Transforming Lives

Session 1: Building an architectural plan in the middle of a hurricane while traveling in a foreign land

Behavioral Health Administration (BHA)

Vision	Mission	Values
People are healthy, People are safe, People are supported, Taxpayer resources are guarded	To transform lives by supporting sustainable recovery, independence and wellness	Honesty and Integrity Pursuit of Excellence Open Communication Diversity and Inclusion Commitment to Service Respect Collaboration and Partnership Accountability Teamwork and Cooperation

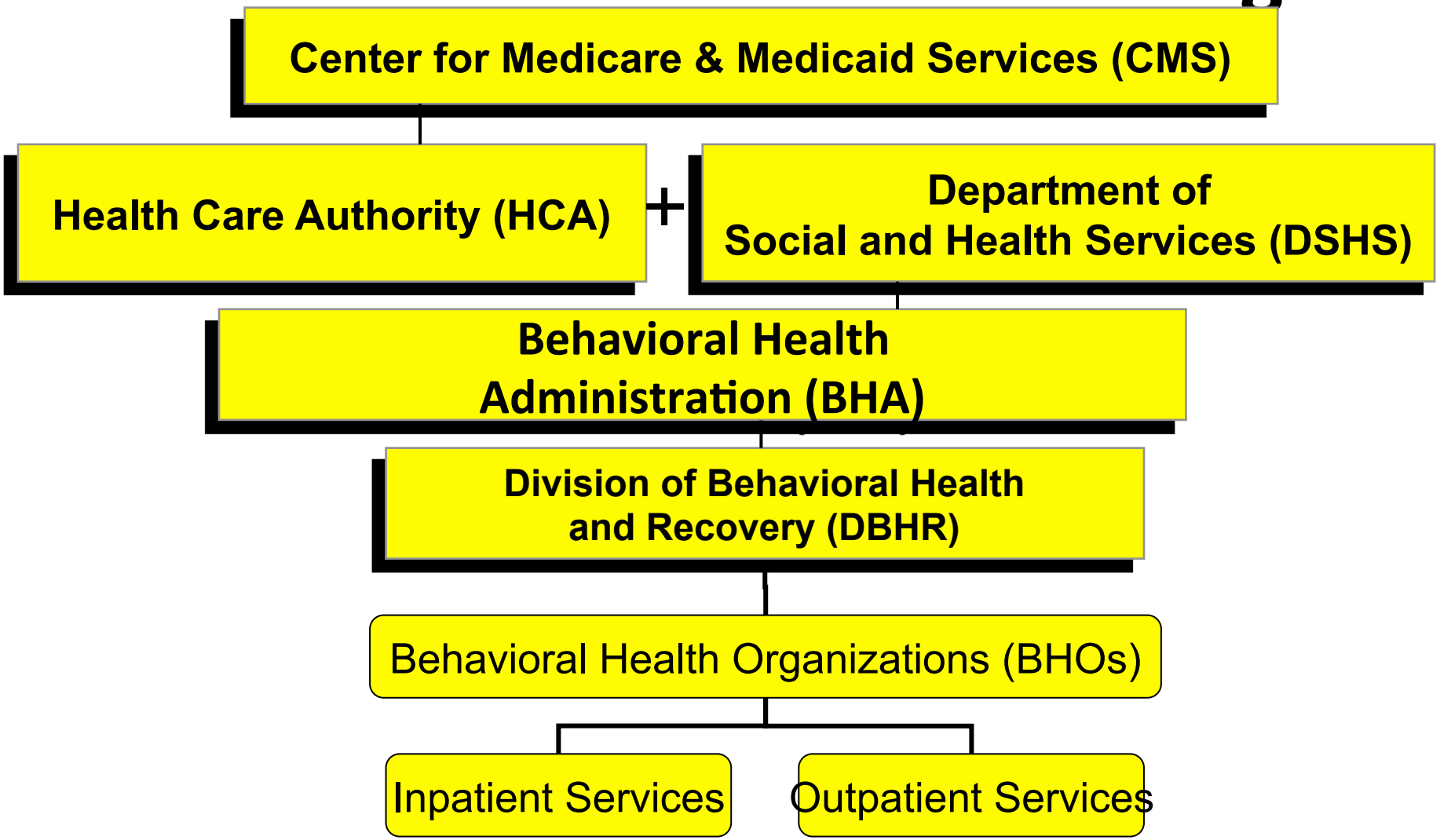
BHA provides prevention, intervention,

inpatient treatment, outpatient treatment and recovery support to people with addiction and mental health needs.

People receiving services in Fiscal Year 2014:

- 153,780 clients participated in mental health treatment provided through Regional Support Networks
- 51,703 clients participated in substance abuse treatment
- 15,965 clients participated in substance abuse prevention activities
- 2,746 clients received competency to stand trial evaluations

