



King County

**Recovery Plan for Mental Health Services
Phase II Implementation Plan**

June 2007

Introduction

On November 15, 2005, the Metropolitan King County Council passed Ordinance 15327, a revised Mental Health Recovery Ordinance. The Recovery Ordinance adopted the recovery model as the policy framework for developing and operating the mental health services for which King County is responsible, and adopted a five-year work plan for implementing changes in the system that would result in a recovery orientation and recovery outcomes.

The council subsequently passed Budget Ordinance 15333 with a proviso to support the plan for changing the system from one based on maintenance of persons with mental illness to one promoting recovery of functioning in community life. As directed in that budget proviso, the Department of Community and Human Services' Mental Health, Chemical Abuse and Dependency Services Division (MHCADSD) submitted to the council on March 1, 2006 a Phase I Recovery Implementation Plan. This Phase I plan was a detailed work program that specified the scope of work, tasks, schedule, milestones, and specific plans for the use of expert consultants. The work plan also included plans for a system change oversight group and implementation planning work groups.

The Recovery Ordinance specified the steps in bringing about the implementation of the recovery model, stating that:

"...the department of community and human services, or its successor, shall complete a detailed recovery system implementation plan. The department shall submit, by June 2007, an ordinance to the council for approval of the plan. The plan shall result from completion of work described in Phase I of the Recovery Plan for Mental Health Services."

Pursuant to the 2005 Recovery Ordinance, MHCADSD has developed a detailed implementation plan for converting the public mental health system in King County to one with a recovery orientation. As directed by the council, the plan is based on activities that have occurred since the development of the Phase I Work Plan (published in March 2006) and describes the next steps in the process of transforming the mental health system.

Recovery refers to the process in which people are able to live, work, learn, and participate fully in their communities. For some individuals, recovery is the ability to live a fulfilling and productive life despite a disability. For others, recovery implies the reduction or complete remission of symptoms.

Phase I Work Plan Activities

During Phase I, MHCADSD staff sought out and worked with a variety of expert consultants, established planning groups, and worked to gather input from key partners in a concerted effort to inform its recovery transformation activities.

A. Worked with Expert Consultants

1. MHCADSD hired an expert on recovery to a part-time temporary position to provide leadership to staff, agencies, and consumers for the transformation activities. In addition to his expertise and knowledge in the field of mental health recovery, he is an experienced provider of mental health services in the publicly funded mental health system, and holds an assistant professorship at the University of Washington, School of Social Work.
2. MHCADSD contracted with Technical Assistance Collaborative, Inc. to develop strategies for aligning financial incentives with recovery practices. That work is just being completed. The next step will be to convene a Financial Work Group.
3. A Request for Proposal (RFP) to select a training consultant was just issued in June 2007. The training plan will include design and development of training workbooks and training sessions consistent with adult learning theory. In addition, training videos will be developed to provide real life examples of recovery oriented practices. Training will be provided at approximately 16 sites over the course of the next one-to-two years.

B. Established Implementation Planning Groups

1. Recovery Implementation Group. This is a stakeholder work group focused on what the new recovery oriented system should look like and how to implement new recovery policies. Members include representatives from the major stakeholder groups, including consumers, family advocates, providers, and county staff. This group has worked extensively on recovery process and outcome measures that will be used to transform current activities to those that promote recovery. The group has also identified barriers to recovery implementation and potential strategies to surmount those barriers.
2. Youth and Older Adult Provider Work Groups. Because recovery literature is primarily concentrated on adult services and outcomes, these work groups were formed to develop and articulate appropriate process and outcome measures for youth and older adults.
3. Consumer directed group-Voices of Recovery. This group of consumers of mental health services was formed, and meets regularly, to provide input into all of the county's recovery transformation activities. This is the first time that a freestanding group consisting of and led by mental health consumers has been involved in a sustained analysis of recovery policies and practices in King County. Their recommendations to date include:

