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# Behavioral Health Collaborative Report



Oregon  
Health  
Authority



OFFICE OF THE DIRECTOR

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## Director's Message

Every day Oregonians experience the “behavioral health system” with a mixture of hope, reluctance, disappointment and success. Every one of us has a friend, a loved one, or a neighbor who has experienced a mental health issue or substance use disorder – and many of us experience these challenges ourselves. While we have made significant progress in Oregon in recent years, and have led the nation in innovation in some important ways, we have much work to do in our transformation of our behavioral health system. And we know we must serve Oregonians better.

That is why during the summer of 2016, the Oregon Health Authority (OHA) created the Behavioral Health Collaborative (BHC) to develop recommendations that would build a 21<sup>st</sup> century behavioral health system in Oregon. The BHC is made up of nearly 50 Oregonians from peer support services, advocates, counties, behavioral health providers, courts, DHS, Oregon's coordinated care organizations, hospitals, education, law enforcement, a representative from an Oregon Tribe, and an urban Indian organization came together over the past eight months to develop the recommendations included in this report.

The recommendations from the BHC are designed to move Oregon towards fully integrating the behavioral health system with physical and oral healthcare. The recommendations provide equitable behavioral health services for all Oregonians, and removes the silos that have long hindered an efficient behavioral health system. The recommendations provide concrete direction for governance, finance, standards of care, competencies, workforce, data and technology.

OHA understands that a key component of a successful behavioral health system is one that fully invests in peer delivered services. OHA has invested in peer delivered services over the past biennium with 236%. We know that peer delivered services are effective and promote recovery and OHA is committed to continue to expand these services across the state.

Honoring the government-to-government relationship with our Oregon sovereign nations, this Behavioral Health Collaborative Report does not apply to tribal governments. OHA included a representative from an Oregon Tribe and an urban Indian health organization as part of the collaborative in hopes of better understanding tribal engagement in Oregon's behavioral health system. This did not replace consultation with each of the nine tribes and further emphasized the need to engage more directly via government-to-government consultation.

## Director's Message

OHA recognizes that Oregon's American Indian and Alaska Native population experience a disproportionate amount of mental health and substance abuse problems, and that tribal governments and an urban Indian health organization are the appropriate vehicle and resource to address the behavioral health needs of Indian people. OHA understands that the Tribes and the state's Urban Indian Health Program work very hard to support their tribal people in the areas of behavioral health, and are an important provider for services to tribal people.

Tribal representatives will be welcomed and encouraged to participate in regional governance of behavioral health organizations resulting from the BHC Report—this would be in addition to recommendations resulting from the on-going tribal work. OHA is committed to ensuring that through the government-to-government consultation process, there is no diminishment of current funding for services to the tribes for behavioral health and to use this consultation process to improve services and funding for tribal behavioral health in the future. OHA has been informed by tribal governments and an urban Indian health organization that current funding does not adequately meet the needs of this population. OHA looks forward to government-to-government consultation and meaningful conversation with the Tribes and the urban Indian health organization on meeting behavioral health needs for tribal people.

OHA is currently in a government to government consultation with Oregon's nine federally recognized tribes and is working on a separate process and set of recommendations specific to the needs of Oregon Tribes. We are committed to recommendations that will reduce disparities, enhance tribal behavioral health services in the near future, and strengthen funding and resources available for Oregon's American Indian and Alaska Native population.

I want to thank all of the BHC members for their commitment, passion, and expertise. I believe that the work of the BHC will transform our behavioral health systems into one that provides a seamless system with coordinated care and allows our loved ones to live to the fullest potential.

Sincerely,

A handwritten signature in cursive script that reads "Lynne Saxton".

Lynne Saxton  
Director

# **Oregon Behavioral Health Collaborative Recommendations for a 21st Century System of Care**

## **Executive Summary**

Oregonians who struggle with mental health challenges and substance use disorders face barriers everyday getting the services and support they need. Fragmentation in the health care system has created artificial silos between physical, oral and behavioral health care, making it harder for individuals to get their needs met and for care providers to work together. With Oregon's coordinated care model, it's time to work together to identify and address the systemic and operational barriers that prevent individuals and their families from getting the right support at the right time.

The Behavioral Health Collaborative (BHC) envisions a coordinated, seamless health care system that treats each individual as a whole person — not a collection of problems and diagnoses. No matter where an individual seeks care in this system, they and their family are at the center. In this 21st century behavioral health system, systems of care are held accountable for all aspects of an individual's care. There is a focus on early intervention, health promotion and prevention. Systems and stakeholders come together to identify priorities and solutions specific to the needs of their community. This system is attainable now within Oregon's health care model.

The recommendations from the BHC create a blueprint for the 21<sup>st</sup> century behavioral health system. These recommendations will move the entire state behavioral health system to a coordinated care model that will integrate behavioral health with physical and oral health and will provide a coordinated system so patients have a team of care and are not left out in the cold to find help on their own.

## **Behavioral Health Collaborative (BHC)**

In the summer of 2016, Oregon Health Authority (OHA) convened the BHC to develop a set of recommendations to chart a new course for behavioral health in Oregon. The BHC was comprised of nearly 50 members from throughout the state that represent every part of the behavioral health system. The BHC worked for over six months to develop a set of recommendations that will transform Oregon's behavioral health system.

### **Recommendation #1: Governance and Finance**

The governance and finance recommendation calls for a single point of shared responsibility for local communities through a regional governance model. This recommendation will help transform the behavioral health system so that all Oregonians will be served by a coordinated care model for their behavioral health needs.

Under this recommendation all organizations in a community that are responsible for behavioral health – everything from community mental health organizations to hospitals to law enforcement to schools to

physical health care – will be included in the governance structure to ensure that local resources are being used in the most effective way and there is coordination of care.

The local governance model would also be a single point of accountability to review and ensure that funding is being used effectively and efficiently.

### **Recommendation #2: Standards of Care and Competencies**

This would set a minimum standard of care for all behavioral health workers. This has led to inconsistencies in practice and this recommendation would develop minimum standards so that all Oregonians receiving behavioral health service will have consistency.

### **Recommendation #3- Workforce**

This recommendation calls for a needs assessment of current workforce and after that assessment is complete to create a plan on how to build the workforce.

### **Recommendation #4- Information exchange and coordination of care**

This recommendation calls for Oregon to strengthen its use of health information technology and data to further the outcome-driven measurement and care coordination across an integrated system.

This calls for both data and measurement that is outcome-focused and patient-centered but also to use technology to integrate and help coordinate care across the behavioral health system. Technology must also be used as a behavioral health promotion and prevention tool and to connect Oregonians to behavioral health care.

When taken together these recommendations will help transform our behavioral health system from one that is fragmented and unable to serve everyone in need, to one that is integrated and providing better health and better care at a lower cost. This is helping move the behavioral health system to a coordinated care system that will provide better results for Oregonians.

