Substance Use Disorder Intake, Screening, & Assessment (SUDISA) Workgroup Meeting Minutes

July 24, 2024, 9:05AM-10:30AM PST

Meeting Recording: Substance Use Disorder Intake, Screening, & Assessment (SUDISA) Committee - SharePoint

☐	Kelley Sandaker, HCA	☒	Bethany Barnard	☐	Amy Ruge
☒	Michelle Martinez, HCA	☒	Brandy Branch	☒	David Sapienza
☐	Theresa Adkison, HCA	☐	Elizabeth Bridges	☐	Bergen Starke
☒	Amy Sawyer, HCA	☐	Dallas Delagrange	☐	Wayne Swanson
☒	Meta Hogan, HCA	☒	Charnay DuCrest	☒	Angela Tonkovich
☒	Ruth Leonard, HCA	☒	Alicia Egan	☐	Lashonti Turner
☐	Gayle Martinsen, HCA	☒	Dominique Fortson-Jordan	☐	Daniel White
☒	Sarah Melfi-Klein, HCA	☐	Trina Gallacci		
☐	Melanie Oliver, HCA	☒	Sarah Gillard		
☒	Eliza Tharp, HCA	☒	Ana Hartu		
☐	Tony Walton, HCA	☐	Garrett Leonard		
☒	Rachel Downs, HCA	☐	Molly Martin		
☒	Brianna Peterson, HCA	☒	Beth Myers		
☐	Cathy Assata	☒	Katie Ramos		
		☐	Cara Reidy		

Meeting Attachments

- Meeting Agenda

Announcements

Michelle Martinez, Senior Project Manager, shared that a separate breakout room session for Certificates of Need has been removed as a main topic of discussion given that it is not something we want to pursue as a recommendation for behavioral health services.

Break-out Session #1 Discussion – Recommendation #1 – Increase the Medicaid fee schedule (reimbursement rates) for behavioral health services so that behavioral health service providers, facilities, and organizations providing substance use disorder treatment can offer higher wages to substance use treatment providers.

Feedback to recommendation from the subcommittee included:

- Replace recommendation description to read: "Use the comparison rate study to inform targeted medicated rate increases on both Manage Care and fee for service for SUD providers for areas that are under resourced. Increase rates for room and board."
- Capturing how many Substance Use Disorder Professionals (SUDP) and Substance Use Disorder Professional Trainees (SUDPT) is the profession short of.
    - A steering committee member captured this information through the Bureau of Labor and DSHS for information that provided statistics for SUDP/SUDPT shortages and pay.
        - https://www.bls.gov/oes/current/oes211018.htm
        - https://www.dshs.wa.gov/sites/default/files/rda/reports/research-4-112.pdf
        - https://hca-tableau.watech.wa.gov/t/51/views/OUDTreatment/Dashboard?%3AisGuestRedirectFromVizportal=y&%3Aembed=y
        - Behavioral-Health-Care-Manager-Caseload-Guidelines_072120-Final.pdf (uw.edu)
- There are cyclical rates of low pay rates/wages. If there are no staff, services cannot be provided.
- Acute detox settings 3.7 (ASAM 4th Edition will overhaul this level of care)
    - Detox facilities have closed increasing burden of ER and other medical healthcare providers
    - Recommend examining reimbursement rates directly for Level 3.7 and Level 4.0
- Room and board reimbursement rates for residential treatment currently $14.20 per day
    - This reimbursement rate does not cover program requirements
    - Recommend pathway for what other states reimbursement rates are, example Montana reimburses around $50 per day

    - Clear understanding of what room and board covers.
- Recommendation that the Office of Insurance Commissioner (OIC) examines contracted rates with Behavioral Health Providers to ensure equitable reimbursement rates.
- Recommendation to fully explore that the Cannabis Tax Revenue is being directed to Behavioral Health instead of into the general fund and utilized for intended purpose.
- Recommend utilizing the comparison rate study and legislature make targeted increases in alignment with these findings, per changes to the "minimum fee schedule".
    - Minimum fee schedule for both residential and outpatient
    - Lower reimbursement rates increase higher caseloads, which leads to burnout and less access to services
- Increase reimbursement rates to support wellbeing of providers and encourage the attractiveness of entering and staying in the field.
    - Recommendation state tuition reimbursement option for SUDPT/SUDPs to further education and knowledge to improve quality of care.
    - Alleviate burnout
- Recommend state speak with CMS to address gaps in Medicare coverage
    - Medicare requires hospital setting to reimburse
- Due to aging population needing SUD treatment with minimal to no treatment options.
- Regarding the financial implications of this recommendation, investigating THC tax funding and CMS rate increases is needed.

