DEPARTMENT OF HEALTH CARE SERVICES
DEPARTMENT OF SOCIAL SERVICES
AB 340 TRAUMA SCREENING ADVISORY WORKGROUP
November 28, 2018 Meeting
10 a.m. – 3:30 p.m.

MEETING SUMMARY

Attendance

Members Attending: Cori Allen, Tuolumne County Department of Social Services; Dr. Ariane Marie-Mitchell, Loma Linda University; Dr. Robert Pynoos, The National Child Traumatic Stress Network and UCLA School of Medicine; Dr. Sara Marques, Center for Youth Wellness; John Bauters, Californians for Safety and Justice; Frank Mecca, County Welfare Directors Association (CWDA); Kimberly Lewis, National Health Law Program; Laura Stillmunkes, Capital Adoptive Families Alliance; Lishaun Francis, Children Now; Lynn Thull, California Alliance for Children and Family Services; Robb Layne, County Behavioral Health Directors Association of California (CBHDA); and Terri Fields Hosler, Shasta County Health & Human Services Agency.

Members not Attending: Debbie Manners, Hathaway-Sycamores; Dr. Chris Esguerra, Care1st Health Plan Dr. Brent Crandal, Rady Children's Hospital in San Diego; Esther Franco, Fresno Council on Child Abuse Prevention (FCCAP); and Susan Holt, County of Fresno.

Members Attending by Phone: Dawan Utecht, County of Fresno; Dianna Wagner, Shasta County Health & Human Services Agency; Maheen Ahmed, Assemblymember Arambula's Office; Dr. Robert Riewerts, Southern California Permanente Medical Group; and Dr. Susan Coats, California Association of School Psychologists (CASP).

DHCS Staff: Jennifer Kent, Dr. Anna Lee Amarnath, Dr. Elizabeth Albers, Stephen Wu, Marilyn Kempster, Tara Zimonjic, and Angeli Lee

CDSS Staff: Mary Sheppard

Public in Attendance: 14 members of the public attended.

Welcome and Introductions
Jennifer Kent, DHCS Director

Director Kent welcomed workgroup members, state representatives, and the public, and she facilitated introductions.

Staying Healthy Assessment (SHA) Change Process
Dr. Anna Lee Amarnath, DHCS

Dr. Amarnath explained that the SHA is DHCS' version of the Individual Health Education Behavior Assessment (IHEBA). It is reviewed by providers annually and has been updated once, in 2013, since its creation in 1999. The SHA is available online in all threshold languages and is broken out into 5 different age groups – 0-6 months, 1-2 years, 3-4 years, 18-55 years, and 55+ years. DHCS has been attempting to update the SHA with stakeholders since 2016.

Change Process Explained: As a part of the SHA update, the following steps would need to be considered: extensive stakeholder engagement, translation to threshold languages, readability check for 6th grade reading level, ADA-compliance, development of an All Plan Letter (APL) for health plans, provider training, and updating SHA provider tip sheets.

Monitoring of SHA Usage: The SHA and other health assessments are all part of the capitation rates, therefore most providers do not receive additional compensation for conducting the SHA. Any follow-ups for the SHA are also a part of the overall capitation payment.. Providers are expected to review the patient's SHA during the exam if any responses warrant a discussion. SHA responses and data are available through medical records, and they are not shared with the plans or DHCS. If a provider or plan wants to use an alternative to the SHA, the plan may request to use an alternative tool from DHCS. Then, DHCS reviews the alternate IHEBA to ensure it meets all the minimum requirements.

Every three years, Medi-Cal managed care health plans (MCPs) complete a Facility Site Review (FSR) and a Medical Record Review (MRR) for their primary care providers (PCPs). As part of the MRR, the MCP pulls a small sample of medical records to assess if PCPs are providing services in accordance with state and federal requirements and accepted standards of medical care. This includes assessing for the completion of the IHEBA, if applicable. If a site fails its site review, the MCP places the provider under a Corrective Action Plan, establishes a plan for how the provider will address deficiencies, and the site is re-assessed for compliance. More information regarding the FSR/MRR process can be found in Policy Letter (PL) 14-004.

Group Discussion:
The group discussed the possibility of creating a CPT code. However, DHCS discussed that this is a more complicated process as CPT codes are set nationally and there is no specific CPT code for the SHA, and is instead a general code for screening – that includes other health screens and other behavioral screens.

Additionally, the group noted that the SHA amendment process takes a significant amount of time. The amendment process's timeline depends on the depth of changes being explored. DHCS raised other avenues where members could get screened, including new member enrollment and risk stratification assessments that health plans have members complete.

Draft Recommendations for SHA
Dr. Sara Marques, Center for Youth Wellness

The Bay Area Research Consortium (BARC) assessment is available as identified and de-identified versions. Currently both versions are being validated against biometrics for both short and long-terms impacts. The BARC has also been reviewed for readability, ease of implementation, and usability. Dr. Marques also mentioned the importance of including introductory language for the trauma screening elements if the BARC would be added into the SHA.

