**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

September 16, 2020
1:00-2:30pm

| 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.<br>*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.<br>2. Increase timeliness and engagement when referred from primary care to specialty behavioral health.<br>3. Standardize screening processes for appropriate levels of follow-up care across services. |

## AGENDA

| | |
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| 1:00-1:15 | Welcome, Land Acknowledgement & Guiding Principles |
| 1:15-2:25 | Strategic Directions |
| 2:25-2:30 | Wrap Up and Next Steps |

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| Future State Metrics – Full Detail |
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| 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<br><br>2. By December 2023, a method is developed to measure timeliness and engagement with specialty behavioral health referred from primary care.<br><br>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. |

# Regional Health Improvement Plan (RHIP) Workgroup

## Guiding Principles

**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

| *Date updated:* | *Workgroup:* | *Version:* |
|---|---|---|

## Background: Why are we talking about this?

**1990s** Mill Closures / Timber Industry Decline
State Hospitals Deinstitutionalized
US Wars impact on Veterans
**2000s** Population Growth in Central Oregon
Housing shortage
Rising suicide rates
Tech Advancement & Screen Time

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.

## 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}

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

# Behavioral Health: Increase Access and Coordination

## Strategic Direction:
## How do these clusters relate to each other?  Which ones have similar intent?

Promote comprehensive staffing retention models

- Incentivize providers to work in ruralareas
- Pursue incentivizing localpsychiatric nursing jobs with COCC, OHSU, Linfield
- Pay to Stay programs through PacificSource tosupport providers working in rural and underserved communities
- More hiring incentives and research around our veterans.

expand, train and support the workforce

- Pursue OHSUpsychiatric resident rotation for child psychiatrists
- Earlyrecruitment of a diverse workforce - starting in elementary and middleschools
- Developrelationship between the health council and local schools with mentalhealth programs like OSU/PSU
- Having Mental Health be developed asa career path in large and small communities, by educating high schoolstudents about career
- Develop shadowing program of BH careers for high schoolers
- increase people of color in the workforce; what opportunities to partner with COCO, OSU, OHSU

develop and pay Traditional Health Worker

- Develop a"Promotora program" within the different community groups
- train people from local neighborhoods into THW, CHW jobs in those communities. Churches as source of contact
- Develop and highlight BH opportunities for peer delivered services
- pilot project for employing and reimbursing THW and Peer support specialists

These are about workforce

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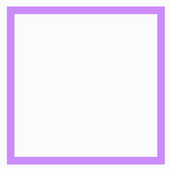

Increase coordination and access

- Build centralized streamlined referralhub or team
- Host monthlyprovider meetings
- develop closed loop referral processes
- Connect CHW with latinx community to better connect care to communities
- not just about access but about quality of services received; could be measured, e.g. completion of treatment
- develop method to measure timliness and engagement with specialty BH
- Offer transportation to and from Central OregonCommunities

increase cultural responsiveness of service delivery

- Build community coalition capacity to address health inequities related to substanceuse and mental health
- Cultural needs assessmentfor behavioral health
- Project where seasoned providers attempt to reach specificpopulations based upon culture, diagnosis, etc and provide culturallybased treatment
- Behavioral HealthScreening at intake in the individual's primary language
- use Culturally and Linguistically Appropriate Services Standards
- have experience engaging with Latinx parents, supporting them in accessing behavioral health services
- Providesame sex interpreter and/or traditional health workers for womenpatients
- communicate in a more meaningful, basic and understandable way

These are about improving service delivery

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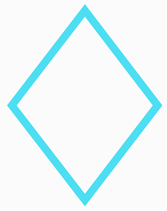

Promote MH for All across the life span

- Identify and implement strategies to work collaboratively withorganizations whose activities advance health equity and promote Health in All Policies
- partner with NAMI of C O (National Alliance of Mental Illness) to host an event to destigmatize mental illness
- host a zoom presentation on a topic that would cover destigmatization
- desigmatize by putting on a program for junior high and high school students. Partner with Younity.
- Provide monthly rotational community events to destigmatizemental health
- Utilize high level speakers strategically to dispel the myth that MH is a character weakness

These are about care across all ages

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advocate for better funding

- Lobby at the state level for funding forproviders
- create value based contracting that has metrics tied to access, engagement and outcomes
- Pay for insurance advocate to advocate for higherreimbursement for BH services
- advocate to have (BIPOC) traditional approaches reimbursed
- value based contracting

These are about funding

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