Oregon
Theodore R. Kulongoski, Governor

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June 2, 2008

The Honorable Peter Courtney, Co-Chair
The Honorable Jeff Merkley, Co-Chair
State Emergency Board
900 Court Street NE
H-178 State Capitol
Salem, OR 97301-4048

DHS Oregon Department of Human Services

Dear Co-Chairpersons:

Nature of the Report
The 2007 Oregon Legislature directed the Department of Human Services (DHS) to report on developing an integrated delivery system of health care for its Medicaid clients and a proposal for the integration of Oregon Health Plan behavioral and physical health services.

Agency Action
During the interim the Department convened a group of providers, county health representatives and DHS staff to discuss this Policy Note and develop a strategy and report.

The group found that there are a number of efforts for integration happening statewide. In order not to duplicate those efforts we sent out a short unscientific survey to gather information concerning barriers to integration and made a decision that we would first tackle the "low hanging fruit" and pave the way for the larger more systemic efforts were implemented.

Attached is the first report which outlines "first steps" of the group. We intend to continue meeting to develop an implementation plan for these "first steps" and to develop the next more comprehensive steps.

Also attached are Appendix A listing the members of the workgroup; Appendix B listing integration efforts currently taking place statewide; and, Appendix C listing other groups currently meeting to discuss integration efforts.

Action Requested
For the Emergency Board to accept receipt of this report. In addition, DHS will submit an update to this report to the September 2008 E-Board.

Legislation Affected

None

Sincerely,

Jim Scherzinger,
Deputy Director of Finance

cc: John Britton, Legislative Fiscal Office
Sheila Baker, Legislative Fiscal Office
Eric Moore, Department of Administrative Services
Patricia O'Sullivan, Department of Human Services

REPORT FOR SENATE HEALTH AND HUMAN SERVICES

Behavioral and Physical Health Integration Committee

June 10, 2008

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Behavioral and Physical Health Integration Committee Report

June 2008

I. Background

The Behavioral and Physical Health Integration Committee was formed in January 2008 as a result of a policy note in HB 5031. Led by the Department of Human Services (DHS), the committee includes representatives from a wide range of stakeholders including representatives from the Medicaid managed care physical and behavioral health plans and county mental health providers. A complete list of committee members may be found in Appendix B.

The Committee was formed to help determine the next best steps the Department could undertake to integrate physical health and behavioral health care in Oregon. Its goal is to help pave the way for creating a broad-reaching, long-range vision for behavioral and physical health integration in the state.

Integration efforts have been under way in various arenas, including DHS, for some time. In 2007 DHS formed the Core Team composed of representatives from Addictions and Mental Health, Division of Medical Assistance Programs and Public Health. The team aims to improve communication and coordinate services across the divisions, identify barriers, and implement best practices. Its work continues today and is expanding to include Children and Family Services and Seniors and People with Disabilities. However, there in no single place in DHS where these efforts are coordinated.

The Behavioral and Physical Health Integration Committee's intent is to build on the existing knowledge-base created by earlier and ongoing efforts. In addition to drawing on the Core Team work, the committee researched past task forces and other workgroup efforts in previous years, the ongoing integration pilots underway in several areas of the state, the

recent new efforts of the Oregon Health Fund Board, as well as innovative integration activities in other states. With input from committee members, DHS has begun an inventory of pilot programs and other integration work under way in Oregon. (Appendix C)

The recommendations presented here are meant to work in conjunction with and in support of the work already under way, particularly the soon forthcoming recommendations of the Oregon Health Fund Board, focusing on those for the healthcare delivery system. Because that work is long-range and high-level, this committee focused on near-term concerns — key actions that can be taken quickly and result in positive outcomes. The most important recommendations are related to developing a framework, setting expectations and coordinating efforts to integrate behavioral and physical health care services for DHS providers and Medicaid clients.

DHS is committed to providing the leadership necessary to implement these recommendations and move Oregon closer to an integrated delivery system, one that partners behavioral and physical health providers. The end result will be improved medical and behavioral outcomes for clients.

