ASSOCIATION OF OREGON COMMUNITY MENTAL HEALTH PROGRAMS

Association of Oregon Community Mental Health Programs

2017 Behavioral Health System Concept Paper

Executive Summary

The Oregon health care system continues to evolve toward the triple aim – better care at a lower cost with better outcomes. We know there is room for improvement in the behavioral health system, but it has never had the opportunity to be fully developed, for a multitude of reasons.

The Affordable Care Act (ACA) has created more demand for behavioral health services than available and has pushed the system beyond capacity. As a Medicaid expansion state, it is challenging to meet the demand in Oregon under the current circumstances.

In a broad sense, the current problem statement can be described as: Oregonians need more timely access to behavioral health services, including prevention and early intervention services, in order to improve overall population health outcomes. Access is a complicated and multifaceted problem affected by multiple factors, such as inadequate investment in the entire care continuum of community-based services, provider shortages, unequal responsibility among payers for behavioral health, unclear roles and gaps between responsibilities of system partners, and unwillingness of individuals to engage in treatment because of stigma, perceptions about the mental health system and other barriers.

The solution is not just to provide more services to more people. Interventions must be customized to the specific needs of individuals, families, cultures and communities and include population based strategies as well as person-centered services. As we figure out how to share and shift responsibilities among federal, state, county and city governments, managed care, and a variety of providers and other system partners, we struggle with different and competitive ideologies. We'll need to work to build trust as we move into new roles and partnerships.

What are the solutions?

We know the behavioral health system alone can't solve all health care and social problems. In the quest for a multi-system set of solutions, we used a cross system context in this concept paper for the next phase of health care system reform in Oregon. We are not likely to make these changes all at once, and availability of resources will force us to prioritize. A summary of overarching recommendations for each focus area is provided here.

1. More investment in health promotion, prevention, and early intervention

There are many things we can do in our communities to get to the root social causes of family distress that cause or exacerbate behavioral health disorders and bad outcomes. We have a

wide range of solutions, starting from universal, low-cost health promotion to increase awareness, lower family stress, reduce stigma, and engage communities in advocating for prevention and early intervention, to group and individual/family interventions that are behavioral health oriented and housed across systems. Priorities include: 1) engaging community members in health promotion and prevention much earlier; 2) funding a continuum of evidence-based prevention services, bringing them to scale statewide with standardized metrics to analyze cost benefit and show return on investment; and 3) establishing cross system partnerships at the local level to promote health and support prevention activities.

2. More investment in decarceration *(for adults and youth)*

Oregon has made some good strides in supporting jail diversion activities, with targeted investments made in crisis services and other key community-based alternatives to incarceration. We recommend continuing funding for crisis services and other jail diversion programs with peer involvement, including housing, Crisis Intervention Training, sobering centers, crisis stabilization centers, mobile crisis, and intensive behavioral health services. We also recommend: 1) improving data gathering and sharing between Law Enforcement and Behavioral Health, standardizing metrics to allow for comparison, outcomes measurement, cost benefit and return on investment analyses; and 2) improving collaboration between Behavioral Health, Criminal Justice/Juvenile Justice and Public Safety to prevent unnecessary incarceration and hospitalization. In addition, it is time to make substantial federal policy changes to allow short term health care coverage in institutional care as a component of some people's continuum of care.

3. Enforcement of Mental Health Parity and Addictions Equity Act of 2008

We will not be able to fully transform our health care system without Commercial Insurance, Medicare and the Veterans Administration (VA) going all in with Medicaid, State and County funders. This will require political will and agency collaboration, particularly at the Federal level, and enforced at the State agency level. We have enough emerging evidence from our CCO "laboratory" and in other Medicaid managed care experiments across the country to convince these insurers, who cover 75% of the population in Oregon, to invest in effective behavioral health care and coordination. To achieve this recommendation, standardized payment must be implemented among all payers, including paying for non-clinic based, pre-treatment outreach and engagement, and non-encounterable behavioral health services, and a systemic, coordinated and collaborative approach must be applied across the continuum of care, regardless of payer, including access to adequate provider networks and sharing of health information data to measure outcomes and track cost benefit.

4. More progress on BH-primary care integration

Three keys to moving integrative care forward are phasing in value-based purchasing (VBP) with the goal of substantially increasing the percentage of VBP to the majority of the funding, advancing a centralized health information technology network of health information exchanges, interoperability of electronic health records, common metrics and consistent data

collection/reporting, and increasing the quantity, flexibility, and compensation of the workforce to perform and thrive in an integrated environment. We also need to continue to make progress on our patient centered primary care homes and behavioral health homes, ensuring strong support for bidirectional integration. These efforts will support the modernization of the substance use disorder delivery system and improve engagement of individuals with mild to moderate mental illness into services.

5. Cross system care coordination

While the Behavioral Health system may be the lead on most behavioral health care, positive health outcomes are dependent on cross system coordination with Public Safety, Criminal Justice, Education, Child Welfare, Primary Care, Housing and other system partners. It will be important to incorporate United States Department of Justice (USDOJ) agreement directives, including stable housing and supports, as well as emerging federal policy priorities, such as assisted outpatient treatment, in evolving cross system care coordination. Additionally, systems must be able to share health information to coordinate care.

It is essential that all system partners have skin in the game: all payers participate and fund care coordination; providers will ultimately have to bear risk for their clients to fully embrace value-based purchasing and want to be involved in care coordination with payers. Cross system partnership includes integrating funding, with all systems pitching in to get to the outcomes.

We look forward to working with the Oregon Health Authority, Legislature, and system partners through the Behavioral Health Collaborative to discuss and prioritize a set of key solutions.

The Challenges We Face

One in four of us will struggle with a mental health or substance use disorder at some point in our lives. Behavioral health disorders are responsible for nearly 25% of all worldwide disability and people with chronic mental illness and substance use disorders die up to 25 years earlier than average.[1] We know that effective treatments exist, but people have problems accessing appropriate behavioral health services, with only 40% receiving treatment - 12% from a psychiatrist, 22% from any mental health specialist, and 23% from primary care providers.[2,3] This low utilization bears out in a recent Oregon gap analysis study (Jarvis 2015) that showed 50% of Medicaid recipients who needed mental health services either did not seek or were unable to access services.[4] The additional cost of meeting the Medicaid unmet mental health need would be just under $200 million per year. During the same period, 66% of Medicaid recipients who need substance use disorder services were also unserved. The additional cost of meeting the Medicaid unmet substance use disorder need would be just under $120 million per year. (Jarvis, 2015) In total the additional cost of meeting the Medicaid unmet behavioral health need would be just under $320 million per year. [5]

While the Affordable Care Act (ACA) has been a blessing for many Americans who did not have health care coverage previously, it also created more demand for behavioral health services than available and has pushed the system beyond capacity, a system which was already challenged by chronic underfunding and not enough providers. As a Medicaid expansion state, it will be especially impossible to meet the demand in Oregon under the current system.

In short, the problem can be labeled in a broad sense as lack of access, exacerbated by deficits in funding, service, and provider capacity, and a complicated, multifaceted problem. Oregonians need more timely access to behavioral health services across the continuum of care, customized to the needs of the individual, family and community. Limited access leads to bottlenecks in emergency departments, at the Oregon State Hospital, and jails, and causes overdependence on crisis services and higher levels of care in restricted settings. Access is affected by many factors, including:

- Unclear and overlapping roles and functions of system partners
- Gaps between the roles and responsibilities of system partners
- The Medicaid structure supports a “Sick care” system rather than health promotion/well care model

- Deficits in behavioral health and primary care workforce: numbers, diversity, licensure and certification requirements, cross-training status, low pay and high turnover, particularly in behavioral health workforce
- Inadequate investment in community-based continuum of services, including flow and flexibility of funding and from primary prevention to high intensity, individualized care
- Problems in reimbursement of services and programs by Medicaid and other payers, including Medicare, commercial insurance, and the VA: those who are under-insured have become the new indigent population
- Health information technology barriers (e.g., information sharing; common EHR)
- Unwillingness of individuals to engage in treatment because of stigma, perceptions about the mental health system and other barriers

Not broken, but evolving

We would describe the Oregon health care system as still evolving toward the vision. We know there is room for improvement in the behavioral health system, but we do not see it as broken, rather that it has never had the opportunity to be fully operational, for a multitude of reasons, as listed above. Change has been incremental, not transformational, so it is difficult to appreciate the improvements that have been made.[6] The behavioral health system is complex - involving other systems and policy (child welfare, disability, criminal justice, education, etc.), a heterogeneous population with diverse needs, and requiring various interventions beyond clinic-based treatment services. The solution is not just to provide more services to more people. They must be customized to the specific needs of individuals, families, cultures and communities. As we figure out how to share and shift responsibilities among federal, state, county and city governments, managed care, and a variety of providers and other system partners, we struggle with different and competitive ideologies. We'll need to work to build trust as we move into new roles and partnerships.

Current funding must be restructured in order to support increased access to more appropriate services and integrated care.[7] Adding to the complexity is the number of funding sources and parameters around medical necessity. It is difficult to develop new programs and creative initiatives when not all payers are willing to participate. Providers often get stuck in the middle with different funding, reporting and program requirements across payers. This results in some clients being able to receive innovative services while others are not eligible. This also causes frustrations for primary care providers and other community partners who struggle to understand why one shared client can receive a more comprehensive service array while other patients have little to no access.

By and large, funding for innovative practices that go beyond medical models of care have come from state and local governments, but with Medicaid expansion, more financial responsibility has transferred to the federal government. While this has resulted in substantial increases in total funding for behavioral health services, the flexibility to use Medicaid funding for non-medical services that improve people's lives has not caught up. Our CCO experiment in Oregon is one of several initiatives to test new models of care and integrate primary and behavioral health care, however, support for flexible use of Medicaid funds is varied among the CCOs.

