United Behavioral Health

Accessibility, Engagement and Utilization of Services for Individuals with High Risk			**Policy Identifier/Number:** CM-07
Annual Review Completed Date: February 2018			
Policy Category: Government - Pierce Regional Support Network	**Applicable Lines of Business:** Medicaid	**Entity/Plan:** Optum Pierce Behavioral Health Organization	**State:** Pierce County, Washington
Approved by: Bea Dixon, Executive Director			**Signature:** 

Policy Statement and Purpose

Optum Pierce Behavioral Health Organization (BHO) has in place the following care coordination standards for individuals who are at high risk:

- Monthly internal Utilization Management meetings are held to discuss planning for individuals who are considered high risk and/or high utilizers of emergency services;
- Behavioral health care providers are required to coordinate care for enrolled individuals who are high risk and/or frequent utilizers of crisis services.

The purpose of this policy is to encourage accessibility, engagement and utilization of services for individuals who are at high risk.

Policy Audience and Applicability

This policy is applicable to the Optum Pierce Behavioral Health Organization (BHO) and benefits administered through the Washington State Department of Social and Health Services (DSHS) current Prepaid Inpatient Health Plan (PIHP).

Policy Definitions

An individual who is at high risk is an individual who meets any of the following criteria:

- Has been identified through the Utilization Management subcommittee as having repeated psychiatric hospitalizations within the past 90 days;
- Does not appear for at least 3 scheduled appointments in a 6 month period **and** has engaged services of the crisis system numerous times during the same time period;
- Has had repeated contact with law enforcement as the result of behavioral health needs;
- Has had repeated visits to the emergency room to seek behavioral health treatment, including psychiatric medications or medication assisted treatment (MAT) medications;
- Has been identified by an Apple Health provider as someone who has a high number of crisis and emergency department (ED) contacts;

Optum is responsible for adhering to all applicable state and/or federal laws governing activities within the scope of this policy, including the Mental Health Parity and Addiction Equity Act (MHPAEA) and the Health Insurance Portability and Accountability Act (HIPAA) privacy requirements, as well as the applicable requirements, standards and regulations as set forth by the Employee Retirement Income Security Act (ERISA), the Center for Medicare and Medicaid Services (CMS), the Department of Labor (DoL), and any applicable accrediting organizations.

- Has been identified by Police, EMS, Emergency Department leaders or other crisis responders as someone who uses a very high number of crisis services related to behavioral health needs

Policy Provisions

1. Optum Pierce BHO Responsibilities:

1.1. High Risk Identification

1.1.1. On a monthly basis, or more frequently if necessary, referral sources (police, fire, EMS, hospital emergency department leaders in Pierce County, and Apple Health plans) will submit lists of the people who use the most crisis services related to behavioral health issues to the Optum Pierce BHO Clinical Manager. Referral sources will consider for referral to the program individuals who are:

1.1.1.1. On Less Restrictive Alternatives or Conditional Release who appear to be under-served;

1.1.1.2. Frequent users of crisis services;

1.1.1.3. Frequent users of crisis triage;

1.1.1.4. Frequent users of emergency departments to address behavioral health issues;

1.1.1.5. Receiving Involuntary Treatment Act (ITA) evaluations frequently;

1.1.1.6. Frequently placed in inpatient or residential behavioral health facilities.

1.1.2. In addition, utilization data are presented and analyzed to detect any concerning trends or patterns and to take any necessary actions.

1.1.3. The Utilization Management Subcommittee meetings are co-chaired by the Optum BHO Associate Director of Clinical Services or his/her designee and the BHO Medical Director, and attended by the Optum Pierce BHO Clinical Operations Manager, Care Managers, Discharge Coordinators, and the QA/PI Manager. The Senior Director of Operations and Executive Director are invited to attend when needed.

1.2. Care Coordination

1.2.1. Optum Pierce BHO-contracted behavioral health agencies provide the following care coordination and care management services to support individuals who are at high risk and/or are high utilizers of crisis services:

1.2.1.1. Follow-up after Inpatient Discharge--Optum Pierce BHO contracts with an agency to provide Peer Bridger services to Pierce County residents who are discharging from inpatient levels of care. Peer Bridgers work on-site with inpatient facilities and outpatient mental health care providers to schedule a follow-up outpatient appointment within 5 calendar days of discharge from inpatient care;

1.2.1.2. If an individual enrolled in behavioral health services does not attend a follow-up appointment after release from an inpatient hospital stay, the Peer Bridger team attempts to reach the individual, help address any barriers keeping the individual from attending appointments, and facilitate individual participation in services. In addition, Optum Pierce BHO requires contracted providers to implement outreach and engagement, including linking individuals to the appropriate level of support services and

contacting the individual through phone or other outreach efforts if an authorization remains open for up to 30 calendar days without the individual attending appointments;

1.2.1.3. Drug Seeking Behaviors--If a pattern of seeking medications from multiple prescribing providers is detected, an individual receives enhanced care coordination services as well as a referral for a substance abuse assessment, if one has not recently been completed.

