OPAL | OREGON STATE UNIVERSITY Policy Analysis Lab

SUMMARY REPORT
COORDINATION & COLLABORATION

COORDINATION & COLLABORATION IN BEHAVIORAL HEALTH & HOUSING

EXECUTIVE SUMMARY

1. Grantee partners from across the state advocate for more inter-agency coordination and collaboration within their communities. [1]
2. Improve communication and information sharing across organizations. [2]
3. Create a data-sharing system for referrals and resources. [3]
4. Invest funding specifically to support collaborations. [4]
5. Develop common standards and definitions for a shared understanding. [5]
6. Fund collaborations and trainings with culturally specific organizations. [6]
7. Support outreach to city and county leaders to build local political partnerships. [7]
8. Create a collaborative support structure for provider staff. [8]
9. Fund system navigators to guide clients in accessing clinical and housing services. [9]
10. Focus coordination efforts on strengthening wrap-around services. [10]
11. Invest in a one-stop shop, resource hub, and/or navigation center, located in each community. [11]

OVERVIEW

Many grantee organizations want greater coordination and collaboration in the behavioral health and housing sector. Partners overwhelmingly view a lack of inter-agency coordination as one of the main barriers that must be overcome to effectively serve their communities. Below is a synthesis of findings from RFGP 5250 grantee reports of the systemic problems and recommendations detailed by grantee partners for whom collaboration and coordination were a top priority in their service area. Please note, Portland-Metro area grantee reports are not included in this report and will be part of a separate, upcoming report.

RECOMMENDATIONS

INCREASE COLLABORATION & COORDINATION AT ALL LEVELS

1. Grantee partners from across the state advocate for **more inter-agency coordination and collaboration** within their communities.

    1.1. Many partners noted a lack of coordination between the social service agencies, medical providers, the housing sector, community-based organizations, and culturally specific organizations, among other groups in their region. A lack of service coordination between providers can lead to inefficiencies, service gaps, and confusion among providers and/or clients.

    1.2. Promisingly, many regions expressed a desire and willingness to collaborate more, but need to develop the systems, forums, or resources to do so.

    1.3. To begin bridging these gaps, partners call for more collaboration, coordination, and information sharing throughout their region and the behavioral health and housing sectors.

2. **Improve communication and information sharing across organizations**. Minimal communication between providers is a prohibitive barrier to creating opportunities for collaboration.

    2.1. Some partners noted a that a disconnect exists between different types of groups. "Cultural, institutional and communication barriers often exist between medical providers, county agencies, and community-based providers and advocates," explains Intercommunity Health Network. Providers working across different scales and areas of expertise may have different communication styles, norms, or expectations.

    2.2. Furthermore, establishing partnerships takes time and effort on all sides. For organizations who are often strained or overworked, it can be a challenge to build and maintain communication between groups.

    2.3. Despite the barriers to communication, it is an important way to spread awareness of the services available in the region. Better communication would allow providers to share helpful resources with each other, share their experiences, and to learn from one another.

3. **Create a data-sharing system for referrals and resources**. Currently, there is a lack of a robust, reliable, and integrated information-sharing system to use among providers, which presents a barrier to coordinating inter-agency care and collaboration.

    3.1. Grantee partners need a system for sharing data, resources, and referrals between the organizations in their community.

    3.2. Furthermore, coordinated **regional resource lists** and **referral systems** would help providers ensure appropriate transitions of care for clients, and/or quicker access to the appropriate services.

> "Health inequities will continue to be present as long as Oregon continues down the same path of siloed services."
>
> – Bridgeway Recovery Services

4. **Invest funding specifically to support collaborations**. Recognizing that collaboration is a time- and labor-intensive process, funding should be invested specifically to support regional partners to organize, communicate, and develop partnerships.

    4.1. Specifically, grantees recommend setting aside **funding for collaborative partnerships** between state agencies, service providers, community-based organizations, and culturally specific groups, to support the regional collaboration efforts and cross-training partnerships.

    4.2. Financial resources can also be leveraged to support partnerships through offering a **funding pool** for services, rather than adhering to a siloed reimbursement style.

    4.3. Multiple grantees mentioned experiencing **competition** for funding among community providers. One provider mentioned that nonprofit groups in small communities tend to guard what they consider to be their 'niche.' A protective and competitive outlook can interfere with attempts to

collaborate or form partnerships. To combat this mindset, it's important to demonstrate that funding is not a zero-sum game, and that working collaboratively will create a positive effect on the communities they serve.

