Washington State Department of Social and Health Services

Transforming Lives

REPORT TO THE LEGISLATURE

Predicting Referrals for Competency Evaluation

Session Law, Engrossed Substitute Senate Bill 5092, Section 202(g)(i)

December 1, 2021

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CONTENTS

Executive Summary

Engrossed Substitute Senate Bill (ESSB) 6032 (Chapter 299, Laws of 2018) directed the Department of Social and Health Services (DSHS) to develop and implement a predictive modeling tool to identify persons with behavioral health needs who are at high risk of future involvement with the criminal court system. In response to this directive, a predictive modeling tool was developed, as described in the legislative report submitted in 2018. This report describes the subsequent operational enhancement of the predictive modeling approach, its implementation and use.

The operationalized approach reflects several considerations including:

- The predominance of Medicaid beneficiaries in the population of persons with behavioral health needs involved in the criminal court system;
- The potential for Medicaid-contracted integrated managed care plans and behavioral health organizations to implement behavioral health interventions to reduce the likelihood of arrest for their high-risk enrollees; and
- The urgency to improve outcomes for persons in the Trueblood class who are at risk of involvement in the forensic mental health system.[1]

The original predictive model was developed using a machine-learning methodology applied to risk factors derived from several data sources to predict the target outcome of a referral for competency evaluation within the following six months. Following exploration of model performance in a validation sample, an alternative method was developed for operational use. The alternative approach provides:

- Higher predictive accuracy in validation samples;
- More equitable risk scoring for persons without prior enrollment in medical, food, or cash assistance programs;
- More timely data for operational use; and
- More accurate identity management in a programmatic context where it is highly desirable to avoid “false positives” that might arise through inaccurate linkage of individual-level information from multiple data systems.

In the model currently in place, the DSHS Research and Data Analysis Division (RDA) identifies individuals with two or more competency evaluation orders in the last two years – a population at relatively high risk of future interaction with the criminal court system. Lists of these clients are then matched with contact information to support targeted outreach and engagement in a model called “Forensic Projects for Assistance in Transition from Homelessness (FPATH).”

Under this approach:

- RDA identifies clients at high risk for involvement with the criminal court system and for future forensic competency evaluation referrals;
- RDA creates monthly datasets of names and contact information for these clients, by Managed Care Organization (MCO) and region;

[1] In April 2015, a federal court found in the case of Trueblood v DSHS that the Department was taking too long to provide competency evaluation and restoration services. As a result, the State has been ordered to provide court-ordered competency evaluations within fourteen days and competency restoration services within seven days. The Trueblood class includes individuals detained in local jails awaiting competency evaluation or restoration services, and individuals previously receiving competency evaluation and restoration services who are released and at-risk for re-arrest or re-hospitalization.

- RDA transfers the datasets to the Health Care Authority (HCA), which then distributes them to MCO and Behavioral Health – Administrative Service Organization (ASO) staff;
- MCOs and ASOs conduct outreach activities and other methods of improving care coordination for these individuals at high risk.

This report will provide a description of the processes currently in place, as well as details about the numbers of clients identified for outreach and a description of how MCOs and ASOs use this information to improve care coordination.

Scope and Purpose

Engrossed Substitute Senate Bill (ESSB) 6032 (Chapter 299, Laws of 2018) directed the Department of Social and Health Services to develop and implement a predictive modeling tool which identifies persons with behavioral health needs who are at high risk of future involvement with the criminal court system. This report is in accordance with the budget proviso *(Engrossed Substitute Senate Bill 5092, Chapter 334, Laws of 2021)*:

> (i) By the first day of each December during the biennium, the department, in coordination with the health care authority, must submit a report to the office of financial management and the appropriate committees of the legislature which summarizes how the predictive modeling tool has been implemented and includes the following: (A) The numbers of individuals identified by the tool as having a high risk of future criminal justice involvement; (B) the method and frequency for which the department is providing lists of high-risk clients to contracted managed care organizations and behavioral health administrative services organizations; (C) a summary of how the managed care organizations and behavioral health administrative services organizations are utilizing the data to improve the coordination of care for the identified individuals; and (D) a summary of the administrative data to identify whether implementation of the tool is resulting in increased access and service levels and lower recidivism rates for high-risk clients at the state and regional level.

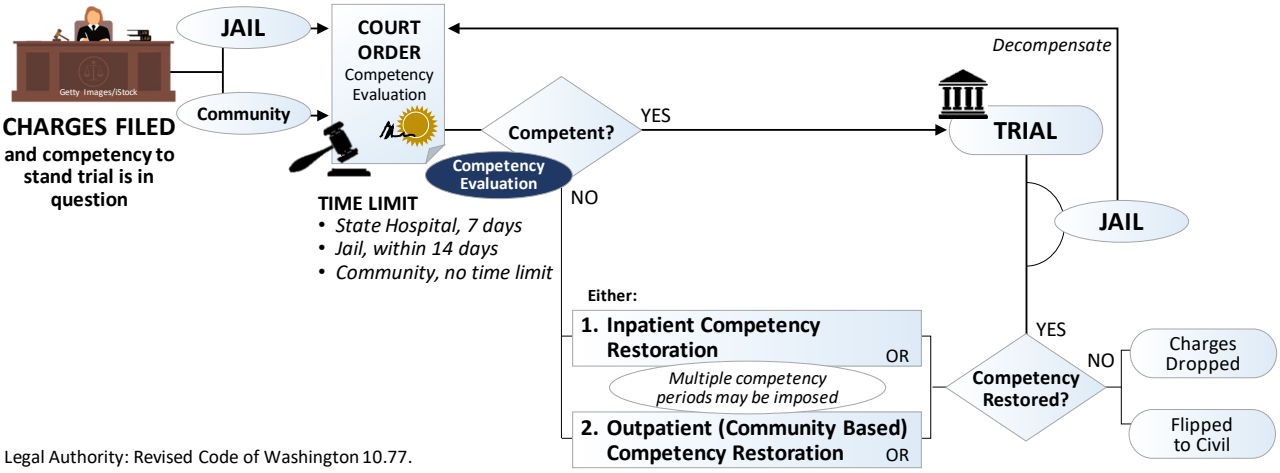
The first section of this report provides an introduction to the Forensic PATH program, and background on the development and refinement of the predictive modeling tool. The following section provides information about numbers of clients identified and related administrative data. The closing section describes the methods of providing information to MCOs and ASOs, and how those organizations use the information.

