Substance Use Disorder Accreditation Workgroup
Report and Recommendations
June 2021

Background and process

As required under House Bill 2257, the Substance Use Disorder Accreditation Advisory Group (SUDAAG) met in 2020 and 2021 to determine a recommendation to the Oregon Health Authority about the establishment of accreditation requirements for treatment programs for substance use disorders (SUD). The legislation required that these recommendations be completed by June 30, 2020, but given the Covid-19 pandemic, meetings were postponed. After a hiatus, the Workgroup resumed its work.

Throughout its meetings, the SUDAAG discussed the benefits and challenges presented by requiring accreditation. In addition, with OHA staff assistance, the group gathered and discussed information from accrediting bodies and other entities and heard from SUDAAG members whose organizations had been through the accreditation process. The SUDAAG held two listening sessions to ensure SUD providers across Oregon had the opportunity to share their perspective on the Workgroup's draft recommendations. Treatment providers and stakeholders across Oregon brought forward concerns and questions that can be categorized in the following ways: 1) implications for small, rural, and/or culturally specific providers; 2) administrative and/or financial burden; and 3) relevance and value of accreditation. Workgroup members compiled and synthesized the feedback with the goal of determining if the recommendation was unrealistic, or if it could be revised in a manner that addressed any potential negative or unforeseen consequences. The group believes the recommendations, implemented as outlined below, adequately address the concerns raised.

Final Recommendation

The SUDAAG recommends that the state of Oregon require substance use disorder treatment programs become accredited by any one of the following national accrediting bodies: The Commission on Accreditation of Rehabilitation Facilities (CARF), the Council on Accreditation (COA), or The Joint Commission (TJC).

Building upon Oregon's ambitious position of leading health reform, the Workgroup believes it in the best interests of individuals currently served by substance use disorder treatment programs in Oregon, those in need of care, and all the residents of the state that this requirement be put into effect for the benefit of all impacted by the preventable devastation of substance use disorders.

Through the Workgroup's external research and organizational experiences, we concluded an accreditation mandate benefits Oregon's full continuum of treatment services because:

1. It has been demonstrated that accreditation provides organizations with a stable framework from which to deliver safe, high quality, and effective care, treatment, and services. Accreditation standards are developed by experts in behavioral health care and addiction medicine. Accrediting bodies provide organizations with technical support and resources vetted by hundreds of other similar organizations providing SUD treatment.

2. Accreditation is an established means of assuring care is individualized, that it is evidence-based and incorporates clinical best practices. Accrediting organizations lead the national effort to measure treatment quality and identify benchmarks to inform care delivery. Accreditation goes beyond clinical standards by focusing organizations on performance improvement, risk management and quality assurance to improve care.

3. An accreditation requirement aligns with the Alcohol and Drug Policy Commission's 2020-2025 Strategic Plan and its goal of implementing "a statewide system that ensures that substance misuse policies, practices, investments and efforts are effective and result in healthy and thriving individuals and communities" (pg. 28). As detailed throughout this recommendation, the accreditation mandate serves to:
    a. Increase the degree to which state agency leadership is working together to coordinate efforts and maximize resources
    b. Increase system capacity to solve substance use problems and implement needed changes to operations
    c. Increase the system's ability to use the most effective practices, processes and programs for priority populations and problems
    d. Increase the system's ability to reduce health disparities and to promote health equity among all vulnerable and at-risk populations
    e. Increase the system's ability to be accountable
    f. Increase the system's ability to be sustainable

4. Accreditation for SUD care will move behavioral and addiction treatment in Oregon closer to parity with medical/surgical care, which has required accreditation for decades. Essentially, accreditation will help to “level the field” between behavioral health care organizations and medical/surgical care providers. Increased scrutiny of the behavioral health field is imminent, with governing bodies and insurers rightly expecting assurance of quality, application of standards and organizational accountability. Accreditation for substance use programs supports Oregon’s capability to respond to this growing demand, rather than leaving it to react to external influence after the fact.

5. Above and beyond this ambition, members of the Workgroup assert that adoption of an accreditation requirement will accelerate Oregon’s goal of truly integrating care for

substance use and mental health disorders. The national accrediting bodies have fully integrated their accreditation requirements for substance use and mental health disorders such that behavioral health care organizations can be accredited to provide care, treatment and services for individuals who have either a substance use disorder, a mental health disorder, or who have both a substance use and a mental health disorder. Rather than taking on this work itself, Oregon's behavioral health leadership can adopt accreditation standards and be confident that high-quality, responsive and meaningful care can be assured statewide.

