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**DISCLOSURE & ACCREDITATION**
**CONTINUING MEDICAL EDUCATION PROGRAM**

CME Activity Title: ***"10th Annual EOCCO Summit", September 21 and 23, 2022***

**Chuck Hofmann, MD, MACP; Sean Jessup; Kali Paine; Kaleema Murphy; Summer Prantl; Jeff Willams; Anand Parekh, MD; Kathryn Hart, CHW; Kathie Pointer; Dana Rush; Sandra Hernandes; Jacque Serrano; Nancy Avery; Kaylynne Todd; Jordan Mikel; Alexis Dinno; Bruce Goldberg, MD; Satya Chandragiri, MD**
agree to the following elements as expected of individuals involved in the planning and implementation of educational activities certified by St. Charles Health System:

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- Deliver balanced and objective evidenced-based content
- Present the source and type or level of evidence (i.e., animal study, meta-analysis, etc)
- Disclose on a slide at the beginning of my presentation any relationship related to (1) the activity's content and/or (2) the activity's supporter(s)
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**(Check all that apply)**

- ☒ NONE
- ☐ Grants/research support:
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- ☐ Stock shareholder (directly purchased):
- ☐ Honorarium/Speaker:
- ☐ Other financial or material support:

| | |
|---|---|
| **Planners** - EOCCO staff: Chuck Hofmann, MD; Audrey Egan, Moda Health; Courtney Valenzuela, Moda Health; Courtney Whidden, Moda Health; Jeanne McCarty, GOBHI; Jorge Ramirez Garcia, GOBHI; Karen Wheeler, GOBHI; Sean Jessup, EOCCO; Summer Prantl, Moda Health; Yale Popowich, Moda Health | Nothing to disclose |
| **CME Committee members, planners and staff** are listed below and have no relevant financial relationships to disclose with the exceptions as listed. Individually signed disclosures (CME committee, faculty, planners, reviewers and staff) are filed in the CME program office.<br>Stephen Mann, DO, Chair CME Committee; Robert Ross, MD, Head of Medical Education and Research; Brandon Boothe; Jeff Bulkley, DO; Sarah Chadwick; Irene Czyszczon, MD; David Dedrick, MD; Dausen Harker, MD; Jinnelle Lewis, MD; Alex Miller, PharmD; Janey Purvis, MD; Jon Roberts, MD; Josh Rust, PA; David Steiger, MD; Jennifer Watters, MD;<br>Disclosures: **None**<br><br>**CME Reviewers, Planners, Staff**:<br>Noura Sall, Manager Research, CME, Med Library, St. Charles Health System<br>Ellie Cuff, Supervisor CME Department, Leslie Borquez, CME Coordinator, Javier Leiva, Medical Librarian, Landon Neet, Outcomes Analyst, David Schumacher, CME Specialist | |

**ACCREDITATION:** This activity has been planned and implemented in accordance with the accreditation requirements and policies of the Accreditation Council for Continuing Medical Education (ACCME) through the joint providership of St. Charles Health System and Moda Health for the Eastern Oregon Coordinated Care Organization (EOCCO). St. Charles Health System is accredited by the ACCME to provide continuing medical education for physicians.

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# 10th Annual EOCCO Summit

| | |
|---|---|
| 8:00 am – 8:05 am | **Welcome and Introductions**<br>Dr. Chuck Hofmann, Eastern Oregon Coordinated Care Organization |
| 8:05 am – 8:45 am | **Approaching Non-medical Needs in Patients with Complex Disease**<br>Dr. Bruce Goldberg, Oregon Health Science University |
| 8:45 am – 9:30 am | **Health-Related Services**<br>Summer Prantl, Moda Health |
| 9:30 am – 10:15 am | **Crisis Response**<br>Dr. Satya Chandragiri, Greater Oregon Behavioral Health, Inc. |
| 10:15 am | **Recap and Adjourn** |

# Announcements

# PowerPoint Slides

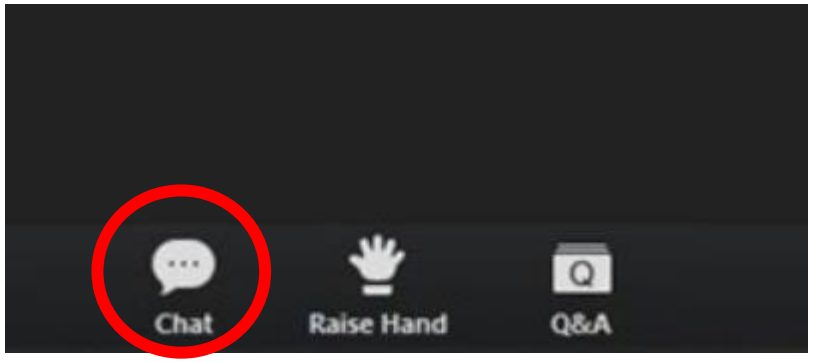
## Where can I find the PowerPoint slides for today's event?

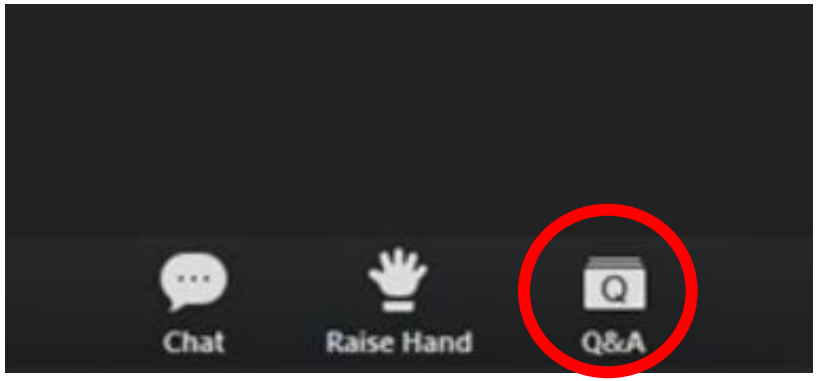
- Scan the below QR code or visit https://www.eocco.com/news/Current/2022-EOCCO-Clinician-and-Staff-Summit.

## Will today's presentations be recorded?

- Yes. The presentations will be recorded and posted to https://www.eocco.com/news/Current/2022-EOCCO-Clinician-and-Staff-Summit after the event.

- Direct questions or comments for EOCCO staff or your peers to the chat.
- Direct questions for the speakers to the Q&A.
- Contact EOCCOmetrics@modahealth.com for questions or concerns after the event.

