Hospital Performance Metrics Advisory Committee
&
Metrics and Scoring Committee

Joint Behavioral Health Learning Session

Oregon Health Authority

Office of Health Analytics

Welcome and Introductions

Robin Gumpert, Facilitator

Oregon Health Authority

OHA Behavioral Health Updates

Karen Wheeler, MA, OHA

Justin Hopkins, OHA

Oregon Health Authority

Behavioral Health Strategic Initiatives and Mapping Efforts

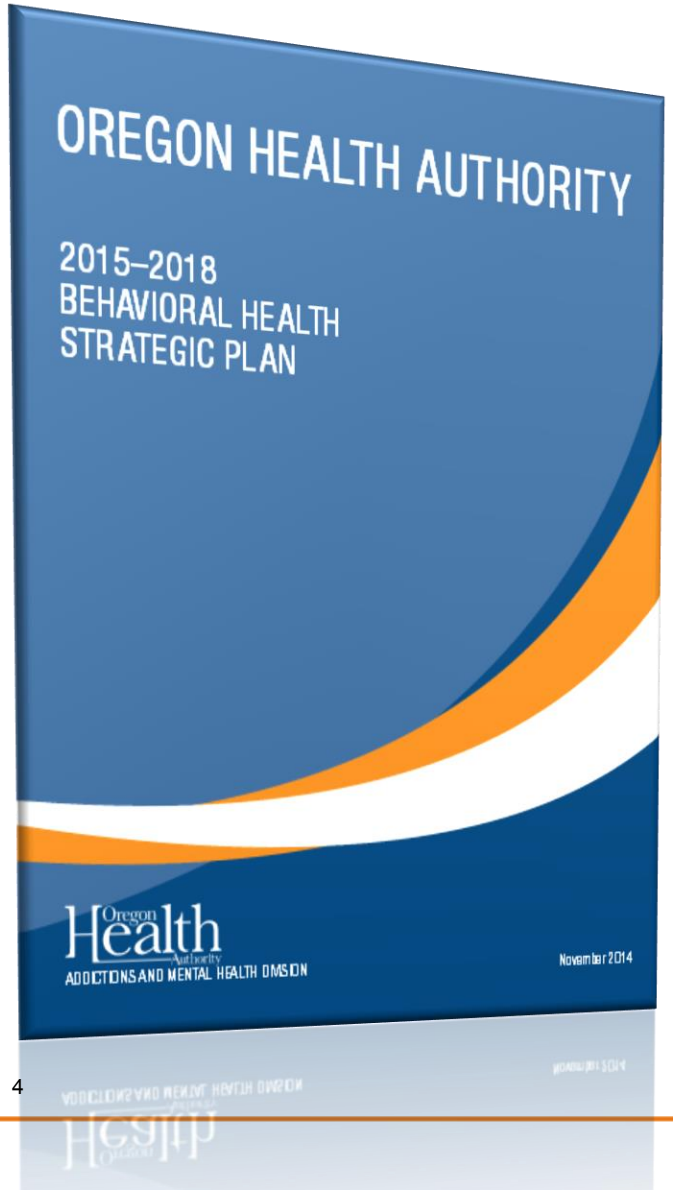
Prepared for
Hospital Performance Metrics Advisory Committee and Metrics and Scoring Committee
Joint Learning Session on Behavioral Health

Justin Hopkins, Compliance and Regulatory Director,
Health Systems Division

Karen Wheeler, Business and Operational Policy Director,
Health Systems Division

Oregon Health Authority

Behavioral Health Strategic Plan (2014)



- Support health equity for all Oregonians
- Provide access to a full continuum of evidence based care
- Promote healthy communities and prevent chronic illness
- Support recovery and a life in the community
- OSH resources are used wisely; discharge is timely
- HSD (formerly AMH) operations support the plan

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Update on use of plan

- Provides guidance to Mental Health and Substance Abuse Prevention and Treatment Block Grant activities
- Measurements have been defined for objectives in the plan and will be reported to SAMHSA
- Still relevant to Oregon State Hospital goals as written in that section of the plan

Behavioral Health Town Halls

- Currently working with Senator Sarah Gelser, members of the legislature and other stakeholders to formulate the vision for behavioral health services in Oregon
- Conducted three of six scheduled behavioral health town hall meetings
- Goal is to listen and learn from the experiences of consumers and people in recovery, family members and the community

Dates, times and locations for remaining town hall meetings

Astoria	Wednesday, Nov. 4	5:00-8:00 p.m. at The Loft: 20 Basin St, Suite F, Astoria
Albany	Monday, Nov. 9	5:00-8:00 p.m. at Linn County Fair Expo: 3700 Knox Butte Rd, Albany (Conf Room 3-4)
Portland	Friday, Nov. 20	3:30-8:00 p.m. at Portland State Office Building: 800 Oregon St., Portland • First meeting: 3:30-5:30 p.m. • Second meeting: 6:00-8:00 p.m.

http://www.oregon.gov/oha/amh/Pages/strategic.aspx

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Behavioral Health Mapping Tool

- **Needs Assessment (current state) -** Behavioral health needs defined by population groups (children, adolescents, adults, families) and demographic variables (population, prevalence, severity, socio-economics, diversity).
- **Needs Projection Model (dynamic) -** A method projecting behavioral health service needs over time with contributing variables such as current funding picture, demographic factors and major related systems: juvenile/adult justice and educational systems.

Behavioral Health Mapping Tool continued

- **System and Client Outcomes Measurement –** A process for measuring community/system, provider and client outcomes that connects to the contracts and resources supporting these services. This process needs to include a dynamic relationship between outcomes and funding.

Behavioral Health Mapping Tool update

- **Phase I (complete):** Developed draft county profiles and an interactive map of Oregon with high-level behavioral health data organized by county.
- **Phase II:** A more fully developed **funding** picture for each county including local and other funds that go directly to the county for behavioral health services.

Behavioral Health Mapping Tool update continued

- The tool is to be populated with **services** data on the non-Medicaid supported services.
- The tool is to be populated with **outcomes** data.
- OHA has formed a technical advisory committee. The committee will review the tools generated for this initiative and provide input to OHA during policy discussions about a service gaps, funding, outcomes and return on investment.

http://www.oregon.gov/oha/amh/Pages/bh_mapping.aspx

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Mapping Tool overview

Refer to handouts and interactive map demonstration.

http://geo.maps.arcgis.com/apps/Viewer/index.html?appid=8ca7822f3e9143c580b08873ac29e036

Questions?

Contact:

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Justin.hopkins@state.or.us

Oregon Health Authority

Panel 1

Dr. Chris Farentinos, Legacy Health

Dr. Laura Fisk, Yamhill CCO

Justin Keller, JD, MPH, OHA

Oregon Health Authority


unity
center for
behavioral
health

Metrics Committee
BH Learning Session
October 30, 2015

Chris Farentinos, MD, MPH
Director Behavioral Health Services
Legacy Health

Regional Dedicated Emergency Psychiatric Facilities

- Can accept walk ins and ambulance/police directly
- Medically unstable patients still have to go to medical ED
- Considered outpatient service, no need for a “bed” – most programs use recliner chairs
- Focus is on relieving acute crisis and referral, not comprehensive psychiatric evaluation

Regional Dedicated Emergency Psychiatric Facilities

- Will treat on-site for up to 23 hours and 59 min (or longer in some areas) avoiding inpatient stays
- Can be expensive to staff and maintain 24/7
- Typically only makes sense for systems >3000 psychiatric emergencies/ year
- Of great interest for insurance companies, which are often willing to pay more than daily rate for inpatient hospitalization

Regional Dedicated Emergency Psychiatric Facilities

- Examples:
  - John George Psychiatric Emergency Service (PES)- Oakland, CA
  - Connections AZ
    - Urgent Psychiatric Center – Phoenix, AZ
    - Crisis Response Center – Tucson, AZ
  - Recovery Innovations – Peoria AZ
  - Unity Center for Behavioral Health PES - Portland, OR

Alameda Model – John George PES

- Averages 1200-1500 very high acuity psychiatric patients/ month, approximately 90% in involuntary detention
- Focus is on collaborative, non-coercive care involving therapeutic alliance when possible
- Presently averaging 0.5% of patients placed in seclusions and restraints – comparable USA PES programs average 8-24% of patients in seclusions and restraints

Alameda Model – John George PES

- EMT - protocol for medical clearance and safe transport
- EMT transports to PES or ED
- Any patient over 65 goes first to nearest ED for medical clearance
- 35% patients come from 11 other local EDs
- 35 recliners
- Were able to reduce the local EDs boarding time from 10.5 hours to 1 hour and 20 minutes
- John George PES discharges 75% of the patients

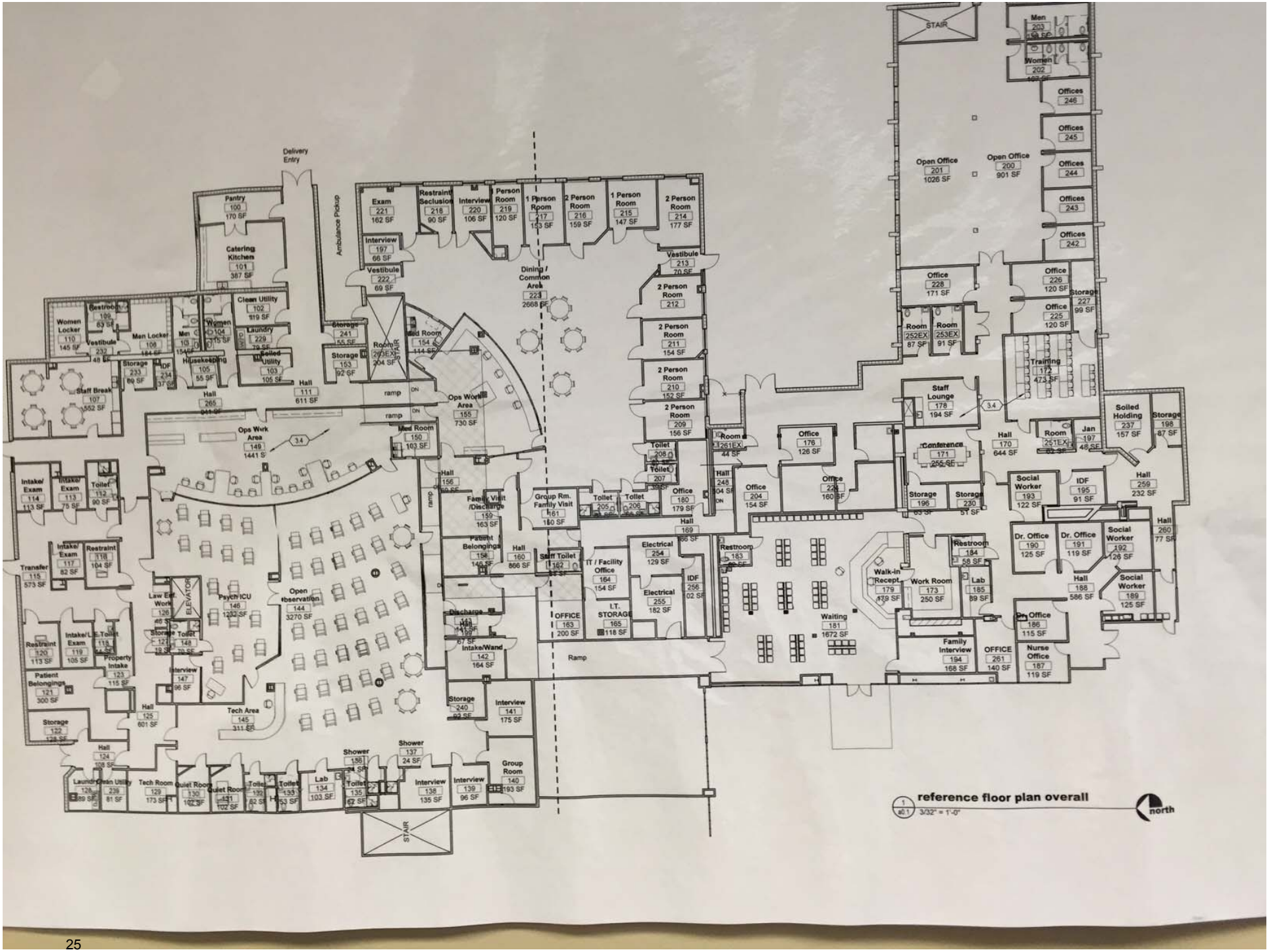
2014 Alameda Model PES Study

- Published in the Western Journal of Emergency Medicine
- http://scholarship.org/uc/item/01s9h6wp
- psych patient boarding times in area ED were only one hour and 48 min – compared to CA average of ten hours and 03 min
- Approximately 76% of the patients were discharged from the PES avoiding unnecessary hospitalization

