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# **Implementation of Priority Standards for Managed Mental Health Care in Washington**

**Division of Behavioral Health and Recovery  
Focused Quality Study Report**

**January 2011**

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**Presented by**

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Presented to the Washington Department of Social & Health Services,  
Division of Behavioral Health and Recovery

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## ACRONYMS USED IN THIS REPORT

CIT	Crisis Intervention Training
CLIP	Children’s Long-term Inpatient Program
CMHA	community mental health agency
CMS	Centers for Medicare & Medicaid Services
DBHR	Division of Behavioral Health and Recovery
DMHP	designated mental health professional
DSHS	Department of Social & Health Services
E&T	evaluation and treatment
EQR	External Quality Review
EQRO	External Quality Review Organization
LRE	least restrictive environment
PACT	Program of Assertive Community Treatment
PCP	primary care provider
PIP	performance improvement project
QAPI	quality assessment and performance improvement
QM	quality management
QRT	Quality Review Team
RCW	Revised Code of Washington
RSN	Regional Support Network
SAMHSA	Substance Abuse and Mental Health Services Administration
WAC	Washington Administrative Code
WRAP	Wellness and Recovery Action Plan

## EXECUTIVE SUMMARY

This focused quality study, conducted for the Division of Behavioral Health and Recovery (DBHR), examines the degree to which the mental health services provided by Washington’s 13 Regional Support Networks (RSNs)

- are age-appropriate
- are culturally and linguistically competent
- are driven by and incorporate enrollee and family voice
- are provided in the least restrictive environment (LRE)
- assist enrollees’ progress toward recovery and resilience
- promote service continuity and integration with other formal or informal systems and settings

The primary data for this study came from the results of 2008–2010 external quality review (EQR) activities, including a review of clinical records at each RSN. To obtain additional qualitative information, Acumentra Health conducted focus groups with consumers, Ombuds, and Quality Review Teams (QRTs); interviews with local law enforcement, community hospital, and evaluation and treatment (E&T) facility staff; and a teleconference with designated mental health professionals.

Acumentra Health synthesized the results of these activities to describe the status of implementation of DBHR’s six priority standards, and to identify strengths and gaps in the RSN system.

The review identified many system-wide strengths and outstanding practices by individual RSNs and community mental health agencies (CMHAs). It also revealed significant gaps and barriers in the system, primarily related to resource shortages. Each section of this report discusses in detail the strengths and gaps associated with a specific priority standard.

## Recommendations

To promote the successful implementation of DBHR’s priority standards through a system-wide approach to managed care, Acumentra Health offers these overarching recommendations.

- DBHR needs to require all RSNs to submit quality management (QM) plans and annual evaluations. DBHR needs to review those plans and evaluations.
- DBHR needs to guide the RSNs in focusing their QM program evaluations on how each RSN uses its collected data, monitoring results, and service verification to advance DBHR’s priority standards.
- To minimize unnecessary hospitalizations, DBHR needs to work with the RSNs on using their limited resources effectively to provide LRE treatment and to promote consumer recovery and resilience.

The following recommendations for DBHR apply to specific priority standards.

### *Age-appropriate services*

- Work with RSNs and CMHAs to establish adequate community-based services as an alternative to acute care for children in the RSN system.
- Encourage RSNs to develop resources for transition-age youth.
- Coordinate with other agencies and with geriatric facilities to ensure that enrollees discharged from state and community hospitals receive long-term care.

### *Culturally and linguistically competent services*

- Work with the RSNs to ensure access to mental health specialists for enrollees in special populations—for example, by disseminating information about specialist availability across RSNs—or work to revise the certification requirements to facilitate certification of additional specialists.

- Work with the RSNs to build capacity for services delivered by bilingual and/or bicultural minority-specific providers.
- Work with the RSNs to ensure that advisory committee membership represents minority groups or special populations in each service area.
- Encourage RSNs to take steps to ensure that enrollees' treatment plans address all cultural issues identified in assessments.

### *Enrollee and family voice*

- Require each RSN's QM program evaluation to include a review of consumers' complaints and grievances handled by provider agencies.
- Work with the RSNs to ensure that at least 51 percent of their advisory board members represent consumers and families.
- Facilitate discussion between RSNs and their QRTs to determine how to incorporate QRT input into the RSN delivery system.
- Encourage the RSNs to develop processes to support family education and inclusion of family members in designing services, to the extent requested by enrollees.

### *Least restrictive environment*

- Work with the RSNs and the Healthy Options MCOs to improve collaboration between behavioral and physical health plans serving Medicaid-eligible consumers.
- Work with the RSNs to establish and maintain a continuum of community-based services and alternatives to acute care or long-term hospitalization.
- Work with RSNs, providers, and consumers to build consensus regarding effective use of crisis plans.
- Encourage all RSNs to implement Crisis Intervention Training to help ensure that

law enforcement officers can intervene effectively with consumers in crisis.

- Work with RSNs to develop processes to monitor crisis encounters and hospital stays, to determine whether these services are related to lack of access to routine care or to inappropriate management at the outpatient level.
- Require the RSNs by contract to monitor the use of seclusion and restraint.
- Work with the RSNs to ensure ongoing community education and staff training regarding advance directives for both mental and physical health.

### *Recovery and resilience*

- Work with the RSNs to develop standards for timely recovery-oriented assessments and to address all identified needs in enrollees' treatment plans.
- Identify creative solutions, such as cross-system funding, to ensure the availability of supported employment programs, job coaching, and adult vocational training.
- Support RSNs' efforts to retain services that enhance recovery and resilience, such as clubhouses, peer support services, peer-run services, and wraparound programs.

### *Integration and coordination with allied agencies*

- Consult with RSNs on ways to improve care coordination between CMHA s and allied service agencies.
- Continue to encourage the RSNs to build relationships with physical health care providers and the Healthy Options plans to ensure that mental health enrollees have access to primary care and that their care is coordinated.
- Work with the RSNs to ensure that their advisory boards include representatives from allied agencies.



## INTRODUCTION

As part of its External Quality Review Organization (EQRO) contract with DBHR, Acentra Health conducted a focused quality study in conjunction with standard EQR activities. The study was designed to assess the status of implementation of DBHR’s priority standards for the delivery of managed mental health services to RSN enrollees.

Data analyzed for this study came from EQR activities conducted during 2008–2010, primarily from reviews of the RSNs’ compliance with regulatory and contractual standards governing managed care, and from clinical record reviews. To obtain additional qualitative information, Acentra Health designed and conducted special data gathering activities, described in the Methods section of this report.

The State of Washington began delivering mental health services under a Medicaid §1915(b) waiver in 1993 for outpatient services, and in 1997 for integrated community mental health. The waiver allows county-based RSNs to enter into capitated managed mental health care contracts, provided that they meet program and fiscal requirements.

The state’s waiver renewal proposal for the Integrated Community Mental Health Program defines these purposes of the program:

1. “Promote age, culturally, and linguistically competent coordination of comprehensive mental health services with regionally managed care through Prepaid Inpatient Health Plans (PIHPs);
2. “Provide community mental health rehabilitation services and community psychiatric inpatient care in a seamless manner, providing continuity and integrated care for persons served by the public mental health system; and
3. “Support recovery and reintegration to the community for persons with mental illness.”

The waiver renewal defines the mission of the state’s mental health system as “to ensure that people of all ages experiencing mental illness can better manage their illness, achieve their personal goals, and live, work, and participate in their community.” The document further lists these values that guide the administration of public mental health services in Washington:

1. “We value the strengths and assets of consumers and their families, and seek to include their participation in decision-making and policy setting.
2. “We respect and celebrate the cultural and other diverse qualities of each consumer.
3. “We work in partnership with allied community providers to deliver quality, individualized supports and services.
4. “We treat people with respect, equality, courtesy and fairness.”<sup>1</sup>

To evaluate the RSNs’ success in implementing the identified priorities for managed mental health care, DBHR asked Acentra Health to examine the extent to which the services delivered to RSN enrollees

- are age-appropriate
- are culturally and linguistically competent
- are driven by and incorporate enrollee and family voice
- are provided in the least restrictive environment
- assist enrollees’ progress toward recovery and resilience
- promote continuity in service and integration with other formal or informal systems and settings

<sup>1</sup>Washington State Department of Social & Health Services. Proposal for a Section 1915(b) Waiver Program Waiver Renewal, 6–7. Olympia, WA, 2010.

## RSN system description

RSN powers and duties are defined under RCW §71.24.045 and WAC §388-865-0200. The RSNs must comply with all applicable federal, state, and local laws and regulations, and with all minimum standards defined by the WAC.

Currently, DBHR contracts with 13 RSNs to deliver mental health services for Medicaid enrollees through managed care. The RSNs

- contract for direct services with provider groups, including community mental health agencies (CMHAs) and E&T units
- provide utilization management and other administrative functions
- develop quality improvement programs and enrollee protections

DBHR's contract requires each RSN to conduct an annual review of the CMHAs within the RSN's contracted network. (§8.2.2) Among other items, this review must address

- the degree to which services are age, culturally, and linguistically competent
- efforts to support the delivery of mental health services that are driven by and incorporate the voice of the enrollee and those identified as family
- monitoring activities performed to ensure that attempts are made to provide services in the least restrictive environment
- services that promote recovery and resilience
- local efforts to provide services that are integrated and coordinated with other service delivery systems

Each RSN must contract with an independent Ombuds service to advocate for enrollees by informing them about their rights and helping them to resolve complaints and grievances. A Quality Review Team (QRT) for each RSN represents consumers and their family members. The QRT may monitor consumer satisfaction

with services and may work with consumers, providers, the RSN, and DBHR to improve services and resolve problems.

RSN organizational structures vary throughout the state. As of 2010:

- Seven RSNs are multi-county, inter-governmental organizations subject to interlocal cooperative agreements. Their governing boards often include members from each county in the RSN region; some counties delegate their representation to the county mental health director.
- Five RSNs are single-county organizations housed in county government departments. The governing bodies of these RSNs typically reflect the priorities of the host department (e.g., the health department or community services). These RSNs are urban, except for Grays Harbor RSN.
- One RSN, serving Pierce County, is operated by a for-profit behavioral health entity, OptumHealth.

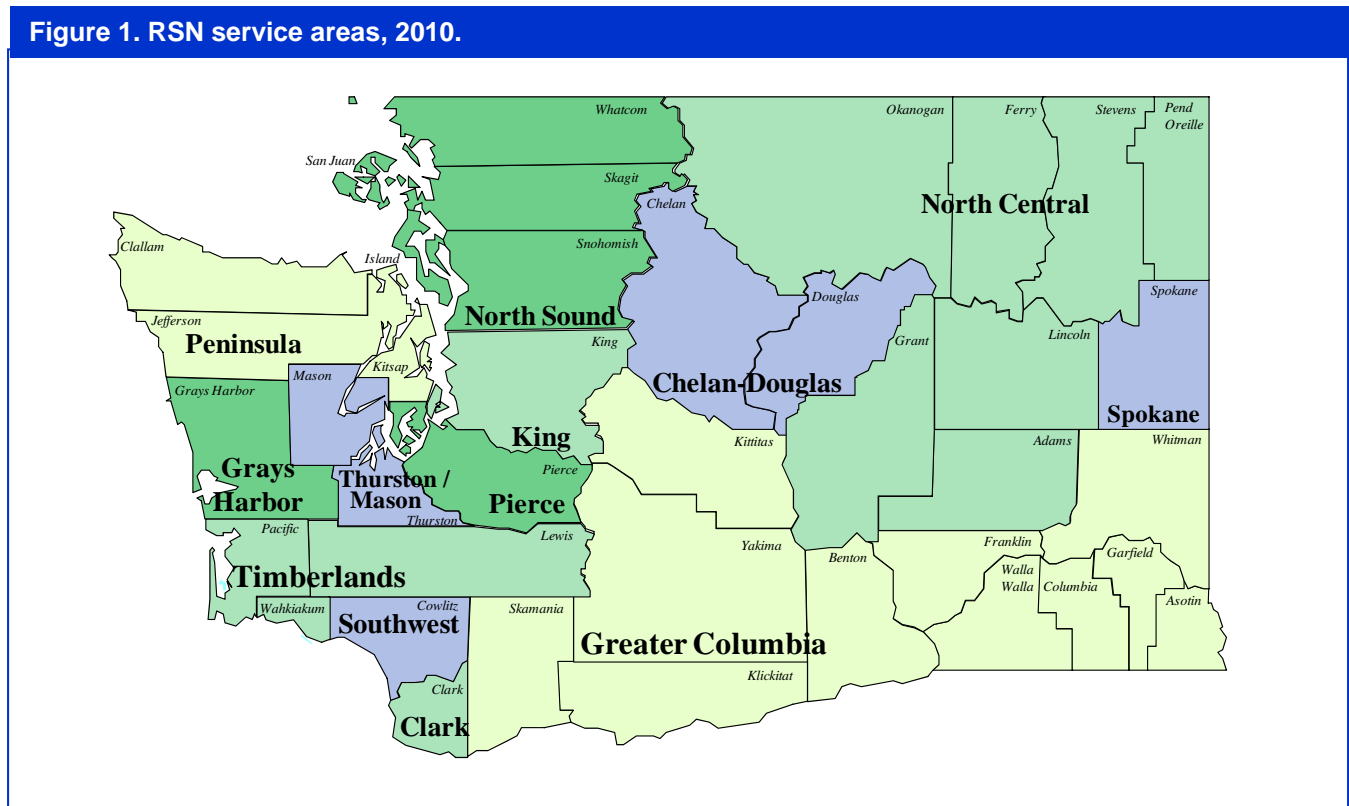
Some RSNs exercise a strong influence on the care provided in their service areas, by means of contractual and subcontractual requirements. In other regions, the CMHAs strongly influence RSN functions and operations.

