Delivery of Whole-Person Care in Southwest Washington

Report on the First 90 Days of Fully Integrated Managed Care

HCA 82-325 (8/16)

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Guide to abbreviations used in this report	
BH	Behavioral Health
BHO	Behavioral Health Organization
BHSO	Behavioral Health Services Only
CCS	Catholic Community Services
CCW	Coordinated Care of Washington
CHPW	Community Health Plan of Washington
CLIP	Children's Long-Term Inpatient Facility
CMT	Collective Medical Technologies
COPES	Community Options Program Entry System
CRRG	Clinical Rapid Response Group
DSHS	Department of Social & Health Services
E&T	Evaluation & Treatment
ED	Emergency Department
EDIE	Emergency Department Information Exchange
EWIs	Early Warning Indicators
EWS	Early Warning System
FIMC	Fully Integrated Managed Care
HCA	Washington State Health Care Authority
HCS	Home and Community Services
ITA	Involuntary Treatment Act
LRA/CR	Least Restrictive Alternative/Conditional Release
MCO	Managed Care Organizations
MHW	Molina Healthcare of Washington
PACT	Program for Assertive Community Treatment
PCP	Primary Care Provider
RCW	Revised Code of Washington
RDA	Research and Data Analysis
RSN	Regional Support Network
SUD	Substance Use Disorder
SWRHA	Southwest Washington Regional Health Alliance
SWWA	Southwest Washington
WISe	Wraparound with Intensive Services
WSH	Western State Hospital
QOC	Quality of Care

See the Healthier Washington Glossary for definitions of some terms.

On April 1, 2016 the Washington State Health Care Authority (HCA) launched fully integrated managed care (FIMC) in partnership with Clark and Skamania counties (Southwest Washington). For the first time, Washington State Medicaid beneficiaries have access to the full continuum of physical health, as well as substance use disorder (SUD) and mental health services (referred in this report as behavioral health), through a managed care plan of their choice.

All Medicaid beneficiaries transitioned to coverage by one of two fully-integrated managed care plans: Molina Healthcare of Washington (MHW) or Community Health Plan of Washington (CHPW). Additionally, HCA and Beacon Health Options launched a regional crisis response system to replace and improve on the previous mental health crisis system managed through the state's regional support network (RSN).

This report analyzes the first 90 days of FIMC implementation, using data collected through the Early Warning System (EWS), daily calls with key implementation players, and anecdotes from clients and providers.

While the implementation of FIMC holds great promise to transform the delivery system and improve health outcomes, the goal during the first 90 days was to successfully transition behavioral health provider contracts and payments from the county and RSN to CHPW, Molina and Beacon Health Options, and to ensure continuity of care and access to services for Medicaid beneficiaries. Success in the first 90 days is defined by stability.

The state, Managed Care Organizations (MCOs), Beacon, and community partners were committed to achieving three priorities during this transition:

1. Ensure continuity of care and access to care for all clients;
2. Ensure behavioral health providers received timely and accurate payments;
3. Reduce administrative burdens and align as much as possible the processes and procedures for behavioral health providers.

The report supports the conclusion that the FIMC program has achieved success in the first 90 days and met its intended goals. In addition, anecdotal evidence suggests that in the first 90 days, care coordination for patients with co-occurring physical and behavioral health conditions is beginning to improve, including improved referrals between behavioral health and primary care providers, and that behavioral health providers are experiencing reduced administrative burdens.

The first 90 days of implementation have not been without challenges, the most significant of which were the back-office changes and reconfigurations necessary for behavioral health providers to transition to billing managed care organizations rather than the regional support network or county. As shown in this report, these challenges are being addressed rapidly and collaboratively between the provider community, the MCOs, and the state, and have in no way impeded access to care for clients. Lessons

learned in Southwest Washington will be applied going forward as the state transitions to full integration between now and 2020.

FIMC "First 90 Days" Highlights

- As of April 1, 2016, 100,982 Medicaid beneficiaries were enrolled in the FIMC program with Molina or CHPW, meaning they receive the full continuum of physical and behavioral health benefits through their managed care plan.
- 14,631 clients are enrolled in the Behavioral Health Services Only (BHSO) program and receive specialty mental health and substance use disorder services through either CHPW or Molina. The BHSO program was designed to provide behavioral health coverage to clients who receive physical health coverage through the Medicaid fee-for-service system or have other coverage (American Indian/Alaskan Natives, Medicare and Medicaid dual coverage, etc.).
- All behavioral health providers that had been under contract with the county substance use disorder (SUD) program or the RSN (mental health) signed contracts with the MCOs and Beacon, and the provider network has been enhanced and expanded with the addition of one new provider in the Southwest region who had not previously been contracted to serve Medicaid.
- Medicaid payment rates to providers were no less than 100 percent of the rate before April 1, 2016. Additionally, MCOs continued paying providers using the same payment methods that were in place before April 1, 2016, to ensure stability for providers during this transition process.
- Molina and CHPW created back up strategies to manually process claims and support cash flow security to providers in case of initial system problems with claims submission.
- CHPW and Molina have worked collaboratively to standardize processes and minimize the administrative burden on providers, and achieved approximately 85 percent alignment of authorization requirements, contracting structures, and data submission processes.
- Based on data supplied by the Emergency Department Information (EDIE) system, emergency department visits for Molina members enrolled in a fully-integrated plan averaged 6 percent lower for April through June. While this is promising data, due to the seasonality of ED visits, material reductions in ED visits are best evaluated within a same time period each year.
- Western State Hospital discharges in the first 90 days held steady at the same rate of discharge before the transition.

