Crestwood Behavioral Health CARF Programs
Annual Performance Analysis Report
2009

A) Introduction

2009 was an extraordinary year full of challenges and opportunities. The economic downturn provided the most significant obstacles to meeting our strategic goals and objectives. We course corrected on a few instances and stayed to our core business principals and mission. We were able to accomplish the following:

1. To anticipate and meet the changing needs of our customers in unprecedented financial statewide challenges.
2. Compliance with regulatory and accreditation agencies.
3. Client and stakeholder satisfaction
4. Continue our ambitious energetic continuous quality improvement through corporate wide clinical initiatives including introducing and implemented EBPs.

Crestwood Behavioral Health, Inc. (CBHI) has been a leader in providing a full array of mental health services throughout the state for more than a decade and 30 years prior under our previous corporate umbrella of Crestwood Hospitals, Inc. Today, under the leadership of George Lytal, President and CEO, Crestwood has more than 1,800 licensed psychiatric beds in more than 16 California facilities ranging in size from 12 to 194 beds. Crestwood's programs provide recovery-oriented mental health services designed to meet the needs of adults, older adults and transition-age youth with severe and persistent mental health issues.

Crestwood provides psychiatric services to those requiring acute stabilization, intensive treatment programs with a high level of security and structure, as well as consumers living in the community requiring support and education to live independently. We serve the Alzheimer's/dementia patients and those with traumatic brain injury through our geropsychiatric programs. The full continuum of care enables us to serve more than 2,500 consumers annually.

The Crestwood continuum of facilities currently includes one psychiatric health facility and one in development, eight residential treatment programs, seven mental health rehabilitation centers, five skilled nursing facilities approved for special treatment programs, two neurobehavioral programs, and eight

community-based out-patient centers. A listing of all facilities within Crestwood Behavioral Health, Inc. is attached as well as a brief description of services offered at each location.

Our vision at Crestwood Behavioral Health is to create a continuum of services that empower consumers to live and succeed in their community. Crestwood has been committed to providing a full array of health, behavioral health and community support services to persons with mental health issues for more than 40 years. We uphold the values and standards set forth in the CARF accreditation process. The values and standards reflect those of Crestwood as stated in the Strategic Plan.

The Behavioral Health Management Team includes corporate clinical leadership staff, as well as the administrators and directors from all of the accredited programs throughout Crestwood, including:

Accredited in:

Residential Care
Crestwood Behavioral Health Center - American River (MHRC)
Crestwood Behavioral Health Center - Bakersfield (MHRC)
Crestwood Behavioral Health Center - Eureka (MHRC)
Crestwood at Napa Valley (MHRC)
Crestwood Center – Sacramento (MHRC)
Crestwood Behavioral Health Center - San Jose (MHRC)
Crestwood Rehabilitation and Recovery Center – Vallejo (MHRC)

Inpatient Care
Crestwood Manor – Vallejo (SNF)
Crestwood Psychiatric Health Facility - Bakersfield (PHF)

Community Housing
Crestwood Bridge – Eureka (ARF)
Fruitridge Transitional Home (ARF)
Crestwood Bridge – Fresno (ARF)
Our House - Solano (ARF)
Pathways - Pleasant Hill (ARF)
Crestwood Bridge - Pleasant Hill (ARF)

The management team reviews and revises the Corporate Strategy annually. This review process was completed mid-year, incorporating several current conditions impacting mental health services in California, including severe budget deficit, emphasis on brief placement in restrictive settings and creating a need for services directed at higher acuity for briefer length of stay.

The goals for the Corporate Strategy were revised to reflect the current conditions of our state economy and the provision of mental health services and the needs of our organization in more specific business and service related goals.

Listed below are the changes to the Corporate Strategy Goals:

1) Business Function Goals:

1. CBHI will deliver recovery-oriented behavioral healthcare in a socially responsible and sustainable manner.
2. We align with our partners including persons served, family, staff, county and regulatory agencies to provide innovative and adaptable services.
    a. To enhance partnerships between Crestwood and our stakeholders in order to respond to the unique needs and economic reality of our diverse communities.
3. We achieve excellence through setting and adhering to optimal standards guided by best practices, core values and integrity.

2) Service Delivery Goals:

1. We will provide opportunities and support for persons served to lead meaningful, healthy and fulfilling lives in the environments where they live, learn, work and socialize.
2. We will provide a full spectrum of recovery-based services that achieve the highest standard of service delivery and stakeholder satisfaction.

In addition to revising the goals, we added the Collaboration value to the Strategic Values for our organization. This change is based on our belief that it is through collaboration rather than competition that we are able to most effectively and humanely meet the needs of the consumers.

3) Collaboration

1. Programs are enriched through partnerships with consumers, families, counties, agencies and other community-based providers.
2. Crestwood is committed to collaboration rather than competition in developing new services.
3. Crestwood believes that the best results are obtained when a team holds responsibility.

The goals and objectives continue to reinforce the vision and values developed and adopted by the Management Authority in 2006 –2007. The Management Authority did add the Collaboration value this year to the strategy reflecting a shift in service delivery throughout California and Crestwood.

The management team has dedicated their actions to conforming to the CARF standards, continually assessing and refining our services for quality and efficacy, and enhancing the lives of the people we serve. The Corporate Strategy, the provision of services at each site and the Corporate Office are overseen by the Behavioral Health Management Team and reviewed annually or more frequently as needed.

This Annual Performance Analysis Report reflects the business functions, service delivery, effectiveness of services, efficiency of services, access to services, and the opportunity for input from stakeholders and the persons Crestwood serves.

