

August 2006

A System-Wide Assessment of Access to Outpatient Mental Health Services in Spokane County



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Limited hard copies are available.

An electronic version is available at www.srhd.org

When citing data from this source, please use
the following citation:

Spokane Regional Health District, Community Health
Assessment Program, *A System-Wide Assessment of
Access to Outpatient Mental Health Services in
Spokane County*, July 2006

Published July 2006



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Preamble

This report describes **access to outpatient mental health services** in Spokane County. It is about the availability and capacity of such services to meet the needs of county consumers; both the services provided by the public community mental health system and the services of private mental health practitioners.

The issues discussed in this report were determined from a survey conducted by the Spokane Regional Health District, Community Health Assessment Services, in cooperation with community partners, including:

Eastern Washington University
Health Services Administration

Spokane County Community Services Department
Regional Support Network

12 community mental health agencies
providing public, non-profit mental health services

284 practitioners
providing private, for-profit mental health services

Washington State Department of Health
Office of Community and Rural Health

Mental health is a vital component of total human health and is “part and parcel” of the overall well-being of the citizens of Spokane County. Therefore, outpatient mental health services comprise an important and necessary portion of all the healthcare services provided by health professionals in the county.

We maintain that **Spokane County deserves to know** about access to outpatient mental health services, the supply of these services to meet the demand of county consumers, and **whether there is a significant shortage of outpatient mental health services** in Spokane County.

This assessment is intended **for use by those who care** about the delivery of outpatient mental health services in Spokane County: consumers and advocates, clinicians and practitioners, administrators and supervisors, educators and students, elected and appointed officials, human and social service agencies and systems, and the community at large.

The introduction to this report presents the background and **summary of pertinent topics** regarding mental illness and mental health services. Results and analysis of the survey follow. The report concludes with a summary of the findings.

Introduction

On April 29, 2002, President George W. Bush announced the creation of the New Freedom Commission on Mental Health, charging the Commission to **study the mental health service delivery system** and to make recommendations that would enable adults with serious mental illnesses and children with serious emotional disturbance to live, work, learn, and fully participate in their communities. After a year of study, on July 22, 2003, the Commission completed its task, submitting its final report, *Achieving the Promise: Transforming Mental Health Care in America*. Findings and recommendations of the Commission's report are informative and of importance to this document.

Incidence of Mental Illness and Emotional Disturbance

Incidence in America. The Commission's report found the incidence of serious mental illness (SMI) for adults and serious emotional disturbance (SED) for children to be significant. These disorders are “shockingly common; they affect almost every American family. **No community is unaffected by mental illnesses**; no school or workplace is untouched”.¹ SMI and SED can occur in anyone, individuals of any age, persons of any ethnic background. SMI and SED are functional impairments that substantially interfere with, or limit, one or more of life's major activities, especially taking good care of oneself. It is important to note the following statistics regard serious illness and disturbance.

Studies cited by the Commission report have found that in any given year, 5 to 7% of adults have a SMI and 5 to 9% of children exhibit SED.¹

Incidence in Washington State. A study of the incidence of SMI and SED in Washington State was required by the legislature in 2003. Based on the 2000 United States census, the study was conducted and reported by the Mental Health Division under the title, *The Prevalence of Serious Mental Illness in Washington State*.

Results of this study estimated that 294,884 Washington citizens had SMI or SED; of these, 105,060 were children exhibiting SED.² Using the 2000 Washington State census count as a basis from which to calculate state-wide percentages, an **estimated 5% of state citizens** live with SMI or SED; this figure is comparable to national findings.

Incidence in Spokane County. The Mental Health Division study also estimates the incidence in Spokane County of individuals with SMI or SED at 22,884.² Another calculation shows the percentage of SMI and SED in Spokane County to be **8% of the population**, which is significantly higher than the state percentage. That this local percentage is so much higher than the state's is a finding of great importance to this document. The higher rate may reflect the county's poverty rate and lead to a central concern of this study, **whether there is a significant shortage of outpatient mental health services** in Spokane County.

Burden of Mental Illness and Costs of Mental Health Care

Disability and Death. The Commission report cites studies by the World Health Organization that find “mental illnesses rank first among illnesses that cause disability in the United States, Canada and Western Europe” and that “suicide world-wide causes more deaths every year than homicide or war”.¹ Annually, over 30,000 lives are lost to suicide in the United States and 90% of those who take their own lives have a mental disorder.

Indirect Costs. In addition to the disability of persons and tragedy of lost lives, SMI and SED cause immense indirect costs to the American economy. In any given year, these **indirect costs are estimated to be \$79 billion dollars**, which result from “loss of productivity as a result of illnesses,” and “premature death”, and “productivity losses for incarcerated individuals and for the time of those who provide family care”.¹ Based on the 2000 United States census of 281,421,906 people, annual indirect costs of mental health services amount to \$636.06 for every U.S. resident.

Direct Costs. The direct costs of mental health treatment are also formidable. The Commission report cites a 1997 federal study, the latest for which comparable data are available, which found that in that year the **direct costs of mental health services in the United States totaled \$71 billion dollars**¹, for an average annual expenditure for mental health services of \$607.62 for every American.

Lack of Parity. Of these direct costs for mental health treatment, 57% were paid by public funds. In comparison, and as an evidence of the historical lack of parity between benefits for mental health and general medical treatment, only 46% of costs for overall medical treatment were paid by public funds.¹ **“Americans deserve a health care system that treats their mental illnesses with the same urgency as it treats their medical illnesses”**.⁴ Lack of parity of payment for mental health services versus general medical services is of importance to this document.

Status of the Mental Health System

Previous to its final report, the Commission published the required *Interim Report of the President's New Freedom Commission on Mental Health*, on October, 29, 2002. This report was intended to **address the status of the mental health system**, particularly “the extent of unmet needs and barriers to care” and provide “examples of community-based care models with success in coordination of services and providing desired outcomes”.³

System is in Shambles. In his cover letter to the *Interim Report* and on behalf of the Commission, its Chairman Michael F. Hogan, Ph.D., stated “our review for this interim report leads us to the united belief that America's mental health service delivery system is in shambles”.³

After six months of study, reaching out to consumers, families, advocates, providers, administrators and researchers, and through public comments and personal testimony, letters and a web site feedback, the Commission concluded, **“the system is fragmented and in disarray** not from lack of commitment and skill of those who deliver care, but from underlying structural, financing and organizational problems”.³

Clearly, the mental health system in Spokane County has its problems, even evidence of fragmentation. However, the county also benefits from competent, effective mental health professionals.

Recovery is Possible. The Commission also found that there are effective treatments for people with SMI and SED and that recovery from SMI and SED can and has become a reality. Innovative services and programs across America have the potential to “make recovery from mental illness the expected outcome”.¹ However, the system is not sufficiently grounded upon the most important goal of the people it serves the hope of recovery. Behavioral healthcare research has produced successful treatments, models that work, and supports that facilitate recovery, but the system does not adequately deliver them. As these evidence-based practices and programs are implemented in the system of care, **“excellent care and recovery can become the norm, not the exception”**.³ To be sure, some testimonials of recovery are heard in the local mental health system. Likewise, Spokane County's system of care is experiencing an influx of evidenced-based services, which have been empirically demonstrated to be effective.

Unmet Needs and Barriers to Care. While many consumers are given good mental health care and recover from their illness, the Commission identified the extent of unmet needs, finding “the reality is that about **one out of every two people who needs mental health treatment does not receive it**”.³ Citizens in Spokane County can expect, and those who work within its mental health system can confirm, this level of unmet need occurs among county constituents.

Negative Stigma. Among the obstacles to care, “the **stigma of mental illness is a major barrier** to treatment”.³ Many people are reluctant to seek services because of the shame society attaches to SMI and SED. Stigma results in ridicule, ostracism, and inexcusable discrimination. Discrimination is found in housing and employment and in depriving individuals of the social support they need to recover. Stigma is often internalized by those who suffer from SMI and SED leading to isolation, hopelessness and self deprecation. The stigma associated with mental illness and emotional disturbance also occurs in Spokane County.

System Complexity. Another multi-faceted barrier to care, is the complexity of the mental health system. The system consists of inpatient, residential, and outpatient settings. Eligibility criteria for accessing mental health services differ among and within these sectors and within public and private funding sources. Mental health services are scattered across levels of government (federal, state and local) and across multiple agencies. Access to services is often different for age cohorts. Children and their families and elder consumers face circumstances making access to services challenging. Consumers transitioning from the children's to the adult's system of care sometimes lose their services. Mental illness co-occurs with substance abuse or developmental disabilities in many needy consumers and families, often making access to treatment more difficult. As a result of these and other factors, the system **“looks more like a maze than a coordinated system of care”**.³ There are those in Spokane County who would agree that complexity in the local mental health system of care, both public and private, perplexes and discourages consumers.

Limited Funding and Benefits. A final barrier to care is financial; **funding, and lack of funding, for mental health services present consumers with obstacles**, making access to mental health services difficult, unsatisfactory or impossible. Some fortunate consumers qualify for public mental health programs, while others have private mental health insurance coverage. However, public dollars for mental health treatment, both federal and state funds, continue to shrink reducing access to services. Private health insurance plans limit mental health benefits or place financial requirements on benefits. These plans characteristically exhibit a lack of parity between medical and behavioral benefits which impacts access to services. Then, there is a group that has no benefits or insurance coverage of any kind who must pay for, or go without, mental health services.

Spokane County's Loss of Federal and State Funds. The shrinkage of public funds for mental health services became a reality in 2005, when both federal and state **funding for Spokane County's public mental health services were cut by 20%**. Federal funds for Medicaid recipients were reduced in two ways: the capitation rate paid to Spokane County for each Medicaid enrollee was decreased and the total number of enrollees shrunk by 6%. For federal fiscal year 2006, Spokane received smaller payments for a smaller pool of Medicaid recipients. State funds authorized by the legislature in 2005 to help fill the short fall caused by the Medicaid reductions were subsequently allocated according to a formula, which decreased Spokane County's funding by 24.7%.

