



Department of Social and Health Services

Health and Recovery Services Administration

Strategic Plan 2009-2013



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The Purpose of This Document

This strategic plan communicates how we will advance our mission and goals in a changing environment and meet our future challenges, so that we can better serve the most vulnerable populations in Washington State. This document is a road map that guides the business policies and improvement strategies for our organization, employees and partners.

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Integration and Synergy

A strategic approach for HRSA 2009-2013

INTRODUCTION

In 2005, Secretary Robin Arnold-Williams challenged the Department of Social and Health Services to create a new paradigm of integration to guide it in the coming decade, looking beyond the silos and boundaries that too often stifled a synergistic approach to the agency's mission. In few administrations was the challenge and the reward greater than the Health and Recovery Services Administration, which was reorganized that summer to include the state's medical assistance programs, mental health services and chemical dependency treatment.

Along with a charge to work across boundaries, Arnold-Williams also challenged the agency to sift its data with new eyes, alert for new approaches to cost controls and quality improvements:

- Up to 20 percent of the most expensive medical assistance population need alcohol-substance abuse treatment -- yet only six percent of them get it.
- One-third of the so-called 5-50 (five percent of the caseload who drive 50 percent of the costs) population has mental health issues, and 13 percent of them have substance abuse and alcohol issues.
- Treatment of depression, schizophrenia and pain represents 60 percent of pharmacy expenditures in the 5-50 population.
- Many providers also struggle with the need to spend additional time assisting disabled patients and seniors with developing chronic conditions that will erode their health and quality of life.
- Emergency rooms are crowded with patients who have undiagnosed or undertreated substance abuse and mental health problems – conditions that are layered under traumatic injuries or medical conditions.

The new Health and Recovery Services Administration has moved quickly to confront these challenges and is actively developing strategies to follow in the coming decade. The Mental Health Division now routinely consults with the Medical Assistance Division, and the alcohol and substance abuse programs are working with the pharmacy planners and authorization staff. In all cases, the new systems increase the effectiveness of services by better connecting funding, other resources and policy development.

Instead of seeing patients as complexes of contract issues that needed to be sorted out organizationally within DSHS, professionals in all areas of HRSA are beginning to see that effective treatments must be integrated to focus on the entire patient and the complex of conditions that make up the whole. Concepts like medical homes, provider access and co-occurring disorders take on a new significance.

Here are some of the program developments that have followed that insight:

Narcotics intervention: One of the early successes was the so-called "320 Project." HRSA identified 320 clients at the high end of Schedule II and III narcotics utilization – all patients who were receiving more than 10 prescriptions per month. Individual providers were recruited to help the effort, and the results were dramatic. In just three months the number of narcotic prescriptions and narcotic costs for the 320 group declined by 25 percent. Today, the program is reducing medical expenses, emergency room use and supporting local providers with much needed information to guide care.

Treatment Expansion: DSHS persuaded the Governor and legislators to transfer \$50 million of its medical care funding into alcohol and substance abuse treatment, making certain that treatment options will be available as quickly as candidates are identified. This treatment expansion project has cut waiting time and increased treatment admissions, opening that option to more than 4,000 adults in fiscal year 2007. Thousands of clients once forced onto waiting lists can now access chemical dependency treatment.

- **Emergency Room Screening:** With the help of \$16 million in federal funding, 27 chemical dependency professionals were placed in nine of Washington's busiest hospital emergency departments over the past two years. About 46 percent of patients have screened positive for substance use or abuse, and those patients receive brief interventions or are referred for follow-up treatment. Preliminary evaluation of the Washington State Screening, Brief Intervention, Referral and Treatment program (WASBIRT) shows that screened patients' use of alcohol and drugs declined, abstinence increased and treatment referrals resulted in significant declines in use of alcohol.

Opioid Dosing Guidelines: A unique panel of Washington State Medical Directors from seven different state agencies looked at narcotics use levels. After intensive study and coordination with physicians who specialize in pain management, the panel developed a set of new narcotics dosage levels for patients suffering chronic pain and began a year-long effort to educate providers in the use of the guidelines. Washington is believed to be the first state to undertake this type of initiative. A dosage guide and the calculator are now posted on the Web at <http://www.agencymeddirectors.wa.gov>.

Washington Medicaid Integration Partnership (WMIP): WMIP is a voluntary integration of Medicaid services for adult Snohomish County clients with Supplemental Security Income (SSI) and who are eligible for both Medicaid and Medicare (dual eligible). WMIP clients' care is coordinated by a single managed care plan, and the different types of care services were phased in starting with medical and chemical dependency in January 2005, mental health services in October 2005, and long-term care in October 2006.

Chronic Care: A new Chronic Care Management Program was launched in 2007 to replace a Disease Management pilot instituted several years earlier. A key difference was that in disease management, the primary diagnosis (diabetes, asthma, etc.) drove patient education and care management, while the client's mental illness was a secondary consideration at best. In the new program, clients who are at highest risk for future costs are selected for care management, and more than 40 percent of them have a substance use or mental illness as the primary driver of utilization.