The activities being monitored, analyzed and reported in this process are limited to the actions of the Governance Authority, Management Authority and of the CARF accredited programs, including Crestwood Behavioral Health Center - American River; Crestwood Behavioral Health Center – Bakersfield; Crestwood Behavioral Health Center – Eureka; Crestwood Center at Napa Valley; Crestwood Center – Sacramento; Crestwood Behavioral Health Center – San Jose; Crestwood Rehabilitation and Recovery Center – Vallejo; Engle House; Crestwood Bridge – Eureka; Fruitridge Transitional Home; Crestwood Bridge – Fresno; Our House - Solano; Pathways - Pleasant Hill; Crestwood Bridge - Pleasant Hill; Crestwood Manor – Vallejo; and Crestwood Psychiatric Health Facility - Bakersfield. .

B) Crestwood Initiatives

The following initiatives were introduced, implemented and/or evolved during 2008. These initiatives reflect the commitment Crestwood has to constant quality improvement throughout our organization.

1) Dialectical Behavior Therapy (DBT)

With a 40-year history of providing mental health services to adults and older adults, Crestwood has researched effective, evidenced-based approaches for treating very difficult behaviors and conditions. In early 2000 Crestwood began to interface and utilize Dialectical Behavior Therapy (DBT) as an approach to working with individuals with Borderline Personality Disorders. We found this very effective and this treatment modality for many of our consumers led to reduced hospitalizations and extended success in the community. In 2007 we attended a week-long training with Dr. Marcia Linahan. We determined that this treatment tool would be a significant modality to infuse into our programs and to include in our skill set. As a result, in 2009 Crestwood has contracted with Behavioral Tech Inc., Dr. Linahan's training organization, and has begun training which will lead to our organization becoming DBT certified.

DBT is a modified cognitive-behavioral treatment that was originally developed to treat chronically suicidal adult women diagnosed with borderline personality disorder (BPD). Since its emergence in the early 1990s, DBT has been tested in 10 randomized controlled trials and adapted for clients whose problems appear to result from emotional dysregulation such as adults diagnosed with drug dependence and BPD, adult women who binge eat, adolescents with depression and suicidality, and geriatric clients with recurrent depression. All findings suggest that DBT is more effective at targeting and reducing suicidal and non-suicidal self-injurious behavior, improved treatment

retention, reduced medical lethality of suicide attempts, decrease in hospitalizations and ER visits. It was also effective at reducing therapist burnout and costs associated with treatment of multi-diagnostic clients. Further, while DBT was originally designed as an outpatient therapy, it is being applied and researched across the full spectrum of mental health services, including residential facilities, forensic settings, day and partial hospitals, inpatient units, and correctional facilities**.**

DBT grew out of a series of failed attempts to apply standard cognitive and behavior therapy (CBT) protocols to chronically suicidal clients. While standard CBT focuses on changing behavior, the nonstop focus on change-based procedures can often be experienced as invalidating by clients. To overcome these obstacles, acceptance strategies derived from eastern and western contemplative traditions were added to balance the use of standard CBT. Unlike change strategies, these techniques and skills emphasized both a radical acceptance of "reality as it is, in the present moment" and validation of clients' current capabilities and behavioral functioning. Examples of acceptance strategies in DBT are the core mindfulness skills (e.g., attention to the present moment, assuming a non-judgmental stance, focusing on effectiveness) and a variety of validation and acceptance-based stylistic strategies. Thus, the fundamental tension in DBT is between acceptance and change. This tension, and the synthesis of these opposing forces, form the basic *dialectic* in DBT and they inspired the treatment's name. The overarching goal of the treatment is *dialectical synthesis* -- a life that reflects balanced thought, feeling, and action as opposed to black and white thinking, emotional extremes, and impulsive behavior. This is achieved through using dialectics as a worldview, a means of persuasion, a way to balance treatment strategies, and a means to structure the therapy.

DBT is a highly structured and comprehensive treatment. Comprehensive treatments address all of the client's problems in a systematic way. They are highly organized and they must serve five critical functions: 1) enhance a person's behavioral capabilities; 2) help the client improve and maintain his or her motivation to change; 3) assure that the client's new capabilities generalize to the natural environment; 4) structure the treatment environment in the ways essential to support the client and therapist capabilities, and, 5) enhance the therapists' capabilities and motivation to treat clients effectively. In standard DBT, these functions are divided among modes of service delivery, including individual psychotherapy, group skills training, phone consultation, and therapist consultation team.

Implementation of DBT

Achieving true implementation of any evidence-based practice requires a significant commitment of time and resources from dedicated staff, from high-level administrators to program directors and front-line clinicians. It also typically involves creative problem-solving and persuasion about how to simultaneously address the system needs and real-world structure while maintaining treatment fidelity, as the system/clinic realities may be very different from the academic

institution where the treatment was developed and evaluated. Depending on outcome goals, funding and staff to support the initiative, full implementation can take anywhere from six months to three years. Typically it is recommend that implementation starts with an orientation training, followed by in-depth Intensive training, then two additional days of training to further solidify learning and practice. Consultation with a DBT expert also occurs throughout the process to ensure that clinical adherence and program fidelity is achieved.

The Project at Crestwood

The DBT implementation project at Crestwood kicked off with two days of training and one day of consultation on March 18th – 20th. In the next step of the training a five-day Intensive Training sessions was held in May 2009 with the second Intensive Training to follow in December. The focus of this training was to assist clinical teams with the implementation and development of full DBT programs. There will be one further training scheduled for April 2010 to bring all the teams back together to check in and update. The training is being led by Linda Dimeff, Ph.D. and Cedar Koons, CSW.

2) Initiative to Reduce and Eliminate Restraints

As part of Crestwood's ongoing efforts to reduce and ultimately eliminate the use of restraints from any of our programs, a two-day training was held in February 2008 that was focused on creating violence and coercion free environments. The training was led by Kevin Huckshorn, RN, MSN, ICADC, and Janice LeBel, Ph.D. both internationally known experts on the topic of restraint reduction and trauma informed care. Every Crestwood facility that uses behavioral restraints was present at the training, as were representatives of many counties, the Department of Mental Health, and other stakeholders.

