Meeting Summary

Joint Task Force on Regional Behavioral Health Accountability

Meeting #3
Link to Task Force on OLIS

Date/Time	January 6, 2025 (link to recording) Hybrid meeting
Attendees	Sen. Dick Anderson, Co-Chair Rep. Charlie Conrad Rep. Rob Nosse Marris Alden Ebony Clarke Annaliese Dolph Melisa Eckstein Bennett Garner Ana Gonzalez Amanda Gray Holly Harris Mahad Hassan Heather Jefferis Alison Noice Jennifer Sewitsky John Shafer Michele Vowell Scott Winkels Lamar Wise Excused: Sen. Kate Lieber (Co-Chair), Dee Butler, DeAnn Carr, Andrew Cherry, Kimberly Lindsay, Korin Richardson, Nan Waller
Oregon Behavioral Health Coordination Center (OBCC) Stephanie Gilliam, Director of OHSU Mission Control Matthias Merkel, Senior Associate Chief Medical Officer, Capacity Management and Patient Flow OHSU Health	Presentation Summary - Each Oregon Trauma Region (7) has a resource hospital, OHSU serves Regions 1 and 6. OHSU serves regional and state functions in addition to health system responsibilities. - OBCC is behavioral health counterpart to the Oregon Medical Coordination Center (OMCC) which OHSU has operated since 2020, the purpose of OBCC is getting the right patient to the right place at the right time, with a goal of decreasing barriers to access to care. OBCC works with the Oregon Health Authority (OHA) to understand how to best integrate into the existing BH system. Partners with hospitals, private facilities, and community health systems. OBCC is intended to support coordination after normal patient transfer referrals fail. - OBCC was created in response to a general lack of transparency and awareness of BH capacity in Oregon for bed capacity and availability, lack of real-time picture of capacity, large number of patients boarding in hospitals with unmet BH needs but no further medical needs, existing provider burden related to reporting. The goal of OBCC to streamline and improve these issues.

- OBCC serves three core functions: **data, staffed coordination center, and analytics**
    - Scope of OBCC includes psychiatric acute care, residential treatment, and partial hospitalization (day treatment); scope currently excludes prevention, intensive outpatient and outpatient facilities.
        - Facilities in scope: psychiatric acute care facilities (OSH, acute care units and freestanding facilities; residential treatment facilities (RTFs), including Class 1 and 2 secure RTFs (SRTFs); substance use disorder (SUD) RTFs, including residential, medical and clinical withdrawal management; and residential treatment homes (RTHs) and adult foster care (AFC).
- Oregon fairly under resourced in number of beds for behavioral health,

Table 1: Distribution of residential SUD, psychiatric acute care, and all behavioral health beds by ATAB region

ATAB Region	Residential SUD Beds	Psychiatric Acute Care Beds	All Behavioral Health Beds (Total: 4682)
1	829	275	1915
2	206	59	1013
3	237	48	727
5	114	24	300
6	0	0	12
7	136	15	324
9	128	0	381

- OBCC's real-time capacity display pulls data from all electronic medical records (EMRs). For facilities without EMRs or that choose not to have admission/discharge/transfer (ADT) data pulled from EMR, there is an ability to provide those to OBCC manually. Participating locations can see all other participating system bed availability. At the time of the presentation to the Task Force, OBCC was not yet to a place where each

participating location could view patient movement within their own facility, though future goals include incorporating a patient movement tile, however challenges around private health information (PHI).

- OBCC tile included real-time data from 10 facilities, including OHSU, Legacy-Unity, PeaceHealth, Kaiser, Salem, OSH, Trillium, LifeWorks NW, Fora Health, and Albertina Kerr. At least nine additional facilities were in the process of joining the tile at the time of the presentation to the Task Force.

Task Force members discussed the information presented to them as part of the OBCC presentation, including the following topics:

- How the PCG Residential Plus study was utilized in creating the OBCC dashboard and the difference between licensed and functional bed capacity within a behavioral health facility
- Differences in what is considered real-time data for RTFs and BH facilities compared to medical facilities
- Types of BH facilities currently participating and what is still not represented in the dashboard, how OBCC information interacts with data compiled by Lines for Life and OHA
- The timeline for when the dashboard might achieve its goal of having all licensed BH facilities represented
- Barriers and challenges encountered by Mission Control in getting OBCC up and running (siloes and reporting burden)
- Future development of OBCC and whether various requirements placed on facilities will be considered to streamline potential reporting burden
- Challenges around terminology and lack of standardized language across facilities

Mental Health Treatment Capacity Model

Dr. Alexandra Nielsen, Modeling and Simulation Engineer, OHSU

Dr. Peter Graven, Director of Advanced Analytics, OHSU

Presentation Summary

- Computer simulation models focus on how people [adults] move through acute mental health crisis systems, including the bottlenecks and barriers that they may experience. The purpose of the model is to facilitate exploration around how the state might improve capacity and how people move through those systems, building models that incorporate complexity for a whole system view, understanding that changes in one part of the system have implications on the entire system (ex. The *Mosman* decision and impact on OSH and other parts of the BH system).
- Simulation modeling is a tool to understand implications of action on a highly complex and interrelated system; synthesizes qualitative interview information with multiple datasets to create a model can answer both “what” and “if” questions. These methods compliment benchmarking methods which compare to standard or comparator. Simulation models

look at models of how well a system is functioning by looking at specific measures.

