Parent Initiated Treatment/Admission Practices Stakeholder Breakout Workgroup

October 2, 2018 Meeting

9:00 AM - 11:00 AM

PIT WORKGROUP HB2779	
(1) The Department of Social and Health Services must convene an advisory group of stakeholders to review the parent-initiated treatment process authorized by chapter 71.34 RCW.25. The advisory group must develop recommendations regarding: (a) The age of consent for the behavioral health treatment of a minor (b) Options for parental involvement in youth treatment decisions (c) Information communicated to families and providers about the parent-initiated treatment process (d) The definition of medical necessity for emergency mental health services and options for parental involvement in those determinations. (2) The advisory group established in this section must review the effectiveness of serving commercially sexually exploited children using parent initiated treatment, involuntary treatment, or other treatment services delivered pursuant to chapter 71.344 RCW. (3) By December 1, 2018, the department of social and health services must report the findings and recommendations of the advisory group to the children's mental health work group established in section 2 of this act.	
(1) Welcome/Introductions	**Facilitator: Lonnie Johns-Brown**
• Introduction of participants and review of meeting goals	**Attendees:** Lonnie Johns-Brown, Brad Forbes **On the Phone:** Peggy Dolane, Jaclyn Greenberg, Avreayl Jacobson, Justin Johnson, Mary Soderlind **HCA Staff:** Diana Cockrell, Mandy Huber, LaRessa Fourre, Lois Williams, Paul Davis Lonnie opened the meeting at 9:05 by asking everyone in the room and on the phone to introduce themselves.
(2) Overview of Meeting Goals	**Facilitator: Lonnie Johns-Brown**
	Lonnie informed that today's meeting is to review the information received about admissions practices from Medicaid and Office of Insurance Commissioner (OIC). The response to insurer survey questions and Summary of Carrier Responses from Association of Washington Healthcare Plans (AWHP) discussed at the

	August 24, 2018 breakout meeting, was resent to the group. An email had gone out to request additional questions and several attendees said they did not get the email. Lonnie will be addressing questions during the meeting and asked for additional questions and goals.
(3) Review of Past Meetings	**Lonnie Johns-Brown**
What have we learned about Medicaid and Commercial Insurance?	Lonnie shared the Association of Washington Healthcare Plans (AWHP) responses to the survey questions that were sent to stakeholder group. The overarching theme was the individual diagnosis of the patient and the efficacy of treatment for the patient. It will vary depending on the patient. Medical necessity comes into play, which relates back to the diagnosis. Parent Initiated Treatment (PIT) and Involuntary Treatment Act (ITA) use the same medical necessity standard; danger to self, others, or gravely disabled. OIC has a requirement for private plans to have a plan for mental health treatment. A parent stakeholder shared that these are internal standards and consumers cannot see the information. Diana said the plans are required to have requirements available for consumers. The question was asked if Medicaid has their criteria spelled out on-line. How about the BHOs? What would be the criteria for posting a requirement for PIT under Medicaid? A parent stakeholder asked if there is a national standard for treating adolescents and is it different than treating adults? It seems that Designated Crisis Responders (DCRs) are using adult criteria and there should be a standard for youth that is a different level than what we are treating adults at. The Children's Long Term Inpatient (CLIP) Administrator responded that DCRs use the same standards for youth and adults. It was asked if there are PIT standards that the child has to meet before they are admitted. She said that over the weekend, Mary Bridge turned away a child with an eating disorder. The CLIP Administrator said she would follow-up with Peggy on this specific case. A parent stakeholder asked what combination of behaviors or diagnoses would qualify a youth for PIT or ITA. Lonnie clarified if the question is, if one behavior alone could be significant enough to lead to the use of PIT or ITA? It was reiterated that PIT and ITA are a usually a constellation of issues that qualify a youth for PIT or ITA. There is a high threshold to meet medical necessity (MN). There is always a check and balance between what a patient thinks they need and what is a MN. It was commented that in the real work, it comes down to the Professional Clinician's individual interpretations of symptoms the youth is presenting. This is true in physical health and behavioral health, we can get one opinion by one physician but may choose to seek 2nd and 3rd opinions. A youth may not be admitted to on hospital but when taken to another hospital, presenting issues

