June 30, 2014

Bill Streur, Commissioner
Alaska Department of Health and Social Services
3601 C Street
Anchorage, Alaska 99503

BY EMAIL AND FIRST CLASS MAIL

Re: Streamlining Initiative Report

Dear Commissioner Streur,

At the start of the year, the Advisory Board on Alcoholism and Drug Abuse (ABADA), Alaska Mental Health Board (AMHB), and Alaska Behavioral Health Association (ABHA) began an initiative with the help of our partners in the Division of Behavioral (DBH) and several representatives from behavioral health providers throughout Alaska. The purpose of the Streamlining Initiative was to examine why we are doing what we are doing and determine if the administrative cost outweighed the benefit to the client and their family, the community, and the State.

We started with an ambitious set of objectives – to survey Federal and State law and regulation, examine requirements from our national accreditors, and review current policy and procedures. We reviewed requirements, collected information from two larger workgroup meetings, worked with individual providers on their data collection and processes, and solicited input from key informants for more in-depth information. Our aim was to deliver a product that could immediately be put into practice to improve our system's efficiency and effectiveness. It was important to us that we deliver this final report to you on time.

The Streamlining Initiative provided two distinct benefits. Working with the people who collect data from clients, prepare for site visits and audits, and input data into our systems, we learned how their efforts inform the system and helped close the gap between their efforts and our collective intention. Comparing current practice against requirements and standards helped us quickly identify activities that were not contributing to quality service delivery.

We encourage the Department to consider a system where information about how we might improve efficiency and effectiveness is continually collected and periodically, and purposefully, analyzed. We recognize there will be resistance to change (there always is), but we believe the enclosed findings and recommendations will improve our system of care by focusing on what is important rather than what is familiar. We conferred with leadership from the Division of Behavioral Health on these recommendations, and it seems that the greatest consensus and opportunity for immediate implementation exists around policy recommendations. We look forward to the more public discussion on other proposed changes.

On behalf of the entire workgroup who dedicated time to this project in a sincere effort to improve the quality and efficiency of our behavioral health system of care, we provide the following 11 recommendations from the Streamlining Initiative.

Kate Burkhart
AMHB and ABADA

Tom Chard
ABHA

cc: Craig Christenson, DHSS Deputy Commissioner
Albert Wall, Division of Behavioral Health, Director

THE STATE
of ALASKA
GOVERNOR SEAN PARNELL

Department of
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MEMORANDUM

DATE: June 30, 2014

TO: William J. Streur
Commissioner

THRU: Craig J. Christenson
Deputy Commissioner

FROM: Albert E. Wall
Director

SUBJECT: Streamlining Initiative

At your request, the Alaska Mental Health Board, in cooperation with the Alaska Behavioral Health Association, has finalized a report concerning the Streamlining Initiative (Initiative) for the Division of Behavioral Health (DBH or the Division). As you know, the Initiative was 1) to identify the various reporting requirements placed upon grantees of DBH, 2) to identify areas where reporting requirements were too stringent or duplicative, and 3) to make recommendations concerning potential changes that may streamline the reporting process.

The Division of Behavioral Health would like to extend its thanks to the Alaska Mental Health Board and to the Alaska Behavioral Health Association for the thorough work they have done on this project and for reaching out to many different types of grantees for their input. I would particularly like to thank them for the matrix they put together that summarizes statutory, regulatory, and other reporting requirements in one place for reference. Some of the recommendations in their report are changes that DBH has already started to initiate or have been in progress and can be sped up to implement. Other recommendations will take time and consideration to evaluate and develop.

The Division has a vested interest in both adequate reporting for tracking performance based measures and program management AND making those requirements realistic for the wide variety of grantees we support. We are committed to continuing to work with our grantees as we address issues of reporting and streamlining.

STREAMLINING INITIATIVE RECOMMENDATIONS JUNE 30, 2014

Summary:

The purpose of this Streamlining Initiative is to provide concrete recommendations to behavioral health providers and the Department of Health and Social Services (DHSS) on ways to consolidate information gathering and documentation practices that comply with federal and state law, regulation, and policy while reducing administrative burden. The scope of work and methodology used are attached (*see* Appendix A).

