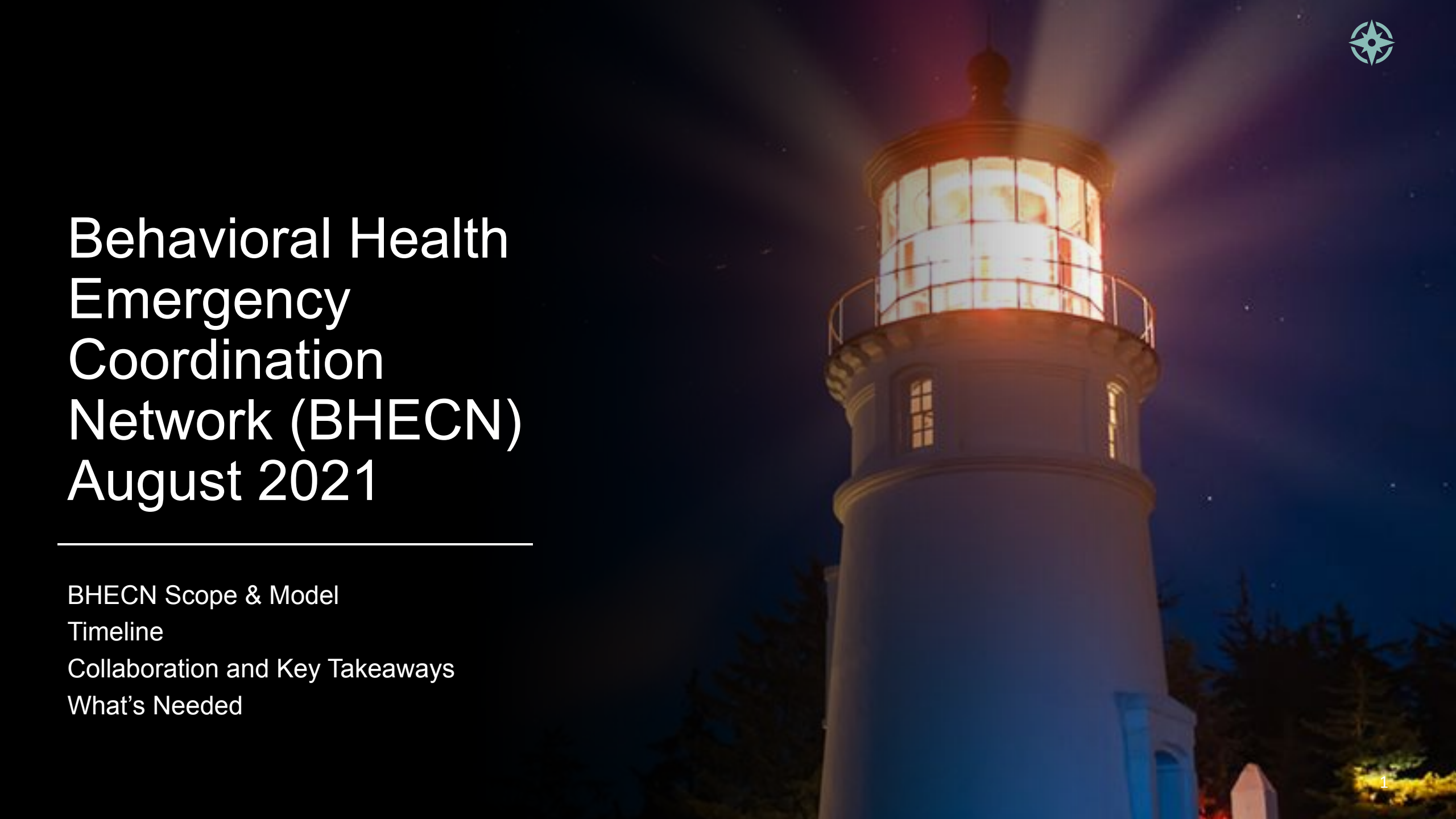
Behavioral Health Emergency Coordination Network (BHECN) August 2021

BHECN Scope & Model
Timeline
Collaboration and Key Takeaways
What's Needed



BHECN Lived Experience Consultant Story

Lived Experience Consultant Interview – Family/Natural Support 1:1 Session / August 30, 2021

- Question 1: Can you share a story of a time when your loved one was in crisis?
- Question 2: What resources, if any, were provided for you to assist your loved one?
- Question 3: What would have helped you navigate the system better?
- Question 4: What would have helped you to build trust with the providers? What would have made your experience better?
- Question 5: What would have meaningfully helped you to support your loved one during this moment and afterwards?

