STATE OF WASHINGTON

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

Olympia WA 98504-5000

July 30, 2001

Robert Reed, Chief
Center for Medicare and Medicaid Services
Medicaid Branch
2201 6th Avenue, RX43
Seattle, Washington 98121-2500

Dear Mr. Reed:

The Mental Health Division (MHD) of the Department of Social and Health Services (DSHS), under the authority of Sections 1915 (b)(1) and (b)(4) of the Social Security Act, requests a renewal of its waiver. The specific provisions to be waived are Section 1902 (a)(1) – Statewideness, the statewideness provision to limit the geographic area in which this program will be implemented initially; Section 1902 (a)(10) – Comparability of Services, the comparability of services provision to allow services not available to other Medicaid recipients; Section 1902 (a)(23) – Freedom of Choice, the freedom of choice provision to limit the recipients' choice of providers to specific Prepaid Health Plans (PHPs) participating in the program; and Section 1902 (a)(30) – Basis of Payment, the basis of payment provision as there is the potential for exceeding the established upper payment limit in a service area.

This waiver renewal request is made so that the state may continue capitation arrangements with regional PHPs for both outpatient community mental health rehabilitation services and psychiatric inpatient in community hospital services to Medicaid recipients in the state of Washington. Under the waiver, the department proposes to continue contracting with a PHP in each service area to provide these services to recipients on a mandatory enrollment basis in lieu of the fee-for-service alternative.

An essential component of this renewal request is to contract with the Regional Support Networks (RSNs) who have demonstrated qualifications and entered into full risk capitated mental health services contract with the MHD. This approach is based on the unique structure of mental health and human service delivery systems administrated by the RSNs under state law. Pursuant to the state's Community Mental Health Services Act (RCW 71.24), the RSNs administer all community mental health services funded by the state. Under the state's Involuntary Treatment Act (RCW 71.05), the RSNs are responsible for investigating and detaining people who are in need of involuntary treatment.

Further, under other state statutes, the counties play a key role in alcohol and drug treatment as well as services for people with developmental disabilities. Counties are also

responsible for local criminal justice systems, including local jails and juvenile detention facilities. As a result of these diverse but interrelated responsibilities, RSNs remain in a unique position to facilitate coordination and integration of their existing program responsibilities with the managed mental health care system to provide seamless care for people covered by Medicaid. Moreover, based on their long history of experience in administering mental health programs, the RSNs are knowledgeable about the comprehensive needs of the high risk populations included in this managed mental health care system. In the event that one or more RSNs are unwilling or unable to demonstrate its qualifications as a PHP, the MHD will secure a qualified alternate.

Whether an RSN-based PHP or other entity holds the managed care contract, with the scope of services requested herein, the contractor will be required to assure an integrated system of mental health care and control the escalation of per eligible costs. This system will ensure access to quality services while slowing the rate of expenditure growth of the system overall.

The enclosed waiver renewal request includes documentation that indicates that this program will result in Medicaid program savings and improve access and quality of care. Furthermore, this program will not interfere with access to family planning or emergency services and will operate in accordance with the purposes of Title XIX of the Social Security Act.

I hope this information is sufficient for your review and approval of this request. However, if you require additional information, please contact Karl Brimner or Paul Montgomery from the Mental Health Division. Karl can be reached at (360) 902-0790 and Paul can be reached at (360) 902-0864.

Thank you for your cooperation and attention in this matter.

Sincerely,

DENNIS BRADDOCK
Secretary

Enclosure

cc: Tammi Hesson, CMS, Central Office
Carol Crimi, HCFA, Region X, M/S-47
Tim Brown, Assistant Secretary, DSHS
Karl Brimner, MHD, DSHS
Paul Montgomery, MHD, DSHS

Washington State – Integrated Community Mental Health Program
Proposal for a Section 1915(b) Capitated Waiver Program
Waiver Renewal Submittal

November 1, 2001- November 1, 2003

Submitted by:
Department of Social and Health Services
Mental Health Division
Karl Brimner, Director

Washington State – Integrated Community Mental Health Program

Washington State – Integrated Community Mental Health Program

Table of Contents

Introduction 1

Section A. General Impact 5
I. Background 5
II. General Description of the Waiver 13
III. Program Impact 22

Section B. Access and Capacity 41
I. Access Standards 41
II. Access and Availability Monitoring 44
III. Capacity Standards 47
IV. Capacity Monitoring 57
V. Continuity and Coordination of Care Standards 59
VI. Continuity and Coordination of Care Monitoring 60

Section C. Quality of Care and Services 71
I. Elements of State Quality Strategies 71
II. Coverage and Authorization of Services 77
III. Selection and Retention of Providers 80
IV. Delegation 82
V. Practice Guidelines 83
VI. Health Information Systems 84
VII. Quality Assessment and Performance Improvement 89

Section D. Cost Effectiveness 93
I. Type of Contract 96
II. Member Months 96
III. Without Waiver Data Sources and Adjustments 97
IV. Without Waiver Development 105
V. With Waiver Development 106
VI. Year 1 Aggregate Costs 109
VII. Year 2 Aggregate Costs 109
VIII. Year 3 Aggregate Costs 110
IX. Year 4 Aggregate Costs 110
X. Cost Effectiveness Summary 110

Section E. Fraud and Abuse 111
I. State Payment Mechanism Controls 111
II. MCO/PHP Provisions 112

Table of Contents (Continued)

Section F. Special Populations 113
I. General Provisions for Special Populations 113
II. State Requirements for MCOs/PHPs 114
Addendum on Special Needs Children 116

Section G. Complaints, Grievances, and Fair Hearings 125
I. Definitions 125
II. State Requirements and State Monitoring Activities 126

Section H. Enrollee Information and Rights 133
I. Enrollee Information-Understandable to Enrollees 133
II. Enrollee Information-Content 134
III. Enrollee Rights 138
IV. Monitoring Compliance with Enrollee Information and Enrollee Rights 139

Section I. Resource Guide 141

Appendices
Appendix D.II Member Months
Appendix D.III Without Waiver Data Sources and Adjustments
Appendix D.IV Without Waiver Development
Appendix D.V With Waiver Development
Appendix D.VI Year 1 Aggregate Costs
Appendix D.VII Year 2 Aggregate Costs
Appendix D.VIII Year 3 Aggregate Costs
Appendix D.IX Year 4 Aggregate Costs
Appendix D.X Cost Effectiveness Summary

Washington State – Integrated Community Mental Health Program

PROPOSAL FOR A SECTION 1915(b) CAPITATED WAIVER PROGRAM

Waiver Renewal Submittal

Introduction

The waiver renewal submittal is for a State's use in requesting renewal of an existing Section 1915(b) waiver program involving Managed Care Organizations (MCOs), Health Insuring Organizations (HIOs) or Prepaid Health Plans (PHPs) that provide contracted services to Medicaid enrollees under their care.

The use of this waiver renewal submittal is voluntary. The purpose is to facilitate the waiver renewal process and, thus, minimize unnecessary and cumbersome paperwork requirements. The completion of this request, used in conjunction with State Medicaid Manual instructions at sections 2106-2112, should expedite the State's effort to request the renewal of an existing waiver and HCFA's effort to process the renewal request.

All waiver renewal requests under section 1915(b) of the Social Security Act (the Act) are subject to the requirements that the State document the cost effectiveness of the project, its effect on enrollee access to and quality of services, and its projected impact on the Medicaid program (42 CFR 431.55(b)(2)). This model section 1915(b) waiver renewal submittal will help States provide sufficient documentation in conjunction with a previously completed waiver application submittal for HCFA to be able to determine whether the statutory and regulatory requirements of section 1915(b) of the Act have been satisfied.

Please note the following qualifications: (1) This version of the capitated waiver renewal submittal does not include new requirements proposed for the Medicaid Balanced Budget Act (BBA) regulation for managed care. Once those regulations are promulgated in their final form, waiver renewal requests will need to document compliance with any new requirements the regulations may contain. (2) States must still have MCO contracts and capitation rates prior approved by their HCFA Regional Office.

HCFA staff will be glad to meet with the State, set up a conference call, or assist the State in any way in the completion of the application. States requesting the renewal of a waiver under only Sections 1915(b)(2), 1915(b)(3), or 1915(b)(4), or a combined 1915(b) and 1915(c), waiver should work with their HCFA Regional Office to identify required submission items from this format.

Instructions

This waiver renewal submittal builds upon the new 1999 format for an initial waiver request. It is essentially the same document, with two changes: each section now

starts with a request for monitoring results from the previous two-year waiver period, and asks for changes proposed for the next waiver period. In the 1999 initial submittal we asked for a description of the waiver program. In this document we ask not only for the program description for the next two years, but a description/confirmation of what occurred in the previous two years.

Each section now starts with one or more items under the heading "Previous Waiver Monitoring." States are asked a couple questions (as appropriate to each Section). First, States are asked to identify any variance between what they said they would do in the last waiver application and what actually happened in the last two years. In a waiver renewal process, HCFA determines whether States adhered to the program descriptions and activities in the previous waiver application. Changes to the waiver program should not be made without obtaining HCFA approval for a modification to the waiver.

In some sections, a second question in "Previous Waiver Monitoring" asks for the results of monitoring various aspects of the waiver program over the previous 2-year waiver period. Please provide a summary of the State's monitoring results, including any breakdown available by sub-populations (i.e., if you have different or additional monitoring for foster care or SSI children than TANF, please indicate).

Following "Previous Waiver Monitoring" is the subsection called "Upcoming Two Year Period." Its purpose is to give the State the opportunity to describe the waiver program for the next two years. Within this section States are asked to identify any items which reflect a future change in program from the previous waiver submittal(s) by placing two asterisks (i.e., "**") the item being changed.

Please fill out this form in its entirety. Since this renewal submittal builds on the new 1999 initial submittal, there is not a one-to-one correspondence between sections in this 1999 and the 1995 format. When filling out the "Previous Waiver Monitoring" part of each section, we have tried to identify corresponding sections of the 1995 format when possible. However, States should provide monitoring results from all relevant sections of their previous waiver.

Waiver Submittal Instructions (See State Medicaid Manual 2106)
Please submit an original and four (4) copies of the waiver request to the appropriate office:

For MCO and PCCM programs:

HCFA, Center for Medicaid and State Operations, FCHPG
Attn: Director, Division of Integrated Health Systems
7500 Security Boulevard
Baltimore, MD 21244

Washington State – Integrated Community Mental Health Program

For Prepaid Health Plan programs focusing on Behavioral Health or Elderly and Disabled populations:

HCFA, Center for Medicaid and State Operations, DEHPG
Attn: Director, Division of Integrated Health Systems
7500 Security Boulevard
Baltimore, MD 21244

At the same time, send at least one copy of the waiver request to the appropriate HCFA Regional Office. A waiver request submitted under 1915(b) of the Act must be approved, disapproved, or additional information requested within 90 days of receipt, or else the request is deemed granted. The Secretary approves or denies such requests in writing or informs you in writing with respect to any additional information which is needed in order to make a final determination with respect to the request. When additional information is requested, the waiver request must be approved or disapproved within 90 days of receipt of your complete response to the request for additional information, or the waiver request is granted.

The 90-day time period begins (i.e., day number one) on the day the waiver is received by the addressee (i.e., the Secretary, the HCFA Central Office (CO) or Regional Office (RO) designee) and ends 90 calendar days later by which time HCFA must either approve or disapprove the request.

General instructions

States should check all items which apply, and provide additional information when specified. Leaving an item un-checked signifies it is not in the State's waiver program. Please note the following:

- A number of the items are required by federal statute, regulation, or policy. These required items are identified as such either in the instructions or headings for a section, or on an item by item basis. State must check-off these required items to affirm the State's intent to comply. If a required item is not checked, States should explain why it is not.

- All items are applicable to both MCOs and PHPs unless otherwise noted (i.e. only MCO or PHP is referenced in the item)

- For any of the sections that require explanations, if possible, please insert them into the document itself instead of attaching the explanation as an appendix.

- Because this is for a renewal of an existing waiver, HCFA is requesting data or summary results from efforts the State has made during the previous waiver period to ensure compliance, quality of services, enrollee protections, etc. In an effort to

ensure a complete submission package and to minimize the amount of additional information requested by HCFA, please be sure to respond to these items as fully as possible so that additional information requests are not necessary.

- If a State modifies the wording of the waiver renewal submittal, please italicize and/or strikeout the modification. States may use italics, underlines, and strikeouts for any State-added information or modification to the standard waiver renewal submittal.

- Please update the table of contents prior to submitting the waiver to HCFA to reflect the current page numbers and appendices.

- Please enclose any attachment directly following the section referenced and number the attachments with the section and question number, (e.g., Attachment C.I.a is the attachment for question a. under point I. Elements of State Quality Strategies in Section C.)

Amendments or modifications during the renewal period
During the renewal period, a State may wish to modify their Section 1915(b) waiver program if an aspect of the program changes. Four (4) copies of the modification request must be submitted to the appropriate CO address listed above. A copy should also be sent to the RO at the same time.

HCFA considers only waiver requests submitted by or through the Governor, State cabinet members responsible for State Medicaid Agency activities, the Director of the State Medicaid Agency, or someone with the authority to submit waiver requests on behalf of the Director.

HCFA reviews the request and makes its recommendation to approve or disapprove the request based on the validity of the request and the documentation that is submitted to support the modification. Approval of modification requests are effective from the date of approval through the end of the renewal period.

HCFA receives a variety of waiver modification requests, which range from being minor in nature to extensive. Regardless of the extent of the needed modification, a State must submit an official request for modification to HCFA as soon as it is aware of the need for a change in its program. The request must be submitted and approved prior to implementation of a change in the waiver program.

Washington State – Integrated Community Mental Health Program

Section A. General Impact

I. Background

[Required] Please provide a brief executive summary of the State's 1915(b) waiver program's activities since implementation, including experiences during the previous waiver period(s) and a summary of any program changes either planned or anticipated during the requested renewal period. Please specify the types of stakeholders or other advisory committee meetings that have occurred in the previous waiver period or are expected to occur under the future waiver period. Please include descriptions of any advisory boards that have consumer representation. In addition, please describe any program changes and/or improvements that have occurred as a result of stakeholder involvement during the previous waiver period(s). Please describe any stakeholder involvement in monitoring of the previous waiver period. Finally, to the extent the State enrolls persons with special health care needs, please describe how the various stakeholders have been involved in the development, implementation, and ongoing operation of the program.

The purpose of this waiver renewal is to continue, through contracts with the Regional Support Networks (RSNs), to: 1) promote comprehensive coordination of services with regionally managed care through Prepaid Health Plans (PHP); 2) provide community mental health rehabilitation services and community psychiatric inpatient care in a seamless manner providing continuity of care for persons served by the public mental health system; and 3) support recovery and community reintegration to the community for persons with mental illness.

The Washington State Legislature passed the Mental Health Reform Act (2SSB 5400) in 1989 and created a single point of local responsibility for mental health services. This 1989 legislation created county-based RSNs to design and administer mental health delivery systems to meet the unique needs of people with mental disorders. Although the RSNs addressed the issue of coordination of outpatient and state hospital care, prior to 1993 they did not have the ability or responsibility to manage care and to control the escalating costs of the Medicaid program.

The capitated managed mental health system gives the RSN the ability to design an integrated system of mental health care and, as necessary, subcontract with a provider[1] network capable of providing quality service delivery which is age and culturally competent.

The Mental Health Division (MHD) began delivering services under a 1915 (b) waiver in 1993, for outpatient mental health services. This established the ability to control the rate of financial growth and improved service outcomes. The services covered under the waiver were the full range of

1 For the purpose of this renewal, when the MHD speaks of a provider we mean it to be a Community Mental Health Center. If we are speaking of the primary person responsible for carrying out the treatment plan, we will refer to them as the PCP. The term(s) therapists, social worker, Dr. are self explanatory.

community mental health rehabilitation services offered previously under the Medicaid State Plan through a fee-for-service reimbursement system. These services stress ongoing community support to provide the enrollee with tailored services, responsive to their individualized needs. It was the State's intention to manage the costs of the community support program while continuing to target service to the most disabled enrollees with better-coordinated services.

In 1997, an amendment to the existing waiver was approved which incorporated community psychiatric inpatient services for adults, older persons, and children into the capitated contracts with the RSNs. This integration furthered the principles of mental health reform and improved the services provided to enrollees.

An essential component of the waiver amendment was to provide the RSNs the first opportunity to demonstrate qualifications and enter into an integrated full-risk capitated mental health services contract with the MHD. The MHD took this approach due to the existing unique structure of mental health and human service delivery systems administered by counties and the RSNs under state law. Pursuant to the State's Community Mental Health Services Act (Revised code of Washington (RCW) 71.24), the RSNs administer all community mental health services funded by the state. Under the State's Involuntary Treatment Act (RCW 71.05), the RSNs are responsible for investigating and detaining people who are in need of involuntary treatment. Further, under other state statutes, the counties play a key role in chemical dependency treatment as well as providing for people with developmental disabilities.

Counties are also responsible for local criminal justice systems, including local jails and juvenile detention facilities. As a result of these diverse but interrelated responsibilities, RSNs maintain a unique position to facilitate coordination and integration of their existing program responsibilities with the managed mental health care system. Moreover, based on their long history of experience in administering mental health programs, the RSNs are knowledgeable about the comprehensive mental health needs of the high risk populations included in managed mental health care system.

Upon requests of a Tribal authority or authorities within a RSN, the joint operating agreement or the county authority shall allow for the inclusion of the tribal authority to be represented as a party to the RSN. The roles and responsibilities of the county and tribal authority shall be determined by the terms of that agreement including a determination of membership on the governing board and advisory committees. The number of tribal representatives to the party to the agreement, and to the provisions of the law shall assure the provision of culturally competent services to the tribes served.

Should the RSNs choose not to become the PHP, the MHD will procure these services. Timing of this occurrence will be critical to maintain services for enrollees. The MHD would continue the existing relationship with the RSN until the procurement was complete to ensure a smooth transition. It may be necessary for a short (time limited) period of time that the State of Washington will have to implement a fee-for-service system in the geographic area relevant to the RSN.

The MHD ensures that whether an RSN-based PHP or other entity holds the managed care

contract, the contractor is required to provide an integrated system of service delivery and control per eligible costs. This system ensures access to quality services while managing the rate of expenditure growth of the overall system. The statewide mission, values, and guiding principles are the basis ofall aspects of service delivery, interpretation, and implementation of the waiver and the RSN contracts. They are:

Mission Statement

Washington State Publicly Funded Mental Health System

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

We are committed to take actions consistent with these values:

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.

Given this mission, we believe the operation of the system should be based on the following principles:

1. Treatment becomes meaningful when participants have voice, access and ownership of the mental health services.
2. Staff at all levels shall treat people in the system with respect, equality, courtesy and fairness.
3. Services shall heed individual diversity and explicitly incorporate the age, culture and preferences of the participant, his or her family and/or natural supports in the plan of care.
4. Participants and their families shall be included in the ongoing process of decision-making and policy-setting in the planning, implementation and operation of the system.
5. Treatment and support is provided in such a way that the lives of people are disrupted as little as possible by mental illness while keeping them and their community safe.
6. Providers of mental health services must work in active partnership with other allied community providers to ensure that participants receive a balanced, coordinated and individualized array of quality supports and services.
7. People shall be provided access to information about mental illness and treatment options.
8. Services shall be offered that are most responsive to the participant's needs in the least restrictive manner and setting possible.
9. Services shall be quickly and conveniently offered so that the right services are available at the right time and in the right place allowing for the greatest possible opportunity for recovery.
10. Participants have the right to receive services from qualified staff who are both clinically and culturally competent.

Washington State – Integrated Community Mental Health Program

11. Effective plans of care shall result from a comprehensive evaluation and be based on the strengths of the person and his or her family or natural supports. They should begin with education on the nature of the mental illness he or she is experiencing and the range of options for treatment and support available in the system. This includes not only medications and formal psychotherapies, but also alternative approaches that may be appropriate to the age, culture and preferences of the participants.
12. Participants who experience persistent but fluctuating effects from their mental illnesses require stable relationships with the network of providers as their needs wax and wane. These relationships must allow for reductions, increases and modifications of support and services without repeated reapplication for enrollment and without constant changes in the personnel with whom the participant and his or her family or natural supports interact.
13. Managing the publicly-funded trust requires acting as stewards for the taxpayers dollars by providing the needed services in the most cost effective and efficient manner possible.

Stakeholder work will occur over the next year to revise and/or update the statewide mission as it is now five years old.

This system of capitated, managed mental health care will continue to provide the following:

1. Provide comprehensive, integrated services within regionally managed care through Prepaid Health Plans;
2. Provide enrollees access to services and active voice in their treatment plan;
3. Provide medically necessary tailored services that are age and culturally competent and which are individualized to meet the needs for those enrollees requiring on-going community support;
4. Ensure service intensity commensurate with each enrollee's level of need;
5. Provide rehabilitation and recovery services enabling each enrollee to live, work and participate more fully in his/her culture in the community;
6. Provide ready access to emergency services;
7. Ensure engagement and services to high-need populations;
8. Ensure community inpatient psychiatric services for adults, older persons, and children in a seamless manner with ongoing care;
9. Provide appropriate utilization of community psychiatric inpatient care for adults, older persons, and children;
10. Promote coordination of services with other systems of care (e.g., vocational rehabilitation, physical health care, alcohol and substance abuse, developmental disabilities, acute care, informal and natural support systems, child welfare, juvenile justice, aging and adult services, tribes, corrections, jails, and education); and
11. Promote collaboration with tribal authorities and ensure American Indians access to culturally competent services.

Washington State – Integrated Community Mental Health Program
Since the RSN serves a specific geographic area, the MHD requires assurances from each RSN that they will have a sufficient number of service sites, both in and out of facility, to ensure enrollees have choices of service locations. In addition, under the rehabilitation services options, most services, especially crisis and emergency services, are provided out of the facility (e.g., enrollee's residence or in other community settings that are comfortable to the enrollee). The MHD assures that adequate service capacity and service diversity can be met through the integrated community mental health program.

The RSN will continue to provide inpatient service through community inpatient providers and will purchase service capacity for adults and children to ensure that services are as close to the enrollee's community as possible so long as it is clinically indicated. The state will contract with hospitals that are licensed and willing to provide inpatient psychiatric care. The state will allow the RSNs to submit a regional plan for direct contracting with psychiatric hospital providers. Any contract between an RSN and local hospital must contain the provision of collaboration for emergency admissions to non-contracted hospitals and the transfer of enrollees to contracted hospitals. The state allows exceptions to this, if the transfer would cause harm to the enrollee, or there is no hospital within reasonable travel time of the residence of the immediate family member who helps with the personal needs of the enrollee. Each RSN will also need to ensure that Medicaid enrollees, who have other insurance but have exhausted their benefits, will receive continuity of care. Any RSN that develops a direct contract network will be required to include the hospitals included in the network in their marketing brochures. They will also be required to develop a plan that ensures hospitals and physicians will by provided orientation to the prepaid health plan. All contracts between a RSN and community hospital will have a grievance procedure for enrollees, which will be made available to enrollees. If a RSN develops a direct contract network, the state will require them to show that they have a capacity (combined in-network and out-of network providers) of at least 110% of their actual utilization for the prior year.

During the last waiver cycle, there was much work done between the MHD, CMS Region X staff and Tribal authorities with regards to mandatory enrollment in the prepaid health plan. In the previous waivers, tribal members were required to seek disenrollment from the prepaid health plan when they sought services from Indian Health programs or tribal clinics. This was a burdensome process and did not provide for the services or supports needed. It is now possible for members to coordinate their array of services with both programs, which is of greater benefit to the members. Tribal members are now not disenrolled when they wish to use the services from indain health Programs or tribal clinics.

On-site monitoring of the system continues to occur annually (and more often if necessary) through the Quality Assurance and Improvement (QA & I) Team. This team is made up of three sections of the MHD's Mental Health Services section described in our last waiver. The three sections were licensing and certification, contract monitoring and the integrated review.

Washington State – Integrated Community Mental Health Program
Stakeholder involvement and advisory committees

The public mental health system in Washington State was and continues to be developed with significant stakeholder and consumer involvement. This is not a new process for the MHD. It is one that has its roots from the 1970's. The MHD receives stakeholder input in a variety of ways.

Consumer and family voice and recovery is the foundation of the service delivery system. The MHD believes that those persons being served should drive the system. The system and advocates are seeing the impact of consumer voice both in policy development and service delivery, and in the structure of the way in which services are delivered. There are many arenas where the MHD collects input from consumers and their families:

- The MHD Office of Consumer Affairs (OCA), in the MHD, meets regularly with consumers, parents, and advocates. Frequent and consistent communication assures an accurate understanding of the points of view of consumers, parents, and other family members, which is then incorporated into the workings of the public mental health system. The OCA reports directly to the MHD Director, and the Administrator of the OCA is a member of the Management Team.
- The Consumer Roundtable includes a consumer representative from each RSN who receives public mental health services. Recovered consumers act as mentors with this group to provide assistance and advice as they assume their role as active participants. This group provides direct input to the MHD Director.
- MHD contracts with two family advocacy groups statewide for education and advocacy purposes. These groups are also very visible during the state's legislative session.
- MHD supports a Parent Council consisting of parents of children who receive services through the public mental health system. These parents each represent a parent organization in their RSN or the Community Connector Project sponsored by the MHD. The parent council provides input through the OCA to the MHD Director.
- Consumers and family members make-up 51% of our state mental health advisory committee (MHAC). This committee (as do all others), includes representatives who are advocates for children and for older person with mental illness, RSNs, service providers and allied systems. The MHAC has a very active role in establishing and monitoring the federal block grant plan submitted to the Center for Mental Health Services at the Substance Abuse Mental Health Administration. They along with their sub-committees, Children, Family and Youth, Ethnic Minority, Sexual Minority, and Aging have set priorities for the next year and are focusing their efforts on Best Practice and stigma reduction. They are very active participants in many of the other stakeholder activities and provide valuable input and insight to the MHD.
- Washington Administrative Code (WAC) requires the existence of an advisory board at the RSN level that has 51% consumers and family members and is demographic in its make-up.
- MHD staff meet regularly with the Department of Social and Health Services (DSHS)

Indian Policy Advisory Committee (IPAC) to share information and to discuss strengths and concerns.

- Ombuds/QRT oversight committee provides policy guidance to MHD about Ombuds and QRT. Examples of this are defining "Functional Independence" and establishing a "Dispute Resolution Policy". An ad-hoc sub-committee has established the basis of an electronic report process for Ombuds and for QRT. They also provide advice to the contractor that provides training and support to Ombuds and QRT members statewide.
- MHD is responsible to answer questions from constituents and the general public regarding the public mental health system that are directed to the Department from legislative office, the Governor's office and the internally through the Department's Office of Community Relations.
- MHD and the Division of Alcohol and Substance Abuse (DASA) staff the co-occurring disorders interagency committee (CODIAC) made up of state, providers from mental health, chemical dependency providers, consumers and other cross-system providers. This group has been in existence for approximately twelve years and addresses co-occurring mental illness and substance related disorders.
- Inpatient Roundtable is a technical assistance group comprised of staff from MHD, Medical Assistance Administration (MAA), RSNs and community hospitals that meet on a routine basis to discuss various issues that arise.
- By contract the RSNs are required to have consumers and family members involved in all levels of service delivery including policy setting and decision making. This is also monitored during the annual on-site monitoring process and by other means.
- MHD staff meets regularly with the RSN administrators and assures that there is representation from the RSNs on any committee, which meets to change, establish or set policy. These committees also include providers, consumers, parents and family advocates. Allied system partners are at times invited to attend. These meetings include topics ranging from performance indicators to Washington Administrative Code changes.
- MHD's management team has a monthly call with the leadership of the RSN where the main purpose is to keep each group informed of current and ongoing activities.
- MHD meets with the Washington Community Mental Health Council. This is a group representing some of the community mental health centers providing services under subcontract with the RSNs. The MHD has also developed ways to receive input from the community mental health centers that do not belong to the Council but subcontract with the RSNs.
- As part of the quality management there were three separate MHD sponsored System Improvement Groups that met for specific tasks. The System Improvement Group (SIG) is a group of stakeholders representing consumers, parents, family advocates, community mental health centers (both council and non-council members, Washington Institute for Mental Illness Research and Training (WIMRT), Regional Support Networks and MHD. The group is divided east/west and has no duplicative service area representation. The first group met to decide on the major focus areas for monitoring and system accountability. This group identified three areas of system focus and set outcomes for each.

Washington State – Integrated Community Mental Health Program

They made recommendations on outcomes and left methodology to achieve each outcome to the responsible entity. The foundation was to begin with the consumers prospective, then the provider, the RSN, and finally the MHD delineating roles and responsibilities at level. The monitoring focus areas identified were consumer voice, quality management, and cross-system collaboration. It was also made clear that each level of the system only had pieces of each of these outcomes and would need to work for several years to attain completion. One recommendation of the first group was to look at duplicate monitoring activities and roles and responsibilities throughout the system. The MHD's management team sponsored the SIG foundation both in process and product as a methodology to move the system forward.

The SIG 2 was formed using the SIG 1 foundation and some of the same individuals for continuity to begin work on the SIG 1 recommendations. SIG 2 defined a pilot project for better coordination of overall monitoring activities (MHD, RSN, CMHC) to reduce duplication of effort. That pilot led to the current realignment of the mental health services section within the MHD to coordinate the activities. As a result of participation on the SIG 2 pilot, consumers and parents are now contractors of the MHD to be an active part of the QA & I team and participate on the annual on-site monitoring.

The SIG 3 group has began to further look at the deeming process and establish working agreements with CARF and JCAHO regarding deeming as a continued look at duplicative monitoring activities. It is the intention of SIG 3 to have a report and recommendations by the end of October 2001.

Other SIG activities may continue to refine additional recommendations using the foundation established. SIG recommendations have been incorporated into the MHD's QM plan, planning, policy, and contracting activities.

The RSN have involved stakeholders in a variety of ways including:

Advisory board	Ombuds/QRT
QRT forums	Consumer advisory committee
Support groups	Contracted family organizations
Community forums to gather information and solicit input	Public health agency
NAMI-WA	Housing authority
Chamber of Commerce	Policy workgroups
Quality Management over-site committee	Cross-system committees
DSHS Regional Advisory Committee	Community Hospital
Provider network survey	Allied systems meetings
Tribal meetings and participation	Use of grievance determinations to make broader QM improvements

The community mental health centers (providers) have involved stakeholders:

Public Health Meetings	NAMI-WA
Allied system meetings	Consumer advisory committee
Clubhouses	Cross-system committee
Consumer and parent voice through direct work	Ombuds/QRT
On boards, committees, forums	community forums
Washington State coalition for homeless	Civic clubs
Liaison with family groups	Community events to gather information and solicit input

Monitoring & evaluation activities are required of the Mental Health Advisory Committee and their subcommittees. This activity is mostly done through communication with their stakeholders and by reading of reports and recommendations. They will be hosting annual large meetings of the entire stakeholder communities. National Alliance for the Mentally Ill (NAMI)-Washington also provides evaluation to the system and provides input to both the MHD and the RSNs. NAMI is also very active in the legislative process at both the state and national level. Their recommendations are used to continue to develop overall system policy and planning and are often blended into the federal block grant application process and into the contract development.

Two stakeholders comments (one came from a parent and the other from a consumer during different meetings) standout as important to follow during this waiver period:

"Stop making the community mental health center the focus of consumer lives. Make it a place for us to get help and move on." and
"It is good for the system and the providers to receive complaints, if they do not, how will they know what to correct to make the system better. They will listen to us and respond when given the chance."

II. General Description of the Waiver Program

Previous Waiver Period

a.___ During the last waiver period, the program operated differently than described in the waiver governing that period. The differences were:

Upcoming Waiver Period – For items a. through m. of this section, please identify any responses that reflect a change in program from the previous waiver submittal(s) by placing two asterisks (i.e., "**") after your response.

Washington State – Integrated Community Mental Health Program

a. The State of Washington requests a waiver under the authority of section 1915(b)(1) of the Act. The waiver program will be operated directly by the Medicaid agency.

The waiver program will continue to be administered directly by the MHD of the Department of Social and Health Services (DSHS), which is the Medicaid single state agency.

b. Effective Dates: This waiver renewal is requested for a period of 2 years; effective November 1, 2001 and ending November 1, 2003.

c. The waiver program is called Integrated Community Mental Health Program.

d. State Contact: The State contact person for this waiver is Paul Montgomery and can be reached by telephone at (360) 902-0864, or fax at (360) 902-0809, or e-mail at montgpr@dshs.wa.gov.

e. Type of Delivery Systems: The State will be entering into the following types of contracts with the MCO or PHP. The definitions below are taken from federal statute. However, many "other risk" or "non-risk" programs will not fit neatly into these categories (e.g. a PHP program for mental health carve out is "other risk," but just checking the relevant items under "2" will not convey that information fully). Please note this answer should be consistent with your response in Section A.II.d.1 and Section D.I.

1.___ **Risk-Comprehensive (fully-capitated--MCOs, HIOs, or certain PHPs):** Risk-comprehensive contracts are generally referred to as fully-capitated and require that the contractor be an MCO or HIO. Comprehensive means that the contractor is at risk for inpatient hospital services and any other mandatory State plan service in section 1905(a), or any three or more mandatory services in that section. References in this preprint to MCOs generally apply to these risk-comprehensive entities. Check either (a) or (b), and within each the items that apply:

(a)__ The contractor is at-risk for inpatient hospital services and any one of the following services:

i.__ Outpatient hospital services *services*,
ii.___ Rural health clinic (RHC) services,
iii.___ Federally qualified health clinic (FQHC) services,
iv.___ Other laboratory and X-ray services,
v.___ Skilled nursing facility (NF) services,
vi ___ Early periodic screening, diagnosis and treatment (EPSDT) services,
vii.__ Family planning services,
viii.__ Physician services, and

ix.___ Home Health services.

(b)__The contractor is at-risk for three or more of the above services ((i) through (ix)). Please mark the services in (a) and list the services in Section A.II.d.1.

2.__ x_ **Other Risk (partially-capitated or PHP):** Other risk contracts having a scope of risk that is less than comprehensive are referred to as partially-capitated. PHPs are the contractors in these programs (e.g., a PHP for mental health/substance abuse). References in this preprint to PHPs generally apply to these other risk entities. Please check either (a) or (b); if (b) is chosen, please check the services which apply. In addition to checking the appropriate item, please provide a brief narrative of the other risk (PHP) model, which will be implemented by the State:

(a)_ x_ The contractor is at-risk for *community inpatient psychiatric* hospital services

OR

(b)__The contractor is at-risk for two or fewer of the below services ((i) through (ix)).

i.__x_ Outpatient *mental health* services,
ii.___ Rural health clinic (RHC) services,
iii._x__ Federally qualified health clinic (FQHC)*mental health* services,
iv.___ Other laboratory and X-ray services,
v.___ Skilled nursing facility (NF) services,
vi.__x_ Early periodic *mental health* screening, diagnosis and treatment (EPSDT) services,
vii.__Family planning services,
viii.__ Physician services, and
ix.___ Home Health services.
x.____ other

3.___ **Non-risk:** Non-risk contracts involve settlements based on fee-for-service (FFS) costs (e.g., an MCO contract where the State performs a cost-settlement process at the end of the year). If this block is checked, replace Section D (Cost Effectiveness) of this waiver preprint with the cost-effectiveness section of the waiver preprint application for a FFS primary care case management (PCCM) program. In addition to checking the appropriate items, please provide a brief narrative description of non-risk model, which will be implemented by the State.

4.___ Other (Please provide a brief narrative description of the model. If the model is an HIO, please modify the entire preprint accordingly):

f. Statutory Authority: The State's waiver program is authorized under **Section**

1915(b)(1) of the Act, which provides for a capitated managed care program under which the State restricts the entity from or through which a enrollee can obtain medical care.

g. Other Statutory Authority. The State is also relying upon authority provided in the following section(s) of the Act:

1.___ **1915(b)(2)** - A locality will act as a central broker (agent, facilitator, negotiator) in assisting eligible individuals in choosing among competing health plans in order to provide enrollees with more information about the range of health care options open to them. See Waiver Preprint Section A.III.B Enrollment/Disenrollment and Section 2105 of the State Medicaid Manual. This section must be checked if the State has an independent enrollment broker.

2.___ **1915(b)(3)** - The State will share cost savings resulting from the use of more cost effective medical care with enrollees by providing them with additional services. Please refer to Section 2105 of the State Medicaid Manual. The savings must be expended for the benefit of the enrolled Medicaid beneficiary.

Please list additional services to be provided under the waiver which are not covered under the State plan in Section A.III.d.1 and Appendix D.III. The services must be for medical or health-related care, or other services as described in 42 CFR Part 440, and are subject to HCFA approval.

3.x___ **1915(b)(4)** - The State requires enrollees to obtain services only from specified providers who undertake to provide such services and meet reimbursement, quality, and utilization standards which are consistent with access, quality, and efficient and economic provision of covered care and services. Please refer to Section 2105 of the State Medicaid Manual.

h. Sections Waived. Relying upon the authority of the above Section(s), the State requests a waiver of the following Sections of 1902 of the Act:

1.__x_ **Section 1902(a)(1)** - Statewideness--This Section of the Act requires a Medicaid State plan to be in effect in all political subdivisions of the State. This waiver program is not available throughout the State.

This waiver program is implemented statewide. It may be necessary however, if at any time the RSN can not or chooses not to demonstrate qualifications, for the State of Washington to implement a fee for service system on a very time limited basis to implement a procurement process for that geographic area. This would be done thoughtfully and carefully so as to not disrupt care to consumers and to maintain cost-effectiveness and the Upper Payment Level.

2.__x__ **Section 1902(a)(10)(B)** - Comparability of Services--This Section of the Act requires all services for categorically needy individuals to be equal in amount, duration, and scope. This waiver program includes additional benefits such as case management and health education that will not be available to other Medicaid enrollees not enrolled in the waiver program.

3.__x__ **Section 1902(a)(23)** - Freedom of Choice--This Section of the Act requires Medicaid State plans to permit all individuals eligible for Medicaid to obtain medical assistance from any qualified provider in the State. Under this program, free choice of providers is restricted. That is, individuals enrolled in this program receive certain services through an MCO or PHP.

4.__x__ **Section 1902(a)(30)** - Upper Payment Limits--This Section of the Act require that payments to a contractor may not exceed the cost to the agency of providing those same services on a FFS basis to an actuarially equivalent nonenrolled population. Under this waiver, a contractor may receive a capitation rate and any other applicable payment which may cause total payments to the contractor to exceed the upper payment limits for the capitated services in a given waiver year. The waiver must still be cost-effective for the two-year period. An example of a program with this waiver is a partial capitation program, where the State gives the capitated entity (or entities) a bonus (which in conjunction with the capitation payment exceeds the UPL) for reductions in Medicaid expenditures for high cost areas, but the State demonstrates cost-effectiveness on the basis that total waiver program expenditures are less than total without waiver program expenditures.

The UPL for this waiver is calculated by age group and region. This waiver program has the potential of exceeding the UPL as it pertains to savings redistribution between the participating RSNs or across age groups. The sharing of these savings may result in total reimbursement in a service area reaching a level above what would have been realized under the traditional fee-for-service system without the waiver. However, the total reimbursement statewide remains less than the UPL.

5._x__ **Other Statutes Waived** - Please list any additional section(s) of the Act the State requests to waive, including an explanation of the request. As noted above, States requesting a combined 1915(b) and 1915(c) waiver should work with their HCFA Regional Office to identify required submission items from this format.

§ 1932(a)(1)	Waiver of this section is necessary in order to allow MHD to provide services through a managed care system that differs from some of the requirements in § 1932, as approved in previous waiver

	renewals.
§ 1932(a)(2)	Waiver of this section is necessary in order to continue MHD's program that requires all Medicaid recipients receive mental health services through managed care, as approved in previous waiver renewals.
§ 1932(a)(3)	Waiver of this section is necessary in order to continue MHD's managed care program that uses a single county-operated PHP for a particular region, as approved in previous waiver renewals.
§ 1932(a)(4)	Waiver of this section is necessary in order to allow MHD to continue to use the disenrollment procedures approved in previous waiver renewals.

To the extent deemed necessary by the federal government, any other provisions of Section 1902 and 1932 of the Act.

i. Geographical Areas of the Waiver Program: Please indicate the area of the State where the waiver program will be implemented. (Note: If the State wishes to alter the waiver area at any time during the waiver period, an official waiver modification request must be submitted to HCFA):

1.__X__ Statewide -- all counties, zip codes, or regions of the State have managed care (Please list in the table below) or

2.____ Other (please list in the table below):

Regardless of whether item 1 or 2 is checked above, please list in the chart below the areas (i.e., cities, counties, and/or regions) and the name and type of entity (MCO, PHP, HIO, or other entity) with which the State will contract:

City/County/Region	Name of Entity*	Type of Entity (e.g., PHP, Staff model HMO)
(Service Area map is in Attachment AIIia)	Chelan/ Douglas Regional Support Network	PHP
	Clark County Regional Support Network	PHP
	Grays Harbor Regional Support Network	PHP
	Greater Columbia Behavioral health Regional Support Network	PHP
	King County Regional	PHP

Washington State – Integrated Community Mental Health Program

City/County/Region	Name of Entity*	Type of Entity (e.g., PHP, Staff model HMO)
	Support Network	
	North Central Regional Support Network	PHP
	Northeast Washington Regional Support Network	PHP
	North Sound Regional Support Network	PHP
	Peninsula Regional Support Network	PHP
	Pierce County Regional Support Network	PHP
	Southwest Regional Support Network	PHP
	Spokane Regional Support Network	PHP
	Thurston Mason Regional Support Network	PHP
	Timberlands Regional Support Network	PHP

*The State should list the actual names of the contracting entities. Cost-effectiveness data should be submitted for every city/county/region listed here as described in Section D.

j. **MCO Requirement for Choice:** Section 1932(a)(3) of the Act requires States to permit individuals to choose from not less than two managed care entities.

1.___This model has a choice of managed care entities.
(a)__At least one MCO and PCCM
(b)__One PCCM system with a choice of two or more Primary Care Case Managers (please use the PCCM preprint instead of this capitated preprint)
(c)__Two or more MCOs
(d)__At least one PHP and a combination of the above entities

2.___ This model is an HIO.

3.___Other: the State requests a waiver of 1932(a)(3). Please list the reasons for the request (Please note: The exception to choice in rural areas, under Section 1932(a)(3) will not apply until final promulgation of the Balanced Budget Act Medicaid Managed Care regulations):

Washington State – Integrated Community Mental Health Program

k. Waiver Population Included: The waiver program includes the following targeted groups of beneficiaries *who choose to recieve public mental health services.* Check all items that apply:

1._x_Section 1931 Children and Related Poverty Level Populations (TANF/AFDC)

2.__x Section 1931 Adults and Related Poverty Level Populations, including pregnant women (TANF/AFDC)

3.__x Blind/Disabled Children and Related Populations (SSI)

4.__x_Blind/Disabled Adults and Related Populations (SSI)

5.__x_Aged and Related Populations (Please specify: SSI, QMB, Medicare, etc.)

Includes SSI, QMB Only, QMB Plus, SLMB Plus, and Medicaid Only Dual Eligibles (Non QMB, SLMB, QDWI, QI-1, or QI-2).

6._x_Foster Care Children

7._x__ Title XXI CHIP - includes an optional group of targeted low income children who are eligible to participate in Medicaid if the State has elected the State Children's Health Insurance Program through Medicaid

8.__x_ Other Eligibility Category(ies)/Population(s) Included - If checked, please describe these populations below.
RCW 71.24.015 Legislative intent and policy.

"It is the intent of the legislature to establish a community mental health program, which shall help people experiencing mental illness to retain a respected and productive position in the community. This will be accomplished through programs, which provide for:

(1) Access to mental health services for adults of the state who are acutely mentally ill, chronically mentally ill, or seriously disturbed and children of the state who are acutely mentally ill, severely emotionally disturbed, or seriously disturbed, which services recognize the special needs of underserved populations, including minorities, children, the elderly, tribal members, disabled, and low-income persons. It is also the purpose of this chapter to promote the early identification of mentally ill children and to ensure that they receive the mental health care and treatment which is appropriate to their developmental level. This care should improve home, school, and community functioning, maintain children in a safe and nurturing home environment, and should enable treatment decisions to be made in response to clinical needs in accordance with sound professional judgment while also recognizing parents' rights to participate in treatment decisions for their children;" This is true also of Medicaid eligibles.

Washington State – Integrated Community Mental Health Program

Revised Code(s) of Washington (RCW) 71.24; 71.34 and 71.05 were attached to our last waiver renewal.

For admission to psychiatric inpatient care being determined to be medically necessary the psychiatric diagnoses (ICD9-CM) that qualify for psychiatric inpatient care are as detailed in the state Medicaid plan.

9.___ Other Special Needs Populations. Please ensure that any special populations in the waiver outside of the eligibility categories above are listed here (Please explain further in Section F. Special Populations)

i.___ Children with special needs due to physical and/ or mental illnesses,
ii.___ Older adults,
iii.___ Foster care children,
iv.___ Homeless individuals,
v.___ Individuals with serious and persistent mental illness and/or substance abuse,
vi.___ Non-elderly adults who are disabled or chronically ill with developmental or physical disability, or
vii.__ Other (please list):

I. **Excluded Populations:** The following enrollees will be excluded from participation in the waiver:

Pregnant women who are eligible for only prenatal care. Residents of State psychiatric hospitals and the Children Long Term Inpatient Program

1.__x__ Medicare coverage *only*, except for purposes of Medicaid-only services;

2. _____ have medical insurance other than Medicaid;

3._____ are residing in a nursing facility;

4.__x__ are residing in an Intermediate Care Facility for the Mentally Retarded (ICF/MR);

5._____ are enrolled in another Medicaid managed care program;

6.___ have an eligibility period that is less than 3 months;

7.___ are in a poverty level eligibility category for pregnant women;

8.___ are American Indian or Alaskan Native;

9.___ participate in a home and community-based waiver;

10.__ receive services through the State's Title XXI CHIP program;

11.__ have an eligibility period that is only retroactive;

12.__ are included under the State's definition of Special Needs Populations. Please ensure that any special populations excluded from the waiver in the eligibility categories in I. above are listed here (Please explain further in Section F. Special Populations if necessary);

i.___ Children with special needs due to physical and/ or mental illnesses,
ii.___ Older adults,
iii.___ Foster care children,
iv.___ Homeless individuals,
v.___ Individuals with serious and persistent mental illness and/or substance abuse,
vi.___ Non-elderly adults who are disabled or chronically ill with developmental or physical disability, or
vii.__Other (please list):

13.__ have other qualifications which the State may exclude enrollees from participating under the waiver program. Please explain those reasons below:

m. Automated Data Processing: Federal approval of this waiver request does not obviate the need for the State to comply with the Federal automated data processing systems approval requirements described in 42 CFR Part 433, Subpart C, 45 CFR Part 95, Subpart F, and Part 11 of the State Medicaid Manual.

n. Independent Assessment: The State will arrange for an Independent Assessment of the cost-effectiveness of the waiver and its impact on enrollee access to care of adequate quality. The Independent Assessment is required for at least the first two waiver periods. **This assessment is to be submitted to HCFA at least 3 months prior to the end of the waiver period.** [Please refer to SMM 2111 and HCFA's "Independent Assessment: Guidance to States" for more information]. Please check one of the following:

1.__ This is the first or second renewal of the waiver. An Independent Assessment has been completed and submitted to HCFA as required.

2.__x__Independent Assessments have been completed and submitted for the first two waiver periods. The State is requesting that it not be required to arrange for additional Independent Assessments unless HCFA finds reasons to request additional evaluations as a result of this renewal request. In these instances, HCFA will notify the State that an Independent Assessment is needed in the waiver approval letter.

III. PROGRAM IMPACT:

In the following informational sections, please complete the required information to describe your program. The questions should be answered for MCOs and, if applicable, for PHPs.

a. Marketing including indirect MCO/PHP marketing (e.g., radio and TV advertising for the MCO/PHP in general) and direct MCO/PHP marketing (e.g., direct mail to Medicaid beneficiaries). For information to enrollees (i.e., member handbooks), see Section H.

Previous Waiver Period

1._x__ During the last waiver period, the program marketing policies operated differently than described in the waiver governing that period. The differences were:

The one change that was required through contract was the addition to brochures to ensure the consumers right to disenroll. This addition to the brochure was monitored for compliance and corrective action plans were completed for RSNs to come into compliance.

2._x__ [Required for all elements checked in the previous waiver submittal] Please describe how often and through what means the State monitored compliance with its marketing requirements [items A.III.a.1-7 of 1999 initial preprint; as applicable in 1995 preprint], as well as results of the monitoring.

The MHD requires the RSNs to submit a marketing plan and their brochures for prior approval biennially and upon change. These are reviewed and approved by the MHD's policy and planning unit and contract monitoring team (now QA & I) for compliance with contract and regulations. Additionally, during any on-site review the team(s) looks for the accessibility of brochures both for service availability and for Ombuds services.

Upcoming Waiver Period Please describe the waiver program for the upcoming two-year period. For items 1. through 7. of this section, please identify any responses that reflect a change in program from the previous waiver submittal(s) by placing two asterisks (i.e., "**") after your response.

Information about how to access the system is not done for the purpose of solicitation of membership, but rather to make the public aware of the system.

1.__The State does not permit direct or indirect MCO/PHP marketing (go to item "b. Enrollment/Disenrollment")

2.___The State permits indirect MCO/PHP marketing (e.g., radio and TV advertising for the MCO/PHP in general). Please list types of indirect marketing permitted.

3.___The State permits direct MCO/PHP marketing (e.g., direct mail to Medicaid beneficiaries). Please list types of direct marketing permitted.

Please describe the State's procedures regarding direct and indirect marketing by answering the following questions and/or referencing contract provisions or Requests for Proposals, if applicable.

4.___ The State prohibits or limits MCOs/PHPs from offering gifts or other incentives to potential enrollees. Please explain any limitation/prohibition and how the State monitors this:

5.___The State permits MCO/PHPs to pay their marketing representatives based on the number of new Medicaid enrollees he/she recruited into the plan. Please explain how the State monitors marketing to ensure it is not coercive or fraudulent:

6._x__The State requires MCO/PHP marketing materials to be translated into the languages listed below (If the State does not translate enrollee materials, please explain):
The MHD requires that all materials be in the language most understood by the enrollee and at the education level of the largest amount of that population. The following are languages that have been specified include but are not limited to:

Spanish	Tagalog
Chinese	Japanese
Korean	German
Vietnamese	Cambodian
Laotian	

**The languages will be updated when census information is released in November 2001. A process will be developed to communicate with the community before major translation occurs. This will be done as an important piece of developing culturally relevant services.

The State has chosen these languages because (check any that apply):
i._x_ The languages comprise all prevalent languages in the MCO/PHP service area.

ii._x_The languages comprise all languages in the MCO/PHP service area spoken by approximately ~~percent~~ *500 people* or more of the population.

iii.__ Other (please explain):

7._x_The State requires MCO/PHP marketing materials to be translated into alternative formats for those with visual impairments *when there is a need for this translation.*

8. **MCO Required Marketing Elements**: Listed below is a description of requirements which the State must meet under the waiver program (items 1.a through 1.g). These items are optional PHP marketing elements. If an item is not checked, please explain why. The State:

(a)_x_ Ensures that all marketing materials are prior approved by the State

(b)_x_ Ensures that PHP marketing materials do not contain false or misleading information

(c)__ Consults with the Medical Care Advisory Committee (or subcommittee) in the review of MCO marketing materials

Does not apply for PHPs. Marketing materials are approved by a designated staff in the Program and Planning section and reviewed by staff in the QA & I section of the MHD.

(d)_x_ Ensures that the PHP distributes marketing materials to its entire service area

(e)__ Ensures that the MCO does not offer the sale of any other type of insurance product as an enticement to enrollment.

The RSNs are governmental agencies serving specific populations with mandatory enrollment and operate within a limited budget. They do not solicit membership, offer incentives or do cold call marketing.

(f)_x__ Ensures that the MCO does not conduct directly or indirectly, door-to-door, telephonic, or other forms of "cold-call" marketing.

(g)_x_ Ensures that PHP does not discriminate against individuals eligible to be covered under the contract on the basis of health status or need of health services.

b. Enrollment/Disenrollment:

Previous Waiver Period

1.___ During the last waiver period, the enrollment and disenrollment operated differently than described in the waiver governing that period. The differences were:

2. x [Required for all elements checked in the previous waiver submittal] Please provide a description of how often and through what means the State has monitored compliance with Enrollment/Disenrollment requirements (items A.III.b of the 1999 initial preprint; items A.8, 9, 17(g-j), 20, and 22 of 1995 preprint). Please include the results from those monitoring efforts for the previous waiver period.

During this current waiver period, as in the past, the MHD has staff assigned to oversee disenrollments. The MHD approves disenrollment for good cause (see WAC 388-865-0340). Through the current waiver cycle there has been one disenrollment allowed. There are two pending hearings on disenrollment. Monitoring of requests for disenrollment show the reasons for disenrollment requests to be primarily associated with one RSN. Several of the requests are from consumers who have requested disenrollment previously and been denied (those reported under our last waiver renewal). It appears that an independent provider may

be using the disenrollment process to try to become part of the provider network or at least to have a contract with the RSN for services. This individual provider has sued the RSN apparently in an attempt to force the RSN to contract. The suit was unsuccessful.

Our historical experience leads us to believe the number of disenrollment requests is small because consumers may change PCP or even to go to another community mental health center without requesting disenrollment. The RSNs contract with a variety of community mental health centers within their service area. These community mental health centers employ a number of persons who act as primary care providers. The WAC defines a primary care provider as the person who is responsible to carry out the individualized service plan. If the enrollee is assigned case manager, that case manager is the primary care provider. The MHD does not track these requests for change. Grievances or complaints regarding a consumer's inability to transfer to another provider would be reported as part of the grievance, fair hearing report process and may come to the attention of the MHD. (WACs are attached as Attachment AIIIb2)

Disenrollment means that the enrollee is no longer in the managed care system and receives services on a fee-for-service or on an encounter rate basis. A transfer to another RSN may occur and the enrollee will continue to receive managed care services through the receiving RSN.

Upcoming Waiver Period - Please describe the State's enrollment process for MCOs/PHPs by checking the applicable items below. For items 1. through 6. of this section, please identify any responses that reflect a change in program from the previous waiver submittal(s) by placing two asterisks (i.e., "**") after your response.

1._**__ **Outreach:** The State conducts outreach to inform potential enrollees, providers, and other interested parties of the managed care program (e.g., media campaigns, subcontracting with community-based organizations or out stationed eligibility workers). Please describe the outreach process, and specify any special efforts made to reach and provide information to special populations included in the waiver program:

A new benefit notification to enrollees will be issued to all persons at the time eligibility for Medicaid is determined. This brochure will describe the public mental health system; the Regional Support Networks; the provider network, including tribal clinics; community psychiatric inpatient care; mental health and mental illness; mental health managed care; and a section designed for stigma reduction by the state. It is anticipated this brochure will be available in May 2002 during Mental Health Month.

2.___ **Administration of Enrollment Process:**

(a)__ State staff conduct the enrollment process.

(b)__ The State contracts with an independent contractor(s) (i.e., enrollment broker) to conduct the enrollment process and related activities. The State must request a waiver of 1915(b)(2) in Section A.II.g.1. (Refer to Section 2105 of the State Medicaid Manual)

i. Broker name: _____

ii. Procurement method:

(A). ____Competitive

(B). ____Sole source

iii. Please list the functions that the contractor will perform:

(c)__ State allows MCOs/PHPs to enroll beneficiaries. Please describe the process and the State's monitoring.

3. **Enrollment Requirement:** Enrollment in the program is:

(a)_x_ Mandatory for populations in Section A.II.I

(b)__ Voluntary -- See Cost-effectiveness Section D introduction for instructions on inclusion of costs and enrollment numbers (please describe populations for whom it will be voluntary):

(c)___ Other (please describe):

4. **Enrollment:**

All Medicaid enrollees are automatically enrolled in the single RSN for there area of residence.

(a)__ The State will make counseling regarding their MCO/PHP choices prior to the selection of their plan available to potential enrollees. Please describe location and accessibility of sites for face-to-face meetings and availability of telephone access to enrollment selection counseling staff, the counseling process, and information provided to potential enrollees.

(b)__ Enrollment selection counselors will have information and training to assist special populations and persons with special health care needs in selecting appropriate MCO/PHPs and providers based on their medical needs. Please describe.

(c)__ Enrollees will notify the State/enrollment broker of their choice of plan by:

i. ___mail

ii.___phone

iii.___ in person at ____

iv.___ other (please describe):

(d)__ [Required for MCOs and PHPs] There will be an open enrollment period during which the plans will accept individuals who are eligible to enroll. Please describe how long the open enrollment period is and how often beneficiaries are offered open enrollment. Please note if the open enrollment period is continuous (i.e., there is no enrollment lock-in period).

(e)__ Newly eligible beneficiaries will receive initial notification of the requirement to enroll into the program. Please describe the initial notification process.

(f)___ Mass enrollments are expected. Please describe the initial enrollment time frames or phase-in requirements:

(g)__ If an enrollee does not select a plan within the given time frame, the enrollee will be auto-assigned or default assigned to a plan.

i. Potential enrollees will have____days/month(s) to choose a plan.
ii. Please describe the auto-assignment process and/or algorithm. What factors are considered? Does the auto-assignment process assign persons with special health care needs to an MCO/PHP that includes their current provider or to an MCO/PHP that is capable of serving their particular needs?

(h) __ The State provides guaranteed eligibility of ____ months for all managed care enrollees under the State plan. How and at which point(s) in time are potential enrollees notified of this?

