OFFICE OF FINANCIAL MANAGEMENT

MENTAL HEALTH INITIATIVES OVERVIEW AND UPDATES

Select Committee on Quality Improvement in the State Hospitals

September 12, 2016

PCG Overview

- PCG is a management consulting firm helping state, county, and other municipal governments achieve their performance goals and better serve populations in need through industry-leading consulting, operations, and technology solutions
- More than ***30 years*** of experience serving the public sector
- Extensive experience in all 50 states, clients in six Canadian provinces, and a growing practice in the European Union

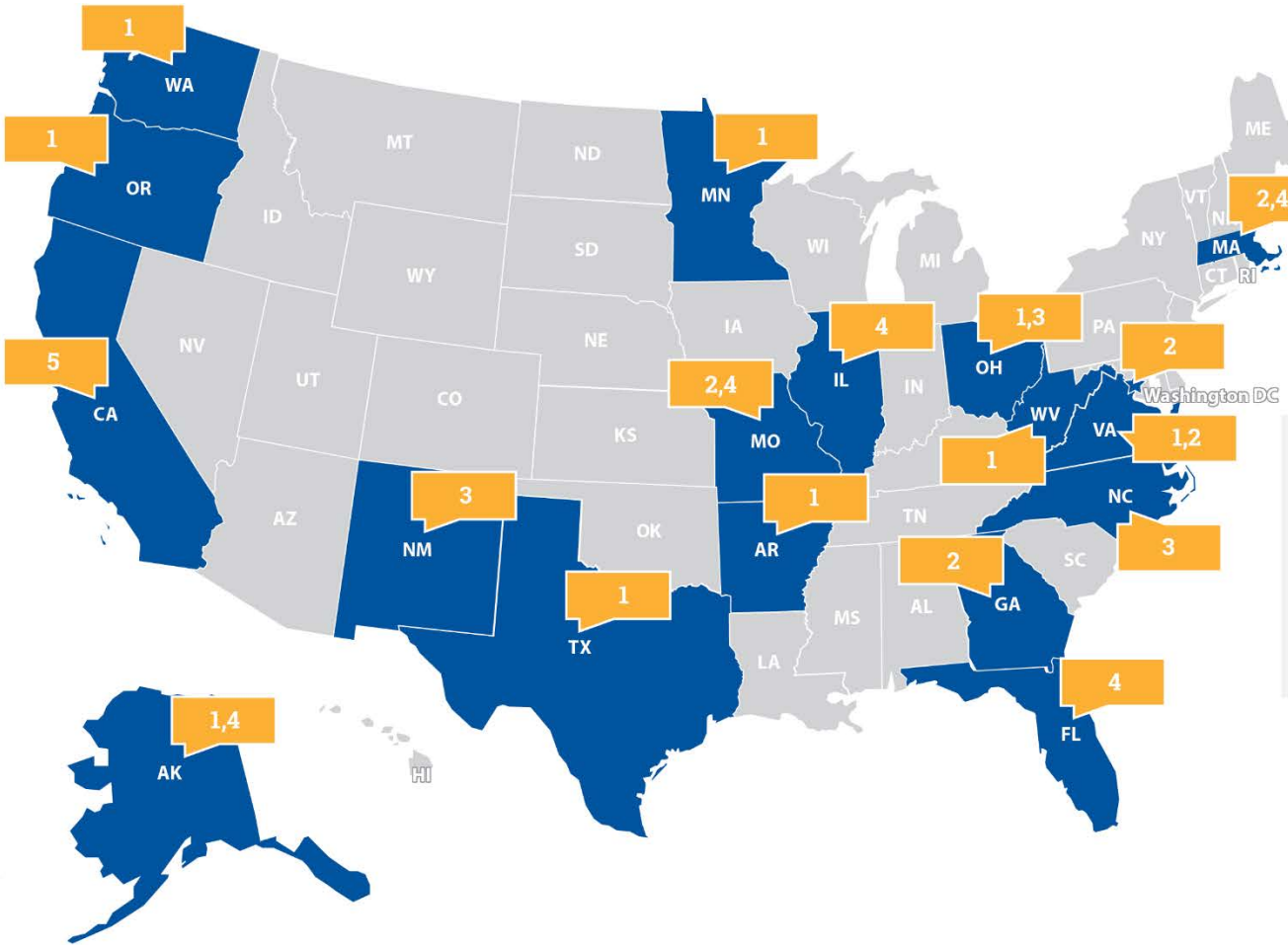
PCG Overview

PCG's behavioral health experience runs the gamut: from state-wide system assessments to provider technical assistance.

