RHIP Behavioral Health Identification & Awareness Workgroup

Deschutes County Building
1300 NW Wall Street, Bend (DeArmond Room)

Agenda: July 26, 2016 from 9:00am-10:00am

Call-In Number: 866-740-1260
7-Digit Access Code: 3063523

1. **9:00-9:05** **Introductions—All**
2. **9:05-9:40** **Work Plan—All**
3. **9:40-9:45** **Data on Referrals to PCP from Out-Patient SU Programs—Rick Treleaven**
4. **9:45-9:50** **PCPCH Tier 5 Recognition—Wade Miller**
5. **9:50-9:55** **Mental Health Prevention & Promotion Grant Update—Jessica Jacks**
6. **9:55-10:00** **Action Items—All**
   - **Next steps**

Next Meeting: **August 23 from 9-10am**
(Deschutes County Building, 1300 NW Wall St, Bend – DeArmond Room)

BH Screening and Awareness (20)	Organization
DeAnn Carr	Deschutes County Health Services
Jeremy Fleming	PacificSource
Mike Franz	PacificSource
Erica Fuller	Rimrock Trails Adolescent Treatment Services
Jessica Jacks	Deschutes County Health Services
Susan Keys	OSU Cascades
Malia Ladd	CAC Consumer Representative/NeighborImpact
Nicole Lemmon	Wellness & Education Board of Central Oregon (WEBCO)
Sondra Marshall	St. Charles Health System
Wade Miller	Central Oregon Pediatrics Association (COPA)
Leslie Neugebauer	PacificSource
Kristi Nix	High Lakes Healthcare
Laura Pennavaria	La Pine Community Healthy Center
Kristin Powers	St. Charles Health System
Sean Reinhart	Bend La Pine School District
Megan Sergi	Rimrock Trails Adolescent Treatment Services
Steve Strang	Mosaic Medical
Rick Treleaven	BestCare Treatment Services
Jeffrey White	CAC Consumer Representative
Scott Willard	Lutheran Community Services Northwest

2016-2019 Central Oregon Regional Health Improvement Plan Work Plan

RHIP Priority: Behavioral Health Identification & Awareness

RHIP Goal: Increase screenings for depression, anxiety, suicidal ideation, and substance use disorders.

Health Indicator(s) addressed	RHIP Strategy	Activity addressing strategy	Timeline
Number of SBIRT/CRAFFT screenings provided in healthcare settings shall exceed 12% (Oregon Health Authority, 2015). Number of depression screenings and follow-up care provided in healthcare settings shall exceed 12% (Oregon Health Authority, 2015)	Use SBIRT/CRAFFT, PHQ2 & 9, GAD 7, and other evidence-based screening tools within healthcare settings.	1. COPA, High Lakes, La Pine CHC, Mosaic, St. Charles, Weeks FM, and Dr. Burkett's Office are all using screenings. (SBIRT, CRAFFT) What about PHQ2 & 9 and GAD 7? What orgs are we missing?	1. Ongoing
Parties Responsible/Responsibility	**Target Metric**	**Implementation Progress and Status**	
	1.	1.	
Health Indicator(s) addressed	**RHIP Strategy**	**Activity addressing strategy**	**Timeline**
Number of SBIRT/CRAFFT screenings provided in healthcare settings shall exceed 12% (Oregon Health Authority, 2015). Number of depression screenings and follow-up care provided in healthcare settings shall exceed 12% (Oregon Health Authority, 2015)	Ongoing regional trainings in screening tools and brief intervention response.	1. COPA trained in CRAFFT. 2. Mosaic trained in SBIRT. 3. St. Charles is scheduling a training by Michael Oyster from OHA. 4. COIPA and Michael Oyster are planning regional trainings.	1. February 2016 2. When did this happen? 3. When? 4. When?
Parties Responsible/Responsibility	**Target Metric**	**Implementation Progress and Status**	
	1. ?	1. ?	
Health Indicator(s) addressed	**RHIP Strategy**	**Activity addressing strategy**	**Timeline**
Number of depression screenings and follow-up care provided in healthcare settings shall exceed 12% (Oregon Health Authority, 2015)	Promote policies that support routine screening and follow-up care for substance use, depression, and anxiety.	1. Attestations of screenings through COIPA, SCHS, and SCMG.	1. By December 2017.
Parties Responsible/Responsibility	**Target Metric**	**Implementation Progress and Status**	
	1.	1.	

RHIP Goal: When screenings are positive, increase and improve primary care-based interventions, and, when appropriate, referrals and successful engagement in specialty services.

