Central Oregon Health Council

RHIP Behavioral Health Identification & Awareness Workgroup

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

Agenda: May 22, 2018 from 8:15am-9:15am

Goals

Clinical Goal(s): (1) Increase screenings for depression, anxiety, suicidal ideation, and substance use disorders.
(2) When screenings are positive, increase and improve primary care-based interventions, and, when appropriate, referrals and successful engagement in specialty services.

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

Health Indicators by 2019	QIM Measure	State Measure	Healthy People 2020
1. Number of SBIRT/CRAFFT screenings provided in healthcare settings shall exceed 12% (Oregon Health Authority, 2015).	√		
2. Number of Depression screenings and follow-up care provided in healthcare settings shall exceed 25% (Oregon Health Authority, 2015).	√		
3. First year develop a baseline of successful referral and engagement in specialty care from primary care. Second year develop performance improvement benchmarks.			

1. 8:15 **Introductions—All**

2. 8:15-8:45 **Final Draft Review/Workgroup Member Approval of Application for Regional Behavioral Health Clinic Engagement Position—Leslie Neugebauer**

3. 8:45-8:55 **Mind Your Mind Project Update/Input—Jessica Jacks**

4. 8:55-9:15 **Cross-Pollination/Ideas with other RHIP Workgroups—All**
   - **Clinical CVD**
   - **Clinical Diabetes**
   - **CVD/Diabetes Prevention Workgroup**

5. 9:15 **Action Items—All**
   - **Next steps**

Next Meeting: **June 26, 2018**
(Deschutes County Bldg, 1300 NW Wall St, Bend: DeArmond Room)

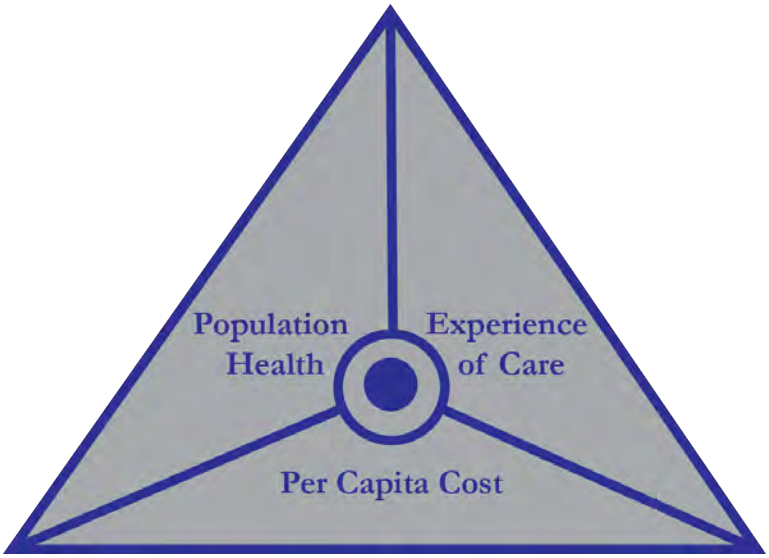
BH Screening and Awareness (14)	Organization
DeAnn Carr, LCSW	Deschutes County Health Services
McKenzie Dean, MD	St. Charles Health System
Janet Foliano	St. Charles Health System
Mike Franz, MD	PacificSource
Sierra Groenewold, LPC	Mosaic Medical
Jessica Jacks, MPH, CPS	Deschutes County Health Services
Katie Keck, LMFT	Rimrock Trails Adolescent Treatment Services
Larry Kogovsek	CAC Consumer Representative
Christy Maciel, PSS	National Alliance on Mental Illness (NAMI)
Leslie Neugebauer, OTR/L, MPH	PacificSource
Kristi Nix, MD	High Lakes Healthcare
Laura Pennavaria, MD	St. Charles Health System
Rick Treleaven, LCSW	BestCare Treatment Services
Molly Wells Darling, LCSW	St. Charles Health System

The Central Oregon Health Council's Regional Health Improvement Application Overview

Thank you for your interest in applying for funding provided by the Central Oregon Health Council. We are excited to partner with the communities where we all live, play, and work. Our Regional Health Improvement Plan (RHIP) is for the benefit of all Oregonians that call Central Oregon home within Crook, Deschutes, Jefferson and Northern Klamath Counties.

