MEETING of the PENINSULA REGIONAL SUPPORT NETWORK ADVISORY BOARD

DATE: September 4, 2014
TIME: 1:00 pm
LOCATION: Quimper Unitarian Universalist Fellowship, Conference Room
2333 San Juan Avenue, Port Townsend, WA

A G E N D A

1. Call to Order
2. Announcements/Introductions
3. Opportunity to Address the Board on Agenda Topics
   (Limited to 3 minutes per speaker)
4. Approval of Agenda
5. Approval of August 7, 2014 Minutes (Attachment 5)
6. Action Items
   a. Information Systems Development
7. Informational Items
   a. Supreme Court Ruling (Attachment 7.a)
   b. State Hospital Proposed Closures
   c. Behavioral Health Organization (BHO) Developments (Attachment 7.c)
   d. EQRO Update (Attachment 7.d)
8. New Business
9. Old Business
10. Provider Update
11. For the Good of the Order
12. Adjournment

ACRONYMS

PROVIDERS

DRC Dispute Resolution Center of Kitsap, Bremerton, Kitsap County
JMHS Jefferson Mental Health Services, Port Townsend, Jefferson County
KMHS Kitsap Mental Health Services, Bremerton, Kitsap County
PBH Peninsula Behavioral Health, Port Angeles, Clallam County
RMHS RMH Services, Bremerton, Kitsap County
WEOS West End Outreach Services, Forks, Clallam County

REGION

ACH Accountable Community of Health
BHO Behavioral Health Organization
PIHP Prepaid Inpatient Health Plans
PRSN Peninsula Regional Support Network
RSN Regional Support Network

DSHS – DEPT OF SOCIAL & HEALTH SERVICES

DBHR Division of Behavioral Health & Recovery
DCFS Division of Child & Family Services
DDA Developmental Disabilities Administration
DVR Division of Vocational Rehabilitation
HCA Health Care Authority
HCS Home and Community Services

HOSPITALS & INPATIENT TREATMENT CENTERS

AIU Adult Inpatient Unit, KMHS, Bremerton
CSTC Child Studies and Treatment
E&T Evaluation and Treatment Center (i.e., AUI, YIU)
HMC Harrison Medical Center, Bremerton
OMH Olympic Memorial Hospital, Port Angeles
WSH Western State Hospital, Tacoma
YIU Youth Inpatient Unit, KMHS, Bremerton

GUIDELINES

CAP Corrective Action Plan
EBP Evidence Based Practice
HIPAA Health Insurance Portability & Accountability Act
QA/I Quality Assurance/Improvement
RCW Revised Code Washington
WAC Washington Administrative Code

REQUESTS

RFP, RFQ Requests for Proposal, Requests for Qualifications

OTHER

AAA Area Agency on Aging
ARNP Advanced Registered Nurse Practitioner
BBA Balanced Budget Act of 1996
CFT Child and Family Treatment
CLIP Children's Long term Inpatient Program
CMS Center for Medicaid & Medicare Services (federal)
DMHP Designated Mental Health Professional
EPSDT Early and Periodic Screening, Diagnosis and Treatment
EQRO External Quality Review Organization
FBG Federal Block Grant
ITA Involuntary Treatment Act
LRA Least Restrictive Alternative
QUIC Quality Improvement Committee
QRT Quality Review Team
SSI Supplemental Security Income

Go to http://www.kitsapgov.com/hr/wsolympic/prsn/prsnpolicies.htm for a full listing of definitions and acronyms.

PENINSULA REGIONAL SUPPORT NETWORK
AGENDA BRIEFING
September 4, 2014

6. ACTION ITEMS

a. Information Systems Development

Attached you will find an in-depth briefing regarding the PRSN's information systems needs and current plans to improve this aspect of our infrastructure. Based on the briefing and discussions, the Board will be asked to make a recommendation to the Executive Board.

7. INFORMATIONAL ITEMS

a. Supreme Court Ruling

Due to the shortage of psychiatric inpatient beds in Washington State, Designated Mental Health Professionals (DMHPs), who are responsible for fulfilling the requirements of the Involuntary Treatment Act (ITA Act), sometimes have a difficult time finding beds into which to place individuals on involuntary holds. When no bed can be located for a person, the practice for the last decade has been to place the individual on an involuntary hold, and "Board" them in an emergency room until a psychiatric bed can be secured, or to place them in a non-psychiatric bed on a "Single Bed Certification" (SBC). On August 14, the State Supreme Court, on appeal, found this practice to be illegal, and ordered it stopped.

Events continue to unfold regarding this finding, including the announcement on August 24 that the state would provide $30,000,000 to mitigate the ruling. An article from the Daily Olympian is attached, and staff will provide the latest information available

b. State Hospital Proposed Closures

At its August meeting, the Board was alerted to the possible closure of 60 additional State Hospital psychiatric beds. The closure was being proposed as a way to fund necessary improvements to care at the state hospitals. It is believed that that proposal is off the table at this point, but staff will know more at the time of the meeting.

c. Behavioral Health Organization (BHO) Developments

The creation of a Behavioral Health Organization to serve Jefferson, Kitsap and Clallam counties is underway, with RSN staff and the Kitsap County Human Services Director beginning discussions with Clallam County Health and Human Services. At this point, it is a little unclear as to how this formation will progress, but hopefully the next PRSN Executive Board meeting will provide some clarity. The three counties did send clarification to the Healthcare Authority and Department of Social and Health Services regarding participation in the Accountable Community of Health which has formed in the western part of the state – the entity originally applied for planning funds to include our three counties in addition to seven others. The health departments from our three

counties are now in the beginning stages of creating a local Accountable Community of Health.

A planning document from last October from the Health Care Authority is attached for the Board's reading pleasure

d. EQRO Update

Attached is the Executive Summary from the draft External Quality Review Organization (EQRO) report based on the review of the Peninsula Regional Support Network by Acumentra Health in July.

The Olympian

State wants more time to stop ‘parking’ mental patients in ERs

By Jordan Schrader, Staff writer, August 22, 2014

State government says it can open more slots for detaining mentally ill patients but needs more time to do it.

Gov. Jay Inslee’s administration said Friday that it has identified an extra 145 beds, including some in Lakewood and Olympia, and authorized spending up to $30 million to fill them.

But state lawyers asked the Washington Supreme Court for a four-month reprieve from the court’s Aug. 7 ruling that it’s illegal to leave people detained in emergency rooms waiting for mental health treatment.

About 200 people are now undergoing such improper “psychiatric boarding.”

“Additional capacity cannot be created overnight,” the state wrote.

“If the mandate is issued on August 27, 2014,” lawyers wrote, “persons who present a likelihood of serious harm to themselves or others, or are gravely disabled and in need of care, will be required to be released immediately, regardless of whether they have a safe place to go.”

The 4:59 p.m. motion with the high court was filed jointly by the state and hospitals, health care workers and advocacy groups.

Years of budget cuts have closed off space at the state psychiatric hospitals. The state says it needs an extra 120 days to start operating 95 beds, including:

• 10 in an unused wing of a building on the campus of Western State Hospital in Lakewood, available by November.

• 10 at the Thurston County evaluation and treatment center run by Behavioral Health Resources, available by November.

• 25 at Fairfax Hospital in Kirkland, 30 more at Fairfax’s outpost in Everett and 20 at Cascade Behavioral Health in Tukwila, all to be available by October.

All of the those except for the beds near Western State are exceptionally expensive because they are at facilities too large to pull down federal matching money. Eventually, the state hopes to replace them with smaller facilities it is building.

