

SECTION 2 - MENTAL HEALTH



INTRODUCTION

The Mental Health Division (MHD) operates with many partners, including the 12 designated Regional Support Networks (RSN) and their network of over 150 subcontracted community-based mental health providers. MHD operates an integrated public mental health system for persons experiencing mental illness who are enrolled in Medicaid, for those who are low income and meet the statutory need definitions, and for those in psychiatric crisis. MHD is committed to a seamless system of care that can support the recovery and resilience of consumers in a cost effective and efficient manner.

This strategic plan is the MHD's blueprint for system transformation and will be accomplished through measurable outcomes that demonstrate increased accountability.

Division strategic priorities for 2009-2013 are to:

- **Improve Access to and Quality of Mental Health Services**
- **Improve Supports for Recovery and Resiliency of Mental Health Consumers**
- **Increase Consumer and Community Safety through Effective Treatment**
- **Strengthen Capacity to Support the Overall Health of Individuals with Mental Illnesses**
- **Making Sound and Effective Community Investments**

SECTION 2 - CHAPTER 1 • OUR GUIDING DIRECTIONS

MISSION

The mission of Washington State's mental health system is to ensure that people of all ages experiencing mental illness can better manage their illness, achieve their personal goals, and live, work and participate in their community.

The mission of the Mental Health Division is to administer a public mental health system that promotes recovery and resiliency as well as personal and public safety.

1. We are committed to taking action consistent with these values.
2. We value the strengths and assets of consumers and their families, and seek to include their participation in decision-making and policy setting.
3. We respect and celebrate the cultural and other diverse qualities of each consumer.
4. We work in partnership with allied community providers to deliver quality, individualized supports and services.
5. We treat people with respect, equality, courtesy and fairness.

VISION

MHD is committed to creating a seamless system of care that is timely, effective and efficient, that treats each person holistically and embraces each person's ability to recover and gain the skills, insight and personal and interpersonal reserves needed to be resilient as circumstances and symptoms change. The hope is that people living with a mental illness will live, work, learn, and participate fully in their communities and without fear of discrimination.

GUIDING PRINCIPLES/CORE VALUES

In 2006, the MHD began to implement the System Transformation Initiative (STI), a planning process to align goals and develop improvements in areas identified by the State Legislature. The STI included a statewide taskforce with monthly meetings, several large public forums, and a series of reports by consultants with recommendations for improvements to the public mental health system. The STI process was expanded in 2007 to include a greater focus on children's mental health issues. The information and recommendations gathered through the STI processes has provided a framework for the MHD's strategic plan and related activities.

MHD has also implemented a statewide tribal mental health work group to respond to requests from Federally Recognized Tribes for government-to-government relations directly with the division. The guiding principals and core values of MHD included in STI planning processes and tribal collaboration processes include:

- Promote the understanding that mental health is essential to overall health for all Washington residents.

- Encourage consumers, their families, and advocates to drive their own mental health care and to be involved in their own individual recovery and resiliency process supported by the mental health system.
- Provide persons with multiple-system needs with an integrated system of care through services that are delivered in community settings whenever possible, and eliminate disparities in mental health services;
- Establish early mental health screening, assessment, and referral to services as common practice;
- Utilize data to drive decisions to continuously improve health care services and accelerate research;
- Require that business practices accommodate a changing environment, to include the use of technology to access mental health care and information

STATUTORY AUTHORITY

- Chapter 10.77 RCW - Provides for the commitment of persons found incompetent to stand trial or acquitted of a crime by reason of insanity, when found to be a substantial danger to other persons or that there is a likelihood of committing acts jeopardizing public safety or security unless under control by the courts, other persons, or institutions. Also provides an indigent person's right to be examined by court appointed experts.
- Chapter 71.05 RCW - Provides for persons suffering from mental disorders to be involuntarily committed for treatment and sets forth that procedures and services be integrated with Chapter 71.24 RCW.
- Chapter 71.24 RCW - Establishes community mental health programs through regional support networks that operate systems of care.
- Chapter 71.32 RCW - Authorizes mental health advance directives.
- Chapter 71.34 RCW - Establishes mental health services for minors, protects minors against needless hospitalization, enables treatment decisions to be made with sound professional judgment, and ensures minors' parents/guardians are given an opportunity to participate in treatment decisions.
- Chapter 72.23 RCW - Establishes Eastern and Western psychiatric state hospitals for the admission of voluntary patients.
- Chapter 74.09 RCW - Establishes medical services, including behavioral health care, for recipients of federal Medicaid as well as general assistance and alcohol and drug addiction services.
- Chapter 38.52 RCW - Ensures the administration of state and federal programs for emergency management and disaster relief, including coordinated efforts by state and federal agencies.

SECTION 2 - Chapter 2 • The People We Serve

OVERVIEW OF PEOPLE SERVED

Following is an overview of statistics related to individuals served in the public mental health system in fiscal year 2007:

- 121,824 people, approximately 95,000 of whom were covered by Medicaid, utilized mental health services in community outpatient settings
- 7,800 people received services in community hospitals
- 2,600 people received inpatient services in state hospitals
- Medicaid eligible people received over 80 percent of service hours delivered
- Some non-Medicaid consumers receive outpatient services (these tend to be minimal hours as would be consistent with a mental health evaluation)
- Many mental health consumers tend to be customers of other human service programs

REGIONAL SUPPORT NETWORKS AND COMMUNITY OUTPATIENT SERVICES

In 1989, the Washington State Legislature enacted the Mental Health Reform Act, which consolidated responsibility and accountability for individuals' community mental health treatment and care through Regional Support Networks (RSNs)¹, also known as Pre-paid Inpatient Health Plans (PIHPs). This consolidation included crisis response and management of the involuntary treatment program. Beginning in October 1993 through 1996, MHD implemented capitated managed care for community outpatient mental health services through a federal Medicaid waiver, creating prepaid health plans operated by the RSNs. In 1996, the waiver was amended to include community inpatient psychiatric care. By 1999, all RSNs were responsible for full risk management of inpatient community mental health care.