Behavioral Health System Analysis	Payment Reform and Rate-Setting	Compliance and Quality Assurance	Cost Reporting	Provider-Specific Offerings
• Statewide and/or System-wide Continuum of Care Gap Analysis • System utilization and cost analysis • CCBHC Readiness Assessments • Organizational Assessments • Programmatic Assessments • Strategic Planning	• Community-Based and Institutional Rate Setting Expertise • Cost Settlement • Prospective Payment Methodologies • Alternative Payment Methodologies	• Performance Reviews • Pre- and Post-Payment Claims Reviews • Provider Screening • Payment Rule and Regulation Training • Member Profiling and Reporting • Training	• Develop community-based cost reporting tools • State psychiatric hospital cost reporting • Hospital efficiency reporting • Cost Report Training • P4P Development	• Billing Efficiency Analysis and Improvement Planning • Strategic Planning • Cost Analysis and Rate-Setting • Cost Report Technical Assistance

PCG Behavioral Health Experience

PCG has notable experience in Behavioral Health consulting, working with agencies across the country to conduct reviews primarily centered around six areas of focus:



Scope of Behavioral Health Work

1. BH System Analysis
2. Payment Reform & Rate Setting
3. Compliance & Quality Assurance
4. Cost Reporting
5. BH Integration
6. Provider Technical Assistance

Behavioral Health System Analysis

Behavioral Health System Analysis and Transformation		
State	Client	Project
Virginia	Department of Behavioral Health and Developmental Services	Technical assistance with a host of behavioral health system transformation projects, including hospital analyses and review of community capacity.
Texas	Health and Human Services Commission	Statewide behavioral health systems analysis
Alaska	Division of Legislative Audit	Performance Evaluations for both the Medicaid Behavioral Health and Long-Term Care programs.
Oregon	Department of Human Services	Assessment & Evaluation of the Mental Health Care Delivery System
West Virginia	Department of Health & Human Resources, Bureau of Behavioral Health & Health Facilities	State-wide assessment of behavioral health strengths and weaknesses, including recommendations for system redesign.
Ohio	Department of Mental Health	Behavioral health administrative cost study
Minnesota	Department of Human Services	Evaluation of Managed Care for State Public Health Care Programs
California	County of San Francisco Department of Public Health	Primary Care Behavioral Health Integration Model

Virginia

- Assisted multi-stakeholder Transformation Teams during the development of system recommendations for the Commissioner.
- Complete comprehensive assessment of hospital utilization and community based provider capacity.
- Assisted state in determining the feasibility of applying for a CCBHC grant, including performing a community needs assessment and working with community service boards to complete cost reports in order to develop a prospective payment rate.

Texas

- Conducted 14 public stakeholder forums across the state and 25 individual stakeholder meetings with providers, advocates, and state staff to assess the environment of the current behavioral health system.
- Submitted report with ten actionable recommendations for system redesign covering the service delivery system, governance and oversight, and funding and financing recommendations to Texas State Legislature .

PCG Scope of Work:
WA Behavioral Health System Assessment

WA Behavioral Health System Assessment

PCG is contracted to examine the current configuration and financing of the state hospital system and make recommendations in several areas as directed in Engrossed Substitute Senate Bill 6656.