Loss of these funds severely impacted the public mental health system in Spokane County, mental health service professional positions were eliminated, and access to services was compromised. It should be noted that the data for the assessment in this report was collected before these reductions took place, increasing the effect on **whether there is a significant shortage of outpatient mental health services** in Spokane County.

Transformation of the Mental Health System

In selecting the title of its final report, *Achieving the Promise: Transforming Mental Health Care in America*, the New Freedom Commission on Mental Health signaled to the President and the country what would be its primary recommendation. After the President's charge, fifteen months of study, and publication of its *Interim Report*, the **“Commission recommends fundamentally transforming how mental health care is delivered in America”**.¹ This core recommendation is reflected in the vision statement which begins the final report:

“We envision a future when everyone with a mental illness will recover, a future when mental illnesses can be prevented or cured, a future when mental illnesses are detected early, and a future when everyone with a mental illness at any stage of life has access to effective treatment and supports for living, working, learning, and participating fully in the community”.¹

To achieve the transformation of the mental health system, the commission submits that six goals must be pursued and accomplished, so that in a transformed system:

- “Americans Understand that Mental Health is Essential to Overall Health;
- Mental Health Care is Consumer and Family Driven;
- Disparities in Mental Health Services are Eliminated;
- Early Mental Health Screening, Assessment, and Referral to Services are Common Practice;
- Excellent Mental Health Care is Delivered and Research is Accelerated; and
- Technology is used to Access Mental Health Care and Information.” (*Achieving the Promise*, p. 8)

Recovery and Resilience. In the mental health system of the future, the “transformation must ensure **mental health services and supports actively facilitate recovery, and build resilience to face life's challenges**”.¹ The final report of the commission provides the following definitions of recovery and resilience:

“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. Science has shown that having hope plays an integral role in an individual's recovery.”¹

“Resilience means the personal and community qualities that enable us to rebound from adversity, trauma, tragedy, threats, or other stresses and to go on with life with a sense of mastery, competence, and hope. We now understand from research that resilience is fostered by a positive childhood and includes positive individual traits, such as optimism, good problem-solving skills, and treatments. Closely-knit communities and neighborhoods are also resilient, providing supports for their members” (*Achieving the Promise*, p. 7).

Subsequent to the report of the New Freedom Commission on Mental Health and its core recommendation, the federal Substance Abuse and Mental Health Services Administration (SAMHSA) announced it would offer financial assistance to the states. Incentive grants would be awarded to seven states to plan and implement mental health system transformation.

Transformation in Washington State. Early in 2005, Washington State was awarded one of the Mental Health Transformation State Incentive Grants, more than \$13.5 million dollars over federal fiscal years 2005 through 2009. This grant provides **funds to transform the state's mental health delivery system** from one based on outdated bureaucratic and financial agendas to a system driven by consumer and family needs that focus on promoting recovery and resilience. The Mental Health Division administers this grant and has convened the required Washington State Transformation Work Group to conduct the grant's initial and first year activities:

- To select the name, *Partnerships for Recovery and Resiliency*, for the state's transformation project and adopt a vision statement and goals;
- To install the infrastructure of the grant, including subcommittees, listening sessions across the state, internet survey, and task groups, with all these components contributing to the preparation of a Mental Health Transformation Plan; and
- To submit the plan to the governor on September 1, 2006 and to SAMHSA on September 30, 2006.

Spokane County is actively involved in the state's *Partnerships for Recovery and Resiliency*⁴ project by placing members on the Transformation Work Group, its subcommittees and task teams, hosting local listening sessions, and participating in the state-wide survey.

Reduction or Elimination of Stigma. If Americans are to understand that mental health is essential to overall health and if healthcare professionals are to address mental health with the same urgency and energy as physical health, then stigma must be eliminated. The actions of “**reducing stigma, increasing awareness, and encouraging treatment will create a positive cycle that leads to a healthier population**”.¹ It is well documented that good mental health has positive effects on physical illnesses, including cancer, heart disease, and diabetes. As part of the Transformation State Incentive Grant, Spokane County will be called upon to participate in activities to eliminate stigma.

Mental Health Parity in Washington State. Mental illnesses are as treatable as physical illnesses. Most consumers who have SMI or SED improve when they receive services, with early intervention yielding the best results. Appropriate mental healthcare reduces the need for costly medical treatments, such as hospital and emergency room services. In recognition of these facts, the Washington State legislature passed the Mental Health Parity Law, March 9, 2005. This new statute, now a part of the Revised Code of Washington (RCW), addresses the Legislature's finding that “**it is not cost effective to treat persons with mental disorders differently than persons with medical or surgical disorders**”.⁵ With a three-phase implementation program, the law requires all health benefit plans and insurance coverage in Washington State to be at parity for mental health.

The Mental Health Parity Law is a significant contribution to the healthcare of Washingtonians, and its passage means that Washington State has met one of the New Freedom Commission's goals for a transformed mental health system.

Evidence-Based, Consensus-Based and Promising or Emerging Best Practices. As acknowledged above, the Commission found that there are many effective treatments and creative community-based programs for those who suffer from SMI or SED. Many of these interventions exhibit a proven track record, based on research studies, and these practices are known as evidence-based or research-based practices. Other practices receive their credibility from the agreement of mental health practitioners as to their effectiveness, called consensus-based practices. Some other practices are referred to as promising or emerging best practices, because these have shown potential, but have not yet been adequately studied and supported by research. In a transformed mental health system, **“Americans with mental illnesses will fully benefit from the enormous increases in the scientific knowledge base and the development of many effective treatments”**.¹

Access to Mental Health Services

Transformation of the mental health system cannot occur unless consumers can access the services they need. As previously mentioned, recovery and resilience of individuals requires the availability of services and supports. Defeating the forces of stigma and discrimination against those with SMI and SED will be an empty victory if mental health services cannot be supplied to these individuals. Parity of mental health care with physical health care will yield little benefit without ample, readily available mental health resources. Evidence-based, consensus-based and promising or emerging best practices will be of little benefit to consumers if they cannot obtain such interventions.

This report, *A System-Wide Assessment of Access to Outpatient Mental Health Services in Spokane County*, is dedicated to this most significant characteristic of the mental health system. Indeed, **the purpose of this document is to provide to Spokane County citizens and public and private healthcare systems a study and analysis of access to outpatient mental health services.**

More specifically, *A System-Wide Assessment of Access to Outpatient Mental Health Services in Spokane County*, intended to answer the following specific questions:

- What is the current availability and capacity of outpatient mental health services to meet the needs of Spokane County consumers?
- Can consumers with special needs obtain outpatient mental health services with the same success as consumers without special needs?
- During a community-wide emergency or disaster, what outpatient mental health services would be available for Spokane County consumers?
- Can a list of outpatient mental health providers be developed and supplied to Spokane County's Disaster Response Team?
- Does Spokane County qualify as a Mental Health Professional Shortage Area?

The vision of the New Freedom Commission is that **“everyone with a mental illness at any stage of life has access to effective treatment and supports”**.¹ The partners in this assessment hope their work helps to make the vision of the New Freedom Commission a reality in Spokane County.

Purposes of the Assessment

The primary purpose of this assessment was to map the capacity for access to outpatient mental health services and to identify gaps in ability to access outpatient mental health care by payer type and ability to pay. *The System-wide Assessment of Outpatient Mental Health Providers in Spokane County* attempts to provide clear baseline understanding of the mental health care delivery system. To our understanding, this is the first comprehensive assessment of the entire delivery system in Washington State. More information about other work done in Washington State regarding mental health can be found at <http://www1.dshs.wa.gov/mentalhealth/index.shtml>, but the information is not at the local level and focuses primarily on the Regional Support Network (RSN) system and Medicaid. The partners in this assessment felt it was critical to have local information on the entire system with which to inform our community.

This assessment is part of the effort of Spokane Regional Health District's, Community Health Assessment program to identify and address health disparities. Identifying populations less served helps to guide programs and direct policy. Other reports addressing health disparities in Spokane County can be accessed on the Health District's website at www.srhd.org by following the [data/publications link](#).

A need to develop public health emergency preparedness and response plans highlighted the lack of comprehensive data on the mental health care system and its capacity for providing assistance in an emergency. Through this assessment, the capacity to respond will be identified and then a list of available mental health responders will be developed.

Finally, detailed data on the Spokane County's psychiatric physicians was needed to assess whether all or parts of Spokane County would meet federal designation requirements for a Health Professional Shortage Area (HPSA). The HPSA designation establishes eligibility for the federal loan repayment programs, enhanced Medicare reimbursement for psychiatrists, and helps when applying for various grants.* The Washington State Department of Health Office of Community and Rural Health requires comprehensive inventory data to prepare and submit HPSA designation requests to the Federal Shortage Designation Branch.** This assessment provided the needed data.

* <http://bhpr.hrsa.gov/shortage/>

** For more detailed information on lessons learned and recommendations for future studies, please contact Alicia M. Thompson at athompson@spokanecounty.org or (509) 324-1670.

Respondents and Response Rates

Survey Document

A system-wide survey of the capacity and diversity of outpatient mental health services has been a long-standing need in Spokane County. “System-wide” is defined to mean both privately and publicly funded services. A small workgroup composed of representatives of three local partners who are stakeholders in community health was formed to revise and update an existing version of a mental health provider survey (See Appendix A). The revised draft survey was presented to directors of mental health agencies funded by the Spokane County Regional Support Network (RSN) and to their delegates, who were assigned to a Quality Improvement Team reporting to the RSN. The individual providers working in these agencies are defined as public, RSN-funded providers. Approximately four private, non-RSN funded mental health providers were identified and also asked to review the revised survey. A final survey was developed from the feedback of these two provider groups. The survey, titled Mental Health Outpatient Services Survey (MHOSS) is included in Appendix B. Except for an introduction letter sent by Dr. Kim Thorburn, Health Officer at the Health District, and the opening statement to the survey, the surveys administered to public, RSN-funded providers and to private, non-RSN-funded providers were identical.

