Appendix Three

Policy Options Emerging from the Comprehensive Review of Reports

HRSA staff used the results from the comprehensive review of past reports to identify a range of potential policy initiatives. Information on these potential initiatives was shared with community members for comment and input through a series of regional community-based meetings held in September and October 2009. From the extensive review of reports on health services, four sets of policy initiatives were identified:

1. Implementation of the Person-Center Health Homes Model,
2. Integrating Children's Services,
3. Promoting Evidence-Based and Promising Practices, and
4. Leveraging Flexible Funding for System Change.

This appendix documents the information presented to participants at the regional community-based meetings on each of the four sets of potential policy initiatives. For each of the four areas, this document briefly reviews **what has been learned** from stakeholders; some of the **progress to date** related to these initiatives, as well as barriers to progress, when applicable; and **options for moving forward**.

In moving toward the incorporation and implementation of any policy initiatives, meeting participants were asked to keep several important points in mind:

- The breadth and complexity of the changes needed to implement what has been learned is staggering.
- Efforts made to date by the state, managed care organizations, regional support networks (RSNs), providers, consumer and family run organizations, individuals and others have led to some improvements from which we can learn.
- Conclusion across prior reports reviewed: In order to achieve the collective vision of stakeholders, Washington State needs a fundamentally different approach to organize the delivery of health care services.
- The Person Centered Health Homes (PCHH) model offers a new framework for organizing the delivery of health care services.

Implementation of the Person-Centered Health Homes Model

How Person-Centered Health Homes Fit with the Summary of Prior Reports

Barbara Mauer recently offered a helpful set of seven principles for Person-Centered Health Homes (PCHH).[1] The PCHH model and the seven principles undergirding it are in harmony with the values, priorities and strategies in the prior reports. These principles are listed below, along

[1] Mauer, B. (2009). *Behavioral health/primary care integration and the person-centered healthcare home*. Washington, DC: The National Council for Community Behavioral Healthcare. Downloaded from: http://www.thenationalcouncil.org/galleries/resources-services%20files/Integration%20and%20Healthcare%20Home.pdf

with observations about how these fit with many of the themes for system transformation from the prior reports.

1. *An ongoing relationship with a personal physician* – There are three ways in which this principle fits with themes from the prior reports. First, with the continuity of care afforded by having a personal physician, there is more opportunity for the health team to work in tandem with natural supports and become part of the natural support system. Second, because this principle indicates a shift from episodic to continuous care, it supports recommendations to eliminate the Access to Care Standards. Third, adult consumers have asked for less disruption in care and more continuity.

2. *The personal physician leads the team taking collective responsibility for care* – This principle fits with a core assumption of High Fidelity Wraparound. In addition, it corresponds with a core assumption of other EBPPs, such as Assertive Community Treatment and Integrated Dual Disorders Treatment, in which the psychiatrist assumes the role of team leader.

3. *The personal physician maintains responsibility for care* – This principle takes accountability to a new level by clearly identifying a focal provider who is responsible, and by ensuring that this person is one with whom the child and family have a continuous relationship.

4. *Care is coordinated and integrated* – This is a core assumption of Systems of Care for children, and is consistent with best practices in children's behavioral health services.

5. *Quality and safety are hallmarks* – An important theme from the review of reports was the continuous monitoring and attention to quality in all service delivery.

6. *Enhanced access to care* – This principle fits with several themes from prior reports, including the elimination of the Access to Care Standards. In addition, it is consistent with the core assumptions of nearly every report reviewed across Chemical Dependency, Mental Health and Primary Care health delivery systems. When combined with a focus on EBPPs and on holistic and wellness related approaches, enhanced access becomes a transformative principle for children's services.

7. *Payment is tied to the health home* – This important principle, which has powerful implications for system transformation, fits with recommendations of multiple reports to tie payment to what is delivered. In addition, implementing this principle can lead to enhanced flexibility to pay for what is needed.

Four key recommendations are found in the Final Report to the Legislature on SHB 2549 (2008) – Payment Options and Learning Collaborative Work in Support of Primary Care Medical Homes. These can also help guide Washington's implementation of the PCHH model.

1. Improved care coordination across providers, settings, and service recipients and their families,
2. Health information technologies (notably registries, electronic health records, and decision support tools),
3. Some form of system organization/integration in support of the first two elements, and
4. Activation of patients (sic) as partners in their care and participants in quality improvement.

