PUBLIC HEALTH DIVISION

Oregon Health Authority

SHIP SUBCOMMITTEE MEETING

☐ Bias ☐ Trauma ☐ Economic Drivers ☐ Access to Care ☒ Behavioral Health

March 2, 2020 https://zoom.us/j/393128009 Conference call (669) 900 6833, ID 393 128 009

Members Present:

_____ Andrew White	__X_ Don Erickson	
__X__ Angela Leet	__X_ Gary McConahay	_____ Karun Virtue
_____ Annaliese Dolph	__X_ Gayle Woods	_____ Katrina Hedberg
_____ Athena Goldberg	_____ Holden Leung	__X__ Kera Hood
__X__ Carol Dickey	____ Isabella Hawkins	_____ Rebekah Schiefer
_____ Cherryl Ramirez	__X_ Jackie Fabrick	_____ Reginald Richardson
_____ Curtis Landers	____ Janice Garceau	_____ Tatiana Dierwechter
__X__ Jeremy Wells		

OHA Staff:

___x__ Kate O'Donnell	___x__ Liz Gharst	_____ Joey Razzano

Members of the Public: None present or on the phone

Others present: Tori Algee, Alcohol, Drug, Policy Commission and Wes Rivers, Governor's Behavioral Health Advisory Council

AGENDA ITEM #1 – Welcome, agenda overview and subcommittee business

Kate opened the meeting by encouraging members joining in remotely to turn their cameras on. Introductions were made for those in the room and remote attendees. Kate thanked and recognized that the pace of the work really accelerated in the last month or so.

AGENDA ITEM #2 – Finalize Strategies

Objective is to identify 10-15 strategies at different levels of intervention – individual, policy, and community levels that will help us get to the goals of the Behavioral Health subcommittee. In the meeting packet is a list of strategies from the last meeting. The group will discuss, identify what's missing, wordsmith and apply strategy criteria and then as a group vote to approve those strategies.

Liz sent out the list of strategies from the other subcommittees except Economic Drivers because they met late Friday afternoon and the subcommittee is still finalizing wording.

Liz held a kickoff call with the mini grantees and shared a sneak preview of the SHIP Navigation Map with draft strategies. The community groups shared the feedback that some of the strategies are very high level and requested examples or a plain language translation of what is meant by each strategy. Liz encouraged subcommittee members as they think about strategy wording to consider if the strategy would be understood for people who are outside the Behavioral Health field. Relevant to the community is one of the criteria for consideration during the review.

Strategies were reviewed for each goal in turn. Robust discussions were held around the following strategies:

- For “increase access to behavioral health services by coordinating across systems and improving integration between behavioral health and other care and service providers” a discussion was held about examples including coordination between community-based organizations and providers. Examples of other service providers included primary care physicians and internal medicine staff. An example for improving integration is embedding behavioral health specialists into local clinics.

- For “Examine, reduce and remove barriers to behavioral health services, for example accessibility, assessment process, transportation, and language,” a discussion was held about issues with the assessment process. Wes Rivers stated one solution the Governor’s Behavioral Health Council is looking at is exploring a “treat first” approach. This may entail some sort of initial diagnoses to build the relationship with a patient over the stretch of 4 clinical visits to build the groundwork for a formal assessment. It would allow for the patient to access services such as peer delivery services or other social supports in helping that person to get the care they need. Wes stated diagnostic codes and assessments are sometimes a barrier, not just for the behavioral health service themselves but perhaps other services like treatment for a co-occurring substance use disorder or ability to see a primary care provider in the same site.

- For “Incentivize treatments that are rooted in science, culturally-informed, and trauma-informed practice” a discussion was held on the use of the term evidence-based and considerations of different wording such as evidence-informed, emerging practice, promising practice, and rooted in science. It was mentioned that the term evidence based can be problematic because for certain communities of color evidence isn’t gathered for their community. It was decided to include the wording rooted in science, culturally informed, and trauma informed as that was deemed more inclusive than evidence based.

- For “Increase funding and resources for culturally and age-responsive suicide prevention and resilience programs for communities most at-risk, for example Native Americans, LGTBQ+ individuals, and veterans,” a discussion was held on potential funding. Jeremy mentioned that there are touchpoints in regards to Senate Bill 52: Adi’s Act and also through Section 36 of the School Prevention Safety System that includes suicide prevention, both of which will go into effect in July Jeremy mentioned there is money allotted that school districts can currently apply for mini grants to be able to implement their plans. Don Erickson also mentioned the SAMHSA Zero Suicide grant that OHA manages. It was suggested that moving forward that ODE can work in collaboration with Jill Baker, Youth Suicide Prevention and Intervention Coordinator at Health Systems Division and the Zero Suicide team within OHA to coordinate work around youth suicide prevention.

