Oregon Educators Benefit Board
Strategies on Evidence and Outcomes Workgroup
April 26, 2016
Meeting Synopsis

The Strategies on Evidence and Outcomes Workgroup (SEOW) of the Oregon Educators Benefit Board held a meeting on April 26, 2016 (10:00 a.m. to noon) in the PEBB/OEBB Boardroom, 1225 Ferry Street SE, Salem, Oregon.

Attendees:

Workgroup Members:
Ron Gallinat
Cherie Maas-Anderson
Nancy MacMorris-Adix
Geoff Brown

Staff/Consultant:
Heidi Williams, OEBB
Glenn Baly, OEBB
Jenny Marks, Willis Towers Watson

Carrier/Other Representatives:
Dr. Keith Bachman, Kaiser
Dr. Neal Mills, Moda
Bill Dwyer, Moda
Dan Thoma, Moda

1. April 26, 2016 SEOW Meeting Synopsis (SEOW Attachment 1)

SEOW approved the April 26, 2016 SEOW Meeting Synopsis without changes.

2. Future SEOW Topics (SEOW Exhibit A)

Geoff Brown proposed that SEOW review OEBB's wellness programs and access to mental health services in upcoming meetings.

SEOW Action/Decision

SEOW agreed that access to mental health services and OEBB wellness programs should be issues for upcoming meetings.

2. <u>2016-17 RFP – Proposed Regions (SEOW Attachment 1)</u>

Jenny Marks recommended specific regions to use for evaluating Organized Systems of Care (OSC) proposers in the 2016-17 RFP selection process. The regions were based on a review of:

- Regions established in the original OEBB RFP
- Current numbers of entities and OEBB membership by county
- Patterns of healthcare typically received in Oregon

Nancy MacMorris-Adix asked if the proposed regions limit proposers to those who cover the entire proposed region. **Jenny Marks** said the regions are for evaluation purposes in the RFP selection process and the Board has the capability to select OSC proposers that cover only a portion of the region.

<u>SEOW Action/Decision</u>

SEOW recommended that the Board approve the proposed regions for OSC proposers to the 2016-17 OEBB RFP.

4. <u>Moda Major Joint Reference Pricing Program Update</u>

Dr. Neal Mills and Bill Dwyer provided an update on Moda's Major Joint Reference Pricing Program, including.

- Program Overview
- Member Experience
- Analytics Overview
- Measures of Success (utilization, claims experience, savings, etc.)

<u>SEOW Action/Decision</u>

Nancy MacMorris-Adix and Geoff Brown asked that Moda Health come back in June with an update on efforts to develop a bundled payment program.

5. <u>Moda SBIRT Survey</u>

Dan Thoma provided an overview of Moda's survey of providers' utilization of SBIRT, including:

- SBIRT tool and process

- Survey results
- Next steps

SEOW Action/Decision

No action or decision required.

No public comment.

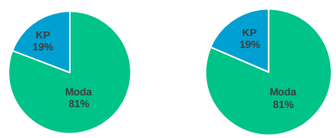
Prior Period : 10/1/13 - 9/30/14 Current Period : 10/1/14 - 9/30/15 Moda Health - incurred, Kaiser Permanente - paid

OEBB Cost and Utilization Dashboard — Moda Health and Kaiser Permanente

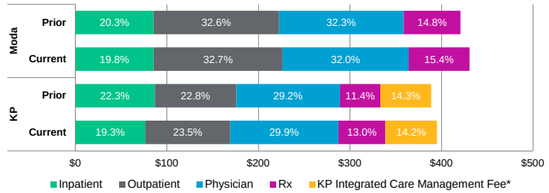
SEOW Attachment 2a - June 7, 2016

Member Experience Summary

Average Members



$PMPM Allowed



	Prior	Current
Total Allowed (Med/Rx)		
Moda	$525.7M	$540.2M
KP	$99.0M	$95.1M
Total	$624.7M	$635.3M
Total Paid (Med/Rx)		
Moda	$423.9M	$434.7M
KP	$93.4M	$88.2M
Total	$517.3M	$522.9M

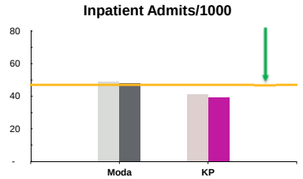
Overall, the number of members decreased by less than 1% over the prior period: +1% for Moda and -4% for KP.

Consistent with the membership change, total allowed and paid costs increased slightly for Moda and decreased by 4 to 5% for KP.

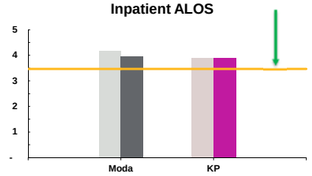
PMPM cost increased about 2% for Moda and KP. Inpatient services PMPM decreased while Rx PMPM increased for both Moda and KP.

Cost and Utilization Summary

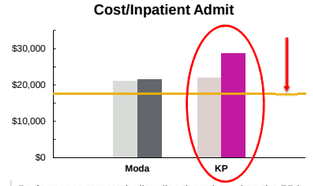
Inpatient Admits/1000



Inpatient ALOS



Cost/Inpatient Admit



Performance targets (yellow lines) are based on the 75th percentiles in the Truven data.

IP admissions are at or below the 75th percentile. The cost per admission is higher and consistent with a higher length of stay. KP's current cost per admission is much higher than the prior and reflects the intensity of services provided.

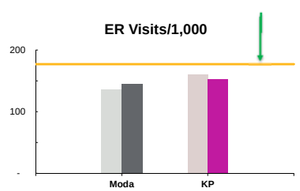
ER visits are well below the 75th percentile while cost per visit is higher indicating members are using the ER for higher cost services.

Radiology service use is slightly above the 75th percentile for Moda and well below for KP. PMPM cost per service is above the 75th percentile.

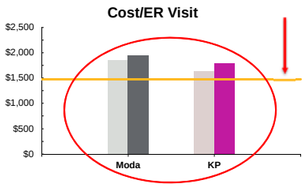
Pharmacy utilization is above the 75th percentile for Moda. KP utilization is lower reflecting a large number of scripts dispensed for 90 days. Higher Rx script costs are due to an increase in total medication costs. Generic Dispensing Rate (GDR) is above 80% but below Best in Class level of 90%.

Recommendation: Improve GDR rate. Every 1% increase in GDR saves 1%-2.5% in pharmacy costs.

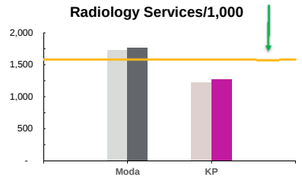
ER Visits/1,000



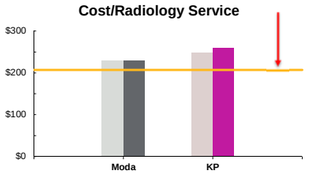
Cost/ER Visit



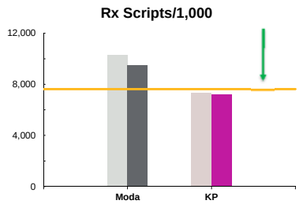
Radiology Services/1,000



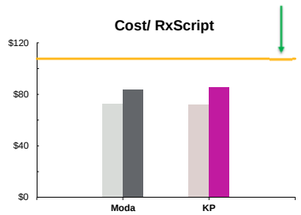
Cost/Radiology Service



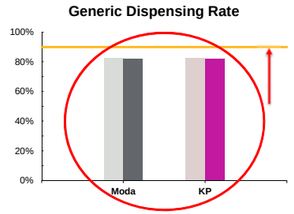
Rx Scripts/1,000



Cost/ RxScript



Generic Dispensing Rate

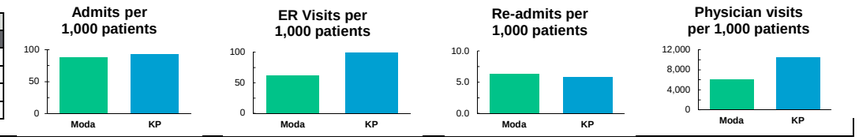


Moda Prior Moda Current KP Prior KP Current 75th Percentile

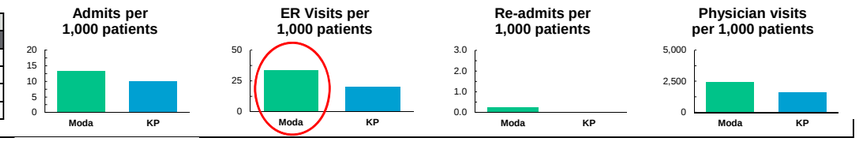
Conditions

Key Measures

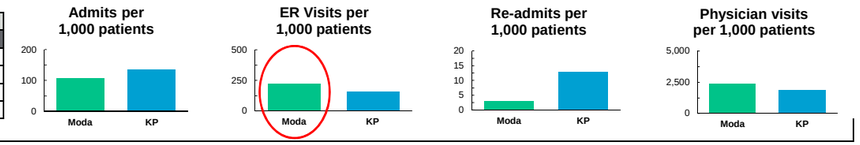
Cancer	Moda	KP
# of Patients	2,500	344
# of HCC	53	3
Total Allowed	$42.7M	$4.2M
% Rx	6%	4%



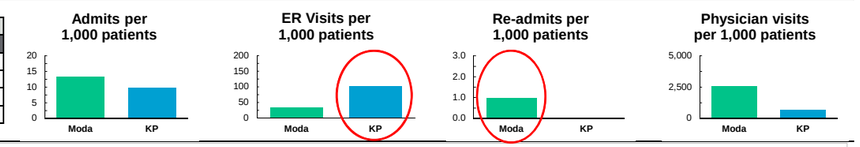
Diabetes	Moda	KP
# of Patients	4,185	201
# of HCC	7	0
Total Allowed	$16.1M	$0.2M
% Rx	60%	23%



Coronary Artery Disease	Moda	KP
# of Patients	914	155
# of HCC	37	8
Total Allowed	$9.4M	$1.3M
% Rx	4%	2%



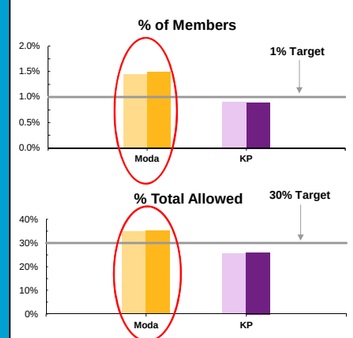
Mental Health - Depression	Moda	KP
# of Patients	6,057	514
# of HCC	1	0
Total Allowed	$8.0M	$0.6M
% Rx	11%	15%



Patients with diabetes and coronary artery disease (CAD) have a higher rate of ER visits for Moda than KP. However, Moda patients have a higher rate of physician visits for both conditions, than KP.
KP mental health patients' higher rate of ER versus physician visits raises potential access concerns.
Recommendation: Evaluate care management resources for high risk members with diabetes and CAD. Ask Kaiser to assess mental health care access to address the higher rate of ER visits.

High Cost Claimants (HCC)

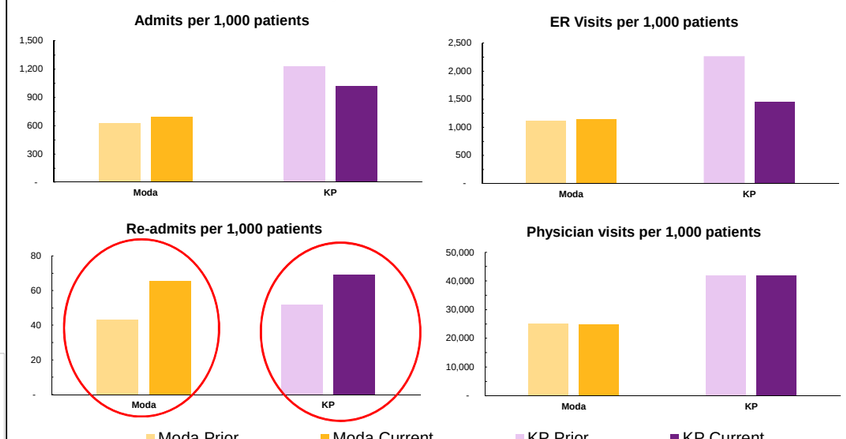
HCC (>$50K)



High Cost Claimants ($50,000 or above) make up 1% or less of total membership in well-managed plans and account for 30% or less of total plan costs. The Moda population is above these targets, while KP is below.

Recommendation: Evaluate the programs and services geared toward HCCs, especially care delivery models for preventing readmissions and ER visits. Specifically, how Moda members are interacting with the Patient Centered Medical Homes, and the Synergy/Summit organized systems of care.

HCC (>$50K) in both Prior and Current Periods



	Moda		KP	
	Prior	Current	Prior	Current
# of Patients	442	442	58	58
Total Allowed	$51.9M	$54.1M	$6.9M	$6.7M
Cost/Admit	$43,332	$37,106	$41,523	$45,063
Cost/ER visit	$2,178	$2,110	$2,406	$2,176
Cost/Re-Admit	$52,240	$46,196	$29,343	$55,092

* Data not risk adjusted for Moda and KP population

OEBB Cost and Utilization Dashboard — Moda Health and Kaiser Permanente

SEOW Attachment 2a - June 7, 2016

Member Experience Summary

Average Members

	Prior	Current
	Average Members	
Moda	104,084	
KP	24,750	104,516
Total	128,835	128,299

$PMPM Allowed

	KP	
	Prior	Current
Inpatient	$87	$76
Outpatient	$89	$93
Physician	$113	$118
Rx	$44	$51
KP Integrated Care Management Fee*	$56	$56
Grand Total	$389	$395

Moda	
Prior	Current
$85	$85
$137	$141
$136	$138
$62	$67
-	-
$421	$431

	Prior	Current
	Total Allowed (Med/Rx)	
Moda	$525.7M	$540.2M
KP	$99.0M	$95.1M
Total	$624.7M	$635.3M
	Total Paid (Med/Rx)	
Moda	$423.9M	$434.7M
KP	$93.4M	$88.2M
Total	$517.3M	$522.9M

Cost and Utilization Summary

Inpatient Admits		
	Prior	Current
Moda	48.9	47.7
KP	41.2	39.2
75th Percentile	46.9	

Inpatient ALOS		
	Prior	Current
Moda	4.2	3.9
KP	3.9	3.9
75th Percentile	3.5	

Cost/Inpatient Admit		
	Prior	Current
Moda	$20,983	$21,481
KP	$21,945	$28,637
75th Percentile	$17,573	

ER Visits/1,000		
	Prior	Current
Moda	136.1	144.9
KP	160.2	152.1
75th Percentile	176.8	

Cost/ER Visit		
	Prior	Current
Moda	$1,843	$1,936
KP	$1,630	$1,790
75th Percentile	$1,474	

Radiology Services/1,000		
	Prior	Current
Moda	1,721.9	1,764.1
KP	1,219.9	1,273.1
75th Percentile	1,581.1	

Cost/Radiology Service		
	Prior	Current
Moda	$230	$230
KP	$249	$260
75th Percentile	$207	

Rx Scripts/1,000		
	Prior	Current
Moda	10,268.6	9,518.3
KP	7,338.1	7,203.6
75th Percentile	7,621.2	

Cost/Script		
	Prior	Current
Moda	$73	$84
KP	$72	$86
75th Percentile	$108	

Generic Dispensing Rate		
	Prior	Current
Moda	83%	82%
KP	83%	82%
75th Percentile	90%	

Conditions

Key Measures

Cancer		
	Moda	KP
# of Patients	2,500	344
# of HCC	53	3
Total Allowed	$42.7M	$4.2M
% Rx	6%	4%

Cancer Per 1,000 Patients		
	Moda	KP
Admits	87.6	93.0
ER Visits	62.0	98.8
Re-admits	6.3	5.8
Physician visits	5961.6	10412.8

Diabetes		
	Moda	KP
# of Patients	4,185	201
# of HCC	7	0
Total Allowed	$16.1M	$0.2M
% Rx	60%	23%

Diabetes Per 1,000 Patients		
	Moda	KP
Admits/1,000	13.3	10.0
Er Visits/1,000	33.9	19.9
Re-admits/1,000	0.2	0.0
Physician visits/1,00	2460.2	1611.9

Coronary Artery Disease		
	Moda	KP
# of Patients	914	155
# of HCC	37	8
Total Allowed	$9.4M	$1.3M
% Rx	4%	2%

