Washington State Health Care Authority

REPORT TO THE LEGISLATURE

Developing Clubhouse Programs

Engrossed Substitute Senate Bill 6032; Section 213(5)(u);

Chapter 299, Laws of 2018

December 1, 2018

Developing Clubhouse Programs

Acknowledgments

We thank the workgroup members for contributing their information, time, and passion to this report.

Washington State Health Care Authority

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Executive Summary

For nearly 70 years, Clubhouse programs have benefitted individuals and communities working toward mental health recovery. Clubhouses' demonstrate positive clinical and social outcomes. Based on the core principles of peer support, self-empowerment, and functionality within a community setting, Clubhouses strive to help members:

- Participate in mainstream employment and educational opportunities;
- Find community-based housing;
- Join health and wellness activities;
- Reduce hospitalizations;
- Reduce involvement with the criminal justice system; and
- Improve social relationships, satisfaction, and quality of life.

The Legislature provided funding in the state's 2017–2019 biennial operating budget for existing Clubhouse services, developing new programs, and developing options for Washington Apple Health (Medicaid) funding. Engrossed Substitute Senate Bill 6032, Sec. 213(5)(u) stated:

> "$200,000 of the general fund—state appropriation for fiscal year 2018 and $1,296,000 of the general fund—state appropriation for fiscal year 2019 are provided solely for clubhouse programs. Of this amount, $400,000 must be used for support of the Spokane clubhouse program and the remaining funds must be used for support of new clubhouse programs. The department must develop options and cost estimates for implementation of clubhouse programs statewide through a Medicaid state plan amendment or a Medicaid waiver and submit a report to the office of financial management and the appropriate committees of the legislature by December 1, 2018."

To determine the best strategy to implement the proviso, the Division of Behavioral Health and Recovery (DBHR) convened a stakeholder workgroup comprised of national subject matter experts, existing Clubhouse personnel, individuals with lived behavioral health experiences, agency representatives, behavioral health advocates, and Behavioral Health Organization (BHO) staff. The group was charged with identifying options and the estimated costs to implement Clubhouse programs statewide using a Medicaid waiver or State Plan amendment. The group examined how to apply a variety of innovative programming models within an integrated behavioral health environment that reflect the values Clubhouse programs represent, including:

1) Focus on recovery — not just treatment;
2) Peer support;
3) Consumer control or empowerment; and
4) Support of work and paid employment as essential elements for consumer recovery.

For the best outcomes, the Clubhouse expansion must recognize the changing times and corresponding advances that have been made in the years since the first Clubhouse. The workgroup recommends expanding the definition of Clubhouse programs to include more consumer-run,

Consumer-Operated and Recovery Café-type services. This expanded definition would support the availability of services statewide, which is necessary for the Centers for Medicaid/Medicare reimbursement. In addition, the workgroup recommends establishing an Apple Health-funded peer support service that covers a variety of Clubhouse programs. Such an approach adapts to individual community needs and desires.

This report is a summary of the strategies to implement the proviso funding, recommendations and options to fund Clubhouse programs.

Background

The Clubhouse model of psychiatric rehabilitation began in the late 1940s as a grassroots movement by a small group of patients at Rockland Psychiatric Hospital in New York. The patients would meet in a hospital "club room" to share stories, read, paint, and participate in various social functions. Soon after being discharged, the group reconnected, determined to re-create the encouraging and supportive group they had formed in the hospital. They initially met on the steps of the New York Public Library until, in 1948, with help from their supporters, the group purchased a building in New York City. The fountain in the garden of their new location represented both hope and rejuvenation and inspired the name "Fountain House."

Fountain House's unique approach emerged at a time when institutionalization was the primary treatment methodology for mental illness. There were no legal protections in terms of non-discrimination, and the concept of "recovery", or even "psychiatric rehabilitation," did not exist. Throughout the 60+ years since, much has changed. Most people are now served in the community. The Americans with Disability Act and other protections have been enacted. Today, recovery is a guiding principle in the field of public community mental health. Consumers seek more direct control over their lives and services, just as other minority groups have done. Employment — both as peer providers and within the general U.S. labor force — is seen as possible, desirable, and healthy for recipients of behavioral health services.

These advances, in many ways stimulated early on by the Clubhouse movement, have led to more federal and state initiatives to expand the principles pioneered by Fountain House. In 2008, the Washington State Legislature passed Substitute House Bill 2654, directing the public mental health system to develop recommendations on implementing mental health care focused on consumer-directed services. The 2008 Report to the Legislature centers on the concept of Consumer and Family Run Organizations[1] providing self-help as their operational approach. The report, which several Clubhouse representatives helped develop, made recommendations regarding implementation and funding strategies. Additionally, the 2014 Legislature (2SSB 6312) directed the

[1] Strategies for Developing Consumer and Family Run Services, SHB 2654, 2008, https://app.leg.wa.gov/ReportsToTheLegislature/Home/GetPDF?fileName=HB2654%20Report%20Final%20Draft%20-%20Revised%2011-17-08-%20Final%20work%20group_b9ef14b8-fe3a-4272-9086-f6f96e9bec41.pdf

behavioral health system to integrate mental health and substance use treatment services through cross-system collaboration.

The principles of the early Clubhouse movement, the direction to integrate behavioral health services, and the 2008 legislative report provided a foundation for the body of work included in this report. Our analysis includes traditional Clubhouse, as well as contemporary out-growths such as Consumer-Operated Services and Recovery Cafés. Any of these models may be appropriate to the needs of a given community.

Clubhouse Model

A Clubhouse is organized to support people living with mental illness. During the course of their participation in a Clubhouse, members access opportunities to rejoin the worlds of friendship, family, employment, and education — and to the services and support they may need to continue their recovery. A Clubhouse provides a restorative environment for people whose lives have been severely disrupted because of their mental illness, and who need the support of others who are in recovery and believe that mental illness is treatable.

Since its inception, Fountain House (see "Background" section) has served as the model for all of the nearly 300 Clubhouses in over 30 countries These communities modeled themselves after Fountain House by embracing the term "Clubhouse" which clearly communicates the message of membership and belonging. This message of inclusion is at the very heart of the Clubhouse way of working.

The concept of membership is essential to the Clubhouse approach. Membership creates a sense of belonging to a group to which any member may make a significant contribution. Belonging instills in members a sense of being both accepted and welcomed. All aspects of the service are designed to require member contribution to succeed, instilling a sense of members being wanted and needed. Fountain House pioneered one such community-based rehabilitation model, the Clubhouse. The essence of Clubhouse membership is expressed in the four guaranteed rights which build on members' wellness: (1) a place to come to (and belong); (2) meaningful work; (3) meaningful relationships; and (4) a place to return to (lifetime membership) (Beard, Propst, & Malamud, 1982).

Fountain House is an "intentional community" based on the belief that its members who experience serious and persistent psychiatric disability can and will achieve normal life goals when provided opportunity, time, support, and fellowship. Within the Clubhouse, members should have available to them comprehensive opportunities, including, (1) daytime work-organized activities focused on the care, maintenance, and productivity of the Clubhouse; (2) evening, weekend, and holiday leisure activities; (3) substantial transitional, supported, and independent employment support and efforts; and (4) a wide range of housing options. In addition, the Clubhouse advocates for members to access community psychiatric services, usually at local outpatient clinics or from nearby private practitioners (Aquila et al., 1999). The uniqueness of the Clubhouse model lies in the emphasis on personal productivity and consumer involvement, the opportunities available for work and skills development, and the sense of safety created to encourage member contribution and success (Moxley, 1993; Cella, Besancon, & Zipple, 1997).

