

# PrimaryHealth of Josephine County



## INTRODUCTION

Primary Health serves over 10,000 members in Josephine County, and its contiguous zip codes in Jackson and Douglas counties. Josephine County is the 12th largest county in Oregon and has a total population of 83,000, and only two incorporated cities: Grants Pass and Cave Junction. Josephine County residents live in predominately rural areas, and have historically been employed in the timber industry, though this focus has shifted towards service and health industries. Residents live below statewide income averages, have lower educational attainment than state averages and are more likely to be elderly.

## COMMITTEE MEMBERS

Kurt Higuera, chair, Siskiyou Community Health Center;  
Larry Gershowitz, co-chair, consumer; Sandi Larsen, consumer;  
Jolene DeLilys, consumer; Cynthia Rich, consumer; Diane Hoover,  
Josephine County Public Health; Kelly Wessels, UCAN

## CHP PROCESS

PrimaryHealth partnered with two other CCOs in the region: AllCare and Jackson Care Connect to complete a Community Health Assessment for the two County region (Jackson and Josephine) due to the overlap in services, members, and health systems.

PrimaryHealth's Community Advisory Council (CAC) participated and advised the work of the Health Assessment and of the CHP through support for Focus Groups, review of data and topics of interest and as members for the three CCO steering committee.

The CHP process involved continued alignment with the other two CCOs in terms of the larger strategy areas: Healthy Beginnings, Health Living and Health Equity. After this alignment work, for community continuity, PrimaryHealth's staff and CAC members identified key areas of focus that align with the CCOs mission, strategies and community and member needs. These strategies that are specific to PrimaryHealth's work are outlined in this poster.

## Community Health Improvement Plan HEALTH PRIORITIES:

1. Prenatal
2. Early Childhood Investment
3. Childhood Trauma
4. Homelessness Among Youth
5. Provider Recruitment and Retention
6. Health Literacy
7. Navigators
8. Chronic Pain
9. Physical Activity
10. Alcohol, Tobacco and Other Drug Prevention

## Examples of strategies selected to address the identified health priorities in the CHP:

### HEALTHY BEGINNINGS: *Early Investment Strategy*

Ensuring that children and youth are healthy, safe and ready to learn requires investment in prevention and attention to interventions that help the most at-risk children. Nurturing children before they enter school and supporting families as the first teachers of their children is correlated with higher learning outcomes and better health outcomes long term.

#### EXPECTED OUTCOME:

- Promotion and support for Love & Logic parenting classes for PHJC and community members through the YMCA.
- PrimaryHealth will partner with YMCA to fund Love and Logic classes in early 2015.
- Delivery of over 700 books to kids throughout the community to promote early literacy.

### HEALTHY LIVING: *Alcohol, Tobacco and Other Drug Prevention Strategy*

The 2013 Community Health Assessment highlighted that drug and alcohol use is not a problem exclusively in adults. Eighth and eleventh grade students in Josephine County reported higher than state averages in binge drinking and use of cigarettes, alcohol, marijuana and illicit drugs.

#### EXPECTED OUTCOME:

- Education and support for high school youth in two local schools to be provided by CHOICES counseling center.
- Participated in Recovery Fair with CHOICES Counseling Center.
- Provided healthy snacks, books, and OHP renewal information to members of the community.



### HEALTH EQUITY: *Navigators Strategy*

PrimaryHealth has supported Community Health Workers (CHWs) for the last year through a limited funding source. The CHWs, work with clients with high costs and other barriers to accessing care.

#### EXPECTED OUTCOME:

- CHW also have coordinated several successful detox plans and helped support individuals during treatment and during transitions in care.

# Behavioral Health, Alcohol & Drug Counselor Integration into Primary Care

PROJECT TEAM: PrimaryHealth of Josephine County, Grants Pass Clinic, Options for Southern Oregon, Choices Counseling Center LEAD STAFF: Jennifer Johnstun, RN

## BACKGROUND

- Community providers were not satisfied with the percent of patients that followed up with behavioral health or alcohol and drug counseling following a PCP referral.
- A baseline measurement in Q1 2013 showed that only 45% of individuals referred to mental health followed through with an assessment at Options.
- Treatment engagement numbers at Choices was also low compared to the referral volume.