Coronary Artery Disease Per 1,000 Patients		
	Moda	KP
Admits/1,000	106.4	135.5
Er Visits/1,000	222.1	161.3
Re-admits/1,000	3.2	12.9
Physician visits/1,00	2392.8	1851.6

Mental Health — Depression		
	Moda	KP
# of Patients	6,057	514
# of HCC	1	0
Total Allowed	$8.0M	$0.6M
% Rx	11%	15%

Mental Health - Depression Per 1,000 Patients		
	Moda	KP
Admits/1,000	13.2	9.7
Er Visits/1,000	34.8	103.1
Re-admits/1,000	1.0	0.0
Physician visits/1,00	2564.6	677.0

High Cost Claimants (HCC)

HCC (>$50K)

% of Members		
	Prior	Current
Moda	1.5%	1.5%
KP	0.9%	0.9%
Target	1%	

% Total Allowed		
	Prior	Current
Moda	34.7%	35.0%
KP	25.6%	26.0%
Target	30.0%	

HCC (>$50K) in both Prior and Current Periods

Admits per 1,000 Patients		
	Prior	Current
Moda	622.2	690.0
KP	1,224.1	1,017.2

ER Visits per 1,000 Patients		
	Prior	Current
Moda	1,117.6	1,151.6
KP	2,258.6	1,448.3

Re-admits per 1,000 Patients		
	Prior	Current
Moda	43.0	65.6
KP	51.7	69.0

Physician Visits per 1,000 Patients		
	Prior	Current
Moda	25,061.1	25,015.8
KP	41,913.8	42,034.5

	Moda	
	Prior	Current
# of Patients	442	442
Total Allowed	$51.9M	$54.1M
Cost/Admit	$43,332	$37,106
Cost/ER visit	$2,178	$2,110
Cost/Re-Admit	$52,240	$46,196

KP	
Prior	Current
58	58
$6.9M	$6.7M
$41,523	$45,063
$2,406	$2,176
$29,343	$55,092

* Data not risk adjusted for Moda and KP population

Annual Medical/Rx Utilization Dashboard for OEBB

June 7, 2016

A presentation to the SEOW

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Reporting periods for medical dashboard

- Current period: 10/1/14 – 9/30/15
- Prior period: 10/1/13 – 9/30/14

Reporting basis

- Incurred claims data — Moda
- Paid claims data — Kaiser

Data sources

Medical data sources:

- Truven

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Highlights from OEBB data and recommended interventions

Highlight from data review	Recommended intervention

Overall ER use lower than benchmark, but opportunity for additional focus:
▪ Focus on frequent users with complex cases:
  ▪ 250 OEBB members with 5+ ED visits/year
  ▪ Some OEBB members with 20 – 70 ED visits per year
  ▪ 14 members with 3 re-admits and 5+ ER visits
	▪ Ensure care plans filed in EDIE*: carriers to confirm PreManage adoption
	▪ Targeted review of OEBB members with multiple ER visits — assign care manager/navigator
	▪ Care management audit

Opportunities for care improvement in members with chronic conditions: ▪ 15,000 members/$82.5M in claims for members with Cancer, Diabetes, Coronary Artery Disease and MH	▪ Clinical care program audit ▪ Establish metrics for carriers to increase participation in care management programs ▪ Consider specialty vendor: second opinion or concierge care management
High Cost Claimants ▪ Optimally managed plan have approximately 1% of members with claims over $50k (1.5% of Moda/OEBB members have claims over $50k)	▪ Clinical care program audit ▪ Navigators to assist members with chronic/acute diseases, ED over use and frequent admissions and post-discharge support ▪ Consider specialty vendor: second opinion or concierge CM ▪ Review options for a Center of Excellence strategy
Generic dispensing rate is good, but opportunity to move closer to best in class rate of 90% ▪ OEBB GDR 83% ▪ $1M reduction in OEBB Rx costs for each 1% increase in Generic use	▪ Review impact from plan design changes for 2016 – 2017 ▪ Carriers to perform targeted education to providers with higher brand dispensing rates

*EDIE — Emergency Department Information Exchange — connects all OR/WA Emergency Departments — real time messaging to triage members to the right care setting

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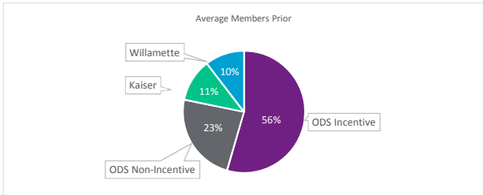
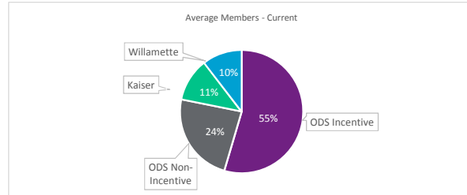
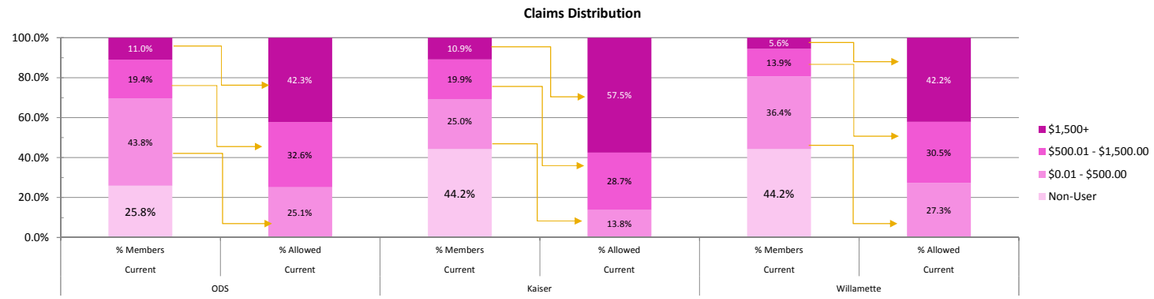
OEBB Dental Dashboard

SEOW Attachment 3a- June 7, 2016

Member Experience

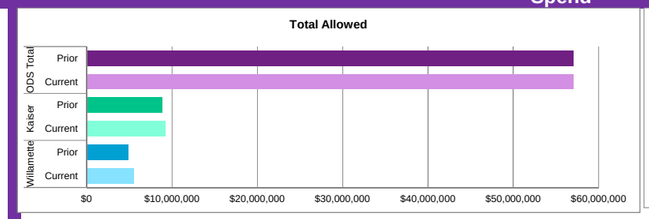


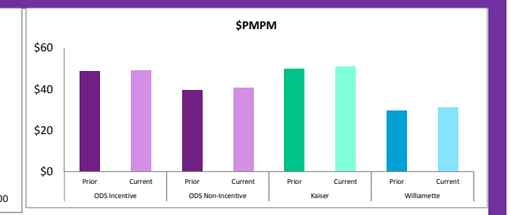




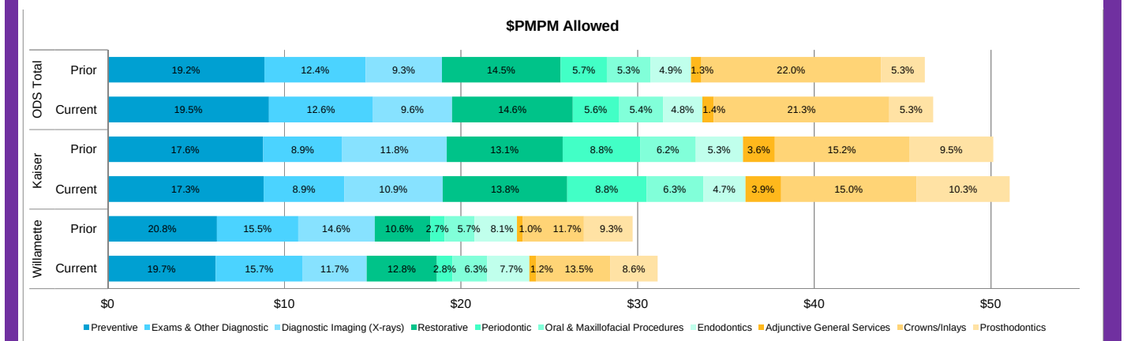
Overall, average members increased by less than 1% over the prior period and remains close to 140,000. ODS membership decreased by more than 1% and shifted to the non-incentive plan which increased by nearly 4%. Kaiser's membership grew slightly more than 3%, and Willamette Dental's increased by nearly 8%. Claims distribution across members remains stable year over year for all carriers. Approximately 45% of Willamette Dental members had no claims in each year compared to 25% of Moda members. Kaiser's allowed claims greater than $1500 make up nearly 58% of cost for the current period, nearly 15% higher than both ODS and Willamette Dental.

Spend

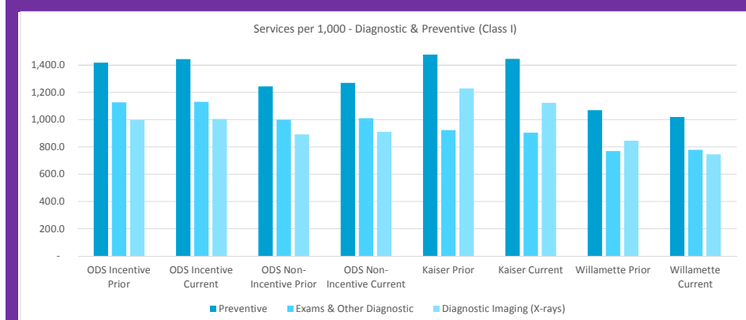


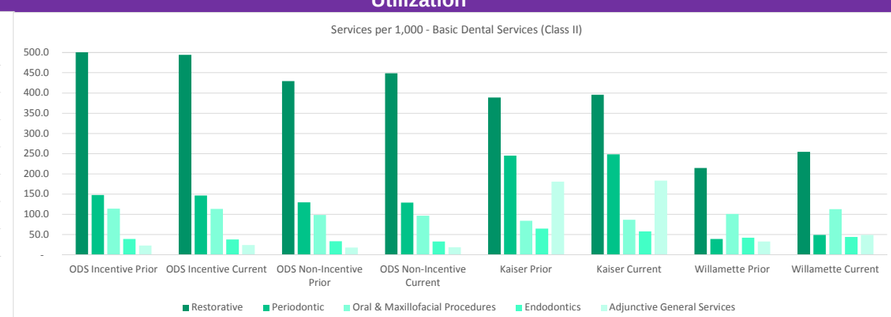


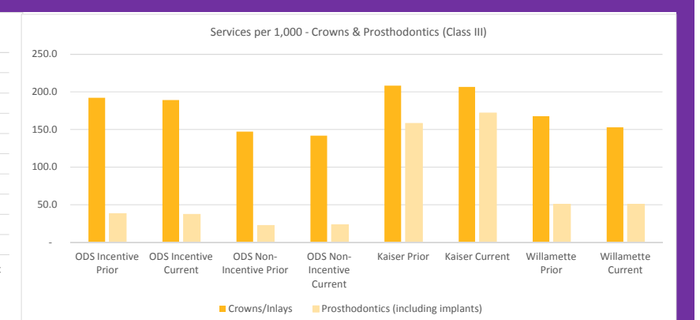
Total Allowed expenses increased 6.8% for ODS Non-Incentive, 4.8% for Kaiser, and 13.1% for Willamette Dental. ODS Incentive decreased by slightly more than 2%. Total Allowed PMPM for prosthodontics for Kaiser and Willamette Dental is nearly twice as high as ODS, likely a result of the ODS dental plan maximum. The Kaiser PMPM allowed dollars, while similar to percent of allowed charges to Willamette Dental, represent nearly double the dollars.



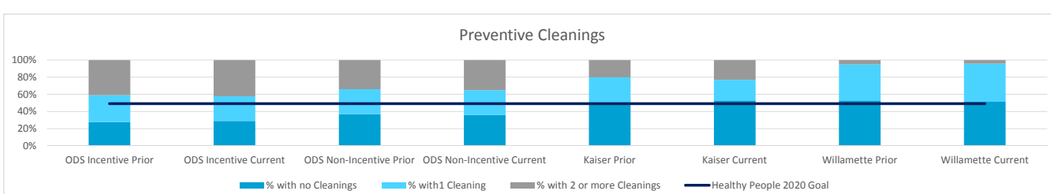
Utilization



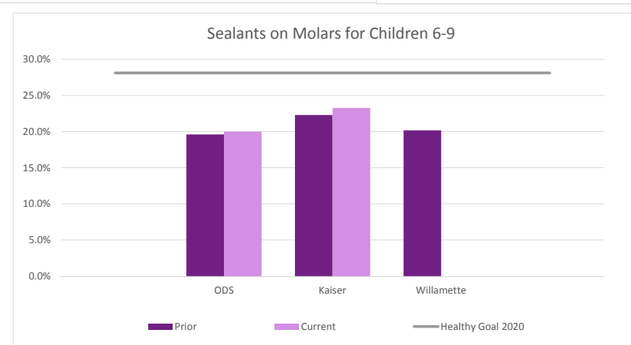




Overall, ODS services per 1000 members increased slightly year over year. For both the incentive and non-incentive plans, all diagnostic and preventive services (Class I) increased while both basic dental services (Class II) and crown & prosthodontic services (Class III) decreased overall. For Kaiser, all Class I services decreased slightly while Class II and III services mostly increased. In contrast, Willamette Class I services and Class III services mostly decreased while all Class II services increased.



For preventive care services, all carriers and plans have remained stable year over year. ODS is trending the highest with nearly 70% of members receiving at least one cleaning per year, which continues to be driven by the incentive plan. Member with at least one cleaning decreased slightly for Kaiser while Willamette Dental increased slightly. The percentage of members with at least two cleanings per year increased for both Kaiser and ODS compared to the prior year. Overall, nearly 40% of ODS members receive two or more cleanings per year. This is nearly double the percentage of Kaiser members that receive at least 2 cleanings per year (20%) and ten times more than the percentage of Willamette Dental members that receive at least 2 cleanings per year. The Healthy People 2020 goal is for 49% of individuals receiving any dental service. Further reporting from the carriers is necessary to confirm whether all OEBB plans are meeting this goal.



Another quality metric is related to placement of sealants on permanent molars of children. OEBB's plans currently fall short of the Healthy People 2020 goals so this may be an area for improvement.

