eocco
EASTERN OREGON
COORDINATED CARE
ORGANIZATION

Comprehensive Behavioral Health Plan

July 2021

Background and Introduction

Eastern Oregon CCO (EOCCO) is a collaborative of organizations serving Oregon Health Plan (OHP) members in twelve Eastern Oregon counties with the vision of "an undivided attention to striving for a healthy community that praises the success and well-being of the individual and as a whole." We have a collective focus on creating whole-person health for our community of members, including addressing their behavioral health and health-related social needs.

EOCCO shows our commitment to an exceptional behavioral healthcare system, in part, through its ownership and governance structure. The following organizations have an ownership stake in EOCCO:

- ODS Community Health, Inc. (Moda Health) (29%)
- Greater Oregon Behavioral Health, Inc. (GOBHI) (29%)
- Good Shepherd Health Care System (10%)
- Grand Ronde Hospital, Inc. (10%)
- Saint Alphonsus Health System, Inc. (10%)
- St. Anthony Hospital (10%)
- Yakima Valley Farm Workers Clinic (1%)
- Eastern Oregon IPA (Independent Physicians Association) (1%)

GOBHI holds a 29% ownership in EOCCO, ensuring that behavioral health always remains prominent in board-level decision-making. Founded in 1994, GOBHI is a rural/frontier behavioral health and social services network, empowering individuals and communities to achieve better health. The organization also has primary responsibility for managing our behavioral health network and ensuring our members across the twelve-county region receive the care they need and deserve.

Service Area

EOCCO covers a vast geographic area of mostly rural and frontier communities in the following counties:

- Baker
- Gilliam
- Grant
- Harney
- Lake
- Malheur
- Morrow
- Sherman
- Umatilla
- Union
- Wallowa
- Wheeler

1 : Environmental Scan

As with any strategic planning effort, it is imperative to create a robust diagnostic of existing strengths and issues in order to create an effective plan, building on what is working to address challenges. Our behavioral health environmental scan utilizes a meta-analysis of multiple and key information sources to understand EOCCO members' needs surrounding mental health, substance use disorders, and social wellbeing; the existing systems to serve those needs; and areas where those services could be more effective. These information sources can be categorized into document review, data analysis, and community partner engagement. The EOCCO environmental scan sources include, but are not limited to:

- Rigorous archival and updated data analysis
- EOCCO's 2020 CHP priority-setting process
- Regular and CBHP-specific community engagement meetings
- CBHP-specific stakeholder survey

The meta-analysis synthesizes common themes from these varied sources and highlights important strengths and gaps in our behavioral health system of care. Below, we provide a brief overview of the sources we accessed and key themes we identified through our analysis of these information sources.

CHA/CHP - Every five years, EOCCO develops a regional community health assessment (CHA) and corresponding community health plan (CHP). To ensure continuous community input into our operations from across the service area, *EOCCO hosts twelve local community advisory councils (LCACs) and a regional community health partnership (RCHP)* composed of representatives from each of the twelve LCACs. These documents, along with hospital and local public health authority (LPHA) and tribal health plans, create a holistic view of the community health needs across our service area. For this CBHP, we incorporated information from all of the 2019 CHA/CHPs to identify behavioral health related themes. In our analysis, a concept qualified as a theme if it arose in at least two different LCAC focus group sessions. The twelve LCAC county-based CHA focus groups raised the following themes related to behavioral health needs across our service area:

- **Lack of access to mental health services**, specifically including inpatient psychiatric capacity, access to independent providers practicing outside of CMHPs, lack of crisis services, and wait time to appointments.
- **Stigma**—concern with people choosing not to access needed services due to stigma.
- **Substance use disorders** – the LCAC focus groups discussed this in terms of concerns of prevalence of drug use rather than concerns about the availability of services.
- **Adverse childhood experiences (ACES)/Trauma**—this was also discussed more as a concern in the community than a concern about the quality or quantity of services available.

LMHA Plans -Similarly, the local mental health authorities (LMHAs) in each county are required to complete local behavioral health plans periodically. We reviewed the most recent LMHA Plans in our service area to identify systemic gaps in behavioral health services under the LMHAs' jurisdictions. Although these documents were more tailored to specific programs and services delegated to LMHAs, some of the themes identified from these documents echoed themes identified in the CHA. Specifically, the LMHA behavioral health plans referenced lack of access to behavioral health services - including inpatient psychiatric, crisis services, and gambling addiction support services (not a Medicaid benefit).

EOCCO CCO 2.0 Application: Behavioral Health Section - OHA's CCO 2.0 RFP outlined many of the state's goals for behavioral health service delivery improvement and integration. Our response to the RFP outlined our five-year plan for assisting OHA to achieve those goals. The application covered a broad spectrum of behavioral health focus areas for the duration of the contract. We responded with a comprehensive plan to address each area of focus to ensure timely access to the appropriate level of care that is both best practice and evidence-based across the behavioral health continuum for all populations, prioritizing integrated treatment and payment models of care. Our plan also included engagement with the community with an overarching goal to improve health literacy and reduce stigma among all EOCCO members. For this CBHP, we again reviewed the document to ensure we remain on track to deliver on our commitments. As we are in year-two of the five-year plan, we have not yet completed all of the planned initiatives, but we remain on track.

GOBHI Annual Report - As the primary behavioral health benefit administrator, GOBHI's programs, services, and operations are central to EOCCO's behavioral health operations. Its most recent annual report includes:

- **Membership overview,** highlighting the diversity of the community across rural Oregon and the common social determinants of health (SDoH) in these counties
- **Overview of community investments** towards promoting quality behavioral health care to the region
- **CCO incentive measures** – success in reaching a majority (14 of 19) of the benchmarks, resulting in earning 100% of quality pool dollars
- **Caring for the Most Vulnerable** – care coordination services that cover the scope of our members' needs, attending to those with the highest utilization rate of BH services
- **CCO Service Array** – A utilization review of each service category within our evidence-based programs including ACT, Case Management, Group Therapy, Peer Services, Therapy, Wraparound and MAT
- **Oregon Center on BH and Justice Integration** – Overview of The Center's (a specialized division of GOBHI) no cost technical assistance services to Oregon communities to mitigate risk of incarceration (or for those already in the system) for individuals with SPMI, intellectual/developmental disabilities, or cognitive impairment
- **Tele behavioral health expansion** – Updates on the development of GOBHI and partners' infrastructure to provide telehealth services, including the implementation of the Mend platform to support virtual BH visits

- **Eastern Oregon Opioid Solutions (EOOS) initiative** – Naloxone distribution and training in MAT as well as other evidence-based approaches for SUD
- **Oregon Kinship Navigator** – providing support, guidance and resources to non-parent relative caretakers
- **Therapeutic Foster Care program and Foster Plus** – providing safe homes for youth involved in the Child Welfare or community mental health system

Overview of programs and initiatives - specifically evidence-based programs serving children and families, the Choice Model, Community Engagement and Health Systems, Frontier Veggie Rx, Mental Health First Aid, Older Adult Behavioral Health, Peer Services, statewide Child Parent Psychotherapy training provider, and Rental Assistance.

1.1 : Behavioral Health Needs

As part of developing and updating the EOCCO Community Health Improvement Plan, we conduct a broad assessment of the socio-economic and social determinant data in the communities we serve. When available, we compare CCO data to statewide measurements. Otherwise, we compare the 12-county Eastern Oregon region to the state as a whole. Following is a summary of data elements where either the region or the CCO diverge notably from the state.

- Socio-economic data reveals that the ***child poverty*** rate is higher in Eastern Oregon than the statewide average (23.1% vs 16.6%) and food insecurity for children is 21.4% in the region compared to 18.9% in the state. The data also shows that the percent of the population without a diploma is 14.9% compared to a statewide average of 9.2%.
- The percent of the overall ***population living below the poverty line*** is 27% higher in the region compared to the statewide rate and the percent of households with single parents is higher at 6.8% compared to the state at 5.4%.
- Social Determinant of Health data reflects the "digital divide" with just 66.4% of ***households with a broadband internet subscription*** compared to the statewide average of 85.9% as well as fewer households with a computer (87.8% for Eastern Oregon compared to 93% statewide).
- ***Maternal depression***, based on Pregnancy Risk Assessment Monitoring System (PRAMS) data shows a significantly higher rate of depression for the EOCCO enrollees compared to statewide data:

Maternal Depression - PRAMS Data by State - EOCCO Rate		
	EOCCO	State
% During Pregnancy	28.90%	20.10%
% Postpartum	47.60%	21.30%
% Depression during pregnancy or postpartum or both	48.10%	29.30%

- Teen health for 8th and 11th grade data elements aligns closely with the statewide average except for a higher percent reporting good, very good, or excellent mental health and a lower use of alcohol, tobacco, and cannabis.

EOCCO Behavioral Health Service Utilization

There are 36,378 adults enrolled in EOCCO and 14% - almost 5,500 members - have a serious and persistent mental illness (SPMI) diagnosis. The service utilization for EOCCO's population of people with SPMI in 2020 was:

	Adult	
	% & Nbr Served	Nbr of Svcs
Crisis Services	1.4% (501)	1166
Intensive Care Coordination	0.1% (43)	N/A
ACT (SPMI Only)	2.67% (132)	7911
Supported Employment	0.8% (288)	2804
SUD Outpt MAT	0.21% (76)	5133
EASA	56	N/A
EASA Referred Not Enrolled	27	N/A
Respite (Facility)	0.2% (62)	207
SUD Detox	0.63% (231)	418
SUD Res	0.71% (257)	2437
MH Acute/Sub/Inpt	0.27% (99)	336
ED Utilization Any BH Dx	0.5% (183)	2060

SUD Service Utilization

The pandemic brought many disruptions to all Oregonians with vulnerable communities disproportionately burdened by COVID-19 challenges. When considering the 17% increase in enrollment in 2020 and the significant disruption in the delivery system, the total number of clients served in the five SUD service types increased by 2% from 3,311 to 3,369 individuals. This indicates that the system adapted to the necessary changes brought about by the quarantine.

Service Type	Percent Utilization Increase/Decrease
SUD Outpatient	-5%
SUD PSS	102%
SUD MAT	124%
SUD Detox	-22%
SUD Residential	-15%

The categories of the top four diagnoses did not change substantially between 2019 and 2020. This affords EOCCO a clear line of sight into SUD priority populations. The table below shows the proportion of those with a particular SUD diagnosis among EOCCO's population of individuals with SUD diagnoses.

Diagnoses	CY 2019	CY 2020
Alcohol Abuse/Dependence	23%	19%
Opioid Dependence	38%	40%
Cannabis Abuse/Dependence	9%	10%
Other Stimulant Abuse/Dependence	30%	33%

The table below shows the number of individuals identified as having these particular diagnoses, separated by age.

Diagnoses	CY 2019 Ages 0-17	CY 2019 Ages 18+	CY 2020 Ages 0-17	CY 2020 Ages 18+
Alcohol Abuse/Dependence	30	1194	18	818
Opioid Dependence	151	543	118	360
Cannabis Abuse/Dependence	1	1,086	1	760
Other Stimulant Abuse/Dependence	14	1,238	6	965

Drug related arrests increased by 65% from 576 in 2019 to 952 in 2020. These are not unduplicated numbers and additional analysis, which is in progress, will identify individuals in this priority population. Drug related cases totaled 537 in 2020 with 85% of the cases occurring in four counties: Umatilla, Malheur, Grant, and Lake.

Prioritized Populations

OHA identified ten priority populations in the CBHP guidance document. We evaluated behavioral health and social health needs of these populations through the extensive environmental scan. As expected, these populations experience the same needs identified more broadly across the membership, though some needs are more prevalent among some populations. To follow is a brief back-drop to challenges in these data analysis.

One challenge in understanding the enrolled population at EOCCO is the relatively large number of members (17.8%) for whom we do not know their race and ethnicity. This makes analysis and needs assessment for the black, Indigenous, and people of color (BIPOC) community and tribes challenging.

While EOCCO has made data collection and analysis a priority, data to support this work has limitations. As OHA subcontractors, much of the data surrounding our membership comes from the OHA, primarily in the form of enrollment/eligibility (834) files. In gathering

data on other priority populations identified in the OHA's guidance document, we do not have access to the required information to fully assess the populations' needs. For example, the enrollment files do not discern between migrant farm workers and others, and that population is not well represented in available census data. While there is a wealth of socio-economic information available on the general population, we lack insight into the clinical health status of that population. In addition, data related to the LGBTQ+ communities is lacking. GOBHI has outlined efforts to increase our understanding of needs for that population via a LGBTQ+ Provider Survey.

The justice involved population is disenrolled when incarcerated and may or may not re-enroll with OHP when released, making identification and tracking of this population challenging. However, GOBHI's Center of Excellence on Behavioral Health and Justice Integration created methodologies to enhance data collection which greatly aids assessing the needs of this population.

EOCCO also has access to robust data elements which provide enhanced insights into the enrolled population of a) people with co-morbidities and co-occurring disorders, b) individuals with substance use disorder (SUD), c) individuals with serious and persistent mental illness (SPMI), d) children and youth, including those with Serious Emotional Disturbance, e) older adults, f) pregnant women, g) and families.

