

Statewide Transformation Initiative
Mental Health Benefit Package Design
Final Report

submitted to

*The State of Washington
Department of Social and Human Services
Health and Recovery Services Administration
Mental Health Division*

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Executive Summary

The Washington State Mental Health Division (MHD) contracted with TriWest Group to provide policy guidance and input regarding potential redesign of its benefit package for publicly-funded managed behavioral health care. This work is one part of MHD's broader System Transformation Initiative (STI). Building on the findings and recommendations of a preliminary report submitted in February 2007,¹ this Final Report integrates a review of comparison states, Washington's benefit design and management processes, national evidence-based and promising practices, Deficit Reduction Act options, and rate methodologies into a final set of options and recommendations for MHD. The recommendations include:

1. Recommendations related to how best to promote current national best practices for adults and older adults, as well as children and families, within the overall recommended benefit design, and
2. Recommendations regarding Washington's Medicaid State Plan and overall mental health benefit design.

Recommendations Related to Mental Health Best Practices

System Level Recommendations for Promoting Best Practices

Best Practice (BP) Recommendation #1: While continuing to promote Evidence-Based Practices (EBPs), be mindful of their limitations. Inherent limitations in the research base for evidence-based practices (for example, a lack of research that addresses the complexities of typical practice settings such as staffing variability due to vacancies, turnover, and differential training) often lead providers, consumers, and other stakeholders to question the extent to which EBPs are applicable to their communities. In addition, many consumers are understandably concerned that having policy makers specify particular approaches might limit the service choices available, and many providers are reluctant to implement EBPs due to the costs and risks involved in training and infrastructure-building, processes that require commitments over years rather than months. Successful EBP promotion begins with an understanding of the real world limitations of each specific best practice, so that the inevitable stakeholder concerns that emerge can be anticipated and incorporated into the best practice promotion effort.

BP Recommendation #2: Specifically address the lack of research on cross-cultural application of EBPs. There is wide consensus in the literature that little research has been carried out to document the differential efficacy of EBPs across cultures. Given that few EBPs have documented their results in sufficient detail to determine their effectiveness cross-culturally, it makes sense that EBPs be implemented within the context of ongoing evaluation efforts to determine whether they are effective for the local populations being served.

¹ See the following website for a full copy of that report:
http://www1.dshs.wa.gov/pdf/hrsa/mh/Mental_Health_Benefit_Package_Design_Report_DRAFT_4_16_2007.pdf.



BP Recommendation #3: Specify the level of consumer and family involvement for each service in the array of best practices to be promoted. The best practices described in this report include a range of consumer and family involvement that varies across practices. In this report, we define the degree to which the best practices reviewed are consumer and family driven, focusing on the levels at which the services involve consumer and family member guidance and input through the following scale:

- **Consumer/Family Run and Operated** – Services delivered by consumers or family members within organizations that are majority owned or otherwise autonomously governed and run by at least 51% consumers or family members.
- **Fully Consumer/Family Delivered** – Services and supports that are delivered by consumers or family members within organizations that are run by professionals.
- **Partially Consumer/Family Delivered** – Services and supports jointly delivered by consumers or family members in partnership with professionals.
- **Consumer/Family Involved** – Services and supports delivered by professionals that include formal protocols for ensuring and enhancing the involvement of consumer and family members in the planning and delivery of the service.
- **Professionally Run and Delivered** – Services designed to be delivered by professionals within organizations run and operated by professionals.

BP Recommendation #4: Ground the promotion of specific best practices within a broader Evidence Based Culture. The increasingly common approach taken by many states of mandating the use of specific EBPs in and of itself has not necessarily led to improved outcomes and does little to help agencies, provider organizations, and communities understand how best to select and implement effective interventions. States that have been more successful in their implementation of EBPs have focused on the need for system and organizational infrastructures to support the implementation, broad dissemination, and ongoing scrutiny of evidence-based practices. Such infrastructures involve the policy, procedural, and funding mechanisms to sustain evidence-based interventions, and they need to be based in system and organizational cultures and climates that value the use of information and data tracking as a strategy to improve the quality of services and increase the likelihood of achieving desired outcomes (a data and learning-centered construct implicit in an array of constructs, including “learning organizations,” “continuous quality improvement,” and others). Some researchers use the term “evidence based culture” to describe the constellation of policy, procedural, and funding mechanisms in concert with a favorable culture and climate that support successful practice.

BP Recommendation #5: Develop Centers of Excellence to support the implementation of those best practices prioritized for statewide implementation. There are increasing efforts by states to develop their own local “centers of excellence” (COE) to provide ongoing sources of expertise, evaluation, training, and guidance to support the initiation and ongoing development of EBPs and promising practices. While there are no definitive studies yet available of what factors best support system-wide EBP promotion, emerging research suggests that states implementing COEs are further along in EBP promotion than those that do not. Washington State has its own emerging COEs through its comprehensive contract



with the Washington Institute for Mental Illness Research and Training to develop ACT capacity statewide and the children’s mental health evidence-based practice institute at the University of Washington established under House Bill (HB) 1088. The critical components of COEs for promoting EBPs include: training, ongoing technical assistance and support, quality improvement and fidelity tracking, outcome monitoring, and dedicated staff for each EBP promoted.

BP Recommendation #6: Develop encounter coding protocols to allow MHD and RSNs to track the provision of other best practices. Currently, the service codes used for encounter reporting lack the specificity needed to differentiate best practices, complicating the promotion of best practices by providing the same reimbursement across different types of best practices, providing the same reimbursement for generic and best practices, limiting the ability of MHD to monitor best practice availability, and limiting the ability of actuarial analysis to factor in the additional costs incurred by the delivery of best practices that require specialized training, reduced productivity, and/or fidelity monitoring. We recommend that MHD develop additional HIPAA-compliant encounter coding modifiers so that all best practices of interest within the public mental health system are tracked, using a mix of coding strategies, including procedure codes, procedure code modifiers, and program codes identifying specific groups of individual providers within agencies. In addition, protocols governing the use of these codes will need to be defined and enforced.

Recommended Priority Best Practices

To prioritize among the 41 best practices analyzed in this report, criteria were developed that included balancing of the selection of best practices across age groups (children, adults, and older adults) and each best practices’ documented potential to reduce inappropriate use of restrictive services (inpatient and residential), promote cross-system integration, support culturally relevant and competent care, and facilitate recovery for adults and resilience for children and their families. These criteria were used to identify five priority practices.

BP Recommendation #7: MHD should prioritize three to five of the following best practices for statewide implementation:

- Peer support services provided directly by **Consumer and Family-Run Organizations**,
- **Integrated Dual Disorder Treatment (IDDT)** for persons with severe co-occurring mental health and substance use disorders,
- **Wraparound Service Coordination** for children with severe emotional disturbances and their families who are served by multiple state agencies,
- **Multidimensional Treatment Foster Care (MTFC)** for children needing intensive out-of-home services, but able to receive care safely in a family-based setting, and
- **Collaborative Care in Primary Care Settings** for populations, such as older adults, most effectively served by mental health clinicians located in primary care settings.



To guide MHD and other stakeholders as they seek to determine the feasibility of implementing these services, TriWest has developed a unit cost methodology for estimating their potential costs. This model was based on the approaches described in the June 2005 Rate Certification by Milliman, Inc., and the approach and specific applications were reviewed in with the actuarial team. Key cost findings based on this model for the five practices are presented below.

Consumer and Family Run Services – We recommend that Washington State establish a new provider type under an amended 1915(b) waiver authority modeled on the State of Arizona’s certification model for providers of “non-licensed behavioral health services” referred to as Community Service Agencies (CSAs). CSA staff members providing services covered by Medicaid must meet the same criteria that staff in more traditional provider settings must meet (such as experience and supervision requirements) for any specific service type provided. The primary service type that we recommend covering is Peer Support. Experience, supervision, and documentation requirements in Washington’s State Plan and state-level regulations would need to be met.

We estimate that the cost per unit of Peer Support delivered through a CSA is comparable to that delivered currently through a community mental health agency (CMHA). We therefore believe that the service costs for this modality were already added to the system based on Washington’s 2005 actuarial study. However, adequate costs to promote the infrastructure necessary to develop CSAs were not. This may very well be a contributing reason to why current levels of peer support provision by most RSNs remain below expectations.

Expanding the current peer specialist certification program into a COE able to promote the provision of Peer Support across an expanded group of potential providers (both CMHAs and the new CSA providers) could help bring Peer Support service delivery up to the levels factored into the current rates. We estimate that this would cost \$425,000 a year and be able to be covered within the Medicaid program, therefore requiring \$215,000 in state expenditures (to cover the Medicaid match). Further assuming that replacing the \$150,000 in federal block grant funding currently spent on Peer Support training could free up State General Funds currently going to pay for other purposes (and thereby allow these State General Funds to be shifted to other mental health priorities), the annual costs would be reduced to \$65,000.

Integrated Dual Disorder Treatment. Integrated Dual Disorder Treatment (IDDT) involves the provision of mental health and substance abuse services through a single treatment team for people with severe needs. We estimated the unit costs to provide IDDT to be \$780 per recipient per month. Looking only at the Medicaid-enrolled population (which does not include state-funded recipients or people who lose Medicaid coverage during periods of a spend-down), we further estimated that 1% of all Medicaid-eligible adults (ages 19 to 59) would be in need of IDDT services, yielding a projection of need for intensive IDDT services across all enrolled adults of 2,971 adults statewide per year. We also estimated the costs of implementing a COE to support this level of IDDT implementation. To serve 2,971 adults with IDDT, an estimated 37 teams would be needed (each serving 80 people, on average). If we assume that statewide implementation of IDDT will occur over a three year period (20



teams in Year One, 10 additional teams in Year Two, and 10 additional teams in Year Three), we estimate a total annual COE cost of \$460,000. We recommend building the COE support into the fee paid to providers given that it represents an additional cost incurred by IDDT providers in order to be certified by the COE as able to deliver IDDT services. As a provider cost, it can be included in the amount reimbursable by Medicaid.

Inclusive of all new costs and backing out anticipated cost offsets and the costs of current service provision, we developed a multi-year cost projection summarized in the table below.

IDDT Multi-Year Utilization Projection				
Variables	Year One	Year Two	Year Three	Year Four
Total Teams	20	30	37	37
Core Team Operating Costs	\$14,976,000	\$22,464,000	\$27,705,600	\$27,705,600
COE Costs	\$ 460,000	\$ 460,000	\$ 460,000	\$ 460,000
Total Cost	\$15,436,000	\$22,924,000	\$28,165,600	\$28,165,600
Average Medicaid Recipients Served Per Month	1,000	2,100	2,750	2,960
Medicaid Revenue (\$793 per person served per month)	\$ 9,516,000	\$19,983,600	\$26,169,000	\$28,167,360
Cost Offsets for Persons Served (\$513 per person served per month)	\$ 6,156,000	\$12,927,600	\$16,929,000	\$18,221,760
Additional Medicaid Costs (Revenue minus Offsets)	\$ 3,360,000	\$ 7,056,000	\$ 9,240,000	\$ 9,945,600
Additional State-Only Funding Needed (Total Cost minus Medicaid Revenue)	\$ 5,920,000	\$ 2,940,400	\$ 1,996,600	\$ -

Wraparound Service Coordination. Wraparound Service Coordination is an intervention designed to coordinate a set of individually tailored services to a child and their family using a team-based planning process. It is important to keep in mind when reviewing the cost analysis provided that Wraparound is not a treatment in itself, but is instead a coordinating intervention to ensure the child and family receives the most appropriate set of services possible. To estimate unit costs, we used the staffing model used by Wraparound Milwaukee, a national benchmark program, yielding an estimated unit cost of \$790 per month. To estimate potential utilization, we averaged estimates from three RSNs currently delivering a version of Wraparound (Clark, Greater Columbia, King) to yield the projection of 0.56 percent of Medicaid-enrolled children (9.1% of children served) or 3,143 children statewide. This estimate compares favorably with information compiled by MHD regarding the number of children with intensive service needs (December 2006 analysis by MHD based on FY2004 data). We estimate the average utilization per user to be 16 months, based on information from national experts (B. Kamradt, M. Zabel), so the total number of service recipients once the program is fully up and running will be 4,191 (one and one-third times the annual need). In addition, we estimate that it would add an additional \$13 per recipient per month to cover the costs of a statewide Center of Excellence to support delivery of Wraparound. The total



cost to deliver Wraparound to a single child per month is therefore \$806 in our model (\$793 for the core service and \$13 for the COE support). The cost per recipient is offset by expected reductions in MHD inpatient and residential costs currently incurred in the system totaling \$63 per recipient per month. This estimate likely significantly understates the potential cost savings.

Furthermore, this estimate only covers the Medicaid-reimbursable costs associated with the intervention. It does not include additional funds for ancillary supports critical to the successful implementation of Wraparound, such as flexible funds (which we would estimate at an additional \$500 per family per year, which would not be reimbursable under Medicaid), transportation supports, and direct services provided to family members of the covered child.

Based on this, the costs to develop teams and provide Wraparound Service Coordination per year varies by year of implementation as a function of the number of teams implemented each year. The amount of Medicaid revenue that can be earned by each team to support both program and COE costs is a function of how quickly each team can ramp up to full capacity. Assuming that it takes nine months for each team to ramp up to full capacity (serving no people in month one, then adding 8 people a month through the end of month nine), 62.5% of costs for each team in their first year of operation can be covered by Medicaid costs (assuming 100% of people served have Medicaid coverage), summarized in the table below.

Wraparound Service Coordination Multi-Year Utilization Projection				
Variables	Year One	Year Two	Year Three	Year Four
Total Teams	22	44	65.5	65.5
Core Team Operating Costs	\$13,339,480	\$26,678,960	\$39,715,270	\$39,715,270
COE Costs	\$ 500,000	\$ 500,000	\$ 500,000	\$ 500,000
Total Cost	\$13,839,480	\$27,178,960	\$40,215,270	\$40,215,270
Average Medicaid Recipients Served Per Month	880	2,288	3,676	4,191
Medicaid Revenue (\$806 per person served per month)	\$ 8,511,360	\$22,129,536	\$35,554,272	\$40,535,352
Cost Offsets for Persons Served (\$63 per person served per month)²	\$ 665,280	\$ 1,729,728	\$ 2,779,056	\$ 3,168,396
Additional Medicaid Costs (Revenue minus Offsets)	\$ 7,846,080	\$20,399,808	\$32,775,216	\$37,366,956
Additional State-Only Funding Needed (Total Cost minus Medicaid Revenue)	\$ 5,328,120	\$ 5,049,424	\$ 4,660,998	\$ (320,082)

² This figure does not include significant cost-offsets in inpatient, residential and institutional services delivered by CA, JRA, and DASA. Cost-offsets are therefore likely underestimated by a significant factor.



Multidimensional Treatment Foster Care (MTFC). The selection of MTFC as a priority for statewide development centered on the need for additional mental health out-of-home treatment capacity. MTFC is a type of therapeutic foster care provided to children and youth living with foster parents or for families who require an intensive period of treatment before reunification. That being said, it is not clear that the MTFC should be implemented in all instances with rigid adherence to the parameters articulated by its purveyor, TFC Consultants, Inc. It seems critical from our discussions with MHD and Children’s Administration (CA) staff closely involved with the current MTFC pilots that some additional flexibility in the model is needed, particularly in terms of the purveyors’ insistence that the model operate with 10 beds. To be of use in more rural areas, it seems important that the model be able to operate with fewer beds (i.e., 5 bed models). Given the importance that family-based interventions be carried out close enough to parents and caregivers that they can be regularly involved, allowing smaller programs in rural areas seems preferable to larger programs located further from families.

MHD is currently estimating costs for MTFC in its Kitsap pilot at \$184 a day. Of these costs, approximately half (\$92) is reimbursable by Medicaid (half of which is funded by the State and half of which is federal financial participation) and the remaining half (\$92) must be paid entirely with State Funds. We are recommending that this service be paid for entirely by MHD in order to spare families the need to coordinate with yet another agency. This assumes that, if families are already involved with CA, CA will cover the costs of needed out-of-home care (outside of the cost estimates in this report). The cost estimates in this report cover only the costs of MTFC delivered by RSNs to mental health consumers not involved with CA. We realize that in many cases out-of-home costs are currently split by CA and RSNs. We have attempted to factor this into our cost-offset calculations by estimating reductions in the use of the portion of these services replaced by the MHD-funded MTFC.

Based on discussions with MHD and CA staff, we projected three utilization scenarios:

- Low Range: A primarily acute care model with 105 beds (five 10-bed programs, plus 11 5-bed programs for smaller RSNs) and ALOS of 6 months.
- Mid-Range: An acute and intermediate stay model with 165 beds (seven 10-bed programs, plus 13 5-bed programs for smaller RSNs) and ALOS of 7.5 months.
- High Range: A more intermediate-term care model with 230 beds (18 10-bed programs, plus 10 5-bed programs for smaller RSNs) and ALOS of 9 months.

The total cost to deliver MTFC to a single child per month in all of the scenarios is \$2,798 per recipient for Medicaid treatment (\$92 per day times 30.4 days per month), \$2,798 per recipient for State funds to support room and board (\$92 per day times 30.4 days per month). The cost per recipient is offset by expected reductions in the costs of currently delivered outpatient services, plus reduced MHD inpatient and residential costs currently incurred in the system, totaling \$1,124 per recipient per month. This estimate likely significantly understates the potential cost savings. In addition, the cost analysis assumes that first year training and fidelity monitoring costs (inclusive of consulting costs and travel) will be \$50,000 for each 10-bed team (\$25,000 for 5-bed teams, assuming that two 5-bed teams meet jointly with the



consultants). Second year and following costs are assumed to be \$10,000 for each 10-bed team (\$5,000 for 5-bed teams, again assuming that two 5-bed teams meet jointly).

Based on our analysis, the costs to develop and provide MTFC per year varies by year of implementation as a function of the number of teams implemented each year. The number of teams needed, persons served by the end of the six year implementation schedule, potential cost offsets, and total costs are summarized in the table below for each of the three estimates.

MTFC Multi-Year Utilization Projections			
Variables	Low Range	Medium Range	High Range
Total Teams in Year Six	16	20	28
Full (10 beds)	5	7	18
Half (5 beds)	11	13	10
Total Cost in Year One	\$1,443,200	\$1,443,200	\$3,968,800
Total Cost in Year Six	\$7,156,800	\$9,201,600	\$15,676,800
Average Medicaid Recipients Per Month in Year Six	105	135	230
Medicaid Cost Offsets in Year Six (\$1,124 per person served)	\$1,416,240	\$1,820,880	\$ 3,102,240
Additional Medicaid Costs in Year Six (Revenue minus Offsets)	\$1,306,942	\$1,680,354	\$ 2,862,825
Additional State-Only Funding Needed in Year Six (\$92 per person served per day, other costs)	\$4,433,618	\$5,700,366	\$ 9,711,735

Collaborative Care in Primary Settings. Collaborative Care is a model of integrating mental health and primary care services in primary care settings. If RSNs are to deliver Collaborative Care, the primary barrier will be the current Access to Care Standards (ACS) that prohibit the delivery of mental health services to people with functional impairments in the moderate (above a GAF/C-GAS score of 50) to mild (above a GAF/C-GAS score of 60) range, depending on diagnosis. A core premise of the delivery of Collaborative Care is that mental health services be provided in primary care settings with minimal barriers. In order to overcome the barriers to the effective delivery of mental health services in primary care settings, mental health clinicians must be willing to take all referrals and not attempt to exclude any persons referred based on functioning.

Much of the leading research nationally related to Collaborative Care is currently conducted by faculty at the University of Washington’s Department of Psychiatry and Behavioral Services and Department of Family Medicine. The costs to establish a Center of Excellence for Collaborative Care would depend on the number of sites being implemented. We estimate that a budget of approximately \$300,000 would be needed to support the development of 10 teams across the state.

The unit costs for Collaborative Care are comparable to those already reimbursed in the system. The primary driver of any cost increases if Collaborative Care is promoted would be



increased utilization of services. We would not expect any measurable cost offsets within the mental health system attributable to the provision of Collaborative Care, though more effective treatment of depression (the diagnosis most frequently targeted for improved service delivery with older adults in Collaborative Care models) would very likely decrease the use of other health care services. People suffering from depression who are receiving services through the primary care system use three to four times as many services for physical health complaints as people without depression.

Given that current data on unmet mental health needs in primary care settings and the potential cost-offsets in primary health care services costs were not available to this project, it is not possible to give a precise estimate of potential costs for expanded delivery of Collaborative Care in primary care settings. However, we believe that the potential cost increases would likely be in the range of other analyses to expand access for the delivery of mental health care to broad populations such as the recent expansion of Healthy Options and fee-for-service benefit limits. Adding these costs to those estimated for a COE to support Collaborative Care, we would estimate the costs of initial Collaborative Care efforts to range between \$1.1 million to \$2.5 million annually.

Other Priority Services. In addition to these five priority services for which we completed comprehensive cost estimates based on the unit cost methodology, the report recommends the continued delivery and development of the following best practices by MHD:

- Supported Employment for adults with serious mental illness,
- Trauma-focused Cognitive Behavioral Therapy (TF-CBT) for children and adolescents,
- Parent-Child Interaction Therapy (PCIT), and
- Multisystemic Therapy (MST).

BP Recommendation #8: 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. For any RSN that has not provided the level of targeted best practices that was funded, the difference between the documented costs incurred for targeted best practice services provided and the amount allocated should be paid back to MHD and the federal portion paid back to CMS.

The cost analyses included in this report were never intended by MHD or TriWest Group to be a substitute for actuarial analysis of any change in benefit funding eventually undertaken. In addition, one of the risks in funding services prospectively through capitation payments is that the services funded may not be delivered. We recommend that DSHS allocate additional actuarial time to MHD to allow for analysis of these factors. The specific analyses should be identified and priced by the actuarial contractor prior to carrying them out.



Recommendations Based on Medicaid State Plan Analysis

Washington's Medicaid managed mental health care system has undergone several significant developmental changes since 2002. These include development of the Access to Care Standards and significant changes to the State Medicaid Plan in 2003 in response to critical reviews from the Center for Medicare and Medicaid Services (CMS), as well as implementation of an External Quality Review (EQR) process in 2004. They also include the enhanced oversight and standardized managed care requirements for RSNs established legislatively by E2SHB 1290 and the 2005-06 RSN procurement process.

The Current Federal Climate. These changes also took place in the context of wider changes at the federal Center for Medicare and Medicaid Services (CMS) that affected all states delivering Medicaid managed care services. These included: August 2002 changes in the required rate calculation methodology from upper payment limits (UPL) to actuarially sound rates, enhanced quality standards for managed care plans set by the Balanced Budget Act of 1997 (implemented in August 2003 under 42 CFR 438), enhanced scrutiny of rehabilitative services, and additional scrutiny under the Deficit Reduction Act of 2005. This federal context was particularly relevant to the development of two system features that are a major focus of this report: (1) The current 18 modalities defined under the Rehabilitative Services section of Washington's Medicaid State Plan, which were developed in response to CMS concerns expressed immediately following the shift from the UPL rate methodology to the actuarially sound rate requirements, and (2) The Access to Care Standards which govern both eligibility and medical necessity determinations for the current Medicaid system, which were developed in response to a contingency from CMS on Washington's 2001 waiver renewal.

Washington's Current Medicaid Managed Care System. Washington's Medicaid mental health benefit is primarily structured by four components from Washington's Medicaid State Plan: Inpatient Hospital Services, Under 21 Inpatient Services, Physician Services, and Rehabilitative Services. The primary focus of the RSN's PIHP programs is the 18 Rehabilitative Services modalities. In addition to the State Plan services, Washington is able to provide three additional non-traditional service types defined within its waiver under the authority of Section 1915(b)(3): Mental Health Clubhouse, Respite, and Supported Employment.

Comparisons with Other States: Arizona, Colorado, New Mexico, and Pennsylvania. Four states were selected for comparison to Washington that, across their various features, represent most of Washington's current system components. These states also allow us to look at Medicaid benefit designs funded at levels comparable to Washington's (AZ and CO), as well as much lower (NM) and much higher (PA). That being said, several structural features are unique to Washington:

- Washington's eligibility requirements include the DC:0-3 standards for infants and toddlers, allowing more diagnostic flexibility for early childhood mental health needs.



- Washington is the only state of the five that imposes functional impairment requirements as a means of determining service eligibility. Other states incorporate impairment scores such as the GAF into discrete level of care guidelines for medical necessity, but none require such impairment for entry into the system.
- Washington is the only state of the five (and the only 1915(b) waiver state of which we are aware) that holds its managed care organizations to be at-risk for acute inpatient care, but only requires them to coordinate the delivery of such care, rather than directly deliver the service through their regional networks.
- Washington operates independent managed care plans with very relatively few covered lives, including four regions with fewer than 25,000 lives and six with fewer than 60,000. Of the comparison states reviewed, none operate regions with fewer than 40,000 covered lives and only Colorado operates regions with fewer than 60,000 lives.

Medicaid State Plan and Waiver (MSP&W) Recommendation #1: Do not propose any changes to CMS regarding the structure of Rehabilitative Services within Washington’s Medicaid State Plan. Our analysis of Washington’s State Plan found that the language of the 18 Rehabilitative Services modalities is sufficiently flexible to promote all of the prioritized best practices summarized in the previous major section of this report. Furthermore, in light of the enhanced scrutiny of Rehabilitative Services that CMS has engaged in over the last two years, resulting in actions by CMS in dozens of states either limiting service flexibility or disallowing current costs under their Rehabilitative Services option, we do not recommend proposing any State Medicaid Plan change to CMS involving Rehabilitative Services. However, if CMS adopts new regulations for Rehabilitative Services under development at the time of this report (July 2007), Washington State will need to revisit the need for possible State Plan changes to respond to those regulations.

While no changes are currently recommended in the language of Washington’s Medicaid State Plan, we offer several recommendations regarding implementation of the State’s 1915(b) Waiver.

MSP&W Recommendation #2: Develop statewide standards for continuing care and discharge under 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. This will require the development of statewide medical necessity standards for all levels of care, including criteria for initial and concurrent reviews. It is our opinion that Washington’s current waiver, combined with the Balanced Budget Act of 1997 requirements under 42 CFR 438 implemented in Washington under E2SHB 1290, gives MHD the authority to proceed with more refined and standardized implementation of the ACS for the Medicaid benefit. The current implementation of the standards is problematic, particularly their exclusive focus on front-end access to care in general and their lack of (1) standards for continuing access, (2) differential criteria for access to levels of care more intensive than routine outpatient, and (3) formal mechanisms whereby ACS numeric functioning score cut-offs can be overridden based on clinical assessment, medical necessity, and individual need.



The current ACS standards include only criteria for limiting front-end access across the board. As such, they are a crude tool for managing care, focusing utilization management resources almost entirely on front-end limitations to outpatient care and shifting the focus of utilization management too much toward management of low-intensity, low cost outpatient care rather than more expensive levels of care such as day services, long-term case management, and residential services. Other states and their managed care organizations (MCOs) have generally evolved the focus of their utilization management activities away from across-the-board front-end restrictions in order to focus limited care management resources on more expensive services. This approach has generally been found to be more cost-effective over time, with any increase in service use more than offset by: (1) better use of utilization management resources for high-end cases, (2) savings through earlier intervention, and (3) reductions in the cost of managed care oversight.

MSP&W Recommendation #3: Prior to the next waiver submission, conduct a full actuarial analysis of the financial impact of revising GAF and C-GAS minimums for routine outpatient care. If financially feasible, raise the GAF and C-GAS minimums to at least 70 for all covered diagnoses. Currently, there is no substantive mental health benefit for Medicaid enrollees outside of the Healthy Options program, an important subgroup since all disabled adults fall outside the Healthy Options program. The most efficient way to extend coverage to these individuals would be to relax the functional requirements for ACS. The primary barrier is that this is likely to cost more money. If these criteria are relaxed, multiple informants reported that there would be a significant increase in referrals to RSNs. However, given recent benefit changes for these programs (the recent expansion of Healthy Options and fee-for-service benefit limits from 12 to 20 visits annually and expanding the types of eligible providers), eligible providers in RSN networks are now able to provide these additional services. Therefore, it is not clear what additional costs would be entailed by integrating these fee-for-service benefits within the RSN structure.

MSP&W Recommendation #4: Revise Current RSN Contract Requirements for Statewideness and Provide Definitive Guidance to RSNs on Implementation. To better reflect all pertinent federal standards, we recommend that the language of the RSN contracts be revised from an emphasis on statewideness under 42 CFR 41.50 to an emphasis on network adequacy under 42 CFR 438.206 and 438.207. This will shift the focus of RSN requirements so that they must demonstrate how needs are documented and met, rather than simply document that the network includes a provider from somewhere in the state that provides a given modality.

Analysis and Recommendations for Tribal Governments and their Members

The basis of the relationship between the government agencies of the State of Washington and the 29 federally recognized Tribes in Washington State is the Centennial Accord signed in August, 1989. The Accord provides a framework for government to government relationships between the State of Washington and each sovereign Tribe, under which MHD, as part of



DSHS, maintains a direct working relationship with each of the 29 Tribes. Members of the 29 federally recognized Tribes in Washington State are able to access mental health services through multiple systems, including their own dedicated Indian Health Service (IHS) and Tribally-administered 638 facilities (funded by Title I or III of the Indian Self Determination and Education Assistance Act – Public Law 93-638), the Medicaid PIHP administered by the RSNs, or a combination of these systems. Given these multiple systems, MHD and each of the 29 Tribes must coordinate activities at multiple levels. While the primary relationship is between each Tribe and the State of Washington, on a day-to-day basis various agents acting on behalf of the State of Washington, including RSNs and state-operated treatment facilities such as the State Hospitals and CLIP facilities, all must coordinate their activities with each individual Tribe.

Through two focus groups carried out in April 2007 involving a broader representation of Tribal Governments, Recognized American Indian Organizations (RAIOs), and DSHS Indian Policy and Support Services (IPSS) managers, as well as follow-up interviews with Tribal representatives, IPSS staff, and MHD staff, the following issues were identified.

- **Recognition of the complexity of Tribal mental health systems.** While an important distinct part of the broader public mental health system, tribal mental health systems are both different and more complex in their regulatory requirements than non-Tribal mental health systems. While RSNs must comply with federal and state regulations through MHD, Tribal providers operate in a system with the additional complexity of direct relationships between Tribes and the State, as well as Tribes and the federal government, and Tribal members are entitled to receive services from multiple systems: Tribal providers, IHS or 638 facilities, RAIOs, and non-Tribal CMHA providers within RSN networks.
- **Lack of clarity regarding the role of Tribal providers.** There is a current lack of clarity regarding the role of Tribal providers in the broader public mental health system, and particularly their involvement in RSN networks. Significant concern was expressed in the focus groups regarding the issue of whether or not Tribal providers were required to be licensed as Community Mental Health Agencies (CMHAs) prior to participation in RSN networks. Federal law governing the Medicaid program (42 CFR 431.110) clearly states that IHS facilities are not subject to state licensure to qualify for Medicaid participation and “must be accepted as a Medicaid provider on the same basis as any other qualified provider.” The requirement goes on to state that, while “the facility need not obtain a [State] license,” it nevertheless “must meet all applicable standards for licensure.” Some Medicaid waiver states (such as New Mexico) comply with this by requiring participation by willing Tribal providers in Medicaid managed care networks regardless of CMHA licensure, but subject to minimum credentialing requirements. Others (such as Arizona) comply by offering Tribes the opportunity to operate their own Tribal Medicaid managed care plans, which provide either a full or partial range of services.
- **Tribal providers serving non-Tribal members.** There is a need to clarify limits for service provision by Tribal providers to non-Tribal members residing on or contiguous to Tribal land. While the June 2006 HRSA Tribal Health Program Billing Instructions defines which non-Tribal members may receive care (“clinical family members”),



clarifying the basis on which Tribal providers may participate in RSN networks would define the extent to which those providers would be available to serve both Tribal members and others eligible for service under that authority.

- **Specific best practices of interest to Tribal representatives.** Interest was expressed in developing a framework through which traditional healing practices could be formally included, defined, and reimbursed within Washington’s public mental health benefit through a formal study of the specific traditional healing practices developed over time by each of the State’s 29 recognized Tribes. While each Tribe’s practices are distinct, reflecting their independent cultures and histories, and there is some risk of “medicalizing” traditional healing approaches if they are made subject to the regulatory requirements of specific funding sources (such as Medicaid), there is precedent in Arizona and New Mexico for reimbursing traditional health practices using State funds. Regarding other services, Tribal focus group participants echoed concerns noted for the broader mental health system and emphasized that Tribal providers need to be involved in broader system initiatives to promote evidence-based and other best practices, with opportunities for input into how these practices need to be modified in their requirements (either administrative or clinical) so as to ensure their availability and responsiveness to the needs and strengths of Tribal members.
- **Need for better tracking of Tribal membership status in mental health information systems.** Focus group participants and key informants noted that the current mental health encounter tracking system through RSNs does not adequately document the range of services delivered to Tribal Members. Participants noted that Tribal membership status is not systematically tracked across RSNs, observing that DASA seems to do a better job of such tracking. They specifically observed the need for data systems to include specific fields to collect data on Tribal membership status and requirements for RSNs and providers to routinely collect such data. This data would be collected in addition to information on race and ethnicity. Any person identifying as a Native American would also be asked about their Tribal membership status.
- **Importance of direct coordination between Tribal governments and MHD.** Focus group participants therefore noted the need for coordination directly with MHD to offer Tribes a direct path to “government-to-government” coordination and to provide a more reliable guide for individual RSN coordination efforts. Participants observed that important steps have already been taken to improve direct communication with MHD, and they were uniformly positive about the current Tribal Billing Instructions and Tribal Mental Health Work Group meetings, which in 2007 occurred more consistently than in the previous year. Participants noted the desire for MHD to identify a senior managerial staff member (preferably reporting directly to the MHD Division Director) who would be able to serve as a single point of responsibility for addressing policy questions related to benefits and other matters of importance to Tribes, with the authority to convene needed DSHS staff to develop definitive policy guidance in response to issues that arise.



In response to these issues that directly affect the availability and quality of care for Tribal members and other Native Americans across the State, the following specific recommendations are offered for additional consideration and implementation by MHD.

Tribal Government and Member (TGM) Recommendation #1: Develop a handbook to guide RSNs in their interactions with Tribal governments and Tribal providers. We recommend that a handbook for RSNs be developed that lays out in one place the requirements to guide RSN interactions with Tribes and their members. The handbook should describe the multiple choices that Tribes and Tribal members have for accessing mental health services and the role of the RSN within that. In addition, it should describe the rights that Tribes have to make choices in how they involve RSNs in the mental health care of their members. It should also incorporate guidance on the involvement of Tribal providers in RSN networks, as well as Tribal members in the provision of care.

TGM Recommendation #2: Develop a clear policy for the involvement of IHS and 638 facility providers in 1915(b) waiver networks. We recommend that willing IHS and Tribal 638 facilities able to comply substantially with RSN credentialing requirements be allowed to participate in RSN networks without CMHA licensure. We further recommend that RSNs be required to provide technical assistance to IHS and Tribal 638 facilities that desire to participate in their networks, but that are not yet able to comply with credentialing requirements. Regulations by MHD to enact these recommendations should be developed with the involvement of Tribal governments, Tribal providers, RAIOS, and RSNs. Such requirements are likely to increase the administrative costs to RSNs to administer their networks and provide technical assistance to providers, so consideration of this should be factored into the administrative component of rate setting. As part of this effort, MHD should consider whether it makes sense to convene a work group to explore mechanisms for direct contracting with Tribes.

TGM Recommendation #3: Convene a work group to develop recommendations on how to incorporate Tribal traditional healing practices within the public mental health benefit. We recommend that MHD work through the Tribal Mental Health Work Group in collaboration with all 29 federally-recognized Tribes to convene a work group to study the traditional healing practices of all of Washington's 29 federally-recognized Tribes.

TGM Recommendation #4: Incorporate specific provisions for the inclusion of Tribes in any systematic efforts to promote best practices. As MHD develops initiatives in response to the broader recommendations of this report, specific provisions to ensure the inclusion of Tribes should be incorporated, particularly regarding the development of integrated mental health / substance abuse services and integrated mental health / primary care services.

TGM Recommendation #5: Continue facilitation of statewide forums such as the Tribal Mental Health Work Group and ensure the participation of senior staff in these forums. We recommend that MHD continue these meetings on a monthly basis and designate at least one senior staff member reporting to the Division Director to consistently attend these meetings.



Introduction

Background and Scope

The Washington State Mental Health Division (MHD) contracted with TriWest Group to provide policy guidance and input regarding potential redesign of its benefit package for publicly-funded managed behavioral health care. This work is one part of MHD's broader System Transformation Initiative (STI).

Washington State's Mental Health Benefits Design work plan included two phases. The first phase focused on compiling a detailed overview comparing Washington's current benefit design with national best practices and benefit designs from comparison states. This phase was completed in February 2007, and the report was posted to the STI website in April.³

Following initial submission of that report in February 2007, a second phase of the project began that focused on refining those preliminary findings and recommendations and developing a transition plan that takes into account the broader statewide system transformation initiative that is also in progress. The second phase culminated in this Final Report, which provides final recommendations for consideration by MHD addressing benefit redesign.

Methods and Approach

The current report integrates a review of comparison states, Washington's benefit design and management processes, national evidence-based and promising practices, Deficit Reduction Act options, and rate methodologies into a final set of options and recommendations for MHD. The recommendations are summarized in two sections.

The first section focuses on **recommendations regarding Washington's overall benefit design**. These recommendations are based primarily on a review of Washington's Medicaid State Plan and broader mental health benefit design, comparing the benefit design of the plan to the benefits of four benchmark states: Arizona, Colorado, New Mexico and Pennsylvania. Underlying these recommendations are the following primary analyses:

- Review and analysis of Washington's Medicaid State Plan (Appendix One provides additional detail on this analysis);
- A specific review and analysis of options provided by the Deficit Reduction Act and applications used by other states in mental health benefits re-design (Appendix One provides additional detail regarding these analyses); and
- Review and analysis of the benefit packages and benefit management processes of the comparison states (Appendix Two provides additional detail on this analysis).

The second section of the report focuses on **recommendations related to how best to promote current national best practices** for adults and older adults, as well as children and

³ See the following website for a full copy of that report:
http://www1.dshs.wa.gov/pdf/hrsa/mh/Mental_Health_Benefit_Package_Design_Report_DRAFT_4_16_2007.pdf.



families, within the overall recommended benefit design. Underlying these recommendations are the following primary analyses:

- Review and analysis of national evidence-based and promising practices, including analysis related to cultural relevance (Appendices Four, Five, and Six provide additional detail on this analysis); and
- Development of a unit cost methodology per service included in the recommended benefit plan, as well as plans for transitioning to a new benefits package (the recommended methodology is defined in the body of the report and applied to each of the five best practices prioritized for statewide implementation in Appendix Eight; similarly, recommendations for transitioning to the new benefits package are provided in the body of the report and applied to each of the five prioritized best practices in Appendix Eight).

Each of these report sections uses different methods and approaches, the main points of which are summarized for each recommendation or provided in more detail in the appendices.

The February 2007 preliminary report summarized an array of issues identified by Washington stakeholders, including consumers of the mental health system, their parents, other family members, providers, RSNs, and allied systems, in addition to Tribal representatives.⁴ This summary also included the perspectives of MHD operational staff, as well as staff from the federal Mental Health Transformation grant awarded to Washington State in 2006. Additional input was also gathered for this report. Overall, input was gathered through the following methods:

- Twelve focus groups were conducted with Washington stakeholders, including adult consumers, family members of adult consumers, parents and caregivers of children served, providers, allied system representatives, and RSN representatives. Two additional focus groups were held with representatives of Tribal governments and Recognized American Indian Organizations.
- Project team members participated in all eight of the monthly STI Task Force meetings and public forums held during the project tenure. This included three public forums in November, January, and May, and five STI Task Force meetings in October, December, January, March, April, and June.
- Numerous interviews with RSN administrators and staff (multiple interviews with 15 informants from nine RSNs), Mental Health Transformation grant leadership and staff (multiple interviews with four informants), allied system staff (six informants), MHD staff (multiple interviews with 21 informants), and people familiar with Tribal issues (two informants).

In the February 2007 preliminary report such additional input was included as a separate section. For this final report, pertinent input is integrated within the two sets of recommendations, so no separate section is included. In addition, full summaries of additional input received since the February 2007 preliminary report are included as appendices to this report (Appendices Three and Seven). The report concludes with a summary of all of the recommendations and concluding observations.

⁴ Input from Tribal representatives is included in a separate chapter of this report.



Recommendations Based on Medicaid State Plan Analysis

Overview of Washington's Managed Mental Health Care System, Medicaid State Plan, and Waiver Services

Washington's Medicaid managed mental health care system has undergone several significant developmental changes since 2002. These include development of the Access to Care Standards and significant changes to the State Medicaid Plan in 2003 in response to critical reviews from the Center for Medicare and Medicaid Services (CMS), as well as implementation of an External Quality Review (EQR) process in 2004. They also include the enhanced oversight and standardized managed care requirements for RSNs established legislatively by E2SHB 1290 and the 2005-06 RSN procurement process.

Additional detail regarding Washington's managed mental health care system, Medicaid State Plan, and Waiver services is provided in Appendix One.

The Current Federal Climate

While many recent changes to the program were driven by forward-looking reforms and initiatives at the state level, including the 2005 Joint Legislative & Executive Mental Health Task Force, these changes also took place in the context of wider changes at the federal program level that affected all states delivering Medicaid managed care services. The major changes included:

- **Change in Rate Calculation Methodology from Upper Payment Limits to Actuarially Sound Rates.** In August 2002 CMS revised requirements for calculating rates in managed care programs by removing the upper payment limit (UPL) requirement (42 CFR 447.361). As the original fee-for-service data used to establish UPLs became outdated nationwide, the validity of the UPL approach became a concern and CMS modified federal regulations to eliminate the UPL and instead require that rates be actuarially sound [42 CFR 438.6(c)]. On the one hand, states experienced a loss of flexibility as future rate setting calculations were limited to encounters that could be counted, tied to Medicaid recipients, and priced on a per unit basis. However, the elimination of the UPL also afforded states increased flexibility during rate setting to project future costs in excess of the costs of current care delivery.
- **Enhanced Quality Standards for Managed Care Plans.** The Balanced Budget Act of 1997, implemented in August 2003 under 42 CFR 438, required states to implement External Quality Review (EQR) standards for quality, timeliness, and access for the health care services furnished to Medicaid recipients by managed care organizations. These new standards drove Washington's development of an EQR process in 2004, as well as many of the new requirements built into the 2005-06 RSN procurement.
- **Enhanced Scrutiny of Rehabilitative Services.** States around the nation have experienced enhanced scrutiny of any changes requested to their Rehabilitative Services over the last two years. In particular, states have experienced questioning of bundled per diem rates and services in 24-hour care settings that included non-medical supports such as room and board and other non-treatment costs. Washington State has



taken steps to construct its per diem rates without such non-medical costs. CMS is expected to issue more stringent requirements for Rehabilitative Services in 2007 addressing these and other issues.

- **Enhanced Scrutiny under the Deficit Reduction Act of 2005.** Finally, the Deficit Reduction Act of 2005 (enacted in February 2006 as PL 109-171) required states to more closely scrutinize specific service types, including case management, targeted case management, and related individual interventions to coordinate services for children involved in mental health and child welfare systems (Section 6052). CMS currently expects to promulgate rules related to the Deficit Reduction Act in 2007.

This developmental context is important for understanding both the recent past from which the system has evolved, as well as the current status of Washington's Prepaid Inpatient Health Plan (PIHP – the technical term with which CMS categorizes Washington's Medicaid mental health managed care plan). This context is particularly relevant to the development of two system features, discussed below, which figure significantly into the stakeholder concerns described in the next major section of this report:

- **Development of the Rehabilitative Services Plan Modalities.** The current 18 modalities defined under the Rehabilitative Services section of Washington's Medicaid State Plan were developed in response to CMS concerns expressed immediately following the shift from the UPL rate methodology to the actuarially sound rate requirements. Given the pressure of the situation under which they were developed, it is remarkable that MHD was able to achieve the breadth of progressive service types within the State Plan that resulted (for example, Peer Support and very permissive Individual Treatment services).
- **Development of the Access to Care Standards.** The Access to Care Standards which govern both eligibility and medical necessity determinations for the current Medicaid system were developed in response to a contingency from CMS on Washington's 2001 waiver renewal approval. The contingency required Washington to develop a single consistent standard for determining initial authorization for outpatient services.

Washington's Current Medicaid Managed Care System

Washington's Medicaid mental health benefit is primarily structured by four components from Washington's Medicaid State Plan: Inpatient Hospital Services, Under 21 Inpatient Services, Physician Services, and Rehabilitative Services. The primary focus of the RSN's PIHP programs is the 18 Rehabilitative Services modalities. In addition to the State Plan services, Washington is able to provide three additional service types defined within its waiver under the authority of Section 1915(b)(3). These are all non-traditional services and include: Mental Health Clubhouse, Respite, and Supported Employment.



Comparisons with Other States: Arizona, Colorado, New Mexico, and Pennsylvania

The goal of the cross-state analysis was to determine how well Washington's Medicaid State Plan and managed care system support evidence-based and promising practices, as compared to other leading managed care states. Four states were selected for comparison to Washington, and information on each is summarized below. See Appendix Two for additional detail on each state and detailed comparisons between their State Medicaid Plans and those of Washington:

- **Arizona** is in many ways the state most like Washington. It is comparable in terms of size, per capita mental health spending (14th compared to Washington at 15th), Medicaid spending (keeping in mind that Arizona's benefit includes both substance abuse and mental health spending), Medicaid members (around 1 million), and a system of regional authorities managing its Medicaid behavioral managed care program.
- **Colorado** was selected as a leading managed care state with a 1915(b) waiver similar to Washington's. Both Washington and Colorado have their PIHP's organized into regions, and both have only two state psychiatric hospitals. Colorado's per capita mental health spending is lower, but its Medicaid mental health spending per member is higher. Its managed care system was initiated about the same time as Washington's, and it has faced many of the same struggles updating its encounter tracking in response to heightened CMS requirements.
- **New Mexico** is in some ways similar to Washington in that it is one of the six states awarded federal Transformation State Infrastructure Grants in 2006. However, its level of mental health funding per capita is much lower (second to last nationally) and it is organized to deliver care through a single Statewide Entity that coordinates care across 6 regions advised by 15 Local Collaboratives and that delivers mental health services on behalf of 15 different state agencies, in addition to Medicaid.
- **Pennsylvania** is at the other extreme from New Mexico in terms of differences from Washington. It has nearly twice the population and much higher overall mental health spending that ranks 2nd nationally, including five times the level of Medicaid mental health care spending with less than 20% more members.

In summary, across these four states, most of Washington's system features are represented. These states also allow us to look at Medicaid benefit designs funded at levels comparable to Washington's (AZ and CO), as well as much lower (NM) and much higher (PA). That being said, several structural features are unique to Washington:

- Washington's eligibility requirements include the DC:0-3 standards for infants and toddlers, which gives the state more diagnostic flexibility in treating the mental health needs of early childhood. Colorado has begun to develop a cross-walk between these standards and ICD-9 diagnoses to support such services, but it does not directly allow services to be delivered under those diagnoses. Other states are only beginning to address the need for different diagnostic categories for young children.



- Washington is the only state of the five that imposes functional impairment requirements as a means of determining service eligibility. Other states incorporate impairment scores using the GAF into discrete level of care guidelines for medical necessity, but none require such impairment for entry into the system. This appears to significantly reduce access to community services in Washington, as compared to these other states, and may limit Washington's ability to promote less intensive community services before symptoms exacerbate. The primary rationale for implementing this impairment requirement was a perception in 2001 that it would reduce costs by limiting access to services. However, we have not found such cost savings in our reviews of other states. By limiting access when impairment is relatively low, the ACS may just as likely be increasing costs overall by excluding some low cost cases and delaying the provision of care for others until conditions worsen and are more expensive to treat. We are not aware of any definitive studies of these issues, but it is true that many states' managed care entities (including those in all four of the comparison states in this report and other states such as Connecticut, Iowa, Florida, and Massachusetts) have eliminated prior authorization requirements for outpatient care across the board until a minimum number of sessions have been provided (generally ranging from six to ten, and sometimes higher). The rationale for this has generally been that the cost of managing this care (particularly utilization management staff reviewing outpatient service requests) has exceeded the possible cost savings in diverting inappropriate low level (and low cost) outpatient care. In fact, we are not aware of any state other than Washington that requires the provision of prior authorization for all outpatient care, including low level outpatient requests.
- Washington is the only state of the five (and the only 1915(b) waiver state of which we are aware) that holds its managed care organizations to be at-risk for acute inpatient care, but only requires them to coordinate the delivery of such care, rather than directly deliver the service through their regional networks. This significantly reduces Washington's available tools for managing inpatient care and is a structural feature that may limit its ability to shift funding from restrictive settings to community-based, evidence-based and promising practices.
- Washington operates independent managed care plans with very relatively few covered lives, including four regions with fewer than 25,000 lives and six with fewer than 60,000. Of the comparison states reviewed, none operate regions with fewer than 40,000 covered lives and only Colorado operates regions with fewer than 60,000 lives.

Recommendations Regarding Washington's Medicaid State Plan

Washington's Rehabilitative Services language defining the limits of most of its mental health services is more highly specified than those of other states, with the notable exception of Pennsylvania. Our opinion is that an integrated and broadly defined conceptual description in the State Plan, backed up by a very specific set of encounter reporting requirements, is the ideal combination for a State Plan in terms of the promotion of best practices. Such an approach gives the maximum level of flexibility between the State and CMS, and allows for the broadest possible support for ongoing service development beyond the specific service set



that is currently in place, an attribute increasingly necessary given the rapid pace of best practice development and adoption.

However, our analysis of Washington's State Plan found that the language of the 18 modalities is sufficiently flexible to promote all of the prioritized best practices summarized in the following major section of this report. Furthermore, in light of the enhanced scrutiny of Rehabilitative Services that CMS has been engaged in over the last two years, we do not recommend proposing any State Medicaid Plan change to CMS that would involve Rehabilitative Services. In an April 2007 conference call for State mental health directors and commissioners,⁵ dozens of states recounted responses from CMS either limiting their flexibility or disallowing current costs under their Rehabilitative Services options, resulting in lost funds, major program revisions (e.g., necessitating the development of 1915(i) waivers), or loss of flexibility (e.g., disallowance of bundling for Rehabilitative Services). In Colorado alone, a request for a minor review of residential treatment standards led to a complete opening of their State Plan for review, leading to the disallowance of tens of millions of dollars of annual Medicaid funding. However, if CMS adopts new regulations for Rehabilitative Services under development at the time of this report (July 2007), Washington State will need to revisit the need for possible State Plan changes to respond to those regulations.

Medicaid State Plan and Waiver (MSP&W) Recommendation #1: Do not propose any changes to CMS regarding the structure of Rehabilitative Services within Washington's Medicaid State Plan.

Recommendations Regarding Washington's 1915(b) Waiver Implementation

While no changes are recommended in the language of Washington's Medicaid State Plan, we offer several recommendations regarding implementation of the State's 1915(b) Waiver.

Recommendations Regarding the Access to Care Standards

Our February 2007 preliminary report offered recommendations to revise the Access to Care Standards (ACS) for Medicaid recipients. The report highlighted a current focus within the RSN system on front-end access to services that was much greater than other leading managed care states we have reviewed, particularly the emphasis on narrowly defined and rigidly implemented functional requirements for initial access to routine outpatient services. Given limitations in funds available for serving people without Medicaid or other insurance, we did not recommend changes in ACS for the State-funded benefit at the current time.

⁵ National Association of State Mental Health Program Directors (NASMHPD). (April 13, 2007). *State mental health directors and commissioners conference call: Medicaid Rehabilitative Services Option*.



It is our opinion that Washington's current waiver, combined with the requirements of 42 CFR 438 (Balanced Budget Act of 1997 standards) implemented in Washington State under E2SHB 1290, gives MHD the authority to proceed with more refined and standardized implementation of the ACS for the Medicaid benefit. Specifically, under the waiver all services can be made available based on individualized enrollee needs, as follows: "The full scope of available treatment modalities may be provided based on clinical assessment, medical necessity and individual need."⁶

The problem we identified was in the current implementation of the standards, particularly their exclusive focus on front-end access to care in general, and lack of the following: standards for continuing access, differential criteria for access to levels of care more intensive than routine outpatient, and specification of the circumstances in which outreach can be provided to high need populations. Furthermore, the practice reported by RSNs and providers was that a single standardized measure of need (specifically, the GAF impairment score for adults and C-GAS for children over age 5) was being enforced too rigidly without consideration of broader information from clinical assessments of individualized need. No contemporary medical necessity criteria used in Medicaid managed care settings with which we are familiar simply imposes numeric cut-offs without the ability of clinical review to augment the decision with the clinical judgment of recognized mental health professionals.⁷

Our subsequent discussions with stakeholders in March and April 2007 differentiated two sets of recommendations to address the current limitations of ACS implementation for Medicaid: utilization management concerns and access concerns.

