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

Join Zoom Meeting
https://us02web.zoom.us/j/200458328?pwd=SmF5aDk4L1VrcTZPUU1WYVdlZE1lZz09

Join by phone:
+1 669 900 6833
Meeting ID: 200 458 328
Passcode: 228307

February 17, 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.

*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

1:00-1:10 Welcome, Land Acknowledgement & Guiding Principles, Introductions

1:10-1:20 PM Workgroup Investment Budget

1:20-2:20 PM Implementation Plan Development
• Small Group Work

2:20-2:30 PM Wrap Up and Next Steps

Working Document: https://docs.google.com/presentation/d/1O8HdpfQPrfK-9T8K0tKUycX3kd_abi3FtoS4Utva0cM/edit?usp=sharing
### 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.
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.
Land Acknowledgement

We recognize and acknowledge the indigenous land of which we live, work, learn, play, and grow. This land of the Mololla, Paiute, Klamath, Modok, Yahooskin Band of Snake Indians, Confederated Tribes of Middle Oregon, and Confederated Tribes of Warm Springs. We acknowledge them as the past, present, and future caretakers of this land. It is on their traditional land where we partner to improve the health and well-being of Central Oregonians. We aspire to be good guests honoring the concept in the Warm Springs culture: “This land is for you to know and live upon and pass on to the children.”
Behavioral Health: Increase Access and Coordination

Background: Why are we talking about this?

<table>
<thead>
<tr>
<th>1990s</th>
<th>2000s</th>
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<tbody>
<tr>
<td>Mill Closures / Timber Industry Decline</td>
<td>Population Growth in Central Oregon</td>
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<tr>
<td>State Hospitals Deinstitutionalized</td>
<td>Housing shortage</td>
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<tr>
<td>US Wars impact on Veterans</td>
<td>Rising suicide rates</td>
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<tr>
<td>Tech Advancement &amp; Screen Time</td>
<td>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.</td>
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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?

- Strengthening and Expanding the Behavioral Health Workforce
- Improving Coordination and Access to Culturally Responsive Behavioral Health Care
- Normalizing and Destigmatizing Mental Health Across the Lifespan
- Advocating and Lobbying for Behavioral Health Funding at Parity with Physical Health

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?

<table>
<thead>
<tr>
<th></th>
<th>Care is culturally inappropriate and unresponsive</th>
<th>Siloed communication and coordination across systems and agencies</th>
<th>Systemic undervaluing &amp; underfunding Behavioral Health</th>
<th>BH careers are undervalued, under-appreciated and not at parity with medical health</th>
<th>BH conditions are viewed as a character weakness</th>
<th>Disjointed systems do not address whole person care</th>
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</thead>
<tbody>
<tr>
<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>
<td>Basic needs (housing, transportation, communication) trump behavioral needs</td>
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<tr>
<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>
<td>Insurance limitations for undocumented &amp; incarcerated people</td>
<td></td>
</tr>
<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></td>
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</tr>
<tr>
<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></td>
<td></td>
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<tr>
<td>Dysfunctional Provider Directories</td>
<td>Need for more residential beds</td>
<td>Remote location work not incentivized</td>
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<tr>
<td>HIPAA/Privacy Myths</td>
<td>Services are not political priority</td>
<td>Wages don't match cost of living</td>
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<tr>
<td>Mental Health dollars cannot cross county lines</td>
<td>Need for bilingual BH specialists</td>
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<td>Funding Payor Issues</td>
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**STRATEGIC DIRECTIONS: What Moves Us Toward Our 2023 Practical Visions**

<table>
<thead>
<tr>
<th>Promote Comprehensive Staffing Retention Models</th>
<th>Expand, Train, and Support the Workforce</th>
<th>Develop and Pay Traditional Health Workers</th>
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<tbody>
<tr>
<td>• Incentivize providers to work in rural areas</td>
<td>• Pursue OHSU psychiatric resident rotation for child psychiatrists</td>
<td>• Develop a “Promotora program” within the different community groups</td>
</tr>
<tr>
<td>• Pursue incentivizing local psychiatric nursing jobs with COCC, OHSU, Linfield</td>
<td>• Having Mental Health be developed as a career path in large and small communities, by educating high school students about career</td>
<td>• Train people from local neighborhoods into THW, CHW jobs in those communities. Churches as a source of contact</td>
</tr>
<tr>
<td>• Pay to Stay programs through PacificSource to support providers working in rural and underserved communities</td>
<td>• Early recruitment of a diverse workforce – start in elementary and middle schools</td>
<td>• Develop and highlight BH opportunities for peer delivered services</td>
</tr>
<tr>
<td>• More hiring incentives and research around our veterans.</td>
<td>• Develop shadowing program of BH careers for high schoolers</td>
<td>• Pilot project for employing and reimbursing THW and Peer Support Specialists</td>
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<td></td>
<td>• Develop relationships between the health council and local schools with mental health programs like OSU/PSU</td>
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<tr>
<td></td>
<td>• Increase people of color in the workforce; what opportunities to partner with COCC, OSU, OHSU</td>
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**Increase Coordination and Access**

- Connect CHW with Latinx community to better connect care to communities
- Build centralized streamlined referral hub or team
- Not just about access but about quality of services received; could be measured, e.g. completion of treatment
- Host monthly provider meetings
- Develop method to measure timeliness and engagement with specialty behavioral health
- Develop closed loop referral processes
- Offer transportation to and from Central Oregon Communities

**Increase Cultural Responsiveness of Service Delivery**

- Build community coalition capacity to address health inequities related to substance use and mental health
- Use Culturally and Linguistically Appropriate Services (CLAS) Standards
- Cultural needs assessment for BH
- Have experience engaging with Latinx parents, supporting them in accessing behavioral health services
- Project where seasoned providers attempt to reach specific populations based upon culture, diagnosis, etc. and provide culturally-based treatment
- Provide same sex interpreter and/or traditional health workers for women patients
- Behavioral Health screening at intake in the individuals’ primary language
- Communicate in a more meaningful, basic, and understandable way.

**Strengthening & Expanding the Behavioral Health Workforce**

**Improving Coordination and Access to Culturally Responsive Behavioral Health Care**
Identify and implement strategies to work collaboratively with organizations whose activities advance health equity and promote Health in All Policies.

- Destigmatize by putting on a program for junior high and high school students. Partner with Younity.
- Partner with NAMI of Central Oregon (National Alliance of Mental Illness) to host an event to destigmatize mental illness.
- Provide monthly rotational community events to destigmatize mental health.
- Host a Zoom presentation on a topic that would cover destigmatization.
- Utilize high level speakers strategically to dispel the myth that mental health is a character weakness.

Promote Mental Health for All across the lifespan

Advocate for Better Funding

- Pay for insurance advocate to advocate for higher reimbursement for Behavioral Health services.
- Lobby at the state level for funding for providers.
- Advocate to have (BIPOC) traditional approaches reimbursed.
- Create value based contracting that has metrics tied to access, engagement and outcomes.
- Value based contracting.

Normalizing and Destigmatizing Mental Health Across the Lifespan

Advocating and Lobbying for Behavioral Health Funding at Parity with Physical Health
Behavioral Health: Increase Access and Coordination
2020-2024 RHIP Workgroup Budget

Updated February 1, 2021

<table>
<thead>
<tr>
<th>Funds Available</th>
<th>$1,947,500</th>
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<tbody>
<tr>
<td>Initial Funds (spread over 5 years)</td>
<td>$2,000,000</td>
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<tr>
<td>Funds Spent</td>
<td>$52,500</td>
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## Amount Invested by Future State Measure

<table>
<thead>
<tr>
<th>Measure</th>
<th>Amount Invested</th>
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<tbody>
<tr>
<td>Improve availability of behavioral health providers in marginalized areas (La Pine, Madras, Redmond)</td>
<td>$27,500.00</td>
</tr>
<tr>
<td>Reduce mental health/substance abuse ED visits in Madras, Prineville, and Warm Springs</td>
<td>$0.00</td>
</tr>
<tr>
<td>Standardize screening processes for appropriate levels of follow-up care across services</td>
<td>$0.00</td>
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</tbody>
</table>

### Allocation of Funds by Measure

- Improve availability of behavioral health providers in marginalized areas (La Pine, Madras, Redmond)

### Allocation of All Funds ($2M)

- Improve availability of behavioral health providers in marginalized areas (La Pine, Madras, Redmond)
- Unallocated
- COVID-19 ($25k pooled funds)
For the 2021-2024 funding years, each workgroup's annual investment goal is a minimum of $500,000. The Central Oregon Health Council is required by law to invest a total of at least $2.5M each year through the workgroups. Each workgroup is expected to do their part in helping to reach this $2.5M annual commitment.
COVID-19 Final Report for NeighborImpact (Non-RHIP)
“PPE for Central Oregon Child Care”

Summary of Results:
- Upon receipt of COHC grant funds, NeighborImpact Child Care resources purchased PPE for Child Care Providers in Central Oregon to support new COVID guidelines and requirements set for by the Early Learning Division (ELD) and the Office of Child Care.
- The result of this grant was hard to access PPE and cleaning supplies were delivered directly to Child Care Providers throughout Central Oregon, in all three counties and Warm Springs, at no cost to providers.
- The outcome of this grant was Central Oregon's Child Care Workforce had access to cleaning supplies and PPE supplies necessary to keep their business doors open and operational during this pandemic.
- The benefit to this grant is that providers were able to access the PPE needed to keep staff and children safe.
- We were able to complete over 170 orders, but there continues to be a need.

Quotes:

"Delivering the PPE was a very positive experience and a great way to connect with providers we already serve and new providers to explain our program (Go Kids Advocates) and how we can support them during this uncertain time. All the providers during our phone calls to connect with them were very grateful and so appreciated that these supplies were not only offered to them but they were delivered to their doorstep. I cannot say enough how much all the providers were so elated to receive items that are so hard to come by but needed to stay in compliance with the CDC Guidelines." Diane Boswell Go Kids Advocate, CCR

“Getting the box of PPE and other COVID-related items was like an early Christmas for us! Right now, I dread going into the stores (and sometimes you can’t even find the items at all), so it was wonderful to be able to receive and use the things we got. We are so overwhelmed with everything right now; our jobs are so much more difficult during this time. The gloves and sanitizer and soap and paper plates and everything is so helpful, practically, and such a morale booster! It also helps financially as right now things are a little tight. Thank you so so much!” Susan Stendahl, Child Care Provider

*Order of projects is by final report submission date  Published February 2021
Summary of Results:

- The project was to provide resources to those experiencing homelessness in the Madras and Warm Springs area.
- This was to be achieved through developed partnerships with community members, governments, and outside organizations. The outreach and resources would be taken to known places where individuals were known to frequent.
- The trailer that was purchased would be stocked with items that were either purchased by Wild Rose Ranch, or through different donation drives with newly developed relationships across the tri-county region and The Confederated Tribes of Warm Springs.
- The partnerships developed were ones that did assist with items, services, and resources to get to those experiencing homelessness, however, one of the obstacles that emerged was sustainability of obtaining items, manpower, education, awareness, and unforeseen logistics.
- Although all items that were collected were made available one of the things that was immediately noticed was the needs are vast, constant, and change with the seasons.
- This brought challenges to the team to be able to always be alter to what those in the elements would be experiencing and how best to meet their needs.
- Those individuals who received items and services were appreciative of the positive and consistent interaction with all volunteers and partners.
- Many were more than grateful for receiving items, but what we all experienced was that many just appreciated the fact that people were there to listen to them.