Since the training in February, Crestwood has developed an overall corporate plan to assist and support each facility in reducing the use of restraints with the ultimate goal of totally eliminating restraint use throughout Crestwood. Each facility developed an individual plan that has been reviewed by the corporate office with ongoing consultation from Kevin Huckshorn and Janice LeBel. Facilities also provide a monthly report of any incidents of restraint, along with both client and staff debriefing forms, to the Director of Clinical Services for review by the Corporate Restraint Committee. This information is analyzed and tracked with any trends or concerns being discussed and addressed at both the corporate and facility levels. Each facility also has a Restraint Reduction Committee that meets regularly to address any issues or concerns that arise in the individual facilities.

These actions by Crestwood are creating a trend of decreased restraints and a greater understanding and awareness of the issues surrounding their use. Crestwood is also working on incorporating trauma informed care into each program, with the goal being to increase each staff member's awareness of individual client's histories and possible issues that may impact their ability to fully engage the recovery process.

3) Recovery

Crestwood has had a Recovery Task Force comprised of front line and leadership staff from all of our programs throughout the state, consumers, family partners, and corporate leadership staff. This group meets regularly to infuse recovery into all of our programs, to expand the recovery services on all levels of service delivery, and to reduce stigma and improve the quality of life for the individuals we serve.

Crestwood believes that recovery is a supportive process where a person is encouraged to maximize their life and achieve a sense of balance and fulfillment. It is a deeply personal and self-directed process built on hope, empowerment, meaningful roles and spirituality. We create an environment that fosters personal choice and active participation in daily activities and life direction. Our services continually evolve based on consumer needs. We place a high value on consumer input by involving consumers in designing, planning, implementing and evaluating our services. We find ways for consumers to make choices on a daily basis and provide the tools to support and validate those choices. We have partnered with Larry Davidson, PsyD, to provide recovery-based training and are currently partnering with Lori Ashcraft of Recovery Innovations (formerly META) to provide training for certified peer specialists and recovery-oriented psychiatric acute and crisis services. Through the Crestwood and Recovery Innovations partnerships we provide training to certify peer provider specialists, parent partner providers, advanced peer and parent training, professional recovery training and ongoing support and consultation.

> According to William Anthony and Lori Ashcraft*: "Recovery has been defined as a journey of healing and transformation enabling a person with a mental health problem to live a meaningful life in a community of his or her choice while striving to achieve his or her full potential."(del Vecchio & Fricks, 2007, p. 7).*
> *The 10 fundamental components of recovery identified are: 1) self direction; 2) individualized and person-centered; 3) empowerment; 4) holistic; 5) non-linear; 6) strengths-based; 7) peer support; 8) respect; 9) responsibility; and 10) hope.*

Crestwood holds the following values as core to recovery for all individuals:

- **Hope** - Hope is the cornerstone in the journey of recovery. Hope is the belief in life's possibilities.
- **Empowerment** - Empowerment is the belief that one has power and control in ones life. It involves taking responsibility and advocating for self and others.
- **Meaningful Roles** - Meaningful Roles are positive identities within the places we live, learn, work and socialize, creating a sense of purpose and value.

- **Spirituality** - Spirituality is the connection to a greater power, others and self. It is the way to find meaning, hope, comfort and inner peace in life. Many people find spirituality through religion. Some find it through music, art or a connection with nature. Others find it in their values and principles.

4) Wellness Recovery Action Plan (WRAP)

Wellness Recovery Action Plan (WRAP) is an evidenced-based treatment tool that Crestwood has been using for nine years. This initiative has been to expand and instill WRAP into all of our services and staff. WRAP has been implemented in each one of our programs, with a variety of approaches being used. While the curriculum of WRAP has core values and ethics that are to be adhered to, there are a variety of ways that it can be taught. Providing WRAP in a variety of approaches enables the consumer to choose the kind of approach that most directly appeals to their needs and interests.

WRAP is typically conducted 4-5 times per week, with several leaders, including a Copeland Center Certified WRAP Facilitator leading the oversight of the curriculum, and leading groups. Lynn Gurko, Crestwood's Director of Recovery Services, and Copeland Center Certified Advanced Level WRAP Trainer, has developed a curriculum that enhances the skills and process of shared power. This training is offered to the WRAP facilitators and their assisting staff and is in the process of being offered to all Crestwood facilities, and has been implemented in four facilities so far.

A typical WRAP class would involve an open-ended, or time-limited class cycle (depending on the facility). A WRAP group would have the leader and consumers in a circle, binders open, going through their plan together. It is a requirement of the WRAP curriculum that if you are going to teach it, you MUST be actively working on your own plan. This would include the group leader, sharing at an appropriate level, what is in their own plan.

Other forms of WRAP groups include, but are not limited to:

- WRAP for women and WRAP for Men
- WRAP to work
- WRAP overview trainings for staff to create their own plan (this includes ALL staff, regardless of whether or not they will be teaching it). Crestwood has provided this overview training for approximately 1,500 staff.

- Applying WRAP to your life outside of the facility i.e. when you get discharged, when you go home for a visit with your family, etc.
- WRAP for School in our supported education programs.

The advantage of having the majority of the Crestwood workforce oriented to having a WRAP plan is that they can support the program through sharing in the common language of the plan, and it assists in the reduction of the us/them power differential that can impede establishing a therapeutic relationship. Programs that conduct WRAP classes four to five times per week have higher statistics in discharging their consumers to lower levels of care.

5) Supported Employment and Supported Education

Supported employment and supported education has been introduced to all of Crestwood's behavioral health programs. It is an evidence-based treatment tool and we believe it is the key to de-institutionalization and successful integration into the community. Crestwood's partnership with Dreamcatchers Empowerment Network (DEN) has provided a rich experience with employing consumers at all levels of services, as well as in the competitive employment in the community. The DEN partnership has enabled us to expand the supported education to include adult education at most of our sites and at some of our facilities that have consumers enrolled in college and completing certificated programs through the community college system.