No silver bullet or quick fix

So what should be our focus? Through much pondering and scrutiny at the state and local level in Oregon and as the light shines on the behavioral health system nationally, there are clearly many possible priorities to devote funding and resources to, but there is no "bold stroke on the horizon to revolutionize the mental health system".[8] We have tried and come across many, many ways to improve the behavioral health system: More accessible and higher quality care, more integration, suicide reduction, a bigger and more competent workforce, overcoming stigma, reforming the criminal justice system, re-evaluating income supports, preparing for demographic changes, meeting needs of veterans and military personnel, changing social conditions to reduce risk of behavioral health disorders, and the list goes on.

We are not likely to make these changes all at once, and availability of resources will force us to prioritize. Luckily, Oregon has been willing to try innovations, particularly in the context of Medicaid expansion and through the 1115 demonstration waiver, which are also supported by State General Funds through key investments to divert people from institutional care and incarceration, with Counties pitching in General Funds for local enhancement of these endeavors as well as for other supports to help keep individuals in their communities. We know for sure that the behavioral health system alone can't solve all health care and social problems. In the spirit of a multi-system solution, we offer discussion points and recommendations for consideration in five focus areas for the next phase of health care system reform in Oregon.

Five Areas of Focus for the Next Phase of Health System Reform

1. More Investment in Health Promotion, Prevention and Early Intervention

"As social beings, we need not only good material conditions but, from childhood onwards, we need to feel valued and appreciated. We need friends, we need more sociable societies, we need to feel useful and we need to exercise a significant degree of control over meaningful work. Without these, we become more prone to depression, drug use, anxiety, hostility, and feelings of hopelessness, which all rebound on physical health." *Richard Wilkinson, Social determinants of health Expert and Author*[9]

There is growing evidence that health promotion* and disease prevention, mostly provided in nonclinical settings, improve the health of communities, reduce risks of chronic diseases and save money in the long run, when pitted against the costs of medical treatments at the acute and crisis end of the spectrum. Considering that we don't have infinite amounts of money for health care, we should focus more of our scarce resources on lower cost prevention initiatives to get the "biggest bang for the buck." Behavior change requires time intensive outreach and engagement by trusted peers and clinicians as well as changes in environment, policy, regulation and norms, all of which are done outside of the medical setting.[10] At the community level, this includes helping families to reduce stress and providing a social network of support in a manner that is sensitive to their cultures.

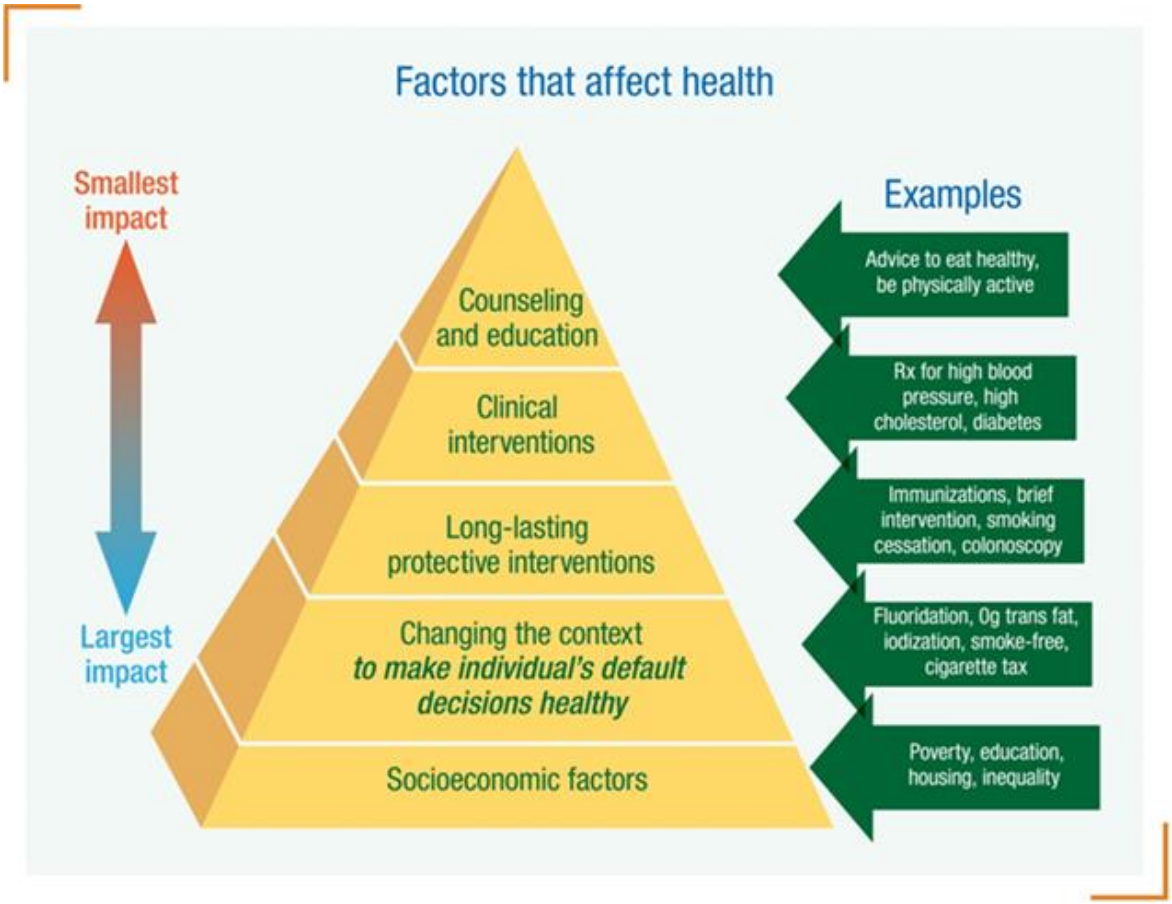
*According to the National Institute of Health, mental health promotion involves "efforts to enhance individuals' ability to achieve developmentally appropriate tasks (developmental competence) and a positive sense of self-esteem, mastery, well-being, and social inclusion and to strengthen their ability to cope with adversity."

Making the Case for Investing in Prevention

The health care system was not originally designed to provide or pay for prevention and health promotion, rather it was built as a sick care, medical model system that pays according to medical necessity. Primary care clinicians have limited time to provide prevention services and clinic based prevention is not the most effective route anyway. It has taken a lot of effort and will require much more to make space for prevention in our health policy and funding priorities. We are learning from years of research that health care payers and administrators must be incentivized financially to make a substantial investment in prevention and early intervention. Up to this point in time, it has been the norm to fund prevention initiatives through time-limited grants with the expectation that the grantee develop a sustainability plan to continue the work without external funding, which dooms many of these efforts to failure.

Behavioral health disorders are certainly tied to the brain, but we can't ignore the influence of socio-economic factors and environment, the so-called social determinants of health, like housing status, adverse childhood experiences, and poverty. One study found that social services expenditures were significantly associated with better health outcomes, concluding that focus on social policy may be helpful in improving health.[11] In order to turn off the spigot of disproportionate acute and crisis level responses, we'll need to increase proactive behavior and build prevention and early intervention strategies across the developmental stages that address: health (mental and physical, and contributing factors, such as sleep, nutrition, and toxic exposure); safety/security (abuse, neglect, violence); resources (adequate housing, food, financing, education, services/treatment); and relationships (family, friends, caregivers, community). Thomas Frieden depicts a public health framework pyramid of the factors that affect health from highest impact (socioeconomic) at the base of the pyramid to lowest impact (counseling/education) at the top with the lowest impact.[12]

A Framework for Public Health Action: The Health Impact Pyramid



It has been well established that mental health disorder symptoms appear by age 14 for about half of those who will develop these conditions.[13,14] Further, suicide is the third leading cause of death among 10-24 year olds and a nationwide survey of high schoolers revealed that 8% attempted suicide in the last year. In Oregon, suicide rates have been higher than the national average for over a decade – suicide is the second leading cause of death among young Oregonians ages 15-34, higher among males than among females (13.8 vs. 5.4 per 100,000) and extremely high among Oregon veterans ages 18-24 at 128 per 100,000.[15,16]

If we don't invest in prevention and intervene early while the brain is still developing, we will continue to deal with the consequences at crisis levels, resulting in continued high rates of suicide, school drop-out, homelessness, and juvenile justice system involvement. We must promote and support healthy social and emotional development early enough, or we will continue down the path to poor, and sometimes tragic outcomes. Consider these sobering statistics:

- 65 to 70% of the 600,000 youth placed in juvenile detention centers annually have diagnosable mental health disorders and more than 90% have been exposed to multiple adverse childhood experiences.[17]
- According to the National Alliance to End Homelessness, approximately 550,000 unaccompanied youth and adults under 24 experience at least one week of

homelessness each year, with 194,301 homeless youth on a single night (HUD 2014) and 20-40% identifying as LGBT.

- Students with disabilities have a 57% rate of high school graduation, and when narrowing to those with emotional disturbance, an even lower rate at 43%. School drop out is also a risk factor for institutionalization (1 in 10 vs. 1 in 33 of those who graduated high school and 1 in 500 of individuals with bachelor's degrees).[18]

There are many interventions along the prevention continuum to avoid bad outcomes, ranging from population-based, universal initiatives, to intensive, clinical interventions for children and families who have identified behavioral health disorders. We discuss a variety of clinical, school and community wide evidence-based interventions that have been tried with success in Oregon as emerging solutions below.