Integrated Children's Services

The review of prior reports described a vision of children's services better integrated at all levels, with families at the center of a collaborative partnership. In summarizing this second set of policy initiatives, we review what has been learned from the review of prior reports about children's health services and integration; progress made to date; barriers to progress; and options for moving forward.

What Was Learned from the Review of Prior Reports about Children's Health Services

There were four key directions that can help drive policy in the area of children's services:
1. Improve Access to Care for All Children and Youth. Eliminate regulatory restrictions for mental health access (Access to Care Standards) and increase access to medical homes.
2. Improve Access to Care for High Need Youth. Increase access to systems of care and better meet the needs of multi-system involved youth, particularly in the juvenile justice and child welfare systems.
3. Evidence Based and Promising Practices (EBPP). Expand and increase access to High Fidelity Wraparound. The system should promote multiple EBPPs to meet the various treatment needs of children and families.
4. Expand Involvement of Youth and Families. In particular, include youth and family in decision-making throughout the system.

What Was Learned about Integrated Care for Children and Families

Recommendations from the prior reports indicated the need for three key policy initiatives.

1. Integrate Chemical Dependency (CD) & Mental Health (MH) Care. Behavioral health services need to be integrated at multiple levels, from clinical treatment to the financing and administration of systems:
- Increase Access to Integrated CD/MH Care,
- Implement Provider/Treatment Integration Strategies, and
- Implement System-Level Integration Strategies - including the development of blended funding and administrative processes.

2. Integrate Behavioral Health (BH) and Primary Care (PC). Needs for Chemical Dependency and Mental Health services (BH services) do not occur in isolation from other health concerns.

Expanding and disseminating the use of the PCHH model and developing other clinical and system integration strategies are needed to enhance care and make it more efficient:

- Increase Use of Medical Homes (the Person-Centered Health Home model),
- Implement Provider/Treatment Integration Strategies,
- Implement System-Level Integration Strategies.

3. Integrate BH Care Across Multiple State Departments. In order to support the kinds of enhancements to care that stakeholders envision, there must be integration across the state departments that currently have authority in funding and monitoring BH and PC services.

Progress on Integration to Date

Much of the progress so far on integrated children's health services was seen as having occurred at the local level or through pilot projects, including those listed below. Efforts to ensure comprehensive access to integrated, evidence-based health services need to capitalize and build on these pioneering programs:

- GA-U pilots;
- Healthy Options;
- Child psychiatry Partnership Access Line;
- SAMHSA System of Care Grants: Clark County, Yakima County;
- High Fidelity Wraparound pilots;
- Partnerships for Success – Thurston County, Tribal partnerships; and
- SAFE-WA local parent support organizations.

Barriers to Progress

However, stakeholder criticism has centered on some noteworthy limitations of these efforts. The following list of concerns should be considered when implementing system transformation initiatives:

- *Need to move beyond pilots to statewide implementation* – Taking pilot projects to scale will involve logistical challenges that must be considered, but the attempt must be made.
- *Barriers to coordination across agencies at the state level* – Bringing integrative and EBPP-oriented approaches to scale will require parallel changes at the state level that ensure the proper alignment of all levels of system administration.
- *Funding stream barriers* – Changes to the Access to Care Standards and related issues must be addressed if integrative, best practices are to be sustained over time.
- *Lack of comprehensiveness in focus of pilots* – Some best practices that offer the most promising opportunities for increasing the efficient use of resources need to be included in the transformation effort. For example, there is a need for an increased focus on prevention, intervention, and early child mental health.
- *Lack of access for high need children to BH services* (for example, children in foster care, special health needs) – Efforts to increase access to integrated and evidence-based services need to ensure that the most vulnerable populations, and the systems in which they tend to be served, are included in any implementation plans.

- *Lack of consistency across health plans and RSNs statewide* (even within a single funding stream) - This concern was voiced with respect to each of the following system issues:
  - Coordination of PC and BH;
  - Availability of service modalities, EBPPs, and peer supports;
  - Collaboration with allied services and Tribal governments;
  - Provider network adequacy and choice; and
  - Child and minority mental health specialists.
- *Additional barriers to funding needed improvements* include:
  - A tendency to keep funding the same providers and services;
  - Multiple administrative structures and retained revenue for reserves – these realities make it more difficult to achieve the kind of integration and efficient use of resources that are required in a transformed system; and
  - Inconsistency in local participation in funding, such that transformation initiatives, which rely significantly on local-level involvement, may lead to inconsistency in outcomes.

