Behavioral Health Emergency Coordination Network (BHECN)

PROJECT STATUS REPORT
Phases I & II

October 2022

Prepared by

LONES MANAGEMENT CONSULTING

Prepared for

City of Portland

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Project Status Report
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Table of Contents

A. EXECUTIVE SUMMARY

1. OVERVIEW

The Behavioral Health Emergency Coordination Network (BHECN, pronounced "beacon") Project is a cross-sector collaboration consisting of more than 80 organizations in the Portland Metropolitan area. The project is focused on addressing a critical gap that prevents people who are experiencing a substance use or mental health crisis from accessing the programs they need to maintain stability. BHECN plans to begin serving the Multnomah County community in 2023 with a tailored approach that is modeled after successful programs in other states that lead to improved outcomes in community safety, jail recidivism, appropriate ED utilization, and stability so that individuals are ready to be housed.

The project aims to address barriers in access to Multnomah County crisis services by:

- Opening a new, low-barrier, 24/7 Stabilization Center in 2023 to serve adults and transition-aged youth
- Supporting first responders, including law enforcement, EMS, fire and rescue and others, through an accessible and appropriate place to take community members in crisis
- Establishing a networked approach focused on sobering, stabilization, and connecting people to community-based services and supports
- Blending funding streams to ensure sustainable support for these programs and solutions

"There is a lack of connection to services to stabilize and then to get the services needed. Lack of communication between organizations. Lack of capacity for those resources. The follow up, the need for a network portion and how to connect everyone so folks can follow up to get the services they need for support. The same folks go into the ED, then leave and you might see them in the same hour again at the ED."
-Family of an individual in crisis

2. BACKGROUND

In 2019, the City of Portland brought together stakeholders to evaluate the viability of a community led effort to stand up a more coordinated approach for behavioral health crisis services with a stabilization center at its hub. After delays due to the COVID-19 pandemic, the project was relaunched in late-2020 when Lones Management Consulting was contracted to provide project management services. After conducting an initial assessment, Lones Management Consulting determined that a community-led approach to the project was strongly favored, and an inclusive engagement model was implemented to strengthen community involvement through each phase.

3. CRISIS SYSTEM CHALLENGES

Today, the communities of Multnomah County lack a 24/7, low-barrier facility for those experiencing acute intoxication from methamphetamine and other substances or co-occurring mental health crisis, as well as the coordinated approach needed to effectively serve these community members,

their families, and natural supports. The following are some of the factors that influence this current state:

- Workforce shortages
- An absence of streamlined coordination across the crisis response system
- Increases in violent crime
- An unprecedented availability and increased potency of dangerous street drugs such as methamphetamine and fentanyl
- Lack of alignment across political jurisdictions and antiquated, misaligned regulatory and funding requirements
- Public opinion regarding law enforcement's role responding to behavioral health emergencies and misdemeanor crimes
- Inadequate access to affordable accessible housing
- Insufficient system-wide capacity to meet the demand for substance use treatment and mental health services

As a result, first responders, law enforcement, clinical providers and housing organizations have few options for helping individuals in crisis. This leads to poor outcomes and increased concerns around community safety, including limiting people's ability to stay housed once they've accessed housing and services. This, in turn, creates a bottleneck, where systems are inappropriately utilized to fill the gaps:

> *"There are too few social workers, no easy access to inpatient psych or SUD treatment programs, no on-demand referrals to detox facilities."*
> *- Emergency Dept. Worker*

- Jails are increasingly called upon to provide substance use treatment, mental health services, and support even though they are not designed for it
- Emergency rooms are inundated with individuals experiencing acute meth and polysubstance psychosis but not equipped to safely serve these people
- Permanent supportive housing solutions are utilized as a transitional option due to heightened recidivism rates as individuals churn through the system without achieving the level of stability needed to stay housed

At a local and regional level, we are seeing the effects of these gaps:

- Oregon ranks highest in the nation for use of illicit methamphetamine (MHACBO, 2021), and meth is now the leading cause of drug-related deaths in Oregon (Mental Health and Addiction Association of Oregon, 2019)
- 50–60% of people in Oregon jails need mental health services or have a substance use disorder (OCBHJI, n.d.)
- In 2021, meth intoxication surpassed alcohol as the leading cause for substance use ED visits at Providence Portland, OHSU, Legacy Emanuel, Legacy Good Samaritan, and The Unity Center for Behavioral Health

- Today's highly potent P2P methamphetamine is contributing to growing "epidemics of mental illness and homelessness" and straining local resources (Quinones, 2021)
- A 2021 federal review found 35 people in Oregon experiencing homelessness per 10,000 people. Only three states had a worse rate (HUD, 2021)
- United Health's 2021 study on health outcomes and rankings in the US found Oregon 48th in the nation for behavioral health, including depression, frequent mental distress and non-medical drug use (United Health Foundation, 2021)

4. PROJECT MANAGEMENT

To ensure the project had sufficient structure to support subsequent phases, Phase 1 of BHECN focused on building alignment around a project management approach, definition of the project's scope, identification of high-level requirements, success criteria, and prioritized project roadmaps. Phase 2 of the project has focused on clarifying requirements, developing solution-focused recommendations that describe a model for BHECN Stabilization Center operations, evaluation of programs outcomes, and the critical infrastructure and services required to support network-wide coordination.

It is important to note that workgroup recommendations were tailored to ensure easy adoption by prospective contractors and future BHECN partners. As such, workgroup recommendations are deliberately specific whenever it is necessary to communicate requirements marked as high priority by the community. Alternatively, whenever workgroups determined it would be best to allow the contractor or BHECN partner to tailor services to fit their organization's unique culture and programs, recommendations remain open to interpretation.

5. OUTCOMES

As of the date of this report, Phase 1 and 2 have yielded the following recommendations and deliverables:

- A clinical, peer-integrated model for a crisis receiving and stabilization center that will provide:
    - The capacity to triage, assess, and care for up to 50 people, for up to 5 days of observation
    - Meth and polysubstance sobering and withdrawal management; medical guidelines were developed by BHECN subject-matter experts that specialize in emergency medicine, psychiatry, social work, withdrawal management, and other essential knowledge areas critical to developing these guidelines
    - A staffing model that places providers (MD, NP, PA), nurses, EMTs, social workers, counselors, specialized SUD staff, and peer providers side-by-side to form multi-disciplinary teams that can provide the complex care that is required to safely stabilize individuals experiencing the effects of prolonged acute intoxication
    - A location for first responders to take people experiencing behavioral health crisis that is an alternative to jail and the emergency department
- A network-focused approach to independent, outside program evaluation to determine what BHECN is doing well and opportunities to improve.

  - By way of a request for proposal (RFP) process led by a BHECN workgroup focused on project data and evaluation, an outside evaluation firm, Comagine Health, was selected to perform this role by the BHECN Core Team

- Recommendations for technologies and systems that can support network-wide coordination without requiring broad-scale implementation of complex or expensive systems across BHECN's diverse spectrum of stakeholder organizations
- Recommendations for essential network functions including referrals into the stabilization center, transportation to the stabilization center, jail diversion, booking diversion, and integration of peer support services
- A Request for Information (RFI) that summarizes BHECN recommendations and requirements for potential contractors
- An interim governance model for the project that is documented by an MOU between The City of Portland and Multnomah County Chair's Office
- A project charter to govern the project in lieu of a permanent governance model
- Recommendations for communications and public relations on the project's behalf
- Broad engagement by a diverse community of stakeholders representing different interests, perspectives, and values

"As far as addiction goes, I continuously preach that there needs to be beds available now, not next Thursday. And if there were safe places to have people stay in those beds, that would help. I remember meeting someone at a program, he said he was waiting to get a bed in an addiction facility, and I said, 'What do you mean you're waiting?' And he said 'Yeah, there's a long waiting list.' And I was appalled, but that's how it goes."
-Lived Experience Consultant

6. BHECN'S PATH FORWARD & KEY CHALLENGES

Considerable progress has been made towards developing a stabilization center model and a better coordinated network of services. Perhaps the most important asset to BHECN as a project has been the commitment of a broad and diverse group of stakeholders representing the crisis system. In addition, collaboration between Multnomah County and the City of Portland has been critical to the project's success to date. Continuing to honor the core BHECN principle of community-led development, and further clarifying the roles of the city, the county, providers, criminal justice agencies, individuals with lived experience, and local businesses is essential to moving forward.

Challenges that must be addressed to ensure BHECN's community-led vision is fully realized and sustained include:

- Fostering and maintaining alignment on the use of civil holds resulting in a balance between clinical best practices, trauma-informed care, and the safety of individuals, crisis system staff, and the community
- Obtaining and advocating for the most appropriate program and facility licensure as state rules for crisis receiving and stabilization models are developed and tested
- Developing a revenue model that effectively "braids" funding sources

- Building network-wide capacity for safe, trauma-informed, and cost-effective transportation for people experiencing a behavioral health crisis, and to support first responders and mobile crisis outreach teams
- Developing a shared communications strategy to help Multnomah County communities understand BHECN's functions and services
- Mitigating risk for BHECN partners and the operator of the BHECN Stabilization Center by advocating for appropriate protection from liability, while holding them accountable to BHECN's standards for accountability and quality
- Integrating additional mental health services as the stabilization center and network develops and grows

B. INTRODUCTION

1. BHECN HISTORY

Originating as the result of several developments in 2019 and 2020, most notably the closure of the long-standing Sobering Center operated by Central City Concern, the project has grown as a community effort. In 2019, the City of Portland brought together stakeholders to evaluate the viability of standing up a more coordinated approach for behavioral health crisis services with a stabilization center at its hub. With the onset of the COVID-19 pandemic, the City of Portland was forced to deprioritize this effort as it responded to the impacts of the pandemic.

The project was relaunched by stakeholder organizations with support from Lones Management Consulting in December of 2020. Due to a long-term and growing disconnect across the many entities representing Portland's behavioral health crisis management continuum and the ongoing effects of the COVID-19 pandemic, no single organization at that time would take on the role of lead for BHECN. The initial project assessment conducted by Lones Management Consulting indicated a strong commitment from stakeholders that the project be a community-led effort. This commitment was subsequently codified as a principle for the project, requiring significant effort to continuously identify, recruit, onboard, and align a broad base of individuals and organizations. To date, 83 organizations represented by more than 200 individuals have participated in the BHECN Project by providing leadership, subject matter expertise, information, or advocacy.

"If someone puts a hold on someone and takes them to the ER and then an hour later, they're on the street again and making more police calls. I kind of wonder, well what happened here? It's not to blame or point fingers of course. For us, it can be frustrating, we're doing everything we can to help, but then maybe there's other areas in the system that are missing."
- First Responder

Under the direction of this diverse group of stakeholders, the BHECN Project defined the project structure and recruited leaders, subject matter experts, and individuals with lived experience. These preliminary workgroups identified systemic gaps, developed potential solutions, and prioritized the project's work. At the same time, a

"Core Team" of executive leaders donated their time to oversee the project and support a governance committee of community leaders that was formed for decision making. This resulted in the shared development of project principles, a set of prioritized roadmaps and alignment on a preliminary set of requirements for the BHECN network and stabilization center. Concurrent with the preliminary design, the BHECN Project developed and began to execute a comprehensive community engagement strategy rooted in the project principles (see below). Also in this timeframe, BHECN stakeholders supported the pursuit of funding to sustain project planning, design, and implementation, paving the way for future pursuits of transportation program funds and capital and operational dollars for the planned Stabilization Center.

In August of 2021, the project management team was expanded to launch Phase 2 -Design (Developing Program Foundation & Clarifying Facility Requirements of Programs) and to create the BHECN operating model and network design from the requirements identified through Phase 1. Additional subject-matter experts and individuals with lived experience were recruited to form new workgroups that were prioritized based on level of importance and dependency during Phase 1. These workgroups focused on development of the BHECN stabilization center operating model, integration of peer services and a network-wide approach to data collection and sharing, evaluation, and governance. In total, 12 workgroups contributed 23 recommendations during Phase 2, until workgroups were suspended.

As of August 2022, Phase 2 workgroups were suspended in anticipation of Multnomah County Health Department assuming project management responsibilities. As of the publication of this report, the Pre-trial and Care Coordination workgroups are ready to launch but remain on hold awaiting transition of project management responsibilities. In addition, workgroups that aim to address essential components of the BHECN network are in various stages of preparation and require coordination to launch but remain suspended. A stakeholder group was identified to develop the BHECN Governance Model and was scheduled to begin Q1 of 2022, however, the development of a memorandum of understanding and project charter between the City of Portland and Multnomah County Chair's Office took precedence, delaying the launch of this activity. As a result of these changes, the BHECN Executive Committee formed to develop a governance model and began its work in September 2022.

2. PRINCIPLES

As stated above, during Phase 1 of the project a large and diverse group of stakeholders identified and aligned on the project principles. These principles have served as the guide for all aspects of the project.

BHECN Project Principles:

Develop a "front door" to the behavioral health crisis management system: Portland has many points of access to the crisis management system. While there is "no wrong door" there is not a clearly defined "front door" to a coordinated network of community services. The BHECN Project aims to create this front door with a person-centered, trauma-informed model that reduces barriers to accessing ongoing engagement and treatment

"We are challenged as a system. When we do get them to the Unity center it is often closed, and our only option is the ER which is taxed. It's an enormous resource draw – it draws their resources for one-on-one care, and they don't have the expertise to continue the process after the crisis period for that follow through care… which isn't being done."
- Emergency Dept Worker

- 24/7 Crisis stabilization and triage capability: BHECN Project partners have identified access to 24/7 crisis stabilization and triage capabilities outside of emergency departments as a critical gap in our current crisis management system
- Community and people with lived experience involved in all levels of planning: The BHECN Project has committed to involving the communities we serve and individuals with lived experience at all levels of planning
- Continuous Quality Improvement (CQI): Given the complexity of the need, the BHECN partners acknowledge that ongoing quality improvement will be required to continuously improve the systems, processes, and services BHECN provides. BHECN is committed to partnering with BIPOC, LGBTQIA2S+, individuals with disabilities, and other marginalized communities and consumer-based organizations to create an accessible and responsive model that ensures individuals have access to intersectional, culturally appropriate, and linguistically specific and responsive services. We ultimately understand that meaningful community engagement takes time and continuous nurturing to build trusting relationships
- First responders are our customers too: The BHECN Project acknowledges that first responders are critical in achieving our aim and we must provide efficient, low-barrier access to the Stabilization Center for not only BHECN's clients but for first responders too
- Deflection and diversion from the criminal justice system: The BHECN Project is committed to assisting criminal justice agencies with deflecting and diverting individuals from arrest and jail so they can receive SUD and mental health services in a trauma-informed and supportive setting
- Efficient coordination and referral: The BHECN Project is committed to a coordinated approach that fills gaps, minimizes systemic duplication and overutilization
- Advocacy for investment in critical system resources: As BHECN expands and evolves, more clarity will be brought to the systemic structural and policy issues that require advocacy from BHECN partners
- In-reach and co-location of partners to mitigate workforce challenges: The use of existing resources through partnerships, co-location, and in-reach programs is strongly encouraged to avoid exacerbating the health care, peer provider, and culturally specific personnel workforce shortages our community is experiencing

3. AIMS

3.1 OPERATING MODEL, DATA AND EVALUATION

The BHECN operating model is being created first for individuals experiencing acute intoxication from stimulants, opiates, alcohol, and polysubstance, and then expanding iteratively to serve a broader population with behavioral health needs. Stakeholders recognize that for this to be effective a more streamlined and networked approach to data sharing, release of information, and the ability to track and evaluate outcomes is critical.

"They placed a peer support specialist with me. I was given one tool, which was the peer support specialist. She was able to walk beside me and guide me."
- Lived Experience Consultant

To achieve these aims, the BHECN Project has convened workgroups comprised of subject-matter experts representing a wide variety of backgrounds and experience in the crisis system to develop solution-focused recommendations for network-wide coordination including:

- Referrals to the BHECN Stabilization Center
- Transportation to and from the Stabilization Center
- Triage, crisis stabilization, sobering, and withdrawal management
- Care coordination with BHECN network providers
- Coordination with jails, courts, and law enforcement agencies
- Peer provider integration throughout referral in, intake, treatment, and referral out processes
- Referrals to partners for support services, including detoxification services (residential/outpatient), insurance assistance, Medication Assisted Treatment (MAT) programs, recovery programs, mental health support services, and housing services
- Data governance, interoperability, release of information, and project evaluation

3.2 SUSTAINABILITY AND POLICY ADVOCACY STRATEGIES

With the concerning behavioral health outcomes seen in Multnomah County communities and many other Oregon jurisdictions, state policymakers are working to shape a new regulatory and funding landscape that more closely aligns with the requirements to address behavioral health crisis response system gaps. While BHECN's design shares many similarities with successful programs locally and nationally and comes directly from a community-led effort, the model is not yet fully aligned with the changing regulatory and funding landscape. For this reason, the project has pursued local, state, and federal funds to seed project development, capital requirements, and ongoing operations. At the same time, project stakeholders are working to submit a bill to the Oregon State Legislature to alter current statutes in favor of a more sustainable and integrated network and stabilization center model, while organizing to support relevant changes during the Oregon Health Authority rule-making process.

4. TIMELINE

The following is a timeline of completed work, work in progress, and future work.

2020-Q2 2021: Phase 1 - Assessment and Planning

- Launch of the BHECN Core Team, a group of crisis system leaders, to provide project oversight
- Conduct initial interviews with key stakeholders to gather input on vision, requirements, success criteria, and voice of customer to determine initial scope
- Recruitment of stakeholders from the broader community including city and county agencies, health systems, behavioral health providers, peer providers, community-based organizations, first responders, and criminal justice agencies
- Organization of stakeholders into committees overseeing governance, criminal justice operating model, clinical operating model, data and evaluation model, and Lived Experience (LEX) Consultant Directory to develop principles, goals, and prioritized roadmaps
- Recruitment and initiation of individuals with lived experience into the Lived Experience Consultant Directory to inform the design of the BHECN model
- Development of funding streams and processes to compensate LEX consultants for time advising on the project

Q3 2021-Q4 2022: Phase 2 - Design (Developing Program Foundation & Clarifying Facility Requirements)

- Formation and initiation of workgroups; recruitment and onboarding of subject-matter experts and additional stakeholders *(iterative)*
- Pursuit of funding opportunities; development of proposals for Measure 110 and USDOJ BJA
- Ramp up of community engagement activities including community "Coffee Conversations" and LEX interviews
- Key BHECN stakeholders visit Pima County, Arizona's Crisis Receiving Center
- Multiple cross-functional workgroups develop clinical and justice related recommendations for a BHECN Stabilization Center operating model and components of the network
- Workgroup recommendations finalized and in review by BHECN Core Team
- Development of City/County MOU and Project Charter
- Development of BHECN Stabilization Center RFI
- Management of the BHECN Stabilization Center RFI process
- Transition of project management activities to Multnomah County project managers
- Award BHECN Stabilization Center contract to vendor

2023: Phase 3-5 -Launch Readiness, Soft Launch, & Refine Model

- Negotiation of agreements with contractor and any subcontractor(s)
- Facility/site inspection, tenant/owner improvements to facilities

- Licensure/credentialing for program(s)
- Oversight and planning for CQI
- Move in planning

2024+: Phases 6-7 -Hard launch, Stabilize & Grow

- Program evaluation
- CQI activities begin
- Compliance and regulatory reporting
- Evaluate expansion of scope

C. LITERATURE REVIEW, RESEARCH, & DATA ANALYSIS

To ensure the design of the Stabilization Center and BHECN network components were well informed by evidence, best practices, and the voices of community members, Lones Management Consulting engaged in the following activities:

- Literature review
- Stakeholder interviews
- Analysis of data provided by BHECN partners
- Site visit to Pima County, Arizona's Crisis Receiving Center and System
- Attended conferences and webinars

In doing so, both qualitative and quantitative data was gathered on the following topics:

- Clinical models for MH and SUD triage, assessment, treatment
- Crisis receiving and stabilization models
- Racial disparities
- Criminal justice deflection and diversion
- Current trends in misdemeanor crime
- Utilization of first responders and emergency department services
- The lived experience of individuals in or assisting those in crisis

In addition, Lones Management Consulting and BHECN stakeholders reviewed many Oregon Revised Statutes, Oregon Administrative Rules, Oregon Coordinated Care Organization contracts, and other states' rules and statutes on subjects including:

- Mental health and sobering (intoxication) holds

- Crisis receiving and stabilization requirements
- Transportation requirements
- Liability
- Compliance and security
- Licensing for facilities and programs

1. LITERATURE REVIEW

Lones Management Consulting and BHECN stakeholders reviewed literature to inform the development of the BHECN network and Stabilization Center Request for Information. Key publications included:

- "Sobering Centers vs. CSUs," by Dr. Edward Lew & Miles Sledd of Central City Concern, in December 2019
- "Intercept 0-1 Sequential Intercept Model Mapping (SIM) Report for Multnomah County," by Policy Research, Inc, in August 2021
- "Multnomah County Mental Health System Analysis," by Human Services Research Institute (HSRI) in August 2018
- "OHA Workforce Survey," by Trauma Healing Project, August 2022
- "Neutral Expert Second Report Regarding the Consolidated Mink and Bowman Cases" by Dr. Debra Pinals, June 2022

The following are summaries of relevant data collected from each key publication above.

1.1 CENTRAL CITY CONCERN

The Central City Concern (CCC) Sobering Center and Central City Concern Hooper Inebriate Emergency Response Service (CHIERS) van ceased operations at the end of 2019 due to rising program costs and emerging changes in public health trends such as an increase in methamphetamine and polysubstance use.

- The sobering center averaged 3,500-5,000 individuals per year when the program closed, which marked a significant decline from peek utilization in the 1990's when the center served more than 20,000 individuals per year
- The sobering center had capacity for approximately 20 men + 20 women + 4 isolation cells (utilization was 80% male, 20% female)
- The sobering center was staffed by EMTs and lay staff who monitored the health of those sobering, primarily people intoxicated on alcohol
- Sobering Center and CHIERS programs cost approximate $2M annually with an average cost per stay of $530

The number of individuals in crisis is not known.

- When the Sobering Center closed, it was serving 3,500-5,000 individuals per year but CCC's report noted there had been a rise in people who were not admitted because of concerning behavior or physical health needs. The final report speculated the primary cause of this change was increased methamphetamine and polysubstance use
- The five proactive Portland Police Bureau (PPB) Behavioral Health Response Teams (BHRT), which pair a patrol officer and a licensed mental health professional from Cascadia's Project Respond (mobile crisis), has a caseload of approx. 500 per year. (Source: Portland Police Bureau, BHU)

1.2 HSRI REPORT AND MULTNOMAH COUNTY SEQUENTIAL INTERCEPT MODEL

Both the Human Services Research Institute (HSRI) and the Sequential Intercept Model (SIM) report recommended Portland open a stabilization center

- These reports cited a fragmented and uncoordinated system with current inpatient psychiatry systems at capacity leading to individuals going to jail or not receiving care at all
- The closing of the CCC Sobering Center eliminated resources to assist agitated clients outside of emergency room settings
- Many mental health services providers will not provide treatment for an individual who is actively using substances. Individuals who are seeking mental health treatment must access detoxification services first but there is often a waitlist for detox services
- Lived-experience stakeholders who had been interviewed said that accessing services was like trying to open a locked door that requires a "secret combination"

"We really need a sobering center. We need a response to mental health and addiction issues and the intersectionality of both."
- Lived Experience Consultant

1.3 OHA WORKFORCE SURVEY

The OHA Workforce Survey identified significant issues with access to services and highlighted the acute level of crises that first responders face with clients

There were 196 interview responses across at least 59 organizations that assist individuals in crisis or individuals who are homeless. Organizations responded from multiple areas in Oregon. The majority of these were in Lane and Multnomah counties and represent various groups: LGBTQIA+, BIPOC, Latinx, youth, individuals and families who are low-income, people who are justice-involved, people with HIV, immigrants and refugees, and individuals with disabilities. These organizations provide basic needs assistance, advocacy, crisis emotional support, and ongoing emotional support as well as temporary and/or long-term housing, and/or medical, dental, and behavioral health services. Key findings relating to BHECN included:

There is a perception that there is a lack of services and resources.

- For the question, "What is hard about your job?" the most frequent response (40%) was the "scarcity of resources or programs." People felt they often couldn't fully help their clients
- When asked "what would make your job better?" the most common response was to "make community investments and make systemic changes"

Most crisis workers and individuals who assist people who are homeless encounter people with significant issues related to behavioral health and social determinants of health, further quantifying this as either "every shift" or "often":

- 73% of respondents encounter people with severe or chronic pain
- 67% of respondents encounter people impaired due to psychosis or other serious mental health problems
- 65% encounter people who go without sleep
- 59% encounter people who go without food
- 56% encounter people who are visibly under the influence of alcohol or other drugs

1.4 NEUTRAL EXPERT SECOND REPORT REGARDING THE CONSOLIDATED MINK AND BOWMAN CASES

There is a need for individuals involved with the criminal justice system to have a place other than jail and the Oregon State Hospital to receive mental health and substance use treatment. The "Neutral Expert Second Report" by Dr. Debra Pinals states that it is important to maximize the use of diversion from Aid and Assist processes for any defendant, for misdemeanant defendants, and for those defendants for whom prosecution is not likely to be pursued, and to do so in the community. She recommends that the time for community restoration services should be, for misdemeanors, the lesser of the maximum permissible sentence (or a portion thereof) for the underlying offense or 90 days. She goes on to say once individuals are referred for competence to stand trial evaluation and restoration, the defendants are at greater risk for jail stays as opposed to opportunities for diversion and treatment.

1.5 OTHER PUBLICATIONS REVIEWED

Below are other publications, reports, and data sources reviewed by BHECN stakeholders to support planning and design. This is not an exhaustive list.

