CLIP IT
CLIP IMPROVEMENT TEAM

A Washington State Building Bridges Initiative

Presentation for Georgetown Training Institutes July, 2014

Transforming lives

What were the problems?

- **System:** Community (parents, community treatment, and acute hospitals) object to delays to admission after referral. Governor targets issue as high level priority (2007-08)
- **Average Increases** to 344 days (2010) from previous years averages of 300.
- **Parents:** Not sufficiently involved in treatment and discharge planning; insufficient community supports following discharge.
- **Youth:** Same
- **Local Treatment:** Same
- **Programs:** CLIP is an “island”, separated from the community geographically, financially, and culturally.

What helped?

Applying wraparound principles and practices

- **Team Based:** Reps of key groups required
- **Family Voice and Choice:** Family must be here
- **Collaboration:** All have equal voice, regardless of system role, power or contract relations.
- **Community Based:** Goal is successful community living, not successful residential living
- **Culture:** Different approach to the work must be respected
- **Individualization:** Solutions must allow every youth and family’s different needs.
- **Persistence:** Continuous effort, despite setbacks
- **Outcomes:** Measured at youth, family, local, program and state level.
- **Flexibility:** Plan adapts to circumstance.
- **Strength Based:** Uses existing system player strengths.
- **No coercion:** Group itself decides whether to meet, when, volunteers only required for extra effort.
- **Face to Face:** Necessary to build real relationship.
- **Staff Support:** Minutes and logistics must be planned for.
- **Facilitation:** Neutral, skilled group leader.
Some extra help from....

- Experienced parent partners already working with CLIP, used to meeting on equal footing;
- Class Action lawsuit demanding more state intensive community based mental health treatment;
- DSHS Secretary who helped create national BBI and familiar with Milwaukee wraparound;
- System of Care Planning & Expansion grant;
- Clip Providers didn’t want to be left out.....

Big task areas

- Admission
- Discharge Planning
- Family Inclusion
- Treatment Plan Review/Meeting Process
- Transition to Community
- Length of Stay Reduction
- Building Bridges Application

Divide into 4 groups, each group with rep from each constituency...each group tackles each task

Summary: What can we do NOW (with no $)? What can we do LATER (with no $)? What can we do LATER (with $)?

Sorted into the “life of a case”

<table>
<thead>
<tr>
<th>Goal</th>
<th>Activity</th>
<th>Who</th>
<th>By when</th>
<th>Track</th>
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<tbody>
<tr>
<td>Pre Admission and Admission</td>
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<tr>
<td>Treatment</td>
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<td>Discharge/Transition</td>
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Sorted by Category and Who’s responsible

- Principles (SOC based)
- Length of Stay and Treatment Expectations
- Treatment Planning Meetings
- CLIP administration (staff) and policies
- CLIP programs
- Parent Advocates
- RSN/Community Treatment providers

The process

Agreed on primary goals:

- Treatment increasing resiliency, hope, recovery
- Families and youth in all decision making
- Safety
- Sustainable residential programs
- Youth must live and grow in community
- Effective communication and shared information
- What are things we want to do Now? Name 1
- What do we want to do Later? Name 1
- What do we do Next? Everyone

What does this process gain?

- Participants get to know each other
- They learn who to contact for problems
- They develop trust in partner’s intentions
- They are continuously exposed to SOC and Building Bridges principles
- They look for other opportunities for change in their shop
- They see results
- These leaders pass these expectations to staff and partners. They continue to want to do this work
### How can you do the same?

- Locate key operators responsible for residential program, community treatment agents, system managers, and parent/youth leaders.
- Target geographic areas that most commonly work together
- Insure representatives have some power to affect change, and yet understand the work
- Everyone has equal voice
- Insure workgroups that cross all role areas and represent all groups
- Make total group size a manageable work body (15 to 30)

### A natural, organic process develops

- CLIP IT Year One: Issue Identification
- CLIP IT Two: Clarification and Initial Implementation
- CLIP IT Three: Key Projects
- CLIP IT Four: System Changes Implemented, Focus on More Difficult Cases, Cross System cases and “sticky points”.