Under the Federal managed care 1915 (b) Medicaid waiver, RSNs enter into full risk PIHP contracts with the state to provide community inpatient and outpatient services to Medicaid eligible children and adults. As prepaid inpatient health plans, the RSN/PIHPs provide community mental health services described in the State Plan to consumers who meet the Access to Care standards for authorization into public outpatient mental health services. The Access to Care Standards were developed as a response to a condition of the 1915 (b) Medicaid waiver renewal which required the state to develop and implement a standard set of criteria, and a standard set of methods of implementation, to be used statewide in all RSNs/PIHPs for screening, assessment and authorization of services. Criteria and methods for implementation must assure that all Medicaid eligible individuals in need of mental health services have access to needed services. Treatment activities must be designed to support consumer goals as documented in the consumer's individual recovery plan. Services provided through the Medicaid waiver include:

- Individual counseling and psychotherapy services
- Medication management
- Crisis and stabilization services

¹ In Pierce County, DSHS has assumed the duties of the former Pierce County Regional Support Network which terminated their contract in January of 2008. Services in Pierce County are currently delivered through fee for service contracts between the state and local mental health providers.

- High Intensity Treatment teams, and evaluation and treatment centers (E&Ts)
- Peer Support services
- Respite care for caregivers, clubhouses, and supported employment as funding allows
- Day treatment (day support) for individuals needing an intensive rehabilitative program

The State Legislature has provided additional state funding designed to address the gaps in services created by restrictions in the Medicaid program. Key non-Medicaid services include:

- Crisis and limited outpatient services for primarily low income individuals who are not eligible for Medicaid
- Room and board for mental health consumers in licensed residential treatment programs
- Program of Assertive Community Treatment (PACT) teams implemented in nine counties
- Services to individuals in and transitioning from jails implemented statewide
- Community integration assistance program services for individuals with mental illness identified as high risk who are transitioning to the community from state prisons
- Innovative service grants for clubhouse and other consumer directed services
- Select evidence-based practice pilot programs for children including:
 - Wraparound pilots in three counties
 - A Multi-Dimensional Treatment Foster Care pilot program implemented in Kitsap County as an inpatient diversion for youth
 - A Multi-Systemic Therapy pilot implemented in Thurston County with the Skokomish tribe; and
 - Trauma Focused Cognitive Behavior Therapy training being disseminated statewide to children's specialty providers

RSNs are also required to promote access to safe and affordable housing and provision of services to individuals who are homeless. RSN community support services emphasize supporting consumers in their own homes and RSNs provide and/or coordinate with rehabilitation and employment services to support consumers seeking employment.

INVOLUNTARY TREATMENT AND INPATIENT SERVICES

RSNs administer the involuntary treatment act and the crisis response system for all people in their service area regardless of income or citizen status. In most communities, crisis and involuntary services are highly integrated. Crisis services include a 24-hour per day crisis line and in-person evaluations to the people of the community presenting mental health crises. Crises are to be resolved in the least restrictive manner and should include family members and significant others as appropriate to the situation and at the request of the consumer.

Involuntary treatment act services are available in all of the communities of the state 24-hours per day. These services include in-person evaluation of the need for involuntary psychiatric hospitalization. This evaluation is used to determine if a person meets any of the following criteria as the result of a mental disorder: is gravely disabled (as defined in 71.05 RCW) or there is a likelihood of serious harm (to self, others, or to property). In order to be hospitalized involuntarily, the person must meet the evaluation

criteria and have refused or failed to voluntarily accept evaluation and treatment to address the presenting symptoms.

For children and youth acute inpatient services are provided either in community psychiatric hospitals or in special units set aside for children and youths. Children's Long-Term Inpatient facilities (CLIP) provide inpatient care for those children and youth who need extended inpatient services. The CLIP facilities include the Child Study Treatment Center which is a 47 bed state run facility on the grounds of Western State Hospital. MHD also holds contracts for the operation of three CLIP programs. These facilities provide capacity for an additional 44 children statewide. Standing agreements between CLIP and the RSN detail the responsibility for the resource management of these 91 beds.

Adult acute services begin in community psychiatric hospitals or in freestanding evaluation and treatment centers (E&Ts.) Freestanding E&Ts are stand alone psychiatric treatment facilities certified to provide short term involuntary treatment services. For individuals requiring longer periods of treatment than community hospitals and E&Ts are able to provide, long term treatment services are provided by the two adult psychiatric hospitals operated by the state. Eastern and Western State Hospitals provide care for approximately 1200 individuals each day. Approximately 70% of individuals at the state hospitals are under civil commitment orders. The remaining 30% are receiving court ordered forensic services. These include:

- Evaluation of individuals for competency to stand trial
- Treatment to restore competency for those deemed not competent to stand trial
- Ongoing treatment for individuals judged not guilty by reason of insanity

In addition to the inpatient services provided at the state hospitals, there are currently forty voluntary residential beds operated as the Program of Adaptive Living Skills (PALS). PALS is a residential program on the grounds of WSH and is intended as a transitional program where former patients are taught community living skills.

Tribal Governments

The relationship between the government agencies of Washington State and the 29 Federally-recognized Tribes located within the State is governed by the Centennial Accord, which provides a framework for government-to-government relationships between the State and each sovereign Tribe. Although the Accord was initiated by the Governor of Washington State, it also recognizes the authority of the "chief representatives of all elements of state government" to ensure complete and broad implementation of the arrangement. The Mental Health Division (MHD), as part of the Department of Social and Health Services (DSHS), thereby maintains a direct working relationship with each of the 29 Tribes pursuant to the Centennial Accord.

While the primary relationship is between the State and each sovereign Tribe, essential relationships have formed between various agents acting on behalf of the State of Washington – including RSNs, and State-operated treatment facilities such as the State hospitals and Children's Long-Term Inpatient Program (CLIP) facilities – regarding day-to-day implementation of provisions of the State's involuntary treatment laws.