Background

The forensic mental health system operates at the intersection of the legal and behavioral health care systems, providing competency evaluation services when a court believes a mental health condition may prevent a criminal defendant from assisting in their own defense, and treatment for restoration when the evaluation finds the defendant is not competent. The court will then order the individual to receive competency restoration services. Figure 1 provides a high-level overview of the operation of the forensic mental health system.

FIGURE 1.

Competency Evaluation/Restoration Pathway



Legal Authority: Revised Code of Washington 10.77.

The Trueblood v. DSHS lawsuit challenged unconstitutional delays in competency evaluation and restoration services for people detained in city and county jails. The Trueblood Contempt Settlement Agreement establishes a plan for providing services to those involved in the criminal court system and for providing treatment to people when needed so they are less likely to become involved in the criminal court system. The Trueblood Settlement Agreement includes a plan for phasing in programs and services:

- Phase 1: Pierce, Southwest and Spokane regions (July 1, 2019 through June 30, 2021)
- Phase 2: King region (July 1, 2021 through June 30, 2023)
- Phase 3: To be determined (July 1, 2023 through June 30, 2025)

Forensic Projects for Assistance in Transition from Homelessness (FPATH)

As part of the Trueblood Settlement of Contempt Agreement, the state is funding targeted outreach and engagement to connect identified individuals with behavioral health services using a federal model called Projects for Assistance in Transitions from Homelessness. In the Agreement, this program is called Intensive Case Management for High Utilizers. HCA, in partnership with DSHS' RDA, created a referral list to identify individuals who are at risk of repeat court orders for competency evaluations. RDA identified individuals with two or more competency evaluation orders in the last two years who are at higher risk of future intersection with the criminal court system. FPATH is focusing outreach and engagement efforts to individuals on that list who are predominately homeless or have had multiple competency evaluations.

FPATH teams, within community behavioral health agencies, include certified peer counselors who have experience working with individuals who may be experiencing homelessness or housing instability combined with multiple competency evaluation orders within the last two years. FPATH teams assertively seek to engage people to help them connect with community supports including housing, transportation, health care, and behavioral health services. People court-ordered for forensic navigator or outpatient competency restoration services may also use FPATH for case management services if they appear on the referral list created by RDA.

Current Status and Areas of Positive Impact

FPATH teams have been providing targeted outreach and engagement to people identified on the referral list since March 2020. Using a model similar to the federal PATH program, teams have been reaching out to eligible individuals with an emphasis on homeless or unstably housed individuals. The goal is to connect people with community resources and services by building relationships and rapport. While most eligible individuals are homeless or unstably housed, some are not. In all instances, teams seek out to engage the individual "where they are at."

FPATH teams are located within community behavioral health agencies with experience providing outreach and engagement services, which allows for warm handoffs to other needed services. This includes services from certified peer counselors who have experience working with individuals involved in the forensic mental health system experiencing homelessness or housing instability.

Teams prioritize outreach and engagement efforts to individuals prioritized by the following criteria: individuals living in rural areas, individuals who have had four or more referrals for competency evaluation in the past 24 months regardless of housing status, and/or individuals experiencing homelessness. The intent behind prioritization is to assist in connecting those most at risk of additional referrals for competency evaluations to services in hopes of diverting them away from further court involvement.

Data – Crisis Triage and Diversion – FPATH

FPATH data in the current report are from the Homeless Management Information System, as well as monthly Excel trackers submitted by FPATH providers in the Phase 1 regions. Program eligibility is based on a referral list (formerly the "high utilizer list") of individuals with two or more competency evaluation referrals in the past 24 months.

The FPATH program began March 1, 2020. Between March 1 2020 and June 30, 2021, 1,067 individuals within the Phase 1 regions were referred to the program. The HCA has asked providers to focus outreach efforts on a subset of these individuals based on housing status (prioritizing unstably housed and homeless), number of referrals (4 or more in the past 24 months), and county of residence (prioritizing rural counties). The number of individuals on the prioritized list was 434.

Of all individuals on the referral list, FPATH providers attempted to contact 514 (48%), and successfully contacted 315 (30%). Initial data indicate that a total of 164 individuals (15% of overall referrals) were enrolled in the FPATH program. Of these, the majority were male (80%) and between 30 and 49 years old (56%). More than half of enrollees (54%) were homeless, while 26% were unstably housed, indicating that providers are focused on enrolling those in the priority population. The Southwest region enrolled the largest portion of those on their referral list (30%).

FPATH operations and data collection methods are complex and practices continue to evolve. Additional information on program services and referrals will be available as data from providers stabilize. Data should be considered preliminary as the program and data collection are still evolving.

Predictive Model Development

Engrossed Substitute Senate Bill (ESSB) 6032 (Chapter 299, Laws of 2018) directed the Department of Social and Health Services (DSHS) to develop and implement a predictive modeling tool to identify persons with behavioral health needs who are at high risk of future involvement with the criminal court system. In response to this directive, a predictive modeling tool was developed, as described in the legislative report submitted in 2018. With consultation with legislative staff, the target population for

the predictive model was focused on referrals for competency evaluation, to align with the Trueblood objectives. Among the key lessons learned and included in the legislative report:

- “Prior experiences in the forensic mental health system are by far the most important information in predicting future competency evaluation referrals.”
- “Rapid-cycle linkage of managed care enrollment with data from the recently implemented Forensic Data System (FDS) offers the most timely opportunity for identifying enrolled Medicaid beneficiaries who are at high risk of a future competency evaluation referral.”
- “We dropped arrest history, adjudication history, and behavioral health diagnosis variables from our final model due to data timeliness limitations in an operational context, with minimal loss of predictive accuracy in the validation sample.”

Subsequent analysis of the validation sample developed for the legislative report (described further below) led RDA to make the following recommendations for operationalizing client lists to support the Forensic PATH program:

- Target the Forensic PATH program to persons with two or more prior competency evaluation referrals in the past 24 months.
- Use rapid-cycle linkage of FDS data, ACES social service data, and ProviderOne Medicaid eligibility, managed care enrollment, and behavioral health data to identify the target population, measure risk factors, and create client lists to be updated on a monthly basis.
- Create distinct client lists for different user groups and populations to align with privacy requirements and care management responsibilities (e.g., separate lists for Medicaid MCOs, ASOs, state agency staff, and Forensic PATH program staff).
- To support triage, outreach/engagement, and intervention planning, supplement client lists with client-level risk factors including: homelessness, prior psychiatric hospitalization, and volume/result of prior evaluation/restoration referrals.

The advantages of the proposed approach include:

- Higher predictive accuracy in validation samples relative to the original model;
- More equitable risk scoring for persons without prior enrollment in medical, food, or cash assistance programs;
- More timely data for operational use; and
- More accurate identity management (in a programmatic context where it is highly desirable to avoid “false positives”) by providing a far more focused set of cases where manual identity linkage is required.