The region served by EOCCO has 205,230 residents, 4.8% of Oregon's total population[1.] In many ways the region's demographics reflect the state's demographics. For example, residents 65 and older comprise 21% of the region's population while the statewide average is 19%. In other ways, the region's demographics differ from the state and EOCCO's enrollees differ from both the region and the state.

Race	EOCCO	Region	State
% White	55.7%	73.6%	75.7%
% American Indian/Alaskan Native	2.6%	1.6%	0.9%
% African American/Black	0.8%	0.7%	1.8%
% Asian or Pacific Islander	0.9%	1.3%	4.7%
% Other/Unknown	17.8%	2.8%	3.1%
Ethnicity			
Hispanic	22.1%	12.16%	13.0%

Black, Indigenous, and Other People of Color (BIPOC) Communities and Tribes

From the data that is available, EOCCO has a much larger percentage of Hispanic members (22.1%) as compared to the region (12.16%) and state (13%). We also have a

[1] Portland State University, Center for Population Research and Census, December 2020

larger American Indian/Alaskan Native population (2.6%) compared to the region (1.6%) and the state (0.9%).

Tribal Nations

There are two federally recognized tribes in the EOCCO service area: the Confederated Tribes of the Umatilla Indian Reservation (CTUIR) and the Burns Paiute Tribe. We reviewed the Tribal Behavioral Health Strategic Plan (2019-2024) completed by OHA and conducted two listening sessions with representatives CTUIR to gather insights for this CBHP. We reached out to the Burns Paiute Indian Tribe but were unsuccessful in our attempts to connect with representative from this Tribe. Efforts to engage with Burns Paiute Tribe will continue. EOCCO recognizes tribal sovereignty and honors indigenous wisdom in the delivery of healthcare services including behavioral health. We are currently pursuing a Behavioral Health services agreement with Yellowhawk Tribal Health Center. Yellowhawk has implemented an impressive integrated, tribal/culturally specific healthcare center offering physical, behavioral, and oral healthcare to tribal members.

Migrant farm workers

Medicaid data does not distinguish the migrant farm worker population, which creates a challenge for our analysis of the needs of this population among our membership. Many migrant farm workers in our service area are Latinx, and we recently began taking steps to develop an intentional partnership with EUVALCREE community-based organization headquartered in Ontario, Oregon, dedicated to empowerment and capacity-building of Latinx communities across multiple counties in Eastern Oregon, Idaho and Washington. We are also in early contract development discussions with the Executive Director of New Horizons, a culturally-specific SUD provider serving Hermiston, Oregon and the surrounding area. We know that migrant workers need services that are provided in their language of choice and during times that they are available that do not conflict with work schedules. For these reasons, we are seeking additional providers who offer tailored services for migrant farm workers to add to our network.

Non-Medicaid population

While we do not have access to health care data about individuals who are not our members, we leverage the data available through the PSU Center for Population Research and Census to understand our broader community needs. We also analyze population health data from the Oregon Healthy Teen Survey, the American Community Survey, and other sources such as the Oregon Health Authority, Public Health Division reports on violent death, injuries, and suicide, Pregnancy Risk Assessment Monitoring System (PRAMS) reports and others to better understand the environmental context and population health trends in Eastern Oregon.

Justice involved population

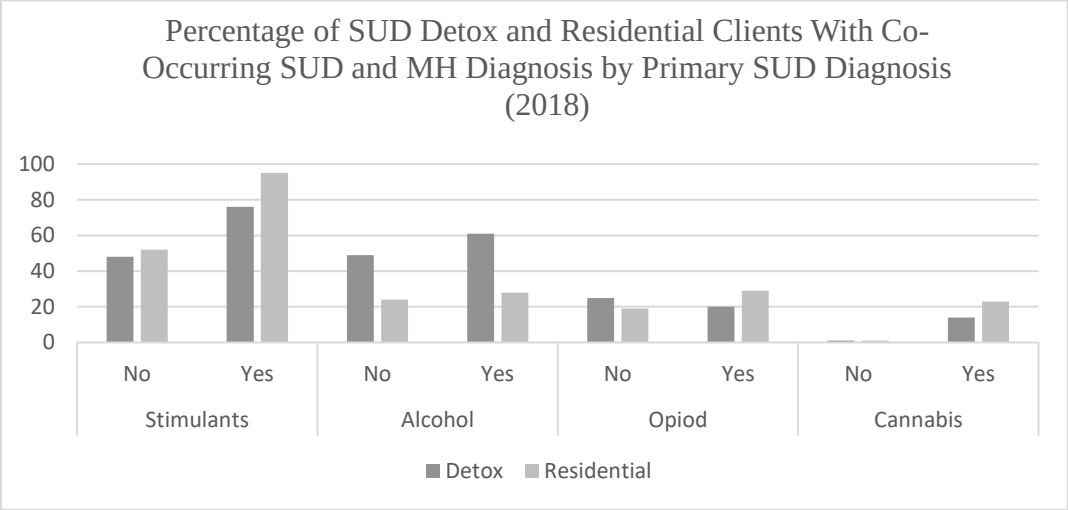
EOCCO is incredibly proud of our GOBHI-sponsored **Oregon Center on BH and Justice Integration**, a specialized division providing no-cost technical assistance and facilitation services to Oregon communities to mitigate risk of incarceration for individuals with SPMI,

intellectual/developmental disabilities, or cognitive impairment. From this work, we know that some major challenges involve transitions from care received while incarcerated to community-based care and a high incidence of substance use disorders and trauma among the population. Based on a one-day snapshot of eastern Oregon jails, 47% of those in jail were EOCCO members and 30% had not engaged in any services in 2020. This indicates that there is an opportunity to engage these populations in behavioral health care services when they exit jail.

Individuals with comorbidities and /or co-occurring disorders

Nearly eleven percent (10.4% or 952 members) of EOCCO members who engaged in a behavioral health service in 2020, had both an identified mental health and substance use disorder diagnosis. The prevalence of co-occurring disorders is much higher among sub-populations of members accessing more intensive services.

In preparation and planning for the implementation of the 1115 SUD Waiver Amendment, we analyzed the presence of co-occurring disorders by diagnostic groups for individuals accessing residential and detoxification. We found that 76 percent of individuals with a primary diagnosis of Stimulant Dependence accessing detoxification services had a co-occurring mental health disorder, and 95 percent of those accessing residential treatment had a co-occurring disorder. The chart below illustrates the presence of co-occurring disorders among clients who accessed both detoxification services and residential treatment by primary SUD diagnosis.



Older adults

Of the 2,735 EOCCO members who are over the age of 65, 6.7% received behavioral health treatment in 2020. 55.4% of those BH services delivered to older adults were outpatient mental health, 31.2% were for evaluation and management services, 2.2%

were for outpatient SUD services, 0.4% were for respite services, and the remaining 11.2% were BH services delivered in higher levels of care.

10 Most Prevalent BH Diagnosis Codes for Members Aged 65+ Engaged in BH Treatment in 2020	
Post-traumatic stress disorder, unspecified	8.3%
Major depressive disorder, recurrent, moderate	7.9%
Schizoaffective disorder, bipolar type	6.3%
Schizophrenia, unspecified	6.0%
Generalized anxiety disorder	5.2%
Bipolar disorder, unspecified	4.4%
Schizoaffective disorder, depressive type	4.0%
Bipolar II disorder	2.4%
Major depressive disorder, recurrent severe without psychotic features	2.4%
Post-traumatic stress disorder, chronic	2.4%

Pregnant women and families with children

EOCCO members have a higher incidence of maternal depression during pregnancy, postpartum, or both (48%) than the general population of the state (29%).

Interviews with over 100 early childhood community partners and stakeholders were conducted between March and December of 2018 as part of a community strengths and needs assessment process to determine strengths, gaps and needs in early childhood and parent behavioral health. Working together with parenting education and early learning partners, we hope to prevent and mitigate the impact of toxic stress on children and families in Eastern Oregon, particularly for families who are experiencing an added layer of adversity due to racism and oppression.

Eastern Oregon Coordinated Care Organization (EOCCO) identified a set of common areas of interest and priority among the 12 diverse counties in its service area to develop its 2019 – 2024 Community Health Improvement Plan (CHP). To this end, the most common priority area among the counties is early childhood prevention and promotion. A priority area related to early childhood toxic stress and trauma was developed as part of the CHP (EOCCO Community Health Improvement Plan. This improvement plan was informed by the community engagement discussions during both the focus groups and

gatherings of early learning professionals during 2017 and 2018. The goal is to *"Promote nurturing environments free from adversity, trauma and toxic stress, fostering healthy social and emotional development during the first five years so children enter Kindergarten with social/emotional mastery and ready to learn."*

Individuals with Substance Use Disorder (SUD) and Serious and Persistent Mental Illness (SPMI)

Our environmental scan indicated several needs specific to these populations. Community members noted through both CHA/CHP processes and through the community partner survey a perceived lack of access to or awareness of SUD services, inpatient mental health services, and crisis intervention services. They also note significant perceived stigma around being diagnosed with one of these conditions or receiving treatment.

EOCCO Members Receiving SUD Services in 2020 by Service Type					
Service Type	SUD Outpatient	SUD Peer Support Services	SUD Medication Assisted Treatment	SUD Detox	SUD Residential
# of EOCCO Members Receiving Treatment	2,305	483	76	231	271
% of EOCCO Members Receiving Treatment	3.5% (All Members)	0.7% (All Members)	0.2% (Adult Members)	0.6% (Adult Members)	0.4% (All Members)

EOCCO Members with SPMI Diagnosis Engaged in Supportive Services (7/1/20-12/31/20)			
Members with SPMI	% Members with SPMI Engaged in ACT	% Members with SPMI Engaged in SE	% Members with SPMI Engaged in Peer Delivered Services
4,042	2.8%	4.8%	6.0%

Children and youth including those with Serious Emotional Disturbances

Through analysis of our claims data, we identified the following proportion of EOCCO children 0-5 receiving Social Emotional Assessments over the last several years.

Percentage of EOCCO Youth Aged 0-5 Receiving a Social Emotional Assessment By Year				
	2016	2017	2018	2019
% Receiving a BH Assessment	5.2%	6.5%	8.3%	15.7%

Families

With limited mental health program options in rural and frontier communities, engaging parents in services, particularly services tailored for young children, is a significant challenge. Transportation issues across the region makes this situation even more challenging. Transportation is a huge barrier for families as described by virtually every stakeholder group interviewed during the 2018-19 analysis.

There is a critical connection between historically traumatic events and current stressors experienced by children, families, and caregivers. Over successive generations throughout hundreds of years, American Indian and Alaska Native people have experienced traumatic assaults that have had lasting consequences. These documented assaults include community massacres, genocidal policies (exclusionary policies), pandemics related to the introduction of new diseases (biological warfare), forced relocation, forced removal of children through Indian boarding school policies, and prohibition of spiritual and cultural practices. Traumatic assaults experienced by indigenous people over multiple generations have an impact today and contribute to the nature of response parents and caregivers have toward messages and outreach from the non-Indian community. Native American / Alaska Native communities have made significant strides in providing culturally specific support and education for children and families that are part of these communities. Partnerships promoting the capacity to deliver culturally specific outreach and services within Native American / Alaska Native communities should be expanded and enhanced.

An added layer of stress and fear exists for parents in our service area who are part of the Hispanic/Latinx community. We heard similar concerns from child and family service representatives in Umatilla, Morrow and Malheur that they have encountered parents who were fearful to ask anyone in a position of authority for help because they were afraid it would lead to deportation and ultimately, family separation. According to Ramon Valdez, Director of Strategic Initiatives at the Innovation Law Lab, ICE raids have a destabilizing effect on families and aggravate post-traumatic stress disorder, anxiety and depression in the community (Oregonian/OregonLive, July 16, 2019). The challenges and barriers experienced by Hispanic/Latinx families requires further exploration by engaging with these communities. Reaching this population will require building relationships with

trusted leaders from this community and tailoring messages that reach parents and caregivers from these communities.

1.2 : Community Engagement

We believe the experts on behavioral health in our region are those living in the EOCCO communities we have the great honor of serving. EOCCO continually engages with the communities we serve through our community advisory councils, collaborative governance structure, behavioral health provider engagement program, and relationships with community-based organizations. We facilitated substantial community engagement efforts to complete our most recent CHA/CHPs in each of our 12 counties—each of which identified behavioral health topics as community health needs. We accessed all of those resources to inform our CBHP environmental scan. In addition, we conducted a survey of community partners and two focus-group style strengths, weaknesses, opportunities, and threats (SWOT) analysis sessions with our provider network about the system of care in our region. Finally, we met individually with community partners to discuss the CBHP specifically. The table below briefly outlines the level of engagement we performed according to OHA's CBHP guidance document. The following narrative describes the methods of community engagement in more detail.