- **The Initial Findings Report was submitted to the OFM on September 2, 2016**.
  - The report is in a draft format and is currently in the review process.
  - This report is not intended to draw conclusions or pose specific recommendations.
  - Key findings presented will provide the foundation for recommendations and implementation plans proposed in the “Final Alternative Options and Recommendations Report” and “Implementation and Communications Plans”.
  - Subsequent deliverables are scheduled for submission to the State on September 30 and November 15, 2016.

BH System Assessment: Initial Findings Report

The Initial Findings Report focuses on specific contract tasks. The report is structured by grouping related tasks together.

Current WA Behavioral Health System

- **Quantitative Data Analysis**
- **Peer State Analysis**

National Best Practices

- **Best Practice Research**

Washington State Perspective

- **Stakeholder Input**
- **Workgroup Input**

Contract Tasks

Initial Findings Report: Approach

Current Washington Behavioral Health System Approach

Contract Task	Process
Quantitative Data Analysis	• Confirmed with the State data points required to accurately describe Washington's current state hospital system, community resources, and funding streams. • Reviewed **data request with the State on July 25, 2016**. • Processed data received and **conducted follow up with identified sources as needed.** • Incorporated data from the previous analysis commissioned by the State.
Peer State Analysis	• Identified and confirmed five states for inclusion: Colorado, Illinois, Massachusetts, Minnesota and Oregon. o **Colorado, Minnesota, and Oregon were chosen by the State.** Colorado and Oregon represent similar geographies and populations, while Minnesota offers best practices at a comparable per capita spend. o **Massachusetts is a highly ranked state nationally**, but also struggles with community resource availability. o **Illinois' system is similarly structured** around large inpatient hospitals.

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Initial Findings Report: Approach

National Best Practices Review Approach

Contract Task	Process
Best Practice Research	• Conducted literature review of **peer-reviewed articles, case studies of relevant programs, white papers from national mental health organizations, and evidence-based practices**. • Summarized findings relevant to the structure and financing of the mental health system.

Initial Findings Report: Approach

Washington State Perspective Approach

Contract Task	Process
Stakeholder Input	• Conducted **20 in-person interviews** from August 8 – 16, 2016 in western and eastern Washington with State-identified stakeholder groups. • Conducted **6 phone interviews** for those unable to attend in-person sessions. • Reviewed input, identifying major themes and conflicting views
Workgroup Input	• Identified project leads for each concurrent contract/initiative underway in Washington. • Created Gantt Chart tracking 10 Behavioral Health System contracts. • Established **weekly meeting with project leads**, beginning August 11, 2016, to support further collaboration. Meetings covered high-level deliverables, milestones, potential overlap, risks to progress as well as monitoring alignment of recommendations.

Initial Report Key Findings

Major Key Findings

PCG identified four major key findings that are summarized below:

1. **State hospital utilization and operations face a number of challenges.**
2. **Community based resources exist in a complex, disparate set of systems that does not effectively support complex patient needs.**
3. **Ambiguity and lack of system-wide standardization weakens the ability of providers, BHOs, and patients alike to effectively use the system.**
4. **Best practices for mental health funding are incentivizing reduced institutionalization and increased outcomes-oriented community care.**

These key findings are supported by a combination of data analysis, research, and stakeholder insight.

Key Finding #1

State hospital utilization and operations face a number of challenges.

- High occupancy rates and a lack of alternative settings for complex patients are compounded by **lean staffing models, organizational silos and a lack of recovery-oriented programming.**

- The hospitals currently serve a broad mix of civil and forensic patients. However, **best practices and current national trends suggest that state hospitals are moving toward a model that serves an increasingly limited patient demographic, mainly focused on the forensic population**. Thus while capacity is strained, systemic issues are likely to continue if additional beds were added.

- Available **utilization data from behavioral health organizations (BHOs) does not indicate overutilization of the state hospital system across the majority of the populations served**. However, lack of uniform acuity data confounds further analysis as to the appropriateness of referrals.

Key Finding #2

Community based resources exist in a complex, disparate set of systems that does not effectively support complex patient needs.

The challenges here are two-fold.

- First, there are **insufficient community resources to support patients who, while having complex medical, social and behavioral needs**, **do not require state hospitalization**.