The Clubhouse model for adults with serious mental health conditions empowers members' participation in the operation of the Clubhouse community (Dickerson, 1998; Doyle, Lanoil, & Dudek, 2013; Hänninen, 2012; Jackson, 2001; Leff & Warner, 2006). Among several program components that make up the Clubhouse model, the work-ordered day is key to the notion of participation, community, and empowerment (Beard, Propst, & Malamud, 1982; Doyle et al., 2013). Unlike traditional workplaces, members and staff make shared decisions about the Clubhouse, making the two parties indistinguishable to outsiders. Work in this context can be instrumental to gaining job skills. Even more importantly, is the opportunity to gain trust in others and regain belief in one's ability to accomplish things and make contributions to society.

Work and productivity have always served as a cornerstone of the Clubhouse movement, even prior to the more recent emphasis on evidence-based supported employment. These are embodied in the following:

- Work units in a Clubhouse program
- Transitional employment
- Supported employment

See Appendix A for expanded descriptions of Clubhouse components.

Consumer-Operated/Peer-Run Service Delivery

Our analysis of Clubhouse includes the evolution into Consumer-Operated Services. The concept of peer support in both mental health and substance use treatment services has been well established for at least 40 years (Bluebird, 2001; Chamberlin, 1979; Copeland & Mead, 2004; Kaufmann, 1995; Copeland, 1997). Over the past decade, peer support services have become an integral component of the behavioral health care system. This system is evolving toward a recovery-oriented system which aims to integrate mental health and substance use services into an individualized, person-centered framework (Kaplan, 2008; Sheedy & Whitter, 2009). Peer providers are defined by Substance Abuse Mental Health Services Administration (SAMHSA) as "a person who uses his or her lived experience of recovery from mental illness and/or addiction, plus skills learned in formal training, to deliver services in behavioral health settings to promote mind-body recovery and resilience" (U.S. Department of Health & Human Services, 2015).

Much of this evolution has been in employing people with lived experience in specifically designated peer provider roles. Another stage that is gaining emphasis is the actual design and development of consumer run, managed, and operated services. In fact, SAMHSA has had an evidence-based *Toolkit for Consumer Operated Services* available since 2011 (U.S. Department of Health & Human Services, 2011). This appears to be a natural outgrowth of several strands of behavioral health efforts over the years.

Consumer-Operated services are fully independent from other mental health agencies, with the authority and responsibility for all oversight and decision-making on governance, financial, personnel, policy, and program issues (Zinman, Harp, & Budd, 1987; Solomon, 2004; Van Tosh & del Vecchio, 2001; Holter & Mowbray, 2005). To a large degree, Consumer-Operated programs are

staffed by individuals who have received services (Mowbray & Moxley, 1997; Goldstrom et al., 2004, 2006). Consumer-Operated programs may include the following:

- Providing mutual support
- Building the community
- Offering services
- Conducting advocacy activities

Consumer-Operated services share some common elements with a variety of program types that incorporate varying functions. These models include mutual support groups, multiservice agencies; independent living centers; peer-run drop-in programs; and specialized supportive services such as housing, employment, supported education, crisis response, and respite (Campbell & Leaver, 2003; U.S. Department of Health & Human Services, 2011). Work to combat stigma has increasingly embodied the importance of consumers themselves educating the community about mental illness (Cook, 2012).

Washington State was in the forefront of expanding consumer control within the Clubhouse movement by creating in 1989 the Capital Clubhouse (now Capital Recovery Center) in Olympia. Its initial consumer-run structure served as a model for other consumer-run programs around the country. An example is Consumer Voices Are Born (CVAB). Based in Clark County, CVAB began as a consumer support and advisory group that has evolved into a consumer-driven, multi-service agency (with sites in Vancouver and the Skagit Valley). CVAB operates the Val Ogden Center Clubhouse in Vancouver and a statewide consumer-perated service SAMHSA development grant.

Strong evidence for Consumer-Operated/Peer-Run services is emerging. Mowbray et al. (2005) developed the Fidelity Rating Criteria for consumer-run drop-in centers to study and evaluate these services. SAMHSA conducted a study between 1998 and 2002. The Consumer-Operated Services and Programs (COSP) Multisite Study identified common ingredients across the seven consumer-operated multiservice agencies participating in the study:

- Program structure;
- Program environment;
- Belief systems;
- Peer support; and
- Education/advocacy.

SAMHSA's Community Mental Health Services' Community Support Program funded 14 projects designed to implement and evaluate Consumer-Operated services from 1988 to 1991. The projects included drop-in centers, outreach programs, businesses, employment and housing programs, and crisis services. Investigators began to conduct more rigorous studies of Consumer-Operated services that included measures of empowerment, hope, self-esteem, well-being, and healing/recovery, among others. It concluded that participating in mutual support groups and drop-in centers improved consumers' perceptions of self, social functioning, and decision making. Access to a crisis hostel program produced greater recovery and a greater sense of empowerment than traditional hospital-based services (Dumont & Jones, 2002; Yanos et al., 2001).

Increasing evidence indicates that consumer self-direction produces positive outcomes for consumers, the behavioral health system, and society. Several studies documented gains by self-directing participants in several domains, including vocational pursuits, independent housing, community inclusion, and using individualized strategies to support wellness and activity engagement (Croft et al., 2018; Croft & Parish, 2016; Snethen et al., 2016). A 2014 review of 15 studies concluded that mental health self-direction is associated with increased quality of life and cost-effectiveness, though there were significant methodological limitations (Weber et al., 2014).

Recovery Café as a Service Innovative Model

The Recovery Café model, developed in Seattle almost 20 years ago, was founded on principles originating in Washington D.C. Samaritan Inns. It has since spread internationally. A Recovery Café is a consumer run organization for individuals experiencing substance use or co-occurring disorders who come together to support each other in their recovery. A Recovery Café is an alternative, therapeutic, supportive community. A drug- and alcohol-free physical location gives individuals a place to interact in positive, safe, and recovery-oriented ways to support each other. Recovery Café's typically teach skills, provide access to housing, social and health services, and provide education and opportunities to form healthy relationships.[2]

Most academic studies found that participants receiving peer intervention showed improvements in substance use, in a range of other recovery outcomes, or both. Peer intervention also improved relationships with providers and increased social support satisfaction with the treatment experience, reduced relapse, and increased treatment program retention. The individuals studied generally had complex needs, in addition to substance use issues, and benefitted from peer support across diverse types of interventions (Bassuk et al., 2016; Reif et al., 2014). One caveat has been that the definition of "peer" varies across most of studies. In addition, services in peer supported substance abuse entities can also vary. However, Recovery Cafés help avoid this problem by providing consistent services.

The Recovery Café model fits well within the parameters of peer-support services established by the Washington State Recovery Oriented System of Care.

Stakeholder Input

The Legislature provided funding in the state's 2017–2019 biennial operating budget for existing Clubhouse services and the development of new programs. To determine the best strategy to implement the proviso, DBHR convened a stakeholder workgroup comprised of national subject matter experts, existing Clubhouse personnel, consumers, agency representatives, behavioral health advocates, and BHO staff. See Appendix C for a list of workgroup members.

