THE 21ST CENTURY OREGON BEHAVIORAL HEALTH ACTION PLAN

Report and Recommendations from the Oregon Behavioral Health Collaborative

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Executive Summary:

There are seven recommendations summarized from the Oregon Behavioral Health Collaborative's work. They offer specifics to OHA to approve and implement a framework for behavioral health in primary care, schools, emergency departments, mental health centers, public safety, state hospital and other state services, tribal settings, and the judicial system. Each recommendation builds the vision set by the Collaborative for a 21st Century behavioral health system that creates a results-driven model to improve outcomes for Oregonians living with behavioral health issues and be financially sustainable for Oregon citizens. Each of these recommendations will be described in more detail below.

Recommendation 1: Create and implement site specific standards and workflows based upon the level of behavioral health need to maintain consistency for what Oregonians can expect for behavioral health in multiple settings (e.g. schools, prisons, primary care).

Recommendation 2: Develop site specific workforce standards and competencies, including credentialing for sites and clinicians, inclusive of the licensed and unlicensed workforce.

Recommendation 3: Advance the implementation and use of technology to coordinate care across the state and system.

Recommendation 4: Create a model of governance, a single point of local accountability, that allows for the control of dollars, shared responsibility for reaching quality, outcome, and cost targets, and prioritization of resources addressing behavioral health. This governance group may include counties, CCOs, providers, and others.

Recommendation 5: Create a minimum data set for behavioral health to be used by all facilities, clinics and clinicians across Oregon that prioritizes client level outcomes. The creation of this data set begins with a) identifying all existing and required measures and metrics and assessing which ones will drive the greatest system improvements, b) parsing measures down based upon stakeholder refinement, CCO, and payer agreement, c) establishing an evidence framework for measurement, and, d) creating an auditing process that can be used to benchmark and hold stakeholders accountable using state data systems.

Recommendation 6: Consolidate funding for behavioral and physical health through a single, integrated funding stream that aligns with the overall CCO global budget. This new fiscal model would be governed by the single point of local accountability created in Recommendation 4. Claims data would be integrated to enable population-based delivery of healthcare services. This will allow for whole-person capitation and more clearly organize risk bearing entities, creating the potential for registries to manage complex individuals through the full spectrum of services.

Recommendation 7: Create a learning collaborative/series of trainings on various topics to support this model including team based care, use of peer services, leveraging data for change, understanding HIPAA, and payment reform.

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Introduction: The Oregon Behavioral Health Action Plan was developed by the Behavioral Health Collaborative, a group convened to create a prioritized plan and series of recommendations that Oregon can pursue to create a behavioral health system for the 21st century. The Collaborative workgroups developed recommendations for systems change. The recommendations are in response to a model of care that creates a system for behavioral health identification, entry, and treatment.

Most states, while aggressively pursuing strategies to address mental health and substance use, are doing so on the back of new programs, payment models, and policy decisions.[1] Rarely do states have the opportunity to make transformative system changes that bring mental health and substance use seamlessly into the fabric of health care delivery. Oregon's plan for mental health and substance use is unique and progressive. It is driven by the goal to use best practices to create measureable outcomes for Oregonians served by the behavioral health system. In addition, this plan aims to assist integrating physical health, behavioral health, and oral health, a required component of achieving the Triple Aim.[2] It is also driven by local leadership. This key element is important – local leaders have coalesced around an idea that more can be done to address mental health and substance use in Oregon building off the successes of the Oregon Health Systems Transformation Work. Stakeholders from across Oregon helped define the problem, identify solutions, and create a vision for excellence and sustainability in Oregon's behavioral health system.

This is *Oregon's 21st Century Behavioral Health Action Plan*.

To create a system for Oregon around behavioral health, there must be a central, coordinated entity, governed by individuals and institutions that allows the system to interact in predictable and measurable ways.[3] Without this framework, programs, organizations, and delivery pieces do not fit together to provide an integrated effective and efficient experience for the person and their family. The fragmentation leads to an undesirable care experience for people in Oregon, costs more, and does not improve patient outcomes. While great strides have been made through Coordinated Care Organizations (CCO), the creation of a system for behavioral health has not yet matured to integrate effective and efficient care. This proposal and corresponding set of recommendations aim to bring a level of consistency and performance to behavioral health in Oregon while taking into account unique local attributes that may be based on community population, rurality, or other existing innovations.

In developing this next generation system, several guiding principles emerge that help ensure statewide transformation:

1) Standards for behavioral health provision across sites
2) Local governance that oversees delivery and financing
3) Transparency of process
4) Accountability to goals, including cost, outcomes, and other quality measures like access

A Behavioral Health Collaborative was convened at the request of the Oregon Health Authority Director, Lynne Saxton, with a charge to create a prioritized plan and series of recommendations that OHA could pursue to create a behavioral health system for the 21st system. The membership of the Collaborative was determined through an application process. Membership included an action-oriented, balanced and diverse group of leaders and stakeholders who were willing to work as a team and in outreach to their stakeholders to achieve system change. Members had expertise in the areas of mental health, addictions, prevention, wellness promotion, peer-to-peer services, tribal needs, education, housing,

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senior services, culturally specific health services, children and youth, consumers, the coordinated care model, tribal health care systems, corrections and public safety, judicial system, natural support systems (community, faith-based and other organizations supporting life success), disability services, and health disparities. The Collaborative met bi-monthly from July through December, 2016; attendance was required. A list of members is attached in Appendix XXXX.

After working together as a Collaborative, members were divided into six workgroups to develop recommendations for systems change. The topics of the six workgroups were: payment reform and financing, workforce, outcomes, waste, scope of responsibility, and data. Workgroups were provided with a set of guiding principles and expected deliverables. Each workgroup had 7-8 members and assigned facilitators, scribes, and subject matter experts from the Oregon Health Authority and the Farley Health Policy Center. Workgroups spent three Collaborative meetings working on their recommendations before sharing their work with the larger Collaborative. Workgroups provided feedback on the full set of recommendations through a series of questions focused to elicit any major concerns, significant missing items, and the recommendations most critical for success. As expected, there were redundancies and dependencies between the workgroup recommendations. This Behavioral Health Action Plan provides a set of recommendations based on a synthesis of the six work groups' recommendations to create a model of care that creates a system for behavioral health identification, entry, and treatment, and exit.

The model:

Oregon's next generation model for our behavioral health system starts with a recognition of the need for improvement.

Oregon is currently ranked XXX in the country for mental health;

Oregon has the XXXX highest suicide rate;

Oregon XXXX (more here)

In 2015, 792,000 Oregonians received a mental health service though commercial, Medicaid, and Medicare insurance. Of those, almost 220,000 were children and adolescents ages 0-17. An additional 20,000 individuals received service funded through state general funds and block grant dollars. This means that commercial and Medicare/Medicaid dollars fund services to roughly 97% of Oregonians receiving a MH service. Data source: Oregon Health Authority, All Payer All Claims, 2015.