Recognizing and hoping we will have interest and applications from 'non-traditional' funding seekers, we seek to explain some of the requirements included in this application. Although our desire is to fund projects for a minimum of one year, innovative one-time projects will also be considered. This is a rolling application process with no established deadlines; however, we do have limited funding resources.

Triple Aim



The Triple Aim is a framework of designing healthcare into a system without errors, waste, delay, and unsustainable costs. The inset illustration is a depiction of the Triple Aim; improving the patient experience of care (including quality and satisfaction), improving the health of populations, and reducing the per capita cost of healthcare. Although the Triple Aim was created through the healthcare lens, it does not preclude efforts that are not typically considered healthcare related.

We hope you will find this application simple and concise. Should you have any questions, please reach out to any of the Central Oregon Health Council staff at 541-306-3523 or info@cohealthcouncil.org.

1 Requestor/Agency

- Please provide project organization and contact information for project lead on this requested investment: Leslie Neugebauer and Mike Franz, PacificSource
- Requestor/agency location(s): Bend, OR
- Will your project include all counties in the region: Crook, Deschutes, Jefferson, and northern Klamath County? If not, why? Yes

2 Project Description/Overview

- Overview
    - Project description: This project was developed collaboratively by the RHIP Behavioral Health Identification & Awareness workgroup after a rigorous A3 process spanning several months of monthly meetings. The project intends to address the primary problem that the RHIP workgroup decided to address: Individuals in our communities are suffering and dying from a lack of a seamless and coordinated conutinuum of care that identifies and effectively responds to behavioral health needs. Our ultimate aim is to identify and engage 100% of individuals in Central Oregon that have a behavioral health need and ensure an effective and timely response. We approach this goal with a health equity lens, intent on eliminating disparities while ensuring culturally repsonsive interventions. To be practical, we limited our scope to primary care. To do this, we envision a target state that 1) universally applies behavioral health screening to the entire Central Oregon primary care population; 2) implements effective behavioral health interventions within primary care to the population screening positive; 3) successfully completes referrals to specialty behavioral health on all members who have a risk stratification indicating that level of intervention is indicated; 4) increases the use of Peer Support Specialists and Recovery Mentors to engage the positively screened population in primary care. To this end, this project will support the employment of an expert in the development and optimization of comprehensive integrated behavioral health in the primary care setting. This person will be able to provide technical assistance to any Central Oregon primary care clinic in the role of champion educator and trainer. The education and training will encompass all aspects of effective integration, from initial universal screenings, to interventions in primary care delivered by a multidisciplenary team inclusive of traditional health workers, to the successful "closed loop" referral to and from specialty behavioral health. The core tasks of the trainer/educator are

        • Facilitate workflows and relationships between community partners to ensure patients' behavioral health needs are being met from screening, engagement, referral, coordination with specialty behavioral health providers, and continuity of care.

- Provide coaching, consultation, and technical assistance to primary care clinics to optimize the delivery of integrated behavioral health care.
- Provide support, training, and resources to help primary care clinics deliver a fidelity model of integrated behavioral health focused on improving population health
- Assess for opportunites to employ peer support specialists/recovery mentors to add value to the delivery of integrated, coordinated behavioral health care
- Assist primary care clinics in complying with the integrated behavioral health requirements of PCPCH, CPC+, and payer initiatives.
- Ensure a culturally responsive approach that also values health equity.

