THURSTON MASON
REGIONAL SUPPORT NETWORK

ABBREVIATED ANNUAL REPORT
Calendar Year 2013
THURSTON MASON REGIONAL SUPPORT NETWORK
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Thurston County Public Health and Social Services Department
Mission Statement

The mission of the Thurston County Public Health and Social Services Department is to make a positive, significant and measurable difference in the environmental, physical and mental health, safety and well-being of our community.

Thurston Mason Regional Support Network
Mission Statement

Thurston Mason Regional Support Network (RSN) is dedicated to providing mental health services to persons with severe and persistent mental illness to promote quality tenure in our community.

Thurston Mason RSN

Thurston Mason RSN is a county program responsible for the administration of publicly-funded mental health services for the residents of Thurston and Mason Counties. TMRSN contracts for outpatient, crisis, residential, peer support and inpatient services through licensed Community Mental Health Agencies (CMHAs), or “Network Providers.”

The primary focus of these publicly-funded services is to serve Title 19 (TXIX) Medicaid eligible adults and older adults who have chronic and persistent mental illness and children/youth with severe emotional disturbances. Individuals without Medicaid may receive acute care and crisis services based on the availability of funding, which is monitored by the Thurston Mason RSN. The services provided are a vital part of maintaining the community’s overall health, safety, and quality of life.

Special Note on the 2013 Abbreviated Annual Report

The 2013 Annual Report is an abbreviated report and does not include many of the graphs and data figures normally included. There are two main contributing factors for why data is not available or complete, 1) the RSN’s conversion to the Managed Care Organization (MCO) module of our Management Information System (MIS) in April 2013, and 2) the Electronic Healthcare Record (EHR) conversion our largest provider, Behavioral Health Resources (BHR) undertook in August 2013. There have been significant issues with successfully submitting data from BHR’s EHR to TMRSN’s MCO MIS as well as issues with the MCO MIS’s ability to receive data from BHR. As a result, there has been a large volume of errors that require extensive “fixes” and the implementation of preventive measures to ensure data accuracy and completeness in future data submissions.

TMRSN’s contracted Information System (IS) vendor, Jet Computer Support (JCS), is working closely with BHR and TMRSN to resolve these data errors. However, it is important to note that TMRSN does not directly manage our electronic data, which includes client, staff, and service encounter data. Rather, TMRSN contracts with JCS to manage our MCO MIS and related databases containing our
client, staff, and service encounter data that is normally included in this annual report. The data errors and MCO MIS programming issues continue to take a considerable amount of time and resources to fully resolve, and we continue to work towards full resolution at the time of this report.

The good news is that through monitoring activities, TMRSN can verify that services were provided to consumers as required under the individual contracts between Network Providers and TMRSN. This annual report, however, will not break down those services into service hours and encounters as has been the tradition of this report. This year’s report is primarily a narrative description of many of the activities that took place during the year, as well as information on the TMRSN budget, quality improvement activities, and performance measures and outcomes. It is TMRSN’s intent to publish accurate 2013 service data in the 2014 Annual Report along with the 2014 data. That report can be expected sometime during the spring of 2015.

Introduction

Washington’s Regional Support Networks (RSNs) contract with licensed Community Mental Health Agencies (CMHAs) and private nonprofit agencies and hospitals to deliver mental health treatment and services. The RSNs are responsible for ensuring that services are delivered in a manner that complies with all legal, contractual, and regulatory standards for effective care. In 2013, the Department of Social and Health Services (DSHS) contracted with eleven (11) RSNs to deliver mental health services for Medicaid enrollees. In 2013 the average number of covered individuals in Thurston and Mason Counties was approximately 46,696. It is normally expected that roughly ten (10) percent of total Medicaid Eligibles (or, 4,669) would be engaged with mental health services. This is referred to as the “penetration rate.”

The Work of TMRSN

TMRSN is responsible for many different functions. Currently, this includes:

- Contract development & management
- Network coordination
- Management Information System (MIS) & IT coordination
- Quality management
- Utilization management
- Customer service coordination
- Crisis services and Involuntary Treatment Act (ITA) evaluations
- Inpatient care management
- Children’s mental health care management
- Adult and Older Adult mental health care management
- Fraud and abuse compliance coordination
- Resource management
- Compliance with Federal and State requirements for mental health managed care
In 2013, TMRSN consisted of eight (8) staff members, including the Director of Social Services and the TMRSN Manager. This number does not include the TMRSN Ombuds and the Quality Review Team (QRT). During 2013, the TMRSN team was specifically responsible for:

- Developing and maintaining a provider network for the delivery of mental health services according to the requirements of the Prepaid Inpatient Health Plan (PIHP) and State Mental Health contracts
- Strategic planning and allocation of State and Federal mental health funds
- Monitoring and analyzing any unmet needs within Thurston and Mason Counties and developing strategies to meet those needs in the future
- Collaborating with local, State and Federal partners for the purpose of consultation, process improvement, exploring new evidence based practices, and developing new services to meet unmet needs
- Developing and monitoring contracts with Community Mental Health Agencies (CMHAs)
- Provision of Medicaid and State-Funded psychiatric inpatient services for residents of Thurston and Mason Counties
- Authorizing all outpatient, residential and voluntary/involuntary inpatient services, and responding to appeals of authorization decisions
- Provision of Involuntary Treatment Act (ITA) Services in involuntary settings, to include investigations and detentions, involuntary court, individual treatment services, monitoring of Least Restrictive Alternatives (LRAs) and completion of continuity of care plans to meet the State Waiver and Medicaid plan
- Provision of services in residential settings for mental health enrollees
- Creating and maintaining a complaint and grievance system for consumers and/or their authorized representatives who are dissatisfied with services provided
- Developing policies, procedures and operational guidelines for CMHAs that reflect contract requirements and State and Federal regulations, including the revised Washington Administrative Code (WAC) that combined mental health, chemical dependency, and problem gambling Financial monitoring of resource allocation against budgeted expenditures and collection of third party revenue
- Maintaining a clinical chart review and administrative audit process to ensure compliance with State and Federal regulations and contract requirements
- Engaging with CMHAs in a vigorous continuous quality improvement program to ensure compliance with State and Federal regulations and to promote quality care and services to consumers

In addition to the functions listed above, TMRSN employs two (2) individuals responsible for Ombuds Services and the Quality Review Team (QRT). Ombuds Services is responsible for addressing consumer complaints and grievances. QRT position is responsible for collecting satisfaction with services and quality improvement data from consumers in the form of personal interviews and surveys. Both positions summarize their work and submit it to the TMRSN Quality Manager and the TMRSN Advisory Board Quality Management Committee. These positions are paid through the TMRSN, yet are functionally independent so as to maintain neutrality.

2013 In Review
2013 continued to be an exciting and challenging time for those working within publicly-funded mental health. Many of those in the health care arena began to adjust their systems to accommodate the changes brought about by the Affordable Health Care Act (ACA), and build tools to navigate the changing landscape. In mental health, this meant preparing to expand services to a new group of Medicaid eligible individuals who would now be covered under the ACA. While this is still an ongoing process, it is expected that in Thurston and Mason Counties thousands of new consumers will be eligible for Medicaid-funded mental health services due to Medicaid expansion. While it is exciting to see those previously ineligible citizens become eligible for needed mental health services, TMRSN has been challenged to find appropriate services and providers to meet those expanded needs. State resources continue to be limited and TMRSN continues to have to make many difficult decisions and refocus on its core mission of bringing mental health services to Thurston and Mason County’s most vulnerable populations. Although it continued to be a year of watchful stewardship over resources, it was also a year of planning for the future. Some of the highlights of 2013 included:

**Access to Mental Health Services**

One of the primary responsibilities of TMRSN is to ensure that Community Mental Health Agencies (CMHA’s) provide appropriate services in a timely manner. Two (2) key measures examine the timeliness of a consumer’s access to mental health services: The length of time between a request for services (within fourteen (14) calendar days); and, the length of time between an intake service and the first routine service (within fourteen (14) calendar days).

