Washington State Health Care Authority

Substance Use and Recovery Services Plan Recommendation

Recommendation – (1) Establish specific data collection and reporting requirements among Behavioral Health Administrative Services Organizations (BHASOs) related to their regional recovery navigator programs (RNPs); (2) Identify data to be included in the RNP quarterly reports for SURSAC review to monitor program effectiveness and inform recommendations for improvements.

Bill Requirement(s) – This recommendation pertains to ESB 5476 Section 1.3(h), related to "reporting requirements by behavioral health administrative service organizations [BHASOs] to monitor the effectiveness of the [Recovery Navigator] programs and recommendations for program improvement," as well as Section 2.5: "Each recovery navigator program must submit quarterly reports to the authority with information identified by the authority and the substance use recovery services advisory committee [SURSAC] for discussion at meetings following the submission of the reports."

Background

As a key aspect of the Plan and the state's response to the State v. Blake supreme court ruling, the Recovery Navigator Program was initiated as soon as possible following the passing of 5476. Uniform Program Standards were established, and HCA developed a draft data collection workbook for use by the BHASOs and RNP contractors to enable data collection as soon as the programs became operational and open to referrals. The data collection workbook was further informed by meetings with the LEAD Bureau and input from the BHASOs.

At the monthly meetings on March 7th and April 4th, the SURSAC was asked to provide feedback for the RNPs regarding what data to include in the quarterly reports that would help the SURSAC assess the effectiveness of the programs and make recommendations for program improvement. Those notes were collected and forwarded to the RNP leads at HCA on April 25th in a document titled, "Section 1.3(h) – RNP Data Collection & Reporting."

Although the feedback from SURSAC has already been provided to the RNPs for immediate implementation where feasible, this formal recommendation aims to summarize and confirm the following:

> Part I: Current BHASO data collection activity, which was informed by meetings with the LEAD Bureau, input from the BHASOs, and SURSAC
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> Part II: New BHASO data collection recommendations that could be implemented immediately given current staffing, funding, and other capacities
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> Part III: Recommendations for RNP Quarterly Report content to be provided to SURSAC as part of RNP monitoring
>
> Part IV: Data collection & reporting recommendations that are contingent on the implementation of a data integration system that would make them possible

Part I: Current State of BHASO Data Collection

The BHASOs are not collecting data directly. The BHASOs have contracted with local providers, and those providers have hired staff who are collecting the data that is being tracked in the data collection workbook described below. The staff collecting these data do not have full knowledge of, or access to, the comprehensive system of services that people are utilizing.

The following data elements are being collected via the Data Collection Tool Excel workbooks in a uniform manner across all regions so they can be combined and reviewed for statewide, as well as regional, analysis (see Appendix A for details).

The workbooks that contain these data are shared with HCA, from which HCA can summarize (and conduct analyses when possible) and share, in aggregate, within the RNP Quarterly Reports that are provided to SURSAC for review.

Referral & Outreach Data

- **Unique identifiers** that can be linked to outcomes (i.e., services received, arrests, health) to demonstrate overall impact of each RNP and prevent unintentional client duplication. Currently, BHASOs are collecting clients' first and last names, dates of birth, social security numbers, and Provider One IDs as forms of unique identifying information, as well as creating a unique client ID for each individual who enrolls in RNP case management.
- **Referral source** (e.g., child welfare, law enforcement, self-referral, etc.)
- **Referral reason** (e.g., safety concern, in crisis, frequent contact with law enforcement, etc.)
- **Referral location** (address/location from which referral call is made)
- **Demographic Information:** BHASOs are collecting individual-level demographic data at referral intake, which can be used to provide a demographic distribution summary for all other data points collected by the RNP. Each Policy Coordination Group (PCG) is required to gather individual demographic data for all RNP participants, including (but not limited to) age, gender identify, sexual orientation, race, and ethnicity. In the aggregate, such data are necessary and relevant to enable robust analysis, including analyses related to racial equity. BHASOs are collecting the following demographic data for each person referred to the RNP:
  - **Race**
  - **Ethnicity**
  - **Gender**
  - **Sexual Orientation**
  - **Source of Income / Support** (to identify who may qualify for state benefits such as ABD or social security disability)
  - **Housing Status**
- **Outreach Outcome** (e.g., not interested in services, consent signed, individual could not be reached, etc.)
- **Screening Outcome & Case Management Level** (e.g., declined services, enrolled in intensive care, etc.)
- **Direct Client Services Provided by RNP** (e.g., Naloxone, bus pass, clothing, hygiene products, shelter, etc.)