*Community Health Workers have played a huge role in engaging members to seek BH and A&D treatment. CHW also have coordinated several successful detox plans and helped support individuals during treatment and during transitions in care.*

## PROJECT GOALS

A full-time Options behavioral health therapist and a full-time Choices CADC were co-located at the Grants Pass Clinic in October 2013.

### The primary objectives of the project are to:

- Coordinate resources in order to increase the percentage of individuals who receive a BH or A&D assessment following a referral from a PCP.
- Improve communication and coordination between the PCP and BH therapist/A&D counselor.
- Increase referral volume to BH and A&D
- Increase/improve mental health and A&D screening practices within the clinic

Other roles were added simultaneously to aid treatment engagement and contribute towards other goals.

- Medical Home assistants help ensure that screening activities (PHQ-2, SBIRT) are carried out and documented appropriately.
- Community Health Workers help members with complex needs through support carried out in the home/community environment. CHWs also assist with coordination of care and barrier reduction.

## IMPLEMENTATION

**Review the Current Referral Process** in order to make modifications that create a more positive member and provider experience.

- Make access easier, improve communication and co-locate services.

### Refine Critical Workflows

- Clarify roles, create a process for a “warm-handoff,” clarify the referral process.

### Share Information

- Clarify HIPAA and information sharing, exchange information needed to coordinate care.

### Coordinate System-Wide Care

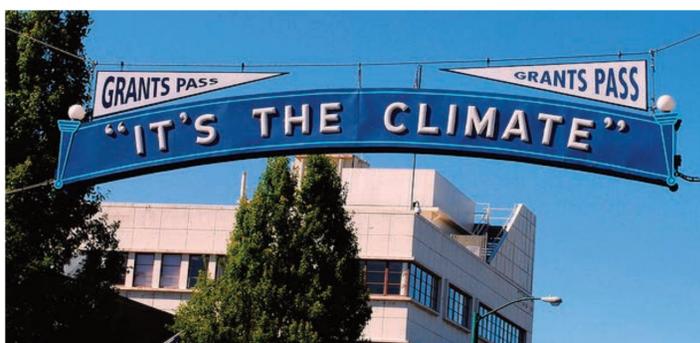
- Coordinate care between agencies and individuals, create protocols for sharing vital information.

### Identify Appropriate Individuals for Referral

- Improve screening practices, provide education and support for staff, reduce barriers to engagement.

### Review Billing and Encounter Procedures

- Review billing considerations, create common understanding of OHP billing/encounter requirements, understand components that may have an effect on sustainability.



*“A new OHP patient came in, concerned about liver functions. He admitted to regular alcohol intake. I suggested he might want to talk with our in-house Choices counselor, but he declined. At his next appointment he was still concerned, and he allowed me to refer him to Choices. At his next appointment he announced he was 8 days without alcohol, and had already seen the Choices counselor twice. I doubt he would have made it to Choices if the in-house counseling was not available.” – A. Luther*



*Treatment numbers have doubled at Choices Counseling Center from 2013 to 2014. 29% of those referred for an assessment have engaged in some level of ongoing treatment at Choices. Some clients are seen individually at the PCP clinic and state they would not have accepted services outside of the primary care environment.*

## PROJECT MEASURES

- % of individuals that receive a BH Assessment following a referral to BH (Goal is 60%)
- Number of referrals to BH and A&D (Target is a 15% increase)
- Track the % of referrals that were warm handoffs (A&D) currently 56%
- Increase % of annual visits

*“Every day I encounter patients who are struggling with their mental health. While this is not unique in primary care, what is unique is being able to tell my patients, We can help you. There are counselors right here in the clinic who can see you right now if you would like.” – E. Moore, PA*

## NEXT STEPS

- Continue to evaluate outcome and process measures, collect provider and member feedback and refine project based on information collected.
- Proceed through the action steps identified in the project charter.