

Rural Mental Health Learning Community: Adapting Oregon's CSC program, the Early Assessment and Support Alliance (EASA) to Rural and Frontier Settings

Presenter:

Katie Hayden-Lewis PhD LPC

Rural Services Director

haydenle@ohsu.edu

EASA Center for Excellence

OHSU-PSU School of Public Health

September 6, 2019



This webinar is hosted the National TA Network for Children's Behavioral Health, operated by and coordinated through the University of Maryland.

This presentation was prepared by the National Technical Assistance Network for Children's Behavioral Health under contract with the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Contract #HHSS280201500007C. The views, opinions, and content expressed in this presentation do not necessarily reflect the views, opinions, or policies of the Center for Mental Health Services (CMHS), the Substance Abuse and Mental Health Services Administration (SAMHSA), or the U.S. Department of Health and Human Services (HHS).

Welcome

KEY CONTACTS:

Shannon Robshaw

srobshaw@ssw.umaryland.edu

Christina Paternoster

christinamariep@pm.me

Matt Buckman

dmattbuckman@gmail.com

Sarah Warner

swarner@ssw.umaryland.edu

Who is With us Today?



Learning Objectives

- To identify 3 implementation areas to consider for adaptations when building fidelity in rural and frontier CSC programs.
- To learn 3 potential strategies effective in supporting implementation in rural, rural-frontier, and frontier communities.
- To commit to one step you and or your organization can take to move toward strengthening these efforts.



Context

- The United States has recently experienced an explosion of Coordinated Specialty Care (CSC) bringing rapid growth in the number of programs that pursue services to persons with early onset psychosis. While there are several of successful early psychosis models available, few have developed adaptations to meet the unique needs of rural and frontier communities.
- The presentation will use Oregon's early psychosis Early Assessment and Support Alliance (EASA) model to highlight adaptations and lessons learned from rural and frontier site development and implementation.
- Adaptations include cultural frameworks specific to rural and frontier regions, technology, role and task driven staffing pattern, training, access, community outreach, engagement, and mobilizing existing agency and community resources.

Kline, E. & Keshavan, M. (2017). Innovations in first episode psychosis interventions. *Schizophrenia Research* (182), 2-3.

Oregon's Story

- Oregon established an initiative to provide Oregon's program, EASA, in every county in the state. EASA Center for Excellence (C4E) has undertaken that initiative as a priority focus since 2012.
- In 2015 the Oregon Health Authority, Greater Oregon Behavioral Health Initiative (GOBHI), and C4E decided to create a position of Rural Services Director to prioritize the successful adaptation of the EASA model into rural and frontier communities in eastern OR (geographically is half the state).
- Development and implementation involved building partnerships, clinical training, program implementation, and ongoing technical assistance across 7 sites serving 10 counties.
- Many communities are on two lane roads, some of which are impassable during inclement weather, many areas have no wifi or cell service.
- Funding was made available through Oregon Health Authority and is managed through the regional Coordinated Care Organization (CCO), GOBHI.
 - Approximately .2FTE per county with some additional dollars set aside for training across the region.



Rural, Frontier, and Rural-Frontier Sites

- The eastern Oregon EASA programs needed to adapt to new and existing resources as well as effective ways to provide year-round equitable services across 1) rural, 2) frontier and 3) sites whose counties were a blend of both rural and frontier communities.
 - In Oregon: **Rural** is defined as any geographic areas that is ten or more miles from a population center of 40,000 people or more.
 - **Frontier** is any county with six or fewer people per square mile.

<https://www.ohsu.edu/oregon-office-of-rural-health/about-rural-frontier/data>

What Were Initial Implementation Challenges?

- No historical precedent for adaptations into rural and frontier settings.
- Required experienced and knowledgeable technical assistance in EASA from someone who could also engage in community settings with teams.
- Transitioning EASA's effective transdisciplinary team model from role driven to task driven.
- Evaluating how much time and what kinds of resources would be required to support implementation.
- Moving agencies away from client driven staffing structure to program as 'client' implementation focus.

What Were Initial Implementation Challenges? (cont.)

