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

Join Zoom Meeting
https://us02web.zoom.us/j/88698019171?pwd=e1M0SEE5aFI4K3BXbXBMaUtSTm1qd09

Join by phone:
+1 719 359 4580
Meeting ID: 886 9801 9171
Passcode: 300638

September 20, 2023
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 - 1:15 PM Welcome, Land Acknowledgement & Guiding Principles, Announcements.

1:15 - 1:40 PM Investments update
- Behavioral Health Navigation Team Overview
  - Becky Johnston LCSW, PacificSource

1:40 – 2:00 PM Advancing Integrated Care: Timely Access and Engagement Metric Development (Update)
- Dawn Creach MS, Creach Consulting Group

2:00 - 2:30 PM Explore options for last investment 2020-2024

Working Document: https://docs.google.com/presentation/d/1jx7QDra_SVxVYXNkTj9No7ODu_dGeDhXf4CsBa-Oo0/edit?usp=sharing

Workgroup Budget: https://docs.google.com/spreadsheets/d/1Gw9dL6iRe1olGhJRMIoxg9pEUofJ-KzU5WnsCBbEX8/edit?usp=sharing
## Behavioral Health: Increase Access and Coordination

Regional Health Improvement Plan Workgroup

<table>
<thead>
<tr>
<th>Future State Metrics – Full Detail</th>
</tr>
</thead>
<tbody>
<tr>
<td>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.</td>
</tr>
<tr>
<td>2. By December 2023, a method is developed to measure timeliness and engagement with specialty behavioral health referred from primary care.</td>
</tr>
<tr>
<td>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.</td>
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</tbody>
</table>
Land Acknowledgment

We recognize and acknowledge the indigenous land on which we live, work, learn, play, and grow. This is the land of the Warm Springs, Wasco, Northern Paiute, Tenino, Klamath, Molalla, and Yahooskin. We acknowledge them as the past, present, and future caretakers of this land. It is on their traditional land that 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 & Coordination

RHIP Workgroup Virtual Meeting
## Five-Year Investment Overview

**All Workgroups**  
January 2020–December 2024

<table>
<thead>
<tr>
<th>Budget</th>
<th>Spent</th>
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<td>$12,000,000</td>
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<td>$4,390,998</td>
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<table>
<thead>
<tr>
<th>Workgroup</th>
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<tr>
<td>Address Poverty</td>
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<td>Behavioral Health</td>
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<td>Physical Health</td>
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<td>Stable Housing</td>
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<td>Substance and Alcohol Misuse</td>
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<td>Upstream Prevention</td>
<td>$1,424,126.00</td>
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## BEHAVIORAL HEALTH
### 2023 Budget Overview

<table>
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<tr>
<th>Category</th>
<th>Budget</th>
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<td>Cycle to Date</td>
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<td>Yearly</td>
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<td>$45,000.00</td>
<td>$455,000.00</td>
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<td>Yearly Mini-Grant</td>
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<td>Yearly Standard Grant</td>
<td>$482,034</td>
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### By Future State Measure (5 year)

<table>
<thead>
<tr>
<th>Measure</th>
<th>Budget*</th>
<th>Spent</th>
<th>Available</th>
<th>Currently Allocated</th>
<th>Projected Available</th>
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<tr>
<td>Rural Providers</td>
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<td>Timeliness Engagement</td>
<td>$554,450.00</td>
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<td>-$40,000.00</td>
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<td>Screening Method</td>
<td>$265,335.00</td>
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<td>$0.00</td>
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*Budget for each FSM reflects the agreed upon 5 year 'soft budget' minus the portion contributed to shared minigrant budget.

### 2023 Investments

<table>
<thead>
<tr>
<th>Organization</th>
<th>Process</th>
<th>Project</th>
<th>Award</th>
<th>Decision Date</th>
<th>Future State Measure</th>
<th>Latest Report</th>
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<tbody>
<tr>
<td>Nami Central Oregon</td>
<td>Mini-Grant Application (2020-2023 RHIP)</td>
<td>NAMI Ending the Silence - Presentations in High Schools</td>
<td>$5,000.00</td>
<td>1.26.23</td>
<td>drawn from shared minigrant budget</td>
<td>Final Report</td>
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<tr>
<td>Creach Consulting</td>
<td>Standard Grant Measure Development for Behavioral Health Specialty Care and Primary Care (2020-2024 RHIP)</td>
<td>Advancing Integrated Care: Timely Access and Engagement Metric Development Addendum</td>
<td>$40,000.00</td>
<td>05.17.23</td>
<td>Measure timeliness and engagement when referred from primary care to specialty behavioral health</td>
<td></td>
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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.