### **Background and context**

Nationally, Oregon is viewed as a leader in health care innovation. We strive to achieve better health, better care and lower costs for all Oregonians. Hallmarks of Oregon’s reform efforts include:

- Local engagement and governance
- Prevention
- Equity
- Person-centered care
- Integration and coordination of services
- Financial sustainability
- System-wide accountability for improved outcomes

Oregon’s coordinated health care system delivers services locally and regionally to people on the Oregon Health Plan (OHP). Coordinated care organizations (CCOs) provide services to OHP members. For the coordinated care model (CCM) to be successful, performance must be closely monitored and costs

held down. The state has made significant progress in containing costs and improving access to quality health care while putting more focus on prevention.

Building on the successes and lessons learned from Oregon's experiment with health system transformation, public health modernization and the creation of CCOs, the recommendations outlined in this report from the Oregon Behavioral Health Collaborative (BHC) create a path for a 21st century behavioral health system.

### **The Behavioral Health Collaborative**

In 2015, Senator Sara Gelser, D-Corvallis, and Oregon Health Authority (OHA) Director Lynne Saxton traveled around Oregon to meet with consumers and family members in a series of Town Halls. Director Saxton convened the BHC in July 2016 to address the concerns that were heard during the Town Halls. Director Saxton asked the BHC to make recommendations defining policy, financing and infrastructure needs to modernize and integrate Oregon's health system with behavioral health (mental health and substance use services) for people who receive services and their families. Stakeholders from across Oregon defined the problem, identified solutions and created a vision for excellence and sustainability in Oregon's behavioral health system.

An integrated system meets the individual's needs to the fullest extent possible regardless of the category of care (physical, mental health, substance use, or oral health). These recommendations create a truly integrated health system for all Oregonians throughout the lifespan, including mental health and substance use identification, entry and treatment, along with primary care and population-based prevention.

Most states aggressively pursue strategies to address mental health and substance use on the back of new programs, payment models and policy decisions. States rarely have the opportunity to make transformative system changes that integrate prevention, mental health and substance use services seamlessly into the community and health care delivery system. Additionally, substance use services are not always given the same attention as mental health services, and staff are paid significantly less than their counterparts in mental or physical health.

### **The Oregon plan**

Oregon's plan is to integrate care and treat mental health, substance use and other health services equitably in local communities. Mental health and substance use must be integrated clinically, operationally and financially into larger, system-wide reform efforts to achieve the BHC's goal. This plan is unique and progressive. We aim to proactively prevent mental health and substance use disorder issues, use best and promising practices to create measureable outcomes for Oregonians served by the health system, and apply trauma-informed principles at all points of contact. This plan recommends steps to create a "whole health" system and culture of health promotion to integrate physical, mental, substance use and oral health care. This system and its resources will operate with financial sustainability to ensure quality outcomes.

This integrated system must have a central, coordinated entity — governed by individuals and institutions — that ensures the components interact in predictable, measurable and cost-effective ways. This framework allows programs, organizations and delivery pieces to fit together to provide an

effective and efficient experience for the person and their family. These recommendations aim to bring a level of consistency and performance to behavioral health services in Oregon, taking into account the opportunity CCOs offer to drive toward a whole health culture, and the unique local attributes found in each community's existing innovations.

The BHC operating model:

- Focuses on the person and caregivers
- Emphasizes prevention, health promotion and early intervention
- Addresses trauma, stigma, cultural and language barriers
- Provides simple, seamless, integrated services with a “no wrong door” approach
- Aligns provider payment with outcome goals
- Ensures financial sustainability and system efficiency

Guiding principles are:

- Build on and complement existing transformation efforts, without duplication.
- Integrate physical health and behavioral health, a hallmark of health system transformation to a fundamental system design focused on quality health care for Oregonians.
- Use OHA's contracting and financing authority for CCOs and community mental health programs (CMHPs) to drive the recommendations and establish baseline expectations, while encouraging and supporting local control and innovation.
- Including all payers — public and private — is critical for success. OHA will work with the Department of Consumer and Business Services (DCBS) to identify the state's collective authority to integrate commercial and publicly insured behavioral health efforts to produce results, efficiencies and parity compliance.

However, the strategies and innovations needed 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, antiquated rules and measures. The proposed systems framework highlights the multiple levels of change necessary for behavioral health. Only a truly integrated system can deliver better care, lower costs and better health outcomes Oregon's citizens deserve.

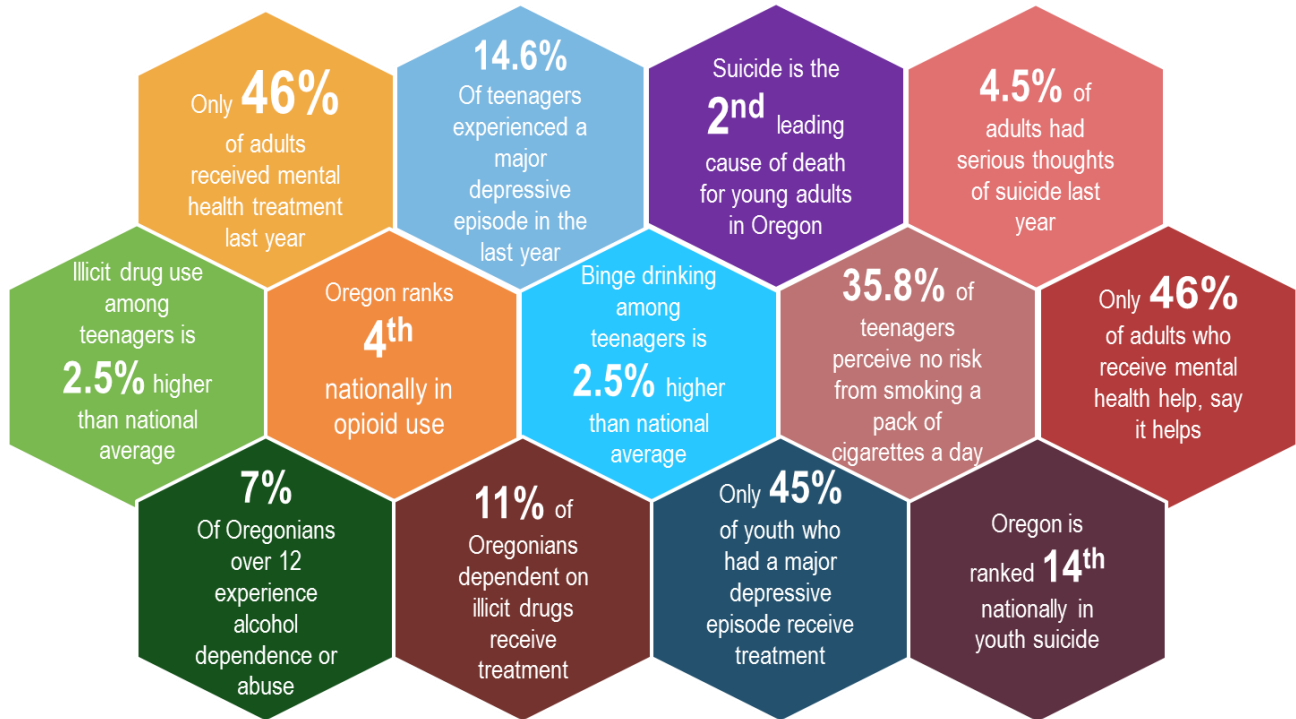
### **Problem statement**

The behavioral health system as a whole continues to include fragmented financing, carve-outs that prevent integration and efficiencies, siloed delivery systems, and services that fail to serve and exacerbate poor health outcomes.

