HB3825 Informational Hearing Follow-Up

Response to Decline in Foster Care Rates question (Rep. McIntire):

Age Group at End of Period	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	Total
0 to 2	1,806	2,657	2,682	2,836	2,947	2,871	2,631	2,294	2,005	1,907	1,824	1,630	12,856
3 to 5	1,779	2,562	2,397	2,506	2,682	2,608	2,439	2,152	1,889	1,608	1,555	1,425	12,468
6 to 8	1,480	2,226	2,195	2,136	2,117	2,010	1,911	1,671	1,426	1,325	1,260	1,214	10,033
9 to 12	1,451	2,134	2,139	2,202	2,348	2,272	2,164	1,852	1,546	1,337	1,230	1,234	9,779
13 to 17	2,176	2,867	2,720	2,665	2,705	2,574	2,464	2,294	2,066	1,860	1,765	1,641	10,778
18+	567	892	863	830	831	802	824	779	753	685	621	608	3,887
Total	8,927	11,541	11,307	11,360	11,818	11,380	10,723	9,563	8,389	7,614	7,220	6,783	39,109

Year	0 to 2	3 to 5	6 to 8	9 to 12	13 to 17	18+
2013	20.2%	19.9%	16.6%	16.3%	24.4%	6.4%
2014	23.0%	22.2%	19.3%	18.5%	24.8%	7.7%
2015	23.7%	21.2%	19.4%	18.9%	24.1%	7.6%
2016	25.0%	22.1%	18.8%	19.4%	23.5%	7.3%
2017	24.9%	22.7%	17.9%	19.9%	22.9%	7.0%
2018	25.2%	22.9%	17.7%	20.0%	22.6%	7.0%
2019	24.5%	22.7%	17.8%	20.2%	23.0%	7.7%
2020	24.0%	22.5%	17.5%	19.4%	24.0%	8.1%
2021	23.9%	22.5%	17.0%	18.4%	24.6%	9.0%
2022	25.0%	21.1%	17.4%	17.6%	24.4%	9.0%
2023	25.3%	21.5%	17.5%	17.0%	24.4%	8.6%
2024	24.0%	21.0%	17.9%	18.2%	24.2%	9.0%

Response to Office of Training, Investigations and Safety Screening Timeline (Rep. Scharf):

For reports of child abuse that are the responsibility of OTIS, OAR requires information and records to be gathered, and the screening completed within three days. To be clear, as soon as a report is identified to meet criteria for assignment it is prioritized to be assigned immediately.

Response to BRS history (Rep. Scharf):

Behavior Rehabilitation Services (BRS) Background:

Oregon receives federal support for residential and proctor foster care programs that qualify as BRS providers. The money is out of the Medicaid (Title XIX) program and matches Oregon's expenses for services. It is intended to support skill building and behavioral intervention, along with a therapeutic environment directed at positive changes in behavior. These improves the lives of children and adolescents by providing behavioral intervention, counseling and skills-training services.

Oregon's BRS program grew out of a multi-agency effort to stabilize and improve services in the residential treatment and shelter programs. This effort resulted in a joint effort by Oregon Health Authority (OHA), Oregon Department of Human Resources (ODHS), and the Oregon Youth Authority (OYA) working collaboratively with providers and key stakeholders to establish and maintain BRS standards and service expectations.

Most BRS programs are managed by Community-based organizations (CBOs) who leverage community-based resources and services (mental health, education, etc.).

BRS Service Types:

Behavioral interventions and skill-building leading to positive changes in behavior, including individual and family counseling, academic engagement, linkage and access to mental health, connection to mentors, peers, and community, as well as other individualized therapeutic supports and services. BRS providers offer these through several key types of services:

- Crisis counseling: The BRS contractor or BRS provider provides the BRS client with counseling on a 24-hour basis in order to stabilize the BRS client's behavior until the problem can be resolved or assessed and treated by a qualified mental health professional or licensed medical practitioner.
- Individual and group counseling: The BRS contractor or BRS provider provides face-to-face individual or group counseling sessions to the BRS client which are designed to remediate the problem behaviors identified in the BRS client's Initial Service Plan (ISP) or Master Service Plan (MSP) plans developed specific to the individual.
- Milieu therapy: The BRS contractor or BRS provider provides the BRS client with structured activities and planned interventions designed to normalize psycho-social development, promote safety, stabilize environment, and assist in responding in developmentally appropriate ways. The program's staff must monitor the BRS client in these activities, which include developmental, recreational, academic, rehabilitative, or other productive work. Milieu therapy occurs in concert with one of the other types of services.