The workgroup had two objectives: (1) Assist in determining how the proviso funds should be distributed to expand Clubhouse services, and (2) contribute to the recommendations for future Apple Health funding. The workgroup identified three funding categories for the solicitation of proviso funds. DBHR gave awards to 10 programs in various stages of development in one of the

[2] Recovery Café Network, retrieved from https://recoverycafenetwork.org/our-model/

three possible funding categories. A list of apparent successful bidders receiving awards are included in Appendix D. Categories consisted of:

- **Start-up:** Start-up activities will help determine community need for Clubhouse services and to develop business plans to create sustainable Clubhouse services. Activities include management structure development, drafting bylaws, evaluation plans, assessing community needs, business planning, obtaining any necessary certification or licensing, community outreach, identifying interventions, site development, pursuit of foundations/grants, sustainability, and board development.
- **Program development:** Program development activities to launch services and agencies that are still in the process of establishing their Clubhouse programs. Activities are related to initial service activities. These include growing management and business models on developing new programming, including a summary and project plan, staff training activities, developing the capacity to deliver services, and initial service provision.
- **Program expansion:** Expansion of Clubhouse programs to serve additional populations or sites, including sustainability planning and feasibility study. Activities include expansion of current services to additional populations and locations and strategies to maintain these efforts.

Funding challenges were a consistent theme among workgroup members (Clubhouse, Consumer-Operated, and Recovery Cafés). Workgroup members discussed the various current funding sources including Apple Health, local tax funding, federal block grant funding, state funds, and Access to Recovery grant funds. Previously, Washington funded Clubhouse services, supported employment services and respite services under the 1915 (b) Medicaid Waiver until 2012. These services were known as the B3 services. The economic downturn and issues around the availability of the B3 services throughout the state resulted in their elimination. Currently opportunities exist to fund the peer- and day-support elements of Clubhouse, Consumer-Operated and Recovery Café programs through the current Washington Medicaid State Plan. However, Apple Health requirements around eligibility, medical necessity, treatment planning and coordination, and documentation requirements restrict the ability to provide flexible and on-demand programming.

The cost implications of service expansion are a major concern regarding fully funding Clubhouses and related programs. The presumption, especially in community behavioral health, is that any new clinical intervention will likely produce positive health and fiscal effects. To some extent, offering almost any service that supports people to maintain themselves in the community rather than requiring more expensive clinic — or hospital-based clinical treatments — has beneficial cost containment effects.

Cost Benefit

The most recent study of the impact of Clubhouse programming on mental health service utilization and cost (Hwang et al., 2017) examined whether frequency of attendance at a local Clubhouse was associated with lower mental health care costs in the Medicaid database, and whether members in the Clubhouse would have lower mental health care costs than a control sample from the same claims database. Participants who attended the Clubhouse three days or more per week had mean one-year mental health care costs of $5,697, compared to $14,765 for those who attended less

often. Clubhouse members had significantly lower annual total mental health care costs than the control group ($10,391 vs. $15,511). The authors concluded that Clubhouse membership was associated with a substantial beneficial influence on health care costs. In an earlier study (Warner et al., 1999), Clubhouse members were matched with similar patients (non-Clubhouse members). Over two years, the pattern of service utilization and costs favored the Clubhouse group. When the two groups were disaggregated for employment status, the Clubhouse group experienced less treatment utilization and lower costs than the non-Clubhouse group. These cost and treatment utilization findings are buttressed by the extensive literature already developed on the cost benefit, vis-a-vis mental health service use and cost for evidence-based employment programs (Dickson et al., 2002; Knapp et al., 2013; Marino, 2014; Whitworth, 2018).

Funding Options

Two major Clubhouse funding approaches have been used around the U.S. One is developing a dedicated state budget line item to provide fiscal stability to Clubhouses within the state. Massachusetts is one long-standing example of this approach. Another is to use Medicaid funding to fund specific types of services that can occur within a Clubhouse environment. New York, for example, has a Medicaid-funded Personal Recovery Oriented Services that supports basic living skills training, benefits and financial management, community living exploration, engagement, structured skill development and support, and wellness self-management. These are all specific interventions commonly provided within a Clubhouse. Another type of Medicaid funding some states have used (including Michigan and Indiana) is the Medicaid Rehabilitation Option to create a specific Clubhouse package of services.

The Clubhouse movement nationally has proposed that the minimally-acceptable budget for Clubhouses that aspire to earn or have achieved Clubhouse International certification[3] status is in the range of $600,000 annually (smaller programs) to $800,000 (larger Clubhouses).

The financing strategy a state may consider for reimbursing Consumer-Operated/Peer-Run/Recovery Café service providers depends on the service model used. Avenues exist for programs serving a mental health population but do not exist for a substance use disorder population. All financing strategies rely on costs and other factors to determine how and, to a certain extent, what a purchaser will reimburse for peer-provided services. These costs, regardless of the model used by a state purchaser, are generally dependent on a number of factors. These factors include personnel costs, direct care costs, overhead, location of service, geography, and the use of in-kind contributions.

Consumer-Operated/Peer-Run services that are site-based (drop-in centers) may have different costs than COSPs that are more mobile. The cost of a crisis-support program will probably be greater than a drop-in center. The latter may incur greater costs for staff transportation and will have different productivity expectations, especially if the services are reimbursed on a unit basis (e.g., hourly, daily rate).

[3] Learn more about accreditation from Clubhouse International at http://clubhouse-intl.org/resources/accreditation

Historically, Consumer-Operated/Peer-Run services relied on volunteers to operate services. The costs associated with these volunteers and other donated resources are generally not included in the historical reported costs included in a state purchaser's reimbursement rate. If these costs were included in the rate, overall program expenses would be higher. In an unpublished study cited by O'Brien et al. (2008), volunteers and other donated resources accounted for 13 to 35 percent of the costs of a Consumer-Operated service program.

In most instances, states may use several funding streams to finance their Clubhouse and Consumer-Operated service programs and peer providers working in traditional mental health agencies (see Appendix B). The Centers for Medicare and Medicaid Services (CMS) recognize the use of peer providers in their policies and programs. Thus, in August 2007, CMS released a guidance letter to Medicaid directors regarding peer support services. The letter provided information regarding supervision, care coordination, training, and peer support service credentialing. A range of Medicaid financing options already exist to support Consumer-Operated/Peer-Run service programs or consumer providers in mental health agencies. These include traditional state plan services and various Medicaid Waivers.

Financing Strategies

Many states, including Washington, have amended their Medicaid plans to cover either peer support services or allow reimbursement for consumer providers rendering various rehabilitative and case management services. Most states currently offer some form of Medicaid-reimbursable peer support services either for clients dealing with mental health or substance abuse challenges. The majority of states with peer support funding, including Washington, offer Medicaid reimbursement for mental health services only; substance abuse services are not covered.

As of 2014, 36 states can bill Medicaid for mental health peer support services and at least 11 states can bill for peer support in substance use disorders (SUD) or co-occurring conditions (Kaufman et al., 2014). This funding disparity is inconsistent with the longstanding emphasis in the substance abuse recovery field on the importance of peer support and the "lived experience" in assisting others to overcome addiction (e.g., Alcoholics Anonymous, Recovery Café).