Inslee will ask for more money in his budget request to the Legislature, which returns in January. Without that approval, the extra $30 million would overspend the Department of Social and Health Services' budget.

That price tag includes the 50 beds that the Department of Social and Health Services has said it can have ready by Wednesday, the day it believes the court ruling takes effect without a reprieve.

DSHS said it has opened 10 beds at Eastern State Hospital near Spokane by hiring new psychiatrists, changed a rule to allow for at least 10 more beds at local boarding homes, and secured 12 beds at the Kirkland hospital and 18 at the Tukwila facility.

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@Jordan_Schrader

Attachment 7.c

Systems to Support Integrated Physical and Behavioral Health Care in Washington Medicaid

Options for the Future
October 2013

manatt

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Attachment 7.c

- The Case for Integration
- Options for Advancing Integrated Care: A Review of Select States
- Advancing State Priorities through Managed Care Contracts
- Getting from Here to There: Pathways to Integration in Washington

Definition of Integration

Attachment 7.c

We use the following definitions of integration, adapted from the Agency for Healthcare Research and Quality's *Lexicon for Behavioral Health and Primary Care Integration*:

Integrated System

Administrative structures with supportive reimbursement arrangements that facilitate and enable the delivery of integrated and coordinated care by providers to people with behavioral and physical health needs.

Integrated Care

A practice team of primary care and behavioral health clinicians working together with patients and families, using a systematic and cost-effective approach to provide patient-centered care.

We use the term "**coordination**" to refer to working relationships, information exchange, and shared planning and decision-making among separate entities and individuals.

We use the term "**integration**" to refer to coordination among entities and individuals under shared governance or administrative structures, or in shared physical space.

The Question

People

Physical Health, Mental Health, and Chemical Dependency Needs, Influenced by Social Determinants of Health

Providers

Physical Health Providers	Mental Health Providers	Chemical Dependency Providers

Systems of Care

Physical Health System	Mental Health System	Chemical Dependency System

Administration

Physical Health Administration	Mental Health Administration	Chemical Dependency Administration

What system structures will support bi-directional integrated care delivered by providers to people with physical and behavioral health needs?

Integrated Care is Cost-Effective and Improves Outcomes

Attachment 7.c

For patients with depression

"More than ten studies of collaborative care models for depression [with mental health specialists or trained primary care providers treating depression in primary care settings] in a wide range of health care systems have demonstrated that they are more effective than usual care. Such models have been shown to improve clinical outcomes, employment rates, functioning, and quality of life, and they are cost-effective compared with other commonly used medical interventions."

For patients with serious mental illness

"[F]or a cohort of patients with serious mental illness, integrated, on-site delivery of primary care was feasible, promoted greater access to primary care and preventive care, and resulted in a significantly larger improvement in health status than usual care."

For patients with substance abuse-related comorbidities

Trials integrating primary care into specialty mental health settings "were consistent in reporting improvements in medical care, quality of care, and patient outcomes. Two programs were found to be cost-neutral ... There was also a significant decline in annual costs for a subsample of patients with substance-related mental and medical comorbidities compared to the control group."

Sources: Unützer, JU, M Schoenbaum, BG Druss, and WJ Katon. January 2006. Transforming Mental Health Care at the Interface with General Medicine: Report for the Presidents Commission. Psychiatric Services 57:1, 37-47. Druss, BG, RM Rohrbaugh, CM Levinson, and RA Rosenheck. September 2001. Integrated Medical Care for Patients With Serious Psychiatric Illness: A Randomized Trial. Archives of General Psychiatry 58:9, 861-868. Butler, M, et al. October 2008. Evidence Report/Technology Assessment No. 173: Integration of Mental Health/Substance Abuse and Primary Care. Rockville: AHRQ.

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- Getting from Here to There: Pathways to Integration in Washington

Minnesota Health Care Delivery System Demonstration

Integration Supported at Provider Level Across FFS and MMC

Financial Accountability for All Services at Provider Level

- Minnesota contracts with Medicaid Health Care Delivery Systems (HCDSs) accountable for total cost of care, including physical health, MH, and CD services; the model is similar to an accountable care organization
  - *Financial accountability for intensive residential MH and CD services is currently optional for HCDSs*
- MMC plans contractually required to use same payment methodologies as fee-for-service (FFS) Medicaid for HCDSs in their networks

Flexible Relationships Between Physical Health, MH, and CD Providers

- Integrated HCDSs provide a broad spectrum of care as a common financial and organizational entity
- "Virtual" HCDSs include providers not part of a formal integrated delivery system

Coordination Incentivized through Shared Savings and Risk

- HCDSs in formally integrated delivery systems with 2,000 or more attributed participants are eligible for shared savings progressing to symmetrical shared savings and risk
- HCDSs not in formal integrated delivery systems, or with 1,000 to 1,999 attributed participants, are eligible only for shared savings

Agnostic to FFS or Managed Care Funding Stream

- HCDSs are eligible to share in savings (and, if eligible, risk) regardless of whether enrollees are in fee-for-service (FFS) Medicaid or MMC

Provides for Partnerships Between Providers and Social Services

- HCDSs must incorporate formal and informal partnerships with community-based organizations, social service agencies, counties, and public health resources as part of care model
- HCDSs are encouraged to incorporate entities directly into payment model

MN Health Care Delivery System Demonstration (cont.)

Attachment 7.c

MN Health Care Delivery System Demonstration (cont.)

Attachment 7 c

Potential Advantages

- Provider integration supported at delivery system level regardless of FFS or MMC
- State can hold a single organization accountable regardless of FFS or MMC financing streams
- Opportunity for shared savings promotes whole-person orientation with regard to care, outcomes, and performance accountability
- May provide for greater provider buy-in

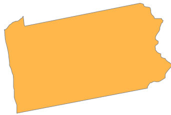
Potential Disadvantages

- May not address coordination and integration challenges posed by separate payment streams and associated regulatory requirements, especially around data sharing
- Coordinating care may be a challenge where care falls outside of HCDS, especially in FFS

Other State Integration Efforts

- Hennepin Health "Safety-Net ACO" Demonstration focuses on integration through county-based health plan, hospital and clinics, incentivizing savings in corrections, social services
- Integrated Dual Disorders Treatment program for MH and CD services
  - New rules require individuals who perform CD or MH assessments to use standardized screening tools for co-occurring mental illness or CD
  - New proposed rules would allow for certification of dual diagnosis treatment programs

Pennsylvania HealthChoices Behavioral Health Program



Attachment 7.c

Carved Out MH and CD Services Offered through BHO

Physical Health Services Delivered through FFS Medicaid or Medicaid Managed Care

- HealthChoices Physical Health MMC plans are responsible for all pharmacy services, with the exception of methadone
- Enrollment in MMC is mandatory in all counties

Statewide, Carved Out Managed Behavioral Health Care Program

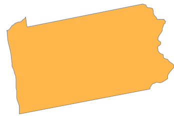
- All mental health and chemical dependency services are provided through behavioral health organizations, with the exception of non-methadone pharmacy services, which are provided through physical health MMC plans
- 1915(b) waiver program

BH Services Administered through State Contracts with Counties, County Consortia, or Directly with BHOs

- Counties have "right of first opportunity" to administer BH services
- About two-thirds of counties have chosen to administer BH services, as individual counties or consortia, through a contract with a BHO
- In remaining counties, State contracts directly with BHO

Coordination Agreements and Pilot Programs Link Physical Health and Behavioral Health Managed Care Systems

- Physical and behavioral health managed care organizations required to develop and implement written coordination agreements
- SMI Innovations Project aimed to improve coordination of physical and behavioral health services for people with SMI in two regions
  - Region- and county-specific collaborations between physical and behavioral health managed care organizations and county BH offices
  - Common State framework between regions for integrated care



PA HealthChoices Behavioral Health Program (cont.)