In 2007 the Mental Health Division and Suquamish Tribe completed a Memorandum of Agreement to allow the Tribe to directly refer children and youth to the statewide CLIP committee for consideration of a voluntary admission to inpatient/residential psychiatric care. Previously, the Tribe was required to utilize the local Regional Support Network for

an initial review prior to the state independent CLIP committee review. This government-to-government agreement gives full faith and credit to the Suquamish Tribe's mental health services and evaluation of their youths' needs for intensive inpatient/residential psychiatric care and may set the precedent for future agreements.

SECTION 2 - Chapter 3 • Environmental Context

APPRAISAL OF EXTERNAL ENVIRONMENT

Regional Support Networks

Over the past five years, there have been a number of factors which have increased pressure on RSNs. The Balanced Budget Act of 2003 increased federal requirements for Medicaid funded organizations operating as prepaid health plans in Washington State. Legislation passed in 2005 and 2006 resulted in increased standards and oversight of RSNs to ensure compliance with federal and state requirements. At the same time standards were being increased, changes in interpretation by the federal government on the use of RSN "savings" resulted in a significant loss of annual federal dollars beginning in fiscal year 2006. The Washington State Legislature provided state funds to make up for most of the loss of federal dollars and has provided additional resources in subsequent years. However, the RSNs continue to have less flexibility in their use of funding, particularly for services to individuals who are not eligible for Medicaid.

The impact of these factors has revealed pressures on the current RSN system. Over the past two years, two RSNs have ceased operations. The three counties previously covered by Northeast Washington RSN were incorporated into North Central Washington RSN in 2006 after Northeast Washington RSN failed to meet the minimum standards of an RFQ process. In August of 2007, Pierce County RSN notified the state they were terminating their contract. MHD took over direct management of services in Pierce County in January 2008. Two other RSNs have informed the state they are considering terminating their contracts as a result of the increased pressures and financial challenges.

A major area of concern for RSNs has been an ongoing loss of community hospital and involuntary treatment beds. The RSNs/PIHPs authorize and pay for community inpatient psychiatric care for residents in their service areas. As Medicare and private insurance continue to cut costs by trimming services and rates, community hospitals are examining their operations in order to eliminate or curtail services that are not cost effective. The result is that community hospitals are downsizing or threatening to close psychiatric wards, and the public mental health system is forced to deal with unmet demand. This situation is compounded by the fact that mental health costs grow at a rate higher than the state expenditure limit, similar to other health care costs.

While hospital resources are tight for everyone, children face even greater challenges due to a very small number of hospitals with specialized resources. This results in children often being hospitalized far from where they live making it difficult for their parents and caregivers to stay actively involved in their treatment. The small number of long term inpatient beds for children has resulted in long waiting lists for admission to CLIP facilities. For children under the age of 13, the waiting time is even longer.

A variety of activities funded by the legislature in the past few years are intended to assist with some of the challenges. These include:

- Funding of PACT teams and other intensive community resources which provide alternatives to inpatient care

- Increases in Medicaid and non-Medicaid funding rates for community hospitals providing psychiatric services to try to avoid further bed closures
- Funding of wraparound pilot programs to provide greater support to families with children in crisis

These initiatives are relatively recent and it will take some time to assess the impact they have on some of the issues noted above.

State Hospitals

The State Hospitals have also seen a number of changes in the past few years. A court ruling in September 2005 which prohibited waiting lists at the state hospitals resulted in the funding of five additional civil wards on a temporary basis. Four of the five wards are scheduled to be closed in conjunction with the implementation of PACT teams throughout the state.

In July 2007, the Legislature provided funding for RSNs to develop community alternatives for many of the individuals living in the PALS program at WSH. The Legislature directed MHD to begin charging RSNs for the cost of any individuals remaining in PALS. RSNs have utilized the funding to develop a variety of innovative community alternatives and the average daily census at the PALS program has dropped from 110 beds to 39 beds.

Although the number of individuals being referred for forensic services seems to have stabilized, pressure on the forensic units at the state hospitals remains. The state hospitals are making progress toward the goal of reducing the number of individuals waiting in jails longer than seven days for forensic evaluations.

Throughout the state hospitals, there has been progress in a number of key areas indicating improvements to treatment of patients:

- The number of Labor and Industries paid assault claims by staff has decreased by 52% since FY 2004 at WSH and by 50% at the CSTC since FY 2006 and claims at ESH continue to meet or be below the target.
- Seclusion episodes have decreased by 27% at WSH since FY 2004 and remain close to target at ESH. CSTC has seen an increase in the episodes of seclusion.
- Restraint episodes have decreased by 14% at WSH since FY 2004 and 2% at ESH since FY 2004 and episodes at CSTC continue to fluctuate significantly due partly to the small number of patients. All state hospitals are currently at or below the target rate.

Recent increases in staffing levels at WSH funded by the legislature should further MHD's ability to improve treatment of patients in the above key areas. That said, all of the state hospitals continue to struggle with recruitment and filling of vacant positions. Improvement in filling vacant positions, particularly physicians and nurses, will be important for meeting ongoing requirements for hospital accreditation and certification processes.

TRENDS IN CUSTOMER CHARACTERISTICS

Mental health consumers include Medicaid eligible persons, publicly funded persons not eligible for Medicaid, and all citizens of the state (for crisis, ITA and disaster response services). Tribal mental health consumers receiving tribal services or care in tribal clinics are not reflected in MHD service data unless the services they receive are provided by a contracted RSN. The percentage of tribal consumers who receive both tribal and RSN services is presently unknown.

