Oregon Health Authority
Behavioral Health

Presented to
Joint Committee on Ways and Means
Subcommittee on Human Services
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Patrick Allen, Oregon Health Authority Director
Steve Allen, Behavioral Health Director

Oregon Health Authority

Overview

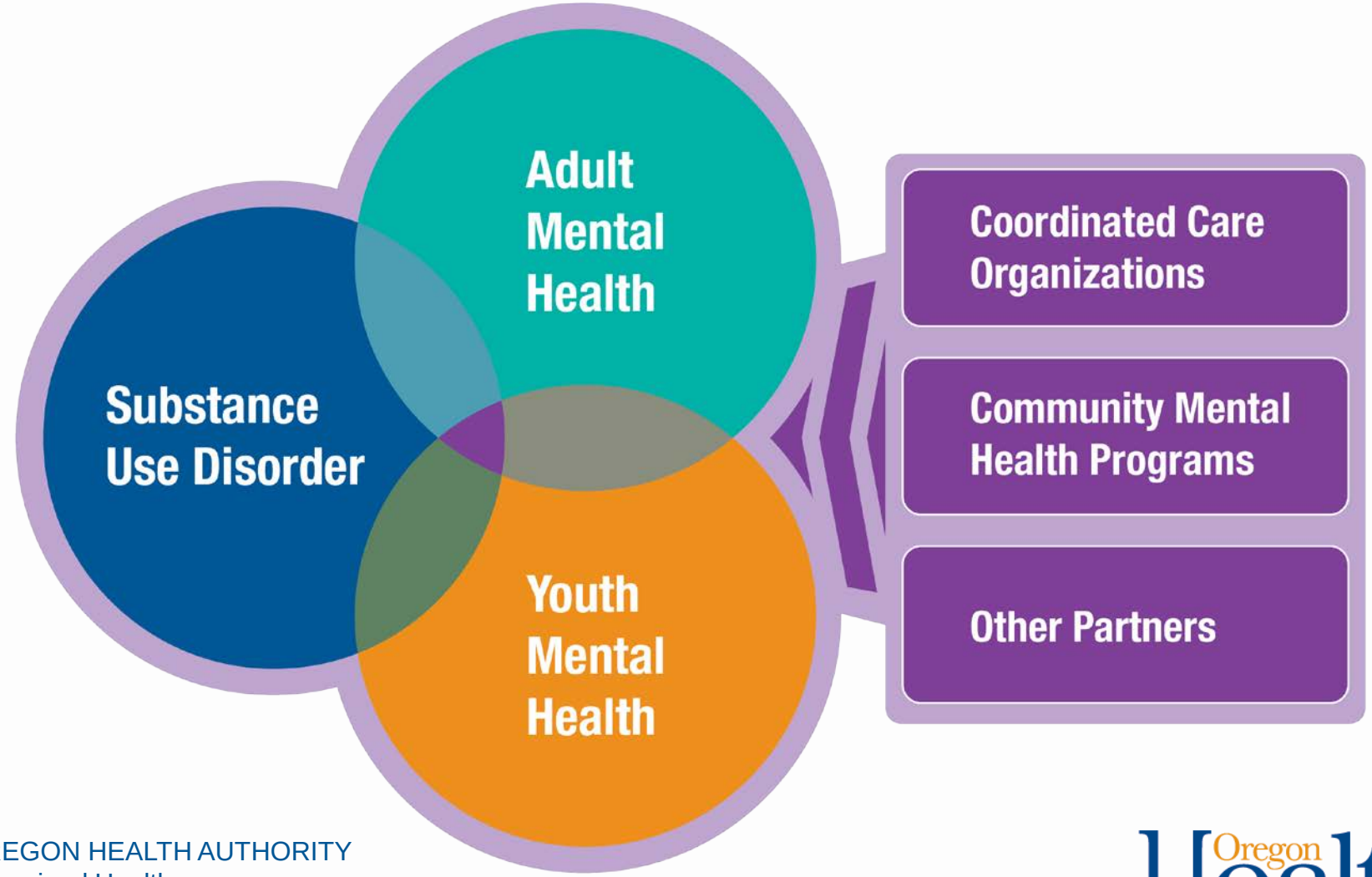
Stories

Budget

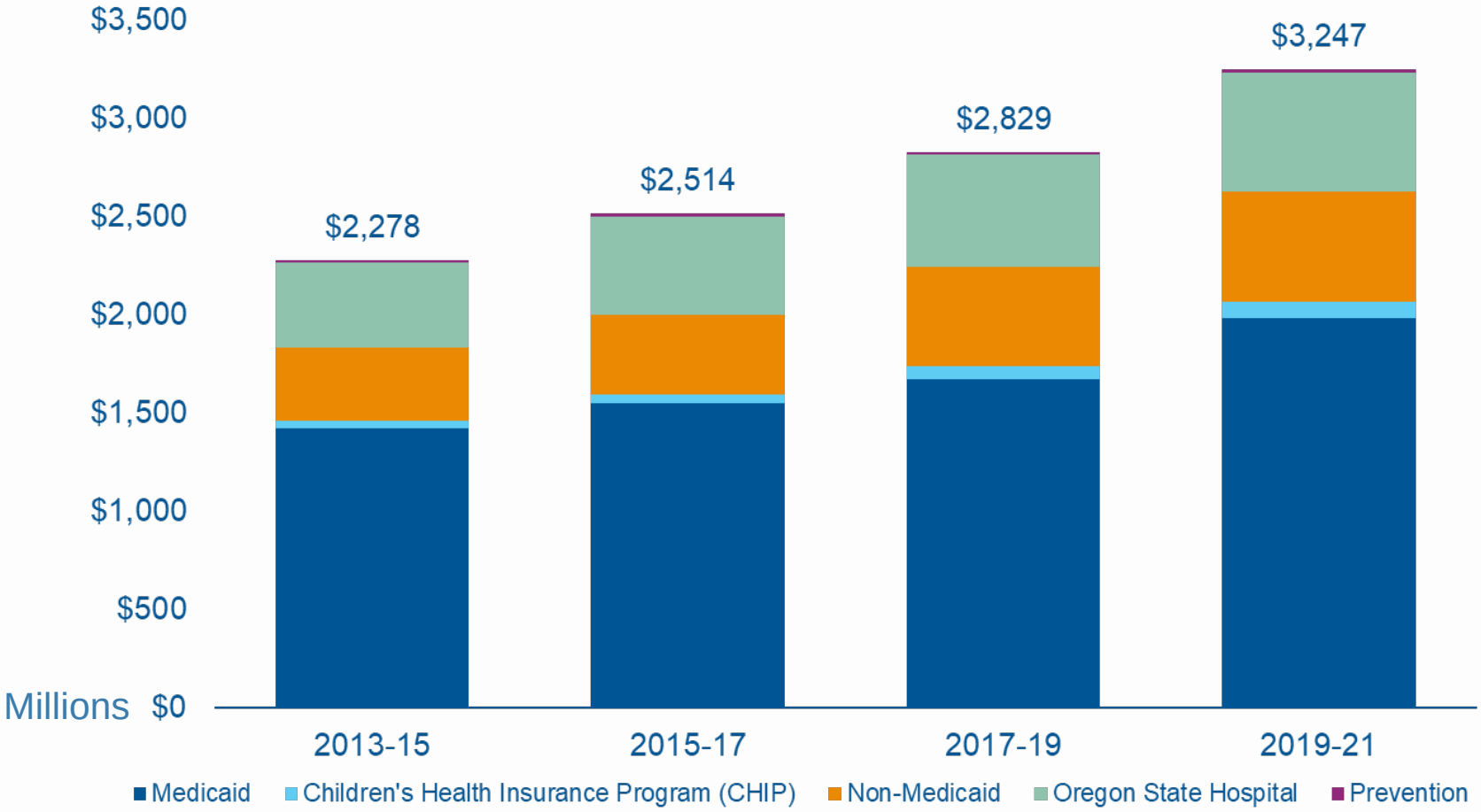
The Triple Aim Vision for Oregon

Elements of Behavioral Health Services

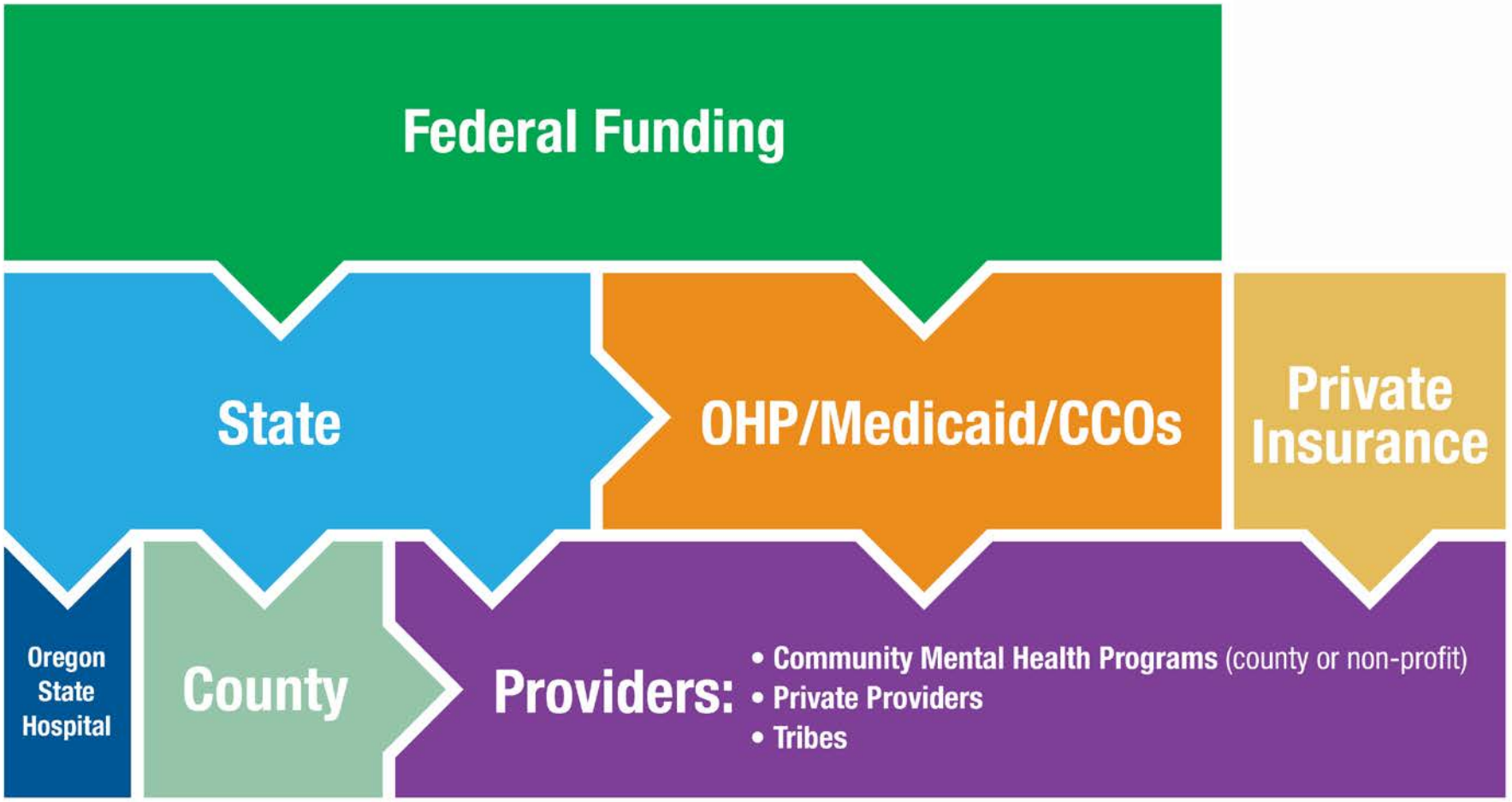
Behavioral Health Service Delivery



OHA Behavioral Health Spending



Behavioral Health Funding Streams



Overview

Stories

Budget

Alexander: Story

- 4-year old boy
- In a rural Head Start program
- Disrupting preschool by:
  - Shoving, hitting, kicking other children
  - Throwing chairs
  - Refusing to interact with his teacher
- Referred by Head Start program staff to county behavioral health clinic for **Parent-Child Interaction Therapy**

Alexander: Service

Parent-Child Interaction Therapy (PCIT)

- Uses evidence-based family therapy to improve the parent-child relationship, communication, regulation of child and parent mood, and reduce negative behaviors in children
- Trained therapists coach the parent-child interaction through a one-way mirror and give real-time therapeutic guidance to parents through wireless "bug-in-the-ear" technology
- Families may self-refer or be referred from primary care, early learning or child development centers, courts, schools, or child welfare
- Available in Spanish at all Oregon locations
  - Via Spanish speaking therapists or interpreters
  - All written materials available in Spanish