At the heart of many of these issues is the recognition that fragmentation has led to challenges in Oregonians accessing behavioral health services. These problems culminate in the Collaborative acknowledging that:

Fragmented financing, delivery systems, and services fail to serve and exacerbate poor health outcomes for children, adolescents, adults, and older adults.

1. Access to behavioral health services, both specialty and general, do not meet the needs of all Oregonians in the right places at the right times in a culturally and linguistically specific manner.
2. Continuum of care, service integration, and coordination between the systems of criminal justice, human services, health, and education is insufficient, administratively complex, and lacking in strategies addressing prevention for all populations.

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3. Social determinants of health, including insufficient housing, employment, and transportation, create barriers to behavioral health resources that vary by community.

4. Oregon is not achieving the Triple Aim of lower cost, improved outcomes, and enhanced person experience through health system transformation despite investing $_____ of state payer dollars annually and $______of federal funds.

The strategies and innovation needed to improve the behavioral health system are not simple – in fact, decades of history and state and federal legislation have relegated behavioral health to its own system with unique and at times archaic rules and measures. Recognizing that new programs are insufficient to bring about true substantive change, a systems framework was proposed to highlight the multiple levels for change necessary for behavioral health. Only a system can deliver the Triple Aim outcomes Oregon needs for its citizens.

As seen in Figure 1, the conceptual framework provided a basis for the recommendations in this report. Specifically, there was a need to highlight the fact that policy, systems, and people are constantly interacting with each other, and that for true redesign of healthcare in Oregon, solutions need to go beyond creating new programs, and development of processes to integrate pieces of the system, collectively, to lead to transformation and results for Oregonians.

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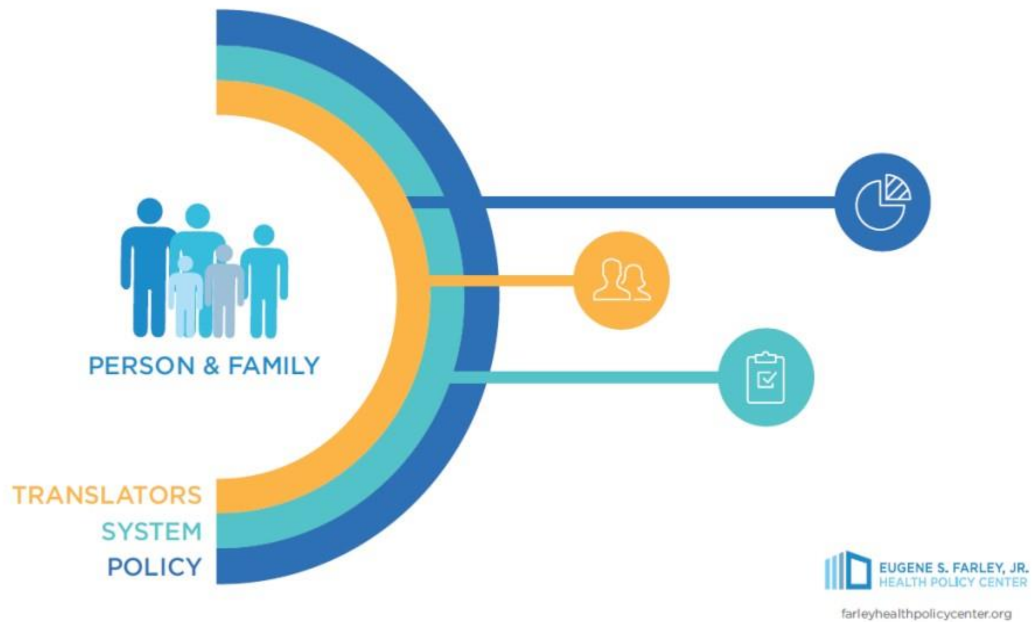

Figure 1: A conceptual framework for transforming healthcare

Throughout this report, there are various definitions that will be used to describe the reform efforts. For a full list of definitions please see Appendix XXXX

The process:

For most systems there exists a pattern of entry for behavioral health services. This process is described below. It is important to understand these steps as a new model will require the system to break the cycle of what has not worked and establish new pathways for what will work.

Trigger event – In every system there is a starting point for where a person may need help for behavioral health. Within this model, we call this the “trigger event” as there is something that happens that brings the person to a place where they are seeking behavioral health. This may be talking to their primary care clinician, being arrested, talking to a teacher, or even simple telling their neighbor.

Next step – After the “trigger event” the person ideally has something happen that leads to a next step. For example, if diagnosed in primary care, the next step may be treatment or a referral. However, in too many places across Oregon, this next step usually does not lead to an immediate intervention or access for the person. Rather the person cycles throughout the system possibly showing up for care in the wrong setting as their symptoms persist or get worse sometimes culminating in a crisis event.

Treatment/intervention – Within a system, it would be logical that after identifying a need, that the individual would receive some type of treatment or intervention. However, due to multiple reasons, including fragmentation of services, people often do not receive the care they need in a timely manner.

Coordination/communication – After receiving treatment, whoever was the treating clinician should be able to coordinate and communicate to the rest of the system to ensure that the person does not fall through the cracks. In addition, having mechanisms that allow for timely follow up with individuals involved in the treatment process helps increase the likelihood that a team based approach will be given to the person.

Continuity/follow up – Along the way, the person needs to have a consistent point of contact to allow for continuity. This helps the person navigate the system and not get lost along the way from identification to completion of treatment. Whoever or wherever this continuity is with, the important thing is that the person receiving care knows how to access the clinician and that the clinician and their team follows up when there is a gap in treatment.

Exit – Finally, there needs to be a mechanism that allows the person to exit the system. While some people will need to be involved in care longer, others may only need to have a brief intervention that helps alleviate their symptoms and give them skills to address future needs on their own. For many in behavioral health, there is not a clear entry or exit point for their treatment.

To accomplish a more seamless approach to behavioral health across all of Oregon, there are certain settings which will be prioritized for behavioral health a) identification; b) treatment; c) referral; and, d) coordination and follow up. While each community may have a different level of need across the settings, the main focus is to integrate a level of consistency for each Oregonian needing care.

The approach:

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To ensure a new model of care works across Oregon, there is a need to leverage local innovations like CCOs to help provide a structure for the following plan. As outlined below, much of the success of these recommendations will be left to local governance including CCOs, CMHPs, and other system participants after being given standards from OHA. These standards apply to multiple locations within a community and will be consistent across the state. In each location there will be a single entity or community board accountable for results, analysis, and financial performance.

Leveraging a model of community accountability, shared responsibility, and open entry points for behavioral health access, these recommendations aim to maximize local resources, leadership, and innovation to increase timely access for behavioral health services.