CMS noted this between the mental health and substance abuse fields in its 2015 Medicaid letter:

> "….There are other important service modalities and approaches vital to effectively treating SUD that we encourage states to provide, including screening and intervention services in a broad range of settings, integration with primary care, medication assisted treatment and recovery supports services such as peer recovery supports and recovery coaches. Providing these services will help achieve better health outcomes among individuals with SUD, helping them to lead healthier and longer lives." (See Letter from CMS, 2015, in Appendix E.)

Medicaid Rehabilitation Option

The Medicaid Rehabilitation Option offers rehabilitative services that a state Medicaid program may add to its state Medicaid plan. Rehabilitative services are defined in 42 CFR §440.130 as: "Rehabilitation option services are provided in community-based, non-institutional settings including the person's natural environment (e.g., home or work)."

Under the Rehabilitation Option, states have qualified consumer providers rendering various community-based mental health services such as assertive community treatment, psychiatric rehabilitation, community support, crisis, and other services for individuals with mental illness.

Section 1915(i) State Plan Option

Another strategy that states may use to cover home and community-based services is Section 6086 of the Deficit Reduction Act (DRA), P.L. 109-171.

Section 6086 established a new provision in the Social Security Act, 1915(i), that gives states the ability to offer home and community-based services (HCBS) to older adults and people with disabilities (with incomes up to 150 percent of the federal poverty level) without requiring a waiver or demonstrating cost neutrality. A state need only amend its Medicaid plan to provide any of the services now covered under HCBS waivers. Section 6086 expands to populations not previously eligible for HCBS waivers, especially to adults from ages 22 through 64 who have a mental disorder.

This program is referred to as the 1915i State Plan Amendment. The Affordable Care Act expanded coverable services under 1915(i) to include any of the HCBS permitted under section 1915(c). These include home- and community-based service (HCBS) waivers, certain services for individuals with mental health and substance use disorders, and other services requested by a state and approved by the Secretary of Health and Human Services. In addition, the changes help ensure the quality of HCBS, require states to offer the benefit statewide and enable states to target 1915(i) State Plan HCBS to particular groups of participants (but not to limit the number of participants who may receive the benefit).

Beginning in 2014, CMS made it possible for states to add peer support specialists as practitioners who are eligible to provide Medicaid-covered prevention services. If a state decides to include peer support specialists on their state list of providers eligible for Medicaid reimbursement for prevention services, it must submit the addition to CMS for approval as a state plan amendment. Cost issues are crucial to consider, as is the philosophy of care that a state chooses to embody.

While Medicaid-financed peer support programs may not result in savings from reductions of costly crisis stabilizations and psychiatric hospitalizations, it does support the principles of self-direction and recovery from severe mental illness. State policy makers must weigh the potential higher cost associated with peer support programs with efforts to redesign the delivery of mental health services.

Data

We have provided a demographic and behavioral health treatment need profile for Clubhouse service recipients who received these services under Washington State's 2005 to 2012 1915(b) waiver. This information is also provided for clients who received similarly intensive per diem services (i.e., day support services) and other Consumer-Operated services previously discussed in this report (i.e., peer support services). Because clients could receive multiple behavioral health services from the state, a given client may be included in more than one of these populations. Individuals were included in this analyses if they: 1) Received either their first mental health

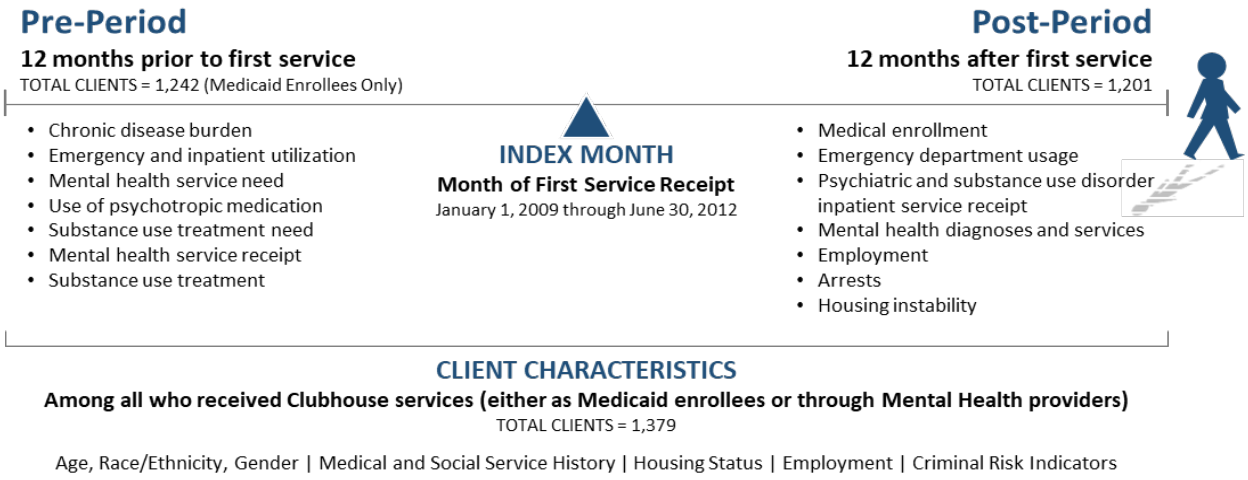
Clubhouse, day support, or peer support services between January 1, 2009 and June 30, 2012;[4] or 2) were 18 years or older as of their first service date.

The month that a client first received a specific service during the January 1, 2009 to June 30, 2012 intake window was used as their index month for that service; client demographic characteristics, such as an individual's age, race, and sex, were measured as of the index month. A client's behavioral health treatment needs, specific mental health diagnoses, and receipt of prescription medications for the treatment of mental illness were measured in the 24-month period prior to their index month. Receipt of inpatient and outpatient mental health and substance use disorder treatment services, emergency department use, and receipt of other state services (e.g., Basic Food, Temporary Assistance to Needy Families, etc.) were measured in the 12 months prior to the index month. All post measures are based on the 12 months after the index month.

As shown in Figure 1, the analysis conducted by the Research and Data Analysis Division of the Washington State Department of Social and Health Services is divided into three time periods. Table 1A provides demographic, arrest, employment, state service receipt, and housing information. Table 1B examines client use of Medicaid-funded behavioral and physical health services; it is restricted to clients who were on medical assistance for at least one month in the year prior to their index month.

Table 2 provides descriptive comparisons of client experiences prior to and following their receipt of mental health Clubhouse, day support, or peer support services. These data are intended for comparative purposes only and do not provide a systematic evaluation of the effectiveness of these programs in improving client outcomes. Instead, they allow us to explore how client experiences before and after treatment may be similar across different types of services.

Figure 1: Time Periods for Analysis



4 While mental health Clubhouse services were first offered as a Medicaid benefit under Washington State's 1915(b) waiver in 2005, these data were restricted to clients who received these services from 2009 onward. We adopted this approach to account for the effect that broader transitions in the state's Medicaid database system might have on the availability of data used to identify client behavioral health treatment needs prior to 2007.