Break-out Session #2 Discussion – Recommendation #2 – Education campaign to clarify state requirements related to intake and assessments that must be administered prior to providing different types of behavioral health services.

Feedback to recommendation from the subcommittee included:

- Providing education campaigns related to removal of X-Waivers, in-patient (no-wrong-door), understanding that Social Workers can conduct substance use disorder (SUD) assessments if within scope, Scala NW, providers ensuring access to medication-assisted treatment (MAT) before SUD assessments, and CJTA funding for peer services to conduct outreach for court0-involved individuals
- Previously, doctors needed an X-waiver to prescribe buprenorphine (Suboxone)However, as of January 12, 2023, the X-Waiver became unnecessary with the implementation of the Waiver Elimination (MAT ACT). In Washington State, there are doctors who are unaware of the removal of the X-waiver.
- Previously, residential treatment centers and withdrawal management required prior authorization, which in turn necessitated a full SUD assessment. However, this requirement placed a heavy burden on individuals seeking treatment. Bill 2642 changed this by eliminating the need for prior authorization to enter residential treatment centers or withdrawal management facilities. Consequently, SUD assessments are no longer necessary for admission, as the number of days covered by insurance depends on whether the treatment is residential or

detox. It's worth noting that some inpatient residential treatment centers still require a full SUD assessment before admitting patients. However, inpatient treatment centers are no longer obligated to conduct a full SUD assessment before entering treatment. It would be helpful to clarify the difference between the WAC requirements, MCO requirements and DOH auditing requirements to give providers a clear picture of what is expected for clinical documentation prior to intake, prior to authorization and ongoing clinical review for DOH audits. If the interpretation of the WAC requirements are clear for all parties involved, it may reduce providers concerns and needs for a "full" ASAM SUD assessment prior to intake.

- Previously, only Substance Use Disorder Professional Trainees or Substance Use Disorder Professionals were responsible for conducting SUD assessments. However, according to the Washington State Plan, certain staff members with specific credentials (such as LMHC, LMHCA, LSW, etc.) who work at a behavioral health agency can now also conduct full SUD assessments if they receive the necessary training and if it falls within their scope of practice. Section 13 D
- Previously, those with Opioid Use Disorder received minimal treatment in the Emergency Room due to limited resources and training. However, Scala NW now makes it possible for all patients with this disorder to receive treatment. The Scala NW website provides healthcare providers with quick access to information on how to treat patients with Opioid Use Disorder. Additionally, Scala NW offers a 24/7 consultation line for further assistance.
- More investigation will be conducted on CJTA funding for peer services.
- Regarding the need for this recommendation, "There is much confusion around how multiple entities (MCO's, ASO's, DOH and SUD Providers) interpret the SUD/ASAM requirements for assessment/intakes into treatment services at all levels of care. If the WAC expectations were clearly explained by the HCA, it could significantly and positively impact providers ability to admit patients more quickly.

Break-out Session #3 Discussion – Recommendation #3 – Expansion of services that can be provided prior to an SUD assessment

Feedback to recommendation from the subcommittee included:

- Change title of recommendation to be more inclusive – "Expand peer specific services that can be provided prior to completion of assessment/intake. Expand BH Care Coordination and Community Reintegration to include other settings (Emergency Departments and Homeless Encampments)."
- Regarding the Summary:
    - Recommend expansion of specific services that can be provided (and reimbursed) by peers prior to the completion of the intake/assessment, e.g., Peer supports/ follow up.
    - Some peer services already provided in crisis/ED arena – ways to connect that to outpatient providers.
    - Expand the SERI language of "Community Support and Care Coordination" to include transitions from community-based settings, homelessness, ED, etc. Need to allow non-inpatient staff to provide this – CPCs and "other clinical staff". Include transitions TO inpatient settings. Specifically allowed in inpatient/incarcerated settings because the formal assessment has already been completed. SERI does may not require these services be preceded by a formal assessment. Including transition services is maybe based on the assumption that a formal assessment was already completed. Discrepancy between SERI requirement and WAC requirement.