(i)__ The State allows otherwise mandated beneficiaries to request exemption from enrollment in an MCO/PHP. Please describe the circumstances under which an enrollee would be eligible for exemption from enrollment. In addition, please describe the exemption process:

5. **Disenrollment:**

(a)_x_ The State allows enrollees to ~~disenroll~~/transfer between MCOs/PHPs. Please explain the procedures for ~~disenrollment~~/transfer:

Enrollees may transfer from one RSN's service area to another with the permission of the receiving RSN. This type of transfer does not require direct and/or prior authorization from the MHD. Enrollees who wish to transfer to another service area may do so at any time without cause with the permission of the receiving RSN. In cases where an enrollee moves from one RSN to another (changes residence), the transfer will be considered automatic, and the new RSN will accept the individual for enrollment without any requirement to enroll on the part of the individual. The receiving RSN shall notify the MHD within 7 working days when an enrollee transfers from one service area to another.

(b)__The State does not allow enrollees to disenroll from the PHP.

(c)_x_ The State monitors and tracks disenrollments and transfers between MCOs/PHPs. Please describe the tracking and analysis:

The MHD is the responsible entity for approval or denial of disenrollments and retains the responsibility to decide upon requests for disenrollment based upon good cause at the state level. RSNs are bound by contractual requirement to participate in and comply with determinations resulting from the process.

Disenrollment from an RSN occurs when the individual is no longer eligible for Medicaid, moves from the service area to another service area or dies. In the events of death or an individual losing eligibility, the people will be disenrolled from the RSN as a matter of general DSHS procedure.

The current standard for disenrollment is that the individual may be disenrolled for "good cause". Good Cause is defined in WAC 388-865-0340. As explained above, in the several years that MHD has operated under a 1915 (b) waiver, there have been only a small number of requests for disenrollment. The MHD has a clearly defined a process and formally established the MHD policy by which a request for disenrollment will be addressed. RSNs are bound to utilize the process through contract. (A copy of the internal policy/procedure is attached s in AttachmentAIII5c.)

(d)__ The State has a lock-in period of ____ months (up to 12 months permitted). If so, the following are required:

i.___ MCO enrollees must be permitted to disenroll without cause within the first 90 days of each enrollment period with each MCO.

ii ___ PHP enrollees must be permitted to disenroll without cause within the first month of each enrollment period with each PHP

ii.___ MCO enrollees must be notified of their ability to disenroll or change MCOs at the end of their enrollment period at least 60 days before the end of that period.

iii.___ MCO and PHP enrollees have the following good cause reasons for disenrollment are allowed during the lock-in period:

(e)__ The State does not have a lock-in, and enrollees in MCOs/PHPs are allowed to terminate or change their enrollment without cause at any time. Please describe the effective date of an enrollee disenrollment request.

6. **MCO/PHP Disenrollment of Enrollees**: If the State permits MCOs/PHPs to request disenrollment of enrollees, please check items below which apply:
We do not allow the RSN to request disenrollment.

(a)_ The MCO/PHP can request to disenroll or transfer enrollment of an enrollee to another plan. If so, **it is important that reasons for reassignment are not discriminatory in any way -- including adverse change in an enrollee's health status and non-compliant behavior for individuals with mental health and substance abuse diagnoses -- against the enrollee.** Please describe the reasons for which the MCO/PHP can request reassignment of an enrollee:

(b)____ The State reviews and approves all MCO/PHP-initiated requests for enrollee transfers or disenrollments.

(c)____ If the reassignment is approved, the State notifies the enrollee in a direct and timely manner of the desire of the MCO/PHP to remove the enrollee from its membership.

(d)____ The enrollee remains a member of the MCO/PHP until another MCO/PHP is chosen or assigned.

c. Entity Type or Specific Waiver Requirements

Previous Waiver Period

1._____ During the last waiver period, the program operated differently than described in the waiver governing that period. The differences were:

Upcoming Waiver Period – Please describe the entity type or specific waiver requirements for the upcoming two-year period. For items 1. through 4. of this section, please identify any responses that reflect a change in program from the previous waiver submittal(s) by placing two asterisks (i.e., "**") after your response.

1.__x___ **Required MCO/PHP Elements:** MCOs/PHPs will be required to comply with all applicable federal statutory and regulatory requirements, including those in Section 1903(m) and 1932 of the Act, and 42 CFR 434 et seq.

2. ___X__ **Required Elements Relating to Waiver under Section 1915(b)(4):** If the State is requesting a waiver under Section 1915(b)(4) of the Social Security Act, please mark the items that the State is in compliance with:

(a)__x__ The State believes that the requirements of section 1915(b)(4) of the Act are met for the following reasons:

i.____ Although the organization of the service delivery and payment mechanism for that service are different from the current system, the standards for access and quality of services are the same or more rigorous than those in your State's Medicaid State Plan.

ii._x__MCO/PHP must provide or arrange to provide for the full range of

Medicaid services to be provided under the waiver.

iii._x__MCO/PHP must agree to accept as payment the reimbursement rate set by the State as payment in full.

iv._x__Per 42 CFR 431.55(f)(2)(i), enrollees residing at a long term care facility are not subject to a restriction of freedom of choice based on this waiver authority unless the State arranges for reasonable and adequate enrollee transfer.

State psychiatric hospital and CLIP residents are excluded from the waiver. Nursing home residents needing medically necessary mental health services can change PCP/provider as can any enrollee. They remain enrolled in the PHP.

v._x__There are no restrictions that discriminate among classes of providers on ground unrelated to their demonstrated effectiveness and efficiency in providing services.

3. The State has/will select the MCOs/PHPs that will operate under the waiver in the following manner:

(a)__ The State has used/will use a competitive procurement process. Please describe.

(b)__ The State has used/will use an open cooperative procurement process in which any qualifying MCO/PHP may participate that complies with federal procurement requirements and 45 CFR Section 74.

(c)_X_ The State has not used a competitive or open procurement process. Please explain how the State's selection process is consistent with federal procurement regulations, including 45 CFR Section 74.43 which requires States to conduct all procurement transactions in a manner to provide to the maximum extent practical, open and free competition.

For the reasons outlined in the original waiver amendment, the first opportunity to demonstrate qualifications and enter into capitated managed mental health care contracts was provided to county-based Regional Support Networks. The first opportunity provision was contingent upon the RSNs agreement to enter into a full-risk capitation contract at an actuarially sound rate determined by the MHD. RSNs were also required to demonstrate capacity to meet the program and fiscal requirements. The RSNs administer the Medicaid mental health care system directly, or subcontract with a qualified organization. Such subcontracts do not relieve the RSNs of ultimate responsibility for compliance with the MHD's program and fiscal requirements. RSNs may impose additional requirements and incentives on subcontractors as may be needed to affect appropriate management oversight and flexibility in addressing local needs.

Washington State – Integrated Community Mental Health Program

Pursuant to the State's Community Mental Health Services Act (RCW 71.24), the RSNs administer all community mental health services funded by the state. Under the State's Involuntary Treatment Act (RCW 71.05), the RSNs are responsible for investigating and detaining people who are in need of involuntary treatment. Further, under other state statutes, the counties play a key role in chemical dependency treatment as well as services for people with developmental disabilities. All RSNs shall meet the requirements of RCW 71.24 as a certified RSN or a licensed mental health agency and the requirements of RCW 48.44, as applicable.

Counties are also responsible for local criminal justice systems, including local jails and juvenile detention facilities. As a result of these diverse but interrelated responsibilities, RSNs maintain a unique position to facilitate coordination and integration of their existing program responsibilities with the managed mental health care system to provide seamless care for people covered by Medicaid. Moreover, based on their long history of experience in administering mental health programs, the RSNs are knowledgeable about the comprehensive needs of the high risk populations included in this managed mental health care system.

RSNs have a growing responsibility for the coordination of improved services with the correction system. The RSNs have developed triage, jail diversion, post-prison and community transition.

If an RSN chooses not to participate in this initiative, or is unable to meet required qualifications, the MHD will secure an alternate contractor.

Whether the PHP is a RSN or another organization, the MHD will ensure that:

1. The PHP embraces and implements the statewide mission, values and guiding principles.
2. The PHP has the ability and capacity to provide the full range of services;
3. The PHP, through appropriate partnerships with both formal and informal allied service systems, has the capacity to manage integrated inpatient and outpatient services for adults and children;
4. The PHP has the administrative structure to perform the duties;
5. The PHP is able to bear the financial risk of operating a capitated mental health managed care system; and

The Department of Social and Health Services will retain its administrative authority as the single state agency and make no inappropriate delegation.

The MHD ensures that whether an RSN or other entity holds the managed care contract, the contractor will be required to provide an integrated system of care and control per eligible costs. This system ensures access to quality services while slowing the rate of expenditure growth of the system overall.

4._ Per Section 1932(d) of the Act, the State has conflict of interest safeguards with respect to its officers and employees who have responsibilities related to MCO contracts and the default enrollment process now established for MCOs.

The Regional Support Networks are all county entities. The DSHS contract General Terms and Conditions does have the required safeguards.

d. SERVICES

Previous Waiver Period

1._____ During the last waiver period, the program operated differently than described in the waiver governing that period. The differences were:

2.__x__ [Required for all elements checked in the previous waiver submittal] Please provide a description of how often and through what means the State has monitored compliance with service provision requirements. [items A.III.d.2-6 of the 1999 initial preprint; items A.13, 14, 21 of the 1995 preprint]. Please include the results from those monitoring efforts for the previous waiver period.

RSNs are required to provide services comparable in scope and intensity to the state plan rehabilitation services and community inpatient services for adults and children. RSNs must also ensure system capacity to provide a full range of services tailored to the individual enrollee's needs in a way that provides for seamless coordination and continuity of services creating the least amount of disruption in the enrollee's life and supports recovery and reintegration to their community. Inpatient services covered under this waiver include acute community psychiatric services for all ages. Psychiatric diagnoses (ICD9-CM) that qualify for psychiatric inpatient care are as detailed in the state Medicaid plan. In addition, admission must be determined to be medically necessary.

The MHD monitors services provided in a variety of ways. In addition to the annual on-site monitoring activities and the meetings with stakeholders, there is additional monitoring through the Information System, monitoring of complaints and grievances, and satisfaction surveys.

During this period the advocates report the growing positive impact of consumer voice in their treatment as well as development of the system. The on-site monitoring team report that services are within the acceptable standards.

Stakeholder meetings continue to express both growth in the service system and the need for more services and a richer funded program that is able to reach more people in need. The difficulty with the public mental health system is that we are both a service system and a "safety net" responsible for the entire population of the state in certain circumstances. There is an ongoing need to be clear in our mandates and services and to continue to work appropriately with cross-system partners for those populations we all serve.

Stakeholders continue to express the need for continuation of work to reduce the duplicative monitoring that takes time and money away from direct services and the need for consumer outcomes and incentives in the system for achieving those outcomes. MHD will continue to

address this issue within the SIG groups and with other stakeholders.

Results of RSN surveys show that consumers are generally satisfied with their services. (RSN surveys are provided in Attachment AIIId2.) The Children with Special Health Care Needs satisfaction survey has been forwarded to CMS with MHD's condition #5 report. This report shows satisfaction with service received

Special term and conditions #2, #4, and #5 required the submittal of all reports from the MHD to the RSNs and from the RSNs to the MHD. There is more information included in those reports.

In Attachment AIIId2ii, please find the data on the number Medicaid enrollees served and the amount of services received.

Upcoming Waiver Period -- Please describe the service-related requirements for the upcoming two year period. For items 1. through 7. of this section, please identify any responses that reflect a change in program from the previous waiver submittal(s) by placing two asterisks (i.e., "**") after your response.

1. The Medicaid services MCO/PHPs will be responsible for delivering, prescribing, or referring to are listed in the chart below. The purpose of the chart is to show which of the services in the State's state plan are/are not in the MCO/PHP contract; which non-covered services are impacted by the MCO/PHP (i.e. for calculating cost effectiveness; see Appendix D.III); and which new services are available only through the MCO/PHP under a 1915(b)(3) waiver. When filling out the chart, please do the following:

(Column 1 Explanation) Services: The list of services below is provided as *an example only. States should modify the list to include:*
- all services available in the State's State Plan, regardless of whether they will be included or excluded under the waiver
- subset(s) of state plan amendment services which will be carved out, if applicable; for example, list mental health separately if it will be carved out of physician and hospital services
- services not covered by the state plan (note: only add these to the list if this is a 1915(b)(3) waiver, which uses cost savings to provide additional services)

(Column 2 Explanation) State Plan Approved: Check this column if this is a Medicaid State Plan approved service. This information is needed because only Medicaid State Plan approved services can be included in cost effectiveness. For 1915(b)(3) waivers it will also distinguish existing Medicaid versus new services available under the waiver.

(Column 3 Explanation) 1915(b)(3) waiver services: If a covered service is not a Medicaid State Plan approved service, check this column. Marking this column will

distinguish new services available under the waiver versus existing Medicaid service.

(Column 4 Explanation) MCO/PHP Capitated Reimbursement: Check this column if this service will be included in the capitation or other reimbursement to the MCO/PHP. All services checked in this column should be marked in Appendix D.III in the "Capitated Reimbursement" column.

(Column 5 Explanation) Fee-for-Service Reimbursement: Check this column if this service will NOT be the responsibility of the MCO/PHP, i.e. not included in the reimbursement paid to the MCO/PHP. However, do not include services impacted by the MCO/PHP (see column 6).

(Column 6 Explanation) Fee-for-Service Reimbursement impacted by MCO/PHP: Check this column if the service is not the responsibility of the MCO/PHP, but is impacted by it. For example, if the MCO/PHP is responsible for physician services but the State pays for pharmacy on a FFS basis, the MCO/PHP will impact pharmacy use because access to drugs requires a physician prescription. All services checked in this column should appear in Appendix D.III (in "Fee-For-Service Reimbursement" column). Do not include services NOT impacted by the MCO/PHP (see column 5).

Service (1)	*Mental Health* State Plan Approved (2)	1915(b)(3) waiver services (3)	*Mental Health State Plan* MCO/PHP Capitated Reimbursement (4)	Fee-for-Service Reimbursement (5)	Fee-for-Service Reimbursement impacted by *Mental Health* MCO/PHP (6)
Emergency *mental health* Services	✓		✓		
EPSDT *mental health*	✓		✓		
Federally Qualified Health Center Services					
Inpatient Hospital – Psychiatric	✓		✓		
Lab					✓
Mental Health	✓		✓		

Washington State – Integrated Community Mental Health Program

Service (1)	*Mental Health* State Plan Approved (2)	1915(b)(3) waiver services (3)	*Mental Health State Plan* MCO/PHP Capitated Reimbursement (4)	Fee-for-Service Reimbursement (5)	Fee-for-Service Reimbursement impacted by *Mental Health* MCO/PHP (6)
Services					
Pharmacy					✓
Physician					✓
Psychologist	✓		✓		
Substance Abuse Treatment Services					
Transportation – Emergency					✓
Transportation - Non-emergency					✓

2. **Emergency Services (Required).** The State must ensure enrollees in MCOs/PHPs have access to emergency *mental health* services without prior authorization even if the emergency *mental health* provider does not have a contractual relationship with the entity. For PHPs, "emergency services" means covered inpatient and outpatient services that are furnished by a provider that is qualified to furnish such *community support* services, and are needed to evaluate or stabilize an emergency *mental health* medical condition.

For MCOs, "emergency medical condition" means a *mental health* medical condition manifesting itself by acute symptoms of sufficient severity ~~(including severe pain~~) such that a prudent layperson, who possesses an average knowledge of *mental* health and medicine, could reasonably expect the absence of immediate medical attention to result in (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, (ii) serious impairment to bodily functions, or (iii) serious dysfunction of any bodily organ or part.

(a)__X__ The State has a more stringent definition of emergency medical condition for MCOs or PHPs than the definition above. Please describe.

Washington State – Integrated Community Mental Health Program

Each RSN has an integrated crisis system, which is accessible 24 hours/7days a week. Responses are from individuals, rather than recorded messages. The intent is to facilitate efficient and effective mental health crisis diversion and resolution; to resolve crises in the least restrictive manner possible, including: emergency services; crisis intervention; crisis respite; investigation and detention services; and evaluation and treatment services. These services are available throughout the RSN, including for American Indians living on or off Indian reservations.

Phone systems must continue to have toll free numbers to ensure access, including access forpeople who may not have the funds to utilize a public pay phone. Services for non-English speaking and hearing impaired enrollees must also be in place. RSNs are required to include the 24-hr crisis response system in their internal quality assurance mechanisms. In addition, the MHD monitors crisis response through direct telephone calls to verify performance capacity and ability. Over the course of the waiver MHD crisis system monitoring may be shifted to an independent contractor.

Results of monitoring indicate response times and access to appropriate personnel are within required and acceptable parameters, with timely access to pertinent information regarding services, individualized treatment and/or crisis plans, medications, case manager, etc.

Pre-authorization is precluded for emergency services under the waiver. The system of service delivery to be established upon approval of the requested waiver renewal does not restrict enrollee access to emergency services. This can be demonstrated in the following manner: outpatient emergency room service is not within the scope of the managed care system under this waiver; physician services under the Medicaid State Plan are not within the scope of the managed care system under the waiver. While crisis response services from RSNs are covered within the scope of the managed care system, access to crisis response is universal, without establishing medical necessity for the first contact and without reference to the enrollee's ongoing coverage under a particular RSN. RSNs triage with local hospitals to reduce unnecessary utilization of emergency rooms through the working agreements with local evaluation and treatment facilities, which are a necessary qualification of RSNs. The agreements assure that enrollees who request mental health services inappropriately from emergency rooms are directed to the crisis response system. The agreements also establish how people served in emergency rooms may be referred for County Designated Mental Health Professional evaluation for possible involuntary treatment. Inpatient services for enrollees admitted through the emergency room are covered provided the designated professional person for the consumer(s) county of residence has conducted a pre-admission certification and conditions of medical necessity are met.

The State takes the following required steps to ensure access to emergency services. If an item below is not checked, please explain.

(b)__x__ The State ensures enrollee access to emergency *mental health* services

by requiring the MCO/PHP to provide adequate information to all enrollees regarding emergency service access (see Section H. Enrollee Information and Rights)

(c)__x__ The State ensures enrollee access to emergency *mental health* services by including in the contract requirements for MCOs/PHPs to cover the following. Please note that this requirement for coverage does not stipulate how, or if, payment will be made. States may give MCOs/PHPs the flexibility to develop their own payment mechanisms, e.g. separate fee for screen/evaluation and stabilization, bundled payment for both, etc.

i.__x__ For the screen/evaluation and all medically necessary *mental health* emergency services when an enrollee is referred by the PCP or other plan representative to the emergency room, regardless of whether the prudent layperson definition was met,

ii.__x__ The screen/evaluation, when an absence of clinical *mental health* emergency is determined, but the enrollee's presenting symptoms met the prudent layperson definition,

iii.__x__ Both the *mental health* screening/evaluation and stabilization services when a clinical emergency is determined,

iv.__x__ Continued emergency *mental health* services until the enrollee can be safely discharged or transferred,

v.____ Post-stabilization services which are pre-authorized by the MCO/PHP, or were not pre-authorized, but the MCO/PHP failed to respond to request for pre-authorization within one hour, or could not be contacted (Medicare+Choice guideline). Post-stabilization services remain covered until the MCO/PHP contacts the emergency room and takes responsibility for the enrollee.
(c) _x_ Family planning services are not included under the waiver.

4.___ **Other Services to Which Enrollee Can Self-Refer**: In addition to emergency care and family planning, the State requires MCOs/PHPs to allow enrollees to self-refer (i.e. access without prior authorization) to the following services (Please note whether self-referral is allowed only to network providers or to non-network providers):

5.___ **Monitoring Self-Referral Services**. The State places the following requirements on the MCO/PHP to track, coordinate, and monitor services to which an enrollee can self-refer:

6. **Federally Qualified Health Center** (FQHC) Services will be made available to enrollees under the waiver in the following manner (indicate one of the following, and if the State's methodology differs, please explain in detail below):

(a)__The program is **voluntary**, and the enrollee can disenroll at any time if he or she desires access to FQHC services. No FQHC services will be required to be furnished by the MCO/PHP to the enrollee during the enrollment period.

(b)_x_ The program is **mandatory** and the enrollee is guaranteed a choice of at least one MCO/PHP which has at least one FQHC as a participating provider. If the enrollee elects not to select the MCO/PHP that gives him or her access to FQHC services, no FQHC services will be required to be furnished to the enrollee while the enrollee is enrolled with the MCO/PHP he or she selected. In any event, since reasonable access to FQHC services will be available under the waiver program, FQHC services outside the program will not be available._____

Please explain how the State will guarantee all enrollees will have a choice of at least one MCO/PHP with a participating FQHC:

Currently there are FQHC contracting for mental health services in the public mental health system and these providers will continue participating in the waiver system. The RSNs are required to contract with at least one FQHC in their service area if the FQHC requests. The FQHC is accessed the same as any other provider (Community Mental health Center) in the RSN service area.

(c)__The program is **mandatory** and the enrollee has the right to obtain FQHC services **outside** this waiver program through the regular Medicaid Program.

7. **EPSDT Services:** The State has coordinated and monitored EPSDT services under the waiver program as follows:

(a) __x The State requires MCOs/PHPs to report EPSDT screening data, including behavioral health data (e.g., detailed health and development history including physical and mental health assessments). Please describe the type and frequency of data required by the State.

Washington State has had an approved EPSDT Plan since 1992. Children covered under EPSDT receive the same mental health services as other children. However, given the same clinical need, the child referred through EPSDT screening will receive appointments first. The plan includes preventive screening and cross-system team planning. This team planning also includes the child and their family. In the mental health system, in the early 90s it was projected that there would be a large influx of children to the system and a special EPSDT flag was established in the data dictionary. While this increase was true of some of our sister agencies, it was found that the mental health system was already seeing these children. We no longer collect EPSDT data differently than other data for children.

One initial requirement contained in our original EPSDT implementation (no longer required by the MHD) that continues today is correspondence and follow-up with physicians or other

referral sources for children with EPSDT screens. The Community Mental Health Centers continue to notify the physician or other referral source when they have seen a child referred and provides information on what service(s) will be offered. This follow-up activity was found to be one of the most influential and helpful activities to increase communication between physical and mental health care for these children. This correspondence loop has also provided for better access to physical health care for the children who are seen in the mental health system initially.

(b)_x_ EPSDT screens *for mental health services* are covered under this waiver.

(c) __ Immunizations are covered under this waiver. Please list the State's immunization rates for previous waiver period. What activities will the State initiate to improve immunization rates for enrollees under the waiver?

(d)__Managed care providers are required to enroll in the Vaccines for Children Program. If not, please explain.

(e)_x_ Mechanisms are in place to coordinate school services with those provided by the MCO/PHP. Please describe and clarify the aspects of school services that are coordinated including IEPS, IFSPs, special education requirements, and school-based or school-linked health centers (e.g., plan requirements for PCP cooperation or involvement in the development of the IEPs).

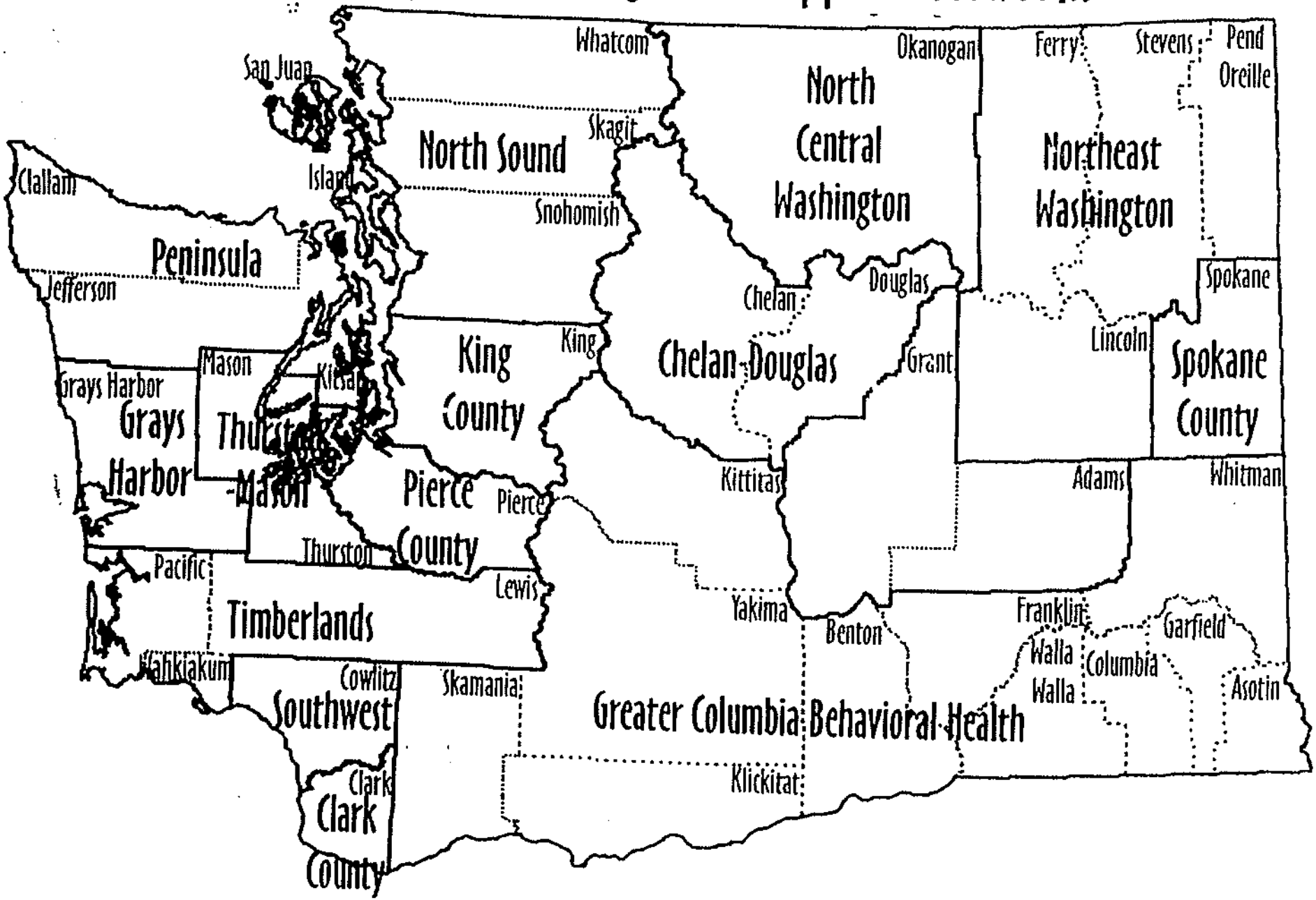
See below

(f)_x_ Mechanisms are in place to coordinate other aspects of EPSDT (e.g., dental, mental, Title V, etc) with those provided by the MCO/PHP. Please describe.

The requirements of this plan still exist in contract such as, the oversight committee for children that is representative of cross-system partners (including schools) serving children. The formal and informal systems and the natural supports (such as the coffee bistro that street youth trust), parents of children and youth are a required member of this oversight committee. The requirement for those individual community teams including the child for the development of service planning for 10% of the children in level II also requires participation by the cross-system providers. This process includes those who know the child best including the teacher whenever possible to address IEP and other requirements. There is also a requirement in the WAC 388-865-0425 with regards to Individual Service Planning that there be connection to the IFSP.

Attachment A.11ia

Washington State Regional Support Networks



Attachment A.111b2

effective 7/1/01

www.wa.gov/DSHS/dockets/apprules.htm

Chapter 388-865 WAC

COMMUNITY MENTAL HEALTH AND INVOLUNTARY TREATMENT PROGRAMS

SECTION ONE--COMMUNITY MENTAL HEALTH AND INVOLUNTARY TREATMENT PROGRAMS 3

WAC 388-865-0100 Purpose 3
WAC 388-865-0105 What the mental health division does and how it is organized 4
WAC 388-865-0110 Access to records of registration 4
WAC 388-865-0115 Access to clinical records 4
WAC 388-865-0120 Waiver of a minimum standard of this chapter 5
WAC 388-865-0150 Definitions 6

SECTION TWO--REGIONAL SUPPORT NETWORKS 9

WAC 388-865-0200 Regional support networks 10
WAC 388-865-0201 Allocation of funds to RNS/PHPs 10
WAC 388-865-0203 Allocation formula for state hospital beds 14
WAC 388-865-0205 Initial certification of a regional support network 16
WAC 388-865-0210 Renewal of regional support network certification 16
WAC 388-865-0215 Consumer eligibility and payment for services 17
WAC 388-865-0220 Standards for administration 18
WAC 388-865-0221 Public awareness of mental health services 19
WAC 388-865-0222 Advisory board 19
WAC 388-865-0225 Resource management 20
WAC 388-865-0229 Inpatient services 20
WAC 388-865-0230 Community support services 21
WAC 388-865-0235 Residential and housing services 22
WAC 388-865-0240 Consumer employment services 22
WAC 388-865-0245 Administration of the Involuntary Treatment Act 23
WAC 388-865-0250 Ombuds services 23
WAC 388-865-0255 Consumer grievance process 24
WAC 388-865-0260 Mental health professionals and specialists 26
WAC 388-865-0265 Mental health professional—Exception 26
WAC 388-865-0270 Financial management 27
WAC 388-865-0275 Management information system 28
WAC 388-865-0280 Quality management process 29
WAC 388-865-0282 Quality review teams 30
WAC 388-865-0284 Standards for contractors and subcontractors 32

MHD Final WAC working copy
06/07/01

A 111 b-2

WAC 388-865-0286 Coordination with a mental health prepaid health plan 32
WAC 388-865-0288 Regional support networks as a service provider 32

SECTION THREE--MENTAL HEALTH PREPAID HEALTH PLANS 33

WAC 388-865-0300 Mental health prepaid health plans 33
WAC 388-865-0305 Regional support network contracting as a mental health prepaid health plan 33
WAC 388-865-0310 Mental health prepaid health plans--Minimum standards 33
WAC 388-865-0315 Governing body 34
WAC 388-865-0320 Utilization management 35
WAC 388-865-0325 Risk management 36
WAC 388-865-0330 Marketing/education of mental health services 37
WAC 388-865-0335 Consumer enrollment 38
WAC 388-865-0340 Consumer disenrollment 39
WAC 388-865-0345 Choice of primary care provider 40
WAC 388-865-0350 Mental health screening for children 41
WAC 388-865-0355 Consumer request for a second opinion 41
WAC 388-865-0360 Monitoring of mental health prepaid health plans 41
WAC 388-865-0363 Coordination with the regional support network 42
WAC 388-865-0365 Suspension, revocation, limitation or restriction of a contract 42

SECTION FOUR--COMMUNITY SUPPORT SERVICE PROVIDERS 42

WAC 388-865-0400 Community support service providers 43
WAC 388-865-0405 Competency requirements for staff 43
WAC 388-865-0410 Consumer rights 44
WAC 388-865-0415 Access to services 45
WAC 388-865-0420 Intake evaluation 46
WAC 388-865-0425 Individual service plan 46
WAC 388-865-0430 Clinical record 47
WAC 388-865-0435 Consumer access to their clinical record 48
WAC 388-865-0436 Clinical record access procedures 49
WAC 388-865-0440 Availability of consumer information 49
WAC 388-865-0445 Establishment of procedures to bill for services 49
WAC 388-865-0450 Quality management process 50
WAC 388-865-0452 Emergency crisis intervention services--Additional standards 50
WAC 388-865-0454 Provider of crisis telephone services only 51
WAC 388-865-0456 Case management services--Additional standards 52
WAC 388-865-0458 Psychiatric treatment, including medication supervision--Additional standards 52
WAC 388-865-0460 Counseling and psychotherapy services--Additional standards 54
WAC 388-865-0462 Day treatment services--Additional standards 54
WAC 388-865-0464 Consumer employment services--Additional standards 54
WAC 388-865-0466 Community support outpatient certification--Additional standards 55
WAC 388-865-0468 Emergency crisis intervention services certification-- Additional standards 56
WAC 388-865-0470 The process for initial licensing of service providers 57
WAC 388-865-0472 Licensing categories 58

WAC 388-865-0474 Fees for community support service provider licensure 59
WAC 388-865-0476 Licensure based on deemed status 60
WAC 388-865-0478 Renewal of a community support service provider license 60
WAC 388-865-0480 Procedures to suspend, or revoke a license 61
WAC 388-865-0482 Procedures to contest a licensing decision 61
WAC 388-865-0484 Process to certify providers of involuntary services 62

SECTION FIVE--INPATIENT EVALUATION AND TREATMENT FACILITIES 63

WAC 388-865-0500 Inpatient evaluation and treatment facilities 63
WAC 388-865-0501 Certification based on deemed status 63
WAC 388-865-0502 Single bed certification 64
WAC 388-865-0504 Exception to rule--Long-term certification 65
WAC 388-865-0505 Evaluation and treatment facility certification--Minimum standards65
WAC 388-865-0510 Standards for administration 66
WAC 388-865-0515 Admission and intake evaluation 68
WAC 388-865-0525 Clinical record 68
WAC 388-865-0530 Competency requirements for staff 69
WAC 388-865-0535 The process for gaining certification and renewal of certification .69
WAC 388-865-0540 Fees for evaluation and treatment facility certification 69
WAC 388-865-0545 Use of seclusion and restraint procedures—Adults 70
WAC 388-865-0546 Use of seclusion and restraint procedures—Children 70
WAC 388-865-0550 Rights of all consumers who receive community inpatient services71
WAC 388-865-0555 Rights of consumers receiving involuntary inpatient services 71
WAC 388-865-0557 Rights related to antipsychotic medication 72
WAC 388-865-0560 Rights of consumers who receive emergency and inpatient services voluntarily 73
WAC 388-865-0565 Petition for the right to possess a firearm 74

SECTION SIX--DEPARTMENT OF CORRECTIONS ACCESS TO CONFIDENTIAL MENTAL HEALTH INFORMATION 75

WAC 388-865-0600 Purpose 75
WAC 388-865-0610 Definitions 75
WAC 388-865-0620 Scope 78
WAC 388-865-0630 Time frame 78
WAC 388-865-0640 Written requests 79

SECTION ONE--COMMUNITY MENTAL HEALTH AND INVOLUNTARY TREATMENT PROGRAMS

WAC 388-865-0100 Purpose

Chapter 388-865 of the Washington Administrative Code implements chapters 71.05, 71.24, and 71.34 RCW, and the mental health Title XIX Section 1915 b Medicaid waiver provisions.

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WAC 388-865-0105 What the mental health division does and how it is organized

(1) The department of social and health services is designated by the legislature as the state mental health authority, and has designated the mental health division to administer the state mental health program.

(2) To request an organizational chart, contact the mental health division at 1-888-713-6010 or (360) 902-8070, or write to the Mental Health Division Director, PO Box 45320, Olympia, WA 98504.

(3) Local services are administered by regional support networks (RSN), which are a county, or combination of counties, whose telephone number is located in the local telephone directory and can also be obtained by calling the mental health division at the above telephone number.

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WAC 388-865-0110 Access to records of registration

The mental health division, regional support networks, mental health prepaid health plans, and service providers must ensure that information about the fact that a consumer has or is receiving mental health services is not shared or released except as specified under RCW 71.05.390 and other laws and regulations about confidentiality as noted below in WAC 388-865-0115.

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WAC 388-865-0115 Access to clinical records

There are numerous federal and state rules and regulations on the subjects of confidentiality and access to consumer clinical

records. Many of the rules are located in chapter 70.02 RCW, RCW 71.05.390, 71.05.400, 71.05.410, 71.05.420, 71.05.430, 71.05.440, 71.05.445, 71.05.610 through 71.05.680, 71.34.160, 71.34.162, 71.34.170, 71.34.200, 71.34.210, 71.34.220, 71.34.225, 13.50.100(4)(b), and 42 C.F.R. 431 and 438, and 42 C.F.R. Part 2 of the Code of Federal Regulations and are not repeated in these rules.

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WAC 388-865-0120 Waiver of a minimum standard of this chapter

(1) A regional support network, mental health prepaid health plan, service provider or applicant subject to the rules in this chapter may request a waiver of any sections or subsections of these rules by submitting a request in writing to the director of the mental health division. The request must include:

(a) The name and address of the entity that is making the request;

(b) The specific section or subsection of these rules for which a waiver is being requested;

(c) The reason why the waiver is necessary, or the method the entity will use to meet the desired outcome of the section or subsection in a more effective and efficient manner;

(d) A description of the plan and timetable to achieve compliance with the minimum standard or to implement, test, and report results of an improved way to meet the intent of the section or subsection. In no case will the mental health division write a waiver of minimum standards for more than the time period of the entity's current license and/or certificate.

(2) For agencies contracting with a regional support network or mental health prepaid health plan, a statement by the regional support network or mental health prepaid health plan recommending mental health division approval of the request, including:

(a) Recommendations, if any, from the quality review team or ombuds staff; and

(b) A description of how consumers will be notified of changes made as a result of the exception.

(3) The mental health division makes a determination on the waiver request within thirty days from date of receipt. The review will consider the impact on accountability, accessibility, efficiency, consumer satisfaction, and quality of care and any violations of the request with state or federal

law.

(4) When granting the request, the mental health division issues a notice to the person making the request, and the involved regional support network if the regional support network is not the applicant, that includes:

(a) The section or subsection waived;

(b) The conditions of acceptance;

(c) The timeframe for which the waiver is approved;

(d) Notification that the agreement may be reviewed by the mental health division and renewed, if requested.

(5) When denying the request, the mental health division includes the reason for the decision in the notice sent to the person making the request.

(6) The mental health division does not waive any requirement that is part of statute.

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WAC 388-865-0150 Definitions

"Adult" means a person on or after their eighteenth birthday. For persons eligible for the Medicaid program, adult means a person on or after his/her twenty-first birthday.

"Child" means a person who has not reached his/her eighteenth birthday. For persons eligible for the Medicaid program, child means a person who has not reached his/her twenty-first birthday.

"Clinical services" means those direct age and culturally appropriate consumer services which either:

(1) Assess a consumer's condition, abilities or problems;

(2) Provide therapeutic interventions which are designed to ameliorate psychiatric symptoms and improve a consumer's functioning.

"Consumer" means a person who has applied for, is eligible for or who has received mental health services. For a child, under the age of thirteen, or for a child age thirteen or older whose parents or legal guardians are involved in the treatment plan, the definition of consumer includes parents or legal guardians.

"Consultation" means the clinical review and development of recommendations regarding the job responsibilities, activities, or decisions of, clinical staff, contracted employees, volunteers, or students by persons with appropriate knowledge and experience to make recommendations.

"Cultural competence" means a set of congruent behaviors, attitudes, and policies that come together in a system or agency and enable that 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.

"Ethnic minority" or **"racial/ethnic groups"** means, for the purposes of this chapter, any of the following general population groups:

(1) African American;

(2) An American Indian or Alaskan native, which includes:

(a) A person who is a member of considered to be a member in a federally recognized tribe;

(b) A person determined eligible to be found Indian by the secretary of interior, and

(c) An Eskimo, Aleut, or other Alaskan native.

(d) A Canadian Indian, meaning a person of a treaty tribe, Metis community, or nonstatus Indian community from Canada.

(e) An unenrolled Indian meaning a person considered Indian by a federally or nonfederally recognized Indian tribe or off reservation Indian/Alaskan native community organization.

(3) Asian/Pacific Islander; or

(4) Hispanic.

"Medical necessity" or **"medically necessary"** - A term for describing a requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions in the recipient that endanger life, or cause suffering or pain, or result in illness or infirmity, or threaten to cause or aggravate a handicap, or cause or physical deformity or malfunction, and there is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the person requesting service. For the purpose of this chapter "course of treatment" may include mere observation or, where appropriate, no treatment at all.

"Mental health division" means the mental health division of the Washington state department of social and health services (DSHS). DSHS has designated the mental health division as the state mental health authority to administer the state and Medicaid funded mental health program authorized by chapter 71.05, 71.24, and 71.34 RCW.

"Mental health professional" means:

(1) A psychiatrist, psychologist, psychiatric nurse or social worker as defined in chapter 71.05 and 71.34 RCW;

(2) A person with a masters degree or further advanced degree in counseling or one of the social sciences from an accredited college or university. Such person shall have, in addition, at least two years of experience in direct treatment

of persons with mental illness or emotional disturbance, such experience gained under the supervision of a mental health professional;

(3) A person who meets the waiver criteria of RCW 71.24.260, which was granted prior to 1986.

(4) A person who had an approved waiver to perform the duties of a mental health profession that was requested by the regional support network and granted by the mental health division prior to July 1, 2001; or

(5) A person who has been granted a time-limited exception of the minimum requirements of a mental health professional by the mental health division consistent with WAC 388-865-265.

"Mental health specialist" means:

(1) A **"child mental health specialist"** is defined as a mental health professional with the following education and experience:

(a) A minimum of one hundred actual hours (not quarter or semester hours) of special training in child development and the treatment of children and youth with serious emotional disturbance and their families; and

(b) The equivalent of one year of full-time experience in the treatment of seriously emotionally disturbed children and youth and their families under the supervision of a child mental health specialist.

(2) A **"geriatric mental health specialist"** is defined as a mental health professional who has the following education and experience:

(a) A minimum of one hundred actual hours (not quarter or semester hours) of specialized training devoted to the mental health problems and treatment of persons sixty years of age or older; and

(b) The equivalent of one year of full-time experience in the treatment of persons sixty years of age or older, under the supervision of a geriatric mental health specialist.

(3) An **"ethnic minority mental health specialist"** is defined as a mental health professional who has demonstrated cultural competence attained through major commitment, ongoing training, experience and/or specialization in serving ethnic minorities, including evidence of one year of service specializing in serving the ethnic minority group under the supervision of an ethnic minority mental health specialist; and

(a) Evidence of support from the ethnic minority community attesting to the person's commitment to that community; or

(b) A minimum of one hundred actual hours (not quarter or semester hours) of specialized training devoted to ethnic minority issues and treatment of ethnic minority consumers.

(4) A **"disability mental health specialist"** is defined as a

mental health professional with special expertise in working with an identified disability group. For purposes of this chapter only, **"disabled"** means an individual with a disability other than a mental illness, including a developmental disability, serious physical handicap, or sensory impairment.

(a) If the consumer is deaf, the specialist must be a mental health professional with:

(i) Knowledge about the deaf culture and psychosocial problems faced by people who are deaf; and

(ii) Ability to communicate fluently in the preferred language system of the consumer.

(b) The specialist for consumers with developmental disabilities must be a mental health professional who:

(i) Has at least one year's experience working with people with developmental disabilities; or

(ii) Is a developmental disabilities professional as defined in RCW 71.05.020.

"Older person" means an adult who is sixty years of age or older.

"Service recipient" means for the purposes of a mental health prepaid health plan, a consumer eligible for the Title XIX Medicaid program.

"Substantial hardship" means that a consumer will not be billed for emergency involuntary treatment if he or she meets the eligibility standards of the medically indigent program that is administered by the DSHS medical assistance administration.

"Supervision" means monitoring of the administrative, clinical, or clerical work performance of staff, students, volunteers, or contracted employees by persons with the authority to give direction and require change.

"Underserved" means consumers who are:

(1) Minorities;

(2) Children;

(3) Older adults;

(4) Disabled; or

(5) Low-income persons.

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SECTION TWO--REGIONAL SUPPORT NETWORKS

WAC 388-865-0200 Regional support networks

The mental health division contracts with certified regional support networks to administer all mental health services activities or programs within their jurisdiction using available resources. The regional support network must ensure services are responsive in an age and culturally competent manner to the mental health needs of its community. To gain and maintain certification, the regional support network must comply with all applicable federal, state and local laws and regulations, and all of the minimum standards of this section. The community mental health program administered by the regional support network includes the following programs:

(1) Administration of the involuntary treatment program, including investigation, detention, transportation, court related and other services required by chapter 71.05 and 71.34 RCW;

(2) Resource management program as defined in RCW 71.24.025(15) and this section;

(3) Community support services as defined in RCW 71.24.025(7);

(4) Residential and housing services as defined in RCW 71.24.025(14);

(5) Ombuds services;

(6) Quality review teams;

(7) Inpatient services as defined in chapter 71.05 and 71.34 RCW; and

(8) Services operated or staffed by consumers, former consumers, family members of consumers, or other advocates. If the service is clinical, the service must comply with the requirements for licensed services. Consumer or advocate run services may include, but are not limited to:

(a) Consumer and/or advocate operated businesses;

(b) Consumer and/or advocate operated and managed clubhouses;

(c) Advocacy and referral services;

(d) Consumer and/or advocate operated household assistance programs;

(e) Self-help and peer support groups;

(f) Ombuds service; and

(g) Other services.

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WAC 388-865-0201 Allocation of funds to RNS/PHPs

This section describes how Medicaid and community mental health funds are allocated to the RSN/PHPs.

(1) Funding allocations are projected at the beginning of

each fiscal year, using forecasted Medicaid enrollees for that fiscal year.

(2) Payments are made on the number of actual Medicaid enrollees each month, which may result in actual payments being higher or lower than projected payments, depending on whether actual Medicaid enrollees are more or less than forecasted enrollees.

(3) The mental health division (MHD) uses two different methodologies to allocate funds:

(a) Historical method;

(b) Eligibles method.

(4) For the period July 1, 2001 to June 30, 2005, the funds will be allocated using the methodologies as follows:

(a) For July, 1, 2001 to June 30, 2002, seventy-five percent of funds of will be allocated using the historical method and twenty-five percent of funds will be allocated using the prevalence method;

(b) For June 1, 2002 to June 30, 2003, fifty percent of funds will be allocated using the historical method and fifty percent of funds will be allocated using the prevalence method;

(c) For June 1, 2003 to June 30, 2004, twenty-five percent of funds will be allocated using the historical method and seventy-five percent of funds will be allocated using the prevalence method;

(d) For June 1, 2004 forward, one hundred percent of funds will be allocated using the prevalence method. These percentages will remain in effect unless the department is directed otherwise by the state Legislature.

(5)(a) Historical method means that federal Medicaid funds projected to be paid to the RSN/PHPs are calculated using actuarially determined per member per month (PMPM) rates specific to each regional support network multiplied by the number of persons enrolled in the Medicaid program in each regional support network for each month during the fiscal year.

(b) The actuarially determined rates were determined at the beginning of the managed care program (1992 for outpatient services and 1997 for inpatient services) and have been increased periodically by the Legislature.

(i) Rates differ by RSN and by category of enrollee (disabled and nondisabled adults and disabled and nondisabled children).

(ii) These rates are tracked by MHD.

(iii) The number of Medicaid enrollees is tracked by the medical assistance administration.

(c) The product of rates and enrollees is the projected amount of Medicaid funding each RSN/PHP will receive during the year.

(i) This amount is divided into two portions - federal funds and state match funds.

(ii) The two portions of Medicaid funds are determined by a percentage known as the Federal Medicaid Assistance Percentage (FMAP). This percentage is set by the federal Health Care Financing Authority and changes each year.

(d) In the inpatient program, each RSN/PHP is allocated the amount of federal and state funds projected in the calculations explained above.

(e) State funds in the outpatient program (also called "consolidated") to be paid to the RSN/PHPs are set by the Legislature These funds are allocated to the RSN/PHPs according to the RSN/PHP's calculated percentage of the total funds. The RSN/PHP's percentage is based primarily on historical fee-for-service data.

(i) The RSN/PHP percentages are tracked by MHD and are carried forward each year.

(ii) The percentage of consolidated funds paid to each RSN/PHP is adjusted each year by the Legislature through budget proviso direction, generally requiring that new funds in the program be allocated according to Medicaid enrollees in each RSN. Therefore, the amount of consolidated funds in the outpatient program at the beginning of the fiscal year (also called "base funds") are allocated according to the percentage tracked by MHD (put in place by the Legislature in the previous year).

(iii) New consolidated funds are allocated as directed by the Legislature, generally according to the number of Medicaid enrollees residing in each RSN.

(f) The base allocation and new consolidated allocations are combined into one percentage that serves as the RSN/PHP's percentage allocation for the next year's base funds.

(g) The sum of federal Medicaid funds, state match funds in the inpatient program, and consolidated funds equals the amount of funding provided to each RSN/PHP.

(6) Eligibles method.

(a) Medicaid and non-Medicaid funds are allocated based on a formula that reflects prevalence of mental disorders in each county. The formula takes into consideration each RSN's:

(i) Concentrations of priority populations;

(ii) Commitments to state hospitals under chapter 71.05 and 71.34 RCW;

(iii) Population concentrations in urban areas;

(iv) Population concentrations at border crossings at state boundaries; and

(v) Other demographic and workload factors such as number of MI/GA-U clients, commitments to community hospitals under

chapter 71.05 and 71.34 RCW, and number of homeless persons.

(b) The RSN/PHP historical method rates for 2001 have been used to calculate a weighted average statewide rate (WASR) for each category of Medicaid eligible (disabled and nondisabled adults and disabled and nondisabled children):

(c) The WASR for each category is determined by:

(i) Adding the RSN/PHP's inpatient and outpatient rates to create one combined rate;

(ii) Multiplying each RSN/PHP's rate by the number of Medicaid enrollees residing in that RSN/PHP;

(iii) Adding the results; and

(iv) Dividing the sum by the state-wide number of Medicaid eligibles.

(d) WASR rates are tracked by MHD.

(e) The number of Medicaid enrollees is tracked by the medical assistance administration.

(f) To project the amount of Medicaid funding each RSN/PHP will receive during the year, MHD multiplies the RSN/PHP's WASR for each category by the projected number of Medicaid enrollees in each category.

(i) This amount is divided into two portions - federal funds and state match funds.

(ii) Each RSN/PHP's projected allocation includes both portions of Medicaid funding (federal and state match funds).

(iii) Payments to the RSN/PHP are made based on the actual number of Medicaid enrollees.

(g) The level of non-Medicaid funds appropriated to the community mental health services program is determined by the state Legislature.

(i) Eighty percent of the non-Medicaid funds appropriated are allocated to the RSN/PHPs according to the number persons enrolled in the state funded general assistance - unemployable, medically indigent and state only "v" programs (persons in the state only "v" program are counted at thirteen percent of the total enrolled).

(A) The number of persons enrolled in these programs is tracked by the medical assistance administration.

(B) The projected number of persons in these programs residing in each RSN, divided by the total persons projected to be in these programs, is multiplied by eighty percent of the total funds appropriated to determine the amount of funding provided to each RSN/PHP.

(ii) Twenty percent of the non-Medicaid funds appropriated are allocated according to a summary z score factor that is calculated using four sub-factors:

(A) The number of urban counties in each RSN;

(B) The number of state and country border counties in each

RSN;

(C) The number of homeless persons in each RSN; and

(D) The number of ITA commitments from each RSN.

These sub-factors are weighted differently, with the urban factor weighted at 0.3, the border county factor weighted at 0.05, the homeless factor weighted at 1.0 and the ITA commitments factor weighted at 0.2. For each of these factors, information is tracked by MHD and the most recent complete year of data is used to calculate z score factors for each sub-factor. These factors are combined into a summary z score factor for each RSN that is multiplied by the total funding available (twenty percent of non-Medicaid funds appropriated).

(7) The mental health division does not pay providers on a fee-for-service basis for services that are the responsibility of the mental health RSN or PHP, even if the RSN or PHP has not paid for the service for any reason.

(8) To the extent authorized by the state legislature, regional support networks and mental health prepaid health plans may use local funds spent on health services to increase the collection of federal Medicaid funds. Local funds used for this purpose may not be used as match for any other federal funds or programs.

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WAC 388-865-0203 Allocation formula for state hospital beds

The mental health division (MHD) allocates nonforensic adult beds at the state hospital utilized by the regional support network (RSN) based on the number of beds funded by the Legislature at that hospital.

(1) The allocation formula is (M x 40%)+(U x 35%)+(P x 25%) x F.

(a) M is the average number of Medicaid eligible persons in the RSN during the period of January to December prior to the start of the biennium, divided by the average number of Medicaid eligible persons at each state hospital catchment area (westside for western state hospital and eastside for eastern state hospital) during the same period;

(b) U is the number of each regional support network's average daily census at the state hospital during the period of January to December prior to the start of each biennium divided by the average daily census at the hospital based on the utilization of beds by the regional support network included in the hospital catchment area during the same period;

(c) P is the percent of the general population that resides within the RSN based on the most recent population estimate on December 1 of the year prior to the start of the biennium

divided by the general population in the hospital catchment area at the same time;

(d) F is the total number of funded nonforensic beds at each state hospital (westside for western state hospital and eastside for eastern state hospital);

(e) The MHD will project and distribute tentative allocations upon issuance of the Governor's budget, and upon enactment of the Legislative budget. The operative allocation will be made and distributed at the start of each fiscal year.

(2) This formula will be phased in as follows:

(a) For July 1, 2001 to June 30, 2002, twenty five percent of the bed allocation will be based on the new formula, and seventy five percent based on the 1999-2001 allocation;

(b) For July 1, 2002 to June 30, 2003, fifty percent of the allocation will be based on the new formula and fifty percent based on the 1999-2001 allocation;

(c) For July 1, 2003 to June 30, 2004, seventy-five percent of the allocation will be based on the new formula and twenty-five percent based on the 1999-2001 allocation;

(d) For July 1, 2004 to June 30, 2005 one hundred percent of the allocation will be based on the new formula;

(e) The formula will be recalculated on or about April 4, 2005 and each biennium thereafter based on data that is current at that time.

(3) If the in-residence census exceeds the funded capacity on any day or days within the fiscal year, the MHD will assess liquidated damages calculated on the following formula:

(a) Only RSNs who are in excess of their individual allocated census on the day or each day of over census will be assessed liquidated damages;

(b) The amount of liquidated damages charged for each day will be the number of beds over the funded capacity of the hospital multiplied by the state hospital daily bed charge consistent with RCW 43.20B.325;

(c) The amount of liquidated damages charged to each RSN will be a percentage based on the number of beds over their allocation divided by the total number of beds over the funded capacity on the day or each day of over census;

(d) The liquidated damages will be recovered by the MHD by a deduction from the monthly payment made by the MHD two months after the end of the month in which the in residence census exceeded the state bed allocation of that RSN.

[]

WAC 388-865-0205 Initial certification of a regional support network

A regional support network is a county authority or group of county authorities that have a joint operating agreement. In order to gain certification as a regional support network, a county or group of counties must submit to the department:

(1) A statement of intent to become a regional support network;

(2) Documentation that the total population in the county or group of counties is not less than forty thousand;

(3) A joint operating agreement if the proposed regional support network is more than one county or includes a tribal authority. The agreement must include the following:

(a) Identification of a single authority with final responsibility for all available resources and performance of the contract with the department consistent with chapter 71.05, 71.24, and 71.34 RCW;

(b) Assignment of all responsibilities required by RCW 71.24.300; and

(c) Participation of tribal authorities in the agreement at the request of the tribal authorities.

(d) A preliminary operating plan completed according to departmental guidelines.

(4) Within thirty days of the submission the department will provide a written response either:

(a) Certifying the regional support network; or

(b) Denying certification because the requirements are not met.

[]

WAC 388-865-0210 Renewal of regional support network certification

At least biennially the mental health division reviews the compliance of each regional support network with the statutes, applicable rules and regulations, applicable standards, and state minimum standards as defined in this chapter:

(1) If the regional support network is in compliance with the statutes, applicable rules and regulations, applicable standards, and state minimum standards, the mental health division provides the regional support network with a written certificate of compliance.

(2) If the regional support network is not in compliance with the statutes, applicable rules and regulations, the mental health division will provide the regional support network

written notice of the deficiencies. In order to maintain certification, the regional support network must develop a plan of corrective action approved by the mental health division.

(3) If the regional support network fails to develop an approved plan of corrective action or does not complete implementation of the plan within the timeframes specified, the mental health division may initiate procedures to suspend, revoke, limit, or restrict certification consistent with the provisions of RCW 71.24.035(7) through (11) and of 43.20A.205. The mental health division sends a written decision to revoke, suspend, or modify the former certification, with the reasons for the decision and informing the regional support network of its right to an administrative hearing.

(4) The mental health division may suspend or revoke the certification of a regional support network immediately if the mental health division determines that deficiencies imminently jeopardize the health and safety of consumers.

[]

WAC 388-865-0215 Consumer eligibility and payment for services

(1) Within available resources as defined in RCW 71.24.025(2), the regional support network must serve consumers in the following order of priority as defined in RCW 71.24.035(5)(b):

(a) Acutely mentally ill persons;

(b) Chronically mentally ill adults and severely emotionally disturbed children;

(c) Seriously disturbed persons.

(2) Consumers eligible for the Title XIX Medicaid program are entitled to receive covered medically necessary services from a mental health prepaid health plan without charge to the consumer;

(3) The consumer or the parent(s) of a child who has not reached their eighteenth birthday, the legal guardian, or the estate of the consumer is responsible for payment for services provided. The consumer may apply to the following entities for payment assistance:

(a) DSHS for medical assistance;

(b) The community support provider for payment responsibility based on a sliding fee scale; or

(c) The regional support network for authorization of payment for involuntary evaluation and treatment services for consumers who would experience a substantial hardship as defined in WAC 388-865-0150.

[]

WAC 388-865-0220 Standards for administration

The regional support network must demonstrate that it meets the requirements of chapter 71.05, 71.24, and 71.34 RCW, and ensures the effectiveness and cost effectiveness of community mental health services in an age and culturally competent manner. The regional support network must:

(1) Establish a governing board that includes, where applicable, representation from tribal authorities, consistent with RCW 71.24.300;

(2) For multi-county regional support networks, function as described in the regional support network joint operating agreement;

(3) Ensure the protection of consumer and family rights as described in this chapter, and chapter 71.05 and 71.34 RCW; and other applicable statutes for consumers involved in multiservice systems;

(4) Collaborate with and make reasonable efforts to obtain and use resources in the community to maximize services to consumers;

(5) Educate the community regarding mental illness to diminish stigma;

(6) Maintain agreement(s) with sufficient numbers of certified involuntary inpatient evaluation and treatment facilities to ensure that persons eligible for regional support network services have access to inpatient care;

(7) Develop publicized forums in which to seek and include input about service needs and priorities from community stakeholders, including:

(a) Consumers;

(b) Family members and consumer advocates;

(c) Culturally diverse communities including consumers who have limited English proficiency;

(d) Service providers;

(e) Social service agencies;

(f) Organizations representing persons with a disability;

(g) Tribal authorities; and

(h) Underserved groups.

