2020 CCO Transformation and Quality Strategy: Behavioral Health Integration

January 15, 2020

Presented by:
Rusha Grinstead, Behavioral Health Planner
Cissie Bollinger, Behavioral Health Policy
Lisa Peetz, Adult Mental Health

Oregon Health Authority

Agenda

1. Provide overview of TQS
2. Provide definition of Behavioral Health Integration component
3. Provide high-level project/program examples
4. Provide detailed project/program examples
   - Why warm handoff is a recommended focus
5. Q&A

Why we do this work…

Purpose of the TQS

To support safe and high-quality care for all CCO members by ensuring the Transformation and Quality Strategy (TQS) adequately covers federal requirements, pushes health transformation forward, and continues the path toward the Triple Aim (better care, better health, lower cost).

NOTE: The Oregon Health Authority recognizes that the programs and projects included in each CCO's TQS are a **showcase of current CCO work** addressing TQS components that aim to make significant movement in health system transformation. Additionally, OHA recognizes that the work highlighted in the TQS is **not a comprehensive catalogue or full representation** of the CCO's body of work addressing each component. CCOs are understood to be continuing other work that ensures the CCO is meeting all OARs, CFRs, and CCO contract requirements.

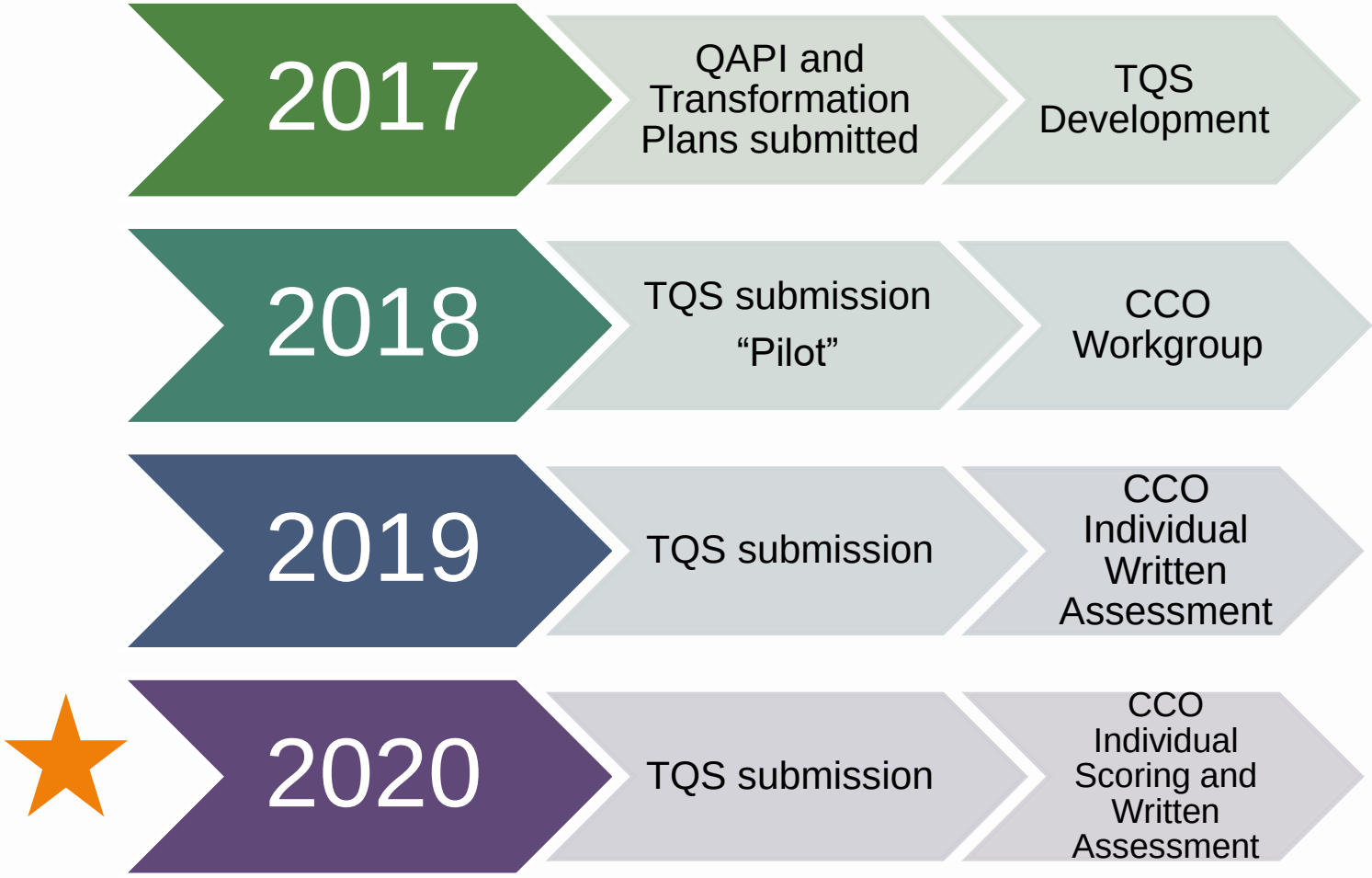
Foundational principles

TQS is a means for CCOs to report health transformation and quality work. The work is determined, developed and implemented by the CCOs with the direction from their community advisory council(s), community and CCO leadership.

The TQS addresses three key principles:

1. Meets CFR, OAR, 1115 waiver and CCO contractual requirements
2. Pushes health transformation through alignment with quality and innovation
3. Decreases administrative burden
   - Supports OHA's use of information to monitor CCOs' progress to benchmarks.
   - Incorporates narrative style and specific/measurement methods.
   - Combines two annual deliverables from prior years (2012-2017).

Key functions



Deliverables

Annually CCOs submit:

- Annual TQS
  - Due March 16
  - Reporting period: January–December
- TQS Progress Report
  - Due September 30
  - Reporting period: progress for January–June

Annually OHA:

- Reviews TQS submissions and provides feedback to CCOs
- Posts TQS to OHA Transformation Center website. Benefits include:
  - Peer learning to see how other CCOs described their work
  - Transparency with clinics and community partners to better align work
- Posts guidance document updates to TC website
  - Due October 1

2020 components

1	Access: Quality and Adequacy of Services	**9**	Oral Health Integration
2	Access: Cultural Considerations	**10**	Patient-Centered Primary Care Home (PCPCH)
3	Access: Timely	**11**	Severe and Persistent Mental Illness (SPMI)
4	Behavioral Health Integration	**12**	Social Determinants of Health & Equity
5	CLAS Standards	**13**	Special Health Care Needs (SHCN)
6	Grievance and Appeal System	**14**	Utilization Review
7	Health Equity: Data		
