Behavioral Health Environmental Scan:
Oregon and Washington

Kaiser Permanente Northwest Community Benefit

April 2016

Pamela A. Martin, Ph.D., ABPP

Table of Contents

Contributors

Many thanks to the community leaders in behavioral health who generously gave time to this project. Each of these busy people participated in a 45-60 minute semi-structured interview and provided a wealth of insight and thoughtful comments about the status of health care and behavioral health care in Oregon and Washington.

Community Informants

Vanetta Abdellatif Director of Integrated Clinical Services Multnomah County, Oregon	Bruce Abel, DSW Chief Behavioral Health Officer Trillium Behavioral Health Lane County, Oregon
Brad Berry Executive Director Consumer Voices Are Born Vancouver, Washington	Ed Blackburn, MA Executive Director Central City Concern Portland, Oregon
Chris Bouneff Executive Director NAMI Oregon	Kristin Burke Community Mental Health Program Director Washington County, Oregon
Leslie Tallyn Chief Clinical Operations Officer Central City Concern Portland, Oregon	Meghan Caughey Peer and Wellness Services Senior Director Cascadia Behavioral Health Portland, Oregon
Dian Cooper CEO Cowlitz Family Health Center Longview, Washington	John Duke, MBA Clinic Director Outside In Multnomah and Clackamas Counties, Oregon

Laurie Francis, RN, MPH Senior Director of Innovation Oregon Primary Care Association Oregon	Vanessa Gaston Director Clark County Community Services SW Washington Behavioral Health Clark County, Washington
RJ Gillespie, MD, MHPE Medical Director, Oregon Pediatric Improvement Partnership Chair of Quality Improvement, Children's Clinic Portland, Oregon	Tim Hartnett, MSW, MHA Executive Director CODA Multnomah, Washington and Clackamas Counties, Oregon
Laurie Hoyt Huffman, MA Executive Director Oregon School Based Health Alliance	Pam Jacobs, PhD Mental Health Director, Addictions Programs Native American Rehabilitation Association (NARA) Portland, Oregon
Bob Joondeph, JD Executive Director Disability Right Oregon Portland, Oregon	David Labby, MD, PhD Former CMO Health Share of Oregon Clackamas, Marion, Multnomah, Washington Counties
Ally Linfoot Peer Services Coordinator Clackamas County, Oregon	Mary Monnat President and CEO LifeWorks NW Clackamas, Multnomah, Washington Counties

Diane Yatchmenoff, PhD
Director
Trauma Informed Oregon

Introduction

Kaiser Permanente Community Benefit has a long history of supporting innovation in health care through grants to community non-profits and safety net health care providers. The purpose of this environmental scan is to prepare for community benefit strategies related to behavioral health over the next 3 year period, including an upcoming Request for Proposals by Community Benefit focused on behavioral health in 2016. The environmental scan focuses on safety net services and the gaps and needs in services for individuals with behavioral health challenges.

Methodology

The environmental scan focused on eight counties in Oregon and Washington. In Oregon the counties were Benton, Clackamas, Lane, Marion, Multnomah and Washington Counties and Clark and Cowlitz in Washington. Community informants were invited to participate based on a number of factors including geographic location and type of provider or advocate and the population they serve. Individuals with particular expertise in areas of interest were also contacted.

The final list was reviewed and approved by Kaiser Community Benefit staff. Each person was contacted by email or phone by the author and received a brief explanation of the project and the questions (See Appendix I). All potential participants were contacted at least twice. Of the twenty-four people contacted, twenty-one (88%) agreed to participate and completed the interview. Interview notes were collated by topic, condensed and are summarized below. Informants are not identified individually, but there are direct quotes included when quotes were helpful in making a particular point. Every effort has been made to accurately reflect the opinions expressed by the informants. The comments, opinions and statements have not been fact-checked, vetted for accuracy or questioned! Each informant was asked to answer the questions from the particular perspective of his or her experience as a clinician, advocate, administrator, and family member, recipient of services, or person who has lived a combination of these roles.

In addition, information concerning the geographic areas of interest was collated and summarized to provide context for the information provided by the informants. Information concerning the basic demographics of each areas is included as are some national reports that rank the states. SAMHSA is an important source of information concerning behavioral health and information from the SAMHSA state Barometers is included. The national advocacy group, Mental Health America published a report in 2015 ranking states on a number of factors that is also summarized. Information that ranks counties, and county plans was also reviewed.

Demographics

Population

In Oregon, Multnomah County has the greatest population followed by Washington County. Benton County has the smallest population and is ranked 11th in population of the 36 counties in Oregon. These six counties have 65% of the total population of Oregon, estimated to be 3,831,000.

Rank	County	Population
1	Multnomah	776,712
2	Washington	562,998
3	Clackamas	394,972
4	Lane County	358,337
5	Marion County	326,110
11	Benton County	86,316
	Total	2,505,445

Multnomah, Washington, Clackamas counties are contiguous and make up the greater Portland metropolitan area. Lane County includes Eugene, home to the University of Oregon and over 24,000 students. Marion County includes Salem and the State Capitol and the largest campus of the Oregon State Hospital. The largest community in Benton County is Corvallis, home to Oregon State University and about 30,000 students.

Clark County is the 5th most populous county in Washington State, and Cowlitz is the 12th of the 39 counties in Washington. These two counties are home to about 8% of the total population of Washington, estimated to be 6,724,540.

Rank	County	Population
5	Clark	425,363
12	Cowlitz	102,410
	Total	527,773

Vancouver is the largest city in Clark County. Vancouver and Portland are divided by the Columbia River and many people commute between the cities daily. Cowlitz County is located north of Clark County and the largest city is Longview.

Poverty

The relationship between poverty and physical and behavioral health is well documented. The international health care community recognizes that not only is mental

illness and substance abuse a pathway to poverty, but poverty contributes to poor physical and mental health creating a cycle of poor health, poor quality of life, multi-generational trauma and premature death for the world's most vulnerable people. In 2014, the World Health Organization (WHO) and the Mental Health and Poverty Project published a series of findings concerning behavioral health and poverty. WHO concluded that many people with mental health disorder experience stigma, abuse and exclusion from the social process. This adverse social environment leads to poverty, poor health, disability and premature death.

The population and poverty rates for any area vary from census to census. In order to compare the states of Washington and Oregon and eight key counties, the data on population and poverty levels were taken from the same source (2010-2014 American Community Survey 5-Year Estimates, US Census Bureau).

The population of the Washington State is 6.7 million and the poverty rate is 13.5%. Oregon has 3.8 million people and a poverty rate of 17.6 %. The Federal Poverty Level (FPL) is set annually by the US Department of Health and Human Services. In 2015 the FPL for a family of four was $24,300. The overall poverty rate for the United States was 15.6%, placing Washington with a poverty rate 2.1% lower than the than the national average and Oregon 2% higher.

Poverty in Oregon and Washington

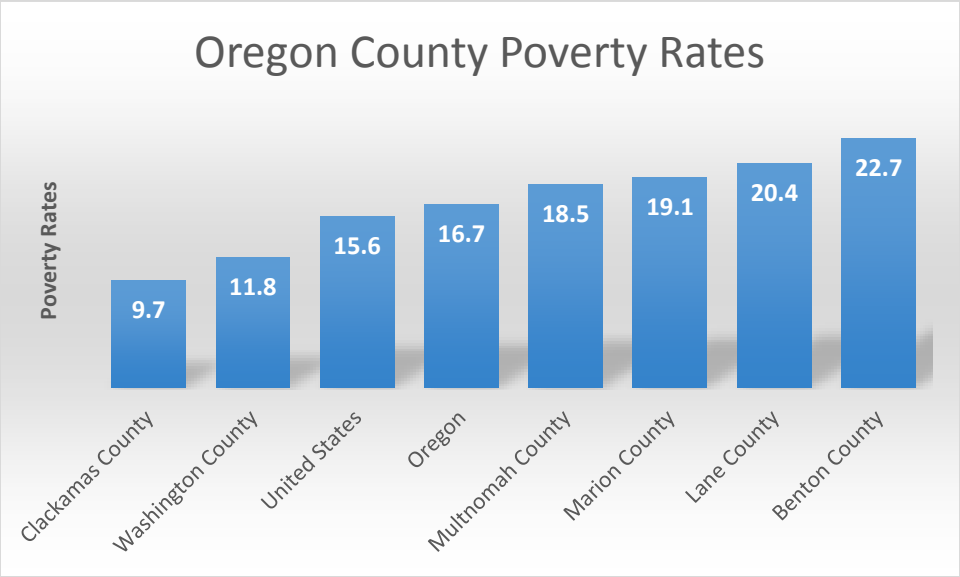

Table 1: Percentage of population in poverty: Oregon
2010-2014 American Community Survey 5-Year Estimates, US Census Bureau

There are clear differences in the poverty rates among Oregon counties. Clackamas County and Washington County, home to Intel, Nike and a number of other large corporations, are below the poverty rates for both Oregon and the US, while Benton County has close to twice the rate of poverty and in fact, has a higher rate of poverty than the worse ranked of all states, New Mexico, where the rate of poverty is 21.4%