All RSNs have contracts with the state to provide additional "state plan" services that are not funded by Medicaid but are available to Medicaid enrollees. As of July 2010, voters in 13 counties had adopted local sales taxes to fund mental health services, enabling RSNs in those areas to continue some programs not funded by Medicaid. Many of the initiatives described as best practices in this study are funded by non-Medicaid revenue.

Table 1 shows each RSN's number of assigned enrollees and percentage of statewide enrollment as of October 2010. Figure 1 illustrates the counties served by each RSN.

Table 1. Mental health RSNs and enrollees, October 2010. <sup>a</sup>			
RSN	Acronym	Number of enrollees	% of all enrollees
Chelan-Douglas RSN	CDRSN	21,605	2.2
Clark County RSN	CCRSN	65,103	6.6
Grays Harbor RSN	GHRSN	14,917	1.5
Greater Columbia Behavioral Health	GCBH	147,910	15.1
King County RSN	KCRSN	209,270	21.3
North Central Washington RSN	NCWRSN	53,877	5.5
North Sound Mental Health Administration	NSMHA	141,544	14.4
Peninsula RSN	PRSN	42,414	4.3
OptumHealth Pierce RSN	OPRSN	120,098	12.2
Southwest RSN	SWRSN	21,042	2.1
Spokane County RSN	SCRSN	82,302	8.4
Thurston-Mason RSN	TMRSN	40,671	4.1
Timberlands RSN	TRSN	19,869	2.0
<b>Total</b>		<b>980,622</b>	<b>100.0</b>

<sup>a</sup> Source: DSHS. Percentages do not add to 100.0 because of rounding.



## METHODS

This report synthesizes results from various EQR activities to present a composite picture of quality management by the Washington RSNs. For its analysis of each study question in this report, including system strengths and gaps, Acumentra Health drew on these sources:

- Acumentra Health’s 2008–2010 EQR reports covering each RSN’s regulatory and contractual compliance and clinical record reviews
- focus groups with consumers and with RSNs’ Ombuds and QRTs
- interviews with law enforcement officials and with staff of hospitals, E&T facilities, and RSNs
- a teleconference with designated mental health professionals (DMHPs)

The individual RSN reports discuss in detail the methods used to generate data from each EQR activity. The procedures used in conducting the focus groups and interviews for this study are outlined below.

### EQR activities

In 2008, Acumentra Health reviewed each RSN’s compliance with federal and state standards for Enrollee Rights and Grievance Systems. As part of this review, the RSNs reported on their communication with enrollees whose primary language was other than English, and on their efforts to ensure that essential notices to enrollees were translated into non-English languages or alternative formats.

The 2009 compliance review covered standards related to Quality Assessment and Performance Improvement (QAPI). Each RSNs reported on how it ensures that

- its delivery network meets the needs of all enrollees, including those from different age and cultural/ethnic groups

- enrollees from special populations or those with specialized needs receive appropriate assessment and treatment
- program planning reflects input from consumers and other stakeholders

Reviewers examined 20 special-population clinical files for each RSN to determine whether the enrollee’s needs were assessed by a qualified mental health care provider, special needs were identified, the treatment plan was developed with enrollee participation, the identified needs were addressed in the treatment plan, and the treatment plan incorporated the recommendations of the mental health specialist(s).

To further examine the priority areas identified by DBHR, Acumentra Health conducted clinical record reviews in conjunction with the EQR site visits in 2008 and 2010. In general, each review analyzed a random sample of more than 100 records from each RSN, at as many as four provider agencies. In all, Acumentra Health analysts reviewed more than 2,500 clinical records at the 13 RSNs.

The same staff that performed the 2008 reviews performed the 2010 reviews. Note: For OPRSN, which was not part of the RSN system in 2008, Acumentra Health conducted a single review covering all topic areas in 2010.

Appendix A presents the aggregated results of the clinical record reviews for all RSNs.

### Focus groups

Appendix B presents the Debrief Guide and Analysis Plan.

### Consumer focus groups

Acumentra Health conducted focus groups with consumers at each RSN. The RSNs assisted by providing contact information and arranging locations for the focus groups, such as local libraries, clubhouses, CMHA facilities, and RSN offices. Acumentra Health prepared recruitment materials, including a brochure and invitation.

The CMHAs and RSNs recruited the consumers. Most groups included 5 to 13 consumers. In total, 99 consumers took part in the focus groups.

Acumentra Health provided incentives for consumer participation. Participants who submitted an information sheet received travel reimbursement ranging from \$10 to \$25, and Acumentra Health furnished refreshments.

Most participants filled out a form detailing their age, gender, and race. Complete information is available on 87 participants. About 71 percent of participants were white, with other racial and ethnic groups' representation ranging from 3 to 5 percent each. About 10 percent of participants selected more than one racial category. Most participants were in their 40s or 50s—though ages ranged from the 20s to the 60s—and the majority (56 percent) were male.

Two Acumentra Health staff members facilitated each focus group. Participants were introduced to the purpose of the focus group and ground rules were agreed upon. After asking initial questions to break the ice, the facilitators asked the following series of questions.

1. What kinds of things have you worked on with your service provider?
2. How does your service provider understand your strengths and what you do well?
3. How does your service provider involve you in choosing the services you get?
4. If you want your family and friends involved, how does that happen?
5. Tell us about your crisis plan.
  - a. Have you ever had to use the plan?
  - b. Did it help?
6. How does your service provider help you with other services (e.g., applying for disability)?

Most focus groups lasted one hour. After each focus group, the facilitators recorded a “debrief” summary of the key points.

## Ombuds and QRT focus groups

Acumentra Health worked with state employees responsible for overseeing the Ombuds and QRTs to arrange these focus groups. Because the Ombuds and QRTs hold quarterly meetings, it was decided to incorporate the Ombuds and QRT focus groups into a quarterly meeting in June 2010.

In advance, Acumentra Health consulted with the QRT coordinators at two RSNs to ensure that the questions would be appropriate and understandable to participants. These staff members suggested surveying all QRT members and Ombuds before conducting the focus groups. The purpose was to prepare the facilitators and participants for the focus groups, and to solicit responses to the focus group questions from Ombuds and QRT members who could not attend. The web-based survey drew 26 responses—14 from QRT members, 8 from Ombuds, and 4 from individuals who identified themselves as “other.”

The June 2010 focus group in Olympia was divided into separate QRT and Ombuds groups, each facilitated by Acumentra Health staff. The questions for both groups followed the same format for each priority standard. For example, the questions related to delivery of age-appropriate services were:

1. What does the RSN do to make sure that mental health services are age-appropriate?
2. Can you identify anything that the RSN should do, but does not do, to make sure that mental health services are age-appropriate?
3. What is blocking or preventing the RSN from making sure that mental health services are age-appropriate?
4. Is there anything else you want to tell us about delivering mental health services that are age-appropriate?

## Interviews

### Hospitals, E&T facilities, law enforcement

Each RSN was asked to identify individuals to take part in structured interviews that were conducted in person or by telephone.

Acumentra Health completed interviews in most RSN service areas, totaling 9 hospital staff members, 4 E&T staff members, and 10 law enforcement agency representatives. Appendix C presents the interview tools for each group, and Appendix D lists all organizations represented in the interviews.

### DMHPs

Six DMHPs from across the state took part in a teleconference with Acumentra Health in October 2010. Questions, listed in Appendix B, pertained to the DMHPs' roles and responsibilities and how the DMHPs work with hospital staff, law enforcement, and others.

### RSN staff

Acumentra Health interviewed the staff of each RSN regarding quality management practices. The questions related to each priority standard followed the same format. For example, the questions related to delivery of age-appropriate services were:

1. To what extent does the RSN use a variety of methods to ensure that services are age-appropriate?
2. To what extent does the RSN involve advocates for age-appropriate services on boards and other committees?
3. Has the RSN identified gaps/barriers to delivering age-appropriate services?
4. Has the RSN implemented interventions to address the identified gaps and/or barriers?
5. Has the RSN communicated the intervention strategies to network providers?

6. To what extent does the RSN monitor the delivery of age-appropriate services?
7. During 2008–2010, has the RSN required corrective action related to lack of age-appropriate services?

Results of the RSN interviews are summarized in tables in each major section of this report. If the RSN had policies and contracts in place that required providers to meet the priority standard, Acumentra Health scored the RSN as “minimally” addressing the standard. If the RSN went above and beyond the minimum by implementing an initiative, practice guideline, training, or other system intervention, Acumentra Health scored the RSN as “extensively” addressing the standard. Answers to “yes/no” questions were based on the RSN’s self-report.

### Qualitative data analysis

To organize and analyze the information gleaned from the focus groups and the interviews with DMHPs and E&T, hospital, and law enforcement staff, Acumentra Health used a program called NVivo, designed for qualitative data analysis. After completing each focus group and interview, staff members uploaded audio files into NVivo along with typed summaries and electronic scans of handwritten notes. Analysts created multiple coding categories and subcategories to capture all elements related to the six priority focus areas, then coded the content to the appropriate categories and identified major themes based on the frequency of occurrence. Coding categories included crisis response, care coordination, lack of services or resources, access barriers, and member involvement in setting treatment goals.

## STUDY QUESTION 1: AGE-APPROPRIATE SERVICES

Positive mental health outcomes depend on providing care that is developmentally appropriate for the consumer's age. The service needs of young children, transition-age youth (age 18–21), adults, and geriatric consumers can and do vary.

The RSN contract requires each RSN to ensure the provision of age-appropriate community mental health services for enrollees for whom services are medically necessary and clinically appropriate. (§7.12.1.2) Each RSN also must “provide a set of treatment services designed to help a Medicaid-enrolled individual attain goals as prescribed in his/her Individual Service Plan. These services shall be congruent with the age, strengths, and cultural framework of the individual.” (§13.5.8)

When necessary, the RSN must provide an evaluation by a child or geriatric mental health specialist that considers age variables specific to the individual being evaluated. (§13.5.16) The specialist's recommendations must be incorporated into treatment planning for the individual.

The wraparound model of mental health care involves intensive care management for youths with serious emotional and behavioral problems, aimed at keeping these youths in their homes and communities. Typically, a team of family members, service providers, and agency staff collaborate to develop and implement an individualized plan of care that includes formal services and interventions, as well as community services and personal support. A trained care manager or “wraparound facilitator” typically coordinates this process. NSMHA, SWRSN, and GHRSN are operating wraparound pilot sites in Skagit, Cowlitz, and Grays Harbor counties that served 71 families in 2010.

### System strengths

- All RSNs have access to child mental health specialists, and the RSNs generally can provide timely access to child specialty services, though access to child psychiatry is spotty, especially in rural areas.
- The RSNs use diverse methods to monitor providers' delivery of age-appropriate services, including:
  - reviewing enrollees' clinical records and treatment plans
  - reviewing utilization and encounter data
  - establishing contractual requirements for providers to ensure and demonstrate age-appropriate services
  - hiring and training staff and providers who deliver age-specific services
- Many CMHAs are becoming more involved in providing services at schools and other community settings. Some provide regular counselors at schools.
- The 2008 clinical record review found that 86 percent of charts recorded an assessment of the enrollee's development level, and needs identified in the assessments were addressed in 87 percent of treatment plans.
- Most RSNs' advisory boards include advocates for children's services, and many RSNs participate on committees with child and senior service agencies in their regions.