Early Warning System

To prepare for a Medicaid transformation of this magnitude, HCA with Clark and Skamania counties created an Early Warning System that allowed a feedback loop and triage process to identify and resolve systemic issues that may result with the launch of full integration. Led by a steering committee, the Early Warning System responds to transition-related issues that require cross-system collaboration and rapid resolution.

EWS Steering Committee

The Southwest Washington Regional Health Alliance (SWRHA) Board of Directors voted to manage data collection and hosting of the Early Warning System Steering

Committee effective April 1, 2016 as part of their general Accountable Community of Health "Health Improvement & Measurement Planning" responsibilities.

The Early Warning System Steering Committee consists of a cross-system membership of providers, managed care plans, state and county representatives, and criminal justice system representatives. Additionally, Commissioner Chris Brong of Skamania County and Clark County Chair Marc Boldt participated in the Early Warning System Steering Committee during the transition to ensure proper steps were being taken to track the impacts of FIMC implementation. Steering Committee membership includes but is not limited to:

- Clark County – Vanessa Gaston
- Skamania County – Tamara Cissell
- Washington State Health Care Authority – Isabel Jones
- Consumer Communities – Melanie Maiorino
- Public Health Department and Accountable Community of Health (SWRHA) – Dr. Alan Melnick
- Behavioral Health Providers – Craig Pridemore
- Primary Care Providers – Nicoletta Alb
- Community Health Plan Washington – Vanessa Mousavizadeh
- Molina Healthcare – Julie Lindberg
- Beacon Health Options – Inna Liu
- Law Enforcement – Comm. Randy Tangen
- Tribal Representatives – Steve Kutz
- Accountable Community of Health (SWRHA) – Tabitha Jensen

> **Extraordinary Emphasis on Provider Input**
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> *I am a director at a medium size behavioral health organization that provides outpatient mental health and substance abuse treatment as well as supported housing. We serve approximately 4,000 unique individuals a year that are primarily Medicaid beneficiaries. I was very concerned about early adopter and the impact that it would have on access, scope of services, workforce depletion, payment dynamics and a myriad of other issues. The transition has been a lot of work, however, all of the concerns that I had did not materialize. In my opinion, that is due to the emphasis place on provider input –which was really extraordinary— county leadership, HCA leadership and collaborative approaches from the health plans. I feel very optimistic that there is a solid platform for making positive changes to the delivery system in Southwest Washington that is a direct result of FIMC.*
>
> ***John "Bunk" Moren, Executive Director, Community Services Northwest***

Final Early Warning System Indicators

Through a consensus process the EWS Steering Committee identified the following Early Warning System metrics.

SW-WA Early Adopter - Early Warning System
Early Warning Indicators (EWIs)

EWI Category	Quantitative Early Warning Indicator(s)
Payment & Utilization Patterns	1. Delay or decrease in provider payments for BH and PH
	2. An increase in proportion of claims with errors or denials for BH
	3. Spikes in Emergency Department use
Client Experience of Care	6. Spikes in grievances or Ombuds complaints
	12. Behavioral health access to care challenges for foster and foster-to-adopt youth
Crisis System, Western State Hospital, and Jail System	11. Spikes in crisis calls
	4. Spikes in jail use (behavioral health-related) and unduplicated re-bookings
	5. Spikes in use of Western State hospital beds

*Qualitative Early Warning Indicator(s):

7. Drops in numbers of Medicaid enrollees seeking treatment
8. Increased wait time for CD inpatient treatment
9. Extended wait times for outpatient BH and PH care
10. Consumers frequently being shifted between different providers due to client choice; access and level of care issues
13. Rx - increases or decreases in number or type of medications on formulary, volume of prior authorizations, number of denials

*Qualitative EWIs will act as a secondary warning system, supplementing quantitative EWIs. Qualitative information will be collected via survey, key informant interviews, and provider/consumer self-report.

Data Summary

The following is a summary of data collected by the Early Warning System Steering Committee during the first 90 days.

Indicators 1 & 2: Claims Processing and Payment – Molina

Molina: April to June 2016 Results

Behavioral health claim volumes were low in April, with steady increases through May and June, with the most significant increase in the last two weeks of June. The percentage of claims paid within 30 days remained constant from baseline with performance running above 99 percent for both physical and behavioral health claims, with the exception of one two-week reporting period.

Due to the small claims volume, the percent of behavioral health claims denied varied between reporting periods but on average remained consistent with the baseline performance. The percent of denied physical health claims in the first 90 days of FIMC implementation averaged one percentage point lower than the baseline period.

Primary Drivers
The low volume of claims received in April and May was due to 1) normal claim lag (the time it takes to submit claims after the first claims were incurred), and 2) providers not having their systems ready to submit claims to Molina. Knowing providers were having some system challenges, Molina made advanced payment options available to providers to ensure adequate cash flow.

Most denied BH claims were due to one large provider who had submitted duplicate claims, and submitted a high-volume service on the wrong claim form. These claims were denied and the provider has resubmitted correct claims.

Mitigation Strategies
Molina instituted several systems to support providers getting paid accurately and timely, which include the following:

- A process to manually review 100 percent of initial claims for all providers before releasing for payment to ensure accurate payment and avoid denials due to submission errors.
- A rapid response claims team to work through any issues quickly.
- A proactive claims data run for all BH providers to identify potential problems, outreach to providers and support to work through identified opportunities.
- Weekly group all-topic meetings scheduled with BH providers to bring forward any issues and/or concerns, which could include claims related issues, data reporting questions, and encounter questions, and non-claim related support.