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# SOCIAL NEEDS SCREENING IN THE CLINICAL SETTING

**BRUCE GOLDBERG, MD,**

**Sept. 23, 2022**

# Disclosure

No disclosures

# Learning Objective

- Apply presented strategies to patients with complex diseases in the Eastern Oregon service area.

# Why Understanding Social Needs Is Important

**Patients with social needs:**

- Obtain fewer preventive services
- Have more chronic health conditions
- Have poorer health outcomes

(McKelvey, 2017) (Meddings, 2017)

## Is just understanding social needs enough? Do patients really want to be questioned about social need?

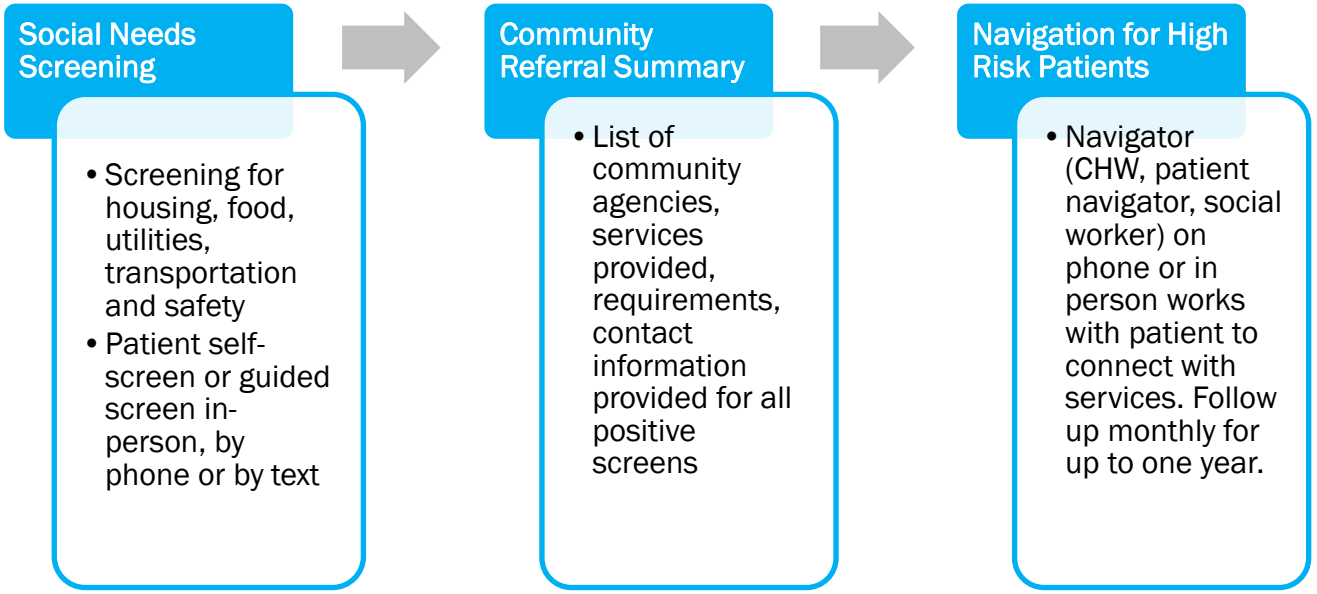
- Screening is certainly needed to inform clinical care, however many clinicians feel that screening should be paired with doing something about the needs that are uncovered.
- Patients are mostly agreeable to being screened
- Providing information about local community resources is valued by participants

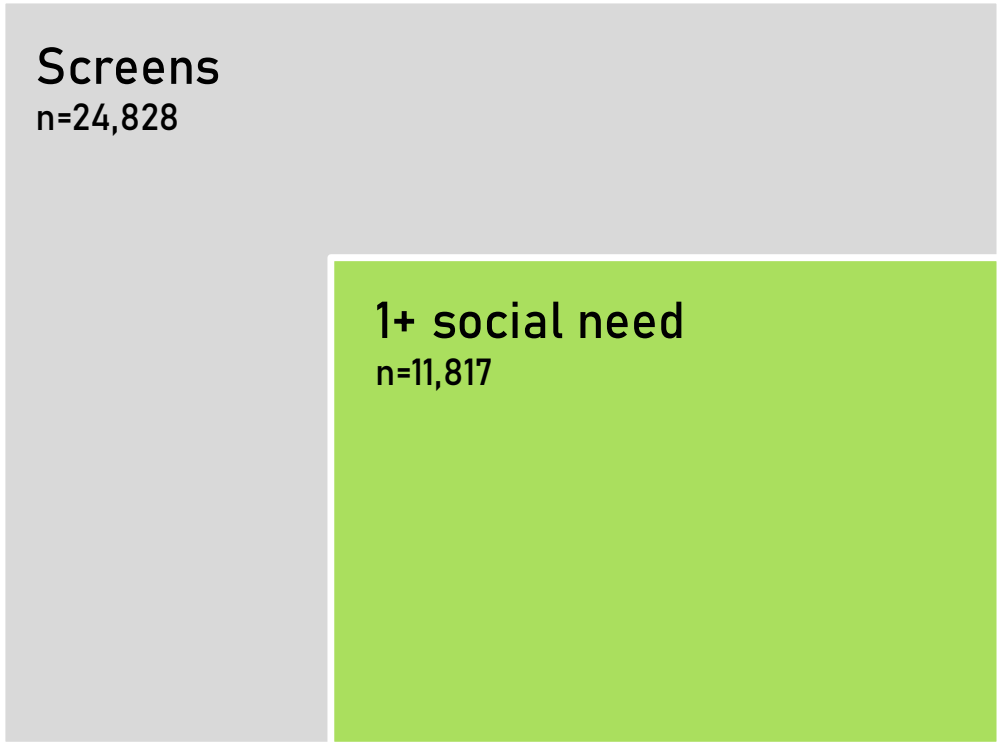
## Experience to date

- 24,828 Medicaid and Medicare recipients have been screened for health-related social needs