- (AZ) Cops, Clinicians, or Both? Collaborative Approaches to Responding to Behavioral Health Emergencies, Margaret E. Balfour, M.D., Ph.D., et al, August 2020
- (AZ) Creating and Sustaining High Quality Crisis Services: A Systemic Approach, Margaret E. Balfour, M.D., Ph.D., 2020
- (AZ) Crisis Response Center: A Hub & Spoke Model for Behavioral Health, Dr. Margie Balfour, January 2021
- (CA) Drug Sobering Center Issue Brief, Mental Health San Francisco Implementation Working Group, April 2021

- (CA) Justice That Heals: Promoting Behavioral Health, Safeguarding the Public, and Ending Our Overreliance on Jails, Craig Haney, Ph.D., J.D et al, 2018
- (NY) Reducing the Misuse and Overuse of Jails in Safety and Justice Challenge Sites, CUNY Institute for State and Local Governance, 2021
- (OR) HB 2417 Report: Statewide Coordinated Crisis Services System, RI International, January 2022
- (OR) Notice of Proposed Rulemaking, OAR Chapter 309, Division 72, Community Based Mobile Crisis Intervention Services, Oregon Health Authority, October 2022
- (OR) Racial and Ethnic Disparities in Multnomah County, W. Haywood Burns Institute for Justice Fairness and Equity, November 2019
- (OR) Senate Bill 2417
- (TX) Implementing A Mental Health Diversion Program, Justice System Partners in collaboration with the oversight committee for the Judge Ed Emmett Mental Health
- (TX) The Judge Ed Emmett Mental Health Diversion Center Final Report, Justice Systems Partners, 2020
- (WA) Crisis Response: Crisis Solutions Center, DESC, June 2021
- Advancements in Crisis Response: Preparing to Pivot, SAMHSA, May 2022
- CCJ/COSCA National Judicial Task Force to Examine State Courts' Response to Mental Illness: Re-envisioning the Courts Response for People with Mental Illnesses, Judge Leifman, September 2020
- Crisis Now: Transforming Services is Within Our Reach, Washington, DC: Education Development Center, Inc., 2016
- Involuntary Commitment and Guardianship Laws for Persons with a Substance Use Disorder, National Judicial Opioid Task Force, 2019
- Involuntary Commitment for Substance Use Disorders: Considerations for Policymakers, Hazelden Betty Ford, July 2017
- Methamphetamine Research Report, National Institute on Drug Abuse, October 2019
- Multnomah County Jail Conditions: Circumstances were Worse for Adults in Custody who are Black and/or Have Mental Health Conditions, Jennifer McGuirk, Multnomah County Auditor, April 2022
- National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit, SAMHSA, 2020
- Roadmap to the Ideal Crisis System, Essential Elements, Measurable Standards and Best Practices for Behavioral Health Crisis Response, Group for the Advancement of Psychiatry, March 2021

2. PRIMARY DATA - INTERVIEWS

2.1 PROJECT VIABILITY ASSESSMENT

When the project was relaunched in December 2020, Lones Management Consulting conducted interviews with key organizational leaders in the crisis continuum to determine commitment to the project, to understand the level of confidence in the success of the BHECN Project, to clarify how stakeholders would rate their level of commitment as an individual to seeing this project through, and to assess how stakeholders would rate their organization's level of commitment. Targeted questions asked for input on BHECN's vision, stakeholder commitment and conditions, desirable outcomes, opportunities, barriers, and risks.

Stakeholders were then re-interviewed between August and September 2021. In the follow-up interviews, stakeholders were asked their perspective on BHECN's progress, barriers and risks, keys for success, location preferences, and whether it should be adjacent to or integrated within a medical facility, and the integration of community partners to run parts or all of the facility.

Overall, there were:

- 22 1:1 and group interviews
- 29 participants
- 18 supporting organizations

Themes on Barriers and Risks

- There is a significant need in so many spaces - SUDs, mental health, housing - chronic needs
- Start smaller and build success and grow it out; BHECN cannot be the end all for everything
- Once BHECN gets funding, it needs to be sustainable
- There is a workforce shortage
- Politics and leadership issues in Oregon around these systems

Themes on Keys for Success

- Diverting people out of the system before they get in
- A physical space for people to go to
- Trust, collaboration across the systems and dedication to serving our community who need this

All organizations interviewed:

1. 4D
2. CareOregon
3. Cascadia Behavioral Health
4. Catholic Charities
5. Central City Concern
6. De Paul Treatment Centers
7. Health Share of Oregon
8. Kaiser
9. Legacy / Unity
10. Metropolitan Public Defender
11. MH Advocate
12. Multnomah County Behavioral Health
13. Multnomah County Circuit Court
14. Multnomah County Commissioner
15. Multnomah County DA
16. Multnomah County Joint Office of Homelessness
17. Multnomah County Local Public Safety Coordinating Council
18. Multnomah County Sheriff
19. National Alliance on Mental Illness, Oregon*
20. Office of the Portland Mayor
21. Office of the State Court Administrator
22. OHSU Psychiatry
23. Oregon Health Authority
24. Oregon Health Authority*
25. Portland Police Bureau Behavioral Health Unit
26. Providence

- A clear vision and the right leadership to lead this
- Strict timeline to move this forward
- Provider and non-provider buy-in

Themes on Location

- Strong support to start with a single site, within or adjacent to a medical facility
- Provides access to other services
- Support of community partners running parts or all facility
- Integrate and connect, leveraging each other and not competing
- Peer wellness/support should be a part of this
- Unity serving as the location
- Build on to Unity and have satellite programs in proximity
- Should be connected to and get medical clearance to make sure people are not in need of emergency care
- Be intentional about access and discharge

2.2 SUBJECT-MATTER EXPERT INTERVIEWS

Throughout the course of phases one and two, Lones Management Consulting confidentially interviewed a diverse cross section of 47 people (both individually and in groups) impacted by behavioral health crisis and from varying backgrounds. Respondents were asked to provide feedback on their personal experience with behavioral health crises and in assisting individuals in mental health and substance use disorder crises. Interviews were performed using Microsoft Teams between May 2021 and July 2022.

Those interviewed included:

- Three owners or staff of small businesses
- Six emergency department workers, including nurses and doctors
- 10 family and natural supports for individuals who had experienced a crisis
- 11 first responders across multiple organizations
- 17 Lived Experience Consultants (LEX)

Overall Themes

- There are so many individuals in behavioral health and substance use crises that first responders are overwhelmed, emergency departments are overcrowded, and people in crisis face long wait times and are discharged too early with little or no resources or care coordination

- There needs to be a level of care and a length of care specific to meth and polysubstance use, outside of the emergency department and separate from EMS, which can handle dual diagnosis and trauma-informed care
- There is a high level of violence and danger during these crises, frequently placing families, first responders and hospital workers in harm's way, but holds are used reluctantly
- Family members and natural supports often resort to desperate measures to get the situation under control and the individual in crisis to care
- All those interviewed expressed the need for a map of services, supports, and specialties, and a need for warm hand-offs by peers and social workers in a trauma-informed and culturally appropriate manner

> *"We have frequent meth-intoxicated, violently ill people. Breaking out of their rooms, takedowns in the hallway, takedowns of patients in our workspace. All of us feel very vulnerable to being hurt."*
> *- Emergency Department Worker*

First Responder & Mobile Crisis Outreach Key Themes

- First responders encounter anywhere from a handful of individuals in crisis per week to upwards of 300
- First responders don't think there are enough suitable facilities or enough capacity for individuals in crisis to be triaged and treated
- Holds are used reluctantly and are not seen as effective because with limited capacity at emergency departments people are usually released before they are fully stabilized, and the cycle continues
- First responders feel they have been trained to handle a crisis but there is never enough training which results in many responders reporting that experience has been their best trainer
- First responders don't feel safe, have seen an increase in violent responses, and generally feel overwhelmed and without resources
- Law enforcement officers felt most confident about their ability to help an individual in crisis, but all other first responders felt law enforcement is non-responsive or reluctant to assist when encountering someone in behavioral health crisis

Family and Natural Supports Key Themes

- There is a need for dual diagnosis programs for individuals who are addicted to substances and have a serious underlying mental health diagnosis
- There is a need for holds longer than five days, especially for meth as that is not enough time to stabilize individuals
- First responders seem reluctant to do holds unless there is a threat of death, even when there is serious risk of harm and injury
- Many people wish there could be holds for SUD crises. People are told, "If they don't want to come with us, we can't do anything." Many wish law enforcement and/or EMS could "rescue" friends and family on meth

- There is a need for transportation to a behavioral health facility other than ambulances to hospitals
- Interviewees would like a map of services and specialties
- Interviewees would like culturally and linguistically appropriate services
- Peers are more helpful and less judgmental or punitive

Emergency Department Key Themes

- Many interviewees report trying to convince patients with emergency physical health needs and experiencing a SUD crisis to accept treatment
- Interviewees all stated a challenge was needing to help those in a physical crisis over a behavioral health crisis but behavioral health, particularly meth, is often more frequent than physical emergencies
- Most mentioned the use of "code gray", a call for security personnel, and the frequent involvement of security. In addition, many report not having enough time or energy to debrief after incidents of violence
- Interviewees report the strain of trying to help someone who doesn't want help and trying to remember their privilege and that the individuals have come from terrible circumstances
- All reports needing more community resources and increased access to social workers. Many stated the need for a long-term meth facility
- All mentioned seeing the same people in crisis repeatedly

> *"I have been bitten, kicked, and punched. I shouldn't think it is part of the job, but I do. Every day we have patients that are stunningly abusive."*
> *- Emergency Dept Worker*

Businesses

- Incidents occur daily. Businesses and their customers are assaulted, threatened, and robbed frequently. Neither feel safe
- Businesses try to be a support system for their staff and often try to help the person in crisis get assistance
- There is confusion about who to call when someone is in crisis. There is a need for a centralized system where they know where a person has been already, what resources they've had, lack of resources and needs, support, etc.
- What has been helpful are the other businesses and staff in their neighborhood. Many have joined together out of a sense of comradery and need for mutual support
- Law enforcement officers are frequently called for property damage, verbal, or violent acts. However, most of the time they come to the scene, talk to the person in crisis and then leave without resolving the situation

Lived Experience Consultants (LEX)

- The behavioral health system is difficult to navigate and most LEX consultants report being able to navigate the system only because they have had experience doing so. There are not enough providers or resources for sobering, detox, recovery, housing, shelter, etc.
- Services are not always culturally appropriate or trauma-informed. LEX consultants of color feel white supremacy shows up in organizations and treatment programs. Providers need to acknowledge and understand the complexities of culture, race, and identity and have empathy and compassion for people in crisis
- There is a need for services that address not just substance use disorders but also mental health
- Mentorship and peer support play a crucial role (i.e., getting to appointments, assisting with housing, custody, and basic needs). But peers with lived experience must be supported to avoid burnout, and there is a need for more people with lived experience working in the field
- Holds are often seen as helpful, and many LEX consultants are thankful they were placed on holds. Some reported that jail was the only place they were able to stay sober
- Many stated that treating individuals placed on involuntary holds with respect and empathy is essential, and that too often providers just medicate them

3. DATA ANALYSIS

Despite requesting data from a wide array of organizations participating in the BHECN Project, few were able to confidently produce data sets or reports. Many cited systemic issues, confounding variables, or data sharing restrictions. Organizations commonly reported one or more of the following issues or constraints:

- Broken or outdated databases or reporting systems
- Incomplete or inaccurate data entry
- Restrictive data sharing policies
- Reporting systems that could not generate dynamic reports (i.e., could not be quarried to produce the desired information)
- The impacts of dramatic shifts in public health trends of a very short period
- The COVID-19 pandemic
- Unwillingness to share data or reports

3.1 MULTNOMAH COUNTY CIRCUIT COURT DATA

Lones Management Consulting performed an analysis of Multnomah County Circuit Court data on misdemeanor citations and arrests between July 1, 2019-June 30, 2022. The analysis informed development of the BHECN Stabilization Center model. Many of these individuals are expected to be referred by law enforcement following a misdemeanor arrest.

The analysis was also performed to test commonly held beliefs about the court system, namely that misdemeanors are not being booked into jail or prosecuted, and that the number of misdemeanors and average daily population in jails are dropping.

- There were18,682 misdemeanor charges, with 67% booked into jail
- There were 11,235 unique court cases
- There were 4,878 individuals with misdemeanor citations, with one to 13 court cases per individual
- The average daily population increased slightly since January 2021 (includes felonies and misdemeanors)
- The number of misdemeanor court cases remained relatively the same, with Q2 2022 slightly higher than Q1 2021
- There was a disproportionate percent of the court population who were Black or African American and comprised only 6% of the Multnomah County population but 21% of the misdemeanor cases

3.2 HOSPITAL DATA

Five hospitals in the Portland area performed an analysis of emergency department (ED) charges for substance use disorders (SUDs) from 2019-2021. These hospitals included Providence Portland Medical Center, Oregon Health Science University Hospital, Legacy Emanuel Medical Center, Legacy Good Samaritan Medical Center, and The Unity Center for Behavioral Health. Their analysis concluded:

"It seems to be the same people over and over again. We are fed up with seeing meth. We see it every day – people coming in with alcohol are generally accepted a little bit more [but] there are still stigma involved with that. It tends to be with the repeat [patient]s."
- Emergency Dept Worker

- There were approximately 22,000 SUD emergency department visits annually across all hospitals that contributed data.
- There were approximately:
    - 7,500 methamphetamine-related visits annually
    - 7,200 alcohol-related visits annually
    - 4,000 opioid-related visits annually
- 95% of patients were insured, 58% of patients were covered by CCO Medicaid, 7.5% of patients were covered by open card Medicaid.

3.3 CAPACITY ESTIMATE

Using data and estimates from first responders, Lones Management Consultants created an estimate of the number of individuals in crisis needing stabilization and the number of beds and bed days needed at a Stabilization Center. Based on recommendations from BHECN workgroups and

subject-matter experts, the Stabilization Center should prioritize meth and polysubstance intoxication. The capacity analysis found that the Stabilization Center should plan for 9,776 visits per year.

Data were solicited from:

- Portland Police Bureau
- Multnomah County Sheriff's Office
- Gresham Police Department
- Port of Portland Police Department
- Multnomah County EMS (American Medical Response)
- Portland Street Response
- Project Respond

Assuming referral estimates are accurate, 50-bed capability (40 beds + 10 "quiet" isolation rooms) would allow an average stay of 1.73 days

The estimate does not include:

- Community referrals (Rapid rehousing programs, SUDs providers, MH providers, other community-based providers, etc.), which will likely be large numbers of individuals
- TriMet referrals
- Jail referrals
- Self-referrals (walk-ins)

Expected Stabilization Center Volume Based on Volume of Stakeholders		
Calculation	Q1 2023	Notes/Assumptions
Per quarter	2,444	
Per month	815	
Per week	188	
Per day	27	One-night stays only
Per day multi-night	8	30% require more than one night stay
Total per day	35	Including one-night stays and up to 30% needing to stay more than one night (low estimate); does not include any community-based provider referrals

Expected Average Length of Stay at the Stabilization Center					
Average Length of Stay	1 day	2 days	3 days	4 days	5 days
Bed days per year	9,776	19,552	58,656	39,104	48,880
Beds needed on any given day	27	54	161	107	134

Volume of SUDs or Mental Health Cases by Stakeholder			
Network Partner	Per Qtr	Data Sources & Notes	Per Yr
Portland Police Bureau	300	Based on First Responder interviews, ((24 per week x 52 weeks) / 12 months) x 3 months = 312 per Quarter	1,200
Mult. County Sheriff's Office	52	Based on First Responder interviews, 3-5 per week	208
Gresham Police Department	221	Based on First Responder interviews, 15-20 per week	884
Port of Portland Police Dept	26	Based on First Responder interviews, 2 per week	104
EMS / AMR* **Per current County EMS protocol AMR can only provide ALS transport to emergency departments.*	1,400	2021 Mult. Co. EMS Data: SUDs+MH, no ALS, adults only. 2021 AMR estimates 2,600 per Q - all adult BH calls, no ALS; not just SUDs+MH. AMR breakdown of highest volume for current transport is Providence North PDX, 15%, Adventist East PDX 11.8%, Legacy Emmanuel 17.3%, OHSU 7.4%, Unity 6.1%, Mt. Hood 9%, no transport 13.1% According to first responder interviews, this could be as many as 4,000 per quarter	5,600
Portland Street Response	300	Based on First Responder interviews, ((24 per week x 52 weeks) / 12 months) x 3 months = 312 per Q	1,200
Project Respond	145	YTD 2022; 11-17 per month on holds, about 100 voluntary	580
TriMet Safety Response Team	TBD	Most likely a significant source of referrals	
Jail Diversion -Booking	TBD		
Housing/ rapid rehousing programs	TBD		
SUDs providers	TBD		
MH providers	TBD		
Other community-based providers	TBD		
Total			**9,776**

D. PROJECT MANAGEMENT APPROACH

When the project was relaunched in December 2020, Lones Management Consulting was brought on as the project management team. The following section is a summary of the work undertaken to execute the strategies and tactics determined by BHECN stakeholders.

1. VIABILITY ASSESSMENT

Initiation of the relaunched BHECN project began with Lones Management Consulting conducting a project viability assessment. The findings from this assessment were used to shape and clarify the project management processes and strategy for moving BHECN forward.

A key learning from the assessment that shaped the project management approach was the high level of commitment from both individual leaders in community and their respective organizations.

The results indicated that there would be high engagement and resourcing from decision-makers, subject-matter experts, individuals with lived experience, first responders and other key stakeholders, lending to a higher likelihood of success than similar initiatives that came before it.

	Score	
What is your level of confidence that BHECN will be a success?	●●●●◐	*"It is so overdue, and everyone realizes we need to do something different."* *"Where's the funding going to come from? My understanding is that the project will rob Peter to pay Paul. It's an uphill battle to figure out funding"* *"I see trust the collaboration. This doesn't feel like one person trying to have a win"*
What is your level of commitment to BHECN as an individual?	●●●◐○	*"I have passion and hope even with my pessimism and realism. We are in this for a reason and want to do better."* *"No need to be flashy for BHECN to be super effective."* *"As much as we hear our system is broken, I hate that. Many weren't around in 1990. We've got a lot of great things in place. We need to figure out stable forms of funding."*
What is your organization's level of commitment?	●●●●◐	*"We are bound by so many competing things right now."* *"There's energy to do something different."*

Figure 1. Sample results - stakeholder commitment. On a scale of 1 to 5. 1 being the lowest likelihood for success. 5 being the highest.

2. PROJECT SCOPE AND REQUIREMENTS

Based on a large body of historical research about the behavioral health crisis in the communities of Multnomah County prior to 2021, and the results from the ensuing BHECN viability assessment, many of the high-level requirements for the project were clear. It was also evident from numerous interviews that action was required, not more "looking at the problem" as several respondents remarked. The following driver diagram was one of the earliest project artifacts to be developed and was used as a tool to align BHECN stakeholders across the continuum on the vision, principles, and scope of the project

Aim	Primary Drivers	Secondary Drivers	Change Ideas
People get the help they need as early as possible, in the safest and most supportive setting as possible	Equity/Racial Justice	Crisis Services	Peer Driven Models
		Diversion	Culturally Specific Resources
		Evaluations	Meth Detox
		Transitions	Stakeholder Governance
		Engagement	Sequential Intercept Model
	Operating Model		Community Restoration
		Access	Braided Funding
			Decriminalization/Equity
		Coordination	City/county Risk Sharing
			Housing Advocacy
		Measurement	ACT
			Shelters w/MH Services
			Outpatient Commitment
		Data Interoperability	Alternatives to Jail
			Innovative Training Models

Figure 2 Sample artifact - consensus building tool.

Based on this alignment, the following scope agreements were developed with the Governance Committee, Core Team, and the broader group of key stakeholders:

List of Scope Agreements
1. BHECN will build in, as part of its continuous quality improvement evaluation model, strong responsiveness to the cultural and linguistic needs of its customers
2. BHECN will have a tight scope at launch and will serve as a sobering drop-off and referral resource that is focused on serving intoxicated and generally high-acuity individuals
3. BHECN will be built as a network with new, innovative, and consistently evaluated referral pathways for its customers, whether it is to step up / warm introductions to PES, jail etc. or down to BHRC, housing, and other community support services
4. BHECN will integrate peer providers from the beginning, whether it is at first encounter, in custody, or at the BHECN front entrance
5. BHECN will serve the community as a centralized source of tight integration between first responders, front line staff at businesses, neighbors, etc., to de-escalate and link as a resource
6. From planning in Phase 2 and on, BHECN and its stakeholders will promote the model as a viable option and clearly articulate what it is and is not (i.e., scope of services)
7. From planning in Phase 2 and on, BHECN will implement an intentional, focused continuous quality improvement (CQI) model that effectively integrates customer voice (including individuals in crisis, business employees, first responders, neighbors, families, natural supports, etc.) and quantitative data to nimbly adapt to community needs while meeting regulatory requirements
8. BHECN will have sobering and MAT capabilities required to meet the needs of the community, with two corresponding clinical pathways: meth/opiates, and alcohol
9. BHECN will be designed to provide short-stay sobering / observation (up to 5 days) with strong harm-reduction, trauma-informed and MAT components
10. BHECN will have strong intake, triage, assessment, and referral capabilities underpinned with innovative universal assessment and global ROI tools
11. From planning in Phase 2 and on, BHECN will focus on building a staff culture that embraces an approach that is innovative, collaborative, and adaptable to the changing needs of the community

3. PROJECT STRUCTURE

Given BHECN stakeholder commitment that the project be community-led and that it deeply engages a broad and diverse group of many organizations and individuals in the crisis system, the challenge of coordinating workgroup and governance structures was significant. In Phase 1 of the project, Lones Management Consulting and key stakeholders began by developing a relatively simple structure, but one that still met the requirements of managing to the complexity. In Phase 2, the structure expanded to encompass the numerous design-focused workgroups that were initiated.

The following is an example of the BHECN (Phase 2) project structure. Note that this is not representative of the current state, as many of the workgroups have completed their work, or have been suspended.

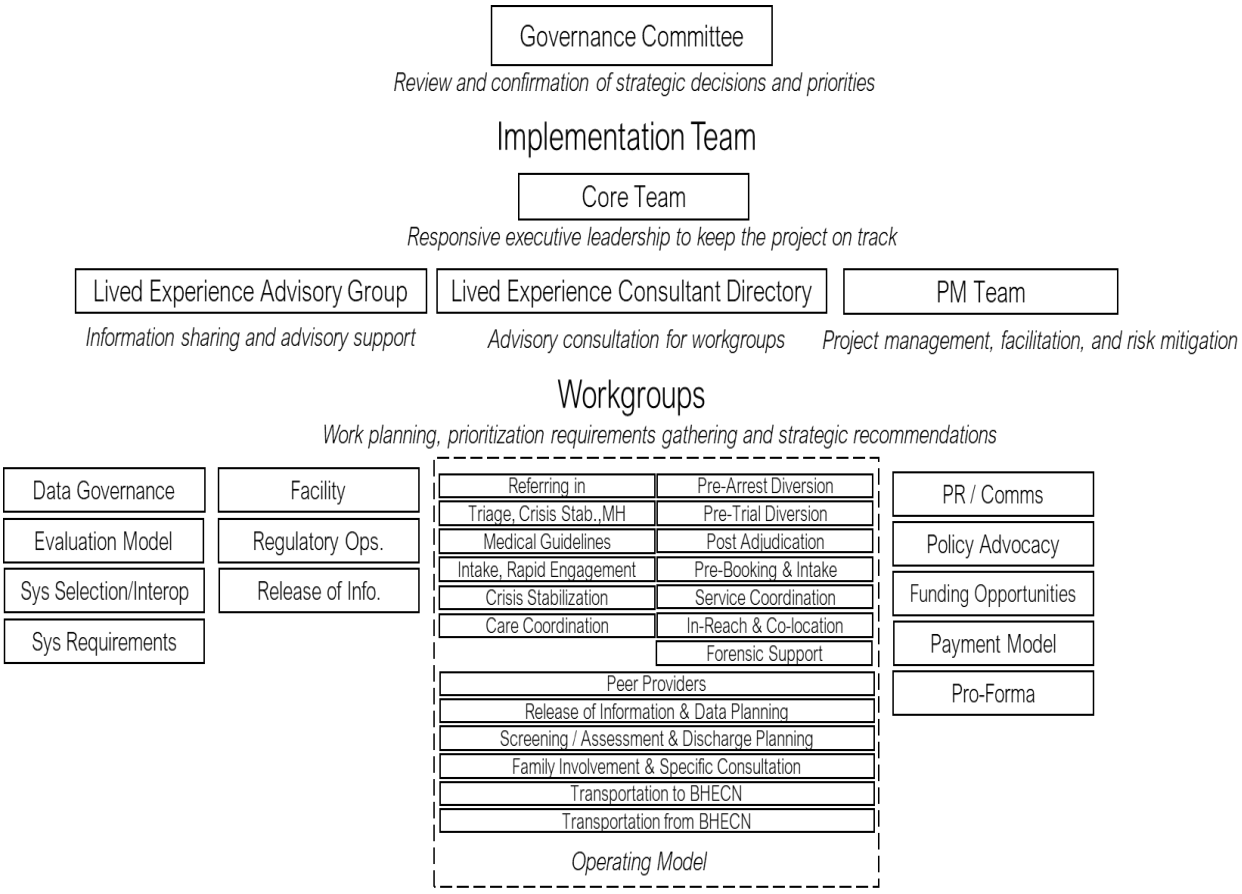


Figure 3 Sample artifact – BHECN Phase 2 project structure

Below are descriptions of workgroup functions for Phase 1 and Phase 2.