Lesson Learned:

- The greatest challenge has been sustainability of resources to give to those experiencing homelessness.
- Many of those that were supportive in the beginning I feel had this idea that with those items collected and given out that there would be an "end" to that need, and the reality of how things actually were was difficult for many helpers. The other challenge was manpower for this project.
- When partnering with outside community members, organizations, and governments is that the priority of this project may have not been their priority.
COVID-19 Final Report for The SHIELD (Non-RHIP)
“Veterans' Counseling 2020 (VC2020)”

Summary of Results:

- The benefits of the project, eliminating barriers to mental health services & providing free counseling for local Veterans can be understood in the context of the 2019 report by OHA & ODVA entitled “Oregon Veterans’ Behavioral Health Services Improvement Study: Needs Assessment & Recommendations Report”.

- The report included the following findings:
  a) “The two main obstacles to Oregon Veterans achieving behavioral health and wellness are access & quality of care.”
  b) “Oregon currently does not have an adequate number of providers to support the behavioral health needs of the state’s Veterans.”
  c) “60% of Veterans identify finding or getting an appointment with a behavioral health care provider as a barrier to accessing care.”
  d) “Veterans with a PTSD diagnosis are 55% more likely that those with no mental health diagnosis to utilize emergency services, putting stress on a system that lacks capacity and training to support their specific needs” (particularly during COVID-19).

Quotes:

A client of THE SHIELD, a Veteran of four combat tours to Iraq & Afghanistan:

"It's ok to not be ok; it's also ok to be ok and to want to get better."

-“Logan”

Full written client testimonial: https://shieldcentraloregon.org/ranger%2Fcop%2Fvp

Client video: https://youtu.be/xJfQijWDveo

*Order of projects is by final report submission date  Published February 2021
RHIP Final Report for The Center Foundation
“OK4Life”
Reviewed and funded by the Promote Enhanced Physical Health workgroup

Summary of Results:

- OK4Life promotes increased physical activity for middle and high school-aged youth, through a visually appealing, youth-focused, activity program delivered via website and mobile device.
- The mini grant offered seed funding to enter the initial stages of the OK4Life project development.
- The goals for the funding included developing a project plan outline, securing collaboration with OSU-Cascades Co-Lab, and creating 8 weeks of activities-based content.
- Due to strong interest from the OSU-Cascades Kinesiology department on our project, we were asked to develop an internship job description for ongoing collaboration for content creation.
- The internship will allow for future research and development using Kinesiology students and overseen by the Foundation.
- The intended benefit of the project is to increase reported activity levels for youth.
- This benefit will only be realized after project completion and user adoption. While the mini grant helped complete phase 1 of project development, more funding will be needed to complete the project and realize its full potential.

Quote:

“To date, The Center Foundation programs have served high school aged youth in Deschutes, Jefferson, and Crook Counties. However, with a vision to improve health for all Central Oregon youth, OK4Life will endeavor to increase physical activity and health for all youth across Central Oregon.”
Sonja Donohue, Executive Director for The Center Foundation.

*Order of projects is by final report submission date
Published February 2021
COVID-19 Final Report for The Giving Plate (RHIP)
“The Giving Plate COVID-19 Food Relief”
Reviewed by the Address Poverty RHIP workgroup

Summary of Results:

- In 2020, we experienced a 23% increase in the number of families served in our food-box program, and we were able to increase the amount of food to those people by 39%.
- So, not only did we help more families, but we were also empowered to be more generous than ever.
- We count that as a major success during an uncertain time. In our Kid's Korner program, we gave over 13,000 bags of food to kids in our community - a 56% increase over 2019.
- As hard as 2020 was, we were able to keep our doors open every day and served our neighbors in need during the shutdown along with friends in need across our state during the fires.
- To read more about what was accomplished in 2020, go to www.thegivingplate.org/2020

Quotes:

“I am a single mother working 3 jobs and I need help with food boxes from time to time. With all 3 of my children at home, our bills have all gone up. This box helps me get through the month and I am grateful and thankful for all you do.”

“I started coming to The Giving Plate when the pandemic hit and my unemployment stimulus checks ended. I got a new job but had two weeks until I would get paid. You guys provided me, my 1 and 2-year-old with healthy food to keep us going.”

*Order of projects is by final report submission date

Published February 2021
Summary of Results:

- Jericho Table is an ongoing program to feed the poor and hungry and operates 25 days each month throughout the year.
- Due to the pandemic, the adjustments made to accommodate our guests were both effective and beneficial while realizing some critical disadvantages as well.
- The positive moves were the curb-side pick-up of food boxes which maintained an outdoor, open-air atmosphere as well as safe distancing as well as our providing masks and hand cleanser during the process.
- The protection of our volunteers and our guests were upmost and the serving from an elevated platform provided additional space and protection.
- The disadvantages were in the loss of a congregate eating experience that promoted open conversation, socialization and the development of relationships.
- Also lost was our regular support such as one-on-one interviews for housing assistance and Thrive and COVO support.

Quotes:

"There is no way that the community can look at what we are doing here and not feel the positive energy and the caring that comes from the food and supplies we provide and the gratitude expressed for our determination to continue. People pick up multiple boxes and take them back to their dwelling places to children, partners and others and thus eliminate the crowding and interaction so much discouraged at this time. It is hard on our volunteers and guests alike who are used to the conversation, interaction and laughter that can be generated by just talking and eating together".

Tia Linsheid, Jericho Table Coordinator
COVID-19 Final Report for Seed To Table Oregon (RHIP)
“COVID 19 Food for All”
Reviewed by the Address Poverty and Upstream Prevention RHIP workgroups

Summary of Results:

- Seed To Table (S2T) historically provided, annually, about 6,000 pounds of fresh produce, in 2020, due to increased demand, we diverted a total of 10,325 pounds of our locally grown fresh produce to food banks and our Fresh Food For All Program for no charge.
- During COVID, anyone who wished to receive reduced-price or free produce could fill out a form attesting to the fact that their income had been negatively impacted by the pandemic.
- Participants could fill out the level of discount they needed, ranging from 50%-100%.
- A total of 298 families benefited from access to fresh produce on a weekly basis at the two, Sisters Food Banks and at the Sisters Farmers Market through our Food For All Discount. 70% of these participants benefited on a regular base (2x a month)
- Conversations and surveys of 75% of participants collected determined:
  - 100% of participants stated S2T produce was essential for their vegetable consumption and for maintaining the wellness of their family
  - 100% of participants stated S2T produce increased their vegetable consumption by at least one serving a day
  - 87% of participants stated they would love more opportunities for fresh produce
  - 79% of participants felt the experience of picking up produce at the SFM, and interactions with the community (all be it distanced) made them feel an increased sense of belonging in the community.
  - 98% of participants stated the availability of produce helped increase their families’ financial and emotional resilience during these trying times.

*Order of projects is by final report submission date Published February 2021
Grant FollowUp

Internal process for historical grants (2016-2019 RHIP) & Quarterly Expenses

PacificSource Community Solutions
Regional Behavioral Health Integration into Primary Care

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<tr>
<th>FollowUp Snapshot</th>
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<tr>
<td>Amount Requested</td>
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<tr>
<td>Organization Contact</td>
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<td>Contact Phone</td>
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<td>Organization Address</td>
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<tr>
<td>Website</td>
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<tr>
<td>Project Lead</td>
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<tr>
<td>Project Lead email</td>
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RHIP Workgroup:
Behavioral Health Identification & Awareness

Future State Measure:
Note: * indicates required questions

**Contact information**

**Investment/Project Name***

*Name of Project.*

Regional Behavioral Health Integration into Primary Care

**Date you are submitting this final report***

01/22/2021

**Project details**

**Final report: Primary activities***

*Please describe the project or program and primary activities.*

The Advancing Integrated Care in Central Oregon (AiC) project was an ambitious and far-reaching effort to promote whole-person care through integrated primary care homes and improved access to and coordination with specialty behavioral health (BH) care. Creach Consulting, LLC was selected to lead the AiC project, which was administered by PacificSource on behalf of the community. The AiC project, working in partnership with PacificSource, represents a significant investment in establishing Central Oregon as the statewide leader at improving access to behavioral health care. This payer-blind project benefitted all Central Oregonians through training, technical assistance and resources to improve relationships and care coordination between primary care and specialty behavioral health professionals. The AiC project provided behind-the-scenes support for new innovative pilot projects, a forum for training and sharing best practices, and acted as a neutral convener for improving provider relationships.

Primary Project Activities Included:

- Performed a Regional Needs Assessment (Fall 2018)
- Conducted a Primary Care Survey & Traditional Health Worker Gap Analysis (Fall 2019)
- Convened a monthly AiC Workgroup learning collaborative, co-hosted with Dr. Mike Franz, including primary care and specialty behavioral health providers
- Provided technical assistance and quality improvement support to individual clinics – both primary care & specialty behavioral health
- Acted as the community connector, the “grease” bringing people and projects together
- Assisted in establishing the Bridging the Gap Between Specialty BH and Primary Care Pilot Project, including developing a new standard of care for outpatient specialty BH (Includes 3 behavioral health agencies & 5 primary care clinics)
- Developed and piloting metrics assessing timely access to and engagement with specialty BH, closed loop referrals, and care coordination between primary care and specialty BH
- Conducted five “Building Bridges Between Behavioral Health & Primary Care” trainings
- Established the Combat COVID-19 social media campaign; conducted a series of live virtual educational events & shared trusted health information directly with Central Oregonians
Final report: Summary of results*

Please provide a summary of results, outcomes, and benefits of the project or program, including an overall assessment of its success and impact.