Indicator 1&2: Claims Processing and Payment – CHPW

CHPW: April to June 2016 Results
Results for the first quarter show that few claims for behavioral health were submitted in April, followed by significantly increased volume by the end of June. As behavioral health claim submissions increased, technical issues or submission errors resulted in below target turnaround times in claims processing, while processing times for physical health continued on trend at near 100 percent processed within 30 days.

Primary Drivers
Variance from expected performance was primarily driven by large numbers of claims submitted by one behavioral health provider with a specific issue, e.g., duplicate claims.

Mitigation Strategies
To support timely provider payment, CHPW proactively audits 100 percent of Fully Integrated Managed Care claims before processing in order to identify opportunities to engage providers early, to resolve issues at their root, and to prevent denial or delayed payment. When a problem is identified, the CHPW Provider Relations and Operations teams are immediately deployed to offer technical assistance. They continue to track progress side by side with the provider until claims are processed according to standard. Interim payment may be made as a temporary solution. Bi-weekly calls are held with behavioral health providers to provide further technical assistance, identify systemic issues, and provide a resource-sharing platform.

In addition, CHPW and Molina hosted local provider trainings jointly as well as separately, to offer guidance and written instructions about how to request prior authorization (when required), submit claims, and request technical assistance. Both MCOs have hosted local provider forums and facilitate regular meetings by telephone to share information, answer questions, and address issues identified by providers.

Indicator 3: Emergency Department (ED) Utilization Patterns

Molina: *April to June 2016 Results*

Considerations for review of data:

- ED data for CHPW was not reportable for this reporting period. Spikes in ED utilization for CHPW members have not been identified either through the partial data available or anecdotally.
- In order to provide real-time ED data to the EWS committee, Molina has relied on Emergency Department Information Exchange (EDIE) data supplied by Collective Medical Technologies (CMT), thus this data should be considered preliminary data until Molina can validate with claims data.
- Because FIMC and Behavioral Health Services Only (BHSO) are new programs, there is no exact ED utilization baseline data for these populations.
- Because there is presumed to be significant overlap of members in Apple Health before April 1, 2016, and FIMC members after April 1, Molina used three months of AH ED claims data as a benchmark comparison for FIMC.
- There is no ED baseline data for BHSO members because most of this enrollment was Medicaid fee-for-service before April 1 and not enrolled with Molina.

For EWS reporting periods starting in July, Molina will add ED claims data to the report. This data will have a two- to three-month lag.

Highlights of the ED visit data include the following:

- FIMC and BHSO populations are reported separately due to variations in acuity.
- ED trends for both FIMC and BHSO populations have been flat since April.
- Comparing FIMC utilization to AH January to March 2016 ED utilization using EDIE/CMT data, FIMC ED visits/1,000 averaged 6 percent lower for April through June. While this is promising data, due to the seasonality of ED visits, material reductions in ED visits are best evaluated within a same time period each year.
- Comparing FIMC utilization to AH January through March 2016 ED utilization using Molina claims data, FIMC ED visits/1,000 for April and May averaged 9 percent lower than the three-month baseline period but the claims data is not complete yet for April and May.

Working Through the Issues as They Appear

We found the transition to have gone pretty much as expected – mostly smooth but with some hiccups— as we work through interfaces between systems. There were and still are some difficulties with billing and a bit of a learning curve for both us and the MCOs, but we're working through the issues as they appear and the MCOs are generally proving to be positive and cooperative partners.

Craig Pridemore, Chief Executive Officer, Columbia River Mental Health Services

Indicator 4: Criminal Justice System Data

Clark & Skamania Sheriff's offices: *April to June 2016 Results*

A vital indicator identified by the Early Warning System Steering Committee during FIMC implementation was the tracking of jail bookings for individuals with behavioral health issues. After April 1, 2016, an inordinately high rate of jail bookings related to mental health or substance use disorder would have been a key indicator of potential problems with the new system of care.

In order to determine baseline for this indicator, data was collected from the former RSN, Southwest Behavioral Health. The baseline report calls out two categories of RSN individuals: 1) Individuals who are receiving services at the time of booking (active) and 2) Individuals who received services in the past but were inactive in the RSN system at the time of the booking.

The percentage of "active" or RSN-involved individual booking was very low at only 4.09 percent for the calendar year 2015, and the total percentage of those booked who were ever in the RSN system was 25.17 percent.

While these statistics are not fully representative of all Southwest Washington residents living with behavioral health conditions, assessment of RSN data provides the most accurate portrayal of those individuals who are frequently interacting with emergency and criminal justice systems in Southwest Washington, and individuals who were impacted by the FIMC transition.

The Clark County Sheriff's Office assessment of baseline percentages suggests that April 2016 booking numbers are falsely inflated due to the implementation of a new database system at the same time as the April 1, 2016 launch of FIMC. Sheriff's office staff struggled to gain proficiency in the new system and internal quality control measures quickly resulted in successful course correction.

May and June 2016 booking data is in direct alignment with established baseline and prior historic averages for the month of May and June in 2015. There are no concerns or irregular trends.

It should be noted that Skamania County Sheriff's Office was unable to provide baseline data due to database systems limitations. Further, Skamania data provided for first 90 days of FIMC did not give specific detail related to behavioral health factors related to arrest and booking. However, the Skamania County Sheriff's Office has not noted any substantial increases or decreases to local booking rates in April, May, and June 2016.

Based on data collected thus far, the conclusion can be drawn, albeit anecdotally for Skamania County, that FIMC has not resulted in increased county jail bookings for individuals with behavioral health conditions in Clark and Skamania counties.