Phase 1: Assessment and Planning		
Workgroup	Goals / Purpose	Frequency
Core Team	Coordinate and manage the project such as maintaining project structure and documentation; facilitate and lead Governance Committee and Stakeholder Workgroup meetings; and mitigate project risks for all workgroups and stakeholders	1x per week
Governance Steering Workgroup	Provide project oversight and support for stakeholder accountability and alignment; confirm decisions with strategic impacts for BHECN; prioritize portfolio of strategic BHECN work; and render decision-making for escalated issues	1x per month
BHECN Stakeholder Workgroup	Receive updates and provide feedback on prioritized strategies to project leadership and Lones Management Consulting project management	Every 3 weeks
Criminal Justice Workgroup	Work planning, prioritization, delegation; requirements gathering and deliverable development; strategic recommendations	Bi-weekly
Clinical Operations Workgroup	Work planning, prioritization, delegation; requirements gathering and deliverable development; strategic recommendations	Bi-weekly
Data and Evaluation Workgroup	Document high level data and evaluation design requirements, opportunities, and risks; identify a data governance model; collaborate with other workgroups to refine scope dependencies; develop strategic recommendations	Bi-weekly
Lived Experience Consultant (LEX) Directory	Provide direct, consistent feedback about project goals and decisions related to operating model design and strategies; and minimize misunderstandings in the community about the goals, objectives and activities of the project	Ongoing

Phase 2: Design			
Workgroup	Goals/Purpose	Scope of Work	Frequency
Data Governance	To develop a data dictionary, data flow, data sharing, and policies and procedures for the Stabilization Center	Delivery of data process maps, policies, and procedures; Data sharing agreements/ templates (shared deliverable)	Bi-weekly
Evaluation	To develop an evaluation model and key performance indicators. Components of this aim included qualitative, quantitative and process outcomes	Delivery of evaluation metrics and evaluator RFP; select evaluation team, performance measurement, community, customer feedback and quantitative indicators	Bi-weekly
Systems Selection & Interoperability	To ensure the Stabilization Center has systems in place to enter and track information, and for the exchange of information between BHECN partners	Delivery of high-level gap assessment, process maps, policies, and procedures, and performance measurement; Ensure timely and seamless portability of information; data sharing agreements	Bi-weekly
Medical Guidelines	To develop a program model that must include multiple clinical pathways addressing the different types of substance use	Operating model recommendations for 1) Medical Guidelines and 2) Safety Protocols	Bi-weekly

Phase 2: Design			
Workgroup	Goals/Purpose	Scope of Work	Frequency
	so that we can effectively sober people experiencing acute intoxication		
Referring In	To create a process for referring individuals into the facility and network so that referrers clearly understand and can implement when and who to send to the BHECN Stabilization Center	Operating model recommendations for 1) Admission Criteria and 2) Network expansion sequence	Bi-weekly
Pre-Arrest Deflection	To develop a recommendation for how to deflect people from jail and to BHECN services	Operating model for jail deflection	Bi-weekly
Transportation to BHECN	Transportation to Stabilization Center	Operating model recommendations for 1) First responder guidelines, needs and facility requirements, 2) BHECN Coordinated Network for Community Transportation (CNCT) Program Model; and 3) Use of cabs, rideshare, and public transportation	Bi-weekly
Intake and Rapid Engagement	To create a workflow whereby one assessment and intake process will connect clients to the next level of service and will enable us to understand very quickly where we need to be to meet their need	Operating model recommendations for 1) Intake Assessment and 2) Intake and Engagement Staffing Model	Bi-weekly
Peer Providers	To develop a model that connects and bridges peers to individuals from first encounter throughout the BHECN continuum	Operating model recommendations for 1) Peer Services provided at the Stabilization Center, 2) Peer Provider Staffing, and 3) Peer Provider Education and Training	Bi-weekly
Jail Booking	To develop a pathway for someone who is in the pre-booking process at jail to access BHECN-related services including the Stabilization Center	Operating model recommendations for 1) Criteria for Pre-Booking Diversion to Stabilization Center and 2) Assessment Tool Enhancements (for the Jail)	Bi-weekly
Community Engagement / Lived Experience Consultant (LEX) Directory	To better serve the community by actively listening and integrating community voice into the design and to minimize misunderstandings in the community about the goals, objectives, and activities of the project	Conduct Community and LEX interviews; ongoing engagement with LEX consultants and the community; maintain relationship with The Alliance; monthly BHECN “Coffee Conversations”; form and maintain LEX Consultant Advisory Group	Bi-weekly
Diversity, Equity, and Inclusion	To recognize culturally specific and meaningful options within	DEI Training for Leadership-level stakeholders; Equity Lens	Bi-weekly

Phase 2: Design			
Workgroup	Goals/Purpose	Scope of Work	Frequency
	the crisis system for under-represented communities and ensuring members of BIPOC, LGBTQ and other under-represented groups are embedded into key roles at all levels of the project structure.	Development sessions; Develop BHECN Project Equity Lens & Tools	
PR / Communications	Evaluate network-wide communications challenges, opportunities, and approaches for the BHECN network of partners.	To develop a recommendation for a BHECN communications plan and strategies for public relations.	Bi-weekly

4. PRIORITIZATION AND EXECUTION

4.1 PROCESS

Based on the results from the viability assessment and a rigorous Phase 1 prioritization of project scope and requirements, a series of roadmaps for the emerging design components, milestones and deliverables were created by workgroups. These roadmaps were reviewed by Core Team and queued for approval by Governance stakeholders. This was a highly iterative process.

The following flow diagram shows the general process that workgroups followed from kickoff to ideation, scoping, work prioritization, recommendation development, and approval.

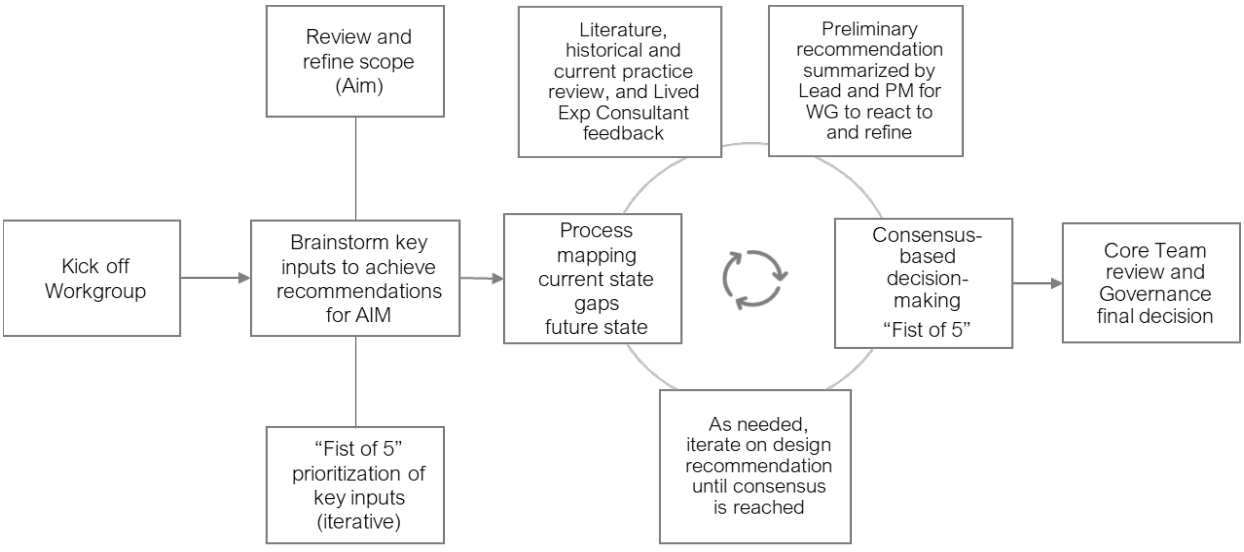


Figure 4. Workshop process - scoping, prioritization, ideation, recommendations, and approval.

Below are examples of (Phase 2) project level, portfolio level and workgroup level roadmaps. Note that these roadmaps are only examples; they are living documents that, due to the iterative nature of this project, have been reviewed and modified.

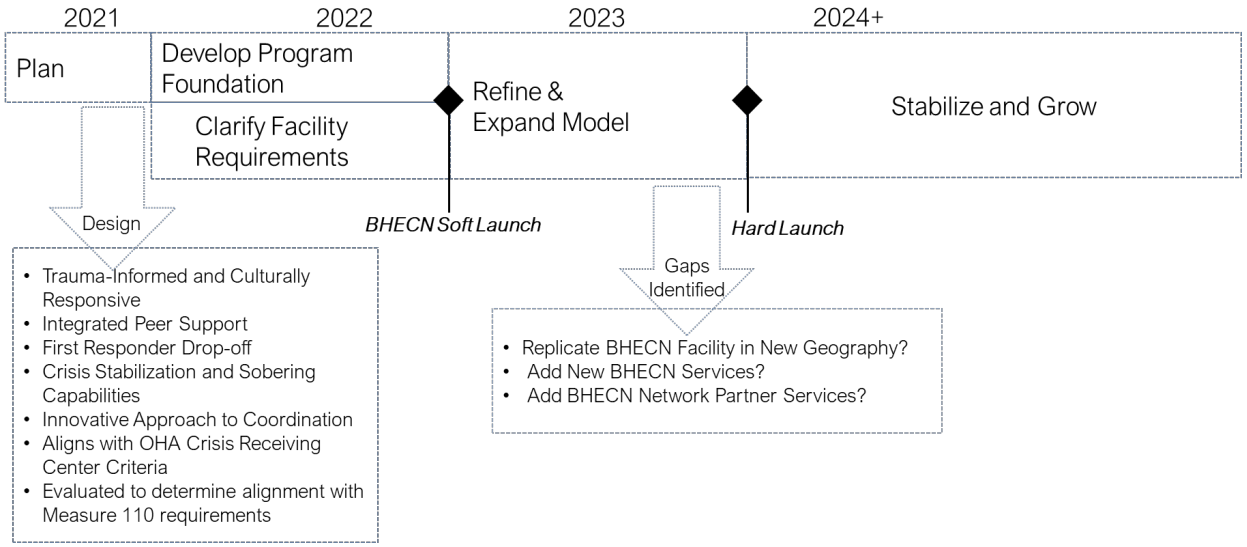


Figure 5. Project level roadmap

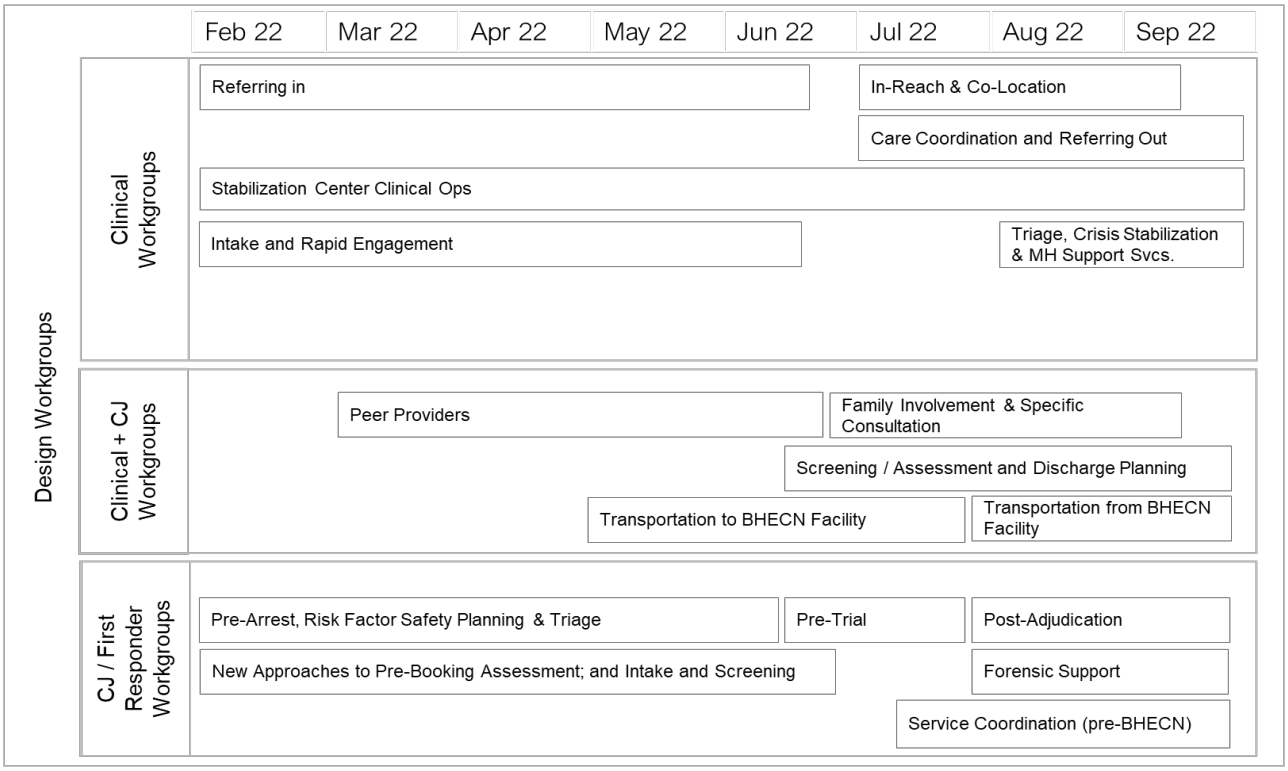


Figure 6. Portfolio level roadmap

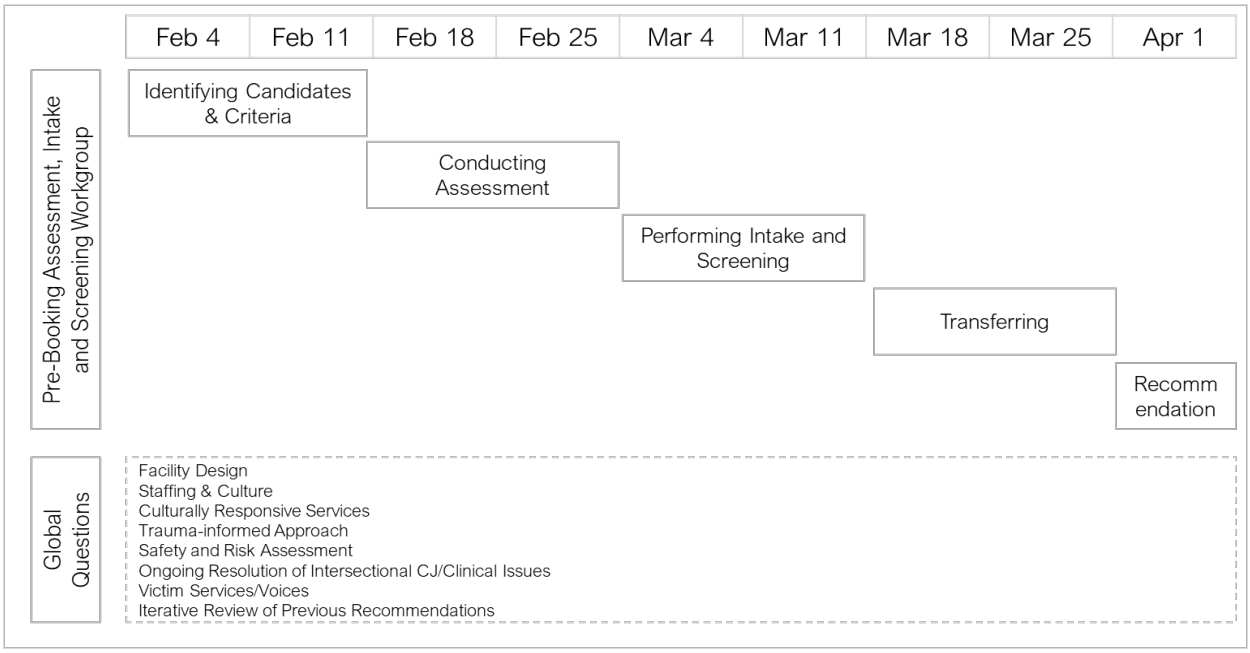


Figure 7. Workgroup level roadmap

Based on roadmaps like the examples above, the BHECN project management team facilitated a phased approach to deliverable development with stakeholders. Below is a breakdown of each phase of work broken down by status – Completed Work, Work in Progress and Future Work.

4.2 COMPLETED WORK

Phase 1 Assessment and Planning

(12/1/20-8/9/21)

In this phase, the BHECN Project initiated work with a large and diverse set of stakeholders. This was achieved through developing partnerships built around shared BHECN principles and aims, and by facilitating and coordinating many individual onboarding interviews. These orientation interviews were conducted with all stakeholders to recruit them to workgroups and committees that were formed based on high-level priorities for the project. Planning sessions were conducted with the newly formed workgroups to develop, align on, and recommend guiding principles, scope, and goals for the project, as well as priorities for Phase 2 workgroups. A review of these recommendations was conducted by Core Team and Governance Committee. The result was a clear project structure and a timeline with milestones; criteria for evaluation of project success, and well-articulated and agreed-upon assumptions and priorities consistent with project- and portfolio-level roadmap priorities.

Key deliverables during this phase were formation and stand-up of a project governance structure and work groups; analysis of existing programs in the community and other geographies nationally,

data and literature review; a high-level operating model design, and prioritized roadmaps to lead the design and launch of a Stabilization Center and network.

Phase 2A Design - Develop Program Foundation & Clarify Facility Requirements

(8/9/21-present)

In this phase, the BHECN Project worked to complete an operating model for a Stabilization Center and network and to align on a sustainable governance model. Nominations for new workgroup members were solicited and received from the primary workgroups listed below in Phase 1. After extensive outreach, interviewing, and onboarding, the resulting workgroups were a broad cross-section of individuals representing an even wider spectrum of community organizations, SUD and Behavioral Health partners, clinical and criminal justice partners and those with lived experience. Stakeholders were then assigned to separate, focused workgroups based on their interests, expertise, and engagement level.

During this phase, Lones Management Consulting initiated and closed 12 workgroups that developed and delivered 23 recommendations.

Phase 2A Workgroup Deliverables		
Workgroup	Recommendation	Delivered
Stabilization Center	Medical Guidelines	4/12/22
Stabilization Center	Safety Protocols	7/5/22
Referring In	Admission Criteria	3/17/22
Referring In	Network Expansion Sequence	5/23/22
Pre-Arrest Deflection	BHECN Jail Deflection	5/4/22
Transportation	First responder guidelines, needs and facility requirements	6/8/22
Transportation	BHECN CNCT Program Model	7/20/22
Transportation	Use of Cabs, Rideshare, and Public Transportation	8/31/22
Intake & Rapid Engagement	Intake Assessment and Exclusions	4/7/22
Intake & Rapid Engagement	Staffing Model	5/23/22
Peer Providers	Peer Services	4/14/22
Peer Providers	Staffing Recommendations	8/10/22
Peer Providers	Education and Training	8/31/22
Jail Booking	Criteria for Pre-Booking Diversion	4/7/22
Jail Booking	Assessment Tool Enhancements (at the Jail)	5/5/22
Evaluation	Evaluation Model: Priority Metrics and Metrics Matrix	7/1/22
System Selection	Systems	6/30/22
Data Governance	Data for Metrics	8/1/22
Communications (PR)	Messaging 1 & 2	7/26/22
Release of Info	Use case recommendations	7/12/22

Including the voice of the customer remained at the forefront as a key equity and continuous quality improvement strategy and was accomplished by sustaining an innovative approach to community feedback, recruiting members, and facilitating a Lived Experience (LEX) Consultant Directory and interviews with communities, first responders, and local businesses.

Other notable work accomplished during this phase included:

- Formation of a Lived Experience Consultant Advisory Group to provide ongoing feedback
- Creation of a Request for Proposal process for an outside evaluation firm and subsequent selection (Comagine Health)
- Monthly BHECN bulletins providing project updates distributed to all BHECN stakeholders
- Monthly "Coffee Conversations" convened with speakers from Oregon and other states to share insights on relevant crisis system topics
- Development of a top-down understanding of costs and funding streams for Stabilization Center design purposes and associated pro-forma
- Pursuit of grant funding for BHECN operations from Oregon Health Authority Measure 110 (not awarded) and federal Bureau of Justice Assistance for transportation (awarded September 2022)
- Solicitation of funding from key community partners to support project, capital, and operational costs for BHECN
- Development of a Memorandum of Understanding and Charter between the City and County for BHECN Project partnership
- Creation of a Request for Information (RFI), managed by the City of Portland, for solicitation of bidders to operate the Stabilization Center
- A draft bill to the Oregon State Legislature to alter current statutes in favor of a more sustainable and integrated network and stabilization center model
- Coordination of BHECN stakeholders to support relevant and critical rule changes during the Oregon Health Authority rule-making process
- Formation of an "Executive Committee" to oversee the project and create a sustainable governance model

4.3 WORK IN PROGRESS

Phase 2B Design (Develop Network Capabilities)

(8/1/22-present)

In this phase, the BHECN project is working to develop a sustainable governance model, funding model and to finalize an operating model for both the Stabilization Center and the expansion of the network of services. Nominations for new workgroup members have been solicited and received from the primary and secondary workgroups listed above in Phase 1 and 2. Stakeholders have been interviewed and assigned to separate, defined, workgroups based on their interests and engagement level for five of the remaining 16 workgroups.

As of the writing of this report, the following work, critical to the completion of the network operating model and funding strategy, has been suspended.

Work Currently Suspended During PM Transition	
Workgroup	Scope of Work
In Reach & Co-Location	To develop a model for using existing resources through partnerships, co-location, and in-reach programs to provide multiple services in a single location to avoid exacerbating the health care, peer provider, and culturally specific personnel workforce shortages our community is experiencing
Care Coordination and Referring Out	To develop an individual's next step after stabilization by expertly coordinating care to maximize the appropriate levels of service within and access to the BHECN network of providers
Service Coordination (pre-BHECN)	To identify the processes and technology needed to connect justice-involved individuals into the BHECN network of services across the CJ continuum
Crisis Stabilization	To develop a recommendation in alignment with network partners for a clinical model of stabilizing people experiencing a behavioral health crisis (non-duplication)
Family Involvement & Specific Consultation	To develop services for natural supports and families of individuals with SUDs and BH needs
Screening/Assessment and Discharge Planning	To develop the workflow and care management plan for discharging individuals from the facility and the network
Transportation from BHECN	Transportation from Stabilization Center
Pre-Trial Diversion	To connect people after booking and before trial to the network of BHECN services
Post-Adjudication	To develop a process by which justice-involved people will access BHECN network of services post adjudication.
CQI Planning	To ingrain continuous quality improvement into all processes and establish good reporting practices
Partnership/Data Sharing	Service agreements and MOUs for data sharing practices and policies
Regulatory Operations	To map out all the requirements that need to be met to open a facility
PR and Communications	Continue to develop a recommendation for a BHECN communications plan and strategies for public relations
Payment Model	To develop a sustainable payment model of braided funding sources to support BHECN Stabilization Center and network operations

4.4 FUTURE WORK

Phase 3 - Readiness

In this phase, Lones Management Consulting has identified a body of future work in the areas of 1) Contract Administration, 2) Final Facility/Site Approvals, 3) Regulatory Operations, 4) Contractor and Subcontractor(s) Readiness, 5) Oversight and planning for CQI, and 6) Move-In.

Phase 4 - Soft Launch

In this phase, Lones Management Consulting has identified a body of future work in the areas of 1) Program Evaluation, 2) Oversight and Maintenance for CQI, and 3) Compliance, Regulatory and Requirements.

Phase 5 - Refine & Expand Model

In this phase, Lones Management Consulting has identified a body of future work in the areas of program evaluation and CQI oversight.

Phase 6 (Hard Launch) and Phase 7 (Stabilize and Grow)

Bodies of work have yet to be forecasted.

5. PROJECT COMMUNICATIONS AND RISK MANAGEMENT

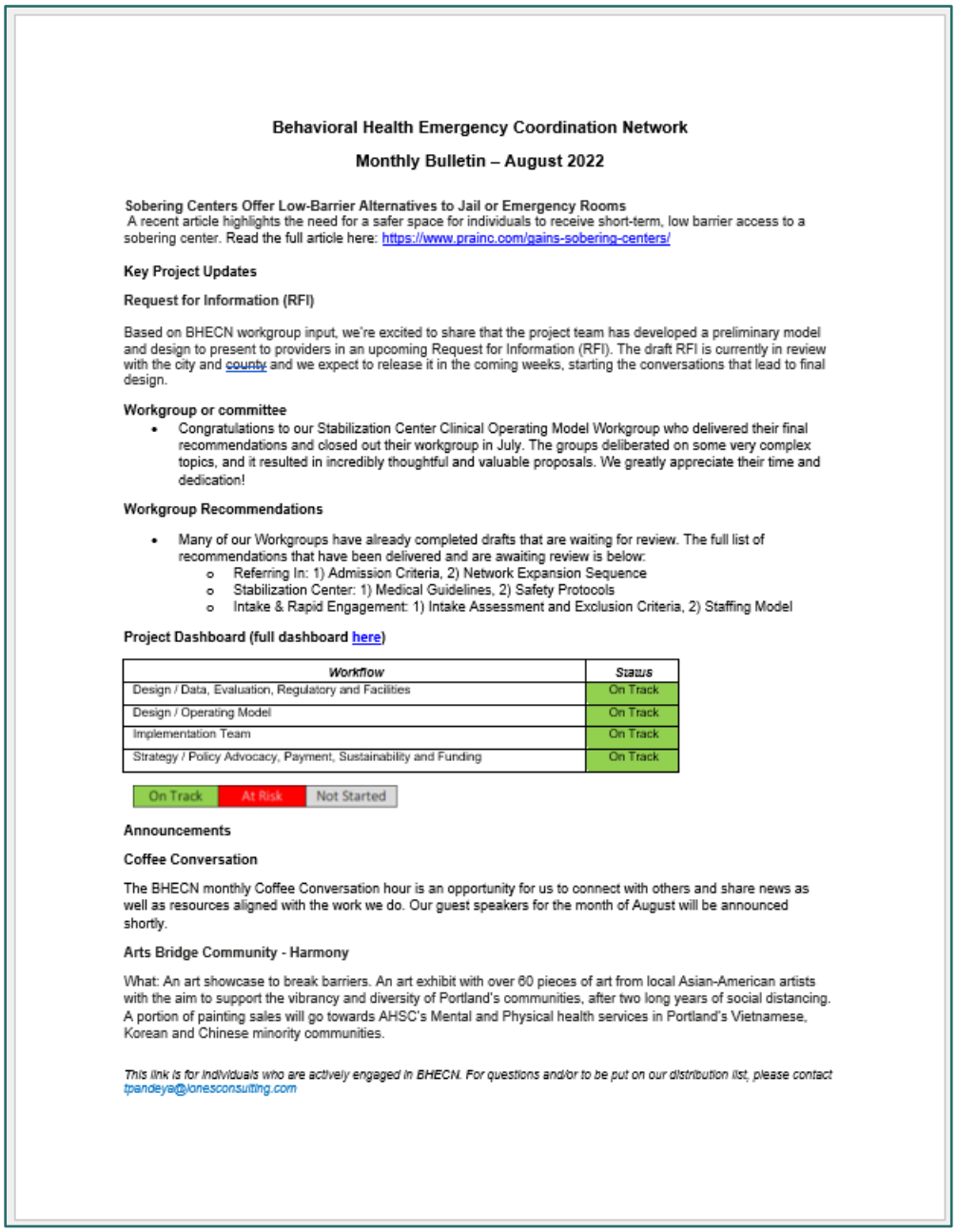
5.1 PROJECT DASHBOARD AND MONTHLY BULLETIN

With a project of this size and scope, the need for consistent project communications delivered at the appropriate level continues to increase. To meet this need and to uphold rigorous project hygiene, Lones Management Consulting with oversight from the Core Team, developed a project dashboard and monthly bulletin that was pushed to the full list of over 200 BHECN stakeholders via email on or around the 1st of every month. In addition to soliciting and considering feedback from the broad group of email recipients, this tool was used in the leadership meetings for the project to provide status updates and key escalations.