6) Cultural Competent Services

Crestwood is dedicated to providing the persons we serve and their families with a full range of recovery-based behavioral health services that are culturally relevant and meet their diverse needs. The purpose of Crestwood's diversity plan is to educate all employees (full-time, part-time, and extra help); interns; contractors; and other designated individuals acting on behalf of Crestwood; of their responsibilities and obligations to provide culturally relevant and linguistically competent services to the persons we serve and our stakeholders. Crestwood employs a Diversity Trainer who works with the programs to ensure and develop cultural competencies for all employees. The following strategies for cultural assessment and service model are applied across all of Crestwood Behavioral Health's programs.

Crestwood uses the following guidelines for transcultural interactions:

1. Consider all clients as individuals first, as members of minority status, and then as members of a specific ethnic group.

2. Never assume that a person's ethnic identity tells you anything about his or her cultural values or patterns of behavior.
3. Treat all "facts" you have ever heard or read about cultural values and traits as hypotheses, to be tested anew with each client. Turn facts into questions.
4. Remember that all minority group people in this society are bicultural, at least. The percentage may be 90-10 in either direction, but they still have had the task of integrating two value systems that are often in conflict. The conflicts involved in being bicultural may override any specific cultural content.
5. Some aspects of a client's cultural history, values, and lifestyle are relevant to your work with the client. Others may be simply interesting to you as a professional. Do not prejudge what areas are relevant.
6. Identify strengths in the client's cultural orientation which can be built upon. Assist the client in identifying areas that create social or psychological conflict related to bi-culturalism and seek to reduce dissonance in those areas.
7. Know your own attitudes about cultural pluralism, and whether you tend to promote assimilation into the dominant society values or stress the maintenance of traditional cultural beliefs and practices.
8. Engage your client actively in the process of learning what cultural content should be considered.
9. Keep in mind that there are no substitutes for good clinical skills, empathy, caring, and a sense of humor. (Nancy Brown Miller, "Social Work Services to Urban Indians," Cultural Awareness in the Human Services, James Green, ed Prentice-Hall, 1982).

7) Reducing the Violence

The experience of significant on-going trauma is said to be between 90% (Goodman, Rosenburg et al., 1997) and 98% (Muesar et al, 1998) of a consumer's background who receives services from county mental health care delivery systems. Many individuals who experience on-going trauma develop extreme coping strategies, such as suicide attempts, substance abuse, dissociation, aggression to others and self, etc. Often people with traumatic backgrounds have a major mental illness diagnosis, but in spite of any co-occurring disorders, trauma can be problematic on its own and lead to extensive treatments.

Crestwood recognizes that trauma can impact symptomology, therapeutic engagement, and treatment effectiveness. Our approach is to assume that all clients have traumatic experiences and to cater our environments and approach in ways that foster safety and recovery. Staff are trained on the impacts of trauma, i.e. feelings of vulnerability, assumption that the world is unsafe, people are harmful, people are unpredictable, feelings of being judged and shame, to name a few. Staff will anticipate risk factors and identification of unmet needs in

an effort to keep a client's stress level to a manageable level while skills are being taught (see DBT in Inpatient Settings).

Crestwood's therapeutic environments are created to be trauma sensitive, such as using strength-based language versus the all too common language that is condescending (words like, manipulative, needy, attention seeking). Displays of power are minimized, such as unduly using positions of power. Clients are empowered vs. intimidated (displays of keys). The culture is an open culture where client, advocates, and supporters are encouraged to have open communication. This is in contrast to a closed system that fosters secrecy. Natural and logical consequences are used rather than punitive measures such as seclusion and restraints. For instance, a client who is agitated, hostile and physically active will be offered a safe place to move around and "blow off steam."

Example from a Direct Care Staff from a presentation by Kevin Huckshorn:

> *"I know that after a couple of difficult incidents on a unit, I certainly felt like I had symptoms of PTSD, about being hyper-aware when I walked to my car, because some of the things that I saw and that I was involved with were very traumatic. I think consumers talk about what it is like to be in restraints, it is also traumatizing to put people in restraints in the same way that I think it is traumatizing for solders to go to war to kill other people. We don't often talk about the impact of that either."*

Crestwood will create teaching programs consistent with staff ability, client need, and level of care. Programs will rely on best practice techniques and draw upon multiple sources. Some examples are: Healing Trauma of Abuse by Mary Ellen Copeland and Maxine Harris, Growing Beyond Survival: A Self-Help Toolkit for Managing Traumatic Stress by Elizabeth Vermilyea and The Relaxation and Stress Reduction Workbook by Martha Davis. The goal of the program is to help people learn specific skills for coping with the problematic effects of past and present traumatic events. Teaching components will consist of topics such as: What is Trauma; The Effects of Trauma; Creating Life Changes; Self-Healing Strategies; and Moving Past Trauma.

In line with the California Department of Mental Health, the President's New Freedom Commission, consumers and stakeholder groups, Crestwood recognizes that the use of seclusion and restraints are traumatizing and often ineffective. Crestwood closely adheres to the six core strategies for Preventing Violence, Trauma and the Use of Seclusion and Restraint in Inpatient Settings developed by Kevin Huckshorn, R.N., M.S.N. These include: 1) Leadership toward organizational change, 2) Use data to inform practices, 3) Develop workforce, 4) Seclusion and restraint prevention tools, 5) Actively recruit and include service users and families in all activities, and 6) Make debriefing rigorous.

Mental health recovery is a right for every client served at Crestwood. We are dedicated to addressing core issues that interfere with a person's ability to achieve their full potential. By acknowledging and addressing trauma, client and

staff relationships become more effective and our environments are transformed from institutions to healing centers.