While some of the AiC project outcomes are difficult to measure, we are confident that the project’s key accomplishments include:

- Increased community awareness around a lack of timely access to specialty behavioral health, especially for people covered under Medicare, people who speak Spanish, and youth
- Improved relationships between primary care & behavioral health stakeholders
- Created a shared understanding of how integrated primary care and specialty behavioral health providers can work together to support whole-person care
- Dispelled myths around information sharing and care coordination between primary care & specialty BH providers
- Conducted five “Building Bridges Between Behavioral Health & Primary Care” trainings that included 349 participants across all 3 counties in Central Oregon
  - 2 trainings in Deschutes County (+April 2020 training cancelled due to COVID)
  - 1 training in Jefferson County/Warm Springs (Aug. 2019)
  - 1 training in Crook County (Jan. 2020)
  - Virtual half-day conference (November 2020)
- Helped establish a new pilot project that is testing metrics and care delivery innovations that will transform patients’ experience with whole-person care (“Bridging the Gap Between Behavioral Health & Primary Care”)

While the AiC project was successful at progressing integrated whole-person care in Central Oregon, the following are identified as work still needed:

- Address disparities in behavioral health access & ensure equitable outcomes, especially among:
  - People of color, including those who speak Spanish
  - Medicare beneficiaries
  - Veterans
  - Children & adolescents
  - Telehealth access
- Diversify the primary care & behavioral health workforce to include more people of color
- Integrate more Traditional Health Workers such as Peers Support Specialists, Behavioral Health Navigators, and Community Health Workers into primary care & specialty BH care teams
- Address health-related social needs (a.k.a. social determinants of health) and the need for cross-system coordination, including the full adoption of the Unite Us/Connect Oregon platform
- Standardize referral pathways and care coordination processes for patients referred from primary care to specialty BH, including establishing a universal referral form/data elements and care coordination form/data elements
Final report: Stories*

Please provide one or two brief stories or anecdotes that illustrate how this grant has had a positive impact on someone’s life.

As the Outpatient Director of Rimrock Trails Treatment Services, I had multiple opportunities to participate in workgroups & projects related to and supported by the AiC grant. I have seen first hand the positive impact the project has had on primary care & BH providers, but most importantly on the services for individuals and families in Central Oregon. As a result of the work done by AiC our agency has been able to initiate, build, & maintain positive coordinated care relationships with PCPs, which has afforded us exponential growth in the types & amount of services we provide. Through the support of AiC, Rimrock Trails is participating in a pilot project in which multiple providers are working together to provide more seamless care for those in need of BH care. This project has significantly improved clients’ experience & decreased barriers to individuals receiving the help they need. The knowledge, experience, & growth we have gained through being involved in the AiC Project is invaluable on a personal, professional, and community level. Thank you to Dawn and the AiC Project Team for all the amazing work they contributed to Central Oregon! Katie Keck, LMFT, CADC II, Outpatient Director, Rimrock Trails Treatment Services

Looking back over the past year I have been amazed at how your work has changed the landscape of our community. I have seen so much enthusiasm to “Put the head back on the body” and though the concept may be easy to embrace, putting it into practice is a whole other story. Many outpatient specialty BH clinicians believe in the idea, but didn’t know where to start. After the Building Bridges meeting in Bend I think it created an excitement for many specialty BH clinicians because for the first time they could see something tangible that they could do to help. Renee’ Loeb, BH Navigator at High Lakes shared with me that since Building Bridges she is now receiving regular communication from several specialty BH clinicians giving her an update on their availability as well as responding back to her when she has questions. Because of your work & the work of AIC, Brightway’s vision is now primarily focused on serving primary care. This vision has infiltrated into all of our administrative & clinical protocols. For example when the status of a client’s engagement in treatment changes, we now contact integrated BHCs. Another example is that we have reshaped our employee contracts to include requirements to be available for community partner meetings & our supervisor is required to return BHCs calls within 24 hours. In staff meetings we have regular conversations about sharing clients with PCPs and thinking in terms of being a part of a team within the medical community. This past year has also led to organizations working together to put the head back on the body as well. For example, Best Care, Rimrock & Brightways are partnering to launch a pilot project to bring integrated care to more PCPs. It all benefits the client in the end. I can’t tell you how many times I have heard clients say with encouragement in their voice; “Wow, that was quick!” or “Thank you so much for calling me.” I have enjoyed the change and the benefit it brings to our community. Thanks for your work and the work of AIC.
Kevin Shaw, LCSW, CADC III

Permission to share final report stories*

Please indicate whether or not the Health Council has permission to use the story or stories you provided above in social media and/or other mediums/publications.

Yes, the Health Council is permitted to share the story or stories I've provided above publicly
Final report: Did you encounter any problems or challenges in fulfilling the terms of the grant?*

Yes

Final report: Problems or challenges (continued)*

*If you stated that you encountered problems or challenges in fulfilling the terms of the grant, provide detail below. Please include an explanation of how you addressed them, a statement about what the organization would do differently if given the opportunity to repeat the project or program, and any lessons learned. If you did not encounter challenges, please type N/A.

When the COVID-19 pandemic hit in March 2020, nearly all AiC grant activities came to a halt. A “Building Bridges Between Behavioral Health & Primary Care” training in April 2020 was cancelled, and quality improvement work was put on the backburner while health care systems transitioned to telehealth and adjusted to new safety protocols. However, with the support of COHC and the community, the AiC project was able to quickly pivot and launch a social media campaign called “Combat COVID-19.” Through a series of live virtual events and sharing trusted health information, the AiC project brought support and resources directly to people in their homes. The recorded videos remain available through the Combat COVID-19 Facebook page and YouTube channel. While this effort was not originally included in grant activities, the flexibility allowed for continued progress toward the project goal of “Identifying and engaging 100% of individuals in Central Oregon who have a behavioral health need and ensure an effective and timely response.”

Regarding the AiC project, one additional challenge was addressing access to behavioral health care for people covered under Medicare. Given Medicare is a federal program, it was extremely difficult to find ways to address some of the barriers that were uncovered as part of this project. By far, the population that struggles most with access to behavioral health care are older adults covered under Medicare, as very few providers accept Medicare insurance. To address the needs of the fastest growing population in Central Oregon, addressing Medicare payment policies and increasing the number of providers who accept Medicare (standard and Advantage) is critical.

One additional challenge associated with the grant was the overarching broad objective, which included all populations in Central Oregon. While the grant provided flexibility to focus attention where needed, at times it was overwhelming given the amount of work needed to achieve the grant aim. In the future, it may be helpful to have a more focused grant aim.

Final report: Connections within the community*

Were there any connections within the community that the Health Council could have facilitated that would have improved implementation and/or success of your program or project?

No

Final report: Connections (continued)*

If you indicated yes above, please provide detail on the connections within the community that you feel the Health Council could have helped facilitate.
Cross-system information sharing*  
*Did you utilize any cross-system information sharing strategies in this project?*

Yes

Cross-system information sharing (continued)*  
*If you indicated yes above, please provide detail on the cross-system information sharing strategies used in this work. If none, please type N/A.*

The need for cross-system information sharing was one of the top priorities identified by the AiC Regional Needs Assessment conducted in fall 2018. We discovered that very little information sharing and care coordination was happening between primary care and specialty behavioral health providers. The barriers identified included a lack of understanding about information sharing allowed legally under HIPAA, the lack of a technology platform, and a lack of insurance payment that incentivized and reimbursed care coordination activities. Through the “Building Bridges Between Behavioral Health & Primary Care” trainings, the AiC project dispelled myths around information sharing, shared best practices, and raised awareness of technology platforms that enable care coordination. Since the AiC project began, there are several reports of improved care coordination happening between primary care and specialty BH providers. Additionally, the AiC project has highlighted the role of Behavioral Health Navigators as a critical component of improving care coordination and providing at-the-elbow support to patients and families struggling to engage in specialty BH treatment when they are referred from primary care. There are now several organizations in Central Oregon establishing a BH Navigator role, and the AiC Workgroup will be continue to be convened by PacificSource in 2021 with a specific focus on supporting Behavioral Health Navigators and referral coordinators who are on the front lines of information sharing across systems.

Older adults served  
*Please provide the unique number of individuals ages 60+ served to date by this project*

0

Adults served  
*Please provide the unique number of individuals ages 18-59 served to date by this project.*

0

Children & Adolescents served  
*Please provide the unique number of adolescents and children ages 17 & under served by this project.*

23
Objective #1

Increase appropriate behavioral (bx) health screenings and populations screened within all primary care, to 100% universal screening in Central Oregon.

Target for objective #1

By 6.30.20 make contact and explore engagement interest with 100% of primary care clinics in Central Oregon and implement universal screening process at 100% of engaged clinics.

Objective #1: Progress*

*Please provide your progress on objective #1 from your proposal (where you actually landed).

The AiC Regional Needs Assessment conducted in fall 2018 did not indicate that improvement on behavioral health screening was a top priority. All primary care clinics in the region have implemented universal screening strategies, aligned with Patient-Centered Primary Care Home must-pass requirements. However, there remains significant variation in screening periodicity and among specific screening tools used. For example, some clinics may only screen for depression annually and may use the PHQ-9 while others may screen for depression at every visit using the PHQ-2, followed by the PHQ-9 if needed. There is also variation in the processes clinics use to identify gaps in care and conduct outreach to close those care gaps (e.g., identifying patients who did not receive a depression screening in prior year).

Given this objective was not identified as a top priority, we conducted one AiC Workgroup learning session in January 2020 focused on behavioral health screening & effective follow-up. Most of the primary care organizations in Central Oregon participated in this meeting. Further, the AiC project participated in and contributed to the Step-up/Step down workgroup that produced a sizeable guidance document that included recommendations for behavioral health screening and transition of care processes at primary care clinics.

Objective #1: Met or not met*

*Did you meet or exceed the target for objective #1?

Yes, I met or exceeded the target for objective #1

Objective #2

Increase internal behavioral health responses based on positive screening to 100%.

Target for objective #2
By 6.30.20 provide education and training to 100% of engaged primary care clinics on best practice for providing an appropriate response to 100% of patients who screen positive on a universal behavioral health screening tool.

**Objective #2: Progress**

*Please provide your progress on objective #2 from your proposal (where you actually landed).*

*If your proposal only contained one objective, please type N/A.*

Similar to the previous objective, this objective did not rise to the top as a priority as identified in the Regional Needs Assessment. However, we conducted one AiC Workgroup learning session in January 2020 on best practices for behavioral health screening & effective response. Most of the primary care organizations in Central Oregon participated in this meeting. Further, the AiC project collaborated closely with the Oregon Pediatric Improvement Partnership’s (OPIP) developmental screening pathways project to ensure alignment and reduce any duplicative efforts.