- Over 50 sites – spanning urban and rural Oregon

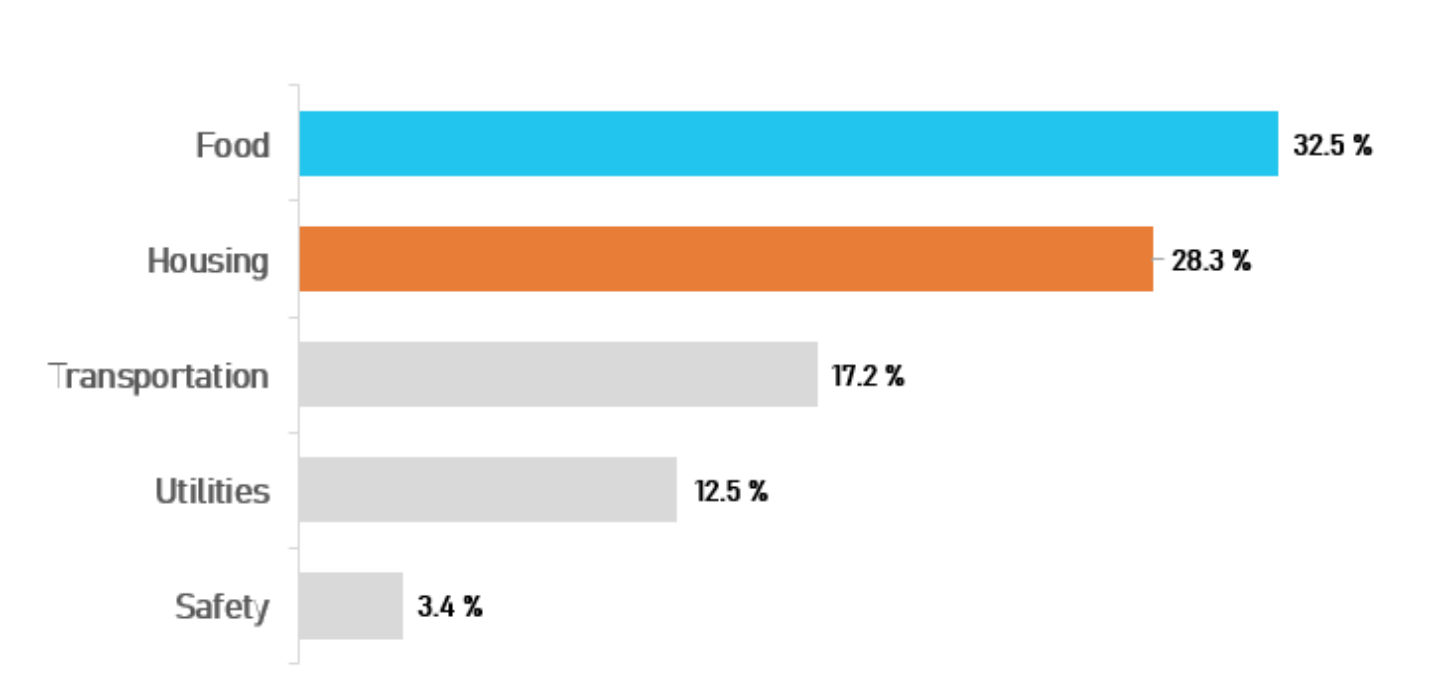
# The Centers for Medicaid and Medicare Services Accountable Health Communities Model

