Central Oregon Health Council

RHIP Behavioral Health Identification & Awareness Workgroup

Deschutes County Health Services (2577 NE Courtney Drive, Bend) Stan Owen Room

Agenda: March 26, 2019 from 8am-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. 8:00-8:05 **Introductions—All**

2. 8:05-8:55 **Discuss Findings & Brainstorm Projects: Advancing Integrated Care—Dawn Creach**
   - **Results of Findings by Payer Type**
   - **Ideas for Additional Workgroup Investments/Funding**

3. 8:55-9:05 **Mind Your Mind Project Update—Rebeckah Berry**

4. 9:05-9:10 **Reliance eHealth Platform Update—Michael Heidenreich**

5. 9:10-9:15 **Action Items/Next Steps—All**
   - **Other Updates**

Next Meeting: **4.23.2019 (Deschutes County Bldg., 1300 Wall Street, Bend: DeArmond Room)**

BH Screening and Awareness (13)	Organization
Dawn Creach, MS	Consultant: Advancing Integrated Care Project
Barrett Flesh	Deschutes County Behavioral Health
Janet Foliano, PsyD	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	NAMI
Kristi Nix, MD	High Lakes Healthcare
Laura Pennavaria, MD	St. Charles Health System
Jason Prinster, PhD	High Lakes Healthcare
Rick Treleaven, LCSW	BestCare Treatment Services

BH ID & Awareness Workgroup: AIC Project Status Update March 2019

AIC Project Support

- PacificSource provides budget management, AIC Workgroup meeting coordination & support, payment administration, and in-kind contribution of Dr. Franz's time & expertise
- Creach Consulting, LLC identified the need for additional support to conduct trainings, CME, project coordination, and other support to facilitate delivering technical assistance
- BH ID & Awareness Workgroup approved proposal at February meeting to add a project coordinator. Creach Consulting, LLC contracted with Erin Solomon for 5 hours/week of AIC support (70 weeks X 5 hrs/week X $40/hr = $14,000 + $1,000 for mileage reimbursement). Funds included in current budget and will be tracked separately as AIC coordination & support. This support will help expand training & TA offerings.

Technical Assistance/Trainings in Progress – Actions steps to start addressing some of the identified needs/gaps

✓ **Building Bridges Between Behavioral Health and Primary Care**

- Vison: Ongoing forum that brings together behavioral health and primary care providers to improve access and coordination
- April 18th 5:30 – 8:00pm at Deschutes Brewery in Bend – Completely full and extensive wait list(!)
  - Significant time being spent on managing the event, making sure the right people are there and that most organizations are adequately represented, and managing the wait list
- Target audience: primary care providers, integrated BHCs, private practice and community-based behavioral health clinicians, BH care coordinators, clinic administrators
- CME Approved! Primary care providers, psychologists, LCSWs, and LPCs will receive CME/certificate of attendance at no cost
- Plan to hold similar meetings in La Pine, Madras, and Prineville

✓ **Developing and supporting best practice pilot sites** – Dawn is facilitating and supporting organizations to help establish "good neighbor" / coordination agreements to outline expectations & processes for increased access & coordination. Some CPC+ clinics may be required to have agreement in place; BH providers have no incentive to participate other than desire to provide better care

- High Lakes and Brightways Counseling Group
- St. Charles and Brightways Counseling Group

- Cascade IM Specialists and Liza Abelson-Gertler, private practice psychologist
- Rimrock Trails and TBD pediatric clinic (?)

✓ **Working closely with COIPA to explore options for smaller practices that don't already have integrated behavioral health**

✓ **BHC Community of Practice & Learning Collaboratives**

- Exploring possibility of training for integrated BHCs around short-term evidence-based treatment for patients with trauma, as well as other topics TBD based on TA survey in development
- Planning to launch TA survey by end of end of April 2019

AIC Grant Outcomes - Data Collection Plan

- Draft measure specifications completed and plan to distribute at AIC Workgroup meeting on 2/25:
  - Metric #1: Completed Referrals: Timely access to specialty behavioral health
  - Metric #2: Access to & engagement with specialty behavioral health treatment
  - Metric #3: Care coordination & communication between primary care & specialty BH
- This is a voluntary effort and would require significant resources from primary care clinics to collect & report data (Fingers crossed that some clinics will participate!)

