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# Ombuds Program 2023 Six Month Report



Oregon  
Health  
Authority

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# EXECUTIVE SUMMARY

Oregon Revised Statute (ORS) 414.712 directs the Oregon Health Authority (OHA) Ombuds Program to serve as the advocate for Oregon Health Plan (OHP - Medicaid and Children's Health Insurance Program) members for access to care, quality of care, and channeling member experience into recommendations for Medicaid systems, policy, and program improvement.

OHA provides a written response to Ombuds reports and implements an action plan to address findings. OHA's formal response and previous OHA Ombuds recommendations, key successes, progress forward and gaps in resolving each finding can be found on the OHA [website](#)<sup>1</sup>.

This 2023 six-month Ombuds Report recommends strategies to prioritize community-based child, youth, and family mental health care<sup>2</sup> in Oregon. The report focuses exclusively on community-based services for children's mental health in tandem with the Ombuds 2022 Year-End Report, which focused on access to mental health and substance use disorder (SUD) services for adult OHP members. Recommendations highlight opportunities to strengthen funding, data, workforce, provider networks, programs and statewide advocacy for children, youth and families. The Ombuds Program urges OHA and the state to prioritize investments and resources in these areas, particularly community supports to the children's mental health continuum of care that reduce resource-intensive emergency department, hospital and mental health residential stays.

The Ombuds Program recommends strategies to prioritize child, youth and family services for:

- Mobile Response and Stabilization Services (MRSS)
- Intensive In-Home Behavioral Treatment Services (IIBHT), and
- Respite Care.

Together, these programs anchor a robust local system of care that meets the needs of children and youth in their own communities.

This report uses Ombuds Program data, member stories and experiences, OHA claims data, and other statewide data sources to elevate and document system barriers experienced by children, youth and families who are OHP members and seek mental health care.

During the first six months of 2023, the OHP service concerns most frequently brought to

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<sup>1</sup> Ombuds Program Reports. <https://www.oregon.gov/oha/ERD/Pages/Ombuds-Reports.aspx>

<sup>2</sup> This OHA Ombuds Reports primarily discusses mental health and refers to mental health rather than discussion behavioral health which would include both mental health and substance use disorder. Strategies to meet the needs of youth, young adults and families for Substance Use Disorder are equally critical for the state of Oregon to also address.

the Ombuds Program by members involved:

1. Specialty care (10%);
2. Primary care (9%);
3. Mental health care (8%);
4. Dental care (8%); and
5. Non-emergent medical transportation (NEMT) (5%).

## Programmatic recommendations

The Ombuds Program recommends that OHA agency leadership, the Oregon Health Policy Board, the Governor and the Oregon Legislature use the recommendations identified in the Ombuds reports to drive action centered on improving access to and quality of care for OHP members. Prioritization of resources to address funding, data, workforce and community-based programs for children, youth and young adult mental health is needed.

Recommendations include:

- **Require statewide networks.** OHA should implement OHP policies requiring a statewide network for both inpatient and outpatient mental health services by requiring coordinated care organizations (CCOs) and OHA fee-for-service (FFS) programs to contract with all willing outpatient and residential behavioral health providers for children and adults in the state;
- **Prioritize funding** of community-based children’s mental health services;
- **Prioritize development and implementation of culturally specific services** to eliminate the racial and linguistic disparities in accessing mental health services, follow-ups from emergency departments (EDs), and overrepresentation of youth of color in ED boarding;
- **Strengthen peer workforce** within children’s mental health;
- **Create pathways** for expedited access to outpatient mental health services for youth accessing Mobile Response and Stabilization Services (MRSS);
- **Fully implement** Intensive In-Home Behavioral Treatment Services (IIBHT) within all CCOs and OHA’s FFS program;
- **Fund and implement** mental health respite care for the entire lifespan;
- **Create an independent Office of the Ombuds for Children and Youth** in Oregon under the Governor’s Office and in collaboration with the Children’s System of Care Advisory Council to advocate for children, youth, young adults and families in need of services across multiple systems.

# Ombuds Program recommendations

Since 2019, the Ombuds Program has grown in volume and work scope as the program has fully moved into its legislatively intended role. This has increased workload for the OHA Ombuds Program to support agency priorities, values and reduce agency risk without additional staffing or support. The essential role of the Ombuds Program to act as a catalyst for systems improvements to Medicaid access to care and quality of care based on OHP member voice is at risk. Based on agency need and Ombuds workload exceeding existing resources, the Ombuds Program formally makes the following recommendations:

- Prioritize through staffing, resources, and responsiveness OHA's formal response and workplan to address recommendations made in this and past Ombuds Program reports;
- Increase Ombuds Program capacity to allow the team to respond to the complexity of current multi-system casework that reflect statewide gaps in mental health and SUD care for OHP members throughout Oregon, and advocate for systems improvement based on Ombuds casework to support making operational recommended changes;
- Strengthen responsiveness to members. Across the agency, OHA should prioritize giving members the same level of responsiveness whether their concern is raised by the Ombuds Program, the member, the member's family or advocate, legislators or media;
- Strengthen Ombuds Advisory Committee with a formal governance structure for the Ombuds Program;
- Develop Ombuds and Agency Charter and ensure full understanding by all agency staff of Ombuds Program role within Medicaid.

## Conclusion

Each person who seeks Ombuds Program assistance deserves nurturing and support. The stories they share often illustrate challenges many others experience. Each story brings lessons for ways to improve Oregon's Medicaid delivery system and to understand the impact of health inequities on Oregonians who receive or are eligible for OHP.

The Ombuds Program is honored to work within an agency that embraces OHP member experience as essential to successful transformation. The Ombuds Program supports Oregon's efforts to ensure health equity through advancing better health, lower costs, and improved patient experience for all people in Oregon, particularly populations experiencing health inequities.

# BACKGROUND

Oregon Revised Statute (ORS) 414.712 directs the OHA Ombuds Program to serve as the advocate for those receiving publicly funded health services. This advocacy is primarily focused on OHP:

- Access to care,
- Quality of care, and
- Channeling member experience into recommendations for systems, policy, and program improvement.

The Ombuds Program submits quarterly reports to the Governor, the OHA Director, and the Oregon Health Policy Board.

- First and third quarter reports provide data about concerns received to the Ombuds Program.
- The six-month and year-end reports include data, additional narrative about emerging or ongoing trends and concerns, and recommendations for improving quality of and access to publicly funded health services.

Within OHA, the Ombuds Program serves as a vehicle for the receipt of OHP concerns, advocacy for their access to quality care, and the elevation of member voices to help OHA center member experience to improve policy and process. Ombuds Program advocacy is a powerful tool to help state agencies be as responsive as possible to those they serve.