Emerging Primary, Secondary and Tertiary Prevention Solutions

Decades of research on family interventions in Oregon have shown positive outcomes across the continuum of primary, secondary and tertiary prevention of behavioral health disorders among youth. Results of numerous studies testing key interventions revealed reductions in child and adolescent problem behavior, and increased positive parenting and academic success. These interventions cover the prevention continuum and address three levels of intensity across three systems: 1) Family formation and adaptation/Public Education, Primary Care, Community Mental Health; 2) Family disruption and maladaptation/Child Welfare; and 3) Family attenuation and dissolution/Child Welfare, Juvenile Justice.[19] Below are brief descriptions of interventions in each of the three levels of intensity:

1) *Family Check-Up* – Strengths-based, family intervention to address child and adolescent adjustment problems; involves an initial assessment and feedback, and parent management training, focusing on positive behavior support, healthy limit setting, and relationship building.

   Good Behavior Game **–** Management of classroom behaviors by rewarding appropriate on-task behaviors during instructional times through team-based competition.

2) *Parent Management Training-Oregon* – With parents as the primary agents of change, intervention is focused on parents to reduce children's behavior problems, including conduct, delinquency and depression.

3) *Treatment Foster Care-Oregon* – Focuses on children and adolescents who have been removed from their family homes because of serious antisocial behavior, severe emotional problems or they have experienced severe child abuse and neglect.

1-3) *Triple P (Positive Parenting Program)* – Covers the range of intensity levels, from parenting information social media campaigns to behavioral interventions with individual families, all with the focus of improving parenting skills and relationships.

Researchers suggest that three behavioral science principles must be addressed to make these interventions successful: 1) the contagion principle – "children and adolescents escalate

problem behaviors in the company of peers in settings without skillful adult leadership"; 2) data-based monitoring and decision-making for behavioral approaches to treatment; and 3) competent adherence to the fidelity of evidence-based practices.

In order to carry out these principles, Tom Dishion et al. recommend:

- Behavioral health providers must be trained, coached, and appropriately compensated.
- Systematic, cost effective assessment and screening
- Provide appropriate levels of intervention to youth and families.
- Monitor intervention progress to decrease or increase support as needed.

As return on investment and cost effectiveness of prevention programs continue to surface, other benefits from these evidence-based programs are clear: ubiquity in behavior support strategies at all levels of family interventions; educational engagement and school retention; decreasing disruptions in school attendance due to residential treatment; reduction in likelihood of residential settings that aggregate high risk students; higher parental retention in services; development of parenting skills; reduced implementation costs due to training and quality of implementation; and unified tracking and billing.[20]

Another way to categorize prevention and early interventions is by developmental stages. Some of these interventions are universal or for those with risk factors, in addition to clinical services for identified behavioral health disorders:

1. Prenatal to early childhood - *Positive Parent-Child interactions; Nurse-Family Partnerships, The Incredible Years, Home visitation programs*
2. Early childhood to puberty - *Good Behavior Game; Support to children undergoing stress; Modifying school environment to help kids adapt socially; Relationship and decision making skills; Nonviolent problem-solving skills for families and youth; Programs that promote mindful, psychological flexibility*
3. Puberty to early adulthood – *Life Skills training; Universal mental health screenings (just like vision and hearing), following up with assessments for positive screens; Universal education about early signs of mental health disorders; Access to specialized services; Coping skills, resilience building, and modifying life style factors and building protective factors that affect behavioral health (*reducing stress, increasing sleep, and proper nutrition).

Examples of Prevention Program Cost Effectiveness and Return on Investment

Program	Cost Effectiveness/Return on Investment
10 out of 12 substance use prevention programs for youth	3:1 to 1000:1.2 cost benefit ratio
SAMHSA Systems of Care initiatives	Reduction in hospital days/year: $2,777 per child Reduction of inpatient care for children by 54% Percentage of youth harming themselves or attempting suicide decreased 32% after 1 year
Good Behavior Game	50-90% decrease in disruptive or disorderly behavior in school 10-30% reduction in referrals, suspensions, or expulsions $1:$58.56 cost benefit ratio

The Triple P – Positive Parenting Program	Reduction in prevalence of conduct disorder; cost savings until prevalence reaches 7%
Life skills training for adolescents using substances	$1:$13 return on investment
Functional Family Therapy	Reduction in juvenile justice system costs, crime and recidivism; Savings of $47,776/individual/year
Multi-systemic Therapy	Reduction in juvenile justice system costs, crime and recidivism; Savings of $17,694/individual/year

Sources: [21,22,23,24,25,26,27]

Special focus on suicide prevention

Recently there has been much more attention to suicide prevention, both at the national and state level. In Oregon, we identified numerous strategies through creation of a youth suicide prevention and intervention plan, which are beginning to be implemented: means safety programs; statewide public-private suicide prevention alliance; increasing community capacity for recognizing mental health care needs of school age children and other at risk populations.[20] (OHA Youth Suicide Prevention and Intervention Plan 2016-20) The Federal Government has also invested in suicide prevention: 1) Helping Families in Crisis bill allocates $30 million a year on adult suicide prevention, another grant of $9 million/year for any age group, an $35 million a year on youth suicide prevention. 2) SAMHSA continues to fund Garrett Lee Smith Youth Suicide Prevention grants to states. 3) The VA is investing in telehealth, community partners, crisis line workers, and creating stronger interagency and public-private partnerships to decrease the suicide rate among veterans.

Recommendations for investing in prevention

At the state and local level, there are many system policy improvements we can implement if we garner the political will to take a long term view of return on investment to prioritize health promotion, prevention and early intervention:

- Cross system partnerships among government agencies, providers, schools, families to create coordinated approaches to preventing mental health and substance use disorders.
- Financial investment in health promotion and prevention programs by all payers.
- Prevention training and standards across disciplines
- Long term tracking of prevalence of mental health and substance use disorders and prevention/ health promotion program metrics, including cost data
- Continued research on efficacy and real-world effectiveness of prevention programs, and adaption of programs for various cultural, linguistic and socio-economic groups
- Close connection with DHS to provide safety net for families with financial insecurity, to prioritize safe neighborhoods and schools, and to improve access to health care and early childhood services and supports
- Provide financial incentives from shared savings for investing in prevention and health promotion.
- Prioritize prevention and early intervention outside the four walls of a clinic.

There are many things we can do in our communities to get to the root social causes of family distress that cause or exacerbate behavioral health disorders and bad outcomes. We have a

wide range of solutions, starting from universal, low-cost health promotion to increase awareness, lower family stress, reduce stigma, and engage communities in advocating for prevention and early intervention, to group and individual/family interventions that are behavioral health oriented and housed across systems, as described previously.

2. Decarceration: Decriminalizing mental illness and substance use disorders

"**Many of the issues of the criminal justice system stem from our inability to see those in the criminal justice system as being members of our community. By understanding that these individuals, and our response to their needs, are fundamentally integrated to our communities, we can change the criminal justice system. Similarly, our behavioral health system is often seen as separate from the broader health system—leading to poor planning regarding how to fund our health systems. Integrating behavioral health services is a means to integrating justice-**involved populations." **Steve Rosenberg, President, Community Oriented Correctional Health Services**

Making the Case for investment in decarceration

Jails and prisons in Oregon are part of the national trend of serving as defacto mental health institutions. Oregon correctional institutions are challenged to adequately serve individuals with behavioral health disorders, and reflect national statistics that a substantial percentage of inmates have mental illness, substance use disorder or co-occurring disorders. Law enforcement officers frequently encounter people who commit misdemeanors — trespassing, panhandling, petty theft — or a minor, nonviolent felony. Each year, nearly 2 million out of the 11.4 million people booked into local jails have mental illness, about 17% of jail detainees.[28]

Inmates with mental illness tend to have longer average jail stays than inmates without a diagnosed mental illness. Some studies have shown the length of stay to be from two to five times longer. Reasons given for the longer stay include difficulty in following jail and prison rules and awaiting availability of beds in psychiatric hospitals.[29] Inmates with mental illness also cost more due to increased staffing needs, psychiatric medications, and an increasing number of lawsuits. An example of the difference in Florida is $80 vs. $130 per day.[30]

People with mental illness are often jailed for acts in which people who do not have mental illness might simply receive a warning or be cited and released. This is essentially the criminalization of mental illness. It should be noted that Law Enforcement is often faced with a choice between arresting an individual with mental illness or leaving them in situations where the safety of the individual is in question, when there is no viable alternative.

Criminalizing behavioral health disorders extends to the juvenile justice system, with a national estimate of 70% of youth who meet the criteria for having at least one mental health disorder,[31] and an estimated trauma exposure prevalence of 93%. Currently in Oregon we do not have an estimate because juvenile departments are not required to screen youth for mental health disorders when they are referred. The inadequacy of mental health services in the juvenile justice system is reported to be similar to the situation in jails[32], compounded by the fact that

youth are commonly in more than one system, with insufficient care coordination and no single system accountable for the youth.

Emerging Solutions and Recommendations for Decriminalizing Mental Illness and Substance Use Disorders

We recommend a robust array of crisis and diversion services to ensure alternatives are available to law enforcement in their frequent role as the primary responders to individuals with mental illness. This array of programs and services includes Crisis Intervention Training (CIT) for Law Enforcement, Assertive Community Treatment, respite services, mobile crisis teams, crisis stabilization centers or psychiatric emergency services, supported housing, sobering centers and detox facilities, together with high quality behavioral health treatment in every county. These enhanced crisis and jail diversion services must be accompanied by meaningful collaboration between Behavioral Health, Criminal Justice and Public Safety systems to achieve success with community based alternatives to incarceration that are available to all residents, regardless of insurance status. Progress has been made in this area through targeted investments in crisis and other jail diversion services across Oregon from State general funds.

