Behavioral Health Justice Reinvestment in Oregon

Steering Committee

Wednesday, January 9

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CSG Justice Center
THE COUNCIL OF STATE GOVERNMENTS

Overview of the Project

The Behavioral Health Justice Reinvestment (BHJR) project is grounded in the shared interest among local, regional, tribal, and state governments to address challenges related to people with serious behavioral health conditions cycling through Oregon's criminal justice and health systems.

Summary of December Meeting

The second presentation in late December to Oregon's BHJR Steering Committee prompted discussion that enabled the committee to reach agreement on a project framework that is the basis for the discussion today.

Agreed Upon Project Framework from 12/20 Meeting

Improving individual and system outcomes for people cycling through Oregon's criminal justice and health systems can be achieved through a set of commitments and coordinated actions with performance measurement strategies:

1. **Support and services.** Establish comprehensive community programming to improve outcomes for this population.
2. **Evaluation, accountability, and innovation.** Build a statewide system of continuous program quality improvement.
3. **Funding strategies.** Establish a system of shared financing to sustainably support these programs.

1 Support and services

Establish comprehensive community programming to improve outcomes for people with frequent criminal justice involvement.

1. Invest in a strong and flexible community supports and services model, anchored in what works for the target population.

2. Support local, regional, and tribal governments in building upon their existing efforts.

3. Develop a limited but critical set of statewide technical assistance services to support communities in designing, requesting, and implementing program services and supports.

4. Strengthen Oregon's workforce to provide the professionals and para-professionals needed for programming, supports, and services.

Build a statewide system of strong and responsive local programs.

1. Establish a statewide system of tracking simple, clear, and meaningful program outcome measures that inform practice and program strategy.

2. Create policy that requires appropriate multiagency and multidisciplinary program information sharing, removing barriers while ensuring data protections.

3. Develop IT infrastructure sufficient to efficiently collect and disseminate program data.

4. Establish a system of continuous quality improvement and promote ongoing innovation.

3 Funding strategies

Establish a system of shared financing between the state and local jurisdictions to sustainably support these programs.

1. Promote increased flexibility within existing funding streams to reduce unhelpful administrative burden.

2. Establish additional state funding.

3. Work aggressively to leverage federal participation for supports and services reimbursable through Medicaid.

4. Create a formula to match state general funds with local and regional investments.

Discussion for Today

Understanding Behavioral Health

Building the Framework for Effective Behavioral Health Services in Populations with Frequent Criminal Justice Involvement

1. Support and services
   - A. Establishing oversight structures
   - B. Defining effective services
   - C. Understanding the current workforce and future needs
   - D. Statewide assistance
2. Evaluation, accountability, and innovation
   - A. Quality improvement
3. Funding strategies
   - A. Leverage federal participation for services reimbursable through Medicaid

Next Steps

Discussion for February

- Analysis from the jail / community corrections / Medicaid / state hospital match
- Financing approach
- Housing
- Accountability, evaluation and innovation
- Bill draft language

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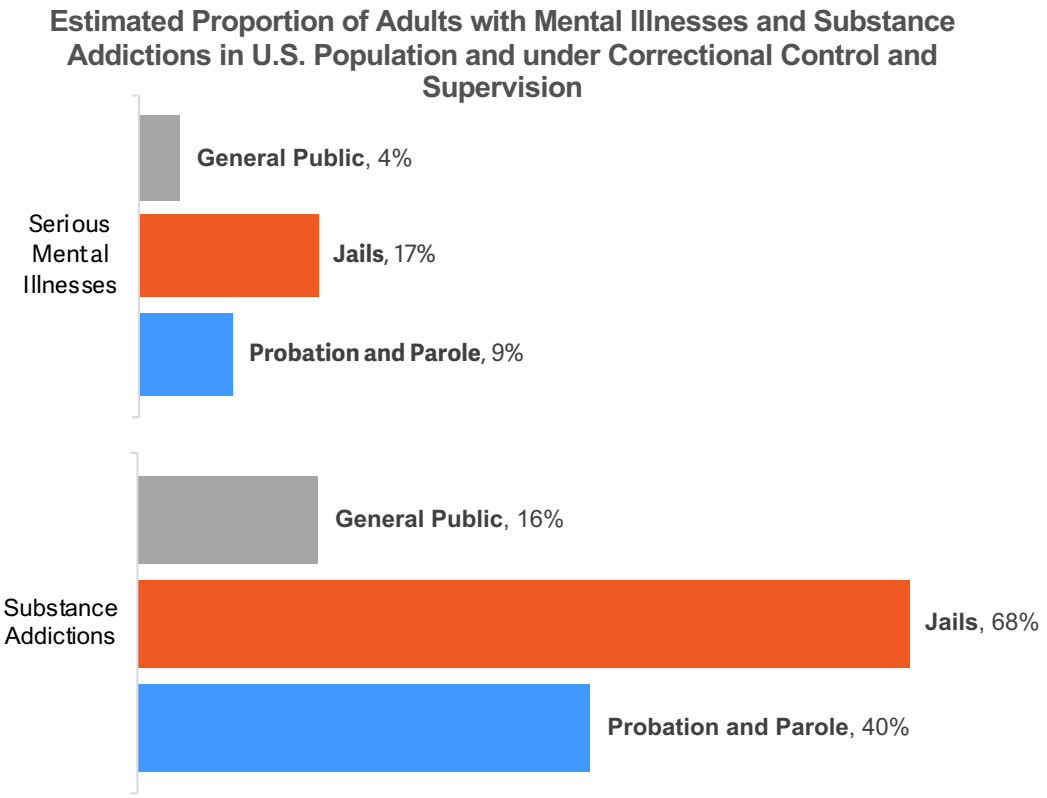
   - A. Leverage federal participation for services reimbursable through Medicaid

Next Steps

National data reflect the challenges in Oregon related to high percentages of people with mental illnesses and substance addictions in its criminal justice systems.



Source: Alex M. Blandford and Fred Osher, *Guidelines for the Successful Transition of People with Behavioral Health Disorders from Jail and Prison* (New York: SAMHSA's GAINS Center and The Council of State Governments Justice Center, November 2013).

Multiple factors contribute to the high prevalence of people with behavioral health conditions in criminal justice systems.

Arrested at disproportionately higher rates

Low utilization of EBPs

Stay longer in jail and prison

Limited access to health care

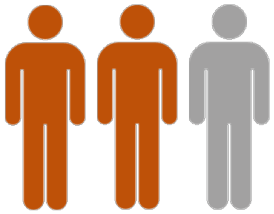
High recidivism rates

More criminogenic risk factors

Homelessness

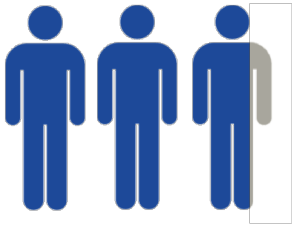
Trauma is strongly associated with mental illnesses, substance addictions, and incarceration.

Substance Addiction



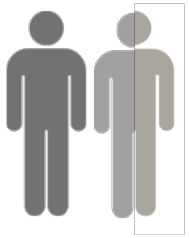
At least **two-thirds** of men and women entering substance addiction treatment report childhood abuse and neglect.

Mental Illness



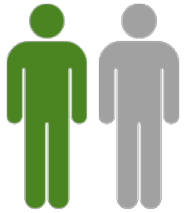
90 percent of men and women in psychiatric hospitals have been exposed to trauma.

Women



50%–98% of women who are incarcerated experienced childhood trauma.

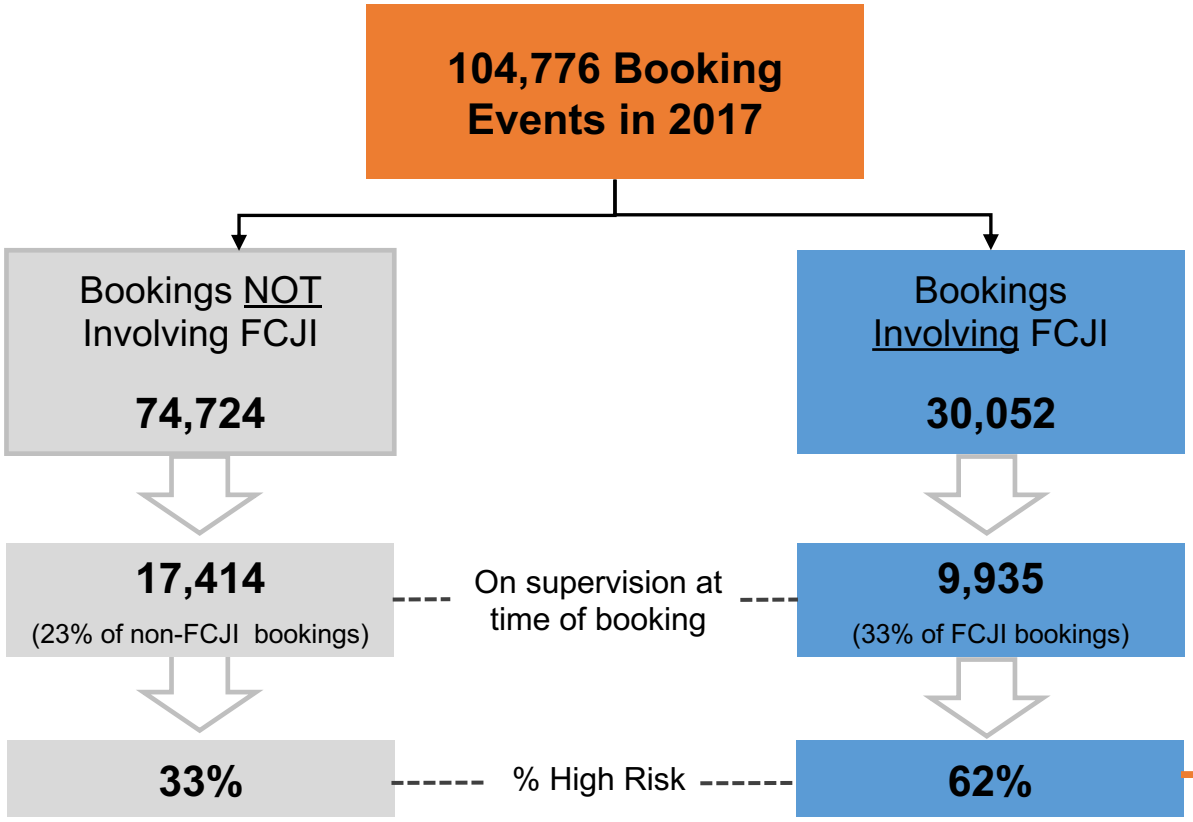
Men



At least **52%** of men who are incarcerated experienced childhood physical abuse.