**Objective #2: Met or not met**

*Did you meet or exceed the target for objective #2?*

Yes, I met or exceeded the target for objective #2

**Objective #3**

Increase completed external/outside referrals from inside primary care to specialty bx health care based on risk by 100% from baseline.

**Target for objective #3**

By 6.30.20 provide education, training, and workflow development to 100% of engaged primary care clinics on best practice for referring patients to specialty bx health care based on patient’s risk.

**Objective #3: Progress**

*Please provide your progress on objective #3 (where you actually landed).*

*If your proposal contained two or less objectives in your original proposal, please type N/A.*

This objective was identified as critical area of need, and considerable effort focused on addressing this. Literature and clinic experience indicate that only about 20% of patients referred from primary care to specialty BH successfully engage in treatment. Further, the AiC survey conducted in summer 2019 revealed the following results from the majority of local primary care organizations:
Almost 88% of clinics said they are somewhat/very interested in increasing completed referrals & communication with outside specialty BH

72% of clinics said they are somewhat/very interested in increasing patient engagement in specialty BH treatment

To address this need, the AiC project conducted five “Building Bridges Between Behavioral Health & Primary Care” trainings that included 349 participants across all 3 counties in Central Oregon

- 2 trainings in Deschutes County (+April 2020 training cancelled due to COVID)
- 1 training in Jefferson County/Warm Springs (Aug. 2019)
- 1 training in Crook County (Jan. 2020)
- Virtual half-day conference (November 2020)

All Building Bridges trainings were approved for CME/CEUs for the following learning objectives:

- Understand best practices for how primary care & specialty behavioral health providers can partner to provide better access and coordination of care.
- State the benefits of collaboration between primary care and behavioral health providers.
- Identify the key components of integrated behavioral health care and it’s benefits for patients and families.

Through expert panel discussions, didactic presentations, and small group sharing, the Building Bridges trainings directly addressed this objective. Further, the AiC project acted as a convener and facilitator in establishing a new pilot project called Bridging the Gap Between Behavioral Health & Primary Care. The pilot includes three behavioral health agencies and five primary care clinics testing new innovations to make it easier for patients who are referred from primary care to engage in specialty BH treatment in a timely manner. A Behavioral Health Navigator is making sure patients don’t fall through the cracks and helping solve barriers that may impede access to care. Early results demonstrate that with the assistance of a BH Navigator coupled with timely access and a coordinated handoff between primary care & specialty BH providers, that 91.5% of patients referred from primary care were successfully engaged in treatment.

**Objective #3: Met or not met**

*Did you meet or exceed the target for objective #3?*

Yes, I met or exceeded the target for objective #3

**Objective #4**

Complete a gap analysis regarding the use of Peer Support Specialists (PSS) and/or Recovery Mentors (RM) in primary care.

**Target for objective #4**

By 6.30.19 provide a gap analysis of the use of PSSs/RMs and provide the results to 100% of engaged clinics

**Objective #4: Progress**
Please provide your progress on objective #4 (where you actually landed).

If your proposal contained three or less objective, please type N/A.

A primary care survey and Traditional Health Worker (THW) gap analysis was completed 9/1/19, with results submitted to the Central Oregon Health Council. Of note is that nearly 90% of primary care clinics said they are somewhat or very interested in opportunities to expand their care teams with THWs (e.g. Peer Support Specialists, Patient Navigators, Community Health Workers, Health Coaches, etc.). However, very few THWs are currently integrated into primary care clinics in Central Oregon. Clinics indicated several different barriers that must be addressed before THW integration, chiefly, insurance reimbursement but several other barriers were also identified. In addition to the THW gap analysis, two of the monthly AiC Workgroup meetings focused on THWs: definitions, sharing of resources, and questions & discussion.

Objective #4: Met or not met*
Did you meet or exceed the target for objective #4?

Yes, I met or exceeded the target for objective #4

Objective #5

Increase the number of completed and timely referrals from primary care to specialty behavioral health care when behavioral health needs of patient are greater than clinic can manage.

Target for objective #5

By 6.30.20 (% of patients identified by primary care as needing a referral to specialty bx health care will have received an intake with the specialty bx provider within 2 weeks of referral.

Objective #5: Progress*
Please provide your progress on objective #5 (where you actually landed).

If you had four or less objectives in your original proposal, please type N/A.

Similar to objective #3, timely access to specialty BH treatment was identified as critical area of need. Primary care clinics, even those with integrated behavioral health clinicians, struggle to find specialty providers who can see patients in a timely manner, thus decreasing the chance they will effectively engage in treatment. To further address this objective, the AiC project conducted five “Building Bridges Between Behavioral Health & Primary Care” trainings that included 349 participants across all 3 counties in Central Oregon

- 2 trainings in Deschutes County (+April 2020 training cancelled due to COVID)
- 1 training in Jefferson County/Warm Springs (Aug. 2019)
- 1 training in Crook County (Jan. 2020)
Additionally, the AiC project acted as a convener and facilitator in establishing a new pilot project called Bridging the Gap Between Behavioral Health & Primary Care. The pilot includes three behavioral health agencies and five primary care clinics testing new innovations to make it easier to patients who are referred from primary care to engage in specialty BH treatment in a timely manner. Metrics were developed for the pilot that align with this grant objective and are being tested in partnership with the OHSU Community Research Hub. Early results of the Bridging the Gap project demonstrate that 78% of patients referred from primary care to specialty BH were offered a first appointment within 2 weeks (52% within 1 week).

Bridging the Gap Metric: Timely Access
Numerator: Of those in the denominator, the number of patients who were offered an appointment within 2 weeks of PCP referral date
Denominator: Total number of patients referred from primary care clinic to the partner specialty outpatient behavioral health clinic
End Point for Analysis:
Percent of patients referred from partner primary care clinics who are offered a specialty BH appointment within two weeks of the primary referral date.

**Objective #5: Met or not met**

*Did you meet or exceed the target for objective #5?*

Yes, I met or exceeded the target for objective #5

**Objective #6**

Increase engagement with behavioral health patients following their intake to specialty bx care.

**Target for objective #6**

*Original target for objective #6*

By 6.30.2020 (x%) of the patients that received a specialty behavioral health assessment will have received 3 services (face-to-face) within 60 days of their initial assessment.

**Objective #6: Progress**

*Please provide your progress for objective #6 (where you actually landed).*

**Objective #6: Progress**

*Please provide your progress for objective #6 (where you actually landed).*
Similar to the objectives above, this objective was also identified as a priority; the AiC survey conducted in summer 2019 found that 72% of primary care clinics said they are somewhat or very interested in increasing patient engagement in specialty BH treatment. The Building Bridges Between Behavioral Health & Primary Care trainings and the Bridging the Gap pilot project addressed this grant objective. Further, we developed metrics and a coordinated data collection & analysis strategy with the OHSU Community Research Hub. Early pilot project data indicates that nearly 60% of patients referred from primary care completed 4 or more specialty BH visits within 60 days of referral.

Bridging the Gap Metric: Increased Engagement
Numerator: Of those in the denominator, the number of patients who had at least 4 visits/encounters with specialty outpatient behavioral health provider within 60 days of PCP referral
Denominator: Total number of patients referred from primary care clinic to the partner specialty outpatient BH clinic
End Point for Analysis:
Percent of patients referred who complete at least 4 visits within 60 days of referral.

Objective #6: Met or not met*
*Did you meet or exceed the target for objective #6?

Yes, I met or exceeded the target for objective #6

Objective #7

Increase care coordination & communication.

Target #7

By 6.30.20 PC will have at least one form of documentation from specialty BH provider after initiation of services for 75% of patients that had been referred externally for bx.

Progress for objective #7

Please provide your progress for objective #7 (where you actually landed).

Objective #7: Progress

Please provide your progress for objective #6 (where you actually landed).

Similar to the objectives above, we addressed this objective through the Building Bridges Between Behavioral Health & Primary Care trainings and the Bridging the Gap pilot project. Special attention was paid to addressing barriers to communication & care coordination between primary care & specialty BH providers. In fact, the October 2019 Building Bridges training was entirely focused on best practices for information sharing & care coordination. We found that many specialty BH providers are still unaware of the importance or are concerned
about legal ramifications of sharing information with primary care providers. To further address this gap, a written Q&A document was developed and disseminated.

Bridging the Gap Metric: Care Coordination & Communication
Numerator: Of those in the denominator, the number of patients for whom the specialty outpatient BH clinic sent at least one chart note within 30 days of referral from primary care
Denominator: Total number of patients referred from primary care clinic who had at least one visit/encounter with outside specialty BH providers/agencies
End Point for Analysis:
Percent of patients who complete at least one visit who have a note provided to the referring PCP.

Bridging the Gap Metric: Transitions of Care
Numerator: Of those in the denominator, the number of patients who were transitioned back to primary care via a discharge summary sent to PCP and integrated BHC
Denominator: Total number of patients who had at least 4 visits/encounters with specialty outpatient behavioral health provider within 60 days of PCP referral
End Point for Analysis:
Percent of patients who complete at least 4 visits within 60 days of the initial referral whose PCP receives a discharge summary.

Objective #7: Met or not met*
Did you meet or exceed the target for objective #7?

Yes, I met or exceeded the target for objective #7

Objective #8

Target #8

Target #8: Progress
Please provide your progress on objective #8 (where you actually landed).

n/a

Objective #8: Met or not met*
Did you meet or exceed the target for objective #8?

N/A, my proposal contained seven or less objectives

Objective #9
Target #9

Objective #9: Progress

*Please provide your progress on objective #9 (where you actually landed).*

n/a

Objective #9: Met or not met*

N/A, my proposal contained eight or less objectives

Additional analytical reports

*Please attach any additional analytical reports or dashboards that you have associated with this project. You may attach up to 3. Files must be uploaded separately.*

Building bridges audience questions for the panel FINAL 10.7.19.pdf

Additional analytical report 2

*Please attach any additional analytical reports or dashboards that you have associated with this project.*


Additional analytical report 3

*Please attach any additional analytical reports or dashboards that you have associated with this project.*

AIC Primary Care Survey Results & Gap Analysis FINAL Aug. 2019.pdf

Photos associated with project*

*Please attach any photos you would like to share associated with your project. You may attach up to three. Photos must be uploaded separately under the ‘photo attachment’ headings below this question. Please indicate whether the Health Council may share and/or publish these photos publicly.*

N/A: Please select this option ONLY if you did not share any photos.