This process helped clarify what was required of providers and the State of Alaska and why. Closing the gap in understanding and practice about activities and intended outcomes helps improves effectiveness and ensure efficiency. It is strongly recommended that this analysis be repeated periodically and that an interim mechanism be established to collect input on potentially ineffective and inefficient requirements.

Recommendations (overview):

1) Eliminate the Requirement of Grantees to Submit Quarterly AKAIMS Summary Reports
2) Eliminate Logic Models in Grant Application and Reporting Process
3) Eliminate Requirement that All Grantees Submit Quarterly Community Action Plan Reports
4) Eliminate Pro Forma Quarterly Narrative Reports
5) Return to 6-month CSR Schedule OR Decouple Administration of the CSR from Mandatory Treatment Plan Updates (Adults Only)
6) Eliminate Required AKAIMS Reporting for Services Not Funded by DHSS
7) Expand Annual Service Limits for Behavioral Health Medicaid Services Pursuant to 7 AAC 135.040
8) Develop Clear and Consistent Standards and Policies for DHSS Audits, Site Visits
9) Align DHSS Quality Assurance Processes with Accreditor Processes to Eliminate Duplication of Effort
10) Eliminate Requirement for Enrollment Prior to Brief (Non-Emergency) Services
11) Eliminate Discharge Requirement for SMI Clients

Recommendation (detail):

Recommendation 1: Eliminate the Requirement of Grantees to Submit Quarterly AKAIMS Summary Reports

The data elements required in quarterly reports for the Comprehensive Behavioral Health Treatment and Recovery Grants, as well as specialty service grants, revealed that at least 40% of the information submitted by grantees each quarter was duplicative of information already entered by grantees into AKAIMS. (*See* Exhibit A.) These reporting requirements are in addition to the quarterly AKAIMS Summary Report required of grantees.

DHSS and the provider community have invested significant resources in developing AKAIMS and learning how to use it effectively. There are providers currently taking advantage of AKAIMS functionalities in their quality assurance and improvement efforts. However, the current grant management and reporting structure does not effectively use this resource, instead creating redundant processes for both DHSS staff and providers.

We recommend that quarterly grant reports focus on information not already available through AKAIMS. Report elements such as the number of client demographics; clients admitted, served, and discharged; referrals to and from other agencies; client employment and housing status, etc. are all available to DHSS grant managers through AKAIMS. We recommend that DHSS staff use the information available contemporaneously in AKAIMS for ongoing management and monitoring of grantee services. We also recommend that provider managers use AKAIMS for program management and monitoring.

What is not available to DHSS staff is the information about the agency itself and the community/communities it serves. *See* **Recommendations 3-4** for more on enhancing narrative reporting value to providers and DHSS.

Recommendation 2: Eliminate Logic Models in Grant Application and Reporting Process

There is little evidence that the logic model framework used for grant application and reporting adds value to either the providers' management of treatment programs or DHSS management of the overall behavioral health system. While DHSS has supported, and continues to support, use of logic models, the department has shifted focus and resources to a core service and results-based accountability (RBA) framework. (*See* Exhibit B.)

The Division of Behavioral Health is working to align the long-standing Performance Based Funding system with the indicators and measures adopted by in the departmental RBA framework. As these efforts appear to be far more likely to support effective management and

quality improvement within the behavioral health system that the logic model framework, we recommend that:

a) Logic models no longer be required for applying for any behavioral health treatment grant from DHSS;
b) Logic model reporting no longer be required of behavioral health treatment grantees;
c) Providers be informed about the DHSS core service and RBA frameworks at the Fall/Winter Change Agent Conference;
d) Providers be given the opportunity to participate in current efforts to align the Performance Based Funding system with the RBA framework;
e) The treatment grant application and reporting process be aligned with the core service and RBA frameworks in a way that is efficient for and provides value to DHSS and providers.

Recommendation 3: Eliminate Requirement that All Grantees Submit Quarterly Community Action Plan Reports

Currently, all treatment grantees must submit a Community Action Planning report. This results in a pro forma process by grantees with multiple submissions of the same report every quarter. As discussed above, the opportunity to collect more substantive and timely information about the context and environment in which providers operate through narrative reports can be gained by reducing requirements that do not add value to either side of the reporting relationship. We recommend that locally designed, comprehensive community action plans be submitted, as required by state law (AS 47.30.530(a)(8); AS47.37.040(1)), with grant applications and then reported on at the end of each fiscal year. We also recommend that DHSS allow this information to be submitted by one party on behalf of the entire Community Action Planning Team/Group to one point of contact within the department.