Source: CSG, Understanding and Addressing Trauma: Developing Trauma Informed Systems of Care; BJA, (2017), Indicators of Mental Health Problems Reported by Prisoners and Jail Inmates, 2011-12; https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3386595/ and http://cjinvolvedwomen.org/wp-content/uploads/2016/06/Fact-Sheet.pdf

The Oregon county jail and community corrections analysis found that people with Frequent Criminal Justice Involvement (FCJI) booked into jail who were also on active community supervision had high rates of substance-related problems.



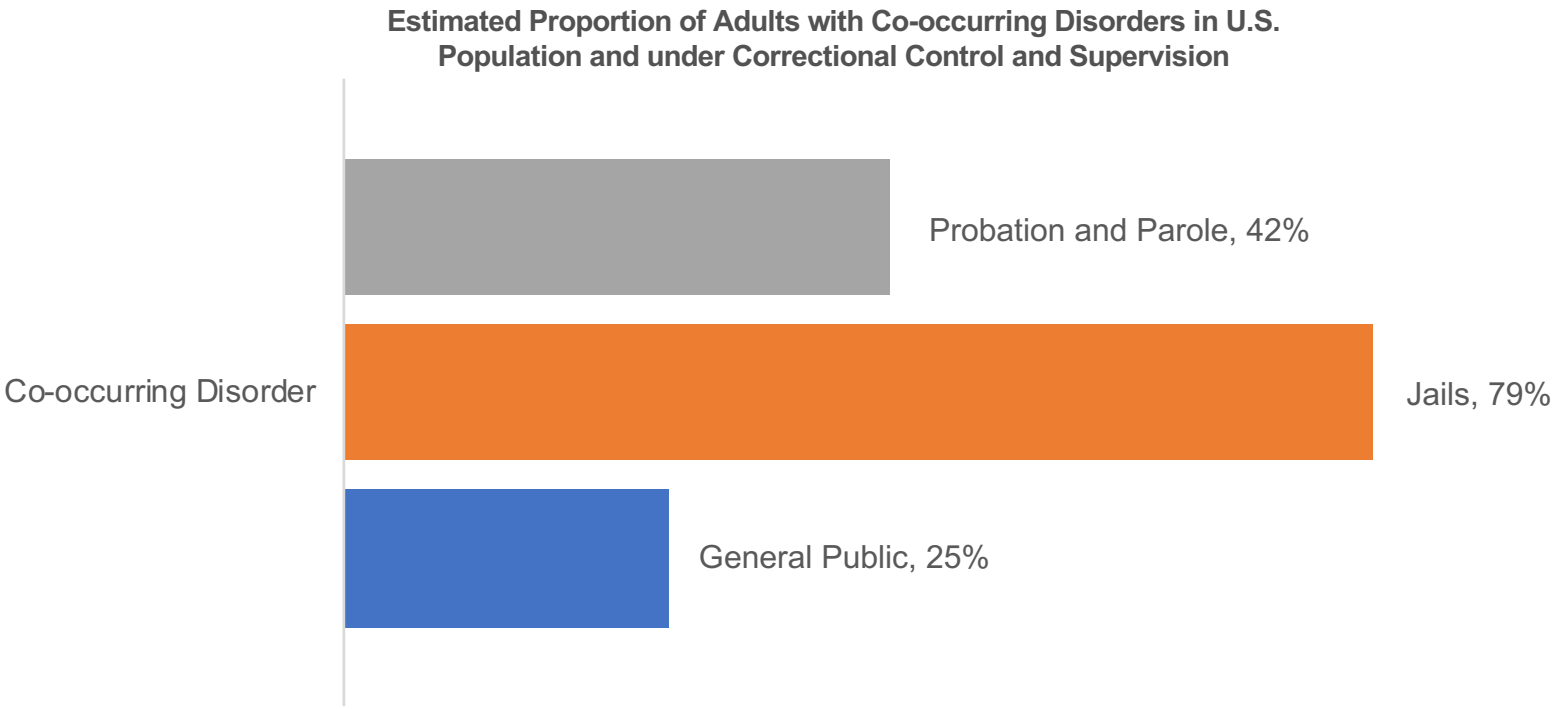
This represents 6,145 booking events involving FCJI people who were on active community corrections caseloads and known as high risk.

81% of these bookings involved people assessed as having high or very high needs (LSCMI).

68% involved people assessed as having high or very high alcohol/drug problem area (LSCMI).

Source: CSG analysis of calendar year 2017 jail bookings data from Clackamas, Deschutes, Gilliam, Hood River, Jackson, Marion, Morrow, Multnomah, Sherman, Umatilla, Wasco, and Washington counties. Hood River, Gilliam, Sherman and Wasco counties are represented by NORCOR jail; CSG analysis of calendar years 2013-17 Community Corrections data from ODOC.

People on community supervision or in jail have much higher rates of co-occurring disorders than the general population.



Source: Alex M. Blandford and Fred Osher, *Guidelines for the Successful Transition of People with Behavioral Health Disorders from Jail and Prison* (New York: SAMHSA's GAINS Center and The Council of State Governments Justice Center, November 2013).

In a recent Canadian study, rates of co-occurring disorders were triple in the population of people with frequent justice involvement and corresponded to much higher average days in custody and combined health care and criminal justice costs.

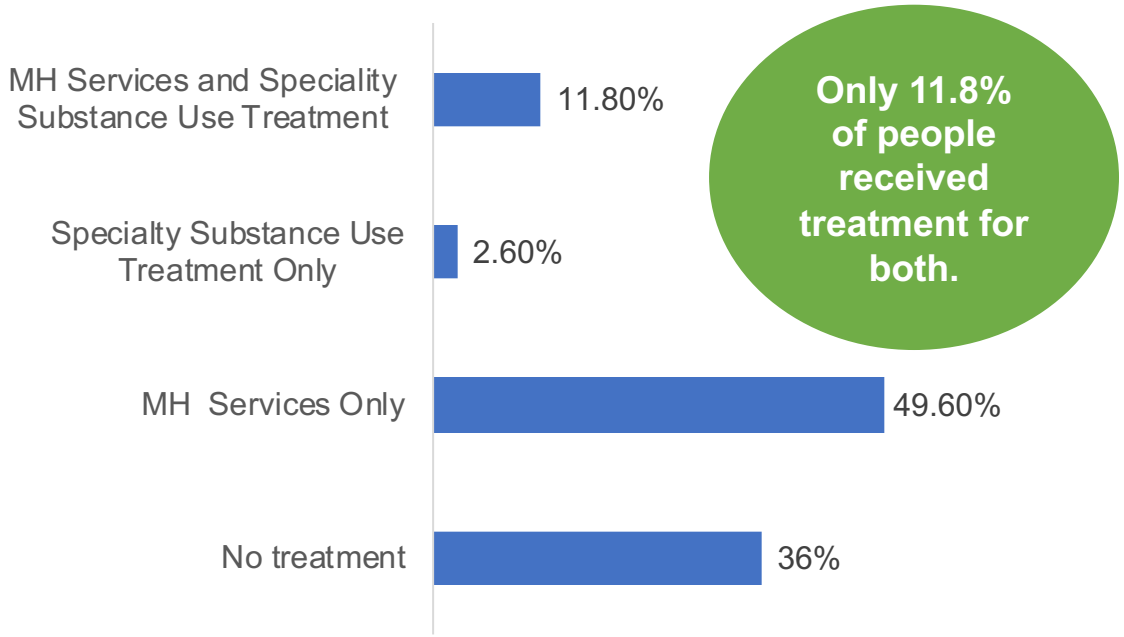
	All N=14,372	Frequent Supervision N=216	Frequent Custody N=107
Rate of co-occurring disorders	30%	82%	**94%**
Average days in custody (5 yr)	93.2	158.4	**590.9**
Total average corrections and health care costs (5 yr)	$53,003	$168,389	**$246,899**

- **Study**: 14,372 Vancouver, B.C. residents with Provincial Court involvement
- Reviewed frequency and costs associated across corrections, health, and social welfare services

Sources: Somers, Julian M., et al. "High-Frequency Use of Corrections, Health, and Social Services, and Association with Mental Illness and Substance Use." Emerging Themes in Epidemiology, vol. 12, no. 1, 2015, doi:10.1186/s12982-015-0040-9.

While having both mental illness and substance addiction worsens health and criminal justice outcomes, national data finds that few people with co-occurring disorders receive appropriate treatment.

Receipt of Mental Health Services and Specialty Substance Use Treatment in the Past Year among Adults Aged 18 or Older with Past Year Serious Mental Illness and Substance Addictions



Co-occurring mental illnesses and addictions multiply the impacts of the other disorder

- Reduced treatment effect
- Poorer psychosocial functioning
- Higher number of days in treatment
- Higher rates of treatment attrition
- More treatment admissions
- Higher disease burden from both the mental illness and substance addiction

National analysis looked at 3.1 million adults (over age 18) with co-occurring serious mental illness and substance use disorders. Eunice Park-Lee, Rachel N. Lipari, and Sarra L. Hedden, "Receipt of Services for Substance Use and Mental Health Issues among Adults: Results from the 2016 National Survey on Drug Use and Health", SAMHSA, September 2017; Linda E Wusthoff, Helge Waal and Rolf W Grawe, "The effectiveness of integrated treatment in patients with substance use disorders co-occurring with anxiety and/ or depression – a group randomized trial. *BMC Psychiatry 2014, 12:67.*

Integrated treatments for people with co-occurring disorders (CODs) is more effective in improving both health and criminal justice outcomes.

A unique behavioral health treatment approach is required when a person has *a* serious mental illness *combined with* a substance addiction.

Integrated treatments simultaneously attend to both sets of disorders, consider them both primary conditions, and adhere to consistent philosophies and treatment plans.

