Early Warning System Workgroup
July 17, 2018
1:30 PM – 2:30 PM
Board Room at Tri-Cities Community Health; 800 W. Court St. Pasco, WA 99301

Meeting Minutes

1. Attendees: Shereen Hunt-Merit Resources Services, Barbara Mead-Lourdes, Martin Sanchez-GCACH, Joey Charlton-Coordinated Care, Pat Flores-Serenity Point Counseling, James Hempsteel-Richland Fire, Jenna Shelton-GCACH, Carol Moser-GCACH, Sam Wardel-GCACH, Eric Lipp-Juvenile Court, Eric Nilsen-Kennewick Fire Department, Diane Halo-GCACH, Jayme Finch-Mental Health Counselor at Juvenile Justice and Program director at Lutheran Community Services, Courtney Ward-Amerigroup, Samantha Zimmerman-HCA, Katie Hamikey-Quality Behavioral Health, Cory Serece- Molina, Krista Concannon-HCA, Niklas Schrader-HCA, Isabel Jones-HCA, Lee Murdock-Yakima County Homeless Network, Megan Gillis-Molina, Cielia Barker-CHPW, Michelle-Quality Behavioral Health, Chris Villeneueve-Catholic Charities

2. Review Charter
   - Goal of Workgroup: Develop recommendations for an Early Warning System that allows a feedback loop and triage process to identify clients who may be falling through the cracks given the transition to integrated managed care and resolve system issues as they arise. Operationalize the system by January 1, 2019 and it would be ideal to have it up and running a few months before that in order to collect some baseline data.
   - Key Deliverables:
     - Draft recommendations on Early Warning Indicators –August 2018
     - Finalized recommendations on Early Warning Indicators – October 2018

3. Go over Standard Indicators Information Sheet – HCA
   HCA sent out the Standard indicators to the ACHs across Washington because they wanted everyone to see the key indicators HCA wants to be track. HCA will be responsible for collecting and reporting on these indicators. Key Indicators Categories are Provider Payments, EDIE Data, Crisis System, and State Hospitals. HCA felt that it is important to monitor these categories to measure if there have been any adverse effects to these Key Categories or if to track if things are going well as we transition to Integrated Managed Care.

   - Provider Payments – There are 3 things in this area HCA wants to track- # or rate of BH claims received by MCOs, # or rate of BH claims rejected by MCOs, and Top 5 reasons a BH claim or encounter is rejected and sent back to the provider. These reasons will include missing or invalid member information, missing or invalid provider information, these sort of common errors. No baseline for these metrics, but HCA will make sure the Behavioral Health providers are able to submit claims to the MCOs to receive payments. If they see for example, that a particular MCO is receiving a high volume of rejected claims then it could be potentially an issue with the MCO system or with the BH provider's system.

   - EDIE Data- Emergency Department Information System that helps you identify high risk complex needs patients. HCA recently finalized an agreement with EDIE to receive data for the Mid-Adopter Regions to monitor ED utilization as well as to monitor the percentage of ED visits with BH diagnosis, because they

want to see if there is an increase or decrease of ED utilization that could potentially show that there is an issue with access to care or if there are improvement.

- Crisis System – HCA will monitor the Crisis Hotline Calls for # of incoming calls, # of calls answered, # of call answer timeliness (within 30 seconds), Average speed of answer (sec), and Abandonment Rate. They will also track # ITA investigations and outcome by the # of Mental Health ITA Investigations, # of SUD ITA Investigations, # Detained, # Voluntary Admit, and the # Discharged with Referral. In this area they will also track the DMHP response time to ensure that the DMHPs are responding quickly. For Bed Availability HCA wants to track to see if IMC is affecting bed availability in anyway. HCA will track the # of No Bed reports and the # of Single Bed Certifications.

- State Hospitals - Bed Census for Average Daily census, Forensic Flips census, Discharges, and Waitlist. HCA wants to see if IMC has been affecting the state hospitals.

HCA will be reporting on all these indicators on a monthly basis. HCA is making changes as to how they are reporting this information. They want to make It as efficient as possible when handling the Early Warning system as they move forward with the 5 regions at the same time. If the HCA does make any changes they will keep everyone posted and let the region know.