An example of a successful community-led effort is in Miami-Dade County, Florida. Spearheaded by Judge Liefman, the local systems recognized the incarceration of people with mental illness and substance use disorders as a shared community problem that would require a shared community solution. They developed a comprehensive, coordinated response, using diverse expertise and resources to divert people from the criminal justice system to community-based mental health services, aiming to improve community outcomes. By using the Crisis Intervention Team model and training many of its officers, they were able to divert 9,000 people to crisis units, making only 109 arrests. The county jail census dropped from 7,200 to 4,000, one jail facility was closed and fatal shootings and injuries have been dramatically reduced.[33] Initially, the target population was people with misdemeanors, but in the last several years the county's post-booking program was expanded to less serious nonviolent felonies. Defendants with mental illness have been diverted to community-based treatment and support services, resulting in a drop in the recidivism rate from about 75% to 20%, with 75% fewer jail bookings and shorter lengths of stay after enrollment in the program.

Although we are just beginning to collect cost benefit data for jail diversion programs in Oregon and in many other states, there are increasing numbers of studies that are showing return on investment - one in Washington State revealed that for those individuals with criminal justice involvement who receive addictions treatment, the re-arrest rate is 33 percent lower than for those who do not receive treatment. This translates to $2.05 in taxpayer benefits per dollar of cost with the largest savings from reduced health care costs.[34]

Crisis Intervention Training (CIT) for law enforcement is a key component of a decarceration strategy because it increases the likelihood of diverting from jail to a crisis stabilization or psychiatric emergency service center before any booking process takes place, where available. Expanding CIT training for law enforcement has also been shown to drop the use of police officer holds, shifting the focus from enforcement to therapeutic responses. The training has

helped build trust and respect between local agencies, through the use of boundary spanners from Law Enforcement and Mental Health, who coordinate treatment options that are in the best interest of the individual and family. In Deschutes County, over 30% of the Sheriff's office and over 50% of the Police Departments have been trained in CIT, with 90% of the Bend Police Department CIT trained. CIT-trained officers are available 24/7 in Redmond and Bend. This training has resulted in a considerable decrease in use-of-force incidents involving people with mental illness and officers – 34% drop in overall use of force in Bend, 55% decrease in physical control, 60% decrease in taser deployments, and 35% decrease in firearm display in Redmond.[35] Oregon continues to invest in CIT from state general funds and will host its first summit this year. The Federal Government also has acknowledged the effectiveness of CIT and invests in states' dissemination through Bureau of Justice and SAMHSA grants**.** Additionally, the "Helping Families in Crisis" bill authorizes $9 million per year for CIT training.

As trust between systems is strengthened through collaboration on CIT trainings, communities are creating other cross system interventions to divert individuals from jail. One "zero intercept" level initiative is the use of community response teams to follow up with people who have previously called in crisis and are at risk for incarceration or hospitalization. The goal is to connect people with appropriate resources to avoid crisis and minimize police contact. The Bend Police Department, Cahoots in Lane County and Crisis outreach response team (CORT) in Marion County are examples of cross system response to individuals needing resources or follow up to prevent them from going into crisis. In 2014, CORT was able to follow up with 933 of the 2,348 individuals reporting a crisis or mental health issue and refer them to appropriate services, which had a significant impact on reducing jail bookings.

Other examples of cross system interventions that have been the recent focus of state, county and Medicaid investment are:

- An "Alameda model" psychiatric emergency services department, linked to the hospital, called the Unity Center in Portland, a model also being planned for Douglas County; "Living Room" crisis stabilization models (not attached to a hospital) have been successful in Marion and Jackson Counties and are being planned for Deschutes and other counties.
- Sobering centers attached to detox facilities in Multnomah, Lane, and Jackson Counties; stand alone sobering centers in the works from recent legislation and state funding in Josephine, Douglas, and Klamath Counties.
- Respite, transitional and supported housing in all counties; more to be developed with new funding streams through Oregon Health Authority and Community Services & Housing.
- Mobile crisis teams developed or in the works in most counties, thanks to State General Fund investments appropriated by the Legislature.
- The Mental Health Response Team in Washington County pairs a clinician with a deputy and is able to provide a co-response to 911 calls anywhere within the county, regardless of jurisdiction.

All of these interventions give Law Enforcement an alternative to taking an individual to jail or to the hospital emergency department. The critical factors leading to success are buy in from criminal justice, local government and public safety, with team building and adequate training.

For those individuals who end up being booked into jails, we recommend universal screenings for behavioral health disorders. Care coordinators with local expertise, who know the defense attorneys, have relationships with judges and can make things happen because people trust them, are key to ensuring their care is not interrupted and that they will continue care when they are back in the community. Trusting relationships take time to develop and care coordination is a central component along with coverage. Criminal Justice will often allow charges to be dropped or sentences to be modified if they understand that it will help get to the root of the issue - why the person was charged in the first place. Treatment Courts are another resource for individuals who have been charged with a crime. Individuals who successfully complete the court ordered treatment are eligible to have their charges dropped.

It is encouraging that the 1115 waiver renewal proposes to use the vehicle of coordinated health partnerships – between Behavioral Health, Criminal Justice, Public Safety, and CCOs – to coordinate care for pre-adjudicated jail inmates for up to 30 days. As the average length of stay for pre-adjudicated individuals in Oregon jails is 15 days, [36] this will allow treatment coordination and planning to assist nearly two-thirds of Oregon jail inmates in having a smooth transition into the community without disruption in care.[37]

Also helpful for another segment of the justice-involved population is recent CMS guidance on how to facilitate access to covered Medicaid services for eligible individuals before and after a stay in a correctional institution. Medicaid pays for eligible individuals: 1) on parole, probation and home confinement; 2) in corrections-supervised community residential facilities, like halfway houses; and 3) Medicaid inpatient exception for those individuals presuming to need more than 24 hours hospitalization. The guidance also reaffirms that states should suspend, not terminate Medicaid benefits for jail and prison inmates, and fortunately Oregon is a suspension state.

It is important to note the over-representation of people of color in correctional facilities. Although Black and Hispanic populations collectively represent 24% of the general population, they comprise 54% of the jail population. While a black male has a 32% chance of spending time in prison at some point in his life and an Hispanic male has a 17% chance, a white male only has a 6% chance.[38] These shocking statistics have compelling implications on drug enforcement vs. treatment policies, and relaxing of IMD exclusion vs. inmate exception policies concerning Medicaid coverage for behavioral health disorder treatment. Extending Medicaid benefits to individuals in jails is essential to ensuring that we do not increase racial disparities by solely allowing IMD exclusion waivers.[39]

Special focus on Youth incarceration

"Many of the issues pointed out in the Juvenile Justice Mental Health Task Force report are substantial issues facing Oregon, but Oregon is not alone. There is a genuine dichotomy between the legal system, which generally views behavior as a choice in the context of free will, versus the view of the behavioral sciences that behavior is strongly predicted by circumstances and biology." *Andrew Nanton MD, Child/Adolescent Psychiatrist*

Incarceration of youth with mental illness and substance use disorders is a disturbing and long standing problem. A Juvenile Justice – Mental Health task force, led by Oregon's Chief Justice, met for a year to study the major issues and make recommendations to reform the juvenile justice system. The task force identified problems related to planning, screening, appropriate placements and coordination, and made many recommendations for improving the system of care for youth who become justice-involved. These recommendations revolved around cross system planning and coordination:

- Creation of a Children's Cabinet with a Juvenile Justice subgroup to address reform
- Improving sharing of information between governmental agencies and service providers
- Early identification and treatment of children with mental health disorders before they are involved in the juvenile justice system
- Mental health screening upon referral to juvenile departments
- More collaboration between systems to ensure positive outcomes
- Regulating psychotropic medications
- Ensuring care coordination as youth transition back to the community

Further, the final report suggested a data team be assembled with representatives from all systems and that analysis needs to be conducted on how these youth are ending up in the system to determine if: (1) earlier interventions could have prevented juvenile justice involvement; and (2) whether there are cases that are inappropriately referred to juvenile departments. We can predict with high confidence that the answer to these two questions is a resounding "Yes".

Emerging solutions

In addition to the broad system policy solutions listed above, a few specific strategies are in the works that may lead to legislation or administrative rule:

- A uniform screening and assessment tool planned for use in schools and medical offices

- Crisis stabilization approaches such as mobile crisis teams and facility-based respite

- Developing an information sharing guide, with an accompanying training requirement – dependent on the age of youth and family relationships

- Psychotropic medication legislation – third party review of psychotropic medication prescriptions for youth in Oregon Youth Authority close custody; protections for youth who are prescribed psychotropic medications and are placed in juvenile detention or shelter care.

- Gather data on residential and crisis placements to determine availability; depending on the results, there may be a recommendation to fund additional residential beds for youth who are extremely difficult to place. (There are some limited federal grant funds, $5

million per year, allocated to create a bed registry or a crisis response plan in the "Helping Families in Crisis" bill.)

Many significant federal policy developments have occurred since deinstitutionalization that led to the warehousing of people with mental illness and substance use disorders in jails. The advent of Medicaid in 1965, which prohibited federal financial participation for individuals in institutions for mental disease (IMDs) and the Olmstead decision in 1999, further disincentivized States from housing people in IMDs for long periods of time. Communities have not been prepared for the influx of people with serious and chronic behavioral health disorders without an appropriate level of resources infused into the community, resulting in the dilemma we now have in our jails and prisons. It is time to make substantial policy changes to allow short term health care coverage in institutional care as well as investment in treatment programs, housing and other supports to help divert people from justice involvement, and to save jail beds for those who are appropriately incarcerated.

3. Mental Health Parity and Addictions Equity

The Mental Health Parity and Addiction Equity Act of 2008 requires most health plans to apply similar rules to mental health and substance use disorder benefits as they do for medical/surgical benefits. Parity applies to copayments, deductibles, yearly treatment limits, prior authorization requirements and proof of medical necessity (what services are covered for which conditions). MH/SUD care must be comparable to physical health care in any of these domains. Additionally, health plans must provide information on MH/SUD benefits, including medical necessity criteria and reasons for denying particular services, and individuals have the right to appeal claims.