Consistent with many OHA initiatives, primary care will be a centerpiece of this approach. The reasons for this are many, but primarily revolve around the need for a person and their family to have a constant point of contact with the healthcare system.[4] As outlined below, primary care has made substantial progress in increasing its capacity to manage behavioral health needs and coordinate care.[5] This integration of care has shown great promise in Oregon as well as nationally.[6,7] While behavioral health integration with primary care should continue, for behavioral health to be more systematically addressed, there are other locations where behavioral health needs are seen and should be addressed. One of the reasons primary care integration has worked so well in Oregon is due to the standards that have been placed on the Patient-Centered Primary Care Home (PCPCH). Building on the foundation of the healthcare transformation plan, and other innovations like the PCPCH program, the application of these innovations to other settings (e.g. schools, prisons, primary care) ensures that attribution of patients to a PCPCH (or otherwise noted) will allow for consistency in who should be tracking and following up with the patient.

To better achieve clinical and financial outcomes there needs to be consistent protocols and expectations for behavioral health identification, coordination, and in some cases treatment across Oregon. This will help establish a consistent level of expectation for individuals receiving care, providers delivering care, and practice sites around behavioral health. However, and most important, this helps create a unifying approach to behavioral health that allows for no wrong entry door for a person with behavioral health needs.

Attribution for patients can be done one of two ways: a) plurality of visit (a predetermined number of visits within a calendar year); or b) auto enrollment by CCO at an agreed upon point in time (e.g. annual enrollment). The goal for this attribution model is to provide a consistent point of contact and accountability for the OHA client to a primary care clinician within a CCO. In addition, this approach will help mitigate any selection bias and denial of responsibility on the part of clinics and providers. The specifics of this mechanism are basic: once a site has the person attributed to them, they are responsible for their care, and bare the financial risk when they do not meet certain standards or quality measures. However, the financial risk for these people must be aligned to ensure adequate incentives for success as well as financial penalties for not adequately addressing behavioral health. In some cases, CMHPs may be the “home” for people, which will require additional attribution to those sites as well and fall into a similar financial risk category.

To move Oregon's behavioral health system forward, behavioral health services and staffing must be assessed, and in some cases, reallocated. Rather than increasing the system's ability to refer everyone to specialty behavioral health, individuals should be treated at any entry point, when possible, for example, at school, or have a warm hand-off to the appropriate setting – such as from a first responder who may leverage a mobile crisis team to primary care or specialty behavioral health. This will require that specific sites, like schools, are staffed with some level of behavioral health expertise. However, staffing alone is insufficient the site and the individual must be adequately positioned and trained to manage the individual and their behavioral health needs.

Figure 1: Creating no wrong door for behavioral health access in Oregon

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Consistent with a systems approach, each of the following recommendations should be seen as connected and not as isolated from one another. Each of these recommendations will require a reallocation of resources: financial, workforce, and technology. Funding will need to be available to specific sites to allow for the level of behavioral health provision as outlined throughout the recommendations.

While there are other examples of behavioral health innovation from different states, Oregon's model is unique in its systemic approach to truly integrate behavioral health across multiple services lines in a systematic way. --- ADD OTHER STATE EXAMPLES HERE

Recommendations:

There are seven recommendations summarized from the Oregon Behavioral Health Collaborative's work. They offer specifics to OHA to approve and implement a framework for behavioral health in primary care, schools, emergency departments, mental health centers, public safety, state hospital and other

state services, tribal settings, and the judicial system. Each recommendation builds the vision set by the Collaborative for a 21st Century behavioral health system that creates a results-driven model to improve outcomes for Oregonians living with behavioral health issues and be financially sustainable for Oregon citizens. Each of these recommendations will be described in more detail below.

Recommendation 1: Create and implement site specific standards and workflows based upon the level of behavioral health need to maintain consistency for what Oregonians can expect for behavioral health in multiple settings (e.g. schools, prisons, primary care).

Recommendation 2: Develop site specific workforce standards and competencies, including credentialing for sites and clinicians, inclusive of the licensed and unlicensed workforce.

Recommendation 3: Advance the implementation and use of technology to coordinate care across the state and system.

Recommendation 4: Create a model of governance, a single point of local accountability, that allows for the control of dollars, shared responsibility for reaching quality, outcome, and cost targets, and prioritization of resources addressing behavioral health. This governance group may include counties, CCOs, providers, and others.

Recommendation 5: Create a minimum data set for behavioral health to be used by all facilities, clinics and clinicians across Oregon that prioritizes client level outcomes. The creation of this data set begins with a) identifying all existing and required measures and metrics and assessing which ones will drive the greatest system improvements, b) parsing measures down based upon stakeholder refinement, CCO, and payer agreement, c) establishing an evidence framework for measurement, and, d) creating an auditing process that can be used to benchmark and hold stakeholders accountable using state data systems.

Recommendation 6: Consolidate funding for behavioral and physical health through a single, integrated funding stream that aligns with the overall CCO global budget. This new fiscal model would be governed by the single point of local accountability created in Recommendation 4. Claims data would be integrated to enable population-based delivery of healthcare services. This will allow for whole-person capitation and more clearly organize risk bearing entities, creating the potential for registries to manage complex individuals through the full spectrum of services.

Recommendation 7: Create a learning collaborative or series of trainings on various topics to support this model including topics on team based care, use of peer services, leveraging data for change, understanding HIPAA, and payment reform.

As described above, the Behavioral Health Collaborative consisted of a series of workgroups that focused on topics critical to address for a behavioral health system redesign. These groups were: workforce, outcomes, data, payment, scope of responsibility, and waste. Each workgroup made a series of recommendations along with sub-recommendations that were more detailed in support of the larger recommendation. The Eugene S. Farley, Jr. Health Policy Center, at the request of the OHA Director, took all the recommendations from each workgroup and consolidated them into seven

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recommendations. It is important to note, that each workgroups recommendations are still within this report and in support of these larger recommendations. Each recommendation has sub-recommendations that came from the Collaborative and workgroups.

Recommendation 1: Create and implement site specific standards and workflows based upon the level of behavioral health need to maintain consistency for what Oregonians can expect for behavioral health in multiple settings (e.g. schools, prisons, primary care).

The first recommendation is foundational. It is built off each workgroup's highlighting three dominate issues that need to be addressed: 1) challenges with timely access to behavioral health services; 2) lack of consistency around expectations and accountability for behavioral health, and, 3) clear standards for sites and the workforce. The main goal of this recommendations is to have OHA create a set of standards to ensure site, clinicians, and CCO consistency for behavioral health care.

The Behavioral Health Collaborative recommends standards for behavioral health care in each of the identified entry point, with primary care as the centerpiece.

As calculated for the CCO incentive measure, 87% of CCO members are enrolled in a recognized Patient Centered Primary Care Home (Data source: Oregon Health Authority, Office of Health Analytics, September 2016). With evidence of the PCPCH program meeting and exceeding the triple aim, the workgroup recommends building upon the success of the PCPCH program. Standards for each setting are adapted from the PCPCH standards.

To create a modern and cohesive behavioral health system, all entry points must be trauma informed, person-centered, and linguistically and culturally appropriate. This should be the lens through which all individuals are identified, treated, referred and followed-up with. Specifically, members of the Collaborative recommended that each behavioral health entry point be required to meet a set of core standards.