MSP&W Recommendation #2: Develop statewide standards for continuing care and discharge under 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. This will require the development of statewide medical necessity standards for all levels of care, including criteria for initial and concurrent reviews.

While not a formal change in the ACS as defined in the current 1915(b) waiver, this recommendation would instead entail the development of statewide standards to guide ACS implementation, particularly statewide standards for continuing care and discharge, carried out under the oversight of and in partnership with the federal Centers for Medicare and Medicaid Services (CMS). The ACS is properly viewed as a tool to allow RSNs to have authority to manage care, as opposed to a rigid requirement that limits RSN utilization management approaches, outreach and service delivery. In addition to continuing stay and

⁶ Washington State Mental Health Division. Proposal for a Section 1915(b) Capitated Waiver Program Waiver Renewal, Washington State Integrated Community Mental Health Program, April 1, 2006 – March 31, 2008. Pp. 15, 18.

⁷ Ironically, in our view the ACS as currently written does include provisions for clinical judgment. Both Levels I and II include the following caveat: "The full scope of available treatment modalities may be provided based on clinical assessment, medical necessity and individual need." However, this process has not been made sufficiently operational and respondents consistently reported to us that GAF and C-GAS scores are routinely used as cut-offs or, more perniciously, lead referral sources to preemptively decide not to refer members for care for fear that ACS criteria will not be met.



discharge criteria, there should be formally acknowledged mechanisms whereby ACS numeric functioning score cut-offs can be overridden in individual cases or more systematically based on “clinical assessment, medical necessity, and individual need.”

The current ACS standards include only criteria for limiting front-end access across the board. As such, they are a crude tool for managing care, and need to be augmented by broader utilization management criteria that encompass differentiated medical necessity criteria by level of care, as well as ways to broaden access for high need populations, either by lowering the GAF threshold or defining specific circumstances in which outreach can be provided to high need populations. Under the current system, multiple respondents we spoke with emphasized how many members of high risk groups (such as children placed out of home by Children’s Administration) are excluded because they either do not currently meet C-GAS functioning severity requirements or, of equal concern, might meet the requirements, but are simply not referred by allied system and other community members who assume that they will not meet ACS requirements based on past experience. Updated RSN requirements based on federal requirements (Balanced Budget Act of 1997 requirements implemented under 42 CFR 438) and implemented in Washington under E2SHB 1290, require RSNs to develop broader utilization management capacities. However, in the absence of broader MHD-sanctioned medical necessity requirements beyond ACS, RSNs appear to continue to center their care management efforts to a large degree on enforcement of the up-front ACS standards.

As a result, the current ACS implementation focuses utilization management resources almost entirely on front-end limitations to outpatient care, shifting the focus of utilization management too much toward management of low-intensity, low cost outpatient care rather than more expensive levels of care such as day services, long-term case management, and residential services. In our interviews, the Medicaid ACS was generally seen by stakeholders to create bureaucratic burdens with little benefit, though RSNs to varying degrees still reported relying on it to limit their financial risk for outpatient care.

Other states and their managed care organizations (MCOs) have generally evolved the focus of their utilization management activities away from across-the-board front-end restrictions in order to focus care management resources on more expensive services. To understand how this can work, we need to first establish that provider compliance with requirements for medical necessity can be reviewed either prospectively or retrospectively. Retrospective review can be by sample, costing less per case. Prospective review is expensive and should be used only in cases with costs that exceed the cost of review and where we expect a clinical review to potentially change course of care.

Retrospective review of inexpensive outpatient care could be carried out by the same RSN utilization review staff that would otherwise carry out prospective review of all cases and would generally only be used with high-volume providers that past utilization management oversight have shown to comply in general with medical necessity standards. With retrospective review, all cases at a lower level of care (such as routine outpatient care lasting only a few sessions) are automatically authorized as long as they do not exceed a maximum



number of sessions (generally ranging from 6 to 10). For each provider, a sample of cases (for example, 25%) is reviewed at the time of the annual or semi-annual site visit. If cases conform to medical necessity criteria, the automatic authorizations stand. If they do not, the care is retroactively denied and costs paid back to the RSN. If a pattern of unnecessary care is detected, up to 100% of cases are subject to retrospective review and possible denial. If the pattern is ongoing, the provider can be moved from retrospective review status to prospective review status where 100% of cases require prior authorization.

Differentiating between retrospective and prospective clinical review, other states have generally moved to a tiered system of review of compliance with medical necessity standards for routine outpatient care, requiring review only after the first 6 to 10 sessions and conducting retrospective reviews of samples for lower level outpatient cases. By reviewing only a subset of these cases rather than 100%, retrospective review allows these plans to shift their resources to more hands-on management of high-end cases. This approach has generally been found to be more cost-effective over time, with any increase in service use more than offset by: (1) better use of utilization management resources for high-end cases, (2) savings through earlier intervention, and (3) reductions in the cost of managed care oversight.

While RSNs are free now to develop such approaches to utilization management under E2SHB 1290, the standardized statewide ACS requirements remain the focus of utilization management efforts rather than the required, broader local medical necessity standards.

MSP&W Recommendation #3: Prior to the next waiver submission, conduct a full actuarial analysis of the financial impact of revising GAF and C-GAS minimums for routine outpatient care. If financially feasible, raise the GAF and C-GAS minimums to at least 70 for all covered diagnoses.

The broader concern articulated by stakeholders regarding the ACS was the way in which they limit access to mental health services. While the degree to which ACS is currently limiting access to outpatient care is not known, all stakeholders we interviewed agreed that there is some level of unmet need that could be served by RSNs. Key findings included:

- Broader access to mental health services was a focus of discussion in all nine focus groups conducted (see Appendix Three for an overview of focus group findings; the access discussion comes at the end of the overview). The specific thoughts expressed related to this topic centered most often on the need for treatment to be provided when a need is expressed, not according to benefit limitations. Treatment should be available “when people need it; not when the ACS says they need it” in the words of one family member of an adult consumer. Outreach for those most in need was nearly as frequently discussed.
- We asked most participants⁸ if they agreed with this dual requirement or if they thought access to routine outpatient services should be based only on having an eligible diagnosis, giving them the opportunity to submit a written vote one way or the other. Of the 88 active participants in the focus groups, 49 submitted a vote, and 84%

⁸ We asked this question at eight of the nine focus groups. We were unable to ask this during the telephone focus group with eastern Washington providers.



(41 of 49) endorsed the option of using only a diagnosis. The closest vote was among STI Task Force members, who had been considering this issue in more detail over several meetings, where only 70% endorsed using only a diagnosis.

- During the May 2007 Community Forum, nearly 95% of participants offering an opinion endorsed expanding eligibility under ACS (see Appendix Seven for additional detail regarding forum results). Nearly 60% endorsed the statement: “Change the requirements so that RSNs can serve all people with covered mental health diagnoses.” Another 36% endorsed the statement: “Change the criteria so that RSNs still serve only those most in need, but they are also able to outreach high-need cases.”
- May 2007 Forum participants were also asked to make choices among the possible priorities, including the five prioritized practices just discussed, a broader-based effort to promote best practices, and the option of changing the ACS to expand access across the board. “Broader ACS criteria to allow RSNs to serve more people across the board” came out as the most often endorsed choice. However, this was because it was a moderately rated choice across most groups (it was not the highest priority of any group other than mental health providers).

Currently, there is no substantive mental health benefit for Medicaid enrollees not covered by the Healthy Options program, an important subgroup, given that all disabled adults fall outside the Healthy Options program. While technically the fee-for-service benefit covers psychiatric services for these Medicaid recipients, numerous stakeholders (including representatives from the DSHS Health and Recovery Services Administration, Division of Health Care Services) noted that very few psychiatrists currently accept Medicaid recipients for treatment outside of the RSN system. Some enrollees may receive mental health services through Federally Qualified Health Clinics (FQHCs), but the general sense from stakeholders was that Medicaid recipients outside the Healthy Options program who do not meet ACS requirements generally do not receive mental health services currently.

One way to extend coverage to these individuals would be to relax the functional requirements for ACS. This could be accomplished by raising the GAF/C-GAS cut-offs to allow moderate severity case (for example, raising the cut-offs to 70 from 50 to 60). It could also be accomplished by strengthening the criteria allowing consideration of other factors within the ACS formula other than GAF/C-GAS scores.

The primary barrier is that this is likely to cost more money. Representatives from Children’s Administration, the Division of Developmental Disabilities, and other agency representatives noted that currently other agencies do not refer some cases to RSNs that they do not believe will meet ACS criteria. If these criteria are relaxed, the informants believed that there would be a significant increase in referrals to RSNs. Therefore, we recommend that a formal actuarial analysis be conducted to estimate the level of potential additional need and associated costs.

It may be that the additional costs are not prohibitive. Actuarial analysis leading up to the 2007 expansion of Healthy Options and fee-for-service benefit limits from 12 to 20 visits annually and expanding the types of eligible providers documented expected costs of



approximately \$2,285,000 in additional Medicaid expenditures.⁹ Given that this change has already been made and eligible providers in RSN networks are now able to provide these additional services, it is not clear what additional costs would be entailed by integrating these fee-for-service benefits within the RSN structure.

MSP&W Recommendation #4: Revise Current RSN Contract Requirements for Statewideness and Provide Definitive Guidance to RSNs on Implementation.

As presented in our February 2007 preliminary report, RSNs must provide the entire range of services from the Medicaid State Plan defined under the scope of the waiver. However, we believe that the current language of the RSN contracts (Section 13.4.23) goes beyond the requirements of “statewideness” under both federal Medicaid requirements (42 CFR 41.50) that require the Medicaid State Plan to be in operation in all jurisdictions of the state, as well as Washington State procurement rules for the RSNs (E2SHB 1290, Section 71.24.320).

The federal statewideness requirements focus on the need for states to cover services within the Medicaid State Plan as made available by providers. A recent Kaiser Report analyzing the availability of long-term care facilities summarizes the requirement well: “The ‘statewideness’ requirement does not guarantee that an individual beneficiary will actually receive covered services in the community in which he or she resides; that is determined by the availability and accessibility of providers.”¹⁰ In other words, an RSN would need to cover the service if available within the network, but could still comply with 42 CFR 41.50 even if there is no current provider willing to offer the service. It is a benefit coverage requirement, not a utilization requirement.

However, additional federal rules require more than do the statewideness standards under 42 CFR 41.50. Rules governing PIHP coverage of services are defined further under 42 CFR 438.206 and 438.207, which regulate access to care and network capacity, respectively. While these rules include the requirement that “Each State must ensure that all services covered under the State plan are available and accessible to enrollees of MCOs, PIHPs, and PAHPs,” they provide additional detail specifying a process for determining the adequacy of network services to meet the needs of the local population served by the PIHP. The process is designed to be tailored to the needs of the local community, not to a statewide minimum requirement of access for every State Plan service.

To better reflect all pertinent federal standards, we recommend that the language of the RSN contracts be revised from an emphasis on statewideness under 42 CFR 41.50 to an emphasis on network adequacy under 42 CFR 438.206 and 438.207. This will shift the focus of RSN requirements so that they must demonstrate how needs are documented and met, rather than

⁹ Barclay, T. S. of Milliman, Inc. (January 22, 2007). Official correspondence with R. Gantz, DSHS, Medical Assistance Administration regarding Medicaid Mental Health Benefit Expansion.

¹⁰ Schneider, A. & Elias, R. (November, 2003). Medicaid as a long-term care program: Current benefits and flexibility, p. 6. Available at:

<http://www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=28090>.



simply document that the network includes a provider from somewhere in the state that provides a given modality.

One way to accomplish this would be to revise Section 13.4.23 of the current RSN contract as follows (revised language is **bolded**):

If the Contractor is unable to **meet the documented medical needs of an enrollee within its existing network**, the services must be purchased **from another RSN that can meet the need** within 28 days for an enrollee with an identified need. The Contractor must continue to pay for medically necessary mental health services outside the service area until the Contractor is able to provide them within its service area.

The current language of that section requires the RSN to purchase services from outside their network in cases where the Contractor is unable “to provide the services covered under this Agreement.” The revised language shifts the emphasis from an ability to provide a specific service to an ability to meet a specific enrollee need.

Recommendations Related to Mental Health Best Practices

System Level Recommendations for Promoting Best Practices

When used in relation to mental health services, “evidence-based” generally refers to a body of knowledge about service practices and the impact of treatments. Flaum¹¹ defines evidence-based practices (EBPs) as “*interventions for which there is consistent scientific evidence showing that they improve client outcomes.*” The definition goes on to specify that this body of evidence must include rigorous research studies, specified target populations, specified consumer outcomes, specific implementation criteria (e.g., treatment manuals), and a track record showing that the practice can be implemented in different settings.

Many approaches ranking and labeling EBPs exist, and recently (February 11, 2005; updated December 15, 2006) the Washington State DSHS Mental Health Division (MHD), Children's Administration (CA), and Juvenile Rehabilitation Administration (JRA) convened an expert panel to review and recommend Evidence Based Practices for children and youth. The expert panel developed a framework in which practices are ranked into five categories.¹² While the level of detailed analysis offered by multi-level classification schemas such as this can be helpful for determining the utility of a specific EBP, the goal in this report is to summarize a wide range of practices for possible promotion by the State's benefit package. After reviewing the multiple definitions and typologies that exist, the most useful distinction for the present report was determined to center on two levels: interventions that are **well established** and those that are **promising**:

¹¹ Flaum, Michael. (2003, October 10). Evidence-Based Practices in Mental Health: Ready or Not, Here They Come. Iowa Psychiatric Society Annual Meeting.

¹² For additional detail see: Children's Evidence Based Practices Expert Panel-Update (2006, December 15).



- **Well established** interventions may be characterized by their support from randomized controlled studies, as well as evidence from real-world care settings. Further, well established interventions are sufficiently documented to allow tracking of fidelity to established standards.
- **Promising interventions** are supported by methodologically sound studies in either controlled or routine care settings and are sufficiently documented to allow at least limited fidelity tracking.

Best Practice (BP) Recommendation #1: While continuing to promote EBPs, be mindful of their limitations. Successful EBP promotion begins with an understanding of the real world limitations of each specific best practice, so that the inevitable stakeholder concerns that emerge can be anticipated and incorporated into the best practice promotion effort. Our February 2007 preliminary report discussed in detail the limitations of evidence-based practice. While EBPs offer a well-documented route to effective treatment in many cases, their promotion faces multiple challenges and controversy.

The reasons for stakeholder concern are well-documented and significant.¹³ First, the literature prioritizes randomized clinical trials (RCTs) that address **efficacy** in controlled research settings, whereas practitioners require research evidence on **effectiveness** in typical practice settings. This “efficacy-effectiveness gap” was clearly defined in the 1999 U.S. Surgeon General’s report on mental health services in America.¹⁴ Second, research that addresses the complexities of typical practice settings (for example, staffing variability due to vacancies, turnover, and differential training) is lacking, and the emphasis on RCTs does not allow for exploration of clinically relevant constructs like engagement and therapeutic relationships.¹⁵ Some point to a concern that the over-reliance on efficacy research has been used to limit the types and duration of services that are funded by managed health care organizations in the United States, fueling concerns that EBPs will be used too narrowly by policy makers in the service of efficiency.¹⁶ Related uncertainties about implementing EBPs in children’s mental health include a lack of clarity about the interactions of development and ecological context with the interventions. While it is generally accepted that development involves continuous and dynamic interactions between children and their environments over time, and is inextricably linked to natural contexts such as families, schools, and communities, the efficacy research literature is largely silent on these relationships.¹⁷ For example, it is not known whether even a well-established treatment such as Cognitive Behavioral Therapy (CBT) for anxiety can be applied across all age groups or to children with complex disorders, meaning that practitioners must constantly extrapolate from the existing research evidence.

¹³ Waddell, C. & Godderis, R. (2005). Rethinking evidence-based practice for children’s mental health. *Evidence-Based Mental Health*, 8, 60-62.

¹⁴ U.S. Surgeon General. (1999). *Mental health: A report of the surgeon general*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health.

¹⁵ Hoagwood, K., Burns, B.J., Kiser, L., et al. (2001). Evidence-based practice in child and adolescent mental health services. *Psychiatric Services*, 52, 1179–89.

¹⁶ Tanenbaum, S.J. (2005). Evidence-based practice as mental health policy: Three controversies and a caveat. *Health Affairs*, 24, 163–74.

¹⁷ Hoagwood K., Burns B.J., Kiser L., et al. (2001).



These inherent limitations in the research base often lead providers, consumers and other stakeholders to question the extent to which the research evidence supporting much-vaunted EBPs is applicable to their communities and the situations they encounter on a daily basis. In addition, when practices are promoted based on the efficacy research, many consumers are understandably concerned that having policy makers specify particular approaches might limit the service choices available. Similarly, many providers are reluctant to implement EBPs due to the costs and risks involved in training and infrastructure-building, processes that require commitments over years rather than months.

BP Recommendation #2: Specifically address the lack of research on cross-cultural application of EBPs. There is wide consensus in the literature that little research has been carried out to document the differential efficacy of EBPs across culture, as clearly documented in the 2001 Supplement to the Surgeon General's Report.¹⁸ There are also emerging strategies to help adapt EBPs when they are applied cross-culturally.¹⁹ Stewart (2007) concludes that, while it makes sense for communities to implement programs such as EBPs that have been shown to work in other settings, two overarching concepts must be kept in mind:

- Given the absence of conclusive studies on the effect of an EBP across racial and cultural groups, we should neither assume that an EBP is culturally competent nor assume that it is not.
- When implementing an EBP in a local community, assessment of the cultural competence of local services should be included in understanding the overall competence of the implementation.

Given that few EBPs have documented their results in sufficient detail to determine their effectiveness cross-culturally, it makes sense that EBPs be implemented within the context of ongoing evaluation efforts to determine whether they are effective for the local populations being served.

BP Recommendation #3: Specify the level of consumer and family involvement for each service in the array of best practices to be promoted. Many consumer and family driven services are themselves promising practices with emerging evidence, including Wraparound Planning for children and families, Peer Support, Wellness Recovery Action Plans (WRAP) for adults, and Mental Health Clubhouse services, among others. The best practices described in this report include a range of consumer and family involvement that varies across practices. In this report, we attempt to define the degree to which the best practices reviewed are consumer and family driven, focusing on the levels at which the services involve consumer and family member guidance and input in areas such as service planning, service delivery,

¹⁸ U.S. Surgeon General. (2001). Mental health: Culture, race, and ethnicity – A supplement to mental health. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health.

¹⁹ Stewart, D. (February 8, 2007). Adapting evidence based practices to culture and community. Presented at the 2nd Annual Advancing Colorado's Mental Health Care Conference, Denver, CO.



and operation of the service agency. We have combined these constructs into the following scale to define the consumer/family-centeredness of each best practice reviewed:

- **Consumer/Family Run and Operated** – The highest level of involvement is found in those services delivered by consumers or family members within organizations that are majority owned by consumers or family members, or that are otherwise autonomously governed and run by at least 51% consumers or family members. Organizations owned or run by 51% or more consumers or family members (parents of children with mental health needs or family members of adults and older adults with mental health needs) are considered to be “Consumer/Family Run and Operated.” For example, Peer Support delivered by a consumer-run organization would qualify as consumer run and operated.
- **Fully Consumer/Family Delivered** – The next level includes services and supports that are delivered by consumers or family members within organizations that are run by professionals. For example, Peer Support delivered by a community mental health agency would be fully consumer delivered, but not consumer run.
- **Partially Consumer/Family Delivered** – While some services and supports such as Peer Support may be fully delivered by consumers or family members, others are jointly delivered by consumers or family members in partnership with professionals. For example, Assertive Community Treatment (ACT)²⁰ as originally designed did not include a peer specialist on the team, but newer conceptualizations of the model do. ACT that includes a peer specialist would qualify as “Partially Consumer Delivered,” whereas ACT that does not would be considered “Professionally Run and Delivered.”
- **Consumer/Family Involved** – The next level are services and supports delivered by professionals that include formal protocols for ensuring and enhancing the involvement of consumer and family members in the planning and delivery of the service. Such protocols need to do more than simply involve the consumer or family member in developing the overall treatment plan, encompassing specific, mandated mechanisms to ensure the involvement of the consumer or family member in the process of care delivery. For example, Wraparound Planning facilitated by a professional would be considered “Consumer/Family Involved” (whereas Wraparound Planning facilitated by a consumer or family member would be considered “Fully Consumer/Family Delivered”).
- **Professionally Run and Delivered** – Some services are designed to be delivered by professionals within organizations run and operated by professionals. These would include formal psychotherapies such as Dialectical Behavior Therapy and algorithms for guiding medication management such as MEDMap. While consumers and family members often are represented among professionals and may deliver such services if properly credentialed, it would be their role as a professional that is seen as qualifying them to deliver the EBP and not their status and life experience as a consumer or family member.

²⁰ In Washington State, ACT is referred to as PACT (Program for Assertive Community Treatment). We use the term “ACT” in this report as a more generic reference that is more typically used nationally.



BP Recommendation #4: Ground the promotion of specific best practices within a broader Evidence Based Culture. Partly in response to the growing recognition that efficacy research provides an insufficient base on which to build policy decisions regarding public mental health benefits, and partly in order to support the successful implementation of EBPs, increasing attention is turning to the need for system and organizational infrastructures that will support the implementation, broad dissemination, and ongoing scrutiny of evidence-based practices. Such infrastructures involve the policy, procedural, and funding mechanisms to sustain evidence-based interventions, and they need to be based in system and organizational cultures and climates that value the use of information and data tracking as a strategy to improve the quality of services and increase the likelihood of achieving desired outcomes (a data and learning-centered construct implicit in an array of broader constructs, including “learning organizations,” “continuous quality improvement,” and others).

Increasingly researchers²¹ use the term “evidence based culture” to describe the constellation of policy, procedural, and funding mechanisms that, in concert with a favorable culture and climate, support successful practice.²² An evidence based culture includes the following:

- Involves all levels of the system – state and regional administrators, provider program managers, clinical supervisors, clinicians, consumers, and family members – in the implementation process;
- Begins with a thorough understanding of the current treatment system, the interventions that are utilized, the need for coordination with other human service systems (e.g., chemical dependency, child welfare, juvenile justice, criminal justice, primary care) and the outcomes being achieved;
- Includes a systematic approach to reviewing available evidence and recommending changes in intervention strategies as appropriate;
- Supports a reimbursement rate commensurate with the level of work required to implement new interventions (including any impact on clinic-based productivity expectations) so that all allowable provider costs are covered;
- Provides reimbursement for the training and clinical supervision, as well as the administrative overhead required by health plans and providers, that are essential to implementation of evidence-based practices;
- Creates and maintains data collection and reporting mechanisms that will document evidence-based practice results;
- Develops and supports policies that facilitate adoption and implementation of evidence-based practices;

²¹ Dixon, G.D. (2003). Evidence-based practices. Part III. Moving science into service: Steps to implementing evidence-based practices. Tallahassee, FL: Southern Coast Beacon (a publication of the Southern Coast ATTC). Available online at http://www.scattc.org/pdf_upload/Beacon003.pdf.

Barwick, M.A., Boydell, K.M., Stasiulis, E., Ferguson, H.B., Blase, K., & Fixsen, D. (2005). Knowledge transfer and implementation of evidence-based practices in children’s mental health. Toronto, Ontario: Children’s Mental Health Ontario.

²² Rivard, J., Bruns, E., Hoagwood, K., Hodges, K., & Marsenich, L. (2006). Different Strategies for Promoting and Institutionalizing an Evidenced-Based Culture. In C. Newman, C. Liberton, K. Kutash, & R. M. Friedman (Eds.), *The 19th Annual Research Conference Proceedings: A System of Care for Children’s Mental Health: Expanding the Research Base*. Tampa: University of South Florida, Louis de la Parte Florida Mental Health Institute, Research and Training Center for Children’s Mental Health.



- Supports bi-directional communication between researchers and clinicians;
- Promotes an appropriate balance between fidelity and adaptation; and,
- Uses outcome data to drive systems change.

In keeping with this line of thought, members of the National EBP Consortium²³ expressed much concern that the increasingly common approach taken by many states of mandating the use of specific EBPs does not necessarily lead to improved outcomes and does little to help agencies, provider organizations, and communities understand how best to select and implement effective interventions. In order to make the most of the movement toward evidence-based practice at the federal, state, and local levels, discussions are increasingly turning towards a systematic process through which decisions are made at the community level so that communities are supported to select, implement, and sustain effective practices. Such a process ideally is inclusive, strategic, and driven by the needs, strengths, and local cultures of the consumers, families, and communities served. The efforts of the states of New York²⁴ and Hawaii²⁵ to implement EBPs statewide offer best practice examples of states working towards an evidence-based culture, and are discussed in more detail in our February 2007 preliminary report.

Washington has taken important steps toward promotion of an evidence-based culture across DSHS. The work of the federally funded Mental Health Transformation grant has helped contribute to this. For example, the Client Services Data Base developed by the Research and Data Analysis Division of DSHS can serve as a basis for a broader evidence-based culture at DSHS by integrating available administrative data from several state and local agencies into a common data set, thereby allowing system monitoring, cross-agency management reports, and research across agencies. The project has substantial support from the Mental Health Transformation grant. The data base is already developed to a significant extent and is being fully developed over a three to four year time line, and will capture data from CY 2004 forward.

BP Recommendation #5: Develop Centers of Excellence to support the implementation of those best practices prioritized for statewide implementation. An emerging concept in support of EBP implementation is the “center of excellence” (COE). While referred to variously across states, there are increasing efforts nationally to develop local COEs within states that provide ongoing sources of expertise, evaluation, training, and guidance to support the initiation and ongoing development of EBPs and promising practices. While there are no definitive studies yet available of what factors best support system-wide EBP promotion, emerging research suggests that states implementing these approaches are further along in EBP promotion than those that do not.

²³ Rivard, J. et al. (2006).

²⁴ Carpinello, S. et al. (2002). New York State’s Campaign to Implement Evidence-Based Practices for People with Serious Mental Disorders. *Psychiatric Services*, (53) 2.

²⁵ Daleiden, E.L. & Chorpita, B.F. (2005). From data to wisdom: Quality improvement strategies supporting large-scale implementation of evidence based services. In B.J. Burns & K.E. Hoagwood (Eds.), (2005). *Evidence-Based Practice, Part II: Effecting Change, Child and Adolescent Psychiatric Clinics of North America*, 14, 329-349.



Our February 2007 preliminary report documents multiple examples of COEs in other states. Washington State has its own emerging COEs through its comprehensive contract with the Washington Institute for Mental Illness Research and Training to develop ACT capacity statewide and the children's mental health evidence-based practice institute at the University of Washington established under House Bill (HB) 1088. The critical components of centers of excellence for promoting EBPs include:

- **Training** – The capacity to provide training that develops and maintains relationships between purveyors, senior clinical staff, and clinicians over time is critical. States including Ohio, Kansas, Maryland and New York have found that, while an organized state-supported approach to training is critical to successful implementation of EBPs, training alone, even when it is fairly intensive, appears to increase knowledge but has a limited impact on practice.²⁶
- **Ongoing Technical Assistance and Support** – In order for training to change practice, several fundamental training-related factors must be addressed. Training materials must be user-friendly and paired with consultation available to support implementation. Regular conference calls among implementers and experts also help facilitate the implementation process.
- **Consumer and Family Involvement** – Involvement of consumers and family members was also central to promoting awareness of the EBP, publicizing relative advantages, and highlighting the consumer/family member role in implementation.
- **Quality Improvement and Fidelity Tracking** – Leading COEs also take a lead role in quality assurance and fidelity monitoring to help local systems develop sustainable, ongoing quality management processes. The tracking of fidelity represents a critical component of a comprehensive implementation and quality assurance plan. If only outcomes are tracked and reported without fidelity data, it is not possible to use the information to tie outcomes to program-level variables to improve service delivery. COEs may partner initially with the purveyor of the EBP to establish fidelity monitoring processes, and then shift responsibility for data tracking and quality assurance to in-state resources coordinated through the COE.
- **Outcome Monitoring** – Given the lack of documentation of effectiveness for many EBPs in real world settings or with minority groups, it is also important that the COE serve as a point of responsibility for coordinating outcome monitoring efforts. Such efforts should not be confused with ongoing efficacy research. The primary focus of the COE should be on promoting implementation of the targeted EBPs, not research. However, additional research grants can enrich the COEs efforts and help link COE staff with emerging trends in other states.
- **Dedicated Staff for Each EBP Promoted** – While many of the leading COEs support the implementation of multiple EBPs (e.g., the Ohio Substance and Mental Illness Coordinating Center of Excellence, ACT Center of Indiana, Maryland Innovations Institute), they all maintain dedicated staff for each discrete EBP promoted. For

²⁶ Torrey, W.C., Finnerty, M., Evans, A., & Wyzik, P. (2005). Strategies for leading the implementation of evidence-based practices. *Psychiatric Clinics of North America*, 26, 883-897.

Fixsen, D.L., Naoom, S.F., Blase, K.A., Friedman, R.M., & Wallace, F. (2005). *Implementation Research: A Synthesis of the Literature*. Tampa, FL: University of South Florida, Louis de la Parte Florida Mental Health Institute, The National Implementation Research Network. (FMHI Publication No. 231).



example, the ACT Center of Indiana employs dedicated experts in ACT, Illness Management and Recovery, and Integrated Dual Disorder Treatment.

BP Recommendation #6: Develop encounter coding protocols to allow MHD and RSNs to track the provision of other best practices.

One of the challenges that MHD faces in promoting best practices is determining the current utilization of such services. Generally, the service codes currently used for encounter reporting lack the specificity needed to differentiate best practices. For example, provision of Individual Psychotherapy 40-50 minutes (CPT Code 90806) could represent any of a number of best practices (such as Cognitive Behavior Therapy, Trauma-Focused Cognitive Behavior Therapy, or Dialectical Behavior Therapy) or an undifferentiated therapy without a documented evidence base. This lack of specificity complicates the promotion of best practices by providing the same reimbursement across different types of best practices, providing the same reimbursement for generic and best practices, limiting the ability of MHD to monitor best practice availability, and limiting the ability of actuarial analysis to factor in the additional costs incurred by the delivery of best practices that require specialized training, reduced productivity, and/or fidelity monitoring.

Therefore, we recommend that MHD develop additional encounter coding modifiers so that all best practices of interest within the public mental health system are tracked, using a mix of coding strategies, including procedure codes, procedure code modifiers, and program codes identifying specific groups of individual providers within agencies.²⁷ In addition, protocols governing the use of these codes will need to be defined and enforced. For example, use of the Multisystemic Therapy (MST) code H2033 should be limited only to certified MST teams. Enforcement of the use of specialty codes for services such as MST with formal certification programs will be simpler than enforcement of the use of specialty codes for more widely available services such as Cognitive Behavior Therapy (CBT). While tracking all of the services would be of value, MHD may want to prioritize for initial development and piloting those services for which codes and oversight protocols are more readily available (such as MST, Wraparound, ACT).

Some best practices already have adequate coding modifiers. These include:

- Assertive Community Treatment (ACT) – H0040,
- Mental Health Clubhouse Services – H2031,²⁸
- Multisystemic Therapy (MST) – H2033,
- Supported Employment – H2023, and
- Therapeutic Psychoeducation – H2027, S9446, and H0025.²⁹

²⁷ These modifiers will need to comply with the standards of the Health Insurance Portability and Accountability Act (HIPAA) of 1996, as do all current electronic reporting protocols.

²⁸ Some stakeholders have raised the question as to whether ICCD-certified clubhouse services should be differentiated from those that are not formally certified. Given that clubhouse services are generally provided by agencies, it seems that ICCD certification could be tracked by agency codes rather than separate modifiers. However, a modifier could be added if desired, similar to the recommendations for other services types below.

²⁹ Given that there are multiple coding options for Therapeutic Psychoeducation, we would further recommend either limiting the allowable codes to one (e.g., H2027) or providing additional guidance to help RSNs and



Others are allowable under current codes, but would require the use of a modifier to differentiate them from more generic services. These include:

- Multiple intensive services that would be reimbursable under the High Intensity Treatment modality. If discrete HCPCS codes are available for any of these services, they should be added. However, for those without discrete HCPCS codes associated with them, we recommend that a modifier be added to the current S9480 code (Intensive OP Psychiatric Services) for each of the following best practices:
 - Integrated Dual Disorder Treatment (IDDT),
 - Family Integrated Transitions (FIT),
 - Functional Family Therapy (FFT), and
 - Multidimensional Treatment Foster Care (MTFC).
- Multiple types of Peer Support could be tracked, including:
 - Drop-in centers,
 - Encounters involving WRAP activities,
 - Individual encounters, and
 - Group encounters.
- Multiple best practices are also reimbursable under the Family Treatment, Group Treatment, and Individual Services modalities. We recommend that modifiers be added to the more generic sets of codes for family therapy (90846, 90847), individual psychotherapy (90804, 90806, 90808), and group therapy (90853, 90857) as appropriate for the following best practices:
 - Brief Strategic Family Therapy (BSFT),
 - Collaborative Care in Primary Care Settings,
 - Cognitive Behavior Therapy (CBT),
 - Dialectical Behavior Therapy (DBT),
 - Illness Management and Recovery (IMR),
 - Multidimensional Family Therapy (MDFT),
 - Supportive Housing,
 - Telepsychiatry, and
 - Trauma-Focused Cognitive Behavior Therapy (TF-CBT).
- Specialized models of Crisis Intervention and Stabilization could also be tracked using modifiers for existing HCPCS codes H2011 and S9485, including:
 - Comprehensive Mobile Crisis Services for Adults and
 - Home-based Crisis Intervention (HCBI) for children and families such as Pierce County's Family Stabilization Team.

There are also a few best practices that will require both the development of more specific encounter tracking protocols and changes to current access or reporting standards. These include:

- Parent-Child Interaction Therapy – This approach employs multiple clinicians, so, in addition to using a modifier to identify this as a subset of family treatment (e.g., 90847), providers will need guidance letting them know that it is acceptable to bill this

providers know which of the three codes to use in which circumstances. If the three cannot be distinguished clearly, we recommend reducing the number of codes.



therapy type. The most straightforward way to accommodate the involvement of multiple clinicians would simply be to view this modality in the same way as any team-based model (for example, MST or ACT), attributing the encounter to a single clinician, but paying the provider a rate that covers the costs of the entire treatment team.

- Early Childhood (0-6) Mental Health Consultation – In addition to using a modifier to identify this as a subset of individual treatment, providers may need guidance clarifying for them that C-GAS scores do not apply to children under six, per the current Access to Care Standards. In addition, the rate paid will need to factor into the productivity expectations for the providers that a significant subset of their work will involve consultation to childcare agency teachers and others that may not be child-specific and therefore not a reimbursable activity.
- Positive Behavior Interventions and Supports (PBIS) – In addition to using a modifier to identify this as a subset of individual treatment,³⁰ the current ACS standards will need to be relaxed to allow for this more prevention-oriented school-based intervention. Also, as with Early Childhood Mental Health Consultation, the rate paid will need to factor into the productivity expectations for the providers that a significant subset of their work will involve consultation to teachers and other school staff that may not be child-specific and therefore not a reimbursable activity. In addition, documentation requirements may need to be modified given that current standards assume a need for comprehensive services over time and are not well suited to time-limited, focused interventions.

Recommended Priority Best Practices

Our February 2007 preliminary report identified 41 discrete best practices with empirical support for possible promotion within Washington State’s benefit package. A detailed inventory of the practices examined for adults and older adults is provided in Appendix Four of this report. A detailed inventory of the practices examined for children and families is provided in Appendix Five of this report. Discussions with stakeholders since February did not add any new practices to the list identified in the preliminary report. Some noted that certain practices identified for adults (such as Integrated Dual Disorder Treatment for people with co-occurring substance abuse and mental health disorders) were also needed for youth, and that other practices identified for children (such as Trauma-Focused Cognitive Behavioral Therapy) were also needed for adults, but no new service types were added to the lists.

When both these practices and various permutations in how they are delivered are considered (for example, a given practice delivered by a consumer-run organization owned and/or operated by consumers versus a provider agency), the total exceeds 50. As was observed in the conclusion to the February 2007 preliminary report, it would not be realistic for the State to effectively promote 50 different practices.

³⁰ The code H0025, Behavioral Health Prevention Education Service, is currently used as a code under Therapeutic Psychoeducation. This code may be usable for PBIS.



At the March 2007 STI Task Force meeting, we identified criteria to guide our prioritization of best practices and confirmed these criteria with MHD. Criteria included balancing the selection of best practices across age groups (children, adults, and older adults), and each best practices' documented potential to reduce inappropriate use of restrictive services (inpatient and residential), promote cross-system integration, support culturally relevant and competent care, and facilitate recovery for adults and resilience for children and their families. Detailed results from the prioritization process that was carried out based on those criteria are provided in Appendix Six. The five practices prioritized through this process included:

- Peer support services provided directly by **Consumer and Family-Run Organizations**,
- **Integrated Dual Disorder Treatment (IDDT)** for persons with severe co-occurring mental health and substance use disorders,
- **Wraparound Service Coordination** for children with severe emotional disturbances and their families who are served by multiple state agencies,
- **Multidimensional Treatment Foster Care (MTFC)** for children needing intensive out-of-home services, but able to receive care safely in a family-based setting, and
- **Collaborative Care in Primary Care Settings** for populations, such as older adults, most effectively served by mental health clinicians located in primary care settings,.

On May 15, 2007, MHD convened a community forum to review the major findings and recommendations from each of the STI projects. A summary of the results from this community forum related to benefit design are provided in Appendix Seven of this report. Of the 149 overall participants in the forum, 134 participated in the discussion and input process for the benefit package design project. Participants used an electronic response system to register their opinions regarding an array of issues presented to them from the project. In reviewing our recommendations and findings on best practice implementation, the vast majority of participants (95%) both had opinions on this matter and wanted MHD to make changes. By a wide majority (with approximately three-quarters in favor), stakeholders wanted MHD to focus on statewide implementation of priority best practices. A significant subgroup (representing about one-quarter of participants) wanted changes to focus instead on broader access rather than best practices (focusing in particular on relaxation of the Access to Care Standards). Furthermore, large majorities of every stakeholder group represented endorsed the option of prioritizing three to five best practices for statewide implementation.

Regarding the five priority best practices identified above, vast majorities (85% and higher) endorsed four of the practices. The remaining practice (consumer and family run services) was endorsed by 67% of all people with opinions. Most stakeholder groups either strongly supported or opposed consumer and family run services. This practice was **supported** by 93% of consumers and 94% of family members. It was **opposed** by 72% of mental health providers, 56% of DSHS staff, and 100% of legal system representatives registering an opinion. RSN representatives fell in between and leaned toward support (63% support).



BP Recommendation #7: MHD should prioritize three to five of the following best practices for statewide implementation:

- Peer support services provided directly by **Consumer and Family-Run Organizations**,
- **Integrated Dual Disorder Treatment (IDDT)** for persons with severe co-occurring mental health and substance use disorders,
- **Wraparound Service Coordination** for children with severe emotional disturbances and their families who are served by multiple state agencies,
- **Multidimensional Treatment Foster Care (MTFC)** for children needing intensive out-of-home services, but able to receive care safely in a family-based setting, and
- **Collaborative Care in Primary Care Settings** for populations, such as older adults, most effectively served by mental health clinicians located in primary care settings.

To guide MHD and other stakeholders as they seek to determine the feasibility of implementing these services, TriWest has developed a unit cost methodology for estimating their potential costs. This model was based on the approaches described in Appendix 11 of the June 2005 Rate Certification by Milliman, Inc., and the approach was reviewed in general with the actuarial team in March 2007. Specific applications of the model were carried out for each of the priority services, and these were reviewed and revised with the actuaries in June 2007. Final, comprehensive analyses of the costs of each of the five priority services (inclusive of estimated unit costs, estimated infrastructure development costs, and possible cost offsets) are provided in Appendix Eight in this report for the five prioritized best practices.

We also include in the unit cost methodology the identification of potential strategies for funding the administrative costs of developing and sustaining these best practices, including factors such as training, provider certification, oversight of fidelity, and outcome monitoring. Strategies include multiple approaches to cover Medicaid administrative expenses, including applicable RSN administrative functions and provider administrative costs directly built into unit cost calculations. Analysis of these strategies was included in the review with the State's actuaries.

Each of the five prioritized cost analyses focused only on Medicaid expenditures, since that is the only program with the potential for sufficient funding per person to cover these services for all persons in need of them. However, the unit cost methodology can be extended to persons in need of each service who are not Medicaid eligible. For those who are Medicaid eligible, we recommend that funding to support each prioritized best practice only be included in the rates paid to each RSN if this is done in the context of expanded rate setting capacity and analysis, per the next recommendation below (BP Recommendation #8). This recommendation would expand rate setting activities for the Prepaid Inpatient Health Plan (PIHP) operated by the RSNs to include the capacity to add selectively to rates each year to promote expanded best practice development, as well as the capacity to analyze actual expenditures at the end of the year and recoup any funds added that were not expended on the targeted best practices. Such accountability would allow RSNs to retain local authority for expenditures, but not lock MHD into paying for enhanced services that are never delivered.



In addition to these five priority services for which we completed comprehensive cost estimates based on the unit cost methodology, MHD asked us to provide guidance regarding several additional modalities, including:

- Supported Employment for adults with serious mental illness,
- Trauma-focused Cognitive Behavioral Therapy (TF-CBT) for children and adolescents,
- Parent-Child Interaction Therapy (PCIT), and
- Multisystemic Therapy (MST).

Because it was beyond the scope of the current project to collect data to estimate the level of statewide need for each of these services, while guidance is offered, no cost estimates are provided.

The following subsections summarize the information gathered for the five priority practices and the four additional practices. Additional detail regarding the comprehensive cost analyses is included in Appendix Eight.

Consumer and Family Run Services

The State of Arizona has developed a certification model for providers of “non-licensed behavioral health services,” referring to this subgroup of providers as Community Service Agencies (CSAs). According to Arizona’s services guide for behavioral health services,³¹ CSAs are able to provide a range of services that do not require delivery by a licensed behavioral health clinician, including psychosocial rehabilitation, peer support, family support, day programs, respite care, and transportation services.³² While Arizona does not include Peer Support in its Medicaid State Plan, CSA staff members providing other services covered by Medicaid must meet the same criteria that staff in more traditional provider settings must meet (such as experience and supervision requirements) for any specific service type provided.

Arizona offers this provider type under its 1115 waiver authority. We recommend that Washington State establish a CSA provider type under an amended 1915(b) waiver authority that is allowed to provide a narrow array of services, at least at the start. The primary service type that we recommend covering in Washington is Peer Support. Experience, supervision, and documentation requirements in Washington’s State Plan and state-level regulations would need to be met. The State Plan currently requires that Peer Support be provided by “peer counselors”, but appropriately leaves the definition of standards for peer counselors to state-level regulations. Washington may also explore allowing CSAs to provide other services,

³¹ AHCCSS Behavioral Health Services Guide: 2007. Arizona Health Care Cost Containment System: Phoenix, AZ. Downloaded at: <http://www.ahcccs.state.az.us/Publications/GuidesManuals/BehavioralHealth/BehavioralHealthServicesGuide.pdf>

³² Keep in mind that the Arizona definitions of these services vary from those of Washington. Differences between Arizona’s covered Medicaid benefits and those of Washington State are described later in this report.



such as Wraparound Service Coordination or Respite, that do not require provision of the service by a licensed mental health clinician under the State's current benefit design. Under a 1915(b) waiver, covered State Plan services may be provided by an alternative provider type such as a CSA as long as the staff providing the service meet the same criteria that staff in a State Plan defined provider setting (i.e., Community Mental Health Agency staff) would meet. For example, Pennsylvania currently uses its 1915 waiver authority to cover outpatient services under its Clinic Services option provided in long-term residential facilities, even though that provider type would not be eligible outside the waiver to deliver such services.

For the cost calculations in this report, we are estimating costs for Peer Support delivered by consumer and family-run CSAs. Staff delivering Peer Support in CSAs would need to meet the same criteria as staff delivering the service in a Community Mental Health Agency (CMHA) setting, specifically being a certified peer specialist. Washington's Peer Support Medicaid State Plan modality allows a wide range of services to be delivered by peer specialists, including: "Self-help support groups, telephone support lines, drop-in centers, and sharing the peer counselor's own life experiences related to mental illness will build alliances that enhance each consumer's ability to function in the community. These services may occur at locations where consumers are known to gather (e.g., churches, parks, community centers, etc)." Washington is the only state of which we are aware that has successfully expanded the model to include family members of child and adolescent consumers.

Emerging evidence suggests that integrating peer specialists into a range of treatment approaches may lead to better outcomes for consumers. For example, one controlled study found that individuals served by case management teams that included consumers as peer specialists had experienced increases in several areas of quality of life and reductions in major life problems, as compared to two comparison groups of individuals served by case management teams that did not include peer specialists.³³ Washington's definition of Peer Support allows such embedding, and it also allows for Peer Support in particular settings such as the following:

- **Drop-in Centers.** Drop-in centers originated in the late 1980s to provide consumers of mental health services with opportunities for socialization, education, and emotional support as an alternative to traditional mental health treatment. Today, the concept of drop-in centers has evolved to be "peer support centers," with a mission to provide a place where consumers can direct their own recovery process and, often, to serve as a complement to other mental health services.³⁴ Although drop-in centers generally are run by consumers, many maintain some kind of collaborative relationship with a mental health provider agency.³⁵ Studies suggest that experience at a drop-in center is

³³ Felton, C.J., Stastny, P., Shern, D., Blanch, A., Donahue, S.A., Knight, E. and Brown, C. (1995). Consumers as peer specialist on intensive case management teams: Impact on client outcomes. *Psychiatric Services*, 46, 1037-1044.

³⁴ Technical Assistance Guide: Consumer-run Drop-In Centers. National Mental Health Consumers' Self-Help Clearinghouse.

³⁵ Kaufmann, C.L., Ward-Colasante, C., and Farmer, J., (1993). Development and Evaluation of Drop-In Centers Operated by Mental Health Consumers. *Hospital and Community Psychiatry* 44 (7): 675-678.



associated with high satisfaction, increased quality of life, enhanced social support, and problem solving.³⁶

- **Wellness Recovery Action Plans (WRAP).** Washington's Peer Support certification training also incorporates training in the Wellness Recovery Action Plan (WRAP) approach, a self-management and recovery system designed to help consumers identify internal and external resources and then use these tools to create their own, individualized plans for recovery. At least one study of WRAP found significant increases in consumers' self-reported knowledge of early warning signs of psychosis; use of wellness tools in daily routines; ability to create crisis plans; comfort in asking questions and obtaining information about community services; and hope for recovery.³⁷ Another widely-cited study found increases in consumers' self-reporting that they have a support system in place; manage their medications well; have a list of things to do every day to remain well; are aware of symptom triggers and early warning signs of psychosis; have a crisis plan; and have a lifestyle that promoted recovery.³⁸
- **Wraparound Service Coordination.** Other states have also begun to utilize family members of children with SED as facilitators for Wraparound Service Coordination. Wraparound is designed to provide a set of individually tailored services to a child and family using a team-based planning process. Wraparound is not a treatment in itself, but is instead a coordinating intervention to ensure the child and family receives the most appropriate set of services possible.³⁹ In our discussions with key informants, they have noted that Wraparound is generally more successful when delivered by BA-level paraprofessionals rather than MA-level clinicians.⁴⁰ Projects are also beginning to draw on family members for this service in Colorado and Maryland.

³⁶ Schell, B. (2003). Program Manual for a Consumer-Run Drop-In Center based on the Mental Health Client Action Network in Santa Cruz, CA. Prepared for SAMHSA COSP-MultiSite Study, FliCA site. Citing Mowbray, C. T. and Tan, C. (1992). Evaluation of an Innovative Consumer-Run Service Model: The Drop-In Center. *Innovations & Research* 1(2):19-24.

³⁷ Vermont Recovery Education Project, cited in Cook, J., *Mental Illness Self-Management through Wellness Recovery Action Planning* (n.d.), retrieved at www.copelandcenter.com.

³⁸ Buffington E., (2003). *Wellness Recovery Action Plan: WRAP evaluation*, State of Minnesota. Minneapolis, MN: Mental Health Consumer/Survivor Network of Minnesota.

³⁹ 2004 Wraparound Milwaukee Report. <http://www.co.milwaukee.wi.us/display/router.asp?docid=7851>.

Aos, S., Phipps, P. Barnoski, R., & Lieb, R. (2001). *The Comparative Costs and Benefits of Programs to Reduce Crime*. Olympia: Washington State Institute for Public Policy.

Bruns, E.J., Walker, J.S., Adams, J., Miles, P., Osher, T.W., Rast, J., VanDenBerg, J.D. & National Wraparound Initiative Advisory Group. (2004, March 1). *Toward a better understood and implemented Wraparound*. 17th Annual System of Care Research Conference, Tampa FL.

Burns, B.J., Hoagwood, K., & Maultsby, L.T. (1998). Improving outcomes for children and adolescents with serious emotional and behavioral disorders: Current and future directions. In Epstein, M., Kutash, K., & Duchnowski, A. (Eds.). *Outcomes for Children and Youth with Behavioral and Emotional Disorders and their Families*. Austin, TX: Pro-Ed.

Hoagwood, K., Burns, B., Kiser, L., et al. (2001). Evidence-based practice in child and adolescent mental health services. *Psychiatric Services*. 52:9, 1179-1189.

Walker, Janet S., Schutte, K. (2003). *Individualized Service/Support Planning and Wraparound: Practice-Oriented Resources*. Research and Training Center on Family Support and Children's Mental Health.

⁴⁰ B. Kamradt, Executive Director, Wraparound Milwaukee, Personal Communication, June 12, 2007.



Based on data from a leading CSA provider in Arizona,⁴¹ we are estimating that the cost per unit of Peer Support delivered through a CSA is comparable to that delivered currently through a CMHA. We therefore believe that the service costs for this modality were already added to the system based on Washington’s 2005 actuarial study.⁴² However, adequate costs to promote the infrastructure necessary to develop CSAs were not. This may very well be a contributing reason to why current levels of peer support provision by most RSNs remain below expectations.

The cost to provide Peer Support services without robust Center of Excellence (COE) supports is currently built into the rates paid to RSNs. In addition, Washington uses approximately \$150,000 in federal block grant funds to pay for the current peer specialist certification program. We estimate that the costs to provide a COE adequate to support statewide implementation of Peer Support to be approximately \$425,000 per year. These costs could be passed on to the Medicaid program in the form of certification expenses for peer specialists. Assuming that 25 peer specialists are trained per session and assuming a total of six sessions per year, this would translate into 150 peer specialists trained a year. A \$3,000 charge per specialist would cover these costs.

By expanding the current peer specialist certification program into a COE able to promote the provision of Peer Support across an expanded group of potential providers (both CMHAs and the new CSA providers), the supports could help bring Peer Support service delivery up to the levels factored into the current rates. Assuming that happened, \$215,000 in state expenditures (to cover the Medicaid match) would be needed as noted in the table below. Further assuming that freeing up the \$150,000 in federal block grant funding currently spent on Peer Support training could free up State General Funds currently going to pay for other purposes (and thereby allow these State General Funds to be shifted to other mental health priorities), the additional costs would be reduced to \$65,000 a year.

Consumer-Run Peer Support Center of Excellence Cost Estimates		
Variables	Costs	Funding Sources
Estimated Annual Cost of Peer Support Center of Excellence	\$425,000	\$215,000 Federal \$215,000 State Match
Annual Cost of Current Peer Support Certification Program	\$150,000	Federal Block Grant
Additional Costs to State if Federal Block Grant Funds Can Be Shifted	\$ 65,000	Additional State Match

⁴¹ G. Johnson, Executive Director, META , Phoenix, AZ, Personal Communication, multiple dates in May 2007.

⁴² Barclay, T. & Knowlon, S. (June 2, 2005). State of Washington, Department of Social & Health Services, Mental Health Division, Actuarial Rate Certification. Appendix 11, page 150. Milliman, Inc.



Integrated Dual Disorder Treatment (IDDT)

Integrated Dual Disorder Treatment (IDDT) involves the provision of mental health and substance abuse services through a single treatment team and co-locates all services in a single agency (or team) so that the consumer is not excluded from or confused by multiple programs.⁴³ IDDT encompasses 14 components, each of which is evidence-based, and, when delivered in an intensive team setting (with staffing ratios of at least 15 consumers per clinician), combined mental health and substance abuse treatment is effective at engaging adults with both diagnoses in outpatient services, maintaining continuity and consistency of care, reducing hospitalization, and decreasing substance abuse, while at the same time improving social functioning.⁴⁴ Integrated treatment has also been shown to reduce symptoms of mental disorders and overall treatment costs for adults.⁴⁵ Fidelity to the components of IDDT is clearly tied to better clinical outcomes for adults with severe disorders.⁴⁶

We estimated the unit costs to provide IDDT to be \$780 per recipient per month, based on costs models developed by Clark County RSN and North Sound RSN. Looking only at the Medicaid-enrolled population (which does not include state-funded recipients or people who lose Medicaid coverage during periods of a spend-down), we further estimated that 1% of all Medicaid-eligible adults (ages 19 to 59) would be in need of IDDT services, yielding a projection of need for intensive IDDT services across all enrolled adults of 2,971 adults statewide per year.