Patient Review and Coordination (PRC): This evolving program has the ability to restrict troubled clients to a single primary care provider, a single pharmacy, a single narcotic prescriber, and a single nearby hospital for non-emergent care. The primary care provider manages and coordinates the client's care. In addition, PRC can even put a hard stop on a client's drug prescriptions when there is evidence that the client is over-using or inappropriately using services, including prescription forgeries, doctor shopping, selling of drugs, multiple inpatient admissions for drug poisoning, and having two or more emergency room visits in a 90-day period. Caseload has jumped from under 200 clients three years ago to approximately 3,000 today, with a total cost savings of over \$30 million.

PACT Teams: In 2007, Washington State launched new Program for Assertive Community Treatment (PACT) teams -- multi-disciplinary units with expertise in mental health, medical and substance abuse. The teams focus on hard-to-serve individuals with high use of psychiatric hospitalization and crisis services. The PACT concept is aimed at serving individuals with significant psychiatric disabilities with extensive outreach.

Anti-Psychotic Drug Guidelines: A class of drugs known as atypical anti-psychotics has been commonly used in recent years to soothe agitation, delusions and aggression in people with dementia-related behaviors, including those present in Alzheimer's disease. Working with providers, Washington State's evidence-based reviews of this research and other scientific findings established guidelines for more appropriate use of these medications.

ADHD Prescriptions for Children: In a similar area, attention-deficit hyperactivity disorder (ADHD) medication for children has become more common in recent years, but national data shows many children receive prescribed doses at double and triple the recommendations of the Food and Drug Administration. HRSA, working with prescribers, has now set age and dose limitations, provided for DSHS reviews, and required a second opinion when children under 18 years of age take more than one type of ADHD medication.

DEVELOPING STRATEGIES

Several key programs and pilots that are already under way will continue to set a direction for HRSA in the next biennium and beyond. Funding for the WASBIRT emergency room pilot will end in the fall of 2008 but the need will continue. The WMIP partnership has sketched a vision of integrated care that can grow far beyond the disciplines of the past.

Among other glimpses of HRSA's integrated future:

Predictive Modeling: HRSA is reviewing the potential for bringing this computer-generated forecast of future health-care expenses in-house, rather than continuing to rely on vendors. Currently HRSA spends \$650,000 annually to purchase these services, but the additional data and decision-support systems available through ProviderOne raise the possibility of developing a DSHS capability to look at our data and risk levels of client populations on an expanded basis, enriching many of the cross-boundary initiatives that can be explored to improve care and streamline efficiencies.

Children's Mental Health Services: Washington's integrated work assisted the

passage of a children's mental health law that envisions the integration of many of the elements discussed above. Programs in the new law will 1) integrate the Medicaid pharmacy benefit with the mental health contractors, 2) integrate the foster care services with new primary care consultation and training programs, 3) establish a high degree of dialogue and discussion that has not occurred in the past to drive targeted and integrated programs.

Improving Foster Care: The Governor and State Legislature have committed the state and DSHS to improve the health of all Washington children, including the children in the foster care system that are more likely to have significant health concerns that can affect their ability to become healthy adults. Children in foster placement experience significant economic disadvantages, including household incomes beneath the poverty level, episodes of homelessness, heightened chance of disabilities and a lack of health insurance. An additional challenge is that children in foster care may face changing placements – making it more difficult to access providers and achieve continuity of care. Virtually all of HRSA's divisions are reaching across administration boundaries, working with the Children's Administration to upgrade care of this special and vulnerable population.

Beyond WASBIRT: The success of the agency's Emergency Room screening program can be applied to other venues in the future. Similar operations could be set up and piloted in physicians' offices or in schools across the state. As in WASBIRT, counselors and other trained personnel would watch for signs of substance abuse and have the resources for quick interventions and timely referral for treatment as appropriate.

Continuum of Care: DASA has adopted a PITA care strategy aimed at four critical stages that enhance integration: **Prevention** – focusing on populations at risk of substance abuse and experimenting; **Intervention** – reducing the risk of harm to individuals via problem behaviors; **Treatment** – services that help individuals re-enter society and achieve recovery; and **Aftercare** – the support services and integrated care that encourage abstinence and recovery.

Preventive Care: The best health care is preventive care, because prevention helps avoid disease and injury. Physical exams, developmental screening, health education, immunizations and well-child checkups – all of these are part of a medical home, a concept that begins to redirect care choices to patients and parents. Working together, making decisions that reflect family involvement, clients and providers will build healthier families, and children who grow up healthy will be healthier adults. A medical home is an investment in every Washington family's future.

Health Literacy: A second area of consumer challenge and choice is the administration's increasing emphasis on health literacy – making sure clients in all HRSA programs have the background and the educational base to make good health decisions.

In summary, the changes are not easy, and many of the initiatives are more evolutionary stages than "final fixes." The cultural changes come slowly and require leadership and nurturing. However, we are better able to see the client as a complete individual with unique and complex needs; in the same way, we also now have a better grasp of our programs as inter-related and bringing more flexible solutions to those needs.