Below are examples of the BHECN Project Dashboard and Monthly BHECN Bulletin.

Workflow	BHECN Committee or Workgroup	Aim	Lead and PM	Status	Complete / On Track / At Risk / Not Started — Notes
Design / Data, Evaluation, Regulatory and Facilities	Data Governance	*Data process maps, policies and procedures, Data sharing agreements/ templates (shared deliverable)*	Jen Gulzow Amanda Cobb	On Track	A data map based on KPIs and evaluation metrics is complete, with data stewards and data elements identified. Finalizing survey questions.
Design / Data, Evaluation, Regulatory and Facilities	Evaluation	*Evaluation metrics, Evaluator RFP, selection of evaluation team, performance measurement – community/customer feedback and quantitative indicators*	Kyle Schwab Amanda Cobb	Complete	Along with Comagine, the Evaluation Model Workgroup has developed a proposed metrics that can will used as key performance indicators and/or for the program evaluation as
Design / Operating Model	Booking Assessment / Intake and Screening	*To develop a pathway for someone who is in the pre-booking process at jail to access BHECN-related services including the Stabilization Center*	Emily Rochon Carrie Buth	Complete	Workgroup delivered two recommendations and has been closed. 1) Pre-Booking Diversion Criteria and 2) Booking Assessment Enhancements.
Design / Operating Model	Care Coordination and Referring Out	*To develop an individual's next step after stabilization by expertly coordinating care to maximize the appropriate levels of service within and access to the BHECN network of providers*	Karissa Smith Carrie Buth	On Track	Lead and PM are currently finalizing and performing outreach to agreed stakeholder list and will kick off end of July.
Implementation Team	Community Engagement / Lived Experience Consultant Directory	*Better serve the community by actively listening and integrating community voice into the design. Consultants are engaged in a way that is meaningful for them*	Core Team Monica Parra / Tara Pandeya	On Track	Next monthly LEX Advisory Group will meet in person at the end of July (TBD). A job description will be posted this month to recruit
Strategy / Policy Advocacy, Payment,	Policy Advocacy	*Increase positive visibility for BHECN among local and state officials, increase funding and partnership opportunities for*	Lead TBD Amanda Cobb	On Track	Will start when issues are identified

Figure 8. Example of project dashboard



Behavioral Health Emergency Coordination Network

Monthly Bulletin – August 2022

Sobering Centers Offer Low-Barrier Alternatives to Jail or Emergency Rooms
A recent article highlights the need for a safer space for individuals to receive short-term, low barrier access to a sobering center. Read the full article here: https://www.prainc.com/gains-sobering-centers/

Key Project Updates

Request for Information (RFI)

Based on BHECN workgroup input, we're excited to share that the project team has developed a preliminary model and design to present to providers in an upcoming Request for Information (RFI). The draft RFI is currently in review with the city and county and we expect to release it in the coming weeks, starting the conversations that lead to final design.

Workgroup or committee

- Congratulations to our Stabilization Center Clinical Operating Model Workgroup who delivered their final recommendations and closed out their workgroup in July. The groups deliberated on some very complex topics, and it resulted in incredibly thoughtful and valuable proposals. We greatly appreciate their time and dedication!

Workgroup Recommendations

- Many of our Workgroups have already completed drafts that are waiting for review. The full list of recommendations that have been delivered and are awaiting review is below:
  - Referring In: 1) Admission Criteria, 2) Network Expansion Sequence
  - Stabilization Center: 1) Medical Guidelines, 2) Safety Protocols
  - Intake & Rapid Engagement: 1) Intake Assessment and Exclusion Criteria, 2) Staffing Model

Project Dashboard (full dashboard here)

Workflow	*Status*
Design / Data, Evaluation, Regulatory and Facilities	On Track
Design / Operating Model	On Track
Implementation Team	On Track
Strategy / Policy Advocacy, Payment, Sustainability and Funding	On Track

On Track | At Risk | Not Started

Announcements

Coffee Conversation

The BHECN monthly Coffee Conversation hour is an opportunity for us to connect with others and share news as well as resources aligned with the work we do. Our guest speakers for the month of August will be announced shortly.

Arts Bridge Community - Harmony

What: An art showcase to break barriers. An art exhibit with over 60 pieces of art from local Asian-American artists with the aim to support the vibrancy and diversity of Portland's communities, after two long years of social distancing. A portion of painting sales will go towards AHSC's Mental and Physical health services in Portland's Vietnamese, Korean and Chinese minority communities.

This link is for individuals who are actively engaged in BHECN. For questions and/or to be put on our distribution list, please contact tpandeya@lonesconsulting.com

Figure 9. Sample monthly bulletin

5.2 RISK MANAGEMENT

The BHECN Project process for managing and mitigating risk was to first determine if a risk was in scope for the group raising it. If it was, it would be recorded in the risk register and discussed to conclusion. The common categories for handling risk would be to decide if an issue should be accepted, transferred, or mitigated. If accepted, the decision was recorded and closed. Depending on the level of the project structure for which the risk was relevant, Core Team, and/or Workgroup Leads would be consulted. If mitigated, either the Core Team, workgroup or the leads of the

workgroup would determine a path for reducing the intensity of the risk. If it was established that a group could not come to agreement on the way in which to resolve it, the issue would be transferred. This means the item would be escalated to a higher level of project authority. Escalation could mean resolving at the level of workgroup leads and project managers or, in some cases, brought up to the Core Team or Governance Committee as a decision to made at next level of project approval and at a higher level of project leadership.

E. WORKGROUPS – SCOPE, MEMBERSHIP AND RECOMMENDATIONS

The following section provides an overview of completed workgroup and community engagement scope and recommendations, as well as the stakeholders who were engaged for these efforts during phases 1 and 2 of the project. This section is organized by functional area, where Phase 1 workgroups defined and prioritized the work of Phase 2 workgroups.

1. CORE TEAM

Core Team – Contributing Stakeholders	
Jill Archer	CareOregon
Ebony Clarke	Multnomah County Health Department
Julie Dodge	Multnomah County Health Department
Mike Myers	City of Portland
Seraphie Allen	City of Portland
Skyler Brocker-Knapp	City of Portland
Greg Miller	Unity
Melissa Eckstein	Unity
Ron Lagergren	Unity
Juliana Wallace	Central City Concern
LaMarr Cuffie	Portland Street Response, LEX Consultant
Bob Day	Lones Management Consulting, Criminal Justice expert
Nerissa Heller	Fora Health
Judge Nan Waller	Oregon Judicial Department
Kevin Mahon	De Paul Treatment
Aaron Lones	Lones Management Consulting

Scope

Project management, facilitation, and risk mitigation while keeping focus on equity lens, voice of customer and stakeholder alignment.

Description

Develop and maintain project structure and documentation. Prepare and facilitate Governance Committee and Stakeholder Workgroup meetings. Coordinate information flow between Governance Committee, Stakeholder Workgroup and others as needed. Generate meeting recaps and project reports as needed. Mitigate project risks or escalate to the Governance Committee.

Timeline

12/15/20: Work Group Kick Off

8/2/22: Suspended for County Transition of Project Management

2. GOVERNANCE STEERING COMMITTEE

Governance Steering Committee – Contributing Stakeholders	
Abbey Stamp	Multnomah County LPSCC
Carl Macpherson	Metropolitan Public Defender
Derald Walker	Cascadia Behavioral Health
Dwight Holton	Lines for Life
Ericka Pruitt	Multnomah County Community Justice
James Schroeder	Health Share of Oregon
Janie Gullickson	MH & Addiction Association of Oregon
Jill Archer	CareOregon
Julie Dodge	Multnomah County Behavioral Health
Liz Stevenson	OHSU Psychiatry
Maree Wacker	De Paul Treatment Centers / Fora Health
Melissa Eckstein	Unity
Michael Leasure	Portland Police Bureau
Mike Reese	Multnomah County Sheriff
Mike Schmidt	Multnomah County DA
Nan Waller	Multnomah County Circuit Court
Robin Henderson	Providence Behavioral Health
Seraphie Allen	City of Portland, Office of the Mayor
Skyler Brocker-Knapp	City of Portland, Office of the Mayor
Sharon Meieran	Multnomah County Commissioner
Tony Vezina	4th Dimension Recovery, LEX Consultant
Aaron Lones	Lones Management Consulting

Scope

To provide project oversight and support for stakeholder accountability and alignment.

Description

Confirm decisions with strategic impacts for BHECN. Review and approve Stakeholder Workgroup's prioritization of strategic BHECN work. Decision-making for escalated issues, and final review of recommendations.

Timeline

4/1/21: Work Group Kick Off

7/30/21: Transitioned work to Core Team and Executive Committee

3. BHECN STAKEHOLDER WORKGROUP

BHECN Stakeholder Workgroup – Contributing Stakeholders (Note that this list is not an exhaustive)	
Abbey Stamp	Multnomah County LPSCC
Andy Mendenhall	Central City Concern
Anne Marie	Gain Center Team
Bob Day	Lones Management Consulting, Criminal Justice expert
Bob Davis	Community Member
Debra Maryanov	Oregon Judicial Department
Ebony Clarke	Multnomah County Behavioral Health
Greg Miller	Unity
Jill Archer	CareOregon
John Bischoff	CareOregon
Juliana Wallace	Central City Concern
Kevin Mahon	De Paul Treatment
Laura Cohen	Cascadia Behavioral Health
Melissa Eckstein	Unity
Nan Waller	Multnomah County Circuit Court
Nimisha Gokaldas	Multnomah County Behavioral Health
Nina Marshall	CareOregon
Sarah Radcliff	Disabilities Rights Oregon
Seraphie Allen	City of Portland, Office of the Mayor
Sharon Meieran	Multnomah County Commissioner
Aaron Lones	Lones Management Consulting

Scope

Information sharing and advisory support for workgroup strategies and designs.

Description

Core Team and Lones Management Consulting Project Team provides updates to and solicitation of feedback from stakeholders on prioritized strategies.

Timeline

12/16/20: Work Group Kick Off

12/15/21: Work Group Close

4. DATA AND EVALUATION WORKGROUP

Data and Evaluation Workgroup – Contributing Stakeholders	
Allison Brenner	Cascadia Behavioral Health
Conor Wall	OJD Behavioral Health Data Analyst
George Keepers	OHSU Psychiatry
Jake Shores	American Medical Response
Jennifer Gulzow	Multnomah County Health Department
Katie Kadigan	Health Share of Oregon
Kyle Schwab	Local Public Safety Coordinating Council
Lynn Smith-Stott	Multnomah County Behavioral Health
Wren Ronan	Portland Street Medicine
Aaron Lones	Lones Management Consulting

Scope

To clearly define requirements based on project vision, goals, and principles for delivery to Stakeholder Workgroup.

Description

Identify data governance model. Document data and evaluation design requirements. Collaborate with other workgroups to refine scope dependencies. Develop strategic recommendations.

Timeline

2/1/21: Workgroup Kick Off

6/30/21: Workgroup Close / Transition to Data Governance, Evaluation Model, and System Selection/Interoperability

Deliverables

- Prioritized roadmaps for phase 2 workgroups, including Data Governance Workgroup, Evaluation Model Workgroup and Systems Selection and Interoperability Workgroup
- High-level design considerations and recommendations, including initial identification of data sources and metrics

5. CRIMINAL JUSTICE OPERATING MODEL WORKGROUP

Criminal Justice Operating Model Workgroup – Contributing Stakeholders	
Adrian Burris	4th Dimension Recovery
Aja Stoner	Central City Concern
Angel Prater	LEX Consultant
Barb Snow	Multnomah County
Bill Osborne	Multnomah Involuntary Commitment Program
Bob Day	Lones Management Consulting, CJ expert
Bonnie Holdahl	Kaiser Mental Health and Addiction
Cassi Sturtz	CareOregon
David Schmidt	City of Gresham, Police Department
Deandre Kenyanjui	Multnomah County Health Department
Emily Rochon	City of Portland, Portland Police Bureau Service Coord Team
Fletcher Nash	Do Good Multnomah, LEX Consultant
Gionni Gamibino	MHAAO
Grant Hartley	Metropolitan Public Defender
Iden Campbell	LEX Consultant
Jenna Plank	Multnomah County DA
Joey Johns	Central City Concern
Laura Cohen	Cascadia Behavioral Health
Liesbeth Gerritsen	City of Portland, PPB Training Division
Lisa Drennan	LEX Consultant
Liv Jenssen	Multnomah County Dept of Community Justice
Marissa Clarke	TriMet
Nan Waller	Multnomah County Circuit Court
Pari Mazhar	Cascadia Behavioral Health
Rian Hakala	Multnomah County Sheriff's Office
Robert McDonald	AMR Multnomah County
Thomas Hunt	TriMet

Scope

Work planning and prioritization of criminal justice operating model design requirements, opportunities, and risks.

Description

Collaborate with Clinical Operating Model Workgroup to refine scope boundaries and identify dependencies. Prioritize work and document timeline for Stakeholder Workgroup review. Develop strategic recommendations.

Timeline

2/1/21: Work Group Kick Off

1/30/22: Transitioned to CJ Ops workgroups

Deliverables:

- Prioritized roadmaps for Phase 2 Criminal Justice Operating Model Workgroups
- High-level design considerations and recommendations:
- Facility design needs to build on physical safety for staff and individuals in crisis
- Triage capabilities such as an option to access low-stimulation environment that is calming and an ability to move customers to different locations
- Security on site and cross-training in crisis response and de-escalation to offer different resources depending on the situation
- Data Gathering and Sharing
- Re-evaluate how we gather CJ data (e.g., jail booking information vs. citations) and identify ways to increase the fidelity of citation data
- Develop a data sharing governance model and more robust data sharing agreements for BHECN partners
- Evaluate interoperability solutions for CJ and clinical systems to share, analyze, segment, and identify needs for customers more effectively
- Advocate for the continued use of clinical providers to support CJ's ability to participate in key referral pathways
- Advocate for systematic engagement and support resources specific to individuals on bench probation (prevention-focused)
- Serve as a training hub for front line staff at businesses and other customers on how to respond to a crisis and who to call
- Support workshops to align, educate and learn from CJ system providers
- SUDs Transportation

- Promote a BHECN culture that acknowledges that addiction is a disease and develop an advocacy strategy for resourcing SUD services and coordinating funding streams
- Location and staffing recommendations to enable a high degree of support for customers to transition from sobering to detox or to other services; this can mean consistent peer-provider engagement, removing any transportation barriers to access the services, or proximity to services and/or intentional use of transportation services

6. CLINICAL OPERATING MODEL WORKGROUP

Clinical Operating Model Workgroup – Contributing Stakeholders	
Albert Parramon	Central City Concern
Amanda Risser	Central City Concern
Amee McFee	4th Dimension Recovery
Andrew Pegram	Hawthorne Crisis Walk-In Clinic
Angel Prater	LEX Consultant
Anne Grosse	Unity
Barb Rainish	LEX Consultant
Beth Epps	Cascadia Behavioral Health
Bill Osborne	Multnomah County Involuntary Commitment Program
Britt Urban	LCSW
Casey Hettman	City of Portland, Police Bureau Behavioral Health Unit
Cheryl Albrecht	Multnomah County Circuit Court
Drew Grabham	Portland Street Medicine
Fletcher Nash	LEX Consultant
Greg Miller	Unity
Iden Campbell	LEX Consultant
Jeremy Koehler	Health Share
Jeremy Lynn, MD	Providence
Jessica Gregg	De Paul Treatment / Fora Health
Juliana Wallace	Central City Concern
John Bischof	CareOregon
John McVay	Multnomah County Dept of Community Justice
Laura Cohen	Cascadia Behavioral Health
Lynn Smith-Stott	Multnomah County Behavioral Health
Meghan Caughey	Cascadia Behavioral Health
Michelle Desai	Unity
Rebecca Boraz	Kaiser Behavioral Health
Tremaine Clayton	Portland Fire, Portland Street Response
Yvette Vera	Trillium Community Health Plan

Scope

Work planning and prioritization of clinical operating model design requirements, opportunities, and risks.

Description

Collaborate with Criminal Justice Operating Model Workgroup to refine scope boundaries and identify dependencies. Prioritize work and document timeline for Stakeholder Workgroup review. Develop strategic recommendations.

Timeline

2/1/21: Work Group Kick Off

1/30/22: Transitioned to Clinical Ops workgroups

Deliverables:

- Prioritized roadmaps for Phase 2 Clinical Operating Model Workgroups
- High-level design considerations and recommendations:
- Intake and ROI
- Develop a universal intake process for BHECN providers
- Integrate a rapid engagement model that streamlines intake, addresses language barriers, and creates improved billing opportunities for providers
- Develop a global release of information process
- In-Reach and Culturally Responsive Care
- Challenge current funding environment to support enhanced in-reach
- Evaluate and develop a BHECN provider network to be effective at on-demand in-reach or sustainable co-location
- Develop an in-reach model with robust culturally responsive care prevention
- 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
- Advocate for and align with an up-to-date evaluation of lived experience community needs regarding post-discharge housing pathways and resourcing

7. DATA & EVALUATION

The Data Governance, Evaluation Model, and Systems Selection and Interoperability Workgroups were formed based on the Data and Evaluation Workgroup's high-level recommendations and prioritization of work for identifying data needed, and requirements for evaluation and IT systems for operations and program evaluation.

7.1 DATA GOVERNANCE WORKGROUP

Data Governance Workgroup – Contributing Stakeholders	
Jennifer Gulzow (Lead)	Multnomah County Behavioral Health
Amanda Cobb (PM)	Lones Management Consulting
David Nagakartti-Gude	Oregon Health Science University
Kyle Schwab	Multnomah County Local Public Safety Coordinating Council
James Wilson	CareOregon
Michelle Hendricks	Comagine Health
Terrence Cheung	Justice Management Institute

Scope

- Develop a data dictionary, data flow, data sharing, and policies and procedures for the Stabilization Center. Success metrics of this aim included:
- Data are identified with clearly defined owners
- Minimal duplication of efforts for data gathering/entry
- Standardized data sharing processes and tools

Description

The Data Governance Workgroup started in February 2022 and met seven times over six months. The group started by brainstorming existing data points across multiple systems, as well as potential new data points from the Stabilization Center. Using the metrics identified by the Evaluation Model Workgroup, the group mapped data points across disparate systems.

The Data Governance Workgroup collaborated with relevant workgroups to refine scope boundaries and identify dependencies. There was significant overlap between the work of the Evaluation Model Workgroup, the Data Governance Workgroup, and the Systems Selection and Interoperability Workgroup, and Lones Management Consulting coordinated across the three groups.

Recommendations

A spreadsheet with each data point and the stewards of those data points was created and provided to Comagine Health with the aim of beginning to design a process and code for the purposes of developing key performance indicators and evaluation analyses. The group mapped 102 data points across the following systems:

- APAC
- CCOs
- Multnomah County Jail
- Multnomah County Circuit Courts
- Multnomah County Sheriff's Office
- Law Enforcement (Portland Police Bureau, Gresham Police Department, etc.)
- Portland Street Response
- Multnomah County 911/EMS
- 988
- Multnomah County Behavioral Health Call Center
- BHECN Behavioral Health Providers
- Hospital Discharge Data
- Measures and Outcome Tracking System (MOTS)
- EDIE/Collective
- Comagine Health

7.2 EVALUATION MODEL WORKGROUP

Evaluation Model Workgroup – Contributing Stakeholders	
Kyle Schwab (Lead)	Multnomah County District Attorney's Office
Caroline Wong	Multnomah District Attorney's Office
Jennifer Gulzow	Multnomah County Behavioral Health
Whitney Black	Oregon Health Science University
Terrance Cheung	Justice Management Institute
Michelle Hendricks	Comagine Health
Barbara Sharp	Oregon Judicial Division
Amanda Cobb (PM)	Lones Management Consulting

Scope

Develop an evaluation model and key performance indicators. Components of this aim included qualitative, quantitative and process outcomes.

Description

Through a rigorous RFP process, this workgroup selected Comagine Health from a pool of evaluation teams to participate in workgroups that would determine the metrics, as well as perform an evaluation. The Evaluation Model Workgroup started in February 2022 and met six times over five months. The workgroup determined what success would look like for the stabilization center, then brainstormed potential metrics. The group then performed a "fist of five" exercise to prioritize which metrics would be included in the first year, as well as which would be monthly key performance indicators. A sub-workgroup then created two surveys, one for customers of the Stabilization Center and one for BHECN partners that includes providers and first responders, from both clinical and criminal justice organizations.

Because BHECN is committed to community and lived experience voices, qualitative metrics were prioritized to ensure that, in addition to quantitative and operational metrics, there would be representation from both customers and BHECN partners.

There was significant overlap between the work of the Evaluation Model Workgroup, the Data Governance Workgroup, and the Systems Selection and Interoperability Workgroup, and Lones Management Consulting coordinated between the three groups.

Recommendations

Key Performance Indicators include:

- Successful data entry & exchange
- Referrals in by type (clinical, criminal justice, law enforcement, front-line)
- Acuity upon presentation
- Length of stay – stratify by SUDs
- Referrals out by triage status
- Ability to track a customer across all providers and agencies
- Number of minutes it takes a first responder to complete drop-off at BHECN

Annual Performance Evaluation metrics include:

- Successful data entry & exchange/ability to track a customer across all providers and agencies
- Acuity upon presentation to the Stabilization Center
- Satisfaction with culturally appropriate services
- Reasons for not referring into the Stabilization Center
- Length of stay – stratify by SUDs
- Rate of release planning success

- Success of people getting connected and staying connected to care and if not, why not (quality of hand-off and staying connected)
- Customer satisfaction with care and referrals
- Follow-up with customers 6 months down the road (connected to care) - random sample
- Follow-up with customers 6 months down the road (stratified by mental health and SUDs diagnoses)
- Number of individuals that don't stay engaged with BHECN and why
- Recidivism decreased (and dollars spent) both for MH/SUDs Crises but also overall
- Lower emergency department utilization (and cost) both for MH/SUDs crises but also overall
- Lower jail utilization (and cost) focused on frequent utilizers
- Lower number of jail stays/arrests (and cost)
- Notice of mental illness decreased
- First responder experience
- Satisfaction and engagement of BHECN Providers/ Partners/First Responders both clinical and criminal justice – satisfaction with BHECN and each other (Comagine to facilitate)
- Satisfaction/engagement with peer provider

7.3 SYSTEMS SELECTION AND INTEROPERABILITY WORKGROUP

Systems Selection Workgroup – Contributing Stakeholders	
Summer Sweet (Lead)	CareOregon
Amanda Cobb (PM)	Lones Management Consulting
Jay Kothari	Oregon Health Science University
Jennifer Gulzow	Multnomah County Behavioral Health
Joe Brookins	Multnomah County Department of County Assets
Don Gingell	Multnomah County Department of County Assets
Sara Simmers	Multnomah County Behavioral Health
Cloy Swartzendruber	Portland Police Bureau
Ed Arib	Portland Police Bureau
Terrance Cheung	Justice Management Institute

Scope

Ensure the Stabilization Center has systems in place to enter and track information and for the exchange of information between BHECN partners.

Description

The Systems Selection and Interoperability Workgroup was tasked with the timely and seamless portability of data so that people get useful information when they need it for better coordination of

services/safety and to reduce duplication and confusion. The group started in April of 2022 and met five times over three months.

Considerations included:

- Minimal duplication of data collection from customers
- Limit how many systems each role must log into
- Would like to push information into EDIE as well as have data from Collective
- A data warehouse is not necessarily needed at stabilization center, but will be needed by BHECN and/or its sponsor
- The simplest solution is to have data flow into EHR and then to warehouse

Recommendations

The Stabilization Center needs to have the following:

Systems

- Oregon (Hospital) Capacity System (used by non-clinical SC admin staff)
- EHR
- Sprokit (MCCJ use; used by Stabilization Center peer support specialist)
- Simple Screens (used by MC jail, pushes into Stabilization Center EHR)

Technology

- Printer/copier access (wi-fi or air card, for law enforcement)
- Radio(s) (for communication with AMR, PPB, and MCSO)
- Cell phone(s)/land line(s) (for PPB and MCSO to communicate status before arriving)

Other systems to consider

- EDIE/Collective
- Unite Us
- Reliance HIE

System Requirements

- Systems must be 42CFR/HIPAA-compliant and secure (Stabilization Center should not have access to CJIS data so security is not an issue)

- The Stabilization Center must have policies and procedures for HIPAA compliance, data security, personally identifiable information, and uses and disclosures of client protected information.
- The Stabilization Center must have a schedule for data validation and verification
- The Stabilization Center must have a schedule for systems updates
- The Stabilization Center must obtain data use agreements with Comagine Health, as well as other BHECN partners, including but not limited to the state of Oregon, Multnomah County, the City of Portland, and a transportation provider that will take individuals to and from the Stabilization Center

8. OPERATING MODEL

Once the Phase 1 Workgroups had completed the high-level design considerations and recommendations, and issued prioritized roadmaps, Lones Management Consulting and project leadership recruited additional stakeholders to help achieve the work of designing a viable model for a Stabilization Center and BHECN network. As stated above, interviews were conducted with all stakeholders and separate and unique workgroups were formed. Design sessions were conducted with the newly formed workgroups to align on guiding principles, value proposition, and goals.