- For “Strengthen enforcement of mental health parity and addictions equity laws at the federal and state levels to assure equitable administrative requirements, payment and access for behavioral health services” it was stated this strategy refers to the federal Mental Health Parity and Addictions Equity Act of 2008.

- For “Ensure that providers are paid for all behavioral health services provided by developing Oregon Health Plan billing codes that support outreach and care coordination and promoting alternative payment models in public and private insurance,” this strategy was initially limited to OHP billing codes, however Gayle stated there are some needs that go beyond outreach and care coordination. Gary stated an example of what does not get paid for are activities such as peer and case managers who are reaching out for follow up to individuals who are released from psychiatric emergency rooms or from psychiatric hospitals and transportation time to and from client appointments. A discussion was held on how this strategy should be broader than OHP and include commercial carriers since the core of the strategy is that providers are paid for the services they are delivering. Gary stated that they do have some alternative payment models but ultimately, they rely on a certain amount of billing. The billing code itself is really key to this recommendation. We can add other language for private insurance but he stated he would not want to lose this specific recommendation because this is actionable and it allows for movement all of these things that came up in the discussion—emergency room follow up, prevention, outreach.

Goal #1: *Reduce stigma and increase community awareness that behavioral health issues are common and widely experienced.*

- Define the need for community behavioral health services in partnership with state, tribal and local entities.
- Create, expand, and fund programs that combat loneliness and increase social connection in older adults.
- Ensure community agencies have access to information to destigmatize and educate communities around issues of behavioral health.
- Implement public awareness campaigns (e.g., "Mind Your Mind", Cultivate Compassion) to encourage people to ask for services when they need them and reduce stigma.

Goal #2: *Increase individual, community and systemic resilience for behavioral health through a coordinated system of prevention, treatment and recovery*

- Create and build upon existing state, local, and tribal governmental partnerships between education, law enforcement, judicial system, housing and social services, payors, hospital systems, and health care practitioners to improve the mental health of Oregonians.
- Increase access to behavioral health services by coordinating across systems and improving integration between behavioral health and other care and service providers.
- Examine, reduce and remove barriers to behavioral health services, for example accessibility, assessment process, transportation, and language.
- Incentivize treatments that are rooted in science, culturally-informed, and trauma-informed practice.
- Increase funding and resources for culturally and age-responsive suicide prevention and resilience programs for communities most at-risk, for example Native Americans, LGTBQ+ individuals, and veterans.

- Identify evidence related to institutional bias and disparities in local education and law enforcement systems in communities of color to create localized solutions to improve mental health.
- Strengthen enforcement of mental health parity and addictions equity laws at the federal and state levels to assure equitable administrative requirements, payment and access for behavioral health services.
- Ensure that providers are paid for all behavioral health services provided by developing Oregon Health Plan billing codes that support outreach and care coordination and promoting alternative payment models in public and private insurance.
- Implement Housing First initiatives creating supportive and supported housing for individuals who are in need, including individuals waiting to access behavioral health treatment.
- Build incentives to recruit, retain, and train a qualified and appropriately trained workforce, reflective of the communities that they serve, including training for evidence-based practices.

Liz reviewed the timeline of this work moving forward. Once all subcommittees have met this month and decided on final wording, the draft plan will go to the PartnerSHIP for review on March 16. The PartnerSHIP will look at each of the strategies under the five priority areas and approve them. Once approval is given, the strategies will go for review by our seven minigrantees representing different communities across the state in April. At the May meeting, subcommittees will reconvene to review the feedback provided, make any changes, and finalize the strategies.

The April meeting will be dedicated to choosing process measures. In addition, the Public Health Division has begun operationalizing the outcome indicators and will have an internal metrics group and the Science and Epidemiology council review to ensure the data points can be calculated. If there are any questions on the indicators chosen, these can be addressed in the April meeting as well.

WRAP UP & NEXT STEPS –

- Liz will categorize individual, community and policy strategies.
- Draft will be finalized on 3 /11 and forwarded to PartnerSHIP for review on 3/16.
- Next meeting will be on 4/15.
- Liz/Kate will create some draft process measures for the group to consider.

PUBLIC COMMENT

There was no public comment.

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