The following data illustrate key trends in the characteristics of individuals being served by the public mental health system:

- Between FY 2005 and 2007 the estimated state population grew by 103,727 people [1.65%] while approximately 6,700 fewer people received outpatient treatment in the public mental health system [5% decline] during the same period [125,871 FY 2005 – 120,942 FY 2006 – 119,208 FY 2007].
- The greatest rate of decline was among youth aged 0-17 years of age – 8% fewer and the least amount of decline was among older adults aged 60+ – 1.5% decline.
- During fiscal year 2007:
 - Youth represented 29% of persons served
 - Adults between the ages of 18-59 represented 62% of people served
 - Older adults represented 9% of people served
- The total number of outpatient hours reported dropped by 21% (-572,419 hours) from FY 2005 to FY 2007. Over 98% of the reduced hours reported were for services provided to Medicaid eligible individuals.
- The average hours of outpatient services for individuals on Medicaid declined 16.5% from 24.2 hours in FY 05 – 20.2 hours in FY 07 while the average outpatient services for non-Medicaid individuals remained relatively stable (7.8 in FY 05 – 8 hours in FY 07)
- The number of individuals that utilized either community hospitals for psychiatric services and/or psychiatric evaluation and treatment facilities declined during the three-year period 2005 through 2007 by 4.4%; however, the total numbers of inpatient bed days and average days per person increased slightly.
- Between 2005 and 2007 the average number of days a person civilly committed in a state hospital or CLIP facility increased from 145.3 days to 157.7 days and the number of individuals served declined slightly by 2.4%.
- The Average Daily Census (ADC) for individuals on civil and forensic wards at the state hospitals and CSTC increased by approximately 7%.
 - The civil ADC increased from 896 in FY 05 – 961 in FY 07
 - The forensic ADC increased from 310 in FY 05 – 331 in FY 07

ACTIVITY LINKS TO MAJOR PARTNERS

- The Washington State Mental Health Planning Advisory Council (MHPAC) is a group mandated by Washington and Federal Law. The council reviews, monitors and evaluates the division's policies, plans and budgets, making recommendations to assure a strong link between government decisions and consumer, family and advocates' needs and concerns. MHPAC's subcommittees include groups dedicated to the needs and concerns of children, elders, ethnic minorities, and sexual minorities.
- The MHD Director sits on the Transformation Work Group (TWG) part of the Mental Health Transformation Project grant. The TWG is comprised of representatives from major state departments and sub-agencies, the Governor's office, Regional Support Networks, provider organizations, consumers and consumer organizations.
- The MHD regularly coordinates with the Children's Administration, Juvenile Rehabilitation Administration, and HRSA Medical Programs on ways to improve children's mental health services. In accordance with 2SHB 1088 passed during the 2007 legislative session, statewide forums and a children's mental health survey are being conducted to identify recommendations for improving access and services for children across systems. These entities are coordinating with the University of Washington on pilot projects and other efforts for implementing evidence-based practices and improving prescribing practices for children with mental illness.
- SAFE-WA (Statewide Action for Family Empowerment of Washington) the statewide parent/family network supported by the MHD and is a major partner in the larger children's system grant submission. SAFE-WA has representation from all of the recognized parent advocacy and support groups and meets quarterly to bring a united voice to the division's management.
- The MHD's Office of Consumer Partnerships supports statewide consumer and self-advocacy training, conferences and events.
- The MHD and RSN administrators meet regularly and RSNs are routinely represented on committees formed to change, establish, or set policy. These committees also include providers, consumers, parents and family advocates and, at times, allied system partners. A special work group will be focusing on reduction of paper work to streamline processes and thus free resources for improved service provision.
- The MHD meets regularly with the Washington Community Mental Health Council (WCMHC) a group representing many community mental health centers that provide services under subcontract with the RSNs. MHD provides support and is involved in planning for the annual conference of the WCMHC.
- The Performance Indicator (PI) Group has produced the "State-Wide Publicly Funded Mental Health Performance Indicators" Report annually since FY 2000. The Performance Data Group (PDG) merged with the PI Group in mid-2005 and has expanded the system data and reviewed and packaged it for decision-making by the Quality Council.
- The Quality Steering Committee (QSC), made up of the quality improvement managers from MHD headquarters and the three state hospitals, meets regularly to

discuss and resolve issues of mutual interest and concern such as employee satisfaction and facility performance reporting.

- MHD and the Division of Alcohol and Substance Abuse staff coordinate on a number of key activities including statewide implementation of a screening tool (GAIN-SS) to identify individuals with mental health and substance abuse issues and implementation of two integrated crisis response pilot projects. The divisions support the Co-Occurring Disorders Interagency Committee (CODIAC), a committee of providers from mental health, chemical dependency, other cross-systems and consumers. The divisions also co-sponsor the annual Co-Occurring Disorders Conference with other partners.
- The Inpatient Roundtable, a technical assistance group comprised of staff from MHD, the Health and Recovery Services Administration (HRSA), RSNs, and community hospitals, meets on a routine basis to consider community psychiatric hospital resource management.
- The Washington Medicaid Integration Partnership (WMIP) is a collaborative effort of HRSA, Division of Alcohol and Substance Abuse (DASA), MHD, and Aging and Disabilities Services Administration (ADSA). The mission of the Partnership is to design and implement a new consumer-focused, coordinated Medicaid delivery system that improves health status and treatment outcomes while reducing expenditures for senior and disabled Medical Assistance consumers. WMIP will serve adults (age 21+) who are categorically eligible for services paid for by DSHS as aged, blind, or disabled Medical Assistance consumers. This is a voluntary participation pilot for up to 6,000 senior and disabled consumers living in Snohomish County (part of North Sound RSN). The current enrollment is 3,000 persons.
- The MHD has increased collaboration with the Division of Vocational Rehabilitation (DVR) and other employment service partners over the past year. This includes implementation of a statewide employment initiative and co-facilitation between DVR and MHD of a number of regional forums focused on increasing coordination between mental health programs and local DVR offices. MHD and DVR both participate on the Medicaid Infrastructure Grant (MIG) advisory committee. The MIG grant supports state-level efforts to enhance employment options for people with disabilities.
- Housing is a critical need for consumers with mental illness. MHD has increased collaborative efforts with the Department of Community Trade and Economic Development (CTED) to promote the development of supported housing models. This includes co-sponsorship with the Washington Families Fund of eight local teams to participate in a Supported Housing Institute where each team will develop concrete proposals for the development of local permanent supported housing projects.
- MHD continues to participate with the Economic Services Administration and Washington Association of Sheriffs and Police Chiefs in the statewide implementation of efforts to expedite the reinstatement of Medicaid eligibility for individuals with mental illnesses who are transitioning from jails and state hospitals.
- MHD continues to be actively involved with the Aging and Disability Services Administration. This includes an on-going memorandum of understanding related to enhanced services which provide community options for older adult state hospital patients as well as those with significant medical and behavioral issues. MHD is also coordinating with ADSA on their implementation of the Money Follows the Person

grant which will provide support for individuals, including those with mental illnesses, transitioning from state hospitals and nursing homes to non-institutional settings. MHD and the Division of Developmental Disabilities continue to partner to improve coordination of services for individuals with mental illness and developmental disabilities and implement requirements of lawsuit settlements related to this population.