1a. Proposed Standards for Primary Care:

1a1. Entry point setting has a screening strategy for mental health, substance use, and developmental conditions and documents on-site and local referral resources and processes. *(see PCPCH Measure 3.C.0 for specifications – this is a must pass measure for all PCPCHs)*

1a2. Entry points setting reports that it routinely offers all of the following categories of services: Acute care for minor illnesses and injuries; Ongoing management of chronic diseases including coordination of care; Office-based procedures and diagnostic tests; Preventive services; Patient education and self-management support. *(see PCPCH measure 3.B.0 for specifications – this is a must pass measure for all PCPCHs.)*

1a3. Entry point setting has a cooperative referral process with primary care, specialty behavioral health, and developmental providers including a mechanism for co-management as needed or is co-located with primary care, specialty behavioral health, and developmental providers. *(see PCPCH measure 3.C.2 for specifications)*

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1a4. Entry point setting tracks referrals to consulting specialty providers ordered by its clinicians, including referral status and whether consultation results have been communicated to patients and/or caregivers and clinicians. *(see PCPCH measure 5.E.1 for specifications)*

1a5. Entry point settings offers and/or uses either providers who speak a consumer's and family's language at time of service in-person or telephonic trained interpreters to communicate with consumers and families in their language of choice. *(See PCPCH measure 6.A.0 for specifications– must pass measure for all PCPCHs)*

See PCPCH Standard 5.C – Complex Care Coordination also. There may be other ideas for core standards here.

1b. Proposed Standards for Specialty Behavioral Health:

1b1. Specialty behavioral health provider has a screening strategy for mental health, substance use, and developmental conditions and documents on-site and local referral resources and processes. *(see PCPCH Measure 3.C.0 for specifications – this is a must pass measure for all PCPCHs)*

1b2. Specialty behavioral health provider reports that it routinely offers all of the following categories of services: screening, assessment, and diagnosis including risk assessment, person-centered treatment planning, outpatient mental health services, targeted case management services and psychiatric rehabilitation. *(see CCBHC standard 3).*

1b3. Specialty behavioral health provider has a cooperative referral process with primary care providers, including a mechanism for co-management as needed or is co-located with primary care. *(see PCPCH measure 3.C.2 and CCBHC standard 4 for specifications)*

1b4. Specialty behavioral health provider tracks referrals to consulting specialty medical providers ordered by its clinicians, including referral status and whether consultation results have been communicated to patients and/or caregivers and clinicians. *(see PCPCH measure 5.E.1 for specifications)*

1b5. Specialty behavioral health provider offers and/or uses either providers who speak a consumer's and family's language at time of service in-person or telephonic trained interpreters to communicate with consumers and families in their language of choice. *(See PCPCH measure 6.A.0 for specifications– must pass measure for all PCPCHs)*

1c. Proposed Standards for Schools (School Based Health Centers must adhere to PCPCH standards above; schools with Behavioral Health Counselors will be required to meet these standards):

1c1. Schools have a screening strategy for mental health, substance use, and developmental conditions and documents on-site and local referral resources and processes. *(see PCPCH Measure 3.C.0 for specifications – this is a must pass measure for all PCPCHs)*

1c2. Schools report that it routinely offers all of the following categories of services: screening, assessment, and diagnosis including risk assessment, person-centered treatment planning, outpatient mental health services, targeted case management services, preventive services, patient education and self-management support. *(see PCPCH measure 3.B.0 for specifications – this is a must pass measure for all PCPCHs and CCBHC standard 3).*

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1c3. Schools have a cooperative referral process with primary care, specialty behavioral health and developmental providers including a mechanism for co-management as needed or is co-located with primary care. *(see PCPCH measure 3.C.2 for specifications)*

1c4. Schools track referrals to consulting specialty providers ordered by its clinicians, including referral status and whether consultation results have been communicated to patients and/or caregivers and clinicians. *(see PCPCH measure 5.E.1 for specifications)*

1c5. Schools offer and/or uses either providers who speak a consumer's and family's language at time of service in-person or telephonic trained interpreters to communicate with consumers and families in their language of choice. *(See PCPCH measure 6.A.0 for specifications– must pass measure for all PCPCHs)*

1d. Proposed Standards for Public Safety:

1d1. Public Safety agencies and employees, such as first responders (e.g. fire, police, emergency medical technicians) will complete a crisis assessment (per OAR 309-019-0150 obtain sufficient information, through face-to-face interview to determine a diagnosis and to plan individualized services and supports), and documents on-site and local referral resources and processes. *(see PCPCH Measure 3.C.0 for specifications – this is a must pass measure for all PCPCHs)* First responders will engage the local Mobile Crisis Services immediately upon identification of a behavioral health crisis (per OAR 309-019-0150 either an actual or perceived urgent or emergent situation that occurs when an individual's stability or functioning is disrupted and there is an immediate need to resolve the situation to prevent a serious deterioration in the individual's mental or physical health or to prevent referral to a significantly higher level of care). *(See Oregon's Performance Plan for Mental Health Services for Adults with Serious and Persistent Mental Illness).*

1d2. Public safety agencies will have a cooperative referral process with primary care and specialty behavioral health. *(see PCPCH measure 3.C.2 for specifications)*

1d3. Public safety agencies will offer and/or uses either providers who speak a consumer's and family's language at time of service in-person or telephonic trained interpreters to communicate with consumers and families in their language of choice. *(See PCPCH measure 6.A.0 for specifications– must pass measure for all PCPCHs)*

1e. Proposed Standards for Emergency Departments:

1e1. Emergency Departments have a screening strategy for mental health, substance use, and developmental conditions and documents on-site and local referral resources and processes. *(see PCPCH Measure 3.C.0 for specifications – this is a must pass measure for all PCPCHs)*

1e2. Emergency Departments have a cooperative referral process with primary care and specialty behavioral health. *(see PCPCH measure 3.C.2 for specifications)*

1e3. Emergency Departments notify primary care and specialty providers that their patient has been seen in the Emergency Department and send appropriate documentation of the visit.

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Recommendation 2: Develop site specific workforce standards and competencies, including credentialing for sites and clinicians, inclusive of the licensed and unlicensed workforce.

Workforce Standards and Competencies

2a. The Collaborative recommends that each entry point for behavioral health be required to meet a set of core standards to identify, treat, refer and manage referrals and coordinate care for individuals. Once site standards are set, much of this comes down to the individual behavioral health workforce member providing the treatment. Behavioral health clinical staff in each entry point will be required to meet education and licensure requirements in addition to the non-clinical workforce (e.g. peer support services).

Workforce Assessment.

2b. There needs to be a more thorough approach to assessing the behavioral health workforce, licensed and unlicensed, throughout the state. In order to best establish how many are needed, where, and at what level, the state is encouraged to perform a needs based analysis, across multiple settings, to assess how many behavioral health are needed. Based upon the findings, new recommendations and strategies may be invested in recruitment and retention. This workforce assessment needs to connect with OHIT Provider Directory plans.