Below is a breakdown and summary of the work that was accomplished by the collaboration of many stakeholders representing many organizations across the healthcare, criminal justice, and behavioral health fields.

8.1 MEDICAL GUIDELINES WORKGROUP

Medical Guidelines Workgroup – Contributing Stakeholders	
Amanda Risser (Lead)	Central City Concern, Senior Medical Director of Substance Abuse
Dr. Laura Barket (Lead)	Unity Center for Behavioral Health, MD, Psychiatrist
Carrie Buth (PM)	Lones Management Consulting
Stacie Andoniadis	CareOregon, Addiction Treatment Medication / Harm Reduction Services
Tracy Winn	Cascadia Health, Medical Director of Substance Use/Addiction
Les(lie) Bigback	Central City Concern, Housing
Caitlin Lee	Central City Concern, Shelter Site Supervisory
Robyn Burek	City of Portland, Portland Street Response, Program Manager
Tremaine Clayton	City of Portland, Portland Street Response, EMT
Dr. Jessica Gregg	For a Health, CMO
Dr. Jim Laidler	Great Circle Recovery, Medical Director
Jeremy Kohler	Health Share, Director of Integrated Services
Amee McFee	LEX, 4D, Director of MLK Sites

Angel Prater	LEX, Aware Consulting
Fletcher Nash	LEX, Do Good Multnomah
John McVay	Mult Co Dept of Community Justice, Parole and Probation, Mgr Mental Health
Bradley Bucheit	OHSU, Medical Director of Harbor Program
Amanda Jensen	Portland Street Medicine
Wren Ronan	Portland Street Medicine
Dr. Jeremy Lynn	Providence Health and Services, MD, Medical Director
Dr. Anne Gross	Unity, Associate Medical Director
Dr. Marian Fireman	Unity Center for Behavioral Health, MD, Psychiatrist
Erica Thygesen	Unity Center for Behavioral Health, Mgr of Counseling & Therapy Services

Scope

To develop a program model that includes multiple clinical pathways addressing the different types of substance use so that we can effectively sober people experiencing acute intoxication.

Description

The workgroup achieved their goal by determining medical guidelines and safety protocols recommended for sobering, withdrawal management and stabilization of individuals experiencing intoxication and acute mental health crisis. Two recommendations were delivered.

Discussion

- Do not replicate the care level in ER or PES
- Handling post-acute withdrawal after 23 hours and into 72 hours/5 days
- The population should be lesser acuity but also those in second phase of withdrawal or requiring medical management
- Threshold for level of treatment needed: agitated, psychotic, takes time, some people overnight and others with additional psychotic incidence can take days
- Patients on stimulants, different than alcohol and other drugs, are totally unpredictable and may need to err on side of giving more meds and seclusion early in the process
- Physical environment should be called out as part of treatment interventions
- Must consider longer than 1-2 days for individuals who still want to stay, and irritability and agitation still exist
- Important to consider 5-day model that opens doors to next care pathway (residential and sober housing)
- Formulary should include environment (safe and not overstimulating) and nutrition, long-acting benzos and antipsychotics for meth, and options for injection meds for vomiting or uncooperative individuals
- Care coordination, support, skilled referral processes with skilled staff and peers built in

- Recommend twice a day rounding (existing community practice ALOS is about 5 days)
- May not be able to change policy to extend holds within the facility beyond the time-bound holds that individuals are brought in on
- Recommend admitting individuals on a public safety hold with experts on staff who are trained to do clinical evaluation for all the things, including when the hold can be lifted - when the hold is lifted, transition to a withdrawal management, support, care coordination services that are voluntary in nature

Assumptions

- This setting will be for individuals who have relatively stable vitals, are intoxicated and/or in withdrawal but are able to coordinate themselves to swallow meds; possibly injectables if vomiting or uncooperative
- Facility will be able to admit individuals on holds
- Facility will be secure and able to care for individuals who may be a harm to self and others, potentially includes those in restraints
- Seclusion (quiet) rooms for people who cannot tolerate being around others
- Not a place where we can take people who have large doses of sedation or any other intervention or state where their airway has potential to be compromised
- Will provide onsite behavioral health support including social support after 24-48 hours, after they have stabilized or when withdrawal has happened
- While it's important to provide low barrier connection to longer term treatment, some people will refuse

Pain Points

- Co-morbidities and multiple substances in one individual
- Individuals who don't meet criteria for inpatient psychiatric admission
- Transportation sometimes takes up to 10-12 hours to get an individual out of ED or PES setting
- Under current statutes, BHECN will not be able to enforce public safety holds unless designated as a hospital and will be limited within the facility to existing 24–48-hour time-bound holds that individuals are brought in on

Timeline

- 12/14/21: Work Group Kick Off
- 4/12/22: Delivered 1st recommendation
- 7/5/22: Delivered 2nd recommendation
- 7/26/22: Work Group closed

Medical Guidelines Recommendations #1 - Medical

Medical Guidelines Recommendations: Medical		
Key Area	Recommendations	Assumptions & Considerations
1. Personnel	• 24/7 licensed provider (LPC, NP, MD, PA, PMHP) • RN staff • Pharmacist (PT or FT) • LCSW • Specialized SUDs Care Coordinators • Peer Providers • Safety / Security • Milieu Management • Medical Director and Associate Medical Director/s • CADC	• Must include skill set and licensure that allows TASC to monitor, maintain and lift holds and can perform complex medical management • Staff who is adept at motivational interviewing • Possibly a peer provider/social work duo • Important to bake in low barrier connection to longer term treatment AND know some people will not want it • Medical Directors should include psychiatric and SUDs expertise.
2. Standard community practice around sobering and withdrawal from alcohol and other substances	• Utilize current standards of care from hospitals and residential settings • Access to point of care testing (incl drug testing, CBG, public health screenings, pregnancy) • Focus on Oral Medication and Injectable medication • Observation, monitoring, supportive care, withdrawal management if needed • Referral to higher level of care • Onsite Behavioral Health support incl social support to help after 24-48 hours, after they've stabilized, or withdrawal has happened	• Exclude intravenous medication • Don't anticipate having easy access to lab technology outside of point of care testing – *(Impacted if adjacent to a hospital or higher level of care that already has one?)* • Consideration for routine or screening EKG for medication management
3. Utilize current Standards of Care around early treatment for methamphetamine intoxication	• Oral Antipsychotics • Benzodiazepines • Calm environment (rest, hydration, nutrition) • Injectable antipsychotics may sometimes be necessary	• Commercial kitchen for nutrition needs
4. Holds management	• Regular evaluation and assessment of legal status at least daily • Daily consideration of appropriate level of care *This section ties to the Facilities Workgroup deciding upon location.*	• Must include skill set and licensure that allows TASC to monitor, maintain and lift holds and can perform complex medical management • Once a hold is lifted, we can continue to support folks voluntarily
5. Pharmacology	• On-site Pharmacy or access to pharmacy services is recommended (with capacity for quick turnaround of several hours in some instances) • Oral or injectable medications that do not require continuous monitoring • Stock medication you store and dispense	• Formulary to provide: • Oral and injectable antipsychotics • Benzodiazepines • Oral phenobarbital • Medications for comfort and adjuncts for withdrawal (i.e. gabapentin, antiemetics, anxiety medications like clonidine, hydroxyzine

Medical Guidelines Recommendations: Medical		
Key Area	Recommendations	Assumptions & Considerations
	• Ability to store and administer personal medications	• Medications for common co-occurring conditions (wounds, soft tissue infections, etc.) • Constipation • Less acute than hospital, but more in line with subacute facility capabilities
6. Facility requirements as non-pharmacologic interventions	• Observation up to 5 days • Quiet, safe environment • Areas of decreased stimulation incl safe seclusion rooms • Comfortable and safe places to rest with beds • Places for low key recreation (TV, puzzles, coloring, etc.) • Space for therapy and group meetings • Access to outdoor space and smoking area?	• Effective and compassionate non pharmacologic interventions are essential • Storage and procedure around personal belongings (policy on weapons)

Medical Guidelines Recommendations #2 – Stabilization Center Safety Considerations & Protocols

Medical Guidelines Recommendations: Stabilization Center Safety Considerations & Protocols		
Key Area	Recommendations	Assumptions & Considerations
1. During intake process	• Personal Belongings	• Contraband check • Remove shoes • Change into facility socks • Catalog valuables while patient changing into scrubs and undergoing skin check in private area
	• Medical Recommendations	• Skin check (same sex RN)-check skin folds but no cavity checks • Staff required to change into facility scrubs • Perform best practice medical assessment and mental health assessment • Initiate actual detox treatment program for alcohol, opiates, or poly-substance use
2. Other safety considerations	• Facility Recommendations	• Managing animals • Managing what to do if no improvement in 48 hours on public safety hold • Decide if PD needs to be involved in conversation about custody discharges as was discussed last meeting • Plan for walk-in portion • Protocol around Weapons and contraband (and storage) • Considerations for designated smoking areas • Alcohol –free products • Clear communication of approved and restricted items • Establishing trauma-informed spaces by centering around equity, specifically racial equity

Medical Guidelines Recommendations: Stabilization Center Safety Considerations & Protocols		
Key Area	Recommendations	Assumptions & Considerations
3. Staff training during agitation	• Verbal de-escalation training (i.e., therapeutic options and CPI) for all staff • Physical de-escalation and containment training (i.e. safety clinch) for BHTS and BHA staff • Contraband • Allowable items	• Safety starts at the door! • Initial and annual training for ALL staff • Establishing trauma-informed spaces by centering around equity, specifically racial equity
4. Managing Agitation: Multipronged approached	• General guidelines to managing agitation in a trauma informed manner	• Clear expectations and boundaries-what is acceptable or not • Expectations need to be consistent and apply equally to everyone • If someone is acting it, it is because they have a need that is not being met • When someone visibly upset, engage with them to figure out what need they have that is not being met • Meet that need if possible: more food, more blankets, a quiet room • Offer comfort medications-the person is in detox after all • Utilize peers to engage the person, as well, but any team member can engage the person and the more contacts and efforts the team has trying to rectify this person's experience, the more successful team will be at establishing rapport and avoid major blow outs if possible • Strategically engage with patient after the RN gives medications to help direct the narrative • Establishing trauma-informed spaces by centering around equity, specifically racial equity
	• Managing agitation with medications	• Use case: when medication is required based on response to other interventions • Two pathways: stimulant vs. depressant • Protocol for treatment of agitation. BZN (benzodiazepine), EPS (extrapyramidal side effects; ETOH (alcohol); IM (intramuscular)
	• If agitation persists beyond these measures	• Having a staff presence may head off violent aggression but in someone intoxicated could also exacerbate it; this is where behavioral health is so nuanced and there is no cookie cutter approach • Recommend taking the person away from main milieu to avoid upsetting other patients and making the event bigger than it needs to be (take into an office if the person is safe enough to engage in that manner) • Decrease stimulation-taking out of main milieu or to quieter area with less distractions and more one on one attention

Medical Guidelines Recommendations: Stabilization Center Safety Considerations & Protocols		
Key Area	Recommendations	Assumptions & Considerations
		• Establish clear expectations: no yelling, no throwing items, and inform when these expectations are not being met gently
5. Managing Agitation: Multipronged approached	• Extreme DTS (self-harm)	• Restraint pathway if all else fails • Ensure medications are offered or given if indicated at this point. It Is how the symptoms will improve if someone is truly psychotic • If necessary, subdue the person physically so they can be transferred to a safe place where they cannot injure themselves • Have patient assist in own transfer if possible • If they refuse to assist, engage transport equipment like transport blanket or taco • Only use restraint chair if the patient will not refrain from harming themselves and make sure that medications are given at this time. This is the therapeutic intervention part above merely keeping the person safe • Person must be observed by a 1:1 through entirety of restraint • Constant observation with 15-30 min checks of restraint equipment, circulation, breathing, etc. • Containment should be as brief as possible – it can be traumatizing • Do not forget to debrief after any event! What went well? What did not? Should be multi-disciplinary conversation
	• Agitation/Aggression DTO	• Seclusion pathway • Make sure to utilize medications rather than just locking someone in a room to “cool off” – must be a therapeutic measure here • Once in seclusion, 15 min checks and frequent vital signs – generally every few hours and seclusions need to be continually reassessed for ongoing need – containment should be as brief as possible • Have patient assist in own transfer or utilize transfer equipment – bring to seclusion room • Provide PRN medications and set very clear expectations to have seclusion discontinued – let the person know what you need to see before they can be released from the room • Continue to assess for patient’s needs, perhaps the person was too agitated to even articulate their needs – keep your eyes and ears open! • Leave seclusion room one at a time after administering medications • 15-minute checks, 2–4-hour vitals while in seclusion • Release as soon as release criteria are met and continue to clearly communicate expectations of release – this is a trauma informed measure

8.2 REFERRING IN WORKGROUP

Referring In Workgroup – Contributing Stakeholders	
John McVay (Lead)	Multnomah County Dept of Community Justice,
Tremaine Clayton (Lead)	Portland Street Response
Carrie Buth (PM)	Lones Management Consulting
John Bischof	CareOregon, Behavioral Health Medical Director
Jackie Thomson	Cascadia Health, Senior Director of Crisis Services
Richard Bruno	Central City Concern Blackburn & Old Town Clinic, Sr Med Dir Primary Care
Billy Kemmer	City of Portland, Portland Police Bureau, Behavioral Health Unit
Emily Rochon	City of Portland, Portland Police Bureau, Services Coordination Team
Robyn Burek	City of Portland, Portland Street Response, Program Manager
Jeremy Koehler	Health Share, Director of Integrated Services
Barb Rainish	LEX Consultant
Barb Snow	Multnomah County Behavioral Health
Jessica Jacobsen	Multnomah County Behavioral Health
Cheryl Albrecht	Multnomah County Circuit Court, Judge
David Rees	Multnomah County Circuit Court, Judge
Ed Ortiz	Multnomah County Health Department, Corrections Health
Rachael Lee	Multnomah County Health Department, Corrections Health
Amanda Jensen	Portland Street Medicine
Wren Ronan	Portland Street Medicine
Yvette Vera	Trillium Community Health Plan
Alison Daniels	Unity Center for Behavioral Health, Lead Crisis Intervention Specialist in PES
Michelle Desai	Unity Center for Behavioral Health, Crisis Intervention, LCSW
Ron Lagergren	Unity Center for Behavioral Health, Dir of Clinical Ops Behavioral Health

Scope

To create a process for referring individuals into the facility and network so that referrers clearly understand and can implement when and who to send to the Stabilization Center and later, the broader BHECN network of providers.

Description

The workgroup achieved their goal by establishing admission criteria and a workflow admission process for first responders. Two recommendations were delivered.

Discussion

- Who qualifies and who determines who qualifies? Who prioritizes?
- Voluntary-Involuntary Continuum and calling it "holds" to reduce stigma
- "No wrong door" for first responders
- How to recognize physical and behavioral health indicators of a candidate
- Removing barriers and ensuring equitable and culturally specific access no matter the source of referral
- Develop and inform by evidence-based practices and tools and existing models
- Reducing trauma while accounting for safety
- Coordinating behavioral health crisis for justice- involved individuals
- Reducing duplication within existing systems for mobile crisis and resources an individual is already connected into
- Presenting and co-occurring mental health issues such as suicidal ideation and combativeness
- Hold types and understanding restrictions, designations, requirements, regulations

"I think when Unity opened people were excited about it. When we do find the people that are in need of hospitalization, Unity was going to be a good option for that, but I feel like maybe it's the pandemic, but it felt like they peeled back. If a person is highly impaired, sending them to an emergency room is not always helpful for mental health. We're not really getting them in front of the people they need to be with."
-First Responder

Assumptions

- Majority of referral sources will not have clinical expertise
- Facility will be able to admit individuals on holds
- Facility will be secure and able to care for individuals who may be a harm to self and others

Pain Points

- Medical emergency and physical capacity
- New charges, warrants, and probation
- We have not historically considered an individual experiencing acute alcohol intoxication to be in crisis and must develop the model to include, not exclude
- Admitting individuals on holds requires consideration of requirements and feasibility
- Accounting for pets and personal belongings
- Individuals who are too sick but not sick enough to access care

- Getting someone in the door is different than keeping someone in
- Any hold that includes criminal conduct

Timeline

- 12/16/21: Work Group Kick Off
- 3/17/22: Delivered 1st recommendation
- 5/23/22: Delivered 2nd recommendation
- 6/6/22: Work Group closed

Referring-In Recommendations #1 - Criteria for Referring into Stabilization Center

In Scope:

Must include:

- Suspected alcohol and/or drug intoxication

May include:

- All presenting/co-occurring Mental Health issues such as suicidal, combative, etc.
- Mental Health Holds where no crime has been committed
- Not on hold but discretionary still needing services
- Transfer from hospital or PES including intoxication/safety holds

Out of Scope:

- Charges that require booking such as new charges, warrants, probation holds
- Medical needs requiring hospitalization or emergency services
- Not intoxicated

Referring-In Recommendations #2 – Network Expansion Sequence

Referring In Recommendations: Network Expansion Sequence			
Months	Program Development	Referral Sources	Assumptions
1-6	Sobering, Stabilization, Triage, Referral (out), Transportation	• Law Enforcement • AMR/EMS • PSR/Fire • Project Respond • TriMet SRT • Unity / ED	• Must consider transportation capability to relieve pressure on community providers and possibly first responders • 1st cohort will account for SUDs/MH Provider access through first responder crisis intervention calls • Will have a system solution so referrers can view access status and consumer disposition
6-12	+/Add: Some Mental Health Crisis capabilities (*hold status still under consideration*), Short term services in facility and with network partners	• Peer Provider Orgs • UWIC, *CATC* • Recovery Housing Orgs • Jail/Corrections • Courts • Mult Cty BHRC *Other shelter providers funneled through a housing retention team*	• Partner / service line agreements need to be part of our workflow **If performance related to access and capacity are good, we can expand referral sources on an escalated timeline*
12+	+/Add: Improved capability to transfer to network partners, better utilization through coordination	• CBOs • SUDs & MH providers • Self-referrals • Walk-ins	• Many SUDs/MH Provider will also be able to access referrals through first responders in Months 1-6 **If SUDs or MH providers develop transportation capability outside of LE, then the sequencing of this might change*

8.3 PRE-ARREST DEFLECTION WORKGROUP

Pre-Arrest Deflection Workgroup – Contributing Stakeholders	
Nathan Vasquez (Lead)	Multnomah County District Attorney's Officer, Prosecutor
Caroline Wong (Lead)	Multnomah County District Attorney's Officer, Prosecutor
Daniel Coffin (PM)	Lones Management Consulting
Lisa St. Helen	Bureau of Emergency Communications
Patrick Jones	Bureau of Emergency Communications
Steve Mawdsley	Bureau of Emergency Communications
Tracy Winn	Cascadia Health, Medical Director of Substance Use/Addiction
Pari Mazhar	Cascadia Health, Senior Director of DEI
Caitlin Lee	Central City Concern, RN Women's shelter
Lt. Jeff Miller	City of Gresham, Police Lieutenant, Service Coordination Team
Adam Speer	City of Portland, Portland Police Bureau
Harold Hays	City of Portland, Portland Police Bureau
Jennifer Butcher	City of Portland, Portland Police Bureau

Nathan Kirby-Glatkowski	City of Portland, Portland Police Bureau
Lt. Christopher Burley	City of Portland, Portland Police Bureau, Lieutenant
Emily Rochon	City of Portland, Portland Police Bureau, Program Mgr, Service Coordination Team
Bob Day	Consultant, Law Enforcement
Terrance Cheung	Consultant, Law Enforcement
Gionni Gambino	LEX, Consultant
Adrian Burris	LEX, 4D
Angel Prater	LEX, Aware Consulting
Lisa Drennan	LEX, Consultant
Fletcher Nash	LEX, Do Good Multnomah
Grant Hartley	Metropolitan Public Defender
Julia Patrick	Metropolitan Public Defender
Sara Mulroy	Metropolitan Public Defender, Supervisor of Misdemeanor Unit
Leah Drebin	Multnomah County
Kathy Shumate	Mult Co Behavioral Health, Program Mgr, Diversion Courts & Commitment Services
David Rees	Multnomah County Circuit Court, Judge
Jenna Plank	Multnomah County Circuit Court, Judge
John McVay	Multnomah County Department of Community Justice
Liv Jenssen	Multnomah County Department of Community Justice, Manager for Transition Svcs
Karla Upton	Multnomah County Pretrial Services, Manager
Cassandra Hernandez	Multnomah County Recog, Manager
Steve Ciccotelli	Multnomah County Sheriff Office
Rian Hakala	Multnomah County Sheriff, Patrol Lieutenant
Stephanie LaCarrubba	Multnomah County Sheriff, Program Unit Manager
Bill Osborne	Oregon Health Authority
Rob Rutledge-Shyrock	Portland Street Medicine
Wren Ronan	Portland Street Medicine
Robyn Burek	Portland Street Response
Marissa Clarke	TriMet
Thomas Hunt	TriMet
Erica Thygesen	Unity Center for Behavioral Health, Mgr of Counseling & Therapy Services

Scope

To develop a recommendation for how to deflect people away from jail and to BHECN services.

Description

Law enforcement officers are often unable to facilitate a connection to first responders who have the training necessary to determine the needs of individuals in crisis in the field and an appropriate facility to transport them to in a timely manner. This results in the overutilization of emergency departments (EDs) and the Multnomah County's jails.

The Pre-Arrest Workgroup was convened to develop a diversion model to help people experiencing a behavioral health crisis connect to the BHECN partner provider network in lieu of arrest and transport to jail by law enforcement officers in Multnomah County.

Discussion

- Cases that do and do not apply for referral to the Stabilization Center
- Authority to detain and chain of custody concerns
- Pima, AZ and Harris, TX models for arrest deflection
- Medical criteria for acceptance for jail deflection
- Holds (criminal and civil)
- Use of force
- Dispatch (which first responder shows up based on BOEC policy)

Assumptions

- Facility will be a secure facility that provides care for individuals who pose harm to self or others and those who may be brought in on a mental health hold
- This is ever evolving work and further clarification around sobering and stabilization will be needed to continue evolving
- The BHECN Stabilization Center will not be a punitive model i.e., not an alternative form of incarceration
- Law enforcement will not use civil safety holds as a primary means of detaining someone to transport them to the BHECN Stabilization Center

Pain Points

- Public opinion regarding law enforcement's role in responding to behavioral health emergencies
- Lessons learned from the LEAD program; must have a simple structure or law enforcements stakeholders will not adopt/utilize the model
- No law enforcement officer discretion allowed in policy enforcement
- Police are not trained to evaluate physical/behavioral health of individual
- Medical clearance: AMR may be liable if they provide an assessment on scene
- Safety for staff and other patients at the facility
- When and how to lift probation detainers and warrants

"Things have to be really bad to put someone on a hold. This action needs to happen so much earlier for real help."
-Family/Natural Supporter of Individual in Crisis

- Civil holds
- USDOJ policy
- Pets and personal possessions

Timeline

- 01/17/22: Work Group Kick Off
- 3/17/22: Delivered draft recommendation
- 5/4/22: Recommendation finalized
- 5/18/22: Work group closed

Pre-Arrest Deflection Recommendations #1 – BHECN Jail Deflection

Inclusion Criteria:

- Cases that qualify for jail deflection:
- Non-person Misdemeanors (most common types of charges that would qualify for specific BH intervention)
- All non-person misdemeanors + suspected intoxication
- Cite-in-lieu warrants + suspected intoxication

Excluded:

- Cases that don't qualify for jail deflection:
- Class A, B, & C* felonies
- Person misdemeanors*
- Domestic violence cases
- Protection order violations
- 'Shall' arrest warrants
- DUI

*Some C felonies and person misdemeanors may be considered in the future post initial implementation

Note: After significant discussion surrounding options for developing an arrest or jail deflection model, the Pre-Arrest Deflection Workgroup determined that any recommendation put forward should be kept simple and provide clear criteria for law enforcement officers. The principle of "starting small and building on success" was adopted to avoid the mistakes of the Law Enforcement Assisted Diversion (LEAD) program piloted in Portland several years earlier. The LEAD program was discontinued shortly after launch due to an overly complicated decision-making structure and insufficient training for police, resulting in poor adoption by officers.

8.4 TRANSPORTATION TO BHECN WORKGROUP

Transportation to BHECN Workgroup – Contributing Stakeholders	
Thomas Hunt (Lead)	Safety Response Manager, TriMet Safety Response Team
Bob Day (Lead)	Consultant, Deputy Chief, Portland Police Bureau (retired)
Daniel Coffin (PM)	Lones Management Consulting
Jackie Thomson	Cascadia Behavioral Health
Marissa Clarke	Senior Coordinator, TriMet Community Engagement Programs
Barb Rainish	LEX, Consultant
Fletcher Nash	LEX, Do Good Multnomah
Lisa Drennan	LEX, Bullier House
Jacob Shores	Clinical Quality Improvement Coord, American Medical Response
Jeff Miller	City of Gresham, Police Lieutenant, Service Coord Team Mgr
Stephanie LaCurrubba	Multnomah County Sheriff's Office, Program Unit Manager
Jeremy Koehler	Director of Integrated Services, Health Share
Orren Johnson	Senior Manager, Procurement, Trillium Community Health Plan
Zeke Martin-Brunkhard	Peer Provider, Portland Street Response

Scope

To develop a recommendation for how to transport people to the stabilization center as early as possible, in the safest and most supportive setting possible.

Description

The transport of individuals experiencing a behavioral health crisis must be safe, trauma-informed, and timely. The Transportation to BHECN workgroup was convened to evaluate existing transport resources, potential modes of transportation, and the needs of Portland's first responder and mobile crisis outreach teams. The workgroup produced three recommendations that outline a model for transportation to the BHECN stabilization center and other potential BHECN network partners locations.