(8) Maintain job descriptions for regional support staff with qualifications for each position with the education, experience, or skills relevant to job requirements; and

(9) Provide orientation and ongoing training to regional support network staff in the skills pertinent to the position and the treatment population, including age and culturally competent consultation with consumers, families, and community members.

(10) Identify trends and address service gaps;

(11) The regional support network must provide an updated

two-year plan biennially to the mental health division for approval consistent with the provisions of RCW 71.24.300(1). The biennial plan must be submitted to the regional support network governing board for approval and to the advisory board for review and comment.

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WAC 388-865-0221 Public awareness of mental health services

The regional support network or its designee must provide public information on the availability of mental health services. The regional support network must:

(1) Maintain listings of services in telephone directories and other public places such as libraries, community services offices, juvenile justice facilities, of the service area. The regional support network or its designee must prominently display listings for crisis services in telephone directories;

(2) Publish and disseminate brochures and other materials or methods for describing services and hours of operation that are appropriate for all individuals, including those who may be visually impaired, limited-English proficient, or unable to read;

(3) Post and make information available to consumers regarding the ombuds service consistent with WAC 388-865-0250, and local advocacy organizations that may assist consumers in understanding their rights.

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WAC 388-865-0222 Advisory board

The regional support network must promote active engagement with persons with mental disorders, their families and services providers by soliciting and using their input to improve its services. The regional support network must appoint an advisory board that:

(1) Is broadly representative of the demographic character of the region and the ethnicity and broader cultural aspects of consumers served;

(2) Is composed of at least fifty-one percent:

(a) Current consumers or past consumers of public mental health services, including those who are youths, older adults, or who have a disability; and

(b) Family, foster family members, or care givers of consumers, including parents of emotionally disturbed children.

(3) Independently reviews and provides comments to the regional support network governing board on plans, budgets, and policies developed by the regional support network to implement

the requirements of this section, chapter 71.05, 71.24, 71.34 RCW and applicable federal law and regulations.

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WAC 388-865-0225 Resource management

The regional support network must establish mechanisms which maximize access to and use of age and culturally competent mental health services, and ensure eligible consumers receive appropriate levels of care. The regional support network must:

(1) Authorize admission, transfers and discharges for eligible consumers into and out of the following services:

(a) Community support services;

(b) Residential services; and

(c) Inpatient evaluation and treatment services.

(2) Ensure that services are provided according to the consumer's individualized service plan;

(3) Not require preauthorization of emergency services and transportation for emergency services that are required by an eligible consumer;

(4) Identify in the agreement with the mental health division any of these duties it has delegated to a subcontractor.

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WAC 388-865-0229 Inpatient services

The regional support network must develop and implement age and culturally competent services that are consistent with chapter 71.24, 71.05, and 71.34 RCW. The regional support network must:

(1) For voluntary inpatient services: Develop and implement formal agreements with inpatient services funded by the regional support network regarding:

(a) Referrals;

(b) Admissions; and

(c) Discharges.

(2) For involuntary evaluation and treatment services:

(a) Maintain agreements with sufficient numbers of certified involuntary evaluation and treatment facilities to ensure that consumers eligible for regional support network services have access to involuntary inpatient care. The agreements must address regional support network responsibility for discharge planning;

(b) Determine which service providers on whose behalf the regional support network will apply on behalf of for certification by the mental health division;

(c) Ensure that all service providers or its subcontractors

that provide evaluation and treatment services are currently certified by the mental health division and licensed by the department of health;

(d) Ensure periodic reviews of the evaluation and treatment service facilities consistent with regional support network procedures and notify the appropriate authorities if it believes that a facility is not in compliance with applicable statutes, rules and regulations.

(3) Authorize admissions, transfers and discharges into and out of inpatient evaluation and treatment services for eligible consumers including:

(a) State psychiatric hospitals:

(i) Western state hospital;

(ii) Eastern state hospital;

(iii) Child study and treatment center.

(b) Community hospitals;

(c) Residential inpatient evaluation and treatment facilities licensed by the department of health as adult residential rehabilitation centers; and

(d) Children's long-term inpatient program.

(4) Receive prior approval from the mental health division in the form of a single bed certification for services to be provided to consumers on a ninety- or one hundred eighty-day community inpatient involuntary commitment order consistent with the exception criteria in WAC 388-865-0502; and

(5) Identify in the agreement with the mental health division any of these duties is has delegated to a subcontractor.

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WAC 388-865-0230 Community support services

The regional support network must develop and coordinate age and culturally competent community support services that are consistent with chapter 71.24, 71.05, and 71.34 RCW:

(1) Provide the following services directly, or contract with sufficient numbers and variety of licensed and/or certified service providers to ensure that persons eligible for regional support network services have access to at least the following services:

(a) Emergency crisis intervention services;

(b) Case management services;

(c) Psychiatric treatment including medication supervision;

(d) Counseling and psychotherapy services;

(e) Day treatment services as defined in RCW 71.24.300(5) and 71.24.035(7); and

(f) Consumer employment services as defined in RCW

71.24.035(5)(e).

(2) Conduct prescreening determinations for providing community support services for persons with mental illness who are being considered for placement in nursing homes (RCW 71.24.025(7) and 71.24.025(9)); and

(3) Complete screening for persons with mental illness who are being considered for admission to residential services funded by the regional support network (RCW 71.24.025 and 71.24.025(9)).

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WAC 388-865-0235 Residential and housing services

The regional support network must ensure:

(1) Active promotion of consumer access to, and choice in, safe and affordable independent housing that is appropriate to the consumer's age, culture, and residential needs.

(2) Provision of services to families of eligible children and to eligible consumers who are homeless or at imminent risk of becoming homeless as defined in Public Law 100-77, through outreach, engagement and coordination or linkage of services with shelter and housing.

(3) The availability of community support services, with an emphasis supporting consumers in their own home or where they live in the community, with residences and residential supports prescribed in the consumer's treatment plan. This includes a full range of residential services as required in RCW 71.24.025(7) and (14); and chapter 71.24.025(14) RCW.

(4) That eligible consumers in residential facilities receive mental health services consistent with their individual service plan, and are advised of their rights, including long-term care rights (chapter 70.129 RCW).

(5) If supervised residential services are needed they are provided only in licensed facilities:

(a) An adult family home that is licensed under chapter 388-76 WAC.

(b) A boarding home facility that is licensed under chapter 388-78A WAC.

(c) An adult residential rehabilitative center facility that is licensed under chapter 246-325 WAC.

(6) The active search of comprehensive resources to meet the housing needs of consumers.

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WAC 388-865-0240 Consumer employment services

The regional support network must coordinate with rehabilitation

and employment services to assure that consumers wanting to work are provided with employment services consistent with WAC 388-865-0464.

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WAC 388-865-0245 Administration of the Involuntary Treatment Act

The regional support network must establish policies and procedures for administration of the involuntary treatment program, including investigation, detention, transportation, court related and other services required by chapter 71.05 and 71.34 RCW. This includes:

(1) Designating mental health professionals to perform the duties of involuntary investigation and detention in accordance with the requirements of chapter 71.05 and 71.34 RCW.

(2) Documenting consumer compliance with the conditions of less restrictive alternative court orders by:

(a) Ensuring periodic evaluation of each committed consumer for release from or continuation of an involuntary treatment order. Evaluations must be recorded in the clinical record, and must occur at least monthly for ninety and one hundred eighty-day commitments.

(b) Notifying the county designated mental health professional if noncompliance with the less restrictive order impairs the individual sufficiently to warrant detention or evaluation for detention and petitioning for revocation of the less restrictive alternative court order.

(3) Ensuring that when a peace officer or county designated mental health professional escorts a consumer to a facility, the county designated mental health professional must take reasonable precautions to safeguard the consumer's property including:

(a) Safeguarding the consumer's property in the immediate vicinity of the point of apprehension;

(b) Safeguarding belongings not in the immediate vicinity if there may be possible danger to those belongings;

(c) Taking reasonable precautions to lock and otherwise secure the consumer's home or other property as soon as possible after the consumer's initial detention.

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WAC 388-865-0250 Ombuds services

The regional support network must provide unencumbered access to and maintain the independence of the ombuds service as set forth in this section and in the agreement between mental health division and the regional support network. The mental health

division and the regional support network must include representatives of consumer and family advocate organizations when revising the terms of the agreement regarding the requirements of this section. Ombuds members must be current consumers of the mental health system, past consumers or family members. The regional support network must maintain an ombuds service that:

(1) Is responsive to the age and demographic character of the region and assists and advocates for consumers with resolving complaints and grievances at the lowest possible level;

(2) Is independent of service providers;

(3) Receives and investigates consumer, family member, and other interested party complaints and grievances;

(4) Is accessible to consumers, including a toll-free, independent phone line for access;

(5) Is able to access service sites and records relating to the consumer with appropriate releases so that it can reach out to consumers, and resolve complaints and/or grievances;

(6) Receives training and adheres to confidentiality consistent with this chapter and chapter 71.05, 71.24, and 70.02 RCW;

(7) Continues to be available to investigate, advocate and assist the consumer through the grievance and administrative hearing processes;

(8) Involves other persons, at the consumer's request;

(9) Assists consumers in the pursuit of formal resolution of complaints;

(10) If necessary, continues to assist the consumer through the fair hearing processes;

(11) Coordinates and collaborates with allied systems' advocacy and ombuds services to improve the effectiveness of advocacy and to reduce duplication of effort for shared clients;

(12) Provides information on grievance experience to the regional support network and mental health division quality management process; and

(13) Provides reports and formalized recommendations at least biennially to the mental health division and regional support network advisory and governing boards, quality review team, local consumer and family advocacy groups, and provider network.

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WAC 388-865-0255 Consumer grievance process

The regional support network must develop a process for reviewing consumer complaints and grievances. A complaint is

defined as a verbal statement of dissatisfaction with some aspect of mental health services. A grievance is a written request that a complaint be heard and adjudicated, usually undertaken after attempted resolution of a complaint fails. The process must be submitted to the mental health division for written approval and incorporation into the agreement between the regional support network and the mental health division. The process must:

(1) Be age, culturally and linguistically competent;

(2) Ensure acknowledgment of receipt of the grievance the following working day. This acknowledgment may be by telephone, with written acknowledgment mailed within five working days;

(3) Ensure that grievances are investigated and resolved within thirty days. This timeframe can be extended by mutual written agreement, not to exceed ninety days;

(4) Be published and made available to all current or potential users of publicly funded mental health services and advocates in language that is clear and understandable to the individual;

(5) Encourage resolution of complaints at the lowest level possible;

(6) Include a formal process for dispute resolution;

(7) Include referral of the consumer to the ombuds service for assistance at all levels of the grievance and fair hearing processes;

(8) Allow the participation of other people, at the grievant's choice;

(9) Ensure that the consumer is mailed a written response within thirty days from the date a written grievance is received by the regional support network;

(10) Ensure that grievances are resolved even if the consumer is no longer receiving services;

(11) Continue to provide mental health services to the grievant during the grievance and fair hearing process;

(12) Ensure that full records of all grievances are kept for five years after the completion of the grievance process in confidential files separate from the grievant's clinical record. These records must not be disclosed without the consumer's written permission, except as necessary to resolve the grievance or to DSHS if a fair hearing is requested;

(13) Provide for follow-up by the regional support network to assure that there is no retaliation against consumers who have filed a grievance;

(14) Make information about grievances available to the regional support network;

(15) Inform consumers of their right to file an administrative hearing with DSHS without first accessing the

contractor's grievance process. Consumers must utilize the regional support network grievance process prior to requesting disenrollment;

(16) Inform consumers of their right to use the DSHS prehearing and administrative hearing processes as described in chapter 388-02 WAC. Consumers have this right when:

(a) The consumer believes there has been a violation of DSHS rule;

(b) The regional support network did not provide a written response within thirty days from the date a written request was received;

(c) The regional support network, mental health prepaid health plan, the department of social and health services, or a provider denies services.

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WAC 388-865-0260 Mental health professionals and specialists

The regional support network must assure sufficient numbers of mental health professionals and specialists are available in the service area to meet the needs of eligible consumers. The regional support network must:

(1) Document efforts to acquire the services of the required mental health professionals and specialists;

(2) Ensure development of a training program using in-service training or outside resources to assist service providers to acquire necessary skills and experience to serve the needs of the consumer population;

(3) If more than five hundred persons in the total population in the regional support network geographic area report in the U.S. census that they belong to racial/ethnic groups as defined in WAC 388-865-0150, the regional support network must contract or otherwise establish a working relationship with the required specialists to:

(a) Provide all or part of the treatment services for these populations; or

(b) Supervise or provide consultation to staff members providing treatment services to these populations.

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WAC 388-865-0265 Mental health professional—Exception

The regional support network may request an exception of the requirements of a mental health professional for a person with less than a masters degree level of training. The mental health division may grant an exception of the minimum requirements on a time-limited basis and only with a demonstrated need for an

exception under the following conditions:

(1) The regional support network has made a written request for an exception including:

(a) Demonstration of the need for an exception;

(b) The name of the person for whom an exception is being requested;

(c) The functions which the person will be performing;

(d) A statement from the regional support network that the person is qualified to perform the required functions based on verification of required education and training, including:

(i) Bachelor of Arts or Sciences degree from an accredited college or university;

(ii) Course work or training in making diagnoses, assessments, and developing treatment plans; and

(iii) Documentation of at least five years of direct treatment of persons with mental illness under the supervision of a mental health professional.

(2) The regional support network assures that periodic supervisory evaluations of the individual's job performance are conducted;

(3) The regional support network submits a plan of action to assure the individual will become qualified no later than two years from the date of exception. The regional support network may apply for renewal of the exception. The exception may not be transferred to another regional support network or to use for an individual other than the one named in the exception;

(4) If compliance with this rule causes a disproportionate economic impact on a small business as defined in the Regulatory Fairness Act, chapter 19.85 RCW, and the business does not contract with a regional support network, the small business may request the exception directly from the mental health division.

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WAC 388-865-0270 Financial management

The regional support network must be able to demonstrate that it ensures the effectiveness and cost effectiveness of community mental health services. The regional support network must:

(1) Spend funds received by the mental health division in accordance with its contract and to meet the requirements of chapter 71.05, 71.24, 71.34 RCW, and the State Appropriations Act;

(2) Use accounting procedures that are consistent with applicable state and federal requirements and generally accepted accounting principles (GAAP), with the following additional requirements:

(a) Include as assets all property, equipment, vehicles,

buildings, capital reserve funds, operating reserve funds, risk reserve funds, or self-insurance funds.

(b) Interest accrued on funds stated in this section must be accounted for and kept for use by the regional support network.

(c) Property, equipment, vehicles, and buildings must be properly inventoried with a physical inventory conducted at least every two years.

(d) Proceeds from the disposal of any assets must be retained by the regional support network for purposes of subsection (1) of this section.

(3) Comply with the 1974 county maintenance of effort requirement for administration of the Involuntary Treatment Act (chapter 71.05 RCW) and 1990 county maintenance of effort requirement for community programs for adults consistent with RCW 71.24.160, and in the case of children, no state funds shall replace local funds from any source used to finance administrative costs for involuntary commitment procedures conducted prior to January 1, 1985 (chapter 71.34 RCW);

(4) Maintain accounting procedures to ensure that accrued interest and excess reserve balances are returned to the regional support network for use in the public mental health system.

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WAC 388-865-0275 Management information system

The regional support network must be able to demonstrate that it collects and manages information that shows the effectiveness and cost effectiveness of mental health services. The regional support network must:

(1) Operate an information system and ensure that information about consumers who receive publicly funded mental health services is reported to the state mental health information system according to mental health division guidelines.

(2) Ensure that the information reported is:

(a) Sufficient to produce accurate regional support network reports; and

(b) Adequate to locate case managers in the event that a consumer requires treatment by a service provider that would not normally have access to treatment information about the consumer.

(3) Ensure that information about consumers is shared or released between service providers only in compliance with state statutes (see chapter 70.02, 71.05, and 71.34 RCW) and this chapter. Information about consumers and their individualized

crisis plans must be available:

(a) Twenty-four hours a day, seven days a week to county-designated mental health professionals and inpatient evaluation and treatment facilities, as consistent with confidentiality statutes; and

(b) To the state and regional support network staff as required for management information and program review.

(4) Maintain on file a statement signed by regional support network, county or service provider staff having access to the mental health information systems acknowledging that they understand the rules on confidentiality and will follow the rules.

(5) Take appropriate action if a subcontractor or regional support network employee willfully releases confidential information, as required by chapter 71.05 RCW.

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WAC 388-865-0280 Quality management process

The regional support network must implement a process for continuous quality improvement in the delivery of culturally competent mental health services. The regional support network must submit a quality management plan as part of the written biennial plan to the mental health division for approval. All changes to the quality management plan must be submitted to the mental health division for approval prior to implementation. The plan must include:

(1) Roles, structures, functions and interrelationships of all the elements of the quality management process, including but not limited to the regional support network governing board, clinical and management staff, advisory board, ombuds service, and quality review teams.

(2) Procedures to ensure that quality management activities are effectively and efficiently carried out with clear management and clinical accountability, including methods to:

(a) Collect, analyze and display information regarding:

(i) The capacity to manage resources and services, including financial and cost information and compliance with statutes, regulations and agreements;

(ii) System performance indicators;

(iii) Quality and intensity of services;

(iv) Incorporation of feedback from consumers, allied service systems, community providers, ombuds and quality review team;

(v) Clinical care and service utilization including consumer outcome measures; and

(vi) Recommendations and strategies for system and clinical

care improvements, including information from exit interviews of consumers and practitioners.

(b) Monitor management information system data integrity;

(c) Monitor complaints, grievances and adverse incidents for adults and children;

(d) Monitor contracts with contractors and to notify the mental health division of observations and information indicating that providers may not be in compliance with licensing or certification requirements;

(e) Immediately investigate and report allegations of fraud and abuse of the contractor or subcontractor to the mental health division;

(f) Monitor delegated administrative activities;

(g) Identify necessary improvements;

(h) Interpret and communicate practice guidelines to practitioners;

(i) Implement change;

(j) Evaluate and report results;

(k) Demonstrate use of all corrective actions to improve the system;

(l) Consider system improvements based on recommendations from all on-site monitoring, evaluation and accreditation/certification reviews;

(m) Review update, and make the plan available to community stakeholders.

(3) Targeted improvement activities, including:

(a) Performance measures that are objective, measurable, and based on current knowledge/best practice including at least those defined by the mental health division in the agreement with the regional support network;

(b) An analysis of consumer care covering a representative sample of at least ten percent of consumers or five hundred consumers, whichever is smaller;

(c) Efficient use of human resources; and

(d) Efficient business practices.

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WAC 388-865-0282 Quality review teams

The regional support network must establish and maintain unencumbered access to and maintain the independence of a quality review team as set forth in this section and in the agreement between mental health division and the regional support network. The quality review team must include current consumers of the mental health system, past consumers or family members. The regional support network must assure that quality review teams:

(1) Fairly and independently review the performance of the regional support network and service providers to evaluate systemic customer service issues as measured by objective indicators of consumer outcomes in rehabilitation, recovery and reintegration into the mainstream of social, employment and educational choices, including:

(a) Quality of care;

(b) The degree to which services are consumer-focused/directed and are age and culturally competent;

(c) The availability of alternatives to hospitalization, cross-system coordination and range of treatment options; and

(d) The adequacy of the regional support network's cross system linkages including, but not limited to schools, state and local hospitals, jails and shelters.

(2) Have the authority to enter and monitor any agency providing services for area regional support network consumers, including state and community hospitals, freestanding evaluation and treatment facilities, and community support service providers;

(3) Meet with interested consumers and family members, allied service providers, including state or community psychiatric hospitals, regional support network contracted service providers, and persons that represent the age and ethnic diversity of the regional support network to:

(a) Determine if services are accessible and address the needs of consumers based on sampled individual recipient's perception of services using a standard interview protocol developed by the mental health division. The protocol will query the sampled individuals regarding ease of accessing services, the degree to which services address medically necessary needs (acceptability), an the benefit of the service received; and

(b) Work with interested consumers, service providers, the regional support network, and DSHS to resolve identified problems.

(4) Provide reports and formalized recommendations at least biennially to the mental health division, the mental health advisory committee and the regional support network advisory and governing boards and ensure that input from the quality review team is integrated into the overall regional support network quality management process, ombuds services, local consumer and family advocacy groups, and provider network; and

(5) Receive training and adhere to confidentiality standards.

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WAC 388-865-0284 Standards for contractors and subcontractors

The regional support network must not subcontract for clinical services to be provided using state funds unless the subcontractor is licensed and/or certified by the mental health division for those services or is personally licensed by the department of health as defined in chapter 48.43, 18.57, 18.71, 18.83, or 18.79 RCW. The regional support network must:

(1) Require and maintain documentation that contractors and subcontractors are licensed, certified, or registered in accordance with state or federal laws;

(2) Follow applicable requirements of the regional support network agreement with the mental health division;

(3) Demonstrate that it monitors contracts with contractors and notifies the mental health division of observations and information indicating that providers may not be in compliance with licensing or certification requirements; and

(4) Terminate its contract with a provider if the mental health division notifies the regional support network of a provider's failure to attain or maintain licensure or certification, if applicable.

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WAC 388-865-0286 Coordination with a mental health prepaid health plan

If the regional support network is not also a mental health prepaid health plan, the regional support network must ensure continuity of services between itself and the mental health prepaid health plan by maintaining a working agreement about coordination for at least the following services:

(1) Community support services;

(2) Inpatient evaluation and treatment services;

(3) Residential services;

(4) Transportation services;

(5) Consumer employment services;

(6) Administration of involuntary treatment investigation and detention services; and

(7) Immediate crisis response after presidential declaration of a disaster.

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WAC 388-865-0288 Regional support networks as a service provider

A regional support network may operate as a community support service provider under the following circumstances:

(1) Meeting the criteria specified in RCW 71.24.037 and 71.24.045;

(2) Maintaining a current license as a community support

service provider from the mental health division.

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SECTION THREE--MENTAL HEALTH PREPAID HEALTH PLANS

WAC 388-865-0300 Mental health prepaid health plans

A mental health prepaid health plan is an entity that contracts with the mental health division to administer mental health services for people who are eligible for the Title XIX Medicaid program. The mental health prepaid health plan must ensure services are responsive in an age and culturally competent manner to the mental health needs of its community. To be eligible for a contract as a mental health prepaid health plan, the entity must:

(1) Provide documentation of a population base of forty-one thousand six hundred Medicaid eligible persons (covered lives) within the service area or receive approval from the mental health division based on submittal of an actuarially sound risk management profile;

(2) Maintain certification as a regional support network or licensure by the Washington state office of the insurance commissioner as a health care service contractor under chapter 48.44 RCW.

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WAC 388-865-0305 Regional support network contracting as a mental health prepaid health plan

A regional support network contracting with the mental health division as a mental health prepaid health plan must comply with all requirements for a regional support network and the additional requirements for a prepaid health plan.

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WAC 388-865-0310 Mental health prepaid health plans--Minimum standards

To be eligible for a contract, a mental health prepaid health plan must comply with all applicable federal, state, and local statutes and regulations and meet all of the minimum standards of WAC 388-865-300 through 388-865-355. The mental health

prepaid health plan must:

(1) Provide medically necessary mental health services that are age and culturally competent for all Medicaid recipients in the service area within a capitated rate;

(2) Provide outreach to consumers, including homeless persons and families as defined in Public Law 100-77, and home-bound individuals;

(3) Demonstrate working partnerships with tribal authorities for the delivery of services that blend with tribal values, beliefs and culture;

(4) Develop and maintain written subcontracts that clearly recognize that legal responsibility for administration of the service delivery system remains with the mental health prepaid health plan, as identified in the agreement with the mental health division;

(5) Retain responsibility to ensure that applicable standards of state and federal statute and regulations and this chapter are met even when it delegates duties to subcontractors;

(6) Ensure the protection of consumer and family rights as described in chapter 71.05 and 71.34 RCW;

(7) Ensure compliance with the following standards:

(a) WAC 388-865-0220, Standards for administration;

(b) WAC 388-865-0225, Resource management program;

(c) WAC 388-865-0229, Inpatient services and treatment services;

(d) WAC 388-865-0230, Community support services;

(e) WAC 388-865-0250, Ombuds services;

(f) WAC 388-865-0255, Consumer grievance process;

(g) WAC 388-865-0260, Mental health professionals or specialists;

(h) WAC 388-865-0265, Mental health professional--Exception;

(i) WAC 388-865-0270, Financial management;

(j) WAC 388-865-0275, Management information system;

(k) WAC 388-865-0280, Quality management process;

(l) WAC 388-865-0282, Quality review teams; and

(m) WAC 388-865-0284, Standards for contractors and subcontractors.

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WAC 388-865-0315 Governing body

The mental health prepaid health plan must establish a governing body responsible for oversight of the mental health prepaid health plan. The governing body must:

(1) Be free from conflict of interest and all appearance of conflict of interest between personal, professional and

fiduciary interests of a governing body member and the best interests of the prepaid health plan and the consumers it serves.

(2) Have rules about:

(a) When a conflict of interest becomes evident;

(b) Not voting or joining a discussion when a conflict of interest is present; and

(c) When the body scan assign the matter to others, such as staff or advisory bodies.

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WAC 388-865-0320 Utilization management

Utilization management is the way the mental health prepaid health plan authorizes or denies mental health services, monitors services, and follows the level of care guidelines. To demonstrate the impact on enrollee access to care of adequate quality, a mental health prepaid health plan must provide utilization management of the community mental health rehabilitation services (42 C.F.R. 440) that is independent of service providers. This process must:

(1) Provide effective and efficient management of resources;

(2) Assure capacity sufficient to deliver appropriate quality and intensity of services to enrolled consumers without a wait list consistent with the agreement with the mental health division;

(3) Plan, coordinate, and authorize community support services;

(4) Ensure that services are provided according to the individual service plan;

(5) Ensure assessment and monitoring processes are in place by which service delivery capacity responds to changing needs of the community and enrolled consumers;

(6) Develop, implement, and enforce written level of care guidelines for admission, placements, transfers and discharges into and out of services. The guidelines must address:

(a) A clear process for the mental health prepaid health plan's role in the decision-making process about admission and continuing stay at various levels is available in language that is clearly understood by all parties involved in an individual consumer's care, including laypersons;

(b) Criteria for admission into various levels of care, including community support, inpatient and residential services that are clear and concrete;

(c) Methods to ensure that services are individualized to meet the needs for all Medicaid consumers served, including

consumers of different ages, cultures, languages, civil commitment status, physical abilities, and unique service needs; and

(d) To the extent authorization of care at any level of care or at continuing stay determinations is delegated, the mental health prepaid health plan retains a sufficiently strong and regular oversight role to assure those decisions are being made appropriately.

(7) Collect data that measures the effectiveness of the criteria in ensuring that all eligible people get services that are appropriate to his/her needs;

(8) Report to the mental health division any knowledge it gains that the mental health prepaid health plan or service provider is not in compliance with all state and federal laws and regulations.

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WAC 388-865-0325 Risk management

The mental health prepaid health plan must:

(1) Assume the financial risk of providing community mental health outpatient rehabilitation services, community hospital services and operation of a capitated mental health managed care system for the Medicaid eligible persons in the service area;

(2) Maintain a risk reserve of annual premium payments as defined by chapter 48.44 RCW or the actuarial analysis submitted with the formal request for waiver for mental health approved by the Health Care Financing Administration. All other mental health reserves and undesignated fund balances shall be limited to no more than ten percent of annual revenues supporting the prepaid health plan's mental health program;

(3) Demonstrate solvency and manage all fiscal matters within the managed care system, including:

(a) Current pro-forma;

(b) Financial reports;

(c) Balance sheets;

(d) Revenue and expenditure; and

(e) An analysis of reserve account(s) and fund balance(s) information including a detailed composition of capital, operating, and risk reserves and or fund balances.

(4) Maintain policies for each reserve account and have a process for collecting and disbursing reserves to pay for costs incurred by the mental health prepaid health plan;

(5) Demonstrate capacity to process claims for members of the contracted provider network and any emergency service providers accessed by consumers while out of the mental health prepaid health plan service area within sixty days using methods

consistent with generally accepted accounting practices;

(6) Comply with the requirements of section 1128 (b) of the Social Security Act, which prohibits making payments directly or indirectly to physicians or other providers as an inducement to reduce or limit services provided to consumers;

(7) In accordance with the Medicaid section 1915b waiver, the mental health prepaid health plan is required to pay for psychiatric inpatient services in community hospitals either through a direct contract with community hospitals or through an agreement with the department. In the event that the mental health prepaid health plan chooses to use the department as its fiscal agent, the plan agrees to abide by all policies, rules, payment requirements, and levels promulgated by the medical assistance administration. If the plan chooses to direct contract, the plan is responsible for executing contracts for sufficient hospital capacity pursuant to a plan approved by the mental health division.

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WAC 388-865-0330 Marketing/education of mental health services

The mental health prepaid health plan must demonstrate that it provides information to eligible persons so that they are aware of available mental health services and how to access them. The mental health prepaid health plan must:

(1) Develop and submit marketing/education plan(s) and procedures to the mental health division within the timeframes in the agreement with the mental health division for approval prior to issuance. The plan shall, at a minimum, include information on the following:

(a) Consumer rights and responsibilities;

(b) The service recipient's right to disenroll;

(c) Cross-system linkages;

(d) Access to mental health services for diverse populations, including other languages than English;

(e) Use of media;

(f) Stigma reduction;

(g) Subcontractor participation/involvement;

(h) Plan for evaluation of marketing strategy;

(i) Procedures and materials, and any revisions thereof and

(j) Maintain listings of mental health services with toll-free numbers in the telephone and other public directories of the service area.

(2) Describe services and hours of operations through brochures and other materials and other methods of advertising;

(3) Assure that the materials and methods are effective in

reaching people who may be visually impaired, have limited comprehension of written or spoken English, or who are unable to read. At a minimum, all written materials generally available to service recipients shall be translated to the most commonly used languages in the service area;

(4) Post and otherwise make information available to consumers about ombuds services and local advocacy organizations that may assist consumers in understanding their rights;

(5) Ensure distribution of written educational material(s) to consumers, allied systems and local community resources including:

(a) Annual brochure(s) containing educational material on major mental illnesses and the range of options for treatment, supports available in the system, including medication and formal psychotherapies, as well as alternative approaches that may be appropriate to age, culture and preference of the service recipient;

(b) Information regarding the scope of available benefits (e.g., inpatient, outpatient, residential, employment, community support);

(c) Service locations, crisis response services; and

(d) Service recipients' responsibilities with respect to out-of-area emergency services; unauthorized care; noncovered services; complaint process, grievance procedures; and other information necessary to assist in gaining access.

(6) Ensure marketing plans, procedures and materials are accurate and do not mislead, confuse or defraud the service recipient.

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WAC 388-865-0335 Consumer enrollment

(1) DSHS enrolls a Medicaid recipient in a mental health prepaid health plan when the person resides in the contracted service area;

(2) An enrolled Medicaid consumer who requests or receives medically necessary nonemergency community mental health rehabilitation services requests and receives such service from the assigned mental health prepaid health plan through authorized providers only;

(3) An enrolled Medicaid consumer does not need to request disenrollment from the mental health division when the recipient moves from one mental health prepaid health plan to another

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WAC 388-865-0340 Consumer disenrollment

(1) The mental health division must disenroll a Medicaid consumer from his/her mental health prepaid health plan only when the consumer:

(a) Loses eligibility for Title XIX Medicaid services; or

(b) Is deceased.

(2) On a case-by-case basis, the mental health division will disenroll a consumer from his/her mental health prepaid health plan when the consumer has "good cause" for disenrollment. For the purposes of this chapter, "good cause" is defined as the inability of the mental health prepaid health plan to provide medically necessary care that is reasonably available and accessible. A consumer will not be disenrolled in a mental health prepaid health plan solely due to an adverse change in the consumer's health. In determining whether the mental health prepaid health plan provides medically necessary care that is reasonably available and accessible the mental health division may consider, but is not limited to considering:

(a) The medically necessary services needed by the consumer;

(b) Whether services are or should be available to other consumers in the mental health prepaid health plan;

(c) Attempts the consumer has made to access services in his/her assigned mental health prepaid health plan;

(d) Efforts by the assigned mental health prepaid health plan to provide the medically necessary services needed by the consumer.

(3) A consumer wishing to disenroll from his/her assigned mental health prepaid health plan must utilize the local mental health prepaid health plan grievance process prior to requesting disenrollment from the mental health division;

(4) A consumer requesting disenrollment must make a request in writing to the mental health division fair hearing coordinator. The request must include:

(a) The consumer's name, address, phone number (or number where the consumer can receive a message), and the name of the consumer's current mental health prepaid health plan;

(b) A statement outlining the reasons why the consumer believes his/her current mental health prepaid health plan does not provide medically necessary care that is reasonably available and accessible.

(5) The mental health division will make a decision within forty-five days of the request for disenrollment or within time frames prescribed by the federal Health Care Financing Administration, whichever is shorter. The mental health division will screen the request to determine if there is sufficient information upon which to base a decision;

(6) The mental health division will notify the consumer within fifteen days of receipt of the request whether or not the request contains sufficient information. If there is not sufficient information to allow the mental health division to make a decision, additional information will be requested from the consumer. The consumer will have fifteen days to provide requested information. Failure to provide additional requested information will result in denial of the disenrollment request;

(7) The mental health division will send written notice of the decision to the consumer:

(a) If a decision to disenroll is made, the mental health division will notify the consumer ten days in advance of the effective date of the proposed disenrollment, including arrangements for continued mental health services;

(b) If the consumer's request to disenroll is denied, the notice will include the consumer's right to request a fair hearing, how to request a fair hearing, and how the consumer may access ombuds services in his/her area.

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WAC 388-865-0345 Choice of primary care provider

The mental health prepaid health plan must ensure that each consumer who is receiving nonemergency community mental health rehabilitation services has a primary care provider who is responsible to carry out the individualized service plan. The mental health prepaid health plan must allow consumers, parents of consumers under the age of thirteen, and guardians of consumers of all ages to select a primary care provider from the available primary care provider staff within the mental health prepaid health plan.

(1) For an enrolled client with an assigned case manager, the case manager is the primary care provider;

(2) If the consumer does not make a choice, the mental health prepaid health plan or its designee must assign a primary care provider no later than fifteen working days after the consumer requests services;

(3) The mental health prepaid health plan or its designee must allow a consumer to change primary care providers in the first ninety days of enrollment with the mental health prepaid health plan and once during a twelve-month period for any reason;

(4) Any additional change of primary care provider during the twelve-month period may be made with documented justification at the consumer's request by:

(a) Notifying the mental health prepaid health plan (or its designee) of his/her request for a change, and the name of the

new primary care provider; and

(b) Identifying the reason for the desired change.

(5) A consumer whose request to change primary care providers is denied may submit a grievance with the plan, or request an administrative hearing.

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WAC 388-865-0350 Mental health screening for children

The mental health prepaid health plan is responsible for conducting mental health screening and treatment for children eligible under the federal Title XIX early and periodic screening, diagnosis, and treatment (EPSDT) program. This includes:

(1) Providing resource management services for children eligible under the federal Title XIX early and periodic screening, diagnosis, and treatment program as specified in contract with the mental health division;

(2) Developing and maintaining an oversight committee for the coordination of the early and periodic screening, diagnosis and treatment program. The oversight committee must include representation from parents of Medicaid-eligible children.

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WAC 388-865-0355 Consumer request for a second opinion

An enrolled consumer in a mental health prepaid health plan must have the right to a second opinion by another participating staff in the enrolled consumer's assigned mental health prepaid health plan:

(1) When the enrolled consumer needs more information about the medical necessity of the treatment recommended by the mental health prepaid health plan; or

(2) If the enrolled consumer believes the mental health prepaid health plan primary care provider is not authorizing medically necessary community mental health rehabilitation services.

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WAC 388-865-0360 Monitoring of mental health prepaid health plans

The mental health division will conduct an annual on-site medical audit and an administrative audit at least every two years for purposes of assessing the quality of care and conformance with the minimum standards of this section and the Title XIX Medicaid 1915 b mental health waiver requirements. The monitoring will include a review of:

(1) The mental health prepaid health plan's conformance to monitoring its service provider network in accordance with the quality management plan approved by the mental health division that includes processes established under the Medicaid waiver for mental health services;

(2) Any direct services provided by the mental health prepaid health plan;

(3) Other provisions within the code of federal regulations for managed care entities, which may include access, quality of care, marketing, record keeping, utilization management and disenrollment functions.

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WAC 388-865-0363 Coordination with the regional support network

If the mental health prepaid health plan is not also a regional support network, the mental health prepaid health plan must ensure continuity of services between itself and the regional support network by maintaining a working agreement about coordination for at least the following services:

(1) Residential services;

(2) Transportation services;

(3) Consumer employment services;

(4) Administration of involuntary treatment investigation and detention services; and

(5) Immediate crisis response after presidential declaration of a disaster.

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WAC 388-865-0365 Suspension, revocation, limitation or restriction of a contract

The mental health division may suspend, revoke, limit or restrict a mental health prepaid health plan contract or refuse to grant a contract for failure to conform to applicable state and federal rules and regulations or for violation of health or safety considerations.

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SECTION FOUR--COMMUNITY SUPPORT SERVICE PROVIDERS

WAC 388-865-0400 Community support service providers

The mental health division licenses and certifies community support service providers. To gain and maintain licensure or certification, a provider must meet applicable local, state and federal statutes and regulations as well as the requirements of WAC 388-865-400 through 388-865-450 as applicable to services offered. The license or certificate lists service components the provider is authorized to provide to publicly funded consumers and must be prominently posted in the provider reception area. In addition, the provider must meet minimum standards of the specific service components for which licensure is being sought:

(1) Emergency crisis intervention services;

(2) Case management services;

(3) Psychiatric treatment, including medication supervision;

(4) Counseling and psychotherapy services;

(5) Day treatment services; and/or

(6) Consumer employment services.

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WAC 388-865-0405 Competency requirements for staff

The licensed service provider must ensure that staff are qualified for the position they hold and have the education, experience, or skills to perform the job requirements. The provider must maintain documentation that:

(1) All staff have a current Washington state department of health license or certificate or registration as may be required for their position;

(2) Washington state patrol background checks are conducted for employees in contact with consumers consistent with RCW 43.43.830;

(3) Mental health services are provided by a mental health professional, or under the clinical supervision of a mental health professional;

(4) Staff performing mental health services (not including crisis telephone) must have access to consultation with a psychiatrist or a physician with at least one year's experience in the direct treatment of persons who have a mental or emotional disorder;

(5) Mental health services to children, older adults, ethnic minorities or persons with disabilities must be provided by, under the supervision of, or with consultation from the appropriate mental health specialist(s) when the consumer:

(a) Is a child as defined in WAC 866-865-0150;

(b) Is or becomes an older person as defined in WAC

388-865-0150;

(c) Is a member of a racial/ethnic group as defined in WAC 866-865-0105 and as reported:

(i) In the consumer's demographic data; or

(ii) By the consumer or others who provide active support to the consumer; or

(iii) Through other means.

(d) Is disabled as defined in WAC 388-865-0150 and as reported:

(i) In the consumer's demographic data; or

(ii) By the consumer or others who provide active support to the consumer; or

(iii) Through other means.

(6) Staff receive regular supervision and an annual performance evaluation; and

(7) An individualized annual training plan must be implemented for each direct service staff person and supervisor in the skills he or she needs for his/her job description and the population served.

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WAC 388-865-0410 Consumer rights

(1) The provider must document that consumers, prospective consumers, or legally responsible others are informed of consumer rights at admission to community support services in a manner that is understandable to the individual Consumer rights must be written in alternative format for consumers who are blind or deaf, and must also be translated to the most commonly used languages in the service area consistent with WA 388-865-0260(3);

(2) The provider must post a written statement of consumer rights in public areas, with a copy available to consumers on request. Providers of telephone only services (e.g., crisis lines) must post the statement of consumer rights in a location visible to staff and volunteers during working hours;

(3) The provider must develop a statement of consumer rights that incorporates the following statement or a variation approved by the mental health division: "You have the right to:

(a) Be treated with respect, dignity and privacy;

(b) Develop a plan of care and services which meets your unique needs;

(c) The services of a certified language or sign language interpreter and written materials and alternate format to accommodate disability consistent with Title VI of the Civil Rights Act;

(d) Refuse any proposed treatment, consistent with the

requirements in chapter 71.05 and 71.34 RCW;

(e) Receive care which does not discriminate against you, and is sensitive to your gender, race, national origin, language, age, disability, and sexual orientation;

(f) Be free of any sexual exploitation or harassment;

(g) Review your clinical record and be given an opportunity to make amendments or corrections;

(h) Receive an explanation of all medications prescribed, including expected effect and possible side effects;

(i) Confidentiality, as described in chapters 70.02, 71.05, and 71.34 RCW and regulations;

(j) All research concerning consumers whose cost of care is publicly funded must be done in accordance with all applicable laws, including DSHS rules on the protection of human research subjects as specified in chapter 388-04 WAC;

(k) Make an advance directive, stating your choices and preferences regarding your physical and mental health treatment if you are unable to make informed decisions;

(l) Appeal any denial, termination, suspension, or reduction of services and to continue to receive services at least until your appeal is heard by a fair hearing judge;

(m) If you are Medicaid eligible, receive all service which are medically necessary to meet your care needs. In the event that there is a disagreement, you have the right to a second opinion from a provider within the regional support network about what services are medically necessary;

(n) Lodge a complaint with the ombuds, regional support network, or provider if you believe your rights have been violated. If you lodge a complaint or grievance, you must be free of any act of retaliation. The ombuds may, at your request, assist you in filing a grievance. The ombuds' phone number is:_____."

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WAC 388-865-0415 Access to services

The community support service provider must document and otherwise ensure that eligible consumers have access to age and culturally competent services when and where those services are needed. The provider must:

(1) Identify and reduce barriers to people getting the services where and when they need them;

(2) Comply with the Americans with Disabilities Act and the Washington State Antidiscrimination Act, chapter 49.60 RCW;

(3) Assure that services are timely, appropriate and sensitive to the age, culture, language, gender and physical condition of the consumer;

(4) Provide alternative service delivery models to make services more available to underserved persons as defined in WAC 388-865-0150;

(5) Provide access to telecommunication devices or services and certified interpreters for deaf or hearing impaired consumers and limited English proficient consumers;

(6) Bring services to the consumer or locate services at sites where transportation is available to consumers; and

(7) Ensure compliance with all state and federal nondiscrimination laws, rules and plans.

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WAC 388-865-0420 Intake evaluation

The community support service provider must complete an intake evaluation in collaboration with the consumer within fourteen days of admission to service. If seeking this information presents a barrier to service, the item may be left incomplete provided that the reasons are documented in the clinical record. The following must be documented in the consumer's intake evaluation:

(1) A consent for treatment or copy of detention or involuntary treatment order;

(2) Consumer strengths, needs and desired outcomes in their own words. At the consumer's request also include the input of people who provide active support to the consumer;

(3) The consumer's age, culture/cultural history, and disability;

(4) History of substance use and abuse or other co-occurring disorders;

(5) Medical and mental health services history and a list of medications used;

(6) For children:

(a) Developmental history and

(b) Parent's goals and desired outcomes.

(7) Sufficient information to justify the diagnosis;

(8) Review of the intake evaluation by a mental health professional.

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WAC 388-865-0425 Individual service plan

Community support service providers must provide consumers with an individual service plan that meets his or her unique needs. Individualized and tailored care is a planning process that may be used to develop a consumer-driven, strength-based, individual service plan. The individual service plan must:

(1) Be developed collaboratively with the consumer and other people identified by the consumer within thirty days of starting community support services. The service plan should be in language and terminology that is understandable to consumers and their family, and include goals that are measurable;

(2) Address age, cultural, or disability issues of the consumer;

(3) Include measurable goals for progress toward rehabilitation, recovery and reintegration into the mainstream of social, employment and educational choices, involving other systems when appropriate;

(4) Demonstrate that the provider has worked with the consumer and others at the consumer's request to determine his/her needs in the following life domains:

(a) Housing;

(b) Food;

(c) Income;

(d) Health and dental care;

(e) Transportation;

(f) Work, school or other daily activities;

(g) Social life; and

(h) Referral services and assistance in obtaining supportive services appropriate to treatment, such as substance abuse treatment.

(5) Document review by the person developing the plan and the consumer. If the person developing the plan is not a mental health professional, the plan must also document review by a mental health professional. If the person developing the plan is not a mental health specialist required per WAC 388-865-405 (5) there must also be documented consultation with the appropriate mental health specialist;

(6) Document review and update at least every one hundred eighty days or more often at the request of the consumer;

(7) In the case of children:

(a) Be integrated with the individual education plan from the education system whenever possible;

(b) If the child is under three, the plan must be integrated with the individualized family service plan (IFSP) if this exists, consistent with Title 20, Section 1436.

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WAC 388-865-0430 Clinical record

The community support service provider must maintain a clinical record for each consumer and safeguard the record against loss, defacement, tampering, or use by unauthorized persons. The clinical record must contain:

(1) An intake evaluation;

(2) Evidence that the consumer rights statement was provided to the consumer;

(3) A copy of any advance directives, powers of attorney or letters of guardianship provided by the consumer;

(4) The crisis treatment plan when appropriate;

(5) The individualized service plan and all changes in the plan;

(6) Documentation that services are provided by or under the clinical supervision of a mental health professional;

(7) Documentation that services are provided by, or under the clinical supervision, or the clinical consultation of a mental health specialist. Consultation must occur within thirty days of admission and periodically thereafter as specified by the mental health specialist;

(8) Periodic documentation of the course of treatment and objective progress toward established goals for rehabilitation, recovery and reintegration into the mainstream of social, employment and educational choices;

(9) A notation of extraordinary events affecting the consumer;

(10) Documentation of mandatory reporting of abuse, neglect, or exploitation of consumers consistent with chapter 26.44 and 74.34 RCW;

(11) Documentation of informed consent to treatment and medications by the consumer or legally responsible other;

(12) Documentation of confidential information that has been released without the consent of the consumer including, but not limited to provisions in RCW 70.02.050, 71.05.390 and 71.05.630.

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WAC 388-865-0435 Consumer access to their clinical record

The service provider must provide access to clinical records for consumers, their designated representative, and/or the person legally responsible for the consumer, consistent with chapter 71.05, 70.02, and 71.34 RCW and RCW 13.50.400(4)(b) for children. The provider must:

(1) Make the record available within fifteen days;

(2) Review the clinical record to identify and remove any material confidential to another person, agency, provider or reports not originated by the community support service provider;

(3) Allow the consumer appropriate time and privacy to review the clinical record;

(4) Provide a clinical staff member to answer questions at

the request of the consumer; and

(5) Charge for copying at a rate not higher than that defined in RCW 70.02.010(12).

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WAC 388-865-0436 Clinical record access procedures

The community support service provider must develop policies and procedures to protect information and to ensure that information about consumers is shared or released only in compliance with state and federal law (see chapter 70.02, 71.05, 71.34, 74.04 RCW and RCW 13.50.100(4)(b)) and this chapter.

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WAC 388-865-0440 Availability of consumer information

(1) Consumer individualized crisis plans as provided by the consumer must be available twenty-four hours a day, seven days a week to county-designated mental health professionals, crisis teams, and voluntary and involuntary inpatient evaluation and treatment facilities, as consistent with confidentiality statutes; and

(2) Consumer information must be available to the state and regional support network staff as required for management information, quality management and program review.

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WAC 388-865-0445 Establishment of procedures to bill for services

Consumers receiving services or the parent(s) of a person under the age of eighteen, the legal guardian, or the estate of the individual is responsible for payment for services received. The provider must establish policies and procedures to:

(1) Bill all third-party payors and private pay consumers. Persons eligible for the Medicaid program are not to be billed for medically necessary covered services.

(2) Develop a written schedule of fees that considers the consumer's available income, family size, allowable deductions and exceptional circumstances:

(a) Payment must not be required from consumers whose income is below TANF standards as defined in WAC 388-478-0020;

(b) The fee schedule must be posted in the agency and available to provider staff, consumers, the regional support network, and the mental health prepaid health plan.

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WAC 388-865-0450 Quality management process

Community support service providers must ensure continued progress toward more effective and efficient age and culturally competent services and improved consumer satisfaction and outcomes, including objective measures of progress toward rehabilitation, recovery and reintegration into the mainstream of social, employment and educational choices by maintaining an internal quality management process. The process must:

(1) Review the services offered and provided to improve the treatment of consumers, including the quality of intake evaluations and the effectiveness of prescribed medications;

(2) Review the work of persons providing mental health services at least annually; and

(3) Continuously collect, maintain, and use information to correct deficiencies and improve services. Such data must include but is not limited to reports of serious and emergent incidents as well as grievances filed by consumers or their representatives.

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WAC 388-865-0452 Emergency crisis intervention services--Additional standards

The community support service provider that is licensed for emergency crisis intervention services must assure that required general minimum standards for community support services are met, plus the additional minimum requirements:

(1) Availability of staff to respond to crises twenty-four hours a day, seven days a week, including:

(a) Bringing services to the person in crisis when clinically indicated;

(b) Requiring that staff remain with the consumer in crisis to stabilize and support him/her until the crisis is resolved or a referral to another service is accomplished;

(c) Resolving the crisis in the least restrictive manner possible;

(d) A process to include family members, significant others, and other relevant treatment providers as necessary to provide support to the person in crisis; and

(e) Written procedures for managing assaultive and/or self-injurious patient behavior.

(2) Crisis telephone screening;

(3) Mobile outreach and stabilization services with trained staff available to provide in-home or in-community stabilization services, including flexible supports to the person where he/she lives.

(4) Provide access to necessary services including:

(a) Medical services, which means at least emergency

services, preliminary screening for organic disorders, prescription services, and medication administration;

(b) Interpretive services to enable staff to communicate with consumers who have limited ability to communicate in English, or have sensory disabilities;

(c) Mental health specialists for children, elderly, ethnic minorities or consumers who are deaf or developmentally disabled;

(d) Voluntary and involuntary inpatient evaluation and treatment services, including a written protocol to assure that consumers who require involuntary inpatient services are transported in a safe and timely manner;

(e) Investigation and detention to involuntary services under chapter 71.05 RCW for adults and chapter 71.34 RCW for children who are thirteen years of age or older, including written protocols for contacting the county designated mental health professional.

(5) Document all telephone and face-to-face crisis response contacts, including:

(a) Source of referral;

(b) Nature of crisis;

(c) Time elapsed from the initial contact to face-to-face response; and

(d) Outcomes, including basis for decision not to respond in person, follow-up contacts made, and referrals made.

(6) The provider must have a written protocol for referring consumers to a voluntary or involuntary inpatient evaluation and treatment facility for admission on a seven-day-a-week, twenty-four-hour-a-day basis, including arrangements for contacting the county designated mental health professional and transporting consumers.

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WAC 388-865-0454 Provider of crisis telephone services only

This section applies only to organizations that receive public mental health funds for the purpose of providing crisis telephone services but are not licensed community support providers. In order to be licensed to provide crisis telephone services, the following requirements must be met:

(1) Staff available to respond to crisis calls twenty-four hours a day, seven days a week;

(2) The agency must assure communication and coordination with the consumer's case manager or primary care provider;

(3) The agency must assure that staff are aware of and protect consumer rights as described in WAC 388-865-0410;

(4) The following sections of WAC subsections apply:

(a) WAC 388-865-0405, Competency requirements for staff;
(b) WAC 388-865-0410, Consumer rights;
(c) WAC 388-865-0440, Availability of consumer information;
(d) WAC 388-865-0450, Quality management process;
(e) WAC 388-865-0452(6)(a) thru (d), Emergency crisis intervention services--Additional standards;
(f) WAC 388-865-0468, The process for licensing service providers;
(g) WAC 388-865-0472, Licensing categories;
(h) WAC 388-865-0474, Fees for community support licensure;
(i) WAC 388-865-0476, Licensure based on deemed status;
(j) WAC 388-865-0478, Renewal of the provider license;
(k) WAC 388-865-0480, Procedures to suspend or revoke a license;
(l) WAC 388-865-0482, Procedures to contest a licensing decision.

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WAC 388-865-0456 Case management services--Additional standards

The community support service provider for case management services must assure that all general minimum standards for community support services and are met, plus the following additional minimum requirements:

(1) Assist consumers to achieve the goals stated in their individualized service plan;

(2) Support consumer employment, education or participation in other daily activities appropriate to their age and culture;

(3) Make referrals to other needed services and supports, including treatment for co-occurring disorders and health care;

(4) Assist consumers to resolve crises in least-restrictive settings;

(5) Provide information and education about the consumer's illness so the consumer and family and natural supports are engaged to help consumers manage the consumer's symptoms;

(6) Include, as necessary, flexible application of funds, such as rent subsidies, rent deposits, and in-home care to enable stable community living.

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WAC 388-865-0458 Psychiatric treatment, including medication supervision--Additional standards

The licensed community support service provider for psychiatric treatment, including medication supervision must meet all general minimum standards for community support in addition to the following minimum requirements:

(1) Document the assessment and prescription of psychotropic medications appropriate to the needs of the consumer. Document that consumers and, as appropriate, family members are informed about the medication and possible side effects in language that is understandable to the consumer, and referred to other health care facilities for treatment of nonpsychiatric conditions;

(2) Provider staff must inspect and inventory medication storage areas at least quarterly:

(a) Medications must be kept in locked, well-illuminated storage;

(b) Medications kept in a refrigerator containing other items must be kept in a separate container with proper security;

(c) No outdated medications must be retained, and medications must be disposed of in accordance with regulations of the state board of pharmacy;

(d) Medications for external use must be stored separately from oral and injectable medications;

(e) Poisonous external chemicals and caustic materials must be stored separately.

(3) Medical direction and responsibility is assigned to a physician who is licensed to practice under chapter 18.57 or 18.71 RCW, and is board-certified or -eligible in psychiatry;

(4) Medications are only prescribed and administered by persons consistent with their license and related requirements;

(5) Medications are reviewed at least every three months;

(6) Medication information is maintained in the clinical record and documents at least the following for each prescribed medication:

(a) Name and purpose of medication;

(b) Dosage and method of giving medication;

(c) Dates prescribed, reviewed, and renewed;

(d) The effects, interactions, and side effects the staff observes or the consumer reports spontaneously or as the result of questions from the staff;

(e) Any laboratory findings;

(f) Reasons for changing or stopping the medication; and

(g) Name and signature of prescribing person.

(7) Assessment and appropriate referrals to or consultation with a physician or other health care provider when physical health problems are suspected or identified;

(8) Address current medical concerns consistent with the individualized service plan;

(9) If the service provider is unable to employ or contract with a psychiatrist, a physician without board eligibility in psychiatry may be utilized, provided that:

(a) Psychiatrist consultation is provided to the physician

at least monthly; and

(b) A psychiatrist is accessible in person, by telephone, or by radio communication to the physician for emergency consultation.

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WAC 388-865-0460 Counseling and psychotherapy services--Additional standards

The licensed community support service provider for counseling and psychotherapy services must assure that all general minimum standards for community support are met.

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WAC 388-865-0462 Day treatment services--Additional standards

The licensed community support service provider for day treatment services must assure that all general minimum standards for community support are met. Day treatment services are defined as work or other activities of daily living for consumers:

(1) Services for adults include:
(a) Training in basic living and social skills;
(b) Supported work and preparation for work;
(c) Vocational rehabilitation;
(d) Day activities; and, if appropriate;
(e) Counseling and psychotherapy services.
(2) Services for children include:
(a) Age-appropriate living and social skills;
(b) Educational and pre-vocational services;
(c) Day activities; and
(d) Counseling and psychotherapy services.

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WAC 388-865-0464 Consumer employment services--Additional standards

The community support service provider licensed for employment services must assure that all general minimum standards for community support and are met, plus the following additional minimum requirements:

(1) Assist consumers to achieve the goals stated in his/her individualized service plan and provide access to employment opportunities, including:

(a) A vocational assessment of work history, skills, training, education, and personal career goals;

(b) Information about how employment will affect income and benefits the consumer is receiving because of their disability;

(c) Active involvement with consumers served in creating and revising individualized job and career development plans;

(d) Assistance in locating employment opportunities that are consistent with the consumer's skills, goals, and interests;

(e) Integrated supported employment, including outreach/job coaching and support in a normalized or integrated work site, if required; and

(f) Interaction with the consumer's employer to support stable employment and advise about reasonable accommodation in keeping with the Americans with Disabilities Act (ADA) of 1990, and the Washington State Antidiscrimination law.

(2) Pay consumers according to the Fair Labor Standards Act; and ensure safety standards that comply with local and state regulations are in place if the provider employs consumers as part of the pre-vocational or vocational program;

(3) Coordinate efforts with other rehabilitation and employment services, such as:

(a) The division of vocational rehabilitation;

(b) The state employment services;

(c) The business community; and

(d) Job placement services within the community.

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WAC 388-865-0466 Community support outpatient certification--Additional standards

In order to provide services to consumers on a less restrictive alternative court order, providers must be licensed to provide the psychiatric and medical service component of community support services and be certified by the mental health division to provide involuntary treatment services consistent with WAC 388-865-0484. In addition, the provider must:

(1) Document in the consumer clinical record and otherwise ensure:

(a) Detained and committed consumers are advised of their rights under chapter 71.05 or 71.34 RCW and as follows:

(i) To receive adequate care and individualized treatment;

(ii) To make an informed decision regarding the use of antipsychotic medication and to refuse medication beginning twenty-four hours before any court proceeding that the consumer has the right to attend;

(iii) To maintain the right to be presumed competent and not lose any civil rights as a consequence of receiving evaluation and treatment for a mental disorder;

(iv) Of access to attorneys, courts, and other legal redress;

(v) To have the right to be told statements the consumer

makes may be used in the involuntary proceedings; and

(vi) To have the right to have all information and records compiled, obtained, or maintained in the course of treatment kept confidential as defined in chapter 71.05 and 71.34 RCW.