- Second**, services that are available may not be fully utilized as their availability is not reported or organized on a system-wide basis.** Thus patients, providers, and care managers alike struggle to identify available resources for patients in need. These issues are further compounded by a lack of interoperability and standardization in the systems that support these services.

Key Finding #3

Ambiguity and lack of system-wide standardization weakens the ability of providers, BHOs, and patients alike to effectively use the system.

- Transition into and out of state hospital settings is managed through **admission and discharge readiness assessments that vary significantly across the system and within facilities**.

- Ambiguity regarding the reasons for admission and discharge has created **skepticism among stakeholders regarding the appropriateness of patient care and ultimately contributes to delays in patient placement.**

Key Finding #4

Best practices for mental health funding are incentivizing reduced institutionalization and increased outcomes-oriented community care.

- **Reductions in federal funding for state hospitals** concurrent with **increased funding for delivery system reform and value-based purchasing** exemplify this trend.
- Effective transition toward this model requires significant focus on improving the availability and accessibility of community resources. **Financial and non-financial strategies must be employed** to accomplish this goal.

Supporting Data and Details

Current Behavioral Health System

Recent State investment into the Behavioral Health System:

In 2016, two additional facilities began providing competency restoration for individuals identified as low acuity..

Yakima and Maple Lane Bed Statistics

Facility	Average Admissions Per Month	Average Discharges Per Month	Bed Count	Average Daily Census	Occupancy Rate	Average Length of Stay (months)
Yakima	5.80	2.80	24	7	29%	1.37
Maple Lane	11.20	8.25	30	13.25	44%	1.12

Overall spending increased by 75% over FY '07-17. Federal funds increased by 142% while State funds increased by 35%.

Mental Health Spending in Washington 2007-2017

State Fiscal Year	General Fund-State	General Fund-Federal	General Fund-Local	Other Funds	Total
FY 2007	$415,255,000	$252,964,000	$26,836,000	$1,058,000	$696,113,000
FY 2008	$450,930,000	$265,034,000	$41,248,000	$3,604,000	$760,816,000
FY 2009	$429,203,000	$308,459,000	$45,830,000	$3,529,000	$787,021,000
FY 2010	$398,968,000	$334,592,000	$39,744,000	$971,000	$774,275,000
FY 2011	$388,588,000	$342,638,000	$41,996,000	$2,505,000	$775,727,000
FY 2012	$438,381,000	$303,863,000	$43,035,000	$2,548,000	$787,827,000
FY 2013	$445,731,000	$309,601,000	$40,530,000	$2,703,000	$798,565,000
FY 2014	$473,782,000	$375,135,000	$38,638,407	$0	$887,555,407
FY 2015	$483,677,000	$572,361,247	$37,970,000	$983,000	$1,094,991,247
FY 2016	$499,964,000	$583,376,000	$34,160,400	$2,778,000	$1,120,278,400
FY 2017	$561,723,000	$612,675,000	$34,085,000	$12,464,000	$1,220,947,000

Current Behavioral Health System

State Hospital Bed Statistics as of June 2016

Bed Type		Eastern State Hospital				Western State Hospital			
		Bed Count	Average Daily Census	Occupancy Rate	Average Length of Stay (months)	Bed Count	Average Daily Census	Occupancy Rate	Average Length of Stay (months)
Forensic Beds	Competency Restoration	27	22	80%	1.97	44	38	85%	2.07
	Forensic Evaluation	28	23	81%	1.97	87	83	96%	2.07
	NGRI	70	59	84%	78.62	154	154	100%	39.44
	Total Forensic	**125**	**103**	**83%**	**45.72**	**285**	**274**	**96%**	**24.00**
Civil Beds	Habilitative Mental Health	10	10	100%	12.71	30	29	97%	22.45
	Adult Psychiatric	60	59	98%	3.13	206	204	99%	11.38
	Geropsychiatric	60	50	83%	3.86	171	169	99%	11.99
	Other/Unspecified	62	46	75%	3.13	150	145	97%	11.38
	Total Civil	**192**	**165**	**86%**	**3.93**	**557**	**547**	**98%**	**12.12**
Hospital Total		**317**	**268**	**85%**	**4.39**	**842**	**821**	**98%**	**15.97**

The Occupancy Rate is nearing 100% capacity at Western, while Eastern is at 85% occupancy.