	and diagnosis is interpreted differently and youth is admitted. It comes down to having to trust the Professional. Behavioral health clinicians, and/or doctors and sometimes situations, lead to a need for a second or third opinion. A question we may want to ask is are there changes that need to be considered around the PIT medical necessity criteria? Should any single behavior or list of behaviors trigger a PIT admission?
(4) What questions still remain	**Lonnie Johns-Brown**
	Lonnie stated that we need to be careful not to intermingle PIT and ITA. We need to concentrate on the PIT criteria that we are charged to recommend. It is a parent initiated process that is the focus. The request is on the table if we should consider if there should be a list of criteria looked at for youth, other than what is in Washington Administrative Code (WAC) or statute. We would need to be careful not to make a hard-fast list, since behavioral health issues vary significantly by degrees based on the individual. We don't want some list that becomes exclusive. Many factors have to be considered. A significant list could be developed of behaviors that can put youth at risk. Rather than pursue a list, the recommendation could be advisory.
(5) Discussion and identification of recommendations	**Lonnie Johns-Brown**
	After a short break, Lonnie verified that everyone on the phone had the documents that were sent out. So far, no one has expressed concerns about prior authorization for PIT. There is a process to let the plan know about the admission and a review is done during the stay. No prior authorization is needed. A parent stakeholder mentioned that in a previous discussion, it was said that there are some differences with Medicaid. It was recalled that the review timeframes and post admit timeframes vary with BHOs for acute IP treatment. This can be clarified by Kathy Brewer with Seattle Children's Hospital (SCH). It was said that it doesn't appear that plans are refusing to turn down post release treatment options, but there does appear to be a gap in places for youth to be released to. A stakeholder said it is unreasonable to expect hospitals that are providing IP care, whether it is voluntary or involuntarily, to have an ability to know all the post-discharge resources for families and youth. If a physician recommends something that is not available through a BHO or MCO, that would not be useful for the youth or family. Lonnie said that if a youth is on a PIT, whether commercial or Medicaid, the hospital is in communication with the plans during the IP stay. Plans are in contact with the lead provider at the hospital, and whoever else is providing care, to weigh in on continued need for hospitalization. Hospitals are most likely aware of many services in the community. It was also said that regional hospitals may not know all the resources outside of their community, whereas the community hospitals would know more local resources.

	It was asked if there are any other identified gaps in actual process that the group wants to discuss or make recommendations about. A stakeholder said that BHOs are value driven to provide supports in the community, even if the youth would qualify for IP treatment. There is a mismatch between hospital regulations and regulations for BHOs in the community. It was asked to clarify the question, as to whether this was about post discharge resources and was told it was about the front end. Lonnie asked if PIT allows for placement other than in a hospital. It was confirmed that PIT allows for placement outside of the hospital. Is there something that should be happening between hospitals, BHOs, and MCOs to know what the community resources are? If it's not happening naturally, then it needs to happen. The secondary question is how do parents know about the options? The CLIP Administrator informed the group that parents get MH or SUD treatment options from the hospital. A parent stakeholder asked about ITA; what does a parent do when the youth is turned away? It was stated that there are gatekeepers for any and all admission types. It was asked who the gatekeeper is? What is the process? Once the PIT is turned down, what do you do? Are there other entry points? It was informed that a parent will get a form which they must sign and the hospital must maintain documentation that outlines the different inpatient pathways for admission for minors. With the future of HCA managing behavioral health, if there is a primary care physician (PCP) stating the youth needs residential care, then what is the intake process for residential treatment? It seems like hospitals are the entry of care. A parent might be told by many providers that their youth needs residential treatment, but the treatment facility denies. It was said that we would never be able to answer this question with one answer, because there are levels and nuances that are unique to every individual's situation. It was further said there is a continuum of care that is available, but the hospital and professional have to be involved in that. There is a continuum of acute hospitalization to CLIP, when a child or youth's clinical presentation justifies and warrants acute hospitalization or CLIP. Lonnie asked if there are ever barriers to CLIP from the hospital setting? The most significant barriers are most likely bed shortage-capacity issues at both acute and CLIP levels. Lonnie clarified the capacity issue. Youth are sometimes turned down, not because treatment is not needed, but because there are not enough providers or facilities. The whole system's lack of funding, workforce, and physical plants are factors. It's Important to know that there are not enough mental health providers so sometimes patients are not committed when they should be. The CLIP Administrator stated that there are about four hospitals consistently using PIT, Seattle Children's Hospital (SCH), Multi-Care (Mary Bridge), Fairfax, and Sacred Heart. It was suggested that if there are ways to expand the number of providers that are willing to offer and provide PIT, this would be significant

