Meeting Report: May 23, 2007 Behavioral Health and Primary Care Integration and Coordination Learning Collaborative – Salem, Oregon

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Thank you for your participation in the Behavioral Health and Primary Care Coordination and Integration Learning Collaborative meeting held May 23, 2007 in Salem at DHS. We appreciate your involvement and active engagement in this effort to improve the integration of behavioral health and primary care.
This report summarizes the May 23rd meeting, including recommended next action steps, key take-away points from the meeting, and summary evaluation of the meeting.

Recommended Next Action Steps:

1) **Regional/Local Meetings**.
   Initiate planning for regional/local meetings based on interest and invitation from local areas. Utilize feedback from the May 23rd meeting in planning and hosting these regional/local meetings. The location and number is to be determined.

   A Special Request regarding Regional or Local Meetings from the Core Team:
   The DHS Core Team is now inviting recommendations from local communities/stakeholders for the location of regional/local meetings. If you have suggested location and key participants/organizations for planning, please send e-mail by August 15th to Core Team liaison Monica Herrera at:
   monica.herrera@state.or.us

   The Core Team will review these recommendations and make contact with key local participants and organizations. The intent would be to plan these regional/local meetings in direct consultation and collaboration with local participants. The locations and dates would

be publicized. Target date for identifying regional or local meetings is by the end of August, 2007.

2) **Develop linkages between the Core Team, regional or local meetings, and the overall Collaborative.**

    a) Convene a small interim working group from those who attended the May 23rd meeting to advise regarding initial activities of the Core Team and especially regarding the development of the Collaborative and linkages to regional or local meetings. Target completion date is Sept 10, 2007.

    b) Increase the Core Team's capacity to act as a resource to communities and organizations by inviting the participation of Seniors and People with Disabilities (SPD) and Children, Adults and Families (CAF), inclusion of a mental health clinician, and making an effort to develop a more diverse core team by August 15, 2007.

    c) Reconvene the "Collaborative" by December, 2007.

3) **Additional Web Site Development**.
Develop the state web site as a resource for sharing information and best practices as a vehicle to support local integration and coordination of behavioral health and primary care. We have begun the process of looking at models for the next step. Feedback from the Collaborative meeting indicated there is high value in this resource. Target date for updated Web Site is October, 2007

    Reminder the web-site address is:
    http://www.oregon.gov/DHS/ph/hsp/integration.shtml

4) **Web Site Information Posting**.
Post key information from the May 23rd meeting on the state web site by end of July, 2007.

5) **Share Participant e-mail list**.
   Share e-mail list of participants with all attendees at May 23rd meeting. Target date for completion is by the end of July, 2007.

6) **Consumer Voice Initiatives**.
   Incorporate consumer voice in the collaborative process. We heard the message that our integration and coordination efforts need to include and embrace the voice of the consumer. The action step is to initiate discussion with the AMH Consumer/Survivor Council, and also to include planning for the consumer voice at upcoming regional/local meetings. Target date for start-up of this phase is by August, 2007.

Key take-away points – May 23rd Collaborative Meeting:

The following points summarize what the Core Team heard as key take-away points from the May 23rd Collaborative Meeting. We invite additional observations on these take-away points and on any key take-away points you believe were not included:

- There is a high degree of interest and engagement on the topic of integration/coordination of behavioral health/primary care;
- Workforce development – in a nutshell, we are not doing enough workforce development and we're not doing it properly;
- Recognition that we need to be working on two tracks – one track is supporting state-wide/system-wide change; the second track is supporting local projects and initiatives in the community;
- There is sense that while some change and improvement will require additional money and resources, there is also a sense that more can be done now with the resources we already have;
- There is concern that our efforts need to include the client/consumer perspective and we need to continue to cultivate the inclusion of the voice of the consumer;
- There is a sense of the need to help the primary care physician in connecting with behavioral health care – there is a need to help redefine primary care and help redesign the delivery system to reflect

mental health integration. This can take many forms, and some good models already exist;

- Aging – with the dramatic change in demographics coming, we need to factor Aging into consideration; where and how does aging and long term care fit within the efforts to integrate care.
- There is a strong consensus of the need for regional or local meetings to follow-up on this initial statewide stakeholders meeting; those regional meetings should be planned in conjunction with the local community; and those regional or local meetings should be as practical and problem-oriented as possible; those regional/local meetings would not be viewed as "state" meetings, but rather regional/local meetings jointly planned and organized between the Core Team and local organizers;
- There is widespread interest in the need to continue to share "best practices" on integration of behavioral health and primary care;
- There is recognition of the need to connect the DHS Core Team with a reasonable size group of stakeholders that could serve to promote communication between DHS and the larger collaborative; a number mentioned there is value in this idea, but that the group should not be too large as it loses its value;
- There is agreement that the state web site should continue to be used as a location for shared resources, best practices and other information which would assist local and state-wide projects;
- There is a sense that we need to continue to develop a 'shared understanding' of what the problems are and a shared vision of what the solutions might be.