### Examples of best practices

- CCRSN seeks out cross-system partners to help develop strategies to address needed services, such as sharing the services of transition-age youth specialists and child psychiatrists. RSN subcontractors provide school-based mental health programs.

- In OPRSN’s service area, Good Samaritan Hospital’s HEROS program provides community education on the signs and symptoms of elderly people who may need crisis intervention, including in-home safety assessments and training for caregivers on dementia.
- In GHRNSN’s service area, Behavioral Health Resources provides geriatric specialty services in nursing homes, adult foster homes, and senior centers.
- KCRSN has implemented a practice guideline for developmentally appropriate services and pays providers an incentive for services that meet the guideline.
- SCRSN contracts with a pharmacist to assist with the medication needs of its geriatric population.
- GCBH has a specific committee to address children’s issues.
- PRSN’s Ombuds refers enrollees to Bridges to Parent Voice, an advocacy program that supports parents of children with complex needs.
- In SCRSN’s service area, the Children’s Home Society of Washington offers mobile services for parents or foster parents who find it difficult to transport their children to services.
- the lack of programs and staffing to serve transition-age youth, particularly those who age out of the foster care system
- service gaps for geriatric consumers, including a shortage of specialists in geriatric care and scarce housing and treatment resources for older adults with dementia-related disorders

Admitting children to hospitals is difficult in many service areas because of the shortage of beds. As a result, RSNs often need to go outside their service networks to ensure delivery of child and adolescent services. RSNs also report difficulty in placing seniors discharged from the Western State Hospital and from community hospitals.

Table 2 reports the status of implementation of age-appropriate services, as determined from RSN interviews. As shown, 10 RSNs extensively use methods to ensure delivery of age-appropriate services; 9 RSNs extensively monitor for the provision of such services; and 12 have identified gaps or barriers in providing such services. The 12 RSNs that have identified gaps or barriers have begun interventions to address them.

## Recommendations

To advance the implementation of age-appropriate services, DBHR needs to

- work with RSNs and CMHAs to establish adequate community-based services as an alternative to acute care for children in the RSN system
- encourage RSNs to develop resources for transition-age youth
- coordinate with other agencies and with geriatric facilities to ensure that enrollees discharged from state and community hospitals receive long-term care

## System gaps

Statewide gaps and barriers in providing age-appropriate services include:

- insufficient funding to contract for hospital diversion services for children
- the need to expand wraparound services to cover more young people
- the lack of respite care for children and lack of alternatives to admitting children to hospitals



<b>Table 2. Implementation of age-appropriate services.</b>		
	<b>Extensively addresses</b>	<b>Minimally addresses</b>
To what extent does the RSN use a variety of methods to ensure that services are age-appropriate?	10 RSNs	3 RSNs
To what extent does the RSN involve advocates for age-appropriate services on boards and other committees?	10 RSNs	3 RSNs
To what extent does the RSN monitor the delivery of age-appropriate services?	9 RSNs	4 RSNs
	<b>Yes</b>	<b>No</b>
Has the RSN identified gaps and/or barriers to delivering age-appropriate services?	12 RSNs	1 RSN
Has the RSN implemented interventions to address the identified gaps and/or barriers?	12 RSNs	1 RSN
Has the RSN communicated the intervention strategies to network providers?	12 RSNs	1 RSN
During 2008–2010, has the RSN required corrective action related to lack of age-appropriate services?	4 RSNs	9 RSNs

## STUDY QUESTION 2: CULTURALLY AND LINGUISTICALLY COMPETENT SERVICES

The RSN contract requires each RSN to provide or purchase linguistically and culturally competent community mental health services for enrollees when medically necessary. (§7.12.1.2) Cultural competence, per the contract, means

a set of congruent behaviors, attitudes, and policies that...enable [a] system or agency to work effectively in cross-cultural situations. A culturally competent system of care acknowledges and incorporates at all levels the importance of language and culture, assessment of cross-cultural relations, knowledge and acceptance of dynamics of cultural differences, expansion of cultural knowledge, and adaptation of services to meet culturally unique needs. (§1.10)

Language and ethnicity may come into play in providing culturally competent services, as may cultural differences with regard to urban versus rural living, poverty, Native American tribal issues, and sexual identity. Because of different regional demographic patterns, some RSNs face a greater challenge than others in meeting all the cultural needs of their enrollees.

When necessary, the RSN must provide an evaluation by an ethnic minority mental health specialist that considers cultural variables specific to the individual being evaluated. (§13.5.16) The specialist's recommendations must be incorporated into treatment planning for the individual. WAC 388-865-0420 requires that the consumer receive a culturally and age-relevant evaluation within 30 days of intake.

Acumentra Health's 2008 clinical record review explored, among other issues, whether the treatment planning for RSN enrollees appeared appropriate for the culture of the enrollees and their families. The domains included language,

ethnicity, cultural and socioeconomic factors, sensory impairments, gender identity, sexual orientation, spirituality, and beliefs and attitudes about medication and mental health treatment. Review results are shown in Appendix A, Tables A-4 and A-5.

### System strengths

- The majority of RSNs have adopted the cultural competence standards of the Substance Abuse and Mental Health Services Administration (SAMHSA).
- The majority of RSNs have programs in place to offer culturally and linguistically competent services.
- All RSNs translate enrollee materials (including satisfaction surveys) into the non-English languages most prevalent in their service areas.
- Many RSNs maintain cultural competency committees.
- The RSNs monitor for the delivery of culturally and linguistically competent services by means of clinical record audits, review of complaints/grievances and utilization data, enrollee satisfaction surveys, enrollee forums, speakouts, and secret shopping.
- Many RSNs provide cultural competency training for providers, for cross-system partners, and for consumers and their families and peers. Some RSNs sponsor training in the needs of Native American, African-American, Hispanic-American, and gay/lesbian/ bisexual/transgender (GLBT) enrollees.
- The 2008 clinical record review found that more than 90 percent of charts documented an assessment of the enrollee's needs related to language and ethnicity.

## Examples of best practices

- CDRSN’s four contracted providers all have Spanish-speaking receptionists, case managers, and clinicians.
- CCRSN maintains a guideline describing the components of a successful mental health specialty consultation, including how to solicit information about cultural beliefs and practices.
- GCBH’s charter identifies the mission of its cultural competency committee as assuring the design, development, and implementation of culturally competent services and business management processes that reflect the diversity of the target population and community.
- GHRSN’s policy on Culturally Competent Services incorporates ethnicity, disability, non-English language, age, self-disclosed sexual orientation, and tribal status as cultural indicators that providers need to take into account. SCRSN’s policy expands the definition of cultural services to include rural vs. urban, consumer and family experience of illness, poverty, and homelessness.
- NSMHA developed a report identifying the percentage of non-English-speaking enrollees, population of each ethnic group, age groupings, and number of clinicians available to serve as specialty consultants. NSMHA publishes a brochure outlining specific resources for the Native American population.
- SCRSN holds an annual Tree of Healing conference for all ages and cultures and an Undoing Racism conference sponsored by the NATIVE Project, a local nonprofit community wellness organization.
- TRSN directed a Spanish-speaking employee to make “secret shopper” calls to find out how many providers could assist Spanish-speaking consumers.

## System gaps

A report by TriWest Group for DSHS looked at disparities in access to and quality of mental health services in Washington, with a special focus on issues surrounding the role of mental health specialists.<sup>2</sup> The report identified workforce issues including (1) too few specialists to provide needed consultation, across all subpopulations; (2) lack of adequate clinical expertise and of consultation skills among the workforce as a whole, (3) barriers to recruiting and retaining specialists, including lack of differential pay, lack of encouragement by provider agencies, and stringent certification requirements; and (4) spotty access to interpreters in rural areas. The findings of the TriWest Group report are consistent with observations from Acumentra Health’s 2008–2010 site visits.

The entire RSN system struggles with lack of access to minority mental health specialists. Clinical record reviews revealed repeated attempts by providers to contact such specialists, with limited success. As a result, RSNs find it hard to meet the 30-day timeline for providing minority mental health specialist consultations.

- RSNs express a need for specialists in cultures that are not ethnic or age-related (e.g., GLBT). Some RSNs need specialists who can work with Russian-speaking consumers and recent immigrants from Eastern Europe, and/or with consumers who are deaf or hearing-impaired.
- Most RSNs report a shortage of bilingual and bicultural staff among their CMHAs.

Washington is unique in requiring mental health services to be delivered by, or in consultation with, a person who qualifies as a mental health specialist in the applicable consumer service group. To be certified as an ethnic minority mental health specialist, a person must (1) complete one year of full-time experience under the supervision of such

<sup>2</sup> TriWest Group. Addressing Behavioral Health Services Disparities: Current and Potential Strategies Within Washington State and the National Context. Seattle, WA: March 2010.

a specialist, *and* either (2a) complete 100 actual hours of in-class training *or* (2b) obtain evidence of support from the ethnic minority community attesting to the person’s commitment to the community. (WAC 388-865-0150)

Many observers have recommended modifying these requirements to facilitate specialist certification for mental health professionals who are members of minority populations. The TriWest Group report, cited previously, also recommended using telemedicine to expand access to specialists in rural areas, and in more highly populated areas that need more specialized or higher-quality expertise.

Cultural competency concerns may arise when an enrollee’s cultural issues are not assessed, and thus cannot be identified, because the clinician does not ask about them. Typically, issues that are sensitive or less obvious are not assessed.

- The 2008 clinical record review found that roughly 40 percent of charts omitted an assessment of the enrollee’s sexual orientation, spirituality, and beliefs and attitudes about medication. Even when cultural issues were assessed, they often were not addressed in the enrollee’s treatment plan. For example, in about one-third of the cases examined, the treatment plans did not address identified needs related to ethnicity, sexual orientation, and other cultural factors.

Most RSNs’ advisory boards do not fully represent local minority enrollee populations such as Asian/Pacific Islander, Latino, Native American, Eastern European, GLBT, and the visual- and hearing-impaired. Many RSNs find it hard to recruit and retain committee members to represent these populations.

- Most RSNs find it hard to enlist tribal participation on boards and committees. One RSN with a relatively large Native American enrollee population finds it difficult even to elicit responses from the tribal elders regarding participation.

Table 3 reports the status of implementation of culturally and linguistically competent services, as determined from RSN interviews. As shown, 12 RSNs extensively use methods to ensure meeting enrollees’ cultural and linguistic needs. Only 6 RSNs extensively involve advocates on boards and committees, and only 4 extensively monitor the delivery of culturally and linguistically competent services. Of 10 RSNs that have identified gaps or barriers in service delivery, 8 have implemented interventions to address them.

## Recommendations

To advance the implementation of culturally and linguistically appropriate services, DBHR needs to

- work with the RSNs to ensure adequate access to certified mental health specialists to consult with enrollees in special populations—for example, by disseminating information about specialist availability across RSNs—or work to revise the existing certification requirements to facilitate certification of additional specialists
- work with the RSNs to build capacity for services delivered by minority-specific providers who are bilingual and/or bicultural
- work with the RSNs to ensure that advisory committee membership represents minority groups or special populations in each service area
- encourage RSNs to take steps to ensure that enrollees’ treatment plans address all cultural issues identified in assessments

**Table 3. Implementation of culturally and linguistically competent services.**

	<b>Extensively addresses</b>	<b>Minimally addresses</b>
To what extent does the RSN use a variety of methods to ensure that enrollees' cultural and linguistic needs are met?	12 RSNs	1 RSN
To what extent does the RSN involve advocates for cultural and linguistic needs on boards and other committees?	6 RSNs	7 RSNs
To what extent does the RSN monitor the delivery of culturally and linguistically competent services?	4 RSNs	9 RSNs
	<b>Yes</b>	<b>No</b>
Has the RSN identified gaps and/or barriers to delivering culturally and linguistically competent services services?	10 RSNs	3 RSNs
Has the RSN implemented interventions to address the identified gaps and/or barriers?	8 RSNs	5 RSNs
Has the RSN communicated the intervention strategies to network providers?	8 RSNs	5 RSNs
During 2008–2010, has the RSN required corrective action related to lack of culturally and linguistically competent services?	5 RSNs	8 RSNs

## STUDY QUESTION 3: ENROLLEE AND FAMILY VOICE

Making sure that consumers and families have a voice in treatment options and services is vital to ensure that consumers' goals and needs are met. The RSN contract requires each RSN to maintain an advisory board that broadly represents regional demographics and that includes at least 51 percent representation of consumers and their family members. (§2.1.1) The RSN must invite enrollees and their families who represent the community being served to take part in planning activities and in implementing and evaluating the public mental health system. (§8.2.4) Treatment goals must be stated in the words of the individual receiving services, and the clinical record must document that statement. (§10.3.2)

One topic addressed by the 2008 clinical record review was the extent to which the enrollee and his/her family, when appropriate, participate in ongoing treatment planning and service provision. Reviewers looked at whether the charts recorded the enrollee's participation in developing his/her treatment plan or goals, a description of the enrollee's participation in his/her own words, and involvement of the enrollee's family or legal guardian in ongoing treatment. Appendix A, Table A-4, presents the review results.