- Influences of geography and natural climate/seasonal on community-based service delivery, ongoing technical assistance, and training schedule.
- Individual Placement Support (IPS) services as sole pathway to delivering supported employment services
- Goal of programs to meet full fidelity and replicate staffing infrastructure on same timeline and with less funding as more urban programs.
- EASA practice guidelines written and implemented at a time when there were no frontier programs (and needing to provide fidelity reviews to evaluate passing/failing programmatic status)

CHAT

- **What would you add from the FEP work you are doing in rural and frontier communities?**



Initial Steps to Address Challenges



- Adopt experimental and growth mindset.
- Move funding from regional CCO for EASA regional TA lead to C4E and establish Rural Services Director. Priority focus as adaptations and implementations of EASA in Oregon's rural and frontier communities (specifically 10 counties in eastern OR).
- Site by site evaluation of existing fidelity programming, clinic and community-based service delivery, staffing patterns.
- Protected time moves away from billable hours to program implementation as primary responsibility and focus.
 - This pushes on on agency wide staffing patterns and resources

Initial Steps to Address Challenges (cont.)



- Look for and build equity for access and service delivery across vast geographic region, with limited EASA FTE.
- Identify needed technology to meet with individual, family members and supporters remotely.
- Identify and acquire technology to engage in ongoing remote training and technical assistance (to reduce strain on resources and accelerate training capacity and readiness).
 - WIFI, internet access, technology devices, cell service (for participants and the team)
 - Low tech to hi tech behaviors and values
- Ongoing feedback: person to person, group meetings, direct service providers, leaders (directors, CEO's CCO, managers) look at fidelity scores and passing/not passing patterns.

Adaptations: Training



- Held in communities located in eastern OR.
 - Moved away from trainings held in metro only areas.
- Rotation of trainings across state in order to work toward access equity.
- Development of web based recorded and web based live trainings.
- Ongoing review and refinement of training objectives to match new benchmark prioritization.
- Promoting training across agency staff.
- EASA-friendly staff that are not officially EASA FTE.
 - Moved away from this as sites are recognizing need for EASA FTE with protected time and need for proactive offering of services

Adaptations: Staffing Pattern

- Task driven rather than role driven team composition.
- Attending to vulnerabilities with staff turnover.
- Evaluating for protected time to focus on program infrastructure and implementation.
- Drive time to provide services in communities and in homes across vast and wild geographic regions.
- Offering supported education and employment based on Individual Service Placement approach and tasks but not required to be IPS staff.

Adaptations: Ongoing Technical Assistance

- Monthly video conference call: for team members completing the initial evaluation using Structured Clinical Interview for DSM (SCID) or Structured Interview for Prodromal Symptoms (SIPS), general call to address all things (except administrative) EASA open to all team members, LMP call, Nursing call, Occupational Therapy for OTs and non-OTs call, Leadership
- Establishing times for: Regional group consultation (staff with very limited EASA FTE and two time zones)
- Offer CEU's and hours toward EASA Level 1 certification
- Working with sites to obtain and learn how to use the technology

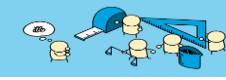


Adaptations: Ongoing Technical Assistance (cont.)

- Quarterly regional in person all day learning collaborative and group consultation:
 - Funding through existing dollars for training and at CCO discretion.
 - Topics for each meeting are approved by the regional network:
 - Generated by a combination of ‘asks’ and patterns of need and interest that have come up in fidelity reviews and consultation.
 - Presenters to date have been a member of C4E team.
 - Learning topics have included:
 - CHR treatment and implementation,
 - Sensory processing assessments and interventions,
 - Family engagement strategies,
 - relapse prevention planning and comprehensive risk assessments,
 - Young Adult Leadership Council and peer support,
 - Family Psychoeducation problem-solving method review of single family and multifamily format,
 - Strengths and value-based assessments and goal setting.
 - Host locations rotate to share the load of travel and time commitment across all teams.
 - Sometimes we have a potluck.



