Behavioral Health: Increase Access and Coordination
Regional Health Improvement Plan Workgroup

Join Zoom Meeting
https://zoom.us/j/200458328

Join by phone:
+1 669 900 6833
Meeting ID: 200 458 328

August 19, 2020
1:00-2:30 pm

Aim/Goal
Increase equitable access to skilled and coordinated care between specialty behavioral health* and the larger health system, including primary care, while decreasing barriers to ensure an effective and timely response.
*Specialty behavioral health: behavioral health, substance abuse, and developmental services that are delivered outside of primary care.

Future State Metrics
1. Increase availability of behavioral health providers in marginalized areas of the region.
2. Increase timeliness and engagement when referred from primary care to specialty behavioral health.
3. Standardize screening processes for appropriate levels of follow-up care across services.

AGENDA
1:00-1:15 Welcome, Land Acknowledgement & Guiding Principles
1:15-2:25 Strategic Directions
2:25-2:30 Wrap Up and Next Steps
### Behavioral Health: Increase Access and Coordination
Regional Health Improvement Plan Workgroup

#### Future State Metrics – Full Detail

1. **By December 2023,** improve the availability of behavioral health providers in the marginalized areas of the region (La Pine, Madras, Redmond) to exceed the Oregon average for rural areas of 0.62 in 2019 as measured by ‘mental health providers per 1,000 population’

2. **By December 2023,** a method is developed to measure timeliness and engagement with specialty behavioral health referred from primary care.

3. **By December 2023,** a method is developed to standardize screening processes to assure clients receive the appropriate level of care and follow-up across various services in Central Oregon.
Shared Focus
We come together to improve the health and well-being of individuals living in various and diverse communities throughout Central Oregon region. We use the Regional Health Improvement Plan (RHIP) as our guide. It is our region’s shared vision of current problems and our aims. As workgroup partners we develop agreed-upon actions to solve the issues and keep the needs of our communities as the main focus.

Shared Metrics
We measure progress, process and outcomes through a shared lens. We use the Regional Health Assessment (RHA), Regional Health Improvement Plan and community dashboard.

Involve Targeted Population
The individuals living in our diverse Central Oregon communities are the center of our work. We make every effort to include people from every part of the region in our workgroups, discussions, processes and decisions.

Collaborate to Solve Complex Issues
Inviting diverse perspectives from throughout the Central Oregon region deepens our shared understanding of complex issues and propels us toward better progress and outcomes. We practice frequent, structured, open communication to build trust, assure shared objectives, and create common motivation. We respect the privacy and sensitivity of information partners share.

Coordinate Collective Efforts
We are made up of diverse partner organizations and individuals with unique strengths, skills, and resources. We coordinate our efforts and use our unique strengths and skills to meet the goals of the RHIP.

Learn and Adapt Together
We embrace shared learning and a growth mindset. We create a space that allows for mistakes, failures, second changes, and a celebration of brave attempts. We adjust and apply our learnings to the complex and changing landscape of health and well-being in Central Oregon.
# Behavioral Health: Increase Access and Coordination

## Background: Why are we talking about this?

| 1990s | Mill Closures / Timber Industry Decline  
State Hospitals Deinstitutionalized  
US Wars impact on Veterans | Mental health affects how we think, feel and act. It determines how we handle stress, relate to others, and make choices. Mental health challenges can increase the risk of physical health problems such as stroke and heart disease. Individuals benefit significantly from intensive coordination of care and outreach activities, which are less available in remote areas of Central Oregon. |
| --- | --- |
| 2000s | Population Growth in Central Oregon  
Housing shortage  
Rising suicide rates  
Tech Advancement & Screen Time |

## Current Condition: What’s happening right now?

- Approximately 1 in 4 adults over 55 in Central Oregon reported a diagnosis of depression
- Percentage of students who reported feeling sad or hopeless has been generally trending upward
- 64% of individuals who died by suicide visited their primary care provider within one year prior to their death

### Current State Metrics:

1. Availability of behavioral health providers is less in the rural areas of the region
2. No way to measure timeliness and engagement with specialty behavioral health when referred by primary care
3. No standardize screening processes for appropriate levels of follow-up care across services

## Goal Statement: Where do we want to be in 4 years?

**Aim/Goal**

Increase equitable access to skilled and coordinated care between specialty behavioral health and the larger health system, including primary care, while decreasing barriers to ensure an effective and timely response.