### System strengths

- The majority of consumers who took part in the focus groups reported satisfaction with instilling their voice and preferences in treatment objectives, and agreed that they felt involved and supported in their treatment process.
- Overall, the majority of the RSNs adhere to contractual and regulatory requirements in this area.
- Most RSNs actively seek out participation of consumers and families on RSN committees and advisory boards, although participation varies from one RSN to another.

- All RSNs have policies and procedures aimed at ensuring that consumers and families have a voice in developing their treatment plans.
- All RSNs audit clinical records at least yearly to monitor for involvement of enrollees and their families in treatment planning, progress notes, advance directives, and crisis plans. The RSNs also survey enrollees, review their complaints and grievances, and hold consumer speakouts and forums.
- Many RSNs conduct community training on recovery topics, including how to ensure consumer and family voice in treatment.
- Many RSNs have developed newsletters through which consumers can relate their own stories, as well as enrollee handbooks specific to the RSN population.
- The 2008 clinical record review found:
  - 88 percent of charts documented the enrollee's participation in developing treatment plans and goals
  - 85 percent described the enrollee's participation in his/her own words
  - 82 percent showed that the provider had inquired about the enrollee's preferences for treatment
  - in appropriate cases, 85 percent documented the family's or guardian's participation in ongoing treatment

### Examples of best practices

- CDRSN's quarterly chart reviews assesses clinical records for the presence of an assessment, treatment plan, crisis plan, advance directives, consultation with a mental health specialist, and statement of the treatment goals and objectives in the enrollee's voice. The audit report defines strengths, opportunities, recommendations, and corrective action plans, if required.

- CCRSN has implemented a consumer-based model of care with comprehensive policies and procedures on enrollee rights. In addition to using the state's benefits booklet for Medicaid enrollees, CCRSN has developed its own handbook with additional information about the service framework in Clark County. Enrollees receive the handbook at the time of their initial assessment with providers.
- GCBH publishes its own enrollee handbook in eight languages, with information about crisis contacts, access to services, enrollee rights, availability of free interpretive services, and the grievance and appeal process. GCBH's website presents similar information and is easy to navigate. The RSN's customer services/community support coordinator developed consumer training on advance directives and consumer-directed treatment.
- KCRSN invites community representatives to serve on the RSN's Quality Council, the Voices of Recovery workgroup (a King County advisory committee), the Program of Assertive Community Treatment (PACT), and Ombuds.
- Consumers account for 30 percent of OPRSN's staff and represent consumer concerns on the RSN's governing board.

*“The RSN should encourage the QRT to conduct consumer and provider surveys, as well as focus/discussion groups with randomly selected consumers, to gather input.”*  
— QRT/Ombuds survey respondent

## System gaps

- Some consumers in the focus groups said their lack of knowledge of available services and the high turnover in case management staff impeded their ability to make the best use of their treatment options.
- Some RSNs' boards and committees provide little representation for consumers and family advocates. One RSN's advisory board includes no consumers. QRT focus group participants generally agreed that the RSNs need to strengthen consumer representation.
- The majority of QRT members in the focus groups expressed a desire for greater involvement and influence in RSN meetings and system decisions. Some QRT members felt that the RSNs did not value their suggestions and input, and some advocated revising the RSN contract to strengthen the provisions related to QRT functions.
- Barriers to incorporating enrollee and family voice, as identified by some in the QRT and Ombuds focus groups, include:
  - lack of understanding by consumers and family members of the mental health system and how they can become involved
  - lack of peer support specialists
  - differing ideals and priorities between RSN management and consumer advocates
  - lack of reimbursement for volunteer activities

*“The system doesn't truly believe in consumer-run services. I am concerned that provider agencies, RSNs, DBHR, the Legislature, and even most consumers themselves do not truly feel that consumers are capable of 'driving' community mental health services.”*  
— QRT/Ombuds survey respondent

Table 4 reports the status of implementation of practices to ensure that services are driven by and incorporate enrollee and family voice. Interview results show that 10 RSNs extensively use methods to ensure that services are driven by and incorporate enrollee and family voice; 8 RSNs extensively involve enrollees and their families on boards and committees; and 9 extensively monitor for enrollee and family involvement. Of 12 RSNs that have identified gaps or barriers, 11 have implemented interventions to address them.

### Recommendations

To help ensure that mental health services are driven by and incorporate enrollee and family voice, DBHR needs to

- require each RSN’s quality management program evaluation to include a review of consumers’ complaints and grievances handled by provider agencies
- work with the RSNs to ensure that their advisory boards represent all enrollees
- facilitate discussion between RSNs and their QRTs to determine how to incorporate QRT input into the RSN delivery system
- encourage the RSNs to develop processes to support family education and inclusion of family members in designing services, to the extent requested by enrollees

<b>Table 4. Implementation of practices to ensure inclusion of enrollee and family voice.</b>		
	<b>Extensively addresses</b>	<b>Minimally addresses</b>
To what extent does the RSN use a variety of methods to ensure that services are driven by and incorporate enrollee and family voice?	10 RSNs	3 RSNs
To what extent does the RSN involve enrollees and families on boards and other committees?	8 RSNs	5 RSNs
To what extent does the RSN monitor providers for these interventions?	12 RSNs	1 RSN
	<b>Yes</b>	<b>No</b>
Does the RSN incorporate the QRT into service development/ needs assessment efforts?	11 RSNs	2 RSNs
Does the RSN review complaints and grievances to identify services that do not reflect enrollee choice?	12 RSNs	1 RSNs
Has the RSN identified gaps and/or barriers to consumer-directed services?	12 RSNs	1 RSN
Has the RSN implemented interventions to address gaps and/or barriers to ensuring that services are driven by and incorporate enrollee and family voice?	11 RSNs	2 RSNs
Has the RSN communicated these changes to network providers?	1 RSN	12 RSNs
During 2008–2010, has the RSN required corrective action related to ensuring that services are consumer-driven?	5 RSNs	8 RSNs



## STUDY QUESTION 4: LEAST RESTRICTIVE ENVIRONMENT

The RSN contract and WAC require each RSN to provide mental health crisis services in the least restrictive environment (LRE).

The contract defines a mental health crisis as “a turning point in the course of anything decisive or critical, a time, a stage, or an event or a time of great danger or trouble, whose outcome decides whether possible bad consequences will follow.” (§13.5.2) Crisis services are intended to stabilize the person in crisis, prevent further deterioration, and provide immediate treatment and intervention in the LRE, in a location best suited to meet the individual’s needs. Consumers are entitled to obtain crisis services, evaluation and treatment, stabilization, and rehabilitation case management prior to an intake evaluation. The RSN must make crisis services available 24 hours a day, 7 days a week. (§7.6.1)

When determining LRE, the CMHA generally considers the nature of the consumer’s disorder; available treatments; the consumer’s level of autonomy, acceptance, and cooperation; the potential for the consumer to cause harm to self or others; and the consumer’s right to be free from seclusion and restraint, including chemical restraint during a crisis situation.

The primary non-hospital alternatives available to consumers in crisis are E&T units, crisis respite/stabilization beds, detoxification units, and voluntary “next-day” appointments with outpatient clinics. All RSNs are required to make E&T services available in freestanding inpatient residential facilities to provide medically necessary evaluation, stabilization, and treatment for enrollees who otherwise would meet criteria for hospital admission. E&T services are designed for individuals who, because of mental illness, pose an actual or imminent danger to self, others, or property, or who have experienced a marked decline in their ability to care for themselves

because of the onset or exacerbation of a psychiatric disorder. Many RSNs contract for E&T services while others, such as SCRSN, operate their own E&T centers.

Practices that can promote the delivery of services in the LRE include:

- maintaining infrastructures to support community-based care that includes settings for consumers with various degrees of independence
- training mental health care providers, law enforcement, and the community in the use of crisis plans and stabilization units
- establishing a consumer crisis plan that
  - identifies support people to contact during a crisis, community supports, and self-coping tools
  - is regularly reviewed with the consumer by a case manager or treatment provider
  - can be implemented when needed
- Wellness and Recovery Action Plan (WRAP) programs, in which participants identify internal and external resources to facilitate recovery, and then use those tools to create their own individual plans for successful living
- “warm lines” run by mental health care consumers who are trained to provide peer support over the telephone
- Crisis Intervention Training (CIT) to help law enforcement officers intervene effectively with consumers in mental health crises

Each RSN contracts with DBHR to provide “state-only” services that include psychiatric inpatient care for RSN enrollees and for uninsured residents of the service area. Each RSN is allocated a specific number of bed days in the state hospital, based on the population of the RSN’s service area and historical utilization patterns. In eastern Washington, the allocation formula also includes

the RSN's service penetration rate. An RSN that exceeds its allocation of bed days must pay the hospital costs for each bed day over the allocation. An RSN that remains below its allocation can receive a proportion of the per-day cost paid by any RSN(s) in the state hospital's catchment area that exceeded their allocation.

Acumentra Health's 2010 clinical review focused on the extent to which RSN enrollees received services in the LRE. Questions included: (1) Does the enrollee's chart include a crisis plan? (2) For an enrollee who had a crisis encounter while a crisis plan was in place, does the chart show evidence that the crisis plan was implemented and that the LRE was considered? Appendix A, Table A-1, presents the review results.

The clinical record review found that 57 percent of enrollees in the sample had crisis plans recorded in their charts. Similarly, about half of the participants in the consumer focus groups reported that they had a crisis plan in place.

## System strengths

- All RSNs maintain crisis lines and support units for enrollees 24 hours a day, either through provider agencies or by contracting with independent crisis lines.
- RSNs have made business arrangements with diverse agencies to ensure that crisis/sub acute services are available, including mobile services, PACT teams, and peer-run "warm lines."
- Most RSNs perform quarterly, monthly, or even weekly monitoring of crisis intake calls and subsequent follow-up.
- A few RSNs have become more proactive in reviewing inpatient authorizations to determine whether LRE care might have been available.
- Focus group participants reported high satisfaction with "warm lines," consumer clubhouses, and all-hour drop-in centers as alternative sources for crisis stabilization and hospital diversion. These services provide a sense of support and stability for consumers in crisis.
- All E&T facility staff interviewed for the study described a focus on securing LRE mental health treatment for consumers. The interviewees stated that DMHPs investigate and pursue LRE options before a consumer is admitted to the E&T unit. All expressed a strong commitment to send consumers to the state hospital only as a last resort, based solely on clinical need. For those deemed unfit for a step-down level of care due to psychiatric acuity, E&T staff reported diligent efforts to stabilize the individuals as quickly as possible to minimize length of stay and resolve any involuntary status. E&T staff showed a working understanding of the importance of adequate coordination of care to ensure that the consumer has sufficient community supports upon discharge to succeed in less restrictive settings (sub-acute, residential placement, or independent living).
- Collaboration between DMHPs and other community agencies (RSNs, hospitals, law enforcement, and outpatient clinics) is widely viewed as successful in intervening in mental health crises. Hospital staff interviewed for the study reported general satisfaction with the support and care coordination offered by DMHPs. The DMHP teleconference participants generally reported positive relationships with hospitals. Increased collaboration has been effective in de-escalating crisis situations that otherwise might have ended up in acute care settings.
- The majority of DMHP interviewees reported a positive working relationship with law enforcement as a direct result of CIT. Law enforcement interviewees said they considered CIT concepts effective in helping to ensure that consumers are treated in the LRE.