These recommendations were presented to Plaintiff’s Counsel and the Court Monitor involved in Trueblood litigation in January 2020, with consensus support for proceeding in the proposed direction.

Validation Sample Analysis

Figure 2 illustrates the efficacy of the implemented approach, relative to the results of the original predictive model, in the validation sample developed for the predictive modeling reflected in the 2018 legislative report. The implemented approach targets the population with 2+ referrals for eligibility for

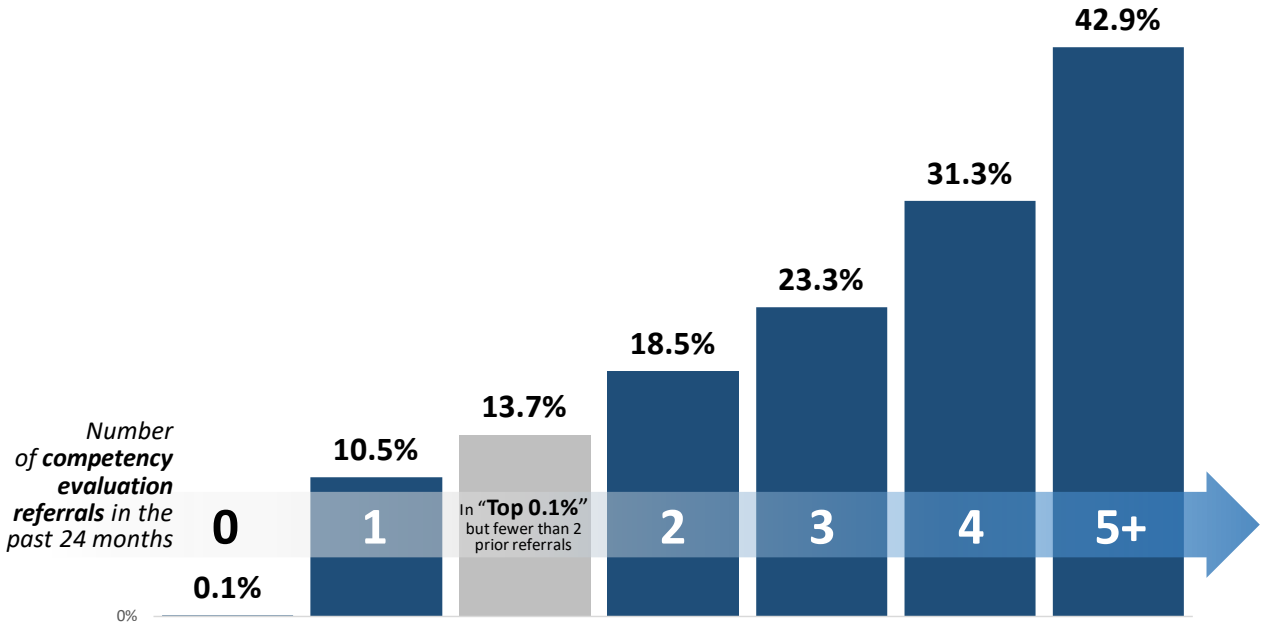
Forensic PATH program services. As shown in the figure below, the population receiving a high risk score via the original predictive model (defined as those in the top 0.1% of the risk pool) who do not meet the 2+ referral criterion have a significantly lower rate of subsequent occurrence of the target outcome (a competency evaluation referral within the next 6 months), relative to persons meeting the 2+ referral criterion.

In part this is an illustration of the overwhelming importance of historical referral patterns in the original predictive model. Most clients scored in the top 0.1% based on the original predictive model did have two or more competency evaluation referrals in the prior 24 months. But among those who did not meet this criterion, observed rates of the target outcome in the validation sample were relatively low. This observation, along with the significant operational considerations previously noted (timeliness of data, identity management implications, equity for persons not connected to public assistance programs), formed the rationale for RDA's proposed (and subsequently implemented) approach.

FIGURE 2.

Assessing Predictive Accuracy: Proportion with an Evaluation Referral in the Following 6 Months, by Number of Previous Referrals

Supplemental analysis of proviso report validation sample data



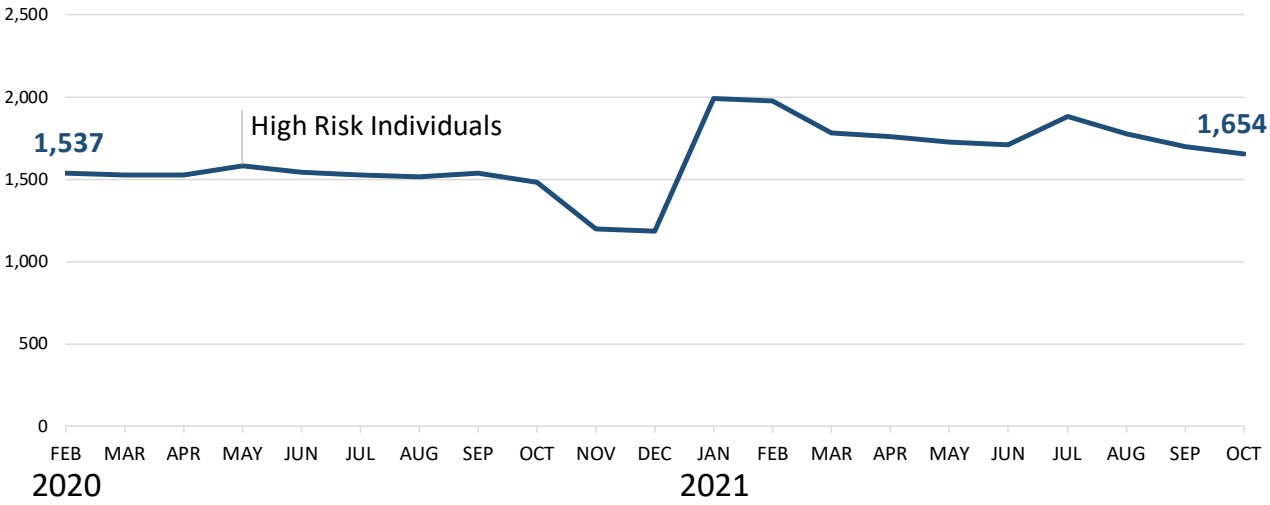
SOURCE: DSHS Research and Data Analysis Division.

