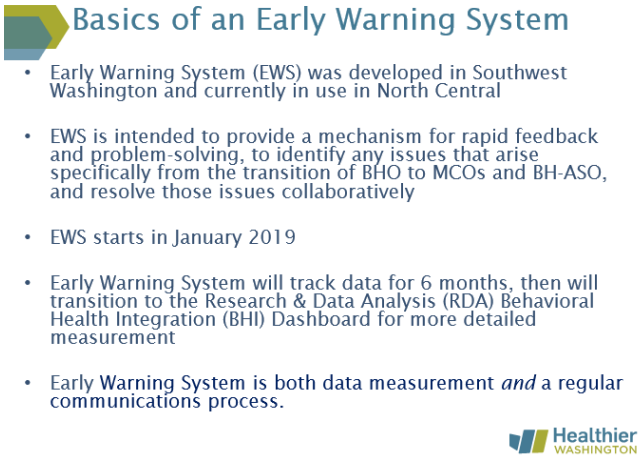
Early Warning System Workgroup
August 14, 2018
10:00 am to 11:00 am
Board Room at Tri-Cities Community Health; 800 W. Court St. Pasco, WA 99301
Meeting Minutes

1. Attendees- Rhonda Hauff-YNHS, Stein Karspeck-Richland Fire Dept, Dimita Warren-Blue Mountain Counseling, Martin Sanchez-GCACH, Gordan Cable-Lourdes Health, Courtney Hesla-Comprehensive, Jesse Flores-Serenity Point Counseling, Jennifer Flores-Serenity Point Counseling, Jaime Carson-Somerset, Veronica Gutierrez-TCCH, Chris De Villeneuve-Catholic Charities, Jenna Shelton-GCACH, Diane Halo-GCACH, Sam Werdel-GCACH, Sara Clark-First Steps, Debra Srebnik-King County, Nik Schrader-HCA, Donnell Barnette-Amerigroup, Donna Arcieri-CHPW, Mike Henne, Joey Charlton-Coordinated Care, Megan Gillis-Molina, Ellen Christian-Molina, Isabel Jones-HCA, Rena Carlson-HCA, Karen Richardson-GCBHO, Samantha Zimmerman-HCA, Matthew Kuempel- Lutheran Community Services, Shereen Hunt-Merit, Michelle Bagby-QBHS

2. EWS Overview presentation – Samantha HCA



The purpose of this EWS Workgroup is not a long term, system improvement, or contract monitoring system. It is a six-month short-term red flagging system to address immediate issues that are arising from the transition to Integrated Managed Care. It starts in January 2019 through June 2019. Then after that it will transition into the Research and Data Analysis Behavioral Health dashboard for more detailed measurement. The EWS is both a data measurement and a regular communications process. We will not only be collecting data for these six-month HCA will be communicating what the data is showing. There will be monthly webinars starting in February 2019 reporting on the data from the previous month. These meetings will have the MCOs, the Providers, and HCA all on the webinars looking at the data together. It is a good way to identify any immediate issues that need to be address, so we can solve the issues together.

Role of HCA

- HCA has developed "standard indicators" for which we have processes in place to collect, analyze and report data.
- Any other indicators are optional and it is the responsibility of the EWS Workgroup to collect and report on those additional indicators.
- HCA's role is:
  - Oversee EWS process to ensure each region has a process and an EWS Committee in place
  - Collect and report on standard indicators
  - Obtain baseline data for standard indicator list
  - Organize monthly early warning system Webinars (send invites, etc.)
  - Facilitate daily check-in calls post go-live
  - Assist and provide TA to regions as needed

