICS

Total Beds

1. It is important to note that RSNs, in the majority of cases, do not have a specified number of beds available at a particular community hospital. RSNs use available beds as needed and wherever a bed is available at the community hospitals for their consumers. As was the case with the adult community hospital data, PCG has represented the number of available beds with the number of beds used by RSN for FY 2003. Data obtained from the Washington Behavioral Health Inpatient Association (WBHIA) discussed later in this narrative show that the actual number of community hospital beds available for RSNs, private pay, etc. has decreased by 12% since FY 2000.

2. Total beds used (average) in inpatient community hospitals over the course of FY 2003 was 152.96.

3. King RSN used the most inpatient community hospital beds (53.70) while Chelan-Douglas used the lowest number of beds. (1.28).

Support for the key findings and statistics for evaluation and treatment centers can be found in **APPENDIX H** of this report.

C. CHILDREN'S PEER STATE COMPARISON STUDY

KEY STATISTICS

A comparison of children's mental health data and statistics within a group of peer states was completed as part of this project in order to illustrate how MHD's children's mental health service system measures up to those in other states. Additionally, this assessment highlights the various directions in which other states of similar structures, geography, and populations to that of Washington have gone in and the programs that are currently being implemented with respect to children's mental health services. Through this evaluation of the structures and services offered to children by mental health departments in other states, clarity is obtained regarding which services or programs are in need of improvement in the State of Washington. In addition, the areas in which the state is performing well are underscored through the results of this study. As an outcome, implementations that Washington could add in the future to greatly benefit the children of the State and their families can be anticipated, and maintenance plans for the State's most effective programs and services for children can be developed, adding strength to the state's continuum of care.

MHD instructed PCG to use as the same peer group for the children's comparison study that was used for the adult peer state comparison study in the 2002 Report. These eight states met the following criteria:

- mid to large size (from 3 million to 11 million people);
- mid to large size child/adolescent population (730,000 to 2,900,000 under 18 years old);
- states with at least one large urban area and large areas with minimum populations; and
- strong county or sub-state administrative systems.

The states selected were Arizona, Colorado, Iowa, Michigan, Minnesota, Ohio, Oregon, and Wisconsin. In addition, MHD asked for Massachusetts to be included in the peer group. Massachusetts also met these criteria as illustrated in the table on the next page.

This study sought data for Fiscal Year 2003 for the child and adolescent population in state-operated inpatient and residential facilities, as well as publicly-operated residential programs. Data sources included:

- original research and data collection by PCG;

- NASMHPD Research Institute;
- SAMSHA; and
- U.S. Census (2000).

Table CPS-1. Peer State Selection Criteria

State	Total Population	Large Urban Area	Sub-State Administrative Agency for MH	Region	Medicaid Managed Care
Arizona	5,130,632	Phoenix / Tucson	County	West	Yes
Colorado	4,301,261	Denver	County	West	Yes
Iowa	2,926,324	Des Moines	County	Midwest	Yes
Massachusetts	6,349,097	Boston	State Regions	East	Yes
Michigan	9,938,444	Detroit	County	Midwest	Yes
Minnesota	4,919,479	St. Paul / Minneapolis	County	Midwest	No[1]
Ohio	11,353,140	Cincinnati / Cleveland / Columbus	County	Midwest	Yes
Oregon	3,421,399	Portland	County	West	Yes
Washington	**5,894,121**	**Seattle**	**County**	**West**	**Yes**
Wisconsin	5,363,675	Madison / Milwaukee	County	Midwest	No[2]

1. ***Minnesota****: Physical health is covered under managed care; behavioral health is not.*
2. ***Wisconsin****: Children's behavioral health services are covered under managed care; adults' services are not.*
3. *Population data provided by the 2000 Census, www.census.gov.*

The nine peer states were evaluated in terms of: age range required to receive children's mental health services, total yearly admissions, average length of stay, average daily census, types of services provided, reliance on contracts with private providers, any changes or new initiatives that are being or will be implemented, and availability of Therapeutic Foster Care programs. All states

were asked to submit data for Fiscal Year 2003 and to describe in depth any mental health service provided to children as well as the breadth of their state's therapeutic foster care program, if applicable.

Collection of the peer state information was accomplished through interviews with key children's mental health staff from the selected states. All interviews were conducted by telephone using a common script. This script included all the questions in hard copy form and were emailed and/or faxed to each respective peer state representative as requested. PCG followed-up with each respondent in all states to ensure consistency and completeness.

KEY FINDINGS

1. Washington's total State Mental Health Administration (SMHA) expenditure is above average, ranking 13th in the nation overall and 19th in per capita spending (see Table CPS-2).

2. The number of Washington residents under the age of eighteen—1,513,843—is close to that of the peer state average, 1,595,005. However, the amount of children and adolescents within that population who are enrolled in Medicaid—534,300—is much higher than the peer state average of 426,189 (see Table CPS-3).

3. It appears that Washington is admitting more children at an acute level to its community hospitals than its peer states. Our research shows that the State maintains an admissions rate of 865 children per year; comparatively, Wisconsin, which has the next highest admissions rate, sustains a rate of 674 children per year. Alternatively, Washington has the shortest Average Length of Stay in state hospitals of all the states analyzed, with a mean of 15 days per inpatient visit. The peer states acknowledged a significantly higher Average Length of Stay, with the range falling between 26 and 80 days for inpatient visits. It appears that the elevated costs associated with admitting a large number of children to the inpatient facilities of Washington State are balanced by the patients' short length of stay (see Table CPS-4).

4. The average amount per day that Washington spends on children's acute-level hospitalizations tends to be higher than the selected peer state grouping; however, hospital costs have historically proven to be lower in the East and Midwest states of the country, and the same trend is probably emerging here in youth acute hospitalization rates (see Table CPS-4).

5. Washington is ahead of many of the peer states in residential programming for long-term care. Many of the states rely on private providers to supply this intensive level of care to their state's youth mental health population—this remains true even in some of the states that have a state-operated, long-term residential program up and running. Washington's Children's Long-Term Inpatient Program (CLIP) is very comparable to those programs of care in Arizona, Colorado, Michigan, and Massachusetts in terms of services offered and cost per diem (see Tables CPS-4 and CPS-5).

6. Therapeutic Foster Care is a flourishing alternative model of service in the nation. Four of the eight states included in our study have established successful Therapeutic Foster Care programs within their mental health departments. Moreover, of the states that are currently not offering any type of Therapeutic Foster Care program, one state (Michigan) is developing a model for implementation, two states (Wisconsin and Ohio) offer the service through county-level or private providers, and one state (Colorado) recognizes the growing need for the program's development and inclusion within its continuum of care. Washington currently provides this service through private providers, but only when requested by a customer who shows apparent need.

Support for the key findings and statistics for evaluation and treatment centers can be found in **APPENDIX I** of this report.

D. MEDICAL RECORD REVIEW OF CLIP FACILITIES

INTRODUCTION

A random selection of fifteen (15) medical records from two CLIP facilities was chosen for review. The facilities reviewed were the Child Study Treatment Center (10 discharged records) and Pearl Street Center (5 active records). The review focused on the clinical indicators and precipitating events that led to admission to the CLIP facility, the course of clinical treatment while at the CLIP facility, and the discharge process including involvement of the family and community providers and identification of barriers to discharge. Additionally, a portion of the review included the evaluation of the role of the state run facility in the continuum of care and possible alternatives other than residential that might best meet the needs of the population reviewed. No interviews were conducted with current or discharged clients.

The review format included utilization of an audit tool originally developed by Public Consulting Group based on the MHD DART Tool and in collaboration with the State of Washington Mental Health Division. The tool was adapted to gather data applicable to the child/adolescent population. The tool emphasized the collection of information targeting adolescent behaviors that are difficult to manage or present safety risks in a community or home setting. These behaviors typically are precursors to hospitalization and often are determinants for long term placement.

The medical records were found to be comprehensive and informative. The records included data specific to the data elements listed in the audit tool. Although the sample was small (15 records), the medical record data identified trends that were significant. Attached to this report is the full data set.

KEY FINDINGS

1. The records reviewed of the children/adolescents in the CLIP facilities indicated that they met the criteria for admission. Admission decisions were prioritized by level of risk to self and others if in the community and the ability of the system to manage the behaviors.

2. Extensive use of wraparound or alternative services such as in home family intervention, short term respite care and temporary foster care placement had been utilized or considered prior to admission to CLIP. There was some variation across RSN as to the availability of community based services and extent to which the community providers were able to manage crisis situations.

3. There is a lack of community-based residential alternatives that lead to longer lengths of stay in CLIP. The goal for each child or adolescent is to return to their home community. A considerable number of treatment interventions were documented that demonstrated this emphasis by the CLIP facility. It appeared that patients remained in the CLIP facility beyond the time medically necessary for stabilization of their psychiatric condition due to the lack of step down alternatives in the community that would provide for a more timely transition.

4. There is a lack of specialized residential, community based services for high risk populations. Children and adolescents with developmental disabilities and /or complex medical problems consistently required longer lengths of stay in the CLIP facility. Although the goal was clearly for family and community reintegration the limited availability of community based step down services prolonged the stay in CLIP.

5. There appears to be a lengthy wait time from referral to CLIP by the Community Hospital to admission. These CLIP admission / Community Hospital discharge delays impact the access to acute care beds on the front end of the system for crisis situations.

6. Therapeutic Foster Care had been under utilized as a treatment modality in several cases. The opportunity to move patients to a community setting from the CLIP program earlier by ensuring the availability of therapeutic foster care placements across all regions will potentially improve access to CLIP beds and divert admissions from community hospitals.

7. There is a well defined role in the continuum of care for the CLIP facilities. The process for entry into a CLIP is standardized and comprehensive. Each case referred is considered carefully and evaluated according to the criteria established before acceptance into a CLIP facility. There was variation among the RSNs as to at what point in the treatment process admission to CLIP was considered. This decision was impacted by access to other resources in the community that might prevent admission.

8. The need for additional CLIP facility beds was not indicated by the record review. The need to increase capacity appeared best addressed by a focus on the reduction in the length of stay with an increase in community based residential options to facilitate earlier discharge. This will increase the availability of CLIP beds.

Supporting facility summaries and data tables for the medical record review of the CLIP facilities can be found in **APPENDIX J** of this report.

VI. Glossary of Terms

Average Daily Census: The mean number of patients that occupy a facility in a day; this number is obtained by dividing total bed days by length of time being measured.

Average Length of Stay: The mean amount of time that a patient spends receiving services in a facility; this number can be obtained by dividing the number of admissions in a certain period of time by the number of days in that period of time.

Civil: The categorization of an individual who goes though a process in which a judge decides whether the person, who is alleged to be mentally ill, should be required to go to a state or community psychiatric hospital or accept other mental health treatment.

CLIP: Children's Long-Term Inpatient Program; a network of four inpatient psychiatric facilities in Washington State that provide services to behaviorally and emotionally disturbed children and youth.

Crisis Respite: A program that provides 24-hour, immediate and temporary psychiatric care.

Crisis Stabilization: A program that provides brief psychiatric intervention for individuals with acute psychiatric conditions. Short inpatient stays result in the return of the patient to his/her own home or placement in a long-term mental health facility or other living arrangement.

Crisis Triage: A program that emphasizes short-term care (maximum length of stay is less than 24 hours); problems are prioritized and facilitating placement of the patient is the focus.

E&T: Evaluation and Treatment Center; a system of facilities in Washington State that provide acute psychiatric care for involuntarily-detained patients as a hospital alternative.

Forensic: The categorization of an individual who has been involuntary admitted to a hospital because he/she has committed a crime due to the state of his or her psychiatric health.

Inpatient: A level of care that requires patients to obtain treatment through admission to a state or community hospital.

Intensive: A program of care that includes room and board with minimum supervision, plus therapeutic services performed by residential staff.

ITA (Involuntary Treatment Act): Under the ITA, a person is committable who is dangerous to self or others or is gravely disabled a result of a mental condition can be required to accept mental health treatment. 'Dangerous' means to cause or seriously threaten physical harm, or damage to the property of others. 'Gravely disabled' means completely unable to acquire shelter or food or other absolute necessities; or imminently endangered by impaired judgment and lack of self control, like walking in traffic or causing cooking fires.

Length of Stay: The total amount of time that a patients spend receiving services in a facility; this number can be obtained by dividing the number of admissions in a certain period of time by the number of days in that period of time.

Medicaid: A joint federal and state program that helps with medical costs for some people with low incomes and limited resources. Medicaid programs vary from state to state, but most health care costs are covered if you qualify for both Medicare and Medicaid. The State of Washington's Medicaid program provides assistance for individuals meeting the federal Medicaid eligibility criteria with the exception of one particular service.

MHD: The Mental Health Division, which falls under the jurisdiction of the Department of Health and Social Services, in the State of Washington.

Non-Intensive: A program of care that includes room and board with minimal supervision performed by residential staff, without therapeutic services offered.

Non-Medicaid: State-only payments made to providers for non-Medicaid consumers served (i.e. General Assistance Unemployable (GAU))

Non-Residential: Psychiatric treatment services that are offered on an outpatient basis.

PALS: Program for Adaptive Living Skills, a residential program located on the campus of Western State Hospital, servicing approximately 100 serious and persistent mentally ill clients. This program includes: a 24-hour staff supervised residential setting, 24-hour availability of onsite nursing coverage, daily access to psychiatry and medical follow-up, daily programming both on and off the unit, and the capacity to intervene quickly if a resident exhibits a change in clinical status that warrants a higher level of care.

Private Provider: Any organization, facility, or individual that provides care to the psychiatric community and does not receive state or federal funding to maintain services.

Residential: A controlled 24-hour environment with intense treatment programs and medical management for psychiatric patients.

RSN: Regional Support Network; fourteen (14) regions within the State of Washington that contract with MHD to administer all public mental health services within their region. Every county in Washington State is part of an RSN and each RSN is headed by a resource manager or other designee.

Step Down Beds: Beds that are utilized by patients when they improve from the more serious crisis beds, but still need specialized medical attention.

Supervised Living: On-site staff is available in the facility 24 hours per day, 7 days per week.

Supported Living: On-site staff is available in the facility for less than 24 hours per day, 7 days per week.

Therapeutic Foster Care: A program that recruits, trains, and closely supervises foster families to accommodate juveniles with a record of emotional or behavioral disturbances. The foster families receive therapy and support, while the children are taught skills for family and school settings, receive psychiatric care, and attend regular therapy sessions. The program is unique because the children remain in a community setting and throughout treatment, the youth's biological family (or adoptive family or other aftercare resource) participates in the treatment.

Voluntary: A patient is admitted to a psychiatric facility by his or her own choice rather than because of external pressure or force.

APPENDIX A

PROVIDER SYSTEM OVERVIEW

Additional Summary Tables

NUMBER OF UNUSED BEDS

As of June 30 2004, there were 121.6 unused beds across the system (84.9 residential beds, 23.3 crisis respite beds, 12.2 state hospital beds, and 1.2 evaluation & treatment center beds). The 121.6 unused beds in 2004 are 74.6 more than the 47 unused beds in June 30 2002, representing a 158.8% increase.

S-8 Summary of Number of Unused Beds by RSN (FY 2004) - Adults
2002 Service Type Categories

RSNs	Residential	Crisis Respite	Community Inpatient		State Inpatient	All Services
			Evaluation & Treatment Centers	Community Hospitals (FY 2003)	State Hospitals (Civil and PALS)	
Chelan-Douglas	-	2.00	-	-	(3.62)	(1.62)
Clark	10.10	-	-	-	5.22	15.32
Grays Harbor	-	-	-	-	3.44	3.44
Greater Columbia	3.00	12.90	-	-	22.37	38.27
King	28.00	5.00	-	-	(9.99)	23.01
North Central	5.00	-	-	-	1.71	6.71
North Sound	-	-	-	-	7.13	7.13
Northeast	-	-	-	-	0.73	0.73
Peninsula	2.00	1.60	1.17	-	6.88	11.65
Pierce	27.00	-	-	-	(4.19)	22.81
Southwest	-	-	-	-	(1.26)	(1.26)
Spokane	-	-	-	-	(21.82)	(21.82)
Thurston-Mason	8.00	-	-	-	0.22	8.22
Timberlands	1.80	1.80	-	-	5.43	9.03
TOTAL 2004	**84.90**	**23.30**	**1.17**	**-**	**12.25**	121.62
Percent of Total	**70%**	**19%**	**1%**	**0%**	**10%**	**100%**
2002 Study	**43**	**2**	**15**	**-6**	**-7**	**47**
Percent of Total	**91%**	**4%**	**32%**	**-13%**	**-15%**	**100%**
VARIANCE	*41.90*	*21.30*	*(13.83)*	*6.00*	*19.25*	*74.62*
% Change	***97.4%***	***1065.0%***	***-92.2%***	***-100.0%***	***-275.0%***	***158.8%***

NUMBER OF BEDS USED PER 100,000 ADULT GENERAL POPULATION (2002)

This table contains 2002 Study bed utilization per 100,000 adult general population. This is provided for reference and for comparative purposes to the 2004 results (Table S-5).

Table S-9. Number of Beds Used Per 100,000 Adult General Population (2002 Study)
2002 Service Type Categories

RSNs	Adult Population (18 and Over)	Residential Utilization		Crisis Respite Utilization		Inpatient Community Hospital Utilization		State Hospital Utilization		Total	
		Residential Beds	Per 100,000	Crisis Respite Beds	Per 100,000	ADC	Per 100,000	State Hospital Beds	Per 100,000	All Beds	Per 100,000
Chelan-Douglas	68,465	20.00	29.20	4.00	5.80	1.00	1.50	7.00	10.20	32.00	46.70
Clark	236,872	46.00	19.40	5.00	2.10	9.00	3.80	45.00	19.00	105.00	44.30
Grays Harbor	49,184	-	-	10.00	20.30	1.00	2.00	24.00	48.80	35.00	71.20
Greater Columbia	413,469	105.00	25.40	19.00	4.60	15.00	3.60	45.00	10.90	184.00	44.50
King	1,291,138	579.00	44.80	22.00	1.70	108.00	8.40	257.00	19.90	966.00	74.80
North Central	83,579	38.00	45.50	-	-	3.00	3.60	18.00	21.50	59.00	70.60
North Sound	678,119	214.00	31.60	39.00	5.80	44.00	6.50	98.00	14.50	395.00	58.20
Northeast	44,082	8.00	18.10	4.00	9.10	1.00	2.30	2.00	4.50	15.00	34.00
Peninsula	243,014	25.00	10.30	-	-	19.00	7.80	46.00	18.90	90.00	37.00
Pierce	516,962	398.00	77.00	6.00	1.20	47.00	9.10	223.00	43.10	674.00	130.40
Southwest	69,037	-	-	-	-	7.00	10.10	17.00	24.60	24.00	34.80
Spokane	308,515	235.00	76.20	8.00	2.60	24.00	7.80	141.00	45.70	408.00	132.20
Thurston-Mason	188,574	8.00	4.20	-	-	7.00	3.70	41.00	21.70	56.00	29.70
Timberlands	66,484	5.00	7.50	3.00	4.50	2.00	3.00	24.00	36.10	34.00	51.10
TOTAL	**4,257,494**	**1,681.00**	**39.50**	**120.00**	**2.80**	**288.00**	**6.80**	**988.00**	**23.20**	**3,077.00**	**72.30**

CHANGE IN NUMBER OF BEDS USED PER 100,000 ADULT GENERAL POPULATION (2002 VS. 2004)

This table depicts the difference in bed utilization per 100,000 adult general population 2004 data (Table S-5) and 2002 data (Table S-9). The per 100,000 utilization change indicated an increase in crisis respite beds (0.6) while decreases were seen in state hospital beds (4.8), residential beds (4.5), and inpatient community hospital beds (0.4).

Table S-10. Change in Number of Beds Used Per 100,000 Adult General Population (2002 to 2004 Study)
2002 Service Type Categories

RSNs	Adult Population (18 and Over)	Residential Utilization		Crisis Respite Utilization		Inpatient Community Hospital Utilization		State Hospital Utilization		Total	
		Residential Beds	Per 100,000	Crisis Respite Beds	Per 100,000	ADC	ADC per 100,000	State Hospital Beds	Per 100,000	All Beds	Per 100,000
Chelan-Douglas	68,465	-	(2.80)	(1.00)	(1.80)	0.98	1.10	7.62	9.10	7.60	5.60
Clark	236,872	14.90	2.30	(5.00)	(2.10)	(1.20)	(1.00)	(9.22)	(6.30)	(0.52)	(7.10)
Grays Harbor	49,184	-	-	-	(0.80)	0.45	0.80	(10.44)	(22.30)	(9.99)	(22.30)
Greater Columbia	413,469	50.00	8.00	23.10	4.50	(1.79)	(0.80)	2.63	(0.60)	73.94	11.10
King	1,291,138	(24.00)	(2.90)	(7.00)	(0.60)	(10.01)	(1.00)	(29.01)	(2.70)	(70.02)	(7.20)
North Central	83,579	(8.00)	(15.40)	-	-	1.12	0.50	(1.71)	(5.10)	(8.60)	(20.00)
North Sound	678,119	(105.00)	(17.10)	8.00	0.40	19.86	2.00	(12.13)	(3.10)	(89.27)	(17.80)
Northeast	44,082	(6.00)	(14.30)	-	(1.40)	1.28	2.10	7.27	13.30	2.54	(0.30)
Peninsula	243,014	7.00	2.70	2.40	1.00	(2.23)	(1.00)	(10.88)	(4.60)	(3.72)	(1.90)
Pierce	516,962	(76.00)	(18.30)	12.00	2.10	(15.12)	(3.30)	(43.81)	(10.50)	(122.92)	(30.00)
Southwest	69,037	47.00	66.50	-	-	(0.70)	(1.20)	(0.74)	(1.60)	45.56	63.70
Spokane	308,515	8.00	(0.20)	-	(0.10)	9.73	2.80	(31.18)	(11.40)	(13.45)	(8.90)
Thurston-Mason	188,574	7.00	3.40	6.00	3.00	1.79	0.70	(7.22)	(4.70)	7.57	2.40
Timberlands	66,484	(0.80)	(1.60)	(1.80)	(2.80)	(0.17)	(0.40)	(10.43)	(16.90)	(13.20)	(21.70)
TOTAL	**4,257,494**	**(85.90)**	**(4.50)**	**36.70**	**0.60**	**3.99**	**(0.40)**	**(149.25)**	**(4.80)**	**(194.46)**	**(9.10)**

PERCENT CHANGE IN NUMBER OF BEDS USED PER 100,000 ADULT GENERAL POPULATION (2002 VS. 2004)

This table depicts the percentage difference in bed utilization per 100,000 adult general population 2004 data (Table S-5) and 2002 data (Table S-9). The per 100,000 utilization change indicated an in crisis respite beds (21.4%) while decreases are indicated for state hospital beds (20.7%), residential beds (11.4%), and inpatient community hospital beds (5.9%). The "total" column indicates changes of all beds within each RSN (Southwest experiences the greatest increase at 182.8%).

Table S-11. Number of Beds Used Per 100,000 Adult General Population (Percent Change between 2002 and 2004 Studies)
2002 Service Type Categories

RSNs	Adult Population (18 and Over)	Residential Utilization		Crisis Respite Utilization		Inpatient Community Hospital Utilization		State Hospital Utilization		Total	
		Residential Beds	Per 100,000	Crisis Respite Beds	Per 100,000	ADC	ADC per 100,000	State Hospital Beds	Per 100,000	All Beds	Per 100,000
Chelan-Douglas	75,823	0.0%	-9.6%	-25.0%	-31.0%	98.4%	73.3%	108.8%	89.2%	23.8%	11.8%
Clark	280,705	32.4%	11.9%	-100.0%	-100.0%	-13.3%	-26.3%	-20.5%	-33.2%	-0.5%	-16.0%
Grays Harbor	51,267	0.0%	0.0%	0.0%	-3.9%	45.2%	40.0%	-43.5%	-45.7%	-28.5%	-31.5%
Greater Columbia	464,338	47.6%	31.5%	121.6%	97.8%	-11.9%	-22.2%	5.8%	-5.5%	40.2%	24.9%
King	1,325,363	-4.1%	-6.5%	-31.8%	-35.3%	-9.3%	-11.9%	-11.3%	-13.6%	-7.2%	-9.6%
North Central	99,525	-21.1%	-33.8%	0.0%	0.0%	37.2%	13.9%	-9.5%	-23.7%	-14.6%	-28.3%
North Sound	753,513	-49.1%	-54.1%	20.5%	6.9%	45.1%	30.8%	-12.4%	-21.4%	-22.6%	-30.2%
Northeast	51,973	-75.0%	-79.0%	0.0%	-15.4%	127.9%	91.3%	363.3%	295.6%	17.0%	-0.6%
Peninsula	245,710	28.0%	26.2%	0.0%	0.0%	-11.8%	-12.8%	-23.7%	-24.3%	-4.1%	-5.1%
Pierce	548,966	-19.1%	-23.8%	200.0%	175.0%	-32.2%	-36.3%	-19.6%	-24.4%	-18.2%	-23.0%
Southwest	70,659	0.0%	0.0%	0.0%	0.0%	-10.1%	-11.9%	-4.3%	-6.5%	189.8%	182.8%
Spokane	319,713	3.4%	-0.3%	0.0%	-3.8%	40.5%	35.9%	-22.1%	-24.9%	-3.3%	-6.7%
Thurston-Mason	198,492	87.5%	81.0%	0.0%	0.0%	25.6%	18.9%	-17.6%	-21.7%	13.5%	7.7%
Timberlands	70,808	-16.0%	-21.3%	-60.0%	-62.2%	-8.5%	-13.3%	-43.5%	-46.8%	-38.8%	-42.5%
TOTAL	**4,556,856**	**-5.1%**	**-11.4%**	**30.6%**	**21.4%**	**1.4%**	**-5.9%**	**-15.1%**	**-20.7%**	**-6.3%**	**-12.4%**

NUMBER OF BEDS USED PER 100,000 ADULT GENERAL POPULATION (NON-HOSPITAL VS. HOSPITAL)

The average FY 2004 non-hospital setting (community residential and crisis respite) utilization across all fourteen RSNs is 60.8% of total utilization. The average FY 2004 hospital setting (state and community hospitals and E&Ts) utilization across all fourteen RSNs is 39.2%. Greater Columbia RSN experienced the highest non-hospital utilization (76.4%), while Timberlands experienced the lowest non-hospital utilization (25.9%).