- Having staff readily accessible at each agency site to help consumers learn how they can resume employment without losing their disability benefits
 - Providing services as soon as possible after consumers are released from jails and hospitals, in order to increase stability in the community and reduce future hospitalizations and incarcerations
 - Increasing the number of peer counselors working at mental health agencies
 - Increasing recovery training for agency staff
 - Addressing housing issues for all homeless consumers
4. Financial Realignment Group. MHCADSD staff has accomplished a considerable amount of developmental work with the help of expert financial consultants. Recommendations from the consultants include the following:
- There is no need to fundamentally change the payment structure; financial incentives can be built into the current system.
 - The incentive system should be implemented incrementally, with an initial focus on structure and process measures.
 - Providers should develop a plan for moving toward recovery and resiliency service approaches, and implementing best practices.
 - Providers and King County should work together to develop baseline measures for performance and outcome indicators.
 - The first year incentive payments should be linked to provider development of an acceptable recovery plan and assurance of timely and accurate data submission.
 - In years two and three, the financial incentives should be based primarily on attainment of performance targets related to specified structure and process measures.
 - In year four, the system would shift toward a greater emphasis on consumer outcome measures.

Major financial restructuring will not be required to implement these recommendations and they are already in the process of being put into practice. As a result, the focus of the financial work group will be somewhat different than originally envisioned. Incentives will be funded from currently available funds. Nonetheless, a significant number of specific implementation strategies still need to be developed in partnership with our provider network.

C. Input from providers, consumers, and family advocates

1. Chief Executive Officer (CEO) Retreats. MHCADSD held three recovery retreats with community mental health agency CEOs, senior managers, and consumers.
 - The first retreat focused on arriving at a shared vision of recovery, system transformation challenges, desirable recovery outcomes, and training needs.
 - At the second retreat, agency CEOs provided updates about recovery practices that were already being implemented, or were planned for implementation. Members of Voices of Recovery shared their views about needed system changes. Providers gave input about potential changes in the financial model to support recovery practices.
 - At the third retreat, a consumer panel described their experiences in the system and spoke about the services that helped, and those that did not help, in their recovery journeys.
2. Roundtable Dialogues. MHCADSD staff conducted a series of 17 roundtable dialogues at provider sites with the participation of middle managers, line staff and consumers. These dialogues were held to elicit staff and consumer views about recovery. Several recurrent themes emerged from those discussions that helped to guide planning and development of the training RFP, among them:
 - There was a pervasive concern that caseload size and workload associated with documentation requirements represented a huge barrier to thinking about, much less implementing a recovery model of care.
 - There was considerable interest in learning about recovery-engendering practices and how they differ from traditional approaches. As a result, the timeline for providing agency training was accelerated.
3. Recovery Initiatives Committee. The Recovery Initiatives Committee is a committee of the King County Mental Health Advisory Board. Their role is to review and comment on plans and documents related to recovery and make recommendations. The Board and its committees are comprised of consumers, advocates, and provider representatives.

Phase II Implementation Plan

In Phase II, MHCADSD will realign fiscal resources, continue to increase awareness of and engagement in recovery-oriented quality improvement activities, engage in intensive county and provider staff development, and increase consumer voice and empowerment. The methods for achieving these goals are based on the results from the Phase I Work Plan. The elements of the implementation plan requested in Ordinance 15327 are addressed in A through F of this section, as follows:

A. Progress Report on developing a shared vision of recovery

All stakeholder groups are in consensus that we should transform the system toward a recovery orientation. Through the activities noted above, MHCADSD staff, consumers, family advocates, and providers have developed a vision that includes the following elements.

1. There will be clearly defined, measurable recovery oriented outcomes.
2. The fiscal system will reward the attainment of the recovery outcomes.
3. The system will be consumer-focused and consumer-directed.
4. Consumers will be less dependent on the public mental health system, and will rely more on themselves, peers, and their communities.
5. The system will be hopeful about recovery for every consumer, and will expect consumer growth and change.
6. There will be higher expectations that some consumers will no longer need ongoing services from the public mental health system.
7. More people will work and live in integrated settings in the community.
8. The system will work to eradicate the stigma associated with mental illness.