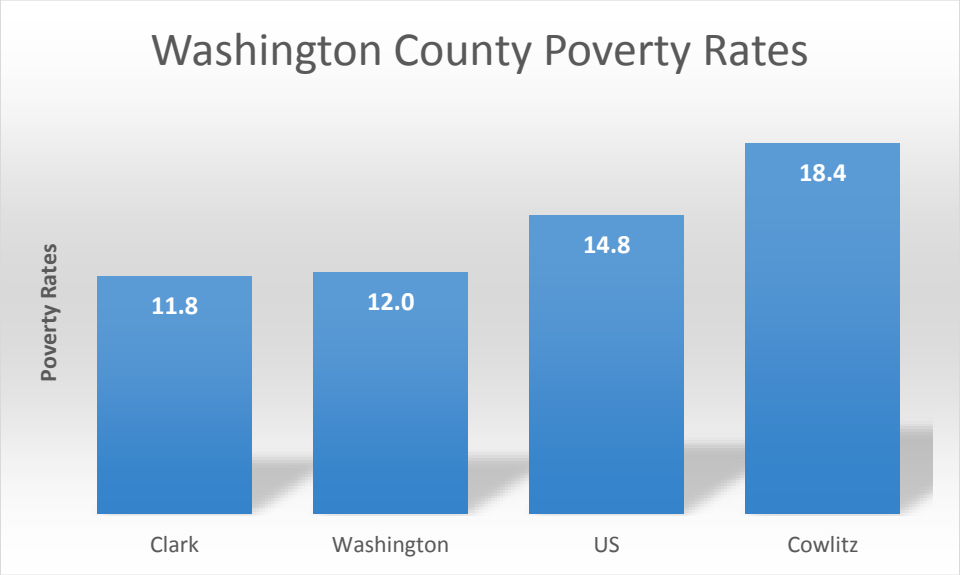

Table 2: Percentage of population in poverty: Washington
2010-2014 American Community Survey 5-Year Estimates, US Census Bureau

Cowlitz County has significantly more poverty than neighboring Clark County. Informants reported that over the last decade, several large mills either closed or downsized in that area and that many union jobs were replaced by low paying service sector employment.

Poverty is not equally distributed across age groups. More children live in poverty and experience food insecurity. The USDA defines 'food insecurity' as "a household-level economic and social condition of limited or uncertain access to adequate food." According to a 2015 Children First for Oregon report, 21.6% of children in Oregon live in poverty and 25.9% experience food insecurity. The Children's Alliance in Seattle reported that 300,000 children (19%) in Washington experience food insecurity. Households with children that are headed by a single woman are more likely to experience food insecurity (35.3%) as are African-American households with children (32.4%) and Hispanic households with children (26.9%).

Race and Ethnicity

Calculating an accurate percentage of individuals in any racial or ethnic category is challenging. Census surveys still have rigid categories and increasingly, individuals do not fit into just one category and may or may not check the box indicating “two or more races” or other vague indicators that do not reflect the multi-cultural, multi-ethnic environment found in many urban areas. The category of Hispanic/Latino can denote either race or ethnicity. However, in order to get some sense of the ethnic mix in Oregon and Washington, recent census data is presented below in five categories. The ‘White Alone’ category consists of people who identify as white and not as ethnically Hispanic or Latino.

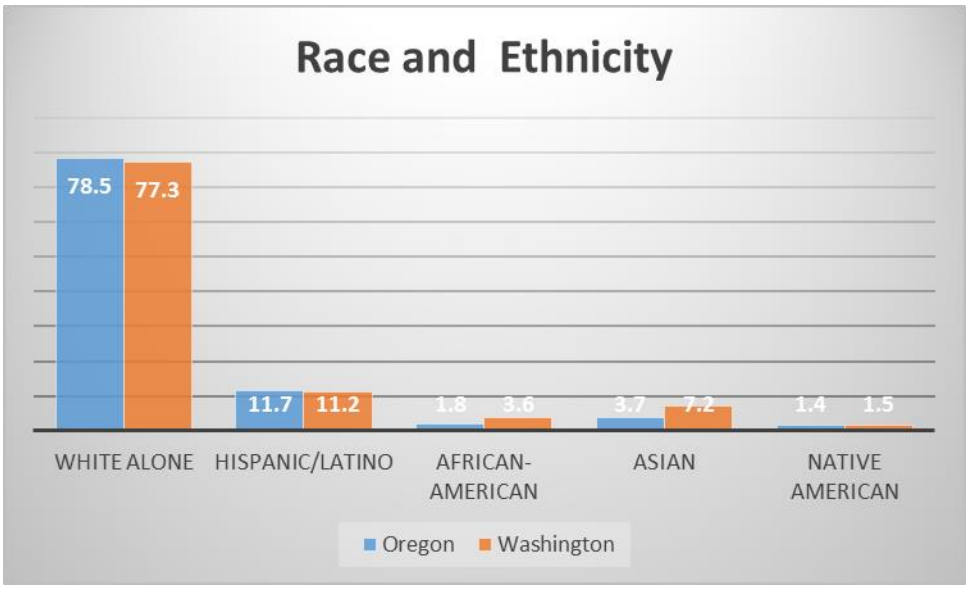

Table 3: Race and Ethnicity
2010-2014 American Community Survey 5-Year Estimates, US Census Bureau

The Medicaid population in Oregon and Washington has a different racial and ethnic profile compared to the general population. Information gathered by the Kaiser Family Foundation shows that the proportion of Medicaid recipients is significantly higher for African-American and Hispanic/Latinos compared to whites.

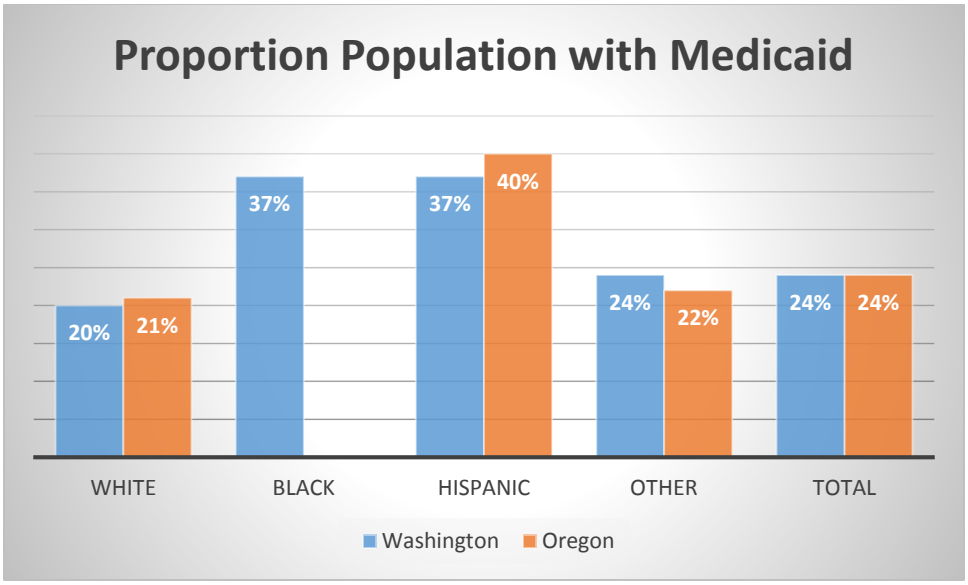

Table 4: Proportion of population with Medicaid
Kaiser Family Foundation estimates based on the Census Bureau's March 2014 and March 2015 Current Population Surveys
Note: Estimates with relative standard errors greater than 30% are not provided.

It should also be noted that the criminal justice system has a disproportionate number of African Americans and Hispanics incarcerated or on parole. According to the NAACP, African American and Hispanics represented 58% of all prisoners in 2008, even though these two groups make up only about one quarter of the US population.

The Medicaid population and those who are in the criminal justice system use the safety net system to a greater degree than the general population. This is an important consideration when discussing culturally appropriate health care in both Oregon and Washington.

National and State Reports

Behavioral Health

In 2014, the Substance Abuse and Mental Health Services Administration (SAMHSA), a division of the U.S. Department of Health and Human Services (HHS) published reports for each state concerning behavioral health. The data is from the National Survey on Drug Use and Health and the National Survey of Substance Abuse Treatment Services. Some of the key findings from the Behavioral Health Barometer: Oregon, and the Behavioral Health Barometer: Washington are summarized below.

Youth Substance Use

In Oregon, about 37,000 (12.7%) adolescents per year reported using illicit drugs within the month prior to the survey; in Washington about 60,000 (11.5%) youth reported illicit drug use, compared to 9.2% in the United States. Binge alcohol use among young people aged 12-20 was higher than the national figure in both Oregon (16.9%) and Washington (15.5%) compared to the national report of 14.7%. Binge alcohol use is defined here as drinking five or more drinks on the same occasion on at least one day in the past 30 days. The reports indicate that about 79,000 young people in Oregon and 136,000 in Washington reported binge alcohol use in the month prior to being surveyed. Two of the counties of particular concern contain 50,000 college students, so this issue might be of particular concern in Benton and Lane counties.

The National Institute of Alcohol Abuse and Alcoholism reports that 60% of college students drink alcohol and that 2 out of 3 engage in binge drinking. The consequences of binge drinking can be devastating, including alcohol poisoning, other alcohol related death, sexual assault, academic problems, suicide attempts, unsafe sex, and contact with the criminal justice system.

Substance use and abuse of both alcohol and illicit drugs remains a significant problem for youth in both Oregon and Washington.

Adult Substance Use

The percentage of adults in Oregon and Washington who were dependent on or abused alcohol were similar to the national percentage. In the United Stated, 6.7% of adults aged 12 or older were dependent on or abused alcohol; in Oregon this was 7.1% and in Washington is was 7.6%. This impacted about 268,000 individuals in Oregon and 390,000 in Washington.

The use of illicit drugs was also similar across the two states and the United States. In Oregon, about 120,000 adults were dependent on or abused illicit drugs and in Washington, about 167,000 were impacted. The age adjusted rate of opioid overdose death in the US is 14.7/100,000. The rate is lower in both Oregon (12.8/100,000) and Washington (13.3/100,000). In 2014 there were 522 overdose deaths in Oregon and 979 deaths in Washington.