- The 2010 clinical record review found that 92 percent of enrollees' crisis plans listed symptoms or events that may precede a crisis, and 82 percent listed family, friends, or case managers who could support the enrollee during a crisis. LRE treatment was considered for about two-thirds of the enrollees who had crisis service encounters while a crisis plan was in place.
- GHRSN contracts with an E&T facility that provides short-term (24-hour) housing for people in crisis.
- CCRSN contracts with a Crisis Outreach Team to provide crisis response and intervention, referral, and linkage services for adult Medicaid enrollees. The team coordinates with other community resources to provide stabilization and recovery services aimed at preventing unnecessary hospitalizations.

### Examples of best practices

- SCRSN initiated community-wide planning that resulted in the development of six alternatives to hospitalization, including a residential treatment facility; supported housing such as apartments and board-and-care homes; day treatment programs; and a new E&T center that reached full capacity within a week after opening.
- TMRSN's Consumer Council developed a Health Care Passport for enrollees—a one-stop document that the consumer can carry every day, recording all information that might be needed during a mental health crisis or medical emergency.
- GHRSN monitors the use of crisis and stabilization services by reviewing utilization data weekly, monthly, and quarterly; performing site visits and chart reviews; surveying members; tracking and analyzing enrollee complaints/grievances; and reviewing reports on enrollees served in community hospitals.
- CCRSN has increased reimbursement to psychiatrists to permit consumers in crisis to receive prescribed medications more quickly.
- One E&T unit in Pierce County has a no-refusal admission policy. Local police can drop off a consumer at any time of the day or night if police feel that the consumer needs to be in the E&T unit rather than in the county jail.
- OPRSN restructured its crisis system in 2009, meeting weekly with providers and allied agencies to deal with implementation issues as they arose. Since the redesign, OPRSN has held state hospital bed days for its consumers below the assigned cap.
- SCRSN provides CIT training for local police and sheriff.
- CDRSN, OPRSN, and GCBH offer WRAP training that is useful and inclusive.

*“[T]he officers’ attitude at point of contact and crisis has changed favorably as the result of CIT. They understand people with mental illness, ways to defuse and de-escalate them, ways to help them. And these skills have tremendously increased over the past few years.” — DMHP interviewee*

### System gaps

Study participants noted that hospitals often are expected to absorb and manage the community's mental health crises without adequate financial support. They pointed to a shortage of beds, inadequate training in mental health issues for emergency department staff, and long wait times for consumers in crisis.

Across the state, hospital staff voiced frustration in their efforts to ensure LRE treatment for consumers with mental illness. The majority of interviewees reported a dearth of suitable community placement options for consumers. Hospital staff unanimously complained of the absence or limited capacity of

sub-acute resources to absorb consumers in crisis situations. Rural hospitals noted a lack of skilled staff to manage crises effectively, as well as the absence of step-down alternatives, resulting in hospitalization with inadequate psychiatric care or “boarding” in emergency departments until a placement becomes available.

*“Length of stay is longer than necessary at times because there’s nowhere else to place people.”  
— Hospital staff interviewee*

DMHPs reported that people with mental illness sometimes wait 8–12 hours in emergency rooms before being admitted or transported to appropriate facilities. During these periods, a common practice is to place the individual in a seclusion room and administer sedation in the form of an antipsychotic cocktail known as a “B-52.”

Law enforcement interviewees reported a lack of resources for violent mentally ill offenders. They reported having to hold people in jail because the E&T units would not accept individuals with felony charges. In rural areas, law enforcement officers must transport people in mental health crises long distances to hospitalize them far from their families and friends, causing the officers to be unavailable for other calls. Conversely, in an urban county, law enforcement officials reported having to leave people in mental health crises on the street because provider services were available only during regular business hours.

Consumers in the focus groups described a common scenario. When an individual is in danger, police or crisis workers are dispatched to take the individual to the hospital whether he or she wants to go or not. If the individual is not at imminent risk, little or no alternative de-escalation or placement options are offered. The individual is directed to see his or her outpatient provider during regular business hours.

*“When you’re in trouble, the system is not easy to navigate.” — Consumer focus group participant*

- While the RSNs are financially responsible for psychiatric inpatient care for enrollees of the Healthy Options medical plans, the RSNs are not always involved in authorizing hospital stays before admission, and thus cannot intervene to offer alternatives to hospitalization, if appropriate.
- Some RSNs struggle to keep state hospital bed days for their consumers below their allocations. Payments for exceeding the caps reduce the revenue that the RSNs could use to develop local LRE resources.
- Most consumers in the focus groups who had crisis plans did not feel that their plans had been helpful during crises. A large majority of crisis plans reviewed in 2010 primarily listed mental health resources and services and did not include techniques that consumers can use to calm themselves.
- The 2010 clinical record review found that among 258 cases when an enrollee with a crisis plan had a crisis service encounter, the crisis plan was implemented only 36 percent of the time.
- A large majority of the consumer focus group participants said that crisis lines had *not* been helpful in diverting a crisis or in finding less restrictive alternatives to hospitalization. These consumers described the crisis lines as impersonal and punitive, in that the crisis line workers appeared concerned only with whether or not the consumer endangered self or others.
- Because of budget cuts, one E&T unit has closed recently, and other E&T facilities have scaled back the number of beds or are considering doing so. Several consumer clubhouses also have closed.
- E&T staff across the state described difficulty finding appropriate placements for geriatric consumers struggling with dementia and co-morbid medical and mental health issues. LRE placements also

are difficult for developmentally delayed consumers with co-morbid cognitive and behavioral issues.

- Budget restrictions are forcing many counties to reduce CIT training. DMHP interviewees said they feared the impact this may have on effective crisis response and intervention in the community.
- Scarce resources make it difficult for some counties to set consumers up with next-day appointments with outpatient clinics. These consumers rapidly decompensate and end up back in the hospital. DMHPs said this is particularly true for geriatric, dual-diagnosis, and developmentally delayed consumers.
- Recent budget cuts have reduced state funding for PACT implementation, making it necessary for RSNs to reduce PACT enrollment and staffing.
- The current RSN contract does not address the federal requirement for managed care plans to maintain policies and procedures governing the use of seclusion and restraint. As a result, few RSNs have adequate policies and procedures in this area. Most RSNs monitor for seclusion and restraint only in E&T facilities. Such monitoring also should occur in crisis support units, child study and treatment centers, and day treatment facilities.
- Most RSNs do not notify enrollees of their rights related to medical and mental health advance directives. Across the state, RSNs have developed few mental health advance directives for individual enrollees.

*“We put band-aids on things. We get them to the hospital and make sure they’re safe, but we don’t know what happens after that.”*  
— Law enforcement interviewee

Table 5 reports the status of implementation of practices to promote the delivery of services in the LRE. The interview results showed that 10 RSNs extensively ensure that services are delivered in the LRE, and 9 RSNs extensively monitor the delivery of services in the LRE. Of 12 RSNs that have identified gaps and barriers in delivering these services, all have begun interventions to address them.

## Recommendations

To advance the implementation of practices that promote the delivery of services in the least restrictive environment, DBHR needs to

- work with the RSNs and the Healthy Options MCOs to improve collaboration between behavioral and physical health plans serving common enrollees
- work with the RSNs to establish and maintain a continuum of community-based services and alternatives to acute care or long-term hospitalization
- work with RSNs, providers, and consumers to build consensus regarding effective use of crisis plans
- encourage all RSNs to implement CIT to help ensure that law enforcement officers can intervene effectively with consumers in crisis
- work with RSNs to develop processes to monitor crisis encounters and hospital stays, to determine whether these services are related to lack of access to routine care or to inappropriate management at the outpatient level
- amend the RSN contract to require the RSNs to monitor the use of seclusion and restraint
- work with the RSNs to ensure ongoing community education and staff training regarding advance directives for both mental and physical health

<b>Table 5. Implementation of service delivery in the least restrictive environment.</b>		
	<b>Extensively addresses</b>	<b>Minimally addresses</b>
To what extent does the RSN ensure that services are delivered in the least restrictive environment?	10 RSNs	3 RSNs
To what extent does the RSN involve advocates for least restrictive environment on boards and other committees?	10 RSNs	3 RSNs
To what extent does the RSN monitor the delivery of services in the least restrictive environment?	9 RSNs	4 RSNs
	<b>Yes</b>	<b>No</b>
Has the RSN identified gaps/barriers to delivering services in the least restrictive environment?	12 RSNs	1 RSN
Has the RSN implemented interventions to address the identified gaps and/or barriers?	12 RSNs	1 RSN
Has the RSN communicated the intervention strategies to network providers?	12 RSNs	1 RSN
During 2008–2010, has the RSN required corrective action related to lack of services in the least restrictive environment?	4 RSNs	9 RSNs

## STUDY QUESTION 5: RECOVERY AND RESILIENCE

Traditional mental health treatment has focused on symptoms, psychiatric medication, and achieving stability for people with mental illness. In this approach, highly trained professionals guide treatment for people who may depend on clinical services for the rest of their lives.

Since the 1990s, however, the focus of treatment has shifted more toward recovery and resilience. This paradigm looks at mental health as a component of overall health. Assessments of an individual take stock of his or her strengths and community supports, and identify specific needs crucial for recovery. Consumers and professionals negotiate treatment that is individualized and community-based. Consumers learn about their disorders and how to manage the symptoms. Treatment is designed with discharge in mind. The ultimate goal is to enable the individual to live as independently as possible.

For some, recovery means the ability to live a fulfilling and productive life despite a disability. For others, recovery implies the reduction or complete remission of symptoms. The RSN contract defines recovery as “the process in which people are able to live, work, learn, and participate fully in their communities.” (§1.33) Resilience is defined as “the personal and community qualities that enable individuals to rebound from adversity, trauma, tragedy, threats, or other stresses, and to live productive lives.” (§1.36)

The contract requires each RSN to conduct an annual review of services provided to promote recovery and resilience. (§8.2.2.10) These services may include consumer clubhouses, peer support services, wraparound programs, supported employment, job coaching, and adult vocational training and involvement.

Consumer/survivors emphasize peer support, peer-delivered services, and peer counselors as integral to recovery and resilience. Self-help support groups, warm lines, and drop-in centers help the

consumer build alliances that enhance his or her ability to recover and live independently.

In 2005, the State of Washington received an infrastructure grant from SAMHSA, aimed at establishing a consumer-driven system in which mental health is understood as an essential element of overall health and a condition from which people can and do recover. A recent report described the outcomes and accomplishments of the mental health “transformation” grant, which ended in 2010.<sup>3</sup>

Acumentra Health’s 2010 clinical review explored the extent to which RSN enrollees receive services that assist their progress toward recovery and resilience. Questions included: (1) Does the chart reflect an assessment of the enrollee’s needs and strengths regarding activities of daily living (ADL), physical limitations, and medical, transportation, housing, and social interaction needs? (2) Do the needs identified during the assessment appear as objectives in the treatment plan? The review results are shown in Appendix A, Tables A-2 and A-3.

### System strengths

- Some RSNs have incorporated recovery concepts into their mission and vision statements. Support for the recovery process is apparent from the language with which RSN staff members describe consumers, and from the language in RSN brochures and other materials.
- A few RSNs employ consumer advocates who are known to be recovering survivors. OPRSN reports that one-third of its staff members are recovering consumers or their relatives.
- Several RSNs have recovery portals on their websites, with links to local and national recovery-related resources and websites. Others hold annual recovery

<sup>3</sup> TriWest Group. Our Journey of Mental Health Transformation in Washington State: An Assessment of the Washington State Mental Health Transformation Project. September 2010.

conferences, poster contests, and other public awareness activities.

- Many RSNs provide system-wide training on recovery and resilience. Some have implemented WRAP training for consumers in their region.
- Many RSNs recruit and train peer-support workers to assist consumers with treatment, crisis situations, and housing and employment opportunities.
- RSNs use various methods to monitor whether consumers and families are building resilience and working toward recovery, including:
  - review of clinical records, encounter and length-of-stay data, and enrollee hospitalization rates
  - feedback from customer surveys
  - use of a recovery index
  - evaluation of outcomes related to housing, employment, and education
- A large majority of consumer focus group participants praised peer support services and clubhouses as offering them a sense of support, meaning, and fulfillment. Some also mentioned the benefits of strengths-based treatment planning with mental health professionals.
- CMHAs across the state are using creative methods to support recovery.
- The 2010 clinical record review found that providers assessed the enrollees' housing, social, and medical needs more than 90 percent of the time, and assessed their ADL and vocational needs more than 80 percent of the time. Identified social needs were addressed in the enrollee's treatment plan 84 percent of the time.