Survey Respondents

To achieve the goals of the survey, the staff felt it was necessary to enlist the participation of individual providers who render outpatient mental health services in both the private and public sectors, including psychiatrists, psychologists, mental health counselors, marriage and family therapists, and social workers. Also included were some advanced registered nurse practitioners (ARNP) and registered counselors who could be confirmed as working as outpatient mental health providers. Such mental health professionals comprised the respondents to the MHOSS.

Respondent Identification

A list of active outpatient mental health providers was not readily available for Spokane County, so multiple sources were utilized to create a comprehensive list. Because one purpose of this assessment was to identify the current level of preparedness to respond to a community wide emergency with mental health services, staff obtained a list of licensed, registered and certified mental health workers from the Washington State Department of Health (DOH). The list from the DOH included 1,950 individuals who were either registered counselors (RC, n=1,224), mental health counselors (LH, n=358), marriage and family therapists (LF, n=67), social workers (LW, n=182), and psychologists (PY, n=119). A list of psychiatrists practicing in Spokane County was obtained from the Spokane Physician's Directory*, and these names were added to a list from DOH, creating a comprehensive mental health provider list for Spokane County.

The request to DOH did not include advanced registered nurse practitioners (ARNPs). Psychiatric nurses play a vital role in prescribing medications to individuals with mental illness. Therefore it is important to realize that the only ARNPs included in this survey were those identified by RSN agencies or through means described in the tracking and response rate section.

Within the DOH list, 64 mental health professionals were identified as holding more than one license or certification. Duplicated names were removed, resulting in a list of 1,886 possible mental health practitioners.

Because of limited resources, The Health District did not send surveys to all 1,886 on the list. To maintain the integrity of the assessment, only those mental health providers that could be confirmed as currently practicing were sent the survey. Confirmation of current practice was accomplished in the manner discussed on page 13.

* Spokane Physician's Directory, P.O. Box 30722, Spokane, WA 99223-3010; (509) 532-8096 or (877) 304-5250.

Respondent Tracking and Survey Response Rate

The Health District’s Community Health Assessment staff first identified those practitioners who were working at the public RSN funded agencies. These agencies were divided into two categories: 1) Spokane Mental Health (SMH) and 2) all others; which included 11 separate agencies. Current employee lists were provided by each agency and cross-referenced with the comprehensive mental health provider list. This process resulted in a list of 413 mental health providers, some of whom were NOT on the comprehensive mental health provider list. Individuals NOT on the previously developed comprehensive list, but who were confirmed as providing outpatient mental health services, were added to the list for inclusion in the survey. This process identified SMH as supporting 261 current practitioners, and all other public RSN-funded agencies as supporting 152 mental health providers. Table 1 shows the survey response rate by licensure status and agency type as well as the total response rate for all providers.

The second step involved moving all provider names associated with public, RSN-funded agencies from the comprehensive mental health provider list to a new tracking database. The names remaining on the list potentially comprised all other practicing mental health providers, who were considered to be in the private or non-RSN-funded category. To confirm whether those on the list were currently practicing, staff cross-referenced the names with telephone book yellow pages and business pages, as well as with mental health provider lists from Group Health, Premera Blue Cross, and Asuris health insurance companies; and conducted Internet queries. In this way, 288 individuals on the comprehensive licensed mental health provider list were confirmed to be in current practice. Four of these providers were subsequently found to be no longer in practice or retired, bringing the total private providers to 284. All other practitioners were dropped from the list. Table 1 shows the survey response rate by licensure category and provider funding type.

The survey response results demonstrate striking differences between the public, RSN-funded and the private, non-RSN-funded workforce (See Table 1). The lowest survey response rates by certification category were for private, non-RSN-funded psychologists, licensed social workers, licensed marriage and family therapists, and licensed mental health counselors.

Table 1

Tracking Results for Providers who Responded to the Survey by Provider Type and Licensure Category - N Indicates the Total Number Identified for that Provider Type and Licensure Category

Licensure Category	Provider Type						Total Providers Identified		# of Returned Surveys n
	SMH*		Other RSN		Private - Non-RSN				
	%	of N	%	of N	%	of N	%	of N	
Marriage and Family Therapist	100.0	4	100	2	37.5	24	50.0	30	15
Mental Health Counselors	90.6	32	73.9	23	46.5	114	58.6	169	99
Social Workers	75.0	8	91.7	12	35.3	34	53.7	54	29
Psychiatrists**	57.1	7	NA***	NA	83.9	31	78.9	38	30
Psychologists	100.0	7	75.0	4	34.3	67	42.3	78	33
Registered Counselor	88.5	122	90.5	74	42.9	14	86.2	210	181
Unknown/Other	75.3	81	100	37	NA	NA	83.1	118	98
Total	83.9	261	90.1	152	45.1	284	69.6	697	485

*Note: SMH = Spokane Mental Health

**Note: Psychiatrists in the Private-Non RSN category include those working for the Veterans Administration, Sacred Heart Medical Center or Deaconess Hospitals.

***Note: NA = no providers of this category were identified for that type of provider.

In order to ensure responses were from providers of outpatient mental health services, two separate questions were asked; the percentage of their practice devoted to providing direct outpatient mental health care and the number of hours per week spent providing direct outpatient mental health care. Respondents who reported either 0% of their practice was devoted to outpatient care or that they spent 0 hours per week providing outpatient care were excluded from the analysis. A total of 61 returned surveys were excluded leaving a total of 424 surveys from outpatient mental health care providers. Survey results only include the 424 respondents who indicated they currently provided outpatient mental health care. Table 2 shows the distribution by major provider category and type.

Survey respondents were grouped into four types of provider: 1) psychiatrists, 2) psychologists, 3) other providers, and 4) multiple provider or group respondent. The other provider type includes all other types of providers. The multiple provider or group respondent includes respondents that provided information for their entire agency. The eight group responses are reported separately from the others.

Respondents were also grouped into two categories of provider: 1) public RSN-funded providers, or 2) private non-RSN-funded providers. RSN-funded providers include the twelve community mental health agencies providing public, non-profit mental health services. The non-RSN-funded providers include the two hundred, eighty-four practitioners some providing private, for-profit mental health services and others who provided services for non-profit or government agencies (Veteran's Administration) but who do not receive funding from the RSN.

Table 2
Distribution of Survey Respondents who were Out Patient Providers of Mental Health Services by Major Provider Category and Provider Type

Provider Category	Provider Type				Total MH System	
	RSN-Funded		Private - Non-RSN-Funded		% Yes	N
	% Yes	N	% Yes	N		
Psychiatrists	1.3%	4	10.3%	12	3.8%	16
Psychologists	1.3%	4	18.8%	22	6.1%	26
Other Providers	96.4%	296	66.7%	78	88.2%	374
Group Response	1.0%	3	4.3%	5	1.9%	8
Total	100%	307	100%	117	100%	424

Survey Administration

Survey Software

Surveys were created using TeleForm software that allows surveys to be scanned, then verified and exported directly into the Statistical Package for the Social Sciences (SPSS). TeleForm also allows the survey to be exported into an HyperText Markup Language (HTML) format for electronic data collection.

Distribution to Public RSN-Funded Providers

RSN-funded agencies were given packets for the number of mental health providers they had indicated were working at their agencies. Each packet consisted of 1) a return self-addressed stamped envelope, 2) a letter from Dr. Kim Thorburn, and 3) a hard copy of the survey. A representative from each public agency was designated as the contact person for that agency, and served as the liaison between the Community Health Assessment program and individual respondents at the public agencies. The agency liaison ensured the survey packets were distributed to participating respondents, and was responsible for following up with participants, as needed. The survey was not anonymous as the content was not personal, allowing staff to track those who had and had not returned the survey. However, confidentiality of the individual's responses was insured.

Distribution to Private Non-RSN-Funded Providers

Private providers were mailed a packet of materials similar to that for the RSN-funded providers. Survey packets returned with a corrected address were resent to the new address. A reminder postcard was mailed to providers who had not responded approximately three weeks after the initial mailing.

Electronic Format Option

All participants had the option of following an Internet link to fill out the survey in its electronic format online. Few respondents ($n = 20$) chose this option for returning their survey. This electronic option seemed to cause confusion as a number of respondents returned multiple electronic surveys. In these instances, the most complete survey was kept and duplicates were deleted.

Increasing Private Non-RSN-Funded Provider Response Rate

Approximately three months after the private provider survey had been distributed, it was necessary to enhance efforts to increase the response rate, particularly from psychiatrists (required for Mental Health Professional Shortage Area designation). The Health District's Public Health Liaisons from the Disease Prevention and Response Division placed telephone calls to psychiatrists who had not yet responded to the survey request. An effort was made to begin calling other providers, including psychologists, the second priority group. However, due to time and resource limitations, this process was not completed prior to discontinuing data collection efforts.

The personal calls made to psychiatrists dramatically increased the response rate for this group of mental health providers. Prior to the calls, 10 psychiatrists had responded. The personal calls resulted in completion of an additional 12 surveys. Five of these surveys reported information for multiple psychiatrists.

Group Respondents

While the majority of respondents answered for their individual practice, there were five private and three RSN-funded agency respondents who provided information for their entire agency. The eight group responses were separated into their own category for analysis.