Health Indicator(s) addressed	RHIP Strategy	Activity addressing strategy	Timeline
First year develop a baseline of successful referral and engagement in specialty care from primary care. Second year develop performance improvement targets.	Create a comprehensive identification and response system that is reflective of the entire primary care practice (from appointment scheduling to office visit).	1. Trauma informed care, compassionate care, and referrals to resources integrated into all clinics in Central Oregon.	1. Ongoing
Parties Responsible/Responsibility	**Target Metric**	**Implementation Progress and Status**	
	1.	1.	
Health Indicator(s) addressed	**RHIP Strategy**	**Activity addressing strategy**	**Timeline**
First year develop a baseline of successful referral and engagement in specialty care from primary care. Second year develop performance improvement targets.	Create a common response matrix that clinics could adopt, including physician intervention, BHC intervention, short-term BH intervention at PCP clinic, and referral to specialty BH services.	1. Regional implementation of a four-tiered plan for positive SBIRTS: (1) PCP only intervention, (2) PCP + Behavioral Health (BHC) response, (3) PCP + BHC + co-located SUD clinician, and (4) PCP + BHC + co-located SUD + referral to specialty care.	1. Discussions taking place beginning April 2016. Rollout to begin ?
Parties Responsible/Responsibility	**Target Metric**	**Implementation Progress and Status**	
	1.	1.	
Health Indicator(s) addressed	**RHIP Strategy**	**Activity addressing strategy**	**Timeline**
First year develop a baseline of successful referral and engagement in specialty care from primary care. Second year develop performance improvement targets.	Create pathway/mapping for referral to specialty care.	1. Identify the problem to develop and clear and ideal pathway that can be shared regionally.	1.
Parties Responsible/Responsibility	**Target Metric**	**Implementation Progress and Status**	
	1.	1.	
Health Indicator(s) addressed	**RHIP Strategy**	**Activity addressing strategy**	**Timeline**
First year develop a baseline of successful referral and engagement in specialty care from primary care. Second year develop performance improvement targets.	Create clear referral and communication protocols.	1. Once an ideal and clear pathway has been mapped out education will begin regionally.	1.
Parties Responsible/Responsibility	**Target Metric**	**Implementation Progress and Status**	
	1.	1.	

Health Indicator(s) addressed	RHIP Strategy	Activity addressing strategy	Timeline
First year develop a baseline of successful referral and engagement in specialty care from primary care. Second year develop performance improvement targets.	Health information shared with primary care coordination team for review and provider follow-up.	1. Closed loop referrals from outpatient back to Primary Care. Begin by documenting bi-directional workplace assessments.	1.
Parties Responsible/Responsibility	**Target Metric**	**Implementation Progress and Status**	
	1.	1.	
Health Indicator(s) addressed	**RHIP Strategy**	**Activity addressing strategy**	**Timeline**
First year develop a baseline of successful referral and engagement in specialty care from primary care. Second year develop performance improvement targets.	The creation of a common response matrix to screenings (i.e., brief provider intervention, BHC, or referral to specialty clinic) will improve the number of screenings and spread cost-effective utilization of behavioral health interventions in healthcare settings.	1. Regional implementation of a four-tiered plan for positive SBIRTS: (1) PCP only intervention, (2) PCP + Behavioral Health (BHC) response, (3) PCP + BHC + co-located SUD clinician, and (4) PCP + BHC + co-located SUD + referral to specialty care.	1. Discussions taking place beginning April 2016. Rollout to begin ?
Parties Responsible/Responsibility	**Target Metric**	**Implementation Progress and Status**	
	1.	1.	
Health Indicator(s) addressed	**RHIP Strategy**	**Activity addressing strategy**	**Timeline**
First year develop a baseline of successful referral and engagement in specialty care from primary care. Second year develop performance improvement targets.	Assessment of resource needs within the community that will be addressed in partnership through multiple organizations, such as payees, public health, hospital, etc.	1. Initial work on this was completed with BH ID & Awareness workgroup participants (Baseline document).	1. April 2016
Parties Responsible/Responsibility	**Target Metric**	**Implementation Progress and Status**	
	1.	1.	

RHIP Goal: Normalize the public's perception of accessing resources for depression, anxiety, suicidal ideation, and substance use.