II. Definitions

The following terms are defined for this report.

Behavioral Health Services: Health services including mental health and addictions treatment.

Integration: Integration of physical and behavioral health exists on a continuum. At its most basic, integration means physical and behavioral health care providers share information about common patients. Moving up the spectrum, integration involves patient screening practices, care coordination, co-location of providers and, ultimately, full clinical, administrative

and financial integration. In this report, integrated health care is discussed in terms of OHP providers and Medicaid clients.

Four-Quadrant Model: A conceptual diagram of a model of integrated care to help organize thinking about particular patient populations and help determine appropriate screening tools based on patient needs. The Four-Quadrant model is referenced in this report as a suggested model; however, because integration may look different at each clinic, the Four-Quadrant model will not be recommended as a requirement for clinics.

Physical Health Services: Physical health can mean health services ranging from basic primary care to specialized care such as cardiology. In this report, physical health is restricted to mean primary care for clients. Although an ultimate goal for integration might be to have all health care services, including specialized care, integrated, this committee focused on the integration of primary care and behavioral care.

III. Integration Priorities and Barriers

Over the years, thorough research has been conducted by other committees and work groups, including the DHS Core Team, Oregon Health Fund Board's Delivery Committee, DMAP's Policy Advisory Panel (PAP) and other DHS groups. In fact, many committee members have been involved in those efforts. Research has included focus groups and other opportunities for stakeholder groups to provide input. This committee also conducted a small, informal survey of OHP Providers. The survey results validated the findings of these broader research efforts. Areas of concern include:

- Critical tasks that could be accomplished/changed quickly for maximum effect (low-hanging fruit).
- Best practices related to integration which are currently being used.

- Barriers to integration.
- Key elements necessary to achieve integration.

Activities identified as very important to facilitating and achieving integration include:

- Increased communication
- Leadership by DHS
- Care coordination
- Training of primary care clinicians
- Training of behavioral health professionals

Common barriers identified by various stakeholders are:

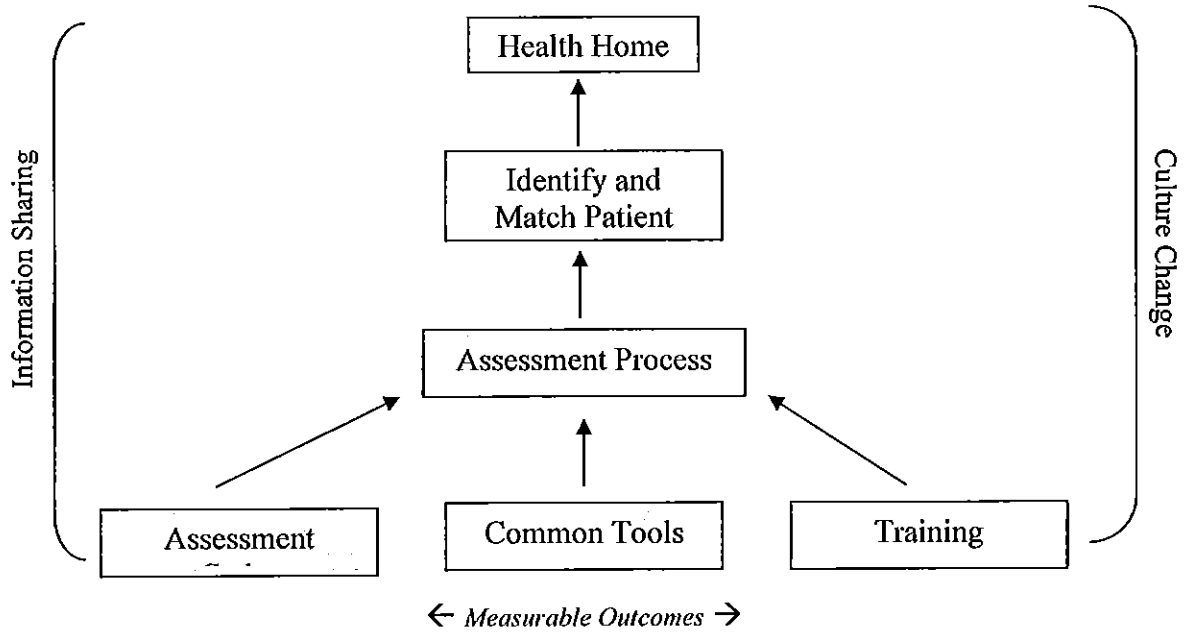
- Sharing client information
- Technology
- Practitioner Documentation Requirements
- Legal barriers – federal and state statutes and requirements
- DHS rules and policies
- Separate funding streams
- Time constraints