Generally, we have found in Oregon that commercial health insurance does not have the same level of transparency or data sharing requirements and does not share the costs for social and support services connected to behavioral health treatment as do payers of Medicaid or State General Funds. That is, the burden of health care transformation is disproportionately placed on the shoulders of CCOs, the State, and Counties, routinely having to attempt to cover the gaps left in coverage by commercial health plans, as well as by Medicare and the VA. The narrowness in scope (limited mostly to prescribers) and requirements of VA service contracts translate to almost no reimbursement to community behavioral health providers, and often veterans and individuals with Medicare or commercial insurance are simply funded through state and county "indigent" funds. *See attached Yamhill County examples of service cost by payer mix.*

The issues related to commercial insurance coverage are also prevalent in the over 65 population as baby boomers reach retirement age and go on Medicare. Medicare, like commercial insurance, inhibits comprehensive behavioral health care for older adults by not allowing payment for certain services, such as coordination of care, and excluding the majority of providers from reimbursement. In discussions with CCOs and CMHPs, 50-60% Medicare

reimbursement for the cost of care was a common estimate. Another barrier they have encountered is with individuals who have exhausted their lifetime Medicare benefits.

The contrast in physical and behavioral health coverage is acutely experienced by families who undergo behavioral health crises that lead them to emergency departments. A set of barriers was identified in an Emergency Department diversion pilot, initiated in response to a Crisis Workgroup's recommendations from November 8, 2014, and reported to the Children's Services Advisory Committee in May 2016:

- Privately insured clients do not have coverage for care coordination/case management services.
- Fiscal incentives or disincentives are not aligned with good care. For example, emergency visits, regardless of whether they are for a medical or mental health crisis, are covered as a flat rate under a medical code rather than a mental health code.
- Many commercial insurers require that deductibles are collected in full for an emergency department or hospital stay, before a patient can be admitted to sub-acute levels of care. This creates an enormous burden for families and further disrupts discharge planning.
- The system is very difficult to navigate; multiple payers can be involved, and all of them may have different benefit packages.
- CCOs and commercial insurance companies have different review practices and methods of authorizing various levels of care.
- Many commercial insurers do not have contracts with acute diversion programs - the kind of programs that offer intensive outpatient care.
- Funding is from a wide variety of sources, including private payers and local, state and federal programs; this complexity can have a negative impact on the array of services available and what is known to be available.

Recommendations for enforcing MHPAEA

Not only do we recommend enforcement of health plan compliance with existing laws, but also equalizing responsibility across payers for innovative best practices that move us toward better health outcomes.

In addition to the simple recommendation that commercial insurance plans start covering care coordination and other support services similarly to Medicaid, there are other recommendations that have come out of the crisis workgroup and ED diversion pilot as well as a group that is meeting to introduce care coordination legislation that builds on previous work from the 2015 session:

- Implement a standard method of informing payers when their members go to emergency departments and hospital units.
- Rather than focusing solely on individual services, a systemic, coordinated and collaborative approach should be applied across the continuum of care.
- Involving family and youth early on and including system navigators should be part of the core strategy.

- Remove up-front deductible payments prior to accessing acute care services.
- Increase use of flexible funding pools to address needs that are not served by providing medical services and thus not traditionally covered by health insurance.
- Create an electronic data base of available acute resources statewide.
- Create effective tools for educating families about the options they have to access routine and acute mental health services, by both insurer and location.
- Open commercial panels to add more of the pool of behavioral health clinicians available to ensure adequate access across insurance networks.

Other emerging solutions initiated at the national level include:

- Centers for Medicare & Medicaid Services (CMS) announced the availability of $22 million in funding to state insurance regulators to use for issuer compliance with Affordable Care Act key consumer protections, allowing states to effectively oversee and enforce mental health parity and addictions equity provisions.

- Because parity is an abstract concept, most people have little understanding of it and need training through public interest messaging to know what they can expect.

- State Health Insurance Commissioners and insurance company personnel need to feel comfortable with these complex concepts through technical assistance sessions and an interactive web capacity.

- The Federal Government—specifically HHS—needs to consistently and transparently monitor implementation and compliance of private insurance with parity requirements. A similar procedure by CMS to monitor parity in state Medicaid programs is a good model.

- Discontinue use of “Fail First” approaches, when similar tactics are not used for medical care.

We will not be able to fully transform our health care system without Commercial Insurance, Medicare and the VA going all in with Medicaid, State and County funders. This will require political will and agency collaboration, particularly at the Federal level, and enforced at the State agency level. We have enough emerging evidence from our CCO “laboratory” and in other Medicaid managed care experiments across the country to convince these insurers, who cover 75% of the population in Oregon, to invest in effective behavioral health care and coordination.

4. Primary – Behavioral Health Integration

Knowing that primary – behavioral health integration is key to reaching the triple aim, we met with CCO leadership to ask how they thought this part of health care system reform was progressing, and where we need to make further improvement. As one CCO executive noted, “The heart of the CCO experiment is behavioral health – primary care integration”. There were a number of common themes that came up in these discussions. The biggest successes reported were the strengthening of relationships between CCOs and CMHPs, and between

primary and behavioral health care systems/providers, making progress on incorporating social determinants of health in the health care milieu, such as innovations in non-emergent transportation and paying for housing supports. Also promising was the establishment of behavioral health networks in some of the communities to ensure network adequacy, alignment, and collaboration among the behavioral health providers.

Boundaries between primary and behavioral health care have been dissolving as trust and respect are strengthened. The CCO-CMHP relationship has been integral to reaching metrics and good health outcomes, many utilizing an open access model, and stepping up customer service. Behavioral health is the common thread that runs through the various systems locally, which has necessitated responding to requests in a different way than services were previously delivered, going to where people are, and CMHPs and other behavioral health providers asserting themselves into a variety of primary care settings. This has meant matching appropriate behavioral health clinicians to particular clinics, convening team meetings between agencies and all partners taking ownership of the health and well being of their communities. Conversely, incorporating physical health care in behavioral health homes, often referred to as bidirectional or reverse integration, along with team-based care, is progressing rapidly. These developments have warranted being bold, taking chances and testing new provider and cross system relationships, and offering an array of customized services in the quest for better care and health outcomes.

Challenges in Primary-Behavioral Health Integration and Emerging Solutions

There was also commonality among the CCOs' challenges, and consistently the top three fell into the categories of payment, technology, and workforce barriers. These three areas are discussed in some depth below, each with emerging solutions.

Additionally, the considerable gaps in treatment for mild to moderate mental health disorders and the dismal utilization of substance use disorder treatment are challenges to be addressed. The Substance Abuse and Mental Health Services Agency estimates that 90 percent of people with substance use disorder and around two-thirds of people with diagnosable mental disorders never seek and/or receive treatment. These statistics are also reflected in the Oregon Health Plan Behavioral Health System gap analysis. We will discuss some developments in the works to increase the numbers of people with mild to moderate mental health disorders and substance use disorders who seek and receive care at the end of this section.

Value based purchasing

In Dan Mistak's recent policy brief, "The Future of the Safety Net: Federal Legislation and Behavioral Health Financing",[40] he describes health care financing as a continuum that begins with fee-for-service (FFS) and ends with population health payments, with increasing levels of risk shared among providers. Dan writes that moving up the structural steps from FFS to bundled payments to population health payments is essential for the behavioral health system to catch up to value-based purchasing. Value-based purchasing is where we are evolving as a

system, and skipping over one financing stage would “leave a system less prepared to adapt to savings-and-quality-based financing mechanism.”

The complications that arise in stepping through these financing stages are in the varied readiness of CCOs, providers, and State and Federal Medicaid to move to more flexible and value based purchasing. One of the issues brought up by several CCOs was in defining flexible service categories, noting that there is a perverse incentive if flexible services can’t be used in the rate-setting process. In order to fully actualize primary-behavioral health integration, we will need to provide services and supports that are not necessarily clinic based and are difficult to bill by encounters, so it follows that we will have to use outside of four walls payment and rate setting models. Some of the problematic areas mentioned were in care coordination, supporting partnerships outside of clinical settings, paying for prevention, addressing a behavioral health issue before it becomes a diagnosable disorder, and capturing coaching without conducting a full assessment. In addition, as previously stated, all payers need to commit to value based purchasing in order to truly transform the health care system.

Emerging solutions

Section 223 of the Protecting Access to Medicare Act – the “Excellence Act”, aka the CCBHC Demonstration Pilot

One door to “unlocking value-based purchasing” and integrating behavioral and physical health is through the Excellence Act, which provides funding and resources for piloting treatment modalities and payment structures that are most appropriate for people with serious and chronic behavioral health conditions. Providers who become certified as community behavioral health clinics and are in one of the eight funded demonstration pilot states will prepare for value-based purchasing through cost accounting to determine a PPS rate, enhance their electronic health record and health information exchange capabilities, improve access to services, use clinical decision support tools, integrate primary care, and track key systemic and outcome measures. The Certified Community Behavioral Health Clinics (CCBHC) planning grant and subsequent demo pilot for 8 of the 24 states that received planning grants is the single largest federal investment in community behavioral health in more than 50 years.

CCBHCs are required to provide:

- Crisis mental health services, including 24-mobile crisis teams, emergency crisis intervention services, and crisis stabilization
- Screening, assessment, and diagnosis, including risk management
- Patient-centered treatment planning
- Outpatient mental health and substance use services
- Primary care screening and monitoring
- Targeted case management
- Psychiatric rehabilitation services
- Peer support and counselor services and family supports

- Services for members of the armed forces and veterans
- Connections with other providers and systems

The CCBHC demo will build on previous and ongoing work OHA has done on health system infrastructure to strengthen physical and behavioral health care delivery integration: Patient-Centered Primary Care Home Program, Behavioral Health Home Learning Collaborative, and the Federally Qualified Health Center (FQHC) Alternative Payment Methodology (APM) Pilot.

