Behavioral Health System
Maturity Assessment of CCO 1.0
January 9, 2018

Background

In September 2017, Governor Brown asked the Oregon Health Policy Board (OHPB) to focus on four key areas when suggesting improvements during the next contracting cycle, including Behavioral Health: ”there is no doubt that we have more to do to improve behavioral health care in Oregon. We have one of the highest rates of mental illness, and far too many Oregonians remain in emergency rooms and in high-cost inpatient hospital rooms awaiting access to appropriate, community-based mental health care.”

This charge goes further, asking that we focus on system integration and access to appropriate services, with a priority on insuring children with serious emotional disturbances have their needs addressed.

Concentrated efforts have already begun to tackle the issues within the Behavioral Health System, and in 2017 The Behavioral Health Collaborative (BHC) issued a substantial report, with recommendations outlined:

- Forming local Regional Behavioral Health Collaboratives
- Increasing and defining Standards of Care and Competencies
- Investing in workforce capacity, starting with a focused needs assessment
- Strengthening use of Health Information Technology (HIT) and data to further care coordination, integration and quality goals

Additionally, Oregon is currently part of an eight state Certified Community Behavioral Health Clinic (CCBHC) demonstration. The focus is on the use of a cost-based reimbursement structure to pay for high quality behavioral health services that integrate primary care within behavioral health settings. In accordance with the 2015 SB 832, OHA has developed standards. Unfortunately, the bill did not grant the authority or funding to recognize clinics that meet those standards. Oregon, in agreement with the US Department of Justice, has also developed the Oregon Performance Plan to address the needs of adults with Severe and Persistent Mental Illness (SPMI).

And finally, OHA currently has several programs and partnerships seeking to address issues around children with Serious Emotional Disturbances (SED): The Intensive Services Capacity Project is focusing on the need for adequate Psychiatric Residential beds, and The Oregon Psychiatric Access Line about Kids (OPAL-K), is a child psychiatric phone consultation service for primary care providers in Oregon, which has reported 80% of its utilizers to be OHP recipients. The Early Assessment and Support Alliance (EASA) provides services to children or young adults and their families experiencing a first episode of psychosis and was recently expanded to every county in Oregon

Indicators of Oregon's Performance

Measure (green indicates positive change, red, negative)	**Data**
ACCESS AND INTEGRATION: *Mental Health*	
NEW Patient Initiation/follow up (time from BH Diagnosis to 1st Visit)	(*FY 2016): 36.4%*[i]
NEW Patient Initiation/follow up (time from BH Diagnosis to 1st Visit, % 2 or more visits	(FY 2016): 15.4%[ii]
Number of individuals with SPMI receiving ACT services	(FY 2017) 1140 +325 from baseline 2015[iii]
Rate of ED visit for OHP members for psychiatric services (FY 2016)	2.16 ED visits / 1,000 [iv]MM/+.62 from baseline 2015
ACCESS AND INTEGRATION: *Substance Use Disorders*	
Rate of initiation in Treatment for individuals with SUD	(FY 2016): 36. 4% / -4.9 from baseline 2011[v]
Rate of engagement in Treatment for individuals with SUD	(FY 2016): 15.4%/ -7.0 from baseline in 2011[vi]
Number of individuals who received peer delivered services (FY 2017)	10,506[vii]
Number of individuals receiving non acute care/non-ED SUDS services regardless of setting (i.e. PCP office or BH provider)	139,669[viii] /+26,851 from baseline CY 2015
OUD Treatment Access: Number of DATA waivered physicians in Oregon	540[ix]
CARE FOR CHILDREN WITH SED	
Percent of children under DHS custody who received a MH assessment within 60 days of entering substitute care	87.7% [x]
Timeline to treatment provided after Assessment for DHS placed children	Incomplete claims data exists for these metrics, see policy suggestions below
CANS frequency for Wraparound enrolled children	

Lessons Learned

Overall Access and Integration

Integration does not have a standard definition or clear metrics to indicate success: Oregon has not adopted a definition of integration. When attempting to define the success of integration, proxy measures are occasionally useful, but do not tell a clear or cohesive story, and can often say more about access or utilization then true system integration. Measuring the success of integration on a system level in quantitative terms is difficult at best.