CBHP Community Partner Engagement Table

Community Partner	Inform	Consult	Involve	Collaborate	Shared Decision Making
Consumer Caucus	Community meetings		Individual meetings		
Culturally Specific Organizations	Community meetings	Survey	Individual meetings		
Tribal Nations (CTUIR)	Community meetings		Individual meetings		
GOBHI	All	All	All	All	EOCCO Board, GOBHI Board, CACs
LMHA	Community meetings	Survey	CACs	CACs	CACs, EOCCO Board, GOBHI Board
CMHPs	Community meetings	Survey	SWOT analysis	Provider network meetings	GOBHI Board, CACs

Regional Children's System of Care	SOC meetings	SOC meetings	SOC meetings	SOC meetings	SOC Executive Council meetings
Hospitals	Community meetings	Survey		Provider network meetings	EOCCO Board
Public Health	Community meetings	Survey			GOBHI Board, CACs
Education	Community meetings	Survey			CACs
Child Welfare	Community meetings				
First Responders	Community meetings	Survey			
Law Enforcement	Community meetings	Survey		Center of Excellence	
Corrections	Community meetings			Center of Excellence	
Courts	Community meetings			Center of Excellence	
DHS	Community meetings				
Housing	Community meetings				

Community Engagement Infrastructure

EOCCO is built to respond to the community. Our collaborative governance structure includes voices from across the health and social services spectrum, and we have thirteen community advisory councils to reflect the specific needs of each of our twelve counties and their shared vision for the eastern Oregon region. Additionally, we facilitate and host a monthly consumer caucus meeting made up of EOCCO members living with serious mental health diagnoses and who receive, or have received, behavioral health services. Together, these bodies contribute to the transparent community-informed governance of our CCO, including oversight of this comprehensive behavioral health plan.

CHA/CHP Process

For this CBHP, our primary mode of community engagement was our community health needs assessment (CHA) and community health improvement plan (CHP) process. This extensive community engagement process, which began in 2018, involved monthly LCAC meetings in each county, as well as a series of 21 focus group style community forums to inform and gather feedback from the people who live in the communities we serve. We consulted the communities through focus groups to gather their thoughts on community health needs. Four of the focus groups were conducted in Spanish.

Then, we reflected back what we heard through focus group reports tailored to each county, as well as an EOCCO-wide summary report. For the regional or EOCCO-wide report, we used software to categorize qualitative comments from participants. High priority topics were determined by counts of the number of participants mentioning the subject area or the length of the discussion during each focus group. ***Behavioral health topics received the second most attention during the focus groups, and the RCAC selected behavioral health integration as a priority for the CCO's regional CHP.***

In the local CHPs, each of the twelve counties raised at least one behavioral health issue and developed plans to address them. This year, we went back to all the LCACs to ask whether their priorities had changed. All LCAC priorities remain the same, though Covid-19 and the resulting containment measures have exacerbated some concerns. When we returned to check in on their CHP priorities, behavioral health issues remained prominent on the priority list in each county.

Individual Community Partner Meetings

Tribal Meetings

Our behavioral health partner, GOBHI, met with CTUIR to present information about EOCCO's service array, CHP, and CBHP. The CTUIR provided feedback on the presentations and input into GOBHI's plans for behavioral health, including highlighting the following needs:

- Gaps in chemical dependency treatment
- Lack of treatment providers
- Gaps in respite and diversion beds
- Telehealth
- Needs for people on the Autism Spectrum
- Transportation challenges
- Need for whole person care and addressing the root causes of health issues
- Desire to consider additional approaches to treatment, such as equine therapy and acupuncture
- Gratefulness for the meeting and a desire for continued involvement

EUVALCREE

As referenced earlier, we are developing an intentional partnership with EUVALCREE, a Community Based Organization whose mission is to build leadership capacity within the Hispanic community. One area that has been identified for immediate partnership is housing. Additional areas for partnership will be examined during a half-day planning session with EUVALCREE, which is currently in the works.

Community Partner Survey

To supplement the extensive community engagement process relied upon in developing the CHA/CHP, which forms the basis of our CBHP, we fielded a 15 question survey with community partners as identified in our CCO 2.0 application to assess behavioral health

needs across our service area. The survey was open for 15 days, and ultimately 274 individuals completed the survey. Themes from the survey are described below.

Access/Availability

- **Access to the full array of MH and SUD treatment** services were ranked as high need for individuals in the community by 2/3 of respondents.
- More than 2/3 of respondent's report that access to inpatient MH treatment, SUD treatment, and outpatient MH treatment are the greatest barriers to accessing treatment.
- Respondents overwhelmingly acknowledged that **telehealth increases access** to services and agree that it should remain an option for people who want to use it.
    - Telehealth is not seen as effective as in person treatment by 50% of respondents, but more than 75% believe telehealth options should remain an option and should expand.
    - When providers were asked about telehealth, 50% agree that it is as effective as in person treatment and 66% agree that it should be expanded.

Effectiveness of Services

- More than 2/3 of the survey respondents disagree with the premise that our system for mental health treatment or SUD treatment for adults or youth is effective
- When asked how the community supports people with mental health conditions, 68% disagree that our community has a wide range of treatment options or a robust public education program to inform people of treatment options
- More than half do not believe our MH treatment programs adequately meet the needs of people with MH conditions

Improvement Opportunities

- Respondents chose **expanding provider options** as the number one improvement to the system of care for mental health, SUD, adult, and youth.
- More than 68% of respondents do not believe our community understands **mental health issues for infants/children under 3.**
- More than 85% of respondents identified **substance use, housing, and poverty** as the most impactful stressors on the mental health of our community.
- Qualitative Responses
- 40% of survey comments focused on limited mental health care services and limited provider options and 20% focused on outpatient/community mental health services. (These were the most frequently cited categories of all comments.)

EOCCO Regional Behavioral Health Provider Network Focus Groups

As another supplemental piece of data to inform our CBHP, we included in our regular behavioral health provider network meetings a strengths, weaknesses, opportunities, and threats (SWOT) analysis of the system of care for behavioral health in EOCCO's service area. In a SWOT analysis, strengths and weaknesses are internal factors and threats and opportunities are external factors. Independent consultants facilitated the focus group

style meetings to solicit honest feedback. Approximately thirteen behavioral health providers participated across the two meetings.

Themes from the behavioral health providers' assessment of the behavioral health system of care included:

BH System of Care Strengths

- Integration with **physical health**
- Comprehensive **provider network** delivers safety net, crisis response, covered benefits, and array of specialty services, despite relative lack of resources
- **Alternative payment models** support providers and leverage other funding sources

BH System of Care Weaknesses

- BH **network arrangements** exclude some providers willing and able to serve members
- Some CMHPs perceived as **resistant to changes** in CCO 2.0
- BH providers **need to build stronger relationships** with health systems and community-based organizations (CBOs)

BH System of Care Opportunities

- Use network relationships to **collaboratively develop workforce** (e.g. master's degrees, QMHP certification, state scholarships, telehealth)
- Expand BH integration into the person-centered primary care homes (PCPCHs) and sustain certified community behavioral health clinics (CCBHCs) to promote **integration** models across counties
- Leverage regional services across **neighboring counties** (e.g. peer support)
- **Expand capacity** (e.g. psych hospital; adult & youth residential treatment) in Eastern Oregon
- **Value-based payment** is a statewide priority, and EOCCO is a leader through infrastructure development, including telehealth
- **Behavioral health policy opportunities,** such as Measure 110, SUD 1115 Waiver Amendment

BH System of Care Threats

- **Workforce shortage** and competition (large companies, physical health, scarce workforce, telehealth pays higher rates to licensed clinicians)
- Risk that **Measure 110** will establish a parallel SUD system leading to fragmentation
- Increased **substance use** in our communities potentially prompting disjointed, competitive approaches to addressing this rise
- **Different regulations** for CMHP providers vs. providers operating within a Patient Centered Primary Care clinic setting
- Fidelity expectations for some programs are exceedingly high, perhaps unrealistic, and difficult to achieve and maintain in **rural or frontier regions** (ACT teams, SE, EASA, Wraparound teams, etc.).
- Increased **regulatory burden** and **unfunded mandates**
- **Funding** for BH services does **not adequately support needs**
- Statewide programs are based on **urban models vs. rural/frontier**

1.3 : Regional Behavioral Health System Description

EOCCO's vast territory covers almost 50,000 square miles (roughly the size of the state of New York) with a total 2018 population of 205,230 people (Portland State University, Population Research Center, Dec. 2020). We serve approximately 66,000 members across our twelve counties with approximately 37.5% in Umatilla County and 20.7% in Malheur County. The region includes two federally recognized Indian Tribes, the Confederated Tribes of the Umatilla Indian Reservation (CTUIR) and the Burns Paiute Indian Reservation. EOCCO is committed to offering evidence-based behavioral health services across the continuum to individuals in the community. EOCCO is proud of our record of service to OHP members with behavioral health needs and our stewardship of public resources. According to the CCO Behavioral Health Report 2020:

- EOCCO tied for the **third lowest rate of emergency department (ED) visits for psychiatric reasons** among CCOs, indicating that our members are accessing care in appropriate settings
- 2.8% of adult EOCCO members with severe and persistent mental illness (SPMI) diagnoses **received Assertive Community Treatment (ACT) services, well above the statewide CCO average** of 1.3%
- 4.8% of adult members with SPMI **received supported employment services, the third highest rate among all CCOs**

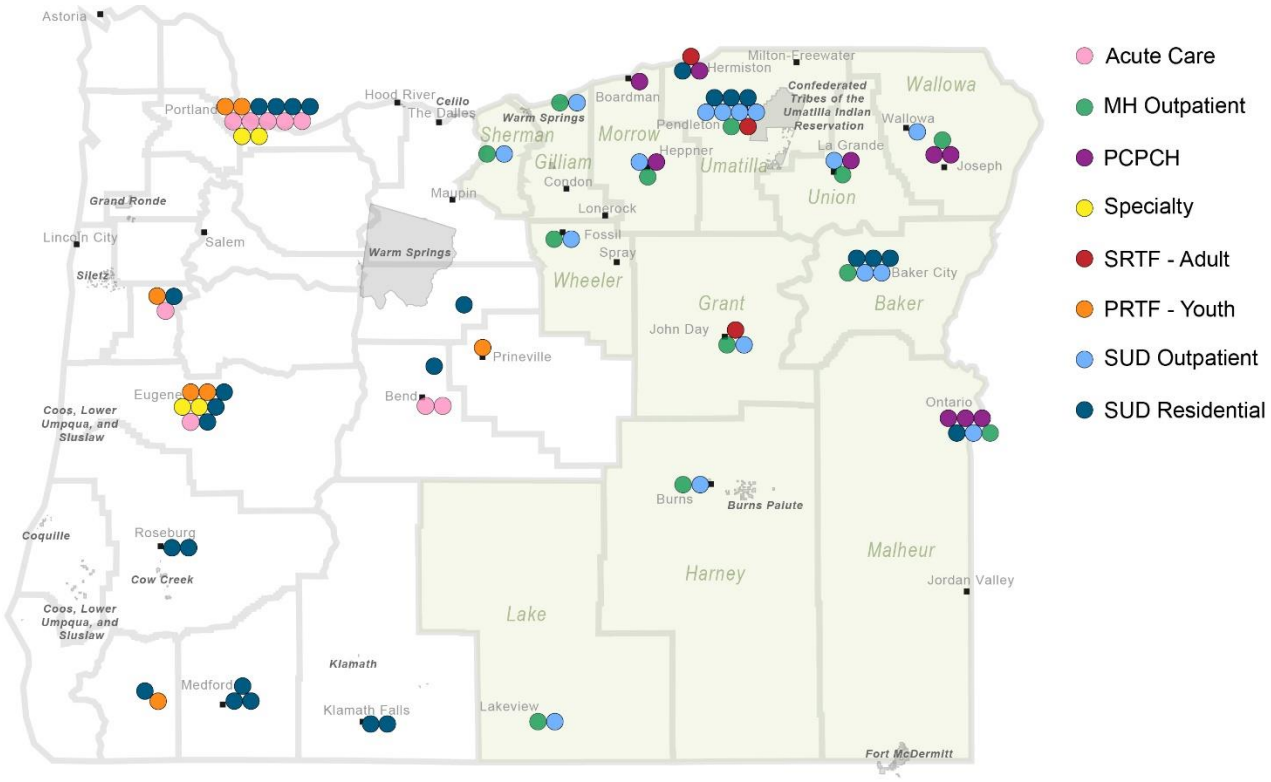
To achieve this level of performance and ensure our members have the highest quality behavioral health care to meet their needs, we administer several innovative programs:

- **Oregon Center on BH and Justice Integration** – (The Center) A major focus of this work is to divert justice-involved individuals with behavioral health issues from the corrections system and emergency department into appropriate treatment while not compromising community safety.
- **Tele-behavioral health expansion** – EOCCO and GOBHI supported the development of infrastructure to provide telehealth services, including the implementation of the Mend platform to support virtual BH visits which proved highly advantageous during the worldwide pandemic. This platform continues to be utilized and expands access in rural communities.
- **Eastern Oregon Opioid Solutions (EOOS) initiative** – This initiative, funded by OHA, supports Naloxone distribution and training in medication-assisted treatment (MAT) as well as other evidence-based approaches for substance use disorder (SUD).
- **Statewide CPP Trainer** – Child-Parent Psychotherapy (CPP) is an intervention model for children aged 0-5 who have experienced at least one traumatic event and/or are experiencing mental health, attachment, and/or behavioral problems, including posttraumatic stress disorder (PTSD).
- **Oregon Kinship Navigator** – This program, funded by the Department of Human Services, provides support, guidance, and resources to non-parent relative caretakers.
- **Therapeutic Foster Care program and Foster Plus** – This program, funded by DHS, provides safe homes with specially trained parent caregivers for youth with significant

emotional / behavioral health needs who are involved in the Child Welfare or community mental health system.