Crestwood's initiatives speak to our values:

- Commitment to providing the most effective and consumer focused services.
- Follow through in services we provide and in our relationship with our stakeholders.
- Being flexible to meet the ever changing needs of the community and the people we serve.
- Enthusiasm in all we do.
- Providing services with integrity and character.
- Expanding the role and support of the family.
- Collaboration, a value added in 2008, reflects our belief that successful community integration only occurs with collaboration.

C) Overview of Performance Analysis Process

1) Business Functions Analysis

The business functions are monitored by the Vice President of CARF operations and Crestwood's central accounting office, corporate office with human resources, government relations, and operations. The Business Functions overview includes but is not limited to the following data for all of the accredited sites:

1. Licensing Surveys for regulatory compliance
2. Complaint and grievance reports
3. Budgetary reports
4. Employee turnover trends and overtime reports
5. Strategic planning activity reports
6. Reporting tools for diversity compliance

2) Service Delivery Analysis

The delivery of service is monitored by the Vice President of CARF operations. The service delivery analysis is assessed through routine monitoring of programs and facilities by the CARF management team and the Vice President, in addition to the following reports for all of the accredited programs:

1. Corporate census reports monthly
2. Licensing Surveys for regulatory compliance
3. Complaint and grievance reports

3) Effectiveness of Services

The effectiveness of services is monitored by the Vice President of CARF operations. The service delivery analysis is assessed through routine monitoring of programs, meeting with county stakeholders, and facilities by the CARF

management team and the Vice President. The tools utilized in this review include routine review of program operations, with focus on input from stakeholders on effectiveness of the services, as well as the following reports for all of the accredited services:

1. Behavioral Health Outcome Metrics
2. Operational semi-annual reports, including strategic planning reports, from each program
3. Corporate census reports

4) Efficiency of Services

The efficiency of services is monitored by the Vice President of CARF operations. The efficiency of the service delivery system is assessed through routine monitoring of programs, meeting with county stakeholders, and facilities by the CARF management team and the Vice President, in addition to the following reports:

1. Program budgets
2. Occupancy reports
3. Recruitment and Retention reports
4. Average length of stay

5) Access to Services

The access to services is monitored by the facility administrator and the Vice President of CARF operations through the following reports:

1. Accessibility Reports

6) Opportunity for input from stakeholders and the persons we serve

The opportunity for stakeholders to provide input is monitored by the facility administrator, the Director of Recovery Services and the Vice President of CARF operations. The analysis is conducted through routine visits to the programs, meeting with specific stakeholder groups, and review of the stakeholder satisfaction tools, including:

1. CQI reports
2. Consumer satisfaction reports

D) 2008 Business Functions Analysis

1) Business Function Goals:

1. To deliver recovery-oriented behavioral healthcare in a socially responsible and sustainable manner.
2. To align with our partners including persons served, family, staff, county and regulatory agencies to provide innovative and adaptable services. To

enhance partnerships between Crestwood and our stakeholders in order to respond to the unique needs and economic reality of our diverse communities.

3. To achieve excellence through setting and adhering to optimal standards guided by best practices, core values and integrity.

The business functions include the operations of the CARF accredited programs. They are monitored by the Vice President, the central accounting office for Crestwood and the corporate office with human resources, government relations, and operations. The efficiency of services is monitored by the CFO, the corporate Treasurer, the corporate controller, the corporate human resource department, and the Vice President of CARF operations. The efficiency of the service delivery system is assessed through routine monitoring of programs, meeting with county stakeholders, and facilities by the CARF management team and the Vice President,

The operations overview includes the following data and data source:

1. Regulatory Compliance (State report and Performance Analysis [PAP] Reports)
2. Complaint and Grievance Analysis (PAP)
3. Budgetary Analysis (budget reports monthly and PAP)
4. Financial/Occupancy (Census reports and PAP)
5. Human Resource Turnover (Human resource and PAP)
6. Diversity Report (corporate reports)
7. Accessibility Summary (facility PAP)
8. Critical Incidences (facility PAP)
9. Employee Satisfaction (facility PAP)
10. Average Length of Stay
11. Demographic Summary (Behavioral Outcomes Metrics)
12. Technology (facility PAP)

2) Regulatory Compliance Analysis

The state regulatory agency that is responsible for licensing, certification and oversight of the Crestwood's Mental Health Rehabilitation Centers (Residential Treatment programs) is the California Department of Mental Health, Licensing and Certification Division. The community housing programs are certified by the California Department of Mental Health, Licensing and Certification Division and licensed by the California Department of Social Services. Both of these agencies provide a survey team, usually consisting of a generalist administration specialist, and a program specialist from the Department of Mental Health, a nursing specialist and a consumer representative. The licensing and certification surveys are conducted upon licensure, and annually thereafter. The division also responds to all complaints and self reports of incidents. They provide a team or specialist for a site visit to investigate each incident.

The Crestwood CARF facilities have an extraordinary compliance record. The following chart reflects the average number of deficiencies over the most recent found at each site:

2008 Compliance Report for Mental Health Rehabilitation Centers

Angwin	2 deficiencies
Bakersfield	0 deficiencies
Eureka	0 deficiencies
American River	3 deficiencies
Sacramento	12 deficiencies
Vallejo	5 deficiencies
San Jose	4 deficiencies

Community Housing Programs

Bridge House-Eureka	1 deficiency
Bridge Program - Bakersfield	3 deficiencies
Bridge Program - Fresno	2 deficiencies
Bridge Program - Pleasant Hill	1 deficiencies
Our House - Solano	1 deficiencies
Fruitridge Transitional Home	4 deficiencies

Inpatient Hospitalization

Crestwood Manor -Vallejo	7 deficiencies
Crestwood Psychiatric Health Facility	0 deficiencies

Crestwood CARF Programs

MHRC's	3.4 deficiencies
Community Housing Programs	1.6 deficiencies
Inpatient Hospitalization	3.5 deficiencies

3) Complaint and Grievance Analysis

The administrators are responsible to receive, review, respond and analyze all grievances related to their programs. The administrators self-report complaints and grievances from stakeholders through bi-annual reports that are reviewed by the CARF management authority team, the Vice President and if unresolved, by the governance authority. The reports for 2006, 2007, and 2008 were able to be resolved at each program by the site leadership team under the direction of the administrator.