2c. Current licensed workforce development

> **2c1.** Recommend a set of competencies for licensed behavioral health providers working in non-traditional settings (e.g., primary care, schools, police departments, emergency departments, correctional facilities)
>
> *One of two processes need to occur for the creation of these competencies:*
>
> **2c1a.** Charge a stakeholder workgroup to identify and endorse a core set of competencies for team-based care (Consistent with OHPB's Healthcare Workforce Committee/Behavioral Health Integration Subcommittee). If this is done, the recommendations would be to apply a method to ensure consensus for the competencies in each setting.
>
> **2c1b.** Endorse existing competencies for behavioral health in primary care (e.g. http://farleyhealthpolicycenter.org/wp-content/uploads/2016/02/Core-Competencies-for-Behavioral-Health-Providers-Working-in-Primary-Care.pdf), and modify to other setting similar to what will be done with site specific standards.

2d. Peer support specialist and community health workers. The Collaborative recommends increasing the use of peer support specialists (PSSs) and other community health workers (CHWs) as an evidence-based and cost-effective strategy to improving workforce shortages and improving outcomes for patients. Critical to success is the recommendation that PSSs and CHWs are paid a living wage.

> **2d1**. Develop system standards and expectations (from by OHA) founded on evidence-based practices as well as tribal-based practices (HB 3110) and monitored for effective and appropriate use of employing peer services.

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2d2. Set goals for the number of peer support specialists employed within a CCO region in order to increase use, graduated over a period of years and based on regional population.

2d3. Include in the OHA-CCO contract mandated language, of a guaranteed service benefit of “peer support services” to be available and offered to all individuals who are receiving behavioral health services treatment in Oregon’s system.

2d4. Establish a standardized training model for all peer-support specialist training that includes a minimum number of supervised peer training hours/practicum, use of a mentor, and a baseline set of competencies for knowledge and skills with internship experiences before certification.

2d5. Recommend improvements to the licensing and certification process to maximize the appropriate use of the unlicensed workforce (e.g. CHWs and PSSs) and establish a certification or licensure program for becoming a PSS/CHW supervisor.

2d6: Require ongoing training of PSSs / CHWs in an area specific to their caseload and specialization (e.g., traumatic brain injury or ACEs) as CEU prerequisites for re-certification for every cycle.

2d7: Establish or utilize existing resources at the state that provides a targeted resource and prevention-focused team to offer free, consistent training in core skills (including “train the trainer” programs) and ongoing assistance to build the workforce.

2e Future workforce development

2e1. Work with universities to ensure the educational content includes classes/practicum experiences relevant to behavioral health system overall (such as the public sector) and not just private practice:

- community based services and safety net role in the community
- social determinants of health, safety net care, etc.

2f. Prevention and public health. Collaborate prevention services administration across OHA.

2g. To address potential shortages and improve retention.

Retention of skilled employees is critical, as experience leads to higher quality of care and better outcomes for individual clients and the system as a whole, in addition to avoiding the costs associated with high turnover

- **2g1**. Build/utilize a central, state-wide recruiting effort that focuses on ensuring a better fit between the provider and the recruiting community
- **2g2**. Provide grants to providers interested in certification for early childhood intervention
- **2g3**. Offer bonus payments for sustainability (X amount after 5 years, 10 years, etc.)
- **2g4**. Offer loan repayment incentive for specific behavioral health needs of community
- **2g5**. Salary and compensation must be addressed to attract and retain skilled workers
- **2g6**. Financial compensation must not be the only metric addressed to increase retention; a thorough workforce plan must address

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- Supervision
    - Support
    - Ongoing training
    - Other benefits (i.e. flexible hours/alternative schedules)
- **2g7**. Provide trauma-informed work environment, promote professional self-care, more reasonable caseload expectations, simplify records management systems
- **2g8**. Develop career pathways for direct care staff to progress into more highly qualified positions to retain their experience in the field
- **2g9**. Ensure that a culturally appropriate workforce is available, especially for Latino and African-American populations which have less implemented services than other cultural sectors.

Recommendation 3: Advance the implementation and use of technology to coordinate care across the state and system.

Technology infrastructure and tools are needed to support the objectives of behavioral health integration. There are various ways technology needs to be implemented and used within behavioral health in order to support its transformation. In order to begin to hold local sites accountable, there needs to be the adequate infrastructure that can track patients throughout their region or community. For example, if a patient is seen in one setting (e.g. emergency department) then that setting should be in contact with the follow up setting (e.g. primary care). Much of this should happen with a good standard of care; however, it can be challenging even for the most sophisticated of sites to know who is indeed responsible for that patient.

Technology needs to be used to facilitate workflows such as referrals and care coordination; obtain screening results to relevant/treating providers; provide access to provider information for appropriate referrals; track patients and their progress; and to collect, track, analyze, and report data.

- HIE Pilot and 42 CFR Part 2: federal ONC grant (with OHA, and JHIE as the subrecipient) focusing on 42 CFR Part 2 data and supporting a common consent model and appropriate electronic sharing of that data within a health information exchange
    - For additional info, see page 4 of OHIT newsletter: http://www.oregon.gov/oha/OHIT/Documents/OHA%202039%20exchange-newsletter-July-2016.pdf)
    - Maintain support for sharing of addiction treatment information in compliance with 42CFR Pt 2.
    - Bridging tools like EDIE and PreManage to connect critical BH teams (e.g., ACT teams) to emergency department settings.
- HIT and BH Scan: a survey/scan coming up to assess the BH HIT environment in Oregon - looking to identify what technology (EHRs, health information exchange) is being used or considered by Oregon BH agencies, barriers, etc.
- HIT tools for BH organizations: We have a few efforts here:
    - working to develop an Oregon program to leverage new federal 90% funding match for bringing Medicaid providers (including BH) onto health information exchanges
    - Funding for/adoption by most ACT teams and several BH agencies of EDIE/PreManage tools to bring real-time hospital event data to care teams to ensure coordination and follow up

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- participation by some BH agencies in regional health information exchanges (including those funded under the ONC grant)
  - engaging the Oregon State Hospital, corrections, counties and others in HIT/HIE efforts
- BH Policy/strategy and HIT:
  - Including BH in our HIT Oversight Council (HITOC) priority, including BH representatives on our committees, etc.
  - supporting the BH Collaborative recommendations with information about HIT opportunities and gaps for the final recommendations
- BH entities and EHRs: participation in discussions with AOCMHP and OCHIN and several CMHPs (and potentially other health systems using Epic) on how/whether the Epic electronic health record can appropriately support BH data given 42 CFR Part 2
- Optimize EHRs capacity to report and manage clinical quality measures

Additionally,

- Payment models need to recognize investments in technology.
- Consider requiring that CCOs make funding resources available for technology.
- Provide training on effective use of technology/data.

Recommendation 4: Create a model of governance, a single point of local accountability, that allows for the control of dollars, shared responsibility for reaching quality, outcome, and cost targets, and prioritization of resources addressing behavioral health. This governance group may include counties, CCOs, providers, and others.