Many of the barriers to integration stem from a lack of a unifying, statewide vision and expectations for providers. Without this framework to guide activities, local integration efforts have difficulty overcoming barriers and are difficult to sustain and grow. A common vision would help evaluate the success of these different efforts and determine how best to invest in future integration projects. A framework for integrated care would then help coordinate efforts and address barriers to implementation.

The committee discussed the need for integrated, coordinated services best captured by the concept of a patient-centered medical home, also referred to as an integrated health home. With this approach, physical and behavioral care is coordinated around the needs of the patient. A patient's

"health home" may be with a physical health care provider where behavioral health consultation is available, or at a behavioral clinic where the patient has access to physical health consultation. Regardless of the home's location, care is built on the continuous relationship between the patient and his/her health care team. The desired goal is to meet patients' needs with care that is safe, effective, efficient, timely and equitable — in other words, the "right care at the right time in the right place".

Using the vision of a "health home" the framework below was developed. To achieve integration that culminates in a health home, significant culture change must occur; however, because integration is a continuum, some initial steps towards integrated care (e.g., information sharing, coordination of care, etc.) need to occur.



As the model above suggests, information sharing and cultural changes are essential to transforming the currently fragmented delivery system into a fully integrated, coordinated one.

Additionally, the model shows the foundation for integration is based on an assessment process that requires 1) adequate reimbursement for time spent that can be captured with appropriate coding methodology, 2) determining and regularly updating best practices for selection of common assessment screening tools, and 3) adequate training and work-force development that promote integration efforts. These core elements can help ensure the most effective methods are understood and the service delivery system for those methods exists. Understanding integration in this way also helped the committee identify the recommendations for the next best steps for integration.

The recommendations below address these issues and also focus on providing the tools necessary to facilitate implementation of the integrated health home concept. In implementing these recommendations, coordination of integration efforts will be improved, data and information will be enhanced, and necessary work-force training needs will be addressed.

IV. Recommendations

The Committee makes four recommendations, each of which is presented with suggested actions, benefits and challenges. Changing the current culture to the ultimate goal of integration can be very challenging. It is important to note that a large integration project involving public and private partners would require an influx of resources, although the ultimate outcomes can be efficient and quality healthcare services, and better health outcomes for those served. Every recommendation requires an element of training to ensure expectations are understood and are aligned with any regulations, and tools are used effectively. The committee will develop a budget request package for the 2009-2011 DHS agency request budget to ensure that the needed resources are requested.

The committee discussed additional actions but felt these recommendations would be the next best steps and will remove some key barriers to integration, while helping build the foundation necessary for achieving a fully integrated system of care.

Recommendation 1: Communicate with and train providers about information that may be shared with and without patient consent.

Integration of physical and behavioral health care, even at its most basic level, requires providers to share information about common patients. Currently, there is confusion or lack awareness about the types and extent of information that may be shared between physical and behavioral health care providers. By addressing this priority, DHS removes one of the most common barriers to integration and clears the way for providers to take the first steps toward integrated care.

Actions

1. Communicate DHS expectations for sharing information among providers:
    a. With patient consent.
    b. Without patient consent.
    c. De-identified information.
    d. For new and existing patients.
2. Train/educate providers and clients/families to ensure information is shared appropriately.
    a. DHS and partners jointly develop and share communications strategy with providers, clients/consumers, families and others.
3. Identify and notify Oregon Health Plan clients of information sharing.
    a. Determine how to comply with notification requirements of Senate Bill 163.