Photo attachment #1

*Please briefly describe the photo.*
Behavioral Health Identification and Awareness*
How much impact did your project have on Behavioral Health: Identification and Awareness? 0 = no impact; 5 = maximum impact.
Max Score: 5
4

Behavioral Health Substance Use and Chronic Pain*
How much impact did your project have on Behavioral Health: Substance Use and Chronic Pain? 0 = no impact; 5 = maximum impact.
Max Score: 5
3

Cardiovascular Disease*
How much impact did your project have on Cardiovascular Disease? 0 = no impact; 5 = maximum impact.
Max Score: 5
0

Diabetes*
How much impact did your project have on Diabetes? 0 = no impact; 5 = maximum impact.
Max Score: 5
1

Oral Health*
How much impact did your project have on Oral Health? 0 = no impact; 5 = maximum impact.
Max Score: 5
Reproductive & Maternal Child Health*
How much impact did your project have on Reproductive & Maternal Child Health? 0 = no impact; 5 = maximum impact.
Max Score: 5

Milestones to Health and Education*
How much impact did your project have on Milestones to Health and Education? 0 = no impact; 5 = maximum impact.
Max Score: 5

Housing*
How much impact did your project have on Housing? 0 = no impact; 5 = maximum impact.
Max Score: 5

Education*
How much impact did your project have on education? 0 = no impact; 5 = maximum impact.
Max Score: 5

Physical activity*
How much impact did your project have on physical activity? 0 = no impact; 5 = maximum impact.
Max Score: 5

Equity, Social Connection & Civic Muscle*
How much impact did your project have on equity, social connection & civic muscle? 0 = no impact; 5 = maximum impact.
Max Score: 5
Jobs & Wealth*
*How much impact did your project have on jobs & wealth? 0 = no impact; 5 = maximum impact
  Max Score: 5

Preventative Services & Policies*
*How much impact did your project have on preventative services & policies? 0 = no impact; 5 = maximum impact
  Max Score: 5

Stable Housing*
*How much impact did your project have on stable housing? 0 = no impact; 5 = maximum impact
  Max Score: 5

Child Abuse Prevention*
*How much impact did your project have on child abuse prevention? 0 = no impact; 5 = maximum impact
  Max Score: 5

Safe Neighborhoods*
*How much impact did your project have on safe neighborhoods? 0 = no impact; 5 = maximum impact
  Max Score: 5

Nutritious Food*
*How much impact did your project have on nutritious food? 0 = no impact; 5 = maximum impact
  Max Score: 5
Healthy Environment*

How much impact did your project have on a healthy environment? 0 = no impact; 5 = maximum impact

Max Score: 5

0

Arts & Recreation*

How much impact did your project have on arts & recreation? 0 = no impact; 5 = maximum impact

Max Score: 5

0

Mental Health Care*

How much impact did your project have on mental health care? 0 = no impact; 5 = maximum impact

Max Score: 5

4

Other comments for final report

Is there anything else you would like us to know?

Please note that due to the nature of the project, it is unknown how many individuals were impacted.
Thank you for this remarkable investment to improve access to whole-person, integrated health care for all Central Oregonians!
FollowUp Files

Applicant File Uploads

- Building bridges audience questions for the panel FINAL 10.7.19.pdf
- AIC Primary Care Survey Results & Gap Analysis FINAL Aug. 2019.pdf
Q1: Does HIPAA permit health care providers to share protected health information (PHI) about an individual who has mental illness with other health care providers who are treating the same individual for care coordination/continuity of care purposes?

- **YES,** HIPAA permits health care providers to disclose to other health providers any protected health information (PHI) contained in the medical record about an individual for treatment, case management, and coordination of care and, with few exceptions, treats mental health information the same as other health information. Some examples of the types of mental health information that may be found in the medical record and are subject to the same HIPAA standards as other protected health information include:
  - medication prescription and monitoring
  - counseling session start and stop times
  - the modalities and frequencies of treatment furnished
  - results of clinical tests
  - summaries of: diagnosis, functional status, treatment plan, symptoms, prognosis, and progress to date.

- **HIPAA generally does not limit disclosures of PHI** between health care providers for treatment, case management, and care coordination, except that covered entities must obtain individuals’ authorization to disclose separately maintained psychotherapy session notes for such purposes. Covered entities should determine whether other rules, such as state law or professional practice standards place additional limitations on disclosures of PHI related to mental health.

- **Psychotherapy notes** are treated differently from other mental health information both because they contain particularly sensitive information and because they are the personal notes of the therapist that typically are not required or useful for treatment, payment, or health care operations purposes, other than by the mental health professional who created the notes. Therefore, with few exceptions, the Privacy Rule requires a covered entity to obtain a patient’s authorization prior to a disclosure of psychotherapy notes for any reason, including a disclosure for treatment purposes to a health care provider other than the originator of the notes. See 45 CFR 164.508(a)(2). A notable exception exists for disclosures required by other law, such as for mandatory reporting of abuse, and mandatory “duty to warn” situations regarding threats of serious and imminent harm made by the patient (State laws vary as to whether such a warning is mandatory or permissible).

- The Privacy Rule defines psychotherapy notes as notes recorded by a health care provider who is a mental health professional documenting or analyzing the contents of a conversation during a private counseling session or a group, joint, or family counseling session and that are separate from the rest of the patient’s medical record. Psychotherapy notes do not include any information about medication prescription and monitoring, counseling session start and stop times, the
Building Bridges Between Behavioral Health & Primary Care – Bend, Oregon October 1, 2019
Best Practices for Care Coordination & Information Exchange between Specialty Behavioral Health & Primary Care
Audience Questions for the Panelists

modalities and frequencies of treatment furnished, or results of clinical tests; nor do they include summaries of diagnosis, functional status, treatment plan, symptoms, prognosis, and progress to date. Psychotherapy notes also do not include any information that is maintained in a patient’s medical record. See 45 CFR 164.501. Source: HHS Privacy Rule and Sharing Information Related to Mental Health

Q2: Is a release of information necessary?
- HIPPA does not require authorization for disclosures or uses that are necessary to carry out treatment, payment, or health care operations. Care coordination is an essential component of patients’ treatment. However, 42 CFR Part 2 (only applies to federally assisted drug & alcohol programs) does require consent unless one of the limited exceptions applies. See OHA webinar Understanding Privacy Laws for Physical & Behavioral Health Information Sharing
- Oregon law requires providers participating in a CCO (Medicaid providers) to disclose Protected Health Information (PHI) including mental health diagnoses to other CCO providers for treatment purposes including care delivery, coordination, service planning, transitional services, and reimbursement. See ORS 192.561, 414.679(3), 414.679(4)
- Resources: HHS Fact Sheet: HIPPA Helps Mental Health Professionals to Prevent Harm
- Resources: HHS Privacy Rule and Sharing Information Related to Mental Health
- Resources: SAMHSA-HRSA Center for Integrated Health Solutions

Q3: Is HIE affordable for individual therapists in private practice? How do you suggest smaller organizations implement Reliance or Epic with the exuberant costs of these?
- Medicaid providers can receive financial support from Reliance, as well as financial support from OHA to offset their administrative costs associated with HIE onboarding. Participation does not require an EHR. Participants may onboard using a portal only connection, an EHR interface connection, or both. See http://reliancehie.org/hieonboarding/

Q4: Are there any steps in place to help support BH access for rural areas? Is telemedicine approach a viable option?
- Telehealth options are growing and there are some primary care & behavioral health organizations in Central Oregon currently using this technology with great success.
- innovaTel, the strategic partner of the National Council for Behavioral Health, offers telepsychiatry options for behavioral health and primary care organizations: https://innovatel.com/
- Resources: SAMHSA-HRSA Telebehavioral health training & technical assistance

This document does not represent legal advice and is not a substitute for reviewing the law or consulting an attorney.
### Q5: Can you expand on how those in private practice are included in the types of health information exchange you’ve described so far?

- Behavioral health providers in private practice can use several different tools to exchange information with primary care clinics, even without an EHR.
- Options to consider include HIPPA-secure fax or email. There will also be an option in Central Oregon for secure provider-to-provider texting; more information will be available in spring 2020.

### Q7: What HIPAA allows without an ROI and what is clinically helpful would be important to define and discuss with clients to protect trust. A template would be helpful.

- As part of the Advancing Integrated Care in Central Oregon project, we will develop a care coordination/information exchange template that could be adopted throughout the region. Stay tuned!
- The SAMHSA-HRSA Center for Integrated Health Solutions offers these quick tips for educating patients on information sharing:

#### Quick Tips: Educating Patients on Information Sharing

Privacy and confidentiality concerns shouldn’t stop addiction, mental health, or primary care providers from providing quality care to patients. Instead of viewing confidentiality as a barrier, focus on educating patients on information sharing to ensure better quality services. CIHS Health Information Technology Director Mike Lardiere shared a few tips to help you navigate information sharing, including:

- Educate patients about informed consent and the importance of sharing information among their other healthcare providers at the time of service. Such communication may prevent many patients from opting out.
- Respect the requests of patients who opt out of sharing their information.
- Implement the use of routine consent forms that include each necessary organization or provider, as well as all information required by state and federal laws and regulations, and make it known to patients. When asking patients to sign consent forms, again, make sure to explain why sharing such information sharing is so important.
- Encourage your patients to expect communication, collaboration, shared treatment plans, and joint decision making from you and their other providers.
- Be transparent.

Q8: Access to therapists has improved greatly especially for OHP patients. Still struggling to get access to prescribing mental health specialists. Suggestions?

- The country continues to experience a shortage of psychiatric providers, especially in rural areas, and this is not expected to improve in the future. Therefore, organizations are encouraged to consider other strategies such as telepsychiatry.
- innovaTel, the strategic partner of the National Council for Behavioral Health, offers telepsychiatry for behavioral health and primary care organizations: [https://innovatel.com/](https://innovatel.com/)
- Primary care providers in Oregon can call the Oregon Psychiatric Access Line at 1-855-966-7255 for free consultations with adult and child psychiatrists.

Q9: Dear PCPs, I know you’re busy caring for patients throughout the day. As a mental health provider, what information is most helpful for you to receive from me as a snapshot on a progress note about a shared client?