B. Identification and analysis of best practices

The federal Substance Abuse and Mental Health Services Administration (SAMHSA) identifies six primary evidence-based practices for adult consumers of mental health services. Evidence-based practices are “interventions for which there is consistent scientific evidence showing that they improve client outcomes.” The SAMHSA evidence-based practices are as follows:

1. Program of Assertive Community Treatment (PACT). This refers to a mobile multi-disciplinary team that carries a small caseload size and is continuously available to help consumers who are at high risk for homelessness, incarceration, or hospitalization develop the skills and supports needed to successfully live in community settings. A substantial body of literature dating back 30 years demonstrates that PACT model case management programs increase community tenure and reduce hospitalizations.
2. Integrated treatment of co-occurring disorders (mental illness and substance use). Simultaneous provision of mental health and substance abuse treatment services in a sustained, integrated fashion is an approach that creates better outcomes than other approaches that attempt to treat mental illness and substance abuse separately.

3. Illness management and recovery. Consumers learn skills and take responsibility for self-management of their psychiatric symptoms and their progress toward recovery.
4. Medication management approaches in psychiatry. Considerable research supports the efficacy of particular medications for specific conditions that have been shown to reduce or eliminate psychiatric symptoms.
5. Family psycho-education. Families develop knowledge and skills to better support family members in managing their mental illnesses.
6. Supported employment. Placement of consumers into integrated community jobs that correspond with consumers' strengths and interests have been shown to lead to improved clinical outcomes. Eleven solid research studies of supported employment demonstrate that it produces large improvements in competitive employment rates when compared to traditional rehabilitation approaches.

In addition to identified evidence-based practices, a number of promising practices support recovery, including the following:

1. Peer support. Peer support is a promising practice strongly endorsed by local and national mental health consumers and family advocates. Peers who have experienced severe mental illness and entered recovery can act as powerful role models for others. They can develop unique empathy and rapport with other consumers by virtue of having experienced mental illness themselves. The evidence is growing that well trained peer counselors can provide a valuable array of behavioral health services, which can augment professional practice. Peer support also has an emerging research base, suggesting that consumer-delivered case management can be as effective as those delivered by non-consumers, and that peer support services can promote community tenure by reducing hospitalization.
2. Wraparound approach for high-risk youth. An approach to providing services and supports, wraparound begins with facilitation of a needs-driven and strengths-based planning process. The child, youth and family are supported by a team of people that include natural/community supports and professionals, eventually evolving to a team of community supports. Wraparound has been shown to improve community tenure, reduce hospitalization, and improve academic performance. King County has successfully implemented wraparound programs and has demonstrated significant positive outcomes.
3. Supported housing. Supported housing is another promising practice that promotes integration into community and enhances a person's quality of life. Consumers move from institutions into community housing supported by rent subsidies and case management services.
4. Criminal justice alternative services. Mental health and chemical dependency service systems provide treatment rather than incarceration for mentally ill and chemically

dependent offenders. The MHCADSD Criminal Justice Initiative (CJI) focuses on treatment and supportive services for individuals being released from jail, including integrated treatment for co-occurring disorders and supported housing approaches modeled after evidence-based practices. These CJI programs have shown reductions in re-incarceration.

5. Clubhouse-model programs. Employment services are central to these consumer-directed day programs in which members experience a sense of being needed and wanted, leading to recovery. Certified clubhouse model programs have standards requiring integrated community employment that exceeds our current overall system employment rate by 53 percent.

Evidence-based and promising practices are identified for replication, in part based upon scientific research supporting their efficacy. Consumer and family member preferences are essential considerations as our system evaluates which best practices to replicate. Consumers and family members strongly prefer services that promote recovery by producing better outcomes in employment, housing, and stabilization/ integration in the community, while also producing a better quality of life. These are the services that will be emphasized in the Phase II implementation process.