The Number of Individuals Identified for the Referral List

Figure 3 shows the trend in the statewide aggregate referral list size. The list was originally restricted to persons with recent participation in food, cash, or medical assistance. The increase in January 2021 reflects the removal of this restriction.

FIGURE 3.

Statewide Monthly Trend in Individuals at High Risk



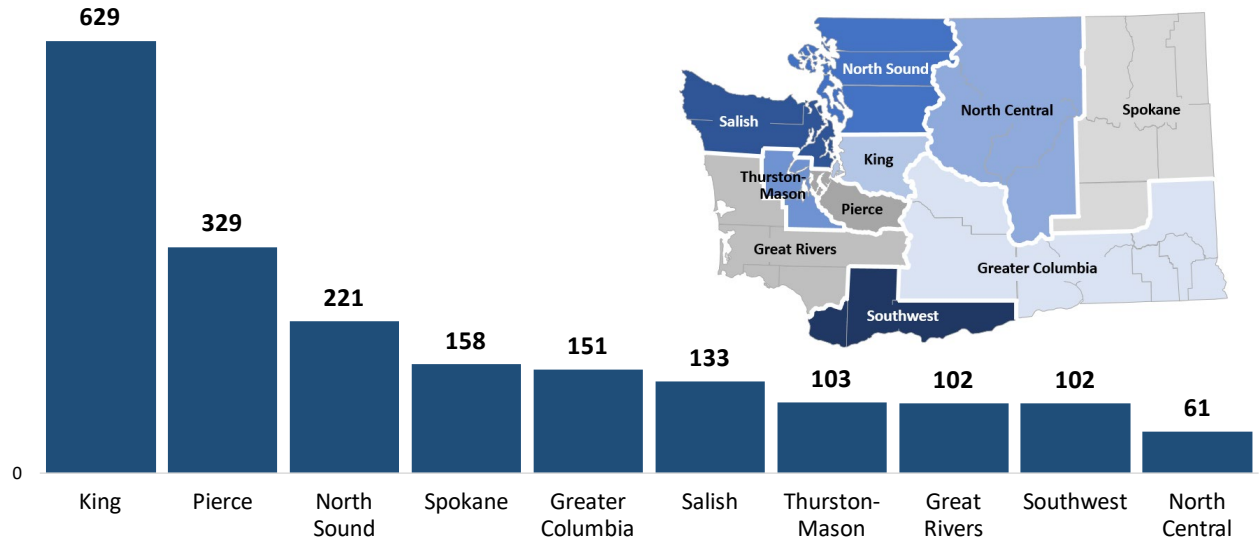
SOURCE: DSHS Research and Data Analysis Division.

Figure 4 provides the distribution of the January 2021 referral list by Apple Health region, excluding one person for whom region could not be assigned. King County represents about a third of the statewide target population.

FIGURE 4.

High-Risk Population by Apple Health Region

January 2021, Total = 1,989



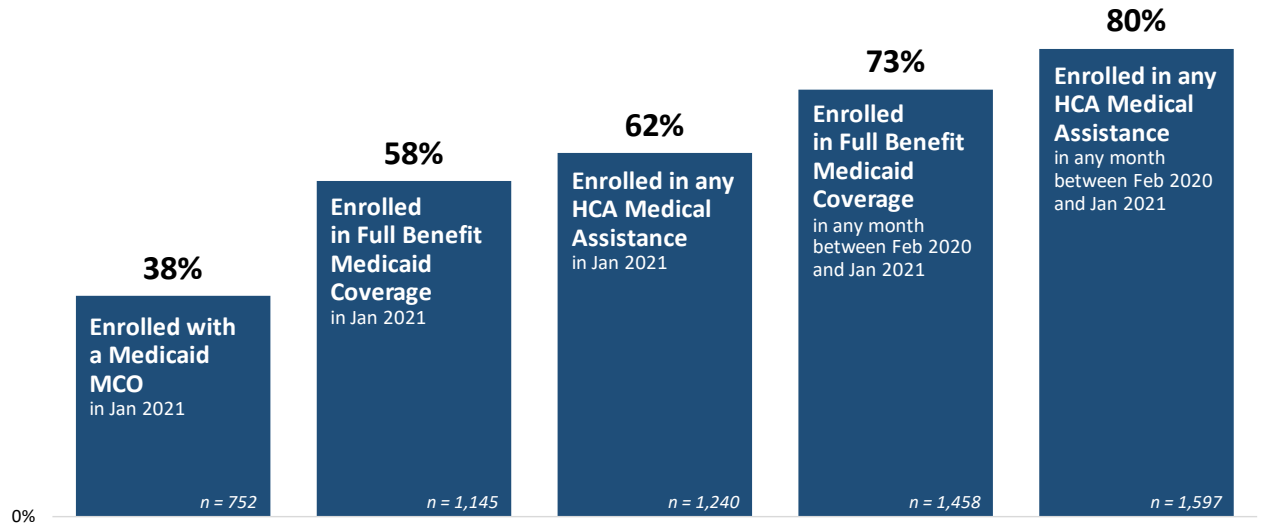
SOURCE: DSHS Research and Data Analysis Division.

Figure 4 provides information about the medical coverage status of the January 2021 referral list in that month (first three columns) or over the twelve-month period ending in January 2021. This figure is discussed further below.

FIGURE 5.

High-Risk Population by Coverage Status

January 2021, Total = 1,990



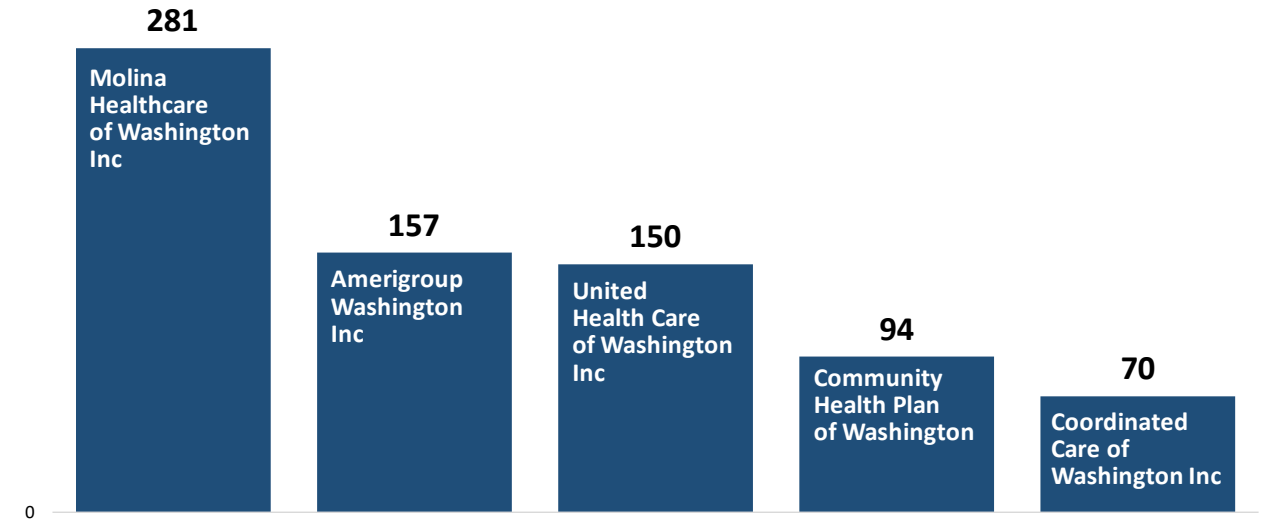
SOURCE: DSHS Research and Data Analysis Division.