Figure 2 **maps all GOBHI in-network behavioral health service** providers across the state, with the EOCCO region noted in light gray.

*Figure 2 – **EOCCO Behavioral Health Network Service Map***



Accessibility

EOCCO promotes access to the full continuum of behavioral health services for children, youth, and adults. As part of the 2021 CMHP value-based payment (VBP) program, all CMHPs must meet the goal of 90% of people seeking their services receiving access to routine care (both MH and SUD) within ten days. Additionally, providers must provide access to 90% of members within the following timeframes to maintain compliance with their EOCCO contracts:

Service	Timeframe
Emergency care	24-hours or as indicated in initial screening
Urgent care	24-hours or as indicated in initial screening
Routine care for non-priority populations:	Assessment within seven days of the request, with a second appointment occurring as clinically appropriate.

Specialty Care For Priority Populations:

1. If a timeframe cannot be met due to lack of capacity, the member must be placed on a waitlist and provided interim services within 72 hours of being put on a waitlist.
2. Pregnant women, veterans and their families, women with children, unpaid caregivers, families, and children ages birth through five years, individuals with HIV/AIDS or tuberculosis, individuals at the risk of first episode psychosis and the I/DD population: Immediate assessment and entry. If interim services are necessary due to capacity restrictions, treatment at appropriate level of care must commence within 120 days from placement on a waitlist;
3. IV drug users including heroin: Immediate assessment and entry. Admission for treatment in a residential level of care is required within 14 days of request, or, if interim series are necessary due to capacity restrictions, admission must commence within 120 days from placement on a waitlist;
4. Opioid use disorder: Assessment and entry within 72 hours;
5. Medication assisted treatment: As quickly as possible, not to exceed 72 hours for assessment and entry;
6. Children with serious emotional disturbance as defined in 410-141-3500: Any limits that the Authority may specify in the contract or in sub regulatory guidance

EOCCO tracks wait times collected from contracted providers on a quarterly basis and conducts an annual member survey to monitor timely access to behavioral health services. Other data collected includes average number of days after initial visit to scheduled routine follow-up, average time from LMP (prescriber) appointment request to date of first available appointment and average time between initial crisis call and start of crisis assessment. We also monitor claims-based data for average timelines from assessment to service plan and from service plan to first delivered follow-up appointment.

Via the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey, access to outpatient care for youth and adults is tracked and reported as one of the CCO quality incentive measures. Our current targets for access to outpatient care are 84.2% for Adults and 91.2% for children. EOCCO is close to these targets, reaching 80.7% (adults) and 86.7% (children) in 2019.

Telehealth is another route to broaden access to behavioral health care, enabling providers to reach individuals throughout the service area and in EOCCO's more remote, rural communities. Through the Mend platform, telehealth visits have increased significantly with over 3,761 telehealth visits in 2019, and 42,493 behavioral health services via telehealth in 2020. This is more than a **1,000% increase between 2019 and 2020.**

The Choice model is an example of an OHA initiative that EOCCO has implemented that promotes the removal of barriers and increased access to integrated services and supports, especially for those persons being discharged from the Oregon State Hospital (OSH) and establishing residence in supported housing. Successful implementation and

operation of the Choice model has resulted in ***no EOCCO members in the Oregon State Hospital in 2020***.

Social Determinants of Health Services and Supports

While healthcare access and quality are important, EOCCO recognizes that health outcomes are most influenced by economic, social, educational, and built environments as opposed to what is provided in a clinical setting. As such, we either provide directly or support organizations to provide services to meet our members' unmet health-related social needs.

Community Benefit Initiative Reinvestment (CBIR) Grants

We invest in the EOCCO service area to help providers and members learn about, plan, and implement strategies to reduce health concerns in Eastern Oregon. EOCCO solicits the following types of grant applications for the CBIR investments:

Transformation Application: This includes "Opt-In" projects aimed at specific incentive measures and opportunities for continuing a previously funded project. For the 2021 application cycle, Opt-in projects are focused on the following areas: COVID-19 primary care, hospital and public health capacity building; language services; comprehensive diabetes care; and immunizations.

LCAC Application: This includes the opportunity for Local Community Advisory Councils to apply for funds allotted to their counties to implement projects aimed at improving the health of their communities.

New Ideas Application: This application allows applicants to propose novel ideas focused on the topic areas outlined in the application form, including incentive measures, new collaborations, telehealth and broadband capacity, behavioral health integration, assessing and addressing health disparities, and assessing and addressing health-related social needs.

Public Health Department Application: This application allows applicants to propose projects led by public health departments to improve the health and wellbeing of EOCCO members and their communities.

One example from our "new ideas" portfolio includes funding to support the work of the Oregon Senior Peer Outreach (OSPO) project. This program, operated by Community Counseling Solutions (CCS), offers friendly weekly calls to older adults who may be experiencing loneliness, isolation, sadness, grief or loss. This peer support program is designed to increase the well-being of Oregon Seniors (55+) who live in the rural and frontier counties and has recently expanded to serve all Oregon older adults who are suffering from isolation due to the worldwide pandemic. The program is offered in English and Spanish. GOBHI older adult specialists make referrals to the program and collaborate to ensure that older adults needing referral to behavioral health services are provided with relevant and timely information and connection to these services.

Health Related Services (HRS)

EOCCO utilizes Health Related Services (HRS) funds to provide non-traditional resources to our members. In 2019, 925 members received support, and in 2020 8,957 members received support. In 2019, of the 925 members who received HRS funds:

- 288 received funds as part of our Cribs for Kids Program
- 409 received funds as part of the Adolescent Well Care Visit Incentive Program
- 168 received funds for Back to School Backpacks that promote oral hygiene and education
- 36 received funds for our online pain management training

Children's Flex Funds

EOCCO's Children's Flex Funds are utilized through our System of Care for youth and families who may receive services through Wraparound, Intensive In-Home BH Treatment (IIBHT) Intensive Care Coordination (ICC), Applied Behavior Analysis (ABA), and Intensive Outpatient Services and Supports (IOSS). These funds cover non-traditional services and resources such as: equine therapy, music/dance lessons, swim passes, fitness center passes, summer camps, school sport fees and equipment, parenting classes, bed bug removal, etc.

In 2020, twenty-eight (28) youth and their families received thirty-eight (38) approvals for flex funds. These flex funds provided items such as weighted blankets, diabetic snacks for youth learning to choose appropriate snacks, punching bags, driver's license for youth needing transportation to work after she purchased a car, restaurant gift cards for families learning to spend quality time together, sheetrock to finish a wall so youth could move home to family, rent payment due to family w/covid-19 being unable to work, camps, gym passes, swim passes, music lessons, and celebrations of many kinds. Members are given the opportunity to decide how to use their flex funds, and one memorable choice was a member wanted matching dishes just so that she and her family would be able to eat off matching dishes for dinner.

Support Services for Seniors

Support services for Seniors includes the Oregon Senior Peer Outreach (OSPO) program, which started in July 2017 and has steadily expanded to reduce isolation and loneliness among seniors living in the rural and frontier regions of Oregon. Loneliness dramatically reduces quality of life, health, and mental functioning. By using Intentional Peer Support, OSPO companion calls have shown reductions in loneliness and an increase in life satisfaction. Almost 30 community partners including GOBHI, Providence, and Community Counseling Solutions, have referred 167 seniors to the program. In addition, 23 seniors self-referred. The three top reasons for referral were loneliness, social isolation, and depression. In 2021 OSPO began offering the Program to Encourage Active and Rewarding Lives (PEARLS) program. PEARLS is an evidence-based intervention for older adults living with mild-to-moderate depression.

Screening for Health Related Social Needs

In addition to the initiatives that are providing Health Related Services (HRS), EOCCO has actively worked to develop an infrastructure to support and sustain timely and effective processes to screen for and address health related social needs. Our Health Equity and Research Consultant has participated in a workgroup convened by the OHA transformation center to design a social needs screening CCO performance metric measure. Working with our health care, research, and community partners, we have developed project plans to drive innovation in the implementation of social needs screening. Such project plans and planned pilots prioritize the community, cultural, and linguistic responsiveness of social needs screening and of the steps that follow to meet identified needs. Innovation initiatives focus on leveraging technology such as digital health platforms and coordinating with community partners, including the community-based organizations that are often in an optimal position to meet the health related social needs.

Regional Social Determinants of Health Priorities

Our regional CHA identified two main region-wide social determinants of health needs and priority areas, food insecurity and housing. We developed several initiatives to address each in our most recent CHP.

Food Insecurity

We have included five objectives under the food insecurity priority area under our current CHP:

1. **Support and expand Frontier Veggie RX program**

The Frontier Veggie Rx (FVRx) Program is a healthy eating initiative that supports individuals and their families in Gilliam, Harney, Sherman, and Wheeler counties. Through this voucher program, local prescribers assess individuals to determine if they are food insecure. If eligible, people may receive a monthly prescription to buy healthy fruits and vegetables from local stores or farmer's markets. The FVRx program improves the overall health of an individual and community by addressing food insecurity issues, collaborating with local vendors to provide a greater variety and lower cost of fresh fruit and vegetables.

2. **Promote Double-Up Food Bucks Program**

We are working with existing Double Up Food Bucks programs to expand opportunities in other places. This program encourages Supplemental Nutrition Assistance Program (SNAP) recipients to use their benefits at Farmer's Markets

3. **Increase knowledge of community members of local Food Banks/Pantries**

We have developed a series of communication tools to increase awareness of food banks and pantries across our service area. These include handouts and a directory of food resources.

4. **Support Community and School-based Garden Programs**

We are also creating communication tools to increase knowledge of and utilization of community and/or school based gardens. This includes an inventory/directory of gardens across the service area and planned social media campaigns.

5. **Partner with Food Corps programs and Oregon State University Extension within the service area**

We are inviting Food Corps staff and OSU Extension staff to join the LCACs and present to the LCACs about existing programs to address food insecurity across the service area.

Housing

Our goal for this health-related social need is to expand upon the knowledge of LCACs and community residents to support their active engagement in community housing planning and development for the purpose of providing safe, healthy, and affordable housing for all residents. We are employing several strategies to meet this goal:

- Establish relationships with **supportive housing providers** and identify funding opportunities.
- Provide information on **Oregon's Point-in-time Homeless count** and solicit interested participants to help with count in coordination with local community action programs.
- As determined by each LCAC, focused activity on identified community housing teams and county housing providers to **inform LCACs about existing services** and how they collaborate.
- **Advocate** for and support housing needs within individual communities.