Table S-12. Number of Beds Used Per 100,000 Adult General Population (Non-Hospital versus Hospital Settings) (FY 2004)
2002 Service Type Categories

RSNs	Adult Population (18 and Over)	Adult Population Per Sq. Mile	Residential & Crisis Respite Utilization			Hospital and E&T Utilization			Total		
			Residential Beds	Per 100,000	Percent of Total Per 100,000	Hospital Beds	Per 100,000	Percent of Total Per 100,000	All Beds	Per 100,000	Percent of Total Per 100,000
Chelan-Douglas	75,823	16.00	23.00	30.40	58.1%	16.60	21.90	41.9%	39.60	52.30	100.0%
Clark	280,705	447.00	60.90	21.70	58.3%	43.58	15.50	41.7%	104.48	37.20	100.0%
Grays Harbor	51,267	26.70	10.00	19.50	40.0%	15.01	29.30	60.0%	25.01	48.80	100.0%
Greater Columbia	464,338	24.80	197.10	42.50	76.4%	60.84	13.10	23.6%	257.94	55.60	100.0%
King	1,325,363	623.40	570.00	43.00	63.6%	325.98	24.60	36.4%	895.98	67.60	100.0%
North Central	99,525	10.10	30.00	30.10	59.5%	20.40	20.50	40.5%	50.40	50.60	100.0%
North Sound	753,513	119.10	156.00	20.70	51.0%	149.73	19.90	49.0%	305.73	40.60	100.0%
Northeast	51,973	6.20	6.00	11.50	34.1%	11.54	22.20	65.9%	17.54	33.70	100.0%
Peninsula	245,710	62.20	34.40	14.00	39.9%	51.88	21.10	60.1%	86.28	35.10	100.0%
Pierce	548,966	327.00	340.00	62.00	61.8%	211.08	38.40	38.2%	551.08	100.40	100.0%
Southwest	70,659	62.00	47.00	66.50	67.6%	22.56	31.90	32.4%	69.56	98.40	100.0%
Spokane	319,713	181.20	251.00	78.50	63.6%	143.55	44.90	36.4%	394.55	123.40	100.0%
Thurston-Mason	198,492	117.60	21.00	10.60	33.1%	42.57	21.40	66.9%	63.57	32.00	100.0%
Timberlands	70,808	19.60	5.40	7.60	25.9%	15.40	21.80	74.1%	20.80	29.40	100.0%
TOTAL	**4,556,856**	**68.50**	**1,751.80**	**38.44**	**60.8%**	**1,130.74**	**24.81**	**39.2%**	**2,882.54**	**63.26**	**100.0%**

NUMBER OF BEDS USED PER 100,000 ADULT GENERAL POPULATION (NON-HOSPITAL VS. HOSPITAL)

This table sorts the information shown in table S-12 based on Residential and Crisis Respite utilization percentage. In FY 2004, there were five RSNs (Greater Columbia, Southwest, King, Spokane, and Pierce) that experienced higher than average residential and crisis respite (non-hospital) utilization. The other nine RSNs experienced lower than average non-hospital utilization.

Table S-13. Number of Beds Used Per 100,000 Adult General Population (Non-Hospital Versus Hospital Settings Sorted By Lowest Hospital Utilization) (FY 2004)
2002 Service Type Categories

RSNs	Adult Population (18 and Over)	Adult Population Per Sq. Mile	Residential & Crisis Respite Utilization			Hospital and E&T Utilization			Total		
			Residential Beds	Per 100,000	Percent of Total Per 100,000	Hospital Beds	Per 100,000	Percent of Total Per 100,000	All Beds	Per 100,000	Percent of Total Per 100,000
Greater Columbia	464,338	24.80	197.10	42.50	76.4%	60.84	13.10	23.6%	257.94	55.60	100.0%
Southwest	70,659	62.00	47.00	66.50	67.6%	22.56	31.90	32.4%	69.56	98.40	100.0%
King	1,325,363	623.40	570.00	43.00	63.6%	325.98	24.60	36.4%	895.98	67.60	100.0%
Spokane	319,713	181.20	251.00	78.50	63.6%	143.55	44.90	36.4%	394.55	123.40	100.0%
Pierce	548,966	327.00	340.00	62.00	61.8%	211.08	38.40	38.2%	551.08	100.40	100.0%
North Central	99,525	10.10	30.00	30.10	59.5%	20.40	20.50	40.5%	50.40	50.60	100.0%
Clark	280,705	447.00	60.90	21.70	58.3%	43.58	15.50	41.7%	104.48	37.20	100.0%
Chelan-Douglas	75,823	16.00	23.00	30.40	58.1%	16.60	21.90	41.9%	39.60	52.30	100.0%
North Sound	753,513	119.10	156.00	20.70	51.0%	149.73	19.90	49.0%	305.73	40.60	100.0%
Grays Harbor	51,267	26.70	10.00	19.50	40.0%	15.01	29.30	60.0%	25.01	48.80	100.0%
Peninsula	245,710	62.20	34.40	14.00	39.9%	51.88	21.10	60.1%	86.28	35.10	100.0%
Northeast	51,973	6.20	6.00	11.50	34.1%	11.54	22.20	65.9%	17.54	33.70	100.0%
Thurston-Mason	198,492	117.60	21.00	10.60	33.1%	42.57	21.40	66.9%	63.57	32.00	100.0%
Timberlands	70,808	19.60	5.40	7.60	25.9%	15.40	21.80	74.1%	20.80	29.40	100.0%
TOTAL	**4,556,856**	**68.50**	**1,751.80**	**38.44**	**60.8%**	**1,130.74**	**24.81**	**39.2%**	**2,882.54**	**63.26**	**100.0%**

NUMBER OF BEDS USED PER 100,000 ADULT GENERAL POPULATION (NON-HOSPITAL VS. HOSPITAL)

This table sorts the information shown in table S-13 based on population density (adult population per square mile). There does not appear to be any correlation between population density and utilization by hospital and non-hospital settings. Grays Harbor, Greater Columbia and Timberlands RSNs have very similar population density. However, their non-hospital versus hospital utilization varies widely. Greater Columbia utilizes services performed in non-hospital setting 76.4% of the time, while Grays Harbor utilizes the non-hospital setting 40.0% of the time and Timberlands 25.9% of the time.

Table S-14. Number of Beds Used Per 100,000 Adult General Population (Non-Hospital / Hospital Settings Sorted By Adults Per Square Mile) (FY 2004)
2002 Service Type Categories

RSNs	Adult Population (18 and Over)	Adult Population Per Sq. Mile	Residential & Crisis Respite Utilization			Hospital and E&T Utilization			Total		
			Residential Beds	Per 100,000	Percent of Total Per 100,000	Hospital Beds	Per 100,000	Percent of Total Per 100,000	All Beds	Per 100,000	Percent of Total Per 100,000
King	1,325,363	623.40	570.00	43.00	63.6%	325.98	24.60	36.4%	895.98	67.60	100.0%
Clark	280,705	447.00	60.90	21.70	58.3%	43.58	15.50	41.7%	104.48	37.20	100.0%
Pierce	548,966	327.00	340.00	62.00	61.8%	211.08	38.40	38.2%	551.08	100.40	100.0%
Spokane	319,713	181.20	251.00	78.50	63.6%	143.55	44.90	36.4%	394.55	123.40	100.0%
North Sound	753,513	119.10	156.00	20.70	51.0%	149.73	19.90	49.0%	305.73	40.60	100.0%
Thurston-Mason	198,492	117.60	21.00	10.60	33.1%	42.57	21.40	66.9%	63.57	32.00	100.0%
Peninsula	245,710	62.20	34.40	14.00	39.9%	51.88	21.10	60.1%	86.28	35.10	100.0%
Southwest	70,659	62.00	47.00	66.50	67.6%	22.56	31.90	32.4%	69.56	98.40	100.0%
Grays Harbor	51,267	26.70	10.00	19.50	40.0%	15.01	29.30	60.0%	25.01	48.80	100.0%
Greater Columbia	464,338	24.80	197.10	42.50	76.4%	60.84	13.10	23.6%	257.94	55.60	100.0%
Timberlands	70,808	19.60	5.40	7.60	25.9%	15.40	21.80	74.1%	20.80	29.40	100.0%
Chelan-Douglas	75,823	16.00	23.00	30.40	58.1%	16.60	21.90	41.9%	39.60	52.30	100.0%
North Central	99,525	10.10	30.00	30.10	59.5%	20.40	20.50	40.5%	50.40	50.60	100.0%
Northeast	51,973	6.20	6.00	11.50	34.1%	11.54	22.20	65.9%	17.54	33.70	100.0%
TOTAL	**4,556,856**	**68.50**	**1,751.80**	**38.44**	**60.8%**	**1,130.74**	**24.81**	**39.2%**	**2,882.54**	**63.26**	**100.0%**

NUMBER OF USED BEDS PER 100,000 ADULT MEDICAID ELIGIBLES

Tables S-15 – S-21 contain an analysis based on Medicaid eligibles, similar to the adult general population-based analysis in tables S-5, S-9, S-10, S-12, S-13, and S-14. This analysis depicts the same trends as the adult general population-based analysis with minor variances. The tables are provided for future reference.

Table S-15. Number of Beds Used Per 100,000 Adult Medicaid Eligibles by RSN (2004 Study)
2002 Service Type Categories

RSNs	FY2004 Adult Medicaid Eligibles	Residential Utilization		Crisis Respite Utilization		Inpatient Community Hospital Utilization		State Hospital Utilization		Total	
		Residential Beds	Per 100,000	Crisis Respite Beds	Per 100,000	ADC	ADC per 100,000	State Hospital Beds	Per 100,000	All Beds	Per 100,000
Chelan-Douglas	8,149	20.00	245.43	3.00	36.81	1.98	24.34	14.62	179.38	39.60	485.96
Clark	27,170	60.90	224.14	-	-	7.80	28.71	35.78	131.70	104.48	384.56
Grays Harbor	7,947	-	-	10.00	125.83	1.45	18.27	13.56	170.67	25.01	314.77
Greater Columbia	57,616	155.00	269.02	42.10	73.07	13.21	22.93	47.63	82.67	257.94	447.69
King	105,971	555.00	523.73	15.00	14.15	97.99	92.47	227.99	215.14	895.98	845.49
North Central	14,781	30.00	202.96	-	-	4.12	27.84	16.29	110.19	50.40	340.99
North Sound	63,797	109.00	170.85	47.00	73.67	63.86	100.09	85.87	134.60	305.73	479.22
Northeast	8,078	2.00	24.76	4.00	49.52	2.28	28.22	9.27	114.69	17.54	217.19
Peninsula	22,162	32.00	144.39	2.40	10.83	16.77	75.66	35.12	158.46	86.28	389.34
Pierce	54,576	322.00	590.00	18.00	32.98	31.88	58.42	179.19	328.34	551.08	1,009.75
Southwest	10,307	47.00	456.00	-	-	6.30	61.08	16.26	157.78	69.56	674.86
Spokane	41,173	243.00	590.19	8.00	19.43	33.73	81.93	109.82	266.73	394.55	958.28
Thurston-Mason	18,958	15.00	79.12	6.00	31.65	8.79	46.36	33.78	178.21	63.57	335.34
Timberlands	9,742	4.20	43.11	1.20	12.32	1.83	18.79	13.57	139.28	20.80	213.49
TOTAL	**450,427**	**1,595.10**	**354.13**	**156.70**	**34.79**	**291.99**	**64.83**	**838.75**	**186.21**	**2,882.54**	**639.96**
2002 Study	426,305	1,681.00	376.02	120.00	28.10	288.00	67.60	988.00	231.80	3,077.00	703.52
VARIANCE	*24,122*	*(85.90)*	*(21.89)*	*36.70*	*6.69*	*3.99*	*(2.77)*	*(149.25)*	*(45.59)*	*(194.46)*	*(63.56)*
% Change	***5.7%***	***-5.1%***	***-5.8%***	***30.6%***	***23.8%***	***1.4%***	***-4.1%***	***-15.1%***	***-19.7%***	***-6.3%***	***-9.0%***

NUMBER OF USED BEDS PER 100,000 ADULT MEDICAID ELIGIBLES

Table S-16. Number of Beds Used Per 100,000 Adult Medicaid Eligibles by RSN (2002 Study)
2002 Service Type Categories

RSNs	FY2001 Adult Medicaid Eligibles	Residential Utilization		Crisis Respite Utilization		Inpatient Community Hospital Utilization		State Hospital Utilization		Total	
		Residential Beds	Per 100,000	Crisis Respite Beds	Per 100,000	ADC	ADC per 100,000	State Hospital Beds	Per 100,000	All Beds	Per 100,000
Chelan-Douglas	7,219	20.00	277.05	4.00	55.41	1.00	13.85	7.00	96.97	32.00	443.27
Clark	24,843	46.00	185.16	5.00	20.13	9.00	36.23	45.00	181.14	105.00	422.65
Grays Harbor	8,158	-	-	10.00	122.58	1.00	12.26	24.00	294.19	35.00	429.03
Greater Columbia	55,481	105.00	189.25	19.00	34.25	15.00	27.04	45.00	81.11	184.00	331.65
King	100,052	579.00	578.70	22.00	21.99	108.00	107.94	257.00	256.87	966.00	965.50
North Central	13,991	38.00	271.60	-	-	3.00	21.44	18.00	128.65	59.00	421.70
North Sound	56,681	214.00	377.55	39.00	68.81	44.00	77.63	98.00	172.90	395.00	696.88
Northeast	7,848	8.00	101.94	4.00	50.97	1.00	12.74	2.00	25.48	15.00	191.13
Peninsula	21,933	25.00	113.98	-	-	19.00	86.63	46.00	209.73	90.00	410.34
Pierce	54,378	398.00	731.91	6.00	11.03	47.00	86.43	223.00	410.09	674.00	1,239.47
Southwest	9,496	-	-	-	-	7.00	73.72	17.00	179.02	24.00	252.74
Spokane	38,458	235.00	611.06	8.00	20.80	24.00	62.41	141.00	366.63	408.00	1,060.90
Thurston-Mason	18,223	8.00	43.90	-	-	7.00	38.41	41.00	224.99	56.00	307.30
Timberlands	9,544	5.00	52.39	3.00	31.43	2.00	20.96	24.00	251.47	34.00	356.24
TOTAL	**426,305**	**1,681.00**	**394.32**	**120.00**	**28.15**	**288.00**	**67.56**	**988.00**	**231.76**	**3,077.00**	**721.78**

NUMBER OF USED BEDS PER 100,000 ADULT MEDICAID ELIGIBLES

Table S-17. Change in Number of Beds Used Per 100,000 Adult Medicaid Eligibles by RSN (2002 to 2004 Study)
2002 Service Type Categories

RSNs	FY2004 Adult Medicaid Eligibles	Residential Utilization		Crisis Respite Utilization		Inpatient Community Hospital Utilization		State Hospital Utilization		Total	
		Residential Beds	Per 100,000	Crisis Respite Beds	Per 100,000	ADC	ADC per 100,000	State Hospital Beds	Per 100,000	All Beds	Per 100,000
Chelan-Douglas	8,149	-	(31.62)	(1.00)	(18.60)	0.98	10.49	7.62	82.41	7.60	42.69
Clark	27,170	14.90	38.98	(5.00)	(20.13)	(1.20)	(7.52)	(9.22)	(49.43)	(0.52)	(38.10)
Grays Harbor	7,947	-	-	-	3.25	0.45	6.01	(10.44)	(123.52)	(9.99)	(114.26)
Greater Columbia	57,616	50.00	79.77	23.10	38.82	(1.79)	(4.10)	2.63	1.56	73.94	116.05
King	105,971	(24.00)	(54.97)	(7.00)	(7.83)	(10.01)	(15.48)	(29.01)	(41.72)	(70.02)	(120.00)
North Central	14,781	(8.00)	(68.64)	-	-	1.12	6.40	(1.71)	(18.47)	(8.60)	(80.71)
North Sound	63,797	(105.00)	(206.70)	8.00	4.87	19.86	22.47	(12.13)	(38.30)	(89.27)	(217.66)
Northeast	8,078	(6.00)	(77.18)	-	(1.45)	1.28	15.48	7.27	89.21	2.54	26.06
Peninsula	22,162	7.00	30.41	2.40	10.83	(2.23)	(10.97)	(10.88)	(51.27)	(3.72)	(21.01)
Pierce	54,576	(76.00)	(141.91)	12.00	21.95	(15.12)	(28.01)	(43.81)	(81.75)	(122.92)	(229.73)
Southwest	10,307	47.00	456.00	-	-	(0.70)	(12.63)	(0.74)	(21.24)	45.56	422.13
Spokane	41,173	8.00	(20.86)	-	(1.37)	9.73	19.52	(31.18)	(99.91)	(13.45)	(102.62)
Thurston-Mason	18,958	7.00	35.22	6.00	31.65	1.79	7.95	(7.22)	(46.79)	7.57	28.03
Timberlands	9,742	(0.80)	(9.28)	(1.80)	(19.12)	(0.17)	(2.17)	(10.43)	(112.19)	(13.20)	(142.75)
TOTAL	**450,427**	**(85.90)**	**(40.19)**	**36.70**	**6.64**	**3.99**	**(2.73)**	**(149.25)**	**(45.55)**	**(194.46)**	**(81.83)**

NUMBER OF USED BEDS PER 100,000 ADULT MEDICAID ELIGIBLES

Table S-18. Number of Beds Used Per 100,000 Adult Medicaid Eligibles by RSN (Percent Change between 2002 and 2004 Studies)
2002 Service Type Categories

RSNs	FY2004 Adult Medicaid Eligibles	Residential Utilization		Crisis Respite Utilization		Inpatient Community Hospital Utilization		State Hospital Utilization		Total	
		Residential Beds	Per 100,000	Crisis Respite Beds	Per 100,000	ADC	ADC per 100,000	State Hospital Beds	Per 100,000	All Beds	Per 100,000
Chelan-Douglas	8,149	0.0%	-11.4%	-25.0%	-33.6%	98.4%	75.7%	108.8%	85.0%	23.8%	9.6%
Clark	27,170	32.4%	21.1%	-100.0%	-100.0%	-13.3%	-20.8%	-20.5%	-27.3%	-0.5%	-9.0%
Grays Harbor	7,947	0.0%	0.0%	0.0%	2.7%	45.2%	49.1%	-43.5%	-42.0%	-28.5%	-26.6%
Greater Columbia	57,616	47.6%	42.1%	121.6%	113.4%	-11.9%	-15.2%	5.8%	1.9%	40.2%	35.0%
King	105,971	-4.1%	-9.5%	-31.8%	-35.6%	-9.3%	-14.3%	-11.3%	-16.2%	-7.2%	-12.4%
North Central	14,781	-21.1%	-25.3%	0.0%	0.0%	37.2%	29.8%	-9.5%	-14.4%	-14.6%	-19.1%
North Sound	63,797	-49.1%	-54.7%	20.5%	7.1%	45.1%	28.9%	-12.4%	-22.2%	-22.6%	-31.2%
Northeast	8,078	-75.0%	-75.7%	0.0%	-2.8%	127.9%	121.5%	363.3%	350.1%	17.0%	13.6%
Peninsula	22,162	28.0%	26.7%	0.0%	0.0%	-11.8%	-12.7%	-23.7%	-24.4%	-4.1%	-5.1%
Pierce	54,576	-19.1%	-19.4%	200.0%	198.9%	-32.2%	-32.4%	-19.6%	-19.9%	-18.2%	-18.5%
Southwest	10,307	0.0%	0.0%	0.0%	0.0%	-10.1%	-17.1%	-4.3%	-11.9%	189.8%	167.0%
Spokane	41,173	3.4%	-3.4%	0.0%	-6.6%	40.5%	31.3%	-22.1%	-27.2%	-3.3%	-9.7%
Thurston-Mason	18,958	87.5%	80.2%	0.0%	0.0%	25.6%	20.7%	-17.6%	-20.8%	13.5%	9.1%
Timberlands	9,742	-16.0%	-17.7%	-60.0%	-60.8%	-8.5%	-10.4%	-43.5%	-44.6%	-38.8%	-40.1%
TOTAL	**450,427**	**-5.1%**	**-10.2%**	**30.6%**	**23.6%**	**1.4%**	**-4.0%**	**-15.1%**	**-19.7%**	-6.3%	-11.3%

NUMBER OF USED BEDS PER 100,000 ADULT MEDICAID ELIGIBLES (NON-HOSPITAL VS. HOSPITAL)

Table S-19. Number of Beds Used Per 100,000 Adult Medicaid Eligibles (Non-Hospital versus Hospital Settings) (FY 2004)
2002 Service Type Categories

RSNs	Adult Population (18 and Over)	Adult Medicaid Eligible Per Sq. Mile	Residential & Crisis Respite Utilization			Hospital and E&T Utilization			Total		
			Residential Beds	Per 100,000	Percent of Total Per 100,000	Hospital Beds	Per 100,000	Percent of Total Per 100,000	All Beds	Per 100,000	Percent of Total Per 100,000
Chelan-Douglas	8,149	1.70	23.00	282.24	58.1%	16.60	203.72	41.9%	39.60	485.96	100.0%
Clark	27,170	43.30	60.90	224.14	58.3%	43.58	160.41	41.7%	104.48	384.56	100.0%
Grays Harbor	7,947	4.10	10.00	125.83	40.0%	15.01	188.94	60.0%	25.01	314.77	100.0%
Greater Columbia	57,616	3.10	197.10	342.09	76.4%	60.84	105.60	23.6%	257.94	447.69	100.0%
King	105,971	49.80	570.00	537.88	63.6%	325.98	307.61	36.4%	895.98	845.49	100.0%
North Central	14,781	1.50	30.00	202.96	59.5%	20.40	138.03	40.5%	50.40	340.99	100.0%
North Sound	63,797	10.10	156.00	244.53	51.0%	149.73	234.69	49.0%	305.73	479.22	100.0%
Northeast	8,078	1.00	6.00	74.28	34.2%	11.54	142.91	65.8%	17.54	217.19	100.0%
Peninsula	22,162	5.60	34.40	155.22	39.9%	51.88	234.11	60.1%	86.28	389.34	100.0%
Pierce	54,576	32.50	340.00	622.98	61.7%	211.08	386.76	38.3%	551.08	1,009.75	100.0%
Southwest	10,307	9.00	47.00	456.00	67.6%	22.56	218.86	32.4%	69.56	674.86	100.0%
Spokane	41,173	23.30	251.00	609.62	63.6%	143.55	348.65	36.4%	394.55	958.28	100.0%
Thurston-Mason	18,958	11.20	21.00	110.77	33.0%	42.57	224.57	67.0%	63.57	335.34	100.0%
Timberlands	9,742	2.70	5.40	55.43	26.0%	15.40	158.06	74.0%	20.80	213.49	100.0%
TOTAL	**450,427**	**6.80**	**1,751.80**	**388.92**	**60.8%**	**1,130.74**	**251.04**	**39.2%**	**2,882.54**	**639.96**	**100.0%**

NUMBER OF USED BEDS PER 100,000 ADULT MEDICAID ELIGIBLES (NON-HOSPITAL VS. HOSPITAL)

Table S-20. Number of Beds Used Per 100,000 Medicaid Eligibles (Non-Hospital Versus Hospital Settings Sorted By Lowest Hospital Utilization) (FY 2004)
2002 Service Type Categories