The grievances that are not resolved at the program site are referred to the corporate office for investigation and closure. In 2008 all grievances were resolved at the CARF facility level.

4) Budgetary Analysis

The CARF accredited programs involve a variety of stakeholders in the budget development, including program staff, consumers, county stakeholders, and the corporate accounting and finance departments. This year the budget process began early in the fourth quarter of the prior year and was completed by the close of the fourth quarter. The administrator involves their local stakeholders in developing a realistic budget, relying on the accounting office to provide historical analysis to assure that the current budget reflects the current anticipated amount. Each program has a budget and each program is expected to meet the budgetary goals.

The financials are prepared by the corporate accounting office with the data submitted by each of the programs. The financials are reviewed by the program administrator, the Vice President and governance authority monthly. The budget review includes an analysis of the program and the ability to meet the specific goals. The financial planning process and budget analysis are documented in the financial planning policy and procedure.

- The Crestwood CARF facilities that did meet the financials goals are: Crestwood Center - Sacramento, Crestwood Behavioral Health Center - Bakersfield, Crestwood Center at Napa Valley.

- Although most of the accredited programs did not achieve their budgetary goals, we did anticipate this due to the budget crisis of California. As a result of these challenges, we formed an executive management leadership team in early 2008. The executive management team includes the CFO, the Treasurer, the Director of Human Resources and both Vice Presidents of Operations. The executive management team developed a financial recovery plan which included both reductions in expenses and increases in revenues. The reductions included a year long wage freeze starting July 1, 2008; a reduction in paid time off – 1 holiday and 2 sick days; and eliminating the 401K match from the organization. The increased revenues included opening a PHF in Bakersfield; increasing the Bridge Pleasant Hill program; increasing Crestwood Manor – Vallejo; increasing the Our House program. These increases occurred as a result of the most profitable and effective programs, while eliminating some of

the less profitable programs, including the MHRC's at Pleasant Hill and Solano.

The following efforts were implemented at the programs with significant losses:

- Crestwood Center – San Jose implemented several changes in March to offset loss of revenue through decreased census. Overtime usage was closely monitored and discouraged. Incentives for reducing overtime were implemented. Cost savings were encouraged and information regarding our financial challenges has been openly shared with staff through meetings, memos and face-to-face contact. As a result of these efforts, overtime usage was contained at slightly above the 1% margin (meets corporate objective). Costs of supplies have also been kept to a minimum. They have been able to maintain a modest profit each month with a year-to-date profit margin of 5%. Financial recovery efforts will continue until we have stabilized. Crestwood Center - San Jose is considering several new options for expanding services through innovative programming and/or creating an unlocked residential treatment wing.

- Crestwood Behavioral Health Center – American River and Fruitridge met budget objectives in the first half of the year with a strong census, but mid-year had a significant reduction in census due completely to the local county experiencing significant budget deficits. The facility implemented cost saving programs and made a significant outreach to more distant counties to increase census. There was some recoup, but ultimately by the end of the year, they were far below budget. This program is anticipating changes in 2009 to meet the current county needs.

- Crestwood Rehabilitation and Recovery Center – Vallejo was profitable, but was below budget due to census reductions. The leadership team made many reductions on expenses of non-essential items and reviewed alternative programs. They are planning to open a RCFE in 2009 reducing the MHRC to a census that is realistic and meeting an unmet need of the county stakeholders.

- Bakersfield was approached in late 2007 to open a PHF. As a result the Bakersfield Bridge was closed to open the PHF, meeting the needs of the local stakeholders and increasing the efficiency of the programs on that campus. In 2008 the Bakersfield MHRC and PHF were profitable.

- The Eureka programs historically operated within budget; however mid 2008, as a direct result of the state budget reductions to counties and county budget challenges, the census dropped significantly and did not return for the remainder of 2008. To address facility losses, overtime was decreased and non-essential projects put on hold. The Eureka leadership

continues to meet with Humboldt County to review options, to increase the census and to meet the unmet needs of the county.

Financials reports for the CARF programs are maintained by the accounting office and available by request to the CARF project manager.

5) Corporate Occupancy Analysis

The corporate occupancy is reviewed and analyzed by the program administrators and the Vice President on a daily basis. There is frequent communication and input from program administrators regarding census and census issues routinely and during behavioral health meetings. The programs work as a team making intra-agency referrals whenever possible to minimize the waiting period for all individuals. The behavioral health administrators developed and implemented a referral process for inter-program referrals.

- The occupancy is provided daily to the corporate office and the reports are analyzed weekly and monthly by the Vice President. The census is analyzed at the facility level on a daily basis by the program administrator and leadership team. The facility makes shifts in operations and admissions as needed.

The facility occupancy rates for 2007 and for 2008 are reflected below:

Mental Health Rehabilitation Centers	**2007 compared to 2008**
Angwin	91 % compared to 94%
Bakersfield	87.4% compared to 92%
Eureka	89% compared to 90%
Sacramento	94% compared to 97.5 %
American River	86% compared to 72%
Vallejo	86 % compared to 79%
San Jose	94% compared to 81%

Community Housing Programs	
Bridge House - Eureka	86% compared to 91%
Fruitridge Transitional Home	95% compared to 78%
Bridge Program - Pleasant Hill	84 % compared to 92%

Bridge Program - Fresno	91% compared to 86%
Our House	86% compared to 79%
Pathways	68% compared to 86.5%

Inpatient Services

Crestwood Manor - Vallejo	96% compared to 98%
Crestwood Psychiatric Health Facility	Start up

Crestwood Accredited Programs

Mental Health Rehabilitation Centers	86% compared to 85.4%
Community Housing Programs	86% compared to 82%

The CARF programs provide the services to the surrounding communities and to the counties that require the specific services that each program provides. Each CARF program is designed to meet a unique clinical need from acute psychiatric with recovery service model, sub-acute services, rehabilitation services, stabilization, community re-entry, vocational preparation, community re-integration and independent living. These services are provided with individual program treatment goals but with a fluid and consistent treatment approach. These services meet the current needs of the mental health communities in Northern California.