5. **Develop common standards and definitions for a shared understanding**. Groups often come into partnerships using different definitions, standards, and approaches to services. Lacking a standard definition is a barrier to collaboration and can lead to misunderstandings, communication difficulties, and a lack of accountability in providing a standardized level of care.

    5.1. Providers have various standards for services including low barrier housing, supportive housing, and trauma-informed and culturally appropriate staff training. Standardizing these definitions would make the quality of care more reliable across the region.

    5.2. Within the community, organizations may also be pursuing separate goals. It's important to reach shared community-wide understandings about desired goals and outcomes. Memorandums of Understanding (MOUs) are another tool that could help organizations create shared objectives.

    5.3. Hosting regular meetings between regional providers, community-based organizations, and other partners would help standardize care and ensure all groups are delivering similar outcomes for clients.

> "Although there is some coordination of care, much more needs to be done."
>
> – Intercommunity Health Network

PROMOTE COLLABORATION WITH KEY PARTNERS

6. **Fund collaborations and trainings with culturally specific organizations**. Many grantees advocated for partnerships with culturally specific organizations to build capacity, reach marginalized groups, and bridge gaps.

    6.1. Culturally specific organizations are already trusted by the communities they serve and are effective in reaching marginalized groups. A funded network of such partnerships would be able to help institutional partners develop cultural competence programs and improve outreach into marginalized communities.

    6.2. Grantees found that collaboration between service providers was necessary to ensure that an individual's needs are being met in a culturally and linguistically appropriate manner.

    6.3. Additionally, trainings provided by culturally specific groups to partners, service providers, and other organizations are a recommended tool to increase cultural competency.

7. **Support outreach to city and county leaders to build local political partnerships**. Within a community, there is often a lack of collaboration and general disengagement between elected officials and service providers.

7.1. In the housing field, some communities face a lack of collaboration in building affordable, supportive, and transitional housing and shelters. Some City leaders may acknowledge the local issue, but then deny the solutions that could be helpful.

7.2. Partnerships between service providers and political leaders can help align local goals and visions for projects.

8. **Create a collaborative support structure for provider staff**. Grantee partner organizations expressed need for greater collaborative support for staff to prevent burnout and offer technical assistance.

8.1. Behavioral health staff could benefit from introducing a peer support collaborative to provide a space for staff to talk to each other, find resources, and share insights.

8.2. Additionally, smaller communities often lack behavioral health housing experts to support local providers in developing projects. A paid 'behavioral health housing team' could help develop projects and provide oversight in collaboration with the local staff, allowing them to focus their energy on providing care.

MEET COMMUNITY NEEDS THROUGH COLLABORATION

9. **Fund system navigators to guide clients in accessing clinical and housing services.** Many grantee partners cited the need for system navigators to work across behavioral health centers, hospitals, and housing to help guide clients in locating and accessing services.

9.1. "If someone comes to an agency with a need that the agency is unable to provide, quite often the individual isn't told about available resources with other agencies." explains Creating Housing Coalition. A navigator or liaison for the city would fill this gap by connecting community members with services and educating them about services available.

9.2. Housing navigators specifically would help clients in finding affordable rental communities, completing housing application systems, accessing behavioral health and affordable housing systems, and in connecting clients to social services.

9.3. The navigators can also connect community members with culturally specific resources and reduce health inequities.

9.4. Furthermore, system navigators could help to streamline services offered in the community, reduce redundancy, and establish new services to fill gaps.

10. **Focus coordination efforts on strengthening wrap-around services.** Currently, there is a gap in coordination between residential/housing and clinical services. Grantees advocated for collaborations between housing/residential and clinical services to develop wrap-around services for clients.

10.1. Explains Klamath Basin Behavioral Health, "Behavioral healthcare providers are not in the housing business, and most housing providers do not have the training or experience to provide the supports needed, especially by those experiencing chronic homelessness, to remain housed." The expertise of each group complements the other well. Coordination can help bridge the gaps in each area of specialization.

10.2. Developing relationships between residential providers and support services will help individuals who are trying to take a "step-down" from a treatment center, or a "step-up" from incarceration.