As discussed earlier, amending the SHA can be a lengthy process, and the existing SHA may also be phased out in the future based on recent conversations from DHCS' Care Coordination Meetings. The workgroup may want to consider using the BARC as a parallel and separate trauma screener to the SHA.

Workgroup Discussion on Draft Recommendations

Workgroup members discussed the possibility of having one or two questions on the SHA that trigger the usage of a secondary trauma screener, such as the BARC. However, some members opposed that notion since they felt that providers may avoid asking difficult questions if affirmative responses may trigger the administration of another screener in order to follow-up with the patient. Therefore, having a mandated trauma screener would ensure the patients' needs are met appropriately.

Proposed Recommendations:

- Present BARC alongside the SHA as two separate tools, with BARC setting the minimum requirements for a trauma screener
- Examine future of SHA development while DHCS could investigate the feasibility of taking the steps necessary to formally integrate the BARC's questions into the SHA and validate the integrated tool to create a single assessment
- Loma Linda University's Whole Child Assessment (WCA) can remain as a separate alternative integrated tool.

- Providers can continue to request DHCS' permission to use an alternate IHEBA for their practice as long as it is comparable to the BARC.

There was some additional discussions as to whether the BARC questions address relevant adolescent issues. However, the workgroup also argued that the intent of the legislation was to put the state on a path for taking action and having a screening tool starts the conversation and allows us to move forward with what is currently available.

John Bauters, Californians for Safety and Justice, offered to draft the recommendation letter. He also conducted a vote by hand to determine if the workgroup members agreed with the proposed recommendations outlined above. The majority of workgroup members voted in agreement.

New Trauma Screening Implementation Discussion: Fiscal Impact, Trainings Support, Compliance, Referrals, Usability, and Data Collection

Fiscal Impact: DHCS does not specifically pay providers or health plans for conducting the SHA since it is part of the capitation they receive. The workgroup can consider providing recommendations to include higher payments to providers that administer screenings and/or spend more time with patients. A "pilot program" could be explored to see if the additional reimbursement rate correlates to higher rates of screenings. Requiring providers to administer the tool would be new and additional responsibility for the plans to implement, which means their contracts may be amended and their capitation rates may be adjusted accordingly. Actuaries will also look at fee-for-service data and evaluate national and other states' data in order to make any rate changes.

Financial motivation plays a role in motivating providers to comply with administering the SHA or other screeners. Other workgroup members noted that providers will be more inclined to use a tool that they want to use or find useful

The workgroup may not be able to parse out all of the financial implications of adding the trauma screening requirement, but this may be deferred to the Budget Committee. The recommendations can include the need to acknowledge the potential additional time and follow-ups that may be triggered based on administering the trauma screening.

Trainings and Support: Generally plans have some responsibility for trainings and DHCS has a limited role in providing trainings. Some trainings that DHCS administers are around provider enrollment and billing. When considering a training for a policy implementation DHCS would seek funding from our foundation partners.

Two bills passed in 2018 (AB 3032 and AB 2193) regarding maternal mental health and screenings may be relevant for the workgroup's recommendations. The bills have some language regarding screenings and trainings that may be helpful to review.

Issues to be considered when developing training:

- The role of trauma-informed care,
- Training for screening for adults to help mitigate the generational trauma,
- Finding services to connect patients,
- Expanding on what general pediatricians counsel on, and
- Trainings for doctors to connect symptoms (e.g. asthma or sleep disturbance) with trauma.

Ways to develop the trainings:

- Work with foundation/external partners
- Develop "learning objectives" for provider trainings
- The National Child Traumatic Stress Network has a number of resources on provider training
- BARC assessment has a list of symptoms that accompany the screening tool
- Public health departments may have lists of referral resources or resource directories, which Shasta County has that are grouped by ACEs
- American Academy of Pediatrics toolkit

Compliance: Development of CPT codes would be the easiest way to track compliance and usage, although it is important to keep in mind that data available tends to lag significantly (6-12 months) It would also be important to include the health plans in these discussions and to incorporate the use of CPT codes in provider trainings. After DHCS receives the workgroup's recommendations, DHCS will meet internally to look into potential CPT codes that could be used for the screening and also externally with the health plans to discuss the implementation rollout.

Referrals: DHCS could modify the tip sheets (FAQs for SHA) for providers to include more information regarding referrals based on affirmative answers on trauma screen. There was a suggestion for DHCS and CDSS to work with county behavioral health directors to discuss efficient case management and how to connect people with needs across multiple different systems.

Data Collection: It is very difficult to get patient-level data and there are always data lags to consider. Workgroup members discussed if it is possible to collect affirmative responses to types of trauma questions on an aggregate level. DHCS cannot provide that information, but academic institutions may be able to assess the data at that level.

Public Comments

There were no public comments.

Closing and Next Steps

Jennifer Kent, DHCS Director

No future meetings need to be scheduled. John Bauters will compose the draft recommendations and circulate them among the workgroup for input. In order to get on committee calendars before the budget hearings begin, the workgroup recommendations should be finalized in January 2019.