We acknowledge the mandate of accreditation may bring with it confusion or anxiety, and it will not be achieved without effort. While the Workgroup recommends the state require accreditation of all SUD providers that would otherwise be mandated to hold license or certification of approval from Oregon Health Authority (OHA), the mandate must be accompanied by the following qualifications so as to eliminate unnecessary redundancy and minimize burden to organizations:

<u>Requirements to Succeed</u>

1. **"Recognition" of accreditation standards**
   a. The accreditation requirement must be accompanied by a reduction of state and CCO surveillance to avoid duplication and undue administrative burden. Achieving accreditation by one of the three national accrediting bodies will be sufficient for programs to meet specified OHA and CCO requirements. Therefore, accredited organizations shall be "recognized" as meeting specified state licensing and CCO auditing conditions.
      - To sufficiently maintain licensing and certification responsibility, OHA and the CCOs shall utilize a crosswalk of standards, to be produced by applicable accrediting bodies (CoA, CARF, Joint Commission) as their guidance when determining *what if any* Administrative Rules or CCO contractual requirements are not sufficiently and meaningfully captured by the accrediting body's published standards. The state would then only conduct reviews on those state standards that the accrediting bodies do not capture in their accreditation. CCOs, by the direction of OHA, would engage in a similar process to streamline and unify provider auditing.
      - The Workgroup acknowledges some changes to CCO requirement(s) may not be feasible until the renewal of the current CCO contract period ending in 2024. The Workgroup expects this requirement will be incorporated into the next iteration of CCO contracting.

   b. "Recognition" is a specific term used to formally accept that, when an organization meets provisional or fully accredited status, it can be recognized as thereby meeting state-imposed standards. This process of recognition has precedent in other states, notably

Alaska, which requires all behavioral health service providers be accredited in order to receive state approval.

c. OHA shall maintain its role in certification and licensing facilities, but through this process of recognition it agrees not to burden organizations with duplication of review by their own body when an organization is able to successfully adopt and maintain independent national accreditation.

2. **Oregon Health Authority staffing and oversight**
   a. The Workgroup recommends that the Oregon Health Authority dedicate one to two FTE, including one senior administrative position, to lead and publicly champion the SUD accreditation requirement. The work of this staff would include, but may not be limited to:
      - Convening an advisory group that will meet regularly to provide guidance and support to OHA in the development and implementation of the accreditation initiative.
      - Planning and implementing of the state's SUD accreditation initiative. OHA staff are strongly encouraged to engage with other states that have previously implemented similar requirements
      - Proactively, clearly and regularly communicating with SUD providers about the planning and progress of the state's SUD accreditation initiative.
      - Facilitating provider accreditation education sessions that are readily accessible to all SUD providers in the state.
      - Convening provider, CCO and accrediting body representatives on a regularly scheduled basis (frequency TBD) to ensure continued alignment in goals, understanding of impacts, and to allow input in the implementation
      - Creating an informational repository and linkage resource so providers may connect directly with technical assistance, consulting services, and connection to currently accredited SUD providers who are willing to mentor organizations through the process.
      - Developing and auditing the process by which organizations will apply for and be awarded financial support.

   b. The Workgroup recommends that the Oregon Health Authority report annually to the Oregon Legislature on the progress of the SUD accreditation initiative throughout the implementation term.

3. **Timing of implementation**
   a. The Oregon Health Authority, through its dedicated staff and advisory group(s) shall develop and oversee a "phased" or "rolling" approach to implementing the accreditation requirement, beginning with a statewide educational and technical assistance campaign, allowing reasonable time during which organizations can review their accreditation

options, prepare for accreditation, apply for any available funding, and complete the required steps for an initial survey.

- Phases shall include:
    1. A statewide campaign directed to behavioral health providers, focused on promoting a) awareness of the new requirement and its implications for existing state certification/licensing; b) the phases, including a timeline, that demonstrates how implementation will occur statewide; and c) an overview of the value of accreditation.
    2. Initiation, completion, and publication of the results of the recognition process, including justification of any OARs and CCO requirements that must be certified directly and separately from accreditation standards. Opportunity for public question and comment is encouraged prior to final publication.
    3. A staggered approach to statewide adoption that geographically distributes timeline requirements so as to mitigate any foreseeable disruptions to services that could occur if several local organizations seek accreditation simultaneously
    4. The state will be transparent in notifying providers about the phases, the timeline, and all relevant deadlines. These notifications will be published and shared with providers.
- Total time to complete all phases will be no less than 24 months, no more than eight years, and will commence no later than 1/1/2022.