  - Overarching goals of the project: All Central Oregonians seen in the primary care setting with a behavioral health need are identified and receive an effective and timely response.
  - Target population: Central Oregonians who receive services in primary care.
  - Identified need: Individuals in our communities are suffering and dying from a lack of a seamless and coordinated continuum of care that identifies and effectively responds to behavioral health needs.
  - Community support: This project will be supported by the numerous community organizations and stakeholders that actively participated on the RHIP workgroup developing this project. This includes leadership from Deschutes County Health Services, St. Charles Health Systems, PacificSource, Mosaic Medical, Rimrock Trails Adolescent Treatment Services, the Central Oregon Health Council's Consumer Advisory Coouncil, National Alliance on Mental Illness, High Lakes Healthcare, and BestCare Treatment Services.
  - Project timeline: The timeline for this initial project will be 2 years.

- How will we know if you are successful? We will use specific metrics that demonstrate significant progress from the current state to the target state.
- What, if any, are the emerging best practices and/or evidence-based guidelines upon which the project is based? This project is based on the wealth of peer-reviewed literature related to behavioral health integration in the primary care setting. This includes the importance of screening, evidenced-based brief interventions, use of traditional health workers and coordination with specialty behavioral health. One example is the Integrated Behavioral Health Alliance of Oregon's (IBHAO) Standards which are drawn from a rich national evidence base and subsequently synthesised by expert consensus into a concise, single page guidance document that ensures fidelity to a model. These same standards are now part of the Patient Centered Primary Care Home (PCPCH) standards administered by the Oregon Health Authority.
- Does your project/program have any national affiliation(s)? Not specifically though the evidence base for this project is national in scope.

- If your program is evidence-based or best-practice will it be reviewed for fidelity? Yes. The expert trainer will also conduct site reviews to ensure fidelity to the IBHAO and PCPCH behavioral health integration standards.
- Are you seeking any funding matches or additional contributions to support your project? No.
- What is your sustainability plan? First, we anticipate that after 2 years of this project providing comprehensive technical support and education to providers that this specific position may no longer be necessary as the providers will have become champions and experts of this work within their practices. Second, we expect this project to demonstrate Triple Aim value to primary care clinics, specialty behavioral health programs, St Charles Health Systems, the Central Oregon Health Council, insurance carriers, schools, businesses, the justice system, and local/regional government such that the community collectively continues to put forth resources that support comprehensive behavioral health integration in primary care. For example, PacificSource is pursuing value-based contracting and reimbursement to support this work in their contracts with providers and other health plans are likely to do this as well. Finally, the Health Council may consider to continue funding a portion of the costs to sustain this work by allocating some of their targeted annual investment in BH. .
- What is your evaluation plan? The RHIP BH workgroup will review the identified metrics and progress toward the objecives for the project as they pertain to the overall goal of the project.

3 Measurement

- Please complete the "Objectives Chart" that accompanies this application, which can be found here. Grantees are required to complete the Objectives Chart at the start of the project, and at the conclusion so progress can clearly be demonstrated. Please ensure that objectives are written in SMART format, (specific, measureable, attainable, realistic and time-bound).
- Grantees are also required to complete a narrative report annually and at the conclusion of your project. the form can be found here.

4 Project Budget

Part I: Projected Project Revenue from COHC	
	$457,294

Other Project Revenue (e.g., funds from the Global Budget; outside sources of revenue such as grants or support from other community partners; etc.)*	Planned	Requested /Pending	Committed	$0
Total Project Revenue	$	$	$	$

Personnel Costs

Name	Position (FTE dedicated to this project)	Salary	Benefits	Total Cost	Amount Requested
PacificSource Project Coordination	0.1 FTE project coordinator	$6855.84	$3016.57	$ 9872.41	$19,746 for 2 years
		$	$	$	$
		$	$	$	$
		$	$	$	$
	Sub-Total: Personnel	**$6856**	**$ 3017**	**$ 9873**	**$19,746**

Materials & Supplies	Total Cost	Amount Requested
Miscellaneous materials	$2000	$4000 for 2 years
	$	$
	$	$
Sub-Total: Materials & Supplies	**$2000**	**$ 4000**