In late 2011 Behavioral Health Resources (BHR), TMRSN’s largest Network Provider, opened the Access Center within the Evaluation and Treatment Center (E&T) in Olympia. The Access Center was an attempt to shorten the length of time between a request for service and a consumer’s intake. The Access Center at BHR developed an “on-demand” mental health intake system. Eligible consumers were free to come into the Access Center during regular business hours and obtain an assessment without an appointment. Prior to the assessment, the consumer was quickly screened to ensure that they met Medicaid eligibility or other priority population status. The consumer then met with a Mental Health Professional for the intake assessment. The Access Center was intended to do the following:

- Reduce the amount of time a consumer has to wait from initial request for services to intake evaluation;
- Create a system whereby consumers can receive short-term, solution-focused therapeutic services from the same Mental Health Professional that conducted the intake evaluation; and
- Reduce the no-show rate typically found for initial intake evaluation appointments.

In the past two (2) years the Access program has been able to demonstrate dramatic decreases in the length of time consumers have to wait between a request for service and an actual intake assessment. While 2013 data is not available at this time, it appears that the Access Center continues to provide mental health intakes within the fourteen (14) day time period roughly ninety-five percent (95%) of the time. This is compared to the non-Access Center rate of approximately sixty percent (60%).

There is a significant difference in the timeliness of intake services for consumers receiving their intakes at the Access Center. One systemic issue remains, however, in that those consumers who wish to receive regular (ongoing) services at a different TMRSN Network Provider other than BHR, cannot
utilize the Access Center services. Similarly, the Access Center only exists in Thurston County and does not benefit Mason County residents. In 2014, BHR has plans to alter its Access Center model to include moving the program out of the Evaluation and Treatment Center and into their primary clinic offices, and to expand on-demand intake services to consumers in the BHR Shelton office.

**Clinical Chart Review System |**

TMRSN continued with its robust clinical chart review and performance improvement program in 2013. The clinical chart review program – part of the overall Quality Management system at TMRSN – ensures that clinical chart reviews (and subsequent performance improvement plans) become part of the continuous quality improvement system for both TMRSN and Network Providers. The TMRSN clinical chart review process includes:

- Yearly review schedules that incorporate regular and consistent TMRSN reviews;
- Quarterly summaries by TMRSN that identify areas of strength, areas in need of further quality improvement, and a record of compliance according to cited requirements;
- Collaboration in the creation of Performance Improvement Plans (PIP’s) for use by Network Providers that focus on agency strengths, resources, and compliance standards; and
- Use of targeted review instruments that focus on areas such as:
  - Following the “Golden Thread” in clinical practice (ensuring that needs presented in the intake evaluation are addressed in the treatment plan and in ongoing interventions)
  - Peer Support Services
  - Request for Services and Intake Evaluation
  - Individualized Treatment Planning
  - Consumer Rights and Service Provision
  - Psychiatric, Medical and Crisis Planning and Services
  - Level of Care / Access to Care Standards
  - Schizophrenia and High Risk – Practice Guidelines
  - High Risk Protocols – Practice Guidelines
  - Evaluation and Treatment Center (E&T) services

Clinical chart reviews of ten percent (10%) of all unduplicated mental health charts in a given year, using standardized review instruments, was initiated on October 1, 2010. The clinical chart review instruments used during the 2013 review cycle included either a Comprehensive Outpatient Services Review (COSR) instrument, or one of several targeted review instruments. During 2013, 474 clinical charts were reviewed (39.5 charts per month) This number exceeds the ten (10) percent requirement set forth by the Prepaid Inpatient Health Plan (PIHP) contract between the Department of Social and Health Services (DSHS) and TMRSN.

| Table 1 below provides a comparison of some key clinical areas over the past three (3) years. Data from all clinical charts reviews, from all Network Providers, was used to create this table. The standard for all reviews – established agency-wide at TMRSN – is ninety percent (90%). |

<table>
<thead>
<tr>
<th>Target Area</th>
<th>2011 Compliance Rate</th>
<th>2012 Compliance Rate</th>
<th>2013 Compliance Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intake Assessments and adherence to the Access to Care Standards (ACS)</td>
<td>79.11%</td>
<td>82.09%</td>
<td>84.96%</td>
</tr>
<tr>
<td>Treatment Planning – including adherence to treatment plan reviews</td>
<td>72.80%</td>
<td>70.57%</td>
<td>64.06%</td>
</tr>
<tr>
<td>Provision of Services – including ensuring client rights</td>
<td>84.49%</td>
<td>83.28%</td>
<td>77.27%</td>
</tr>
<tr>
<td>Psychiatric, Medical and Crisis Services and Planning</td>
<td>92.64%</td>
<td>95.40%</td>
<td>94.44%</td>
</tr>
<tr>
<td>Utilization Management – including appropriate services and intensity</td>
<td>90.76%</td>
<td>87.44%</td>
<td>81.92%</td>
</tr>
</tbody>
</table>

**Table 1 – Clinical Chart Review Results: CY2013**

**Table 2** below provides a summary of how crisis services performed in 2013, as provided by TMRSN’s Evaluation and Treatment center (operated by BHR):

<table>
<thead>
<tr>
<th>E&amp;T Program Area</th>
<th>BHR</th>
</tr>
</thead>
</table>
| **Evaluation & Treatment Unit (ETU) Clinical Chart Review** (Standard: 90%) | # of reviews = 14  
% compliance achieved = 96.47%  
PIP required/completed: No |
| **Crisis Resolution Services (CRS)** (Standard: 90%) | # of reviews = 21  
% compliance achieved = 94.43%  
PIP required/completed: No |
| **Crisis Stabilization & Transitional Unit (CSTU)** (Standard: 90%) | # of reviews = 12  
% compliance achieved = 94.52%  
PIP required/completed: No |

**Table 2 – E&T Chart Review Results: CY2013**

**Community and Staff Involvement**

In 2013, TMRSN continued its tradition of involving staff and community stakeholders in reviewing quality and performance measures, program design, and the production of consumer-focused materials. Some of the ways that TMRSN utilized community members, as well as its own staff, in 2013 included:

- **Treatment Sales Tax** (TST) – Community stakeholders were involved in reviewing the plan for how Treatment Sales Tax funds would be used in Thurston and Mason Counties. Treatment Sales Tax revenue is intended to fund mental health services that strive to reduce the negative impacts of mental health and substance abuse on children and families and reduce risk of criminal justice involvement.

- **Mason-Thurston Wraparound Initiative (MTWI)** – The MTWI Coordinator, a parent with lived experience and a certified peer counselor, facilitated quarterly MTWI Steering Committee meetings, allowing community members to participate in many of the ongoing operational activities for the Mason-Thurston Wraparound Initiative. MTWI provides intensive, individualized care planning and support for high risk children/youth and their families.

- **Thurston Mason Mental Health Advisory Board** – The Advisory Board is a body of community volunteers that meet monthly to provide input on service delivery and quality improvement initiatives. The Board consists of consumers, family members of consumers, and organizations that have a stake in mental health delivery and quality. TMRSN representatives attend each meeting as staff.

- **Family Alliance for Mental Health** – TMRSN contracts with a parent of a child with mental illness (TMRSN Parent Network Contractor) to lead a parent/caregiver-driven network dedicated to
engaging community partners in providing support services and education for parents and caregivers of children with mental health challenges.

- **Children's Community Consensus Teams (CCCT)** – The CCCT is an on-going team, represented by child-serving agencies and community members, whose purpose is to implement the principles of individualized care and to support children with mental health issues and their families. The CCCT also is the local gatekeeper and referral source for Thurston and Mason County residents seeking voluntary admission into the Children’s Long Term Inpatient Program (CLIP).