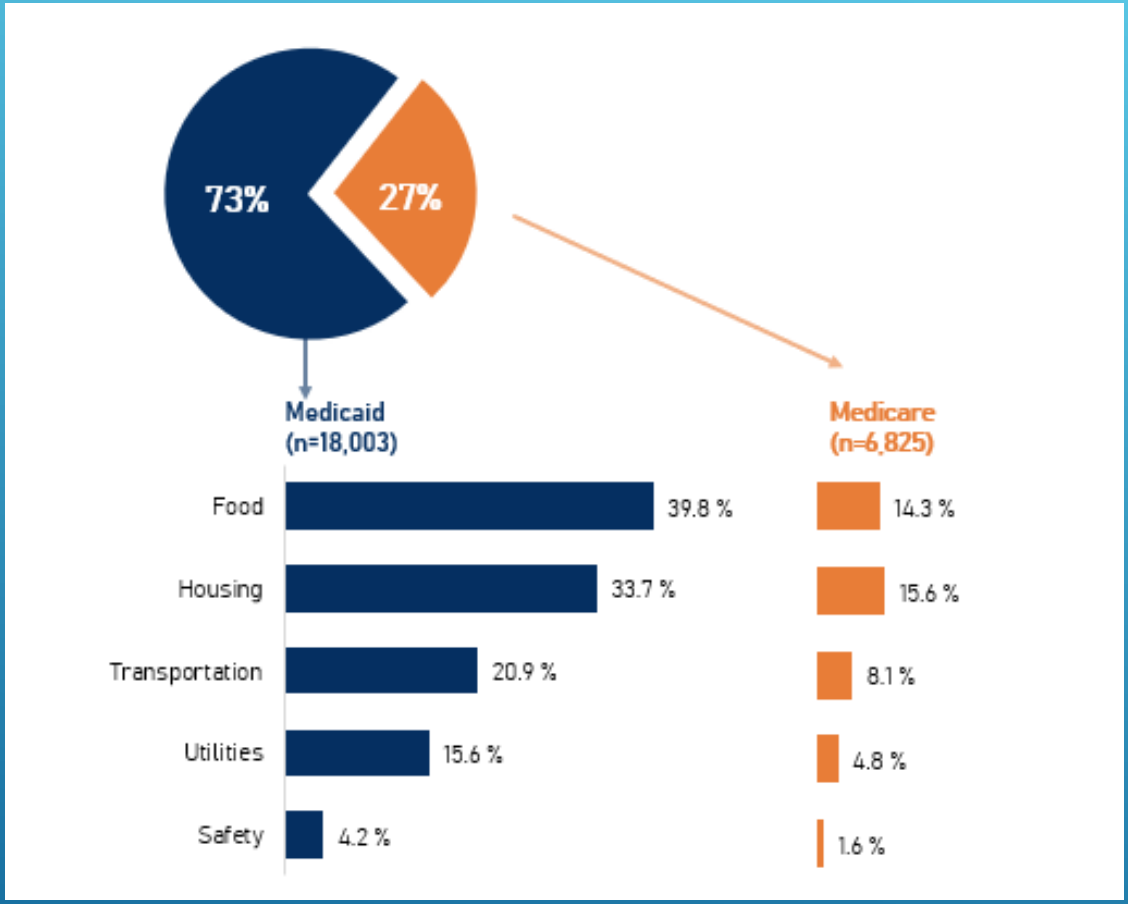





Of the patients who were screened, **47%** had at least one social need

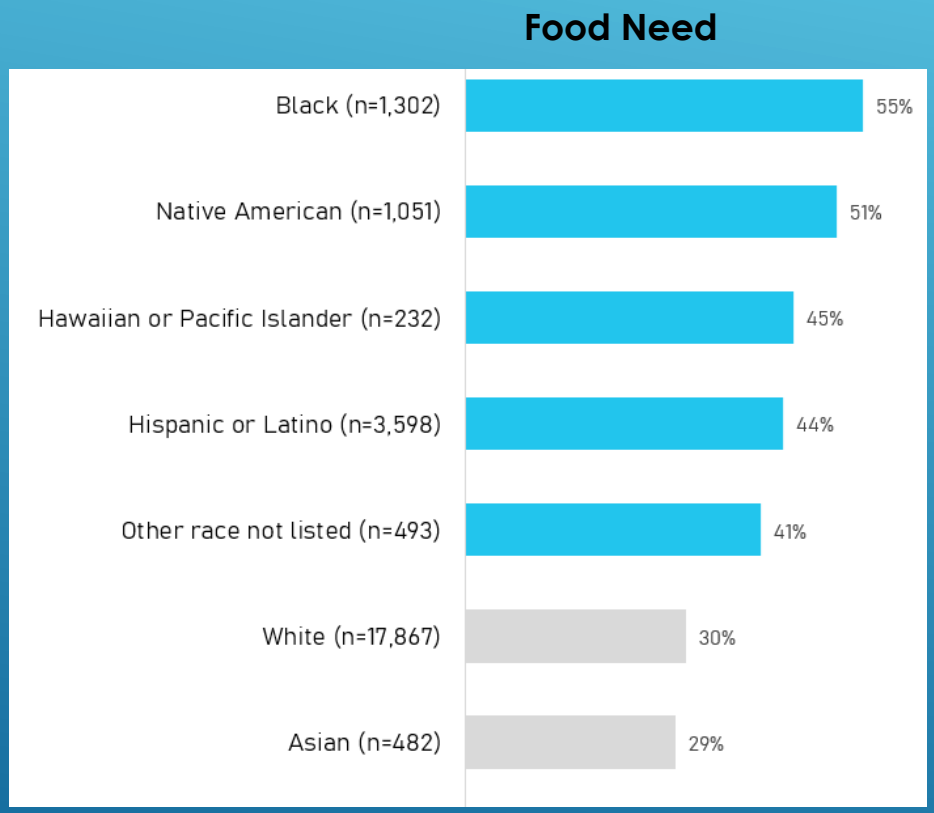
Among all screened patients (n=24,828), **Food** and **Housing** were the most common social needs.

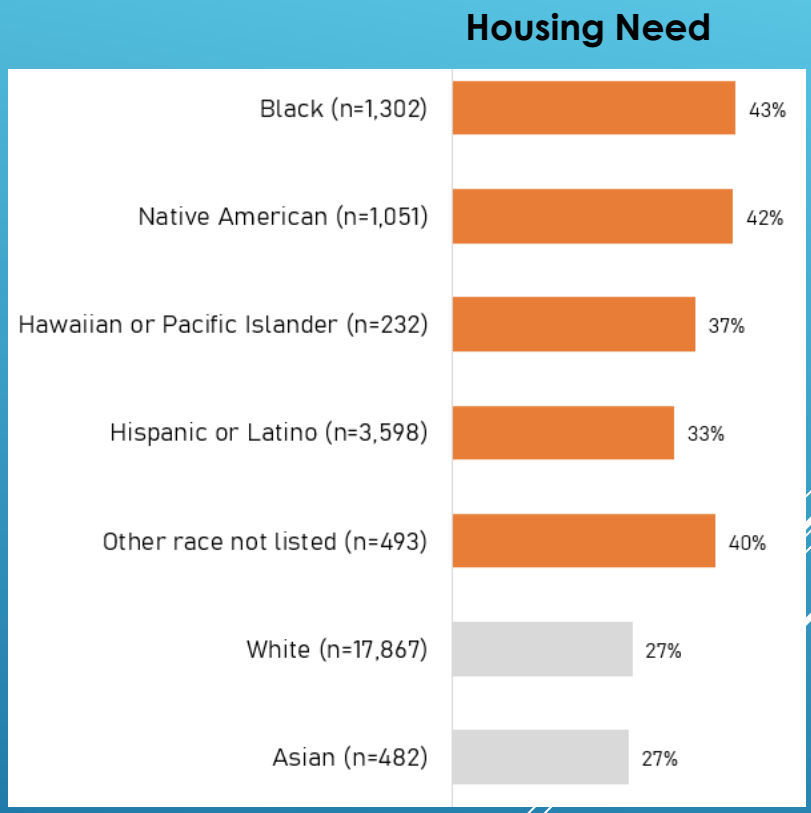


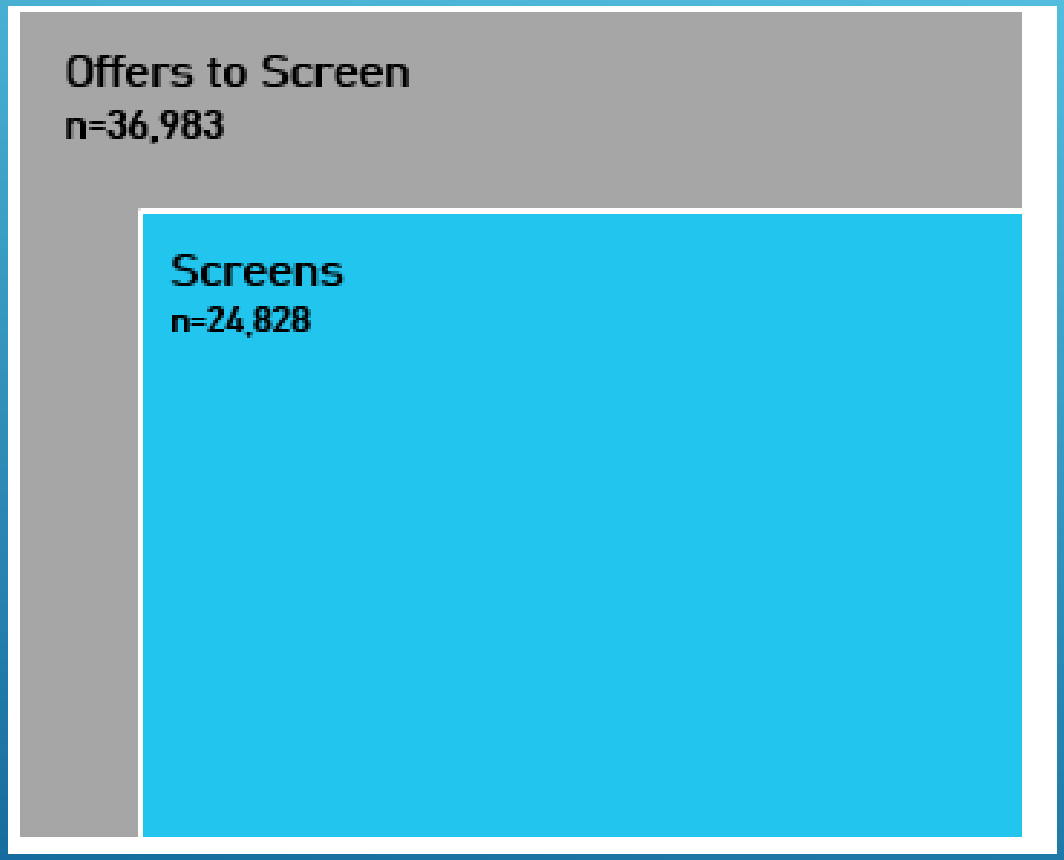



Medicare beneficiaries comprised 27% of the screened patients, and reported fewer needs than Medicaid beneficiaries

# Food and Housing needs reported **for** 5 racial and ethnic groups






For **all screening methods**: of the 36,983 patients who were offered screening*, **67%** accepted

*Offer to screen included in-person and telephone discussions with patients about the screening.