Themes:

- Culturally and linguistically responsive care and support
- Asking questions and listening to the person in need of support
- Communities have lost trust with crisis system
- Need for compassion and understanding
- Communication that can give people confidence on who to call
- Relationship building with the community
- In home services and support (this includes making sure people are getting their basic needs met)

Behavioral Health Emergency Coordination Network

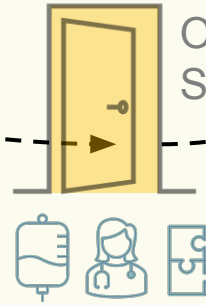
Creating a "Front Door" and Networked Approach to the Multnomah County / Portland Metro Crisis System

- Culturally responsive services and in-reach with peer-provider support at first encounter and throughout the process
- Continuous quality improvement that prioritizes customer and community voice
- Coordinated with Multnomah County Local Mental Authority and community MH programs
- Designed to meet evolving OHA Crisis Receiving Center and Measure 110 design criteria

People get the help they need as early as possible, in the safest and most supportive setting as possible

Low-Barrier 24/7 Access

- First responder drop-offs
- Community provider referrals*
- Pre-arrest and pre-trial diversion programs



Onsite Services

- Screening, intake, triage, and peer-provider engagement
- Crisis stabilization capabilities and MH support services
- Innovative clinical sobering pathways for meth/opiates, and alcohol

Coordinated Access to Community-Based Services

- Psychiatric emergency services
- Urgent Walk-In
- Voluntary, low-barrier detox options
- Behavioral health and other needed resources
- Housing, job skills and placement options

*Self-referrals from individuals and families to be phased in after the model is tested

Analysis of Programs like BHECN

When we look at successful programs nationally:

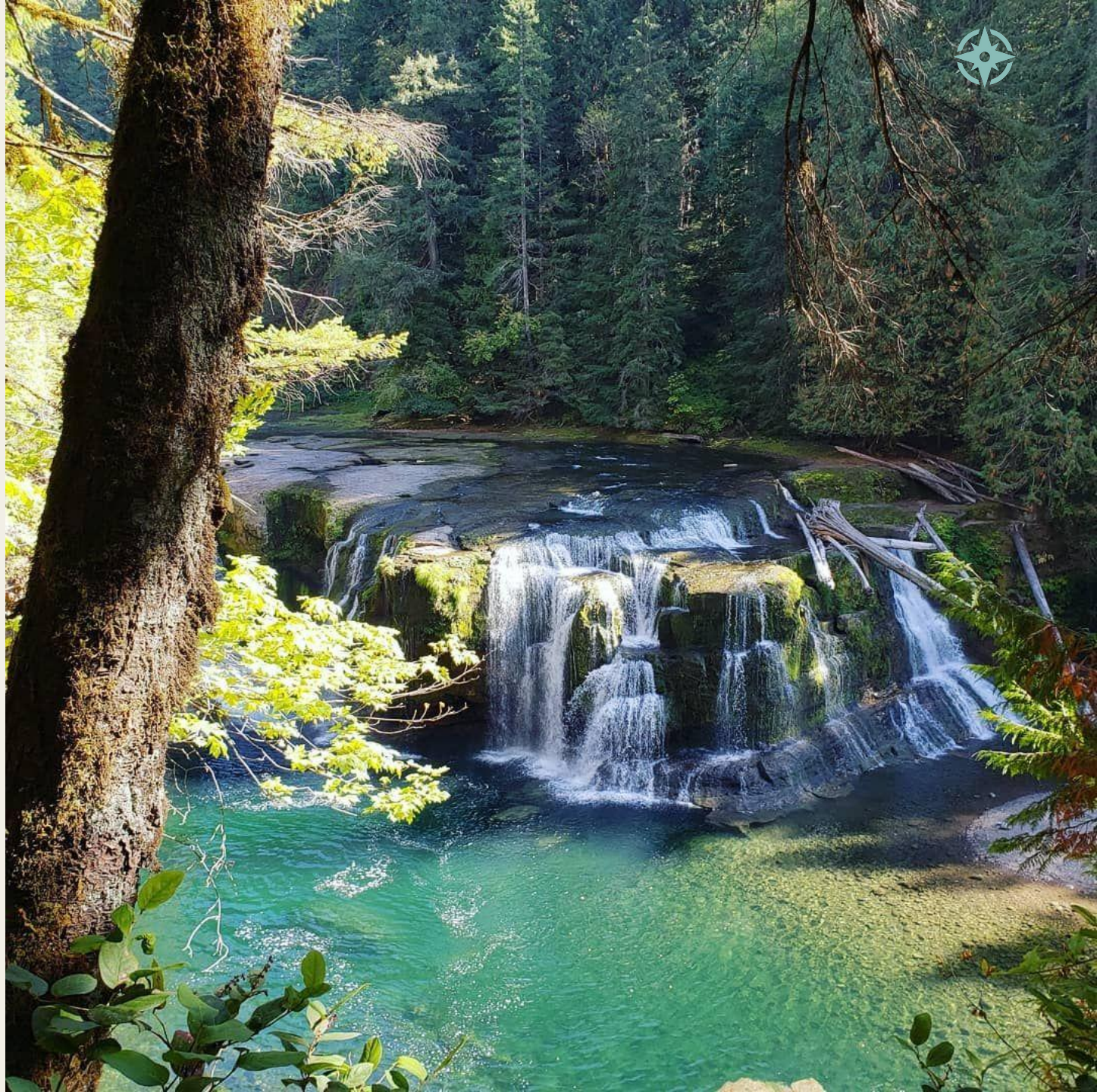
- Often created in response to a legal ruling, and therefore a requirement
- Braided funding model that leverages Medicaid and government general funds
- County or City level governance (not large, collaborative effort)
- Long lead time to develop, test, adapt and improve systems and processes
- Long lead time to create a culture shift in how first responders, peer providers, EDs, SUD/MH providers and other key constituents interact
- Other systems started with nothing and that made it easier. Metro already has components; this supports a phased approach to scoping the project

BHECN Scoping

Assumption: As a key for success, the following characteristics must be in place *at launch:*