Studies citing qualitative experiences help us assess the level of integration accomplished during the first years of waiver, and pinpoint mechanisms that aided integration. Specifically, *The Summative Waiver Evaluation Report* notes that co-Location of services occurred, and that this was beneficial in increasing integration. Specific examples included co-location of behavioral health within primary care, adding primary care to behavioral health clinics, and embedding both within school based clinics. [xi] Qualitative data from listening sessions echoes this suggestion: "co-locating dental, primary, and mental health care was discussed as a way to greatly enhance connection. This topic prompted some to suggest that

without colocation, and the ability to literally take a patient to a MH/PCP/dental provider from another provider type, that truly connecting these services may be extremely difficult"[xii]

However, such reports also reveal frustration with barriers to integration, and no specific quantitative measurements were utilized to call out obstacles or reflect work done to address the process issues associated with these barriers.

Access, transitions between levels of care and navigating the system are cumbersome: It is important to recognize that people do not enter the behavioral health system through specialty behavioral health care. Generally, they enter through primary care, corrections, emergency department visits, schools, or child welfare, to provide a few examples. The Regional Behavioral Health Collaboratives aim to bring these points of entry together to address behavioral health within local communities. Additionally, individuals transition between levels of care within the behavioral health system. The behavioral health system can be very confusing and overwhelming for individuals and family members accessing treatment.

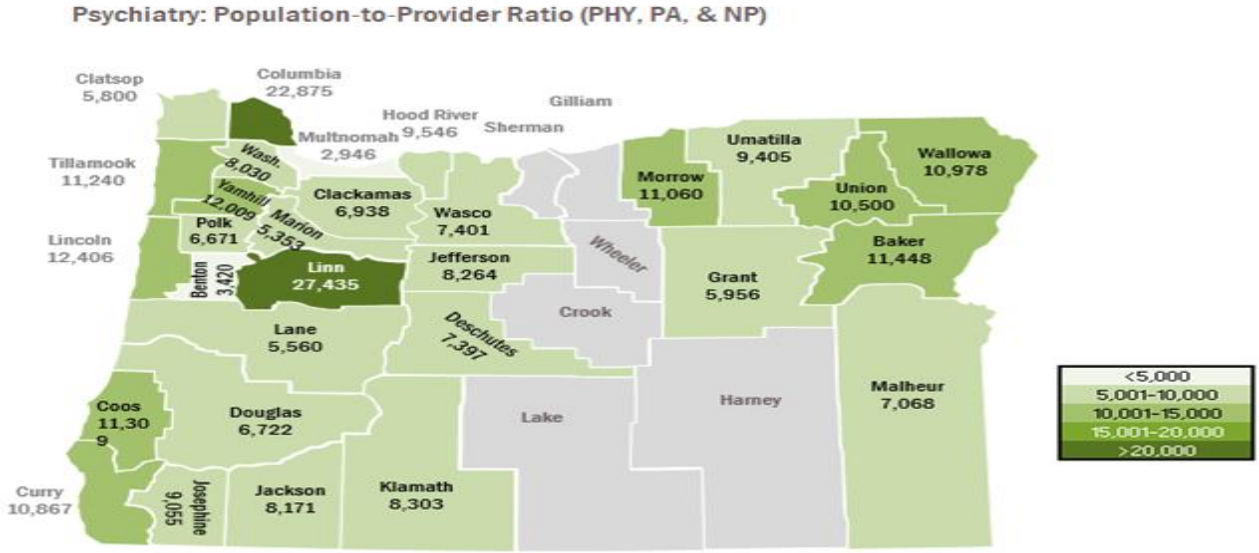
Administrative and billing barriers impeded integration efforts, created barriers to access and effective care in both SPMI and SUDS: These were highlighted in the summative evaluation: "while there is evidence that funding streams were initially integrated, it is clear that factors that existed before the waiver were difficult to overcome—including contracting systems, billing restrictions, and federal regulations—did not encourage CCOs to promote integration at the clinic level and created challenges for funding behavioral health services delivered in primary care clinics …Contracting and payment systems that impeded integration proved difficult to change. Before CCOs, counties received funding for many behavioral health services and contracted with behavioral health providers to deliver these services to Medicaid members. CCOs' global budgets were intended to promote integration by allowing CCOs to flexibly allocate funding to physical or behavioral health care as needed. However, most CCOs studied by Kroening-Roche et al, continued to pass funding for mental health clinics to counties, limiting their promotion of the integration of physical and behavioral health care at the clinic level. ".[xiii] Physical health providers are not able to bill for behavioral health codes and the opposite is true as well: behavioral health locations are not able to bill for physical health. This is a significant barrier to integration. Additionally, CCOs must contract with behavioral health to pay for services. If there is not a contract with the entity, that entity is not able to bill for those services and will need to refer the patient to another location. This is a significant access barrier.