- Access to specialty and general behavioral health services does not meet the needs of all Oregonians in the right places at the right times in a culturally and linguistically specific manner.
- Continuum of care, service integration and coordination between criminal justice systems, human services, health and education is insufficient, administratively complex and lacking in strategies addressing prevention for all populations.
- Social determinants of health, including insufficient housing, education, employment and transportation, create barriers to behavioral health resources that vary by community.

### **Oregon's current behavioral health system**

Data shows consumers are not currently receiving sufficient or consistent behavioral health services throughout Oregon (data are from SAMHSA’s 2015 Behavioral Health Barometer unless otherwise indicated) and Oregon has ample opportunities for improvements in prevention.



### Current behavioral health structure

In 2013, Oregon established 16 CCOs through a health system transformation process. The CCOs manage the physical, dental and behavioral health benefit for individuals who have Medicaid. As a result, Oregonians are experiencing improved and more integrated care. However, as described above, behavioral health has not been as integrated within this framework as possible. Health plans and their providers using the coordinated care model could better prevent and manage behavioral health and chronic conditions to help keep people healthy and out of high cost delivery settings, such as the emergency department.

The statewide behavioral health structure also relies on community mental health programs (CMHPs). CMHPs, at a minimum, maintain the mental health safety net system, manage children and adults at risk of entering or transitioning from the Oregon State Hospital, manage the mental health crisis system and community-based specialty services, and require care coordination of residential services.

### The vision

This coordinated care model should build off current successes and infrastructure, such as those found in CCOs, to help provide a framework for integrating mental health and substance use services. As



outlined in the recommendations, much of the integration work will be by local governance, which includes CCOs, community mental health programs, local mental health authorities, local public health authorities, health systems, primary care and other system participants (e.g., schools, providers, faith community). The metrics and standards OHA sets to help guide communities as they integrate mental health and substance use services with physical and oral health are key to this work. Leveraging a model of community accountability, shared responsibility, transparency and open entry points for behavioral health access, these recommendations aim to maximize local resources, leadership and innovation to increase timely and effective access for mental health and substance use services.

### **The recommendations**

The BHC developed four recommendations through workgroups (Appendix A). The recommendations align with and build on [\*Oregon's Performance Plan for Mental Health Services for Adults with Serious and Persistent Mental Illness\*](#), developed through a collaborative process with the Civil Rights Division of the United States Department of Justice (USDOJ) in July 2016.

The Waste and Efficiencies Workgroup made specific recommendations to reduce waste and streamline processes throughout the behavioral health system (Appendix B). The four final recommendations incorporate the recommendations of that workgroup throughout and will be developed into an action plan and implemented.

OHA will use its dual contracting relationships with CCOs and CMHPs to implement the recommendations in the next contracting cycle. All OHA grants and funding will support these systems working in tandem and without duplication.

## **Recommendation 1: Governance and finance**

Oregon's CCO model has transformed health care for the Medicaid population, especially for individuals with complex physical health needs. This model can achieve further success through integration of physical, behavioral and oral health to ensure individuals can access whole health wherever they present for care. CCOs, as local, patient-centered organizations, along with provider organizations, peer and family supports, and other community partners need to align accountabilities and incentives within their mutual service area to accelerate integration and deliver improved population health outcomes. Using existing structures, the BHC recommends establishing a single point of shared accountability, based on the values and guidelines outlined below, to successfully implement needed change. OHA will align metrics, financial incentives and remove barriers to achieve integration.

### **Governance - single point of shared accountability:**

**Within each geographic service area, create a single point of shared accountability with a single plan for system coordination that builds on existing structures and partnerships and fosters further innovation and collaboration with other organizations. This local collaboration will encourage system recommendations for the allocation of resources; shared responsibility for reaching quality, outcome and cost targets; and prioritization of services and resources to meet local needs.**

### **Funding and payment:**

**Funding for health care will be aligned to produce desired outcomes. The local collaboration will be the single point of accountability to review and ensure funding within each geographic service area is effectively and efficiently invested to best meet local needs. The local collaboration will help promote rapid achievement of patient-centered quality, outcome and cost targets. Provider reimbursement should be value-based and encourage improved performance and quality, increased provider risk and population-based payment approaches that support a full continuum of services and behavioral health integration.**

#### **Values and guidelines**

- Build on and complement existing transformation efforts, without duplication.
- Integrate physical, oral and behavioral health (mental health and substance use treatment) to achieve better health outcomes across all delivery systems.
- Accountable, person-centered systems reduce health disparities and recognize the impact of trauma on the cost of health care, education, public safety, and other social services and supports.
- Investments in prevention, health promotion and early intervention are key to improved population health outcomes.
- Use OHA's contracting authority for CCOs, local mental health authorities (LMHAs)/community mental health programs (CMHPs) and local public health authorities (LPHAs) to drive the recommendations and establish baseline expectations, while promoting and supporting local control and innovation.
- All recommendations should reduce administrative burden and system complexity, and move toward value-based payment.
- Shared financial risk based on clear accountability and span of control.

OHA will dedicate sufficient staffing and support to ensure initiation is successful. OHA will establish and align contractual obligations for CCOs, LMHAs/CMHPs and LPHAs, consistent with these recommendations, and provide oversight to ensure the requirements are met. The OHA Transformation Center will provide technical assistance or learning collaboratives on data sharing, organizing local structures around shared outcomes, blended funding models, and maintaining equity and transparency within the governance model.

OHA's role is to focus on results rather than being prescriptive about the process to achieve them. OHA will require CCOs to invest in prevention and health promotion as identified in the community health improvement plan, using a population-based approach to maintain and improve wellness. Prevention, health promotion, early intervention and safety net services must be protected and preserved. This will ensure a proactive response that improves the overall wellness of each community, reduces the risk of developing chronic illness and moves away from dependence on the system.

