ASSOCIATION OF OREGON COMMUNITY MENTAL HEALTH PROGRAMS
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Testimony in support of SB 832A with the -5 Amendments

May 28, 2015

Dear Chair Rosenbaum and Members of Senate Committee on Rules,

On behalf of the Association of Oregon Community Mental Health Programs (AOCMHP) I would like to express our support for SB 832A with the -5 amendments. We are particularly happy that behavioral health homes have been included as a critical component of integrated care for people whose primary diagnoses are mental health or substance use disorders. As we have worked on the revision of this bill it has become clear that we need to provide education to dispel myths about the current state of the community mental health system.

First, in order to provide integrated care for all Medicaid recipients, there must be more than a one size fits all model. Although the majority of CCO members will go to a patient centered primary care home (PCPCH), some people with severe and persistent mental illness or co-occurring disorders will prefer behavioral health homes (BHHs) when there is a choice. While these individuals represent a smaller percentage of the total Medicaid population, the cost of care for their complex conditions is a disproportionately higher percentage of total health care costs. It is very important that we are careful about how to build the model of care across the state to accommodate people who are not as effectively served in a PCPCH. If we only consider adults with serious mental health, substance use or co-occurring disorders, about 15% of the 600,000 adults with Medicaid in Oregon, or 90,000, may be best suited to receive integrated care at behavioral health homes *(Dale Jarvis & Associates)*. Even if only half of this population chooses to go to behavioral health homes, 45,000 is a significant number of people who could benefit.

Second, people with serious mental illness <u>do</u> receive services from both licensed and unlicensed behavioral health providers. Staff in the lead positions are licensed, and therapists and other masters-prepared qualified mental health professionals (QMHPs) are more likely to be licensed, while qualified mental health associates (QMHAs) who provide case management, wraparound, engagement, and monitoring services, skills training, and employment assistance are not.

Most counselors are licensed or working toward licensure, which requires considerable supervision by licensed staff. It takes two to three years after completing a graduate degree to gather enough supervised hours for licensure. Community Mental Health Programs (CMHPs) work closely with staff on the process to become licensed in Oregon and pay for the cost of obtaining the license.

Although there is no registry for unlicensed QMHPs, they do apply for a Medical Assistance Program (MAP) provider number, and the designation of QMHP by the mental health director is based on education, training and experience. CMHPs go through a credentialing process required for all QMHPs, which includes setting policies for required trainings that mirror requirements of most licensing boards.

AMH reviews the documentation of QMHP designations at site reviews. For Addictions or Problem Gambling Counselors, certification is the credential, and Continuing Education is a requirement for retaining the certification.

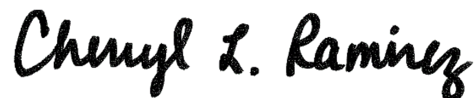
Unlicensed QMHPs are allowed to diagnose and develop treatment plans at community mental health centers certified by the Division of Addictions and Mental Health (AMH)/Oregon Health Authority, however, unlicensed providers must gain approval from a licensed provider to deliver the recommended care. Any treatment plan developed by an unlicensed QMHP must be signed off by a Licensed Health Care Professional *(OAR 309-019-0140: Service Plan and Service Notes)*. Unlicensed QMHPs must also receive clinical supervision *(OAR 309-019-0130: Personnel Documentation, Training and Supervision)*.

Third, in Oregon we have a licensed behavioral health workforce shortage. Virtually all of our CMHPs have struggled to recruit sufficient numbers of licensed clinical social workers (LCSWs), licensed professional counselors (LPCs), licensed marriage and family therapists (LMFTs), psychiatrists and psychiatric nurse practitioners. Many new hires are coming from out of state – competition is high and increased wages, flexible hours, and other benefits must be offered to fill positions. Several regions have a Health Resources and Services Administration (HRSA) designation that recognizes this shortage.

Licensed QMHPs, unlicensed QMHPs working toward licensure, QMHAs, Psychiatrists, Psychiatric Mental Health Nurse Practitioners, Nurses, and peer support specialists all work together within CMHPs to perform integral clinical and support functions for people with complex mental health and substance use disorders, and are essential partners in Oregon's healthcare transformation.

Thank you for the opportunity to provide testimony in support of SB 832A with the -5 amendments and to address the critical roles of Behavioral Health Homes, Patient Centered Primary Care Homes, and licensed and unlicensed behavioral health care workers for the successful implementation of integrated care in Oregon.

Sincerely,



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