Benefits

- Sharing key information is necessary to coordinate and enhance quality of care provided in both behavioral and physical health settings.
- Reduce unnecessary use of resources (duplicated testing, consultations, history-taking, etc.).
- Optimize timely delivery of treatment to clients.

Challenges

- Need to relieve fears of restrictions on privacy.
- Technology challenges of sharing information in a timely manner will need to be addressed so that information is available when needed by providers and clients.
- Technology — data systems differ across providers and make information sharing challenging.
- Resources to provide training to physical and behavioral health providers.

Recommendation 2: Clarify how and when to use current health services/assessment codes.

Integrated physical and behavioral health care may occur in a variety of ways and settings. Incentivizing providers to coordinate care is an integral component to a successful integration effort. Busy providers need to have adequate time to do detailed assessments in order to guide care to meet the needs of the clients. One way integration can be an incentive is through providers' use of care coordination and case management health services and assessment codes. Providers often do not know who may use particular codes or when they should be used; this is particularly true of CPT codes 96150-96155 that were approved for inclusion in the Prioritized List of Health Services by the Health Services Commission (HSC) earlier this year.

By clarifying this information, providers can afford to spend additional time with the client and more accurately document when and how they provide integrated care. Guidance and training of providers and their staff ensure more providers will be encouraged to engage in integrated care, decrease unnecessary utilization of services through better care coordination and DHS will be better able to track the delivery of integrated services at the state level.

Actions

1. Develop guidance on how to use new health and behavior assessment and intervention codes that capture integrated care during patient encounters (e.g., behavioral health assessment during a primary care appointment).
    a. Define criteria for using codes.
    b. Who qualifies as a provider?
    c. What criteria must be met to use specific codes and how to affectively inform providers?
2. Provide joint training across all plan types on use of codes.
3. Evaluate use of new behavioral health codes and their effectiveness in optimizing care.

Benefits

- Encourages integration efforts by rewarding key care coordination activities and ensuring their completion.
- Correct use of codes to avoid errors or re-billing issues.

Challenges

- May be initial cost increases in reimbursement.
- Resources to provide training.

Recommendation 3: Establish DHS as leader in integration efforts across the state.

Integration of physical and behavioral health care is occurring in Oregon. However, without statewide leadership, it is often

localized and dependant on local leadership and resources. DHS is in a unique position to help provide an integration framework for all of Oregon's Medicaid providers. One of the most important things DHS can do to support integration is to provide a vision, set expectations, leverage resources, identify best practices and address barriers.

Actions

1. Establish a full-time position at DHS with expertise in integration, focused on areas such as addressing barriers, resolving local issues, identifying best practices in Oregon and other states, training, data collection, etc.
2. Work with Medicaid managed care organizations to define leadership role, which may include:
    a. Outreach and guidance — "carrying the torch" for integrated care.
    b. Acting as a single point of contact.
    c. Keeping informed of integration activities across DHS, other state agencies (PEBB, OEBB) as well as across Oregon and in other states.
    d. Coordination with other DHS committees and divisions to ensure alliance with common vision of the agency.
    e. Leveraging current efforts (e.g., training, Quality Care Institute, AMH, DMAP and OHFB work)
    f. Leveraging resources
    g. Conducting outreach with communities
3. Bring together those already integrating care to gather best practices, capture data and train others.
    a. Work with partners to develop and deliver meaningful training and make the best use of time.

Benefits

- Coordinates and ensures all efforts are aligned toward a common vision.

- Operationalize past and current integration efforts that have not had stewardship across divisions and over time.

Challenges

- Establishment and cost of a position.
- Ensuring access to division and agency leadership to coordinate and carry the message across all DHS activities.