Recommendation 4: Eliminate Pro Forma Quarterly Narrative Reports

Information about recruitment and retention of staff, continuing education needs, changes in board leadership, community need, the effect of changes made to the larger behavioral health system as well as within the community, and unexpected developments (sudden resignations, financial issues, natural disasters, etc.) is important for the effective management of the behavioral health system but is currently not well collected. We recommend that grantees be asked for more substantive grant narratives, in a format flexible enough to permit a true picture of the context and environment of their practice to be shared. We recommend that grantees continue to provide the minutes/records of full board and board committee meetings to DHSS –

and we also recommend that DHSS grant managers attend (in person or telephonically) the board and finance committee meetings of providers for which they are responsible.

Recommendation 5: Return to 6-month CSR Schedule OR Decouple Administration of the CSR from Mandatory Treatment Plan Updates (Adults Only)

We recommend adjusting the required administration of the CSR after admission to every 6 months, or removing the requirement to update the treatment plan after each CSR, for adult clients. Federal reporting standards require information collected on the CSR every six months.[1] While there may be benefits from the decision to collect the information more frequently (every 90-135 days per 7 AAC 135.100(c)(6)), the cost to providers and clients has proven substantial.

With the increased frequency of CSRs comes the requirement of more frequent updates of treatment plans (7 AAC 135.120(a)(6)). While providers report that completing the CSR with clients can take just 15 minutes, updating the treatment plan takes an average of 1 hour per client per clinician. For medication management only clients (adults experiencing SMI who are stable), the requirement to update the treatment plan is often without any clinical significance and/or resisted by these clients. The additional burden of CSR and treatment planning – absent any clinical basis for the updating of the treatment plan – results in a significant reduction in clinical capacity and access to services.

The benefit of more frequent CSRs must be weighed against the cost to the client, provider, and State. Without compelling evidence of the clinical benefit of the more frequent treatment planning schedule, we recommend that DHSS separate the requirement to update the treatment plan from administration of the CSR or collect information every 6 months only.

Recommendation 6: Eliminate Required AKAIMS Reporting for Services Not Funded by DHSS

AKAIMS data is not as precise as it could be. Currently, grantees are asked to enter data for clients that are receiving services paid for with public resources *as well as* for those who pay for their own treatment or whose treatment is paid for by private insurance or other means. As a consequence of this policy, data does not accurately describe the behavioral health system managed by DHSS.

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[1] Core Client Outcome Measures (reflected in the National Outcomes Measures (NOMS)) reporting is required by the Government Performance Results Act (GPRA) and GPRA Modernization Act of 2010 (GPRAMA), which require the Substance Abuse and Mental Health Services Administration to set program-specific performance targets, to measure program performance on a regular basis against those targets, and to report annually to Congress on the Agency's results. Block grant recipients must comply with NOMS reporting requirements.

The current policy – reporting on all clients – is not fairly enforced. Tribal behavioral health providers have consistently argued against reporting on services delivered to customer owners/tribal members funded exclusively by the Indian Health Service or by non-state payers. Those tribal providers who have chosen not to report all behavioral health clients through AKAIMS have not reported any penalty or funding consequences. Thus, this policy creates an unfair and disparate burden on community behavioral health centers not affiliated with tribal authorities.

In addition to being inconsistently implemented, the current policy creates a barrier to developing third party and other reimbursement streams. Providers are required to collect information and complete processes that are not reimbursed by private payers, and that inconvenience clients used to the private behavioral health system. The policy has been identified as an impediment to achieving the obligation to determine individuals' and private payers' shared role in the behavioral health system.

We recommend that DHSS withdraw the requirement for AKAIMS reporting on all clients served. Instead, providers should be required to report the minimum data set only on clients that are a) Medicaid eligible; b) Medicare eligible; or c) receiving services at reduced or no cost pursuant to a Comprehensive Behavioral Health Treatment, specialty service grant, or other funds from DHSS.