(b) A copy of the less restrictive alternative court order and any subsequent modifications are included in the clinical record;

(c) Development and implementation of an individual service plan which addresses the conditions of the less restrictive alternative court order and a plan for transition to voluntary treatment;

(d) That the consumer receives psychiatric treatment including medication management for the assessment and prescription of psychotropic medications appropriate to the needs of the consumer. Such services must be provided:

(i) At least weekly during the fourteen-day period;

(ii) Monthly during the ninety-day and one-hundred eighty day periods of involuntary treatment unless the attending physician determines another schedule is more appropriate, and they record the new schedule and the reasons for it in the consumer's clinical record.

(2) Maintain written procedures for managing assaultive and/or self-destructive patient behavior, and provide training to staff in these interventions;

(3) Have a written protocol for referring consumers to an inpatient evaluation and treatment facility for admission on a seven-day-a-week, twenty-four-hour-a-day basis;

(4) For consumers who require involuntary detention the protocol must also include procedures for:

(a) Contacting the county designated mental health professional regarding revocations and extension of less restrictive alternatives, and

(b) Transporting consumers.

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WAC 388-865-0468 Emergency crisis intervention services certification--Additional standards

In order to provide emergency services to a consumer who may need to be detained or who has been detained, the service provider must be licensed for emergency crisis intervention services and be certified by the mental health division to provide involuntary treatment services consistent with WAC 388-865-0484. In addition, the provider must:

(1) Be available seven-days-a-week, twenty-four-hours-per-day;

(2) Follow a written protocol for holding a consumer and

contacting the county designated mental health professional;

(3) Provide or have access to necessary medical services;

(4) Have a written agreement with a certified inpatient evaluation and treatment facility for admission on a seven day a week, twenty four hour per day basis; and

(5) Follow a written protocol for transporting individuals to inpatient evaluation and treatment facilities.

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WAC 388-865-0470 The process for initial licensing of service providers

An applicant for a community support license must comply with the following process:

(1) Complete and submit an application form, along with the required fee to the mental health division. A copy of the application form must be provided to the area regional support network. The regional support network may make written comments to the mental health division about the provider's application for licensure. The application must indicate the service components the applicant wants to offer, as listed in WAC 388-865-0400;

(2) A regional support network may submit an application to the mental health division to operate as a licensed community support service provider as defined in WAC 388-865-0288;

(3) The mental health division conducts an on-site review to examine agency policies and procedures, personnel records, clinical records, financial documents, and any other information that may be necessary to confirm compliance with minimum standards of this section;

(4) The consumer chart review is conducted during a second site review within twelve month of the issuance of the provisional license for the agency or service component if the site review is being conducted in response to a license application for a new agency or a new service component in a currently licensed agency;

(5) The mental health division may include representatives of the regional support network or mental health prepaid health plan in the licensing review process. If a provider is licensed based on deemed status as outlined in WAC 388-865-0476, input from the accrediting agency may be considered;

(6) The on-site review concludes with an exit conference that includes:

(a) Discussion of findings, if any;

(b) Statement of deficiencies requiring a plan of correction;

(c) A plan of correction signed by the applicant agency director and the mental health division review team

representative with a completion date no greater than sixty days from the date of the exit conference, unless otherwise negotiated with the review team representative. Consumer health and safety concerns may require immediate corrective action.

(7) If the provider fails to correct the deficiencies noted within the agreed-upon timeframes, licensure will be denied. The mental health division notifies the applicant in writing of the reasons for denial and the right to a review of the decision in an administrative hearing;

(8) If licensure is denied, the applicant must wait at least six months following the date of notification of denial before reapplying.

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WAC 388-865-0472 Licensing categories

The mental health division assigns the community support service applicant or licensee one of the following types of licenses:

(1) Provisional license. This category is given only to a new applicant. The mental health division may grant a provisional license for up to one year if the provider, has:

(a) An acceptable detailed plan for the development and operation of the services;

(b) The availability of administrative and clinical expertise required to develop and provide the planned services;

(c) The fiscal management and existence or projection of resources to reasonably ensure stability and solvency; and

(d) A corrective action plan approved by the mental health division, if applicable, for any deficiencies.

(2) Full License. Full licensure means that the applicant or licensee is in substantial compliance with the law, applicable rules and regulations, and state minimum standards.

(3) Probationary license. The mental health division may issue a probationary license if the service provider is substantially out of compliance with the requirements of state and federal law, applicable rules and regulations and state minimum standards. The mental health division provides the service provider with a written notice of the deficiencies.

(a) If the deficiency has caused or is likely to cause serious injury, harm, impairment or death to a consumer the deficiencies must be corrected within a timeframe specified by the mental health division;

(b) If the provider fails to complete a corrective action plan or correct deficiencies according to the corrective action plan, the license may be suspended or revoked;

(c) To regain full licensure, a service provider in probationary status must provide a written statement to the

mental health division when it has made all required corrective actions and now complies with relevant federal and state law, applicable rules and regulations, and state minimum standards;

(d) The mental health division may conduct an on-site review to confirm that the corrections have been made.

(4) The mental health division may perform an onsite visit to determine the validity of a complaint or notice that a community support service provider is out of compliance with law, applicable rules and regulations, and state minimum standards.

(5) If the service provider does not demonstrate compliance with the requirements of this section, the mental health division may initiate procedures to suspend or revoke a license consistent with state and federal laws, rules and regulations consistent with the provisions of RCW 71.24.035(7) through (11) and of 43.20A.205.

(6) A regional support network or prepaid health plan may choose to contract with a service provider with a provisional license, full license, or probationary license, but may not contract with a provider with a suspended or revoked license.

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WAC 388-865-0474 Fees for community support service provider licensure

(1) Fees are due with an initial application or for annual license renewal;

(2) Fees must be paid for a minimum of one year;

(3) If an application is withdrawn prior to issuance or denial, one-half of the fees may be refunded at the request of the applicant;

(4) A change in ownership requires a new license and payment of fees;

(5) Fee payments must be made by check, electronic fund transfer, or money order made payable to the mental health division;

(6) Fees will not be refunded if a license or certificate is denied, revoked, or suspended;

(7) Failure to pay fees when due will result in suspension or denial of the license;

(8) The following fees must be sent with the application for a license or renewal:

Range	Service Hours	Annual Fee
1	[illegible]-3,999	$291.00
2	4,000-14,999	422.00
3	[illegible]	[illegible]

4	30,000-49,999	842.00
5	50,000 or more	1,030.00

(9) Annual service hours are computed on the most recent year. For new entities, annual service hours equals the projected service hours for the year of licensure. The provider must report the number of annual service hours based on the mental health division consumer information system data dictionary.

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WAC 388-865-0476 Licensure based on deemed status

(1) The mental health division may deem compliance with state minimum standards and issue a community support service license based on the provider being currently accredited by a national accreditation agency recognized by and having a current agreement with the mental health division. Deeming will be in accordance with the established agreement between the mental health division and the accrediting agency.

(2) The mental health division will only grant licensure based on deemed status to providers with a full license as defined in WAC 388-865-0472.

(3) Specific requirements of state regulation, contract or policy will be waived through a deeming process consistent with the working agreement between the mental health division and the accrediting agency;

(4) Specific requirements of state or federal law, or regulation will not be waived through a deeming process.

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WAC 388-865-0478 Renewal of a community support service provider license

(1) Each year the community support service provider must renew its license. The community support service provider sends the reapplication for licensure to mental health division along with the required fee.

(2) If the service provider contracts with the regional support network or prepaid health plan it must send a copy of the application to the regional support network or mental health prepaid health plan. The regional support network or mental health prepaid health plan may make written comments to the mental health division about renewing the service provider's license. They must send the service provider a copy.

(3) The mental health division considers the request for renewal, along with any recommendations from the regional

support network or mental health prepaid health plan and the results of any onsite reviews completed.

(4) If the provider is in compliance with applicable laws and standards, the mental health division sends the service provider a renewed license, with a copy to the regional support network or mental health prepaid health plan if applicable.

(5) Failure to submit the annual application for renewal license and/or to pay fees when due results in expiration of the license and the provider will be placed on probationary status.

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WAC 388-865-0480 Procedures to suspend, or revoke a license

(1) The mental health division may suspend, revoke, limit or restrict the license of a community support service provider, or refuse to grant or renew a license for failure to conform to the law, applicable rules and regulations, or state minimum standards.

(2) The mental health division may suspend, revoke, limit or restrict the license of a service provider immediately if there is imminent risk to consumer health and safety.

(3) The mental health division sends a written decision to revoke, suspend, or modify the former licensure status under RCW 43.20A.205, with the reasons for the decision and informing the service provider of its right to an administrative hearing. A copy of the letter will be sent to the area regional support network.

(4) A regional support network or mental health prepaid health plan must not contract with a service provider with a suspended or revoked license.

(5) The mental health division may suspend or revoke a license when a service provider in probationary status fails to correct the health and safety deficiencies as agreed in the corrective action plan with the mental health division.

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WAC 388-865-0482 Procedures to contest a licensing decision

To contest a decision by the mental health division, the service provider, regional support network, or mental health prepaid health plan must, within twenty-eight calendar days:

(1) File a written application for a hearing with a method that shows proof of receipt to: The Board of Appeals, P.O. Box 2465, Olympia, WA 98504; and

(2) Include in the appeal:

a. The issue to be reviewed and the date the decision was made;

(b) A specific statement of the issue and law involved;

(c) The grounds for contesting a decision of the mental health division; and

(d) A copy of the mental health division decision that is being contested.

(3) The appeal must be signed by the director of the service provider and include the address of the service provider.

(4) The decision will be made following the requirements of the Administrative Procedure Act, chapter 34.05 RCW and chapter 388-02 WAC.

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WAC 388-865-0484 Process to certify providers of involuntary services

In order to be certified to provide services to consumers on an involuntary basis, the provider must comply with the following process:

(1) Be licensed as a community support provider consistent with this section or licensed as a community hospital by the department of health;

(2) Complete and submit an application for certification to the regional support network;

(3) The regional support network selects providers for certification and makes a request to the mental health division for certification;

(4) The mental health division conducts an on-site review to examine agency policies and procedures, personnel records, clinical records, financial documents, and any other information that may be necessary to confirm compliance with minimum standards of this section;

(5) The mental health division grants certification based on compliance with the minimum standards of this section and chapter 71.05 RCW;

(6) The certificate may be renewed annually at the request of the regional support network and the provider's continued compliance with the minimum standards of this section;

(7) The procedures to suspend or revoke a certificate are the same as outlined WAC 388-865-0468;

(8) The appeal process to contest a decision of the mental health decision is the same as outlined in WAC 388-865-0462

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SECTION FIVE–INPATIENT EVALUATION AND TREATMENT FACILITIES

WAC 388-865-0500 Inpatient evaluation and treatment facilities

The mental health division certifies facilities to provide involuntary inpatient evaluation and treatment services for more than twenty-four hours. Facilities must be certified in order to provide services to consumers who are authorized by the regional support network or mental health prepaid health plan to receive psychiatric inpatient evaluation and treatment services on an involuntary basis.

(1) The following facilities must be licensed by the department of health:

(a) General hospital;

(b) Psychiatric hospital; or

(c) Residential (nonhospital) inpatient facility such as adult residential rehabilitation centers and psychiatric institutions for children and youth.

(2) The following state psychiatric hospitals for adults or children are not licensed by the state, but certified by the Health Care Financing Administration and accredited by the Joint Commission on Accreditation of Healthcare Organizations:

(a) Eastern state hospital;

(b) Western state hospital; and

(c) Child study and treatment center.

(3) No correctional institution or facility, juvenile court detention facility, or jail may be used as an inpatient evaluation and treatment facility within the meaning of this chapter.

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WAC 388-865-0501 Certification based on deemed status

(1) The mental health division may deem compliance with state minimum standards and issue an inpatient evaluation and treatment certificate based on the provider being currently accredited by a national accreditation agency recognized by and having a current agreement with the mental health division. Deeming will be in accordance with the established agreement between the mental health division and the accrediting agency;

(2) The mental health division will only grant certification based on deemed status to providers that have

attained full certification as defined in WAC 388-865-0472;

(3) Specific requirements of state regulation, contract or policy will be waived through a deeming process consistent with the working agreement between the mental health division and the accrediting agency;

(4) Specific requirements of state or federal law or regulation will not be waived through a deeming process.

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WAC 388-865-0502 Single bed certification

At the discretion of the mental health division, an exception may be granted to allow treatment to an adult on a seventy-two hour detention or fourteen-day commitment in a facility that is not certified under WAC 388-865-0500 or for a maximum of thirty days to allow a community facility to provide treatment to an adult on a ninety- or one hundred eighty-day inpatient involuntary commitment order.

(1) The regional support network or its designee must submit a written request for a single bed certification to the mental health division prior to the commencement of the order;

(2) The facility receiving the single bed certification must meet all requirements of this section unless specifically waived by the mental health division;

(3) The request for single bed certification must describe why the consumer meets at least one of the following criteria:

(a) The consumer requires services that are not available at a state psychiatric hospital; or

(b) The consumer is expected to be ready for discharge from inpatient services within the next thirty days and being at a community facility would facilitate continuity of care.

(4) The mental health division director or the director's designee makes the decision and gives written notification to the requesting regional support network in the form of a single bed certification. The single bed certification must not contradict a specific provision of federal law or state statute;

(5) The mental health division may make site visits at any time to verify that the terms of the single bed certification are being met. Failure to comply with any term of the exception certification may result in corrective action or, if the mental health division determines that the violation places consumers in imminent jeopardy, immediate revocation of the certification;

(6) Neither consumers nor facilities have fair hearing rights as defined under chapter 388-02 WAC regarding single bed certification decisions by mental health division staff.

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WAC 388-865-0504 Exception to rule--Long-term certification

(1) At the discretion of the mental health division, a facility may be granted an exception to WAC 388-865-0229 in order to allow the facility to be certified to provide treatment to adults on ninety-or one hundred eighty-day inpatient involuntary commitment orders.

(2) The exception certification may be requested by the facility, the director of the mental health division or his designee, or the RSN for the facility's geographic area.

(3) The facility receiving the exception certification for ninety- or one hundred eighty-day patients must meet all requirements found in chapter 388-865 WAC for the evaluation and treatment facility short-term inpatient component.

(4) The exception certification must be signed by the director of the mental health division. The exception certification may impose additional requirements, such as types of patients allowed and not allowed at the facility, reporting requirements, requirements that the facility immediately report suspected or alleged incidents of abuse, or any other requirements that the director of the mental health division determines are necessary for the best interests of patients.

(5) The mental health division may make unannounced site visits at any time to verify that the terms of the exception certification are being met. Failure to comply with any term of the exception certification may result in corrective action or, if the mental health division determines that the violation places patients in imminent jeopardy, immediate revocation of the certification.

(6) Neither consumers nor facilities have fair hearing rights as defined under chapter 388-02 WAC regarding the decision to grant or not to grant exception certification.

WAC 388-865-0505 Evaluation and treatment facility certification--Minimum standards

To gain and maintain certification to provide inpatient evaluation and treatment services under chapter 71.05 and 71.34 RCW, a facility must meet applicable local, state and federal laws and regulations including department of health licensure requirements and WAC 388-865-500 through 388-865-560:

(1) Designate a physician or other mental health professional as the professional person in charge of that facility. This person must be given the authority and be responsible for:

(a) Making admission and discharge decisions on behalf of that facility;

(b) Supervision of clinical services provided by the

facility; and

(c) Explore less restrictive alternatives, in considering the filing of all petitions for involuntary commitments to inpatient treatment including possible community support or residential treatment, to see if the consumer can be as well or better served, preferably within his or her home community.

(2) Have the capability to admit consumers needing inpatient evaluation and treatment services seven days a week, twenty-four hours a day. Psychiatric institutions for children and youth are exempted from this requirement;

(3) Have at least one seclusion room meeting the requirements of WAC 246-320-365(12)(d)(ii);

(4) Assure access to necessary medical treatment, emergency life-sustaining treatment, and medication.

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WAC 388-865-0510 Standards for administration

The inpatient evaluation and treatment facility must develop policies to address the following administrative requirements:

(1) Protect clinical records against loss, defacement, tampering, or use by unauthorized persons;

(2) Maintain adequate fiscal accounting records;

(3) Bill and collect payment for services from all private payors and third party payors, including Medicaid and Medicare consumers;

(4) Ensure the protection of consumer and family rights as described in this chapter and chapter 71.05 and 71.34 RCW;

(5) Maintain written protocols to physically and legally detain a consumer who refuses voluntary treatment and meets the legal criteria for involuntary commitment, including the method to contact the county designated mental health professional;

(6) Maintain written procedures for managing assaultive and/or self-injurious consumer behavior;

(7) Maintain written procedures to ensure the safety of children and adults in an inpatient evaluation and treatment facility:

(a) Adults must be separated from children who are not yet thirteen years of age;

(b) Children who have had their thirteenth birthday, but are under the age of eighteen, may be served with adults only if the child's clinical record contains a professional judgment saying that placement in an adult facility will not be harmful to the child or adult.

(8) Develop policies and procedures to inform and provide relevant information on persons who are absent from the facility without leave consistent with RCW 71.05.410 and 71.05.420;

(9) Maintain written procedures to either admit all consumers who have been detained or arrange for transfer to a more appropriate facility only after it is confirmed that the facility will admit the consumer;

(10) Maintain written procedures to ensure the protection of the consumer's property including:

(a) Inventory articles brought to the facility and not kept by the consumer;

(b) Use reasonable precautions to safeguard the property of the consumer.

(11) If the facility treats children, it must maintain written procedures to ensure that:

(a) Whenever a child is conditionally released or discharged before the end of the commitment, the professional person in charge gives the court written notice of the release within three days of the release. If the child is on a one a one hundred and eighty day commitment the children's long-term inpatient placement committee must also be notified.

(b) If the child elopes, the professional person in charge immediately notifies the parents and the appropriate law enforcement agencies.

(12) Maintain written procedures to ensure that upon discharge of a consumer of voluntary services:

(a) The consumer's permission is sought for release of a clinical summary to the community physician, psychiatrist, or therapist of his/her choice, or to the local treatment facility or licensed service provider.

(b) Information sharing complies with RCW 71.05.390.

(c) The consumer is advised of his or her competency and given the following written notice: "No person is presumed incompetent nor does any person lose any civil rights as a consequence of receiving evaluation and treatment services for a mental disorder, whether voluntary or involuntary, as required by RCW 71.05.390."

(13) Maintain written procedures to ensure that the county designated mental health professional who detained a person can not also be one of the two mental health professionals who examines and evaluates a person within twenty-four hours of admission to determine what treatment he or she requires. An exception can be made only by the director or the mental health division and because no other mental health professional is reasonably available to do the necessary examination and evaluation.

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WAC 388-865-0515 Admission and intake evaluation

The provider must include the following documentation in the intake evaluation:

(1) An initial treatment plan;

(2) A copy of any advance directives, powers of attorney or letters of guardianship provided by the consumer;

(3) That the consumer was advised of his/her rights;

(4) Consideration of a less restrictive treatment alternative for each patient at the time of detention, admission, and discharge;

(5) For consumers who have been involuntarily detained, evaluations to determine the nature of the disorder, the treatment necessary, and whether or not detention is required at least within twenty-four hours of the initial detention of the consumer, including Saturdays, Sundays and holidays. The evaluation must include at least a:

(a) Medical evaluation by a an appropriately licensed medical professional within his/her scope of practice; and

(b) Psychosocial evaluation by a mental health professional.

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WAC 388-865-0525 Clinical record

The treatment record for each consumer must contain:

(1) A comprehensive plan for treatment developed collaboratively with the consumer;

(2) Copies of advance directives, powers of attorney or letters of guardianship provided by the consumer.

(3) A plan for discharge including a plan for follow-up where appropriate;

(4) Sufficient information to justify the diagnosis;

(5) Documentation that the facility has provided for or arranged for diagnostic and therapeutic services prescribed by the attending professional staff. This may include participation of a multi-disciplinary team or mental health specialists as defined in WAC 388-865-0150, or collaboration with members of the consumer's support system as identified by the consumer;

(6) Documentation of the course of treatment;

(7) Documentation that a mental health professional has contact with each involuntary consumer at least daily for the purpose of:

(a) Observation;

(b) Evaluation; and

(c) Continuity of treatment.

(8) Documentation that a mental health professional and

licensed physician are available for consultation and communication with both the consumer and the direct patient care staff twenty-four hours a day, seven days a week;

(9) Documentation of evaluation of each involuntarily committed consumer for release from commitment at least weekly for fourteen-day commitments.

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WAC 388-865-0530 Competency requirements for staff

In order to gain and maintain certification as an inpatient evaluation and treatment facility, the provider must document that staff are qualified for the position they hold and have the education, experience, or skills to perform the job requirements, including:

(1) All staff have a current Washington state department of health license or certificate or registration as may be required for his/her position;

(2) Washington state patrol background checks are conducted for employees in contact with consumers consistent with RCW 43.43.830;

(3) Clinical supervisors meet the qualifications of mental health professionals or specialists as defined in WAC 388-865-0150;

(4) Staff receive an annual performance evaluation; and

(5) An individualized annual training plan must be implemented for each direct service staff person and supervisor in the skills he or she needs for his/her job description and the population they serve. Such training must include at least:

(a) Least restrictive alternative options available in the community and how to access them;

(b) Methods of patient care;

(c) Management of assaultive and self-destructive behavior; and

(d) The requirements of chapter 71.05 and 71.34 RCW, this chapter, and protocols developed by the mental health division.

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WAC 388-865-0535 The process for gaining certification and renewal of certification

These processes are the same as described in WAC 388-865-0434.

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WAC 388-865-0540 Fees for evaluation and treatment facility certification

Inpatient facilities certified to provide inpatient evaluation

and treatment services are assessed an annual fee of thirty-two dollars per bed.

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WAC 388-865-0545 Use of seclusion and restraint procedures—Adults

Consumers have the right to be free from seclusion and restraint, including chemical restraint. The use of restraints or seclusion must occur only when there is imminent danger to self or others and less restrictive measures have been determined to be ineffective to protect the consumer or others from harm and the reasons for the determination are clearly documented. The evaluation and treatment facility must develop policies and procedures to assure that restraint and seclusion procedures are utilized only to the extent necessary to ensure the safety of patients and others:

(1) Staff must notify, and receive authorization by, a physician within one hour of initiating patient restraint or seclusion;

(2) The consumer must be informed of the reasons for use of seclusion or restraint and the specific behaviors which must be exhibited in order to gain release from these procedures;

(3) The clinical record must document staff observation of the consumer at least every fifteen minutes and observation recorded in the consumer's clinical record;

(4) If the use of restraint or seclusion exceeds twenty-four hours, a licensed physician must assess the consumer and write a new order if the intervention will be continued. This procedure is repeated again for each twenty-four hour period that restraint or seclusion is used;

(5) All assessments and justification for the use of seclusion or restraint must be documented in the consumer's medical record.

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WAC 388-865-0546 Use of seclusion and restraint procedures—Children

Consumers have the right to be free from seclusion and restraint, including chemical restraint. The use of restraints or seclusion must occur only when there is imminent danger to self or others and less restrictive measures have been determined to be ineffective to protect the consumer or others from harm and the reasons for the determination are clearly

documented. The evaluation and treatment facility must develop policies and procedures to assure that restraint and seclusion procedures are utilized only to the extent necessary to ensure the safety of patients and others:

(1) In the event of an emergency use of restraints or seclusion, a licensed physician must be notified within one hour and must authorize the restraints or seclusion;

(2) No consumer may be restrained or secluded for a period in excess of two hours without having been evaluated by a mental health professional. Such consumer must be directly observed every fifteen minutes and the observation recorded in the consumer's clinical record;

(3) If the restraint or seclusion exceeds twenty-four hours, the consumer must be examined by a licensed physician. The facts determined by his or her examination and any resultant decision to continue restraint or seclusion over twenty-four hours must be recorded in the consumer's clinical record over the signature of the authorizing physician. This procedure must be repeated for each subsequent twenty-four hour period of restraint or seclusion.

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WAC 388-865-0550 Rights of all consumers who receive community inpatient services

The rights assured by RCW 71.05.370 and the following rights must be prominently posted within the department or ward of the community or inpatient evaluation and treatment facility. You have the right to:

(1) Adequate care and individualized treatment.

(2) To have all information and records compiled, obtained, or maintained in the course of receiving services kept confidential, under the provisions of RCW 71.05.390, 71.05.420, and 71.34.160.

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WAC 388-865-0555 Rights of consumers receiving involuntary inpatient services

Consumers who are receiving inpatient services involuntarily have the rights provided in RCW 71.05.370 plus the following rights. The provider must ensure consumers are informed of his or her rights and that all consumer rights are protected, including:

(1) At admission, each consumer must be informed in writing or orally of his or her rights to have a responsible member of the immediate family if possible, guardian or conservator, if any, and such other person as designated by the consumer given

written notice of the consumer's inpatient status, and his or her rights as an involuntary consumer;

(2) A medical and psychosocial evaluation within twenty-four hours of admission to determine whether continued detention in the facility is necessary;

(3) A judicial hearing before a superior court if the consumer is not released within seventy-two hours (excluding Saturdays, Sundays, and holidays), to decide if continued detention within the facility is necessary.

[]

WAC 388-865-0557 Rights related to antipsychotic medication.

All consumers have a right to make an informed decision regarding the use of antipsychotic medication consistent with the provisions of RCW 71.05.370(7) and 71.05.215. The provider must develop and maintain a written protocol for the involuntary administration of antipsychotic medications, including the following requirements:

(1) At the time of admission inform the consumer of his or her right to:

(a) Make an informed decision regarding the use of antipsychotic medication;

(b) Refuse all treatment except lifesaving treatment beginning twenty-four hours prior to any hearing;

(c) Refuse antipsychotic medication beginning twenty-four hours before any court proceeding wherein the consumer has the right to attend and is related to his or her continued commitment;

(d) The consumer must be asked if he or she wishes to decline treatment during the twenty-four hour period, and the answer must be in writing and signed when possible. Compliance with this procedure must be documented in the consumer's clinical record.

(2) The clinical record must document:

(a) The physician's attempt to obtain informed consent;

(b) The reasons why any antipsychotic medication is administered over the consumer's objection or lack of consent.

(3) The physician may administer antipsychotic medications over a consumer's objections or lack of consent only when:

(a) An emergency exists, provided there is a review of this decision by a second physician within twenty-four hours. An emergency exists if:

(i) The consumer presents an imminent likelihood of serious harm to self or others;

(ii) Medically acceptable alternatives to administration of antipsychotic medications are not available or are unlikely to

be successful; and

(iii) In the opinion of the physician, the consumer's condition constitutes an emergency requiring that treatment be instituted before obtaining an additional concurring opinion by a second physician.

(b) There is an additional concurring opinion by a second physician for treatment up to thirty days;

(c) For continued treatment beyond thirty days through the hearing on any one hundred eighty-day petition filed under RCW 71.05.370(7), provided the facility medical director or director's medical designee reviews the decision to medicate a consumer. Thereafter, antipsychotic medication may be administered involuntarily only upon order of the court. The review must occur at least every sixty days.

(4) The examining physician must sign all one hundred eighty-day petitions for antipsychotic medications files under the authority of RCW 71.05.370(7);

(5) Consumers committed for one hundred eighty days who refuse or lack the capacity to consent to antipsychotic medications have the right to a court hearing under RCW 71.05.370(7) prior to the involuntary administration of antipsychotic medications;

(6) In an emergency, antipsychotic medications may be administered prior to the court hearing provided that an examining physician files a petition for an antipsychotic medication order the next judicial day;

(7) All involuntary medication orders must be consistent with the provisions of RCW 71.05.370(7)(a) and (b), whether ordered by a physician or the court;

(8) This section does not preclude use of physical restraints and/or seclusion in compliance with WAC 388-865-0545 and 388-865-0546.

[]

WAC 388-865-0560 Rights of consumers who receive emergency and inpatient services voluntarily

(1) At admission, each consumer must be informed in writing or orally of his or her right to immediate release, and other rights as defined in this section and in RCW 71.05.[illegible] for adults and chapter 71.34 RCW for children.

(2) The following rights of voluntary consumers must be prominently displayed within the department or ward where the consumer is housed. You have the right to:

(a) Release, unless involuntary commitment proceedings are initiated.

(b) A review of condition and status at least each [illegible]

hundred and eighty days as required under RCW 71.05.050, 71.05.380, and 72.23.070.

(3) All voluntary consumers have the right to:

(a) Adequate care and individualized treatment;

(b) Make an informed decision about the use of antipsychotic medication.

[]

WAC 388-865-0565 Petition for the right to possess a firearm

A person is entitled to the immediate restoration of the right to firearm possession when he or she no longer require treatment or medication for a condition related to the involuntary commitment. This is described in RCW 9.41.040(6)(c).

(1) The person who wants his or her right to possess a firearm restored may petition the court that ordered involuntary treatment or the superior court of the county in which he or she lives for a restoration of the right to possess firearms. At a minimum, the petition must include:

(a) The fact, date, and place of involuntary treatment;

(b) The fact, date, and release from involuntary treatment;

(c) A certified copy of the most recent order of commitment with the findings and conclusions of law.

(2) The person must show the court that he/she no longer require treatment or medication for the condition related to the commitment.

(3) If the court requests relevant information about the commitment or release to make a decision, the mental health professionals who participated in the evaluation and treatment must give the court that information.

[]

SECTION SIX--DEPARTMENT OF CORRECTIONS ACCESS TO CONFIDENTIAL MENTAL HEALTH INFORMATION

WAC 388-865-0600 Purpose

In order to enhance and facilitate the department of corrections' ability to carry out its responsibility of planning and ensuring community protection, mental health records and information, as defined in this section, that are otherwise confidential shall be released by any mental health service provider to the department of corrections personnel for whom the information is necessary to carry out the responsibilities of their office as authorized in RCW 71.05.445 and 71.34.225. Department of corrections personnel must use records only for the stated purpose and must assure that records remain confidential and subject to the limitations on disclosure outlined in chapter 71.05 RCW, except as provided in RCW 72.09.585.

[]

WAC 388-865-0610 Definitions

Relevant records and reports includes written documents obtained from other agencies or sources, often referred to as third-party documents, as well as documents produced by the agency receiving the request. Relevant records and reports do not include the documents restricted by either federal law or federal regulation related to treatment for alcoholism or drug dependency or the Health Insurance Portability and Accountability Act or state law related to sexually transmitted diseases, as outlined in RCW 71.05.445 and 71.34.225.

(1) **"Relevant records and reports"** means:

(a) Records and reports of inpatient treatment:

(i) Inpatient psychosocial assessment - Any initial, interval, or interim assessment usually completed by a person with a master's degree in social work (or equivalent) or equivalent document as established by the holders of the records and reports;

(ii) Inpatient intake assessment - The first assessment completed for an admission, usually completed by a psychiatrist or other physician or equivalent document as established by the holders of the records and reports:

(iii) Inpatient psychiatric assessment - Any initial

interim, or interval assessment usually completed by a psychiatrist (or professional determined to be equivalent) or equivalent document as established by the holders of the records and reports;

(iv) Inpatient discharge/release summary - Summary of a hospital stay usually completed by a psychiatrist (or professional determined to be equivalent) or equivalent document as established by the holders of the records and reports;

(v) Inpatient treatment plan - A document designed to guide multi-disciplinary inpatient treatment or equivalent document as established by the holders of the records and reports;

(vi) Inpatient discharge and aftercare plan database - A document designed to establish a plan of treatment and support following discharge from the inpatient setting or equivalent document as established by the holders of the records and reports.

(b) Records and reports of outpatient treatment:

(i) Outpatient intake evaluation - Any initial or intake evaluation or summary done by any mental health practitioner or case manager the purpose of which is to provide an initial clinical assessment in order to guide outpatient service delivery or equivalent document as established by the holders of the records and reports;

(ii) Outpatient periodic review - Any periodic update, summary, or review of treatment done by any mental health practitioner or case manager. This includes, but is not limited to: documents indicating diagnostic change or update; annual or periodic psychiatric assessment, evaluation, update, summary, or review; annual or periodic treatment summary; concurrent review; individual service plan as required by WAC 388-865-0425 through 388-865-0430, or equivalent document as established by the holders of the records and reports;

(iii) Outpatient crisis plan - A document designed to guide intervention during a mental health crisis or decompensation or equivalent document as established by the holders of the records and reports;

(iv) Outpatient discharge or release summary - Summary of outpatient treatment completed by a mental health professional or case manager at the time of termination of outpatient services or equivalent document as established by the holders of the records and reports;

(v) Outpatient treatment plan - A document designed to guide multi-disciplinary outpatient treatment and support or equivalent document as established by the holders of the records and reports.

(c) Records and reports regarding providers and medications:

(i) Current medications and adverse reactions - A list of all known current medications prescribed by the licensed practitioner to the individual and a list of any known adverse reactions or allergies to medications or to environmental agents;

(ii) Name, address and telephone number of the case manager or primary clinician.

(d) Records and reports of other relevant treatment and evaluation:

(i) Psychological evaluation - A formal report, assessment, or evaluation based on psychological tests conducted by a psychologist;

(ii) Neuropsychological evaluation - A formal neuropsychological report, assessment, or evaluation based on neuropsychological tests conducted by a psychologist;

(iii) Educational assessment - A formal report, assessment, or evaluation of educational needs or equivalent document as established by the holders of the records and reports;

(iv) Functional assessment - A formal report, assessment, or evaluation of degree of functional independence. This may include but is not limited to: occupational therapy evaluations, rehabilitative services database activities assessment, residential level of care screening, problem severity scale, instruments used for functional assessment or equivalent document as established by the holders of the records and reports;

(v) Forensic evaluation - An evaluation or report conducted pursuant to chapter 10.77 RCW;

(vi) Offender/violence alert - A any documents pertaining to statutory obligations regarding dangerous or criminal behavior or to dangerous or criminal propensities. This includes, but is not limited to, formal documents specifically designed to track the need to provide or past provision of: duty to warn, duty to report child/elder abuse, victim/witness notification, violent offender notification, and sexual/kidnapping offender notification per RCW 4.24.550, 10.77.205, 13.40.215, 13.40.217, 26.44.330, 71.05.1[illegible], 71.05.330, 71.05.340, 71.05.425, 71.09.140, and 74.34.035;

(vii) Risk assessment - Any tests or formal evaluations administered or conducted as part of a formal violence or criminal risk assessment process that is not specifically addressed in any psychological evaluation or neuropsychological evaluation.

(e) Records and reports of legal status - Legal documents are documents filed with the court or produced by the court indicating current legal status or legal obligations including but not limited to:

(i) Legal documents pertaining to chapter 71.05 RCW;

(ii) Legal documents pertaining to chapter 71.34;

(iii) Legal documents containing court findings pertaining to chapter 10.77 RCW;

(iv) Legal documents regarding guardianship of the person;

(v) Legal documents regarding durable power of attorney;

(vi) Legal or official documents regarding a protective payee;

(vii) Mental health advance directive.

(2) **"Relevant information"** means descriptions of a consumer's participation in, and response to, mental health treatment and services not available in a relevant record or report, including all statutorily mandated reporting or duty to warn notifications as identified in WAC 388-865-610(1)(d)(vi), Offender/Violence alert, and all requests for evaluations for involuntary civil commitments under chapter 71.05 RCW. The information may be provided in verbal or written form at the discretion of the mental health service provider.

[]

WAC 388-865-0620 Scope

Many records and reports are updated on a regular or as needed basis. The scope of the records and reports to be released to the department of corrections are dependent upon the reason for the request.

(1) For the purpose of a pre-sentence investigation release only the most recently completed or received records of those completed or received within the twenty-four-month period prior to the date of the request; or

(2) For all other purposes release all versions of records and reports that were completed or received within the ten year period prior to the date of the request that are still available.

[]

WAC 388-865-0630 Time frame

The mental health service provider shall provide the requested relevant records, reports and information to the authorized department of corrections person in a timely manner, according to the purpose of the request:

(1) Pre-sentence investigation - within seven calendar days of the receipt of the request. If some or all of the requested relevant records, reports and information are not available within that time period the mental health service provider shall notify the authorized department of corrections person prior to

the end of the seven-day-period and provide the requested relevant records, reports or information within a mutually agreed to time period; or

(2) All other purposes - within thirty calendar days of the receipt of the request. If some or all of the requested relevant records, reports and information are not available within that time period the mental health service provider shall notify the authorized department of corrections person prior to the end of the thirty-day period and provide the requested relevant records, reports or information within a mutually agreed to time period.

[]

WAC 388-865-0640 Written requests

The written request for relevant records, reports and information shall include:

(1) Verification that the person for whom records, reports and information are being requested is under the authority of the department of corrections, per chapter 9.94A RCW, and the expiration date of that authority.

(2) Sufficient information to identify the person for whom records, reports and information are being requested including name and other identifying data.

(3) Specification as to which records and reports are being requested and the purpose for the request.

(4) Specification as to what relevant information is requested and the purpose for the request.

(5) Identification of the department of corrections person to whom the records, reports and information shall be sent, including the person's name, title and address.

(6) Name, title and signature of the requestor and date of the request.

[]

Attachment A.1115c

Washington State DEPARTMENT OF SOCIAL & HEALTH SERVICES

MENTAL HEALTH DIVISION
POLICIES AND PROCEDURES

Approved by: (signature on file)
Karl Brimner, Director
Date issued: July 1, 2001

Effective Date: July 1, 2001

POLICY STATEMENT NO. 4.02

SUBJECT: **SERVICE RECIPIENT DISENROLLMENT DETERMINATION PROCEDURES**

I. PURPOSE

The purpose of this policy is to provide guidance on the processing of requests received by Medicaid service recipients/enrollees for disenrollment from his/her mental health prepaid health plan.
Reference: WAC 388-865-0340

II. SCOPE

This policy applies to employees of the Mental Health Division (MHD) Central Office.

III. POLICY

On a case-by-case basis, the MHD will disenroll a service recipient from his/her mental health prepaid health plan when the service recipient has "good cause" for disenrollment. For the purposes of this policy, "good cause" is defined as the inability of the mental health prepaid health plan to provide medically necessary care that is reasonably available and accessible (WAC 388-865-0340).

IV. PROCEDURE

All requests for service recipient disenrollment from his/her mental health prepaid health plan will be routed to the MHD fair hearing coordinator for processing in accordance with the following guidelines.

A. Disenrollment Due to Changed Circumstances

Due to the provisions already in WAC for disenrollment, there normally should not be a need for a written request for disenrollment to MHD when the service recipient is no longer eligible for Title XIX categorically and medically needy services nor when the person is deceased. A service recipient does not need to request disenrollment from one PHP when the person moves to another PHP.

A 115C

B. Requests for Disenrollment for Good Cause

A Medicaid enrollee may request disenrollment for good cause. The request for disenrollment shall be made to the MHD Fair Hearing Coordinator (FHC). A written request must be submitted, stating the reason(s) for the request. The requestor and/or representative is expected to assist MHD to gather sufficient information to determine whether the request may be justified. Prior to requesting disenrollment from MHD, the Medicaid enrollee must use the local RSN/PHP grievance procedures.

C. Review of Requests for Disenrollment: Initial Process

1. The initial screening will focus on whether the person is Title XIX eligible. The Fair Hearing Coordinator (FHC) will access the MHD internal production database to determine medical eligibility and Third Party Liability information of the individual. If the person requesting disenrollment from the PHP is not a Medicaid enrollee, the FHC will notify the individual that the request for disenrollment does not apply, as the individual is not enrolled in the PHP. The response will include notice that an Ombudsperson is available locally to assist with their concerns and access to service. The response will also inform the individual of the right to request an Administrative Hearing on the determination.

2. If the person is Medicare eligible and Medicaid eligible, the FHC will notify the individual that the request for disenrollment does not apply, as Medicaid coverage is a supplement to Medicare benefits, which is their primary benefit. A Medicare eligible individual is not limited to accessing mental health services from an RSN/PHP. The notification will also include information about accessing Ombuds services and the right to an Administrative Hearing on the determination.

3. If the person is Medicaid eligible but not Medicare eligible, the FHC will proceed with additional procedures for the disenrollment determination.

    - The FHC will determine whether local grievance procedures have been utilized. If they have not, the service recipient will be referred to the local grievance process, including information about how to access the local Ombuds service.

    - If the local grievance procedures have been utilized, the FHC will proceed with the Disenrollment Procedure.

4. The FHC will screen any supporting documentation received with the request for disenrollment and decide whether there appears to be sufficient information available on which to base a determination. If there is insufficient information available to determine whether potential for disenrollment exists, the FHC will respond within fifteen (15) days

from receipt of request with a statement that insufficient information has been received to make a determination.

- Where insufficient information has been provided, the FHC will request additional information. The request will include Release of Information forms that will authorize the department to access additional information from related providers as well as from PHP contractors and relevant others. The FHC will work with the service recipient or his/her representative to gather sufficient information on which to base a determination.

- The initial response to the service recipient will provide information about complaint and grievance processes that exist at the provider and RSN/PHP levels. The service recipient will be notified about how to access the PHP Ombuds service.

D. Review of Disenrollment: Disenrollment Review Panel (DRP)

1. When the FHC has documentation and information that should be sufficient on which to base a determination about a disenrollment request, the information will be submitted to a review panel. A determination as to good cause will be made within fifteen(15) additional days of when sufficient information is available or as provided for in Health Care Finance Administration federal regulations. Notice of further consideration of the request will be given to the service recipient.

2. The DRP will be convened within 10 days of notice to the individual of further consideration of the request. A DRP Chair shall be selected and will be responsible for facilitating the review of the request for disenrollment

E. Panel Composition

- The panel shall be composed of three members. The members shall include:

  - a person who is independent of the MHD and RSN/PHPs;
  - an RSN/PHP representative that is a peer of the RSN/PHP in which the request for disenrollment has been filed;
  - a representative of MHD.

- At least two of the panel members shall have clinical expertise that meets the requirements for the definition of mental health professional. In the case of a child, elder, ethnic minority or person with a disability, at least one of the panel members shall be a mental health specialist appropriate to the characteristics of the individual.

- Each of the panel members will be a voting member. The panel shall strive to arrive at disenrollment determinations by consensus.

- The FHC, who is not a voting member, will provide staff support to the panel.

F. Panel Review Procedures

- A record of the panel's proceedings shall be made.

- The panel will review materials related to the request for disenrollment. The panel may invite the person requesting the disenrollment and others to provide information orally.

- The panel will send a recommendation to the Mental Health Division Director about whether good cause for disenrollment exists within 5 days after it has been called to convene.

G. Basis for Determination

1. The basis for disenrollment shall be predicated upon the terms of the MHD 1915 (b) waiver from HCFA, which states:

   "a recipient may seek disenrollment from a PHP for good cause. Good cause is defined as an inability of the PHP to provide appropriate access or care within the scope of the waiver defined services".

2. It is not the intent of this process to identify each instance in which "Good Cause" may exist. It is the intent of this process for the panel members to consider the circumstances of each individual service recipient's request and to make a pertinent recommendation.

3. When considering whether "Good Cause" may exist, panel members shall review, but are not limited to, the following:

   - the service recipient's medical necessity;
   - whether services are or should be available to others within the RSN/PHP;
   - attempts by the service recipient to access needed services;
   - efforts by the RSN/PHP to provide needed services;
   - whether the RSN/PHP has assured that it and its contractors have assumed the burden of access to services, particularly when the service recipient's needs may be unusual or difficult to serve;

4. Panel members shall not presume that the objective ability of a provider or an RSN/PHP to provide services generally meets .he test of having the ability to deliver services to a particular individual. Decisions about the ability or inability to provide services shall be made on an individual basis.

5. Final Determination
    - The MHD Director or his/her designee will consider the recommendation of the panel and will make a final disenrollment determination.

    - Notification of the decision will be sent to the service recipient requesting the disenrollment or their representative within 5 days of receipt of recommendation from 'he review panel or within HCFA requirements.

    - If the request for disenrollment is approved, the response will inform the service recipient of the name of a person who will contact them to assist in the process of accessing medically necessary services. Notification will include a statement that the services will be paid for through Medicaid benefits at no cost to the service recipient. The service recipient shall also be notified that disenrollment does not preclude the person from enrolling in a PHP at a later date.

    - In the event that the request for disenrollment is denied, the response will also inform the service recipient of the right to request an Administrative Hearing on the determination and inform the person how to access the local Ombuds service.

Attachment A.11d2i

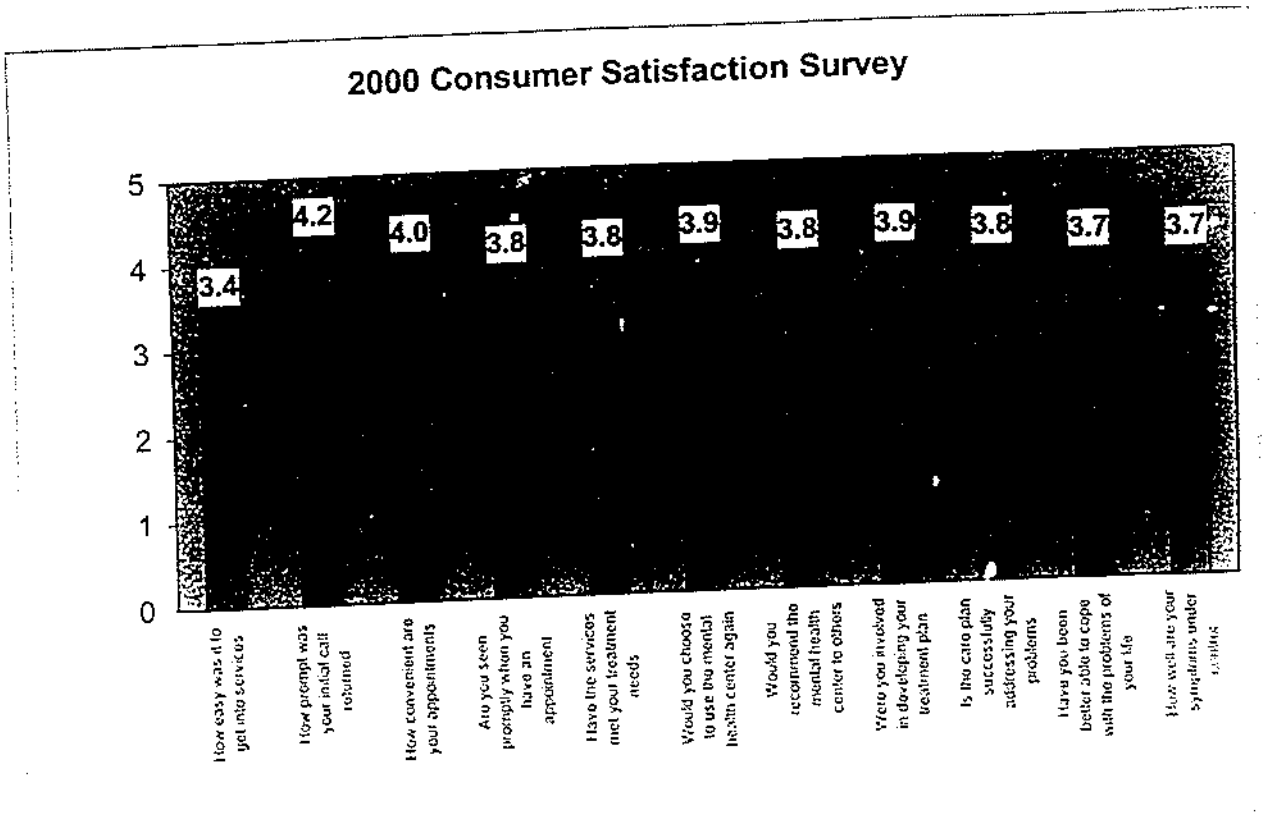
SW RSN

TOTAL 3.38

July TO December 2000 Report Sample 373	A	B	C	D
QUALITY A = Services have been good B = Services have been ok C = Services have not been ok D = Services have been poor	3.45			
AMOUNT A = Services offered have been just right B = Services offered have been about right C = Services offered have not been quite enough D = Services offered have not been enough	3.41			
RESPECT A = I have been treated very well B = I have been treated well C = I have not been treated well D = I have been treated very poorly	3.47			
HELPFULNESS A = Services were extremely helpful B = Services were helpful C = Services were not much help D = Services made things worse	3.30			
RESULTS A = My needs were completely met B = My needs were fairly well met C = Some of my needs were not met D = None of my needs were met	3.15			
RECOMMENDATION A = I would definitely come again and/or refer a friend B = I would probably come again and/or refer a friend C = I'm not sure I would come again nor refer anyone D = I will not come back or tell anyone else to come here	3.45			

PRSN Consumer Report
FY 2000

Consumers, in general, reported high rates of satisfaction with mental health services. A composite sample of the 2000 survey responses is represented in the graph below.



RECEIVED
JUL 13 2001
DSHS/Mental Health

Greater Columbia Behavioral Health

Date: July 10, 2001

GCBH QRT SEMI-ANNUAL REPORT

Prepared by: Joyce Schroeder

Report Period: January 1 – June 30, 2001

1. NUMBER OF MENTAL HEALTH CARE PROVIDER SITE VISITS: 4

1.1 Number of adult consumers in focused interviews and completed satisfaction surveys: **184**

1.2 Number of children consumers in focused interviews and completed satisfaction surveys: **21**

1.3 Number of family members of consumers in focused interviews and completed satisfaction surveys: **0**

1.4 Number of case managers interviewed: **7**

PROVIDER SITES VISITED:

Benton/Franklin
Nueva Esperanza Counseling Center

Klickitat County
Central Washington Comprehensive Mental Health, Goldendale
Central Washington Comprehensive Mental Health, White Salmon

Yakima County
Central Washington Comprehensive Mental Health
(Yakima and Sunnyside)
Clubhouse in Yakima

1.5 Demographic data of consumers/family members:

Gender: Male **82**
Female **123**

Race/Ethnicity:
American Indian/Eskimo **7**
Asian/Pacific Islanders **1**
Black/African American **10**
White/Caucasian **175**
Hispanic **12**
Individuals checking more than one ethnicity **3**

Age Group: 0-13 **9** 14-17 **12** 18-59 **180** 60+ **4**

cc: Sandy, LaToya, Jeannie, Judy G.

A 11d 2 - 3

1.6 Total number of GCBH consumers:

Unduplicated 205 Duplicated ___

2. *NUMBER OF SITE VISITS TO ALLIED SYSTEMS OF CARE: 3*

Hospitals
Memorial ____
St. Mary's ____
Lourdes ____
Eastern State ____
Other _____

Schools
Elementary ____
Middle ____
High School ____
College ____
Other ____

Police Departments ____
Justice Centers ____

Juvenile Detention Centers ____
Juvenile Rehabilitation Centers ____

Nursing Homes ____
Aging and Long-Term Care __1__
Adult Family Homes ____

DCFS ____
CPS ____
Shelters ____

DVR ____
DASA 1 - Quest
DDD ____

Other ____ (see below)
Children and Family Services
Clubhouse

3. *SURVEYS OF GCBH/PHP PERFORMANCE*

3.1 Number of mental health care providers surveyed: 3

3.2 Number of allied care providers surveyed: 3

3.3 Counties included in these surveys: 3

4. *ACTIVITIES, MEETINGS, PROGRAMS PARTICIPATED IN:*

4.1 Meetings Attended:

Board of Directors __5__ Regional Advisory Board __4__ Ombuds ____ Quality Management Oversight Committee __3__ National Alliance for the Mentally Ill __4__ Other (please name): Technical Review Group __1__; Benton/Franklin Mental Health Advisory Board __4__; Consumer Roundtable __2__

4.2 Training Programs Attended:

Basic I 1 – Repeat Basic II ____ Quarterly 3 Other (please explain) Washington Behavioral Healthcare Conference

4.3 Other Programs/Activities (please list): Interviewed for Eastside Consumer-to-Provider Program; regular in-house staff meetings; MHD Integrated Review; revised consumer, staff, and allied provider forms; Excel program for learning MHSIP.

5. ***NUMBER OF SPEAKING ENGAGEMENTS***: 0

5.1 Number of People Attending: 0

5.2 List of organizations, agencies, etc.

1.
2.
3.

1. Sample of strengths identified during mental health care provider visits:
   1. Consumers were very willing to fill out the MHSIP.
   2. Staff was caring and worked well with all ages and ethnic groups.
   3. There was bi-lingual staff at the provider agencies.
   4. They were able to work well with the allied providers in their community.
   5. Consumers felt quality and access to services were very good.

2. Sample of strengths identified during allied systems of care visits:
   Worked well with providers, mostly in rural communities. Sometimes in urban communities it is a little more of a problem. Allied systems were not afraid to refer clients to the mental health system.

3. Sample of strengths identified on Provider surveys of GCBH/PHP performance:
   1. Knowledge of the system in which they work.
   2. Quite knowledgeable about the allied providers.

4. Sample of concerns/findings identified on mental health care provider and allied care site visit:
   More low-cost housing needed. More resources for peer support groups. Consumers are still having symptoms of illness and side effects of medications. Their overall personal life work, study, and recreation can still use some improvement.

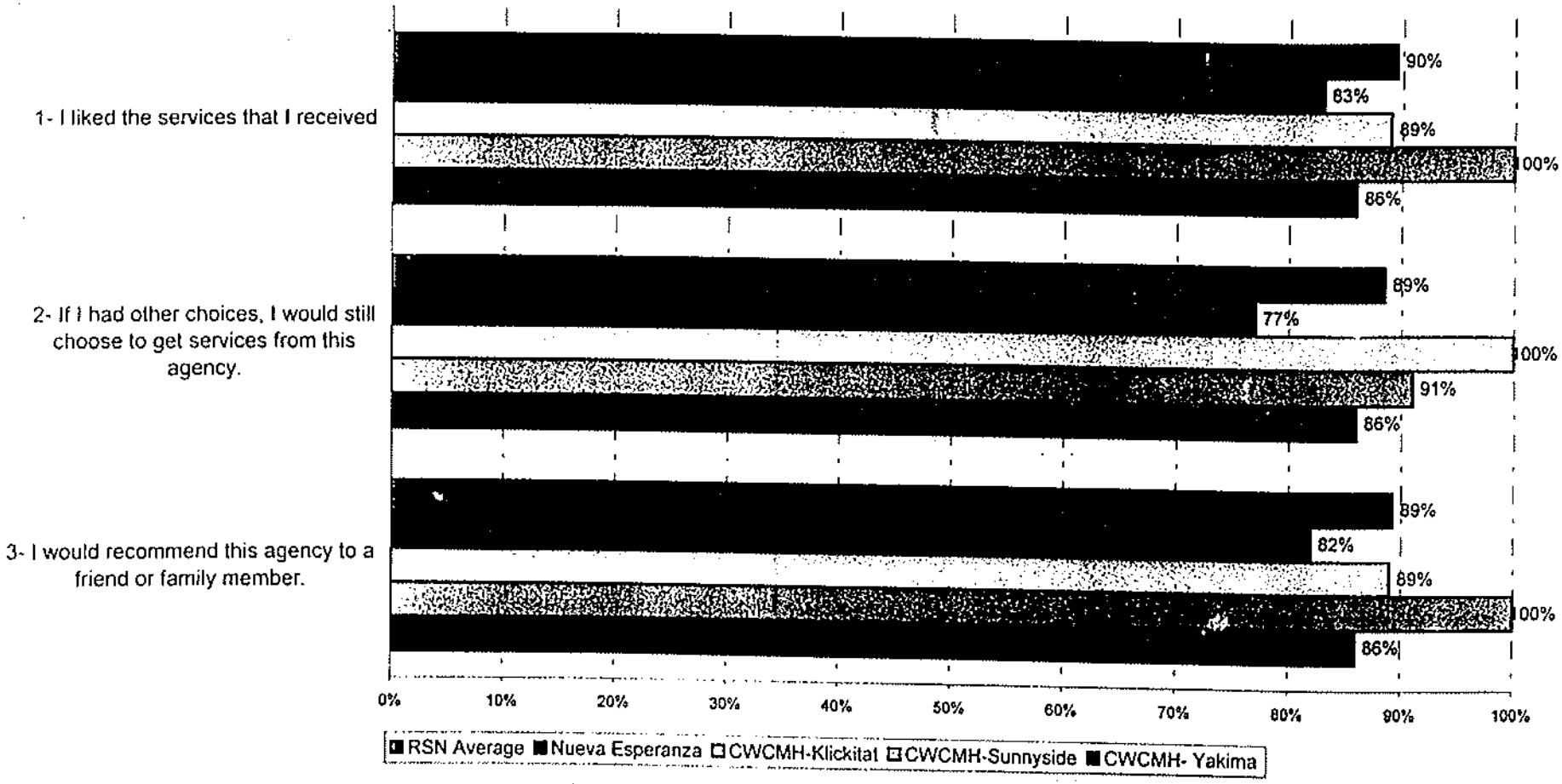
A 11d 2 - 4

5. Sample of Recommendations for Provider System Improvements:
   1. Better coordination between mental health providers and allied systems for the same client.
   2. More training for consumers so they can advocate for themselves.
   3. Lower consumer to staff ratio.
   4. Streamline paper work so staff can spend more time with consumers.
   5. Shorter access time in urban areas.
   6. Better communication is needed between administrative staff and line staff.

The GCBH Quality Review Team started using the short version of MHSIP in 2001 after much consideration. This is the first report that shows the results for four QRT site visits.

The attached graphs show results of consumer satisfaction.

