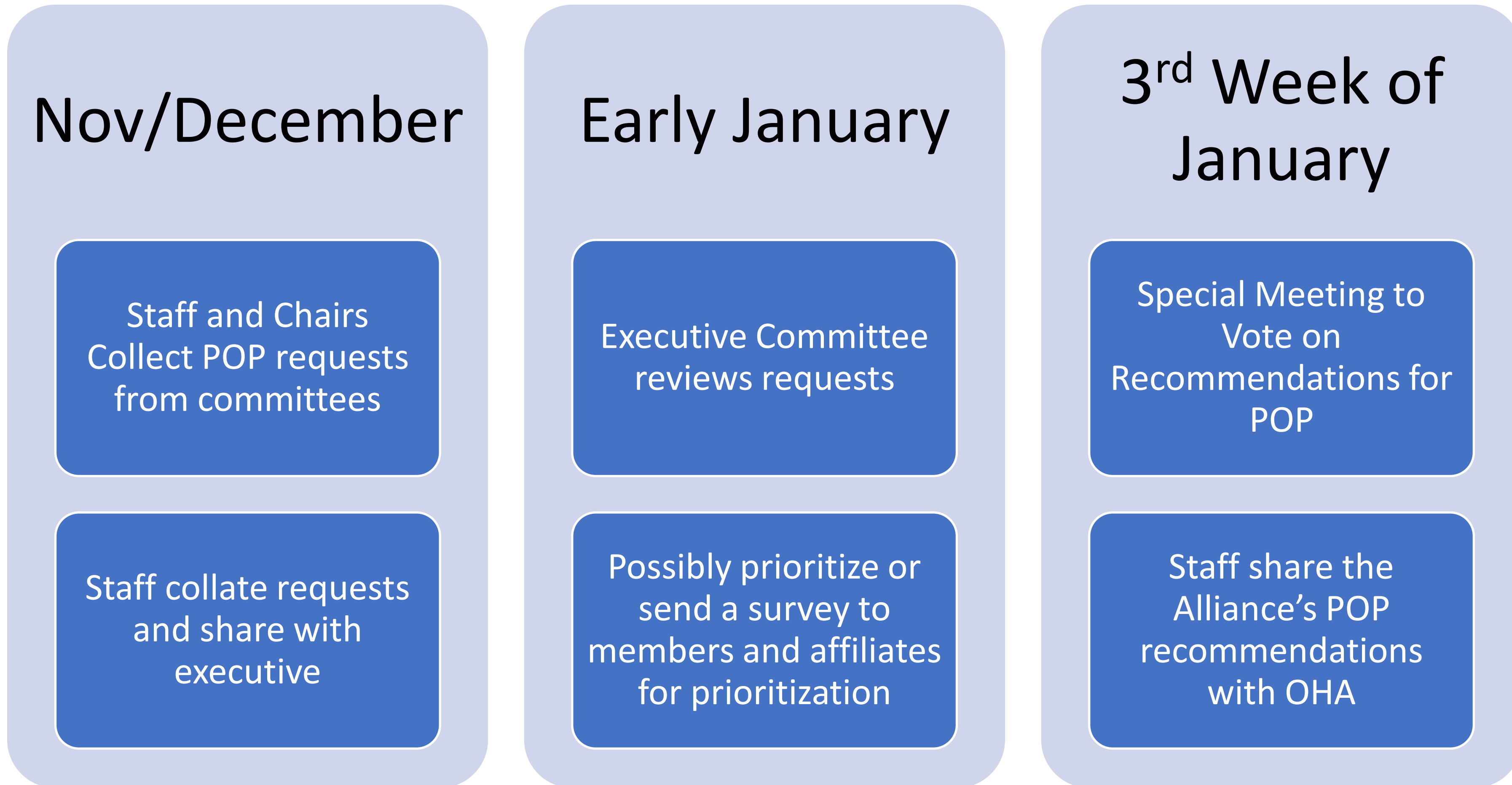
Alliance Policy Option Package Recommendation Process PROCESS



Proposed Format for POP Proposals

- Rationale for Ask
- How it supports the YSIPP/ASIPP
- Details of the Ask
- How does the ask address equity?
- Community partners involved in the ask
- Resources needed for the ask (staffing, funding etc.)

Sample: Evaluation and Data Committee

Proposal: Statewide Mental Health Survey with Suicide Prevention Specific Questions

Suicide prevention and mental health promotion strategies include population-based approaches related to public policy, public health and health care system design.