Current Behavioral Health System

State Hospital Bed Statistics as of June 2016

Bed Type		*Eastern State Hospital*				*Western State Hospital*			
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- **Both Eastern and Western State Hospitals currently operate above 80 percent capacity** for civil and forensic beds.
- Recent literature suggests that **occupancy below 85 percent may foster a safer psychiatric treatment milieu.**

Current Behavioral Health System

State Hospital Bed Statistics as of June 2016

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Hospital Total		**317**	**268**	**85%**	**4.39**	**842**	**821**	**98%**	**15.97**

The Average Length of Stay at Eastern for a forensic patient is 11 times longer than that for a civil patient. This is driven by the NGRI population.

Current Behavioral Health System

Average Number of People on Waitlist for State Hospitals

Bed Type	Western State Hospital			Eastern State Hospital		
	# of People	Average Days on Waitlist	Median Days on Waitlist	# of People	Average Days on Waitlist	Median Days on Waitlist
Adult Psychiatric*	47	24.91	15	12	7.30	7
Geropsychiatric**	24	50.75	40.5	4	4.25	4.5
Forensic***	29	7.52	8	5	4.80	4

*WSH PTRC-Central tends to have the general adult population at WSH. Central includes APU, GPU, and E&T Units
**WSH PTRC-East tends to include geropsychiatric and TBI populations, but there are several general adult wards. East includes APU, GPU, and E&T Units
***Forensic includes competency evaluation, not guilty by reason of insanity and forensic evaluation

Western State Hospital shows an average wait time of 25 to 50 days for adult and geriatric civil beds.

In contrast, Eastern State Hospital patients experience an average wait time of less than 8 days.

Current Behavioral Health System

Average Number of People on Waitlist for State Hospital

Bed Type	Western State Hospital			Eastern State Hospital		
	# of People	Average Days on Waitlist	Median Days on Waitlist	# of People	Average Days on Waitlist	Median Days on Waitlist
Adult Psychiatric*	47	24.91	15	12	7.30	7
Geropsychiatric**	24	50.75	40.5	4	4.25	4.5
Forensic***	29	7.52	8	5	4.80	4

*WSH PTRC-Central tends to have the general adult population at WSH. Central includes APU, GPU, and E&T Units
**WSH PTRC-East tends to include geropsychiatric and TBI populations, but there are several general adult wards. East includes APU, GPU, and E&T Units
***Forensic includes competency evaluation, not guilty by reason of insanity and forensic evaluation

The number of adult psychiatric patients waiting for treatment at Western State Hospital represents roughly 20% of their total capacity for this population.

- **Data is limited** to formal hospital waitlist data and **does not account for patients in need of hospitalization who have been unable to access the system entirely.**

Current Behavioral Health System

Number of Forensic Flips by State Hospital

Fiscal Year 2015	Western State Hospital		Eastern State Hospital	
	Newly Flipped*	Total Flips**	Newly Flipped*	Total Flips**
July	8	113	2	25
August	14	119	1	20
September	3	113	1	21
October	6	113	5	20
November	5	116	2	20
December	4	116	6	24
January	4	111	3	24
February	10	117	2	18
March	10	120	4	21
April	15	128	3	22
May	8	128	6	26
June	9	129	4	27
Average/Month	**8**	**119**	**3**	**22**

The high number of forensic flips at Western State Hospital may contribute to the capacity strain for civil beds..