Recommendation 4: Work toward a process of using a common assessment process and screening tools across physical and behavioral health providers to allow for optimal screening of clients' needs to best determine allocation of care resources

Part of the assessment process is the screening of a client's needs. Physical health will focus primarily on particular medical illnesses, while behavioral health or addictions providers will focus on behavioral health issues. In an integrated care model, all of these needs must be identified, prioritized and coordinated. For example, by considering the behavioral issues that might be exacerbating a physical health condition, health care services can be more efficiently utilized to avoid unnecessary physical health diagnostic testing or under treatment of critical behavioral issues that can worsen without adequate attention. Assessing best practices for a common approach such as the Four Quadrant model does, can assure that the multiple needs of the patient can be optimally addressed. The ultimate outcome is enhanced health and well-being.

Actions

1. Continue work to identify the best practices regarding current assessment models and screening tools.

2. Assess feasibility of using Four Quadrant model as standard tool for assessing client needs and its use in both behavioral and physical health clinical settings.
3. Determine barriers to Four Quadrant model use and if incentives are needed to implement it broadly; and its usefulness in various geographic and different size settings.
4. Ensure training efforts include the standard models and tools selected.
5. Ensure ability to reimburse for time spent to utilize the tools, including by ancillary staff, with adequate education to providers in both behavioral and physical health arenas.

Benefits

- Ensures care is delivered in the right place at the right time.
- Standardizes assessment process across behavioral and physical health settings.

Challenges

- Behavioral health screening tools not commonly used in physical health settings as in behavioral ones.
- Lack of expertise and resources in behavioral health settings to provide physical health screening.
- Information collection and dissemination resulting from use of the tool.
- Will need regular updating and monitoring of selected standard tool as clinical care advances with time.

Summary

All of these priorities/recommendations move toward the common goal of an integrated health system, using key tools to facilitate that integration. Achieving these goals ultimately will result in multiple benefits to clients, providers, the state and the public. These include:

- High quality, efficient, coordinated care delivered to clients/patients

- Impact may be initially to the Medicaid population, but can benefit all Oregonians as healthcare providers change how care is delivered in their offices and clinics.

Other benefits include cost containment, achieved by:

- Prevention and early intervention.
- Providing right interventions at the right time in the right place.
- Creating administrative ability to handle both physical and behavioral health systems of care.

Core Team and additional DHS integration information may be found at www.oregon.gov/DHS/ph/hsp/integration.shtml.

Oregon Health Fund Board, Delivery System Committee information may be found at http://www.oregon.gov/OHPPR/HFB/Delivery_Systems_Committee.shtml

V. Next Steps

The committee has identified the following next steps:

- Identify specific outcomes for each of the above recommendations.
- Develop operational implementation plans for each of the above recommendations
- Identify key activities for the next phase of integration, including addressing barriers.
- Address resources issues, including funding for work-force development and service delivery transformation.
- Develop next group of recommendations to move integration forward
    - Coordinate with DHS Core Team
    - Ensure future recommendations in sync with other integration work (e.g., Oregon Health Fund Board)

- Develop a policy option package for the 2009-2011 DHS agency request budget to include a coordinator position and adequate funding for training needs.

VI. Appendix

Appendix A: Policy Note language
Appendix B: Committee members
Appendix C: Inventory of current integration projects

Appendix A

HB 5031 – DHS Budget Note

The Department of Human Services is directed to prepare a report on developing an integrated delivery system of health care for its Medicaid clients. The report will investigate ways to reduce system fragmentation, improve health outcomes, and control costs through an integrated system of care. In addition, the report shall include a proposal for the integration of Oregon Health Plan behavioral and physical health services. The department will work with appropriate stakeholders to prepare the report and shall present it to appropriate 2007-09 interim legislative committees, including the Emergency Board, by June 30, 2008

Appendix B

Members of the DHS Behavioral and Physical Health Integration Committee are:

Cindy Becker, Coalitions for a Health Oregon & Clackamas County

Rhonda Busek, Lane Individual Practice Association

Rebecca Chi, FamilyCare Inc.

