April 25, 2025

Co-Chairs Campos and Valderrama
Sub-committee on Human Services
Joint Committee on Ways and Means
800 Court Street
Salem OR

RE: Behavioral Health Programs and Funding Presentation, April 22-23, 2025 follow up questions

Dear Senator Campos and Representative Valderrama:

Again, thank you for the opportunity to more completely describe the inner workings of the OHA Behavioral Health Division and the behavioral health system. OHA welcomes the opportunity to follow up with supplemental information on questions that subcommittee members asked during the hearing.

April 22, 2025 Responses

Number of people reached in each category on Slide 12

Data associated with each of those slices is kept in different administrative data systems and with different timeframes, each is addressed.

Mental Health and Substance Use Disorder counts of unique individuals served in the most recent biennium (23-25): 485,000 were served for MH diagnoses, while 108,000 were served for substance use disorders. These counts are associated with all funding sources described in the presentation and all types of services including residential, outpatient services, talk therapy, and others.

In problem gambling is only to summarize for fiscal years. In 2023-24, the system served 849 clients, with 10,788 treatment encounters. Compared to the previous fiscal year, the number of clients treated increased by 6.7%. In addition to traditional treatment services, funding for problem gambling services also includes wraparound type resources, such as free access to a gambling related health app and gambling financial services from financial counselors, along with prevention, intervention, and

recovery services, data collection, evaluation and workforce and professional development efforts.
The Oregon State Hospital (OSH) served 2,400 individuals for the 23-25 biennium. This includes individuals under forensic commitments (aid and assist and guilty except for insanity), as well as civil commitments.

Counts of individuals served under prevention services delivered by public health are more difficult to total given the variety of services provided, which include individual based services as well as population based services.

OHA's control over OSH admissions and cost sharing with other entities

OSH is only allowed to admit patients based on the amended federal court order, which was signed by Judge Mosman in the *Mink/Bowman* litigation. Currently, OSH cannot admit patients except as provided by Neutral Expert, Dr. Debra Pinals' recommendations or as otherwise specified in federal court. Aid and Assist and Guilty Except for Insanity defendants are admitted via court order and according to their place on the admissions waitlist or pursuant to the expedited admissions policy. OSH may admit PSRB GEI Revocations and Extremely Dangerous Civil Commitments (ORS 426.701). OSH is not able to admit other civilly committed persons or admit "voluntary by guardian" persons unless they meet the criteria int he expedited admissions policy. Likewise, OSH does not admit transfers from the Oregon Department of Corrections unless they meet the expedited admissions policy. OSH also does not admit persons from OYA except as specifically provided by the federal court order.

Incentives for treatment at the local level vs treatment at OSH

ORS 430 focuses on mental and behavioral health treatment in Oregon, including provisions for community-based services. While it outlines the services to be provided by community mental health programs, it does not explicitly mandate incentives to keep people at the local level instead of state-level service provision. However, the statute does emphasize the importance of community-based care, which encourages local service delivery.

The intent of the County Financial Awards is to strengthen local mental and behavioral health infrastructure, improve accessibility, and reduce reliance on state-operated facilities.

Community-based providers in Oregon may refer individuals to OSH under certain circumstances, primarily when local treatment options are insufficient to meet the individual's needs. This can include Severe Mental Health Crisis, Aid and Assist

Cases, Civil Commitment, Lack of specialized psychiatric facilities, Complex or Behavioral Needs.

ORS 430.389 focuses on Measure110 Behavioral Health Resource Networks to establish a framework of grants to behavioral health providers to fund local organizations that deliver essential services. The intent is to encourage local care rather than centralized state-level services.

Budgets for capital projects and one-time funding vs funding for care

The 2023-25 Legislatively Approved Budget for capital projects is $230.8 million Total Funds, which represents approximately 17% of total spending in the Behavioral Health Division's program budget. The remaining 83%, or about $1,151 million Total Funds, is for "care services."

The 2021-23 biennial spending for capital projects is $86 million Total Funds, which represents approximately 8% of total spending in the Behavioral Health Division program budget. The remaining 92%, or about $929.4 million Total Funds, is for "care services."

There may be additional spending for capital projects associated with a portion of the funding provided to CMHPs through HB 5202 (2022) because some counties have not yet reported how their funding was disbursed. Approximately $26 million has not been fully categorized by counties. The $26 million amount has been assumed to be spending for program services (care services) in the table above. The increased budget amount from the 21-23 biennium to the 23-25 biennium resulted more from carry over amounts from one biennium to the next. The dollars were awarded across these biennia, and although OHA has worked to spend the dollars as quickly as possible, there are instances where appropriate projects have taken longer to start than others. These delays range from changes in plans to coordination with other funders to appropriate zoning being addressed.