8	Health Equity: Cultural Responsiveness		

2020 TQS template

Section 2: Transformation and Quality Program Details

(Complete Section 2 by repeating parts A through E until all TQS components have been addressed)

A. **Project or program short title**: Add text here

Continued or slightly modified from prior TQS? ☐Yes ☐No, this is a new project or program

B. **Components addressed**

i. Component 1: Choose an item.
ii. Component 2 (if applicable): Choose an item.
iii. Component 3 (if applicable): Choose an item.
iv. Does this include aspects of health information technology? ☐ Yes ☐ No
v. If this component addresses social determinants of health & equity, which domain(s) does it address?

☐ Economic stability ☐ Education
☐ Neighborhood and build environment ☐ Social and community health

C. **Background and rationale/justification**:

Add text here

D. **Project or program brief narrative description**:

Add text here

E. **Activities and monitoring for performance improvement**:

Activity 1 description (continue repeating until all activities included): Add text here

☐ Short term or ☐ Long term

Monitoring activity 1 for improvement: Add text here

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)

2020 TQS support

Annually OHA Transformation Center provides:

- Webinar series to support learnings from submission and guidance on TQS updates
- Monthly office hours
  - Open to those who just want to call in
  - Quality improvement, quality assurance, transformation leads

Supporting resources provided annually

- Guidance document for template completion (data dictionary)
- FAQ
- TQS example strategies
- Health equity lens guidance document
- Available at: www.oregon.gov/oha/HPA/dsi-tc/Pages/Transformation-Quality-Strategy-Tech-Assist.aspx

TQS definition: Behavioral Health Integration

- The BHI component refers to your CCO's development and implementation of an equitable, integrated, person-centered behavioral health system that seamlessly and holistically integrates physical, behavioral and oral health.
- This system should be one that members can count on, regardless of where they live, to meet their needs.
- **Integrated behavioral health (mental health and substance use disorder) should allow members to receive behavioral health services in primary care settings and primary care services in behavioral health settings.** In order to achieve this, the behavioral health infrastructure should support all integration models from communication to coordination to co-management to co-location to the fully integrated patient-centered primary care home and behavioral health home. Services should cover the continuum of care: prevention, treatment and recovery.

Project/program examples

- **Integrate medication assisted treatment** for opioid dependency in primary care

- Develop and implement plans, in collaboration with the behavioral health provider community, to **expand the range of behavioral health services that engage individuals in the community** with the services and supports they need, when they need them, where they need them, and at the right intensity.