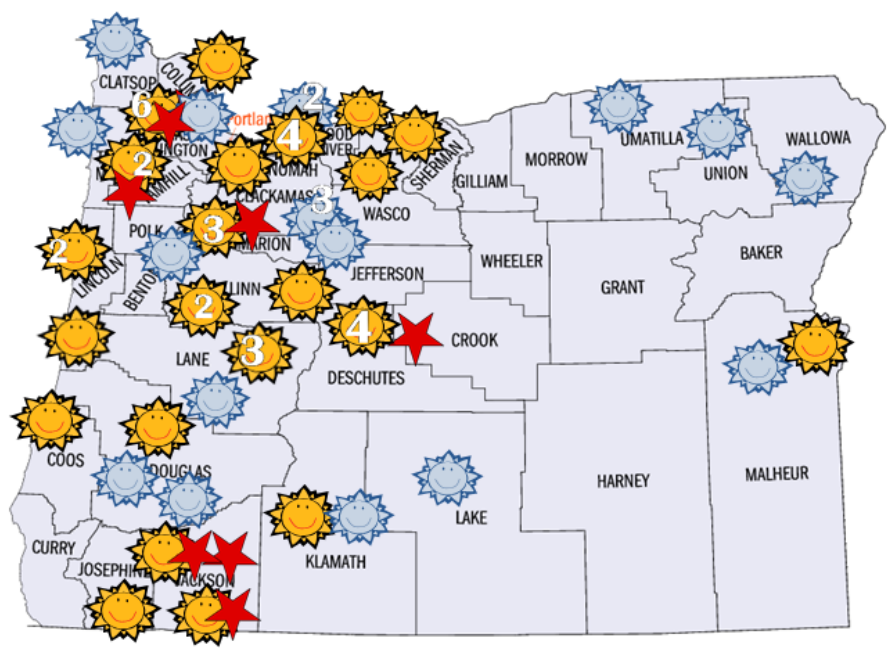
Alexander: Service, continued

Alexander: System

- PCIT is a “fidelity model”
  - Requires providers to closely follow the treatment protocols
  - OHA has strong training and certification requirements
- Funding
  - Medicaid and private insurance reimburse for PCIT when the child has a behavioral health diagnosis
  - OHA General Fund:
    - Pays for services for families without insurance
    - Helps counties develop their PCIT programs and infrastructure to support dissemination of fidelity PCIT
    - Gives grants to provide the intensive training required by PCIT

Alexander: System, continued

- Locations:
  - Currently in 19 counties
  - Projected to rise to 30 counties in 2019, with about 60 sites



PCIT site *(numbers = multiple sites)*

Projected sites (2019)

PCIT trainer(s)

Alexander: Outcome

- After completing 16 sessions of PCIT with his parents, Alexander:
  - Demonstrated behavior within the normal range for his age
  - Made progress with emotional regulation and social interaction
  - No longer acts out with physically aggressive behaviors
- His teacher was very impressed with his overall progress and his improved classroom behavior
- His mother was much more confident in her own ability to parent

Alexander: Lessons

- Extreme and repeated acting out may be a behavioral health issue requiring treatment, not just misbehavior requiring discipline
  - Families need support and guidance to facilitate healing and protect intergenerational bonds between parent and child
- PCIT is very successful for the majority of participants
  - 85% of Oregon families who participate in 4 or more PCIT therapy sessions demonstrate improvement in child behavior, positive communication, and positive parenting skills
  - Families who remain in the full course of treatment (16-20 sessions) see their children's behavior return to the normal range
- Availability has been increasing in Oregon steadily since 2004

Brooke: Story

- 14-year old girl
  - Severely depressed and suicidal, few coping skills, very attached to and dependent upon her mother
- Mother felt overwhelmed and scared by Brooke's suicidal thoughts
  - Brought her to emergency department
- Brooke and her mother feared having her go to an inpatient psychiatric unit away from her family
  - Concerns about missing school and not being near significant natural supports
- Emergency department staff connected them to a **Crisis and Transition Services** team administered by a local nonprofit social service agency

Brooke: Service

Crisis Assessment and Treatment Services (CATS)

- Serves children and youth under 18 experiencing mental health crisis who cannot cope with their symptoms on their own or with family help, but may not need a hospital stay
  - A *mental health crisis* usually means that the symptoms of a person's illness have gotten significantly worse, the person might hurt themselves or another person, or the person's symptoms are significantly interfering with their ability to function at normal levels
- Incorporates safety planning, care coordination, and family peer support along with mental health treatment
- Team includes family peers who provide support, advocacy, and mentoring

Brooke: Service, continued

Crisis Assessment and Treatment Services (CATS)

- Includes outpatient follow-up:
  - Mental health assessment with plan for treatment in the community
  - Connection with resources necessary for each person to remain stable, such as housing, basic needs assistance, and care for physical health needs
  - Longer term treatment could be needed which is more intensive and possibly occur in a secure facility, where stabilization from 4 to 14 days can occur as their mental health symptoms are treated