- **Training, Conference participation and scholarships** – Each year, staff from TMRSN attend training specific to their specialty (i.e., child mental health specialist certification). In 2013, TMRSN staff attended trainings on ethics, evidence-based practices, health care reform, continuous quality improvement within managed care, and a host of other, specialty-specific training courses. TMRSN has a tradition of involving as many community stakeholders as is possible in these various trainings and conferences. In 2013, nine (9) consumers received scholarships to attend the statewide Behavioral Health Conference in Yakima.

- **Sponsorship of the Annual Mental Health Forum** – This was a forum developed collaboratively by the TMRSN staff, RSN Mental Health Advisory Board, consumers, providers, and other interested community members. In 2013, the focus of the implementation of the Affordable Health Care Act. At this year’s event, held in Shelton, staff were on hand to assist community members to sign up for healthcare using the HealthCare.gov Website.

**Evidence Based Practice (EBP)**

TMRSN continues to explore opportunities to bring more evidence based practices (EBPs) into Thurston and Mason Counties. EBPs are treatments or services that have demonstrated their effectiveness through rigorous research studies and considerable documentation. Other treatment modalities that are in the midst of clinical research are oftentimes referred to as Emerging (or Promising) Best Practices. These treatments and services are generally less thoroughly evidence based, but show some positive treatment response. Currently, TMRSN is engaged in the following EBPs:

- Multisystemic Therapy (MST)
- Positive Parenting Program (Triple P)
- Assertive Community Treatment (PACT)
- Trauma Focused Cognitive Behavior Therapy through the Skokomish Tribe.
- Cognitive / Interpersonal Therapies for Depression
- High Fidelity Wraparound through MTWI
- Family Psychoeducation
- Peer Support (Capital Clubhouse)
- Screening, Brief Intervention and Referral to Treatment (SBIRT)
- Jail Division / Community Re-entry (MIO, MIJOP)

**External Quality Review (EQR)**

Federal law requires that the State of Washington – and all of the Regional Support Networks – undergo an annual, independent external quality review (EQR) for health care services delivered to Medicaid enrollees. Acumentra, Washington State’s External Quality Review Organization (EQRO), reviews various performance areas on a yearly basis. Some of these topics include consumer rights, grievance systems and the RSN’s responsiveness to complaints and grievances, data security and confidentiality, and the RSN’s Quality Assessment and Performance Improvement (QAPI) programs. In
addition, each RSN must create and implement two (2) Performance Improvement Projects (PIPs) to improve clinical and non-clinical services provided to Medicaid enrollees.

The focus of the 2013 EQR consisted of three (3) distinct areas: An Information Systems Capabilities Assessment (ISCA); a clinical chart review on clinical adherence to the Golden Thread; and, the annual review of TMRSN’s two (2) PIPs. The Golden Thread review examines whether the intake assessment in the consumer’s record substantiates the diagnosis, whether the treatment plan goals and objectives are consistent with the diagnosis, and whether progress notes address the treatment plan goals and stated interventions.

Overall, TMRSN performed very well during the 2013 EQR, with the exception of a couple of recommendations and findings for TMRSN’s management information system (MIS). These recommendations and findings were addressed through a performance improvement plan submitted by TMRSN and approved by DBHR.

**Figure 1** below shows some of the key scores TMRSN received during its 2013 ISCA. Please note that Acumentra utilizes a three-point scoring system, and that scores between 3.0 and 2.5 translates to “fully met”, scores between 2.5 and 2.0 translates to “partially met”, and a scores below 2.0 translates to the item not being “met”.

![Figure 1 - External Quality Review results: CY2013](image)

**Table 3** below shows the results of the Golden Thread review. Please note that Acumentra reviewed a total of 88 children and adult clinical records for this review.

<table>
<thead>
<tr>
<th>#</th>
<th>Study Question</th>
<th>% Yes</th>
<th>% Partially</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Does the assessment substantiate the (Category A) diagnosis?</td>
<td>94.2%</td>
<td>2.9%</td>
</tr>
<tr>
<td>2</td>
<td>Does the assessment substantiate the (Category B) diagnosis?</td>
<td>100%</td>
<td>0.0%</td>
</tr>
<tr>
<td>3</td>
<td>Does the treatment plan include interventions and goals consistent with issues identified in the assessment?</td>
<td>84.7%</td>
<td>0.0%</td>
</tr>
<tr>
<td>4</td>
<td>Do the progress notes address interventions identified in the treatment plan and the individual’s progress towards meeting stated goals?</td>
<td>69.1%</td>
<td>9.9%</td>
</tr>
<tr>
<td>5</td>
<td>Are the treatment plan objectives individualized?</td>
<td>87.4%</td>
<td>0.0%</td>
</tr>
</tbody>
</table>
The next area that Acumentra examined was the Program Improvement Projects (PIPs). PIPs are projects that are created out of an identified community need. They strive to address particular gaps or problems in the mental health system. They are generally three (3) year projects and are evaluated by Acumentra on an annual basis. TMRSN will continue to work on Performance Improvement Projects in the coming years and will develop new PIPs to meet community needs.

The topic areas for TMRSN’s performance improvement projects for 2013 were:

- **Non-Clinical PIP – Increasing the Percentage of Medicaid Clients who Receive an Intake Service within 14 Days of Service Request:** According to Acumentra: “This PIP, initiated in 2013, focuses on reducing voluntary psychiatric hospital readmissions for adult Medicaid enrollees, particularly those not engaged in outpatient services at the time of initial discharge. For its intervention, TMRSN plans to expand a peer support program now being run by one of its provider agencies. TMRSN is developing the intervention in consultation with community hospital and discharge planners...The nonclinical PIP had not advanced to remeasurement at the time of the PIP review.” This PIP – in the first year of development – received a score of 53 out of a possible 90 points. This represents a Partially Met rating.

- **Clinical PIP – High-Fidelity Wraparound:** According to Acumentra: “TMRSN and local stakeholders have identified the High-Fidelity Wraparound model developed by the University of Washington as an important component of their efforts to improve children’s mental health. The RSN implemented the wraparound intervention for eligible high-risk children/youth and their families beginning July 1, 2011...The clinical PIP has been well designed and executed to date.” This PIP has received – in the first remeasurement period – a score of 88 out of a possible 90. This represents a “Fully Met” rating.

**Grievance and Complaint System**

During 2013 new rules by DBHR mandated that RSNs stop the practice of categorizing consumer statements of dissatisfaction as “complaints.” DBHR made the decision that all client statements of dissatisfaction – regardless of the scope or severity of the perceived infraction – should be categorized as grievances. Since a grievance is a formal process, defined by Washington State Administrative Code (WAC), all statements of dissatisfaction are now subject to the formal notification requirements. The result of these changes has been that relatively simple complaints have now become part of a formal process; such processes often take longer to resolve.

TMRSN’s guiding principle with regards to grievances, however, explicitly stated in the TMRSN Grievance Policy, is that all grievances must be resolved at the lowest level possible. This means that grievances are resolved as quickly as possible, with the least amount of consumer stress and “red tape”, and with direct consumer input into the type of resolution sought. Generally, the TMRSN Ombuds answers the questions and investigates all grievances. The TMRSN Quality Manager reviews all grievance investigations and resolutions. The Quality Manager also makes recommendations for Network Providers, as necessary. In some circumstances, the TMRSN Quality Manager must also investigate grievances and create corrective action plans for Network Providers. TMRSN responds to and tracks all consumer grievances, appeals and fair hearings. TMRSN also logs and tracks all “system
concerns” and “information and referral” contacts when clients, family members or other community members inquire about available services within the RSN.