We also estimated the costs of implementing a COE to support this level of IDDT implementation. To serve 2,971 adults with IDDT, an estimated 37 teams would be needed (each serving 80 people, on average). If we assume that statewide implementation of IDDT will occur over a three year period (20 teams in Year One, 10 additional teams in Year Two, and 10 additional teams in Year Three), we estimate a total annual COE cost of \$460,000 to support such development. We recommend building the COE support into the fee estimate paid to providers given that it represents an additional cost incurred by IDDT providers in order to be certified by the COE as able to deliver IDDT services. As a provider cost, it can be

⁴³ Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Mental Health Services (CMHS) (2003). Evidence-Based Practices: Shaping Mental Health Services Toward Recovery: Co-Occurring Disorders: Integrated Dual Diagnosis Treatment Implementation Resource Kit. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services. (SAMHSA/CMHS IDDT Resource Kit).

⁴⁴ U.S. Surgeon General's Report, (1999). p. 288, citing Miner, C.R., Rosenthal, R.N., Hellerstein, D.J. & Muenz, L.R. (1997). Predictions of compliance with outpatient referral in patients with schizophrenia and psychoactive substance use disorders. *Archives of General Psychiatry*, 54, 706-712 and Mueser, K.T., Drake, R.D., and Miles, K.M. (1997). The course and treatment of substance use disorders in persons with severe mental illnesses. *NIDA Research Monograph*, 172, 86-109.

⁴⁵ Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Mental Health Services (CMHS) (2003). Evidence-Based Practices: Shaping Mental Health Services Toward Recovery: Co-Occurring Disorders: Integrated Dual Diagnosis Treatment Implementation Resource Kit. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services. (IDDT Resource Kit).

⁴⁶ Drake, R., Essock, S., et al. (2001). Implementing Dual Diagnosis Services for Clients with Mental Illness. *Psychiatric Services* 52, 469-476.



included in the amount reimbursable by Medicaid. We recommend that the COE be funded through a mix of state funding and certification payments from Medicaid IDDT providers. We recommend that the certification payments from Medicaid providers be based on the expected costs per recipient per year at full capacity (\$13 per recipient per month), with any additional funding paid for through state funds.

Inclusive of all new costs and backing out anticipated cost offsets and the costs of current service provision, we developed a multi-year cost projection summarized in the table below.

IDDT Multi-Year Utilization Projections				
Variables	Year One	Year Two	Year Three	Year Four
New Teams	20	10	7	0
Established Teams	0	20	30	37
Total Teams	20	30	37	37
Core Team Operating Costs	\$14,976,000	\$22,464,000	\$27,705,600	\$27,705,600
COE Costs	\$ 460,000	\$ 460,000	\$ 460,000	\$ 460,000
Total Cost	\$15,436,000	\$22,924,000	\$28,165,600	\$28,165,600
Average Medicaid Recipients Served Per Month	1,000	2,100	2,750	2,960
Medicaid Revenue (\$793 per person served per month)	\$ 9,516,000	\$19,983,600	\$26,169,000	\$28,167,360
Cost Offsets for Persons Served (\$513 per person served per month)	\$ 6,156,000	\$12,927,600	\$16,929,000	\$18,221,760
Additional Medicaid Costs (Revenue minus Offsets)	\$ 3,360,000	\$ 7,056,000	\$ 9,240,000	\$ 9,945,600
Additional State-Only Funding Needed (Total Cost minus Medicaid Revenue)	\$ 5,920,000	\$ 2,940,400	\$ 1,996,600	\$ -



Wraparound Service Coordination

Wraparound Service Coordination (Wraparound) is designed to provide a set of individually tailored services to a specific child and their family using a team-based planning process. The process focuses on strengths and includes a balance between formal services and informal community and family supports. It is important to keep in mind when reviewing the cost analysis below that Wraparound is not a treatment in itself, but is instead a coordinating intervention to ensure the child and family receives the most appropriate set of services possible.⁴⁷ As such, it enhances the effectiveness of other services, but does not replace them. The model was recently established as a key component of Washington’s children’s mental health system under House Bill 1088. Based on our key informant interviews with allied systems, the model is also consistent with the priorities of the Children’s Administration and Juvenile Rehabilitation Administration, as well as recent emphases of Washington’s Division of Alcohol and Substance Abuse (DASA) on a system of care model for adolescents with co-occurring substance abuse and mental health needs.

Wraparound is currently a reimbursable code under High Intensity Treatment. The model of fidelity-based Wraparound described here is the model based on the consensus statement of the National Wraparound Initiative (NWI).⁴⁸ We recommend that fidelity-based Wraparound be distinguished in the encounter reporting protocols from other approaches termed “wraparound”, many of which also include active treatment services in addition to service coordination. We further recommend that fidelity be monitored for any provider delivering fidelity-based Wraparound. The most widely used scale for assessing Wraparound fidelity is the Wraparound Fidelity Index – Version 3.0 (WFI-3). In order to address limitations in the WFI-3 (primarily that it only assesses adherence to principles and not fidelity to a model or set of specific activities), a revised version of the tool has been developed incorporating the guidance of the NWI. This version, the WFI-4, reflects recent development of a model that

⁴⁷ 2004 Wraparound Milwaukee Report. <http://www.co.milwaukee.wi.us/display/router.asp?docid=7851>.

Aos, S., Phipps, P., Barnoski, R., & Lieb, R. (2001). *The Comparative Costs and Benefits of Programs to Reduce Crime*. Olympia: Washington State Institute for Public Policy.

Bruns, E.J., Walker, J.S., Adams, J., Miles, P., Osher, T.W., Rast, J., VanDenBerg, J.D. & National Wraparound Initiative Advisory Group. (2004, March 1). *Toward a better understood and implemented Wraparound*. 17th Annual System of Care Research Conference, Tampa FL.

Burns, B.J., Hoagwood, K., & Maultsby, L.T. (1998). *Improving outcomes for children and adolescents with serious emotional and behavioral disorders: Current and future directions*. In Epstein, M., Kutash, K., & Duchnowski, A. (Eds.). *Outcomes for Children and Youth with Behavioral and Emotional Disorders and their Families*. Austin, TX: Pro-Ed.

Hoagwood, K., Burns, B., Kiser, L., et al. (2001). *Evidence-based practice in child and adolescent mental health services*. *Psychiatric Services*, 52:9, 1179-1189.

Walker, Janet S., Schutte, K. (2003). *Individualized Service/Support Planning and Wraparound: Practice-Oriented Resources*. Research and Training Center on Family Support and Children’s Mental Health.

⁴⁸ Bruns, E.J., Walker, J.S., Adams, J., Miles, P., Osher, T.W., Rast, J., VanDenBerg, J.D. & National Wraparound Initiative Advisory Group. (2004). *Ten principles of the wraparound process*. Portland, OR: National Wraparound Initiative, Research and Training Center on Family Support and Children’s Mental Health, Portland State University.



includes a description of specific phases and activities of the Wraparound process.⁴⁹ The WFI-4 assesses both adherences to principles as well as fidelity to these activities. At this time, the WFI-4 exists only in a pilot form. The Wraparound Evaluation and Research Team, based at the University of Washington and headed by Eric Bruns, PhD, is able to make the form available for sites that wish to participate in the pilot.

To estimate unit costs, we began with the staffing model used by Wraparound Milwaukee, which employs BA-level care managers with maximum caseloads of 9 (they assume an average of 7.5 for budgeting), a more senior lead worker with a half caseload, a supervisor, and administrative support.⁵⁰ This yielded an estimated unit cost of \$790 per month.

To estimate potential utilization, we averaged RSN estimates from three RSNs (Clark, Greater Columbia, King) to yield the projection of 0.56 percent of enrolled children (9.1% of children served) or 3,143 children statewide needing Wraparound. This estimate compares favorably with information compiled by MHD regarding the number of children with intensive service needs (December 2006 analysis by MHD based on FY2004 data).⁵¹ We estimate the average utilization per user to be 16 months, based on information from national experts (B. Kamradt, M. Zabel), so the total number of service recipients once the program is fully up and running will be 4,191 (one and one-third times the annual need).

In addition, we estimate that it would add an additional \$13 per recipient per month to cover the costs of a statewide Center of Excellence to support delivery of Wraparound. This estimate was based on the approximate budget of Maryland's Innovations Institute (\$500,000), the leading COE nationally supporting statewide implementation of Wraparound Service Coordination.⁵² The total cost to deliver Wraparound to a single child per month is therefore \$806 in our model (\$793 for the core service and \$13 for the COE support). The cost per recipient is offset by expected reductions in MHD inpatient and residential costs currently incurred in the system totaling \$63 per recipient per month. This estimate likely significantly understates the potential cost savings.

Furthermore, this estimate only covers the Medicaid-reimbursable costs associated with the intervention. It does not include additional funds for ancillary supports critical to the successful implementation of Wraparound, such as flexible funds (which we would estimate at an additional \$500 per family per year, which would not be reimbursable under Medicaid), transportation supports, and direct services provided to family members of the covered child.

⁴⁹ Bruns, E.J., Walker, J.S., Adams, J., Miles, P., Osher, T.W., Rast, J., VanDenBerg, J.D. & National Wraparound Initiative Advisory Group. (2004, March 1). Toward a better understood and implemented Wraparound. 17th Annual System of Care Research Conference, Tampa FL.

Brun, E.J., Walker, J.S., Adams, J., Miles, P., Osher, T.W., Rast, J., VanDenBerg, J.D. & National Wraparound Initiative Advisory Group. (2004). Ten principles of the wraparound process. Portland, OR: National Wraparound Initiative, Research and Training Center on Family Support and Children's Mental Health, Portland State University.

⁵⁰ B. Kamradt, Executive Director, Wraparound Milwaukee, Personal Communication, June 12, 2007.

⁵¹ J. Hall, MHD, Personal Communication, June 18, 2007. This was an untitled December 2006 powerpoint presentation regarding children with complex needs.

⁵² M. Zabel, Director, Innovations Institute, Personal Communication, multiple dates in June 2007.



Based on this, the costs projected to develop teams and provide Wraparound Service Coordination per year varies by year of implementation as a function of the number of teams implemented each year. The amount of Medicaid revenue that can be earned by each team to support both program and COE costs is a function of how quickly each team can ramp up to full capacity. Assuming that it takes nine months for each team to ramp up to full capacity (serving no people in month one, then adding 8 people a month through the end of month nine), 62.5% of costs for each team in their first year of operation can be covered by Medicaid costs (assuming 100% of people served have Medicaid coverage), with remaining “start-up” costs covered by State General Funds, as summarized in the table below.

Wraparound Service Coordination Multi-Year Utilization Projections				
Variables	Year One	Year Two	Year Three	Year Four
New Teams	22	22	21.5	0
Established Teams	0	22	44	65.5
Total Teams	22	44	65.5	65.5
Core Team Operating Costs	\$13,339,480	\$26,678,960	\$39,715,270	\$39,715,270
COE Costs	\$ 500,000	\$ 500,000	\$ 500,000	\$ 500,000
Total Cost	\$13,839,480	\$27,178,960	\$40,215,270	\$40,215,270
Average Medicaid Recipients Served Per Month	880	2,288	3,676	4,191
Medicaid Revenue (\$806 per person served per month)	\$ 8,511,360	\$22,129,536	\$35,554,272	\$40,535,352
Cost Offsets for Persons Served (\$63 per person served per month)⁵³	\$ 665,280	\$ 1,729,728	\$ 2,779,056	\$ 3,168,396
Additional Medicaid Costs (Revenue minus Offsets)	\$ 7,846,080	\$20,399,808	\$32,775,216	\$37,366,956
Additional State-Only Funding Needed (Total Cost minus Medicaid Revenue)	\$ 5,328,120	\$ 5,049,424	\$ 4,660,998	\$ (320,082)

⁵³ This figure does not include significant cost-offsets in inpatient, residential and institutional services delivered by CA, JRA, and DASA for youth served. Cost-offsets are therefore likely underestimated by a significant factor.



Multidimensional Treatment Foster Care (MTFC)

MTFC is a well established EBP that has demonstrated outcomes and cost savings when implemented with fidelity.⁵⁴ MTFC has research support for its efficacy with Caucasian, African American, and American Indian youth and families. It is a type of therapeutic foster care provided to children and youth living with foster parents or for families who require an intensive period of treatment before reunification. This approach is well described in literature disseminated by the developers of MTFC,⁵⁵ with a primary goal to decrease problem behavior and to increase developmentally appropriate normative and prosocial behavior in children and adolescents who are in need of out-of-home placement. Youth come to MTFC via referrals from the juvenile justice, foster care, and mental health systems. As an alternative to residential, institutional, or group care for youth with significant mental health problems, MTFC provides treatment in a foster care home with trained parents. The foster parents go through an extensive training program and receive continued support during treatment. The foster parents work closely with the case manager, who is the team leader, to tailor the program to meet the individual youth's needs and coordinate with various other community services including a family therapist, parole/probation officer, a psychiatrist for medication management, and a school liaison to monitor behavior in school. There are three versions of MTFC designed to be implemented with specific ages. Each version has been subjected to evaluation and found to be efficacious. The programs are:

- MTFC-P for preschool-aged children (3-5 years);
- MTFC-L for latency-aged children (6-11 years); and
- MTFC-A for adolescents (12-18 years).

The selection of MTFC as a priority for statewide development centered on the need for additional mental health out-of-home treatment capacity documented by stakeholders, and the recommendation of the 2004 PCG study and the literature cited in Appendix Five documenting the efficacy of family-based placements. Furthermore, 86% of the May 2007 Community Forum participants agreed or strongly agreed that MTFC should be a “top priority” for MHD to promote statewide.

That being said, it is not clear that the MTFC should be implemented in all instances with rigid adherence to the parameters articulated by its purveyors, TFC Consultants, Inc. It seems clear from our discussions with MHD and Children’s Administration (CA) staff closely involved with the current MTFC pilots that some additional flexibility in the model is needed

⁵⁴ Chamberlain P, Reid J.B. (1991). Using a specialized foster care community treatment model for children and adolescents leaving the state mental hospital. *Journal of Community Psychology*, 19, 266-276.

Hoagwood, K., Burns, B., Kiser, L., et al. (2001). Evidence-based practice in child and adolescent mental health services. *Psychiatric Services*, 52:9, 1179-1189.

Kazdin, A.E., & Weisz, J.R. (Eds.) (2003). *Evidence-based psychotherapies for children and adolescents*. New York: Guilford Press.

Weisz, J.R., Doss, J.R., Jensen, A., & Hawley, K.M. (2005). Youth psychotherapy outcome research: A review and critique of the evidence base. *Annual Review of Psychology*, 56, 337-363.

⁵⁵ Multidimensional Treatment Foster Care (MTFC) website. (2006). MTFC Program Overview. <http://www.mtfc.com/overview.html>.



on the part of the purveyors, particularly in terms of their insistence that the model operate with 10 beds. To be of use in more rural areas of Washington, it seems important that the model be able to operate with fewer beds (i.e., 5 bed models). Since family-based interventions need to be carried out close enough to parents and caregivers so that they can be regularly involved, allowing smaller programs in rural areas seems much preferable to larger programs located further from families. In order to implement effectively the statewide capacity recommended in this cost analysis, it seems imperative that TFC Consultants, Inc., be willing to work with MHD to develop and pilot additional variations of the model to meet the broad range of needs of children and their families in Washington.

MHD is currently estimating costs per day for MTFC in its Kitsap pilot at \$184 a day.⁵⁶ Of these costs, approximately half (\$92) is reimbursable by Medicaid (half of which is funded by the State and half of which is federal financial participation) and the remaining half (\$92) must be paid entirely with State Funds.⁵⁷ We are recommending that the State General Fund portion of this service be paid for entirely by MHD in order to spare families the need to coordinate with yet another agency. This assumes that, if families are already involved with CA, CA will cover the costs of needed out-of-home care (outside of the cost estimates in this report). The cost estimates in this report cover only the costs of MTFC delivered by RSNs to mental health consumers not involved with CA. We realize that in many cases out-of-home costs are currently split by CA and RSNs. We have attempted to factor this into our cost-offset calculations by estimating reductions in the use of the portion of these services we expect to be replaced by the MHD-funded MTFC.

Based on discussions with MHD and CA staff, we are projecting three different utilization scenarios:

- Low Range: This represents a model focused only on acute cases with 105 beds (five 10-bed programs, plus 11 5-bed programs for smaller RSNs) and ALOS of 6 months.
- Mid-Range: This represents a model focused on acute and intermediate stay cases with 165 beds (seven 10-bed programs, plus 13 5-bed programs for smaller RSNs) and ALOS of 7.5 months.
- High Range: This represents a model focused on more intermediate-term care with 230 beds (18 10-bed programs, plus 10 5-bed programs for smaller RSNs) and ALOS of 9 months.

Infrastructure support costs vary between the first year and following years since it will take time to ramp up to a full level of service provision. It is expected that it will take six months for each 5-bed team to ramp up to full capacity (serving no people in month one, then adding one person a month through the end of month five), and eleven months for each 10-bed team to ramp up to full capacity (serving no people in month one, then adding one person a month through month eleven). Given the scope of the planned implementation, it may be possible to negotiate a reduced rate with the purveyor, TFC Consultants, Inc. However, this cost analysis assumes that first year training and fidelity monitoring costs (inclusive of consulting costs and

⁵⁶ R. McIlvaine, MHD, Personal Communication, June 21, 2007.

⁵⁷ This percentage is approximately the typical proportion of BRS treatment foster care typically reimbursable under Medicaid, per J. Greenfield, DSHS Children's Administration, Personal Communication, August 1, 2007.



travel) will be \$50,000 for each 10-bed team (\$25,000 for 5-bed teams, assuming that two 5-bed teams meet jointly with the consultants). Second year and following costs are assumed to be \$10,000 for each 10-bed team (\$5,000 for 5-bed teams, again assuming that two 5-bed teams meet jointly with the consultants).

The total cost to deliver MTFC to a single child per month is therefore \$2,798 per recipient for Medicaid treatment (\$92 per day times 30.4 days per month), \$2,798 per recipient for State funds to support room and board (\$92 per day times 30.4 days per month), and the additional infrastructure costs for TFC Consultants, Inc., noted above. The cost per recipient can be expected to be offset by reductions in the costs of currently delivered outpatient services, plus reduced MHD inpatient and residential costs currently incurred in the system, totaling \$1,124 per recipient per month. This estimate likely significantly understates the potential cost savings.

Based on our analysis, the costs to develop and provide MTFC per year varies by year of implementation as a function of the number of teams implemented each year. The number of teams needed, persons served by the end of the six year implementation schedule, and costs are summarized in the table below for each of the three capacity estimates.

MTFC Multi-Year Utilization Projections			
Variables	Low Range	Medium Range	High Range
Total Teams in Year Six	16	20	28
Full (10 beds)	5	7	18
Half (5 beds)	11	13	10
Total Cost in Year One	\$1,443,200	\$1,443,200	\$3,968,800
Total Cost in Year Six	\$7,156,800	\$9,201,600	\$15,676,800
Average Medicaid Recipients Per Month in Year Six	105	135	230
Medicaid Recipients Served Per Year in Year Six	210⁵⁸	216⁵⁹	307⁶⁰
Medicaid Cost Offsets in Year Six (\$1,124 per person served)	\$1,416,240	\$1,820,880	\$ 3,102,240
Additional Medicaid Costs in Year Six (Revenue minus Offsets)	\$1,306,942	\$1,680,354	\$ 2,862,825
Additional State-Only Funding Needed in Year Six (\$92 per person served per day, plus other costs)	\$4,433,618	\$5,700,366	\$ 9,711,735

⁵⁸ Assumes average length of stay of 6 months.

⁵⁹ Assumes average length of stay of 7.5 months.

⁶⁰ Assumes average length of stay of 9 months.



Collaborative Care in Primary Care Settings

Collaborative Care is a model of integrating mental health and primary care services in primary care settings in order to: (1) treat the individual where he or she is most comfortable; (2) build on the established relationship of trust between a doctor and consumer; (3) better coordinate mental health and medical care; and (4) reduce the stigma associated with receiving mental health services.⁶¹ Two key principles form the basis of the Collaborative Care model:

1. Mental health professionals or allied health professionals with mental health expertise are integrated into primary care settings to help educate consumers, monitor adherence and outcomes, and provide brief behavioral treatments according to evidence-based structured protocols; and
2. Psychiatric and psychological consultation and supervision of care managers is available to provide additional mental health expertise where needed.

Key components of the Collaborative Care model include screening, consumer education and self-management support, stepped up care (including mental health specialty referrals as needed for severe illness or high diagnostic complexity), and linkages with other community services such as senior centers, day programs or Meals on Wheels.⁶²

Several randomized studies have documented the effectiveness of collaborative care models to treat anxiety and panic disorders,⁶³ depression in adults,⁶⁴ and depression in older adults.⁶⁵ For example, a study of IMPACT (Improving Mood: Promoting Access to Collaborative Treatment for Late Life Depression) – a multi-state Collaborative Care program with study sites in five states, including Washington – led to higher satisfaction with depression treatment, reduced prevalence and severity of symptoms, or complete remission as compared to usual primary care.⁶⁶

If RSNs are to deliver Collaborative Care, the primary barrier will be the current Access to Care Standards (ACS) that prohibit the delivery of mental health services to people with

⁶¹ Unutzer, J., Katon, W. Hogg Foundation Integrated Care Initiative (2006). Training presentation retrieved at: http://www.hogg.utexas.edu/programs_ihc_program.html.

⁶² Unutzer, J., Katon, W., Sullivan, M., and Miranda, J. (1999). Treating Depressed Older Adults in Primary Care: Narrowing the Gap between Efficacy and Effectiveness. *The Milbank Quarterly*, 77, 2.

⁶³ Katon, W.J., Roy-Byrne, P., Russo, J. and Cowley, D. (2002). Cost-effectiveness and cost offset of a collaborative care intervention for primary care patients with panic disorder. *Archives of General Psychiatry*, 59, 1098-1104.

⁶⁴ Katon, W., Von Korff, M., et al. (1999). Stepped collaborative care for primary care patients with persistent symptoms of depression: A randomized trial. *Archives of General Psychiatry*, 56, 1109-1115.

⁶⁵ Unutzer, J., Katon, W., et al. (2002). Collaborative care management of late-life depression in the primary care setting: A randomized controlled trial. *Journal of American Medical Association*, 288, 2836-2845.

See also President's New Freedom Commission on Mental Health Final Report at 66.

⁶⁶ Katon, W.J., Schoenbaum, M., Fan, M., Callahan, C.M., Williams, J., Hunkeler, E., Harpole, L., Zhou, A.X., Langston, C., & Unutzer, J. (2005). Cost-effectiveness of improving primary care treatment of late-life depression. *Arch Gen Psychiatry*. 2005;62:1313-1320. Downloaded at <http://archpsyc.ama-assn.org/cgi/reprint/62/12/1313.pdf>.



functional impairments in the moderate (above a GAF/C-GAS score of 50) to mild (above a GAF/C-GAS score of 60) range, depending on diagnosis. A core premise of the delivery of Collaborative Care is that mental health services be provided in primary care settings with minimal barriers. In order to overcome the barriers to the effective delivery of mental health services in primary care settings, mental health clinicians must be willing to take all referrals and not attempt to exclude any persons referred based on functioning.

Much of the leading research nationally related to Collaborative Care is currently conducted by faculty at the University of Washington's Department of Psychiatry and Behavioral Services and Department of Family Medicine. The costs to establish a Center of Excellence for Collaborative Care would depend on the number of sites being implemented. We estimate that a budget of approximately \$300,000 would be needed to support the development of 10 teams across the state.

The unit costs for Collaborative Care are comparable to those already reimbursed in the system. The primary driver of any cost increases if Collaborative Care is promoted would be increased utilization of services. We would not expect any measurable cost offsets within the mental health system attributable to the provision of Collaborative Care. More effective treatment of depression (the diagnosis most frequently targeted for improved service delivery with older adults in Collaborative Care models) would very likely decrease the use of other health care services. People suffering from depression who are receiving services through the primary care system use three to four times as many services for physical health complaints as people without depression.⁶⁷ This finding has led many to believe that there is a potential cost-offset from mental health treatment because it will reduce the disproportionate use of primary care services.⁶⁸

Given that current data on unmet mental health needs in primary care settings and the potential cost-offsets in primary health care services costs were not available to this project, it was not possible to develop a precise estimate of potential costs for expanded delivery of Collaborative Care in primary care settings. However, it is conceivable that the potential cost increases would likely be in the range of other analyses to expand access for the delivery of mental health care to broad populations such as the recent expansion of Healthy Options and fee-for-service benefit limits. Adding these costs to those estimated for a COE to support Collaborative Care, we would estimate the costs of initial Collaborative Care efforts to range between \$1.1 million to \$2.5 million annually.

⁶⁷ Katon, W., & Schulberg, H. (1992). Epidemiology of depression in primary care. *General Hospital Psychiatry, 14*, 237-247.

⁶⁸ Olfson, M., Sing, M., & Schlesinger, H. J. (1999). Mental health/medical care cost offsets: Opportunities for managed care. *Health Affairs, 18*, 79-90.



Other Priority Services

In addition to the five priority services with comprehensive cost estimates just reviewed, MHD asked TriWest to provide guidance regarding the four additional best practices discussed below, each of which has been shown to have significant potential for improving outcomes if promoted more broadly:

- Supported Employment for adults with serious mental illness,
- Trauma-focused Cognitive Behavioral Therapy (TF-CBT) for children and adolescents,
- Parent-Child Interaction Therapy (PCIT), and
- Multisystemic Therapy (MST).

Supported Employment. Supported Employment promotes rehabilitation and a return to mainstream employment for persons with serious mental illnesses and co-occurring disorders. Supported Employment programs integrate employment specialists with other members of the treatment team to ensure that employment is an integral part of the treatment plan. Employment specialists are responsible for carrying out vocational services while all members of the treatment team understand and promote employment.

A considerable body of research indicates that Supported Employment models, such as Independent Placement and Support (IPS), are successful in increasing competitive employment among consumers.⁶⁹ A seven-state, multi-site study supported by the federal Substance Abuse and Mental Health Services Administration (SAMHSA) found that Supported Employment participants were significantly more likely (55%) than comparison participants (34%) to achieve competitive employment.⁷⁰ A review of three randomized controlled trials found that, in general, 60-80% of people served by a Supported Employment model obtain at least one competitive job.⁷¹

To better understand how funding levels and fidelity can be implemented across an entire state to achieve improved employment outcomes, we spoke with key informants in several other states to compile information on Supported Employment (SE) costs and expected outcomes. Key findings include:

- Studies consistently report that typical employment rates for persons with severe mental illness range around 15%.⁷² SE can dramatically increase this, but outcomes vary based on fidelity to the SE model, local unemployment rates, and the scope of

⁶⁹ Drake, R.E., Becker, D.R., Clark, R.E. & Mueser, K.T. (1999). Research on the individual placement and support model of supported employment. *Psychiatric Quarterly*, 70, 289-301.

⁷⁰ Cook, J. Executive Summary of Findings from the Employment Intervention Demonstration Program. Retrieved at www.psych.uic.edu/eidp/EIDPexecsum.pdf.

⁷¹ New Freedom Commission on Mental Health (2003). *Achieving the Promise: Transforming Mental Health Care in America*. Final Report. Rockville, MD: DHHS Pub. No. SMA-03-3832 at 41, *citing* Drake, R.E., Becker, D.R., Clark, R.E., and Mueser, K.T. (1999). Research on the individual placement and support model of supported employment. *Psychiatric Quarterly*, 70, 289-301.

⁷² Becker, D.R., Xie, H., McHugo, G.J., Halliday, J., & Martinez, R.A. (2006). What predicts supported employment outcomes? *Community Mental Health Journal*, 42(3), 303-313.



funded SE activities.⁷³ Maryland and Kansas are the two states nationally with the widest dissemination of SE. Based on their experience, a reasonable high-end estimate of the potential employment achievable through SE would be 40%. This is lower than the results achieved in individual studies and is based on feedback from key informants familiar with the statewide implementation efforts in Kansas and Maryland.

- Nationwide, states vary widely in their approaches to paying for SE, including in their use of Medicaid. We identified two states as achieving particularly strong SE outcomes: Kansas and Maryland.
- Kansas pays a premium of \$15 per hour for established SE providers, versus other programs (\$125 versus \$110 per hour). Medicaid SE services are provided alongside vocational rehabilitation services. Kansas tracks the fidelity of SE service delivery using the SAMHSA toolkit protocols and requires a rating of good to be eligible for the enhanced payment level. The University of Kansas serves as a Center of Excellence to support SE implementation (they also support IDDT implementation).
- Maryland pays for SE through a formal partnership between vocational rehabilitation and the mental health department. Vocational Rehabilitation (VR) and State general funds are used to pay for the first phases of the process. Medicaid then takes over payment through a monthly case rate (\$400 per month) once the consumer is stabilized on a job for 90 days (at which point they are closed as a case to vocational rehabilitation). People without Medicaid can also receive this service, but paid at \$325 per month out of State general funds. Providers also receive additional funding for clinical care coordination. This approach was seen as working well to support SE given that it was collaboratively developed by VR and mental health and that the funding model is simple and very clear to providers. Maryland has used their federal Mental Health Transformation grant to support development of this braided funding approach.

In Washington, MHD has launched a major initiative to promote and support SE. To support these efforts, we recommend that MHD continue to work with the Department of Vocational Rehabilitation (DVR) to clarify for providers how to provide SE in collaboration with the efforts of DVR. As noted in our February 2007 preliminary report, the current interpretation of SE services under the encounter reporting manual requires the consumer to be served either by the RSN or DVR, but not by both. This interpretation seems more rigid than the language required by the B-3 service description, which focuses on services “currently received” and “provided” by DVR, as opposed to those that would theoretically be “covered” or possibly could be “available.” The B-3 language seems like it could support provision of services by both DVR and the RSN, as long as the two were coordinated at some level to avoid redundancy.

⁷³ Drake, R.E., Becker, D.R., Goldman, H.H., & Martinez, R.A. (2006). The Johnson & Johnson – Dartmouth community mental health program: Disseminating evidence-based practice. *Psychiatric Services*, 57(3), 302-304.



Trauma-focused Cognitive Behavioral Therapy (TF-CBT). TF-CBT has strong support for efficacy with children and youth aged three to 18 years old, and their parents.⁷⁴ TF-CBT is a treatment intervention designed to help children, youth, and their parents overcome the negative effects of traumatic life events such as child sexual or physical abuse; traumatic loss of a loved one; domestic, school, or community violence; or exposure to disasters, terrorist attacks, or war trauma. TF-CBT has been adapted for Hispanic/Latino children and some of its assessment instruments are available in Spanish. In partnership with CA and JRA, MHD has taken the lead with implementing TF-CBT across the state and has made a major investment in training in TF-CBT, in one year training 41 sites across 13 RSNs, involving just over 150 clinicians. Continuing such training and enhancing the ability to track the provision of TF-CBT per BP Recommendation #6 above is recommended.

Parent-Child Interaction Therapy (PCIT). PCIT has strong support as an intervention for use with children ages three to six who are experiencing oppositional disorders or other problems.⁷⁵ PCIT works by improving the parent-child attachment through coaching parents in behavior management. PCIT has been adapted for use with Hispanic and Native American families.

In partnership with MHD and JRA, CA has taken the lead in promoting PCIT use in Washington. We recommend continuing such collaboration and training, as well as enhancing the ability to track the provision of PCIT per BP Recommendation #6 above. In particular, we recommend that codes be identified to allow the funding of the PCIT model, taking into account the involvement of multiple clinicians and training costs.

Multisystemic Therapy (MST). Multisystemic Therapy (MST) is a well-established EBP with proven outcomes and cost benefits when implemented with fidelity for youth living at home with more severe behavioral problems related to willful misconduct and delinquency.⁷⁶

⁷⁴ Cohen, J.A. & Mannarino, A.P. (1996). A treatment outcome study for sexually abused preschool children: Initial findings. *Journal of the American Academy of Child & Adolescent Psychiatry* 35(1), 42-50.

King, N., Tonge, B., Mullen, P., Myerson, N., Heyne, D., Rollings, S., Martin, R., & Ollendick, T. (2000). Treating sexually abused children with posttraumatic stress symptoms: A randomized clinical trial. *Journal of the American Academy of Child & Adolescent Psychiatry* 39(11), 1347-1355.

Mannarino, A.P., & Cohen, J.A. (1996). A follow-up study of factors that mediate the development of psychological symptomatology in sexually abused girls. *Child Maltreatment* 1(3), 246-260.

Stein, B., Jaycox, L., Kataoka, S., Wong, M., Tu, W., Elliott, M., & Fink, A. (2003). A mental health intervention for school children exposed to violence: A randomized controlled trial. *Journal of the American Medical Association* 290(5), 603-611.

⁷⁵ Chaffin, M., Silovsky, J., Funderburk, B., Valle, L., Brestan, E., Balachova, T., et al. (2004). Parent-Child Interaction Therapy with physically abusive parents: Efficacy for reducing future abuse reports. *Journal of Consulting and Clinical Psychology* 72(3), 500-510.

Eyberg, S.M. (2003). Parent-child interaction therapy. In T.H. Ollendick & C.S. Schroeder (Eds.) *Encyclopedia of Clinical Child and Pediatric Psychology*. New York: Plenum.

Querido, J.G., Eyberg, S.M., & Boggs, S. (2001). Revisiting the accuracy hypothesis in families of conduct-disordered children. *Journal of Clinical Child Psychology*, 20, 253-261.

⁷⁶ Huey, S.J. Jr., Henggeler, S.W., Brondino, M.J. & Pickrel, S.G. (2000). Mechanisms of Change in Multisystemic Therapy: Reducing Delinquent Behavior Through Therapist Adherence and Improved Family and Peer Functioning. *Journal of Consulting and Clinical Psychology*, 68 (3), 451-467.



MST is an intensive home-based service model provided to families in their natural environment at times convenient to the family. MST is intensive and comprehensive with low caseloads and varying frequency, duration, and intensity levels. MST is based on social-ecological theory that views behavior as best understood in its naturally occurring context. MST was developed to address major limitations in serving juvenile offenders and focuses on changing the determinants of youth anti-social behavior.⁷⁷

Washington is a leading state in the provision of MST in its juvenile justice system and allows payment for MST through its Medicaid mental health system. In partnership with MHD and CA, JRA has taken the lead in developing and promoting MST within the state. Research is also underway at the University of Washington to adapt MST for broader populations and to incorporate features from other successful in-home models (such as the FAST model developed by Pierce County). We recommend continuing such collaboration and efforts to promote MST, as well as exploring the ability to leverage currently allowed federal Medicaid funding to expand access to MST. As MST is adapted to respond better to the needs of children with mental health needs, it may be necessary to develop additional coding protocols to track delivery of these enhanced services. Development of codes to track other discrete in-home services such as FAST should also be considered.

Additional Recommendations Related to Priority Best Practices

BP Recommendation #8: 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. For any RSN that has not provided the level of targeted best practices that was funded, the difference between the documented costs incurred for targeted best practice services provided and the amount allocated should be paid back to MHD and the federal portion paid back to CMS.

The cost analyses included in this report were never intended by MHD or TriWest Group to be a substitute for actuarial analysis of any change in benefit funding eventually undertaken. In addition, one of the risks in funding services prospectively through capitation payments is that the services funded may not be delivered. This concern was addressed with representatives of the Milliman, Inc., actuarial team under contract with DSHS and the recommendation above was developed based on that discussion. While the change in rate calculation methodology from upper payment limits to actuarially sound rates [under 42 CFR 438.6(c)] in August 2002 has led to many challenges for states, it also allows them to more proactively employ actuarial analysis both to set rates and ensure PIHP contractor

Schoenwald S.K., Henggeler S.W., Pickrel S.G., & Cunningham P.B. (1996). Treating seriously troubled youths and families in their contexts: Multisystemic therapy. In M. C. Roberts (Ed.), *Model programs in child and family mental health*, (pp. 317-332). Mahwah, NJ: Lawrence.

⁷⁷ Henggeler S.W., Weiss, J., Rowland M.D., Halliday-Boykins C. (2003). One-year follow-up of Multisystemic therapy as an alternative to the hospitalization of youths in psychiatric crisis. *Journal of the American Academy of Child & Adolescent Psychiatry* 42(5), 543-551.



accountability. We recommend that DSHS allocate additional actuarial time to MHD to allow for these analyses. The specifics of the analyses should be identified and priced by the actuarial contractor prior to carrying them out.

Analysis and Recommendations for Tribal Governments and their Members

Overview of Relationships Between MHD and Sovereign Tribes in the State of Washington

The basis of the relationship between the government agencies of the State of Washington and the 29 federally recognized Tribes in Washington State is the Centennial Accord signed in August, 1989. The Accord provides a framework for government to government relationships between the State of Washington and each sovereign Tribe. Although the Accord was initiated by the Governor of Washington State, it also recognized the “chief representatives of all elements of state government” to ensure complete and broad implementation of the arrangement. MHD, as part of DSHS, thereby maintains a direct working relationship with each of the 29 Tribes.

Members of the 29 federally recognized Tribes in Washington State are able to access mental health services through multiple systems, including their own dedicated Indian Health Service (IHS) and Tribally-administered 638 facilities (funded by Title I or III of the Indian Self Determination and Education Assistance Act – Public Law 93-638), the Medicaid PIHP administered by the RSNs, or a combination of these systems. Given these multiple systems, MHD and each of the 29 Tribes must coordinate activities at multiple levels. While the primary relationship is between each Tribe and the State of Washington, on a day-to-day basis various agents acting on behalf of the State of Washington, including RSNs and state-operated treatment facilities such as the State Hospitals and CLIP facilities, all must coordinate their activities with each individual Tribe.

Coordination across these systems is supported through the 7.01 planning and policy development process, through which an overall Updated Report is renewed every two years to coordinate the efforts of DSHS overall, DMH, and the RSNs. Each of the 13 RSNs contracting with MHD are also required to carry out 7.01 planning at a local level with the Tribes located within their geographical boundaries. Coordination is critical, given differences between Tribes in terms of their resources, needs and the services they provide, as well as differences in their relationships with DSHS, DMH, and local RSNs.

MHD also provides two regular forums for coordinating system issues related to the delivery of mental health services through Tribal providers and for Tribal members. The first forum is a monthly Tribal Mental Health Work Group that addresses a broad range of coordination issues. The second is a Tribal Billing Instructions Work Group that addresses issues related to encounter reporting and reimbursement.



Methodology and Approach

There were multiple sources of information drawn upon in developing this chapter. First, input was sought directly from representatives of Tribal Governments, Recognized American Indian Organizations (RAIOs), and DSHS Indian Policy and Support Services (IPSS) managers. Initial input was obtained through a Tribal Forum held in February 2007.

Based on input from that Forum, two focus groups were carried out in April 2007 involving a broader representation of Tribal Governments, RAIOs, and IPSS managers. One group was held in eastern Washington at the American Indian Health Center in Spokane, Washington. The group involved representatives from three eastern Washington Tribes (Colville Confederated Tribes, Kalispel Tribe, and Confederated Tribes of the Yakama Nation), five representatives from RAIOs, and two IPSS staff. The second group was held in western Washington and involved the Tribal Chairman of the Stillaguamish Tribe, other representatives from seven western Washington Tribes (Makah Nation, Puyallup Tribe, Shoalwater Bay Tribe, Skokomish Tribe, Stillaguamish Tribe, Tulalip Tribe, and Upper Skagit Tribe), and two IPSS staff. In addition, we conducted follow-up interviews with interested focus group participants, as well as interviews with the MHD Tribal Liaison. We also conducted additional targeted legal research regarding how other states involve Tribal Providers within their managed care delivery systems, focusing on Arizona (an optional Public Law 83-280 state like Washington) and New Mexico (a non-P.L. 280 state).

Tribal Issues Identified Related to Benefit Design

Through the focus groups, additional interviews with Tribal representatives, IPSS staff, and MHD staff, the following issues were identified as unique to MHD's relationships with Tribal Governments, Tribal providers, and services to Tribal members.

Recognition of the complexity of Tribal mental health systems. One key observation across both focus groups and our regulatory review is that Tribal mental health systems are a distinct part of the public mental health system that are both different and more complex in their regulatory requirements than non-Tribal mental health systems. While RSNs must comply with federal and state regulations through MHD, Tribal providers operate in a system with the additional complexity of direct relationships between Tribes and the State, as well as Tribes and the federal government.

One example noted in the focus groups was the regulations whereby Tribal members are entitled to receive services from multiple systems: Tribal providers, IHS or 638 facilities, RAIOs, and non-Tribal CMHA providers within RSN networks. This was seen as complicating service delivery, resulting in confusion at the administrative level, a frequent response that "someone else" was responsible for providing care, and, to some degree, increased confusion on the part of Tribal members as they seek to access care.

Lack of clarity regarding the role of Tribal providers. Focus group participants clearly articulated a current lack of clarity regarding the role of Tribal providers in the broader public mental health system, and particularly their involvement in RSN networks. Some of this lack of clarity reflects the multiple ways in which Tribes may choose to organize their health services. Tribal providers delivering Medicaid mental health services may choose between fee



for service reimbursement using the federal encounter rate or participation in RSN provider networks. However, the lack of clarity seemed also to stem from different interpretations by different RSNs working with Tribes in their geographic areas.

Significant concern was expressed in the focus groups regarding the issue of whether or not Tribal providers were required to be licensed as Community Mental Health Agencies (CMHAs) prior to participation in RSN networks. The June 2006 HRSA Tribal Health Program Billing Instructions clearly define how Tribes may choose between the following designations for their health providers:

- Designation as IHS or Tribal 638 facilities paid the federal IHS encounter rate,
- Tribal facilities paid under the state's fee for service system, or
- Tribal federally qualified health clinics (FQHCs).

The manual is also clear about the choice that Tribal members have between receiving mental health services through RSNs, directly through IHS or Tribal 638 facilities or through both systems. These facilities may also provide services to non-Tribal members under the "clinical family" definition (which is discussed in more detail later in this chapter).

What is not clear in this manual or other Washington State documentation we reviewed is the manner in which IHS and Tribal 638 providers may participate in RSN networks. Federal law governing the Medicaid program (42 CFR 431.110) clearly states that IHS facilities are not subject to state licensure to qualify for Medicaid participation and "must be accepted as a Medicaid provider on the same basis as any other qualified provider." The requirement goes on to state that, while "the facility need not obtain a [State] license," it nevertheless "must meet all applicable standards for licensure."

Consistent with this requirement, a state may require their managed care organizations (entities analogous in role to RSNs in those states) to involve IHS and Tribal 638 facilities directly in their managed care provider networks without additional licensure. For example, New Mexico's regulations governing its managed care provider networks require the extension of network participation to IHS and Tribal 638 facilities, as well as properly credentialed RAIOS. In New Mexico, mental health waiver and other mental health services are delivered by a single managed care organization (MCO) referred to as the "Statewide Entity" or "SE." While New Mexico's program operates on a statewide rather than a regional basis, the SE is analogous to Washington's RSN designation. The administrative requirements for the SE state: "The MCO/SE shall enter into contracts with 'essential' providers that include, but are limited to, IHS, 638 tribal programs and providers serving particular linguistic or cultural groups."⁷⁸ Accordingly, New Mexico incorporates the following requirement into its current MCO/SE contract: "The SE shall maintain contracts with IHS of Albuquerque and Navajo Area IHS and with 638, Tribal, Nation, Pueblo and Urban Indian behavioral health providers that meet minimal credentialing requirements for service delivery within New Mexico who want to contract with the SE."⁷⁹ It is important to note that, while Tribal

⁷⁸ New Mexico Administrative Code 8.305.6.15(E)

⁷⁹ 2007 State of New Mexico Interagency Behavioral Health Purchasing Collaborative Statewide Behavioral Health Services Contract, Section 3.16.L



providers are recognized as a distinct provider type for network participation (not subject to other state-level licensing requirements), they are still subject to the same minimal credentialing requirements as any other network provider.

However, New Mexico's current 1915(b) Waiver put the burden of effort to involve Tribal providers primarily on the SE, rather than the Tribes, as seen in the following excerpt:

Native American providers such as Indian Health Service (IHS), tribal providers and 638 providers designated by the tribes will be considered essential providers with whom the SE will be obligated to contract so long as they can be credentialed for the services they provide and they want to contract with the SE. Credentialing of IHS and Tribal 638 facilities should take into account federal standards for licensure as well as special cultural issues associated with Native American providers, whether Tribal, federal or urban Indian. While credentialing offers a degree of assurance about quality of providers, the SE's single credentialing process may be difficult for some Native American providers and practitioners. The SE will be asked to take this into account and adjust the credentialing process accordingly. (New Mexico's January 27, 2007 Section 1915(b) Waiver Proposal, page 6)

Arizona takes a different approach. As in Washington, IHS and Tribal 638 facilities may have direct fee for service payment relationships with the State, and, if so, their services are not reimbursed by Regional Behavioral Health Authorities (RHBAs), which is Arizona's equivalent entity to Washington's RSNs. However, Arizona also offers Tribes the opportunity to operate their own Tribal RBHAs, which provide either a full or partial range of RHBA services. Some Tribes (Gila River Indian Community and Pascua Yaqui Tribe) operate full RBHAs, subject to the same requirements as any other RHBA, and others (Navajo Nation, Colorado River Indian Tribes) operate partial RBHAs that allow them to provide a range of additional mental health services, such as case management. The T-RHBA designation allows Tribes in Arizona the ability to provide services under the broader waiver authority allowed for RBHAs, in addition to or instead of direct fee for service arrangements.

Washington State does not offer RSNs such definitive guidance for the involvement of Tribal providers. While the written Tribal coordination plans that are required offer an important basis for collaboration between Tribes and RSNs, there does not seem to be either a specific requirement (like New Mexico) that RSNs involve willing Tribal providers in their networks (regardless of CMHA licensure, but subject to minimum credentialing requirements) or a specific exclusion (like Arizona) that puts Tribal providers outside of the RSN system independently under a managed care waiver. The 2006 Washington Mental Health Transformation Plan: Phase 1 recognized this lack of clarity when it recommended that: "License/certification criteria needs to be changed to deem Tribally certified professionals and facilities as eligible to be reimbursed for services, including where desired, direct state contracts."⁸⁰

⁸⁰ Chapter 3, page 119.



Tribal providers serving non-Tribal members. Focus group participants also discussed the need for clarity regarding the limits for service provision by Tribal providers to non-Tribal members residing on or contiguous to Tribal land. The definition of a “clinical family member” was central to this discussion. The June 2006 HRSA Tribal Health Program Billing Instructions define a “clinical family member” able to receive mental health services as “A person who maintains a familial relationship with a Tribal member” and goes on to specify four family relationships centering on being either a spouse/partner, child in the care of an eligible Tribal member, woman pregnant with the child of an eligible Tribal member, or adult under the guardianship of an eligible Tribal member.

Focus group participants talked about how Tribes such as the Stillaguamish Tribe take an expanded view of people for whom the Tribe is responsible to provide health care. This was expressed as both a duty to others, as well as a pragmatic concern to address the health care needs of people living on or near Tribal land, particularly in the case of Tribes whose land is in multiple parcels that are sometimes separated by non-Tribal land. Some participants suggested that the reference to a “familial relationship” in the first section of the definition of a “clinical family member” could be viewed within the cultural context of some Tribes to include a wider range of relationships beyond those more specifically defined.

The Washington requirements focus on the rights of Tribal members and, by extension, their family members as a way to offer guidance in these matters. Both New Mexico and Arizona take a different approach, addressing this issue by defining both the rights of Tribal members to receive services and the rights of Tribal providers either to participate in Medicaid managed care networks operated by a statewide entity (New Mexico) or Tribal managed care organizations (Arizona). If Washington were to clarify the basis on which Tribal providers may participate in RSN networks, those providers would be available to serve both Tribal members and others eligible for service under that authority.

Specific best practices of interest to Tribal representatives. Focus group participants noted a range of practices that they would like to see better incorporated into Washington’s mental health benefit design. Much of the discussion centered on traditional medicine, the specific traditional healing practices developed over time by each of the State’s 29 recognized Tribes. While commonalities across Tribes are sometimes noted, focus group representatives underscored that each Tribe’s practices are distinct, reflecting their independent cultures and histories. In discussing these practices, several focus group participants noted that different cultures value different types of evidence for the effectiveness of health services, and that community recognition of the value of a practice was at least as important (and in some cases more so) to Tribes as the scientific evidence more commonly cited in discussions of evidence-based practices within Washington’s mental health system.

While focus group participants were interested in expanding access to traditional healing services, they also noted the risks of “medicalizing” traditional healing approaches if they are made subject to the regulatory requirements of specific funding sources, particularly Medicaid. Participants also seemed clear that an encounter-based reimbursement system did not seem to be a good fit for funding such services.



Arizona has developed an encounter-based system for reimbursing traditional health practices. Their July 2007 Covered Behavioral Health Services Guide defines H0046 Mental Health Services NOS (formerly Traditional Healing Services) as “Treatment services for mental health or substance abuse problems provided by qualified traditional healers. These services include the use of routine or advanced techniques aimed to relieve the emotional distress evident by disruption of the person’s functional ability.” These services are reported in 15 minute increments and are paid for only by State funds (not Medicaid). Arizona also defines a provider type for this service of Tribal Traditional Service Practitioner.

New Mexico requires its statewide managed care organization (known as the “Statewide Entity” or “SE”) to make available a range of traditional healing services: “The SE shall ensure that alternative/ traditional healing services (i.e., traditional healers, sweat lodges, ceremonies, acupuncture, etc.) provided through Native American programs continue and/or are developed as appropriate.”⁸¹

Despite their concerns about the process for doing so, focus group participants were generally desirous of the development of a framework through which traditional healing practices would be formally included, defined, and reimbursed within Washington’s public mental health benefit. There was also clear guidance from both focus groups that such a benefit be carefully developed through consultation with all of Washington’s 29 recognized Tribes. Both focus groups also recommended that a formal study of traditional healing practices in Washington State be carried out in support of developing such a benefit.

Access to traditional medicine can be supported through both involvement of traditional practitioners and support of specific traditional practices. While the inclusion of specific traditional practices in Washington’s mental health benefit would require the process of comprehensive input and involvement described above, better involvement of Tribal providers could in and of itself also help promote access to traditional healing practices integrated within Tribal medical settings. Wider involvement of Tribal provider facilities in RSN networks or independently would offer one route.

The role of Native American Ethnic Minority Mental Health Specialists (EMMHS) was also discussed. Focus group participants were generally negative toward the current implementation of the EMMHS model for Tribal members, primarily because these specialists are seen as part of the CMHA and RSN systems and therefore viewed as not well integrated into the Tribal provider system. This seemed to be in large part related to the barriers to Tribal provider participation noted earlier in this chapter. If these previously noted barriers are addressed, it may be that the EMMHS designation could serve as a basis for developing traditional healing services as part of the mental health benefit. However, the current EMMHS designation does not include criteria for specialization for specific ethnic minority groups. Development of such criteria for Native American traditional healing practices within specific Tribal communities might make the EMMHS designation more

⁸¹ 2007 State of New Mexico Interagency Behavioral Health Purchasing Collaborative Statewide Behavioral Health Services Contract, Section 3.16.R.



effective in promoting traditional healing services, but would also require comprehensive involvement and participation from all 29 Tribes.

Several focus group participants noted that the process for designating providers as qualified traditional healers should be less a process of conforming to written criteria than a process whereby a Tribal community formally recognizes traditional healers through its own traditional processes. Recognizing the need for Tribes to designate their own traditional healers in accord with established custom was a central theme articulated in the focus groups.

In addition to improving access to traditional healing practices, focus group participants also underscored the importance of the following best practices for Tribal members:

- Integrated substance abuse and mental health services,
- Mental health services integrated within primary care and other human service settings, and
- Improved outreach to Tribal members in need, particularly in eastern Washington areas where providers are often located long distances from Tribal members and others in need.

Integrated mental health services with substance abuse services and primary care services were among the top five priorities for statewide system development. Tribal focus group participants also underscored the need for start-up funding to pay for training and infrastructure for providers adopting evidence-based integrated practices. These concerns echoed those noted for the broader mental health system. Focus group participants emphasized that Tribal providers need to be involved in broader system initiatives to promote evidence-based and other best practices, with opportunities for input into how these practices need to be modified in their requirements (either administrative or clinical) so as to ensure their availability and responsiveness to the needs and strengths of Tribal members.

Need for better tracking of Tribal membership status in mental health information systems. Focus group participants and key informants noted that the current mental health encounter tracking system through RSNs does not adequately document the range of services delivered to Tribal Members. Participants noted that Tribal membership status is not systematically tracked across RSNs, observing that DASA seems to do a better job of such tracking. They specifically observed the need for data systems to include specific fields to collect data on Tribal membership status and requirements for RSNs and providers to routinely collect such data. This data would be collected in addition to information on race and ethnicity. Any person identifying as a Native American would also be asked about their Tribal membership status.