4. **Financial support for organizations**
    a. Financial resources must be designated by the Oregon Legislature in order to assure complete and successful implementation of the requirement. This is of specific concern for SUD providers that are small, rural, and/or offer culturally specific services. The legislature and OHA should investigate all possible sources of funds, including but not limited to Medicaid dollars, tax revenue (marijuana, tobacco, alcohol), lottery funds, Covid-19 relief funds, opioid settlement funds, and cost savings from shifts in Health Systems Division: Licensing and Certification funding.
    b. The Workgroup emphasizes that funding to support the recommendation ***must not be diverted away from existing reimbursements or provider funds***.
    c. Funds identified by the Oregon Legislature to support this initiative would be dispersed over the full length of the timeframe, suggesting that only a portion of the funds must be identified and set aside each year.
    d. Organizations need financial support to achieve initial accreditation. Funding should be targeted toward the dedication of staff, participation in technical assistance provided by the accrediting body or a private consultant, and for the application for initial accreditation.

e. Given significant variability in organizational size and existing provider accreditation status, the Workgroup recognizes it is difficult to know the cost for all SUD providers to achieve accreditation. While this group does not have access to all of these details, we submit with this recommendation a template for determination of provider funding levels. We recognize further analysis by OHA is required to estimate full cost over the lifetime of the project.

f. The Workgroup suggests below a strategy for dissemination of funding. *It should be considered draft*, but we believe the format and parameters effectively mitigate concerns about equitable distribution and disproportionate impact. Essential is the designation of full support to organizations providing tribal, culturally, or linguistically specific care:

SAMPLE

OHA will fund initial accrediting activity at the following rates, with a total maximum allowable of $60,000 per provider across the designated period. Organizations will be required to submit budget detail and justification prior to approval.

Permissible activities for funding include:

- Staff FTE dedicated to implementation and assurance of required policies. FTE may represent staff exclusively dedicated to accreditation, or may be portions of FTE distributed across individuals employed by the organization.
- External consultant(s) or contractors
- Technical Assistance provided directly by an accrediting organization
- Onsite initial survey fees and first year of accrediting fees
- Up to 10% of total requested funds may be dedicated toward facility improvements.

The following formula will be used to determine the percentage of funding provided:

0-75 FTE	76-150 FTE	151-300 FTE	301+ FTE
100%	75%	50%	25%

- Organizations for whom at least 51% of operations are dedicated to tribal, culturally or linguistically specific care will be funded at the 0-75 FTE level regardless of organization's FTE
- Organizations for whom all or a portion of programs are already accredited will be funded at a maximum of 50%, regardless of organization's FTE

SAMPLE

Equity considerations

The Workgroup wants to ensure that accreditation promotes, rather than negatively impacts health equity. The Workgroup reflected on and heard concerns about potential for negative impacts on culturally relevant care and the possibility of unintended impacts on disparities. Preliminary background research found no indication that accreditation would exacerbate disparities, but this must remain a focus. It is critical that these programs are able to maintain culturally specific clinical and operational practices.

Impacts on small/rural providers

The Workgroup is concerned about the impact on small and rural providers. As with concerns raised about equity impacts, the group found no indication that accreditation represented an insurmountable achievement for small/rural providers. However, we anticipate disproportionate financial burden for those organizations with limited infrastructure and the distribution of funds must recognize this. Additionally, any implications for the workforce, which is already strained, need to be considered when rolling this requirement out statewide.

Attached to these recommendations are the following:

- Workgroup roster with additional information about represented organizations
- Public input
    - Summation of questions and comments from two listening sessions
    - Letter submitted to Oregon Health Authority by the Tri-County Behavioral Health Provider Association
    - Letter submitted to the SUDAAG Workgroup by CareOregon

This report is submitted by the Substance Use Accreditation Advisory Group. We had consensus on our recommendations with one dissenting vote from Lifeworks NW.

First Name	Last Name	Title	Organization
Francesca Barb	Barnett Seater	SUD Services Director (member until 12/2020) Associate Clinical Director (member starting 12/2020)	Lifeworks NW/Project Network Lifeworks NW
Dr. John	Hardy	Medical Director	AMG Physicians LLC
Barbara	Heath	CEO	Transformations Wellness Center
Lisa	Hubbard	Director of Training and Staff Development	Adapt
Dr. Alan	Ledford	Executive Director	OnTrack, Inc.
Cynthia	Levesque	Director/Therapist	Kolpia Counseling Services
Dr. Moxie	Loeffler	President	Oregon Society of Addiction Medicine
Megan	Marx	Director of Integrated Care	ORTC, LLC
Tim	Murphy	Executive Director	Bridgeway Recovery

Alison	Noice	Executive Director	CODA, Inc.
Eva	Williams	Deputy Director	Willamette Family, Inc.
DJ	Alex*	Behavioral Health Peer Support Outreach Specialist	Providence Health & Services *Appointed to Workgroup; did not participate.