Case Management Data

- **Case management phase / engagement level** (light or intensive case management)
- **Contingency Management Participation** (yes/no)
- **Outreach follow-up** (yes/no)
- **Referral to services made** (multiple selection, see Appendix A for options)
- **Linkage to Care / Warm Hand Off** (multiple selection, see Appendix A for options)
- **Release of Information (ROI) signed** (yes/no)
- **Consent form signed** (yes/no)
- **Individualized Service Plan Created/Updated** (yes/no)

Engagement Report

The following information is also provided quarterly to HCA within each BHASO's Data Collection Tool (PCG = Policy Coordinating Group; OWG = Operational Workgroup):

- Frequency of PCG and OWG meetings (measure of stakeholder engagement)
- Partner attendance at PCG and OWG meetings (measure of stakeholder engagement)
  - Number of attendees

- Representation from law enforcement, prosecution, public defense, government agencies, community advocacy groups, service providers, other relevant local stakeholders

How often did your PCG and your OWG meet this quarter?				
	Meeting Day/Time	Frequency	Counties Covered	Identify meeting participants job titles
List PCG Meetings in Region				
PCG				
OWG				
Please discuss any barriers to the development and ongoing operations of the PCG and OWG.				
How many times has the team engaged in technical assistance this quarter? Are you receiving the level of technical assistance that you need?				
Recovery Navigator Program(s) worked with community groups/business groups this quarter to coordinate approaches and encourage referrals.				
New Engagements	Total Engagements	New Enrollments	Total Enrollements	
Recovery Navigator Program(s) worked with existing outreach programs, families, fire/EMS, hospitals, homeless shelters, and faith-based organizations to coordinate care and encourage referrals.				
New Engagements	Total Engagements	New Enrollments	Total Enrollements	

Part II: New Recommendations for BHASO Data Collection (Immediate Implementation)

BHASO Data Collection

- Seek funds to implement a data integration platform that can serve both as a common database for diversion efforts across the state and as a data collection and management tool for practitioners. If possible, leverage existing platforms already in use by HCA-funded efforts and any closed loop referral systems implemented in the future.
- Establish a quality assurance process for BHASOs to ensure that data in the data collection workbooks are clean, complete, and accurate before submitting to HCA, and a plan in place for data that is deemed out of bounds / unverified for submission
- Where applicable, add data validation to data fields in the data collection workbook (e.g., only dates accepted under DOB and date of referral, only 7-digit numbers accepted in Provider One ID, etc.)

Part III: Recommendations for RNP Quarterly Report Content

It is expected that RNP clients will be engaged in long-term, intensive case management. While some "light touch" participants could see significant individual benefits in a relatively short period of time, many individuals will have complex co-occurring challenges, including extensive criminal-legal system

contact. For these participants, progress toward health, wellness, and stability is expected to take much longer than a year, so evaluations of the RNP in its early years should include formative measures and measures of change (in knowledge, attitudes, or actions) for systems stakeholders, not only data that can assess participant-level formative and outcome metrics. These metrics should include:

- **Referral Response Time** (average and range)
- **Narrative description of referral processes** available for the RNP and any changes to referral processes that have occurred in the quarter
- **Frequency of community referral source and referral source percentages, statewide and for each BHASO**: Number of referrals from different community sources (e.g., casinos, child welfare, family member, etc.)
    - Implement system to add and track referral sources based on submissions in "other" category into the tracking sheets
- **Demographic summaries of RNP outreach and referral data, statewide and by BHASO)**: Total number, racial/ethnic composition, gender composition, sexual orientation composition, and housing status of populations:
    - Referred to RNP through law enforcement diversion
    - Referred through law enforcement social contact
    - Referred through community referral processes
    - Referred but not enrolled (outreach referral)
    - Agreeing to outreach but not case management (outreach status)
    - Enrolled in light case management
    - Enrolled in intensive case management
- **Frequency of reasons for referral statewide and for each BHASO:** Number of referrals made for different reasons (e.g., concern for public safety, concern for self-harm, unlawful possession of controlled substances, etc.)
- **Number and Types of Direct Client Services Received, statewide and by BHASO**: Number and types of services received directly from RNP (e.g., Naloxone, housing voucher, bus pass, etc.)
- **Number and types of services participants have been referred to, statewide and by BHASO** (e.g., healthcare, transportation, behavioral health services, legal services, employment assistance, public benefits, withdrawal management, SUD assessment, outpatient treatment, inpatient treatment, community support organization, housing support, etc.)
- **Number and types of services to which participants have received warm hand-off and engaged in services, statewide and by BHASO** (e.g., healthcare, transportation, behavioral health services, legal services, employment assistance, public benefits, withdrawal management, SUD assessment, outpatient treatment, inpatient treatment, community support organization, housing support, etc.)
- **Number and attendance of PCG meetings, statewide, by BHASO, and by local RNP:** Number of PCG meetings, attendance by representatives with decision-making power from law enforcement, prosecution, public defense, service providers, local behavioral health and other government agencies, advocacy organizations, and other local community partners as relevant.
- **State Census Data** (source: Office of Financial Management)