Number of Medicaid lives covered within FFS/CCOs

As of March 2025, approximately 1.4 million people are enrolled in Medicaid. Of those, about 7% are open-card, also known as fee-for-service.

Behavioral Health successes

Moving from analysis to action to transparency on behavioral health residential capacity: In June 2024, BHD published the landmark Residential+ Facility Study on the current state of residential capacity in Oregon. The study findings filled gaps in knowledge about the current system capacity and identified

how the state must evolve investment and development to meet projected needs. Once the findings were finalized, BHD moved into action, determining how to rapidly allocate appropriations for behavioral health residential facilities in alignment with the study's findings. This secured the addition of 465 beds by December 2026. By fall 2024, BHD also established the BH Investments Residential/Housing (Facility) Capacity Dashboard. Finally, OHA issued the Res+ Study Request for Information (RFI) from Aug. 13, 2024 – Sept. 16, 2024. This RFI sought to expand understanding established by the Residential+ Facilities Study (Res+ Study) and offer communities across the state to share their most pressing residential treatment capacity needs. The results of the Res+ Study RFI informed the 2025-2027 biennial budgetary resource recommendations for the expansion of Behavioral Health Residential Treatment capacity across Oregon.

Delivery of required reports - Residential+ Facility Study, 4092 Cost Study, HB2235 Initial Workforce Recommendations: The Oregon Legislature funded OHA to conduct three essential studies on the current state of Oregon's behavioral health system. Each study evaluates a different element of Oregon's behavioral health system and together begin to build a more complete picture of the current state and future needs. Each enables strategic and evidence-based decisions about how to prioritize investments and development in Oregon's behavioral health system. The timely delivery of these reports increased planning and implementation of interventions to advance Oregon's behavioral health system, including expanding residential capacity, advancing new behavioral health work force supports, and increasing clarity around localized resources for mandated populations.

Tackling Administrative Burnout workgroup closeout and transition to the 4092 Workgroup: This project began in 2022 following the establishment of the Tackling Administrative Burnout (TAB) workgroup by the Oregon Legislature. Eight TAB workgroup recommendations were developed into 10 project plans and several OHA divisions supported implementation of the recommendations. By January 2025, TAB determined its originally assigned scope of work was complete. In recognition that five project plans were in process, tracking of their progress transitioned to the 4092 Workgroup. More broadly, OHA's efforts to reduce administrative burden continue through rule process enhancements, staff training, HB 2235 recommendation project plans and through the CFAA redesign, in addition to other projects.

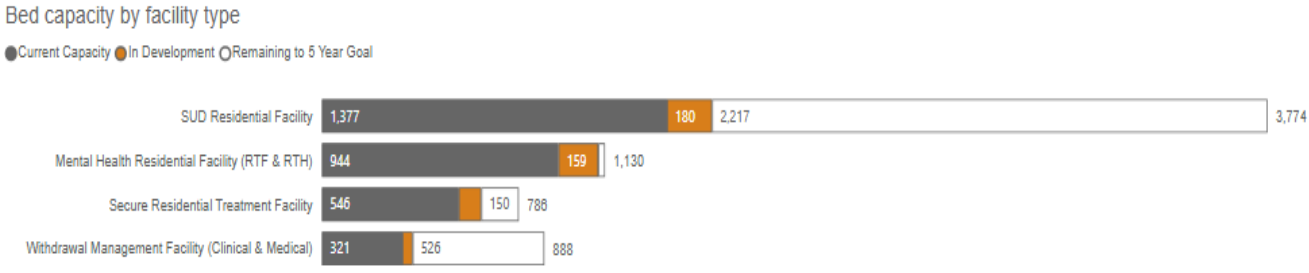
Establishing the Behavioral Health Division and stabilizing behavioral health leadership: The shift to a distinct division brought an opportunity to step into the authority and oversight of behavioral health in Oregon more intentionally and position the division to be more transparent and accountable to internal and external partners. This was more than a name-change, as infrastructure and backbone

support for the division did not remain as they were previously supported. Processes, teams, and roles were revised or established to increase scope clarity, collaboration, and agility. Alongside development of the Division, OHA have stabilized the BH leadership team with the addition of Lynnea Lindsey as the Deputy Director for Equity, Community Partnerships, and Quality Assurance and Abbey Stamp as the Measure 110 Program.