Substance Use Disorder Accreditation Workgroup

Additional Information about Workgroup Membership

June 2021

Francesca Barnett (Member until 12/2020)

SUD Services Director, Lifeworks NW/Project Network

Size of Agency: LifeWorks NW is in Multnomah, Clackamas and Washington county with over 600 employees.

Service Location(s): Washington, Multnomah and Clackamas Counties.

Services Provided: Outpatient MH and Addictions services for adults, children and youth.
Full spectrum of MH services from crisis response, ACT, outpatient, residential facilities. Culturally specific Residential SUD and MH services for Black women and children. We also serve women of other racial / ethnic backgrounds. SUDS include IOP and OP, and DUII services. Residential Treatment for women and children.

Individuals Served: Project Network is culturally specific for Black/African American women and children, Spanish speaking IOP in Washington county, culturally specific for Black/African American youth. Integrated BH and medical at Virginia Garcia.

Additional Information: I am Black and Native American - Muscogee Creek Nation- and a person with lived experience. Project Network employs individuals with diverse backgrounds and lived experience.

Barb Seatter, CADC III, MS

Associate Clinical Director, LifeWorks NW (Advisory member starting 12/2020)

See above for agency information
Additional Information: I am a white woman with lived experience, in recovery for 35 years. LWNW employs 12 Peer Specialists/Certified Recovery Mentors and a peer coordinator who supports these staff. Our culturally specific programs employ staff with like racial backgrounds and many counselors share lived experiences with addiction.

John H. Hardy, Jr., M.D., FASAM

Medical Director, AMG Physicians LLC

Size of Agency: Solo practitioner in a small medical group and medical director of a rural 20-bed residential program.

Service Location(s): Provide services in Portland, and Klamath Falls (via telehealth).

Services Provided: Addiction Medicine, primarily medication assisted treatment (MAT) for opioid use disorder.
Individuals Served: Primarily adult patients, not focused on any specific cultural, demographic.

Additional Information: I am Caucasian, non-ethnic; no lived experience regarding SUD; work with physicians in my group practice, and counselors in the rural program, who have SUD lived experience.

Barbara Heath, BS, MA, CADC II, QMHP

CEO, Transformations Wellness Center

Size of Agency: 24 employees

Service Location(s): Klamath Falls, Klamath County, we have both rural and health care worker shortage designations.

Services Provided: Outpatient, DUII, OBOT, peer support services and residential SUD treatment.

Individuals Served: Any adult age 18 or older from any background, race or culture.

Additional Information: I am a person with lived experience (in recovery) for the past 34 years and I am also part of Oregon's aging population. 83% of our employees are people with lived experience and 42% of our employees are from our local BIPOC and LGBTQIA+ communities.

Lisa Hubbard LCSW

Director of Training and Staff Development, Adapt Integrated Health Care

Size of Agency: 400 employees across 3 divisions (mental health, SUD, medical care) and across counties (Douglas, Coos and Josephine).

Service Location(s): Primary care, SUD and MH in Douglas County (primarily Roseburg) and SUD services in Josephine and Coos counties. All counties and locations served are considered rural.

Services Provided: SUD – outpatient for youth and for adults, residential for adults and for youth, OTP (2 locations), sobering center, sober housing for CWP involved families in early recovery; MH – we are the CMHP in Douglas county and provide all safety net and specialty programming as well as general outpatient therapy / medication management for all ages; medical – we have a primary medical clinic with two locations in Douglas county.

Individuals Served: SUD- youth and adults; MH- all ages, Medical – all ages.

Additional Information: I am Caucasian. We employ peers / persons with lived experience in MH / SUD in several of our programs.

Alan Ledford, PhD

Former Executive Director at OnTrack Rogue Valley, owner of Dragonfly Behavioral Health Consulting

Size of Agency: 115 employees Most of these individuals have lived experience.

Service Location(s): Jackson and Josephine Counties, serving Josephine County in Merlin, Cave Junction and Grants Pass.

Services Provided: Services include residential treatment for women and their children, men and their children in Jackson County; a coed residential facility in Josephine County; outpatient services are offered in Grants Pass, Cave Junction, and Medford; DUII services for adolescent and adult clients, batterer intervention programs in Medford; transitional housing and permanent housing for adults including those with disabilities in Jackson and Josephine County.

Individuals Served: OnTrack serves adolescents in outpatient services, and adults in residential and outpatient services.

Additional Information: I am a person who is a member of an underserved population. I have been abstinent from drugs and alcohol for 37 years after a lengthy addiction to multiple substances, including heroin. At the time the Workgroup began, I was the executive director at OnTrack until leaving January 1st. I am a practicing psychologist with over 35 years of experience in addiction and mental health treatment. OnTrack received CARF accreditation in December of 2020.