    - The larger SUDISA group will be consulted on what peer services is indicative of, but a steering committee member also reiterated the importance of ensuring that peers are involved in this discussion
- Regarding the Need:
    - A need to be able to start the process to start services regardless of having an assessment.
    - Pull data from outreach about these providers are seeing that people don't engage unless peers are involved.
    - Often the highest need populations to not walk into treatment services or may have barriers accessing services. If peers could provide services to the highest need populations (example - homeless) to assist them with getting engaged in services, this is likely to increase individuals being served and get some of their need met prior to formal treatment.
    - Additionally, outreach/engagement services are not Medicaid billable services and rely on state funds. If peers could bill services prior to intake/assessment, this should increase funding capacity.
- Regarding the anticipated impact of recommendation:
    - A counter argument may be that there are sufficient peer-based programs funded by the state, and that expansion to this new domain may confuse roles and expectations for providers with specific credentials. At the provider level, we cannot bill for the service coordination/access needs until after an assessment is completed (unless from an inpatient setting). If peers could assist with coordination within the provider network, it is likely to increase engagement and access to services. Outreach and engagement is generally limited to 3 contacts prior to intake/assessment and is limited to the individual (patient) not coordination with a service provider or peer-based program.
    - Additionally, a counter argument could be that assessments are necessary to establish diagnosis and severity of that diagnosis, which affects placement in programs and levels of care that are appropriate for an Individual. Yes, but often people with the greatest barriers won't reach out for help or if they do ask for help, do not have the support necessary to access treatment (like transportation, phones, food, etc.).

Questions included:

Q: Is peer engagement different than case management in this context?

A: Yes – this is not a request for peer case management to take place prior to intake/assessment; this is request to allow peers to engage with clients to help them access treatment and find other support services (groups, housing resources, transportation, etc.) prior to treatment/while awaiting treatment access.

Comments included:

- Only SUDPs can do case management, technically, in state plan
- New modality as of Jan 2024 - Behavioral health care coordination and community integration – can be provided by peers in crisis work. Expanding peer services to general care coordination outside of crisis would increase engagement while awaiting access to services/supports.

Break-out Session #4 Discussion – Recommendation #4 – Expanding remote access pathways to receiving an SUD assessment (e.g., via phone or video call) and increasing virtual treatment options

Feedback to recommendation from the subcommittee included:

- Regarding the summary:
    - Could we allow phone assessments for certain reasons.
    - Brief intake to allow care now instead of later.
    - Increase in virtual treatment options
    - Brief LOC assessment as provided by new ASAM
    - Allow for assessments to be completed over the phone with no video if this is a barrier.
    - Update green book for telehealth services
- Regarding the anticipated impact of the recommendation:
    - If phone only evaluations are widely accepted, providers may never "see" their patients to evaluate general health and wellness.
    - HCA to support/encourage SUD Treatment Agencies to update P&Ps regarding what is allowable for SUD Telehealth and align the SUD agency's clinical standards with HCA standards and reimbursement models.
    - HCA to provide education on the differences between audio only and telemedicine-based services and what is consider safe standards of practice for SUD care for these.
    - Offer HCA support on what is allowable vs not allowable for various SUD services and telehealth service delivery options (video, telephone, etc.)-->more widespread awareness of HCA Guidelines and point of contact at HCA to support agencies in developing these policies.
        - HCA to help agencies understand why telephone only ASAM assessments are not allowed and alternatives that could be offered such as video-based ASAM.
    - HCA to do another push to SUD Agencies regarding what is allowable vs not allowable to for video vs audio-only care and the reimbursement rates regarding these services.
    - Offer additional support to agencies who are hesitant to providing telehealth services for SUD to provide guidance on first steps, workflows, etc. to remain in compliance with state regulations.
        - HCA could create some type of Pathway to Telehealth document to support SUD agencies starting to provide telemedicine and help them remain in compliance.
    - HCA to create and publish list of SUD agencies/consultation services who can perform SUD Assessments virtually while patient is in the hospital/ER to facilitate rapid completion of the ASAM and inpatient placement.
    - Collaborate with DOH regarding adding requirements surrounding providing telehealth/telemedicine, either a plan on how its provided or indicating they do not provide as part of their licensing/provider agreements.

Next Steps

1. SUDISA committee leadership will be inviting input from other workgroup members to solidify the recommendations and then share them with associations after the meeting on August 12, 2024.
2. Input from various associations on recommendations will be gathered by no later than August 23, 2024.

Next Meeting

August 12, 2024 – 1:05PM-2:35PM PST

Addendum Links:

Link to the public SUDISA webpage: SUD Intake, Screening, and Assessments (SUDISA) work group | Washington State Health Care Authority