Connections AZ – Urgent Psychiatric Center- UPC

- UPC has three different programs:
  - Urgent clinic – bridge medication
  - PES – 23 hour observation model
  - 16 bed adult inpatient unit
- 35-36 patients per day
- ALOS summer is 24 hours, winter is 16 hours
- About 20% are SMI
- 32 chairs - separate areas by gender.
- Focus on crisis or danger to self or others. Strong medical necessity orientation
- 900 pt brought by back door each month, 85% involuntary. 100 pt through the front door walk in
- Police turn around wait is 7 min
- All staff CPI trained


PERFORMANCE
&
GOALS


reference floor plan overall
3/32" = 1'-0"
north

Recovery Innovations

- Peer lead organization
- Strong culture of shared power
- Culture of recovery and hope
- Offer choices to guests
- “no force first” culture
- Healing Environment - with light, windows, plants.
- When pt shows up meets nurse and peer, which is the first encounter
- Train staff on CPI and Therapeutic Options

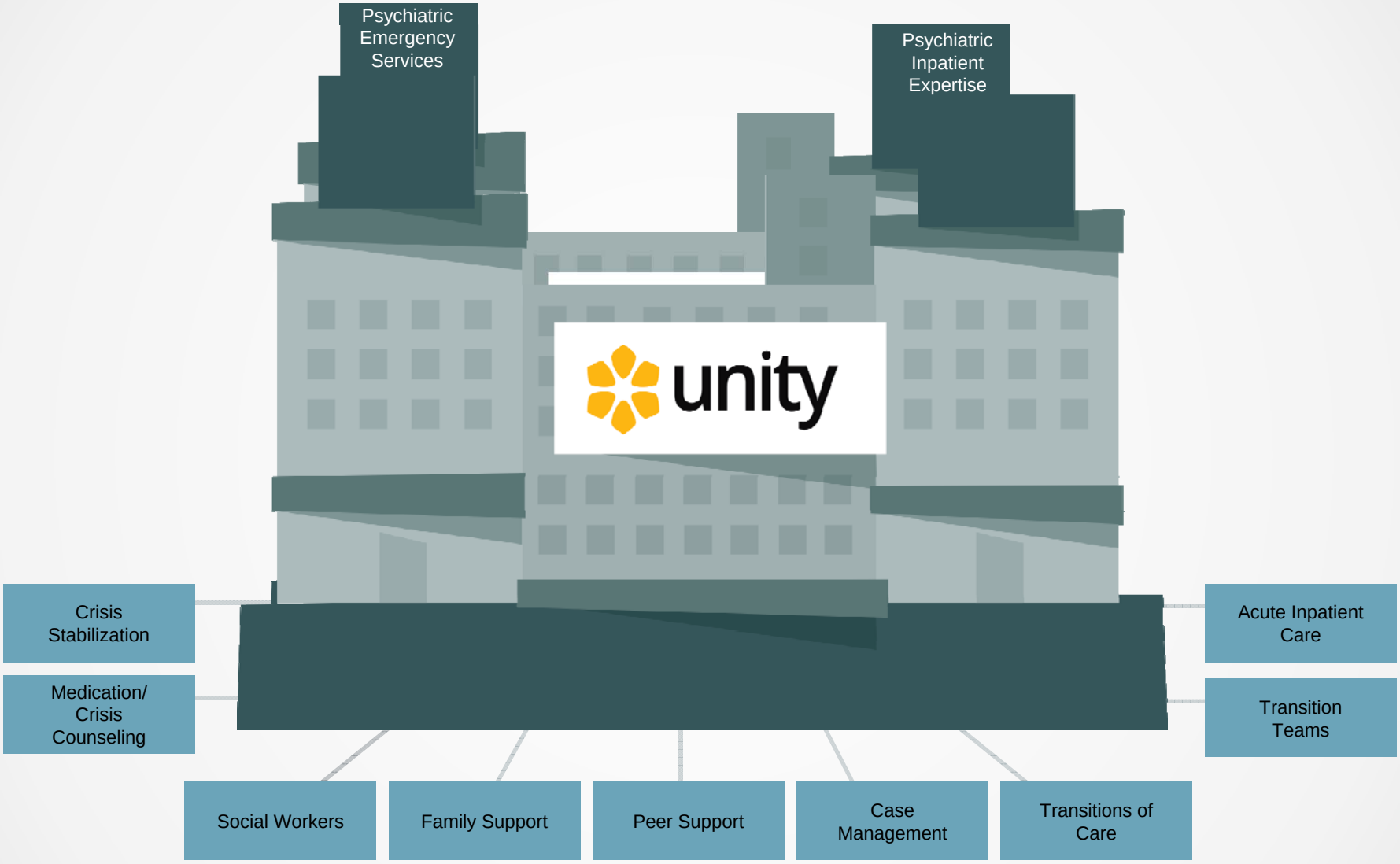
Crisis Response Center – Connections AZ

- **The highlight of the trip**
- UPC and CRC most similar to what Unity PES will be
- Adult PES has two separate milieus
  - 25 PES beds main unit (semi close nursing station)
  - 9 PES beds lower acuity, getting ready to discharge (open station)
  - Option to stay in street clothes or scrubs
- Serves 900 adults and 250 kids per month
- Have a Kids PES with 15 recliners
- Urgent Clinic - urgent care model, helps with med adjustment, or social needs. If in doubt, then admit to PES
- 60% voluntary, 40% involuntary
- 50% of patients get discharged from urgent clinic environment, 50% go to PES proper
- S&R 8/1000

CRC – integrated peers and discharge model

- Peers talk to patient along with nurse or CI at triage, offers water, any other comfort item
- Peers help deescalate pt, are the first line for pt complaint and resolve 75% of the problems. They have a real rapport with pt. Peers help run the milieu. Main goal is to instill hope in recovery
- Peers have similar job to psych techs
- Co-located HOPE SPAN, peer based organization that helps pt connect to services
- Also co-located with several community based organizations
- Counselors have their laptops and data base available to share info and to help with the transition of care
- Go on divert 10-30 % of the time, send email community wide, trying to mitigate the problem


CRISIS RESPONSE CENTER


Psychiatric Emergency Services
Psychiatric Inpatient Expertise
unity
Crisis Stabilization
Medication/ Crisis Counseling
Acute Inpatient Care
Transition Teams
Social Workers
Family Support
Peer Support
Case Management
Transitions of Care


OREGON
HEALTH
&SCIENCE
UNIVERSITY
OHSU


LEGACY
HEALTH


Adventist
Health


KAISER
PERMANENTE®

Unity Center for Behavioral Health

- Collaboration between Legacy, OHSU, Adventist and Kaiser
- Will provide services to the region
- Legacy making the capital investment ($50 million and facility will be licensed under LEMC
- 101 inpatient beds (79 adult beds, 22 adolescent beds)
- Adult Psychiatric Emergency service (45-55 pts./day)
- Built in space for Community Providers to help navigate handoffs from Unity to community
- Strong Peer Support built into structure of Unity

Unity Center for Behavioral Health

- Majority of providers at Unity will be employed by OHSU and will be part of the OHSU faculty
- OHSU will be moving their Adult Psychiatry Residency and their Child/Adolescent Fellowships to Unity
- Unity will also serve as a training site for ED residents, medical students, nurse practitioner and nursing students.

Unity Model
Psychiatric Emergency Service

- PES will have 30-35 recliners and 6-8 rooms that can be assigned to calming patients, in rare cases for seclusions and restraints
- Environment designed to reduce agitation by giving patients control and using verbal de-escalation skills
- Calming architecture and colors to create environment of hope, recovery and hospitality
- Milieu is kept safe through relationships that are caring and respectful

Unity Center for Behavioral Health

- **What is different about this model?**
  - Collaboration between four health systems
  - Community wide effort (city, counties, payers, EMS, police, mental health and addictions providers)
  - De-criminalization of mental illness – aims to get police away from transporting patients with mental illness
  - 24/7 access to psychiatric care
  - Intentional design for transitions of care
  - Model of hospitality, hope and recovery
  - Peer support specialists part of the skill mix

Unity Care Model

- Unity Center's philosophy and operation will embrace the tenants of **Trauma Informed Care** with the goal of promoting safety, hope, growth and recovery.
- Unity Center will fully integrate the knowledge about trauma into its policies, procedures and practices.
- Unity Center will also embrace the concept of **integration mental health and substance use disorder treatment**, which will be reflected in its policies, procedures and practices.

Quality Measures for PES

- Timelines: door to diagnostic evaluation, left without being seen, median time from ED arrival to ED departure (pt discharged, admitted or transferred), admit decision time to ED departure time (for admitted and transferred)
- Safe: rate of self-directed violence with moderate or severe injury, rate of other-directed violence with moderate or severe injury, incidence of workplace violence with injury
- Accessible: denial referral rate, call quality
- Least restrictive: community dispositions, conversions from involuntary to voluntary, hours in physical restraints, hours of seclusion, rate of restraints use
- Effective: unscheduled return visits in 72 hours – for admitted or not admitted

Quality Measures for PES

- Consumer and family centered: consumer satisfaction and family involvement
- Partnership:
  - EMS or police drop off interval
  - Hours on divert
  - Median time from ED referral to acceptance for transfer
  - Post discharge continuing care plan transmitted to next level of care upon discharge
  - Post discharge continuing care plan transmitted to primary care provider upon discharge

Yamhill Community Care Organization
Your Local Health Partner

Yamhill Community Care Organization
Wellness Center
Persistent Pain Program

Laura Fisk, PsyD

Wellness Center Behaviorist

Wellness Center

Yamhill Community Care Organization
Your Local Health Partner

- Discussion started in 2013
- Reduce opioids to a safer dose
- Alternative treatments for Persistent Pain

