Washington State Health Care Authority

Washington State Department of Health

Monthly Tribal Meeting

September 5, 2018

Jessie Dean
Tribal Affairs Administrator
Office of Tribal Affairs

Tamara Fulwyler
Tribal Relations Director
Office of the Director

Agenda

9:00 AM	Welcome, Blessing, Introductions
	Health Care Authority
9:10 AM	Behavioral Health Updates
9:15 AM	Review of Substance Abuse Block Grant Data on Prevention, Treatment, and Crisis Services
9:40 AM	Behavioral Health Conferences
9:50 AM	Tribal Opioid Media Campaign, Resources, & Tribal Opioid Grants
10:10 AM	Peer Support Services for Substance Use Disorder
10:50 AM	Standardized Consent Management for 42 CFR Part 2
11:00 AM	Post-Eligibility Review for Apple Health (Medicaid)
11:15 AM	Scheduling of State-Tribal Workgroups
11:20 AM	Updates on Apple Health (Medicaid)
	Health Care Authority and Department of Health
11:30 AM	Open Session for Questions, Issues, and Discussion
12:00 PM	Closing

Lucilla Mendoza, Tribal Behavioral Health Administrator

Behavioral Health Updates

Block Grant Consultation Follow Up

Sarah Mariani, Supervisor

Lucilla Mendoza, Tribal Behavioral Health Administrator

SABG Data on Prevention, Treatment and Crisis Services

Outcomes Data-SUD Prevention (Tribal Programs)

State Fiscal Year	Total # of Programs
2014	70
2015	77
2016	45
2017	117*

* Programs which had activity data entries in SFY 2017

State Fiscal Year	Unduplicated participants	Single service participants
2014	684	1,286
2015	742	897
2016	471	665
2017	370	14,354

Outcomes Data – SUD Prevention (Prevention System)

All Prevention Services Data	Total	AI/AN	Percentage
Unduplicated Participants (all prevention services without Tribal Programs)	15,341	412	2.6%
Unduplicated Participants (all prevention services including Tribal Programs)	15,711	782	5%

Outcomes Data-SUD Treatment

(*Data is dependent upon if Tribes use SABG funds for SUD Treatment)*

2017 NOT YET AVAILABLE

Service Type	FY 2013–2014 **N=9 Tribes*	FY 2014–2015 **N=9 Tribes*	FY 2015–2016 **N=8Tribes*
IOP group therapy	10,692.3 hours	7,601.75 hours	4,393.86 hours
IOP indiv. therapy	1,050.08 hours	933.58 hours	707.21 hours
IOP case mgmnt	108 hours	18.16 hours	8 hours
OP group therapy	5,104.05 hours	2,455.08 hours	1,140 hours
OP indiv. therapy	1,052.48 hours	593.1 hours	230.16 hours
OP case mgmnt	69.5 hours	14.71 hours	2 hours
SUD assessments	561 assessments	423 assessments	194 assessments
UAs/screenings	317 UAs/screenings	199 UAs/screenings	128 UAs/screenings
Total clients served	1,663 clients	1,022 clients	532 clients

Crisis Services 2017

Service Category	STATEWIDE 2017		Statewide Totals/Percentages	
Service Category	**AIAN_P1[3]**	**Non-AIAN**	**AI/AN Percentage 2017**	**AI/AN Percentage 2015**
Any DBHR-MH Service (BHO)	9,329	169,547	5.22%	9.95%
Any BHO Outpatient Service				
Any OP (all modalities)	9,220	168,274	5.19%	9.95%
Crisis Services (OP)	1,827	24,641	6.90%	12.45%
Involuntary Tx Investigation or Hearing	468	6,844	6.40%	11.37%
Any Psychiatric Inpatient	684	10,711	6.00%	11.20%
Evaluation & Treatment	174	2,581	6.32%	12.23%
Community Hospital	459	7,822	5.54%	10.38%
State Mental Hospital	122	1,669	6.81%	13.09%
CLIP	16	167	8.74%	13.10%

Race code used for FY 2017 changed from FY 2015. In 2015 total AI/AN population served is 106,100 compared to 89,341 in FY 2017.