### Major CLIP IT products

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<tr>
<td><strong>Building Bridges Self Assessment Tool Pilot:</strong> Examined data systems, collection, and tool use by Subcommittee including all segments, and added a youth currently in care to this project. Youth joined CLIP IT activity in process.</td>
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<td><strong>Pre Admission Meeting:</strong> Established regular meeting process, and developed form to guide conversation of key participants prior to CLIP Admission. Currently a regular operational practice.</td>
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<td><strong>Voluntary Referral Help Guide:</strong> Prepared family friendly guide to simplify application process by referents and parents.</td>
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### Roads to Community Living

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<td>CMS Money Follow the Person Grant requires program to provide community care alternatives for Medicaid recipients in long term institutional care.</td>
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<td>For state hospital residents, IMD rule eliminates eligibility for mental health only clients from ages 21 to 65.</td>
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<td>Population eligible = Age 0 to 21, and 65+.</td>
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<td>Children’s Long Term Inpatient Program (CLIP) Program (91 beds) becomes primary focus of initial efforts (ages 0 to 18):</td>
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<td>CLIP is comprised of 47 beds in the Child Study Treatment Center, the children’s section of Western State Hospital, and 44 beds in 3 contracted Psychiatric Residential Treatment Facilities.</td>
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<td>RCL effort and concept completely supports CLIP Improvement Team efforts, and System of Care and children’s mental health redesign efforts.</td>
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### DBHR Roads: Development

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<td><strong>June, 2010:</strong> Exploration of funding methods for the Child Study Case example makes it clear RCL supports must be passed through an RSN contract.</td>
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<td><strong>Fall, 2010 to Spring 2011:</strong> DBHR initiates CLIP Improvement Project, collaborative effort to improve transitions and discharge planning. RCL option is completely aligned with this effort.</td>
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<td><strong>Spring, 2011:</strong></td>
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<td>Two RSN’s agree to sign RCL contracts; Spokane and Timberlands.</td>
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<td>DSHS Secretary meets with CMS and SAMHSA to discuss use of RCL for mental health clients</td>
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| **June, 2011:** Collaborative Training by ADSA RCL and DBHR staff to market RLC program option to other RSN’s.
RCL/DBHR Primary Service Elements

- Professional Therapy Services
- Life Skills Services
- RCL Family and Informal Support
- Community Choice Guide Services
- Challenging Behavior Consultation Service
- Items for Community Transition Services
- Transitional Mental Health Services

DBHR RCL Service

- Number of CLIP/DBHR RCL Cases enrolled to date: = 76
  - Spokane = 51
  - Thurston-Mason = 9
  - Timberlands = 1
  - Greater Columbia = 6
  - Chelan-Douglas = 2
  - North Sound = 6
  - Southwest = 1
- Approximate Number Received Service to date: = 42
  - Spokane = 30
  - Other Areas = 12
- Re-institutionalization Rate (Spokane) 1/30 = 3%

DBHR/RCL Lessons Learned

- Small size of Washington’s CLIP Programs make this program option “small impact” for a “big idea”.
- Requirement of two layers of contracting slows down expansion
- RSN’s have to adjust to learning they can contract with non-mental health providers who can provide RCL
- The RSN’s can recover some small portion of their administrative time, but in reality have to do this because it’s a commitment to “do the right thing” more than that they will be paid for this.
- RCL option is occurring in a climate of major child system change in an environment that continues to be cost challenged; this effort is difficult to maintain commitment to.
- RCL services help teach communities how to think flexibly about client and family needs, and can teach implementation of wraparound team service concepts where this does not exist.

Reactions to RCL

- Client quotes interviewed 5 months into program:
  - Anything surprise you? “More hands on with activities in this program”
  - Favorite part or your new lifestyle? “Learned how to handle emotions better”
  - Tell others about program? “Go for it. It helps out with transition and you can’t lose out.” “Better program than most”.
- Spokane Children Coordinator: June, 2014
  - “Provides out of the box’ solutions to what kids and families need”
  - “Gives us creative ways for youth to re-enter the community”
  - “Mom was so happy she wanted to adopt’ the worker RCL provided her
  - “Child was in the emergency room every day... We provided RCL, no ED visits for a month”.
- State CLIP Manager: Teaches teams how to “think wraparound”.