Part IV: Future Evaluation Recommendations Contingent on New Data Infrastructure

While the impacts of a systems-change initiative like RNP are unlikely to be seen within the first few years, Washington State should currently work to establish the necessary capacities and processes to enable both formative evaluation and summative evaluation of effectiveness. This will likely require the integration of a new data infrastructure or processes that can exploit existing and new streams of

data pertaining to an individual's criminal legal system encounters/involvement, and the outreach, treatment, and recovery support services they receive through RNPs.

Collection of the metrics below should commence – and be included in RNP quarterly reports -- once a data infrastructure has been established that supports user-friendly data collection and management for practitioners:

System utilization

- Use of emergency medical services
- Emergency Department utilization
- Arrest, days in jail
- **New charges with incident date after of referral to RNP** (broken into felony, misdemeanor), to be added to Case Management tab in RNP Data Collection tool
- **Convictions with incident date after date of referral to RNP** (broken into felony / misdemeanor), to be added to Case Management tab in RNP Data Collection tool
- Access to and engagement with culturally appropriate, non-punitive, community-based resources

System response

- Capacity and variety of local services aligned with RNP's commitment to harm reduction and holistic care
- Number and percent of substance-possession related law enforcement encounters that result in arrest, booking, and/or convictions for RNP-eligible behaviors, as well as the demographics of those individuals engaged by law enforcement in these encounters
- **Racial disparity analysis** that compares demographics of individuals who are arrested and booked into jail, compared to the demographics of those who are referred to RNP, among diversion-eligible individuals

Quality of life

- Self-report quality life/well-being
- Improved mental and physical health

- **Services & Access Gap Analysis**: Indicated by comparing services needed/requested by RNP participants, referrals made, referred services received by BHASO region, and reasons why services were not received (if applicable). If the data collection burden for case managers is too great for this level of analysis, request that case managers report areas where service gaps are a persistent problem.
- **Participant Satisfaction**: Collected via survey every six months following enrollment in RNP, with procedures in place outlining minimum and maximum contact efforts and whether anyone (e.g., those who un-enroll from RNP case management, or move out of state) should not be included in follow-up data
- **Number and percent of substance-possession related law enforcement encounters that result in RNP referral**: The BHASOs will be tracking "source of referral" for each RNP participant, which includes referrals from law enforcement officers, so the quarterly reports can include # and % of referrals from LEO to the RNP. However, this new recommendation refers to numbers indicating the percent of LEO encounters or arrests that do *and do not* lead to RNP referral – and the associated demographics. Since the BHASOs do not have access to this law enforcement encounter data, implementation of this recommendation is contingent on having a method for collecting such data.
- **Demographics of non-diverted arrests** for RNP-eligible behaviors

Approximate Financial Support & Staffing Needed:

Funding to execute Parts I-III are secured with the existing RNP budgets (approximately $20 million per year).

Implementation of Part IV would require additional funding to support the following:

- Investment in the software selected by the state to create the necessary infrastructure
- Technical Assistance to setup and provide ongoing technical support to every BHASO to implement the new data
- At least one FTE to manage data coordination with the new infrastructure and prepare data for RNP quarterly reports that are out of scope for the BHASOs to collect

Collaboration with Existing Resources:

- *Law Enforcement jurisdictions*
- *Behavioral Health Administrative Services Organizations*
- *Community behavioral health treatment & recovery support services providers*

SURSA Committee Feedback:

The overall data structure/architecture isn't clear – it would be helpful if this were diagrammed.
Unfortunately, we don't have time to create a diagram in time to provide prior to the SURSAC vote, but this could be provided at a later point for clarification. The data infrastructure that could provide these types of diagrams are captured in the 2nd data recommendation, #13.