Figures Two and Three below represent the number of grievances by type, and the types of resolutions:

**Grievance Type and Frequency: CY 2013**

![Bar chart showing grievance types and frequency for CY2013]

**Grievance Resolution Type and Frequency: CY 2013**

![Bar chart showing grievance resolution types and frequency for CY2013]

In 2013, there were 260 calls to the Ombuds. This compares with 257 calls in 2012. This included both Information and Referral / concern calls (199) and actual grievances (61). Since new rules around
grievances went into effect in 2013 it is difficult to compare grievances year-to-year. However, during 2012 there were a total of 122 complaints and grievances combined; in 2013 there were a total of 61 grievances and no complaints. This might represent a dramatic decrease in expressions of dissatisfaction by consumers, or it might imply that consumers do not wish to enter into a formal grievance process with TMRSN. Finally, in 2013 there was one (1) fair hearing and no appeals from a denial or alteration of services.

New Level of Care System (LOCUS/CALOCUS)

In 2013 TMRSN began the process of adopting a new level of care system for all consumers enrolled in TMRSN services. Using a “Level of Care” system has long been used as a means of determining appropriate services and service intensity for a consumer. For many years, TMRSN utilized a two (2) tiered system (Level of Care “B” and Level of Care “C”) to help determine the appropriate level of services for consumers. Level of Care “B” was intended for brief treatment needs, while Level of Care “C” was intended for longer-term, community-based services. In recent years TMRSN has recognized that a more sophisticated, consumer sensitive system was needed. In late 2012 TMRSN made the decision to adopt a new Level of Care system – the Level of Care Utilization System (LOCUS) and the Children and Adolescent Level of Care Utilization System (CALOCUS).

The LOCUS/CALOCUS was developed by the American Association of Community Psychiatrists (AACP) and the American Academy of Child and Adolescent Psychiatry (AACAP). The purpose of these instruments is to help guide assessment (both at the time of initial intake and at the time of re-authorization), to help make appropriate service Level of Care placement decisions, to define continuing stay criteria, and to help measure clinical outcomes. By adopting the LOCUS/CALOCUS TMRSN will better be able to manage limited mental health resources. After the LOCUS/CALOCUS is administered, a Level of Care is recommended to TMRSN by the Network Provider – based on the results of the instrument. Under each Level of Care a “menu of services” exists where case managers and therapists can select the appropriate level of treatment. TMRSN will be able to monitor utilization under each Level of Care, as well as encourage providers to better define the consumer’s episode of care. LOCUS/CALOCUS is recovery based in that it encourages intensive services up front, requires more supporting documentation at re-authorization, and helps identify service gaps within the system.

In 2013 all providers were trained on use of the LOCUS/CALOCUS instruments. The new system was officially implemented on January 1, 2014. During the first six months of the implementation providers will be allowed to practice completing the LOCUS/CALOCUS instruments. As of July 1, 2014 all consumers will be required to have a LOCUS/CALOCUS Level of Care.

Operational Review Program

In 2011 a new review program was devised to thoroughly and comprehensively review programs that are funded through TMRSN. Although all programs have traditionally undergone annual contract reviews, and each has their own set of contract performance measures, expectations and deliverables, some programs did not historically undergo a comprehensive, “top to bottom” review. The Operational Review process was established so that each year all major programs funded by TMRSN will undergo a formal operational review. Operational Reviews consist of three (3) distinct elements:
• **Clinical Chart Review:** Standardized review instruments were developed for each program that encompassed (1) WAC/RCW requirements, (2) TMRSN policy and procedure, and (3) specific contract requirements from the program’s Statement of Work (SOW).

• **Program Review:** The program review examines how the specific program is operating on a day-to-day basis. It includes a thorough review of the program’s Statement of Work, interviews with program staff and supervisors, and an evaluation of whether or not consumers are being served as originally intended by the program. A unique set of questions were developed for each program in order to get an understanding of how the program is operating in the “real world.”

• **Utilization Review:** The utilization review examines the total number of consumers served, the total hours of service provided, and the costs – as compared to consumers served and the overall units (hours) of service. The utilization review also critically examines whether or not services were delivered in the appropriate categories, durations, and intensities (according to TMRSN Data Reporting Guidelines, Contract requirements, Level of Care Guidelines, and clinical best practice).

In 2013, Seven (7) Operational Reviews were performed. At the end of each review, a detailed report was provided to the agency responsible for administering the program. This report listed any deficiencies that were noted in the review and requested that the agency submit a performance improvement plan (PIP) on how those deficiencies will be corrected.

Eight (8) programs have been identified to receive Operational Reviews on a rotating basis, which include:

- Mentally Ill Offender (MIO) Program
- Mentally Ill Juvenile Offender Program (MIJOP)
- Access Center
- Mental Health Services in a Residential setting (Residential Pathway Program)
- Program of Assertive Community Treatment (PACT)
- Projects for Assistance in Transition from Homelessness (PATH)
- Mason Thurston Wraparound Initiative (MTWI)
- Children’s Crisis and Stabilization and Support program

**Thurston Thrives |**

Thurston Thrives is a community health improvement initiative of the Thurston County Board of Health aimed at bringing together community partners of Thurston County around the common work shared by all. Thurston County Public Health and Social Services (PHSS), in which TMRSN resides, coordinates the initiative. One of the primary aims of the project is to ensure that the County is thriving through vigorous collaboration of public health and social service agencies in order to honor those who make Thurston County a healthy and safe place to live, and to align efforts to make an even bigger difference in the health of the community. The purpose is to engage leaders across the board to move forward an action agenda all citizens can believe in to improve health (length of life and quality of life) for all Thurston County residents.
Nine (9) Thurston Thrives Action Teams, each focused on a key factor in the overall health of the community, have been developing strategies to advance the community’s health. The nine (9) teams include: Food, Economy, Community Design, Housing, Education, Child and Youth Resilience, Environment, Community Resilience, and Clinical & Emergency Care. As of the end of 2013, four (4) of the action teams had completed preliminary strategy maps.

What is crucial about these nine (9) different strategies is that they offer the community defined activities, directed goals and objectives and a vision to improve overall community health, including behavioral health. Some of the critical behavioral health strategies that are part of Thurston Thrives and TMRSN include:

- Integration of Care
- Decreasing utilization of jails as a mental health holding facility
- Providing on-site services to shelters, transitional, and permanent housing
- Improving the provider network for outpatient and peer support of behavioral health care to ensure a greater diversity of contractors who can deliver integrated, evidence-based recovery and resiliency, and community oriented care
- Diversion and transition of patients from emergency departments, jails, and homelessness

**Treatment Sales Tax**

The Revised Code of Washington (RCW) 82.14.460 stipulated that one tenth (1/10) of one percent (1%) of collected sales tax dollars go towards services that would reduce the negative impacts of mental health and substance abuse on children, families and adults with an emphasis on those individuals involved with, or at risk of, involvement with the jail/correctional system. In 2009, the Thurston County Board of County Commissioners adopted Ordinance #14138 that further defined how this revenue should be spent. After a lengthy cross-departmental collaborative process and public review, TMRSN secured funding for several programs during this period, looking to either offset state funding reductions for services or to fund services not otherwise covered by Medicaid. Some of these programs included:

- **The Mentally Ill Offender Program (MIO)** – MIO is a program that provides mental health and crisis services to incarcerated adults in the Thurston and Mason County Jails. MIO services include: (1) identifying incarcerated adults who are mentally ill and in need of mental health services, (2) on-site crisis services, (3) referrals to other key services such as outpatient mental health treatment, (4) enrollment in publicly-funded benefits when the participant is released from jail, and (5) diversion alternatives to incarceration (i.e. Thurston County Mental Health Court), if appropriate.

- **Mentally Ill Juvenile Offender Program (MIJOP)** – Similar to the adult MIO program, MIJOP provides on-site services to youth in the Thurston and Mason County Juvenile Justice system. Services emphasize support of the family to help the adolescents re-engage successfully in the community.