The number of adults enrolled in substance use treatment for alcohol dependence or abuse (on a single day in 2013) was about 22,000 in Oregon and 42,000 in Washington, indicating that about 10% of adults with alcohol problems are receiving treatment. The

single day count of adults receiving treatment for illicit drug use was about 14% in Oregon and 11% in Washington.

Youth Mental Health

The Barometer reports looked at the number of adolescents aged 12-17 who experienced a major depressive episode (MDE) in the past year. In these reports, an MDE is defined as a period of at least 2 weeks in the past year when a person experienced a depressed mood or loss of interest or pleasure in daily activities and had a majority of specified depression symptoms. Youth in both Oregon and Washington had a somewhat higher percentage of MDE within the year being surveyed than all youth in the United States. In Oregon, about 35,000 (12.7%) of young people had at least one MDE and in Washington there were about 57,000 youth impacted by major depression, compared to 9.9% nationally.

Adult Mental Health

The percentage of adults aged 18 or older with Serious Mental Illness is similar for Oregon, Washington and the United States. Serious Mental Illness (SMI) is defined by SAMHSA as a diagnosable mental, behavioral, or emotional disorder (excluding developmental and substance use disorders) that meets diagnostic criteria specified within the 4th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV) that has resulted in serious functional impairment, which substantially interferes with or limits one or more major life activities.

Suicide is one of the leading causes of death in Oregon and Washington with more than 500 suicides a year and several thousand hospitalizations due to suicide attempts. The number of adults who had serious thoughts of suicide within the previous year were consistent with the national percentages (Oregon: 4.4%, Washington: 4.4% and US: 3.9%). In Oregon, suicidal thoughts were experienced by 133,000 adults and in Washington about 250,000 in the year prior to the survey. Disparities exist among racial and ethnic groups. In Oregon in 2012, the age-adjusted rate of deaths from suicide was highest among Hispanic and non-Hispanic Whites. There are also dramatic differences in gender and age. Suicide is essentially a men's health issue; males commit 75-80% of suicides although women attempt suicide four times more frequently. For men, the rate of suicide increases with age and for example, doubles after age 85.

Mental Health America State Rankings

In 2015 Mental Health American (MHA) published 'Parity or Disparity: The State of Mental Health in America'. This report pulled data from reports and surveys done by agencies such as SAMHSA, NSDUH Report: State Estimates of Adult Mental Illness,

National Surveys on Drug Use and Health, the US Department of Education, National Center for Education Statistics.

In the MHA publication states are compared on a number of measures. For this report, a lower ranking is better.

Both Oregon and Washington ranked high on the number of people with any mental illness. 'Any Mental Illness' is defined here as a diagnosable mental, behavioral, or emotional disorder, other than a developmental or substance use disorder, assessed by the Mental Health Surveillance Study (MHSS) Structured Clinical Interview for the Diagnostic and Statistical Manual of Mental Disorders—Fourth Edition—Research Version—Axis I Disorders (MHSSSCID) which is based on the 4th edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV).

The MHA report estimates that 18.19% of people in United States have any mental illness; Washington was ranked 47th with 20.77% or 1,074,000 people experiencing any mental illness and Oregon was ranked 48th with 20.89% or 624,000 with any mental illness.

In addition, Oregon was ranked 40th among the states in the prevalence of mental illness and lowest rates of access to care; Washington was ranked 48th among the states with the highest prevalence of mental illness and the lowest rates of access to care.

Other key findings include:

Adult Dependence or Abuse of Illicit Drugs or Alcohol:

- Oregon ranked 26th with 3.91% or 117,000 adults
- Washington ranked 44th with 4.32% or 224,000 adults

Youth Dependence or Abuse of Illicit Drugs or Alcohol

- Oregon ranked 31st, 6.71% or 20,000 youth
- Washington ranked 38th, 6.98% or 37,000 youth

Children with Emotional Behavioral Developmental Issues (Defined as a child between age 2-17 with any kind of emotional, developmental, or behavioral problem for which he or she needs treatment or counseling).

- Oregon ranked 34th, 10.42% or 78,838 children
- Washington ranked 31st, 10.02% or 139,204 children

Adults with Any Mental Illness Reporting Unmet Need

- Oregon ranked 42nd , 24.5% or 159,000
- Washington ranked 50th or 308,000

Mental Health Workforce Availability

- Oregon ranked 7th with a ratio of 410:1
- Washington ranked 14th with a ratio of 533:1

Some of the conclusions of the report were:

- Everyone should have access to care which should include medications, talk therapy, peer supports, work therapy, housing, and educational supports. MHA believes that long term services and supports should be provided in the community rather than in institutional settings.
- Youth should have access to screening and early intervention in order to reduce the negative impact of mental illness for the individual and their family.
- States should help create a strong mental health workforce (In the lowest ranked state the workforce ratio was over 1,800:1.)
- Insurance coverage should be transparent. Consumers should have more specific information about services and costs before buying insurance.
- More data about behavioral health data should be collected, and it should be uniform across the states.

Oregon Health Authority, Town Hall Meetings

In 2015, Lynne Saxton, Director of the Oregon Health Authority and Senator Sara Gelser, Chair, Senate Human Services and Early Childhood Committee, conducted six town hall meetings and one virtual town hall and heard from 550 consumers concerning mental health and substance abuse services in Oregon. Two themes were consistent across all the meetings. The first theme was Systemic Challenges that included:

- Need for improved access to services
- Lack of certain services
- Lack of coordination among providers, schools, police
- Administrative complexity

The second theme was the need for Holistic Supports that included:

- Housing
- Employment
- Transportation

The report also noted that Oregon has 237 peer support specialists and 418 certified recovery mentors working mainly at non-profits and the VA systems

Community Health Improvement Plans (CHIP)

Community Health Improvement Plans (CHIP) are developed by public health departments in all regions of the United States. The purpose of the CHIP is to help communities develop a vision of a healthy community that meets local needs. The process begins with a Community Health Assessment (CHA) and engages providers, educators, advocates, the faith-based community, law enforcement and many others to assess the gap and needs in their area. Data is gathered through community surveys, focus groups and advisory groups using national and state data particular to their geographic area. Hundreds of individuals, agencies and programs are involved in CHIP development. Counties are in the process of developing CHIPs due in 2016. Each county has a unique approach and each has decided on a set of priorities, goals and strategies.

The 2012 CHIPS for the eight counties of interest are reviewed below. The purpose of reviewing the CHIP plans is to understand how each community has prioritized health issues through their own process of assessing needs and gaps. The priorities, goals and objectives from each CHIP have been summarized and paraphrased and formatted in a similar way whenever possible to facilitate comparisons among the county plans.. Objectives and strategies that relate to health equity, access to services, mental health and substance abuse have been described in more detail than initiatives related to areas such as tobacco use.

Benton County

In 2012, Benton County initiated a community planning process to develop and implement a Community Heath Assessment (CHA) and Community Health Improvement Plan (CHIP). The Benton County process is representative of the development of the CHA and CHIP. The CHA and CHIP were developed in collaboration with numerous community leaders and other agency and organizational partners. Staff from every Benton County Health Department program and over 200 community partners contributed to the effort. Some of the data Benton County used to determine their priority areas is also included below as examples of how counties use data.

The Benton County priorities areas are:

> **1. Reduce Food Insecurity:** Over 14 percent of Benton County residents live in households that meet the definition of being food insecure, representing 21.7 percent of Benton County's children. The goals include:
>
> - Improve access to fresh and healthy food

- Improve utilization of food assistance programs

2. Reduce the Prevalence of Obesity: Thirty-five percent of adults are overweight and another 21 percent are obese. Twelve percent of eighth graders are overweight and 7 percent are obese. The goals include:

- Decrease the prevalence of overweight and obesity across the lifespan
- Encourage physically active lifestyles
- Reduce consumption of soda and other sugar-sweetened beverages among youth.

3. Increase Housing and Transportation: Approximately 35 percent of homeowners with a mortgage and 62 percent of renters spent more than 30 percent of their income on housing costs. The goals include:

- Improve housing quality for all residents
- Improve home safety for young children and older adults
- Improve utilization of alternative transportation;
- Improve safety for pedestrians and bicyclists on public roads
- Expand trails, bike lanes and connections among all communities.

4. Improve Behavioral Health: Several thousand people in Benton County have significant mental health problems. The suicide rate among adults is slightly higher than the state suicide rate. The goals include:

- Improve mental health and wellbeing among middle-school and high-school youth
- Improve mental health and wellbeing among adults aged 18 and older

5. Health Care / Community Health: In 2012, there was still a significant group of adults and children who were uninsured. The goals include:

- Promote overall health and wellbeing
- Increase access to health services
- Improve the health and wellbeing of women, infants, children and families

Clackamas County

As in Benton County, a broad group of community partners and organizations participated in development of the CHIP.