Figure 6 shows the distribution of the MCO-enrolled January 2021 referral list by organization. At 37 percent, Molina Healthcare of Washington had the largest share of Medicaid beneficiaries on the January 2021 referral list.

FIGURE 6.

Forensic PATH Referral List by Plan

January 2021, Total = 752



SOURCE: DSHS Research and Data Analysis Division.

In conclusion, we highlight the following observations derived from Figure 5:

- A far higher proportion of this target population is enrolled in FFS coverage than the broader Medicaid population. For example, about a third of the population with full benefit Medicaid coverage on the January 2021 list were enrolled in fee-for-service coverage.

- There is significant Medicaid coverage churn in this population, likely driven by relatively high rates of incarceration and homelessness. For example, among persons on the January 2021 list, 58 percent had full benefit Medicaid coverage in that month, while 73 percent had full benefit Medicaid coverage at some time over the 12-month period spanning February 2020 through January 2021.

Analysis of Impacts on Access to Services and Recidivism

The budget proviso asks the Department to provide "a summary of the administrative data to identify whether implementation of the tool is resulting in increased access and service levels and lower recidivism rates for high-risk clients at the state and regional level." Data are not sufficiently mature to evaluate impacts in the context of Forensic PATH program operations, but an evaluation design and timeline have been developed and shared with the Trueblood Plaintiff's Counsel and Court Monitor as part of the State's Trueblood Settlement Agreement activities. In this section we describe the planned evaluation approach and timeline, along with potential measurement challenges.

The ability to evaluate a specific Trueblood program component such as the Forensic PATH program, and evaluation design options, will depend on factors including:

- Availability of encounter (or similar) data identifying when clients engage in services,
- A sufficient number of persons served by the program component to detect likely effect sizes, and
- The extent of overlap with services provided through other Settlement Agreement components.
- The extent to which the FPATH target population in regions not yet implementing Trueblood programs was targeted for intervention by MCOs and ASOs, vitiating the "natural experiment" of phased Trueblood program implementation.

The target population for the Forensic PATH program is defined through processes maintained by RDA, with target populations generated monthly on a statewide basis for all regions. This data resource could support an intent-to-treat, difference-of-difference evaluation design based on the populations identified in the monthly lists, assuming that the rate of engagement in Forensic PATH program services is relatively high. An intent-to-treat approach is desirable because it would help mitigate the threat that selection bias poses to measurement validity (discussed further below). To date, engagement has been relatively modest due to the relatively high number of eligible clients, and the challenges associated with building provider capacity and engaging a population with high rates of homelessness and co-occurring serious mental illness and substance use disorders. With currently observed engagement rates, an intent-to-treat approach would likely wash out any effect of the Forensic PATH program on "treated" beneficiaries, by including their experience with the larger number of untreated persons in the target population.

Given currently observed engagement rates, we might consider a propensity score matching approach to identify an untreated comparison group whose experiences will be contrasted with the experiences of persons engaging in the program. This simulates the treatment/control structure of a clinical trial. The comparison group would be defined through a matching process comprised of the following steps:

- Comparison frames for matching would be identified by criteria that align with the program targeting criteria outside of the Phase 1 regions. This initial stage of the process identifies all person-months for persons not engaging in the Forensic PATH program where the person

meets the targeted risk criteria in the relevant time period. The comparison matching frame may exclude non-participants from the Phase 1 regions meeting program targeting criteria to help mitigate the impact of selection bias (see internal validity discussion below).

- Key predictors of engagement within the pooled intervention and comparison matching frame would be examined to ensure inclusion of appropriate measurement dimensions in the propensity score model. This includes creating an extensive set of "engagement predictors" that are determined, ex ante, to be potentially relevant to the matching process. This set of predictors is expected to span a wide range of the measurement domains contained within RDA's integrated client data environment.
- Application of machine-learning techniques (e.g., stepwise logistic or lasso regression) to determine the final propensity score model. Propensity score matching will be conducted using procedures in the R programming language. Exact matching may be required for key variables (e.g., race, gender, prior evaluation referral count).

Impact analyses generally would be conducted using a difference-of-difference design, where the pre-to-post change in experiences for treatment group members will be compared against the pre-to-post change experienced by the matched comparison group. For analyses using a difference-of-difference design, the pre-post boundary for the treatment group will be based on the point at which they engage in the Forensic PATH program. The pre-post boundary for the comparison group would be defined through the matching process, which uses a person-month matching frame for matching against the "person-months" associated with entry into the intervention by the treatment group. This approach leverages the richness of RDA's integrated analytical data infrastructure, which supports data management techniques that scan all relevant persons at all relevant points in time when they might be a "best" match to a person at the time they entered the specific intervention under study.

Analyses will likely focus on the following outcome areas:

- Arrests,
- Subsequent referrals for competency evaluation,
- Changes in housing status (e.g., becoming stably housed),
- Enrollment in Medicaid, and
- Use of Medicaid-funded mental health or SUD treatment services.

Preliminary estimates of the impact of specific Trueblood Settlement Agreement components will be available no earlier than the spring of 2022. This assumes that the initial study populations will include persons entering services during the first six months of program operations, with a minimum six-month follow-up period, seven months for data maturity, and at least three months for data integration, analysis, and reporting.