Attachment 7.c

Medicaid

State

Integration Pilot Projects

Coordination Agreements

Counties

Behavioral Health Organizations

Medicaid Managed Care Plans

Mental Health and Chemical Dependency Providers

Physical Health Providers

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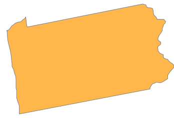


PA HealthChoices Behavioral Health Program (cont.)

Attachment 7.c

Potential Advantages

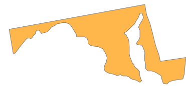
- Provides integrated financing and administration for mental health and chemical dependency services
- Ensures that beneficiaries access services through an entity focused on behavioral health

Potential Disadvantages

- Coordination with physical health remains a challenge, requiring additional efforts through contractual requirements and pilot projects

Maryland Performance-Based ASO Carve-Out

Attachment 7.c



Carved Out MH and CD Services Offered through ASO

Physical Health Services Delivered through MMC

- Statewide mandatory MMC program enrolls children and adults, with and without disabilities (excluding dual eligibles, the institutionalized, children with special health care needs)
- PCPs may provide limited BH services

Specialty MH Services Carved out and Provided MFFS through ASO

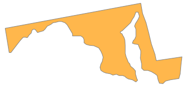
- ValueOptions contracts with the Mental Hygiene Administration to manage specialty MH services (i.e., services for people with SMI, mental health drugs) on a managed FFS basis

CD Services to Transition from MMC to ASO

- CD services currently included in MMC benefit package
- In 2014, Maryland will procure an ASO to provide both MH and CD services on a managed FFS basis, beginning in 2015
- Medicaid agency will monitor ASO contract

Financial Incentives and Coordination Requirements will Encourage Integrated Care

- Financial performance incentives (e.g., shared savings) for ASOs will encourage reductions in hospitalizations
- ASO and MCOs will be required to have care coordinators for individuals served in both systems
- MH clinics and methadone clinics eligible to participate in Maryland Health Home program targeted at people with SMI and SUD
- MMC and ASO systems will be required to share data using statewide HIE



Maryland Performance-Based ASO Carve-Out (cont.)

Attachment 7.c

Medicaid

State

Financial Incentives

Data Sharing Requirements

Coordination Requirements

MFFS Contract

Administrative Services Organization

Medicaid Managed Care Plans

Mental Health and Chemical Dependency Providers

Physical Health Providers

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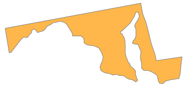
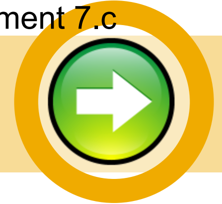


Maryland Performance-Based ASO Carve-Out (cont.)

Attachment 7.c

Potential Advantages



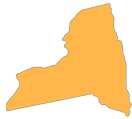
- Covers populations excluded from MMC, including dual eligibles
- Single ASO reduces administrative burden on providers with respect to credentialing, prior authorization, utilization review, payment rates, and contracting practices
- Offers single point of transition for individuals churning in and out of Medicaid eligibility

Potential Disadvantages

- Coordination of care and data sharing across systems may pose challenges
- Early identification and prevention for BH conditions is more difficult when primary care is provided through a separate system

Other State Integration Efforts

- Maryland will merge its Mental Hygiene Administration and Alcohol and Drug Abuse Administration in 2014
- Maryland is attempting to reduce duplicative and burdensome regulatory requirements for BH agencies by increasing the role of accreditation and minimizing the role of regulations in licensing



Integration of Physical Health and BH in MMC

Attachment 7.c

MMC Plans Responsible for All Physical and Behavioral Health Services

- All mental health and chemical dependency services will be "carved in" to MMC plans; MMC plans will be capitated for comprehensive benefits, including physical and behavioral health
- Implementation is currently scheduled for 2015
- Will be implemented under amendment to 1115 Partnership Plan waiver

Heightened Plan Requirements to Serve Individuals with MH and CD Needs

- Person-centered, individual plans of care and care coordination, including coordination of non-plan services (e.g., housing)
- Enhanced quality metrics
- Interfaces with social service systems, counties, and State psychiatric centers

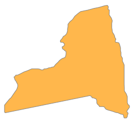
Two Plan Types

Traditional Medicaid Managed Care Plans Serve Individuals with MH and CD Needs

- Plans unable to meet heightened requirements on their own will be required to contract with qualifying behavioral health organizations

New Special Needs Plans Serve Individuals with Serious MH and CD Needs

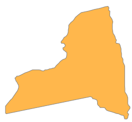
- Must offer additional recovery-oriented services subject to specialized medical and social necessity/utilization review approaches
- Subject to additional quality metrics and incentives
- Anticipated that many, if not all, will be existing MMC plans



New York State Medicaid Managed Care Program (cont.)

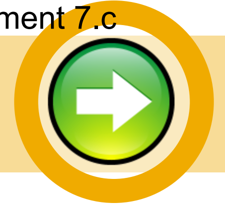
Attachment 7.c

Medicaid



New York State Medicaid Managed Care Program (cont.)

Potential Advantages



- One entity has responsibility for physical health, mental health, and chemical dependency services
- Patients have an integrated source of care for physical and behavioral health needs at all levels
- People with serious behavioral health needs may receive additional services through a plan with focused expertise

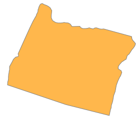
Potential Disadvantages

- Medicaid managed care plans have limited experience with behavioral health service providers
- Disruption of current pathways to access services and navigating MMC may pose challenges for enrollees, especially those with serious behavioral health needs

Other State Integration Efforts

- New York has implemented health homes as networks of providers that contract with the State and MMC plans to provide care management and coordination to enrollees with SMI or multiple chronic conditions, including mental illness and chemical dependency
  - Establish relationships between physical and behavioral health providers who have not previously worked together, supported by PMPM payments

Oregon's Coordinated Care Organizations (CCOs)



Attachment 7.c

Capitated Model with Integration of Physical Health and BH

Community-Based Entities Governed by a Partnership of Providers, Community Members, and Risk-Bearing Entities

- Governance structure must include a mental health or chemical dependency treatment providers

Receive Capitated Payments to Provide Physical Health, Mental Health, and Chemical Dependency Services to Members

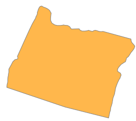
- Includes services previously provided through separate physical health organizations (including CD), mental health organizations (carved out MH services), and dental care organizations
  - *Mental health drugs are not included in CCO budgets*
- Payment anticipated to move toward more cost and quality accountability over time
- Operated under Oregon Health Plan Waiver

Institute Payment and Delivery Reforms with Providers Individually

- CCOs will, by contract, transition to "alternative payment methodologies" with contracted providers over time

Collaborate with Local Stakeholders to Meet Community Needs

- CCOs expected to develop community health assessments and improvement plans in consultation with local hospitals, public health agencies, social services organizations, and mental health authorities
- CCOs required to establish agreements with local mental health authorities and county governments regarding maintenance of non-Medicaid mental health safety net



Oregon's Coordinated Care Organizations (cont.)