The Collaborative's payment reform workgroup offered up a framework for local governance, which is useful for this recommendation. Specifically, the payment reform workgroup described the need to promote regional collaboration to advance payment reform in support of behavioral health. These regional approaches to collaboration would assist in local communities assessing and addressing their community's needs, remaining mindful where statewide solutions might be beneficial (e.g. specialty services and populations such as acute and subacute facilities for children).

- Explore the idea of regional collaboration to support health transformation goals at the local level with the overall intent to transform healthcare in the region and use integrated and coordinated healthcare systems to improve health; increase quality, reliability, availability, and continuity of care; provide a way to purchase services differently; and reduce the cost of care through elimination of duplicative or unnecessary services.

- Regional collaborations would not create a new entity or burdensome administrative structure, but provide a process to allow current entities to better coordinate and collaborate. One mechanism for regional collaboration could be through a local council structure that determines regional behavioral health and health-related social needs and priorities and provides oversight to address those needs.

- The collaboration would be a single point of local accountability with financial responsibility for outcomes and provision of essential services. These benchmarks and standards would be set by OHA to help hold the community accountable.

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- Regional collaborations would coordinate activities across sectors, such as assessment and planning of outcomes; jointly implement new health related projects; and advise state agencies on how to best address health needs within their geographic area.

- Members of the collaboration should include, at a minimum, representatives from CCOs, county agencies, community mental health programs, the educational system, community based organizations, patients and families, juvenile/criminal justice system and, in later stages, commercial health plans.

- Regional priorities would be based on findings and recommendations from the Community Health Assessment, the Local Plan for Behavioral Health Services, the Behavioral Health Mapping Tool, and other information on regional needs.

- The first phase of regional collaboration would focus on developing the infrastructure and partnerships necessary to set strategic direction within individual communities.

Currently, CCOs are accountable for treatment, identification, referral, and follow-up for its members. This new model will require additional partnerships within the community to insure that all settings are meeting the above standards and competencies. While specifics of what this look like are not in place, formal agreements between the CCO and local government for settings in which the CCO does not have authority. OHA could be instrumental in creating these.

The entity taking on the governance role should also be responsible for supporting/ensuring that needed technology/data infrastructure is in place, which could include providing funding, data use agreements, etc.

Successful implementation of this model will require a collaborative governance structure across systems. This workgroup recommends a system that includes the following representatives: payer, primary care, specialty behavioral health, schools, first responders, emergency department, corrections, and consumers.

The regional collaborations governance group will receive quarterly data updates on specific measures for behavioral health within the CCO. In addition, more details on non-Medicaid individuals as well as those not covered by Medicaid would need to be clarified for these data and within this approach.

Recommendation 5: Create a minimum data set for behavioral health that is to be used by all facilities, clinics and clinicians across Oregon that prioritizes client level outcomes. The creation of this data set begins with a) identifying all existing measures and metrics including those required and assess which ones will drive the greatest system improvements, b) parse these measures down based upon stakeholder refinement, CCO, and payer agreement, c) establish an evidence framework for measurement, and, d) create an auditing process that can be used to benchmark and hold stakeholders accountable

Outcomes and measurement

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The success of the proposed model hinges on having the ability to consistently assess what's working and what's not in each community. In addition, being able to measure, at a client level, what is actually improving is critical. Throughout the Collaborative, one of the main areas that required substantial attention was surrounding how we can measure outcomes. Said differently, how can OHA and the local governance assess its investment, success of its contracts, based upon specific data like client level outcomes. Like many states, Oregon has a plethora of measures being used for a myriad of reasons. While some of these measures are tied directly to federal funding, many of these measures may have come with specific state initiatives. However, and this is important to note, there are different layers here for measurement. For example, what the OHA may need to collect data on may be different than the CCO. These different layers and measures at the different are important to delineate, and will be important to clarify.

5a. Develop a parsimonious, minimum data set that can be used consistently across facilities, clinics, and providers and reflects all individuals and populations and their unique outcomes.

> **5a1.** After reviewing more than 275 measures from existing measure sets, including SAMHSA's National Behavioral Health Quality Framework, the Behavioral Health Collaborative Outcomes workgroup has identified a list of existing metrics they believe will drive the greatest system improvements and lead to the best outcomes. These metrics may be used as a preliminary list for further public discussion and vetting (see Appendix XXXX). A public process for finalizing the behavioral health system measures should be established in parallel to the existing systems used for the selection of incentive measures for CCOs and hospitals. This includes a legislatively-mandated committee, charged with identifying outcome measures and benchmarks for the behavioral health system. In addition to measure alignment across and between existing measure sets (to ease provider and system measurement burden), alignment between the behavioral health system and other systems, as well as ongoing coordination across the behavioral health system, is necessary.

5b. Develop a stratification process for different populations and their unique outcomes (e.g., children and older adults) for the behavioral health system. Examples of variables to be included within the stratification include, but are not limited to: race, ethnicity, language, age, gender, disability, geography, tribal membership, severity of mental illness, co-morbidity, interaction with other systems (e.g., child welfare, criminal justice), payer type, and insurance status. While some measures have stratification built in, additional stratification may be beneficial for better targeting and population management. For example, the follow-up after hospitalization for mental illness measure looks at health plan members age six and up, who have been hospitalized for a mental health related reason. This measure can be further stratified by adding adults (18+) and children (6-17 years of age). The basic stratification process has to be standardized for comparisons across CCOs, and other settings, and it would be allowable to create substratifications

5c. Creating a framework will be essential in organizing the measurement and outcome efforts for the state. This framework will need to be flexible, as any identified standards and practices cannot be so prescriptive that they stifle innovation. Contracted organizations, providers and communities must have sufficient flexibility to look at new evidence and emerging practices, and work creatively to improve outcomes. Additionally, not all standards and practices are applicable for all populations, or work in all settings, and adaptation may be needed. This framework needs to be integrated with outcome and measurement tracking for the broader healthcare system.

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There are at least two potential models that could be borrowed from or adapted to establish this framework. In addition to proposing client-level outcomes, system-level outcomes must be established, too.

1. Develop a subgroup under the existing Health Evidence Review Commission (HERC), that would be dedicated to reviewing behavioral health evidence and promoting evidence-based behavioral health practice statewide through similar reviews, ensuring equal or greater focus on social determinants of health. This behavioral health evidence review group must be payer-agnostic; while there are key implications for Medicaid and other state-funded services, commercial payers should be included.

> Health Evidence Review Commission (HERC) – the Health Evidence Review Commission, or HERC, is charged with reviewing medical evidence in order to prioritize health spending for Medicaid, and to promote evidence-based medical practice statewide through comparative effectiveness reports, including coverage guidance, health technology assessments, and evidence-based guidelines.[1] HERC uses a transparent public process to ensure that its decisions are made in the best interest of patients and taxpayers while considering input from providers and members of the public, including those affected by the conditions discussed. HERC is also working on guidance for multi-sectoral interventions, or those strategies for population health management on topics such as obesity, chronic pain, tobacco use, etc for services not traditionally billed as medical services. This guidance includes strategies that may be outside the traditional doctor/patient relationship.