- MHD continues to be actively involved with the Department of Corrections in statewide efforts toward coordinating services for individuals with mental illnesses being released from prisons. This includes coordination on the Community Integration Assistance Program for high risk individuals being released from prison.
- In 2007, the MHD increased efforts toward improving relationships with tribal governments. This included reinstatement of a monthly tribal mental health work group as requested by representatives of tribal governments. It also included holding a number of tribal roundtable meetings as part of the STI process to discuss the unique issues and concerns of the Tribes and Recognized American Indian Organizations.
- The State Hospitals have continued to increase collaboration with unions and workers toward improved safety at the facilities. Active involvement of upper management and integration of safety initiatives into core business practices has resulted in a number of initiatives which have led to the reduction of worker injuries and the use of seclusion and restraint.

STAKEHOLDER INPUT

In 2006, SSB 6793 and SSB 3081 provided direction and funds to begin planning for a comprehensive transformation of the public mental health system. In response a System Transformation Initiative (STI) process was undertaken that focused on:

- Expanding community housing options for people with persistent mental illness;
- Revising the utilization review system to assure people receive appropriate levels and durations of inpatient care;
- Conducting a comprehensive review of the state's involuntary commitment statute;
- Re-designing the benefit package for publicly-funded mental health care to integrate and include best practices; and
- Improving employment for youth and adult mental health consumers.

In order to inform this transformation effort, the Legislature called for planning and studies on: expanding housing options for people with persistent mental illness, a utilization review system to assure people receive appropriate levels and durations of inpatient care, a review of the state's involuntary commitment statute and system, and alternative approaches to establishing Medicaid managed care rates, with particular emphasis on approaches that emphasize defined benefits levels and risk adjustment.

These studies were completed by using the overarching STI through which highly respected consultants, national and local experts, allied systems, families and consumer stakeholders collaborated from June 2006 through September 2007. Each consultant-led study area had a standing expert/constituent Task Force, comprised of 35-40 members from a variety of interested parties, which met monthly. Additionally, four Community

Forums were held that engaged approximately 600 stakeholders. Three tribal roundtables were held with representatives from Tribes and Recognized American Indian Organizations to discuss issues specific to tribal governments.

The Mental Health Division (MHD) analyzed the consultant reports and integrated the knowledge gained into a comprehensive package of recommendations for prioritization by policymakers to achieve the long term goals of the STI. The input gathered through the STI process has become the major foundation for recommendations included in the following Goals, Objectives, Strategies and Measures.

CHALLENGES AND OPPORTUNITIES

Since 2004 significant research, legislation, policy interpretation and funding patterns have dramatically impacted the public mental health system in Washington State and to which much of the Mental Health's Division's strategic plan responds and upon which it is built.

- Governor Gregoire's office received one of 8 five-year grants that resulted in the Partnerships for Recovery: Transformation the Mental Health System in Washington State. With the full support and participation of the director of every department, agency, and division serving people with mental illness in the state of Washington and with consumers and family members as equal partners, the Partnerships for Recovery has launched a transformation effort to achieve the goals of the President's New Freedom Commission for all people in the State of Washington.
- In 2006, the WA State Legislature began providing \$10.3 million annually for the statewide implementation of 10 Program of Assertive Community Treatment (PACT) teams, part of the comprehensive package to transform the delivery of Washington State's public mental health services. Besides improved outcomes for the most difficult-to-serve clients, the PACT teams are expected to result in eventual reductions in overall State Hospital utilization. Between September 2008 through October 2009, 4 State Hospital wards (3 at Western State and 1 at Eastern State) are expected to close due to PACT success.
- In 2006, SHB 1088, the Children's Mental Health Act was passed and will shape the Division's activities relating to children's mental health program and planning over the next several years. By 2012, the Department is required to substantially improve the delivery of children's mental health services. This improved system will emphasize early identification, intervention and prevention. It will also require coordination among existing categorical children's mental health programs and funding, and eliminate duplicative care plans and case management. Among the systemic changes that are recommended are the greater use of evidence-based practices statewide, focus on resiliency and recovery, integration of educational support services and the achievement of specific performance based outcomes
- Policy changes are under consideration from the Center for Medicare & Medicaid Services (CMS). Recent CMS policy interpretations and draft rules denote a growing intent to limit funding to mental health services that emphasize medical necessity, ensuring rehabilitation, active treatment, and treatment related improvement and completion.