OHA provides a written response to Ombuds reports and implements an action plan to address findings. The Ombuds Program tracks all recommendations and OHA's progress addressing concerns. Ombuds reports and a dashboard with previous and current recommendations since 2020 are available on the OHA [website](#).



**Ombuds recommend improvements based on OHP member experience and prioritize recommendations impacting health equity.**



The Ombuds Program is independent of Medicaid program implementation, operations or compliance.

The program provides recommendations and oversight internally to OHA Medicaid programs and externally to Medicaid contractors.

# CHILDREN'S MENTAL HEALTH

The [2022 Ombuds Program Report](#) focused on critical actions to improve mental health and substance use disorder residential and home and community-based services for adults. The Ombuds Program believes it is just as essential to elevate the mental health needs of children, youth, and young adults in Oregon.

**1 in 4** Oregon youth ages 12 through 17 have experienced a “major depressive episode” in the past year. That is the second-highest rate in the nation.<sup>3</sup>

This 2023 six-month Ombuds Report recommends strategies to prioritize community-based child, youth, young adult and family mental health care in Oregon<sup>4</sup>. Strategies to meet the needs of youth, young adults and families for Substance Use Disorder are critical for the state of Oregon to also address but are not the focus of this report.

Implemented effectively together, the programs featured here anchor a local system of care that meets the needs of children and youth in their own communities. The Ombuds Program recommends strategies to prioritize child, youth, young adult, and family services for:

- Mobile Response and Stabilization Services (MRSS),
- Intensive In-Home Behavioral Treatment Services (IIBHT), and
- Respite care.

These services create a community safety net for early identification of children and youth at risk, crisis intervention, and connection to services. Provided in combination, they:

- Support children and youth in their home and communities in a safe and stable manner,
- Improve youth and family outcomes and wellbeing,
- Reduce the need for costly higher-end interventions such as residential care<sup>5</sup>,
- Reduce the likelihood of entry into the adult mental health system, and
- Promote better physical health outcomes.

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<sup>3</sup> SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2021.

<sup>4</sup> This OHA Ombuds Reports primarily discusses mental health and refers to mental health rather than behavioral health, which would include both mental health and substance use disorder.

<sup>5</sup> Stroul, B., Pires, S., Boyce, S., Krivelyova, A., & Walrath, C. (2015). Issue Brief: Return on investment in systems of care for children with behavioral health challenges. Washington, DC: Georgetown University Center for Child and Human Development, National Technical Assistance Center for Children's Mental Health. Accessed online Oct 2023at <https://gucchd.georgetown.edu/products/SOCReturnOnInvestment/ssueBrief.pdf>

This report uses Ombuds Program data, member stories and experiences, and statewide data sources to elevate and document the systems barriers experienced by OHA children, youth, young adults, and families seeking mental health care.

## OHP Member Story: Youth Mental Health Crisis

### OHP Member Experience: No in-state services for youth

**Sensitive Content:** *This story references youth mental health crisis and suicide. It may be activating. **If you are thinking about suicide, help is available. Speak with someone today. The 988 Suicide and Crisis Lifeline is available 24/7 by phone (988), text, or chat.***

Late last winter, Sam (they/them, age 16) experienced worsening mental health. They had thoughts about suicide. Sam's coordinated care organization (CCO) supported outpatient care for Sam, but they needed more intensive community mental health services than were available in their rural community. Without these services, providers increased medications and therapy for Sam. But medications and therapy failed to improve Sam's mental health. The increased medication made it hard for Sam to function. Sam's school could not meet their needs, and they could no longer attend. Their thoughts of suicide increased. While at home, Sam needed round-the-clock care for their safety. Sam's family provided that care. One parent had to use all their family medical leave to be absent from their job.

As Sam's mental health got worse, their CCO care coordinator tried to find residential care for Sam in Oregon. But Sam's needs were deemed either "too acute" or "not acute enough" for such care. No Oregon facilities would admit Sam. Sam visited several Oregon Emergency Departments (EDs). No Oregon ED admitted Sam for inpatient care during this time. Many of the support services offered, including those featured in this report as part of Sam's discharge plan from Oregon EDs, were canceled or not available after discharge.

Over the next several months, Sam's care coordinator and family attempted to locate care across three different states outside of Oregon. During this time Sam:

- Was denied admission to all youth-serving inpatient mental health facilities in Oregon;
- Was seen at five different EDs in three states;
- On two occasions was forced while in EDs to take medication they had a known adverse reaction to;
- Was denied admission to all youth-serving mental health residential facilities in a third state; and
- Survived several suicide attempts.

By late spring, Sam was in the acute care psychiatric wing of an out-of-state hospital. The Ombuds Program, OHA Medicaid leadership and the CCO care coordination team advocated together to bring Sam back to Oregon. Sam was finally able to enter care at an Oregon residential facility. During Sam's stay, their CCO engaged the providers Sam would need in their community through a series of specialized agreements. This created a safety net of services that allowed Sam to return to their community, their family, and home after four months away.

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**95** Oregon youth ages 0 - 25 died by suicide in 2021.

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Sam's story is not unique. In 2021, **1 in 5** eleventh grade students reported unmet emotional or mental health care needs in the previous 12 months<sup>6</sup> and 95 Oregon youth died by suicide.

Stories such as Sam's, and others reflected in Ombuds casework and statewide data, highlight how critical it is to provide services rooted in the communities where children, youth, and young adults live. Gaps in a community's local system of care create impacts in multiple directions. Sam's CCO worked hard to bring specialized care into place for Sam. However, with full implementation of programs focused on in this report, it is likely that Sam and their family - and other youth in similar circumstances in their community - would have had:

- 24/7 access to mobile crisis and supportive response for up to two months,
- Intensive in-home treatment with a therapist and peer, and
- Access to respite supports for Sam and their family to decompress, rest, and regroup.

Absence of these services cause children and youth in Oregon to experience:

- Prolonged periods of elevated mental health crisis,
- Repeated ED visits,
- Long wait times to access residential care,
- Time out of their home and community,
- Increased likelihood of need for more intensive treatment, and
- Negative impacts on overall health.

This escalation of need has both upstream and downstream impacts on Oregon's children, youth, young adults, families and the adult mental health and substance use disorder system. Impacts include:

- Job and income loss by families as they care for their children and youth or pay out of pocket for services. This puts families into debt, creates additional hardships, and often leads to greater family instability,
- Family and youth housing instability,
- Increased burden to Oregon's multiple child-serving systems such as Child Welfare, Developmental Disabilities, Juvenile Justice, Oregon Youth Authority, Department of Education, and Oregon Health Authority,

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*“We can't find a place to live because of all the damage our son did in our last apartment.”*

*“The system feeds itself. There is too little upfront. It forces us into higher levels of care and ODHS.”<sup>7</sup>*

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<sup>6</sup> 2020 Student Health Survey

<sup>7</sup> OFSN survey, SOC Plan <https://www.oregon.gov/oha/HSD/BH-Child-Family/Documents/SOC-Plan-2022-23.pdf>

- Increased burden to Oregon hospitals and EDs to compensate for absent or overstretched community-based services,
- Decreased overall family well-being and mental health impact to other children and youth in the household,
- Adults who will need increased and higher levels of care because they did not receive early intervention services as children or youth,
- Increased need for parents' mental health services, often after the child or youth has achieved some stability.