Co-Occurring Treatment

Physical Health/Behavioral Health, Mental Health/SUD

EOCCO's PCPCH Behavioral Health Integration model involves the development and sustainability of collaborative care teams between physical health and behavioral health to meet the needs of each member and situation. To improve primary care services for patients with behavioral health care needs, EOCCO incorporates the following objectives as part of the overall scope of work:

- Ensure that behavioral health clients are enrolled in Patient Centered Primary Care Homes (PCPCH) Tier 3 or higher within the EOCCO region. PCPCH's plan to incorporate the Primary Care Behavioral Health (PCBH) or Collaborative Care Model (CCM).
- Increase access and availability to behavioral health services to all members
- Incorporate a systemic clinical approach that:
  - Employs methods to identify patients who benefit from integrated care
  - Creates seamless processes of collaboration and coordination with local Community Mental Health Providers (CMHP) and SUD Providers
  - Engage patients, caregivers and/or their families in identifying needs within their PCPCH

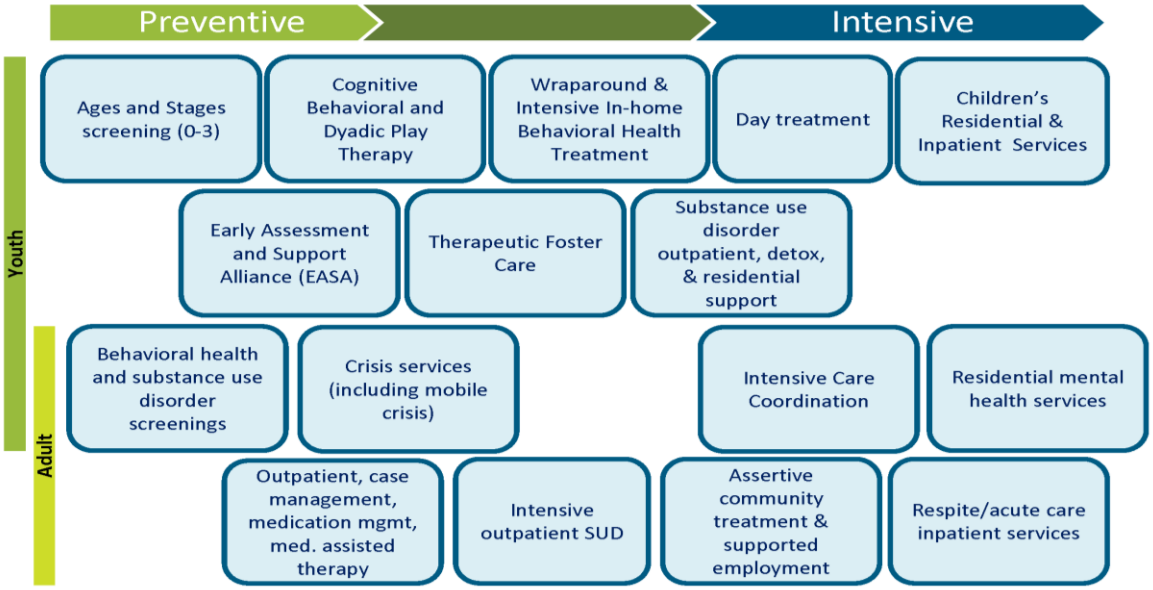
- Incorporate a team based care approach in member decision making (includes PCPCH, member, caregivers and/or family, CMHP and/or SUD providers as needed)
- Utilize an explicit, unified, and shared care plan with CMHP and/or SUD, when necessary
- Establish guidelines for a systemic and seamless referral and follow-up plan for members and the care teams
- Utilize a population-based approach for group visits/interventions for high-impact group

The **Certified Community Behavioral Health Clinic** (CCBHC) model is being piloted in three Community Mental Health Programs (CMHP) in our region to integrate physical health in behavioral health care clinics. This model of care was created through Section 223 of the Protecting Access to Medicare Act (PAMA), which established a demonstration program based on the Excellence in Mental Health Act. EOCCO staff and the EOCCO data analytics platform provide data to help track progress on quality measures. In smaller communities where the population does not support providing primary care within the CMHP, we utilize contracting expectations to ensure that care is coordinated between the CMHP and the PCPCH. The region is moving toward a **prospective primary care payment system** in which clinics will receive an enhanced payment up front for agreeing to provide integrated behavioral health services and adhering to a set of evidence-based standards for providing that care. As of the implementation of CCO 2.0, EOCCO funds behavioral health provided in a primary care setting and will provide funding for primary care delivered in a behavioral health setting.

Capacity to Serve In Different Levels of Care

As depicted and described below, EOCCO's network of behavioral health providers deliver a comprehensive array of behavioral health services to our members across the continuum of care needs. We offer access to all covered behavioral health services from preventive to intensive for all ages, regardless of diagnosis, severity of condition, or level of care required.

Figure 4 ***– EOCCO Behavioral Health Service Array***



Community-Based Services

Many of our members rely on community-based services, such as Assertive Community Treatment (ACT), supported employment services, supportive housing services, peer delivered services, in-home behavioral health treatments, and applied behavioral analysis (ABA) therapy for children on the autism spectrum. These are often wraparound services provided to help members with behavioral health conditions thrive in the communities where they live. Some of our innovative community-based services programs include:

- EOCCO believes in the power of peer services in assisting people with behavioral health conditions to achieve recovery and build resilience. EOCCO's behavioral health program has overseen a peer delivery system that provided services to more than 900 members for mental health and substance use disorder in 2020. We utilize **certified peers** in the delivery of care for both adolescents and adults. Peer services are available in-person through local CMHPs and through HIPAA compliant tele-behavioral health software. In addition, EOCCO led the effort for members to become certified peer support specialists. EOCCO through GOBHI utilizes a network of 72 peer support specialists and was one of the first CCOs to establish a rate of reimbursement to support the utilization of these workers at a competitive salary.
- The **Positive Parenting Program (Triple P)** provides parenting education, which allows a practitioner to identify family needs for supports and services. The program provides incentives to participating families, such as diapers, formula, gas cards, and home safety supplies. EOCCO funded a Triple P Coordinator position in Umatilla County as a pilot program through June 2019 and has since spread the model to other counties.

- Until March 2020, EOCCO also contributed financial support to expand staffing in the two Eastern **Oregon Relief Nurseries** that are located in Umatilla and Malheur counties. Relief Nurseries offer in-home family support, provide transportation, connect clients to community supportive services, meet immediate needs such as diapers, food, safety equipment, clothing and much more. Relief nurseries also provide therapeutic classrooms for babies and young children, parenting education, and respite care provided through relief nursery staff and services. Relief Nurseries work closely with Oregon's Department of Human Services (DHS) to keep children at risk of child welfare system involvement at home with their primary parent or guardian. Our behavioral health partner, GOBHI, pays rent to the Pioneer Relief Nursery for use of their space for our ABA clients, and our Triple P Manager sits on their board of directors.
- EOCCO has a strong partnership with Oregon Supported Employment Center for Excellence (OSECE) to provide **supported employment services**. This program partners with Assertive Community Treatment providers to assist members with SPMI with employment.

Outpatient

EOCCO offers the full array of outpatient behavioral health services from screenings to outpatient case management, medication management, and cognitive behavioral therapy. For children, we provide evidence-based developmental screenings, cognitive behavioral and dyadic play therapy, and Early Assessment and Support Alliance (EASA) services for children experiencing symptoms of psychosis for the first time. Some areas where our efforts led to dramatic improvements include:

- Grant County **developmental screening rates** have increased from 5.2 percent in 2014 to 32 percent in 2019. EOCCO's Grant county LCAC partnered with early learning, early intervention, local pre-school providers, Grant county public health, Strawberry Wilderness Community Clinic, and public schools worked together to support an annual Community Developmental Screening Week. This campaign encourages parents to conduct the ASQ screening with their children and the assistance of early learning providers. Families receive local gift card incentives to participate, at both the point of screening (incentive provided by early learning hub) and again at the appointment or well-child visit to review the screening results with their primary care provider (incentive provided by the LCAC). The LCAC also provides funds to cover the cost of mailing screening results from parents to the primary care provider.
- EOCCO's assessments and plans for **Intensive Care Coordination (ICC)** are based on current OARs (410-141-3860-410-141-3870) and the CCO 2.0 contract. The Intensive Care Coordination Plan (ICCP) is an interdisciplinary document that includes supports, outcomes, and personal goals. The ICC assessment identifies the physical, behavioral, oral, and social needs of the member. Members of prioritized populations shall automatically be assessed for ICC services within 10 calendar days of a completed health risk screening or sooner if indicated. When there are triggering events such as an ER visit or New Chronic Disease diagnosis; including behavioral

health, the member is contacted if it is determined by the ICC in their professional opinion it is necessary to reassess the member or update the ICCP.

Inpatient

EOCCO also covers the full spectrum of inpatient and residential psychiatric and substance use disorder care for our members. Although some inpatient and residential services must be provided outside of our service area due to lack of availability, we have been successful in providing access to other programs and service supports such that we did **not have a single Oregon State Hospital admission in 2020.**

- EOCCO continues to look for opportunities to invest in and partner with the development of both large and small, **specialized residential treatment and adult foster home capacity** that can work with certain subsets of the population who are extremely difficult to place. Knowledgeable and experienced Residential Care Management staff continue to promote flexible clinical programs, designed to adapt to the specific needs of individuals at risk for higher levels of care.

Crisis

EOCCO's CMHP providers are responsible for responding to behavioral health crises at the location in the community where the crisis arises within either 1, 2, or 3 hours based on the location's designation as either urban, rural, or frontier. Additionally, EOCCO CMHPs provide mobile crisis services as part of the 24/7 crisis standard. These mobile crisis services are designed to respond to members in crisis in the community without requiring a trip to the local emergency department (ED). We have invested in several additional programs to reduce unnecessary law enforcement involvement or emergency department use:

- Pilot programs are underway with Crisis workers "riding along" with local law enforcement to help facilitate getting Members to the appropriate care immediately.
- Via the Collective Medical Technology's platform, EOCCO and CMHPs are notified each time a member visits an ED. Our care managers then review reports of these ED visits to determine members with 2 or more ED visits who need to be contacted and assisted in connecting to appropriate services. Individualized Management Plans are developed and implemented for members with 2 or more visits to the ED within a six month period.

We are developing alternatives to ED services, including:

- **Tele-behavioral health services** allowing members to connect with psychiatrists, therapists, care managers and peer support without the member needing to leave their home or any other location. With support from a three-year HRSA grant, EOCCO is working to make these services available 24 hours per day, utilizing shared services across the EOCCO region. Funds are also available to provide members with cell phones, iPads, cellular data, or internet access as needed.
- EOCCO CMHPs have worked to **extend office hours** to provide easier access to

members and in some areas have transitioned to offer same day access with no appointment necessary. Many CMHPs now have evening or weekend hours. EOCCO will continue to provide incentives to expand these services.

- For children and adolescents who are in the child welfare system or at risk for out of home placement, EOCCO uses Therapeutic Foster Care (TFC) to establish a **Planned and Crisis Respite program** across the EOCCO service area. CMHP staff are able to refer to and access Crisis Respite services from highly trained foster parents, with 24/7 on-call crisis support from the TFC team.
- EOCCO is currently working to develop and implement a **Regional Crisis Center (RCC)** in Wasco, Oregon for Oregon DHS Youth to defer from hospitalization and out of state placement. The proposed facility will be a temporary residential placement for DHS identified youth. The RCC will complete an evaluation of individual needs and provide treatment services. The RCC will use an array of clinical methods to stabilize the behavior of youth in crisis.

Substance Use Disorder

EOCCO offers all covered substance use disorder treatment and recovery services to our members from outpatient to detoxification/withdrawal management and residential treatment. We are very excited to begin implementing strategies with OHA in support of the newly approved SUD 1115 Waiver as well, which will further expand the service array to include outreach, engagement and transition supports for individuals with serious SUD conditions. Services are available to youth, and adults. Highlighted programs include:

- Our Eastern Oregon Opioid Solutions (EOOS) initiative that leverages state and federal funding to support the **distribution of naloxone**, a life-saving opioid overdose reversal drug, to members of the general public and community partners. EOOS is an interdisciplinary team representing social work, human services, clinical services, and law enforcement. This team seeks to form meaningful relationships with various stakeholders across the region in an effort to implement several evidence-based strategies for addressing addiction and preventing overdose.
- **Certified Peer Recovery Mentors** are deployed to broaden the spectrum of care beyond traditional walls and provide care to all who need it, including people in the ambivalent or pre-contemplative stage of readiness.

Care Transitions

EOCCO's approach to care for members with an established residential treatment history focuses on transition issues and building long-term connections to natural systems of support. Coordination between Care Management (CM), Utilization Management (UM), clinical staff and community partners is critical as members move through various levels of care. We provide Choice Model and Care Coordination staff with a variety of skills to work with CMHPs and community partners to assure these transitions are successful.

EOCCO requires our provider network to initiate discharge planning at the beginning of an episode of care. We collaborate with CMHPs in discharge planning involving all

members moving between levels of care and episodes of care. Our utilization management team monitors the Collective Medical Technology's platform daily and notifies the CMHP the same day of an admission. The Intensive Care Coordinator (ICC) immediately begins the discharge planning process and communicates the plan with EOCCO Care Manager within one to two days. The patient or patient's representative are included in the discharge process. Throughout the discharge planning process, open communication and close collaboration occurs among the CMHP, EOCCO UM and EOCCO CM staff to ensure a timely and successful discharge.

Collaboration with the Confederated Tribes of the Umatilla Indian Reservation and the Burns Paiute Tribe have been, and continues to be, ongoing in the area of systems and services for tribal members with SPMI who need effective transitions from institutions, including jail, or transitions back to community from hospital levels of care. Representatives from both tribes participate in helping determine and develop strategies regarding needs and gaps related to Member transitions of care.

Levels of Care
EOCCO provides coordination and support through transitions between all levels of care for both mental health and SUD services.

EOCCO oversees care coordination of members throughout the system at all levels of care and over multiple episodes of care, including outside the service area. Each member involved in different levels of care is assigned to a CMHP ICC as determined by county of record (COR). The ICC coordinates the care of the member, including outside the COR. The ICC works with the member's providers across the health spectrum to ensure the member receives needed services including medical, behavioral, and oral healthcare. EOCCO monitors these members through provider specific reports. EOCCO staff are available daily to assist ICCs in care coordination. We achieve continuity of care because each member has one care coordinator throughout episodes of care and throughout different levels of care.

EOCCO collaborates with CMHPs in discharge planning involving all members moving between levels of care and episodes of care. EOCCO collaborates with CMHPs in discharge planning involving all members moving between levels of care and episodes of care. EOCCO uses an enhanced PMPM payment for clinics that employ behavioral health providers to provide brief behavioral health interventions, enhanced screening, and bridges to higher levels of care if indicated.