TABLE 1A: Client Characteristics, Prior to Program Entry

Clients Who First Received Services Between January 1, 2009 and June 30, 2012						
					Clients Receiving Peer Support Services	
			Clients Receiving Day Support Services			
	Clients Receiving Clubhouse Services					
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
Population Size	1,379	—	2,034	—	9,164	—
Demographic						
Mean Age at Baseline	42.5		40.8		40.7	
18–24 Years of Age	120	9%	246	12%	1,047	11%
25–34 Years of Age	249	18%	447	22%	2,101	23%
35–44 Years of Age	357	26%	482	24%	2,206	24%
45–54 Years of Age	444	32%	589	29%	2,562	28%
55–64 Years of Age	185	13%	212	10%	1,041	11%
65 or Older	24	2%	58	3%	207	2%
White, Non-Hispanic	966	70%	1,303	64%	5,755	63%
Minority	409	30%	724	36%	3,386	37%
African American	144	10%	303	15%	1,720	19%
Hispanic/Latino(a)	100	7%	180	9%	620	7%
Asian or Pacific Islander	75	5%	138	7%	625	7%
American Indian	166	12%	215	11%	1,053	11%
Unknown	*	*	*	*	16	0%
Female	600	44%	1,062	52%	4,831	53%
Male	779	56%	972	48%	4,333	47%
Services from the Dept. of Social and Health Services, 12 Months Prior to Receiving Services						
Developmental Disabilities Administration	52	4%	93	5%	202	2%
Economic Services Administration	1,161	84%	1,725	85%	7,811	85%
Aged, Blind, or Disabled Cash Assistance	69	5%	120	6%	555	6%
General Assistance (Unemployable)/Disability Lifeline	323	23%	432	21%	1,823	20%
Basic Food	1,118	81%	1,655	81%	7,521	82%
Temporary Assistance to Needy Families	64	5%	171	8%	1,214	13%
Other History, 12 Months Prior to Receiving Services						
Homeless	392	28%	594	29%	2,602	28%
Employed in Previous Year	231	17%	426	21%	1,825	20%
Ever Arrested or Convicted of a Crime	776	56%	1,052	52%	5,267	57%
Ever Arrested or Convicted of a Crime in Prior 12 Months	302	22%	420	21%	2,204	24%
Medicaid Coverage, 12 Months Prior to Receiving Services						
Any Medical Assistance	1,242	90%	1,821	90%	8,226	90%

TABLE 1B: Client Physical and Behavioral Health Histories Prior to Program Entry

Clients Who First Received Services Between January 1, 2009 and June 30, 2012, and Who Had Any Medical Assistance in the Year Prior to First Service Receipt						
	Clients Receiving Clubhouse Services		Clients Receiving Day Support Services		Clients Receiving Peer Support Services	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
Population Size	1,242	—	1,821	—	8,226	—
Physical Health History for Clients Receiving Any Medical Assistance, 12 Months Prior to Receiving Services						
Chronic Disease Burden At or Above Average for SSI Population	591	48%	849	47%	3,918	48%
Emergency Department Outpatient Visit (1 or more)	518	42%	798	44%	3,711	45%
Emergency Department Inpatient Hospitalization (1 or more)	114	9%	206	11%	808	10%
Behavioral Health History, Client Treatment Needs and Medication Receipt, 24 Months Prior to Receiving Services						
Mental Health Service Need Indicator	1,197	96%	1,744	96%	7,930	96%
Serious Mental Illness Indicator	1,040	84%	1,454	80%	6,736	82%
Psychotropic Medication (Any)	1,032	83%	1,525	84%	6,789	83%
Substance Use Disorder Treatment Need	572	46%	830	46%	3,795	46%
Behavioral Health History, Clients Receiving Mental Health Treatment Services, 12 Months Prior to Receiving Services						
DBHR Mental Health Services	1,098	88%	1,543	85%	7,157	87%
Any Mental Health Service	1,096	88%	1,540	85%	7,172	87%
Any Outpatient Mental Health Treatment	1,091	88%	1,523	84%	7,136	87%
Any Psychiatric Inpatient Services	257	21%	322	18%	1,201	15%
Any Substance Use Disorder Treatment	264	21%	374	21%	1,512	18%
Any Outpatient Substance Use Disorder Treatment	224	18%	281	15%	1,141	14%
Any Substance Use Disorder Inpatient Services	100	8%	108	6%	481	6%
Emergency Department Visits or Inpatient Admissions, Per 1,000 Member Months, 12 Months Prior to Receiving Services						
Number of Emergency Department Outpatient Visits	191.9		194.5		182.6	
Number of Emergency Department Inpatient Hospitalizations, General Medical Setting	16.3		20.4		19.3	

TABLE 2: Client 12-Month Pre-Enrollment and Post-Enrollment Comparisons

Clients Who First Received Services Between January 1, 2009 and June 30, 2012, and Had Any Medical Assistance in the Year Prior to and Following First Service Receipt						
	Clients Receiving Clubhouse Services		Clients Receiving Day Support Services		Clients Receiving Peer Support Services	
Note: These data were prepared for descriptive purposes only. These pre-post comparisons have not been risk-adjusted across the different groups and do not include comparisons to statistically-matched samples.	Pre-Period (12 months prior to first service)	Post-Period (12 months after first service)	Pre-Period (12 months prior to first service)	Post-Period (12 months after first service)	Pre-Period (12 months prior to first service)	Post-Period (12 months after first service)
Population Size	1,201	—	1,765	—	7,937	—
Medicaid Coverage						
Months Receiving Any Medical Assistance	10.4	11.1	10.3	11.0	10.3	10.9
Use of Emergency Department Services						
Emergency Department Outpatient Visit (1 or more)	42%	39%	44%	42%	45%	42%
Emergency Department Inpatient Hospitalization (1 or more)	9%	10%	11%	11%	10%	10%
Self-Harm Diagnoses, Per 1,000 Member Months						
Number of Self-Harm Diagnoses	3.1	2.6	4.1	4.6	3.1	2.5
Number of Overdose Diagnoses	0.9	0.3	1.1	0.7	0.9	0.6
Number of Other Poisoning	1.2	1.0	1.2	1.4	1.0	0.8
Number of Attempted Suicides	0.9	0.9	1.0	0.9	0.8	0.5
Number of Possible Attempted Suicides	0.2	0.2	0.7	1.4	0.4	0.4
Behavioral Health Services						
Number of Outpatient Mental Health Treatment Services, Per 1,000 Member Months	5,934	8,533	4,575	7,525	4,010	5,437
Any Psychiatric Inpatient Services	20%	11%	18%	12%	14%	10%
Any Substance Use Disorder Inpatient Services	8%	6%	6%	6%	6%	5%
Total Number of Clients, Emergency Department Visits or Inpatient Admissions, Per 1,000 Member Months						
Number of Emergency Department Outpatient Visits	192.8	151.3	191.9	171.3	182.6	156.0
Number of Emergency Dept. Inpatient Hospitalizations, General Medical Setting	16.4	15.4	20.0	19.4	19.0	18.1
Number of Emergency Dept. Visits with a Mental Health Diagnosis	117	102	112	97	113	118
Other Outcomes						
Ever Employed in 12–Month Period	15%	12%	19%	14%	18%	14%
Ever Arrested in 12Month Period	17%	13%	18%	16%	19%	18%
Ever Unstably Housed in 12–Month Period	29%	26%	31%	28%	29%	28%

Recommendations

For the best outcomes, the Clubhouse expansion envisioned in the 2017–2019 proviso must recognize the advances that have been made in the years since Fountain House became the original Clubhouse. The workgroup recommends a wide variety of Clubhouse programs to include evidence-based Clubhouse models, evidence-based consumer-run, consumer-operated, and Recovery Café-type services. These approaches maintain the core values that Fountain House helped institutionalize — peer support and increased consumer control of services — while offering a broad array of treatment options that take into account the in-recovery models. Adopting a progressive approach to Clubhouse development will create more opportunities for the growth and success of individuals working toward behavioral health recovery in the state of Washington.