Clackamas County priority areas include:

1. Reduce Health Disparities and Health Risks

- Decrease the prevalence of obesity
- Reduce the number of youth under age 18 who use tobacco products
- Reduce the number of falls among adults over age 65

2. Engage Communities

- Establish a Public Health Advisory Committee (PHAC)

3. Strengthen Partnerships to Support Educational Achievement

- 100% of children from birth to 18 years will have access to screening and preventive physical, dental, behavioral health services

4. Increase Access to and Coordination between Services

4a. Identify collaborative opportunities and initiatives involving various organizations focused on serving Clackamas County residents

Lane County

Lane County priority areas include:

1. Improve Health Equity

- Examine the implementation of all Community Health Improvement Plan strategies through an "equity lens" to assess any disproportionate impacts on specific populations and make any necessary modifications to improve health equity
- Increase CHIP Leadership Team's and other community leaders and stakeholders understanding of health disparities in order to build capacity to address disparities
- Engage diverse communities in policy initiatives to help ensure that the impacts on health equity are considered when implementing policies
- Increase the capacity of Lane County's diverse populations to participate in community health improvement activities
- Collaborate with educational institutions and employers to diversify the workforce in health-related fields
- Increase the level of cultural competency of the workforce in health-related fields

- When determining priorities for improving health, set measurable goals for reducing health disparities
- Ensure that health information systems include data on race/ethnicity and other characteristics
- Disseminate lessons learned

2. Prevent and Reduce Tobacco Use

3. Reduce the Prevalence of Obesity

4. Prevent and Reduce Substance Abuse and Mental Illness

- Increase public, educator and healthcare provider awareness and education of substance abuse and mental health, including:
    - Risk and protective factors;
    - Mental health promotion strategies
    - Adverse Childhood Experiences
    - Stigma reduction
    - Positive social norms

- Support the adoption and implementation of mental health- friendly workplace environments to promote mental health and reduce substance abuse
- Implement policies to reduce access to lethal means of self-harm (firearms, poisons, prescription medications, alcohol and drugs)
- Implement policies that reduce the retail and social availability of alcohol and other drugs
- Support healthcare and social service providers in adopting evidence-based and trauma informed mental health and substance abuse screening, assessment, and referral policies

5. Improve Access to Care

- Increase the number of people enrolled in a health insurance plan
- Increase the number of people with a medical home
- Increase access to disease self-management programs
- Increase immunization rates
- Improve access to health care for rural Lane County residents
- Improve oral health
- Improve patient connectivity with physical, mental and behavioral health services
- Expand health care workforce – Consider directing Lane Workforce Partnership to work with the CHIP's "Access to Care" committee to

collaboratively develop a plan to expand the community's ability to meet the local health care workforce needs

Marion County

The Marion County Health Department, Salem Health, Santiam Hospital and Silverton Health formed a steering committee in 2011 and became the Marion County Community Health Improvement Partnership and developed the Marion County Community Health Improvement Plan. Marion County selected ten key health indicators which were presented to the community for review through surveys of residents and health, education and social service providers. The Marion County CHIP identified top health issues in four geographic regions. The issues are identified and the priority number assigned by each region is below:

	Salem-Keizer	Santiam Canyon	Silverton Area	Woodburn / North Co
Teen Pregnancy	1	1		2
Adult Obesity	2			1
Early Prenatal Care	3			
Adult Activity		2	1	
Teen Marijuana Use		3		
Teen fruit and veg consumption			2	3
Teen Activity			3	

Table 5: Marion County Regional Priorities

Marion County priority areas are:

1. Reduce Prevalence of Teen Pregnancy

2. Reduce Prevalence of Obesity

3. Increase Adult Activity

4. Increase Fruit and Vegetable Consumption by Teens

5a. Increase Early Prenatal Care

5b. Reduce Teen Marijuana Use

5c. Increase Teen Activity

Multnomah County

Multnomah County conducted a very extensive Community Health Assessment including 13 focus groups composed of prioritized individuals such as immigrants and

refugees and people living in rural area of Multnomah County. In addition, about 500 community residents completed and returned surveys.

Multnomah County priorities include:

1. Involvement in public decision making

- Commitment to social and civic engagement
- Responsiveness and accountability to community input and priorities
- Access to the legislative process
- Self-advocacy
- Knowing your voice counts
- Voting

2. Economic and employment opportunities

- Commitment to economic prosperity
- Innovation in workforce development
- Equity in access to living wage, employment opportunities and economic recovery
- Commitment to poverty reduction
- Access to financial education
- Hiring of more bilingual/ bicultural staff
- Pay incentives for linguistic and cultural skills
- Providing basic needs for survival
- Assistance with utility bills
- Ability to become self sufficient

Washington County Behavioral Health 2015-2020 Strategic Plan

Washington County Department of Health and Human Services conducted a survey of service providers, stakeholders and consumers to assess needs and gaps in behavioral health services. Information was gathered through a structured facilitation process with a number of councils and workgroups and the information gathered was used to create a survey that could be answered on line or on paper. A total of 207 responses were received.

Washington County priority areas include:

1. Crisis Services

- Improve access to facility-based crisis stabilization services

2. Housing

- Improved access to low-barrier and affordable housing for individuals in mental health and addictions treatment.

3. Access

- Timely access to treatment services.

Other areas of concern include:

- Improving relationships with primary care
- Maintaining good communication between county and behavioral health providers
- Retaining quality, experienced staff
- Transportation
- Access to shelters

Cowlitz County

The Cowlitz County health priorities were presented at a public forum where over 150 county residents representing 39 community organizations, faith groups, and institutions. Feedback from the forum supported the county health priorities.

Cowlitz County priority areas include:

1. **Ensure healthy starts to life for all children**

- Reduce teen pregnancy
- Reduce maternal smoking
- Reduce domestic violence

2. Improve healthy habits for residents of all ages

- Reduce adult smoking
- Reduce adult obesity
- Increase access to recreational facilities
- Increase access to healthy food

3. Increase opportunities for economic success

- Reduce unemployment
- Increase college attendance
- Reduce the number of children in poverty

Clark County Needs Assessment 2014

In 2013, Clark County conducted a community survey of needs to identify gaps in services. Thirty agencies and a total of 800 people participated in the survey. Households ranked needs in 25 categories.

Clark County priority areas are:

1. **Food assistance**
2. **Dental Care**
3. **Health Care**

These area were identified as the three highest needs in 2010 and again in 2013. Mental health services were ranked 12th, emergency shelter/housing was ranked 17th and substance abuse treatment was ranked 23rd.

Summary of County Plans

A scan of the county plans shows a wide range of concerns. The table below lists the priority areas on the left and shows how many counties listed that topic in their assessments or plans. The top two priority areas endorsed by five counties each were obesity and access to care (physical, dental, behavioral health). Food insecurity and/or concerns about nutrition were listed by four counties while three counties listed mental health/mental health crisis, tobacco, substance abuse and workforce issues as priority areas.

Topic	Benton	Clackamas	Lane	Marion	Multnomah	Washington	Cowlitz	Clark	Rank
Obesity	X	X	X	X			X		5
Access	X	X	X			X		X	5
Food Insecurity/Nutrition	X			X			X	X	4
Mental Health /Crisis	X		X			X			3
Tobacco		X	X				X		3
Substance Use			X	X		X			3
Workforce			X		X	X			3
Housing	X					X			2
Transportation	X					X			2
Health Care	X							X	2
Collaboration		X				X			2
Teen Health/Pregnancy				X			X		2
Policy Input			X		X				2
Poverty					X		X		2
Cultural Competency			X		X				2

Table 6: Summary of County Priorities.

Priority areas that were of concern in only one county were:

- Adult Falls
- Child Screening
- Domestic Violence
- Education
- Employment
- Health Equity
- Pre-Natal Care

Oregon Coordinated Care Organizations (CCO)

The Coordinated Care Organizations are an integral part of the health care delivery system in Oregon. The CCOs bring together a network of health care providers including physical health, behavioral health and dental services to serve people on the Oregon Health Plan (Medicaid). CCOs' are required to create Community Advisory Councils (CAC) to oversee the Community Health Needs Assessment (CHA) and Community Health Improvement Plan (CHP) every three years. The majority of the members on the CACs must be members of the Oregon Health Plan (Medicaid).

There are sixteen CCOs. The CCOs listed below have members in the six Oregon counties of interest.

FamilyCare, Inc. (Clackamas, Multnomah, Washington, parts of Marion County)

FamilyCare's CHIP focuses on transition age youth ages 15-25. This is a vulnerable population who are often not engaged in the health care system at a time when it would be an invaluable and supportive resource. This age group have untreated behavioral health issues but do not connect to treatment. The priorities include:

- Access to and engagement in care, specifically around mental health and substance use treatment.

- A culturally-competent healthcare system that has understanding of the transition age youth population, and operationalizes best practices in serving them.

- Support in transitioning patients from child to adult healthcare systems, especially in the area of mental health services, and for youth exiting the foster care system.

  The goals include:

- Increase health literacy and wellness knowledge for 15-25-year-old

- Increase engagement in health and healthcare for 15-25-year-old

- Improve cultural competency of FamilyCare Health Systems for 15-25 year-old members.

- Be guided by the voices of 15-25 year-old members.

Health Share of Oregon (Clackamas, Multnomah, Washington Counties)

Health Share has priorities in behavioral health and in the treatment of chronic disease. The behavioral health priorities include:

- Increase availability of culturally-specific Peer Support workers to Health Share members who identify as people of color, who speak a preferred language other than English, who identify as LGBTQ, who have a disability or who are young or elderly
- Teach primary care provider teams about peer resources and referral to Peer Support workers

- Employ Peer Support workers to provide education and outreach to communities and individuals about mental health and addictions and specific programs and services available to members
- Host community discussions about mental health and addictions issues; engage community members in a preventive manner
- Reduce disparities in utilization of mental health and addiction services by members who identify as people of color and who speak a language other than English
- Increase diabetes screening rates for members with Severe and Persistent Mental Illness (SPMI)
- Decrease hospitalization rates for members with SPMI
- Increase follow-up after hospitalization for mental illness rates for members with SPMI
- Develop ability to conduct disparities-sensitive analysis of members diagnosed with SPMI

The chronic disease priorities include:

- Increased availability of culturally-specific Community Health Workers to members who identify as people of color, who speak a language other than English, who identify as LGBTQ, who have a disability or who are young
- Culturally Specific Community Health workers share information about and lead healthy eating and physical activity groups in their communities
- Community Based Organizations train Community Health Workers on chronic disease outcomes and clinical services related to the CCO's Quality Improvement Plan
- Community Based Organizations train providers on culturally and linguistically appropriate care and Chronic Disease prevention and management in the primary care setting, including how to integrate the use of Community Health Workers into their practice
- Community Based Organizations employ Community Health Workers to conduct culturally specific health needs assessments with members
- Decrease chronic disease outcomes disparities based on Quality Improvement Plan metrics

Intercommunity Health Network (IHN) CCO (Benton County)

IHN priority addresses access issues broadly, and included capacity, availability of culturally sensitive care, language and health literacy:

Access priorities include:

- Ensure adequate provider capacity for primary care, dental health, mental health, and substance use for members
- Ensure members are seen by their healthcare provider in a timely manner
- Promote the availability of culturally sensitive care, particularly in the areas of language and health literacy
- Promote educational opportunities for all providers and staff on trainings that focus on, but are not limited to, health equity, health literacy, cultural competence, cross-cultural communication, and working with non-traditional healthcare
- Utilize and expand programs for all types of Traditional Health Workers (THWs), including Health Navigators
- Promote health equity by reducing the barriers for Latino/Hispanic and minority and seasonal farmworker children and families in accessing health and social services.