Of all the patients who were offered screening in a clinic, 70% completed the screening

# Primary Care Screening Approaches

- In-office screening (50+ clinical sites)

- Telephone screening (added due to COVID-19)

- Text screening (added due to COVID-19)

# In-Office Screening Methodologies

Of the 50 clinics:

- 41% had patients take screening on paper
- 24% used an iPad
- 18% used the OCHIN Epic flowsheet
- 12% used a desktop computer
- 6% used an Epic tablet

# Screening Consistently In-Office: Facilitators

- **Time-** try using only longer visits (e.g., CHW, prenatal, well-child)
- **Staff-** to listen to patients, navigate services, handle difficult conversations
- **Training-** trauma-informed screening, social care pathways
- **Resource Documents-** up-to-date lists of resources for different populations, geographies, cultures and languages
- **Documentation-** so clinical care can be informed
- **Monitoring-** is the screening happening?

# TAKEAWAYS FOR PRIMARY CARE

- A lot of our patients have social needs, and many of these are invisible to us
- Poverty overall and social needs in particular contribute substantially to health status
- Clinics are committed to understanding and addressing social needs
- Clinics have difficulty screening consistently

## To Effectively Do This Work, Clinics Should Consider:

1. Feasibility of adding other modalities of screening:
   - Mailing, telephone, text, other?
2. Population approaches
3. Pick a small number of questions & a tool that is easily understood by lower literacy patients, and patients of diverse backgrounds
4. Align with existing screenings (e.g., SBIRT) to lighten workflow
5. Partnerships (e.g., data sharing with payers, community agencies, participating in community information exchange, partnering with research organizations)

# QUESTIONS, THOUGHTS?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# Health Related Services

## Focus: Flexible Service

Summer Prantl Nudelman

# Disclosure statement

I do have a relevant financial relationship with commercial interest whose products or services relate to the content of the educational presentation.

- Company: Moda Health
- To ensure independence and balance of content, current conflicts of interest were resolved by basing recommendations on structured review for best evidence.

# Learning objective

- Summarize the qualifiable requests for health-related services.

# Agenda

- What are Health Related Services
- Examples of services
- Utilization
- Panel
- Q&A

# Health Related Services background

# Background

Health Related Services include:

Flexible Services: Cost-effective services delivered to an individual OHP member to supplement covered benefits and improve their health and well-being

Community Benefit Initiatives: Community-level interventions that include, but are not limited to, OHP members and are focused on improving population and health care quality

Medicaid covered services cannot be a Health Related Service

# Background

- Health Related Services criteria, must meet all bullets below:
  - Designed to improve health quality
  - Increase the likelihood of desired measurable health outcomes
  - Directed to either individuals, segments of enrollees or the population beyond those enrolled without additional cost
  - Grounded in evidence-based medicine, clinic best practice, or accredited

- Health Related Services criteria part 2, must meet at least 1:
  - Improve health outcomes and reduce health disparities
  - Prevent avoidable hospital readmissions
  - Improve patient safety, reduce medical errors, and lower infection and mortality rates
  - Implement, promote, and increase wellness and health activities
  - Support expenditures related to health information technology and meaningful use requirements

# Examples

# Example

Case details:

- 62-year-old female diagnosed with low back pain, chronic pain, degenerative disc disease, depression and anxiety
- Member is residing in a shed with no heat or running water while waiting for housing
- Member is sleeping on the ground in cold weather exacerbating her condition
- Due to pain, member is not mobile

Flex services provided:

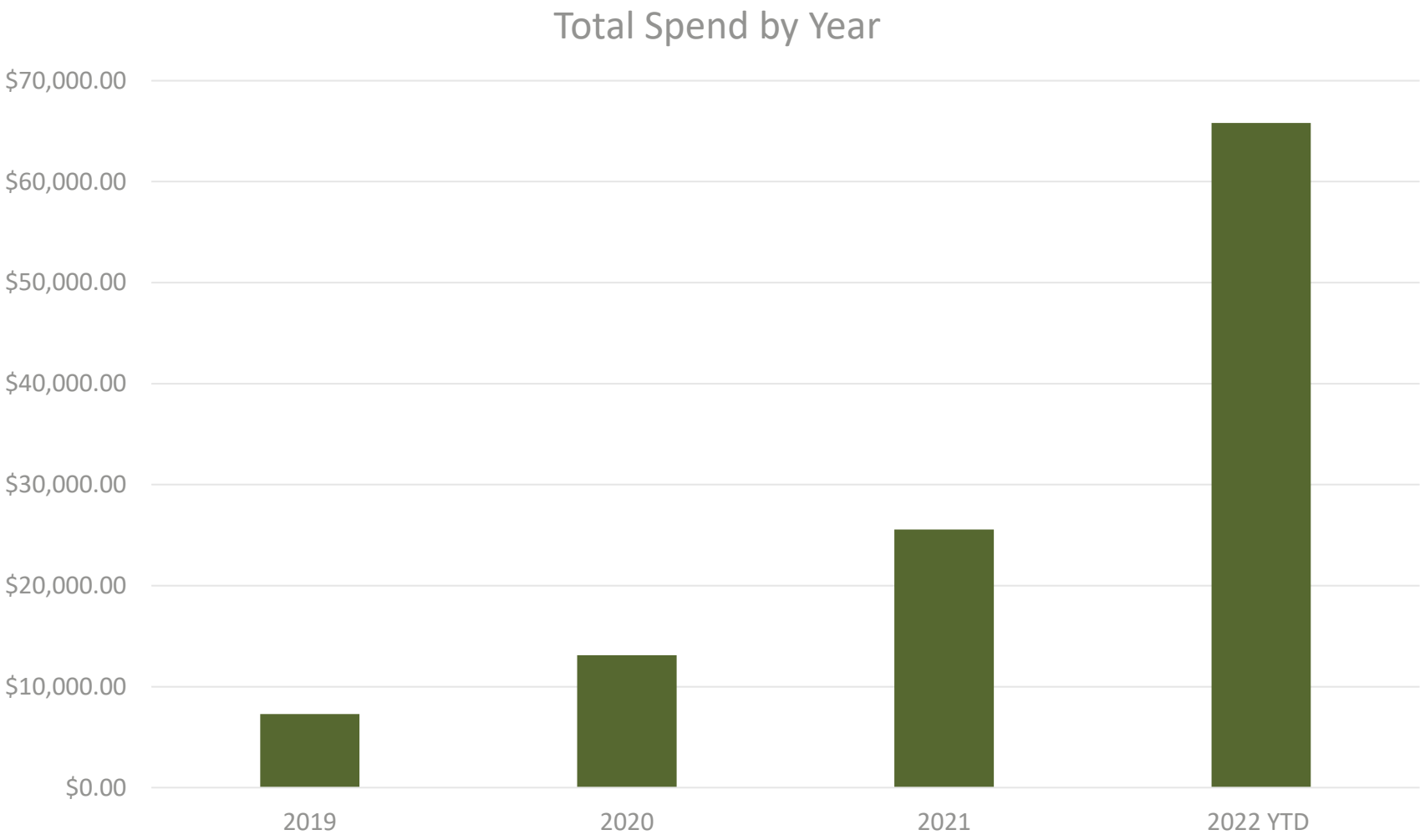
- Portable fold up mattress

# Examples of other flex services

- Cell phone and phone card minutes
- Gym memberships
- Non-covered DME such as scales, humidifiers, air purifiers, air conditioners, and blood pressure monitors
- Pest control services, such as bed bugs and sugar ants
- Temporary housing for pre- and post-discharge
- Items for the living environment such as crockpots, hot plates, and mini refrigerators
- Moving expenses and utilities

# Utilization

# Utilization by year

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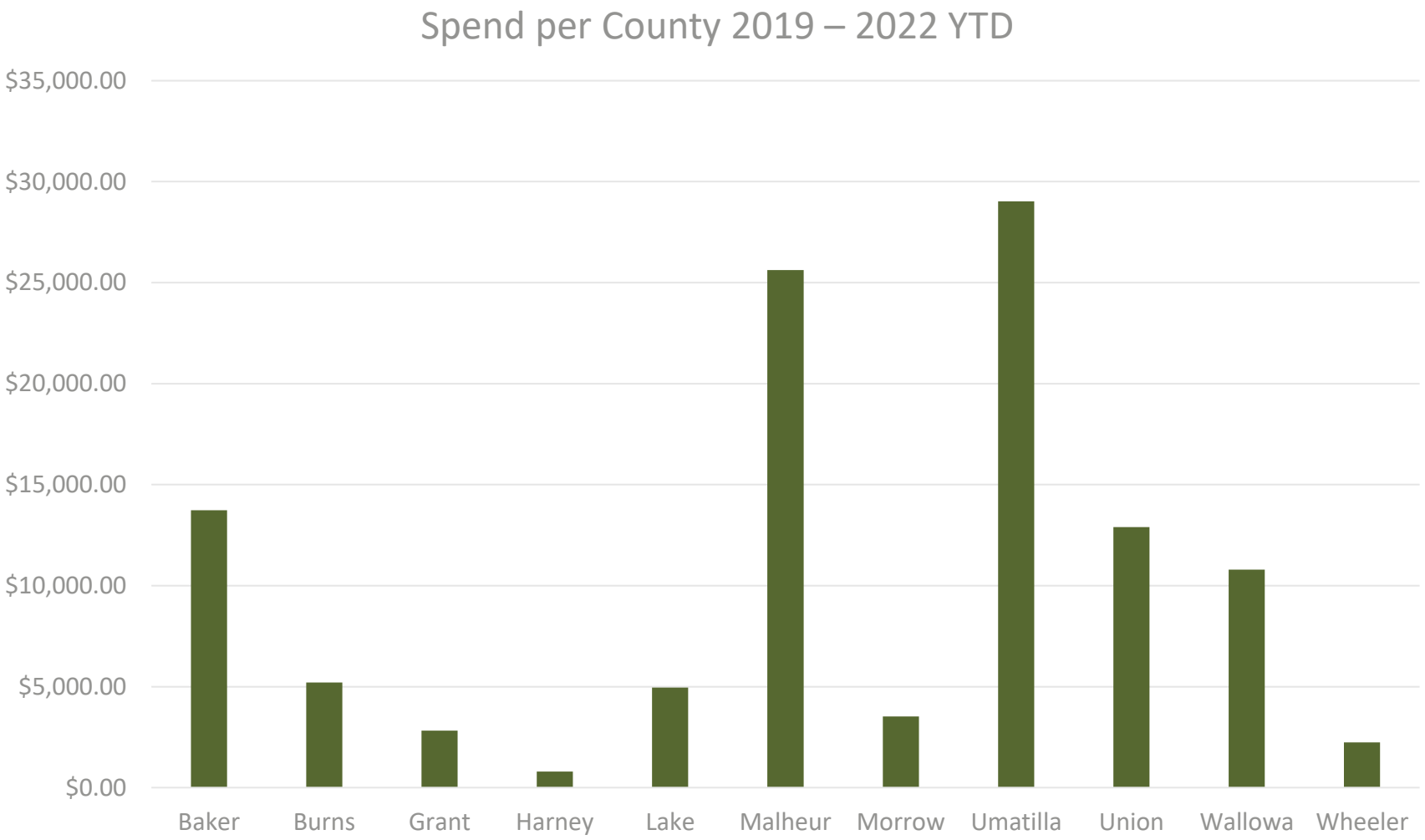
# Utilization by county

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# Utilization by clinic

| Clinic | Total Spend | Number of Requests |
|---|---|---|
| Valley Family Health Care | $23,864 | 69 |
| Grande Ronde Hospital | $11,098 | 43 |
| St Lukes Clinic Eastern Oregon | $9,856 | 31 |
| Winding Waters | $8,033 | 31 |
| Irrigon Medical Clinic | $5,388 | 29 |
| La Pine Community Health | $4,106 | 25 |
| Praxis Medical Group | $6,866 | 21 |
| St Anthony Hospital Family Clinic | $1,982 | 8 |
| Pendleton Primary Care | $3,350 | 7 |
| St Anthony Hospital | $2,954 | 7 |
| SAMG Baker City | $2,433 | 7 |
| Walla Walla Clinic | $3,293 | 6 |
| Snake River Peds | $1,503 | 6 |


QUESTIONS?