These three models — Clubhouses, Consumer-Operated Service Programs/Peer Supports/Recovery Café — share common values and recovery philosophies complementary to the Recovery Oriented System of Care developed in Washington State's DBHR/HCA and highlighted through the Foundational Community Supports (Supportive Housing and Supported Employment Services) 1115 Medicaid waiver. The descriptions included in this report showed the links that tie each together and the overall recovery approach to services for people with behavioral health challenges in Washington State.

Common links among all three service modalities include:

- Peer support as an essential component
- Emphasis on community supports versus institutional services
- Focus on biopsychosocial causes of mental illness — not solely biological causes
- Use of "natural supports" along with professional supports
- Service participants are not seen as "patients" but as voluntary members of affiliated groups
- Credibility for empowerment and consumer self-direction
- Grassroots community energy fueling establishment of each of these structures

Consumer self-direction and control is manifest in both academic literature and state and federal policies. Therefore, it is well within the parameters of Washington State's philosophy of care for its residents with behavioral disorders to support conceptually and financially each of these service delivery models.

This support must be conditional on the overall health care fiscal decisions the state has to make. Each of the approaches is amenable to fitting within the rules and regulations of Medicaid, either as waivers or Rehabilitation Option plans (assuming they are included and approved in terms of how each specific service is delivered). For example, as highlighted earlier, Clubhouse, Consumer-Operated programs, and Recovery Cafés can either be funded within already-existing specific peer service and day support service delivery strategies or as a specific package of services overall. What is most crucial is not the method of funding — presuming it fits the financial prudence of state funding required for any service — but that each of these options is recognized as part of the overall set of services the state seeks to offer.

Traditional Clubhouse and contemporary models of Consumer-Operated services and Recovery Cafés are cost effective for the health care system. Establishing a Medicaid-funded peer support service that covers a variety of models is an approach that adapts to individual community needs and desires. A combination of the three models would support the availability of services to be provided throughout the state, as is necessary for Medicaid.

Appendix A: Components of a Clubhouse

Clubhouse Work Units

Clubhouse work units are specific work entities set up to get needed tasks done. In many ways, work units form the centerpiece of the Clubhouse approach to rehabilitate people with long-term mental illness (Vorspan, 1989). This pattern of service delivery, commonly referred to as the "work-ordered day," fosters members and staff working productively together.

A tenet of Clubhouse administration is that staffing should always be such that the work of the club could not be accomplished without the active contributions of both members and staff (Beard et al., 1982.) In some respects, this structure was developed as a counterpoint to the view, prevalent in the 1950s, of psychiatric treatment as psychodynamic "talk" therapy. It emphasizes the value of productivity (Whitehead & Marrone, 1986). This tenet is essential to the rehabilitation philosophy, while, less consciously, helping a person develop their capacity to nurture and support others as a way of enhancing self-esteem.

Traditionally, Clubhouse work unit programs include:

- Kitchen/café
- Janitorial/housekeeping
- Clerical (attendance, record keeping, and fiscal)
- Public relations (newsletters, tours, public speaking)

Sometimes, Clubhouse members also do maintenance and repair functions, community volunteer activities, fundraising, and odd jobs in the community.

The essential purpose of Clubhouse work units is to benefit the members through their contributions to keeping the club functioning. Work units are **not**:

- Volunteer work
- Specific skills training
- A means of assessment

Except in large programs, specific assignment to a work unit is not crucial. Someone may spend part of a day or a week in one unit, and then move on to other units. Some programs may use daily member meetings to divide the tasks.

Transitional Employment

Transitional Employment (TE) is also a core tenet of a pure Clubhouse model (Malamud & McCrory, 1988). However, many programs do not always follow the fidelity or accreditation to the model and don't include TE, citing difficulty finding jobs for their members. TE grew out of the intuitive sense that "in vivo" learning was a good way for people to acquire work habits. Members — who may lack skills and solid work histories and face stigma as ex-mental patients — often have difficulty securing employment (Beard et al., 1982.) or gaining work skills in a setting less demanding than a typical full-time job. The major components are:

1) The responsibility for job development lies with the program — not the individual member.
2) The program accepts the responsibility of recruiting, hiring, and training members for each job. Program staff learn the job first and then teach the member (similar to a job coach in Supported Employment).
3) The employer gives up the option of screening the member out via the interview process.
4) The employer agrees to pay workers directly — not through the program — and at least minimum wage.
5) Most full-time jobs are broken up into two part-time jobs.
6) There are time limits on how long a member can hold each TE job (usually 6 months). In the "pure" Clubhouse model, consumers may switch TE jobs in 4 to 8 months, but stay in the TE program. In recent years, funding restrictions have led some programs to limit members to one TE experience.
7) The Clubhouse manages the placement into the TE positions and members don't "own" the job.
8) The Clubhouse establishes a regular support mechanism away from the job, usually in the form of a weekly or bi-weekly dinner meeting. This enables TE workers to "compare notes" and for potential workers to hear about TE experiences firsthand.

Clubhouse programs are increasingly attempting to match TE opportunities with members' vocational interests. However, many of the jobs available are usually limited to food service, janitorial, grounds keeping, messenger, and entry-level clerical jobs.

TE is typically most appropriate for people with limited work experience, who haven't worked in over two years, or who are unsure if paid work is an option. Other practical considerations include that TE:

- Works best in urban or suburban settings rather than rural areas;
- Positions are typically service-driven rather than manufacturing-related;
- Requires jobs that can be quickly taught; and
- Requires a steady flow of new clients and jobs, including employers willing to provide multiple TE opportunities.

The major advantages of a TE approach, particularly vis-a-vis supported employment, include:

1) The worker gets a sense of "graduation," which is often the first successful adult experience.
2) For the worker who is having trouble, the time-limited nature of the experience allows a sense of "light at the end of the tunnel." For the worker who is not able to complete a TE position, the finiteness of the program enables them to think through the experience as having made it one sixth, one fourth, one third, etc. the way through.
3) Because TEs are usually part-time, each job can serve two people at a time.

Supported Employment

Following extensive research showing the benefits of evidence-based Supported Employment and the Individual Placement and Support model, Clubhouses have been more focused on competitive employment outcomes distinct from their Transitional Employment services. The Clubhouse offers its own Supported and Independent Employment Programs to assist members to secure, sustain, and better their employment. As a defining characteristic of Clubhouse Supported Employment, the

Clubhouse maintains a relationship with the working member and the employer. Members and staff in partnership determine the type, frequency, and location of desired supports.

Members who are working independently continue to have available all Clubhouse supports and opportunities including advocacy for entitlements, and assistance with housing, clinical, legal, financial and personal issues, as well as participation in evening and weekend programs. [5]

Employment, with the exception of the Individual Placement and Support model, focuses on longer-term (not time-limited) jobs. The current Washington State BEST grant, funded by SAMHSA, has as a primary goal of expanding state capacity to offer such evidence-based employment services throughout the state. A major support for this outcome is the recent establishment of the Medicaid 1115 Foundational Community Supports waiver.