Brooke: System

- CATS works closely with other parts of the mental health crisis structure which includes:
  - Urgent crisis care in emergency department or crisis center: immediate crisis care
  - Police and emergency departments: refer patients in crisis
- 8 counties now have CATS programs: Benton, Clackamas, Deschutes, Jackson, Linn, Marion, Multnomah, Washington
- 6 more sites became operative in 2017 and 2018 in Harney, Josephine, Klamath, Linn, Malheur, Tillamook and Umatilla counties
  - These counties used their own flexible funds to create a CATS-like structure in their communities

Brooke: System, continued

- Funding
  - Capital: Local and state contribution to build inpatient centers
  - Operating: General Fund and Mental Health Block Grant (federal) currently support these targeted investments, paid both by OHA directly and via counties
  - In 2017-2019, OHA funded 7 hospital sites and 1 non-hospital sites with $1.85 million
  - Programs bill Medicaid and private insurance where they can, but those sources do not cover the full cost of providing this program

POP 402:
Suicide Intervention and Prevention, and Mental Health in Schools

Brooke: Outcome

- CATS program timeline:
  - **Within an hour,** provided assessment, safety planning, and contact information in case of a crisis
  - **Within a day,** provided support and guidance about accessing mental health services
  - **Within a week,** arranged for ongoing outpatient services, including medication management and family peer support
- Mother and daughter called the crisis line a few times, and received phone support rather than having to return to emergency room
- Over the next four weeks, CATS program visited family's home and:
  - Supported safety and coping skills
  - Assisted Brooke and her family connect with a long-term therapist
  - Worked with her school to ensure support there

Brooke: Lessons

- Crisis services are needed immediately in the moment of crisis
- Rapid access and connectivity to community treatment can reduce or avoid future crises and the expense of crisis services
  - In 2018, of youth served by CATS:
    - 435 (68%) were diverted from the emergency department within 24 hours
    - 577 (90%) were diverted within 48 hours
    - CATS teams created a safety plan with 588 (91%)
- Connection to community services when discharging from inpatient settings helps to interrupt cycling through the system under crisis
  - In follow-up interviews after two months, most families say they still connect with a therapist or counselor, and they feel confident about what to do in a crisis

Caleb: Story

- 12-year old boy
- Behavioral health crises
  - Multiple occasions when he became violent and aggressive toward parent, foster parent, and himself
  - Has injured himself and parents during a crisis episode
- Taken to local emergency department by parent
- Assessed in emergency department and referred for **Intensive Treatment Services for Children and Adolescents**

Caleb: Service

Intensive Treatment Services for Children and Adolescents

- Levels of intensive inpatient treatment (highest to lowest)
  - **Secure Children's Inpatient Program/Secure Adolescent Inpatient Program (SCIP/SAIP):** State hospital level of care provided in secure, residential community facility for youth under age 18
  - **Acute:** Intensive, secured hospital facility
  - **Sub-acute:** Less intensive with comprehensive 24/7 treatment availability in facility
  - **Psychiatric Residential Treatment Services (PRTS):** Residential facility with a high degree of supervision and availability of comprehensive treatment

Caleb: System

- Provided by private behavioral health treatment centers
  - Facilities certified by DHS
  - Programs licensed by OHA
- Funding
  - Medicaid and private insurance reimburse
  - OHA General Fund pays for services for families without insurance

Caleb: System

- Severe capacity limits
  - Capacity for Subacute and PRTS has decreased by at least 100 beds in past 5 years
    - Current capacity: 145 beds
    - Needed capacity: 212 beds
      - **Short by 67 beds**

POP 403: Intensive In-Home Behavioral Health Services
SB 221: Appropriates moneys for intensive in-home services for children with behavioral health needs

Caleb: Outcome

- No intensive services were available for Caleb
  - Acute programs found him not acute enough, **denied admission**
  - Subacute programs found him to be too acute, **denied admission**
  - Psychiatric Residential Treatment Programs for his age group had **a wait list over three weeks long**
- Because of the lack of appropriate services, Caleb:
  - Stayed in the emergency department for 16 days before being discharged to a community placement
  - Had at least two more emergency department visits
  - Was charged in the juvenile court system
  - Because of facility denials, required involvement by OHA before he could access services to meet his needs

Caleb: Lessons

- Children with complex needs and their families need better community services and access to those services
- Coordination challenges, often involving multiple state systems, can create unnecessary disruption and stress for children
- Lack of access to appropriate service levels within behavioral health systems affects DHS and OHA's ability to provide safe and appropriate residential placement
  - Increased number of youth with intensive needs
  - Not enough providers or providers of the right type to meet demand, resulting in long wait times
  - Stakeholders and families have reported negative effects for youths needing access to intensive services
- Total funding need to meet estimated capacity need is $8.125 million

