Behavioral Health Collaborative

Standards of Care and Competencies Work Group Report to Steering Committee

Instructions: Please complete the work plan as well as this template for the BHC Steering Committee. Please be brief in your response, but include all relevant details.

Deliverable 1:

Workgroup will establish core competencies for care providers and team based care for each entry point to ensure consistent protocols and expectations for behavioral health identification, health promotion and prevention, assessment, coordination and treatment (including other research and outcome based practices, and standardized guidelines that have proven effective). These competencies should create a unifying approach to behavioral health services that allows for no wrong entry door.

Summary of work group's recommendation:

The Standards of Care and Competencies Workgroup reviewed and expanded on recommendation on Standards of Integrated Care from SAMHSA, and Competencies for Integrated Primary and Behavioral Health Care recommended by the Farley Center, to be adopted by Oregon in various settings. The group also included Oregon's standards for Patient Centered Primary Care Homes as part of recommended standards to be adopted in other settings whenever relevant.

One of the initial tasks the workgroup completed was creating an exhaustive list of settings that can serve as an entry point for individuals in need for behavioral health care services. Standards and competencies of care to create an integrated BH system were recommended with the primary goal of care coordination between all these various settings, existing barriers in terms of trainings and competencies, and ways to prevent re-traumatization of individuals navigating at each entry point. The various entry points were identified using ASAM standards and stakeholder input as references.

The exhaustive list of Behavioral Health entry points for an individual can be found in Appendix A of this document.

The workgroup's recommendations focus on establishing standards for BH providers to work more effectively as a member of an interdisciplinary team and focus on included but not limited to the following:

- Effective outcomes and not just evidence based programs
- Preventing disruption of continuum of care in the incarcerated population
- Training and licensing requirements for educators
- CCO standards for coordinating patient information with community BH providers
- Continuity of care for children in foster care
- Payment reform to move away from encounter based billing
- State adopted standardized medical necessity criteria
- Limitations of Medicaid reimbursement in housing services

- Early training pf providers in higher education institutions
- Continuous assessment of service providers.

Recommended competencies for providers at various entry points by the workgroup are:

Endorsed Standard 1 (Source: SAMHSA)

Communicate effectively with other providers, staff, and patients: BH providers should communicate effectively with other providers, patients, and primary care team (if exists) with a willingness to initiate patient and family contact outside routine face-to-face clinic work. BH providers communicate in ways that build patient understanding, availability, and satisfaction to participate in care across the treatment continuum.

Recommendation 1

Considering the perceived limitations of HIPAA, FERPA, and 42.CFR Part 2, educate BH providers in various settings (including licensed, unlicensed, certified, non-certified) about the allowable activities under HIPAA, FERPA, and 42.CFR Part 2, to encourage confidence in care-coordination and information sharing without compromising confidentiality.

Action Items

- DOJ will set unified legal interpretations for HIPAA, FERPA, and 42.CFR part 2, that can be used across agencies.
- Train non-licensed BH providers on HIPAA, FERPA, and 42.CFR Part 2 along with training on.
- ODE to provide information on the Student Threat Assessment System that engages multiple organizations that work collaboratively under an MOE, to exchange BH information and assess appropriate outcomes for individuals. Includes both children and adults.

Recommendation 2

Create a 100% teaching workforce trained in youth Mental Health First Aid (MHFA). In addition, create a workforce trained in youth and adult MHFA.

Action Item

- Include youth MHFA training as a required part of licensing process for non-Licensed BH providers and staff.
- Include MHFA as part of the teaching license curricula to ease resource burden on school districts implementing efforts to adopt MHFA training as a standard.

Recommendation 3

OHA will establish a learning collaborative (utilizing existing workgroups to unduplicate efforts) with the goal of creating a standardized training for neurobiological concepts to address Trauma Informed Care.

Action Item

OHA will collaborate with 9including but not limited to) the licensing board, Trauma Informed Oregon, Oregon Dept. of Education, Children's System Advisory Council, and Southern Oregon Success to establish the recommended learning collaborative.

This LC will focus on existing research based neurobiological concepts for TIC (example: Sensory Processing) and emerging research to inform continuous standardized training.