Attachment 7.c

Medicaid

State

Coordinated Care Organizations

Alternative Payment Methodologies

Physical Health, Mental Health and Chemical Dependency Providers

Social Services

Public Health Agencies

Mental Health Authorities

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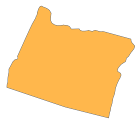


Oregon's Coordinated Care Organizations (cont.)

Potential Advantages

- Requires representation of major components of the health care delivery system in governance structure, in addition to entities bearing risk
- Involvement of mental health community stakeholders in governance and community health improvement planning provides for a local role in capitated model

Potential Disadvantages

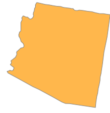
- Requires dramatic system transformation dependent upon new partnerships

Other State Integration Efforts

- County-level, non-Medicaid publicly-funded behavioral health service system undergoing parallel system change aligned with movement to CCOs, including global budgeting and outcomes-based accountability
- Integrated Services and Supports Rule targeted at reducing and streamlining paperwork for providers and patients, including through consolidated screening, so that patients are able to receive treatment sooner

Arizona Integrated Care System for People with SMI

Attachment 7.c



Capitated Model for Physical Health and BH Services through Regional BH Authority for People with SMI

Regional Behavioral Health Authority (RBHA) Responsible for BH Services in Maricopa County

- Department of Health Services/Division of Behavioral Health Service contracts with RBHA to provide coordination, planning, administration, regulation and monitoring for BH system,
- Includes BH services carved out of MMC program

RBHA will be at Risk for All Physical and BH services for Medicaid Enrollees with SMI

- Under 1115 waiver amendment and recent procurement, Maricopa RBHA will assume responsibility for physical health services for Medicaid enrollees with SMI
- Implementation is anticipated in October 2014
- State intends to introduce similar procurements in the rest of the state

Scope of RBHA Responsibilities Includes Connections to Social Services, Housing, Peers, and Criminal Justice

- At least 25 percent of RBHA board's voting members must be peers and family members who are or have been active participants in the Maricopa County BH system
- RBHA required to develop and manage housing and employment services
- RBHA must have collaborative protocols with state agencies, criminal justice, and local law enforcement
- RBHA required to hold periodic meetings to gather input from providers, peers, and family members

AZ Integrated Care System for People with SMI (cont.)

AZ Integrated Care System for People with SMI (cont.)

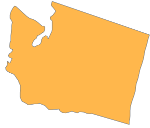
Potential Advantages

- One entity has responsibility for physical health, mental health, and chemical dependency services
- Provides a specialized service system attentive to the unique needs of people with SMI
- Includes specific requirements for connections to social services, housing, peers, and criminal justice

Potential Disadvantages

- Risks a stigmatizing effect due to creation of separate systems of physical health care for people with SMI and people without SMI
- RBHA may have limited experience contracting with physical health service providers
- Potential for churn as individuals fluctuate on the behavioral health status continuum over their lifetimes

Washington Medicaid Integration Partnership (WMIP)



Attachment 7.c

Capitated Model with Comprehensive Benefit Package

Integrated Managed Care Pilot Program in Snohomish County

- Covers Medicaid beneficiaries with MH or CD needs
- Funding and enrollment caps apply
- Only SSI beneficiaries eligible
- Limited to Snohomish County and to one health plan
- Implemented using 1915(a) authority

Plans Responsible for Physical Health, MH, CD, and LTSS

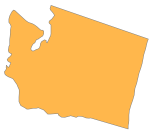
- Responsibility for physical health, mental health, chemical dependency, *and* long-term services and supports (LTSS) falls under a single managed care entity

Plans Required to Implement Care Coordination System

- Health risk assessment
- Monitoring of patient symptoms
- Patient education
- Coordination of physical health, mental health, CD, and LTSS
- 24/7 nurse line for all members

Plan Required to Ensure Access to and Integration of All Covered Services

- Plans must:
  - Ensure communication and coordination of an enrollee’s care across network provider types and settings
  - Ensure smooth transitions for enrollees who move among various care settings
  - Assist enrollees in maintaining program eligibility



Washington Medicaid Integration Partnership (cont.)

Attachment 7.c

Medicaid

State

Care Coordination System

Medicaid Managed Care Plans

Physical Health, Mental Health, Chemical Dependency, and LTSS Providers

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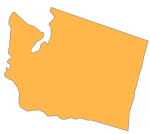
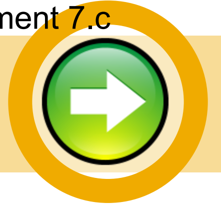


Washington Medicaid Integration Partnership (cont.)

Attachment 7.c

Potential Advantages

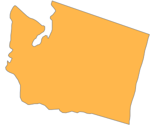


- One entity has responsibility for physical health, mental health, and chemical dependency services
- Added responsibility for long-term services and supports ensures that plans are responsible for the full spectrum of Medicaid services
- Enrollees have integrated source of care for physical and behavioral health needs at all levels

Potential Disadvantages

- Healthy Options plans have limited experience with behavioral health service providers
- Disruption of current pathways for enrollees to access services may pose a challenge, especially for individuals with serious behavioral health needs
- Requires large ramp up of small demonstration program
- There have been longstanding concerns among stakeholders regarding the quality of care coordination and service delivery in WMIP

HealthPath Washington Capitated Demonstration



Integrated Medicare-Medicaid Health Plans Cover All Services for Dual Eligibles in King, Snohomish Counties

Medicare-Medicaid Integrated Health Plans Responsible for Physical Health, MH, CD, and LTSS

- Coverage of physical health, mental health, chemical dependency, and long-term services and supports (LTSS) falls under a single managed care entity

Final MOU and Initial Roll-Out Pending

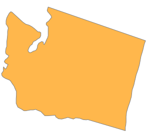
- Limited to dual Medicare-Medicaid enrollees in King and Snohomish counties
- In other counties, Washington will pursue integration for high-cost, high-risk dual eligibles through a managed FFS Health Home program

Three-Tiered Care Coordination and Integration System Dependent on Level of Need

- Level One: Supported Self-Care Management
- Level Two: Disease/Episodic Care Management
- Level Three: Intensive Care Management for Enrollees with Special Health Care Needs

Intensive Care Management Includes Referrals to Community and Social Support Services

- Comprehensive care management
- Care coordination and health promotion
- Comprehensive transitional care between care settings
- Individual and family support (including authorized representatives)
- Referral to community and social support services
- Use of health information technology to link services



HealthPath Washington Capitated Demonstration (cont.)

Attachment 7.c

Medicaid

Medicare

Three-Tiered Care Coordination and Integration System

Medicare-Medicaid Integrated Health Plans

Physical Health, Mental Health, Chemical Dependency, and LTSS Providers

Regional Health Alliances

Community and Social Support Services

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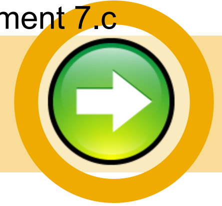
HealthPath Washington Capitated Demonstration (cont.)