Indicator 5: Western State Hospital
Health Care Authority: *April to June 2016 Results*

Individuals with serious or long-term mental illness who meet the criteria for involuntary treatment and receive a court order for 90 or 180 days of treatment are admitted to Western State Hospital (WSH) as a bed becomes available and per the state wait list criteria.

Based on the percent of the population served in Southwest Washington, CHPW, Molina, and Beacon Health Options were allocated a portion of Southwest Washington's 40 beds at WSH. Molina Healthcare was allocated 25 beds; CHPW eight beds; and Beacon Health Options seven beds. All three organizations have consistently stayed below their individual allocations and as a group have been four to six beds below the state allocation since April 1, 2016.

CHPW, Molina, and Beacon Health Options have each appointed a WSH liaison to work closely with WSH staff, Home and Community Services (HCS) staff, and other community partners in developing discharge plans, and in finding appropriate settings once individuals are ready for discharge.

WSH staff report high satisfaction in working with the organizational liaisons, citing a proactive approach to discharge planning, problem solving, and identification of barriers to discharge. In the first three months since implementation the WSH liaisons facilitated discharges for six people, in line with the rate of discharge prior to April 2016 (approximately two per month).

WSH Civil Census for Southwest Washington
Aggregated Average Monthly Census
Southwest Washington Allocation = 40 beds

Month	Average Census	# Discharges
April 2016	35	1
May 2016	35	2
June 2016	34	3
	Total	**6**

Notably, the MCO liaisons have also worked closely with HCS staff and behavioral health community partners to create care and crisis plans for 12 individuals preparing to discharge to the new DSHS Home and Community-Based Services Enhanced Services Facility expected to open in 2016, which is based in Clark County. This new type of facility will serve some of the most complex individuals in the state who are discharging back to the community. Preparing these individuals for a smooth and sustained discharge requires an unprecedented degree of collaboration with the behavioral health community to develop care and crisis plans. The two MCO liaisons, in partnership with the HCS liaison, lead these efforts.

Client Spotlight

A Molina Member's Experience

A Molina Liaison helped locate an adult family home for an individual who was leaving Western State Hospital and planned for a pre-placement visit. The liaison arranged follow up appointments for mental health treatment with an outpatient provider as well as team level of care that was program assertive community treatment.

There were complications with this discharge; the member was diagnosed with diabetes in between the completion of the Comprehensive Assessment Reporting Evaluation (CARE) and the time of discharge. Discharge orders related to diabetic management were not included in the Home and Community Services (HCS) CARE assessment, and there were no official orders regarding how the member's diabetes should be managed in the adult family home.

In addition, the social worker had not been able to locate a payee in Clark County before discharge. The Molina Liaison worked with Western State Hospital, the adult family home, the newly assigned primary care clinic, the pharmacy, and mental health case manager to ensure member was able to get a quick follow up appointment, get medications filled, and get the correct orders written for the adult family home.

The liaison also worked to secure transition to a local payee.

This member is in the Behavioral Health Services Only (BHSO) program with Molina, and has Medicare as the primary insurer, and Medicaid fee-for-service as secondary. The Molina eligibility staff worked with the Health Care Authority's eligibility staff to ensure the member was active in coverage immediately after discharge to meet any urgent medical needs.

While this was not a perfect discharge, it reflects Molina's commitment to continuing to work with clients and their placement locations to facilitate smooth transition back into the community.

Indicator 6: Client Experience of Care – Molina

CHPW and Molina Healthcare use 10 grievance categories when addressing member grievances, as required in contract with HCA. These categories include: health plan-specific issues; concerns with written materials provided by the plan; access to care issues for the provider network; plan coverage and benefits; eligibility and membership in a plan; quality of customer service provided by the plan; billing and/or claims issues; problems with referrals and authorizations, and general quality of health care within the network.

Grievance Categories:

Grievance Categories
Health Plan
Written Materials
Access
Coverage and Benefits
Eligibility/Membership
Quality of Service (QOS)
Billing/Claims
Other
Referral/Authorization
Quality of Care (QOC)

Molina: April to June 2016 Results
The number of grievances reported by members increased slightly in April and May from baseline, with a significant (five-fold) increase in the month of June.

Primary Drivers
The primary driver of the June grievance increase was due to a retraining of all Molina member contact center representatives on how to recognize and document grievances in the first and second week of June. The increased volume of grievances related to grievance training was expected and is considered a desirable outcome. The five-fold increase in grievances reporting was consistent with Molina members statewide for all other lines of business.

The second issue impacting grievance counts was a high-volume primary care provider (PCP) leaving a large provider group and the reassignment of members to a different provider group per the direction of the initial provider group. Thus 1,400 members had to change both primary care provider and medical group.

Mitigation Strategies
Better identification of grievances allows Molina to better identify opportunities for improvement. The majority of the June grievances were related to PCP assignment/re-assignment (30 percent), followed by ID card issues (12 percent), and eligibility verification (8 percent). Grievances specifically categorized as related to behavioral health represented .1 percent of the grievances. In Southwest Washington where Molina identified a significant increase in PCP change requests from one particular provider group's members, the Member Contact Center outreached to the members who had submitted grievances to collect additional information. Molina was able to reach and interview 69 percent of the members. The information was aggregated and key themes were shared with the provider directly.

As noted, a large driver of the grievances was related to PCP reassignment. It is regrettable when members have to be reassigned involuntarily and Molina makes every effort to avoid these situations. However, 100 percent of the members were successfully reassigned and Molina continues to work to open additional access within its existing network to provide more PCP choices.