Current Behavioral Health System

Eastern State Hospital BHO Bed Allocations and Utilization (2015)

BHO Name	Bed Allocations	Allocated Bed Days	Bed Days Used	Utilization %
North Central Washington BHO**	27	9,855	4,698	**48%**
Greater Columbia BHO	55	20,075	14,050	**70%**
Spokane County Regional BHO***	110	40,150	37,174	**93%**
King County BHO	-	-	806	*
North Sound BHO	-	-	357	*
Salish BHO	-	-	-	*
Optum Pierce BHO	-	-	239	*
SW Washington FIMC (Fully Integrated Managed Care)	-	-	92	*
Thurston Mason BHO	-	-	-	*
Great Rivers BHO	-	-	26	*
Total	**192**	**70,080**	**57,442**	**82%**

*BHO is not allocated beds for this region.
** North Central BHO utilization data does not include utilization from Grant County, due to lack of county level data to fully convert utilization data from RSNs to BHOs.
*** Spokane BHO utilization data includes utilization from Grant County, due to lack of county level data to fully convert utilization data from RSNs to BHOs.

From an annual perspective, none of the BHOs in Eastern over utilized their bed allocation.

Current Behavioral Health System

Western State Hospital BHO Bed Allocations and Utilization (2015)

BHO Name	Bed Allocations	Allocated Bed Days	Bed Days Used	Utilization %
North Central Washington BHO	-	-	-	*
Greater Columbia BHO	-	-	65	*
Spokane County Regional BHO	-	-	62	*
King County BHO	234	85,410	83,712	98%
North Sound BHO	119	43,435	39,111	90%
Salish BHO	33	12,045	9,488	79%
Optum Pierce BHO	94	34,310	34,279	100%
SW Washington Fully Integrated Managed Care**	40	14,600	16,753	115%
Thurston Mason BHO	34	12,410	11,327	91%
Great Rivers BHO***	33	12,045	6,077	50%
Total	**587**	**214,255**	**201,174**	**94%**

*BHO is not allocated beds for this region.
** Southwest FIMC utilization data includes utilization from Cowlitz County, due to lack of county level data to fully convert utilization data from RSNs to BHOs.
*** Great Rivers BHO utilization data does not include utilization from Cowlitz County, due to lack of county level data to fully convert utilization data from RSNs to BHOs.

BHO utilization is higher in Western than Eastern. But, only two BHOs were at or above their allocated bed amount.

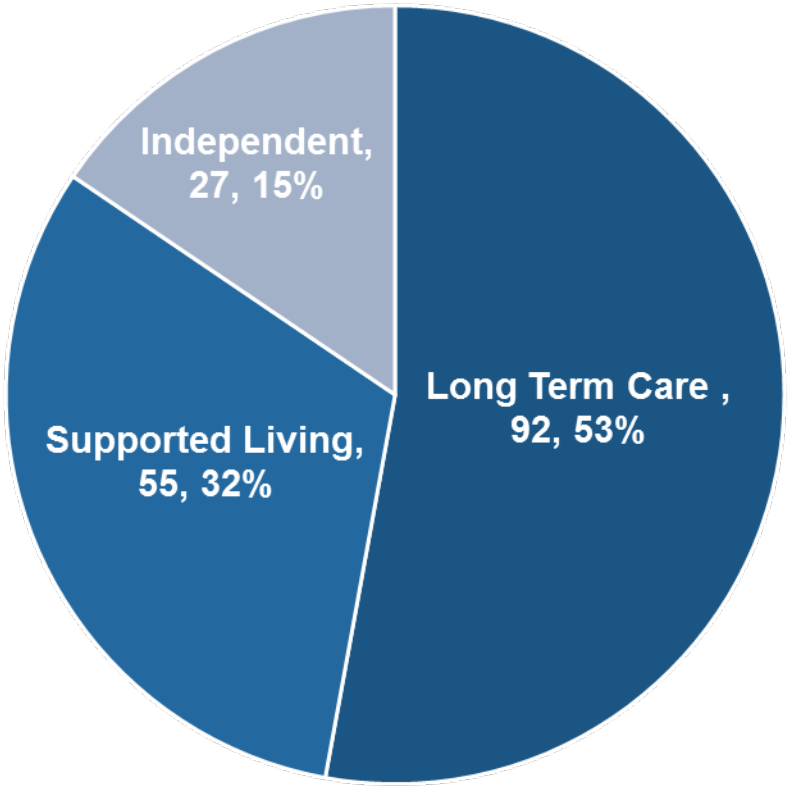
Current Behavioral Health System

Community Placement

The primary barrier to discharge identified is the lack of community resources to permit timely discharge for individuals with complex needs.