At this time, there is insufficient specificity in data from federal and state surveys to identify populations to prioritize for intervention, assure racial, demographic and gender equity, and track progress on outcomes related to public attitudes, help-seeking, service utilization, protective factors, etc. over time across the life course for all Oregonians.

For this reason, the Data and Evaluation Committee of the Alliance has identified a statewide representative survey as a priority investment needed to measure the implementation and impact of the Oregon Health Authority's YSIPP and ASIPP. It is recommended that funds be identified to support hiring a contract research organization to finalize questions through a stakeholder process, sample (including over-sampling of populations at higher statistical risk), field, analyze and report the survey in a publishable, publicly accessible format.

988 and Crisis Services

Proposal: Robust funding to crisis stabilization service and for 988 implementation

The Alliance recognizes that in Oregon, Lines for Life and certain county crisis call centers provide invaluable support at critical times and connect individuals to services that can save lives. A growing need for financial support of crisis line services in the State exists because of the (federal) National Suicide Hotline Designation Act (S.2661). Starting in July 2022, **988** will be the number people dial or text to get access to mental health crisis services – the suicide prevention lifeline as we know it today is being restructured and modernized which will result in an increased volume of calls and texts. Without additional funding, people in crisis will not get the help they need when they need it.

Adequate funding from diverse sources is needed to ensure that calls can truly be answered 24/7/365 by trained, in-state crisis counselors who can connect callers to in-person crisis response services as needed and other lifesaving follow-up care.

In addition, The Alliance supports further investment into crisis response services that are beyond the scope of the Lines for Life and county crisis lines such as mobile crisis response units, training for first responders, efforts to partner with historically oppressed communities to ensure access for all and other programs that are proven prevent suicide in Oregon.

The Alliance recommends that the Oregon Health Authority take every action within its power to strengthen the crisis response service network in Oregon.

Workforce Training

POP PROPOSAL: Supporting HB2315; Preparing for Future Legislation

1. Adopt and apply standards for suicide intervention, treatment and management continuing education for behavioral health workforce (and in future selected healthcare.)
2. Require for suicide intervention, treatment and management for relevant contractors (???)
3. Support curriculum development
4. Develop centralized website with a training registry of existing and approved for suicide intervention, treatment and management continuing education options
5. Provide funding to support licensing board implementation of for suicide intervention, treatment and management education for re-licensure
6. Either through state staff or via a contract, staff a standing suicide prevention committee for ongoing assessment of continuing education options Recommendations to Oregon's Health Professional Licensing Boards

Oregon's medical and behavioral health professionals generally do not receive training in suicide assessment, treatment and management in their advanced degree programs. Thus, these professionals need continuing education (CE) to ensure care to the public focuses on suicide safety.

SB48 Report

- NOTE: The Oregon Alliance to Prevent Suicide is convening relevant stakeholders and developing a legislative concept to be introduced in 2023 long session to require CME's for healthcare professionals. We are still determining the specific ask and which healthcare professionals should be included.

ASIPP and Local Funding

- Fully fund a lifespan approach

Discussion: What level of specifity in this ask?

For example: Fund regional coalitions as one key element in an integrated lifespan approach (mini-grant proposal with network support)

Questions for Consideration

- Does it help prevent suicide or help heal after a suicide?
- How do we know if it helps prevent suicide or help heal after a suicide?
- Does it address the needs of population(s) at high risk of suicide?
- Does it address the needs of historically targeted and/or under resourced communities?
- Is it strategic for us to align with another organization or go it alone? Is there another group pushing something where we can be a visible partner/advocate?
- Is this a lifespan or youth focused issue? Does that make a difference in how much energy we expend here?
- Does the proposed new policy or policy change require legislative action? Or, does it make to use other policy levers to change a policy that is in place but is not legislatively required?