Health Indicator(s) addressed	RHIP Strategy	Activity addressing strategy	Timeline
Number of SBIRT/CRAFFT screenings provided in healthcare settings shall exceed 12% (Oregon Health Authority, 2015). Number of depression screenings and follow-up care provided in	Implement a program like "Mind Your Mind" campaign.	1. Develop and implement a Central Oregon mental health promotion campaign.	1. Develop campaign by October 2016 2. Implement campaign November 2016 – June 2017

healthcare settings shall exceed 12% (Oregon Health Authority, 2015)			
Parties Responsible/Responsibility	**Target Metric**	**Implementation Progress and Status**	
Mental Health Promotion and Prevention Grant Steering Committee (Muriel Delavergne Brown, Kimberlee Jones, Jessica Jacks) and Identification and Awareness Workgroup as Advisory Council	1. TBD: Need to establish baseline for media reach based on planned approach	1. Establish Central Oregon steering committee September 2015 2. Include mental health promotion as a strategy on the RHIP 3. Meet and learn from Lane County's implementation of MindYourMind campaign 4. Establish an advisory council (COHC Identification and Awareness Workgroup) 5. In process of hiring a contractor to create messaging for Central Oregon	
Health Indicator(s) addressed	**RHIP Strategy**	**Activity addressing strategy**	**Timeline**
Number of SBIRT/CRAFFT screenings provided in healthcare settings shall exceed 12% (Oregon Health Authority, 2015). Number of depression screenings and follow-up care provided in healthcare settings shall exceed 12% (Oregon Health Authority, 2015)	Social/emotional health curriculum taught in schools aligned with Oregon Department of Education (ODE) standards for health and evidence-based practice.	1. MindUp (Deschutes) 2. Expect Respect (Crook) 3. Girl's Circle and Boy's Council (Jefferson) 4. Lines for Life School Youth School Outreach	1. Staged rollout across Deschutes County school districts starting 2014 2. Staged rollout across Crook County school districts starting 2014 3. Staged rollout across Jefferson County starting 2016 4. Lines for Life implementation starting fall 2016
Parties Responsible/Responsibility	**Target Metric**	**Implementation Progress and Status**	
Deschutes County Health Services (MindUp) Crook County Health Department (Expect Respect) BestCare Treatment Prevention Office (Girl's Circle/Boy's Council) Lines For Life	1. 80% of K-8th graders engaged in MindUp at participating schools (Deschutes) 2. Decrease referrals from the start of the year to the end of the year as measured by the SWIS data system (Crook) 3. Girl's circle attendees report improved self-esteem as a result of participation.	1. MindUp implemented in Sisters (2014-15) and La Pine (2015-16) 2. MindUp implementation in scheduled for Redmond and Bend in 2016-17 3. Expect Respect implemented in Crook County middle school 2014-15 with expanded rollout in 2016-17 4. Girl's Circle and Boy's Council implementation starting in fall 2016	
Health Indicator(s) addressed	**RHIP Strategy**	**Activity addressing strategy**	**Timeline**
Number of SBIRT/CRAFFT screenings provided in healthcare settings shall exceed 12% (Oregon Health	Alcohol, tobacco, and other drug health curriculum taught in schools aligned with ODE standards for	1. Redmond School District (RSD) high school curriculum mapping and alignment	1. RSD high school 2014-15 2. RSD middle school 2015-16 3. Bend/La Pine School 2016-17

Authority, 2015). Number of depression screenings and follow-up care provided in healthcare settings shall exceed 12% (Oregon Health Authority, 2015)	health and evidence-based practice.	2. Redmond School District middle school curriculum mapping and alignment 3. Bend-La Pine Schools (BLS) ATOD mapping and alignment 4. Jefferson County Schools, Too Good For Drugs implementation	4. Jefferson County Schools ongoing since 2012
Parties Responsible/Responsibility	**Target Metric**	**Implementation Progress and Status**	
Deschutes County Health Services BestCare Treatment Prevention Office	1.	1.	
Health Indicator(s) addressed	**RHIP Strategy**	**Activity addressing strategy**	**Timeline**
Number of SBIRT/CRAFFT screenings provided in healthcare settings shall exceed 12% (Oregon Health Authority, 2015). Number of depression screenings and follow-up care provided in healthcare settings shall exceed 12% (Oregon Health Authority, 2015)	Implement low-risk drinking guidelines (compliment to SBIRT) in the community.	1. Public Service Announcement for 18-25 years	1. Launch in 2015
Parties Responsible/Responsibility	**Target Metric**	**Implementation Progress and Status**	
Shared Future Coalition	1. TBD	1. Campaign materials developed for audio, video, social media memes 2. 2015 distribution on Pandora, Facebook, The Source Weekly, The Source Weekly Happy Hour Guide, YouTube, KTVZ TV, local radio 3. Building communication plan for 2016-17 for shorter, targeted campaigns to saturate multiple media types and seek partnerships with local employers to share campaign internally	
Health Indicator(s) addressed	**RHIP Strategy**	**Activity addressing strategy**	**Timeline**
Number of SBIRT/CRAFFT screenings provided in healthcare settings shall exceed 12% (Oregon Health Authority, 2015). Number of depression screenings and follow-up care provided in healthcare settings shall exceed 12% (Oregon Health Authority, 2015)	Promote policies that support public awareness and acceptance of mental health and substance use wellness strategies.	1.	1.