Each geographic service area (as self-defined by principal payers, providers and partners within a locality) will be required to establish a single plan for shared accountability. Each service area must include, at a minimum, participation of CCOs, LPHAs, LMHAs/CMHPs, local hospitals and health systems, schools, corrections, courts, primary care, behavioral health, and oral health. When the state contracts with multiple private or governmental entities within a service area, the contract

or other binding agreement will mutually obligate the entities to work collaboratively in support of these recommendations.

The single point of shared accountability will build on existing local and regional collaborations and committees and should not produce additional infrastructure or administrative costs. The plan will address significant access and penetration issues and integrate public health, physical, behavioral and oral health focusing on quality of health care. CCO members, indigent individuals, Medicare, Tribal Health Services, the VA and those with other health insurance can and should be included in the plan as warranted in each locality.

In the first year, each locality will develop a single plan to meet the specific needs of the respective community, allowing for flexibility and innovation. This plan will include documented and committed participation from the required entities noted above and any other participating organizations, and allow for those entities to share accountability and align funding. OHA will review and approve plans, consistent with these recommendations, to ensure sufficient membership, system coordination and measureable improvements and outcomes are identified.

Minimum requirements for plans:

1. Full engagement of all required participants in process, outcome identification and attainment, and shared risk.
2. Financial incentives are based on both local and state metrics and funds.
3. Prevention, health promotion and early intervention are prioritized and recognized as effective and required to meet the triple aim.
4. Include ways to improve health equity.
5. Include ways to integrate health care for total health.
6. Crisis services, improved access and the USDOJ Oregon Performance Plan requirements are addressed.
7. Require equity of governance and transparency in all financial agreements, budgets and incentives.

The plan will review the depth and breadth of health services across multiple settings, reduce fragmentation and promote integration, and establish clear outcomes and metrics to monitor performance. Participants will have authority to direct services and resources from their own organizations and will advise system partners in their resource allocation. A longer-term goal is to have a shared pool of cross-system funds dedicated to efficiently meet community health goals. This will benefit from state incentives, technical assistance and changes to rules. OHA should establish incentives for CCOs, LMHAs/CMHPs and LPHAs to collaborate and invest in the most effective and responsive local system of care that can be created with available resources. This must include opportunities to carve in services such as MH residential, state hospital and system of care for children. Oregon State Hospital and residential will be carved into this system to the fullest extent possible by the beginning of the 2019–21 biennium.

The plan must include other relevant system and community partners. Primary and specialty care providers will be essential for health care integration success. Tribes and culturally specific providers can identify relevant and effective service models. Emergency department and hospital participation will increase transitional support with high cost services. Justice and community

safety representation will reduce inappropriate use of jails. School representation will improve retention and graduation. Providers, peers, consumer and family member representation ensures proposals meet the needs of those they are intending to serve. Where there is an identified community need, a proposed solution and shared responsibility for outcomes, appropriate community representation and commitment to the plan is required.

All efforts to improve the system should reduce complexity. Changes or proposals that increase the administrative burden or increase costs without improving outcomes should not be considered.

Financial incentives based on state metrics and the priorities established by the single point of shared accountability should be built into the plan. There should be shared risk for outcomes. Early in the process it is possible that only CCOs, LMHAs/CMHPs and LPHAs are contributing resources to a shared risk model and will share in incentive payments. The hope is, over time, more partners will contribute funding to better coordinate services and payment and share in incentive payments. The plan should address alternative payments with contractors and move toward value-based payments instead of the traditional fee-for-service structure. This shared risk with providers is essential to further transform the delivery system and move toward an outcome-driven system.

The first year plan will address, at a minimum, Medicaid and indigent services funded through the CCOs, the state and counties. Simultaneously, OHA will work with DCBS to encourage private payers to fund services they are not currently obligated to pay, including crisis services, prevention and the children's state hospital system. OHA will work with DCBS and commercial payers to identify the state's collective authority to integrate commercial and publicly insured behavioral health efforts to produce results, efficiencies and parity compliance. OHA will meet with DCBS and commercial payers to review issues and propose possible solutions. Efforts will align with the SB 231 workgroup recommendation that "carve-outs that impact behavioral health services be invisible to service recipients and providers." As applicable, this and other work under SB 231 will be considered and combined to move these efforts forward.

OHA will commit to having an integrated data system within three years that tracks individual client, program and cost outcomes.

## Recommendation 2: Standards of care and competencies

**Establish and implement minimum standards of care and competencies for both mental health and substance use in multiple settings and at all levels of service both at the point of contact and the point of entry. Standards should emphasize trauma-informed care practices, person-centered planning, culturally and linguistically appropriate services, focus on prevention, the social determinants of health and other research-based, outcome-driven interventions.**

Oregon has not previously established specific standards to address timely access to care, nor been explicit in its guidance regarding standards for clinicians. This gap has led to inconsistencies in practice. Developing and implementing minimum standards will provide confidence that all providers consistently use best and emerging practices, resulting in equitable and timely access to services for individuals. Every individual should have the same options for services irrespective of where they live in Oregon. In the current system, inequity in benefits exist based on type of coverage (e.g., uninsured, Medicaid,

Medicare, commercially insured, veteran benefits). There must be a standardization or clear guidelines of available benefits, services and funding across these types.

Better clinical and financial outcomes require consistent protocols and expectations for behavioral health identification, health promotion and prevention, assessment, coordination and, in some cases, treatment across Oregon and across all behavioral health entry points. This will help establish a consistent level of expectation for individuals receiving care, providers delivering care and practice sites around behavioral health, even if that has not historically been their responsibility. However, and most importantly, this helps create a unifying approach to behavioral health that allows for no wrong entry door for a person who has behavioral health needs while cultivating a culture of care coordination through a person's primary care provider.

We must evaluate behavioral health services and staffing, and reallocate both to sufficiently support a variety of entry points. We should treat individuals at any entry point, whenever possible, or provide a smooth transition to the appropriate setting, rather than increasing the system's ability to refer everyone to specialty behavioral health. The primary care home should be considered the main entry point, with responsibility for coordinating care and providing referrals to specialty care as necessary. For some, the health home will be a community mental health center, commonly referred to as a behavioral health home. For others, the health home will be a certified community behavioral health clinic. This will require staff have an appropriate level of behavioral health expertise, and at the very least, actionable plans for immediate release. While staffing is important, managing the individual's behavioral health needs requires a well-positioned site and adequate training.