- **Multisystemic Therapy (MST)** – MST is a program used with severely behaviorally challenged and substance-abusing juvenile offenders (age 11 – 17). Therapy focuses on promoting positive social behavior while decreasing antisocial behavior and can occur in the home, school, or other
community setting. MST is family-oriented, based on the philosophy that the most effective and ethical route to help youth includes helping their families.

- **Mason-Thurston Wraparound Initiative (MTWI)** - MTWI provides high-fidelity Wraparound supports modeled after the principles of the national wraparound model. MTWI is not a treatment program; rather, it is a community-based family planning process that shows promise in reducing the number of children placed in more restrictive settings (e.g. therapeutic foster care, psychiatric hospitals) due to improvements in behavior and functioning. MTWI is voluntary; however, the approach is highly participatory as the family or caregiver of the child must be committed to engage in team development, goal setting, and implementing the strategies and/or services identified by the team.

- **Co-occurring Treatment Services (COD)** – COD services are for clients with a dual diagnosis of chemical abuse and mental illness. Services emphasize the need to cross over care for both disorders with staff trained to do so.

- **Mental Health Court** – An evidence based practice that combines a specialized court docket with mental health care coordination and treatment for individuals that can be diverted from jail or have their length of stay in jail reduced.

### Program Descriptions

**Outpatient Services |**

Outpatient programs are designed to offer a wide array of mental health services to enrolled consumers. TMRSN must consider the capacity of current available services and work towards making the full range of contracted services available – in sufficient number, mix and geographic distribution - to all current and anticipated Medicaid enrolled individuals. This includes closely monitoring population trends, anticipated Medicaid enrollments, and the feasibility of the current mental health system to expand to meet unmet needs, if necessary.

**Access/Entry**

Access and Entry refer to the “front door” of service provision. It is the point at which most individuals come into services. After a consumer requests mental health services, and financial eligibility (Medicaid) is determined, initial services in the form of a mental health intake assessment is provided. If the consumer meets Washington State Access to Care Standards (ACS) – which includes meeting Medical Necessity – they are enrolled into appropriate services (programs). If consumers do not meet Medical Necessity, they may be referred to other community resources or be provided with brief crisis services. Access/Entry services also include outreach to hospitals and liaison work with Western State Hospital to facilitate entry into outpatient services.

**Core Outpatient Services**
Core Outpatient Services is considered a program within the overall array of outpatient services. The vast majority of all consumers – both children and adults – receive basic Core Outpatient Services. These services are provided in Community Mental Health Agencies (CMHAs) or by other community providers, by Mental Health Professionals (MHPs) or other trained mental health providers. Core outpatient services include, but are not limited to:

- Case management
- Psychiatric evaluation
- Crisis services
- Psychosocial rehabilitation services
- Medication monitoring
- Group therapy
- Medication management
- Peer support services
- Community support and outreach
- Psychoeducational services

**Medication Management and Monitoring**

The prescribing, administering, and/or reviewing of medications and their side effects is a critical medication management core service and is provided by licensed mental health care providers. Medication monitoring involves face-to-face, one-on-one cueing, observing, and encouraging an individual to take medications as prescribed. It also includes working closely with the persons licensed to provide medication management services for the direct benefit of the individual. Medication management and medication monitoring can be a consumer’s primary service; however, all network providers (at this time) require that a consumer also be enrolled in a secondary outpatient service, such as case management services, in order to better monitor a consumer’s progress.

**Community Support Services**

Community Support Services can refer to a core case management program that provides individual, group and/or family treatment services along with case management, medication evaluation and monitoring. These services are typically provided in the community or in the consumer’s home.

Community Support Services can also refer to outpatient services provided to consumers on a Less Restrictive Alternative (LRA) court order when involuntary treatment services are necessary, consistent with statutory regulations.

**Other Outpatient Programs**

In addition to traditional outpatient services and programs (Core Services), there are a variety of TMRSN-funded programs that offer value to consumers’ lives. Some of the major outpatient programs are briefly described below:

- **Washington Program of Assertive Community Treatment (WA-PACT):** PACT is an evidence-based treatment approach and program designed to provide high intensity services to individuals with a current diagnosis of a severe and persistent mental illness who are experiencing severe symptoms and have significant impairments. These individuals must also have demonstrated a combination of continuous high service needs and functional impairments and have not shown to benefit significantly from other outpatient programs currently available. The program is currently operated by Behavioral Health Services (BHR).
• **Partial Hospitalization**: Partial hospitalization is a day treatment program designed to assist those who are struggling with the transition from hospitalization, or other inpatient setting, to traditional community living. Consumers in this program receive up to six (6) hours of service per day. The program is currently operated by Providence St. Peter Hospital in Olympia.

• **Mental Health Services in a Residential Setting**: This is a program that seeks to assist the consumer in maintaining their residential setting by providing necessary mental health support. In 2013, mental health services were provided in three (3) apartment complexes to over fifty (50) consumers. Services are intended to provide supportive services for acutely or chronically mentally ill adults, seriously disturbed adults at risk of becoming acutely or chronically mentally ill, and/or those with a significant risk of becoming homeless due to their mental illness. Services include medication monitoring, skills development, social and vocational integration into the community, and symptom management and recovery.

In late 2013 the Residential Program underwent some significant changes. Beginning in 2014 TMRSN will expand allowable coding to support “mental health services to support residential placements.” This means that providers will be encouraged to provide services in the community – regardless of the type of residential setting – to help stabilize and maintain a consumer’s current residential status. Part of these changes will allow for more psychosocial rehabilitation and skills development services. By expanding coding for mental health services in a residential setting, services to prevent homelessness can more accurately be collected and providers encouraged to provide the services. One of the priorities of TMRSN in 2014 is to increase community outreach and engagement in order to assist consumers who are homeless or are in danger of becoming homeless.

• **Mentally Ill Offender Program (MIO)**: This service provides cross-system coordination and services between mental health and local correctional institutions (Thurston County Jail, Olympia City Jail, and Mason County Jail). Services include identification and referral, intake assessments, diversion, crisis intervention services, transitional case management and discharge planning, training, and consultation for incarcerated individuals who meet the criteria for “priority population” due to acute/chronic mental illness.

Late in 2013 TMRSN began the process of redesigning this program to fold MIO services under a new, expanded program to include community outreach and engagement. This new program – entitled the Community Integration and Outreach (CIO) program – would include all components of the MIO program, but also add in an aggressive community outreach and intensive case management component to reach others who are homeless, or who are in a higher level of care such as community hospitals or E&T.

• **Services to At-Risk Seniors (STARS)**: STARS is a program designed for older adults. It is a day-program that strives to assist disabled adults live as independently as possible in their own homes – with family members or caregivers. The service is designed to enhance the physical, mental, cognitive and social well being of seniors with chronic, mental health issues and progressive diseases such as Alzheimer’s or other forms of dementia. STARS has historically been overseen through a contract with Behavioral Health Resources (BHR). In 2013, however, BHR decided to retire this program. As of April 1, 2014 STARS is no longer offered in the TMRSN catchment area.
• **Peer Support Services:** The Peer Support program is a specialty service offered by Capital Clubhouse d/b/a Capital Recovery Center (CRC). CRC is a newly licensed Community Mental Health Agency that is consumer run and operated. It provides peer support services in the form of individual and group services. Peer Support services are provided by certified peer counselors to individuals under the consultation, facilitation and supervision of a Mental Health Professional who understands rehabilitation and recovery. This service provides scheduled activities that promote socialization, recovery, self-advocacy, development of natural supports, and maintenance of community living skills.

• **Projects for Assistance in Transition from Homelessness (PATH):** PATH is a federally funded outreach program that focuses on identifying resources for the mentally ill homeless population, or those in danger of becoming homeless. It is intended to link individuals who are not currently engaged with the mental health system with both mental health and housing services. This program is currently administered by the Capital Recovery Center.