Adaptations: EASA Practice Guidelines Benchmark Project



- **EASA Practice Guidelines:**

- Developed by cohort of EASA team members from across existing statewide programs representing different professions.
- Implemented by all existing EASA programs in 2013.
- Built off Australian guidelines.
 - There were no frontier programs at the time of guideline development and implementation.
 - Initial fidelity reviews in rural and frontier sites in eastern OR led to a regional fail and then repeated fails at re-reviews.
- C4E took the repeated fails to meet fidelity passing threshold of 80% as feedback that we needed to adjust the pass/fail framework that drove the fidelity evaluation process.

Melton, R.P., Penkin, A., Hayden-Lewis, K., Blea, P., Sisko, S., & Sale, T. (2013) The early assessment and support alliance practice guidelines and fidelity manual. Retrieved November 14, 2018 from

http://www.eastcommunity.org/shop/images/EASA_guidelines_final_Jun12_with_contrib_list.pdf

Adaptations: EASA Practice Guidelines Benchmark Project (cont.)

- Have taken the past 8 months to review practice guidelines and identify elements that are associated with best practices and outcomes for: new sites, sites that have repeatedly not passed reviews, sites that are passing but not achieving fidelity threshold on benchmark targets.
- This led to a change in our approach moving us away from a pass/fail framework and into a developmental evaluation model.
 - Benchmark Level 1: 263/485 points or a 54% score
 - Level 2: 342/485 points or a 70% score
 - Meeting full fidelity threshold: 388/485 points or a 80% overall score
- Still needed: Recommended timelines for reaching each of the three tiers.

Melton, R.P., Penkin, A., Hayden-Lewis, K., Blea, P., Sisko, S., & Sale, T. (2013) The early assessment and support alliance practice guidelines and fidelity manual. Retrieved November 14, 2018 from http://www.eastcommunity.org/shop/images/EASA_guidelines_final_Jun12_with_contrib_list.pdf

EASA Practice Guideline Benchmark Project

- **The successful roll out of the developmental fidelity evaluation model will involve:**
 - Clear articulation of the purpose of the changes.
 - Education to the network about how to use the new version of the tool to benefit their program and inform their strategic planning.
 - Internal training of fidelity reviewers on how to use the tool.
 - Review of intended outcomes (reduce stress, improve strategic implementation efforts, move toward passing threshold sooner or with greater ease).
 - Promoting attitude shifts toward developmentally informed lens and strategic planning, away from pass/fail lens.
- **Unanticipated gains:**
 - Clarification of C4E team on elements and what should be included at the start up level of a program.
 - Sites that are meeting fidelity threshold of 80% overall score using the new version to guide their strategic planning.
 - Capacity for all sites, regardless of score to continue to focus on and protect the benchmark items necessary for programmatic success.
 - Reprioritization of required training *and* scaffolding of updating training elements and objectives to promote site benchmark and Level 2 achievement
 - Licensed Medical Provider role refinement and LMP caseload ratio recommendations
 - Further clarifying what interventions can be undertaken by professionals not trained in occupational therapy.

What's Still Missing?

- Timelines for achieving benchmark, Level 2, and full fidelity thresholds:
 - September 2019
- Possible need for rural and frontier program brochure
- Engagement of tribal/first nations people living in rural and frontier areas:
 - Oregon Health Authority issued funding and hired a researcher with a specialty in healthcare equity for marginalized groups to get an initial impression to inform next steps. Complete: August 2019
 - Develop first stage strategic plan based on findings.
- Missing gathered local knowledge about negative social attitudes and discrimination in rural and frontier communities as influencers of community education messaging, strategies, and engagement.

What's Next?

- Roll out of the developmentally framed fidelity evaluation tool.
- Secure ongoing funding in person quarterly regional learning community meetings.
- Assess need for tribal, rural and frontier program brochures
- Program sustainability
 - Adapting CHR practices to rural and frontier communities
 - Ongoing streamlining of tasks
 - Regional capacity and resources to take over some of the technical assistance

Questions



Thank You

SAMHSA's mission is to reduce the impact of substance abuse and mental illness on America's communities.

Katie Hayden-Lewis PhD LPC, Rural Services Director

haydenle@ohsu.edu

www.samhsa.gov

1-877-SAMHSA-7 (1-877-726-4727) • 1-800-487-4889 (TDD)