BH Program and Data Reporting Systems

- Compile listing of all BH programs
- Identify total number of contractors/providers/Tribal organizations
- Identify how data is collected (data reporting system)
- Identify if demographic data is collected
  - If so, if there is data collected specifically for the AI/AN population

- *Pull up draft BH Program and Data Document*

Lucilla Mendoza, Tribal Behavioral Health Administrator

Behavioral Health Conferences

Tina Anderson, STR Program Manager

Cheryl Wilcox, Tribal Wellness Program Manager

Tribal Opioid Media Campaign, Resources, & Tribal Opioid Grants

Year 2 of the Tribal Prevention and Treatment Resources Campaign

- Transition the campaign to HCA, and assign new vendors
- Coordinate with Tribes that DBHR was unable to reach in Year 1 to get their feedback
- Provide technical assistance to tribes to customize and distribute campaign materials in their communities
- Plan a series of media trainings on how to implement the campaign in communities
- Develop a photo library of Tribally approved photos for Tribes to use in customizing their media materials

Year 2 Tribal Resources Development

- Provide funding to add opioid treatment training tracks to currently established Tribal conferences
- Provide funding for Tribal participants to attend Opioid misuse related conferences
- Create a "presentation in a box" for the following:
  - Opioids 101
  - MAT 101
  - Licensing of Medical Assisted Treatment
- Expand current campaign to include messaging and materials focused on Parenting and Pregnant Women
- Continue to disseminate media materials to Tribes and partners

Tribal Opioid Mini Grant Updates

- Tribes chose either or both prevention and treatment services to address Opioid Epidemic
- 26 of the 29 Federally Recognized Tribes are receiving grant funds
- Fiscal is providing A-19s to the tribes as the contracts are executed
- Prevention Services - Minerva Data Entry Webinar: September 5, 2018 from 2:30 – 4:30
  - Click on the link below to register
  - https://attendee.gotowebinar.com/register/4546409505572998659

SUD Peer Support Services Development

SUD Peer Services Workgroup-Two Strategic Plan Development Goals

1. SUD Peer Services funded by Medicaid in SUD treatment agencies

- Timeline over 2-3 years
- Goal services in mid 2019 or 2020
- Develop Medicaid State Plan Amendment
- Increase staffing through Training and Certification program

  (budget $650,000: mirror of MH Certified Peer Counselors (CPC) budget)
- National technical assistance
- Training and certification updated
- WAC development
- Preparation and education for agencies and community
- Training of SUD CPC's

2. Community Recovery Supports/Services

- Strategize sustainable funding
- Work on decision Package for State Support
  Identify funding sources:
  - Dedicated Marijuana Account funds
  - Technical assistance regarding funding options in other states
  - General State Funds
  - Grants/Foundations
  - Block Grant funds
    - Develop strategies for Block Grant funds
  - Increased Legislative direction for the use of block grant funds
- Propose action steps
  - BHAC
  - SAMHSA application options

Current Process to Become a Certified Peer Counselors

Anyone can apply and go through the certification process and tribal members are regularly in attendance at DBHR CPC trainings.

- Qualified Peer Counselor: a personal lived experience as MH/SUD consumer or parent of child in services
- Application/approval process
- Training: online & 40 hour
- Testing: oral & written
- Required DOH credential / AAC upon employment + DSHS background
- Part of a clinical team and responsible for documentation
- Peer services connected to treatment goals
- Mandatory reporters
- Oversight by DBHR, DOH, & agency
- Continuing education topics recommended: WRAP, Boundaries, Trauma Informed, etc.

Differences & Value of Each Role

#AllRoadsToRecovery

Mental Health and SUD Certified Peer Counselor

These are peers working a Behavioral Health Medicaid agency

- Personal lived experience as MH/SUD consumer or parent of child in services
- Application/approval process
- Training: Online & 40 hour
- Testing: Oral & written
- Required DOH credential/ AAC upon employment + DSHS background
- Part of a clinical Team, responsible for documentation
- Peer Services connected to treatment goals
- Mandatory reporters
- Oversight by DBHR, DOH & agency
- Continuing education recommended: WRAP, boundaries, Trauma informed, etc.

Community Peer

These would be peers working in non-Medicaid agencies or community organizations

- Personal lived experience as MH/SUD consumer or parent of child in services
- Services based on organizations mission
- Relationship based on availability of peers/agency funding
- Volunteer and/or employed
- Documentation minimal/determined by org and/or funding requirements.
- If required by organization:
- Training: online & 40 hour
- Testing: Oral & written
- Background checks depend on org. policy, funding, etc.
- Minimal required oversight

Recovery Coach

These are people who have been through the CCAR recovery coach training and work or volunteer in their community

- Personal experience, parent or community member affected by SUD
- CCAR training
- Volunteer and/or employed
- Recovery Community & network support
- Continuing education: boundaries, culture, etc.
- Autonomy, oversight by RC community.
- Flexibility to work with peer over time, regardless of treatment or services
- Confidential, not tied to treatment/services/documentation
- Minimal barrier: Level of background checks depend on org. policy, funding, etc.