The bottom line challenge is this: To do more of the things prioritized by past recommendations, Washington State needs to say “no” to some things that have not been prioritized that are currently done. This will require continued effort to communicate with stakeholders about system changes and to develop a spirit of collaboration and partnership.

Potential Policy Options for Moving Forward

Several potential policy options were identified for review and input with forum participants:

1. Support the current system as it continues to evolve. We have made substantive progress in the past few years, and we need to recognize and build on these successes. However, there is still a long way to go in achieving the level of integration, access and effectiveness that stakeholders envision. More must be done.

2. Enhance state contract requirements for PC, MH and CD to support integrated and effective services for children. In implementing this option, these initiatives must be developed and implemented system-wide:

- More rigorous contract standards and enforcement,
- Requirements for coordination of care, and
- Performance measures and pay for performance.

3. Combine all funding for children’s PC, MH and CD services into a single system of funding and contract requirements. In considering various options for achieving this ambitious goal, the following should be explored:

- Multiple examples of special population carve-outs: Florida’s foster care system, New Jersey’s foster care system, Connecticut’s Behavioral Health Partnership;
- The use of administrative efficiencies to fund service expansion;
- Ways to develop more consistent contract requirements;

- More effective state oversight of one, rather than dozens of specialized health plans; and
- The incorporation of regional strategies (as does New Mexico's statewide plan) to achieve integration, access, and effectiveness in a way that does not seem forced on local communities, but, rather, allows them to tailor system-wide strategies to local realities.

Promoting Evidence-Based Care and Promising Practices

What Was Learned from the Review of Prior Reports: Modernizing Clinical Systems

Six major themes emerged related to modernizing clinical systems and promoting the use of evidence-based and promising practices (EBPPs):

1. Expand Peer-Run Services

- Develop a broader, more diverse array of consumer- and family-run organizations that are independent of other providers, and which receive comprehensive system support in the form of certification requirements and technical assistance.

2. Implement Systemic Approaches to Increase EBPP Availability

- Create entities, such as Centers of Excellence, to support the systematic use of EBPPs.
- Support community and Tribal-level decision-making on EBPP adoption, so that a sense of ownership is increased and the appropriateness and effectiveness of EBPPs are maximized.
- Update reimbursement approaches in order to support EBPP use.
- Be mindful of the limitations of EBPPs, particularly given the fact that many of them were developed within certain cultural groups and with particular populations. They may not generalize to other groups, unless they are tailored to the particular needs of those cultural groups and populations.

3. Expand access to EBPPs for child and family mental health

- Expand access in particular to High Fidelity Wraparound services, which involve integration of care and have such a strong track record of good outcomes.
- Ensure access to other EBPPs, such as Multidimensional Treatment Foster Care, Multysystemic Therapy, Family Integrated Transitions, Functional Family Therapy, Multidimensional Family Therapy, crisis continuum, Trauma-Focused Cognitive-Behavioral Therapy, Parent-Child Interaction Therapy, Positive Behavioral Interventions and Support, and others. Ensure access to appropriate EBPPs in Child Long-term Inpatient Program (CLIP) facilities, also.

4. Expand access to EBPPs for adult and older adult mental health

- Expand EBPPs and other practices that are recovery-oriented, cost-effective, and person-centered. These include, for example, Assertive Community Treatment, Integrated Dual Disorders Treatment, and IMPACT program for treating depression in older adults.

- Promote consumer control over services through the implementation of self-directed care models, consumer-run/peer-delivered services, and processes for increasing consumer choice in services.
- Expand models that integrate care within BH services (Chemical Dependency and Mental Health) and between Behavioral Health and Primary Care. Models include, for example, Integrated Dual Disorders Treatment (BH) and the Person-Centered Health Home (BH/PC).
- Increase the availability of housing, employment, other non-medical supports.

5. Expand access to EBPPs for primary care/physical health

- Examples of EBPPs for which access should be expanded include the HRSA bariatric surgery and pharmaceutical protocols.
- There should be a primary focus on the Health Technology Assessment, in order to:
  - Promote excellent health care by investigating what works and contracting for impartial, peer reviewed evidence-based reports to support better decision making;
  - Use the expertise of an independent committee of practicing health care providers; and
  - Maintain an open process for nominations of health technologies and support a centralized location for state agencies to share information on coverage decisions.
  - It is recommended that six technologies be selected in the first year and an additional eight technologies in the second year for study and coverage decisions.