As of July 2016, there were **174 civil patients** on Western State Hospital's discharge wait list. **85% of these patients need specialized housing.**

Types of Housing Needed for Civil Patients Awaiting Discharge



Current Behavioral Health System

State Hospital Staffing

- **Washington State Hospital vacancy rate: 14.3%**
  Eastern State Hospital vacancy rate: 8.6%
- Western State Hospital's forensic day shift has a staff to bed ratio 10 percent higher than Eastern State Hospital.

Top Five Highest Vacancy Rates for Permanent Staff Position Titles at Western State Hospital

Position Title	Actual Positions in Job Class	Vacant Positions	% Vacancy
Physician 3	17	3	17.6%
Psychologist 4	32	7	21.9%
Licensed Practical Nurse 2	108	27	25.0%
Psychiatric Security Nurse	80	23	28.8%
Recreation Therapist 2	10	3	30.0%
Registered Nurse 2	230	69	30.0%

Key personnel, such as psychologist and registered nurses, have the highest vacancy rates.

Peer State Comparison

Data Point	Source	WA	CO	IL	MA	MN	OR
Total State Population	U.S. Census 2015 Projections	7,170,351	5,456,574	12,859,995	6,794,422	5,489,594	4,028,977
Total State Medicaid Population	CMS Report June, 2016	1,776,851	1,356,251	3,088,448	1,650,379	1,027,909	1,035,319
Total State Beds 2016	State data	1,213	531	1,299	1,022	659	653
Total number of state beds per 100k population	PCG calculation	16.9	9.7	10.1	15.0	12.0	16.2
State Civil Beds 2016	State data	749	174	578	672	278	237
State Forensic Beds 2016	State data	464	357	721	350	381	416
Total number of civil beds per 100k population	PCG calculation	10.4	3.2	4.5	9.9	5.1	5.9
Total number of forensic beds per 100k population	PCG calculation	6.5	6.5	5.6	5.1	6.9	10.3
Total number of private psychiatric beds	PCG calculation using multiple sources	792	830	4,031	2,399	1,082	n/a

Peer State Comparison

Data Point	Source	WA	CO	IL	MA	MN	OR
Total State Population	U.S. Census 2015 Projections	7,170,351	5,456,574	12,859,995	6,794,422	5,489,594	4,028,977
Total State Medicaid Population	CMS Report June, 2016	1,776,851	1,356,251	3,088,448	1,650,379	1,027,909	1,035,319
Total State Beds 2016	State data	1,213	531	1,299	1,022	659	653
Total number of state beds per 100k population	**PCG calculation**	**16.9**	**9.7**	**10.1**	**15.0**	**12.0**	**16.2**
State Civil Beds 2016	State data	749					
State Forensic Beds 2016	State data	464					
Total number of civil beds per 100k population	**PCG calculation**	**10.4**	**3.2**	**4.5**	**9.9**	**5.1**	**5.9**
Total number of forensic beds per 100k population	**PCG calculation**	**6.5**	**6.5**	**5.6**	**5.1**	**6.9**	**10.3**
Total number of private psychiatric beds	PCG calculation using multiple sources	792	830	4,031	2,399	1,082	n/a

Across the six states, Washington ranks first in number of state beds per 100k population, first in number of civil beds per 100k, and falls in the middle for forensic beds per 100k.