For the SPMI population, each member involved in different levels of care is assigned to a CMHP ICC in their county of record. The ICC coordinates the care of the member across all levels of care, including outside the COR. The ICC conducts in-reach activities in the hospital and subacute settings as needed. ACT staff may provide jail in-reach as needed. The ICC takes primary responsibility for the care coordination of the individual across all levels of care.

EOCCO works within a continuum of statewide residential treatment capacity, allowing for transitions from higher level to lower levels of care in a thoughtful and carefully coordinated manner. Strategically placed resources have helped eliminate travel barriers between the different levels of care often needed for members with SPMI.

EOCCO also identifies members with SUD diagnoses and reaches out to engage these individuals who were in higher levels of care but have no documented follow-up.

Referrals to Community-Based Services
EOCCO supports a person-centered plan for each individual who requires community-based services. The plan includes care coordination and appropriate level of community-based services and supports. In addition to the outpatient services noted above, EOCCO ensures providers offer members a range of community-based services including Individual Placement and Support, a model of Supported Employment for people with serious mental illness, peer delivered services and other community resources including supportive housing.

Children, Youth, and Young Adults
EOCCO does not refer members between the ages of zero to five to residential levels of care, or partial hospitalization for day treatment. If a youth age 6 and above requires a higher level of care including day treatment, subacute, or Psychiatric Residential Treatment Services, the child and family is automatically eligible for and offered fidelity Wraparound. Regardless of the interest in the Wraparound process, the youth is provided ICC services and supports. If a child is placed into a facility based residential treatment program, EOCCO contracts with service providers who are equipped with both video conferencing and other reasonable accommodations to continue treatment while in out-of-home placement. Once youth are enrolled in these highest levels of care, EOCCO utilizes the Wraparound model to maintain parental participation in their child's plan of care. EOCCO currently has a certified provider of Intensive In-Home Behavioral Health Treatment (IIBHT) in 11 counties with the remaining county expecting to be certified in July 2021. This expanded level of care for children through age 20 addresses several existing gaps in the children's mental health service array. IIBHT services are tailored to meet the individual needs of the child and family and includes access to a multidisciplinary team of professionals and 24/7 proactive and crisis response to the home.

We also learned about the behavioral health needs of our children and youth, including those with serious emotional disturbances, through the Oregon 2020 Health Complexity Report, a partnership project between Oregon Pediatric Improvement Partnership (OPIP), Oregon Health Authority (OHA), and Department of Human Services (DHS), we identified the population of children and caregivers with the following three social complexities:

1. Parental Substance use-22.3%
2. Mental Health for the Child-29.4%

We are developing a unique pilot project that addresses the effects of Family System homeostasis disruption for the children when their parents enter the recovery process. The curriculum is designed to provide families an opportunity to learn coping skills that help both parents and children address the changes in a healthy rehabilitative manner. Specifically this project will provide evidence based treatment through group and individual therapy for both parents and children which is also known as “dyadic work”.

This project will also capitalize on existing evidence approaches embedded in the community such as the Positive Parenting Program ® also known as “Triple P” and Trauma-Focused Cognitive Behavioral Treatment (TF-CBT). Triple P is designed to give parents the skills they need to raise confident, healthy children and teenagers and to build stronger family relationships.

EOCCO continues to be committed to provide fidelity-based EASA programs in all of our Eastern Oregon counties. At the end of 2020, all EASA programs in EOCCO passed their fidelity review with a score of 80% or higher. Below are program strengths listed in a past Site Evaluation and TA Report completed by the OHSU EASA Center for Excellence:

- Flexibility and willingness to wear ‘different hats’ to meet the needs of EASA individuals and their families.
- Practice going above and beyond daily to remove barriers to accessing services.
- Capacity to work with existing resources and supports to make a difference in the lives of the individuals and families they serve as well as in the lives of their colleagues.
- Identify and negotiate complexities of rural and frontier cultures.
- Strong willingness to share resources internally across agencies and across county lines.

Provider Needs Assessment

Workforce

EOCCO conducts regular analytics on provider type and availability to membership, using industry established practitioner-to-member ratios in determining workforce shortage areas and hiring needs. The current analysis shows that EOCCO has one (1) psychiatrist for every 1,990 enrolled members, with a best practice ratio of 1: 2,000. This pattern exists for LCSWs with a current ratio of 1: 995, with best practice ratio of 1: 1,000. EOCCO contracts with more than twice as many MFC/LPCs as suggested as a best practice, with a current ratio of 1: 1,170, with a best practice ratio of 1: 3,000.

We conduct the same analytics on the location of practitioner types (psychiatrist, LCSW, MFC/LPC) to members within the geographic coverage area. EOCCO currently has over 99% of all practitioner types within 60 miles of each known member. With approximately 80% of all enrollees being within ten (10) miles of each of these practitioner types. These reviews are done at least quarterly to ensure adequate access to covered benefits by all enrolled members.

EOCCO recognizes that due to the rural / frontier nature of our service areas, workforce shortages exist in all 12 counties in our service areas. In the Behavioral Health Provider Network focus groups conducted recently, workforce challenges were identified by all participants. Providers spoke about losing staff to telehealth opportunities which have increased in 2020/21 related to the impact of the pandemic. External competition from local and regional integrated delivery systems, jails/prisons, and education has also challenged workforce sustainment and development in the region.

Workforce has been identified as a priority in this CBHP, and strategies to address this priority are outlined in the Priority Areas section below.

Resources

The behavioral health system of care in our service area lacks some resources that providers need to fulfil their duties and to maintain their workforce. For example, there is not an adequate health information exchange (HIE) connecting the behavioral health workforce to other health care providers. This makes many programmatic initiatives to improve quality and effectiveness of care more challenging. For example, to ensure warm handoffs during transitions of care or alerting the providers when one of their patients has a hospital interaction relies on a HIE that extends beyond the OHP enrollee population. Similarly, the region is lacking an acute inpatient psychiatric facility, making it challenging to provide the full range of treatments that providers want to be able to offer their patients. CMHPs are generally less well-appointed than health systems, making job sites less attractive for staff. The lack of investment in community mental health takes a toll on the desirability of employment in these settings, however, we are encouraged by recent legislative investments. Housing shortages throughout the region also make it challenging to recruit new providers.

Reimbursement

During the provider SWOT analysis focus groups we conducted for this CBHP, many providers cited EOCCO's capitation model as a strength of the system of care. However, they also noted challenges with being able to compete for providers and other staff because the spread of telehealth has meant they must now compete with organizations all over the state, if not the country, for providers and staff who can work from anywhere.

Summary - Behavioral Health and Health-Related Social Needs

The environmental scan identified several behavioral health and health-related social needs among our membership and in the communities we serve. In general, the needs that rose to prominence in the above analysis include:

- **Lack of access to some behavioral health services**, specifically inpatient psychiatric care, crisis response services, and substance use disorder services
- **Stigma / bias against people with behavioral health needs** or those accessing behavioral health services

- **Dissatisfaction with the breadth of our network of behavioral health providers**, specifically our reliance on CMHPs and provider turnover
- **Lack of access to affordable housing**

2 : Gap Analysis

Through our environmental scan we identified community behavioral health needs and evaluated our behavioral health system of care to identify how it could be improved to better meet those needs. This is our gap analysis.

2.1 : Gaps

We identified several clear themes of gaps through the various components of the environmental scan detailed above. These include:

- **Inadequate workforce**
- Our **network** is sometimes challenged with serving the full continuum of care, especially those with mild/moderate mental illness
- **Inpatient and crisis capacity**—lack of local inpatient psychiatric beds and crisis facilities
- Lack of **resources to serve children/youth:** PRTS, SUD resources (detox/residential)
- Prevalent **housing insecurity**
- **Stigma** related to both mental health and substance use diagnoses and treatment
- **Lack of awareness** of behavioral health conditions and resources

Causes of Gaps

- **Workforce:** The worldwide COVID-19 pandemic and resulting quarantine promoted a remote or virtual work model. In turn, additional employment opportunities became available to the local qualified workforce. This negatively affected the availability of qualified staff in the EOCCO region. Prior to the pandemic, the lack of resources in our behavioral health system of care made it a less desirable place to work. Aside from higher salaries and growth opportunities, many staff prefer to work in better funded organizations that offer the tools they need to do their jobs more efficiently and in areas offering better housing options.
- **Network:** Our network is primarily based on CMHPs, which sometimes lack capacity to serve members with mild/moderate mental illness in the settings most accessible to the members. Integrated service delivery is not yet uniformly available across the region. We are also lacking some key services within our region, such as acute psychiatric care beds.
- **Inpatient psychiatric and residential service capacity:** There are no inpatient psychiatric beds for children/youth or adults in the region. In addition, there are no youth SUD residential programs. Providers indicate that it is extremely difficult to make these 24/7 programs work in rural / frontier regions due to workforce shortages and a lack of economy of scale related to needing smaller programs to serve the populations requiring higher intensity service in rural Oregon.
- **Housing instability:** Housing instability is a problem across the state. As housing

prices rise in more urban areas, people are driven to more rural communities. With the increase in remote work possibilities, this also brings more people who are able to pay higher prices, which in turn, drives up the cost of housing and reduces accessibility for many eastern Oregonians.

- **Stigma:** Behavioral health stigma is also pervasive across the country. In some rural communities the stigma is more acute because individuals may feel like they are more individually identifiable. There are also people in active recovery who feel stigmatized in our small communities even though they continue to take measures to support their wellness and sustain recovery. As one of our focus group participants put it, “It is hard to ‘be cool’ and be in recovery here.” It is important to increase awareness of the prevalence of behavioral health issues and eliminate the stigma around receiving treatment for them.
- **Lack of awareness:** This gap goes hand-in-hand with stigma. Through our focus groups and stakeholder survey, it is clear that our communities are not aware of the prevalence of behavioral health diagnoses, nor the treatments or resources available in our communities. This is likely due to a decades-long societal focus on physical health and separating the behavioral health system of care from the rest of health care.

Impact of Gaps

Workforce: The impact of these gaps in the workforce can best be summarized as:

- The lack of social workers and psychiatrists places strain on the work environment, in turn creating a more stressful member experience.
- Existing staff absorb extra work which places additional stress on social workers.
- Open positions are difficult to fill. When a clinician leaves a position, that workload passes to colleagues in the interim. This creates longer wait times for Members.
- A chronic impact is on the need for ABA staff, skills training, medication management, case management, and individual therapy for those who require it.

This creates a reactive rather than proactive environment. Members often wait for treatment, which can lead to crisis situations.

Network: As access to healthcare coverage increases, the provider network has not been able to keep pace with this growth. When the network options are limited, it impacts the ability for some to access desperately needed care. Timeliness of access is a key factor. With limited walk-in clinics, those seeking treatment cannot get immediate access.

The lack of culturally specific services impacts those seeking these services or serves as a deterrent to seeking services.

Education is needed for front-office staff and administrative support professionals regarding what services are available. They must be trained in how to explain these services to members and to be nonjudgmental in their approach. In such a complex system, support is needed to help members navigate through the hurdles of filling out forms and related steps.

Inpatient Psychiatric / residential services: Gaps in these critical services translate to significant community impacts. For example, the lack of acute non-hospital / acute hospitalizations strains the entire system. While the service approach is to provide effective community based services when at all possible, inpatient is a necessary part of the treatment continuum for those in need of these services. It is not the default or first option, but when individuals escalate to needing inpatient care, it is a significant gap in treatment.

In addition, the risk involved in transporting a member is high, and even more so during the winter months. It is a minimum 5-hour drive to the closest acute hospital for most of Eastern Oregon. This places both the member and driver at greater risk. As a result, members spend longer times in the ED in order to get to acute care, this is due to metro areas taking people in their ED first, and the wait times to get secure transportation.

When EOCCO members are placed in urban settings, families cannot easily engage in treatment face to face or support their loved one. Members are less likely to go far for treatment voluntarily. Warm handoffs are nearly impossible. A member leaves acute care and they end up being dropped off, usually after hours at a clinic, then being taken to their home. There is not sufficient time to make sure the member has items needed in their home. These include basic needs and logistics for travel such as groceries or a phone with a charger. Local treatment, access to support services, and supported re-integration are all critical elements of evidence-based support services. The impact of these issues is lack of access to needed resources, and an increased likelihood of relapse/ destabilization for individuals who do access them in out of region locations.

Housing instability: The negative impacts of housing instability in rural communities is prolific. This level of difficulty creates situations where it is easier for individuals to give up on trying to find housing. For example**:**

- The associated difficulty of tracking medications when a person is moving from place to place
- Stress increases additional risk factors such as family and occupation related challenges
- Loss of support services and systems, when having to leave a community to find housing elsewhere
- Less engagement in treatment without safe and welcoming housing
- Increases probability of substance use relapse when returning from SUD treatment and into the housing where others are using

Stigma: The stigma associated with behavioral health and its effects on accessing care is not a regional issue; it is a national crisis. However, the intensity of those impacts in rural, frontier and tribal communities is heightened. This can result in members not getting treatment for behavioral health needs or not staying on needed medications, or they only access treatment when a crisis has erupted. The stigma of seeking services can cause people to be afraid to ask for help or be seen parking at the provider's building. This adds

to the shame associated with behavioral health. In addition, members report that there is a lack of community support and activities for those in recovery.