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Standard Indicators

- Provider Payments *(Provided by MCO's)*
  - BH claims received by MCO's
  - BH claims rejected by MCO's
  - Reasons for rejections
- EDIE Data *(Provided by HCA/AIM team)*
  - ED Utilization
  - ED Utilization for client with past BH diagnosis
  - Portion of ED visits with BH diagnosis
- State Hospitals- WSH and ESH *(Provided by HCA)*
  - Average Daily census
  - Discharges
  - Forensic flips
- Crisis System *(Provided by BH-ASO)*
  - Crisis Hotline Calls
    - # of incoming calls
    - # calls answered
    - # call answer timeliness (within 30 seconds)
    - Average speed of answer
    - Abandonment rate
  - DHMP response time
  - # ITA investigations and outcome
    - Detention
    - Discharge with referral
    - Voluntary admit
  - # of no bed reports
  - # of single bed certifications

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Starting January 1, 2019 HCA will be doing daily check-in calls with the regions to see how things are going to identify any issues right away. Then once a week HCA will be opening up those daily calls to a broader group of stakeholders which will include the EWS Committee Members. HCA will also assist and provide technical assistance as needed.

On the standard Provider Payments Indicators HCA is currently re-evaluating this section. They are trying to figure out a better way to capture this type of data when there are so many regions going live at the same time. They are working on finalizing this section and will keep the EWS workgroup informed once they finalize that.

Principles for Other Key Indicators

- Real-time data
- Related to specific IMC transition issues
- Not administratively burdensome to collect

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Questions?

Federal Notice: The project described was supported by Funding Opportunity Number CMS-1G1-14-001 from the U.S Department of Health and Human Services, Centers for Medicare & Medicaid Services. The contents provided are solely the responsibility of the authors and do not necessarily represent the official views of HHS or any of its agencies.

Keep in mind this group wants to Track and other Indicators not on the Standard Indicators. These indicators need to be able to be tracked in Real-time data. That means that we must pick indicators that can be tracked with monthly data or bi-weekly data. Example if you want to track homelessness data and that data is only available every 3 months then that data won't be helpful for the early warning system because that wouldn't help us identify immediate issues arising that month.

An Example of an indicator that might work that we discussed last EWS Meeting was tracking residential treatment services in the region that we could get from prior authorization data. This is an indicator that could possibly work because you have access to that real time prior authorization data.

The important things to look when deciding on indicators for your region is: Do we have timely data? Is it specific to IMC transition issues? If not then the EWS Workgroup should not be tracking this data. Also, what is the administrative burden on collecting the data?

3. Discussion on the approach when considering additional EWS Indicators

Framework or approach as to how to decide on indicators that would work.

- 2-3 broad categories that we are concerned about
- Then under each category brainstorm on potential indicators that would actually be affected by the transition to IMC
- Can they be tracked with real-time data and how burdensome would it be to collect the data?

4. Workgroup exercise/discussion on Indicators for GCACH region

Question: How often does BH/MH services have to have prior authorizations?
Answer: In North Central there was no prior authorization except for residential bed/inpatient treatment and some other additional services such as psychiatric services or additional days in treatment. This would happen after the authorization had been processed. In North Central it was a timely challenge.

HCA: This is something you would need to work with the MCOs to collect the data.

Is this something that the MCOs the data to be able to be track? They believe this is something they can provide monthly.

Prior Authorization Data

- Turnaround times
- Call in service
- # of Auths
- # of denials clinical/administrative
- # of Approvals
- Type of prior auth

Encounter Data

- Total # of Encounters Submitted
- Total Authorizations Requested – Type of service

This could be provided by the provider. Would a simple survey monkey be helpful to track this information? This should be something the provider could do on a weekly or monthly basis. Then GCACH could track it.

The encounter data could be part of the standard indicator provider payment section. HCA will edit it and let us know what other indicators they are going to add. HCA needs to talk with MCO to find out what exact data will

go into this section. In Northcentral they had the providers submit their encounter data to the HCA and the MCOs submitted their encounter data they had received from the providers. This could be an indicator as to something is wrong if the numbers are different. Such as are the getting stuck in the clearing house or other reasons such as denials or rejects. HCA has all five regions going live at the same time so this might be something each region will need to track. HCA and the MCOs will discuss this and decide on what they will be able to track on their end.