Behavioral Health priorities include:

- Increase child and youth mental health and wellbeing
- Build capacity to engage youth in substance use and mental health issues affecting the community

Chronic Disease priorities include:

- Implement primary prevention strategies to promote health and reduce prevalence of chronic disease, particularly in areas such as obesity, tobacco use, asthma, and environmental toxins
- Strengthen partnership with Public Health

Maternal and Child Health priority:

- Improve overall maternal and child health and wellbeing, including preconception needs

Trillium (Lane County)

Trillium used local community health data from a variety of sources to select five priority areas that are consistent with the Lane County CHIP:

- Advance and Improve Health Equity
- Prevent and Reduce Tobacco Use
- Slow the Increase of Obesity

- Prevent and Reduce Substance Abuse and Mental Illness
- Improve Access to Health Care

Willamette Valley Community Health LLC (parts of Marion County)

The priority areas identified by Willamette Valley Community Health include:

- Obesity Prevention and Intervention
- Tobacco Prevention and Cessation
- Access to Early Prenatal Care

The Willamette Valley CHIP strategy also included increasing the engagement in primary care in depression screening and treatment. Goals include increasing:

- Depression screening
- Treatment
- Appropriate referral

Yamhill CCO (parts of Clackamas and Marion Counties)

The Yamhill CHIP includes four priority areas:

- Promote overall well-being by reducing prevalence of chronic conditions
    - Reduce rates of obesity from the current rate of 29% to 26% in adult members and from the current rate of 12.4% to 11.2% in child members
    - Develop regularly offered provider education courses to integrate chronic conditions, mental health, and health literacy topics
    - Increase the number of patient and community education courses offered about chronic conditions available and course participation rates
    - Increase resources available to Yamhill CCO members to manage diabetes and pre-diabetic conditions

- Integrate oral health with physical and behavioral health
    - Establish a system to integrate expanded practice dental hygienists with maternal medical homes and preschool expansion programs
    - Incentivize pediatric medical providers to provide early childhood caries[9] prevention services into the well-child
    - Expand sealant programs for children
    - Increase preventative and periodontal services
    - Increase tobacco and other drug cessation counseling in dental homes

    - Community Health Workers and peer support specialists will discuss oral health need referrals with 50% of members
    -
- Leverage existing providers and health care teams' capacities in more innovative and creative ways

    - Implement a system to connect Electronic Health Record (EHR) clinical data for physical, mental, and oral health providers
    - Develop and establish a holistic provider recruitment and retention plan that includes physical, behavioral, and oral health providers and staff
    - Develop Yamhill CCO consumer education materials and classes

- Value the mind-body connection by integrating behavioral and physical health prevention, education, and treatment

    - Offer community health and prevention education courses for providers and members
    - Strengthen crisis outreach and intervention in the community
    - Expand care coordination between behavioral and physical health for both co-located and stand-alone clinics for adult and child members in need of mental health services
    - Expand alcohol and other drug services for members by 10%

Washington State Medicare System

It should be noted that the public sector behavioral health system in Washington State is in the middle of significant change. As of April 2016 Clark County became one of the first counties in the state to provide whole-person care to Medicaid clients. The full continuum of physical health, mental health and substance use disorder services will be provided within one program by managed care organizations (MCOs) and the Washington State Health Care Authority (HCA), which purchases health care services for Medicaid clients. The three MCOs providing care are Community Health Plan of Washington, Molina, with crisis services provided by Beacon Health Options.

State Plans

Oregon Health Authority, Addictions and Mental Health

In 2014 Oregon Health Authority, Addictions and Mental Health Division conducted a series of town hall meetings and requested input from three formal advisory groups and a specially convened Behavioral Health Strategic Plan Workgroup. The final report

reflected the top behavioral health priorities of the more than 500 consumers, families, providers and advocates who participated in the process. The areas of concern and interest articulated by stakeholders were:

- Prevention and promotion
- Early intervention services
- Behavioral health crisis and treatment services
- Recovery support and recovery oriented system of care
- Trauma informed care
- Innovative and flexible services
- Health equity and health disparities

The AMH Strategic Plan translated these areas into initiatives with goals and metrics in these areas:

- Promote health equity and eliminate avoidable health gap and health disparities
- Target and treat common chronic health conditions faced by people with severe and persistence mental illness, substance use disorder and co-occurring disorders
- Increase equitable access to culturally and linguistically appropriate prevention, treatment and recovery services and supports in underserved areas of the state
- Expand access to crisis services in all areas of the state
- Expand statewide access to Medication-Assisted Treatment
- Ensure all Oregonians have access to prevention and early intervention programs that are specifically responsive to diverse cultural health beliefs and practices, preferred languages and literacy levels.
- Increase the availability of physical health care professionals in behavioral health care settings.
- Develop and enhance programs that emphasize prevention, early identification and intervention for at-risk children and families.
- Strengthen the prevention, screening and treatment of the psychological, physical and social impacts of early childhood and lifespan trauma.
- Increased access to safe, affordable housing for people in recovery
- Provide supported employment services to people in recovery
- Reduce the stigma related to addictions and mental health through partnerships with people in recovery and their families.
- Provide recovery support services, including those that are specifically responsive to diverse cultural health beliefs and practices, preferred languages and literacy levels, to people who are transitioning out of substance use disorders treatment and gambling disorders as part of their continuing care plan to support ongoing recovery.

Oregon Health Authority, Office of Equity and Inclusion

The Office of Equity and Inclusion focuses on the health disparities in Oregon and promotes awareness of how cultural and linguistic diversity impacts the delivery of health care and human services. The Office of Equity and Inclusion received input from their Community Advisory Council, Strategic Planning Steering Committee and 368 community partners and stakeholder during the development of their strategic plan. Many of their strategic initiatives concerned promoting an organizational direction structure within the Oregon Health Authority that supports health equity. The outward facing strategic initiatives include:

- Foster dynamic, strength-based and authentic relationships among Oregon's diverse communities, the OHA and Oregon's health promoting systems.
- Identify and engage critical strategic and statewide constituencies to assist with policy and organizational development priorities.
- Include community in co-creating policy, data, research
- Facilitate investment in the capacity of Oregon's diverse communities to promote regional and community solutions to avoidable health gaps.
- Develop relationships with local and national researchers to identify and disseminate promising and best practice models for achieving health equity.

Oregon Health Authority, Public Health

In 2014, Oregon Public Health Division started revising the existing state health improvement plan. Input was gathered from community sessions across the state. The priorities are based on a number of factors including the leading causes of death in Oregon, where there is alignment with the Centers for Disease Control and Prevention's (CDC) Winnable Battles program. The revised plan identifies seven priority areas for improving health and quality of life in Oregon over the next five years:

- Prevent and reduce tobacco use
- Slow the increase of obesity
- Improve oral health
- Reduce harms associated with alcohol and substance use
- Prevent deaths from suicide
- Improve immunization rates
- Protect the population from communicable diseases

.

Key Informant Interviews

Safety Net Services

The term ‘Safety-Net Service’ or ‘Safety-Net’ Provider refers to social welfare services provided at the state and local level to support vulnerable individuals. These are services such as housing, supported employment or education, food, and transportation. This also includes behavioral health services not typically provided by commercial insurance, Medicaid or Medicare.

There appeared to be general consensus about the gaps and needs listed in nine categories of services and issues.

#1 Affordable Housing

Affordable housing was the number one concern voiced by almost every key informant. It was reported several times that Vancouver and Clark County have a 2% vacancy rate and it is similar in Portland. The national vacancy rate is about 6%. Portland is attractive, the economy is strong and rents have gone up. It was noted there is “no market reason” a developer would build affordable housing. Lending practices, tax credit allocations and investor cash flow needs do not encourage building affordable housing.

The housing crisis impacts staff as well as clients. For example, in Washington County many staff cannot afford to live in the communities where they work. One provider in Multnomah County discovered an employee was living in his car.

Homelessness is on the rise. Over the last ten years there has been a change in the homeless population. Historically, the homeless have been individuals with Severe and Persistent Mental Illness (SPMI) and/or those with severe substance use disorders. There was a predictable rise in homelessness beginning with the closing of many state hospitals in the 1970s. The number of homeless individuals in Assertive Community Treatment (ACT) teams has risen. Homeless individuals do not do well in ACT teams or Medication Assisted Treatment (MAT) programs or dealing with chronic medical problems. It was reported that an increasing number of people are leaving residential substance abuse programs with no place to live.

There are many more ‘singles’ who camp on the streets of Portland or who live in one of the three sanctioned areas set aside for homeless camps, Right 2 Dream Too, Dignity Village and Hazelnut Grove. Right 2 Dream Too is well organized, has stable leadership and has a blog and Facebook page. Many in this group lost jobs during the recession and are struggling to return to employment. The third group are families, often with a single mother as head of household. This group is in hiding, often living in cars or vans or couch surfing with relatives or friends and actively avoiding social welfare agencies. These families have had negative encounters with the safety net and social welfare system and fear their children will be removed.