Summary of the May 23rd Meeting Evaluation (45 returned evaluations)

Overall, how would you rate today's session?

7% - Excellent
29% - Above Average
55% - Satisfactory
7% - Below average
2% - no response

Facilitators were well prepared:

31% - Strongly Agree

44% - Highly Agree
16% - Agree
7% - Disagree
2% - Strongly Disagree

Facilitators actively encouraged audience participation:

71% - Strongly Agree
13% - Highly Agree
9% - Agree
7% - Disagree

Facilitators demonstrated knowledge and understanding of the topic:

33% - Strongly Agree
38% - Highly Agree
18% - Agree
9% - Disagree
2% - no response

Overall assessment from an internal DHS analyst indicates: The feedback evaluation data indicate that we could improve in three areas generally: overall meeting satisfaction, knowledge and understanding of the topic, and being prepared.
We believe that overall satisfaction would be improved with the following: Focus on selected topics: access, financing, clinical focus to integration, populations, structure, and assuring that appropriate expertise is at hand. Also be as clear as possible about goals, expectations, boundaries and role: What is the final product? Process or outcome? Policy change recommendations? Be less abstract and more tangible – be relevant to both the community issues and clinical issues. Create opportunities for local problem-solving communication, increase task orientation, define existing policy and the "should be" state, identify barriers and how to get over them – create local action plans that informs state policy and priorities. A key role of the State is to facilitate transfer of knowledge.

Evaluation Feedback Comments By Participants:

Note: The Core Team believes that there is value in sharing all of the comments received as this demonstrates a wide range of observations

and provides important and rich context for understanding the key take-away points and next action steps. Thank you again for providing your candid comments.

What specific part of today's session was more useful?

- continued synergy of key issues
- networking
- comments from what is going on statewide from attendees
- acknowledgement of systems problem and workforce problems, great active discussion
- listening to some of the specific examples
- the logic model, but this is an extended process and will required some sort of electronic format to continue to collect ideas and discussions
- progress stories from City Central Concern and Wallowa Country and wrap-up
- bringing physicians and bh folks together; it would be helpful to get a participant contact list
- hearing from participants, meeting core team
- sharing of info strategies
- hearing other plans actions/successes; good that DMAP willing to work with plans
- hearing what other healthcare orgs are doing to integrate MH back into primary care
- getting a better understanding of organizations in Oregon
- it's a start
- website availability, identification of core team members that can act as resources
- sharing of different models already working
- sharing information, Joel Young's and Charles Gallia's presentation
- examples of on-the-ground implementation occurring today
- the logic model completion by the audience and the audience speakers
- exchange of ideas on how people are attempting to integrate; but frankly I don't have a lot of faith in a 'total system revamp'
- what about various cultures – look at people of color who have MH or addictions; P.S. your core team is all white and all male (there are two female members – Chris Barber and Monica Herrera)

- Dialog demonstrated there is hope where there is existing collaborative – trust exists in non-competitive environment. What was alluded to, but not said was in many communities where there is competition built into system (there is no system of care comments) of care delivery systems not working in mental health arena. Taking show on the road as Ralph Summers suggests is critical
- Dialog on logic model – flushed out some very specific details
- Good to see the core team's vision; glad to see the passion; my belief is that it will be local but with financial regularly and administrative help from the core team
- Lots of audience participation – it was good to hear from everyone!
- I especially appreciate the opportunity of discussing and brainstorming a better way of providing effective services to all and being preventative rather than reactive
- A bit heavy on theory/broad bureaucratic concepts; too low on eliciting concrete barriers to integration
- I expected f\much more focus and new material from something labeled a "collaborative". You started with a very expert and interested audience, and I'm not sure this moved us forward much, except perhaps for brining new people into the dialog
- It would have been helpful to do a presentation of the content of the integration recommendations (matrix model) so that people start on the same page
- Hearing what others have going already
- Networking
- Side conversations

What constructive suggestions would you make to improve the content and/or process of this learning experience?