Sustaining and expanding the behavioral health workforce: To address workforce gaps, Oregon made investments to develop workforce at every stage of the pipeline: education, licensure and certification, recruitment, professional development and advancement, and retention. Cost of education and licensure are one of the most common and persistent barriers to people entering the workforce or progressing to a more advanced level of practice, so OHA has widely distributed funds to directly cover exam fees, loan repayment and other professional fees. OHA entered into 495 contracts with local organizations and institutions to distribute funds and/or offer trainings and development opportunities, including the Nine Federally Recognized Tribes in Oregon and Oregon's designated Urban Indian Health Program, CMHPs, community based organizations, and Oregon based graduate schools and training programs. This translates to more rapid increases in the workforce and helps to diversify the workforce, expanding opportunity for communities that are less economically advantaged. Also, the efforts focused on recruitment and retention that fosters growth from within Oregon. Within the loan repayment program, 90% of program participants have remained in Oregon's behavioral health workforce. The program especially focused on retaining culturally and linguistically specific providers and rural providers.

Progress on gap analysis

The Residential+ Study, mentioned earlier, provided goals associated with licensed adult residential care capacity for both adult mental health and substance use disorder services. A dashboard tracking OHA's progress towards those goals can be found here. As of March 25, 2025, the progress is good. The chart below shows current capacity, projected capacity based on projects in progress, and the ultimate goals statewide.

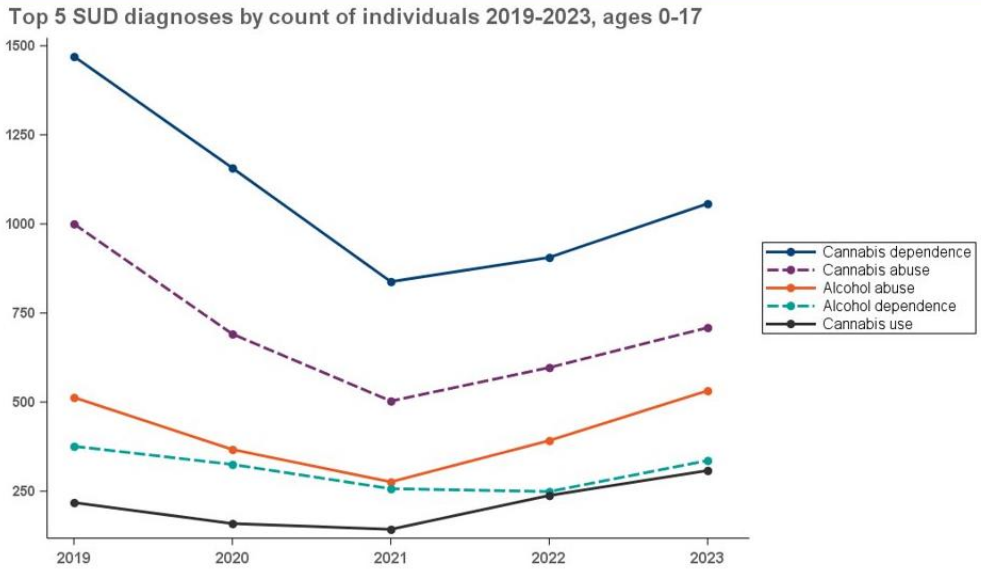


April 23, 2025 Responses

Substance use disorder training for youth providers relating to alcohol and cannabis

The chart below shows the changes in most used substances for ages 0-17 based on the results from the Student Health Survey, administered by the OHA Public Health Division. The report can be found here.

Top 5 SUD diagnoses, ranked by count of individuals, ages 0 – 17, 2019 – 2023



Counties served by Certified Community Behavioral Health Clinics (CCBHCs)

Oregon has a CCBHC in the following counties: Multnomah (2 CCBHCs), Columbia, Grant, Deschutes, Klamath, Washington, Hood River, Wasco, Sherman, Josephine, Lane, Harney, Wallowa, Yamhill.

The $7 million cost savings is a relative annual cost savings calculated by using a change in utilization multiplied by a uniform cost for selected categories and normalized to the CCBHC population's member months. OHA assessed 22 services categories including but not limited to MH inpatient services, emergency department visits (MH, SUD, and physical), outpatient primary care, MH adult residential, and SUD residential.