[5] Clubhouse International Quality Standards: http://clubhouse-intl.org/resources/quality-standards/

Appendix B: Consumer-Run Drop-In (COSP) Fidelity

TABLE 1: ***Fidelity Rating Criteria for Consumer-Run Drop-in Centers***

Criteria Item	*Lowest Rating (1)*	*Middle Rating (3)*	*Highest Rating (5)*
Structure			
Voluntary—extent that attendance or participation is required or coerced, and members can come and go at will	More than two thirds of consumers compelled to attend; generally can't leave without permission	20% to 35% compelled to attend and participation may be expected; or > 20% compelled but consumers pressed to participate	Attendance and participation completely voluntary; members come and go as they wish and participate only if they choose
Consumer determination of policy, operations, and planning	No consumer board; staff makes virtually all decisions; consumers have almost no input	Director, staff, or small group of consumers make most decisions; little democratic participation	Democratic process is usual and expected: regular open meetings; ideas encouraged and implemented
Transportation—accessibility, affordability, dependability, safety	Difficult for consumers to get to the center: no public transport, remote location, etc.	Public transport unreliable, costly, dangerous, or limits flexibility	Easy for consumers to come and go as they wish
Exterior physical environment—appearance, neighborhood safety, wheelchair accessibility	Neighborhood appears unsafe; exterior unappealing; may not be wheelchair accessible	Neighborhood and center exterior somewhat unpleasant; may be difficult for wheelchairs	Neighborhood and building appear safe and pleasant; entrance is wheelchair accessible
Interior physical environment—space, smokiness, cleanliness, comfort level, wheelchair accessible interior	Potentially unhealthy: smoky, filthy, foul odors, disrepair, crowded, broken furniture, wheelchair inaccessible	Unpleasant: unkempt, lacks comfortable furniture, minor maintenance problems, kitchen too small, or wheelchair barriers	Clean, comfortable; well laid-out; large enough for growth; large enough kitchen; wheelchair accessible
Facilitating referrals—getting member needs met in the community	No useful postings or referrals by staff for necessary services in the community	Staff not proactive v/v SPELL OUT information; helpful if asked; some postings but may be outdated or not user-friendly	Much usable information posted; staff are knowledgeable, helpful, and proactive in sharing information regularly
Outreach to recruit new members and to increase visibility in community	No emphasis on recruiting new consumers or increasing visibility in the community	Center asks case managers at mental health agency to tell new clients about center	Center has mental health agency tell new clients about center, maintains contacts with other local agencies
Activities and services—provision for meeting basic needs in the center	Center provides 0 to 1 of (a) quality meals or snacks; (b) meals or snacks for all almost every day; (c) telephone; (d) washer and dryer; (e) at least one of: hygiene products, clothing, showers, or food pantry	Center provides any three of (a) quality meals or snacks; (b) meals or snacks for all almost every day; (c) telephone; (d) washer and dryer; (e) at least one of: hygiene products, clothing, showers, or food pantry	Center provides all of (a) quality meals or snacks; (b) meals or snacks for all almost every day; (c) telephone; (d) washer and dryer; (e) at least one of: hygiene products, clothing, showers, or food pantry
Housing, transportation, education, and job assistance services	Center provides none of these services on a regular basis	Center provides one of these services regularly	Center provides two or more of these services regularly
Social recreational activities	Center may have TV, stereo, or even a few cards or games but nothing more for in-house activities, and activities away from the center are less than monthly, if any	Center may have excellent social-recreation options in or outside the center, but not both; or center has infrequent activities outside and a few inside beyond TV	Center has many enjoyable options at the center and activities away from the center more than two to three times per month
Process—Belief Systems			
Group empowerment—opportunities (groups, activities, conversations, posted information, conferences) to learn about social and political issues affecting consumers	Consumers see troubles as individual rather than group-based; no lobbying, attending rallies, consumer conferences, or antistigma activities	Some evidence: talk, postings, meetings, events where consumers identify as part of affected group; center may encourage conferences, lobbying, antistigma activities—consumers less interested	Much evidence that consumers identify as members of an affected group: talk about laws, bureaucracies, discrimination, and how to effect change; attend conferences, rallies, lobbying events

TABLE 1 (continued)

Criteria Item	*Lowest Rating (1)*	*Middle Rating (3)*	*Highest Rating (5)*
Process—Belief Systems			
Practice and improve social and work-related skills—opportunities provided	No computers, clerical tasks, activities to plan, discussion groups, or meal preparation opportunities	Groups at center plus two of following: (a) computers, (b) clerical tasks, (c) meal prep, (d) info gathering, (e) organize activities, or (f) attend conferences	Groups at center, and three of following: (a) computers, (b) clerical tasks, (c) meal prep, (d) information gathering, (e) organize activities, or (f) attend conferences
Recovery orientation, personal growth, and development—emphasize strengths, skill-building, and independence	Staff lack hope for consumers; sense that consumers should keep expectations low; staff do for rather than with consumers	Perspectives are mixed: one half recovery and hope, one half disability and resignation; or recovery orientation is absent	Hope is pervasive; activities and talk regarding jobs, housing, and education focus on strengths, skills, and independence
Process—Opportunity Role Structure			
Consumer involvement in wide variety of tasks to operate the center	If consumers are involved, it's mainly in janitorial tasks	Some consumers are involved in more than janitorial tasks	Many consumers are involved at varying responsibility and skill levels
Consumer choice and decision-making regarding how to spend their time at center	No choice; participation tightly structured; strict or arbitrary rules	Some choice; some activities may be restricted; may have too many rules	Freely choose level of participation at all times
Nonhierarchical structure between staff and members	Staff maintain strict hierarchy; restrictive rules for consumers, not staff; staff have more resources; staff are condescending	Some hierarchies apparent: some staff condescend, some staff more respectful and encourage democratic participation	Consumers do not automatically defer to staff; no differences in rules or access to resources; staff are not condescending
Process—Social Support			
Member retention activities—friendly atmosphere, orientation for newcomers	Indifferent atmosphere; little or no recognition of consumers' contributions; little welcoming and orienting of newcomers; no contact with those who've been away	Somewhat friendly atmosphere; some recognition of contributions; occasional contact with those who've been away; newcomers introduced to at least two others	Very friendly, welcoming; recognition for contributions; visit or telephone members in hospital and sometimes those who've been away; comprehensive orientation
General respect toward members—polite, respectful, no threat of commitment	General disrespect, unkind, impolite; staff may threaten to report consumers to case managers or others or threaten commitment or treatment	Occasional put-downs by staff or other consumers in a half-joking way; a few get picked on; no threats to report or commit	Pleasant and respectful; disrespect doesn't go unnoticed: others respond to uphold respect as community standard; no threats to report or commit
Respect for diversity—inclusive, no racist, sexist, antigay, or demeaning speech or behavior	Racist, sexist, antigay, or other demeaning speech or behavior is frequent or severe and incurs no meaningful response	Infrequent and less severe racist, sexist, antigay, or demeaning speech with half-hearted or insufficient response	Attitudes and behavior appear free of prejudice; concerted effort toward respectful and inclusive environment
Social support—social relationships and social networks at the center	Superficial relationships; don't know each other well; may be isolated, indifferent, or unfriendly	Meaningful friendships; know about each other's lives and express support	Meaningful friendships that extend beyond the center; or at the center, show extraordinary support
Sense of community—positive attachments to the center by members	No ownership: see center as place for services, no pride in center or sense of belonging	Seem to like each other, but lack communality; not a cohesive group; little ownership or pride in the center	Sense of belonging to the larger group; feel appreciated; sense of ownership and pride
Self-help and reciprocity—sharing information, problem-solving, role-modeling among members	Little or no sharing information or problem-solving among members; helping only when a functional necessity	Few or brief information sharing or problem-solving; share some experiences to get or give advice	Much info exchange, problem-solving, and encouragement toward independence in housing, jobs, and education

