Alliance
Transitions of Care Committee Meeting
Second Thursdays 1:00pm – 2:30pm
Thursday, March 14, 2024

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 Liz Schwarz, Craig Leets, Erin Porter, Jill Baker, Mary Massey, Meghan Crane, Rachel Ford, Rachel Howard, Tanya Pritt

Absent Today: Co-Chair Charlette Lumby

Alliance Staff Present: Annette Marcus, Jenn Fraga

Alliance Staff Absent: N/A

Guest(s): Aaron Townsend, Beth Holliman, Brian Pitkin, Dean Carson, Gordon Clay, Rose Thompson, Sarah Adelhart

Time	Agenda Item	What / Update Action Item(s)	Notes
1:00	**Welcome** Agenda Review	*Introduce new members.* Group Agreements	Attendees introduced themselves at the beginning of the meeting.
	Announcements		No announcements.
	988 Presentation		OHA's 988 team provided a presentation on the 988 and MRSS models. This training was recorded and can be found here and the slides from the PowerPoint are included in the meeting materials.
	988 Presentation Q&A		Q: Is the suicide screening required both at time of call to 988 and when crisis team goes out on a response and is there an agreed upon protocol or does each one choose their own screen? A: OARs state that there has to be a screening for every person when someone goes out to meet a family in the community. As we know, someone may not have thoughts of suicide during the call but may when there is an in-person response. When there is a 72-hour follow-up, another screening is done as well as a safety plan. If a screening is unable to be completed, it has to be well documented why it can't be done. OHA has incentivized YouthSAVE for mobile crisis workers and CMHPs to train staff in that model. Q: How is the caring contact/follow up call offered? Tracked for accountability for 988? A: There is follow-up across the lifespan when someone calls into 988. P&P that were part of the national crisis line prior to 988 still exist and are part of this program. Mobile response is also required to do follow-up within 72-hours. Rose will look into more details and send us the rest of this

			information. Q: When to use 911 vs. 988? A: At a high level, 988 is only 2-years old and many of our counties have had mobile crisis teams since 2018. As we work on messaging and marketing, it's important to understand that as a descendant of the Suicide Lifeline, 988 is there for emotional support. The narrative that 988 is the mental health of 911 is not completely accurate. 98% of the time, 988 calls are fully handled over the phone whereas most of 911 calls are handled with some kind of first responder responding in person. Imminent risk cases will be connected with emergency services. The connection with mobile crisis to be a quick response and the same from community-to-community will take more time to run smoothly. Q: Are the mobile crisis services reliably being offered around the state? What about the 8 weeks of stabilization services for youth? A: This is still being built across the state. OHA is currently asking CMHPs what services they will have available and when they will be available. Most counties look like they will have stabilization services available in the next month or two. The Portland Metro area is already doing this. The biggest barrier for counties is around workforce concerns. OHA team has completed review for mobile crisis. They heard back from every county – 24 were able to have 2-person, 24/7 coverage and the remaining ones are having a hard time with overnight coverage and staffing. In some rural and smaller counties the need for overnight coverage isn't as needed there so they are working with OHA

			around what the staffing needs. Q: How have other states funded their crisis stabilization services? What kind of policy advocacy would be needed to get these in place in Oregon? A: Oregon was accepted into a 10-state policy academy to talk with others around what works well, what have they been doing, what can Oregon model after, and what are the best practices that can be brought to Oregon. Q: Is there a back-up service for 988 text in Oregon to handle over-flow? A: Yes, all texts (and calls) not answered by Oregon's 988 centers get answered by another 988 Lifeline center - also known as a "backup" center. For example, Crisis Text Line is one of the national 988 text staffers. Q: If 988 transfers to a local crisis line, is it a warm hand-off waiting for the direct hand off versus just switching the person off to wait on the line alone? A: It is supposed to be a warm handoff and, also it is known that this experience did not happen well. Q: Does 988 have to occur to get the other services available, like stabilization services? A: Either a call to 988 or the county crisis line is what starts the mobilization response. The only difference is for youth when emergency rooms could be a starting point for them to receive stabilization services. Q: Interest in what has gone well in working between 988 and the CMHPs? What areas still need to be improved? A: Relationships between 988 and crisis centers are longer relationships who have