Bridging from Recovery Coach to CPC

Similarities

Recovery Coach & Peer Support have similar Core Principles of Recovery and similar trainings.

- Person-Centered Approach
- The relationship is the foundation
- Begin with welcoming – outreach and engagement
- Both trainings includes:
  - Trauma Informed
  - Ethics and Boundaries
  - Recovery options
  - Communication
  - Outreach
  - Person Centered
  - Goal setting
- Personal recovery is central from beginning to end
- Peer support & coaching is voluntary; people engage or disengage as they choose

Bridge Training

*This 2day bridge training is being developed as part of the SUD Peer workforce strategic plan.
Additional training/skills needs to become a CPC.

- Appropriate use of personal story
- Ethics and boundaries for clinical work
- Documentation
- Mandatory Reporting
- Supervision Requirements
- Working on a treatment team

Plus

- Online CPC course
- Pass written and oral exam

All certified peer counselors must be able to obtain a Agency Affiliated Counselor Registration from the Department of Health and pass all required background checks

SUD Peer Services Workgroup

Meetings 2 times per month:

1st Thursday 10:00 -11:00 am : Conference call for updates and planning

3rd Thursday 11:00am -1:00 pm: In Person workgroup meeting

Response to invites/participants

Suquamish
Seattle Indian Health Board
NW Portland Area Indian Health Board

Invites through monthly meeting (Lucy), DBHR contacts, & personal invitation. Official letter to inform and invite in process. Other ideas?

Next step for SUD workgroup is to create a strategic plan, which may include:

- Inform and advise on curriculum updates.
- Created recommendations for CMS SPA Amendment language.
- Create recommendations for proposed WAC changes to agencies certification and behavioral health peer services.
- Advise on education and training for agencies.
- Learn from technical assistance teams.
- Strategize ways to fund non-Medicaid peer support services.

Amber Sexton, Data Governance Program Manager

Standardized Consent Management for 42 CFR Part 2

SUD Consent Management Overview

Transformation Hub

September 5, 2018

slalom

Contents

SUD Consent Management Overview

What is SUD Consent Management?

Why is this needed now?

Why SUD Consent Management?

- SUD treatment data can typically only be **shared with patient consent**
- 42 CFR Part 2 is meant to ensure patient privacy but **creates some barriers to seamless care coordination**
- Historically, Part 2 **did not account for technical advances** and only recently provides limited guidance regarding use of technology in care management
- WA State needs a **scalable solution** (e.g. consent form, guidance, consent management tool) for implementing 42 CFR Part 2
- Supports **integrated care coordination** between physical and behavioral health providers to better address patient safety and health outcomes
- Critical need to **address the opioid crisis**

What is Substance Use Disorder (SUD) Consent Management?

Substance Use Disorder Data (SUD) (n):

Data related to the treatment of use of alcohol or another substance that has resulted in health issues or problems at work, school, or home.