OEBB Dental Dashboard

SEOW Attachment 3a - June 7, 2016

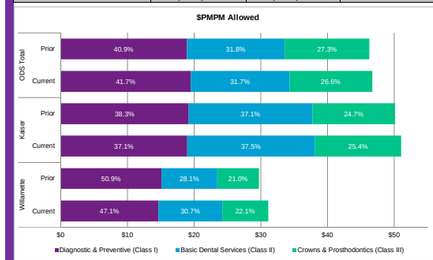
Member Experience

	Average Members			Average Age	
	Prior	Current	% Change	Prior	Current
ODS					
Incentive*	78,960	76,431	-3.2%	36.75	36.60
Non-Incentive**	31,998	33,189	3.7%	36.80	36.49
ODS Total	110,958	109,620	-1.2%	36.76	36.57
Kaiser	15,432	15,924	3.2%	33.52	33.67
Willamette	13,565	14,643	7.9%	34.10	34.10
Total	**139,955**	**140,187**	**0.2%**	**36.15**	**35.98**

	ODS Total		Kaiser		Willamette	
	Current		Current		Current	
% Members	% Allowed	% Members	% Allowed	% Members	% Allowed	% Members
Non-User	0.0%	25.8%	0.0%	44.2%	0.0%	44.2%
$0.01 - $500.00	25.1%	43.8%	13.8%	25.0%	27.3%	36.4%
$500.01 - $1,500.00	32.6%	19.4%	28.7%	19.9%	30.5%	13.9%
$1,500+	42.3%	11.0%	57.5%	10.9%	42.2%	5.6%

Spend

	Total Allowed		
	Prior	Current	% Change
ODS			
Incentive*	$43,314,970.01	$42,330,206.28	-2.3%
Non-Incentive**	$13,785,848.56	$14,725,721.90	6.8%
ODS Total	$57,100,818.57	$57,055,928.18	-0.1%
Kaiser	$8,807,853.00	$9,229,178.00	4.8%
Willamette	$4,857,156.00	$5,495,804.00	13.1%
Total	**$70,765,827.57**	**$71,780,910.18**	**1.4%**



	ODS Incentive		ODS Non-incentive		Kaiser		Willamette	
	Current	Prior	Current	Prior	Current	Prior	Current	Prior
Diagnostic & Preventive (Class I)	$20.09	$19.54	$18.07	$17.34	$18.97	$19.19	$14.67	$15.12
Basic Dental Services (Class II)	$15.55	$15.47	$13.07	$12.68	$19.15	$18.58	$9.57	$8.36
Crowns & Prosthodontics (Class III)	$13.66	$13.80	$9.51	$9.71	$12.95	$12.37	$6.89	$6.24
Total	$49.30	$48.81	$40.65	$39.74	$51.07	$50.14	$31.13	$29.72

	ODS Total Allowed PMPM		Kaiser Allowed PMPM		Williamette Allowed PMPM	
General Service Category	Prior	Current	Prior	Current	Prior	Current
Preventive	$8.88	$9.13	$8.80	$8.83	$6.18	$6.12
Exams & Other Diagnostic	$5.73	$5.89	$4.48	$4.57	$4.61	$4.90
Diagnostic Imaging (X-rays)	$4.31	$4.48	$5.91	$5.57	$4.33	$3.65
Restorative	$6.73	$6.84	$6.57	$7.05	$3.15	$3.97
Periodontic	$2.62	$2.61	$4.40	$4.48	$0.80	$0.88
Oral & Maxillofacial Procedures	$2.46	$2.50	$3.13	$3.22	$1.70	$1.96
Endodontics	$2.29	$2.23	$2.68	$2.39	$2.40	$2.39
Adjunctive General Services	$0.59	$0.64	$1.80	$2.01	$0.31	$0.37
Crowns/Inlays	$10.18	$9.95	$7.61	$7.67	$3.48	$4.20
Prosthodontics	$2.47	$2.48	$4.76	$5.28	$2.76	$2.69
Total	$46.26	$46.73	$50.14	$51.07	$29.72	$31.13

Utilization

Diagnostic & Preventive (Class I)
Exams and Other Diagnostic
Diagnostic Imaging (X-Rays)
Preventive
Basic Dental Services (Class II)
Adjunctive General Services
Endodontics
Oral & Maxillofacial Procedures
Periodontics
Restorative
Crowns & Prosthodontics (Class III)
Crowns/Inlays
Prosthodontics

Service Category	ODS Total Prior	ODS Total Current	ODS Incentive Prior	ODS Incentive Current	ODS Non-Incentive Prior	ODS Non-Incentive Current	Kaiser Prior	Kaiser Current	Willamette Prior	Willamette Current
Preventive	1,368.91	1,391.57	1,417.92	1,442.89	1,243.56	1,269.91	1,476.41	1,445.50	1,068.20	1,018.60
Exams & Other	1,090.77	1,094.24	1,127.03	1,130.05	998.02	1,009.34	922.16	903.80	769.40	778.10
Diagnostic Imaging (X-	967.00	975.52	996.61	1,003.54	891.23	909.09	1,229.25	1,123.24	844.60	745.50
Restorative	482.34	480.54	503.28	493.97	428.77	448.70	388.27	395.18	214.40	254.00
Periodontic	142.36	140.73	147.47	145.94	129.27	128.40	244.64	247.86	38.90	48.80
Oral & Maxillofacial	109.13	107.87	113.45	112.89	98.07	95.97	83.57	86.41	100.80	112.60
Endodontics	37.23	35.89	38.89	37.20	33.00	32.80	64.23	57.58	41.70	43.70
Adjunctive General	20.95	22.05	22.38	23.70	17.30	18.15	180.40	182.71	32.60	48.80
Crowns/Inlays	179.32	175.04	191.92	189.09	147.09	141.75	208.28	206.42	167.70	152.80
Prosthodontics (including	33.83	33.08	38.31	37.19	22.38	23.35	158.26	171.89	50.80	50.70
Total	**4,431.84**	**4,456.54**	**4,597.25**	**4,616.46**	**4,008.68**	**4,077.46**	**4,955.47**	**4,820.59**	**3,329.00**	**3,253.60**

	ODS Incentive Prior	ODS Incentive Current	ODS Non-Incentive Prior	ODS Non-Incentive Current	ODS Total Prior	ODS Total Current	Kaiser Prior	Kaiser Current	Willamette Prior	Willamette Current
% with no Cleanings	28%	29%	37%	36%	31%	31%	50%	53%	53%	51%
% with1 Cleaning	31%	29%	29%	29%	30%	29%	30%	24%	42%	44%
% with 2 or more Clean	41%	42%	34%	35%	39%	40%	20%	23%	5%	4%
Healthy People 2020 G	49%	49%	49%	49%	49%	49%	49%	49%	49%	49%

Sealants on Molars for Children 6-9			
	Prior	Current	Benchmarks
ODS	19.60%	20.00%	28.10%
Kaiser	22.30%	23.30%	28.10%
Willamette	20.18%	N/A	28.10%

Annual Dental Utilization Dashboard for OEBB

A presentation to the SEOW

SEOW Attachment 3b

June 7, 2016

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Reporting periods for dental dashboards

- Current period: 10/1/14 – 9/30/15
- Prior period: 10/1/13 – 9/30/14

Data sources

Dental data sources:

- ODS
- Kaiser Permeate
- Willamette Dental

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Highlights from OEBB data and recommended interventions

Highlight from data review	Recommended intervention
Stable enrollment overall with increasing shift in enrollment to lower cost plans ▪ Enrollment in ODS incentive plans dropped by 3%, non-incentive plans grew by 4% with most of that growth in the lowest cost plan — Plan 6 ▪ Kaiser membership has increased by 3% ▪ Willamette Dental membership has increased by 8%	▪ Assess the relative value of the incentive plan designs — how many members are at what plan reimbursement levels. The average reimbursement for adults is 86% of allowed charges for the current plan year. ▪ Consider consolidation of plans — five ODS plans could be reformed into a high, medium and low value plan selection

Significant difference in utilization
▪ Utilization of preventive care services is high
▪ Within each carrier, utilization patterns are consistent year over year but there are significant differences between carriers
  ▪ Kaiser has significantly higher utilization of periodontic services
  ▪ Prevalence of crowns is lower in the ODS non-incentive plans than in any of the other programs
  ▪ Kaiser's utilization of prosthodontics and implant services is four to five times higher than ODS and Willamette Dental
	▪ Consider adopting the recommended OHA's CCO — DCO Dental Quality Metrics and require providers to report on at least some of the recommended Quality Measure Core Set specifically:
	  ▪ Percentage of adults who received at least one dental service
	  ▪ Percentage of children who received at least one dental service
	  ▪ Percentage of children who received at least one preventative dental service
	  ▪ Monitor emerging Kaiser dental experience to determine if 2016 – 2017 plan design changes impact utilization and cost of prosthodontics and implant services
	▪ Consider the impact of an office visit copay for Kaiser and Willamette Dental — the $20 may be a barrier to care for preventive services.
	▪ Review the current frequency limits within each plan to be certain they are in alignment with current industry standards

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http://natct.internal.towerswatson.com/clients/612555/OEBB2016HGB/Documents/SEOW_Dental_Dashboard.pptx

OEBB Medical and EAP Plans
Mental Health & Substance Abuse Services Overview

	Mental Health			Chemical Dependency		
	Outpatient Services	Inpatient & Residential	Emergency Room & Urgent Care	Outpatient Services	Inpatient & Residential	Emergency Room & Urgent Care
Kaiser Permanente	✓	✓	✓	✓	✓	✓
Moda Health	✓	✓	✓	✓	✓	✓
Reliant Behavioral Health (EAP)*	✓		✓	✓		

*EAP plans come with limited face-to-face counseling dependent upon plan choice and access to 24/7 telephone support for members experiencing a crisis. Chemical dependency services are limited to substance abuse case management and DOT evaluations.

Responding to Mental Health & Addiction Needs

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SEOW Attachment 5
June 7, 2016

Oregon

What We'll Cover Today

- About NAMI.
- Mental health by the numbers.
- What are best practices?
- Focus areas: Where to start?

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National Alliance on Mental Illness

Mental illness is not a scandal —
it is an illness.
And like physical illness,
it is treatable.

— President's New Freedom Commission on Mental Health

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NAMI Is Here to Help
Education • Support • Advocacy

NAMI offers free classes and presentations for all those affected by mental illness, including individuals living with illness and their family members, friends and loved ones.

NAMI programs fill in the information gaps in mental health treatment and support system.

In 2015 – 630 programs; 7,063 served

– 2,000 Helpline calls at state level

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The Numbers:
Why This Issue Is So Pressing

By the Numbers

- 1 in 10 children has a mental health condition that causes significant impairment.

- Half of all lifetime cases of mental illness begin by age 14 and three-quarters, or 75 percent, by age 24.

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By the Numbers

- 1 in 5 adults experiences a mental disorder in any given year.
- 1 in 17 adults lives with serious mental illness such as schizophrenia, bipolar disorder or major depression.

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Ages 13 to 18 years old

- 20 percent of youth ages 13-18 live with a mental health condition.
- About half of students 14 years and older with mental illness drop out of high school.

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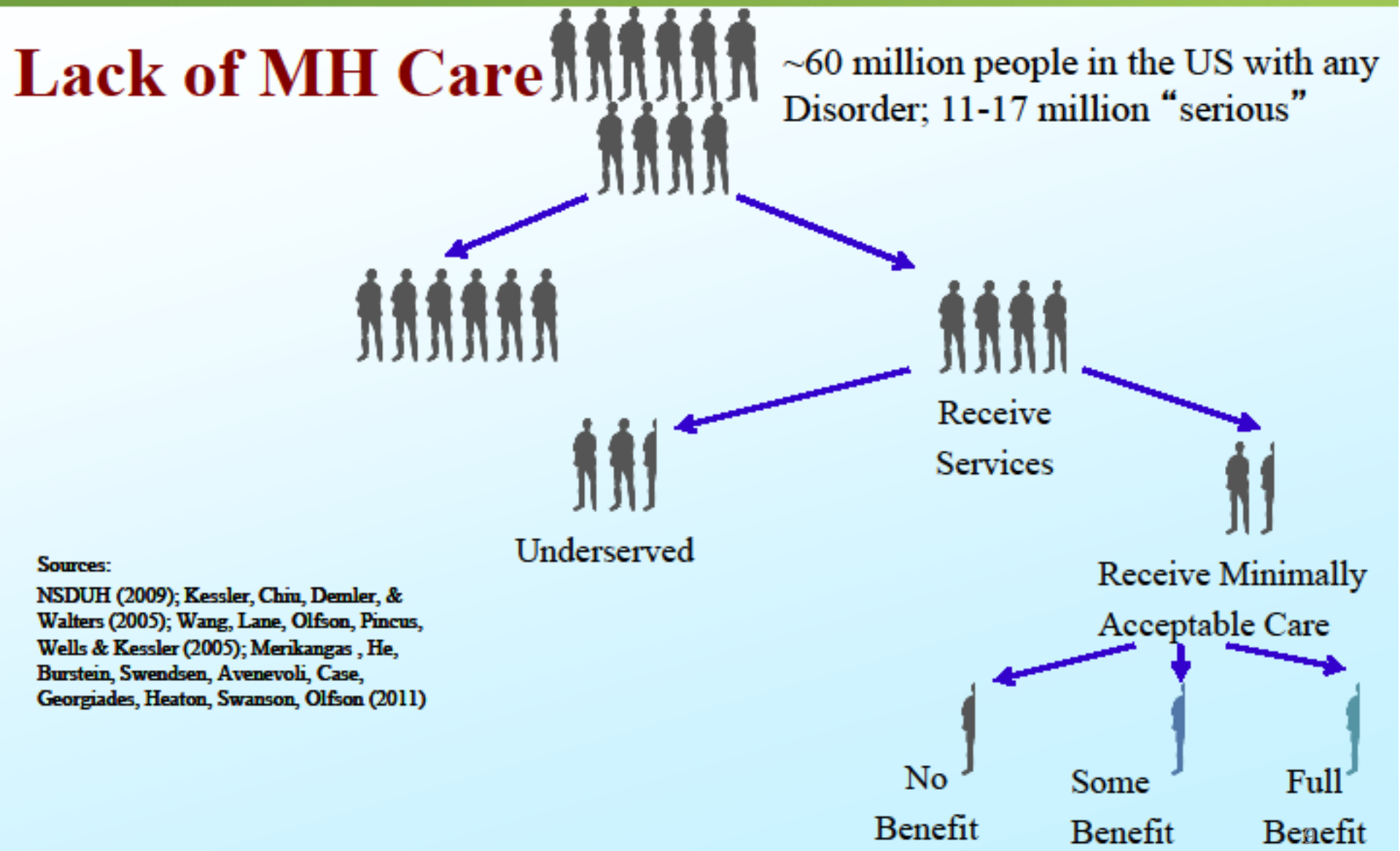
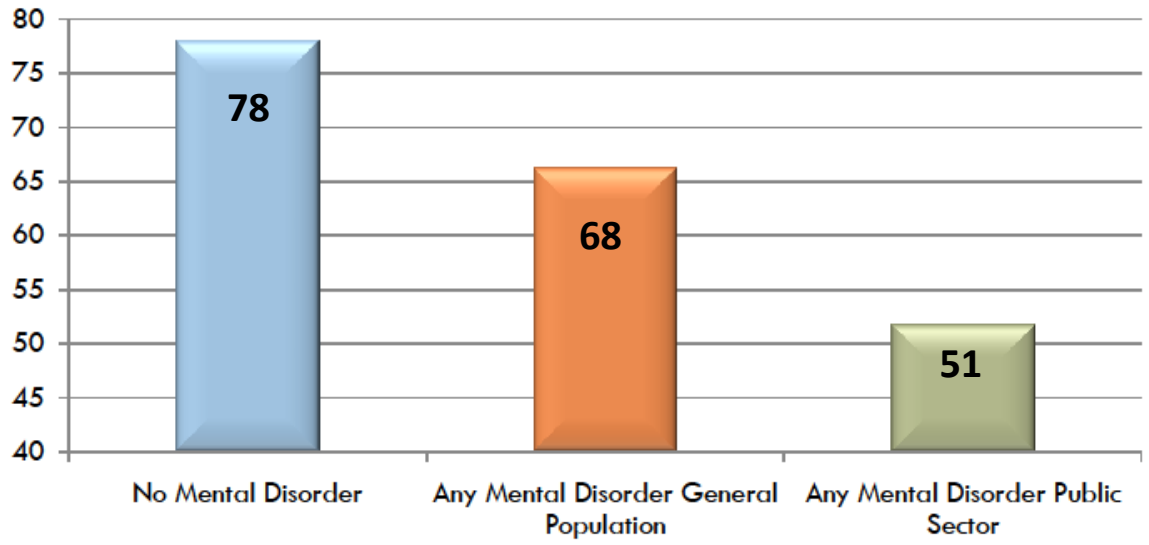
Why have we failed to bend the curve?



Sources:
NSDUH (2009); Kessler, Chiu, Demler, & Walters (2005); Wang, Lane, Olfson, Pincus, Wells & Kessler (2005); Merikangas , He, Burstein, Swendsen, Avenevoli, Case, Georgiades, Heaton, Swanson, Olfson (2011)

Mental Illness and Life Expectancy



Psychiatry Res. 2010 Apr 30;176(2-3):242-5
Med Care. 2011 Jun;49(6):599-604

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Why it's difficult to reach out or find help?

Because mental illness is a disorder of the brain that impacts moods and behaviors, symptoms of these conditions are still more commonly blamed on character flaws, moral failings or, in the case of children, poor parenting.

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What Would You Do?

When mental illness first strikes, few families know where to turn for help or where to find the right help.

There is an **8-year delay** from onset of first symptoms to appropriate treatment.

- *What's happening to me or my loved one?*
- *How do I know I'm getting the right advice or help?*
- *What do all those letters and titles mean?*

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Alphabet Soup – Who does what?