Key Findings - Survey Results and Estimated Direct Patient Care Capacity

Two methods were used to describe Spokane's Mental Health System. The tables and sections with “Survey Respondents” in the title summarize the responses of the 424 mental health providers who responded to the survey. This is the best representation of how the Spokane Mental Health providers responded to the survey and how they perceive their role in the mental health system.

The DOH Office of Community and Rural Health used the survey data to estimate and describe the capacity and structure of the entire system and capacity for providing direct outpatient care using methods developed for Health Professional Shortage Area designation. These estimates include information on both respondents and non-respondents. These estimates were developed using a two stage process.

1. Survey data and lists of non-responding providers were combined. Survey respondents who did not report they provided direct patient care and non-respondents where there was evidence they were not active or providing direct patient care or in a few cases duplicate entries were deleted. This accounts for the difference in the Survey Sample (n=697) in Table 1 and the estimated number of providers in direct patient care (652) in Table 4. Providers with more than one credential were coded to credential that reflected the highest level of training. For example a Licensed Marriage and Family Therapist (LMFT) who also was a Registered Counselor was coded as a LMFT. This was done to provide a gauge of the overall capacity
2. Respondent data on the hours of direct patient care was cleaned to remove outlying values (over 50 hours of direct patient care) or survey responses representing multiple providers. Hours of direct patient care for non-respondents and respondents with missing data were estimated using averages for similar credentials and organization. A similar process was used to estimate payer shares.

Estimates may provide a more comprehensive perspective of the overall system capacity than the survey respondent results, in the sense that the total number of mental providers is between 650 and 700 as opposed to the number of respondents (424), it is important to be aware that the “extrapolation” process relied heavily on the analysts judgment and assumptions to resolve conflicting responses and fill in missing data. The amount error introduced by inappropriate judgments or through bias can not be known with any certainty. Areas with the least survey data to extrapolate from and the most likely bias are non-RSN providers and the payer mix data for all providers.

The extrapolated data can be viewed as the “best available ballpark estimate” of what the entire system for mental health outpatient care may look like. The survey results and the extrapolated data (which were developed independently of each other) provide alternative and complementary windows into Spokane's Capacity to provide direct outpatient care for mental health.

Education and Credentials

Question one of the MHOSS asked respondents to indicate their education and credentials by marking all of the options that apply. Both private and RSN-funded agencies employed mental health providers with a wide range of educational levels and credentials. Table 3 shows the percentage and number of respondents for each education/credential category for both public and private sectors. These percentages do not add up to 100% because many providers have multiple educational degrees and credentials.

This table also shows there are major differences in the credentials and educational levels reported by RSN-funded providers and private non-RSN-funded providers. RSN-funded providers are more likely to report they are registered counselors, while non-RSN-funded providers are more likely to report they are licensed mental health counselors. Currently, to become a registered counselor in Washington State an individual must submit an application and provide documentation that he or she has attended an approved HIV/AIDS training class. The registration of an individual “does not include a recognition of any practice standards, nor necessarily imply the effectiveness of any treatment”.⁶ Licensure indicates the individual has passed a state examination.

The issue of the predominance of “registered counselors” in the RSN system is potentially sensitive and could be read to mean they use less trained personnel. Part of the difference may be due to differences in the type of work done. For example, the non-RSN system, especially the privates may be more likely to be providing counseling services and therapy, whereas RSN providers may be more engaged in “case management” activities.

Table 3

Percentage and Number of Survey Respondents by Provider type for Credential and Educational Level Reported

Credential/Educational Level	Provider Type				Total	
	RSN-Funded (n = 307)		Private - Non-RSN-Funded (n = 117)			
	%	n	%	n	%	N
Psychiatrist	1.3	4	11.1	13	4.0	17
Physician's Assistant	0.0	0	0.9	1	0.2	1
Psychologists (Ph.D.)	1.3	4	19.7	23	6.4	27
Psychologists (Psy.D.)	0.0	0	0.9	1	0.2	1
Psychology Intern	1.0	3	0.0	0	0.7	3
Advanced Registered Nurse Practitioner (ARNP)	2.3	7	0.9	1	1.9	8
Registered Nurse	7.8	24	2.6	3	6.4	27
Licensed Practical Nurse	1.0	3	0.9	1	0.9	4
Licensed/Certified Social Worker (LCSW)	2.9	9	9.4	11	4.7	20
Licensed Social Worker	5.9	18	8.5	10	6.6	28
Licensed/Certified Master's Degree	10.7	33	24.8	29	14.6	62
Licensed Marriage and Family Therapist	2.6	8	17.1	20	6.6	28
Licensed Mental Health Counselor	20.2	62	47.9	56	27.8	118
Master's Level Intern	5.5	17	0.0	0	4.0	17
Chemical Dependency Mental Health Professional (CDMHP)	5.5	17	0.0	0	4.0	17
Chemical Dependency Counselor (CDC)	2.3	7	6.0	7	3.3	14
School Counselor	1.3	4	1.7	2	1.4	6
Certified Peer Counselor	2.0	6	0.0	0	1.4	6
Registered Counselor	39.1	120	4.3	5	29.5	125
Bachelors Degree Practitioner	24.1	74	0.0	0	17.4	74
Other Educational Credentials	16.9	52	9.4	11	14.9	63

*Note: Percentages do not add up to 100% as credentials and educational level are not mutually exclusive and respondents were asked to choose all categories that applied for them

Estimated Workforce Distribution of “Primary” Credentials Including Non-Respondents

Table 4 shows the estimated distribution of the primary credentials found in the mental health system. Estimates are for distributions within a credential across provider type, public RSN-funded versus private non-RSN-funded systems, and for the total mental health workforce in Spokane County.

“Advanced degree” practitioners (psychiatrists, psychologists) are more likely to be located in the private non-RSN-funded system. Likewise, licensed marriage and family therapists (LMFT) and licensed mental health counselors (LMHC) are more common in the private non-RSN funded system. Licensed/certified masters practitioners (LMAP), registered counselors (RCs) and bachelors prepared counselors (BAP) and registered & bachelors prepared counselors (RCPC), are more common in the RSN funded system.

Table 4

Estimated Distribution of Total Spokane County Workforce by Provider Type and Licensure Category - N Indicates the Total Number Identified as Providing Out Patient Mental Health Care for that Provider Type and Licensure Category

Licensure Category	Provider Type								% of Total MH Workforce
	Public RSN-Funded		Private - Non-RSN-Funded		Veterans Admin		Total Providers Identified		
	%	N	%	N	%	N	%	N	
Psychiatrists	21.1	4	68.4	13	10.5	2	100.0	19	2.91
Psychologists	13.0	10	87.0	67	0	0	100.0	77	11.81
Resident/Intern	100.0	14	0.0	0	0	0	100.0	14	2.15
Advanced Registered Nurse Practitioner (ARNP)	90.9	10	9.1	1	0	0	100.0	11	1.69
Registered Nurse	100.0	32	0.0	0	0	0	100.0	32	4.91
Licensed/Certified Social Worker (LCSW)	51.9	27	48.1	25	0	0	100.0	52	7.97
Licensed Marriage and Family Therapist (LMFT) - Licensed Mental Health Counselor (LMHC)	36.3	74	63.7	130	0	0	100.0	204	31.3
County Designated Mental Health Professional (CDMHP)	100.0	8	0.0	0	0	0	100.0	8	1.23
Licensed/Certified Masters Degree Practitioner (LMAP)	85.7	12	14.3	2	0	0	100.0	14	2.15
Registered Counselor (RC)	90.5	105	9.5	11	0	0	100.0	116	17.78
Bachelors Prepared Counselor (BAP) - Registered and Bachelors Prepared Counselor (RCPC)	100.0	55	0.0	0	0	0	100.0	55	8.44
Multiple Provider	37.5	3	50.0	4	12.5	1	100.0	8	1.23
Other Providers	69.1	29	30.9	13	0	0	100.0	42	6.43
Total	58.7%	383	40.8%	266	0.5%	3	100.0%	652	100.0%

*Note; SMH = Spokane Mental Health

**Note; Psychiatrists in the Private-Non RSN category include those working for the Veterans Administration, Sacred Heart Medical Center or Deaconess Hospitals.

***Note; NA = no providers of this category were identified for that type of provider.

Provider Type and Category

The survey respondents were grouped into four provider types: 1) psychiatrists, 2) psychologists, 3) other providers, and 4) multiple provider or group respondent. The “other providers” includes all other types of providers listed in Table 3. Respondents were also grouped into two categories of providers: 1) public RSN-funded providers, or 2) private non-RSN-funded providers. As mentioned previously the private non-RSN-funded providers includes responses from individuals providing services in non-profit and governmental agencies. The remaining survey results will be reported using these provider types and categories for comparison purposes.

Survey Results - Hours of Outpatient Client and Clinician Mental Health Care Provided

Question four of the MHOSS asked respondents to estimate the number of hours of direct outpatient client and clinician mental health care they provided each week. These hours did not include hours of service provided in inpatient settings and excluded time spent doing administrative paperwork, training, and/or supervision.

Table 5 shows the mean hours per week spent providing outpatient mental health services with standard deviations reported for each provider category and by RSN-funded or private non-RSN-funded providers. There was a significant difference between the average number of hours provided by public RSN-funded and private non-RSN-funded psychologists ($t = 2.11, p = .045$).

Table 5

Mean Hours per Week of Direct Outpatient Mental Health Care (\pm SD) by Provider Category and Type. Differences Are Tested by Independent Samples t-Test.