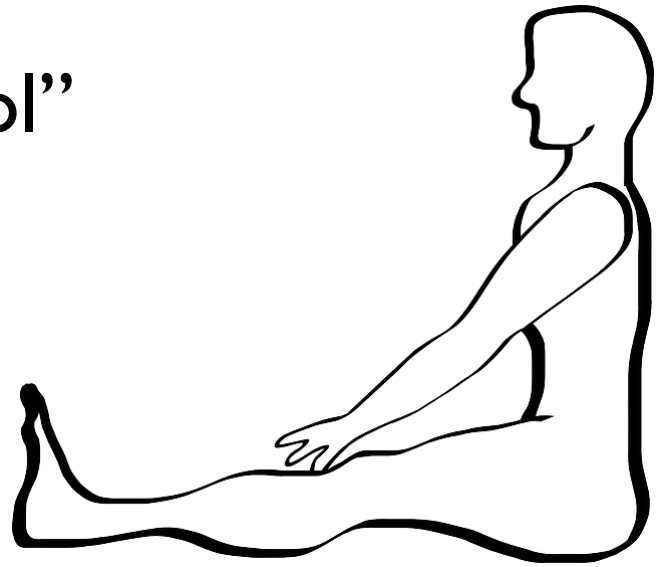
Persistent Pain Program

Yamhill Community Care Organization
Your Local Health Partner

8 week group-based model

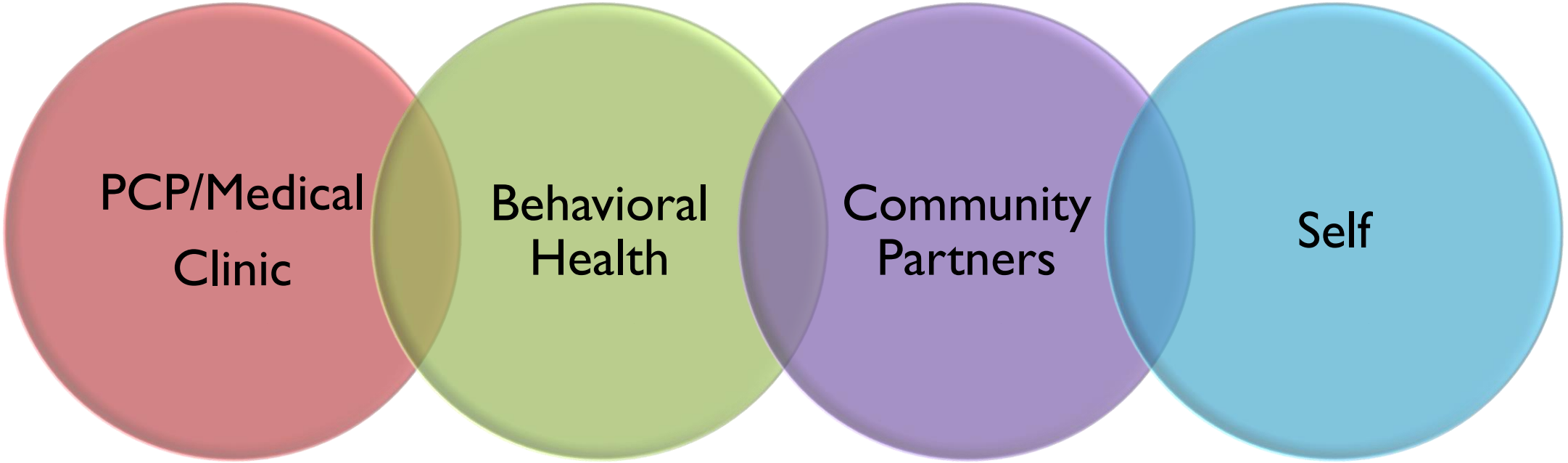
Meet once a week

- 1 hour Psychoeducation – "Pain School"
- 1 hour Movement Therapy – Yoga



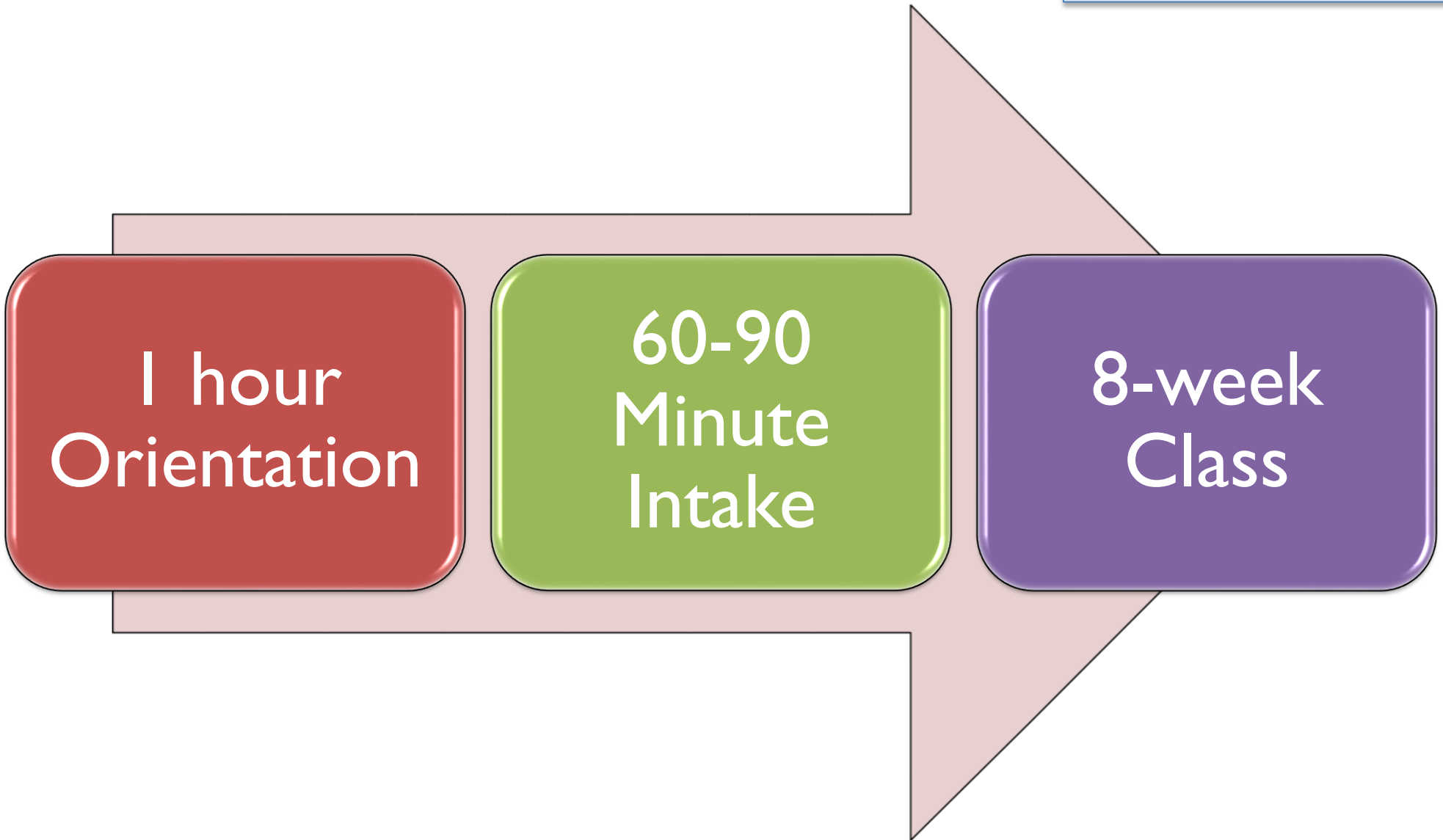
Referrals

Yamhill Community Care Organization
Your Local Health Partner



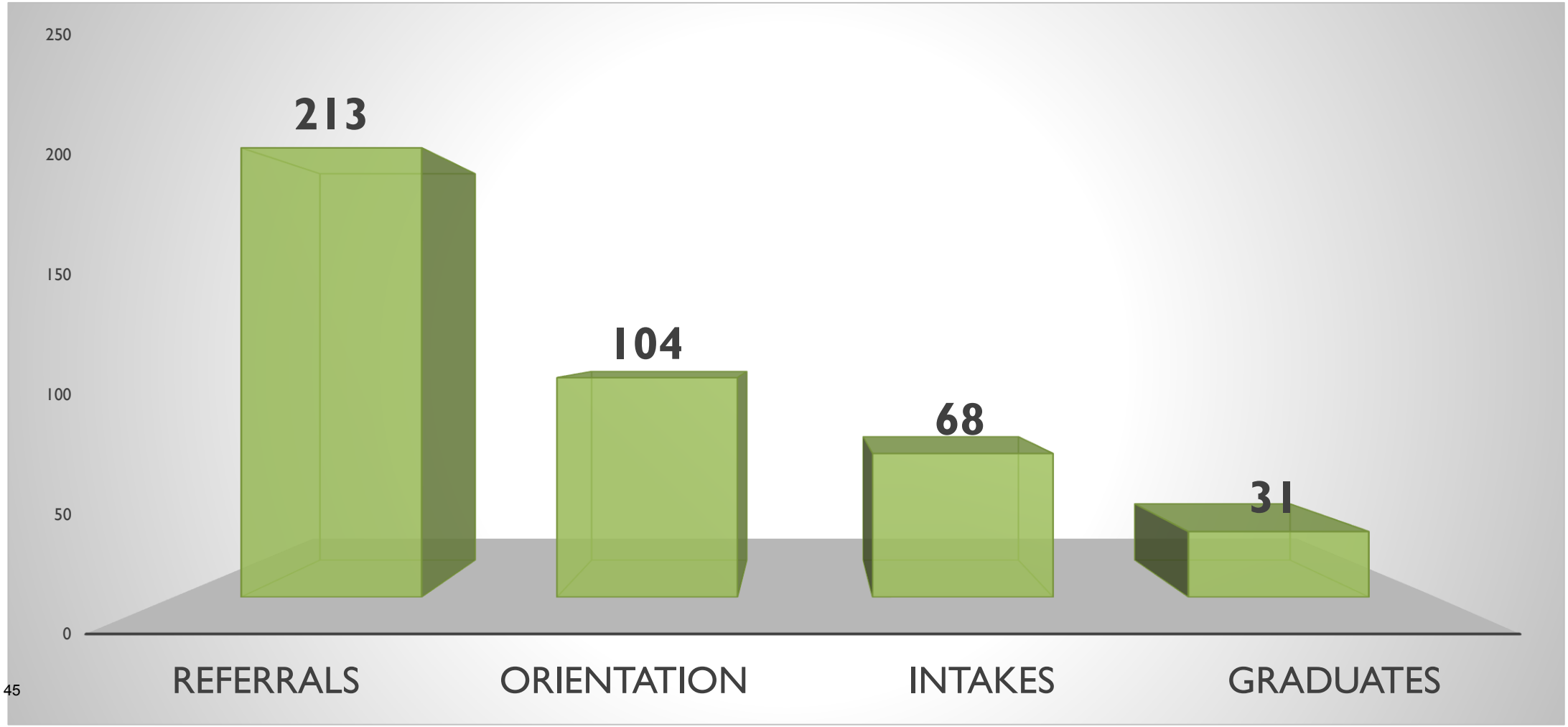
Program Participation

Yamhill Community Care Organization
Your Local Health Partner



Utilization (Feb – Oct 2015)

Yamhill Community Care Organization
Your Local Health Partner



Pain School Classes

Yamhill Community Care Organization
Your Local Health Partner

1. Understanding Chronic Pain
2. Stress & Pain
3. CBT for Pain
4. Adaptation – Pacing & Flare Ups
5. Medication Management
6. Communication
7. Sleep Hygiene/ACT
8. Resiliency & Graduation

Outcome Measures

Yamhill Community Care Organization
Your Local Health Partner

- Brief Pain Inventory
- Oswestry Low Back Pain Disability Questionnaire
- Fear of Movement
- Patient Health Questionnaire (PHQ-9)
- Duke Health Profile
- Pain Self-Efficacy Questionnaire
- Patient Activation Measure