Client Spotlight

A Molina Member's Experience

A Molina case manager was assigned to work with a client who had been admitted to the hospital or treated in the emergency department on 24 out of 31 days that month. The client also had been dismissed from two primary care clinics that month.

The case manager organized a multi-disciplinary care team that included mental health provider staff, Community Connectors (community health workers), a Health Homes care coordinator, and hospital psychiatric liaisons. She also worked with the client to find a new primary care provider and establish care.

The client's care team identified strengths and barriers and created an action plan, including a process for follow up communication with the team.

The following month, the client's use of hospital care and emergency department visits dropped to eight --a third of the client's use in previous months. In the next three months the client's emergency department visits dropped to three and the client has had no inpatient stays.

Molina's Community Connector has helped the client form productive relationships with new providers. Molina's case management team currently talks to the client two to three times a day.

Between the Community Connector and the case manager, the Molina health plan has remained an integral piece of ensuring the client's many service providers are connected, integrated and working as one team.

Indicator 3: Client Experience of Care – CHPW

CHPW: April to June 2016 Results

The number of grievances submitted by members was relatively stable. A spike in the number of grievances due to health care coverage ID cards was identified early in the period.

Primary Drivers

The spike in grievances due to ID cards was due to the lag between receipt of a health plan ID card and the eligibility updates in the state's health care management information system. This spike was a consequence of a State policy change in determining the eligibility date. As of April 1, 2016, the eligibility date is retroactive to the first of the month, rather than the first day of the month following application for benefits. Grievances in this area decreased after the initial spike, though are expected to continue to be an issue for enrollees seeking to use services within the first days of retroactive eligibility being established. It should be noted that this issue did not pertain solely to the FIMC region but affected members of all MCO plans across the state.

Mitigation Strategies

When CHPW identifies an increase in grievances, patterns and root causes are identified and a team is assembled to determine action steps for resolution. On a daily basis incoming calls are monitored by the CHPW Customer Service Leadership Team in order to quickly identify any issues that lead to a spike in grievances. That information is shared with other department leads so that resolution and/or talking points can be shared with the customer service representatives. The sharing of such information occurs via email, as well as during morning information huddles that take place three

days per week and are attended by the entire Customer Service Department. Additionally, the information is aggregated and reviewed on a bi-weekly and monthly basis. The information is analyzed quarterly to look at the effectiveness of interventions that are implemented.

Client Spotlight

A CHPW Member's Experience

When a member asked to change medication providers the member was referred to medical case management for care coordination by CHPW's behavioral health care management team.

The case manager consulted with the member's outpatient mental health provider, to discuss the case manager's role and identify the member's providers at the facility.

The case manager shared information with the member about collaboration with the member's provider and talked about options.

The case manager talked about the importance of complying with the medication regimen and treatment regardless of choice of providers. And, they developed a medication schedule for the member.

The case manager and mental health therapist worked together to support the member in following the medication schedule and succeeding in the community.

Through the education and encouragement provided by the case management and linkage with a therapist, the member chose to remain with the current provider, came to recognize the importance of treatment compliance and is successfully functioning in the community.

The member also felt they didn't need the level of services offered at the current residence, a supportive living center. Working with the member's therapist, the case manager discussed alternative housing options and helped the member apply for the Community Options Program Entry System (COPES) so the member could get community services.

The member now lives in an apartment and requires minimal support.

The member was accepted into COPES and will receive caregiver assistance at home. The member now works with a case manager through his outpatient mental health provider.

Indicator 6: Ombudsman Utilization Data

Beacon Health Options: *April to June 2016 Results*

From April to June 2016, the behavioral health ombudsman served 22 individuals in April, 22 individuals in May, and 19 individuals in June. In total in the fourth quarter of fiscal year 2015/2016 the behavioral health ombudsman served 63 individuals, as compared to 40 individuals in the same time period in FY 2014-2015. As reported by the ombudsman, this increase is related to:

- Transition from reporting only mental health grievances to reporting both mental health and substance use disorder grievances;
- Influx of Medicaid expansion consumers;
- Access to formal appeal and grievance process by substance use disorder services enrollees have that was formerly only given to mental health services recipients;
- Changes in regional mental health service authorization process as transition from RSN to MCOs occurs;
- Increased access to care for individuals seeking substance use disorder treatment. As more people are able to navigate treatment, it is expected that there will be more grievances reported.

April saw an increase in grievances related to consumer rights, dignity and respect and physician and medications. In May there were more grievances related to dignity and respect and physician and medications. June saw higher grievances related to consumer rights. At least 50 percent of the grievances were brought to resolution through information and referral. Average days to resolution ranged from 2.8 days in April, 4.5 days in May and 3.4 days in June, or 3.5 days to resolution on average during the fourth quarter of FY 2015/2015. This is compared to 3.6 average days of resolution in Q4 FY 2014/2015.

> **No Interruption in Mental Health Services**
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> Consumers of public mental health services were completely uninterrupted by the April 1, 2016 roll out of the early adopter plan in Southwest Washington. The transition was really almost seamless. One case stands out as experiencing difficulties accessing services but the issues were not with the transition of care but rather miscommunication. The ombudsman's office has been really pleased with the collaborative work this new era has inspired. Kudos to the managed care organizations for hitting the ground running, to the providers for maintaining the highest level of integrity in services provision and to the Health Care Authority for being available, willing and ready to seek solutions to any concerns.
>
> **Melanie Maiorino, Behavioral Health Ombudsman, Southwest Washington**

Indicator 11: Crisis Hotline

Beacon Health Options: *April to June 2016 Results*

The crisis line received 1,516 calls in April, 1,605 calls in May and 1,484 calls in June. The data is broken down by calls directly to the toll-free number and calls routed to the toll-free number through the Skamania office line phone tree during business hours.