Assessment of Data Limitations and Threats to Validity

In the context of quasi-experimental evaluation of programs such as Forensic PATH, in the absence of randomized design for program implementation the key potential threat to the validity of measured impacts is selection bias. Selection bias refers to uncontrolled differences between treatment and comparison group members that account for observed differences in outcomes between the two groups. Although propensity score matching (often combined with second-stage regression adjustment) is recognized as a valid evaluation design and frequently accepted in the peer-reviewed literature, this approach may not fully mitigate the threat of selection bias. It would be critical to understand the processes associated with engagement in Forensic PATH services and to use this

knowledge to define a credible “matching frame” and set of engagement predictors in creating the matched comparison group. The richness of the administrative data available to the RDA evaluation team would help reduce the threat of selection bias to the validity of measured impacts.

Process for Sharing Information

Lists of FPATH eligible clients are created and distributed on a monthly basis to FPATH providers, Managed Care Organizations (MCOs) and Behavioral Health Administrative Service Organizations (ASOs).

FPATH Providers

The Health Care Authority’s Division of Behavioral Health and Recovery contracted with four licensed community behavioral health agencies in three regions that have implemented Trueblood projects. Each of the four agencies are under contracts that include data transmission requirements for the secure transfer of sensitive information about program referrals. The providers include Comprehensive Mental Health and Greater Lakes Mental Health for the Pierce County region; Frontier Behavioral Health in the Spokane region; and SeaMar Community Health Centers/Community Services Northwest in the Southwest Region. Each of these agencies have a history of providing homeless outreach and engagement in their respective communities through their PATH (Projects in the Assistance in Transitions from Homelessness) programs. PATH provides outreach and engagement services for harder to serve individuals, specifically individuals living in places not meant for human habitation.

Every month the contracted agencies receive an Excel workbook that contains a list of all individuals eligible for Forensic PATH who are considered residents in their region. The workbook includes information on the number of competency evaluation orders; their housing status; the most recent contact information; type of insurance; the region they reside in; and the managed care organization they are enrolled in. Individuals new to the list or with new contact information are flagged. DBHR also provides a prioritized list for their targeted outreach and engagement, e.g. for individuals who have had multiple competency evaluations, and those who may be more vulnerable and in greater need of intensive engagement due to their housing status.

Managed Care Organizations

The Health Care Authority contracts with five MCOs across the State of Washington. MCO contracts were amended to include language requiring them to develop and implement plans for improving access to timely and appropriate treatment for individuals with behavioral health needs and current or prior criminal justice involvement who are eligible for services under these contracts[2]. Each of these organizations provides care coordination that includes assistance with accessing behavioral health services, primary care services, employment and housing services. MCOs are also able to work with jail release planners on an individual’s release plan, helping to ensure that they have access to as

[2] See Appendix 1 for excerpts from the Apple Health Integrated Managed Care contract related to clients involved in the criminal justice system. The specific requirement related to the FPATH lists is found at 14.6.15: “The Contractor will provide Care Coordination to Enrollees who are named on the HCA Referral List, also known as the “high utilizer list,” in the Trueblood, et al., v. Department of Social and Health Services Settlement Agreement. HCA will provide the HCA Referral List to the Contractor monthly. The Contractor will support connecting Enrollees with behavioral health needs and current or prior criminal justice involvement to receive Care Coordination.” Found at https://www.hca.wa.gov/assets/billers-and-providers/ahimc-medicaid.pdf

many resources as possible at time of release. Services and resources provided to individuals can be done in-person or over the phone.

Each month, MCOs receive a list of individuals enrolled in their plans, with the intent that they provide care coordination services, and refer clients to the FPATH program when eligible enrollees present at an emergency room or other provider. In April, 2020, HCA prepared the MCOs for this new activity by participating in the MCO Allied Services Coordination Workgroup. Training on FPATH was provided at that time; subsequently HCA staff met with each MCO individually to answer questions about the FPATH program.

Behavioral Health Administrative Service Organizations

The Health Care Authority contracts with eight Behavioral Health Administrative Service Organizations in ten regions across the State of Washington. ASOs may provide the following services to individuals who are not eligible for Apple Health[3]:

- Mental health evaluation and treatment services for individuals involuntarily detained or who agree to a voluntary commitment.
- Residential SUD treatment services for individuals involuntarily detained as described in state law.
- Outpatient behavioral treatment services, in accordance with a Less Restrictive Alternative court order.
- Within available resources, the ASO may provide non-crisis behavioral health services, such as outpatient SUD and/or mental health services, or residential SUD and/or mental health services to low-income individuals not eligible for Apple Health and who meet other eligibility criteria.

Within the region, the ASO may:

- Provide a behavioral health ombudsman to assist individuals with grievances and appeals.
- Manage the block grants based on locally approved block grant plans.
- Manage Criminal Justice Treatment Account funds and Juvenile Drug Court funds.
- Oversee committees formerly led by the regional behavioral health organization, such as the Behavioral Health Advisory Board, Wraparound with Intensive Services, Children's Long-term Inpatient Program, and Family Youth System Partner Round Table.

ASOs receive the list of FPATH eligible individuals for their region. In an instance where an individual receives a crisis service or is detained for involuntary evaluation and treatment, the ASO refers the eligible individual to the FPATH program.

Misdemeanor diversion funds within the HCA budget have been leveraged to resource ASOs to provide outpatient treatment services for non-Medicaid individuals on the FPATH referral list, in outpatient competency restoration, or with other criminal court involvement. These limited resources were distributed statewide and distributed based on the number of non-Medicaid enrolled individuals with multiple competency evaluation orders. ASOs were provided with a Frequently Asked Questions document regarding diversion funds in the summer of 2020.

[3] HCA fact sheet found at https://www.hca.wa.gov/assets/program/bhaso-fact-sheet.pdf.

MCO and ASO Use of Information

Statewide, the MCOs and ASOs have begun using the lists of FPATH eligible clients to improve care coordination. In Phase One regions, their options actions are enhanced by local efforts to connect local partners in the community. These activities are described below.

Phase One Regional Collaborations

In Phase One regions, MCOs and ASOs participate in regional collaborative groups. These are generally hosted by the Accountable Communities of Health (ACH) but could be convened by various entities in each region. In addition to MCOs and ASOs, participants include the partners who have responsibility for Trueblood activities such as Forensic PATH, Forensic Housing and Recovery through Peer Services (FHARP), and forensic navigators. In some regions, criminal justice partners are active participants as well.

These collaborative meetings bring people together to:

- Identify who in the region works with Trueblood class members, including those eligible for FPATH;
- Exchange information about programs in the region;
- Educate attendees about the role of the MCO and ASO in care coordination:
- Break down silos across organizations working with people involved in the criminal justice system;
- Identify and address barriers to referral and access to services needed by participants in the criminal court system;
- Eliminate duplication of services; and
- Improve care coordination for participants in the criminal court system.