• **Children’s Mental Health Specialist – Joint Position:** The Joint Program is a joint project between the Division of Child and Family Services (part of DSHS) and TMRSN. The purpose of this program is to enhance cross system collaboration and to assure early linkage and intervention for acute or severely emotionally disturbed children. The program funds one (1) individual whose responsibilities include triage, assessments, next day appointments, crisis case management, home/community outreach, consultation, cross system coordination, medication referrals, and referral/linkage to other local resources.

• **Multisystemic Treatment (MST) / Children’s Evidence Base Practice:** TMRSN is always looking at Evidence Base Practices (EBPs) and ways to incorporate them into the milieu of offered services. EBPs are treatment modalities, or approaches, that have been extensively studied and have demonstrated success in the field. MST is one of the EBPs TMRSN is currently engaged with. It is funded through a combination of grants, Treatment Sales Tax and Medicaid. The program follows national standards on who is served, what services are provided, and the level of clinical skills required to provide the services. The MST program is specifically concerned with youth who are considered at-risk and/or who have had involvement with the juvenile justice system. This program is currently administered through Community Youth Services (CYS).

• **Mason Thurston Wraparound Initiative (MTWI):** This high-fidelity Wraparound program was implemented in Thurston County in November 2010 using Treatment Sales Tax dollars. After rigorous monitoring of the program for a 6-months period, it was determined that the program was meeting the National Wraparound Initiative’s adherence standards and was generating sufficient encounters to fiscally justify expansion using TMRSN-Medicaid dollars. The program has expanded several times since first being introduced. At the end of 2013 the program had capacity to serve sixty-two (62) Medicaid children, and four (4) non-Medicaid children.

MTWI provides wraparound supports and services modeled after the principles of the national wraparound model. It is a community-based program that relies on utilizing identified family and natural supports to assist in the planning process in order to reduce the number of children placed in more restrictive settings (e.g., therapeutic foster care, psychiatric hospitals). MTWI is voluntary; however, the approach is highly participatory as the family or caregiver of the child must be
committed to engage in team development, goal setting, and implementing the strategies and/or services identified by the team.

- **Children’s Crisis Stabilization & Support Program:** This program is currently offered by Catholic Community Services of Western Washington for consumers in Thurston and Mason Counties. The program provides immediate crisis stabilization services for children and adolescents. Services are provided in the community on a 24/7 basis. Once immediate stabilization has been achieved, the program offers a supplemental support program that can last an additional sixty (60) days if it is clinically indicated and will help achieve a lasting period of stabilization.

- **Mentally Ill Juvenile Offender Program (MIJOP):** This mobile crisis program provides mental health diversion services for adjudicated and at-risk juveniles who are severely mentally ill in Thurston and Mason Counties. These services include identification, diversion, referral, staff and family support, consultation, and training provided by a Child Mental Health Specialist. This program took a brief hiatus in 2013 as it transitioned to a new CMHA (Community Youth Services), but is now back offering these services.

**Crisis Services |**

**Crisis Information and Referral Services**

This program maintains complete, accurate and current information on mental health and human service resources in data banks, published materials and directories, and provides information, referral and crisis telephone services to residents of Thurston and Mason Counties 24 hours a day, seven days week by trained adult and teen volunteers. This program was administered though a sub-contract with Behavioral Health Resources (BHR) during 2013. In early 2014 this program is scheduled to leave BHR and become a direct contract through TMRSN.

**Crisis Resolution Services (CRS)**

This is a service whereby crisis interventionists and Designated Mental Health Professionals (DMHPs) provide crisis evaluation and intervention anywhere within Thurston and Mason Counties. If, after careful evaluation, the consumer can demonstrate enough insight, self-care ability, and/or community and family support to remain safely in their primary residence, they are encouraged to do so. If the consumer can remain safely in their primary residence, CRS staff will work with the consumer to provide information on other community resources and will provide follow up services, as necessary. If a consumer is unresponsive to CRS intervention, declines voluntary services, appears to present a risk of harm to self or others, or appears gravely disabled, the DMHP may evaluate the consumer for involuntary treatment if found to be medically necessary.

**Crisis Stabilization and Transitional Unit (CSTU)**

The CSTU is a voluntary, short-term (generally not over 30 days) program designed to provide observation, evaluation and brief treatment for adults in crisis. In addition, it provides voluntary transitional care for adults who require a more structured therapeutic environment than can be
provided in an outpatient setting alone. The CSTU is oftentimes used as a step-down program for those transitioning out of Western State Hospital (WSH) or discharging from the Evaluation and Treatment Center (E&T) or community inpatient setting. The CSTU provides a place for consumers to rest, sleep, eat and recover – with a minimum of auditory and visual stimulation. Authorizations for the CSTU must come from the TMRSN. The CSTU is located at the Evaluation and Treatment Center (E&T) in Olympia and has a total of ten (10) available beds.

Inpatient Care |

**Evaluation and Treatment Unit (ETU)**

TMRSN funds the Evaluation and Treatment Unit (ETU) within the Evaluation and Treatment Center (E&T) – housed in a County-owned building on Mary Elder Way in Olympia. The ETU, while not considered a hospital, is the only location in Thurston or Mason Counties where individuals may be involuntarily detained. If, in the opinion of specially trained Designated Mental Health Professionals (DMHPs), a person presents as a danger to him/her self or the public at large or is determined to be gravely disabled, he/she may be detained at the ETU. Consumers in the ETU receive acute psychiatric care that is comprehensive and individualized. Authorizations for placement in the ETU must come from the TMRSN. There are a total of fifteen (15) available ETU beds.

ETU staff are only able to treat individuals that do not have major medical or physical problems, as they are not considered a hospital. Consumers are generally required to have a medical/physical evaluation prior to admission into the ETU. Consumers that are brought to the ETU by law enforcement for a misdemeanor crime as a result of a mental illness may receive services. For those with a felony charge, law enforcement presence may be required during an assessment. Consumers under the influence of recreational (street) drugs or alcohol may receive mental health services at the E&T Center. However, for those who require medically monitored detoxification, the consumer may be transferred to a suitable drug and alcohol program.

**Community Hospitals**

Serving Thurston and Mason Counties, Providence St. Peter Hospital has an inpatient psychiatric facility where individuals may temporarily (and voluntarily) stay in order to stabilize a crisis episode. Oftentimes, a person will transition into the E&T or the CSTU from community hospitalization. When space is not available in Thurston County, other available community hospital settings are sought. Community inpatient hospitalizations must be pre-authorized by TMRSN.

**Western State Hospital**

Western State Hospital (WSH) is one of two (2) state-operated mental health hospitals in the State of Washington. Individuals residing at WSH are there voluntarily or involuntarily. Due to the high cost of hospitalization (both at WSH and in community hospitals) and requirements around Least Restrictive Alternatives (LRAs), the goal is always to move people out of hospital-settings and into more community-based programs and services. Authorizations for placement at Western State Hospital must come from the TMRSN.
Beds at Western State Hospital are paid for by the Department of Social and Health Services (DSHS). TMRSN was allotted thirty (30) beds at any given time in 2013. If utilization goes over the allotted number of beds, TMRSN must cover the additional costs.

Providers in the TMRSN Network

Thurston Mason Regional Support Network consists of six (6) primary Network Providers. Of TMRSN’s network of providers, Behavioral Health Resources (BHR) is the largest provider in both Thurston and Mason Counties.