LCSW

NP

MD

CADC

PsychNP

PCP

MSW

LMFT

PhD

MC

MFT

LPC

QMHA

Psychologist

QMHP

Psy.D

Psychiatrist

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What Are the Best Practices for Access?
It's Hard to Say

Mental Health Enters the Modern Age

- 2005 – Insurance parity legislation in Oregon
  Rules finalized in 2006. Rolled out in 2007-08.
- 2008 – Federal parity legislation approved
  Rules weren't finalized until 2013.
- 2010 – Affordable Care Act
  Insurance exchange and expansion in 2014.
- 2016 – CMS issues final Medicaid parity rule

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One Foot Still in the Dark Ages

We haven't had coverage for very long. We still live in a system stunted by:

- Lack of knowledge.
- Lack of standards.
- Lack of investment.

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Early Thoughts on Access: NIATx in 2007
(Network for the Improvement of Addiction Treatment)

- 6 percent of people who called for help ever completed treatment.
- About half of all people who entered treatment didn't complete treatment.
- No-show rate was significant.

What could be done to improve outcomes for an underfunded system?

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NIATx – Look at the Process

- 70 percent show rate for initial assessment if appointment within 24 hours.
- Show rate drops every 24-hour interval. Gains lost after 72 hours.
- High show rate if “intake” is within 7 days of assessment.
- High treatment completion rate if 4 or more treatment services are received within 30 days.

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Similar Findings in Mental Health

- 88 percent attended same-day appointment
- 77 percent attended next-day appointment
- 58 percent attended appointment within 7 days
- 56 percent attended appointment within 13 days

Gallucci, G., W. Swartz, and F. Hackerman. 2005. Impact of the wait for an initial appointment on the rate of kept appointments at a mental health center. *Psychiatric Services* 56(3):344-346.

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The Conclusion?

Reducing wait times for mental health services is particularly critical, as evidence shows that the longer a patient has to wait for such services, the greater the likelihood that the patient will miss the appointment.

Patients respond best to mental health services when they first realize that they have a problem.

Transforming Health Care Scheduling and Access, Institute of Medicine, 2015

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Time Keeps on Ticking

- 25 days – Average wait to see a mental health specialist even with insurance.
- 2/3 of primary care reports poor access to mental health care for their patients.

"We couldn't get a psychiatrist, but perhaps you'd like to talk about your skin. Dr. Perry here is a dermatologist."

"The Mental Health Landscape—2015 and Beyond," Linda Rosenburg, CEO, National Council on Behavioral Health, Presentation at NIMH Outreach Partnership Program Annual Meeting, Aug. 19, 2015.

Examples of Standards

	Urgent Care	Routine Care	Referred/Specialty Care	Wellness/Preventive Care
Appointment Wait Time	Not to exceed 24 hours	Not to exceed 7 days	Not to exceed 4 weeks	Not to exceed 4 weeks
Drive Time	N/A	Within 30 minutes from home	Within 60 minutes from home	N/A
Wait Time in Office	Not to exceed 30 minutes for non-emergency situations			

* Access standards for TRICARE Prime beneficiaries

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Examples of Standards

Urgent Appointments	**Wait Time**
for services that don't need prior approval	48 hours
for services that do need prior approval	96 hours
Non-Urgent Appointments	**Wait Time**
Primary care appointment	10 business days
Specialist appointment	15 business days
Appointment with a mental health care provider (who is not a physician)	10 business days
Appointment for other services to diagnose or treat a health condition	15 business days

* California Dept. of Managed Health Care.

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Examples of Standards

In Oregon, you'll hear a lot about:

- 14 days from referral to appointment.
- 7 days from hospital discharge to appointment.

Why these?

Medicaid benchmarks based on percentiles.

Are they quality benchmarks?

Nobody knows.

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Data Refresher

- 88 percent attended same-day appointment
- 77 percent attended next-day appointment
- 58 percent attended appointment within 7 days
- 56 percent attended appointment within 13 days

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Focus on Mental Health:
Where to Start?

Urgent or Routine?

- Mr. Smith, I'm sorry to tell you that you broke your left arm. Good news, though. You're right-handed. And you're not in any pain. Since it's not urgent, here's a sling. We'll schedule a follow-up.
- Well, Ms. Smith, you have the early stages of a bacterial infection. But you're symptoms are mild. Your lungs are still fairly clear. This isn't urgent yet. We'll try to get you a follow-up appointment in 14 days.

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Urgent or Routine?

A 16-year-old high school student presents in primary care with the early symptoms of psychosis. Symptoms not very disruptive. Still in school, though grades are suffering. Behaviors have not led to school discipline. Parents worried about erratic behavior at home.

In 2015/16, more than 50% of people experiencing a first episode of psychosis will be treated with a NICE approved care package within two weeks of referral.

* Achieving Better Access to Mental Health Services by 2020 -- Dept. of Health, NHS, United Kingdom

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Urgent or Routine?

Dr. Jones, I can't get out of bed. I'm drinking heavily. I'm in danger of losing my job. I keep thinking I want to hurt myself. What's wrong with me? I'm getting worse, and I don't know what to do.

Let's have you see a specialist. Dr. So-and-So is available in:

- 10 days
- 14 days
- 25 days
- Two months

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Delay Impacts: Mental Health and Addiction

- Symptoms worsen. Harder to treat.
- Drop out of care entirely.
- Employment – Lost productivity, lost jobs.
- School – Attendance, fall behind, drop out.
- Family – Struggles at home.
- Physical – Develop other medical conditions.
- Self-harm – Cutting, suicide.

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Access: Focus Areas

Process Measures

- Time from call to appointment.
- Time from appointment to next service.
- Time between services.

Cost

- Are co-pays prohibitive? Mental health and addiction often on specialty tier.

Provider Mix

- Is there a **wide variety** of providers and specialties?
- Are evidenced-based therapies easily accessed for those who need them?
- Cognitive Behavioral Therapy, Dialectical Behavior Therapy, Cognitive Remediation, First Episode Psychosis.

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Benefit Mix: Can I Access What Works?

Commercial

↓

Managed Care

- Hospitalization.
- Outpatient.
- Medication.
- Residential treatment – kids only.

Oregon Health Plan

↓

Managed Care

- Early intervention for psychosis.
- Assertive Community Treatment.
- Crisis respite.
- Supported education.
- Supported employment.
- Residential treatment – adults and kids.
- Family education and therapy.

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Minding the Doors We Enter

Primary Care

- Patient Centered Primary Care Homes
- Screenings conducted for wide array of symptoms
- Clinicians on site (integrated or co-location?)
- Interventions in real time

Hospitals

- ERs – Does anyone know I'm here? Will anyone help me with a discharge plan? What do I do next?
- Inpatient – Does anyone know I'm here? Discharge planning? What next?

Primary Care or Health Plan

- Is anyone coordinating my care? Who knows what's happening to me, what should be happening to me, and what my family and I need?

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Take the First Bite:
Start Somewhere

Oregon

Education • Support • Advocacy

Contact Us

Chris Bouneff

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Oregon Network Adequacy Requirements

Mental Health & Substance Abuse

SEOW Handout 6

June 7, 2016

Agenda/Objectives

- Current Network Adequacy Requirements
- HB 2468 & Proposed Rules
- Status & Next Steps

Current Network Adequacy Requirements

- Annual Summary, Uniform Indicators of Network Adequacy OAR 836-053-1190
  - Information self-reported by insurers
  - Due annually by March 1
  - No specific requirements for disclosure related to access to mental health and substance abuse

HB 2468
New Oregon Network Adequacy Standards

- Effective January 1, 2017 for health benefit plans in force on or after that date
- Requirements apply to individual and small group health benefit plans and the provider directory requirements apply to large group health benefit plans

HB 2468
New Oregon Network Adequacy Standards

- Require networks of providers that are sufficient in number, geographic distribution and types of providers to ensure that all covered services, including mental health and substance abuse treatment, are accessible to enrollees without unreasonable delay

HB 2468
New Oregon Network Adequacy Standards

- Include requirement for access to essential community providers for plans sold through the marketplace
- Require adequate network in areas for enrollees covered by plans sold outside of the marketplace who reside in low-income or medically-underserved areas

HB 2468
New Oregon Network Adequacy Standards

- Provide two ways for insurers to demonstrate compliance
  - Nationally-recognized standard
    - Federal Qualified Health Plans (QHP)
    - Medicare Advantage
  - Factor-based approach
    - Access to Care
    - Consumer Satisfaction
    - Quality of Care and Cost Containment
    - Transparency

Proposed Rules for Nationally Recognized Standard

- Federal QHP Standard includes Mental Health (Including Substance Use Disorder Treatment) in list of specialties to which time and distance standards will apply
- Medicare Advantage requirements include Psychiatry on the list of specialty codes for providers and Inpatient Psychiatric Facility Services on list of specialty codes for facilities

Proposed Rules for Factor-Based Approach

- Small selection of factors for each of the four categories set in statute:
  - Transparency
  - Consumer Satisfaction
  - Quality of care and cost containment
  - Access to care consistent with the needs of the enrollees served by the network
- No specific requirements related to mental health care

Status/Next Steps

- Rules filed May 13, 2016 with anticipated effective date of July 1, 2016
- In public comment period now – hearing scheduled for June 28, 2016
- Will publish any modifications to nationally-recognized standards

Links to Additional Information

- Committee webpage: http://www.oregon.gov/DCBS/Insurance/legal/committees-workgroups/Pages/network-adequacy.aspx
- Proposed rules: http://www.oregon.gov/DCBS/Insurance/legal/laws/Pages/rulemaking.aspx

Links to Additional Information

- Medicare Advantage 2017 Network Adequacy Standards:

  https://www.cms.gov/Medicare/Medicare-Advantage/MedicareAdvantageApps/Downloads/CY2017_MA_HSD_Network_Criteria_Guidance.PDF

- Federal 2017 QHP Network Adequacy Standards:

  https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Final-2017-Letter-to-Issuers-2-29-16.pdf

Contact Information

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Kaiser Permanente Behavioral Health:
Access and Population Care Report

Prepared for:
OEBB Strategy for Evidence and Outcomes Workgroup
June 7, 2016

SEOW Attachment 7

Presented by:
Herb Ozer, LCSW, Senior Administrator, Mental Health Services
Han-chun Liang, MD, Chief of Mental Health

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Executive Summary

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Behavioral Health is a cornerstone to Total Health

2016 Priorities

- Improve care integration of Behavioral Health Services
- Develop and Achieve clear clinical criteria and access standards
- Develop a Zero Suicide culture
- Focus on early intervention
- Decrease stigma and shame associated with mental health or addiction issues
- Consistent identification and coordination of behavioral health care needs across all primary and specialty care providers

Critical Investments

- Implement 6 Mental Health Programs to drive improved access through managed demand, and addresses the quality, service, & care continuity needs of our members
- Add 53 full time employees (FTEs) over 2016 staff levels
- Increase training, tools and aids to support clinical teams
- Update Quality metrics to focus improvement efforts

Key Outcomes & Impacts

- Routine Access: 80% of cases within 14 days
- Urgent Access: 80% of cases within 48 hours
- Improved utilization of internal resources and external provider partners
- More timely response to clinical and non-clinical needs of our members
- Improved overall health outcomes for our members

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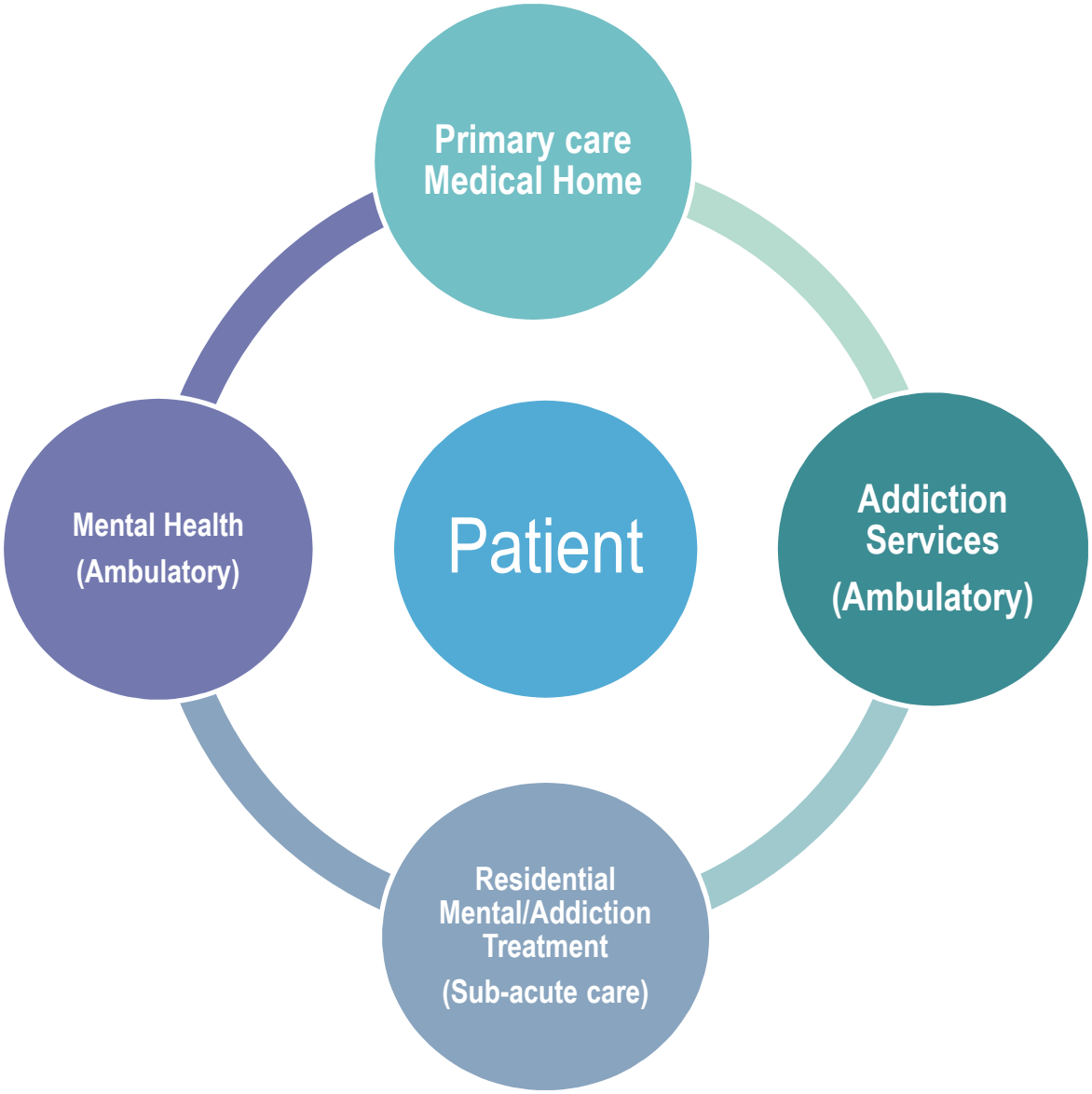
Behavioral Health Services: coordinated continuum of care