Endorsed Standard 2 (Source: Farley Center)

Provide efficient and effective care delivery that meets the need of the population of care: BH providers use their availability and their team's availability and effort on behalf of the practice population of care, setting prioritized agendas with patients and the care team, managing patient encounters effectively, and identifying areas of immediate and future work with appropriate follow-up, so that BH availability is maintained.

Recommendation 1

Require CCOs to train and recruit workforce dedicated to starting OHP reinitiating process to ensure timely coverage for individuals reentering community from the prison system, including those on Alternative Incarceration Programs.

Action Items

- Require CCOs to employ dedicated staff who work in coordination with Oregon State Hospital and Dept. of Corrections to ensure individuals reentering the community from AIP are identified within 30 days before their release to ensure reinitiating of OHP without gap.
- Need for services, upon reentering the community is different for youth and young adults, who need a hand-carried sague to access specialty services.

Please identify any barriers or challenges to implementation. Have any efforts to mitigate these been identified?

Deliverable 2:

Workgroup to recommend minimum standards of care for each entry point.

Summary of work group's recommendation:

The workgroup identified the following standards for various BH settings:

Endorsed Standard 1 (Source: SAMHSA)

System oriented care: The ability to function effectively within the organizational and financial structures of the local system of healthcare.

Recommendation 2

Establish billing guidelines for providers who provide services through phone.

Action Item

- OHA will establish a workgroup to set billing guidelines for providers who are providing services to patients and families through phone.

Recommendation 3

Identify ways to leverage funds for rental assistance and barrier removal, for persons in recovery.

Action Items

- Apply for Medicaid to allow for Barrier removal and rental assistance through CMS Waiver Application.
- Contractually require CCOs to coordinate with CMHPs and other community recovery support service providers, to leverage non-Medicaid funds to pay for barrier removal and rental assistance, for individuals in transitional housing.

Recommendation 4

Implement statewide standard and criteria for medical necessity and Level of Care Assessment.

Action item

- Definition of medical necessity: it needs to distinguish between what is helpful vs. what is necessary and covered under OHP.
- Definition of the purpose of each level of care. This will help with consistency for providers and health plans.
- Standardized medical necessity criteria for each level of care and specialty service. I've included an example of what medical necessity criteria looks with the Magellan Med Necessity criteria.
    - Refer to Magellan Healthcare Guidelines for Medical Necessity Criteria as an example.

Endorsed standard 3

SAMHSA: Collaboration and team work the ability to function effectively as a member of an inter-professional team that includes BH and other care providers, consumers, and family members.

Farley Center: Help observe and function care team function and relationship: BH providers help each other to provide services to the patient, to monitor and improve care through a collaborative relationship. By knowing their own and other's roles, they help the interprofessional team to pool knowledge and experience to inform treatment, engage in shared decision making with each other and with patient, and share responsibility for care and outcomes.

Recommendation 1

Use the structure of High Fidelity Wraparound model as a reference for other settings, including adult BH health care settings. The standards of this model touches mobile therapy services, behavioral specialist consulting, therapeutic staff support, psychological evaluation, and other BH services, all while prioritizing the family.

Action Items

- Invest in a workgroup establish adult behavioral health programs that follow the structure of Wraparound Services as the standard for CCOs and other community BH providers. Portland State university is working on a pilot program for older adults, currently.
- For regions that do not include ODE in advisory panels for the System of Care and Wraparound Services, hold CCOs and CMHPs of that region contractually accountable for including ODE input as a consistent part of coordination of care. This will ensure implementation of System of Care and Wraparound services across the state.

Recommendation 2

Revisit Medicaid rule to suspend OHP for incarcerated population.

Action item

- Revisit SUD Waiver proposal to continue Coordination of BH Services to be covered by Medicaid for incarcerated population, to ensure continuum of care, and increase engagement in treatment, thus, eventually, reducing recidivism.

Endorsed standard 3

SAMHSA: Screening and assessment: The ability to conduct brief, evidence-based and developmentally appropriate screening and to conduct or arrange for more detailed assessments when indicated.