Patrick Curran, CareOregon

Deborah Friedman, Clackamas Mental Health Organization

Amy Goodall, Oregon Medical Association

Gina Nikkel, Association of Oregon Community Mental

Bob Joondeph, Oregon Advocacy Center

Kathy, Savicki, Mid-Valley Behavioral Care Network

Jane Ellen Weidanz, Oregon Association of Hospitals and Health Systems

Mitchell Anderson, Benton County Mental Health

DHS Staff:

Jeanene Smith, Office for Oregon Health Policy and Research, DHS

Patricia O'Sullivan, Director's Office, DHS

John Pelkey, Medical Assistance Programs, DHS

Andy Smith, Addictions and Mental Health, DHS

Ralph Summers, Addictions and Mental Health, DHS

Joel Young, Public Health, DHS

Megan Hornby, Seniors and People with Disabilities, DHS

Amy Blake, Communications, DHS

Katie Smith, Forecasting, DHS

APPENDIX C

CURRENT STATEWIDE INTEGRATION PROJECTS/ACTIVITIES

Name of Program/Location	Implementers	Target Population	Model/Approach	Funding Source(s)	Goals	Outcomes	Main Contact/phone/email
Benton County							
Benton County Health Services (combined and co-located FQHC, public health and community mental health/addictions	Benton County		Creating and integrated health home including PH prevention, care coordination for physical and mental health conditions, behaviorists and psychiatry working with primary care as part of care teams.				
Clackamas County							
Federally Qualified Health Centers (FQHC)			Behavioral health consultants on staff at FQCH primary care clinics				
			School-based health clinic				
			Adult MH programs offer health education to clients (tobacco cessation, diabetes management, and pain management classes)				
			Integrated MH and A&D treatment model for adult clients				
Deschutes County							
Accountable Behavioral Health Alliance			Identification and coordination of primary health care service needs for members with co-occurring mental health symptoms and substance abuse disorders.				

CURRENT STATEWIDE INTEGRATION PROJECTS/ACTIVITIES

			Central Oregon Independent Health Solutions (COIHS), Deschutes County Chemical Dependency Organization (CDO), and Accountable Behavioral Health Alliance (ABHA) and will focus on integrative health care needs of Oregon Health Plan (OHP) clients with co-occurring disorders who are concurrently enrolled in each organization.				
Douglas County							
DCIPA			??				
Jefferson County							
Standardized Referral Process: A collaboration Between Physical/Mental Health Care Plans	Jefferson Behavioral Health Family Care		• Joint non-clinical performance improvement project • Formation of "The Mind-Body Connection," with representation from 7 FCHPs, 1 DCO, JBH and 6 county mental health programs • Informal networking and problem solving to facilitate OHP enrollees obtain both mental and physical health services				
JBH/Fully capitated health plans in the JBH Region			The Mind-Body Connection is focused on improving the collaborative relationship between mental and physical health professionals by the using and monitoring a standardized referral too.				
Lane County							
Federally Qualified Health Centers (FQHC)	Lane County		Integrated mental and physical health services				

CURRENT STATEWIDE INTEGRATION PROJECTS/ACTIVITIES

Lane County Mental Health	Lane County		Primary care offices being constructed in the Lane county mental Health facility that will be staffed with an MD				
	LaneCARE (mental health org.) and Lane IPA (fully capitated health plan)		• Shared consumer advisory committee • Shared Performance Improvement Project • Participation on organizational governance and advisory committees • Project Homeless (supported by LaneCare and LIPA)				
	Rhonda Busick		Integrated MH and A&D programs	LIPA Managers CD			
	Rhonda Busick		Integrated M and DHS child welfare programs				
	?		100 % Access community partnerships promoting integration of care				
LaneCare / LIPA / Hayden Family Dentistry / ODS			Looking at diabetes in members age 18 and older who are prescribed second generation anti-psychotic medications. Conducting health screenings on this population who receive treatment at Lane County Mental Health. The second part will be education and referral to PCPs and dentists. Data will be tracked to see if the individuals connected with their PCP and dentist.				
Lincoln County							
FQHC	Lincoln County Health Department		Creating and integrated health home including PH prevention, care coordination for physical and mental health conditions, behaviorists and psychiatry working with primary care as				