Quantifying CCBHCs' annual increases in access

There was a 3.6% increase between 2017-2019 (36,777 to 38,106). There was an additional 1.2% increase from 2019-2021 (38,106 to 38,592). OHA does not have data on differences between 2021 and 2022; however, there was a 1% decrease from 2022 to 2023 (35,890 to 35,364). 50,031 unique persons were served between 2021-2023.

Individuals served annually by the problem gambling program

For fiscal year 2023-2024, the problem gambling treatment system served 849 clients, with 10,788 treatment encounters. Compared to the previous fiscal year, the number of clients treated increased by 6.7%. In addition to traditional treatment services, funding for problem gambling services also includes wraparound type resources, such as free access to a gambling related health app and gambling financial services from financial counselors, along with prevention, intervention, and recovery services, data collection, evaluation and workforce and professional development efforts.

Effectiveness data for harm reduction programs

The Substance Abuse and Mental Health Services Administration (SAMHSA) defines harm reduction as *"A practical and transformative approach that incorporates community-driven public health strategies — including prevention, risk reduction, and health promotion — to empower people who use drugs (PWUD) and their families with the choice to live healthy, self-directed, and purpose-filled lives. Harm reduction centers the lived and living experience of PWUD, especially those in underserved communities, in these strategies and the practices that flow from them."* At the heart of harm reduction is listening without judgment or agenda, meeting immediate basic needs, and supporting the personal health goals of people who use drugs. While supplies such as naloxone, sterile syringes, sharps containers and wound care kits are also essential to the mission, they serve as a bridge to authentic, trust-based relationships and services.

Harm reduction is backed by decades of research and evidence. Over 19,000 overdose reversals have been reported by Save Lives Oregon partners — and the real number is likely to be much higher because a number of Save Lives Oregon partners distribute naloxone in ways where reporting use is not possible, such as at jail release, onsite through EMS/Fire responses and more. Harm reduction strategies are shown to substantially reduce HIV and hepatitis C infection among people who inject drugs, reduce overdose risk, enhance health and safety. Lastly, people who inject drugs are five times more likely to enter treatment after engaging with sterile syringe programs.

While many community members are aware of harm reduction programs that “stand alone”, like Syringe Service Programs, harm reduction strategies are integrated across the Substance Use Continuum of Care interventions, social service programs and community safety agencies in Oregon.

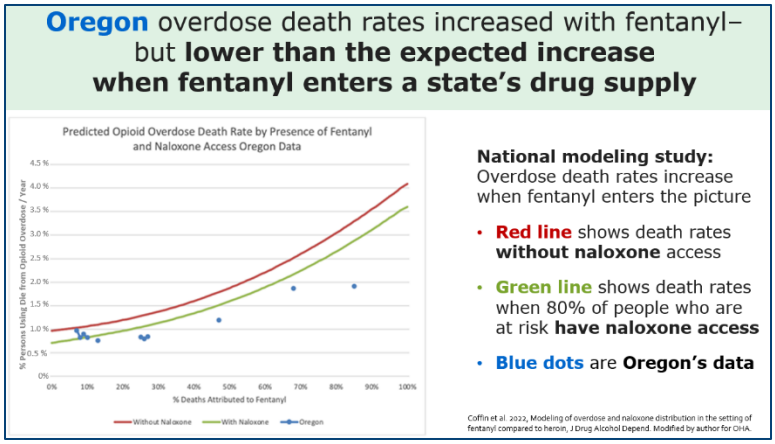
For example, the harm reduction strategy of naloxone distribution prevents opioid overdose deaths, and this strategy is implemented by a wide range of entities from syringe service programs to peer recovery programs, substance use treatment, fire/EMS, jails, food banks, libraries and more.

From the Save Lives Oregon Partners: In the Save Lives Oregon 2024 Annual Survey one of the questions was “What do you wish people understood about harm reduction?” and answers from participating agencies included

- *”That it is a holistic approach to having an individual feel safe and not segregated from society. Those who participant in Harm Reduction efforts are more likely to quit drug use, unsafe sex and are able to heal from wounds from drug use. These individuals are also likely to become productive members of society, gain meaningful employment, and sustainable housing."*
- *Harm reduction builds trust. Harm reduction is a tool of care and community. if people can get support without judgement, they will more likely ask for other support and get help*.
- *That it not only saves lives but it creates relationships between organizations and the people that are need of services seeing a friendly face that is willing to show up for them helps them when they are actually ready to get clean to know exactly where to go and who to turn to.*

Harm reduction strategies, like overdose education and naloxone distribution, in combination with increased access to medications for opioid use disorder (MOUD) and increased linkage to and retention in MOUD treatment improve outcomes for people with opioid use disorder. Harm reduction outcomes include reduction in substance use and/or risk behaviors and decreased opioid deaths.
Harm reduction strategy outcomes have been documented by the Save Lives Oregon Initiative and Oregon’s State Opioid Response (SOR) program PRIME+ program.

