Washington State Health Care Authority

Policies for successful transitions 12-months post Behavioral Health discharge for youth ages 15-25

Policies within HCA contracting, current options, opportunities to grow, and barriers

Project Background

Origin

HCA published a report in June 2021 outlining best practice discharges for Transition Age Youth (TAY) ages 15 or 16 through age 25 to ensure youth are discharged into safe and supportive communities. This work came out of previous reports from the Office of Homeless Youth and Away Home WA in 2020 showing **66% of** homeless youth had discharged from a behavioral health inpatient. **20% of total TAY** exiting behavioral health inpatient experienced homelessness within 12 months of discharge.

Workgroups

HCA approved a charter in December of 2021 to implement the recommendations in the report mentioned above. This document outlines what HCA is currently doing to support successful transitions followed by expansion opportunities and barriers HCA faces. Workgroups were formed to compile these documents and further the implementation process. Division of Behavioral Health and Recovery (DBHR) co-organized this work with subject matter experts from the following internal divisions: DBHR-Office of Financial Planning, Medicaid Programs Division (MPD), Office of Tribal Affairs (OTA), and Clinical Quality and Care Transformation (CQCT)- Health Information Technology (IT).

Background and process

HCA holds contracts with both Medicaid managed care entities, Behavioral Health Administrative Services Organizations, direct providers for individuals not in managed care, Tribes and Urban Indian Health Programs, Federally Qualified Health Centers (FQHCs), and plans implementing Public Employee Benefits Board (PEBB) and School Employee Benefits Board (SEBB). These contractors administer health benefits so that Washingtonians enrolled in these plans receive comprehensive healthcare. During the workgroup process, members examined managed care organizations (MCO), Behavioral Health administrative Organizations (BHASOs), accountable communities of health, and PEBB and SEBB health plans' coverage and further clarification from those entities. UIHPs, accountable communities of health, and direct agreements are not yet reviewed.

During this process the workgroup discovered two key values that support successful policies:

- **Continuity** in how policy design is shaped and managed.
- **Alignment** across systems and communities as to collaboratively dismantle inequities.

Definitions

In the following documents you may encounter new terms. While this is not a comprehensive list, you can refer to these definitions from the Integrated Managed Care (IMC) Contract and BH-ASO Contract, effective January 1st, 2022.

"Care Coordination" means an Individual's healthcare needs are coordinated with the assistance of a primary point of contact. The point of contact provides information to the Individual and the Individual's caregivers and works with the Individual to ensure the Individual receives the most appropriate treatment, while ensuring that care is not duplicated.

Peer Bridger- The Peer Bridgers will attempt to engage Individuals in planning their discharge. Hospital staff and the IMC/BH-ASO Hospital Liaisons will help the Peer Bridgers identify potential participants. The Peer Bridger is not a case manager, discharge planner or a crisis worker. However, the Peer Bridger can bring the Individual's perspective into the provision of those services.

"Certified Peer Counselor (CPC)" means Individuals who: have self-identified as a consumer of behavioral health services; have received specialized training provided/contracted by HCA, Division of Behavioral Health and Recovery (DBHR); have passed a written/oral test, which includes both written and oral components of the training; have passed a Washington State background check; have been certified by DBHR; and are a registered Agency Affiliated Counselor with the Department of Health (DOH).

"In reach" means service connection identified in discharge planning engaging with individual prior to exiting residential/ inpatient setting to orient to what to expect, meet the care team, and work out details of discharge/ re-entry needs in a whole person support lens.

"Rehabilitation Case Management" means a range of activities by the outpatient CMHA's liaison conducted in or with a Facility for the direct benefit of an Individual in the public mental health system.

Warm handoff- "A warm handoff is a handoff that is conducted in person, between two members of the health care team, in front of the patient (and family if present)."[1]

Important overview

Within the behavioral health world, there are two primary supports that aid successful transitions, **care coordinators** and **case managers**. These two positions facilitate **warm-hand offs, outreach,** and **in-reach** allowing the outpatient service provider to meet the client before the client leaves inpatient or before they have their outpatient visit. The **case manager** and **care coordinator** follow up with the client to ensure that the youth/young adult is linked with, and understands, what they need to do to successfully receive services. This process increases the likelihood that the TAY will engage in further clinical services and get linked with other needed supports.

Current contract policies supporting transitions phase I

HCA supports policies that aim to enhance positive outcomes during TAY transitions. **MCO** and **BH-ASO** contracts include supports to transition objectives such as basic needs, relationships, and recovery assistance. At state legislative levels, **RCW 70.02** supports health care information access and disclosure while WAC **246-341** informs behavioral health practices.

This table cites MCO and BH-ASO contract sections in the 2022 version that hold potential for use to further develop support and improvement for discharge transitions for transition age youth exiting behavioral health residential/ inpatient settings:

Opportunity	Section	Transition objective
MCO	14	Care coordination (recovery)
MCO	9	Screening and referral in subcontracts (recovery)
MCO	1	Definitions (all)
MCO	11	Discharge supports (basic needs and recovery)

[1] https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/quality-patient-safety/patient-family-engagement/pfeprimarycare/warm-handoff-guide-for-clinicians.pdf

BH-ASO	9	Coordination needs (basic needs and recovery)
BH-ASO	14, 16	Care coordination (basic needs and recovery)
BH-ASO	18, 21	Funding supports (basic needs and recovery)
BH-ASO	1.287	WISe (recovery, relationships)
BH-ASO	1.232	Psychological assessment (recovery)
BH-ASO	17	Case management (relationships and recovery)
BH-ASO	1	Definitions (all)

HCA expansion plans for WG3 phase II

There are many policy opportunities within HCA contracting and beyond to improve transitions.

During phase two, this workgroup hopes to focus on two pieces.

1. Linking with government to government, managed care, and other partners to collaboratively explore state-wide solutions for TAY transitions.
2. Forming a policy crosswalk to inform the alignment of future TAY transition solutions.

This table outlines options that could be expanded:

Opportunity
Build a workgroup with the HCA, MCOs, BH-ASOs, and government to government partners to problem solve TAY transition.
Create clear policy around what should plans be accountable for to reduce disparate care and increase responsiveness.
Follow this with implementation into contract language to ensure accountability by translating the policy into deliverables that are sensitive to the needs of special populations including BIPOC and LGBTQ+ communities.
Identify federal and state level policies and current requirements outlining culturally and developmentally appropriate care.
Collaborate with Accountable Communities of Health (ACH) to identify opportunities that strengthen TAY transition policies.
Create an intra-agency workgroup to align behavioral health recovery language internally with the intention of shifting to an inter-agency workgroup that improves and creates this consistency throughout the behavioral health system.
Work on decision packages or getting other funding to hire a dedicated FTE within MPD that has experience working with tribes, to monitor TAY transition policy shifts and work with MCOs, BH-ASOs, and government to government contract incentives that increase provider connection. HB 1905 linkages may be helpful.
Clarify contract language to identify transition responsibilities.

Increase successful community connections by adding language that enables contractors better access developed inventory of community services that could be shared via interoperable electronic formats.

Identify and create a 3rd party verification and periodic program audit structure of HCA and contractor work around TAY transitions.

Add explicit language highlighting areas for TAY and developmentally appropriate care throughout HCA contracts.

Clarify protective health information data sharing requirements and procedures for providers.