Managed Care Organization Activities

All Apple Health – Integrated MCOs have contractual responsibilities to reduce barriers to care for their members involved in the criminal justice system, and specifically to participate in activities that improve care coordination for FPATH-eligible members. While their specific actions vary somewhat across MCOs, they use the regional and statewide collaborative meetings to share best practices. Each MCO employs staff who are responsible for assisting with members who are at risk for criminal justice involvement. The following activities vary with the complexity of the client and ability of MCO staff to make the appropriate connections:

- MCOs download the monthly FPATH eligible files provided by HCA, and the information is added to the systems used by care coordination staff. Data mining takes place to identify patterns of care and establish priorities for outreach and engagement. If enrollees are eligible for Health Home or complex case management services, staff in those programs are alerted to the need to coordinate their services with forensic program partners. Some care coordinators are assigned based on region or primary need (medical vs. behavioral health), so triaging enrollees and referring to the right care coordinator is an important step.
- Care coordinators cross-reference other systems to locate enrollees eligible for FPATH, identifying those currently in jail or other institutions, and then forwarding the information to the appropriate case manager. For example, the crisis logs received from ASOs include information about enrollees who have been recently detained or hospitalized.

- Care coordinators attempt to contact their enrollees on the FPATH eligible list, using multiple attempts at different times of day to locate them. (Typically, MCOs employ community health workers or outreach workers for this role; they can assist with basic information, referral, and access to services. If the person needs more complex assistance, a social worker or nurse case manager takes over.) The lists contain multiple addresses and phone numbers which are used when enrollees cannot be located with the most recent information. MCOs may put enrollees on a "continuous outreach" list, meaning they will continue to try to engage them if the first attempts fail.
- Care coordinators also reach out to providers who have been involved with the enrollee. The coordinators look for gaps in service, including gaps in medication refills and behavioral health visits, to identify service needs. They contact providers who are actively seeing the enrollee to ensure the provider knows the enrollee is eligible for additional assistance with housing and other services. In some cases, the service agency can then provide ongoing case management without further MCO assistance.
- In at least two regions, case conferences are facilitated by the use of signed releases of information and confidentiality agreements. This allows multiple case managers from ASO and MCOs to participate in case review and problem solving.
- If FPATH eligible members are already engaged with behavioral health agency case managers, forensic navigators, and/or FPATH and FHARPs staff, the MCO care coordinator's role may be focused on avoiding confusion and duplication of services. The MCO can offer assistance with locating primary care or specialty medicine providers, and provide contact information to the team so they can be brought in as needed for help.
- If FPATH eligible members are not already engaged with other case managers, and especially if the member is known to care coordination staff, the care coordinator will assess for immediate needs and for the member's ability to participate in care planning. If able, the member will set goals and establish a care plan with the care coordinator.

It is important to note that despite these efforts, persons eligible for FPATH can be very difficult to reach. It is not uncommon for contact information derived from public program eligibility data to be out of date, and calls from unknown staff to be screened. Enrollees living in shelters may not have access to phones during the hours care coordinators are available. When reached, MCO enrollees are usually asked to confirm identifying information, which may lead to a reasonable concern when the coordinator is unknown. MCOs may ask to record coordination calls, another request that may increase reluctance of the enrollee to share information with a stranger. Finally, the primary need for the enrollee may be something that is not the primary responsibility of the MCO. The coordination among MCO care coordinators and medical and behavioral health providers then becomes the primary activity.

Behavioral Health Administrative Service Organizations

ASOs do not have "members" but are responsible for crisis services within a geographic region. Therefore they use the FPATH eligible lists in somewhat different ways than the MCOs. In addition, the activities are different in Phase One regions, since there the ASOs are more involved in collaboration with forensic partners as described above. The description that follows reflects the most common activities taken by ASOs in response to receiving the FPATH eligible lists.

- ASOs download their monthly lists that include all clients who are considered residents of their region.

- ASOs then match FPATH eligible clients to internal databases to see whether clients on the list are served by other programs, such as PACT or crisis diversion.
- ASOs may reach out to clients once they review the recent experience; ASOs have access to Trueblood Misdemeanor Diversion funds,[4] and can offer services to clients who have gaps in care and coverage.
- If clients are found to be engaged by PACT or other case management teams, the ASO reaches out to alert them of the clients' risk for involvement with the criminal justice system. They establish regular communication to ensure that clients' needs are met.
- The ASO staff may also meet regularly with the MCOs for care coordination; in one region there is a monthly focus on people on the FPATH referral list within this existing care coordination structure.
- In regions without a FPATH program, there may be more active attempts to engage the clients on the FPATH list. For example, the ASO can check for lost Medicaid eligibility and reach out to assist the client to reestablish their eligibility. There is less possibility of duplication of efforts, so the ASOs operating outside of Phase One regions have a greater role in assisting non-Medicaid clients on the FPATH lists to gain access to needed services.

In King County, the FPATH list drove this specific action:

> Upon initial receipt of the HCA FPATH referral list in spring 2020, King County's Performance Measurement and Evaluation unit within the Department of Community and Human Services (DCHS) engaged in matching the list to local data systems to understand outpatient penetration, crisis utilization, and people's housing needs, which helped identify a likely undercount of homelessness in the State data. King County found that while in ACES data about **51%** of the list was indicated as experiencing homelessness/housing instability (a higher rate than the statewide average), when matched to the local behavioral health system (BHRD) and homeless service system (HMIS) databases, about **81%** of the list had an indicator of homelessness in a 30-month period in at least 1 of the 3 databases.
>
> This illuminated the need for resources not addressed by forthcoming Phase 2 contempt settlement agreement programs: housing inventory and long-term subsidies. DCHS then pursued a Trueblood Diversion housing grant and is working to secure dedicated Permanent Supportive Housing (PSH) units through these funds, as well as developing tools for the local Coordinated Entry system to match Trueblood class members into these units. King County anticipates this will be a major asset for current diversion programs and future FPATH and FHARPS programs to successfully meet the needs of people on the referral list.

Discussion

RDA and HCA have partnered for eighteen months on sharing lists of potential FPATH participants who are at high risk of a subsequent competency evaluation referral. Important lessons from the initial use of these lists by MCOs and ASOs include:

- MCOs and ASOs are actively using these lists to improve internal and external referrals for care coordination;

[4] HCA amended ASO contracts in an off-cycle amendment April 2020 with the following language: "Trueblood Misdemeanor Diversion Funds…are funds for non-Medicaid costs associated with serving individuals in crisis triage, outpatient restoration, Forensic PATH, Forensic HARPS, or other programs that divert individuals with behavioral health disorders from the criminal justice system."