### **Operational considerations**

- It is essential to establish core competencies for behavioral health care providers and team-based care for each entry point.
- Oregon must adopt minimum standards of care for entry points, including primary care, emergency departments, hospitals and health systems, schools and corrections.
- Leverage the success of the PCPCH and CCBHC programs and adopt standards when appropriate.
- Standardize protocols for identification, assessment, coordination of care and treatment across entry points, with agreements to adopt existing evaluations whenever possible to reduce trauma.
- Require entry points and providers share assessment and individual information, as applicable and in compliance with HIPAA and 42 CFR part 2, to reduce unnecessary assessments and risk of re-traumatizing individuals.
- All entry points will have a cooperative referral process to direct care as needed including referrals to primary care, specialty behavioral health care, prevention services and crisis services.
- Entry point settings track referrals to consulting providers and document plans of care in accessible databases (e.g., EDIE/PreManage).
- Establish mechanisms for co-management of individuals who require specialty behavioral health care.
- Offer and use either providers who speak an individual's language of choice at time of service or in-person or telephonic interpreters to communicate with the consumer and families.

- Point of contact (public safety and first responders) should actively navigate to a point of entry, such as specialty behavioral health, and/or contact the local mobile crisis team.
- Mobile crisis teams are must respond when a first responder identifies a behavioral health crisis.

### Recommendation 3: Workforce

**Assess the current behavioral health workforce to identify gaps. Develop standards for a well-trained behavioral health workforce, inclusive of certified, licensed and unlicensed, peer support specialists and community health workers throughout the state. Use learning opportunities to support a workforce that is trauma-informed, person-centered, culturally and linguistically appropriate and prepared to work in integrated care settings.**

Oregon’s statewide workforce is the best resource for better health and better care at lower costs in all behavioral health services. A diverse, experienced and well-trained workforce is critical to promote prevention and wellness and support team-based care. Also critical is the retention of consistent and skilled staff. Experienced staff provides 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 and regional workforce shortages.

This requires a thorough approach to assessing the behavioral health workforce, including mental health and substance use service providers — certified, licensed and unlicensed — and physicians throughout the state. Use of peer support specialists (PSSs), certified recovery mentors (CRMs) and community health workers (CHWs) are evidence-based and cost-effective strategies to reduce workforce shortages. These workers help improve outcomes for individuals and are an essential component of a primary care system able to address behavioral health issues.

#### **Operational considerations**

- Perform an analysis across multiple settings to assess how many and what type of behavioral health providers Oregon needs. Develop new recommendations and strategies in recruitment and retention based on the findings. This workforce assessment needs to connect and coordinate efforts with OHIT Provider Directory plans.
- Support workforce development and retention in rural and frontier areas, including telehealth opportunities and loan reimbursement.
- Build and support a culturally and linguistically appropriate workforce statewide.
- Develop a set of competencies for licensed or certified behavioral health providers working in nontraditional settings (e.g., primary care, schools, police departments, emergency departments, hospitals, correctional facilities). Either convene a workgroup or endorse existing competencies for behavioral health.
- Require behavioral health clinical and nonclinical staff in each entry point to meet education and licensure or certification requirements.
- Train providers (physical, mental, behavioral, social workers, etc.) to achieve competency in team-based settings, nonmedical settings and medically assisted treatment programs.
- Require workforce training that promotes prevention and wellness, focuses on team-based care, and implements trauma-informed care.

- Address the structural deficit (locations, quality of buildings, staffing, wages, etc.) between public and nonprofit providers.
- Develop system standards and expectations (from OHA) founded on evidence-based and promising practices as well as tribal-based practices (HB 3110). Monitor for effective and appropriate use of peer services.
- Establish a target ratio of peer support specialist to members.
- Develop a required standardized training model for all peer support specialists that includes a minimum number of supervised peer training hours/practicum, the use of a mentor and a baseline set of competencies for knowledge and skill.
- Address workforce shortages specific to psychiatry and addiction medicine, including telehealth opportunities and evaluation of scope of practice so all providers are working at the very top of their licenses.
- Improve the licensing and certification process to maximize the appropriate use of the unlicensed workforce (e.g., CRMs, CHWs and PSSs) and establish a certification or licensure program for becoming a PSS/CHW/CRM supervisor. Require ongoing training of PSSs/CHWs/CRMs in an area specific to their caseload and specialization (e.g., traumatic brain injury or adverse childhood experiences) as CEU prerequisites for re-certification for every cycle. Peer support specialist competency and training issues include:
  - 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
  - Lack of qualified peers in rural areas
- Workforce development and retention:
  - Work with universities and community colleges to develop educational content that includes classes and practicum experiences relevant to the behavioral health system overall. This experience should include the public sector and not just private practice, such as community-based services, the safety net role in the community, social determinants of health and safety net care, etc.
  - Establish or target existing state resources to provide a prevention-focused team to offer consistent training in core skills (including “train the trainer” programs) and ongoing assistance to build the workforce.
  - Establish a central, statewide recruiting mechanism that ensures a better fit between the provider and the recruiting community.
  - Develop career pathways for direct care staff to progress into more highly qualified positions and retain their experience in the workforce.
  - Address ways to support a living wage for the behavioral health workforce.
  - Provide a trauma-informed work environment, promote professional self-care and adopt more reasonable caseload expectations.
  - Provide ongoing technical assistance to improve access for clinicians, including lower no-show rates and open access.
- Launch a learning collaborative for CCOs and/or providers that shares effective and appropriate methods for hiring, retaining and using community health workers, certified recovery mentors and peer support specialists in the most effective way possible.

## Recommendation 4: Information exchange and coordination of care

### **Strengthen Oregon's use of health information technology and data to further outcome-driven measurement and care coordination across an integrated community.**

Health information technologies and data are vitally important to help focus the behavioral health systems and to measure progress. As health information technology and information exchange improves, so too will the ability for more granular measurement. Behavioral health outcomes must be imbedded within CCO metrics.

#### Data and measurement

### **Develop an outcome-focused, person-centered behavioral health measurement framework to assess the impact of integrated services and hold regional collaborations accountable for clinical and cost targets.**

Oregon must be able to monitor performance and outcomes for the regional collaborations to assess successes and challenges in each community. Similarly, each regional collaboration will need access to timely, reliable, individual-level data to identify potential disparities and support quality improvement efforts. Oregon needs common outcomes to ensure the whole system moves together in the right direction.

There are currently hundreds of measures in use across Oregon's behavioral health system. Some are tied directly to federal funding or to specific state or payer initiatives. The alignment may be revised to reflect some measures are more appropriate for state-level monitoring, others for payer/system level, and still others are more appropriate for individual clinics or providers.

The BHC Outcomes Workgroup reviewed more than 275 existing measures and identified a subset that may drive the greatest system improvements and outcomes. Measurement should account for all Oregonians receiving behavioral health care; there needs to be additional discussion to identify accountability mechanisms for commercial insurers. The subset will be reviewed as these recommendations are adopted.