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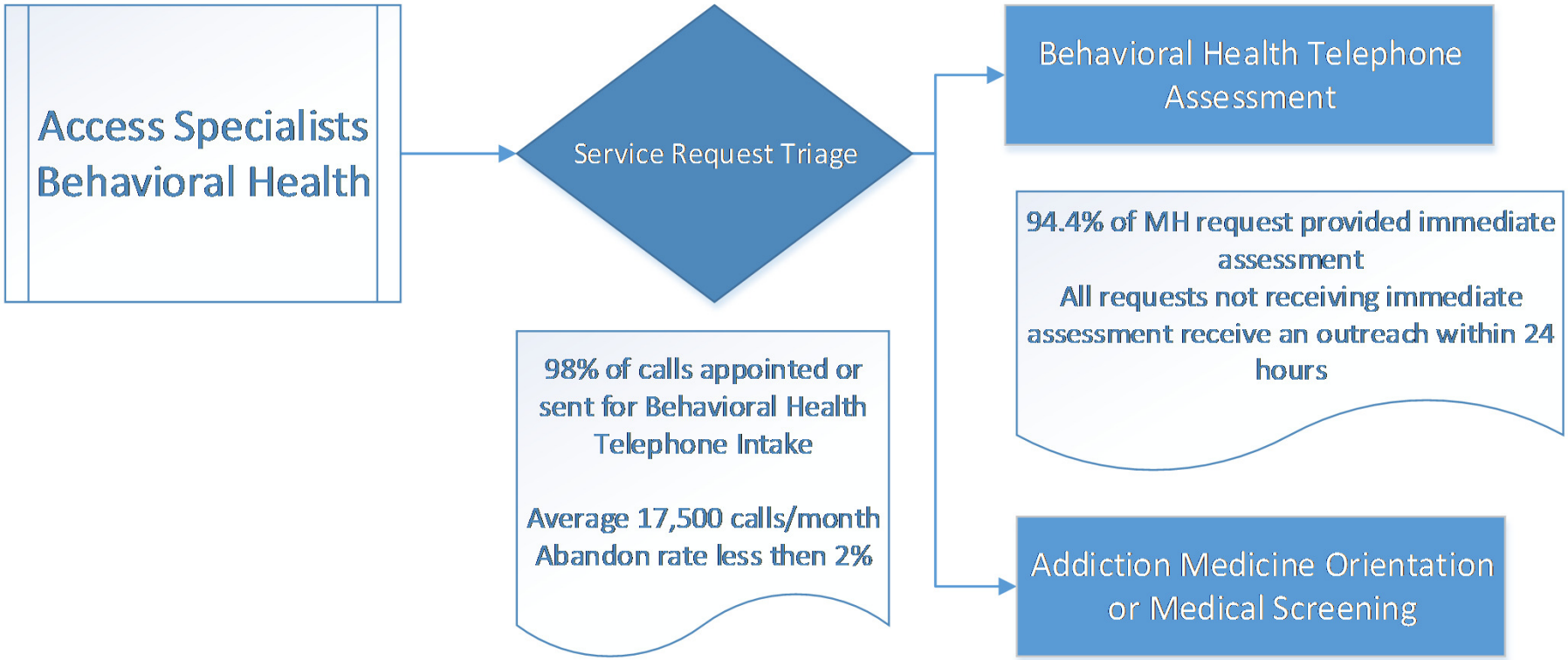
Behavioral Health Services: accessing care



Performance Metric Highlights

- Goal – 95% people immediately connected with clinician for initial assessment call
- MTD – 94.4%
- YTD – 90.49%
- Average call length – 28 Minutes

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Dashboard: Weekly Access Report

MH & ADDM Internal Weekly Access - Regional

DEPT	% of Urgents Seen in 48 Hours Target >= 80%				% of Routine News Seen in 14 Days Target >= 80%			Average Time to Third for Returns Target <= 14 Days		
	Week of 04-25-16	# of Urgent News for Week of 04-25-16	38 Week Average	38 Week Sparkline Trend	Week of 04-25-16	38 Week Average	38 Week Sparkline Trend	Week of 04-25-16	38 Week Average	38 Week Sparkline Trend
MH PRES	100.0%	1	38.2%	100% 75% 50% 25% 0%	32.1%	33.1%	100% 75% 50% 25% 0%	12.4	15.2	40 30 20 10 0
MH THER	100%	1	38.7%	100% 75% 50% 25% 0%	22.7%	22.6%	100% 75% 50% 25% 0%	13.7	15.8	40 30 20 10 0
ADDM	83.3%	6	59.9%	100% 75% 50% 25% 0%	59.5%	69.1%	100% 75% 50% 25% 0%	18.5	21.0	40 30 20 10 0

MH External Monthly Access - Regional

	% of Urgents Seen in 48 Hours Target >= 80%				% of Routine News Seen in 14 Days Target >= 80%		
	Month of Mar 2016	# of Urgent News for Month of Mar 2016	8 Month Average	8 Month Sparkline Trend	Month of Mar 2016	8 Month Average	8 Month Sparkline Trend
Western	57.1%	21	55.7%	100% 75% 50% 25% 0%	57.6%	54.5%	100% 75% 50% 25% 0%
Other	#N/A	#N/A	40.0%	100% 75% 50% 25% 0%	61.3%	64.8%	100% 75% 50% 25% 0%

MH External & Internal Monthly Access - Regional

	% of Urgents Seen in 48 Hours Target >= 80%				% of Routine News Seen in 14 Days Target >= 80%		
	Month of Mar 2016	# of Urgent News for Month of Mar 2016	8 Month Average	8 Month Sparkline Trend	Month of Mar 2016	8 Month Average	8 Month Sparkline Trend
MH Therapy	50.0%	40	46.0%	100% 75% 50% 25% 0%	38.2%	37.7%	100% 75% 50% 25% 0%

Performance Metric Highlights

- MTD: 73% of all urgent patients have a follow up within 48 hours after initial telephone assessment
- Average time to appointment from referral date (self or MD): 1.7 Days

Key:
MH PRES – Mental Health Prescribers
MH THER – Mental Health Therapy
ADDM – Addiction Medicine

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Performance Metrics: residential treatment admission data

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- 2015 - Mental Health Services
  - Total admissions: 853
  - Average Length of Stay (ALOS): 5.9 days
  - Average time from a complete referral to time of acceptance/decline notification: 2 hours
  - Annual unscreened referrals due to lack of bed capacity: 33

- 2015 - Addiction Treatment Services
  - Total admissions: 824
  - Detox service admissions: 626 (103 detox service members transitioned to residential services)
  - ALOS for residential services: 15.5 days
  - ALOS for detox services: 3.6 days
  - Average time from residential care referral to bed date: 5.1 days
  - Average time from detox services referral: < 24 hours from provider visit to bed date (if not referred to BSC they would be bedded at external provider)

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Mental Health Programs

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Goal	Key Investments	Impact
Delivering Care Where and When Our Members Need Us	**Role Diversification** Expand internal capacity, increase throughput and build speedy escalation pathway	• Maximize team approach • All clinicians practice using standard protocols • **routine patient appointing within 14 days**
	Rapid Access Team Supports ongoing care provision and ease return access struggles	• Manage demand at front door for appropriate or rapid access • **urgent appointments within 48 hours**
	Solutions Team Partners with Mental Health Team to support Zero Suicide initiative and care navigation for members	• Maximize scheduled appointment & unmet demand • Mental Health & Addiction Medicine needs equally addressed • **Routine appointments within 14 days & internalize outside visits**
	Behavioral Health Integration Prevent excess dependence on specialty care services	• Assist Primary Care in managing mental health needs • Establish best practice guidelines • **Facilitation of TBC, shift demand (from high acuity to lower acuity)**
	Portals of Entry Eliminate waste and confusion regarding flow of care and methods to meet care needs	• Optimize access to meet a range of behavioral health needs • **Lean improvement on all 13 ways identified that people come in & out of department**
	Child Program Establish comprehensive outpatient program	• Provide better access for children & internalize care • **Provide continuum of services and prevent an elevation in levels of care**

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Mental Health Programs: status update

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	Progress to date	Coming up
Role Diversification Expand internal capacity, increase throughput and build speedy escalation pathway	**75% complete** • All new roles developed: navigators, triage, case managers, additional therapists • Pilots using Team Based Care model in process	• Case Managers being added at 3 remaining locations
Rapid Access Team Supports ongoing care provision and ease return access struggles	**80% Complete** • Saturday clinics running - using rapid access model • Processes and protocols in place • Staff hired & two pilots completed successfully	• Hiring completion • First therapists start 5/4 and 5/16 • Staff training and communications
Solutions Team Partners with Mental Health Team to support Zero Suicide initiative and care navigation for members	**40% Complete** • Processes, protocols & staff roles developed • Care Manager jobs posted • Integration with local staff & leadership • Pilot launched 5/1/16 – full implementation 6/1/16	• Remaining job openings posted • MH team integration / communications • Training programs
Behavioral Health Integration Prevent excess dependence on specialty care services	**30% Complete** • Processes tested and in place • Addiction Med/BH integration - report created to track shared clients, plan to establish monthly coordinated review of care between providers	• 8 additional positions posted
Portals of Entry Eliminate waste and confusion regarding flow of care and methods to meet care needs	**15% Complete** • Training program 80% complete • PI consultant on board • Model review + workflows underway	• Recommendation for standardizations • UBT/PIA outreach and partnership for change
Child Program Establish comprehensive outpatient program	**50% Complete** • Program workflow complete • NFS construction timeline complete • Staff training program in process	• Job postings/Hiring • Construction start 6/16

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Expanding Capacity

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- Internal Resources: hiring 53 additional FTE in 2016

Status	Therapy- General Solutions Team Outpatient IOP Groups BHC	Triage (Therapist)	Rapid Access Team (Therapy and Prescriber)	Other Support Staff	Total	% Complete	% Complete Target Q1
Hired	9	3	3	4	19	36%	28%
Posted	10	0	4	6	20	38%	50%
To be posted	2	0	2	9.5	13.5	26%	22%
Subtotal	21	3	9	19.5	**52.5**		

- External Resources: contracted clinicians added to network
  - 8 Mid-Valley
  - 25 Metro Portland (Western Psychological additions)
  - 50 additional external clinicians in credentialing/contracting process

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Staff Hiring Plan and Access Impact

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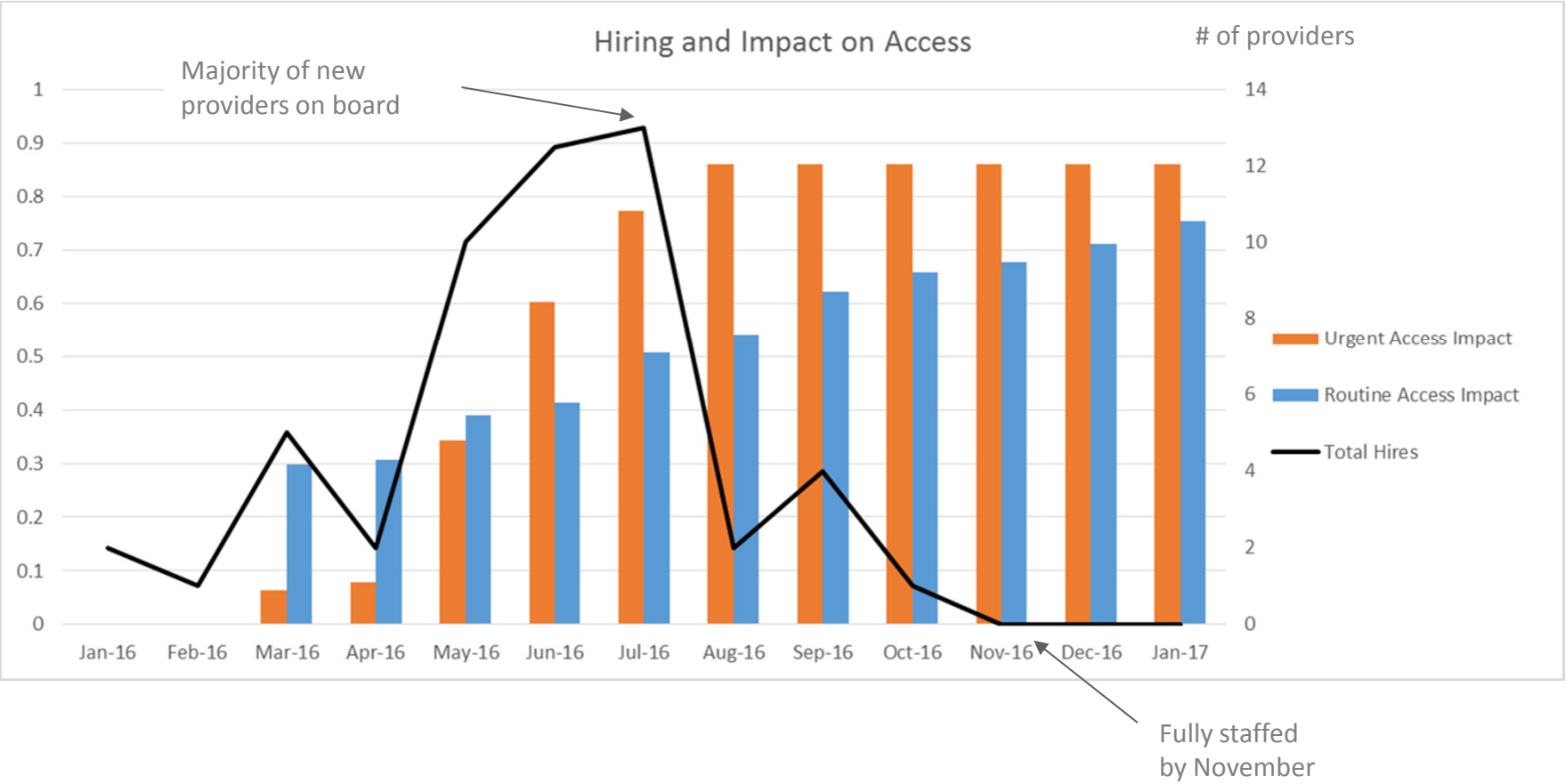

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APPENDIX

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Developed Policies to Formalize Standards

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Access Policy

I. Policy:

- The mental health department will utilize the most current published standards of The National Committee for Quality Assurance (NCQA) to guide patient access parameters. The department monitors, analyzes and establishes improvement initiatives utilizing these standards to promote the highest quality of services to our members.

II. Purpose:

- To ensure quality of services that are in keeping with national norms for clinically appropriate services.

III. Scope:

- This policy applies to all members of the mental health department including therapists, prescribers and appointing staff.

IV. Definitions

- NCQA

V. Appendices

1. NCQA Net 2 (2016)
2. Clinical Acuity policy

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Acuity Criteria and Access Standards Policy

I. Policy:
- KPNW mental health department applies acuity criteria in a consistent manner based on the clinician's assessment.

II. Purpose:
- To ensure wise and consistent handling of patients and resources.

III. Scope:
- This policy applies to all outpatient clinical staff documentation and appointment utilization

IV. Protocol
- Note: clinical acuity is a complex clinical decision. The safety of the patient is of the utmost importance, so this criteria should be considered a protocol.

EMERGENT	Member requires immediate assistance. 911 or referral to Emergency Room.
URGENT	If patient meets medical necessity criteria and at least one of the following, they are clinically URGENT and should be seen within 48 hours, UNLESS a safety plan and/or use of natural supports can mitigate one or more risk issue(s) and thereby lower the acuity to Priority: • Member is at moderate risk of hospitalization, suicide or other harm. • Member is evidencing sudden decrease in functioning, likely due to a psychiatric condition, or is in high-risk population (e.g., older adult, child/adolescent, co-morbid medical problems, co-morbid substance use, etc.). • Member is evidencing grossly impaired functioning and/or decision-making capacity (ex: unable to safely parent children, perform at work/school, etc.) and can be expected to further decompensate if not seen within 48 hours. • Member has Psychotic or bipolar disorder with increasing symptoms likely to result in decompensation or need for higher level of care if not treated within 48 hours. • Member has recorded a GAD 7 greater than14 with significant change from baseline. • Member has recorded a PHQ 9 greater than 23 with significant change from baseline.
PRIORITY	Patient meets medical necessity and clinical assessment indicates they should be seen in less than 2 weeks to avoid meeting URGENT criteria. OR Member would have met Urgent criteria except for the creation of a short term plan to sufficiently mitigate risk concerns and lower the immediate acuity
ROUTINE	Patient meets medical necessity and does not meet Priority criteria
SUB-CLINICAL	Member does not meet medical necessity criteria for treatment.