## Youth mental health in Oregon by the numbers

The Ombuds Program recommendations in this report are rooted in understanding of member experiences through Ombuds casework in the top areas of mental health concern brought by members aged 26 and under from 2019-2023:

- 1) Provider access,
- 2) Care coordination,
- 3) Residential care,
- 4) Quality of care, and
- 5) Interpreter services.

**Table 1: Children, youth and young adult mental health needs ages 26 and under brought to Ombuds Program (June 1, 2019- June 30, 2023).**

	2019	2020	2021	2022	2023	Total
<b>Provider access</b>	2	6	7	10	7	<b>32</b>
<b>Care coordination</b>	1	3	7	10	7	<b>28</b>
<b>Residential care</b>	2	4	6	5	6	<b>23</b>
<b>Quality of Care</b>	1	2	1	3	3	<b>10</b>
<b>Interpreter services not available</b>		1	1	2	1	<b>5</b>
<b>Total top concerns</b>	<b>6</b>	<b>16</b>	<b>22</b>	<b>30</b>	<b>24</b>	<b>98</b>
<b>Total concerns</b>	9	18	26	32	30	115

Of the 115 concerns brought to the Ombuds Program, 83 - or 72 percent of cases – concerned provider access, care coordination, or residential care. Many of the children

and youth coming to the Ombuds Program with mental health concerns need services and supports across multiple state and local systems. Examples include:

- A grade-school child's foster family and CCO could not find needed mental health supports. The child lost placement with the family and was housed in a hotel with Child Welfare staff;
- A teen was denied needed mental health services due to the presence of a developmental disability;
- A grade-school child could not access needed specialized physical, mental, and developmental health services in their rural area;
- A grade-school child with multiple care needs had no living parent or guardian. This impacted their ability to access health care. The child's teacher referred them to the Ombuds Program;
- A grade-school child in Child Welfare custody with repeated ED visits could not access residential care because the ED did not coordinate with admitting hospital;
- A non-English-speaking young teen hospitalized with an eating disorder could not be safely discharged due to lack of culturally specific mental and physical health services in the community;
- A teen in Oregon Youth Authority (OYA) custody was denied Wraparound services;
- A teen parent with Child Welfare involvement could not access residential SUD and mental health treatment, impacting their parental rights.

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*National studies have found that after 12 months of services in a system of care, 8.6% of youth had dropped out of school, compared with an average of 20% of high school students with mental health challenges [not receiving system of care supports]<sup>8</sup>*

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For youth with complex mental health challenges and multiple system involvement, the path to meeting their needs is difficult. Most child-serving state agencies lack the presence of a formal Ombuds devoted to advocacy for children, youth and families. *There is no Ombuds with jurisdiction across these agencies.*

## What's in a number? What makes a trend?

Child, youth and young adult mental health concerns coming to the Ombuds Program frequently present due to underlying systems barriers impacting access to and quality of mental health care.

The Ombuds Program is designed to provide resource and advocacy when concerns have not been resolved through existing care coordination and complaint processes. CCOs, the OHA Child and Family Behavioral Health Unit and OHP Client Services Unit all receive concerns about child and youth mental health needs. If these front-line

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<sup>8</sup> <https://gucchd.georgetown.edu/products/SOCReturnOnInvestmentIssueBrief.pdf>

resources cannot resolve complex child and youth concerns, they bring them to the Ombuds Program. Representatives from other systems also contact the Ombuds Program when they cannot achieve resolution in a case. School districts, Child Welfare and Developmental Disability staff, pediatric providers, peer support providers, hospitals, local systems of care, family members and others often advocate for youth and families when they bring concerns that represent system barriers to the Ombuds Program.

Concerns brought to the Ombuds program represent only a tiny fraction of all concerns experienced by OHP members. Importantly, one member and their experience can give voice to many others. Many OHP **members specifically state that they contacted the Ombuds Program because they want OHA to use their own experience and voice to improve services for other OHP members.** As part of OHA’s commitment to eliminating health inequities and co-creating with community, it is essential for OHA as an agency to listen and learn from individual concerns. OHA should at times act on concerns even without larger amounts of data, particularly for concerns impacting health equity.

**OHP Member Experience: Emergency Department Visits**

From July 1, 2021, through June 30, 2023, Oregon Hospital Discharge Data showed 1,923 OHP members under age 18 visited an ED with mental health concerns as their primary reason for the visit. Data for all visits, regardless of insurance or OHP status, show that more than 11 percent need to return within three months. These are often youth like Sam, who experienced repeat visits to the ED, frequently because of an absence of robust community supports.

From July 1, 2021 – June 30, 2023, Oregon Hospital Discharge Data showed a total of 4,725 emergency room visits among OHP members ages 25 and under with mental health diagnosis as their primary diagnosis. Among all youth, regardless of insurance, from Oregon Hospital Discharge Data, the mean length of ED stay was 14 hours.

- However, for youth who stayed longer than 24 hours, the mean length of stay was almost three days.
- The maximum ED stay was 35 days in ages 18-25 and 17 days for ages 25-17.

**Table 2: Longest length of stay (in days), mental health, ages 0-25, Fiscal year 2022**

	Ages 0-9	Ages 10-13	Ages 14-17	Ages 18-25
Maximum Length of Stay	13.96 days	14.86 days	17.63 days	35 days

Like Ombuds data, child and youth ED visits for mental health represent an indicator of greater community needs for local services.

34%

Percentage of OHP members age 18 or younger (496,705 of 1,455,419)<sup>9</sup>

57%

Of all 869,610 youth ages 25 and under in Oregon, 495,677 are enrolled in OHP

## Equity impact: Disparate impact for priority populations

Children, youth, young adults, and families impacted by health inequities in Oregon face additional disparate impacts and gaps in mental health services. Finding a local provider is often difficult. Finding mental health providers that offer culturally and linguistically aligned care for individuals who prefer a language other than English or who have specific cultural preferences is often impossible.

Healthier Oregon data, CCO incentive metrics data and ED boarding data respectively indicate potential disparate outcomes for individuals who prefer a language other than English and have been traditionally excluded from Medicaid, American Indian and Alaska Native (AI/AN) populations, and African American youth.