Potential Advantages



- One entity has responsibility for physical health, mental health, and chemical dependency services
- Added responsibility for long-term services and supports ensures that plans are responsible for the full spectrum of Medicaid and Medicare services
- Addresses lack of financial alignment and responsibility across federal and state government, in addition to different state service systems
- Tiered care coordination and integration system targets dual eligible individuals at all levels of need, focusing resources on individuals with the greatest need

Potential Disadvantages

- Plans have limited experience with behavioral health service providers
- Plans have limited experience administering integrated Medicare and Medicaid services
- Disruption of current pathways for enrollees to access services may pose a challenge, especially for individuals with serious behavioral health needs
- Requires significant ramp up from limited demonstration

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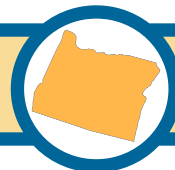
- Options for Advancing Integrated Care: A Review of Select States
- State Drivers of Integration: The Key Players
- Advancing State Priorities through Managed Care Contracts
- Getting from Here to There: Pathways to Integration in Washington

State Drivers of Integration

Strong Executive with a Clear Vision

New York

- Upon taking office in **January 2011**, Governor Andrew Cuomo established a Medicaid Redesign Team (MRT) of state officers, members of the Legislature, plans, providers, business, labor, and consumer representatives.
- In a **2-month** period, the MRT developed a set of recommendations for inclusion in the 2011-2012 Executive Budget.
- In **March 2011**, the Legislature adopted nearly all MRT recommendations from the Executive Budget, including the establishment of BHOs to perform concurrent review of FFS BH services as a one-year bridge to an integrated MMC program.
- New York's Medicaid agency, Office of Mental Health, and Office of Alcoholism and Substance Abuse Services have collaborated to present a unified vision for integrated managed care options for people with mental health and substance abuse needs.



Oregon

- In **January 2011** Governor John Kitzhaber requested that the Oregon Health Policy Board charter a Health System Transformation Team (HSTT) to identify elements of successful delivery system transformation, a budget and value proposition, and draft legislative language.
- Between **January and March 2011**, the HSTT met eight times to develop a straw proposal for CCOs, which was submitted to the Legislature **March 23rd** and formed the basis of enabling legislation for CCOs.
- Governor Kitzhaber has publicly championed Oregon's Medicaid CCOs and their extension to the state's public employees and the state at large. He was personally involved in negotiating the state's receipt of $1.9 billion in 1115 waiver funding for implementation.

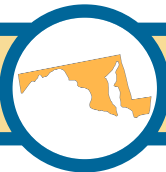
State Drivers of Integration

Attachment 7.c

Legislative Mandate

Oregon

- In **June 2011,** HB 3650, with bipartisan support, established legislative authority for CCOs and directed the Oregon Health Policy Board to produce an implementation plan by **January 2012.**
- In **February 2012**, again with bipartisan support, the Legislature passed SB 1580, which approved the establishment of CCOs and directed the state to examine how to spread the Coordinated Care Model to state employees.



Maryland

- In language accompanying Maryland's **April 2011** budget bill for SFY 2012, the chairmen of the budget committees requested that the Department of Health and Mental Hygiene (DHMH) "convene a workgroup of interested parties to develop a system of integrated care for individuals with co-occurring serious mental illness and substance abuse issues," requesting recommendations by December 15, 2011.
- After consultant engagement, stakeholdering, and DHMH endorsement of a combined MH/CD ASO, **March 2013** budget language required DHMH make a decision on implementation of the ASO, submitting a report to the chairmen by December 2013.

Minnesota

- In **May 2010,** the Minnesota Legislature passed and the Governor signed legislation compelling Department of Human Services to develop and authorize the HCDS demonstration.

State Drivers of Integration

Stakeholder Engagement

New York

- New York's MRT continues to shape the development of New York's integrated Medicaid managed are program for people with behavioral health needs.
- From **June to September 2011**, an MRT behavioral health work group composed of State and New York City officials, providers, managed care organizations, advocates, and other stakeholders met four times to develop recommendations on transformation of behavioral health services in New York.
- From **October to December 2011,** the work group issued and the MRT adopted a series of recommendations for integrated managed care that continue to guide the State's development of the model.
- The work group reconvened in **October 2012** and **May 2013** to discuss the model proposed by the State.

Maryland

- From **April to December 2011**, Maryland engaged a consultant to examine its current system, consider integration options, and provide recommendations on financing structures. The consultant:
  - Conducted five structured group interviews
  - Held three listening sessions
  - Held meetings to review proposed options
  - Produced a report summarizing findings and presenting two integration options
- From **March to September 2012,** DHMH held six public stakeholder meetings to inform model selection, collected public comments, and established four workgroups that met 3-4 times to address specific issue areas
- From **June 2013 to present**, Maryland has held 4 stakeholder meetings on details of the ASO procurement

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Managed Care Contract Provisions: Governance

Require peer and family representation

Arizona (Maricopa County Regional Behavioral Health Authority Scope of Work)

"The Contractor shall . . . Include in its Governance Board or governance structure at least twenty-five per cent (25%) of the voting members to be equally divided between peers and family members who are or have been active participants in the Maricopa County Behavioral Health system."

Require provider and community representation

Oregon (CCO Model Contract)

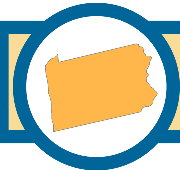
"Contractor shall establish, maintain and operate with a governance structure that complies with the requirements of ORS 414.625(1)(o)."

ORS 414.625(1)(o):
"Each coordinated care organization has a governance structure that includes:
(A) A majority interest consisting of the persons that share in the financial risk of the organization;
(B) The major components of the health care delivery system; and
(C) The community at large, to ensure that the organizations decision-making is consistent with the values of the members and the community."

Note: Regional Behavioral Health Authorities (RBHAs) coordinate, plan, administer, regulate, and monitor the state public behavioral health system in Arizona, acting as regional BHOs for Medicaid and non-Medicaid services. Under the recent Maricopa County RBHA procurement, the RBHA will be at risk for all physical and behavioral health services for Medicaid enrollees with SMI.

Managed Care Contract Provisions: County Collaboration

Require coordination agreements with local government agencies



Pennsylvania (HealthChoices BH Contract)

"The Primary Contractor or its BH-MCO is required to coordinate service planning and delivery with human services agencies. The Primary Contractor or its BH-MCO is required to have a letter of agreement with:

a. Area Agency on Aging.
b. County Juvenile Probation Office ...
c. County Drug and Alcohol Agency…
d. County offices of MH and ID, including coordination with the Health Care Quality Unit (HCQU)...
e. Each school district in the county.
f. County MH/ID Program, County Prisons, County Probation Offices, Department of Corrections and Pennsylvania Board of Probation and Parole to ensure continuity of care and enhanced services for individuals as they enter and leave the criminal justice system.
g. Early intervention…"

Require participation in existing local planning process

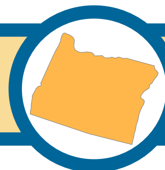
New York (Current MMC Contract)

Current MMC contract:

"The Contractor also agrees to participate in the local planning process for serving persons with chemical dependence, to the extent requested by [a local department of social services (LDSS)]. At the LDSS's discretion, the Contractor will develop linkages with local governmental units on coordination procedures and standards related to Chemical Dependence Services and related activities."

Under State guidance, county governments, Health Homes, and managed care organizations locally determine how individuals receiving involuntary treatment, exiting jail, or existing institutions for mental disease are prioritized for enrollment in Health Home care management.

Create new local planning process



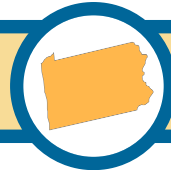
Oregon (CCO Model Contract)

"Contractor shall establish a [Community Advisory Council (CAC)] that includes appropriate community representation in each Service Area. The duties of the CAC shall include, the following, in collaboration with community partners:

a. Identifying and advocating for preventive care practices to be utilized by the Contractor;
b. Overseeing a Community Health Assessment and adopting a Community Health Improvement Plan [developed in collaboration with the local public health authority, local mental health authority, community based organizations and hospital systems] to serve as a strategic plan for addressing health disparities and meeting health needs for the communities in the Service Area(s); and
c. Annually publishing a report on the progress of the community health improvement plan."