Cynthia Levesque

Director, Kolpia Counseling

Size of agency: Under 10 FTE, under 6 FTE for clinicians.

Service Locations: Ashland and Medford--serves rural counties.

Services Provided: Outpatient mental health and substance use treatment (highest level of care for SUD is 2.1 Intensive Outpatient).

Individuals Served: We serve ages 14+, seniors, professionals, LGBTQ+, multicultural.

Additional Information: Our small staff includes individuals who identify as persons of color, indigenous, queer, and individuals with lived experience. Our agency is not currently accredited.

Moxie Loeffler, DO, MPH

President, Oregon Society of Addiction Medicine

Agency Size: Works in Eugene, Oregon for Community Health Centers of Lane County (CHCLC) and Lane County Treatment Center and Methadone Program (LCTC and LCMTP). We employ about 200 and serve about 10,000 unique patients annually.

Service Locations(s): Lane County clinics serve patients in two medium sized cities, but the county as a whole is rural. They offer care that integrates interpreters. CHCLC and LCTC are part of an FQHC and do not have Substance Use Disorder accreditation. LCMTP is accredited by CARF (Commission on Accreditation of Rehabilitation Facilities).

Individuals Served: Serves Asian immigrants and their descendants, Latinx migrant farm workers, uninsured and low-income people, and transgender patients.

Additional Information: I am bisexual, white, Buddhist, and have practiced medicine in three states. Studied health equity for my Masters of Public Health degree at UC Berkeley and am the President of Oregon Society of Addiction Medicine. We employ people with lived experience.

Megan Marx, MPA, NCPRSS

Director of Integrated Care, Oregon Recovery & Treatment Centers (ORTC, LLC)

Size of Agency: Provides care, treatment, and services to just over 1,000 patients. We currently employ 85+ professionals in our clinics. This includes physicians, nurses, medical assistants, certified counselors, and certified recovery mentors.

Service Location(s): Clinics in Bend, Grants Pass, Medford, Springfield, and Pendleton, recently opened a clinic in the Tri Cities area in Washington, serving rural counties.

Services Provided: Outpatient medication assisted treatment services for individuals experiencing an opioid use disorder. Patients receive medication as well as counseling and case management services.

Individuals Serve: We serve adults of all ages.

Additional Information: I am white and in active and sustained recovery, 29 years.

Our agency is licensed by the state as well as by the DEA, we are certified by SAMHSA and accredited by the Joint Commission. The agency employs people with lived experience.

Tim Murphy

Executive Director, Bridgeway Recovery

Size of Agency: 110 employees, serving approximately 600 individuals per month

Service Location(s): All services are in Marion County however we do offer IOP services remotely and can serve the entire State of Oregon. The Detox and residential services are considered a statewide resource, so can be accessed by individuals in any of the 36 counties.

Services Provided: Outpatient Mental Health, Outpatient CD, Outpatient COD, Outpatient Problem Gambling, Medically Managed Withdrawal (Detox), Residential Problem Gambling, Residential Chemical Dependency,

Primary Care, Medication Assisted Treatment (limited). In addition, we offer housing in our 16-unit apartment complex, we have an adolescent CD/MH program with approximately 100 kids enrolled.

Individuals Served: We serve adults in our detox and residential program, we serve adolescents in our Outpatient Adolescent Program.

Additional Information: Employees are Native American, Black, Brown and Caucasian. We employ Peers and Health workers with lived experience, and 50% of our staff are in Recovery.

Alison Noice, MA, MS, CADC III

Executive Director, CODA, Inc.

Size of agency: Approximately 275 employees, across 14 programs.

Service Locations: The majority of services are provided in the tri-county (Multnomah/Washington/Clackamas counties), with one program serving the rural North Coast (Clatsop/Tillamook/Columbia counties).

Services Provided: A continuum of substance-use disorder treatment services, including Residential, Intensive Outpatient, Outpatient, DUII, Transitional Recovery Housing, and Opioid Treatment Programming.

Individuals served: Adults. Included in our programs are specialized services for pregnant and parenting women, individuals working toward family reunification, and criminal justice involved individuals. We also have an independent research department and are part of the Clinical Trials Network.

Additional Information: CODA employs a cohort of Certified Recovery Mentors, though they are a minority of our total workforce. Individuals with lived experience are represented throughout the organization, including within senior administration and across clinical programs. We do not have any dedicated, culturally specific programs.

Eva Williams

Deputy Director, Willamette Family

Agency Size: Medium.225 personnel

Service Location(s): Lane County. 7 locations. Rural Cottage Grove location (impacted by COVID).

Individuals Served: Adults, co-occurring/comorbid condition's, women with children, families, marginalized communities including those who are houseless, BIPOC, older adults, Veterans, and LGBTQIA+.