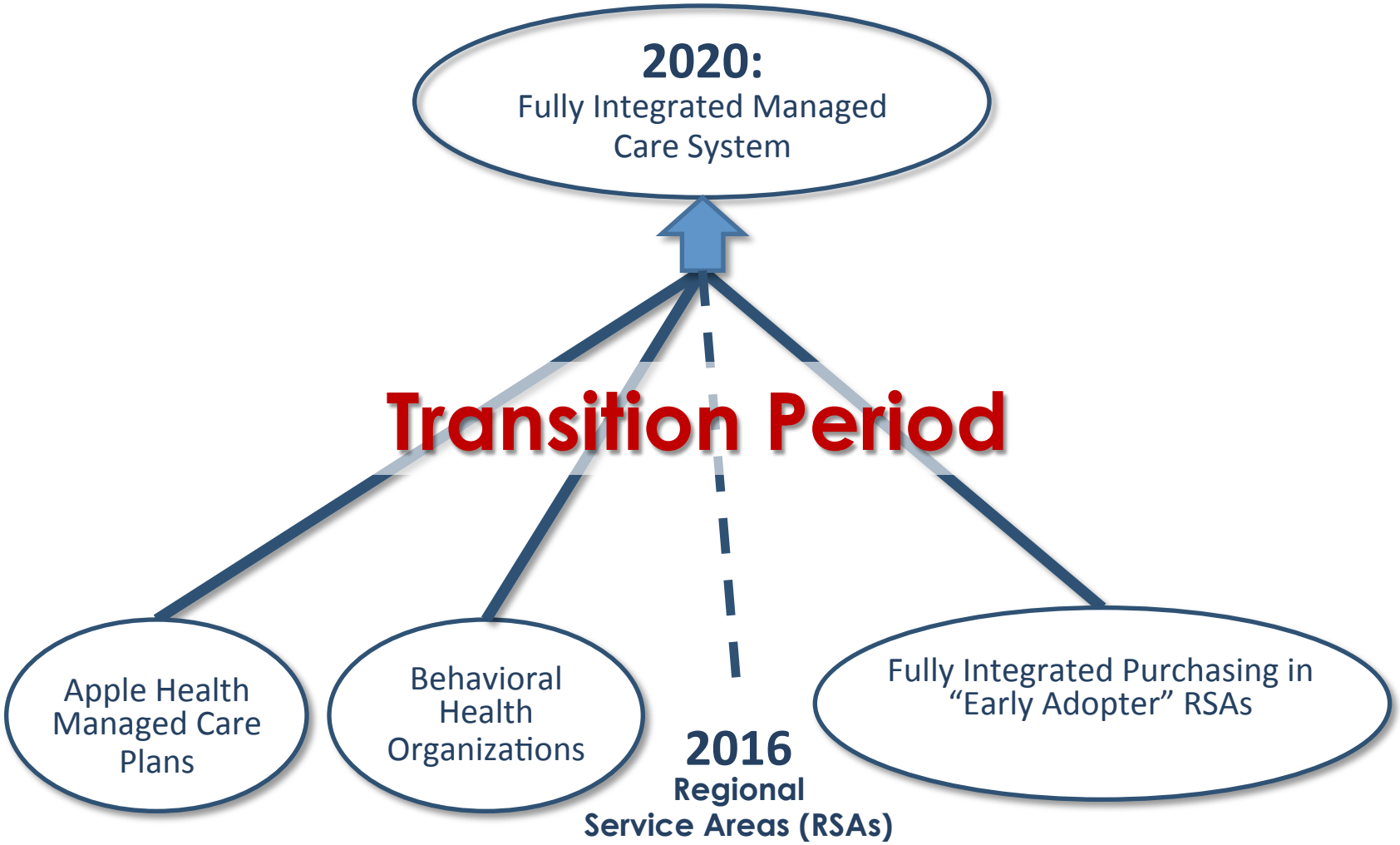
Behavioral Health Funding



Behavioral Health Organizations

- In 2014 the State Legislature passed Senate Bill 6312, directing DSHS to integrate funding and oversight for behavioral health (mental health and substance use) treatment services. An important reason for this change is to better coordinate care for people with co-occurring disorders.
- In the past, the state purchased BH services from two separate systems: Regional Support Networks and counties. As of April 2016, these services will be purchased by regionally operated Behavioral Health Organizations (BHOs) through a managed-care structure.

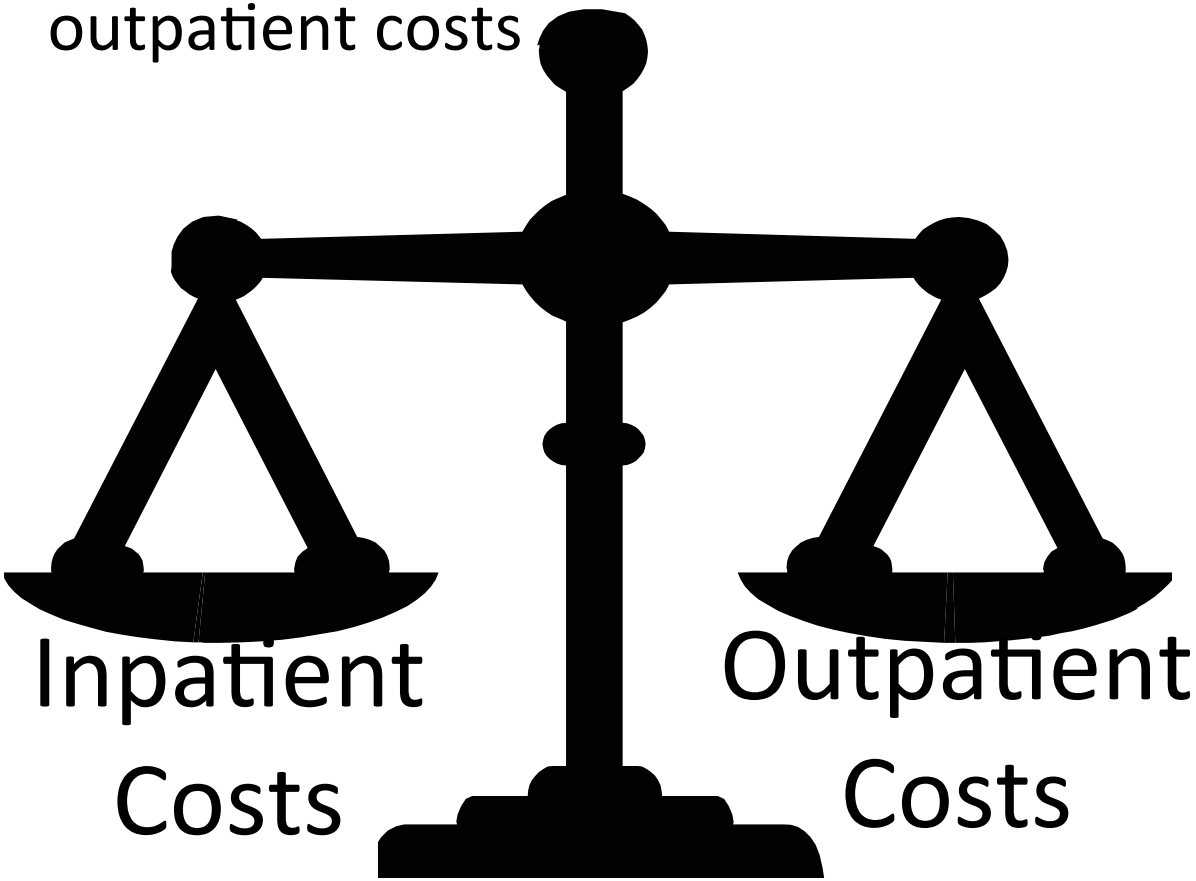
Parallel Paths to Purchasing Transformation