Peer State Comparison

Data Point	Source	WA	CO	IL	MA	MN	OR
FY2014 Per Capita Community Mental Health Expenditures	NOMS 2015	$91.72	$98.15	$47.15	$95.30	$169.78	$181.68
State Ranking for Per Capita Spending on Community Based Services	NRI SMHA Expenditures 2013	21	27	38	23	13	11

- **Across the six states, Washington ranks second to last in per capita spending** on community mental health expenditures
- **Nationally, Washington is in the in the 50th percentile** on community health spending per capita.
- Note these two data points are from different years: 2015 and 2013.

Peer State Comparison

Data Point	Source	WA	CO	IL	MA	MN	OR
Ave LOS Civil (State hospitals)	NOMS 2015	67	48	11	52	36	122
Ave LOS NGRI (days)	TAC Report 2016 WA State Provided Data	ESH: 2358 WSH:1183	3,176	2,001	180	2,555	945
State hospital readmission 30 days	NOMS 2015	2.6%	6.7%	12.4%	8.7%	14.4%	0.4%
State hospital readmission 180 days	NOMS 2015	10.4%	14.7%	19.3%	11.1%	26.6%	9.0%

- **Washington has the second lowest 30-days and 180-days readmission rate**
- **This statistic posed positive and negative implications.**
  Positive: Low readmissions may indicate that once individuals are discharged to the community, they tend to access stable community services.
  Negative: A recent DSHS report found that patients who received timely outpatient care had higher readmission rates but significantly lower mortality rates.

National Best Practices

- **States are increasingly limiting state hospital admissions to forensic patients and a smaller portion of civil patients**, mainly those with psychotic disorders and bipolar diagnoses classified as high acuity due to behavioral or complex medical conditions.

- **Identifying the optimal number of beds per capita is challenged by 1) a lack of consistent reporting and identification of available beds** across public and private systems, and **2) issues quantifying population need** as individuals face hurdles entering the system.

- **Federal funding for institutional care continues to decline in favor of alternative, community-based models.** The relationship between reduced disproportionate share funding and significant support for innovative models, such as delivery system reform incentive pools, exemplifies this trend.

Stakeholder Input

Based on this collection of input, PCG identified major themes from stakeholder feedback:

Common Themes	Concerns
Limited availability and accessibility of community resources	• Specific and significant shortfalls in affordable housing, substance use disorder services, peer support, crisis stabilization and appropriate residential facilities for complex, long-term care represent the greatest concern. • In areas where there are services available, accessing those services is hindered by awareness, the ability to make appropriate connections, and lack of incentive for private providers to accept high need, low income patients.
Lack of transparency and standardization	• Processes for admission and discharge to the state hospitals are not well understood among those impacted by such determinations. • Compounding this issue, admission, discharge, and related evaluation protocols differ from facility to facility, creating confusion and distrust in the system.
Numerous operational and operational challenges	• For both hospitals, continuity across wards and units, multiple staffing issues, and a lack of recovery-oriented practices (such as peer support and substance use disorder services) were cited among these challenges.

Stakeholder Input

Based on this collection of input, PCG identified major themes from stakeholder feedback:

Common Themes	Concerns
Unclear on the effectiveness of increasing financial risk of BHOs will have on hospital utilization	• Other issues identified, if not prioritized, will continue to hinder appropriate state hospital utilization under a per member per month risk structure and must be considered in any new model of reimbursement. • Stakeholders stressed that placing BHOs at risk for state hospital beds will also require significant changes in the level of control that BHOs may exercise over the populations under the risk arrangement.
Jail diversion programs show promising results	• Results are preliminary and mixed in many states exploring this type of initiative.

Additional specific stakeholder groups' identified issues and recommendations are detailed in the report.

Additional Efforts Underway

PCG is monitoring the progress and synchronization of other concurrent behavioral health system contracts and collaborating efforts to strengthen the quality of recommendations that come from them.

Other Behavioral Health System Initiatives:

- Behavioral Health Integration
- Workforce Development
- Jail Diversion Study
- Select Committee on Quality Improvement in the State Hospitals Committee on Improvement
- UW Training Unit
- Discharge Geropsychiatric Patients
- Discharge Planning
- DSHS Staffing Consultant
- Systems Improvement Agreement

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