Diana: Story

Young adult woman with a young child

- Has a substance use disorder
- Involved in the child welfare system
- Her child welfare caseworker:
  - Identified her need for **Withdrawal Management** and then **Residential Substance Use Disorder Treatment**
  - Arranged for her treatment
  - Developed a plan that keeps Diana with her child throughout treatment

Diana: Story, continued

- Is enrolled in a CCO through Oregon Health Plan
- Completed withdrawal management
- **But then** the available residential treatment facility was in a different county, not within the CCO service area
  - Treatment staff could not take her unless an authorization was received by the CCO
  - Initially the CCO would not authorize, so family began the process of changing insurance in order to have access to treatment
  - OHA staff reached out to CCO care coordinator, and coverage was obtained

Diana: Service

Withdrawal Management

- Medically or clinically monitored detoxification from alcohol and other drugs
- By itself, does not constitute treatment for dependence
  - Should be linked to ongoing treatment

Residential Substance Use Disorder Treatment

- Provides assessment, treatment, rehabilitation, and 24 hour observation and monitoring, including detoxification programs, for individuals with substance use dependence
- Housing facilities for up to 16 individuals

Diana: System

- Medicaid funds cannot currently be used to pay for residential treatment in facilities with more than 16 beds
  - OHA is applying for a new 5-year 1115 demonstration waiver that would allow Medicaid coverage for more than 16 beds
- Residential treatment facilities that keep a family together (with beds for adults and children) are limited
  - If a bed is available, a person needs to accept and have payment approved immediately or they will “lose” the bed

Diana: Outcome

- After OHA staff reached out to CCO care coordinator, and coverage was obtained, Diana entered residential treatment in a “Mommy and Me” program
  - Handoff from withdrawal management was successful
- CCO covered the residential SUD treatment, but not any other health care she might need while there, because she would be residing out of their coverage area
  - Accessing other medical needs is complicated even with CCO authorization for treatment as she is temporarily residing in an out-of-area provider setting

Diana: Lessons

- Residential substance services are statewide resources
  - But often treated as ‘local only’ resources
- Limited access for residential treatment, especially for women who are pregnant and/or parenting
- Problems with health coverage for people who access residential treatment outside of their CCO region
  - Community partners and stakeholders may be not familiar with CCO care coordinators, to troubleshoot like OHA did, which leads to disruption of care
  - CCO 2.0 to require demonstration of capacity building and continued services out of region

Ethan: **Story**

- Adult man
  - Working part-time, attending college
- Drug user of methamphetamines and opioids
  - Had earlier received Medication Assisted Treatment, but relapsed after treatment ended
- Self-referred, walked into a community mental health provider seeking new **Medication Assisted Treatment**
- Was indigent at walk in
  - Community mental health resources helped him apply for Medicaid and enroll with a CCO

Ethan: **Service**

Medication Assisted Treatment (MAT)

- Medication-based intervention that binds or blocks the opioid receptors in the brain
  - Methadone (fully bind), buprenorphine (partially bind), naltrexone (block)
- Shown to:
  - Reduce intravenous drug use
  - Decrease risk of overdose
  - Reduce exposure to infectious diseases
  - Reduce criminal behavior
  - Increase ability to stay in a structured treatment environment

He also required Residential Substance Use Disorder Treatment

Ethan: **System**

- CCO physician with DATA waiver (i.e., is authorized to dispense controlled substances) was located to prescribe MAT
- Funding
  - Medicaid and private insurance reimburse
  - OHA General Fund pays for services for those without insurance
- Limited availability
  - No residential bed available in entire state of Oregon that participated with Medicaid
  - No MAT prescriber available in city in which individual resided
  - No Opioid Treatment Program (OTP) in city in which individual resided

Ethan: **Outcome**

- Unable to be served during walk-in, **needed an appointment**
- At appointment, was screened for substance use disorder, but unable to receive full assessment, **needed another appointment**
- At next appointment, received full assessment that indicated need for Medication Assisted Treatment (MAT)
- Nearest MAT provider was in next town, 15 miles away, **needed an appointment**
- At MAT appointment, Ethan was under the influence of methamphetamines and opioids, therefore unable to induce on buprenorphine, **needed another appointment**

Ethan: Outcome, continued

- **Almost 4 weeks passed** from walk-in to beginning of MAT
- Was prescribed 3 days' worth of buprenorphine
- Returned for additional dose
  - Was refused an additional prescription because he tested positive for methamphetamines
- Residential care was still not available
- **Did not follow up** on further treatment
  - At last report, Ethan was homeless, arrested multiple times for stealing and possession, and still using methamphetamines and opioids