- focus learning collaborative on selected topics: access, financing, clinical focus to integration, populations, structure
- too general of a session; many of us are far down the road of integrations and need much more technical help regarding rules, finance, etc. I hope the collaborative will take this into account and vary the content to meet the range of needs
- the core team needs a MH clinician
- more networking and individual groups
- figure out how to connect the State Leavy Group to local level

- presentation of the logic model was confusing – more clear articulation of how it related to the conversation would have been useful, or was it not a necessary component at this point in the discussion?
- Tailor workshops to local needs and strengths
- I would really like to see an email list of today's participants with a note about whether the person is involved in an integrative process
- Very loose – would prefer advance input from the group
- Be more clear on your desired outcome, smaller groups many allow better sharing; how about a conference with best practices highlighted?
- It would help to know who was here
- I think this may have been a good start to this concept but there really wasn't a great deal of substance. I would strongly encourage DHS to consider a wider group of stakeholders as part of the core team
- Integrated group discussion between physical and mental health
- This is the tip of the iceberg…we need to move the agenda forward and not lose momentum
- Share ultimate goals prior if didn't
- Very broad topic; unclear that title represents what happened (thought this would be more MH provider-PC provider dialog)
- Process 1) establish clear goals, objectives, and outcomes for the learning collaborative and each of its meetings 2) use a skilled facilitator so that the core team members are free to contribute their expertise to the content 3) consider small group break-outs to increase participation.
- Content: 1) summarize and build on works that's already been done (somatic health, matrix, DHS reports/recommendations Joel referenced) 2) establish common definitions and language so that we can develop a common framework logic model and vision together, then move toward shared activities. 3) have some topic-specific sessions to address issues in depth 4) use Oregon-specific data to help inform dialog and recommendations 5) clarify content expertise of core team members and when to contact them
- I think this is a good start, however there is much work to be done to really impact the system and will change most often when funding sources are considered
- More direction
- Keep your team small so that you are productive

- People at the table rather than audience style set-up
- Did not think there was a sense of state level leadership; too vague as an agenda that is several years old
- Either get a large space for the meeting or breakout/overflow space in closer proximity
- Logic model section was fuzzy regarding purpose
- Be up front about being confined to current funding and county roles, or in the future providing a safe place for such discussions.

Additional comments:

- focused agenda if subsequent discussion; at the break I wasn't clear on purpose of the meeting; thought both overviews were too vague
- as a consumer/policy advocate, I was not intended as your audience today and I shouldn't have been; the "from within" comment has me believing that providers need to have a culture awareness growth period
- thanks for keeping the conversation going; core team is fine; be clear it is DHS core team, not necessarily THE core team for all integration
- consider shorter and more efficient meetings with faster pace
- it is a good first step; add physical health providers to your core team; you might even want to do this same program for physical health providers ex. Primary Care Association
- regional meetings of 'stakeholders' might be more useful for real dialog trying to identify problems and find solutions to local problems and then statewide meetings for special populations; child, geriatric, dual diagnosis; tele-psychiatry, tele-mental health evals could work for rural areas/provide shortage for specialties
- dental care organizations are part of the system of care; mental health issues cause people to not seek dental provider – infection- physical health – invite DCO's/encourage attendance
- a list of attendees with contact info would be great
- looking forward to the regional meetings
- concern: if the scope becomes so big that the goals are overwhelmed with input and the magnitude of what needs to be done, a "bit at a time", integration will happen when "we do it" looking at ways to link systems and speak from what can be done; share expectations, limitations and what can be done; together we can make it happen, don't expect dollars; thank you OHP for taking 1st step to integrate at state

- mental health parity was an effort to recognize mental health diagnoses as medical to look at the whole "person" however it has been my experience that PCP's are resistant to treating mental health diagnoses, most often stating they feel unprepared or trained; yet when offered training they did not participate; the example for Lakeview is ideal and a worthy goal
- involve hospitals – 25% of all hospital admissions are people with mental health or substance abuse disorder; hospitals would be highly motivated to help cut that rate
- primary care is looking for more services than what community mental health models provide, too many road blocks to come; I heard a lot about seniors and kids, what are we doing about the folks who are not covered but very chronic
- let Oregon Psychiatric Association know if we can help
- I agree with the comment that we need to redefine primary care to include mental health and redesign our delivery system to reflect their integration; focus on co-location of serious and physical health/mental health case management as a standard of care
- I came to today's meeting expecting a policy discussion and ways to change our current system. I'm going away feeling that any change will have to come from the providers and DHS will only be a sounding board. DHS really needs to look at the role of counties. Is this the best way to use limited funds?

Thank you again for your valuable contributions to our mutual efforts to support integration of behavioral health and primary care.