The April figures for the Skamania office line phone tree are lower than May and June due to the routing set on the end of the business day on March 31, 2016. It was correctly routed by May 2016. On average, 92 percent of calls are answered within 30 seconds. The average speed of answer is 14 seconds and the average abandonment rate is 3.3 percent.

SWWA Crisis Line- Clark and Skamania County Direct Call Utilization Data

Month	Total calls	Calls Answered w/in 30 sec	% Calls answered w/in 30 sec	Avg speed of answer	% Abandonment Rate
Apr-16	1516	1489	98.2	13	2.7
May-16	1605	1465	91.3	13	2.6
Jun-16	1484	1476	86.0	17	4.6
TOTAL/AVG	4605	4227	91.8	14	3.3

Indicator 11: Crisis Diversion and Involuntary Commitments

Beacon Health Options: *April to June 2016 Results*

Crisis system data collected from Beacon Health Options suggests a stable crisis system, with mental health and SUD detention rates consistent with baseline data.

Clark County: From April through June 2016 the Clark County crisis team conducted:

- 335 crisis calls, 64 ITA investigations in April, 28 detentions and 13 individuals who voluntarily admitted;
- 278 crisis calls, 59 ITA investigations in May, 23 detentions and 15 individuals were voluntarily admitted;
- 294, 55 ITA investigations in June, 23 detentions and 19 individuals voluntarily admitted

Of the total number of in person meetings, only 28 percent required hospitalization resulting in a diversion rate of 71 percent.

For comparison to available baseline data from Southwest Behavioral Health, an average of 19 individuals per month were detained in 2013, and an average of 24 individuals per month in 2014. Baseline data on voluntary admissions is not available.

Skamania County: From April through June 2016, the Skamania County crisis team conducted:

- 10 crisis calls in April, 2 ITA investigations, 0 detentions;
- 8 crisis calls in May and 4 ITA investigations, 0 detentions;
- 11 crisis calls in June and 4 ITA investigations, 0 detentions.

On average, the crisis team responded to 48 percent of crisis calls with an in- person meeting after providing phone support. As a result, 100 percent of crisis calls the Skamania County crisis team responded to in person were diverted from higher level of care.

This is consistent with available baseline data from 2015, in which no individuals were detained in Skamania County.

Clark County Mobile Crisis	Skamania County Mobile Crisis

April 2016

Clark County: Mobile Crisis and ITA	
Total calls received	335
Resolved after call	235
Required in person follow up	110
ITA Investigation	64
Detained	28
Voluntary Admit	13
Discharged with Referral	10
Other	3

Skamania County: Mobile Crisis and ITA	
Total calls received	10
Resolved after call	6
Required in person follow up	4
ITA Investigation	2
Detained	0
Voluntary Admit	0
Discharged with Referral	2
Other	0

May 2016

Clark County: Mobile Crisis and ITA	
Total calls received	278
Resolved after call	184
Required in person follow up	97
ITA Investigation	59
Detained	23
Voluntary Admit	15
Discharged with Referral	18
Other	3

LRA/CR Monitoring (as of 6/7)	
Least Restrictive Alternative	24
Conditional Release	3

Skamania County: Mobile Crisis and ITA	
Total calls received	8
Resolved after call	3
Required in person follow up	5
ITA Investigation	4
Detained	0
Voluntary Admit	0
Discharged with Referral	3
Other	1

June 2016

Clark County: Mobile Crisis and ITA	
Total calls received	294
Resolved after call	211
Required in person follow up	82
ITA Investigation	55
Detained	23
Voluntary Admit	19
Discharged with Referral	8
Other	6

LRA/CR Monitoring (as of 7/5)	
Least Restrictive Alternative	25
Conditional Release	3

Skamania County: Mobile Crisis and ITA	
Total calls received	11
Resolved after call	7
Required in person follow up	4
ITA Investigation	4
Detained	0
Voluntary Admit	0
Discharged with Referral	4
Other	0

Indicator 11: Substance Use Disorder Commitments

Beacon Health Options: *April to June 2016 Results*

HCA received baseline data from Pioneer Human Services to determine the rate of SUD commitments per RCW 70.96A.140. In 2014, 92 people from Clark County received SUD involuntary commitment services, or an average of 7.6 per month. In the past seven years, two people from Skamania County have received SUD involuntary commitment services.

Consistent with baseline rates:

- Six people from Clark County were committed to SUD treatment in April;
- Seven people from Clark County were committed to SUD treatment in May;
- Five people from Clark County were committed to SUD treatment.
- Zero individuals from Skamania County were committed to SUD treatment in April, May or June 2016.

Indicator 12: Foster System Coordination

Coordinated Care: April – June 2016 Results

Medicaid foster clients who live in Skamania or Clark County receive behavioral health benefits through the Behavioral Health Services Only (BHSO) program in the SW WA region. These clients choose between CHPW and MHW for specialty mental health and substance use disorder health services and receive physical health services and mild-moderate mental health services through the statewide foster care plan with Coordinated Care of Washington (CCW). [1]

CHPW and Molina have collaborated to ensure strong care coordination for these clients, including:

- Using the BHO Access to Care Standards to support determining appropriate level of care, and whether the services should be provided by the BHSO program or CCW;
- Collaborating through case conference on individual cases requiring care coordination;
- Sharing a list of in-network behavioral health providers. Coordinated Care targeted all of these providers for contracting to ensure member continuity of care;
- Developing formal agreements to allow for data sharing.