Healthier Oregon provides full OHP benefits to people of all ages who meet income and other criteria, no matter their immigration status. Youth under age 19 have been eligible since 2018. Members speak 69 languages, and most speak English less than very well.<sup>10</sup>

- Children and youth from the general OHP population receive mental health services at twice the rate of Healthier Oregon children and youth.

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### Oregon Health Authority

*Oregon will have established a health system that creates health equity when all people can reach their full health potential and well-being and are not disadvantaged by their race, ethnicity, language, disability, age, gender, gender identity, sexual orientation, social class, intersections among these communities or identities, or other socially determined circumstances.*

*Achieving health equity requires the ongoing collaboration of all regions and sectors of the state, including tribal governments to address:*

- *The equitable distribution or redistribution of resources and power; and*
  - *Recognizing, reconciling and rectifying historical and contemporary injustices.*
- 

<sup>9</sup><https://app.powerbigov.us/view?r=eyJrIjoiaMTRhMmNhZDktYzY4OS00MzIxLTg4NTAtNjc4NmVINjA1NzI4IiwidCI6IjY1OGU2M2U4LThkMzktNDk5Yy04ZjQ4LTEzYWYyOTQ1MmY0YyJ9&pageName=ReportSection4f305eee24d2c830b04a>

<sup>10</sup> Oregon Health Authority. Healthier Oregon: Better Care for More People: HB 3352 Report to the Legislature [Internet]. Oregon Health Authority. Salem, OR. 2023. Available from: <https://sharedsystems.dhsosha.state.or.us/DHSForms/Served/le-110196.pdf>

- Even though Healthier Oregon children and youth visit their primary care providers at nearly the same rate as the general OHP population, they are less likely to receive mental health assessments and services.
- Claims data from 2019-2021 indicate that Healthier Oregon children and youth receive mental health assessments at lower rates and are less likely to access mental health therapy, especially therapies like applied behavioral analysis; the OHP general population is five times more likely to receive this therapy.

[CCO Performance Metrics](#) report on the follow-up visit within seven and 30 days after emergency department visits for mental illness for all members ages 6 and older. In 2024, these data will be disaggregated further by age and region. This may help to identify additional inequalities by race, ethnicity and age. Current inequalities exist for AI/AN OHP members regardless of age. From 2021 to 2022, fewer AI/AN members received follow-up within 7 and 30 days of an ED visit for mental illness.

Oregon Hospital Discharge Data indicates that racial inequalities appear to be an indicator for ED boarding in which a youth with a mental health disorder diagnosis is held in an ED for more than 24 hours before being discharged either to a higher level of care or to the community. These data look at all children and young adults through age 25 seen in EDs regardless of insurance or OHP status for health primary diagnosis. Black or African American people make up 2.75 percent of the total population of Oregon, however they represented 8.1% of the population of youths boarded for more than 24 hours, a difference of 5.3 percentage points between July 1, 2021, and June 30, 2023.

These data serve as a proxy to understand that while there are barriers to accessing mental health for all individuals in Oregon, **OHP populations who are impacted by historical and contemporary injustices appear to be disparately impacted.**

## Services and supports to meet the mental health needs of Oregon’s children, youth and families in their own communities

This section discusses community-based mental health supports for child, youth, young adult, and family mental health services in Oregon. The Ombuds Program recommends strategies to prioritize child, youth and family services for:

- Mobile Response and Stabilization Services (MRSS),
- Intensive In-Home Behavioral Treatment Services (IIBHT) and
- Respite Care.

*“We need support close to home” – (North Coast Youth Advisory Council)*

Together these programs create a more comprehensive safety net that allows for early identification of children and youth at risk, crisis intervention and connection to services.

Each needs to be fully operational and braided together to support children, youth, young adults, and families in their communities and reduce ED visits and the need for residential stays.

## Mobile Response and Stabilization Services (MRSS)

### OHP Member Experience: MRSS in Sam's community

Sam and their family engaged with the local community's MRSS team, but this service was not available 24/7 and could not always respond timely when contacted, worsening the crisis and resulting in more frequent ED visits.

The Oregon Legislature allocated funding for Mobile Crisis Services and Supports (MRSS) and call center resources in 2021 through [House Bill 2417](#). This model is implemented by individual counties across Oregon and accessed through the 988 Suicide & Crisis Line. Any person in Oregon can access mobile crisis intervention services by calling 988 or their country crisis line for immediate crisis response. Youth ages 20 and under may be eligible for more support following a crisis through MRSS.

MRSS is a national best practice model for rapid response, home-and community-based crisis intervention customized to meet the needs of children, youth, young adults, and their families by linking to a continuum of care. **The main goal of MRSS is to help maintain youth in their own homes and avoid unnecessary emergency room visits** while connecting the youth and family to ongoing resources and services after the initial crisis response.

OHA requires all counties to have specific MRSS services available, including:

- Two-person mobile crisis intervention teams available 24 hours a day, 7 days a week, to provide an in-person response by providers trained in developmentally appropriate assessments and interventions for children and youth,
- Connection of youth and their families to rapid behavioral health supports at home and in their communities, and
- Help de-escalating crisis situations.

High-quality, fully implemented MRSS services can:

- Connect youth and their families to Intensive In-Home Behavioral Health Treatment (IIBHT), respite care, and other community-based supports,
- Reduce costs and prevent unnecessary trips to emergency departments, ED boarding, hospital stays and out-of-home placements,
- Help prevent interactions with law enforcement, and
- Identify and treat other behavioral needs that can lead to larger issues if not addressed.

MRSS is different than the approach to crisis support taken by programs for adult populations. It is mainly provided through immediate access to a clinician and a Family Support Specialist. The response team determines services and supports collaboratively with the youth and their family. The services and supports are flexible and designed to be ready for the family to use before need escalates.

Barriers to providing MRSS in a way that meets the needs of children, youth, young adults and their families include:

- Reported lack of interpreter services and culturally aware services for traditionally underserved populations. This reduces trust and use of these services in priority populations impacted by health inequities,
- Inability to enter schools in some settings,
- Inadequate workforce for youth-serving populations,
- Call centers and counties who have yet to fully implement the MRSS face-to-face intervention model regardless of crisis or issue,
- Long wait times to access other community mental health services that MRSS seeks to connect individuals to.

**Partners report barriers to fully implementing MRSS in a way that meets the needs of youth involved in multiple systems.**

*In Oregon last year a youth experienced a mental health crisis in school and an MRSS team was called. When they arrived, school policy did not allow the team to enter the building. Instead, the school called law enforcement and let them in so that the youth in crisis was met with a police response, while trained behavioral health responders waited outside.*

## Intensive In-Home Behavioral Treatment Services (IIBHT)

### OHP Member Experience: IIBHT in Sam's community

As part of Sam's care after one ED visit, the hospital discharge plan included IIBHT. However, IIBHT was not yet fully implemented in Sam's community and did not meet the level of care Sam required. **Of the youth IIBHT served in 2022, only 11 percent went on to need residential care<sup>11</sup>.** Access to a robustly implemented IIBHT model may have prevented Sam from having to leave their community for over four months to access care.