Importance of direct coordination between Tribal governments and MHD. Focus group participants discussed a range of concerns related to the current level of coordination between MHD and Tribal Governments. Participants discussed an overall sense that rules are used “to say no” rather than to identify ways to move forward. This seemed related to a perception that communication and decision-making has been problematic across multiple issues. Some of this concern seemed to relate to issues with specific RSNs. While some Tribes were very positive about their collaboration with RSNs, others were not. Currently, most coordination of



services seems to be expected to happen between RSNs and the Tribes in their geographic areas, so variability across these many relationships seems inevitable. Focus group participants therefore noted the need for coordination directly with MHD to offer Tribes a direct path to “government-to-government” coordination and to provide a more reliable guide for individual RSN coordination efforts.

Participants observed that important steps have already been taken to improve direct communication with MHD, and they were uniformly positive about the current Tribal Billing Instructions and Tribal Mental Health Work Group meetings, which in 2007 occurred more consistently than in the previous year. However, participants noted the desire for MHD to identify a senior managerial staff member (or members) who would be able to serve as a single point of responsibility for addressing policy questions related to benefits and other matters of importance to Tribes. One person could carry out this role or the role could be differentiated across policy areas (e.g., network participation, billing, involuntary treatment). This staff position would involve more than what participants perceived the current Tribal Liaison position to entail, in that the position would be a senior manager (preferably full time and reporting directly to the MHD Division Director) with authority to convene needed DSHS staff to develop definitive policy guidance in response to issues that arise.

While these specific ideas were offered, it appeared that the concern underlying these suggestions involved a need for “government-to-government” forums between senior MHD representatives and Tribal governments. MHD subcontractors (such as RSNs) and mid-level managers (such as Tribal Liaisons) can provide important coordination activities, but participants were clear that regular forums that included the involvement of senior MHD staff were also needed.

Related to this was an additional need to more clearly differentiate between formal policy consultation (subject to the communication requirements of the 7.01 process) and less formal gathering and sharing of information to inform the development of policy. It seemed clear that participants valued the communication requirements surrounding formal policy consultation, but also desired more timely and less cumbersome processes for (1) communication and clarification of current policy and (2) information gathering for future policy development. It may be that the reinstated Mental Health Work Group and Tribal Billing Instructions meetings may offer such forums, but there seemed to be a need to articulate criteria for when the deliberations of these groups were subject to formal review under 7.01.

Recommendations

All of the issues expressed in the focus groups and discussed above are important issues at the heart of MHD’s relationship with each of Washington’s 29 federally-recognized Tribes, and these issues also directly affect the availability and quality of care for Tribal members and other Native Americans across the State. Given this, MHD should review all of these issues so that they can inform efforts to coordinate services for Tribal members in all relevant venues with Tribes, including both statewide forums such as the Mental Health Work Group and RSN-specific efforts.



In addition to this, we offer the following specific recommendations for additional consideration and implementation by MHD. These recommendations have been developed with consideration of the broader recommendations in the chapter on “Mental Health Transformation in Collaboration with Indian Country” offered through the 2006 Washington Mental Health Transformation Plan: Phase 1.⁸²

Tribal Government and Member (TGM) Recommendation #1: Develop a handbook to guide RSNs in their interactions with Tribal governments and Tribal providers. Given the complexity of Tribal mental health systems, MHD risks continuing confusion, frustration, and barriers to care if all 13 RSNs are left to conduct their relationships with Tribal governments and providers without additional guidance. We recommend that a handbook for RSNs be developed that lays out in one place the requirements to guide these RSN interactions. The handbook should describe the multiple choices that Tribes and Tribal members have for accessing mental health services and the role of the RSN within that. In addition, it should describe the rights that Tribes have to make choices in how they involve RSNs in the mental health care of their members. It should also incorporate guidance on the involvement of Tribal providers in RSN networks, as well as Tribal members in the provision of care, including clinical family members.

TGM Recommendation #2: Develop a clear policy for the involvement of IHS and 638 facility providers in 1915(b) waiver networks. Federal rules (42 CFR 431.110) stipulate that states may not exclude IHS providers from their Medicaid systems. While Washington is in compliance with this requirement by offering IHS and Tribal 638 facilities access to encounter-based fee for service reimbursement, it does not ensure the involvement of these providers in its 1915(b) waiver network, either through RSN networks or through direct relationships with Tribes similar to those developed in Arizona for Tribal RHBAAs. At a minimum, we recommend that willing IHS and Tribal 638 facilities able to comply substantially with RSN credentialing requirements be allowed to participate in RSN networks without CMHA licensure. We further recommend that RSNs be required to provide technical assistance to IHS and Tribal 638 facilities that desire to participate in their networks, but that are not yet able to comply with credentialing requirements. Regulations by MHD to enact these recommendations should be developed with the involvement of Tribal governments, Tribal providers, RAIOS, and RSNs. Such requirements are likely to increase the administrative costs to RSNs to administer their networks and provide technical assistance to providers, so consideration of this should be factored into the administrative component of rate setting. As part of this effort, MHD should consider whether it makes sense to convene a work group to explore mechanisms for direct contracting with Tribes. Consultation with the federal Center for Medicare and Medicaid Services (CMS) should also be undertaken to determine if modifications of the 1915(b) waiver similar to those incorporated by New Mexico are needed, or if existing federal statutes (e.g., 42 CFR 431.110) offer sufficient authority without modification of the waiver.

TGM Recommendation #3: Convene a work group to develop recommendations on how to incorporate Tribal traditional healing practices within the public mental health

⁸² Chapter 3, pages 116 to 121.



benefit. Many ideas were offered in the focus groups and discussed above about how to define such a benefit, but definitive guidance in this area is beyond the expertise of the authors of this chapter. Therefore, we recommend that MHD work through the Tribal Mental Health Work Group in collaboration with all 29 federally-recognized Tribes to convene a work group to study the traditional healing practices of all of Washington’s 29 federally-recognized Tribes. This study should draw on the guidance of best practice sources such as the National Center for American Indian and Alaska Native Mental Health Research at the University of Colorado Health Sciences Center.⁸³

TGM Recommendation #4: Incorporate specific provisions for the inclusion of Tribes in any systematic efforts to promote best practices. As MHD develops initiatives in response to the broader recommendations of this report, specific provisions to ensure the inclusion of Tribes should be incorporated. Furthermore, Tribal representatives expressed particular interest in the development of integrated mental health / substance abuse services and integrated mental health / primary care services, and Tribal input should be sought in the design of any initiatives to promote such services.

TGM Recommendation #5: Continue facilitation of statewide forums such as the Tribal Mental Health Work Group and ensure the participation of senior staff in these forums. It was the clear preference of focus group participants that these forums continue and that the level of MHD representation should be senior enough to respond definitively to the complex issues involved in coordinating mental health services across 29 distinct Tribes. We recommend that MHD continue these meetings on a monthly basis and designate at least one senior staff member reporting to the Division Director to consistently attend these meetings. These meetings will also offer a forum for addressing other important issues raised in this chapter and in other forums, such as the need to develop information system supports sufficient to track Tribal member service use.

Conclusion and Summary of Recommendations

The current report integrated a review of comparison states, Washington’s benefit design and management processes, national evidence-based and promising practices, Deficit Reduction Act options, and rate methodologies into a final set of options and recommendations for MHD. The recommendations fell into two areas.

The first area focused on **recommendations regarding Washington’s overall benefit design.** These recommendations were based primarily on a review of Washington’s Medicaid State Plan and broader mental health benefit design, comparing the benefit design of the plan to the benefits of four benchmark states: Arizona, Colorado, New Mexico and Pennsylvania. They include:

- **Medicaid State Plan and Waiver (MSP&W) Recommendation #1: Do not propose any changes to CMS regarding the structure of Rehabilitative Services**

⁸³ http://aianp.uchsc.edu/ncaianmhr/ncaianmhr_index.htm



within Washington’s Medicaid State Plan. Our analysis of Washington’s State Plan found that the language of the 18 modalities is sufficiently flexible to promote all of the prioritized best practices identified in this report. Furthermore, in light of the enhanced scrutiny of Rehabilitative Services that CMS has been engaged in over the last two years, we do not recommend proposing any State Medicaid Plan change to CMS that would involve Rehabilitative Services at the current time.

- **MSP&W Recommendation #2: Develop statewide standards for continuing care and discharge under 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. This will require the development of statewide medical necessity standards for all levels of care, including criteria for initial and concurrent reviews.** While not a formal change in the ACS as defined in the current 1915(b) waiver, this recommendation would entail the development of statewide standards to guide ACS implementation, particularly standards for continuing care and discharge, carried out under the oversight of and in partnership with the federal Centers for Medicare and Medicaid Services (CMS).
- **MSP&W Recommendation #3: Prior to the next waiver submission, conduct a full actuarial analysis of the financial impact of revising GAF and C-GAS minimums for routine outpatient care. If financially feasible, raise the GAF and C-GAS minimums to at least 70 for all covered diagnoses.** Currently, there is no substantive mental health benefit for Medicaid enrollees not covered by the Healthy Options program, an important subgroup, given that all disabled adults fall outside the Healthy Options program. An efficient way to extend coverage to these individuals would be to relax the functional requirements for ACS. Given recent benefit changes for these programs (the recent expansion of Healthy Options and fee-for-service benefit limits from 12 to 20 visits annually and expanding the types of eligible providers), eligible providers in RSN networks are now able to provide these additional services. Therefore, it is not clear what additional costs would be entailed by integrating these fee-for-service benefits within the RSN structure.
- **MSP&W Recommendation #4: Revise Current RSN Contract Requirements for Statewideness and Provide Definitive Guidance to RSNs on Implementation.** To better reflect all pertinent federal standards, we recommend that the language of the RSN contracts be revised from an emphasis on statewideness under 42 CFR 41.50 to an emphasis on network adequacy under 42 CFR 438.206 and 438.207. This will shift the focus of RSN requirements so that they must demonstrate how needs are documented and met, rather than simply document that the network includes a provider from somewhere in the state that provides a given modality.

The second area of the report focused on **recommendations related to how best to promote current national best practices** within the overall recommended benefit design, as well as how to promote prioritized practices for children and families, adults, and older adults. These recommendations include:

- **Best Practice (BP) Recommendation #1: While continuing to promote EBPs, be mindful of their limitations.** Successful EBP promotion begins with an understanding of the real world limitations of each specific best practice, so that the



inevitable stakeholder concerns that emerge can be anticipated and incorporated into the best practice promotion effort. While EBPs offer a well-documented route to effective treatment in many cases, their promotion faces multiple challenges and controversy.

- **BP Recommendation #2: Specifically address the lack of research on cross-cultural application of EBPs.** Given that few EBPs have documented their results in sufficient detail to determine their effectiveness cross-culturally, it makes sense that EBPs be implemented within the context of ongoing evaluation efforts to determine whether they are effective for the local populations being served.
- **BP Recommendation #3: Specify the level of consumer and family involvement for each service in the array of best practices to be promoted.** The best practices described in this report include a range of consumer and family involvement that varies across practices, so we have sought to describe the degree to which the best practices reviewed are consumer and family driven, focusing on the levels at which the services involve consumer and family member guidance and input in areas such as service planning, service delivery, and operation of the service agency.
- **BP Recommendation #4: Ground the promotion of specific best practices within a broader Evidence Based Culture.** States that have been more successful in their implementation of EBPs have focused on the need for system and organizational infrastructures that will support the implementation, broad dissemination, and ongoing scrutiny of evidence-based practices. Such infrastructures involve the policy, procedural, and funding mechanisms to sustain evidence-based interventions, and they need to be based in system and organizational cultures and climates that value the use of information and data tracking as a strategy to improve the quality of services and increase the likelihood of achieving desired outcomes.
- **BP Recommendation #5: Develop Centers of Excellence to support the implementation of those best practices prioritized for statewide implementation.** There are increasing efforts by states to develop their own state-level Centers of Excellence to provide ongoing sources of expertise, evaluation, training, and guidance to support the initiation and ongoing development of EBPs and promising practices. While there are no definitive studies yet available of what factors best support system-wide EBP promotion, emerging research suggests that states implementing these approaches are further along in EBP promotion than those that do not.
- **BP Recommendation #6: Develop encounter coding protocols to allow MHD and RSNs to track the provision of other best practices.** We recommend that MHD develop additional HIPAA-compliant encounter coding modifiers so that all best practices of interest within the public mental health system are tracked, using a mix of coding strategies, including procedure codes, procedure code modifiers, and program codes identifying specific groups of individual providers within agencies. In addition, protocols governing the use of these codes will need to be defined and enforced.
- **BP Recommendation #7: MHD should prioritize three to five of the following best practices for statewide implementation.** Based on analysis of the potential for each best practice reviewed to reduce inappropriate use of restrictive services (inpatient and residential), promote cross-system integration, support culturally relevant and competent care, and facilitate recovery for adults and resilience for



children and their families, the following five practices are recommended for statewide implementation:

- Peer support services provided directly by **Consumer and Family-Run Organizations**,
 - **Integrated Dual Disorder Treatment (IDDT)** for persons with severe co-occurring mental health and substance use disorders,
 - **Wraparound Service Coordination** for children with severe emotional disturbances and their families who are served by multiple state agencies,
 - **Multidimensional Treatment Foster Care (MTFC)** for children needing intensive out-of-home services, but able to receive care safely in a family-based setting, and
 - **Collaborative Care in Primary Care Settings** for populations, such as older adults, most effectively served by mental health clinicians located in primary care settings.
- **BP Recommendation #8: 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. For any RSN that has not provided the level of targeted best practices that was funded, the difference between the documented costs incurred for targeted best practice services provided and the amount allocated should be paid back to MHD and the federal portion paid back to CMS.** While the change in rate calculation methodology from upper payment limits to actuarially sound rates [under 42 CFR 438.6(c)] in August 2002 has led to many challenges for states, it also allows states to more proactively employ actuarial analysis both to set rates and ensure PIHP contractor accountability. We recommend that DSHS allocate additional actuarial time to MHD to allow for such analyses

The report also analyzed important issues related to MHD's relationship with each of Washington's 29 federally-recognized Tribes, issues that directly affect the availability and quality of care for Tribal members and other Native Americans across the State. The following specific recommendations are offered for additional consideration and implementation by MHD:

- **Tribal Government and Member (TGM) Recommendation #1: Develop a handbook to guide RSNs in their interactions with Tribal governments and Tribal providers.** We recommend that a handbook for RSNs be developed that lays out in one place the requirements to guide RSN interactions with Tribes and their members. The handbook should describe the multiple choices that Tribes and Tribal members have for accessing mental health services and the role of the RSN within that. In addition, it should describe the rights that Tribes have to make choices in how they involve RSNs in the mental health care of their members. It should also incorporate guidance on the involvement of Tribal providers in RSN networks, as well as Tribal members in the provision of care, including clinical family members.
- **TGM Recommendation #2: Develop a clear policy for the involvement of IHS and 638 facility providers in 1915(b) waiver networks.** We recommend that willing



IHS and Tribal 638 facilities able to comply substantially with RSN credentialing requirements be allowed to participate in RSN networks without CMHA licensure. We further recommend that RSNs be required to provide technical assistance to IHS and Tribal 638 facilities that desire to participate in their networks, but that are not yet able to comply with credentialing requirements. Regulations by MHD to enact these recommendations should be developed with the involvement of Tribal governments, Tribal providers, RAIOS, and RSNs. Such requirements are likely to increase the administrative costs to RSNs to administer their networks and provide technical assistance to providers, so consideration of this should be factored into the administrative component of rate setting. As part of this effort, MHD should consider whether it makes sense to convene a work group to explore mechanisms for direct contracting with Tribes.

- **TGM Recommendation #3: Convene a work group to develop recommendations on how to incorporate Tribal traditional healing practices within the public mental health benefit.** We recommend that MHD work through the Tribal Mental Health Work Group in collaboration with all 29 federally-recognized Tribes to convene a work group to study the traditional healing practices of all of Washington's 29 federally-recognized Tribes.
- **TGM Recommendation #4: Incorporate specific provisions for the inclusion of Tribes in any systematic efforts to promote best practices.** As MHD develops initiatives in response to the broader recommendations of this report, specific provisions to ensure the inclusion of Tribes should be incorporated, particularly regarding the development of integrated mental health / substance abuse services and integrated mental health / primary care services.
- **TGM Recommendation #5: Continue facilitation of statewide forums such as the Tribal Mental Health Work Group and ensure the participation of senior staff in these forums.** We recommend that MHD continue these meetings on a monthly basis and designate at least one senior staff member reporting to the Division Director to consistently attend these meetings.



Appendix One: Additional Detail on Washington’s Managed Mental Health Care System, Medicaid State Plan, and Waiver Services

Background

The evolution of Washington’s managed mental health care system began with the creation of the Regional Support Network (RSN) infrastructure in 1989, continued through the initiation of the Medicaid managed care program in 1993, and reached the milestone of a fully integrated Medicaid managed care system by 1997.

The Washington State Legislature passed the Mental Health Reform Act (2SSB 5400) in 1989 and created a single point of local responsibility for mental health services. This 1989 legislation created single and multi-county RSNs to design and administer mental health delivery systems, receive and coordinate available resources, and meet the unique needs of local residents with mental illness. Although the RSNs addressed the issue of coordination of outpatient and state hospital care, prior to 1993 they did not have the responsibility to manage the Medicaid benefit.

The Mental Health Division (MHD) began managing Medicaid mental health services under a 1915(b) waiver in 1993 for outpatient mental health services and integrated community hospital services into the program in 1997. The full risk capitated managed mental health system gives RSN’s the ability to design an integrated system of mental health care and subcontract with a network of Community Mental Health Agencies (CMHAs) capable of providing necessary non-inpatient services. Full-risk managed care systems such as Washington’s give states both the financial leverage necessary to control the rate of expenditures and the cross-system infrastructure to work to improve the quality of services.

Washington’s Medicaid managed mental health care system has undergone several significant developmental changes since 2002. These include development of the Access to Care Standards (ACS)⁸⁴ and significant changes to the State Medicaid Plan in 2003 in response to critical reviews from the Center for Medicare and Medicaid Services (CMS), as well as implementation of an External Quality Review (EQR) process in 2004. They also include the enhanced oversight and standardized managed care requirements for RSNs established legislatively by E2SHB 1290 and the 2005-06 RSN procurement process.

The Current Federal Climate

While many of these changes were driven by forward-looking reforms and initiatives at the state level, including the 2005 Joint Legislative & Executive Mental Health Task Force, these changes also took place in the context of wider changes at the federal program level that affected all states delivering Medicaid managed care services. The federal changes are reviewed below.

⁸⁴ The Access to Care Standards (ACS) were implemented as a condition of waiver approval by CMS in 2001.



Change in Rate Calculation Methodology from Upper Payment Limits to Actuarially Sound Rates. In August 2002 CMS revised requirements for calculating rates in managed care programs by removing the upper payment limit (UPL) requirement (42 CFR 447.361). This limit had previously required managed care spending to remain the same or lower than prior projected fee-for-service levels. Washington, like most states implementing Medicaid managed care, had set its UPL using historical fee-for-service data from the early 1990s that had increasingly become outdated. While Washington State engaged actuaries as part of its rate setting during this time, the UPL defined the limit of rate growth and set the parameters for actuarial calculation during this time. As the original fee-for-service data used to set UPLs for states operating under 1915(b) waivers became outdated nationwide, the validity of the UPL approach became a concern and CMS modified federal regulations to eliminate the UPL and instead require that rates be actuarially sound [42 CFR 438.6(c)]. Revisions to the federal regulations became effective in August 2003. This change in basis for rate calculation had multiple effects.

On the one hand, state's experienced a loss of flexibility as future rate setting calculations were limited to encounters that could be counted, tied to Medicaid recipients, and priced on a per unit basis. Under the UPL approach, many states had adopted flexible funding formulas that were not tied to specific services delivered. "Savings" left over after the delivery of all necessary Medicaid services were used to fund a broad array of alternatives, including in many cases services for non-Medicaid populations. The primary experience of the change from the UPL for many states was the "loss" of funds used for non-Medicaid populations and the need for systems at the state and local managed care organization levels to begin to more accurately track encounters and fees paid. While this led to much consternation and significant difficulties for states trying to come into compliance with the new rules, the elimination of the UPL also afforded states increased flexibility during rate setting to project future costs in excess of the costs of current care delivery. States are only now starting to realize the opportunities inherent in rate setting methodologies that allow them to adjust rates upward in response to projected changes in the pattern, levels, and costs of service delivery.

Enhanced Reporting Requirements for State Plan and Waiver (B-3) Services. As part of the new regulations governing rates implemented in August 2003, CMS began to require State Medicaid Agencies operating managed care programs under a 1915(b) waiver, such as Washington's, to track and determine payment rates for services covered under the State Medicaid Plan separately from payment rates and services covered under Section 1915(b)(3) of the state's managed care waiver (referred to as "B-3" services). Section 1915(b)(3) services are those services provided in addition to State Medicaid Plan services as a result of savings achieved from operating a managed care program. This enhanced accounting created the need for many states, including Washington, to quickly implement Medicaid State Plan Amendments and waiver revisions to be sure that services provided fell either under State Plan or waiver-based B-3 service definitions.

Enhanced Quality Standards for Managed Care Plans. The Balanced Budget Act of 1997, implemented in August 2003 under 42 CFR 438, required states to implement External



Quality Review (EQR) standards for quality, timeliness, and access for the health care services furnished to Medicaid recipients by managed care organizations. These new standards drove Washington's development of an EQR process in 2004, as well as many of the new requirements built into the 2005-06 RSN procurement.

Enhanced Scrutiny of Rehabilitative Services. States around the nation have experienced enhanced scrutiny of any changes requested to their Rehabilitative Services over the last two years. In particular states have experienced questioning of bundled per diem rates and services in 24-hour care settings that included non-medical supports such as room and board and other non-treatment costs. Washington State has taken steps to construct its per diem rates without such non-medical costs. CMS is expected to issue more stringent requirements for Rehabilitative Services in 2007 addressing these and other issues.

Enhanced Scrutiny under the Deficit Reduction Act of 2005. Finally, the Deficit Reduction Act of 2005 (enacted in February 2006 as PL 109-171) required states to more closely scrutinize specific service types, including case management, targeted case management, and related individual interventions to coordinate services for children involved in mental health and child welfare systems (Section 6052). CMS currently expects to promulgate rules related to the Deficit Reduction Act in 2007.

This developmental context is important for understanding both the recent past from which the system has evolved, as well as the current status of Washington's Prepaid Inpatient Health Plan (PIHP – the technical term with which CMS categorizes Washington's Medicaid mental health managed care plan). Key changes include:

- **Development of the Rehabilitative Services Plan Modalities.** The current 18 modalities defined under the Rehabilitative Services section of Washington's Medicaid State Plan were developed in response to CMS concerns expressed immediately following the shift from the UPL rate methodology to the actuarially sound rate requirements, with their accompanying need to specify State Plan and B-3 modalities. In response, a multi-stakeholder group involving MHD, RSNs, and others came together and defined an initial list of approximately 30 modalities. Through negotiations with CMS, the current 18 modalities were agreed upon. Given the pressure of the situation under which they were developed, it is remarkable that MHD was able to achieve the breadth of progressive service types within the State Plan that resulted (for example, Peer Support and very permissive Individual Treatment services). This will become clearer later in this section when we compare Washington's Medicaid State Plan to the benchmark states.

The drawback was that the resultant State Plan language reads more like a laundry list than an integrated and broadly defined conceptual description. While this is not necessarily problematic, a list as specific as Washington's can make innovation more challenging as service types must conform to specific service attributes specified in the State Plan. For example, Washington's current definition of Peer Support limits availability to four hours per enrollee per day. Under a managed care plan, there might



be scenarios under which an RSN would want to be able to provide more Peer Support than this to avoid use of a more expensive service. Similarly, the Mental Health Services in Residential Settings requires a minimum of eight hours of service per day. While other modalities might be used to provide less intensive services in residential settings, our discussions with stakeholders found that some RSNs are reluctant to provide less intensive residential services due to the State Plan language.

More preferable is the more flexible language found in Rehabilitative Services definitions such as Arizona's long-standing definition or Kansas' recently approved definition, both of which offer the broadest possible support for ongoing service development beyond the specific service set that is currently in place.

- **Development of the Access to Care Standards.** The Access to Care Standards (ACS) which govern both eligibility and medical necessity determinations for the current Medicaid system were developed in response to a contingency from CMS on Washington's 2001 waiver renewal approval. The contingency required Washington to develop a single standard for determining initial authorization for outpatient services. The contingency on the waiver came about after CMS found differential entrance criteria and prior authorization determinations during on-site reviews of multiple RSNs. In response, Washington worked with CMS to develop a standardized process for applying eligibility and medical necessity standards for accessing care over the next year, the same year during which CMS was promulgating the EQR requirements for network adequacy and access to services.

The Washington ACS requirements were a response to pressure from CMS for more uniformity and standardization. The original goal was to develop a standard set of level of care requirements, encompassing standard initial authorization, continuing stay, and discharge criteria for outpatient services. By the time of implementation, only the initial authorization standards were completed, with the continuing stay and discharge standards put on hold (related to this, the ACS specifically notes that the standards are not to be used for continuing stay decisions). The ACS requirements were originally conceptualized as an initial step toward standardizing access to care to set a minimum level of access statewide, which RSNs would be free to go beyond if they had Medicaid savings. In subsequent negotiations with CMS the ACS became restrictive allowing only those who met the eligibility criteria to be served, and the use of savings was restricted to only providing B-3 services to those who met the ACS. The result prevented the delivery of care to people whose needs could not be documented at a moderate to severe level of impairment as defined in the ACS.

Since then, E2SHB 1290 has formalized rule changes flowing from the broader federal changes discussed above (Balanced Budget Act of 1997 requirements under 42 CFR 438, including External Quality Review (EQR) standards) and these standards include access provisions that go well beyond the scope of the ACS requirements. E2SHB 1290 established comprehensive utilization management standards for RSNs that provide a broad and standardized framework for initial authorization, continuing stay,



and discharge criteria. These utilization management standards are much more rigorous than the initial attempt of the ACS to wed medical necessity to eligibility in response to CMS pressure for consistent standards. However, despite these positive changes in the broader system, the ACS themselves have not been updated to reflect the development of the system over the five years since their crafting.

Washington’s Current Medicaid Managed Care System

Overall, the state and federal level changes just summarized have left Washington in an unprecedented position as it examines its current Medicaid State Plan mental health benefits to determine how well they support its goals for a transformed mental health system. Important transitions have been overcome, and the RSN system is on the soundest footing in terms of managed care standards in its 18 year history. While there is still much work to be done, standards are now in place by which to measure and maintain progress. In addition, MHD and the Legislature continue to examine how best to support the vision of federal law under 42 CFR 438 (which implemented the Balanced Budget Act of 1997 requirements), as well as state requirements under E2SHB 1290 and subsequent legislation. This is the context in which this report examines Washington’s current Medicaid mental health benefit.

While the focus of our discussion of the mental health benefit centers on the 18 modalities of the Rehabilitative Services service category, Washington’s Medicaid mental health benefit is broader than that. It is primarily structured by four components from Washington’s Medicaid State Plan: Inpatient Hospital Services, Under 21 Inpatient Services, Physician Services, and Rehabilitative Services. In addition, other components of the State Plan also create benefits the State must provide (for example, parts of the EPSDT and FQHC benefits covering mental health), but these other service categories do not create discrete service modalities which RSNs must provide. Below we summarize the service types in each of these four State Plan service categories, focusing lastly on the broadest of the four categories, Rehabilitative Services. At the end we describe a fifth category of services, specifically the B-3 services types defined under Washington’s current 1915(b) waiver.

Inpatient Hospital Services. Inpatient hospital services are a mandatory service category for Medicaid State Plans. RSNs are at risk for these services through the PIHP program, but they do not directly provide these services. While the 18 Rehabilitative Services modalities fall under Section 13.4 of the RSN contract that the RSN “must provide,” Inpatient Services fall under Section 13.7, which describes “Service Coordination” responsibilities. Unlike other leading managed care states, RSNs’ primary tool for managing inpatient care is coordination of care and the delivery of outpatient services. In comparison to other states, the ability of RSNs’ to directly provide and manage inpatient care is truncated. This is due to several factors, including: (1) the role of the Designated Mental Health Professional (DMHP – which is regulated outside of the RSN system) which circumvents the RSN prior authorization processes in determining access for involuntary admissions (for which RSNs are obligated to pay), (2) the lack of an ability to set rates (which are currently set by the State using fixed DRG and RCC methodologies), and (3) the lack of a direct claims paying mechanism which adds additional steps to authorization enforcement and paid claims analysis.



Under 21 Inpatient Services. RSNs are also responsible for coordinating inpatient services delivered to children in Children’s Long-term Inpatient Program (CLIP) facilities, although they do not authorize these services or pay for them. As with acute Inpatient Hospital Services, RSNs do not directly deliver these services through their networks. The RSN role again falls under the “Coordination of Care” responsibilities (Section 13.7) of the RSN contract. This is different from many states where the managed care entity directly provides and manages such services. However, unlike acute Inpatient Hospital Services, RSNs are not at risk for the costs of CLIP stays and do not authorize these services. Given the limited CLIP capacity in the State (discussed further in the later section of this report on Stakeholder Concerns), this has less financial impact on RSNs.

Physician Services. In Washington, most psychiatric services are provided under the Rehabilitative Services section of the State Plan under multiple modalities (primarily Medication Management). However, the State Plan also allows for services to be provided by any physician (including psychiatrists) under the mandatory Physician Services section of the plan. There is some lack of clarity regarding authority for Physician Services by RSNs. While the current RSN contract and 1915(b) waiver both require provision of Medication Management (which can be provided by a physician), the RSN contract is silent regarding any responsibility for Physician Services delivered by a psychiatrist and the current 1915(b) waiver specifically excludes them. Additional analysis of the overlap between these two sections of the State Plan will be carried out for future reports of this project.

Rehabilitative Services. The primary focus of the RSN’s PIHP programs are the 18 Rehabilitative Services modalities. These are each defined specifically in the Medicaid State Plan. Comparison states (Arizona and Colorado) and model states such as Kansas (the only state of which we are aware to have a Rehabilitative Services State Plan Amendment approved in the last year) tend to define their Rehabilitative Services broadly in their State Plan and provide more definitive guidance to their managed care organizations and providers through encounter manuals and services guides. In contrast, given the press to incorporate a multitude of specific services into the State Plan described above, Washington put very specific service descriptions directly into its State Plan, and only recently (January 2007) developed more specific encounter reporting guidelines. The 18 Rehabilitative Services Modalities are noted in the table below, organized by three subsets: Care in 24 Hour Settings, Traditional Outpatient Modalities, and Non-Traditional Outpatient Modalities. Note that Individual Treatment Services falls into two categories, since it incorporates both traditional outpatient counseling, as well as more contemporary psychosocial rehabilitative interventions.



Washington's Rehabilitative Services Modalities		
Care in 24 Hour Settings	Traditional Outpatient Modalities	Non-Traditional Outpatient Modalities
Freestanding Evaluation & Treatment	Brief Intervention Treatment	Crisis Services
	Intake Evaluation	Rehabilitation Case Management
Mental Health Services in Residential Settings	Individual Treatment Services	
	Family Treatment	High Intensity Treatment
Stabilization Services	Group Treatment	Peer Support
	Day Support	Therapeutic Psychoeducation
	Psychological Assessment	
	Special Population Evaluation	
	Medication Monitoring	
	Medication Management	

B-3 Services. In addition to the four sets of State Plan services described above, Washington is able to provide three additional service types defined within its waiver under the authority of Section 1915(b)(3). These are all non-traditional services and include: Mental Health Clubhouse, Respite, and Supported Employment.



Appendix Two: Detailed Comparisons with Other States (Arizona, Colorado, New Mexico, and Pennsylvania)

Organization of the Comparison States' Managed Care Systems

Four states were selected for comparison to Washington. The goal of the analysis was to determine how well Washington's Medicaid State Plan and managed care system support evidence-based and promising practices, as compared to other leading managed care states. The four states chosen for comparison are leading managed care states, and key aspects of their managed care system design are contrasted with Washington's in the table on the following two pages.

Four states were selected for comparison to Washington. The goal of the analysis was to identify comparison data and contrast inpatient utilization management processes for other leading managed care states. The four states chosen for comparison are leading managed care states.

Organization of the Comparison States' Managed Care Systems

This subsection summarizes key aspects of each state's managed care system design, comparing these with Washington's. Overall, across these four states, most of Washington's system features are represented. These states also allow us to look at Medicaid systems funded at levels comparable to Washington's (AZ and CO), as well as much lower (NM) and much higher (PA). That being said, Washington is the only state of the five (and the only 1915(b) waiver state of which we are aware) that holds its managed care organizations (MCOs) at-risk for the costs of acute inpatient care, but does not give them full authority for direct contracting, setting payment mechanisms (for example, per diem versus episode-based), fee negotiation, and claims payment. While RSNs are able to authorize voluntary admissions, they are not able to tailor their payment approaches for inpatient care to their local markets. For example, with a hospital that manages care efficiently, an RSN may want to negotiate a flat episode rate to minimize the need for concurrent utilization review. By contrast, with hospitals that have longer than typical lengths of stay, the RSN may want to pay on a per diem basis, approving payment a few days at a time. Direct contractual relationships with hospitals would also allow RSNs to use more creative payment mechanisms, such as higher per diems for the first few days of an episode when care is more intensive or performance incentives for facilities with positive outcomes (such as low levels of readmission). What's more, in cases where inpatient payments are governed by DRGs, the RSNs have no ability to impact the costs of stays, limiting the impact of the care authorizations simply to managing admissions, rather than trying to facilitate more efficient returns to the community. The lack of this broader array of care management tools for inpatient care significantly reduces Washington's ability to manage inpatient care and is a structural feature that cuts across all of the differences with other states noted in this section.



Findings for each state are summarized in the table on the following two pages, then summarized by state in the narrative that follows.



	Washington ⁸⁵	Arizona ⁸⁵	Colorado ⁸⁶	New Mexico ⁸⁷	Pennsylvania ⁸⁸
2006 Population⁸⁹	6,395,798	6,166,318	4,753,377	1,954,599	12,440,621
Per Capita MH Spending Rank (FY2002)⁹⁰	15th	14th	31st	49 th	2 nd
Approximate Per Capita MH Spending (FY2002)⁶	\$92	\$102	\$68	\$37	\$165
Populations Served by Managed Care Organization	Medicaid and State-funded	Medicaid and State-funded	Medicaid	Medicaid and State-funded	Medicaid
Medicaid Mental Health Spending	\$305 million (FY2007) ⁹¹	\$544 million (FY2006, includes substance abuse)	\$164.8 million (FY2006, MH only)	\$235 million (estimate, MH only)	\$1,564.5 million (FY2007 projection, MH only)

⁸⁵ Unless otherwise cited, Arizona-specific data came from the following sources:

Arizona Department of Health Services, Division of Behavioral Health Services. (January 2006). Behavioral health at a glance [Electronic version]. Retrieved at: <http://www.azdhs.gov/bhs/bhsglance.pdf>.

Arizona Department of Health Services, Division of Behavioral Health Services. (2006). Arizona Department of Health Services, Division of Behavioral Health Services and Arizona State Hospital Annual Report [Electronic version]. Retrieved at: http://www.azdhs.gov/bhs/annual_report/annualrpt_fy2006.pdf

Center for Medicaid and Medicare Services (CMS). (November 6, 2006). Arizona Demonstration Fact Sheet. Retrieved at: <http://www.cms.hhs.gov/MedicaidStWaivProgDemoPGI/downloads/Arizona%20Health%20Care%20Cost%20Containment%20System%20Fact%20Sheet.pdf>

⁸⁶ Unless otherwise cited, Colorado-specific data came from: Colorado State Auditor. (November, 2006). Performance Audit: Medicaid Mental Health Rates, Department of Health Care Policy and Financing. Denver, CO: Office of the State Auditor.

⁸⁷ Unless otherwise cited, New Mexico-specific data came from: New Mexico Interagency Behavioral Health Purchasing Collaborative. (October, 2006). Needs assessment, resource inventory, & demographic data. Retrieved at: http://www.bhc.state.nm.us/pdf/NM_NARID.pdf.

⁸⁸ Unless otherwise cited, Pennsylvania-specific data came from: Pennsylvania Department of Public Welfare, Office of Mental Health and Substance Abuse Services. (March 9, 2006). Budget Briefing 2006-2007. Retrieved at: <http://www.dpw.state.pa.us/General/FormsPub/MentalHealthPublications/003672619.htm>.

⁸⁹ U.S. Census Bureau. Retrieved on February 20, 2007 from <http://www.census.gov/popest/states/NST-ann-est.html>.

⁹⁰ Lutterman, T., Hollen, V., & Shaw, R. (2004). *Funding sources and expenditures of state mental health agencies: Fiscal Year 2002*. Alexandria, VA: NASMHPD Research Institute.

⁹¹ Mental Health System Transformation Initiative Implementation, Community Forum [Electronic version]. (November 15, 2006). Washington State Department of Social & Health Services.



	Washington	Arizona ⁸⁵	Colorado ⁸⁶	New Mexico ⁸⁷	Pennsylvania ⁸⁸
Medicaid Members	1,088,078 (FY2006) ⁹²	994,293 (FY2006)	383,000 (FY2006)	411,000 (10/2006) ⁹³	1,280,000 (FY2007 projection)
Medicaid Members Served in Managed Care	Community Outpatient Only: 101,095 (FY2005) ⁹⁴	Data Not Available	All MH Services: 45,000 (FY2005)	Data Not Available	All BH Services: 130,903 (FY2004-05) ⁹⁵
Number of State Psychiatric Hospitals	Two	One	Two ¹¹	One	Eight
Medicaid Waiver Authority⁹⁶	1915(b)	1115	1915(b)	1915(b)	1915(b)
Date Started MH Managed Care	1993 (completed in 1997) ⁹⁷	1982 overall; 1990 for behavioral health (completed in 1995)	1995 (completed in 1998)	2005 ¹²	1997 (completed in 2007)
Organizational Structure	Regional Authorities selected by State	Regional Authorities selected by State	Regional Authorities selected by State	Single Statewide Entity with Regional Advisory Boards	County MCOs selected by County; Regional MCO for rural counties selected by State

⁹² J. Hall, MHD, Personal Communication, June 12, 2006.

⁹³ New Mexico Medical Assistance Division. (July 5, 2007.) Monthly All Client Eligibility Report. Retrieved at: http://www.hsd.state.nm.us/mad/pdf_files/Reports/AllClient.pdf.

⁹⁴ Current reporting does not break down inpatient or crisis use for Medicaid recipients.

⁹⁵ HealthChoices (Pennsylvania's Medicaid managed care program) enrollment was projected to be higher in FY2007 because of the expansion of the HealthChoices program statewide. Prior to expansion, enrollment was closer to 1 million.

⁹⁶ Data on Waiver Authority for all States came from the following source: U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services. Retrieved at http://www.cms.hhs.gov/MedicaidStWaivProgDemoPGI/08_WavMap.asp

⁹⁷ Washington State's Mental Health Transformation Project (SAMHSA Grant # 6 U79 SM57468-01-2). (September, 2006.) Washington Mental Health Transformation Plan – Phase 1: p. 2. Retrieved at: http://mhtransformation.wa.gov/pdf/mhtg/CMHP_WithAppendix.pdf



	Washington	Arizona ⁸⁵	Colorado ⁸⁶	New Mexico ⁸⁷	Pennsylvania ⁸⁸
Number of Regions	13 Regional Support Networks (RSNs) serve single and multi-county regions	6 General Service Areas (GSAs) served by 4 Regional Behavioral Health Authorities (RBHAs); plus 4 independent Tribal RBHAs	5 Behavioral Health Organizations serve five single and multi-county regions	One statewide plan, advised by 15 Local Collaboratives	12 Behavioral Health Managed Care Organizations (BHMCOs) serve 25 counties; one region of 42 rural counties to start 2007
Risk for Acute Inpatient Care	Full	Full	Full	Full	Full
Oversight of Acute Inpatient Hospital Services	RSN coordinates this service & authorizes voluntary care (prior and concurrent); State pays claims, negotiates rates; Counties oversee involuntary admissions	RBHA directly delivers this service & pays claims, negotiates rates, authorizes all inpatient care (prior and concurrent, voluntary and involuntary)	BHO pays claims, negotiates rates, authorizes all inpatient care (prior and concurrent, voluntary and involuntary)	Statewide Entity pays claims, negotiates rates, authorizes all inpatient care (prior and concurrent, voluntary and involuntary)	BHMCO pays claims, negotiates rates, authorizes all inpatient care (prior and concurrent, voluntary and involuntary)



Arizona. Arizona is in many ways the state most like Washington. It is comparable in terms of size, per capita mental health spending (14th compared to Washington at 15th), Medicaid spending (keeping in mind that Arizona’s benefit includes both substance abuse and mental health spending), Medicaid members (around 1 million), and a system of regional authorities managing its Medicaid behavioral managed care program. It has only one state hospital, in the middle of the state, which has much less capacity than Washington’s two state hospitals. However, the design of Arizona’s system is significantly different from Washington in several ways:

- It operates under an 1115 waiver, which gives it more flexibility than a 1915(b) waiver.
- Unlike Washington, Arizona’s regional MCOs directly contract, negotiate fees, and pay claims for community hospital inpatient care.
- The system is organized into six regions, plus four autonomous tribal authorities. The regions are in general much larger than Washington’s in terms of covered lives (Washington has four regions with fewer than 25,000 lives and six with fewer than 60,000).
- Its managed care system began operating in 1982, predating most waivers across the country. However, its behavioral health component predated Washington’s mental health program by only two years.
- Eligibility requirements center on diagnosis and are very broad. The current Regional Behavioral Health Authority (RBHA – analogous to Washington’s RSNs) contract states that coverage is available for “any behavioral or mental diagnosis and/or substance use (abuse/dependence) diagnosis found in the most current version of the DSM or ICD.”
- Medical necessity is defined separately from eligibility, as opposed to Washington’s ACS that combines the two for prior authorization.

Colorado. This state was selected as a leading managed care state with a 1915(b) waiver similar to Washington’s. Both Washington and Colorado have their PIHP’s organized into regions and both have only two state psychiatric hospitals. Colorado’s per capita mental health spending is lower, but its Medicaid mental health spending per member is higher. Its managed care system was initiated about the same time as Washington’s, and it has faced many of the same struggles updating its encounter tracking in response to heightened CMS requirements.⁹⁸ Key differences include:

- Unlike Washington, Colorado’s regional MCOs directly contract, negotiate fees, and pay claims for community hospital inpatient care.
- It is comprised of five regions, and the regions are in general larger than Washington’s in terms of covered lives (none of Colorado’s regions has fewer than 40,000 lives, though two have fewer than 60,000).
- Eligibility requirements center on diagnosis only (there are no impairment standards), but are otherwise similar in scope to Washington’s in terms of diagnoses covered.
- Medical necessity is defined separately from eligibility, as opposed to Washington’s ACS that combines the two for prior authorization.

⁹⁸ Colorado State Auditor. (November, 2006). Performance Audit: Medicaid Mental Health Rates, Department of Health Care Policy and Financing. Denver, CO: Office of the State Auditor.

New Mexico. New Mexico is in some ways similar to Washington in that it is one of the six states awarded federal Transformation State Infrastructure Grants in 2006, and it operates its Medicaid mental health managed care system under a 1915(b) waiver. However, it has many differences from Washington:

- It is much smaller, with less than one-third the population of Washington.
- Its level of mental health funding per capita is much lower (second to last nationally).
- It is organized to deliver care through a single Statewide Entity that coordinates care across 6 regions advised by 15 Local Collaboratives and delivers mental health services on behalf of 15 different state agencies, in addition to Medicaid.
- Unlike Washington, New Mexico’s statewide MCO directly contracts, negotiates fees, and pays claims for community hospital inpatient care.
- Eligibility requirements center on diagnosis only (there are no impairment standards), but are otherwise similar in scope to Washington’s in terms of diagnoses covered.
- Medical necessity is defined separately from eligibility, as opposed to Washington’s ACS that combines the two for prior authorization.

Pennsylvania. This state is at the other extreme from New Mexico in terms of differences from Washington. While similar in terms of operating a managed care system under a 1915(b) waiver, organizing its system by single and multi-county regions, and being viewed as a leading managed care state, Pennsylvania’s similarities to Washington end there. Key differences include:

- It has nearly twice the population and much higher overall mental health spending that ranks 2nd nationally.
- It has five times the level of Medicaid mental health care spending, but less than 20% more members.
- It operates eight state hospitals, instead of two.
- Unlike Washington, Pennsylvania’s regional MCOs directly contract, negotiate fees, and pay claims for community hospital inpatient care.
- Eligibility requirements center on diagnosis and are very broad, including V-codes.
- Medical necessity is defined separately from eligibility, as opposed to Washington’s ACS that combines the two for prior authorization.

In summary, across these four states, most of Washington’s system features are represented. These states also allow us to look at Medicaid benefit designs funded at levels comparable to Washington’s (AZ and CO), as well as much lower (NM) and much higher (PA). That being said, several structural features are unique to Washington:

- Washington’s eligibility requirements include the DC:0-3 standards for infants and toddlers, which gives the state more diagnostic flexibility in treating the mental health needs of early childhood. Colorado has begun to develop a cross-walk between these standards and ICD-9 diagnoses to support such services, but it does not directly allow services to be delivered for those categories. Other states are only beginning to address the need for different diagnostic categories for young children.
- Washington is the only state of the five that imposes functional impairment requirements as a means of determining service eligibility. Other states incorporate



impairment scores using the GAF into discrete level of care guidelines for medical necessity, but none require such impairment for entry into the system. This appears to significantly reduce access to community services in Washington, as compared to these other states, and may limit Washington's ability to promote less intensive community services before symptoms exacerbate. The primary rationale for implementing this impairment requirement was a perception in 2001 that it would reduce costs by limiting access to services. However, we have not found such cost savings in our reviews of other states. By limiting access when impairment is relatively low, the ACS may just as likely be increasing costs overall by excluding some low cost cases and delaying the provision of care for others until conditions worsen and are more expensive to treat. We are not aware of any definitive studies of these issues, but it is true that many states' managed care entities (including those in all four of the comparison states in this report and other states such as Connecticut, Iowa, Florida, and Massachusetts) have eliminated prior authorization requirements for outpatient care across the board until a minimum number of sessions have been provided (generally ranging from six to ten, and sometimes higher). The rationale for this has generally been that the cost of managing this care (particularly utilization management staff reviewing outpatient service requests) has exceeded the possible cost savings in diverting inappropriate low level (and low cost) outpatient care. In fact, we are not aware of any state other than Washington that requires the provision of prior authorization for all outpatient care, including low level requests.

- Washington is the only state of the five (and the only 1915(b) waiver state of which we are aware) that holds its managed care organizations to be at-risk for acute inpatient care, but only requires them to coordinate the delivery of such care, rather than directly deliver the service through their regional networks. This significantly reduces Washington's available tools for managing inpatient care and is a structural feature that may limit its ability to shift funding from restrictive settings to community-based, evidence-based and promising practices.
- Washington operates independent managed care plans with very relatively few covered lives, including four regions with fewer than 25,000 lives and six with fewer than 60,000. Of the comparison states reviewed, none operate regions with fewer than 40,000 covered lives and only Colorado operates regions with fewer than 60,000 lives.

Medicaid Benefit Design

Our comparison of Washington's Medicaid State Plan benefits includes two levels: (1) an overall comparison of the language defining Rehabilitative Services among the five states (as well as additional comparison to a model example from the state of Kansas) and (2) a modality-by-modality comparison contrasting each modality from Washington's State Plan with the State Plan modalities and encounter reporting requirements of the four comparison states.

State Plan Language. We discussed in Appendix One how Washington's Rehabilitative Services language defining the limits of most of its mental health services (found in the Supplement to Attachment 3.1A of the State Plan) is more highly specified than those of other



states. Our opinion is that an integrated and broadly defined conceptual description in the State Plan, backed up by a very specific set of encounter reporting requirements, is the ideal combination for a State Plan in terms of the promotion of best practices. Such an approach gives the maximum level of flexibility between the State and CMS, and allows for the broadest possible support for ongoing service development beyond the specific service set that is currently in place, an attribute increasingly necessary given the increasingly rapid pace of best practice development and adoption. In addition to the flexibility of the broad State Plan definitions, more specific direction in the form of detailed service descriptions at the level of specific encounter codes (CPT/HCPCS) gives direction to providers and alleviates both the lack of uniformity and the innovation-chilling anxiety that can affect providers asked to interpret State Plan modalities without the benefit of detailed coding guidance.

A good example of how such an approach more effectively facilitates the use of evidence-based practices can be seen by looking more closely at the example of Washington's current modalities and how they support interventions in residential settings. Several of the best practices noted earlier in this report take place in residential-like settings, including Supportive Housing for adults and Multidimensional Treatment Foster Care (MTFC) for children. The only two current modalities that specifically address care in residential settings are Mental Health Services in Residential Settings and Stabilization Services. However, both of these have specific conditions that limit their use to fund Supportive Housing or MTFC (primarily the criteria for eight hours of service per day for Mental Health Services in Residential Settings and the two-week limit for Stabilization Services). Now, some RSNs are nonetheless providing Supportive Housing and MTFC using other modalities (primarily High Intensity Treatment Services or knitting it together with Individual Treatment Services, Family Treatment, and Group Treatment). However, other RSNs and some providers noted that they are not comfortable providing such services under the State Plan given a lack of clarity on their appropriateness. Support of Supportive Housing and MTFC would be more sound in Washington if the January 2007 Service Encounter Reporting Instructions were to include in future versions specific codes or guidance for reporting Supportive Housing and MTFC under a consistent modality. Furthermore, rate setting would be better supported if all Supportive Housing and MTFC were delivered under a consistent coding scheme. Broad State Plan language and specific encounter reporting instructions would offer the soundest footing.

We will further explore the aspects of this approach throughout this subsection. However, we also offer a caution. Just because we contend that more conceptual and broader language in the State Plan would be ideal from the perspective of best practice promotion, it does not necessarily follow that such changes to the State Plan should be pursued. Given the current climate at CMS in response to State Plan Amendments for Rehabilitative Services described earlier, changes to Washington's current plan should only be pursued if no alternative approach within the current plan (or B-3 waiver options) is available.

Arizona provides a good example of the broadest possible State Plan language for Rehabilitative Services. The entire text of the Rehabilitative Services limitations from the Supplement to Attachment 3.1A of their State Plan is provided in the following single sentence:



Rehabilitative Services provided by a behavioral health and/or substance abuse rehabilitation agency.

That single sentence is the entire Rehabilitative Services section of Arizona’s State Plan. The only limitation specified simply requires that the services be provided by an agency, rather than individual providers. What is more, Arizona defines a broad array of agencies eligible to deliver such services under the rubric of a “rehabilitative agency,” including traditional outpatient clinics, as well as community service agencies (which can be consumer or family-run), habilitation providers, and therapeutic foster care homes, among others.

To implement this broad definition, Arizona has developed one of the most specific encounter coding manuals available. Like Washington’s January 2007 Service Encounter Reporting Instructions, the Arizona Covered Behavioral Health Services Guide⁹⁹ defines specific HCPCS and CPT codes for all covered services. However, it goes one step further and provides more detailed guidance in terms of defining specific services to go with each code. While Arizona’s Medicaid State Plan is much more general than Washington’s, their encounter manual is much more specific. Furthermore, Washington is the only state of the five reviewed (and the only state of which we are aware) that uses the exact same service definitions in its Medicaid State Plan as in its encounter reporting guide.

In addition, Arizona’s plan balances this broad agency inclusion with a similarly broad role for Other Practitioners’ Services, an optional State Plan category that Washington currently does not include in its RSN service array. Non-agency behavioral health providers are specifically included in Arizona, and the limitations to this service define a very inclusive role for non-physician behavioral health professionals, some practicing in “approved behavioral health settings” and other practicing independently. This is defined in the following excerpt:

Non-physician behavioral health professionals, as defined in rule, when the services are provided by social workers, physician assistants, psychologists, counselors, registered nurses, certified psychiatric nurse practitioners, behavioral health technicians, and other approved therapists who meet all applicable state standards. Except for behavioral health services provided by psychologists, certified psychiatric nurse practitioners and physician assistants supervised by AHCCCS registered psychiatrists, all non-physician behavioral health professional services shall be provided by professionals affiliated with an approved behavioral health setting, in accordance with AHCCCS policies and procedures.

Colorado took a similar approach for its Rehabilitative Services. While its definition does include a list of specific modalities referenced in statute, it concludes with very broad language allowing for an array of other services in community mental health center settings:

. . . any medical or remedial services recommended by a physician, which may reduce physical or mental disability, and which may improve functional level. Such services

⁹⁹ See http://www.azdhs.gov/bhs/bhs_gde.pdf for a copy of the guide.

*shall be provided to Medicaid-eligible individuals **by a licensed community mental health center or clinic** under the direction of a physician when deemed to be medically necessary. [emphasis added]*

Colorado did not follow the approach of Arizona in adding a broad definition of Other Practitioners' Services within its State Plan to complement agency services with those of independent providers. However, through its 1915(b) waiver, Colorado allows its managed care entities to enroll independent psychiatrists, psychologists, and licensed mental health professionals directly in their networks as independent providers.