+

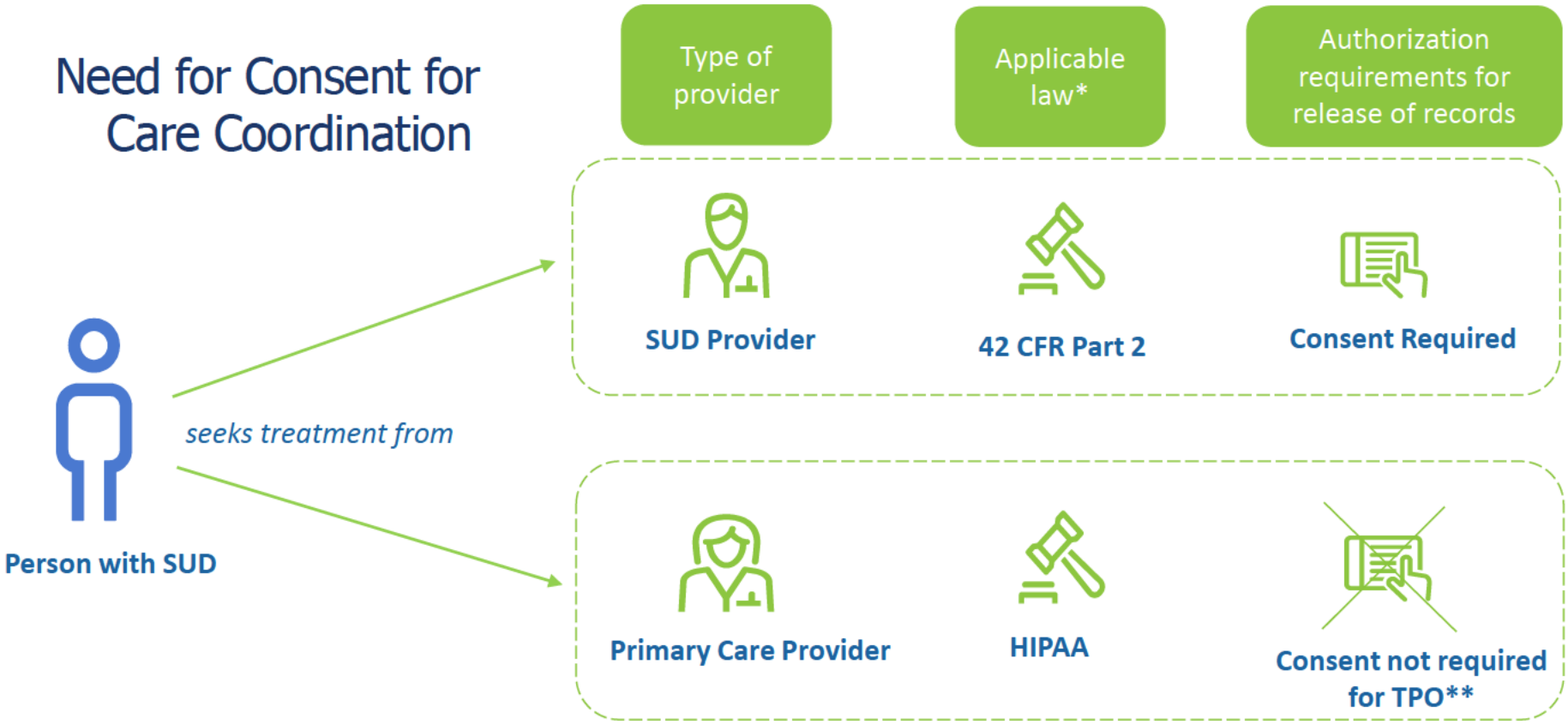
Consent Management (n):

A system, process or set of policies for allowing consumers and patients to determine what health information they are willing to permit their physical health and behavioral health care providers to access.

SUD Consent Management:

- Enables providers to **request consent management in a consistent manner**
- **Supports patient/client decision** to share data
- **Contributes to whole-health care** by facilitating a more comprehensive view of a patient's care
- Supports **transparent decision-making**
- Promotes the **treatment of patient data** as an important **asset and tool**
- Promotes **provider understanding** as to when a request is needed and what can be shared
- Mitigates **unintended data usage** & **release**

Need for Consent for Care Coordination



42 CFR Part 2 (also known as *Confidentiality of Alcohol and Drug Abuse Patient Records*) – A federal statute that governs confidentiality for people seeking treatment for substance use disorders from federally assisted programs. This law generally requires a federally assisted substance use program to have a patient's consent before releasing information to others. It encourages people to seek treatment and reassures patient privacy. Additional information found here: https://www.samhsa.gov/health-information-technology/laws-regulations-guidelines

* RCW 70.02 – Medical Records – Health Information Access and Disclosure is presumed to still apply. RCW 70.02

**Treatment, Payment, and Health Care Operations

Q: Why is SUD Consent Management Needed now?