Farley Center: Identify and assess behavioral health needs: BH providers apply knowledge of cognitive, emotional, biological, behavioral, and social aspects of health, MH, and medical conditions across the lifespan; and incorporate their clinical observations into an overall, tea-based primary care assessment that may include identifying, screening, assessing, and diagnosing.

Recommendation 1

OHA will establish a workgroup that will identify a set of evidence based universal assessment tools to be used across providers at each level of care, as a statewide standard.

Action Item

- The workgroup will use the Hub and Spoke model to establish a learning collaborative that implements this standard.
- OHA will establish a workgroup that identifies statewide standard for all BH providers to follow while examining criteria for Medical Necessity and Level of Care Assessment. The standardized criteria will help providers achieve better interrater reliability.

Deliverable 3:

Recommend mechanisms for co-management of individuals who require specialty BH. Recommend method by which OHA will enforce this requirement.

The recommendations involved reviewing existing CCO contracts for minimum standards contractually required from CCOs. The workgroup identified shortfalls in terms of upstream prevention. The following recommendations around CCO contracts were proposed:

Recommendation 1

Revisit rules for CCOs to ensure continuity of care for children who are in substitute care placement and move from one CCO region to another.

Action Item

- OHA will establish a workgroup or utilize an existing workgroup to identify a better standard to ensure continuity of care for foster children who move from one CCO region to another.

- The workgroup will explore ways to reimburse providers and case managers for travel and time so these children can continue to get services form providers they have already established a relationship with.
- The workgroup will explore ways to reduce retraumatization of these children as they move from one CCO region to another.

Recommendation 2

Define upstream prevention in CCO contracts and establish CCO metric measures for upstream prevention for patients and their families.

Action Item

- OHA will identify definition for upstream prevention to be included in CCO contracts.
- OHA will identify measures for upstream prevention for children and their families who are screened for wellness and development.
- OHA will contractually hold CCOs accountable to work with Public Health, community prevention specialists, and their communities, to address upstream prevention in their community through a robust assessment that will be reported back to OHA by CCOs.
- OHA will establish standards through CCO contracts, on how communities can hold CCOs accountable for collaborating with them, and align a community based Biennial Implementation Plan with CCO Community Health Improvement Plan. This plan should leverage both Medicaid and non-Medicaid BH funds.

Please identify any barriers or challenges to implementation. Have any efforts to mitigate these been identified?

- Provider still might run into the issue of finding a single point of accountability under the statewide implementation of High Fidelity Wraparound Services Model structure.
- Lack of resources makes it difficult to implement training requirements for teaching staff in school system. Required trainings should be introduced as part of licensing process.
- PCPCH standards are not aimed for as a goal by all providers due to administrative burden.
- Reimbursement, even under APMs such as CPC+ are still encounter based.
- CCOs do not have a clear understanding of upstream Prevention in their contract.
- There is no processes in place, currently, for communities to hold CCOs accountable for not collaborating and coordinating with community BH service providers.
- EEBPs are not scrutinized well at legislative level for inclusion of diversity, and effective outcome in various population settings.

How will this move Oregon towards full integration of BH, physical and oral health?

Appendix A

List of Settings through which Individuals Enter BH System

Acute care general hospital or acute psychiatric hospital

Addiction programs with direct access to psychiatric/medical/laboratory services such as Day Treatment

After-school programs

Boarding houses

Child welfare

Childcare facilities

Clinical office

College health centers

Community center

Correctional system

Crisis response

Early learning hubs

Emergency response including 911

Employee assistance programs

ER

Faith based organizations

Group homes (with clinical services and 24 hour staff)

Individual's home

Inpatient services

Judge and other probational programs

Law Enforcement

Needle exchange programs

Occupational therapists

Opioid Treatment Programs (OTP)

Outpatient programs (intensive)

Pain management clinic

Pre and post-natal care services

Primary care office

School

School based health clinics

Sober houses

Social service centers

Specialty care: chronic conditions including pain management

SUD inpatient care

SUD programs

Team of Tx professionals and credentialed MH and/or SUD service providers: PCPCH, CCBHC

Veterans treatment centers

Warm lines

Work site