Behavioral Health Resources (BHR)

Behavioral Health Resources provided mental health services for over ninety (90) percent of the Medicaid and State-Funded eligible consumers (who sought mental health services) in Thurston and Mason Counties during 2013. BHR offers a large, comprehensive package of mental health services including:

- A full array of comprehensive adult outpatient mental health services, including an Assertive Community Treatment (ACT) team, a Client Accessed Support Team (CAST), and a residential services program designed to support a consumer’s mental health needs within a residential setting.
- A full array of children’s outpatient mental health services, including a co-occurring disorders program, Mentally Ill Juvenile Offender Program (MIJOP), and an integration program for children transitioning back into their home of origin after a facility detention.
- Crisis services – including the Crisis Stabilization and Transitional Unit (CSTU) and Crisis Resolution Services (CRS).
- Inpatient services – including the Evaluation and Treatment Unit (ETU).

BHR operates at six (6) locations in Thurston and Mason Counties. These include:

<table>
<thead>
<tr>
<th>Office Name</th>
<th>Address</th>
<th>City / State</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult Services and Administration</td>
<td>3857 Martin Way E</td>
<td>Olympia, WA</td>
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<tr>
<td>Medical Services</td>
<td>4422 Sixth Avenue</td>
<td>Lacey, WA</td>
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<tr>
<td>Children Services</td>
<td>3773-A Martin Way E</td>
<td>Olympia, WA</td>
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<tr>
<td>Recovery Services</td>
<td>6128 Capitol Blvd</td>
<td>Tumwater, WA</td>
</tr>
<tr>
<td>Adult and Children Services</td>
<td>110 West K Street</td>
<td>Shelton, WA</td>
</tr>
<tr>
<td>Evaluation and Treatment Center</td>
<td>3436 Mary Elder Road</td>
<td>Olympia, WA</td>
</tr>
</tbody>
</table>

Table 4 - Behavioral Health Services (BHR) Thurston and Mason County locations

Capital Clubhouse d/b/a Capital Recovery Center

Capital Recovery Center has been a Thurston County tradition since 1989 – operating as the Capital Clubhouse and providing clubhouse services for consumers in downtown Olympia. In 2012 the Clubhouse received its initial Community Mental Health Agency license and changed its name to the Capital Recovery Center (CRC). In the fall of 2012 the CRC began providing peer-support services –
both as a primary provider and as an ancillary service. CRC is located at 1000 Cherry Street SE, Olympia, WA 98501.

**Catholic Community Services**

Catholic Community Services (CCS) is TMRSN’s provider for the Mason-Thurston Wraparound Initiative (MTWI) and Children’s Crisis Stabilization Support program. Catholic Community Services and Catholic Housing Services (CHS) have been in Western Washington for more than ninety (90) years. The mission of CCS and CHS is to serve as an advocate for “individuals, children, families, and communities struggling with poverty and the effects of intolerance and racism.” Catholic Community Services is located at 148 Rogers Street NW, Olympia, WA 98502.

**Community Youth Services**

Community Youth Services was founded in 1970 as the Thurston Youth Services Society. Initially it was established to assist youth who were involved in the criminal justice system. Today, CYS is the largest child serving agency in southwestern Washington, supporting over seventeen (17) programs with a staff of seventy-five (75) paid employees and 120 volunteers. CYS programs serve some 3000 children per year. Community Youth Services is the Multisystemic Therapy (MST) provider for Thurston and Mason Counties. In mid-2013 CYS took over administration of the Mentally Ill Juvenile Offender Program (MIJOP) that had been with Behavioral Health Resources. CYS is located at 711 State Ave NE Olympia, WA 98506.

**Providence St. Peter Hospital**

Providence St. Peter Hospital (PSPH) is primarily a health care facility and hospital – treating the full spectrum of physical health maladies. The hospital is located at 413 Lilly Road in Olympia. The hospital also provides mental health services, including:

- An 18-bed voluntary acute care unit for inpatient psychiatry. Treatment is provided to adults eighteen (18) and older who are experiencing a mental health crisis. The treatment team includes a psychiatrist, social worker, psychiatric nurses and occupational and recreational therapists.
- A program of partial hospitalization that serves as a transition and/or alternative to traditional hospitalization. It is an intensive weekday program that includes group therapy and activities, family support, education and links to community resources. Flexible scheduling encourages an early return to independent living.
- Older adult services that specialize in working with adults age 55 and older who are seeking diagnosis and treatment for mental health problems and support for maintaining tenure in the community. Services are designed to provide symptom management and to facilitate social integration in the community.

**Sea Mar**

Sea Mar is a health and human services provider that began in Seattle in 1978. Their primary focus is working with low income, underserved, and uninsured populations in Western Washington – with a primary emphasis on work with Latino populations. Sea Mar is a Federally Qualified Health Center (FQHC) that provides medical care for these populations.
SeaMar offers English and Spanish outpatient mental health services – including case management, individual and family counseling, and psychiatric medication assessments and management for adults. Sea Mar also offers chemical dependency and substance abuse outpatient treatment for both English and Spanish speaking consumers, including intensive outpatient and after care.

Sea Mar has been expanding within the TMRSN catchment area for the last several years. They now offer services in several locations throughout Thurston County specifically. These include:

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<th>Office Name</th>
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<th>City / State</th>
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<tr>
<td>Tumwater Behavioral Health</td>
<td>409 Custer Way</td>
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<tr>
<td>Olympia Behavioral Health</td>
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<tr>
<td>Lacey Behavioral Health</td>
<td>669 Woodland Sq. Loop SE</td>
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Table 5 – Sea Mar Behavioral Health locations

**Budget and Expense Review**

Information about the expenses of TMRSN can be found in Figures 4 and 5 below. This information represents Calendar Year 2013 (January 1, 2013 through December 31, 2013). Figure 4 displays a comparison of the eight (8) major expenditure categories between 2011, 2012 and 2013. Figure 5 includes percentages of the total costs for 2013 expenditures.
Figure 4 – Budget Expenditures: 2011, 2012 and 2013 Comparison

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<th></th>
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Figure 4 – Budget Expenditures: 2011, 2012 and 2013 Comparison
Looking Ahead

TMRSN was faced with many new and existing challenges and opportunities at the start of 2013. During the 2013 legislative session there were renewed calls for consolidation between the various RSN’s – namely to reduce the overall number of RSN’s from eleven (11) to nine (9) – in order to increase efficiency and share resources. A new bill required that a task force be established to look at combining some of the existing RSN’s, or to reconfigure the mental health service delivery regions. A report on this task force is due to the Legislature in mid-2014.

Several other significant developments occurred during 2013 that will have an effect on the mental health delivery system in 2014. The first revolved around concerns that the Center for Medicare & Medicaid Services (CMS) had regarding how mental health services were procured in Washington State. These concerns – ultimately alleviated though conversation between DBHR and CMS – brought to light some of the difficulties with managing eleven (11) separate entities. Another important development was the release of new Washington State Administrative Code (WAC). This WAC (388-877) closely tied mental health services to chemical dependency and problem gambling. In 2014 providers on both the mental health and chemical dependency sides will have to determine how to
best meet the intent of these new regulations. Closely related to this, Washington’s new Governor has publically stated that it is his intent to ensure that the full array of health services (mental health, physical health, chemical dependency) are all brought together under one cohesive service delivery system. While the State has not achieved this goal, as yet, it will certainly be on the horizon for all RSN’s and health care providers statewide.

There continues to be an increased awareness with regards to shared resources and close collaboration amongst of the RSNs. In 2012 DBHR asked the RSN’s to collaborate more effectively and respond quickly to systemic needs. During 2013 the RSN’s began working on joint programs together. For TMRSN, this level of cooperation will continue into 2014, with projects both small (with one other RSN), and large (multiple RSN’s). One such project – described in greater detail in the body of this report – was the implementation of the LOCUS and CALOCUS with Grays Harbor RSN, Timberlands RSN, and TMRSN.