Outcome Measures

Yamhill Community Care Organization
Your Local Health Partner

Pre- and Post-measure are collected

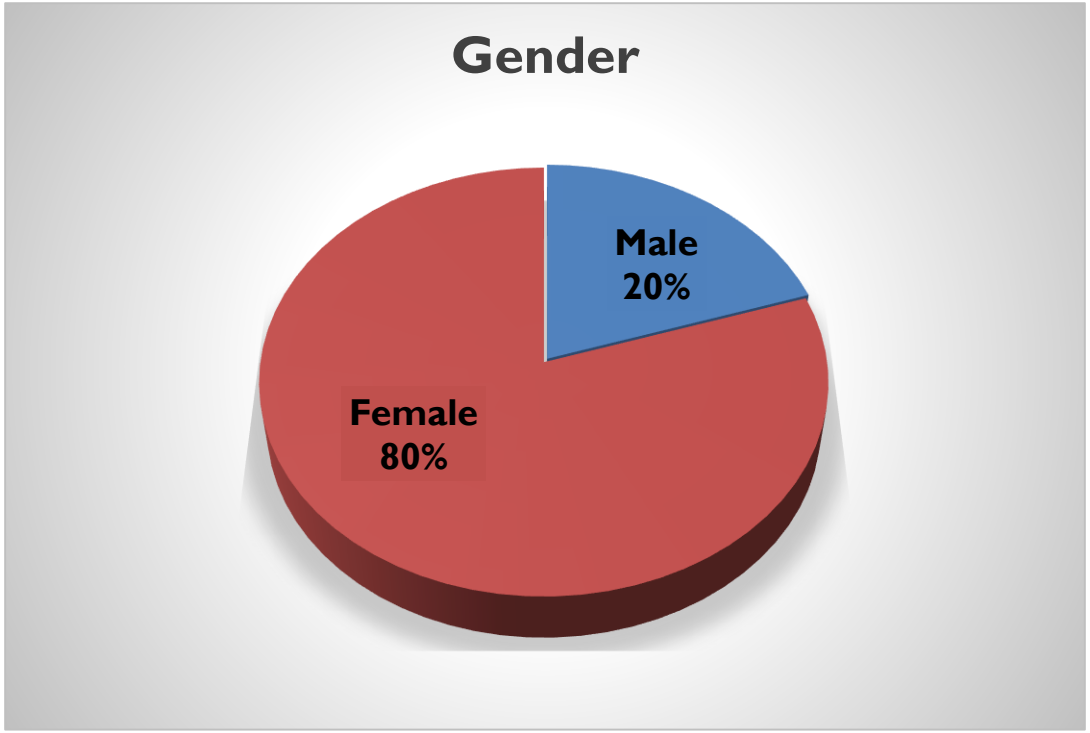
Time 1 = **90-minute Intake**

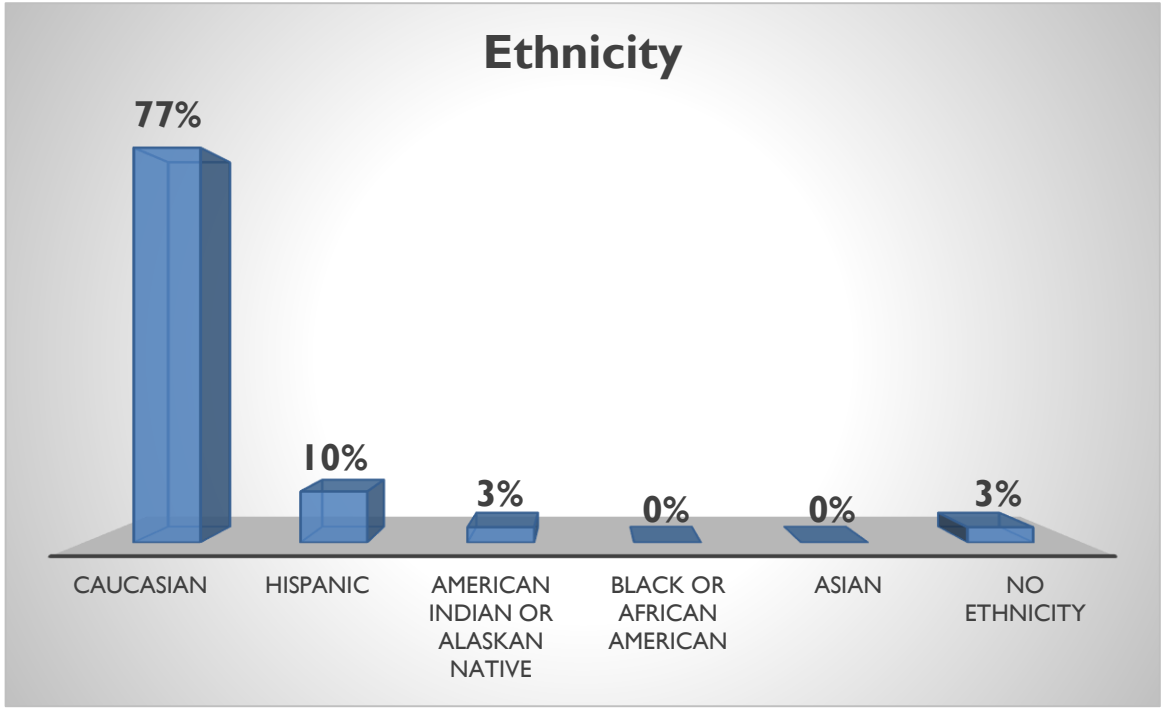
Time 2 = **Week 8 – Graduation**

Demographics

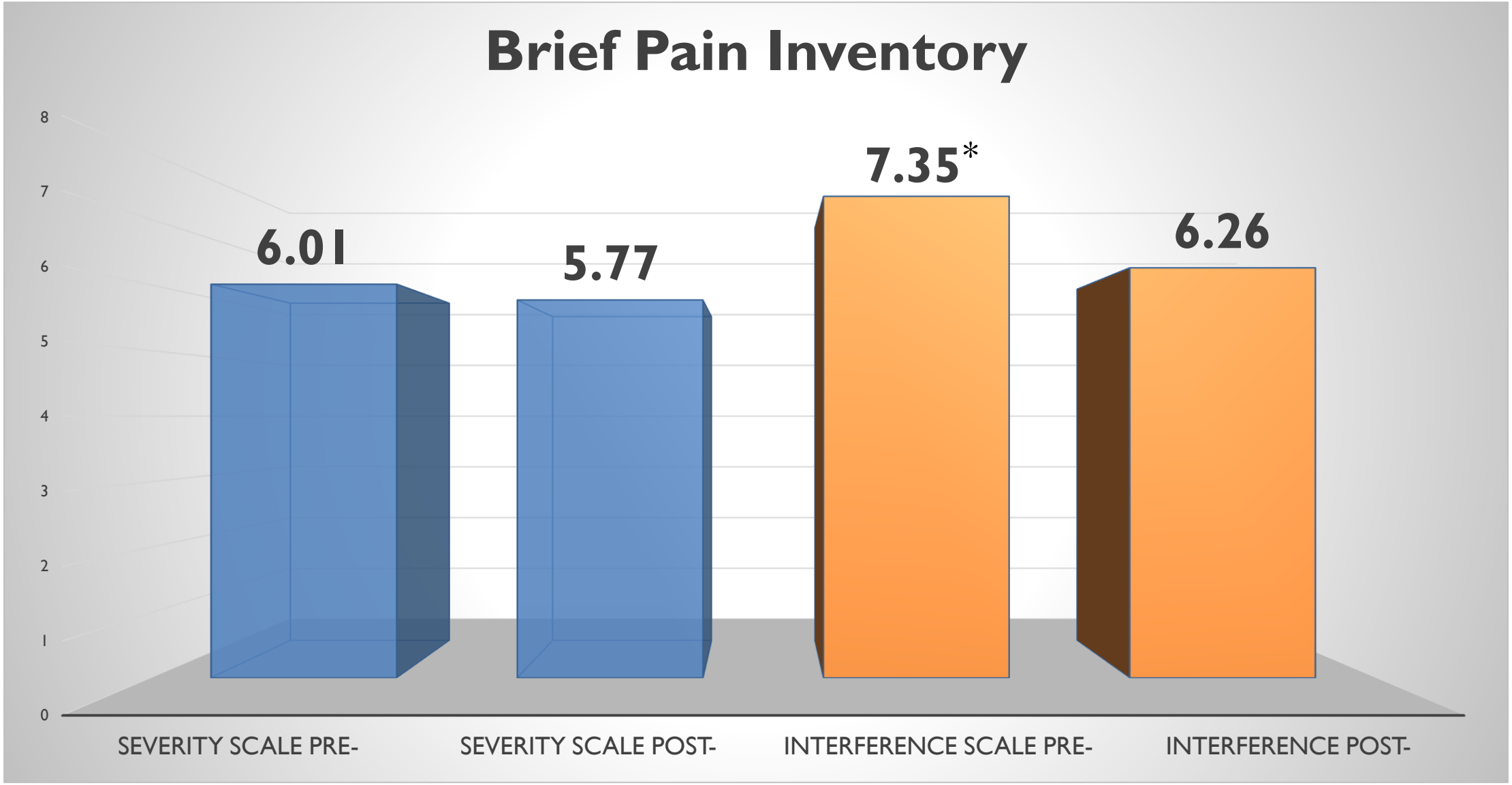
Yamhill Community Care Organization
Your Local Health Partner

Graduates = 31 Members





Average Age = 46.6 (Max = 63; Min = 23)