RSNs	Adult Population (18 and Over)	Adult Medicaid Eligible Per Sq. Mile	Residential & Crisis Respite Utilization			Hospital and E&T Utilization			Total		
			Residential Beds	Per 100,000	Percent of Total Per 100,000	Hospital Beds	Per 100,000	Percent of Total Per 100,000	All Beds	Per 100,000	Percent of Total Per 100,000
Greater Columbia	57,616	3.10	197.10	342.09	76.4%	60.84	105.60	23.6%	257.94	447.69	100.0%
Southwest	10,307	9.00	47.00	456.00	67.6%	22.56	218.86	32.4%	69.56	674.86	100.0%
King	105,971	49.80	570.00	537.88	63.6%	325.98	307.61	36.4%	895.98	845.49	100.0%
Spokane	41,173	23.30	251.00	609.62	63.6%	143.55	348.65	36.4%	394.55	958.28	100.0%
Pierce	54,576	32.50	340.00	622.98	61.7%	211.08	386.76	38.3%	551.08	1,009.75	100.0%
North Central	14,781	1.50	30.00	202.96	59.5%	20.40	138.03	40.5%	50.40	340.99	100.0%
Clark	27,170	43.30	60.90	224.14	58.3%	43.58	160.41	41.7%	104.48	384.56	100.0%
Chelan-Douglas	8,149	1.70	23.00	282.24	58.1%	16.60	203.72	41.9%	39.60	485.96	100.0%
North Sound	63,797	10.10	156.00	244.53	51.0%	149.73	234.69	49.0%	305.73	479.22	100.0%
Grays Harbor	7,947	4.10	10.00	125.83	40.0%	15.01	188.94	60.0%	25.01	314.77	100.0%
Peninsula	22,162	5.60	34.40	155.22	39.9%	51.88	234.11	60.1%	86.28	389.34	100.0%
Northeast	8,078	1.00	6.00	74.28	34.2%	11.54	142.91	65.8%	17.54	217.19	100.0%
Thurston-Mason	18,958	11.20	21.00	110.77	33.0%	42.57	224.57	67.0%	63.57	335.34	100.0%
Timberlands	9,742	2.70	5.40	55.43	26.0%	15.40	158.06	74.0%	20.80	213.49	100.0%
TOTAL	**450,427**	**6.80**	**1,751.80**	**388.92**	**60.8%**	**1,130.74**	**251.04**	**39.2%**	**2,882.54**	**639.96**	**100.0%**

NUMBER OF USED BEDS PER 100,000 ADULT MEDICAID ELIGIBLES (NON-HOSPITAL VS. HOSPITAL)

Table S-21. Number of Beds Used Per 100,000 Medicaid Eligibles (Non-Hospital Versus Hospital Settings Sorted By Adults Per Square Mile) (FY 2004)
2002 Service Type Categories

RSNs	Adult Population (18 and Over)	Adult Medicaid Eligible Per Sq. Mile	Residential & Crisis Respite Utilization			Hospital and E&T Utilization			Total		
			Residential Beds	Per 100,000	Percent of Total Per 100,000	Hospital Beds	Per 100,000	Percent of Total Per 100,000	All Beds	Per 100,000	Percent of Total Per 100,000
King	753,513	49.80	570.00	537.88	63.6%	325.98	307.61	36.4%	895.98	845.49	100.0%
Clark	280,705	43.30	60.90	224.14	58.3%	43.58	160.41	41.7%	104.48	384.56	100.0%
Pierce	464,338	32.50	340.00	622.98	61.7%	211.08	386.76	38.3%	551.08	1,009.75	100.0%
Spokane	75,823	23.30	251.00	609.62	63.6%	143.55	348.65	36.4%	394.55	958.28	100.0%
Thurston-Mason	99,525	11.20	21.00	110.77	33.0%	42.57	224.57	67.0%	63.57	335.34	100.0%
North Sound	245,710	10.10	156.00	244.53	51.0%	149.73	234.69	49.0%	305.73	479.22	100.0%
Southwest	70,808	9.00	47.00	456.00	67.6%	22.56	218.86	32.4%	69.56	674.86	100.0%
Peninsula	51,267	5.60	34.40	155.22	39.9%	51.88	234.11	60.1%	86.28	389.34	100.0%
Grays Harbor	548,966	4.10	10.00	125.83	40.0%	15.01	188.94	60.0%	25.01	314.77	100.0%
Greater Columbia	319,713	3.10	197.10	342.09	76.4%	60.84	105.60	23.6%	257.94	447.69	100.0%
Timberlands	51,973	2.70	5.40	55.43	26.0%	15.40	158.06	74.0%	20.80	213.49	100.0%
Chelan-Douglas	1,325,363	1.70	23.00	282.24	58.1%	16.60	203.72	41.9%	39.60	485.96	100.0%
North Central	198,492	1.50	30.00	202.96	59.5%	20.40	138.03	40.5%	50.40	340.99	100.0%
Northeast	70,659	1.00	6.00	74.28	34.2%	11.54	142.91	65.8%	17.54	217.19	100.0%
TOTAL	**4,556,856**	**6.80**	**1,751.80**	**388.92**	**60.8%**	**1,130.74**	**251.04**	**39.2%**	**2,882.54**	**639.96**	**100.0%**

APPENDIX B

STAKEHOLDER INTERVIEWS

Supporting Interview Summaries & Tables

INPATIENT COMMUNITY HOSPITALS

Interviews with the representatives of the Washington Hospital Association and inpatient community hospitals identified nine (9) significant problems that demonstrate a system imbalance to providing necessary patient care services in the most appropriate and cost effective setting. These issues are listed below and accompanied with the risks and potential consequences of the identified problem. Possible solutions for consideration are also provided.

1. Increase use of Emergency Room Boarding (3 to 4 days are not uncommon) due to the lack of clinically appropriate inpatient psychiatric beds (freestanding E&T facilities, community and state hospital) in the public mental health system.

   Risks and negative consequences:
   A. Delays in or the prevention of the patient receiving the appropriate treatment
   B. Inappropriate use of more costly and limited inpatient hospital resources
   C. Decreased capacity to accept appropriate Emergency Room admissions
   D. Greater potential for injury to hospital staff or other patients (e.g. aggressive adolescents with developmental disabilities)
   E. Increased liability for violating patient civil rights

   Possible solution for consideration:
   A. Preservation of existing inpatient capacity through improved reimbursement (where payment rates are less than cost)
   B. Development of increased capacity for acute inpatient treatment

2. Increase use of Single Bed Medical Ward Certification for Psychiatric Services due to the lack of clinically appropriate inpatient psychiatric beds.

   Risks and negative consequences: See # 1 above

   Possible solution for consideration: See # 1 above

3. Reduction of Title XIX services (due to the new interpretation of the federal waiver) to the uninsured population that is anticipated to increase the number of patient inpatient referrals.

   Risks and negative consequences:

   A. Greater incidents of patients decompensating due to lack of less costly community outpatient resources (including medication) for both early intervention to avoid hospital admissions and for hospital aftercare
   B. Higher system costs and additional inpatient capacity shortfalls
   C. Increased pressure on public health clinics to keep up with demand for services, thereby further inhibiting patient access to care

   Possible solution for consideration:
   A. Develop lower cost community-based E&T Certified beds to reduce psychiatric bed certification in medical units and Emergency Room Boarding at Community Hospitals

4. Inappropriately extended length of stay beyond the 14 day commitment period limit established for Community Hospitals per state licensure requirements due to inadequate state hospital capacity, delays in CLIP admissions for children, and public defender admission diversions from Western State Hospital in some counties (e.g. King and Pierce).

   Risks and negative consequences:
   A. Extended community hospital patient stays
   B. Delays in arranging the most appropriate clinical service delivery setting for 90 day commitments

C. Decreased ability to accept new or emergency admissions

Possible solution for consideration:

A. Development of increased capacity for acute inpatient treatment

5. Delays to discharge patients in a timely manner (Medicaid eligible and uninsured populations) due to a lack of sufficient capacity in the state hospitals (90 day commitment capacity), residential capacity or outpatient services.

   Risks and negative consequences:

   A. Extended community hospital patient stays
   B. Higher than necessary cost of care
   C. Delays in arranging the most appropriate clinical service delivery setting for 90 day commitments
   D. Decreased ability to accept new or emergency admissions
   E. Increased recidivism rates

   Possible solution for consideration:

   A. Increased crisis beds (step down) and residential (long-term) capacity to allow community and state hospitals to discharge non-acute psychiatric patients to more appropriate settings

6. Need to service older and medically complicated patient base due to the lack of state-wide capacity to meet the specialized needs of chronic, long-term patient populations with psychiatric and complex medical needs.

   Risks and negative consequences:

   A. Increased case complexity resulting in increased service levels and higher than necessary cost of providing care

   Possible solution for consideration:

   A. Development of specialized services designed to meet the needs of select patient populations such as older populations with complex medical needs in addition to psychiatric conditions

7. Lack of ease to navigate the system for community placement and to arrange wrap-around services due to the lack of a clearly defined and highly integrated continuum of care with RSNs and other state agency systems of care.

   Risks and negative consequences:
   A. Less than ideal match of patient needs with provider treatment capabilities
   B. Service system inefficiencies regarding resource utilization and cost

   Possible solution for consideration:
   A. Development of a formal interagency service map
   B. Alternative funding mechanisms (service funds follow patient based on need)
   C. Increase management oversight and system planning

8. Medicaid reimbursement rates that do not meet the cost of care (specifically applicable to the adult population) due to system funding restrictions.

   Risks and negative consequences:
   A. Increased reluctance of community hospitals to maintain the current capacity of inpatient psychiatric beds
   B. Reduced access to inpatient care resources
   C. Additional pressures to on other providers within the continuum of care to respond to system deficiencies

   Possible solution for consideration:
   A. Evaluate rate structure for psychiatric services provided by community hospitals
   B. Amend Medicaid payment rates to more closely align with actual cost to provide services

9. Upcoming change in Medicare reimbursement from a retrospective to a prospective payment system that may impact the ability to preserve the existing inpatient psychiatric capacity.

   Risks and negative consequences:
   A. Increased reluctance of community hospitals to maintain the current capacity of inpatient psychiatric beds

B. Reduced access to inpatient care resources (especially for the geriatric population who are very expensive to treat and may not be adequately reimbursed)
C. Additional pressures to on other providers within the continuum of care to respond to system deficiencies

Possible solution for consideration:

A. Evaluate rate structure for psychiatric services provided by community hospitals

Table SI-1. STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES - MENTAL HEALTH DIVISION
INPATIENT COMMUNITY HOSPITALS

Ref.	*Problem*	*Underlying Reason*	*Risks and Negative Consequence*	*Possible Solution for Consideration*	*Adults*	*Children*
1	Increase use of Emergency Room Boarding (3 to 4 days are not unusual)	Lack of clinically appropriate inpatient psychiatric beds (freestanding E&T facilities, community and state hospitals) in the public mental health system.	Patient delayed from receiving appropriate treatment; inappropriate use of limited hospital resources; decreased capacity for appropriate ER admissions; higher cost of care in ER; increased liability for violating patient civil rights or for injury to hospital staff or other patients	Preservation of existing inpatient capacity through improved reimbursement; Development of increased capacity for acute inpatient treatment	✓	✓
2	Increase use of Single Bed Medical Ward Certification for Psychiatric care	Lack of clinically appropriate inpatient psychiatric beds (freestanding E&T facilities, community and state hospitals) in the public mental health system.	Patient delayed/prevented from receiving appropriate treatment; inappropriate use of limited hospital resources; decreased capacity for appropriate med/surg admissions; increased liability for violating patient civil rights or for injury to hospital staff or other patients	Preservation of existing inpatient capacity through improved reimbursement; Development of increased capacity for acute inpatient treatment	✓	

Table SI-1. STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES - MENTAL HEALTH DIVISION
INPATIENT COMMUNITY HOSPITALS (continued)

Ref.	*Problem*	*Underlying Reason*	*Risks and Negative Consequence*	*Possible Solution for Consideration*	*Adults*	*Children*
3	Reduction of Title XIX services; anticipated to increase number of inpatient referrals	New federal waiver interpretation and the impact this will have on available funding for services provided to the uninsured	Greater incidents of patient decompensation due to lack of available resources to provide the early access / intervention of less costly outpatient services (including medications) and for hospital aftercare; result in greater use of inpatient resources which leads to higher system costs and additional capacity shortfalls; increased pressure on health clinics to provide adequate capacity thereby inhibiting patient access to care	Development of lower cost community-based E&T Certified beds to reduce psychiatric bed certification in medical units and Emergency Room Boardings of Community Hospitals	✓	
4	Inappropriately extended length of stay beyond the 14 day commitment period limit established per state licensure for Community Hospitals	Inadequate state hospital capacity for adults; Delays in CLIP admissions for children; public defender admission diversion from Western State Hospital to Community Hospitals in some counties (e.g. King, Pierce)	Extended community hospital stays for the patient; higher cost of care than is necessary; delay in arranging most appropriate clinical service delivery setting for 90 day commitments; decreased ability to accept new or emergency admissions	Development of increased capacity for acute inpatient treatment	✓	✓

Table SI-1. STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES - MENTAL HEALTH DIVISION
INPATIENT COMMUNITY HOSPITALS (continued)

Ref.	*Problem*	*Underlying Reason*	*Risks and Negative Consequence*	*Possible Solution for Consideration*	*Adults*	*Children*
5	Delays to discharge patients in a timely manner (Medicaid eligible and uninsured)	Lack of sufficient state hospital (90 day commitments), residential capacity or outpatient services (makes effective discharge planning with medication follow-up more difficult to attain)	Extended community hospital stays for the patient; higher cost of care than is necessary; delay in arranging most appropriate clinical service delivery setting for 90 day commitments; decreased ability to accept new or emergency admissions	Increased crisis beds (step down) and residential (long-term) capacity to allow community and state hospitals to discharge non-acute psychiatric patients to more appropriate setting	✓	✓
6	Service older and more medically complicated patient base	Lack of state-wide capacity to meet the specialized needs of chronic, long-term patient populations (state hospitals, community hospitals, nursing homes) with psychiatric and complex medical needs (e.g. End Stage Renal Disease)	Increase in complexity presents service delivery challenges and can lead to increasing service levels and higher than necessary cost of providing care	Development of specialized services designed to meet the needs of select patient populations (e.g. older populations with complex medical needs in addition to psychiatric needs)	✓	
7	System not easy to navigate for community placement and to arrange wrap-around services	Lack of a clearly defined and highly integrated continuum of care with RSN and other state agency systems of care	Less than ideal match of patient needs with provider treatment capabilities; system resource utilization and cost inefficiencies	Formally developed interagency service map, alternative funding mechanisms (funding follows patient), increased management oversight and system planning	✓	✓

Table SI-1. STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES - MENTAL HEALTH DIVISION
INPATIENT COMMUNITY HOSPITALS (continued)

Ref.	*Problem*	*Underlying Reason*	*Risks and Negative Consequence*	*Possible Solution for Consideration*	*Adults*	*Children*
8	Medicaid reimbursement rates do not meet cost of care	System funding restrictions	Increased reluctance to maintain current capacity of inpatient community psychiatric beds; reduced access to inpatient care resources; additional pressures on other providers within the continuum of care to respond to system deficiencies	Evaluate rate structure for psychiatric services provided by community hospitals; amend Medicaid payment rates to more closely align with actual cost to provide services	✓	
9	Upcoming change in Medicare reimbursement from retrospective to a prospective payment system (not yet finalized but considered an additional threat to the existing funding stream for community hospital inpatient psychiatric services)	Additional concern of inpatient community hospitals regarding viability of maintaining existing inpatient psychiatric capacity	Increased reluctance to maintain current capacity of inpatient community psychiatric beds; reduced access to inpatient care resources (especially for geriatric population who are very expensive to treat and may not be adequately reimbursed); additional pressures on other providers within the continuum of care to respond to system deficiencies	Evaluate rate structure for psychiatric services provided by community hospitals	✓	

STATE PSYCHIATRIC HOSPITALS

The Mental Health Division operates two state psychiatric hospitals, Eastern State Hospital (ESH), located in Medical Lake near Spokane, and Western State Hospital (WSH), located in Steilacoom near Tacoma. It is important to note that differences exist between the two state hospitals regarding patients served, primarily in that Western State Hospital has a higher proportion of long-term (more than a year length of stay) patients.

Western State Hospital (WSH)

Interviews with WSH administration and key personnel identified eight (8) significant problems that demonstrate a system imbalance to providing necessary patient care services in the most appropriate and cost effective setting:

1. Waiting lists exist for Adult and Forensic hospital beds due to the lack of available alternative community programs.

   Risks and negative consequences:
   A. Inability to accommodate new admissions
   B. Delays in discharging certain select populations
   C. Forensic admissions can become civil admissions leading to less access for other admission sources

   Possible solution for consideration:
   A. Develop alternative community programs for select populations to free up WSH capacity

2. Patients who are civil commitments are kept on the forensic wards (approximately 20 per day) due to a lack of adult beds or the need to provide treatment for the behavioral health needs of the patient.

   Risks and negative consequences:
   A. Delays or prevents forensic admissions

Possible solution for consideration:

A. Develop alternative community programs for select populations to free up WSH capacity

3. Reduction of Title XIX services (due to the new interpretation of the federal waiver) to the uninsured population that is anticipated to increase the number of patient inpatient referrals.

   Risks and negative consequences:

   A. Greater incidents of patients decompensating due to lack of less costly community outpatient resources (including medication) for both early intervention to avoid hospital admissions and for hospital aftercare
   B. Higher system costs and additional inpatient capacity shortfalls
   C. Increased pressure on public health clinics to keep up with demand for services, thereby further inhibiting patient access to care

   Possible solution for consideration:

   A. Develop lower cost community-based E&T Certified beds to reduce psychiatric bed certification in medical units and Emergency Room Boarding at Community Hospitals

4. Difficulty to discharge select populations to appropriate alternative community settings due to the lack of community placement capacity and specialized programming for select populations and the inability to make psychiatric stable discharges due to community protection laws.

   Risks and negative consequences:

   A. Extended hospital stays beyond what is reasonably necessary
   B. System cost inefficiencies
   C. May prevent admission and treatment of a patient who needs inpatient psychiatric care due to lack of available capacity

   Possible solution for consideration:

A. Develop alternative community-based programs for up to 110 to 144 long-term hospital patients and 60 PALS residents that could be well served in the community (potentially high cost of serving small population subsets over a wide geographic area is a consideration, however, for some hospital patients)
    i. Developmentally disabled patients (up to 34 patients)
    ii. Geriatric patients (up to 30)
    iii. Traumatic Brain Injury patients (up to 30)
    iv. Decertified patients from Adult Wards (up to 30)
    v. Sexual deviant behavior patients (up to 20 patients)
    vi. PALS residents (60 to 90 residents)

5. Developmentally Disabled population subset will have additional barriers to discharge due to funding formulas to provide alternative community based services and community cautiousness in accepting placement.

   Risks and negative consequences:
   A. Less emphasis of community based services which will be less costly and more appropriate for this population

   Possible solution for consideration:
   A. None at this time

6. Insufficient ability to focus on patient discharge process due to hospital staff acceptance of RSN perspective that alternative community placement options are unavailable.

   Risks and negative consequences:
   A. Diverts more highly compensated clinical staff time to managing patient transfers within the hospital to accommodate high census levels versus working on timely patient discharges
   B. Discharge delays for patients ready for discharge
   C. A diminished admission and treatment capacity for new patients

   Possible solution for consideration:
   A. Promote more active discharge planning beginning with the date of admission and work through RSN concerns

7. Inconsistent definition of detention among RSNs due to different attitudes on how to best respond to individual situations.

   Risks and negative consequences:
   A. Increased demand for adult hospital beds

   Possible solution for consideration:
   A. Develop consistent standards for detention across the state with published guidelines and performance monitoring to measure adherence to the guidelines.

8. Lack of central control to coordinate policy and decision making decisions regarding the individual RSN development of resource capacity in the community.

   Risks and negative consequences:
   A. The optimum use of resources does not occur without a responsible party overseeing the system, defining and measuring performance, continuum of care deficiencies and bottlenecks within the system

   Possible solution for consideration:
   A. Enhanced MHD role in resource management

Table SI-2. STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES - MENTAL HEALTH DIVISION
WESTERN STATE HOSPITAL

Ref.	*Problem*	*Underlying Reason*	*Risks and Negative Consequence*	*Possible Solution for Consideration*	*Adults*	*Children*
1	Waiting list exists for Adult and Forensic hospital beds	Lack of available beds to accommodate new admissions and delays in discharging certain select populations due to lack of available alternative community programs	Forensic admissions can flip to civil admissions in the Adult wards; leading to less access to admissions coming from other sources	Alternative community programs for select populations to free up WSH capacity	✓	
2	Patients who are civil commitments are kept on the forensic wards (approximately 20 per day)	Lack of adult beds or CFS is the appropriate treatment structure for the behavioral health needs of the patient	Delays or prevents forensic admissions	Alternative community programs for select populations to free up WSH capacity	✓	
3	Reduction of Title XIX services; anticipated to increase number of inpatient referrals	New federal waiver interpretation and the impact this will have on available funding for services provided to the uninsured; lack of existing community-based resources sufficient to meet current demand; lack of certified E&T beds	Greater incidents of patient decompensation due to lack of available resources to provide the early intervention of less costly outpatient services; result in greater use of inpatient resources which leads to higher system costs and additional capacity shortfalls; increased pressure on health clinics to provide adequate capacity thereby inhibiting patient access to care	Development of lower cost community-based E&T Certified beds to reduce psychiatric bed certification in medical units and Emergency Room Boardings of Community Hospitals	✓	

Table SI-2. STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES - MENTAL HEALTH DIVISION
WESTERN STATE HOSPITAL (continued)

Ref.	*Problem*	*Underlying Reason*	*Risks and Negative Consequence*	*Possible Solution for Consideration*	*Adults*	*Children*
4	Difficulty to discharge select populations to appropriate alternative community settings	Lack of alternative community placement capacity and specialized programming for select populations; community protection laws (e.g. 6358) prevent stable psychiatric discharges (applies to CFS and CAS)	Extended hospital stays for the patient beyond what is medically necessary; system cost inefficiencies; may prevent admission and treatment of a patient who needs inpatient psychiatric care	An estimated total of 110 to 144 hospital patients and 60 PALS residents could be discharged if community resources were available for select population subsets. The hospital population includes Developmentally Disabled patients (estimated 34 patients included in Adult Wards); Geriatric patients (estimated at 30 patients); Traumatic Brain Injury patients (estimated 30 patients); decertified patients from Adult Ward (30 patients); and those with Sexual Deviant Behavior (estimate of 20 patients). All are long-term patients that could be well served in the community to the benefit of patients and families; potentially high cost of serving these smaller population subsets with high geographic dispersion is a concern, however.	*V*	

Table SI-2. STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES - MENTAL HEALTH DIVISION
WESTERN STATE HOSPITAL (continued)

Ref.	*Problem*	*Underlying Reason*	*Risks and Negative Consequence*	*Possible Solution for Consideration*	*Adults*	*Children*
5	The Developmentally Disabled population subset will have additional barriers to discharge	Funding formulas are based on number of slots versus funding to provide alternative community based services; community is cautious about placement	Less emphasis on community based services which will be less costly and more appropriate for this population		✓	
6	Insufficient ability to focus on patient discharge process	Hospital staff acceptance of RSN perspective that alternative community placement options are not available	Diverts more highly compensated clinical staff time to managing patient transfers within the hospital to accommodate high census levels versus working on timely patient discharges; discharge delays for patients who are ready for discharge; a diminished admission and treatment capacity for new patients	Promote more active discharge planning beginning with the date of admission and to work through the concerns identified by the RSNs	✓	

Table SI-2. STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES - MENTAL HEALTH DIVISION
WESTERN STATE HOSPITAL (continued)

Ref.	*Problem*	*Underlying Reason*	*Risks and Negative Consequence*	*Possible Solution for Consideration*	*Adults*	*Children*
7	Inconsistent definition of detention among RSNs	Different attitudes on how to best respond to individual situations (e.g. Pierce RSN emphasizes detention to gain access to hospital beds; King RSN has broader standard of detainment (individuals with misdemeanors and no past criminal histories are sent to WSH for 90 day evaluation); North Sound RSN is illustrative of best practice; Kitsap County also emphasizes return of patients detained to WSH to residential treatment center when community beds are available	Increased demand for Adult hospital beds	Develop consistent standards for detention across the state with published guidelines and performance monitoring to measure adherence to the guidelines	✓	
8	Lack of central control to coordinate policy and decision making decisions regarding the individual RSN development of resource capacity in the community	The Regional Support Network is structurally designed to be a decentralized system centered around county system of government to provide a more flexible system of care; however; this results in the loss of a full system perspective and approach	The optimal use of resources does not occur without a responsible party overseeing the system, defining and measuring performance, continuum of care deficiencies and bottlenecks within the system	Enhanced MHD role in resource management	✓	

Eastern State Hospital (ESH)

Interviews with ESH administration and key personnel identified six (6) significant problems that demonstrate a system imbalance to providing necessary patient care services in the most appropriate and cost effective setting:

1. Waiting lists exist for Adult (6 to 7 per day), Geriatric (1 to 2 per day) and Forensic (25 to 35 per day) hospital beds due to the lack of available alternative community programs, closure of community hospital beds, and insufficient community crisis triage or other diversion capacity.

   Risks and negative consequences:
   A. Inability to accommodate new admissions

   Possible solution for consideration:
   A. Additional E&T or hospital bed capacity
   B. Preserve existing community hospital capacity

2. Patients who are civil commitments are kept on the forensic wards (approximately 6 to 15 per day) due to lack of adult beds or alternative community placements.