# Flexible Services Panel

# Panelists

- **Nicole Fenimore, RN, CCM, AATMC, CMCN**
  - Supervisor, Case Management
  - Oversees processes and approves many of the requests
- **Sylvia Ixta**
  - CHW at Valley Family Health Care

# Questions

1. Please introduce yourself and briefly describe your role in the Flexible Services process.
2. How do you receive requests for flexible services and what happens after you get the request?
3. What are some challenges you face when identifying member needs?
4. Any workflows or processes that you have found to be helpful?
5. Can you tell us about a success story?


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# CRISIS RESPONSE IN MENTAL HEALTH CARE


- Satya Chandragiri MD
- Chief Medical Officer
- GOBHI
- schandragiri@gobhi.org

# Disclosures

- No disclosures

# Learning Objective

- Apply the presented crisis responses strategies to reduce risk of harm to patient or others.

# Crisis Response in Mental health care

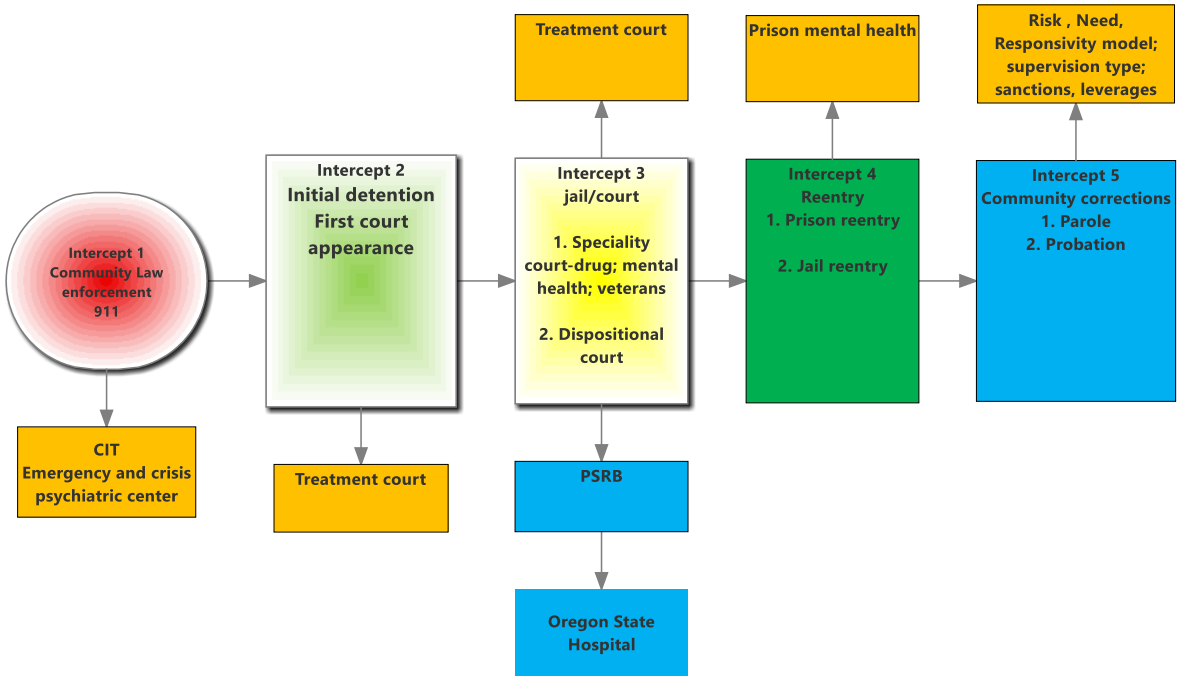
-Crisis response as gateway for treatment

- GOBHI- MODA/ CMHP rounds- Collective platform

- Challenges and opportunities- 988, Mobile response, Measure 110


No health or sustainable development
without mental health

# Mental health crisis and Justice involvement



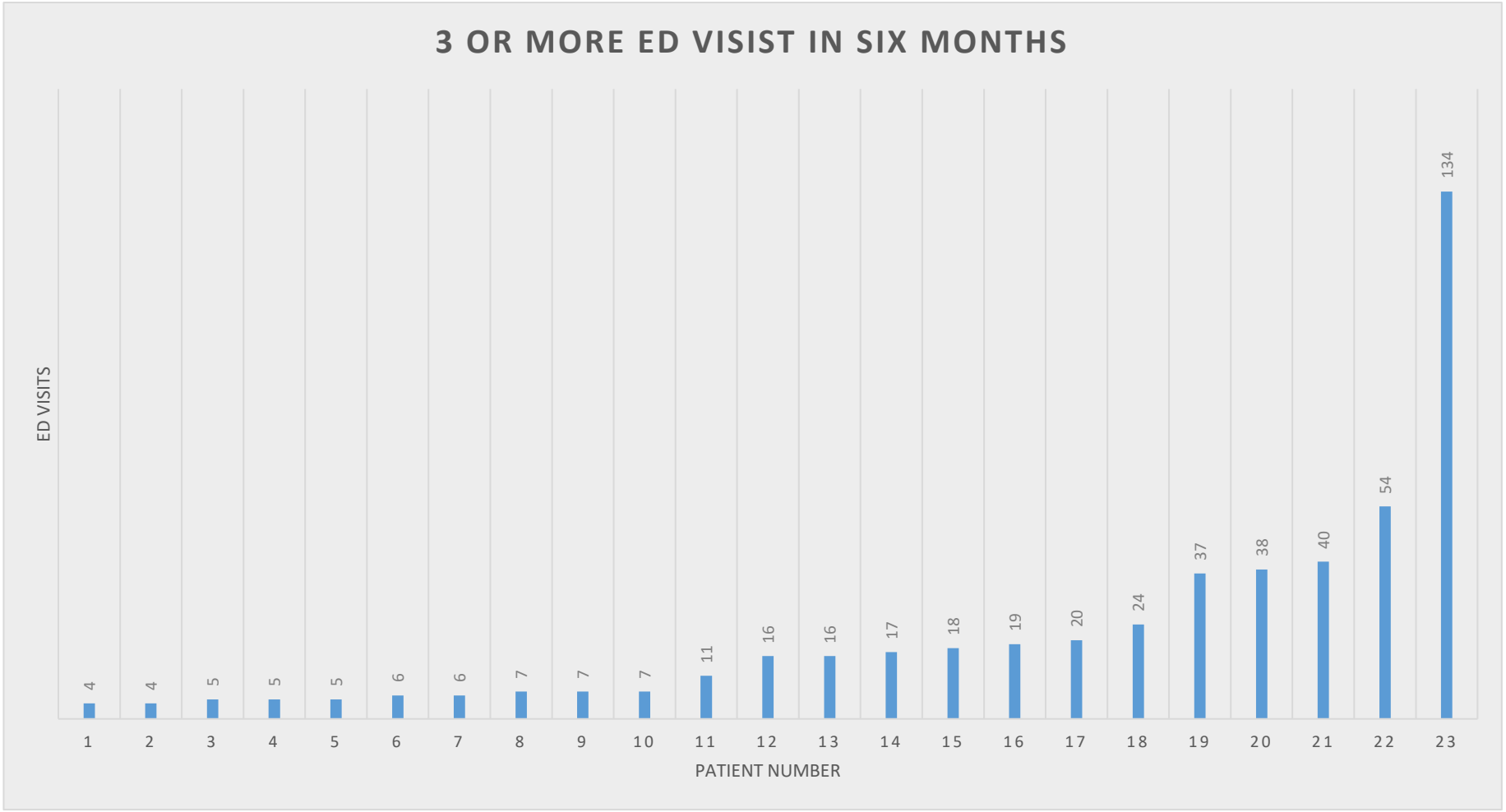
| Area Services | Total Group 49,641 | High Risk 5,011 (10.1%) | High Risk & MH (PCP) 3,588 (7.2%) |
|---|---|---|---|
| Avg. # Primary Care Visits | 1.6 | 4.4 | **4.8** |
| Avg. # ER Visits | 3.2 | 15.3 | **18.7** |
| Avg. # RX Filled | 8.9 | 44.6 | **48.3** |
| % RX Opioid | 18.4% | 63.2% | **70%** |
| Avg. Costs PH & BH | $2,072 | $11,548 | **$13,011** |