In 2019, the Oregon Legislature directed \$6.6 million in funds to include Intensive In-Home Behavioral Health Treatment (IIBHT) as a Medicaid-covered benefit for children and youth through age 20. These services provide evidence-based intensive community-based alternatives to residential treatment and inpatient hospitalization. They are tailored to meet the individual needs of the child and family and include access to a multidisciplinary team of professionals and 24/7 proactive and crisis response to the home. Intensive In-Home Services have been demonstrated nationally to produce

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<sup>11</sup> Intensive In-Home Behavioral Health Treatment 2022 Annual Report. <https://www.oregon.gov/oha/HSD/BH-Child-Family/Documents/IIBHT-Annual-Report-2022.pdf>

positive outcomes for youth, significant returns on investment, and reduction of residential care costs. In Oregon, 88 percent of youth served by this program have a trauma history and 39 percent are youth currently or previously in foster care.<sup>12</sup>

Implementation began in 2020 for OHP Open Card members through Oregon's fee-for-service (FFS) program. Although CCOs also provide other intensive community-based services for children, youth and families outside of the IIBHT model, in 2021 CCO contracts required CCOs to provide IIBHT to all eligible members. Some CCOs use other community-based models such as Intensive Community Treatment Services, Community-Based Intensive Services, and the Intercept Model. However, IIBHT is distinguished from other intensive community based services in that IIBHT requires:

- Offering a Family Support Specialist to each family,
- Making a youth peer available if needed,
- Providing four hours of services a week, and
- Tracking pre- and post-entry youth outcome data.

To be eligible for IIBHT, youth must:

- Have OHP benefits,
- Be age twenty (20) or younger,
- Have two primary mental health diagnoses funded on the Prioritized List of Health Services, and
- Have a mental health provider document asserting that the member:
  - Has intensive behavioral health needs that may include significant health and safety risks or concerns impacting school, home, or community.
  - Requires intensive services for community stabilization to prevent the need for facility-based care or to step down to the community from facility-based care.

Importantly, the [2023 CCO contract](#) specifies that CCOs cannot put eligible members on an IIBHT wait list due to lack of capacity. The contract also states CCOs must provide eligible members IIBHT services within fourteen (14) days of the member's IIBHT eligibility determination.

To support implementation, OHA:

- Increased CCO budgets to support this new level of care,
- Provides IIBHT Foundations training, Clinical Training and Peer-Delivered Services Training free to all new program staff. OHA has trained hundreds of staff in the model to date,

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<sup>12</sup> Intensive In-Home Behavioral Health Treatment 2022 Annual Report. March 2023. <https://www.oregon.gov/oha/HSD/BH-Child-Family/Documents/IIBHT-Annual-Report-2022.pdf>

- Facilitates a bimonthly IIBHT Learning Collaborative for all staff and a Rural Specific IIBHT learning collaborative,
- Monitors CCO IIBHT policies and procedures and has created a Quarterly Report for CCOs around referrals, enrollments, barriers and plans to resolve capacity issues,
- Contracted with Oregon Health & Sciences University (OHSU) to provide quarterly reports on outcome data for all youth served, and
- Worked with the University of Washington to create a Readiness Tool and Supervision tool for providers.

**IIBHT Program Data as of end of 2022 highlights gaps in IIBHT implementation and access across the state.<sup>13</sup>**

**1,500**

Number of youth originally proposed to access IIBHT services per year

**321**

Number of youth receiving IIBHT services Jan 1, 2021-June 20, 2023

**20**

Total number of IIBHT programs in Oregon

**9 of Oregon’s 16 CCO’s have provided IIBHT services to 10 or more members since 2022<sup>14</sup>**

For the purpose of this report, the Ombuds Program does not consider CCOs to have implemented IIBHT if they provided services to fewer than 10 members from January 1, 2022 – June 30, 2023. **Seven CCOs and Oregon’s FFS program have not implemented IIBHT according to this measure.**

**Barriers to Accessing the Recommended Care:** The IIBHT 2022 annual report, providers, CCOs and community members all articulate various barriers in accessing the recommended level of care across the state, including:

- Some IIBHT programs are in early or incomplete states of implementation, or have limited ability to serve the entire geographical area covered by the CCO,
- Limited access to IIBHT providers,

<sup>13</sup> Intensive In-Home Behavioral Health Treatment: 2022 Annual Report. March 2023. <https://www.oregon.gov/oha/HSD/BH-Child-Family/Documents/IIBHT-Annual-Report-2022.pdf>

<sup>14</sup> CCO’s that provided IIBHT services in 2022 and/or the first six months of 2023 are Advanced Health; AllCare CCO, Eastern Oregon CCO; Health Share of Oregon, Jackson Care Connect; PacificSource Central, Lane and Marion-Polk, and Umpqua Health Alliance.

- Lack of program capacity at the provider level where providers may not maintain wait lists or accept new clients. Referring providers are often told that the IIBHT program is full and to not submit a referral,
- Workforce shortages throughout the behavioral health system but particularly in rural areas of the state with real or perceived prioritization of filling adult mental health workforce positions,
- Increased administrative burden on CCOs and providers,
- Real or perceived failure to acknowledge other similar, non-IIBHT services provided by the CCOs in the community.

OHA cannot adequately evaluate whether eligible youth are being referred for, or accessing, IIBHT services. This is due to a statewide lack of data about referral pathways, number of youth and families referred, number and percent qualifying and accessing services, wait time length (required by contract to be less than 14 days), and how many escalate to residential care/ED while they wait. The data also do not fully account for the number of youth/families who:

- Seek IIBHT,
- Are offered it but cannot access it due to lack of capacity,
- Are on wait lists, or
- Are simply turned away because provider capacity is so poor that wait lists are not offered.