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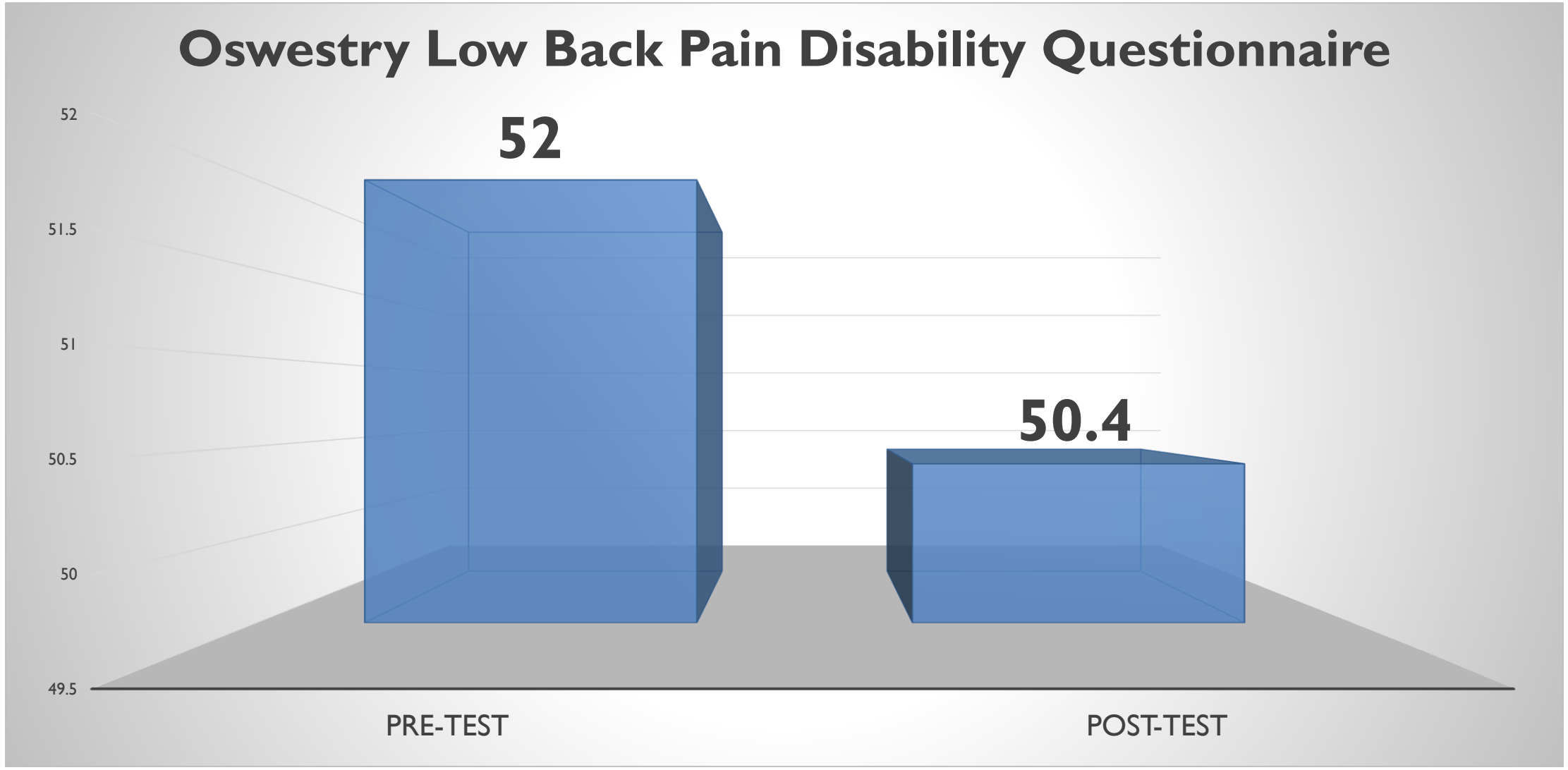
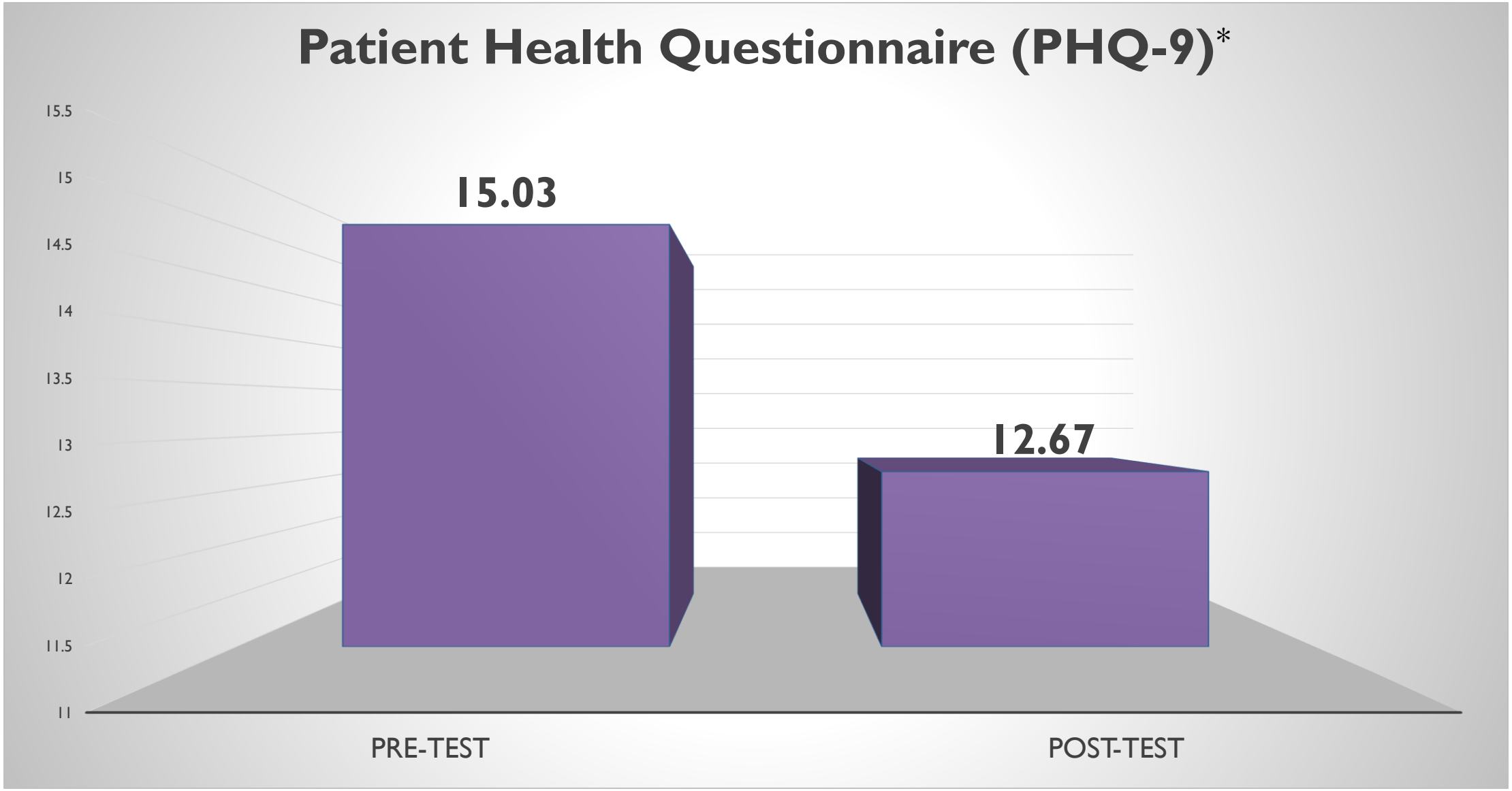

Oswestry Low Back Pain Disability Questionnaire
52
51.5
51
50.5
50
49.5
52
50.4
PRE-TEST
POST-TEST