# Mental health crisis-provider versus member

- Admission criteria- legal hold criteria, liability concerns, insurance algorithms
- Average length of stay has shortened
- Step down outpatient programs access varies
- Repeated ER presentation- severity and lack of access
- Not knowing their diagnosis
- Not understanding how treatment recommendations offered were relevant to their needs or treatment trajectory
- Not knowing their next care step was or how to be discharged

# GOBHI rounds

- Collective Medical Platform
- CMHP, MODA, GOBHI- UM/CM
- Review all ED visits
- 3 days follow up, pregnancies high risk, hospitalizations, SUD, medical concerns and mental health


3 OR MORE ED VISIST IN SIX MONTHS
ED VISITS
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PATIENT NUMBER


SI/HI
Unhoused, not living in his county
schizoaffective/ bipolar, depression
32 years old male
Malingering
Meth, cannabis, alcohol
Pain, scalp injury, leg pain, chest pain

# 134 ED visits in 12 months

- Hospitals 14 different ED
- Peace Health Southwest Medical Center
- Legacy Salmon Creek
- Legacy Good Samaritan
- KP Westside Medical Center
- Providence Milwaukie Hospital
- Legacy Mount Hood
- Unity
- Tuality Community Hospital
- Oregon Health and Science University
- Legacy Emanuel
- KP Sunnyside Medical Center
- Legacy Meridian Park
- Adventist Health Portland
- Providence Portland Medical Center
-

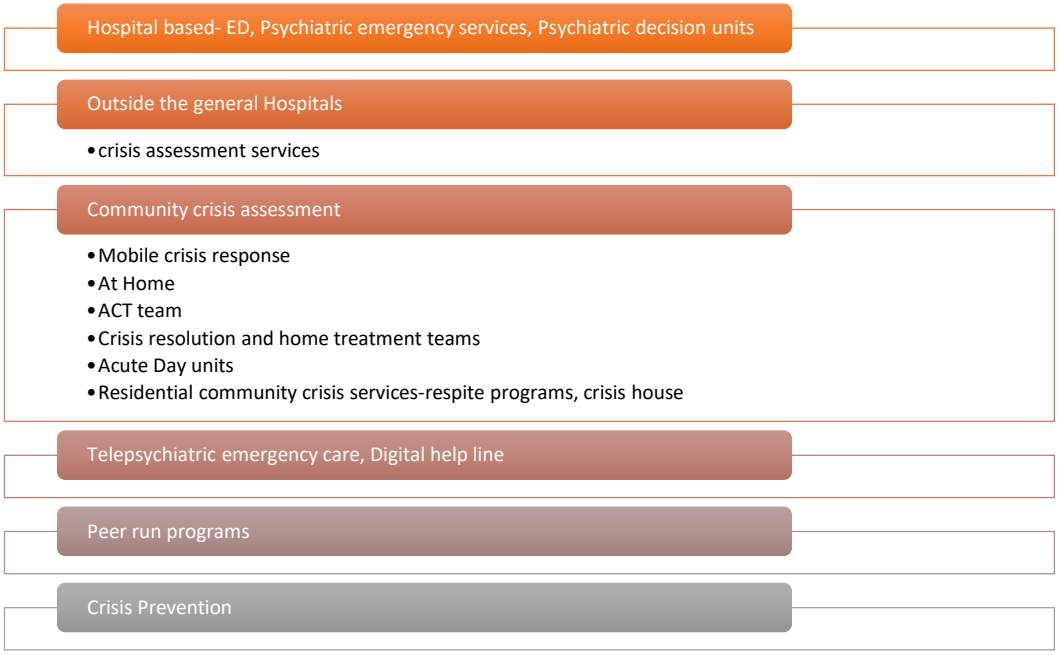
# Challenges and Opportunities

- Nearly 20% of the members, use crisis and higher levels of care
- Children mental health care crisis
- SUD, mental health
- Justice involvement and crisis leads to challenges with access to state hospital
- Diversity and population increase and health inequity

# Oregon Civil commitment 1996-2019

| year | investigation | hearing | %inv to hearing | % hearing to civil C |
|---|---|---|---|---|
| 1996 | 5942 | 1023 | 17.2% | 14.6% |
| 2019 | 5178 | 656 | 12.7% | 9.9% |

# No wrong door approach



# Crisis resolution outside hospital

Mobile crisis response (Non Police models)

Police only model including CIT trained officers

Mental Health- Law enforcement Co responder model

# Measure 110 Substance use disorder treatment

- Addiction treatment
- Housing challenges and opportunities
- Treatment of co occurring addiction and mental health crisis

Telemedicine, digital help

988 line

Digital apps

Telepsychiatric services

# Thank you

- Questions and answers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Thank you!

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  - You will have access to the activity code for 24-hours.
  - Email EOCCOmetrics@modahealth.com if you did not download your CME certificate within the allotted time.
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*Note: The activity code will expire on Saturday, September 24, 2022 at 8 am*