   Risks and negative consequences:
   A. Delays or prevents forensic admissions
   B. Increased difficulty coordinating the care of civil patients on the forensic wards
   C. Family and patient dissatisfaction
   D. Increased risk management issues regarding perception of civil right violations admissions

   Possible solution for consideration:
   A. Additional E&T or hospital bed capacity
   B. Preserve existing community hospital capacity

3. Forensic ward is operating above the stated capacity for Forensic inpatient services (83; 95 censuses; 25 to 35 on admission wait list) due to a lack of forensic beds.

   Risks and negative consequences:
   A. Delays or prevents forensic admissions

   Possible solution for consideration:
   B. Increase forensic capacity from current 83 beds to 100 beds to better match demand for services

4. Reduction of Title XIX services (due to the new interpretation of the federal waiver) to the uninsured population that is anticipated to increase the number of patient inpatient referrals.

   Risks and negative consequences:

   A. Greater incidents of patients decompensating due to lack of less costly community outpatient resources (including medication) for both early intervention to avoid hospital admissions and for hospital aftercare
   B. Higher system costs and additional inpatient capacity shortfalls
   C. Increased pressure on public health clinics to keep up with demand for services, thereby further inhibiting patient access to care

   Possible solution for consideration:
   A. Preserve existing hospital beds
   B. Expand residential capacity
   C. Develop lower cost community-based E&T Certified beds to reduce psychiatric bed certification in medical units and Emergency Room Boarding at Community Hospitals

5. Difficulty to discharge select populations to appropriate alternative community settings due to a lack of alternative community capacity and specialized programming for select populations including patients with co-occurring mental health and chemical dependencies.

Risks and negative consequences:

A. Extended hospital stays beyond what is necessary
B. May prevent admission and treatment of new patients who need inpatient psychiatric care

Possible solution for consideration:

A. Alternative community programs for select populations to free up ESH capacity (average of 5 patients in residence in need of rehabilitative residential services or other specialized services)

6. Increased difficulty to discharge patients with co-occurring mental health and chemical dependency conditions due to reductions in community treatment capacity for co-occurring conditions (e.g. DASA funded Mental Illness / Substance Abuse evaluations at the hospital have been eliminated; available but difficult to obtain in the community).

Risks and negative consequences:

A. Delays timely hospital discharges
B. Extended hospital stays beyond what is necessary
C. Increased system cost inefficiencies
D. Additional admission backlog

Possible solution for consideration:

A. Increase in community treatment capacity
B. Development of specialized residential programs

Table SI-3. STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES - MENTAL HEALTH DIVISION
EASTERN STATE HOSPITAL

Ref.	*Problem*	*Underlying Reason*	*Risks and Negative Consequence*	*Possible Solution for Consideration*	*Adults*	*Children*
1	Waiting lists exist for Adult (6 to 7 patients per day average), Geriatric (1 to 2), and Forensic (25 to 35) hospital beds at ESH	Lack of available beds to accommodate new admissions due to lack of available alternative community programs; closure of community hospital beds; insufficient community crisis triage capacity (only 8 voluntary bed capacity with less than 24 hour stay focusing on restarting medication) or other diversion capacity	Less access to needed hospital services for patients	Additional E&T or hospital bed capacity; preserve community hospital capacity	✓	
2	Patients with civil commitments are located on the forensic wards (6 to 15 per day) due to no available beds on the Adult Psychiatric Unit	Lack of adult beds or alternative community placement	Delays or prevents forensic admissions; more difficulty in coordinate care of civil patients on forensic wards as the programs for care are not the same in focus or structure. Family and patient dissatisfaction for civil patients; increased risk management issues regarding perceptions of rights violations due to treatment in a forensic environment	See Ref. # 1 above	✓	

Table SI-3. STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES - MENTAL HEALTH DIVISION
EASTERN STATE HOSPITAL (continued)

Ref.	*Problem*	*Underlying Reason*	*Risks and Negative Consequence*	*Possible Solution for Consideration*	*Adults*	*Children*
3	ESH is operating in excess of stated capacity for Forensic inpatient services (83 capacity; 95 census; 25 to 35 on admission wait list)	Lack of forensic beds	Delays or prevents forensic admissions	Increase ESH forensic capacity from current 83 beds to 100 beds to better match demand for services	✓	
4	Reduction of Title XIX services; anticipated to increase number if service referrals	New federal waiver interpretation and the impact this will have on available funding for services provided to the uninsured; lack of community-based services to meet demand; lack of certified E&T beds	Greater incidents of patient decompensation due to lack of available resources to provide the early intervention of less costly outpatient services; result in greater use of inpatient resources which leads to higher system costs and additional capacity shortfalls; increased pressure on health clinics to provide adequate capacity thereby inhibiting patient access to care	Preserve existing hospital beds and expand residential capacity; develop lower cost E&T Certified beds	✓	

Table SI-3. STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES - MENTAL HEALTH DIVISION
EASTERN STATE HOSPITAL (continued)

Ref.	*Problem*	*Underlying Reason*	*Risks and Negative Consequence*	*Possible Solution for Consideration*	*Adults*	*Children*
5	Difficulty to discharge select populations to appropriate alternative community settings	Lack of alternative community placement capacity and specialized programming for select populations including patients with co-occurring mental health and chemical dependencies (community services in this area are being reduced)	Extended hospital stays for the patient beyond what is necessary; system cost inefficiencies; may prevent admission and treatment of a patient who needs inpatient psychiatric care	Alternative community programs for select populations to free up ESH capacity (average 5 patients in residence in need of rehabilitative residential services or other specialized services)	✓	
6	Increased difficulty to discharge patients with co-occurring mental health and chemical dependency conditions	Community treatment capacity for co-occurring conditions is being reduced; DASA funded MI/SA evaluations at the hospital have been eliminated (available in the community but with difficulty)	Aids to promote timely discharges have been reduced (DASA funding); delays in timely discharging of patients extended hospital stays beyond what is necessary; increased system cost inefficiencies; additional admission backlog	Increase in community treatment capacity and develop specialized residential programs	✓	

CHILDREN'S LONG-TERM INPATIENT PROGRAM (CLIP)

The mental health division serves 96 children and adolescents in four CLIP facilities. The four facilities are the Child Study and Treatment Center (or CSTC) located on the campus of Western State Hospital with 47 beds, the McGraw Center located in Seattle with 21 beds, Tamarack Center located in Spokane with 16 beds, and Pearl Street located in Tacoma with 12 beds. Interviews with the administration and key representatives of each of these facilities identified four (4) significant problems that demonstrate a system imbalance to providing necessary patient care services in the most appropriate and cost effective setting:

1. The geographical dispersion of the CLIP facilities due to the limited number of programs state-wide.

   Risks and negative consequences:
   A. May require the child to be far from home and family

   Possible solution for consideration:
   A. As CLIPS are a last resort for treatment, solutions lie with increased levels of early intervention and improved discharge placement options

2. Need for improved funding to maintain CLIP program quality and preserve existing bad capacity.

   Risks and negative consequences:
   A. Further reduction of participating programs and available CLIP bed capacity (excludes CSTC which is currently reimbursed based on costs)

   Possible solution for consideration:
   A. Increased reimbursement rate of $84 per day (from current payment rate of $339 per day to $423 per day) will cover program operating costs exclusive of medication

3. Lack of state-wide planning that has resulted in a "patchwork quilt" of services that have been developed over the years with no cogent state-wide philosophy.

Risks and negative consequences:

A. Children are underserved

Possible solution for consideration:

A. Enhance the role of the Mental Health Division in resource management in association with other agencies providing child services

4. Need to expand non-CLIP services to serve the needs of children.

Risks and negative consequences:

A. Children are underserved

Possible solution for consideration:

A. Additional hospital inpatient access
B. Additional child psychiatry services
C. More early intervention residential capacity
D. Additional community based family services both prior to admission and post discharge (including home based services)
E. Additional parental training and coping supports
F. Increased hospital day treatment (e.g. CSTC day treatment program)
G. Additional foster families to serve as a bridge to reunite children with their families
H. Additional group homes when foster families are unavailable
I. A state-wide system to assist in the re-entry of kids back to the community
J. Improved liaison support to facilitate discharge
K. More comparable funding levels by region to support discharge
L. Increased parent education and support services
M. Full time parent advocates on CLIP staff
N. Community based programs to address the needs of the Developmentally Disabled population

Table SI-4. STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES - MENTAL HEALTH DIVISION
CHILD LONG-TERM INPATIENT PROGRAM

Ref.	*Problem*	*Underlying Reason*	*Risks and Negative Consequence*	*Possible Solution for Consideration*	*Adults*	*Children*
1	Geographic dispersion of CLIPS	Limited number of programs state-wide	May require child to be far from home and family	CLIPs are last resort; solutions lie with increased levels of early intervention and improved discharge placement options		✓
2	Need for improved funding to maintain CLIP program quality and preserve existing bed capacity	Current rate of $339 per bed day for non-CSTC facilities	Further reduction of participating programs and available CLIP bed capacity	Increased reimbursement rates (requested rate of $423 per bed day has been proposed and will cover costs excluding medications)		✓
3	Lack of state-wide planning	Patchwork quilt of services have been developed over the years with no cogent state-wide philosophy	Children are underserved	Enhanced MHD role in resource management in association with other agencies providing child services		✓

Table SI-4. STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES - MENTAL HEALTH DIVISION
CHILD LONG-TERM INPATIENT PROGRAM (coninued)

Ref.	*Problem*	*Underlying Reason*	*Risks and Negative Consequence*	*Possible Solution for Consideration*	*Adults*	*Children*
4	Need to expand non-CLIP services to serve children needs	Outpatient system is crisis based and funding is insufficient	Children are underserved	Additional hospital inpatient access		*V*
" "	" "	" "	" "	Additional child psychiatry services		*V*
" "	" "	" "	" "	More early intervention residential capacity		*V*
" "	" "	" "	" "	Additional community-based family services both prior to admission and post discharge		*V*
" "	" "	" "	" "	Additional parental training and coping supports		*V*

Table SI-4. STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES - MENTAL HEALTH DIVISION
CHILD LONG-TERM INPATIENT PROGRAM (continued)

Ref.	*Problem*	*Underlying Reason*	*Risks and Negative Consequence*	*Possible Solution for Consideration*	*Adults*	*Children*
4 cont.	Need to expand non-CLIP services to serve children needs	Outpatient system is crisis based and funding is insufficient	Children are underserved	Increased hospital day treatment (e.g. CSTC)		✓
" "	" "	" "	" "	Additional foster families to serve as a bridge to reunite children with their families		✓
" "	" "	" "	" "	Additional group homes when foster families are unavailable		✓
" "	" "	" "	" "	State-wide system to assist in the re-entry of kids back to the community		✓
" "	" "	" "	" "	Improved liaison support to facilitate discharge		✓

Table SI-4. STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES - MENTAL HEALTH DIVISION
CHILD LONG-TERM INPATIENT PROGRAM (continued)

Ref.	*Problem*	*Underlying Reason*	*Risks and Negative Consequence*	*Possible Solution for Consideration*	*Adults*	*Children*
4 cont.	Need to expand non-CLIP services to serve children needs	Outpatient system is crisis based and funding is insufficient	Children are underserved	More comparable funding levels by region to support discharge		✓
" "	" "	" "	" "	Increased parent education and support services		✓
" "	" "	" "	" "	Full time parent advocates on CLIP staff		✓
" "	" "	" "	" "	Community-based programs to address the needs of the Developmentally Disabled population		✓

APPENDIX C

STATE PSYCHIATRIC HOSPITALS

Support for Key Findings & Statistics

Total Beds

Civil and PALS total capacity (number of beds available) at ESH and WSH has decreased by 147 beds (15.0%) from 981 in FY 2001 (July 1, 2001) to 834 in FY 2005 (July 1 2004). Respectively, WSH capacity decreased by 120 beds (15.7%) and ESH capacity decreased by 27 beds (12.3%) from FY 2001 to FY 2005.

Table SH-2. State Hospital Capacity Overview

Institution	FY 2001	FY 2005	Change (Beds)	Change (Percent)
ESH	219	192	(27)	(12.3%)
WSH (Includes PALS)	762	642	(120)	(15.7%)
Total	981	834	(147)	(15.0%)

Note:
1. PALS total beds for FY 2001 is 120 and 103 for FY 2005.

RSN Civil and PALS Allocation of Available Staffed Beds

Due to the reduction in state hospital beds, the allocation of the Civil and PALS beds at ESH and WSH decreased for each of the Regional Support Networks (RSNs) from FY 2001 to FY 2005 except for North Central and North Sound RSNs, which respectively gained one bed in their allocation. Half of the fourteen RSNs experienced allocation decreases greater than 10%. The largest bed allocation decreases were experienced by Pierce RSN (56 beds, 26.3%) and King RSN (43 beds, 16.6%).

Table SH-3. Change in State Hospital Bed Allocation (Civil)

RSN	FY 2001 to FY 2005 Change (Beds)	FY 2001 to FY 2005 Change (Beds)	FY 2001 to FY 2005 Change (Percent)	FY 2001 to FY 2005 Change (Percent)
	ESH	WSH	ESH	WSH
Chelan-Douglas	0		0.0%	
Clark		(2)		(4.4%)
Grays Harbor		(4)		(20.0%)
Greater Columbia	(4)		(5.3%)	
King		(43)		(16.6%)
North Central	1		5.6%	
North Sound		1		1.0%
Northeast	(1)		(9.1%)	
Peninsula		(7)		(14.3%)
Pierce		(56)		(26.3%)
Southwest		(2)		(11.8%)
Spokane	(23)		(22.3%)	
Thurston-Mason		(3)		(7.9%)
Timberlands		(4)		(17.4%)
Total	(27)	(120)	(12.3%)	(15.7%)

Note that the RSN civil and PALS allocations include PALS beds.

RSN Civil and PALS Allocation) of Available Staffed Beds

When excluding PALS beds (120 in FY 2001 and 103 in FY 2004) from the RSN allocation, the allocation of the Civil and PALS beds at ESH and WSH decreased for each of the Regional Support Networks (RSNs) from FY 2001 to FY 2005 except for North Central RSN, which gained one bed in its allocation. Six of the fourteen RSNs experienced allocation decreases greater than 10%. The largest bed allocation decreases were experienced by Pierce RSN (48 beds, 26.7%) and King RSN (37 beds, 17.0%).

Table SH-4. Change in State Hospital Available Beds (Civil)

RSN	FY 2001 to FY 2005 Change (Beds)	FY 2001 to FY 2005 Change (Beds)	FY 2001 to FY 2005 Change (Percent)	FY 2001 to FY 2005 Change (Percent)
	ESH	WSH	ESH	WSH
Chelan-Douglas	0		0.0%	
Clark		(2)		(5.3%)
Grays Harbor		(3)		(17.6%)
Greater Columbia	(4)		(5.3%)	
King		(37)		(17.0%)
North Central	1		5.6%	
North Sound				
Northeast	(1)		(9.1%)	
Peninsula		(6)		(14.6%)
Pierce		(48)		(26.7%)
Southwest		(1)		(7.1%)
Spokane	(23)		(22.3%)	
Thurston-Mason		(3)		(9.4%)
Timberlands		(3)		(15.8%)
Total	(27)	(103)	(12.3%)	(16.0%)

In order to exclude the PALS beds from the RSN bed allocation, PCG calculated the allocation of PALS beds based on the percent distribution of the total beds described in the table on previous page of this report.

Civil Admissions

Due to the reduction in state hospital beds, the number of combined civil admissions at ESH and WSH decreased by 442, or 23.7%, from FY 2001 to FY 2004. On an RSN level, Chelan-Douglas, Greater Columbia, King, Northeast, and Southwest experienced increases in admissions from FY 2001 to FY 2004. Eight of the remaining ten RSNs experienced significant admission decreases ranging from 22.8% to 71.0%. The largest admission decrease was experienced by Pierce RSN (151 beds, 41.7%).

SH-5. Change in State Hospital Admissions (Civil)

RSN	FY 2001 to FY 2004 Change (Admissions)	FY 2001 to FY 2004 Change (Admissions)	FY 2001 to FY 2004 Change (Percent)	FY 2001 to FY 2004 Change (Percent)
	ESH	WSH	ESH	WSH
Chelan-Douglas	20	-	66.7%	-
Clark	-	(65)	-	(66.3%)
Grays Harbor	-	(35)	-	(68.6%)
Greater Columbia	22	(2)	16.2%	(100.0%)
King	-	6	-	(3.2%)
North Central	(21)	(1)	(22.8%)	(100.0%)
North Sound	1	(58)	-	(40.6%)
Northeast	3	-	7.0%	-
Peninsula	-	(48)	-	(40.7%)
Pierce	-	(151)	-	(41.7%)
Southwest	-	2	-	7.1%
Spokane	(30)	(3)	(6.8%)	(100.0%)
Thurston-Mason	-	(53)	-	(62.4%)
Timberlands	-	(22)	-	(71.0%)
MHD	1	(8)	-	(88.9%)
Total	(4)	(438)	(0.5%)	(39.2%)

Civil Average Daily Census

The combined civil average daily census (ADC) for ESH and WSH decreased by 124.26, or 14.3%, from FY 2001 to FY 2004. Only two of the fourteen RSNs (Chelan-Douglas and Southwest) experienced increases in ADC from FY 2001 to FY 2004. Of the twelve RSNs experiencing decreases, only three experienced decreases less than 10% (Greater Columbia; King; and Northeast).

Table SH-6. Change in State Hospital Average Daily Census (Civil)

RSN	FY 2001 to FY 2004 Change (ADC)	FY 2001 to FY 2004 Change (ADC)	FY 2001 to FY 2004 Change (Percent)	FY 2001 to FY 2004 Change (Percent)
	ESH	WSH	ESH	WSH
Chelan-Douglas	7.32	-	100.4%	-
Clark	-	(7.69)	-	(18.2%)
Grays Harbor	-	(7.67)	-	(38.6%)
Greater Columbia	(2.41)	(0.85)	(4.8%)	(97.5%)
King	-	(16.58)	-	(8.0%)
North Central	(4.68)	(0.02)	(22.3%)	(100.0%)
North Sound	0.24	(10.07)	0	(12.5%)
Northeast	(0.41)	-	(4.3%)	-
Peninsula	-	(5.87)	-	(17.2%)
Pierce	-	(43.32)	-	(21.8%)
Southwest	-	3.13	-	28.3%
Spokane	(15.25)	1.00	(12.5%)	413.4%
Thurston-Mason	-	(11.14)	-	(27.0%)
Timberlands	-	(7.67)	-	(40.7%)
MHD	0.14	(2.24)	-	(98.3%)
Total	(15.40)	(109.01)	(7.2%)	(16.6%)

Civil Average Length of Stay

The civil average length of stay (ALOS) increased by 5.0 days (3.1%) at ESH and by 140.0 days (55.0%) at WSH from FY 2001 to FY 2004. Eleven of the fourteen RSNs experienced increases in ALOS from FY 2001 to FY 2004.

Table SH-7. Change in State Hospital Average Length of Stay (Civil)

RSN	FY 2001 to FY 2004 Change (ALOS)	FY 2001 to FY 2004 Change (ALOS)	FY 2001 to FY 2004 Change (Percent)	FY 2001 to FY 2004 Change (Percent)
	ESH	WSH	ESH	WSH
Chelan-Douglas	(14.5)	-	(9.5%)	-
Clark	-	317.4	-	186.9%
Grays Harbor	-	396.2	-	208.0%
Greater Columbia	(53.7)	(97.0)	(25.9%)	(82.9%)
King	-	0.8	-	0.2%
North Central	(9.6)	(206.0)	(6.3%)	(100.0%)
North Sound	-	73.8	-	27.9%
Northeast	31.6	-	28.7%	-
Peninsula	-	51.1	-	41.0%
Pierce	-	106.6	-	46.1%
Southwest	-	362.0	-	137.6%
Spokane	25.7	76.0	16.3%	844.4%
Thurston-Mason	-	132.6	-	74.6%
Timberlands	-	408.7	-	238.1%
MHD	111.0	620.3	-	12,399.2%
Total	5.0	140.00	3.1%	55.0%

Civil Discharges by Length of Stay (LOS)

Comparing FY 2004 to FY 2000, more state hospital patients are staying longer than they did four years ago (7.5% increase in discharges with more than 90 days length of stay). In FY 2004, ESH and WSH together experienced 2,416 discharges versus 1,864 discharges in FY 2000. Of the 2,416 FY 2004 discharges, 12.6% had LOS greater than 365 days, 19.0% had LOS between 181 and 365 days, and 26.0% had LOS between 90 and 180 days. Only 15.7% of the FY 2004 discharges had LOS of 30 days or less, while 26.7% of the FY 2004 discharges had LOS between 31 and 90 days.

Table SH-8. State Hospital Discharges by Length of Stay (Civil)

Institution	Total FY 2004 Discharges	Discharges < 90 Days (% of Total)	Discharges 91 – 180 Days (% of Total)	Discharges 181 – 365 Days (% of Total)	Discharges > 365Days (% of Total)	Sum of Discharges > 90 Days (% of Total)
ESH:						
FY 2000	745	43.3%	37.7%	13.6%	5.4%	56.7%
FY 2004	1,069	39.0%	37.2%	14.4%	9.4%	61.0%
ESH Variance	324	(4.3%)	(0.5%)	0.8%	4.0%	4.3%
WSH:						
FY 2000	1,119	54.4%	16.8%	18.3%	10.5%	45.6%
FY 2004	1,347	45.1%	17.1%	22.6%	15.2%	54.9%
WSH Variance	228	(9.3%)	0.3%	4.3%	4.7%	9.3%
Combined:						
FY 2000	1,864	49.9%	25.2%	16.4%	8.5%	50.1%
FY 2004	2,416	42.4%	26.0%	19.0%	12.6%	57.6%
Combined Variance	552	(7.5%)	0.8%	3.4%	4.1%	7.5%

Civil Utilization Per 100,000 Adult General Population

The number of state hospital beds used per 100,000 adults decreased by 4.8 beds (20.7%) from 23.2 beds in FY 2001 to 18.4 beds in FY 2004. Two of the fourteen RSNs (Chelan-Douglas and Northeast) experienced increases in state hospital beds used per 100,000 adults from FY 2001 to FY 2004.

Table SH-9. State Hospital Utilization Per 100,000 Adult General Population (Civil)

RSN	FY 2001 Beds Used per 100,000	FY 2004 Beds Used per 100,000	FY 2001 to FY 2004 Change (Beds Used)	FY 2001 to FY 2004 Change (Percent)
Chelan-Douglas	10.2	19.3	9.1	89.2%
Clark	19.0	12.7	(6.3)	(33.2%)
Grays Harbor	48.8	26.5	(21.5)	(45.7%)
Greater Columbia	10.9	10.3	(0.6)	(5.5%)
King	19.9	17.2	(2.7)	(13.6%)
North Central	21.5	16.4	(5.1)	(23.7%)
North Sound	14.5	11.4	(3.1)	(21.4%)
Northeast	4.5	17.8	13.3	295.6%
Peninsula	18.9	14.3	(4.6)	(24.3%)
Pierce	43.1	32.6	(10.5)	(24.4%)
Southwest	24.6	23.0	(1.6)	(6.5%)
Spokane	45.7	34.3	(11.4)	(24.9%)
Thurston-Mason	21.7	17.0	(4.7)	(21.7%)
Timberlands	36.1	19.2	(16.9)	(46.8%)
Total	**23.2**	**18.4**	**(4.8)**	**(20.7%)**

Civil Utilization Per 100,000 Medicaid Eligibles

The number of state hospital beds used per 100,000 adults decreased by 45.6 beds (19.7%) from 231.8 beds in FY 2001 to 186.2 beds in FY 2004. Three of the fourteen RSNs (Chelan-Douglas; Greater Columbia; and Northeast) experienced increases in state hospital beds used per 100,000 adults from FY 2001 to FY 2004.

Table SH-10. State Hospital Utilization Per 100,000 Medicaid Eligibles (Civil)

RSN	FY 2001 Beds Used per 100,000	FY 2004 Beds Used per 100,000	FY 2001 to FY 2004 Change (Beds Used)	FY 2001 to FY 2004 Change (Percent)
Chelan-Douglas	97.0	179.4	82.4	84.9%
Clark	181.1	131.7	(49.4)	(27.3%)
Grays Harbor	294.2	170.7	(123.5)	(42%)
Greater Columbia	81.1	82.6	1.5	1.8%
King	256.9	215.1	(41.8)	(16.3%)
North Central	128.7	110.2	(18.5)	(14.4%)
North Sound	172.9	134.2	(38.7)	(22.4%)
Northeast	25.5	114.7	89.2	349.8%
Peninsula	209.7	158.5	(51.2)	(24.4%)
Pierce	410.1	328.3	(81.8)	(19.9%)
Southwest	179.0	157.8	(21.2)	(11.8%)
Spokane	366.6	266.7	(99.9)	(27.3%)
Thurston-Mason	225.0	178.2	(46.8)	(20.8%)
Timberlands	251.5	139.3	(112.2)	(44.6%)
Total	**231.8**	**186.2**	**(45.6)**	**(19.7%)**

Civil Peer State Comparison

State Staffed Beds per 100,000 (Including PALS)
The combined ESH and WSH (including 95 PALS beds) number of civil staffed beds per 100,000 for FY 2004 was 18.7, which were 3.7 beds (16.6%) less than the 22.4 beds in January 2002. Washington's FY 2004 18.7 beds per 100,000 is the highest when compared to eight peer states, the same ranking reported in the 2002 Report.