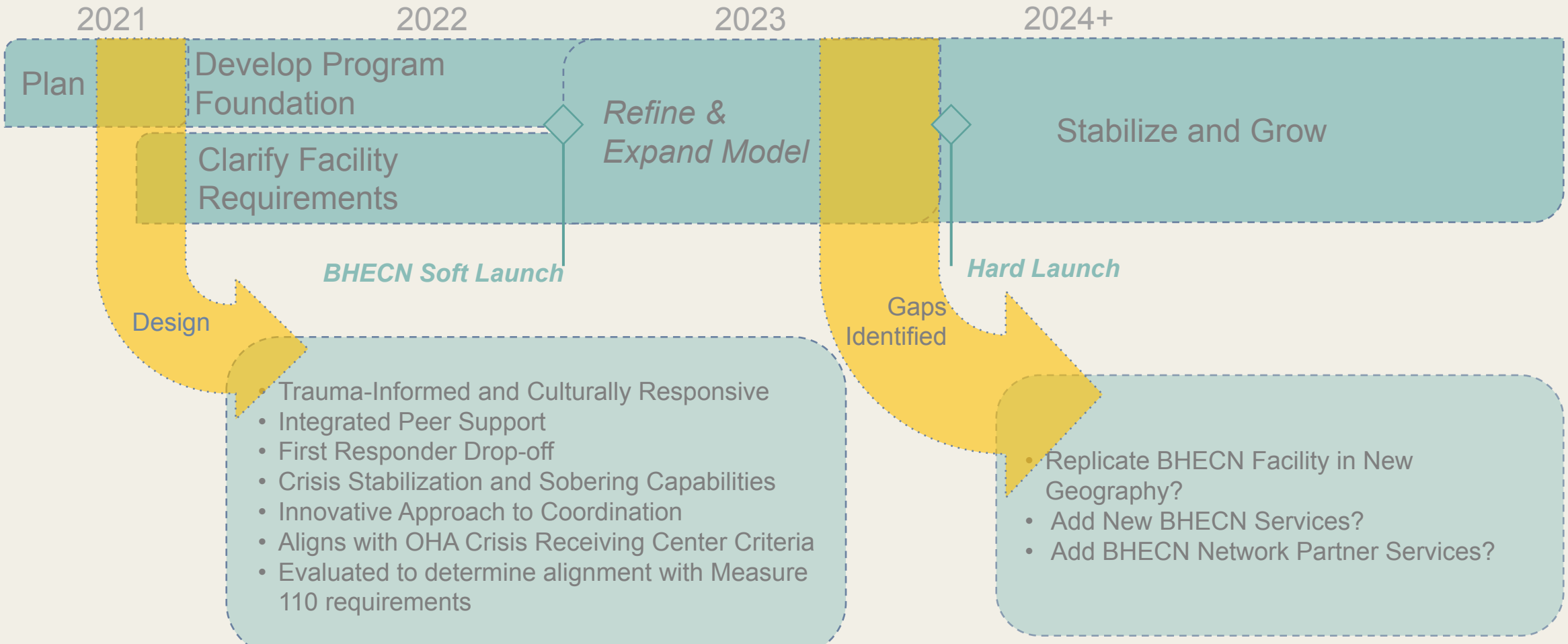
1. Tight scope - less is more

2. Phased approach to growth in services and/or geography



BHECN Approach – Phase 2+

Creating a "Front Door" and Networked Approach to the Multnomah County / Portland Metro Crisis System



Participating Organizations*

- *4D*
- *CareOregon*
- *Cascadia Behavioral Health*
- *Catholic Charities*
- *Central City Concern*
- *De Paul Treatment Centers*
- *Health Share of Oregon*
- *Kaiser*
- *Legacy / Unity*
- *Mental Health & Addiction Association of Oregon*
- *Metropolitan Public Defender*
- *MH Advocates*
- *Multnomah County Behavioral Health*
- *Multnomah County Circuit Court*
- *Multnomah County Commissioner*
- *Multnomah County Community Justice*
- *Multnomah County DA*
- *Multnomah County Joint Office of Homelessness*
- *Multnomah County Local Public Safety Coordinating Council*
- *Multnomah County Sheriff*
- *National Alliance on Mental Illness, Oregon*
- *Office of the Portland Mayor*
- *Office of the State Court Administrator*
- *OHSU Psychiatry*
- *Oregon Health Authority*
- *Portland Police Bureau Behavioral Health Unit*
- *Portland Business Alliance*
- *Providence Health System*
- *TriMet*

**This list is not comprehensive*

Governance Committee

Members

- *Abbey Stamp, Multnomah County LPSCC*
- *Carl Macpherson, Metropolitan Public Defender*
- *Derald Walker, Cascadia Behavioral Health*
- *Dwight Holton, Lines for Life*
- *Erika Preuitt, Multnomah County Community Justice*
- *James Schroeder, Health Share of Oregon*
- *Janie Gullickson, MH& Addiction Assoc. of Oregon*
- *Jill Archer, CareOregon*
- *Julie Dodge, Multnomah County Behavioral Health*
- *Liz Stevenson, OHSU Psychiatry*
- *Maree Wacker, De Paul Treatment Centers*
- *Melissa Eckstein, Unity Center for Behavioral Health*
- *Michael Leasure, Portland Police Bureau*
- *Mike Reese, Multnomah County Sheriff*
- *Mike Schmidt, Multnomah County DA*
- *Nan Waller, Multnomah County Circuit Court*
- *Oregon Health Authority*
- *Robin Henderson, Providence Behavioral Health*
- *Seraphie Allen, Office of the Portland Mayor*
- *Sharon Meieran, Multnomah County Commissioner*
- *Tony Vezina, 4D*