## Examples of best practices

- KCRSN promotes progress toward recovery through its practice guideline. The RSN pays providers an incentive for recovery-oriented services.
- CCRSN and OPRSN have implemented PIP interventions aimed at increasing employment among adult enrollees.
- NSMHA has adopted a recovery model grounded in informed consent, enrollee participation, and inclusion of family and natural supports in treatment planning.
- OPRSN and CDRSN contract with Recovery Innovations, which uses a mix of peers and professionals to provide crisis services.
- TRSN's provider allowed consumers to install a soda machine on agency premises and use the proceeds to publish marketing materials for consumer-run businesses. This consumer-run project has evolved into a local economic resource, providing a variety of consumer goods and services and a transportation system that operates trips to and from the coast.
- TMRSN's large CMHA operates a 15-week supported employment program.
- GCBH's customer services/community support coordinator is a member of the management team. The RSN publishes a quarterly newsletter for enrollees called *Resiliency Review*.
- CCRSN has dedicated staff to promote peer support services. The Recovery Vision Workgroup established the RSN's principles and values related to recovery, posted on CCRSN's website.
- CDRSN's administrator conducts training for peer support workers. The RSN recently issued a Request for Qualifications (RFQ) soliciting providers that employ peer support workers.



*“We have peers on staff to help with activities and provide peer-to-peer support... We would like to have on-call peer support who would be with clients throughout their stay.”*  
— E&T facility interviewee

## System gaps

Throughout the state, gaps in the system for supporting recovery and resilience are mainly due to resource limitations, leading to the closure of services such as clubhouses and peer support services. Consumers in the focus groups expressed discouragement about the potential loss of these services due to funding cuts.

The 2010 clinical record review found that most RSNs need to work with their providers to assess enrollees’ needs and strengths consistently in all domains, and to address identified needs through objectives in enrollees’ treatment plans.

- Although providers assessed enrollees’ strengths in most domains in the majority of cases, assessment of strengths was much less consistent than assessment of needs.
- More than half the time, identified needs related to finances, transportation, and physical limitations were *not* addressed in the enrollees’ treatment plans. Addressing such needs can be integral to enhancing an enrollee’s self-reliance.

*“I see too much emphasis on consumer rights and not enough on consumer responsibility.”*  
— QRT/Ombuds survey respondent

Table 6 reports the status of implementation of practices to promote recovery and resilience. As shown, 12 RSNs extensively ensure that services build resilience and work toward recovery, and all 13 RSNs monitor their enrollees’ progress toward recovery and resilience. All 13 have identified gaps and barriers in delivering these services, and 9 have begun interventions to address them. In addition, all 13 RSNs furnish training on recovery and resilience for their provider agencies.

## Recommendations

Acumentra Health observed much progress in moving the mental health system toward embracing recovery and resilience. Completing this transformation, however, will require more time and diligence on the part of the RSNs. An RSN may need to reframe its mission statement and policies, and revise its contracts to require providers to implement recovery-oriented services. As learning progresses, the RSN may decide to empower its advisory boards and hire recovering consumers as part of its staff.

As the RSNs implement recovery and resilience initiatives, they are learning how to facilitate change in the provider community. For example, KCRSN found that implementing a recovery practice guideline in itself did not cause services to be more recovery-focused. Provider behavior changed only when the RSN either paid or withheld incentives.

Finally, implementing recovery initiatives can be as difficult for consumers as for providers. Such initiatives require consumers to take on more responsibility for their own recovery.

To advance the implementation of practices that support consumers’ progress toward recovery and resilience, DBHR needs to

- work with the RSNs to develop standards for timely recovery-oriented assessments and to address them in treatment plans
- identify creative solutions, such as cross-system funding, to ensure the availability of supported employment programs, job coaching, and adult vocational training
- support RSNs’ efforts to retain services that enhance recovery and resilience, such as clubhouses, peer support services, peer-run services, and wraparound programs

**Table 6. Implementation of practices to promote recovery and resilience.**

	<b>Extensively addresses</b>	<b>Minimally addresses</b>
To what extent does the RSN ensure that services build resilience and work toward recovery?	12 RSNs	1 RSN
To what extent does the RSN involve advocates and enrollees on boards and other committees?	8 RSNs	5 RSNs
	<b>Yes</b>	<b>No</b>
Has the RSN identified gaps/barriers to delivering services that support progress toward recovery and resilience?	13 RSNs	
Has the RSN implemented interventions to address the identified gaps and/or barriers?	9 RSNs	4 RSNs
Has the RSN communicated the intervention strategies to network providers?	11 RSNs	2 RSNs
Does the RSN monitor that enrollees are progressing toward recovery?	13 RSNs	
Does the RSN monitor whether enrollees and their families are building resilience?	13 RSNs	
During 2008–2010, has the RSN required corrective action related to lack of age appropriate services?	6 RSNs	7 RSNs
Are the RSN’s provider agencies trained on the recovery/resilience model?	13 RSNs	

## STUDY QUESTION 6: INTEGRATION AND COORDINATION WITH ALLIED AGENCIES

In providing mental health services for Medicaid enrollees, the RSNs must coordinate extensively with allied service agencies. The RSN contract requires each RSN to maintain an allied system coordination plan describing how the RSN proposes to interact with aging and disability services, chemical dependency and substance abuse services, the Children's Administration, community health clinics, federally qualified health centers, Healthy Options plans, criminal and juvenile justice systems, and vocational rehabilitation. (§13.10.1)

In the past several years, the RSNs have made progress in coordinating care with enrollees' primary care providers (PCPs) and with the Healthy Options medical plans. To facilitate this coordination, the state legislature enacted HB 2025 in 2009, allowing the release and sharing of mental health treatment records without the consumer's consent among licensed professional providers and their support staff.

One topic addressed by the 2008 clinical record review was the extent to which RSNs coordinated their enrollees' care with services provided by their PCPs and by allied agencies. Questions included whether (1) the clinical assessment identified the enrollee's PCP; (2) the chart showed evidence of coordination of care with the PCP; (3) the relevant agencies had secured release of information (ROI) consents; and (4) the chart showed a two-way exchange of information between the mental health service provider and allied agencies. Appendix A, Table A-4, presents the results of that review.

### System strengths

- In general, the RSNs maintain policies and procedures related to coordination of care, and incorporate these requirements into their contracts with CMHAs. All RSNs monitor the performance of their CMHAs related to care coordination.
- Most RSNs meet with allied agencies in a variety of settings. In some single-county RSNs, these meetings are facilitated by the host agency's intergovernmental coordinating committee.
- Some RSNs have extensive memoranda of understanding (MOUs) with allied agencies to facilitate coordination of care.
- Some RSNs participate in monthly case staffing by multidisciplinary teams that include representatives of allied agencies such as schools and juvenile justice.
- Consumer focus group participants offered many examples of service coordination, including, but not limited to, vocational rehabilitation, benefits and insurance, housing, transportation, and medical care. These examples indicated effective case management and coordination of care.
- The 2008 clinical record review found that three-quarters of all charts documented the enrollee's PCP in the clinical assessment and treatment plan.

### Examples of best practices

- KCRSN's medical director cochaired a committee that sought to identify ways to improve integration of services within the county. Committee members represented Public Health, chemical dependency programs, primary care clinics, health plans, federally qualified health clinics, acute care facilities, and corrections.
- GHRSN has had a policy on coordination and continuity of care for enrollees since

2004. The RSN's contract with Behavioral Health Resources requires an annual review of the agency's efforts to provide services that are integrated and coordinated with other service delivery systems.

- SWRSN's advisory boards and committees bring together mental health and allied service providers to promote service continuity for consumers.
  - SCRSN contracts with Spokane Public Schools and with the county jail and juvenile services to serve as community mental health centers.
  - CCRSN promotes service continuity and integration through planning meetings with vocational rehabilitation, alcohol and drug treatment, development disabilities, and other service providers. Representatives of the local school district, employment services, family services, police, and other allied agencies serve on the RSN's internal committees.
  - CDRSN, KCRSN, and PRSN are conducting PIPs aimed at improving Metabolic Syndrome screening and intervention for mental health consumers. TRSN's nonclinical PIP aims to improve care coordination with PCPs.
- While ROI consents generally were completed at intake for consumers, the review often found no documentation that coordination had occurred. Consents for exchange of information with allied agencies often did not identify the agency contact.
  - Consumers in the focus groups reported that their lack of knowledge of available community resources often prevented them from obtaining services from agencies other than their outpatient providers. While consumers may be connected with essential resources through their case managers, they often are not informed of additional services available. Consumers reported finding out about these resources through "word of mouth" from their peers in clubhouses and other peer services.
  - Law enforcement interviewees noted that terminating a person's Medicaid benefits during incarceration complicates service coordination and integration. For offenders with acute mental illnesses, services and benefits are not automatically or easily reinstated upon release. Those offenders tend not to receive adequate community support and stabilization to prevent them from reoffending.

## System gaps

- Acumentra Health's 2008 clinical record review revealed significant gaps in coordination of care.
  - Only about half of the clinical records showed evidence that RSN enrollees' care was coordinated with PCPs.
  - Only about half of the charts documented coordination of care with allied agencies. Coordination with hospitals was documented in only 36 percent of cases.

Table 7 reports the status of mental health service integration and coordination with allied agencies. Interview results show that 11 RSNs' delivery systems extensively reflect continuity and integration of services with other systems and settings, and 10 RSNs extensively involve formal and informal stakeholders and allied service providers on boards and other committees. All 13 RSNs extensively monitor for integration and coordination, all have identified gaps and barriers, and all have implemented interventions.

## Recommendations

To help the RSNs improve service integration and coordination with allied agencies, DBHR needs to

- consult with the RSNs on ways to improve care coordination between CMHA s and allied service agencies
- continue to encourage the RSNs to build relationships with physical health care

providers and the Healthy Options plans to ensure that mental health enrollees have access to primary care services and that their care is coordinated

- work with the RSNs to ensure that their advisory boards include representatives from allied agencies

**Table 7. Implementation of service integration and coordination with allied agencies.**

	<b>Extensively addresses</b>	<b>Minimally addresses</b>
To what extent does the RSN delivery system reflect continuity and integration of services with other formal/informal systems and settings?	11 RSNs	2 RSNs
To what extent does the RSN involve formal and informal stakeholders and allied service providers on boards and other committees?	10 RSNs	3 RSNs
	<b>Yes</b>	<b>No</b>
Has the RSN identified gaps and/or barriers to continuity and integration of care?	13 RSNs	
Has the RSN implemented interventions to address the identified gaps and/or barriers?	13 RSNs	
Has the RSN communicated the intervention strategies to network providers?	13 RSNs	
Does the RSN monitor the continuity of service delivery and integration with other formal/informal systems and settings?	13 RSNs	
During 2008–2010, has the RSN required corrective action related to continuity in service delivery and integration with other formal/informal systems and settings?	6 RSNs	7 RSNs

## DISCUSSION AND RECOMMENDATIONS

Review activities for this study identified many commendable practices among individual RSNs and CMHAs in implementing DBHR's priority standards, as well as system-wide strengths. The review also revealed many gaps and barriers, primarily due to resource shortages.

Across the state, however, the study revealed no consistent system-wide approach to managing mental health care. While a few RSNs have developed an integrated approach to care management, most RSNs attempt to manage care for their enrollees through individual case review at the provider level, rather than managing population care at the system level.

An integrated system-wide approach would better enable the RSNs to succeed in implementing the individual priority standards—for example, to deliver LRE care and to provide recovery-based options to hospitalization. This, in turn, would improve the efficiency of managed care by preventing costly hospitalizations where possible, thus freeing more resources to devote to recovery-oriented programs.

Federal regulations at 42 CFR §438.240(e) require DBHR to review, at least annually, the impact and effectiveness of each RSN's QAPI program. The state may require that the RSNs evaluate their own QAPI programs. WAC 388-865-0280 requires each RSN to submit a quality management (QM) plan to the state biennially.