6. Expand access to EBPPs for chemical dependency

- The goal has been set to ensure that 50% of county prevention programs are based on EBPPs.
- Training and regional efforts are promoting EBPPs in treatment settings, and these should be supported and expanded.

Progress to Date

Despite significant progress in various areas across health care delivery systems, there is still a tremendous distance to travel. Reasons include the following six issues:

1. Awareness of some EBPPs is still lacking;
2. Providers and systems report lacking time and resources to transition to EBPPs;
3. Some EBPPs pose system-level and logistical challenges;
4. There is often a belief that many EBPPs are not sufficiently funded in the system;
5. Workforce issues – not enough providers are trained in evidence-based practices; and
6. Stakeholder concerns about EBPPs – for example, will moving towards EBPPs interfere with continuity of care and culturally competent services?

Potential Policy Options for Moving Forward

Several potential policy options were identified for review and input with forum participants:

1. Support the current system as it continues to evolve. We have made substantive progress in the past few years, and we need to recognize and build on these successes. However, there is still a long way to go in achieving the level of integration, access and effectiveness that stakeholders envision. More must be done:

2. Enhance state contract requirements for PC, MH and CD to support integrated and effective services for children. In implementing this option, three initiatives must be developed and implemented system-wide:

- More rigorous contract standards and enforcement,
- Requirements for coordination of care, and
- Performance measures and pay for performance.

3. Require a scheduled ramp-up for adoption of EBPPs. Tie this to specific funding targets (for example: 25% to 50% to 75% to 100% of all spending, increasing across years). Implement an EBPP adoption process over a specified time period—for example, four years—that ensures the system has enough time to implement EBPPs effectively and can absorb the change smoothly.

4. Reprioritize the benefit structure to support the adoption of EBPPs.

5. Combine the reprioritization and ramp up options.

Leveraging Flexible Funding for System Change

What Was Learned from the Review of Prior Reports: Need for Flexible Funds

Medicaid funds medical services only. Although making use of flexible options within Medicaid can be helpful – and Washington has taken advantage of many of these – other sources must be tapped if the goals of a transformed system are to be realized.

Many stakeholder priorities cannot be paid for with Medicaid (or face limitations), including, for example:

- A broader, more diverse array of consumer/family-run organizations that are independent of other providers;
- Flexible wraparound supports;
- Housing development and supports;
- Consumer self-directed care;
- Early childhood and school-based consultation; and
- Transition, outreach and coordination services.

In addition, maintaining too much reliance on Medicaid and/or avoiding the use of creative problem solving have sometimes led to two key problems that must be overcome: not prioritizing services based on community data; and not capitalizing on opportunities to use blended/braided funds.

What are the Flexible Funds?

Local 1/10 of 1% sales tax and other local funds are among the most flexible sources for funding health services. However, the amount of local money leveraged for services ranges considerably across counties, from nothing to millions of dollars.

Unmatched state general funds are a close second, in terms of flexibility of use for services.

Next, federal block grant funds are flexible, within federal funding priority areas (which are much more responsive to state priorities than federal Medicaid medical service definitions). There are three federal block grants that need to be used effectively in any transformation strategy:

- Substance abuse treatment services,
- Substance abuse prevention, and
- Mental health services.

The biggest barrier in this area is that there are not enough funds to do everything that needs to be done. Again, creative solutions must be sought, but priorities must be set.

Challenges and Opportunities for Flexible Funds

Currently, flexible funds are divided in line with historical funding patterns, with the bulk going to local jurisdictions. Some jurisdictions leverage with local funds, but some do not. Some jurisdictions use these to support broader stakeholder priorities, but some do not. A major challenge is to make optimal use of flexible funds to bring about needed system-wide changes, while respecting the importance and the need to maintain local control.

Within this context, it is important to note that there are other approaches to allocating flexible funds. For example,

- Some states require local jurisdictions to fit spending within broader priorities set by the state (e.g., housing);
- Some states require local jurisdictions to use local funds (county funds, sales tax revenue) to access flexible funds; and
- Some states are more directive in applying federal funding priorities such as funding for family/consumer run services.

In other words, Washington could decide to help communities maximize their use of local funds by helping them connect their solutions for local problems to a statewide effort to integrate and improve the effectiveness of services. If local communities can see a compelling connection between their participation in statewide system change and the likelihood of an increase in access to effective services at the local level, the improved system that stakeholders envision is more likely to be realized.