COD treatment approaches have been shown to be more effective than treating them separately.

People with CODs are more likely to be arrested, violate conditions of community supervision, and commit acts of violence.

In the criminal justice population, receiving COD treatment while incarcerated is correlated with significantly reduced recidivism rates. Reduced recidivism is maximized when they receive treatment in both prison and community settings.

Sources: Co-Occurring Substance Use and Mental Disorders in the Criminal Justice System: A New Frontier of Clinical Practice and Research *Psychiatric Rehabilitation Journal © 2015* American Psychological Association 2015, Vol. 38, No. 1, 1–6 1095-158X/15/$12.00 http://dx.doi.org/10.1037/prj0000135.
Talbott, J. (2006). Prevalence and Co-occurrence of Substance Use Disorders and Independent Mood and Anxiety Disorders: Results From the National Epidemiologic Survey on Alcohol and Related Conditions. *Yearbook of Psychiatry and Applied Mental Health, 2006*, 135. doi:10.1016/s0084-3970(08)70128-2

While integrated treatment for co-occurring disorders is more effective than treatment for only one disorder or treatments performed separately, there are multiple systemic barriers to providing integrated treatment in Oregon.

The barriers to providing COD treatment in OR are similar to most states, and include both agencies and individual providers.

The burden falls on the agencies and the individual providers to establish and maintain dual licensure as a mental health specialist *and* substance addiction treatment provider.

Reimbursement rates are not designed to support or incentivize provision of such services.

- No salary incentive for providers
- No funding incentive for agencies

Adhering to the Risk-Need-Responsivity (RNR) principles is central to improving criminal justice outcomes.

Principle	Implications for Supervision and Treatment
Risk Principle	Focus resources on higher **RISK** individuals; limited supervision of lower **RISK** individuals
Needs Principle	Target the **NEEDS** associated with recidivism such as antisocial attitudes, antisocial associates, unemployment, substance addiction
Responsivity Principle	General and specific factors impact the effectiveness of treatment. Be **RESPONSIVE** to learning style, motivation, culture, demographics, and abilities of the offender

Substance Addiction is a recidivism **Risk Factor**

Mental Illness is a **Responsivity Factor**

Co-occurring disorders include both **Risk and Responsivity Factors**

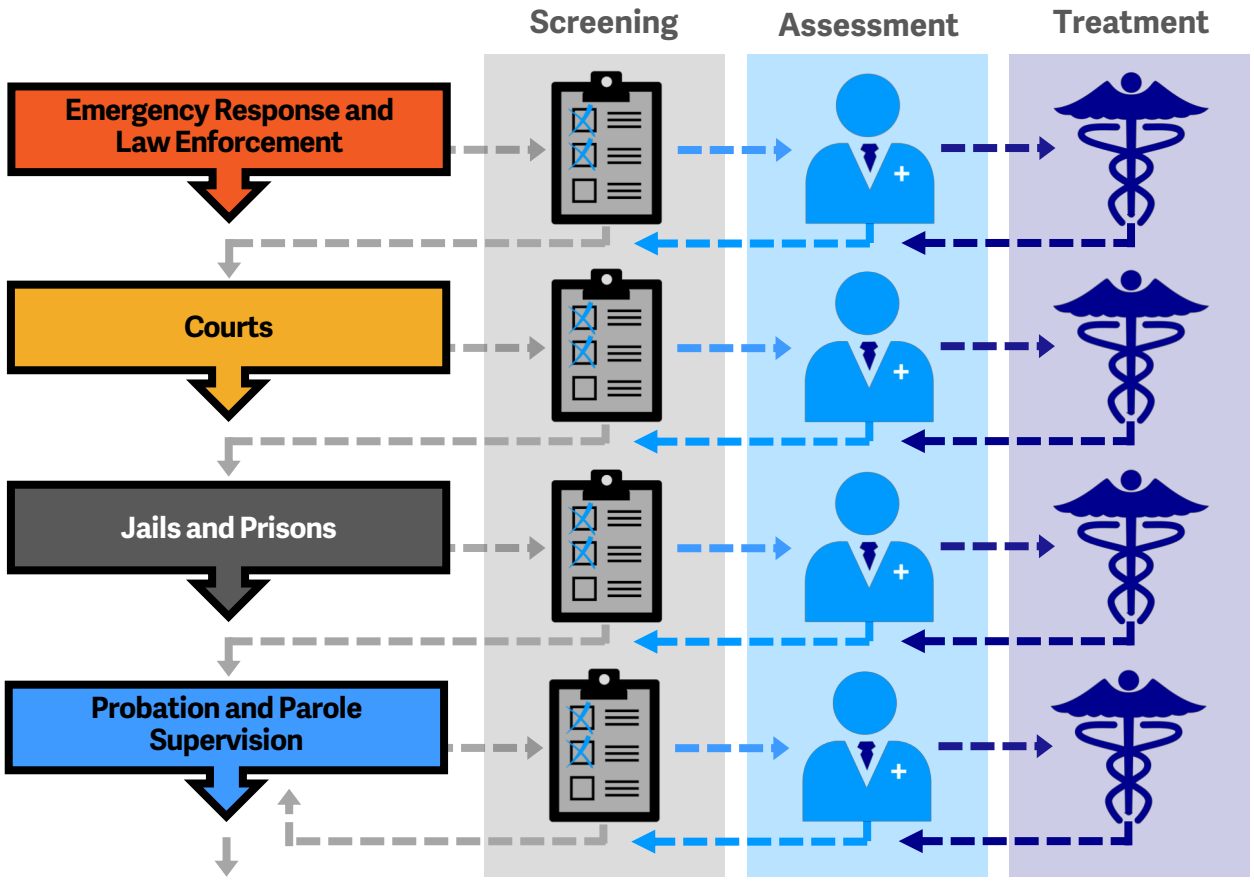
Source: Donald Arthur Andrews and James Bonta, *The Psychology of Criminal Conduct* (Cincinnati: Anderson), 2010.

Improving health and public safety outcomes requires states to address four key challenges at a systemic and statewide level.

1. **Improve identification** of people who have behavioral health needs in the criminal justice system.
2. **Ensure access to** a comprehensive array of treatment and services.
3. **Increase effectiveness** of treatment to improve public safety and health outcomes.
4. **Strengthen collaboration** between behavioral health and criminal justice agencies at the state and local level.

1 **Improve identification** of people who have behavioral health needs in the criminal justice system.

We can't treat what we don't identify. All too often, the criminal justice system doesn't screen and assess for behavioral health needs. Data must always be collected, recorded, and shared at every point in the criminal justice system.



People with complex needs require a broad range of supports and services to overcome barriers and to address criminogenic and behavioral health needs.

Common Access Challenges:

- Funding limitations
- Practical barriers (transportation, housing, etc.)
- Workforce and capacity shortages
- Waiting lists
- Provider reluctance
- Reimbursement rates
- Regional shortages

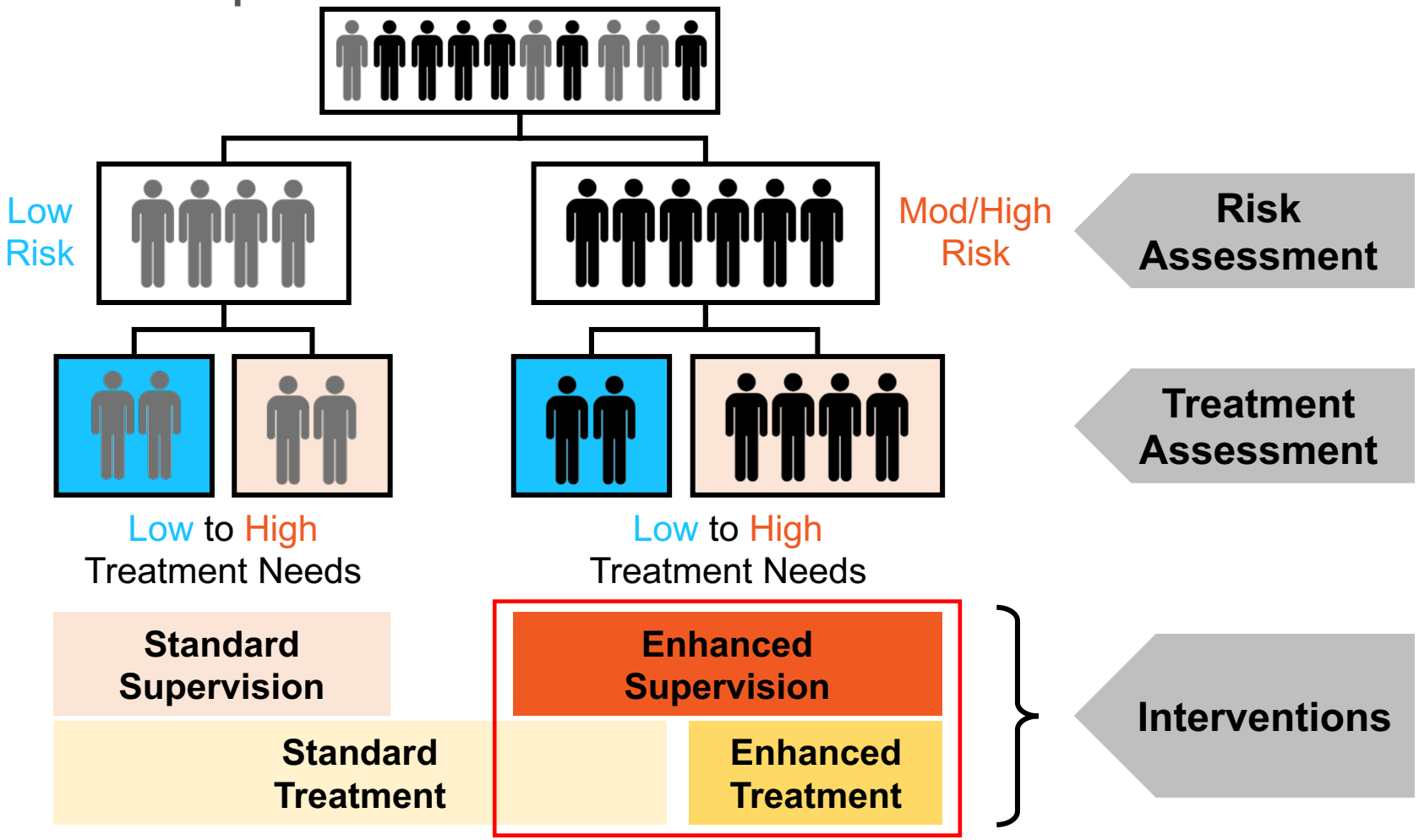
To improve public health and safety outcomes, services must be targeted to the right people, be evidence based, and of high quality.