Recommendation 7: Expand Annual Service Limits for Behavioral Health Medicaid Services Pursuant to 7 AAC 135.040

Service Authorizations were originally intended to act as a Prior Authorization of services, to help ensure that only medically necessary services were delivered to Medicaid eligible individuals. Current practice – by providers and the Division of Behavioral Health – has evolved to make this process moot, while still achieving the intent of cost containment and ensuring only medically necessary services are provided.

Providers must submit a service authorization any time services exceed the annual service limit. Originally, these Authorizations were contemplated as occurring before services were initiated (serving as Prior Authorizations). However, given the needs of the client population served, services are typically begun even before the authorization was received.

Current business practice is that Service Authorizations are typically submitted as clients begin services or while services are ongoing. This results in a shifting of risk from the State of Alaska to providers, who assume financial responsibility for services delivered pending authorization.

Providers report that, prior to the transition to the new MMIS system, Service Authorizations for behavioral health Medicaid services were denied at an extremely low rate. Troubleshooting efforts during the MMIS transition have included automatic approval of certain types of service authorizations, rendering this process a pro forma requirement in many instances.

The low denial rate for Service Authorizations and the use of automatic approvals of service authorizations during the current MMIS situation lead to the recommendation that annual service limits for standard clinical and rehabilitative services be raised based on review of the actual Service Authorization data from FY2012-2014. Service Authorizations require an immense amount of time and effort from providers, DHSS, and Xerox – without actually serving as the mechanism to contain costs and ensure only medically necessary services are provided.

Providers report than the majority of clients' treatment plans show medically necessary services exceeding the current regulatory annual limits. We recommend that the Division of Behavioral Health and Health Care Services work together with providers to determine annual service limits pursuant to 7 AAC 135.040 that are more aligned with the medically necessary treatment needs of clients served, with the goal of reducing the need for pro forma Service Authorizations. We also recommend that DHSS explore whether Service Authorizations for standard behavioral health services (therapy, etc.) provide any value to the system (and if not, act to remove the requirement entirely). This recommendation does not extend to travel/transportation or pharmacy/prescription prior authorization processes.

Recommendation 8: Develop Clear and Consistent Standards and Policies for DHSS Audits, Site Visits

Behavioral health providers are subject to a variety of site visits and audits by state, federal and accrediting entities. DHSS is required by law to "visit each [mental health] treatment facility at least annually to review methods of care or treatment for patients" (AS 47.30.660(b)(11)), investigate patient complaints (AS 47.30.660(b)(12)), and "inspect, on a regular basis, approved public and private [substance abuse] treatment facilities at reasonable times and in a reasonable manner" (AS 47.37.140(b)).

The director of the Division of Behavioral Health has asserted that providers should look forward to visits from DHSS staff. However, state audits and site visits have come to be seen as punitive and laborious by providers, especially when multiple audits and site visits occur at the same or within a short period of time. These visits can divert scarce resources from treatment services, so every effort should be made to reduce the overall number and impact to clients and providers.

These authorities are interested in the same (or very similar) information. Audits frequently overlap, and site visits occur at times that do not take into account staff capacity or other

authorities' visits. Findings from the site visits and audits, presumably meant to improve quality of care and compliance, are delayed for sometimes years with little to no communication providing updates.

We recommend that DHSS develop clear and concise policies outlining both the process and intended outcome of DHSS audits and site visits – to include standardized information gathering and reporting protocols. We also recommend that DHSS designate a coordinator of state audits and site visits of behavioral health providers, to ensure coordination and reduce the number and overlapping nature of efforts. We recommend that the coordinator and behavioral health program manager work together toward consistent information sharing with providers – and to allow providers to elect to share information from audits/site visits with their colleagues if it promotes system improvements.

Recommendation 9: Align DHSS Quality Assurance Processes with Accreditor Processes to Eliminate Duplication of Effort

National accreditors, specifically those expressly required in regulation governing delivery of behavioral health services, are independent and well-respected experts in the field of quality assurance and continuous quality improvement for behavioral health services. The Joint Commission has been recognized as the leader in health care standards of care and accreditation for over 50 years. CARF has international experience and recognition related to accrediting substance abuse treatment providers and human services facilities. The Council on Accreditation, founded in 1977, specializes in behavioral health and family-services accreditation. These accreditors constantly solicit input from the industry and revise their standards to keep pace with national trends.