GCBH QRT Semi-Annual Report Jan-June 2001
Satisfaction Survey Results: Domain 1- Consumer Satisfaction



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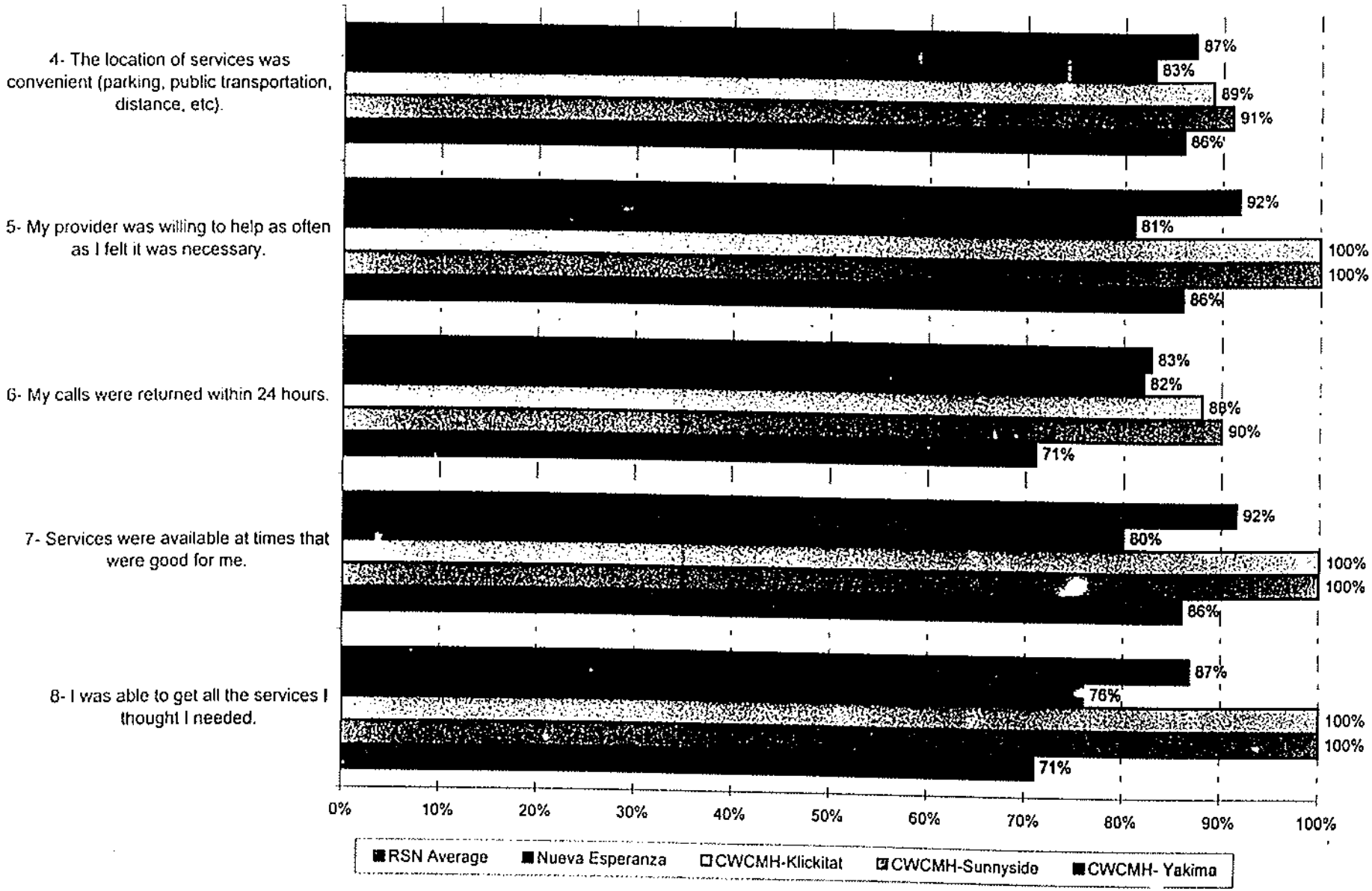
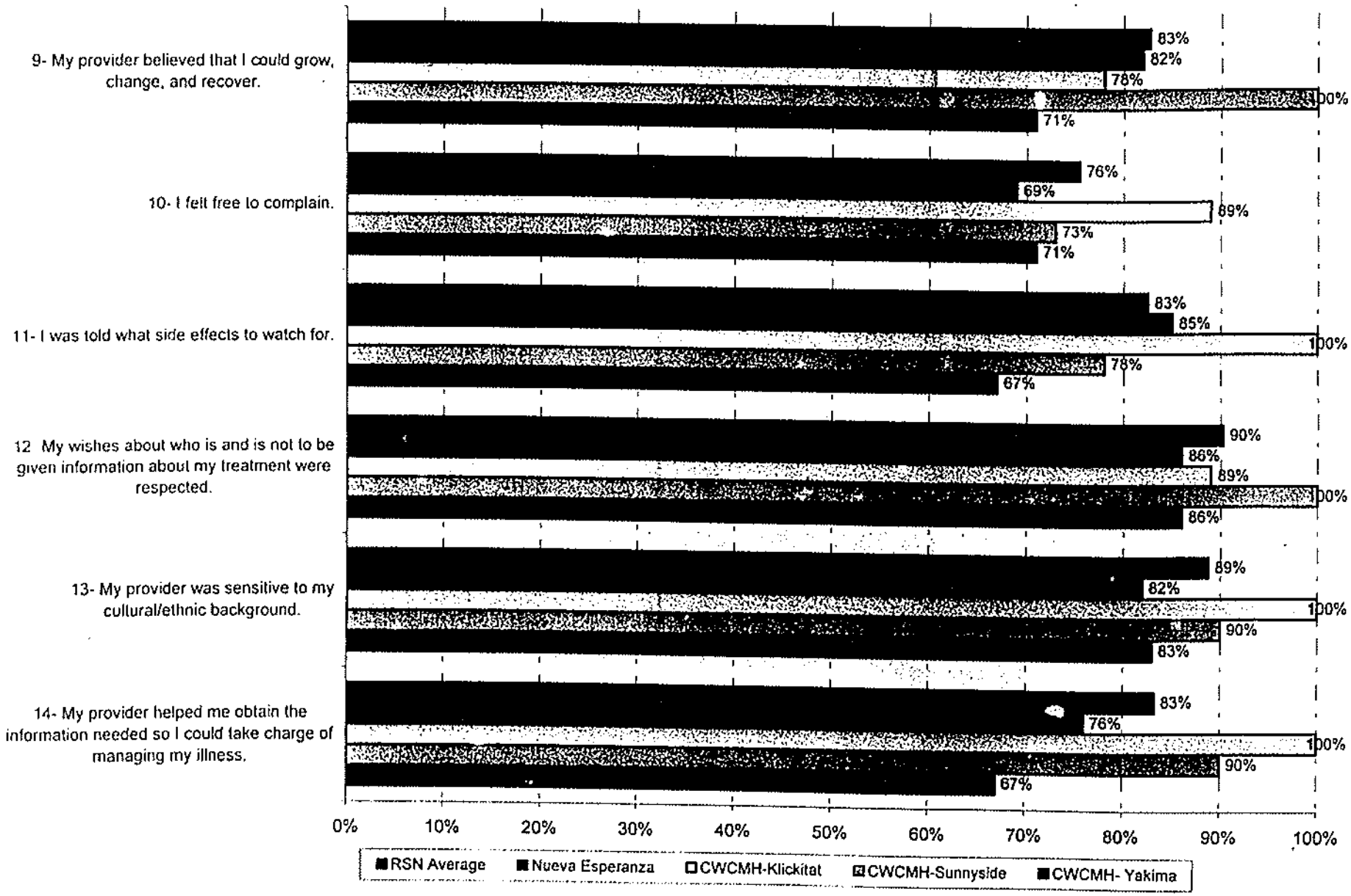
GCBH QRT Semi-Annual Report Jan-June 2001
Satisfaction Survey Results: Domain 2- Access



GCBH QRT Semi-Annual Report Jan-June 2001
Satisfaction Survey Results: Domain 3- Quality and Appropriateness



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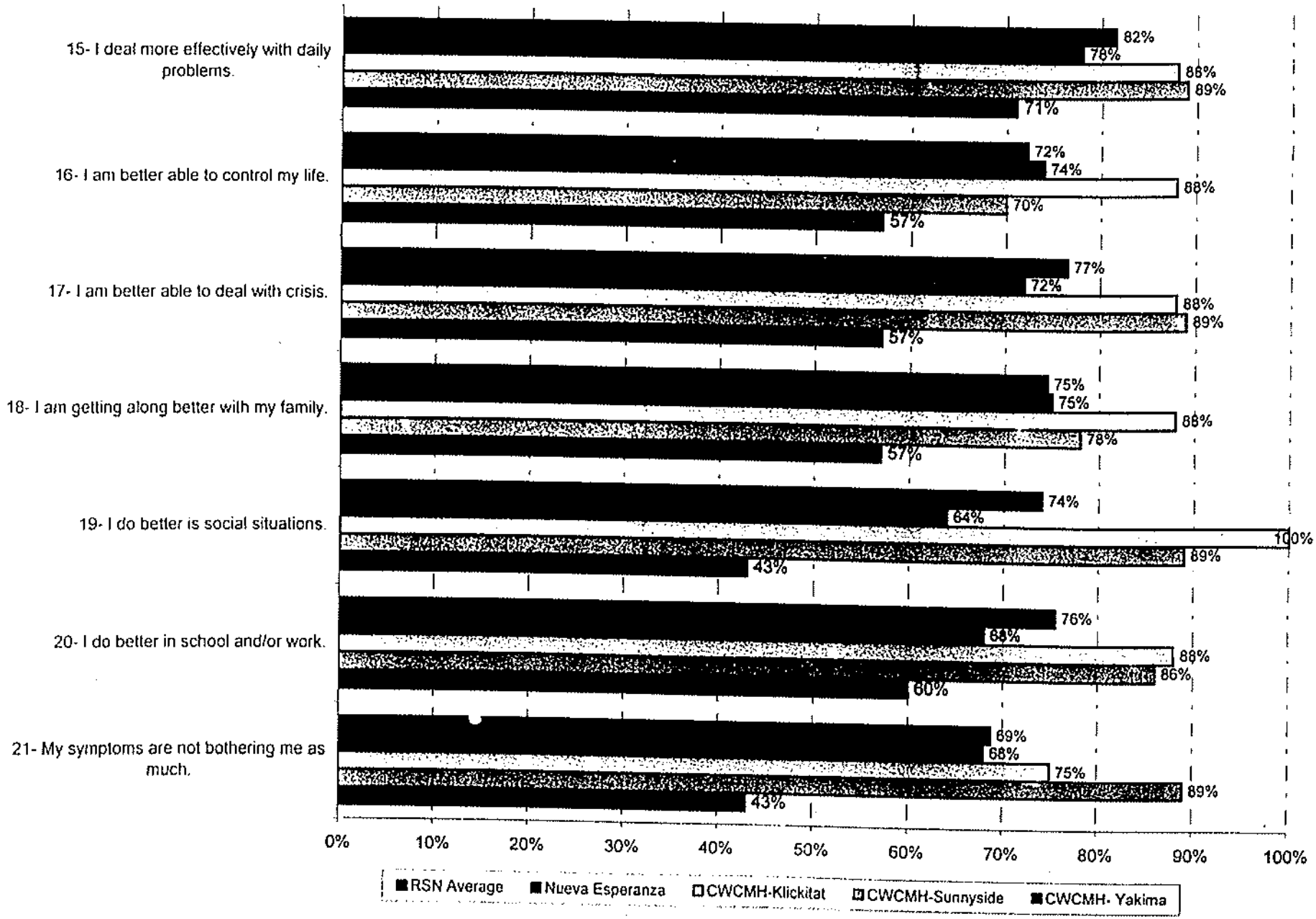
GCBH QRT Semi-Annual Report Jan-June 2001
Satisfaction Survey Results: Domain 4- Outcomes



NCWRSN

How Are We Doing Today Survey Summary – 2000

This survey was distributed to 135 clients region wide by our Quality Review Team. 94 surveys were returned.

The survey asked 5 questions. Two of the questions were open ended and three were yes or no responses, with comments.

The questions were as follows:

1) What did you like about the services you have received here?
   The most frequent response was that their case manager was caring and friendly.
2) What would you like improved about the services you have received here?
   There were no consistent themes identified here.
3) Has it been easy and convenient for you to schedule appointments with us?
   Yes = 90 No = 3
4) Have you been treated with respect by our staff?
   Yes = 91 No = 2
5) Have you had a change in your Primary Case Manager in the last 6 months?
   Yes = 18 No = 73

2001 - 1st qtr

Chelan- Douglas Behavioral Health Clinic
Satisfaction Survey

CDBHC Collected 25 surveys from January 3rd to March 29th

C-DBHC staff included me in my planning.

YES	NO	NO OPINION	Question not answered	
22	0	3	0	

C-DBHC staff showed respect for my cultural background.

YES	NO	NO OPINION	Question not answered	
21	1	3	0	

C-DBHC staff treated me with respect.

YES	NO	NO OPINION	Question not answered	
25	0	0	0	

C-DBHC staff promptly returned my phone calls.

YES	NO	NO OPINION	Question not answered	
18	1	6	0	

I feel that C-DBHC staff is listening to my concerns.

YES	NO	NO OPINION	Question not answered	
24	1	0	0	

I have been able to get service appointments for myself within a reasonable amount of time.

YES	NO	NO OPINION	Question not answered	
23	0	2	0	

I received services in the language of my choice.

YES	NO	NO OPINION	Question not answered	
23	0	2	0	

The time and location of services was convenient for myself.				
YES	NO	NO OPINION	Question not answered	
22	2	1	0	
The services at C-DBHC provided me were helpful.				
YES	NO	NO OPINION	Question not answered	
24	0	1	0	
The cost of services has caused a financial hardship for me.				
YES	NO	NO OPINION	Question not answered	
5	19	1	0	
I would recommend C-DBHC to a family member or friend.				
YES	NO	NO OPINION	Question not answered	
23	0	2		
I would use C-DBHC again if I had a problem.				
YES	NO	NO OPINION	Question not answered	
23		2		
Over all I would rate my experience with C-DBHC.				
Very Good	Good	Fair	Poor	Very Poor
12	11	1	1	

Chelan- Douglas Behavioral Health Clinic
Satisfaction Survey
July 10, 2000

2nd Qtr

RECEIVED
JUL 27 2000
CHELAN DOUGLAS
REGIONAL SUPPORT NETWORK

C-DBHC staff included me in my planning.					
YES	NO	NO OPINION	Question not answered		
24	1	1			26

C-DBHC staff showed respect for my cultural background.					
YES	NO	NO OPINION	Question not answered		
24	1	1			26

C-DBHC staff treated me with respect.					
YES	NO	NO OPINION	Question not answered		
25	0	1			26

C-DBHC staff promptly returned my phone calls.					
YES	NO	NO OPINION	Question not answered		
21	3	2			26

I feel that C-DBHC staff is listening to my concerns.					
YES	NO	NO OPINION	Question not answered		
22	1	1	2		26

I have been able to get service appointments for myself within a reasonable amount of time.					
YES	NO	NO OPINION	Question not answered		
20	2	3	1		26

I received services in the language of my choice.					
YES	NO	NO OPINION	Question not answered		
21	1	3	1		26

The time and location of services was convenient for myself.					
YES	NO	NO OPINION	Question not answered		
22	0	3	1		26

The services at C-DBHC provided me were helpful.				
YES	NO	NO OPINION	Question not answered	
24	0	2		
The cost of services has caused a financial hardship for me.				
YES	NO	NO OPINION	Question not answered	
0	23	3		
I would recommend C-DBHC to a family member or friend.				
YES	NO	NO OPINION	Question not answered	
22	0	4		
I would use C-DBHC again if I had a problem.				
YES	NO	NO OPINION	Question not answered	
23	0	3		
Over all I would rate my experience with C-DBHC.				
Very Good	Good	Fair	Poor	Very Poor
16	6	3	1	0

Chelan- Douglas Behavioral Health Clinic
Satisfaction Survey

← 3rd Qtr 2000

3rd qtr

C-DBHC staff included me in my planning.				
YES	NO	NO OPINION	Question not answered	
24		1		
C-DBHC staff showed respect for my cultural background.				
YES	NO	NO OPINION	Question not answered	
24		1		
C-DBHC staff treated me with respect.				
YES	NO	NO OPINION	Question not answered	
25				
C-DBHC staff promptly returned my phone calls.				
YES	NO	NO OPINION	Question not answered	
22	2	1		
I feel that C-DBHC staff is listening to my concerns.				
YES	NO	NO OPINION	Question not answered	
23			2	
I have been able to get service appointments for myself within a reasonable amount of time.				
YES	NO	NO OPINION	Question not answered	
25				
I received services in the language of my choice.				
YES	NO	NO OPINION	Question not answered	
24		1		
The time and location of services was convenient for myself.				
YES	NO	NO OPINION	Question not answered	
24		1		

The services at C-DBHC provided me were helpful.				
YES	NO	NO OPINION	Question not answered	
25				

The cost of services has caused a financial hardship for me.				
YES	NO	NO OPINION	Question not answered	
3	20	1	1	

I would recommend C-DBHC to a family member or friend.				
YES	NO	NO OPINION	Question not answered	
25				

I would use C-DBHC again if I had a problem.				
YES	NO	NO OPINION	Question not answered	
25				

Over all I would rate my experience with C-DBHC.				
Very Good	Good	Fair	Poor	Very Poor
17	8			

Chelan- Douglas Behavioral Health Clinic
Satisfaction Survey

RECEIVED 4th qtr
JAN 1 1 2001
CHELAN DOUGLAS
REGIONAL SUPPORT NETWORK

C-DBHC staff included me in my planning.				
YES	NO	NO OPINION	Question not answered	
30	4	3	1	
C-DBHC staff showed respect for my cultural background.				
YES	NO	NO OPINION	Question not answered	
32		6		
C-DBHC staff treated me with respect.				
YES	NO	NO OPINION	Question not answered	
38				
C-DBHC staff promptly returned my phone calls.				
YES	NO	NO OPINION	Question not answered	
19	11	7	1	
I feel that C-DBHC staff is listening to my concerns.				
YES	NO	NO OPINION	Question not answered	
31	2	3	2	
I have been able to get service appointments for myself within a reasonable amount of time.				
YES	NO	NO OPINION	Question not answered	
36	1	1		
I received services in the language of my choice.				
YES	NO	NO OPINION	Question not answered	
35		3		
The time and location of services was convenient for myself.				
YES	NO	NO OPINION	Question not answered	
31	5	1	1	

The services at C-DBHC provided me were helpful.

YES	NO	NO OPINION	Question not answered	
34	1	3		

The cost of services has caused a financial hardship for me.

YES	NO	NO OPINION	Question not answered	
5	27	5	1	

I would recommend C-DBHC to a family member or friend.

YES	NO	NO OPINION	Question not answered	
37		1		

I would use C-DBHC again if I had a problem.

YES	NO	NO OPINION	Question not answered	
38				

Over all I would rate my experience with C-DBHC.

Very Good	Good	Fair	Poor	Very Poor
18	12	8		

Clark Co

MENTAL HEALTH OMBUDSMAN
HUMAN SERVICES COUNCIL
P. O. Box 425
Vancouver, WA 98666-0425
(360) 694-6577

A Few Brief Lessons On How To Treat A Person With A Disability.

1. Like a person.
2. Like a person
3. Like a person
4. Like a person
5. Like a person
6. Like a person
7. Like a person
8. Like a person
9. Like a person

A.11d21-12

A New Vision of Recovery:

People can fully recover from mental illness, it is not a life-long process

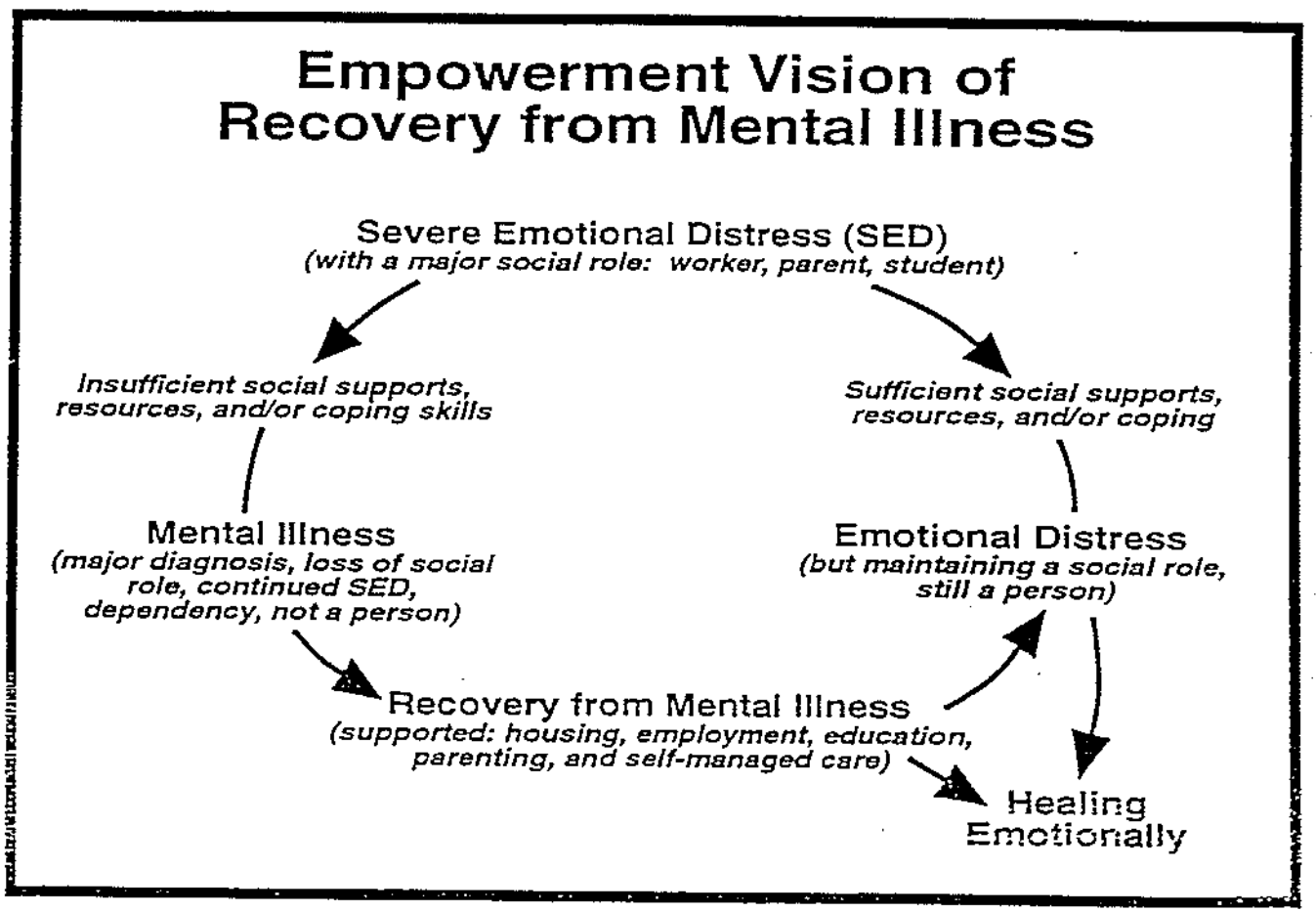
By Daniel Fisher, M.D., Ph.D.

These days people are talking about recovery from mental illness. This is a great step forward. Even using the word recovery in a field too long dominated by the goal of stabilization is refreshing. But whose vision of recovery are people talking about? I thought we were all talking about the same view of recovery. I see two distinctly different visions of recovery emerging, however. We will call these the Rehabilitation and Empowerment views of recovery. It is especially important to clarify what recovery means in each model because many states and counties nationally are proposing to create recovery-centered policies and services. Distinctly different policies would result depending on whose picture of recovery those policies are based on.

Rehabilitation View: Recovery of Function Despite Still Having the Permanent Impairment of Mental Illness

According to this view, mental illness is seen as a primary, permanent impairment similar to a spinal cord injury resulting in paralysis. This impairment causes a disability depending on the degree to which it interferes with a person's capacity to function in a major social role such as worker, parent, or student. The rehabilitation view of recovery from spinal cord injury is that, with supports, a person can once again function in society. Their impairment, however remains permanent. As William Anthony, from the Boston University Center for Psychiatric Rehabilitation states, "a person with paraplegia can recover even though the spinal cord has not. Similarly, a person with mental illness can recover even though the illness is not 'cured.'" (*Recovery from Mental Illness* Psychosocial Rehabilitation Journal, 16:12-23, 1993). The rehabilitation view of recovery from mental illness is that people can regain some social functioning, despite having symptoms, limitations, medication, and remaining mentally ill. Though this rehabilitation view works in describing recovery from the effects of physical impairments, it does not help explain how people can recover from mental illness. Whereas in paralysis a person's spinal cord is injured, separating their functioning head from the rest of their poorly functioning body, in mental illness the whole person is separated from

(Continued on page 13)



New Vision of Recovery

(Continued from page 12)

the people around them. They are considered less than human. They experience a loss of civil rights. Once a person is labeled mentally ill, they are discredited and disqualified from full membership in society solely as a result of that label. Therefore, to say that the person's mental illness is a permanent condition is to forever ostracize the person from society and say that they will never be able to regain a major social role. No wonder there is such a high rate of unemployment (85-90%) among those labeled with mental illness. The label defines the person as being incapable of work. No wonder so many people labeled with mental illness lose their children; the label itself defines the person as being an incompetent parent.

A New Vision of Recovery: the Empowerment Vision

In contrast to the Rehabilitation View of Recovery, people who have recovered from mental illness have an empowering view that full recovery is possible for everybody. According to this Empowerment Vision, people are labeled with mental illness through a combination of severe emotional distress and insufficient social supports/resources/coping skills to maintain the major social role expected of them during that phase in their life. The psychosocial nature of mental illness is highlighted by the common experience most consumer/survivors have gone through of having had a variety of diagnoses. In fact, the degree of interruption in a person's social role is more important in affixing the label mental illness to someone than their diagnosis. Recovery is possible through a combination of supports needed to (re)establish a major social role and the self-management skills needed to take control of the major decisions affecting one. This combination of social supports and self-management help the person regain membership in society and regain the sense of being a whole person. Self-help and peer support are fundamental elements in this journey of recovery because often the only people who can truly understand the feeling of exclusion are those who have also been labeled. The diagram summarizes our view of recovery. The usefulness of this model is seen in the description of two young adults in this issue. They were equally distressed but one boy found the belief, social supports and resources to heal his emotional distress while the other lacked the necessary beliefs, supports and resources. The first boy was able to maintain a social role of student while the second boy was not able to remain a student and was labeled with mental illness.

According to this vision, one is capable of recovering from the mental illness itself, not merely regaining functioning while remaining mentally ill. This distinction is critical in a person's motivation to improve as well in the attitudes of society towards people who have been labeled. Ideally this recognition will be the first step towards finding a way to provide benefits, such as social security, for people whose functioning is compromised by emotional difficulties without needing to first reject them as members of society. We realize that the idea that people can recover from mental illness will create more work on the part of entitlement programs. Instead of a single, once-in-a-lifetime determination of disability, episodic periods of disability will need to be supported. We also realize that people will fear they will lose their social security before they are able to live without it. Hopefully Social Security can be reformed to provide the needed gradual transitions back to work. (Some of these issues are addressed in an accompanying article.)

In this model, treatment is part of self-managed care. The goal of treatment here is assisting people in gaining greater control of their lives and assisting them in regaining valued roles in society. The primary goal of treatment should not be to control the person's behavior. The use of medication does not itself mean that a person has not recovered from mental illness. It depends upon the degree to which the person and those around them see the medication as constantly needed. Ideally, each person should learn to take medication on an as-needed basis, after having learned to self-monitor. Many people also embrace holistic health as an alternative to medication.

In addition, people regain a valued social role through support services in housing, work, education, and parenting. As many of these services as possible should be run by people who have recovered. These services are as vital to recovery as any medical procedure.

This model also differentiates between recovery from mental illness which involves a limited number of people over limited periods of time, and the nearly universal healing and transformation from emotional distress and trauma which can occupy a lifetime.

Role of Work in Recovery

Psychiatric disabilities are unique because the label of mental illness itself creates a barrier to people returning to work. Perhaps more than any other label in our society, mental illness indicates to the person and those around them that he/she will never be capable of work. This may explain why so few people labeled with mental illness are working in competitive jobs. Therefore, to truly remove this barrier to people returning to work it is necessary to recognize that people recover from mental illness and that work helps in that process.

In this new vision of recovery, work plays an important role in recovery from mental illness. In many cases, loss of work plays an important role in a person being labeled mentally ill. In addition, boring, unfulfilling work can lead to stresses which contribute towards mental illness. Without work, or another equivalent social role (parent or student), a person loses membership in this society and the identity which accompanies membership. It then becomes necessary to assume a new identity as a consumer. The movement to find jobs for people labeled with mental illness as mental health providers helps many of us to regain an identity as worker and member of society and thereby recover from the mental illness. (NEC has produced a video on this topic.)

Recovery from mental illness does not mean that the person no longer needs support. In fact, those continued supports are often critical in the person's recovery. Though working persons, with a history of mental illness, may no longer need cash benefits, they continue to need other benefits such as health insurance (see article in this newsletter) and housing. According to our new vision of recovery many people have recovered from mental illness, although they and those around them still think they have not. They are, however, carrying out important social roles and have learned to take control of their own lives. They still experience at times severe emotional states, but they and the people around them have learned to cope with them. They are surprised to learn that they are now dealing with the states that many people never labeled with mental illness go through. They seem to go through a combination of relief and fear at the idea that they are no longer mentally ill. We hope that this model will raise this topic of discussion about recovery being a goal which can be achieved in a period of time rather than it needing to be a life-long process. ☐

Believing you can recover is vital to recovery from mental illness

Daniel Fisher, M.D., Ph.D.

In our last newsletter I highlighted the importance to recovery of having people in your life who believe in you. I pointed out that these people affirm our deepest self and have confidence in our ability. What I should have made clear is that they believe that we can recover. I was reminded of the importance of this belief in our recovery by a letter recently sent to me by a reader. She was prompted to write me because she could personally relate to my article in a previous newsletter, "Recovery is Real." She had read about my experience of my recovery being denied by a psychology professor and was amazed to see how similar that attitude was to one she had been subjected to. She wrote:

"I had suffered from severe mental illness in my mid-20's and early 30's (I am now 53). Then, through the grace of God, I was able to find my way out of this debilitating condition and make a full recovery. A few years ago I had the opportunity to work in a mental health agency as secretary to the Executive Director. Unfortunately I didn't realize that his mindset was like those you describe in your article - he needed me to either deny that I had ever been sick or otherwise go back to the 'consumer mode.' Eventually that stigmatizing attitude surfaced and I was forced to leave the job." She also sent us a letter to the editor she had published in her local paper which elaborated on this theme.

"When I worked in the mental health field for several years as a secretary, I observed...[that] many workers do not believe in recovery. They categorize everyone as either "sick" or "well," placing themselves...in the "well" group.

"Their assessment of their own mental health seems to be based on a comparison of themselves with those who are ill rather than on a knowledge of themselves. This puts them on very shaky ground and they do more harm than good since they end up discouraging rather than encouraging recovery.

"Work in this field is complex and demanding. It requires enlightened,

(Continued on page 15)

Believing you can

(Continued from page 1)

secure individuals who recognize that full recovery is possible."

She has recovered from mental illness and yet while she was working at a mental health agency her recovery was denied. This view *that if one becomes mentally ill one will always be sick* not only interferes with emotional recovery but also prevents one from identifying as a contributing member of society. This interferes with striving to return to work or establishing long-term relationships, which are essential aspects of recovery (see accompanying article on work and recovery).

The belief that one can recover from mental illness is well established as an important aspect of the healing experience. This relationship has recently been pointed out in Dr. Herbert Benson's book, *Timeless Healing*. A similar point about the importance of belief in one's own capacity to heal is found in Deepak Chopra's book *Quantum Healing* (p.189) in which he discusses Ayurvedic Medicine:

"Ayurveda is...a system for curing delusions, for stripping away the convincing quality of a disease and letting a healthy reality take its place. [The name] comes from two Sanskrit roots, Ayus or life and Veda which means knowledge or science. The literal meaning then is the "science of life." ...I spend much of my time just talking, trying to get people not to be so convinced by their disease. In Ayurveda, this is the first, most important step in healing. As long as the patient is convinced by his symptoms, he is caught in a reality where being sick is the dominant input. The reason why meditation is so important in Ayurveda is that it leads the mind to a free zone that is not touched by the disease. Until you know that such a place exists, your disease will seem to be taking over completely. This is the principal delusion that needs to be shattered."

Although it is encouraging that Western medicine is beginning to acknowledge the central role of a positive belief in recovery in the area of physical illness, it is disturbing that psychiatry does not see the wisdom of such an attitude for mental illness. Even though the weight of personal testimony and epidemiological studies argues that most people are able to regain a productive role in society and recover from mental illness, the mental health field in particular persists in a belief that mental illness is a permanent condition. The more of us who have recovered who can tell our stories the more truth will displace falsehood. We welcome your letters by or about anyone who has made a complete recovery from mental illness. As I point out in another article in this newsletter, by complete recovery we mean that the person has regained a meaningful role in society, can cope with life's stresses, and is not considered sick by others around them. ☐

How far we've come, but how far to go

The following are remarks made by Judi Chamberlin at the signing of the Massachusetts Mental Health Bill of Rights.

This is a very happy occasion, culminating many years of work by hundreds of people, who have lobbied and rallied to pass this bill, which guarantees five fundamental rights to patients in psychiatric facilities in Massachusetts. These are very basic rights, which are the right to make and receive telephone calls, to see visitors of one's choosing, to send and receive uncensored mail, to have a humane physical environment, and to have access to legal advocacy services. In these days of privatization, the law now makes explicitly clear that these rights belong to patients in private hospitals just as much as they do to patients in state hospitals.

It took a broad-based coalition to bring this bill to passage, spearheaded by former-patient activists who have ourselves experienced how painful it is to be denied one's basic rights as a consequence of receiving psychiatric treatment. Our organizations formed the core of the coalition, which also included legal advocacy groups, mental health professionals, and others. Marylou Sudders, the Commissioner of Mental Health, agreed to support the bill, and has lobbied vigorously on its behalf.

At the same time that we are celebrating, I think it is also important to remind ourselves how difficult it has been to pass this bill, which would seem, on its face, not to be controversial. The fact that it has taken years of effort to get this far, and that the bill is scaled down from a broader bill which would have established even more rights, shows us that the label of "mental illness" still carries enormous consequences. Proponents of the "medical model of mental illness" are fond of saying that "mental illness is an illness like any other"; the fact that this bill is necessary reminds us how different it is. No one would dream of telling a cancer patient or a heart disease patient that he or she was forbidden to make a phone call or that his or her mail was subject to censorship. Such actions, were they to be attempted by hospital staff, would simply not be tolerated. But, somehow, because we are labeled as "mental patients," we are different. Our rights can be abrogated because someone else can decide it is in our "best interest" to separate us from our friends and our support systems or to prevent us from learning about our legal rights. The passage of this bill, therefore, must remind us not merely of how far we have come, but of how far we still have to go.

There are still many people out there who think that the label of "mental illness" means that people are incapable

(Continued on page 17)

How far we've come

(Continued from page 15)

of knowing or acting on our own best interests, and that someone else should be making decisions on our behalf. They do not see us as people who actively advocate for our rights, as people who hold jobs, who go to school, who live in our own apartments, and make our own decisions. The stereotypes of who we are get in the way of seeing our full humanity.

Now that this bill is law, we must work to make sure that it is enforced. We must ensure that patients in psychiatric wards and hospitals know what their rights are, are able to exercise their rights, and that there are appropriate penalties for facilities that do not observe the law. We still have a lot of work to do.

Let us celebrate, therefore, but let us also be mindful that until the day when the term "mental illness" carries no more legal implications than the terms "cancer," "heart disease," or "diabetes," our full citizenship rights are still limited. Our goal must be full legal rights, full citizenship, full equality, and nothing less. ❐

Labeling oneself:
A lesson in love

On the first day of my life they
labeled me a funny-looking kid
In the 5th year they labeled me
hyperactive
In the 6th year they labeled me
mentally retarded
In the 8th year they labeled me
learning disabled
In the 9th year they labeled me
tone deaf (sing off key)
In the 10th year they labeled me
gifted and talented
In the 12th year they labeled me
overachiever
In the 15th year they labeled me
emotionally disturbed
In the 18th year they labeled me
schizophrenic
In the 30th year they labeled me
career-woman burnout
In the 40th year they labeled me
over the hill

But
Today I gave it all up
and threw all the labels away,
I really was:
Brilliant and creative.
Sensitive and strong.
Smarter than the shrinks,
Social changer,
Freedom fighter,
Life-role explorer.
Natural musician,
Quite good looking,
Curious and inquisitive,
Joyous.
and an outstanding human
being.

Author unknown. Submitted by Nancy Calvert, NAPS member from Vancouver, Washington.

YOU AND I

I am a resident. You reside.
I am admitted. You move in.
I am aggressive. You are assertive.
I have behavior problems. You are rude.
I am noncompliant. Your don't like being told what to do.

When I ask you out for dinner, it is an outing. When you ask someone out, it is a date.

I don't know how many people have read the progress notes people write about me. I don't even know what is in there. You didn't speak to your best friend for a month after they read your journal.

I make mistakes during my check-writing program. Someday I might get a bank account. You forgot to record some withdrawals from your account. The bank called to remind you.

I wanted to talk with the nice-looking person behind us at the grocery store. I was told that it was inappropriate to talk to strangers. You met your spouse in the produce department. They couldn't find the bean sprouts.

I celebrated my birthday yesterday with 5 other residents and 2 staff members. I hope my family sends a card. Your family threw a surprise party. Your brother couldn't make it from out of state. It sounded wonderful.

My case manager sends a report every month to my guardian. It says everything I did wrong and some things I did right. Your are still mad at your sister for calling your mom after you got that speeding ticket.

I am on a special diet because I am 5 pounds over my ideal body weight. Your doctor gave up telling you. I am learning household skills. You hate housework.
I am learning leisure skills. Your shirt says you are a "couch potato".

After I do my budget program tonight, I might get to go to McDonald's if I have enough money. You were glad that the new French restaurant took your charge card.

My case manager, psychologist, R.N., occupational therapist, physical therapist, nutritionist and house staff set goals for me for the next year. You haven't decided what you want out of life.

Someday I will be discharged, ...maybe.
You will move onward and upward.

Elaine Popovich
Lutheran Social Services, Midland

Recovering Our Sense of Value After Being Labeled

By Patricia E. Deegan, PhD

In the final decade of this millennium, after centuries of being so fundamentally and brutally devalued by our culture, there is a glimmer of hope that people who have been labeled with mental illness can reclaim their dignity, can be viewed by others as being people of worth, and can begin to achieve valued roles. There is no doubt that the landmark piece of civil rights legislation, the Americans with Disabilities Act, will help to remove many of the barriers that have historically prevented those of us with psychiatric disabilities from achieving valued roles in this society. We are all charged with the valued role of carrying a new message of hope, of healing, and of recovery back into the communities where we live, love, work, and worship.

Patricia E. Deegan, PhD, is program director, Northeast Independent Living Program, Lawrence, Massachusetts; and consultant, National Empowerment Center, Lawrence.

This article was originally presented at a conference entitled "Rehabilitation of Children, Youth, Adults With Psychiatric Disabilities: Achieving Valued Roles," in Tampa, Florida, on January 28, 1993.

Address correspondence to Patricia E. Deegan, PhD, 39 High Street, Ipswich, MA 01938.

A Retrospect

As I was preparing this article, I found myself wondering how those of us who have experienced being profoundly devalued as a result of being labeled with a mental illness move from thinking we have little or no value, to discovering our own unique value. How do we reclaim and recover our sense of worth and value when we have been devalued and dehumanized? In the course of my reflections I found myself thinking back to the days when I was an adolescent and was first diagnosed with major mental illness. I was thinking about my first two hospitalizations and how I was labeled with schizophrenia and three months later, at my second hospital admission, I was labeled with chronic schizophrenia.

I was told I had a disease that was like diabetes, and if I continued to take neuroleptic medications for the rest of my life and avoided stress, I might be able to cope. I remember that as these words were spoken to me by my psychiatrist it felt as if my whole teenage world—in which I aspired to dreams of being a valued person in valued roles, of playing lacrosse for the US Women's Team or maybe joining the Peace Corp—began to crumble and shatter. It felt as if these parts of my identity were being stripped from me. I was beginning to undergo that radically dehumanizing and devaluing transformation from being a person to being an illness; from being Pat Deegan to being "a schizophrenic."

As I look back on those days I am struck by how all alone I was. This profound sense of being all alone only served to compound my sense of feeling worthless and of having no value. Granted, people gave me medications, people monitored my blood pressure, people did art therapy, psychotherapy, occupational therapy, and recreational therapy with me. But in a very fundamental way I experienced myself as being all alone, adrift on a nameless sea without compass or bearing. And that deep sense of loneliness came from the fact that although many people were talking to me about my symptoms, no one was talking to me about how I was doing. No one came to me and said, "Hey, I know you're going through hell right now. I know you feel totally lost in some nightmare. I know you can't see a way out right now. But I've been where you are today. I got labeled with schizophrenia and a whole bunch of other things too. And I'm here to tell you that there is a way out and that

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your life doesn't have to be about being in mental institutions. I'm around if you want to talk."

No one ever came to me and said those words. All I knew were the stereotypes I had seen on television or in the movies. To me, mental illness meant Dr. Jekyll and Mr. Hyde, psychopathic serial killers, loony bins, morons, schizos, fruitcakes, nuts, straight jackets, and raving lunatics. They were all I knew about mental illness, and what terrified me was that professionals were saying I was one of them. It would have greatly helped to have had someone come and talk to me about surviving mental illness—as well as the possibility of recovering, of healing, and of building a new life for myself. It would have been good to have role models—people I could look up to who had experienced what I was going through—people who had found a good job, or who were in love, or who had an apartment or a house on their own, or who were making a valuable contribution to society. But as I said, this did not happen for me in those early years.

So today I want to take the opportunity to say the things that no one ever said to me back then. I want to talk with the seventeen-year-old girl that I once was. I want to talk to her about what I know now but didn't know then. I want to talk to her and in so doing speak to all of us who have been labeled with mental illness, who have suffered deeply, who have known despair, who have been told that we have no value and who have felt alone, abandoned, and adrift on a dead and silent sea.

A Bleak, Monotonous Existence. I turn my gaze back over the twenty-one year span of time that separates me from that seventeen year old girl. I am trying to see her . . . it's difficult to look at her. I can see the yellow, nicotine-stained fingers. I can see her shuffled, stiff, drugged walk. Her eyes do not dance. The dancer has collapsed and her eyes are dark and they stare endlessly into nowhere. It is the time between the first and second hospitalization and she is back living at her parents' home. She forces herself out of bed at 8 o'clock in the morning. In a drugged haze she sits in a chair, the same chair every day. She is smoking cigarettes. Cigarette after cigarette. Cigarettes mark the passing of time. Cigarettes are proof that time is passing and that fact, at least, is a relief. From 9 AM to noon she sits and smokes and stares. Then she has lunch. At 1 PM she goes back to bed to sleep until 3 PM. At that time she returns to the chair and sits and smokes and stares. Then she has dinner. She returns to the chair at 6 PM. Finally, it is 8 o'clock in the evening, the long-awaited hour, the time to go back to bed and to collapse into a drugged and dreamless sleep.

This same scenario unfolds the next day, and then the next, and then the next, until the months pass by in numbing succession, marked only by the next cigarette and then the next . . .

The cry of an anguished person has the power to awaken the cry, the wound, the brokenness that exists inside every person.

And as I watch her, I know it is not so much mental illness that I am observing. I am witnessing the flame of a human spirit faltering. She is losing the will to live. She is not suicidal—but she wants to die because nothing seems worth living for. Her hopes, her dreams, and her aspirations have been shattered. She sees no way to achieve the valued roles she had once dreamed of. Her future has been reduced to the prognosis of doom she had been given. Her past is slipping away like a dream that belonged to someone else. Her present is empty but for the pungent cigarette smoke that fills the void like a veiled specter. No, this is not mental illness I am seeing. I am seeing a young woman whose hope for living a full and valuable life has been shattered. She feels herself to be among the living dead and her spirit is wavering under the weight of it all.

What I Wish I Could Tell He walk into the room and sit near her, I want to talk to her. Just the thought of it makes me want to start to cry. What should I say to her? I lean towards her as she sits smoking in her chair.

"Patricia . . . I'm worried about you. I can see that you are suffering deeply. Your suffering is not invisible to me. I know that the professionals have been very busy observing you, treating your symptoms, and trying to rehabilitate you; but no one has addressed the way you are suffering. The fact that you have felt so alone in your suffering doesn't mean there's something bad or shameful about you. Try to understand that most professionals—in fact most people—are afraid to sit quietly and to be with a person who is suffering. It's the same sort of thing that happens at a funeral—when people line up to console the person who is bereaved, they get all anxious and awkward and don't know what to say.

"People find it frightening to just spend time with people who are in great pain. You see, a person who is in great anguish is crying out. Eve they are totally silent like you are, way down deep I can hear you crying out. And that cry, the cry of an anguished person, has the power to awaken the cry, the wound, the brokenness that exists inside every person. Every person, no matter how high up the social ladder they have climbed or no matter how valued their role is in our society, every person has a cry, a wound, a brokenness down deep inside of them. Thus, to be with a person who is anguished is to risk experiencing the cry that is way down deep inside each of us. That is why the professionals have been so busy doing things to you, rather than being with you. Granted, it's their job, but it's also true that staying busy by doing things to you helps keep their anxiety under control, which in turn helps to distance them from the cry that your suffering might evoke in them.

"I also hear anger in your suffering. You are angry because you have been diagnosed with a major mental illness. You feel angry because all your friends are doing normal stuff like going school, going on dates, and dreaming their dreams. You feel, 'Why me. Why

has this happened to me?' I don't know the answer to that question. I don't know why you were dealt this hand of cards. But what I do know is this: You may have been diagnosed with a mental illness, but you are not an illness. You are a human being whose life is precious and is of infinite value.

"You are at a critical juncture, a very important time. The professionals are telling you that you are a schizophrenic. Your family and friends are beginning to refer to you as 'a schizophrenic.' It is as if the whole world has put on a pair of warped glasses that blind them to the person you are and leaves them seeing you as an illness. It seems that everything you do gets interpreted through the lenses of these warped glasses. If you don't laugh, that is worrisome and, if you laugh too much, that is also worrisome. If you don't move, they get alarmed and, if you move around too much, they get alarmed. The range of behaviors and feelings you are allowed has been dramatically narrowed as a result of the blinders that those around you have put

"Almost everything you do gets understood in reference to your illness. You used to have days when you had 'ants in your pants' but now they say you are agitated. You used to feel sad sometimes but now you are said to be depressed. You used to disagree sometimes but now you are told you lack insight. You used to act independently but now you are told that your independence means you are uncooperative, noncompliant, and treatment resistant. You used to take risks. You learned from your failures as you were growing and learning. But now that you have been labeled with a mental illness the dignity of risk and the right to failure have been taken from you. No wonder you get angry. Normal people get to make many stupid choices over and over again in their lives. Nobody tells them that they need a case manager. How many times has Elizabeth Taylor been married? At last count it was seven or eight times, I think. The poor woman lacks insight! She exercises poor judgment! She is failing to learn from past experiences! She is making the same dumb choice again! How come they don't get her a case manager?

"But this is a critical time for you because there is the great danger that you might succumb to the messages you are being given. You might slowly find yourself putting on those same warped glasses and viewing yourself as others are seeing you. The great danger is that you might undergo that radically devaluing and dehumanizing transformation from being a person to being an illness: from being Patricia to being 'a schizophrenic' (or 'a bipolar' or 'a multiple'). The reason this is so dangerous is because once a person comes to believe that he or she is an illness, there is no one left inside to take a stand toward the illness. Once you and the illness become one, then there is no one left inside of you to take on the work of recovering, of healing, of rebuilding the life you want to live. Once you come to believe that you are a mental illness, you give away all your power—and others take responsibility for you and for your life.

The great danger is that you might undergo that radically devaluing and dehumanizing transformation from being a person to being an illness.

"That is why I say that this is a critical and dangerous time. It is important that you resist the efforts, however unintentional they might be, to transform you into an illness. In this regard let your anger, especially your angry indignation, be your guide. See how your anger flares up into angry indignation each time you get referred to as an illness. You are not an illness, and that angry indignation is like a fiery shield that blazes up to protect you and your dignity. Some people will try to tell you that your anger is a symptom of mental illness. Don't believe them. Anger is not a symptom of mental illness. Some people may even try to medicate you in order to make your anger go away. This can be dangerous—by extinguishing someone's anger through the use of medications we run the risk of breaking their spirit and of wounding their dignity. Many of us know that recovering from the effects of such spirit-breaking practices is far more difficult than recovering from mental illness.

"Your anger is not a symptom of mental illness. Your angry indignation is a sane response to the situation that you are facing. You are resisting the messages you are being given. In and through your fiery indignation your dignity is saying, 'No, I am not an illness. I am first and foremost a human being. I will not be reduced to being an illness or a thing. I will keep my power and save a part of myself that will, in time, be able to take a stand toward my distress and begin the process of recovery and healing.

"What really needs to happen is that people must understand that it's going to take you a while to figure out what is going on with you. You need to find a way of making sense of what is happening to you that you can live with. For many of us, this takes time and even some trial and error. You may want to talk with professionals, other people who have been diagnosed, clergy, and/or friends. You might decide to read up on the subject to learn more about it. Maybe you'll get a second or third opinion from other professionals. Make sure to think things over for yourself. Know that as you grow you can develop, change, and modify your understanding of what is going on with you and/or your life situation. I'm not saying that nothing is going on. Something happened that caused you to end up in a mental hospital. You need to start defining for yourself what that something is and what you can do to change it.

"As for me, after years of trying to sort this out and, like most of us, having received all sorts of diagnoses, I've settled on trying to keep it simple. The way I see it is that I have some pretty uncomfortable experiences like hearing voices that put me down and strong

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urges to hurt myself and sometimes my thoughts get all jumbled and I can't communicate well. I don't care what they want to call it. All I know is that sometimes these experiences can get so overwhelming that I find it difficult to work or go to school or have friends. I've decided that I have a disability. To me it's important to say that I have a disability but that I am not a disabled person. You see the great thing is that I have learned that it is possible to live a whole and healthy life and still have a disability. People don't usually think of these words going together but it's true: I live a whole and healthy life and I have a psychiatric disability. The reason I can do this is because the most valued and important thing I do in my life is work on my recovery. The most valued role I fulfill every day is to remain faithful to my journey of recovery. My journey of recovery and healing is my work. If I do that work, everything else falls into place.

"One of the biggest lessons I have had to accept is that recovery is not the same thing as being cured. After 21 years of living with this thing it still hasn't gone away. So I figure I'm never going to be cured but I can be in recovery. Recovery is a process, not an endpoint or a destination. Recovery is an attitude, a way of approaching the day and the challenges I face. Being in recovery means I know I have certain limitations and things I can't do. But rather than letting these limitations be an occasion for despair and giving up, I have learned that in knowing what I can't do, I also open up the possibilities of all I can do.

"To me recovery means I try to stay in the driver's seat of my life. I don't let my illness run me. Over the years I have worked hard to become an expert in my own self-care. For me, being in recovery means I don't just take medications. Just taking medications is a passive stance. Rather I use medications as part of my recovery process. In the same way I don't just go to the hospital. Just 'going to the hospital' is a passive stance. Rather, I use the hospital when I need to. Over the years I have learned different ways of helping myself. Sometimes I use medications, therapy, self-help and mutual support groups, friends, my relationship with God, work, exercise, spending time in nature—all these measures help me remain whole and healthy, even though I have a disability.

It is important to understand that we are faced with recovering not just from mental illness, but also from the effects of being labeled mentally ill.

"Being in recovery is not a panacea. It doesn't mean the pain or suffering is over. Every day I have to get up and reaffirm my intention to stay whole and healthy and to work on my recovery. I still have relapses but I try to understand that having a relapse is not a failure on my part. I find that when I relapse in recovery, it is because I am breaking through into some new and scary and wonderful part of living.

"I have found that although my symptoms may seem the same or even worse, relapsing while in recovery is not the same thing as 'having a breakdown.' When I relapse in recovery, I'm not breaking down; rather I am breaking out or breaking through. It may mean I am breaking out of some prison or fear-filled place where I have been trapped inside of myself. It may mean I am breaking through to new ways of trusting people and myself. So you see, when I have a relapse within the context of my recovery, I try not to see it as a failure. It means I am growing, breaking out of old fears and breaking through into new worlds—like learning to make friends and keep them, to trust people, and to love people.

"I find it important to choose to work with professionals who understand the difference between breaking down and breaking through/breaking out. The symptoms may appear identical, but if you examine my life, if you look at life from the standpoint of my journey of recovery, there's a big difference between breaking down and breaking through/breaking out. If you choose to work with professionals in your recovery, it is important to find ones who understand this distinction.

"Everyone's journey of recovery is unique. Each of us must find our own way and no one can do it for us. However, talking with other people with psychiatric disabilities who are in recovery can be very helpful, perhaps even the most helpful thing of all.

"It is important to understand that we are faced with recovering not just from mental illness, but also from the effects of being labeled mentally ill. I believe many of us emerge from mental institutions with full-blown post-traumatic stress disorders that are a direct result of the trauma and abuse we may have experienced or witnessed in mental institutions or in community based programs. We are also faced with recovering from the process of internalizing the stigma we are surrounded with, as well as the effects of discrimination, poverty, and second-class citizenship. Indeed, there's no doubt that the label of mental illness comes as a 'package plan' that too often includes poverty, trauma, dehumanization, degradation, being disenfranchised, and being unemployed. Many of us find that the recovery process goes hand in hand with the empowerment process. We find that recovery means becoming politicized and aware of the social, economic, and human injustices we have had to endure. We find that empowerment and recovery means finding our collective voice, our collective pride, and our collective power and challenging and changing the injustices we face.

"Finally, Patricia, I want to mention one other thing that can happen and that you must guard against during these early years of being in the mental health system. You might hear professionals referring to you or other people as being 'high functioning' or 'low functioning.' Whether you get labeled high functioning or low functioning, don't fall into the trap of believing it. These are not attributes that exist inside a person. They are value judgments that are put on a person. [illegible] those words really mean is that there

are those people whose actions or talents or gifts we value and there are those people in which we find no value. There are no high-functioning or low-functioning people. There are people whose contribution we are able to see and value and there are those whose gifts we have failed to see and have failed to value. When you hear a mental health worker say that someone is low functioning, say to yourself, 'That person is not low functioning. It's just that the mental health worker has failed to see and value the gifts and special talents of that person.'

"The real challenge in all this is to somehow learn to value yourself. That can seem like such an impossible task because you get bombarded with messages and images that are so negative and degrading. How is it, when we are surrounded by such messages of despair, that we can begin to value ourselves? That's a difficult question to answer. I am twenty-one years older and I am still working on really valuing myself—but somehow when I look back at you, Patricia, as I watch you smoking and staring, when I see the way you are suffering and are all alone, somehow, despite all they have said about you, I see you and a tenderness fills my heart. You are precious and good. You are not trash to be discarded or a broken object that must be fixed. You are not insane. You do not belong in institutions for the rest of your life. You don't belong on the streets. And even though they tie us down in four-point restraints and though they lock us up against our will like animals, you are not an animal. You are a human being. You carry within you a precious flame, a spark of the divine.

"Patricia, if I could reach back through the years I would hold you. I would say you are beautiful. I would say don't listen to the prognosis of doom. You are more than all their words. There is a place for you. There is a reason. This is not suffering for the sake of just more pain. A new life can be born of this labor. A water that is life giving can be found in this desert. Don't give up. Although there is no magic answer, no magic drug, and no magic cure, I would hold you now. I would tell you I love you. I would want to protect you. I would want to rescue you, but I know that I couldn't. It's not about being rescued. It's about taking up your journey of recovery, finding good people who will accompany you on that journey and then following your journey to wherever it leads you.

"They may tell you that your goal should be to become normal and to achieve valued roles. But a role is empty and valueless unless you fill it with your meaning and your purpose. Don't become normal. Our task is not to become normal. You have the wondrously terrifying task of becoming who you are called to be. And you are not called to be an inhuman thing. You are not called to be a mental illness. You were born into this world for a reason and only you can discover what that reason is. You were born into this world to grow and it is possible to grow into a whole, healthy person who also has a psychiatric disability. Your life and your dreams may have been shattered—but from such ruins you can build a new life full of value and purpose.

"The task is not to become normal. The task is to take up your journey of recovery and to become who you are called to be. You were born to love and to be loved. That's your birthright. Mental illness cannot take that from you. Nobody can take that from you. Patricia, become who you are called to be. Do what you do with love. Loving and being loved is what matters. That is the value."