Access to care could be another broad topic we could track.
How would we track Access to Care?
It would have to come from the providers. This should be information that would in our systems and the providers could provide this information. They could get their numbers from last year and once IMC is implemented then they would be able to see if those numbers change whether it is an increase in the number of patients requesting service, if there's delays in getting their intakes done, or if there is delays in getting their routine visit after the intake has been complete. Some providers do not track the request for services but this may be something they could start collecting.

Access to Care

- Increase in Crisis #s due to not being able to get into the provider
- Outpatient
- Screenings for services/Next appointment
- Request for services
- What type of services
- Total # of Auths submitted
- Total # of Auths Approved

Could we track capacity? We could track the request for assessment, then the time frame to the first routine visit and what type of visit is needed for the next routine visit. You could see if your time frames are going longer. This would be an indicator that something is going wrong. It could be a variety of reasons. This could be something practices could look at for quality, but not sure if it would be for the EWS.

Question: Help me try to understand the impact on Crisis response and how that is going to be tracked? What happens if they have a to call the crisis team more often then they were before? How do we connect that with IMC?
Answer: HCA tracks under Crisis System Category on the Standard Indicators they track the number of calls, number of calls answered, and the timeliness of calls. So, if there is a sudden spike in crisis hotline calls because people are having problems with access to services or something. It would show an increase and give us some idea something is wrong and will be reflected in the data.

Question: Are you capturing all crisis encounters submitted and not just through the local crisis response team when looking at this specific indicator? Calls to the hotline have a specific encounter CTP code but calls or services provided by a DCR is another CPT code. We just want to make sure it includes all the codes.
Answer: This would be calls going to the crisis hotline for this specific indicator. It's not being tracked by codes. In other regions we have been able to track the number of calls answered, average speed of answered calls to the hotline as well as the response time of the designated crisis responders and the outcome of the ITA investigation such as involuntary detentions, voluntary admissions, or number of patients discharged with a

referral. Also, through the ASO have been tracking the number of no beds reports and number of single bed certifications filed.

Comment: Things in our region we may want to track are where the DCR is being requested at provider offices, hospital, or jails.
Comment: If we are just focusing on the hotline, we are missing the ones that walk into an outpatient provider in crisis. In this region there is a lot of activity on the outpatient level with crisis in dealing crisis prior to accessing the crisis system or the hotline. I think we are missing a chunk of potential data if we only look at that crisis hotline. I think this can be captured by tracking CPT codes and it could track as to what the crisis system is doing as a whole and what the DCRs are doing.

Comment: I guess it all depends on what you are wanting to track. If we are speculating that there may be an uptick in crisis calls because of access to care issues then it not necessarily as important to track people who already have care. They are walking in to their local community mental health provider and getting crisis services there. If we are trying to just track simply if there are a bunch of people calling the crisis hotline because they are not able to access routine services. If we want to see the impact on the whole crisis system as a whole then tracking it by CPT code could be the best way. There are a lot of people that don't enter into our formal crisis system if the outpatient provider is taking care of the crisis and it doesn't ever get to the level of a DCR.

Comment: If we are looking at the social determinates of care issue, we should be looking at where the DCR is responding to. If we are seeing an uptick in the number of referrals from the jails, hospitals, and the provider is the last resort. This could possibly be an indicator something is wrong within the system.

Comment: If you are tracking the CPT codes then you could actually have a relative proportion as to how many are being served by there outpatient providers and then how many are involving the crisis service and having a DCR involved.

Comment: We should be able to pull the historical data from the jails and hospitals DCR referrals information and use that for comparison for the first six months of IMC.

Question: On the standard indicator under Crisis - # of ITA investigations and outcome section, how is that data collected? It looks like that would be from CPT codes.
Answer: In Northcentral they have a daily report that the providers provide to the ASO on what the outcomes were such as the number of ITA investigations, a brief description that was provided, and if they were detained or not detained.
HCA: This is something that HCA needs to talk with the ASO about.

Next Steps:

- HCA will meet with MCOs so decide on what the Provider Payment Indicator Category. They will decide on what is trackable on their end.
- HCA will talk with ASO about the crisis indicators.

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