Indicator Category	Indicator Sub-Category	Specific Indicator Tracked	Owner for Reporing Baseline Data	Owner for reporting after January 2019	Frequency of Reporting
Provider Payments Note: HCA may be modifying the way we report these metrics. Finalized method TBD.	1. Behavioral Health Claims Status (Reported by each MCO for each BH provider individually)	a. # or rate of BH claims received by MCOs b. # or rate of BH claims rejected by MCOs	1a. N/A - Baseline is not collected on this metric 1b. N/A - Baseline is not collected on this metric	1a. MCOs 1b. MCOs	1a. Monthly 1b. Monthly
	2. Measure of top 5 reasons for BH claim or encounter re-submission	a. Top 5 reasons a BH claim or encounter is rejected and sent back to the provider	2a. N/A - Baseline is not collected on this metric	2a. MCOs	2a. Monthly
EDIE Data	1. ED Utilization	a. ED Utilization b. ED Utilization for client with past BH diagnosis	1a. HCA/AIM 1b. HCA/AIM	1a. HCA/AIM 1b. HCA/AIM	Monthly
	2. Percentage of ED visits with BH diagnosis	a. Portion of ED visits with BH diagnosis	2a. HCA/AIM	2a. HCA/AIM	Monthly
Crisis System	1. Crisis Hotline Calls	a. # of incoming calls b. # of calls answered c. # of call answer timeliness (within 30 seconds) d. Average speed of answer (sec) e. Abandonment Rate	1a. BHO 1b. BHO 1c. BHO (if available) 1d. BHO(if available) 1e. BHO (if available)	1a. BH-ASO 1b. BH-ASO 1c. BH-ASO 1d. BH-ASO 1e. BH-ASO	1a. Monthly 1b. Monthly 1c. Monthly 1d. Monthly 1e. Monthly
	2. # ITA investigations and outcome	a. # of Mental Health ITA Investigations b. # of SUD ITA Investigations c. # Detained d. # Voluntary Admit e. # Discharged with Referral	2a. BHO 2b. BHO 2c. BHO 2d. BHO 2e. BHO	2a. BH-ASO 2b. BH-ASO 2c. BH-ASO 2d. BH-ASO 2e. BH-ASO	2a. Monthly 2b. Monthly 2c. Monthly 2d. Monthly 2e. Monthly
	3. DMHP	a. DMHP response time	3a. BHO	3a. BH-ASO	3a. Monthly
	4. Bed Availability	a. # of No Bed reports b. # of Single Bed Certifications	4a. RDA 4b. RDA	4a. BH-ASO 4b. BH-ASO	4a. Monthly 4b. Monthly
State Hospitals- WSH & ESH	1. Bed Census	a. Average Daily census b. Forensic Flips census c. Discharges d. Waitlist	1a. RDA 1b. RDA 1c. RDA 1d. RDA	1a. RDA 1b. RDA 1c. RDA 1d. RDA	1a. Monthly 1b. Monthly 1c. Monthly 1d. Monthly

Questions: Under the ED Utilization the first indicator, is it for clients with a past BH diagnosis? Is the second indicator under this area with a past BH diagnosis as well or a current?
Answer: Yes, the first one is doing a 2 year look back in the claims data to see if there has been any BH issue. The second one is if on the ED claim there was BH issue diagnosis. HCA is going to try to see if this will work. Usually BH diagnosis aren't done in the ED but they will take a look. We just need to be clear as what data is going to be captured. It will be the HCA tracking these indicators.

Question: Does the EDIE system capture SUD diagnosis?
Answer: If the diagnosis is made in the ED. That is why we look at the history for 2 years back to get the full picture. Isabel from the HCA recommended that as workgroup we should really think about what we would want to monitor related to clients coming into the ED. Then Krista from HCA could go and clarify what HCA is actually able to capture and track from the EDIE system. What HCA was hoping monitor with this indicator was if people were going the ED for BH related reason or visit which could be an indicator that they weren't able to access other provider agencies before they went to the ED.

HCA will also be tracking the basic ED utilization for any reason, not just the BH diagnosis. The diagnosis of the BH condition usually isn't made in the ED. They will include the overall measurement as well so they can get a good tracking all ED utilization going on in general.

Comment form Carol, GCACH: Beyond using the data being used to make sure people aren't falling through the cracks when we migrate to the Integrated Managed Care, I'm actually interested in bringing our community together to just have Early Warning Systems developed in general. That's why we have expanded the members of this this committee. We have invited new people in especially the Juvenile Justice System because I believe there is an opportunity beyond the life of this short project to understand what we should be looking for in the system. My knowledge is that the Behavioral Health Organization hasn't had this kind of a working group before, and yet we hear out in the field frequently that the reason people are going to the ED is because they can't get DMHP to come in and give them an assessment. The patient ends up in crisis situation and they end up going to the ED. This has nothing to do the fact that it is being managed by an MCO, it has everything to do with the current behavioral health system failing some of our patients in a crisis situation. I just wanted to make that point.

Isabel from HCA brought up the fact that HCA is very conscious of scope creep and they don't want to put turn into a long-term performance measurement. HCA is interested to know what other indicators in these categories Greater Columbia region would like to track. HCA will not have the capacity to track other indicators. If there are other indicators beyond the standard indicators then this workgroup could talk about how this data will come in and who will be responsible for collecting the data.

