3/8/2023

Chair Nosse, Vice-Chairs Goodwin and Nelson, Members of the Committee,

I am writing on behalf of Oregon Council for Behavioral Health. OCBH is the statewide association of behavioral health providers that deliver treatment for substance use disorders and mental illness.

We are here today to express support for the *intent* of HB 2235, which we believe to be an effort to improve the heavy workload being carried by the behavioral health workforce. However, we have serious concerns about the mechanism to do this outlined in the -1 "dash one" amendment.

The current amendment does not factor access for the consumer into the calculus around caseload limits. In the midst of a behavioral health crisis, we cannot support a conversation that does not consider access. Nor does it take into account the fact that consumers can be court-mandated to access treatment, which could exacerbate current legal battles in the behavioral health space – which are a product of too little access to services.

We would support having a workgroup to study the number and types of workers needed to meet the demand for access in Oregon. This would be a much-needed companion to the studies being done to determine the number of beds needed within the state for residential mental health and substance use disorder treatment. We would also support coming together to develop strategies to recruit and better invest in Oregon's behavioral health workforce, work we're doing alongside our union partners in advocating for pay increases and reduced administrative burden.

We would also like you to consider that a countable caseload may not be the best way to assess a providers' workload given the current state of BH delivery – let me explain:

- Our providers are contracted with OHA through a certificate of approval and are delivering care predominately to individuals on the Oregon Health Plan. This looks very different than what you might think of in private practice, where the primary intervention is a one-on-one session between a therapist and a client.
- This care, across the board, happens through a team-based model. This allows needs of the client to be distributed across roles, which supports all staff operating at the top of their licenses.
- The amendment considers team-based care for only specific program models and does not acknowledge the complexity calculating caseloads across the BH continuum when most or all consumers are not served by a sole provider.

- Further, behavioral health is in its infancy in terms of moving away from a direct relationship between revenue generating interventions and the services most needed by clients. Focusing on a caseload cap risks locks service provision into an old model of payment instead of allowing us to move more toward value-based care.
- Additionally, the idea of using acuity to determine the size of the cap ignores as individuals' health improvement as they engage with their care team. Ideally a treatment process is driven by ever-changing needs of an individual as well as the interplay between practitioner-assessed need, patient preference and interest, and the type of intervention that best matches all the above. Caseload caps oversimplifies the goal of treatment as one driven by external forces.
- We know, and the bill acknowledges, that the reasons folks are leaving the BH workforce are complicated and includes; lack of a professional wage, emotional distress/toll of the job, and high workloads.

We hope to come together with our union partners to find a solution that more comprehensively address these challenges, while committing to maintaining access to care.

Thank you,

Heather Jefferis Executive Director OCBH