State Admissions per 100,000 (Including PALS)
The combined ESH and WSH (including 95 PALS beds) number of admissions per 100,000 for FY 2004 was 34.2, which were 12.2 admissions (12.2%) less than the 46.4 admits per 100,000 indicated by FY 2001 data. Washington's FY 2004 34.2 admissions per 100,000 is the 4th highest when compared to eight peer states, the same ranking reported in the 2002 Report.

State Hospital Daily Bed Rates

State hospital daily bed rates have increased from FY 2000 to FY 2005.

The ESH daily bed rate increased 39.3% from $381.30 in FY 2000 to $531.19 in FY 2005.

The WSH daily bed rate increased 20.7% from $363.00 in FY 2000 to $438.00 in FY 2005.

The PALS daily bed rate increased 15.3% from $229.00 in FY 2000 to $264.00 in FY 2005.

APPENDIX D

INPATIENT COMMUNITY HOSPITALS (ADULTS)

Support for Key Findings & Statistics

Community Hospital Financial Data

Community hospital summary financial and statistical information was provided to PCG by the Washington Hospital Association as part of this study. This information indicates that the hospitals are not recovering the cost of care in their payment rates for inpatient psychiatric services. A total of fourteen hospitals provided volume (patient days) and revenue (gross and net) information for Medicaid, State Only programs, Medicare, Self Pay and Commercial insurers. On a per patient day basis, net revenue received for inpatient psychiatric care falls short of covering the calculated cost of care from 17% (Medicare) to 80% (self-pay / uninsured) as shown below.

Amounts in Dollars:

Program	*Payment / Day*	*Cost / Day*	*Cost/ Payment*	*Shortfall / Day*	*Shortfall/ Payment*
Medicare	683.21	827.32	83%	(144.11)	17%
Commercial / Other	669.04	817.38	82%	(148.34)	18%
Medicaid	605.04	735.33	82%	(130.30)	18%
State Only	236.52	793.23	30%	(556.71)	70%
Self Pay	172.46	845.56	20%	(673.10)	80%

This shortfall in reimbursement for delivered services jeopardizes the continued availability of the current number of inpatient psychiatric beds available for use. To the extent that community hospitals have other profitable areas of operation, these shortfalls may be covered from earned surpluses from these other service areas. However, yearly losses in providing inpatient psychiatric services can lead to the closure of hospitals and parts of hospitals when a large percentage of their total revenue is derived from inpatient psychiatry. While additional research should be conducted in this area to validate these findings, the current rate structure should be evaluated to better align the cost of care with the cost of providing services. This evaluation should focus not only the Medicaid insured population but also on the state only and uninsured populations.

Community Hospital Combined (Medicaid and non-Medicaid) Utilization and Payments by RSN (FY 2003)

On the following page, FY 2003 data is presented that details the total volume of Medicaid and non-Medicaid services utilized by each RSN. Included in this table is the following data:

- Total number of admissions 9,444
- Total bed days 85,602
- Average length of stay 9 days
- Average allowed per day
  - Voluntary $672.62
  - Involuntary $577.62
  - Non-specified $111.52
  - Total combined $511.68

Table IA-3. Community Hospital Utilization & Payments by RSN (FY 2003)

RSN	Non-Specified					Voluntary				
	# of Admissions	Bed Days	ALOS	Total Allowed	Allowed Per Day	# of Admissions	Bed Days	ALOS	Total Allowed	Allowed Per Day
Chelan-Douglas	22	152	7	$ 37,025.06	$ 243.59	28	230	8	$ 185,186.14	$ 805.16
Clark	56	451	8	$ 44,080.65	$ 97.74	130	772	6	$ 510,621.24	$ 661.43
Grays Harbor	11	96	9	$ 9,257.00	$ 96.43	25	176	7	$ 107,511.91	$ 610.86
Greater Columbia	39	276	7	$ 34,074.58	$ 123.46	207	1,441	7	$ 1,136,157.46	$ 788.45
King	369	2,762	7	$ 492,161.56	$ 178.19	1,771	12,280	7	$ 7,519,127.20	$ 612.31
MHD	732	6,598	9	$ 774,338.70	$ 117.36	42	150	4	$ 221,490.26	$ 1,476.60
North Central	46	518	11	$ 31,523.48	$ 60.86	70	446	6	$ 417,846.80	$ 936.88
North Sound	272	1,726	6	$ 206,119.24	$ 119.42	976	7,528	8	$ 4,956,168.34	$ 658.36
Northeast	16	314	20	$ 20,183.46	$ 64.28	24	322	13	$ 194,009.80	$ 602.51
Peninsula	64	476	7	$ 61,688.48	$ 129.60	72	370	5	$ 325,172.62	$ 878.84
Pierce	136	1,340	10	$ 102,138.20	$ 76.22	734	5,950	8	$ 4,244,193.76	$ 713.31
Southwest	22	226	10	$ 27,457.91	$ 121.50	212	1,315	6	$ 969,877.79	$ 737.55
Spokane	276	3,826	14	$ 281,759.50	$ 73.64	382	3,500	9	$ 2,095,410.14	$ 598.69
Thurston-Mason	60	600	10	$ 43,840.58	$ 73.07	182	1,518	8	$ 1,246,648.26	$ 821.24
Timberlands	14	154	11	$ 10,723.34	$ 69.63	50	334	7	$ 308,109.20	$ 922.48
TOTAL	**2,135**	**19,515**	**9**	**$ 2,176,371.74**	**$ 111.52**	**4,905**	**36,332**	**7**	**$ 24,437,530.92**	**$ 672.62**

RSN	Involuntary					TOTAL COMBINED				
	# of Admissions	Bed Days	ALOS	Total Allowed	Allowed Per Day	# of Admissions	Bed Days	ALOS	Total Allowed	Allowed Per Day
Chelan-Douglas	24	342	14	$ 186,245.76	$ 544.58	74	724	10	$ 408,456.96	$ 564.17
Clark	197	1,624	8	$ 695,033.52	$ 427.98	383	2,847	7	$ 1,249,735.41	$ 438.97
Grays Harbor	23	258	11	$ 146,956.75	$ 569.60	59	530	9	$ 263,725.66	$ 497.60
Greater Columbia	315	3,106	10	$ 2,043,636.90	$ 657.96	561	4,823	9	$ 3,213,868.94	$ 666.36
King	633	8,680	14	$ 4,448,130.37	$ 512.46	2,773	23,722	9	$ 12,459,419.13	$ 525.23
MHD	48	320	7	$ 68,728.28	$ 214.78	822	7,068	9	$ 1,064,557.24	$ 150.62
North Central	36	538	15	$ 396,047.84	$ 736.15	152	1,502	10	$ 845,418.12	$ 562.86
North Sound	272	3,104	11	$ 2,003,499.74	$ 645.46	1,520	12,358	8	$ 7,165,787.32	$ 579.85
Northeast	12	196	16	$ 117,382.14	$ 598.89	52	832	16	$ 331,575.40	$ 398.53
Peninsula	24	226	9	$ 123,632.10	$ 547.04	160	1,072	7	$ 510,493.20	$ 476.21
Pierce	314	4,348	14	$ 2,690,762.90	$ 618.85	1,184	11,638	10	$ 7,037,094.86	$ 604.67
Southwest	72	757	11	$ 392,165.90	$ 518.05	306	2,298	8	$ 1,389,501.60	$ 604.66
Spokane	330	4,986	15	$ 3,005,083.92	$ 602.70	988	12,312	12	$ 5,382,253.56	$ 437.16
Thurston-Mason	90	1,090	12	$ 754,662.16	$ 692.35	332	3,208	10	$ 2,045,151.00	$ 637.52
Timberlands	14	180	13	$ 115,028.74	$ 639.05	78	668	9	$ 433,861.28	$ 649.49
TOTAL	**2,404**	**29,755**	**12**	**$ 17,186,997.02**	**$ 577.62**	**9,444**	**85,602**	**9**	**$ 43,800,899.68**	**$ 511.68**

RSN Allocation of Used Beds

The total number of community hospital beds used by the RSNs increased by 22.16 beds, or roughly 11.5%, from FY 2001 to FY 2003. Peninsula RSN had the largest percentage decrease in the number of community hospital beds used (41.26%). Six RSNs had a reduction in use of community hospital beds of 21.04, or a 24.7% decrease. The remaining eight RSNs increased their utilization 43.2 beds (40%).

Table IA-4. Number of Inpatient Community Hospital Beds Used by RSN

RSNs	FY 2001 (Used Beds)	FY 2003 (Used Beds)	FY 2001 to FY 20043 Change (Used Beds)	FY 2001 to FY 2003 Change (Percent)
Chelan-Douglas	1.00	1.98	0.98	98.36%
Clark	9.00	7.80	(1.20)	-13.33%
Grays Harbor	1.00	1.45	0.45	45.21%
Greater Columbia	15.00	13.21	(1.79)	-11.91%
King	52.00	64.99	12.99	24.98%
North Central	3.00	4.12	1.12	37.17%
North Sound	19.00	33.86	14.86	78.20%
Northeast	1.00	2.28	1.28	127.95%
Peninsula	5.00	2.94	(2.06)	-41.26%
Pierce	47.00	31.88	(15.12)	-32.16%
Southwest	7.00	6.30	(0.70)	-10.06%
Spokane	24.00	33.73	9.73	40.55%
Thurston-Mason	7.00	8.79	1.79	25.56%
Timberlands	2.00	1.83	(0.17)	-8.49%
TOTAL	**193.00**	**215.16**	**22.16**	**11.48%**

1. FY 2001: Data come from PCG's 2002 Report. "Beds Available" was collected from the RSNs in the 2002 Report; RSNs stated that beds can only be used when available and are used on an as-needed basis. No contract exists between the RSNs and community hosp

2. FY 2003: Data come from MHD. "Beds Available" is given as the number of beds used by each RSN, given that beds are available and used on an as-needed basis. "Beds Used" data was calculated by MHD using te MHD data obtained.

Number of People Served

The total number of people served across all RSNs decreased by 533, or 6.89% from 7,736 in FY 2001 to 7,203 in FY 2003. Peninsula RSN showed the largest percentage decrease in number of individuals served (76.61%) while Pierce RSN incurred the largest decease in actual number of individuals served (369). Chelan-Douglas RSN had the largest percentage increase in the number of people served (111.43%) while King increased the actual number of people served the most (85).

Table IA-5. Number of People Served in Inpatient Community Hospitals by RSN

RSNs	FY 2001 (No. Served)	FY 2003 (No. Served)	FY 2001 to FY 2003 Change (Used Beds)	FY 2001 to FY 2003 Change (Percent)
Chelan-Douglas	35	74	39	111.43%
Clark	344	383	39	11.34%
Grays Harbor	69	59	-10	-14.49%
Greater Columbia	521	561	40	7.68%
King	2688	2773	85	3.16%
North Central	86	99	13	15.12%
North Sound	1117	1062	-55	-4.92%
Northeast	38	34	-4	-10.53%
Peninsula	449	105	-344	-76.61%
Pierce	1234	865	-369	-29.90%
Southwest	304	306	2	0.66%
Spokane	554	561	7	1.26%
Thurston-Mason	231	266	35	15.15%
Timberlands	66	55	-11	-16.67%
TOTAL	**7736**	**7203**	**-533**	**-6.89%**

1. FY 2001: Data came from PCG's 2002 Report. Number of People Served came from MHD.
2. FY 2003: Data came from MHD.

Number of Inpatient Community Hospital Beds – Adult General Population

The total number of beds used by the RSNs in FY 2003 was 4.72 beds per 100,000 adults (7.50 % higher than FY 2001).

Table IA-6. Number of Inpatient Community Hospital Beds Available by RSN Per 100,000 Adult General Population

RSNs	Adult General Population (18 & Over) FY 2001	FY 2001 Available Beds Per 100,000	Adult General Population (18 & Over) FY 2004	FY 2004 Available Beds Per 100,000	FY 2001 to FY 2004 Change (Available Beds)	FY 2001 to FY 2004 Change (Percent)
Chelan-Douglas	68,465	1.46	75,823	2.62	1.16	79.11%
Clark	236,872	4.64	280,705	2.78	(1.87)	-40.16%
Grays Harbor	49,184	2.03	51,267	2.83	0.80	39.31%
Greater Columbia	413,469	3.63	464,338	2.85	(0.78)	-21.56%
King	1,291,138	4.03	1,325,363	4.90	0.88	21.76%
North Central	83,579	2.39	99,525	4.13	1.74	72.79%
North Sound	678,119	2.80	753,513	4.49	1.69	60.37%
Northeast	44,082	2.27	51,973	4.39	2.12	93.34%
Peninsula	243,014	1.65	245,710	1.20	(0.45)	-27.38%
Pierce	516,962	8.32	548,966	5.81	(2.51)	-30.17%
Southwest	69,037	10.14	70,659	8.91	(1.23)	-12.12%
Spokane	308,515	7.46	319,713	10.55	3.10	41.52%
Thurston-Mason	188,574	3.18	198,492	4.43	1.25	39.16%
Timberlands	66,484	3.01	70,808	2.58	(0.42)	-14.08%
TOTAL	**4,257,494**	**4.39**	**4,556,856**	**4.72**	**0.33**	**7.50%**

1. FY 2001: Data come from PCG's 2002 Report. "Beds Available" was collected from the RSNs in the 2002 Report; RSNs stated that beds can only be used when available and are used on an as-needed basis. No contract exists between the RSNs and community hosp

2. FY 2004: Data come from MHD. "Beds Available" is given as the number of beds used by each RSN, given that beds are available and used on an as-needed basis. "Beds Used" data was calculated by MHD using te MHD data obtained.

3. FY 2001 Adult General Population comes from MHD. FY 2004 Adult General Population is based on data from State of Washington, Office of Financial Management, Forecasting Division: June 30, 2004. Adult Population (18 and Over) is an average of CY2003 and CY2004.

Number of Inpatient Community Hospital Beds - Medicaid Population

The total number of beds used by the RSNs in FY 2003 was 47.77 beds per 100,000 Medicaid adults (5.51% higher since FY 2001).

Table IA-7. Number of Inpatient Community Hospital Beds Used by RSN Per 100,000 Adult Medicaid Eligibles

RSNs	Adult Medicaid Eligibles (18 & Over) FY 2001	FY 2001 Available Beds Per 100,000	Adult Medicaid Eligibles (18 & Over) FY 2004	FY 2004 Available Beds Per 100,000	FY 2001 to FY 2004 Change (Used Beds)	FY 2001 to FY 2004 Change (Percent)
Chelan-Douglas	7,219	13.85	8,149	24.34	10.49	75.72%
Clark	24,843	36.23	27,170	28.71	(7.52)	-20.76%
Grays Harbor	8,158	12.26	7,947	18.27	6.01	49.06%
Greater Columbia	55,481	27.04	57,616	22.93	(4.10)	-15.17%
King	100,052	51.97	105,971	61.33	9.36	18.00%
North Central	13,991	21.44	14,781	27.84	6.40	29.84%
North Sound	56,681	33.52	63,797	53.07	19.55	58.32%
Northeast	7,848	12.74	8,078	28.22	15.48	121.46%
Peninsula	21,933	22.80	22,162	13.25	(9.54)	-41.87%
Pierce	54,378	86.43	54,576	58.42	(28.01)	-32.41%
Southwest	9,496	73.72	10,307	61.08	(12.63)	-17.14%
Spokane	38,458	62.41	41,173	81.93	19.52	31.28%
Thurston-Mason	18,223	38.41	18,958	46.36	7.95	20.69%
Timberlands	9,544	20.96	9,742	18.79	(2.17)	-10.35%
TOTAL	**426,305**	**45.27**	**450,427**	**47.77**	**2.50**	**5.51%**

1. FY 2001: Data come from PCG's 2002 Report. "Beds Available" was collected from the RSNs in the 2002 Report; RSNs stated that beds can only be used when available and are used on an as-needed basis. No contract exists between the RSNs and community hospitals for a specified number of beds. "Beds Used" is MHD's ADC for inpatient community hospital "used beds" data.
2. FY 2004: Data come from MHD. "Beds Available" is given as the number of beds used by each RSN, given that beds are available and used on an as-needed basis. "Beds Used" data was calculated by MHD using te MHD data obtained.
3. FY 2001 Adult Medicaid Eligibles population data was used in the 2002 Report and came from MHD. FY 2004 Adult Medicaid Eligibles population also came from MHD.

APPENDIX E

EVALUATION & TREATMENT CENTERS

Support for Key Findings & Statistics

Available Beds

West Seattle Psychiatric Hospital was the only E&T facility experiencing a change in available beds between FY 2001 and FY 2004, a decrease of 49.2%.

Table ETA-2. Change in E&T Available Beds (FY 2001 – FY 2004)

RSN	Institution	FY 2001	FY 2004	Change (Beds)	Change (Percent)
King	West Seattle Psychiatric Hospital	65	33	(32)	(49.2%)
Peninsula	Kitsap Mental Health Services	15	15	0	0%
North Sound	Compass Health Snohomish	15	15	0	0%
North Sound	Compass Health North Sound	15	15	0	0%

Admissions

Statistics obtained from the RSNs that contain E&T facilities—namely King, Peninsula, and North Sound—revealed a 10.3% escalation in total admissions rates between Fiscal Years 2001 and 2003.

Table ETA-3. Change in E&T Admissions (FY 2001 – FY 2003)

RSN	E&T Facility	FY 2001 Admissions	FY 2003 Admissions	FY 2001 to FY 2003 Change (Admissions)	FY 2001 to FY 2003 Change (Percent)
King	West Seattle Psychiatric Hospital	923	1,301	378	41.0%
Peninsula	Kitsap Mental Health Services	482	490	8	1.7%
North Sound	Compass Health Snohomish and Compass Health North Sound	793	633	(40)	(20.2%)
TOTAL		2,198	2,424	226	10.3%

Average Daily Census

Most of the E&T increase in average daily census from FY 2001 to FY 2003 was due to West Seattle Psychiatric Hospital (up 44.1%).

Table ETA-4. Change in E&T Average Daily Census (FY 2001 – FY 2003)

RSN	E&T Facility	FY 2001 (ADC)	FY 2003 (ADC)	FY 2001 to FY 2003 Change (ADC)	FY 2003 to FY 2004 Change (Percent)
King	West Seattle Psychiatric Hospital	34	49	15	44.1%
Peninsula	Kitsap Mental Health Services	22	21	(1)	(4.5%)
North Sound	Compass Health Snohomish and Compass Health North Sound	23	23	0	0%
TOTAL		79	93	14	17.7%

Average Length of Stay

The average length of stay rose at all four E&T Centers in Washington State at an average of 7.7%.

Table ETA-5. Change in E&T Average Length of Stay (FY 2001 – FY 2003)

RSN	E&T Facility	FY 2001 (ALOS)	FY 2003 (ALOS)	FY 2001 to FY 2003 Change (ALOS)	FY 2001 to FY 2003 Change (Percent)
King	West Seattle Psychiatric Hospital	13	14	1	7.7%
Peninsula	Kitsap Mental Health Services	16	17	1	6.3%
North Sound	Compass Health Snohomish and Compass Health North Sound	11	12	1	9.1%
TOTAL		13	14	1	7.7%

Discharges

E&T discharges increased by 12.4% from FY 2001 to FY 2003, mostly due to West Seattle Psychiatric Hospital, which grew by 44.1%.

Table ETA-6. Change in E&T Discharges (FY 2001 – FY 2003)

RSN	E&T Facility	FY 2001 (Discharges)	FY 2003 (Discharges)	FY 2001 to FY 2003 Change (Discharges)	FY 2001 to FY 2003 Change (Percent)
King	West Seattle Psychiatric Hospital	910	1,311	401	44.1%
Peninsula	Kitsap Mental Health Services	482	487	5	1.0%
North Sound	Compass Health Snohomish and Compass Health North Sound	780	644	(64)	(17.4%)
TOTAL		2,172	2,442	470	12.4%

Utilization Per 100,000 Adult General Population

E&T bed utilization per 100,000 adult population increased by 40%, mostly due to West Seattle Psychiatric Hospital, which grew at 88.9%.

Table ETA-7. Change in E&T Utilization Per 100,000 Adult General Population (FY 2001 – FY 2003)

RSN	E&T Facility	FY 2001	FY 2003	FY 2001 to FY 2003 Change	FY 2001 to FY 2003 Change (Percent)
King	West Seattle Psychiatric Hospital	0.9	1.7	0.8	88.9%
Peninsula	Kitsap Mental Health Services	4.0	4.1	0.1	2.5%
North Sound	Compass Health Snohomish and Compass Health North Sound	2.0	2.0	0	0%
TOTAL		0.5	0.7	0.2	40.0%

Note:
Estimated population data (calendar years 2002, 2003 and 2004) provided by State of Washington, Office of Financial Management, Forecasting Division: June 30, 2004.

Utilization per 100,000 Medicaid Eligibles

Based on Medicaid Eligibles per 100,000, there was no change in E&T bed utilization between FY 2001 and FY 2003.

Table ETA-8. Change in E&T Utilization Per 100,000 Medicaid Eligibles (FY 2001 – FY 2003)

RSN	E&T Facility	FY 2001 (Days)	FY 2003 (Days)	FY 2001 to FY 2003 Change (Days)	FY 2001 to FY 2003 Change (Percent)
King	West Seattle Psychiatric Hospital	0.2	0.3	0.1	50.0%
Peninsula	Kitsap Mental Health Services	0.7	0.7	0	0%
North Sound	Compass Health Snohomish and Compass Health North Sound	0.3	0.4	0.1	33.3%
TOTAL		0.1	0.1	0	0%

Note:
Estimated population data (calendar years 2002, 2003 and 2004) provided by State of Washington, Office of Financial Management, Forecasting Division: June 30, 2004.

APPENDIX F

RESIDENTIAL

Support for Key Findings & Statistics

Residential bed data for FY 2004 and FY 2001 (2002 Report) discussed in this report do not include supported housing or providers that are classified under the "Transitional Housing" category of the 2002 Major Residential Categories. Given that supported housing and "transitional housing" data were not reported/collected consistently across the RSNs, these data, where provided, have been excluded from this analysis. This will ensure more consistent analysis across RSNs and, consequently, more accurate recommendations.

In addition, it is important to note that the providers and corresponding beds defined under the 2004 Residential Supported Living service setting definition do not reflect numbers for supported housing or other "transitional housing" providers excluded from this study.

Number of Providers Used

From Fiscal Year 2001 to Fiscal Year 2004, Boarding Homes increased by 36.4%, Adult Residential Treatment providers decreased by 28.6%, and Adult Family Homes decreased by 28.6%. Crisis respite providers were viewed separately from the residential categories depicted in the following chart.

Table R-2. Number of Residential Providers Used by RSN (FY 2004)
2002 Major Residential Categories

RSNs	Boarding Homes	Adult Residential Treatment	Adult Family Home	Other	TOTAL
Chelan-Douglas	1	-	-	-	1
Clark	2	3	1	-	6
Grays Harbor	-	-	-	-	-
Greater Columbia	10	3	1	-	14
King	3	5	-	1	9
North Central	3	1	3	-	7
North Sound	3	1	-	-	4
Northeast	1	-	-	-	1
Peninsula	2	-	-	-	2
Pierce	16	5	2	-	23
Southwest	4	1	-	-	5
Spokane	12	1	-	-	13
Thurston-Mason	2	-	3	-	5
Timberlands	1	-	-	-	1
TOTAL	**60**	**20**	**10**	**1**	**91**
2002 Study	44	28	14	1	87
VARIANCE	*16*	*-8*	*-4*	*0*	*4*
% Change	***36.4%***	***-28.6%***	***-28.6%***	***0.0%***	***4.6%***

1. Data come from RSNs and is an average for all of FY 2004. If RSNs were unable to provider an average, data was provided as of June 30, 2004.

2. 'Hospital Diversion/Alternatives' service setting definition includes four sub-categories - crisis respite, crisis triage, crisis stailization, and step down beds.

Number of Providers Used

RSNs reported 82 providers (68.9% of the total) as Residential Supervised Living, 8 providers (6.7%) as Residential Supported Living and 29 providers (24.4%) as Hospital Diversion/Alternatives. Of the 29 Hospital Diversion/Alternative providers currently reported, 23 are classified as crisis respite, 3 as crisis stabilization, 2 as crisis triage, and 1 as step-down beds. All Hospital Diversion/Alternative facilities have the capacity for serving 24 hours or more. The 82 providers categorized as Residential Supervised Living are split somewhat evenly between intensive (45) and non-intensive (37).