**Future State Metrics - By December 2023:**

1. Increase availability of behavioral health providers in marginalized areas of the region.
2. Increase timeliness and engagement when referred from primary care to specialty behavioral health.
3. Standardize screening processes for appropriate levels of follow-up care across services.

## Analysis: What’s keeping us from getting there?

- Care is culturally inappropriate and unresponsive
- Behavioral Health Careers are undervalued, underappreciated and not at parity with medical health
- Siloed communication and coordination across systems and agencies
- Behavioral Health Conditions are viewed as a character weakness
- Systemic undervaluing & underfunding of Behavioral Health
- Disjointed systems do not address whole person care

## Strategic Direction: What are we going to try?

{insert}

## Focused Implementation: What are our specific actions? (who, what, when, where?)

{insert}

## Follow-Up: What’s working? What have we learned?

{insert}
## Behavioral Health Access and Coordination

### Root Cause Barriers: What is blocking us from moving toward our future state measures?

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<thead>
<tr>
<th>Root Cause Barriers</th>
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<tbody>
<tr>
<td>Care is culturally inappropriate and unresponsive</td>
<td>Siloed communication and coordination across systems and agencies</td>
<td>Systemic undervaluing &amp; underfunding Behavioral Health</td>
<td>BH careers are undervalued, under-appreciated and not at parity with medical health</td>
<td>BH conditions are viewed as a character weakness</td>
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<td>Cultural barrier of trust with minority groups (Persons of Color, veterans, etc)</td>
<td>Systems &amp; policy do not support care coordination</td>
<td>Funding lessons from COVID (billing codes, purchase of phones/tablets)</td>
<td>Limited pathways to BH careers in region (recruitment of HS, minority &amp; Bilingual)</td>
<td>Culture of individualism (pull yourself up by your bootstraps)</td>
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<td>Insufficient knowledge of dyadic therapies for children/families</td>
<td>Needs assessments differ between groups</td>
<td>High cost of living/insufficient reimbursement rates</td>
<td>Education &amp; training for providers from marginalized groups</td>
<td>Stigma: neuroscience vs. Flawed character</td>
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<tr>
<td>Insufficient knowledge of dyadic therapies for children/families</td>
<td>Organizations are siloed/don't communicate</td>
<td>Prioritization of screening tools which are reimbursed</td>
<td>Career trajectory out of agency work leaving a “brain drain”</td>
<td>Insurance limitations for undocumented &amp; incarcerated people</td>
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<td>Screening processes are not humanistic</td>
<td>Behavioral health operates in silos</td>
<td>Insurance reimbursement policies</td>
<td>Incentives for rural providers, practice &amp; communication</td>
<td>Unaffordable and inaccessible technology</td>
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<td>Dysfunctional Provider Directories</td>
<td>Need for more residential beds</td>
<td>Remote location work not incentivized</td>
<td>Wages don't match cost of living</td>
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<td>HIPAA/Privacy Myths</td>
<td>Services are not political priority</td>
<td>Need for bilingual BH specialists</td>
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<td>Mental Health dollars cannot cross county lines</td>
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<td>Funding Payor Issues</td>
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Desigmitize MH for all

Partner with NAMI of CO (National Alliance of Mental Illness) to host an event to desigmitize mental illness

Host a zoom presentation on a topic that would cover desigmitization

Utilize high level speakers strategically to dispel the myth that MH is a character weakness

Desigmitize by putting on a program for junior high and high school students. Partner with Younity.

Provide monthly rotational community events to desigmitize mental health

Incentivize hiring for specific needs

Incentivize providers to work in rural areas

Pursue incentivizing local psychiatric nursing jobs with COCC, OHSU, Linfield

Pursue OHSU psychiatric resident rotation for child psychiatrists

Pay to Stay programs through PacificSource to support providers working in rural and underserved communities

More hiring incentives and research around our veterans.

Sources

Christina's group

Nick's group

Catalina's group

Lindsey B's group

Katie P's group

2020 Health Equity Report

Additional Ideas (Kristin, Susanne, Christina)

Increase cultural responsiveness of service delivery

Cultural needs assessment for behavioral health

Project where seasoned providers attempt to reach specific populations based upon culture, diagnosis, etc and provide culturally based treatment

Behavioral Health Screening at intake in the individual's primary language

Use CLAS Standards

Have experience engaging with Latinx parents, supporting them in accessing behavioral health services

Provides same sex interpreter and/or traditional health workers for women patients

Communicate in a more meaningful, basic and understandable way