BEHAVIORAL HEALTH & SERVICE INTEGRATION ADMINISTRATION

Data Consolidation Projects for BHO

Transforming Lives

Request	FY16	FY17	15-17
FTE	2.0	2.0	2.0
GF-State	$152,000	$148,000	$300,000
Total	**$254,000**	**$247,000**	**$501,000**

DECISION PACKAGE SUMMARY

The Behavioral Health and Service Integration Administration (BHSIA) requests staff, hardware and software licenses, and external consulting in order to develop and implement a data store integrating information and management for mental health and substance use disorders clients. By funding this request, BHSIA is expected to support and comply with legislation requiring the creation of the Behavioral Health Organization (BHO) on April 1, 2016.

PROBLEM STATEMENT

The passage of SB 6312 in 2014 alters the framework for how mental health and substance use disorder treatment services will be delivered, managed, monitored, and outcomes evaluated. The new approach, which is mandated to take effect on April 1, 2016, integrates purchasing and delivery of these services , which currently are not integrated and alters the role of the DSHS BHSIA relative to substance use disorder treatment providers. In addition, SB 5732/HB 1519 (2013) require the inclusion and monitoring of client outcome performance measures in BHO contract.

Existing information technology systems currently in use by the agency will not support the new framework. The state is currently using two aging data systems with different data definitions and duplicate data entry and submission for a shared population. Dual data systems are cumbersome for providers and do not support oversight of integrated mental health and chemical dependency services, or effective monitoring of client outcomes.

The legislation requires integration of purchasing and delivery of mental health and substance use disorder services. New entities, BHOs, will be responsible for contracting with the service providers and providing information to BHSIA, which retains oversight responsibility. Under the new structure, BHOs will contract with both substance use disorder and mental health providers, and BHSIA will no longer be contracting directly with counties or residential providers for substance use disorder treatment services. Current data reporting systems will not meet the integration or the contractual relationship needs, which take effect April 1, 2016.

PROPOSED SOLUTION

The overall project is conceived in three phases, with the first in Fiscal Year 2016 required to support the formation of the BHOs. Phase One will identify and document the BHO data reporting requirements and allow BHSIA to accept data transmission from the BHOs, including BHO encounter submissions through ProviderOne. Phase Two expands and broadens the data sources to include data from other administrative data sources such as employment data from the Employment Security Department (ESD), criminal justice data from the Administrative Office of the Courts (AOC) and

Department of Corrections (DOC), and housing data from the Department of Commerce to enhance state and federal reporting. Phase Three would align with and prepare for Health Information Exchange (HIE) requirements in 2020 with the Health Care Authority (HCA), which is not planned for in the current biennium; additional resources will be necessary in the 2017-19 Biennium.

BHSIA will create a data store which will accept and store client information from BHOs, as well as the Tribes and Problem Gambling providers who fall outside the BHO scope. This is conceived as a series of relational tables within a Microsoft SQL database, which will support integrated reporting and analysis required for program planning and development through an existing web-based reporting application, known as the System for Communicating Outcomes, Performance and Evaluation (SCOPE). Regular standardized program management reporting will be provided to facilitate DSHS oversight responsibilities.

The staffing requested are a Business Analyst and Data Architect to ensure all requirements are included and the data model is structured for optimal extensibility and ease of reporting. Projected contracted services will be required, as the project will require independent verification and validation and a Senior Project Manager.

EXPECTED RESULTS

This project ensures that the information required for oversight of the new BHO model will be in place on April 1, the legislated implementation date for the BHOs. Consumer health will be viewed from a cohesive perspective when providers are determining treatment. The state will no longer be dependent on two aging data systems with different data definitions and duplicate data entry and submission for a shared population. The integrated data store will ensure improved analytics and reporting, allowing BHSIA to meet the mandated duty to implement and monitor client outcome performance measures.

System maintenance will be reduced. (The recent requirement to move from the Windows 2003 platform to more current platforms required extensive retrofit work to ensure the security compliance for Consumer Information System (CIS) and Treatment and Assessment Report Generation Tool (TARGET).)

The project aligns with and prepares for the 2020 HIE initiative of the HCA.

STAKEHOLDER IMPACT

Treatment Providers – Currently 30 to 40 percent of clients who receive publically funded behavioral health services have both a substance use disorder and a mental illness. There are provider agencies that are licensed to provide both substance use disorder and mental health treatment services. Under the current structure, treatment providers must enter client-level information into two systems; CIS for mental health and TARGET for substance use disorders. This dual entry of similar information is a burden for providers. In the case of mental health information, the data goes to the Regional Support Networks (RSNs) and then a subset to the state. For substance use disorders, it goes directly to the state.

BHOs – Moving to an integrated system changes the nature of Substance use Disorder (SUD) management from fee-for-service to managed care, which requires a different way of reporting client information services. Some Tribal SUD providers have solely relied on the TARGET system to meet their data reporting and information management needs. As part of this project, TARGET will be decommissioned, which may adversely impact Tribal SUD providers. The Division of Behavioral Health and Recovery (DBHR) is currently assessing the impact and will work with the tribes to mitigate any negative impacts to tribal provider agencies caused by decommissioning TARGET.