CURRENT STATEWIDE INTEGRATION PROJECTS/ACTIVITIES

			part of care teams.				
Marion/Polk County							
MPCHP/MCBCN			Creation of an integrated clinic to engage chronic pain patients in self-management, provide consultation to PCPs and specialized follow-up care for any behavioral health conditions				
Multnomah County/Portland							
Multnomah Co., CareOregon/Central City Concerns			Integrated MH, PC, Addictions care for the homeless				
Chemical Dependency	Allied & FC		Integrated mental health and physical health within CD clinics engaging consumer in all services.				
Primary Care LPN's			Creating mental health practitioners in primary care offices.				
Providence ElderPlace Portland	Providence ElderPlace	Older adults	Increase availability and effectiveness of mental health care services for older adults in program. Assist in maintaining maximum levels of health and independence while reducing the need for acute hospitalization, nursing home placement, emergency room use and outpatient mental health/substance abuse clinic visits. Address SAMHSA RFA No SM-08-008 goal to "help communities provide direct services and build necessary infrastructure for meeting diverse mental health needs of older persons". Program designed to address gaps in the care delivery system.	SAMHSA offers up to $414,400 every year for three years (Substance Abuse and Mental Health Services Administration)	Increase availability and effectiveness of mental health care services for older adults. Improved prescribing practices and quality of care for the elderly. Increase level of psychosocial functioning, quality of life satisfaction and decreased need for services.		

CURRENT STATEWIDE INTEGRATION PROJECTS/ACTIVITIES

					Assure elder care work force has sufficient knowledge and skills to manage older adults with mental health/substance abuse issues in community-based settings.		
Increasing Coordination and Integration of Medical and Mental Health Services	Verity CareOregon Kaiser Lifeworks Cascadia	All Medicaid clients presenting at behavioral health clinics with serious and persistent mental illness	Experienced nurse functioning in the mental health clinics	CareOregon Kaiser	65% of the enrolled clients have an encounter with PCP within 12 months after enrollment if they have not seen a PCP within the previous 12 months	* Not completely defined at this time. Increased # of PCP visits Decrease ED utilization	Ann Blume 503 416 1723 Charmaine Kinney 503 849 7964
FamilyCare (FHQC & MHO)			Effects of Co-location of Practitioners (physical health and behavioral health) on Health Service Utilization and Care Coordination. 1. Will the utilization of outpatient behavioral health services be improved by the co-location of behavioral health practitioners in a physical health clinic? 2. Will the co-location of providers enhance the communication and coordination of care between the physical health and behavioral health providers?				

APPENDIX C

CURRENT STATEWIDE INTEGRATION PROJECTS/ACTIVITIES

Medicaid Advisory Committee							
			Start integration discussion	No partner available			
Mid-Valley Behavioral Care Network/INH							
	Linn County Health Department		Shared case management model to assess medical risk and motivation, partner to create and follow individualized care plans for individuals dealing with serious mental illness and diabetes.				
Washington County							
	Virginia Garcia Clinic and LifeWorks NW		Mental health services provided at Virginia Garcia primary care clinics by LifeWorks NW				
Providence			Geriatric mental health specialist at Providence primary care clinic				
LifeWorks, Cascadia, Luke Dorf			Integrated CD/mental health treatment at LifeWorks, Cascadia and Luke Dorf				
Joint Performance Improvement Project	Washington County MHO, Tuality Health Alliance and Providence Health Plan						
Diabetes Education	Eli Lilly/Tuality Health Alliance		Diabetes education for mental health providers				

CURRENT STATEWIDE INTEGRATION PROJECTS/ACTIVITIES

FQHC			School based health clinics integrated MH, integrated mental and physical health services				