The homelessness problem is apparent in all communities. For example, Lane County has 4-5 tent communities and many people camp out nightly.

#2 Access to Health and Behavioral Health Services

"Time is tragically wasted by putting people through a gauntlet of inappropriate services."

Access to health providers was identified as a significant problem. Both Oregon and Washington expanded Medicaid in 2012. The expansion of services has not kept pace with new demand and a backlog of unmet need. Expansion in both states was larger than anticipated and programs have not yet adapted to higher demands.

Dental services are a "big issue". Many dental providers will not accept Medicaid. Although a number of dentists generously volunteer their time in free clinics, many will not take insurance. A Washington state informant said the dental community there is blocking attempts to expand the role of dental assistants, who presumably could provide some services independently. Addictions programs also lack access to basic dental services.

Access to psychiatric services is also problematic. Providers talked about long wait times to get clients an appointment. Lane County recently lost three psychiatrists. There is also a lack of psychiatrists for addictions program.

There are not enough substance abuse services. The substance abuse service system is barely adequate for Medicaid, much less to serve indigent and commercial clients. There is a lack of addiction services for children and teens. Initiation of alcohol and meth use in kids as young as 10 years old is common but these kids are not identified until they are in their teens. There is also a need for more transitional housing for those finishing substance use disorder treatment, such as Oxford Houses.

There is concern for the 'legacy patients" who are dependent on prescription opioids. In the past, 75% of those seen in addiction programs used IV drugs and 25% were dependent on prescription medications. Now, 80% are addicted to prescriptions and 20% are IV drug users. There are a number of programs, guidelines, and technical assistance being put in place to support prescribers to reduce the dissemination of prescription opioids. However, those patients who are already addicted are turning to heroin, which is cheap and easily available. There are new business models in place for the distribution of heroin which include home delivery and sales events. Like pizza.

There is concern about the impact of the legalization of marijuana in Oregon on youth in particular.

Mental health services are hard to find for families. There is no community map or comprehensive directory of behavioral health services in Oregon. Coordination is

difficult because there are a few big behavioral health providers but otherwise a medical clinic has to call a “a hundred different therapists” to find appropriate services. A physician described using Google and the local crisis line to look for services for his patients.

Providers were also clear that ACA expansion did not reduce the need for indigent care although some of the indigent funds were moved away from agencies.

There also is a need for more access to primary care services especially for some vulnerable populations. People with SPMI have higher rates of mortality and morbidity than the general population (NASMHPD, 2006). Poor nutrition, smoking, obesity, lack and exercise and the side effects of antipsychotic medications are associated with diabetes, dyslipidemia and metabolic syndrome. People with SPMI die an average of 25 years earlier than the general population from treatable chronic conditions. There is a need for more integrated programs that target and treat chronic health conditions for individual with SPMI and co-occurring disorders. There is also a lack of access for individuals with developmental disabilities.

#3 Crisis Services

Crisis services are inadequate. There is a pressing need for more jail diversion programs that use the Sequential Intercept Model. People are getting arrested and ‘flooding’ into Oregon State Hospital for misdemeanor and felony charge evaluations. After the so called ‘370’ evaluation is completed, the individual is sent back to jail where the charges are usually dropped and they are released from jail without housing or other services.

There is a need for ER diversion services and more programs like the Crisis Assessment and Treatment Center (CATC) in Multnomah County. Lane County just opened a crisis program but there is a need to add crisis stabilization and a resolution center with housing attached. Mobile crisis teams are very effective but are at capacity.

It is anticipated that the Unity project will consolidate psychiatric emergency services in the Portland metropolitan area and be able to provide enhanced discharge planning.

#4 Access to social services and social supports

“Systems are constructed with incorrect assumptions about how people use resources.”

In this category of needs, informants focused on deficits in basic services that are huge barriers that prevent children and families from thriving.

Many informants talked about food insecurity. One physician commented that kids getting free and reduced lunches are having weight problem because the food is not healthy. Kids in poverty who develop obesity have little or no control over what they eat because so many of their meals are eaten at school. Food banks in many areas are overwhelmed and SNAP benefits are running out for some families.

Transportation is a problem for many families. Even if families live in an urban area, packing little kids onto a crowded bus can be daunting. Those who live outside urban areas have serious problems getting to and from appointments.

There is need for accessible and high quality child care. There is no consistent funding source for child care. Families are under stress and some parents cannot reliably keep appointments to take care of health and legal issues. In Portland, there are waiting lists for child care, even for families that can afford services.

There is also a need for supported employment and supported education services. Employment and education are what can ultimately break the poverty cycle and improve health and quality of life. Washington and Oregon need to improve high school graduation rates.

#5 Workforce Issues

"Work force turnover is in the high teens and twenties because of crappy working conditions and bad pay."

Informants were blunt about workforce issues and the low retention rates experienced by agencies that provide behavioral health services.

Non-profit agencies are not able to match the salaries and benefits of state and county jobs or large commercial health plans. The increase in the minimum wage in Oregon is applauded as a step forward but will, at the same time, exacerbate the budget problems experienced by small agencies. Another new rule in Oregon mandates that an employee making less than $50,400 will be non-exempt. When this takes effect, the number of staff who will be eligible for overtime pay will increase.

Another issues of concern is the high numbers of Boomer era professional staff who are retiring each year. Another headache is that some providers are working with as many as three unions. And, although there is general recognition of the need to provide continuous staff training, access standards and financial demands leave little time for staff development.

Traditional Health Workers

"A peer is not there to convince your client to be compliant."

Many agencies are using traditional health workers in physical health and behavioral health and wellness roles. There are many titles used to describe this group of workers. Traditional health workers typically have from 40-120 hours of formal training and many more hours of on the job training. It is desirable that the worker live in the same community as his or her clients and share languages and cultural background. For some certifications and types of positions it is mandatory that the person self-identify as a past or present consumer of services. Here are the many job titles discussed by community informants:

Certified Peer Counselor*	Community Health Worker*
Doulas*	Mental Health Peer*
Native American Healer	Outreach Worker
Patient Health Navigators	Peer Mentor
Peer Support Specialist*	Peer Wellness Specialist*
Personal Health Navigator *	Promotora
Recovery Coach	Recovery Mentor*

*certification available

There may or may not be state certification as a result of training. Community Health Workers (CHWs) receive an 8 week training course (but not certification) from the Washington Department of Health and can bill Medicaid for services. Consumer Voices are Born has the Washington State contract to train Certified Peer Counselors who then take both an oral and written test and can also bill Medicaid. Recovery Coaches in Washington are paid for by a SAMHSA grant. Clark County uses Outreach Workers to work with their homeless population. There is also a 40-hour training program for Mental Health Peers and the services of supervised mental health peers are billable. Both Oregon and Washington have statewide workgroups addressing issues around community health workers.

In Oregon there are five provider types that can received certification from the Oregon Health Authority:

- Community health workers (CHW) assist community members in receiving the healthcare.
- Peer support specialists (PSS) provide support and assistance to addictions and mental health consumers.
- Peer wellness specialists (PWS) provide support and assistance to address physical and mental health needs.
- Personal health navigators (NAV) provide care coordination for health care

- Doulas provide non-medical support for women through childbirth and post-partum

There are several training programs. The Multnomah County Health Department Community Capacitation Center has a 90-hour training program for CHWs. There is a 40-hour program for Peer Support Specialists which leads to certification and an 80 hour program for Peer Wellness Specialist who are trained to work in integrated setting with both behavioral health and physical health problems. Recovery Mentors are certified through the Addiction Counselor Certification Board of Oregon (ACCBO).

There are both certified and non-certified workers in many programs. Outside In has a long history of success working with homeless youth using Peer Mentors. Trillium uses CHWs in their clinics and have had good results with Spanish speaking clients and with helping clients address social needs. Marion and Yamhill Counties are using peers as well. Virginia Garcia uses Promatoras and Lifeworks has 15 peers working in programs. Volunteers of American uses Recovery Mentors in the Drug Courts and to assist with reentry from prison. A large staff of peers is working in Clackamas County, where 95 peers work in 14 programs. The county contracts with seven difference contractors that are all peer run organizations.

There appear to be three general groups of traditional workers. First are people who work primarily in prevention and health like Promotoras, Doulas and CHWs and who have a strong history and have strong organizations. There are thousands of CHWs in Oregon. The second group seem to have their historical roots in the self-help addiction recovery movement, such as AA. These people have lived experience with addiction and often hold strong opinions about the need to have a background and history that closely matches the people they are assigned to help. These mentors and sponsors are invaluable in jail and prison re-entry programs and drug and alcohol programs and Drug Courts. They know the criminal justice and prison systems.

The third group is composed of navigators who are trying to help ordinary people through an extraordinarily complex health care system and of people who are consumers of behavioral health services or who have family members with behavioral health problems. There appears to be the most uncertainty about how to use this group successfully and how to pay for their work. For example, Washington's Patient Health Advocates are sometimes being used as 'glorified receptionists' according to one informant. Peers can also become the program' taxi cab drivers' or 'mini-case managers'. And, there is a myth that the traditional health worker is there to serve the treatment team when, in fact, their role is to support the path the client wants to take.