[1] This is the same system as foster clients experience in all other regions of the state. Foster clients in all other regions receive behavioral health benefits through the regional Behavioral Health Organization and are enrolled in the statewide foster care managed care plan through Coordinated Care of Washington for physical health and mild-moderate mental health.

Beyond the Early Warning System Data

Implementation Issues and Solutions

To ensure a smooth implementation and a mechanism for rapid problem-solving HCA hosted daily phone calls in April 2016 with key implementation stakeholders, including CHPW, Molina, Beacon, Clark and Skamania counties, providers, and a representative from the Regional Health Alliance. During the second month of implementation, calls decreased to three times per week, and decreased to once per week beginning in June.

The following is a summary of the main implementation issues that arose on the calls, and resolution.

Implementation Issues and Solutions	
➢ ***Educating SUD providers outside Clark and Skamania***	
Issue:	**Resolution:**
During the first several days of implementation, HCA and DSHS received reports that SUD providers outside of Southwest Washington thought they could not accept clients or referrals from clients residing in Clark or Skamania counties.	HCA and DSHS issued a joint letter to SUD providers statewide, with information on how to use ProviderOne to identify a client's managed care plan. The letter directed SUD providers to contact the managed care plan if they have a client from Southwest Washington in treatment. Additionally, Molina and CHPW reissued communications to providers about single-case agreements, which allow providers without a contract with CHPW or Molina to be reimbursed for services provided to Southwest Washington residents. These efforts, along with additional education and communication efforts between the state, providers and plans resolved the issue.

Implementation Issues and Solutions	
➢ ***Protected Addresses***	
Issue:	**Resolution:**
Clients with protected addresses are assigned to Thurston/Mason BHO, but request services in Southwest Washington (as well as other regions – statewide issue). Providers in Southwest Washington were unsure how to bill for services for these clients.	Clients with protected addresses, such as victims of domestic violence, must contact HCA to enroll into CHPW or Molina. Additionally, HCA communicated to providers in Southwest Washington that when a client with a protected address arrives for services, they should have the client contact HCA to enroll in CHPW or Molina for coverage.

Implementation Issues and Solutions	
➢ ***American Indian/ Alaska Natives (AI/AN) Enrollment***	
Issue:	**Resolution:**
As of April 1, 2016 AI/AN clients in Clark and Skamania counties were auto-enrolled in “behavioral health services only” coverage and fee-for-service physical health coverage. For AI/AN clients who had previously opted-in to managed care for physical health services, this had the effect of removing their enrollment from managed care for physical health.	AI/AN clients or their heads of household in Clark or Skamania counties may enroll in the FIMC program at any time either online at www.wahealthplanfinder.org or by calling the Medical Assistance Customer Service Center at 1-800-562-3022. HCA shared this information with the Cowlitz Tribe on April 13, 2016.

Implementation Issues and Solutions	
➢ ***Interpreter Services***	
Issue:	**Resolution:**
Before April 1, 2016, mental health providers in Southwest Washington were able to obtain interpreters from private language agencies and receive reimbursement from the RSN. On April 1, 2016, HCA transitioned providers in Southwest Washington to the use of CTS LanguageLink, which is HCA’s statewide interpreter services vendor. CTS LanguageLink is primarily designed and contracted to provide interpreter services in the outpatient setting and had not been contracted to provide translation services in behavioral health settings before April 1, 2016. Certain providers in Southwest Washington, such as crisis service providers and Evaluation and Treatment providers require access to services on a rapid basis, and are not able to provide 72-hour notice for interpreter service requests. Additionally, some languages were not as readily available through CTS. Providers were concerned that they no longer had a mechanism to receive reimbursement if they worked with a different language agency.	By May 3, 2016, HCA developed a process to allow behavioral health providers to access interpreters from private language agencies, as they had before April 1, when they cannot obtain an interpreter through CTS. This process allows behavioral providers to submit an invoice to CTS and be reimbursed for the cost of the private language agency interpreter, as they did before April 1 under the RSN system.

Implementation Issues and Solutions	
➢ ***Juvenile Justice/WISe***	
Issue:	**Resolution:**
The Clark County Juvenile Justice Center supports a program called Connections, which provides wraparound and specialized probation services to juvenile offenders with behavioral health support needs. At times, there are youth who receive services from both Connections and the WISe program through Catholic Community Services (CCS). CCS provides intensive wraparound services to youth and their families in the mental health system. The concern was a duplication of services without clarity of responsibility.	Two different approaches were implemented to provide clarity to this issue. Connections and the WISe programs function from a team model and each program has multiple teams. The experience level of team members as it relates to clinical and community knowledge dictates the length and path of the conversations. Both programs are focused on the highest level of support for families while avoiding any duplication of efforts. This continues to be achieved through ongoing communication and coordination. In addition to this practice, Molina initiated several meetings with the staff of Juvenile Justice, Beacon Health Options, and the MCOs – including Coordinated Care for foster youth, foster alums, and foster-to-adopt enrollees – to gain knowledge from each other and to discuss how they can work together to better support youth in the juvenile justice system. The management staff at Juvenile Justice described the response to this issue as being incredibly helpful and proactive.