Comment from Lee Murdock: There is a homeless management system that also tracks mental health status and locally there is a high percentage of homeless populations that may or may not have medical coverage.
Question: Would this be something valuable to add to this? This sounds like it would be a local decision, not necessarily added to this set of indicators.
Answer: Many other regions are looking at other indicators such as homelessness or impacts to the criminal justice system. However, I don't know if HCA would have that ability to track this data. There might be another way that your region can track homeless data.

Comment: There is a standardized way to track homelessness through the Department of Commerce that can pull community wide or region wide data.

Comment: Jayme Finch – One of issue the Juvenile court has in regards to the Crisis System Category is getting the DMHP to respond in a timely matter. It has been a real challenge getting the DMHP to respond to a crisis service within our Juvenile court system.
Question: Under the crisis system metric is there a way to capture the DMHP response time for the Juvenile justice system or is this a separate metric we would have to measure internally?
Answer: DMHP response time is one of our metrics and HCA definitely wants to be able to track the response time not just for the early warning system but as a performance metric.

Jayme - If a youth detained in a Juvenile detention facility, are they getting any response at all for crisis and what kinds of barrier to successful outcomes does that present? From his experience DMHP do not come into detention centers and if they do there certainly not opportunities for youth to access services beyond that.

Eric Lipp, Juvenile Court - He agrees that there is an issue with DMHPs not coming to evaluate the kids at all. There are a lot of challenges around documentation. From his experience he finds them to of little help to them. Is it documented if there is no response at all?

Isabel suggests that there be an additional meeting outside of this meeting to discuss this DMHP. This sounds like a system improvement that we can try to address and work out before we go into Integrated Managed Care. Barbara Mead -Lourdes has the contract. She would like to be part of this meeting.

Chris Villeneueve, Catholic Charities - In North Central for the DCR and DMHP evaluation time, the data will come out of the DCR report, so whatever data is entered into the system the DCR will show the response time as well as when the initial request was sent out by the for the referral source. In North Central they had the referral time coming from crisis system and then we were able to show the turnaround response time for the DCR. You would want to make sure that it is tracked by the location codes. We want to make sure that the ASO has this information as one of the specified location codes we want to track.

Barb - Questions with the EDIE data - From her understanding what we are trying to figure out is, if a patient with a primary BH diagnosis goes to the ED, we all know that if other physical health diagnosis such as Asthma end up in the ED and also have a BH diagnosis. Are we trying to capture that whole big group or just people that people that go to the ED with a primary the BH diagnosis including Mental Health and Substance Abuse?
Answer: HCA wants to track the primary BH diagnosis, the purpose of getting the EDIE data is to see if there is an increase or decrease of people with BH conditions going to the ED for care and not being able to access other community resources.

Suggestion from CHPW – When the data is reported, suggest breaking it out by Medicaid and then the BHO-ASO population because at CHPW when we look at this data regularly they see variances between the two populations. If you put them together it shows one thing but when you look at them separately you can see differences. HCA thinks this is a good idea and will look into it.

Chris– It is important to get a baseline data from the past 2 years. Then we have a better idea going into January 1, 2019.

HCA – Yes, they will definitely be getting baseline data and at least 1 year. That way we can get a good understanding what the BH diagnosis need to be tracked.

Question: Do you have a list of the BH diagnosis that is going to be tracked?
Answer: HCA is going to use DSHS RDAs definition for Mental Health treatment, they can forward that documentation. Then once we do they can create the EDIE measure we will provide good documentation as well.

Question: I see we are collecting data on the State Hospital, what about the smaller local Psychiatric Hospitals such as Lourdes and Comprehensive, also including the SUD residential?
Answers:
CHPW - The issue is claims lag. You can't get information quickly. It is hard to track it in real-time.
HCA – That is the reason we haven't been able to include them in the Early Warning System because we can't track them in real-time by using claims data. If there is a way at the community level that these can be tracked in real-time then we would be open to that.

Question: Isn't EDIE data real-time? Why can't we get the data from there?
Answer: For the smaller providers like Comprehensive or Lourdes the data is not going to come out of the EDIE. It would be easier to capture it from the DCR paperwork that is going to go to the ASO. It would be faster to collect the data at the ASO rather than waiting for the data to show up in EDIE. It all has to go through the ASO, can me make that a mandatory reporting element coming from the DCRs?