In tandem with this is limited provider choice in rural Oregon. Some people do not connect on a personal level with the local provider but that is the only one they have to choose from. Also in frontier communities patients have stigma regarding their reputation as a patient. In a smaller community it is more likely that the clinic will already be aware of their issue. Hesitance to seek treatment due to stigma can promote the use of crisis/emergency and inpatient services. This impact further exposes the vulnerabilities in the behavioral health system of care, including lack of preventive and integrated models of care.

2.2 : Priority Areas

We identified three priority areas through our environmental scan, community engagement, and gap analysis, which are outlined in the table below.

Priority Area	Description	Gap that led to Priority	Rationale for Prioritization
Workforce Development	Increase workforce development and retention to ensure that we have an adequate, sustainable, local workforce to serve all our members' needs.	Access to services and provider turnover	Addresses several persistent gaps identified.
Network Evaluation	Systematically evaluate the composition of the BH network to ensure it is meeting the needs of our members.	Access to services, stigma	In addition to workforce, there are gaps in the network that may be contributing to both lack of timely access and stigma related to site of service.
Housing	Increase access to supportive housing services and partners to leverage investment in brick and mortar housing.	Housing insecurity	Lack of access to housing has been a community-wide concern for several years

2.3 : Community Engagement Process for Prioritization

We included selection of priority areas in our extensive community engagement activities for our environmental scan. Many of the strategies we intend to employ to address the priority areas are included in our existing regional CCO-wide community health improvement plan. We conducted a robust community engagement process to identify those priorities and develop plans to address them with our LCACs. We then confirmed

the behavioral health priorities through additional CBHP community engagement and validated the existing CHA strategies with the LCACs. Finally, we presented the proposed priorities and plans in this document to the GOBHI and EOCCO boards of directors for final guidance and approval.

Roles and Responsibilities of Community Partners - Community partners have the responsibility to inform our assessment of community behavioral health needs, choose priorities to address, and continue to monitor our progress and hold us accountable. They do this through our formal governance and community engagement processes.

Monitoring Accountability and Deliverables from Partners - When partners are assigned a task, such as hosting a community forum or distributing a survey, we have staff who have responsibility for holding community partners accountable for the tasks they agreed to take on. For the CBHP issue prioritization process, we do not have enforcement mechanisms. However, for the action plans to address each priority issue, we will.

Challenges to Community Engagement - In this particular process, the main challenge has been the abbreviated short time between when the CBHP guidance, which included prescriptive community engagement guidance, and the due date of the CBHP.

Approach to Resolve Challenges - Fortunately, we had already conducted significant community engagement on behavioral health issues—including selection of priorities—and have a community engagement infrastructure that allows for ongoing collaboration and timely shared decision-making.

Plan to Address Priority 1 – Workforce Development

Goal: Ensure adequate licensed and unlicensed local behavioral health workforce to meet the needs of EOCCO members.

Goal in measurable terms: EOCCO will develop an adequate and diverse workforce by meeting these three objectives:

1. Decrease provider vacancies
2. Reduce turnover and stabilize the workforce
3. Ensure the workforce in each county reflects the respective Member population

Intervention/Improvement Plan

	Activity	Roles & Responsibilities	Timeline	Measures to Track Improvement
Objective #1: Decrease behavioral health provider vacancies	1. Partner with contracted providers to either expand existing strategies or create new strategies that focus on recruitment of behavioral health providers: A. Facilitate the Eastern Oregon Human Resources Network for behavioral health. Efforts include assistance with developing best business practices for hiring processes, sourcing, salary surveys, passive candidate recruiting, screening, and establishing interviews. B. Develop a regional contract with a national recruiting firm. C. Develop marketing campaigns to demonstrate the reasons why serving people with behavioral health needs in eastern Oregon is attractive. D. Investigate and identify funding options to support the above activities, including a blended funding approach. E. Expand telehealth opportunities that support a remote work environment F. Review total compensation packages.	**EOCCO:** ● Facilitate the Eastern Oregon Human Resources Network ● Be responsible for managing the BH Network Development with each provider by leveraging its HR resources ● Assist in developing a sustainable metric system for measuring progress towards goals. ● Organize and facilitate an annual Summit for Behavioral, Physical, and Oral Health providers. **CMHPs:** ● Participate in the EO Human Resources Network ● Commit to collaborating on activity #1 and sub-activities	A – D: July 2021-July 2022 E-I: Jan. 2022 - ongoing	**Baseline Measurement:** Total number of behavioral health practitioner vacancies in each EOCCO county through 12/31/21. Will also review and consider the "Area of Unmet Need" report from the Office of Rural Health **Outcomes:** ● Establish reasonable goals with each provider for both recruitment and retention of staff; and ● Demonstrate annual reductions in 12 month vacancy numbers across the CCO. **Baseline Measurement:** Percentage of vacancies filled within 60 days of initial posting. Providers will report the number of days to fill for each vacancy to establish average days to fill. **Outcome**: Demonstrate annual improvement of 5% across the CCO of vacancies filled within 60 days.

	G. Offer a competitive signing bonus. H. Offer a referral bonus that supports word-of-mouth and employee referrals. I. Assist candidates with licensure expenses.	**PCPCHs:** ● Commit to collaborating on activity #1 and sub-activities **CACs:** ● Provide input and collaboration on the current CHP to demonstrate the connectivity of the two plans**.**		
Objective #2: Reduce Turnover and Stabilize the Workforce	**Activity**	**Roles & Responsibilities**	**Timeline**	**Measures to Track Improvement**
	2. Partner with our contracted providers to either expand or create new strategies that focus on retention of behavioral health workforce: A. Offer behavioral health provider training to support professional development and retention. B. Develop workplace culture enhancement programs to improve desirability of working with EOCCO provider organizations. C. Offer loyalty bonuses.	**EOCCO:** ● Convene partners around regional retention strategies ● Sponsor and support appropriate trainings that are organized in Eastern Oregon by collaborating partners listed below **CMHPs:** ● Participate in the EO Human Resources Network ● Commit to collaborating on activity #2 and sub-activities ● Commit to registering 25% of staff for CCO sponsored trainings. **PCPCHs:** ● Commit to collaborating on activity #2 and sub-activities **CACs:** ● Provide input and collaboration on the current	Ongoing	**Baseline Measurement:** Number of trainings sponsored each year. **Outcomes:** ● At least six trainings each year ● Reaching at least 25% of its behavioral health provider network each year

		CHP to demonstrate the connectivity of the two plans **Early Childhood Providers:** ● Umatilla Head Start and Intermountain ESD hold an annual conference for Early Childhood Providers in EO.		
	Activity	**Roles & Responsibilities**	**Timeline**	**Measures to Track Improvement**
Objective #3: Ensure the workforce in each county reflects their respective Member population	3. Partner with providers, institutions of higher education, and community-based organizations to expand or develop strategies to expand provider diversity by: A. Share the CCO's THW Integration Plan with culturally-specific organizations. B. Partner with Northwest Instituto Latino and Oregon Washington Health Network (OWHN) to provide a Certified Recovery Mentor (CRM) training for Spanish speakers in Eastern Oregon, in September 2021. C. Develop relationships with culturally-specific organizations to help strengthen outreach, recruitment, and retention of a diversified workforce.	**EOCCO:** ● Facilitate partnerships, convene community organizations, provide technical assistance **CMHPs:** ● Commit to collaborating on activity #3 and sub-activities **PCPCHs:** ● Commit to collaborating on activity #3 and sub-activities **CACs:** ● Provide input and collaboration on the current CHP to demonstrate the connectivity of the two plans **Northwest Instituto Latino and Oregon Washington Health Network:** ● Collaborate funding and efforts to provide a Spanish	Ongoing 3.B: Q3-4 2021	**Baseline Measurement:** Providers will report demographics of staff based on race, ethnicity, and languages spoken to the CCO to establish baseline information. EOCCO will provide data regarding race, ethnicity, and linguistic preferences of the community and members to utilize in goal setting. **Outcomes:** ● Identify key differences in demographics of provider staff and the community being served; ● Identify goals and strategies for increasing the number of new hires from underrepresented groups in their service area; and ● Demonstrate annual progress towards staffing goals in reporting new hires that address staffing needs related to diversity. **Baseline:** Total number of Traditional Health Worker (THW) employed and providing peer services. **Outcomes:**

		CRM Training in Eastern Oregon.		• Establish staffing goals with each provider based on current THW staffing; and • Demonstrate annual increases in the total number of THWs providing services to EOCCO members.

Description of Oversight and Performance Monitoring:

EOCCO will work with our identified partners to compile and distribute reports on a semiannual basis focusing on the workforce development measurements that have been outlined. Data reviewed at the Eastern Oregon Human Resources Network will include markers of progress towards annual goals as well as identify areas for ongoing improvement. Performance on these measures will be assessed with this group annually and provide opportunities for adjustments in strategy and goal setting.

Ongoing Collaboration with Community Partners:

All partners will receive updated reports of progress and will have opportunities to provide feedback and suggestions for changes or improvements to the plan. Community partners will also identify individuals as representatives to participate in a monthly committee *(Eastern Oregon Human Resource Network)* that will review data, strategies, information from the community, and progress. This committee will also be responsible for adjusting and updating this plan.

EOCCO also has ongoing human resources (HR) collaborative meetings with network providers. These quarterly meetings are designed to strategically assess workforce capacity with regards to recruitment, retention, and development. In addition to these collaborative efforts, staff are also assigned to work with statewide resources/entities such as Mental Health & Addictions Certifications Board of Oregon (MHACBO), Children's System Advisory Council, the National Association for Health Care Recruitment (NAHCR), and Eastern Oregon Workforce board. These efforts are to ensure our workforce have the most current information, possess the highest qualifications, and utilize the best practices.

Prioritizing Consumer Voice

Methods for prioritizing and supporting the consumer voice through the duration of the plan: EOCCO will share with and seek input on workforce development strategies from the Consumer Caucus, a representative group of EOCCO members throughout the twelve-county region.

Measurement of consumer engagement in this plan: EOCCO will document its engagement with the Consumer Caucus and share performance on this plan and EOCCO's actions in response to the Consumer Caucus's advice throughout the duration of the plan.

Technical Assistance Needs	Timeline for TA Requests
Institutional Bias: We are requesting assistance with curriculum development, including learning objectives, to support our efforts to address Institutional Bias in our provider network to increase awareness and better support our members. **State Health Improvement Plan:** We are requesting that OHA provide a separate analysis of the workforce shortage in frontier and rural Oregon that increases the knowledge base regarding unique challenges of these communities; which may include OHA's efforts in promoting regions of the state, outside of urban areas, as desirable places to live.	

Issues that Will Not Be Addressed
We will not address the inadequacy of the current provider reimbursement fee schedule for the Oregon Health Plan that has a compounding effect on workforce shortages. We will continue to work collaboratively with the OHA to improve the fee schedule in the future.

Plan to Address Priority 2 – Behavioral Health Network Development

Goal: Enhance the behavioral health provider network to support our member's needs.

Goal in measurable terms: EOCCO will ensure the provider network meets member needs by:

1. Conduct a comprehensive assessment with an accompanying strategic plan for the behavioral health provider network based on, a) capacity of the available community providers to deliver appropriate and timely access to covered services including culturally and linguistically specific services, and b) member and stakeholder satisfaction
2. Expanded peer supported and outpatient SUD services for adolescents.
3. Expanded parent education and dyadic therapy services for children, ages 0 – 5, and their caregivers.