Labeling KEY POINTS

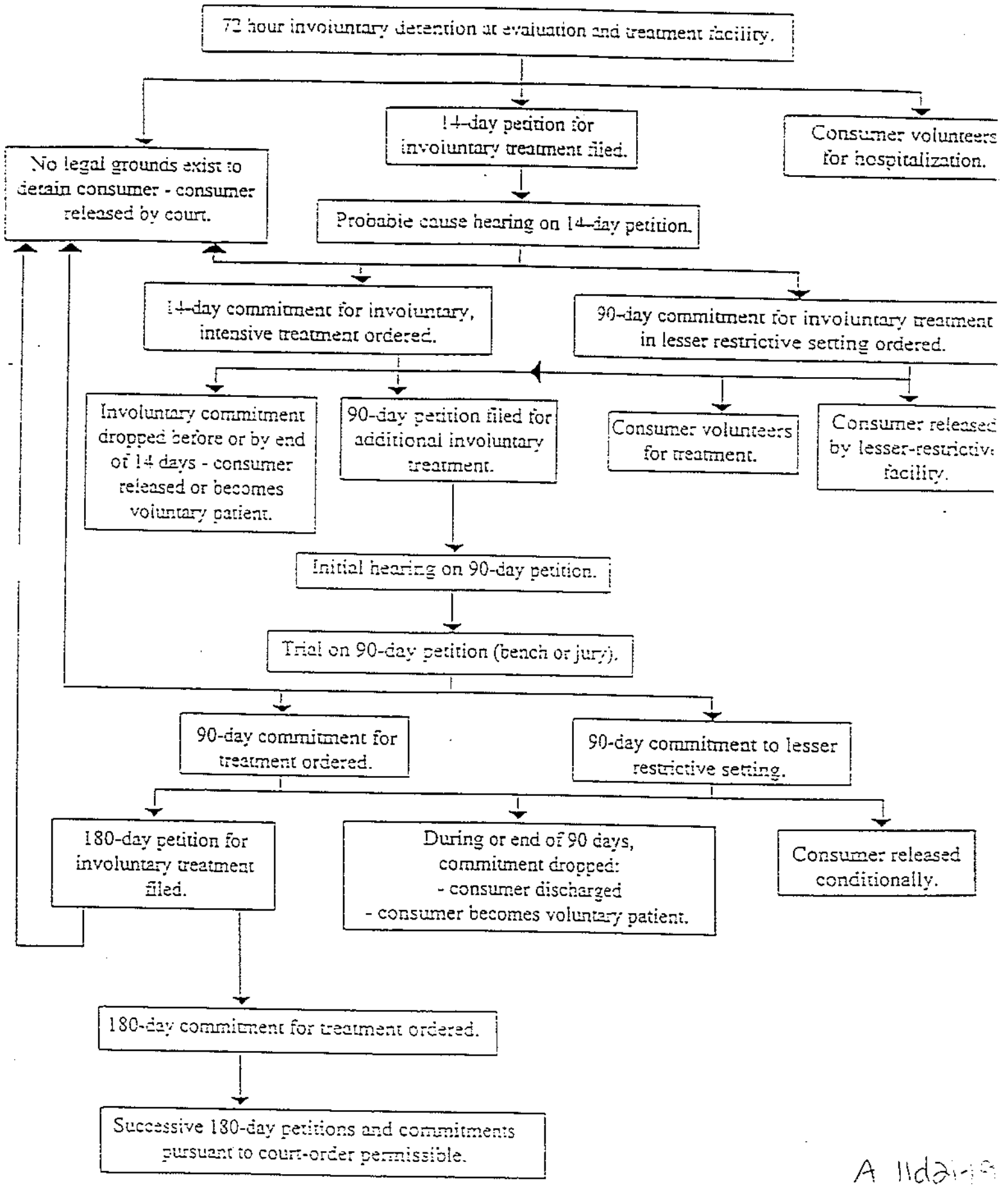
Recovering Our Sense of Value After Being Labeled Mentally Ill. Deegan, P.E. *Journal of Psychosocial Nursing and Mental Health Services* 1993; 31(4):7-11.

1. People with mental illness must know that mental illness does not mean they can no longer lead full lives. Role models—successful people who have mental illness—are needed.

2. There is great danger in labeling a person as an illness. Once people believe they are an illness, there is no one left inside to take a stand toward the illness; they give up control and others take responsibility for them.

3. "High functioning" and "low functioning" are not attributes that exist inside a person. They are value judgments that are put on a person. There are no high-functioning or low-functioning people. There are people whose contribution we are able to see and value and there are those whose gifts we have failed to see and have failed to value.

The Involuntary Commitment Process



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Involuntary Commitment Process

Adults

How Does The Process Begin?

The individual is referred to a county designated mental health professional for an evaluation. The professional evaluates the individual and makes an initial determination whether, as a result of a mental disorder, the person is gravely disabled, a danger to self, others, or property. If such a determination is made, the individual can be held for up 72 hours at a mental health facility for further evaluation and treatment. RCW 71.05.150. Within 24 hours of this determination, the evaluation and treatment facility must file a petition with the court for initial detention. RCW 71.05.160.

Individuals brought to a facility by a peace office without prior authorization by the county designated mental health professional must be examined by a mental health professional within three hours of the arrival to the facility. WAC 275-55-241(3)(g)(I). In addition, such persons must be released within twelve hours unless the county designated mental health professional files a supplemental petition for initial detention and the detained person receives a copy as described under RCW 71.05.150(5). WAC 275-55-241(3)(g)(ii).

Fourteen Day Commitment For Intensive Treatment and Ninety Day Commitment to Less Restrictive Treatment

At the end of the 72 hours, one of the following must occur:

- If there are no legal grounds to involuntarily treat the person (e.g., the person is not found to be a danger to self, others/gravely disabled) the person must be released;
- The consumer is willing and able to volunteer for hospitalization; or
- A 14 day petition for involuntary treatment is filed with the court pursuant to RCW 71.05.230 or a 90 day petition for less restrictive involuntary treatment is filed pursuant to RCW 71.05.230.

It should be noted that even after a petition for 14 day or 90 day involuntary treatment is filed, the prosecutor or the evaluation and treatment facility may withdraw the petition prior to the hearing and the patient is either released or is placed on voluntary treatment status.

A-11d21-20

Probable Cause Hearing -Legal Rights

After the petition is filed, there is a probable cause hearing that is held in court. See RCW 41.05.240. The hearing must be held within 72 hours of the filing of the petition. RCW 71.05.240. The hearing, however, can be postponed for up to 48 hours, at the request of the detained person. The hearing may also be postponed for up to 24 hours by the petitioner upon written notice and a showing of good cause. Id. Prior to the hearing the patient is entitled to : communicate immediately with an attorney and, if indigent, the right to have an attorney appointed to represent the patient before and at such hearing; and be told the name and address of the attorney appointed; the right to remain silent; and the right to be told statements the patient makes may be used in involuntary proceedings. WAC 275-55-241(3)(b)(I) and (ii),(c) and (d).

At the hearing, the patient has the right to present evidence and to cross examine witnesses testifying against the patient at the probable cause hearing; has the right to refuse medication beginning 24 hours before any court proceeding wherein the patient has a right to attend and which bears upon the continued commitment of the patient. WAC 275-55-241(3 (e) and (f).

If, after the probable cause hearing, the court finds that the state has proven that by a preponderance of the evidence that, the individual is gravely disabled, a danger to self, others or property, the petition for 14 day or 90 day treatment will be granted. See RCW 71.05.240.

Termination of Involuntary Treatment

If at any time during the 14 day period, the person is no longer gravely disabled, a danger to self, others or property, involuntary treatment shall be terminated. See RCW 71.05.260(1)(a) and (b). Similarly, involuntary treatment shall end if, at any time during this period, the patient is willing and able to accept voluntary treatment. See RCW 71.05.260 (c) and (d).

Ninety Day Commitment for Additional Treatment

At the end of the 14 day intensive treatment, if there is cause to believe that the individual continues to be gravely disabled, a danger to self, others or property, the facility can petition the court to confine the patient for additional treatment for a period of 90 days. See RCW 71.05.290(1). If the facility files such a petition, it must do so at least three days before the expiration of the 14 day period for intensive treatment. RCW 71.05.300. At that time, a hearing on the matter is set for the next judicial day, unless waived by the individual's attorney. As soon as possible after filing the petition for additional treatment, the designated county mental health professional must notify and provide copies of the petition to the person detained, his or her attorney (if any), his or her guardian or conservator (if any), and the prosecutor.

Following the filing of the petition for additional treatment, the detained person has the right to appear before the court. At that time, he or she must be notified of the right to representation by an attorney and his or her right to a jury trial. If the detained individual is indigent, he or she must benotified that the court will appoint an attorney to represent them. Further, the court, if requested,

shall appoint a licensed physician, psychologist, or psychiatrist to examine and testify on behalf on the detained person.

After the petition has been filed for the 90 day commitment, the patient makes an initial appearance in court and is informed of his or her legal rights, including the right to a hearing on the issues of the proposed commitment. The hearing on the 90 day petition for additional treatment shall occur within five judicial days of the initial court appearance. RCW 71.05.310. The hearing can be delayed for up to five additional judicial days for good cause, upon written request of the detained individual or their attorney. In cases where the individual detained has requested a jury trial, the trial shall occur within ten days of the initial court appearance. The burden of proof at the hearing is clear and convincing evidence and is on the petitioner. If this burden is not met, the patient is released. If, however, it is met, the patient can be committed to the facility for an additional 90 days of treatment. However, at any time during the 90 days, the facility can drop the involuntary commitment if the patient agrees and is able to be a voluntary patient or if he or she no longer meets the legal criteria for civil commitment. See RCW 71.05.330(1).

Less Restrictive Orders

For individuals who have not be successfully treated pursuant to a commitment to 90 days of less restrictive treatment, the court may remand them to the custody of the Department of Social and Health Services (DSHS) for further intensive treatment not to exceed the remainder of the 90 day commitment. See RCW 71.05.320. Less restrictive treatment involves mental health treatment in a setting with a lower level of care than in an intensive treatment facility. Before the court can make such an order, however, the detained person is entitled to a hearing with full due process protections as discussed above.

One Hundred and Eighty Day Commitment For Additional Treatment

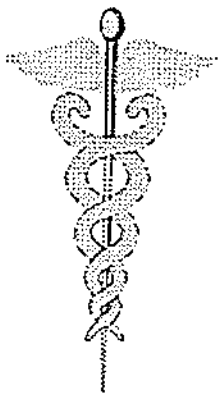
At the end of the 90 day commitment, an individual can be committed for additional mental health treatment not to exceed 180 days if there is clear and convincing evidence that the detained individual continues to be gravely disabled, a danger to self, others or property. See RCW 71.05.320. However, before this additional treatment can occur, there must be a valid court order for such commitment. See Id. The detained individual is entitled to a hearing with full due process protections as discussed previously.

Additional One Hundred and Eighty Day Commitments

Such commitments are possible if the petitioner shows by clear and convincing evidence that the detained individual continues to be gravely disabled, a danger to themselves, others, or property. Just as for all involuntary commitments, the detained person is entitled to a hearing with all of the due process procedures discussed above. See RCW 71.05.320(2).

CONSUMERS' RIGHTS
Inpatient

All mental health consumers, whether **voluntary or involuntary**, at an inpatient facility have the following rights:



★ The right to adequate care and an individualized treatment plan;

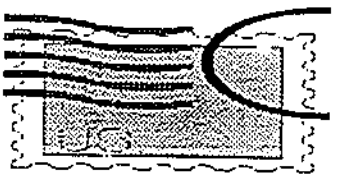
★ The right to make an informed decision regarding the administration of antipsychotic medication except where there is an emergency or a judicial determination that the individual is unable to make such a decision;

★ The right to wear one's own clothes and shoes and to keep one's personal possessions, unless deprivation of these rights is necessary to ensure the protection and safety of the patient or others;

★ The right to spend a reasonable sum of one's own money;

★ The right to access to individual storage space for one's own private use;

★ The right to have visitors at reasonable times;



★ The right to have ready access to letter writing material, including stamps, and to send and receive uncensored correspondence through the mails;

★ The right not to consent to the performance of electroconvulsive therapy (ECT) or surgery, except in a emergency, life-saving surgery, and to not have ECT or nonemergency surgery absent a judicial order after a hearing with full due process protections;

★ The right to dispose of property and sign contracts unless the person has been adjudicated incompetent in a court proceeding directed to this particular issue;

★ The right to object to detention or request release through a writ of habeas corpus;

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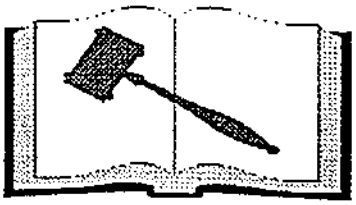
★ The right to be presumed competent and not lose any civil rights as a consequence of receiving mental health treatment except possession of firearms after a 90 day hearing;



★ The right to access to attorneys, courts and other legal redress at any time;

★ The right to confidentiality in all information and records compiled, obtained or maintained in the course of receiving services.

See RCW Section 71.05.370; WAC 275-55-241

Additionally, all **voluntary** patients shall have the right to:

✓Release from a facility, unless civil commitment proceeding have been initiated (Specific rights regarding release depend upon the individual's legal status (minor, guardianship, etc.);

✓Review of condition and status at least every 180 days.

See WAC 275-55-241(2)(a) and (b).

Each facility must post a list of the consumer rights above in a place visible to all consumers.

In addition to these rights, all mental health patients retain all other rights except where those rights have been specifically denied by law. See RCW 71.05.360(1). See also RCW 71.05.370.

I Denial of Rights

The rights cannot be denied except to prevent imminent danger to the patient or to others. If a right is denied to prevent such harm, there must be nexus between the dangerous behavior and the right that is denied. See WAC 246-322-070(7)(b)(I). For example, if an individual is making constant phone calls to the emergency number, "911" it is appropriate to deny that person their right to use the phone, except to call their attorney. However, if a person is calling "911" all the time, it is not appropriate to deny them their right to wear their own clothes as there is no relationship between wearing one's own clothes and making calls to "911."

In some situations there may be word policies that apply to all patients that restrict certain privileges generally.

It is also important to note that a patient's right may not be denied as a means of punishment or for the convenience of staff.

When a right is denied, there should be proper documentation in the patient's chart as to what right is being denied, the **specific** reason for the denial, the lesser restrictive alternatives attempted, the date, and the time.

II Restoration of Rights

When the threat of harm to self or others which led to the denial of the rights no longer exists, the right may no longer be denied and must be restored. There should be regular review of the patient's condition, to ensure that a patients' rights are not denied unnecessarily.

III. Remedies for Violation of Rights

While an individual may be able to bring legal action to seek a remedy for violation of some rights, this is often not possible for a variety of reasons. However, a person can use alternate means of remedying such violations. Remedies include licensing violations, staff trainings and discipline, among others.

If you have questions or a complaint
you can contact:

MENTAL HEALTH OMBUDSMAN
HUMAN SERVICES COUNCIL
P. O. Box 425
Vancouver, WA 98666-0425
(360) 694-6577

A 11d 21-23

CONSUMER RIGHTS
Restraint and Seclusion

Regulation of the use of restraint and seclusion:

A mental health patient may not be physically or chemically restrained or secluded unless such action is in response to assaultive, self-destructive, or unruly patient behavior. See WAC 275-55-263(2)(c). In such cases, restraint or seclusion is only permissible to the extent and duration necessary to ensure the safety of the patient, others, and property. WAC 246-318-280(4)(k)(I). Additionally, restraint and seclusion are subject to the following conditions:

- In the event of an emergency use of restraints or seclusion, a licensed physician must be notified within one hour, and shall decide whether to authorize the continued use of seclusion or restraints. The authorization need not be based on a personal exam as it can be ordered by phone;

- No patient shall be restrained or secluded for a period in excess of two hours without having been evaluated by a mental health professional;

- All patients placed in seclusion or restraint must be directly observed every 15 minutes and the observation recorded in the patient's clinical record and be given adequate food, water and exercise. It should be noted that for the 15 minute checks, no person to person communication is required. Rather, staff may observe the patient by looking through a window;

- If an individual is secluded or restrained for a period exceeding 24 hours, he or she must be examined by a licensed physician. The results of this examination as well as any determination to continue the seclusion or restraint, must be recorded in the patient's records and be accompanied by the signature of the authorizing physician. This procedure must be repeated for each subsequent 24 hour period of seclusion or restraint.

See WAC 275-55-263(2)(c)(I)(ii)(iii) and (iv))(emphasis added).

Other limitations on the use of restraint and seclusion:

- A patient may not be secluded or restrained as a means of punishment. For example, if a patient refuses to go to group therapy, he or she may not be secluded or restrained as a punishment for not going to the therapy group.

- Additionally, restraint and seclusion may not be used as a means of convenience for staff.

Key things to look for when investigating the use of restraint and seclusion:

- ✓ Documentation: Look for documentation in the patient's records that states that he or she was restrained and secluded and the specific reasons for the restraint or seclusion. Specificity is extremely important. A specific description of the behavior leading to the restraint or seclusion will explain why such action was justified. An example of good specific charting is:

  - "patient running through hall hitting other patients on the head with fists."

  On the other hand, an example of poor charting is:

  - "patient crying and upset."

  The problem with nonspecific charting is that it does not explain the behavior that led to the seclusion, so there is no way from the record to tell whether it was warranted.

  Additionally, it is important to see if all of the relevant conditions mentioned in the WACs have been documented. For example, there should be a record of the patient being observed at least every 15 minutes. Even if there is a record of 15 minute checks, it is important to look to see whether this record is adequate. Look to see if the 15 minute checks were consistently done every 15 minutes, were they done only a few times, and if the notes say the same thing as if done rotely.

- ✓ Less Restrictive Alternatives: Look to see what led up to the incident and whether any less restrictive alternatives were attempted before staff resorted to the use of restraint or seclusion. If so, what was tried and was this documented? Examples include: attempts to verbally deescalate the situation, understand patient concerns, and direct patient away from others.

- ✓ Personal Observation of the Seclusion/Restraint Room: Go and personally observe the seclusion/restraint room. When doing so, you should:

  - look at the condition of the bed, if one was used;
  - look to see if the room is clean;
  - observe where the observation window is in relationship to the bed;

- ✧ observe the amount of light in the room;
- ✧ smell the room to see if it smells excessively of cleaning fluids or other odors,
- ✧ observe whether there are any video cameras being used.

✓ Interview Patients: It is important to speak with patients who are willing to talk to you about their experience in restraints or seclusion. When interviewing them, you should ask questions such as whether the restraints were too tight, whether they were given food, water, and the opportunity to go to the bathroom when necessary, whether staff explained why they were restrained or secluded, whether they were given privacy, clothing, an opportunity to clean up, and whether they were told what would be done with their personal items.

When interviewing clients, do not assume a particular viewpoint on restraint and seclusion. Some view restraint and seclusion as a violation of their rights and not a valid treatment modality. Others, however, see it as a necessary precaution when they become assaultive or want to hurt themselves.

✓ Interview Staff: When interviewing staff, you should attempt to determine their understanding of the seclusion and restraint process and patients rights regarding this process. You should also solicit their opinions about the process and any problems they may perceive with this process.

✓ Review Relevant Facility Policy and Procedure: As part of your investigation you should be sure to review any and all relevant facility policies and procedures regarding the use of seclusion and restraint. You should also investigate the amount and type training that staff has received regarding the seclusion and restraint process.

This list is not exhaustive of the steps you should take in investigating the use of restraint and seclusion, it is merely a list of suggestions. Each case will be different and will require a specific approach.

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Vancouver, WA 98666-0425
(360) 694-6577

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Consumer Rights
Confidentiality

Informed Consent For Disclosure Of Information

An individual's mental health records and related information is confidential. See RCW 71.05.630(1). Before a legally authorized person consents to release of information regarding mental health treatment, his or her informed consent, in writing, must be obtained. To constitute valid informed consent, the person must be given the following information:

- The name of the individual, agency, or organization to which the disclosure is to be made;
- The name of the individual whose treatment record is being disclosed;
- The purpose or need for the disclosure;
- The specific type of information to be disclosed;
- The time period during which consent is effective;
- The date on which the consent is signed; and
- The signature of the individual or person legally authorized to give consent for the individual.

RCW 71.05.620(1)(a)-(g).

Instances Where Informed Consent is Not Necessary

There are many exceptions to the rule regarding informed consent and the release of records. These include:

(when this information is released, the person or entity receiving such information must keep it confidential)

- Release to an individual or agency as necessary for management or financial audits, or program monitoring and evaluation;
- To the Department of Social and Health Services (DSHS) or the RSN for billing purposes;
- For the purposes of research as permitted by state law;

A.11d21-32

- ✧ Pursuant to a lawful court order;

- ✧ To qualified staff members of DSHS, the director of RSNs, and management services responsible for serving a patient as necessary to determine the progress and adequacy of treatment and to determine whether a person can be served in a less restrictive setting;

- ✧ To individuals employed to provide training or volunteer programs within a facility where the patient is receiving treatment;

- ✧ Within DSHS to coordinate treatment for those under the supervision of Department;

- ✧ To a licensed physician where the life or health of individual has been deemed in danger and that treatment without this information could be harmful to the patient;

- ✧ To a facility that is to receive an individual for involuntary commitment (relevant information only);

- ✧ To a correctional facility or corrections officer who is responsible for an individual receiving inpatient or outpatient evaluation or treatment. Release under this section is limited to:

  - ✓ An evaluation report pursuant to a written treatment plan;

  - ✓ The discharge summary of all somatic treatments;

  - ✓ Any information necessary to establish or implement changes in the individual's treatment plan or the level or kind of supervision as determined by resource management services. In cases involving a transfer back to a correctional facility, this information shall be disclosed only to clinical staff;

- ✧ To the individual's attorney or guardian ad litem, without modification, at any time in order to prepare for involuntary commitment or recommitment proceedings, related actions, or with regard to patients' rights;

- ✧ To a corrections officer who is responsible for the supervision of an individual who is transferred or discharged from a treatment facility;

- ✧ To the staff at the Protection & Advocacy or other nonprofit, legal organizations advocating on behalf of persons with mental and developmental disabilities.

See RCW 71.05.630(2)(a)-(m).

In addition to the above exceptions, there are additional similar exceptions regarding information specific to involuntary commitment. See RCW 71.05.390(1)-(14) for more information.

Penalties For Unauthorized Disclosure

Any individual (except for limitations applicable to individuals convicted of committing sex offenses pursuant to RCW 4.24.550) whose mental health records were improperly disclosed can bring a civil action against the person who has willfully and improperly released confidential information. RCW 71.05.440 The penalty for such disclosure is $1000.00 or three times the amount of actual damages that the individual sustained, if any. RCW 71.05.440(1) and (2). An individual may also bring a legal action to prevent the release of confidential information. RCW 71.05.440

It should be noted that there are certain other rules regarding confidentiality that apply in specific situations, such as involuntary commitment.

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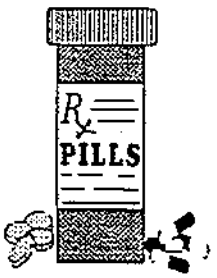

CONSUMER RIGHTS

Emergency Medication, Right to Refuse Medication, & Informed Consent

Informed Consent of Antipsychotic Medications

Unless otherwise required by law (see below), a mental health patient has the right to give informed consent before taking antipsychotic medications.

Before a patient can make an informed decision, his or her doctor must provide the following information:

- The nature and character of the proposed treatment ;
- The anticipated results of the proposed treatment;
- The recognized possible alternative forms of treatment;
- The recognized serious possible risks, complications, and anticipated benefits involved in the treatment and in the recognized possible alternative forms of treatment, including nontreatment.

See RCW Sections 7.70.050 and 7.70.060.

Emergency Medication

Mental health patients can be involuntarily medicated in certain instances. One such situation is where there is an emergency.

An emergency is defined as existing when:

- The patient presents an imminent likelihood of serious harm to self or others; and
- Medically acceptable alternatives to the administration of antipsychotic medications is not available; and
- In the opinion of the physician, the patient's condition constitutes an emergency requiring that treatment be instituted before obtaining a second opinion by a nonattending physician.

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See WAC 275-55-241(1)(c)(I)(A),(B), and (C).

Where emergency medication is administered, there must be specific documentation in the patient's records as to the reason for the administration of the emergency medication. WAC 275-55-241(1)(c). In addition, there must be documentation explaining attempts made at obtaining the patient's informed consent prior to the administration of the medication and why that was not successful. All decisions to administer emergency medications must be reviewed by a nonattending physician within 24 hours of the administration of the medication. WAC 275-55-241(1)(c)(I).

For instances of administration of emergency medication for individuals committed for 180 days, there must be a petition for an order authorizing the administration of antipsychotic medications filed the next judicial day. RCW 71.05.370(7)(a)(iii). There must then be a hearing held within the next two judicial days. The physician, if he or she deems it necessary, may continue to administer the medication involuntarily until the hearing is held.

Right to Refuse Antipsychotic Medications: *Other Limitations*

As stated above, pursuant to certain conditions, mental health patients have the right to refuse antipsychotic medications. If, after receiving the requisite information regarding the medications, the patient wishes to refuse the medications, he or she has the following rights.

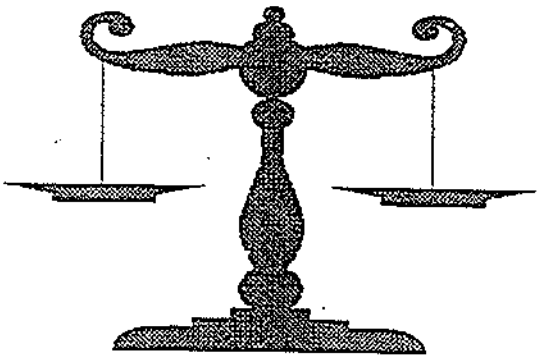
For up to 30 days, a patient can only be involuntarily medicated after there has been a review of the decision to medicate the patient by another nonattending physician. WAC 275-55-241(1)(c)(ii). This is different from an emergency in that before antipsychotic medication can be given involuntary, that decision must be reviewed which is not the case for the administration of emergency medication.

Before a patient can be involuntarily medicated for continued treatment beyond 30 days through a hearing on a 180 day petition, the facility medical director or his or her designee must review the decision to medicate the patient. He or she must review this decision at least every 60 days thereafter. WAC 275-55-241(1)(c)(iii).

- ✧ Patients who are committed for 180 days have the right to a court hearing before the administration of involuntary medication, except in an emergency. See RCW 71.05.370(7), WAC 275-55-241(c)(iii)(B).

- ✧ In court, the party requesting the involuntary medication has the burden to show by clear and convincing evidence that there is a compelling state interest that justifies overriding the patient's lack of consent to the administration of antipsychotic medications, that the proposed treatment is necessary and effective, and that the medically acceptable alternative forms of treatment are not available, have not been successful, or are not likely to be effective. RCW 71.05.370(7)(a).

At the hearing the patient shall have the following rights:



- to be present;
- to be represented by a court appointed attorney;
- to present evidence;
- to cross-examine witnesses;
- to have the right to have the rules of evidence enforced;
- to view and copy all petitions and reports from the court file;
- to remain silent;
- to reasonable notice and opportunity to prepare for the hearing; and
- in some cases, to have a psychiatrist, psychologist, or physician appointed to testify on behalf of the patient.

See RCW 71.05.370(7).

References

Washington v. Harper 110 S. Ct. 1028 (1990).

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WA Protection and Advocacy System *September 1995*

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Spokane

Summary of April, June and August CCP Consumer responses

Quality of life improvements

1. IOP
2. Groups, classes
3. First Call for Help
4. therapy

Opinions listened .o?

1. 63 yes (N=7)
2. 36 no (N=4)

Things done differently

1. Diverse, alternative programs including partial programs
2. special mobility programs needed for GAU folks
3. IOP added back to mix
4. Better knowledge about service availability including respite care availability and education to police, etc.
5. Less emphasis on drugs, more on counseling
6. need informal supports
7. change limitations regarding SEER students.
8. Get rid of ubh

A. 11d 21-30

Spokane Quality Review Team

Results from the **Allied Provider Survey**

April 30, 2001

Prepared by:

Darla K. Torno Connie Rundle Jamie LaBelle

A 1142 - 3

QUALITY
REVIEW TEAM
SPOKANE COUNTY

Great Western Building
905 W. Riverside, Suite 203, Spokane, WA 99201
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Allied Provider Survey

April 30, 2001
Prepared by Darla K. Torno, Jamie LaBelle, and Connie Rundle

Background/ Summary

The *Mental Health Division Report for Spokane Regional Support Network* (RSN) *Prepaid Health Plan*, dated May 30, 2000 requested the Quality Review Team (QRT) to "evaluate the RSN's relationship with allied systems, schools". In addition, the *Mental Health Division's Integrated Services Contract*, dated October 1, 1997-June 30, 1999, page 31 discusses the expectations of relationships with Allied Systems. Allied Systems are defined as agencies, practitioners and schools that have clients in common with the RSN's Spokane County Public Mental Health System. We refer to these agencies as *Allied Providers*. The QRT conducted this project in consultation with the RSN and the Washington Institute: Mental Illness Research and Training.

A Likert-type scale was chosen as the survey instrument, with answers ranging from Strongly Agree to Strongly Disagree. (See Attachment A) The survey listed each Spokane County Public Mental Health Provider. Participants were able to evaluate more than one agency and to provide comments. This report does not include a detailed summary of each exclusive agency. A complete copy of the individual agency results will be available only by specific request. This report is titled: *Allied Provider Survey; Individual Results for Public Mental Health Agencies.*

The QRT developed a comprehensive list of 87 agencies consisting of schools, health care professionals, hospitals, and public and private agencies. At the suggestion of the RSN, Public Mental Health Providers were included. The QRT sent out 1176 surveys by the first week of January and asked that all responses be returned by January 31, 2001. We received 683 responses from 63 different agencies. A total of 585 surveys were used for the results with another 98 surveys disqualified as unusable. Surveys were determined unusable with reasons varying from multiple agencies being marked on one form to not indicating which agency they were reporting on. An overwhelming 299 comments made by 261 respondents were collected - totaling 15 pages. All comments were documented as closely to the original statement as possible. The QRT did edit out distinguishing remarks to keep the anonymity of the participants. A complete list of the comments will be available only by specific request. This report is titled: *Detailed Copy of Comments from the Allied Provider Survey.*

Results

After reviewing total numbers for the Public Mental Health System, the QRT found the most positive responses were for the following items of the survey. The quotations in parenthesis are representative examples of such positive responses.

- **When referring someone for mental health services, agency staff are courteous and helpful.** (68%) (e.g. "*Staff cooperative and courteous with other agencies.*")
- **I am usually in agreement with the type of services provided.** (62%) (e.g. "*I have referred 3 children for SAY (Sexually Aggressive Youth) assessments & have been pleased with the services provided in this program.*")
- **Staff are sensitive to persons of diverse cultural and ethnic populations.** (63%) (e.g. "*The SMH Homeless Outreach Team is exceptional in terms of the accessibility and willingness to go the extra mile.*")

The lowest numbers of positive responses were for the following statements:

- **Access to services begins within an appropriate time frame.** (46%) (e.g. "*Waiting list is too long-Children and families with critical issues must be seen sooner!*")
- **I am satisfied with my level of communication with this agency.** (55%) (e.g. "*Workers do not seem to return calls in a timely way to both our staff and their clients they work with.*")
- **I receive requested progress reports and/ or treatment plan.** (37%) (e.g. "*I'm not always sure this agency responds in a timely manner because it is usually weeks before I get a report that the client has been contacted. I never get a report on progress or treatment plans.*")
- **I am familiar with the role of the Mental Health Ombuds services.** (53%) (e.g. "*What is this?*")

Along with these results 96 comments stressed poor communication issues, including phone calls not returned or sending written progress notes/treatment plans when requested. A large number of Practitioners in our community expressed a concern that issues around medications were not being documented and referred back appropriately. There were 93 comments that emphasized concerns about long waiting lists or poor access to services for consumers. There were 22 comments that targeted issues around high turnover, inexperienced and/or inadequately trained staff. In addition there were numerous comments regarding the need for increased staff and funding.

Recommendations

1. The RSN to work with the contracted System of Care agencies on how to consistently improve their communication with Allied Providers. Areas identified as needing improvement were promptly returning phone calls, forwarding requested progress notes, and increase collaboration on behalf of consumers.
2. The RSN and UBH meet to discuss strategies of decreasing waiting lists and how to implement changes. The QRT requests a written report outlining these plans.
3. The RSN to increase education to Allied Providers about the options available to people who qualify for public mental health services. (e.g. "Would like other agencies to provide more information about services")
4. The RSN to meet with the Ombuds service to provide education about their service to Allied Providers. The QRT asks that posters and/or brochures be left at these sites for easy access and referral. The QRT will offer suggestions on how to accomplish this.

Cc
RSN
Provider Network
County Commissioners
WPAS

Mental Health Division
Kasey Kramer
Consumer Consultation Panel

NAMI
QIT
MHAB

Attachment A

Allied Provider Survey

Satisfaction Survey of Public Mental Health Services

Spokane Quality Review Team

1. Which RSN funded Mental Health agency have you interacted with the most? PLEASE CIRCLE

Catholic Family Services	Goodwill Industries	Sacred Heart Psychiatric Svcs
Children's Home Society	Grief Counseling Services	SEER
Congregate Care Facilities	Hope Partnership	Spokane Mental Health
Deaconess School Project	Lutheran Social Services	St Luke's Rehabilitation Institute
Excelsior Youth Center	Mental Health Ombuds	Supported Living Program
Family Service Spokane	NATIVE Project	Tamarack Center
	Pre Vocational Training Center	United Behavioral Health

Specify which service location, if applicable: _____

Please rate the following statements based on your overall experience with this agency.

		Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	Not Applicable
2.	When referring someone for mental health services, agency staff are courteous and helpful.						
3.	People I refer are generally accepted into services.						
4.	Access to services begins within appropriate time frames.						
5.	I am usually in agreement with the type of services provided.						
6.	I am satisfied with my level of communication with this agency.						
7.	Staff are sensitive to persons of diverse cultural and ethnic populations.						
8.	Services provided result in positive changes for consumers.						
9.	I receive requested progress reports and/or treatment plans.						
10.	Services are individualized to the needs of the consumer.						
11.	I am familiar with the role of the Mental Health Ombuds services.						
12.	I would recommend this agency to my friends and/or family.						

13. Please make any suggestions or comments _____

Allied Survey Chart Percentages

To focus on the positive statements for providers and to minimize the volume of the report, the QRT chose graphing only Strongly Agree/ Agree Percentages for all Public Mental Health agencies combined, (please reference Page 1, Paragraph 2). Agency names and number of survey totals are listed below.

Agency Names	Number of surveys returned
Catholic Family Services	15
Children's Home Society	16
Congregate Care Facilities	11
Deaconess School Project (CAP)	14
Excelsior Youth Center	12
Family Service Spokane	46
Goodwill Industries	4
Grief Counseling Services	6
Hope Partners	16
Lutheran Social Services	44
Mental Health Ombuds	4
NATIVE Project	8
Pre Vocational Training Center	7
Sacred Heart Psychiatric Services	77
SEER	3
Spokane Mental Health	224
St. Luke's Rehabilitation Institute	21
Supportive Living Program	19
Tamarack Center	5
United Behavioral Health	33

Question Number 11- "*I am familiar with the role of the Mental Health Ombuds Services*," was excluded in the bar charts, as it did not reflect the measurement of how allied providers view the public mental health system. This question was included for informational purposes only. (See Recommendations, #4)

We would like to bring to your attention that the QRT did not make comparisons based on agency size, clientele, and different levels of service. The following information is provided solely by data gathered from the completed surveys. The results have not been verified by other sources.

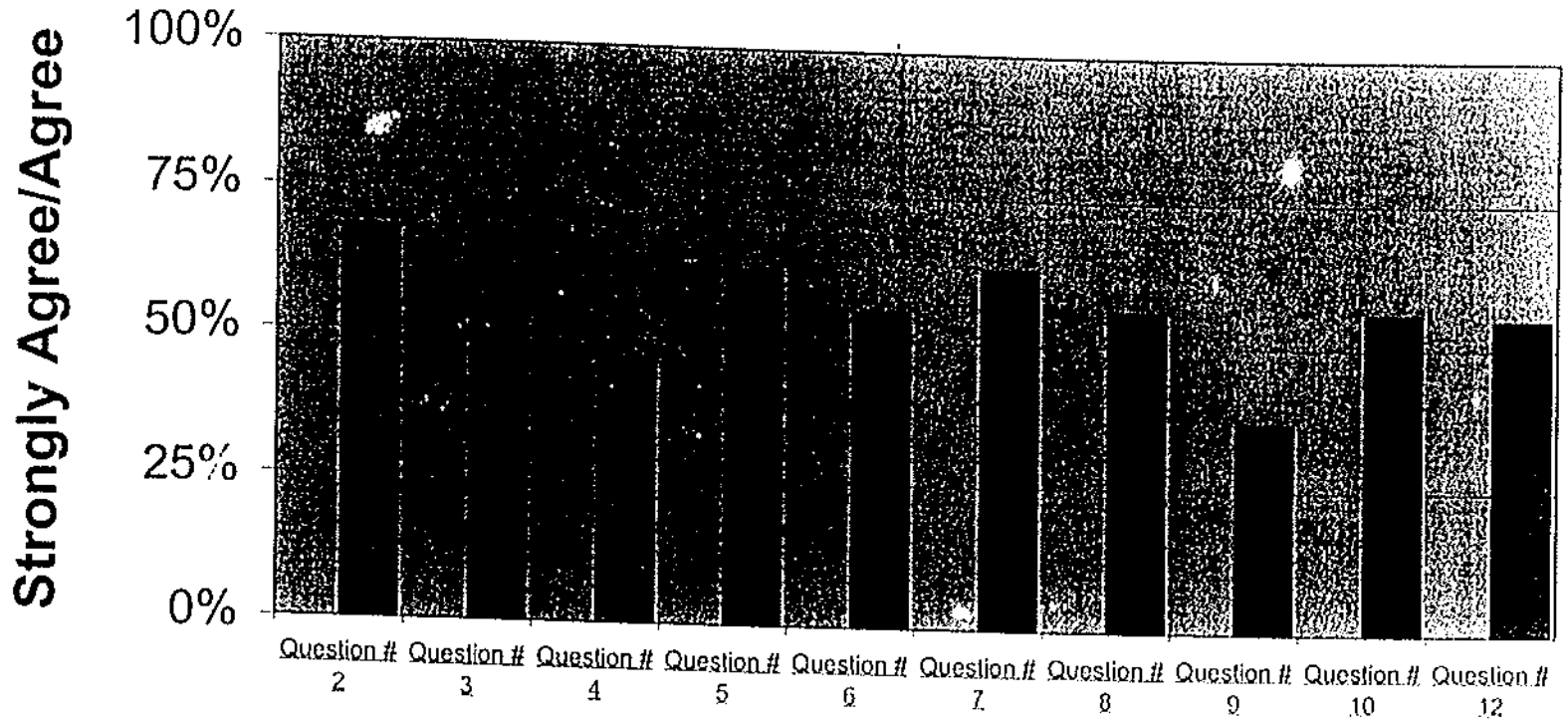
* Please note that numbers vary from 99%-101%. This is the result from the reporting system we chose to use.

Allied Provider Survey Results

1. **All Agencies Combined - 585 Surveys**

		Strongly Agree- Agree totals	Neutral	Disagree- Strongly Disagree totals	Not Applicable
2.	When referring someone for mental health services, agency staff are courteous and helpful.	68%	15%	23%	5%
3.	People I refer are generally accepted into services.	56%	15%	29%	7%
4.	Access to services begins within appropriate time frames.	46%	15%	34%	4%
5.	I am usually in agreement with the type of services provided.	62%	16%	29%	4%
6.	I am satisfied with my level of communication with this agency.	55%	15%	31%	1%
7.	Staff are sensitive to persons of diverse cultural and ethnic populations.	63%	22%	25%	10%
8.	Services provided result in positive changes for consumers.	56%	25%	34%	3%
9.	I receive requested progress reports and/or treatment plans.	37%	17%	31%	20%
10.	Services are individualized to the needs of the consumer.	56%	24%	34%	5%
11.	I am familiar with the role of the Mental Health Ombuds services.	53%	15%	30%	8%
12.	I would recommend this agency to my friends and/or family.	55%	16%	29%	4%

All Agencies Combined/ 585 Surveys

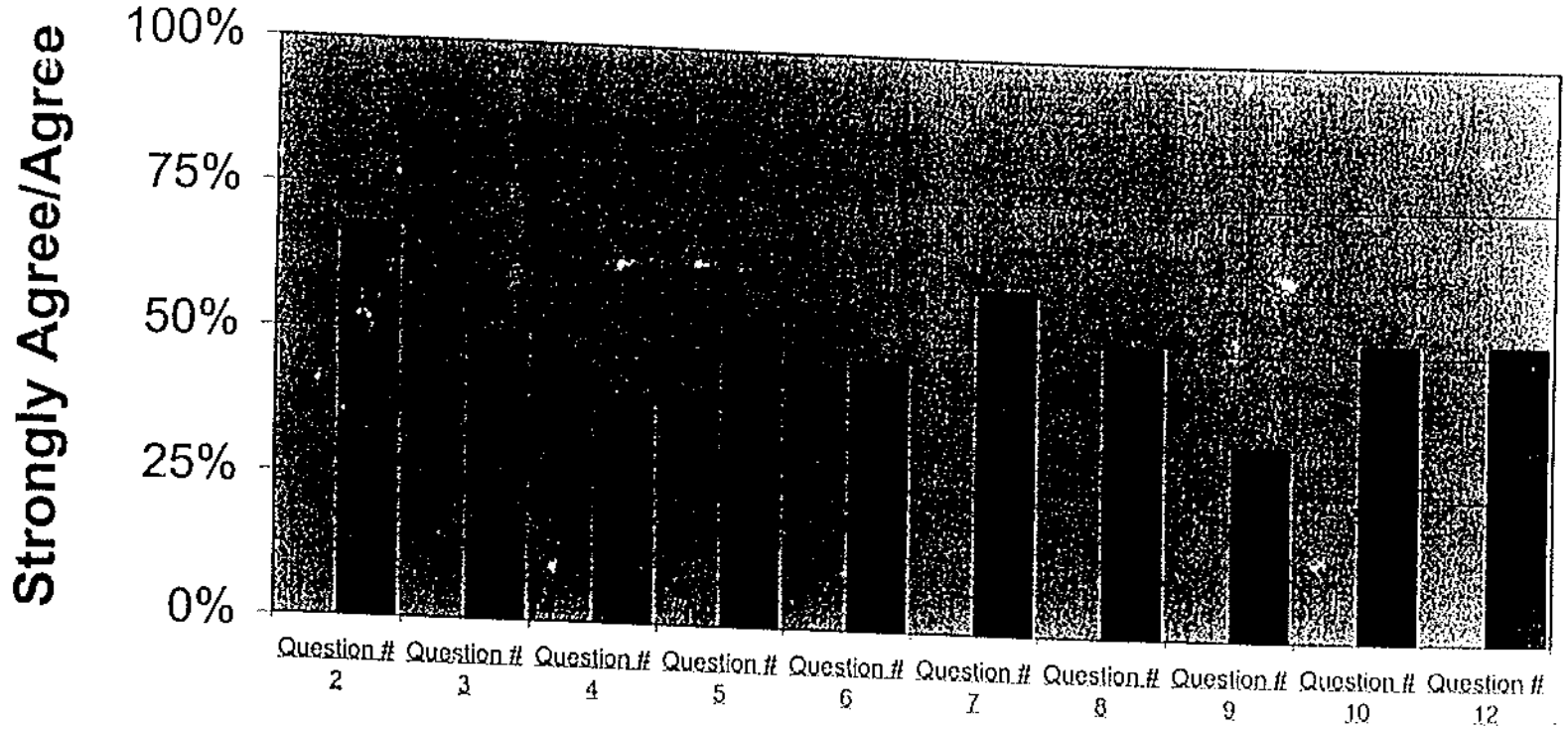


Allied Provider Survey Results

1. Allied Provider Responses For All Agencies - 370 Surveys

	Strongly Agree- Agree totals	Neutral	Disagree- Strongly Disagree totals	Not Applicable
2. When referring someone for mental health services, agency staff are courteous and helpful.	68%	16%	13%	3%
3. People I refer are generally accepted into services.	50%	18%	29%	2%
4. Access to services begins within appropriate time frames.	40%	16%	42%	2%
5. I am usually in agreement with the type of services provided.	54%	19%	24%	4%
6. I am satisfied with my level of communication with this agency.	47%	18%	34%	2%
7. Staff are sensitive to persons of diverse cultural and ethnic populations.	60%	23%	6%	12%
8. Services provided result in positive changes for consumers.	51%	29%	18%	3%
9. I receive requested progress reports and/or treatment plans.	34%	18%	31%	17%
10. Services are individualized to the needs of the consumer.	52%	26%	17%	5%
11. I am familiar with the role of the Mental Health Ombuds services.	39%	16%	36%	8%
12. I would recommend this agency to my friends and/or family.	52%	16%	28%	3%

Allied Providers/ 370 Surveys

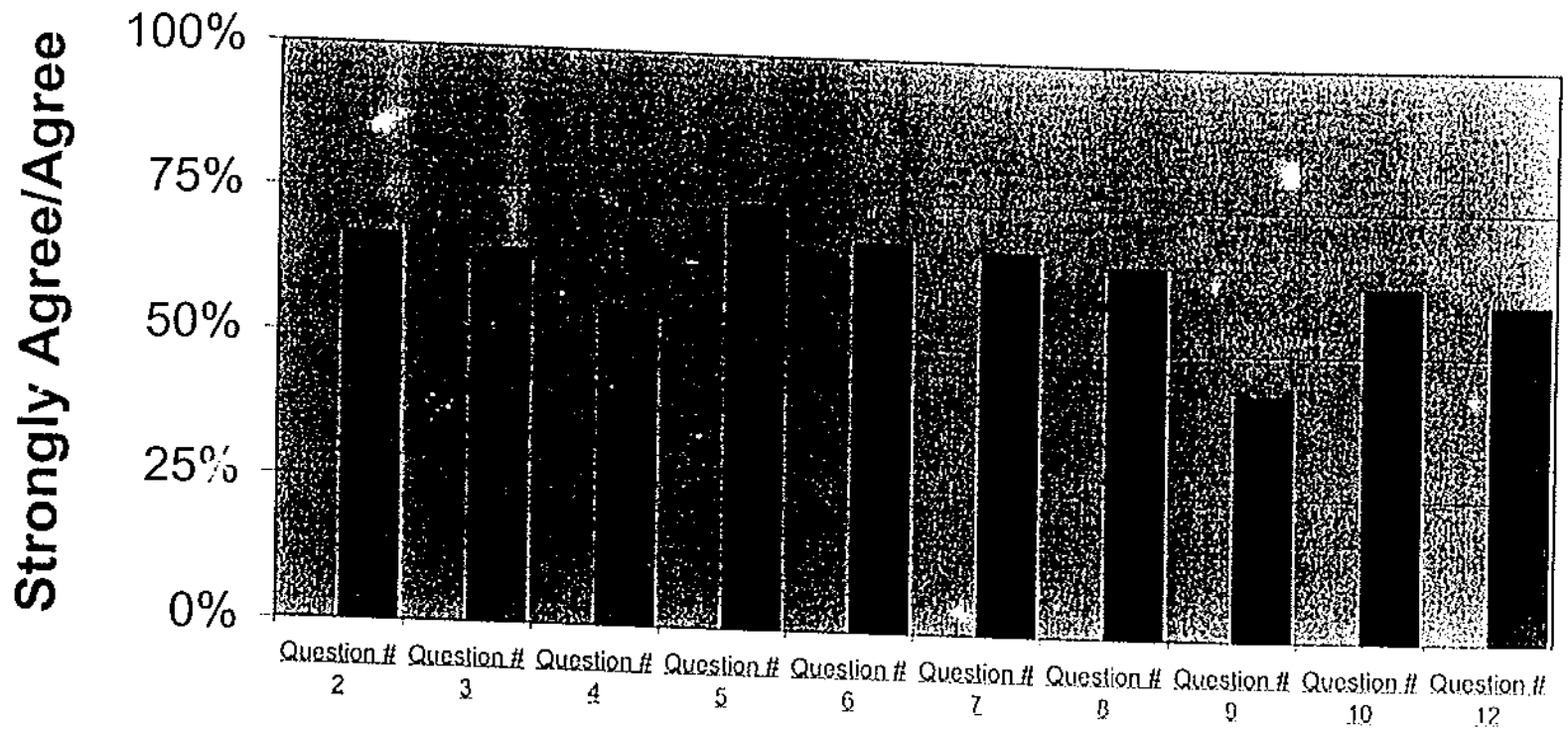


Allied Provider Survey Results

1. Contracted Provider Responses For All Agencies - 215 Surveys

	Strongly Agree- Agree totals	Neutral	Disagree- Strongly Disagree totals	Not Applicable
2. When referring someone for mental health services, agency staff are courteous and helpful.	67%	13%	12%	8%
3. People I refer are generally accepted into services.	65%	9%	11%	14%
4. Access to services begins within appropriate time frames.	55%	13%	24%	7%
5. I am usually in agreement with the type of services provided.	74%	11%	11%	4%
6. I am satisfied with my level of communication with this agency.	68%	9%	22%	0%
7. Staff are sensitive to persons of diverse cultural and ethnic populations.	67%	22%	4%	7%
8. Services provided result in positive changes for consumers.	65%	19%	13%	4%
9. I receive requested progress reports and/or treatment plans.	43%	14%	18%	24%
10. Services are individualized to the needs of the consumer.	62%	20%	13%	5%
11. I am familiar with the role of the Mental Health Ombuds services.	78%	13%	1%	8%
12. I would recommend this agency to my friends and/or family.	59%	15%	21%	5%

Contracted Providers/215 Surveys



CLARK COUNTY MENTAL HEALTH SYSTEM QRT

Satisfaction Survey

Percent of Consumers Agreeing or Strongly Agreeing with Statement.

Question	Adults and Children May 1998 Report	Adults and Children October 1998 Report	Adults and Children October 1999 Report	Adults and Children February 2000 Report	Adults and Children March 2000 Report	Adults and Children June 2000 Report	Adults and Children September 2000 Report
I have a person in the mental health system that I can trust.	94%	89%	90%	92%	90%	92%	92%
I have been involved in planning my own services with the people in the mental health system	89%	84%	80%	87%	83%	60%	87%
The professionals I work with focus on my strengths.	89%	90%	86%	92%	89%	56%	88%
My mental health professional is helping me meet my needs and goals.	91%	83%	82%	91%	87%	87%	86%
The professionals I work with in the mental health system are knowledgeable and provide me with the information I need.	89%	87%	86%	88%	88%	88%	87%
I have had good continuity in service providers.	86%	84%	76%	86%	86%	85%	83%
There is good communication among different people who provide services to me.	83%	79%	69%	86%	86%	75%	86%
In general I am able to get the help that I need.	90%	88%	85%	92%	90%	88%	86%
Services in the mental health system are offered at a place and time which are convenient for me.	86%	91%	83%	95%	91%	88%	88%
I receive the help I need when I am in crisis.	89%	89%	75%	84%	85%	78%	85%
The people I work with in the mental health system have been easy to contact.	80%	87%	75%	77%	78%	76%	76%
I feel respected by people at my mental health service provider.	90%	89%	79%	92%	90%	83%	93%
I have been made aware of my rights as a consumer of mental health resources.	91%	94%	91%	94%	85%	88%	94%
My rights have been respected.	95%	91%	91%	95%	93%	86%	94%
My quality of life has improved because of the services I receive from the mental health system.	90%	83%	83%	84%	93%	82%	88%
The mental health system provides education and support to my family or the other people who are important to me.	90%	75%	68%	75%	80%	72%	79%
Average score	3.28	3.25	3.03	3.19	3.19	3.19	3.26

*9/2000 All Agencies = 100 (12 PeaceHealth, 29 SWMC, 12 CC, 7 CHS, 28 CRMHS, 9 HAS)
*6/2000 All Agencies = 109 (11 CC, 4 CHS, 47 CRMHS, 5 HAS, SWMC 13, OTHER 29
*3/2000 All agencies = 109 (50 CRMHS, 6 ADAPT, 11 CC, 33 CHS, 3 other)
*2/2000 All Agencies = 97(60 CRMHS, 1 SWMC, 8 CC, 10 CHS, 8 PH)
*10/99 All Agencies = 80 (40 adults 40 children/teens)
*10/98 All Agencies=150(83 adults 67 children/teens)
*05/98 All Agencies=105 (41 adults 64 children/teens)

CLARK COUNTY MENTAL HEALTH SYSTEM QRT

Satisfaction Survey

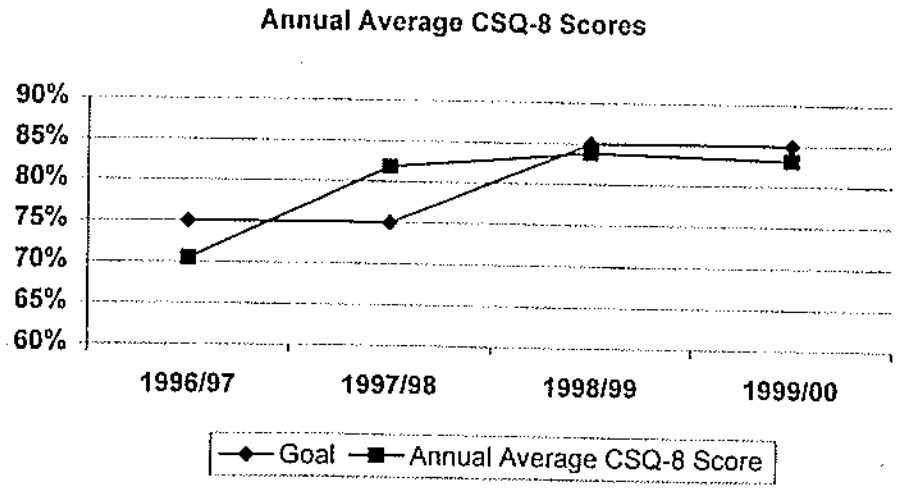
Percent of Consumers Agreeing or Strongly Agreeing with Statement.

Question	Adults and Children January 2001 Report **		
I have a person or people in the mental health system whom I trust.	89%		
I have been involved in planning my own services with people in the mental health system.	93%		
The professionals I work with in the mental health system focus on my strengths.	90%		
I believe I can recover.	82%		
My mental health provider is helping me meet my needs and goals.	88%		
The professionals I work with in the mental health system are knowledgeable and provide me with the information I need.	90%		
I have good continuity in service providers.	83%		
There is good communication among different people who provide services to me.	72%		
In general, I am able to get the help I need.	80%		
Services in the mental health system are offered at a place and time which are convenient for me.	84%		
I received the help I need when I am in crisis.	75%		
The people I work with in the mental health have been easy to contact.	77%		
I feel respected by people at my mental health service provider.	92%		
I have been made aware of my rights as a consumer of mental health resources.	92%		
My rights have been respected.	92%		
My quality of life has improved because of the services I receive from the mental health system.	77%		
The mental health system provides education and support to my family or other people who are important to me.	70%		
I would recommend my mental health service provider to a friend.	87%		
Average Score	3.09		

**Based on12 months rating of service satisfaction 01/2001 All Agencies=48 (35 CRMHS, 4 CC, 2 CHS, 4 SWMC/ADAPT, 3 PH)

Average CSQ-8 Scores	Mar-97	Jun-97	Sep-97	Dec-98	Mar-98	Jun-98	Sep-98	Dec-98	Mar-99	Jun-99	Sep-99
1 How would you rate	78%	65%	76%	86%	83%	84%	81%	86%	82%	85%	83%
2 Did you get the kind	74%	65%	74%	86%	81%	82%	81%	90%	82%	83%	83%
3 To what extent has	71%	60%	69%	81%	77%	78%	77%	80%	78%	79%	79%
4 If a friend were in ne	80%	69%	78%	91%	86%	83%	82%	91%	87%	84%	85%
5 How satisfied are yo	73%	62%	73%	85%	81%	83%	82%	88%	82%	82%	80%
6 Have the services y	76%	67%	78%	89%	75%	84%	84%	91%	84%	85%	85%
7 In an overall, gener	75%	65%	73%	87%	85%	84%	80%	88%	82%	82%	83%
8 If you were to receiv	80%	68%	79%	92%	89%	87%	84%	90%	85%	87%	87%
Average	**76%**	**65%**	**75%**	**87%**	**82%**	**83%**	**81%**	**88%**	**83%**	**83%**	**83%**

	1996/97	1997/98	1998/99	1999/00
Annual Average CSQ-8 Score	71%	82%	84%	83%
Goal	75%	75%	85%	85%



Dec-99	Mar-00	Jun-00	Sep-00	Dec-00
88%	85%	82%	87%	87%
84%	84%	80%	84%	83%
79%	77%	77%	78%	82%
87%	87%	85%	89%	90%
83%	83%	78%	83%	84%
84%	83%	84%	86%	88%
82%	84%	82%	85%	86%
86%	88%	84%	88%	90%
84%	**84%**	**82%**	**85%**	**86%**

CSQ-8 SEPTEMBER 2000 COMPILATION

	Labels Produced	Mailed Out	Returned Undeliverable	Received by Mail	Received by Box	Received by Distribution	Rollover	Total Received
CRMHS	188	147	16	14	7	0	8	29
HAS	0	0	0	0	9	0	0	9
CHS	23	23	4	2	3	0	2	7
Child Ctr	75	73	4	4	34	0	2	40
SWWMC	43	43	6	3	9	17	0	29
PeaceHlth	52	47	8	7	4	0	1	12
Totals	381	333	38	30	66	17	13	126

	Average Scores
CRMHS	80%
CHS	74%
Child Ctr	92%
SWWMC	85%
PeaceHlth	86%

RSN Average Score 85.3%

Timberlands RSN

COMMENTS ON CONSUMER SATISFACTION SURVEYS
DONE THROUGH PROVIDERS JANUARY - MARCH 2001

The following issues appear to reflect consumer perceptions that may warrant additional study and quality improvements. Most of these issues surfaced at more than one TRSN provider. QMC may wish to request further focus group study of these issues by QRT and/or review through the Clinical Services Review Team.

Access: Many consumers (9-21%) view providers as unable to provide appointments within 10 minutes of the scheduled time. (This item, which is not part of contract expectations, was not part of the survey WCMHS distributed). Consumers at WCMHS expressed problems with accessing medical services. Nine percent of Cascade respondents disagreed that services were provided when needed, or that they were able to obtain help when in crisis.

Acceptability/Interaction: Wahkiakum consumers expressed relatively low ratings of agreement (75% adults, 57% children) regarding their involvement in planning their services. 10-13% of consumers at Willapa and Cascade indicated difficulties with their provider understanding their needs and problems.

Rights and Confidentiality: Concerns regarding awareness of rights were expressed by 11% of Willapa consumers.

Provision of Information: 10-11% of consumers at Willapa and Cascade indicated difficulties with the provision of information about the range of services provided and effective treatment options.