Provider Category	Provider Type						df	t	p
	RSN-Funded			Private Non-RSN-Funded					
	Mean Hrs per Wk	n	SD	Mean Hrs per Wk	n	SD			
Psychiatrists	23.0	4	12.1	24.8	11	14.1	13	0.227	0.824
Psychologists	12.8	4	8.5	26.1	22	12	24	2.11	0.045*
Other Providers	20.8	293	9.4	22.6	78	10.2	369	1.58	0.116
Group Response	116.0	3	46.1	265	5	344.9	6	0.721	0.498

* $p < .05$

Estimated Total Direct Patient Care Capacity by Primary Credential

To adjust for differences in the amount of self-reported hours of direct care among providers, time was standardized to Full-Time Equivalents (FTEs), where 1 FTE equals forty hours of direct patient care. Its important to understand that 1 FTE is not a standard for how much direct care we can expect, but simply a method to enable “apples to apples” comparisons adjusting for less than full-time work and time not available for providing direct care. As shown in Table 6, the 652 providers identified in the Spokane Mental Health system reported 397 FTEs of care. With FTE adjustments, the RSN’s share of total provider capacity decreases from 59% (Table 4) to 53%. As noted earlier, these calculations may be affected by differences in response rates between the RSN and non-RSN system. Even with that accounted for; a fairly significant share of mental health provider capacity in Spokane County is outside the RSN-funded system.

Taken as a whole the entire mental health system yields .61 FTEs for each provider (397/652). This finding is generally consistent with the survey data reported in Table 5. At an individual provider level 24 hours of direct patient care equals .6 FTE, and similar to Table 5 the average amount of direct patient care differs by provider credential. With the exception of residents and interns, the ratios range between .55 and .65.

The amount of time in direct patient care per provider in the mental health system (.6 FTE) appears to be lower than what the DOH Office of Community and Rural Health has observed in capacity analyses for primary care physicians (.9) or physician assistants and ARNPs (.75)*. There are several possible explanations for this which may bear further examination. The structure of workload may differ in that mental health providers have responsibility for, or are required to do more administrative tasks. The intense and stressful nature of working directly with patients in crisis may preclude full time direct patient care.

Table 6

Estimated Composition of the Mental Health Workforce in Spokane County Adjusted to Full-Time Equivalencies - 1 FTE = 40 Hours of Direct Patient Care by Provider Credential and Type

Provider Credential	Provider Type			
	RSN-Funded	Private-Non-RSN-Funded	Veterans Admin	Total MH System
	FTE	FTE	FTE	FTE
Psychiatrists	2.3	8.4	1.1	11.8
Psychologists	4.0	43.3		47.4
Resident/Intern	4.8			4.8
Advanced Registered Nurse Practitioner (ARNP)	5.6	0.5		6.1
Registered Nurse	17.8			17.8
Licensed/Certified Social Worker (LCSW)	12.5	15.2		27.7
Licensed Marriage and Family Therapist (LMFT) - Licensed Mental Health Counselor (LMHC)	36.4	68.1		104.5
County Designated Mental Health Professional (CDMHP)	4.6			4.6
LMAP	6.8	0.03		6.8
Registered Counselor (RC)	60.2	7.2		67.5
Bachelors Prepared Counselor (BAP) - Registered and Bachelors Prepared Counselor (RCPC)	31.4			31.4
Multiple Provider	8.7	11.1	22	41.8
Other Providers	15.4	9.2		24.7
Total FTE	210.5	163.03	23.1	396.8
Percentage of Total FTE	53.0%	41.1%	5.8%	100%

* Primary Care Capacity Studies are available at <http://www.doh.wa.gov/hsqa/ocrh/har/hcresrch.htm>

Estimated Direct Patient Care Capacity by Payer

The payer mix for the Mental Health System in Spokane County was estimated by multiplying FTE by reported and estimated payer shares. Payer mix data should be interpreted with caution since in addition to missing data from non-respondents, data from respondents posed several challenges. Many respondents did not provide payer share information. There was evidence that RSN providers were not always aware of payer mix.** It is likely that Federal Block Grant and Other State Grant dollars were underestimated. Reported Medicaid shares for the RSN system are roughly in line with state-wide estimates of funding for the seriously mentally ill (SMI) and seriously emotionally disturbed (SED) population (89%) reported in the Washington's Mental Health Transformation State Improvement Grant proposal.⁴ Medicare fee for service (FFS) shares may be underestimated in both the RSN and non-RSN providers. But low Medicare managed care shares are consistent with the lack of Medicare managed care presence in the Spokane market. Much of the sliding fee schedule capacity for the non-RSN- funded providers is likely to be “cash discount” from walk-in business and not necessarily “pro bono” or care for the uninsured.

Although we expect the estimates reported here may be imprecise, the important message of this data is that providers outside the RSN contribute significant mental health capacity to the overall system. At the same time much of capacity outside the RSN system is not available to the special needs population. While Medicaid is the largest payer, this data suggests, that when the entire mental health delivery system is considered, Medicaid finances between 50 to 60% of mental health capacity.

Other studies conducted by the Washington State Department of Health, Office of Community and Rural Health, looking at primary care service and payer structure have found major differences by market. Differences in mental health services and financing among markets could also be dramatic.

Table 7

Estimated Total Spokane County Mental Health Provider Capacity by FTE and by Percentage of Payer Distribution

Payer Category	Provider Type					
	RSN-Funded		Private Non-RSN-Funded		Total MH System	
	FTE	%	FTE	%	FTE	%
Employers Insured	4.9	2.3	103.6	62.6	110.7	29.2
Medicaid Fee for Service	169.8	80.2	3.5	2.1	173.3	45.7
Medicaid Healthy Options	14.6	6.9	10.7	6.5	25.3	6.7
Medicare Fee for Service	5.3	2.5	12.4	7.5	17.6	4.6
Medicare Managed Care	0.4	0.2	1.2	0.7	1.5	0.4
Basic Health Plan	3.4	1.6	11.8	7.1	15.2	4
Other State Grants	2.7	1.3	5.9	3.6	8.8	2.3
Federal Block Grant	6.1	2.9	0.6	0.4	6.6	1.7
Sliding Fee Discount	4.5	2.1	15.7	9.5	20.4	5.4
Total	211.7	100.0	165.4	100.0	379.4	100.0

** For example providers in the same facility, with the same credential, serving the same population with very different payer profiles. For more detailed information on lessons learned and recommendations for future studies please contact Alicia M. Thompson at athompson@spokanecounty.org or (509) 324-1670.

Survey - Pro Bono Care

Survey respondents were asked to report the approximate percentage of their current patients whose cost was charged to uncompensated care (pro bono). It is important to distinguish between providing care to the uninsured which is mostly provided by RSN-funded agencies through state and federal block grants and uncompensated care. The non-RSN-funded providers offer additional capacity by providing more overtly “pro-bono” care to those who can not afford mental health services.

Private practice non-RSN-funded psychiatrists, account for most of the uncompensated care offered in Spokane County with an average of 13.7% of current patients currently receiving services on a pro bono basis (See Table 8.). The “other provider” type was the only type in the public system that reported providing uncompensated care, however, the number of respondents (n = 106) and the percentage of patients (2.5%) was small.

Table 8

Mean Percentage of Current Patients Who's Cost is Charged to Uncompensated Care (Pro Bono)*

Provider Category	Provider Type								
	RSN-Funded			Private - Non-RSN-Funded			MH System Total		
	Mean %	SD	N	Mean %	SD	N	Mean %	SD	N
Psychiatrists	-	-	-	13.7	30.7	10	13.7	30.7	10
Psychologists	0.0	0.0	1	6.8	7.9	20	6.5	7.8	21
Other Providers	2.5	10.4	106	7.3	16.9	72	4.4	13.6	178
Group Response	-	-	-	3.0	2.4	4	3.0	2.4	4

* Note: The N in this table represents the number of respondents who indicated they provided uncompensated care.

Caseload Constituencies and Ability to Provide Care

Specific Populations

Question six of the MHOSS asked respondents to provide the approximate percentage of their caseloads constituted by the following populations; 1) adults, 2) families, 3) couples, 4) adolescents, 5) children, and 6) elders/seniors. Table 9 shows the mean percentage and standard deviation of the caseload devoted to the specific population by provider category and type. Percentages do not add up to 100% because the categories are not mutually exclusive.

Adults comprised more than 50% (mean percentage) of the caseloads for both RSN-funded and non-RSN-funded providers, both systems report a similar mean percentage of caseloads in families and adolescents. The RSN-funded system is more likely to serve children and seniors, while the non-RSN-funded system is more likely to serve couples.

Table 9

Mean Percentage of Caseload Devoted to Specific Populations by Provider Category and Type

Specific Pop Provider Cat	Provider Type					
	RSN-Funded		Private - Non-RSN-Funded		Total MH System	
	Mean % of Caseload	SD	Mean % of Caseload	SD	Mean % of Caseload	SD
Adults						
Psychiatrists	83.8	29.3	66.4	26.9	70.8	27.6
Psychologists	24.3	48.5	63.5	27.3	57.5	33.4
Other Providers	51.3	42.3	53.7	27.4	51.8	39.6
Group Response	60.0	56.6	73.0	19.9	69.3	28.9
Adults - Total	51.5	42.4	57.7	27.4	53.2	38.8
Families						
Psychiatrists	0.0	0.0	8.8	28.7	6.6	24.9
Psychologists	23.8	41.1	3.2	6.3	6.3	17.1
Other Providers	8.9	19.8	10.2	19.2	9.2	19.7
Group Response	7.5	10.6	4.0	5.5	5.0	6.5
Families - Total	9.0	20	8.5	18.5	8.8	19.6
Couples						
Psychiatrists	0.0	0.0	1.3	3.1	<1	2.7
Psychologists	0.0	0.0	8.3	10.6	7.0	10.2
Other Providers	<1	2.8	15.4	15.9	3.9	9.7
Group Response	7.5	10.6	10.0	17.3	9.3	14.8
Couples - Total	0.8	2.9	12.3	14.8	4.1	9.7
Adolescents						
Psychiatrists	6.3	12.5	9.4	22.7	8.6	20.2
Psychologists	10.8	16.3	10.0	8.9	10.1	9.9
Other Providers	12.2	21.9	12.1	14.3	12.2	20.6
Group Response	10.0	14.1	9.0	8.9	9.3	9.3
Adolescents - Total	12.1	21.7	11.3	14.2	11.8	19.9
Children						
Psychiatrists	6.3	12.5	7.9	21.9	7.5	19.6
Psychologists	41.3	45.9	11.6	17.7	16.2	25.2
Other Providers	17.2	27.4	7.2	11.3	15.1	25.2
Group Response	5.0	7.1	5.4	8.4	5.3	7.5
Children - Total	17.3	27.5	8.0	13.9	14.7	24.8
Seniors						
Psychiatrists	3.8	4.8	14.6	9.4	11.9	9.6
Psychologists	0.0	0.0	7.1	7.1	6.0	7.0
Other Providers	10.3	25.6	2.9	4.3	8.7	23.0
Group Response	10.0	14.1	10.6	9.3	10.4	9.6
Seniors - Total	10.1	25.2	5.3	6.9	8.7	21.8

*Note: Percentages do not add up to 100% as caseloads are not mutually exclusive and respondents were asked to report percentage of caseload all categories that applied for them.