Barb - Not all patients enter the Psychiatric Hospitals are detained. Some are voluntary or referred by their provider. They are not all involuntary, so they might not even go through the DMHP.
Chris - We could use the pre-authorization, that is something we could work into the details. We would need to look at smaller local Psychiatric Hospitals such as Lourdes and Comprehensive including the SUD residentials. Anything that has to have an authorization from the MCOs or the ASO for inpatient stay. We should be including in our Early Warning System.

Question: Can a patient be transported by EMS or Police directly to Lourdes Transitions or other BH facilities?
Barb – Yes from her perspective.
Answer: Eric Nilsen-Kennewick Fire Department – No they won't take the patient without a medical screening evaluation and that is going to get done in the ED. The EMS can't do it. The police have to take them to the ED to get the screening, the police may call the EMS to do a crib side and if there is something major then the EMS would take the patient to the ED. But more times then not the police will take them because they may be going to jail. Unless they are going to be evaluated to crisis right away. There is a something in legislature right now that is trying to get the law changed that EMS can transport to an inpatient facility, but even when that happens it's going to be up to the counties to agree to that. It might be technically possible but it might not work out.

Question: What about all the patients the EMS see that don't get transported to the ED? If we don't transport the patient it doesn't go into EDIE. We see patients a dozen times before they have an injury that requires them to go to the hospital, catching these patients with BH and SUD issues early would be ideal.

Question: Does EMS have a database that this can be tracked?
Answer: The EMS are transferring to a new Records Management System (Image Trend), it provides them with tremendous amount of flexibility to be able to put specific questions in that can be tracked or flagged, or if a specific diagnosis is identified that can be tracked. The EMS will be highly motivated to answer these questions to help provide as much details as possible because this is a burden on EMS. When someone doesn't know who to call they call 911 and often we don't have all the answers for them.

Questions: Have you ever administered Narcan and then there is no follow up because the patient might not have a medical provider and you have go back because they overdosed again? Is it because their care is not being coordinated?
Answer: We don't typically administer Narcan and leave the patient. We usually transport them to the ED after that we don't know what happens.

Question: Can Image Trend uploaded to Pre-Managed?
Answer: Image Trend is all about integration. There may be away to upload the information into Pre-Manage. It is capable to export but it is a matter of money to be able get that programed.
Comment: GCACH wants to provide Pre-Manage to EMS and Police.

Eric - There is an interface that has been created that is called Image Trend Hospital HUB. This allow EMS when they identify what hospital they are transferring to and as soon as it is posted it goes to the hospital they are being transferred too. EMS may be able to create a way to capture this as week as the ones that don't get transferred.

Question: Does the EMS enter the information as to whether it is drug or alcohol related?
Answer: Yes, it that information is known or if it is evident or obvious we could. There are many things we can track.

Question: SUD is not diagnosed in the ED. How can we use that as an indicator for an ED Visit? Can we change the it to track if ED visit has anything to do with drugs or alcohol?
Answer: That is the reason that we have the measure for the ED utilization for people with past history of Mental Health or SUD. There really is not a way to show that the individual ED visit was because of their SUD or if it was unrelated.

4. Brainstorm Indicators –
    - Homeless Management System
    - Tracking Jail services - In North Central they had issues with getting the information to be able to track it. It was hard to get the data.
    - Ombudsman have many different things that they track. Get in touch with them to see what reports they are already doing.
    - Barb – What about tracking completed suicides? If you have a patient that is in treatment and they complete suicides the provider is required to report it.

- Chris - One thing we want to think about is the difference between the Early Warning System and a System of Care Report. We are really looking at the Early Warning System in this workgroup. Focusing on the encounter data and things like that we are going to see problems with in the first two to three months of the Integrated Managed Care. then after that roll it into a System of Care Reporting System. This is where we can track data around centennial events, DMHP response times, and hospitalizations that are going to start falling outside of the Early Warning System reporting.
- Any services that requires Pre-Authorizations such as; inpatient or detox
- Under the Provider Payments – Timeliness of the Payments.
  Add Payment time frame to the providers. Should add the different payment mechanisms. Some payments are received from finance whether based on invoices or are paid on a capitation which is a generation of payment based on a different structure.

5. Anyone missing that needs to be part of this workgroup?
   - Get in touch with Jerry Hatcher from Benton County Sheriff's Office
   - Ombudsman are on the front line and would be good to reach out to them to be on the workgroup

6. Next Steps –
   - Diane will schedule meeting with those involved with DMHP issue.
   - Diane will reach out to the Ombudsman, BHO, and Jerry Hatcher about them being on this workgroup.
   - Add Timeliness of Payments to Provider Payment indicator
   - Send any questions to Diane to discuss for next meeting.

7. Next Meeting August 14, 2018 at 10:00 am – 11:00 am
8. Future Meetings will be 2nd Tuesday of the month 10:00 am – 11:00 am