**Partner with Priority Populations**
The individuals living in our diverse Central Oregon communities are the center of our work. We make every effort to include people from every part of the region in our workgroups, discussions, processes and decisions.

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

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

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

**Background: Why are we talking about this?**

1990s Mill Closures / Timber Industry Decline
- State Hospitals Deinstitutionalized
- US Wars impact on Veterans

2000s Population Growth in Central Oregon
- Housing shortage
- Rising suicide rates
- Tech Advancement & Screen Time

Mental health affects how we think, feel and act. It determines how we handle stress, relate to others, and make choices. Mental health challenges can increase the risk of physical health problems such as stroke and heart disease. Individuals benefit significantly from intensive coordination of care and outreach activities, which are less available in remote areas of Central Oregon.

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

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

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

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

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

**Future State Metrics - By December 2023:**
1. Increase availability of behavioral health providers in marginalized areas of the region
2. Increase timeliness and engagement when referred from primary care to specialty behavioral health
3. Standardize screening processes for appropriate levels of follow-up care across services

**Analysis: What's keeping us from getting there?**

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

**Date updated: 8.2022**

**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?)**

<table>
<thead>
<tr>
<th>Future State Measure</th>
<th>What</th>
<th>When</th>
<th>Who/How</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Create a community-driven behavioral health workforce development pipeline prioritizing rural areas</td>
<td>2022 - 2025</td>
<td>Behavioral Health Consortium; St.Charles Health System</td>
</tr>
<tr>
<td>2</td>
<td>Identify, create or adapt regional measure for timeliness and engagement and integrate into payer models</td>
<td>2021 - 2024</td>
<td>Consultant, Creach Consulting Group, LLC.</td>
</tr>
<tr>
<td>3</td>
<td>Standardize screening processes and communication to assure clients receive the appropriate level of care and follow-up</td>
<td>2022-2024</td>
<td>Addendum to Timeliness and Engagement Project</td>
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</tbody>
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**Follow-Up: What’s working? What have we learned?**

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<table>
<thead>
<tr>
<th>Root Cause Barriers: What is blocking us from moving toward our future state measures?</th>
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<tbody>
<tr>
<td><strong>Care is culturally inappropriate and unresponsive</strong></td>
</tr>
<tr>
<td>Cultural barrier of trust with minority groups (Persons of Color, veterans, etc)</td>
</tr>
<tr>
<td>Insufficient knowledge of dyadic therapies for children/families</td>
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<tr>
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</tr>
<tr>
<td>Screening processes are not humanistic</td>
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<tr>
<td>Dysfunctional Provider Directories</td>
</tr>
<tr>
<td>HIPAA/Privacy Myths</td>
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<tr>
<td>Mental Health dollars cannot cross county lines</td>
</tr>
<tr>
<td>Funding Payor Issues</td>
</tr>
</tbody>
</table>
## 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>
</tr>
</thead>
<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>
</tr>
</tbody>
</table>

### 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. |
Promote Mental Health for All across the lifespan

- 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.

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
BH Navigation Team Overview
Why have a BH Navigation Team?

- The team was developed in response to BH access barriers across CCO (Medicaid) regions in order to provide:
  - Navigation support for members
  - Enhanced, “high touch” support for members to clarify understanding about how to access to BH services with OHP and PCS (e.g., members believing they need a referral from PCP, belief depression is always treated inpatient, assuming all providers take OHP)
  - Simplify finding providers accepting new clients
  - Assistance for providers that maintain waitlists for members but are not meeting access timelines for several reasons (capacity, awareness of OAR, etc.)
Who is the BH Navigation Team?

• Team of 4 Member Support Specialists & 1 Clinician Team Lead
• Serving all PCS CCOs (Marion/Polk, Lane, Central Oregon, Gorge)
• Team is primarily member facing and provides linkage to OP behavioral health providers
• The team is part of Care Management does not perform usual Care Management functions (i.e., assistance with connection to services for SDOH needs or care coordination beyond finding a behavioral health provider)
  • The team will collaborate with Care Management for ongoing services or resources when the needs are identified and member consents
• BH Nav Team Phone Number: 458-240-8018
Who is the BH Navigation Team?