Consistent evaluation of the RSNs' QM programs would improve DBHR's ability to monitor the RSNs' progress in implementing the standards. However, the 2009 EQR Annual Report noted

that only half of the RSNs had comprehensive QM programs in place. Most RSNs that had such programs did not evaluate them annually, and most did not routinely submit their QM plans to the state. "Only a few RSNs had robust QM plans that included indicators, performance goals, and benchmarks...The majority of RSNs did not perform comprehensive monitoring of over- and underutilization."<sup>4</sup> The annual report offered this recommendation:

- *DBHR needs to require all RSNs to submit QM plans and annual evaluations, and DBHR needs to review those plans and evaluations.*

Although DBHR conducted statewide training in quality management for the RSNs in October 2010, the 2009 corrective action plans issued by DBHR did not contain the requirement for RSNs to submit QM plans for state approval. Thus, the above recommendation remains valid.

In addition to the recommendations listed under each priority standard in this report, we offer the following overarching recommendations.

- DBHR needs to guide the RSNs in focusing their QM program evaluations on how each RSN uses its collected data, monitoring results, and service verification to advance DBHR's priority standards.
- To minimize unnecessary hospitalizations, DBHR needs to work with the RSNs on using their limited resources effectively to provide LRE treatment and to promote consumer recovery and resilience.

Many of the best practices of RSNs and CMHAs cited in this report offer creative solutions, and DBHR should encourage their application across all service areas, as resources permit.

<sup>4</sup> Acumentra Health. 2009 External Quality Review Annual Report, 22. Olympia, WA, December 2009.

## Appendix A. Clinical Record Review Results

To assess the quality of mental health care in priority areas identified by DBHR, Acumentra Health conducted clinical record reviews in conjunction with EQR site visits in 2008 and 2010. In general, each review analyzed a random sample of more than 100 records from each RSN, at as many as four provider agencies.

Before conducting the record review at any RSN, Acumentra Health trained all reviewers to use a customized data collection tool and scoring criteria and guidelines approved by DBHR. The same staff that performed the 2008 reviews performed the 2010 reviews. Note: For OptumHealth Pierce RSN, which was not part of the RSN system in 2008, Acumentra Health conducted reviews covering all topic areas in 2010.

The **2010 review** addressed two special focus areas outlined below, analyzing 1,274 charts of RSN enrollees. The chart samples from each RSN included consumers served from July 1, 2008, through June 30, 2009, each of whom had at least four service encounters (including at least one outpatient encounter and one non-crisis encounter) during the year before the review period.

- Focus Area 1:** The enrollee receives mental health services in the least restrictive environment (LRE). (1) Does the consumer's chart include a crisis plan? (2) For an enrollee who had a crisis encounter while a crisis plan was in place, does the chart show evidence of implementation of the crisis plan and consideration of LRE?
- Focus Area 2:** The enrollee receives mental health services that assist his or her progress toward recovery and resilience (R&R). (1) Does the chart reflect an assessment of the enrollee's needs and strengths regarding activities of daily living (ADL, tasks such as preparing meals and keeping house), physical limitations, and medical, transportation, housing, and social interaction needs? (2) Do the needs identified by the assessment appear as objectives in the enrollee's treatment plan? Reviewers scored all objectives in each domain, whether or not the assessment had identified the need. If the assessment found that the enrollee did not have a need in a given domain and the treatment plan contained no objective in that domain, the item was scored as not applicable.

For each focus area, the data collection tool prompted reviewers to complete a series of questions concerning aspects of LRE or R&R. After examining the clinical record and progress notes, reviewers recorded responses to each question in the tool. Using the SAS Proc Freq function, analysts calculated the distribution of responses for each question.

Table A-1 shows the distribution of answers to the questions for Focus Area 1. Each row of this table shows the number of enrollees and the percentage of all eligible enrollees. Note that the percentage calculation occurs separately for each question, with missing data points removed from the denominator.

Table A-2 shows the distribution of answers to questions for Focus Area 2. The Assessed–Needs column shows the number and percentage of enrollees who were assessed and found to have needs pertaining to each domain. The Assessed–No Needs column shows the number and percentage who were assessed but found to have no needs in the domain listed. The Not Assessed column shows the number and percentage who were not assessed for each domain. The right side of this table shows whether enrollee strengths in completing ADL, dealing with medical needs or transportation needs, etc., were assessed or not assessed.

Table A-3 shows the number and percentage of enrollees assessed as having needs in each area, who had or did not have treatment plan goals set to address those issues. The reviewers scored all objectives on the treatment plan in the domains as addressed. If an item was not assessed and not addressed, reviewers scored that item as not applicable.

The **2008 review** focused on three standards related to enrollee rights and quality of care, listed below. Analysts reviewed 1,251 charts for RSN enrollees served in 2007. Each enrollee in the sample had at least four service encounters (including at least one outpatient encounter and one non-crisis encounter) during the year before the review period.

- **Standard 1:** The enrollee and his/her family, when appropriate, participate in ongoing treatment planning and service provision.
- **Standard 2:** Input from other health, education, social service, and justice agencies is included in treatment planning as appropriate and is consistent with privacy requirements.
- **Standard 3:** Treatment planning and progress notes are appropriate to the culture of the enrollee and his/her family.

To assess the degree to which each standard was met, reviewers completed a series of questions pertaining to each standard. After examining the clinical record and progress notes, reviewers responded to each question by selecting “Present,” “Not present,” “Partial,” or “N/A.” For example, the second question for Standard 1 asked whether the chart documented that a mental health professional had inquired about the enrollee’s perceptions and preferences for treatment. If the reviewer found notes demonstrating such an inquiry, the reviewer responded “Present” for this question. Not all options were available in answering each question.

Table A-4 shows the distribution of answers to the questions for each standard. Note that not all questions applied to every chart in the sample. Therefore, the percentage calculation occurred separately for each question, with inapplicable charts removed from the denominator.

Table A-5, similar to Table A-3, shows the number and percentage of enrollees assessed as having needs in each area of the 2008 review, who had or did not have treatment plan goals set to address those issues.



**Table A-1. Clinical record evidence of providing services in the least restrictive environment.**

<b>Number of charts reviewed (N=1316)</b>	<b>Yes</b>	<b>No</b>
Does the chart contain a crisis plan?	753 (57.2%)	526 (40.0%) <sup>a</sup>
<b>Charts that contained crisis plans (N=753)</b>	<b>Yes</b>	<b>No</b>
1. Does the crisis plan describe symptoms or events that may precede a crisis?	694 (92.2%)	59 (7.8%)
2. Does the crisis plan list family, friends, or case managers from whom the enrollee prefers to receive support during a crisis episode?	614 (81.5%)	139 (18.5%)
3. Does the crisis plan list backup persons who may be able to provide support if the primary support person is unable to respond?	446 (59.2%)	307 (40.8%)
4. Does the crisis plan document a safe place the enrollee prefers to go when in crisis?	398 (52.9%)	355 (47.1%)
5. Is there a backup safe place the enrollee would prefer to go when in crisis?	154 (20.4%)	599 (79.6%)
<b>Charts for enrollees with a crisis plan in place who had crisis service encounters (N=258)</b>		
1. Was the enrollee's crisis plan implemented?	94 (36.4%)	164 (63.6%)
2. Were least restrictive environments considered?	90 (67.2%)	44 (32.8%)

<sup>a</sup> An additional 37 enrollees (2.8%) refused a crisis plan.

**Table A-2. Clinical record evidence of providing services that promote recovery and resilience (N=1316).**

Domains	Needs			Strengths	
	Assessed— needs	Assessed— no needs	Not assessed	Assessed	Not assessed
Activities of daily living	472 (35.9%)	647 (49.2%)	197 (15.0%)	804 (61.1%)	512 (38.9%)
Medical needs	509 (38.7%)	676 (51.4%)	131 (9.9%)	972 (73.9%)	344 (26.1%)
Physical limitations	190 (14.4%)	829 (63.0%)	297 (22.6%)	630 (47.9%)	686 (52.1%)
Transportation needs	192 (14.6%)	539 (41.0%)	585 (44.4%)	478 (36.3%)	838 (63.7%)
Housing needs	364 (27.7%)	860 (65.3%)	92 (7.0%)	1047 (79.6%)	269 (20.4%)
Vocational needs	660 (50.2%)	485 (36.8%)	171 (13.0%)	894 (67.9%)	422 (32.1%)
Financial needs	417 (31.7%)	509 (38.7%)	390 (29.6%)	740 (56.2%)	576 (43.8%)
Social needs	958 (72.8%)	308 (23.4%)	50 (3.8%)	1051 (79.9%)	265 (20.1%)

**Table A-3. Needs addressed and not addressed in enrollee treatment plans (2010).**

Domains	Needs addressed	Needs not addressed
Activities of daily living (N=698)	490 (70.2%)	208 (29.8%)
Medical needs (N=609)	328 (53.9%)	281 (46.1%)
Physical limitations (N=215)	70 (32.6%)	145 (67.4%)
Transportation needs (N=262)	84 (32.1%)	178 (67.9%)
Housing needs (N=441)	269 (61.0%)	172 (39.0%)
Vocational needs (N=802)	467 (58.2%)	335 (41.8%)
Financial needs (N=423)	173 (40.9%)	250 (59.1%)
Social needs (N=1095)	921 (84.1%)	174 (15.9%)

Note: All objectives on the treatment plan in these domains were scored as addressed.

**Table A-4. Clinical record evidence of adherence to enrollee rights and quality-of-care standards.**

<b>Standard 1. Does the enrollee participate in treatment? How does the enrollee participate?</b>					
	<b>Present</b>	<b>Not Present</b>	<b>Partial</b>	<b>N/A</b>	
1. Record documents client support system (family, friends, etc.)	1,263 (93.6%)	77 (5.7%)	9 (0.7%)		
2. Record documents inquiry about client perceptions and preferences for treatment	1,095 (81.5%)	236 (17.6%)	13 (1.0%)		
3. Client's participation in developing treatment plan/goals is documented	1,188 (88.3%)	86 (6.4%)	43 (3.2%)	29 (2.2%)	
4. Client's participation is documented in client's own words	1,144 (85.1%)	200 (14.9%)			
5. Involvement of family/legal guardian documented in plan of care and ongoing treatment	632 (47.1%)	106 (7.9%)	16 (1.2%)	589 (43.9%)	
<b>Standard 2. Do agencies coordinate care with the enrollee's PCP and with other agencies?</b>					
	<b>Present</b>	<b>Not Present</b>	<b>Partial</b>	<b>N/A</b>	
1a. PCP is identified in clinical assessment and plan	994 (74.2%)	310 (23.1%)		36 (2.7%)	
1b. Consent is signed for exchange of information with PCP	839 (62.2%)	338 (25.1%)		171 (12.7%)	
1c. Consent specifies information to be exchanged and is current with appropriate signatures and dates	736 (56.1%)	298 (22.7%)	13 (1.0%)	266 (20.3%)	
1d. Clinical documentation provides evidence of coordination of care with PCP	537 (40.0%)	512 (38.2%)	43 (3.2%)	249 (18.6%)	
<b>Standard 3. Are treatment planning and progress notes appropriate for the enrollee?</b>					
	<b>Assessed</b>	<b>Addressed</b>	<b>Not addressed</b>	<b>N/A</b>	<b>Not assessed</b>
Development level	1,156 (85.9%)	625 (54.2%)	97 (8.4%)	432 (37.4%)	189 (14.1%)
Cognitive ability	1,243 (92.1%)	583 (47.0%)	111 (8.9%)	547 (44.1%)	106 (7.9%)
Cultural factors	1,083 (80.6%)	271 (25.0%)	139 (12.8%)	672 (62.1%)	261 (19.4%)
Socioeconomic factors	1,178 (87.7%)	585 (49.8%)	164 (14.0%)	426 (36.2%)	165 (12.3%)
Sensory impairments	964 (71.8%)	216 (22.4%)	85 (8.8%)	661 (68.7%)	379 (28.2%)
Language	1,259 (93.7%)	126 (10.0%)	40 (3.2%)	1,090 (86.8%)	84 (6.3%)
Ethnicity	1,256 (93.7%)	165 (13.2%)	90 (7.2%)	998 (79.6%)	85 (6.3%)
Sexual orientation	794 (59.2%)	66 (8.3%)	34 (4.3%)	693 (87.4%)	548 (40.8%)
Spirituality	844 (62.9%)	186 (22.1%)	79 (9.4%)	577 (68.5%)	498 (37.1%)
Beliefs / attitudes about medication	827 (61.9%)	654 (79.4%)	43 (5.2%)	127 (15.4%)	510 (38.1%)
Beliefs / attitudes about mental health treatment	898 (67.1%)	698 (78.2%)	58 (6.5%)	137 (15.3%)	440 (32.9%)
			<b>Yes</b>	<b>No</b>	
Was consumer informed of consumer support options?			519 (39.2%)	806 (60.8%)	
Was there a specific assessment/treatment planning conference related to cultural concerns?			249 (18.8%)	1078 (81.2%)	

**Table A-5. Needs addressed and not addressed in enrollee treatment plans (2008).**

	<b>Addressed</b>	<b>Not addressed</b>
Development level	625 (86.6%)	97 (13.4%)
Cognitive ability	583 (84.0%)	111 (16.0%)
Cultural factors	271 (66.1%)	139 (33.9%)
Socioeconomic factors	585 (78.1%)	164 (21.9%)
Sensory impairments	216 (71.8%)	85 (28.2%)
Language	126 (75.9%)	40 (24.1%)
Ethnicity	165 (64.7%)	90 (35.3%)
Sexual orientation	66 (66.0%)	34 (34.0%)
Spirituality	186 (70.2%)	79 (29.8%)
Beliefs/attitudes about medication	654 (93.8%)	43 (6.2%)
Beliefs/attitudes about mental health treatment	666 (92.0%)	58 (8.0%)

## Appendix B. Debrief Guide and Analysis Plan

The analysis strategy is based on post-session debriefings for both focus groups and interviews. Moderators and interviewers should follow the debriefing protocol closely in order to yield consistent data.