- As part of the Advancing Integrated Care in Central Oregon project, we will develop a care coordination/information exchange template that could be adopted throughout the region. In the meanwhile, here is what the PCPs from the Building Bridges panel discussion said:
  - **From Dr. Peoples:** A brief SOAP note would be great (Subjective, Objective, Assessment, Plan). What I specifically want to see from a MH provider are their thoughts/formulation – how things are going, getting better/worse, diagnoses, etc. Essentially the assessment/plan. A note that is just contains the notes of the conversation (e.g. a lot of S) with the patient with no MH provider assessment is not that helpful.
  - **From Dr. Smart:**
    - Psych diagnosis (this is important as often there is not a clear diagnosis in the chart)
    - Medication recommended or prescribed with recommended dose escalation and monitoring (labs, levels, or interactions with other medications the patient maybe taking, etc.)
    - Plan for who will be the prescriber – especially with controlled substances such as benzodiazepines or stimulants
    - Action plan in terms of counseling, therapy (such as EMDR), or patient activities
    - When referral back to specialty mental health provider is indicated
    - If discharged form an inpatient setting what is the follow up plan (when and with whom)
    - Any safety concerns for the team (such as suicidal or aggressive behavior)
    - Any substance abuse treatment planning or needs

This document does not represent legal advice and is not a substitute for reviewing the law or consulting an attorney.
Q10: As a recovery center that does medical assisted treatment, how can we better Coordinate with PCP offices?

Please refer to these resources:

- Understanding Privacy Laws for Physical & Behavioral Health Information Sharing
- Disclosure of Substance Use Disorder Patient Records
- Reliance Behavioral Health Exchange Legal Analysis Report
- Reliance Behavioral Health Use Case Matrix
- SAMHSA-HRSA Center for Integrated Health Solutions MAT resources

Q11: With BH are you needing referrals, or can patients call to schedule on their own?

- Patients can “self-ref” to behavioral health services or can be referred from their primary care office.
- Some specialty BH providers may not accept referrals, but this is beginning to change as the need for better coordinated care grows, ensuring that patients don’t “fall through the cracks.”

Q12: In MH I was taught that our ethics obligation to clients requires an ROI unless client meets an exception i.e. mandatory reporting, suicidal intent, etc. These ethics are apart from HIPAA, so wondering if this has changed with this integrated mvmt?

- The excerpt below is from the APA code of ethics that guides psychologists’ practice. As noted below, the ethics code allows for disclosure of confidential information without consent of an individual where permitted by law. Thus, patient chart notes, for example, may be disclosed without the patient consent for coordination of care efforts if information is germane to the purpose of coordination of care. However, HIPAA law does expressly require an ROI to disclose separately maintained psychotherapy session notes. Also see question #1 above.

- **4.05 Disclosures**
  (a) Psychologists may disclose confidential information with the appropriate consent of the organizational client, the individual client/patient, or another legally authorized person on behalf of the client/patient unless prohibited by law. (b) Psychologists disclose confidential information without the consent of the individual only as mandated by law, or where permitted by law for a valid purpose such as to (1) provide needed professional services; (2) obtain appropriate professional consultations; (3) protect the client/patient, psychologist, or others from harm; or (4) obtain payment for services from a client/patient, in which instance disclosure is limited to the minimum that is necessary to achieve the purpose.

Source: [https://www.apa.org/monitor/2014/04/disclosing-information](https://www.apa.org/monitor/2014/04/disclosing-information)
Q13: Is anyone tracking access to medical records on the community Heath record site? How are we ensuring that only those on the care team have access to patients records? How are patients being informed of this new information sharing (informed consent?)

Glossary of Terms

**Advancing Integrated Care in Central Oregon (AIC):** A regional health improvement plan (RHIP) project funded by the Central Oregon Health Council’s Behavioral Health Identification & Awareness Workgroup. The overarching project goal is to identify and engage 100% of individuals in Central Oregon that have a behavioral health need and ensure an effective and timely response. The project is focused on supporting primary care clinics and improving access and coordination between behavioral health and primary care. For more info see: [https://cohealthcouncil.org/id-and-awareness/](https://cohealthcouncil.org/id-and-awareness/)

**Alternative payment model (APM):** A payment structure that is not fee-for-service payment. See also: Value-Based Payment.

**Behavioral health:** An umbrella term that encompasses a variety of mental health, substance use, developmental conditions and health behaviors that contribute to overall health (see below). While the term is problematic for several reasons, it is commonly used until a more widely accepted alternative arises.

- Mental health & substance use disorders - e.g., anxiety, depression, substance abuse, psychotic disorders, eating disorders, etc.
- Health behavior and psychosocial well-being e.g., stress, substance use, prevention, habits, functioning, nutrition, exercise, relationships & attachment, resiliency, problem-solving, family factors, Adverse Childhood Experiences/trauma, etc.
- Developmental disorders/disabilities - e.g., autism, ADHD, learning disabilities, developmental delay, communication & motor disorders, etc.

**Behavioral Health Clinician:** As defined in amended ORS 414.025, (a) a licensed psychiatrist; (b) a licensed psychologist; (c) a certified nurse practitioner with a specialty in psychiatric mental health; (d) a licensed clinical social worker; (e) a licensed professional counselor or licensed marriage and family therapist; (f) a certified clinical social work associate; (g) an intern or resident who is working under a board-approved supervisory contract in a clinical mental health field; or (h) any other clinician whose authorized scope of practice includes mental health diagnosis and treatment.

**Central Oregon Health Council:** is a not-for-profit, tax-exempt public and private community governance entity. The COHC is dedicated to improving the health of the region and providing oversight of the Medicaid population and Coordinated Care Organization (CCO). COHC was officially created by Senate Bill 204 in 2011 to promote the health of the region’s residents and seeks to achieve the Triple Aim of health care reform. The COHC and Central Oregon’s CCO, PacificSource Community Solutions (PSCS), work together to transform health care in the region and to use integrated and coordinated health care systems to improve health; increase quality, reliability, availability, and continuity of care; and reduce the cost of care. [https://cohealthcouncil.org/](https://cohealthcouncil.org/)
Glossary of Terms

Certified Community Behavioral Health Clinic (CCBHCs) a.k.a. behavioral health homes, sometimes called “reverse integration”: CCBHCs provide mental health and integrated primary care services to all who seek help, but particularly for individuals with serious mental illness (SMI), those with severe substance use disorders, children and adolescents with serious emotional disturbance (SED), and those with co-occurring mental, substance use or physical health disorders. CCBHCs must meet a set of criteria to be certified.

Community Mental Health Program: (CMHP) Per OAR 309-008-0200, CMHP means the organization of various services for individuals with a mental health diagnosis or addictive disorders operated by or contractually affiliated with a local mental health authority and operated in a specific geographic area of the state under an agreement with the Division pursuant to OAR 309-014-0000.

CMHPs receive Medicaid and other general funds to provide safety net services for the community and are accountable to the county commissioners as the designated local mental health authority. CMHPs provide a wide variety of services & supports for people with more severe behavioral health needs. In Central Oregon the CMHPS are Deschutes County Behavioral Health (Deschutes County), BestCare Treatment Services (Jefferson County), and Lutheran Community Services Northwest (Crook County).

Collaborative Care/Psychiatric Collaborative Care Model: A specific model of behavioral health integration in primary care settings that aims to treat common mental health conditions such as depression and anxiety that require systematic follow-up due to their persistent nature. Based on principles of effective chronic illness care, collaborative care focuses on defined patient populations tracked in a registry, measurement-based practice and treatment to target. Trained primary care providers and embedded behavioral health professionals provide evidence-based medication or psychosocial treatments, supported by regular psychiatric case consultation and treatment adjustment for patients who are not improving as expected. (AIMS Center https://aims.uw.edu/collaborative-care)

Comprehensive Primary Care Plus (CPC+): A five-year multi-payer advanced medical home model launched by the Centers for Medicare and Medicaid Services offering an innovative payment structure to improve health care quality and delivery. In Oregon, fourteen payers and over 150 primary care clinics are participating. CMS will introduce the next version of CPC+ in 2020, which is being called Primary Care First. CPC+ milestones can be found in the CPC Payer Partner Roadmap document: https://www.milbank.org/wp-content/uploads/2016/11/CPC-Payer-Partner-Roadmap-final.pdf
Electronic health record (EHR), certified: An electronic health record that stores data in a structured format allowing health care providers to easily retrieve and transfer patient information and use the EHR in ways that can aid patient care. A certified EHR has been approved by the Centers for Medicare & Medicaid Services for use in promoting interoperability programs.

Health Equity: Means that everyone has fair and just opportunity to be as healthy as possible. This requires removing economic and social obstacles to health such as poverty and discrimination. (RWJF)

Health Information Exchange (HIE): The secure and timely sharing of electronic health data across the boundaries of health care institutions.

Integrated Behavioral Health Alliance (IBHA): The Integrated Behavioral Health Alliance of (IBHA) is an Oregon-based multi-stakeholder workgroup of healthcare payers, providers and policy developers. IBHA promotes the full integration of behavioral and physical health services in primary care settings, as well as other physical health settings. In 2015, IBHA developed recommended minimum standards for primary care practices providing integrated behavioral health. Those recommendations were incorporated into the 2017 Patient Centered Primary Care Home (PCPCH) standards to define what advanced integrated primary care looks like.

Integrated health care: As defined in amended ORS 414.025, means care provided to individuals and their families in a Patient-Centered Primary Care Home or behavioral health home by licensed primary care clinicians, behavioral health clinicians and other care team members, working together to address one or more of the following: mental illness; substance use disorders; health behaviors that contribute to chronic illness; life stressors and crises; developmental risks and conditions; stress-related physical symptoms; preventive care; and/or ineffective patterns of health care utilization.

Medication Assisted Treatment (MAT): The use of medications in combination with counseling and behavioral therapies for the treatment of substance use disorders. A combination of medication and behavioral therapies is effective in the treatment of substance use disorders and can help some people to sustain recovery.
Glossary of Terms

**Outpatient behavioral health:** Usually individual or group psychotherapy aimed at covered conditions such as Depressive Disorders, Anxiety Disorders, PTSD, and “higher functioning” Bipolar Disorder. About 20% may also see a Psychiatrist or Psychiatric Nurse Practitioner, with many receiving psychiatric medications through their PCP. Problems can range from an Adjustment Disorder that can be handled in a few sessions to Complex PTSD which can involve intensive or longer-term therapy.