Travel Expenses	Total Cost	Amount Requested
Car travel 200 miles/week x 46 weeks x $0.545/mile= 9200 miles/year	$5014/year	$10,028 for 2 years
	$	$
	$	$
Sub-Total: Travel Expenses	**$5014**	**$10,028**

Consultants & Contracted Services	Total Cost	Amount Requested
Expert Integration Consultant (0.8 FTE equivalent: vendor billing 32 hrs/week at $130/hr for 46 weeks/year)	$191,360/year	$382,720 for 2years
	$	$
Sub-Total: Contracted Services	**$191,360**	**$ 382,720**

Meeting Expenses	Total Cost	Amount Requested
Host 12 local meetings/year @ $1000/meeting (includes confernece room, all food, materials, any guest speakers' fees)	$12,000	$24,000 for 2years
Attend 4 state meetings connected to this work per year @ $1200/meeting -- registration fees/hotel/food for TA consultant and 1 Workgroup member	$4,800	$9,600 for 2years
24 Lunches @$150/lunch for "Lunch and learnns" at individual clinics	$3,600	$7,200 for 2 years
	$	$
Sub-Total: Meeting Expenses	**$20,400**	**$ 40,800**

Professional Training and Development	Total Cost	Amount Requested
At vendor's expense	$0	$0
	$	$
Sub-Total: Training and Development	**$0**	**$ 0**

Other Budget Items	Total Cost	Amount Requested
	$	$0
	$	$

Sub-Total: Other	**$0**	**$ 0**
Total Project Budget	**$**	**$ 457,294**

Application Checklist

5 Application Checklist

- Did you complete all portions of the application? Yes ☒ No ☐
- Did you include a proposed budget? Yes ☒ No ☐

- Does your proposal align with the Triple Aim? Please briefly explain how:
- Does the project have reach to all counties in the Region (Crook, Deschutes, Jefferson and Northern
- Klamath) Yes ☒ No ☐ If not, why?
- Was your project solicited by a RHIP workgroup as part of an A3 process? Yes ☒ No ☐
- Did you present your project to the appropriate RHIP workgroup? Yes ☒ No ☐
- Is your proposal outside of a RHIP workgroup? Yes ☐ No ☐
- What component(s) of the RHIP does your proposal impact (please select all that apply)

☒ Behavioral Health Identification and Awareness
☐ Behavioral Health Substance Use and Chronic Pain
☐ Cardiovascular Disease: Clinical
☐ Diabetes: Clinical
☐ Cardiovascular Disease and Diabetes Prevention
☐ Oral Health
☐ Reproductive & Maternal Child Health
☐ Social Determinants of Health: Education & Health
☐ Social Determinants of Health: Housing

OR

☐ My proposal addresses a pillar 10 vital condition:

☐ Education
☐ Equity, Social Connection & Civic Muscle
☐ Jobs & Wealth
☐ Preventative Services & Policies
☐ Stable Housing
☐ Child Abuse Prevention
☐ Safe Neighborhoods
☐ Physical Activity
☐ Nutritious Food
☐ Healthy Environment
☐ Arts & Recreation
☐ Mental Health Care

6 Application Submission

- Completed applications and attached budget proposals must be submitted via email to Donna.Mills@cohealthcouncil.org.
- If you have questions or need any assistance, please contact any member of the COHC staff at 541-306-3523.

7 Process Following Submission

- Projects will be assigned a RHIP Project identifier.
- Projects will be reviewed for minimum requirements as indicated in the application checklist.

Central Oregon Health Council

INVESTMENT OBJECTIVES CHART

Date: 5/15/2018

Organization PacificSource **Investment/Project Name BH Integration Trainer**

RHIP Applicability

If your proposal was submitted through a RHIP Workgroup's A3 process, it must contain at least one metric that corresponds with a RHIP workgroup's A3.