- Parent training: Direct care staff or social service staff provide planned activities or interventions (face-to-face or by telephone) to the BRS client's family or identified aftercare resource family. Parent training is designed to assist the family in identifying the specific needs of the BRS client, to support the BRS client's efforts to change, and to improve and strengthen parenting knowledge or skills indicated in the ISP or MSP as being necessary for the BRS client to return home or to another community living resource
- Skills-training: The BRS contractor or BRS provider provides the BRS client with planned, curriculum-based individual or group sessions designed to improve specific areas of functioning in the BRS client's daily living as identified in the ISP or MSP. Skills-training may be designed to develop appropriate social and emotional behaviors, improve peer and family relationships, improve self-care, encourage conflict resolution, reduce aggression, improve anger control, and reduce or eliminate impulse and conduct disorder

<u>Focused Opportunities for Children Utilizing Services (FOCUS) Policy Option Package (POP) 111</u>

ODHS CW has put forward a policy option package specifically targeted to meet the needs of children with intensive needs with the intent of stabilizing children in their placement so they may not need to enter a higher level of care, or temporary lodging. Specifically, this POP would fund the expansion of two programs currently piloted that have demonstrated success in stabilizing young people with intensive needs, The Response and Support Network and Child Specific Caregiver Supports programs.

- Child Specific Caregiver Supports
  - Includes a package of supports such as coaching, training, resource navigation and on-call support services for Resource Parents, Relative Caregivers and Parents specifically focused on meeting the individual special needs of the identified child. This non-clinical support service is focused around educating and coaching the child's parent or resource parent to understand and meet the child's daily behavioral needs. Its goal is to not only stabilize the child's placement but also to support the caregiver, improving resource home retention and maintaining children in their homes. Services remain open until individualized goals are achieved. Pilots were initiated May 2022 which included Multnomah, Clackamas, Washington, Lane, Linn, Benton, Marion, Polk, and Yamhill Counties. With the additional investment, in the POP ODHS expects to roll Child Specific Caregiver Supports out to 11 additional counties. In 2027-2029, an additional 10 counties would be added, with the final 6 counties being added in 2029-2031. The average cost per county for this service is $180,000 per biennium.

- Response and Support Network (RSN)
    - RSN is a short-term (60-90 days) intensive, urgent response and support for Resource Parents with clinical and non-clinical providers, as part of a collaboration with CareOregon to offer immediate cross-system response and referrals. RSN further offers a unique support when OHA's Mobile Response Support Service (MRSS) is fully integrated; the key to MRSS is the immediacy of the 24/7 crisis response and connection to ongoing services like RSN. RSN offers a seamless connection to services that are tailored to a priority population and can leverage the success of MRSS. Services that are tailored to priority populations have shown to be more effective than service availability for the general population. When MRSS is fully integrated, RSN will modify its services offering to next business day response modeling instead of the current 24/7 initial response, which will reduce the cost of the service further. Once fully available, 24/7 response will be achieved through RSN for the cohort. When and if BRS in-home services are offered through OHA, RSN looks to convert its service offering to bill Medicaid for eligible BRS clients whenever possible. Based on the current trajectory, OHA may have these services available in approximately 3-5 years. Future MRSS and in-home BRS services success and infrastructure leverage will be propelled by RSN's existence. Resource Families and Child Welfare clients will continue to benefit from the core highly tailored trauma-specific supports offered in RSN and the partnerships it represents with CCOs.