**Primary Care Behavioral Health:** A specific model of behavioral health integration in primary care settings aimed at improving effectiveness of caring for patients with a variety of mental health, substance use, and developmental issues as well as health behaviors that impact chronic medical conditions and providing prevention & early intervention. Licensed BHCs partner with PCPs to provide same-day assessments & interventions and short-term evidence-based treatment (Robinson, Reiter, Strosahl)

**Primary care provider (PCP):** A physician, naturopath, nurse practitioner, physician assistant or other health professional licensed or certified in Oregon, whose clinical practice is in primary care. PCPs include Family Medicine, Internal Medicine, Pediatric and some women’s health providers.

**Patient-Centered Primary Care Home (PCPCH) Program:** Oregon’s medical home recognition program that sets the standards of care for primary clinics. Oregon has over 650 participating primary care practices. See [www.primarycarehome.oregon.gov](http://www.primarycarehome.oregon.gov)

**Payer:** Any carrier that sells health insurance in Oregon.

**Primary, Secondary, Tertiary Care:**

- **Primary Care:** the widest scope of health care, including all ages of patients, patients of all socioeconomic and geographic origins, patients seeking to maintain optimal health, and patients with all types of acute and chronic physical, mental and social health issues, including multiple chronic diseases. Consequently, a primary care provider must possess a wide breadth of knowledge in many areas. Continuity is a key characteristic of primary care, as patients usually prefer to consult the same PCP for routine check-ups and preventive care, health education, and every time they require an initial consultation about a new health problem.

- **Secondary Care:** includes acute and specialty care. Necessary treatment for a short period of time for a brief but serious illness, injury, or other health condition. This care is often found in hospital settings but many secondary care providers such as behavioral health clinicians, occupational therapists, most dental specialties or physiotherapists work in private practice outpatient specialty settings. Depending on insurance requirements, some patients may be
required to see a primary care provider for a referral before they can access secondary care. Secondary care also includes skilled attendance during childbirth, intensive care, and medical imaging services.

- **Tertiary care** is specialized consultative health care, usually for inpatients and on referral from a primary or secondary health professional, in a facility that has personnel and facilities for advanced medical investigation and treatment, such as a tertiary referral hospital. Examples of tertiary care services are cancer management, neurosurgery, cardiac surgery, and palliative care.

**Reliance eHealth Collaborative:** The health information exchange platform adopted by Oregon Health Authority to provide onboarding services for the Health Information Exchange (HIE) Onboarding Program. The HIE Onboarding Program will provide financial support for certain initial costs of connecting (onboarding) priority Medicaid providers to a community-based HIE that provides meaningful data exchange. The HIE Onboarding Program will help Medicaid providers (especially rural providers, behavioral health providers, and non-medical providers) connect to a well-established community-based health information exchange to share health information in order to improve patient care. The program will be voluntary and will help providers who, in the past, may not have been able to connect to an HIE due to financial or other barriers, and providers who have previously been ineligible to receive federal financial support for health IT. There are four main components of the platform: eReferrals, Community Health Record, Insight reporting and population health tool, and secure messaging. See: [http://reliancehie.org/](http://reliancehie.org/)

**Socially complex patients:** Patients experiencing a set of co-occurring individual, family or community characteristics that can have a direct impact on health outcomes or an indirect impact by affecting a person’s access to care and/or a family’s ability to engage in recommended medical and mental health treatments. Definition based on work of The Center of Excellence on Quality of Care Measures for Children with Complex Needs.

**Social determinants of health (SDOH):** The social, economic, political, and environmental conditions in which people are born, grow, work, live, and age. Another commonly used term is **health-related social factors. Social determinants of equity** are the structural factors such as racism, sexism, able-ism, and others that determine how different groups of people experience social determinants of health.

**Specialty behavioral health:** Mental health, substance abuse, and developmental services that are delivered in specialty settings (outside of primary care) and are typically accessed via referral from primary care providers or by patient choice. There are many different types of specialty behavioral health providers and levels of care including but not limited to:

- Community Mental Health Programs (CMHPs) – see definition above
Glossary of Terms

- Private practice or outpatient paneled specialty behavioral providers
  Some primary care clinics may also offer co-located specialty behavioral health services, but this is different than integrated care.

**Triple Aim/Quadruple Aim:** Developed by the National Institute for Healthcare Improvement, the triple aim framework serves as the foundation for organizations and communities to successfully navigate the transition from a focus on health care to optimizing health for individuals and populations. The goals are to (1) simultaneously improve the health of the population, (2) enhance the experience and outcomes of the patient, and (3) reduce per capita cost of care for the benefit of communities. The quadruple aim includes the addition of improving the work life of providers and care teams.

**Value-based payment (VPB):** A payment structure that is not based on fee-for-services and rewards services associated with quality, outcomes, and cost-effectiveness rather than volume of services.
Background

Advancing Integrated Care in Central Oregon (AIC) is a regional health improvement plan (RHIP) project funded by the Central Oregon Health Council’s Behavioral Health Identification & Awareness Workgroup. The overarching project goal is to identify and engage 100% of individuals in Central Oregon that have a behavioral health need and ensure an effective and timely response. This two-year project is focused on supporting primary care clinics and improving access to and coordination with behavioral health.

PacificSource is administering the AIC grant on behalf of the community, however, the project is payer-blind and is intended to benefit all Central Oregon residents. E. Dawn Creach, MS, of Creach Consulting, LLC, was selected to lead the AIC project and Dr. Mike Franz, Medical Director of Behavioral Health at PacificSource, is a collaborator and advisor.

### Advancing Integrated Care (AIC) Key Components:

1) **Identification:**

   Increasing universal behavioral health screening in primary care clinics

2) **Integration:**

   Implementing population-based and outcome-oriented behavioral health interventions in primary care clinics

3) **Referrals:**

   Increasing timely and completed referrals to specialty behavioral health for people with needs beyond what can be served in primary care (or by choice)

4) **Coordination:**

   Increasing effective communication between primary care & specialty behavioral health providers

5) **Expanding the Care Team:**

   Identifying opportunities to increase use of traditional health workers such as Community Health Workers, navigators, Peer Support Specialists, and Recovery Mentors
Primary Care Survey

To learn more about primary care clinics in Central Oregon, E. Dawn Creach, MS, conducted a survey in spring 2019. The survey objectives were to:

1. Identify quality improvement (QI) goals and technical assistance priorities for meeting the behavioral health needs of patients and families
2. Conduct a gap analysis for Traditional Health Workers (THW) in primary care settings (an AIC grant requirement)

Efforts were made to invite all primary care clinics in Central Oregon to participate in the survey. Clinics were asked to submit one survey response on behalf of the entire clinic site. They were encouraged to collaborate with clinic leadership and other team members so that responses represented the overall clinic rather than any one individual. As a result, the survey respondents’ roles varied including medical directors, clinic managers/administrators, and integrated behavioral health clinicians (BHCs).

A total of 27 responses were received representing the following organizations:

- Weeks Family Medicine
- La Pine Community Health Center
- High Lakes Health Care: Upper Mill and Shevlin clinics
- Central Oregon Pediatric Associates (NW Crossing, East Bend, Redmond, South Bend)
- Summit/BMC (1 response for all sites)
- Mosaic Medical: Prineville, Bend High SBHC, East Side FM, East Side Peds, Bridges Internal Medicine, Redmond, Madras, Madras High SBHC
- St. Charles: Women’s Health, Sisters, Prineville, Madras, Redmond, East Bend
- Madras Medical Group
- Cascade Internal Medicine Specialists
- Fall Creek Internal Medicine

Survey Results: Behavioral Health Technical Assistance Needs & Quality Improvement Goals

Primary care clinics were asked to select from a list of possible behavioral health quality improvement (QI) goals to understand their current priorities. This data will help inform targeted technical assistance (TA) & trainings during the final year of the AIC project.
What are your clinic’s quality improvement goals to better care for your patients’ behavioral health needs? (check all that apply)

<table>
<thead>
<tr>
<th>ANSWER CHOICES</th>
<th>RESPONSES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increasing “population reach %” of integrated behavioral health services</td>
<td>83.3%</td>
</tr>
<tr>
<td>Effective team-based care, including involving BHCs in caring for patients with chronic medical conditions</td>
<td>62.5%</td>
</tr>
<tr>
<td>Improving coordination and co-management with outside specialty behavioral health providers</td>
<td>54.2%</td>
</tr>
<tr>
<td>Establishing standardized workflows for integrated BHC intervention with target sub-populations (e.g. diabetes, depression, etc.)</td>
<td>50.0%</td>
</tr>
<tr>
<td>Increasing behavioral health screening rates</td>
<td>45.6%</td>
</tr>
<tr>
<td>Increasing access to psychiatric consultation and/or in-person access</td>
<td>41.7%</td>
</tr>
<tr>
<td>Improving behavioral health outcomes via measurement-based care (e.g. tracking PHQ-9 and GAD-7 scores over time)</td>
<td>41.7%</td>
</tr>
<tr>
<td>Adding Traditional Health Workers to the care team (e.g. peer support specialist, community health worker, etc.)</td>
<td>41.7%</td>
</tr>
<tr>
<td>Implementing a fidelity &quot;Collaborative Care&quot; model of behavioral health integration</td>
<td>37.5%</td>
</tr>
<tr>
<td>Increasing completed referrals to outside specialty behavioral health providers</td>
<td>33.3%</td>
</tr>
<tr>
<td>Implementing trauma-informed care</td>
<td>33.3%</td>
</tr>
<tr>
<td>Meeting IBHA/PCPCH standards for integrated behavioral health</td>
<td>33.3%</td>
</tr>
<tr>
<td>Hiring new integrated BHCs</td>
<td>25.0%</td>
</tr>
<tr>
<td>Implementing tablets for behavioral health screening</td>
<td>20.8%</td>
</tr>
<tr>
<td>Creating a registry of patients with behavioral health conditions</td>
<td>20.8%</td>
</tr>
<tr>
<td>Implementing group visits for patients with behavioral health conditions</td>
<td>16.7%</td>
</tr>
<tr>
<td>Starting an integrated behavioral health program</td>
<td>12.5%</td>
</tr>
<tr>
<td>Implementing evidence-based interventions for patients who have experienced trauma/ACEs</td>
<td>12.5%</td>
</tr>
</tbody>
</table>

Total Respondents: 24
Additional Respondent Comments:

- Per Mosaic system QI and TA: 1) Assist in training new BHC supervisors 2) Improve operational efficiencies for same day BHC access 3) Improve clinical involvement of BHCs in physical health conditions
- Transportation; childcare services
- Sustainability for providers-reducing burnout to prevent turnover of staff

Over 83% of clinics are focused on “increasing the population reach % of integrated behavioral health services.” This was not surprising given that PacificSource CCO currently has quality incentive funding attached to clinic performance on this metric. Approximately 63% of clinics are also focused on implementing more effective team-based care including involving the integrated BHCs in caring for patients with chronic medical conditions, and 50% are working to establish standardized workflows for integrated BHC interventions with target subpopulations, such as patients with diabetes or depression. Over 54% of clinics are working to improve coordination & co-management with outside specialty BH providers, which aligns with the objectives of the AIC grant’s Building Bridges Between Behavioral Health & Primary Care trainings.