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Acuity Criteria and Access Standards Policy - continued

Use Prescriber Urgent	Use MH Therapist Urgent
Member meets urgent criteria and one of the following: • Member demonstrates acute mania, acute psychosis, severe depression, severe anxiety or severe insomnia with increasing symptoms likely to result in decompensation or need for higher level of care if not treated within 48 hours, or • Member has BOTH sudden decrease in functioning, AND is in a high-risk population. • Prescriber appointing can be secondary to urgent clinician appointing	• All other urgent patients • Potentially emergent patients or those for whom a prescriber urgent is appropriate, BUT for whom there is a plan, or a plan can be created, to mitigate the risk issues. • Patient supports and status manageable with ongoing ambulatory support. • Urgent appointment can help maintain stable level of care need or facilitate member engagement and entry into other ongoing care services. • Use of Clinical Intervention as bridge prior to prescriber appointing to maintain safety and stability of member

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Performance Metrics

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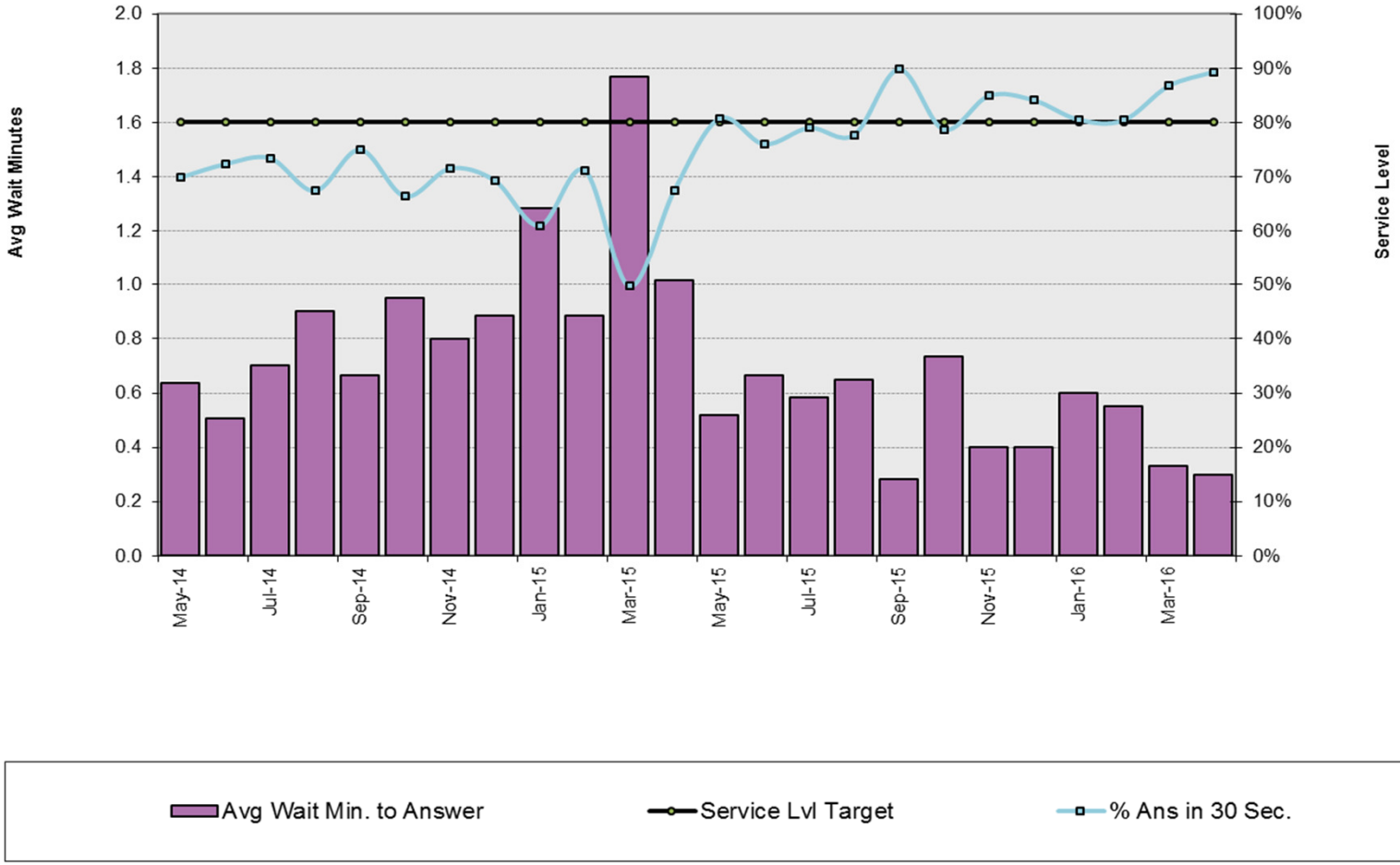
Patient Access Specialists – Answer Speed

- 80% of calls answered within 30 seconds



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Performance Metrics

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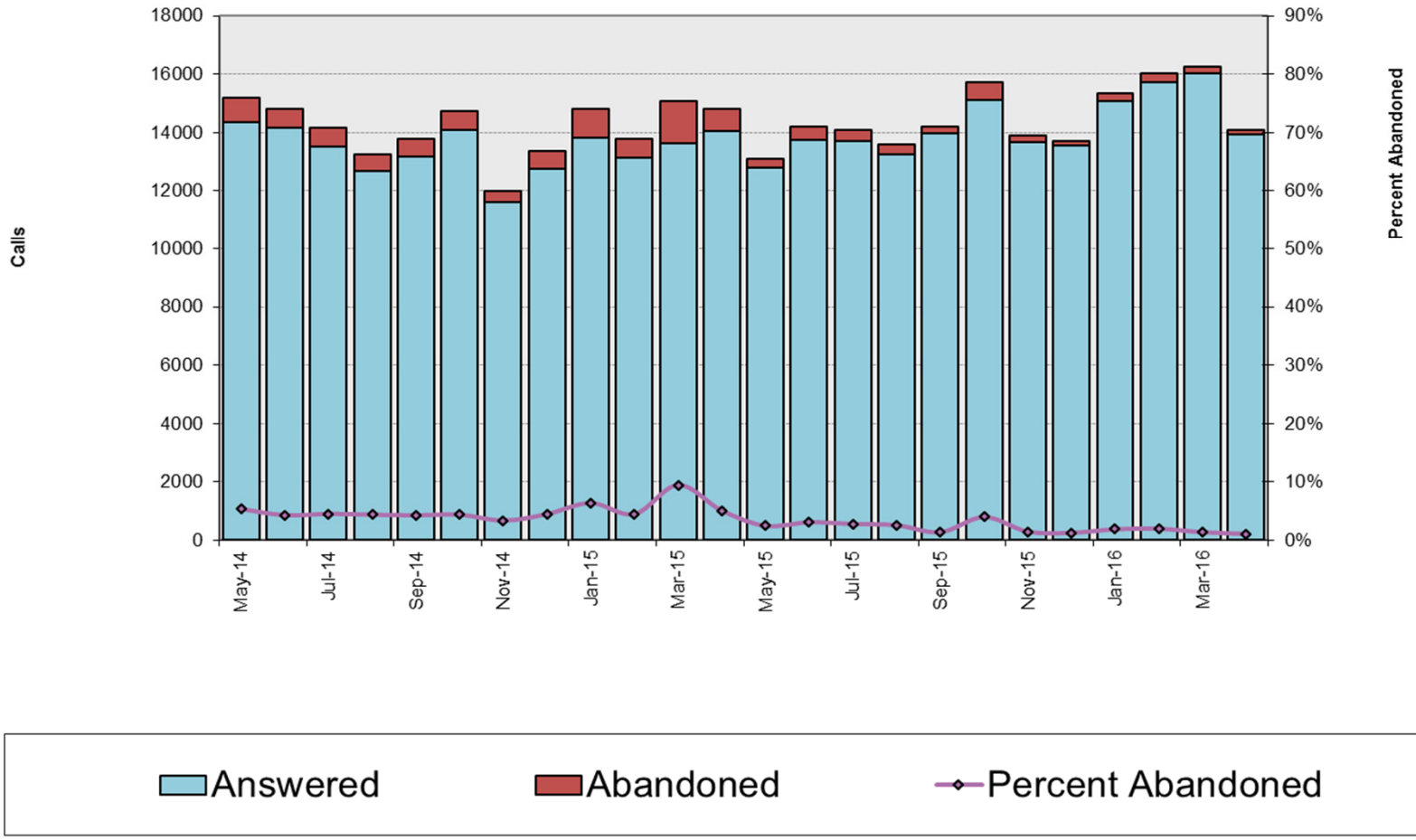
Patient Access Specialists – Answer Rate

- 98% of calls appointed or sent for immediate Behavioral Health assessment



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Mental Health and Addiction Medicine: a Shared Focus

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- Brookside Center (BSC) is an Oregon licensed 40 bed Secure Residential Treatment Center
- Brookside offers three service delivery types:
  - Mental Health Treatment (RMH)– Short-term alternative for voluntary inpatient (5-6 days)
  - Addiction Medicine Residential (RAM) (2-3 weeks)
  - Detox – Offered primarily in RAM but also in RMH (2-3 days)
- We focus on meeting patient care needs across program areas, across disciplines, and across job duties whenever possible to facilitate patient care for Kaiser Permanente members.
- Treatment emphasizes community support, engagement, and trauma-informed care. It is not a typical medical service delivery model but supports members experience practical, skill-based support and opportunities to learn.

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moda

Access to Mental Health and Substance Abuse Treatment

Dan Thoma, LPC
Manager, Behavioral Health

SEOW Attachment 8
June 7, 2016

Standards and Monitoring

Behavioral Health Access Standards

- Urgent appointments: 48 hours
- Routine Appointments: 10 business days
- All provider types

Monitoring

- Member Complaints and Comments
- Moda staff experience when providing assistance
  - Provider location
  - Provider types and specialties
- Annual Member Survey
- Provider Surveys

2015 Member Survey

- Sent to: 14,775
- Respondents: 2,527
- Sought BH Help: 300

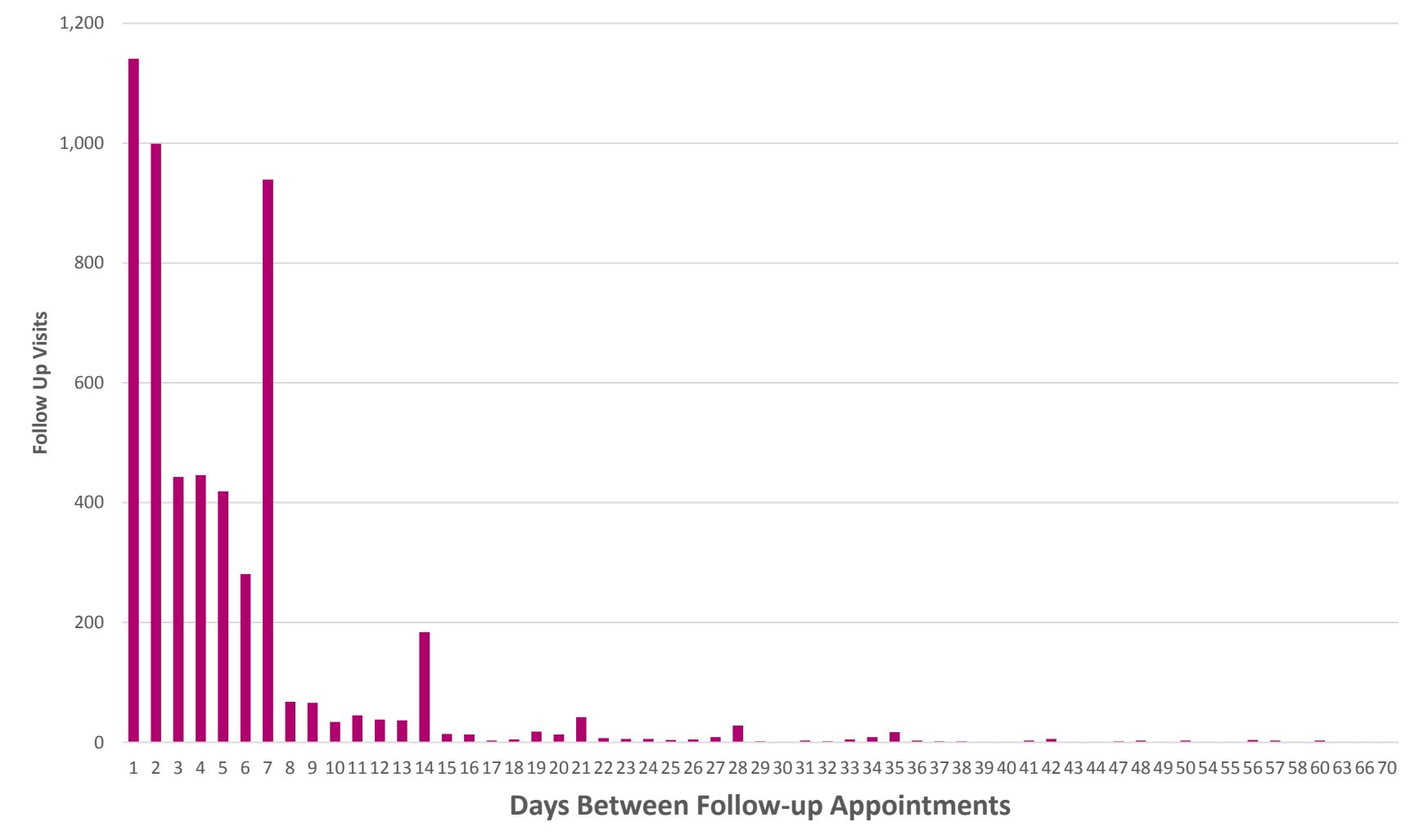
Survey item	Moda Health goal	OR 2014	OR 2015
In the last 12 months, not counting the times you needed urgent mental health care, how often were you able to get mental health care within two weeks? [1]	80%	79.8%	79.2%
In the last 12 months, if you needed urgent mental health care, how often were you able to get care within two days? [1]	90%	69.7%	54.2%
How easy was it to find a mental health or substance use provider skilled in treating your specific problems?[2]	-	-	73.8%
How easy was it to find a mental health or substance use provider who understood your culture?[2]	-	-	84.0%

[1] Rate =“usually” + ”always” responses
[2] Rate = “very easy”+ ”somewhat easy”

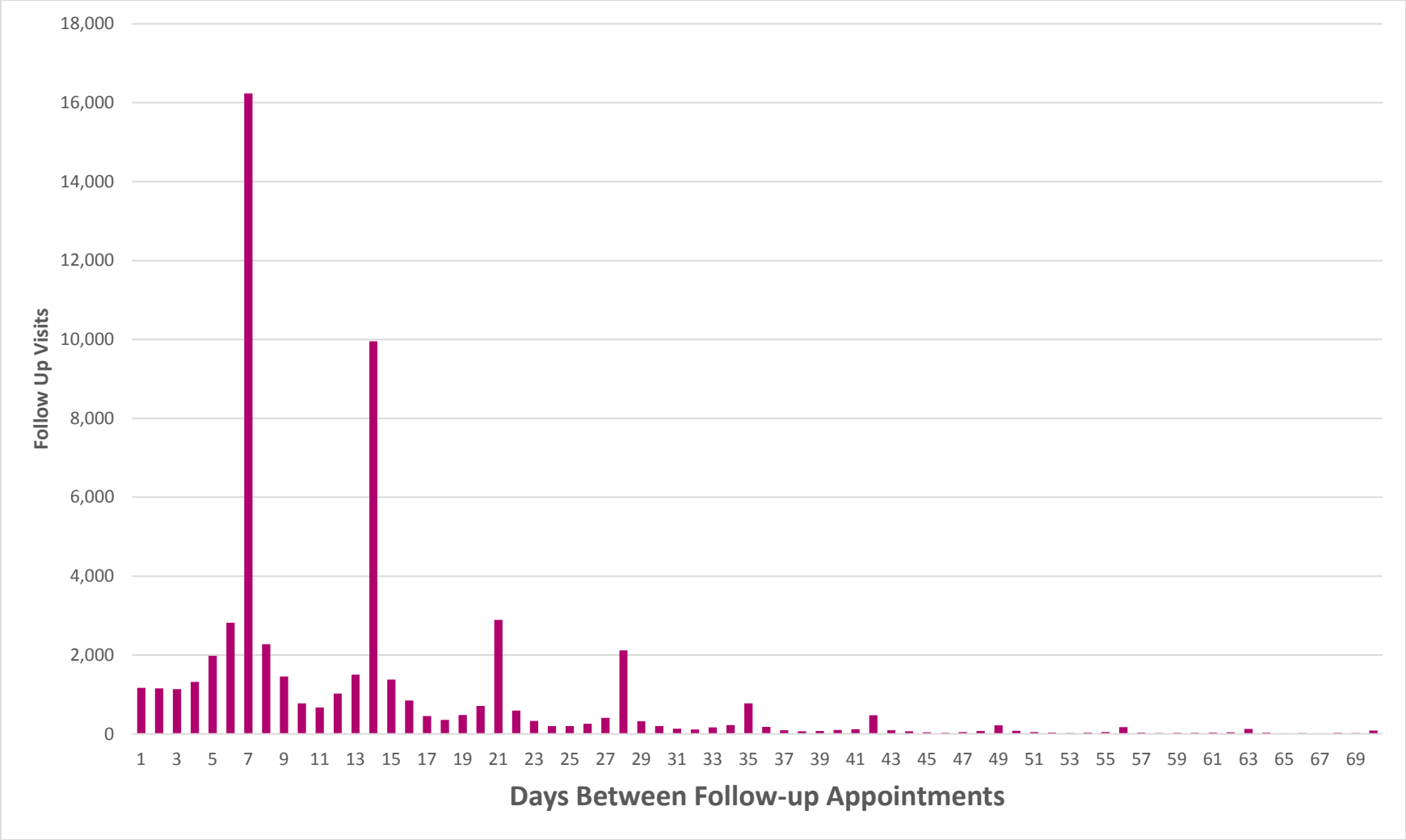
Follow-up Appointments

Average Days Between Follow-up Appointments				
Provider Specialty Category	**Member Count***	**Follow Up Visits**	**Mean Days Between Appts.**	**Median of Days Between Appts.**
Chemical Dependency	338	5,423	6.0	4
Mental Health	6076	60,267	15.1	10
Prescribing	2237	11,994	34.1	25