Regional Needs Assessment

- Dawn will write final report with results from needs assessment
- AIC needs assessment results will be included in the RHA

Results from Regional Needs Assessment

- **December -** Presented high level results based on themes consistently heard across ALL populations (Medicaid, Medicare, Commercially Insured, All Geographic Areas)
- **January –** Presented results based on themes for each of the 5 key components of the AIC project
- **March –** Present results based on insurance type (Medicaid, Medicare, commercial and considerations for special populations)

Medicare Insured

- Many key informants reported that access to BH is the most difficult for Medicare patients
    - Places huge burden on Internal Medicine & rural primary care clinics – LOTS of Medicare patients in Prineville, La Pine, Madras
- Medicare patients include older adults but also young disabled adults, many of whom have very high needs
- Very few private practice BH providers accept Medicare; Belief that it is burdensome, pays the least, and has increased chances of audits
- Lack of Medicare payment for LPCs is huge barrier, particularly in rural areas
    - PacificSource Medicare Advantage started to reimburse LPCs on 1/1/19 to help address this, but most patients have Medicare standard (and it's a federal CMS issue)
- FQHCs in Central Oregon care for a significant number of Medicare patients; lack of specialty BH access puts significant strain on integrated BHC
- Dawn is working with HealthInsight to find potential avenues to share barriers/needs with CMS/Medicare

Commercially Insured

- Access is a real barrier - Commercially insured people have few options, particularly for those with high needs
- Many private practice BH providers tend to only accept insurance plans that pay the most or do not accept insurance at all; contributes to lack of access
- Many patients report that private practice BH providers do not pick up the phone and do not call patients back, or have a voice message that says they are full and not accepting new patients
    - Culture shift needed: Tree to forest perspective; Being full is considered a "successful private practice"
    - No incentive to do anything different
- Commercial insurance does not reimburse for any of the wrap-around, coordination, or team-based services
    - This makes private practice BH providers uncomfortable with risk and unable to care for many higher-needs patients
- Private practice BH providers are stuck on the fee-for-service rat wheel that disincentivizes better coordination & access
    - Unable to be reimbursed for coordination or non-face-to-face services; no incentives to provide more timely access

    - Lack of a large specialty BH organization in Central Oregon that would allow for group and value-based contracting, more accountability, infrastructure, etc.
  - For integrated BH in primary care, inconsistent payment coverage across many commercial health plans is a huge barrier
    - Primary Care Payment Reform Collaborative's new policy recommendations would solve many payment issues, if truly implemented across all payers

Medicaid/CCO Insured

- For Medicaid patients with the highest needs, the full array of services available at CMHPs is very helpful
- Timely access is a problem but has improved recently
  - Primary care clinics report long waits for people to access care at CMHPs. Patients can get in for an assessment, but treatment is a long wait
  - PacificSource opening the Medicaid panel to outpatient BH providers has helped with access and people finding the right level of care, but more providers are needed
- CMHPs operate under a wide range of OAR requirements, outcome requirements, and capitation limitations – they feel misunderstood and under-appreciated
  - At the same time, primary care is frustrated that behavioral health is different than other medical specialties
- Many patients do not want to participate in group therapy sessions, which are required, so they end up in primary care
- Very little ability to step up/step down patients - PCPs won't take patients back from specialty because of the inability to get them back into specialty BH in a timely manner
- Lack of trust between primary care & specialty BH - both feel like patients are "dumped" on them
- Opportunity for better coordination among organizations with Epic EHR, e.g. primary care clinics reported that DCBH not entering patient medications in Epic
- Many private practice BH providers believe Medicaid is "too burdensome," they are nervous about liability when caring for higher-needs people, and that the PacificSource Medicaid panel in Bend is "closed" (which is not accurate)
  - Private practice BH providers who are accepting Medicaid report generally good experiences and competitive payment rates

Considerations for Special Populations

- Harriman Health Center at DCBH downtown clinic & the Cascade Peer Center are providing great care for people with SMI and those experiencing homelessness
    - Peers are critical members of the care team & addressing social determinants of health
    - Funding for the Cascade Peer Center is tenuous
- Access to BH is especially acute in rural areas (Prineville, Madras, La Pine, Warm Springs)
    - Lack of access takes many forms, is multi-dimensional and has many root causes, not just a workforce shortage issue
- Access to BH is especially difficult for people who speak Spanish; Lack of bi-cultural, bi-lingual behavioral health providers
- Lack of services for pediatric patients, especially for adolescents, early childhood (0-5), and eating disorders
    - Private practice BH providers often see children as "too risky"
    - Lots of confusion about where to send children with developmental issues - Do we need a centralized "hub" to send patients/families?
    - Lack of clear pathways & supports for new parents, positive post-partum depression screenings, etc.
    - Lack of capacity and reimbursement for prevention & early intervention of early childhood social-emotional issues
    - Opportunity for AIC project to partner with Oregon Pediatric Improvement Partnership to address 0-5 social-emotional health
- Native Americans & Warm Springs Reservation – Lack of BH access & stigma
    - Health & Wellness Center has "medical social worker" but is not embedded into the primary care clinic (they would like to change this)
    - Specialty BH located in a separate building – would like to integrate with the rest of healthcare services in new building planned for next 3-5 years
    - Stigma around mental health & small community issues - Lots of tribal members travel to Madras for BH care