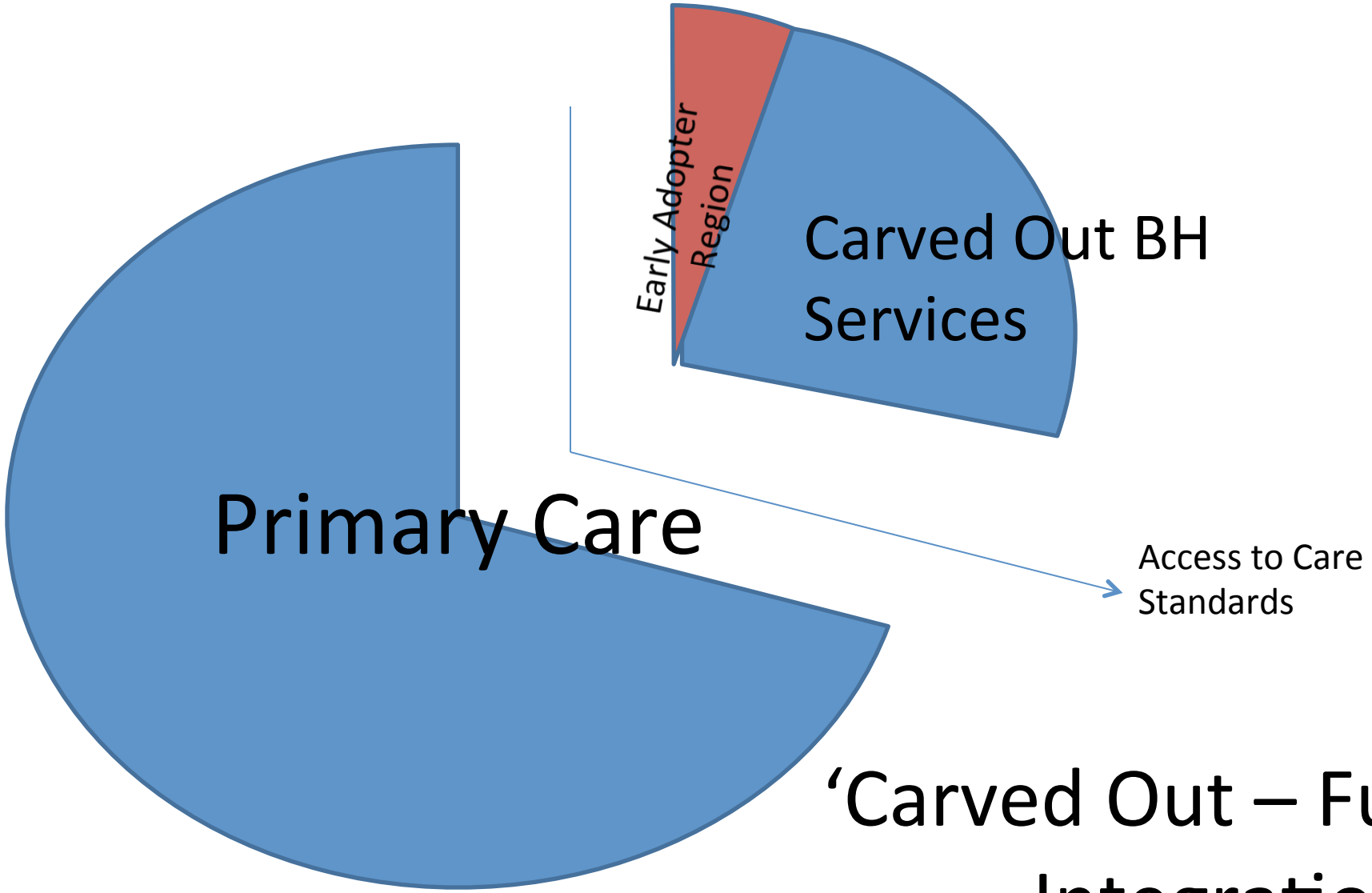


What is Managed Care?

- Managed Care is a health care delivery system organized to manage cost, utilization, and quality. Medicaid managed care provides for the delivery of Medicaid health benefits and additional services through contracted arrangements between state Medicaid agencies and managed care organizations (MCOs) that accept a set per member per month (capitation) payment for these services. www.medicaid.gov
- BHOs act as Managed Care Organizations for the BH poulations

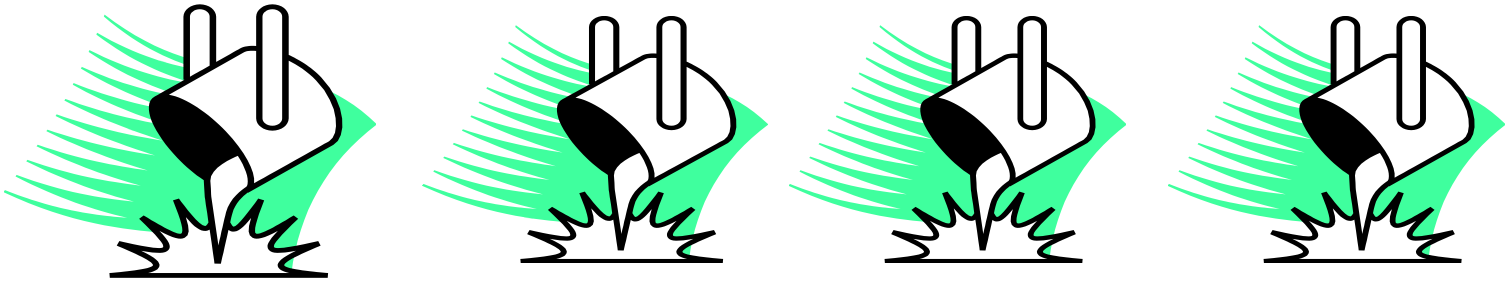
BHOs are responsible as the Prepaid Inpatient Health Plan to manage inpatient costs and outpatient costs





'Carved Out – Full Integration'

