Alliance
Transitions of Care Committee Meeting
Second Thursdays 1:00pm – 2:30pm
Thursday, April 11, 2023

https://us02web.zoom.us/j/89796541408?pwd=OGpPRVArcDhTS1MzWml3YUhaZHV3dz09

Can also be joined by calling 669.900.9128,,89796541408#,,,,*651946#

Committee Vision/Mission:

The *Transition of Care Committee* identifies best practices, innovative approaches, and gaps to safe and uninterrupted transitions for youth, young adults and their caregivers when experiencing mental health crisis or risk of crisis. It promotes policies and practices that effectively support their needs for continuity during the period in which intentional coordination of care is imperative.

Members List: Co-Chair Charlette Lumby, Co-Chair Liz Schwarz, Erin Porter, Mary Massey, Meghan Crane, Rachel Ford, Rachel Howard, Tanya Pritt

Staff: Annette Marcus (Alliance), Jennifer Fraga (Alliance)

Present Today: Co-Chair Charlette Lumby, Co-Chair Liz Schwarz, Craig Leets, Erin Porter, Meghan Crane, Rachel Ford

Absent Today: Mary Massey, Rachel Howard, Tanya Pritt

Alliance Staff Present: Jenn Fraga

Alliance Staff Absent: Annette Marcus

Guest(s): Kristine O'Brien

Time	Agenda Item	What / Update Action Item(s)	Notes
1:00	**Welcome** Agenda Review	*Introduce new members.* Group Agreements	Welcome Kristine!
	Announcements		Charlette is transitioning out of co-chair for this Committee as she is transitioning into her new role of Chair for the Alliance. Meghan oversees the SAMSHA Zero Suicide Grants (Quality improvement for suicide safer care). The grant is focused on ages 25+. They are starting a community of practice for those implementing Zero Suicide across the state and is voluntary for them to attend.
	Committee Logistics	Leadership Meeting frequency	Liz asked the group if anyone is interested in becoming a co-chair for this Committee. The ask for the co-chair position is to join monthly meetings and be part of planning discussions for upcoming meetings. If you are interested in this, please reach out to Jenn and Liz. Liz's capacity for monthly meetings, especially with her being the only chair, is limited. She asked if the group would be open to meeting every other month instead of monthly for a while. The group present today is open to this and are okay with following this schedule for a bit. The group talked about potentially having in between work with only meeting every other month. Liz said that we wouldn't meet in May, would meet in June, and potentially not meeting in July or August as summer attendance historically drops. Action Step: Send out meeting frequency to Committee members.

	Committee Role in 988 Work		Discussion from March meeting around this: - Ongoing contact after a 988 call or in-person response – what does that look like? How are we keeping folks accountable? - Stabilization may be the weaker point of the system at this point. These services don't exist really in the state. The centers can be so key to give someone space to stabilize and support for those could be really helpful. - Some counties don't have 24/7 response, not even 1 person response. What are the consequences of not being able to meet the staffing requirement for this? Jenn sits on the advisory council for 988 (BHCSAC) and could serve as a liaison between the two groups. Rachel shared about a presentation from Brian Pitkin her advisory council received earlier today. One piece of his presentation is that there is not consistent funding for where people can go after a crisis and is often why people get stuck in the ED. - Crisis Receiving and Stabilization Centers - Goal: To provide a safe and secure environment that is staffed with clinical practitioners to (1) stabilize an individual (2) interrupt the jail/hospital pipeline (3) help those in crisis quickly return to their community - CRCs are less than 24-hour outpatient facilities: Accepts all age-appropriate referrals; Primarily utilizes recliners - CSCs are 24-hour to 14-day inpatient facilities: Accepts all referrals from a

			CRC; Facility with beds - Statewide crisis receiving and stabilization centers are currently in the planning phase - There is currently no statewide funding stream Liz asked about who our legislative champions are. Action Step: Jenn will do some research on this and see who we could reach out to build relationships with around this work. Craig said that ongoing marketing and advertising for 988 would be important to also follow as it seems that many aren't aware of the resource at this time. Kristine can bring us a presentation around the veteran side of 988 so we can learn more about the process. Action Step: Kristine will reach out to someone on her team to present during our June committee meeting. 988 Committee decision: Jenn will serve as a liaison between this committee and the 988 advisory council. If something comes up that this committee wants to do more work on, we can do so then.
	Committee discussion to determine what the Committee's role is when receiving a monitoring update	How do we want to respond to updates? What about OHA written reports? (D&E example)	Liz is interested in seeing reports and potentially providing a response to OHA. This would be available to other committee members as well and will be discussed during meetings. The Joint Commission released a national report on hospital practices relating to safer suicide care and the numbers were not great. Data from the report:

			‘only 61% of hospitals nationwide conduct formal safety planning; 37% provide warm handoffs to outpatient care; 30% follow-up with patients after discharge; 28% provide lethal means safety planning.’
2:30	**Round Table / Announcements / Adjourn**		Next meeting: 1. What is our committee scope of work? Look at current responsibilities and finalize our role / scope / committee description. Ongoing topics we are interested in: 1. Look at how we can have a voice around Medicaid billing codes 2. Bring in items around our structure for our committee

Where We Are Now

Implementation of 3090/3091 **has faltered** due to:

- limited oversight,
- siloed work,
- inadequate communication, and
- a lack of accountability.