***This means that Oregon cannot currently understand who qualifies but does not access IIBHT services and for what reasons.***

## Respite care

Respite Care for families with children or youth with mental health needs provides parents and other primary caregivers with planned or emergency short-term care for their child. This support helps children and youth with mental health needs to remain in a safe and supportive environment in their own homes and communities. Key benefits include:

- Temporary relief to primary caregivers and reduction in caregiver stress,
- Reduction of social isolation,
- Improved family stability,
- Reduced risk of neglect or abuse of the child or youth,
- Positive social experiences with caregivers other than families,

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*“You need a break, or you wind up breaking.” – System of Care Plan for Oregon: Two Year Strategic Plan, 2022-2023*

*“It’s a place where you can go to spend time with people your own age and get connected to resources and have a hot meal available.” – Youth (North Coast Youth Advisory Council)*

*“(Respite is) when I meet with you (peer support) to talk about what’s going on in the day.” – Youth (North Coast YAC)*

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- Fewer out of home placements.<sup>15</sup>

Youth and their caregivers do not have routine access across Oregon to mental health respite supports to prevent escalation into crisis. Instead, counties, CCOs and regions implement respite care as locally prioritized, resulting in inequitable access to this intervention depending on where youth and families live. The result is increased use of the emergency room and greater risk for Child Welfare involvement and calls to law enforcement.

Oregon provides respite care through a variety of funding sources to youth and their caregivers, but this does not include mental health respite care for children and youth. Respite care is provided to youth or their caregivers through:

- Oregon Department of Human Services (ODHS) Aging and Physical Disabilities services for youth with intellectual or physical disabilities,
- ODHS Child Welfare, and
- Peer-run respite centers for adults in need of mental health respite. [HB 2980 \(2021\)](#) allocated \$6 million to fund four regional centers.

Additionally, although Medicaid billing codes exist for mental health respite care, OHP does not cover such care for adults or children. Some CCOs choose to implement and fund respite care, but mainly for the adult population. During the 2023 legislative session, OHA recognized these needs and proposed both mental health respite care throughout the lifespan and funding for respite care services for any youth with any mental illness (AMI) across Oregon. Neither proposal was funded.

“Respite care has been identified by families as something that is desperately needed in [County].... Increasing respite accessibility with a comprehensive standardized State plan would reduce trauma exposure to children who are kept in the ER, provide relief and safety net for families and youth, develop positive relationships with another family, reduce stress, help maintain positive relationships, and help foster homes and parents with an additional local resource.”<sup>16</sup>

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<sup>15</sup> Boothroyd et al., 1998; Bruns & Burchard, 2000; Focal Point, 2001; (Child Welfare Information Gateway, 2018). <https://www.cmhnetwork.org/wp-content/uploads/2021/05/The-Evolution-of-the-SOC-Approach-FINAL-5-27-20211.pdf>

<sup>16</sup> <https://www.oregon.gov/oha/HSD/BH-Child-Family/SOCReports/Lane-061120-Narrative.pdf> LANE COUNTY SYSTEM OF CARE BARRIER SUBMISSION: Lack of Planned and Scheduled Respite Care Providers/Services June 11, 2020, Accessed October 2023.

# OMBUDS RECOMMENDATIONS FOR CHILD AND YOUTH MENTAL HEALTH



## OHP Member Experience: Perspectives from Sam's care coordinator

*"Oregonians are in dire need of systemic change that recognizes the role of trauma and mental health needs for youth and focuses on treatment in years where it is most effective. Legislative efforts are needed to address provider network inadequacy, leading to understaffed and over-capacity facilities logjammed with increasingly acute cases, without anywhere to go." - Sam's care coordinator*

The Ombuds Program, based on the experiences and data identified throughout this report, makes recommendations to improve:

- Child and youth mental health funding, data, workforce and provider networks;
- Child and youth serving programs:
  - Mobile Response and Stabilization Services (MRSS)
  - Intensive In-Home Behavioral Treatment Services (IIBHT)
  - Respite care, and
- Statewide child and youth advocacy.

## Recommendations to improve funding, data, workforce and provider networks

### Require statewide networks

The Oregon Health Authority should implement OHP policies requiring a statewide network for both inpatient and outpatient mental health services by requiring CCOs and OHA FFS programs to contract with all willing behavioral health providers (SUD, mental health, outpatient and residential) for children and adults in the state. Current limited network contracting practices taken by CCOs under existing state policies and oversight do not meet statewide OHP member needs.

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*My 16 year old daughter, who is black and an Oregon Health Plan member, has never had a black therapist in her eight plus years of therapy. We finally found a black therapist who is accepting clients and whose website said they accept OHP. But, as it turns out, the provider is approved for two CCOs, neither of which are the one that my daughter is enrolled in. I was instructed to ask the provider to fill out a prior authorization form and/or apply to be an approved provider for my daughter's CCO. Both solutions seem like unnecessary systemic barriers. In Oregon's current CCO driven network adequacy system, providers have to get approved for each different CCO.*

*– Mother of OHP youth seeking mental health services*

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## Prioritize funding of community-based children's mental health services

The state legislature, OHA and CCOs should prioritize investments in community-based child and youth mental health services and workforce serving children and youth at amounts equal to or greater than investments in adult mental health funding and at least proportional to the number of young people in Oregon.

### Workforce development

- Prioritize development and implementation of culturally specific services to eliminate the racial and linguistic disparities in access to mental health services, follow-ups from EDs, and overrepresentation of youth of color in ER boarding,
- Develop workforce to increase cultural relevance for minoritized communities via use of Traditional Health Care Workers, family and youth peers and bilingual, bicultural clinicians, and
- Develop workforce skills to increase appropriate services and supports for young people and their families who experience both intellectual and developmental disability and behavioral health concerns.

### Support priority populations

- Develop specific outreach and education for behavioral health literacy and stigma reduction to encourage earlier connection with behavioral health services for Healthier Oregon population and other populations accessing fewer services,
- Enhance language access that supports both youth and their families who may prefer a language other than English; include CCO and FFS network adequacy reviews that account for culturally and linguistically specific services provided in writing and spoken by providers.

### Leverage existing data

OHA should use, disaggregated by REALD and age, existing statewide Medicaid claims data and other available statewide data sources whenever possible to 1) provide ongoing program quality assurance and improvement; 2) target technical assistance and resources to areas most in need; and 3) reduce burden on providers and CCOs in reporting. These data should be used to:

- Understand Crisis and MRSS response implementation at the county level for children youth and families,
- Understand and track IIBHT referral, wait time to accessing services once referred, and service provision,
- Track other community-based mental health services,
- Leverage upcoming disaggregation of data by age and region for CCO Quality Incentive Metrics for follow-up visit within seven and 30 days after an emergency

department visits for mental illness for all members ages 6 and older. This will enable agencies and programs to better understand the local needs of children, youth and young adults with ED mental health visits.<sup>17</sup>

## Strengthen peer workforce within children's mental health

Prioritize making operational a robust peer workforce to support the mental health needs of children, youth, young adults and families in Oregon. Leverage Traditional Health Worker (THW) peer-delivered services through the employment of state-certified Peer Support Specialists - specifically Youth Support Specialists, Family Support Specialists, and Peer Wellness Specialists whenever possible to expand children's mental health workforce.