Behavioral Health Funding Sources



Medicaid

State allocated funds – As you know the state funding is shrinking

Federal Block Grant Funds

Local Tax Funding 1/10th of 1%

Used to fund outpatient services/inpatient/crisis/ residential services

Services for non-Medicaid individuals or non-Medicaid billable services

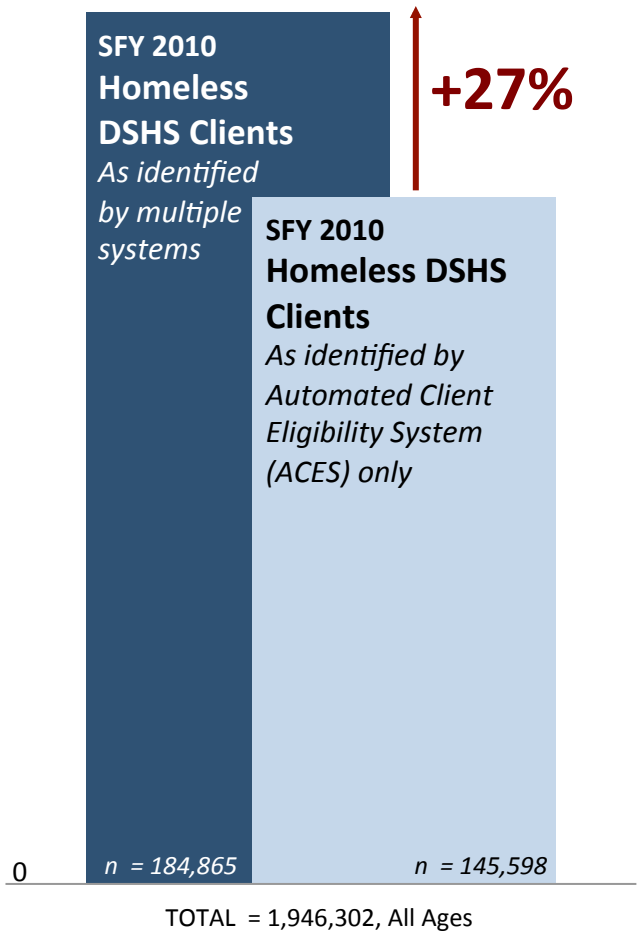
BHO's choose how to spend the funds

PIHP funds are block granted to BHOs Per Member Per Month based on the number of individuals eligible for Medicaid in 4 areas

Non-Disabled Adults	Non-Disabled Children
Disabled Adults	Disabled Children

WHY THE FOCUS ON HOUSING AND EMPLOYMENT?

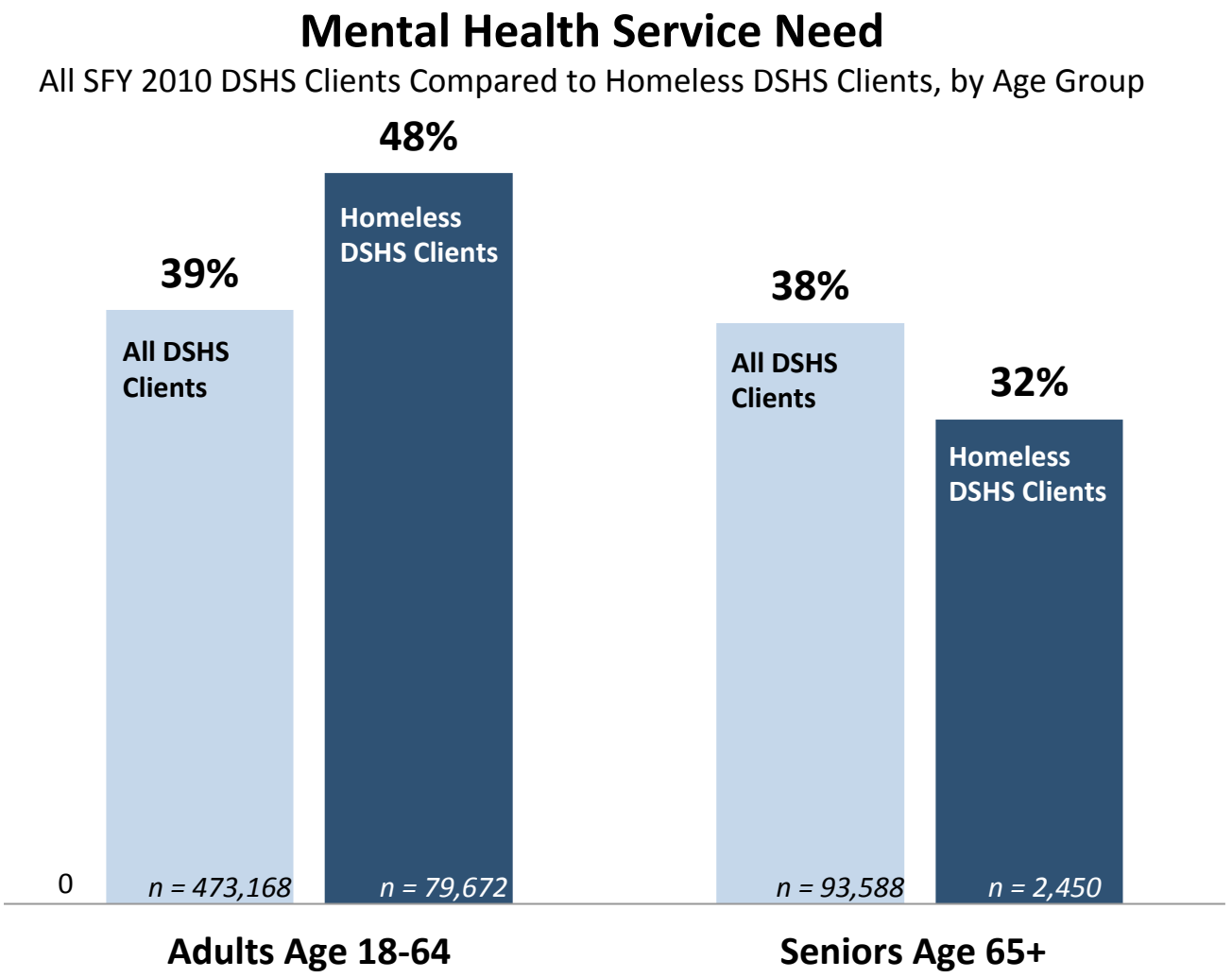
Identifying homeless and unstably housed DSHS clients in multiple service systems