- Over the last several years the Washington State Legislature has provided state funding to lessen the impact of federal actions while enhancing funding for additional services, with increases specifically for mental health line staff wages/cost of living. Additional people will be income eligible to receive Medicaid mental health services in 2009 because of Legislative action in 2008 (SSB 6583) to increase the income eligibility ceiling for Categorically Needy to 85% of the federal poverty level. Between 2005 and 2009 \$27.5 million was provided for community hospital in-patient rates for psychiatric services to reverse the trend of community hospitals eliminating psychiatric beds due to inadequate reimbursement rates.
- In 2007, EHB 1217 directed the Division to establish standards and certify mental health clubhouse programs.
- In 2008, SHB 2654 directed the Division to submit a report to the Legislature by January 2009 that lays out strategies for the development and funding of consumer and family-run services, including possible changes to the state plan and federal waiver.
- The 1999 Washington State Legislature passed SSB 5011/RCW 71.24.470 to improve the process of identifying and providing additional mental health treatment for mentally ill offenders who are being released from the Department of Corrections (DOC) and who pose a threat to public safety. The program is called the Dangerous Mentally Ill Offenders Program (DMIO)/Community Integration Assistance Program (CIAP). Through interagency collaboration, the legislation intends to promote a safe transition to the community by having state funds support intensive mental health treatment with intensive case management, chemical dependency treatment and other services. Since April 2000, there have been more than 500 individuals designated as Dangerous Mentally Ill Offenders. As of 2008, only 8 of 39 counties in the State were served by CIAP/DMIO contractors. Limited funding may require reduced service and potentially affect community safety in the future. The Washington State Institute for Public Policy, February 2008 update found that the DMIO Program reduced overall felony recidivism rates by 37% and generated \$1.24 for every dollar spent.
- The dissolution of the Pierce County RSN on January 1, 2008 has led to the creation of a fee-for-service (FFS) system in that county. This required the creation of new rates for mental health services delivered in Pierce County. The MHD has no recent history with FFS payments and therefore has no way to predict the financial impact of this change in funding on service delivery patterns. In order to provide the Department with greater ability to select qualified RSN management, SSB 6404 in 2008 establishes a process to replace a managing entity that voluntarily no longer continues as the RSN operator and allows for additional entities to serve as an RSN.
- The 2008 Legislature provided funding to enhance staffing levels at WSH and directed a review, cost benefit analysis, and recommendations on ward size and patient mix at state hospitals and discharge practices at the hospitals including Child Study and Treatment. Despite the additional funding, the State Hospitals continue to have difficulty recruiting and filling key vacant positions such as physicians, psychiatrists and nurses. Significant progress is being made within the state hospitals to eliminate the use of restraints, increase staff and patient safety and improve overall risk management.

- The 2008 Legislature provided funding for a comprehensive plan for reducing the Spokane RSN use of Eastern State Hospital (Spokane Acute Care Diversions). The Legislature also provided funding for increasing non-Medicaid services to other RSNs.

SECTION 2 - Chapter 4 • Goals, Objectives, Strategies, and Performance Measure

Goal 1: Improve Access to and Quality of Mental Health Services

Objectives:

1. Increase the number of persons of all ages living with a mental illness receiving community mental health services.
2. Increase the number of persons living with a mental illness receiving culturally relevant and evidence-based services.
3. Increase access to and the effectiveness of mental health services provided to individuals and families.

Strategies:

- a. Conduct a full actuarial analysis of the financial impact of revising GAF and C-GAS minimums for routine outpatient care. Revise the Access to Care Standards to increase the number of individuals for whom treatment would be defined as medically necessary, resulting in earlier intervention.
- b. Promote and support the expansion of children's evidence based practices including wraparound, MST, MTFC, and TFCBT.
- c. Increase the number and geographic coverage of PACT teams.
- d. Identify and track at least four RSN performance outcomes currently not being measured, and determine each RSN's ability to meet the established standards.
- e. Revise current RSN contract requirements for "state wideness" and provide definitive guidance to RSNs on implementation.
- f. Develop Centers of Excellence to support the implementation of those best practices prioritized for statewide implementation and for any best practices promoted statewide and paid for under Medicaid; conduct a formal actuarial analysis of costs prior to implementation; and conduct additional analysis at the end of each year to determine if RSNs have developed the funded services.
- g. Develop and implement statewide standards for continuing care and discharge under the Access to Care Standards (ACS) in order to shift the utilization management focus of RSNs from front-end restrictions for all enrollees to proactive care management of services for enrollees with intensive, ongoing needs.
- h. Conduct a study of effectiveness of current use of mental health specialist consults in Washington as well as other state models to develop recommendations for systemic improvements.

Performance Measures and Targets:

- a. Increase the percentage of consumers who are seen in the mental health system within seven days following discharge from inpatient services.
- b. RSNs will meet the monthly enrollment targets in state-funded PACT services (432 by July 1, 2008; 672 by July 1 2009).
- c. Report to the Legislature on recommendations for revising access to care standards and improving children's services by January 2009.
- d. Increase access for children to CLIP by reducing the average number of children waiting more than 30 days for admission from 17 to 14 at any point in time.

Goal 2: Improve Supports for Recovery and Resiliency of Mental Health Consumers

Objective:

1. Increase the number of consumers receiving Permanent Supportive Housing.
2. Increase the number of consumers in competitive employment.
3. Increase the involvement of peers, both consumer and family, in the provision of services and decreased risk factors such as substance abuse.

Strategies:

- a. Support the development of permanent supportive housing units by securing funding for rental subsidies, landlord incentives, and ensuring necessary services are in place.
- b. Provide training and technical assistance to RSNs and mental health providers on developing permanent supportive housing.
- c. Review the physical building conditions and services in all supervised living beds funded for mental health consumers statewide and establish long-term plans for all units.
- d. Collect data at RSN/provider level and publish an annual statewide report on the housing status and tenure of all consumers served in the public mental health system.
- e. Increase the number of mental health clubhouses capable of providing supportive employment.
- f. Develop a joint funding model for supported employment among relevant state agencies.
- g. Substantially improve benefit planning assistance and consultation for mental health consumers and employment providers.
- h. Expand peer counseling training and programs to support consumers across the life span.
- i. Prioritize statewide expansion of peer support services provided directly by Consumer and Family Run Organizations based on the report presented to the Legislature to Implement SHB 2654, and amend as appropriate the Medicaid waiver and state plan to incorporate such services.
- j. Explore the development of mechanisms to increase access to housing and employment for people living with a mental illness who have criminal records.

Performance Measures and Targets:

- a. Increase the percent of adult mental health outpatient consumers who are employed.
- b. Increase the percent of adult outpatient consumers reported as living independently.
- c. Provide the required report to the Legislature on consumer and family led services by January 2009.