New Mexico has followed a similar approach to that of Colorado, with its State Plan a mix of some specifically defined modalities such as Assertive Community Treatment and more broadly defined EPSDT and Rehabilitative Services options for a broad array of psychosocial supports. Unlike Colorado (but similar to Arizona), New Mexico provides no service modalities under its waiver authority (B-3): all of its modalities are within its State Plan.

Within its State Plan, New Mexico defines detailed and broad parameters for providing services to disabled children under EPSDT authority. Both community mental health agencies and independent licensed providers can provide services. The State Plan also provides broadly defined Rehabilitative Services. This is defined in the following excerpt:

5. Psychosocial Interventions: Provides rehabilitation services toward the remediation of functional limitations, deficits, and behavioral excesses exhibited in patients. Services focus on improving daily living skills, impaired social skills, and problem solving.

Under this broad authority, New Mexico provides Comprehensive Community Support Services for adults with SMI and children with SED that include a wide range of community-based supports, as well as peer support by Certified Peer Specialists and Family Specialists. Psychosocial Rehabilitation Services are also provided (including broadly defined clubhouse services), as well as home and community-based Behavior Management Services for children. Specific EBPs are provided with specific encounter reporting codes, including Assertive Community Treatment (which is defined in the State Plan) and Multisystemic Therapy (which is not specified in the State Plan, but is offered under EPSDT authority).

Several types of services are not reimbursed by Medicaid, including residential services for adults, supported employment, respite, family training for children under age 3, and other home-based services for children and families. Psychoeducation and flexible funds are not covered.

Stepping back, we see that Arizona most clearly, and to lesser extents Colorado and New Mexico, have taken a two-fold approach to defining their primary outpatient mental health benefit, combining (1) an agency-focused Rehabilitative Services benefit that is both conceptual and inclusive coupled with a detailed service guide defining the specific codes that can be reported and (2) an inclusive set of Other Practitioners' Services. The state of Kansas



followed this approach in 2006 when developing a State Plan Amendment to define services for its newly approved 1915(b) waiver. At the time, Kansas was under close scrutiny from CMS following a very negative audit. While the Rehabilitative Services language used in Kansas is significantly more detailed than Arizona's (language as broad as Arizona's is unlikely to be approved in the current climate and outside of an 1115 waiver), it is still conceptual in its focus and does not include any specific minimums in terms of hours of service availability, service length, or narrow agency limitations. It includes only five Rehabilitative Services modalities instead of Washington's 18, and each is broad enough to encompass multiple, more specific encounter codes. As far as we are aware, the Kansas amendment was the only Rehabilitative Services State Plan Amendment approved by CMS in the last year. It is included in Attachment One for your reference.

Pennsylvania's Medicaid State Plan is at the other extreme. Most of its services are traditional and are provided under its Clinic Option. These clinic services include many specific limitations in the State Plan, including maximum numbers of hours for psychiatrist and outpatient visits. Furthermore, these services can only be provided in clinic settings. It also includes a few Rehabilitative Services, including crisis supports for all ages and family-based (in-home) services for children. In the last year a State Plan Amendment has been submitted to add two additional Rehabilitative Services: Mobile Outpatient Services (individual, group and family interventions outside of a clinic setting) and Peer Support. The plan also includes broadly available Psychiatric Residential Treatment Facility (PRTF) services (Under 21 Inpatient), broad-based rehabilitative supports for children under EPSDT, multiple levels of acute and sub-acute psychiatric Inpatient Hospital Services, and Targeted Case Management.

Given the traditional focus and restrictions of Pennsylvania's plan, most of its non-traditional, community-based services are delivered either under the EPSDT rubric for children or expanded 1915(b) waiver services for adults. Under its waiver, Pennsylvania does not require its managed care organizations (referred to as Behavioral Health Managed Care Organizations or BHMCOs) to abide by limitations in the State Plan on service frequency. Furthermore, a host of supplemental services (similar to Colorado's and Washington's B-3 services) have been developed.

In addition, like Washington and Colorado, Pennsylvania has only recently begun to offer guidance to its managed care organizations (BHMCOs) to promote standard encounter reporting under its State Plan and waiver categories for community-based services. Traditional inpatient, residential, and clinic-based services are readily reported and comprise a large proportion of ongoing costs. However, community-based waiver and EPSDT services vary across BHMCOs and make promotion of EBPs difficult. The State Plan design and lack of common standards for community-based encounter reporting make both cost-control and EBP promotion difficult.

Analysis by Modality. We also conducted a detailed analysis by modality focused on how Washington's State Medicaid Plan, managed care waiver, and accompanying encounter reporting guide come together to define its covered Medicaid mental health services, contrasting this with how the State Plans, managed care waivers, and encounter reporting



guides of the other four states define their benefits. For the current report, we analyzed Washington's modalities arranged in the three groupings discussed earlier (Care in 24 Hour Settings, Traditional Outpatient Modalities, and Non-Traditional Outpatient Modalities). In addition to the 18 Rehabilitative Services modalities, we also analyzed within these three groupings the three other Medicaid modalities coordinated by RSNs (Inpatient Hospital Services, Under 21 Inpatient Services, and Physician Services) and the three B-3 services.

We included in Appendix Three of the February 2007 Preliminary Report a detailed table providing specific comparisons and identification of issues for each inpatient, physician, rehabilitative service, and B-3 modality analyzed. The table includes in its second column an array of issues identified for each of the modalities reviewed in terms of their flexibility and limits. These issues are summarized below and served as the basis for our cumulative analysis the ability of Washington's Medicaid State Plan to promote best practices.

Care in 24 Hour Settings. Several issues were identified related to inpatient and residential services, including:

- As noted above, RSNs in Washington are at risk for acute Inpatient Hospital Services similar to the four comparison states. While the service modalities are similar across all the states, the other four states allow their managed care organizations to contract directly with hospitals, set rates, and pay claims.
- Other states define sub-acute levels of inpatient care under their Inpatient Hospital Services definition which might be an option for Washington to examine if there is interest in developing less costly inpatient services in hospital settings that, unlike Freestanding Evaluation and Treatment services, could include room and board in their rates.
- Currently two narrowly defined types of residential care are included in the State Plan: Mental Health Services in Residential Settings and Stabilization Services. Both include restrictions within the State Plan that limit their applicability (a requirement for eight hours a day of services for Medicaid coverage of Mental Health Services in Residential Settings and a two-week limit on Stabilization Services). Two of the comparison states with such limitations in their State Plans waive these limits under their Waivers, a practice CMS typically allows in our experience.
- In Washington, those RSNs that want to cover other types of 24-hour services (such as less intensive residential services or therapeutic foster care) do so under other modalities that are not specifically labeled as applicable in residential settings, but that are also neither excluded in such settings. Modalities able to support these other 24-hour services include bundled modalities like Day Support (applicable if the service is at least 5 hours/day, 5 days/week) and High Intensity Treatment (applicable if the service is available at least at a 1:10 ratio and if other requirements apply) or unbundled modalities, such as Individual Treatment Services, Family Treatment, Group Treatment, and Medication Management.

Traditional Outpatient Modalities. Several issues were identified related to traditional, often clinic-based outpatient services, including:



- Brief Intervention Treatment is broken out as a separate modality to allow shorter-term access under the Access to Care Standards and fewer paperwork requirements for services that otherwise would fall under other modalities (Individual Treatment Services, Group Treatment Services, and Family Treatment). It is not clear why a separate modality definition is needed for this, as comparison states typically provide such services under their broad outpatient modalities without a separate modality. Furthermore, paperwork requirements are driven by WAC standards, not the Medicaid State Plan, so it is unclear why a reduction in paperwork requirements would necessitate a separate State Plan modality. This is not necessarily problematic, but it is an example of a State Plan modality that might not need to be implemented if the ACS requirements were revised as recommended later in this report and short-term reporting codes were developed under the broader Individual Treatment Services, Group Treatment Services, and Family Treatment modalities.
- Intake Evaluation is another example of a Washington State Plan modality that is simply a subtype of other broader outpatient modalities in the comparison states (though New Mexico also breaks this out separately). While not necessarily problematic, it is an example of past effort to include detail in the State Plan rather than in an encounter reporting manual.
- Washington’s Individual Treatment Services is a unique category that covers interventions that in other states fall under multiple modalities, most often a mix of clinic-based outpatient services and non-traditional rehabilitation and case management services. As such, this modality fell into both the traditional and non-traditional analysis we conducted. This definition is a significant advantage to Washington State compared to other states as other states face mounting criticism from CMS in recent years over case management and less-defined rehabilitative services.
- Special Population Evaluation services are also a modality unique to Washington. While other states embed such evaluations in their more generic outpatient assessment codes, by highlighting this service Washington has put a special emphasis on specialty cultural or age-based consultation and evaluation that seems to have been successful in promoting and differentially paying for enhanced culturally and age-specific interventions.
- Other states will also cover traditional outpatient services when delivered by an independent practitioner outside of a CMHA setting, either through their State Plan (AZ, NM) or waiver (CO, PA). Washington does not allow this currently, but could under its waiver.
- Physician services are covered in the other four comparison states under the mandatory Physician Services category, rather than as a modality under Rehabilitative Services (Medication Management) like Washington does. Those other states also include Physician Services partially under their waiver (for mental health diagnoses). By covering physician services under two categories, Washington introduces some additional complexity into the benefit design. However, this also gives the potential advantage of covering services for mental health diagnoses under both the carve out and broader primary care physician services under Medicaid, a design feature that may be helpful in promoting collaborative care.



Non-Traditional Outpatient Modalities. Several issues were identified related to non-traditional outpatient services and supports, including:

- Washington’s Individual Treatment Services modality covers both traditional and non-traditional outpatient supports, a feature of Washington’s benefit design that seems superior to the comparison states, which tend to cover this range of services under multiple modalities. By including non-traditional skill-building and coordination services under this modality rather than a separate Targeted Case Management or broad rehabilitative category, Washington has avoided potential negative scrutiny by CMS for such categories that other states have had to endure.
- Given the broadness of the Individual Treatment Services definition, it is not clear why a separate modality is needed for Rehabilitation Case Management. Breaking out this service seems to be potentially confusing to providers who need to bill case management type interventions under this modality during transitions from 24-hour care settings and under Individual Treatment Services modalities in other cases. This might be an example of a State Plan modality that could be eliminated (either formally under a State Plan Amendment or informally by simply no longer requiring provision of this service under the waiver).
- The definition of Crisis Services is very broad and could support more specific encounter and reporting codes if more extensive use of evidence-based crisis supports was desired.
- High Intensity Treatment offers a broad base for expanding the promotion of a wide range of intensive evidence-based supports by developing additional encounter codes for reporting in addition to the intensive outpatient, ACT, wraparound, and MST codes currently provided. The current practice of covering STI PACT services outside of this definition make sense, given that it allows enhanced oversight of service quality and availability, ensuring that capacity is available to meet the legislative goals of the STI to reduce inpatient usage. However, once the service is fully established and STI goals adequately achieved, Medicaid reimbursement for PACT could be feasible under this modality.
- Washington’s Peer Support modality is very broad and superior to those of most of the comparison states (other than AZ), which either currently do not cover this service or do so only under their waiver. However, the requirement that the service be provided by a CMHA complicates the peer-nature of service delivery by requiring that it take place in a professional setting. Washington’s waiver could allow delivery of this service in other defined consumer and family-run settings similar to those allowed under Arizona community support agency provider type. While this adds to the administrative burden of provider oversight by the State and managed care organizations, it also allows delivery of these peer-run services by less costly providers. In addition, the limit on use of this service to four hours per enrollee per day should be able to be exceeded as needed by RSNs as a cost-effective alternative under the State’s 1915(b) waiver authority.
- Mental Health Clubhouses must conform to ICCD guidelines under the State’s current B-3 definition. While the comparison states do not include this requirement, by doing so Washington ensures a higher quality of service. Furthermore, less formal drop-in

services could potentially be covered under the current Peer Support modality and could be more widely covered if Peer Support availability was expanded under the waiver to include peer-run agencies.

- The current interpretation of Supported Employment services under the encounter reporting manual requires the consumer to be served either by the RSN or the Department of Vocational Rehabilitation (DVR), and not by both. This interpretation seems more rigid than the language required by the B-3 service description, which focuses on services “currently received” and “provided” by DVR, as opposed to those that would theoretically be “covered” or possibly could be “available”. The B-3 language seems like it could support provision of services by both DVR and the RSN, as long as the two were coordinated at some level to avoid redundancy.
- The B-3 definition of Respite Care is very flexible and the encounter reporting approach is also very flexible, more so than the approaches taken by the comparison states. This definition could support a wide range of evidence-based uses of respite, including crisis diversion. This could conceivably even support longer term use of Stabilization Services beyond the current two week limit; individual cases should be able to exceed this limit as determined by RSNs when this would be a cost-effective alternative to more expensive care under the State’s 1915(b) waiver authority.
- The definition of Therapeutic Psychoeducation is also quite broad and generally superior to those of the comparison states. Limiting the provision of this service to CMHAs does potentially increase costs and limit provision of the service by peer-run organizations. The approaches discussed above for potentially expanding Peer Support to be provided by peer-run organizations could also apply in the case of psychoeducation.
- RSNs are currently prohibited from expending Medicaid funds on flexible non-medical supports. However, other states such as Colorado and Massachusetts do use Medicaid funds to pay for such supports as cost-effective alternatives under the authority of 42 CFR 438.6(e). As such, these costs cannot be included in rate-setting and they can only be used to avoid more costly care. Despite these limitations, other states have found it useful to allow such expenditures in controlling high-cost care.



Appendix Three: Focus Group Findings

Focus Group Approach and Participants

A primary source of guidance for the development of the final recommendations of this report was a series of nine stakeholder focus groups held in February and March. The goal of these focus groups was to elicit stakeholder opinions regarding three primary questions:

- The specific services and supports seen by stakeholders as most helpful in promoting recovery for adults and older adults and resiliency for children and families;
- Barriers and challenges to the promotion of best practices; and
- Perspectives about how well overall access to services affects the ability of the public mental health system to promote best practices.

The focus group findings were central to our analysis of how best to promote best practices, as this process immersed us in the experience of Washington stakeholders who have been receiving services, working in, and living with the State's public mental health system for many years. One adult consumer participant articulated particularly well the hopes of many focus group participants that real change will come about through the STI process: "Have the guts to say what really is and be willing to put your career on the line to make things really better and not just make a tweak." Based on reactions from the group, he spoke for many participants who clearly cared greatly about the input they gave and what will be done with it.

The following stakeholder groups were targeted for participation:

- **Consumers of Mental Health Services.** A total of 33 consumers from eastern and western Washington participated in two focus groups.
- **Parents and Caregivers of Child and Adolescent Consumers.** A total of 14 parents and caregivers of children and adolescents served in Washington's public mental health system participated in two groups.
- **Family Members of Adult Mental Health Consumers.** A total of 11 family members of adult consumers from eastern and western Washington participated in two focus groups.
- **Community Mental Health Agency Clinical Leaders.** A total of 19 representatives from community mental health agencies (CMHAs) serving RSN enrollees participated (western Washington providers attended an in-person focus group and eastern Washington providers requested a telephone conference to reduce the travel burden of participation).
- **STI Task Force Members.** Fifteen (15) of the Task Force members participated in an additional focus group.

Focus Group Methodology

Written notes were taken for each group by the facilitator and an independent note taker. The facilitator's notes were analyzed to identify the "thought units" related to the primary areas of interest: best practice and other service priorities, challenges to implementation, and perspectives on broader access questions. This process involved dividing each set of notes



into what could be called "thought units." As used by Strauss and Corbin (1990)¹⁰⁰ and Rhodes, Hill, Thompson and Elliott (1994),¹⁰¹ the concept of "thought unit" refers to portions of the transcript which express a unique idea.

In addition, most of the focus groups also included the collection of written input from participants regarding the services and supports they saw as best promoting either recovery for adults and older adults or resilience for children and families. The thought units in this written input were also analyzed. Two focus groups did not have this additional written input collected due to logistical issues (one was conducted by phone; the other involved only one family and written input was not practicable).¹⁰² Thought units were grouped into categories of similar units and ranked by the total of number of times that a related thought was expressed, both in the broader discussion captured in the facilitator's notes and in the additional written input provided by participants.

When interpreting the results regarding priority best practices, it is important to keep in mind the context behind the thought units documented in each focus group. Two overall factors are most pertinent. First, the thought units were documented in the context of a discussion about what services best promote recovery and resilience. Thought units may have been expressed as part of that discussion or written down in response to questions about which were "most important." As such, the thought units yield information about what services participants think are most important.

Second, the different focus groups each had different amounts of input from our project prior to responding. The STI Task Force members have had numerous presentations on the best practices we had prioritized, some since November 2006. The other focus group participants were generally considering the information regarding priorities for this first time in this context. While all participants have considerable personal and/or professional experience regarding these services, they had only considered the specific questions we were asking about priorities generally for the first time the day of the group.

In addition, all participants were given handouts at the start of the group listing the best practices we had identified for each group. Generally, the STI Task Force members and CMHA clinical leaders made more direct use of these lists. In the other focus groups, some

¹⁰⁰ Strauss, A. & Corbin, J. (1990). Basics of qualitative research. New York: Sage.

¹⁰¹ Rhodes, R. H., Hill, C. E., Thompson, B. J., Elliott, R. (1994). Client retrospective recall of resolved and unresolved misunderstanding events. Journal of Counseling Psychology, 41, 473-483.

¹⁰² This lack of additional written input complicated analysis of the stakeholder-specific results. For example, since western Washington providers had input captured in two ways (facilitator notes and written input by participants) and eastern Washington providers had input captured in only one way (facilitator notes), there was more opportunity for western Washington thought units to be captured. Since the total number of related thought units was used to set priorities, this created a bias against the eastern Washington provider input. To attempt to correct for this, priorities were analyzed two ways: once using raw thought unit totals and once where the eastern Washington totals were doubled in an attempt to compensate for the difference in data collection methods. While both methods identified the same top concerns, the order of priority varied somewhat. Since the "doubling" method resulted in greater variability across the rankings, we decided to use the raw data when computing overall results across all groups (where results were already variable) and use the "doubling" approach when analyzing within-group priorities.



members read and made use of the lists and others did not. This seems related to the finding that Task Force and CMHA respondents tended to use more technical terms to describe the services than did participants in the other three groups (discussed in more detail below).

Similar protocols based on the same questions were used with each group of stakeholders. In February and early March, TriWest conducted nine in-depth focus groups with 92 diverse stakeholders. The following stakeholder groups were targeted for participation:

- **Consumers of Mental Health Services.** A total of 33 consumers from eastern and western Washington participated in two focus groups. The first group was held in rural eastern Washington. It involved 14 consumers recruited by a local Affiliate Director of the Washington Health Empowerment Network, as well as consumer advocates from Eastern State Hospital and eastern Washington Regional Support Networks (RSNs). The second group was organized and held at Western State Hospital. It involved 19 consumers, of whom 15 actively participated. The group was attended by both consumers currently residing at the state hospital, as well as consumers identified by the Director of Consumer Affairs at Western State Hospital, consumer advocates from western Washington RSNs, and a local consumer group (Consumer Voices Are Born). The focus groups involved 15 men and 14 women who offered input. Three attendees were African American, and one was Hispanic.
- **Parents and Caregivers of Child and Adolescent Consumers.** A total of 14 parents and caregivers of children and adolescents served in Washington’s public mental health system participated in two groups, one held in rural eastern Washington and the other in the Seatac area of western Washington. Only two parents were able to attend the eastern Washington group, due to unexpected schedule changes for the other participants. Twelve (12) parents and caregivers participated in the western Washington group. All participants were recruited by SAFE Washington and RSN advocates.
- **Family Members of Adult Mental Health Consumers.** A total of 11 family members of adult consumers from eastern and western Washington participated in two focus groups. Three attended a group held in rural eastern Washington, and eight attended a group held in the Seatac area. All participants were recruited by NAMI and RSN advocates. The 11 participants represented eight families, and included five men and six women.
- **Community Mental Health Agency Clinical Leaders.** A total of 19 representatives from community mental health agencies (CMHAs) serving RSN enrollees participated. Seven (7) western Washington providers attended an in-person focus group in the Seatac area in mid-February. Eastern Washington providers requested a telephone conference to reduce the travel burden of participation, and one was held with 12 participants in early March. The providers represented 14 different agencies, nine with a primary focus on child and family services, one with a primary focus on adult and older adult services, and 4 that served a full range of child, adult, and older adult consumers. Providers were recruited by the Washington Community Mental Health Council and RSN administrators.
- **STI Task Force Members.** Even though the benefit design project benefits from the input and guidance of STI Task Force members on a monthly basis, we decided to



conduct a focus group with these stakeholders to see if their input varied from that of the other 78 stakeholders who participated in the other focus groups. We were interested in seeing if the input of stakeholders more familiar with the content and focus of our project differed from that of the other stakeholders. Fifteen (15) of the Task Force members participated in the focus group. They represented consumers, parents and caregivers of child and adolescent consumers, family members of adult consumers, community mental health agency clinical leaders, RSN administrators, DSHS allied service agency representatives, federal Transformation grant representatives, legal system representatives, and MHD staff.

When reviewing the data presented below, the reader should keep in mind that there are multiple valid ways to organize and make sense of the information provided through the focus groups. As readers consider the interpretation of results offered in this section, we ask that reviewers be mindful that the approach of counting thought units is an inexact method of prioritizing. While one can legitimately conclude that the topics with the most thoughts expressed were quite likely more on the minds of participants than those with fewer, care should be taken with comparisons between topics with similar numbers of thought units (for example, topics rated 3rd and 4th, or even 3rd and 8th). In our analysis, we have focused on broad levels of priority (such as, the top one, top three, top five, or top ten topics). However, all topics expressed should be viewed as important to at least some participants. We will discuss these broader differences throughout the section and offer our own interpretation of the differences observed.

Focus Group Findings: Priority Best Practices

Adult Services Priorities. By far the most-discussed priority was consumer and family driven services, with an emphasis on peer support in particular, but also included discussion of a broad-range of supports delivered by consumers and families. This priority was discussed more than twice as often as the next-most discussed priority. The importance of consumer and family driven services to the stakeholders who participated cannot be overstated. While family members and providers discussed this less often, it still ranked in their top five. As one consumer put it, “It is also my belief and that of many of my fellow consumers that the relationships / connections developed Peer to Peer in the beginning of one's Recovery Journey truly are the more solid blocks in the foundation of our Recovery Success. That peer that says to us those words of encouragement and hope as well as modeling how to keep moving forward with one's recovery.” The top 10 overall services across all respondents overlapped significantly with those of the four primary stakeholder groups involved with adult services: adult consumers, family members of adult consumers, CMHA providers, and Task Force members. The top ten included: (1) consumer / family driven services, (2) relationship with an individual therapist, (3) employment related services; (4) intensive adult teams (PACT/ACT), (5) housing related; (6) psychoeducation; (7) comprehensive crisis supports; (8) medication related; (9) inpatient services; and (10) integrated substance abuse and mental health services.

The table below presents the top rankings for adult services across the relevant stakeholder groups (all respondents, adult consumers, family member of adult consumers, providers, and



task force members). The focus of the analysis was to identify the top 10 priority supports for each stakeholder group. Rankings across all participants are provided for a range sufficient to cover the top 10 of each group. Gray boxes are used for a category not rated by a given stakeholder group.

Top Adult Service Priorities

Prioritized Support	All	Consumers	Family	Providers	Task Force
Sample Size	88	29	11	19	15
Consumer / Family Driven	1	1	2	5	1
Relationship with individual therapist	2	2	8		9
Employment Related	3	3	3	10	2
Intensive Adult Team (PACT/ACT)	4	7	1	5	10
Housing Related	5	5	6	8	5
Psychoeducation	6	6	3	2	
Comprehensive Crisis Supports	7	>10	6	10	6
Medication Related	8	3	8		>10
Inpatient Services	9	8	3		>10
Integrated SA/MH Services	10	10	10	5	
Clubhouse	11	9	>10		6
Respite	12	>10	>10		2
Illness Management and Recovery	13	>10	>10	3	2
WRAP	14	>10	>10		10
Psychosocial rehabilitation	15	>10		10	6
Diversion from criminal justice	18	>10	10		
Cognitive Behavioral Therapy (CBT)	> 20			1	>10
Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)	> 20			3	>10
Dialectic Behavioral Therapy (DBT)	> 20			8	>10

STI Task Force members and providers tended to discuss specific types of treatment (such as Illness Management and Recovery, WRAP, CBT, TF-CBT, and DBT) more often than did the other three groups. However, four of the five groups (all but providers) discussed consumer and family-driven supports (including the specific treatment approach of Peer Support) and employment-related supports (including the specific treatment approach of Supported Employment) between most often and third most often. Also of interest was the very high amount of time that the individual therapy relationship was discussed among consumers (which drove its overall number two ranking).

Older Adult Services Priorities. Only two services were discussed that were specifically related to older adult services: Collaborative Care in Primary Care Settings (integrated mental



health and primary care) and the Gatekeeper Program for Older Adults. Both were discussed by adult consumers, family members of adult consumers, and Task Force members, and neither was directly discussed as a priority by CMHA providers. It should be kept in mind that all of the services discussed above as adult services priorities also apply to older adults.

The table below presents the top rankings for specific older adult services across the relevant stakeholder groups (all respondents, adult consumers, family member of adult consumers, providers, and task force members).

Top Older Adult Service Priorities

Prioritized Support	All	Consumers	Family	Task Force	Providers
Gatekeeper Program	1	2	1	1	
Collaborative Care (Mental Health / Primary Care)	2	1	1	2	

Child and Family Services Priorities. The priority most often discussed for all groups other than providers was consumer and family driven services. The priority discussed between most often and third-most often by all groups were topics related to Wraparound Service Coordination (including related topics such as individualized and tailored care). While agreement varied considerably after these top two categories, there was significant overlap for these top two priorities. The top 10 included: (1) consumer / family driven, (2) wraparound related supports, (3) psychoeducation, (4) home-based crisis intervention for families, (5) inpatient capacity, (6) team-based child and adolescent care such as MST and FFT, (7) respite, (8) natural supports, (9) mentoring, and (10) school-based services.

The final table on the following page presents the topics most often discussed related to child and family services across the relevant stakeholder groups (all respondents, parents and caregivers of child and adolescent consumers, task force members, and providers). As with adult services, we limited the focus of the analysis to the top 10 priority supports for each stakeholder group. Rankings across all participants are provided for a range sufficient to cover the top 10 of each group.



Top Child and Family Service Priorities

Prioritized Support	All	Parents & Caregivers	Providers	Task Force
Participants	88	14	19	15
Consumer / Family Driven	1	1	6	1
Wraparound Related	2	2	1	3
Psychoeducation	2	4		
Home-based crisis intervention for families	4	>10	7	5
Inpatient capacity	5	>10		
Team-Based Child and Adolescent Care (e.g., FFT, MST)	6	8	2	2
Respite	7	5	8	3
Natural Supports	8	5		
Mentoring / Big Brothers, Big Sisters	9	9	2	7
School-Based	10	>10		6
Parenting Education / Training	11	4		
Age 0-5 Services	12	9		>10
Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)	12		2	8
Integrated SA/MH Services	14	3	8	
Employment / Independent Living for Transition Age Youth	14	5		
Parent-Child Interaction Treatment (PCIT)	14		2	8
Dialectic Behavioral Therapy (DBT)	14	>10	8	>10
Community-based out-of-home care	14	>10		8
Housing Related	>15	9		
Clubhouse	>15	12		

For child and family services, the overlap of the top 10 ten rankings across stakeholder groups is less strong than with adults. Important services for parents and caregivers such as integrated services for youth with co-occurring substance abuse and mental health disorders, parenting education/training, and employment and independent living supports for transition age youth were top five concerns that did not fall into the top 10 across all participants. For providers, specific evidence-based approaches such as Parent-Child Interaction Treatment (PCIT) and Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) tied with two other approaches for second priority (mentoring and team-based child and adolescent care such as Functional Family Therapy / FFT and Multisystemic Therapy / MST), but did not fall into the top 10 across all participants (the other two approaches did fall into the top 10). Other services in the top 10 of specific subgroups, but not overall included:

- For parents and caregivers of child and adolescent consumers: integrated substance abuse and mental health services (ranked 3rd), parenting education and training (ranked 4th), employment / independent living supports for transition age youth (ranked 5th), and housing related supports (ranked 9th).



- For CMHA providers: TF-CBT and PCIT (both tied for 2nd ranking), integrated substance abuse and mental health services and Dialectic Behavioral Therapy (DBT) (both tied for 8th ranking).
- For the STI Task Force: TF-CBT, PCIT, and community-based out of home care (all tied for 8th ranking).

Focus Group Findings: Challenges to Implementing Best Practices

The next category of focus group findings related to challenges observed in promoting best practices. This was an explicit topic of discussion only in the focus group with CMHA clinical leaders. Other groups (with the exception of the STI Task Force) tended not to draw sharp distinctions between specific evidence-based approaches and more generic care, instead talking positively about both. The following sub-section also reviews support for more access overall to generic services, which was an emphasis in all nine focus groups and is related to the more specific discussion of the trade-offs of best practices discussed in this sub-section.

The facilitators focused specifically on the topic of barriers to implementing evidence-based and other specific best practices with the CMHA clinical leaders in order to benefit from their experience over recent years trying to implement many of these best practices within the RSN system. The clinical leaders all have been struggling over the last two years to implement best practices and, while generally still supportive of the concept, were all too familiar with the challenges involved.

Participants discussed a range of concerns about best practice implementation, including:

- **Desire for more clarity in encounter reporting procedures.** The most frequently discussed concern was a desire for more clarity regarding the documentation and reporting of best practices. As one participant summarized: "Lack of guidelines creates an environment of fear where we do not feel comfortable doing things." They noted a lack of clarity in general on which best practices could be covered within each State Plan modality (other than ones that are specified such as Multisystemic Therapy). There were also particular concerns about how to document best practices that involved more than one clinician, such as Parent-Child Interaction Therapy or Wraparound Service Coordination.
- **Need to account for the additional costs of best practices.** The bottom line across many concerns in this area was that historical rates based on generic mental health services are not adequate to cover the additional costs incurred in delivering best practices. Some practices have expensive training, fidelity monitoring and certification compliance requirements that must be purchased from outside vendors, often at premium prices (thousands of dollars per year per clinician). In addition, even if the external costs are paid for by the State or another funding source (such as the RSN) and there are not ongoing proprietary charges, providers must incur lost productivity by having clinicians participate in training and other non-clinical activities related to implementation, as well as incur administrative expenses in complying with data collection and monitoring activities. For providers in eastern and some parts of western Washington, the time to travel to training events compounds costs even more.



- **Staffing challenges.** Providers also observed the finding in the literature noted in our February report that best practices are too often validated outside of real-world settings. Re-training staff is often not a popular activity and costs more than training staff that are hired from the start to implement a specific practice. Additionally, coping with staff turnover was a major challenge cited, both as a barrier to delivering best practices (or any practices, for that matter) in a continuous manner, as well as an additional cost factor as valuable training resources and time are invested, only to have staff leave and create the need to start over.
- **Burden of encounter reporting procedures.** There was also concern about the difficulty of reporting discrete encounters for multi-staff and multi-intervention models within a fee-for-service reimbursement model. Some providers were concerned that services would need to be unbundled by time units (e.g., every 15 minutes), different procedures (e.g., individual versus group interactions), and different clinicians (e.g., therapist and psychiatrist). While participants in both groups acknowledged that the federal Centers for Medicare and Medicaid Services (CMS) are moving reimbursement for Rehabilitative Services such as Washington’s away from bundled all-inclusive daily rates, there were degrees of concern expressed. For example, unbundling by time (e.g., documenting in 15 minute increments versus daily) poses one level of burden, but documenting by different procedure codes would make the process even more difficult.
- **Additional burden in rural areas.** In addition to the additional travel costs noted above for rural areas, other challenges relate to the smaller numbers of eligible people in rural areas for specific best practices. Providers described starting new best practice programs, only to have to stop them a year later because not enough participants could be recruited. It is generally recognized that rural mental health practices must by nature be more generalist in approach, given that there are not large numbers of people with similar needs as in more populated areas. Therefore, best practices with more flexibility and robust outcomes with regard to variation for different target populations are better fits than less flexible models.

Despite these challenges, participants were responsive to the idea of developing best practices within a setting that addressed proactively the concerns noted above. Possible changes to improve the situation include: specific guidance on how to code and report best practices, rates adjusted to reflect the higher cost structure of best practices (both external expenditures and lost productivity), and efforts to mitigate the risks that providers take on when developing best practices (such as providing financial or other incentives to providers willing to incorporate best practices). The notion of a “Center of Excellence” to serve as a resource to support best practice development was received as positive by both groups when the facilitator shared the finding from the February report that this concept has been effective in states such as New York and Hawaii. Nevertheless, given current challenges several participants were negative about the concept of best practices. Several noted that money would be better spent on increasing access in general to existing, more generic services.

Providers also expressed concerns about specific best practices. These included consumer and family-run services (most frequently noting concerns about “economies of scale” and



competition for limited funds, particularly in rural areas), supported employment (given the currently rigid requirements when a consumer is also involved with the Division of Vocational Rehabilitation), lack of coverage for room and board costs, and reduced access to flexible funds.

Focus Group Findings: Support for Broader Access to Mental Health Services

The final category of focus group findings centers on broader access to mental health services. This was a focus of discussion in all nine focus groups and would have ranked sixth overall had it been ranked alongside the specific best practices (tied with psychoeducation). Among family members of adult consumers, it was discussed third most often, ahead of employment and inpatient care, and among adult consumers it would have ranked as the fifth most discussed topic (just behind employment and medication, and ahead of housing). Specific input related to this topic centered most often on the need for treatment to be provided when a need is expressed, not according to benefit limitations. Treatment should be available “when people need it; not when the ACS says they need it” in the words of one family member of an adult consumer. An adult consumer put it this way: “lighten up on the qualification for services – be reasonable and logical.” Outreach for those most in need was nearly as frequently discussed. Also discussed were specific ways to improve access such as providing better information on service availability and the need to eliminate system barriers.

At the end of eight of the nine focus group (we were unable to ask this during the telephone focus group with eastern Washington providers) we also asked participants about the Access to Care Standards, specifically about the requirement that people seeking care needed to have both a diagnosis and a significant level of impairment verified by a clinician. We asked participants if they agreed with this dual requirement or if they thought access to routine outpatient services should be based only on having an eligible diagnosis, giving them the opportunity to submit a written vote one way or the other. Of the 88 active participants in the focus groups, 49 submitted a vote (17 adult consumers, 9 family members of adult consumers, 6 parents / caregivers, 7 providers, and 10 STI Task Force members). When given the choice between the two, 84% (41 of 49) endorsed the option of using only a diagnosis. The closest vote was among STI Task Force members, who had been considering this issue in more detail over several meetings, where only 70% endorsed using only a diagnosis.



Appendix Four: Best Practices for Adults and Older Adults

Well Established Practices for Adults and Older Adults

Assertive Community Treatment (ACT).¹⁰³ ACT is an integrated, self-contained service approach in which a range of treatment, rehabilitation, and support services are directly provided by a multidisciplinary team composed of psychiatrists, nurses, vocational specialists, substance abuse specialists, peer specialists, mental health professionals, and other clinical staff in the fields of psychology, social work, rehabilitation, counseling, and occupational therapy. Given the breadth of expertise represented on the multidisciplinary team, ACT provides a range of services to meet individual consumer needs, including (but not limited to) service coordination, crisis intervention, symptom and medication management, psychotherapy, co-occurring disorders treatment, employment services, skills training, peer support, and wellness recovery services. The majority of ACT services are delivered to the consumer within his or her home and community, rather than provided in hospital or outpatient clinic settings, and services are available round the clock. Each team member is familiar with each consumer served by the team and is available when needed for consultation or to provide assistance. The most recent conceptualizations of ACT include peer specialists as integral team members. ACT is intended to serve individuals with severe and persistent mental illness, significant functional impairments (such as difficulty with maintaining housing or employment), and continuous high service needs (such as long-term or multiple acute inpatient admissions or frequent use of crisis services).^{104, 105}

The National Alliance on Mental Illness (NAMI) has developed specific program standards for ACT implementation,¹⁰⁶ which several states have adopted and promulgated. The Substance Abuse and Mental Health Services Administration (SAMHSA) also developed an ACT Implementation Kit (often referred to as a “toolkit”) to provide guidance for program implementation.¹⁰⁷

¹⁰³ In Washington State, ACT is referred to as PACT (Program for Assertive Community Treatment). We use the term “ACT” in this report as a more generic reference that is more generally used nationally.

¹⁰⁴ Allness, D.J. & Knoedler, W.H. (2003). A manual for ACT start-up. Arlington, VA: National Alliance for the Mentally Ill.

¹⁰⁵ Morse, G., & McKasson, M. (2005). Assertive Community Treatment. In R.E. Drake, M. R. Merrens, & D.W. Lynde (eds.). Evidence-based mental health practice: A textbook.

¹⁰⁶ Allness, D., & Knoedler, W. (2003, June). National Program Standards for ACT Teams. Retrieved at http://www.nami.org/Content/ContentGroups/Programs/PACT1/National_ACT_Standards.pdf.

¹⁰⁷ Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Mental Health Services (CMHS). (2003). Evidence-Based Practices: Shaping Mental Health Services Toward Recovery: Assertive Community Treatment Implementation Resource Kit. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services. (SAMHSA/CMHS ACT Resource Kit).



ACT is one of the most well-studied service approaches for persons with SPMI, with over 50 published studies demonstrating its success¹⁰⁸, 25 of which are randomized clinical trials (RCTs).¹⁰⁹ Research studies indicate that when compared to treatment as usual (typically standard case management), ACT substantially reduces inpatient psychiatric hospital use and increases housing stability, while moderately improving psychiatric symptoms and subjective quality of life for people with serious mental illnesses.¹¹⁰ Studies also show that consumers and their family members find ACT more satisfactory than comparable interventions and that ACT promotes continuity.

This intervention is most appropriate and cost-effective for people who experience the most serious symptoms of mental illness, have the greatest impairments in functioning, and have not benefited from traditional approaches to treatment. It is often used as an alternative to restrictive placements in inpatient or correctional settings.

Cognitive Behavior Therapy (CBT). CBT is widely accepted as an evidence-based, cost-effective psychotherapy for many disorders.¹¹¹ It is sometimes applied in group as well as individual settings. CBT can be seen as an umbrella term for many different therapies that share some common elements. For adults and older adults, CBT is often used to treat depression, anxiety disorders, and symptoms related to trauma and Post Traumatic Stress Disorder.

CBT can also be used for Substance Abuse, Eating Disorders, and ADHD. It can be used with family intervention. The premise is that a person can change the way they feel/act despite the environmental context. CBT programs can include a number of components including psychoeducational, social skills, social competency, problem solving, self-control, decision making, relaxation, coping strategies, modeling, and self-monitoring.

Collaborative Care. Collaborative Care is a model of integrating mental health and primary care services in primary care settings in order to: (1) treat the individual where he or she is most comfortable; (2) build on the established relationship of trust between a doctor and consumer; (3) better coordinate mental health and medical care; and (4) reduce the stigma associated with receiving mental health services.¹¹²

Two key principles form the basis of the Collaborative Care model:

¹⁰⁸ The Lewin Group. (2000). Assertive community treatment literature review. from SAMHSA Implementation Toolkits website: http://media.shs.net/ken/pdf/toolkits/community/13.ACT_Tips_PMHA_Pt2.pdf

¹⁰⁹ Bond, G. R., Drake, R.E., Mueser, K.T., & Latimer, E. (2001). Assertive community treatment for people with severe mental illness: Critical ingredients and impact on patients. *Disease Management & Health Outcomes*, 9, 141-159.

¹¹⁰ Bond, G. R., Drake, R.E., Mueser, K.T., & Latimer, E. (2001). Assertive community treatment for people with severe mental illness: Critical ingredients and impact on patients. *Disease Management & Health Outcomes*, 9, 141-159.

¹¹¹ Chambless et al. (1998). Update on empirically validated therapies II. *The Clinical Psychologist*, 51 (1), 3-21.

Gatz, M., Fiske, A., Fox, L. S., Kaskie, B., Kasl-Godley, J. E., McCallum, T. J., & Wetherell, J. L. (1998). Empirically-validated psychological treatments for older adults. *Journal of Mental Health and Aging*, 4, 9-46.

¹¹² Unutzer, J., Katon, W. Hogg Foundation Integrated Care Initiative (2006). Training presentation retrieved at: http://www.hogg.utexas.edu/programs_ihc_program.html.



1. Mental health professionals or allied health professionals with mental health expertise are integrated into primary care settings to help educate consumers, monitor adherence and outcomes, and provide brief behavioral treatments according to evidence-based structured protocols; and
2. Psychiatric and psychological consultation and supervision of care managers is available to provide additional mental health expertise where needed.

Key components of the Collaborative Care model include screening, consumer education and self-management support, stepped up care (including mental health specialty referrals as needed for severe illness or high diagnostic complexity), and linkages with other community services such as senior centers, day programs or Meals on Wheels.¹¹³

Several randomized studies have documented the effectiveness of collaborative care models to treat anxiety and panic disorders,¹¹⁴ depression in adults,¹¹⁵ and depression in older adults.¹¹⁶ For example, a study of IMPACT (Improving Mood: Providing Access to Collaborative Treatment for Late Life Depression) – a multi-state Collaborative Care program with study sites in five states, including Washington – led to higher satisfaction with depression treatment, reduced prevalence and severity of symptoms, or complete remission as compared to usual primary care. The 2003 Final Report of the President’s New Freedom Commission on Mental Health suggested that collaborative care models should be widely implemented in primary health care settings and reimbursed by public and private insurers.

Dialectical Behavior Therapy (DBT). Dialectical Behavior Therapy (DBT) is a modification of cognitive behavioral therapy in which an ongoing focus on behavioral change is balanced with acceptance, compassion, and validation of the consumer.¹¹⁷ Services are delivered through individual therapy, skills group sessions, and telephonic coaching.

Randomized studies have shown that DBT reduces severe dysfunctional behaviors that are targeted for intervention, increases treatment retention, and reduces psychiatric hospitalization. Although published follow-up data are limited, the available data indicate that improvements may remain up to one year after treatment.¹¹⁸ DBT is specifically designed to

¹¹³ Unutzer, J., Katon, W., Sullivan, M., and Miranda, J. (1999). Treating Depressed Older Adults in Primary Care: Narrowing the Gap between Efficacy and Effectiveness. *The Milbank Quarterly*, 77, 2.

¹¹⁴ Katon, W.J., Roy-Byrne, P., Russo, J. and Cowley, D. (2002). Cost-effectiveness and cost offset of a collaborative care intervention for primary care patients with panic disorder. *Archives of General Psychiatry*, 59, 1098-1104.

¹¹⁵ Katon, W., Von Korff, M., et al. (1999). Stepped collaborative care for primary care patients with persistent symptoms of depression: A randomized trial. *Archives of General Psychiatry*, 56, 1109-1115.

¹¹⁶ Unutzer, J., Katon, W., et al. (2002). Collaborative care management of late-life depression in the primary care setting: A randomized controlled trial. *Journal of American Medical Association*, 288, 2836-2845.

See also President’s New Freedom Commission on Mental Health Final Report at 66.

¹¹⁷ Swenson, C.R., Torrey, W.C., and Koerner, K. (2002). Implementing Dialectical Behavior Therapy. *Psychiatry Serv* 53:171-178.

¹¹⁸ Swenson, et al. (2002), citing Linehan MM, Heard HL, Armstrong HE 1993). Naturalistic follow-up of a behavioral treatment for chronically parasuicidal borderline patients. *Archives of General Psychiatry* 50:971-974. See also Comtois, K.A. (2002). A Review of Interventions to Reduce the Prevalence of Parasuicide. *Psychiatr Serv*, 53, 1138-1144.



address the particular needs of people who have borderline personality disorder and/or self-harming behaviors.

Family Psychoeducation. Family psychoeducation is a method of working in partnership with families to provide current information about mental illness and to help families develop increasingly sophisticated coping skills for handling problems posed by mental illness in one member of the family.¹¹⁹ They last from nine months to five years, are usually diagnosis specific, and focus primarily on consumer outcomes, although the well-being of the family is an essential intermediate outcome.¹²⁰ Under this approach, the practitioner, consumer, and family work together to support recovery, incorporating individual, family, and cultural realities and perspectives.

Family psychoeducation can be used in a single family or multi-family group format and can vary in terms of the duration of treatment, consumer participation, and treatment setting, depending on the consumers and family's wishes, as well as empirical indications. Although several treatment models exist, the following are essential elements of any evidence-based program.¹²¹

1. The intervention should span at least nine months.
2. The intervention should include education about mental illness, family support, crisis intervention, and problem solving.
3. Families should participate in education and support programs.
4. Family members should be engaged in the treatment and rehabilitation of consumers who are mentally ill.
5. The information should be accompanied by skills training, ongoing guidance about management of mental illness, and emotional support for family members.
6. Optimal medication management should be provided.

Extensive research demonstrates that family psychoeducation significantly reduces rates of relapse and re-hospitalization. When compared to consumers who received standard individual services, differences ranged from 20-50% over two years. Recent studies have shown employment rate gains of two to four times baseline levels, especially when combined with supported employment, another EBP. Families report a decrease in feeling confused, stressed, and isolated and also experience reduced medical care costs. In addition, studies consistently indicate a very favorable cost-benefit ratio, especially in savings from reduced hospital admissions, reduction in hospital days, and in crisis intervention contacts.

¹¹⁹ Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Mental Health Services (CMHS) (2003). Evidence-Based Practices: Shaping Mental Health Services Toward Recovery: Family Psychoeducation Implementation Resource Kit. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services. (SAMHSA/CMHS Family Psychoeducation Resource Kit).

¹²⁰ Dixon, L., McFarlane, W., Lefley, H., et al. (2001). Evidence-Based Practices for Services to Families of People With Psychiatric Disabilities. 52 Psychiatric Services, 7, 903-910.

¹²¹ See literature review provided in McFarlane, W., Dixon, L., Lukens, E., and Lucksted, A. (2003). Family Psychoeducation and Schizophrenia: A Review of the Literature. 29 Journal of Marital and Family Therapy, 2, 223-245.



The SAMHSA/CMHS Family Psychoeducation Resource Kit suggests that family psychoeducation is most beneficial for people with the most severe mental illnesses and their families. Although most research involves consumers with schizophrenia, improved outcomes have been found with other psychiatric disorders, including bipolar disorder, major depression, obsessive-compulsive disorder, anorexia nervosa, and borderline personality disorder.

Gatekeeper Program. The Gatekeeper Program engages and trains a range of community members who have frequent contact with older adults – such as utility, cable telephone, bank, housing, and postal workers – as well as emergency medical technicians, firefighters, police officers, and other first responders to identify older adults who may need mental health services and report them to a central information and referral office.¹²²

After referral, a clinical case manager and nurse visit the individual at his or her home, making repeat visits as needed to overcome the individual’s suspicion and promote engagement. An interdisciplinary team, usually including a psychiatrist and physician, develop a plan of care and, if appropriate, meets with the individual’s family with a goal of providing community-based rather than institutional services.

Research suggests that the Gatekeeper Program is effective in reaching older adults with mental illnesses who are more likely to be economically and socially isolated than older adults referred by a medical provider or other traditional referral source.¹²³ Some studies found that Gatekeeper referrals were no more likely to be placed out-of-home than those referred by other sources.¹²⁴ Although there is limited data regarding specific clinical outcomes associated with the Gatekeeper Program, a recent literature review suggests that multidisciplinary approaches to serving older adults in their homes may be effective in reducing symptom severity.

The Gatekeeper program is designed to identify older adults with any level of mental health needs. MHD had collaborated with Area Agencies of Aging in the mid-1990s to implement Gatekeeper programs using federal block grant funds. However, many of these programs have been modified at the local level outside of MHD oversight over time and many no longer have fidelity to the Gatekeeper model.

Illness Management and Recovery. Illness Management and Recovery (IMR) is a set of specific evidence-based practices for teaching people with severe mental illness how to manage their disorder in collaboration with professionals and significant others in order to achieve personal recovery goals. These practices include: (1) psychoeducation; (2) behavioral tailoring to improve medication adherence; (3) relapse prevention training; (4) increasing

¹²² Center for Mental Health Services, Substance Abuse and Mental Health Services Administration. (2005). Community Integration of Older Adults with Mental Illnesses: Overcoming Barriers and Seizing Opportunities. DHHS Pub. No. (SMA) 05-4018. Rockville, MD: Author.

¹²³ Van Citters, A.D. and Bartels, S.J. (2004). A Systematic Review of the Effectiveness of Community-Based Mental Health Outreach Services for Older Adults. *Psychiatric Services*, 55,1237-1249.

¹²⁴ U.S. Administration on Aging. (2001). Older adults and mental health: Issues and opportunities. Rockville, MD: U.S. Department of Health and Human Services.



copied skills; and (5) social skills training. IMR involves a series of weekly sessions in which specially trained professionals use these practices to help people who have experienced psychiatric symptoms in developing personal strategies for coping with mental illness and moving forward in their lives.¹²⁵

Practitioners educate consumers on nine topic areas, ranging from recovery strategies and illness information, to coping with stress and finding help in the mental health system. IMR practitioners combine motivational, educational, and cognitive-behavioral strategies aimed at helping consumers make progress towards personal recovery goals. The program can be provided in an individual or group format and generally lasts between three and six months.

Research has demonstrated that IMR can increase an individual's knowledge about mental illness, reduce relapses and hospitalizations, help consumers cope more effectively, reduce distress from symptoms, and assist consumers in using medications more effectively.¹²⁶ In addition, when using IMR practitioners often report a high rate of job satisfaction as consumers learn to reduce relapses, avoid hospitalization, and make steady progress toward personalized recovery goals.

This intervention is most appropriate for people who have experienced symptoms of schizophrenia, bipolar disorder, or depression at various stages of the recovery process. Emerging research suggests that this intervention may also be effective for people with serious mental illnesses in the criminal justice system.¹²⁷

Integrated Dual Disorder Treatment (IDDT) for Co-Occurring Mental Illness and Substance Use Disorders. Integrated Dual Disorder Treatment (IDDT) provides mental health and substance abuse services through one practitioner or treatment team and co-locates all services in a single agency (or team) so that the consumer is not excluded from or confused by multiple programs.¹²⁸ IDDT encompasses 14 components, each of which is evidence-based, including but not limited to: (1) screening and assessments that emphasize a “no wrong door” approach; (2) “blended” treatment to ensure compatibility in treatment approaches; (3) stage-wise treatment that recognizes that different services are helpful at different stages of

¹²⁵ Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Mental Health Services (CMHS) (2003). Evidence-Based Practices: Shaping Mental Health Services Toward Recovery: Illness Management and Recovery Implementation Resource Kit. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services. (SAMHSA/CMHS IMR Resource Kit).

¹²⁶ See also review of the literature provided by Mueser, K., Corrigan, P., Hilton, D., Tanzman, B. et al. (2002). Illness Management and Recovery: A Review of the Research. *53 Psychiatric Services* 10, 1272–1284.

¹²⁷ Mueser, K. and MacKain, S. (2006). *Illness Management and Recovery*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, The National GAINS Center for Systemic Change for Justice-Involved People with Mental Illness.

¹²⁸ Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Mental Health Services (CMHS) (2003). Evidence-Based Practices: Shaping Mental Health Services Toward Recovery: Co-Occurring Disorders: Integrated Dual Diagnosis Treatment Implementation Resource Kit. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services. (SAMHSA/CMHS IDDT Resource Kit).



the recovery process; and (4) motivational interviewing and treatment, using specific listening and counseling skills to develop consumer awareness, hopefulness, and motivation for recovery.

Combined mental health and substance abuse treatment is effective at engaging people with both diagnoses in outpatient services, maintaining continuity and consistency of care, reducing hospitalization, and decreasing substance abuse, while at the same time improving social functioning.¹²⁹ Integrated treatment also reduces symptoms of mental disorders and overall treatment costs.¹³⁰ Fidelity to the components of IDDT is clearly tied to better clinical outcomes.¹³¹

This intervention is appropriate for individuals with co-occurring mental illness and substance use disorders. A “conceptual framework” developed jointly by the National Association of State Mental Health Directors (NASMHPD) and the National Association of State Alcohol and Drug Abuse Directors (NASADAD) suggests that mental health and substance abuse treatment should be provided along a continuum of coordination, collaboration, and integration among service systems, depending on the severity of the mental illness and substance abuse disorder.¹³²

Medication Management Approaches in Psychiatry (MedMAP). Medication Management Approaches in Psychiatry (MedMAP) comprise an approach to using medication in a systematic and effective way as part of the overall treatment for severe mental illness.¹³³ MedMAP provides research-based algorithms—scientific formulas or procedures—that practitioners can use as a guide for prescribing medications and dosages. MedMAP includes the following essential elements:¹³⁴ (1) A systematic approach; (2) clear, thorough documentation; (3) objective measurement of outcomes; and (4) shared decision-making between consumers and professionals

¹²⁹ U.S. Surgeon General’s Report, (1999). p. 288, citing Miner, C.R., Rosenthal, R.N., Hellerstein, D.J. & Muenz, L.R. (1997). Predictions of compliance with outpatient referral in patients with schizophrenia and psychoactive substance use disorders. *Archives of General Psychiatry*, 54, 706-712 and Mueser, K.T., Drake, R.D., and Miles, K.M. (1997). The course and treatment of substance use disorders in persons with severe mental illnesses. *NIDA Research Monograph*, 172, 86-109.