In examining the waiver results, a modest increase in Behavioral Health Spending was revealed[xiv], decreasing rapidly in subsequent years, however, a myriad of issues make it unclear whether these dollars were spent in community mental health programs, or in more acute settings.

Limited information sharing produces an additional barrier: An additional barrier is the limited ability of behavioral health providers to share information with partners, including physical health providers. OHIT is currently finalizing a report on the adoption of HIT by behavioral health organizations and recommendations for addressing barriers. A comprehensive survey of behavioral health providers revealed several challenges with information sharing, including low adoption of health information exchange opportunities, limited use of electronic health records and substantial challenges in navigating the complex web of privacy, security and release of information requirements. Organizations that lacked an EHR cited cost as a significant barrier, and organizations that utilized an EHR cited interoperability of

systems as a significant barrier. The Health Information Technology Oversight Committee (HITOC) has requested OHIT bring together a group of the behavioral health providers to prioritize recommendations from the report and advise HITOC on next steps.

Workforce capacity was not robust enough to insure access: When examining capacity, it is clear that many counties are experiencing low ratios of behavioral health provider to population. Between 2013 and 2017, the number of people covered through Medicaid (OHP) grew exponentially thanks to ACA expansion. Policy leaders knew that support was needed to expand behavioral health services to meet the needs of the population and explored multiple options, with some success. [xv] However, in the most recent workforce needs assessment, only 2 counties (Multnomah and Benton) were shown to have a (minimally) adequate population: provider ratio below 3,500 people : 1 provider.



Additionally, current data on behavioral health capacity is incomplete. The BHC recommended a needs based assessment of the behavioral health workforce, which is currently underway with a report due summer 2018 which will include analysis of the data, including gaps and recommendations. OHA intends to use the assessment to develop a recruitment and retention plan for the behavioral health workforce. There are issues regarding insufficient rates for behavioral health services, which leads to an underpaid workforce and high turnover. A rate analysis and adjustment would need to be completed to completely address the issue, while at the same time containing costs.

Substance Use Disorder treatment access was also impeded by lack of resources to provide Medication Assisted Treatment (MAT). Oregon has one of the highest rates in the country for Opiate Use Disorder (OUD) especially in relationship to the number of DATA waiver providers contracted with by CCO. MAT is an evidenced based treatment for this disorder but access remains limited in the state, especially to vulnerable populations.

Care for children with serious emotional disturbances

Emergency department issues are a result of broader access issues: In the children's behavioral health system, there is an access and capacity issue for the intensive levels of care. Oregon is experiencing a crisis in providing access to higher levels of care to children with behavioral health challenges, and while the result of this is felt in emergency department (ED) utilization (repetitive visits, overly long holds), the

root is found in access and coordination issues prior to these visits. Currently nearly 50 children are receiving intensive care in other states because the care they need is not available in Oregon. This is not just an issue of adding capacity at the higher levels of care, but more importantly it is a reflection of intense community services not being available. Additionally, it continues to be important to ensure children who are being placed out of their homes receive a mental health assessment within 60 days. Overall, we currently are about 86% which is not high enough.

Data is insufficient to analyze the flow of services from assessment to delivery of care: While data is available on the frequency of assessment, we need more robust data on what occurs post: having a metric from Approval/Denial of a higher level of care to the service that is provided would give us important data regarding care and impact on emergency department utilization. Additionally, wraparound is a contracted service through the CCO and CANS assessment tool is part of that service provided. A metric to measure frequency of CANS claims per child in Wraparound would show compliance with this service/expectation in the contract.

CCO 2.0 Questions for 2018 Investigation

Based upon lessons learned, existing data, and subject matter expertise, the gray boxes below identify questions that could be further explored in 2018 in order to build upon the first phase of CCOs. At the 2018 OHPB retreat, board members will consider and confirm whether answering these specific questions will address the lessons learned and give them the information needed to develop final recommendations for CCO 2.0.