Key Principles and Practices for Increasing Program and Treatment Effectiveness

Priority	Principle	Practice
1	**WHO:** target the right people based on risk	✓ Assess risk ✓ Program based on risk ✓ Address multiple needs
2	**WHAT:** rely on effective programs	✓ Use research ✓ Integrate services ✓ Intensity and speed ✓ Offer a continuum
3	**HOW WELL:** implement with quality and fidelity	✓ Implement consistently ✓ Ensure fidelity ✓ Evaluate programs ✓ Train staff

3 **Increase effectiveness** of treatment to improve public safety and health outcomes.

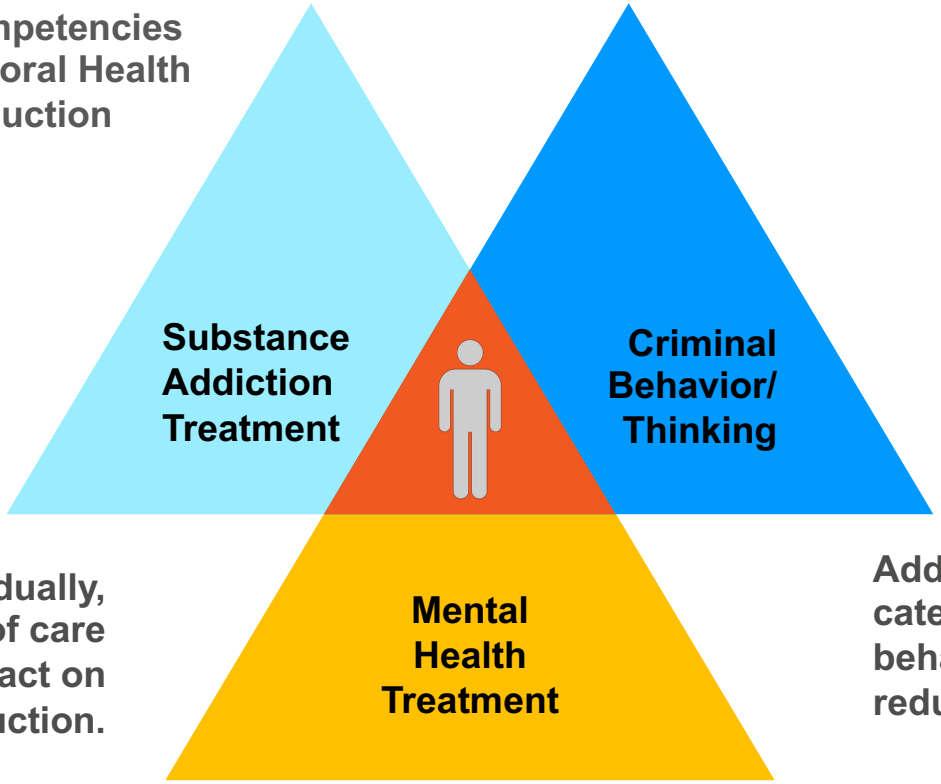
Risk-needs assessments combined with behavioral health assessments help ensure that people receive the types and intensities of interventions needed to improve outcomes.



3 **Increase effectiveness** of treatment to improve public safety and health outcomes.

Effective interventions for people in the criminal justice system who have behavioral health challenges address both criminogenic and health needs.

Core Treatment Competencies Required for Behavioral Health and Recidivism-Reduction Improvements



Addressed individually, these categories of care have minimal impact on recidivism reduction.

Addressed together, these categories of care improve behavioral health and reduce criminal behavior.

For people working with people in criminal justice systems, there are sets of fundamental knowledge and skills essential to improving outcomes.

Core correctional practices

- Effective use of authority
- Appropriate modeling and reinforcement
- Skill building and problem-solving strategies
- Effective use of community resources
- Relationship factors

Cognitive behavioral Interventions

Behavioral health

- Basics of addiction and mental health
- Mental Health First Aid

Systems of ensuring fidelity

Culturally responsive approaches

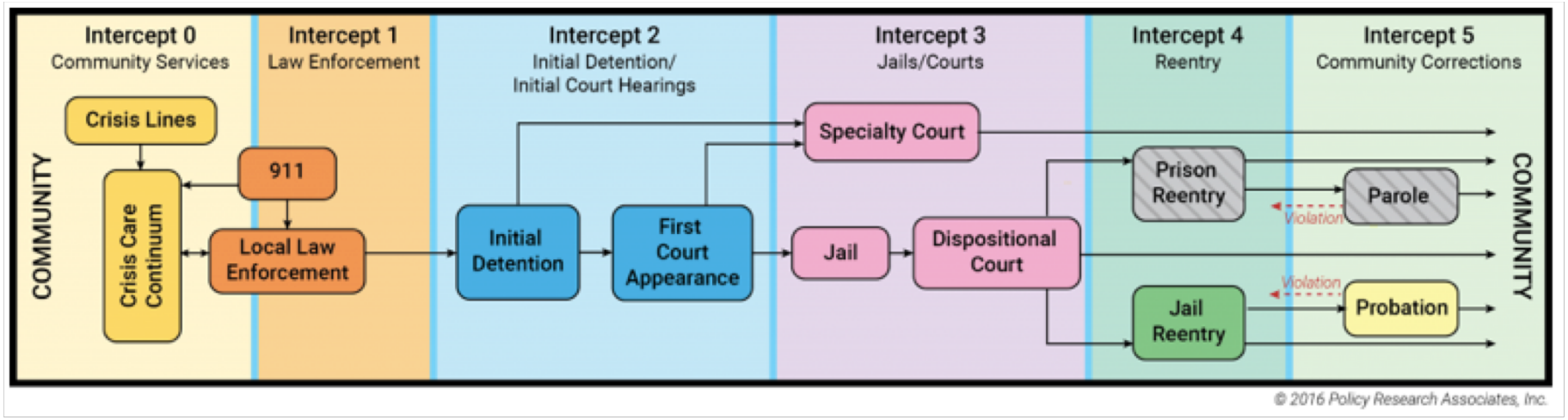
Engagement

- Motivational Enhancement

Trauma-informed approach

3 **Increase effectiveness** of treatment to improve public safety and health outcomes.

Because people with complex conditions often are engaged by multiple agencies at various intercepts, improving outcomes depends on a broad, multifaceted training approach.