The State of Washington and all RSNs remain concerned, however, over the critical issue of State and Federal budget reductions and their impact on social and health services. Funding for TMRSN is subject to the fluctuations in State and Federal levels of funding. Expectations are that TMRSN will maintain current levels of service, regardless of any reduction in budget or increase in expense. TMRSN will, by necessity, examine ways to be more efficient and reduce non-required programming in order to maintain essential service delivery. The first priority of TMRSN will continue to be funding for acute care needs and to serve individuals in their own community. Other services, and those priority populations served, will have to be evaluated over the next year for continued funding and support.

In 2014, TMRSN will be focusing on several initiatives. These include:

1. **Health Care Reform:** As 2014 dawned health care across America changed for everyone. Changes brought about by the Affordable Health Care Act continue to be developed while, at the same time, thousands of new enrollees are entering into the Medicaid system for the first time. According to a January 6, 2014 report by the Washington State Health Care Authority, Thurston County had achieved 139 percent of the anticipated Medicaid enrollment for adults. This means that more people than anticipated have entered the system. What this ultimately means – for the mental health system – is that more consumers could be enrolled in mental health services. This will require that TMRSN be prepared to accept all new Medicaid consumers, and that there is system capacity to deliver the services.

   In 2014 TMRSN will continue to work with new and existing providers in order to forge new alliances, and strengthen existing ones, in order to better understand how service delivery care models will change and what the role of TMRSN and Thurston County will be as a result of these changes. Planning is already underway so that TMRSN will be well positioned to make decisions in response to the many health care reforms that are expected to take place during 2014.

2. **Health Care Integration:** Senate Bill 6312, and the companion House Bill 2639, passed the Legislature in early 2014 with Governor Inslee signing the bill on April 4, 2014. The law requires that mental health services and chemical dependency services be integrated by 2016. It further requires that physical health care be fully integrated with mental health and chemical dependency by 2020. The law also mandates that RSN’s be reduced in size to no more than nine (9) entities and that by 2016 they be referred to as Behavioral Health Organizations (BHOs). During 2014 different
task forces will be convened to recommend new regional configurations, funding structures, and integration strategies to make this transition as seamless as possible. TMRSN will continue to work closely with other Regional Support Networks, as well as the Washington State Association of Counties (WSAC) and the State, in order to represent the needs of Thurston and Mason Counties and its consumers.

3. **Outpatient Mental Health Expansion:** In late 2013 TMRSN began the process of developing a Request for Qualification (RFQ) in order to expand outpatient mental health services and providers within Thurston and Mason Counties. In 2014 TMRSN will be developing a community-wide survey to gather input about the current mental health system. Also, TMRSN will be hosting a cross-system forum to discuss key priorities and objectives of TMRSN. Partners at the forum will include representatives from criminal justice, housing, education, employment, as well as mental health providers. From the input gathered, TMRSN will develop a RFQ and submit it statewide. The purpose of the RFQ will be to diversify mental health providers within Thurston and Mason Counties, and to select providers who are in alignment with those priorities and objectives identified from community input gathering. TMRSN hopes to conclude the RFQ process, and select new providers, by the fall of 2014.

4. **Utilization Management:** In 2014 TMRSN will continue to focus on the implementation of the Level of Care Utilization System (LOCUS) and the Child and Adolescent Level of Care Utilization System (CALOCUS). As stated in the body of this report, TMRSN is heavily invested in managing its limited resources in the most logical, systematic and ethical ways possible. The LOCUS/CALOCUS affords TMRSN an opportunity to manage utilization in an effective manner. The LOCUS/CALOCUS will provide much clearer authorization guidelines for Network Providers, as well as more flexibility in providing a level of care that more closely fits with the needs of the consumer.

The LOCUS and CALOCUS project will continue to be a joint initiative between Timberlands RSN, Grays Harbor RSN and TMRSN. However, each entity is now at a different place with regards to implementation. The purpose of this project was to re-evaluate and re-write the Level of Care Guidelines within TMRSN. The Level of Care Guidelines is the current authorization structure that providers use when authorizing a consumer for services. It provides guidance on the length of service, intensity, and allowable services. This was accomplished in 2013. In 2014 TMRSN will focus on ensuring that the instruments are used consistently among all network providers, and that all agency personnel have been appropriately trained. The new guidelines – along with a continued emphasis on treatment and discharge planning (to clearly define an “episode of care”) – will help TMRSN better manage limited resources and ensure that consumers receive an appropriate amount of service for an appropriate amount of time.

5. **Wraparound with Intensive Services (WISE):** A class action lawsuit was filed against Washington (T.R. et al v. Quigley and Teeter) on November 24, 2009. The Settlement Agreement dated December 19, 2013 requires Washington to implement Wraparound with Intensive Services (WISE) statewide over the following five years. The WISE program is intended to address the needs of Medicaid-enrolled children/youth (up to age 21 years) needing intensive services in their own homes and communities rather than in out-of-home care and institutional settings. The benefit of WISE is that it pairs the family-driven Wraparound care planning model with individualized, evidence-based therapies and it allows clients/families to address their needs in one program rather than through multiple providers. Eligibility will be determined through a WISE screen, which
includes use of the Child and Adolescent Needs and Strengths (CANS) screening tool to determine medical necessity.

TMRSN is in a unique position to fully implement WISE in July 2014. Thurston-Mason was selected as one of the early implementation locations due to our community’s readiness. The Mason-Thurston Wraparound Initiative has been in operation since December 2010 and the program has produced statistically significant outcomes across most domains. Similarly, the Multisystemic Therapy program has produced outstanding outcomes over the past year and will be recognized as an “enhancement” to WISE. TMRSN will use the existing infrastructure to develop our WISE Programs. During the first six (6) months of 2014 TMRSN, will be engaged with its community partners and contractors (Donna Obermeyer, Catholic Community Services and Community Youth Services) in training and preparations for the WISE program. TMRSN will also be partnering with the University of Washington’s Dr. Eric Bruns, who will serve as the primary consultant for this project.

6. **Improved Access to Care:** In 2013, positive changes were sustained in the length of time between a request for service and an intake appointment. These changes were brought about when the network’s largest provider – BHR – developed and opened up the Access Center. The Access Center, which provided on demand (walk-in) intakes, opened in late 2011 and the affect for Thurston County residents over the past two years has been dramatic. In 2014 BHR will incorporate key concepts of the Access Center (Walk-in model) into their traditional outpatient program. This means that there will no longer be a central location for new intakes, but rather, all on-demand intakes will be available in the same location where consumers would go for ongoing, routine mental health services.

In addition to these changes, in 2014 TMRSN will continue to focus its efforts on improving the wait time between initial intake appointment and the first routine visit. This quality improvement project will include working with network providers to ensure that consumers have an appointment set for their first routine appointment when they leave their intake appointment and that the appointment is within fourteen (14) calendar days from the intake.

7. **DSM-5 / ICD-10 Conversion:** In 2013 the American Psychiatric Association (APA) updated the Diagnostic and Statistical Manual of Mental Disorders (DSM). Also in 2013 the World Health Organization (WHO) finalized the International Statistical Classification of Diseases and Related Health Problems (ICD). Of note with the publication of these two manuals is that the DSM-5 now uses the same coding as the ICD-10. Under the Health Insurance Portability and Accounting Act (HIPAA), managed health care organizations must use HIPAA-approved billing codes for all health related reporting. In short, this means that all mental health codes normally found within the DSM are now also found in the ICD-10. Beginning October 15, 2015 all managed health care organizations – to include RSNs – must begin using the new codes for billing and reporting mental health encounters.

In 2014 the RSNs will be joining with the State to create a crosswalk between the DSM-IV and the DSM-5. The new DSM-5 has some significant changes that will also necessitate the creation of a new Access to Care Standards (ACS) document for Washington State. One of the biggest changes is that the Global Assessment of Functioning (GAF) and the Children’s Global Assessment Scale
(CGAS) will be eliminated. In its place the State must determine new eligibility criteria in which consumers will be accepted into mental health services.