E) Employee Turnover Trends

The recruitment and retention of excellent employees is the goal of the Management Authority, the governance authority and Crestwood human resource department.

- In 2006, 2007 and 2008 there has been an increased focus of attention on the reduction of turnover by the Crestwood leadership team and Human Resource Department. The focus on turnover led the team to establish a recruitment and retention task force, including a variety of employee stakeholders, to look at trends and to establish best practices for recruitment and retention. These best practices were introduced and implemented as needed at the accredited programs. They experienced a

significance decrease in turnover, and a significant improvement in the recruitment and hiring process.

- The following reports are reviewed and analyzed by the Vice President on a monthly basis. This information is utilized to provide feedback to the program management teams and administrators to assist in efforts to provide stable and effective personnel. The reports are developed and produced by the payroll department and maintained in the accounting department.

The reports include:

1. New Hire and Termination Reports
2. Active Headcount Report
3. Corporate and Facility Overtime and Double Time Reports (Overtime and double time frequently reflect the programs need for additional staff and inability to recruit effective staff).
4. Overtime and double time by department.

In 2008 the CARF programs average a turnover rate follows:

Mental Health Rehabilitation Centers

Angwin	24 %
Bakersfield	32%
Eureka	29 %
Sacramento	38%
San Jose	14%
Vallejo	16%
American Rover	24%

Community Housing Programs

Bridge House - Eureka	18%
Fruitridge Transitional Home	11%
Bridge Program Fresno	48%
Bridge Program Pleasant Hill	42%
Our House	50 %
Engle Program	36%

Crestwood Inpatient Program

Crestwood Manor - Vallejo	24%

Crestwood Psychiatric Health Facility	62% (new program expected turnover)

Crestwood CARF Program Turnover

Mental Health Rehabilitation Centers	25.7%
Community Housing Programs	34%
Crestwood Inpatient Program	43%

The turnover trends are reviewed at each site on a semi-annual basis or more often if needed by the accreditation management team.

F) Analysis of Diversity Compliance

The corporate diversity plan was developed and implemented by the Crestwood leadership team and a group of stakeholders related to Crestwood.

- The plan enables the programs to develop their objectives to meet the specific demographics and needs of each community. The diversity training plan is designed to enable each program to provide orientation and routine training on diversity. The training also gives the program the freedom to design specific training to meet the unique needs at each site. The corporate diversity plan and training plan is maintained at the corporate office and the program diversity plans are maintained at each site.
- The facilities have been very effective at meeting their demographics in their employee make up. The programs and the corporate office are moving closer toward expanding the diversity of the facility management teams and the corporate leadership team and were able to hire individuals who meet all of the position requirements and are in a minority, including administrators and corporate support staff.

G) Accessibility Analysis Reports

Crestwood's programs have made services extremely accessible, continually monitoring and removing barriers on an ongoing basis. The programs' accessibility reports include identification of barriers and efforts made to remove these barriers. The accessibility reports reflects excessive length of time a waiting list, convenience of services, and response time to referrals.

- The facility maintains a waiting list with disposition and wait time data. Services are extremely accessible and whenever possible, any consumer referred to a wait list is referred to another Crestwood CARF program to minimize the waiting time and to provide swift and efficient services. These reports are maintained at each facility and available for review.

- Each facility completes a semi-annual review of accessibility including the following areas: architecture, environmental, attitude, financial, employment, communication, transportation, and any other identified barriers. Each program scans their environment for barriers and proactively identifies the barriers and establishes a plan to remove or remediate each item. The reports are maintained by the Project Manager and available upon request.

H) Analysis of Average Length of Stay

Crestwood programs provide occupancy data daily to the corporate office, which provides the basis for the average length of stay. This data is provided annually at the close of the CARF year by each program. It is analyzed and the outcomes are discussed with the program to ensure that the program remains focused on consumer recovery and community re-integration.

The facilities average length of stay for 2008 is reflected in the following table:

Mental Health Rehabilitation Centers

Angwin	72 days
Bakersfield	111days
Eureka	137 days
American River	98 days
Sacramento	109 days
San Jose	154 days
Vallejo	194 days

Community Housing Programs

Fruitridge Transitional Home	81 days
Bridge House - Eureka	98 days
Bridge Program - Fresno	56 days
Bridge Program - Pleasant Hill	191 days
Our House	158 days
Pathways	62 days

Inpatient Services

Crestwood Manor - Vallejo SNF	278 days
Crestwood Psychiatric Health Facility	6.4 days

Crestwood CARF Programs

Mental Health Rehabilitation Centers	135 days
Community Housing Programs	104 days

I) Critical Incidents Analysis

Critical incidents are reviewed at the program by the program leadership team including, but not limited to, the administrator, medical director and health professional. The incidents are also reviewed at the corporate office by the Risk Management team and the Vice President based on level of risk and outcome of the incident. The analysis of the incidents for each program is included in the semi-annual Performance Analysis Report. This analysis is reviewed by the Vice President, the Director of Clinical Services, and the Behavioral Health Management Team at the semi-annual meetings.

Demographic Summary is included in the Behavioral Health Outcomes analysis below.