Law enforcement
Dispatch
Crisis staff

Courts
Prosecutors
Defense attorneys
Diversion programs

Jail staff
Treatment personnel

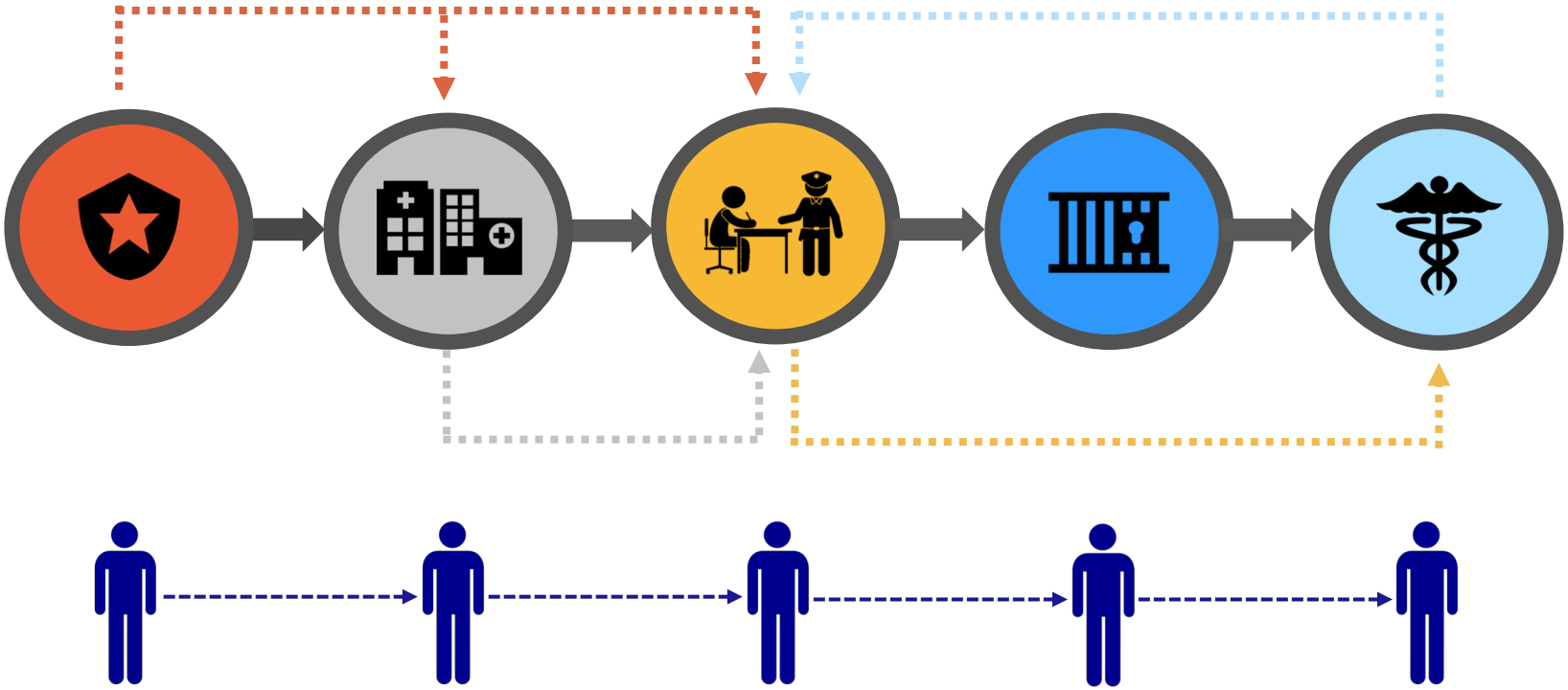
Reentry staff

Community Supervision
Community Supports and Service staff

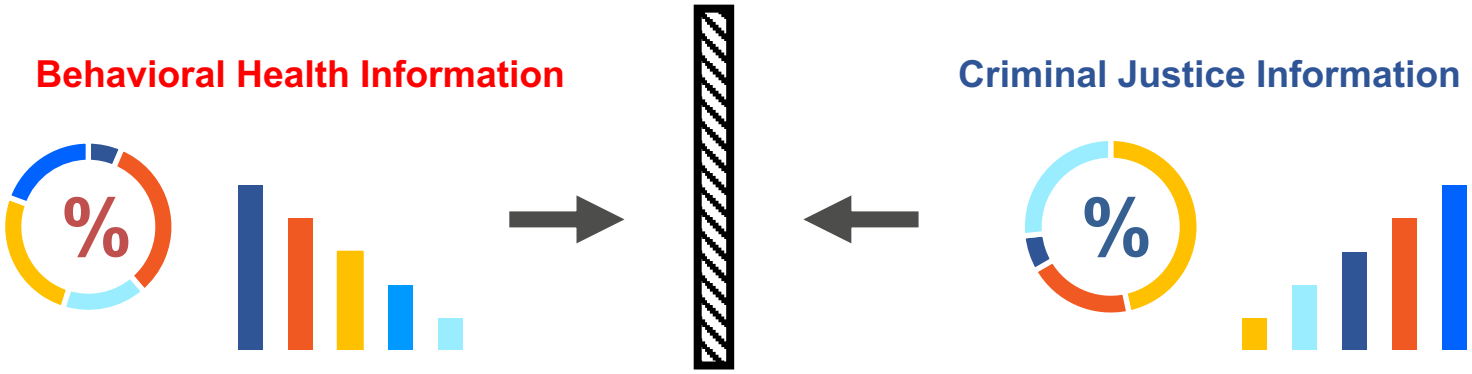
Adherence can be supported through a combination of regulation, standards, technology, and funding.

4 **Strengthen collaboration** between behavioral health and criminal justice agencies at the state and local level.

When agencies communicate, collaborate, and coordinate, a person with behavioral health needs is more likely to move smoothly through the system and have their needs more comprehensively addressed.



Data and case information sharing across behavioral health and criminal justice systems is crucial to delivering effective care to people but is often impeded by structural barriers.



Data sharing for people in both criminal justice and behavioral health systems is necessary for

- Ensuring continuity of care;
- Eliminating duplication;
- Applying consistency in assessment, evaluation, and case planning; and
- Evaluating outcomes.

Policymakers and practitioners are often stymied by persistent beliefs about the impossibility of data sharing, such as

- No one can access addiction information;
- Only health care providers can share personal health information ("PHI"); and
- You always need a patient's authorization to release information.

The remaining slides will be used to facilitate resource and policy discussions to build upon the agreed upon project framework from the 12/20 Oregon Behavioral Health Justice Reinvestment Steering Committee meeting.

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   - A. Establishing oversight structures
   - B. Defining effective services
   - C. Understanding the workforce and workforce challenges
   - D. Statewide assistance
2. Evaluation, accountability, and innovation
   - A. Quality improvement
3. Funding strategies
   - A. Leverage federal participation for services reimbursable through Medicaid

Next Steps

The new program will require oversight which could be accomplished through a standing committee that receives assistance through the establishment of standing and task-specific subcommittees.

§ BHJR Committee
Standing multiagency committee charged with project oversight

- Reviews, approves applications
- Monitors grantee performance
- Generates reports to legislature
- Links with existing committees and task forces
- Oversees standing and interim subcommittees

Subcommittee 1	Subcommittee 2	Subcommittee 3

A critical role for the BHJR committee would be to oversee the program application and granting processes.

§ BHJR Committee
Standing multiagency committee charged with project oversight

Application process

- Funding attached to a grant process
- Counties, regional consortiums, and tribal governments eligible to submit proposals
- Process designed to allow potential grantees to "opt in"

Includes commitments by the applicant

- Multiagency signatories
- Financial and other commitments
- Data requirements

The new program oversight structures granting authority and process should be established in legislation, along with funding necessary to accomplish these functions.

§ *Statute change*

Establish program oversight structure requirements

- Oversight committee authority
- Oversight committee composition

Establish key granting parameters

- Define target population and program goals
- Identify eligible entities to receive grant funding

Set minimum legislative reporting requirements

$ *Funding request*

- Ensure sufficient funds to staff key committee(s)
- Provide funds for committee member travel, per diem, training, and communication technology

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Next Steps

1 **Support and services.** Establish comprehensive community programming to improve outcomes for this population.

The BHJR Committee, in consultation with relevant subcommittee(s), would define an evolving set of supports and services authorized for funding under the program.

BHJR Committee
Approves grant applications

Subcommittee

- Updates service "menus" based on evaluations and research
- Provides feedback to jurisdictions on program performance
- Approves "off the menu" requests

Tier 1: Foundational Services
Oregon Performance Plan

Tier 2: Additional Services and Supports

Tier 3: Emerging Services

Given the anticipated crossover between the program's high utilizer and Oregon's Performance Plan (OPP) populations, it is essential that communities establish sufficient access to OPP services.

Tier 1:
Foundational Services
(*Oregon Performance Plan)*

- Assertive community treatment
- Mobile crisis services
- Supported housing
- Supported employment
- Peer-delivered services
- Transitional services (OSH + ED)

Oregon Performance Plan

In 2012, Oregon entered into agreement with the U.S. DOJ to increase access to community-based services for people with severe and persistent mental illnesses.

Expanded community-based services are designed to:

- Improve transitions to more integrated settings
- Increase number of people successfully integrated in community
- Avoid incarceration and unnecessary hospitalization

A set of additional authorized funded supports and services would be established based on strong evidence of effectiveness for the target population.

Tier 2:
Additional Services and Supports
Examples of additional services and supports

- Care coordination
- Case management
- Transportation
- Medications
- Co-payments
- Employment supports
- Workforce
- Training
- Supportive Housing
- Other housing options
- Crisis Units
- Sobering/Detox Centers
- Pretrial supervision
- Bench probation
- Specialized probation

The BHJR committee would establish a process for reviewing requests for funding services with compelling justifications but that are not included in Tiers 1 or 2.

Tier 3:
Emerging Services

Specialized or Emerging Practice Services

- Evidence-based or promising practice
- Targeted to population
- Seen as critical to facilitate other needed supports and services

Subcommittee
Reviews and provides recommendations to BHJR committee regarding grantee requests to fund specialized or emerging practice services

1 **Support and services.** Establish comprehensive community programming to improve outcomes for this population.

To help ensure program funds are expended effectively, the BHJR committee should be given clear responsibility and authority to determine the types of supports and services to be funded under this program and to assist grantees in prioritizing supports and services mostly likely to help grantees reach their outcome goals.

§ *Statute change*

Establish BHJR committee authority and process to determine the types of supports and services authorized to receive program funding

$ *Funding request*

Service funding recommendations included in funding section

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Next Steps

There are significant behavioral health workforce and recruitment and retention challenges across the state.

Key Takeaways from Heath Share of Oregon Market Rate Study, 2017
Tri-County Region (includes Clackamas, Multnomah and Washington Counties)

Inability to meet patient demand. Since the expansion of Medicaid in 2014, behavioral health providers have had challenges hiring and retaining sufficient clinical workforces to meet patient demand.

Gaps between current payment rates and payment costs. Health Share's combined mental health and addictions payment rates are between 7% and 19% below current costs, including clinician compensation and overhead. The gap is significantly larger for addiction services—payment rates are 25% to 39% below costs.

Difficultly in providing salaries that are competitive. Nonprofit behavioral health clinics in the Tri-County Region compete with local hospitals and government clinics to hire and retain staff. Other contributing factors affecting staff retention include low pay, high patient no-shows, high caseloads, and the inability to meet the needs of existing clients who are being underserved.

Health Share Provider Network clinician salaries and network benefits are not competitive. Clinician salaries in the Health Share Behavioral Health Provider Network are currently 1.9% below median salaries in the region and 20.8% below salaries at the 75th percentile. Clinician benefits in the Health Share Behavioral Health Provider Network are currently 27.4% below median benefits of a comparison group of Health and Social Service Organizations and 35.8% below Hospital benefit rates.

A behavioral health workforce includes a wide range of position types and training.

Medical Prescribers
(Requires license)

Psychiatrists

Addiction Medicine MDs

Nurses Practitioners

Professional Clinical Positions
(Requires license)

Psychologists

Clinical Social Workers

Licensed Counselors and Therapists

Paraprofessional and Non-traditional Positions
(Can be certified or unlicensed)

Certified Alcohol/Drug Counselor

Case managers

Peer and Mentor Roles

Oregon is already experiencing a shortage of psychiatrists and addiction counselors, and those shortages are projected to worsen over the next decade.

Examples from DHHS Workforce Analysis

Occupation	Supply	Adequacy of Supply	
		Current	2030
Psychiatrist	600	(170)	(240)
Nurse practitioners	200	30	60
Addiction Counselor	1700	(60)	(510)
Mental Health Counselors	2790	520	610

Source: *U.S. Department of Health and Human Services, Health Resources and Services Administration, National Center for Health Workforce Analysis. 2018. State-Level Projections of Supply and Demand for Behavioral Health Occupations: 2016-2030, Rockville, Maryland.*

Note: *Data unavailable for paraprofessional and non-traditional occupations*

While each type of behavioral health position is critical to overall service delivery, the development lead time and cost varies widely.