¹³⁰ Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Mental Health Services (CMHS) (2003). *Evidence-Based Practices: Shaping Mental Health Services Toward Recovery: Co-Occurring Disorders: Integrated Dual Diagnosis Treatment Implementation Resource Kit*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services. (IDDT Resource Kit).

¹³¹ Drake, R., Essock, S., et al. (2001). Implementing Dual Diagnosis Services for Clients with Mental Illness. *Psychiatric Services* 52, 469-476.

¹³² The National Association of State Alcohol and Drug Abuse Directors and the National Association of State Mental Health Program Directors. (2005). *The Evolving Conceptual Framework for Co-Occurring Mental Health and Substance Abuse Disorders: Developing Strategies for Systems Change*. Final Report of the NASMHPD-NASADAD Task Force on Co-Occurring Disorders. Authors: Washington, DC & Alexandria, VA.

¹³³ North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services. *Mental Health Systems Transformation: Medication Management Toolkit*. Retrieved at: http://www.governorsinstitute.org/index.php?option=com_content&task=view&id=31&Itemid=60.

¹³⁴ Herndon, S., (2003). Six at a Glance. 11 SAMHSA News 2. Rockville, MD: Substance Abuse and Mental Health Services Administration.



Studies of medication algorithms have shown that, when carefully applied, they reduce psychiatric symptoms, hospitalizations, and medication side effects.¹³⁵ Many consumers report being more satisfied with their treatment and outcomes than individuals who are prescribed medication without algorithms. However, it is still unclear how well algorithms can be adapted to real-world practice settings. MedMAP currently is designed for use in treating schizophrenia, although research efforts are underway to expand the evidence base for this approach for treatment of other mental illnesses.

Psychosocial Rehabilitation. Psychosocial rehabilitation refers to a range of services designed to help individuals with serious mental illnesses recover functioning and integrate or re-integrate into their communities, generally with the least amount of professional intervention possible.¹³⁶ Psychosocial rehabilitation programs combine pharmacologic treatment, independent living and social skills training, psychological support, housing, vocational rehabilitation, and access to leisure activities.

Because psychosocial rehabilitation is an approach and not a program model, it can be applied in a variety of settings or programs, including case management and vocational programs that serve people who are homeless. Typically, such programs focus on independent living and social skills training, psychological support to individuals and their families, housing, vocational rehabilitation, social support, and access to leisure activities. Psychosocial rehabilitation programs that serve people who are homeless may have an added emphasis on outreach and on building trusting relationships that will allow individuals to explore their choices and learn the skills they need to succeed.

Randomized clinical trials have shown that participants in psychosocial rehabilitation programs have fewer and shorter hospital stays and are more likely to be employed.¹³⁷ Studies of the use of psychosocial rehabilitation with people who are homeless indicate that this approach is successful at engaging disaffiliated individuals, expanding their use of human services, and improving their housing conditions, mental health status, and quality of life.¹³⁸

This intervention is appropriate for adults and older adults with serious mental illnesses. The emphasis on choice, individual potential, and real-world settings may be especially attractive

¹³⁵ See overview provided in Hyde, P., Falls, K., Morris, J. and Schoewald, S. (2003). *Turning Knowledge Into Practice: A Manual for Behavioral Health Administrators and Practitioners About Understanding and Implementing Evidence-Based Practices*. Boston, MA: The Technical Assistance Collaborative, Inc. and the American College of Mental Health Administration.

¹³⁶ Anthony, W., Cohen, M., Farkas, M. (1990). *Psychiatric Rehabilitation*. Boston, MA: Center for Psychiatric Rehabilitation.

¹³⁷ U.S. Surgeon General's Report, (1999). p. 287, citing, among others, Bell, M.D. and Ryan, E.R. (1984) Integrating psychosocial rehabilitation in the hospital psychiatric service. *Hospital and Community Psychiatry*, 35, 1017-1022 and Bond, G.R. and Dincin, J. (1986). Accelerating entry into transitional employment in a psychosocial rehabilitation agency. *Rehabilitation Psychology*, 31, 143-154.

¹³⁸ Shern, D.L., Tsemberis, S., Anthony, W., Lovell, A.M., Richmond, L., Felton, C.J., Winarski, J., and Cohen, M. (2000). Serving street-dwelling individuals with psychiatric disabilities: outcomes of a psychiatric rehabilitation clinical trial. *American Journal of Public Health* 90(12), 1873-1878.

to people with serious mental illnesses who have had prior negative experiences with professionally-directed treatment programs.

Supported Employment. Supported Employment promotes rehabilitation and a return to mainstream employment for persons with serious mental illnesses and co-occurring disorders. Supported Employment programs integrate employment specialists with other members of the treatment team to ensure that employment is an integral part of the treatment plan. Employment specialists are responsible for carrying out vocational services while all members of the treatment team understand and promote employment. All Supported Employment programs are based on the following principles:

1. Eligibility is based on consumer choice. Individuals interested in employment are not screened for job readiness.
2. Supported employment is integrated with treatment. Employment specialists coordinate plans with the treatment team, including the case manager, therapist, psychiatrist, and others.
3. Competitive employment is the goal. The focus is on community jobs anyone can apply for that pay at least minimum wage, including both part-time and full-time work.
4. Job search starts soon after a consumer expresses interest in working. There are no requirements for completing extensive pre-employment assessment and training, or intermediate work experiences (like transitional employment or sheltered workshops). Follow-along supports are continuous.
5. Individualized supports to maintain employment continue as long as consumers want the assistance.
6. Consumer preferences are important.

A considerable body of research indicates that Supported Employment models, such as Independent Placement and Support (IPS), are successful in increasing competitive employment among consumers.¹³⁹ A seven-state, multi-site study supported by the federal Substance Abuse and Mental Health Services Administration (SAMHSA) found that Supported Employment participants were significantly more likely (55%) than comparison participants (34%) to achieve competitive employment.¹⁴⁰ A review of three randomized controlled trials found that, in general, 60-80% of people served by a Supported Employment model obtain at least one competitive job.¹⁴¹

In addition, the research consistently shows that specific consumer factors such as diagnosis, age, gender, disability status, prior hospitalization, co-occurring substance abuse disorder, and

¹³⁹ Drake, R.E., Becker, D.R., Clark, R.E. & Mueser, K.T. (1999). Research on the individual placement and support model of supported employment. *Psychiatric Quarterly*, 70, 289-301.

¹⁴⁰ Cook, J. Executive Summary of Findings from the Employment Intervention Demonstration Program. Retrieved at www.psych.uic.edu/eidp/EIDPexecsum.pdf.

¹⁴¹ New Freedom Commission on Mental Health (2003). *Achieving the Promise: Transforming Mental Health Care in America*. Final Report. Rockville, MD: DHHS Pub. No. SMA-03-3832 at 41, *citing* Drake, R.E., Becker, D.R., Clark, R.E., and Mueser, K.T. (1999). Research on the individual placement and support model of supported employment. *Psychiatric Quarterly*, 70, 289-301.



education are not strong or consistent predictors of an individual's work outcomes.¹⁴² Supported employment remains more effective than traditional vocational services for consumers with both good and poor work histories. This intervention should be offered to all individuals with mental illnesses and/or co-occurring disorders who want to work, regardless of prior work history, housing status, or other population characteristics.¹⁴³

Promising Practices for Adults and Older Adults

Case Management. The primary purpose of case management is to coordinate service delivery and to ensure continuity and integration of services.¹⁴⁴ There are many models of case management for people with mental illnesses. Clinical case management and targeted case management generally include at least five integrated functions: (1) assessing consumers' needs; (2) planning service strategies to respond to identified needs; (3) linking consumers to appropriate services, including non-mental health specialty services such as housing, employment supports, or other social services; (4) monitoring consumers' progress to detect changing needs; and (5) providing follow up and ongoing evaluation.¹⁴⁵ Some models may also include limited skills building techniques.

In addition, intensive case management may also involve the actual delivery of service. ACT is sometimes thought of as a model of intensive case management, although many distinguish intensive case management as usually relying less on a team approach to service delivery, likely involving more brokering than delivery of services, and focusing more on facilitating participation by consumers in treatment decisions.

Considerable research suggests the effectiveness of intensive case management models, including ACT, in reducing inpatient use among high-risk consumers. Several studies also suggest improvements in clinical and social outcomes over conventional case management approaches.¹⁴⁶ However, at least one recent study has suggested that intensive case

¹⁴² Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Mental Health Services (CMHS) (2003). Evidence-Based Practices: Shaping Mental Health Services Toward Recovery: Co-Occurring Disorders: Supported Employment Implementation Resource Kit. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services. (Supported Employment Resource Kit).

¹⁴³ North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services. Mental Health Systems Transformation: Supported Employment Toolkit. Retrieved at: http://www.governorsinstitute.org/index.php?option=com_content&task=view&id=32&Itemid=61&PHPSESSID=c0381139b8ae1fb19764f80bd8d57992.

¹⁴⁴ U.S. Surgeon General's Report, (1999). p. 286.

¹⁴⁵ Taube, C., Goldman, H., and Salkever, D. (1990) Medicaid Coverage for Mental Illness: Balancing Access and Costs. Health Affairs, Spring 1990.

¹⁴⁶ The Schizophrenia Patient Outcomes Research Team (PORT) Treatment Recommendations. (1998). Agency for Healthcare Quality and Research, Rockville, MD. Retrieved at: <http://www.ahrq.gov/clinic/schzrec.htm>. Citing Scott J.E., Dixon L.B. (1995). Assertive community treatment and case management for schizophrenia. Schizophrenia Bulletin 21(4), 657-68.



management programs are effective only in community settings where there is an ample supply of treatment and support services.¹⁴⁷

There is less of a research base to support more traditional clinical and targeted case management approaches. One review of the research found that clinical case management was as effective as ACT in reducing symptoms of illness, improving social functioning, and increasing consumer and family satisfaction with services. However, that review also found that clinical case management increased hospitalizations and the proportion of consumers hospitalized.¹⁴⁸

Comprehensive Crisis Services. In general, crisis services involve short-term, round-the-clock help provided in a non-hospital setting during a crisis with the purposes of stabilizing the individual, avoiding hospitalization or other high-cost services, and helping individuals return to pre-crisis functioning as quickly as possible. Crisis services can also help assure that emergency room, ambulance, law officer, and jail resources are not inappropriately utilized for behavioral health crises.¹⁴⁹

Best practice components of comprehensive crisis services include but are not limited to:

1. A 24-hour telephone response system staffed by qualified mental health professionals with immediate capacity for face-to-face assessment and on-call consultation with a psychiatrist.
2. Mobile services capacity with transportation to assist individuals in getting to stabilization facilities.
3. Access to short-term intensive residential treatment resources for stabilization and hospital diversion.
4. Cultural and linguistic competency to facilitate assessment.
5. Access to appropriate linkages with other healthcare resources.

Research suggests that when crisis services are provided in non-hospital settings, the likelihood of inpatient admission is reduced.¹⁵⁰ At least one study has found that, for individuals with serious mental illness in need of hospital level care and willing to accept voluntary treatment, residential crisis centers provided the same outcomes as inpatient hospitals for significantly less cost.¹⁵¹

¹⁴⁷ Meyer, P.S., and Morrissey, J.P. (2007). A Comparison of Assertive Community Treatment and Intensive Case Management for Patients in Rural Areas. *Psychiatric Services* 58, 121-127.

¹⁴⁸ Ziguras, S.J., Stuart, G.W., and Jackson, A.C. (2002). Assessing the evidence on case management. *The British Journal of Psychiatry* 181, 17-21.

¹⁴⁹ St. Luke's Health Initiatives. (2001). *Into the Light: A Search for Excellence in the Arizona Public Behavioral Health System, Volume II.*

¹⁵⁰ Mercer Government Human Services Consulting. (2006). *Strategies for Promoting Recovery and Resilience and Implementing Evidence-Based Practices.* Commonwealth of Pennsylvania, Office of Mental Health and Substance Abuse Services, p. 58.

¹⁵¹ Fenton, W.S., Hoch, J.S., Herrrell, J.M., Mosher, L., Dixon, L. (2002). Cost and cost-effectiveness of hospital vs. residential crisis care for patients who have serious mental illness. *Archives of General Psychiatry*, 59 (4), 357-64.



Comprehensive crisis services are appropriate for individuals with an acute mental illness experiencing a crisis that puts them at risk of hospitalization or other high-cost care.

Drop-In Centers. Drop-in centers originated in the late 1980s to provide consumers of mental health services with opportunities for socialization, education, and emotional support as an alternative to traditional mental health treatment. Today, the concept of drop-in centers has evolved to be “peer support centers,” with a mission to provide a place where consumers can direct their own recovery process and, often, to serve as a complement to other mental health services.¹⁵² Although drop-in centers generally are run by consumers, many maintain some kind of collaborative relationship with a mental health provider agency.¹⁵³

Drop-in centers have a high rate of satisfaction among consumers.¹⁵⁴ At least one study suggests that individuals who use self-help services such as those provided in a drop-in center were also more likely to be satisfied with professional mental health services that they received.¹⁵⁵ Other studies suggest that experience at a drop-in center is associated with high satisfaction, increased quality of life, enhanced social support, and problem solving.¹⁵⁶

International Center for Clubhouse Development (ICCD) Clubhouse. A Clubhouse offers a model of rehabilitation in which people with mental illnesses are members, not patients, and their strengths, rather than their illnesses, are emphasized. Clubhouses are operated by individuals recovering from mental illness in collaboration with a small number of non-consumer staff who work side by side in a unique partnership.¹⁵⁷ Members participate in a “work-ordered day,” volunteering to participate in activities essential to running the Clubhouse. Members also have an opportunity to engage in transitional employment. Clubhouses provide members with other aspects of their lives, including securing housing, advancing their educations, and maintaining government benefits.

The International Center for Clubhouse Development (ICCD) has developed a comprehensive set of standards for the Clubhouse Model of Rehabilitation. These include but are not limited to the following:

1. Membership is voluntary and without time limits.
2. Members choose the way they utilize the Clubhouse and the staff with whom they work.

¹⁵² Technical Assistance Guide: Consumer-run Drop-In Centers. National Mental Health Consumers’ Self-Help Clearinghouse.

¹⁵³ Kaufmann, C.L., Ward-Colasante, C., and Farmer, J., (1993). Development and Evaluation of Drop-In Centers Operated by Mental Health Consumers. *Hospital and Community Psychiatry* 44 (7): 675-678.

¹⁵⁴ Tennessee Department of Mental Health and Developmental Disabilities. Retrieved at: <http://www.state.tn.us/mental/recovery/dropin.html>.

¹⁵⁵ Hodges, J.Q., Markward, M., Keller, C., and Evans, C.J. (2003). Use of Self-Help Services and Consumer Satisfaction with Professional Mental Health Services. *Psychiatric Services* 54, 1161-1163.

¹⁵⁶ Schell, B. (2003). Program Manual for a Consumer-Run Drop-In Center based on the Mental Health Client Action Network in Santa Cruz, CA. Prepared for SAMHSA COSP-MultiSite Study, FliCA site. Citing Mowbray, C. T. and Tan, C. (1992). Evaluation of an Innovative Consumer-Run Service Model: The Drop-In Center. *Innovations & Research* 1(2):19-24.

¹⁵⁷ International Center for Clubhouse Development. Retrieved at: <http://www.iccd.org/article.asp?articleID=3>.



3. All members have equal access to every Clubhouse opportunity with no differentiation based on diagnosis or level of functioning.
4. The Clubhouse is located in its own physical space, separate from any mental health center or institutional settings, and is distinct from other programs.

An emerging body of evidence suggests that ICCD Clubhouses may be as effective as Assertive Community Treatment (ACT) and Supported Employment programs in helping consumers obtain and keep competitive jobs and in increasing their earnings.¹⁵⁸

ICCD Clubhouse standards provide that membership is open to any person with a history of mental illness, unless that person poses a “significant and current threat to the general safety of the Clubhouse community.”¹⁵⁹

Program to Encourage Active, Rewarding Lives for Seniors (PEARLS)

The PEARLS program teaches depression management techniques to older adults through a series of eight in-home counseling sessions followed by monthly telephone calls. Through PEARLS, counselors do the following: teach participants to recognize symptoms of depression and understand the link between unsolved problems and depression; help participants resolve problems using a structured set of steps; help participants meet recommended levels of social and physical activity; and help participants identify and participate in personally pleasurable activities.

One study indicated that PEARLS participants were three times more likely than non-participants to significantly reduce or eliminate symptoms of depression. The study suggests that participants’ functioning and emotional well-being improved and that utilization of health care services was reduced. This intervention is appropriate for older adults with minor depression.

Peer Support. Peer Support is a service through which consumers can: (1) direct their own recovery and advocacy process and (2) teach and support each other in the acquisition and exercise of skills needed for management of symptoms and for utilization of natural resources within the community.¹⁶⁰ This service typically provides structured, scheduled activities that promote socialization, recovery, self-advocacy, development of natural supports, and maintenance of community living skills, often under the direct supervision of a mental health professional. Peer Support can also encompass a range of supports delivered by consumers, including informal services or as part of a consumer-operated service.

¹⁵⁸ See, e.g., Macias, C., Rodican, C.F., Hargreaves, W.A. Jones, D.R., Barreira, P.J., & Wang, Q. (2006). Supported Employment Outcomes of a Randomized Controlled Trial of ACT and Clubhouse Models. *Psychiatric Services* 57(10):1406-15.

¹⁵⁹ International Center for Clubhouse Development. Retrieved at: <http://www.iccd.org/article.asp?articleID=3>

¹⁶⁰ Georgia Medicaid Guidelines – Peer Supports for Adults. Retrieved at: www.gacps.org/files/peer_supports_guidelines2_3.doc.



An innovative Georgia model, which receives Medicaid reimbursement for peer support and which has been replicated in several states, emphasizes the role of Certified Peer Specialists,¹⁶¹ who provide direct services to assist consumers in developing the perspective and skills to facilitate recovery and who also model the possibility of recovery through their own experiences as consumers engaged in self-directed recovery. A job description defines specific support activities, including helping consumers create a wellness recovery action plan and supporting vocational choices.

The Georgia certification process includes two required weeklong trainings followed by a written and oral examination, as well as periodic continuing education seminars and workshops. Certified Peer Specialists are paid employees of public and private providers and operate as part of a clinical team, which can be integrated into a range of emergency, outpatient (including ACT), or inpatient settings. A Georgia-model Peer Support service reimbursable under Medicaid must be operated at least 12 hours a week, at least four hours per day for at least three days per week.

Emerging evidence suggests that integrating peer specialists into a range of treatment approaches may lead to better outcomes for consumers. For example, one controlled study found that individuals served by case management teams that included consumers as peer specialists had experienced increases in several areas of quality of life and reductions in major life problems, as compared to two comparison groups of individuals served by case management teams that did not include peer specialists.¹⁶²

Under the Medicaid-reimbursable model implemented in Georgia, peer support services are geared toward consumers with severe and persistent mental illness. These consumers may have co-occurring mental retardation or substance abuse disorders.¹⁶³

Respite Care. Respite care is designed to provide community-based, planned or emergency short-term relief to family caregivers, alleviating the pressures of ongoing care and enabling individuals with disabilities to remain in their homes and communities.¹⁶⁴ Respite care frequently is provided in the family home. Without respite care, many family caregivers experience significant stress, loss of employment, financial burdens, and marital difficulties.

¹⁶¹ In Washington State, the term Certified Peer Counselor is used, and we use this term when referring to the Washington State peer support modality. We use the more widely used “Peer Specialist” term when referring to the best practice model used nationally, but the terms are essentially synonymous as used in this report.

¹⁶² Felton, C.J., Stastny, P., Shern, D., Blanch, A., Donahue, S.A., Knight, E. and Brown, C. (1995). Consumers as peer specialist on intensive case management teams: Impact on client outcomes. *Psychiatric Services*, 46, 1037-1044.

¹⁶³ Georgia Medicaid Guidelines – Peer Supports for Adults. Retrieved at: www.gacps.org/files/peer_supports_guidelines2_3.doc.

¹⁶⁴ New Freedom Commission on Mental Health. (2003). *Achieving the Promise: Transforming Mental Health Care in America*. Final Report. Rockville, MD: DHHS Pub. No. SMA-03-3832 at 40.



Little existing research is available regarding the effectiveness of this intervention either for family caregivers or mental health consumers. The majority of family caregiving studies identify a need for greater quality, quantity, variety, and flexibility in respite provision.¹⁶⁵

Standardized Screening for Substance Abuse Disorders. Effective treatment for co-occurring disorders begins with accurate screening and assessment in settings where individuals present for treatment.¹⁶⁶ Failure to detect substance abuse disorders can result in a misdiagnosis of mental disorders, sub-optimal pharmacological treatments, neglect of appropriate substance abuse interventions, and inappropriate treatment planning and referral.¹⁶⁷ In addition, since use of even limited amounts of alcohol or other drugs can be associated with negative outcomes among people with mental illnesses,¹⁶⁸ routine screening is an important component of mental health prevention and treatment.

The clinical screening process enables a service provider to assess if an individual demonstrates signs of substance abuse or is at risk of substance abuse. Screening is a formal process that is typically brief and occurs soon after the consumer presents for services.¹⁶⁹ The purpose is not to establish the presence or specific type of such a disorder, but to establish the need for an in-depth assessment.

A broad range of effective screening tools exist for specific populations. Many are brief self-report screens that can be completed as part of an initial intake interview for an individual with a severe mental illness.¹⁷⁰ For example, Washington State is currently using the Global Appraisal of Individual Needs – Short Screener (GAIN-SS), a shortened version of a leading tool for a broad range of substance use.¹⁷¹ DSHS was required under RCW 70.96C.010 to implement an integrated and comprehensive screening process for chemical dependency and has implemented the GAIN-SS across MHD, CA, JRA, and the Division of Alcohol and Substance Abuse (DASA), and the Washington Department of Corrections has also implemented it.

¹⁶⁵ Jeon, Y.H., Brodaty, H., and Chesterson, J. (2005). Respite care for caregivers and people with severe mental illness: literature review. *Journal of Advanced Nursing*, 49(3), 297–306.

¹⁶⁶ U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (2002). Report to Congress on the Prevention and Treatment of Co-Occurring Substance Abuse Disorders and Mental Disorders.

¹⁶⁷ Drake, R.E., Mueser, K.T., Clark, R.E., et al. (1996). The course, treatment and outcome of substance disorder in persons with severe mental illness. *American Journal of Orthopsychiatry* 66: 42-51.

¹⁶⁸ RachBeisel, J., Scott, J. and Dixon, L. (1999). Co-Occurring Mental Illness and Substance Use Disorders: A Review of Recent Research. *Psychiatric Services*, 50, 1427-1434.

¹⁶⁹ Center for Substance Abuse Treatment. (2006). Screening, Assessment, and Treatment Planning for Persons With Co-Occurring Disorders. COCE Overview Paper 2. DHHS Publication No. (SMA) 06-4164. Rockville, MD: Substance Abuse and Mental Health Services Administration, and Center for Mental Health Services.

¹⁷⁰ RachBeisel, et al. (1999).

¹⁷¹ Dennis, M.L., Chan, Y.-F., & Funk, R.R. (2006). Development and validation of the GAIN Short Screener (GAIN-SS) for psychopathology and crime/violence among adolescents and adults. *The American Journal on Addictions*, 15 (supplement 1), 80-91. Downloaded on April 11, 2007 at http://www.chestnut.org/LI/gain/GAIN_SS/Dennis_et_al_2006_Development_and_validation_of_the_GAIN_Short_Screener.pdf.



Other screening tools are also available. The Michigan Alcoholism Screening Test (MAST) is considered reliable and valid as a screening tool for persons with primary alcoholism, but includes items that are irrelevant or confusing for people with severe mental illness.¹⁷² Research suggests that the Dartmouth Assessment of Life Style Instrument (DALI) is effective for individuals with acute mental illness.

Prevention and both early identification and intervention of substance abuse disorders are appropriate for individuals of all ages, but are especially critical for young people and individuals whose substance use problems have not risen to the level of seriousness to require treatment.

Supportive Housing. Supportive housing (sometimes called supported housing) is a term used to describe a wide range of approaches and implementation strategies to effectively meet the housing needs of people with disabilities, including people with mental illnesses. Supportive housing may include supervised apartment programs, scattered site rental assistance, and other residential options. NASMHPD has identified supportive housing as a best practice in the field,¹⁷³ and SAMHSA's Center for Mental Health Services is in the process of developing an Evidence-Based Practice Implementation Resource Kit for this approach.

The overall goal of supportive housing is to help consumers find permanent housing that is integrated socially, reflects their personal preferences, and encourages empowerment and skills development.¹⁷⁴ Program staff provide an individualized, flexible, and responsive array of services, supports, and linkages to community resources, which may include such services as employment support, educational opportunities, integrated treatment for co-occurring disorders, recovery planning, and assistance in building living skills. The level of support is expected to fluctuate over time.¹⁷⁵

Numerous studies of consumer preferences agree that mental health consumers generally prefer normal housing and supports over congregate residential living. Furthermore, people tend to want to live alone or with another person of their choice, rather than with groups of people who have psychiatric disabilities.¹⁷⁶ Residential stability and life satisfaction are increased when consumers perceive they have choices and when their housing and support preferences are honored.¹⁷⁷

¹⁷² Rosenberg, S., Drake, R., et al. (1998). Dartmouth Assessment of Lifestyle Instrument (DALI): A Substance Use Disorder Screen for People with Severe Mental Illness. *Am J. Psychiatry*, 155, 232-238.

¹⁷³ Housing for persons with psychiatric disabilities: Best practices for a changing environment. Alexandria, VA: National Technical Assistance Center for State Mental Health Planning.

¹⁷⁴ U.S. Surgeon General's Report, (1999). p. 293.

¹⁷⁵ U.S. Surgeon General's Report, (1999). p. 293.

¹⁷⁶ Schutt, R.K. & Goldfinger, S.M. (1996). Housing preferences and perceptions of and health and functioning among homeless mentally ill persons. *Psychiatric Services*. 47, 381-386.

¹⁷⁷ Srebnick, Debra S. (1992). Perceived choice and success in community living for people with psychiatric disabilities. Unpublished doctoral dissertation. Burlington, VT: University of Vermont, Department of Psychology.



All supportive housing models should maximize, to the extent possible, the following components of an ideal model of supportive housing: (1) choice of housing; (2) separation of housing and services; (3) decent, safe, and affordable housing; (4) housing integration; (5) access to housing; and (6) flexible, voluntary services.¹⁷⁸

A significant body of research demonstrates that people in supportive housing experience reduced homelessness, increased residential stability, reduced recidivism to hospitalization and shorter lengths of stay, and reduced time spent incarcerated.¹⁷⁹ A few studies relate supported housing to reductions in psychiatric symptoms, increased social functioning, and improved quality of life.¹⁸⁰

Supportive housing program models have been successfully adapted and implemented to meet the needs of people with serious mental illnesses and co-occurring substance abuse and developmental disabilities, including those with special needs such as veterans, people who are homeless, families with children, transition-age youth, people who have histories of trauma, people with HIV/AIDS, and offenders leaving prisons or jails.

Telepsychiatry. Telepsychiatry is a method of providing expert psychiatric treatment to consumers at a distance from the source of care. Its use has been suggested for the treatment of consumers in remote locations or in areas where psychiatric expertise is scarce.¹⁸¹ Telepsychiatry sometimes includes educational initiatives for providers and other non-clinical uses.

Psychiatric interviews conducted by telepsychiatry appear to be generally reliable, and consumers and clinicians generally report high levels of satisfaction with telepsychiatry.¹⁸² Current technologies make telepsychiatry feasible, increases access to care, and enables specialty consultation.¹⁸³ There is little evidence to date regarding clinical outcomes or cost-effectiveness of telepsychiatry as compared to in-person treatment. However, at least one randomized, controlled study has found that remote treatment of depression by means of telepsychiatry and in-person treatment of depression have comparable outcomes and equivalent levels of consumer adherence and satisfaction.¹⁸⁴ In that study, telepsychiatry was found to be more expensive per treatment session, but this difference disappeared if the costs

¹⁷⁸ Fidelity Scale for Ideal Permanent Supportive Housing (2007). Draft in progress for inclusion in SAMHSA Supportive Housing Implementation Resource Kit.

¹⁷⁹ Ridgeway, P. and Marzilli, A. (2006). Supported Housing and Psychiatric Disability: A Literature Review and Synthesis: Prepared for the Development of an Implementation Toolkit. (unpublished document)

¹⁸⁰ Ridgeway, P. and Mazilli, A. (2006). Citing Hough, R., Harmon, S., et al. (1994). The San Diego project: providing independent housing and support services. In Center for Mental Health Services (eds.). Making a difference: Interim status report on the McKinney research demonstration program for mentally ill adults, at 91-110.

¹⁸¹ Ruskin, P.E., Silver-Aylaian, M., et al. (2004). Treatment Outcomes in Depression: Comparison of Remote Treatment Through Telepsychiatry to In-Person Treatment. *Am J Psychiatry* 161, 1471-1476.

¹⁸² Frueh, B.C., Deitsch, S.E., Santos, A.B., et al. (2000). Procedural and Methodological Issues in Telepsychiatry Research and Program Development. *Psychiatric Services* 51, 1522-1527.

¹⁸³ Hilty, D.M., Marks, S.L., Urness, D., Yellowlees, P.M., Nesbitt, T.S. (2004). Clinical and educational telepsychiatry applications: a review. *Can J Psychiatry* 49(1):12-23.

¹⁸⁴ Ruskin, P.E., et al. (2004).



of psychiatrists' travel to remote clinics more than 22 miles away from the medical center were considered.

Wellness Recovery Action Plan (WRAP). The Wellness Recovery Action Plan (WRAP) approach is a self-management and recovery system designed to help consumers identify internal and external resources and then use these tools to create their own, individualized plans for recovery. Under the WRAP model developed and disseminated by Mary Ellen Copeland,¹⁸⁵ WRAP services are provided by facilitators who have developed and used their own WRAP and who are trained and certified through participation in a five-day seminar.

A WRAP includes the following six main components: (1) developing a Daily Maintenance Plan, including a description of oneself when well and tools needed on a daily basis to maintain wellness such as maintaining a healthy diet, exercise, or stable sleep patterns; (2) identifying triggers to illness; (3) identifying early warning signs of symptom exacerbation or crisis; (4) identifying signs that symptoms are more severe; (5) developing a crisis plan or advance directive; and (6) developing a post-crisis plan.

The WRAP model includes a pre-test/post-test tool to measure the impact of the intervention. At least one study using this tool found significant increases in consumers' self-reported knowledge of early warning signs of psychosis; use of wellness tools in daily routines; ability to create crisis plans; comfort in asking questions and obtaining information about community services; and hope for recovery.¹⁸⁶ Another widely-cited study found increases in consumers' self-reporting that they have a support system in place; manage their medications well; have a list of things to do every day to remain well; are aware of symptom triggers and early warning signs of psychosis; have a crisis plan; and have a lifestyle that promoted recovery.¹⁸⁷

The WRAP model has been integrated into MHD's current peer counseling training curriculum, and federal block grant funds have been used to support training in the last fiscal year.

¹⁸⁵ Copeland, ME., WRAP-Wellness Recovery Action Plan. Retrieved at www.mentalhealthrecovery.com/art_aboutwrap.html.

¹⁸⁶ Vermont Recovery Education Project, cited in Cook, J., Mental Illness Self-Management through Wellness Recovery Action Planning (n.d.), retrieved at www.copelandcenter.com.

¹⁸⁷ Buffington E., (2003). Wellness Recovery Action Plan: WRAP evaluation, State of Minnesota. Minneapolis, MN: Mental Health Consumer/Survivor Network of Minnesota.



Appendix Five: Best Practices for Children and Families

Well Established Practices for Children and Families

Applied Behavior Analysis (ABA). ABA has good support for the treatment of autism.¹⁸⁸ ABA is used to teach new skills or eliminate negative behaviors in children two to 15 years old. ABA can be used in a school or clinic setting and is typically delivered between two and five days per week for two weeks to 11 months.

ABA is one of the most widely used approaches with this population. The ABA approach teaches social, motor, and verbal behaviors, as well as reasoning skills. ABA teaches skills through use of behavioral observation and positive reinforcement or prompting to teach each step of a behavior. Generally ABA involves intensive training of the therapists, extensive time spent in ABA therapy (20-40 hours per week), and weekly supervision by experienced clinical supervisors known as certified behavior analysts. It is preferred that a parent or other caregiver be the source for the generalization of skills outside of school. In the ABA approach, developing and maintaining a structured working relationship between parents and professionals is essential to ensure consistency of training and maximum benefit.

Behavior Therapy. Behavior therapy has support for the treatment of Attention and Hyperactivity Disorders; Substance Abuse; Depression; and Conduct Problems. Typically behavior therapy features behavior management techniques taught to teacher / parents to aid the child in replacing negative behaviors with more positive ones.¹⁸⁹

Brief Strategic Family Therapy (BSFT). Brief Strategic Family Therapy (BSFT) is a problem-focused family-based approach to the elimination of substance abuse risk factors. It targets problem behaviors in children and adolescents six to 17 years of age, and strengthens their families. BSFT provides families with tools to decrease individual and family risk factors through focused interventions that improve problematic family relations and skill

¹⁸⁸ Harris, S.L.P., and L.P. Delmolino. (2002). "Applied Behavior Analysis: Its Application in the Treatment of Autism and Related Disorders in Young Children". *Infants and Young Children*, 14(3):11-17.

Smith, T., Groen, A.D. & Wynn, J.W. (2000). Randomized Trial of Intensive Early Intervention for Children with Pervasive Developmental Disorder. *American Journal on Mental Retardation*, 105 (4), 269-285.

McConachie, H. & Diggl, T. (2006). Parent implemented early intervention for young children with autism spectrum disorder: a systematic review. *Journal of Evaluation in Clinical Practice*. (early release).

Sallows, G.O. & Graupner, T. D. (2005). Intensive Behavioral Treatment for Children with Autism: Four-Year Outcome and Predictors. *American Journal on Mental Retardation*, 110 (2), 417-438.

Eikeseth, S., Smith, T., Jahr, E. & Eldevik, E. (2002). Intensive Behavioral Treatment at School for 4- to 7-Year-Old Children with Autism: A 1-Year Comparison Controlled Study. *Behavior Modification*, 26 (1), 49-68.

Shook, G.L. & Neisworth, J.T. (2005). Ensuring Appropriate Qualifications for Applied Behavior Analyst Professionals: The Behavior Analyst Certification Board. *Exceptionality*, 13(1), 3-10

¹⁸⁹ Pelham, W. E., Wheeler, T., & Chronis, A. (1998). Empirically supported psychosocial treatments for ADHD. *Journal of Clinical Child Psychology*, 27, 190-205.



building strategies that strengthen families. It targets conduct problems, associations with anti-social peers, early substance use and problematic family relations.¹⁹⁰

The program fosters parental leadership, appropriate parental involvement, mutual support among parenting figures, family communication, problem solving, clear rules and consequences, nurturing, and shared responsibility for family problems. In addition, the program provides specialized outreach and engagement strategies to bring families into therapy. BSFT is recognized as a Model Program by SAMHSA. It was developed at the Spanish Family Guidance Center in the Center for Family Studies, University of Miami and has research support for its efficacy with Hispanic families.

Cognitive Behavior Therapy (CBT). CBT is widely accepted as an evidence-based, cost-effective psychotherapy for many disorders.¹⁹¹ It is sometimes applied in group as well as individual settings. CBT can be seen as an umbrella term for many different therapies that share some common elements. For children and youth, CBT is often used to treat depression, anxiety disorders, and symptoms related to trauma and Post Traumatic Stress Disorder.

CBT can be used for Anxious and Avoidant Disorders, Depression, Substance Abuse, Disruptive Behavior, and ADHD. It can be used with family intervention. Specific pediatric examples include Coping Cat and the Friends Program. CBT works with the individual to understand their behaviors in the context of their environment, thoughts and feelings. The premise is that a person can change the way they feel/act despite the environmental context. CBT programs can include a number of components including psychoeducation, social skills, social competency, problem solving, self-control, decision making, relaxation, coping strategies, modeling, and self-monitoring.

Functional Family Therapy (FFT). Functional Family Therapy is a well-established EBP with proven outcomes and cost benefits when implemented with fidelity for targeted populations. FFT is a research-based family program for at risk adolescents and their families, targeting youth between the ages of 11-18. It has been shown to be effective for the following range of adolescent problems: violence, drug abuse/use, conduct disorder, and family conflict. FFT targets multiple areas of family functioning and ecology for change and features well developed protocols for training, implementation (i.e., service delivery, supervision, and organizational support), and quality assurance and improvement.¹⁹²

¹⁹⁰ Szapocznik J. & Williams R.A. (2000). Brief strategic family therapy: Twenty-five years of interplay among theory, research and practice in adolescent behavior problems and drug abuse. *Clinical Child and Family Psychology Review*, 3(2), 117-135.

Szapocznik J. & Hervis O.E. (2001). *Brief Strategic Family Therapy: A revised manual*. In National Institute on Drug Abuse Treatment Manual Rockville, MD: NIDA. BSFT has support for use with Hispanic families.

¹⁹¹ Hoagwood, Kimberly, Burns, Barbara, Kiser, Laurel, et al. (2001). Evidence-based practice in child and adolescent mental health services. *Psychiatric Services*, 52:9, 1179-1189.

Weisz, J. R., Doss, J. R., Jensen, A., & Hawley, K. M. (2005). Youth psychotherapy outcome research: A review and critique of the evidence base. *Annual Review of Psychology*, 56, 337-363.

¹⁹² Alexander, J., Barton, C., Gordon, D., Grotper, J., Hansson, K., Harrison, R., et al. (1998). *Blueprints for Violence Prevention Series, Book Three: Functional Family Therapy (FFT)*, Boulder, CO: Center for the Study and Prevention of Violence.



FFT focuses on family alliance and involvement in treatment. The initial focus is to motivate the family and prevent dropout. The treatment model is deliberately respectful of individual differences, cultures, and ethnicities and aims for obtainable change with specific and individualized intervention that focuses on both risk and protective factors. Intervention incorporates community resources for maintaining, generalizing and supporting family change.¹⁹³

FFT has been widely implemented in over 130 sites (individual and statewide) in many states, including Washington, Idaho, Nevada, and Colorado. Evaluation in Washington has demonstrated reductions in recidivism and improvements in school functioning for juvenile justice involved youth.¹⁹⁴

Multidimensional Family Therapy (MDFT). MDFT is a family-based program designed to treat substance abusing and delinquent youth. MDFT has good support for Caucasian, African-American and Hispanic/Latino youth between the ages of 11 and 18 in urban, suburban and rural settings.¹⁹⁵

Treatment usually lasts between four to six months and can be used alone or with other interventions. MDFT is a multi-component and multilevel intervention system that assesses and intervenes at three levels including:

- Adolescent and parents individually,
- Family as an interacting system, and
- Individuals in the family, relative to their interactions with influential social systems (e.g., school, juvenile justice) that impact the adolescent's development.

MDFT interventions are solution-focused and emphasize immediate and practical outcomes in important functional domains of the youth's everyday life. MDFT can operate as a stand-alone outpatient intervention in any community-based clinical or prevention facility. It also has been successfully incorporated into existing community-based drug treatment programs, including hospital-based day treatment programs.

¹⁹³ Rowland, M., Johnson-Erickson, C., Sexton, T., & Phelps, D. (2001). A Statewide Evidence Based System of Care. Paper presented at the 19th Annual System of Care Meeting. Research and Training Center for Children's Mental Health.

¹⁹⁴ A Washington State Institute for Public Policy study demonstrated reductions in 18 month recidivism rates of over 15% for overall recidivism, 31.2% for felony recidivism, and 45.5% for violent recidivism. The study also demonstrated cost benefits of \$16,250 per adolescent when comparing costs of providing FFT compared to the costs of traditional treatments, incarceration and victim costs for youth not receiving FFT. R. Barnoski, (2004) Outcome Evaluation of Washington State's Research-Based Programs for Juvenile Offenders. Olympia: Washington State Institute for Public Policy.

¹⁹⁵ Hoagwood, K., Burns, B., Kiser, L., et al. (2001). Evidence-based practice in child and adolescent mental health services. *Psychiatric Services*, 52:9, 1179-1189.

Hogue, A.T., Liddle, H.A., Becker, D., & Johnson-Leckrone, J. (2002). Family-based prevention counseling for high risk young adolescents: Immediate outcomes. *Journal of Community Psychology*, 30(1), 1-22.

Liddle H.A., Dakof G.A., Parker K., Diamond G.S., Barrett K., Tejada M. (2001). Multidimensional Family Therapy for adolescent drug abuse: Results of a randomized clinical trial. *American Journal of Drug and Alcohol Abuse*, 27, 651-687.



Multidimensional Treatment Foster Care (MTFC). MTFC is a well established EBP that has demonstrated outcomes and cost savings when implemented with fidelity.¹⁹⁶ MTFC has research support for its efficacy with Caucasian, African American and American Indian youth and families. It is a type of therapeutic foster care provided to children and youth living with foster parents or for families who require an intensive period of treatment before reunification. This approach is well described in literature disseminated by the developers of MTFC,¹⁹⁷ with a primary goal to decrease problem behavior and to increase developmentally appropriate normative and prosocial behavior in children and adolescents who are in need of out-of-home placement. Youth come to MTFC via referrals from the juvenile justice, foster care, and mental health systems.

As an alternative to residential, institutional, or group care for youth with significant mental health problems, MTFC provides treatment in a foster care home with trained parents. The foster parents go through an extensive training program and receive continued support during treatment. The foster parents work closely with the case manager, who is the team leader, to tailor the program to meet the individual youth's needs and coordinate with various other community services including a family therapist, parole/probation officer, a psychiatrist for medication management, and a school liaison to monitor behavior in school.

MTFC treatment goals are accomplished by providing close supervision; fair and consistent limits; predictable consequences for rule breaking; a supportive relationship with at least one mentoring adult; and reduced exposure to peers with similar problems. Intervention is multifaceted and occurs in multiple settings. Components include:

- Behavioral parent training and support for MTFC foster parents;
- Family therapy for biological parents (or other aftercare resources);
- Skills training for youth;
- Supportive therapy for youth;
- School-based behavioral interventions and academic support; and
- Psychiatric consultation and medication management, when needed.

There are three versions of MTFC designed to be implemented with specific ages. Each version has been subjected to evaluation and found to be efficacious. The programs are:

- MTFC-P for preschool-aged children (3-5 years);
- MTFC-L for latency-aged children (6-11 years); and
- MTFC-A for adolescents (12-18 years).

¹⁹⁶ Chamberlain P, Reid J.B. (1991). Using a specialized foster care community treatment model for children and adolescents leaving the state mental hospital. *Journal of Community Psychology*, 19, 266-276.

Hoagwood, K., Burns, B., Kiser, L., et al. (2001). Evidence-based practice in child and adolescent mental health services. *Psychiatric Services*, 52:9, 1179-1189.

Kazdin, A.E., & Weisz, J.R. (Eds.) (2003). *Evidence-based psychotherapies for children and adolescents*. New York: Guilford Press.

Weisz, J.R., Doss, J.R., Jensen, A., & Hawley, K.M. (2005). Youth psychotherapy outcome research: A review and critique of the evidence base. *Annual Review of Psychology*, 56, 337-363.

¹⁹⁷ Multidimensional Treatment Foster Care (MTFC) website. (2006). MTFC Program Overview. <http://www.mtfc.com/overview.html>.



Multisystemic Therapy (MST). Multisystemic Therapy (MST) is a well-established EBP with proven outcomes and cost benefits when implemented with fidelity for youth living at home with more severe behavioral problems related to willful misconduct and delinquency.¹⁹⁸ In addition, the developers are currently working to develop specialized supplements to meet the needs of specific sub-groups of youth.

MST is an intensive home-based service model provided to families in their natural environment at times convenient to the family. MST is intensive and comprehensive with low caseloads and varying frequency, duration, and intensity levels. MST is based on social-ecological theory that views behavior as best understood in its naturally occurring context. MST was developed to address major limitations in serving juvenile offenders and focuses on changing the determinants of youth anti-social behavior.¹⁹⁹

At its core, MST assumes that problems are multi-determined and that, in order to be effective, treatment needs to impact multiple systems, such as a youth's family and peer group. Accordingly, MST is designed to increase family functioning through improved parental monitoring of children, reduction of familial conflict, improved communication, and related factors. Additionally, MST interventions focus on increasing the youth's interaction with "prosocial" peers and a reduction in association with "deviant" peers, primarily through parental mediation.²⁰⁰

MST features well developed training and fidelity tracking protocols. Therapist adherence to these protocols has demonstrated a clear relationship to outcomes in which improved family functioning (specifically, increased parental monitoring, reduction of conflict, improved communications, and related factors) leads to decreased delinquent peer affiliation, causing a subsequent decrease in delinquent behavior. Findings revealed the successful implementation of MST leads to improved family functioning, and indirectly to a decrease in peer affiliation and youth delinquency. Studies have also found that therapists who are directive without first gaining the trust and support of family members may be less effective or even detrimental. This finding fits with increasing evidence that suggests that an initial focus on collaborative, relationship building elements is necessary before the more active components of MST can be effectively applied.

¹⁹⁸ Huey, S.J. Jr., Henggeler, S.W., Brondino, M.J. & , Pickrel, S.G. (2000). Mechanisms of Change in Multisystemic Therapy: Reducing Delinquent Behavior Through Therapist Adherence and Improved Family and Peer Functioning. *Journal of Consulting and Clinical Psychology*, 68 (3), 451-467.

Schoenwald S.K., Henggeler S.W., Pickrel S.G., & Cunningham P.B. (1996). Treating seriously troubled youths and families in their contexts: Multisystemic therapy. In M. C. Roberts (Ed.), *Model programs in child and family mental health*, (pp. 317-332). Mahwah, NJ: Lawrence.

¹⁹⁹ Henggeler S.W., Weiss, J., Rowland M.D., Halliday-Boykins C. (2003). One-year follow-up of Multisystemic therapy as an alternative to the hospitalization of youths in psychiatric crisis. *Journal of the American Academy of Child & Adolescent Psychiatry* 42(5), 543-551.

²⁰⁰ Huey, S.J. Jr., Henggeler, S.W., Rowland, M.D, Halliday-Boykins, C.A., Cunningham, P.B., Pickrel, S.G., Edwards, J. (2004) Multisystemic Therapy Effects on Attempted Suicide by Youths Presenting Psychiatric Emergencies. *Journal of the American Academy of Child & Adolescent Psychiatry*. 43(2):183-190.



Parent - Child Interaction Therapy (PCIT). PCIT has strong support as an intervention for use with children ages three to six who are experiencing oppositional disorders or other problems.²⁰¹ PCIT works by improving the parent-child attachment through coaching parents in behavior management. It uses play and communication skills to help parents implement constructive discipline and limit setting. In order to improve the parent-child attachment through behavior management, the PCIT program uses structural play and specific communication skills to teach parents and children constructive discipline and limit setting.

PCIT teaches parents how to assess their child's immediate behavior and give feedback while the interaction is occurring. In addition, parents learn how to give their child direction towards positive behavior. The therapist guides parents through education and skill building sessions and oversees practicing sessions with the child. PCIT has been adapted for use with Hispanic and Native American families.

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT). TF-CBT has strong support for efficacy with children and youth aged three to 18 years old, and their parents.²⁰² It can be provided in individual, family, and group sessions in outpatient settings. TF-CBT addresses anxiety, self esteem and other symptoms related to traumatic experiences.

TF-CBT is a treatment intervention designed to help children, youth, and their parents overcome the negative effects of traumatic life events such as child sexual or physical abuse; traumatic loss of a loved one; domestic, school, or community violence; or exposure to disasters, terrorist attacks, or war trauma. It integrates cognitive and behavioral interventions with traditional child abuse therapies, in order to focus on enhancing children's interpersonal trust and re-empowerment. TF-CBT has been applied to an array of anxiety symptoms as well as: intrusive thoughts of the traumatic event; avoidance of reminders of the trauma; emotional numbing; excessive physical arousal/activity; irritability; and trouble sleeping or concentrating.

²⁰¹ Chaffin, M., Silovsky, J., Funderburk, B., Valle, L., Brestan, E., Balachova, T., et al. (2004). Parent-Child Interaction Therapy with physically abusive parents: Efficacy for reducing future abuse reports. *Journal of Consulting and Clinical Psychology* 72(3), 500-510.

Eyberg, S.M. (2003). Parent-child interaction therapy. In T.H. Ollendick & C.S. Schroeder (Eds.) *Encyclopedia of Clinical child and Pediatric Psychology*. New York: Plenum.

Querido, J.G., Eyberg, S.M., & Boggs, S. (2001). Revisiting the accuracy hypothesis in families of conduct-disordered children. *Journal of Clinical Child Psychology*, 20, 253-261.

²⁰² Cohen, J.A. & Mannarino, A.P. (1996). A treatment outcome study for sexually abused preschool children: Initial findings. *Journal of the American Academy of Child & Adolescent Psychiatry* 35(1), 42-50.

King, N., Tonge, B., Mullen, P., Myerson, N., Heyne, D., Rollings, S., Martin, R., & Ollendick, T. (2000). Treating sexually abused children with posttraumatic stress symptoms: A randomized clinical trial. *Journal of the American Academy of Child & Adolescent Psychiatry* 39(11), 1347-1355.

Mannarino, A.P., & Cohen, J.A. (1996). A follow-up study of factors that mediate the development of psychological symptomatology in sexually abused girls. *Child Maltreatment* 1(3), 246-260.

Stein, B., Jaycox, L., Kataoka, S., Wong, M., Tu, W., Elliott, M., & Fink, A. (2003). A mental health intervention for school children exposed to violence: A randomized controlled trial. *Journal of the American Medical Association* 290(5), 603-611.



It also addresses issues commonly experienced by traumatized children, such as poor self-esteem, difficulty trusting others, mood instability, and self-injurious behavior, including substance use. TF-CBT has been adapted for Hispanic/Latino children and some of its assessment instruments are available in Spanish.

Promising Practices for Children and Families

Dialectical Behavior Therapy (DBT) Approaches for Adolescents. DBT is well supported for adults, but also has moderate support for helping youth to develop new skills to deal with emotional reaction and to use what they learn in their daily lives.²⁰³ DBT for youth often includes parents or other caregivers in the skills-training group so that they can coach the adolescent in skills and so they can improve their own skills when interacting with the youth. Therapy sessions usually occur twice per week.

There are four primary sets of DBT strategies, each set including both acceptance-oriented and more change-oriented strategies. Core strategies in DBT are validation (acceptance) and problem-solving (change). Dialectical behavior therapy proposes that comprehensive treatment needs to address four functions. It needs to help consumers develop new skills, address motivational obstacles to skill use, generalize what they learn to their daily lives, and keep therapists motivated and skilled. In standard outpatient DBT, these four functions are addressed primarily through four different modes of treatment. These are group skills training, individual psychotherapy, telephone coaching between sessions when needed, and a therapist consultation team meeting, respectively. Skills are taught in four modules: mindfulness, distress tolerance, emotion regulation, and interpersonal effectiveness.

Miller, Rathus, Linehan, Wetzler, and Leigh (1997) described an adaptation of DBT for treatment of suicidal adolescents.²⁰⁴ The primary modifications included: (1) shortening treatment to 12 weeks, (2) reducing the number of skills taught and simplifying the language on the skills-training handouts, (3) including parents or other caregivers in the skills-training group in order to help them coach the adolescent in skills use and to improve their own skills when interacting with the adolescents, reducing the amount of family dysfunction, and (4) including family members in some of the adolescent's individual therapy sessions when family issues were paramount. Individual therapy sessions occur twice per week.

Early Childhood (0-6) Mental Health Consultation. Mental health consultation in early childhood settings, such as child care centers, emphasizes problem-solving and capacity-

²⁰³ Miller, A. L., Wyman, S.E., Huppert, J.D., Glassman, S.L. & Rathus, J.H. (2000). Analysis of behavioral skills utilized by suicidal adolescents receiving DBT. *Cognitive & Behavioral Practice* 7, 183-187.

Rathus, J.H. & Miller, A.L. (2002). Dialectical Behavior Therapy adapted for suicidal adolescents. *Suicide and Life-Threatening Behavior* 32, 146-157.

Trupin, E., Stewart, D., Beach, B., & Boesky, L. (2002). Effectiveness of a Dialectical Behavior Therapy program for incarcerated female juvenile offenders. *Child and Adolescent Mental Health* 7(3), 121-127.