"Services received" isn't an outcome. "Effectiveness," which is the standard in the law, is a measure of actual outcomes, e.g., health, arrest, not process or services received.
When the subcommittee discussed this, the general consensus was that "services received" can be considered an outcome if providing services to RNP enrollees is one of the goals of the program. However, the point was well taken that "receiving services" does not measure improvement of quality of life in and of itself, and "arrests" and "health" have been added as examples of outcomes that could more directly capture overall effectiveness.

Collecting Provider One IDs as a unique identifier only helps for people who get public funding. What about SSN, and trying to link to the all payer claims database?
Omitting "social security numbers" from the initial list of unique identifiers was an oversight, and that has been added. First name, last name, date of birth, and social security number should be sufficient unique identifiers. During implementation, the feasibility of using these unique identifiers to link to data from the All Payers Claims Database can be explored.

(Referring to page 2, "Direct Client Services Provided by RNP"): Naloxone, bus passes, clothing, hygiene products, etc. are supplies, not services.
The subcommittee views "providing supplies" as a service, and this is the language used in the RNP Workbooks. If this issue should be pursued further, "Direct Client Supports" could be an alternate way to phrase this in the workbooks and reports.

Somewhere there should be a safety/harm reduction plan and services identified separately from direct services provided.
These types of services are outlined in the client's individualized service plan

How is contingency management measured – that they indicate they want to start, that they do start, how many sessions, results? Y/N is inadequate to document receipt of contingency management.

Contingency Management participation is tracked in the workbook (see Appendix A) with a new entry for each engagement, so each engagement prompts a Y/N outcome, as opposed to a single Y/N response to indicate whether they are participating in CM in general or not.

Unless "referral response time" is tracked in real time, it doesn't seem such summary data would be available.
While a warm hand-off is ideal – in which case there would be effectively no time between referral and response – there will be situations when there will still be a time gap between the initial referral and when the RNP can respond to that referral. This data (date/time of referral, date/time of response, and time elapsed between the two) is being collected in the workbooks (see Appendix A), so it will be available. The subcommittee would like clarification for what is meant by "real time," if this response does not address the concern.

Not sure what you mean by "formative and summative evaluation." The law specifies "effectiveness" which mean real world outcomes utilizing individual level data. Presumably with some quasi-experimental design, either within-person longitudinal or a comparison group.
We may be able to use quasi experimental design to assess effectiveness, as well as other measures of effectiveness.

"Use of Emergency Medical Services" data is very hard to get, vs. health care utilization, e.g., Emergency Department of hospitalization/CHARS. Do you think you'll get this from WEMSIS?
The source of this data would need to be determined if/when new data infrastructure (outlined in the other data recommendation, #13) is implemented. In the meantime, "Emergency Department utilization" has been added below "Use of Emergency Medical Services," as that is a measure of interest as well.

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Appendix A: BHASO Data Collection Tool for RNPs

[BHDS]= Dropdown options (demographic fields) aligned with Behavioral Health Data System

Referral & Outreach Data

Data Element	Data Type / Validation
Provide One ID	7-digit numeric-only entry (data validated)
Client ID	8-character alpha-numeric: Aa11aa11
First Name	Letters only
Last Name	Letters only
Alternate Name / AKA	Letters only
Date of Birth	Indicate "unknown" if not collected
Date of Referral	mm/dd/yy
Time of Referral	Please use 24 Hour clock (3:15pm = 15:15)
Referral Response Time	Please use 24 Hour clock (3:15pm = 15:15) URBAN response time goal: within 30-45 minutes RURAL response time goal: within 60-90 minutes
Referral Source	SINGLE SELECTION: • Business Community • Casinos • Child Welfare • Community Based Organization • Criminal Legal System (e.g., Probation, Pretrial Services) • Emergency Department • Faith-Based Organization • Family Member • Fire/EMS • Harm Reduction Program (SSP) • HealthCare Referral • Homeless Encampment • Law Enforcement – Arrest Diversion • Law Enforcement – Social Contact Referral • Motels • Outreach • Self-Referral • Social Contact • Other
Referral Reason	SINGLE SELECTION: • Concern about safety of others • Concerns about self-harm • Unlawful possession of controlled substance (ESB 5476) • Frequent contact with law enforcement (LE) • In crisis • Interfering with business • Solicitation • Theft • Other
Location of Referral / Outreach	Full street address if known Alternatively: list location and zip code (e.g., Seeley Lake Park, 98499)
Race [BHDS]	MULTIPLE SELECTION: • American Indian / Alaska Native • Asian Indian • Black or African American • Cambodian • Chinese • Filipino • Guamanian or Chamorro • Native Hawaiian • Japanese • White • Korean • Laotian • Middle Eastern • Other Asian • Other Pacific Islander • Other Race • Unknown