Workgroups, OHA staff, stakeholders, members of the public and OHPB members will all be consulted and included in the process to investigate these questions and consider next steps and potential policy options in the spring/summer of 2018.

<table>
<tr><td colspan="2">Defining and Measuring Integration More Clearly
➢ Existing recommendations related to this area
1. CCBHC
2. PCPCH level 5
3. TA to providers that adopt a model of integration</td></tr>
<tr><td>How will we measure integration?</td><td>Policy options to investigate:
(1) adopt definition of integration
(2) identify how to measure process of integration
(3) identify how to measure the impact of integration</td></tr>
<tr><td colspan="2">Enhancing Integration
➢ Existing recommendations related to this area
o Regional Behavioral Health Collaboratives
o Survey BH providers EHR capacity
o Identify common risk assessment tool for all entry points</td></tr>
<tr><td>What is the best strategy for holding the CCOs accountable for the integration of BH and physical health</td><td>Policy options to investigate:
(1) Behavioral Health Home recognition program support, including Medicaid authority to continue CCBHC
(2) Enforcement of BH parity
(3) billing barriers between physical health and behavioral health codes</td></tr>
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<tr><td></td><td>(4) budgetary barriers between behavioral health and physical health
(5) care coordination standards in CCO contracts for people in jails and Oregon State Hospital</td></tr>
<tr><td colspan="2">Workforce capacity
➢ Existing recommendations related to this area:
o Perform Focus Needs Assessment to Understand Capacity more fully (underway)
o Increase number of DATA Waivered Providers
o Opal-K
o Project ECHO</td></tr>
<tr><td>Question:
How can we work with the CCOs to insure that the system has the work force need to achieve expected outcomes?</td><td>Policy options to investigate:
(1) review and implement recommendations needs based assessment of the behavioral health workforce, including the children's behavioral health system, including rate analysis
(2) core competencies for a well-trained BH workforce
(3) Opal-A and other telehealth options (OPAL-A is a proposed, as of yet, unfunded model).</td></tr>
<tr><td colspan="2">Insuring Children have necessary access to higher levels of care
➢ Existing recommendations related to this area:
o Support Intensive Services Capacity Project
o Emergency department diversion
o Support OPAL-K collaboration
o SB 944 – centralize access to higher levels of care
o Evidence based practices including parent child interaction therapy (PCIT)
o Increasing peer support and family support across the system
o Early Assessment and Support Alliance (EASA) for first episode of psychosis
o System of care and wrap-around initiative
o Suicide prevention
o ECANS
o Trauma informed care policy updates</td></tr>
<tr><td>What strategies should OHA take to insure CCOs provide a children's BH system of care to achieve expected outcomes?</td><td>Policy options to investigate:
(1) needs based assessment recommendation of the behavioral health workforce, including the children's behavioral health system, including rate analysis
(2) options to share and pay based on use of evidence based practices.
(3) Data option to ensure that OHA has quality metrics
(4) use of in-home services
(5) opportunities to work across systems</td></tr>
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[i] DSSURS
[ii] ibid
[iii] Oregon Performance Plan October 2017 Data Report
[iv] Ibid

[v]Ibid
[vi] Ibid
[vii] Ibid
[viii] Ibid
[ix] Ibid
[x] Ibid
[xi] Summative Evaluation of Oregon's Medicaid Waiver
[xii] 2016Listening Sessions Report, Summary and
[xiii] Ibid
[xiv] Ibid
[xv] Workforce Needs Assessment 2017

Behavioral Health
CCO 1.0 Maturity Assessment

OHPB Retreat – January 16, 2018

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Governor's Letter

Governor Brown sent a letter to the OHPB in September 2017 calling out Behavioral Health as one of the 4 areas to focus on, intending to:

- Increase integration across the system
- Address issues impeding access to community-based mental health care
- Ensure children have their behavioral health needs addressed

Behavioral Health Topic Area: System Integration

Lessons learned: Integration does not have a standard definition or clear metrics to indicate success. Oregon has not adopted a definition of integration, and measuring the success of integration in quantitative terms requires using proxy measures in access and utilization.