C. Assessment of existing services, resources, reimbursement models, and resource realignment

Most agencies in the King County provider network are in the initial stages of moving forward with new recovery services; with several having made significant progress. The array of recovery services currently being provided includes the following:

1. Hiring and training peer counselors. There is potential to improve the service array and consumer satisfaction through enhanced use of peer support. Increased availability of peer counselors may also provide a way to re-distribute duties in ways that alleviate workload barriers to implementing recovery practices.
2. Consumers are in leadership positions on quality improvement and strategic planning committees, in addition to involvement with other administrative functions.
3. Wraparound services for high-risk youth.
4. Supported employment services are in place in several agencies.
5. Two new PACT programs, which will begin accepting clients in July 2007.
6. Supported housing services.
7. Criminal justice diversion programs.
8. Treatment plans are being redesigned as Recovery Plans or Goal Plans. These newly designed service plans better incorporate consumer choices.

9. Wellness Recovery Action Plan (WRAP) is a self-help strategy experiencing burgeoning popularity with consumers. A WRAP plan is based on consumer preferences in managing their illnesses and maintaining their progress towards recovery.
10. Two clubhouses are in the process of obtaining certification by the International Center for Clubhouse Development.

D. Strategies, goals, action steps, timelines for implementing system change

Currently, the primary resource available for providing services is federal Medicaid. These resources will be aligned with the goals and values of recovery through the strategies for system change described below.

Expert consultation and a review of the literature describe how other localities are transforming their systems to a recovery model, suggesting that three primary strategies are needed to transform agency and practitioner practices.

Strategy I: Change the financial model to reward structures, processes and outcomes that promote recovery

MHCADSD has determined that there are sufficient Medicaid resources available during the remainder of 2007 to build infrastructure to support recovery practices. Providers were given an ongoing 2.5 percent rate increase beginning May 1, 2007. From July through December 2007, up to five percent additional incentive funding will be available for those providers that meet established goals in the delivery of new recovery practices. Funds will continue to be available in future years to sustain the available incentive pool.

In consultation with the Technical Assistance Collaborative, Inc., MHCADSD plans to adopt a graduated approach over the next five years of using financial incentives to shape agency administrative and direct service recovery practices. MHCADSD plans to use financial incentives to initially reward agencies for the development of structures and processes that promote recovery. Structures are the service delivery models that meet fidelity standards and/or are priority services or practices that promote recovery. Processes are the activities agencies engage in that ultimately result in desired outcomes for consumers. For example, defining the role of consumers in the agency or implementing high fidelity supported employment are structural components. Examples of process components are employing consumers at a variety of levels in the agency and delivering an increased number of supported employment services.

MHCADSD has adopted the plan to start with paying incentives for establishing processes and outcomes, and gradually shifting over time toward payment for outcomes. This is to assure that there are systemic changes in practice at the agency level. Also, because the population served includes people with severe and persistent mental illness who may be at various levels of recovery, perverse incentives for providers to selectively serve clients who are more likely to attain outcomes must be avoided. The value of recovery for all clients

needs to be well established. Once recovery processes and structures become institutionalized, progressively more emphasis will be placed on paying for the recovery outcome measures that are most valued by consumers and family members, such as increased employment, increased independent living, increased satisfaction with life, and greater perception of choice.

During the remainder of 2007, agencies will earn financial incentives by achieving the following:

1. Submission of a letter of intent to participate in the change process toward a more recovery oriented system.
2. Submission of an Agency Recovery Plan by October 1, 2007. The Agency Recovery Plan will detail the strategies the agency will employ to put new or expanded system structures and processes in place to effect broad change within the agency. The Agency Recovery Plan will be based on an agency self assessment that will assist the agency in articulating their current status with respect to recovery structures and processes, where they would like to be in a few years, and how they intend to accomplish that change process. The assessment plan will address:
 - The role of consumers/families in development of the recovery plan
 - The desired future role of consumers and families in agency governance, planning, program assessment, and quality management
 - The plan for re-tooling staff job descriptions, duties, and performance evaluations to include recovery competencies.
 - The plan for increasing the number of consumers employed by the agency
 - How consumer choice will be incorporated into individualized, person- centered recovery plans
 - How recovery principles and practices will be incorporated into the agency at all levels (e.g., administrative, clinical, support functions)
 - Specific plans for implementing evidence-based practices of supported employment, wraparound, peer support/family support services, and other recovery oriented best practices
 - Plans for accessing these services on behalf of enrolled consumers, if not offered directly by the agency
 - How recovery oriented services and recovery principles will be tailored for special populations served by the agency (e.g., diverse cultural/linguistic populations, youth, elders, etc.)

- How the agency's quality management/quality improvement process will improve performance related to consumer-driven outcomes and performance goals.

For 2008, agencies will earn financial incentives by completing and beginning to implement their Agency Recovery Plan, and by improving the quality of their process and outcome data. The data improvement process is fundamental to establishing an accurate baseline from which to assess subsequent progress towards outcomes goals. MHCADSD has a robust information system that captures a great deal of data. A number of the recovery measures that have been defined are "soft" measures, however, that cannot be reported with a simple code. MHCADSD will be working with providers to develop operational definitions, reporting methodologies, and improvements to the accuracy of the data.

For 2009, agencies will have the potential to earn incentives based on their performance on the established structure and process measures. During 2010-2011, incentives will begin to shift toward outcome measures and away from structure and process measures.

Strategy II: Provide workforce training in recovery practices

MHCADSD anticipates hiring a training consultant during the summer of 2007 to develop and provide training on recovery practices to agency staff. Training will begin in the fall of 2007 and continue for one to two years. This training will utilize adult learning principles to develop values, skills, and knowledge about recovery. There will be three full days of training at each agency site, spread over the course of a year, with homework assignments and mentoring offered between didactic sessions. Workbooks and DVDs will be developed as training tools for new employees.

Although use of peer counselors is a valued recovery practice, there are insufficient certified peer counselors in the state. To date, the only training available for peers to become certified has taken place at the state level. The number of trainings and slots statewide has been very limited, and as a result, not enough King County peer counselors are able to complete the required training to address the need for certified peer counselors in our large system. After successfully negotiating with the state, MHCADSD plans to sponsor its own 40-hour training and testing sessions using the state's curriculum and training materials. This effort will further develop this critical resource.

Strategy III: Use regulatory practices to promote change, including more focused monitoring of policies, procedures, and contracts

The level of regulatory activity needed to transform practices is greater during times of rapid change. MHCADSD will devote additional resources to more closely monitor emerging new recovery practices to include the following:

1. Revising policies, procedures, and contracts to include enhanced recovery language and concepts by January 2008

2. For 2008 contracts, develop contract language that will articulate performance expectations
3. Targeted follow-up and oversight subsequent to provider site reviews, with emphasis on implementation of recovery-oriented practices, starting in spring 2008.

E. Defined outcome and other appropriate performance measures

Both SAMHSA and the national literature tend to focus on adult recovery outcomes and services that lead to recovery for adults. For children and youth or older adults the concept of recovery is less applicable than the philosophy of pursuing resiliency. As a result, MHCADSD and the providers who serve children/youth and older adults are developing outcomes appropriate to those age groups. At the same time, processes that will lead to those outcomes are being identified. This is groundbreaking work being accomplished here in King County.