²⁰⁴ Miller, J.H., Rathus, M.M., Linehan, S., Wetzler, E. L. (1997) Dialectical behavior therapy adapted for suicidal adolescents. *Journal of Practical Psychiatry and Behavioral Health*.



building intervention within a collaborative relationship between a professional consultant with mental health expertise and one or more individuals, primarily child care center staff, with other areas of expertise.²⁰⁵

Early childhood mental health consultation aims to build the capacity (improve the ability) of staff, families, programs, and systems to prevent, identify, treat, and reduce the impact of mental health problems among children from birth to age six and their families. Two types of early childhood mental health consultation are generally discussed, program level and child/family level. The goals of program level mental health consultation seek to improve a program's overall quality and address problems that affect more than one child, family or staff member. Consultants may assist the setting in creating an overall approach to enhance the social and emotional development of all children.

Child/family-centered consultation seeks to address a specific child or family's difficulties in the setting. The consultant provides assistance to the staff in developing a plan to address the child's needs, may participate in observation, may meet with the parents of the child, and in some cases may refer the child and family for mental health services.

Family Integrated Transitions (FIT). FIT has moderate research support as an intensive treatment program for youth who are re-entering the community from the juvenile justice system.²⁰⁶ Treatment begins in the juvenile institution and continues for four to six months in the community. FIT is based on features of other evidence-based programs (Multisystemic Therapy; Motivational Enhancement Therapy; Relapse Prevention; Dialectical Behavior Therapy). For FIT, youth receive intensive family- and community-based treatment. The most important task of the family-based intervention is to engage the family in treatment.

Home Based Crisis Intervention (HCBI). HCBI provides in-home crisis services to children and families where a child is at imminent risk of psychiatric hospitalization or out-of-home placement. According to the Report of the Surgeon General on Mental Health, there is a strong record of effectiveness for home based services, including Multisystemic Therapy.²⁰⁷ A

²⁰⁵ Brennan, E.M., Bradley, J.R., Allen, M.D., Perry, D.F., & Tsega, A. (2006, February). The evidence base for mental health consultation in early childhood settings: Research synthesis addressing staff and program outcomes. Presented at the 19th Annual Research Conference, A System of Care for Children's Mental Health, Tampa, FL.

Child Health and Development Institute of Connecticut, Inc. (2005, April). Creating a statewide system of multi-disciplinary consultation for early care and education in Connecticut. Farmington, CT.

Cohen, E. & Kaufmann, R. (2005). Early Childhood Mental Health Consultation. DHHS Pub. No. CMHS-SVP0151. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration.

Gilliam, W. (2005, May). Prekindergarteners Left Behind: Expulsion Rates in State Prekindergarten Programs. Foundation for Child Development Policy Brief Series No. 3. New York: Foundation for Child Development.

²⁰⁶ Aos, S. (2006). Washington State's Family Integrated Transitions program for juvenile offenders: Outcome evaluation and benefit-cost analysis. Document No. 04-12-1201. Olympia: Washington State Institute for Public Policy.

²⁰⁷ Burns, B., Hoagwood, K., Mrazek, P.J. (1999). Effective treatment for mental disorders in children and adolescents. *Clinical Child and Family Psychology Review*, 2 (4), 199-254.



major goal of home based services is to prevent an out-of-home placement. Linked to emergency rooms, these programs provide intensive in-home intervention for four to six weeks with the goals of diversion from out-of-home placement, teaching problem solving skills to the family, and linking the child and family with community-based resources and supports.

Mentoring Children with Severe Emotional Disorders. Big Brothers/Big Sisters have developed a mentoring model with moderate support for youth aged 10-16.²⁰⁸ In mentoring, an adult works one-on-one with a child to foster a positive relationship and provide a positive role model. The goal is for the child to learn positive social skills and problem solving skills through normal, everyday interactions.

The child and mentor participate in many different activities together in the community. The program benefits are realized as the child and mentor pursue activities together to develop self-esteem, social skills and competencies. Examples include playing a sport together, going to a museum, or engaging in any other productive and interesting activity.

Big Brothers/Big Sisters' model has research support for Caucasian, African American and other youth of color.

Positive Behavior Interventions and Supports (PBIS). PBIS is a school-based application of a behaviorally-based systems approach to enhance the capacity of schools, families, and communities to design effective environments that improve the link between research-validated practices and the environments in which teaching and learning occurs. The model includes primary (school-wide), secondary (classroom), and tertiary (individual) systems of support that improve functioning and outcomes (personal, health, social, family, work, and recreation) for all children and youth by making problem behavior less effective, efficient, and relevant, and desired behavior more functional. PBIS has three primary features: (1) functional (behavioral) assessment, (2) comprehensive intervention, and (3) lifestyle enhancement.²⁰⁹

The value of school-wide PBIS integrated with mental health, according to the Bazelon Center, lies in its three-tiered approach. Eighty percent of students fall into the first tier. For them, school-wide PBIS creates “a social environment that reinforces positive behavior and

U.S. Surgeon General. (1999). *Mental health: A report of the surgeon general*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health.

²⁰⁸ Hoagwood, K., Burns, B., Kiser, L., et al. (2001). Evidence-based practice in child and adolescent mental health services. *Psychiatric Services*, 52:9, 1179-1189.

²⁰⁹ Adelman, H. S., & Taylor, L. (1998). Reframing mental health in schools and expanding school reform. *Educational Psychologist*, 33, 135-152.

Horner, R.H., & Carr, E.G. (1997). Behavioral support for students with severe disabilities: Functional assessment and comprehensive intervention. *Journal of Special Education*, 31, 84-104.

Koegel, L.K., Koegel, R.L. & Dunlap, G. (Eds.). (1996). *Positive behavioral support: Including people with difficult behavior in the community*. Baltimore, MD: Paul H. Brookes.

Positive Behavior Interventions and Supports website: <http://www.pbis.org/main.htm>.



discourages unacceptable behaviors.”²¹⁰ A second tier of students benefits from some additional services, often provided in coordination with the mental health system. This, the report notes, makes it “easier to identify students who require early intervention to keep problem behaviors from becoming habitual” and to provide that intervention. Finally, tier-three students, who have the most severe behavioral-support needs, can be provided intensive services through partnerships between the school, the mental health system, other child-serving agencies, and the child’s family.

Problem Solving Skills / Parent Management Training. Problem Solving Skills Training has moderate support for children and youth ages 7-15 that are having problems with disruptive behavior and conduct disorders. It teaches the child how to understand social situations and use prosocial responses. Parent Management Training teaches parents to change the child's behavior at home.²¹¹ It teaches the child how to deconstruct interpersonal situations and apply prosocial responses through the three steps: learning to make practical statements that aid in effective solutions, fostering prosocial behaviors through modeling, and directing reinforcement and structural tasks.

Problem Solving Skills Training is often combined with Parent Management Training. Parent Management Training teaches parents to alter the child's behavior at home through operant conditioning. Typically, children and youth attend 12 weekly sessions for 30-50 minutes while parent training involves two to 16 weekly home sessions of 45-60 minutes each.

Respite Care. Respite care for children and families is designed to provide community-based, planned or emergency short-term relief to parents and caregivers, alleviating the pressures of ongoing care and enabling individuals with disabilities to remain in their homes and communities.²¹² Respite can be particularly effective as a diversion option in crisis situations. Respite care frequently is provided in the family home. Without respite care, many parents and caregivers experience significant stress, loss of employment, financial burdens, and marital difficulties.

Little existing research is available regarding the effectiveness of this intervention for parent, caregivers, or mental health consumers. The majority of family caregiving studies identify a need for greater quality, quantity, variety, and flexibility in respite provision.²¹³

Wraparound Service Coordination. The Washington Mental Health Division’s Expert Panel on Children’s EBPs determined that Wraparound is a service delivery process through

²¹⁰ Bazelon Center. (2006). Way to Go: School Success for Children with Mental Health Care Needs. Available at www.bazelon.org

²¹¹ Kazdin, A.E., & Weisz, J.R. (Eds.). (2003). Evidence-based psychotherapies for children and adolescents. New York: Guilford Press.

Weisz, J. R., Doss, J. R., Jensen, A., & Hawley, K. M. (2005). Youth psychotherapy outcome research: A review and critique of the evidence base. *Annual Review of Psychology*, 56, 337–363.

²¹² New Freedom Commission on Mental Health. (2003). Achieving the Promise: Transforming Mental Health Care in America. Final Report. Rockville, MD: DHHS Pub. No. SMA-03-3832 at 40.

²¹³ Jeon, Y.H., Brodaty, H., and Chesterson, J. (2005). Respite care for caregivers and people with severe mental illness: literature review. *Journal of Advanced Nursing*, 49(3), 297–306.



which any of the listed EBPs could be administered as part of a coordinated, individualized care plan. They contend that the principles and values of Wraparound (such as services are family driven and care is individualized to the unique needs of each child and family) should be incorporated into all EBP implementation planning efforts.

Wraparound is designed to provide a set of individually tailored services to the child and family using a team-based planning process. The process focuses on strengths and includes a balance between formal services and informal community and family supports. Wraparound is not a treatment in itself, but is instead a coordinating intervention to ensure the child and family receives the most appropriate set of services possible.²¹⁴

The Wraparound research base is only emerging and more extensive implementation and empirical research is needed. The National Wraparound Initiative²¹⁵ has defined ten core Wraparound Principles that guide the implementation of this planning model, including:

- **Family voice and choice** — Families must be full and active partners in every level of the Wraparound process, exercising both voice and choice.
- **Team-based** — The Wraparound approach must be a team-based process involving the family, child, natural supports, agencies, and community services working together to develop, implement, and evaluate the individualized service plan.
- **Natural supports** — Wraparound plans must include a balance of formal services and informal community and family resources.
- **Collaboration** — The plan should be developed and implemented based on an interagency, community-based collaborative process.
- **Community-based** — Wraparound must be based in the community.
- **Cultural competence** — The process must be culturally competent, building on the unique values, preferences, and strengths of children and families, and their communities.

²¹⁴ 2004 Wraparound Milwaukee Report. <http://www.co.milwaukee.wi.us/display/router.asp?docid=7851>.

Aos, S., Phipps, P., Barnoski, R., & Lieb, R. (2001). *The Comparative Costs and Benefits of Programs to Reduce Crime*. Olympia: Washington State Institute for Public Policy.

Bruns, E.J., Walker, J.S., Adams, J., Miles, P., Osher, T.W., Rast, J., VanDenBerg, J.D. & National Wraparound Initiative Advisory Group. (2004, March 1). *Toward a better understood and implemented Wraparound*. 17th Annual System of Care Research Conference, Tampa FL.

Burns, B.J., Hoagwood, K., & Maultsby, L.T. (1998). *Improving outcomes for children and adolescents with serious emotional and behavioral disorders: Current and future directions*. In Epstein, M., Kutash, K., & Duchnowski, A. (Eds.). *Outcomes for Children and Youth with Behavioral and Emotional Disorders and their Families*. Austin, TX: Pro-Ed.

Hoagwood, K., Burns, B., Kiser, L., et al. (2001). *Evidence-based practice in child and adolescent mental health services*. *Psychiatric Services*. 52:9, 1179-1189.

Walker, Janet S., Schutte, K. (2003). *Individualized Service/Support Planning and Wraparound: Practice-Oriented Resources*. Research and Training Center on Family Support and Children's Mental Health.

²¹⁵ Bruns, E.J., Walker, J.S., Adams, J., Miles, P., Osher, T.W., Rast, J., VanDenBerg, J.D. & National Wraparound Initiative Advisory Group. (2004). *Ten principles of the wraparound process*. Portland, OR: National Wraparound Initiative, Research and Training Center on Family Support and Children's Mental Health, Portland State University.



- **Individualized** — Services and supports must be individualized and meet the needs of children and families across life domains to promote success, safety, and permanence in home, school, and community.
- **Strengths-based** — Services and supports must identify and build upon the strengths of the child and family.
- **Persistence** — An unconditional commitment to serve children and families is essential.
- **Outcome-based** — Outcomes must be determined and measured for the system, for the program, and for the individual child and family.



Appendix Six: Detailed Best Practice Prioritization Process Results

At the March 2007 STI Task Force meeting, we identified criteria to guide our prioritization of best practices and subsequently confirmed these criteria with MHD. The criteria centered on the initial requirements of the contract for the benefit design project, as well as additional priorities noted by the Task Force, and they included:

- Maximizing the clinical impact on the overall system of care, with emphasis on promoting appropriate utilization of inpatient, residential, and other restrictive services, reducing inappropriate incarceration, and achieving outcomes related to housing and employment;
- Promoting recovery for adults and older adults and resilience for children and their families;
- Promoting culturally relevant practices and cultural competence more broadly;
- Promoting consumer and family-driven care;
- Leveraging best practices to promote broader system transformation; and
- Distributing effort to promote best practices across age groups, particularly children and families, adults, and older adults.

A set of secondary goals was also identified for consideration when prioritizing practices:

- Choosing practices with the widest and most immediate possible impact;
- Prioritizing five practices for possible statewide promotion, but promoting a broader culture to support as many best practices as possible; and
- Considering potential cost-offsets.

To make use of these criteria, we developed four weighting scales that were applied to each of the best practices identified (lower weighting equates to a higher priority):

- **Overall Focus Group Priority.** We used the focus group ratings to weight each best practice. Practices in the top three most discussed overall were weighted with a 1; those fourth through six with a 2; those seventh through tenth with a 3; and those over tenth with a 4. As discussed earlier, the focus groups tended to discuss recovery and resiliency focused practices more often.
- **Potential to Reduce Use of Restrictive Services.** We rated each of the best practices on their potential for reducing the use of inappropriate inpatient and residential care, as well as incarceration. Those with evidence of Major Reductions were weighted with a 1; those with evidence of Likely Reductions were weighted with a 2; and those with evidence of Possible Reductions were weighted with a 3.
- **Cross-System Integration Potential.** Some of the services analyzed pull together multiple systems to better coordinate the delivery of care. We used three levels of weighting here: high potential (1), moderate potential (2), and low potential (3).
- **Flexibility.** One of the primary concerns about best practices expressed during the focus groups and by key informants was the need for flexibility. Most best practices are rigid by design and this is key to their outcomes. Others are more flexible, either because they incorporate multiple evidence-based components (for example, Integrated Dual Disorder Treatment involves more than 10 discrete evidence-based



approaches), because they are not highly specified (for example, Peer Support and Case Management can both be used in a wide range of circumstances), or because they can be used across multiple diagnoses (such as Cognitive Behavioral Therapy). Those practices with flexible use were weighted with a 1; those without weighted with a 2.

Detailed results from the prioritization process for child and adolescent practices, adult practices, and older adult practices are provided in the table on the following pages. Based on the weighting process, we identified five priorities for statewide promotion by MHD: two child and adolescent practices, two adult practices, and one older adult practice.

For children and families, Wraparound Service Coordination received an overall weighting of 4, making it the clear top priority. Four other services received weightings of either 7 or 8: MST (7), FFT (8), MTFC (8), and FIT (8). Of these four, we selected Multidimensional Treatment Foster Care (MTFC) as the other recommended priority for two reasons. First, MTFC has the highest potential among the four for reducing the use of restrictive inpatient and residential care. Second, MST, FFT, and FIT are primarily designed for use with youth in the juvenile justice system, and the Juvenile Rehabilitation Administration has taken the lead to coordinate training and resources statewide for these services.

For adults, Integrated Dual Disorder Treatment (IDDT) received an overall weighting of 6, followed closely by Assertive Community Treatment (7), Supported Employment (7), and Peer Support (7). Based on this, we recommend that MHD prioritize IDDT and Peer Support delivered by Consumer and Family Run Organizations for statewide promotion. IDDT came out on top. Among the other three, Peer Support offers the best single modality for supporting the broad mandate from the focus groups to promote Consumer and Family Driven services. While Peer Support is currently available statewide, it is not able to be delivered currently by independent Consumer and Family Run Organizations. If the benefit design were changed to allow for the delivery of Peer Support by independent consumer and family-run organizations, we believe statewide promotion of the delivery of Peer Support by such organizations would be most responsive to the focus group priorities, and would also facilitate delivery of related supports, such as drop-in centers. ACT is not recommended for consideration as a new top priority for statewide promotion because it is already being adequately promoted. Supported Employment was not chosen as one of the top two statewide priorities because it has less potential for reducing the use of restrictive care than IDDT.

For older adults, the adult best practices may also be used. However, among practices more specifically suited to the needs of older adults, Collaborative Care in primary care settings and the Gatekeeper Program were weighted on top (Collaborative Care received a 5 and Gatekeeper one behind at a 6). Both are important supports, but we are recommending statewide promotion of Collaborative Care given its more direct service delivery nature and its broader applicability to many populations. While the Gatekeeper Program is well established and effective, it is primarily a community-based tertiary prevention initiative rather than a medical service provided to an individual consumer. While such initiatives may be funded through other sources, they are not amenable to coverage under the Medicaid program.



Best Practices for Children and Families

Prioritization of Best Practices for Children and Families						
Best Practice	Brief Definition	Overall Focus Group Priority	Potential to Reduce Restrictive Services	Cross-System Integration Potential	Flexibility	Total
Applied Behavior Analysis (ABA)	ABA supports treatment of autism by teaching new skills or eliminating negative behaviors in children 2 to 15 years old. ABA can be used in school or clinics and is typically done between 2 and 5 days per week for 2 weeks to 11 months.	4	3	3	2	12
Behavior Therapy	This involves behavior management techniques taught to teachers and parents to aid children in replacing negative behaviors with more positive ones.	4	3	3	1	11
Brief Strategic Family Therapy (BSFT)	BSFT is designed to reduce the risk of substance abuse in children and adolescents, 6 to 17 years, by providing them and their families with tools to improve family relations. BSFT has been successful with Hispanic families.	4	3	3	2	12
Cognitive Behavior Therapy (CBT)	CBT is a specific form of individual treatment that can be used for Anxious and Avoidant Disorders, Depression, Substance Abuse, Disruptive Behavior, and ADHD. CBT helps the child or youth understand their behaviors in terms of their environment, thoughts and feelings.	4	3	3	1	11
Functional Family Therapy (FFT)	FFT is a structured family therapy program designed for at-risk and court involved teens (aged 11 to 18) with significant family risk factors. FFT helps youth and their families understand their positive and negative behaviors and make wanted changes. All family members attend sessions which typically last about 3 months.	2	2	2	2	8



Prioritization of Best Practices for Children and Families						
Best Practice	Brief Definition	Overall Focus Group Priority	Potential to Reduce Restrictive Services	Cross-System Integration Potential	Flexibility	Total
Multidimensional Family Therapy (MDFT)	MDFT is a family-based program designed to treat substance abusing and delinquent youth ages 11-18. Treatment usually lasts 4 to 6 months and can be used alone or with other interventions. It has been successful with African American, Hispanic and Caucasian families.	4	3	3	2	12
Multidimensional Treatment Foster Care (MTFC)	MTFC is an alternative to residential, institutional, or group care for children and youth with significant mental health problems. MTFC provides treatment in a foster care home with trained parents. The foster parents go through an extensive training program and receive continued support during treatment. MTFC has been successful for youth ages 9 – 18, especially those with juvenile justice involvement.	4	1	1	2	8
Multisystemic Therapy (MST)	MST is a family-oriented, home-based program for juvenile offenders 12 to 17 years old. It is an intensive 3-5 month intervention that is based on the philosophy that the most effective and ethical way to help youth is by helping their families.	2	2	1	2	7
Parent-Child Interaction Therapy (PCIT)	PCIT is for use with children ages 3-6 who are experiencing oppositional disorders or other problems. PCIT works by improving the parent-child attachment through coaching parents in behavior management. It uses play and communication skills to help parents implement constructive discipline and limit setting.	4	3	2	2	11



Prioritization of Best Practices for Children and Families						
Best Practice	Brief Definition	Overall Focus Group Priority	Potential to Reduce Restrictive Services	Cross-System Integration Potential	Flexibility	Total
Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)	TF-CBT is designed for children 3 to 18 years old and their parents. It can be provided in individual, family, and group sessions in outpatient settings. TF-CBT helps with anxiety, self-esteem and other symptoms related to traumatic experiences.	4	2	2	1	9
Dialectical Behavior Therapy (DBT) Approaches for Adolescents	DBT helps youth develop new skills to deal with emotional reactions and to use what they learn in their daily lives. DBT for youth often includes parents or other caregivers in the skills-training group so that they can coach the adolescent in skills and so they can improve their own skills when interacting with the youth. Therapy sessions usually occur twice per week.	4	2	3	2	11
Early Childhood (0-6) Mental Health Consultation	Mental health consultation in early childhood settings, such as child care centers, emphasizes problem-solving and capacity-building intervention within a collaborative relationship between a professional consultant with mental health expertise and one or more individuals, primarily child care center staff, with other areas of expertise.	4	3	1	1	9
Family Integrated Transitions (FIT)	FIT is an intensive treatment program for youth who are re-entering the community from the juvenile justice system. Treatment begins in the juvenile institution and continues for four to six months in the community. FIT is based on features of other evidence based programs such as Multisystemic Therapy, Motivational Enhancement Therapy, Relapse Prevention, and Dialectical Behavior Therapy.	2	2	2	2	8



Prioritization of Best Practices for Children and Families						
Best Practice	Brief Definition	Overall Focus Group Priority	Potential to Reduce Restrictive Services	Cross-System Integration Potential	Flexibility	Total
Home Based Crisis Intervention (HCBi)	These are in-home services to support a child and his or her family during an emergency in order to provide diversion in a crisis situation from hospitalization or other out-of-home placements.	2	2	3	2	9
Mentoring Children with Severe Emotional Disorders	Big Brothers/Big Sisters have developed this successful model in which an adult works one-on-one with a child to foster a positive relationship and provide a positive role model. The goal is for the child to learn positive social skills and problem solving skills through normal, everyday interactions.	3	3	3	2	11
Positive Behavior Interventions and Supports (PBIS)	PBIS is a school-based application of a behaviorally-based systems approach to enhance the capacity of schools, families, and communities to design effective environments that improve the link between research-validated practices and the environments in which teaching and learning occurs. PBIS has three primary features: (1) functional (behavioral) assessment, (2) comprehensive intervention, and (3) lifestyle enhancement.	4	3	1	1	9
Problem Solving Skills / Parent Management Training	Problem Solving Skills Training teaches the child how to understand social situations and respond constructively. Parent Management training teaches parents to change the child's behavior at home. It is used with children and youth ages 7-15 who are having problems with disruptive behavior and conduct disorders.	4	3	3	1	11



Prioritization of Best Practices for Children and Families						
Best Practice	Brief Definition	Overall Focus Group Priority	Potential to Reduce Restrictive Services	Cross-System Integration Potential	Flexibility	Total
Respite Care	Respite care is designed to provide community-based, planned or emergency short-term relief to family caregivers or individuals, alleviating the pressures of ongoing care and enabling individuals with disabilities to remain in their homes and communities. Respite can be particularly effective as a diversion option in crisis situations.	3	2	3	1	9
Wraparound Service Coordination	Wraparound is designed to provide a set of individually tailored services to the child and family using a team-based planning process. The process focuses on strengths and includes a balance between formal services and informal community and family supports. Wraparound is not a treatment in itself, but a coordinating and planning intervention. The National Wraparound Initiative has defined ten core Wraparound Principles that guide the implementation of this planning model	1	1	1	1	4



Best Practices for Adults

Prioritization of Best Practices for Adults						
Best Practice	Brief Definition	Overall Focus Group Priority	Potential to Reduce Restrictive Services	Cross-System Integration Potential	Flexibility	Total
Assertive Community Treatment (ACT)	ACT is an integrated, self-contained service approach in which a range of treatment, rehabilitation, and support services are directly provided by a multidisciplinary team composed of psychiatrists, nurses, vocational specialists, substance abuse specialists, peer specialists, mental health professionals, and other clinical staff in the fields of psychology, social work, rehabilitation, counseling, and occupational therapy. ACT was designed for people at risk of going to the hospital or jail, or becoming homeless.	2	1	2	2	7
Cognitive Behavioral Therapy (CBT)	CBT is a specific form of individual and group treatment that can be used for Anxiety, Depression, and Trauma, with specialized forms for Substance Abuse, Eating Disorders, and ADHD. CBT helps the adult or older adult understand their behaviors in terms of their environment, thoughts and feelings.	4	3	3	1	11
Dialectical Behavior Therapy (DBT)	Dialectical behavior therapy (DBT) is designed specifically for people with self-harming behaviors and delivered through individual therapy, skills group sessions, and phone coaching.	4	2	3	2	11
Family Psychoeducation	Family psychoeducation helps families understand and cope with a family member's mental illness by providing information about the illness and developing skills for handling problems posed by mental illness.	2	2	3	2	9



Prioritization of Best Practices for Adults						
Best Practice	Brief Definition	Overall Focus Group Priority	Potential to Reduce Restrictive Services	Cross-System Integration Potential	Flexibility	Total
Illness Management and Recovery (IMR)	Illness Management and Recovery teaches people with severe mental illness how to work with professionals and significant others to manage the illness and achieve personal recovery goals.	4	2	3	2	11
Integrated Dual Disorder Treatment (IDDT)	Integrated Dual Disorders Treatment (IDDT) provides both mental health care and substance abuse services through one practitioner or treatment team in a single agency so that the consumer is not excluded from or confused by multiple programs.	3	1	1	1	6
Medication Management Approaches in Psychiatry (MedMAP)	Medication Management Approaches in Psychiatry (MedMAP) provides research-based scientific formulas or procedures to use as a guide for prescribing medications and dosages as part of the overall treatment for severe mental illness.	4	3	3	2	12
Psychosocial Rehabilitation	Psychosocial rehabilitation refers to a range of services, not including clinical treatment, designed to help individuals with serious mental illnesses recover functioning and integrate or re-integrate into their communities, generally with the least amount of professional intervention possible.	4	3	3	1	11
Supported Employment	Supported Employment brings people who specialize in employment into the treatment team. The goal is to ensure that employment is an integral part of the treatment plan and to promote a rapid return to mainstream employment.	1	2	2	2	7
Case Management	Case management coordinates service delivery to ensure continuity and integration of services for people using multiple supports.	4	2	2	1	9



Prioritization of Best Practices for Adults						
Best Practice	Brief Definition	Overall Focus Group Priority	Potential to Reduce Restrictive Services	Cross-System Integration Potential	Flexibility	Total
Comprehensive Crisis Services	Comprehensive crisis services provide short-term, round-the-clock help in a non-hospital setting during a crisis. The goal is to stabilize the individual without hospitalization or other high-cost services, and help them return to pre-crisis functioning as quickly as possible.	3	1	3	2	9
Drop-In Centers	Drop-in centers are a kind of Peer Support center – that is, centers operated by consumers themselves – with a mission to provide a place where people can direct their own recovery process. These centers can often serve as a complement to other mental health services.	1	3	3	2	9
International Center for Clubhouse Development (ICCD) Clubhouse	Mental health clubhouses are a type of rehabilitation program that is operated by consumers and staff who work side-by-side in partnership. Clubhouse members participate in a work-ordered day that emphasizes strengths rather than illnesses and provides opportunities for transitional employment.	4	2	3	2	11
Peer Support	Peer Support can encompass a range of supports delivered by consumers, including structured, scheduled activities delivered under the direct supervision of a mental health professional, informal services, or as part of a consumer-operated service, in order to support other consumers in (1) navigating services and (2) learning and exercising skills needed for coping and utilization of natural resources within the community.	1	3	2	1	7



Prioritization of Best Practices for Adults						
Best Practice	Brief Definition	Overall Focus Group Priority	Potential to Reduce Restrictive Services	Cross-System Integration Potential	Flexibility	Total
Respite Care	Respite care is designed to provide community-based, planned or emergency short-term relief to caregivers to help them cope with the pressures of ongoing care and enable individuals with disabilities to remain in their homes and communities.	4	2	3	1	10
Standardized Screening for Substance Abuse Disorders	Standardized screening for substance abuse needs is a brief, formal clinical process to identify whether a person would benefit from an in-depth assessment of substance use treatment needs (not to establish the presence or specific type of a substance abuse disorder).	3	3	1	2	9
Supportive Housing	Supportive housing (sometimes called supported housing) is a term used to describe various ways through which program staff provide individualized, flexible, and responsive services, supports, and community connections that help consumers find permanent housing that is integrated socially, reflects their personal preferences, and encourages empowerment and skills development.	2	2	2	2	8
Telepsychiatry	Telepsychiatry is a method of providing expert psychiatric treatment via telecommunications for consumers in remote locations or in areas where psychiatric expertise is scarce.	3	3	3	1	10
Wellness Recovery Action Plan (WRAP)	The Wellness Recovery Action Plan (WRAP) program is a self-management and recovery system, taught by trained facilitators who have personal experiences with WRAP plans. It is designed to help consumers identify internal and external resources and then use these tools to create their own, individualized plans for recovery.	4	3	3	2	12



Best Practices for Older Adults

Prioritization of Best Practices for Older Adults						
Best Practice	Brief Definition	Overall Focus Group Priority	Potential to Reduce Restrictive Services	Cross-System Integration Potential	Flexibility	Total
Collaborative Care	Collaborative care provides mental health care together with primary care in primary care settings in order to: (1) treat a person where he or she is most comfortable; (2) build on the established relationship of trust between a doctor and a consumer; (3) better coordinate mental health and medical care; and (4) reduce the stigma associated with receiving mental health services.	1	2	1	1	5
Gatekeeper Program for Older Adults	The Gatekeeper Program enlists and trains people who have frequent contact with older adults, such as mail carriers, bank tellers, and utility workers, to assist in identifying older adults who may need mental health services and to report them to a central information and referral office.	1	2	1	2	6
Program to Encourage Active, Rewarding Lives for Seniors (PEARLS)	The PEARLS program teaches depression management techniques to older adults through a series of eight in-home counseling sessions followed by monthly telephone calls. This intervention is appropriate for older adults with minor depression.	4	3	1	2	10



Appendix Seven: May 2007 Community Forum Results

On May 15, 2007, MHD convened a community forum to review the major findings and recommendations from each of the STI projects. Of the 149 overall participants in the forum, 134 participated in the discussion and input process for the Benefit Package Design project. Participants used an electronic response system to register their opinions regarding an array of issues presented to them from the project. This section summarizes the results of that input process. Overall, the input received through the forum reflected the priorities and input received from the earlier forums and the stakeholder focus groups described earlier in this report.

Representing a broad cross-section of stakeholders, 125 reported representation as follows:

- 20 consumers of mental health services,
- 21 family members, parents and caregivers of adult, adolescent and child consumers, of whom we estimate 13 were family members of adult or older adult consumers and 8 were family members of child and adolescent consumers,²¹⁶
- 11 represented RSNs,
- 25 represented mental health provider agencies,
- 3 represented providers from other systems,
- 19 represented DSHS staff,
- 14 represented other state, county or city government agencies,
- 2 represented the legal system (law enforcement, public defenders, prosecutors),
- 1 represented legislative staff, and
- 9 represented other stakeholder groups.

Across all stakeholder groups, 50 participants (39%) claimed to represent urban communities, 49 represented suburban communities (39%), and 28 represented rural communities (22%). Most people were from western Washington (115 or 89%), with 14 (11%) from eastern Washington.

For the benefit design discussion, we asked participants to pick a primary age group as their primary focus for the discussion:

- 22 participants chose children and families as their focus.
- 45 participants chose adults as their focus.
- 13 participants chose older adults as their focus.
- The remaining participants did not choose a specific focus.

²¹⁶ The methodology used for the electronic response did not differentiate between family members of adult and child consumers on this question, but a follow-up question asked those people who considered themselves family members to note the age group of their family member who was a consumer. More people (61) responded to this question because it allowed people to identify themselves as family members without designating that grouping as their primary stakeholder group. Of these 61 people, 24 (39%) were family members of children or adolescents, 32 (52%) family members of adults, and 3 (8%) family members of older adults. We applied these proportions to the 21 people who identified themselves as family members to estimate the breakdown reported.



Given the diversity of perspectives represented in the forum, we analyzed all responses across the stakeholder groupings, primary focuses, and community-level differences noted. Where applicable, we report key differences across groups based on these analyses.

Input on Access to Care Standards

One primary area that we reviewed with forum participants was our project’s findings and recommendations regarding Access to Care Standards (ACS). We shared the four reasons for potentially making a change in the implementation of the ACS and participants as a whole ranked the reasons as follows:

1. Many people with less intensive mental health needs do not receive care because of ACS functional requirements,
2. RSNs and providers spend too much time and resources complying with paperwork for ACS requirements (this ranked #1 for the legal system representatives),
3. High-risk people in need do not receive care because of ACS functional requirements,
4. RSNs and providers spend too little time and resources trying to manage the care of people with complicated needs (this ranked #1 for the legislative representative), and
5. Other specific concerns noted by stakeholders.

We also shared potential concerns about making a change to the implementation of the ACS. There was less consensus regarding these across stakeholder groups, so no clear ranking emerged:

- It will cost too much additional money to provide mental health care through RSNs to people with a covered diagnosis but less functional impairment, or to high-risk groups (this was the #1 concern for most groups),
- Expanding access to RSN services will dilute the ability of RSNs to serve those most in need (this was the #1 concern for RSNs and the legislative staff member),
- Expanding access to RSN services will create unwanted duplication with Healthy Options and FFS services (this was ranked #1 by other system providers), and
- Other concerns noted by individuals was ranked highest as a category by consumers, family members, and the grouping of other stakeholders.

After reviewing the concerns on both sides of the matter, we asked participants which of the following statements best represented their views about potential changes in ACS implementation:

- 52% endorsed the statement: “Change the requirements so that RSNs can serve all people with covered mental health diagnoses.”
- 32% endorsed the statement: “Change the criteria so that RSNs still serve only those most in need, but they are also able to outreach high-need cases.”
- 12% endorsed the statement: “No opinion – Not enough information provided to rate.”
- 4% endorsed the statement: “Make no changes to the current Medicaid ACS.”

When we analyzed these results by stakeholder grouping, we found that stakeholders from outside the mental health system (other system providers, other government, legislative staff, other) reversed the top two priorities. Of those offering an opinion, just under 5% endorsed making no changes to the current Medicaid ACS implementation.



Input on Implementing Best Practices

We also reviewed findings on best practice implementation. After participants spent time at their tables discussing the findings, we asked them to endorse one of four options summarizing their perspective on best practice implementation. Results were as follows:

- 60% endorsed the statement: “Prioritize three to five Best Practices for statewide implementation with new funds (adjusted rates, legislative appropriations) and ‘Centers of Excellence’.”
- 23% endorsed the statement: “Do not promote Best Practices; focus on broader access (NOTE: consumers ranked this option highest).”
- 12% endorsed the statement: “Prioritize three to five Best Practices for statewide implementation with new funds (adjusted rates, legislative appropriations).”
- 4% endorsed the statement: “No opinion – Not enough information provided to rate.”
- 1% endorsed the statement: “Make no changes: Continue to let RSNs choose Best Practices and develop them within current funding levels.”

The vast majority of participants (95%) both had opinions on this matter and wanted to make changes. However, approximately three-quarters wanted those changes to focus on statewide implementation of priority best practices and one-quarter wanted those changes to focus on broader access rather than best practices. Prioritization of potential changes varied somewhat by stakeholder group:

- Consumers were split with 46% endorsing more emphasis on overall access and 46% endorsing one of the two options for statewide promotion of priority best practices.
- Significant minorities of other state/county/city governmental agency staff (26%), mental health providers (24%), RSN representatives (20%), family members (17%), and DSHS staff (13%) also endorsed a primary emphasis on expanded access.

Overall, large majorities of every group endorsed the option of prioritizing three to five best practices for statewide implementation. We then explored with participants the five priority best practices identified by the Benefit Design project through the focus group input process described above. We presented information on each of the five best practices and asked participants how strongly they supported statewide promotion of each:

- Of those with an opinion (106 participants) on consumer and family run services, 67% agreed (strongly agree or agree) with this as a priority.
- Of those with an opinion (109 participants) on Integrated Dual Disorder Treatment, 88% agreed (strongly agree or agree) with this as a priority.
- Of those with an opinion (122 participants) on collaborative care in primary care settings, 86% agreed (strongly agree or agree) with this as a priority.
- Of those with an opinion (95 participants) on Multidimensional Treatment Foster Care, 86% agreed (strongly agree or agree) with this as a priority.
- Of those with an opinion (110 participants) on Wraparound Service Coordination, 85% agreed (strongly agree or agree) with this as a priority.

Of those who registered opinions during the forum, vast majorities (85% and higher) endorsed four of the practices. The remaining practice (consumer and family run services) was endorsed by 67% of all people with opinions. While RSN representatives endorsed this



practice at about the same level (63%), most stakeholder groups either strongly supported or opposed it. It was supported by 93% of consumers and 94% of family members. It was opposed by 72% of mental health providers, 56% of DSHS staff, and 100% of legal system representatives registering an opinion.

We then asked participants to help us make choices among the possible priorities, including the five prioritized practices just discussed, a broader-based effort to promote best practices, and the option of changing the ACS to expand access across the board. While the previous questions found all of the recommendations discussed to be endorsed by participants, given the realities of choices regarding funding, we asked participants to choose their top three priorities based on the entire discussion. These are the priorities that emerged:

- “Broader ACS criteria to allow RSNs to serve more people across the board” came out as the most often endorsed choice. However, this was because it was a moderately rated choice across most groups and was not the highest priority of any group other than mental health providers.
- “Statewide support to implement Integrated Dual Disorder Treatment (IDDT)” was rated 2nd overall, but 1st by RSNs, 1st by other system providers, 1st by DSHS, 1st by legal system representatives, and 3rd by those with a focus on services for children and adolescents.
- “Statewide support to implement Consumer/Family Run Community Service Agencies (CSAs)” was rated 3rd overall, but rated 1st by a wide margin by consumers and 1st by family members and those with a focus on services for children and families (just ahead of Wraparound Service Coordination for both groups).
- “Statewide support to implement Wraparound Service Coordination” was rated 6th overall, but 2nd by family members as a whole, 2nd by those with a focus on services for children and families, and 2nd by other system providers.
- “Statewide support to implement Collaborative Care in Primary Care Settings” was rated 4th overall, but 1st by participants with a focus on services for older adults, 2nd by mental health providers, 2nd by DSHS, 2nd by legal system representatives, 3rd by consumers, and 3rd by other system providers.
- “Support for a broad-based ‘evidence-based culture’” was rated 5th overall, but 1st by other state/county/city government representatives and 2nd by consumers.
- “Statewide support to implement a different practice” was rated 7th overall, but 3rd by legal system representatives.
- “Statewide support to implement Multidimensional Treatment Foster Care (MTFC)” was rated last (8th) overall and no group had this in its top three.

Overall, the mix of recommendations seems to reflect the priorities of the group, with the exception of MTFC. In some ways this is not surprising. During the focus groups, no group in particular identified MTFC as a need. Many parents and caregivers of children and adolescent consumers did discuss the difficulty accessing inpatient capacity, particularly longer-term inpatient capacity. Instead, the rationale of this project for choosing MTFC centered on the need for additional mental health out-of-home treatment capacity, and the recommendation of the 2004 PCG study and the literature cited in our February 2004 Preliminary Report documenting the efficacy of family-based placements. Nevertheless, 86% of forum



participants agreed or strongly agreed that MTFC should be a “top priority” for MHD to promote statewide (tied for 2nd with collaborative care and just behind top rated IDDT at 88%).



Appendix Eight: Comprehensive Cost Calculations for Prioritized Best Practices

To guide MHD and other stakeholders as they seek to determine the feasibility of implementing these services, TriWest has developed a unit cost methodology for estimating their potential costs. This model was based on the approaches described in Appendix 11 of the June 2005 Rate Certification by Milliman, Inc., and the approach was reviewed in general with the actuarial team in March 2007. Specific applications of the model were carried out for each of the priority services, and these were reviewed and revised with the actuaries in June 2007. Final, comprehensive analyses of the costs of each of the five priority services (inclusive of estimated unit costs, estimated infrastructure development costs, and possible cost offsets) are provided below for the five prioritized best practices.

Consumer and Family Run Services

The State of Arizona has developed a certification model for providers of “non-licensed behavioral health services,” referring to this subgroup of providers as Community Service Agencies (CSAs). According to Arizona’s services guide for behavioral health services,²¹⁷ CSAs are able to provide a range of services that do not require delivery by a licensed behavioral health clinician, including psychosocial rehabilitation, peer support, family support, day programs, respite care, and transportation services.²¹⁸ CSA staff members providing services covered by Medicaid must meet the same criteria that staff in more traditional provider settings must meet (such as experience and supervision requirements) for any specific service type provided.

Arizona offers this provider type under its 1115 waiver authority. We recommend that Washington State establish a CSA provider type under an amended 1915(b) waiver authority that is allowed to provide a narrow array of services, at least at the start. The primary service type that we recommend covering is Peer Support. Experience, supervision, and documentation requirements in Washington’s State Plan and state-level regulations would need to be met. The State Plan currently requires that Peer Support be provided by “peer counselors”, but appropriately leaves the definition of standards for peer counselors to state-level regulations. Washington may also explore allowing CSAs to provide other services, such as Wraparound Service Coordination or Respite, that do not require provision of the service by a licensed mental health clinician under the State’s current benefit design. Under a 1915(b) waiver, covered State Plan services may be provided by an alternative provider type such as a CSA as long as the staff providing the service meet the same criteria that staff in a State Plan defined provider setting (i.e., Community Mental Health Agency staff) would meet. Pennsylvania currently uses its 1915 waiver authority to cover outpatient services under

²¹⁷ AHCCSS Behavioral Health Services Guide: 2007. Arizona Health Care Cost Containment System: Phoenix, AZ. Downloaded at: <http://www.ahcccs.state.az.us/Publications/GuidesManuals/BehavioralHealth/BehavioralHealthServicesGuide.pdf>

²¹⁸ Keep in mind that the Arizona definitions of these services vary from those of Washington. Differences between Arizona’s covered Medicaid benefits and those of Washington State are described later in this report.



its Clinic Services option provided in long-term residential facilities, even though that provider type would not be eligible outside the waiver to deliver such services.

For the cost calculations in this report, we are estimating costs for Peer Support delivered by consumer and family-run CSAs. Staff delivering Peer Support in CSAs would need to meet the same criteria as staff delivering the service in a Community Mental Health Agency (CMHAs) setting, specifically being a certified peer specialist. Washington's Peer Support Medicaid State Plan modality allows a wide range of services to be delivered by peer specialists, including: "Self-help support groups, telephone support lines, drop-in centers, and sharing the peer counselor's own life experiences related to mental illness will build alliances that enhance each consumer's ability to function in the community. These services may occur at locations where consumers are known to gather (e.g., churches, parks, community centers, etc)." Washington is the only state of which we are aware that has successfully expanded the model to include family members of child and adolescent consumers.

Emerging evidence suggests that integrating peer specialists into a range of treatment approaches may lead to better outcomes for consumers. For example, one controlled study found that individuals served by case management teams that included consumers as peer specialists had experienced increases in several areas of quality of life and reductions in major life problems, as compared to two comparison groups of individuals served by case management teams that did not include peer specialists.²¹⁹ Washington's definition of Peer Support allows such embedding, and it also allows for Peer Support in particular settings such as drop-in centers.

Drop-in centers originated in the late 1980s to provide consumers of mental health services with opportunities for socialization, education, and emotional support as an alternative to traditional mental health treatment. Today, the concept of drop-in centers has evolved to be "peer support centers," with a mission to provide a place where consumers can direct their own recovery process and, often, to serve as a complement to other mental health services.²²⁰ Although drop-in centers generally are run by consumers, many maintain some kind of collaborative relationship with a mental health provider agency.²²¹ Studies suggest that experience at a drop-in center is associated with high satisfaction, increased quality of life, enhanced social support, and problem solving.²²²

²¹⁹ Felton, C.J., Stastny, P., Shern, D., Blanch, A., Donahue, S.A., Knight, E. and Brown, C. (1995). Consumers as peer specialist on intensive case management teams: Impact on client outcomes. *Psychiatric Services*, 46, 1037-1044.

²²⁰ Technical Assistance Guide: Consumer-run Drop-In Centers. National Mental Health Consumers' Self-Help Clearinghouse.

²²¹ Kaufmann, C.L., Ward-Colasante, C., and Farmer, J., (1993). Development and Evaluation of Drop-In Centers Operated by Mental Health Consumers. *Hospital and Community Psychiatry* 44 (7): 675-678.

²²² Schell, B. (2003). Program Manual for a Consumer-Run Drop-In Center based on the Mental Health Client Action Network in Santa Cruz, CA. Prepared for SAMHSA COSP-MultiSite Study, FliCA site. Citing Mowbray, C. T. and Tan, C. (1992). Evaluation of an Innovative Consumer-Run Service Model: The Drop-In Center. *Innovations & Research* 1(2):19-24.



Washington's Peer Support certification training also incorporates training in the Wellness Recovery Action Plan (WRAP) approach, a self-management and recovery system designed to help consumers identify internal and external resources and then use these tools to create their own, individualized plans for recovery. At least one study of WRAP found significant increases in consumers' self-reported knowledge of early warning signs of psychosis; use of wellness tools in daily routines; ability to create crisis plans; comfort in asking questions and obtaining information about community services; and hope for recovery.²²³ Another widely-cited study found increases in consumers' self-reporting that they have a support system in place; manage their medications well; have a list of things to do every day to remain well; are aware of symptom triggers and early warning signs of psychosis; have a crisis plan; and have a lifestyle that promoted recovery.²²⁴

Other states have also begun to utilize family members of children with SED as facilitators for Wraparound Service Coordination. Wraparound is designed to provide a set of individually tailored services to a child and family using a team-based planning process. Wraparound is not a treatment in itself, but is instead a coordinating intervention to ensure the child and family receives the most appropriate set of services possible.²²⁵ In our discussions with key informants, they have noted that Wraparound is generally more successful when delivered by BA-level paraprofessionals rather than MA-level clinicians.²²⁶ Projects are also beginning to draw on family members for this service in Colorado and Maryland. Additional costs for CSAs to provide Wraparound Service Coordination have not been incorporated into the rates projected below for CSAs. However, the later section below estimating additional costs to be added for Wraparound would also cover the costs of any family-run CSAs offering the service.

Cost per Unit. Based on data from a leading CSA provider in Arizona,²²⁷ we are estimating that the cost per unit of Peer Support delivered through a CSA is comparable to that delivered

²²³ Vermont Recovery Education Project, cited in Cook, J., *Mental Illness Self-Management through Wellness Recovery Action Planning* (n.d.), retrieved at www.copelandcenter.com.

²²⁴ Buffington E., (2003). *Wellness Recovery Action Plan: WRAP evaluation*, State of Minnesota. Minneapolis, MN: Mental Health Consumer/Survivor Network of Minnesota.

²²⁵ 2004 Wraparound Milwaukee Report. <http://www.co.milwaukee.wi.us/display/router.asp?docid=7851>.

Aos, S., Phipps, P. Barnoski, R., & Lieb, R. (2001). *The Comparative Costs and Benefits of Programs to Reduce Crime*. Olympia: Washington State Institute for Public Policy.

Bruns, E.J., Walker, J.S., Adams, J., Miles, P., Osher, T.W., Rast, J., VanDenBerg, J.D. & National Wraparound Initiative Advisory Group. (2004, March 1). *Toward a better understood and implemented Wraparound*. 17th Annual System of Care Research Conference, Tampa FL.

Burns, B.J., Hoagwood, K., & Maultsby, L.T. (1998). *Improving outcomes for children and adolescents with serious emotional and behavioral disorders: Current and future directions*. In Epstein, M., Kutash, K., & Duchnowski, A. (Eds.). *Outcomes for Children and Youth with Behavioral and Emotional Disorders and their Families*. Austin, TX: Pro-Ed.

Hoagwood, K., Burns, B., Kiser, L., et al. (2001). *Evidence-based practice in child and adolescent mental health services*. *Psychiatric Services*. 52:9, 1179-1189.

Walker, Janet S., Schutte, K. (2003). *Individualized Service/Support Planning and Wraparound: Practice-Oriented Resources*. Research and Training Center on Family Support and Children's Mental Health.

²²⁶ B. Kamradt, Executive Director, Wraparound Milwaukee, Personal Communication, June 12, 2007.

²²⁷ G. Johnson, Executive Director, META, Phoenix, AZ, Personal Communication, multiple dates in May 2007.



currently through a CMHA. We therefore believe that the service costs for this modality were already added to the system based on Washington's 2005 actuarial study.²²⁸ However, adequate costs to promote the infrastructure necessary to develop CSAs were not. This may very well be a contributing reason to why current levels of peer support provision by most RSNs remain below expectations, as discussed in more detail below.

The total costs add up to \$425,000 per year. These costs could be passed on to the Medicaid program in the form of certification expenses for peer specialists. Assuming that 25 peer specialists are trained per session and assuming a total of six sessions per year, this would translate into 150 peer specialists trained a year. A \$3,000 charge per specialist would cover these costs.

Factoring those costs into the Medicaid payments made to each RSN would require the costs to be added to the fees paid per hour of Peer Support delivered. In CY 2006, 75,929 hours of Peer Support were delivered statewide.²²⁹ Factoring the costs of an expanded Peer Support COE across each hour of service would add \$5.60 to the cost of each. Factoring this across the Medicaid eligible population in CY2006 of 1,088,078 yields an additional per member per month factor of \$0.033.

Anticipated Utilization and Utilization per User. As noted previously, costs for Peer Support utilization were added to RSN rates following the last rate certification. However, as of CY2006, only seven RSNs were delivering Peer Support services. In CY2006, Statewide penetration for Peer Support was 1,924 consumers or 0.18% of the Medicaid eligible population. Six RSNs provided no Peer Support. Across those that did, penetration ranged from a low of 0.01% to a high of 0.72%. Based on this, we believe that current utilization is below the amount factored into the rates following the 2005 actuarial study.

Infrastructure Support Costs per Unit. Currently Washington operates a certification program for peer specialists which provides multiple sessions per year and trains adult and family peer specialists together in a single group. The cost to operate this program is approximately \$150,000 per year and covers primarily the costs of training and limited ongoing coaching. This core capacity would have to be significantly expanded in order to support a true Center of Excellence for Peer Support. Recommended enhancements include:

- **Developing separate training tracks for adults and children** – The Peer Support needs of adults and their families and those of the parents and caregivers of children with mental health needs are quite different. Multiple stakeholders we spoke with commented on the need to develop separate tracks for adult and child peer specialists. We estimate that this would increase the costs of operating the COE by one FTE (which we estimate at \$50,000 in fully loaded costs for a peer specialist training supervisor for children and families) and three additional trainings sessions per year (which we estimate at \$20,000 per session).

²²⁸ Barclay, T. & Knowlton, S. (June 2, 2005). State of Washington, Department of Social & Health Services, Mental Health Division, Actuarial Rate Certification. Appendix 11, page 150. Milliman, Inc.

²²⁹ Statewide, only seven RSNs delivered Peer Support services. Data was provided by K. Weaver-Randall, Personal Communication, July 23, 2007.



- **Adding an evaluation capacity** – We recommend adding an evaluation capacity so that the COE includes the capacity to track fidelity and outcomes. We estimate the costs of a staff member with sufficient evaluation skills to be \$65,000 per year in fully loaded costs.
- **Adding capacity to support CSA infrastructure** – All of the informants we interviewed in Washington and other states underscored the challenges in supporting consumer and family run agencies, including coaching, administrative support, and targeted grants to support capacity. We estimate that the costs of adding this capacity to the current Peer Support infrastructure would involve one FTE (estimated at \$50,000 in fully loaded costs) and an additional \$50,000 in targeted grants to support CSA development.

Anticipated Cost Offsets. We are not estimating any additional cost offsets to the system other than those already incorporated into the current rates. However, by incorporating the costs of the current certification program into the Medicaid rates, the State will realize a cost offset through the additional Federal Financial Participation (FFP). The additional FFP would cover much of the additional costs of retooling the program to have separate adult and child-focused tracks.

Potential Annual Expenditures Needed. The cost to provide Peer Support services without robust COE supports is currently built into the rates paid to RSNs. In addition, Washington uses approximately \$150,000 in federal block grant funds to pay for the current peer specialist certification program. By expanding the current peer specialist certification program into a COE able to promote the provision of Peer Support across an expanded group of potential providers (both CMHAs and the new CSA providers), the supports could help bring Peer Support service delivery up to the levels factored into the current rates. Assuming that happened, \$215,000 in state expenditures (to cover the Medicaid match) would be needed as noted in the table below. Further assuming that freeing up the \$150,000 in federal block grant funding currently spent on Peer Support training could free up State General Funds currently going to pay for other purposes (and thereby allow these State General Funds to be shifted to other mental health priorities), the additional costs would be reduced to \$65,000 a year.

	Costs	Funding Sources
Estimated Annual Cost of Peer Support Center of Excellence	\$425,000	\$215,000 Federal \$215,000 State Match
Annual Cost of Current Peer Support Certification Program	\$150,000	Federal Block Grant
Additional Costs to State if Federal Block Grant Funds Can Be Shifted	\$ 65,000	Additional State Match

The table on the following page summarizes all of the factors included in the costs analysis for statewide Peer Support implementation through Community Service Agencies and CMHAs.