Ethan: **Lessons**

- Initial MAT ended as soon as individual was stable, then he destabilized
  - Need to reduce stigma around MAT
  - Need to encourage individualized treatment plans, not plans set to a specific length of time
- Demand for residential level of care continues to exceed capacity
- Demand for MAT prescribers continues to exceed capacity
- Opioid treatment programs are not available in all communities across Oregon

POP 411:
Behavioral Health Homes

Faith: Story

- 35-year old woman
- Drug user of methamphetamines and opioids for 10 years
  - Lost custody of all 4 children due to drug use
  - In and out of jail
- While in jail awaiting sentencing for burglary, was approached by staff of a nonprofit social service agency offering **Peer Delivered Recovery Support Services** with supportive housing

Faith: Service

Peer Delivered Recovery Support Services

- Services that are planned, delivered, and administered by people who have experienced both substance use disorder and recovery
- Mentoring continues throughout the process of change, giving emotional, and instrumental support to help people become engaged in the recovery process and reduce the likelihood of relapse
- Peer Support Specialists can:
  - Build personal relationships with people experiencing behavioral health challenges
  - Help people plan for appointments
  - Share problem-solving skills including; scheduling, household management, self care, and life-work balance
  - Model a healthy recovery lifestyle

Faith: System

- Peer Support Specialists (PSS) and Peer Wellness Specialists (PWS) are defined as Traditional Health Workers (THW)
  - OHA certifies THWs, who must complete an OHA-approved peer-delivered services training program
- Funding:
  - Paid by OHA General Funds
  - To bill through Medicaid, there would need to be a Substance Use Disorders Waiver to allow Peer Run Service Organizations to bill Medicaid directly
    - OHA has begun discussions with federal government for a waiver

Faith: Outcome

- One year sober
- Working and living independently
- Regaining custody of children

Faith: Lessons

- Success begins with housing and services provided in the community
- Treatment approaches should be individualized
  - In this case, prior approaches weren't working well enough and alternative strategies were warranted
- Peer Delivered Services have a strong record of helping individuals find the services and resources they need to be successful
- Funding needs to be available and sustainable through Medicaid, not only General Fund

Gabriel: Story

- Adult man
  - Started experimenting with drugs and alcohol at a young age
  - Diagnosed with schizophrenia in his early 20s
  - Addictions grew worse in his 30s
- Committed a violent crime while experiencing delusions about people hurting his family
  - Pled guilty except for insanity
  - Under jurisdiction of Psychiatric Security Review Board
  - Placed at **Oregon State Hospital**

Gabriel: Service

Oregon State Hospital

- Psychiatric treatment for adults who need hospital-level care
- Services include psychiatric evaluation, diagnosis, and treatment, as well as community outreach and peer support
- Hospital-level care includes 24-hour, on-site nursing, psychiatric and other credentialed professional staff, treatment planning, pharmacy, laboratory, food and nutritional services, vocational and educational services

Gabriel: System

- There is no voluntary pathway to the state hospital
  - A judge must order commitment through civil commitment, GEI, aid and assist, or voluntary by guardian (very few)
- Funding:
  - General Funds pays about $1,300 per patient per day
  - Not eligible for Medicaid, under federal law

Gabriel: Outcome

- Inpatient at the state hospital for 18 months
- Received treatment for his mental illness and substance use disorder
  - Gabriel's dual diagnosis (mental and physical) made it harder for him to access services before his commitment to the state hospital
- Participated in art therapy, employment training, and peer recovery supports
  - Began working, first as a dishwasher and later as a cashier
  - Earned privileges to go on community outings
- Discharged from the hospital into a group home
- Eventually transitioned to **Permanent Supportive Housing**

Gabriel: Service, part 2

Permanent Supportive Housing (PSH)

- OHA Permanent Supportive Housing programs contract with community providers who provide supportive housing services
- Includes rental assistance, housing support services, and barrier removal

Gabriel: System, part 2

- Most clients have Severe and Persistent Mental Illness (SPMI), such as schizophrenia, major depression, and borderline personality disorder
  - Others have substance use disorders
- Funding:
  - OHA General Fund
    - 2013-15: 576 residential slots, $8.2M
    - 2015-17: 972 residential slots, $27.4M
    - 2017-19: 1,154 residential slots, $36.5M
  - May be able to better leverage Medicaid for supports, but rental assistance will remain GF

Gabriel: Outcome, part 2

- Lives independently
  - His criminal record creates barriers, but his PSH provider helped him navigate that history with his landlord
- Sees a psychiatrist and therapist on a regular basis
  - Has been sober for three years
  - Is no longer under the jurisdiction of the Psychiatric Security Review Board
- Recently completed a 12-week work training program, which he hopes will lead to full-time work