Parties Responsible/Responsibility	Target Metric	Implementation Progress and Status	
	1.	1.	
Health Indicator(s) addressed	**RHIP Strategy**	**Activity addressing strategy**	**Timeline**
Number of SBIRT/CRAFFT screenings provided in healthcare settings shall exceed 12% (Oregon Health Authority, 2015). Number of depression screenings and follow-up care provided in healthcare settings shall exceed 12% (Oregon Health Authority, 2015)	Increased public awareness of the role of behavioral health wellness in overall wellness will improve patient acceptance of behavioral health screenings.	1. See Mental Health Promotion campaign implementation above	1.
Parties Responsible/Responsibility	**Target Metric**	**Implementation Progress and Status**	
	1.	1.	

The 2017 PCPCH Standards will be implemented in January. We are currently working on the technical specifications for the revised standards and measures, and plan to publish an updated Technical Specifications and Reporting Guidelines document in August. There will be a series of webinars and other communications about the new standards in the fall. You can sign up here to receive announcements about the program and upcoming webinars.

The criteria for the PCPCH Tier 5 recognition – called 5 STAR – aligns with the 3 STAR criteria in the current PCPCH model. The 5 STAR designation distinguishes clinics that are exemplary because they have implemented truly transformative processes into their workflow using the PCPCH model framework and recommended best practices. 5 STAR designated practices must meet the following criteria:

- Be recognized as a PCPCH Tier4 under the 2017 PCPCH Standards
- Attest to 255 points or more on the clinic's most recently submitted PCPCH application
- Meet 11 or more of 13 specified measured (listed below)
- Receive a site visit to verify they are meeting all PCPCH standards attested to. The designation will not be awarded on attestation only.

5 STAR Designation Criteria Measures

Measure 1.B.1 **After Hours Access**	PCPCH offers access to in-person care at least 4 hours weekly outside traditional business hours.
Measure 2.D.3 **Quality Improvement**	PCPCH has a documented clinic-wide improvement strategy with performance goals derived from patient, family, caregiver and other team feedback, publicly reported measures, and areas for clinical and operational improvement identified by the practice. The strategy includes a quality improvement methodology, multiple improvement related projects, and feedback loops for spread of best practice.
Measure 3.C.2 **Referral Process or Co-location with Mental Health, Substance Abuse or Developmental Providers**	PCPCH has a cooperative referral process with specialty mental health, substance abuse, and developmental providers including a mechanism for co-management as needed or is co-located with specialty mental health, substance abuse, and developmental providers
Measure 3.C.3 Integrated	PCPCH provides integrated behavioral health services, including population-based, same-day

behavioral health services	consultations by behavioral health providers.
Measure 4.B.3 **Personal Clinician Continuity**	PCPCH meets a benchmark in the percent of patient visits with assigned clinician or team (80%).
Measure 5.C.1 **Responsibility for Care Coordination**	PCPCH demonstrates that members of the health care team have defined roles in care coordination for patients,-and tells each patient or family the name of the team member responsible for coordinating his or her care.
Measure 5.C.2 **Coordination of Care**	PCPCH describes and demonstrates its process for identifying and coordinating the care of patients with complex care needs.
Measure 5.C.3 **Individualized Care Plan**	PCPCH develops an individualized written care plan for patients and families with complex medical or social concerns. This care plan should include at least the following: self-management goals; goals of preventive and chronic illness care; and action plan for exacerbations of chronic illness.
Measure 5.E.1 **Referral Tracking For Specialty Care**	PCPCH tracks referrals to consulting specialty providers ordered by its clinicians, including referral status and whether consultation results have been communicated to patients and/or caregivers and clinicians.
Measure 5.E.2 **Coordination with Specialty Care**	PCPCH demonstrates active involvement and coordination of care when its patients receive care in specialized settings (hospital, SNF, long term care facility).
Measure 5.E.3 **Cooperation with Community Service Providers**	PCPCH tracks referrals and cooperates with community service providers outside the PCPCH, such as dental, educational, social service, foster care, public health, non-traditional health workers and pharmacy services.
Measure 6.A.1 **Language/Cultural Interpretation**	PCPCH translates written patient materials into all languages spoken by more than 30 households or 5% of the practice's patient population.
Measure 6.C.2 or 6.C.3 **Experience of Care**	6.C.2 - PCPCH surveys a sample of its population at least annually on their experience of care using one of the CAHPS survey tools. 6.C.3. - PCPCH surveys a sample of its population at least annually on their experience of care using one of the CAHPS survey tools and meets benchmarks on the majority of the domains.