DHSS has mandated accreditation – to ensure Alaskans receive the best services possible. However, DHSS continues to engage in quality assurance efforts that duplicate those of the accreditation processes that behavioral health providers spend a lot of money, time and effort to go through. We recommend that DHSS deem all duly accredited providers as meeting the requirements of Title 47 related to being "approved" treatment facilities under the Uniform Alcoholism and Intoxication Treatment Act and/or the Community Mental Health Services Act.

Recommendation 10: Eliminate Requirement for Enrollment Prior to Brief (Non-Emergency) Services

Not all people who seek services from community behavioral health centers are within priority populations. A significant number of people seeking services are eventually determined to have mild or moderate disorders (if their problems even rise to the disorder threshold at all). Thus any services delivered are not eligible for reimbursement.

Providers' current practice is that every person who presents for services complete a standard intake including screening (AST) and assessment, an initial CSR, and a treatment plan before services can be offered. The actual amount of time spent on the intake process can easily exceed the value it offers when dealing with individuals needing only brief direction (non-clinical referrals up to very brief case management, etc.) or who decide that they do not want to enter treatment.

It appears that short-term brief crisis intervention services can also be provided to adults experiencing emotional disturbances (*see* 7 AAC 135.020), which would allow providers to address the needs of these clients without incurring unreimbursed costs. We recommend that DHSS clarify whether and how these short-term brief crisis intervention services can be used and then offer training to providers on appropriate use of this service type. If this service type does not offer a solution to this problem, we recommend eliminating the requirement for enrollment prior to brief non-emergency services.

Recommendation 11: Eliminate Discharge Requirement for SMI Clients

Both the federal government and DHSS have committed to the integration of behavioral health and primary care services as a way to improve client health outcomes. This integration of health care requires alignment of clinical and business practices, as well as state policy and regulation. One concrete example of where behavioral health policy is contrary to the practices and policies of integrated care is the emphasis on discharge/disenrollment.

In the context of primary care (physical health), a person is encouraged to have a consistent provider whom they see on a regular basis (not just when he is sick). For those individuals with chronic health care conditions, like diabetes, this stable ongoing health care relationship is even more strongly encouraged. Thus, a primary care patient is "empaneled for life" (or until they move to a new provider or die).

In our system, the emphasis is on discrete and time-limited episodes of care rather than providing services for on-going mental and emotional health care. Not only is this emphasis out of sync with the larger health care perspective, it does not reflect the dynamic and variable nature of recovery for people experiencing behavioral health disorders. Neither does this policy create an environment that promotes individual help-seeking when there is a risk relapse or crises (or after relapse/crisis).

Requiring discharge of clients creates an unnecessary burden on providers who must re-empanel clients who return for services. Providers have access to clients' information and clinical histories through AKAIMS and their own clinical records. Yet providers must begin all over

again with a client who has not recently accessed services, instead of more efficiently updating the client's information and moving more quickly into services.

Medicaid eligible Alaskans receiving primary care services, or services for chronic health conditions, are not required to "start from scratch" each time they seek services. Therefore, this policy treats Medicaid recipients and Medicaid providers differently on the basis of disability. We recommend that DHSS eliminate those policies and requirements that prevent behavioral health clients from being "empaneled for life" and having ready access to necessary services as needed. This recommendation will allow DHSS policies and practice to better support integration of health care, acknowledge and support the unique nature of recovery in behavioral health, and provide for equitable treatment of Medicaid recipients and providers across the health care system.

For Ongoing Streamlining Efforts:

- **Recommendation 1: Develop Suite of Standardized Forms That Meet All State, Federal, Accreditor Requirements**
- **Recommendation 2: Develop Guidance Documents for Implementation of Electronic Health Records in Conjunction with AKAIMS and the Health Information Exchange**

These were intended deliverables from the Streamlining Initiative. Unfortunately, the ambitious scope of work exceeded the six-month timeframe. The Streamlining Initiative has begun comprehensive review of providers' forms and documents, in order to determine what elements will meet the needs of all entities exerting oversight. The Streamlining Initiative has also begun intensive stakeholder interviews about the use of AKAIMS and EHRs. The Alaska Behavioral Health Association, the Alaska Mental Health Board, and Advisory Board on Alcoholism and Drug Abuse will continue to work with Initiative partners and DHSS to develop these forms and guidance documents for consideration.