- **DSHS Economic Services Administration caseworkers record homelessness among public assistance clients in ACES**
- **By including information from four other information systems, we improve our ability to identify homelessness**
- ***However*, this measure is imperfect and each data source has its own limitations that can lead us to over or underestimate the number of homeless clients at any given point in time**

Identifying Homeless and Unstably Housed DSHS Clients in Multiple Service Systems, DSHS Research and Data Analysis April 2012, http://publications.rda.dshs.wa.gov/1457/

Homeless working-age adult clients more likely to have mental health problems

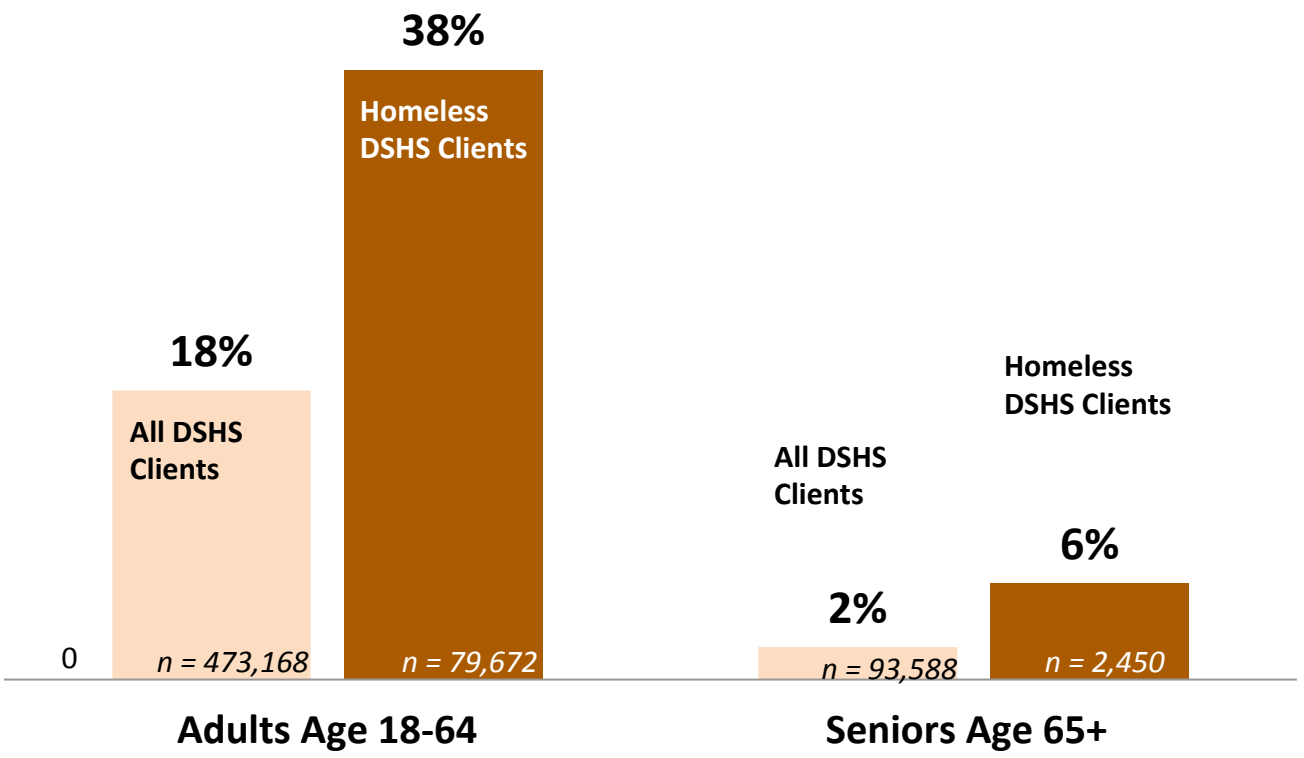


Identifying Homeless and Unstably Housed DSHS Clients in Multiple Service Systems, DSHS Research and Data Analysis April 2012, http://publications.rda.dshs.wa.gov/1457/

Homeless DSHS clients more likely to have alcohol or other drug (AOD) treatment need

Alcohol or Other Drug Treatment Need

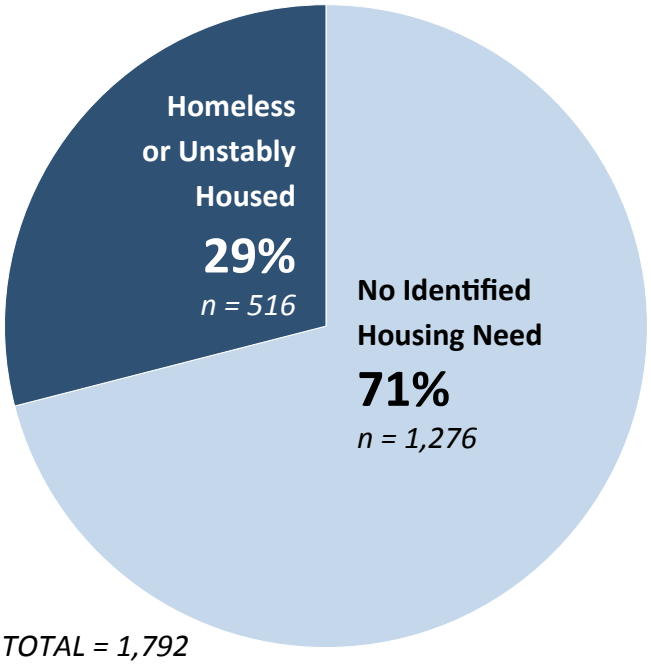
All SFY 2010 DSHS Clients Compared to Homeless DSHS Clients, by Age Group



Identifying Homeless and Unstably Housed DSHS Clients in Multiple Service Systems, DSHS Research and Data Analysis April 2012, http://publications.rda.dshs.wa.gov/1457/

About 30 percent of state mental hospital residents have a housing need in the year after discharge