Implementation Issues and Solutions	
➢ ***Client addresses in CLIP, SUD Residential and Western State Hospital***	
Issue:	**Resolution:**
HCA has uncovered a variety of issues related to client addresses during the transition to FIMC. Correct client addresses are of greater importance in the transition to full integration, because Medicaid beneficiaries cannot be enrolled in coverage with CHPW or Molina unless they have a correct address/ZIP code in the Clark and Skamania coverage area. HCA has learned that addresses in ProviderOne are typically changed to the facility address when clients go to: • Children's Long-Term Inpatient Facility (CLIP); • Substance use disorder residential treatment; • Western State Hospital This has the effect in Southwest Washington of removing the client from enrollment in CHPW/Molina coverage, and enrolling them in the BHO that corresponds to the address. This address change creates a variety of issues, because the BHO receives a premium payment and becomes financially at-risk for the individual; however they are not the entity that authorized the original treatment. And, typically the individual is discharged back to the Southwest region and CHPW or Molina need to coordinate discharge planning and a treatment plan to prepare for discharge. Upon investigating this issue further, HCA has determined that it is of critical importance that addresses not be changed in ProviderOne simply because an individual has relocated temporarily to receive treatment in an inpatient or residential setting.	HCA and DSHS jointly established an address workgroup to identify solutions to the problem of changed addresses. In May, HCA proposed solutions to the BHO Administrators, which were approved. The solution will allow addresses at SUD residential facilities and CLIP facilities to stay in place as the client's home address, rather than reverting to the facility address. HCA and DSHS are jointly working on a process & communications plan to initiate this change with CLIP facilities and SUD residential providers.

Beyond the EWS Data: Collaborative Systems Developed in Southwest Washington

Behavioral Health Planning Council
The Southwest Washington Region created the Behavioral Health Planning Council, consisting of representatives from Clark and Skamania counties, consumer organizations, the Behavioral Health Provider Alliance, Beacon Health Options, Council for the Homeless, Molina Healthcare, and Community Health Plan of Washington (CHPW). The primary focus of this council is to improve and strengthen the Behavioral Health System Continuum of Care to address unmet consumer needs in a coordinated and integrated manner for the region. The Behavioral Health Planning Council meets monthly and is in the process of developing an ongoing regional plan, using the following guiding principles:

- Make data-driven decisions
- Assess if a topic is a priority/need
- Foster community partnerships
- Support development of provider capacity
- Include consumer voice
- Collaborate and execute with action

The Behavioral Health Planning Council is currently mapping out the existing regional behavioral health systems and identifying top priorities to focus on using community needs assessment data. The group has already started to collaborate on efforts to improve access to services for people with behavioral health disorders and in need of housing. The council has already started working collaboratively on various projects. An example of one is the joint funding a Behavioral Health Specialist to work directly with Lincoln Place, which implemented a “housing first” program in Vancouver, Washington. Partners working on this project include Clark County, Molina Healthcare, CHPW, Beacon Health Options and providers Community Services NW and Share Vancouver. Another effort is focused on providing housing support and treatment to two new apartment complexes that will provide housing targeting people with behavioral health disorders.

The Behavioral Health Planning Council has also created a work group to develop a legislative proposal to submit to the Governor and Legislature during the next legislative session. The proposal will request capital funds to support creating a regional crisis stabilization center to help divert people from emergency rooms, jails and Western State Hospital.

Clinical Rapid Response Group (CRRG)
The Clinical Rapid Response Group (CRRG, pronounced *surge*) was established by CHPW, Molina, and Beacon Health Options to enable immediate response to any difficult clinical scenarios in which the guarantor for services is not immediately obvious. For these situations, decision makers from each funding source (Medicaid or non-Medicaid) have agreed to set up a same-day conference call with each other and the providers to assess the circumstances and determine the immediate and ongoing funding obligations. The CRRG group has been successful in establishing a protocol that

is able to respond to emerging needs immediately and develop a plan of action and communication loop. The CRRG was deployed on one occasion during the first 90 days of implementation and it had the successful outcome of determining short-term funding and long term obligations for services. More importantly, the individual who needed services was able to receive them without delay or administrative interference that could have been a barrier had the CRRG not been in place.

Looking Ahead

As Southwest Washington stabilizes transition-related processes, strategic planning work has begun to increase integration of care and services at multiple levels, and identify and close critical gaps in the continuum of services and supports. The primary areas of focus are:

1) Expand and enhance the full continuum of behavioral health services, particularly crisis response services, detox beds and developing a more structured mobile outreach program for substance use disorder treatment;
2) Increase coordination and communication between medical and behavioral health providers;
3) Convene physical and behavioral health providers to explore co-location opportunities, and
4) Develop collaborative relationships with housing providers to expand affordable, supportive housing services.

Initial specific goals include:

1) Expand children's crisis mobile response services and development of short-term respite services;
2) Increase the number of Evaluation and Treatment (E&T) beds for adults and children to reduce single-bed certifications and out-of-region placements;
3) Develop a training curriculum on the core elements of clinical integration all providers can adopt, such as effective use of Release of Information, and brief screening and intervention models; and
4) Accelerate co-location efforts that are already under way.

The newly formed Behavioral Health Strategic Planning Council, a coalition of MCOs, Beacon Health Options, behavioral health providers, Clark and Skamania counties staff, and consumer and housing representatives is leading the planning to improve the behavioral health system of care. Working collaboratively with the ACH, a similar coalition will be convened this year by the MCOs and Beacon to drive strategy planning for broader health systems integration.

Additionally, beginning with the first nine months implementation baseline period, Department of Social & Health Services (DSHS) Research and Data Analysis (RDA) staff will measure the four key performance targets (mental health treatment penetration; SUD treatment penetration; hospital readmission rates; and emergency department use), and will report results quarterly. The HCA also plans a formal evaluation of the FIMC program.