- Model was developed through over 65 interviews across Oregon, covering perspectives within crisis, justice, hospital, post/sub-acute, and residential systems. Data include administrative data, public reports, survey data, existing literature, and interview-based estimates to fill in data gaps. Beta version is undergoing participatory validation sessions with various experts to confirm that the model functions in a way that represents the lived experiences of people within the system. Estimating completion in June of 2025.
- The current model shows how people move through the system depending on the risk of the population to experience a crisis and the potential treatment services that they may require as they move through the system. The model includes “stop signs” which represent places where forward flow is blocked by full capacity (ex. acute inpatient environment is full and therefore people must board in the emergency department, vs full capacity in the post-acute system which results in people having to board in the acute inpatient environment). Allows for experimentation with capacity expansion at specific points to see what might happen at the various bottleneck points and accounts for capacity across ATAB regions.
- Current work is to refine the model to account for the different needs of the different populations at risk, team is working to develop that piece of the system capability in a more specific way.

Task Force members discussed the information presented to them as part of the OBCC presentation, including the following topics:

- How future iterations of the model might include the impact of a lack of capacity and congestion within the BH system on RTFs, SRTFs, and how this can feed into acute inpatient settings
- Whether the product of this work will further drive emphasis on building new facilities or if there is a way that process improvements can be considered to support improving efficiency in the existing system
- The way that the PCG Residential Plus study was utilized in building the model and the intention of the model as a complement to the study
- How the model considers different levels of care required by an individual
- How the model might support Legislative decision making and if the model could be adapted to show where investments have been made in the past across the BH system.
- Considerations for replicating what works well in one area

Task Force Workplan and Discussion

LPRO staff summarized information, including the four recommendation areas, and Task Force discussion from the December meeting regarding refining the Task Force charge and direction for member priorities after the 2025 legislative session.

Co-Chair Anderson and LPRO Staff

- Initial member priorities that surfaced during the Task Force Needs Assessment:
  - Achieving a statewide behavioral health system
  - Aligning governance and funding structures
  - Increasing system transparency
- Revised member priorities based on Task Force and Co-Chair discussion:
  - **Strengthening Systems-Level Collaboration**
    - Statewide system
      - Reducing service barriers and system silos
      - Improving regional and population-specific accessibility
    - Aligning governance and funding
      - Improving alignment of governance structures
      - Balancing regulatory oversight and accountability with administrative burden
  - **Increasing system transparency**
    - Mapping the current system and creating funding transparency
    - Creating tools and resources that are useful and transparent

- Summary of discussion from December:
  - How should regional be defined? Who should be collaborating and through whom? Who is responsible and who takes priority when responsible entities overlap?
- Avoiding duplication – concurrent legislatively mandated efforts
  - HB 2235 (2023) Behavioral Health Workforce Recruitment and Retention. HB 4092 (2024) CMHP funding Study, Administrative Burden work group
- Introduction of the Task Force Problem Statement developed by the Co-Chairs based on member discussion:
  - Funding decisions in Oregon's behavioral health system are made based on a variety of factors specific to the funding source and without consistent collaboration across these entities. While there is care coordination at the ground level, at the systems level there is a need to improve transparency and collaboration to support efficient funding across the system.

	LPRO staff provided an overview of activities during the 2025 legislative long session, including an LPRO research project inventorying statutory, regulatory, and public contractual requirements, incorporating informational interviews with funding system partners.
	- Task Force members discussed how the session research product could support the work of the Task Force, including what kinds of questions would be answered by an inventory product, what an inventory could help Task Force members learn about collaboration in the behavioral health system, and how the output of the research might best be presented to Task Force members.
	  ○ Members requested a post-session update about relevant bills that are likely to have implications for Oregon's public behavioral health system
	  ○ Members requested a map-based product that illustrated primary and ancillary funding streams and how they come together with information about requirements around those streams.

Public Comment	*None*
Meeting Materials	• 12-9-24 JTFBHA Meeting Summary • 1-6-25 JTFBHA LPRO Staff Presentation Slides • 1-6-25 OHSU Presentation Mental Health Treatment Capacity Model • 1-6-25 OHSU Presentation Oregon Behavioral Health Coordination Center • Staff Memo – Overview of SAMHSA Data on Behavioral Health Care