- Develop and implement processes to **improve and standardize communication** between physical and behavioral health providers.

Project/program examples

- Assess and improve **access for priority populations to intensive care coordination (ICC) services** that are person-centered, trauma informed, and delivered as part of a care-team approach in a care setting that best meets the needs of the member.

- **Improve coordination of care** within the behavioral health system, in particular focusing on the most vulnerable populations. (aligns with SPMI component)

Detailed project/program example: Medication assisted treatment in primary care

Background and rationale

- High rate of opioid abuse in CCO area and few MAT prescribers
- X waivered providers are hesitant to accept patients: low reimbursement and higher complexity patients

Activities

- PCP and BH provider under the same roof: integration of primary care in BH settings to expedite medical services required for MAT induction
- PCP and BH clinic partnership for complex patients: induct at BH clinic and send back to PCP for maintenance
- Incentivize providers to accept more patients
- Community outreach efforts on MAT: availability, benefits, appropriateness
- Train existing providers: change perspective of patient population
- Implement outreach efforts in the community to educate the population on availability of MAT, appropriateness and benefits of MAT
- Invest in MAT trainings such as Project ECHO for contracted providers
- Allow MAT providers in CCO networks
- Utilize Peers and THW to get individuals at the door

MAT example continued: Monitoring activities

- Percentage of individuals who initiated MAT
- Availability of appropriate staff at provider office to initiate treatment
- Community outreach efforts on MAT: availability, benefits, appropriateness
- Number of providers and provider staff that have gone through MAT trainings such as Opioid ECHO

Detailed project/program example: Warm handoff from acute care settings

- A project example for both BHI and SPMI components could include the required work of CCOs in the area of "Warm Handoff"
- "Warm Handoff" will be described in the following example as it relates to SPMI (not primary care "warm handoff")

Warm handoff: definition

- **Warm handoff** is the process of transferring a patient from an acute care psychiatric hospital to a community provider at discharge, that involves face-to-face meetings with the patient, either in person or through the use of telehealth, and coordinates the transfer of responsibility for the patient's ongoing care and continuing treatment and services.

- A warm handoff shall either
  a) include a face-to-face meeting with the community provider and the client, and if possible, the hospital staff, or
  b) provide a transitional team to support the client as a bridge between the hospital and the community provider, and ensure that the client connects with the community provider.

Why a warm handoff project for BHI and SPMI components

- Increase successful community integration following hospitalization in an acute care psychiatric facility.
- 21.9 percentage point increase (July 2017-April 2019): Nearly doubled in the two years but still more work to do
- Successful warm handoff requires coordination between the acute care psychiatric facility, CCOs, and community partners.