"Over 50% of all 911 calls are Mental Health or substance use disorder related."
- First Responder

Discussion

- First responder guidelines, needs, and facility requirements
- CNCT Network Transport Design
- Cabs, Ride Share, and Public Drop offs

Assumptions

- Medicaid NEMT benefit will not be utilized during soft launch of the stabilization center because of the lead time to gain approval (~24 hours)
- Some transports by AMR will have Medicaid or other insurance for qualifying reimbursement (this will depend on changes to the county's EMS transport protocols)
- Facility will admit people who are on holds (civil and jail/booking deflection/diversion)
- Alternative forms of transportation will be utilized with appropriate referral for voluntary transports, e.g., ride share and cabs
- Facility will be secure and admit people who are on civil safety holds and Law Enforcement jail deflection day one
- CNCT should provide medical clearance in field prior to transport when possible
- CNCT will operate in public spaces only

Pain Points

- Transport of individuals placed on holds
- Law enforcement's role enforcing mental health director's holds
- Law enforcement role in transporting civil holds for intoxication
- Multnomah County's protocol for emergency response to 911 calls and emergency medical transportation requirements

Timeline

- 3/18/22: Work Group Kick Off
- 6/08/22: Delivered 1st recommendation
- 07/20/22: Delivered 2nd recommendation
- 8/31/22: Delivered 3rd recommendation
- 8/31/22: Work Group closed

Transportation Recommendations #1 - First responder guidelines, needs, and facility requirements

Guiding principles for first responder guidelines (developed by the workgroup to support alignment):

- Destigmatize transportation; this is about getting help and support
- Integrate peers or people with LEX whenever possible to build connections with those in crisis
- First responders must be trauma-informed and trauma-aware
- The use of holds (civil or criminal) should be reserved for
- Use appropriate form(s) of transport based on needs and acuity
- Reinforce the positive mental attitude

Transportation Recommendations - First responder guidelines, needs, and facility requirements		
Key Area	Recommendations	Assumptions & Considerations
Facility Recommendations	• A well-marked designated point of entry for first responders (must have good signage) • Adequate parking for first responder vehicles • Radio and phone communications capabilities • Must be efficient; first responders must be able to quickly transfer care or custody • Integration with Oregon Capacity System (OCS) • Ability to collect data from law enforcement (state ID number) • Work area for paramedics and law enforcement with access to computer, printer, scanner, copier • Onsite resources to help first responders with people entering facility on a hold (de-escalation and security) • Fast medical clearance upon arrival • Minimize transfers to ED or jail	• Facility staff will need training specific to each type of first responder making referral (EMS, mobile crisis outreach, law enforcement) • Knowledge of processes must be widely understood to prevent breakdown if the facility's personnel changes • State ID number will be necessary to track jail/booking diversion • Primary means of determining capacity will be use of radio or phone to check OCS status
First Responder Needs in Field	• Minimal paperwork to make referral if not accompanying during transport (e.g. people who will arrive by cab) • Training for first responders on how to refer into facility, acceptance criteria, and medical clearance requirements e.g., no ALS transports, must be suspected of intoxication • Means of communicating specifics about individuals to the facility in a discrete way to avoid conflict • Ability to quickly determine facility status/capacity (OCS)	• Preferably referrals can be made electronically by mobile crisis outreach teams who will not accompany client to stabilization center • For each first responder organization an initial cohort of first responders will be trained and then expanded on

Transportation Recommendations #2 – BHECN CNCT Program Model

Coordinated Network for Community Transportation (CNCT) Goal:

To support first responders and mobile crisis outreach teams in the field by providing safe, trauma-informed transportation without duplicating their scope of services.

Transportation Recommendations – BHECN CNCT Program Model		
Key Area	Recommendations	Assumptions & Considerations
Vehicle design (interior/exterior)	• Minivan or passenger van • Interior must be easy to clean • Must be wheelchair accessible • Physical barrier between driver and clients • Must have room to place someone in recovery position • Communication via radio and cell phone • Seat for clients and staff member(s) in the passenger compartment • Dashcam with interior/exterior video/audio capability • Clear signage with thoughtful marketing approach • Amber lights and reflective tape on exterior for staff safety • Cargo space to transport (limited) personal belongings • Ability to transport 1-3 clients at a time and 2-3 staff at a time	• Do *NOT* make vehicles or staff look like law enforcement • The vehicle must be low to the ground and easy to assist people into • Seat belts pose a safety risk. If they are provided 4-point restraints are recommended • If seat belts are not provided, then no transport on highways • People will often get sick during transport, the ability to place them in the recovery position is critical • Staff will not ride in the back of vehicle with individuals in crisis
Program	• Staff: Peers with SUD LEX, and EMTs (A or B) • Training: Trauma-informed care, crisis de-escalation (MOAB), safety/security, defensive driving, and others • Medical clearance: Basic vitals + Broset score of ≤ 4 • Telephonic interpretation capabilities • *No use of force by CNCT staff* • Cooperative holds only, if restraints (chemical or physical) or use of force is necessary then LE/AMR will transport • Contraband check: no weapons or drug paraphernalia allowed (this may be just asking them to surrender contraband) • Mandatory reporter requirements • Focus on report building and de-escalation.	• Assumption: CNCT will support and be supported by teams with QMHA/QMHP/LMHP staff • Assumption: Men and women will be transported together on a case-by-case basis • Assumption (if adopted/implemented): *CNCT hours of operations, service levels, and service areas will depend on level and source(s) of funding* • Wound care supplies: AED and naloxone should be on hand in case of a medical emergency • During periods of low utilization CNCT can transport people to other facilities (step down/step sideways), home, or pick people up from jail, EDs, or other BHECN partners

Transportation Recommendation #3 - Use of cabs, rideshare, and public transportation

Scope

Cabs, rideshare and public transportation will be used as a mode of transport for individuals only as a voluntary service and as medically appropriate according to physical and mental capacity.

Payment

- MOUs for flat fee rate will be contracted for cab and independent medical transport companies
- MOUs with rideshare companies can be contracted for flat fee, monthly or per ride billing capability
- Prepaid vouchers, such as TriMet Hot Pass, will be made available for first responders for person-to-person transfers.
- TriMet SRT and Lift programs will enter a community partnership BHECN.
- Would require close monitoring of service times
- Warm introduction to ride provider or having a first responder accompany someone to the Stabilization Center, whenever possible.

Out of Scope

- Advanced Life Support (ALS) and high acuity BH transports
- Ride to Care or other NEMT benefits
- Self-referrals (initially, self-referrals will be assessed once the stabilization center opens)
- Referral workflow (this will be developed by the organization(s) that are responsible for operationalizing the BHECN Stabilization center)
- Children (<18)

8.5 INTAKE AND RAPID ENGAGEMENT WORKGROUP

Intake and Rapid Engagement Workgroup – Contributing Stakeholders	
Beth Epps (Lead)	Cascadia Health, Chief Community Officer
Carrie Buth (PM)	Lones Management Consulting
Jackie Thomson	Cascadia, Senior Director of Crisis Services
Richard Bruno	Central City Concern, Blackburn, Old Town Clinic, Sr Medical Dir of Primary Care
Les(lie) Bigback	Central City Concern, Housing
Cindy Hackett	City of Portland, Portland Police Bureau, BHU clinician
Jim Laidler	Great Circle Recovery (Salem, OR), Medical Director
Jeremy Koehler	Health Share, Director of Integrated Services
Iden Campbell	LEX, Consultant
Amee McFee	LEX, 4D, Director of MLK Sites

Angel Prater	LEX, Aware Consulting
Cheryl Lemley	Multnomah County Behavioral Health, Call Center Supervisor
Liv Jenssen	Multnomah County Department of Community Justice, Mgr for Transition Services
Jeremy Lynn	Providence, ER MD, Med Director
Yvette Vera (opt)	Trillium Community Health Plan
Alison Daniels	Unity Center for Behavioral Health, CIS Lead
Kyra Sherrin	Unity Center for Behavioral Health, CIS, Day shift lead
Michelle Desai	Unity Center for Behavioral Health, Crisis Intervention, LCSW

Scope

To create a workflow whereby one assessment and intake process will connect clients to the next level of service and will enable us to understand very quickly where we need to be to meet their need.

Description

The workgroup achieved their goal by determining what patient information must be obtained immediately and what clinical and supportive staffing roles are appropriate and necessary to accomplish this work. Two recommendations were delivered.

Discussion

- Population served, insurability and priority
- Appropriate level of acuity and medical clearance
- Making use of existing information and systems
- Privacy issues
- Obtaining self-reported information from individuals experiencing crisis and intoxication
- Understanding an individual's medical, mental health history and connection to other BH resources
- Accounting for individuals who are justice-involved
- Voluntary-Involuntary continuum
- Creating collaboration between service providers and cutting down on duplication of services
- Breaking down barriers to accessing care
- Continuous training on cultural awareness, trauma informed, safety and crisis de-escalation for staff
- Solving for social determinant needs

Assumptions

- Facility will be able to admit individuals on holds

- Facility will be secure and able to care for individuals who may be a harm to self and others
- Current data tracking in the community shows intake processes can take anywhere from 15 mins to 2 hours depending on level of acuity
- Some individuals will not be able to provide information due to limited function and capacity
- Variation of transferrable medical information depending on how an individual is transported to the center (AMR, law enforcement, other referral sources)
- Data sharing systems will be in place to enable access to EHR, medications, other healthcare providers and community resources, insurance, criminal justice
- Facility will have multiple pathways for condition (intoxicated, in crisis) and need (milieu vs. secure room)
- Cultural awareness beyond equity and diversity is critical, as is providing ongoing education and training

Pain Points

- Individuals with acute medical needs will need to be stepped up to an ER or PES care setting
- Treating psychosis not related to intoxication or substance use disorders
- Reliability of information exchange and reducing duplication of processes and services
- Individuals admitted on an involuntary basis may be unwilling to share information
- Intersection of HIPAA and criminal justice system is tricky

Timeline

- 12/16/21: Work Group Kick Off
- 4/7/22: Delivered 1st recommendation
- 5/23/22: Delivered 2nd recommendation
- 6/6/22: Work Group closed

Intake & Rapid Engagement Recommendations #1 - Intake Assessment

Intake & Rapid Engagement Recommendations #1 - Intake Assessment				
Category	Personnel Recommendation	Data Points	Possible Tools	Assumptions & Considerations
Medical Screening	MA, EMT or RN with Peer Support Specialist *Under the onsite direction of LIP / physician*	• Vital signs (Temp, SBP, DBP, Respirations, Pulse) • Medical criteria such as orientation to time, day, place as indicator of aphasia, stroke • Level of consciousness • Visible injuries • Physical complaints (SOB, chest pain, abdominal pain, vomiting, diarrhea) • Pregnancy • Withdrawal status • Current prescription medications • Intoxication: Alcohol, Meth, Other substance	• Sobering Station • CHIERS • Unity • Best practice • Community Standards	• *Assessment tools are an essential for tracking/documenting critical information about the patient, but they don't take the place of provider training and experience.* • *An individual exhibiting even questionable or concerning signs should be escalated to LIP (Licensed Independent Practitioner) level staff immediately.* • *The recommendation is for staff performing intake screenings to work as a team of one clinical staff and one peer support specialist.* • *QMHP or LMHP will be onsite and available as dictated by the OARs.* • *LIP will be onsite and available 24/7.* • *Adopting an accredited tool for non-licensed staff to perform mental health assessments will be critical.*
Mental Health Screening	MA, EMT or RN with Peer Support Specialist *Under the onsite direction of a Mental Health professional*	• Confusion, Irritability, Boisterousness, Verbal Threats, Physical Threats, Attacks on objects • Presence of suicidal/self-harm ideation and behavior • Presence of homicidal ideation/behavior • Presence of psychosis, delusions, hallucinations • Does individual feel safe or unsafe o receive services	• Broset • Sobering Station • CHIERS • Best practice • Community Standards	
Social Determinants Screening	MA, EMT or RN with Peer Support Specialist	• Basic Needs: Food, water, warmth • Housing status • Linguistic needs		

Intake & Rapid Engagement Recommendations #2 - Intake and Engagement Staffing Model

In Scope:

- First contact and engagement will be 24/7 duo/s of medical staff paired with a certified peer provider
- Medical staff defined as MA (Medical Assistant), EMT (Emergency Medical Technician) and/or RN (Registered Nurse) credentials
- Peer Providers must be certified and have experience with BH and SUDs. *Peer credentials have been established by Peer Providers Workgroup
- On site staff resources who are available for consult 24/7
- QMHP (Qualified Mental Health Professional) or LMHP (Licensed Mental Health Professional) as dictated by the OARs
- LIP (Licensed Independent Practitioner)
- Ensuring safety for both staff and individuals through safety and crisis de-escalation training

Out of scope:

Decisions appropriate for the future Medical Director of the facility, such as:

- Specific staffing model with workload and capacity
- Staff ratio
- Criteria for staff on the intake and engagement team and well-defined process for first responders
- Education and training model

8.6 PEER PROVIDERS WORKGROUP

Peer Providers Workgroup – Contributing Stakeholders	
Amee McFee (Lead)	LEX, 4D, Dir of MLK Sites
Carrie Buth (PM)	Lones Management Consulting
Monica Parra (PM)	Lones Management Consulting
Tara Pandeya (PM)	Lones Management Consulting
Rhea Wolf	Cascadia, Peer Wellness Specialist at Crisis Respite Center
Clay Robbins	Cascadia, Program Sup for Peer Services on Crisis Team, Project Respond
Pari Mazhar	Cascadia Health, Senior Director of DEI
Joey Johns	Central City Concern, Associate Director of Supportive Housing Services
Heather Middleton	City of Portland, Portland Street Response, Case Manager
Allyson Linfoot	Clackamas County Behavioral Health, Peer Services Coordinator
Jim Laidler	Great Circle Recovery (Salem, OR), Medical Director

Adrian Burris	LEX, 4D
Todd Gleason	LEX, 4D
Lisa Drennan	Lived Exp, Bullier House
Barb Rainish	LEX, Consultant
Fletcher Nash	LEX, Do Good Multnomah
Andrew Pegram	LEX, Hawthorne Crisis Walk-in Clinic (Hillsboro)
Julia Patrick	Metropolitan Public Defender, Lead Social Worker
Lynn Smith-Stott	Multnomah County Health Department
Laura Malstrom	Multnomah County Sheriff, Programs Unit Lead Counselor
Becky Wilkinson	Providence BOB
Kristen Powers	Providence BOB
Yvette Vera (opt)	Trillium Community Health Plan
Marissa Clarke	TriMet, Community Engagement Coordinator
Tommy Hunt	TriMet, Manager Safety Response Team
Ron Lagergren	Unity Center for Behavioral Health, Dir of Clinical Ops Behavioral Health
Erica Thygesen	Unity Center for Behavioral Health, Mgr of Counseling & Therapy Svc

Scope

To develop a model that connects and bridges peers to individuals from first encounter throughout the behavioral health continuum.

Description

The workgroup achieved their goal by defining the services peer providers will deliver to individuals experiencing behavioral health crisis within the stabilization center and outlining best practice for hiring and staffing process. Three recommendations were delivered.

Discussion

- Language matters
- Primary role should be making an individual feel more comfortable and creating a safer sense of safety for an individual from first contact and throughout the crisis system
- Focus on relationship building and stabilizing, not to overwhelm
- Facility must offer individuals services and supports that are trauma-informed, culturally, and linguistically appropriate
- Outward-facing education is needed on the specific work of peer providers including services, abilities, best uses, strengths, supports provided and advocation

"Treatment didn't prepare me for when I left, the tools I needed on the streets didn't transfer. If people had the ability to have resources together, housing, peer support, etc., the transition from dress rehearsal (treatment centers) to the show (life), then it would allow you to change the lifestyle and the behaviors of lifestyle. It's a total lifestyle change. The focus should be on the transition."
-Lived Experience Consultant

- Keeping equity and inclusion at the forefront
- Peer providers need to receive livable wages
- Certifications are necessary but not more than lived experience and competencies
- Not all individuals will want the same kind of support from a peer provider therefore we must offer a variety of services based on an individual's wishes
- Peers must be included at the leadership level in the facility, and peer workforce must have peer supervisors who are seasoned peer providers themselves

Assumptions

- Recommendations pertain to services that can be provided by a peer specialist during the first 48 hours of admission to facility
- Facility will be a secure facility that provides care for individuals who are a harm to self or others and those who may be brought in on a mental health hold
- This is ever evolving work and further clarification around sobering and stabilization will be needed to continue evolving
- Peer providers will be part of a clinical duo that will be the first contact point with an individual upon arrival at the facility
- Oregon Health Authority (OHA) standards and Traditional Health Worker (THW) rules will guide the scope of practice and what role a peer provider can play
- Medicaid reimbursement require peers to be certified
- Must have robust training program and pathway for professional advancement
- Hire right peer for right job

Pain Points

- Overall lack of understanding and education about peer support roles both in the clinical and the criminal justice setting
- Unable to ensure that same peer from Stabilization Center will be connected to an individual throughout the continuum of care
- Under current law and policy, the non-person misdemeanor criteria for individuals in crisis to access BHECN services was too narrow
- Historical budgetary constraints around equity, living wages and career development opportunities for peer provider profession

"There isn't an adequate facility for follow-up. It's one thing to get into the recovery center but then there's no continuous care."
-Emergency Department Worker

Timeline

- 1/19/22: Work Group Kick Off

- 4/14/22: Delivered 1st recommendation
- 8/10/22: Delivered 2nd recommendation
- 8/31/22: Delivered 3rd recommendation
- 8/31/22: Work Group closed

Peer Providers Recommendations #1 - Peer Services for the Stabilization Center

In Scope

Must include:

- First point of contact upon an individual's arrival - initial connection, meet and greet, providing trauma-informed care in a safer environment
- Support/Assess and connect to meet basic needs such as food, water, warmth, clothing, rest
- Motivational Interviewing
- Focus on relationship building to stabilize but not overwhelm an individual during first 48hrs and to help them understand who to communicate with and what to expect in the process
- Provide a safer environment by being a grounded presence for peers experiencing an intense state and attempting to create a connection
- Inclusion and communication skills, but being clear about what behavior we cannot manage

May include (as optional and on a case-by-case basis):

- Private 1:1 meetings with clients
- Provide support for individuals as peers and work within a team of staff during intake and rapid engagement process, such as assisting individuals with paperwork or answering questions
- Talking to family members/natural support
- Warm introductions to clinicians and other BHECN staff as needed
- Cultural interpretation such as linguistic and interpretation needs (trained interpreter)

Out of Scope:

- Performing the screening and assessment
- Performing any sort of physical restraint of an individual
- Placing hands on an individual
- Enforcing rules or any other task that can confuse a peer provider with law enforcement or authority figure
- Linguistic and trained interpretive services that are not within the scope of peer provider work and have not been built into the staffing and compensation model adequately

Peer Providers Recommendations #2 - Peer Provider Staffing

Recommended:

- Two or more peers on staff 24/7 with a ratio of 1:2 (one peer to two clinical staff)
- Staff must have lived experience with SUDs and Mental Health, and be certified as Peer Wellness Specialist (PWS), Peer Support Specialist (PSS), or Certified Recovery Mentor (CRM)
- Peers can only work in the field of their personal experience
- Leadership: Program Director (requiring lived experience with BH and SUDs) at the Leadership team level (preferred)
- Director of peer services at the Leadership team level
- Experienced Supervisor/s as required by OARs. As a support to peers, supervisor must be a seasoned peer themselves with lived experience
- People of lived experience at the table and in decision making
- Offer support: Support group for peer providers
- Coordination/collaboration and shared understanding between clinical and peer supervisors

Out of Scope:

Items to be determined by future facility Leadership Team, including Peer Provider management team:

- Must clearly define competencies needed and not just what certifications are required
- No educational requirements for peers; needs to be based on experience
- Specific staffing model with workload and capacity
- Education and training model
- Patient to peer ration
- Stand-alone CRM role without MH experience
- PSS role without SUDs and MH experience
- Determining billing and best practices

Peer Providers Recommendations #3 - (Framework for) Peer Provider Education and Training

Recommended

- Peer staff should receive ongoing training by peer providers specific to the unique roles and values of peer providers in addition to other organizational trainings
- Concise introduction of role including education for clinical staff on vision and understanding of the value and importance of peer support role (peer provider would deliver)
- Annual budget for the ongoing and specific peer provider training
- Invest in peer providers to build skills and career advancement during work hours

- On-going trauma-informed training and trauma aware care - specifically address mistrust (based on best practice in current orgs) for participants coming to the BHECN
- Training around trauma-informed approach, such as dealing with triggers and self-care for all staff at BHECN
- Suicide specific training - ASIST (Applied Suicide Intervention Skills Training) for all staff including admin, anyone coming in contact
- Tools in communication to be able to connect with a person (i.e., motivational interviewing)
- Mental Health First Aid for all staff
- How to create empathetic and healthy (therapeutic) boundaries
- How to have healthy partnerships between peer providers and clinicians and understanding each other's roles
- DEI training for all staff
- Looking at how social determinants of health fit into the work that we are doing including discrimination and mistreatment of individuals with MH and SUDs challenges and experiencing houselessness; provide person-centered, trauma-informed care for these individuals.

"My mentors continue to help me out and get things I need. They take me to my appointments and that's what gets me going. If it wasn't for that, I'd be back in prison again. I've been locked up all my life."
-Lived Experience Consultant

8.7 JAIL BOOKING WORKGROUP

Jail Booking Workgroup – Contributing Stakeholders	
Emily Rochon (Lead)	City of Portland, Portland Police Bureau, Program Manager, Service Coordination Team
Carrie Buth (PM)	Lones Management Consulting
Pari Mazhar	Cascadia Health, Senior Director of DEI
Lt. Jeff Miller	City of Gresham, Police Lieutenant, Service Coordination Team Manager
Lt. Christopher Burley	City of Portland, Portland Police Bureau, Lieutenant
Bob Day	Consultant, Law Enforcement
Gionni Gambino	LEX, Consultant
Adrian Burris	LEX, 4D
Todd Gleason	LEX, 4D
Angel Prater	LEX, Aware Consulting
Michael Foster	LEX, Aware Consulting
Lisa Drennan	LEX, Consultant
Fletcher Nash	LEX, Do Good Multnomah
Andrey Maccracken	LEX, Mental Health and Addictions Association of Oregon
Grant Hartley	Director, Metropolitan Public Defender
Sara Mulroy	Metropolitan Public Defender, Supervisor of Misdemeanor Unit

Kathy Shumate	Multnomah County Behavioral Health, Program Manager, Diversion Courts & Commitment Services
David Rees	Multnomah County Circuit Court, Judge
Adam Gibbs	Multnomah County DA, Pre-Trial
Caroline Wong	Multnomah County DA, Prosecutor
Liv Jenssen	Multnomah County Department of Community Justice, Manager for Transition Services
Karla Upton	Multnomah County Pretrial Services, Manager
Cassandra Hernandez	Multnomah County Recog, Manager
Rian Hakala	Multnomah County Sheriff Office, Patrol Lieutenant
Stephanie LaCarrubba	Multnomah County Sheriff Office, Program Unit Manager

Scope

To develop a pathway for someone who is in the booking process at jail to access BHECN-related services, including the Stabilization Center

Description

The workgroup achieved their goal by establishing admission criteria into BHECN and assessment recommendations for the Sherriff's office to consider during pre-booking process at the jail. Two recommendations were delivered.

Discussion

- Must identify a path to remove low level warrants so an individual doesn't go to jail
- Overlapping criteria will need to be fleshed out – distinguish medical/health cs. CJ/underlying offense
- Can we help people who shouldn't be in jail and lack insight into their own crisis state?
- To create an easy pathway, we must decrease barriers for a referrer (hospital, jail, fire, police) to utilize the services
- What is the difference between network and facility and can someone access network services even if not admitted into facility
- Pre-booking to pre-trial could be lengthy and might be a gap
- How to partner with and not duplicate efforts from the Jail Diversion team already conducting 365 diversion as an existing resource
- Define this intercept point as when someone has been arrested and taken down to intake, at the jail counter
- Non-person misdemeanors and non-person felonies can be considered
- Crimes with a victim should not be considered – officers will not want to assume liability here – include domestic violence, certain types of burglary, menacing

- Prostitution is not being booked and sex trafficking, though rare, is high level and would not be eligible
- Bias crimes and hate crimes, even those including MH crisis, are considered a community danger and should be off the table
- High level felony crimes should be off the table
- Serviceable warrants (aka "shalls") shall go to jail unless site-in-lieu/site-and-release or non-extraditable warrant
- Protection orders (stalking, etc.) shall go to jail
- Consideration of individuals not residing in tri-county resulted in the decision that all counties/cities are eligible
- Consideration of criminal addiction even though it may not be categorized as BH/MH illness resulted in decision of ineligible
- Workgroup proposes to add MH and addiction service to the first assessment and not to add an additional screening
- Some deputy discretion related to voluntary participation and if an individual is a repeat visitor who might benefit from BHECN services
- During assessment, seek information about recovery as a means to identify candidates for BHECN

Assumptions

- Charges will dictate if a person is eligible for BHECN
- Facility will be able to admit individuals on holds
- Facility will be secure and able to care for individuals who may be a harm to self and others

Pain Points

- Not many non-person misdemeanors are coming through the jail right now
- Criteria may not be clear depending on what point a customer has been referred in
- Consider how transportation barriers will impact success
- Culture shift to seeing people as life experience vs. criminals, compassion fatigue and burnout
- Burden is on Sheriff's office; new Sheriff will be in office in November 2022

Timeline

- 1/13/22: Work Group Kick Off
- 4/7/22: Delivered 1st recommendation
- 5/5/22: Delivered 2nd recommendation
- 5/9/22: Work Group closed

Jail Booking Recommendations #1 - Criteria for Pre-Booking Diversion to Stabilization Center

Inclusion Criteria:

- Individual must be actively under the influence of suspected alcohol and/or drug intoxication
- Charges that may qualify are:
- Non-person Misdemeanors (most common types of charges that would qualify for specific BH intervention)
- Trespass (e.g., someone looking for shelter who is suffering delusions)
- Disorderly Conduct
- Criminal Mischief, including Vandalism
- Public Order offenses, such as false info to police officer, driving while suspended, some instances of victimless hit-and-run
- Non-person Felonies
- Criminal Mischief I (e.g., property damage, vandalism over $1k or to TriMet bus, breaking windows)
- Burglary II (e.g., non-residential burglary)
- Felony drug charges not appearing on the PJO
- Other charges that are eligible for release from booking

Excluded:

- Charges that require booking such as new charges, warrants, probation holds, PO detainers
- Current Presiding Judge Orders
- Person Misdemeanors
- Protection Orders
- Burglary I
- DUI (high risk)
- 1095 Methamphetamine Charges
- Firearms, Violent Crimes, Sex Trafficking
- Anything under Measure 11
- Individuals who do NOT present with mental illness and/or intoxication

Jail Booking Recommendations #2 - Assessment Tool Enhancements

In Scope:

- Assessment of risk of harm to self or others
- Utilization of proposed charge-based criteria during screening process
- Assessment of behavioral and physical signs of BH needs that would indicate an individual may benefit from the services the Stabilization Center provides
- Policy must be made to ensure medical, mental health and social determinant information gathered during assessment process is protected information
- Conducting new assessment beyond preliminary report to account for trauma/crisis
- Is this person a repeat visitor that might benefit from receiving services at BHECN to stop the cycle?
- Consider including screening tools for non-licensed individuals such as ACOK
- Consider additional "extra door" between clinicians and Recog officers for specially trained MH professionals to do the MH and Addictions assessment piece

Out of scope:

- Basic needs: Basic safety, food, water, housing
- Providing peer support during booking process
- Developing specific screening tools for Sheriff's office
- Criminal addiction as a mental health consideration
- Removing low level warrants
- Individuals who will be released after booking or arraignment
- Individuals already booked into jail who will be getting out

8.8 COMMUNICATIONS (PR) WORKGROUP

Communications (PR) Workgroup – Contributing Stakeholders	
Becca Thomsen	Communications Manager, CareOregon
Elizabeth Baker	Legacy Health, Public and Communications Relations
Jennifer Moffatt	Senior Communications Director, Cascadia Health
Jeremy Graybill	Communications Manager, Health Share of Oregon
Julia Comnes	City of Portland Mayor's Office
Kate Yeiser	Multnomah County Health Department
Julie Sullivan-Springhetti	Multnomah County Communications Director
Jack Coleman (Lead)	Consultant, Jack Coleman Communications
Dan Coffin (PM)	Lones Management Consulting

Scope

To evaluate network wide communications opportunities, challenges, strategies, and approaches for the BHECN network of partners.