Senate Bill 440 (2015) established the Health Plan Quality Metrics Committee, charged with developing aligned measures for use with CCOs, PEBB and OEBC carriers, and health plans sold on the insurance exchange. Ideally, these measures will be coordinated with those selected by the Health Plan Quality Metrics Committee. One way to support coordination and alignment is to establish a behavioral health metrics workgroup under the Health Plan Quality Metrics Committee. This workgroup would identify a cost-effective set of accountability measures for the regional collaborations.

The identified behavioral health measures should be stratified by population and other demographic factors, as much as there are available data from OHA. Ideally, variables should include, but are not limited to race, ethnicity, language, age, gender, disability, geography, tribal membership, severity of mental illness, substance use disorder, comorbidities, interactions with other systems (e.g., child welfare, criminal justice), insurance status and payer type. While we recognize access to all of this information is not currently available, it is critical to use as much stratification as possible to identify potential disparities and support quality improvement efforts at both the population and practice level.



All Oregon's health data systems, including behavioral health, require strengthening to support robust performance measurement and stratification. To achieve this, Oregon needs to develop a minimum data set to use consistently across facilities, clinics and providers, reflecting all individuals and populations and their unique outcomes. The minimum data set should align with identified standards for the behavioral health system (see Recommendation 2: Standards of care and competencies). Data must accurately reflect the services and outcomes happening at the local level.

Oregon will also need to invest resources in functional data systems to provide reliable data at both the state and local levels. Investment in a functional data system, centralized at the state with local and regional partnerships, common data definitions, and in close coordination with health information technology and health information exchange initiatives described below, is critical to support this work.

Improved data collection and more robust measurement is not complete without transparency. Regional collaborations or other organizational level should publicly report on accountability measures and outcomes, and for stratified populations when appropriate.

### **Operational considerations**

- Ensure outcomes measurement is person-centered and includes the voice of the consumer.
- Develop a statewide set of behavioral health outcomes, measures and benchmarks in coordination with existing structures (e.g., Health Plan Quality Metrics Committee).
- Identify a flexible measurement framework to guide this work and to address how to hold the behavioral health system accountable, including multiple levels of accountability within the behavioral health system. The state will hold the new regional collaborations accountable, health plans and/or contracted organizations will hold their subcontractors and/or provider networks accountable, etc. It would be ideal to expand this accountability to include education, corrections and other settings.
- Align measures with other state and national initiatives, including CPC+, MACRA (MIPS), Medicare STARS, etc., to reduce duplication.
- Align outcomes measurement with identified standards for behavioral health.
- Use real-time, actionable, outcome data to improve the treatment process for each individual.
- Provide training and technical assistance at the local and provider level so data can be used to improve services within local communities.
- Continue to develop data systems and measurement to address social determinants of health.
- Develop a financial incentive structure to support improvement and accountability.

### **Technology**

**Advance the use of technology to integrate and coordinate care across the state and behavioral health system. This would be a requirement for each CCO to ensure integration took place.**

Health information technology infrastructure and tools are needed to support behavioral health system transformation and further integration. Technology can be used to facilitate referrals and care coordination, obtain screening results for treating providers, track individuals and their progress, support measurement, and more. Tools can reduce costs, track outcomes, augment care and improve satisfaction; specifically, telehealth tools can help improve access, particularly in rural areas.

Behavioral health presents a unique challenge in that many of the people who could benefit do not know about the services available, are skeptical of services, are undiagnosed or are wary of the behavioral health system. Certain populations, such as the LGBTQ community and under-documented individuals, avoid care until costly avenues like hospitalization and residential services are necessary. Technology can play a key role in serving populations that are not receiving care.

OHA should leverage technology and social media as a behavioral health promotion and prevention tool, for treatment resources and for ongoing recovery. The rising youth suicide rate underscores the opportunity and urgency to better use technology to engage young people. Oregon must begin using these remarkable connecting tools to engage Oregonians who would benefit from behavioral health care, and invest in and develop targeted strategies to reach youth and young adults.

To hold the new regional collaborations accountable, there will need to be adequate infrastructure to track individuals throughout their region and support care coordination for both behavioral health providers and organizations. (For example, emergency departments will need to be in contact with outpatient services to coordinate follow-up care.) OHA will monitor and enforce this through the new contracting structure.

The Health Information Technology Oversight Council (HITOC) has identified behavioral health as a priority. There are multiple state and local-level initiatives underway to develop and adopt health information technology (HIT) that will support behavioral health system transformation without reinventing the wheel.

### **Operational considerations**

- Ensure payment models recognize investments in HIT. Regional collaborations may be required to make funding resources available or specific investments in HIT to further the spread and use of these tools.
- Provide training to providers and agencies on adoption of and effective use of technologies. Regional collaborations and the state should consider ways to provide training and technical assistance, particularly for smaller organizations or regions with more limited capacity.
- Identify ways for the state and regional collaborations to support the continued adoption and use of electronic health records and information sharing across payers and platforms. Interoperability is a particular challenge for behavioral health providers that must be addressed. Individual information should be portable and reduce the need for multiple assessments.
- Identify ways to address barriers to information sharing and client confidentiality (e.g., 42 CFR part 2).
- Identify ways to continue to develop and support technology that allows performance measurement based on electronic health records, which can reduce provider burden and reliance on administrative (claims) data.
- OHA should address the youth suicide rate by launching an initiative to use social media tools to help connect youth to behavioral health services.
- Provide statewide leadership and support for innovative technology to reach and engage Oregonians who can benefit from behavioral health services.

- CCOs should establish technology and social media strategies to ensure regional emphasis and locally appropriate use of technology to engage Oregonians. Metrics should be established to evaluate use of technology and social media strategies.
- OHA should appoint a Youth and Technology Council on Behavioral Health to provide innovation and input in using technology.

## **Conclusion**

These recommendations developed by the Behavioral Health Collaborative will move Oregon forward in developing a 21st century behavioral health system and achieving better health and better care at lower costs. By building on Oregon's successes and innovations, these recommendations will integrate prevention, mental health and substance use services operationally and financially into the health care system. We can develop a whole health system, focusing on prevention and trauma-informed principles at all points of contact, which can improve the health of all Oregonians.