Services Provided: Sobering, Partial Hospitalization, Intensive Outpatient, Outpatient, DUII; Transitional Recovery Housing, Housing (Housing First Model), Primary Care, State Certified Childcare, and Peer Support.

Additional Information: I am White, Female, Lesbian (LGBTQIA+ community member), and have Lived experience (23 years of active Recovery). Willamette Family employs individuals with lived experience for all positions (we do not ask questions about "lived experience" during interviewing, but often this information is volunteered by candidates). Peer Support Specialists work with clientele drawing from their lived experience.

Questions and Comments from Accreditation Listening Session #1

April 16, 2021

Reducing State and CCO Oversight

- CCOs typically use OAR certification requirements as their auditing standards. Has your workgroup enlisted CCO input about whether the CCOs will incorporate accreditation standards in their auditing standards? Put another way, will CCO auditing standards expand based on accreditation standards?
- Accrediting bodies do not provide the oversight needed to prevent fraud and abuse. The CCOs will still have to provide this piece. Accreditation is a fantastic goal but will not remove this requirement nor will accreditation only prevent fraud and abuse. Substance Abuse providers are typically some of the smallest agencies with the lowest amount of funding and increasing administrative burden will never improve access to care. It is concerning that this is moving forward during a period of time when access to BH care and parity is a major discussion at the National level.
- Any investigation into accreditations impact on SUD integration with MH and M/S - pros or cons?
- Do these recommendations mean that CMHPs would no longer have the option to designate staff who have a license + 60 hours of SUD training hours as being SUD credentialed to bill for SUD services?
- Has OHA agreed to deemed status designation if a provider is accredited?
- National Accreditation doesn't remove the need for oversight for Medicaid funding. There would still need to be oversight around service delivery. How would this still happen without additional reviews?
- One local CCO does not accept OHA allowed service provision of SUD services while in the education/practice hours toward certification process (CADC-r), so that suggests the state rule does not prevail.

Cost/Funding

- Is the state going to provide funding for capital improvements for the smaller non-profits to get their buildings up the standards that accrediting bodies require?
- Could members of the committee speak to the cost of accreditation? I think it may be helpful in the discussion.
- Costs don't scale linearly. The cost of accreditation for a smaller organization would appear to likely be a much higher % of its operating budget and man hours than it would be for larger organizations. The fact that accrediting agencies would charge less for smaller organizations is only a small part of the cost equation.

- Has the group done research of the impact of accreditation on increases in cost of services to compensate for additional costs and how that would impact access to services for people of color and compromised communities?
- Agreed 100% with Chris Turner. And the costs cannot be reduced to $$$ (fees, etc.) Much more cumbersome is the time they take away from work with the clients to work in the back office - certainly not the equation we are looking for.
- I would specifically suggest that the state create a fund to support accreditation costs for small, BIPOC, and other culturally specific providers. I would also suggest providing TA to those organizations.
- Money for wrap around and housing in my estimation would be more impactful on improvements in outcomes
- It's not the costs that are paid the accreditation organizations that are concerning. It is the staff costs, the building costs, etc. Those are much greater than the upfront costs.

Administrative Burden

- The most crucial questions have to do with the actual additional reviews accredited agencies will need to respond to as well as the actual costs. I would request the committee seek these practical concrete answers to fully inform us.
- Would the requirement for accreditation also pertain in equal measure to small entities (with staff numbered 2-3 members that by definition do not have the administrative power to handle large-scale administrative aspects)' they target niche segments of our community (i.e., specific ethnic and culturally-specific needs within the community) that are extremely important. It may present a burden on the entities and cause them to sink under the heavy weight of the administrative minutiae to the detriment of the hands-on immediacy service to our clients.
- Beside Oregon OARs, what other rule sets will accrediting bodies be asking us to meet? Do they keep organizations up to date as rule sets evolve?
- I'm wondering how it will play out with 3 different accrediting organizations, as each might potentially have different elements which OHA may feel are necessary to audit in individual agencies.

Impact on Culturally Specific Services

- Smaller organizations are much more likely to be serving underserved/specific populations that are already underserved. I don't really see any way that this wouldn't magnify disparities in service availability.
- The work group recognized that we did not have a good representation from culturally specific programs and are seeking additional input at these listening sessions.

- I endorse what Barb pointed out regarding the lack of diversity on the committee and encourage the committee to specifically seek out input from culturally specific groups.
- While I can be on board with the idea of accreditation, I hesitate when the OHA leadership doesn't appear to have diversity. I think the cart is ahead of the horse, perhaps a pause to actively ensure equity and inclusion for all those making recommendations. To include underserved populations. I am stumbling on my words and for that I am sorry.
- "Taking into consideration" is different from OHA doing the work to bring BIPOC providers to the table when the workgroup is being formed.
- Accreditation is valuable for standards but does not also resolve the huge impacts of the 'social determinants of health'. That is a larger barrier to available and effective treatment.
- Did the workgroup access data show that accreditation improves care for BIPOC populations?