Ethnicity [BHDS]	MULTIPLE SELECTION: • Cuban • Hispanic – Specific Origin Unknown • Mexican • Not of Hispanic Origin • Other Specific Hispanic (e.g. Chilean) • Puerto Rican • Unknown • Refused • Not Collected
Gender [BHDS]	SINGLE SELECTION: • Female • Male • Transgender • Intersex • Transgender Female • Transgender Male • Unknown
Sexual Orientation [BHDS]	SINGLE SELECTION: • Heterosexual • Gay/Lesbian/Queer/Homosexual • Bisexual • Questioning • Choosing not to disclose
Source of Income / Support *per Sec 1.3(m)*	SINGLE SELECTION • Wage/Salary • Public Assistance • Retirement pension • Disability • Other • None • Unknown • Not collected
Housing Status [BHDS]	SINGLE SELECTION: • Homeless without housing • Foster home/ foster care • Residential care • Crisis residence • Institutional setting • Jail / correctional facility • Private residence • Independent living • Dependent living • Private residence – youth • Other residential status • Homeless with Housing • Unknown
Screening Outcome / Case Management Level	SINGLE SELECTION: • Outreach referral (declined services) • Outreach status • Enrolled in light case management • Enrolled in intensive case
Direct Client Services	MULITPLE SELECTION: • Naloxone • Shelter (e.g. housing, motel voucher, sleeping bag) • Coffee • Food/Gift Card • Hygiene Products • Family Support Services (e.g. childcare, diapers, food) • Bus pass • Medical expenses • Clothing • Other • Multiple Resources Provided
Outreach Outcome	MULITPLE SELECTION: • Not interested in services • Consent signed • Exchanged contact information • ROI signed – enrolled • Unsuccessful contact attempt (i.e., person absconded) • Provided list of resources

	• Called Crisis Services • Scheduled Follow-up meeting • Individual arrested after referral • Other

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Case Management Data

New entry (row of data) created for each case management event

Provider One ID	7-digit numeric-only entry (data validated)
Client ID	8-character alpha-numeric: Aa11aa11
Date of Case Management Event	Mm/dd/yy
Case Management Phase / Engagement Level	SINGLE SELECTION: • Light case management • Engaged/intensive case management
Contingency Management (Participation)	SINGLE SELECTION: • Yes • No
Outreach Follow-Up	SINGLE SELECTION: • Yes • No
Referral to Services Made	MULITPLE SELECTION: • Basic Needs e.g. hygiene, food, clothing • Public Benefits (e.g. DES, Social Security, Health Insurance) • Physical healthcare referral • SUD Referral – Withdrawal Management • SUD Referral – Assessment • SUD Referral – Outpatient • SUD Referral – Inpatient • Community Support Organization (Recovery Café, other nonprofit) • Self Help Support Group (AA/NA/ Alanon/SMART recovery/etc) • Faith-based organization • Housing
Linkage to Care (Warm Hand-Off)	MULITPLE SELECTION: • Basic Needs e.g. hygiene, food, clothing • Public Benefits (e.g. DES, Social Security, Health Insurance) • Physical healthcare referral • SUD Referral – Withdrawal Management • SUD Referral – Assessment • SUD Referral – Outpatient • SUD Referral – Inpatient • Community Support Organization (Recovery Café, other nonprofit) • Self Help Support Group (AA/NA/ Alanon/SMART recovery/etc) • Faith-based organization • Housing
ROI Signed	SINGLE SELECTION: • Yes • No
Consent Form Signed	SINGLE SELECTION: • Yes • No
Individualized Service Plan Created / Updated	SINGLE SELECTION: • Yes • No