If your proposal was submitted outside of a RHIP workgroup, you must select at least one pillar 10 vital condition that it addresses.

Select RHIP Workgroup:

- [x] BH Identification/Awareness
- [ ] CVD: Clinical
- [ ] Oral Health
- [ ] Substance Use & Chronic Pain
- [ ] SDOH: Milestones Ed/Health
- [ ] Diabetes: Clinical
- [ ] Reproductive/Maternal Child
- [ ] CVD/Diabetes Prevention
- [ ] SDOH: Housing

Select workgroup metric that your proposal addresses (select all that apply):

- [x] Increase screenings for depression/anx/s.i/SUD
- [ ] Improve hypertension control
- [ ] Normalize public's perception of behavioral health
- [ ] Improve control type II diabetes
- [ ] Create bi-direc/integrated approach for SUD
- [ ] Keep children cavity free
- [ ] Responsible prescribing Opioids and Benzos
- [ ] Kindergarten readiness
- [ ] Increase awareness of risk factors for CVD
- [ ] Third grade reading scores
- [ ] Decrease the # of those at risk for type II diabetes
- [ ] Stabilize 200 chronically homeless
- [ ] Improve oral health pre/post-natal women
- [ ] Prevent unintended pregnancies
- [ ] Reduce prevalence of low birth weight infants
- [x] Improve primary care response when behavioral health screen is position

- [ ] My proposal is outside of a RHIP Workgroup and addresses a pillar 10 vital condition

Please select pillar 10 vital condition (select all that apply):

- [ ] Education
- [ ] Physical Activity
- [ ] Equity, Social Connection & Civic Muscle
- [ ] Jobs & Wealth
- [ ] Preventative Services & Policies
- [ ] Stable Housing
- [ ] Child Abuse Prevention
- [ ] Safe Neighborhoods
- [ ] Nutritious Food
- [ ] Healthy Environment
- [ ] Arts & Recreation
- [ ] Mental Health Care

Objective	Relevant Historical and/or baseline data	Expected Results	Actual Results (*To be completed at the end of Grant Period.)*	Source of data
1. Increase appropriate behavioral (bx) health screenings and populations screened within all primary care, to 100% universal screening in Central Oregon.	Baseline bx health screenings and populations screened within all primary care in Central Oregon is not at 100%.	By 6.30.20 engage (X number) of primary care clinics in Central Oregon and implement universal screening process at 100% of engaged clinics.		
2. Increase internal behavioral health responses based on positive screening to 100%.	Response(s) to internal bx health screens that are positive is/are not at 100%.	By 6.30.20 provide education and training to (100%) of engaged primary care clinics on best practice for providing an appropriate response to 100% of patients who screen positive on universal screening tool.		
3. Increase completed external/outside referrals from inside primary care to specialty bx health care based on risk by 100% from baseline.	External/outside referrals from inside primary care to specialty bx health	By 6.30.20 provide education and training to 100% of engaged primary care clinics on best practice for referring patients to		

	provider based on risk is not at 100%.	specialty bx health care based on patient's risk.		
4. Complete a gap analysis regarding the use of Peer Support Specialists (PSS) and/or Recovery Mentors(RM) in primary care.	Little to no use of Peer Support Specialist (PSS)/Recovery Mentors (RM) used to engage patient.	By 6.30.20 provide a gap analysis of the use of PSSs/RMs and provide to results to 100% of engaged clinics		
5. Increase the number of completed and timely referrals from primary care to specialty behavioral health care when behavioral health needs of patient are greater than clinic can manage.	(The CMHPs track this and submit it to PS – Melanie Harris or Jeremy Fleming should have baseline data on this)	By 6.30.20 (x%) of patients identified by primary care as needing a referral to specialty bx health care will have received an intake with the specialty bx provider within 2 weeks of referral.		*Aspirational measure. Requires engagement and resources from primary care clinics and specialty bx health providers. Denominator: Total number of patients referred externally to bx care. Numerator: of those referred, number of pts who received an intake w/in 2 weeks of referral