Other Questions and Comments

- What research and data were gathered by the committee to support the assumptions that accreditation of ALL SUD providers will accomplish the intentions of HB2257? Specifically the expected outcome of increasing access to SUD services for all Oregonians.
- Part of the discussion also needs to include parity. Is there going to parity for physical health? Are all physical health clinics going to be required to have accreditation?
- Is there already unanimous support in the task group for requiring accreditation? Is there another view on this in the group?
- Can there be consideration of adding additional accreditation options than the three identified? And additional research conducted on impact on culturally specific programs?
- The provision of care for substance use disorders has been profoundly impacted by COVID-19. This advisory group's work appears to have begun in an era before the pandemic. What have the 3 accrediting bodies (CARF, Joint Commission, etc.) done to adapt to these changes that have been brought about by COVID-19? Any assumption that accreditation will improve the quality of care needs to consider this issue
- How many of the committee members are already part of an organization that is accredited?
- Ultimately we have to be careful to maintain the agility of services that small entities provide by filling in the gaps in the larger texture of services provided by larger organizations. That a la carte aspect has a lot of value to our clients, and we want to make sure that we stay lean and mean on administration and rich on individualized client services - that is what our client's value in our operations.

- This may have already been asked or answered elsewhere, I apologize if so. I'm wondering how this would apply to OBOT programs, and if it would add another layer of accreditation to medical facilities providing MAT services
- Will the accrediting boards be reviewing DUII Services Providers for compliance with their OARs?
- We are accredited through AAAHC. Not sure if they are viable for these purposes, but they might be another organization to consider for fit.

Questions and Comments from Accreditation Listening Session #2

April 22, 2021

Reducing State and CCO Oversight

- What problem is this actually trying to solve? Is OHA site survey process not working?
- OHA holds a high standard in reviews now.
- OHA do an excellent job in their reviews. many of the positives for this national accreditation process that are being championed already exist currently.
- Re Dr. Loeffler's statement of Joint Commission: this is already established through use of ASAM with the exception of costs. Samhsa approved UA labs speak to that process. Oregon is an ASAM state.
- Excellent standards already exist right now. Everyone one of those standards is what we already focus on. This isn't new stuff.

Cost/Funding

- Will the expectation be for OHA to cover the costs related to accreditation for all current and future providers? Would private, for-profit agencies be eligible or just non-profits?
- If an agency has multiple programs, they would all need to be accredited. Do you have any ideas of costs?
- How long would that financial support last? What if the provider can't get there?
- The real cost of accreditation isn't the fees from the accreditation agency, it's the personnel costs that go along with meeting and maintain the standards. How long would OHA be required to support personnel costs associated with getting and maintaining accreditation?
- In terms of reimbursement, will accreditation give OHA leverage to require reimbursement parity for SUD services from private insurance and Medicare?

Administrative Burden

- Adding another process to provide local services by our smaller rural mental health and addiction outpatient services, we are certified by state OHA, PacificSource, state corrections dept, and already are overwhelmed with ongoing paperwork and costs in payroll to maintain our program. All of our counselors have certifications and some licensed also. Accreditation seems more necessary and important for larger non-profits or profit organizations. We already have so much data keeping, paperwork. This seems over kill and could really negatively impact small agencies providing much needed services.
- How does this not add to administrative burden to an already overly taxed and under paid system?

Impact on Culturally Specific Services

- If this group doesn't represent minority programs or persons, is it going to push forward with an agenda that doesn't meet an equity and inclusion ethic? In conversations with two OHA compliance monitors they shared that OHA will never take a back seat in audits. I suggested a week ago that this is an example of Oregon's tendency to put the cart ahead of the horse. Until there is equity and inclusion in this membership it just doesn't feel well thought out. I do not mean to be contrary; I am simply sensitive to the apparent lack of inclusion in this endeavor.
- This could be absolutely devastating to culturally specific programs and programs that serve in small communities that don't have the resources to meet national accreditation. Measure 110 is about making treatment more accessible, and to help communities get help that haven't been able to get help. Coming from a minority community we face disadvantages, where we have to bring in outside providers to our communities that do not know our cultures.
- How many culturally specific programs have signed on to this? Who? And are they a small rural program?
- As a Siletz Tribal member and owner of Substance Use Disorder Outpatient Treatment program who provides culturally specific treatment. How does this National Accreditation Process help us provide treatment to our community? We are a small organization trying to serve underserved communities. We have gone through the accreditation process.