Intervention/Improvement Plan

Objective #1:	Activity	Roles & Responsibilities	Timeline	Measures to Track Improvement
Conduct a comprehensive assessment with an accompanying strategic plan for the behavioral health provider network based on, a) capacity of the available community providers to deliver appropriate and timely access to covered services including culturally	1. Conduct gap assessment and evaluate capacity of the available community providers to deliver appropriate and timely access to services stratified by: A. Culturally specific populations B. People with severe and persistent mental illness (SPMI) C. People with mental health concerns receiving services in the specialty BH network	**EOCCO:** • Provide data related to the Network adequacy assessment capacity and functionality • Provide staffing resources to complete assessment and strategic plan. **CMHPs:** • Commit to collaborating on all aspects of the assessment and strategic plan development. • Participate in the assessment, mapping	1: July 2021 – July 2022 2: April 2022 – April 2023	**Baseline Measurement:** Current time to get a first mental health assessment Current length of time to get follow up appointments Current length of time for med management appointments **Outcomes:** Increase access to needed services provided in a culturally appropriate expertise **Baseline Measurement:** **Timeliness to services** **Member and Stakeholder satisfaction survey current** **Outcomes:** Member and stakeholder satisfaction survey

specific services, and b) member and stakeholder satisfaction	D. People with mental health concerns receiving services in the physical health network E. Specialized services such as eating disorders treatment, expertise with LGBTQ+ Members including gender reassignment training, F. This work will build on the efforts of Network Adequacy conducted by the CCO 2. Based on the SUD and MH provider gap assessment, develop a strategic plan with tactical initiatives to close the gaps and enhance the behavioral health provider network for EOCCO members. A. Develop assessment tools to identify and measure member and stakeholder satisfaction	and identification of needed services within the region **Physical Health Systems and PCPCHs:** • Commit to collaborating on all aspects of the assessment and strategic plan development. Commit to collaborating on activity #3 and sub-activities. **CACs:** • Provide input on the assessment, findings, and recommendations to enhance the behavioral health provider network. • Participate in the Network assessment to elevate the member's voice as central in the gap analysis and in the planning how best to meet identified needs **Consumer Caucus:** • Provide input on the assessment, findings, and recommendations to enhance the behavioral health provider network.		
	Activity	**Roles & Responsibilities**	**Timeline**	**Measures to Track Improvement**

Objective #2: Expand peer supported and outpatient SUD services for adolescents	1. Collaborate with SUD providers to identify ways to expand the provision of peer supported and outpatient SUD services for adolescents. A. Charter a multi-stakeholder committee to ensure a robust process of evaluation, identification, and implementation. B. Complete an asset mapping process to identify existing programmatic and geographic SUD services for adolescents. C. Through a gap analysis, identify priority areas for geographic and service area expansion based on member need and asset map. D. Evaluate effectiveness of existing services and identify desired models of care for replication/expansion. E. Investigate options for financial resources to achieve program expansion.	**EOCCO:** Charter a multi-stakeholder committee • Conduct the gap analysis and present findings • Conduct cost forecast models prior to any service expansion to ensure sustainability Create a final recommendation for the CCO regarding contracting to achieve expansion of adolescent SUD services **CMHPs:** • Participate in the multi-stakeholder workgroup • Collaborate with workgroup in identifying provider partners and informing funding recommendations **Physical Health Systems and PCPCHs:** • Participate in the multi-stakeholder workgroup **CACs:** • Participate in the assessment to elevate the member's voice as central in the gap	1. A – E: July 2021 – July 2022 1.F: April 2022 – end of 2023	**Baseline Measurement #1:** Percent of adolescent members with access to peer supported and outpatient SUD services: • Based on population density, • Capacity of existing programs, • Geographic proximity, and • Culturally responsive programs **Outcomes:** Improve access compared to baseline measurements on four attributes. **Baseline Measurement #2:** Percent of adolescent members that are referred for SUD services are receiving peer supported and outpatient SUD services **Outcomes:** Increase in penetration of adolescents receiving peer supported and outpatient SUD services.

	F. Expansion of available SUD services for adolescents.	analysis and in the planning how best to meet identified SUD needs **Consumer Caucus and Children's SOC Committees:** • Review quarterly reports and provide feedback and suggestions for successfully expanding SUD services for adolescents		
Objective #3: Expanding parent education and dyadic therapy services for children, ages 0 – 5, and their caregivers.	**Activity**	**Roles & Responsibilities**	**Timeline**	**Measures to Track Improvement**
	1. Expand our delivery of Triple P Parent Education to parents of children in DHS services. A. Continue our current contract with District #12 DHS Branch. B. Develop new contracts with other DHS districts in Eastern Oregon. 2. Sustain Child Parent Psychotherapy (CPP) contract with OHA to provide training to clinicians throughout the state to receive their certificate in	**EOCCO:** • Develop new contracts with other DHS districts in Eastern Oregon. • Use a data driven targeted approach for identifying and training clinicians to maximize the number of children 0-5 served by dyadic interventions. **CMHPs:** • Promote and support opportunities for clinicians to participate in dyadic trainings • Review quarterly reports of parent	1: July 2022 – July 2023 1.A: On-going 1.B: April 2022 – Ongoing 2: On-going	**Baseline Measurement:** Number of DHS District contracts **Outcomes:** Increase in number of DHS District contracts **Baseline Measurement**: Number of members 0-5 who received 4 or more dyadic sessions **Outcomes:** Reach a 4% penetration rate of members 0-5 who receive 4 or more dyadic sessions

	CPP. 3. Increase the frequency and number of trainings to provide current employees with the clinical skills needed to provide dyadic interventions to children 0-5 and their caregivers.	education and dyadic therapy services provided for children 0 – 5. **CACs:** • Review quarterly reports of parent education and dyadic therapy services provided for children 0 – 5. **ECPs/Children's SOC** • Review quarterly reports of parent education and dyadic therapy services provided for children 0 – 5.	3: Jan. 2022 - ongoing	

Description of Oversight and Performance Monitoring:
EOCCO will work with our identified partners to compile and distribute reports on a semiannual basis focusing on the network enhancement initiatives that have been outlined. Data reviewed at the various stakeholder and oversight meetings will include markers of progress towards annual goals as well as identification of areas for ongoing improvement. Performance on these measures will be assessed with the relevant groups quarterly and provide opportunities for adjustments in strategy and goal setting.

Ongoing Collaboration with Community Partners: All partners will receive updated reports of progress, as well as have opportunities to provide feedback and suggestions for changes or improvements to the plan. EOCCO works with community stakeholders, providers, tribal and county leadership to support network enhancement initiatives and to ensure that the BH provider network can meet the needs of EOCCO's members.

Prioritizing Consumer Voice
Methods for prioritizing and supporting the consumer voice through the duration of the plan: In addition to prioritizing participation and meaningful contributions from our Local and Regional Community Advisory Councils, EOCCO will share with, and seek input on, network enhancement strategies from the Consumer Caucus, Early Childhood Providers, and the Children's System of Care committee. The Consumer Caucus represents EOCCO members throughout the twelve-county region,

Measurement of consumer engagement in this plan: EOCCO will document its engagement with the LCACs, RCAC, Consumer Caucus, Early Childhood Providers, and the Children's System of Care committee and share performance on this plan and EOCCO's actions in response to the advice received from these groups throughout the duration of the plan.	
Technical Assistance Needs: The current QMHP/QMHA Certification Process has been fraught with confusion; consequently, we are asking OHA for assistance to create a consistent and responsive process that works for all providers.	**Timeline for TA Requests**
Issues that Will Not Be Addressed **Description** Individual Provider Compensation Arrangements **Rationale** Provider compensation arrangements are typically restricted to governance functions and not typically shared across stakeholders **Future Plan** Maximize available BH funding for service delivery to members.	

Plan to Address Priority 3 – Housing Instability				
Goal: Improve access to safe, healthy, and affordable housing for county residents through active engagement with the community in planning and development of resources to address housing instability.				
Goal in measurable terms: By expanding the existing community collaboration model, coordinating efforts and resources, and maximizing opportunities for supported housing for members, EOCCO will assist the communities of Eastern Oregon to: 1. Improve access to housing by expanding the depth and breadth of supported housing. 2. Improve housing conditions and reduce disparities for EOCCO members and their families experiencing homelessness or housing instability.				
Intervention/Improvement Plan				
Objective #1: Improve access to housing by expanding the depth and breadth of supported housing.	**Activity**	**Roles & Responsibilities**	**Timeline**	**Measures to Track Improvement**
	1. Participate in the creation of an ongoing Housing Stability Collaborative (HSC) that will meet quarterly to assess progress, create action plans, and coordinate our effort and funding in housing opportunities throughout Eastern Oregon; A. Participate in the planning, development, and implementation of a Housing Solution Summit in	**EOCCO:** ● Organize, implement, and facilitate the HSC ● Leadership role in hosting Housing Solution Summit ● Lead the creation of a comprehensive inventory map **CMHPs:** ● Participate on HSC. **Physical Health Systems and PCPCHs:** ● Participate on HSC.	1.A – B: July 2021 – July 2022 1.C: April 2022 – ongoing	**Baseline Measurement #1:** Comprehensive inventory of existing housing services as a percent of needed housing services. **Outcome #1:** Reduce gap between available and required housing services by 5% **Baseline Measurement #2**: Calculate inventory of current total funding available, current use of

	Eastern Oregon, scheduled by January 2022. B. Based on the process and outcomes of the summit, we will create a comprehensive inventory map that will identify existing housing services and gaps in services both geographically, by populations served, and type of housing. C. The Housing Stability Collaborative will jointly develop/implement plans for addressing identified issues & needs; as well as available resources in the community. 2. Within the work of the Housing Stability Collaborative, EOCCO will collect and review DATA on EOCCO members that are currently experiencing houselessness, in danger of becoming houseless, or experiencing difficulties with barriers (i.e. evictions, criminal past, lack of rental history, etc.) A. Develop population specific strategies to improve housing stability. B. Using the Plan, Do, Study, Act (PDSA) cycle, we will pilot innovative member-centric efforts to improve housing stability stratified	● Leverage hospital community benefit funding for HSC initiatives. **CACs:** ● Participate on HSC. **Key Collaborators and Participants in HSC:** ● Community Business Owners ● EUVALCREE ● Community Action Program of East Central Oregon ● Housing Authorities throughout Eastern Oregon ● Department of Human Services ● CTUIR Housing Authority ● Probation and Parole Representatives ● EO Recovery Center ● Oregon Housing and Community Services ● Community in Action ● Community Connection of NE Oregon ● Klamath/Lake Community Action Services ● Mid-Columbia Community Action Council	2: July 2021 – July 2023	available funds, and populations receiving available funds for assistance and stipends. **Outcome #2:** Inform future funding allocation decisions according to priority populations as defined by the Housing Stability Collaborative. **Baseline Measurement #3**: Stratification and measurement of member populations by housing needs including geographic, populations served, and type of housing. **Outcome #3:** Establish targeted initiatives to reduce member needs as defined above and use PDSA cycle to measure improvements. **Baseline Measurement #4**: Number of individuals supported by, as well as the total amount of financial support distributed through, the following housing and housing-related programs: ● Rental Assistance Program ● CHOICE ● OUD/Stimulant Housing ● Other

	by population such as families, single males, members eligible for Housing First programs, and justice involved. C. Share findings and data with the Housing Stability Collaborative to evaluate opportunities to spread effective pilot programs.			
Objective #2: Improve housing conditions and reduce disparities for EOCCO members and their families at risk and experiencing homelessness or housing instability.	**Activity**	**Roles & Responsibilities**	**Timeline**	**Measure to Track Improvement**
	3. Combine efforts with community partners to strategically utilize the SHARE initiative funding to improve and expand the housing conditions and reduce disparities. A. Fund supportive or supported housing initiatives. B. Evaluate housing infrastructure within the EO Region. C. Identifying structures that require assistance in meeting HUD required code.	**EOCCO:** ● Implement RFA for potential projects ● Evaluating for appropriate funding opportunities **CMHPs:** ● Provide referrals **CACs:** ● Provide recommendations for funding at local community level **Key Collaborators (same as objective 1)** ● Engage this diverse group in participatory design in developing the RFA process	3.A-B: Dec. 2021 3.C: Ongoing	**Baseline Measurement #1:** Development, distribution, and evaluation of RFA **Outcome #1:** To award funding for RFA requests **Baseline Measurement #2**: Review and analyze local data on available housing **Outcome #2:** Gaps in housing availability to be identified and matched with community resources **Baseline Measurement #3**: Connect with housing inspectors to gather information on necessary improvements to make units move in ready/rentable **Outcome #3:** Increase the availability of affordable rentals in Eastern Oregon
Description of Oversight and Performance Monitoring: EOCCO and members of the Housing Stability Collaborative will provide an initial review of housing availability and member access to housing assistance data to inform goals towards measured improvement over the course of the plan. Data will be updated by EOCCO staff and distributed to identify partners on a semi-annual basis to track progress on outlined measures.				

Ongoing Collaboration with Community Partners EOCCO Housing Solution Summit will gather above community partners to a) engage in a SWOT analysis of current conditions, b) identify areas of collaboration and improvements, c) create a work plan for building on strengths to address current challenges. For the "Share Initiative," EOCCO will partner with our Community Advisory Councils to gather and review our Social Determinants of Health (SDOH) Partnership List. The partners listed in the above section will participate in the "Housing Stability Collaborative." During the developing phase, the group will create a charter, which will include the frequency of meetings and roles of partners.	
Prioritizing Consumer Voice 1. Consumer Caucus and Children's System of Care Advisory Committees will participate in the planning of our Housing Solution Summit and we will also invite them to share their experience of obtaining secure housing in EO. If members do not wish to present at the Summit, we will invite several to share their stories during their monthly meeting and ask if we can present their story at the Summit. 2. Members from the Consumer Caucus and Children's SOC will be invited to participate on the Housing Stability Collaborative; and 3. 12 Community Advisory Councils- provide monthly updates to LCACs and seek input from EOCCO members and other attendees. Create an LCAC Housing Sub-committee in the larger more densely populated counties.	
Technical Assistance Needs We are requesting assistance with curriculum development, including learning objectives, to support our efforts to address issues affecting homelessness and housing instability. **State Health Improvement Plan:** We are requesting that OHA provide a separate analysis of the housing shortage in frontier and rural Oregon that explains the unique challenges of these communities.	**Timeline for TA Requests**