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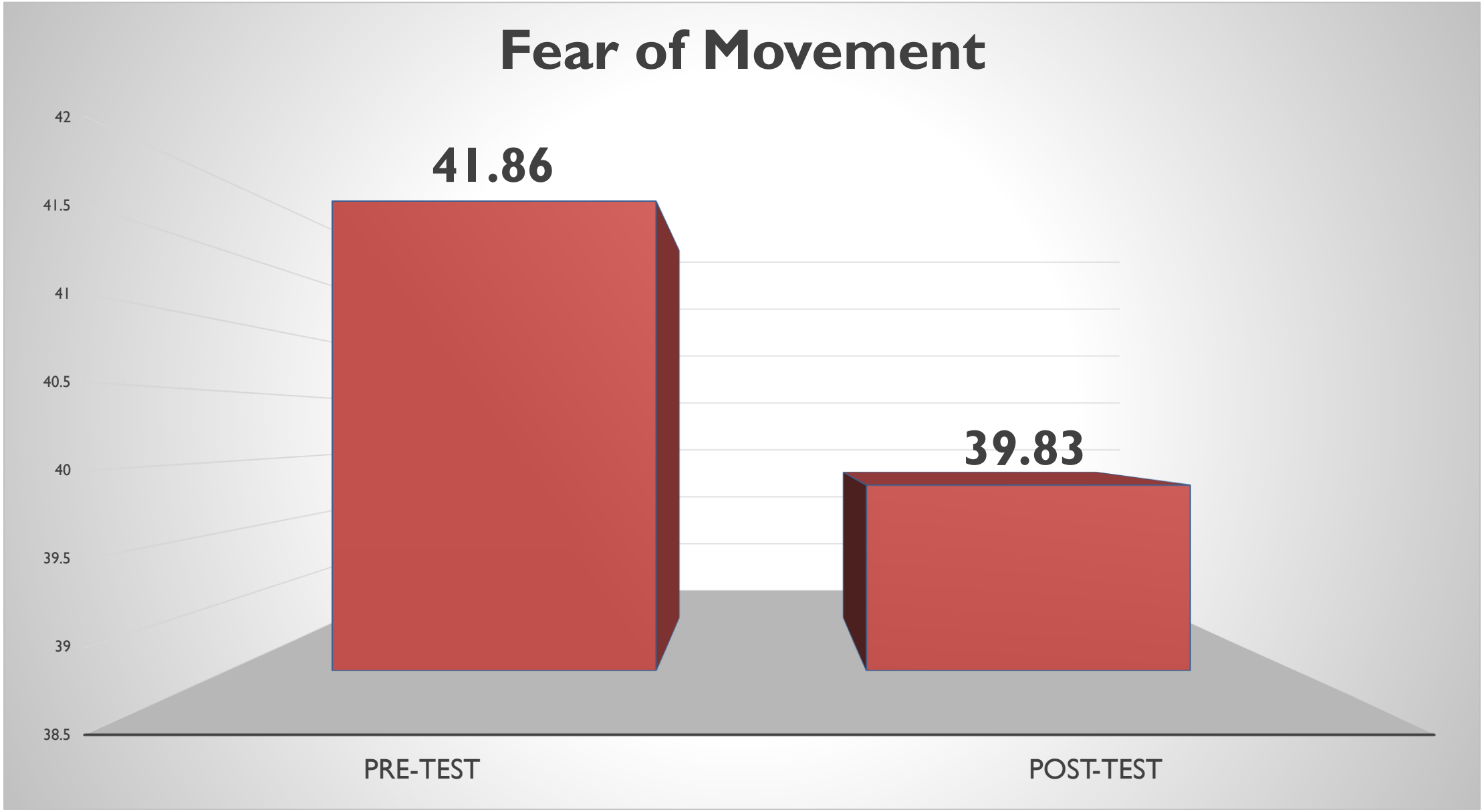
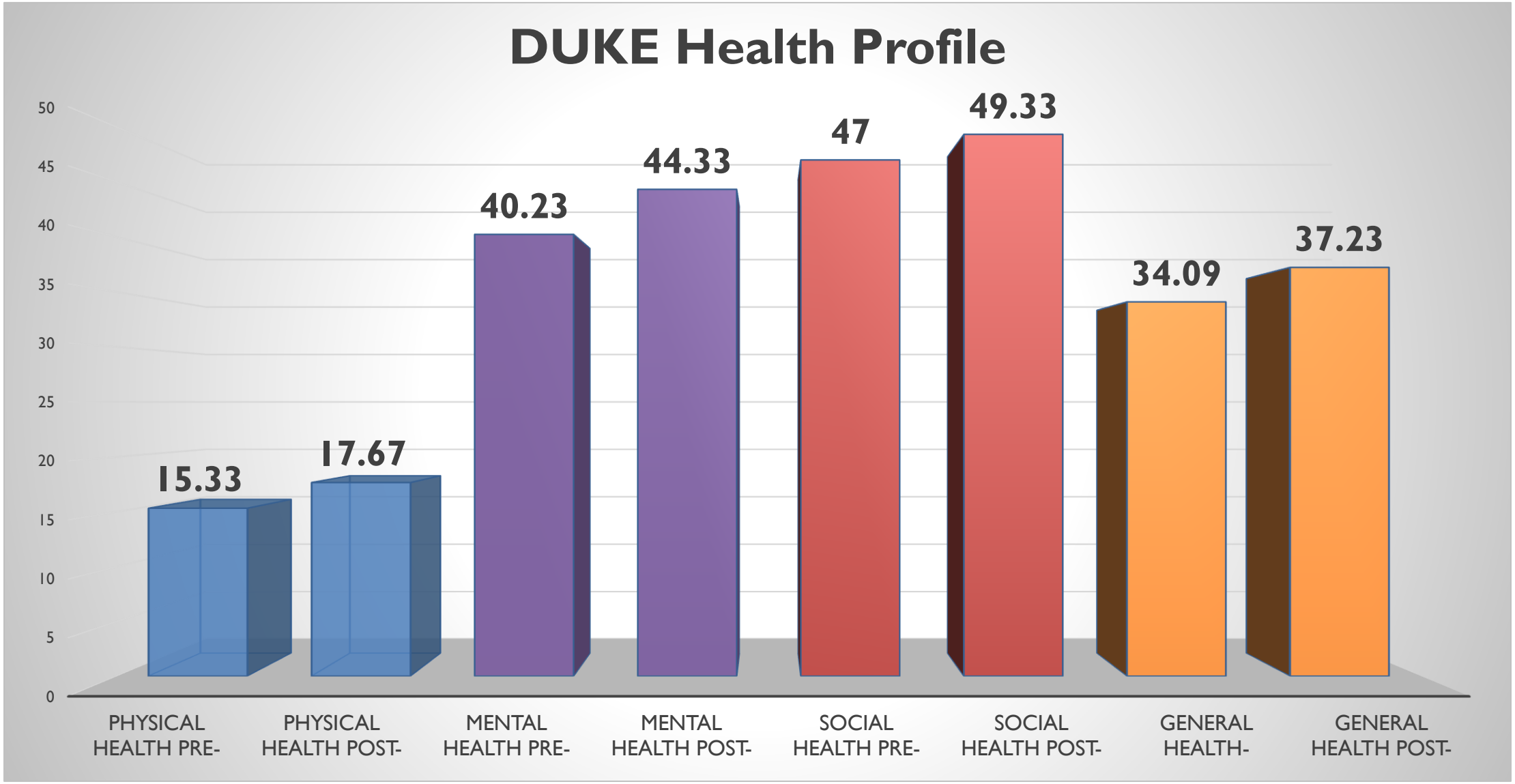
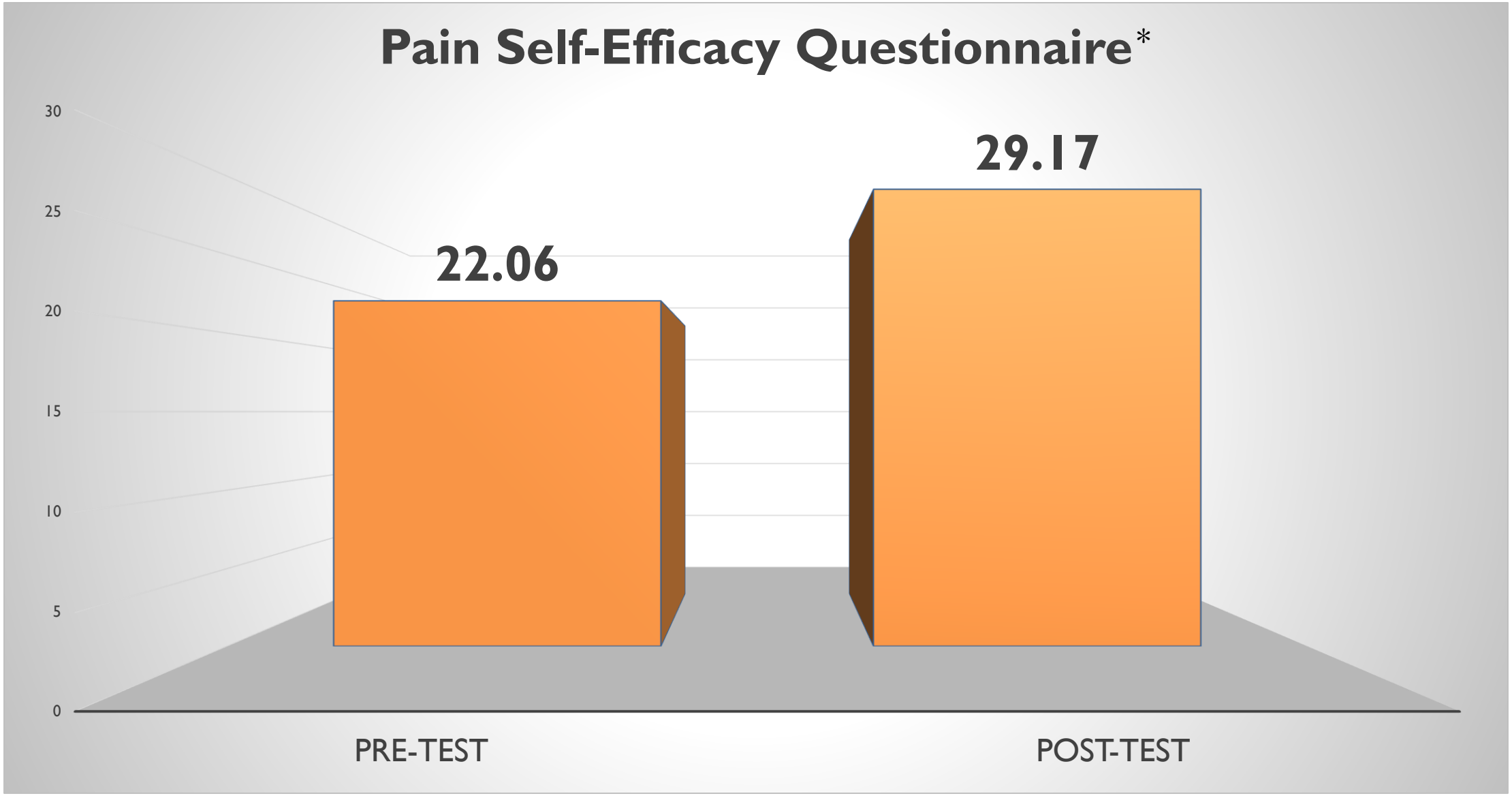

Fear of Movement
42
41.5
41
40.5
40
39.5
39
38.5
41.86
39.83
PRE-TEST
POST-TEST


DUKE Health Profile
50
45
40
35
30
25
20
15
10
5
0
15.33
17.67
40.23
44.33
47
49.33
34.09
37.23
PHYSICAL HEALTH PRE-
PHYSICAL HEALTH POST-
MENTAL HEALTH PRE-
MENTAL HEALTH POST-
SOCIAL HEALTH PRE-
SOCIAL HEALTH POST-
GENERAL HEALTH-
GENERAL HEALTH POST-



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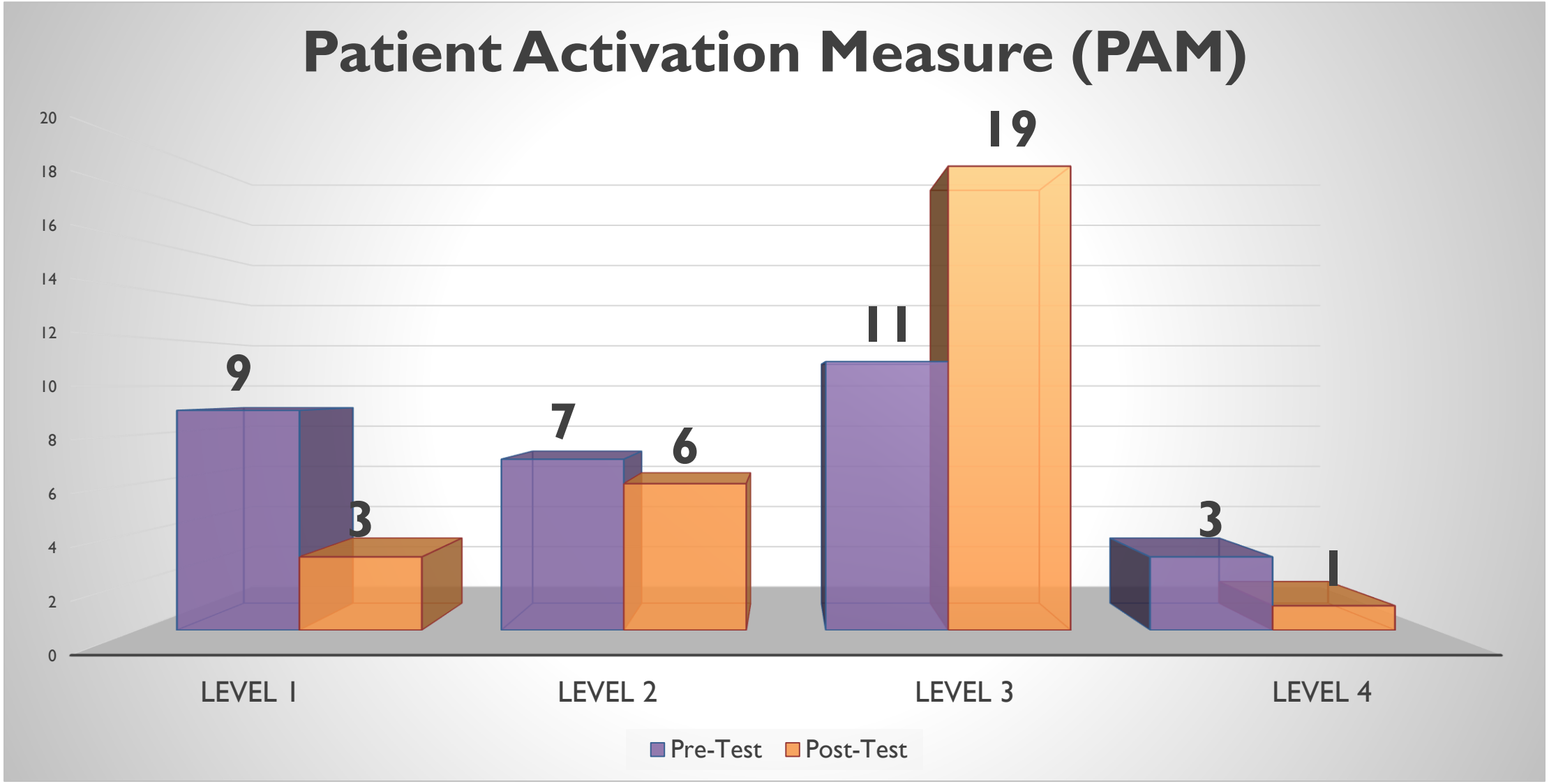
Patient Activation Measure (PAM)
20
18
16
14
12
10
8
6
4
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9
3
7
6
11
19
3
1
LEVEL 1
LEVEL 2
LEVEL 3
LEVEL 4
Pre-Test
Post-Test

Summary

Yamhill Community Care Organization
Your Local Health Partner

- Persistent Pain Program
  - 8-week Pain School and Movement Therapy for Yamhill CCO members with persistent pain.
- Outcome measures demonstrate improvement over 8-week program
- Next Steps:
  - Continue tracking outcomes (pre/post measures, claims data, etc.)
  - Provide additional services (massage therapy, chiropractor, etc.)
  - Provide additional groups/classes for Health & Wellness.