		Formal Development*	Recommended Salary Estimates***
Prescribers	Psychiatrist	12 years	$261,800
	Nurse Practitioner	6-8 years	$129,500
Licensed Professionals	Psychologist	8-10 years	$91,700
	QMHP	8 years	$71,600
	SUD Counselor CADC I CADC II	150 hours BA+	$38-48,000
Para-professionals	QMHA	3-4 years	$45,800
	Below Bachelor Degree	Varies	$38,100
	Peer	2 weeks**	$38,100

**Includes time required for formal education and training for independent practice*

*** Peers also require significant meaningful life experience to inform practice*

Source: Drawn from 2017 Health Share of Oregon Behavioral Health Rate Study Focus Group Recommendations (except psychologist and CADC salaries which were drawn from review of current Oregon job postings)

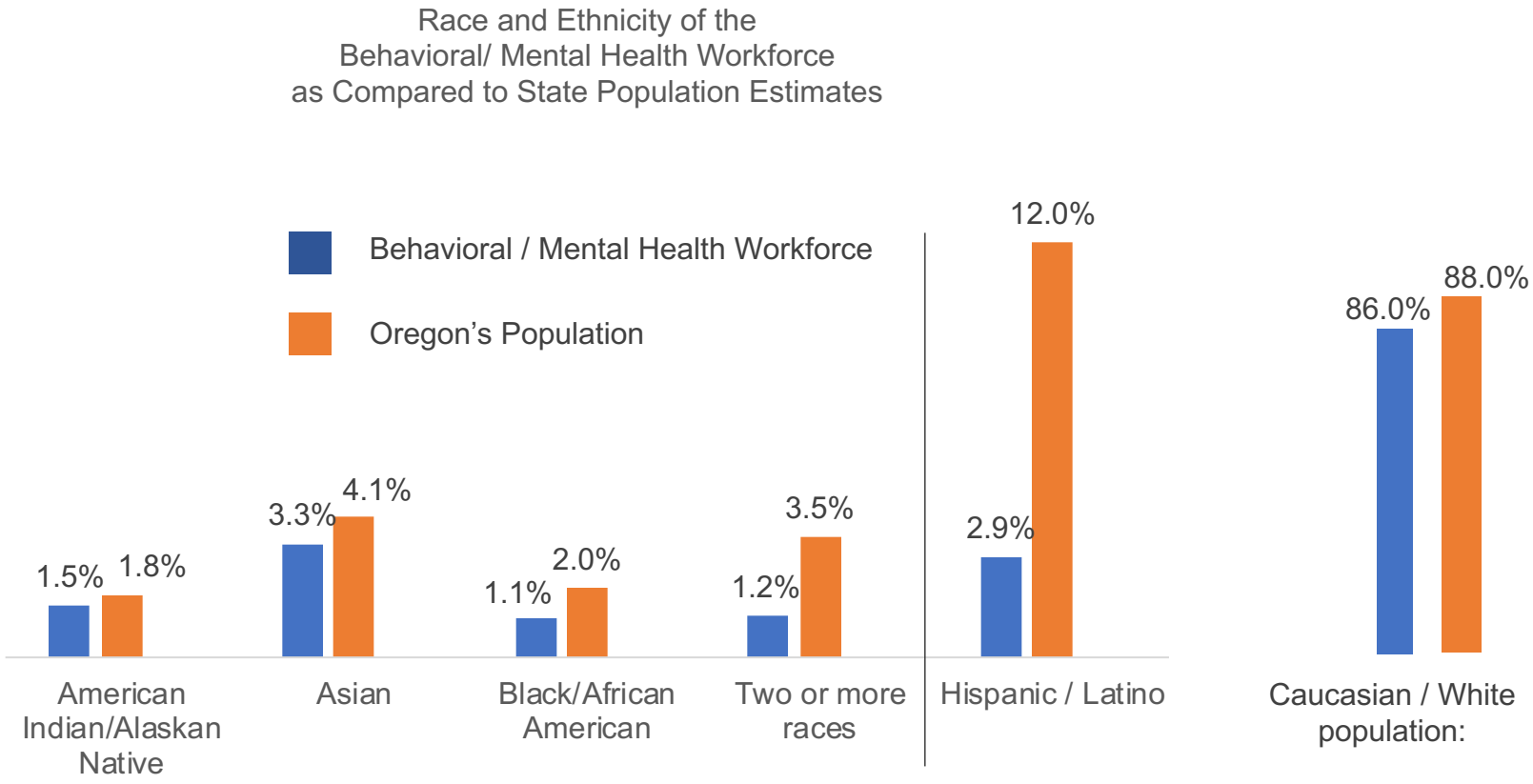
Oregon has a more developed peer support workforce than many other states, and there are opportunities to strengthen it.

Peer support specialists (PSS) have lived experience of mental illness and/or addiction issues, are in recovery, and are willing to disclose and utilize their experience to assist others in earlier states of recovery.

PEER SUPPORT LITERATURE REVIEW*
Reduction in number and length of psychiatric hospitalizations
Improved treatment retention
Decrease in substance use
Decreased criminal and increased prosocial behaviors
Improved outcomes for individuals with SPMI

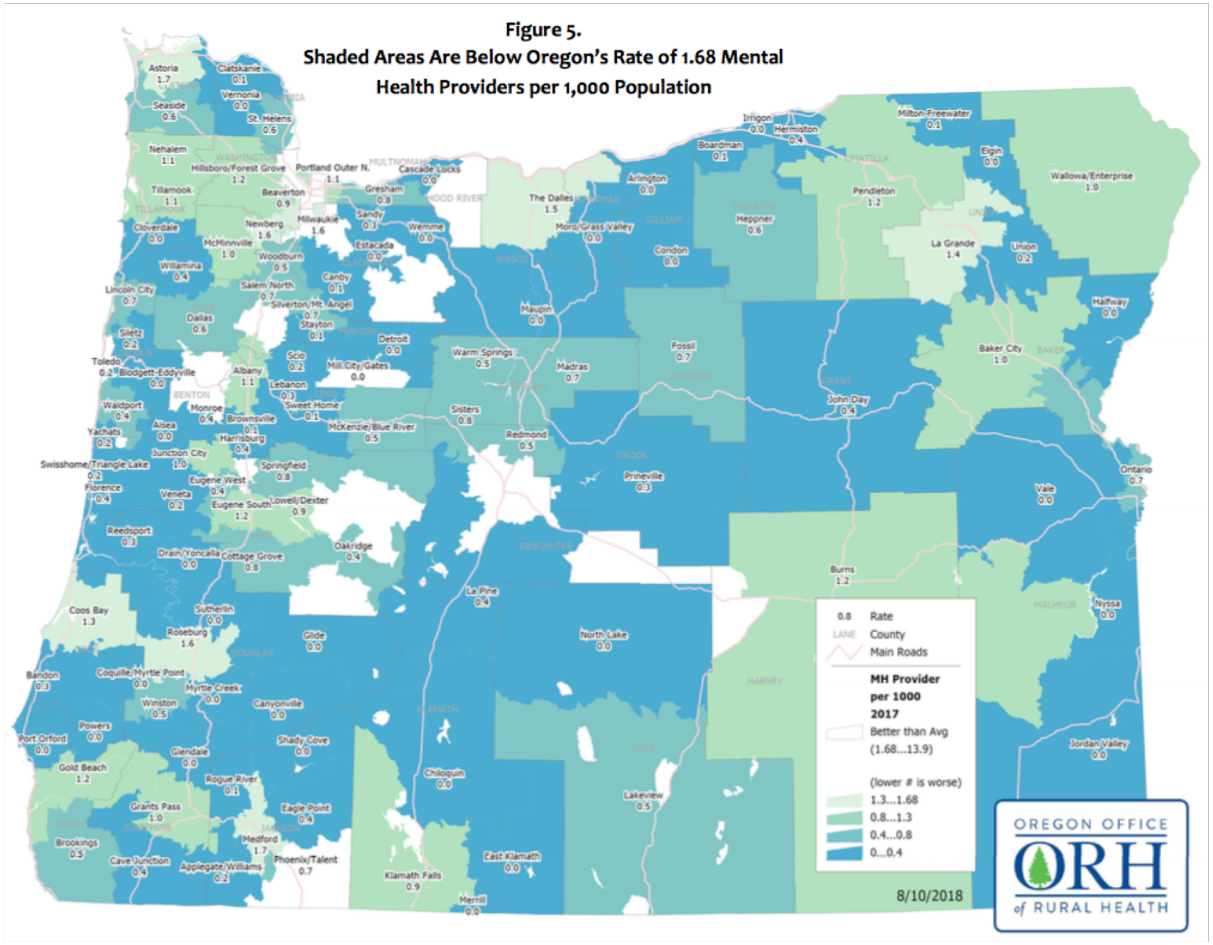
Sources: The majority of studies on the impact of PSS services are on people with SUD's, with or without CJ involvement. There are fewer studies specifically on CJ-related impact. Needs further study. Gulstad, J. M., (2018) Review of Peer Support Services in Criminal Justice Settings. Unpublished Manuscript not submitted for publication. For full list of articles reviewed, please see Appendix. For additional information regarding Medicaid healthcare felony exclusions, see Social Security Laws: SEC. 1128. **[**42 U.S.C. 1320a–7**]**

Oregon's behavioral health workforce is least reflective of the state's general population among black/African American and Hispanic/Latino populations.



Source: Oregon Health Authority, "Oregon's Licensed Behavioral/Mental Health Care Workforce: A Profile of Selected Behavioral/Mental Health Occupations", June 2015 https://www.oregon.gov/oha/HPA/ANALYTICS/HealthCareWorkforceReporting/Oregon%27s-Licensed-Behavioral-Mental-Health-Care-Workforce-June2015.pdf

Access to mental heath care is remarkably uneven across Oregon.