Description

Given BHECN's project approach, a community lead effort to address the gaps in Portland's behavioral health crisis management system, alignment across BHECN's partner organizations regarding communications is essential. The BHECN Communications Workgroup was convened to evaluate the opportunities that exist around developing messaging for the BHECN network prior to the launch of BHECN services. Several key audiences were considered including peer providers, the community at large, law enforcement, elected officials, and executive leaders.

Discussion

- Audiences
- Communications Goals & Objectives
- Partner/Stakeholder Engagement & Considerations
- Discovery and Peer/Competitor Analysis
- Tactics including public relations, collateral, web/digital
- BHECN Differentiators
- Communications Strategy
- Branding & Messaging

Assumptions

- BHECN will develop a physical location (e.g., a stabilization center) in addition to network services
- To be sustainable the BHECN stabilization center will require funding from multiple sources
- To be sustainable BHECN services will require broad advocacy
- BHECN will fund and support ongoing communications efforts

Pain Points

- Branding for BHECN
- Alignment regarding approach to messaging
- Alignment regarding content of messaging
- Style for content & collateral
- Uncertainty regarding support/resources for communications

Timeline

- 3/12/21: Work Group Kick Off
- 7/16/22: Workgroup Suspended

Communications Recommendations

Overall Strategic Communications Considerations

- BHECN must grapple with baggage left by past programs and efforts. This effort will inevitably face some skepticism in the community; good communications and messaging will not convince everyone, especially not at first
- However, communications can (and should) be used to demonstrate progress and impact. Communicate it, continue improving, measure, and repeat. Just be cautious not to oversell it
- BHECN must clearly define what it does/does not do. Refine and reinforce messages about BHECN's laser-specific focus on filling gaps in the crisis response system, while also communicating how it connects to other big picture issues such as houselessness.
- To gain support and disseminate information among its distinct audiences, BHECN should seek to identify, activate, and support messengers that those audiences trust
- While BHECN is a new concept/model for Portland, there are several other programs nationally that BHECN can learn from or model its communications on, including Austin and Travis County Sobering Center, and Houston Recovery & Sobering Center

Initial Recommendations

Based on a discovery process led by consultant Jack Coleman, the following preliminary recommendations were presented for BHECN's consideration, prioritization, and additional discussion.

Branding & Messaging

- Select a memorable, plain language name for the sobering facility. For example, the "Portland Crisis & Sobering Center"
- Continue developing BHECN's messaging framework, building on the work to-date, including a positioning statement, headlines, key messages, elevator speech, and several specific messages for audiences such as LEO and peers
- Establish branding and a basic brand style to drive consistency across BHECN communications. This may include a wordmark or logo, a color palette, fonts, graphics, iconography, and co-branding guidelines for partners

Messengers

- Lend authenticity and impact to communications through the voices of those who can share their firsthand experiences navigating or being impacted by SUDs and mental health crises
- Identify and equip a set of engaged messengers from BHECN's key audiences (e.g., peer provider, law enforcement, EMT, healthcare leaders, etc.) to help disseminate messages via the channels that are most appropriate for those audiences, including events, social media, forums, bulletin boards, organization's internal communications, culturally specific groups, etc.
- Support those audiences by providing resources and ongoing, useful, and timely content, materials, media training, talking points, etc.

Collateral

Develop a suite of informative and useful materials to assist BHECN messengers with communicating about the program. Update regularly as the project advances. Assess the need for transcreation/translation to ensure information reaches those who need. Recommendations include:

- FAQ
- General one pager
- Audience-specific one pagers (e.g., peers, law enforcement)
- Brochure
- Annual Impact Report

Digital & Content Strategy

- Maintain a monthly email bulletin to provide regular updates to stakeholders. In the longer-term, transition to a public-facing newsletter (with an opt-in on the website) to provide news and updates to BHECN stakeholders and the engaged public
- Develop and launch a simple, informational website to serve as a centralized location for general audiences to find and share information about BHECN, including FAQs, contact information, news and stories, how to support/get involved, and an opt-in for future communications
- Dedicated BHECN social media channels are not recommended at this time. However, an opportunity exists for BHECN to support leadership and stakeholders in using their voices/presence on social media to disseminate BHECN communications. (e.g., social media kit, sharable images, quotes, news/blog)
- Create a 2–3-minute web video on the why and how of BHECN, highlighting voices from multiple audiences
- Consider explainer or training videos to be used in concert with other training efforts for key stakeholders/audiences such as peers and first responders

Public Relations

- Seek to publicize news around specific and tangible stories that demonstrate progress. For example, issue press releases on grants/funding, lease signing, facility opening, and the release of impact data
- In preparation for inevitable press coverage, identify, designate and media train 3-5 spokespersons who can speak from different perspectives (lived experience, law enforcement, business, etc.)
- Explore speaking engagements at events like Oregon Health Forum, State of Reform, and industry/sector-specific events for police, peers, etc. where key audiences gather
- To inform and build support among elected officials and decision makers, develop co-authored op-eds for placement in local newspapers such as The Oregonian, Portland Tribune, The Skanner, The Observer, Street Roots. Co-authors should represent different audiences, demonstrating BHECN's unique cross-sector collaborative nature. Focus on specific community needs that can be backed up with data and include some sort of call to action (get involved, fund, support, etc.)
- Consider presenting to local news editorial boards to encourage supportive editorials. Again, this should include BHECN stakeholders representing different audiences

9. COMMUNITY ENGAGEMENT, EQUITY, AND LIVED EXPERIENCE CONSULTANT DIRECTORY

BHECN stakeholders understand that meaningful community engagement takes time and continuous nurturing to build trusting relationships. The project is committed to this work, connecting with BIPOC, LGBTQIA2S+ and other marginalized communities to create an accessible and responsive model that ensures individuals have access to intersectional, culturally, and linguistically specific and responsive services.

9.1 LIVED EXPERIENCE CONSULTANT DIRECTORY

The Lived Experience Consultant (LEX) Directory was launched to create an intentional and measured approach to engage individual subject-matter experts with lived experience to consult project design, and ongoing operations as BHECN is implemented. Stakeholders have recognized that this ongoing feedback is a critical component for continuous quality improvement and can serve to build trust, minimize, and clarify misunderstandings in the communities BHECN will serve.

Lived Experience Consultants (Note that this list is not exhaustive)

Adrian Burris	4th Dimension Recovery
Amee McFee	4th Dimension Recovery
Andrey MacCracken	Mental Health and Addiction Association
Angel Prater	Aware Consulting
Barb Rainish	Person with Lived Experience
Chris Bouneff	National Alliance on Mental Illness
Evelyn Lui	Person with Lived Experience
Fletcher Nash	Do Good Multnomah
Gionni Gambino	Person with Lived Experience
Iden Campbell	Twelve6 Strategies
Janie Gullickson	Mental Health and Addiction Association
Joey Johns	Central City Concern
LaMarr Cuffie	Portland Street Response, City of Portland
Lisa Drennan	Bullier House
Lynn Smith-Stott	Multnomah County Health Dept
Meghan Caughey	Cascadia Behavioral Health
Reina Bowers	Mental Health and Addiction Association
Terry Leckron-Meyers	Mental Health and Addiction Association

Scope

LEX consultants are engaged to provide subject-matter expertise that informs BHECN project design development and workgroup recommendations. They are paid through a stipend program from partnership with Cascadia Behavioral Health and a grant from Legacy Foundation.

Description

Since its inception in May 2021, the LEX Directory has grown to 26 consultants from highly diverse backgrounds and has become a vital resource for guiding the BHECN Project's design and governance processes. Additionally, individuals participate in the newly formed LEX Advisory Group which meets monthly.

"You can't put all Asian, Black, Latinx people in one box. There is so much complexity there. Acknowledging the complexity is necessary. In Asian culture there so many languages, countries, people and many differences… In all my 62 years of being on this earth, no one looked at the systems, they didn't think of culture at all. What would have made it better, just having some cultural awareness and people stepping up not just at face value."
-Lived Experience Consultant

Strategy for LEX engagement includes:

- Consultants are engaged in a way that is meaningful for them and the project
- Build a method to measure and communicate to BHECN stakeholders and the community the work with LEX
- Minimize misunderstandings in the community about the goals, objectives, and activities of the project

- Embed LEX into all aspects of the design of the BHECN Stabilization Center and future network of services and providers
- Include LEX and peer providers in every level of project leadership and operating model workgroups

Lived Experience Consultant (LEX) Advisory Group

- Participation in a monthly LEX Advisory Group
- A group rounding on design recommendations and feedback with the opportunity to advise BHECN stakeholders, and to meet as an affinity group

Process for LEX Consultant Interviews

- In dialogue, reading out specific questions that have an impact on BHECN design and ensuring that the questions are clear and understood
- Asking LEX consultants to tell a story in their own way about their journey
- Taking notes, reading back their story, and asking if it is accurate
- Reading back themes identified during the story which relate to the questions and asking if the themes are accurate
- Confirming with the lived-experience consultant that the story and themes are okay to share with key BHECN partners
- Using themes and stories to guide design, development, and decision-making
- LEX interviews and themes are presented to BHECN workgroups to guide design, development, and decision-making. See example below:

Example Interview: Lived Experience Consultant Small Group Interview, 6/18/2021

Questions:

- Can you tell us a story of a time when you or a peer were brought in on an involuntary hold?
- What would have helped you to build trust with the providers? What would have made your experience better?
- What would have helped motivate you on your journey?
- What would have helped you and your support systems/family navigate the system better?

Themes:

- Therapist or provider should ask more questions instead of making assumptions
- Calling the police immediately without thinking of the circumstances. Take time to evaluate the situation, ask more questions and then act as necessary
- Lost trust with therapist but family and friends helped them find someone else

- Alternatives to calling the police, providing resources and/or other options

Timeline

- 5/1/21: Recruitment of LEX consultants begins (on-going)
- 5/1/21–8/31/22: LEX consultant interviews and workgroup participation (on-going)
- 3/10/22: First LEX Consultant Advisory Group meeting
- 4/21/22: LEX Consultant Advisory Group meeting
- 6/16/22: LEX Consultant Advisory Group meeting
- 7/2/22: LEX Consultant Advisory Group meeting
- 9/12/22: LEX Consultant Advisory Group meeting
- Monthly Updates Q1/2021-Q3/2022: BHECN Project updates presented at Alliance of Culturally Specific Behavioral Health Providers

9.2 COMMUNITY ENGAGEMENT

Community Outreach

In addition to engaging a broad and diverse range of stakeholders to participate in workgroups, BHECN gained the feedback from the community at large, consistently reaching out to a broad and diverse range of organizations and individuals impacted by the behavioral health crisis in Multnomah County communities. Examples include:

- Monthly attendance at meetings of the Alliance of Culturally Specific Behavioral Health Providers (The Alliance)
- Presenting updates on the BHECN project at provider and community stakeholder meetings, listening to feedback, and following up
- Outreach and recruitment of individuals with different perspectives of the crisis system and criminal justice system.
- Interviews of people with lived experience, families, and natural supports of people with lived experience

"It's been manageable for 20-30 years, but this corner of the neighborhood has a gas station where you can get beer, there's a shelter where you can get food and then a drug dealer on one corner. I spend 4 hours or more with people with heightened violent behavior. We lose customers and they never come back after being screamed at."
- Portland Business Owner

- Interviews of first responders, emergency department staff, and local businesses
- Outreach to the Portland Business Alliance and neighborhood associations

Continuous Quality Improvement (CQI) Evaluation Model

BHECN's CQI model is rooted in the project's commitment to prioritize voices from the many communities that BHECN will serve and particularly of those with lived experience. This model was

designed to integrate a tailored approach to data collection, validation, and evaluation with continuous qualitative feedback from LEX consultants. In Phase 1, the vision for an independent evaluation model was adopted by the project's stakeholders to ensure that BHECN's outcomes would be evaluated objectively and transparency into BHECN's performance would be maintained. BHECN's Data and Evaluation workgroup was launched to identify CQI metrics, develop a request for information for evaluation services and facilitate the selection of an evaluator.

After responses to the BHECN Data and Evaluation RFP were evaluated, Comagine Health (Comagine) was selected as the BHECN independent third-party evaluator. Comagine's background in system wide quality improvement and health system research and evaluation was determined to be the best fit for BHECN's goals, vision, and community led model for services. Once BHECN programs are launched in 2023, Comagine will work with the contractors, subcontractors, and other BHECN partners to evaluate the Stabilization Center and BHECN network's performance on a quarterly basis. The quarterly performance reports generated by Comagine will be used to assist the contracting entities review, prioritize, and deprioritize evaluation metrics as strengths and gaps in BHECN's services are identified. Comagine will also support BHECN's iterative CQI planning process.

In Phase 1 of the BHECN project it was acknowledged that the scope of BHECN's services would require ongoing quality improvement given the size of gaps the project aims to address, and the risks associated with providing services for sobering and detoxification from meth and polysubstance use. To ensure that BHECN can balance the many needs of its diverse spectrum of stakeholders the following CQI process is recommended to take place once per quarter.

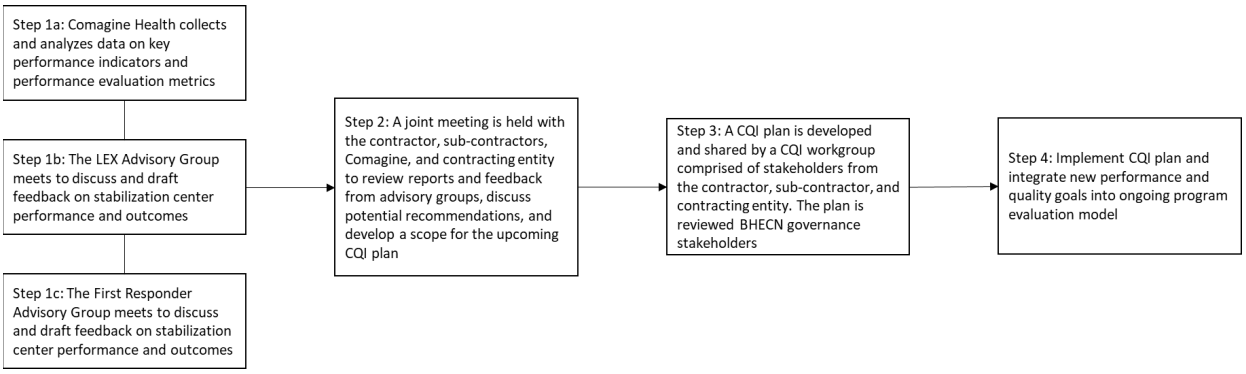


Figure 17. Transportation program recommendations

To ensure voices of lived experience have an ongoing role in the BHECN CQI process two permanent advisory groups will support CQI evaluation and planning.

Lived Experience (LEX) Consultant Advisory Group

The lived experience consultant advisory group is composed of BHECN LEX consultants and meets monthly to provide perspectives on the complex issues impacting individuals in crisis, including

SUD, acute and chronic mental illness, and houselessness. This group aims to provide representative perspectives on the needs of people in crisis, particularly those from historically marginalized or excluded communities.

First Responder Advisory Group

BHECN's First Responder Advisory Group will meet quarterly and bring together first responders to address public safety and crisis response needs in our community. The group will include individuals from fire, law enforcement, emergency transportation and medical services as well as public and private community response agencies in Multnomah County. This group will aim to prioritize effective coordination and utilization of public safety services in our community and provide key feedback on the quality of the BHECN network and crisis Stabilization Center.

Coffee Conversations

Starting in June 2021, the BHECN project convened information style "coffee conversations" – learning sessions, featuring experts in behavioral health, crisis response, deflection, and other relevant subjects. All BHECN stakeholders were invited to attend and dialogue with these experts. Presentations included:

- Kevin Mahon, Fora Health
- Adrian Burris, Program Director at 4th Dimension Recovery Center
- Portland Police Bureau's Behavioral Health Unit
- Pima County, Arizona Deflection/Drug Diversion Program
- Klamath Basin, Behavioral Health Link Access Center
- Justin Volpe, trauma-informed care practices
- Iden Campbell, Suicide Prevention Summit
- Terrance Cheung and Gerald William Sr., MacArthur Foundation's Safety and Justice Challenge Initiative and Justice Reform Community Collaborative in Pima County, Arizona
- Bill Conway, Clackamas EMS coordinator and former Fire Division Chief who helped to create Clackamas Fire's Community Paramedic (CP) program
- David Westbrook, Chief Operating Officer and Chief of Staff for Lines of Life (988)

To advertise BHECN's coffee conversations, Lones Management Consulting sent out a regular newsletter (BHECN Bulletin) with information on the speaker and their topic, as well as upcoming conferences, learning sessions, films, and job opportunities. Coffee Conversations were suspended in June 2022.

9.3 EQUITY LENS

Integrated Diversity, Equity, and Inclusion Lens:

From the start, BHECN project partners acknowledged the importance of developing an equity lens and process by which the community and individuals with lived experience would be continuously placed at the center of its design. With the support of Kathleen Holt of Holt Consulting, the Core Team set out to develop an equity lens to guide the work of the BHECN project. The goals of this group, as agreed upon by all stakeholders, were to ensure equitable and inclusive engagement; to provide a framework for decision-makers to discuss equity and inclusion considerations and impacts; and to hold decision-makers accountable to diversity, equity and inclusion values and vision.

Throughout the fourth quarter of 2021, four equity lens development sessions were conducted. The resulting equity lens includes four tools designed to inform the governance and day-to-day operations of the Stabilization Center and the BHECN network. The four tools are: Group Agreements and Guidelines, DEI Definitions, Equity Values and DEI Approach and Questions.

Equity Tool #1 - Group agreements and guidelines

How to use: Start meeting by asking attendees to transition into a space where they will have conversations about equity, justice, and power. These conversations might be difficult, and these agreements ask everyone to hold the space meaningfully, bravely, and respectfully.

- Stay engaged
- Speak your truth and hear the truth of others
- Expect and accept non-closure
- Experience discomfort
- Name and account for power dynamics in the room and in the work
- Step up, step back / Take space, make space
- Confidentiality: stories stay, learnings leave
- Acknowledge intent but center impact
- Share responsibility for the success of our work together

Equity Tool #2 - DEI Definitions

How to use: When disagreements and misunderstandings about DEI arise, revisit these definitions to clarify.

DEI Definitions
Diversity
Voices, perspectives, and wisdom of peoples from communities that have been historically marginalized, colonized, or enslaved are present in a particular environment. Simple presence, however, does not necessarily mean that these voices, perspectives, or wisdom are included in the discussion. (Source: Southwest Washington Accountable Communities of Health (SWACH))
Inclusion
Integrating and prioritizing the voices, perspectives, and wisdom of people from communities that have been historically marginalized, colonized, or enslaved into power structures, and into the decision-making process from beginning to end. Inclusion means that people from these communities are empowered and invested in them so that they can thrive. (Source: SWACH, Oregon Library Association (OLA))
Equity
Addresses systems and structures that prevent the just and fair distribution of and access to power and resources. Equity means actively providing resources and creating programs that uplift and empower folks who have not been seen, heard, protected, and respected as they deserve. (Source: OLA, SWACH)
Racial justice / Racial equity
Racial equity is when people have the chance to reach their full potential and are not more likely to encounter life's burdens or benefits just because of the color of their skin. Racial equity involves work to address the root causes of inequities, not only their manifestation. This work includes the elimination of policies, practices, attitudes, and cultural messages that reinforce differential outcomes by race. (Source: SWACH)
Culturally responsive care development
Meaningfully including culturally responsive organizations to develop care services that are effective, equitable, understandable, and responsive to a diversity of cultural health beliefs, practices, and needs (Source: adapted from Oregon Health Authority).
Trauma-Informed Care (TIC)
TIC is an organizational framework, an approach used not just on the path from staff to client but in all ways, including how the organization interacts with staff and the community. TIC is grounded in strengths of the individual, system, and community. It is striving to understand and support safety for everyone, both physically and emotionally. It is a commitment to stop and examine the "way things are done" in the name of seeking the systemic nature of oppression and trying on a new way of doing things through hearing the voices of those involved. (Source: Central City Concern)

Equity Tool #3 - Equity Values

How to use: Ground the model creation process in these values.

Equity Values
Community voices / Lived Experience
Focusing on the stories and experiences of those most impacted and using these stories to drive the governance, design, and development processes
Access
Understanding and eliminating the barriers to engagement and service
Accountability
Being responsible to one another and to the communities of impact
Power building
Supporting the knowledge and skill sets of people from impacted communities to be effective leaders in positions of power and decision-making
Community care
Centering the needs of communities especially in times of crisis

Equity Tool #4 - DEI Approaches and Questions

How to use: Pose these values-aligned questions at key decision points in the BHECN design process and ongoing operations or when processes feel confusing or off track.

- What voices, experiences, and perspectives are present that help us fully understand conditions, needs, and realities?
- Who is missing, what are the barriers to their participation, and how do we remove those barriers?
- What relationships can we build and nurture to ensure that we have these voices, perspectives, and experiences in the future?
- Who will be responsible for ensuring this relationship building is done?
- Are we hearing the same voices, experiences, and perspectives?
- What are the barriers to bringing in different people and communities?
- How are we understanding and accounting for the impacts of our work?
- Where are these impacts beneficial and where are they burdensome, and in both cases, for whom?
- How do we know we're working with the right partners?
- What do we expect of our partners and what do they expect of us?
- What are our partners goals and needs?
- Where is our power greatest and what is our ability/appetite for using our power to invest in and support our partners and their work?
- How are we building power with and caring for our partners/communities through this program, initiative, process, or decision?

F. SUMMARY OF FINDINGS

1. BHECN ACHIEVEMENTS TO DATE

The BHECN Project has been grounded in a broad cross-section of community voices and progress has come through systematic engagement with crisis-system leaders, subject-matter experts, individuals with lived experience, first responders and other key stakeholders. This community approach has yielded an action-oriented view of the gaps present in Multnomah County communities' behavioral health crisis system, and enabled alignment among stakeholders on priorities and requirements. To date, the accomplishments of the BHECN Project include:

Phase I:

- Key stakeholders and stakeholder groups were identified
- BHECN's principles were defined and alignment by key stakeholders was achieved
- Detailed requirements and success criteria for design of BHECN's Stabilization Center and Network were identified
- A preliminary design of the Stabilization Center and network functions was created
- Detailed recommendations for design workgroups' scope were developed
- Prioritized clinical, criminal justice, data and evaluation, and clinical/criminal justice roadmaps for Phase 2 workgroups were developed to guide these workgroups
- The Lived Experience Consultant Directory was established, a process to compensate lived experience consultants was implemented and grant funding was secured

Phase II:

- Over 120 cross-functional stakeholders from a wide variety of backgrounds (clinical, LEX and criminal justice) developed detailed design recommendations for the BHECN Stabilization Center operating model and several key network components
- Data governance, program evaluation, interoperability, and data system models were developed, and an RFP process was used to select an independent evaluator (Comagine Health) for BHECN program evaluation post-implementation
- The City of Portland and Multnomah County established an MOU to support cross-jurisdictional collaboration and ownership of the BHECN Project
- A project charter between The City of Portland and Multnomah County was developed to govern the project on an interim basis until a permanent governance model is established
- A Request for Information (RFI) was developed to solicit input from potential contractors and sub-contractors interested in operating the BHECN Stabilization Center. The RFI vetted by experts and shared with key stakeholders for feedback
- Key communications documents were developed including, a BHECN 1-pager, FAQ, discovery report, and draft messaging

These recommendations and accomplishments have come by way of thousands of hours of time volunteered by leaders, subject-matter experts, and other key stakeholders who are integral to Multnomah County communities' behavioral health crisis system. The greatest accomplishment of BHECN thus far is building the community trust and momentum necessary to develop these recommendations. This has been accomplished regardless of the day-to-day struggle that these stakeholders face in their work and lives because it is acknowledged that BHECN is an essential foothold to improve the outcomes for those they serve.