A: Barriers to Integrated Care

Current Situation:

- **42 CFR Part 2 confusing** to providers
- **Over exclusion** of SUD data by providers
- **Inappropriate sharing** of data by providers
- **No consistent mechanism** for sharing
- **Burdensome requirements** dissuading providers from asking for consent

Gaps:

People:

- Inconsistent understanding of 42 CFR Part 2
- Adverse outcomes due to lack of sharing information for patient care (lack of full integration)

Policy & Process:

- Lack of statewide guidance regarding 42 CFR Part 2
- No standardized consent form

Technology:

- Lack of technical solution to manage consent
- Partner agencies/providers utilize numerous systems

Path to Success

- We must **address the people, process and technology gaps** to
  - Ensure a successful project outcome
  - Increase patient and provider adoption of consent form and tool
  - Encourage inter-agency participation in informing the design of the consent management tool

Gaps:

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Benefits

HCA, partner agencies, providers and SUD patients/clients will realize the following benefits by implementing SUD Consent Management:

Improved Whole Health Care

- Integration of PH and BH provider records
- Informed provider/patient communication

Streamlined Consent

- Reduction in number of forms
- Increased comfort for patients
- Statewide standardized form

Improved Compliance

- Better provider understanding of 42 CFR Part 2
- Improved patient privacy
- Greater confidence from providers to share data

Increased Trust in Data

- Standard data requested in consent form
- Security-based access to data

Implementing SUD Consent Management

What is HCA doing now?

Who is involved?

What is the timeline?

SUD Consent Management Workgroup Overview

Work group members participated in the creation of the **project scope**

Through stakeholder interviews, **partner agencies expressed a strong belief** that a statewide common SUD consent form, consent management tool, and education materials will benefit both patient and provider

The **standardized consent management form** will be reviewed by workgroup members and representative legal resources, as well as and all **Part 2 guidance** and **training and education materials** created

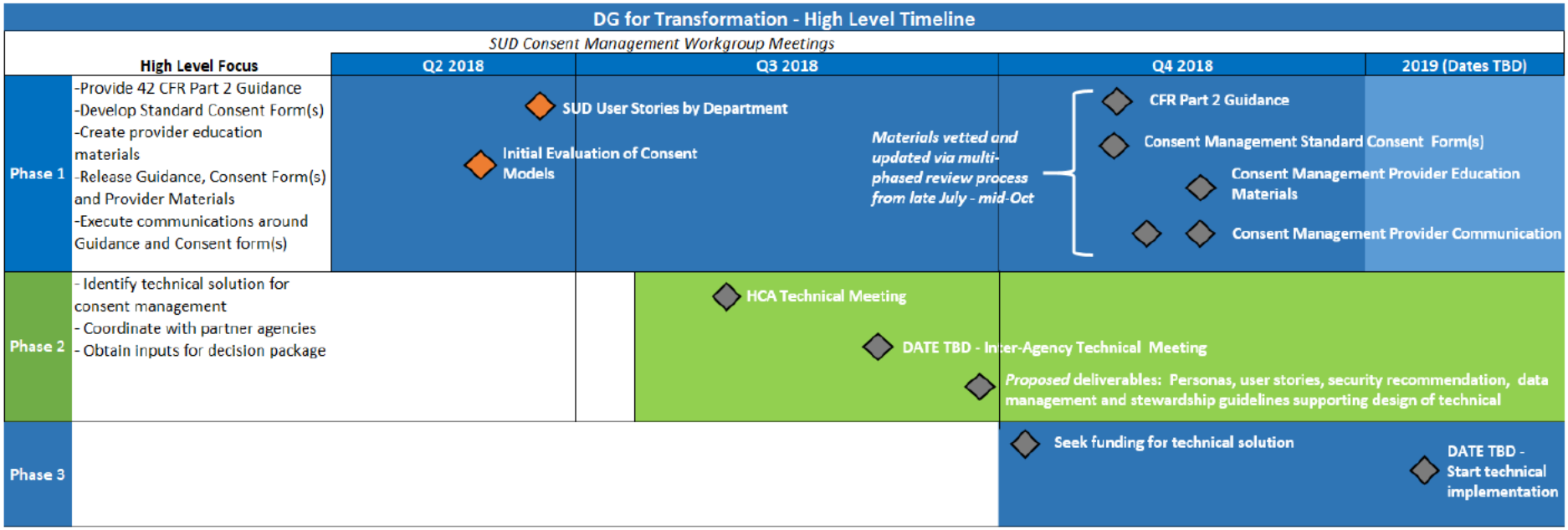
We have **gathered user stories** from each agency, **ranked consent management principles by priority** and are **inviting partner agencies to participate in technical sessions** to provide input into the design of a consent management tool

Stakeholder expectations have been set about the need to jointly participate in the technical design sessions so that the consent management tool