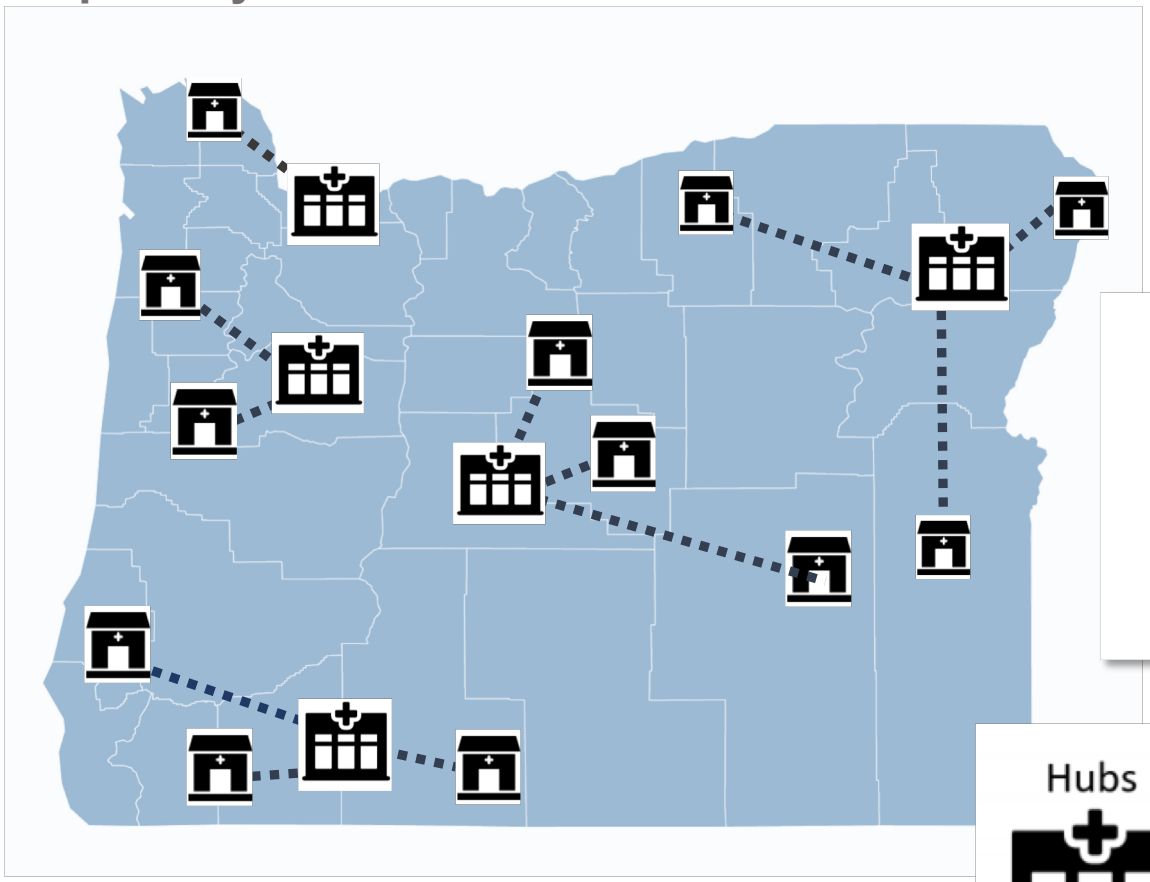
28 of 130 service areas had **no providers**

39 had **.5 or fewer providers** per 1000 people

Portland Downtown, Eugene/University and Portland Inner South had the highest ratios

Source: The Oregon Office of Rural Health, " Oregon Areas of Unmet Needs Report," August 2018. Report published online at: https://www.ohsu.edu/xd/outreach/oregon-rural-health/about-rural-frontier/upload/2018-Area-of-Unmet-Health-Care-Need-Report.pdf

Oregon could build on OHSU's Oregon Psychiatric Access Line (OPAL) model by developing a system of regional hubs and spokes for a variety of specialty services.



VERMONT
AGENCY OF HUMAN SERVICES

Vermont Blueprint for Health

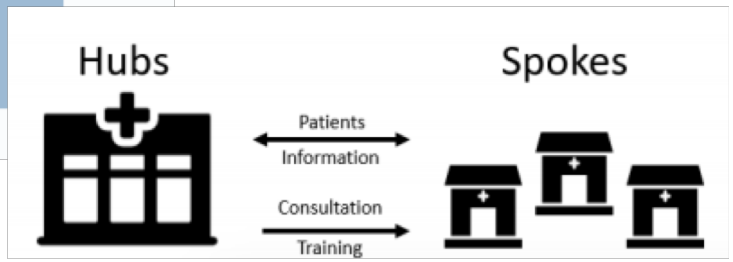
Hub & Spoke

Vermont's Opioid Use Disorder Treatment System

Hub and Spoke is Vermont's system of Medication Assisted Treatment, supporting people in recovery from opioid use disorder. Nine Regional Hubs offer daily support for patients with complex addictions. In over 75 local Spokes, doctors, nurses, and counselors offer ongoing addiction treatment fully integrated with general healthcare and wellness services. This framework efficiently deploys addictions expertise and helps expand access to opioid user disorder treatment for Vermonters.

Medication Assisted Treatment: The Evidence-Based Approach to Opioid Addiction

Medication Assisted Treatment (MAT) uses medication such as methadone and buprenorphine, as part of a comprehensive opioid use disorder treatment program that includes counseling. Medication Assisted Treatment is not the only treatment for opioid addiction, but it is the most effective treatment for most people. It is supported by the American Medical Association, the American Academy of Addiction Psychiatry, and the American Society of Addiction Medicine. Federal regulations designate two settings where Medication Assisted Treatment can take place, Opioid Treatment Programs (OTPs) and Office Based Opioid Treatment (OBOT) settings. Vermont takes this structure as a starting point, and strengthens and connects the elements.



Source: OPAL: https://www.ohsu.edu/xd/education/schools/school-of-medicine/departments/clinical-departments/psychiatry/divisions-and-clinics/child-and-adolescent-psychiatry/opal-k/ and Vermont's Hub and Spoke: https://blueprintforhealth.vermont.gov/about-blueprint/hub-and-spoke

Oregon already has some programs in place to support rural workforce development, but the impact of these programs is modest.

Examples of Current Incentive Programs

Loan Repayment Programs

Tax-free funds for qualified health care providers working in approved disciplines at eligible practice sites, in exchange for a service obligation.

Loan Forgiveness Programs

Tax-free funding for qualified students enrolled in an approved academic program(s) in exchange for a future service obligation.

Rural Medical Practitioners Insurance Subsidy Program

Provides partial payments to authorized medical professional liability insurance carriers on behalf of health care providers in rural Oregon who otherwise would have to pay the full cost of malpractice insurance themselves.

Tax Credits

Grants personal income tax credits to eligible rural providers

34.9% of Oregon's population lives in rural and frontier communities

In 2017:

- 125 loan repayment and 32 loan forgiveness recipients were practicing in 118 rural or urban underserved sites.
- Oregon Rural Health approved loans for 4 students totaling $140,000 through the Primary Care Loan Forgiveness Program.

Source: Oregon Office of Rural Health, *2017 Year-End Report*

Practical long- and short-term strategies can reduce barriers for recruitment to and retention of behavioral health positions.

Key Recruitment and Retention Barriers

- Compensation
- Work schedule
- Housing availability and quality
- Cultural activities
- Spousal employment
- Continuing education

In February 2019, the State Legislature will receive a Health Care Workforce Needs Assessment for communities and patients in Oregon (2017 HB 3261)

Short-term

- Pay competitive wages and benefits to help recruit and retain existing workforce
- Leverage and expand tuition reimbursement and loan forgiveness programs
- Provide clinical supervision and mentoring
- Provide continuing education
- Ensure housing access
- Strengthen access to tele-health technology

Longer-term

- Initiate recruitment in high schools for rural areas
- Remove barriers to education access
- Strengthen cultural and linguistic workforce diversity
- Strengthen and utilize career ladders
- Strengthen rural access to specialized expertise (psychiatry, addiction medicine)

Source: *Behavioral Health + Economics Network. Addressing the Behavioral Health Workforce Shortage.* http://www.med.und.edu/about-us/_files/docs/third-biennial-report.pdf.

Workforce is critical to program success and must be included in program requirements along with adequate funding.

§ *Statute change*

Require grantees to address workforce needs in program proposals, adequate to meet requested services needs:

- Recruitment
- Retention
- Workforce development and supports

Require development of minimum training standards along with annual continuing education for individuals and agencies providing services through the program.

$ *Funding request*

Authorize a portion of the overall program funding to be applied to local workforce initiatives to support the program.

Discussion for Today

Understanding Behavioral Health

Building the Framework for Effective Behavioral Health Services in Populations with Frequent Criminal Justice Involvement

1. **Support and services**
   - A. Establishing oversight structures
   - B. Defining effective services
   - C. Understanding the current workforce and future needs
   - **D. Statewide assistance**
2. Evaluation, accountability, and innovation
   - A. Quality improvement
3. Funding strategies
   - A. Leverage federal participation for services reimbursable through Medicaid

Next Steps

Develop a limited but critical set of statewide technical assistance services to support communities in designing, requesting, and implementing program services and supports.

Training Fund

1. Statewide training remotely or in person, mandatory or voluntary
2. Training or clinical supervision that could be used as a request
3. Provide/require mutual training for judges, district attorneys, and defense attorneys, behavioral health professionals, and law enforcement on complex cases involving defendants with behavioral health issues, best practices, and existing options in Oregon statute.
4. Behavioral health workforce training

Statewide Assistance

1. DA resource prosecutor to consult on complex behavioral health cases
2. Technical assistance for troubleshooting program data collection requirements and information sharing between relevant parties
3. Strengthen statewide “hub and spoke” clinical supports for “hard-to-find” professional specialties, including addiction medicine and psychiatry
4. Grantee proposal technical assistance

Statewide Program Assistance Policy Recommendations

§ *Statute change*

- Authorize use of up to 20% of program funding for a system of statewide program supports that are deemed critical for program success.
- BHJR Committee designated spending authority
- Activities and spending under this provision to be included in annual reports to legislature.

$ *Funding request*

Set aside up to 20% of overall funding to establish and sustain a set of critical statewide program supports.