2. SYSTEMIC CHANGE THAT MEETS COMMUNITY NEEDS

The BHECN Project originated as an effort to replace the loss of the CCC sobering center with a more compassionate and trauma-informed approach to sobering that is better suited to address rising methamphetamine, opioid, and polysubstance use. Since its inception, the project has worked to bring together a diverse community of nonprofits, small businesses, community-based organizations, various entities within the city and county, health systems, first responders, and criminal justice agencies to develop a more coordinated and stepped approach to behavioral health crisis services. Throughout the course of the project, the public health issues (housing, substance use, and mental health) that have driven the need for a well-coordinated approach to behavioral health crisis response and stabilization have been exacerbated by the impacts of the COVID-19 pandemic, health care workforce impacts, reduced access to outpatient and residential SUD treatment, and rising rates of violent crime.

After extensive workgroup discussions led by subject-matter experts working in Multnomah County communities' behavioral health crisis system, what remains clear is Portland needs a crisis receiving, triage, and stabilization setting that is designed specifically to address the needs of individuals experiencing acute intoxication resulting from substance use and co-occurring mental health disorders. Stakeholders working in emergency departments frequently state that behavioral health patients require a level and specialization of care that they are unable to provide, especially when people with life-threatening physical health emergencies are competing for limited Emergency Department (ED) resources. These stakeholders resoundingly state that access to Portland's existing outpatient and residential SUD and mental health programs have inadequate capacity given the current level of demand. As a result, triage, treatment, and referrals from ED settings often fall short of providing the interventions behavioral health patients need to find stability and recovery.

> *"We have at times more behavioral health patients than rooms and the situation seems backed up for admittance. Often many are sobering holds, which just takes up space and in our overcrowded department."*
> *- Emergency Department Worker*

BHECN's clinical workgroups have developed a model for intake, rapid engagement, assessment, and treatment that can alleviate the pressure put on emergency departments and first responders by providing better access to behavioral health providers. BHECN's model will place providers (MD,

NP, PA) and nurses alongside social workers, peer providers, certified drug and alcohol counselors, and other specialized SUD resources, all acting as a multi-disciplinary team. These teams will work together to assess each individual presenting in crisis and to tailor a plan to meet their needs utilizing established standards of care and best practices.

From the initiation of the BHECN Project, it was envisioned that BHECN would serve as a single point of entry into the behavioral health crisis system, where first responders could take individuals in need of assessment to a "hub" for triage, stabilization, and care coordination. Without an established behavioral health crisis receiving capability focused on SUD and co-occurring disorders, BHECN workgroups designed the Stabilization Center to act as that hub for Multnomah County communities' behavioral health crisis system. While the Stabilization Center will provide sobering, withdrawal management, and care coordination, it is not intended to duplicate the scope of successful programs or services, but rather help those in need of specific services to access them in a timelier manner.

Referrals in and out of the Stabilization Center will be made based on the individual's needs and level of acuity. BHECN stakeholders have described a model in which referrals to network partners are made in a "step-up, step sideways, or step-down" fashion. Following that guidance, the BHECN Referring In workgroup delivered a "soft launch" network expansion sequence recommendation to prevent the Stabilization Center from being overwhelmed by referrals once open. Initially, only first responders, mobile crisis outreach teams, and emergency departments will be able to refer into the Stabilization Center. The goal of limiting referrals to these organizations is to maximize downstream impacts which in turn will allow BHECN network partners time to stabilize and add additional treatment capacity. Once initial service levels are achieved the Stabilization Center will expand its referral network to include a broader range of clinical, peer, housing, criminal justice, and community-based organizations in an iterative fashion.

While the Care Coordination and Referring Out workgroups have been delayed due to workgroup suspension, it has been widely acknowledged that referrals to and from the following organizations will be essential to maintain the BHECN Stabilization Center's intake and triage capacity, as well as each network partner's capacity for timely intake and treatment:

- The Unity Center for Behavioral Health
- Emergency departments
- Crisis Assessment and Treatment Center (CATC)
- Outpatient Mental Health programs
- Cascadia Health's Behavioral Health Urgent Walk-in Clinic
- Outpatient and residential SUD treatment programs
- Peer providers

While many of these network partners are currently inundated by referrals, the BHECN Stabilization Center will serve as an upstream point of entry and initial crisis stabilization, which in turn will allow these programs the ability to focus on their prospective populations served. Without a single point of entry and triage, BHECN network partners will continue to be overwhelmed with care coordination and referral responsibilities, which in turn limits their ability to deliver timely services.

To ensure the Stabilization Center has the intended impact on provider capacity, first responders, and other key stakeholders the BHECN network of partners must implement a suitable structure to coordinate network activity. The BHECN System Selection and Interoperability workgroup has developed recommendations for systems that will enable BHECN network partners to share information across health systems, criminal justice agencies, and nonprofit partner organizations while protecting sensitive information. A primary consideration for developing these recommendations was using available IT systems and resources to the greatest extent possible, avoiding the need for implementation of new IT systems across BHECN's diverse network of partners.

"The hospital put a hold on me. That was the gateway out to a new life. I agree with needing a hold. Whatever got me to jail or the hospital, I was crying for help, and I didn't know how to ask for help."
- Lived Experience Consultant

BHECN's commitment to be a community-led project requires a program evaluation model that prioritizes the voice of individuals with lived experience and communities that have been historically underserved, marginalized, and excluded. The BHECN Project acknowledges that racial and social justice requires continuous engagement with these communities and BHECN services will need to adapt to their needs. This requirement was prioritized by the BHECN Data Governance and Evaluation Model workgroups resulting in a Continuous Quality Improvement (CQI) model centered on the voice of the customer. The model aims to develop a systematic and standardized approach to program evaluation provided by outside evaluators contracted by the BHECN network to minimize the effects of bias and promote transparency. These workgroups also focused on incorporating promising practices from local and nationally recognized programs in their recommendations for data collection, validation, sharing, and evaluation.

The BHECN Project has developed a crisis stabilization center model that fits Multnomah County communities' unique needs. However, Portland is not the only community in Oregon working to develop these services. The 988 and mobile crisis response implementations mandated by Senate Bill 2417 have set Oregon in motion to join many other states throughout the country that have better alternatives to 911 for behavioral health emergencies. Unfortunately, Senate Bill 2417 stopped short of requiring the implementation of crisis receiving and stabilization centers. The bill, however, did require the Oregon Health Authority (OHA) to begin rulemaking for these facilities, which is due to begin in the fourth quarter of 2022. In addition, Oregon's 1115 non-IMD exclusion waiver for SUD treatment facilities was approved by CMS in April of 2021 and marks a significant milestone toward developing crisis receiving capabilities on the scale required to address Portland's SUD crisis. What remains unclear is exactly how the Oregon Health Authority will augment their existing framework of OARs to incorporate these changes, although some early indications are

encouraging. Those advocating for BHECN's implementation have a significant opportunity to influence OHA's rulemaking process through their public comment process in 2022 and 2023.

3. BHECN'S PATH FORWARD AND KEY CHALLENGES

BHECN was designed as a systematic approach to improve on Multnomah County communities' fractured behavioral health crisis management system. While considerable progress has been made towards developing a stabilization center model that can serve as a hub from a better coordinated network of services, there is still work to be done to both implement the stabilization center and define the BHECN network of services and how it will be governed.

The challenges that BHECN must overcome to succeed are indicative of years of structural issues that are primarily philosophical, political, and financial in nature. Throughout Phases 1 and 2 issues that were identified included:

3.1 MANDATED CLINICAL SOBERING MODELS AND COMMUNITY-LED BEHAVIORAL HEALTH SERVICES

In the past several years, there has been a strong push for a non-clinical community-led sobering and detoxification model in which voluntary participation in programs is mandatory. There exists a stark divide in Multnomah County communities' behavioral health crisis management system between those who think the use of involuntary civil holds is sometimes necessary to protect the welfare of people affected by severe acute intoxication, and those who believe that voluntary participation in sobering and withdrawal management programs is the only pathway to recovery. This divide often centers around two common disagreements: the outcomes for those placed on holds, and the trauma inflicted by being placed on a hold. Despite this contention, every stakeholder with whom the Lones Management team consulted confirmed that, if civil holds are used, they should be reserved only for meth-induced psychosis, when an individual is clearly a danger because of their substance use, or other extreme circumstances. Based on the evidence shared by stakeholders supporting either side, what is clear is different models have worked in different communities throughout the country and their definition of success varies based on the weight given to considerations such as the potential to cause trauma, SUD outcomes, community and staff safety, and individual rights.

Early in the project, criminal justice and clinical workgroups called for a more nuanced perspective on voluntary and involuntary models for BHECN services. When discussing severe methamphetamine and polysubstance intoxication, clinical, peer, criminal justice and first responder stakeholders aligned on the concept of a voluntary-involuntary continuum, acknowledging that this form of intoxication presented in a markedly distinct clinical disposition from alcohol, heroin, cocaine and other substances, and additional measures beyond an exclusively voluntary model would be required. Post implementation, it is essential that these stakeholders are part of the BHECN program evaluation process and their recommendations are integrated into

BHECN's Continuous Quality Improvement (CQI) processes to build a shared definition of success and lasting alignment surrounding the topic of involuntary holds.

3.2 LICENSING THE BHECN STABILIZATION CENTER

Presently, two viable options exist for licensing the BHECN Stabilization Center with the Oregon Health Authority, but without crisis receiving and stabilization services defined in rule, each option is limited and neither fully meets the intent of the recommendations put forward by BHECN workgroups. Existing options include:

Option A: Partner with an IMD (institution for mental disease), preferably a hospital or medical center located within the City of Portland

OR

Options B: Partner with an organization operating under a non-IMD license such as a secure residential treatment facility. This option must receive approval from OHA to utilize their SUD 1115 exclusion waiver to have more than 16 beds

Option A, partnering with an existing hospital or medical center, would allow full-scale implementation of BHECN services without the restrictions non-IMD facilities are currently subject to, and would allow for quick access to emergency department services in the event of a physical health emergency. Executive leaders engaged in the BHECN project have generally supported Option A, as it provides an integrated model for care delivery, utilizes existing resources for triage, offers greater support services such as imaging and laboratory services on site, and mitigates risk in the event of physical health emergency. While these are compelling benefits, many stakeholders are concerned about co-locating the Stabilization Center with a hospital or medical center.

The preponderance of feedback from family members, natural supports, LEX consultants, first responders, and emergency department staff interviewed during Phases 1 and 2 have voiced concern that emergency departments are not an appropriate setting to address a behavioral health crisis. The reasons they provide in support of this claim include, poor past experiences for themselves or someone in their care, lack of staff that specialize in behavioral health, long wait times for intake and triage, poor care coordination upon discharge, and the stigma associated with arriving at an emergency department for a behavioral health crisis. These stakeholders support an alternative model that would provide services in a setting that represents an intermediary between a hospital and an existing outpatient service provider such as residential detoxification services.

Reconciling the benefits of Option A with these concerns would require the hospital providing stabilization services to build trust with first responders, emergency department staff, other providers and the broader community. For this reason, it would be critical that the hospital fully adopt the BHECN workgroup recommendations for Continuous Quality Improvement (CQI). The

BHECN CQI model provides outside evaluation of BHENC services by an independent third-party evaluator and impowers these stakeholders by involving them directly in quality improvement planning initiatives through a permanent advisory group structure. Full adoption of BHECN's CQI model would allow the hospital to cultivate trust with these otherwise apprehensive stakeholders.

Another consideration to integrating BHECN's behavioral health crisis services with a hospital or medical center are the capital and licensing requirements to establish a hospital. Because these models require a much higher degree of licensure than their non-hospital counterparts, fewer partnership opportunities exist within the City of Portland. This in turn narrows the prospect for competition and potential cost savings during procurement and contracting processes.

BHECN stabilization center services could be provided by an organization operating as a non-IMD (Option B), such as a secure residential treatment facility, and pursue approval from OHA to expand services beyond the 16-bed limit non-IMDs are subject to by Center for Medicare and Medicaid Services (CMS). Option B depends on the use of OHA's SUD 1115 exclusion waiver, which was approved by CMS in April of 2021 and is currently being integrated into OHA's application process for non-IDM facilities as of the publication of this report. There are several benefits to Option B, including fewer staffing requirements, more potential locations for the facility, an expedient application timeline and process, decreased reporting requirements, and a broader range of potential partners. It is also likely that this will be a lower cost alternative to hospital co-location.

"If they aren't ill enough to require in-patient treatment, then there are very few options. We give them a piece of paper, we give them a few resources and you are going to see that person again in a few days."
-Emergency Dept Worker

In turn, there are several challenges that must be addressed for Option B to be viable, including determination of a satisfactory process for medical clearance at the facility, triage of physical health emergencies, transportation to the facility (discussed below), and additional requirements to obtain "secure" facility status as defined by 309-033-520. Partnering with a non-IMD would likely result in a faster implementation of the BHECN Stabilization Center and many of the barriers identified above may be resolved by the OHA's upcoming rulemaking session on behavioral health crisis services.

As previously mentioned, OHA is due to begin rulemaking for crisis receiving centers (CRCs) and crisis stabilization centers (CSCs) in the fourth quarter of 2022. A recent report developed by RI International and published by OHA stated that OHA plans to revise its existing rules for psychiatric emergency services (PES) and secure residential treatment facilities (SRTF) to include CRC and CSC services. This rulemaking process presents an opportunity for BHECN advocates to seek clarification from OHA on topics such as medical clearance, triage, transportation requirements, secure licensure and any other unresolved issues identified by BHECN workgroups as OHA solicits public comments. It is recommended that BHECN advocates take a proactive approach to developing a prioritized list of issues complicating the Stabilization Centers implementation prior to commencement of OHA's public comment period.

3.3 SUSTAINABLE FUNDING

The BHECN Stabilization Center will require thoughtful financial planning to ensure long-term sustainability. Cost models were developed in preparation for the Stabilization Center RFI and reviewed by subject-matter experts, however revenue models have yet to be developed. Revenue modeling for the Stabilization Center should begin by assessing insurance reimbursement for covered and non-covered services. Revenue models must include a range of estimates pertaining to insurance coverage rates for the population served, case mix, payer mix, reimbursement rates, and other factors that affect reimbursement. In January of 2022, OHA implemented a new fee schedule for behavioral health service reimbursement. The new fee schedule was created to expand on existing services in response to CMS' approval of the SUD 1115 waiver requested by OHA. Subject-matter experts knowledgeable in Medicaid benefit models, medical billing, claims, utilization management, and local CCO policies should analyze this new fee schedule in conjunction with the Stabilization Center's clinical model for services to develop estimates on the Stabilization Center's revenue potential for billable services.

In addition to insurance revenues, other sources of revenue that should be evaluated include state and federal funding for justice system diversion, program allocations made by the city and county, 988 investments allocated by Senate Bill 2417, future Measure 110 allocations, grants from foundations and health system partners and investments by local CCOs. These sources will be necessary to cover the Stabilization Center's cost of operations as it is unlikely that insurance reimbursement alone will cover the full cost if the center provides treatment to everyone including the uninsured, as was envisioned by key BHECN workgroups.

"My aunt and uncle did try calling the police a couple times when she first started to run away [to do meth] and they never really did anything. They would just say that they couldn't do anything for her. They would plead to them to just go find her and make sure she was alive."
-Family/Natural Supporter of an Individual in Crisis

As of the writing of this report and due to the suspension of workgroups, a considerable amount of the work to design the BHECN network and how it will interact with the Stabilization Center remains undone. The network sustainability model will depend on network design, and network providers may be eligible for the same sources of funding stated above. In addition, a promising source of revenue for crisis-related services within the network, but outside of the Stabilization Center's purview, is Substance Abuse and Mental Health Services Administration (SAMHSA) Certified Community Behavioral Health Clinic (CCBHC) funding.

3.4 TRANSPORTATION

Transportation to the BHECN Stabilization Center represents a significant logistical challenge for those experiencing and responding to behavioral health crises. First responders and mobile crisis outreach teams who encounter someone in crisis have limited transportation options available to them, and frequently state specialized transportation capabilities are needed to provide safe, timely, and trauma-informed service. Data collected by the BHECN transportation workgroup suggests that most behavioral health encounters made by first responders result in transportation to the emergency department. First responders participating in BHECN workgroups frequently state that

facilitating transportation of individuals experiencing acute behavioral health crisis often places them at risk, that police are reluctant to use force to enforce civil holds placed for mental health, and the frequency of first responders being assaulted during behavioral health transport is rising.

As a result of the USDOJ's settlement agreement with Portland Police Bureau (PPB), officers no longer transport individuals placed on civil holds for mental health or intoxication unless exigent circumstances arise. Currently, nearly all transports for individuals experiencing mental health crisis are provided by American Medical Response (AMR), an emergency medical services provider that is contracted with Multnomah County. PPB and AMR work together to enforce mental health directors' holds in the community, but these holds are frequently a point of contention between AMR, PPB, and mental health agencies as the criteria for placing a hold is not always agreed upon. Additionally, AMR must transport their patients to an emergency department for evaluation per Multnomah County's EMS protocol for emergency medical transport stated in ordinance 1204 §21.416 (H) which eliminates the ability for evaluation in alternative settings.

Prior to the closure of CCC's Sobering Center, PPB frequently placed civil holds for intoxication when an individual encountered in public was determined to be unable to care for themselves, but this practice has been discontinued because of the closure of the Sobering Center and the USDOJ settlement agreement. Police participating in BHECN workgroups frequently state the need for a secure, non-emergency transportation option that can respond to calls where public intoxication is the primary cause for concern. The BHECN transportation workgroup has developed a recommendation for a new model of transportation called Coordinated Network for Community Transportation (CNCT, pronounced "connect".) The CNCT model avoids duplicating the scope of first responders and mobile crisis outreach teams by focusing exclusively on transportation of individuals experiencing a behavioral health crisis with low acuity physical health needs. The CNCT program would fill this critical gap in Portland's crisis transportation system, but there are several issues that complicate its implementation including authority to maintain holds, EMS protocols, and funding. Two potential pathways to implementation of the CNCT program have been evaluated, but neither option is ideal given current constraints:

Option A: Non-Emergent Medical Transportation Model

This model would entail licensing a secure non-emergency medical transportation service as defined in ORS 410-136-3120.

OR

Option B: Community Safety Led Model

This model would entail developing an alternative transportation capability that is not considered medical transportation by OHA, but operates in a similar fashion to Portland Street Response

The main advantage of Option A is that transportation services would qualify for NEMT reimbursement for Oregon Health Plan members if prior authorization is approved by their CCO in

advance of the transport. The CCO representatives participating in the Transportation to BHECN workgroup have voiced support for any model that adds new capacity to the NEMT system and have indicated they will advocate for a reimbursement program that would forego the need for prior authorization for members experiencing behavioral health emergency. The main disadvantage of Option A is that it would require Multnomah County to amend ordinance 1204 §21.416 to allow for medical transportation by a non-ambulance provider responding to an emergency to a location other than a hospital emergency department. Any amendment to ordinance 1204 §21.416 must comply with OARs 410-136-3120 and 309-033-200 through 309-033-0970 which define secure transportation services, licensing requirements, and approved use of secure transportation. Additionally, the directives for the County's Bureau of Emergency Communications (BOEC) operations would need to change.

"I've lived in Portland my whole life. People would ask me, 'How safe is it to be outside?' Some years ago, I would've said, it depends on your comfort in a city. But now, I say, stay alert, have your mace, don't be on your phone with your head down and not paying attention."
-Business Owner

"There have been assaults on paramedics and ambulances by the public. The safety of EMS providers is being threatened because we are being associated with Law Enforcement."
-First Responder

With Option B, the CNCT program could operate in a similar fashion to Portland Street Response (PSR). PSR is restricted to responding to police calls that are determined to be low acuity, behavioral health in nature, and only in public places. These calls are dispatched by BOEC's computer aided dispatch (CAD) system, but through the Portland Fire Bureau side rather than PPBs side of CAD. The advantage of this model is that like PSR, the CNCT program could transport individuals in crisis to the Stabilization Center without the need to license as a secure medical transportation provider or amend ordinance 1204 §21.416 to allow for transportation to locations other hospital emergency departments.

The disadvantages of Option B are that CNCT services would not qualify for NEMT reimbursement and would not be able to provide secure transportation unless the staff are deputized to place civil holds for intoxication like former CHIERS employees were, or state statute 430.399 is amended to allow police officers to transfer custody to a designated transportation provider.

The Transportation workgroup carefully considered the need to balance trauma-informed care with the ability to provide secure transportation. Their recommendation states that PPB and AMR should continue to enforce mental health director's holds, but secure transportation of individuals who are intoxicated or experiencing crisis due to a co-occurring disorder would be in the scope of CNCT, if they meet certain criteria. The workgroup also clearly stated that any individual who is determined to be unable to care for themselves should be given the option to go voluntarily and that CNCT staff (EMTs and Peers) should not use force to place them on a hold so that the program can build trust and fidelity with the community.

As part of the 988 implementation, Senate Bill 2417 directed OHA to develop new OARs defining Community-Based Mobile Crisis Intervention Services (CBMCIS) in division 72 of chapter 309. Currently the Crisis System Advisory Workgroup (CSAW) steering committee is advising OHA on the development of these new draft rules. BHECN stakeholders participating in the CSAW steering committee have noted that as of August 2022, OHA is not currently considering revisions to the transportation rules mentioned above. Given the significant logistical issue that transportation to the BHECN Stabilization Center poses, it is recommended that BHECN stakeholders advise OHA to consider revisions to OARs defining the types of transportation allowed for community members experiencing a behavioral health crisis.

At of the writing of this report, the US Department of Justice's Bureau of Justice Assistance (BJA) has provided a notification of award to the City of Portland's Community Safety Division to implement its proposed three-year CNCT demonstration project.

3.5 HELPING OUR COMMUNITY UNDERSTAND BHECN

The BHECN Project is a new approach to behavioral health crisis stabilization; a collaborative network of partners who are committed to include any member organization that wants to participate in good faith and is willing to dedicate resources towards advancing BHECN's vision and principles. Given BHECN's collaborative nature and evolving project structure, helping our community understand what BHECN is and how it is working to improve Multnomah County communities' behavioral health crisis system is essential to build and maintain trust and fidelity in our community. BHECN's Communication (PR) workgroup has developed recommendations for messaging to this effect.

One of the most frequent questions encountered by the BHECN project management team during the Phase 1 and 2 was, "how will BHECN differ from the existing psychiatric emergency services provided by The Unity Center for Behavioral Health?" BHECN's Stabilization Center is intended to complement Unity, not replace it nor duplicate the services it provides. As an inpatient psychiatric hospital, Unity's focus on psychiatric emergency care will remain a critical component of Portland's behavioral health crisis receiving system and a key resource for patients experiencing mental health crisis who are triaged at the Stabilization Center and require mental health services beyond its scope. If implemented, BHECN can complement Unity by providing care to individuals who primarily need a safe, culturally, and linguistically appropriate, and trauma-informed setting for triage, sobering, and early withdrawal management.

As the BHECN network expands and evolves clearly answering questions like this one about BHECN's role in the behavioral health crisis system will be essential to ongoing coordination.

3.6 RISK MITIGATION & LIABILITY

As previously discussed, crisis receiving and stabilization center models and the rules that will govern them in Oregon are in development now. To ensure that Crisis Receiving and Crisis Stabilization centers are protected from liability and can appropriately mitigate risks that come with treating this complex population, advocacy for change at the state and federal level is necessary. The current liability protections defined in Oregon statute for treatment and sobering centers have

significant gaps and currently do not extend to crisis centers. This places providers and other key members of the behavioral health crisis system at significant risk when incidents occur, even if it is determined that probable cause exists that they were acting in good faith and without malice. To ensure these stakeholders can provide high quality care confidently, state statutes should be amended to account for the nature of crisis receiving and stabilization services. Finally, advocates should support efforts to expand access to Federal Tort Claims Act (FTCA) coverage for organizations delivering services throughout the behavioral health crisis management continuum.

3.7 TIMELY INTEGRATION OF MENTAL HEALTH CAPABILITIES

After considering the gaps present in Multnomah County communities' behavioral health crisis management system, BHECN stakeholder have prioritized SUD assessment, triage, sobering, and withdrawal management services for meth and polysubstance users for initial implementation. Because many people experiencing a behavioral health crisis present with co-occurring SUD and mental health disorders, the BHECN Stabilization Center must carefully consider how to integrate mental health services as the center grows. Criminal justice stakeholders in the BHECN project representing Multnomah County's jails, courts, pretrial services, and the district attorney's office have repeatedly called for services capable of address both substance use and mental health needs concurrently. To maintain alignment with existing mental health programs and providers that are currently participating in the BHECN project, in-reach and co-location of mental health services should be prioritized after initial implementation.

4. CONCLUSION

Recent collaboration between the City of Portland and Multnomah County has provided a foundation for interim project governance and the stewardship necessary to drive the project forward. As the City of Portland and Multnomah County's various bureaus, divisions, departments, and agencies work together in support of BHECN, the development of service level agreements (SLAs) and supplemental MOUs between the city and county, and other key network partners will be necessary to ensure responsibilities are well understood. Given their role, the following organizations must continue to lead efforts to address the systemic issues that BHECN aims to address:

- Division of Community Safety -The City of Portland
- Portland Police Bureau -The City of Portland
- Portland Fire Bureau / Portland Street Response -The City of Portland
- Portland Mayor's Office -The City of Portland
- Multnomah County Department of Health
- Multnomah County Chair's Office
- Local Mental Health Authority - Multnomah County
- Bureau of Emergency Communications -Multnomah County
- Multnomah County Sheriff's Office

- Multnomah County District Attorney's Office
- Multnomah County Courts
- Joint Office of Homelessness - Multnomah County / The City of Portland

BHECN's path forward depends on continued support from the diverse community of stakeholders that have formed to support of the project thus far. The project's commitment to centering the voices of stakeholders with lived experience with behavioral health crisis will remain a critical aspect for gathering the information and feedback necessary for success. As the project progresses, the BHECN network must continually evaluate the many roles partner organizations fill as the Multnomah County communities' behavioral health system evolves and grows.

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