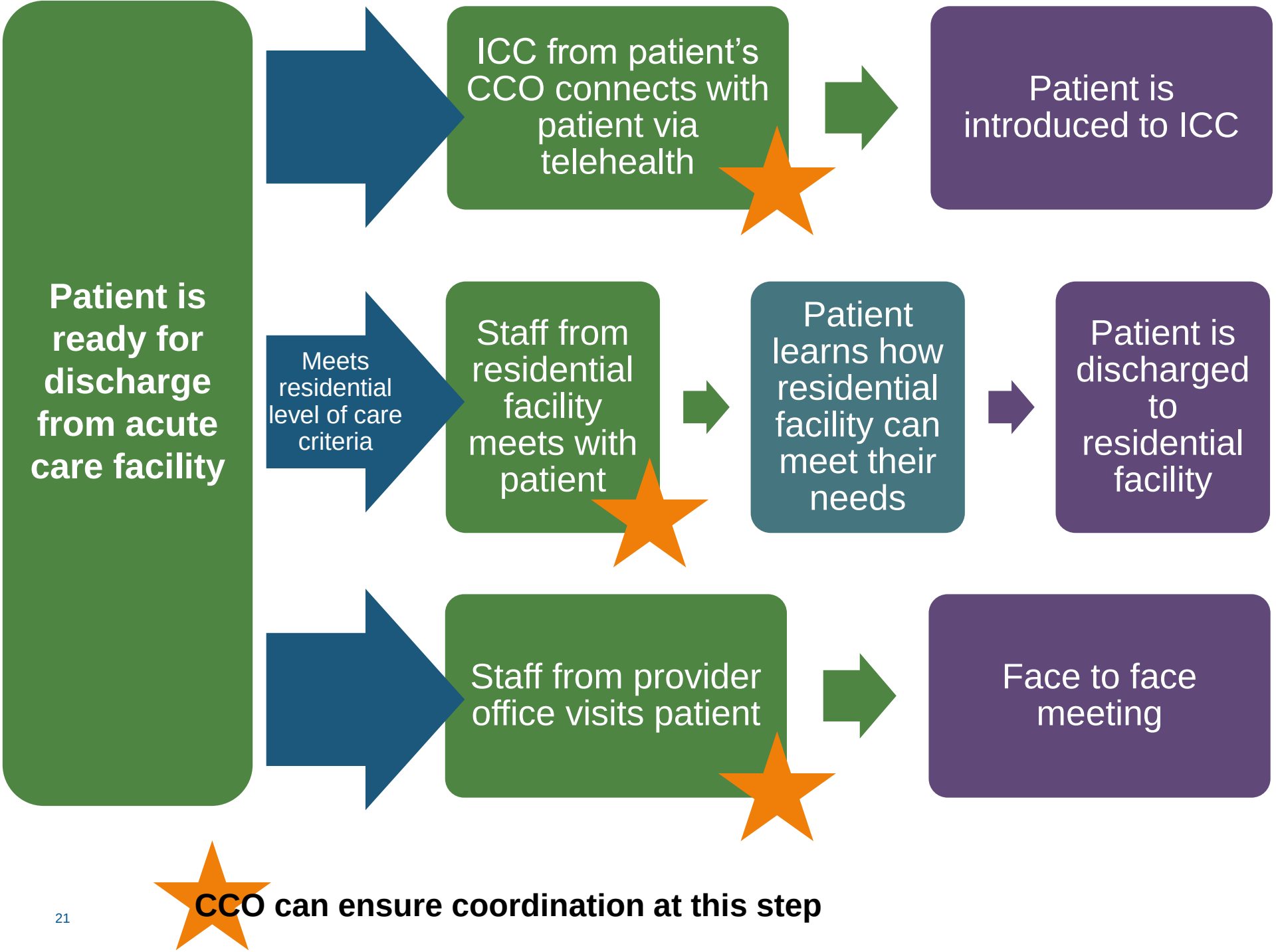
- OAR 309-032-0850 through OAR 309-032-0890: OHA requires a warm handoff to be offered as part of the discharge planning process from an acute care psychiatric facility for individuals (18 and older) with Serious Persistent Mental Illness (SPMI).

Warm handoff criteria

- Must occur prior to discharge – which means it can occur within any of the days leading up to discharge
- Must be face-to-face (in-person or via telehealth)
- Must involve the client and a community provider or a transition team

Warm handoff: project description

- The CCO plans to assess and address gaps in warm handoffs, inclusive of CCO role in care coordination with acute care facilities at discharge


Patient is ready for discharge from acute care facility
ICC from patient's CCO connects with patient via telehealth
Patient is introduced to ICC
Meets residential level of care criteria
Staff from residential facility meets with patient
Patient learns how residential facility can meet their needs
Patient is discharged to residential facility
Staff from provider office visits patient
Face to face meeting
CCO can ensure coordination at this step

Potential monitoring activities for performance improvement

Offer warm handoff as part of the discharge planning process

- Targets/benchmarks: X% of patients discharged offered warm handoff

Implement process to ensure staff/provider's contact with the individual meets the criteria and purpose of a warm handoff

- Targets/benchmarks: Workflow developed (process measure)

Document efforts to engage patient if patient declines warm handoff

- Targets/benchmarks: X% of patients declining warm handoffs whose engagement was documented

- Please type your questions and comments into the “Questions” box on your GoToWebinar control panel.
- We will update our Frequently Asked Questions after each webinar in this series.

For more information:

- **OHA TQS Leads:**
  - Lisa Bui, Health Policy & Analytics Division: Lisa.T.Bui@dhsoha.state.or.us
  - Anona Gund, Health Policy & Analytics Division: Anona.E.Gund@dhsoha.state.or.us
  - Veronica Guerra, Health Systems Division: Veronica.Guerra@dhsoha.state.or.us
  - Tawnya Elmore, Health Systems Division: Tawnya.Elmore@dhsoha.state.or.us

- **OHA TQS SME:**
  - Rusha Grinstead, Behavioral Health Policy: Rusha.Grinstead@dhsoha.state.or.us

- All TQS resources, including the templates, guidance document, examples and technical assistance schedule are available on the **Transformation Center website**: www.oregon.gov/oha/HPA/dsi-tc/Pages/Transformation-Quality-Strategy-Tech-Assist.aspx

- The templates and guidance document are also cross-posted on the **CCO Contract Forms page**: www.oregon.gov/oha/HSD/OHP/Pages/CCO-Contract-Forms.aspx