Peer Support Cost Factors Overview		H0038 – Peer Support
Medicaid Modality / Service Code		
Subject:		May want to develop additional modifiers to capture different types of interventions: WRAP activities, drop-in centers, individual interventions, group interventions
Eligibility Groups:		Adult Disabled, Child Disabled, Adult Non-Disabled
Monthly Cost Per Member Per Month (PMPM):		
Adult Disabled:	\$	0.87 2005 Actuarial Study
Child Disabled:	\$	1.39 2005 Actuarial Study
Adult Non-Disabled:	\$	0.17 2005 Actuarial Study
Center of Excellence Estimate:	\$	0.033 \$425,000 annual cost divided across 1,088,078 eligibles per month
Expected Additional Cost Offsets:		Not Applicable
ALOS:		Not Applicable
CY2006 Utilization:		
Statewide:		
Enrolled Members:		1,924 CY2006 data: 320 age 0-17, 1,502 age 18-59, 102 age 60+
H0038 Penetration:		1,088,078 0.18%
Clark RSN:		497
Enrolled Members:		69,161
H0038 Penetration:		0.72%
Greater Columbia RSN:		11
Enrolled Members:		164,010
H0038 Penetration:		0.01%
King County RSN:		1,242
Enrolled Members:		228,680
H0038 Penetration:		0.54%
Northeast RSN:		33
Enrolled Members:		16,623
H0038 Penetration:		0.20%
Peninsula RSN:		16
Enrolled Members:		49,095
H0038 Penetration:		0.03%
Spokane RSN:		66
Enrolled Members:		94,782
H0038 Penetration:		0.07%
Southwest RSN:		59
Enrolled Members:		22,691
H0038 Penetration:		0.26%



Integrated Dual Disorder Treatment (IDDT)

Integrated Dual Disorder Treatment (IDDT) involves the provision of mental health and substance abuse services through a single treatment team and co-locates all services in a single agency (or team) so that the consumer is not excluded from or confused by multiple programs.²³⁰ IDDT encompasses 14 components, each of which is evidence-based, and, when delivered in an intensive team setting (with staffing ratios of at least 15 consumers per clinician), combined mental health and substance abuse treatment is effective at engaging adults with both diagnoses in outpatient services, maintaining continuity and consistency of care, reducing hospitalization, and decreasing substance abuse, while at the same time improving social functioning.²³¹ Integrated treatment has also been shown to reduce symptoms of mental disorders and overall treatment costs for adults.²³² Fidelity to the components of IDDT is clearly tied to better clinical outcomes for adults.²³³

Cost per Unit. North Sound and Clark have both estimated costs for IDDT pilots targeting people with intensive needs at \$770 and \$783 per recipient per month, respectively. Timberlands currently provides IDDT, but focuses on a broad cross-section of people in need for \$106 per recipient per month. King County operates an IDDT pilot for its criminal justice system at a cost of \$1,050 per recipient per month. We are therefore estimating base costs at \$780 per recipient per month.

Anticipated Utilization. To estimate potential utilization, we examined RSN estimates of need from the four RSNs just noted (Clark, North Sound, King, and Timberlands). King and Timberlands were only able to estimate the percentage of all adults in need of co-occurring services (not just those in need of an intensive service such as IDDT). These estimates of need (8.1% and 3.8% of all adult enrollees) are likely higher than the need for intensive IDDT services. Clark and North Sound have both developed estimates of need for initial pilot demonstrations focused only on those most in need, but not targeted for services by the new statewide PACT program. These estimates were much lower (0.55% and 0.24%, respectively) and may understate the need for intensive IDDT somewhat, given that they are pilots. Based

²³⁰ Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Mental Health Services (CMHS) (2003). Evidence-Based Practices: Shaping Mental Health Services Toward Recovery: Co-Occurring Disorders: Integrated Dual Diagnosis Treatment Implementation Resource Kit. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services. (SAMHSA/CMHS IDDT Resource Kit).

²³¹ U.S. Surgeon General's Report, (1999). p. 288, citing Miner, C.R., Rosenthal, R.N., Hellerstein, D.J. & Muenz, L.R. (1997). Predictions of compliance with outpatient referral in patients with schizophrenia and psychoactive substance use disorders. *Archives of General Psychiatry*, 54, 706-712 and Mueser, K.T., Drake, R.D., and Miles, K.M. (1997). The course and treatment of substance use disorders in persons with severe mental illnesses. *NIDA Research Monograph*, 172, 86-109.

²³² Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Mental Health Services (CMHS) (2003). Evidence-Based Practices: Shaping Mental Health Services Toward Recovery: Co-Occurring Disorders: Integrated Dual Diagnosis Treatment Implementation Resource Kit. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services. (IDDT Resource Kit).

²³³ Drake, R., Essock, S., et al. (2001). Implementing Dual Diagnosis Services for Clients with Mental Illness. *Psychiatric Services* 52, 469-476.



on these estimates, we recommend that 1% of all Medicaid-eligible adults (ages 19 to 59) be estimated to be in need of IDDT services. This yielded a projection of need for intensive IDDT services across all enrolled adults of 2,971 adults statewide per year. This is slightly more than the number of adults hospitalized in CY2005 with co-occurring disorders (2,631). We also compared this to initial GAIN data from January through March 2007, which showed about two times this number (5,712) identified with Quadrant IV needs, so the statewide estimate of need we are using appears to cover only the top 52% (2,971 divided by 5,712) of people in need of co-occurring treatment.

Utilization per User. We estimate the average utilization per user to be 12 months of IDDT service, since the RSN estimates were based on annual data.

Infrastructure Support Costs per Unit. Given the recommendation that COEs be developed to support each best practice prioritized for statewide development, we estimated the costs of implementing a COE to support this level of IDDT implementation. We used as a basis for this the Year Two budget developed for Washington's statewide PACT implementation, which represents the first full year of statewide development efforts. That budget is approximately \$305,000 to support the development of 10 teams across the state. To serve 2,971 adults with IDDT, an estimated 37 teams would be needed (each serving 80 people, on average). If we assume that statewide implementation of IDDT will occur over a three year period (20 teams in Year One, 10 additional teams in Year Two, and 10 additional teams in Year Three), we estimate that an additional \$155,000 is needed to double the variable costs within the PACT implementation support budget in order to accommodate the additional 10 teams implemented each year. This yields a total annual COE cost of \$460,000.

We recommend building the COE support into the fee estimate paid to providers given that it represents an additional cost incurred by IDDT providers in order to be certified by the COE as able to deliver IDDT services. As a provider cost, it can be included in the amount reimbursable by Medicaid. The cost per person served varies by each year of implementation:

- In Year One, if 20 teams are implemented, they should all be operating at full capacity by the end of the year (1,600 persons served). However, it will take time to ramp up to that level of service provision. Assuming that it takes nine months for each team to ramp up to full capacity (serving no people in month one, then adding 10 people a month through the end of month nine), for 20 teams the average number of persons served per month would be more like 1,000 (62.5% of total capacity). That yields an estimate of \$38 per recipient per month (\$460,000 divided by 12 months divided by 1,000 average recipients per month).
- By Year Two, if 30 teams are implemented, 20 at full capacity and 10 averaging 62.5% of capacity, the average number of persons served per month would be 2,100. That yields an estimate of \$18 per recipient per month (\$460,000 divided by 12 months divided by 2,100 average recipients per month).
- By Year Four, all 37 teams will be at full capacity, serving an estimated 2,971 persons per month. That yields an estimate of \$13 per recipient per month (\$460,000 divided by 12 months divided by 2,971 average recipients per month).



We recommend that the COE be funded through a mix of state funding and certification payments from Medicaid IDDT providers. We recommend that the certification payments from Medicaid providers be based on the expected costs per recipient per year at full capacity (\$13 per recipient per month), with any additional funding paid for through state funds.

Anticipated Cost Offsets. The total cost to deliver IDDT to a single person per month is therefore \$793 in our model (\$780 for the core service and \$13 for the COE support). The cost per recipient is offset by several costs currently incurred in the system totaling \$513 per recipient per month, including:²³⁴

- **Cost of current mental health community outpatient services** – For the most recent year available (FY2005), the cost to serve one person in the community was \$2,161 or \$180 per month. Unfortunately, cost information is not currently collected statewide by person served, so breakdowns by age (child versus adult) or utilization (top 1% of users versus average user) are not available. Given that the group of consumers with intensive co-occurring mental health and substance abuse service needs is likely more expensive to serve than the average consumer, we estimate that current service use for those targeted for IDDT is between two and three times the average use, yielding an offset of \$450 (\$180 multiplied by 2.5) per recipient per month.
- **Reductions in inpatient and residential costs** – The cost to serve one person in an inpatient setting (community acute inpatient, evaluation and treatment unit, residential care) in FY2005 was \$7,539 on average or \$628 per recipient per month. IDDT has been shown to lead to reduced inpatient costs (reductions of up to 80% have been reported). However, given Washington's limited acute inpatient capacity, it is very likely that any reductions in community inpatient use would be back-filled by other people in need. We therefore estimate a conservative factor of 10% savings in inpatient use per recipient. Since most IDDT users are expected to be at a level of need where they will need inpatient or residential services, we will apply this conservative factor across all 2,971 users for a per recipient per month cost-offset of \$63.
- **Additional costs savings not included** – Many of the consumers with co-occurring needs targeted for IDDT are also likely using chemical dependency services through DASA. Given that the IDDT model incorporates substance abuse services within the mental health service array, DASA service use for IDDT recipients should be reduced. Data on average costs from DASA were not incorporated into this analysis, but do represent additional offsets to IDDT costs. Costs in emergency room use can also be expected to be reduced.

Potential Annual Expenditures Needed. The costs to develop and provide IDDT services per year varies by year of implementation as a function of the number of teams implemented each year. Key factors include the following:

- The average cost per team is \$748,800 (when divided by 12 months and 80 consumers served, this yields the per recipient per month figure of \$780).
- The total cost for COE support is estimated at \$460,000 per year.

²³⁴ MHD. (August, 2006). Performance Indicator Data, Expenditures per consumer for community outpatient and inpatient services. Retrieved in July 2007 from: <http://www1.dshs.wa.gov/mentalhealth/researchreports.shtml#Exp>



- The amount of Medicaid revenue that can be earned by each team to support both program and COE costs is a function of how quickly each team can ramp up to full capacity. Assuming that it takes nine months for each team to ramp up to full capacity (serving no people in month one, then adding 10 people a month through the end of month nine), 62.5% of costs for each team in their first year of operation can be covered by Medicaid costs (assuming 100% of people served have Medicaid coverage).

These factors yield the cost estimates per year summarized in the table below.

Variables	Year One	Year Two	Year Three	Year Four
New Teams	20	10	7	0
Established Teams	0	20	30	37
Total Teams	20	30	37	37
Core Team Operating Costs	\$14,976,000	\$22,464,000	\$27,705,600	\$27,705,600
COE Costs	\$ 460,000	\$ 460,000	\$ 460,000	\$ 460,000
Total Cost	\$15,436,000	\$22,924,000	\$28,165,600	\$28,165,600
Average Medicaid Recipients Served Per Month	1,000	2,100	2,750	2,960
Medicaid Revenue (\$793 per person served per month)	\$ 9,516,000	\$19,983,600	\$26,169,000	\$28,167,360
Cost Offsets for Persons Served (\$513 per person served per month)	\$ 6,156,000	\$12,927,600	\$16,929,000	\$18,221,760
Additional Medicaid Costs (Revenue minus Offsets)	\$ 3,360,000	\$ 7,056,000	\$ 9,240,000	\$ 9,945,600
Additional State-Only Funding Needed (Total Cost minus Medicaid Revenue)	\$ 5,920,000	\$ 2,940,400	\$ 1,996,600	\$ -

The table on the following page summarizes all of the factors included in the costs analysis for statewide IDDT implementation.



Integrated Dual Disorder Treatment (IDDT) Cost Factors Overview	
Medicaid Modality / Service Code	S9480 - Intensive Outpatient Services
Subject:	IDDT with Fidelity (recommend adding modifier to designate - eg, "I")
Eligibility Group:	Adult Disabled
Monthly Cost Per Member Served:	\$ 780
Clark RSN:	\$ 783 Estimate for new team to be developed
Timberlands RSN:	\$ 106 Estimated costs per user
King County RSN:	\$ 1,050 Costs per user for criminal justice system pilot
North Sound RSN:	\$ 770 Estimate for new team to be developed
Center of Excellence Estimate:	\$ 13
Expected Cost Offsets:	\$ 513
Baseline Community OP Costs:	\$ 450 250% of average CY2005 community OP costs per person served
Inpatient / Residential Savings:	\$ 63 10% of average CY2005 community inpatient and residential costs per person served
Other Offsets (reduced ER use, DASA savings):	Not Estimated
ALOS:	Assume 12 months
Estimate of need:	
Statewide Need:	2,971 Estimate of 1% of enrollees
Enrolled Members:	297,092 FY2005 MH Performance Indicators - Enrollees Age 18-59
Estimated S9480I Penetration:	1.00%
Number of Teams Needed:	37 Assuming 80 persons served per team
Clark RSN Need:	100 Current projections for IDDT
Enrolled Members:	18,065 FY2005 MH Performance Indicators - Enrollees Age 18-59
Estimated S9480I Penetration:	0.55%
Timberlands RSN Need:	260 Clients served July - Dec 2006
Enrolled Members:	6,794 FY2005 MH Performance Indicators - Enrollees Age 18-59
Estimated S9480I Penetration:	3.83%
King County RSN Need:	5,176 30% system-wide prevalence factor applied to Tier 3A and 3B clients
Enrolled Members:	64,092 FY2005 MH Performance Indicators - Enrollees Age 18-59
Estimated S9480I Penetration:	8.08%
North Sound RSN Need:	100 25% of LOCUS Level Four clients estimate used in RFQ 2007
Enrolled Members:	42,230 FY2005 MH Performance Indicators - Enrollees Age 18-59
Estimated S9480I Penetration:	0.24%



Wraparound Service Coordination

Description of Best Practice. Wraparound Service Coordination (Wraparound) is designed to provide a set of individually tailored services to the child and family using a team-based planning process. The process focuses on strengths and includes a balance between formal services and informal community and family supports. It is important to keep in mind when reviewing the cost analysis below that Wraparound is not a treatment in itself, but is instead a coordinating intervention to ensure the child and family receives the most appropriate set of services possible.²³⁵ As such, it enhances the effectiveness of other services, but does not replace them.

Wraparound is currently a reimbursable code under High Intensity Treatment. The model of fidelity-based Wraparound described here is the model based on the consensus statement of the National Wraparound Initiative (NWI).²³⁶ We recommend that fidelity-based Wraparound be distinguished in the encounter reporting protocols from other approaches termed “wraparound”, many of which also include active treatment services in addition to service coordination. We further recommend that fidelity be monitored for any provider delivering fidelity-based Wraparound. The most widely used scale for assessing Wraparound fidelity is the Wraparound Fidelity Index – Version 3.0 (WFI-3). In order to address limitations in the WFI-3 (primarily that it only assesses adherence to principles and not fidelity to a model or set of specific activities), a revised version of the tool has been developed incorporating the guidance of the NWI. This version, the WFI-4, reflects recent development of a model that includes a description of specific phases and activities of the Wraparound process.²³⁷ The

²³⁵ 2004 Wraparound Milwaukee Report. <http://www.co.milwaukee.wi.us/display/router.asp?docid=7851>.

Aos, S., Phipps, P. Barnoski, R., & Lieb, R. (2001). *The Comparative Costs and Benefits of Programs to Reduce Crime*. Olympia: Washington State Institute for Public Policy.

Bruns, E.J., Walker, J.S., Adams, J., Miles, P., Osher, T.W., Rast, J., VanDenBerg, J.D. & National Wraparound Initiative Advisory Group. (2004, March 1). *Toward a better understood and implemented Wraparound*. 17th Annual System of Care Research Conference, Tampa FL.

Burns, B.J., Hoagwood, K., & Maultsby, L.T. (1998). *Improving outcomes for children and adolescents with serious emotional and behavioral disorders: Current and future directions*. In Epstein, M., Kutash, K., & Duchnowski, A. (Eds.). *Outcomes for Children and Youth with Behavioral and Emotional Disorders and their Families*. Austin, TX: Pro-Ed.

Hoagwood, K., Burns, B., Kiser, L., et al. (2001). *Evidence-based practice in child and adolescent mental health services*. *Psychiatric Services*, 52:9, 1179-1189.

Walker, Janet S., Schutte, K. (2003). *Individualized Service/Support Planning and Wraparound: Practice-Oriented Resources*. Research and Training Center on Family Support and Children’s Mental Health.

²³⁶ Bruns, E.J., Walker, J.S., Adams, J., Miles, P., Osher, T.W., Rast, J., VanDenBerg, J.D. & National Wraparound Initiative Advisory Group. (2004). *Ten principles of the wraparound process*. Portland, OR: National Wraparound Initiative, Research and Training Center on Family Support and Children’s Mental Health, Portland State University.

²³⁷ Bruns, E.J., Walker, J.S., Adams, J., Miles, P., Osher, T.W., Rast, J., VanDenBerg, J.D. & National Wraparound Initiative Advisory Group. (2004, March 1). *Toward a better understood and implemented Wraparound*. 17th Annual System of Care Research Conference, Tampa FL.

Bruns, E.J., Walker, J.S., Adams, J., Miles, P., Osher, T.W., Rast, J., VanDenBerg, J.D. & National Wraparound Initiative Advisory Group. (2004). *Ten principles of the wraparound process*. Portland, OR: National Wraparound Initiative, Research and Training Center on Family Support and Children’s Mental Health, Portland State University.



WFI-4 assesses both adherences to principles as well as fidelity to these activities. At this time, the WFI-4 exists only in a pilot form. The Wraparound Evaluation and Research Team, based at the University of Washington and headed by Eric Bruns, PhD, is able to make the form available for sites that wish to participate in the pilot.

Cost per Unit. The staffing model in the table below was used to estimate a unit cost of \$793 per month. This staffing approach is based on the model used by Wraparound Milwaukee, which employs BA-level care managers with maximum caseloads of 9 (they assume an average of 7.5 for budgeting), a more senior lead worker with a half caseload, a supervisor, and administrative support.²³⁸

Wraparound Service Coordination Staffing and Cost Model			
Salaries	Salary/Rate	# FTEs	Cost
Supervisor	\$50,000	1	\$50,000
Lead Worker (half caseload)	\$40,000	1	\$40,000
Care Managers (BA-level)	\$30,000	8	\$240,000
Administrative Assistant	\$25,000	1	\$25,000
Sub-Total Salary		11	\$355,000
Benefits/Taxes	22%		\$78,100
Total Personnel Costs		11	\$433,100
Non-Payroll Costs	25%		\$108,275
Total Direct Expenses			\$541,375
Indirect	12%		\$64,965
Total Program Costs			\$606,340
Cases Per Month	Assume average of 7.5		63.75
Average Costs Per Child			Rate
			Monthly
			\$793

This model likely differs to some degree from those reported by RSNs, which ranged from \$742 to \$2,588 a month in costs. The higher costs reported by some RSNs may have reflected additional in-home treatment costs embedded in the Wraparound model, which in this cost analysis would need to be broken out from the costs simply of the Wraparound Service Coordination. Furthermore, this estimate only covers the Medicaid-reimbursable costs associated with the intervention. It does not include additional funds for ancillary supports critical to the successful implementation of Wraparound, such as flexible funds (which we would estimate at an additional \$500 per family per year, which would not be reimbursable under Medicaid), transportation supports, and direct services provided to family members of the covered child.

Anticipated Utilization. To estimate potential utilization, we averaged RSN estimates from three RSNs (Clark, Greater Columbia, King) to yield the projection of 0.56 percent of enrolled children (9.1% of children served) or 3,143 children statewide needing Wraparound. This estimate compares favorably with information compiled by MHD regarding the number of children with intensive service needs; to the extent our estimate is incorrect, it is likely too

²³⁸ B. Kamradt, Executive Director, Wraparound Milwaukee, Personal Communication, June 12, 2007.



low. In a December 2006 analysis by MHD based on FY2004 data,²³⁹ the following trends were documented:

- 1,345 children per year served by MHD alone in inpatient, institutional, or residential settings.²⁴⁰ This is in addition to 1,465 children with mental health needs served by Children's Administration (CA) in residential settings and 2,046 children with mental health needs served by Juvenile Rehabilitation Administration (JRA) in institutional settings.
- 2,397 children were served by three or more DSHS programs (MHD, CA, JRA, or Medical Assistance). 4,499 were served by some combination of MHD and CA or JRA.
- 4,441 children used both DASA and MHD services (this number may overlap with the numbers of children just noted as served by multiple DSHS agencies).

Utilization per User. We estimate the average utilization per user to be 16 months, based on information from national experts (B. Kamradt, M. Zabel). This also matches the utilization of the Greater Columbia RSN project. To incorporate this, the total number of service recipients once the program is fully up and running will be 4,191 (one and one-third times the annual need).

Infrastructure Support Costs per Unit. In addition, we estimate that it would add an additional \$13 per recipient per month to cover the costs of a statewide Center of Excellence to support delivery of Wraparound. This estimate was based on the approximate budget of Maryland's Innovations Institute (\$500,000 a year), the leading COE nationally supporting statewide implementation of Wraparound Service Coordination.²⁴¹ These costs were divided across the expected 3,143 annual users.

Anticipated Cost Offsets. The total cost to deliver Wraparound to a single child per month is therefore \$806 in our model (\$793 for the core service and \$13 for the COE support). The cost per recipient is offset by expected reductions in MHD inpatient and residential costs currently incurred in the system totaling \$63 per recipient per month. This estimate likely significantly understates the potential cost savings. Key factors considered include:²⁴²

- **Cost of current mental health community outpatient services** – For the most recent year available (FY2005), the annual cost to serve one person in the community was \$2,161 or \$180 per month. As previously noted, cost information is not currently collected statewide by person served, so breakdowns by age (child versus adult) or utilization (top 1% of users versus average user) are not available. Given that the group of children in need of Wraparound Service Coordination is likely more

²³⁹ J. Hall, MHD, Personal Communication, June 18, 2007. This was an untitled December 2006 powerpoint presentation regarding children with complex needs.

²⁴⁰ The 1,345 figure excludes children receiving only Children's Long-term Inpatient (CLIP) services. A total of 39 children with mental health diagnoses were in long-term CLIP placements as of January 2007, per data provided by MHD (C. Du, MHD, Personal Communication, July 20, 2007).

²⁴¹ M. Zabel, Director, Innovations Institute, Personal Communication, multiple dates in June 2007.

²⁴² MHD. (August, 2006). Performance Indicator Data, Expenditures per consumer for community outpatient and inpatient services. Retrieved in July 2007 from:

<http://www1.dshs.wa.gov/mentalhealth/researchreports.shtml#Exp>



expensive to serve than the average consumer, we estimate that current service use for those targeted for Wraparound is between four and five times the average use, yielding an estimate of current outpatient costs of \$810 (\$180 multiplied by 4.5) per recipient per month. However, since Wraparound is not an active treatment service, we do not estimate any reduction in community outpatient costs. There may be reductions in length of stay (to the extent stays average more than 16 months), but this data was not available for incorporation into the analysis.

- **Reductions in inpatient and residential costs** – The cost to serve one person in an inpatient setting (community acute inpatient, evaluation and treatment unit, residential care) in FY2005 was \$7,539 on average or \$628 per recipient per month. This does not include CA residential or JRA institutional expenditures. However, given Washington’s limited acute inpatient and mental health residential capacity, it is very likely that any reductions in community inpatient or residential use would be back-filled by other people in need. A decrease in residential use of 15% to 25% is reasonable based on past research on Wraparound Service Coordination. We estimated this by computing a rough mid-point between the findings of major studies of Wraparound, including a best case scenario based on Wraparound Milwaukee data, which achieved a 21% reduction in residential treatment costs per youth after the first year, reaching maximum savings of 65% by year six.²⁴³ We also looked at the lowest estimate we found in a major study, the Vermont Wraparound study’s documentation of a decrease of 10% the first year, reaching a savings of 18% by year two (the study did not document changes after year two).²⁴⁴ Based on all of this, we therefore estimate a conservative factor of 10% savings in inpatient and residential use per recipient, for a per recipient per month cost-offset of \$63.
- **Additional costs savings not included** – Many of the children targeted for Wraparound are also using residential services through CA, institutional services through JRA, and chemical dependency services through DASA. Given that Wraparound can be expected to reduce all residential services and better coordinate other supports, this additional service use should also be reduced, by factors of 10-20% based on a typical length of stay. Data on average costs from CA, JRA, and DASA were not incorporated into this analysis, but do represent additional offsets to Wraparound costs.

Potential Annual Expenditures Needed. The costs to develop and provide Wraparound Service Coordination per year varies by year of implementation as a function of the number of teams implemented each year. Key factors include the following:

- The average cost per team is \$606,340 (when divided by 12 months and 63.75 children served per month, this yields the per recipient per month figure of \$793). It will take 65.5 teams to serve the 4,191 children that will need the service each year once the program is fully implemented.

²⁴³ B. Kamradt, Executive Director, Wraparound Milwaukee, Personal Communication, June 12, 2007. See also: 2004 Wraparound Milwaukee Report. <http://www.co.milwaukee.wi.us/display/router.asp?docid=7851>.

²⁴⁴ Kendziora, K., Bruns, E., Osher, D., Pacchiano, D., & Mejia, B. (2001). *Systems of Care: Promising Practices in Children’s Mental Health, 2001 Series, Volume 1*. Washington, D.C.: Center for Effective Collaboration and Practice, American Institutes for Research.



- The total cost for COE support is estimated at \$500,000 per year.
- The amount of Medicaid revenue that can be earned by each team to support both program and COE costs is a function of how quickly each team can ramp up to full capacity. Assuming that it takes nine months for each team to ramp up to full capacity (serving no people in month one, then adding 8 people a month through the end of month nine), 62.5% of costs for each team in their first year of operation can be covered by Medicaid costs (assuming 100% of people served have Medicaid coverage).

These factors yield the cost estimates per year summarized in the table below.

Variables	Year One	Year Two	Year Three	Year Four
New Teams	22	22	21.5	0
Established Teams	0	22	44	65.5
Total Teams	22	44	65.5	65.5
Core Team Operating Costs	\$13,339,480	\$26,678,960	\$39,715,270	\$39,715,270
COE Costs	\$ 500,000	\$ 500,000	\$ 500,000	\$ 500,000
Total Cost	\$13,839,480	\$27,178,960	\$40,215,270	\$40,215,270
Average Medicaid Recipients Served Per Month	880	2,288	3,676	4,191
Medicaid Revenue (\$806 per person served per month)	\$ 8,511,360	\$22,129,536	\$35,554,272	\$40,535,352
Cost Offsets for Persons Served (\$63 per person served per month)²⁴⁵	\$ 665,280	\$ 1,729,728	\$ 2,779,056	\$ 3,168,396
Additional Medicaid Costs (Revenue minus Offsets)	\$ 7,846,080	\$20,399,808	\$32,775,216	\$37,366,956
Additional State-Only Funding Needed (Total Cost minus Medicaid Revenue)	\$ 5,328,120	\$ 5,049,424	\$ 4,660,998	\$ (320,082)

The table on the following page summarizes all of the factors included in the costs analysis for statewide Wraparound implementation.

²⁴⁵ This figure does not include significant cost-offsets in inpatient, residential and institutional services delivered by CA, JRA, and DASA for youth served. Cost-offsets are therefore likely underestimated by a significant factor.



Wraparound Service Coordination Cost Factors Overview	
Medicaid Modality / Service Code	H2022 – Community Based Wraparound
Subset:	With Fidelity to NWI Standards (recommend adding modifier to designate - eg, "F")
Eligibility Group:	Child Disabled
Monthly Cost Per Member Served:	<p>Clark RSN: \$ 793</p> <p>Greater Columbia RSN: \$ 2,588</p> <p>King County RSN: \$ 2,169</p> <p>Estimated H2022F Penetration: \$ 742</p>
Center of Excellence Estimate:	Based on Wraparound Milwaukee staffing model
Expected Cost Offsets:	<p>Current cost per member served per month (13,781 hours at \$74.38 annually across avg of 33 youth/month)</p> <p>Assumes 1:8 ratio, 3 care coordinators, parent partner, program budget of \$624,600</p> <p>Monthly cost of \$396 for 1:15 ratio converted to 1:8 ratio</p> <p>Assumes annual cost of \$500,000</p>
Other Offsets (reduced ER use, DASA savings):	Assumes no community OP cost savings since Wraparound is a service coordination intervention, not a treatment intervention
ALOS:	10% of average CY2005 community inpatient and residential costs per person served
Estimate of need:	Data not available for estimate
Statewide Need:	Per Key Informants (B. Kamradt, M. Zabel)
Enrolled Members:	Midpoint of 0.56% of enrollees
Estimated H2022F Penetration:	FY2005 MH Performance Indicators - Enrollees Under Age 18
Number of Teams Needed:	561,268
Clark RSN Need:	0.56%
Enrolled Members:	65.5
Estimated H2022F Penetration:	Assuming 64 persons served per team
Greater Columbia RSN Need:	RSN estimate - 5% of children served
Enrolled Members:	132
Estimated H2022F Penetration:	FY2005 MH Performance Indicators - Enrollees Age 18-59
Greater Columbia RSN Need:	RSN estimate - 10% of children served
Enrolled Members:	486
Estimated H2022F Penetration:	FY2005 MH Performance Indicators - Enrollees Age 18-59
King County RSN Need:	All Tier 3b children in 2006 (4Q proportion extrapolated to entire year)
Enrolled Members:	826
Estimated H2022F Penetration:	FY2005 MH Performance Indicators - Enrollees Age 18-59
Statewide Utilization:	Statewide need multiplied by factor of 1.333 given 16 month ALOS
Estimated H2022F Penetration:	4,191



Multidimensional Treatment Foster Care (MTFC)

Description of Best Practice. MTFC is a well established EBP that has demonstrated outcomes and cost savings when implemented with fidelity.²⁴⁶ MTFC has research support for its efficacy with Caucasian, African American and American Indian youth and families. It is a type of therapeutic foster care provided to children and youth living with foster parents or for families who require an intensive period of treatment before reunification. This approach is well described in literature disseminated by the developers of MTFC,²⁴⁷ with a primary goal to decrease problem behavior and to increase developmentally appropriate normative and prosocial behavior in children and adolescents who are in need of out-of-home placement. Youth come to MTFC via referrals from the juvenile justice, foster care, and mental health systems. As an alternative to residential, institutional, or group care for youth with significant mental health problems, MTFC provides treatment in a foster care home with trained parents. The foster parents go through an extensive training program and receive continued support during treatment. The foster parents work closely with the case manager, who is the team leader, to tailor the program to meet the individual youth's needs and coordinate with various other community services including a family therapist, parole/probation officer, a psychiatrist for medication management, and a school liaison to monitor behavior in school. There are three versions of MTFC designed to be implemented with specific ages. Each version has been subjected to evaluation and found to be efficacious. The programs are:

- MTFC-P for preschool-aged children (3-5 years);
- MTFC-L for latency-aged children (6-11 years); and
- MTFC-A for adolescents (12-18 years).

The selection of MTFC as a priority for statewide development centered on the need for additional mental health out-of-home treatment capacity, and the recommendation of the 2004 PCG study and the literature cited in Appendix Five documenting the efficacy of family-based placements. Furthermore, 86% of the May 2007 Community Forum participants agreed or strongly agreed that MTFC should be a “top priority” for MHD to promote statewide.

That being said, it is not clear that the MTFC should be implemented in all instances with rigid adherence to the parameters articulated by its purveyors, TFC Consultants, Inc. It seems clear from our discussions with MHD and CA staff closely involved with the current MTFC pilots that some additional flexibility in the model is needed on the part of the purveyors, particularly in terms of their insistence that the model operate with 10 beds. To be of use in

²⁴⁶ Chamberlain P, Reid J.B. (1991). Using a specialized foster care community treatment model for children and adolescents leaving the state mental hospital. *Journal of Community Psychology*, 19, 266-276.

Hoagwood, K., Burns, B., Kiser, L., et al. (2001). Evidence-based practice in child and adolescent mental health services. *Psychiatric Services*, 52:9, 1179-1189.

Kazdin, A.E., & Weisz, J.R. (Eds.) (2003). *Evidence-based psychotherapies for children and adolescents*. New York: Guilford Press.

Weisz, J.R., Doss, J.R., Jensen, A., & Hawley, K.M. (2005). Youth psychotherapy outcome research: A review and critique of the evidence base. *Annual Review of Psychology*, 56, 337-363.

²⁴⁷ Multidimensional Treatment Foster Care (MTFC) website. (2006). MTFC Program Overview. <http://www.mtfc.com/overview.html>.



more rural areas of Washington, it seems important that the model be able to operate with fewer beds (i.e., 5 bed models). Given the importance that family-based interventions be carried out close enough to parents and caregivers so that they can be regularly involved, allowing smaller programs in rural areas seems much preferable to larger programs located further from families. Given the scope of implementation recommended in this cost analysis, it seems imperative that TFC Consultants, Inc., be willing to work with MHD to develop and pilot additional variations of the model to meet the broad range of needs of children and their families in Washington.

Cost per Unit. MHD is currently estimating costs per day for MTFC in its Kitsap pilot at \$184 a day.²⁴⁸ Of these costs, approximately half (\$92) is reimbursable by Medicaid (half of which is funded by the State and half of which is federal financial participation) and the remaining half (\$92) must be paid entirely with State Funds.²⁴⁹ We are recommending that this service be paid for entirely by MHD in order to spare families the need to coordinate with yet another agency. This assumes that, if families are already involved with CA, CA will cover the costs of needed out-of-home care (outside of the cost estimates in this report). The cost estimates in this report cover only the costs of MTFC delivered by RSNs to mental health consumers not involved with CA. We realize that in many cases out-of-home costs are currently split by CA and RSNs. We have attempted to factor this into our cost-offset calculations by estimating reductions in the use of the portion of these services we expect to be replaced by the MHD-funded MTFC.

Anticipated Utilization and Utilization Per User. Based on discussions with MHD and CA staff, we are projecting three different utilization scenarios:

- Low Range: This represents a model focused only on acute cases with 105 beds (five 10-bed programs, plus 11 5-bed programs for smaller RSNs) and ALOS of 6 months.
- Mid-Range: This represents a model focused on acute and intermediate stay cases with 165 beds (seven 10-bed programs, plus 13 5-bed programs for smaller RSNs) and ALOS of 7.5 months.
- High Range: This represents a model focused on more intermediate-term care with 230 beds (18 10-bed programs, plus 10 5-bed programs for smaller RSNs) and ALOS of 9 months.

Infrastructure Support Costs per Unit. Infrastructure support costs vary between the first year and following years since it will take time to ramp up to a full level of service provision. It is expected that it will take six months for each 5-bed team to ramp up to full capacity (serving no people in month one, then adding one person a month through the end of month five), and eleven months for each 10-bed team to ramp up to full capacity (serving no people in month one, then adding one person a month through month eleven). Given the scope of the planned implementation, it may be possible to negotiate a reduced rate with the purveyor, TFC Consultants, Inc. However, this cost analysis assumes that first year training and fidelity monitoring costs (inclusive of consulting costs and travel) will be \$50,000 for each 10-bed

²⁴⁸ R. McIlvaine, MHD, Personal Communication, June 21, 2007.

²⁴⁹ This percentage is approximately the typical proportion of BRS treatment foster care typically reimbursable under Medicaid, per J. Greenfield, DSHS Children's Administration, Personal Communication, August 1, 2007.



team (\$25,000 for 5-bed teams, assuming that two 5-bed teams meet jointly with the consultants). Second year and following costs are assumed to be \$10,000 for each 10-bed team (\$5,000 for 5-bed teams, again assuming that two 5-bed teams meet jointly with the consultants). These costs range by year differently for each of the three estimates:

- Low Range: Assuming a six year implementation time-frame, infrastructure costs for 5 10-bed programs, plus 11 5-bed programs for smaller RSNs ranges from \$100,000 to \$185,000 per year (see the first major table below).
- Mid-Range: Assuming a six year implementation time-frame, infrastructure costs for 7 10-bed programs, plus 13 5-bed programs for smaller RSNs ranges from \$100,000 to \$260,000 per year (see the second major table below).
- High Range: Assuming a six year implementation time-frame, infrastructure costs for 18 10-bed programs, plus 10 5-bed programs for smaller RSNs ranges from \$230,000 to \$390,000 per year (see the third major table below).

Anticipated Cost Offsets. The total cost to deliver MTFC to a single child per month is therefore \$2,798 per recipient for Medicaid treatment (\$92 per day times 30.4 days per month), \$2,798 per recipient for State funds to support room and board (\$92 per day times 30.4 days per month), and the additional infrastructure costs noted above. The cost per recipient is offset by expected reductions in the costs of currently delivered outpatient services, plus reduced MHD inpatient and residential costs currently incurred in the system, totaling \$1,124 per recipient per month. This estimate likely significantly understates the potential cost savings. Key factors considered include:²⁵⁰

- **Cost of current mental health community outpatient services** – For the most recent year available (FY2005), the annual cost to serve one person in the community was \$2,161 or \$180 per month. As previously noted, cost information is not currently collected statewide by person served, so breakdowns by age (child versus adult) or utilization (top 1% of users versus average user) are not available. Given that the group of children in need of MTFC is likely more expensive to serve than the average consumer, we estimate that current service use for those targeted for MTFC is between four and five times the average use, yielding an estimate of current outpatient costs of \$810 (\$180 multiplied by 4.5) per recipient per month. Since MTFC is an all inclusive service, all of these costs are saved.
- **Reductions in inpatient and residential costs** – The cost to serve one person in an inpatient setting (community acute inpatient, evaluation and treatment unit, residential care) in FY2005 was \$7,539 on average or \$628 per recipient per month. This does not include CA residential or JRA institutional expenditures. However, given Washington’s limited acute inpatient and mental health residential capacity, it is very likely that any reductions in community inpatient or residential use would be back-filled by other people in need. A decrease in inpatient and residential use of 50% nevertheless seems reasonable based on discussions with MHD and CA staff. Based

²⁵⁰ MHD. (August, 2006). Performance Indicator Data, Expenditures per consumer for community outpatient and inpatient services. Retrieved in July 2007 from:
<http://www1.dshs.wa.gov/mentalhealth/researchreports.shtml#Exp>



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on all of this, we therefore estimate a conservative factor of 50% savings in inpatient and residential use per recipient, for a per recipient per month cost-offset of \$314.

- **Additional costs savings not included** – Many of the children targeted for MTFC might also use residential services through CA, institutional services through JRA, and chemical dependency services through DASA. Given that MTFC can be expected to reduce all residential services and better coordinate other supports, this additional service use should also be reduced. Data on average costs from CA, JRA, and DASA were not incorporated into this analysis, but do represent additional offsets to MTFC costs.

Potential Annual Expenditures Needed. Based on our analysis, the costs to develop and provide MTFC per year varies by year of implementation as a function of the number of teams implemented each year. The number of teams needed, persons served by the end of the six year implementation schedule, and costs are summarized in the table below for each of the three capacity estimates.

Variables	Low Range	Medium Range	High Range
Total Teams in Year Six	16	20	28
Full (10 beds)	5	7	18
Half (5 beds)	11	13	10
Total Cost in Year One	\$1,443,200	\$1,443,200	\$3,968,800
Total Cost in Year Six	\$7,156,800	\$9,201,600	\$15,676,800
Average Medicaid Recipients Per Month in Year Six	105	135	230
Medicaid Recipients Served Per Year in Year Six	210²⁵¹	216²⁵²	307²⁵³
Medicaid Cost Offsets in Year Six (\$1,124 per person served)	\$1,416,240	\$1,820,880	\$ 3,102,240
Additional Medicaid Costs in Year Six (Revenue minus Offsets)	\$1,306,942	\$1,680,354	\$ 2,862,825
Additional State-Only Funding Needed in Year Six (\$92 per person served per day, plus other costs)	\$4,433,618	\$5,700,366	\$ 9,711,735

Additional detail regarding each of the three estimate scenarios is summarized in the tables on the following pages (Low Range, Mid-Range, High Range).

²⁵¹ Assumes average length of stay of 6 months.

²⁵² Assumes average length of stay of 7.5 months.

²⁵³ Assumes average length of stay of 9 months.



Cost Summary for MTFC Implementation (Low Range Estimate)

Variables	Year One	Year Two	Year Three	Year Four	Year Five	Year Six
New Teams	3	3	4	3	3	0
Full (10 beds)	1	1	1	1	1	0
Half (5 beds)	2	2	3	2	2	0
Established Teams	0	3	6	10	13	16
Full (10 beds)	0	1	2	3	4	5
Half (5 beds)	0	2	4	7	9	11
Total Teams	3	6	10	13	16	16
Full (10 beds)	1	2	3	4	5	5
Half (5 beds)	2	4	7	9	11	11
Core Team Operating Costs	\$1,343,200	\$2,686,400	\$4,365,400	\$5,708,600	\$7,051,800	\$7,051,800
COE Costs	\$ 100,000	\$ 120,000	\$ 165,000	\$ 165,000	\$ 185,000	\$ 105,000
COE Costs Per Recipient Per Day	\$21	\$12	\$9	\$6	\$5	\$3
Total Cost	\$1,443,200	\$2,806,400	\$4,530,400	\$5,873,600	\$7,236,800	\$7,156,800
Average Medicaid Recipients Per Month	13	28	51	73	93	105
Medicaid Recipients Served Per Year (based on 6 month LOS)	26	55	103	145	185	210
Medicaid Revenue (\$92 per person served per day plus Per Day COE Costs)	\$ 400,307	\$ 782,589	\$1,414,485	\$1,949,667	\$2,468,369	\$2,723,182
Cost Offsets for Persons Served (\$1,124 per person served per month)	\$ 174,220	\$ 370,920	\$ 691,260	\$ 977,880	\$1,247,640	\$1,416,240
Additional Medicaid Costs (Revenue minus Offsets)	\$ 226,087	\$ 411,669	\$ 723,225	\$ 971,787	\$1,220,729	\$1,306,942
Additional State-Only Funding Needed (\$92 per person served per day, plus other costs)	\$1,042,893	\$2,023,811	\$3,115,915	\$3,923,933	\$4,768,431	\$4,433,618



Cost Summary for MTFC Implementation (Medium Range Estimate)

Variables	Year One	Year Two	Year Three	Year Four	Year Five	Year Six
New Teams	3	6	6	3	2	0
Full (10 beds)	1	2	2	1	1	0
Half (5 beds)	2	4	4	2	1	0
Established Teams	0	3	9	15	18	20
Full (10 beds)	0	1	3	5	6	7
Half (5 beds)	0	2	6	10	12	13
Total Teams	3	9	15	18	20	20
Full (10 beds)	1	3	5	6	7	7
Half (5 beds)	2	6	10	12	13	13
Core Team Operating Costs	\$1,343,200	\$4,029,600	\$6,716,000	\$8,059,200	\$9,066,600	\$9,066,600
COE Costs	\$ 100,000	\$ 220,000	\$ 260,000	\$ 200,000	\$ 195,000	\$ 135,000
COE Costs Per Recipient Per Day	\$21	\$17	\$9	\$5	\$4	\$3
Total Cost	\$1,443,200	\$4,249,600	\$6,976,000	\$8,259,200	\$9,261,600	\$9,201,600
Average Medicaid Recipients Per Month	13	35	75	108	124	135
Medicaid Recipients Served Per Year (based on 7.5 month LOS)	21	56	120	172	198	216
Medicaid Revenue (\$92 per person served per day plus Per Day COE Costs)	\$ 400,307	\$1,046,478	\$2,083,880	\$2,857,395	\$3,262,902	\$3,501,234
Cost Offsets for Persons Served (\$1,124 per person served per month)	\$ 174,220	\$ 472,080	\$1,011,600	\$1,449,960	\$1,669,140	\$1,820,880
Additional Medicaid Costs (Revenue minus Offsets)	\$ 226,087	\$ 574,398	\$1,072,280	\$1,407,435	\$1,593,762	\$1,680,354
Additional State-Only Funding Needed (\$92 per person served per day, plus other costs)	\$1,042,893	\$3,203,122	\$4,892,120	\$5,401,805	\$5,998,698	\$5,700,366



Cost Summary for MTFC Implementation (High Range Estimate)

Variables	Year One	Year Two	Year Three	Year Four	Year Five	Year Six
New Teams	7	7	7	5	2	0
Full (10 beds)	4	4	4	4	2	0
Half (5 beds)	3	3	3	1	0	0
Established Teams	0	7	14	21	26	28
Full (10 beds)	0	4	8	12	16	18
Half (5 beds)	0	3	6	9	10	10
Total Teams	7	14	21	26	28	28
Full (10 beds)	4	8	12	16	18	18
Half (5 beds)	3	6	9	10	10	10
Core Team Operating Costs	\$3,693,800	\$7,387,600	\$11,081,400	\$14,103,600	\$15,446,800	\$15,446,800
COE Costs	\$ 275,000	\$ 330,000	\$ 385,000	\$ 390,000	\$ 310,000	\$ 230,000
COE Costs Per Recipient Per Day	\$23	\$14	\$9	\$6	\$4	\$3
Total Cost	\$3,968,800	\$7,717,600	\$11,466,400	\$14,493,600	\$15,756,800	\$15,676,800
Average Medicaid Recipients Per Month	33	66	121	169	210	230
Medicaid Recipients Served Per Year (based on 9 month LOS)	44	117	191	254	294	307
Medicaid Revenue (\$92 per person served per day plus Per Day COE Costs)	\$1,035,259	\$1,916,011	\$ 3,342,440	\$ 4,542,480	\$ 5,521,364	\$ 5,965,065
Cost Offsets for Persons Served (\$1,124 per person served per month)	\$ 443,980	\$ 893,580	\$ 1,635,420	\$ 2,276,100	\$ 2,832,480	\$ 3,102,240
Additional Medicaid Costs (Revenue minus Offsets)	\$ 591,279	\$1,022,431	\$ 1,707,020	\$ 2,266,380	\$ 2,688,884	\$ 2,862,825
Additional State-Only Funding Needed (\$92 per person served per day, plus other costs)	\$2,933,541	\$5,801,589	\$ 8,123,960	\$ 9,951,120	\$10,235,436	\$ 9,711,735



Collaborative Care in Primary Care Settings

Description of Best Practice. Collaborative Care is a model of integrating mental health and primary care services in primary care settings in order to: (1) treat the individual where he or she is most comfortable; (2) build on the established relationship of trust between a doctor and consumer; (3) better coordinate mental health and medical care; and (4) reduce the stigma associated with receiving mental health services.²⁵⁴ Two key principles form the basis of the Collaborative Care model:

1. Mental health professionals or allied health professionals with mental health expertise are integrated into primary care settings to help educate consumers, monitor adherence and outcomes, and provide brief behavioral treatments according to evidence-based structured protocols; and
2. Psychiatric and psychological consultation and supervision of care managers is available to provide additional mental health expertise where needed.

Key components of the Collaborative Care model include screening, consumer education and self-management support, stepped up care (including mental health specialty referrals as needed for severe illness or high diagnostic complexity), and linkages with other community services such as senior centers, day programs or Meals on Wheels.²⁵⁵

Several randomized studies have documented the effectiveness of collaborative care models to treat anxiety and panic disorders,²⁵⁶ depression in adults,²⁵⁷ and depression in older adults.²⁵⁸ For example, a study of IMPACT (Improving Mood: Providing Access to Collaborative Treatment for Late Life Depression) – a multi-state Collaborative Care program with study sites in five states, including Washington – led to higher satisfaction with depression treatment, reduced prevalence and severity of symptoms, or complete remission as compared to usual primary care.

Cost per Unit. The unit costs for Collaborative Care are comparable to those already reimbursed in the system. Collaborative Care is an office-based model, delivered primarily through the modalities of Individual Treatment (both psychotherapy and consultation), Group Treatment, and Family Treatment. No new service types need to be delivered for Collaborative Care, though it was noted earlier in this report that the development of

²⁵⁴ Unutzer, J., Katon, W. Hogg Foundation Integrated Care Initiative (2006). Training presentation retrieved at: http://www.hogg.utexas.edu/programs_ihc_program.html.

²⁵⁵ Unutzer, J., Katon, W., Sullivan, M., and Miranda, J. (1999). Treating Depressed Older Adults in Primary Care: Narrowing the Gap between Efficacy and Effectiveness. *The Milbank Quarterly*, 77, 2.

²⁵⁶ Katon, W.J., Roy-Byrne, P., Russo, J. and Cowley, D. (2002). Cost-effectiveness and cost offset of a collaborative care intervention for primary care patients with panic disorder. *Archives of General Psychiatry*, 59, 1098-1104.

²⁵⁷ Katon, W., Von Korff, M., et al. (1999). Stepped collaborative care for primary care patients with persistent symptoms of depression: A randomized trial. *Archives of General Psychiatry*, 56, 1109-1115.

²⁵⁸ Unutzer, J., Katon, W., et al. (2002). Collaborative care management of late-life depression in the primary care setting: A randomized controlled trial. *Journal of American Medical Association*, 288, 2836-2845.

See also President's New Freedom Commission on Mental Health Final Report at 66.



modifiers for encounter reporting would allow MHD to track the delivery of this treatment type.

Anticipated Utilization and Utilization per User. The primary driver of any cost increases if Collaborative Care is promoted would be utilization. If RSNs are to deliver Collaborative Care, the primary barrier will be the current Access to Care Standards (ACS) that prohibit the delivery of mental health services to people with functional impairments in the moderate (above a GAF/C-GAS score of 50) to mild (above a GAF/C-GAS score of 60) range, depending on diagnosis. A core premise of the delivery of Collaborative Care is that mental health services be provided in primary care settings with minimal barriers. In order to overcome the barriers to the effective delivery of mental health services in primary care settings, mental health clinicians must be willing to take all referrals and not attempt to exclude any persons referred based on functioning. In the first major section of this report, we offer MSP&W Recommendation #3 to conduct an actuarial analysis and raise the GAF/C-GAS cut-offs to at least 70 for all covered diagnoses if financially feasible. Conducting such an actuarial analysis is beyond the scope of the current study, but we believe that the potential costs could be similar to those estimated by the actuarial analysis conducted in preparation for the recent expansion of Healthy Options and fee-for-service benefit limits from 12 to 20 visits annually and expanding the types of eligible providers. This was expected to cost approximately \$2,285,000 in additional Medicaid expenditures.²⁵⁹ Given that this change has already been made and eligible providers in RSN networks are now able to provide these additional services, it is not clear what additional costs would be entailed by expanding eligibility for services within the RSN structure.

Infrastructure Support Costs per Unit. We are not aware of a current Center of Excellence nationally to promote the provision of Collaborative Care within the public sector. Much of the leading research in this area is currently conducted by faculty at the University of Washington's Department of Psychiatry and Behavioral Services and Department of Family Medicine. The costs to establish a Center of Excellence for Collaborative Care would depend on the scope of the development effort, which would vary primarily as a function of the number of sites being implemented. If we again use as a basis for estimation the Year Two budget developed for Washington's statewide PACT implementation, a budget of approximately \$300,000 would be needed to support the development of 10 teams across the state. Costs would rise if more sites are implemented.

Anticipated Cost Offsets. We would not expect any measurable cost offsets within the mental health system attributable to the provision of Collaborative Care. More effective treatment of depression (the diagnosis most frequently targeted for improved service delivery with older adults in Collaborative Care models) would very likely decrease the use of other health care services. People suffering from depression who are receiving services through the primary care system use three to four times as many services for physical health complaints as

²⁵⁹ Barclay, T. S. of Milliman, Inc. (January 22, 2007). Official correspondence with R. Gantz, DSHS, Medical Assistance Administration regarding Medicaid Mental Health Benefit Expansion.



people without depression.²⁶⁰ This finding has led many to believe that there is a potential cost-offset from mental health treatment because it will reduce the disproportionate use of primary care services.²⁶¹ Measurement of such offsets should be incorporated into any actuarial analysis conducted for Collaborative Care.

Potential Annual Expenditures Needed. Given that current data on unmet mental health needs in primary care settings and the potential cost-offsets in primary health care services costs were not available to this project, it is not possible to give a precise estimate of potential costs for expanded delivery of Collaborative Care in primary care settings. However, we believe that the potential cost increases would likely be in the range of other analyses to expand access for the delivery of mental health care to broad populations such as the recent expansion of Healthy Options and fee-for-service benefit limits. For example, North Sound RSN recently initiated two Collaborative Care pilots in federally qualified health centers using \$120,000 a year in federal block grant funds. If comparable efforts were undertaken across all 13 RSNs, the estimated cost would be approximately \$827,000 a year (dividing the North Sound costs by its covered population, then multiplying this factor by current figures regarding the covered populations of the other 12 RSNs). Adding these costs to those estimated for a COE to support Collaborative Care (approximately \$300,000), we would estimate the costs of initial Collaborative Care efforts to range between \$1.1 million (costs of expanding the North Sound pilot statewide, plus COE costs) to \$2.5 million (the cost range of the recent Health Options and fee-for-service benefit expansion, plus COE costs). Given that more precise estimates cannot be made with available data, we are not able to provide additional detail on potential expenditures.

²⁶⁰ Katon, W., & Schulberg, H. (1992). Epidemiology of depression in primary care. *General Hospital Psychiatry, 14*, 237-247.

²⁶¹ Olfson, M., Sing, M., & Schlesinger, H. J. (1999). Mental health/medical care cost offsets: Opportunities for managed care. *Health Affairs, 18*, 79-90.