Ease

- Does it require additional funds and/or resources? If so, what will it require to secure needed funds and/or resources?
- Is there organized opposition?
- Are we developing something new or replicating something that has been done/is working?
- Is there an existing effort we can partner with and/or champion?
- Are there sufficient staff and/or volunteer resources to handle the workload of initiating a new policy or a policy change?
- Impact

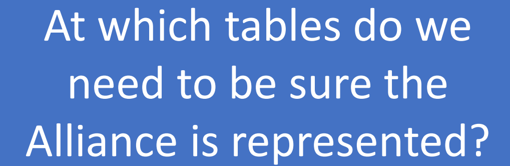
Impact

- Will it help us achieve YSIPP goals?
- Is the proposed policy something that will have a statewide impact? How?
- Will the proposed policy require multiple systems to shift and/or change? Is it feasible and reasonable to expect that shift and/or change to occur?
- Is the proposed policy addressing a need of a high-risk group?
- What will be required to implement and sustain the policy change?
- Are we the best people to advocate for a particular issue (such as housing) or would either partnering or being a champion for the cause be more effective?
- Is the proposed policy a recommended priority from Alliance advisory groups and/or workgroups?
- Is it a short-term effort or long-term goal?
- Does it require a legislative fix or can the outcome be achieve through other policy avenues such as a rule change or collaborative agreement reached with a state department and/or advocacy group?

Assessing Whether Changes Needed to Existing Legislation

- How is implementation of passed legislation progressing?
- Is additional legislation required to achieve desired outcome of the bill?
- What is standing in the way of full implementation? Will the proposed policy support implementation of passed bills or clear roadblocks? What will be required in terms of staff time, resources, collaboration with partners, etc.?
- Is it an initiative that has gotten stuck that needs a legislative or rules fix?

Advisory Committees



- Children’s System Advisory Council
- Addictions and Mental Health Planning Council
- Children’s System of Care State Advisory Council
- Oregon Consumer Advisory Council
- Behavioral Health Taskforce (legislative)
- School Safety Task Force
- 988 Lived Experience
- 988 Children and Family
- State Health Improvement Plan
- OHA Community Advisory Council (Equity and Inclusion)

6 December 2021

To: Oregon Health Authority

From: The Oregon Alliance to Prevent Suicide Executive Committee, on behalf of the Transitions of Care Committee

RE: HB 3090 Emergency Department Release Survey of Hospitals 2021 Legislative Report

Thank you for the opportunity to review the hospital survey results and report developed by OHA on implementation successes and barriers for HB 3090 (2017). After careful review of the report and recommendations, the Transitions of Care Committee within the Oregon Alliance to Prevent Suicide has the following overall feedback, as well as additions or modifications to OHA recommendations:

Overall feedback:

- The committee is very impressed at the 100% participation rate, the overall findings, and the ease in reading the results.
- As was expected when this law was passed, resources seem to be a barrier to implementation of some of the requirements. This barrier could be addressed, resulting in a positive impact, however it is unclear as to where responsibility lies in the system of care. Clarifying responsibilities and accountabilities will help to identify solutions, as well as identifying where specific infrastructure already exists in the system to build on those foundational processes.
- This report is a powerful tool with important data and information that should be leveraged to address the critical behavioral health workforce shortage Oregon faces.

Lack of Hospital Policies Available on Public Facing Websites or Provided to Patients:

- Policy summaries should be provided to patients and lay caregivers in plain language when admitted AND at discharge to ensure patient and lay caregivers understand what is required by law.
- Policy summaries should also be available on hospital websites. The requirement to have the policies made publicly available was intended to create transparency for patients, lay caregivers, and those who may become patients and lay caregivers to know what is required by hospitals and what can be expected. When our group performed a scan of public information on hospital websites, we were only able to locate a handful of hospitals that made their policies publicly available. Improvements in this area will increase accessibility to patients and lay caregivers.

Misinterpretation of Rules by Hospitals:

- As noted in the report, a significant number of respondents misinterpreted that the rules apply to their responsibilities and not that of patients. We would like to add a date for the report's stated recommendations to review OHA and OAHHS guidance, as well as add an outreach effort made to hospitals clarifying what the rules require of them, to take place no later than December 2022.

- We also would like to see added to recommendations that when each hospital's policies are finalized, staff must be trained on the existence of the policies, what they entail, and how to implement them.

Responsibility of Hospitals When Contracting Out Rule Requirements:

- Regular quality improvement assessments should be completed every two years.
- The mental health workgroup *(recommended in next section)* should consider the unique barriers for houseless individuals AND when patients experience substance use disorders (SUD) and co-occurring disorders.

Lack of Understanding on How Companion Bill, HB 3091, Supports Implementation Efforts:

- For hospitals reporting financial resource limitations on their successful implementation, it is critical that HB 3091 (2017) rules are directly aligned with the activities required by HB 3090 (2017), as this was created to address the financial barrier hospitals reported during the legislative process.