## Appendix A: BHC workgroups

Workgroup	Staff	Workgroup Participants
Data	<p>SMEs: Jon Collins Marta Makarushka</p> <p>Facilitator: Rosa Klein Scribe: Brian N.</p>	<p>Rick Blackwell, Dept of Consumer &amp; Business Svcs Chris Bouneff, NAMI OR Rodney Cook, Clackamas County Kenny LaPoint, Housing &amp; Comm Svcs Sheriff Myers, Marion County Joe O’Leary, OYA Martin Rafferty, Youth MOVE</p>
Payment Reform and Finance	<p>SMEs: Summer Boslaugh Karen Wheeler Chelsea Guest Veronica Guerra</p> <p>Facilitator: Diana Bianco Scribe: Alfonso Ramirez</p>	<p>Bruce Abel, Lane Cty/Trillium BH Sandy Bumpus, OFSN Kevin Campbell, GOBHI Mike Franz, PacificSource Robin Henderson, Providence Bob Joondeph, Disability Rights OR Bill Murray, FamilyCare Kim Scott, Trillium FS Silas Halloran-Steiner, Yamhill County</p>
Workforce	<p>SMEs: Stephanie Jarem Stacey Shubert</p> <p>Facilitator: Nicole Corbin Scribe: Michael Oyster</p>	<p>Mark Bradshaw, AllCare Caroline Cruz, Tribal Rebecca Curtis, OSH Ashley Carson-Cottingham, DHS-APD Kristina Derksen, Deschutes County BH Chris Farentinos, Unity Center Kevin Fitts, OR MH Consumers Assoc. Ajit Jetmalani, OHSU</p>
Outcomes	<p>SMEs: Sarah Bartelmann Mike Morris</p> <p>Facilitator: Elaine Sweet Scribe: Claire T</p>	<p>Maggie Bennington-Davis, HealthShare Juliet Britton, PSRB Commissioner Carlson, Marion County Dwight Holton, Lines for Life Robert Lieberman, Kairos Truls Neal, AOC Comm Corr Director Dan Thoma, Moda Health Jackie Mercer, NARA Cherryl Ramirez, AOCMHP</p>
Waste	<p>SMEs: Lisa Bui Dan Reece</p> <p>Facilitator: Dustin Zimmerman</p>	<p>Caroline Fisher, Samaratin Health Svcs Kevin George, DHS Judge Grove, Columbia County David Hidalgo, Mult. Co. Healthshare Mary Monnat, Lifeworks NW</p>

Workgroup	Staff	Workgroup Participants
	Scribe: Ellen Pinney	Royce Bowlin, ORPA
Scope of Responsibility	SMEs: Jackie Fabrick Ben Miller As needed: PCPCH Staff  Facilitator: Angela Leet Scribe: Jeston Black	Mohamed Alyajouri, ORPCA Mitch Anderson, Benton County Jill Archer, CareOregon John Bischof, CCC Sheila North, OPERA Emily Rochon, Portland Police Lilia Teninty, DHS-DD Jeremy Wells, Dept. of Ed.

# Appendix B: Waste and efficiencies workgroup recommendations

Oregon Health Authority

## Behavioral Health Collaborative

### WASTE WORKGROUP RECOMMENDATIONS

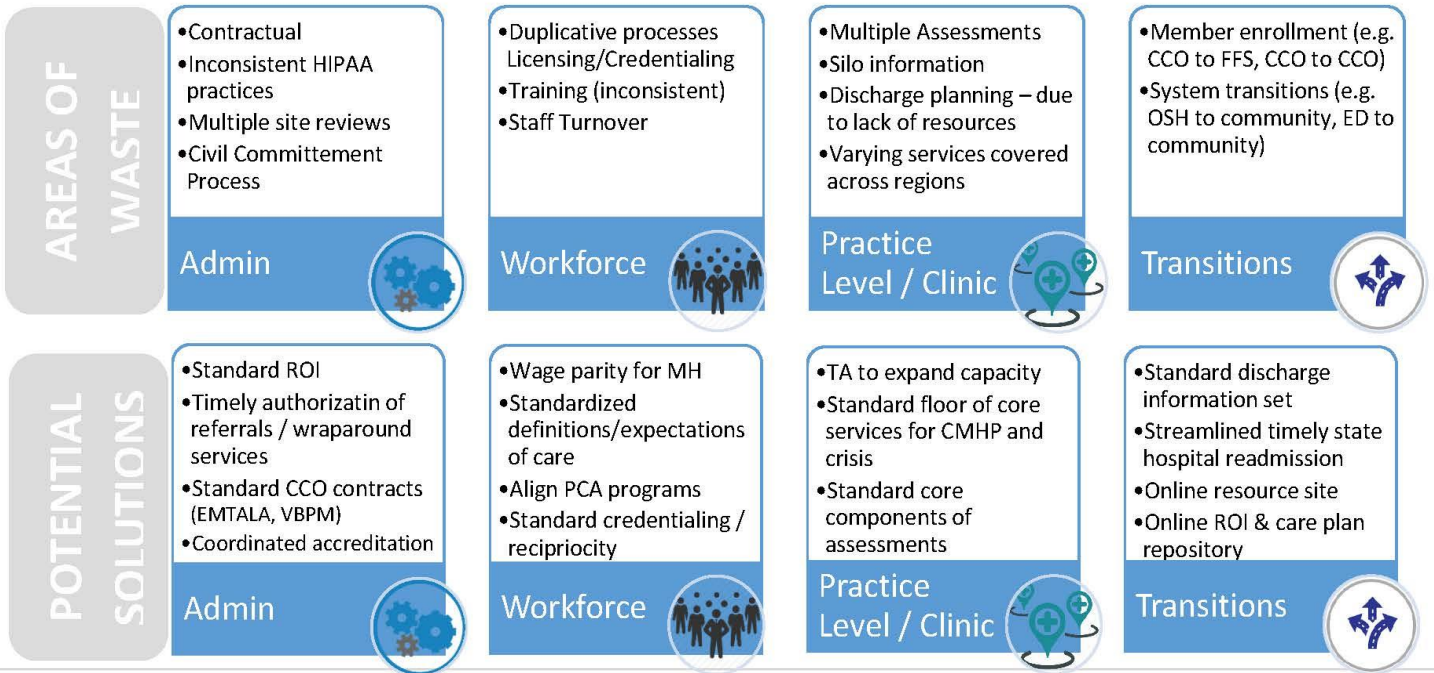


**Deliverable 1:** Identify areas of waste within the current system. Define waste areas in scope, workforce and payment and recommend areas that must be addressed to eliminate waste in the Farley Center model, considering all entry points (schools, corrections, ED, primary care, etc...)

**Deliverable 2:** Recommend a streamlined care coordination and system coordination that reduces the number of assessments and increases efficient care coordination between providers/systems, considering all entry points in the Farley Center model.

**Deliverable 3:** Determine what could be standardized to improve both consumer and provider experience.

**Deliverable 4:** Recommend system improvements to remove barriers between mental health and substance use disorder treatment.