Table R-3. Number of Providers Used by RSN (FY2004)
2004 Service Setting Definitions

RSNs	2004 SERVICE SETTING DEFINITIONS			
	Hospital Diversion / Alternatives	Residential Supervised Living	Residential Supported Living	TOTAL
Chelan-Douglas	1	1	-	2
Clark	-	6	-	6
Grays Harbor	1	-	-	1
Greater Columbia	13	14	-	27
King	1	8	1	10
North Central	-	7	-	7
North Sound	5	4	-	9
Northeast	1	-	1	2
Peninsula	1	2	-	3
Pierce	2	23	-	25
Southwest	1	-	4	5
Spokane	1	13	-	14
Thurston-Mason	1	4	1	6
Timberlands	1	-	1	2
TOTAL	29	82	8	119

1. Data come from RSNs and is an average for all of FY 2004. If RSNs were unable to provider an average, data was provided as of June 30, 2004.

2. 'Hospital Diversion/Alternatives' service setting definition includes four sub-categories - crisis respite, crisis triage, crisis stailization, and step down beds.

Number of Available Staffed Beds by 2002 Study Residential Provider Categories

From FY 2001 to FY 2004, there was an available bed increases in Boarding Homes (119 beds or 11.7%). There were available bed decreases reported in Adult Residential Treatment (96 or 15.6%) and Adult Family Home (43 or 70.5%) from FY 2001 to FY 2004. Overall, residential available beds decreased by 44 beds or 2.6% from FY 2001 to FY 2004.

Table R-4. Number of Residential Beds Available by RSN (FY 2004)
2002 Major Residential Categories

RSNs	Boarding Homes	Adult Residential Treatment	Adult Family Home	Other	TOTAL
Chelan-Douglas	20.0	-	-	-	20.0
Clark	34.0	36.0	1.0	-	71.0
Grays Harbor	-	-	-	-	-
Greater Columbia	95.0	62.0	1.0	-	158.0
King	362.0	215.0	-	6.0	583.0
North Central	29.0	2.0	4.0	-	35.0
North Sound	93.0	16.0	-	-	109.0
Northeast	2.0	-	-	-	2.0
Peninsula	34.0	-	-	-	34.0
Pierce	192.0	155.0	2.0	-	349.0
Southwest	45.0	2.0	-	-	47.0
Spokane	213.0	30.0	-	-	243.0
Thurston-Mason	13.0	-	10.0	-	23.0
Timberlands	6.0	-	-	-	6.0
TOTAL	**1,138.0**	**518.0**	**18.0**	**6.0**	**1,680.0**
2002 Study	1,019	614	61	30	1,724
VARIANCE	*119*	*-96*	*-43*	*-24*	*-44*
% Change	***11.7%***	***-15.6%***	***-70.5%***	***-80.0%***	***-2.6%***

Number of Available Beds by 2004 Study Residential Service Setting Definition Categories

Available bed counts, based on 2004 service setting definitions, are 1,595 (85.7% of the total) Residential Supervised Living, 83 (4.5%) Residential Supported Living, and 182 (9.8%) Hospital Diversion/Alternatives.

Table R-5. Number of Available Beds by RSN (FY 2004)
2004 Service Setting Definitions

RSNs	2004 SERVICE SETTING DEFINITIONS			
	Hospital Diversion / Alternatives	Residential Supervised Living	Residential Supported Living	TOTAL
Chelan-Douglas	5.0	20.0	-	25.0
Clark	-	71.0	-	71.0
Grays Harbor	10.0	-	-	10.0
Greater Columbia	55.0	158.0	-	213.0
King	20.0	561.0	22.0	603.0
North Central	-	35.0	-	35.0
North Sound	47.0	109.0	-	156.0
Northeast	4.0	-	2.0	6.0
Peninsula	4.0	34.0	-	38.0
Pierce	18.0	349.0	-	367.0
Southwest	2.0	-	45.0	47.0
Spokane	8.0	243.0	-	251.0
Thurston-Mason	6.0	15.0	8.0	29.0
Timberlands	3.0	-	6.0	9.0
TOTAL	**182.0**	**1,595.0**	**83.0**	**1,860.0**

Number of Used Beds by 2002 Study Residential Provider Categories

There were less beds (1,595.1) used in FY 2004 than in FY 2001 (1,681), a decrease of 5.1%. Fewer Adult Residential Treatment beds (117 or 19.2%) and Adult Family Home beds (70 or 85.4%) were used in FY 2004 than in FY 2001. A total of 125 more (13.0%) Boarding Home beds were used in FY 2004 than in FY 2001.

Table R-6. Number of Residential Beds Used by RSN (FY 2004)
2002 Major Residential Categories

RSNs	Boarding Homes	Adult Residential Treatment	Adult Family Home	Other	TOTAL
Chelan-Douglas	20.0	-	-	-	20.0
Clark	30.6	29.3	1.0	-	60.9
Grays Harbor	-	-	-	-	-
Greater Columbia	92.0	62.0	1.0	-	155.0
King	338.0	211.0	-	6.0	555.0
North Central	24.0	2.0	4.0	-	30.0
North Sound	93.0	16.0	-	-	109.0
Northeast	2.0	-	-	-	2.0
Peninsula	32.0	-	-	-	32.0
Pierce	181.0	139.0	2.0	-	322.0
Southwest	45.0	2.0	-	-	47.0
Spokane	213.0	30.0	-	-	243.0
Thurston-Mason	11.0	-	4.0	-	15.0
Timberlands	4.2	-	-	-	4.2
TOTAL	**1,085.8**	**491.3**	**12.0**	**6.0**	**1,595.1**
2002 Study	961	608	82	30	1,681
VARIANCE	*125*	*-117*	*-70*	*-24*	*-86*
% Change	***13.0%***	***-19.2%***	***-85.4%***	***-80.0%***	***-5.1%***

Number of Used Beds by 2004 Study Residential Service Setting Definition Categories

Residential Supervised Living beds account for the majority of the total used beds in FY 2004 (1,512.9 of the 1,751.8 total used beds, or 86.4%). Of the total 158.7 Hospital Diversion/Alternative beds used in FY 2004, 129 were categorized as crisis respite beds. The remaining beds are categorized as 18.1 crisis triage, 9.6 crisis stabilization, and 2.0 step down beds. All Hospital Diversion/ Alternative beds used in FY 2004 had the capacity for serving 24 hours or more.

Table R-7. Number of Used Beds by RSN (FY 2004)
2004 Service Setting Definitions

RSNs	2004 SERVICE SETTING DEFINITIONS			
	Hospital Diversion / Alternatives	Residential Supervised Living	Residential Supported Living	TOTAL
Chelan-Douglas	3.0	20.0	-	23.0
Clark	-	60.9	-	60.9
Grays Harbor	10.0	-	-	10.0
Greater Columbia	42.1	155.0	-	197.1
King	15.0	534.0	21.0	570.0
North Central	-	30.0	-	30.0
North Sound	47.0	109.0	-	156.0
Northeast	4.0	-	2.0	6.0
Peninsula	2.4	32.0	-	34.4
Pierce	18.0	322.0	-	340.0
Southwest	2.0	-	45.0	47.0
Spokane	8.0	243.0	-	251.0
Thurston-Mason	6.0	7.0	8.0	21.0
Timberlands	1.2	-	4.2	5.4
TOTAL	**158.7**	**1,512.9**	**80.2**	**1,751.8**

Utilization per 100,000 Adult Population (2002 Report Service Type Categories)

Utilization per 100,000 general population was lower by 4.5% in FY 2004 (35.0) when compared to FY 2001 (39.5). Spokane RSN used the most beds per 100,000 in FY 2004 (76.0) while Southwest RSN used the second most beds per 100,000 (66.5).

Table R-8. Number of Residential Beds Used Per 100,000 Adult General Population by RSN
2002 Major Residential Categories (Combined)

RSNs	Adult General Population (18 and Over)	Residential Utilization	
		Beds Used	Per 100,000
Chelan-Douglas	75,823	20.0	26.4
Clark	280,705	60.9	21.7
Grays Harbor	51,267	-	-
Greater Columbia	464,338	155.0	33.4
King	1,325,363	555.0	41.9
North Central	99,525	30.0	30.1
North Sound	753,513	109.0	14.5
Northeast	51,973	2.0	3.8
Peninsula	245,710	32.0	13.0
Pierce	548,966	322.0	58.7
Southwest	70,659	47.0	66.5
Spokane	319,713	243.0	76.0
Thurston-Mason	198,492	15.0	7.6
Timberlands	70,808	4.2	5.9
TOTAL	**4,556,856**	**1,595.1**	**35.0**
2002 Study	4,257,494	1,681	39.5
VARIANCE	-	*-86*	*-4.5*
% Change	-	***-5.1%***	***-11.3%***

Notes:
1. Adults general population figures is based on data from State of Washington, Office of Financial Management, Forecasting Division: June 30, 2004.
2. Adult Population (18 and Over) is an average of CY2003 and CY 2004 populations in order to more accurately represent the timeframe of FY 2004.

Available Beds Per 100,000 Adult General Population & Medicaid Eligibles (2004 Service Setting Definitions)

Of the total available beds per 100,000 adult general population (40.8), 85.8% were available as Residential Supervised Living beds, 4.4% as Residential Supported Living beds, and 9.8% as Hospital Diversion/Alternative. Within Hospital Diversion/Alternatives, crisis respite comprised the majority of available beds per 100,000 population with 3.0 beds per 100,000. Out of the 35.0 beds per 100,000 for Residential Supervised Living, 52.3% were available as intensive beds and 47.7% were available as non-intensive beds. Of the 1.8 beds per 100,000 available as Residential Supported Living, 44.4% were available as intensive and 55.6% were available as non-intensive.

Table R-9. Number of Available Beds by RSN Per 100,000 Adult General Population
2004 Service Setting Definition Summaries

RSNs	Adult General Population (18 and Over)	2004 SERVICE SETTING DEFINITIONS							
		Hospital Diversion / Alternatives	Per 100,000	Residential Supervised Living	Per 100,000	Residential Supported Living	Per 100,000	TOTAL	Per 100,000
Chelan-Douglas	75,823	5.0	6.6	20.0	26.4	-	-	25.0	33.0
Clark	280,705	-	-	71.0	25.3	-	-	71.0	25.3
Grays Harbor	51,267	10.0	19.5	-	-	-	-	10.0	19.5
Greater Columbia	464,338	55.0	11.8	158.0	34.0	-	-	213.0	45.9
King	1,325,363	20.0	1.5	561.0	42.3	22.0	1.7	603.0	45.5
North Central	99,525	-	-	35.0	35.2	-	-	35.0	35.2
North Sound	753,513	47.0	6.2	109.0	14.5	-	-	156.0	20.7
Northeast	51,973	4.0	7.7	-	-	2.0	3.8	6.0	11.5
Peninsula	245,710	4.0	1.6	34.0	13.8	-	-	38.0	15.5
Pierce	548,966	18.0	3.3	349.0	63.6	-	-	367.0	66.9
Southwest	70,659	2.0	2.8	-	-	45.0	63.7	47.0	66.5
Spokane	319,713	8.0	2.5	243.0	76.0	-	-	251.0	78.5
Thurston-Mason	198,492	6.0	3.0	15.0	7.6	8.0	4.0	29.0	14.6
Timberlands	70,808	3.0	4.2	-	-	6.0	8.5	9.0	12.7
TOTAL	**4,556,856**	**182.0**	**4.0**	**1,595.0**	**35.0**	**83.0**	**1.8**	**1,860.0**	**40.8**

Notes:
1. Adults general population figures is based on data from State of Washington, Office of Financial Management, Forecasting Division: June 30, 2004.
2. Adult Population (18 and Over) is an average of CY2003 and CY 2004 populations in order to more accurately represent the timeframe of FY 2004.

When looking at bed availability on a Medicaid eligible basis, 412.9 beds per 100,000 are available. Hospital Diversion/Alternatives beds are available at a rate of 40.4 beds per 100,000 while 354.1 beds per 100,000 are available for Residential Supervised Living and 18.4 beds per 100,000 are available for Residential Supervised Living. Within Hospital Diversion/Alternatives, crisis respite comprised the majority of available beds per 100,000, with 30.6 beds per 100,000.

Table R-10. Number of Available Beds by RSN Per 100,000 Adult Medicaid Eligibles (FY 2004)
2004 Service Setting Definition Summaries

RSNs	FY 2004 Adult Medicaid Eligibles	2004 SERVICE SETTING DEFINITIONS							
		Hospital Diversion / Alternatives	Per 100,000	Residential Supervised Living	Per 100,000	Residential Supported Living	Per 100,000	TOTAL	Per 100,000
Chelan-Douglas	8,149	5.0	61.4	20.0	245.4	-	-	25.0	306.8
Clark	27,170	-	-	71.0	261.3	-	-	71.0	261.3
Grays Harbor	7,947	10.0	125.8	-	-	-	-	10.0	125.8
Greater Columbia	57,616	55.0	95.5	158.0	274.2	-	-	213.0	369.7
King	105,971	20.0	18.9	561.0	529.4	22.0	20.8	603.0	569.0
North Central	14,781	-	-	35.0	236.8	-	-	35.0	236.8
North Sound	63,797	47.0	73.7	109.0	170.9	-	-	156.0	244.5
Northeast	8,078	4.0	49.5	-	-	2.0	24.8	6.0	74.3
Peninsula	22,162	4.0	18.0	34.0	153.4	-	-	38.0	171.5
Pierce	54,576	18.0	33.0	349.0	639.5	-	-	367.0	672.5
Southwest	10,307	2.0	19.4	-	-	45.0	436.6	47.0	456.0
Spokane	41,173	8.0	19.4	243.0	590.2	-	-	251.0	609.6
Thurston-Mason	18,958	6.0	31.6	15.0	79.1	8.0	42.2	29.0	153.0
Timberlands	9,742	3.0	30.8	-	-	6.0	61.6	9.0	92.4
TOTAL	**450,427**	**182.0**	**40.4**	**1,595.0**	**354.1**	**83.0**	**18.4**	**1,860.0**	**412.9**

Notes:
1. FY 2004 Adult Medicaid eligibles data provided by State of Washington, Mental Health Division.

Used Beds Per 100,000 Adult General Population & Medicaid Eligibles (2004 Service Setting Definitions)

The total beds used per 100,000 across the RSNs in FY 2004 were 38.4 beds per 100,000. The overall utilization rate for Hospital Diversion/Alternatives beds was 3.5 beds per 100,000 while the utilization rate was 33.2 beds per 100,000 for Residential Supervised Living and 1.8 beds per 100,000 for Residential Supported Living. Within Hospital Diversion/Alternatives, crisis respite was used at the highest rate (2.8 beds per 100,000). Utilization of intensive (17.5 beds per 100,000) and non-intensive (15.7 beds per 100,000) Residential Supervised Living beds was fairly even. Utilization of intensive beds (0.73 beds per 100,000) was slightly lower in FY 2004 than utilization of non-intensive beds (1.03 beds per 100,000) for Residential Supported Living.

Table R-11. Number of Used Beds by RSN Per 100,000 Adult General Population
2004 Service Setting Definition Summaries

RSNs	Adult General Population (18 and Over)	2004 SERVICE SETTING DEFINITIONS							
		Hospital Diversion / Alternatives	Per 100,000	Residential Supervised Living	Per 100,000	Residential Supported Living	Per 100,000	TOTAL	Per 100,000
Chelan-Douglas	75,823	3.0	4.0	20.0	26.4	-	-	23.0	30.3
Clark	280,705	-	-	60.9	21.7	-	-	60.9	21.7
Grays Harbor	51,267	10.0	19.5	-	-	-	-	10.0	19.5
Greater Columbia	464,338	42.1	9.1	155.0	33.4	-	-	197.1	42.4
King	1,325,363	15.0	1.1	534.0	40.3	21.0	1.6	570.0	43.0
North Central	99,525	-	-	30.0	30.1	-	-	30.0	30.1
North Sound	753,513	47.0	6.2	109.0	14.5	-	-	156.0	20.7
Northeast	51,973	4.0	7.7	-	-	2.0	3.8	6.0	11.5
Peninsula	245,710	2.4	1.0	32.0	13.0	-	-	34.4	14.0
Pierce	548,966	18.0	3.3	322.0	58.7	-	-	340.0	61.9
Southwest	70,659	2.0	2.8	-	-	45.0	63.7	47.0	66.5
Spokane	319,713	8.0	2.5	243.0	76.0	-	-	251.0	78.5
Thurston-Mason	198,492	6.0	3.0	7.0	3.5	8.0	4.0	21.0	10.6
Timberlands	70,808	1.2	1.7	-	-	4.2	5.9	5.4	7.6
TOTAL	**4,556,856**	**158.7**	**3.5**	**1,512.9**	**33.2**	**80.2**	**1.8**	**1,751.8**	**38.4**

Notes:

1. Adults general population figures is based on data from State of Washington, Office of Financial Management, Forecasting Division: June 30, 2004.

2. Adult Population (18 and Over) is an average of CY2003 and CY 2004 populations in order to more accurately represent the timeframe of FY 2004.

The total beds used per 100,000 across the RSNs in FY 2004 were 388.9 beds per 100,000. The overall utilization rate for Hospital Diversion/Alternatives beds was 35.2 beds per 100,000 while the utilization rate was 335.9 beds per 100,000 for Residential Supervised Living and 17.8 beds per 100,000 for Residential Supported Living. Within Hospital Diversion/Alternatives, crisis respite was used at the highest rate (28.6 beds per 100,000). Utilization of intensive (176.8 beds per 100,000) and non-intensive (159.1 beds per 100,000) Residential Supervised Living beds was fairly even. Utilization of intensive beds (7.4 beds per 100,000) was lower in FY 2004 than utilization of non-intensive beds (10.4 beds per 100,000) for Residential Supported Living.

Table R-12. Number of Used Beds by RSN Per 100,000 Adult Medicaid Eligibles
2004 Service Setting Definition Summaries

RSNs	FY 2004 Adult Medicaid Eligibles	2004 SERVICE SETTING DEFINITIONS							
		Hospital Diversion / Alternatives	Per 100,000	Residential Supervised Living	Per 100,000	Residential Supported Living	Per 100,000	TOTAL	Per 100,000
Chelan-Douglas	8,149	3.0	36.8	20.0	245.4	-	-	23.0	282.2
Clark	27,170	-	-	60.9	224.1	-	-	60.9	224.1
Grays Harbor	7,947	10.0	125.8	-	-	-	-	10.0	125.8
Greater Columbia	57,616	42.1	73.1	155.0	269.0	-	-	197.1	342.1
King	105,971	15.0	14.2	534.0	503.9	21.0	19.8	570.0	537.9
North Central	14,781	-	-	30.0	203.0	-	-	30.0	203.0
North Sound	63,797	47.0	73.7	109.0	170.9	-	-	156.0	244.5
Northeast	8,078	4.0	49.5	-	-	2.0	24.8	6.0	74.3
Peninsula	22,162	2.4	10.8	32.0	144.4	-	-	34.4	155.2
Pierce	54,576	18.0	33.0	322.0	590.0	-	-	340.0	623.0
Southwest	10,307	2.0	19.4	-	-	45.0	436.6	47.0	456.0
Spokane	41,173	8.0	19.4	243.0	590.2	-	-	251.0	609.6
Thurston-Mason	18,958	6.0	31.6	7.0	36.9	8.0	42.2	21.0	110.8
Timberlands	9,742	1.2	12.3	-	-	4.2	43.1	5.4	55.4
TOTAL	**450,427**	**158.7**	**35.2**	**1,512.9**	**335.9**	**80.2**	**17.8**	**1,751.8**	**388.9**

Notes:
1. FY 2004 Adult Medicaid eligibles data provided by State of Washington, Mental Health Division.

Percent Distribution of Beds Used Per 100,000 Adult General Population & Medicaid Eligibles

FY 2004 data indicate that the highest percentage of beds used across the state are Residential Supervised Living beds at 86.4% of all beds used in FY 2004. Residential Supported Living beds were 4.6% of the beds utilized while Hospital Diversion/Alternatives beds constituted 9.1% of the total. Six RSNs (Clark, King, North Central, Peninsula, Pierce, and Spokane) used Residential Supervised Living beds at a rate of 90% or higher of total beds used. Only one RSN (Southwest) used Residential Supported Living beds at a rate of 90% or higher of total beds used; the next highest utilizer was Timberlands RSN (77.8%). Only two RSNs (Grays Harbor and Northeast) utilized Hospital Diversion/Alternatives beds at a rate of 60% or higher of total beds used. The next highest utilizer was North Sound RSN (30.1%).

Table R-13. Percent Distribution of Number of Beds Used by RSN Per 100,000 Adult General Population
2004 Service Setting Definitions

RSNs	Adult Population (18 and Over)	Hospital Diversion / Alternatives		Residential Supervised Living		Residential Supported Living		TOTAL	
		Beds Used	Per 100,000	Beds Used	Per 100,000	Beds Used	Per 100,000	Beds Used	Per 100,000
Chelan-Douglas	75,823	13.0%	13.0%	87.0%	87.0%	0.0%	0.0%	100%	100%
Clark	280,705	0.0%	0.0%	100.0%	100.0%	0.0%	0.0%	100%	100%
Grays Harbor	51,267	100.0%	100.0%	0.0%	0.0%	0.0%	0.0%	100%	100%
Greater Columbia	464,338	21.4%	21.4%	78.6%	78.6%	0.0%	0.0%	100%	100%
King	1,325,363	2.6%	2.6%	93.7%	93.7%	3.7%	3.7%	100%	100%
North Central	99,525	0.0%	0.0%	100.0%	100.0%	0.0%	0.0%	100%	100%
North Sound	753,513	30.1%	30.1%	69.9%	69.9%	0.0%	0.0%	100%	100%
Northeast	51,973	66.7%	66.7%	0.0%	0.0%	33.3%	33.3%	100%	100%
Peninsula	245,710	7.0%	7.0%	93.0%	93.0%	0.0%	0.0%	100%	100%
Pierce	548,966	5.3%	5.3%	94.7%	94.7%	0.0%	0.0%	100%	100%
Southwest	70,659	4.3%	4.3%	0.0%	0.0%	95.7%	95.7%	100%	100%
Spokane	319,713	3.2%	3.2%	96.8%	96.8%	0.0%	0.0%	100%	100%
Thurston-Mason	198,492	28.6%	28.6%	33.3%	33.3%	38.1%	38.1%	100%	100%
Timberlands	70,808	22.2%	22.2%	0.0%	0.0%	77.8%	77.8%	100%	100%
TOTAL	**4,556,856**	**9.1%**	**9.1%**	**86.4%**	**86.4%**	**4.6%**	**4.6%**	**100%**	**100%**

Notes:

1. Adults general population figures is based on data from State of Washington, Office of Financial Management, Forecasting Division: June 30, 2004.

2. Adult Population (18 and Over) is an average of CY2003 and CY 2004 populations in order to more accurately represent the timeframe of FY 2004.

Percent Distribution of Beds Used Per 100,000 Adult General Population & Medicaid Eligibles Within Service Setting Definition

FY 2004 data indicate that out of the total number of Hospital Diversion/Alternatives services beds, the RSN using the most beds is North Sound RSN (29.6%), followed by Greater Columbia RSN (26.5%). The RSN using the highest number of total Residential Supervised Living is King RSN (35.3%) followed by Pierce RSN (21.3%). Southwest RSN (56.1%) used the most Residential Supported Living beds; King RSN (26.2%) uses the second highest percentage of total Residential Supported Living beds.

Table R-14. Percent Distribution of Number of Beds Used Within Service Setting Definition by RSN Per 100,000 Adult General Population
2004 Service Setting Definitions

RSNs	Adult Population (18 and Over)	Adult Population (18 and Over)	Hospital Diversion / Alternatives		Residential Supervised Living		Residential Supported Living		TOTAL	
			Beds Used	Per 100,000	Beds Used	Per 100,000	Beds Used	Per 100,000	Beds Used	Per 100,000
Chelan-Douglas	75,823	1.7%	1.9%	113.6%	1.3%	79.4%	0.0%	0.0%	1.3%	78.9%
Clark	280,705	6.2%	0.0%	0.0%	4.0%	65.3%	0.0%	0.0%	3.5%	56.4%
Grays Harbor	51,267	1.1%	6.3%	560.1%	0.0%	0.0%	0.0%	0.0%	0.6%	50.7%
Greater Columbia	464,338	10.2%	26.5%	260.3%	10.2%	100.5%	0.0%	0.0%	11.3%	110.4%
King	1,325,363	29.1%	9.5%	32.5%	35.3%	121.4%	26.2%	90.0%	32.5%	111.9%
North Central	99,525	2.2%	0.0%	0.0%	2.0%	90.8%	0.0%	0.0%	1.7%	78.4%
North Sound	753,513	16.5%	29.6%	179.1%	7.2%	43.6%	0.0%	0.0%	8.9%	53.9%
Northeast	51,973	1.1%	2.5%	221.0%	0.0%	0.0%	2.5%	218.6%	0.3%	30.0%
Peninsula	245,710	5.4%	1.5%	28.0%	2.1%	39.2%	0.0%	0.0%	2.0%	36.4%
Pierce	548,966	12.0%	11.3%	94.1%	21.3%	176.7%	0.0%	0.0%	19.4%	161.1%
Southwest	70,659	1.6%	1.3%	81.3%	0.0%	0.0%	56.1%	3618.5%	2.7%	173.0%
Spokane	319,713	7.0%	5.0%	71.8%	16.1%	228.9%	0.0%	0.0%	14.3%	204.2%
Thurston-Mason	198,492	4.4%	3.8%	86.8%	0.5%	10.6%	10.0%	229.0%	1.2%	27.5%
Timberlands	70,808	1.6%	0.8%	48.7%	0.0%	0.0%	5.2%	337.0%	0.3%	19.8%
TOTAL	**4,556,856**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**

Notes:

1. Adults general population figures is based on data from State of Washington, Office of Financial Management, Forecasting Division: June 30, 2004.