The process of system transformation will involve putting processes and structures in place so that all consumers have access to services that are recovery oriented. Once those processes are well established, incentive payments will be rebalanced toward outcomes. Priority services in four domains will be measured and monitored. The domains include:

1. Employment/Education/Life Activities
2. Housing
3. Community Tenure (staying out of hospitals and jails)
4. Quality of Life

These domains are priorities identified by consumers and are consistent with Department of Community and Human Services priorities. The following examples illustrate how process and outcome measures are related to the priority domains:

Domain: Employment (for adults)

Process: Increased number of supported employment services provided

Outcome: The number of individuals who acquire or maintain paid competitive employment

Domain: Education/Life activities (for children and youth)

Process: Increased number of developmental assessments

Outcome: Children/youth progress along normal developmental trajectory

Domain: Community Tenure (for children, adults, or older adults)

Process: Face-to-face service provided within seven days of release from hospitalization or incarceration

Outcome: Decreased number of hospital days

Outcome: Decreased number of days of incarceration

Multiple process and outcome measures have been identified for each of the four domains. All of these measures will be tracked. In order for the incentive payments to have sufficient weight to motivate change, however, only a subset of these measures will have incentive payments attached. Those measures are tailored to address the differences in the needs of children and youth, adults, and older adults. Based on what has been learned from efforts in other parts of the country, as incentives are earned and the processes are fully integrated, they can be considered established. Additional measures will then be selected to have incentives attached.

F. System for monitoring, evaluating, and reporting progress in implementation

The primary sources of data for measuring progress on recovery structures, processes, and outcomes are information submitted by providers to the MHCADSD information system (IS); and agency site visits/audits. MHCADSD has determined that an array of new and existing measurement tools is needed, in order to evaluate and report on progress toward recovery transformation.

1. First, as noted above, the quality of the data being submitted to the IS needs to improve. In calendar year 2008, a portion of the incentive pool dedicated to building infrastructure will be contingent on the assurance of data quality.
2. Data will be collected from consumers, family members and case managers regarding recovery outcomes using an instrument required by the state, the Washington State Consumer Outcomes Survey (Telesage). This survey is designed to be completed by consumers at intake and at prescribed follow-up intervals. It yields data regarding employment, quality of life, housing, and other recovery indicators.
3. Data regarding the use of recovery-promoting services (such as peer support, clubhouse, supported employment, and wraparound services for children/youth) will be submitted by providers to the IS. MHCADSD will carefully monitor the number of these services that are provided.
4. Case managers will be expected to report changes in consumer employment, housing, and related recovery measures to the IS at the time of the change.
5. The King County Regional Support Network quarterly report card already tracks a number of recovery outcomes and will be modified as needed to reflect additional recovery measures.
6. Agency-specific reports tailored for assessing recovery outcomes and services across the system will be developed. These published reports will show how each provider agency is performing.

An Executive Oversight Committee will be convened comprised of leaders from the county departments who have an interest in mental health issues: the Department of Community and

Human Services, Department of Adult and Juvenile Detention, and District Court. Consumer representation and council staff will also be included in this committee that will be tasked with reviewing progress toward established goals and making recommendations for course corrections should they be needed.

Finally, annual written progress reports will be generated for review by the Executive Oversight Committee and the Recovery Initiatives Committee of the Mental Health Advisory Board, and submitted to the Regional Policy Committee and the Metropolitan King County Council.

Summary and Conclusion

King County and its provider network have made considerable progress to date. MHCADSD has established a consumer/family driven advisory group, a number of best practices are already being implemented and relevant system and consumer-level data is being collected and reported. Available resources have been identified to be used for incentives.

While incentive funding is a great advantage, it can not be the sole source of funds for developing new services or increasing the provision of the most desirable services. Provider agencies will need to examine their own practices and business plans, retool their service systems and redeploy their staff and financial resources to promote recovery-oriented practices. This implementation plan will provide the framework for these efforts.

The recovery movement for persons with mental illness was launched when professionals began to listen and understand what consumers had to say about their experience with treatment. In King County, consumer voice is being promoted at all levels of the system – in individualized treatment/recovery planning, in agency and county-level policy decisions, in governance and oversight functions, and in the workforce. Services identified as recovery-oriented or recovery-promoting are those that consumers themselves identify as the services that they need, want, and will use. By listening to their voices and implementing the services that will most assist them in their recovery journeys, King County is making a fundamental change in the philosophy that guides the way the mental health system does business. The result will be an exemplary, recovery-oriented mental health service system that one day will be a national model of excellence.