1.2.1.4. Individuals who are identified through either the UM process or the high risk identification process may be referred to the Community Support Partner program. This program offers intensive care coordination services to help individuals with high needs to connect to essential services in order to reduce the need for crisis services.

1.2.1.5. Crisis Triage Readmissions–Any individual who has multiple admissions to Crisis Triage may be referred to the Community Support Partner program of enhanced care coordination services with a possible referral to the Program for Assertive Community Treatment (PACT) team.

1.2.1.6. ITA Evaluations–Any individual who has frequent ITA evaluations may be referred to the Community Support Partner program of enhanced care coordination services with a possible referral to the PACT team.

1.2.1.7. Evictions–Any individual who has a behavioral health condition and is unable to maintain housing may be referred to the Community Support Partner program of e n h a n c e d care coordination services.

1.2.1.8. Multiple Foster Care Placements–Any child/youth who is unable to maintain placement due to his/her behavioral health condition may be referred to the Family Assessment and Stabilization Team (FAST).

1.2.1.9. Children's Long Term Inpatient (CLIP)–Any child who is currently in CLIP receives enhanced care coordination.

1.3. Provider Monitoring

1.3.1. Optum Pierce BHO uses encounter and claims data to determine if appropriate follow-up care was provided within 5 calendar days after individuals were discharged from an inpatient psychiatric hospital, a withdrawal management program, or a substance use disorder residential program.

1.3.2. Optum Pierce BHO performs on-site audits of provider records to gather more detailed information about follow-up activities, if warranted, and on an as- needed basis in addition to the annual audits.

2. Behavioral Health Care Provider Responsibilities:

2.1. Behavioral health care providers are responsible for the following coordination activities related to high-risk individuals and individuals who are frequent users of crisis services:

2.1.1. Outreach to the individual;

2.1.2. Filing a crisis alert and/or updated Individual Crisis Plan (ICP) with the Crisis Team;

2.1.3. Establishing an ICP and/or inclusion of the ICP in the individual's Individual Services Plan (ISP). The individual must participate in the development of the ICP and be provided with a copy of the plan as will the Crisis Team and any other approved safety net providers;

2.1.4. Assigning a Peer Counselor to assist the individual in getting to appointments, managing his/her crisis plan and developing a WRAP Plan if clinically indicated;

2.1.5. Referring each individual to the most appropriate level of service and site of care for his or her current and individual needs and situation;

2.1.6. Based upon clinical need:

2.1.6.1. Arranging and providing assistance if necessary for a follow-up appointment for an individual within 5 calendar days of discharge from an inpatient psychiatric facility, a withdrawal management program, or a substance use disorder residential treatment program.

2.1.6.2. Arranging for follow-up within 24 hours for any individual who has received emergency room or other crisis services related to his/her behavioral health condition, when known;

2.1.7. If an individual enrolled in the Community Support Partner program misses 3 or more outpatient appointments within the period of a month, initiating a home-based visit to check on well-being and discuss current treatment needs.

2.1.8. Referring the individual to the PACT team if he/she meets eligibility criteria

3. Referring the individual to natural supports in the community such as the Recovery Café, "A Common Voice", the Tacoma Area Coalition for Individuals with Disabilities (TACID), or other supports as applicable.

Related Policies, Procedures & Materials

- Optum Pierce Behavioral Health Organization policy: CM-01- *Development of Service Plans*
- Optum Pierce Behavioral Health Organization policy: CM-02- *Crisis Plans*
- Optum Pierce Behavioral Health Organization policy: CM-03- *Timely Access to Care*
- Optum Pierce Behavioral Health Organization policy: CM-04- *Access to Care Standards for Adults, Older Adults, Children and Youth*
- Optum Pierce Behavioral Health Organization policy: CM-05- *UM/Resource Management Plan*
- Optum Pierce Behavioral Health Organization policy: CM-06- *Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services*
- Optum Pierce Behavioral Health Organization policy: CM-08- *Coordination of Care Between Primary Care Physicians, Emergency Rooms and Other Health Care Providers*
- Optum Pierce Behavioral Health Organization policy: CM-09- *Engagement of Community Resources*
- Optum Pierce Behavioral Health Organization policy: CM-10- *UM/Authorization and Concurrent Reviews*
- Optum Pierce Behavioral Health Organization policy: CM-11- *Involuntary Evaluation and*

Treatment

- Optum Pierce Behavioral Health Organization policy: CM-12- *Individual Access to Housing*
- Optum Pierce Behavioral Health Organization policy: CM-13- *Coordination with Rehabilitation and Employment Services*

Attachments

N/A

Approval History

- Policy created and effective: 07/2009
- Operational Procedures and Standards Committee reviewed and accepted: 09/28/15
- Optum Pierce BHO reviewed and accepted: February 2018