Testimony for LC 270
Oregon State Senate Mental Health Committee
Improving Co-Occurring Disorders Treatment in Oregon

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High Value Populations
For the past six years, my agency, in collaboration with the local CCO, PacificSource Community Solutions, has been building services for two high-value populations:

1. People with severe mental illnesses who do not engage with the community mental health program, but cycle through the county jail and local emergency departments. Nearly all of these people have a co-occurring substance use disorder, multiple medical problems, insecure or no housing, and are at risk of state hospitalization.
2. People with substance use disorders (80% alcohol) who are high utilizers of the emergency departments and hospitals. The majority of these people also suffer from chronic depression, PTSD, multiple serious health problems, including heart disease, diabetes, chronic pain, etc. Virtually none of these people have engaged previously in mental health or substance use disorder treatment.

These two populations are high value because they cost the health care and public safety system an extraordinary amount of funds, time, and energy, and we have shown that if we can engage them in effective services we can dramatically reduce the costs to the systems.

Recent Initiatives in Service Array

1. In recent years, the Oregon State Legislature and the Oregon Health Authority have provided funding to the CMHPs for mobile crisis, jail diversion, mental health courts, assertive community treatment, and mental health peer services. This has gone a long ways toward providing a continuum of outreach and engagement services aimed at people with severe mental illness who are not otherwise engaged in services.
2. In the past year, through grants provided by PacificSource, BestCare and St. Charles Health Systems have collaborated to embed behavioral health Community Engagement Teams in all four Central Oregon hospitals (Bend, Redmond, Madras, and Prineville). Each team is engaging 30-50 patients a month who are high utilizers and have serious behavioral health problems. The early data is that this approach is reducing Emergency Department and medical floor readmissions by 75%.
3. For the past three years, BestCare and St. Charles Women's Center for Health have provided outreach services to pregnant women who are using opiates or methamphetamine. We have been able to engage over half these women in

long-term SUD treatment, fundamentally changing the life trajectory of their children.

Gaps that the Initiatives have Highlighted

1. **All of the initiatives are grant funded and not eligible for Medicaid billing.** Because the rules for Medicaid billing for behavioral health require an extensive assessment and approved service plan, these rules require a person to be already motivated for behavioral health services before we provide services. This means that the highest value populations are excluded artificially and providers are financially punished for providing services to them.
2. **The recruitment and retention of qualified staff has been a huge barrier to effectively implementing services to these high value populations.** There are not many people both qualified and motivated to provide services to these complex people and our pay ranges are not competitive. The housing crisis continues to be a problem in recruitment, with prospective staff withdrawing from consideration when they see the cost of housing or just the lack of housing.

Needed Reforms

1. **Implement a Treat First Model:** Outreach and engagement are critical components of the service array to reach the highest value populations.
2. **Co-Occurring Treatment facility licensing**, coupled with higher rates to support the higher costs of services.
3. **Work Force**
    a. Pay and benefits: With current reimbursement rates, we are not able to pay our staff the wages that can draw people into the profession. If a potential employee has actually chosen our profession, community-based behavioral health providers are unable to compete with hospitals and primary care clinics, who now hire behavioral health staff. These outreach models draw in a new set of clients into our services, clients who are more complex than we have seen before. These more complex clients require us to change our treatment services and employ better-trained staff.
    b. Training and licensing: training and licensing standards have not kept up with the rapidly changing field. In many ways, the licensing boards have been making it more difficult to recruit staff from out of state or to work at their full scope of practice.
4. **Antiquated administrative burden:** The basic framework of our administrative system in behavioral health seems to reflect the best thinking of the 1980's. Too often we need two assessments and two treatment plans to provide the necessary treatment.
5. **Reimbursement for Peer Services:** Our most productive peer staff can only cover half their costs. The staff who are doing the most outreach and engagement are the "least" productive in a fee-for-service model.

Oregon should focus on becoming the place to go for behavioral health professionals: better wages, less regulatory burden, welcoming environment, supportive credentialing process and a place to live.