Informants also said these positions are 'hard to fund' and that funding is 'scattered' and 'unsustainable'. Small programs may never be able to afford peer services. There is concern that the training programs needs to be longer (more than 40 hours) and

'credible'. The CHWs and PPS should be cross-trained, and is a need better definitions of the various titles and clearer job descriptions. There was also concern about how difficult it is to manage a cadre of (often) part-time workers with low retention rates. Clackamas County has addressed some of these issues by making a major (1.7M) investment in peer services. Peers do best in a setting where there are more than one or two peers working and where supervision is co-managed by a Peer Supervisor and a Clinical Supervisor. Training should include basic job skills, such as asking for accommodations, setting boundaries and calling in when sick. Many peers may have not worked for years or may be completely new to employment. Mental Health America has a training program to assist the newly employed to understand the implicit rules at a workplace and to acclimate to the traditional work environment.

There was praise for the work done by peers with traumatized families and homeless youth. In both cases peer involvement is invaluable in helping a young person or family overcome long held fears about the health and social welfare system. There are peer administrated programs doing well such as FolkTime, NAMI NorthStar Clubhouse, and Dual Diagnosis Anonymous. Central City Concern started a Recovery Mentor program with grant funding in 1999 and since that time the number of peers has grown to be about half the staff.

Finally, there was concern that people who enter these positions do not have a clear career path and that those in behavioral health peer mentor type positions will be stuck in low paying jobs. Central City Concern's human resource department helps people develop the 'soft' skills needed in the workplace using strength-based supervision which helps people prepare for positions anywhere. Clackamas County has created a career path for the peer workforce and their contractors are required to provide a living wage. The large number of peers and the years of sustained funding has allowed this program to sort through many of the issues faced by other systems.

#6 Culturally Appropriate Services

"Connecting people with their culture is part of healing."

There is understanding and support for providing culturally sensitive, relevant and appropriate behavioral health care. The difficultly for both Oregon and Washington providers is to find the workforce needed. Community organizations working on these issues include the Alliance for Culturally Specific Providers, the OHSU Intercultural Psychiatric Program and Lutheran Community Services, but there is still too little diversity in the typical workforce.

There have been successes. Cascadia Behavioral Health partnered with the Urban League to provide scholarships for culturally diverse student to become CHW. There are strong partnerships with vital local groups such as the African American Health Care

Coalition Outside In staff includes people from the LBGTQ community and Virginia Garcia uses Promatoras.

But in general it is very difficult to find masters prepared staff from diverse background, including Asian, Hispanic, Latin, and Russian cultures and to meet the growing needs of refugees and immigrant groups like South Pacific Islanders. There was a sense that some of the groups are relatively small which makes it very difficult to pull a program together. Clackamas County has the largest migrant farm worker population in Oregon, and while there are organizations working with this group statewide, many needs have not been addressed.

Providers are seeking guidance about how to make their workplace a professional and nurturing environment for a diverse work force and also how to train staff in cultural sensitivity. There was discussion about the 'culture of poverty' in Oregon and Washington and how staff would benefit from training about this as a cultural difference that impacts the partnership between patient and provider.

#7 Trauma Informed Care

"The workforce is populated with trauma survivors."

The health care field has galvanized around the ongoing Adverse Childhood Experience Study (ACES) conducted by the Centers for Disease Control (CDC) and Kaiser Permanente, San Diego. The study links childhood trauma to long-term health, education and social consequences.

There are many organizations participating in efforts around trauma informed care. In Lane County, Trillium CCO is taking the lead. In Multnomah County, the Native American Rehabilitation Center (NARA) was jointly funded by Kaiser and the National Council for Behavioral Health for technical assistance around a pilot study. NARA created a culturally appropriate screening questionnaire and identified 34 individuals with a high ACE score and diabetes. The hypothesis being tested is that attention to ACE scores will result in better self-care. HealthShare of Oregon is working with many Oregon FQHCs on trauma informed care. The Gladstone School District in Gladstone Oregon has embraced trauma informed care. In Washington State, the Children' Home Society and Public Health have sponsored a number of trainings around trauma informed care.

Trauma Informed Oregon reports an "explosion" of requests for training on ACE and trauma informed care. Many organization are familiar with the National Center for Trauma Informed Care and use their materials and information. The Oregon Pediatric Society has also developed a training program for providers.

Agencies are also aware that trauma activation is an issue for CHWs and other staff. At the same time agencies are attempting to create a trauma informed environment for patients, there is a desire to create a trauma informed environment for staff. Some peer staff have high ACE scores. One informant said it is fair to assume that if you have been diagnosed with a mental illness you have probably been restrained, arrested, locked up, threatened and victimized. Another said that 'every single peer has a trauma history'. There is a strong awareness that becoming a trauma informed program or agency calls for intervention with both the staff and clients to be successful.

There are many barriers to creating a trauma informed health system. Clinics can be a 'chaotic environment with many triggers', and trauma informed care encompasses every part of the health care experience beginning with the patient's interaction with the receptionist, or when making an appointment on the phone. Agencies need capital improvement funds to create a healing welcoming environment and to be able to pull providers and staff away from daily work for in depth training over time. Providers are also concerned that screening for ACEs creates an ethical obligation to treat and some providers are unsure of next steps. There is system change fatigue. There are many demands on PCPs and their staff and there is a sense that ACEs is just one more metric, one more box to check.

#8 Technology

Providers continue to struggle with information technology systems. There are communication problems among medical and behavioral health providers that are being addressed but are not solved. Some of the problems stem from misinterpretations of HIPAA regulations regarding the exchange of information among providers and some problems originate with the laws and regulations surrounding release of certain types of information. The exchange of information about substance use disorders is regulated by 42CFR Part 2 which retards or blocks the appropriate exchange of information among treatment team members and impacts the development and use of Electronic Medical Records (EHR). The issue with 42CFR Part 2 must be solved at the federal level.

Beyond the EHR, providers are in need of the software programs, programmers and other staff who can install, maintain, extract and interpret health data and produce reports. Health analytics is an extremely important part of managing the business of health care as well as improving clinical care. Small organizations cannot afford to make the necessary investments. However, small organization are very capable of using data when available. For example, because of the Emergency Department Information Exchange (EDIE) PreManage system, one provider was very surprised to find that 67 of their clients had used emergency rooms (ER) in one month. The provider mobilized resources and formed a rapid response team for ER diversion.

#9 Policy

Policy issues are those that remain to impact care and outcomes after everything possible has been done to understand, implement, accommodate and train on the legal and regulatory framework around the work. The origins of some policies are not clear, and some laws and regulations that impact care every day are decades out of date, like 42CFR Part 2. Public policy issues create the framework for the business of health care and also drive clinical care. Providers are frustrated with the amount of paper work required for Oregon Health Plan members, but are not always aware that most of the requirement are set by Medicaid. Informants discussed institutional, local, regional, county, state, federal and union regulations that impact the daily delivery of health care. But laws and regulations can and do change. For example, changes in the complex state laws regulating Naloxone have resulted in thousands of overdose reversals nationally.

Other Identified Needs and Gaps

- Health literacy programs
- Home visits for parents with high ACE scores
- Improve high school graduation rates
- More WRAP (Wellness, Recovery and Action Planning)
- Programs that emphasize family reunification
- Programs that promote healthy eating and physical activity like “Hallways to Health”
- Programs to enroll eligible individual in Medicaid
- Respite centers for families with teens
- School based health centers in every high school
- Services for young fathers and young parents
- Stable source of funding for suicide prevention programs directed towards10-24 year olds
- Technical assistance directed towards Washington State prescribers to address the problems of prescription drug abuse
- Timely foster case assessments

Barriers to developing safety net services

Budget and Funding

- Oregon has a budget deficit because the state employee retirement system (PERS) issues were not resolved in the last legislative session.

- Counties manage the state's traditional safety-net funds and county funds will be vulnerable in the next budget cycle.
- The structure of public funding does not facilitate collaboration across silos. Mobile crisis may not show a return on investment (ROI) for a county system, but the ROI may shows up in another budget (e.g. bed days saved at the jail) that is unrelated to the mobile crisis budget.
- Services are siloed and compartmentalized. Funding for services has not been structured in to encourage develop of a true system of care. Systems are not connected or integrated. We have "set up disconnected levels of care."
- There is a historic lack of understanding about how to use contracts to get desired outcomes.
- There are still many uninsured children and adults in Oregon and Washington.

Data and Metrics

- Agencies are overwhelmed with clinical care and it is difficult to provide quality care, gather required metrics and have time and energy to participate in learning collaboratives. Targeted funding is needed to hire and assign personnel to track and trend, gather data and conduct analysis. FQHCs already have a huge grid of data collection responsibilities.
- Paperwork required by Medicaid is cumbersome and the regulations are different for medical charts and behavioral health charts.
- 42CFR Part 2 still a significant barrier to sharing information among providers.

Strengths

Many of the informants talked about specific programs when discussing the strengths of the system. Here are some of the programs informants thought were working well, are model programs or show promise:

- ACT teams in Oregon/ PACT teams in Washington
- Behavioral Health Unit (BHU) Multnomah County/Partnership with Sherriff's Office
- CCO innovative projects and targeted grants
- Clackamas County Peer services system
- Clark County faith-based community safety net services
- Clark County providers strong collaborative relationship
- Cornerstone Crisis Center, Clackamas County
- Milwaukie culturally specific Addiction and Treatment Program for Latinos
- Kaiser funding and support for SBIRT
- Kaiser funding and support for school based health centers
- Kaiser 'Hallways to Health' program

- Kaiser and Northwest Health Foundation work on health disparities
- Lane County mobile crisis
- Multnomah County 'Reach Out and Read'
- Naloxone promotion by Multnomah County and Outside In
- Naloxone promotion by Washington State Public Health
- OHA Transformation Center work with FamilyCare to develop youth voice in regional planning councils
- Oregon CCO model
- Oregon Early Learning Hubs
- Oregon Legislative funding for behavioral health programs
- Oregon Traditional Health Workers Commission
- Project Nurture, for opiate dependent pregnant women, Health Share of Oregon
- Unity project
- Vancouver school system's 'family resource centers'
- Washington County in reach into jails to support mentally ill detainees
- Washington County Zero Suicide Initiative

Priorities and Solutions

"We can't boil the ocean."