The graph shown below was modified from the Journal of Urban Health Paper “Modeling of overdose and naloxone distribution in the setting of fentanyl compared to heroin” by the author, Dr. Phillip Coffin. The original graph was developed based on data from national epidemiological studies of overdose mortality. The graph illustrates the opioid overdose death rate increases as fentanyl enters the drug supply.



This suggests that widespread naloxone distribution made possible by community projects, including Save Lives Oregon since 2021, slowed the growth of opioid overdose death rates in Oregon. This estimate is especially remarkable considering the steady growth of fentanyl-involved overdose deaths over the same period. The Oregon data also demonstrates the importance of continued prioritization of naloxone distribution in high-yield settings, including the direct distribution of naloxone to people who are using drugs.

Peer Recovery Initiated in Medical Establishments + HCV/HIV Testing and Linkage to Treatment (PRIME+) are other prime examples of harm reduction programs with positive impact:

- PRIME+ connects certified Peer Support Specialists and Certified Recovery Mentors with people who are at risk of or receiving treatment for overdose, infection, or other health issues related to substance use.
- PRIME+ peers engage people who may be out of treatment and who are at varying stages of change using a harm reduction approach.
- The goals of the PRIME+ are to (1.) prevent acute life-threatening outcomes of substance use, and (2.) connect people to resources, services, and care for substance use related conditions.

In addition, outcomes from a recent PRIME+ Evaluation (December 2022 to September 2024) show:

PRIME+ served 3,928 participants. Fifty-four percent (54%) of participants received three or more contacts and PRIME+ peers recorded 25,738 total participant contacts during the evaluation period.

The referrals to PRIME+ originated from hospitals or emergency departments (26%), referrals by self or loved one (26%), and peer outreach (19%). Sixty-nine percent (69%) of PRIME+ sites linked people to telemedicine buprenorphine.

PRIME+ peers linked participants to infectious disease testing and treatment, substance use treatment, and recovery support groups. Of the 402 participants tested for hepatitis C, 37% tested positive, and 56% of those who tested positive received treatment.

Almost 1,000 participants received either substance use treatment or medications for SUD.

Statistically significant changes documented by PRIME+ from intake to 6-month follow up included:

- Decreases in the number of days of substance use reported (from 22.3 to 19.1 days).
- Decreases in Emergency Department visits for substance use related issues (from 32.6 to 13%).
- Decreases in client self-reported anxiety (from 84.5 to 76.1%).
- Decreases in client self-reported depression (from 77.4 to 64.6%).
- Increases in housing in the past 30 days (from 49.1 to 62.6%).
- Increases in employment status reported (from 15.9 to 27.3%).
- Increases in any lifetime HIV testing (from 72-83.9%), and
- Increases in any lifetime Hepatitis C testing (from 73.9 to 82.9%).

Generally, substance use treatment programs that collaborate with harm reduction centered programs and substance use treatment programs that integrate harm reduction strategies have the potential to reach more people who are using substances with information, tools and supplies that can improve their health, save their lives, and support continued engagement.

How Oregon compares to other states for services for children, including PRTF and services for behavioral health

Oregon has been working with the University of Connecticut to both evaluate Oregon as it compares to other states' use of Medicaid (report), and to achieve best practices in Oregon based on the System of Care model. At times it can be difficult to compare because Oregon manages Medicaid dollars differently than other states with the CCO model, so comparisons are not always appropriate.

OHA continues to work toward national best practice models and programs utilized in other states. Oregon has implemented Intensive In-home Behavioral Health Treatment (IIBHT) and Mobile Response and Stabilization Services (MRSS), which are used successfully in other states. The 2023 Ombuds report recommends expanding these models and streamlining the youth system to be less confusing for parents and more similar to other states in providing comprehensive community supports.