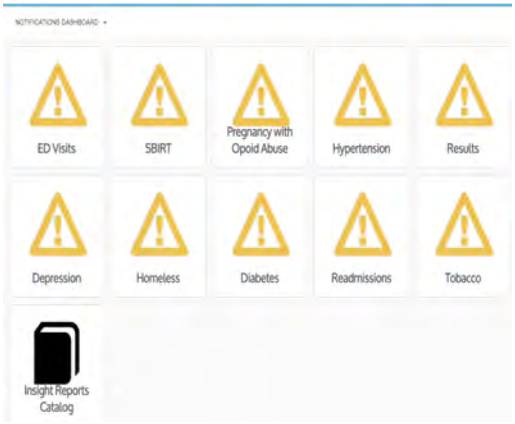
All Data Contributors to Reliance Community will have access to a "*Notifications Dashboard* "of 10 which list 10 reports that they can click on and run at any time. The Report Details are:

Report Name	Purpose
ED Visits	This report provides a list of patients that have visited the Emergency Department. The output shows how many times a patient has visited the ED and provides a column to show if a patient has any indication of mental illness. Mental illness is defined according to the Oregon Health Authority Members Experiencing Mental Illness Value Set that is defined here: https://www.oregon.gov/oha/HPA/ANALYTICS/CCOData/disparity-ED-utilization-mental-illness-2018.pdf
SBIRT	This report provides a list of patients aged 12 and older who received appropriate "screening, brief intervention, and referral to treatment" (SBIRT) for alcohol or other substance abuse.
Opioid Abuse	The purpose of this report is to identify patients that have a diagnosis of opioid abuse.
Pregnancy with Opioid Abuse	The purpose of this report is to identify patients with a positive pregnancy screening and have a diagnosis of opioid abuse. UMLS coding concepts: 2.16.840.1.113883.3.666.5.1595 I 2.16.840.1.113883.3.464.1003.106.12.1004
Hypertension	The purpose of this report is to identify patients 18-85 that have a blood pressure reading > 125/90mmHg
Results	The purpose of this report is to identify if patient results are available for viewing. Report parameters filter allows end user to run by result type (All, Lab, Micro, BLB, PTH, RAD,TRANS)
Depression	This report identifies patients aged 12 and older who were screened for clinical depression using an age appropriate standardized depression screening tool but were missing follow-up on the date of the positive screen.
Homeless Report	The purpose of this report is to identify patients that may be homeless. We use a combination of diagnosis codes and text based searches to identify possible homeless patients. UMLS coding concept: 2.16.840.1.113883.3.666.5.1595
Diabetes Management	This report identifies patients 18-75 years of age whose most recent HbA1c level (performed during the measurement period) is >9.0%.
Readmission Under 30 Days	This report generates a list of readmissions within the measurement period that occurred less than 30 days before last discharge from a hospital.
Tobacco Use 13 and Older	The purpose of this report is to identify patients 13 and older on the date of service and are tobacco users.

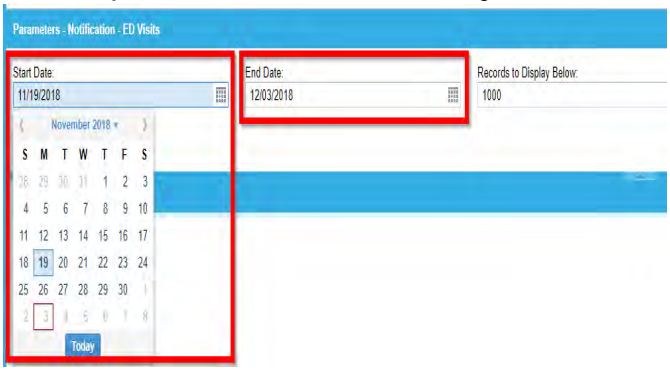
To Run a report:

1. Open CHR 2.0
2. Open the Notifications Dashboard

3. Select the Notification Report you wish to run

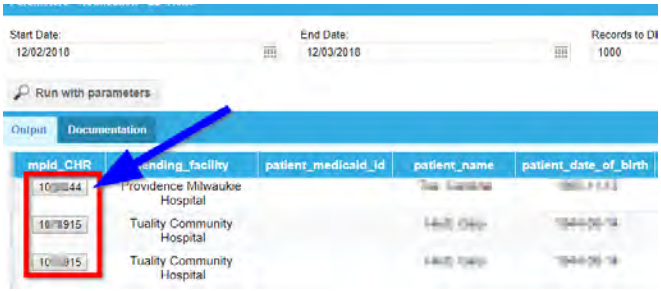


4. Define the parameters you would like to run. Note each report has been preset to default parameters that can be adjusted



Note: *Record to Display* field assists in speeding up the running of a report.

5. To access/review the individual Patients Community Health Record, click on the mpid_CHR icon in the first column.



6. To see all data rows associated to report download a .CSV version of the report