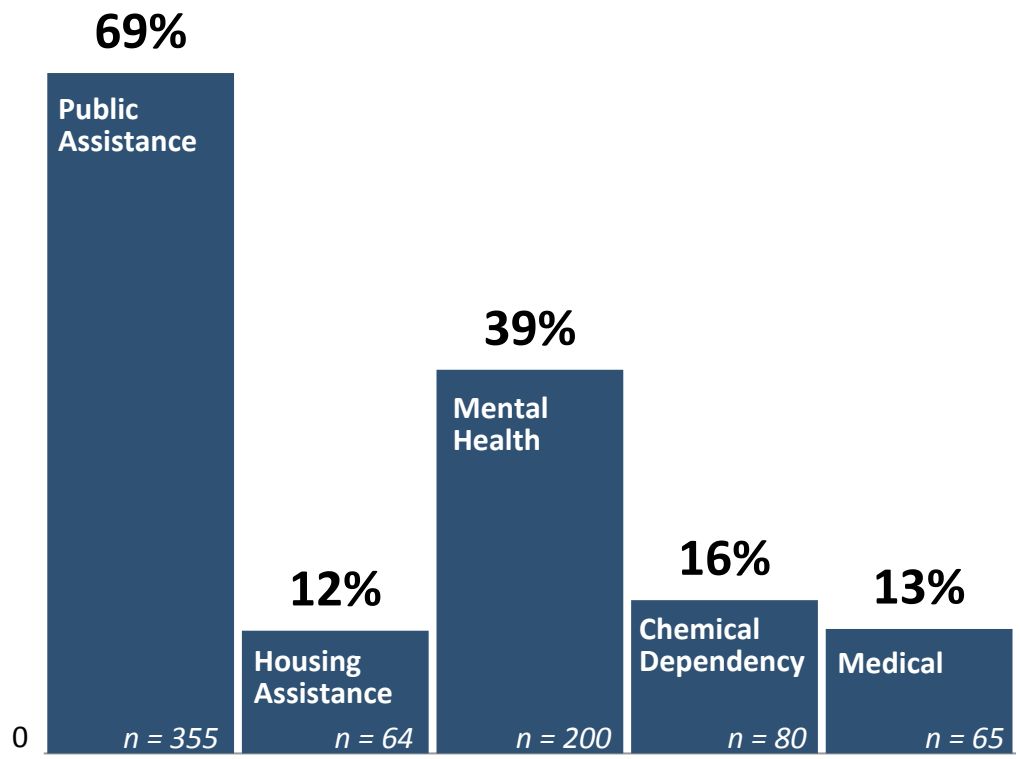
Housing Status in 12-Month Follow-up Period



TOTAL = 1,792

Systems in which Housing Need is Identified

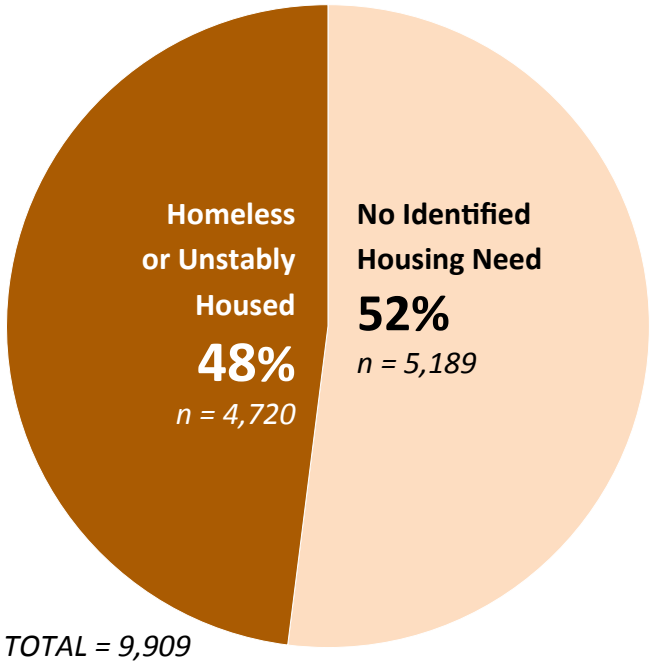
Among Leavers with Housing Need *(n = 516)*



The Housing Status of Individuals Discharged from Behavioral Health Treatment Facilities, DSHS Research and Data Analysis, July 2012, http://publications.rda.dshs.wa.gov/1460/

Almost half of residential CD treatment clients have a housing need in the year after discharge

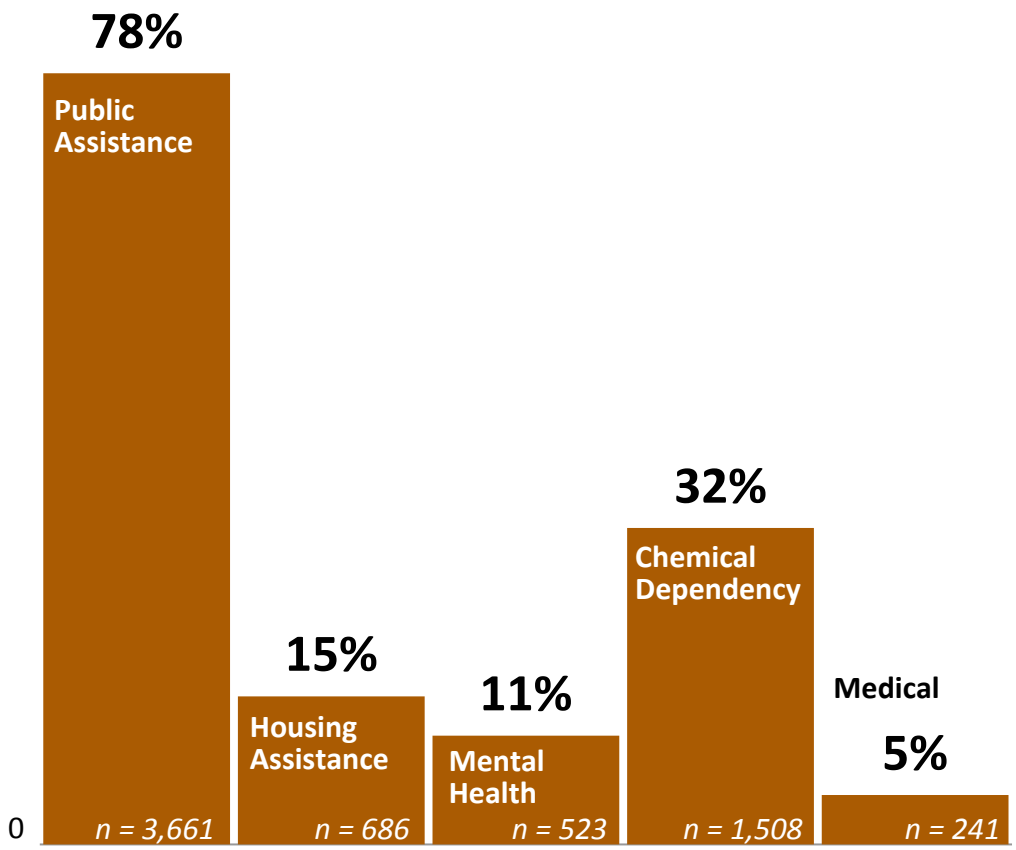
Housing Status in 12-Month Follow-up Period