"I'm afraid we're all going to be doing different science projects."

The table below lists the priority areas identified by the key informants and the goals and strategies that were suggested as well as additional strategies consistent with the prioritized goals.

Each of the goals and strategies below can be scaled to achieve a meaningful impact in within clear parameters. In some cases the impact will be greatest for individuals, in some cases a program will have greatest impact in the future.

	Priority Areas	Goals	Strategies	Synergy
#1	Housing	Increase the number of people with Severe and Persistent Mental Illness who are living in safe and affordable housing.	Fund Supported Housing programs with small caseloads to assist vulnerable people to overcome barriers to housing and stay in housing once placed; focus on ACT and PACT clients.	Several community behavioral health providers are building affordable housing. Both Oregon and Washington States have ACT/PACT programs. ACT/PACT are ineffective without stable housing. Consistent with Profile of KP NW Prioritized Health Needs.
#2	Access to Health Care	Increase the number of Suboxone Providers.	Develop 'hub and spoke' model partnerships so prescribers have rapid access to support for the percentage of patients needing additional assistance.	Kaiser has a robust Suboxone program. Consistent with Profile of KP NW Prioritized Health Needs.
#2	Access to Health Care	Increase the number of behavioral health staff in medical offices and the number of medical staff in behavioral settings.	Assist in the community planning and practical next steps towards applying for the next phase of the CCBHC grant.	Oregon Health Authority was awarded a planning grant for the Certified Community Behavioral Health Center (CCBHC). (Washington State is not a grantee.)

#2	Access to Health Care	Noloxone will be readily available to individuals and families of individuals addicted to opioids.	Develop a policy academy for Oregon and Washington to explore broadening the availability of Noloxone through pharmacies.	Many states are working on aligning Good Samaritan laws and other aspects of Naloxone dispensing and use.
#2	Access to Health Care	Increase the number of Noloxone training and dispensing programs in target regions.	Develop a Noloxone training program that can be replicated in communities in Oregon and Washington and fund Noloxone kits.	Multnomah County and Outside In have a successful model and the Washington State Public Health Dept. has a Naloxone program.
#3	Crisis Services	Support the Unity project.	Begin active exploration of a child and adolescent psychiatric emergency system similar to Unity.	Unity project has active participation of key behavioral health systems.
#4	Access to Social Services	See Housing		
#5	Workforce	Increase the number of traditional health workers, medical assistants and interpreters to become certified.	Fund providers to offer sign-on bonuses to traditional health workers, medical assistants and interpreters equal to the cost of becoming certified.	Consistent with Profile of KP NW Prioritized Health Needs.

#5	Workforce	Increase the number of students majoring in social work.	Offer scholarships to students majoring in social work and/or sponsor student loan forgiveness for students working in publically funded programs.	Kaiser has an existing scholarship program.
#6	Culturally Appropriate Services	Increase the number of students from diverse cultures, backgrounds and life styles majoring in social work and behavioral health fields.	Offer scholarships to students majoring in social work and/or sponsor student loan forgiveness for students working in publically funded programs.	Kaiser has an existing scholarship program.
#7	Trauma Informed Care	Increase screening for Adverse Childhood Experiences (ACE) School-Based settings.	Built on Kaiser funded school-based health projects. Add screening element and provide referral services.	American Academy of Pediatrics, Trauma Informed Oregon and regional physician champions are involved in ACE efforts. Ongoing ACE study is a joint Kaiser- CDC effort.
#8	Technology	Behavioral health agencies will use health analytics to improve care.	Assist smaller agencies to purchase software and support staff who can use health analytics methodology.	EDIE PreManage program.

#8	Technology	Behavioral health agencies will use health analytics to improve care.	Develop a learning collaborative and consortium of behavioral health agencies to use health analytics methodology.	
#9	Policy	Policy issues that impact behavioral health will be addressed at local, state and federal levels.	Develop and fund a statewide policy academy to identify and address barriers to behavioral health care that can be addressed with state and federal agencies and through local, state and federal government.	For example: Legislative interest in federal policy issues regarding 42CFR Part 2. CCC in discussion with HUD. OHA in discussion with SAMHSA re CCBHC development. Federal government is considering increasing number of Suboxone clients to 200 per prescriber.

Summary

There was consensus among a diverse group of community leaders about the needs and gaps in the current behavioral health system. The key informants were clear that moving a system forward takes energy, collaboration and resources but they were also clear that establishing programs and changing the culture of systems takes time – much more time than is usually provided by grant cycles. There was also concern that short-term, critical needs must be addressed first in clinical work and that prevention programs and long-term infrastructure building, workforce development and development of technological capabilities is often set aside while the crisis of the week consumes all available resources. Health care outcomes are also inextricably tied to sweeping societal issues such as food insecurity, poverty, homelessness, teen pregnancy and domestic violence. Leaders also cautioned that projects need to be appropriately scaled, need to include sufficient funding to execute and gather data, and should be consistent with the goals of work already underway

References

2010-2014 American Community Survey 5-Year Estimates, US Census Bureau. https://www.census.gov/programs-surveys/acs

2015 Status of Oregon's Children. Children First for Oregon. https://www.cffo.org

2015-2018 Behavioral Health Strategic Plan Oregon Health Authority, Addictions and Mental Health Division, November 2014.

2016 County Health Rankings, Oregon. University of Wisconsin Population Health Institute. www.countyhealthrankings.org/oregon

2016 County Health Rankings, Washington. University of Wisconsin Population Health Institute. www.countyhealthrankings.org/washington

Behavioral Health Barometer: Oregon. Substance Abuse and Mental Health Services Administration, *2014*. HHS Publication No. SMA–15–4895OR. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2015.

Behavioral Health Barometer: Washington. Substance Abuse and Mental Health Services Administration. *2014*. HHS Publication No. SMA–15–4895WA. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2015.

Behavioral Health Town Halls 2015 Report, Oregon Health Authority, http://www.oregon.gov/oha/amh/strategicplandocs/OHA_2015_Behavioral_Health_Town_Hall_Report.pdf

Clark County Needs Assessment, Clark County Washington, January 2014, Adopted by Community Action Advisory Board Mary 2015.

Fact Sheet on College Drinking. National Institute on Alcohol Abuse and Alcoholism. http://www.niaaa.nih.gov

Hungry in Washington, September 2015. END Childhood Hunger, Washington and Children's Alliance, Seattle WA. http://www.childrensalliance.org

Injury Prevention and Control: Opioid Overdose Deaths, Centers for Disease *Control,* http://www.cdc.gov/drugoverdose/data/statedeaths.html.

Medicaid Coverage Rates for the Nonelderly by Race/Ethnicity. Kaiser Family Foundation, http://kff.org/medicaid/state-indicator/rate-by-raceethnicity-3

Lane County's Healthy Future Version 1.0 A Plan for Empowering the Community. A Community Health Improvement Plan for Lane County, Oregon April 2013. http://www.lanecounty.org/Departments/BCC/Documents/2013_AGENDAS/101513agenda/W.A.1.pdf

Mental Health and Development: Targeting people with mental health conditions as a vulnerable group. WHO and Mental Health and Poverty Project, 2010.

Morbidly and mortality in people with serious mental illness. National Association of State Mental Health Program Directors (NASMHPD) Medical Directors Council (2006). Alexandria, VA.

NAACP Criminal Justice Fact Sheet. http://www.naacp.org/pages/criminal-justice-fact-sheet

Office of Equity and Inclusion 2011-2016 Strategic Plan, Oregon Health Authority.

Oregon Public Health State Health Improvement Plan 2015-2019, Oregon Health Authority.

Parity or Disparity: The State of Mental Health in America, 2015. Mental Health America. https://www.cffo.org

2015 Point-In-Time Count of Homelessness, Department of Commerce, State of Washington. http://www.commerce.wa.gov/Programs/housing/Homeless/Pages/Annual-Point-In-Time-Count.aspx

2015 POINT-IN-TIME Count of Homelessness in Portland/Gresham/Multnomah County, Oregon, Kristina Smock Consulting June 2015.

United States Dept. of Agriculture Economic Research Service. http://www.ers.usda.gov/topics/food-nutrition-assistance/food-security-in-the-us/definitions-of-food-security.aspx#characteristics

University of Wisconsin County Health Rankings. http://www.countyhealthrankings.org

Washington County Behavioral Health 2015-2020 Strategic Plan, Human Services Division, Washington County Health and Human Services.

Winnable Battles 2010-2015 Progress Report 2014, Centers for Disease Control, 2015, http://www.cdc.gov/winnablebattles/targets/pdf/winnablebattles2010-2015_progressreport2014_.pdf

Appendix I: Key Informant Questions

1. What behavioral health safety net services are missing or underdeveloped in your community?
2. What are the barriers to developing these services where you are?
3. What are strengths of the behavioral health safety net programs that should be retained?
4. What do you think should be the highest priority for safety net program development in the next three years?
5. Is your organization involved in providing the services of traditional health workers? If so, describe. If not, are you interested in developing programs? Who are your key partners? How are outcomes being measured?
6. What are the barriers to developing and expanding the roles of traditional health workers in the behavioral health and health settings in your area?
7. What are the major barriers to providing culturally appropriate care in health care settings?
8. Is your organization involved in providing trauma informed care? Who are your key partners? How are outcomes being measured?
9. What are the barriers to developing and expanding trauma informed care in your organization and community?
10. What other services do you think are key to the emotional and social well-being of children, adolescents and adults?
11. Are there any recent publications or surveys about behavioral health issues in your region that should be included in the research for this project?