Co-Occurring Disorders, Homeless, and Migrant Populations

Providers were asked to estimate the percentage of their caseload that met certain criteria. These criteria included: 1) co-occurring mental health and substance abuse disorders (COD), 2) homelessness, and 3) being a migrant farm worker. Table 10 shows the estimated percentage of clients by provider type with the particular issue.

Providers in the RSN-funded system reported a greater mean percentage of caseload having co-occurring disorders or being homeless. Providers in both systems reported less than 1% of their caseloads were devoted to serving migrant populations.

Table 10

Mean Percentage of Caseload Devoted to Serving Co-occurring Disorders, Homeless and Migrant Populations by Provider Category and Type

Specific Pop Provider Cat	Provider Type					
	RSN-Funded		Private - Non-RSN-Funded		Total MH System	
	Mean % of Caseload	SD	Mean % of Caseload	SD	Mean % of Caseload	SD
Co-occurring Disorders						
Psychiatrists	42.5	17.1	36.0	25.7	37.9	23.1
Psychologists	26.7	41.9	21.3	21.6	21.9	23.6
Other Providers	38.3	30.4	24.6	22.0	35.4	29.3
Group Response	63.3	16.1	38.0	28.0	47.5	26.3
COD - Total	38.5	30.3	25.6	22.6	34.9	28.9
Homeless						
Psychiatrists	10.0	4.1	3.5	7.4	5.1	7.2
Psychologists	1.3	2.5	2.5	6.6	2.3	6.2
Other Providers	13.6	22.3	2.2	7.5	11.3	20.6
Group Response	21.7	15.3	3.6	4.2	10.4	12.8
Homeless - Total	13.5	22	2.5	7.2	10.5	19.7
Migrant Farm Workers						
Psychiatrists	0.0	0.0	1.3	3.1	<1	2.7
Psychologists	0.0	0.0	0.0	0.0	0.0	0.0
Other Providers	<1	1.9	<1	0.6	<1	1.7
Group Response	7.0	11.3	0.0	0	2.6	7.0
Migrant Farm Wkrs - Total	0.5	2.2	0.2	1.1	0.4	1.9

Special Needs Populations

There are certain populations within Spokane County that may have a greater difficulty accessing mental health care due to developmental disabilities, traumatic brain injuries, veteran status, co-occurring mental health and substance abuse disorders, English as a second language, or hearing impairments. Providers were asked to tell us if they served individuals with these special needs, and whether or not they had a consumer referral source for the issues they were unable to serve.

Table 11 shows the percentage of providers who said they served each of the special need categories. The data show that provision of mental health care in the private sector to the hearing, impaired and those who speak English as a second language, is a significant issue.

Table 11

Percentage of Providers Who Reported They Served Individuals with Special Needs by Need and Provider Category and Type

Special Need Provider Cat	Provider Type					
	RSN-Funded		Private - Non-RSN-Funded		Total MH System	
	% Yes	N	% Yes	N	% Yes	N
Developmental Disabilities						
Psychiatrists	100.0	4	50.0	12	62.5	16
Psychologists	50.0	4	50.0	22	50.0	26
Other Providers	83.4	296	33.3	78	73.0	374
Group Response	100.0	3	0.0	5	37.5	8
DD - Total	83.4	307	36.8	117	70.5	424
Traumatic Brain Injuries						
Psychiatrists	100.0	4	58.3	12	68.8	16
Psychologists	50.0	4	54.5	22	53.8	26
Other Providers	59.1	296	14.1	78	49.7	374
Group Response	100.0	3	20.0	5	50.0	8
TBI - Total	59.9	307	26.5	117	50.7	424
Veterans						
Psychiatrists	50.0	4	50.0	12	50.0	16
Psychologists	0.0	4	63.6	22	53.8	26
Other Providers	52.4	296	48.7	78	51.6	374
Group Response	100.0	3	20.0	5	50.0	8
Veterans -Total	52.1	307	50.4	117	51.7	424
Co-occurring Disorders						
Psychiatrists	100.0	4	75.0	12	81.3	16
Psychologists	50.0	4	68.2	22	65.4	26
Other Providers	89.2	296	73.1	78	85.8	374
Group Response	100.0	3	60.0	5	75.0	8
COD - Total	88.9	307	71.8	117	84.2	424
English as a 2nd Language						
Psychiatrists	75.0	4	33.3	12	43.8	16
Psychologists	0.0	4	31.8	22	26.9	26
Other Providers	57.4	296	12.8	78	48.1	374
Group Response	100.0	3	20.0	5	50.0	8
ESL - Total	57.3	307	18.8	117	46.7	424
Hearing Impaired						
Psychiatrists	75.0	4	25.0	12	37.5	16
Psychologists	0.0	4	18.2	22	15.4	26
Other Providers	60.8	296	15.4	78	51.3	374
Group Response	100.0	3	40.0	5	62.5	8
Hearing Imprd - Total	60.6	307	17.9	117	48.8	424

The question asking providers whether or not they had a referral source for clients with special needs they were not able to accommodate, was a blanket question that covered all of the conditions listed. Therefore, there is no way to identify the conditions for which respondents did or did not have a referral source. It was unknown at the time the survey was created that such a disparity in the provision of care to individuals with these special needs would be found. Table 12 shows the results to this question.

Table 12

Percentage of Providers Who Reported They had A Referral Source for Those Individuals with Special Needs They DID NOT Serve

Provider Category	Provider Type				Total MH System	
	RSN-Funded		Private - Non-RSN-Funded		% Yes	N
	% Yes	N	% Yes	N		
Psychiatrists	75.0	4	30.0	10	42.9	14
Psychologists	75.0	4	55.0	20	50.0	26
Other Providers	79.8	253	49.3	69	73.0	374
Group Response	50.0	2	66.7	3	62.5	8

Serving Suicidal Consumers

The provision of effective mental health services to suicidal consumers is a critical need in Spokane County. The rate of attempted suicide for all ages in Spokane County is consistently higher than that for Washington State's general population. Some age categories have particularly high attempt rates and completion rates. The QPR Institute* assisted in the development of a question to be included in the survey. Question number 11 of the MHOSS asked respondents if they were prepared to accept, assess, manage and treat suicidal consumers. Most respondents, regardless of provider and agency type, believed they were prepared to provide care to suicidal consumers. Table 13 presents the results of this question by provider category and type.

The results shown in table 13 are not reflective of the data collected by the QPR Institute. In an effort to identify the extent of knowledge and skill among mental health providers in dealing with suicide, suicide the QPR Institute offers an online survey. The consistent finding from the QPR Institute survey is that mental health professionals in general do not have adequate knowledge and skill to provide care to suicidal consumers.

Table 13

Percentage of Providers Who Reported They Were Prepared to Accept, Assess, Manage and Treat Suicidal Consumers

Provider Category	Provider Type				Total MH System	
	RSN-Funded		Private - Non-RSN-Funded		% Yes	N
	% Yes	N	% Yes	N		
Psychiatrists	100.0	4	75.0	12	81.3	16
Psychologists	75.0	4	77.3	22	76.9	26
Other Providers	92.4	288	79.5	78	89.6	366
Group Response	100.0	3	80.0	5	87.5	8

* The QPR Institute is nationally known and offers comprehensive suicide prevention training programs, educational and clinical materials for the general public, professionals, and institutions. To learn more about the QPR institute go to www.qprinstitute.com.

The providers who said “yes”, they were prepared to accept, assess, manage and treat suicidal consumers were also asked to record how many suicidal clients per month they were prepared to serve and if there was a waiting list for their suicidal consumers. Private non-RSN-funded provider responses ranged between 1 and 20 suicidal clients per month. Responses from public RSN-funded providers ranged between 1 and 999, with 24 RSN-funded agency respondents reporting they were able to serve 25 or more suicidal clients per month. *(These results produce highly improbable numbers for how many suicidal clients are seen by RSN-funded agency providers)*. Although the ranges differed between RSN-funded and non-RSN-funded providers, 88% of the all providers said there was not a waiting list for consumers. Table 14 provides the mean number of suicidal clients per month by provider type and category.