Lack of Referral Options for Hospitals to Support Patients in Care Coordination:

- Recommendation 3 should read, "Develop AND enhance community resources in rural communities to support rural hospital execution of care coordination rules." Identify funding sources to ensure this recommendation is feasible.
- Recommendation to align the current explorations for creating Comprehensive Psychiatric Emergency Programs (CPEP) as a strategy to increase hospital capacity to fulfill the requirements of these rules and better meet the needs of patients.

Need to Review Staff Appropriate to Provide Services:

- We support the formation of a workgroup to evaluate if administrative rules should be expanded regarding who can do follow up Caring Contacts. Because "Caring Contacts" is a specific therapeutic intervention, it is important that those who are making these contacts are trained. "Some mental health training" is not specific enough for this section. Examples of topics and areas of focus should be specified.

Regarding the recommended formation of a workgroup, members of the Alliance to Prevent Suicide Transitions of Care Committee would like to be included, as well as having input on additional members, based on continuity of stakeholders who were involved in the writing of the laws and rules.

Thank you for accepting this feedback and our suggestions for additional recommendations to be included in the OHA report and we look forward to any additional follow up engagements on this process.

Signed,

Alliance Executive Committee

Oregon Alliance To Prevent Suicide

Data and Evaluation Committee

Address

Address

Oregon Health Authority

Child and Family Behavioral Health

Adult Mental Health

Injury and Violence Prevention Section

Address

Address

Suicide Prevention Programs Staff,

The Oregon Alliance to prevent suicide is charged with advising the implementation and evaluation of the Youth Suicide Intervention and Prevention Plan (YSIPP). To that end, the Data and Evaluation Committee of the Alliance has identified several metrics relevant to the evaluation of the "Big River" trainings - key strategies and areas of significant investment for the YSIPP. These trainings and programs include:

- Sources of Strength
- Mental Health First Aid
- Youth Suicide Assessment in Virtual Environments (Youth SAVE)
- Question, Persuade Refer (QPR)
- Applied Suicide Intervention Skills Training (ASIST)
- Counseling on Access to Lethal Means (Oregon CALM)
- Connect Postvention
- Advanced Clinical Training – Assessing and Managing Suicide Risk (AMSR), Collaborative Assessment and Management of Suicidality (CAMS), Cognitive Behavioral Therapy and Dialectical Behavioral Therapy

From the perspective of a collective impact model, shared data collection and measurement across all trainings and programs ensures efforts remain aligned and stakeholders hold each other accountable. Some of the metrics recommended below are already being tracked by all or some of the OHA staff and contracted organizations responsible for the state-wide coordination of these trainings, while others are not currently being collected. The Data and Evaluation Committee recommends that these metrics be recorded for all trainings when possible so that YSIPP stakeholders can identify who is delivering trainings, who is being trained, where people are being trained, participant experience and ultimately how these trainings influence suicidal crises in the state of Oregon. The Data and Evaluation Committee would be happy to discuss these recommendations further with relevant staff members to advise them on the development of systems to capture these data and appropriate analyses.

We thank you for your consideration of these recommendations and look forward to discussing them with relevant staff to ensure that the evaluation of the YSIPP and the Big River programs is robust and informative.

Signature

Recommended Data Elements and Analyses

Category	**Variables**	**Rationale**
Trainers	Type of Trainings Certified in For each training type • Year first Certified • Year last Certified • Number of Trainings/Year REALD – Race, ethnicity, language disability SOGI – Sexual orientation, gender Lived experience Age Education Occupation and Employer Organizational affiliations Counties host organization serves County of residence	Track trainer availability Track rate of trainer entry/exit Assess demographic and regional gaps in trainer availability to guide recruitment of new trainers Know which organizations and types of organizations are the most active partners
Trainings	Trainer(s) training Date of training Location of training Host offering training # of participants Language of delivery Type of training Fidelity Form when possible?	Track numbers trained Assess demographic and regional gaps relative to risk Describe group composition (size, heterogeneity, etc.)
Participants	REALD – Race, ethnicity, language disability SOGI – Sexual orientation, gender Lived experience Age Sector/Profession Baseline knowledge/confidence Motivation for attending Referral/recruitment source County of Residence Location(s) of Skill Application Training acceptability Post knowledge/confidence Likely referrals to…	Describe who is trained Assess participation gaps relative to risk Describe group composition Inform recruitment efforts Monitor fidelity Measure effectiveness
Those Supported by Participants	Skills applied Referral rates Increased access/use of services No increase in ED admissions No increase in suicide rates	Number reached Skills used to reach others Number referred where Number accessing services Suicide related outcomes