Impact (of treatment): Consumers at all three providers indicated a lack of impact with regard to their support system improving (14-18%). Consumers at Cascade and Willapa also indicated a lack of positive change in their outlook (12-14%) and in their level of safety (10-14%).

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CASCADE MENTAL HEALTH CARE
CONSUMER SURVEY MARCH 2001

Eight hundred four surveys were mailed ou'. One hundred thirty, or 16.5% were returned

	Agree	Not Applicable	Disagree
ACCESS OF CARE			
1. Services have been provided when I/my child needed them.	86%	2%	9%
2. Services are in a convenient location.	94%	4%	1%
3. I am able to obtain help when needed in a crisis and an emergency.	71%	18%	9%
4. I am able to get an appointment in a timely manner.	91%	3%	6%
5. My appointments have been kept within 10 minutes of my/their scheduled time with the therapist.	84%	6%	9%
6. Services have been provided in a language I understand.	91%	7%	1%
PROVISION OF INFORMATION			
1. I have been informed about benefits, risks, and side effects of my/their medications.	65%	28%	5%
2. I have been informed about the range of services provided.	80%	9%	11%
3. I have been informed of effective treatment options that could be available to me.	81%	8%	11%
4. I have been informed of the cost of services and how they will be paid for.	76%	15%	6%
RIGHTS AND CONFIDENTIALITY			
1. I have been made aware of my rights as a mental health consumer.	93%	1%	5%
2. My rights to confidentiality have been protected.	89%	2%	2%
3. My rights have been respected.	90%	3%	3%
INTERACTION			
1. I have been treated with dignity and respect.	94%	2%	2%
2. My service provider has a clear understanding of my needs and problems.	86%	3%	10%
3. My/ service provider has been helpful in meeting my needs.	88%	1%	9%
4. I have been involved in planning my services and treatment goals.	88%	4%	7%
5. I would recommend these services to a friend.	81%	2%	7%
6. The front office staff is helpful.	90%	5%	2%
IMPACT			
1. My quality of life has improved since services began.	72%	11%	9%
2. I have been able to more effectively deal with crises.	61%	15%	14%
3. I have had less need for inpatient hospitalization and/or emergency visits.	41%	51%	5%
4. My support system has improved.	63%	19%	14%
5. My activity level has improved.	58%	72%	14%
6. My level of safety has improved.	59%	26%	10%
7. My outlook has improved.	72%	9%	12%

WILLAPA COUNSELING CENTER
CONSUMER SURVEY JANUARY 2001

Three hundred surveys were mailed out. Twenty-three were returned by the post office. Sixty-two, or 21% were returned by the consumer.

	Agree	Not Applicable	Disagree
ACCESS OF CARE			
1. Services have been provided when I/my child needed them.	87%	5%	5%
2. Services are in a convenient location.	92%	5%	0
3. I am able to obtain help when needed in a crisis and an emergency.	68%	18%	5%
4. I am able to get an appointment in a timely manner.	83%	3%	8%
5. My appointments have been kept within 10 minutes of my/their scheduled time with the therapist.	72%	3%	21%
6. Services have been provided in a language I understand.	89%	6%	0
PROVISION OF INFORMATION			
1. I have been informed about benefits, risks, and side effects of my/their medications.	65%	22%	8%
2. I have been informed about the range of services provided.	79%	6%	10%
3. I have been informed of effective treatment options that could be available to me.	72%	8%	10%
4. I have been informed of the cost of services and how they will be paid for.	79%	11%	5%
RIGHTS AND CONFIDENTIALITY			
1. I have been made aware of my rights as a mental health consumer.	72%	10%	11%
2. My rights to confidentiality have been protected.	72%	11%	8%
3. My rights have been respected.	56%	32%	2%
INTERACTION			
1. I have been treated with dignity and respect.	90%	0	3%
2. My service provider has a clear understanding of my needs and problems.	80%	0	13%
3. My/ service provider has been helpful in meeting my needs.	82%	3%	8%
4. I have been involved in planning my services and treatment goals.	90%	3%	0
5. I ould recommend these services to a friend.	80%	6%	5%
6. The front office staff is helpful.	90%	0	3%
IMPACT			
1. My quality of life has improved since services began.	72%	10%	11%
2. I have been able to more effectively deal with crises.	72%	11%	8%
3. I have had less need for inpatient hospitalization and/or emergency visits.	56%	32%	2%
4. My support system has improved.	74%	14%	5%
5. My activity level has improved.	66%	8%	16%
6. My level of safety has improved.	56%	22%	14%
7. My outlook has improved.	71%	6%	14%

Wahkiakum County Mental Health Services
Satisfaction Survey Summary January 2001

76 surveys were mailed out. 7 child and 16 adult surveys were returned (total 23, or 30%). Responses to "strongly agree" and "agree" were collapsed in the summary percentages below, as were "disagree" and "strongly disagree". Adult percentages precede child percentages.

	Strongly Agree	Agree	Neutral or not applicable	Disagree	Strongly Disagree
ACCESSIBILITY:					
1. Services are in convenient locations.	81%/57%		18%/14%	0%/28%	
2. I am satisfied with the length of time between requesting a service and when services begin:					
for counseling and case management:	87%/71%		6%/14%	0	
for medical services:	31%/42%		18%/42%	6%/0	
3. Services have been appropriate to my age, gender, culture, and individual needs.	81%/85%		12%/14%	0/14%	
ACCEPTABILITY:					
1. I have been involved in planning my own services, or services for my child.	75%/57%		18%/28%	0/14%	
2. My services provider has understood the kind of help I (or my child) need.	93%/71%		6%/28%	0	
3. The service provider treats me with respect and my rights have been respected.	93%/100%		6%/0	0	
IMPACT:					
1. My (or my child's) quality of life has improved since services began.	93%/71%		6%/14%	0/14%	
2. Services have helped me to manage symptoms, and to live, work and participate in the community.	93%/57%		6%/28%	0	
3. Services have given me (or my child) a greater understanding of my mental condition and resources available to me.	100%/57%		0/71%	0	
Since service began...					
1. I have been able to deal better with crises.	100%/57%		0/71%	6%/0	
2. I (or my child) have had less need for hospital and crisis services.	81%/28%		12%/57%	12%/0	
3. My support system has improved.	68%/85%		8%/14%	18%/0	
4. My level of safety has improved.	62%/71%		31%/28%	6%/0	
5. My activity level has improved.	87%/42%		6%/28%	6%/14%	
6. My outlook has improved	75%/42%		18%/57%	6%/0	

WILLAPA COUNSELING CENTER
TIMBERLANDS REGIONAL SUPPORT NETWORK
CONSUMER SURVEY RESULTS

Consumer surveys were sent out during the second week of December. A total of 275 were mailed out and 59 were returned. The results are as follows:

	Agree	Not Applicable	Disagree
ACCESS OF CARE			
1. Services have been provided when I/my child needed them.	44	2	1
2. Services are in a convenient location.	46		2
3. I am/my child is able to obtain help when needed in a crisis and an emergency.	36	7	3
4. I am/my child is able to get an appointment in a timely manner.	46	1	1
5. My/my child's appointments have been kept within 10 minutes of my/their scheduled time with the therapist.	40	3	6
6. Services have been provided in a language I/my child understand(s).	49	1	1
PROVISION OF INFORMATION			
1. I/my child have/has been informed about benefits, risks, and side effects of my/their medications.	32	13	3
2. I/my child have/has been informed about the range of services provided.	36	2	6
3. I/my child have/has been informed of effective treatment options that could be available to me/them.	34	5	8
4. I have been informed of the cost of services and how they will be paid for.	35	7	6
RIGHTS AND CONFIDENTIALITY			
1. I/my child have/has been made aware of my/their rights as a mental health consumer.	42	1	2
2. My/my child's rights to confidentiality have been protected.	45		1
3. My/my child's rights have been respected.	40	4	
INTERACTION			
1. I/my child have/has been treated with dignity and respect.	45	1	1
2. My/my child's service provider has a clear understanding of my/their needs and problems.	44		3
3. My/my child's service provider has been helpful in meeting my/their needs.	44		2
4. I/my child have/has been involved in planning my services and treatment goals.	40	4	2
5. I/my child would recommend these services to a friend.	43		1
6. The front office staff is helpful.	44	1	1
IMPACT			
1. My/my child's quality of life has improved since services began.	33	3	8
2. I/my child have/has been able to more effectively deal with crises.	34	2	9
3. I/my child have/has had less need for inpatient hospitalization and/or emergency visits.	31	11	4
4. My/my child's support system has improved.	30	8	6
5. My/my child's activity level has improved.	28	7	6
6. My/my child's level of safety has improved.	31	7	5
7. My/my child's outlook has improved.	29	5	8

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Please comment on any aspect of accessibility:
(For example: Did you receive help soon after you requested help? Were you aware of what services were available to you? How did you hear about the services you are now using?)

The following are consumers' written responses to the above questions:

1. My case was handled in a timely manner. Had heard about the Center through customers and friends.
2. Somewhat aware. I asked for it myself. Through my doctors and friends.
3. My appointment was made when there was time.
4. I really don't know how you knew I needed help; maybe my daughter or nursing home?
5. I heard about my services from Donna Collins. I think that services could be a little more acceptable and on time a little better.
6. Received help almost immediately. Was aware of services through Yellow Pages.
7. I received a letter about the clinic from Dept. of Social & Health Services. It said I was eligible for clinic's services. Got appointment right away, then found out about HMO'S and the referral. I needed one from Primary Health Provider.
8. I was happy with all the help Caryl gave me. She was a good listener and I felt very comfortable with her.
9. Yes, the services were explained to me. My counselor explained all the services.
10. Yes. Yes. ?
11. I received help immediately. From another patient.
12. Yes.
13. Not always available because of requirements of the insurance company.
14. This part was OK.
15. Need to know ahead of time of side effects of medicine given to take.
16. Yes, the same day. No. From St. Peters Hosp.
17. I felt the waiting period was too long to be approved. No. Newspaper
18. Yes. No. By word of mouth and local paper.
19. My help was received very fast and very polite.
20. Heard about services through Bill Grimberg.
21. I received help soon after requesting it. I was aware of the services. I moved to Long Beach; I sought a new psychiatrist.
22. I received help immediately. Yes. I am not needing help now, but know if I ever need it again, it's just a phone call away.
23. Services were rendered shortly after requested. I heard about services through CPS.
24. Doug Schaffer recommended.
25. Yes. Yes. My Mom.
26. No. No. DSHS.
27 From my counselor.
28. I received help soon after a friend took me to Willapa Counseling. I had a nervous breakdown and was hospitalized.
29. I am very happy with the services I am receiving.
30. Yes. Yes. Phone calls

Please comment on any aspect of acceptability of services:
(For example: Did you want to be more involved in creating your service plan? What was the best aspect of service? Were services acceptable? What are some suggestions for improving services?)

The following are consumers' written responses to the above questions:

1. No. The Counselor, Bill Grimberg. None.
2. I have an excellent counselor in Glenn Peterson.
3. Services are acceptable & had caring counselors and doctors.
4. Make sure they see you on time, not 45 minutes later.
5. It was good.
6. Very acceptable.
7. My child has become more open.
8. Do not send me to Western.
9. Yes, services were acceptable.
10. Services very acceptable.
11. No, I'm trying to be very independent.
12. No. Being able to talk to a neutral party & get suggestions. Yes. Not setting a limit on # of sessions, but letting the person come to counseling as long as they need it.
13. Services are acceptable.
14. It's been clearly explained and talked about.
15. No service plan. Just call as needed.
16. More available days (re: insurance).
17. I am involved in creating a service plan. My counselor now takes all counseling time doing my budget and doesn't really spend time counseling.
18. Yes. ? Yes. Bus service to Aberdeen.
19. Yes, I helped in creating my plan. Everyone has been helpful. Service has been wonderful & at this time I cannot think of any improvements.
20. I wish regression hypnosis and group therapy were available to me with my medical program.
21. No, (did not want to be involved). Yes, services were acceptable.
22. My service plan is OK.
23. I was involved in my service plan after a period of time. Always encouragement-never a down period from any persons or departments. I would not be where I am today without the services allowed to me - Good work all!
24. I would like to be able to get in more than 10 times a year if I need it.
25. Yes, I like to be involved in my care.
26. Felt included in the service plan from the start. My counselor is an intelligent, warm-hearted person. Dr. Rowlett has been exceedingly helpful in the management of my medications and is a delightful person. Would like to commend you on your office personnel, in particular I would mention Reta, who has been my advocate to other services and is both very, very busy, and very efficient, as is all the staff

Please comment on any aspect of the impact of your services:
(For example: How is treatment working or not working? How has your life changed since treatment began? In what ways has life improved?)

The following are consumers' written responses to the above questions:

1. Almost from the start of treatment my sense of burden has been lightened. Have also felt that my treatment counselors have joined with me to make my treatment a team effort. I think that attitude being established in each patient's mind is very clever on your part and very beneficial to the patient.
2. I'm not as much depressed as I had been. I have help when I need it and I have friends to talk to and help if they can.
3. No. No. No.
4. I was completely unable to care or think for myself in my mental state. Now, thanks to Willapa Counseling Services, I am able to live alone in a low income apt. I have a chore person to do physical things I'm unable to do (9 hrs. a wk.). I'm alive again - thanks to all my counseling! Thank God.
5. My life has a little bit less stress in it.
6. Working.
7. Since my physical health hasn't been fixed yet, I'm still living in same place (good, hasn't washed away yet). Back operation limits my activity, little money, but thankful.
8. She (Caryl) helped me believe that I could do almost anything as long as I believed in it and tried it.
9. I seem to be able to handle situations better. My stress has dropped using your services.
10. Both. Not much.
11. Treatment has changed my temperament and reduced neurotic symptoms.
12. Not working. No change. Still feel at loose ends.
13. Treatment has improved since Mary Gardner came into my life.
14. I need to get back my SSI. I can't seem to get a job. I'm not getting any younger.
15. Treatment is working. I get out more. I see more people.
16. I now feel there is hope.
17. I am learning better ways to deal with situations, causing less stress and anxiety.
18. Lessened. By going to church and help from friends and payee.
19. A lot of these questions don't apply to me.
20. Treatment is working. I am not going crazy when relations die.
21. I am now in an assisted living and have lots of help.
22. My child has become more mature emotionally
23. Having someone to listen to my problems.
24. It's working well so far.
25. Hasn't.
26. I'm a little more at ease with people. Other than that, my life hasn't changed that much. But then again, I haven't been there that long, and it took many years to get into this condition and I don't think it can be better overnight.
27. Medication and counseling has improved my life.
28. My treatment is working very well. The office staff is very friendly, too!
29. Helping. yes, less depressed. I am not "out of the woods" yet, but am looking forward to see Bill Grimberg as often as possible to get out of my terrible depression.
    Dr. Rowlett is also a wonderful help to me.
    P.S. Everybody at the office is nice, friendly and very helpful.
30. I think that my counseling sessions have not been helpful and wish my counselors could help me out more. I also want more time with both my counselors. My life hasn't improved one bit!

TRSN QUALITY IMPROVEMENTS in 2000

1. Increased use of MIS data to increase awareness of system problems (e.g. initial access, minority specialist consultation, Protocall access, etc.)
2. QRT identification of issues needing special focus (e.g. access to medications in jails) with increased review of jail procedures
3. Recruitment of a child psychiatrist to serve children in TRSN, to begin July 2001.
4. Development of Native American and Asian mental health specialists within TRSN, as well as a LIST certified interpreter for Spanish speaking consumers.
5. Implementation of a variety of service enhancements: jail based case management and diversion, intensive case manager, new CM aide and community partner positions, day program for high need consumers; MICA (COD) services positions, assertive community treatment coordinator, and children's behavioral specialist still under recruitment.
6. Development of agreement with DDD to improve coordination; cross system meeting on implementation issues and plan for increased crisis coordination.
7. Enhancement of crisis respite as a facility-based resource for TRSN consumers to decrease unnecessary hospitalizations.
8. Improved documentation of crisis respite and stabilization services to allow better monitoring/utilization review.
9. Improved coordination of hospital discharge with written provider plans for this activity.
10. Development of plans by each provider for incremental development of integrated treatment approach for persons with co-occurring disorders.
11. Development and implementation of a method for tracking changes in employment, education, and residential status. Ongoing quarterly review of these outcomes by QMC.
12. Implementation of process for integrated complaint reporting for children and adults.
13. Use of consultation to enhance development of wraparound plans for persons discharged from Western State Hospital. Ongoing ITC consultation to build on those skills (for both adults and children).
14. Development of a paid QRT Coordinator position to provide leadership for QRT activities.
15. Increased family involvement in QMC structure and process.
16. Revision of forms to increase consistency across TRSN, using agency staff input.
17. Improved tracking of alternatives to hospitalization, use of crisis respite for hospital diversion, and documentation of health and safety issues for new referrals.
18. Implementation of TRSN Training Committee. Staff survey on extent of best practice implementation. Training on screening for organic cognitive deficits.
19. Recruitment of peer mentors for Ombuds to support consumers in making complaints (in response to possible fears of retaliation).
20. Revision of Client Rights and Responsibilities statement to better reflect active consumer involvement in services.
21. Maintenance of WSH census at or below TRSN's target number of 25.
22. Expansion of "community partner" and other support services focusing largely on persons discharged from WSH.
23. Implementation of new crisis plans for persons at CM2 and CM3 levels of care. Plans cross reference any Advance Directives developed by consumers.
24. Revision of Consumer Complaint and Grievance procedure to streamline timeframes for response.
25. Development of standard for access to routine psychiatric services.
26. TRSN provision of resource for exceptional costs to support wraparound services.

Revised February 5, 2001

A 11 d 21 - 47

27. Development of standard for Protocall responsiveness (crisis phone response)for regular monitoring and review by QMC.
28. Increased mental health outreach and screening for geriatric consumers.
29. Implementation of Y2K system upgrade ensuring Y2K compliance.
30. Development of a variety of new MIS reports:
    - Outcome measurements (employment, education, residential)
    - Ethnic minority consultations
    - Access to services
    - Equitable access (revision)
    - Level of Services reports (service hours by level of care and average service hours by level of care)
    - Crisis respite utilization
31. MIS annual audit comparing provider chart to TRSN database
32. Analysis of provider and TRSN statistics and TRSN and MHD statistics
33. Regular meetings with data entry staff at each provider to improve consistency in data.

Provider Specific Improvements

34. Development of new formalized provider Quality Management plans that tie more directly to TRSN's QM Plan (WCMHS, CMHC)
35. Increased involvement of supervisors in QA process and documentation of supervisory involvement in case review (CMHC)
36. Development of new housing options by WCC in Pacific Co. (2 triplexes that will serve 10 persons).
37. Use of community extension on LRA to support community stability for persons with longterm history of hospital cycling (WCC)
38. Improved access to community activities via new van and therapeutic activity programming (WCC)
39. Review and enhancement of facilities to improve clinical use and safety (WCMHS).
40. Increased accuracy and consistency of MIS data (WCMHS).
41. Increased access to employment services and opportunities (WCMHS).
42. Changes in agency QA procedures as a result of Clinical Service Review Team findings. Changes address documentation of strength-based services, crisis plans, use of natural supports, cross-system documentation, and IST involvement (CMHC).

King County
Mental Health, Chemical Abuse and Dependency Services Division
Department of
Community and Human Services
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RECEIVED
JUN 22 2001
DSHS/Mental Health

June 20, 2001

To All Interested Parties:

The King County Quality Review Team (QRT) has finished the 2000 Client Satisfaction Survey (CSS). We have visited each public Mental Health Agency in King County, and we are enclosing with this letter a copy of our report.

The report contains a history of Client Satisfaction Surveys done since the Prepaid Health Plan took effect. Each question from the Client Satisfaction Questionnaire (CSQ8) is presented with a table explaining client responses. The three open-ended questions include comments made by clients. We made an effort to include all special population groups: ethnic minorities, sexual minorities, youth, elderly, homebound, and language groups for whom we could get a translation of the CSQ8.

We found a trend of higher percentages of positive responses to the CSQ8. We invite your feedback and questions.

Sincerely,

Shannon Greene
QRT
(206) 205-1319

Lenore Meyer
QRT
(206) 205-1315

Darleen Vernon
Judy Gosney

A11021-5

RECEIVED
JUN 2 2 2001
DSHS/Mental Health

CLIENT SATISFACTION SURVEY 2000

CLIENT'S SATISFACTION SURVEY 2000

Measures of client satisfaction are an integral part of a quality management system. They tell us how our service recipients are viewing the system we administer on their behalf. A principle of the Prepaid Health Plan (PHP) is to have a system tailored to meet client needs. A client satisfaction survey helps us understand whether the system is tailored to meet client needs.

The first client satisfaction survey done by King County Regional Support Network (KCRSN) was a telephone survey in 1995 shortly after the PHP began. It gave the KCRSN an opportunity to hear how things were working for clients under the new system. In 1998, a follow-up survey was conducted, again on the telephone and using the same survey instrument, the Client Satisfaction Questionnaire 8[1]. The new survey provided an opportunity to hear how things were working for clients after the PHP had been operational for three years. In 1999, United Behavioral Health undertook the client satisfaction survey using a client self-report version of the CSQ 8.

The King County Quality Review Team (QRT) conducted the client satisfaction survey for the KCRSN in the Year 2000. The QRT used the CSQ8 to measure client satisfaction with the outpatient mental health services that are being provided through the PHP provider network.

As UBH did in 1999, we tried to develop a system to be used to measure client satisfaction. We will be able to look for trends by comparing the 1998 RSN survey, the 1999 UBH survey and the current 2000 survey being done by the QRT. We could not locate a copy of the 1995 survey.

PURPOSE

1. To provide a measure of client satisfaction that could be used to identify areas in the public mental health system that could be improved.

2. To compare trends with previous satisfaction surveys.

3. To attempt to reach youth 13 or older.

4. To include language groups for whom English is not the primary language.

METHODOLOGY

In order to be consistent with the three previous client satisfaction surveys, the QRT used the CSQ8. We added four optional questions which had been used in the 1995 and 1998 surveys. One was a multiple-choice question and three were open-ended questions, giving the clients an opportunity to voice their opinions in their own words.

[illegible] Client Satisfaction Scales: the Client Satisfaction Survey [illegible] Testing for Treatment, Planning and Outcomes Assessment [illegible]

A11d21-52

The initial plan was for the QRT to administer the surveys to clients through face-to-face interviews. Because this approach would restrict the survey to clients who came into their mental health centers, we decided to use another strategy to reach those clients who do not ordinarily come in. Our intent was to have case managers deliver the survey to the hard-to-reach clients when they saw those clients.

We visited the Clinical Directors of the Agencies to introduce ourselves and we asked to be invited to a staff meeting of case managers at each agency. We presented the CSQ8 at each staff meeting and asked the case manager to take 10 surveys each to give to the clients who come in infrequently.

We also wanted to increase the participation of youth, so an additional youth interviewer was added to the team. The thinking was that a younger interviewer might ease some of the age-related barriers to youth participation.

We worked to include minorities, foreign language (Spanish, Russian, Tagalog, Vietnamese, Cambodian, Chinese, Korean, Laotian, and Japanese); youth, ages 13-20, medically comprised and homebound; elderly; deaf and hard of hearing; and sexual minorities.

RESULTS

We gave out 381[illegible] surveys and received back 643 (16.9%). 299 were done in face-to-face interviews [illegible] the remaining 344 came in the mail.

The results of the eight questions are presented in the following tables.

Question 1 "[illegible] of service you have received?"

Answer	Number	[illegible]
Poor	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]
Excellent	[illegible]	[illegible]
No answer	[illegible]	[illegible]
Total	[illegible]	[illegible]
[illegible]		

Question 2 "[illegible]"

[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]

Question 3, "To what extent has our program met your needs?"

Answers	Numbers	%
None of my needs have been met	13	2.0
Only a few of my needs have been meet	73	11.4
Most of my needs have been met	295	45.9
Almost all of my needs have been met	255	39.7
No answer	7	1.1
Totals	643	100%

Means = 3.31

Question 4 "If a friend were in need of similar help, would you recommend our program to him or her

Answers	Numbers	%
No, definitely not	13	2.0
No, I don't think so	34	5.3
Yes, I think so	214	33.3
Yes, definitely	380	59.1
No answer	2	.3
Totals	643	100%

Means = 3.52

Question 5, "How satisfied are you with the amount of help you have received?"

Answers	Numbers	%
Quite dissatisfied	33	5.1
Indifferent or mildly dissatisfied	55	8.6
Mostly satisfied	273	42.5
Very satisfied	277	43.1
No answer	5	.8
Totals	643	100

Means = 3.29

Question 6, "Have the services you received helped you to deal more effectively with your problem?"

Answers	Numbers	%
No, they seemed to make things worse	13	2.0
No, they really didn't help	26	4.0
Yes, they helped somewhat	241	37.5
Yes, they helped a great deal	360	56.0
No answer	3	.5
Totals	643	100

Means = [illegible]

Question 7 "In an overall, general sense, how satisfied are you with the service you have received?"

Answers	Numbers	%
Quite dissatisfied	15	2.3
Indifferent or mildly dissatisfied	48	7.5
Mostly satisfied	281	43.7
Very satisfied	295	45.9
No answer	4	.6
Totals	643	100

Means = 3.37

Question 8, "If you were to seek help again, would you come back to our program?"

Answers	Numbers	%
No, definitely not	15	2.3
No, I don't think so	33	5.1
Yes, I think so	227	35.3
Yes, definitely	362	56.3
No answer	6	.9
Totals	643	100

Means = 3.52

Question [illegible] "[illegible] satisfied are you with how long you had to wait before you got the help you wanted?"

Answers	Numbers	%
Very dissatisfied	13	2.0
Dissatisfied	28	4.4
Satisfied	208	32.3
Very satisfied	205	31.9
No answer	189	29.4
Total	643	100

We added to the English version of the CSQ8, an optional question on ethnic group which is presented in Table 10 and shows the number of clients answering the survey questions in each major ethnic category.

Ethnic Groups

	Numbers	%
Asian	23	3.6
Pacific Islander	13	2.0
African-American	83	12.9
American Indian	24	3.7
Hispanic	15	2.3
Caucasian	310	48.2
No answer	174	27.1
Totals	643	100

The following table presents the language groups for which we were able to order CSQ 8 surveys in each language.

Language Groups

	# distributed	# returned	%
Cambodian	52	5	10
Chinese	72	13	18
Japanese	20	5	25
Korean	30	2	7
Laotian	[illegible]	2	10
Russian	[illegible]	0	0
Spanish	248	34	14
Tagalog	[illegible]	3	11
Vietnamese	[illegible]	18	17

The survey also [illegible] three open-ended questions allowing clients to voice their opinions. In order [illegible] analyze each question the answers were written on index cards and separated by themes. The most common themes [illegible] each question are presented in this paper.

Question 10: "Tell us what you liked best about your mental health services?"

The responses to this question fit best into four major categories:

1) The quality of the relationship between the client and his/her provider
2) Helpfulness
3) The availability of services
4) The [illegible]

1) The quality of the relationship between the client and his/her provider. For the most part, the relationships between the client and his/her provider are positive and a good relationship with their provider is considered essential to good mental health. The following comments attest to the importance of this link:

- "…his special caring attitude"
- "I like the medical staff and case manager."
- "I have one of the best counselors I could ask for. He has guided me through some difficult times without being judgmental. He is understanding."
- "My therapist is very strong yet compassionate and understanding."

2) Helpfulness answers. Client answers often contain the word helpful, thus implying that consumers' needs are being met.

- "Staff are very helpful, supportive, and encouraging."
- "The people are friendly and work hard to help."
- "The whole staff is very helpful."
- "I like the fact that I can come in and express what's on my mind. Positive energy is something I get and need."
- "The caseworker…they care about the needs and help.
- "Care and compassion and the zeal to be helpful."

2) The availability of services. Availability of services talks about services being convenient to the client. The buildings can be conveniently located, also, the availability of staff people for appointments [illegible] the phone.

- "[illegible] and day treatment in the same building."
- "[illegible] need of help, I can call, and tell them and usually within an hour someone will [illegible] me [illegible] up me."
- "[illegible] vided [illegible]"
- "When I [illegible] in for my intake appointment, one week later I saw a doctor and a therapist."
- "[illegible] on to my problem."
- "Just being [illegible] to talk to someone."

4) The [illegible] provided. There are a great variety of services accessible to the public mental health [illegible] presented in the following quotes.

- "[illegible] has helped me a lot.
- "[illegible] are very friendly and very much one on one."
- "[illegible] counselor."
- "[illegible] provides variety for the clients."
- "[illegible] with the responsiveness of the housing staff. Friendly, [illegible]
- [illegible]
- [illegible]

Question 11: "Tell us what you liked least about your mental health services?"

There are five major categories of responses to this question:

1) Needs not met
2) Availability of services
3) Turnover
4) Bureaucracy
5) No critical comment

1) Negative Experience. This is a broad category allowing clients to express negative experiences or feelings about their services. The first two are about medications:

- " The tendency to encourage or in some instances to direct client's to rely, principally, if not solely on pharmacological treatment, which may not be the most effective or sensible approach in a significant number of cases."
- "The nurse practitioners don't know enough about the new medications.
- "Sometimes when I come for my appointment, the message does not get through, the counselor does not know that I am here, I think I am a no show."
- "My program has too many people to take care of."
- "I had an authoritarian case manager…who used confrontation techniques. the treatment was abusive."
- "Need more or larger waiting area.
- "No teaching about problem solving."
- "The police having to come on the agency grounds."

2) Needs not met

- "Tardiness of the counselor: sometimes I have had to wait up to ½ hour for a counselor who then talks to me for 10 minutes.
- "…take too long to get my needs met, i.e. clothes."
- "Client-staff ratio."
- "Not enough time spent with clients."
- "The fact that my case manager is overworked with too many clients."
- "People are overworked and don't have extra time when you need it."

3) Availability of services

- "Never being able to see a psychiatrist…"
- "That it's time limited. I hope I will be well enough when my time is up to work and pay to keep seeing my therapist."
- Not being able to receive assistance when needed due to limited service hours."
- "Being unable to talk to someone."

4) Turnover

- "That I have to change counselors every few months."
- That other group leaders have left - things were kind of up in the air. I felt confused and a little disappointed, at losing some good leaders."

5) Bureaucracy

- "Paper work, waiting to begin therapy can be a frustration for the consumer."
- "There's always an amount of bureaucratic legwork to do in processing a client. It's a necessary evil."

6) No critical responses. A large number of survey respondents either did no want to or could not think of anything negative about their mental health services.

- "I like what I have received."
- "The services are all very good."
- "I can't think of anything."
- "There is nothing I dislike about the services."

Question 12. "What is most important to you about your services?" There are five categories of answers to this question."

1) Services
2) Benefits of counseling
3) Needs are met
4) Availability
5) Interpersonal relationships

1) Services. Respondents feel positive about their services, workers are reliable, feelings of safety, there were several comments about the importance of medication.

- "Availability of medication…has been good so far."
- "Medications helped me, I now feel better."
- "Availability of nurse and therapist which has been good so far."

2) Benefits of counseling

- "…gets you socially accepted."
- "…more relationship with people."
- "They help me calm down, not hit, not throw things."
- "For me, it is very important to disclose my concerns, I feel relieved after each session."
- "I feel safe. It keeps me stable. I participate in the process-get to make choices."
- Be able to understand my diagnosis and dealing with it.
- [illegible] understanding why I react the way I do."

3) Needs are met.

- "The services are tailored to the individual."
- "Each individual's services are tailored to the individual requests, needs and capabilities."
- "They always seem to know what is right for me. They understand my individual needs."
- "They are able to direct me in exactly the right direction in which I need to be in."

4) Availability

- That people follow through on plans and that they are easy to access, i.e. return phone calls promptly…"
- "…regularly scheduled appointments at not too infrequent intervals."
- "Regularity of staff in attendance."
- "Availability of medication nurse and therapist which has been good so far."
- "Getting meds on time
- "I can increase the amount of services whenever needed."

5) Interpersonal qualities of provider

- "Consideration, respect, and kindness."
- "They listen with compassion."
- "I know people here care about one another."
- "…regularity and confidentiality…"
- "…the most important things to me are care and confidentiality."
- "…unconditional positive regard…"

Discussion

Trends

We would like to look for trends by comparing the three studies: the King County CSS1998, the UBH CSS in 1999, and the King County Quality Review Team CSS2000.

One set of statistics they all three have in common is the positive response to each of the eight questions in the CSQ.

Cue words		% of Positive responses				Rank Order		
		'98	'99	2000		1998	1999	2000
Rate quality	Q1	72	88	88	Q1	5	4	4
Get wanted	Q2	81	88	92	Q2	2	4	2
Met needs	Q3	64	83	86	Q3	7	7	5
Tell friend	Q4	-	89	92	Q4	8	3	2
Amount help	Q5	71	74	86	Q5	6	6	5
Problems	Q6	83	92	94	Q6	1	1	1
How satisfied	Q7	74	87	90	Q7	4	5	3
Come back	Q8	78	91	92	Q8	3	2	2

Question 6 has the highest response in all three studies. Question 6 asks, "Have the services you received helped you to deal more effectively with your problems?"

Given that the response to Question 6 is consistent across the population and across time, we can reasonably conclude that most clients feel that the services they receive help them to deal with their problems.

Question 3 has the lowest response on the studies in 1998 and1999 and ties with #5 in the 2000 study. Question 3 asks, "To what extent has our program met your needs?" Similarly, because Question 3 has tended to be the lowest consistently, we can conclude that most clients are less satisfied with the extent to which the program meets their needs.

Feedback to Improve Method

The Quality Review Team called the agencies we had visited and asked for feedback about how we could improve our process. Following are some comments:

1) "Face to face is the best way to get information from the hard to reach homeless population."
2) "Would have liked the surveys coded so case managers could know how the clients feel about their individual agencies."
3) "We should have come to the Tuesday all staff meeting to include the foster parents."
4) "Because of the roles the counselors doing outreach have, it's difficult to engage youth to do surveys."

The temporary youth who was hired to interview youth left these words about her job.

"Stipends are a really good incentive for youth."

"Most youth mental health agencies don't have programs that are appropriate to face-to-face interviews. Some agencies have school-based programs, but the attendance is inconsistent."

"Most of the case managers were defensive and hard to talk to. They felt the surveys were hard to understand with "Big Words" and adult phrases. The surveys were definitely not youth friendly."

The youth are not aware that their attendance at school is considered participation in services. They didn't understand the questions that included the word "services".

Recommendations

1. For future CSS, the party doing the survey could pay a current client in good standing with his/her agency a lump sum of money to conduct surveys. Otherwise, we don't seem to get into the inner workings of each agency. We obviously need a novel method of surveying to improve our measure of the client voice.

2. Communicate with the agencies and case managers about how important it is to get a true representation of the consumer voice.

3. Plan to share the results of each survey with the clients at the public mental health centers. The QRT has a plan to hold several public forums at the agencies we have visited. We will ask the clients in what way the program does not meet their needs based on our findings in the response to Question 3 of the survey.

4. Let youth know that we value their opinions and would like to include them in the consumer voice.

NSRSN

QUALITY REVIEW TEAM QUARTERLY REPORT for 2000

reported to:

DSHS/Mental Health Division – Advisory Board – Governing Board – Quality Oversight Committee – All Interested Parties

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Date: January 19, 2001

Calendar Quarter Period: Jan – Mar, Apr – Jun, Jul - Sept, **Oct – Dec**

RSN/PHP: North Sound Regional Support Network

Prepared By: North Sound Regional Support Network – Quality Review Team
- Dolores Holtcamp – QRT Lead
- Beckie Bacon – QRT Associate

1. **Enrolled clients with the RSN/PHP: approx. 9765** (open cases)
2. **Contracted sites with the RSN/PHP: 50 - 55**
3. **Number of Provider site visits during this Quarter: 15**
4. **Number of service recipients face to face interviewed this Quarter: 161**
5. **Number of Provider Sites visited year 2000: approx. 53** (revisits & audits)
6. **Number of consumers surveyed in the year 2000: 456**
7. **Percentage of consumers surveyed in the year 2000: 4.66%** (5% goal)
8. **Number of Agency On-Site Audit Review Team visits this quarter: 1**
   (Team consists of RSN, Fiscal, Contracts, Clinical/QA & QRT)
9. **Number of Agency On-Site Audit Review Team visits in year 2000: 5**
   - Community mental Health Services – May 2000
   - Compass – July 2000
   - Associated Provider Network – July 2000
   - Lake Whatcom Residential & Treatment Center – November 2000
   - Whatcom Counseling & Psychiatric Clinic – October 2000 (4 days w/ MHD)

10. **Methods used for Outreach:**
    - **Outreach** with surveys, brochures and access card:
      - Survey visits – Distribute all brochures at all Provider Sites.
      - Schools – 350 packets mailed out to the 5 Counties.
      - Hospital Tours – 4 w/ outreach packets handed out.
      - Resource Center – visit w/ outreach packet Oak Harbor
      - Lake Whatcom Residential Center – Drop-in outreach visit

11. **Activities and Meetings Attended:**
    - Staff Meetings (6)
    - Advisory Board (3)
    - QMOC (2)
    - Resource Managers Meeting (1)
    - Advisory Board Tour (1)
    - OCA Meetings (4)
    - NAMI (2)
    - QMAC – Compass (3)

12. **Training's attended by QRT:**
    - PTSD Informational Training (2 QRT's)
    - Beginning Supervisor Seminar (1 QRT)
    - WAPAS Quarterly meeting (2 QRT's)
    - Excel level 1 (2 QRT's)

13. **Case Management Study:**
    - Staff Interviews – 7
    - Case Management survey question asked to: 161 (this quarter)
      456 (year 2000)

14. **Volunteers of America <u>CRISIS LINE CALLS</u> by QRT:**
    - <u>3</u> Crisis line test calls conducted by QRT

15. **<u>FINDINGS:</u>**
    - **Case Management – dissatisfaction w/ case management was reported by Consumers interviewed through-out the 5 County Region Provider Sites.**
      <u>-Areas of dissatisfaction:</u>
      - Case Managers were reported by the consumers to be unavailable or less available to them as time goes on.
      - Consumers reported that the case managers do not return their phone calls.
      - Consumers report they like their case managers but the case managers are too busy and too stressed and the consumers feel sorry for them.
    - **Crisis Plans – Consumers do not know what their personal crisis plans are.**
      - The responses most often given by the consumers when asked, " ***Are you satisfied with the crisis plan provided for you?***
      - Consumers statement examples:
        - "I don't have a crisis plan."
        - "What is a crisis plan?"
        - "I'm not sure if there is a specific plan."
        - "No, I don't think I have one."
        - "I'm not sure I have one."
        - "I'm not aware of a crisis plan."

- **CMHS Access question – Were you satisfied with the length of time it took to begin Mental Health Services?**
  - CMHS was the only Provider site which received a greater # of consumer complaints regarding access.

16. **RECOMMENDATIONS:**
    - **Case Managers need continued *training* to understand the full scope of their jobs in order to best serve the consumers with:**
      - crisis plans
      - treatment plans
      - time management
      - all job responsibilities
      - personal stress management
    - **Case Management Team approach is recommended to assure the consumers are receiving the continued individualized support required.**
    - **CMHS needs to comply with the contract requirement that states consumers will be offered access to services within 10 business days.**

17. **ACCOMPLISHMENTS:**
    - CMHS – Repaired roof at M.V. Crisis Respite House due to QRT advocating.
    - Lake Whatcom Residential Center – Implementation of QRT request of QI, in L.W.R.C. QM plan concerning – signs – trash – night staff - etc.
    - Madison House & Sno-Alp – Notified QRT they will be modifying the crisis plan and treatment plans paper work and going over them with Residents.
    - Haven House – QRT made the supervisor aware that there were many complaints from the resident consumers. Such as: house rules too strict & changing a lot – denied meds – residents not allowed to use upper deck – residents locked out during staff meeting – not enough activities – due to the dissatisfaction of the residents QRT alerted Ombuds who visited and interviewed consumer residents, resulting in staff making changes in consumer interactions.
    - Green House – When QRT made a drop-in visit to Green House residential it was not in clean condition. We let the supervisor know that we did not find the condition of the resident to be respectfully clean for the consumers who lived there. When we arrived for the QRT survey interviews we found the site to be in an acceptable state of cleanliness.
    - Aurora House – QRT advocated for a diabetic at this residential site who felt their needs were not being met & respected. The staff responded cooperatively.
    - Stanwood/ Camano – QRT observed that this site did not have a computer available for the staff working there. Due to the QRT report the staff has been provided with a computer.
    - Weekly visitations to the Mukilteo E & T by the QRT has assisted in changing the negative atmosphere and helped to improve the quality of services.
    - APN – The QRT needed the support from the Associated Provider Network in educating the provider sites as to what the QRT's job and purpose is about. Some provider sites didn't seem to understand the importance of the consumer voice survey interviews by QRT to assure quality of services for the consumers. Jere LaFollette supported the QRT by sending a letter out to the providers explaining the importance of their cooperation in QRT site visits.

- Case Management Study– QRT has shared reports with the Advisory Board and the QMOC. The recommendation from QRT states – Case management is still a key issue among consumers. QRT recommends a case management team approach throughout the providers, and continued data gathering of case loads. This is being done through NSRSN/QM, APN/QM, and QRT data.

Dolores Holtcamp - QRT Lead

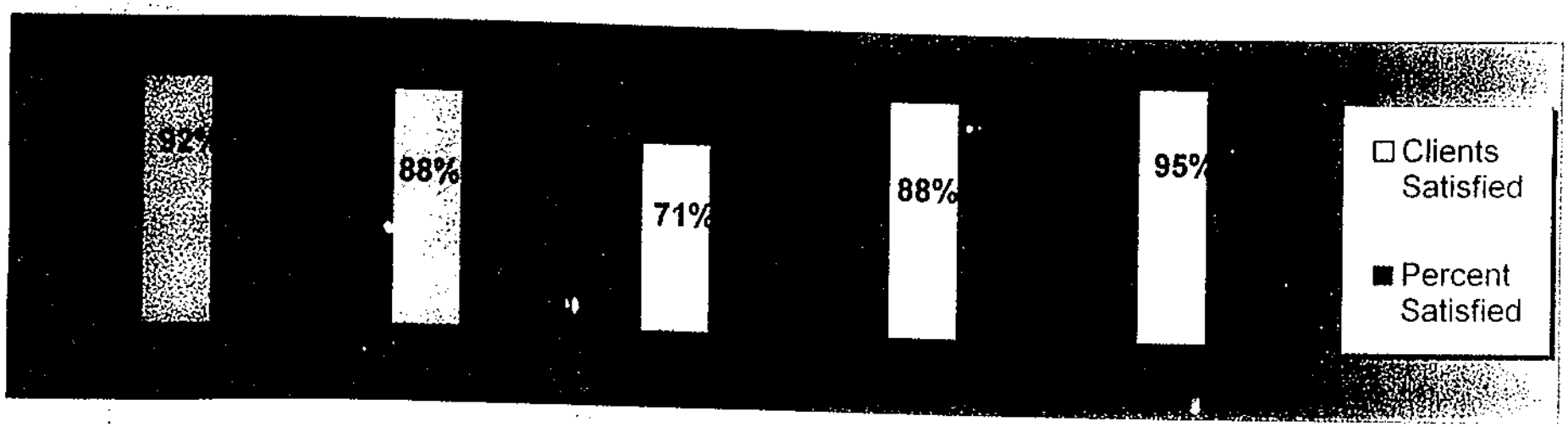
Beckie Bacon – QRT Associate

Overview of 12 Mental Health Provider Sites 2000

(Providers with 1 - 3 Sites - Level of Consumer Satisfaction)

Number of Sites:	12
Enrolled Consumers:	2089
Consumers Surveyed:	139
Percentage Surveyed:	6.65%

Provider	# of Clients	Access	Case Management	Crisis Plans	Treatment Plans	Respect & Dignity
Sun Community	4	3	2	3	2	3
Lake Whatcom Clinic	15	15	12	8	14	14
Lake Whatcom Residential	23	22	18	11	19	19
WCPC	23	21	19	19	21	23
Sno - Alp (Rainbow Res)	11	9	11	6	10	11
Madison House (Rainbow)	9	8	8	3	5	9
CCS - Bellingham	8	8	8	8	8	8
CCS - Mt. Vernon	12	11	11	10	11	12
Sea Mar - Bellingham	11	10	11	11	11	11
Sea Mar - Mt. Vernon	3	3	3	2	3	3
Sea Mar - Everett	12	12	11	11	11	11
Rainbow Activity Center	8	6	8	6	8	8
[illegible]	[illegible]	122	122	98	123	132
		91%	88%	71%	88%	95%



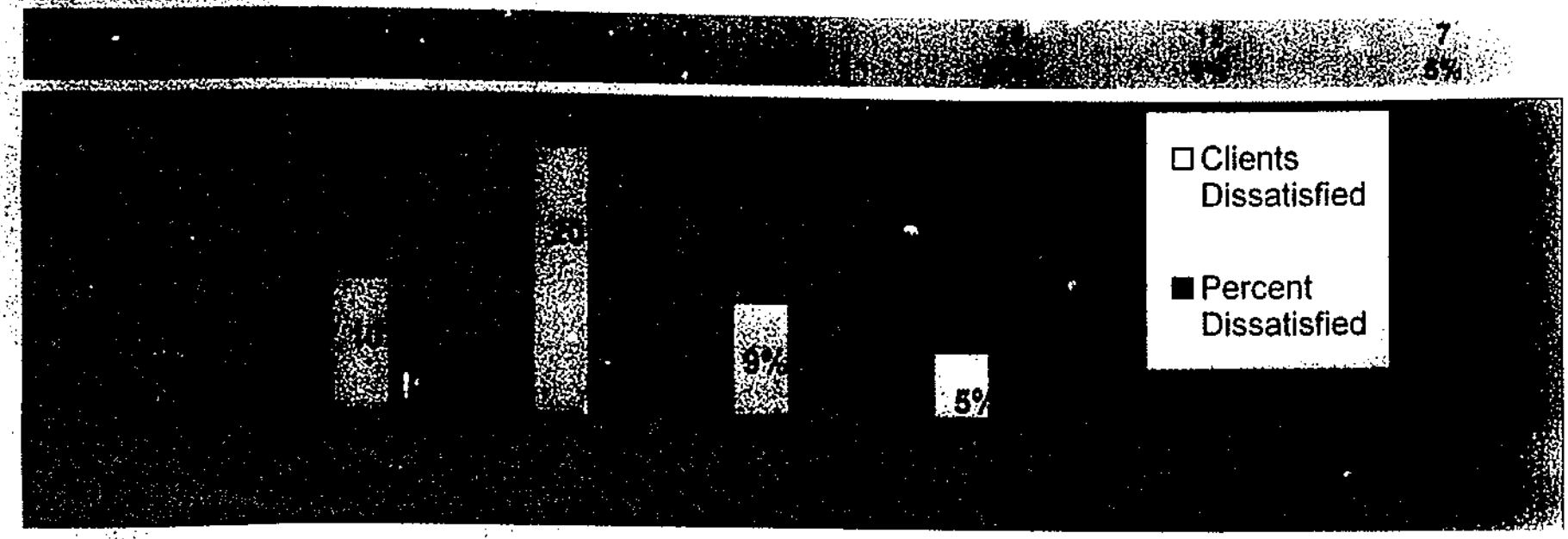
Percentage	[illegible]	2%	3	12	4	0
			2%	9%	3%	0%

Overview of 12 Mental Health Provider Sites 2000

(Providers with 1 - 3 Sites - Level of Consumer Dissatisfaction)

Number of Sites: 12
Enrolled Consumers: 2089
Consumers Surveyed: 139
Percentage Surveyed: 6.65%

Provider	# of Clients	Access	Case Management	Crisis Plans	Treatment Plans	Respect & Dignity
Sun Community	4	1	2	1	1	1
Lake Whatcom Clinic	15	0	3	7	0	1
Lake Whatcom Residential	23	1	5	11	3	4
WCPC	23	2	2	0	1	0
Sno - Alp (Rainbow Res)	11	1	0	2	1	0
Madison House (Rainbow)	9	1	1	5	4	0
CCS - Bellingham	8	0	0	0	0	0
CCS - Mt. Vernon	12	0	0	1	1	0
Sea Mar - Bellingham	11	0	0	0	0	0
Sea Mar - Mt. Vernon	3	0	0	0	0	0
Sea Mar - Everett	12	0	1	1	1	1
Rainbow Activity Center	8	2	0	0	0	0



NSRSN
QUALITY REVIEW TEAM QUARTERLY REPORT for 2001

DSHS/Mental Health Division - Advisory Board – Governing Board - Quality Oversight Committee – All Interested Parties

Date: April 19, 2001

Calendar Quarter Period: Jan – Mar, Apr – Jun, Jul - Sep, Oct – Dec.

RSN/PHP: North Sound Regional Support Network

Prepared By: North Sound Regional Support Network – **Quality Review Team**
- Dolores Holtcamp – QRT Lead
- Beckie Bacon – QRT Associate

1. **Accomplishments:**
   - Completion of last years gathered survey information of 53 Provider Sites.
     - Overview of final reports.
   - Presentations & Recommendations to QMOC and Advisory Boards and All interested parties on final reports.
   - All current surveys, reviewed, updated and shortened with focus questions for year
   - 2001.
   - Designed computerized data linking process, resulting in Provider level of satisfaction graphs.
     - New process provides for objective unbiased reporting.
   - Began the research and planning for the PTSD and Dissociative Disorders presentation.
     - OCA, QRT, Ombuds, Advisory Board members and Executive Director
   - Collaborative meetings were held with QRT, Provider, APN, MHD and NSRSN.
     - Better understanding of job roles, responsibilities and procedures for all.
   - Lead Quality Review Team job description created.
   - Revision of Functional Independence guidelines.
   - Collaborative information meetings with Resource Managers.
   - Providers have a better understanding of the Quality Review Team goals.
     - QRT advocate for the quality of services that meet client needs, by interviewing face to face.

2. **Enrolled clients with the RSN/PHP:** approx. 10,000

3. **Agencies contracted/sub-contracted with the RSN/PHP:** approx. 54
   - Total agencies visited for outreach or interviews Jan. – Mar.: 11

4. **Number of Provider site visits during this Quarter:** 7
   - Total of service recipients spoken to in structured interviews: 68

5. **Number of Agencies visited with the On-Site Audit Review Team:** 1
   - Rainbow Resources
     - Team consists of Quality Management, QRT, Fiscal and Contract Employees.

6. **Collaboration meetings with Provider Agencies:** 2
   - Total in attendance: 9

7. **Number of Speaking Engagements:** 2
   - Total in attendance: 52
     - Consumers, Advocates, Family Members and Interested Parties.

8. **Activities and Meetings Attended:**
   - Board of Director's Retreat: 1
   - Advisory Boards: 3
   - QMOC: 3
   - Compass QMAC: 3
   - NAMI: 1
   - Resource Managers & OCA Meetings: 2
   - Executive Director – OCA – Ombuds – QRT & Advisory Board: 1

9. **Training's attended by QRT:**
   - Conflict Resolutions Seminar: 1
   - WPAS Quarterly Meeting. 1
   - Sexual Diversity Training. 1

10. **Number of Outreach & Drop-In site visits during this Quarter:** 4
    - Total of outreach contacts made: 49

11. **Methods used for Outreach:**
    - The Quality Review Team restocks the Client Rights, RSN, QRT, Ombuds, and Crisis Line Brochures at all sites.

    - QRT visit the Friendship Houses, the Missions, Hospitals, etc.
      - Visits to Homeless Shelters: 3

    - QRT supplied outreach brochures and posters at all attended meetings, trainings, and seminars.
      - Post Card – listing *Access, Crisis line & Ombuds*., these are left wherever there may be a chance that a person in need of mental health services may read them.

12. **Volunteers of America Crisis Line Test Calls:**
    - 3 test calls

13. **Listed below are results of 7 Provider Site Reports during this Quarter.**
    - **AREAS OF SATISFACTION:**
        - 6 Sites reported satisfaction with ***Respect and Dignity.***
        - 5 Sites reported satisfaction with ***Case Management Support.***
        - 5 Sites reported satisfaction with ***Crisis Plan.***
        - 5 Sites reported satisfaction that ***Services were Helpful.***
        - 4 Sites reported satisfaction with ***Access.***
        - 4 Sites reported satisfaction with ***Treatment Plans***
        - 2 Sites reported satisfaction with the ***Care they need.***
        - 1 Site reported satisfaction with ***How Easy it is to get Services.***

    - **AREAS OF CONCERN:**
        - 2 Sites reported ***Access*** problems.
        - 1 Site reported no knowledge of ***Crisis Plan.***
        - 1 Site reported not receiving the ***Care they need.***
        - 1 Site reported ***Services*** were not ***Helpful.***

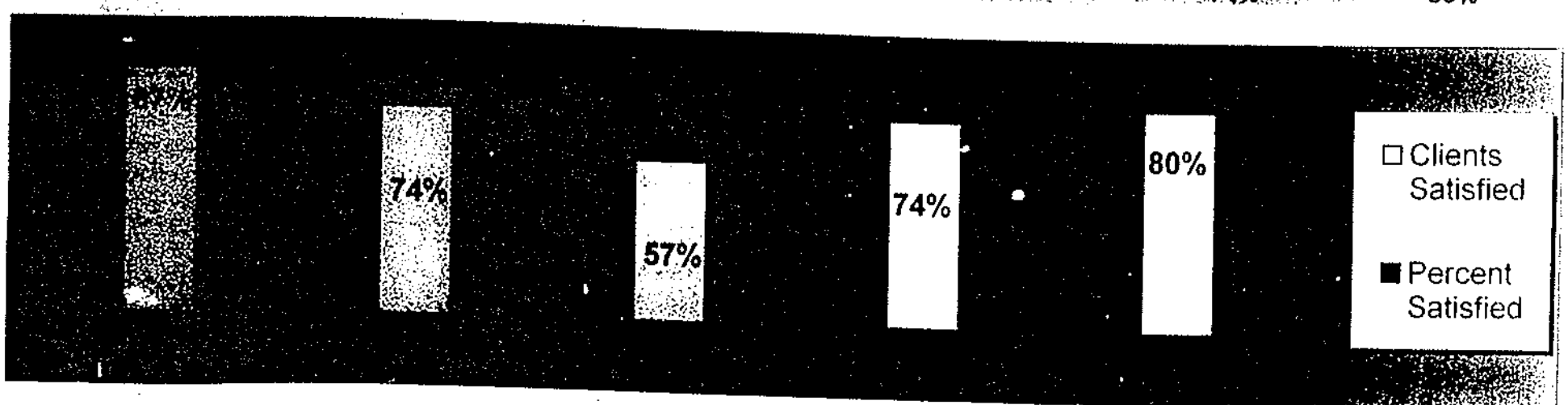
    - **UNACCEPTABLE AREAS:**
        - There were **no unacceptable areas** at the 7 Provider Sites surveyed during this Quarter.

Overview of Compass Health Residentials, Crisis Beds, E & T Sites 2001

Level of *Satisfaction*

Number of Sites:	6
Enrolled Consumers:	94
Consumers Surveyed:	54
Percentage Surveyed:	57.45%

Provider	# of Clients	Access	Case Management	Crisis Plans	Treatment Plans	Respect & Dignity
Aurora House	8	8	8	8	8	8
Greenhouse Everett	12	10	9	5	9	11
Haven House	7	7	7	6	6	7
Snohomish Crisis Beds	9	9	7	7	5	9
Mukilteo E & T	6	4	2	0	4	2
North Sound E & T	12	9	7	5	8	6
[illegible]	[illegible]	47 [illegible]	40 74%	31 57%	40 74%	43 80%



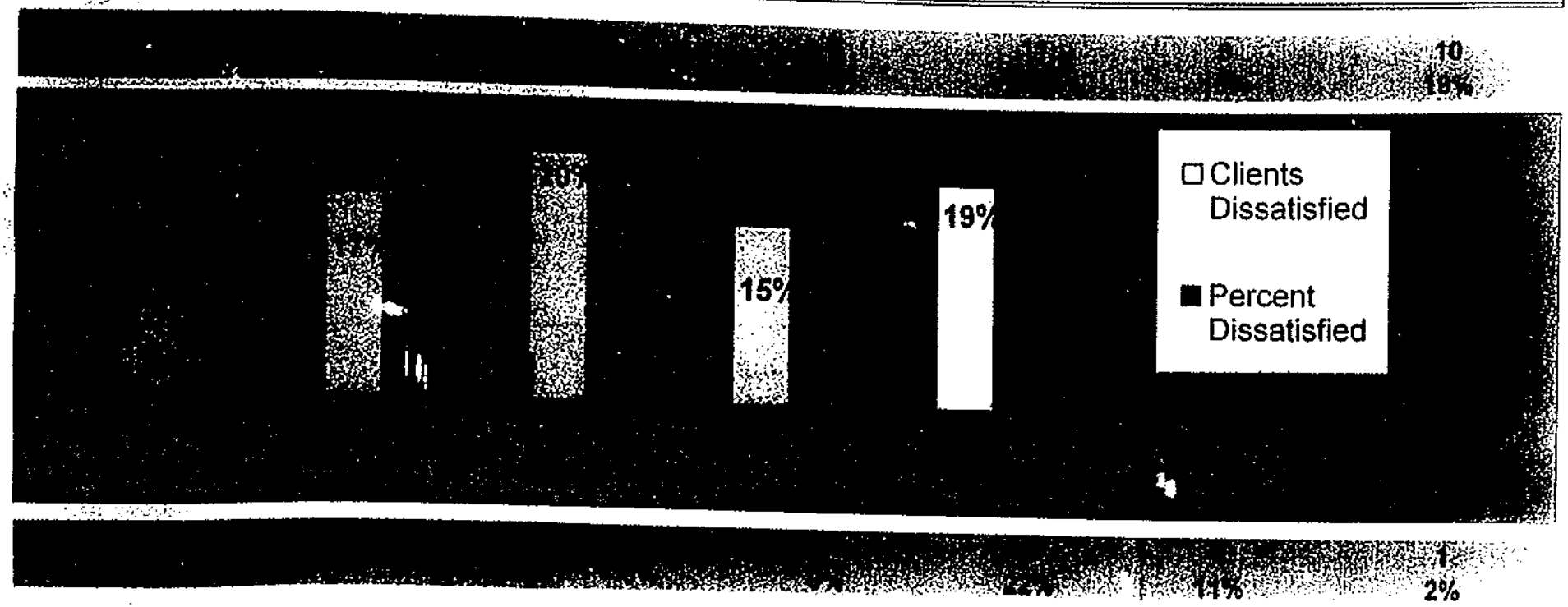
[illegible]	[illegible]	[illegible]	9%	22%	11%	1 2%

Overview of Compass Health Residentials, Crisis Beds, E & T Sites 2001

Level of *Dissatisfaction*

Number of Sites: 6
Enrolled Consumers: 94
Consumers Surveyed: 54
Percentage Surveyed: 57.45%

Provider	# of Clients	Access	Case Management	Crisis Plans	Treatment Plans	Respect & Dignity
Aurora House	8	0	0	0	0	0
Greenhouse Everett	12	1	2	0	0	0
Haven House	7	0	0	1	1	0
Snohomish Crisis Beds	9	0	1	1	1	0
Mukilteo E & T	6	2	3	3	2	4
North Sound E & T	12	1	3	6	4	6



NSRSN

QUALITY REVIEW TEAM – 2nd QUARTERLY REPORT for 2001

DSHS/Mental Health Division - Advisory Board – Governing Board - Quality Oversight Committee – All Interested Parties

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Date: July 17, 2001

Calendar Quarter Period: Jan – Mar, **Apr – Jun,** Jul - Sep, Oct – Dec.