Goal 3: Increase Consumer and Community Safety through Effective Treatment

Objectives:

1. Improve the safety of consumers and the community by decreasing the number and impact on consumers involved in the criminal justice system, by improving treatment services at the state psychiatric hospitals and by responding to state disasters.

2. Improve the management of high cost in-patient services and involuntary treatment services to ensure limited resources are effectively utilized.
3. Maximize the appropriate use of in-patient services and the processes and services that impact involuntary treatment.

Strategies:

- a. Increase the number of inpatient/residential beds as well as high intensity community services available to children in crisis.
- b. Increase the capacity for the CIAP program for both the numbers of individuals that can be served and the geographic coverage of CIAP contracts.
- c. Expand Crisis Intervention Training to first responders.
- d. Support the development of crisis triage and crisis respite beds which can provide alternatives to hospitalization for individuals in crisis and alternatives to incarceration for individuals with severe mental illnesses arrested for low level misdemeanor crimes.
- e. Coordinate a review and make recommendations on ward size and patient mix at state hospitals, discharge practices at the hospitals including Child Study and Treatment, and community placement and provide recommendations to the legislature by October 15, 2008 for system improvements including cost/benefit analysis.
- f. Provide staffing and compensation levels at state hospitals adequate to ensure provision of active treatment, maintain accreditation and certification requirements, and meet reductions in the incidents of patient assaults on staff and use of seclusion and restraint.
- g. Seek sufficient staffing capacity to fulfill the State Mental Health Authority's obligation under the Stafford Act and Comprehensive Emergency Management Plan.
- h. Complete a study of each RSN's hospital diversion and discharge options in order to forecast needed areas of development.
- i. Review the financial incentives underlying involuntary treatment payments and align payments with the systems most appropriately responsible for ongoing care.
- j. Establish a statewide standardized utilization management protocol for both acute and extended inpatient admissions and continuing stays.
- k. Continue training on client centered treatment planning at all state hospitals.
- l. Study ITA and sentencing laws and statutes for effective ways to treat and detain individuals whose history provides likely predictability for crime or high risk of violence.

Performance Measures and Targets:

- a. Increase safety in the State Hospitals by lowering the number of L&I Assault Claims paid. (Lower the L&I claims paid per 1,000 client bed days at state psychiatric hospitals).
- b. Increase safety in the State Hospitals by lowering the number of Seclusion Episodes to 6 per 1,000 client bed days.
- c. Increase safety in the State Hospitals by lowering the number of Restraint Episodes to 6 per 1,000 client bed days.
- d. Decrease the number of adults waiting in jail more than seven days for inpatient competency evaluations to zero.
- e. Reduce the number of state hospital forensic patients that wait more than seven days for an outpatient evaluation to be initiated to zero.
- f. Increase the percent of the State's population with Dangerously Mentally Ill Offender services in their county to 70%.

Goal 4: Strengthen Capacity to Support the Overall Health of Individuals with Mental Illnesses.

Objective:

1. Improve the overall health status of persons living with a mental illness through integrated services and treatment which address co-occurring substance abuse as well as physical health care needs.

Strategies:

- a. Implement campus wide no-smoking policy at the state hospitals and provide support for other smoking cessation and wellness activities.
- b. Implement Integrated Dual Disorder Treatment for persons with co-occurring mental health and substance use disorders statewide.
- c. Implement Collaborative Care Models for integrating medical and mental health treatment for populations most effectively served by clinicians located in primary care settings.
- d. Implement strategies and provide training and technical assistance to improve prescribing practices of physicians with a focus on reducing the overuse of polypharmacy and off label prescriptions.
- e. Implement a Mental Health First Aid Program.
- f. Ensure that individuals receiving mental health services are appropriately screened with the GAIN-SS tool to identify potential co-occurring substance abuse disorders.
- g. Hire or contract for a psychiatric medical director that will work in close conjunction with the HRSA Medical Director and the MHD Director to lead initiatives to improve clinical practices and oversight of the public mental health system.
- h. Provide training for staff on essential subjects, including medication error tracking, suicide prevention, and cultural assessments.
- i. Provide improved beds on state hospital wards that allow safe restraint while ensuring patient safety as well as beds which can accommodate individuals with extreme medical issues or who have just returned from an acute hospital.

Performance Measures and Targets:

- Increase the completion rates for GAIN-SS screenings completed by RSNs.

Goal 5: Making Sound and Effective Investments

Objective:

1. Improve systems to analyze, manage and limit financial and community risk, maximize revenue, and strengthen accountability within the mental health treatment system based on the coordinated use of data.
2. Create a partnership with the community mental health system characterized by open and timely communication, proactive response to issues, comprehensive community planning and engagement, and an emphasis on a measurable return on investment.
3. Improve fiscal oversight of the RSN system including ensuring resources are adequate and used in accordance with legislative priorities.

Strategies:

- a. Complete a project to reduce paperwork requirements in the community mental health system with an emphasis on standardization and improved efficiency.
- b. Design and conduct an RSN procurement process for Pierce County, in accordance with the legislative direction provided in SSB 6404.
- c. Complete a transition from a fee-for-service to a managed care treatment system in Pierce County.
- d. Work with RSNs to encourage more proactive diversion and active discharge planning for individuals being considered for admission to the state hospitals and CSTC on 90 or 180-day court orders.
- e. Review funding distribution and inflationary factors to identify and secure adequate resources for RSNs to meet federal and state requirements
- f. Provide support and oversight of RSNs to ensure they meet targets for reducing state hospital utilization.
- g. Design, implement and consistently apply monitoring tools that are based on the CMS-approved RSN contract language and state and federal laws.
- h. Evaluate current client rights regulations at the state and federal level in order to identify those areas where the guiding documents, training provided, and monitoring activities can be clarified to support a more consistent application of these regulations.
- i. Review the current Mental Health Ombudsman system for opportunities including a potential change in structure to assure this service is provided with consistency across the state.
- j. Increase oversight of RSNs including annual on site contract monitoring reviews for each RSN.
- k. Improve hospital revenue collection by upgrading the existing system used to track and bill for Medicare Part D.
- l. Ensure the long-term health and safety of clients by ensuring that IT systems at the state hospitals are able to function and support improvements when they are approved.