OHA and CCOs should address capacity concerns of the programs discussed in this report by prioritizing career paths and entryways to leverage the peer-delivered service workforce and implement workforce payment parity:

- Ensure that IIBHT programs provide, as required by OARs, peer support services and provide technical assistance to strengthen when not in compliance with OARs.
- OHA and CCOs should provide training about how Peer Support Specialists can work as part of a multidisciplinary clinical team to strengthen their role in MRSS, IIBHT and Respite Care.

Prioritize funding from and administration of the [Health Care Provider Incentive Program](#) to support peer workforce and allocate significant investments from the \$6 million investment by the Oregon Legislature in 2023 to the workforce for community-based children's mental health services and peer workforce.

Provide technical assistance to support peer-run mental health services and facilities. Review and update as appropriate all various taxonomy needed to allow for Medicaid fidelity of referrals from multiple licensed practitioner types that interface with youth and families including primary care physicians, nurse practitioners, school nurses, and others.

## Recommendations to strengthen MRSS

OHA should provide increased technical assistance to counties to ensure MRSS services are available as required by OARs.

OHA Behavioral Health and Medicaid staff should work with CCOs and counties to provide technical assistance to support Medicaid billing for MRSS services. This should be a county-by-county approach with updated dashboard and metrics of county billing practices and CCO reimbursements to identify where MRSS billing is successful and

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<sup>17</sup> CCO Metrics Program (2023). *CCO Metrics Performance Dashboard*. Interactive display accessed [10/3/2023]. Portland, OR: Oregon Health Authority. <https://visual-data.dhsosha.state.or.us/t/OHA/views/CCOPerformanceMetrics/welcome>

who needs greater support.

Programmatically OHA, CCOs and county mental health programs should create pathways for expedited access to outpatient mental health services for youth accessing MRSS.

## Recommendations to prioritize IIBHT

OHA and its contractors should, when developing any centralized behavioral health referral platforms, include IIBHT referrals. This should include a centralized IIBHT referral platform and process so that all CCOs, all referring providers, all IIBHT providers and OHA can all view all youth referred to services, providers with available capacity, and youth referred not yet accessing treatment on a statewide level.

OHA FFS program should ensure it fulfills the same IIBHT requirements that CCOs fulfill by rule and contract.

Prioritize CCO and OHA resources for implementation of the IIBHT recommendations found in the [2022 IIBHT Annual Report](#), specifically recommendation 3: *For more accurate and meaningful data to drive systems improvement, OHA and OHSU should:*

- *Continue to highlight the importance of data collection to programs, and to identify barriers to timely and accurate data reporting;*
- *Develop a mechanism to track referrals to IIBHT that are not accepted or delayed due to capacity issues, and to track the barriers preventing prompt enrollment;*
- *Develop mechanisms to integrate data about youth mental health programs and services, including IIBHT, across the behavioral health continuum of care, to create a more comprehensive picture of needs as well as strengths in the system.*

OHA and CCOs should support additional IIBHT providers across the state and support increased access to existing programs.

## Recommendations to provide mental health respite care

The Oregon Legislature should prioritize funding for mental health respite as follows:

- Fund start-up and ongoing children's mental health respite care at the same levels as given to respite care for adult mental health, children with intellectual and developmental disabilities and child welfare families.
- Fund mental health respite care for the entire lifespan, and at a minimum those ages 0-26, so that OHA can immediately obtain a State Plan Amendment to implement through Medicaid and leverage federal funds.

# Recommendations to prioritize statewide child and youth advocacy

Oregon should create an independent Office of the Ombuds for Children and Youth in Oregon under the Governor's Office and in collaboration with the Children's System of Care Advisory Council. This office:

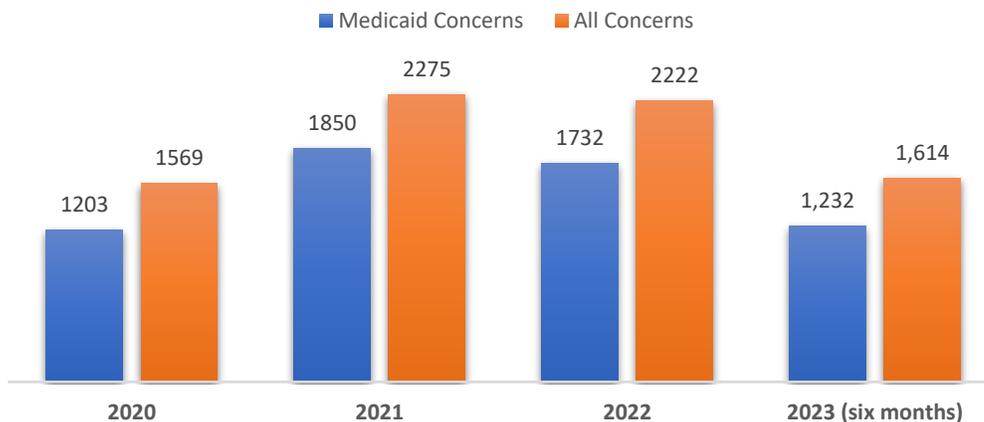
- Should engage in case resolution and advocacy for improved outcomes and the betterment of policy and processes for children, youth, and young adults ages 0-26 and families in need of services across multiple systems,
- Should draw on the model and tools employed by the OHA Ombuds Program to advocate for and elevate the voices and concerns of individuals,
- Should base its values on person-centered experience to improve policy and process,
- Should be an advocacy program rather than an organizational or impartial program,
- Should have jurisdiction across all child-serving state agencies, including but not limited to Oregon Health Authority, Oregon Department of Human Services Child Welfare and Intellectual and Developmental Disability Services, Department of Early Learning and Care, Oregon Youth Authority, and Oregon Department of Education, and
- Should expressly be devoted to advocacy for the needs of children, youth and families across multiple state systems that serve them.

## OHP Member Experience: Sam's desire for better services in Oregon

***The one thing Sam wants to come out of this has started [sharing of their story to create system change]. ... On top of all the mental health struggles Sam now has medical trauma and has a very hard time trusting the people that should be helping them. Each and every place had a different tactic. They would medicate, ignore, let Sam fall. Sam also got kicked out of school. A mental health condition got a child taken out of school. The high school students did a sit in at the school - they sat in the long hallway outside the office in protest until Sam came back. It was amazing to walk into the school, and all the kids clapping. - Sam's Parent***

# OMBUDS PROGRAM RECOMMENDATIONS

## Chart 1: Ombuds Program concerns received 2020 – 2022 and first six months 2023



Since formation as a full Ombuds Program in 2019, the Ombuds Program has grown in volume and work scope. This is for a variety of reasons including:

- Increasing agency commitment to community engagement and hearing directly from community,
- Focus on agency responsiveness to concerns impacting health equity,
- Increased case volume coming to the Ombuds Program as the Ombuds Program strategically reaches out to populations who face historical and contemporary health inequities and lack of access to care,
- Increased complexity which reflects the reality of Oregon’s needs related to:
  - Access to treatment for substance use and mental health disorders,
  - Redeterminations and disruptions to care for priority populations, and
  - Housing and social determinants of health.
- Increased need to bring OHP member voice into policy work.