Appendix C: Workgroup Members

DBHR Clubhouse Workgroup Members			
Name	**Agency**	**Name**	**Agency**
Barbara Gerrior	Clark County Department of Community Services	Jim Kenney	Goodwill (Former Clubhouse Director)
Georgia Butler	Community Minded Enterprises	Kailey Fiedler	Hero House
Joe Marrone	Consultant	Lisa Floyd	King County BHO
Aaron Wolfman	Consumer	Melet Whinston	Molina Health
Melodie Pazolt	DBHR	Linda Batch	NAMI
Cheryl Wilcox	DBHR	Kimberly Miller	Public
Lisa Bennett-Perry	DBHR	Taylor Danielson	RDA
Julie Cipale	DBHR - Admin Asst.	Mike Hudson	Reach Center
Richard L. VanCleave	DBHR - Federal Programs Manager	David Uhl	Recovery Café
Jennifer Bliss	DBHR - Office of Consumer Partnerships	Larry Clum	Seattle Clubhouse
Katie Mirkovich	DVR	Bruce Waddell	Spokane BHO
Harold McClure	Everett Clubhouse	Gail Kogle	Spokane BHO
Sue Grant	Evergreen Clubhouse	Joe Stoudt	Spokane BHO
Mike Marcus	Evergreen Clubhouse	Kathleen Torella,	Spokane BHO
Wanda Johns	Former Clubhouse member	Brad Berry	Val Ogden Center/CVAB
Mike Markus	Frontier Behavioral Health	Sarah Bowens	Val Ogden Center/CVAB
Mike Hatchett	Washington Provider Council	Teesha Kirschbaum	WA Rehab Council

Appendix D: Clubhouse Request for Proposal Apparent Successful Bidders:

Start Up	
Hero House Everett	Everett WA
Kitsap Mental Health Services	Bremerton WA
The Progress House	Pierce County WA
Development	
Community Minded Enterprises	Spokane WA
Hero House Seattle	Seattle WA
Okanagan Behavioral HealthCare	Okanagan County WA
Seattle Area Support Groups (SASG)	Seattle WA
Expansion	
Hero House Bellevue	Bellevue WA
The Recovery Café	Seattle WA
Consumer Voices Are Born (CVAB)	Vancouver WA

Appendix E: Medicaid Information Bulletins

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-
12 Baltimore, Maryland 21244-1850

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Center for Medicaid and State Operations

SMDL #07-011

August 15, 2007

Dear State Medicaid Director:

The purpose of this letter is to provide guidance to States interested in peer support services under the Medicaid program. The Centers for Medicare & Medicaid Services (CMS) recognizes that the mental health field has seen a big shift in the paradigm of care over the last few years.
Now, more than ever, there is great emphasis on recovery from even the most serious mental illnesses when persons have access in their communities to treatment and supports that are tailored to their needs. 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.

Background on Policy Issue
States are increasingly interested in covering peer support providers as a distinct provider type for the delivery of counseling and other support services to Medicaid eligible adults with mental illnesses and/or substance use disorders. Peer support services are an evidence-based mental health model of care which consists of a qualified peer support provider who assists individuals with their recovery from mental illness and substance use disorders. CMS recognizes that the experiences of peer support providers, as consumers of mental health and substance use services, can be an important component in a State's delivery of effective treatment. CMS is reaffirming its commitment to State flexibility, increased innovation, consumer choice, self-direction, recovery, and consumer protection through approval of these services. The following policy guidance includes requirements for supervision, care-coordination, and minimum training criteria for peer support providers.

As States develop behavioral health models of care under the Medicaid program, they have the option to offer peer support services as a component of a comprehensive mental health and substance use service delivery system. When electing to provide peer support services for Medicaid beneficiaries, State Medicaid agencies may choose to collaborate with State Mental Health Departments. We encourage States to consider comprehensive programs but note that regardless of how a State models its mental health and substance use disorder service delivery system, the State Medicaid agency continues to have the authority to determine the service delivery system, medical necessity criteria, and to define the amount, duration, and scope of the service.

States may choose to deliver peer support services through several Medicaid funding authorities in the Social Security Act. The following current authorities have been used by States to date:

- Section 1905(a)(13)
- 1915(b) Waiver Authority
- 1915(c) Waiver Authority

Delivery of Peer Support Services

Consistent with all services billed under the Medicaid program, States utilizing peer support services must comply with all Federal Medicaid regulations and policy. In order to be considered for Federal reimbursement, States must identify the Medicaid authority to be used for coverage and payment, describe the service, the provider of the service, and their qualifications in full detail. States must describe utilization review and reimbursement methodologies.
Medicaid reimburses for peer support services delivered directly to Medicaid beneficiaries with mental health and/or substance use disorders. Additionally, reimbursement must be based on an identified unit of service and be provided by one peer support provider, based on an approved plan of care. States must provide an assurance that there are mechanisms in place to prevent over-billing for services, such as prior authorization and other utilization management methods.

Peer support providers should be self-identified consumers who are in recovery from mental illness and/or substance use disorders. Supervision and care coordination are core components of peer support services. Additionally, peer support providers must be sufficiently trained to deliver services. The following are the minimum requirements that should be addressed for supervision, care coordination and training when electing to provide peer support services.

1) Supervision

Supervision must be provided by a competent mental health professional (as defined by the State). The amount, duration and scope of supervision will vary depending on State Practice Acts, the demonstrated competency and experience of the peer support provider, as well as the service mix, and may range from direct oversight to periodic care consultation.

2) Care-Coordination

As with many Medicaid funded services, peer support services must be coordinated within the context of a comprehensive, individualized plan of care that includes specific individualized goals. States should use a person-centered planning process to help promote participant ownership of the plan of care. Such methods actively engage and empower the participant, and individuals selected by the participant, in leading and directing the design of the service plan and, thereby, ensure that the plan reflects the needs and preferences of the participant in achieving the specific, individualized goals that have measurable results and are specified in the service plan.

3) Training and Credentialing

Peer support providers must complete training and certification as defined by the State. Training must provide peer support providers with a basic set of competencies necessary to perform the peer support function. The peer must demonstrate the ability to support the recovery of others from mental illness and/or substance use disorders. Similar to other provider types, ongoing continuing educational requirements for peer support providers must be in place.

Please feel free to contact Gale Arden, Director, Disabled and Elderly Health Programs Group, at 410-786-6810, if you have any questions.

Sincerely,

/s/

Dennis G. Smith
Director

cc:

CMS Regional Administrators

CMS Associate Regional Administrators
Division of Medicaid and Children's Health

Martha Roherty
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American Public Human Services Association

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