Performance Measures and Targets:

- a. No less than 80% of jail proviso funding available to RSNs will be expended on jail services each quarter.
- b. Increase the percent of contract risk assessments and monitoring plans completed to 90%.
- c. RSNs average daily census of state hospital civil beds shall not exceed the levels appropriated by the legislature during any quarter.
- d. The wait list for 90 day civil commitments shall not exceed an average of 15 persons on any given day.

Goal 6: Improved Services to Tribal Members

Objective:

- 1. Strengthen and expand Tribal partnerships.

Strategies:

- a. Develop a handbook to guide RSNs in their interactions with Tribal governments and Tribal providers.

- b. Explore options for allowing Tribes to detain individuals independent of RSN approval by giving Tribes and Tribal Courts the ability to appoint Tribal DMHPs with authority to order involuntary treatment independently.
- c. Increase the resources available to Tribal governments for housing and services for mental health services clients including access to support services and landlord risk mitigation funds.

Performance Measures and Targets:

- a. Complete, distribute and host training on RSN handbook for working effectively with Tribal governments and providers.

SECTION 2 - Chapter 5 • Organization Assessment Summary

PERFORMANCE ASSESSMENT

The MHD continues to make strides in analyzing performance data and making performance improvement changes. The Balanced Budget Act of 1997 requires states that contract with a Prepaid Inpatient Health Plan for mental health services to develop and implement a written strategy for assessing and improving the quality of public mental health services (42 CFR, 438.202). The quality strategy will be updated whenever significant contractual or system changes are made.

In June 2007, MHD submitted a revision of the Quality Strategy to The Centers for Medicare & Medicaid Services (CMS). This was an update of the prior Quality Strategy that was approved in December 2003. The strategy summarizes a systematic approach to assessing and improving the quality of Medicaid mental health care, and sets a course for promoting ongoing, systematic quality assessment and performance improvement within a recovery-based public mental health care delivery system. The following areas represent the primary areas of quality assessment in MHD.

Certification Reviews and Contract Monitoring

MHD has implemented a new contract monitoring system this year. This system documents and tracks the receipt, review, acceptance or Corrective Action request of each contract deliverable required by MHD. This system will decrease response times, improve continuity in monitoring, and increase consistency in MHD responses.

MHD monitors RSN contracts through receipt and review of contract deliverables, on-site visits conducted by MHD staff, and record reviews. MHD has developed a new contract monitoring tool and is in the process of implementing this in annual on site contract monitoring visits for all RSNs.

In addition, MHD has monitors conducting annual fiscal reviews of RSN Revenue and Expenditure (R & E) reports; information technology specialists reviewing data submission errors, data timeliness and data certifications; and has implemented a system to track critical incident reporting.

EQRO Review

MHD contracts with an External Quality Review Organization (EQRO) that conducts extensive on-site reviews of each PIHP using the requirements listed in each of the following CMS protocols:

- Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs)- Subparts C, D, F, H;
- Validating Performance Indicator protocol;
- Validating Performance Improvement Projects protocol; and
- Encounter Validation protocol.

Results from the EQRO are reviewed by MHD within 10 days of publication of the final report for each PIHP. MHD requests Corrective Action Plans for those PIHPs not meeting the minimum standards of the protocols, and PIHPs are re-reviewed the following year. For those EQRO findings which indicate a significant health and safety risk, follow-up reviews are scheduled by MHD immediately upon discovery. The EQRO Statewide Technical Report is reviewed to identify areas for a quality improvement focus in the next year's PIHP contracts and EQRO review.

The 2006 EQRO report, which was released in June 2007, noted improvements among the PIHPs in a variety of areas. Recommendations by the EQRO for PIHP system wide improvements in a variety of areas are included as Exhibit 5 which is attached to this plan.

Government Management Accountability and Performance

MHD continues to work toward improvement in the identification of key performance measures for the Government Management Accountability and Performance process. MHD was recently added to the Governor's GMAP review for vulnerable children and adults. While not all targets have yet been met, key areas of success noted in April 2007 GMAP presentation included:

- WSH paid L&I claims have decreased by 40% since FY 2004.
- WSH has significantly reduced episodes of seclusion and restraint since FY 2004 (-27% and -14% respectively).
- The number of adults waiting in jail for inpatient evaluation has been declining since October 2006 even though the number of court ordered evaluation referrals have increased 19%.

A key area of challenge noted during the presentation relates to children waiting for long-term inpatient care. This problem is exacerbated for children under the age of 12 who typically wait twice as long (90 days compared to 45 days for older kids) because of limited capacity for meeting their needs.

MHD will continue to work toward monitoring and implementing actions to meet all GMAP performance targets.

Other Performance Audits

In February and March of 2007, an audit of the MHD was done by DSHS Operations Review and Consultation to assess compliance with required contract monitoring activities. These activities, as listed in Administrative Policy (AP) 13.11, include risk assessments, and contract performance monitoring plans, and payment review.

The audit resulted in eight findings.

- MHD's policy on contract monitoring was not consistent with DSHS administrative policy.
- MHD did not prepare risk assessments for each type of service or individual contract, nor did they develop monitoring plans for their contracts.
- MHD monitoring plans did not contain all elements required by AP 13.11.
- MHD did not have a process to ensure required contract deliverables were submitted.

- MHD did not provide adequate oversight to ensure all contractors conducted background checks.
- MHD staff did not enter monitoring activities or background check information into the Enterprise Agency Contracts Database (EACD).
- MHD did not submit a list to Central Contract Services (CCS) of staff responsible for conducting contract performance monitoring activities.
- MHD did not prepare the Risk Assessment Self Evaluation (RASE) for Contract Management.

MHD has implemented a corrective action plan to address all audit findings and has significantly expanded efforts to assess risk and monitor and provide oversight to contracts.