CLIP IT Outcomes

- Length Of Stay Is Reduced from 344 days to 237 days from FY 2010 to FY 2014.
- Waiting List Declines from 9.4 to 7.6 average cases between calendar 2011 and 2012. Issue removed from Governor office indicators due to meeting targets for two consecutive years.
- Youth Discharged per year Increases from 89 in fiscal years 2010-11 to 108 in FY2012-14.
- Increased evidence of family, RSN and community mental health participation in CLIP treatment found in annual CLIP Inspection of Care audits.
- Time of service expectation, by CLIP IT agreement, is now described as a “three to six month” treatment intervention.

System Adjustment Needed...

- Per diem bed rate for PRTF Programs
- Provider incentives are to:
  - Not discharge client if bed will be empty (PRTF).
  - No incentive for state hospital budgeted program, paid empty or full days.
  - No fiscal connection of CLIP to community MH treatment system
  - No ability to provide multi-service residential and community treatment option for CLIP, due to separate legal funding streams, and geography.
  - Cannot easily “save expense” by discharging to less costly community treatment
  - High intensity community treatment not widely available
CLIP Plan 2013-15

CLIP builds on improvements, utilizing existing fund allocations to:

- Reduce PRTF beds from 44 to 37, increase rate, and hold unit sizes to 12-13.
- Advocate addition of parent advocate positions and improved family visit support at CSTC program.
- Increase family visit and transportation support.
- Provide web access for virtual meeting and treatment sessions.
- Partner with University of Washington project to increase Evidence Based Treatment in CLIP.
- Establish youth peer program in PRTF’s and CLIP steering committee.
- Convert CLIP Parent to Parent Training Events from MHBG to regular service provision funds.
- Add Administration support for CLIP IT and increased clinical review activities.

Hills to Climb...

- Too many other challenges.
- Unspent money eagerly used elsewhere.
- Unspent funds unavailable to retain in child mental health, across fiscal year barriers.
- Lawsuit work is high priority focus.
- Supervisor quits.
- Plan involves rate change; politically difficult.
- Legislature takes two overtime sessions to pass budget; still dealing with recession pressures.

RESULTS!

- Plan implemented 6 months late (January, 2014).
- Legislature briefed on change.
- CLIP IT added to list of 5 major state child mental health initiatives.
- Support provided by state management, and all CLIP IT representative groups.

Key Gains Made

- Rate increase after 7 years no change in PRTF rate. No increase in total system funding.
- Reduce disparity with state hospital funding levels.
- Add youth peer PRTF requirement.
- Add requirement for transportation/visit support for families.
- Add requirement for interactive Web-X for families to access remotely.
- Increase community service options in last month of residential stay.

More Key Gains

- Planning for discharge done before placement.
- Intensity of recertification reviews doubled.
- Elevate SOC concepts in state hospital planning.
- More family and community collaboration in case planning.
- Better clarity of expectations of residential treatment prior to placement.
- Reduced LOS.
- Serving more youth with fewer beds.
- Fully connected to EBP, SOC, and Lawsuit Projects.

LESSONS

- Significant gains are possible, without new resources, by applying wraparound principles and techniques to system players.
- In stressful times progress is self-reinforcing.
- Multiple initiatives using SOC principles reinforce one another, and increase the power of the change.
- Insuring positive working relationships and respect among key representatives is critical.
- Logistical, support and work flow interference has to be anticipated.
- Youth and family inclusion in the system create far more return on investment.
BUILD YOUR OWN BRIDGE!

Mark Nelson, Program Administrator
CLIP/Children's Mental Health Unit
Division of Behavioral Health and Recovery
Behavioral Health and Service Integration Administration, DSHS
Blake Office Park East; 2nd Floor
4500 10th Avenue SE
Lacey, Wa. 98503
(360) 725-1388
(360) 725-2280 (fax)
Mark.Nelson@dshs.wa.gov