Appendix C: BHC Roster

Behavioral Health Collaborative -- Membership Roster					
Last name	First	Organization	Title	Email	
Abel	Bruce	Lane Cty/ Trillium BH	Chief Behavioral Health Officer	<a href="mailto:bruce.abel@co.lane.or.us">bruce.abel@co.lane.or.us</a>	
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Beglau	Walt	Marion County, ODAA	District Attorney	<a href="mailto:WBeglau@co.marion.or.us">WBeglau@co.marion.or.us</a>	
Bennington-Davis	Maggie	Health Share	Chief Medical Officer	<a href="mailto:maggiebd@healthshareoregon.org">maggiebd@healthshareoregon.org</a>	
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Blackwell	Rick	Dept. of Consumer & Business Services	Policy Manager, Financial Regulation	<a href="mailto:Richard.Y.Blackwell@oregon.gov">Richard.Y.Blackwell@oregon.gov</a>	
Bouneff	Chris	NAMI OR	Executive Director	<a href="mailto:chris@namior.org">chris@namior.org</a>	
Bowlin	Royce	ORPA	President	<a href="mailto:royce.bowlin@cascadiabhc.org">royce.bowlin@cascadiabhc.org</a>	
Bradshaw	Mark	AllCare Health	Chief Medical Officer	<a href="mailto:mark.bradshaw@allcarehealth.com">mark.bradshaw@allcarehealth.com</a>	
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Bumpus	Sandy	OFSN	Executive Director	<a href="mailto:sandy.bumpus@ofsn.net">sandy.bumpus@ofsn.net</a>	
Campbell	Kevin	GOBHI	CEO	<a href="mailto:kevin.campbell@gobhi.net">kevin.campbell@gobhi.net</a>	
Carlson	Janet	AOC, Marion County	Commissioner	<a href="mailto:jcarlson@co.marion.or.us">jcarlson@co.marion.or.us</a>	
Carson Cottingham	Ashley	DHS - APD	Director	<a href="mailto:ashley.b.carson-cottingham@state.or.us">ashley.b.carson-cottingham@state.or.us</a>	

Last name	First	Organization	Title	Email
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Curtis	Rebecca	OSH	Director of Social Work	<a href="mailto:rebecca.l.curtis@state.or.us">rebecca.l.curtis@state.or.us</a>
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Last name	First	Organization	Title	Email
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Thoma	Dan	Moda Health	Behavioral Health, Case Management, Credentialing	<a href="mailto:dan.thoma@modahealth.com">dan.thoma@modahealth.com</a>
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## Appendix D: BHC Charter

Oregon Health Authority

### State Behavioral Health Collaborative Charter

Release Date: June 7, 2016



#### Purpose and background

**Challenge statement:** Chart the course for excellence and sustainability in behavioral health services across systems. Over the past year, the Oregon Health Authority has collected data and engaged the community. Now our challenge is to build the system that will best serve Oregonians.

The Behavioral Health Collaborative will chart a course for excellence and sustainability in Oregon's behavioral health system, with an emphasis on cross-system coordination and collaboration. The Collaborative will produce an achievable Action Plan that defines the policy, financing, and infrastructure needed to modernize and integrate Oregon's behavioral health system with individuals and families at the center of our consciousness and quality client outcomes as our goal. This re-conceptualized system is oriented toward the triple aim and supports Oregonians who are experiencing behavioral health conditions (mental health, substance misuse, and problem gambling) and in need of a variety of flexible clinical, community-based and natural supports. This effort will rely on qualitative and quantitative data developed over the past year through efforts such as the Behavioral Health Town Halls, the Behavioral Health Mapping Tool, OHA's partnership with the United States Department of Justice, a special report produced by Oregon State University, and other information.

The principles for the Behavioral Health Action Plan shall be to ensure:

- Individuals and families are at the center of the system;
- A variety of flexible clinical, community-based and natural supports are available to people experiencing behavioral health challenges;
- Adherence to the triple aim: better health, better care, lower costs;
- Understanding that early intervention and providing services and supports at the right place and the right time are key to avoiding crises, incarceration, institutionalization and high-cost emergency interventions; and
- Outcomes for individuals and families that are measureable and sustainable.

The goals of the triple aim—better population health, improving service outcomes through better care and system improvements, and achieving increased efficiencies—will result in effective use of funding, not only for the behavioral health system, but also for partners such as law enforcement, school systems, cities and counties.

## Membership and governance

Collaborative membership will include an action-oriented, balanced and diverse group of leaders and stakeholders willing to work as a team and in outreach to their stakeholders to achieve system change. Members will have expertise in the areas of mental health, addictions, prevention, wellness promotion, peer-to-peer services, tribal needs, education, housing, senior services, culturally specific health services, children and youth, the coordinated care model, tribal health care systems, corrections and public safety, natural support systems (community, faith-based and other organizations supporting life success), disability services, and health disparities.

The Behavioral Health Collaborative will include representation from the following groups:

- a) Consumers
- b) Human services
- c) Education
- d) Housing
- e) Coordinated care organizations
- f) Commercial insurers
- g) Providers: community mental health, primary care, substance use disorder specialists, mental health specialists, peer providers, hospitals
- h) Service providers: residential providers
- i) Local government: counties and cities
- j) Tribal health representatives
- k) Law enforcement
- l) Advocacy organizations
- m) Legislature
- n) Judicial system: mental health courts, drug courts
- o) Community supports
- p) Early Learning Hubs

Member appointment and terms: The membership of the collaborative will be determined by the Director of the Oregon Health Authority based on an application process. The term is July 2016 through February 1, 2017.

Subgroups: The Behavioral Health Collaborative will use subgroups to focus on specific issues, likely in the areas of: system design and continuum of care; statutory framework and policy; system financing; infrastructure and workforce needs.

Attendance: Members of the collaborative are expected to **attend the first meeting and at least 9 of the 11 meetings in person**. Accommodations will be made for rural members to participate via video conference on an as-needed basis. Members are expected to orchestrate, with administrative support, communication and collaboration with their peer organizations in their respective groups.

### **Meeting dates, times, and locations are as follows:**

- July 14, 3:30-6:30, Portland
- July 28, 3:30-6:30, Portland
- August 10, 3:30-6:30, Salem
- August 25, 3:30-6:30, Portland
- September 14, 3:30-6:30, Salem
- September 29, 3:30-6:30, Portland
- October 12, 3:30-6:30, Salem
- October 27, 3:30-6:30, Portland
- November 9, 3:30-6:30, Salem
- December 1, 3:30-6:30, Portland
- December 14, 3:30-6:30, Salem

### **Process**

Logistics: OHA will set meeting times and dates and arrange for meeting space.

Minutes: OHA will provide administrative support staff to take minutes following a format that tracks agreements, actions and decisions for each meeting. The minutes will be reviewed and approved at the next regularly scheduled collaborative meeting.

### **Timeline for completion and meeting frequency**

The products resulting from the Collaborative's work will be ready to inform discussions during the 2017 Legislative Session.

The entire group, as well as working subgroups, will meet at least one to two times per month, beginning in July. Meetings will conclude no later than February 1, 2017.