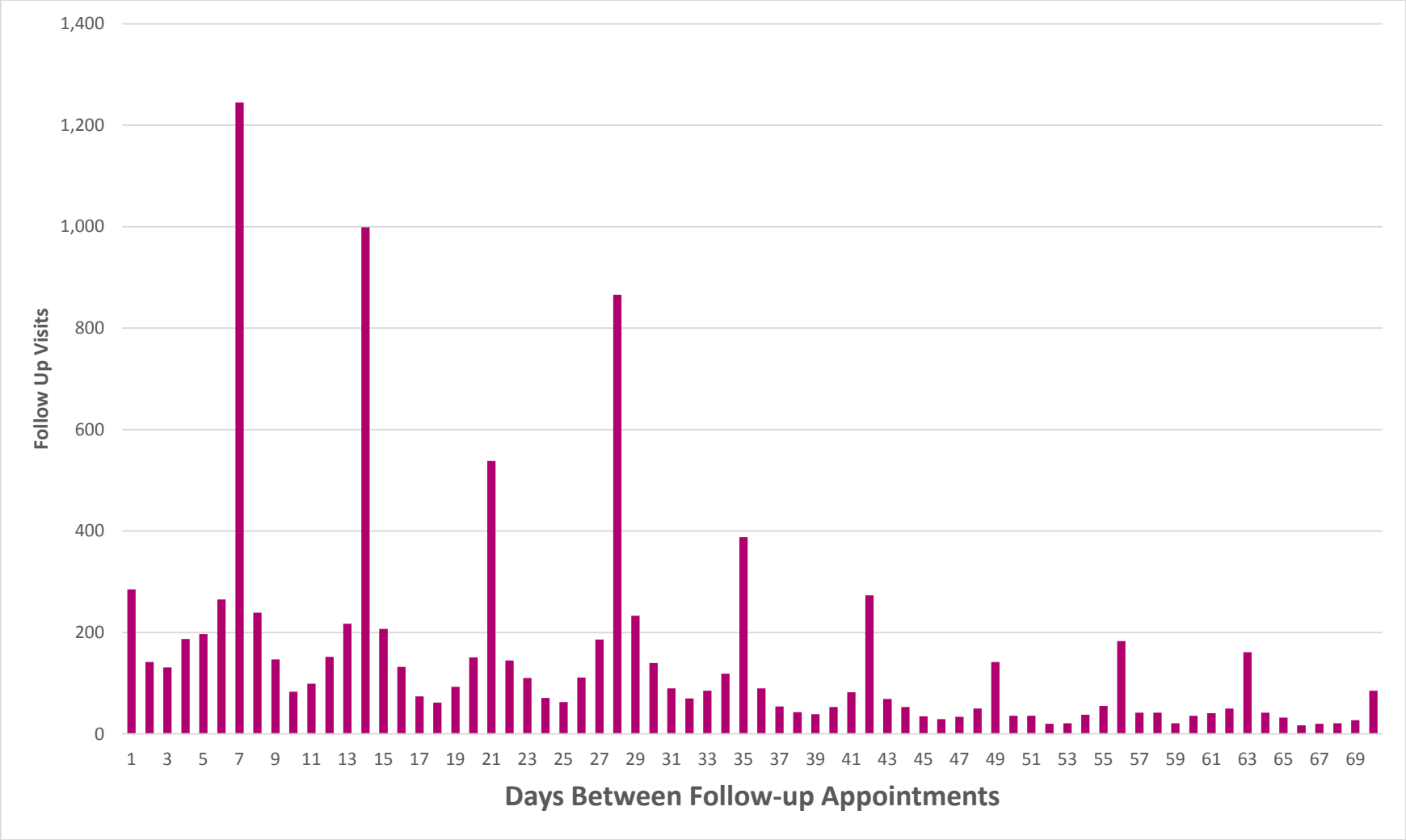
Chemical Dependency



Mental Health



Prescribing Providers



Residential Treatment

Mental Health and Chemical Dependency

Mental Health Residential Treatment

Location	Programs	Beds
Portland	2	59
Corvallis	1	43
Eugene/Springfield	2	52
Gladstone	1	55
Grants Pass	1	12
Denver	1	33

Chemical Dependency Residential Treatment

City	Programs	Beds
Baker City	1	24
Boise	1	150
Coburg	1	70
Corvallis	1	45
Eugene	1	81
Gladstone	1	55
Gooding	1	48
Grants Pass	1	10
Klamath Falls	1	40
Madras	1	15
Medford	2	35

Facilities	Programs	Beds
Newberg	1	95
Ontario	1	37
Portland	3	72
Prineville	1	21
Redmond	1	MM*
Roseburg	1	35
St. Helens	1	MM*
Tigard	1	MM*
Vancouver	1	MM*
Yakima	1	170

*MM: Data not available at this time

Complaints

Written and Verbal Complaints

- Formal Complaints: 0
- Comments from Member Survey:

Type of Concern	Number of Comments
Quality of information available online or from Customer Service	9
Desired providers not in-network	4
In-network providers did not have available appointments	3

Member Survey Comments

"I was looking for someone who specialized in working w anxiety, OCD, and possible hoarding. There was no way to identify what people area of specialty is."

"Have been with my provider for many years who is not in network and for whom I am asked to pay ridiculous amounts for co-pay and out-of-network services."

"The wait was 3 months. A bipolar patient can't wait 3 months to be seen. It would be easier if I were on welfare."

Improving Access

Actions Taken

- Increasing Panel Size
  - Emphasis on under-served areas, e.g., Corvallis, Western Washington County, Bend
  - Emphasis on needed specialties, cultural and language competence
- Data Clean-up
  - LexisNexis scrubbing for current information
  - Internal database with specialties—statewide cleanup completed Feb, 2016
- Assistance in making appointments
  - Two levels: Customer Service and BH team
- New IPA Contract with Performance Guarantee
  - 90% Urgent access within 48 hours

Looking Forward

- Guiding philosophy: Timeliness *and* Quality
- Continuous Assessment
- Continue improvements to data available on-line
- Deepen partnerships with providers
- Educate members about available assistance

Be better

RBH
Reliant Behavioral Health

Reliant Behavioral Health OEBB EAP Program Access Standards & Report

SEOW Attachment 9
June 7, 2016

RBH Access Standards

Regardless of provider type, RBH standards:

Emergent Calls (at immediate risk of self-harm): *Same day appointment. RBH internal clinical staff councils and facilitates appointment with RBH network provider or emergency response, as appropriate.*

Urgent Calls (in crisis but not at-risk of self-harm): *Same day or next day appointment. RBH internal clinical staff councils and facilitates appointment with RBH network provider (unless caller chooses to schedule own appointment).*

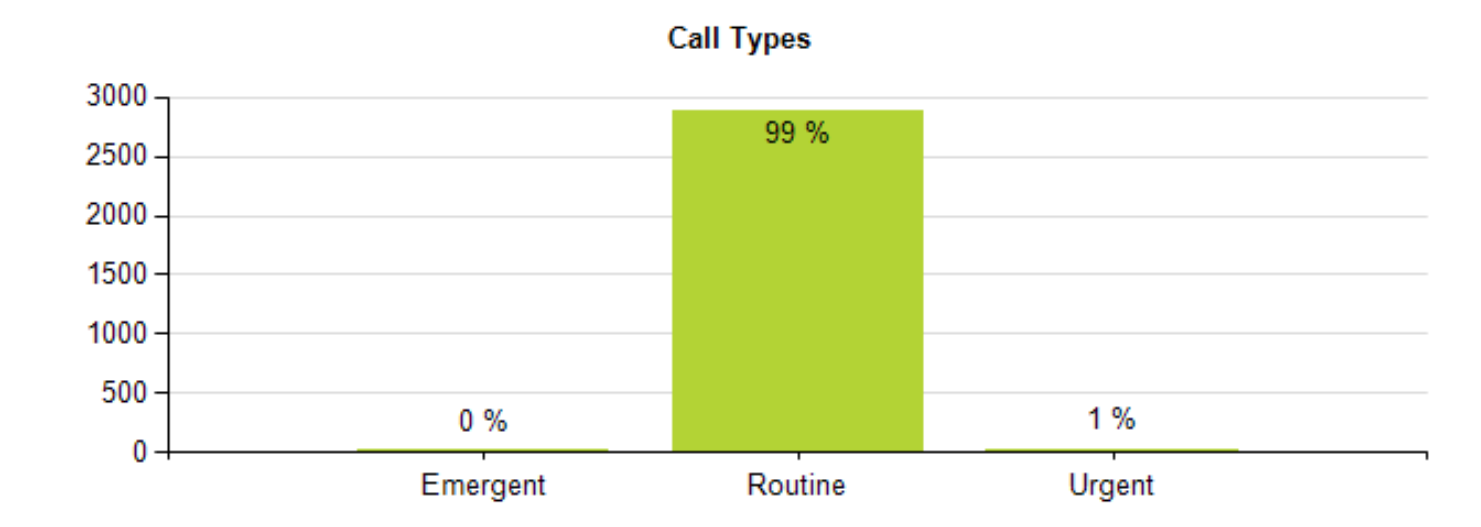
Routine Calls (non-emergent; non-urgent): *RBH Customer Service staff works with caller to provide referral to a network RBH counselor with whom they can make an appointment. Caller is advised to call RBH back if they are not able to get an appointment within what the caller deems to be a "reasonable amount of time."*

RBH
Reliant Behavioral Health

OEBB Customer (Individual) Feedback

Customer (individual)	Date Created	Feedback Type	Level	Issue	Disposition
Linn Benton Lincoln ESD	7/29/2015 7:45	Complaint	Level 1	Appointment Not Available in Reasonable Time	Clinical team assisted member in scheduling appointment
Bend-LaPine SD 1	8/12/2015 14:02	Complaint		Appointment Not Available in Reasonable Time	Member declined assistance, but CM sent list of 4 counselors with availability that week
Portland SD 1J	2/11/2016 9:04	Complaint	Level 1	Appointment Not Available in Reasonable Time	Clinical team assisted member in scheduling appointment
Hood River County SD	10/19/2015 10:52	Complaint		Provider is no longer taking clients	Difficulty finding Spanish speaking counselor. Member chose to engage telephonic counselor through EAP that week.
Linn-Benton Community College	2/11/2016 6:51	Complaint	Level 1	Provider is no longer taking clients	Clinical team offered assistance 3 times. Member did not respond to scheduling assistance.

OEBB Member Call Types 2014-15



RBH
Reliant Behavioral Health

Total OEBB Employees with EAP Benefits through RBH; Total Utilization %

Total Utilization	2012-2013	2013-2014	2014-2015
Total Employees	42,503	41,819	47,080
Total Services	7,312	7,017	9,177
% Utilization	17.2%	16.8%	19.5%

Appendix

- OEBB EAP Case Utilization
- OEBB EAP Participant Types
- OEBB EAP Top Five Utilization Categories
- OEBB EAP Case Disposition
- SAMHSA (Substance Abuse & Mental Health Services Admin.) Data Comparing Drug and Alcohol Abuse Across Industries

Case Utilization

Overall Utilization	**2012-2013**	**2013-2014**	**2014-2015**
Total F2F Visits	5669	5678	5858
Avg. F2F Visits	3.2	3.3	3.3
New Case Utilization	2561	2393	2903
Ongoing Case Utilization	297	389	392
% Case Utilization	6.0%	5.7%	6.2%

***(% Case Utilization –% Case Utilization** – shows the percentage of individuals participating in an initial counseling session during the reporting period.)*

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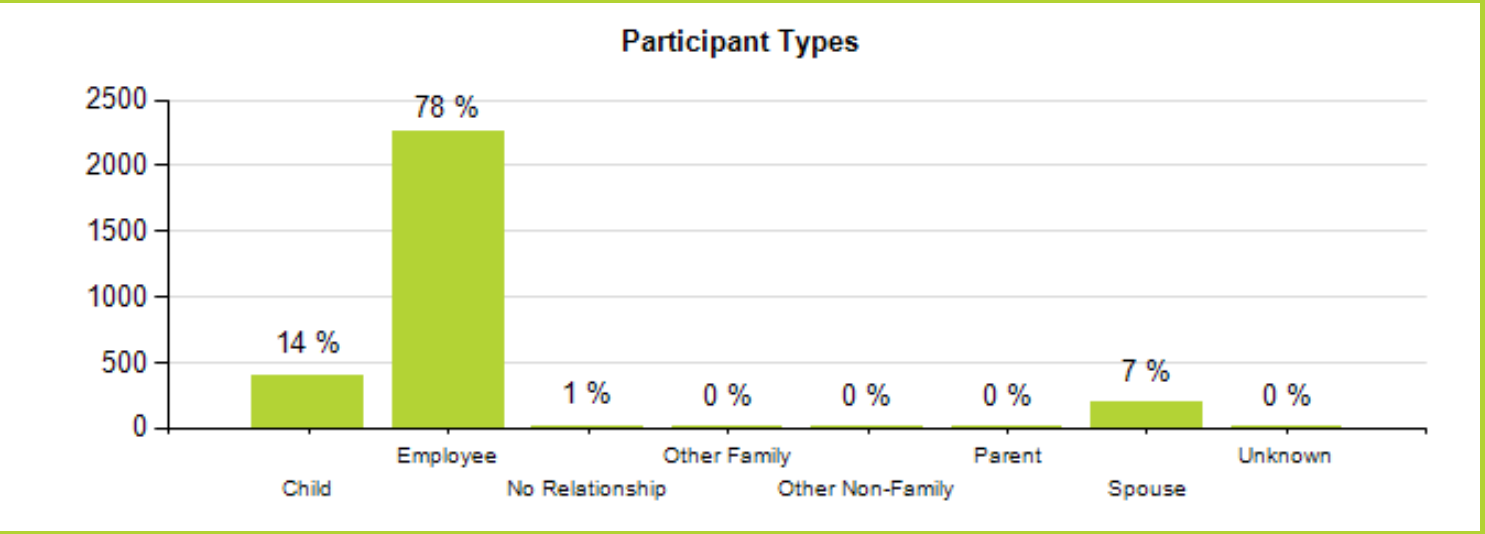
Participant Types 2014-2015



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Top Five Utilization Categories 2014-15

	2012-2013	2013-2014	2014-2015	Book of Business
Couples/Relationship	19.5%	19.81%	19.01%	16.92%
Legal	16.8%	15.92%	14.12%	16.07%
Family/Parenting	11.4%	11.66%	12.33%	10.02%
Anxiety	9.6%	8.73%	10.9%	8.99%
Depression	7%	7.06%	5.96% (5th)	7.24%
Stress - Home			6.72% (4th)	7.05%

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Reliant Behavioral Health

Case Problem Distribution

	2012-2013		2013-2014		2014-2015	
Problem Type	Reported	Assessed	Reported	Assessed	Reported	Assessed
ADHD	9	14	6	10	7	6
Alcohol	20	17	20	20	8	15
Anger Management	32	36	32	33	46	47
Anxiety	212	246	131	209	230	317
Career Counselling	0	0	0	0	0	0
Career Development	28	30	18	22	23	21