TOTAL = 9,909

Systems in which Housing Need is Identified

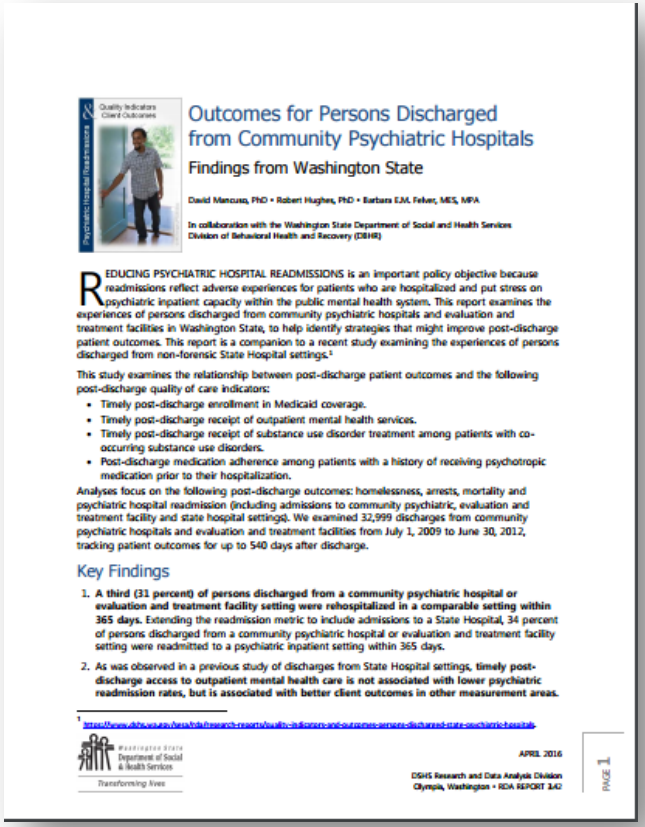
Among Leavers with Housing Need *(n = 4,720)*



The Housing Status of Individuals Discharged from Behavioral Health Treatment Facilities, DSHS Research and Data Analysis, July 2012, http://publications.rda.dshs.wa.gov/1460/

Outcomes for Persons Discharged from Community Psychiatric Hospitals

- One in six persons (16 percent) discharged were identified as homeless or unstably housed in the month prior to their admission. Unstably housed persons have higher readmission risk.



Outcomes for Persons Discharged from Community Psychiatric Hospitals

Findings from Washington State

David Mancuso, PhD • Robert Hughes, PhD • Barbara EM. Felver, MES, MPA

In collaboration with the Washington State Department of Social and Health Services Division of Behavioral Health and Recovery (DBHR)

REDUCING PSYCHIATRIC HOSPITAL READMISSIONS is an important policy objective because readmissions reflect adverse experiences for patients who are hospitalized and put stress on psychiatric inpatient capacity within the public mental health system. This report examines the experiences of persons discharged from community psychiatric hospitals and evaluation and treatment facilities in Washington State, to help identify strategies that might improve post-discharge patient outcomes. This report is a companion to a recent study examining the experiences of persons discharged from non-forensic State Hospital settings.[1]

This study examines the relationship between post-discharge patient outcomes and the following post-discharge quality of care indicators:

- Timely post-discharge enrollment in Medicaid coverage.
- Timely post-discharge receipt of outpatient mental health services.
- Timely post-discharge receipt of substance use disorder treatment among patients with co-occurring substance use disorders.
- Post-discharge medication adherence among patients with a history of receiving psychotropic medication prior to their hospitalization.

Analyses focus on the following post-discharge outcomes: homelessness, arrests, mortality and psychiatric hospital readmission (including admissions to community psychiatric, evaluation and treatment facility and state hospital settings). We examined 32,999 discharges from community psychiatric hospitals and evaluation and treatment facilities from July 1, 2009 to June 30, 2012, tracking patient outcomes for up to 540 days after discharge.

Key Findings

1. **A third (31 percent) of persons discharged from a community psychiatric hospital or evaluation and treatment facility setting were rehospitalized in a comparable setting within 365 days.** Extending the readmission metric to include admissions to a State Hospital, 34 percent of persons discharged from a community psychiatric hospital or evaluation and treatment facility setting were readmitted to a psychiatric inpatient setting within 365 days.
2. As was observed in a previous study of discharges from State Hospital settings, **timely post-discharge access to outpatient mental health care is not associated with lower psychiatric readmission rates, but is associated with better client outcomes in other measurement areas.**

[1] https://www.dshs.wa.gov/sesa/rda/research-reports/health-indicators-and-outcomes-persons-discharged-state-psychiatric-hospitals