2. Or, assess whether there are structures or components of the existing Patient-Centered Primary Care Home Standards that could be expanded to apply to behavioral health evidence-based practices more broadly.

> Patient-Centered Primary Care Home Standards – The Patient Centered Primary Care Home (PCPCH) program has established standards that must be met as part of recognition. Similar standards for behavioral health homes have been discussed in Oregon, both as part of the PCPCH program and the CCBHC pilot.

5d. Multiple levels of accountability are needed as part of a robust measurement framework. This includes the state holding contractors accountable, health plans and/or contracted organizations holding their subcontractors and/or provider networks accountable, etc. Of note, this recommendation is a bit beyond Recommendation 2 above, which describes a single point of accountability – this recommendation is specific to measurement and highlights the importance of measuring at different levels within and across the system and the rich opportunities for quality improvement.

Other parts of the system, including cross sectoral partners, need to be included in the accountability system. For example, CCOs are currently held accountable for ensuring that their members receive follow-up visits within seven days of being discharged from the hospital for mental health reasons; hospitals are also held accountable for the same measure to ensure coordination on both sides. Ideally, this model would be expanded across the board to include education, corrections, and other settings in which behavioral health care occurs.

Although additional discussion is needed to identify accountability mechanisms for commercial insurers, the workgroup is strongly in agreement that the auditing process should account for all Oregonians receiving behavioral health care.

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In addition to multiple levels of accountability, multiple mechanisms are also needed. The workgroup recommends a diverse portfolio of accountability mechanisms that can be implemented across the system, including, but not limited to:

Transparency – measures and outcomes should be publicly reported, and organizations should be identified in the reporting, at minimum, to build accountability throughout the system.
Financial incentives – regardless of the end structure for the behavioral health system redesign, the organization(s) that the state contracts with should be held accountable through incentive metrics and other financial structures beyond pay-for-performance. These structures could include value-based purchasing, shared savings, etc.

Creating a public process in parallel to the existing systems for the selection of incentive measures for CCOs and hospitals for the behavioral health system is needed. This includes a legislatively-mandated committee, charged with identifying outcome measures and benchmarks for the behavioral health system. In addition, there should be additional requirements that bring incentives down to the provider and community level to ensure that they are working towards meaningful outcomes that are closely connected with client or member priorities. This could include contract language requiring that any financial incentives earned are reciprocally distributed to providers, or a required reinvestment structure to ensure that contracted organizations are working closely with their communities. Collaboration with providers and practices will be needed to create buy-in for any implementation activities.

Recommendation 6: Consolidate funding for behavioral and physical health through a single, integrated funding stream that aligns with the overall CCO global budget. This new fiscal model would be governed by the single point of local accountability created in Recommendation 4. Claims data would be integrated to enable population-based delivery of healthcare services. This will allow for whole-person capitation and more clearly organize risk bearing entities, creating the potential for registries to manage complex individuals through the full spectrum of services.

The evidence remains clear that segregated payment systems make it challenging to integrate behavioral health on the ground.[8-10] Truly no other recommendation for healthcare transformation is as challenging and politically laden as changing how care is paid for, especially behavioral health. The payment reform workgroup outlined a series of recommendations to allow for a more thoughtful movement to value based payments for behavioral health; however, consistent with all recommendations in this report, a central theme remains the need to integrate and simplify what communities are doing.

The overarching approach for this recommendation, spelled out in more detail below, is that consolidating resources will allow for more flexibility for behavioral health delivery, shared accountability, and increased community responsibility. Divisions divide when it comes to payment and delivery therefore the main thrust of this recommendation is increase the opportunity for behavioral health to be addressed in a multitude of settings while simultaneously mitigating financial barriers.

There are four main themes from this recommendation:

Maximize and leverage funding

Ensure funding adequacy

Alternative payment methodologies/value-based payments

Risk sharing with Oregon State Hospital and other service locations

Each of these themes, and specific action items, will be outlined below under their relative heading. Overall, for the financing of behavioral health, the various recommendations assume that a phased approach to payment and finance will be used that encourages, facilitates, and tests innovative models. Since there is not likely one size that will fit all for payment reform, principles should guide the development of a payment and finance system for behavioral health.

Overarching principles are:

- Service recipients should have consistent services across the state, regardless of payer, with continuity of care between regions and similar levels of services regardless of region.
- Build on the successes of Health System Transformation.
- Reduce system inefficiencies and administrative overhead.
- Coordinate and align with existing initiatives including the Coordinated Care Model (CCM), 1115 waiver, Primary Care Payment Reform Collaborative (SB 231) and CPC+.
- Ensure the funding, financing and payment system is invisible to service recipients and providers. If this is not possible, OHA should evaluate the elimination of carve outs as these have been consistently identified as a barrier for integrating behavioral health.
- Maximize existing opportunities for using flexible funds to create additional flexibility and incentivize prevention and health promotion.
- Support the needs of patients with complex physical and behavioral health needs, including social determinants of health.
- Support integration of primary care and behavioral health across multiple settings, building system capacity and the team-based care model

Bringing public and private payers and other stakeholders together within a community and holding them jointly accountable is a critical element to ensure change for behavioral health services. For the purpose of this recommendation, the need to build off CCOs work with local governance is recommended as outlined in recommendation two. Consistent with language used by payment workgroup, “regional collaborations” are proposed to be the oversight or governance for each community. The proposed regional collaboration would be tasked with prioritizing resources to ensure that behavioral health services, across the identified geographical boundaries overseen by the regional entity, are adequate and sufficient. The payment reform workgroup recommended that this be done through a series of maximizing and leveraging funding activities.

Recommendation 6a: Maximize and leverage funding

- Maximize and leverage funding including, but not limited to state, county, CCO and other funds as possible to maximize the Medicaid match.

- Offer incentives to encourage pilots to begin to aggregate/braid funding, wherever possible, and determine the feasibility of broader system funding integration.

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In addition, with some fears around not adequately funding behavioral health when the financial resources are consolidated, another major consideration was to ensure funding adequacy for behavioral health.

Recommendation 6b: Ensure funding adequacy

- Increase the investment in the behavioral health system (or, at a minimum, do not reduce existing levels of funding).
- Shifts in financing and funding should avoid harming individuals, families and communities.
- Ensure that the level of investment is sufficient to attract and retain needed behavioral health human resources.
- Assess cost structures of non-profit and public providers of behavioral health services for financial sustainability and viability.
- Cost allocation plans must be sufficient to support recruitment and retention of a highly qualified and skilled workforce and promote the traditional health workforce; facilities and infrastructure; and reserves to participate in value-based payment.
- Funding models should take into consideration regional differences.