Hospital Notifications ("EDIE") and Assertive Community Treatment

Justin Keller
Lead Policy Analyst
Office of Health IT

Oregon Health Authority

Statewide Hospital Notifications and EDIE

- Real-time alerts to providers and the care team when their patient has a hospital event (emergency department, inpatient, discharge)
- Oregon is pursuing statewide hospital notification through a two stage process:
  - Emergency Department Information Exchange (EDIE) Utility – provides hospital notifications to all hospitals in the state
  - PreManage – Expands EDIE notifications to health plans, CCOs, clinics and providers

PreManage Overview

- Web-based software that provides real-time notifications to subscribers when their patient/member has a hospital event
  - Includes ED and inpatient events in Oregon
  - ED events in Washington, parts of California
- Notifications fully customizable
- PreManage dashboards provide real-time population-level view of ED visits
- Care guidelines—subscribers can add key care coordination information into PreManage, viewable by other PreManage and EDIE users

PreManage Implementation

User	"Live"	"Implementing"	"In Discussion"
Health Plans/CCOs	7	5	8
Clinics	100+	80+	50+
ACT Teams	3	6	3

Coming focus: FQHCs, mental/behavioral health, EMS, long-term care, post-acute care, others

PreManage Pilot for ACT Teams

- Approximately 30 ACT teams across the state
  - Provide comprehensive, focused services for individuals with complex behavioral health needs at high-risk for hospitalization
- OHA using SIM funds to support a PreManage subscription for all teams through February 2016
  - Working closely with OCEACT – Center for Excellence for ACT Teams

ACT Pilot Implementation Status

- Three teams are live:
  - Central City Concern (Portland)
  - Sequoia Mental health Services (Hillsboro/Aloha)
  - Yamhill County Mental Health (McMinnville)
- Six teams have signed contracts and should be live soon:
  - Benton County Mental Health (Corvallis)
  - Cascadia Forensic ACT (“FACT”) Team (Portland)
  - Cascadia Clackamas Lake Road ACT Team (Milwaukie)
  - Laurel Hill Center (Eugene)
  - Symmetry Care (Burns)
  - Mosaic ACT Team (Bend)
- Pilot through February 2016

User Experience and Impact for ACT Teams

- Encouraging outcomes around early use of PreManage:
  - Improved communication and coordination of care
  - Real-time interventions on high-risk patients
  - Mechanism for more comprehensive care planning for high-risk patients

- Early feedback from ACT Teams:
  - Work flows changing through use of PreManage
  - Physical health hospitalization information helpful

Break

10 minutes

Panel 2

Dr. Lynnea Lindsey-Pengelly, Trillium CCO

Dr. Robin Henderson, St. Charles Health System

Trillium Integration Incubator Project

TIIP

OHA Metrics & Scoring Committee

October 30, 2015

Trillium

“The TIPPing Point”:

How Little Things Can Make a Big Difference

“The tipping point is that magic moment when an idea, trend, or social behavior crosses a threshold, tips, and spreads like wildfire.”

- Malcolm Gladwell

TIIP – Leadership

- Lynnea Lindsey-Pengelly, PhD, MSCP
- Trillium CCO
  - Medical Services Director - BH

What is required to align the work of integrating physical and behavioral health care with healthcare transformation?

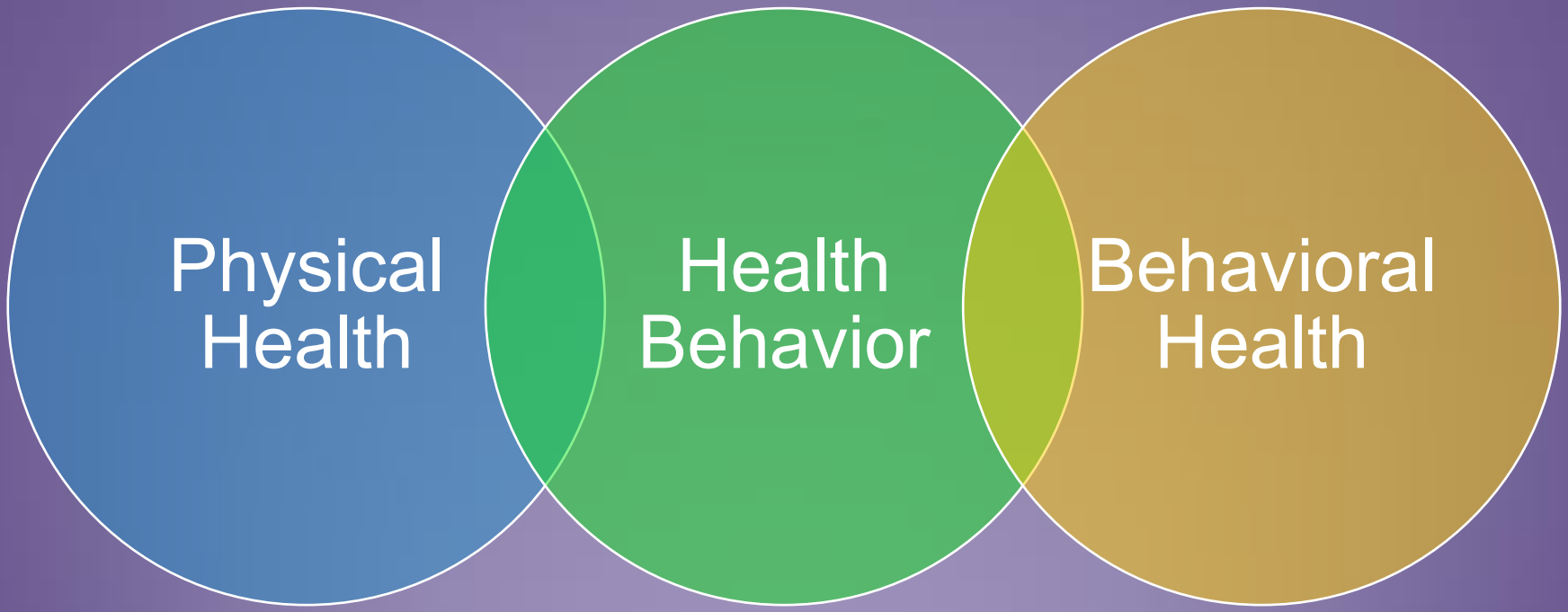
What is TIIP?

- Two RFPs issued in Spring 2014 – for integrating primary care AND for integrating behavioral health
- Four submissions for each RFP
- Review committee met on June 5th 2014 and **ALL** eight projects were chosen
- Launch date was set for July 1, 2014

Eight TIIP Sites

Primary Care Medical Homes	Behavioral Health Medical Homes
Eugene Pediatrics added Thrive Behavioral Health	Center for Family Development partnered with Springfield Family Physicians
Oregon Medical Group – Crescent partnered with Options Counseling, The Child Center and Strong Integrated Behavioral Health	Lane County Behavioral Health moved from co-located model with the Community Health Centers to an integrated model of care
PeaceHealth Medical Group – University District and Santa Clara brought in internal BH resources	Peace Health Behavioral Health EASA/Young Adult Hub expanded adding primary care services
Springfield Family Physicians partnered with Center for Family Development	Willamette Family Treatment Services opened an integrated Medical Clinic

Spectrum of Advanced Care = Requires Integration to Achieve



TIIP to TIP TIMELINE

7/01/2014 - 2015

- Support Early Adoption of Integrated Care
- Develop Comprehensive Program Standards
- Establish Measurement standards
- Establish Payment Standards

2016

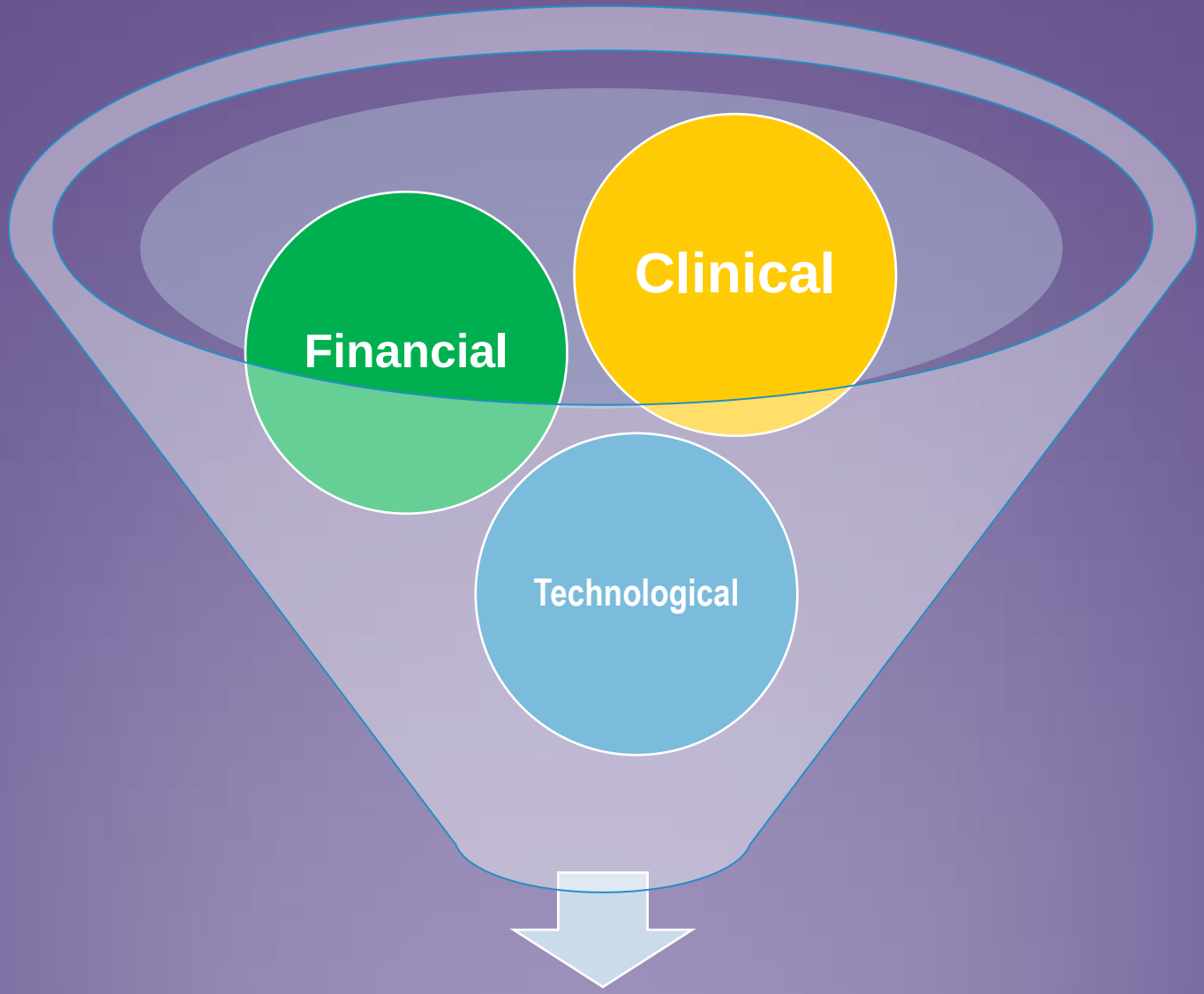
By July 1, have 40% of Trillium Members care provided in an integrated Medical Home that meets the OHA PCPCH Standards AND the Trillium Standards

2017

By July 1, have 60% of Trillium Members care provided in an integrated Medical Home that meets the OHA PCPCH Standards AND the Trillium Standards