- The clients identified by this process are extremely difficult to locate, and when reached, are reluctant to engage with an unknown care coordinator.

The data shared above also highlight the importance of coordinating across service delivery systems. First, because of the large proportion of fee-for-service clients, the ASOs have a major role in helping to locate those who use the crisis system, to make new resources available to those clients, to reestablish eligibility, and to make connections back to providers and MCOs where possible. Second, regional collaborative groups have supported new cross-sector connections for education, coordination, and maximizing local resources that support clients at high risk.

These activities are new to most organizations; the experience of the early champions of this work in Pierce and Southwest regions provides a helpful model for regions which have not yet initiated FPATH programs.

APPENDIX 1

MCO Requirements Related to Criminal Justice

Examples of specific contract requirements from the Apple Health Integrated Managed Care contract:[5]

- 14.1.7 The Contractor shall provide for the smooth transition of care for Enrollees who lose Medicaid eligibility while hospitalized in behavioral health inpatient or residential treatment facilities or while incarcerated or in homeless shelters. The Contractor shall include protocols for coordination with the ASO to facilitate referral for state funded or federal block grant services, when such funds are available, in order to maintain Continuity of Care.
- 14.6.9 Care Coordinators shall monitor, provide referrals to community-based social services and assess referral completion, education, and facilitate and encourage adherence to recommended treatment.
- 14.6.15 The Contractor will provide Care Coordination to Enrollees who are named on the HCA Referral List, also known as the "high utilizer list," in the Trueblood, et al., v. Department of Social and Health Services Settlement Agreement. HCA will provide the HCA Referral List to the Contractor monthly. The Contractor will support connecting Enrollees with behavioral health needs and current or prior criminal justice involvement to receive Care Coordination.
- 14.11.1 The Contractor shall coordinate with, and refer Enrollees to, health care and social services/programs, including, but not limited to: (examples below)
  - 14.11.1.16 Qualified Health Homes contracted with HCA; 14.11.1.17 Supported Housing and Employment programs; 14.11.1.18 State and/or federal agencies and local partners that manage access to housing;
  - 14.11.1.25 Any Offender Re-entry Community Safety Program (ORCSP) within the boundaries of the Contractor that is not a Subcontractor of the Contractor.
- 14.17.4.2 The Contractor must work with behavioral health treatment agencies to ensure there is adequate coordination for Enrollees transitioning between various levels of treatment services to ensure continuity of care, including in accordance with RCW 71.24.618. As used in this section, "continuity of care" means the situation under which an Enrollee who is receiving services from an individual provider is entitled to receive timely and applicable follow-up services from ancillary referral agencies with the goal of providing
- 14.21 Transitional Planning for Incarcerated Enrollees. For the purposes of this subsection, "correctional facility" includes city and county jails, Department of Corrections (DOC) facilities, and Juvenile Rehabilitation facilities.
  - 14.21.1 In accordance with SSB 6430 (Laws of 2016, chapter 154), the Contractor shall coordinate care for Enrollees as they transition into a correctional facility or upon release from a correctional facility. The Contractor shall initiate development of and make progress toward obtaining data sharing agreements with correctional facilities to enable the Contractor and these facilities to share health information about the Enrollees. Transitional care coordination shall be provided for up to the first thirty (30) calendar days of incarceration or as needed and upon the Enrollee's release, including honoring another MCOs prior authorization for admission to SUD residential facility. When correctional facilities opt out of this activity the Contractor is not required to pursue these facilities.
- 15.2.6.3 The Contractor shall designate one (1) or more Community Liaisons to work within Washington State, county behavioral health leadership, and ACHs within its service area. This shall include a liaison to Enrollee and family organizations for children, youth and families and a liaison to

[5] https://www.hca.wa.gov/assets/billers-and-providers/ahimc-medicaid.pdf.

other member-serving systems including, but not limited to State and local criminal and juvenile justice agencies, foster care agencies, housing administrators/homeless services and vocational administration.

APPENDIX 2

ASO Requirements Related to Criminal Justice

Examples of specific contract requirements from the ASO contract:[6]

14.1 Care Coordination Requirements:

- 14.1.1 The Contractor shall develop and implement protocols that promote coordination, continuity, and quality of care that address the following:
  - 14.1.1.1 Access to crisis safety plan and coordination information for Individuals in crisis.
  - 14.1.1.2 Use of GFS/FBG funds to care for Individuals in alternative settings such as homeless shelters, permanent supported housing, nursing homes or group homes.
  - 14.1.1.3 Strategies to reduce unnecessary crisis system utilization as defined in the Crisis System Section of this Contract.
  - 14.1.1.4 Care transitions and sharing of information among jails, prisons, hospitals, residential treatment centers, withdrawal management and sobering centers, homeless shelters and service providers for Individuals with complex behavioral health and medical needs.
  - 14.1.1.5 Continuity of Care for Individuals in an active course of treatment for an acute or chronic behavioral health condition, including preserving Individual- provider relationships through transitions.
- 14.1.2 The Contractor will provide Care Coordination to Individuals who are named on the HCA Referral List, also known as the "high utilizer list," in the Trueblood, et al., v. Department of Social and Health Services Settlement Agreement. HCA will provide the HCA Referral List to the Contractor monthly. The Contractor will support connecting Individuals with behavioral health needs and current or prior criminal justice involvement receive Care Coordination. The Contractor will report semi-annually, using the Semi-Annual Trueblood Misdemeanor Diversion Fund Report template. Reports must be submitted to HCA by January 31, for the reporting period of July through December of the previous year, and by July 31, for the reporting period of January through June of the current year.
- 14.2.1 The Contractor shall coordinate with External Entities including, but not limited to:
  - 14.2.1.6 The Criminal Justice system (courts, jails, law enforcement, public defenders, Department of Corrections, juvenile justice system).
- 16.6.2 The Contractor shall coordinate with the regional MCOs, community court system, First Responders, criminal justice system, inpatient/residential service providers, Tribal governments, IHCPs, and outpatient behavioral health providers, to include processes to improve access to timely and appropriate treatment for Individuals with current or prior criminal justice involvement.
- 16.6.3 The Contractor shall, in partnership with the MCOs operating in the RSA, develop protocols to engage and collaborate with First Responders and other partners within the criminal justice system to coordinate the discharge and transition of incarcerated adults and Transitional Age Youth (TAY) with SMI for the continuation of prescribed medications and other Behavioral Health services prior to re-entry to the community.

[6] Current BH-ASO contract found at: https://www.hca.wa.gov/assets/billers-and-providers/bh-aso.pdf.