	improvement to the system across the state. There should be recommendations to the Legislature to make the current safeguards more robust to protect hospitals, E&T, and Treatment facilities from litigation so more hospitals and E&Ts would offer PIT. Lonnie said that participation in certain kinds of care is voluntary. You cannot compel private entities in terms of what they offer. Same with individual providers, we can't require that they see youth or other groups. It was asked if there was something the legislature can do that would encourage more hospitals to provide PIT? Stakeholders agreed to this request. There would be a need to hear from hospitals more broadly about this. A WA Hospital Association (WSHA) stakeholder said that she would discuss barriers restricting provision of PIT with her members, as well as complexities in coordinating care between hospitals and BHOs.
(6) Other Business	**Lonnie Johns-Brown**
	None
(7) Next Steps	**Lonnie Johns-Brown**
• Questions that still remain • Recommendations to the Children's Mental Health Workgroup	Next Steps: Lonnie asked for recommendations for the legislature and what questions remain **Remaining Questions:** 1. Are there changes that need to be considered around the PIT criteria? Should any specific behavior trigger that? Professionals evaluating the minor will have requisite expertise to evaluate. Please note RCW 71.34.720, which refers to inpatient evaluation "by a Children's Mental Health Specialist." 2. How can hospitals be encouraged to offer PIT as an admission option? How can the current safeguards be strengthened for hospitals and Evaluation and Treatment Centers (E&T's) to encourage them to consider offering PIT admissions? 3. Are there other issues beyond concerns around litigation, such as concerns around minor's constitutional rights (aka meaningful due process) for the youth? 4. Should a list of criteria be developed that are youth specific for PIT, other than what is in WAC or statute?

	5. What are ways to improve hospitals' knowledge of non-hospital treatment pathways at the time PIT is sought? **Recommendations:** 1. Recommend funding access for additional services. 2. Recommend safeguards or other supports for hospitals and E&T's that encourage, rather than discourage, the provision of PIT. 3. Request possible increase in Medicaid rate. Some hospitals don't accept the Medicaid rate, leaving BHOs and MCOs to fund the remaining cost of treatment. 4. Education and communication developed as to what community resources are available between hospitals, BHOs, and MCOs and inform parents of the resources. Lonnie asked stakeholders to look at the survey, are there other questions? Upon Kathy Brewer's return next week, she can tell us about the gaps between Medicaid and private pay. There seems to be an issue around pre-authorization. The notes will be broken out to remaining questions and recommendations. HCA will compile meeting notes and will be sent to Lonnie by Thursday for review. HCA lead will send out the meeting notes to the group. Stakeholders can return feedback to Lonnie by COB next Tuesday, and refine what is needed to move it forward. Then the document should be ready by next week to put out to the larger group. Meeting adjourned at 10:40.
End Meeting	**Lonnie Johns-Brown**