RSN/PHP: North Sound Regional Support Network

Prepared By: North Sound Regional Support Network – **Quality Review Team**

- Dolores Holtcamp – QRT Lead
- Beckie Bacon – QRT Associate

1. **Accomplishments:**
   - Presentations & Recommendations to QMOC and Advisory Boards and All interested parties on final reports.
   - All current surveys, reviewed, updated and shortened allowing more time for consumer contacts.
   - Designed computerized data linking process, resulting in Provider level of satisfaction graphs completed.
     - New process provides for objective unbiased reporting.
   - Collaborative information meetings with Resource Managers.
   - Completion of Compass level of satisfaction graphs.
   - Beckie received Employee of the Quarter Recognition.
   - Providers have a better understanding of the Quality Review Team goals.

2. **Enrolled clients with the RSN/PHP: approx. 10,000**

3. **Agencies contracted/sub-contracted with the RSN/PHP: approx. 54**
   - Total agencies visited for outreach or interviews **April – June: 17**

4. **Number of Provider Survey Site visits during this Quarter: 13**
   - Total of service recipients spoken to in structured interviews: 208

5. **Number of Agencies visited with the On-Site Audit Review Team: 1**
   - Sea Mar -
     - Team consists of Quality Management, QRT, Fiscal and Contract Employees.

6. **Collaboration meetings with Provider Agencies: 2**
   - Total in attendance: 10

7. **Number of Speaking Engagements: 2**
   - Total in attendance: 24
     - Consumers, Advocates, Family Members and Interested Parties.

8. **Activities and Meetings Attended:**
   - Advisory Boards: 3
   - QMOC: 3
   - Compass QMAC: 3
   - OCA/Ombuds/QRT Retreat:: 1
   - Critical Incident Review Committee: 2
   - NAMI: 2
   - Resource Managers & OCA Meetings: 2
   - Compass "Walk-a-thon" : 1
   - Tribal Conference: 1
   - OCA/Ombuds/QRT: 3
   - Behavioral Health Conference: 1
   - APN GAU meeting: 1
   - Long Term Ombuds meeting: 1
   - Ombuds Poster Contest support: 1

9. **Training's attended by QRT:**
   - PTSD Training. 3
   - Adult Disorders Training: 1
   - Employee Advisory Service Training: 1
   - Co-Occurring Training: 1
   - Resource Management Training: 1
   - Government of Indian Affairs: 1

10. **Volunteers of America Crisis Line Test Calls:**
    - 3 test calls

11. **Number of Outreach & Drop-In site visits during this Quarter:** 4
    - Total of outreach contacts made: 49
    - Total of face to face outreach and interviews made: 257

12. **Methods used for Outreach:**
    - The Quality Review Team restocks the Client Rights, RSN, QRT, Ombuds, and Crisis Line Brochures at all sites.
    - QRT visit the Friendship Houses, the Missions, Hospitals, etc.
      - Visits to Homeless Shelters: 2
    - QRT supplied outreach brochures and posters at all attended meetings, trainings, and seminars.
      - Post Card – listing *Access, Crisis line & Ombuds.*, these are left wherever there may be a chance that a person in need of mental health services may read them.

13. **Included with this Quarterly Report are the Level of Satisfaction graphs for the 20 Compass completed sites.**

Dolores Holtcamp QRT Lead NSRSN

Beckie Bacon QRT Associate NSRSN

Completed QRT Survey Site Visits - 2001

Compass Health:

Residentials		Date	Enrolled	# Surveyed	%
1	Aurora House	3/1	19	8	42.1%
2	Greenhouse	4/12	20	12	60.0%
3	Haven House	4/19	12	7	58.3%
4	Mukilltio E & T	5/31	12	6	50.0%
5	North Sound E & T	5/14	14	12	85.7%
6	Snohomish Crisis Beds	3/6	17	9	52.9%
			94	**54**	**57.45%**

Outpatient					
1	Adult Ext - Drop-in - Broadway	4/9	650	39	6.0%
2	Adult Ext - Edmonds	3/27	400	15	3.8%
3	Adult Ext - Marysville	4/3	100	9	9.0%
4	Adult Ext - Smokey Point	3/20	170	6	3.5%
5	Adult Ext - Snohomish	3/28	225	17	7.6%
6	Children's Ext - Edmonds	3/22	150	13	8.7%
7	Children's Ext - Everett	3/15	25	2	8.0%
8	Children's Ext - Smokey Point	4/4	115	17	14.8%
9	Compass Main Bldg - Everett	4/25	950	16	1.7%
10	Multicultural - Everett	5/4	210	11	5.2%
11	Primary Care - Lynnwood	4/24	500	29	5.8%
12	Primary Care - Monroe	4/5	200	25	12.5%
13	Primary Care - Smokey Point	5/9	400	17	4.3%
			4095	**216**	**5.27%**
		Sheet 1 Total	**4189**	**270**	**6.45%**
		Sheet 2 Total	**125**	**8**	**6.40%**
		Sheet 3 Total			
		Grand Total	**4314**	**278**	**6.44%**

Completed QRT Survey Site Visits - 2001

Community Mental Health Services:

Residentials		Date	Enrolled	# Surveyed	%
1					
2					
3					
4					
5					
6					
7					
8					
9					
			0	0	#DIV/0!

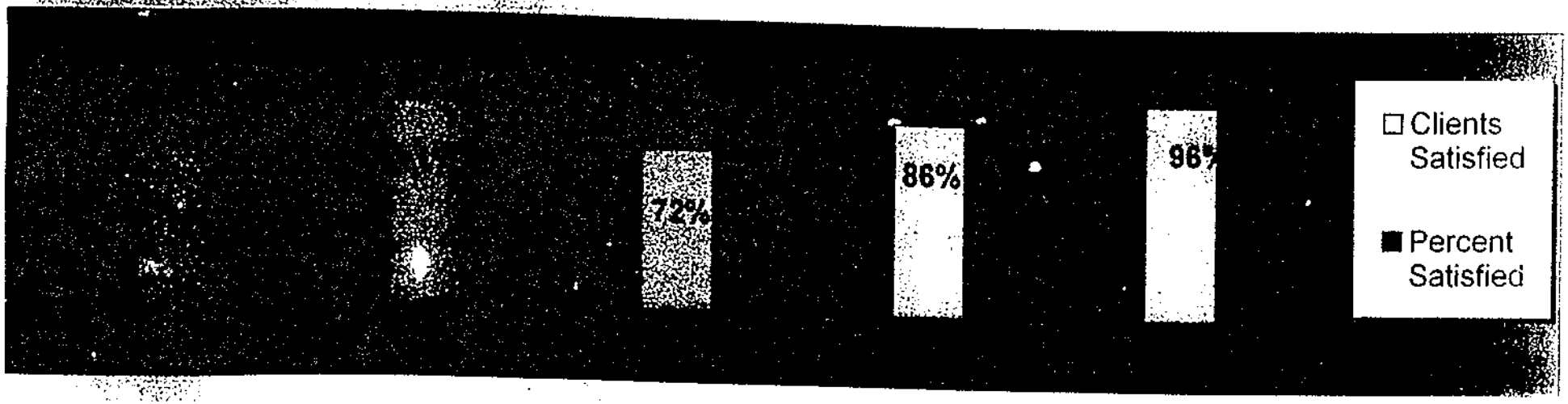
Outpatient					
1	Older Adult Services	5/19	125	8	6.4%
2					#DIV/0!
3					#DIV/0!
4					#DIV/0!
5					#DIV/0!
6					#DIV/0!
7					#DIV/0!
8					#DIV/0!
9					#DIV/0!
10					#DIV/0!
11					#DIV/0!
12					#DIV/0!
13					#DIV/0!
			125	8	6.40%
		Total	125	8	6.40%

Overview of Compass Health Provider Sites 2001

Out Patient Level of *Satisfaction*

Number of Sites: 13
Enrolled Consumers: 4095
Consumers Surveyed: 216
Percentage Surveyed: 5.27%

Provider	# of Clients	Access	Case Management	Crisis Plans	Treatment Plans	Respect & Dignity
Broadway Adult Ext Care	39	35	31	27	30	35
Edmonds Adult Ext Care	15	13	15	13	14	15
Edmonds Children's Ext Care	13	8	11	7	13	13
Everett Children's Ext	2	1	1	2	2	2
Everett Compass Main Building	16	14	16	12	13	16
Everett Multi Cultural Services	11	10	11	9	9	10
Lynnwood Primary Care	29	23	28	21	24	29
Marysville Adult Ext Care	9	6	7	7	7	8
Monroe Primary Care	25	22	24	16	22	25
Smokey Pt. Adult Ext Care	6	6	6	6	6	6
Smokey Pt. Children's Ext Care	17	16	16	13	16	16
Smokey Pt. Primary Care	17	12	14	7	15	16
Snohomish Adult Ext Care	17	15	16	16	15	16
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	207
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	96%



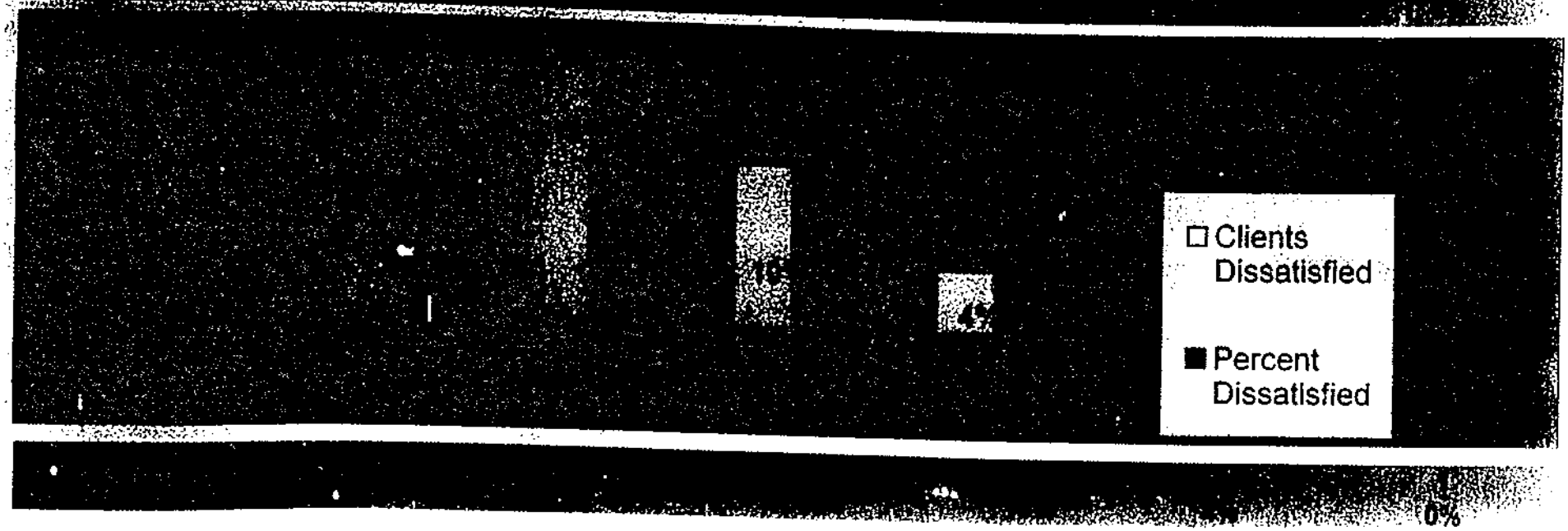
[illegible] 0%

Overview of Compass Health Provider Sites 2001

Out Patient Level of *Dissatisfaction*

Number of Sites: 13
Enrolled Consumers: 4095
Consumers Surveyed: 216
Percentage Surveyed: 5.27%

Provider	# Of Clients	Access	Case Management	Crisis Plans	Treatment Plans	Respect & Dignity
Broadway Adult Ext Care	39	3	6	8	6	4
Edmonds Adult Ext Care	15	2	0	2	1	0
Edmonds Children's Ext Care	13	3	0	1	0	0
Everett Children's Ext	2	0	0	0	0	0
Everett Compass Main Building	16	1	0	2	1	0
Everett Multi Cultural Services	11	1	0	2	2	1
Lynnwood Primary Care	29	6	0	5	5	0
Marysville Adult Ext Care	9	1	1	2	1	1
Monroe Primary Care	25	2	1	2	0	0
Smokey Pt. Adult Ext Care	6	0	0	0	0	0
Smokey Pt. Children's Ext Care	17	0	0	0	1	0
Smokey Pt. Primary Care	17	5	3	9	2	1
Snohomish Adult Ext Care	17	2	0	0	2	1



Children 12 & Under
NSRSN QRT survey 2001

Mental Health Provider _____ Date _____

1. **Are you happy about how long it took to come here and talk to your counselor?**
   ☐not happy ☐kind of unhappy ☐don't know ☐kind of happy ☐real happy

2. **Are you happy that your counselor is there for you when you need help?**
   ☐not happy ☐kind of unhappy ☐don't know ☐kind of happy ☐real happy

3. **Are you happy with your plan if you don't feel good?**
   ☐not happy ☐kind of unhappy ☐don't know ☐kind of happy ☐real happy

4. **Are you happy your counselor has a plan about how to help you feel better?**
   ☐not happy ☐kind of unhappy ☐don't know ☐kind of happy ☐real happy

5. **Are you happy the people here make it easy to get the care you need?**
   ☐not happy ☐kind of unhappy ☐don't know ☐kind of happy ☐real happy

6. **Are you happy & comfortable that services are helpful to you?**
   ☐not happy ☐kind of unhappy ☐don't know ☐kind of happy ☐real happy

7. **Do you feel happy the people here are nice and treat you with respect?**
   ☐not happy ☐kind of unhappy ☐don't know ☐kind of happy ☐real happy

8. **What would you change about the way you receive services?**

_____

_____

_____

_____

(staff, rights, discrimination, confidentiality)

Consumer Demographics

Gender: ☐Male ☐Female

Age: ☐ 0 - 12

Race: ☐American Indian/Alaskan Native ☐Asian/Pacific Islander
☐African American/Black ☐White/Caucasian
☐Hispanic/Latino ☐Other_____

Needs: ☐ Developmentally disabled ☐Other_____

Adult and Adolescent Consumers 13+
NSRSN QRT survey 2001
(Adult & Adolescent Clinician/Drop In Center)

Mental Health Provider _____ Date _____

1. **Were you, satisfied with the length of time it tock to access mental health services?**
   ☐ dissatisfied ☐somewhat dissatisfied ☐neutral/NA ☐somewhat satisfied ☐ satisfied

2. **Are you satisfied with the availability and support you receive from your case manager?**
   ☐ dissatisfied ☐somewhat dissatisfied ☐neutral/NA ☐somewhat satisfied ☐ satisfied

3. **Are you satisfied with the crisis plan provided for you?**
   ☐ dissatisfied ☐ somewhat dissatisfied ☐neutral/NA ☐somewhat satisfied ☐ satisfied

4. **Are you satisfied with your involvement in the development of your treatment plan?**
   ☐ dissatisfied ☐ somewhat dissatisfied ☐neutral/NA ☐somewhat satisfied ☐ satisfied

5. **Are you satisfied with how easy it is to get the care you need?**
   ☐ dissatisfied ☐somewhat dissatisfied ☐neutral/NA ☐somewhat satisfied ☐ satisfied

6. **Are you satisfied these services are helpful to you?**
   dissatisfied somewhat dissatisfied neutral/NA somewhat satisfied satisfied

7. **Are you satisfied the staff treats you with dignity and respect?**
   dissatisfied somewhat dissatisfied neutral NA somewhat satisfied satisfied

Family Member of Adult/Child
NSRSN QRT survey 2001

Mental Health Provider _____ Date _____

1. **Were you satisfied with the length time, it took your family member/child to access mental health services?**
   ☐ dissatisfied ☐somewhat dissatisfied ☐neutral/NA ☐somewhat satisfied ☐ satisfied

2. **Are you satisfied with the availability and support of your family member's/child's case manager?**
   ☐ dissatisfied ☐somewhat dissatisfied ☐neutral/NA ☐somewhat satisfied ☐satisfied

3. **Are you satisfied with the crisis plan provided for your family member/child?**
   ☐ dissatisfied ☐somewhat dissatisfied ☐neutral/NA ☐somewhat satisfied ☐ satisfied

4. **Are you satisfied with the involvement you and your family member/child have in the development of their treatment plan?**
   ☐ dissatisfied ☐somewhat dissatisfied ☐neutral/NA ☐somewhat satisfied ☐ satisfied

5. **Are you satisfied with how easy it is to get the care you need for your family member/child?**
   ☐ dissatisfied ☐somewhat dissatisfied ☐neutral/NA ☐somewhat satisfied ☐ satisfied

6. **How satisfied are you that the services are helpful to your family member/child?**
   ☐ dissatisified ☐somewhat dissatisfied ☐neutral/NA ☐somewhat satisfied ☐ satisfied

7. **Are you satisfied the staff treats you and your family member/child with dignity and respect?**
   ☐ dissatisfied ☐somewhat dissatisfied ☐neutral/NA ☐somewhat satisfied ☐ satisfied

Residential/Crisis Beds - Adult
NSRSN QRT survey 2001

Mental Health Provider _____ Date _____

1. **Were you, satisfied with the length of time it took to access residential/crisis bed services?**
   ☐ dissatisfied ☐somewhat dissatisfied ☐neutral/NA ☐somewhat satisfied ☐ satisfied

2. **Are you, satisfied with the availability and support you receive from your case manager?**
   ☐ dissatisfied ☐somewhat dissatisfied ☐neutral/NA ☐somewhat satisfied ☐ satisfied

3. **Are you satisfied with the crisis plan provided for you?**
   ☐ dissatisfied ☐somewhat dissatisfied ☐neutral/NA ☐somewhat satisfied ☐ satisfied

4. **Are you satisfied with your involvement in the development of your treatment plan?**
   ☐ dissatisfied ☐somewhat dissatisfied ☐neutral/NA ☐somewhat satisfied ☐ satisfied

5. **Are you satisfied with how easy it is to get the care you need?**
   ☐ dissatisfied ☐somewhat dissatisfied ☐neutral/NA ☐somewhat satisfied ☐ satisfied

6. **Are you satisfied these the services are helpful to you?**
   ☐ dissatisfied ☐somewhat dissatisfied ☐neutral NA ☐somewhat satisfied ☐ satisfied

7. **Are you satisfied that staff treats you with dignity and respect?**
   ☐ dissatisfied ☐somewhat dissatisfied ☐neutral NA ☐somewhat satisfied ☐ satisfied

E & T and Hospital - Adults
NSRSN QRT survey 2001

Mental Health Provider _____ Date _____

1. **Are you satisfied, with the length of time it took to access the E&T Center /Hosp.?**
   ☐ dissatisfied ☐somewhat dissatisfied ☐neutral/NA ☐somewhat satisfied ☐ satisfied

2. **Are you satisfied with the availability and support of your E&T/Hosp. contact person/clinician?**
   ☐ dissatisfied ☐somewhat dissatisfied ☐neutral/NA ☐somewhat satisfied ☐ satisfied

3. **Are you satisfied with the crisis plan being provided for you?**
   ☐ dissatisfied ☐somewhat dissatisfied ☐neutral/NA ☐somewhat satisfied ☐ satisfied

4. **Are you satisfied with your involvement in the development of your treatment plan?**
   dissatisfied somewhat dissatisfied neutral/NA somewhat satisfied satisfied

5. **Are you satisfied with how easy it is to get the care you need?**
   dissatisfied somewhat dissatisfied neutral/NA somewhat satisfied satisfied

6. **Are you satisfied these services here are helpful to you?**
   dissatisfied somewhat dissatisfied neutral/NA somewhat satisfied satisfied

7. **Are you satisfied the staff treats you with dignity and respect?**
   dissatisfied somewhat dissatisfied neutral/NA somewhat satisfied satisfied

The NSRSN QUALITY REVIEW TEAM wants to know……

What would you change about the way mental health services are provided for you?

Please answer these demographics if you want to…

Race _____ Age _____ male or female

Name of Provider Site _____ Date _____

North Sound Regional Support Network
Ombuds
117 N. First Street, Suite 8
Mount Vernon, Washington 98273
Phone: 1-888-336-6164
(360) 416-7008

MEMO

DATE: July 18, 2001

SUBJECT: Ombuds Liaison Meeting Change

TO: Chuck Benjamin, NSRSN Executive Director, Sharri Dempsey, NSRSN Office of Consumer Affairs Manager, Melissa DeCino, Ombuds, Dolores Holtcamp, QRT Lead, Beckie Bacon, QRT, Ombuds Liaison Committee: Joan Lubbe, Chuck Albertson, Janet Lutz-Smith, Eileen Rosman

FROM: Anne Hoffman, Ombuds

Due to scheduling conflicts, the first meeting of the Ombuds Liaison Meeting, originally scheduled for Monday, July 23, 2001 from 3:00 pm to 4:30 pm, has been cancelled.

Our first meeting is now planned for the fourth Monday in August, August 27, 2001 from 1:00 pm to 2:30 pm. The meeting will be held in the NSRSN conference room.

Please contact me at (360) 416-7008, extension 238 at your earliest convenience to let me know if you will be able to attend.

Thankyou

The NSRSN QUALITY REVIEW TEAM wants to know……

What would you change about the way mental health services are provided for you?

Please answer these demographics if you want to…

Race _____ Age _____ male or female

Name of Provider Site

Date

EXPLANATION SHEET
for
3 REPORT EXAMPLES - OF ACTUAL QRT SURVEY PROCESS & PROVIDER REPORT RESPONSES

- QRT agency contact sheet for QRT use only.
- Date for survey visit is set with Provider for busiest consumer day.
- Letter sent stating set date and explanation of QRT purpose to be shared with all provider staff.
- Colorful flyers and 1 large poster sent in advance with the cover letter to notify consumers of QRT visit.
- Brochures & Postings check list.
- Tally sheet for computerized data linking process resulting in provider level of satisfaction after each site visit.
  - number of consumers receiving services.
  - number of consumers interviewed.
  - demographics.
  - quantifiable satisfaction levels.
  - percentages.
- Letter requesting a written response within 30 days if there are Unacceptable Areas.
- Report lists-
  - Areas of Satisfaction
  - Areas of Concern
  - Unacceptable Areas
  - Recommendations
  - Observations
- Provider response letter – if requested.

Need 2 QRTs - [illegible] has 2 levels - 30 - 6% surveyed

Agency contact sheet for Survey Visit

QRT [illegible]

Agency Name: [illegible]

Type of services provided: [illegible]

Address: [illegible]

Phone: [illegible] Date of Contact: [illegible]

Contact Person: [illegible]

Date of Survey Visit: 4-24-01 Time: [illegible]

Directions: Exit 181 right at exit [illegible] on next block - go [illegible] take right into driveway, same bldg. as chiropractor.

Letter and Posters mailed out: 3-30-01

Thank you sent: 11/25/01 Report sent: 5/7/01

Clients Receiving Services: 500 #Surveyed: 24, 5 mail in = 29

Clients Receiving Services Last Year 350 #Surveyed last year: 14

Agency Information

- Identify yourself as a Quality Review Team Member from the NSRSN.
- Explain what we do – we are Consumers, Family Members or Advocates, we conduct face to face interviews with Consumers to find out how satisfied they are with their Mental Health Services.
- We need to know how many consumers are served.
- Let them know that all information is confidential, we take no names for surveys.
- Make it clear that we need a high volume day to make contact and survey as many consumers as possible on our visit. The information we gather goes to the Agency, RSN and State in a Quarterly Report.
- If there are sites other than the Main Office, will another contact need to be made in order to establish coordinated visits.
- If an agency works with children, we need to know because parental consent is necessary, we have a parental and child's survey.
- Let the phone contact know of the [illegible] Managers can play in getting the flyers [illegible] the consumers [illegible] they choose.
- [illegible] This is necessary for the [illegible]

QUALITY REVIEW TEAM
North Sound Regional Support Network
117 North First Street, Suite 8
Mount Vernon, WA 98273
1-800-684 3555 or 360-416-7013

February 13, 2001

Linda Taylor
Compass – Primary Care
4807 196th SW
Lynnwood WA 98026

Dear Ms. Taylor and Staff:

The North Sound Regional Support Network Quality Review Team will survey consumers and family members at your facility on April 24, 2001. The QRT is mandated by the Federal Medicaid Waiver and WAC 275-57-150 to survey a percentage of the mental health population.

We will appreciate your cooperation by informing consumers about this confidential opportunity to voice their level of satisfaction with their mental health services. Please share a copy of this letter with all staff and consumers and post the attached flyer in a visible area.

The QRT will also need a private room from 1:00 – 4:00 pm for surveying. The survey-interview will take each participant a short time to complete.

When the scheduled time has been completed, the QRT will take a few minutes to meet with the provider contact for debriefing of the survey results. A formal report will be sent to you and other interested parties when it is complete.

Thank you for your assistance. Our goal is to survey approximately 5% of your agency's consumer population.

Sincerely,

Dolores Holtcamp
Quality Review Team Lead

Beckie Bacon
Quality Review Team Associate

CONSUMERS OF MENTAL HEALTH SERVICES

The Quality Review Team

North Sound Regional Support Network

1-800-684-3555

Satisfaction Survey

Location: Lynnwood Primary Care

Date: April 24, 2001

Time: 1:00 pm - 4:00 pm

QUALITY REVIEW TEAM

NORTH SOUND REGIONAL SUPPORT NETWORK

ORT PROVIDER VISIT – BROCHURES & POSTINGS CHECK LIST

Provider Agency: Lynnwood Primary Care

- Are Provider (APN) Brochures easily accessible to consumers? ☒yes ☐no
  - Languages available? 2
- Are NSRSN Brochures easily accessible to consumers? ☒yes ☐no
  - Languages available? 8
- Are Ombuds Brochures easily accessible to consumers? ☒yes ☐no
  - Languages available? 8
- Are QRT Brochures easily accessible to consumers? ☒yes ☐no
  - Languages available? 8
- Are VOA Crisis Response System brochures available? ☒yes ☐no
  - Languages available? _____
- Are Consumer Rights posted, including right to interpreter? ☒yes ☐no
  - Languages available? 8

comments: [illegible] Rights [illegible] given to provider & [illegible] posted. Provider to contact [illegible] to obtain [illegible]

VOA brochures - call them for languages

All brochures need to be available in all 8 languages to be contract compliant.

Reviewer Name: [illegible] Date: [illegible]

A	B
Mental Health Provider:	Date
Lynnwood Primary Care	4/24/01
Total Clients:	500
# Surveyed:	20

1 = dissatisfied
2 = somewhat dissatisfied
3 = neutral
4 = somewhat satisfied
5 = satisfied

#	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8				
Resp 1	5	5	5	5	5	5	5		f	18-59	w	co
Resp 2	5	5	5	5	3	5	5		f	0-12	w	
Resp 3	5	5	5	5	5	5	5		f	13-59	w	co
Resp 4	5	3	5	5	5	5	5		f	18-59	w	
Resp 5	5	5	5	5	4	5	5		f	13-59	w	
Resp 6	5	5	1	2	5	5	5		f	18-59	w	
Resp 7	5	5	5	5	5	5	5		m	13-59	w	
Resp 8	5	5	5	5	4	5	5		m	18-59	w	
Resp 9	5	5	1	4	5	5	5		f	13-17	w	
Resp 10	5	5	5	5	5	5	5		f	13-17	w	
Resp 11	2	5	5	5	5	5	5		f	0-12	w	
Resp 12	5	5	1	5	5	5	5		f	13-59	w	
Resp 13	5	5	1	5	5	4	5		m	13-17	w	co
Resp 14	5	4	5	5	5	5	5		m	13-17	w	
Resp 15	1	5	3	5	4	4	5		f	0-12	w	
Resp 16	5	4	5	5	5	5	5		m	13-59	w	
Resp 17	5	5	5	1	1	5	5		f	0-12	w	
Resp 18	5	5	1	1	4	4	5		m	0-12	w	
Resp 19	5	5	5	5	5	5	5		m	0-12	w	dd
Resp 20	1	5	4	2	2	5	5					
Resp 21	1	5	5	5	5	5	4		m	0-12	w	
Resp 22	5	5	5	5	2	4	5		m	0-12	w	
Resp 23	5	4	5	2	3	5	5		f	18-59	w	
Resp 24	2	5	5	5	1	5	5		f	18-59	w	
Resp 25	5	5	5	5	5	5	5		f	0-12	w	
Resp 26	5	5	3	5	5	5	5		f	0-12	w	
Resp 27	5	5	3	5	5	5	5		f	18-59	w	
Resp 28	2	5	5	5	1	5	5		f	18-59	w	co
Resp 29	5	5	5	5	5	5	5		m	13-17	w	

Jim
Copy

Quality Review Team
North Sound Regional Support Network
117 North 1st Street, Suite 8
Mount Vernon, WA 98273
1-800-684-3555

May 4, 2001

Linda Taylor
Compass Health – Primary Care
4807 196th SW
Lynnwood, WA 98026

Dear Ms. Taylor:

This letter is to report to you the results of North Sound Quality Review Team surveys conducted at Primary Care in Lynnwood on April 24, 2001. The Team conducted a total of 24 face to face interviews with consumers and received 5 mail-ins. We consider this to be satisfactory. The results of the survey are enclosed for your review. Please make copies and post where accessible to consumers and staff at your facility.

The QRT has recently converted our report process to a new computerized system allowing us to track percentages of satisfied to dissatisfied in an objective manner. The system tallies answers by numbers and then computes these to percen ages. Areas of Satisfaction have percentages of *satisfaction* from 90 - 100% (congruent to the MHD audit process). Areas of Concern have percentages of *dissatisfaction* from 11 - 13%. Unacceptable Areas, (or findings), have percentages of 14% or greater of *dissatisfaction.*

There is no need for a written response at this time as there were no findings by the NSRSN Quality Review Team. Please address the Areas of Concern. Recommendations have been provided for your convenience.

We appreciate your efforts in helping make this a successful and informational report. Our goal is the same as yours – Consumer Satisfaction. If you have any questions regarding the Quality Review Team's report feel free to contact us at 1-800-684-3555 ext. 241 or 223.

Sincerely,

Dolores Holtcamp
Dolores Holtcamp,
Quality Review Team Lead

Beckie Bacon
Beckie Bacon
Quality Review Team Associate

Cc: Chuck Benjamin, Executive Director NSRSN
Sharri Dempsey, OCA Manager NSRSN
Francene Thompson, Clinical/QA NSRSN
Mary Cline, Compass Quality Assurance
Jere LaFollette, APN Executive Director

NSRSN - QUALITY REVIEW TEAM – Survey Report 2001

LYNNWOOD PRIMARY CARE – COMPASS:

Quality Review Team: Dolores Holtcamp, Lead - Beckie Bacon, Associate

Date & Time of site visit: April 24, 2001 – 1:00 pm to 4:00 pm

Consumers enrolled at site: approx. 500

Consumers surveyed: 24 face to face, 5 mail-in

Percentage surveyed: 5.8 %

Entrance comments: The Quality Review Team made a consumer survey interview visit to the Lynnwood Primary Care site. Staff was accommodating and had two private and semi-private spaces ready for client interviews. Front staff worked hard to encourage participation from the clients. Postings of the QRT visit were visible to clients and the atmosphere was friendly and collaborative. Thank you for your assistance and cooperation as this was a successful visit. Please read the client responses on the comments page included and post this information where readily available to residents and staff.

Areas of Satisfaction:

1. **Clients and Guardians** – were *somewhat satisfied to satisfied* with services in 3 out of 7 questions asked.
   - QUESTION #2 Case Management – 28 clients and guardians are somewhat satisfied to satisfied (97%). 1 neutral (3%).
   - QUESTION # Helpful Services – 29 clients and guardians are somewhat satisfied to satisfied (100%)..
   - QUESTION #7 Respect & Dignity – 29 clients and guardians are somewhat satisfied to satisfied. (100%).

Areas of Concern:

1. There were no areas of concern.

Unacceptable Areas:

1. **Clients and Guardians** – were *somewhat dissatisfied* to *dissatisfied* with the following:
   - QUESTION # 1 Access – 6 (21%).
   - QUESTION # 3 Crisis Plan - 5 (17%). Did not know about or were dissatisfied with their *crisis plans.*
   - QUESTION # 4 Treatment Plans - 5 (17%). Did not know about or were dissatisfied.
   - QUESTION # 5 Easy Care - 5 (17%).

Recommendations:

1. Review access and availability of services, crisis plan and case management procedures according to agency policy and contract compliance.

Observations:

1. The QRT notes that Lynnwood Primary Care also serves clients with a variety of insurances of whose criteria does not require compliance to the contract with the NSRSN.
   - Rights were posted.
   - Brochures available in [illegible] languages of VOA and [illegible] Provider [illegible] available.

Lynnwood Primary Care

Face to Face Comments from 24 Consumers and Family Members to QRT and 5 Mail-in.

1. Were you satisfied with the amount of time it took to access services?
   - I was given very little choices of an appointment.
   - No, it took a long time to access these services.
   - I'm dissatisfied because my son was suicidal and we called in soon for an intake. Then another intake – I finally took him to Children's where he got meds.
   - It was pretty fast.
   - For my daughter, it took awhile.
   - It didn't take long at all.
   - It took a week.
   - It took longer than expected. It took 3 weeks total.

2. Are you satisfied with the availability and support you receive from your case manager?
   - I don't have a case manager, but would like to consider having one, or finding out more about them and what they do.
   - I really enjoy my group.
   - Availability isn't good. She is really busy. It's been 2 months.
   - Sometimes it feels like a long time between services. It had been every 2 weeks.
   - Sometimes I feel rushed.
   - She's supportive and keeps a regular schedule.

3. Are you satisfied with the crisis plan provided for you?
   - I don't know of one – not sure what that is.
   - I'm not sure.
   - We don't have a crisis.
   - Not really.
   - I don't know about one.
   - I wish that there was one.
   - I've never called VOA.
   - I'd call VOA, but I've never had to.
   - I don't need one.
   - I don't know what that is. I've only been here twice.
   - I haven't had to use it.

4. Are you satisfied with your involvement in the development of your treatment plan?
    - I like the idea to set my goals, and then have someone state that – I meant that good.
    - I don't have a treatment plan yet. It's my 3rd time here.
    - I'm not sure if I have one.
    - We are not getting the full services my granddaughter needs. She is violent and needs to be placed appropriately.
    - I'm not aware of it.
    - I. isn't easy to get help.
    - We have different priorities.

5. Are you satisfied with how easy it is to get the care you need?
    - It's not easy when you're low income but not on welfare.
    - Care is only available once a week. Side effects and med changes not soon enough.

6. Are you satisfied these services are helpful to you?
    - No comments.

7. Are you satisfied the mental health staff treats you with dignity and respect?
    - No comments.

8. What would you change about the way services are provided for you?
    - Maybe just later hours so we didn't have to miss time from school for my child. But other than that it is fine.
    - I wouldn't change my therapist at all. Secondly, I wish I could come in more often because she is very helpful & very insightful. I've been in and out of counseling and therapy for eight or nine years and I've never benefited to the extent that I have with my current therapist. I can tell that she cares about what happens to her clients and is genuinely sincere. She has a magnetic effect of positive energy flooding to everyone. She has truly made a difference in my life.
    - More night appointments available.
    - I think to have individual counseling for adults and group sessions.
    - Need to make psychiatric care more readily available for med checks and etc.
    - My CM and front desk staff are always nice to me.
    - I don't know. Use meds as a last resort.
    - Everything is fine and working out fine.
    - Have a sliding fee scale for us even with insurance because my insurance pays so little.
    - Be more intuitive to the way others need to learn. Give me credit. Take my ideas more seriously.

8. CONT'D What would you change about the way services are provided for you?

- Even the first intake was not a good feeling. I would like empathy to be treated to me as they would be treated in my shoes. Finances have a large baring on getting into see a psych. Coupons are a barrier. Crappy financial deal.
- It took 2 years to find the resources for my son.
- I would get her help that she really needs. Counseling is not enough.
- It is hard to find a time that works for me to bring him in.
- I would like to be reminded of my appointments.
- More time with my CM.
- Our crisis is over. At the moment of the crisis there is nobody there to help you or guide you.
- The one thing I would change is they make you come back. Choice of medication.
- They could do a better job of helping the family members with the many side of things. The visits are limited. We had help with what other programs are but there is never help to make out the forms. We had help at a hospital with the forms. We were handed a large amount of forms. They need a program just to help with the forms.
- I'm really confused about my insurance. I need some help sorting out the co-pay and what it covers.

Letter and Posters mailed out: 3/30 [illegible]

Thank you sent: 4-10-01 **Report sent:** 5/7/01

Clients Receiving Services: 100 **#Surveyed:** 1 2 mail-ins.

leave 30 envelopes w/ survey or mail in packet earlier **#Surveyed last year:** 52

Agency Information

- Identify yourself as a Quality Review Team Member from the ESSSH.
- Explain what we do – we are Consumers, Family Members or Advocates, we conduct face to face interviews with Consumers to find out how satisfied they are with their Mental Health Services.
- We need to know how many consumers are served.
- Let them know that all information is confidential, we take no names for surveys.
- Make it clear that we need a high volume day to make contact and survey as many consumers as possible on our visit. The information we gather goes to the Agency, ESSSH and state in a Quarterly Report.
- If there are sites other than the Main Office, will another contact need to be made in order to establish coordinated visits.
- If an agency works with children, we need to know because parental consent is necessary, we have a parental and child's survey.
- Let the phone contact know of the importance Case Managers can play in getting the flyers out to the consumers so they can participate in the survey process if they choose.
- Explain the need for a secluded room or area for the survey process. This is necessary for the confidentiality of participants.
- Once again participants identity is confidential.

Response rate

CONSUMERS OF MENTAL HEALTH SERVICES

The Quality Review Team
North Sound Regional Support Network
1-800-684-3555

Satisfaction Survey

Location: Adult Extended Care

Date: 4-3-01

Time: 1 – 4 pm

- We survey Mental Health Consumers and Family Members in order to advocate for improvement of quality of services.
- We educate consumers, families and providers

QUALITY REVIEW TEAM
North Sound Regional Support Network
117 North First Street, Suite 8
Mount Vernon, WA 98273
1-800-684-3555 or 360-416-7013

February 8, 2001

Kim Brown
Compass Health
Adult Extended Care
1227 2nd Street
Marysville, WA 98223

Dear Ms. Brown and Staff:

The North Sound Regional Support Network Quality Review Team will survey consumers and family members at your facility on April 3, 2001. The QRT is mandated by the Federal Medicaid Waiver and WAC 275-57-150 to survey a percentage of the mental health population.

We will appreciate your cooperation by informing consumers about this confidential opportunity to voice their level of satisfaction with their mental health services. Please share a copy of this letter with all staff and consumers and post the attached flyer in a visible area.

The QRT will also need a private room from 1:00 – 4:00 pm for surveying. The survey-interview will take each participant a short time to complete.

When the scheduled time has been completed, the QRT will take a few minutes to meet with the provider contact for debriefing of the survey results. A formal report will be sent to you and other interested parties when it is complete.

Thank you for your assistance. Our goal is to survey approximately 5% of your agency's consumer population.

Sincerely,

Dolores Holtcamp
Quality Review Team Lead

Beckie Bacon
Quality Review Team Associate

File

Quality Review Team
North Sound Regional Support Network
117 North 1st Street, Suite 8
Mount Vernon, WA 98273
1-800-684-3555

May 3, 2001

Cindy Ainsley
Compass Health
Adult Extended Care
1227 2nd Street
Marysville, WA 98223

Dear Ms. Ainsley:

This letter is to report to you the results of North Sound Quality Review Team surveys conducted at Adult Extended Care April 3, 2001. QRT conducted a total of 7 face to face interviews with consumers at your facility, and received 2 mail-in surveys. We consider this to be satisfactory. The results of the survey are enclosed for your review. Please make copies and post where accessible to consumers and staff at your facility.

The QRT has recently converted our report process to a new computerized system allowing us to track percentages of satisfied to dissatisfied in an objective manner. The system tallies answers by numbers and then computes these to percentages. Areas of Satisfaction have percentages of *satisfaction* from 90 - 100% (congruent to the MHD audit process). Areas of Concern have percentages of *dissatisfaction* from 11 - 13%. Unacceptable Areas, (or findings), have percentages of 14% or greater of *dissatisfaction.*

The Quality Review Team requires written responses to the Unacceptable Areas with in 30 days. Please include the plan and timeline with your response.

We appreciate your efforts in helping make this a successful and informational report. Our goal is the same as yours – Consumer Satisfaction. If you have any questions regarding the Quality Review Team's report feel free to contact us at 1-800-684-3555 ext. 241 or 223.

Sincerely,

Dolores Holtcamp,
Quality Review Team Lead

Beckie Bacon
Quality Review Team Associate

Cc: Chuck Benjamin, Executive Director NSRSN
Sharri Dempsey, OCA Manager NSRSN
Francene Thompson, Clinical QA NSRSN
Mary Cline, Compass Quality Assurance
Jere Labollette, APN Executive Director

QUALITY REVIEW TEAM – FACILITY OBSERVATIONS & RECOMMENDATIONS

~~1999~~ 2001

Provider Facility: Marysville Adult Ext

Date: 4/3/01

Rights Posted? yes

Brochures accessible? need languages

QRT flyer posted? yes

Waiting Room appearance? good

Receptionists - (friendly, respectful, attentive)? yes

Privacy Area for surveys? yes

QUALITY REVIEW TEAM

NORTH SOUND REGIONAL SUPPORT NETWORK

ORT PROVIDER VISIT – BROCHURES & POSTINGS CHECK LIST

Provider Agency: Marysville - Adult Extended

- Are Provider (APN) Brochures easily accessible to consumers? ☒yes ☐no
  - Languages available? 1
- Are NSRSN Brochures easily accessible to consumers? ☒yes ☐no
  - Languages available? 1
- Are Ombuds Brochures easily accessible to consumers? ☒yes ☐no
  - Languages available? 8
- Are QRT Brochures easily accessible to consumers? ☒yes ☐no
  - Languages available? 1
- Are VOA Crisis Response System brochures available? ☒yes ☐no
  - Languages available? 8
- Are Consumer Rights posted, including right to interpreter? ☒yes ☐no
  - Languages available? 8

comments: left out copy of consumers rights

Reviewer Name: [illegible] Date:

A	B
[redacted]	Date:
Marysville Adult Ext Care	4/3/01
[redacted]	100

Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Sex	Age	Race	Zip
5	5	5	5	5	5	5		f	18-59	[illegible]	[illegible]
5	5	5	4	5	5	5		f	60+	w	[illegible]
3	3	5	3	5	3	5		m	60+	w	[illegible]
5	5	5	5	5	5	5		m	18-59	w	
1	1	1	1	1	1	5		m	13-59	w	
5	5	2	4	5	2	2		m	18-59	w	
4	5	5	5	5	5	5		m	18-59	w	co
3	5	5	5	5	5	5		f	18-59	w	
4	5	5	5	1	5	5		m	18-59	w	[illegible]

NSRSN - QUALITY REVIEW TEAM – Survey Report 2001

MARYSVILLE ADULT EXTENDED – COMPASS:

Quality Review Team: Dolores Holtcamp, Lead - Beckie Bacon, Associate

Date & Time of site visit: April 3, 2001 – 1:00 pm to 4:00 pm

Consumers enrolled at site: approx. 100

Consumers surveyed: 7 face to face, 2 mail-in

Percentage surveyed: 9 %

Entrance comments: The Quality Review Team made a consumer survey interview visit to the Adult Extended Care in Marysville. Staff was accommodating and had a private space ready for client interviews. Staff encouraged participation from the clients. Postings of the QRT visit were visible to clients and the atmosphere was friendly and collaborative. Thank you for your assistance and cooperation as this was a successful visit. Please read the client responses on the comments page included and post this information where readily available to residents and staff.

Areas of Satisfaction:

1. Clients and Guardians – were *somewhat satisfied to satisfied* with the following:
   - QUESTION #7 Respect & Dignity – 8 clients and guardians are somewhat satisfied to satisfied. (89%). 1 neutral (11%).

Areas of Concern:

1. Clients and Guardians – were *somewhat dissatisfied* to *dissatisfied* with the following:
   - QUESTION #2 Case Management – 1 dissatisfied (11%). 1 neutral (11%).
   - QUESTION #4 Treatment Plans – 1 dissatisfied (11%). 1 neutral (11%).
   - QUESTION #1 Access - 1 dissatisfied. 2 neutral (22%).

Recommendations:

1. Review access, case management and treatment plan procedures according to agency policy and contract compliance.

Unacceptable Areas:

1. Clients and Guardians – were *somewhat dissatisfied* to *dissatisfied* with the following:
   - QUESTION # 5 Easy Care– 2 (22%).
   - QUESTION # 6 Helpful Services - 2 (22%).
   - QUESTION # 3 Crisis Plan - 2 (22%). Did not know about their *crisis plans*.

Recommendations:

1. Review crisis plan procedures according to agency policy and contract compliance.
2. Review agency policy and contract to ensure services are easy to get and helpful.

Observations:

1. Rights were posted.
2. Brochures available. Language of NSRSN, Provider, APN and QRT were not available required by contract.

Adult Extended Care - Marysville

Face to Face Comments from 7 Consumers and Family Members to QRT and 2 Mail-in.

1. Were you satisfied with the amount of time it took to access services?
   - It worked within about 3 weeks to get an assessment and a case manager.
   - I had to spend a lot of time convincing Compass to look at him.
   - I got right in.
   - I had to wind up in the hospital before I found services.
   - I don't know.

2. Are you satisfied with the availability and support you receive from your case manager?
   - She is very easy for me to get a hold of.
   - My son can't stand her and I don't like her. If anything needs to be done it is done by me. She does nothing. She threatens to cut off meds if my son doesn't see her.
   - She is pretty good.
   - I get a lot of support here.

3. Are you satisfied with the crisis plan provided for you?
   - It is great if you can stick to it.
   - I've never had to call VOA.
   - I know nothing about a crisis plan.
   - The Everett hospital just tells me to sit there. No help from VOA. I've called 15-20 times. I got the feeling they d n't want people committing suicide on their shift. They tell me to blow in a bag or beat a pillow – there's nothing they can do.
   - It's effective. The VOA gave me what I needed – not what I wanted.
   - VOA was helpful.

4. Are you satisfied with your involvement in the development of your treatment plan?
   - She sticks behind what she believes in and practices.
   - No, they tried to put him in a DD group when he is schizophrenic.

5. Are you satisfied with how easy it is to get the care you need?
   - Sometimes the doctor doesn't give me enough meds and I run out. I want to change doctors so I can stay on my meds.

6. Are you satisfied these services are helpful to you?
   - Yes, definitely.

7. Are you satisfied the mental health staff treats you with dignity and respect?

- Except the case manager.
- The clinician who teaches the classes. When, in a group, a feeling chart was passed around and I wrote down a "2" then the clinician became argumentative and said several times, "now, you know that's not true." I felt helpless and mad. I didn't appreciate being called a liar because I felt like a "2." She humiliated me.

8. What would you change about the way services are provided for you?
   - Take walks.
   - I don't know. Sorry.
   - I would make land taxes on someone who's buying a home.
   - I want a different doctor that will give me enough meds so I don't run out – (for my bipolar).
   - More field trips.
   - It would be helpful if there was access to a 'roving case manager' in the evenings. One of the case managers here so you don't have to start from scratch with VOA.
   - More one on one therapy. Give "how to" when making suggestions. Quit cutting back services and re-establish things like lunch and the socials. Stop "graduating" people when they are not ready – they get kicked out. Clinicians should treat us with dignity and respect.
   - Have groups with those who have same or similar disorder.
   - I wouldn't change a thing. They do a good job.

COMPASS Health

June 5, 2001

Dear Dolores Holtcamp and Becky Bacon:

I am sorry to be two days late with my response to the Quality Review Team report of April 3, 2001 regarding services at Adult Extended Care in Marysville. I organized the response to the Bailey Center report first, as I missed the fact it was actually completed after the Marysville report, which led to my missing the deadline.

Compass Health remains very committed to achieving high levels of consumer satisfaction and your report will help us move toward this goal in Marysville.

You have identified three unacceptable areas in your report: ease of receiving care, helpfulness of services and knowledge of crisis plans. I have shared the specific comments consumers made regarding each of these items with the manager responsible for client care in Marysville. We have discussed how clinicians can change how they work with their clients to improve satisfaction in each of these areas. She will also review with their staff the pertinent contractual obligations and agency protocols. We expect to have the above retraining completed within the next 14 days.

Thank you once again for providing us with such helpful feedback.

Sincerely,

Barb McFadden ARNP MN
Director of Adult Extended Care Services

CONSUMERS OF MENTAL HEALTH SERVICES

The Quality Review Team
North Sound Regional Support Network
1-800-684-3555

Satisfaction Survey

Location: Lynnwood Primary Care

Date: April 24, 2001

Time: 1:00 pm - 4:00 pm

- We survey Mental Health Consumers and Family Members in order to advocate for improvement quality of services.
- We educate consumers for self-empowerment.

Attachment A.111d2bii

Title XIX Eligible People Receiving Outpatient Services in WA State

July 16, 2001

This note presents a series of tables and definitions to support the CMS (formerly HCFA) waiver report.

Determining Title XIX Eligibility: The current state of the MHD data systems vary in their ability to determine whether a recipient of services is title xix eligible.

Outpatient: The RSN based outpatient information system (MHD-CIS) flags clients as title xix eligible at the time of service and as such is a reasonable indicator. Because a person's eligibility can change we make two important assumptions for purposes of reporting. First, if someone has a mixture of services in a month and only some of those services are flagged as being provided while the person is title xix eligible we treat the whole month as being all title xix eligible. Second, if someone is title xix eligible for part of a reporting period (calendar year, fiscal year, quarter) we consider them to have been title xix eligible for the entire time period. All tables in this note are based upon these assumptions.

In an effort to provide the most current information possible, we are including incomplete outpatient service utilization data for FY2001. This information is incomplete because when an RSN provides a service they have 60 days from the end of the month to report, edit and revise service data. Occasionally even this limit is exceeded. This means that some service information takes 90 or more days to appear into our systems. The data for this report was extracted July 13, 2001 so April, May and July are not completely reported. Therefore we expect that significantly more people will appear in the reports for this fiscal year.

Inpatient: Title XIX eligibility is tracked by the Medical Assistance Administration (MAA). However, none of the inpatient information systems currently in use by the MHD contain that title xix eligibility information. This restricts our ability to report on this population in terms of inpatient services. We expect improvement in our ability to report on this population as part of our internal quality improvement activities and our response to the HIPAA initiative. A number of state data systems are changing such that when a person becomes title xix eligible that information is quickly made available to other departments and divisions such as the MHD. We expect to see the first stable electronic access to eligibility information due to these changes in 2002.

Table 1a. Title XIX eligible people seen and outpatient service hours provided. Unduplicated statewide.

	July 1, 1998 - June 30, 1999	July 1, 1999 - June 30, 2000	July 1, 2000 - June 30, 2001
Medicaid Served in State	67,188	64,513	65,210
Total Served in State	108,656	113,626	113,339
Number of Medicaid served as percent of total	59.3%	59.1%	57.5%
Hours of service provided to Medicaid served	2,341,704	2,116,193	1,706,807*

Table 1b. DRAFT RESULTS. Partial data on Title XIX eligible people seen and outpatient service hours provided. Unduplicated statewide.

Partial Data	July 1, 2000 - June 30, 2001
Number of Medicaid Served in State	65,208
Hours of service provided to Medicaid served	1,944,737

While Table 1a shows that the number of title xix clients decreased from FY99 to FY2000 it also shows that the overall number of people served decreased. The proportion of Title XIX eligible served has remained constant across these years, however.

Table 2a shows that the changes in people served and amount of service have not affected all ethnic groups equally. Overall we see a slight decrease in the number of caucasians served and a corresponding decrease in the percent of service hours consumed.

We see a similar trend in Table 3a which shows Title XIX eligible clients by age group. While the relative number of people and hours decreases for working age, we see a relative (but not absolute) increase in youth seen and service hours for those youth. The number of elders represents a slight decrease in the proportion of people seen, but there is a slight increase in the proportion of hours of service for those elders.

Inpatient to Community Linkages. As indicated above, currently the inpatient utilization data sets do not contain Title XIX eligibility. Table 4 presents limited information on all inpatient to community service linkages. Note, however, there are two major limitations to the data which are used to create this table. First, the outpatient service utilization records that are currently available are only available through November 17, 2000. Any outpatient services after that time will not be reflected in this table. Second, often the inpatient discharge disposition is to some facility other than RSN based outpatient. We have no way of knowing when this is the case. Therefore, many of the episodes shown to have never been seen by outpatient were not expected to be seen there. Indeed they may have gone to nursing homes, skilled nursing facilities, or private or Veterans facilities. Therefore the number who are reported as never seen presents a bleaker picture than is true.

Table 2a. Title XIX eligible people seen and service hours by ethnicity.

	July 1, 1998 – June 30, 1999				July 1, 1999 - June 30, 2000			
Ethnicity	*Number Seen*	*Percent of Total*	*Number of Hours*	*Percent of Total*	*Number Seen*	*Percent of Total*	*Number of Hours*	*Percent of Total*
African American	4,933	7.34	201,665	8.61	4,994	7.74	192,809	9.11
Asian Pacific Islander	2,326	3.46	75,880	3.24	2,326	3.61	72,568	3.43
Caucasian	50,432	75.06	1,794,467	76.63	47,706	73.95	1,586,962	74.99
Hispanic	4,618	6.87	117,755	5.03	4,712	7.30	117,731	5.56
Native American	2,225	3.31	67,254	2.87	2,084	3.23	58,149	2.75
Other	2,654	3.95	84,680	3.62	2,692	4.17	87,972	4.16
Totals	67,188	100.00	2,341,701	100.00	64,514	100.00	2,116,191	100.00

Table 2b. DRAFT RESULTS. Partial data on Title XIX eligible people seen and service hours by ethnicity.

Partial Data	July 1, 2000 – June 30, 2001			
Ethnicity	*Number Seen*	*Percent of Total*	*Number of Hours*	*Percent of Total*
African American	5,246	8.05	182,644	9.39
Asian Pacific Islander	2,427	3.72	71,666	3.69
Caucasian	48,028	73.65	1,436,137	73.85
Hispanic	4,508	6.91	105,027	5.4
Native American	2,211	3.39	63,037	3.24
Other	2,788	4.28	86,223	4.43
Totals	**65,208**	**100.00**	**1,944,734**	**100.00**

Table 3a. Title XIX eligible people seen and service hours by age group.

	July 1, 1998 - June 30, 1999				July 1, 1999 - June 30, 2000			
Age	*Number Seen*	*Percent of Total*	*Number of Hours*	*Percent of Total*	*Number Seen*	*Percent of Total*	*Number of Hours*	*Percent of Total*
0 – 17	24,648	36.69	690,905	29.51	24,126	37.41	693,196	32.76
18 – 59	35,933	53.50	1,485,695	63.46	34,443	53.40	1,271,861	60.11
60 and over	6,589	9.81	164,664	7.03	5,928	9.19	150,976	7.13
Totals	**67,170**	**100.00**	**2,341,264**	**100.00**	**64,497**	**100.00**	**2,116,033**	**100.00**

Table 3b. DRAFT RESULTS. Partial data on Title XIX eligible people seen and service hours by age group.

Partial Data	July 1, 2000 – June 30, 2001			
Age	*Number Seen*	*Percent of Total*	*Number of Hours*	*Percent of Total*
0 – 17	24,039	36.88	678,102	34.87
18 – 59	35,211	54.01	1,126,001	57.91
60 and over	5,939	9.11	140,457	7.22
Totals	**65,189**	**100.00**	**1,944,560**	**100.00**

Table 4* (Revised 8/22/2001)

	Episode Start Date					
Time from Inpatient Discharge to 1st OP Visit	*January 1998*	*Percent of Total*	*January 1999*	*Percent of Total*	*January 2000 or later*	*Percent of Total*
Within 7 days	18,688	32.73%	13,244	30.41%	14,235	45.50%
More than 7 days	11,751	20.58%	7,318	16.83%	7,683	24.60%
Not seen	26,652	46.68%	22,945	52.76%	9,360	29.90%
Totals	**57,091**	**100.00%**	**43,487**	**100.00%**	**31,278**	**100.00%**

* - This report was recently rerun and includes data beyond November 17, 2000.