Ensuring treatment of veterans

The CCBHC demo includes services for members of the armed forces and veterans as one of the nine required services. Working with the VA has been a challenge, but with the suicide rate of veterans totaling 23% of all suicide deaths in Oregon, we need to find a solution for providing the care they need. According to SAMHSA, 60% of Afghanistan and Iraq war veterans receive medical services outside the U.S. Department of Veterans Affairs (VA) system, requiring community behavioral and physical health providers to understand military culture and the complex VA benefits categories to provide appropriate care to veterans and their families.[41] It also is important to note that National Guard members, who generally remain in the service after returning home from deployment, are not considered veterans and are not served by the VA. It is encouraging that the CCBHC demo will attempt to address this complicated problem.

1115 Waiver Renewal

Remedies to value based purchasing barriers will be tested in the 1115 waiver renewal for Medicaid members, if approved by CMS. One of the barriers mentioned above - concerning paying for flexible services – is specifically authorized through the waiver, instead of or as an adjunct to covered benefits. Community benefit initiatives, also proposed, are population-based rather than member-specific. The intent in paying for these health-related services is to address social determinants of health.

Additionally, the demonstration renewal requires CCOs to enter into value-based payment arrangements with network providers. The State will be required to submit a value-based payment plan to CMS, describing how Oregon will achieve the specific percentage of value-based payments by the end of the demonstration period. Implementation of sharing risk and meeting quality metrics will be phased-in.

Health Information Technology

Sharing health information is paramount to integrated care. All three components of the triple aim are dependent on well functioning, interoperable health information systems – linked inextricably to value-based payment, tracking an individual's care by various providers, and measuring health outcomes. The ideal health information technology (HIT) system would include social services and links to the Criminal Justice, Public Safety, Education, and Child

Welfare systems, in addition to physical, behavioral and oral health care, and individuals and families would have access to their health records.

HIT challenges for Behavioral Health have been a long time in the making, as the Behavioral Health System had a later start than Physical Health in using electronic health records and adopting HIT systems, due to prohibitive costs, non-outcomes based payment, and complexity of behavioral health services measurement. Sharing health records has also been a bigger barrier for behavioral health clinicians with HIPAA and 42 CFR Part 2 concerns. Compared to Oregon hospitals, which are all on certified electronic health records with meaningful use payments, and 80% of all eligible professionals who have EHRs, fewer BH providers have EHRs connected to physical health. In the last several years, behavioral health agencies have committed to adopting electronic health records and have invested in expensive HIT systems that have not always proved to be compatible with the physical health world. Behavioral health providers have also been disproportionately burdened with documentation and reporting requirements, and because of the complexity and unclear definitions of service codes, and the waiving of documentation requirements for certain providers of behavioral health, the statewide data often is not completely accurate.

Emerging HIT solutions and recommendations

The Oregon Health Information Technology division has improved certain aspects of information sharing: supporting regional health information exchanges and encouraging statewide expansion; implementing the Emergency Department Information Exchange (including PreManage software, in which the user loads its client list and gets alerts when a client is hospitalized), and direct secure messaging through CareAccord.

To increase participation of Behavioral Health in health information exchanges (HIE), OHIT will conduct a scan to provide information about adoption, barriers, plans and priorities, highlighting areas of needed support. Oregon is also applying to participate in 90/10 HITECH funding for HIE costs to onboard providers, with a special focus on behavioral health. Additionally, a federal network, the Sequoia Project, has been initiated to connect to federal agencies, and others like CCOs, health plans, IPAs, etc.

As part of Oregon's 1115 waiver demo proposal, OHIT supports care coordination across providers, including housing and corrections, and costs of HIE entities. The HIT objectives include a commitment for providers to have access to pertinent information to ensure timely and informed health care decisions, for systems to use the data for quality improvement and population management, and to inform policy development.

A common consent model for behavioral data exchange will require a universal interpretation of HIPAA and other privacy laws for health information exchange, disclosure, and re-disclosure of drug, alcohol and mental health data. A common release of information form and educational opportunities for physical and behavioral health care clinicians, privacy officers, and legal counsel statewide should help everyone to be on the same page with information sharing. Support from state/federal grants for HIT development will also facilitate information sharing,

and if adopted, proposed changes in 42 CFR Part 2 by SAMHSA will allow for universal consent.

Because value-based purchasing is dependent on health outcomes, and measurement is or should be completely conducted using HIT, with a common set of outcome metrics, we recommend considerable investment in statewide HIT infrastructure and oversight. A strong state HIT infrastructure, including a singular system statewide or one that is fully compatible with the current HIT array and with sufficient resources to generate the data and specialized reports, is necessary to reform our health care system. Documentation requirements should be the same for everyone who provides behavioral health care. The Measurement Outcomes Tracking System (MOTS) is not just for specialty mental health care, and if the data in MOTS is not reliable, we need to come up with another solution to complement the MMIS Medicaid claims data reports.

Workforce

With only 2-4% of medical school graduates entering psychiatry[42] and practicing psychiatrists aging out (55% are age 55 or older), the shortage of both Adult and Child psychiatrists is a national crisis. Only 26% of psychiatrists accept new patients and average wait time for appointment is 25 days.[43] We can push to expand telepsychiatry/ health and the use of other providers such as CNPs, psychologists, and other mental health clinicians, both licensed and unlicensed, but we are not able to keep up with the demand.

Workforce shortage was also a deficit identified in the Oregon behavioral health system at the townhall meetings and in the gap analysis. No one knows better than those working in the behavioral health field that more people are needed as well as retraining of the current workforce to expand into integrated care. Although prescribers, particularly psychiatrists, are in high demand, other workers are also needed, including licensed and non-licensed clinicians, and peers at all service levels. It will take a transdisciplinary workforce, cross system training and boundary spanners to get us to where we need to go. We not only need sheer numbers, but we need people who specialize in working with children, older adults, veterans, and who represent the cultural groups they serve.

While we know what we need, it has been difficult to retain behavioral health workers. There is a considerable disparity in pay between public behavioral health and private behavioral health or medical systems. It is a common occurrence that licensed clinicians go to work elsewhere after being trained by CMHPs. The public behavioral health system simply cannot compete with the salaries offered by private entities.

Emerging Workforce Solutions

Health care workforce investment and recruitment is another component of the 1115 waiver renewal. This effort will test new ways of recruiting and retaining workforce and probably provide some relief for providers of Medicaid clients. Telehealth is a gap measure that works for

many people and OPAL K is expanding to provide psychiatric consulting to primary care physicians who serve adults.

We need a statewide solution for workforce development, beyond Medicaid, including addressing gaps in training and curriculum to promote integrated and team-based care. Integration supports whole person care and can help address some of the shortages in licensed mental health professionals in the behavioral health system, but it won't cover the whole gap. It will be an important challenge for the public behavioral health system to engage private behavioral health providers to expand access while managing the network for quality. Additionally, incorporating peers in every program will not only help address behavioral health workforce shortages, but lead to better health care and outcomes.

On the national scene, the Comptroller General will study peer support in 10 states to identify possible 'best-practices.' The House bill also authorizes grants to colleges of $10 million a year for 5 years ($50 million) to increase the behavioral health paraprofessional workforce, including peers. This bill also includes $12 million a year for five years ($60 million) to train psychologists to work with those with more advanced conditions.

Addressing gaps in treatment for people with mild to moderate mental illness and substance use disorders

Much research over the last 30 years has been done to improve effective treatment for behavioral health disorders in primary care settings. Efforts have included screening, co-location of mental health providers in primary care clinics, referral to specialty mental health care, traditional disease management programs, and provider education and training. These efforts alone have not been found to improve health outcomes or reduce costs. Primary care has its own challenges with a time-constrained clinic model and inconsistent access to behavioral health specialists –only 13% of people diagnosed with a behavioral health condition and 5% diagnosed with a substance use disorder received minimally adequate treatment in a medical setting.[44] This has serious consequences, including suicide attempts and completions, higher use of emergency departments, high hospital readmission rates, and fatal physical health problems that would have been treatable.[45]

Primary Care Providers express feeling ill-equipped to identify and treat mild to moderate mental health and substance use disorders. The addition of Behavioral Health Consultants within primary care settings has gone a long way to support improved service.

One national effort to improve behavioral health care in primary care settings is the Collaborative Care (CC) model through Medicare. It is a team-based approach that includes the primary care provider, patient, care manager and a psychiatric consultant and the model has been supported by meta analyses and 80 randomized control trials.[46] The model delivers particularly good outcomes for depression, and its effectiveness is increasing for anxiety disorders, PTSD, and comorbid conditions such as heart disease, diabetes and cancer. Trials have shown improvements in functioning at home and work, clinical outcomes and quality of life, and a reduction in disability. More seasoned CC programs are able to improve outcomes for people with substance use disorders. This model was tested on older adults in the IMPACT

study (Improving Mood – Promoting Access to Collaborative Treatment). In order to implement CC and achieve the outcomes, the payment structure must allow for integrated care practices, a sufficient mental health workforce trained in primary care settings and the willingness of primary care practices to implement CC. Return on investment was $6 saved for every dollar spent.[47,48]

Many of the components in the collaborative care model are found in Oregon's Person Centered Primary Care Home (PCPCH) model and aspired to in the Behavioral Health Home (BHH) model, in recognition that many individuals with behavioral health disorders prefer BHHs as their main point of contact with the health care system. In fact OHA's 2015-18 Behavioral Health Strategic Plan set a goal to increase the number of physical health providers offering care in BHHs. Recently, behavioral health homes have begun to integrate primary care services in order to improve services to individuals with moderate to severe mental health and substance use disorders.