J) Service Delivery Analysis

1) Service Delivery Goals:

1. We provide opportunities and support for persons served to lead meaningful, healthy and fulfilling lives in the environments where they live, learn, work and socialize.
2. We will provide a full spectrum of recovery-based services that achieve the highest standard of service delivery and stakeholder satisfaction.

The delivery of services and the effectiveness of services are monitored by the Vice President of CARF operations. The review includes observation and input from stakeholders on the plant services, the program operations including groups and classes, consumer empowerment efforts, community linkage and vocational development.

The service delivery analysis is assessed through routine monitoring of programs and facilities by the CARF management team and the Vice President, in addition to the following reports:

1. Client Satisfaction
2. Grievance/Complaints Summary
3. Average Length of Stay

4. Outcomes Report: Outcomes Measures
    - Community Integration
    - Wellness and Recovery
    - Education Participation
    - Employment Preparation/Stakeholders Outreach
    - Discharge Disposition
    - Client Participation: (program)
    - Service Access

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K) Analysis of the Opportunity for Input from Stakeholders Including the Persons We Serve

The opportunity for stakeholders to provide input is monitored by the facility administrator, the Director of Recovery Education, Director of Clinical Services, the Director of Vocational Wellness and the Vice President. The analysis is conducted through routine visits to the programs, meeting with specific stakeholder groups, and review of the stakeholder satisfaction tools, including:

1. Consumers Satisfaction Reports
2. Staff Satisfaction Reports

The CARF programs have their roots in stakeholder involvement from the inception of all of the programs. The MHRC license requires that the county stakeholders have some responsibility for the oversight of the programs. Crestwood has provided a forum for each community to participate in the development and design of the programs, dating back to 1997, when Contra Costa County Department of Mental Health and consumer leaders, walked through a vacant building to participate with Crestwood in the design and direction for the Solano program. In 1998 both Humboldt County for the Eureka program and Kern County for the Bakersfield program walked through buildings, brought in other stakeholders, including NAMI and the children's division to have input in the process. More recently in 2002, Crestwood partnered with consumers to write the first consumer written program licensed in the state of California and in 2005 partnered with multi-stakeholders, including NAMI, consumers, patient rights, multiple county mental health departments and a CBO to author the first multi-stakeholder written program licensed in the state.

1. In 2007 Crestwood became a Mental Health Services Act partner with Solano County. We created a consumer operated Wellness and Recovery Program. This program has four locations:
    a. Vallejo at the Crestwood Behavioral Health Center – Solano campus
    b. Fairfield - at a location that formerly housed a Consumer Drop In Center

c. Dixon - at a center which provides culturally competent services offering bi-lingual and bicultural services.
d. Solano Community College providing a supported education program offering a certificate in Horticulture.

Stakeholder input and collaboration is a core to the development and delivery of services for Crestwood CARF programs.

2. In 2008 Crestwood opened our first Psychiatric Health Facility (PHF) in Bakersfield at the request of Kern County Mental Heath. We expanded the Pleasant Hill Bridge and eliminated the Pleasant Hill MHRC at the request of community stakeholders and the county. Crestwood expanded Our House and closed the Solano MHRC at the request of San Francisco County and Solano County. CQI reports provide data that is directly from the stakeholder satisfaction questionnaire and is analyzed at both the program level and the corporate office. The satisfaction measures have been strengths in the behavioral health outcomes for the CARF programs.

3. Each program completes a consumer and employee satisfaction questionnaire semi-annually. These surveys were developed with the input of consumers and management. The results of the surveys are reviewed at the facility leadership level and the administrator provides the data and analysis to the CARF management team for the final review and analysis. These have provided rich feedback for program development and staff recognition.

4. The corporate leadership team and the local program leadership team meet routinely with a variety of stakeholders. Each program meets with their host county several times a year and the corporate Vice President meets with most of the counties that we service at least once per year. The corporate office and local leadership also meet with local Community Based Organizations, NAMI stakeholders and provide support to consumer groups and committees throughout Northern California.

5. The input from stakeholders is constantly gathered and analyzed and utilized to provide continuous quality improvement to the programs and throughout the corporate office. The corporate projects and quality improvement projects at each program are designed with the consumer first and frequently come directly from consumer feedback and input. The Quality Improvement Reports are maintained at each facility and the corporate projects are described in the corporate outcomes committee briefings and in the corporate outcomes description of annual accomplishments.

I) Analysis of Behavioral Health Outcomes

In 2007 the Behavioral Health leadership team determined that our existing system of collecting and analyzing the behavioral health outcomes was not meeting our needs or contributing to the Quality Improvement efforts for our programs. Crestwood began the process of analyzing what we should be measuring, how to measure, who to include in the measurement, when to measure and how to most effectively use this information to improve our services.

This process took over a year of analysis and consultation. We employed a group of consultants who assisted us in developing the current Behavioral Health Metric which measures the following:

- Community Integration
- Wellness and Recovery
- Education Participation
- Employment Preparation/Stakeholders Outreach
- Discharge Disposition
- Client Participation: (program)

The programs complete the metrics monthly and analyze them bi-annually submitting the analysis to the Behavioral Health management team for a full review and analysis. The Director of Clinical Services does the final analysis and communicates directly with the programs on the findings, suggestions and commendations. The outcome charts for 2008 are attached to the report.

L) Conclusion

The corporate leadership team, the program leadership teams, the CARF management team, the Director of Recovery Education, the CARF Project Manager, the Director of Clinical Services, the Director of Wellness Education and the many stakeholders that Crestwood partners with share in the opportunity and the challenge to provide exceptional recovery-based mental health residential services to the consumers of Northern California. Crestwood has provided mental health residential services for more than 41 years. Crestwood CARF programs have provided recovery-based consumer centered collaborative programs from the time each program is licensed or certified. This quality of service and willingness to extend ourselves in order to meet the needs of consumer and stakeholder partners is the cornerstone of the Crestwood programs.