Appendix A

APPENDIX A

AMHB AND ABADA STREAMLINING INITIATIVE

PROPOSED SCOPE AND WORK PLAN

Purpose:

The purpose of this Streamlining Initiative is, by building and expanding upon similar efforts, to provide concrete recommendations to behavioral health providers and the Department of Health and Social Services (DHSS) of ways to consolidate information gathering and documentation practices to comply with federal and state law, regulation, and policy while reducing administrative burden. We intend to complete this work by June 30, 2014.

Scope of Work:

1. Identify all federal and state laws and regulations governing intake, assessment, treatment, and discharge policies and practices.
2. Identify all policies and expectations related to intake, assessment, treatment, and discharge required by accrediting bodies (Joint Commission, CARF, etc.).
3. Create a comprehensive list of baseline information required by law, regulation, and accreditation.
    a. Identify the reason such information is collected.
    b. Identify all concrete uses of such information by DHSS, DBH, providers, and others.
    c. Identify data elements that contribute to trend analyses.
4. Create a comprehensive list of information needed to meet state policy and/or accepted standards of care.
    a. Identify the reason such information is collected.
    b. Identify all concrete uses of such information by DHSS, DBH, providers, and others.
    c. Identify data elements that contribute to trend analyses.
5. Define the current "minimum dataset" and recommend any changes.
6. Acquire and review all intake, assessment, treatment, and discharge forms and policies currently implemented by Alaska behavioral health providers.
    a. Identify those components that meet requirements of law and accreditation.
    b. Identify those components that meet policy and standard of care expectations.
    c. Identify additional components to meet requirements of law and accreditation.
    d. Identify additional components that meet policy and standard of care expectations.
7. Quantify the cost of collecting data and information under current structures.
8. Review all AKAIMS data fields.
    a. Identify those components that meet requirements of law and accreditation.
    b. Identify those components that meet policy and standard of care expectations.

APPENDIX A

   c. Identify additional components to meet requirements of law and accreditation.
   d. Identify additional components that meet policy and standard of care expectations.
9. Develop a suite of standardized and accessible model intake, assessment, treatment, and discharge forms that comply with legal and accreditation requirements.
   a. Develop standard language for treatment plans and other documentation that meets legal and accreditation requirements.
10. Identify AKAIMS data fields that can be removed or made optional.
11. Identify AKAIMS data fields that should be added to meet legal and accreditation requirements.
12. Quantify the cost of collecting data and information under recommended structures.
13. Develop guidance documents related to behavioral health electronic health records and the health information exchange to promote streamlining.
   a. Identify business practices to promote efficient and effective use of AKAIMS

Timeline: (dates are "by when")

February 5, 2014	Invitations to participants
February 10, 2014	Federal and State Requirements Identified (DBH,Boards)
February 17, 2014	First work group meeting – focus on statutory authority
February 28, 2014	Accreditation Requirements Identified (ABHA)
March 10, 2014	Second work group meeting – focus on accreditation requirements
March 31, 2014	Provider intake etc. paperwork acquired, provided to work group (ABHA)
April 30, 2014	In-person third work session – minimum data set (10-4:30)
May 15, 2014	AKAIMS data fields provided (DBH)
May 30, 2014	In person fourth work session – AKAIMS recommendations (10-4:30)
June 5, 2014	Draft standardized forms, tools to workgroup
June 15, 2014	Fifth work session – review draft forms, recommendations
June 25, 2014	Draft of all recommendations, tools to work group
June 30, 2014	Approval of work group products to forward to DHSS

Streamlining Initiative Participants

Representing	Agency	Contact (lead in bold)
Behavioral Health Providers	ABHA	**Tom Chard, Co-Chair** tom.abha@gmail.com
Planning Councils	AMHB and ABADA	**Kate Burkhart, Co-Chair** kate.burkhart@alaska.gov Pat Sidmore patrick.sidmore@alaska.gov
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