Substance Use Disorder Treatment has particularly low utilization

Despite emerging innovations in substance use disorder treatment, state, local and federal governments incur millions of dollars of unnecessary costs in health care, criminal justice and child welfare systems because utilization of the treatment delivery system is limited due to the persistent stigma of addiction and significant challenges with motivating people to seek and/or participate in treatment. In a recent article summarizing 49 studies from 2007 through 2015 to evaluate the economic impact of opioid use disorder intervention, Murphy and Polsky found that only 10% of individuals with an opioid use disorder receive any treatment.[49,50] Making matters worse, Oregon's delivery system for substance use disorder (SUD) treatment is a legacy of the 1980's, fragmented and underfunded. Reflecting national estimates, only one in ten people with substance use disorders in Oregon is able to access treatment.

The solution is an integrated system of care for SUD, mental health, and medical services. Primary care settings in Oregon should provide a much wider and timely use of Screening, Brief Intervention, and Referral to Treatment (SBIRT), and easy access to a SUD-trained behavioral health consultant for patient support. A full continuum of best practices should be available, incorporating both psychosocial and pharmacological therapies, including: withdrawal management; medication assisted treatment; short-term inpatient and residential services; care coordination; long-term recovery supports and services; and aftercare/coaching.

Emerging solutions for under-resourced substance use disorder treatment

Fortunately, Oregon is taking CMS up on its offer to transform the SUD system. Using the CMS guidance as a template, we will seek to modernize and more adequately resource SUD treatment through an 1115 waiver amendment, shortly following the renewal proposal, with these key components:

- Comprehensive evidence-based benefit design
- Appropriate standards of care – ASAM
- Strong network development plan

- Integration of physical health and SUD
- Program integrity safeguards – risk-based screening of all newly enrolling providers and revalidating existing providers
- Benefit management – utilization review processes
- Community integration – Home and Community based services
- Strategies to address prescription drug abuse and Opioid use disorder
- Services for adolescents and youth with SUD
- Reporting of quality measures

The redesign of substance use disorder care delivery will not only contribute to primary-behavioral health integration success, but because of the CMS position to allow states to request authority for federal financial participation (FFP) for IMDs (institutions of mental disease), if Oregon's 1115 proposal meets the programmatic expectations, Oregon could redirect an estimated $13-16 million in state general funds that currently support IMDs as well as savings in overall health care costs.[51]

The recent passage of the Comprehensive Addictions and Recovery Act (CARA) in the House and Senate is also encouraging, representing an important, bipartisan step forward in efforts to address the nation's opioid use and abuse epidemic. The final report prioritizes prevention, treatment and recovery support services for those living with and in recovery from addiction. It also makes available overdose reversal medications and trainings as well as law enforcement and criminal justice education.

The redesign of SUD care delivery will require cooperation among multiple systems and should not be the work of SUD prevention and treatment providers alone. We must strive to ensure consistency of benefits across the state, align efforts with the CCBHC demo pilots, and incorporate value-based purchasing, health information exchange and care coordination as in the broader behavioral health system.

Recommendations for advancing primary – behavioral health care integration

Three keys to moving integrative care forward are phasing in value-based purchasing with the goal of substantially increasing the percentage of VBP to the majority of the funding, advancing a centralized health information technology network of health information exchanges, interoperability of electronic health records, common metrics and consistent data collection/reporting, and increasing the quantity, flexibility, and compensation of the workforce to perform and thrive in an integrated environment. We also need to continue to make progress on our patient centered primary care homes and behavioral health homes, ensuring strong support for bidirectional integration. These efforts will support the modernization of the substance use disorder delivery system and improve engagement of individuals with mild to moderate mental illness into services.

5. Coordinating Care/System Management

In order for any components of the continuum of care, from health promotion and prevention to institutionalized care to be implemented effectively, it is absolutely necessary that the care is not only managed within the behavioral health system, but also closely coordinated with other systems, i.e., Criminal Justice, Public Safety, Education, Child Welfare, Public Health, Physical Health, Housing, etc. This is the most critical part of the equation for successful behavioral health care system reform. We can implement evidence-based practices and have a qualified workforce, but all of the services and programs need to be connected and woven in with other systems in order to reach our vision of the triple aim. The areas where this is most strongly apparent are in the transitions between community, acute care, corrections, and institutional care.

For the most efficient use of our limited resources and to ensure our behavioral health care system is running smoothly, system management responsibilities must be clarified and processes among the system partners established. This will require constant communication and trusting relationships. In this section we will discuss recommendations on system roles and some key factors that greatly influence care coordination policy currently or in the near future.

Housing

Because stable housing is so critical for people to remain in their communities and the absence of secure housing is a huge risk factor for justice involvement and higher levels of care, housing is often at the center of care coordination. Homelessness continues to be a complex public health challenge in Oregon. In the Portland metro, population growth exceeds new construction, leaving the most vulnerable individuals at the highest risk of being unable to secure affordable housing. According to the Center for Outcomes Research and Education (CORE), Oregon's homeless population increased by 9% from 2014 to 2015, and on a single night there were 13,176 homeless individuals of which 3,991 were chronically homeless.[52] In Multnomah County, more than half of those counted as homeless in 2013 suffered from one or more serious physical, mental or substance use disorder-related conditions. Even though individuals and families who are homeless are at greater risk of poor health outcomes, many homeless programs lack connections to other federal, state and local programs serving similar populations. Rental assistance and housing supports tend to be paid through waivers, 1915i and State and County general funds, not by public or private health insurance.

In the recent CORE housing study, "Health in Housing Study: Exploring the Intersection between Housing and Health Care", the authors noted: "Limited services exist to address homelessness, and often available supportive housing services contain gaps, lack coordination and education to ensure services are fully used." The study assessed the impact of affordable housing on health care costs. Key findings included: 1) Costs to health care systems were lower after people moved into affordable housing (Medicaid expenditures declined by 12%); 2) Primary care visits went up after move-in (+20%) and ED visits went down (-18%); 3) Residents reported that access to care and quality of care improved after moving into housing; 4) Integrated health services to housing residents were a key driver of lower costs (-$115 PMPM).[53] The study concluded that forming a stronger housing and health care cross-

sector collaboration would benefit health outcomes. We concur with strengthening relationships between behavioral health and housing entities to create innovative housing solutions and to prioritize housing for additional funding. It is encouraging that Oregon is requesting use of Medicaid funds for those transitioning from acute care facilities to transitional housing up to 60 days through its 1115 waiver renewal.

Assisted Outpatient Treatment

An area that has been steeped in controversy due to ideological differences between judiciary and behavioral health systems, and between individuals and families, is assisted outpatient treatment. The primary ideological divide is between protecting civil rights/personal privacy and reducing risk to self or others through (in)voluntary inpatient or outpatient commitment. Proponents of assisted outpatient treatment (AOT) programs see this as a way to reduce the incidence and duration of psychiatric hospitalization, homelessness, incarceration, and interactions with the criminal justice system while improving the health and social outcomes of individuals with a serious mental illness.[54,55,56] Opponents see AOT as forced treatment. Given the strong positions on both sides, it's not clear whether we can bridge the ideological differences. With the passage of Representative Murphy's "Helping Families in Crisis" bill in the House, which is supportive of assisted outpatient treatment, and SAMHSA's current solicitation for community-level AOT programs, it is worth considering. Murphy's bill allocates funding to pay for a provision that was approved last year by Congress to establish AOT pilots and increases the amount of funding and the length of those pilots.

One important stipulation that SAMHSA includes in its RFP is that grants will only be awarded to applicants operating in jurisdictions that have an existing, sufficient array of services in place for individuals with SMI such as Assertive Community Treatment (ACT), mobile crisis teams, supportive housing, supported employment, peer supports, case management, outpatient psychotherapy services, medication management, and trauma informed care. This highlights that the key to making a significant impact on lowering recidivism and decreasing hospitalizations for this population is an appropriate level of housing and intensive services in the community, with the duration of the court order longer than 6 months.

Much work on AOT has been done in New York and California, where they have built programs that do not include forced medication or an involuntary commitment stipulation. These states have acknowledged that housing and intensive services must be well resourced in the community and the outcomes are better if the duration of the court order is longer than six months. AOT is seen as an option in the tool box for a very specific, narrow population.

USDOJ agreement to comply with Olmstead decision

The State of Oregon entered into an agreement with the US Department of Justice in 2012 to prevent an Olmstead lawsuit by using its Coordinated Care Organization experiment as the vehicle for change and by making targeted investments in community-based mental health services and programs. The goal is to hold down the number of people committed to the state hospital and to ensure individuals with serious and persistent mental illness are in the least

restrictive settings possible. As of this writing, a revised agreement is about to be released and is presumed to include the following components:

- ACT upon discharge from OSH
- Improved acute care processes – warm handoffs and referrals to housing resources
- No boarding at emergency departments - connect people with services in a timely manner
- More ACT teams
- More supported employment opportunities
- Secure residential treatment facilities with peer support, incorporating HCBS regulations, and utilization review
- More peer delivered services
- Increased numbers of people with SPMI in supported housing
- Increased numbers of people diverted from jail; Data exchange on inmates with SPMI from jails

The USDOJ agreement will provide direction for care coordination priorities and further investments in the community mental health system. We will need to be mindful of this agreement as we are prioritizing behavioral health system changes to ensure they are complementary to the aims of the Olmstead Act.

Clarifying roles and responsibilities of system partners

As AOCMHP envisioned the future of the behavioral health system in Oregon, we decided to create a matrix showing the main health care system functions grouped by areas of responsibility: Oversight and Mobilization; System Transformation; and Core Services. We separated functions by populations served as applicable, and connected each of these functions to relevant statute, rule, or contract clause. Lastly, we connected the functions to the responsible entity or entities.