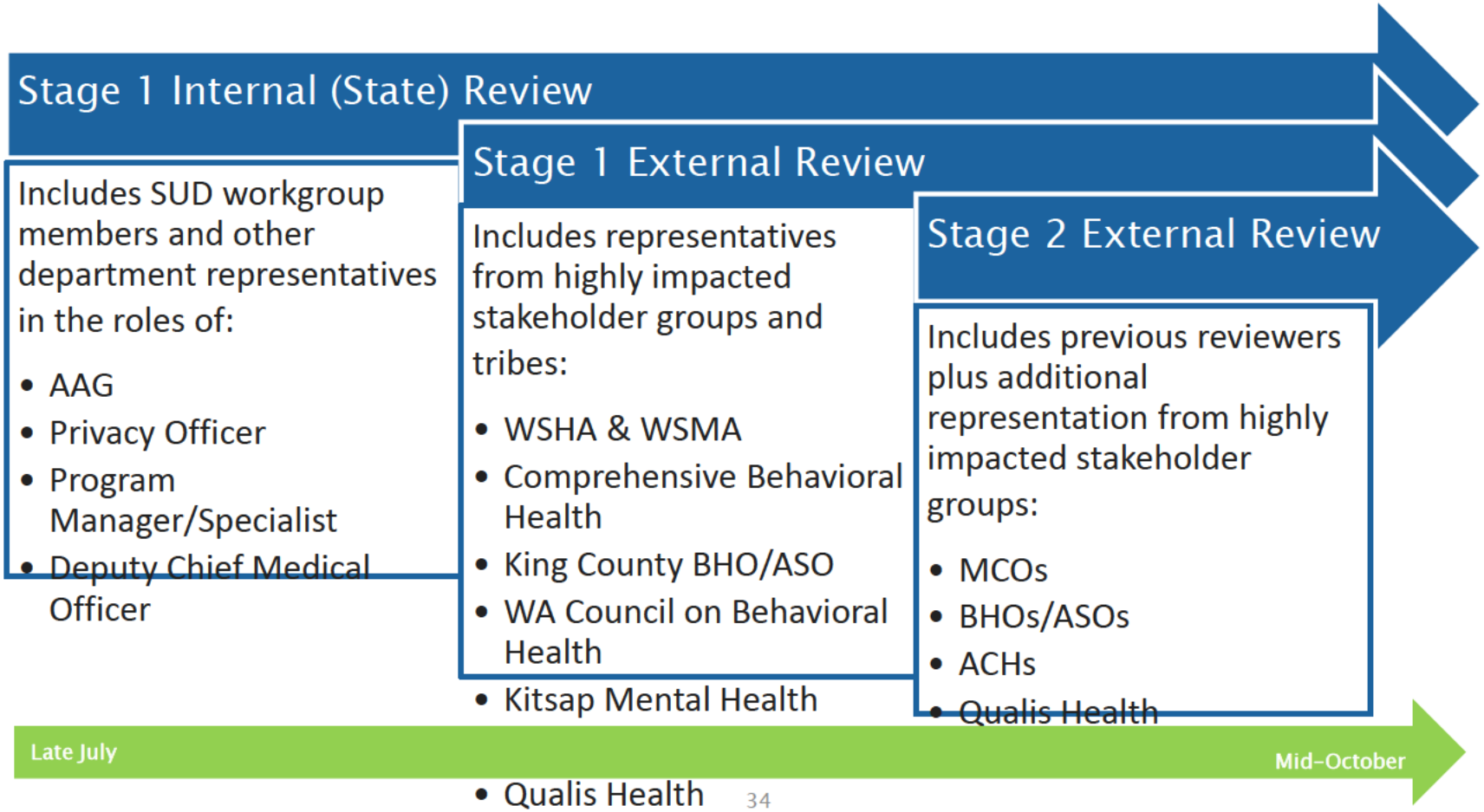
A **high level design for the consent management tool** will be created as an outcome of the technical design sessions

A **communication outreach campaign** will be executed to increase awareness among agencies and providers about this work

SUD Consent Management Workgroup – Phased Timeline



Multi-Phased Guidance Review Process



Deliverables to be approved

- Consent form(s) finalized
- Part 2 guidance document
- Education and training materials for patients and providers

What We Need From You – Workgroup Members

- Let Jessie know who has an interest in participating in review
- Schedule a meeting during September to launch review