Managed Care Contract Provisions: Social Services

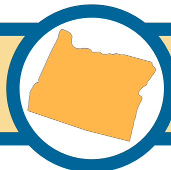
Require physical or behavioral health provider networks to coordinate with social service providers



Pennsylvania (HealthChoices BH Contract)

"The Primary Contractor or its BH-MCO must ensure management of the Provider network through agreements which include the following provisions…

- Requirements for coordination and continuity of care of Behavioral Health Services with social services; e.g., intellectual disabilities, area agencies on aging, juvenile probation, housing authorities, schools, child welfare, juvenile and county and state criminal justice."

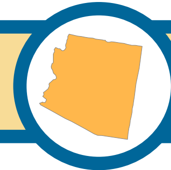


Oregon (CCO Model Contract)

"Contractor's employees or Subcontractors providing substance use disorder services shall provide to Member, to the extent of available community resources and as clinically indicated, information and referral to community services which may include, but are not limited to: child care, elder care, housing, transportation, employment, vocational training, educational services, mental health services, financial services, and legal services."

"Contractor shall work with Providers to develop the partnerships necessary to allow for access to and coordination with social and support services, including culturally specific community based organizations, community based mental health services, DHS Medicaid-funded long term care services and mental health crisis management services."

Require development and management of housing and employment services



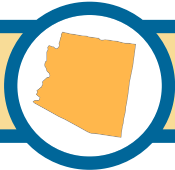
Arizona (Maricopa County RBHA Scope of Work)

"The Contractor shall…

- Develop and manage state and federal housing programs and deliver housing related services…
- Develop and manage a continuum of vocational employment and business development services to assist SMI members, including transition age youth to achieve their employment goals."

Managed Care Contract Provisions: Community Linkages

Require collaborative protocols with state agencies, criminal justice, and local law enforcement



Arizona (Maricopa County RBHA Scope of Work)

"The Contractor shall…

- Address …Procedures to have providers co-located at [Child Protective Services] offices, juvenile detention centers or other agency locations as directed by [the State]…
- Address in the collaborative protocol with the Administrative Office of the Courts, Juvenile Probation and Adult Probation strategies for the Contractor to optimize the use of services in connection with Mental Health Courts and Drug Courts…
- Meet, agree upon and reduce to writing collaborative protocols with local law enforcement and first responders, which, at a minimum, shall address:
  - Continuity of covered services during a crisis;
  - Information about the use and availability of Contractor's crisis response services;
  - Jail diversion and safety;
  - Strengthening relationships between first (1st) responders and providers when support or assistance is needed in working with or engaging members; and
  - Procedures to identify and address joint training needs."

Require periodic meetings to gather input from providers, peers, and family members

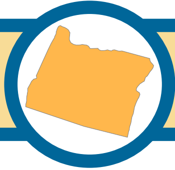
Arizona (Maricopa County RBHA Scope of Work)

"The Contractor shall…

- Periodically meet with a broad spectrum of behavioral and physical health providers to gather input; discuss issues; identify challenges and barriers; problem-solve; share information and strategize ways to improve or strengthen the integrated health care service delivery…
- Periodically meet with a broad spectrum of behavioral health providers to gather input; discuss issues; identify challenges and barriers; problem-solve; share information and strategize ways to improve or strengthen the behavioral health service delivery…
- Periodically meet with a broad spectrum of peers, family members, peer and family run organizations, advocacy organizations or any other persons that have an interest in participating in improving the system. The purpose of these meetings is to gather input; discuss issues; identify challenges and barriers; problem-solve; share information and strategize ways to improve or strengthen the service delivery system."

Managed Care Contract Provisions: Provider Reimbursement

Require alternative payment arrangements with network providers



Oregon (CCO Model Contract)

- "Contractor shall demonstrate how it will use alternative payment methodologies alone or in combination with delivery system changes to achieve better care, controlled costs, and better health for Members.

  Contractor shall define its schedule for Contractor implementation of alternative payment methodologies, with benchmarks and evaluation points identified. Contractor shall assign a high priority to payments to Patient-Centered Primary Care Homes for individuals with chronic conditions. Contractor shall develop a protocol for ensuring prompt payments to Patient-Centered Primary Care Homes for implementation in the first year of Contractor operations."
- "'Alternative Payment Methodology' means a payment other than a fee-for-services payment, used by coordinated care organizations as compensation for the provision of integrated and coordinated health care and services. 'Alternative Payment Methodology' includes, but is not limited to:

  (1) Shared savings arrangements;

  (2) Bundled payments; and

  (3) Payments based on episodes."

Require participation in a State-administered alternative payment methodology

Minnesota (Medical Assistance and MinnesotaCare MMC Contract)

"The MCO and the STATE will participate in a shared savings and losses payment methodology through the Health Care Delivery Systems (HCDS) Demonstration with the STATE's contracted HCDS Entities in the MCO's provider network, in accordance with Minnesota Statutes, § 256B.0755…

The STATE will notify the MCO in writing of the shared savings for the interim and final payments to be paid to the HCDS Entity or Entities. The MCO shall issue payment to the HCDS Entity as identified by the STATE within thirty (30) days from the date of the notification from the STATE…

The MCO shall work with the STATE on the development of the allocation methodology across the MCOs for the shared savings payment to the HCDS Entities."

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Levels of Integration at the System Level: Framework

Attachment 7.c

Minimal Coordination	Basic Coordination	Close Coordination	Full Integration
▪ Have separate systems	▪ Have separate systems	▪ Some shared systems and workarounds	▪ Function as one integrated system
▪ Limited understanding of each other's roles and resources	▪ Appreciation of each other's roles as resources	▪ Understanding of each other's roles and culture	▪ Roles and cultures that blur or blend
▪ Communicate rarely, typically under compelling circumstances only	▪ Communicate periodically about shared patients, driven by specific patient needs	▪ Frequent communication and collaboration	▪ Consistent communication and collaboration
▪ Physical and behavioral health needs treated as separate issues	▪ Physical and behavioral health needs treated separately	▪ Physical and behavioral health needs treated collaboratively for certain sets of patients	▪ Physical and behavioral health needs treated collaboratively for all patients
▪ No coordination or management of collaborative efforts	▪ Some leadership efforts around systematic information sharing	▪ Leadership support for integration through mutual problem-solving	▪ Leadership support for integration as driving model of operations
▪ Separate funding streams, and no resource sharing	▪ Separate funding streams with some shared resources	▪ Blended funding streams, with some shared expenses	▪ Integrated funding, with shared resources, expenses

While there are some instances of integrated service infrastructure, Washington's overall physical, mental health and substance abuse service systems largely reflect "basic coordination" at the administrative and system levels

Note: Levels of integration adapted from the SAMHSA-HRSA Center for Integrated Health Solutions' *A Standard Framework for Levels of Integrated Healthcare*

Beyond the Status Quo: New Options for Washington

1 Maintain Existing Structure; Address Major Obstacles

- Retain current division of responsibility between Healthy Options, RSNs/BHOs, and counties
- Competitively procure BHO contracts
- Resolve impediments to better coordination and integration including:
  - Data sharing
  - State reporting infrastructure
  - Streamlined/coordinated assessment tools
  - Aligned and simplified regulatory requirements
  - Strengthen requirements and accountability (including incentives and penalties) in state contracts