6. Increase engagement with behavioral health patients following their intake to specialty bx care.	(Baseline data from Q1 2016-Q3 2017 shows this metric at ~39%)	By 6.30.2020 (x%) of the patients that received a bx health intake will have received 3 services within 60 days of their initial assessment.		*Aspirational measure. Denominator: That pts referred from primary care that received an intake at a specialty bx health provider. Numerator: the pts that received 3 services within 60 days of their intake.
7. Increase care coordination & communication.	No current baseline data	By 6.30.20 primary care clinic(s) will have received at least one chart note from specialty bx provider for (x%) of patients that had been referred externally for bx heath care.		*Aspirational measure. Requires engagement and resources from primary care and specialty bx providers. Denominator: Number of pts who received an intake with specialty bx provider. Numerator: Number of pts for

				whom the primary care clinic received at least one chart note from the bx health provider.

MYM Primary Care Provider Partnership Input

Below is a list of potential items to help inspire a culture of support and acceptance around mental health challenges and care. These item would be contained in a "toolkit" and distributed to primary care office managers for implementation. After you have reviewed this plan we will send out a fillable PDF form and ask you to complete and make comments as appropriate.

Mind Your Mind website and handout card

A Mind Your Mind branded website will be developed to provide local mental health care resources and information. Primary care teams will be encouraged to hand out a MYM business card to patients as appropriate. The card will direct patients to the MYM website address and QR code.

Website content to include:

- Emergency call 911
- Key messages from communication plan
- List of Central Oregon resources
- List of National resources
- Symptoms/signs of depression
- Tips and lifestyle changes for daily mental health maintainence and ways to mind your mind
- Links to articles pertaining to mental health
- General information about the science of the brain
- Inspirational videos/storytelling
- Frequently Asked Questions
- (Phase 2: Champions video(s), blogs)

Exam Room Poster

Poster would remind patients to think about their "brain" health as they would the health of any other part of their body. It would encourage patients to "Mind their Minds" on a daily basis and talk to their primary care providers if they have stress or anxiety. Poster would display the Mind Your Mind website address and QR code.

Mind Your Mind table top display

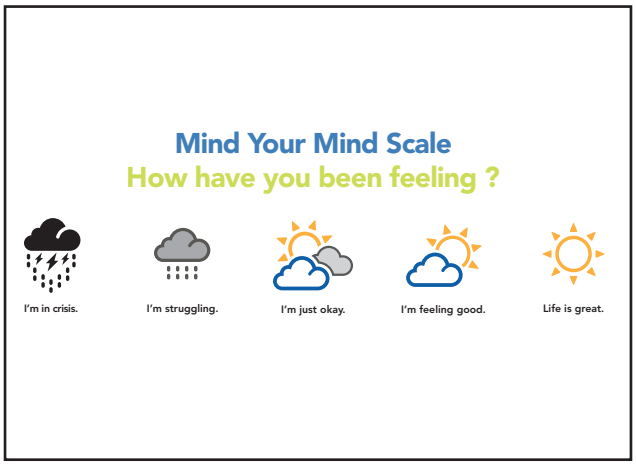
This message on this small free-standing display would be similar to the MYM poster: reminding patients to think about their "brain" health as they would the health of any other part of their body and encourage patients to "Mind their Minds" on a daily basis. Also, a reminder to share any fellings of depression or anxiety with their primary care provider. Display would feature the Mind Your Mind website address and QR code.

Mind Your Mind rack-style brochure

Brochure content would contain educational information on mind health and the science of the brain in layman's terms. Content to stress the importance of "minding your mind" on a daily basis and give simple tips and lifestyle changes that could help relieve common stress and anxiety. Brochure would direct patients to the Mind Your Mind website address and QR code for more detailed information and local mental health care resources.