Discussion for Today

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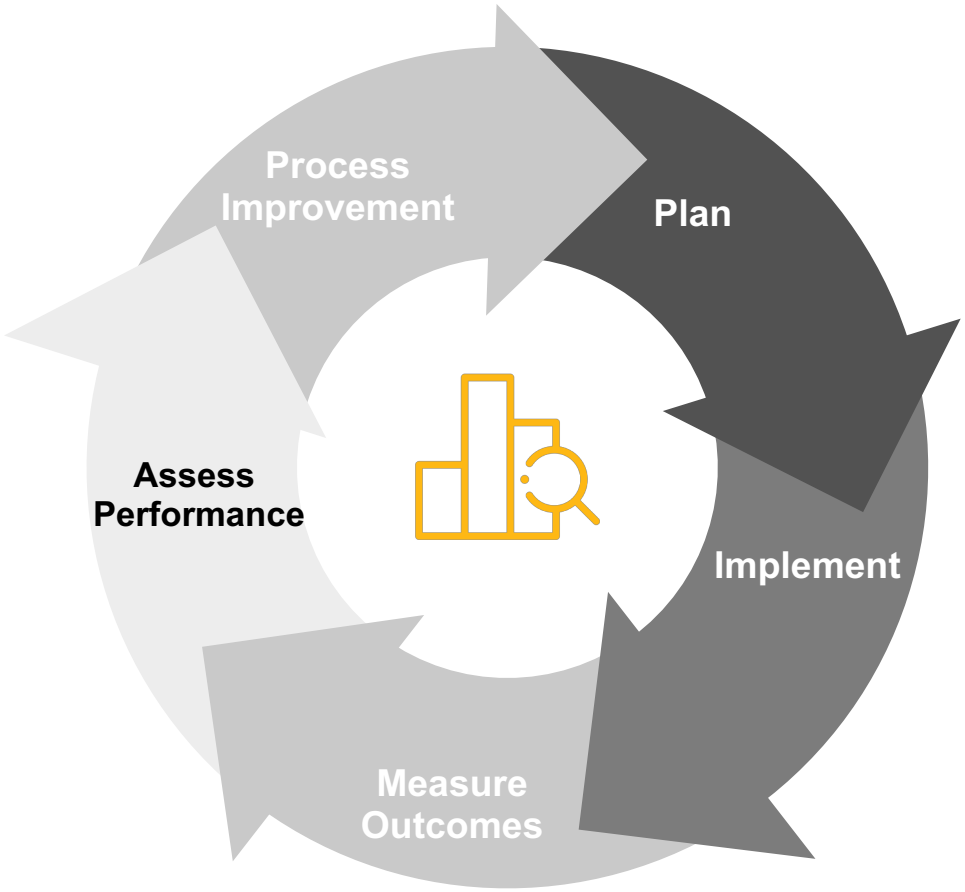
   - **A. Quality improvement**
3. Funding strategies
   - A. Leverage federal participation for services reimbursable through Medicaid

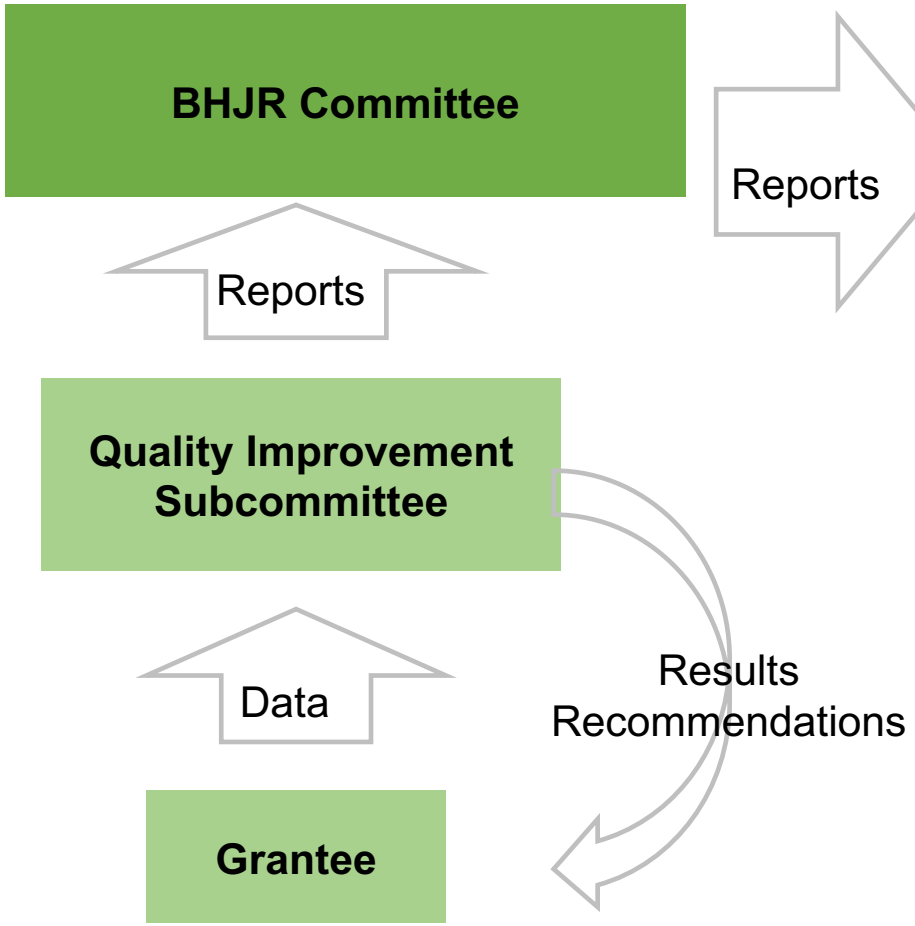
Next Steps

Quality Improvement



A robust and responsive system of program measures can improve system focus and refine approach to achieve public safety and health outcomes goals.

Quality Improvement



Quality Improvement subcommittee tasked with:

- Evaluating results at the local, regional, and statewide levels
- Providing guidance to assist local and regional participants to improve results
- Promoting and studying innovation

Quality Improvement Subcommittee

Suggested Membership

Key state agencies
Research universities
Critical stakeholders
Funders

In addition to improving practice, results from program data can be used to help contribute to both Oregon specific and national databases and literature.

Oregon Knowledge Bank
a local public safety resource

EVIDENCE-BASED PRACTICES
RESOURCE CENTER

Research Publications

Quality Improvement (QI) Recommendations

§ *Statute change*

- Identify a lead agency responsible for developing and reporting outcomes to grantees, the BHJR Committee, and the legislature.
- Establish a system of meaningful, clear, and consistent program metrics.
- Establish the composition of the QI subcommittee.
- Structure the QI subcommittee to report to the BHJR Committee.
- Require the QI subcommittee to report at least annually to the BHJR Committee and legislature on its activities and spending.

$ *Funding request*

Set aside 5% of overall program funding to support QI functions with funding distributed to the lead agency.

Discussion for Today

Understanding Behavioral Health

Building the Framework for Effective Behavioral Health Services in Populations with Frequent Criminal Justice Involvement

1. Support and services
   - A. Establishing oversight structures
   - B. Defining effective services
   - C. Understanding the current workforce and future needs
   - D. Statewide assistance
2. Evaluation, accountability, and innovation
   - A. Quality improvement
3. **Funding strategies**
   - **A. Leverage federal participation for services reimbursable through Medicaid**

Next Steps

3 **Funding strategies.** Establish a system of shared financing to sustainably support these programs.

Oregon can maximize the impact of local and state general fund investments by ensuring that all reimbursable health care services are provided leveraging federal financial participation (FFP) through Medicaid.

Traditional Medicaid

Disability-based

$1 spent by the state → **$1.67** federal dollars matched

~63% costs covered by federal match

smaller eligible population

Medicaid Expansion

Income-based

$1 spent by the state → **$9.00** federal dollars matched

90% costs covered by federal match

larger eligible population

Providing services through the Oregon Health Plan (OHP) also helps strengthen communication, collaboration, and coordination with other needed health care services.

Maximizing FFP and helping to ensure program services are integrated with broader Oregon health systems will require a series of actions supported by legislation.

§ *Statute change*

- Require program providers to inquire about program participants' OHP status and enroll all eligible program participants in Medicaid.
- Require grantees to routinely gather and report OHP status and enrollment data.
- Require OHA and grantees to work collaboratively to streamline enrollment and to minimize the length of time eligible program participants lack active coverage.
- Require program providers, when appropriate, to demonstrate their eligibility to provide Medicaid billable services and to bill for all Medicaid eligible services.
- Require OHA to review program service data at least annually with the goal of developing action steps that maximize health care service integration and FFP.

Medicaid Pilot Concept #1

Incentivize CCOs to help improve criminal justice along with health outcomes for targeted individuals for whom inadequately treated mental illnesses and/or substance addictions are a primary driver of the individual's criminal justice involvement.

- An estimated 90% of the targeted "high impact" individuals will be OHP members or OPH eligible
- Leverages Oregon's health care systems to address challenges well-suited for health system strategies (managing and coordinating care for individuals with complex conditions)
- Leverages federal financial participation

Medicaid Pilot Concept #2

CCO agrees to accept financial responsibility for primary and behavioral health care within one or more jails.

- Substantial majority of people booked into Oregon jails are expected to be OHP members or eligible for OHP
- Jail health care becomes integrated with the rest of Oregon's OHP health care systems, increasing continuity of care and improving health outcomes
- Cost of care can be better managed
- CCOs incentivized to support services and practices that help reduce instances of incarceration, reducing associated criminal justice impacts and related costs

The two identified pilots could be established administratively, but key local and state agencies may benefit from legislative guidance and support.

- These pilots could be highly valuable in informing future practice and CCO contract development.
- Pilots would be of national interest.
- Pilots require participation by multiple agencies who may not find compelling reasons for participation.
- Strong commitments to technical assistance and financial incentives may stimulate interest.

$ *Funding request*

Modest funding for technical assistance and performance incentives

Discussion for Today

Understanding Behavioral Health

Building the Framework for Effective Behavioral Health Services in Populations with Frequent Criminal Justice Involvement

1. Support and services
   - A. Understanding the workforce and workforce challenges
   - B. Establishing oversight structures
   - C. Defining effective services
   - D. Statewide assistance
2. Evaluation, accountability, and innovation
   - A. Quality improvement
3. Funding strategies
   - A. Funding concepts and Medicaid

Next Steps

Next Steps

- Create an inventory of ideas reflecting agreement from today's discussion
- Engagement with steering committee members in mid to late January
- Fourth and final steering committee meeting on Thursday, February 7

Thank You

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Appendix

Peer Literature Review

The majority of studies on the impact of Peer Support services are on people with SUD's, with or without CJ involvement. There are fewer studies specifically on CJ-related impact. Needs further study. Gulstad, J. M., (2018) Review of Peer Support Services in Criminal Justice Settings.

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