			worked together for a while. A few structures in place that help with collaboration that have helped with 1:1 connections. Memorandums of Understanding (MOUs) are being worked on between agencies to help with services being provided. They ask for feedback to be shared to identify system gaps. Q: Provider safety – we already have a provider shortage. Is there a screening to make sure providers aren't being sent into dangerous situations like domestic violence? A: All 988 calls are expected to have a suicide assessment at some point in the call. In the case where it looks like dispatch is needed, then 988 centers gather information about the situation – is this a private residence, are there any weapons present, and other detailed situational information gathered.
	Committee Discussion about Presentation		- 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? Next steps: Identify plan for how this Committee wants to add this into our work.

2:30	**Round Table / Announcements / Adjourn**		Look at how we can have a voice around Medicaid billing codes 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

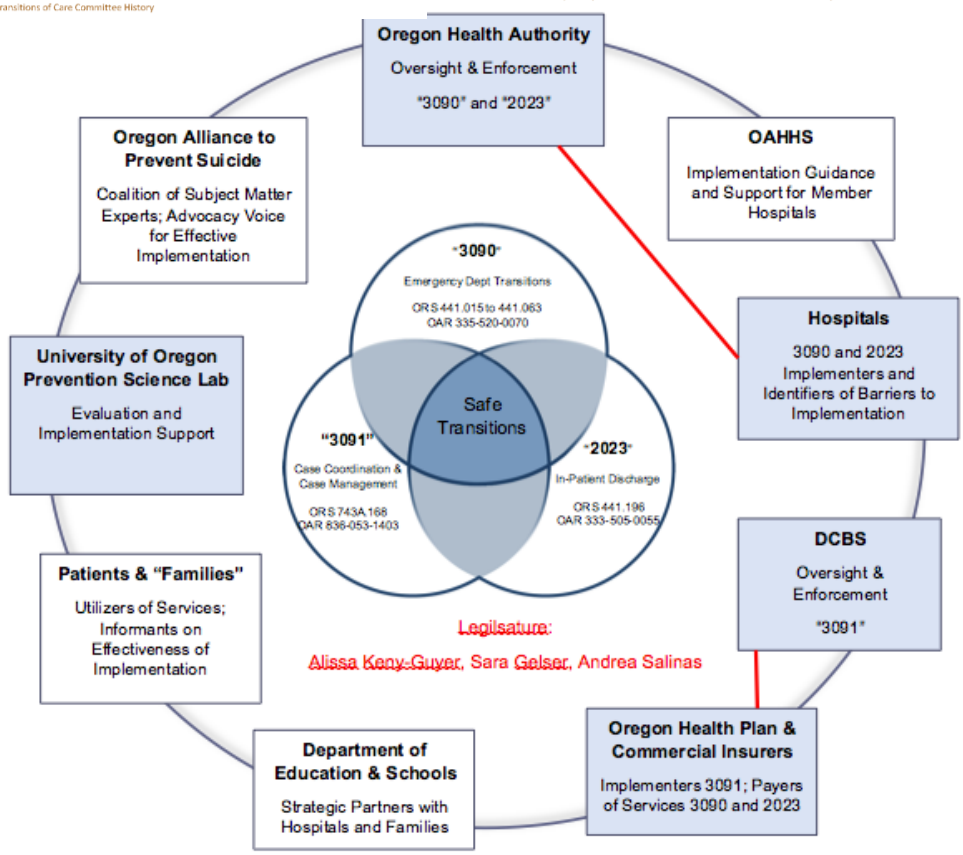
The Transitions of Care Committee identified nine stakeholder entities that fill vital roles in effective implementation of rules

- 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.