Where We Are Now

Effective implementation would **benefit** from:

- a collaboration of the interconnected group of stakeholders,
- a convening authority,
- designated communication channels, and
- clarity of roles.

Where We Are Now

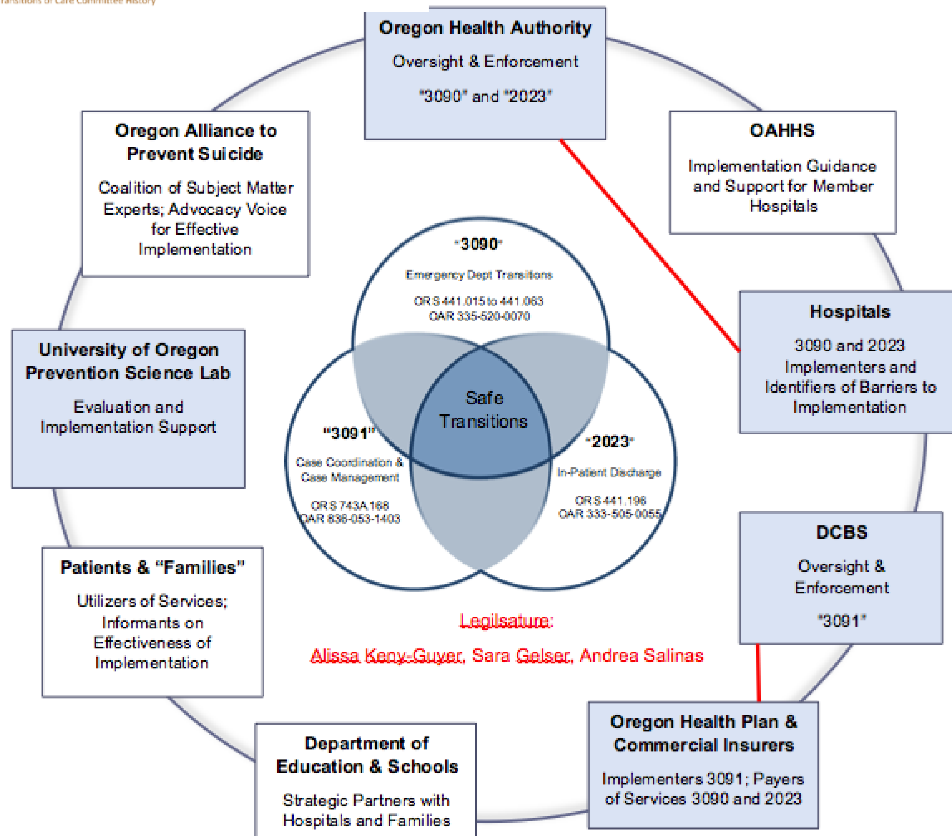
The Transitions of Care Committee identified nine stakeholder entities that fill vital roles in effective implementation of rules

- OHA,
- OAHHS,
- individual hospitals,
- patients and families,
- DCBS,
- public and private insurance,
- schools,
- the UO Suicide Prevention Lab, and
- the Oregon Alliance to Prevent Suicide (specifically the Transitions of Care Committee).

Where We Are Now

Partners in the work:

"The Oregon Alliance to Prevent Suicide and the Suicide Prevention Lab within the College of Education at the University of Oregon remain ready to collaborate with OHA to ensure these laws are fully adopted and established in practice by all stakeholders in Oregon to which the laws apply."



Standing questions from group (revisit these as topics arise):

1. Does anyone know off hand how much hospitals are reimbursed for post-discharge caring contact work?
    a. Are they reimbursed? based on early conversations with my hospital months ago I hadn't thought there was an expectation for reimbursement.
        i. HB 3091 was created because hospitals said they weren't covered for those services. 3091 stated that case management and care coordination to be covered by both commercial health insurance plans and Oregon Health Plan (OHP).
2. Is there a way to know if the amount of reimbursement requests are consistent with the number of behavioral health crisis admissions/discharges? (Claims data?)
3. Should we include insurance providers to the list of groups to engage around billing codes? Hospitals make sense as the first entities to make sure they have access to them, just want to make sure that insurance providers are also aware since so many rely on them and it seems like small changes can sometimes interfere with costs they can cover.