Next, clinics were asked about their interest in receiving training or TA for each of the AIC grant objectives.

Please rate your clinic’s interest in receiving training or technical assistance for achieving the following objectives:
Nearly 88% of clinics said they are somewhat or very interested in TA or training to increase completed referrals & communication with outside specialty behavioral health providers, with over 62% of those saying they are very interested. This was also identified as a critical need from the AIC regional needs assessment and aligns with current grant efforts including Building Bridges Between Behavioral Health & Primary Care trainings, as well as work underway to support pilot project partnerships focused on increasing access & coordination.

Similarly, about 88% of clinics said they are somewhat or very interested in exploring opportunities to expand their primary care teams with Traditional Health Workers (THW). This was higher than expected, indicating a window of opportunity to develop a comprehensive plan for increasing the use of THWs in Central Oregon. The second section of the survey focuses on this topic.
Survey Results: Traditional Health Worker Gap Analysis

Traditional Health Worker (THW) is an umbrella term for frontline public health workers who work in a community or clinic under the direction of a licensed health provider. Primary care clinics employing THWs is relatively new, but there is growing interest in expanding the THW workforce, particularly to address social determinants of health (SDOH) and behavioral health concerns. The AIC grant was charged with completing a gap analysis of THW to understand the current and desired state for THWs in Central Oregon primary care practices. Below is a list of various types of THWs and a brief description of their role, as defined in the primary care survey questions.

- **Community Health Worker:** A front-line public health worker who is a trusted member of and/or has an unusually close understanding of the community served; Serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery; Builds individual and community capacity by increasing health knowledge and self-sufficiency through activities such as outreach, community education, informal counseling, social support and advocacy.

- **Personal Health Navigator:** Provides information, assistance, tools and support to enable a patient to make the best health care decisions.

- **Peer Support Specialist:** Someone who has current or former experience with mental health or addiction treatment or has faced difficulties in accessing education, health, and wellness services due to behavioral health barriers. Provides supportive services with a focus on recovery from addiction/mental health. Includes Recovery Mentors and Family and Youth Support Specialists.

- **Peer Wellness Specialist:** Someone who has current or former experience with mental health, addiction, or chronic medical conditions or has faced difficulties in accessing education, health, and wellness services due to behavioral or physical health barriers. Provides supportive services with a focus on recovery from addiction/mental health and physical conditions.

- **Birth Doulas:** Assists women and their family with pre-natal, childbirth and post-partum care.

- **Health & Wellness Coach:** Works with individuals to help them improve health and maintain a healthy lifestyle. Includes establishing dietary plans, safe exercise routines, and monitoring systems.

- **Patient Advocate:** Someone patients can trust to act on their behalf, help navigate the health care system, connect to community resources, and work closely with patients' healthcare team.
Current State of Traditional Health Workers in Primary Care Settings

Primary care clinics were asked if any THWs were currently employed at their clinic and their staffing levels by full-time equivalent (FTE). As shown on the graph below, 56% (14 clinics) currently employ Community Health Workers (CHWs), but other types of THWs are not widely utilized. It is important to note that from the consultant’s observations and experience, it is unclear if CHWs currently employed at primary care clinics are operating in the way the role is intended. For example, many CHWs are utilized to connect patients to community resources or focus on quality improvement metrics, but not necessarily to do community outreach & education, cultural competency work, informal counseling, social support, and advocacy.

For current THW staffing levels, only 36% of clinics (8 clinics) have a full time CHW, while 13.6% (3 clinics) have more than 1 FTE and the same number have less than 1.0 FTE (see graph on next page). Two clinics indicated that they have a Personal Health Navigator, one at 1.0 FTE and one at more than 1.0 FTE. Four clinics indicated they have a Patient Advocate and two said they have a Health & Wellness Coach.
Future Desired State of Traditional Health Workers in Primary Care Settings

As primary care continues to tackle a myriad of medical, behavioral, and social complexity in caring for patients and families, the need to expand care teams is evident. While clinical interventions are vital, they may fall flat if patients have more pressing needs such as housing, food insecurity, personal safety, or are struggling with managing behavioral health conditions.

THWs are paraprofessionals that can often connect with patients in ways that licensed clinical professionals cannot – ultimately helping bridge the divide between socioeconomic status, culture, and lived experience. THWs can also do time-intensive work across systems and connect with patients in the community, outside of medical settings. The widespread implementation of THWs could dramatically change the delivery of healthcare, connecting patients and families at the point of care with at-the-elbow assistance to mitigate whatever issues are impacting their health.

However, it will be challenging to integrate THWs in primary care settings. The next section of the survey focuses on understanding clinics’ perception of THWs, desired staffing level in an ideal world, and barriers to implementation.
Considering the behavioral health needs of your patients & families, which of the following roles do you think would be the most beneficial at your clinic? Behavioral health includes mental health, substance use, developmental concerns, and health behaviors that contribute to chronic disease.

![Bar Chart]

Respondent comment: *If we had to choose between Peer Support Specialist and Peer Wellness Specialist, Peer Wellness Specialist seems like it would be a better fit for our patients since many also have chronic medical conditions in addition to mental health and addiction.*

Primary care clinics in Central Oregon believe that Community Health Workers, Patient Advocates, Peer Support Specialists, and Personal Health Navigators would be the most beneficial for addressing patients’ behavioral health needs. However, because the concept of these roles functioning in primary care settings is relatively new, views may change as knowledge of THWs grows over time.

Next, the survey asked clinics to indicate their desired FTE for various THW roles in an ideal world (see next page). Eighty percent of clinics would like 1.0 FTE or more of CHWs, while nearly 69% desire to have 1.0 FTE or more of a Patient Advocate. Fifty percent of clinics would like 1.0 FTE or more of Health & Wellness Coach and/or a Peer Support Specialist. Approximately 43% would like 1.0 FTE or more of a Personal Health Navigator and 39% said they would like a Peer Wellness Specialist. Three clinics said they would like a full time Birth Doula.

Primary care clinics in Central Oregon see value in adding a variety of THWs to their care teams, but there is a large gap between the current and ideal state. To address this gap, we must first understand more about the perceived barriers to integrating THWs. When asked about barriers, clinics cited several that would need to be addressed if Central Oregon intends to expand primary care staffing with THWs.
If your clinic wanted to add any of the Traditional Health Workers (THW) listed above, what barriers would need to be addressed? (check all that apply)
Respondent Comments: Lack of space in our clinic - we’ve outgrown our current space. Lack of relying on current resources who know how to implement these programs.

By far the barrier cited most frequently is a lack of funding or reimbursement for THWs, followed by lack of knowledge about how to start a program & hire THWs, and a lack of time to develop & manage a program. It is also clear that additional information/knowledge is needed on how THWs can supplement the work of primary care teams to address medical, behavioral, and social challenges.

Finally, the survey asked clinics if they have any other comments related to behavioral health QI goals, training or technical assistance needs, or integrating Traditional Health Workers.

Respondent Comments:

- With Prineville being in a rural community, provider recruitment and retention are significant barriers.
- There seems to be lack of overall funding for BHCs given our population. OHP appears to be financially supportive but only 35%-40% of our funding mix is OHP which makes expanding our program difficult.
- We are hoping that COIPA will help us meet our measures and goals.
Assessment

The survey indicates that many primary care clinics in Central Oregon are interested in integrating a variety of Traditional Health Workers. However, there are several financial and operational barriers that would need to be addressed at a larger level before implementation was feasible. Additionally, because the idea of integrating various THWs is relatively new, there is a knowledge gap around what these roles are and how they could be effectively deployed in primary care settings.

As part of the research for this report, the consultant conducted a site visit to St. Charles FamilyCare in Prineville. While reviewing responses to the primary care survey, the clinic had initially indicated that they employed a Peer Support Specialist (PSS). To learn more, the consultant met with the clinic’s integrated behavioral health clinician (BHC), medical director, and clinic manager. Further conversation revealed that while the PSS is not employed by St. Charles, they have been closely working with a grant-funded team from BestCare Treatment Services. The team, which consists of a case manager and PSS, is tasked with addressing Emergency Department (ED) utilization at the St. Charles Prineville hospital but due to a lack of space in the ED, the team typically works out of an office in the same building as the primary care clinic. By virtue of physical proximity, the integrated BHC, a psychologist, begun calling in the case manager when patients who meet the program criteria (e.g. high ED utilization and behavioral health diagnoses) presented in primary care. The BHC spoke extensively about how helpful the case manager and PSS are, and how patients and families are much more open to receiving assistance if they can come in the exam room to meet directly with patients on the same day (vs. referral). According to the integrated BHC, “Our clinical interventions won’t work unless many of the social determinants of health are met first,” referring to a concept called Maslow’s hierarchy of needs.

Maslow’s hierarchy of needs is a motivational theory in psychology comprising a five-tier model of human needs, often depicted as hierarchical levels within a pyramid (see next page). Needs lower down in the hierarchy must be satisfied before individuals can attend to needs higher up. Indeed, it seems that Traditional Health Workers may be the key to addressing underlying patient factors that could make primary care and integrated behavioral health more effective overall.
Maslow's Hierarchy of Needs

Conclusion

Central Oregon is a leader at adopting integrated behavioral health but given the myriad of medical, behavioral, and social challenges faced by patients & families, clinical interventions alone may be inadequate if patients’ basic needs are not addressed first. The integration of Traditional Health Workers into primary care settings is a promising concept to address the social determinants of health and make clinical interventions more effective, as well as providing vital cross-system coordination. Traditional Health Workers can also help address workforce shortages that contribute to the lack of primary care and behavioral health access. And while paraprofessionals cannot replace clinical interventions by licensed clinicians, THWs could provide critical services to supplement the work of clinical teams.

A surprising finding of the survey is that almost 90% of Central Oregon primary care clinics expressed great interest in integrating Traditional Health Workers of various types. However, there are several financial and operational barriers that would need to be addressed first in order to make it feasible. The information from this report can serve as a solid first step towards addressing those barriers at the community level and creating innovative approaches to expand primary care teams with Traditional Health Workers.