2 Integrate Mental Health and Chemical Dependency Systems

- Establish behavioral health organizations (BHOs) or Administrative Services Organization (ASO) with responsibility for MH *and* CD*
- Carve out all CD and BH benefits to BHO or ASO:
  - Counties could organize and form a BHO or ASO, or could be contracted providers to a BHO or ASO
  - Require BHOs/ASO and physical health systems to coordinate with non-Medicaid county services (jails, courts, EMS, etc.)
- Develop stringent coordination and data sharing requirements subject to incentives and penalties between BHOs or ASO and physical health systems
- Competitively procure contracts under risk-bearing arrangements (e.g., shared savings, capitation), integrating financial incentives:
  - Reinvest savings
  - Define performance requirements, incentives and enforceable penalties

Examples: Pennsylvania HealthChoices, Arizona RBHAs (currently), Maryland performance-based ASO (forthcoming; managed FFS model without full risk)

3 Centralize Responsibility for all MH, CD & Physical Health

- Accountability for full spectrum of physical health, MH, and CD services in accountable risk bearing entities
- Agreements with "accountable communities of health" to coordinate with non-covered or non-Medicaid services
- Competitively procure contracts under global capitation, shared savings or other risk bearing arrangements supported by subcontracts where warranted:
  - Reinvest savings
  - Consider special arrangements for targeted populations (e.g., dual eligibles, people with SMI)
  - Define performance requirements, incentives and enforceable penalties
- Define sustainable community level resource linkages

Examples: NY MMC (forthcoming), OR CCOs, MN Hennepin, AZ Maricopa RBHA (forthcoming)

*ASO would coordinate care & providers would bill on a FFS basis; BHO would be capitated, coordinates care while providers bill the BHO

Option 1: Address Barriers, but Maintain Existing Framework

Attachment 7.c

(1) Develop competitive procurement of MH services if required by CMS

(2) Enable data sharing between physical health, MH, and CD systems

- Develop data use agreements, defined safe harbor, and incentives to use infrastructure to share data
- Consider whether legislation is needed to facilitate sharing of sensitive information

(3) Streamline reporting requirements and update State reporting and querying infrastructure

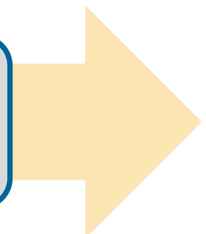
(4) Develop a unified assessment tool for MH and CD systems and require use statewide through contracting

(5) Establish a BH professional "dual diagnosis treatment" license for providers to serve individuals with MH and CD conditions, with rational experience requirements

- Stakeholder review period for regulations may be necessary based on past rulemaking

(6) Modify Healthy Options, RSN, and county contracts to provide financial and other incentives and penalties (e.g., holds on enrollment, shared savings) related to both physical and BH outcomes

Timeline



Total Time: 18-24 months

Regulatory changes include stakeholdering process and public comment and may require over two years to implement. The development of regulations aligning BH agency licensing requirements took three years to implement in Washington.

Option 2: Integrate MH and CD Services; Maintain PH System

Attachment 7.c

(1) Implement Option 1 steps #2-#5 enabling data sharing, streamlining reporting, developing unified assessments and establishing dual diagnosis treatment license

(2) Convene stakeholders; evaluate and compare FFS arrangement with ASO and capitated BHO carve-out options; address issue of linkages with physical health and counties; staging of roll-out (if not statewide); select preferred approach

(3) Secure authorizing legislation

(4) Secure any necessary waivers

(5) Develop and release RFP; select ASO or BHO; develop contract provisions and execute contracts

Timeline

Year 1: Stakeholder Process

- Reach agreement on option and legislation

Year 2: Legislation

- If waivers needed, secure approval

Year 3: Procurement/Implementation

- Select entities to provide integrated MH and CD services

Option 3: Centralize Responsibility for PH, MH and CD Services

(1) Implement Option 1 steps #2-#5 enabling data sharing, streamlining reporting, developing unified assessments and establishing dual diagnosis treatment license

(2) Convene stakeholders; evaluate fully integrated model addressing key issues including: staging of rollout, integration of LTSS, crisis services, and involuntary treatment and linkages with social supports, criminal justice, etc.

(3) Evaluate role for "accountable communities of health" to coordinate non-covered or non-Medicaid services (e.g., county services such as jails, courts, EMS) with risk bearing entities responsible for Medicaid services

(4) Secure authorizing legislation

(5) Secure any necessary waivers

(6) Determine contract provisions; develop RFP; and select accountable risk bearing entities

Timeline

Year 1: Stakeholder Process

- Reach consensus on options (focusing on steps 2 and 3 above) and legislation

Year 2: Legislation

- If waivers needed, secure approval

Years 3-4: Phased Procurement/Implementation

- Phase implementation by county or region, based on county/regional readiness

Available Resources

Attachment 7.c

Potential Funding Sources to Support Integration

- 1115 waiver funding may provide opportunities to invest in infrastructure and alternative payment arrangements to support development of bidirectional integrated care.
    - Oregon received $1.9 billion to support implementation of CCOs.
    - California and Texas received billions of dollars to expand enrollment in Medicaid managed care and promote health care delivery system reform.
    - Citing savings from its MRT initiatives, New York has requested $10 billion from CMS, including investments in supportive housing and care management infrastructure for Health Homes (Waiver request has been pending for more than a year).
- Ninety percent federal matching funds for Health Homes under ACA Section 2703 could provide transitional support for two years. (Two year period has commenced at least in part in State).
- CMMI State Innovation Model funding can support development and implementation of Washington's integration initiatives.

Thank You

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Jonah Frohlich

Sandra Newman

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Manatt Health Solutions

Attachment 7.d

Peninsula Regional Support Network

Division of Behavioral Health and Recovery External Quality Review Report

July 2014

Contract #1432-95249

Presented by

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Fax 503-279-0190

DBHR-EQR-WA-14-3

EXECUTIVE SUMMARY

The Washington Department of Social & Health Services, Division of Behavioral Health and Recovery (DBHR) contracts with Acumentra Health to perform external quality review (EQR) of mental health services provided for Washington Medicaid enrollees. 42 CFR §438.350 requires an annual EQR in states that deliver Medicaid services through managed care.

This report summarizes the 2014 review of Peninsula Regional Support Network (PRSN), one of 11 regional support networks (RSNs) with which DBHR contracts to deliver managed mental health services. The major EQR activities are:

- review of the RSN's compliance with federal and state regulations and contract provisions governing managed care
- evaluation of the RSN's performance improvement projects (PIPs)
- validation of the statewide performance measures used to evaluate the quality of RSN services, including an Information Systems Capabilities Assessment (ISCA)
- validation of encounter data sent by the RSN to DBHR
- a special focus study of implementation of the Children's Mental Health System Principles by the RSNs

The reviews rate PRSN's overall performance, identify strengths and opportunities for improvement, and offer recommendations to address deficiencies. The results summarized below are presented in more detail in the main body of the report.

Compliance review results

The 2014 compliance review found that PRSN *fully met* the standards for both Enrollee Rights and Grievance Systems. Detailed results, including recommendations to enhance the RSN's compliance efforts, begin on page 6.

Enrollee Rights: PRSN's detailed website displays the RSN's member handbook, reports, and policies and procedures. PRSN informs enrollees about grievance, appeal, and fair hearing procedures and time frames through its member handbook and through a separate brochure that is sent to the enrollee with each letter acknowledging receipt of a grievance.