2. Adult Population (18 and Over) is an average of CY2003 and CY 2004 populations in order to more accurately represent the timeframe of FY 2004.

APPENDIX G

ADULT PEER STATE COMPARISON STUDY UPDATE

Support for Key Findings & Statistics

Comparison of Washington Data – 2002 Report & FY 2004

Washington has changed in the following areas since the 2002 Report:

General Data

The number of state hospital staffed beds (including PALS) available to Washington consumers has decreased from 981 to 851. This change was a net decrease of 130 beds, or 13.3%. The number of admissions has decreased 23.3%, or 473 admissions, from 2,032 to 1,559. Washington state hospital ADC was reduced 14.4%, or 141, over this time period; the ADC moved from 979 as reported in the 2002 Report to 838 in FY 2004.

Per 100,000 Adult General Population

The number of beds available for Washington consumers decreased 3.7 beds per 100,000 from 22.4 to 18.7. This represents a change of 16.6%. Admissions to Washington's state hospitals have seen a 35.6% reduction, moving from 46.4 admissions per 100,000 to 34.2 admissions per 100,000. This is a change of 12.2 admissions per 100,000 since the 2002 Report. ADC at the state hospitals in Washington has decreased by a rate of 4.0 beds per 100,000. This resulted in a decrease in Washington's utilization rate from 22.4 beds per 100,000 to 18.4 staffed beds per 100,000. This represents a decrease of 17.7%

Per 100,000 Medicaid Eligibles

Staffed beds available to consumers rose from 138.7 per 100,000 in the 2002 Report to 188.9 per 100,000 in FY 2004. This represents an increased availability of 50.2 staffed beds per 100,000, or 36.2%. There was an increase in admission per 100,000 Medicaid eligibles from 287.3 per 100,000 to 346.1 admissions per 100,000. This marks a 20.5% increase, or about 58.8 admissions per 100,000. The ADC per 100,000 also increased; Washington's state hospital ADC moved from 138.4 ADC per 100,000 to 186.3 ADC per 100,000. Utilization increased 34.6 % (47.8 ADC per 100,000).

Admissions Per Available Bed

Washington averaged 2.07 admissions per available bed according to data in the 2002 Report. Current data show the admissions per available bed at 1.83. This represents a decrease of approximately 11.6%. This decreased number of admissions per bed across studies, though a small increment, illustrates that the available beds at the state hospital are been occupied on an annual basis longer than beds were in the 2002 Report. The calculated average length of stay per admission on an annual basis according to 2002 Report data was 176.21 days. Recent data show a higher average length of stay of 199.24 days. This represents an increase of 23.03 days, or 13.1%.

Comparison of Washington and Peer States – 2002 Report & FY 2004

Washington compared in the following areas relative to the peer state comparison group surveyed in the 2002 Report:

General Data

The reduction in the number of state hospital staffed beds available moved Washington closer to the peer state average (481) and median (372). However, Washington is still 76.9 % above the average and 128 % above the median. Washington's reduced number of admissions (1,559) has brought the state 15% below the peer state average (1,835).

Per 100,000 Adult General Population

Washington data in the 2002 Report show it to be approximately 78% above the peer state median of 12.6 staffed beds per 100,000. Washington data in FY 2004 show the number of available beds to be about 48% above the peer state median. This shows that Washington reduced the number of available beds relative to the peer state median by roughly 30%.

Admissions per 100,000 data in the 2002 Report showed Washington 1.1% below the peer state average for the number of admissions per 100,000. However, Washington was 41.7% above the peer state median. In FY 2004, demonstrated a significant decrease of 26.3%, or 12.2 admissions per 100,000. This reduction places Washington only 4.5% above the peer state median.

ADC of 22.4 per 100,000 in the 2002 Report was 84.7% above both the peer state mean (12.1) and median (12.1). Washington's 17.7% reduction in ADC per 100,000 to 18.4 also reduced its percentage to 51.9% above the peer state mean and median. This is shows that Washington has had a decline in the overall utilization of state hospital beds per 100,000 the adult general population.

Per 100,000 Medicaid Eligibles

Washington's increase in the number of available staffed beds per 100,000 Medicaid eligibles resulted in an increase from 50.1% to 104.4% above the peer state mean. Similarly, Washington shifted from approximately 40.5% above the peer state median in the 2002 Report to 91.3% above the median according to current data.

Admissions per 100,000 also increased. Washington moved from 40.5, admissions per 100,000, or 16.4%, above the peer state median (246.9) in the 2002 Report to 99.3 admissions per 100,000, or 40.2% above the median in FY 2004. Relative to the peer state average, Washington had 109.5 admissions per 100,000, or 27.6%, less than its peers but the increase shown in FY 2004 data indicates 50.7 admissions per 100,000 less than the peer state average, or 12.8%.

Utilization of state hospital beds has increased amongst the Medicaid eligible population when compared to the peer states. Washington was 39.7% (39.3 ADC per 100,000) above the peer state median in the 2002 Report and increased this gap to 87.9% above the median (87.2 ADC per 100,000) in FY 2004.

Admissions Per Available Bed

The number of admissions per available bed has decreased and the calculated average length of stay has increased Washington. Data included in the 2002 Report show that Washington had a rate of 2.07 admissions per available bed while the average for the peer states was 4.29 admissions per bed. Washington was nearly 51.7% percent below the peer state average for admission per available bed. Similarly, Washington is roughly 48.9% below the peer state median.

FY 2004 data show that the admissions per bed have decreased from the 2002 Report level. Admissions per bed for Washington have decreased 11.6% to 1.83 admissions per bed. This decrease increases the gap between Washington and the peer state mean from 51.7% to 57.3 % below the mean. Likewise, Washington has moved from 48.9% to 54.9% below the peer state median.

Not only do the data show lower admissions per available bed in the 2002 Report, the length of stay per admission is longer when compared to Washington's peer state group. Analysis of the 2002 Report data indicates an average length of stay of 176.21 days per admission to state hospital available beds. This average length of stay is just over 91.18 days (107.2%) longer than the peer state average, according to 2002 Report data. When looking at the peer state median (100.53 days per admit), Washington is 75.6% (75.68 days) above the peer state median of days per admission.

FY 2004 data shows an increase in the average length of stay per admission 199.24 days. This was an increase of 23.03 days, or 13.1%. This increase in average length of stay puts Washington approximately 98.2% above the peer state median.

PS-1. Peer State Comparison Update - Civil Beds with PALS (FY 2004) - *Per 100,000 Adult General Population*

State	Population	Over 18 Population	State Staffed Beds	State Staffed Beds Per 100,000	Admissions	Admissions Per 100,000	ADC	ADC Per 100,000
Arizona	5,130,632	3,765,884	150	4.0	411	10.9	306.3	8.1
Colorado	4,301,261	3,200,138	400	12.5	2,958	92.4	360.3	11.3
Iowa	2,926,324	2,191,817	219	10.0	1,943	88.6	178.0	8.1
Michigan	9,938,444	7,344,510	929	12.6	2,248	30.6	944.8	12.9
Minnesota	4,919,479	3,630,576	539	14.8	1,198	33.0	546.0	15.0
Ohio	11,353,140	8,469,442	1,142	13.5	6,143	72.5	1,094.0	12.9
Oregon	3,421,399	2,576,313	347	13.5	837	32.5	727.0	28.2
Washington	**5,894,121**	**4,379,332**	**981**	**22.4**	**2,032**	**46.4**	**979.0**	**22.4**
Wisconsin	5,363,675	3,995,938	121	3.0	776	19.4	106.4	2.7
Peer State Average			*481*	*10.9*	*1,835*	*46.9*	-	*12.1*
Peer State Median			*372*	*12.6*		*32.8*		*12.1*
Washington (2004)	6,133,050	4,556,856	851	18.7	1,559	34.2	838	18.4
VARIANCE (WA 2002)	-	-	*-130*	*-3.7*	*-473.0*	*-12.2*	*-141.0*	*-4.0*
% Change	-	-	***-13.3%***	***-16.6%***	***-23.3%***	***-26.3%***	***-14.4%***	***-17.7%***

Notes (from 2002 Report):

1. ***Arizona:*** ADC is based on the combined total of forensic and civil commitment beds. The total is 315 beds.
2. ***Minnesota:*** ADC is given as a system-wide number (includes 114 children/adolescent beds).
3. ***Ohio:*** Admissions number based on year ending November 2001.
4. ***Washington:*** State staffed beds are based on January 20002 allocation; ADC is based on Calendar Year 2000.
5. ***Wisconsin:*** Number are given for the two state-operated facilieities (Mendota Mental Health Institute and Winnebego Mental Health Institute.
6. State data comes from FY2001 unless otherwise noted.
7. Population data comes from Census 2000.

Update Notes:

1. Calculation of staffed beds per 100,000, admissions per 100,000, and ADC per 100,000 have been revised to exclude Washington from the average. (The peer state averages of 12.2 staffed beds per 100,000, 47.0 admissions per 100,000, and 13.3 ADC per 100,
2. The number of admission (2,081) for the State of Washington given in the 2002 Report included civil admits (including PALS) and 49 admits to CSTC. The number has been corrected in this analysis to reflect civil admits (including PALS) only.
3. Population data for 'Washington (2004)' is an average of Calendar Years 2003 and 2004 estimates provided by State of Washington, Office of Financial Management, Forecasting Division: June 30, 2004. This data was separated into adults only (over 18) using the Census 2000 rate of 25.7% of persons under 18 years old.
4. Washington: Updated bed numbers reflect July 1, 2003 allocation.

PS-2. Peer State Comparison Update - Civil Beds with PALS (FY 2004) - *Per 100,000 Adult Medicaid Eligibles*

State	Population	Over 18 Population	State Staffed Beds	State Staffed Beds Per 100,000	Admissions	Admissions Per 100,000	ADC	ADC Per 100,000
Arizona	5,130,632	401,066	150	37.4	411	102.5	306.3	76.4
Colorado	4,301,261	234,753	400	170.4	2,958	1,260.0	360.3	153.5
Iowa	2,926,324	206,882	219	105.9	1,943	939.2	178.0	86.0
Michigan	9,938,444	1,130,608	929	82.2	2,248	198.8	944.8	83.6
Minnesota	4,919,479	439,133	539	122.7	1,198	272.8	546.0	124.3
Ohio	11,353,140	975,415	1,142	117.1	6,143	629.8	1,094.0	112.2
Oregon	3,421,399	378,894	347	91.6	837	220.9	727.0	191.9
Washington	**5,894,121**	**707,245**	**981**	**138.7**	**2,032**	**287.3**	**979.0**	**138.4**
Wisconsin	5,363,675	395,336	121	30.6	776	196.3	106.4	26.9
Peer State Average			*481*	*92.4*	*1,835*	*396.8*	-	*102.4*
Peer State Median			*372*	*98.8*		*246.9*		*99.1*
Washington (2004)	6,133,050	450,427	851	188.9	1,559	346.1	839	186.3
VARIANCE (WA 2002)	*238,929*	*-256,818*	*-130*	*50.2*	*-473.0*	*58.8*	*-140.0*	*47.8*
% Change	***3.9%***	***-57.0%***	***-13.3%***	***36.2%***	***-23.3%***	***20.5%***	***-14.3%***	***34.6%***

Notes (from 2002 Report):

1. ***Arizona:*** ADC is based on the combined total of forensic and civil commitment beds. The total is 315 beds.
2. ***Minnesota:*** ADC is given as a system-wide number (includes 114 children/adolescent beds).
3. ***Ohio:*** Admissions number based on year ending November 2001.
4. ***Washington:*** State staffed beds are based on January 20002 allocation; ADC is based on Calendar Year 2000.
5. ***Wisconsin:*** Number are given for the two state-operated facilieities (Mendota Mental Health Institute and Winnebego Mental Health Institute.
6. State data comes from FY2001 unless otherwise noted.
7. Population data comes from Census 2000. Medicaid Eligibles data come from *SAMHSA State Profiles, 2000, on Public Sector Managed Behavioral Health Care* (June 2001).

Update Notes:

1. Calculation of staffed beds per 100,000, admissions per 100,000, and ADC per 100,000 have been revised to exclude Washington from the average. (The peer state averages of 12.2, 47.0, and 13.3, respectively, in the 2002 Report included Wasshington.)
2. The number of admission (2,081) for the State of Washington given in the 2002 Report included civil admits (including PALS) and 49 admits to CSTC. The number has been corrected in this analysis to reflect civil admits (including PALS) only.
3. Adult Medicaid Population data for 'Washington (2004)' comes from data provided by the Mental Health Division.
4. Washington: Updated bednumbers come from July 1, 2003 allocation.

PS-3. Peer State Comparison Update - Admissions Analysis

State	Admissions Per Available Bed	Average Length of Stay Per Admit
Arizona	2.74	133.21
Colorado	7.40	49.36
Iowa	8.87	41.14
Michigan	2.42	150.84
Minnesota	2.22	164.22
Ohio	5.38	67.85
Oregon	2.41	151.32
Washington	**2.07**	**176.21**
Wisconsin	6.41	56.91
Peer State Average	*4.29*	*85.03*
Peer State Median	*4.06*	*100.53*
Washington (2004)	1.83	199.24
VARIANCE (WA 2002)	*-0.24*	*23.03*
% Change	***-11.56%***	***13.07%***

1. 'Admissions Per Available Bed' calculated using 2002 Report peer state data and updated Washington (2004) data.
2. 'Average Length of Stay Per Admit is calculated using a 365-day time period.

APPENDIX H

INPATIENT COMMUNITY HOSPITALS (CHILDREN)

Support for Key Findings & Statistics

Table IC-1. Number of Children Inpatient Community Hospital Beds Available and Used by RSNs

RSN	FY 2003 Total Beds Available	FY 2003 Total Beds Used	Utilization
Chelan-Douglas	1.28	1.28	100.00%
Clark	6.82	6.82	100.00%
Grays Harbor	1.57	1.57	100.00%
Greater Columbia	10.18	10.18	100.00%
King	53.70	53.70	100.00%
North Central	2.22	2.22	100.00%
North Sound	19.84	19.84	100.00%
Northeast	0.84	0.84	100.00%
Peninsula	1.78	1.78	100.00%
Pierce	25.93	25.93	100.00%
Southwest	4.81	4.81	100.00%
Spokane	16.25	16.25	100.00%
Thurston-Mason	6.12	6.12	100.00%
Timberlands	1.63	1.63	100.00%
TOTAL	**152.96**	**152.96**	**100.00%**

Note:
1. Data come from MHD.

Utilization Information

Total admissions to community hospitals were 6,128 in FY 2003. King RSN had the most admissions (2,240) while Northeast RSN had the least number of admissions (24).

Total bed days were 55,831 in FY 2003. King RSN had the highest number of bed days (19,599) while Northeast RSN had the lowest number (305).

The average length of stay for children in the community hospitals was 9.11. The RSN with the longest average length of stay was Spokane (13.03) while the shortest length of stay was Peninsula (6.43).

Nearly $30.4 million was spent on children's inpatient community hospital services in FY 2003, an average of $544.56 per bed day. Pierce RSN average the highest amount per bed day ($739.41) while Clark RSN averaged the lowest amount ($417.91).

Table IC-2. Inpatient Community Hospital Utilization Information

RSN	Admissions	Bed Days	Average Length of Stay	Total Allowed	Allowed Per Day
Chelan-Douglas	46	467	10.15	$ 246,394.76	$ 527.61
Clark	303	2,490	8.22	$ 1,040,588.75	$ 417.91
Grays Harbor	64	572	8.94	$ 291,997.84	$ 510.49
Greater Columbia	425	3,717	8.75	$ 2,222,914.89	$ 598.04
King	2,240	19,599	8.75	$ 10,085,556.82	$ 514.60
North Central	87	810	9.31	$ 449,057.45	$ 554.39
North Sound	922	7,243	7.86	$ 3,403,602.80	$ 469.92
Northeast	24	305	12.71	$ 136,605.59	$ 447.89
Peninsula	101	649	6.43	$ 419,140.70	$ 645.83
Pierce	915	9,466	10.35	$ 6,999,298.60	$ 739.41
Southwest	245	1,756	7.17	$ 1,064,213.82	$ 606.04
Spokane	455	5,930	13.03	$ 2,507,744.43	$ 422.89
Thurston-Mason	235	2,233	9.50	$ 1,214,717.95	$ 543.98
Timberlands	66	594	9.00	$ 321,582.76	$ 541.39
TOTAL	**6,128**	**55,831**	**9.11**	**$ 30,403,417.16**	**$ 544.56**

1. Data comes from MHD and is for FY 2003.
2. Data includes Medicaid and Non-Medicaid children served.
3. 'Average Length of Stay' and 'Allowed Per Day' was calculated by PCG using MHD data.

Available and Used Beds Per 100,000 Children General Population

Washington used 9.7 beds per 100,000 children general population in FY 2003. Southwest RSN (19.68) had the highest utilization per 100,000 of all RSNs while Peninsula (2.09) had the lowest utilization per 100,000.

Statewide utilization per 100,000 children Medicaid eligibles shows a rate of 23.7. The highest utilizer amongst RSNs was King RSN (41.74). Peninsula (6.16) was the lowest utilizer.

Table IC-3. Number of Children Inpatient Community Hospital Beds Available and Used by RSNs Per 100,000 Children General Population

RSN	Children's General Population (FY 2004)	FY 2003 Total Beds Available	Available Beds Per 100,000	FY 2003 Total Beds Used	Used Beds Per 100,000	Utilization
Chelan-Douglas	26,227	1.28	4.88	1.28	4.88	100.00%
Clark	97,095	6.82	7.03	6.82	7.03	100.00%
Grays Harbor	17,733	1.57	8.84	1.57	8.84	100.00%
Greater Columbia	160,612	10.18	6.34	10.18	6.34	100.00%
King	458,437	53.70	11.71	53.70	11.71	100.00%
North Central	34,425	2.22	6.45	2.22	6.45	100.00%
North Sound	260,637	19.84	7.61	19.84	7.61	100.00%
Northeast	17,977	0.84	4.65	0.84	4.65	100.00%
Peninsula	84,990	1.78	2.09	1.78	2.09	100.00%
Pierce	189,884	25.93	13.66	25.93	13.66	100.00%
Southwest	24,441	4.81	19.68	4.81	19.68	100.00%
Spokane	110,587	16.25	14.69	16.25	14.69	100.00%
Thurston-Mason	68,658	6.12	8.91	6.12	8.91	100.00%
Timberlands	24,492	1.63	6.64	1.63	6.64	100.00%
TOTAL	**1,576,194**	**152.96**	**9.70**	**152.96**	**9.70**	**100.00%**

Notes:
1. Data come from MHD.
2. An average adult & children general population for CY 2003 and CY 2004 in order to more accurately represent the timeframe of FY 2004.
3. Percentage of the population under 18 came from Census 2000 and was used to calculate the children's general population.
4. Children general population figures for CY2003 and CY 2004 come from State of Washington, Office of Financial Management, Forecasting Division: June 30, 2004.

Table IC-4. Number of Children Inpatient Community Hospital Beds Available and Used by RSNs Per 100,000 Children Medicaid Eligibles

RSN	Children's Medicaid Eligibles (FY 2004)	FY 2003 Total Beds Available	Available Beds Per 100,000	FY 2003 Total Beds Used	Used Beds Per 100,000	Utilization
Chelan-Douglas	14,636	1.28	8.74	1.28	8.74	100.00%
Clark	43,196	6.82	15.79	6.82	15.79	100.00%
Grays Harbor	9,944	1.57	15.76	1.57	15.76	100.00%
Greater Columbia	103,101	10.18	9.88	10.18	9.88	100.00%
King	128,633	53.70	41.74	53.70	41.74	100.00%
North Central	27,239	2.22	8.15	2.22	8.15	100.00%
North Sound	94,468	19.84	21.01	19.84	21.01	100.00%
Northeast	10,987	0.84	7.61	0.84	7.61	100.00%
Peninsula	28,879	1.78	6.16	1.78	6.16	100.00%
Pierce	77,058	25.93	33.66	25.93	33.66	100.00%
Southwest	13,620	4.81	35.32	4.81	35.32	100.00%
Spokane	54,278	16.25	29.93	16.25	29.93	100.00%
Thurston-Mason	26,611	6.12	22.99	6.12	22.99	100.00%
Timberlands	12,703	1.63	12.81	1.63	12.81	100.00%
TOTAL	**645,353**	**152.96**	**23.70**	**152.96**	**23.70**	**100.00%**

Notes:

1. Data come from MHD.

2. Children Medicaid Eligibles came from MHD.

Inpatient Community Hospital Provider Capacity

There has been a 12% decrease in the number of available community hospital beds available to the entire system (not just RSN) between FY 2000 and FY 2004. There has been a 14% decrease in the number of beds available with the capacity to serve ITA between FY 2000 and FY 2004.

Total adult and geriatric psychiatric beds available are not all available for RSN use. This capacity also includes beds only available to private pay and other non-RSN sources. (This total available to private pay and other non-RSN sources is not differentiated by WBHIA data)

Table IC-5. Inpatient Community Hospital Provider Capacity

WASHINGTON STATE COMMUNITY HOSPITAL STAFFED PSYCHIATRIC BEDS

	1994			2000			2001			2002			2003			2004		
	CHILD/ ADOLESCENT	TOTAL	ACCEPT ITA?	CHILD/ ADOLESCENT	TOTAL	ACCEPT ITA?	CHILD/ ADOLESCENT	TOTAL	ACCEPT ITA?	CHILD/ ADOLESCENT	TOTAL	ACCEPT ITA?	CHILD/ ADOLESCENT	TOTAL	ACCEPT ITA?	CHILD/ ADOLESCENT	TOTAL	ACCEPT ITA?
Auburn Regional Medical Center	0	0	N	0	0	N	0	0	N	0	0	N	0	0	N	0	0	N
Central Washington Hospital	0	0	Y	0	0	-	0	0	-	0	0	-	0	0	-	0	0	-
Children's Hospital & Medical Center	15	15	Y	15	15	Y	15	15	Y	15	15	Y	15	15	Y	15	15	Y
Fairfax Hospital	60	60	Y	60	60	Y	46	46	Y	46	46	Y	46	46	Y	45	45	Y
Harborview Medical Center	0	0	Y	0	0	Y	0	0	Y	0	0	Y	0	0	Y	0	0	Y
Harrison Memorial Hospital	0	0	N	0	0	N	0	0	N	0	0	N	0	0	N	0	0	N
Highline Community Hospital	0	0	Y	0	0	N	0	0	N	0	0	N	0	0	N	0	0	N
Lake Chelan Community Hospital	0	0	N	0	0	N	0	0	N	0	0	N	0	0	N	0	0	N
Lourdes Counseling Center	10	10	Y	10	10	Y	10	10	Y	10	10	Y	10	10	Y	10	10	Y
Northwest Hospital	0	0	N	0	0	Y	0	0	Y	0	0	Y	0	0	Y	0	0	Y
Overlake Hospital	8	8	N	14	14	N	14	14	N	14	14	N	14	14	N	14	14	N
Providence St. Peter	0	0	Y	0	0	Y	0	0	Y	0	0	Y	0	0	Y	0	0	N
Puget Sound Behavioral Health	0	0	Y	0	0	Y	0	0	Y	0	0	Y	0	0	Y	0	0	Y
Sacred Heart Medical Center	24	24	Y	24	24	Y	24	24	Y	24	24	Y	24	24	Y	24	24	Y
Skagit Valley Hospital	0	0	Y	0	0	Y	0	0	Y	0	0	Y	0	0	Y	0	0	Y
Snoqualmie Valley Hospital	0	0	-	0	0	N	0	0	N	0	0	N	0	0	N	0	0	N
Southwest Washington Medical Center	0	0	Y	0	0	Y	0	0	Y	0	0	Y	0	0	Y	0	0	Y
St Francis Community Hospital	0	0	N	0	0	N	0	0	N	0	0	N	0	0	N	0	0	N
St John's Medical Center	0	0	Y	0	0	Y	0	0	Y	0	0	Y	0	0	Y	0	0	Y
St. Joseph (Bellingham)	0	0	Y	0	0	Y	0	0	Y	0	0	Y	0	0	Y	0	0	Y
St. Joseph (Tacoma)	0	0	N	0	0	N	0	0	N	0	0	N	0	0	N	0	0	N
St. Mary Medical Center	0	0	Y	0	0	Y	0	0	Y	0	0	-	0	0	-	0	0	-
Stevens Hospital	2	2	Y	2	2	Y	2	2	Y	2	2	Y	0	0	Y	0	0	Y
Swedish Medical Center-Providence	0	0	N	0	0	N	0	0	N	0	0	N	0	0	N	0	0	N
United General	0	0	Y	0	0	Y	0	0	Y	0	0	Y	0	0	Y	0	0	-
University of WA Medical Center	0	0	N	0	0	N	0	0	N	0	0	N	0	0	N	0	0	Y
Valley General Hospital	0	0	-	0	0	Y	0	0	Y	0	0	Y	0	0	Y	0	0	Y
Valley Medical Center	0	0	N	0	0	N	0	0	N	0	0	N	0	0	N	0	0	-
West Seattle Psychiatric Hospital	0	0	Y	0	0	Y	0	0	Y	2	2	Y	2	2	Y	2	2	Y
Yakima Valley Memorial Hospital	0	0	Y	0	0	Y	0	0	Y	0	0	Y	0	0	Y	0	0	Y
TOTAL	**119**	**119**		**125**	**125**		**111**	**111**		**113**	**113**		**111**	**111**		**110**	**110**	
TOTAL BEDS AVAILABLE FOR ITA	**111**	**111**		**111**	**111**		**97**	**97**		**99**	**99**		**97**	**97**		**96**	**96**	

Total Beds Available for ITA' are not exclusively ITA beds. These numbers represent the portion of total number of community hospital beds that can be use for ITA, but are not designated solely for this purpose1. Data come from Washington Behavioral Health Inpatient Association

Days Delayed in Inpatient Community Hospitals

A total of 29 of 152 involuntary consumers in FY 2003, or 19%, were delayed in inpatient facilities. The average length of delay per consumer was 35 days. Total days delayed for these 29 consumers were 989. This delay constituted approximately 53% of the total length of stay of these consumers. The delay in discharge from community hospitals can be attributed to the shortage of long-term care beds in the community.