For **focus groups**, the assistant moderator should record participants' responses to questions and any important quotes or comments, and should be prepared to offer a summary at the end of the focus group. For **interviews**, the interviewer should record notes and observations on a sheet that outlines each question asked in the interview.

Debrief after the focus group/interview is completed, immediately or as soon as possible. First think about the answers to the following questions, then turn on the tape recorder to summarize the answers. Begin by describing the focus group or interview, including the number and composition of participants and any notable circumstances that influenced the discussion. Next, answer the following seven questions for *each focus group or interview question asked*. Then, answer the three general questions considering the entire focus group.

1. What were the most important themes or ideas discussed/most discussed?
2. Which topics generated the most energy?
3. Which topics generated consensus or differences of opinion?
4. Were participant responses different from what we expected? If so, how?
5. Did participant responses differ from what occurred in earlier focus groups or interviews? If so, how?
6. What points need to be included in the report?
7. What quotes should be remembered and possibly included in the report?
8. Were there any unexpected or anticipated findings?

### General Questions

1. Should we do anything differently for the next focus group?
2. Did we get the information we were hoping for?
3. Was there anything in the summary that participants disagreed with?

**Analysis plan:** Each debrief should contain between 20 and 30 minutes of dictation. Upload the audio file and any field notes into N\*Vivo, create a transcript, and proceed with analysis based on the taped debrief session. The analysis will focus primarily on two quality domains: (1) least restrictive environment and (2) recovery and resilience.

## Appendix C. Interview Tools

### Designated Mental Health Professional Interview Tool

RSN/Agency: \_\_\_\_\_ Date: \_\_\_\_\_

Interviewee(s) Name(s): \_\_\_\_\_

Acumentra Health is conducting a study that will describe, in part, how mental health services in your region are provided in the least restrictive environment, and in a manner that promotes recovery and resilience.

**As I go through these questions, please let me know if your answer is different for persons who have a legally responsible parent or guardian.**

1. What responsibilities are included in your role as a Designated Mental Health Professional (DMHP)?
2. Who can request your services as a DMHP and how does that happen?
3. Please describe how you, as the DMHP, evaluate the person, determine whether the person meets criteria for involuntary admission, and facilitate alternative placements.
4. How is the procedure different for persons who have a parent or guardian who are responsible for them?
5. Do you have an alerting system that mental health providers can use to advise you on how to assist known persons who you evaluate?
6. Generally, what is your availability?
7. Do you have timeliness guidelines or standards? Yes  No   
If so, what are they?
8. What percent of the time do you meet the timeliness guidelines or standards?
9. What are the barriers to meeting timeliness guidelines or standards?
10. Please tell me about the options, other than hospitalization, available for people who are in crisis with a mental or emotional disorder?
11. Generally, how often do you find an alternative to hospitalization for people?

12. What happens if you determine that the person does not to meet criteria for involuntary placement, but is still in need of immediate services?
13. What are the barriers to a person accepting or being placed in alternative services?
14. If an alternative to involuntary care is available, generally how long does it take for the person to be transferred there? —
15. What happens while the person is waiting for transfer?
16. How is the person transported to the alternative site?
17. If an alternative is available, generally how long does it take for the person to be transferred there?
18. How do the following staff work with you?
  - a. Emergency department staff
  - b. Prescriber
  - c. Law enforcement
  - d. Community mental health agency staff
  - e. RSN/mental health service authorization staff
  - f. Family or friends
19. What happens if you think a person needs to be involuntarily detained?
20. If the person needs to be transferred, what happens while the person is waiting for transportation if it is different than transport to an alternative to involuntary care?
21. How is the person transported to the acute care hospital or E&T?
22. Is there anything I should know that I haven't asked about concerning crisis services and alternatives to hospitalization?

Thank you for your time.

## Law Enforcement Interview Tool

RSN: \_\_\_\_\_ Agency: \_\_\_\_\_ Date: \_\_\_\_\_

Interviewee(s) Name(s): \_\_\_\_\_

Role(s): \_\_\_\_\_

Acumentra Health is conducting a study that will describe, in part, the availability of emergency mental health services in this region. I will ask you questions about your professional experience in dealing with persons who have a mental/emotional crisis, with mental illness, or persons who are threatening to harm themselves or others. I will also ask about the availability of mental health crisis services to assist you with that task.

**As I go through these questions, please let me know if your answer is different for consumers who have a legally responsible parent or guardian.**

1. Please describe the process or system you have in place for dealing with a crisis.
2. What assistance from mental health providers is available to law enforcement when dealing with persons in crisis?
3. Is the response generally timely? Yes  No
4. How easy is it to get mental health assistance?
5. Please describe any specific training you have had in dealing with persons in crisis or with mental illness?
6. If you have to take a person in crisis into custody, where do you take them? How far is it?
7. Who transports a person involuntarily detained to the hospital or the E&T?
8. What happens when Law Enforcement brings someone to the emergency department? Do the officers wait until the person is evaluated? Generally, how long must the officers wait?
9. Do you ever get called back to the hospital or E&T to transport the person to another facility (e.g., the state hospital)? How often?
10. What is your experience dealing with persons in crisis, or with mental illness while on duty?
11. Is there anything else I should know that I haven't asked about?

Thank you for your time.



## E&T Facility Interview Tool

RSN: \_\_\_\_\_ Agency: \_\_\_\_\_ Date: \_\_\_\_\_

Interviewee(s) Name(s): \_\_\_\_\_

Role(s): \_\_\_\_\_

Acumentra Health is conducting a study that will describe, in part, how mental health services in this region are provided in the least restrictive environment, and in a manner the promotes recovery and resilience.

**As I go through these questions, please let me know if your answer is different for consumers who have a legally responsible parent or guardian.**

1. Please describe the services available at the E&T?
2. What is your capacity (i.e., number of beds)?
3. What is your average length of stay?

**First, I want to ask you some questions about how consumers access the E&T.**

4. What are your admission requirements?
5. How do consumers get to the facility?
  - Law enforcement
  - Mental health provider
  - Family/friend
  - Self
  - Ambulance or other transport service
  - Other

6. What happens when one of the following brings someone to the E&T?

Party	Do they wait until the person is evaluated?		Generally, how long do they wait (hours)?	Comment
	Yes	No		
Law Enforcement	<input type="checkbox"/>	<input type="checkbox"/>		
Mental health provider	<input type="checkbox"/>	<input type="checkbox"/>		
Family/friend	<input type="checkbox"/>	<input type="checkbox"/>		
Ambulance or other transport service	<input type="checkbox"/>	<input type="checkbox"/>		
Other	<input type="checkbox"/>	<input type="checkbox"/>		

7. Please briefly describe your intake process.

8. How do primary mental health providers participate in the intake process?
9. What alternatives to admission to the E&T are available, and how do consumers access them?
10. Generally, what percent of consumers are voluntarily admitted to the E&T?
11. Please describe what happens when it determined that a consumer requires involuntary admission to the E&T.
12. How responsive are the DMHPs?
13. How timely are the DMHPs?
14. If the consumer is determined by the DMHP not to meet criteria for involuntary admission, does the DMHP negotiate with the consumer to accept other services, and facilitate access to them?
15. If it is determined that the consumer needs hospitalization, how does that occur? Who provides transportation from the E&T to the hospital? Is there any difference between voluntary and involuntary consumers?
16. Similarly, if it is determined that the consumer needs to be transferred to the E&T from the hospital, how does that occur? Who provides transportation from the hospital to the E&T? Is there any difference between voluntary and involuntary consumers?

**Now, I want to ask you some questions about coordination of care while a consumer is at the E&T.**

17. How do primary mental health providers participate in treatment while the consumer is at the E&T? How is care coordinated with primary mental health providers?
18. How are other issues (e.g., medical, housing, employment, etc.) dealt with during the consumer's stay at the E&T?
19. How are family and friends included while the consumer is at the E&T?
20. How does discharge planning occur? Who is responsible, E&T or primary provider?
21. What alternatives are available for discharge?
22. What are the barriers to discharge?
23. Is there anything else I should know that I haven't asked about?

Thank you for your time.

## Hospital Interview Tool

RSN: \_\_\_\_\_ Agency: \_\_\_\_\_ Date: \_\_\_\_\_

Interviewee(s) Name(s): \_\_\_\_\_

Role(s): \_\_\_\_\_

Acumentra Health is conducting a study that will describe, in part, how mental health services in this region are provided in the least restrictive environment, and in a manner that promotes recovery and resilience.

**As I go through these questions, please let me know if your answer is different for consumers who have a legally responsible parent or guardian.**

1. Please tell me about the options, other than hospitalization, available for people who present at the emergency department with a mental or emotional disorder?
2. What crisis services are available to assist you with these cases?
3. How is the procedure different for persons who have a parent or guardian who are responsible for them?
4. How does community mental health staff work with emergency department staff?
5. What happens when Law Enforcement brings someone to the emergency department? Do the officers wait with the consumer until the person is evaluated? Generally, how long must the officers wait?
6. Do you have an alerting system that mental health providers can use to advise you how to assist known consumers who present at the emergency department?
7. What happens if you think a person needs to be involuntarily detained?
8. How responsive are the Designated Mental Health Professionals (DMHPs)?
9. How timely are the DMHPs?
10. Please describe how the DMHP evaluates the consumer, determines whether the person meets criteria for involuntary admission, and facilitates alternative placements.
11. Generally, how often does the DMAP find an alternative to hospitalization for the person?
12. If the consumer is determined by the DMHP not to meet criteria for involuntary admission, does the DMHP negotiate with the consumer to accept other services, and facilitate access to them?
13. What alternatives are available for placement?
14. What are the barriers to placing a consumer at alternatives?
15. If an alternative to hospitalization is available, generally how long does it take for the consumer to be transferred there?

16. What happens while the consumer is waiting for transfer?
17. How is the consumer transported to the alternative?
18. Is there something I should know that I haven't asked about concerning crisis services and alternatives to hospitalization I should know?

Thank you for your time.

## Appendix D. List of Interviewed Organizations

### **Law enforcement**

Bremerton Police Department  
Lakewood Police Department  
Moses Lake Police Department  
Olympia Police Department  
Seattle Police Department  
Skagit County Sheriff's Department  
Spokane Police Department  
Vancouver Police Department  
Walla Walla County Sheriff's Department  
Wenatchee Police Department

### **Evaluation and treatment (E&T) facilities**

Kitsap Mental Health Services Adult Inpatient Unit, Bremerton  
Navos Mental Health Solutions, Seattle  
Spokane County E&T, Spokane  
Telecare-Pierce County E&T, Lakewood

### **Hospitals**

ADAPT (outpatient program of Southwest Washington Medical Center), Vancouver  
Central Washington Hospital, Wenatchee  
Good Samaritan Hospital, Puyallup  
Harborview Medical Center, Seattle  
MultiCare Health System, Tacoma  
Olympic Medical Center, Port Angeles  
Providence St. Peter's Hospital, Olympia  
Sacred Heart Medical Center, Spokane  
Skagit Valley Hospital, Mount Vernon