Core Team / Support

- *Aaron Lones, Lones Management Consulting*
- *Bob Day, Bob Day Consulting*
- *Greg Miller, Unity Center for Behavioral Health*
- *Jill Archer, CareOregon*
- *Juliana Wallace, Central City Concern*
- *Julie Dodge, Multnomah County Behavioral Health*
- *Kevin Mahon, De Paul Treatment Centers*
- *Mike Myers, City of Portland*
- *Monica Parra, Lones Management Consulting*

Key Takeaways

- There is a system gap and strong community stewardship is needed to fill it
- BHECN offers an actionable solution by:
  - Creating a front door and systematic approach for coordinating the emergency BH crisis system
  - Getting first-responders back into the roles they are trained for by giving them a place to bring people
- In line with the urgency and need in the community we are committed to a BHECN soft-launch in 2022

What's Needed

- LPSCC has a vital role to play in guiding the development and implementation of BHECN as a central point where behavioral health needs will come in contact with the criminal justice system

- As we launch phase 2 of the BHECN project your advocacy and support is crucial

Questions?

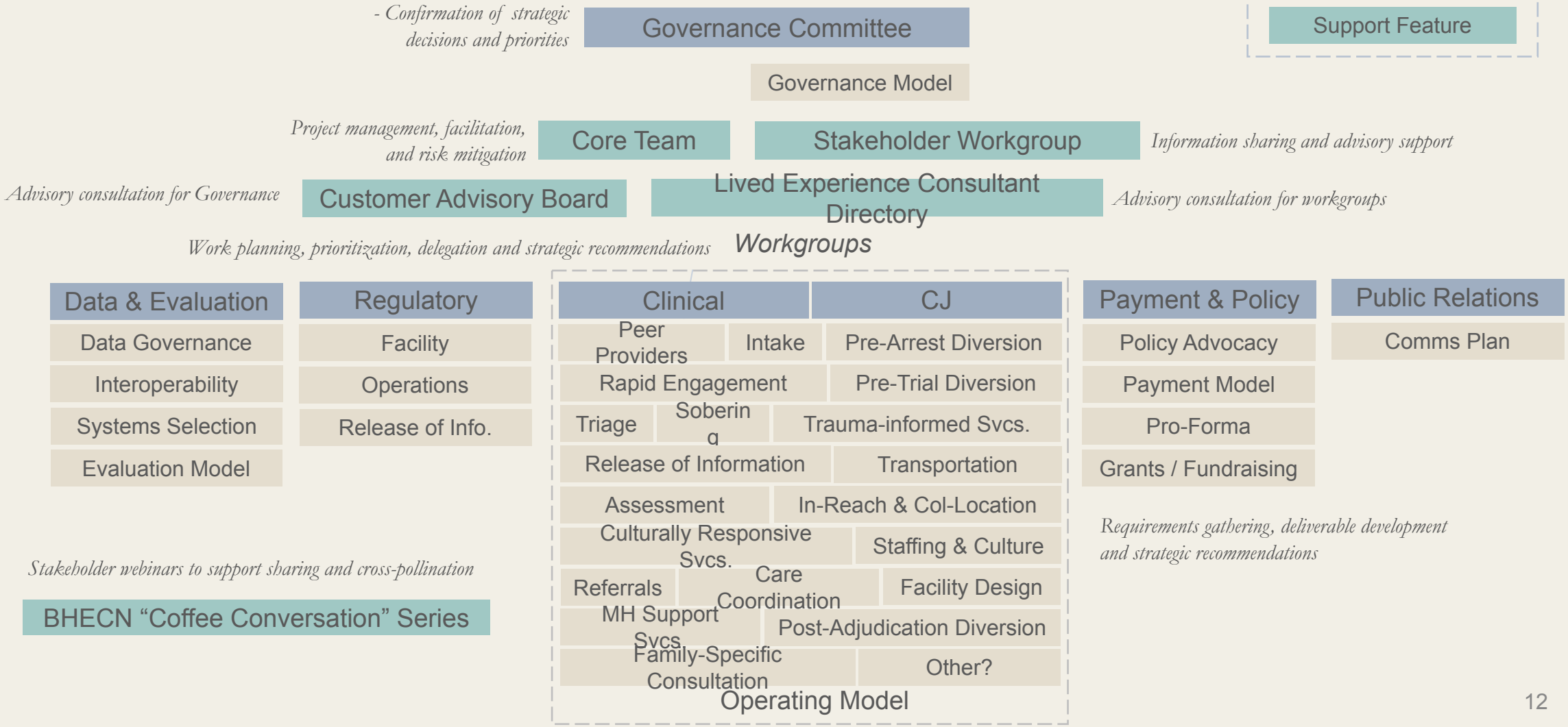
Appendix

Project Structure

Examples of Key BHECN Design Components

BHECN Phase 2 Project Structure

Project structure that summarizes group scope and relationship (not a hierarchical org chart)



Summary of Key Design Components – Goals and Objectives

Culturally Responsive Services and In-Reach

Goal: Develop an on-demand in-reach model with robust culturally-responsive care

Key Objectives:

- Evaluate and develop a BHECN provider network to be effective at on-demand in-reach, or sustainable co-location
- Partner to identify how to support organizations that have trusted relationships with specific populations (e.g., refugees)
- Evaluated strategies for case-specific consultation or short-term work, and telehealth partnership with communities that have access to more professionals with cultural/linguistic expertise
- Integrate lived experience peer-providers from first encounter on, into the BHECN network model
- Advocate for new payment methodologies to support culturally response care and peer-provider integration

Summary of Key Design Components – Goals and Objectives

DEI Framework integrated with Governance Model

Goal: *Establish ongoing engagement workflows and model for continuous BHECN improvement and integration of DEI lens into governance*

Key Objectives:

- BHECN Core Team engaged over 5 months with DEI consultant to develop recommendations for Governance Committee; monthly topics include: *Collaborative and Co-Creative Process, Buy-in Building, Early clarity on decision-making process and points, Building on and honoring history, Shared tools: agreements, definitions, values, and questions, Modeling of how to have conversations about DEI, Applying tools to real problems and projects, Celebration and gratitudes*