Gabriel: Lessons

- Housing first
- Oregonians with serious and persistent mental illness need access to services and supports to help them achieve and maintain stability in their own communities
- Gabriel's dual diagnosis made it harder for him to access services before his commitment to the state hospital
- System changes may have altered Gabriel's trajectory earlier
  - The goal is to **prevent** crises and the need for hospitalizations whenever possible

Governor's Budget
$4.5 million to OHA to operate Permanent Supportive Housing services
$50.0 million to Oregon Housing and Community Services to build supportive housing

Henry: Story

- 25-year old man
  - Severe mental health issues
- Cycling between jail and community
  - Would stabilize in the state hospital, come out, relapse on drugs within a week or two, and repeat the cycle
- Same with civil commitment
  - Would be placed in a transitional treatment bed, but chose to leave as soon as he was able
- After another arrest, was sent to the state hospital again on a .370 (Aid & Assist) commitment
- Assigned to **Assertive Community Treatment** and **Community Restoration Services**

Henry: Service

Assertive Community Treatment (ACT)

- Comprehensive treatment and support services to individuals who are diagnosed with serious mental illness
- Provided by a multidisciplinary team: team leader, licensed medical practitioner (psychiatrist or PMHNP), nurses, therapists, substance abuse specialists, supported employment specialists, peer support specialists, case managers, and other mental health specialists
- Provided in the most integrated setting possible to maximize independence and community integration

Community Restoration Services (CRS)

- Services designed to restore a person's ability to aid and assist in their legal defense in a community setting, rather than in a hospital setting

Henry: System

- Funding
  - Assertive Community Treatment paid by Medicaid
    - OHA allows General Fund for team start-up costs
  - Mental health residential services have historically been funded through General Fund, but are transitioning to Medicaid on July 1 through the rate standardization process
  - Community Restoration Services funded through county contracts
- Provided by various community providers

Henry: Outcome

- ACT team served him in his community, where he was able to maintain connections with family
- Transitioned to Permanent Supportive Housing where he has resided for the last three years

Henry: Lessons

- When a criminal defendant comes to the state hospital as Aid & Assist, the hospital is ordered to restore their ability to aid and assist in their own defense
- OSH must return the defendant to jail once they reach this level of functioning
- Community Restoration allows the individual to build supports and a treatment plan **in the community to which they will return**
- 60% of criminal defendants who come to the state hospital are homeless

POP 410: Community restoration for Aid & Assist Defendants
SB 24: Modifies procedures related to criminal defendants lacking fitness to proceed

Overview

Stories

Budget

POP 403: Intensive In-Home Behavioral Health Treatment

- Creates and expands intensive community-based behavioral health care
  - Provides alternatives to residential services for Medicaid-eligible children and youth
  - Increases diversity of services
  - Treats more children at home and in their communities

	General Fund	Total Funds	Positions
POP 403	**$5.4 M**	**$5.7 M**	**-**

POP 402: Suicide Intervention and Prevention, and Mental Health in Schools

- Funds the 2016-2020 priorities outlined in Oregon's Youth Suicide and Prevention Plan.
- It also funds development of an Adult Suicide Prevention and Postvention Plan.
- For youth, early intervention for adults and youth improves learning outcomes and saves lives
- Expands School-Based Mental Health services
  - Mental health consultation and treatment services

	General Fund	Total Funds	Positions
POP 402	**$13.1 M**	**$13.1 M**	**3**

POP 410: Community Restoration for Aid & Assist Defendants

- Funds community-based Aid and Assist treatment for defendants charged with only misdemeanors
- Expanded community-based treatment
  - Relieves Oregon State Hospital workloads by 40 percent
  - Aligns with US DOJ expectations for community-based treatment

	General Fund	Total Funds	Positions
POP 410	**$7.6 M**	**$7.6 M**	**-**

POP 411: Behavioral Health System Investments

- Technology Investments
- Behavioral Health Homes
- Mental Health Clinical Advisory Group continuation

	General Fund	Total Funds	Positions
POP 411	**$5.4 M**	**$5.7 M**	**4**

POP 414: Building a Modern Behavioral Health Information System

- Funds work to establish a modern, comprehensive behavioral health reporting system
- Improves data collection and collaboration among OHA programs, behavioral health providers and partners
- Improves caseload forecasting

	General Fund	Total Funds	Positions
POP 411	**$6.7 M**	**$6.7 M**	**2**

Thank You

Oregon Health Authority