Connecting youth to appropriate treatment and placements

Oregon is not unique in facing challenges connecting youth to appropriate treatment and placements. Many states are facing similar challenges as Oregon as it relates to the need for placements of children involved with child welfare, as well as ensuring they have a full robust flexible continuum of care for all children to access. When the children's behavioral health continuum is not resourced to be able to meet the health care needs of children, when they need it – often the child and family teams are looking for the closest, next best treatment to meet the needs of the youth. Sometimes if placement (a need to find a place for the child to live) also becomes a need, the treatment need and placement need can become intermingled. OHA works closely with ODHS on the treatment needs of children and families in their care and continue to advocate to resource the behavioral health continuum, in order to have the right service at the right time for the duration needed.

OHA has also worked with University of Connecticut on the implementation of SB 1557, and a comprehensive review of state processes for determining appropriate level of care for Psych Under 21 was conducted as part of their study. It was determined that Oregon's current system varies significantly across the state and requires a consistent definition and process for determining level of care. OHA is working to develop these definitions, in conjunction with families, CCOs, providers, and national best practice models.

Tracking usage of restraints and seclusion on youth

The Oregon Department of Human Services (ODHS) maintains data on restraints and seclusions, as required by statute, and providers across the state report data to them.

OHA is finalizing the most recent Restraint and Seclusion report and will be published on the Child and Family Behavioral Health website. OHA agrees that further analysis of both Oregon's data and that of other states is needed. OHA will work to identify resources for this level of research and analysis.

Progress on residential facility numbers and expansion

OHA publishes a dashboard to show the progress: https://www.oregon.gov/oha/hsd/amh/pages/housing-dashboard.aspx

Needs assessment for youth residential facilities

OHA and ODHS were directed by the Child Welfare Oversight Board on July 31, 2019, to conduct a joint analysis to review system capacity needs at the PRTS level of care within Oregon and make a recommendation to develop additional capacity if needed. The goal of 286 beds came from that analysis. Additional details can be found in this memo of this process and annual memos detailing both agencies' efforts can be found here.

As referenced in the presentation OHA has built and implemented with providers the Referral Capacity Management system that is giving us real time data on the referrals and bed availability. In addition to this data and reported we are working collaboratively with ODHS to research further. OHA is also working with OHSU on their capacity system to ensure that the needs of the children's system are included in their efforts.

Oregon's specialty care programs

Oregon does have programs that specialize in areas of treatment for children and families. For example, one psychiatric residential treatment program, Clementine, is an eating disorder program, and they recently expanded and opened a new program last month adding additional capacity. Another example is Looking Glass, this provider has two programs providing psychiatric residential treatment specific to children involved with Child Welfare. It is clear from the data, as well as partners in Child Welfare and community that Oregon continues to need more access for children and families to get the treatment they need, when they need it.

In consultation with other states through the National Association of State Mental Health Program Directors (NASMHPD) OHA is aware that other states also are challenged to right size their children's continuum of care including residential and specialty care. For example, in a recent survey of states Oregon was one of few states that have residential treatment for eating disorders.

As Oregon continue to build up and better resource the children's behavioral health system, providers will be able to better respond to the individual needs of children and families, including specialty needs, and serving youth closer to their families, homes, and communities.

Out-of-state specialty care access

Coordinated Care Organizations (CCOs) do have the ability to access healthcare outside of Oregon, inclusive of Behavioral Health treatment and specialty services, for their members. If an out of state provider chooses to become a Medicaid provider for Oregon, members of Fee for Service OHP can access these services as well.

There is current statute that restricts access for children in Child Welfare custody from receiving treatment out of state unless the provider is fully licensed and certified by the state of Oregon. Often, out of state providers are hesitant to do this due to the administrative burden and complexity of following multiple state laws, requirements, and licensing standards. There is current legislation proposing changes that would create a different process for these children to access care outside of the state if it is medically necessary and appropriate – and is not available in Oregon.

PRTF capacity improvements vs historical capacity

OHA does have this information currently including the number of current licensed beds, program beds and the number of youth waiting for these programs. While OHA does not license the beds (this is done through Oregon Department of Human Services) OHA did begin tracking available beds and capacity during the COVID pandemic. OHA has built a Referral Capacity Management (RCM) system to continue to closely monitor residential capacity. Using the RCM system, OHA will be able to develop reports and analysis to support policy and decisions about the system development and expanding capacity moving forward.

OHA is unable to determine the number of beds from past compared to present outside of what has been published previously. OHA is willing to partner in these conversations and look at the timelines and history as it relates to programs that were licensed through OHA.

Thank you again for the opportunity to testify in front of your subcommittee on these important topics.

Sincerely,

Kris Kautz
Acting Director