Testimony to House Behavioral Health Committee 2/24/2022

From, Heather Jefferis, Executive Director, OCBH

Chair Nosse, Vice-Chairs Reynolds and Moore-Green,

My name is Heather Jefferis. I am the Executive Director of Oregon Council for Behavioral Health. OCBH is the largest statewide behavioral health association in Oregon, of around sixty primarily nonprofit providers that deliver treatment for substance use disorders and mental illness. While language is evolving in this space, we use the term "behavioral health" to encompass both substance use disorder and mental health. It is likely, the behavioral health providers you have met in your districts are members of OCBH. Our members are highly agile mission driven and community based. Each of our member providers were created by the community of the community to meet unmet needs perceived by the community. Most are small business well under five hundred employees, they do & must partner with each other to share strengths and create opportunities to increase equitable access to treatment and needed services for their consumers. We also share members with AOCMHP and other associations as our members are multifaceted community needs-based organizations. Our members join OCBH to benefit from our focus on both the clinical and operational side of their business it takes a team with diverse talents and skills to deliver quality care.

Our work supports our members in their mission to delivery equitable access to a robust system of care. We do this through advocacy and policy as you are accustomed to seeing us, and even more so through creating communities of practice for our members and all their staff, using committees such as our DEI committee that advises all our internal and front facing activities from training, through policy and operations. Communities of practice are member driven supporting training, direct benefit projects including clinical and operational skills, improving vendor relations with IT, contracting, banking, insurance, and legal supports and a myriad of business model quality improvement and efficiencies resources.

I will start by explaining a bit about what our providers do and who we serve and then help you better understand why providers are struggling right now.

- Our members deliver both substance use disorder and mental health treatment, as well as prevention services. This runs the gamut and includes crisis lines, residential programming for both youth adults, sobering centers and withdrawal management programs, as well as myriad of innovative outpatient services
- Here are a few examples to paint a picture of some typical OCBH members
    - A substance use disorder forward program might have adult residential, also operates family services, co-occurring services aka staff that can address both MH and SUD needs. The same provider might also have a medication assisted treatment program, which provides regular doses of medications like methadone or buprenorphine, naltrexone to individuals living with substance use disorder.
    - Another provider may focus on the specialty needs of serious mental illness, providing different programs along the continuum of mental health care, including secure, or locked, residential treatment facilities (called SRTFs). This type of setting is safe for some of the individuals who might otherwise need to stay at the Oregon State Hospital and is often more patient-centered and less costly than a state hospital visit. This same provider might also offer what you have heard described as step-down services, like residential treatment facilities that are not secure, and housing with integrated mental health supports and outpatient care with or without co-occurring capacity.
    - Many of our providers, being agile and innovative leaders in their communities, are implementing modern and emerging programming. For example, some of our members are Certified Community Behavioral Health Centers ((CCBHC) a federal defined integrated BH and physical health care model that can be used in a variety of business model settings, such as Hospitals, non-profits, CMHPS, private health care providers etc..) , Federally Qualified Health Centers, Addiction medicine clinics or other physical health integrated services. Some have staff integrated into hospital settings emergency rooms, and other setting such as those that support pregnant mothers experiencing opioid addiction , or other partner sites to increase ease of access and engagement. Some have extensive outreach services. Whole family care is delivered in a variety of settings, but most particularly amongst our members with residential substance use

disorder services that allow a parent to bring the child to residential treatment with them knowing the alternative often means the child enters foster care.
    - This is just a small sample, and we would very much encourage you to connect with your local provider(s) to tour their innovative life changing programs in the interim. The good news is currently BH providers have research and practices that are proven and effective. Now the sector needs the support and diverse workforce to scale at a population health impact level.

- Next, I will explain a bit about the current challenges faced by providers
    - The simple fact is historically and even today, mental health concerns and addiction have been systemically stigmatized, leading to a lack of federal and state attention, and a lack of resources from the same, dedicated to this critical work. This fact is deeply woven into all aspects of the system. Agile mission driven providers and consumers experience the impacts of this historic burden every day.
    - As our physical health counterparts were resourced to ensure access to healthcare, behavioral health providers saw little to no changes in the rates paid by Medicaid for decades and Medicare as mentioned is still not included is federal parity law.
    - This underpayment for critical services has compounded over the years, leading providers to have little room to grow and update facilities, create fidelity to modern practice and leaves new employees disappointed in their ability to actuate their hard-earned expertise
    - The wage compression caused by a lack of pay parity limits budgets resulting in non-competitive wages to the entire BH workforce, leaving the BH workforce feeling undervalued -- rightfully so.
    - We are inspired by the recent legislative support, to hope our system is on the right track to help providers begin to dig ourselves out of this crisis, by finally attempting to remedy chronic underpayment. However even with our agility and small business ingenuity, it will take many years to see our system recover. The pipeline of workers interested in doing this work has diminished. The positive aspect is as we rebuild, we can finally address equity, increase anti-racism and remove the burden of systemic stigma in our system.
        - Changing the rate today will help keep the workforce we currently have, but it will take years to see our pipeline recover.

- Changing the rate today will help providers keep facilities operational, but it will take years for them to save the capital to break ground and build new facilities.
- Changing the rate today will help providers respectfully recruit diverse workers without perpetuating past systemic issues.
- Changing the rate today will help providers steward their philanthropic investment in program research, improvement, data collection and operational infrastructure verses wages, aligning our operations to something like parity with our physical health partners.
- The historic systemic issues and lack of parity has left programs preciously financially vulnerable.
- The best analogy is that a program often operates like a tree, building out new branches to become eligible for grant dollars, braiding them with other funding streams to keep their operations afloat, only to see those branches wilt when grant dollars dry up. This requires the program to completely alter itself, including making staffing changes, to become eligible for new grant dollars, reaching out new branches in hopes of staying alive.
- This funding model is inefficient and harmful. It is costly for providers to constantly apply for dollars just to stay afloat, and it is harmful, not allowing a provider to predict if they hire a nurse today if they will be able to pay their salary 6 months from now. It is damaging to the workforce leaving them underpaid, unsure of their employment status and inflects moral injury as services needed by consumers are wiped away by system fluctuation. And it is the most harmful for consumers and their families who must suffer workforce turnover and a lack of equitable access.

- To return to the metaphor, our tree trunk has been rotting – and without change there is no stability for providers to deliver care.

As I mentioned earlier there is reason for hope, recent legislative support (thank you), and within this panel of partners including CCOs, CMHPs county, tribal and nonprofit, and consumers. Our current crises of covid, systemic stigma and racism are the last pressures collapsing our systemic issues. Crises is opportunity for clarity it is clear to all that improving rates is a critical solution to stable funding and it our determination to do better and hope by working together. All of us here today want our workers to spend less time applying for patch work funds and more

time delivering services. Improving equitable access and a diverse skilled workforce is what brings us together. We look forward to your partnership as we seek to build an equitable sustainable system that delivers the right service, at the right time, on our street, farm, forest, or coast.