Becky Johnston, LCSW
Clinical Team Lead, Bend

- Jade Underwood (8/21/23)
  MSS, Bend

- Sarah Rost
  MSS, Springfield

- Erin Kerley
  MSS, Bend

- Jesseca Redd
  MSS, Medford
Who is the BH Navigation Team?

- The work will be identified by priorities:
  - **Priority 1**: Members calling in for support in accessing OP services (*and not already open to CM*)
  - **Priority 2**: Providers seeking care for members (i.e., PCP, BHC, housing case manager)
  - **Priority 3**: UM support – assist members who request out of network (OON) exceptions in connecting to providers who are in network (INN)
  - **Priority 4**: Waitlist easing – work with providers and members to find providers with availability
Priority 1: Members seeking care

- Members who call to BH Navigation Team line will be offered screening and support in accessing OP services
- Providers who do not wish to maintain waitlists will be offered the option to redirect members seeking care to the BH Navigation Team for help
- For calls during non-business times, voicemail will offer crisis line information
- Members who call to MSS line or CS and are not already open to CM services can be referred to the BH Nav team for support
Priority 2: Provider Referrals

• BH Navigation Team supports provider referrals including physicians, specialists, and other community providers (i.e., housing case manager) who want to help a member access care.

• Providers are encouraged to facilitate a warm-transfer to the BH Navigation Team to reduce barrier to outreach after need has been identified.

• When unable to facilitate a warm transfer, the BH Navigation Team will attempt to contact the member to complete the BH screening and assist with connecting the member to a provider with availability.
Priority 3: UM Support

• Members who are receiving services from an OON provider or are requesting services from an OON provider will be referred to the BH Navigation Team to assist with INN options.

• Team will coordinate with UM on INN options for the member.

• If no INN provider available to meet member’s needs, the BH Navigation Team will collaborate with UM regarding the potential for an OON exception.

• Continuity of care is a major consideration when determining whether a member should be transitioned from an OON provider.

• Quality of care concerns are another major consideration when considering transitioning a member from existing OON providers.

• Members open to Care Management will continue to be supported by the existing care coordinator.
Priority 4: Waitlist Management

• BH Providers may place members on waitlists, and current regulations require services to be provided within specific timeframes depending on member needs.

• If a timeframe cannot be met due to lack of capacity, the member must be placed on a waitlist and provided interim services within 72 hours.

• Using the weekly provider survey to determine who needs assistance with waitlist management, the Team will prioritize waitlist reduction through outreach calls to providers.

• BH provider are encouraged to refer members to the BH Navigation Team rather than add them to the waitlist, whenever possible.
Processes

• Outpatient behavioral health (excludes IOP and PHP)
• Assists with psychiatric medication management and psychological assessment referrals
• Members are screened for additional SDoH needs and connect to care management for additional resources and support.
• Members with higher level of care needs (i.e., IOP, PHP, residential, IP) are referred to CM for additional resources and support.
What the Team is

- The team is:
  - Systems navigators to help members connect with outpatient BH care
  - Primarily Member-facing
  - Consultants to colleagues to help a member locate a BH provider
    - Recommendations for open providers
    - Providing recommendations on specific providers for modalities or under-represented groups (i.e., providers treating LGBTQ+ or bilingual providers)
  - A support to BH providers to alleviate waitlist burden
  - An access point for members not engaged in existing CM services
  - A resource to community providers, including primary care
What the Team is not

• The Team is not:
  • Clinical consultants—Team has MSS with clinical support from TL.
  • Crisis management or a crisis referral resource for internal or external partners
  • An extension of CM in terms of intensive care coordination or referral to additional services (i.e., SDOH needs)
  • Care coordinators to access higher levels of care such as eating disorder programs, SAIP, SCIP, sub-acute or other CM oriented services
  • Discharge planners for members exiting IP settings, OSH or residential treatment programs
Questions?

Contact:

Becky Johnston, LCSW, Team Lead, BH Navigation Team

Phone: 208-333-1555, Email: Becky.Johnston@pacificsource.com

BH Navigation Team Line: 458-240-8018

Email: MedicaidBHNaviagation@pacificsource.com