Recommendation 6c: Support payment reform – Alternative payment methodologies/value-based payments

- Focus on total cost of care, shifting investments and funding to accelerate achieving the triple aim.
- Payment methodologies should be value-based, incentivizing integration, access, penetration and continuity of care across a continuum of medically necessary services, as well as services and supports that meet the social determinants of health needs for an entire regional population.
- Align financial, clinical and other health outcome metrics, including the hospital metric pool.
- Facilitate the right care at the right time by creating incentives for the system to provide services where people need them -- in schools, primary care, judicial system, etc. (i.e. bring payments and finance systems to the people, not people to the system).
- Create incentives to support prevention, early intervention and positively impact environmental and social indicators of health including, but not limited to adverse childhood events (ACEs).
- Implement value-based payment reform strategies that move towards improved performance and quality, increased provider risk, and population based payment approaches that support a full continuum of services and behavioral health integration.

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- Performance metrics should incentive value and integration and drive towards improved outcomes, as represented in the CMS payment framework from the Health Care Payment Learning and Action Network.

Recommendation 6d: Risk sharing with Oregon State Hospital and other service locations
The Oregon State Hospital is a critical component of the overall system of care. In order to facilitate an integrated system of care across community and hospital placement, shared risk should be considered and OSH episodes should be seen as time-limited and part of a continuum of services.

Ideas for shared risk include:

- A phased approach to shared risk based on outcomes and financial metrics should be developed beginning with the OSH and spread to other service locations (e.g. waitlist and inpatient care for children and adolescents).

- Savings to general funds should be leveraged to improve services.

- Shared risk for OSH admissions (civil and .370) between counties (non-CCO residents), CCOs (for members) and OSH. This would require transfer of funds to counties and CCOs with payment agreements in place and would be modeled after inpatient payments for local hospitals. If CMHPs or CCOs have a community-based option available and OSH chooses to not discharge, OSH would be liable for the cost of the stay.
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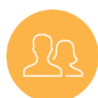
- Shared risk for outcomes to meet DOJ Performance Plan objectives. CMHPs, CCOs and OHA work collaboratively to define strategies for meeting measures and leveraging local resources and existing initiatives.

Recommendation 6e. Establish cost-based reimbursement for behavioral health providers, especially for residential providers.

Recommendation 6f. Create a functional data system for both Medicaid and the minimum data set as well as non-Medicaid services (MOTS). While a great deal of the recommendations in the Behavioral Health Action Plan are aimed at Medicaid, it is important to also address the non-Medicaid data and payment system in order to assist with more widespread adoption. To this end, having a data system on the commercial claims side would allow for increased support and outcomes for clients who are both Medicaid and non-Medicaid eligible. Having such a functional data system would better allow for OHA and CCOs to draw more accurate conclusions around what’s working, for whom, and at what cost.



Recommendation 7: Create a learning collaborative or series of trainings on various topics from this model including team based care, use of peer services, leveraging data for change, understanding HIPAA, and payment reform.

Many of the efforts described throughout this Behavioral Health Action Plan lean heavily on the ability for people and systems to change. However, changing culture is difficult, and should rely on a larger community who can work towards common goals together. It seems that in order to tie together

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consistently the recommendations, an ongoing learning platform should be set up that can help with the details of such unique issues like workforce competencies and scale all the way up to creating a learning mechanism for CCOs on how best to implement the model.

For the purpose of organizing the recommendations in line with the workgroups, each workgroups ongoing training needs are outlined below under the workgroup headings.

Competency and Training Issues: These are issues both at the initial training stage (within the training program itself), as well as the ongoing training needs of practicing providers. Some of the largest challenges include:

- Training for providers (physical, mental, behavioral, social workers, etc.) to work in team-based settings, or non-medical settings; this is especially important for proper treatment of co-occurring disorders
- Curriculum models that train students for private-practice settings
- Training for physicians in Medically Assisted Treatment
- Peer support specialist competency and training issues
    - Inconsistent initial orientation and onboarding
    - Inconsistent training programs (no “baseline” competency)
    - Inconsistent mentorship and peer training hour requirements
    - Shortage of peer supervisors; expensive to be trained as a supervisor

Recommendation 7.1. Work with universities to ensure the educational content includes classes/practicum experiences relevant to behavioral health system overall (such as the public sector) and not just private practice:

- community based services and safety net role in the community
- social determinants of health, safety net care, etc.

The outcome of this work will be a reduction of redundancies in the system (read waste). However, the Waste workgroup also had several important recommendations that align with the need for ongoing training.

- Provide ongoing technical assistance for clinicians to improve access, including lower patient no-show rates and open access. This would be ideally a state job.
- Standardize training for behavioral health workforce.
- Require standardized training in behavioral health information sharing for all persons responsible for transferring patient health record and risk management personnel

Recommendation 7.2. Launch a learning collaborative for CCOs and/or providers that shares effective and appropriate methods for hiring, retaining, and using community health workers and peer support specialists in the most effective way possible.

Summary/conclusion:

In summary, the state of Oregon has done something quite unique – it has brought together leaders to make concrete recommendations on creating a true system for behavioral health. Building off many of the innovations that have shown promise (e.g. CCOs), Oregon and the OHA have within this report a framework for a new model for addressing behavioral health at a population level. Specifically

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accounting for standards, payment reform, workforce, measures, and ongoing learning opportunities, Oregon can transform multiple areas of behavioral health need simultaneously.

Now is the time for change.

Beginning with a vision and a model for behavioral health transformation, this Behavioral Health Action Plan outlines specific recommendations to achieve more seamless population based care for mental health and substance use.

Other states interested in behavioral health reform could learn a lesson from Oregon in both the vision, the framework, and the method to achieve this level of change and transformation.

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Appendix XXX Definitions

This report uses definitions from the Agency for Healthcare Research and Quality (AHRQ) Lexicon for Behavioral Health and Primary Care Integration.[11] These definitions are provided below to ensure consistency across Collaborative participants, readers, and various stakeholders.

Integrated Behavioral Health. The care that results from a practice team of primary care and behavioral health clinicians, working together with patients and families, using a systematic and cost-effective approach to provide patient-centered care for a defined population. This care may address mental health, substance abuse conditions, health behaviors (including their contribution to chronic medical illnesses), life stressors and crises, stress-related physical symptoms, and ineffective patterns of healthcare utilization.

Mental Health Care. Broad array of services and treatments to help people with mental illnesses and those at particular risk of developing them—to suffer less emotional pain and disability and live healthier, longer, more productive lives. Although often defined separately, substance abuse services are regarded in many communities as part of mental health care.

Chemical Dependency/Substance Use Care. Services, treatments, and support to help people with addictions and substance abuse problems of all kinds suffer less emotional pain, family and vocational disturbance, and physical risks and live healthier, longer, more productive lives. Also included under "mental health care."

Behavioral Health Care. A very broad category often used as an umbrella term for care that addresses behavioral problems bearing on health, including patient activation and health behaviors, mental health conditions, substance use, and other behaviors that relate to health. In this sense, behavioral healthcare is the job of all kinds of care settings, and is done by clinicians and health coaches of various disciplines or training, including but not limited to mental health professionals. It is a competency of clinics, not only of individuals.

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