Appendix

Stakeholders in SUD Consent Management Workgroup

Agency	Representative	Agency Role
HCA	Amber Sexton	Data Governance Manager, Work Group Co-Lead
	Matt King	Privacy Officer, Work Group Co-Lead
	Jennie Harvell	HIT/HIE Advisor
	Karen Jensen	Acting Director, AIM
	Dylan Oxford	Technical Manager, Clinical Data Repository
	Colette Rush	Behavioral Health, Nursing Consultant
	Christine Quinata	Community Transformation Specialist
	Charissa Fotinos	Deputy Chief Medical Officer, HCA & Medical Director, DBHR
	Brad Finnegan	HCA Contractor
	Shaun Wilhelm	HIT Manager
LNI	Noha Gindy	Health Services Analysis
	Angela Wharton	Privacy Governance Manager
	Tyson Lewis	IT

Agency	Representative	Agency Role
DCYF	Taku Mineshita	Supervisor, Well-Being Unit
	Trishia Benshoof	Program Manager, Screening and Assessment
OFM	Mandy Stahre	APCD Program Manager
	Thea Mounts	APCD Program Director
DOC	Dawn Williams	Program Administrator, Substance Abuse Discovery Unit
	Bryan Smith	Program Specialist, Substance Abuse Discovery Unit
	Jennifer Davenport	Correctional Program Manager – Clinical Services
DSHS	Katy Ruckle	Privacy Officer
HCA/BHR	Jared Langton	Program Director, WA Recovery Youth Services
	Huong Nguyen-Nabors	Sr. Project Manager
DOH	Mary Beth Brown	Director, Practice Transformation Support Hub

Maggie Clay, Office of Medicaid Eligibility and Policy

Post-Eligibility Review for Apple Health (Medicaid)

Post-Eligibility Review

When individuals apply for Washington Apple Health, they report their current countable income on their application and are approved on this reported amount real time.

This reported income is verified with state and federal data sources. If income is found to be not reasonably compatible, a post-eligibility review is completed by HCA staff.

