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.