<u>Other Questions and Comments</u>

- Just curious, does the research show that services are better for clients if a program is accredited?
- I direct an alternative school that is nationally accredited. It costs me a lot of money; I have to put up a team in a hotel when they come to review; it generally doesn't bring forth new ideas; we have to teach them about SUD every time and it stresses out the staff when they come. Is the juice worth the squeeze? I don't think so but I can at least say that we are accredited. It is window-dressing in this realm.
- These recommendations will put small, excellent practitioners out of business. “Quality care” does not come from increased accreditation.
- This all makes me sad. As much as I appreciate the work and expertise of OHA…it is wrong to carry forth an agenda that doesn't include its constituents.
- I also do not feel that this is even close to moving forward. This is the first I have heard of this. This is huge and will affect OYA’s treatment greatly as well as many other small programs.

August 20, 2020

Steve Allen
Behavioral Health Director, OHA
500 Summer Street NE
Salem, OR 97301

Cc: Nicole Corbin, Addiction Treatment, Recovery, and Prevention Manager, OHA

RE: SUD Treatment Accreditation determination

Dear Director Allen,

I am writing on behalf of the Tri-County Behavioral Health Providers Association (TCBHPA) which represents 30 community-based mental health and addiction providers in Clackamas, Multnomah and Washington counties. Our members serve the majority of Health Share's behavioral health clients as well as indigent, state and county general fund supported consumers.

Upon consideration our members do not support the State requiring Substance Use Disorder (SUD) treatment accreditation. They feel they are already subject to too much regulation. Accreditation is an expensive, extended process that does not rise to the top of many competing priorities as it doesn't necessarily add value to an organization's capacity and expertise. SUD providers have worked hard in recent years to ensure they are providing high-quality services, individually and by working together with CCOs and other partners on outcome measurement, training and related efforts. With an already overstretched and under-compensated workforce, the priority instead should be support in recruiting and retaining a qualified workforce through improved SUD rates and other incentives. Let's please leave accreditation as an individual organization decision if and when an organization otherwise needs or wants to pursue it.

We understand the committee is still meeting to explore the issues in order to make a recommendation. We support such an investigation but wanted to make our views known in the hope they will be taken into account as providers who will be impacted by this decision. Thank you for taking the time to hear us on this important topic as we work together to serve the important needs of OHP, indigent, and general fund supported clients in our community.

Sincerely,

P Morin

Pierre Morin, TCBHPA President

CareOregon Support for SUD Treatment Accreditation

Dear Members of the Substance Use Disorder Accreditation Advisory Group:

CareOregon is a nonprofit that has served Oregon Health Plan members for over 25 years and is a founding member of Health Share of Oregon, one of the CCOs that contracts to manage Medicaid benefits in the Portland Metro area. CareOregon manages the behavioral health benefits for all of Health Share's 300,000 members, the physical health benefits for 200,000 of those members, and dental health benefits for 70,000 Health Share Members. Additionally, CareOregon manages OHP benefits for 45,000 members in Jackson County through ownership of Jackson Care Connect, and 30,000 members in Clatsop, Columbia and Tillamook counties through ownership of Columbia Pacific CCO.

CareOregon has been following the work of the Substance Use Disorder Accreditation Advisory Group (SUDAAG), formed as required under House Bill 2257. Operating coordinated care organizations in three distinct regions in Oregon, we have seen firsthand the impact of increasing substance use disorders and overdoses with no corresponding increase in funding or capacity for treatment. The result is an inability for providers to focus on infrastructure and quality when they are trying to make ends meet, all while challenged by staff turnover and long waiting lists.

CareOregon supports the recommendation that all organizations providing substance use treatment who hold a license or certification of approval from Oregon Health Authority become accredited by a national accrediting body. This requirement will provide a statewide floor for quality and safety, reduce the oversight burden by Oregon Health Authority and allow Oregon to benchmark against national standards of care. It will also allow a pathway to the broader provision of integrated dual diagnosis treatment, expanding that service to meet the growing need.

To successfully create an accredited network, CareOregon further supports SUDAAG's strategic requirements meant to mitigate the burden of achieving and maintaining accreditation, including a phased or rolling approach, incorporation of financial support for providers to assist with preparation for accreditation, and a process whereby accredited organizations are deemed as meeting OHA certifying and licensing standards.

We believe this recommendation puts Oregon's behavioral health system on a path out of last place in the nation and into a place where Oregon can again pride itself as a leader of

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transformative care. Oregon's residents, families and communities need this investment, and we applaud Oregon's legislature for creating this opportunity where we may serve as a model for the rest of the country.

Sincerely,

Stefan Shearer, MPA:HA
Public Policy & Regulatory Affairs Specialist
CareOregon