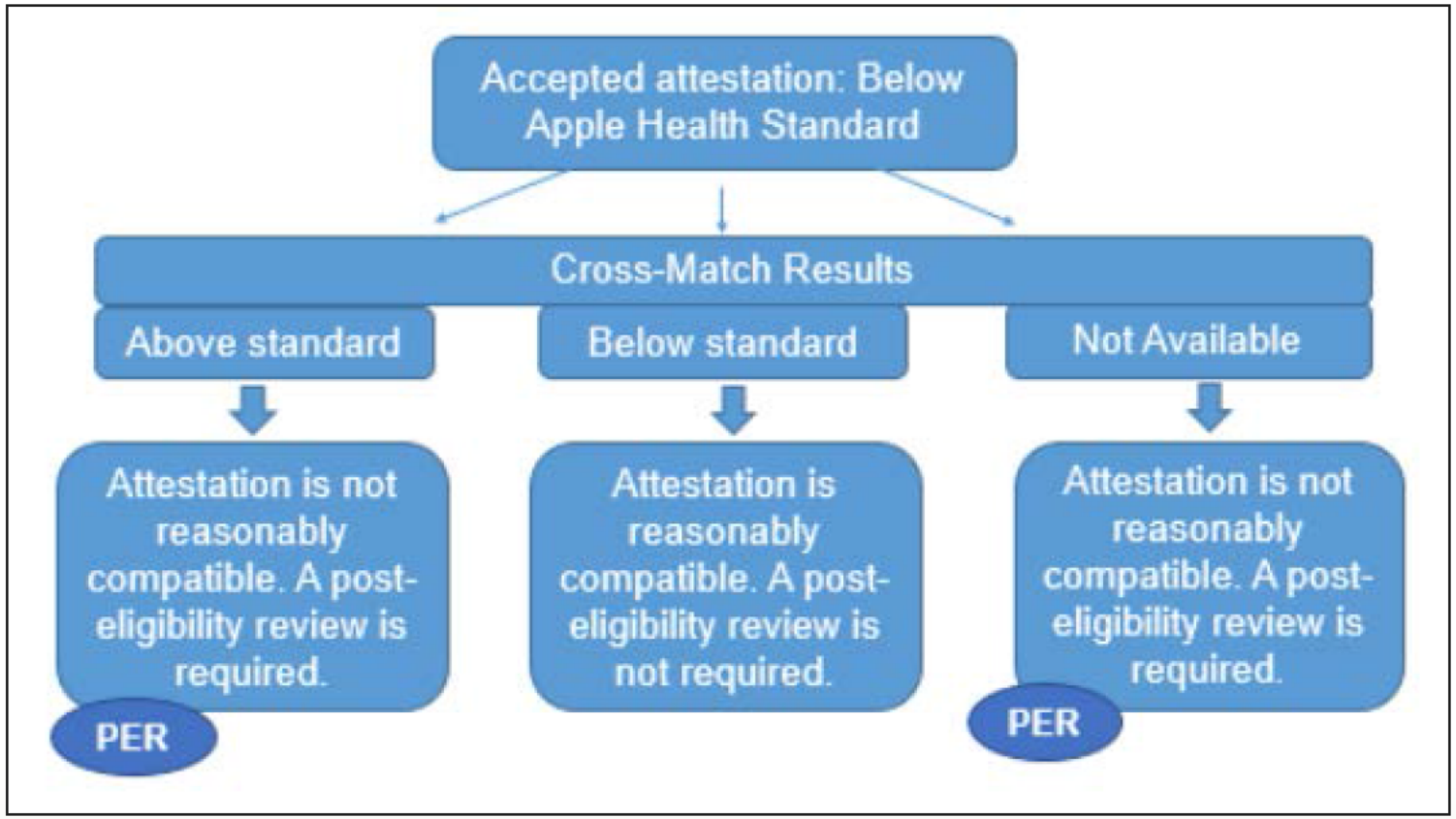
Post-Eligibility Review

Income is described as not reasonably compatible with federal and state sources when:

- The reported income is below the Apple Health standard, but the data sources indicate the income is above the Apple Health standard; or
- The data sources are not available.

See 42 CFR 435.947 and 42 CFR 435.949

Post-Eligibility Review



Post-Eligibility Review

In Washington State that has elected post-eligibility, only a fraction of individuals who are found to be not reasonably compatible have to provide verification of their household income.

HCA staff attempt to verify income using what is readily available, however, as a last resort, they will request the household to provide current verification of the household's income.

See 42 CFR 435.952 and Washington State's Verification Plan

Health Care Authority

Scheduling of Workgroups

Scheduling of State-Tribal Workgroups

- HCA Tribal Consolidated Contracts Workgroup
  - Develop processes and terms for tribal contracts with HCA
  - Target date in late September or early October
  - Meetings will be 1 hour long
  - Materials will be sent at least 1 week before

Scheduling of State-Tribal Workgroups

- Governor's Indian Health Council Workgroup
  - Prepare report on:
    1. Increasing savings to the state from the 100% Federal Medical Assistance Percentage applicable to services received through an IHS or tribal 638 facility
    2. Appropriating these savings for an Indian health improvement reinvestment account to be spent solely for improving AI/AN health outcomes and access to quality and culturally appropriate care
    3. Developing written and technical assistance to support the incorporation of cultural awareness and of strategies to address historical trauma and intergenerational trauma in treatment planning
    4. Expanding tribal representation on state agency boards, committees (including the Emergency Management Council), and nongovernmental entities to the state delegates activities or tasks that directly impact AI/AN health care
  - Target start date in late September
  - Materials will be sent 1 week before

Health Care Authority

Updates on Apple Health (Medicaid)

2019 Managed Care[1]

	Amerigroup	CHPW	Coordinated Care[2]	Molina	United
Greater Columbia	●	●	●	●	
Great Rivers[3]	Through 2019, every MCO along with Great Rivers BHO in every county.				
King	●	●	●	●	●
North Central	●		●	●	
North Sound	●	●	●	●	●
Pierce	●		●	●	●
Salish[3]	Through 2019, every MCO along with Salish BHO in Jefferson and Kitsap Counties; only Molina in Clallam County on a voluntary basis.				
Spokane	●	●		●	
Southwest	●	●		●	
Thurston–Mason[3]	Through 2019, every MCO along with Thurston–Mason BHO in both counties.				

● = Offers Integrated Managed Care in the region.

[1]American Indian/Alaska Native Medicaid enrollees may opt in/opt out of managed care.

[2]Coordinated Care also provides Apple Health Core Connections to Apple Health Foster Care enrollees statewide.

[3]The Great Rivers, Salish, and Thurston-Mason regions will convert to Integrated Managed Care in January 2020.

Health Care Authority and Department of Health

Open Session for Questions, Issues, Discussion

Washington State Health Care Authority

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Washington State Department of Health

Web: ***https://www.doh.wa.gov/ForPublicHealthandHealthcareProviders/TribalPublicHealth***