ONE-STOP SHOP, RESOURCE HUB & NAVIGATION CENTER

11. **Invest in a one-stop shop, resource hub, and/or navigation center, located in each community.** Multiple grantees across the state recommended creating a central location in their community. This center was described as a "one-stop shop," a "resource hub," or a "navigation center" by different partners, but each followed a similar "one-stop" model. The center would bring together multiple agencies and services to maximize collaboration and communication between providers, and to make services more accessible for clients.

    11.1. The one-stop shop would be a drop-in center and trusted space where community members could receive service navigation, referrals, case management, crisis response, care coordination, and other necessary services. The co-located model would reduce the barriers of transportation and gaps in the continuum of care for clients.

    11.2. Culturally specific service providers would be included at the one stop shop to help overcome cultural barriers, and better serve marginalized populations. Co-locating culturally specific groups with other agencies will also promote collaboration in cultural competency training and outreach to marginalized groups.

    11.3. However, partners also noted the importance of **multiple satellite resource hubs** to complement a centralized location, that could reach rural areas and marginalized communities. Notably, Intercommunity Health Network found that informants who self-identified as "white" were more likely to recommend a centralized location, while members of marginalized communities emphasized the need for their own culturally specific spaces and services.

> "No one organization can meet the current and expected future needs in the community in a vacuum."
>
> – Klamath & Lake Community Action Services

REFERENCED GRANTEE PARTNERS

Grantee Partner	Primary Counties Served	Contact Address(es)
Advanced Health CCO	Coos, Curry	289 Laclair St, Coos Bay
All Care Community Foundation	Josephine, Jackson	P.O. Box 1972, Grants Pass
Bandon Community Health Center	Curry	1010 1st St SE #110, Bandon
Bay Area Enterprises	Curry	200 Ross, Coos Bay
Bay Area First Step	Coos	155 S Empire Blvd, Coos Bay
Bridgeway Recovery Services	Marion, Polk	3325 Harold Dr NE, Salem
Clatsop Behavioral Healthcare	Clatsop	65 N. Highway 101, Suite 204 Warrenton
Columbia Health Services	Columbia	2370 Gable Rd, St Helens
Community Outreach Inc.	Benton	865 NW Reiman Ave, Corvallis
Creating Housing Coalition	Linn	PO Box 892, Albany
Creating Opportunities	Marion, Polk, Yamhill	777 13th Street SE, Suite 120, Salem
Crossroads Communities	Benton, Linn, Coos, Douglas, Jackson, Marion	1875 Stoltz Hill Rd, Lebanon
Douglas CARES	Douglas	545 W Umpqua St STE 1, Roseburg
EUVALCREE	Malheur	67 SW 2nd Avenue, Ontario
Hearts With a Mission	Jackson, Josephine	521 Edwards St, Medford
Homestead Youth & Family Services	Umatilla, Wasco, Morrow, Hood R., Sherman	816 SE 15th St, Pendleton
Intercommunity Health Network CCO	Benton, Lincoln & Linn	2300 NW Walnut Blvd, Corvallis
Jackson Care Connect	Jackson	33 N Central Ave #320, Medford
Klamath & Lake Community Action Services	Klamath, Lake	2316 S 6th St C, Klamath Falls
Klamath Basin Behavioral Health (KBBH)	Klamath	2210 N Eldorado Ave, Klamath Falls
Lane Independent Living Alliance	Lane	20 E 13th Ave, Eugene
Mid-Columbia Community Action Council	Wasco, Hood River, Sherman	312 E. 4th St, The Dalles 606 State St., Suite 1B, Hood River
Mid-Willamette Valley Community Action Agency	Marion, Polk	2475 Center St NE, Salem

Morrow County	Morrow	100 S. Court Street, Heppner
New Directions Northwest, Inc.	Baker	3425 13th Street, Baker City
Olalla Center	Lincoln (Statewide)	321 SE 3rd St, Toledo
Oregon Building Community Resiliency	Marion, Polk, Benton, Lincoln, Linn	10570 SE Washington St, Suite 203, Portland
Polk County Community Corrections	Polk, Marion	820 SW Church St Ste 100, Dallas
Restoration House	Clatsop	208 North Holladay Drive, Seaside
Tillamook Family Counseling Center	Tillamook	906 Main Ave, Tillamook
Umatilla County	Umatilla	216 SE 4th St., Pendleton
Willamette Family	Lane	195 W. 12th Ave. Eugene