RBH
Reliant Behavioral Health

Case Problem Distribution

	2012-2013		2013-2014		2014-2015	
Problem Type	Reported	Assessed	Reported	Assessed	Reported	Assessed
Childcare	4	4	5	5	2	2
Concierge	1	1	1	1	1	1
Couple/Relationship	446	499	434	474	503	552
Co-Worker/Supervisor Conflict	24	27	9	11	14	19
Crisis	13	21	10	15	15	14
Depression	185	178	151	169	178	173
Domestic Violence	5	5	5	5	3	8

RBH
Reliant Behavioral Health

Case Problem Distribution

	2012-2013		2013-2014		2014-2015	
Problem Type	Reported	Assessed	Reported	Assessed	Reported	Assessed
Drugs - Illegal	12	15	11	6	4	3
Drugs Prescription	2	3	2	4	2	1
Eating Disorder	6	7	7	6	4	4
Elder Care	15	15	8	8	6	6
Family/Parenting	282	292	287	279	366	358
Financial	77	81	73	74	72	74
Gambling	1	1	1	2	3	2

RBH
Reliant Behavioral Health

Case Problem Distribution

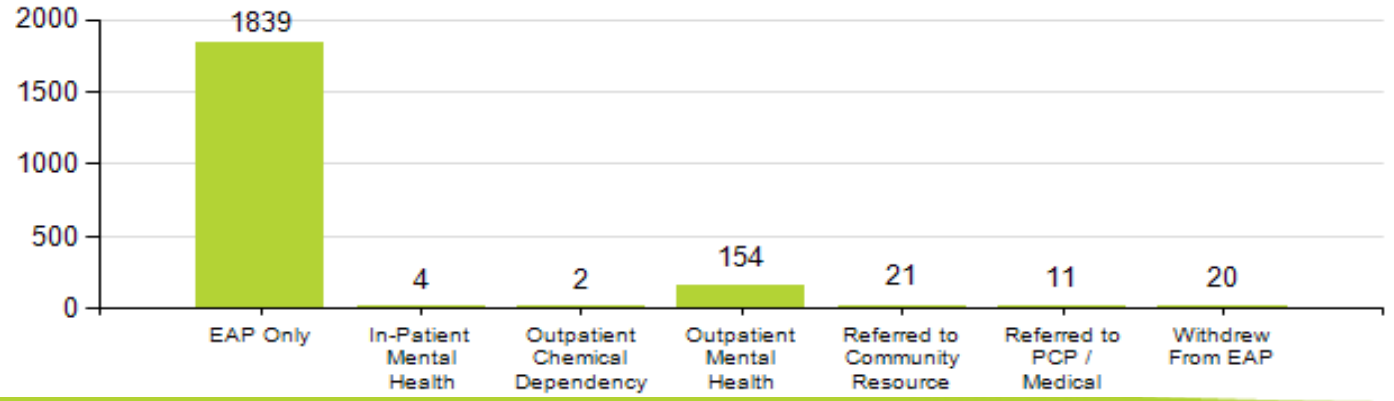
	2012-2013		2013-2014		2014-2015	
Problem Type	Reported	Assessed	Reported	Assessed	Reported	Assessed
Home Ownership	6	6	7	7	13	13
ID Theft	4	4	3	3	2	2
Legal	426	429	380	381	409	410
Medical	31	24	33	22	32	29
No Show	0	18	0	9	0	16
Other	265	112	231	99	260	141

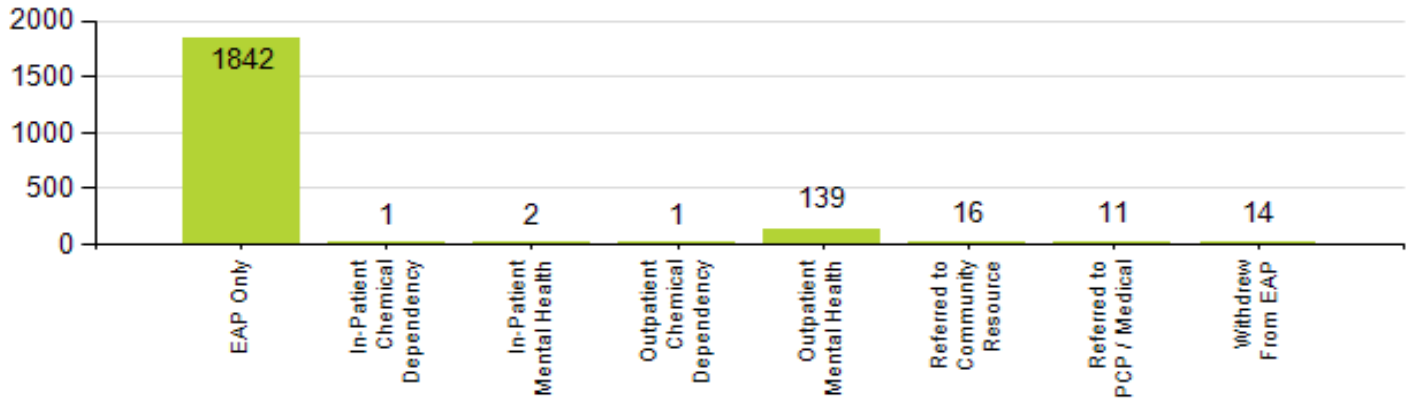
RBH
Reliant Behavioral Health

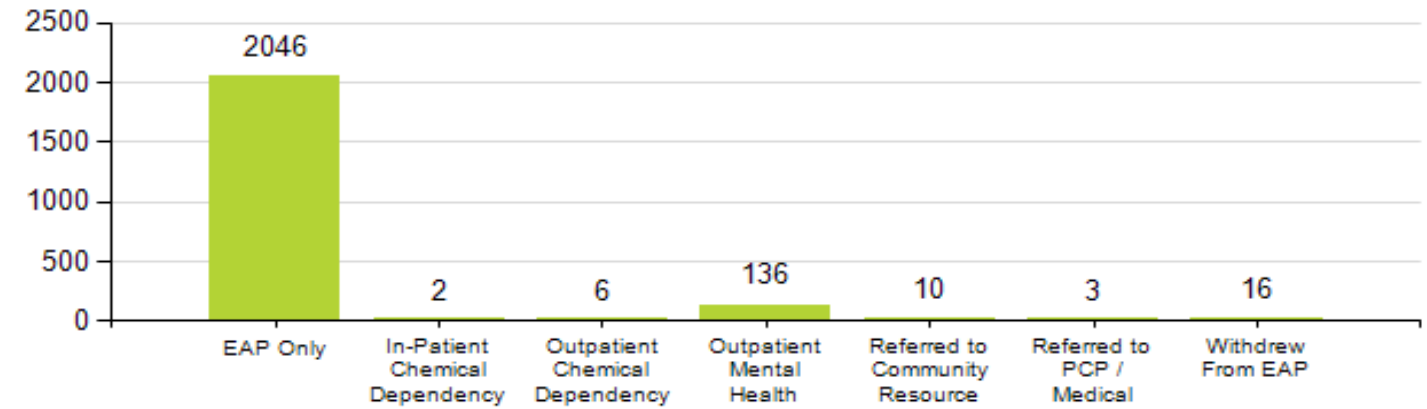
Case Problem Distribution

	2012-2013		2013-2014		2014-2015	
Problem Type	Reported	Assessed	Reported	Assessed	Reported	Assessed
School Issues	18	25	17	19	16	21
Self-Harm	1	3	10	7	9	7
Stress-Home	69	84	121	110	233	195
Stress-Workplace	118	116	117	118	169	167
Will Kit	139	139	135	135	139	139
Workplace Aggression	7	8	8	6	9	12

Case Disposition

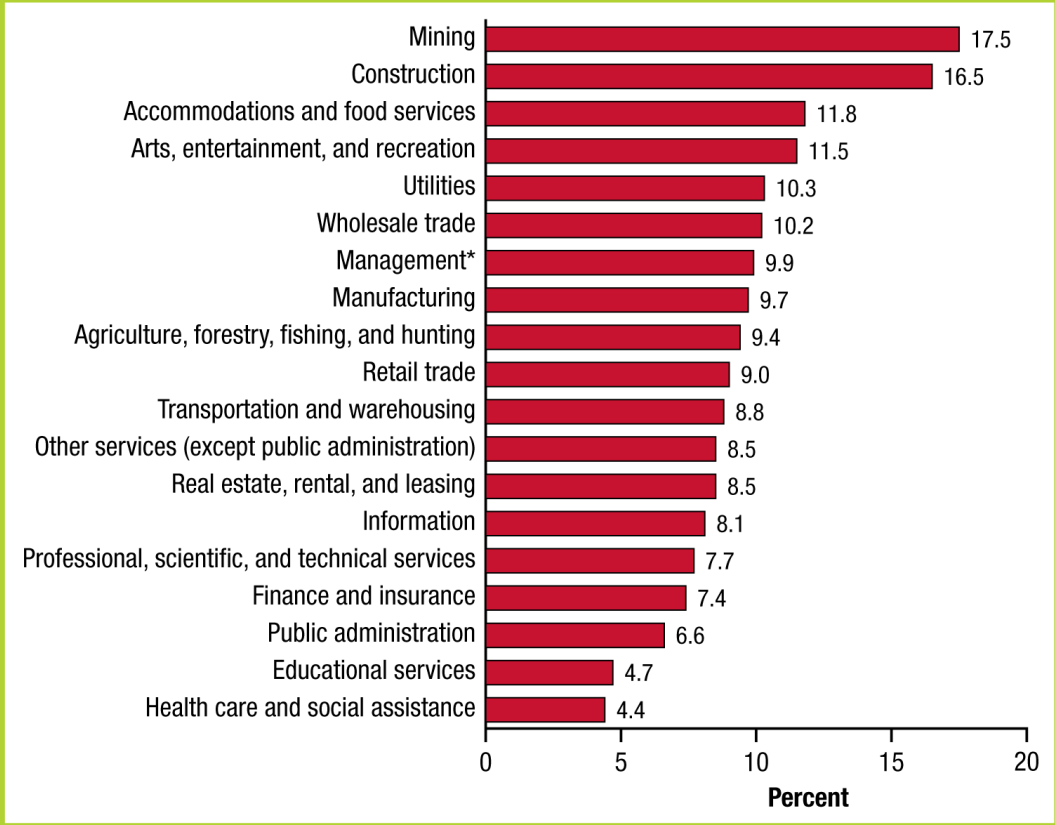




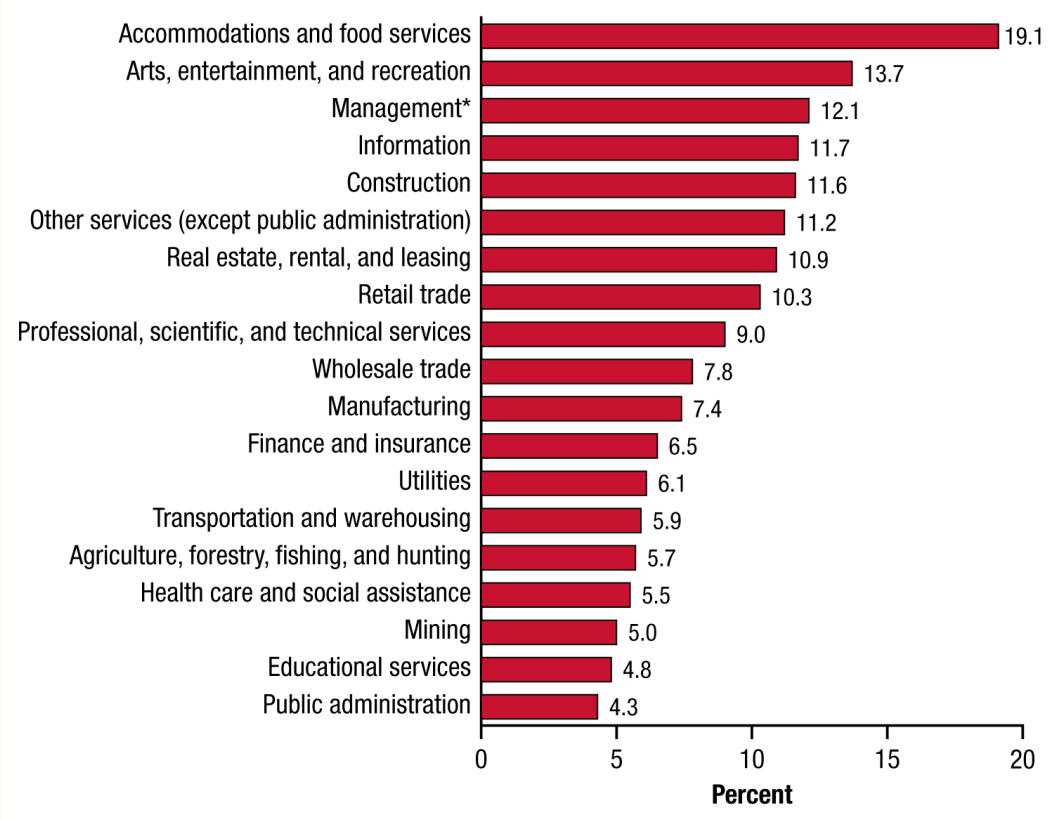
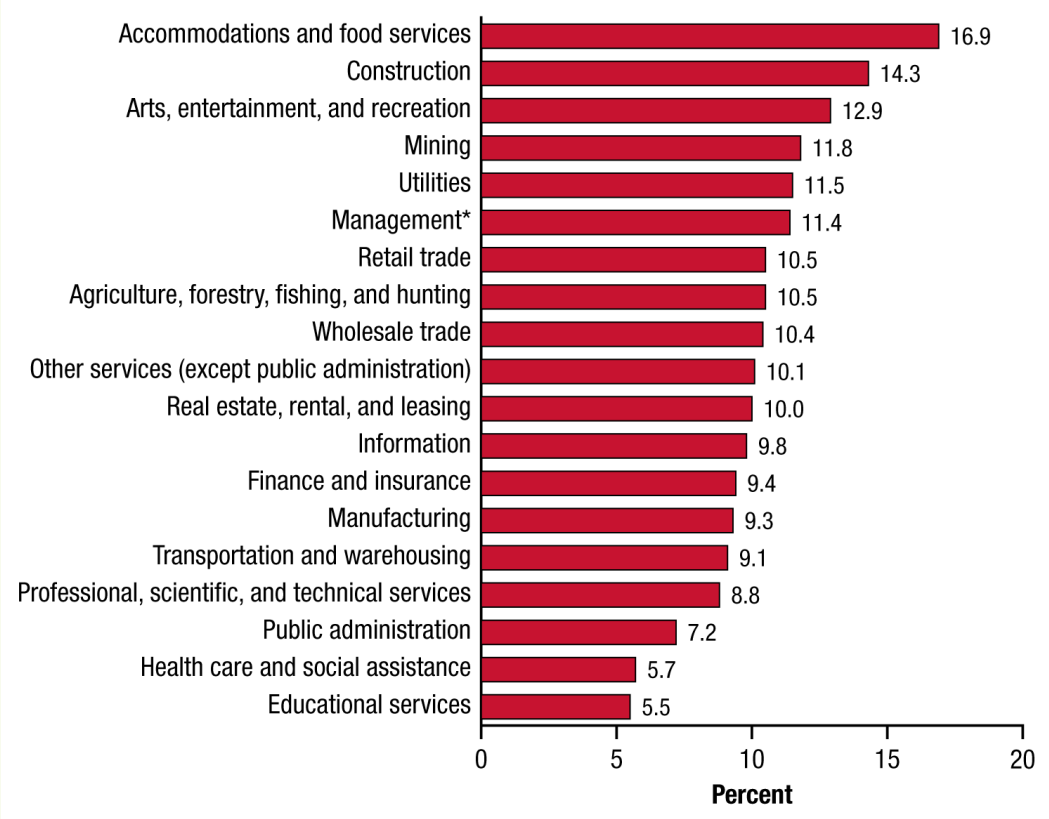


Past month heavy alcohol use among adults aged 18 to 64 employed full time, by industry category: combined 2008 to 2012

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Surveys on Drug Use and Health (NSDUHs) 2008 to 2010 (revised March 2012) and 2011 to 2012.



Past month illicit drug use among adults aged 18 to 64 employed full time, by industry category: combined 2008 to 2012



Past year substance use disorder among adults aged 18 to 64 employed full time, by industry category: combined 2008 to 2012