- *Key information/Data on integration:*
  - There are 629 Patient Centered Primary Care Homes (PCPCHs), 39 are Tier 5
  - There are 12 Certified Community Behavioral Health Clinics (CCBHCs)

CCO 2.0 Question for 2018 Investigation:	**Potential next steps and policy options to consider:**
How will we measure integration?	(1) Adopt definition of integration (2) Identify how to measure process of integration (3) Identify how to measure the impact of integration

Behavioral Health Topic Area: Enhancing Access to Community based Behavioral Health (administrative)

Lessons learned: Access, transitions between levels of care and navigating the system are cumbersome. Administrative and billing barriers impede integration efforts, and create barriers to access and effective care in both mental health and substance use disorder services. Limited information sharing produces an additional barrier.

Key information:

- NEW Patient Initiation/follow up (% with new BH Diagnosis making it to 1st Visit): (FY 16): 36.4%
- NEW Patient Initiation/follow up (% engaging in 2 or more visits: (FY 16): 15.4%
- ED visit for OHP members for psychiatric services (FY 2016) : 2.16 ED visits / 1,000 MM/+.62 from baseline 2015 (for context, Ambulatory Care ED Utilization rates (FY 2016): 46.5/1,000 MM/-14.5)

CCO 2.0 Question for 2018 Investigation:	**Potential next steps and policy options to consider:**
How can OHA encourage CCOs to invest in behavioral health and hold CCOs accountable for these investments?	(1) Behavioral Health Home recognition program support, including Medicaid authority to continue CCBHC (2) Enforcement of Behavioral Health parity (3) Billing barriers between physical health and behavioral health codes (4) Budgetary barriers between behavioral health and physical health (5) Care coordination standards in CCO contracts for people in jails and Oregon State Hospital

Behavioral Health Topic Area: Enhancing Access to Community based Behavioral Health (workforce)

Lessons learned: Workforce capacity is not robust enough to ensure access to mental health and substance use disorder service delivery. Current data on behavioral health capacity is incomplete and there are issues regarding insufficient rates for behavioral health services, which leads to an underpaid workforce and high turnover.

Key information:

- Population to Provider shortages *(3,500 people – 1 provider (considered MINIMALLY adequate)):*
  - Adequate: 2 counties (Multnomah and Benton)
  - Moderate Shortages: 17 counties
  - Severe Shortages: 11 counties

CCO 2.0 Question for 2018 Investigation:	**Potential next steps and policy options to consider:**
How can we work with the CCOs to ensure that the system has the work force needed to achieve expected outcomes?	(1) Review and implement recommendations from the needs based assessment of the behavioral health workforce, including rate analysis (2) Core competencies for a well-trained BH workforce (3) Oregon Psychiatric Access Line for Adults (OPAL-A) and other telehealth options (OPAL-A is a proposed, as of yet, unfunded model).

Behavioral Health Topic Area: Ensuring Children have Necessary Access to Higher Levels of Care

Lessons learned: Emergency Department issues are a result of broader access issues, the children's behavioral health system has an access and capacity issue for the intensive levels of care. Data is insufficient to analyze the flow of services from assessment to delivery of care.

Key information:

- Percentage of children under DHS custody who received a MH assessment within 60 days of entering: 87.7%

- Timeline to treatment provided after assessment for DHS placed children/Child and Adolescent Needs and Strengths (CANS) assessment frequency for wraparound enrolled children: data exists on client level, but is not readily available for analysis

CCO 2.0 Question for 2018 Investigation:	**Potential next steps and policy options to consider:**
What strategies should OHA take to ensure CCOs provide a children's BH system of care to achieve expected outcomes?	(1) Needs based assessment recommendation of the behavioral health workforce, including the children's behavioral health system, including rate analysis (2) Options to share and pay based on use of evidence based practices. (3) Data option to ensure that OHA has quality metrics (4) Use of in-home services (5) Opportunities to work across systems

CCO 2.0 Questions for 2018 Investigation

- How will we measure integration?
- What is the best strategy for holding the CCOs accountable for the integration of BH and physical health?
- How can we work with the CCOs to insure that the system has the work force need to achieve expected outcomes?
- What strategies should OHA take to insure CCOs provide a children's BH system of care to achieve expected outcomes?