Response to data on referrals vs. who got into treatment - (Rep. Nosse)

The following data was collected by the Referral and Capacity Management tool (RCM). RCM is a secure web-based platform developed by Oregon Health Authority's (OHA) Information Technology teams (Compass and OIS), in collaboration with the OHA Child and Family Behavioral Health unit and referral and intake staff from youth residential programs in Oregon. Its purpose is to collect data on referrals and program capacity in order to fulfill the directive of House Bill 2086, Section 13, from the 2021 legislative session. RCM was designed not only to collect data for OHA, but to be a referral management and tracking tool for providers to manage and organize their referrals and waitlists. The success of RCM is heavily dependent on provider participation, so it was imperative to find a tracking method that would both reduce the administrative burdens of tracking data for OHA and give our providers a sophisticated platform to use as part of their daily referral management. Residential children's providers began using RCM in 2024 and continue to partner with OHA by providing user feedback on RCM so that it can continue to be improved.

For children’s Psychiatric Residential Treatment Programs, between January 1, 2025 and February 4, 2025, 268 referrals were made. Of these children referred:

- 68 approved for residential, 36 are still awaiting residential placement (see additional information below)
- 13 referrals were denied for various reasons
- 86 referrals were canceled before a determination was made.
- 101 referrals were still active and waiting on a determination. (Note that the numbers below do not match the totals because, as standard procedure to protect privacy, data has been omitted for categories of referrals with less than 10 individuals counted.)

Of the 36 referrals approved and awaiting an opening:

- 12 have been waiting for 0-10 days
- 15 have been waiting 11-32 days

Of 101 referrals that are still active and awaiting a determination:

- 41 have been waiting for 8 days or less
- 21 have been waiting for 11-20 days
- 16 have been waiting for 21-32 days
- 23 of these referrals are missing wait time data

Of these same 101 referrals:

- 14 were in the emergency department when referred (they are likely still there)
- 12 were at a psychiatric acute inpatient unit (5 of which were out-of-state hospitals; it is unclear at this time if these youth are Oregon residents or not)
- 21 were in a community setting (home with family, group home, etc.) when they were referred.
- 48 of the active referrals did not include information on the child's location, so we are unable to clearly identify if the child is in the emergency department, residential facility, or the community

Oregon Department of Human Services and Oregon Health Authority author an annual memo on the capacity of these programs and identified barriers and needs. The most recent memo can be found here. Previous memos can be found here.

Response to licensed beds vs. what people can actual fill - (Rep. McIntire)

When a Child-Caring Agency (CCA) is initially licensed, the provider specifies the number of beds they wish to have licensed. CCA licensing will approve this request, provided it aligns with regulations regarding the facility's physical capacity. It is common for CCA providers to regularly operate under their licensed capacity.

Response to training in school settings - (Rep. Walters)

(See email response from Nicole Peterson with ODE.)

Response to licensing standards for inpatient hospital beds in Oregon vs. other states – (Rep. Hartman)

Oregon requires any youth inpatient facilities providing treatment services to be dually licensed: one license from OHA's Behavioral Health Division (BHD) for behavioral health services and one license from the Oregon Department of Human Services (ODHS) as a Child Caring Agency (CCA). In addition, any new Psychiatric Residential Treatment Facility (PRTF) serving Medicaid clients also must undergo an additional CMS inspection/survey at least once every five years, in addition to the bi-yearly licensing reviews from both OHA and ODHS.

For PRTF settings licensed by OHA's Behavioral Health Division (BHD), the facility must meet the requirement for participation of a non-hospital facility accredited by the Joint Commission on Accreditation of Health Care Organizations (JCAHO), the Commission on Accreditation of Rehabilitation Facilities, the Council on Accreditation of Services for Families and Children, or by any other accrediting organization with comparable standards that is recognized by the State.

Although we are unaware of any research based on other state requirements, OHA does hear from providers that Oregon has higher standards in several areas. We have heard comments specifically to the requirements around the following: staffing ratio, clinical supervision, abuse reporting requirements, restrictions, and oversight of the use of restraints & seclusion, and the licensing oversight by dual agencies. Oregon's focus on limiting Seclusion and Restraint (S&R) and the reporting requirements when S&R is used is also something agencies identify as higher-level requirements in Oregon.