RHIP Workgroup Updates: June

Behavioral Health: Identification & Awareness

- This group meets the fourth Tuesday of every month from 9-10am and currently has 20 members.
- In June, the group began problem solving how to track referrals to behavioral health (BH) from primary care (PC). The group discussed coding for a referral even though one is not necessarily required for BH in order to track and follow-up with PC after a patient seeks BH services. In July, the group will review a draft work plan and continue to strategize how to successfully refer to BH and allow PC to receive patient updates. The group will also receive updates on the "Mind Your Mind" project, discuss how to talk about suicidal ideation with patients, and delve more deeply into peer navigators as a strategy to support successful referrals for the region.

Behavioral Health: Substance Use and Chronic Pain

- This group meets the third Wednesday of every month from 4-5pm and currently has 19 members.
- In June, the group discussed a treatment algorithm to support primary care toward better addressing substance use. The group plans to focus their efforts during next month's meeting to develop an expedited and standardized process for intervention and referrals to treatment based on level of risk. This algorithm will be shared broadly throughout the community to offer better alignment and provider education of process. The group will finalize their work plan at the July meeting and have it ready to review by OPs in August.

Cardiovascular Disease—Clinical

- This group meets the fourth Tuesday of every month from 4-5pm and currently has 9 members.
- In June, the group discussed blood pressure standardization in greater detail. Other clinics were invited to participate in the discussion and the decision was made to explore the developing a proposal for a regional blood pressure standardization attestation contest. COIPA, St. Charles, and PacificSource will develop a draft of this in the next four weeks, and it will be part of this group's work plan.

Diabetes—Clinical

- This group meets the second Thursday of every month from 9-10am and currently has 12 members.
- In June, the group decided to develop a standardized care pathway for treating pre- and type 2 diabetes throughout the region. The group will develop this pathway in July and begin to draft their work plan.

Cardiovascular Disease & Diabetes—Prevention

- This group meets the fourth Tuesday of every month from 4-5pm and currently has 25 members.
- This was the first combined prevention workgroup meeting. They spent time familiarizing what each workgroup had in the works prior to combining. Presentations were given on the CDC's School Health Index (SHI) and a CVD and diabetes program resource guide for providers and the community. The workgroup decided to add the SHI to their work plan and were in favor, but will make their final decision by email on adding the resource guide once they have additional information. They will review their draft work plan in July.

RHIP Workgroup Updates: June

Oral Health

- This group meets the third Tuesday of every month from 11-12pm and currently has 19 members.
- Virginia Olea, Mosaic's new dental hygienist, presented Phase I of their new dental pilot. This pilot includes hygienists in each of the Mosaic clinics, with the 'dentist' following the next week. Virginia has become a regular member of the workgroup. Maria Hatcliffe provided a quick training on 'One Key Question'. A great deal of discussion followed regarding how we integrate this initiative at ALL levels/disciplines of care. Brenda Comini and MaryAnn Wren presented on Early Literacy and Health Outcomes – Brush, Book and Bed is a component of their concept paper. A draft work plan will be presented to the workgroup between now and their next meeting for review prior to submission to the Operations Council (probably August).

Reproductive Health/Maternal Child Health

- This group meets the second Tuesday of every month from 4-5pm and currently has 22 members.
- Two presentations were given to the workgroup; first was a data presentation given by Elizabeth Fitzgerald and Jennifer Weeks from Deschutes County Health Department around Adverse Childhood Experiences, the second a proposal presentation given by Tricia Wilder from Planned Parenthood. A draft work plan will be presented to the workgroup between now and their next meeting for review prior to submission to the Operations Council (probably August).

Social Determinants of Health

- This group meets the third Friday of every month from 10-11am and currently has 27 members in kindergarten readiness and 26 members in housing.

Education & Health

- Brenda Comini presented the Kindergarten Readiness Assessment data to the workgroup. There was much discussion and interest in defining the 'whys' around the data. A draft work plan will be presented to the workgroup between now and their next meeting for review prior to submission to the Operations Council (probably August).

Housing

- In June, the workgroup solidified their purpose, bridging housing solutions with the health system. They will focus their efforts on policy around affordable housing and homelessness; advocacy in regarding to helping pass legislation, impacting state and federal housing policies and/or countering NIMBY; outreach and awareness; and new initiatives by being a resource in developing new cross sector (health and housing) initiatives. They will review their draft work plan in July.