Table 14

Mean Number of Suicidal Clients the Respondents Reported they Were Prepared to Accept, Assess, Manage and Treat per Month

Provider Category	Provider Type								
	RSN-Funded			Private - Non-RSN-Funded			Total MH System		
	Mean # per Month	SD	N	Mean # per Month	SD	N	Mean # per Month	SD	N
Psychiatrists	14.0	6.9	4	12.8	7.0	5	13.3	6.6	9
Psychologists	1.0	0.0	2	3.7	2.8	17	3.4	2.8	19
Other Providers	18.4	77.3	188	3.5	2.4	54	15.1	68.4	242
Group Response	40.0	49.5	2	15.0	7.1	2	27.5	32.3	4

Mental Health Disaster/Critical Incident Response Readiness

As wave after wave of natural disasters hit the United States in 2005, it became all too apparent that communities are not prepared to respond to widespread disasters or critical incidents. The Health District continues to work with community stakeholders on emergency preparedness. One factor in responding to a disaster or critical incident is the ability to provide care for the mental health needs of the victims.

In an effort to identify the level of mental health preparedness that exists in Spokane County, the MHOSS included a series of preparedness questions. The first question asked: “Does your agency/practice have policies and procedures in place that address how you would respond to a Critical Incident/Disaster in Spokane County?” The results indicate a lot of work needs to be done in this area, with both private and public providers of mental health services. Fewer than half of the respondents in each provider type and category, except psychiatrists in the RSN-funded system, reported having such policies and procedures in place. Table 15 shows the percentage of respondents who said “yes” they had policies and procedures in place by provider type and category.

Table 15
Percentage of Providers Who Reported They had Policies/Procedures in Place for Responding to a Critical Incident/Disaster

Provider Category	Provider Type					
	RSN-Funded		Private - Non-RSN-Funded		Total MH System	
	% Yes	N	% Yes	N	% Yes	N
Psychiatrists	50.0	4	33.3	12	37.5	16
Psychologists	0.0	4	9.1	22	7.7	26
Other Providers	46.2	288	20.5	78	40.7	366
Group Response	33.3	3	40.0	5	37.5	8

In addition to identifying whether policies and procedures were in place for the agencies and practices, the survey also collected information about the types of mental health services that would be available during a community wide disaster or emergency. Table 16 (page 29) shows the percentage of respondents who indicated they would be able to provide particular services in such situations.

Table 16

Percentage of Providers Who Reported They or Their Agency Would be able to Provide Specific Services During a Community Wide Disaster or Emergency

Specific Service Provider Cat	Provider Type					
	RSN-Funded		Private - Non-RSN-Funded		Total MH System	
	% Yes	N	% Yes	N	% Yes	N
Mental Health Response Team						
Psychiatrists	50.0	4	41.7	12	43.8	16
Psychologists	0.0	4	31.8	22	26.9	26
Other Providers	26.0	296	35.9	78	28.1	374
Group Response	0.0	3	60.0	5	37.5	8
MH Resp Team - Total	25.7	307	36.8	117	28.7	424
Crisis Incident Stress Debriefing						
Psychiatrists	25.0	4	25.0	12	25.0	16
Psychologists	0.0	4	40.9	22	34.6	26
Other Providers	22.3	296	55.1	78	29.1	374
Group Response	0.0	3	60.0	5	37.5	8
CISD - Total	21.8	307	49.6	117	29.5	424
Crisis Incident Stress Management						
Psychiatrists	25.0	4	33.3	12	31.3	16
Psychologists	0.0	4	45.5	22	38.5	26
Other Providers	23.0	296	53.8	78	29.4	374
Group Response	0.0	3	40.0	5	25.0	8
CISM - Total	22.5	307	49.6	117	29.9	424
Outreach/Mobile Capacity						
Psychiatrists	25.0	4	0	12	6.3	16
Psychologists	0.0	4	13.6	22	11.5	26
Other Providers	16.9	296	25.6	78	18.7	374
Group Response	0.0	3	20.0	5	12.5	8
Outreach/Mobile - Total	16.6	307	20.5	117	17.7	424
24 Hour Telephone Response						
Psychiatrists	50.0	4	25	12	31.3	16
Psychologists	25.0	4	18.2	22	19.2	26
Other Providers	30.7	296	28.2	78	30.2	374
Group Response	0.0	3	40.0	5	25.0	8
24 Hr Tele Resp - Total	30.6	307	26.5	117	29.5	424
24 Hour Face-to-Face Response						
Psychiatrists	25.0	4	25	12	25.0	16
Psychologists	0.0	4	18.2	22	15.4	26
Other Providers	18.6	296	25.6	78	20.1	374
Group Response	0.0	3	20.0	5	12.5	8
24 Hr Face-to-Face Resp - Total	18.2	307	23.9	117	19.8	424
24 Hour On-site Staffing at Evacuee Centers						
Psychiatrists	25.0	4	8.3	12	12.5	16
Psychologists	0.0	4	18.2	22	15.4	26
Other Providers	8.1	296	10.3	78	8.6	374
Group Response	0.0	3	20.0	5	12.5	8
24 Hr Staff at Evac Cntrs - Total	8.1	307	12.0	117	9.2	424
Screening and Referral						
Psychiatrists	25.0	4	25	12	25.0	16
Psychologists	25.0	4	59.1	22	53.8	26
Other Providers	36.8	296	41.0	78	37.7	374
Group Response	0.0	3	40.0	5	25.0	8
Screening & Referral - Total	36.2	307	42.7	117	38.8	424
None - NO Services Could be Provided						
Psychiatrists	0.0	4	8.3	12	6.3	16
Psychologists	0.0	4	18.2	22	15.4	26
Other Providers	2.4	296	15.4	78	5.1	374
Group Response	0.0	3	20.0	5	12.5	8
None - Total	2.3	307	15.4	117	5.9	424

A total of 164 respondents indicated that their contact information could be included on a list of Mental Health Disaster/Emergency Responders (See Table 17). This list would be provided to local health jurisdictions state-wide for them to share as appropriate with local emergency management, medical reserve core, and local Red Cross mental health facilities.

Table 17

Percentage of Providers Who Indicated They Could be put on a List of Mental Health Disaster/Emergency Responders

Provider Category	Provider Type				Total MH System	
	RSN-Funded		Private - Non-RSN-Funded			
	% Yes	N	% Yes	N	% Yes	N
Psychiatrists	25.0	4	33.3	12	31.3	16
Psychologists	0.0	4	59.1	22	50.0	26
Other Providers	30.2	288	70.5	78	38.0	366
Group Response	0.0	3	80.0	5	0.5	8

Health Professional Shortage Area Designation

On April 17, 2006 four requests for mental health shortage area designation were submitted to the United States Department of Health and Human Services, Federal Shortage Designation Branch, for review. The designation process requires obtaining and reporting information to characterize primary care capacity in the proposed areas and establishing eligibility for federal aid programs in underserved areas of Washington State to improve access to health care. Although the entire county was eligible, Federal Rules limit designations to a maximum population of 250,000. Consequently, the county was subdivided and four separate designation requests were prepared:

- 1) a new low-income/homeless designation for the City of Spokane,
- 2) a new geographic designation for the city of Deer Park,
- 3) a new geographic designation for the Southeast portion of Spokane County, and
- 4) a new geographic designation for the Southwest portion of Spokane County.

Summary of Assessment Findings

Availability and Capacity

Is there enough mental health capacity to serve the needs of Spokane County consumers? Estimates of the number of individuals with serious mental illness (SMI) or serious emotional disturbance (SED) in Spokane County range between 23,000 and 34,000 (see Introduction). The estimated FTE available to provide care (see Table 6) was 396.8, just under 16,000 hours of direct outpatient care available per week. This means that between 7,000 and 18,000 individuals who would benefit from weekly support from a mental health professional are not able to receive it.

Access to Mental Health Services for Special Needs Populations

Can consumers with special needs obtain outpatient mental health services with the same success as consumers without special needs? The RSN-funded system reports serving special populations to a greater degree than the non-RSN-funded system. Individuals who speak English as a second language, or are hearing impaired, would find it difficult to access outpatient mental health services in the non-RSN-funded sector (see Table 11).

Disaster Preparedness and Mental Health Services

During a community-wide emergency or disaster, what outpatient mental health services would be available for Spokane County consumers? Results indicate that fewer than half of providers responding to the survey have policies and procedures in place for responding to a critical incident or disaster (see Table 15). Providers in the RSN system would most likely be able to provide screening and referral services (36.2%) during an emergency or disaster. In the non-RSN system, the most likely services to be provided are crisis incident stress debriefing (49.6%) and management (49.6%). The least likely service to be available during an emergency or disaster is 24 hour on-site staffing at evacuee centers with 8.1% of RSN-funded and 12.0% of non-RSN-funded respondents marking this service.

List of Mental Health Disaster/Emergency Responders

A total of 164 respondents (38.7% of all respondents) indicated that their contact information could be included on a list of mental health disaster/emergency responders.

Mental Health Professional Shortage Area Designation

Does Spokane County qualify as a Mental Health Professional Shortage Area? The entire county meets the eligibility criteria of designation. Four separate requests were submitted to the United States Department of Health and Human Services, Federal Shortage Designation Branch, for review: A low-income/homeless designation for the City of Spokane and geographic designations for the City of Deer Park, and the Southeast, and Southwest portions of Spokane County.