Most of the behavioral health system roles are divided or shared between CCOs and CMHPs; other responsible entities for some of the functions are Public Health, hospitals and clinics. Many of the core services pertaining to behavioral health are delegated to CMHPs through the Local Mental Health Authority (LMHA), as prescribed in HB 3650, the originating legislation for CCOs. These core services include care management, mental health, substance use disorder, and intellectual/developmental disabilities services; management of populations with behavioral health disorders at high risk for institutional care; care coordination of residential services; crisis system; community-based specialized behavioral health services; and management of services for individuals with behavioral health disorders who have criminal justice involvement.

LMHA/CMHP and CCO roles are complementary. While the CCO's members are Oregonian's insured with Oregon Health Plan/Medicaid, the LMHA/CMHP statutory core services are a safety net for the entire community, and are not limited to individuals who are Medicaid eligible. Combining efforts produces a broader impact on the health of our communities. Incidentally, we strongly believe that funding for safety net services that are intended for the whole community

should not be allocated through competitive RFPs between counties. Accountability for these critical services should be addressed through agreed upon outcomes. By using another means to allocate these statutorily obligated funds, OHA could apply a health equity approach to ensure these critical services are present and fully functional across Oregon.

Although the community behavioral health system is the lead on transitions from levels of behavioral health care, safety net services and population-based behavioral health disorder prevention, these responsibilities hinge on the interaction with other systems. An example of inter-reliance is the .370 initiative, in which critical decisions are made by the Judiciary System that affect the level of care in the Behavioral Health System. Progress is being made on community restoration alternatives for people who are unable to aid and assist in their defense, a disproportionate number of whom have been inappropriately sent to the Oregon State Hospital for restoration. This initiative stems from 2015 state legislation directing the Court to order consultation with the CMHP to determine if the CMHP has resources necessary to safely serve and supervise a defendant towards capacity in community.

Other examples of cross system coordination are in crisis services, with shared responsibilities among Behavioral Health, Hospital, Public Safety and DD systems; and suicide reporting and postvention, involving a communication process with the Medical Examiner, Public Health, Law Enforcement, Education, and Local Government.

While there are components of the community mental health system statutes that need updating, such as civil commitment**,** we recommend that in this time of health care system transformation we are careful to avoid destabilizing the system. Acknowledging that we share the experience of funding constraints and levels of need with our system partners, and that everyone is overloaded, which exacerbates the gaps, it is important that we combine efforts to produce a broader impact for our communities. As we continue to grow our relationships and evolve the scope of integrated and coordinated care, change should be driven according to the health outcomes we want to achieve and to improve the quality of life for our communities.

Emerging Care Coordination Solutions

1115 Waiver Renewal and Amendment as Laboratory for Health Care Reform in Oregon

Oregon's proposal for an 1115 waiver renewal contains all of the key components necessary to enter the next phase of health care reform: value-based payment, which moves us to outcome-based performance metrics; investment in a more robust behavioral health system, with flexible services beyond the clinic, through partnerships with counties, corrections and community-based programs; expanded health information technology infrastructure, making it possible to focus on whole person care and to use data to improve quality of care and increase healthy outcomes; access to housing and housing supportive services, allowing people to remain in their communities; expanded use of peer support specialists and other traditional health care workers in the delivery system, and increasing the entire workforce continuum in behavioral health settings; and focusing attention on the Substance Use Disorder system with much needed modernization through a subsequent amendment in 2017. We look forward to piloting an additional vehicle for delivery system reform - coordinated health partnerships - and we are

in the position to make this work, with the aspiration that components of these demonstration pilots will be expanded to the rest of the health care system.

Transitions to and from the Oregon State Hospital are reliant on good communication and coordination between OSH, acute care hospitals, community mental health programs, residential providers, and social services. To this end, the Coordinated Health partnerships will serve as a locally-governed, cross-system model to increase integration and build infrastructure to ensure that people have stable housing, health care and social services to effectively transition to lower levels of care and stay in their communities. We also are supportive of Medicaid coverage for care coordination services for individuals who are in their final 30 days prior to discharge from the Oregon State Hospital. The focus will be on sharing community treatment information for discharge planning so that individuals will be able to swiftly return to their communities. Additionally, coordination on the front side for short lengths of stay will help decrease use of higher levels of care upon discharge.

Aligning the use of 1915(i)/HCBS with the 1115 waiver coordinated health partnerships will also help fill gaps in services for individuals who are Medicaid eligible to attain/maintain their maximal level of independence, such as daily living assistance to live at home or other community-based settings, and psychosocial rehabilitation to reduce impairment of an individual's functioning associated with symptoms of a mental disorder or to restore functioning to the highest degree possible. All of these developments will not only move us closer to the triple aim, but it will help Oregon successfully follow the terms of its agreement with the USDOJ.

Complementary to Oregon's 1115 waiver renewal, Federal care coordination policy is adjusting overall to help lift barriers for Medicaid managed care, and as a result of evidence-based programs showing good outcomes, some of them from years of implementation at this point. Here are examples of federal policy reform and investment to support care coordination:

- The new Medicaid Managed Care Rule lifts the IMD exclusion partially, to include short-term stays in capitation payments and applies to hospitals providing psychiatric or substance use disorder inpatient care and subacute facilities providing psychiatric or SUD crisis residential services. Medicaid coverage is limited to fewer than 15 days in any month, with flexibility to create longer stays by aligning stays over two consecutive months (14 days in one month and 14 in the next for total of 28 days).
- Helping Families in Crisis bill provides $5 million a year for 2018-2022 to expand Assertive Community Treatment teams.

- The focus of the CCBHC demo pilot is care coordination. This will require CCBHCs to partner with the entire health landscape, including non-health system partners, to keep individuals engaged. The care coordination requirement also ensures that CCBHCs are not competitive with other providers so as to ensure a high quality continuum of services for individuals who may have difficulty accessing traditional clinic based services. The CCBHC will have care coordinators on their staff to assess the individual's needs and how they can be met, either by the CCBHC or by one of its collaborating agencies.

As alluded to in previous sections, it is essential that all system partners have skin in the game: all payers participate and fund care coordination; providers will ultimately have to bear risk for their clients to fully embrace value-based purchasing and want to be involved in care coordination with payers. As an interim solution for some Medicaid payers and CMHPs, we need to find a group of State Medicaid plan codes to accommodate integrated care and care coordination. Cross system partnership includes integrating funding, with all systems pitching in to get to the outcomes. Besides pooled funding, electronic health records must be shared among physical and behavioral health care, with DHS entities, Criminal Justice/Public Safety, and Education.

Conclusion and Recommendations for Policy and Legislative Change

We have been in the new model of Medicaid managed care through Coordinated Care Organizations for four years now, enabling Oregon to get an early start on integrating and coordinating care to identify and begin to overcome barriers in reforming the health care system. With the added benefit of expanding Medicaid, we have been able to try additional innovations in health care, many through our 1115 waiver demonstration and others with support from state general fund targeted investments. We have made progress in establishing and nurturing relationships between systems that have not always collaborated or communicated well, and with funding support have improved primary-behavioral health integration and cross system care coordination. Building on these efforts, our overarching recommendations for next steps in health system reform, with particular emphasis on behavioral health, are:

1. **More investment in health promotion/prevention, and early intervention**
    - Engage community members in health promotion and prevention much earlier to identify the root causes of behavior health disorders, helping to alleviate family stress and addressing the social determinants of health.
    - Fund a continuum of evidence-based prevention services and bring to scale statewide with standardized metrics to be able to compare results, measure outcomes, and analyze cost benefit and return on investment.
    - Establish cross system partnerships at the local level to promote health and support prevention activities.

2. **More investment in decarceration *(for adults and youth)***
    - Continue to target funding for crisis services and other jail diversion activities with peer involvement, including housing, Crisis Intervention Training, sobering centers, crisis stabilization centers, mobile crisis, and intensive behavioral health services.
    - Improve data gathering and sharing between Law Enforcement and Behavioral Health; standardize metrics to allow for comparison, outcomes measurement, cost benefit and return on investment analyses.
    - Continue improving collaboration between Behavioral Health, Criminal Justice/Juvenile Justice and Public Safety to prevent unnecessary incarceration and hospitalization.

3. **Enforcement of Mental Health Parity and Addictions Equity Act of 2008**
    - Implement standardized payment among all payers, including paying for non-clinic based, pre-treatment outreach and engagement, and non-encounterable behavioral health services (e.g., crisis services equal to the cost of their members' utilization.
    - Apply a systemic, coordinated and collaborative approach across the continuum of care, regardless of payer, including access to adequate provider networks and sharing of health information data to measure outcomes and track cost benefit.

4. **More progress on BH-primary care integration**
    - The next phase of integrated care necessitates: 1) phased approach to value-based purchasing, 2) remedies for behavioral health workforce shortages and need for retraining; and 3) a statewide solution to health information technology challenges.
    - Special attention is needed to fully incorporate substance use disorder treatment into the integrated system of care and to engage people with mild to moderate mental illness in treatment.

5. **Cross system care coordination**
    - While the Behavioral Health system may be the lead on most behavioral health care, positive health outcomes are dependent on cross system coordination with Public Safety, Criminal Justice, Education, Child Welfare, Primary Care, Housing and other system partners.
    - Housing is central to care coordination and must always be considered in any potential solution for an individual at risk for or transitioning out of institutional care.
    - Important federally-initiated policy developments that Oregon must incorporate into care coordination and policy change are the USDOJ agreement to comply with the Olmstead Act and the move toward assisted outpatient treatment for a small, narrowly defined population.
    - Systems must be able to share health information to coordinate care.

We look forward to working with the Oregon Health Authority, Legislature, and system partners through the Behavioral Health Collaborative to discuss and prioritize a set of key solutions.

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