Washington State Department of Social & Health Services

Transforming lives

APRIL 2016

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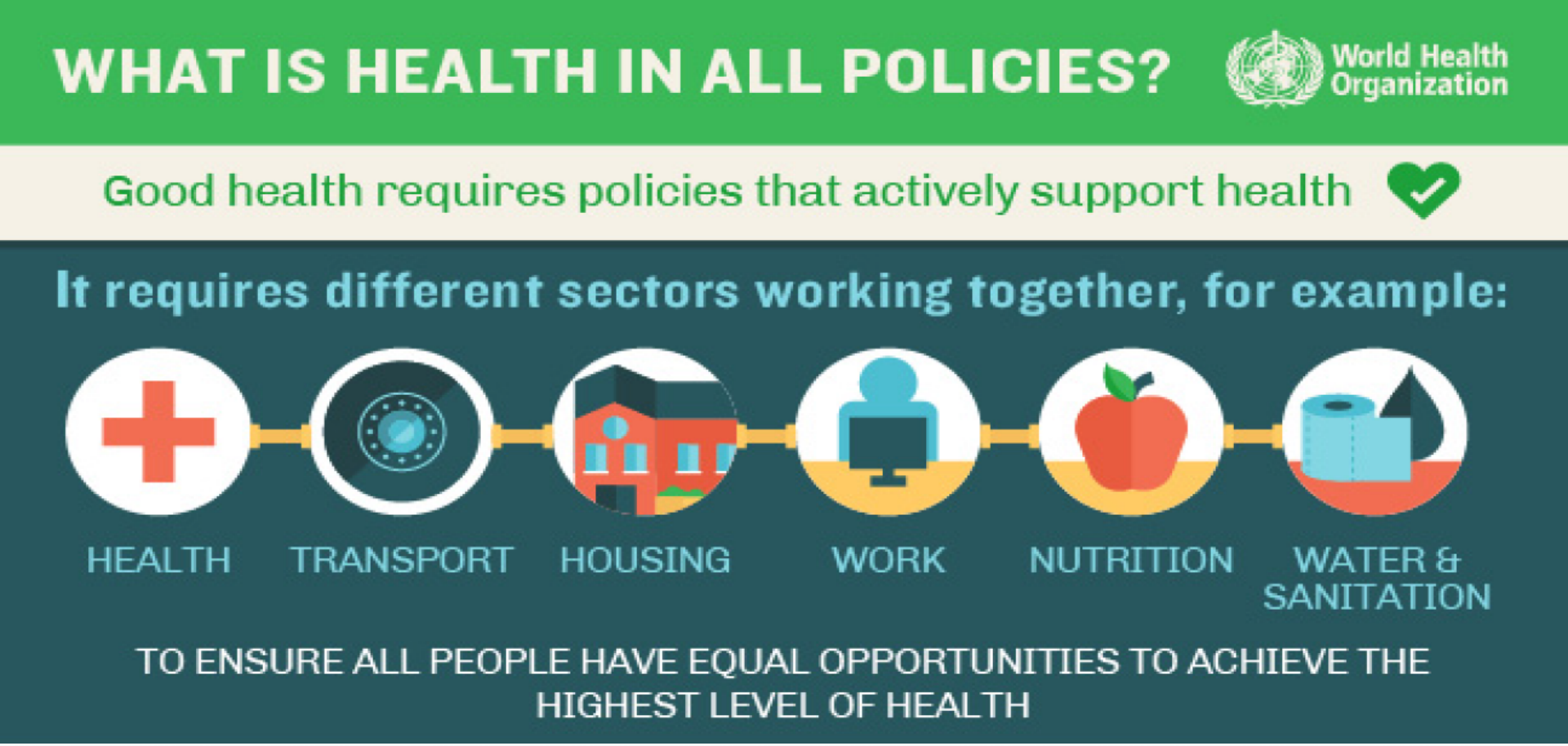
Employment Rate through UI data for adults in outpatient mental health services WA State

Individuals	2013:Q1	2013:Q2	2013:Q3	2013:Q4	2014:Q1
Total with SSNs	50,387	50,834	48,812	47,962	51,165
Employed Clients	4,514	5,183	5,184	4,960	5,142
% Emp	**9%**	**10%**	**11%**	**10%**	**10%**
WAGES					
Monthly Wages	$754	$764	$766	$782	$788
Wage Rate	$12.10	$11.97	$11.80	$12.15	$11.99
HOURS					
Weekly Hours	14	15	15	15	15

History of DBHR's Housing focus

- In October 2007, DBHR completed a Mental Health Housing Action Plan that assessed the need for community-based housing
- **Co-funded a Supportive Housing Institute**
- **Mental Health Housing Consortium (MHHC)**
- **PACT teams address housing issues**
- **Olmstead plan and support services**
- RSN's (now called BHOs) have funded special housing projects
- Projects to Assist in Transition from Homelessness (PATH)
- Offender Re-Entry Community Safety Services
- Oxford Houses – Revolving Account and Outreach services



Social determinants of health are the economic and social conditions that affect health outcomes and are the underlying, contributing factors of health inequities. Examples include housing, educational attainment, employment and the environment.

Unemployment is bad for your health:

- Higher rates of unemployment cause more illness and premature death.

- As job insecurity continues, it acts as a chronic stressor whose effects grow with the length of exposure; it increases sickness absence and health service use.

http://www.euro.who.int/__data/assets/pdf_file/0005/98438/e81384.pdf

REMAINING UNEMPLOYED IS WORSE FOR YOU THAN BEING EMPLOYED IS GOOD FOR YOU.

AVOIDING LONG TERM UNEMPLOYMENT IS A BETTER OPTION THAN WAITING FOR AN IDEAL OR PERFECT JOB MATCH.

SEE EPIDEMIOLOGICAL HANDOUTS

Joe Marrone
Institute for Community Inclusion

Supportive Housing is the Best Medicine:

Access to safe, quality, affordable housing - and the supports necessary to maintain that housing - constitute one of the most basic and powerful social determinants of health.

See more at: http://www.csh.org/resources/housing-is-the-best-medicine-supportive-housing-and-the-social-determinants-of-health/#sthash.1XhAiVeO.dpuf

Building on Opportunities – Housing & Employment:

- Legislative direction to improve client outcomes (Employment and Housing) and use **Evidence-based, Research-based, and Promising Practices – SB5732-HB1519** (2013)
- Nationally Recognized Policy Academies (Housing 3000: Chronic Homeless Policy Academy & Olmstead Policy Academy)
- Supportive Housing and Supported Employment services authorized in SB 6312 (2014)
- Healthier Washington SIM Grant - CMMI