PRSN's process for monitoring contracted providers is extensive and detailed. During the administrative walkthrough of provider facilities, PRSN interviews the clinical records staff on policies and procedures for enrollees who request copies of their records.

Grievance Systems: Annually, PRSN analyzes trends in grievances and appeals and forwards the results to the Quality Improvement Committee, which uses this information to evaluate potential system improvements. System changes are implemented through staff training and monitored by provider audits.

To ensure adherence to grievance process timelines, PRSN needs to ensure that more than one staff member is trained on the grievance process.

PIP evaluation results

PIPs conducted by the RSNs may be in different stages at the time of the EQR evaluation. Per the protocol approved by DBHR, Acumentra Health scores all PIPs according to the same criteria, regardless of the stage of completion. As ongoing projects, the PIPs may not meet all standards the first year, but a PIP is expected to achieve better scores as project activities progress, eventually reaching full compliance.

Acumentra Health reviewed a children's PIP and a nonclinical PIP conducted by PRSN:

1. **Children's PIP—Improving Identification of Intensive Needs Children and Youth:** This PIP, initiated in 2013, targets children and youth who need or who are at risk for needing intensive home- and community-

based mental health services. In selecting and prioritizing PIP topics, PRSN discovered that each of its provider agencies used a different method to identity the target population. The current PIP focuses on accurately identifying high-risk, high-need children and youth, which PRSN called "the first step in ensuring they are provided the increased support and services needed." In cooperation with stakeholders and provider clinicians, PRSN created standardized criteria for identifying high-risk, high-needs children and youth, and developed appropriate documentation for the electronic health record (EHR). PRSN began training provider clinicians on the new criteria and data entry into the EHR in December 2013, and implemented the intervention January 1, 2014. At the time of the PIP review, the study had not progressed to the first remeasurement.

2. **Nonclinical PIP—Weight Monitoring:** This project, first reported in 2012, grew out of PRSN's previous PIP on metabolic syndrome. Local data showed that 76% of PRSN's Medicaid enrollees who were prescribed atypical antipsychotic medications were overweight or obese, putting them at risk of early death from diabetes and cardiovascular conditions. PRSN identified regular weight monitoring as an established practice guideline and first step in clinical intervention to improve weight outcomes. As of October 1, 2011, all enrollees receiving medical appointments with Jefferson Mental Health Services (JMHS) must have their body mass index (BMI) or weight and height documented in the EHR. Medical staff at JMHS received documentation training before this policy took effect. PRSN reported that the study indicator (percentage of eligible enrollees with recorded BMI or weight/height) improved significantly from 11.3% at baseline to 87.0% at first remeasurement and to 80.1% at second remeasurement. PRSN plans to continue monitoring the documentation of BMI in the EHR as part of its routine QI efforts. As this PIP has demonstrated sustained improvement, Acumentra Health supports PRSN's decision to choose a new PIP topic for 2015.

The children's PIP scored 67 on a scale of 85, earning a Substantially Met rating. The nonclinical PIP scored 99 on a 100-point scale, earning a Fully Met rating.

Documentation of the children's PIP procedures is generally sound, requiring only a minor amount of additional supporting detail. Once the PIP has progressed to the first remeasurement, PRSN needs to conduct a statistical test to analyze any differences from baseline to remeasurement; discuss how the intervention affected the study results; identify confounding factors; demonstrate whether or not the PIP met the target goal; discuss any lessons learned; and describe next steps.

The nonclinical PIP has demonstrated sustained improvement. To achieve a perfect score for this PIP, PRSN would need to clarify the tracking and monitoring data for the second remeasurement period. PRSN has recommended annual retraining on weight monitoring, and will continue to monitor performance to sustain the observed gains.

ISCA follow-up results

Acumentra Health reviewed PRSN's response to findings and recommendations of the full ISCA performed in 2013. The goal was to determine the extent to which the RSN's information technology systems supported the production of valid and reliable state performance measures and the capacity to manage enrollees' health care.

The 2013 ISCA resulted in 18 recommendations for improvement, many related to administrative functions subcontracted to Kitsap Mental Health Services. As of the 2014 follow-up review, PRSN had made progress on implementing most recommendations related to information and hardware systems, data security, administrative data, and enrollment systems. The RSN had taken no action on three recommendations.

For additional detail, see the section beginning on page 37.

Encounter data validation

DBHR requires each RSN to conduct an annual encounter data validation (EDV) to determine the accuracy of encounter data submitted by RSN providers. In 2014, Acumentra Health reviewed a sample of the encounters and clinical records in each RSN's EDV report to ensure that the EDV contained no significant errors.

PRSN's EDV sample represents enrollees served by the RSN, is sufficiently large, and is chosen in a random manner. The record review procedure is also adequate, as all required review elements were examined and scored with an appropriate mechanism. Acumentra Health recommends that PRSN implement an inter-rater agreement process if one is not already in place, and break out agency-specific results in its EDV report.

PRSN's encounter data processed by the state were complete and populated with values within the expected range, except that 1,116 records (20.6%) omitted the enrollee's Social Security number, an optional field.

In the onsite review, Acumentra Health reviewers found a 100% match on all demographic variables in all 35 charts reviewed. Provider name and service date also matched in all encounters reviewed, while provider type, service location, and procedure code matched in more than 97% of encounters. The progress note matched the service code in 95.1% of encounters. Due to a known issue with ProviderOne processing of service minutes and units, service duration matched in only 77.1% of encounters.

Acumentra Health compared the enrollee charts with data processed by ProviderOne, whereas PRSN compared the charts with data submitted by the RSN. PRSN found a 100% match between enrollee charts and electronic data in all encounter elements. This resulted in a discrepancy of less than 5% between PRSN and Acumentra Health reviewers in all elements except service duration, for which there was a 22.9% discrepancy in the validation results.

Additional details appear in the section beginning on page 44.

Children's focus study

Acumentra Health interviewed PRSN and provider agency staff to assess local progress in implementing the Children's Mental Health System Principles. The interviews probed barriers to implementation and steps the RSN planned to take to address those barriers.

Separately, Acumentra Health reviewed clinical records of young enrollees at one outpatient provider agency to determine whether the records documented a cross-system care plan and the required elements of Child and Family Team (CFT) meetings.

Clinical documentation reviewed at the provider agency reflected PRSN's stage of implementing the Children's Mental Health System Principles. For example, the records documented some elements of High-Intensity Treatment (HIT) services related to treatment plan and meetings. However, the HIT code was used for other services, such as individual or family therapy, that were not part of multidisciplinary team meetings and did not match the HIT definition.

As PRSN has completed training for the providers on how to correctly use the HIT code, current use of this code has ceased. The majority of the records reviewed used CFT codes. The CFT records documented most elements of a CFT meeting with the exception of a cross-system care plan. The current treatment plans focus more on mental health than on multiple domains for the child and family. However, the CFT meetings did include multiple allied partners and cross-system planning.

As PRSN progresses in its efforts to implement Wraparound with Intensive Services (WISe), it will be necessary to provide training on the WISe principles for mental health professionals who serve children and on how to document a cross-system care plan.

PRSN will need to facilitate coordination of care between its mental health providers and the agency selected to implement wraparound services. The clinical records demonstrated that many of the young enrollees in high-intensity services were involved with the DSHS system (protective service, foster care, and/or adoption). PRSN will need to continue to work with the DSHS system to include youth voice and presence in CFT meetings. It will be important for PRSN to integrate other agencies involved with these children and families into its WISe program.

See related discussion and data analysis in the section beginning on page 50.