- Governance engaged by DEI consultant to adopt and implement recommendations (timeframe TBD)
- Continuous engagement in design and quality improvement, during project phases and following program launch, with individuals, groups and families who are a part of the BHECN Lived Experience Consultant Directory
- Customer advisory board aligned with the Lived Experience Consultant Directory, design workgroups, and Governance Committee to incorporate customer voice into design and ongoing evaluation processes

Summary of Key Design Components – Goals and Objectives

Sobering and Detox Services

Goal: *Evaluate promising practices in Portland and other communities to develop an innovative, onsite sobering model that addresses care requirements for alcohol, meth and opiates. The model will be connected via robust referral pathways with transportation options to community detox providers*

Key Objectives:

- Integrated sobering and MAT capabilities required to meet the needs of the community, with two corresponding clinical pathways: meth/opiates, and alcohol
- Short-stay sobering / observation (up to 5 days) with strong harm-reduction, trauma informed and MAT components
- Develop low-barrier access to voluntary detox services from the BHECN sobering site, accounting for geography and transportation
- Evaluate at-home detox telehealth options for lower acuity customers

Summary of Key Design Components – Goals and Objectives

Partnership with Psychiatric Emergency and Inpatient Services

Goal: *Improve the coordination of emergency and inpatient services through the development of an interdisciplinary provider network and team.*

Key Objectives:

Interdisciplinary Provider Network:

- Identify and develop an “air traffic controller” model to support appropriate utilization and access to services at the right time
- Ability to identify and track the system barriers that are leading to “no” for customers
- Have a clear model/pathway for accountability, escalation, and decision-making that supports getting to “yes”
- Build a culture across BHECN providers of collaboration based on measurable outcomes (e.g., service line agreements); appreciate the unique value of the services of others and create productive ways to provide feedback across BHECN partners

Interdisciplinary Provider Team

- Evaluate ways to get clinical staff working at the top of their license for whole health stabilizations - medications, wound care, engagement, etc.
- Whenever possible, deliver a transparent, skilled and timely approach to explain treatment recommendations and expectations, taking into account CJ implications; e.g., this can support customers who are court/parole mandated to take medications