Exam Room Mental Health Scale

A visual mental health scale (example below) would be designed similar to the ubiquitous "pain scale" seen in hospital and exam rooms. This scale could help primary care providers quickly asscess a patient's need for resource referral.



Thank you!

Thank you for your time in reviewing this plan. We look forward to hearing your thoughts and suggestions once you receive the fillable PDF form.

— The Mind Your Mind Team

COHC Spring 2018 RHIP Updates

Behavioral Health Identification & Awareness

AIM: Identify and engage 100% of individuals in Central Oregon that have a behavioral health need and ensure an effective and timely response.

Recent Activities

- Voted to request PacificSource house a regional behavioral health support person.

Behavioral Health Substance Use & Chronic Pain

AIM: All Central Oregonians with a SUD that enter the hospital system including the ED will receive engagement, treatment, or harm reduction services.

Recent Activities

- Collected LOIs from organizations to employ two individuals embedded in St. Charles Bend who will support and make referrals for SUD patients.

Cardiovascular Disease & Diabetes Prevention

AIM: Cost will never be a barrier to participate in a variety of physical activities for students.

Recent Activities

- Released RFP and awarded funds for region-wide project to increase Active Modes of Transportation for youth
- Drafting RFP for region-wide project for provider-based referrals to physical activity for youth

- Began A3 to increase healthy diets in Central Oregon

Cardiovascular Disease Clinical

AIM: Reduce the rate of youth tobacco use in Central Oregon from 17.3% to 15% in 8th graders, and 23.2% to 20% in 11th graders.

Recent Activities

- Discovered few resources exist for helping teens quit tobacco. Held focus groups and determined those resources were not well-received.
- Pursuing more information regarding the work of school-based health centers in reference to tobacco.

Diabetes Clinical

AIM: 95% of Central Oregonians with Type 2 Diabetes will have an HbA1c of < 9%

Recent Activities

- All A1c algorithms completed
- Preparing comprehensive diabetes materials roll-out events in three locations (Bend, Madras, Prineville) in September for all healthcare providers.
- QIM grant clinics are being trained and processes are being put in place for Point of Care A1c testing.
- **Funded Initiative:** High Desert Food & Farm Alliance Veggie Rx Pilot

Oral Health

AIM: Improve Oral Health and keep children cavity free.

Recent Activities

- Cross proposal with Diabetes Workgroup
- Launch New A3 – Oral Health for the older adult
- Launch New A3 – Integration with Primary Care initiative

Reproductive Maternal Child Health

AIM: Prevent Unintended Pregnancies

Recent Activities

- Released RFP for Unintended Pregnancies media campaign
- Partnered with Power to Decide to bring a One Key Question training to Central Oregon
- Partnering with Milestones workgroup on Early Learning pathways

SDOH: Housing

AIM 1: Central Oregon communities have sufficient, actionable data to guide direction, establish priorities, support regional solutions and bring a call to action to mobilize citizens to create a healthier Central Oregon.

AIM 2: The approximately 200 chronically homeless and/or high utilizers in Central Oregon will be stabilized and supported to achieve well-being.

Recent Activities

- Began work on homelessness prevention A3.
- **Funded Initiatives:** Sisters Habitat for Humanity, Sisters Cold Weather Shelter, Redemption House, Jericho Road, Thrive

SDOH: Milestones to Health & Education

AIM 1: Central Oregon children become more resilient

AIM 2: Every Central Oregonian thriving in the face of diversity

AIM 3: Children in Central Oregon have lifelong health and learning challenges due to lack of early identification and access to services

AIM 4: Every child in kindergarten has the early literacy skills to be ready to learn

Recent Activities

- Nurturing 3 subgroups; Literacy, Social and Emotional, Access to Integrated Services (TRACEs part of Social and Emotional subgroup)
- Literacy team partnering with Equity Team around reading program proposal
- TRACEs awarded $2m by COHC Board of Directors
- Partnering with Reproductive Maternal Child Health on Early Learning Pathways