Table IC-6. Consumer Days Delayed in Inpatient Facilities

Individual	Length of Stay	#Days Delayed
1	83	53
2	95	65
3	84	54
4	84	54
5	41	11
6	34	14
7	56	26
8	31	1
9	55	25
10	55	25
11	37	7
12	61	31
13	69	39
14	90	55
15	53	23
16	76	46
17	59	29
18	41	11
19	49	19
20	119	89
21	58	28
22	62	32
23	63	33
24	70	40
25	79	49
26	62	32
27	74	44
28	53	23
29	61	31
TOTAL	**1,854**	**989**

Notes:
1. Data is for FY 2003 and comes from Washington Behavioral Health Inpatient Association.

APPENDIX I

CHILDREN'S PEER STATE COMPARISON STUDY

Support for Key Findings & Statistics

CONCLUSIONS

Reviewing admissions and length of stay statistics, program breadth and variation, expenditures, and selected demographic data across the peer states lead to the following conclusions:

1. Washington is admitting more children to their state-operated mental health facilities than all other peer states, although for shorter periods of time than most other states. This signifies a need for a reduction in inpatient admissions, which can be achieved through the inclusion of a new residential program of service for children in MHDs structure.

2. To supplement the services of state-operated facilities and private provider contracts, many states have incorporated the Therapeutic Foster Care model, the effectiveness of which has been confirmed in a number of studies. In keeping with MHDs commitment to provide a high level of quality service and infuse the Division with the latest in healthcare innovations, the State should look into the implementation of this model. The addition of the Therapeutic Foster Care model could benefit Washington in the following ways:

    - Expand the continuum of children's mental health services in Washington;
    - Reduce the State's high rate of children's admissions, causing the average daily cost in the state hospitals to decrease;
    - Washington, similar to many in the peer group, would be utilizing innovative mental health services to their residents.

3. Many states do not operate a residential program comparative to Washington's CLIP, instead choosing to focus on affording long-term children's mental health care through contracts with private service providers. In this capacity, Washington may be

somewhat ahead of the nation; however, efforts should be made to ensure that maintaining the CLIP facilities does not detract from the quality or breadth of services offered within the state and community hospitals.

Table CPS-2. SMHA Mental Health Actual Dollar and Per Capita Expenditures by State (FY 2001)

State	Total SMHA Expenditure	Total Rank	FY 2001 Per Capita	Per Capita Rank
Arizona	$472,341,791	15	$89.36	18
Colorado	$282,614,825	25	$64.24	31
Iowa	$213,046,761	30	$73.18	26
Massachusetts	$682,218,519	9	$107.38	10
Michigan	$895,065,635	4	$89.96	17
Minnesota	$517,963,917	14	$104.60	12
Ohio	$692,287,984	8	$61.12	34
Washington	**$525,564,708**	**13**	**$88.13**	**19**
Wisconsin	$389,416,626	20	$72.39	27
Peer State Average	$518,946,751	--	$84.78	--
National Average	$448,518,107	--	$83.51	--

1. *National figures reflect all 50 states plus the District of Columbia*
2. *Data from NASMHPD Research Institute, www.nri-inc.org: "Funding Sources and Expenditures of State Mental Health Agencies, Fiscal Year 2001."*
3. *A dash (-) indicates that data for the specific field was not found or calculated in the NASMHPD Report.*

Table CPS-3. Peer State Comparison: Population and Medicaid Eligibles for the Under 18 Population (FY 2003, unless otherwise noted)

State	Population	Under 18 Population	Age Range to be Classified as a "Child"	Medicaid Enrollees under 18
Arizona	5,130,632	1,366,947	0-17	391,000
Colorado	4,301,261	1,100,795	Child: 0-11 Adolescent: 12-17	198,100
Iowa	2,926,324	733,638	0-17	156,900
Massachusetts	6,349,097	1,500,064	0-18	452,900
Michigan	9,938,444	2,595,767	0-17	738,400
Minnesota	4,919,479	1,286,894	0-17, some counties up to 21	307,700
Ohio	11,353,140	2,888,339	0-17	769,900
Washington	**5,894,121**	**1,513,843**	**0-17**	**534,300**
Wisconsin	5,363,675	1,368,756	Under 13	286,500
PEER STATE AVERAGE	*6,241,797*	*1,595,005*	---	*426,189*

1. *Population data come from 2000 census. All other State data comes from FY 2003 unless otherwise noted.*
2. *"Medicaid Enrollees" is from the Kaiser Family Foundation website, "Distribution of State Medicaid Enrollees by Enrollment Group, FFY2000." www.statehealthfacts.org. This report was based on data obtained from Medicaid Statistical Information System reports from the Centers for Medicare and Medicaid Services.*
3. *Age Range to be Classified as a "Child" obtained from key staff from the Mental Health Departments of the peer states.*
4. *The response "N/A" in a cell block denotes that information was not available from staff in that state.*

Table CPS-4. Peer State Comparison: Long-Term Residential Programs (FY 2003, unless otherwise noted)

State	Name of Program	Total Yearly Admissions	Capacity	Average Length of Stay (in days)	Services Offered	Cost Per Day	Changes / New Initiatives
Arizona	Arizona State Hospital	15	16	247.69	Treatment, rehabilitation, and medical services plus pharmacy	$333.79	"Aligning Out of Home Services with the Arizona Vision and 12 Principles" plan; developing interventions to inpatient care
Colorado	Mountain Star	42	20	180	Open setting for treatment of disturbed adolescents, ages 12-20	Varies	New rules are being drafted by the State's Medicaid agency
Iowa	12 PMICs (psychiatric medical institutes for children)	N/A	259	75	24 hour per day / 7 day per week care in non-secure institutions for children under the age of 21	$246.80	None
Massachusetts	2 Clinically Intensive Residential Treatment Programs (CIRT) 5 Intensive Residential Treatment Programs (IRTP)	7 42	24 73	732 523	CIRTs are for younger children; IRTPs serve adolescents who require longer term treatment in a secure setting	CIRT: $98.00-336.00 IRTP: $317.00-483.00	System will be reprocured in 2 years to better integrate services purchased by child welfare agency and through Medicaid
Michigan	Hawthorn Center	317	118	57.17	Psychiatric, social work, psychological testing, education, dental, nutrition, pharmacy, employment training	$499.00	None
Minnesota	Willmar Regional Treatment Center, Brainerd Regional Treatment Center	354	51	51	Long-term inpatient care	N/A	None
Ohio	2 private providers for residential, partial hospitalization care	142	N/A	285	Residential treatment for children and adolescents	$109.51	None
Washington	Children's Long-Term Inpatient Programs (CLIP)	115	91	240	Evaluation & Treatment, Screening, Counseling, Medication, Day Treatment, Crisis	$339.00	None
Wisconsin	Winnebago Mental Health Institute	674	70	45	Residential treatment program for children / adolescents, ages 4-17	$579.00	None

1. *Information obtained by PCG original research and interviews with state mental health department key staff.*

Table CPS-5. Peer State Comparison: Services Offered Through Private Providers and Therapeutic Foster Care (FY 2003, unless otherwise noted)

State	Services Through Private Providers? (Y / N)	Description	Therapeutic Foster Care Program? (Y / N)	Description
Arizona	Y	Any provision can be contracted for if not offered by Arizona's mental health division or if patient's needs are not fully covered by division's services	Y	A foster parent or family provides the following for the in-home portion of a behavioral health service plan: supervision, behavioral health support services (especially prescribed interventions), psychosocial rehabilitation, skills training and development, transportation, participation in treatment, discharge planning
Colorado	Y	Youth correctional and other residential treatment services	N	Colorado is limited in their offering of this type of service and recognizes the need for an increase in these services
Iowa	Y	A wide range of services, which may or may not include mental health services for children	Y	CORE ONE: Therapy/counseling services for child, legal family or both CORE TWO: Family/Social/Restorative Living skill development CORE THREE: Behavioral management for child or treatment family
Massachusetts	Y	Continuing care inpatient, intensive residential and clinically intensive residential treatment, other community-based treatment, and special education	Y	For children who need treatment outside the home, but do not require the structure of group care; homes occasionally used for respite care
Michigan	Y	Emergency medical care, lab work	N	Development of this service is in process
Minnesota	Y	An array of services that cannot be pinpointed	Y	Therapeutic supports for foster care offered by both public and private providers; called Children's Therapeutic Services and Supports (CTSS), it is a benefit set under the Medicaid rehabilitation option. CTSS includes psychotherapy, skills training, behavioral aides, crisis assistance
Ohio	N	Local Mental Health authorities, not the state, contract for services	N	Only private providers licensed through the state supply this service
Washington	Y	Regional Support Networks (RSN) contracts for services such as screening, therapy, medication management, day treatment, crisis intervention	N	RSNs contract with private providers to supply these services
Wisconsin	N	State does not contract out for services—counties are responsible	N	Therapeutic foster homes are offered by the county or by private providers, not by the state

1. *Information obtained by PCG original research and interviews with state mental health department key staff.*

APPENDIX J

MEDICAL RECORD REVIEW OF CLIP FACILITIES

Supporting Facility Summaries & Data Tables

CHILD STUDY TREATMENT CENTER (CSTC)

This facility is located on the grounds of Western State Hospital. CSTC typically manages a wide range of age groups and accepts children and adolescents with complex medical and psychiatric problems. The records reviewed included the following key statistics which are relevant to the intent of this report:

- The age range of records reviewed was 11-17 years old. The facility treats children and adolescents that are seventeen years old or less.

- A review of the referral sources to CTSC identified that six patients were admitted upon referral from a community hospital, two patients were admitted directly from a home setting, one patient was admitted from an unsuccessful group home placement and one patient was transferred from a long-term residential placement.

- The average length of stay statistics for this sample provided interesting information regarding this episode of care. Of the ten records reviewed the average length of stay in a Community Hospital prior to admission to the facility was 3.6 months with the range of acute hospitalization being six weeks to five months. Upon admission to CSTC the average length of stay was 7.2 months. These statistics when combined indicate that the average continuous length of stay for twenty four hour care in the acute hospital plus CLIP facility was 10.8 months.

- Discharge placements from CSTC were the following: seven patients returned home either with parents or extended family members, two patients were referred to a therapeutic foster care placement and one was admitted to a group home for

continued psychiatric care. Of note, one of the records reviewed included a patient that was referred to CSTC from a community hospital subsequent to their first in-patient psychiatric hospitalization.

THE PEARL STREET CENTER

The Pearl Street Center has twelve CLIP beds and admits patients seventeen years or younger. The Center specializes in treating adolescents. The records reviewed were active and included the following statistics:

- The age range was 14-16 years old (the facility at the time of review had all female residents).
- The referral sources reviewed identified that four of the patients were admitted to the Pearl Street Center from a community hospital and one patient was admitted from a home setting.
- The length of stay information provided in the record averaged five months with the shortest resident having been there one month and the longest one year. Length of prior hospitalization ranged from one-two months. The average episode of acute inpatient care plus current duration of treatment in the CLIP facility at the time of review was 6.5 months.
- The discharge planning process was reviewed. Records indicated that active treatment was focused towards the goal of four patients returning home either with parents or a family member and one was to be placed in a group home setting.
- Of interest this facility also had one resident who was referred to the CLIP facility subsequent to their first acute care hospitalization.

Each facility clearly managed very difficult children and adolescents who presented with the history of safety risk and exhibited severe behavior problems that were unmanageable in the community setting. It was evident that creative attempts had been made to provide additional services in the home or residential setting prior to referral to inpatient care in order to prevent hospitalization. Families were involved and included in the treatment process whenever possible. This was evident by the large percentage of children and adolescents that were targeted to return to their home setting upon discharge. Family reunification efforts were explored in all cases. Strong efforts were continuously made by the clinical staff in an effort to engage families in the treatment process.

Table MR-1. DART Medical Record Review for Child Long-Term Inpatient Program (CLIP)

	PEARL STREET RESULTS			CSTC RESULTS			CONSOLIDATED RESULTS	
RECORD HEADER:	**TTL or AVG**	**PERCENT**		**TTL or AVG**	**PERCENT**		**TTL or AVG**	**PERCENT**
MR #	-	-		-	-		-	-
RECORD TYPE	Active	-		Discharged	-		-	-
LOCATION	-	-		-	-		-	-
DATE OF ASSESSMENT	-	-		-	-		-	-
SCREENER	-	-		-	-		-	-
RSN	-	-		-	-		-	-
DATE OF BIRTH	-	-		-	-		-	-
AGE AT TIME OF ADMISSION	-	-		-	-		-	-
ADMIT DATE	-	-		-	-		-	-
DISCHARGE DATE	-	-		-	-		-	-
LENGTH OF STAY	-	-		-	-		-	-
DIAGNOSIS:								
Axis 1	-	-		-	-		-	-
Axis 2	-	-		-	-		-	-
Axis 3	-	-		-	-		-	-
Axis 4	-	-		-	-		-	-
Axis 5	-	-		-	-		-	-
ADMIT FROM: (1 for yes)								
Community Hospital (>14 days)	0	0%		1	10%		1	7%
Community Hospital (>30 days)	1	20%		1	10%		2	13%
Community Hospital (>60 days)	2	40%		0	0%		2	13%
Community Hospital (>90 days)	0	0%		0	0%		0	0%
Community Hospital (>120 days)	0	0%		2	20%		2	13%
Community Hospital (>150 days)	0	0%		2	20%		2	13%
Community Hospital (>180 days)	0	0%		0	0%		0	0%
Community Hospital (>210 days)	0	0%		0	0%		0	0%
Failed Community Residential - CD/MH	0	0%		0	0%		0	0%
Failed Community Residential - CD	0	0%		0	0%		0	0%
Failed Community Residential - MH	1	20%		2	20%		3	20%
Home with Parent(s)	1	20%		2	20%		3	20%
Home with Other Family Member	0	0%		0	0%		0	0%
Therapeutic Foster home	0	0%		0	0%		0	0%
Triage	0	0%		0	0%		0	0%
Total	5	100%		10	100%		15	100%

Table MR-1. DART Medical Record Review for Child Long-Term Inpatient Program (CLIP) (coninued)

	PEARL STREET RESULTS			CSTC RESULTS			CONSOLIDATED RESULTS	
PREVIOUS LOCATION PRIOR TO ADMIT FROM COMM. HOSPITAL: (1 for yes)								
Failed Community Residential - CD/MH	0	0%		0	0%		0	0%
Failed Community Residential - CD	0	0%		0	0%		0	0%
Failed Community Residential - MH	1	20%		2	20%		3	20%
Home with Parent(s)	4	80%		3	30%		7	47%
Home with Other Family Member	0	0%		2	20%		2	13%
Therapeutic Foster Care	0	0%		3	30%		3	20%
Triage	0	0%		0	0%		0	0%
Total	5	100%		10	100%		15	100%
BEHAVIORAL PROBLEMS: (Less than 30 days) (1 for yes)								
Agitation, intimidation, verbal abuse	5	100%		9	90%		14	93%
Arson, fire hazard	0	0%		0	0%		0	0%
Assaultive	2	40%		0	0%		2	13%
Drug, alcohol abuse	0	0%		0	0%		0	0%
History of sexual offenses	0	0%		0	0%		0	0%
Impulsive behavior	5	100%		10	100%		15	100%
Legal involvement	0	0%		0	0%		0	0%
Property destruction	0	0%		0	0%		0	0%
Psychotic symptoms	4	80%		8	80%		12	80%
Run-away	0	0%		0	0%		0	0%
Self-injurious	3	60%		2	20%		5	33%
Sexually inappropriate	2	40%		1	10%		3	20%
Suicidal monitoring, self-harm attempts, gestures, ideation	5	100%		0	0%		5	33%
UL risk	1	20%		0	0%		1	7%
Any of the Above	5	100%		10	100%		*15*	*100%*

Table MR-1. DART Medical Record Review for Child Long-Term Inpatient Program (CLIP) (continued)

	PEARL STREET RESULTS			CSTC RESULTS			CONSOLIDATED RESULTS	
BEHAVIORAL PROBLEMS: (History) (1 for yes)								
Agitation, intimidation, verbal abuse	5	100%		9	90%		14	93%
Arson, fire hazard	1	20%		1	10%		2	13%
Assaultive	5	100%		8	80%		13	87%
Drug, alcohol abuse	2	40%		2	20%		4	27%
History of sexual offenses	2	40%		0	0%		2	13%
Impulsive behavior	5	100%		9	90%		14	93%
Legal involvement	3	60%		6	60%		9	60%
Property destruction	3	60%		7	70%		10	67%
Psychotic symptoms	4	80%		9	90%		13	87%
Run-away	1	20%		3	30%		4	27%
Self-injurious	4	80%		9	90%		13	87%
Sexually inappropriate	2	40%		2	20%		4	27%
Suicidal monitoring, self-harm attempts, gestures, ideation	5	100%		8	80%		13	87%
UL risk	1	20%		4	40%		5	33%
Any of the Above	5	100%		10	100%		*15*	*100%*
HEALTH PROBLEMS AFFECTING FUNCTIONING: (1 for yes)								
Asthma	0	0%		6	60%		6	40%
Cystic Fibrosis	0	0%		1	10%		1	7%
Diabetes	0	0%		1	10%		1	7%
Obesity/Weight Gain	3	60%		1	10%		4	27%
Polypharmacy	1	20%		5	50%		6	40%
Seizures	0	0%		2	20%		2	13%
Sleep Apnea	0	0%		1	10%		1	7%
Tics	1	20%		1	10%		2	13%
Psychsomatic symptoms	1	20%		4	40%		5	33%
TBI	0	0%		1	10%		1	7%
Weight loss	0	0%		2	20%		2	13%
Other	3	60%		10	100%		13	87%
LOF: (#)								
GAF	40	-		36	-		37	-

Table MR-1. DART Medical Record Review for Child Long-Term Inpatient Program (CLIP) (continued)

	PEARL STREET RESULTS			CSTC RESULTS			CONSOLIDATED RESULTS	
MOST APPROPRIATE PLACEMENT AT THIS TIME: (1 for yes)								
CLIP	5	100%		0	0%		5	33%
Community Hospital	0	0%		0	0%		0	0%
Community Residential - CD/MH	0	0%		0	0%		0	0%
Community Residential - CD	0	0%		0	0%		0	0%
Community Residential - MH	0	0%		1	10%		1	7%
Home with Support	0	0%		7	70%		7	47%
Therapeutic Foster Care	0	0%		2	20%		2	13%
Total	5	100%		8	80%		13	87%
REASON FOR CONTINUING STAY AT CURRENT LEVEL:								
Current behaviors require this level of care:	5	100%		10	100%		15	100%
Less restrictive setting appropriate but barrier(s) prevent placement:	0	0%		0	0%		0	0%
Histories include:								
Arson	1	20%		0	0%		1	7%
Awaiting placement	0	0%		4	40%		4	27%
Custody issues	1	20%		5	50%		6	40%
Difficult placement	4	80%		8	80%		12	80%
Patient, family resistance	5	100%		8	80%		13	87%
Recent medication change	1	20%		4	40%		5	33%
Seeking placement	0	0%		0	0%		0	0%
Serious assault history	3	60%		5	50%		8	53%
Severe trauma history	5	100%		8	80%		13	87%
None Specified	0	0%		0	0%		0	0%
Other	4	80%		7	70%		11	73%
Any of the Above	5	100%		10	100%		15	100%
SUBSTANCE ABUSE INDICATORS: (1 for yes)								
Prior CD treatment	2	40%		2	20%		4	27%
Prior criminal offenses while under the influence	1	20%		0	0%		1	7%
Self, collaterally reported CD	3	60%		2	20%		5	33%
None Indicated	2	40%		8	80%		10	67%
Any of the Above	5	100%		10	100%		15	100%

Table MR-1. DART Medical Record Review for Child Long-Term Inpatient Program (CLIP)

	PEARL STREET RESULTS			CSTC RESULTS			CONSOLIDATED RESULTS	
JUSTIFICATION FOR RECOMMENDED CONTINUATION OF CURRENT LEVEL OF CARE: (1 for yes)								
Agitation	5	100%		8	80%		13	87%
Assault/ assault history	5	100%		6	60%		11	73%
Continuing psychiatric symptoms	5	100%		10	100%		15	100%
Danger to self	4	80%		7	70%		11	73%
Patient/ family resistance	5	100%		9	90%		14	93%
Property destruction	1	20%		5	50%		6	40%
Recent medication change	2	40%		5	50%		7	47%
Sexually inappropriate	0	0%		1	10%		1	7%
Treatment resistant	4	80%		10	100%		14	93%
Using drugs/ alcohol	1	20%		0	0%		1	7%
Any of the Above	5	100%		10	100%		15	100%
At discharge which RESIDENTIAL LEVEL OF CARE is recommended								
Community Residential - CD/MH	1	20%		0	0%		1	7%
Community Residential - CD	0	0%		0	0%		0	0%
Community Residential - MH	0	0%		1	10%		1	7%
Home with Parents with Support	3	60%		3	30%		6	40%
Home with Other Family with Support	1	20%		4	40%		5	33%
Therapeutic Foster Care	0	0%		2	20%		2	13%
Total	5	100%		10	100%		15	100%

APPENDIX K

SUPPORTED HOUSING DATA

Tables for Statistics

Data for supported housing and similar services categorized as "transitional housing" using the 2002 Report major residential categories definitions were excluded from this report. PCG did not receive this type of data from all RSNs given that this type of service is generally considered part of community support services discussed in recommendation A-8 of this report. In order to ensure consistency across all RSNs and an accurate analysis of residential services in Washington, the FY 2004 supported and "transitional" housing data was excluded from our analysis. Likewise, these data were removed from the 2002 Report residential figures that appear in this report to ensure a consistent and accurate comparative analysis.

The supported and "transitional" housing data excluded from this report and removed from the 2002 Report figures have been included in this appendix. It is important to note that the following two tables do not represent a complete picture of available and used beds for the entire system due to the lack of universal collection/reporting of these data. Additional analysis of supported housing and similar community support services should be reviewed in order to determine the level of needed expansion discussed in Recommendation A-8.

2002 Report

Table H-1. Transitional Housing Providers *(2002 Major Residential Categories)*
Available and Used Beds by RSN

RSN	Number of Providers	Available Beds	Used Beds
Chelan-Douglas	1	16	15
Clark	-	-	-
Grays Harbor	1	5	5
Greater Columbia	6	43	35
King	-	-	-
North Central	-	-	-
North Sound	1	12	12
Northeast	-	-	-
Peninsula	-	-	-
Pierce	-	-	-
Southwest	-	-	-
Spokane	-	-	-
Thurston-Mason	1	14	14
Timberlands	1	4	4
TOTAL	**11**	**94**	**85**

Notes:
1. Data come from RSNs as of June 2002

2004 Report

Table H-2. Transitional and Supported Housing Providers *(2002 Major Residential Categories)*
Available and Used Beds by RSN

RSN	Number of Providers	Available Beds	Used Beds
Chelan-Douglas	1	16	13
Clark	-	-	-
Grays Harbor	1	6	6
Greater Columbia	18	132	116
King	-	-	-
North Central	-	-	-
North Sound	-	-	-
Northeast	-	-	-
Peninsula	4	15	15
Pierce	18	328	305.8
Southwest	3	3	3
Spokane	-	-	-
Thurston-Mason	1	14	14
Timberlands	-	-	-
TOTAL	**46**	**514**	**472.8**

Notes:
1. Data come from RSNs and is an average for all of FY 2004. If RSNs were unable to provider an average, data was provided as of June 30, 2004.