Required Elements

- Financial
- Clinical
- Technological/Data/Measurement



Integrated Care

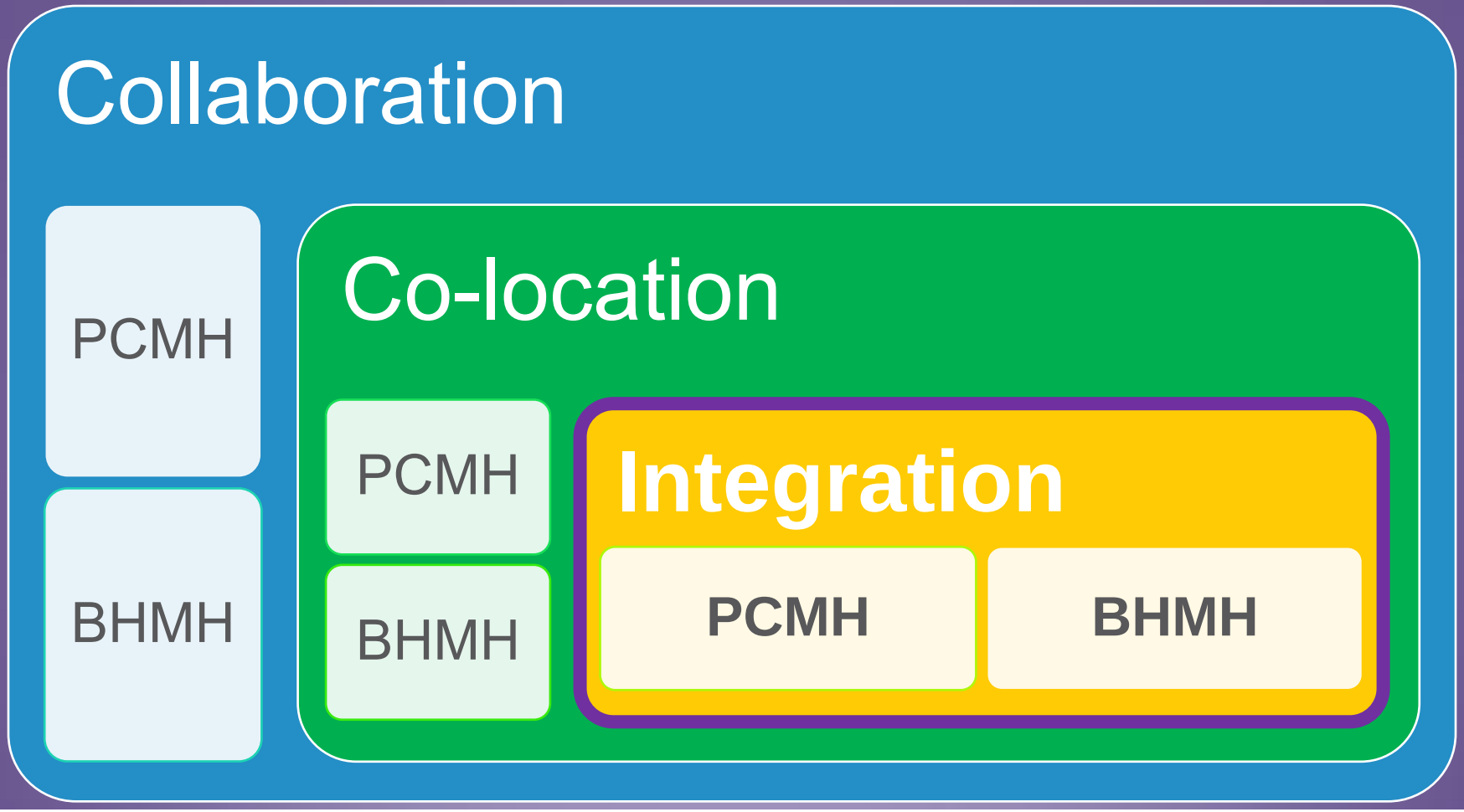
What are the essentials…

- What are the elements that make up an advanced medical home?

OHA - PCPCH Core Attributes

- 1. Access to Care (Accessible)
- 2. Accountability (Accountable)
- 3. Comprehensive Whole Person Care (Comprehensive)
- 4. Continuous (Continuity)
- 5. Coordination and Integration (Coordinated)
- 6. Person & Family Centered Care (Patient and Family Centered)

Connecting Physical & Behavioral Health Care



Spectrum of Health Care - Physical & Behavioral Health

Primary Care

- Day to day non-emergent care for the whole person

Secondary Care

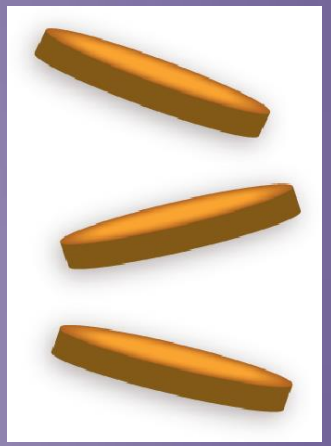
- Outpatient Specialty Services

Tertiary Care

- Urgent and Emergent Services most often requiring residential and/or inpatient care

Three Sides: What is necessary

1. Population perspective
2. Team approach
3. A payment model (APM)

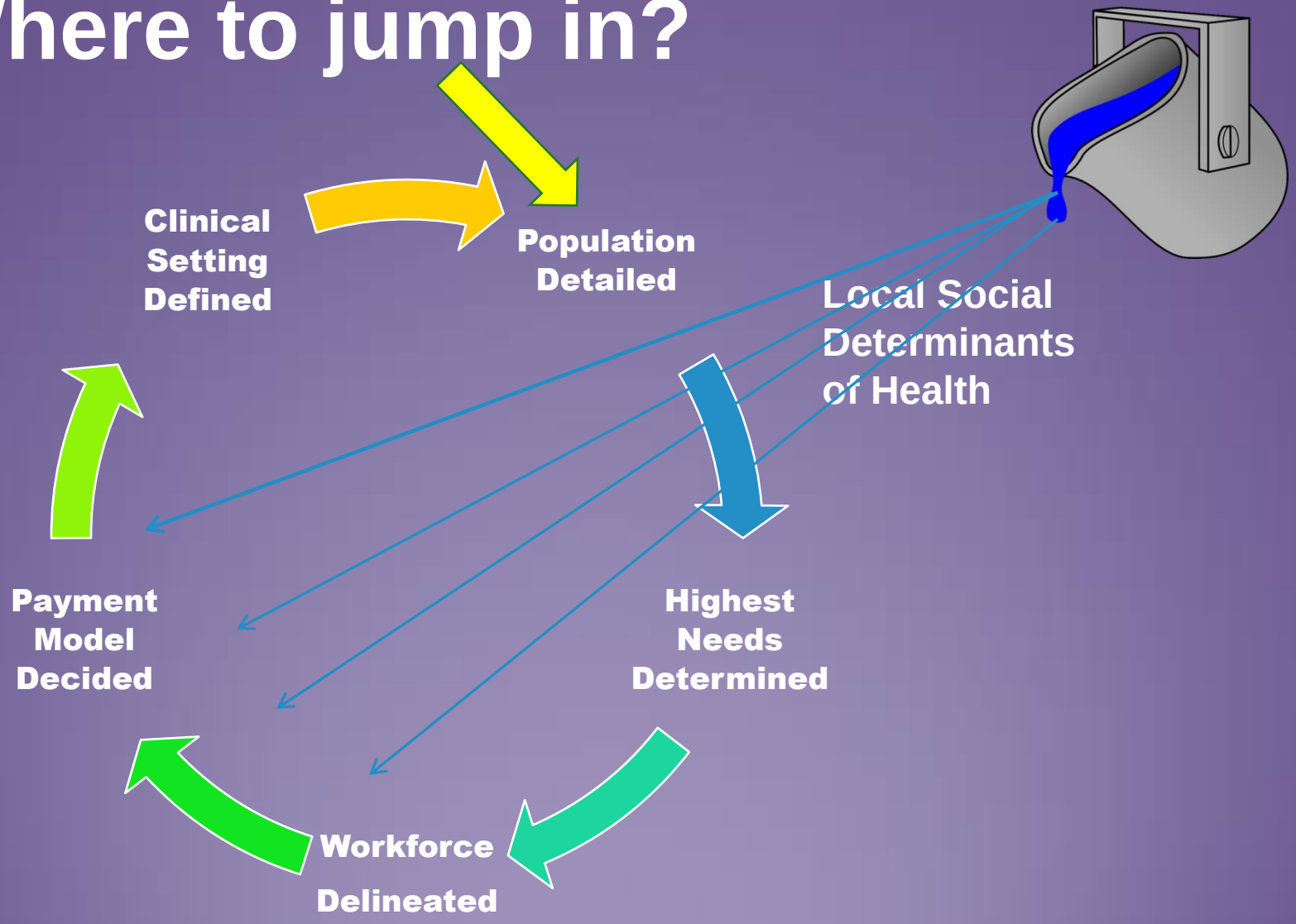


Supporting Early Adoption of Integrated Care

- Teachable moments:
- Monthly TIIP Learning Collaborative
- Targeted Learning Opportunities
- Weekly e-Newsletter TIIP Sheet
  - Brief articles
  - Live Links to research, resources and trainings

- Experts in PCMH and PCBH
- TIIP Advisory Committee: Community experts
- Internal learning: TIIP Operations

Where to jump in?

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Thank you!

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Behavioral Health, Metrics and the Broader Health System: Lessons from Other States

Robin Henderson, PsyD

Chief Behavioral Health Officer & VP, Strategic Integration

AHRQ Behavioral Health Integration Checklist

- Patient Centered Care
- Population Based are
- Measurement Based treatment to target
- Evidence Based Care
- Accountable Care
- Patient Identification and Diagnosis
- Engagement in Integrated Care
- Follow up, Adjustment and Relapse Prevention
- Communication and Care Coordination
- Case Review and Consultation
- Program Oversight and QI

Colorado SIM metrics: Embedded BH

- Embedded BH in PCPCH
  1. Attest to practice/system support for embedded BH provider for a minimum of 3 years
  2. BH provider available 20 hours/week min with at least 50% availability
  3. 50% of patients screened for at least one BH condition with a documented practice workflow with BH involvement for positive screens
  4. 90% of patients screened as above
  5. 80% of highest risk patients receive care management services with an integrated treatment plan (BH & PH goals)

IBHAO Recommended Minimum Standards

- Integrated BHS Services are routine care:
  - Defined by ORS 414.025
  - 1 BHC/6 FTE Primary Care Clinicians
  - Rural practice accomodations (virtual services)
- Broad array of evidence-based BH services
  - Mental illness, substance use disorders
  - Chronic illness, life stressors
  - Developmental risks and conditions
  - Stress-related, preventative care
  - Ineffective patterns of use
- Same day open access to care
  - Warm handoffs, brief assesment and intervention
  - Real time point of care at least half the time

IBHAO Recommended Minimum Standards, cont

- Shared medical record
  - Collaborative treatment planning
  - Case conferences/daily huddles
- Integrated primary care team
  - Shared physical space
- Population-based approach to care delivery
  - Universal BH screening, care coordination and panel management
  - Written protocols for referrals
- Psychiatric consultative resources

Other potential metrics

- OAHHS Budget note:
  - Measures time of ED Boarding
- NAMI Discharge Bill:
  - Compliance with ED Discharge planning requirements for all BH patients
- PCPCH SAC:
  - New standards will make some practices non-compliant—what then?
- Access
  - % of patients identified - % of patients treated

If Robin Ruled the World ☺

- Year One metrics
  - Attest to practice/system support for embedded BH provider for a minimum of 3 years
  - BH provider available 20 hours/week min with at least 50% availability
  - 50% of patients screened for at least one BH condition with a documented practice workflow with BH involvement for positive screens
- Subsequent Years
  - Base % of patients screened, identified and intervened upon
  - Benchmark rate of complex patients engaged with BHC providers
  - Pick one condition to intervene on and show improvement (Chronic pain, sleep, etc.)

Discussion

Robin Gumpert, Facilitator