References

- ¹ President's New Freedom Commission on Mental Health. (2003). *Achieving the Promise: Transforming Mental Health Care in America Executive Summary*. (DHHS Publication No. SMA-03-3831). Washington, DC: U.S. GPO.
- ² Washington State Department of Social and Health Services: Health and Rehabilitative Services Administration, Mental Health Division. (2003). *Report to the Legislature: The Prevalence of Serious Mental Illness In Washington State*. Olympia, WA: Department of Social and Health Services.
- ³ President's New Freedom Commission on Mental Health. (2002). *Interim Report of the President's New Freedom Commission on Mental Health*. (Presidential Executive Order 13263). Washington, DC: U.S.GPO.
- ⁴ Mental Health Transformation Plan 2006: *Partnerships for Recovery and Resiliency*.
<http://mhtransformation.wa.gov>
- ⁵ Revised Code of Washington. *RCW 41.05.600*.Mental Health Services. Definition--Coverage required when Findings Intent. 2005 c 6 | 1.
- ⁶ Revised Code of Washington. *RCW 18.19.060*. Information disclosure to clients. 2001 c 251 22; 1987 c 512 | 6.
- ⁷ Washington State Department of Health, Office of Community and Rural Health.
<http://www.doh.wa.gov/hsqa/ocrh/>

Appendix A Sample Health Professional Shortage Area survey

MENTAL HEALTH PROVIDER SURVEY

The Office of Community and Rural Health (Department of Health) and community partners are surveying providers to identify access issues in your county. Patient care (direct, consultation, or supervision) must be in an ambulatory or short-term setting. **DO NOT COUNT THE HOURS OF PRACTICE IN INPATIENT CARE.**

1. Provider's Practice Name: _____

2. Provider's Practice Address (include zip code): _____

3. Provider's Name: _____

Provider's Education / Credentials: _____

Psychiatrist

4. What is the approximate **percentage** of the provider's practice devoted to providing outpatient mental health care?

None	<5	5	10	15	20	25	30	35	40	45	50	55	60	65	70	80	90	95+
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5. How many **hours** of direct outpatient mental health care are provided at this location?

_____ (i.e. 20, 32, 40+ hours per week, etc.)

6. Does the provider have an **additional** office location: Yes No

If yes, what is the address of the additional office location? *(please include name, address, telephone number and zip code):* _____

How many hours of direct patient care are provided at this **additional** location? _____ # hours

7. Does the provider have hospital admitting privileges? Yes No

If yes, how many hours (average) per week are spent at the hospital seeing their patients? _____ # of hours
(Do not include on-call and hospital meetings)

9. Does the provider fluently speak a language other than English? Yes No

- Spanish
- Japanese
- Chinese
- Korean
- Vietnamese
- Russian
- Other *(please specify)* _____

This section is about how the provider's current patients pay for services.

In the most recent fiscal year, what percentage of patients used each of the following payment types? Please circle the approximate percentage. *Your responses should total 100%.*

10. Privately-insured/ Employer-insured / Self-Pay

None	<5	5	10	15	20	25	30	35	40	45	50	55	60	65	70	80	90	95+
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11. Medicaid Fee for Service

None	<5	5	10	15	20	25	30	35	40	45	50	55	60	65	70	80	90	95+
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12. Medicaid Healthy Options (includes plans...)

None	<5	5	10	15	20	25	30	35	40	45	50	55	60	65	70	80	90	95+
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13. Medicare Fee for Service

None	<5	5	10	15	20	25	30	35	40	45	50	55	60	65	70	80	90	95+
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14. Medicare Managed Care (including....)

None	<5	5	10	15	20	25	30	35	40	45	50	55	60	65	70	80	90	95+
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15. Basic Health Plan

None	<5	5	10	15	20	25	30	35	40	45	50	55	60	65	70	80	90	95+
------	----	---	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	-----

16a. Pre-Arranged, Sliding Fee Scale or Ability-to-Pay Plan

None	<5	5	10	15	20	25	30	35	40	45	50	55	60	65	70	80	90	95+
------	----	---	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	-----

16b. Is the sliding-fee schedule pre-arranged and posted in a location visible to all patients?

Yes No

17. What is the approximate percentage of the provider's current patients whose cost is otherwise charged to uncompensated care? _____%

18. Is the provider currently accepting:

- ANY NEW patients (panel is full)?** Yes No *Skip to Question 20*
- New insured/self-pay patients?** Yes, Unrestricted Yes, Restricted No
- New Medicaid fee-for-service patients?** Yes, Unrestricted Yes, Restricted No
- New Medicaid Healthy Options patients?** Yes, Unrestricted Yes, Restricted No
- New Medicare fee-for-service patients?** Yes, Unrestricted Yes, Restricted No
- New Medicare managed care patients?** Yes, Unrestricted Yes, Restricted No
- New Basic Health Plan patients?** Yes, Unrestricted Yes, Restricted No
- New Sliding fee scale, ability to pay, pre-arranged payment plan?** Yes, Unrestricted Yes, Restricted No

Comments concerning other restrictions on new patients:

19. When a patient calls the provider's office to request a routine (non-urgent, symptomatic) visit, what is the usual elapsed time between the request and the appointment for: (example 2 days)

- A new patient? _____ Days
- An established patient? _____ Days
- A Patient covered by Medicaid? _____ Days
- A Patient covered by Medicare? _____ Days

20. Does your practice see walk-in patients? Yes No

21. For patients who need anti-psychotics, are you able to provide them with new generation drugs?

Please check box for each payer type.

	Always	Often	Sometimes	Rarely	Never
Privately or Employer Insured / Self Pay					
Medicaid Fee for Service					
Medicaid Healthy Option					
Medicare Fee for Service					
Medicare Managed Care					
Basic Health Plan					
Sliding Fee Scale / Uninsured					

22. Does the provider plan to retire or leave practice in King County in the next 5 years? Yes No

Name of the person responding to this survey: _____

Title: . _____ Phone: _____

Thank you so much for completing the survey. Your answers will help us as we look at mental health access issues in King County.

S:/HPSA/HPSA/SURVEYS/Mental2004.doc (revised 09/10/2004)



9820

16. Does your agency/practice have policies and procedures in place that address how you would response to a Critical Incident/Disaster in Spokane County? Yes No

17. During a community wide disaster or emergency, which of the following services would you,your agency, or practice be able to provide?

- Outreach/mobile capacity
- 24 hour telephone response
- 24 hour face-to-face response
- 24 hour on-site staffing at evacuee centers
- Mental Health Response Teams
- Crisis Incident Stress Debriefing
- Crisis Incident Stress Management
- Screening and referral
- None
- Other _____

18. May we include your contact information on a list of Mental Health Disaster/Emergency Responders? Yes No

If yes, what is your telephone number? - -

19. In the most recent fiscal year, what percentage of your patients used each of the following payment types? **Your responses to all categories should total 100%.**

Privately-insured/ Employer-insured/ Self-pay

None	<5%	5	10	15	20	25	30	35	40	45	50	55	60	65	70	75	80	85	90	95%+
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Medicaid Fee for Service (Coupons)

None	<5%	5	10	15	20	25	30	35	40	45	50	55	60	65	70	75	80	85	90	95%+
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Medicaid Managed Care-Medicaid Healthy Options (e.g. Asuris, Group Health, Molina, etc.)

None	<5%	5	10	15	20	25	30	35	40	45	50	55	60	65	70	75	80	85	90	95%+
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Medicare Fee for Service

None	<5%	5	10	15	20	25	30	35	40	45	50	55	60	65	70	75	80	85	90	95%+
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Medicare Managed Care (e.g. Sterling Life, etc.)

None	<5%	5	10	15	20	25	30	35	40	45	50	55	60	65	70	75	80	85	90	95%+
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Basic Health Plan (e.g. Group Health Cooperative, Community Health Plan of Washington, Molina, etc.)

None	<5%	5	10	15	20	25	30	35	40	45	50	55	60	65	70	75	80	85	90	95%+
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Non-Medicaid state funds

None	<5%	5	10	15	20	25	30	35	40	45	50	55	60	65	70	75	80	85	90	95%+
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Federal Block Grant Funding for Service

None	<5%	5	10	15	20	25	30	35	40	45	50	55	60	65	70	75	80	85	90	95%+
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Uninsured/ Self-pay including Sliding Fee Schedule, discounted, or uncompensated care clients

None	<5%	5	10	15	20	25	30	35	40	45	50	55	60	65	70	75	80	85	90	95%+
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



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20. NOTE: This question addresses a subset of Uninsured/Self-Pay clients from question 19. What percentage of the provider's uninsured/self-pay clients pay on a Pre-arranged Sliding Discount Fee Schedule (ability-to-pay) plan? %

20b. Is the sliding-fee schedule discount eligibility determined prior to visit and posted in a location visible to all patients? Yes No

21. What is the approximate percentage of the provider's current patients whose cost is otherwise charged to uncompensated care? (Pro Bono) %

21b. Does your practice see walk-in patients? Yes No

22. Is the provider currently accepting:

- ANY new patients (panel is full)?..... Yes No ----> Skip to Question 24.
- New insured/self-pay patients?..... Yes, Unrestricted Yes, Restricted No
- New Medicaid fee-for-service patients?..... Yes, Unrestricted Yes, Restricted No
- New Medicaid Managed Care patients?..... Yes, Unrestricted Yes, Restricted No
- New Medicaid Healthy Options patients?..... Yes, Unrestricted Yes, Restricted No
- New Medicare fee-for-service patients?..... Yes, Unrestricted Yes, Restricted No
- New Medicare Managed Care patients?..... Yes, Unrestricted Yes, Restricted No
- New Basic Health Plan patients?..... Yes, Unrestricted Yes, Restricted No
- New Sliding fee scale, ability to pay, pre-arranged pay plan? Yes, Unrestricted Yes, Restricted No

23. If the provider accepts new patients with restrictions, what are the most common restrictions for each of the following payers? (Check any that are relevant)

<i>Restrictions or limits on new patients currently in place for...</i>	Insured	Medicare	Medicaid	Uninsured
Patients without referrals from other healthcare providers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Patients who are not family members of established patients	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Patients from public or private insurance provider with inadequate reimbursement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Patients from outside a local service area or zip code (or district if tax supported)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Comments concerning other restrictions on new patients: _____

24. When a patient calls your practice/agency to request a routine (non-urgent, symptomatic) visit, what is the usual elapsed time between the request and the appointment for...:

A new patient? # of days A patient covered by Medicaid? # of days

An established patient? # of days A patient covered by Medicare? # of days

Thank you for completing this survey!
Your answers are critical to understanding access to mental health services in Spokane County.