This has led to increased workload for the Ombuds Program to support agency priorities, elevate agency values and reduce agency risk without additional staffing or support. The Ombuds Program’s essential role as a member-centered catalyst for Medicaid systems improvements is at risk. Based on agency need and Ombuds workload exceeding existing resources, the Ombuds Program makes these formal recommendations.

- Increase Ombuds Program capacity that allows team to:
  - Respond to complex, multi-system Ombuds cases for child and adult casework that reflect statewide gaps in access to care for mental health and substance use disorders for OHP members.
  - Ensure adequate project management and subject matter expert support to advocate for essential systems improvements within Medicaid policies teams to operationalize recommended changes.
  - Increase receptiveness and understanding of OHP member experience by other OHA programs and divisions.
  - Strengthen responsiveness to members across the agency. OHA should prioritize giving members the same level of responsiveness whether their concern is raised by the Ombuds Program, the member, the member's family or advocate, legislators or media.
  - Prioritize through staffing, resources, and responsiveness OHA's formal response and workplan to address recommendations made in this and past Ombuds Program reports.
- Strengthen Ombuds Advisory Committee with a formal governance structure for the Ombuds Program.
- Develop charter between Ombuds Program and OHA to ensure full understanding by all agency staff of Ombuds Program role within Medicaid.

# OMBUDS PROGRAM DATA: JANUARY 1- JUNE 30, 2023

## Total concerns

The Ombuds Program received a total of 1,492 concerns during the first 6 months of 2023. In alignment with the Ombuds Program’s advocacy for OHP members, seventy percent (1,046) of these concerns were Medicaid-related. Data presented below provides quarterly and cumulative 2023 data.

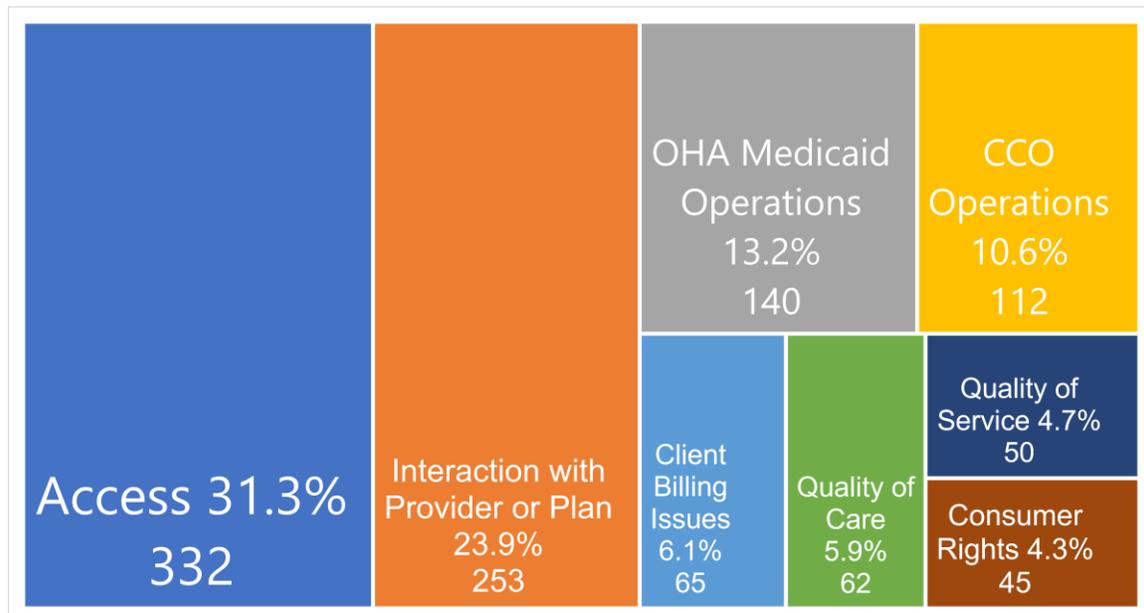
The Ombuds Program provides advocacy and systems elevation for improvement for Medicaid-related concerns; for non-Medicaid related cases, the Ombuds Program ensures a person-centered approach and serves as the right door to the right program.

Table 3: Total Medicaid and non-Medicaid concerns

	Q1	Q2	Q3	Q4	2023 YTD	
					%	N
<b>Total concerns</b>	744	748			100.0%	1,492
<b>Medicaid</b>	519	545			70.1%	1,046
<b>Non-Medicaid</b>	225	203			29.9%	428

Chart 2: First 6 months 2023 Medicaid concerns (1046 total)

All Medicaid concerns fall into one of eight categories below. The access to care category makes up most of the concerns.



	Q1	Q2	Q3	Q4	2023 YTD	
					%	N
<b>Total Medicaid concerns</b>	519	541			100.0%	1061
<b>Access</b>	164	168			31.3%	332
<b>Interaction with provider or plan</b>	126	127			23.9%	253
<b>OHA Medicaid operations</b>	50	90			13.2%	140
<b>CCO operations</b>	53	59			10.6%	112
<b>Client billing issues</b>	38	27			6.1%	65
<b>Quality of care</b>	39	23			5.9%	62
<b>Quality of service</b>	31	19			4.7%	50
<b>Consumer rights</b>	17	28			4.3%	45

### Interaction with provider or plan: 23.9 percent (253)



These concerns included difficulty navigating the CCO complaint/grievance process, difficulty finding a new provider, difficulty requesting health-related services through providers. These concerns were often resolved with the engagement of a CCO care coordinator.

### OHA Medicaid operations: 13.2 percent (140)

These concerns are about implementation and operation of Medicaid policies and programs. These included requests for air conditioners, CCO enrollment challenges, and requests to OHA's FFS program in order to maintain continuity of care with providers outside the CCO's network.



### CCO operations: 10.6 percent (112)



The majority of concerns about CCO operations were about health-related services including requests for air conditioners and housing/rental assistance. One concern also included questions about lack of transparency for CCO board meetings.

### Client billing issues: 6.1 percent (65)

OHP members continue to raise in state and out of state billing concerns. During the first six months of 2023, the majority of these cases related to billing by dentists, ambulance, emergency department providers, and for pharmacy copays.



### Quality of care: 5.9 percent (62)



These included member concerns about adverse outcomes from medical and dental treatments and reports about inadequate care from hospitals including early discharges and lack of discharge planning.

## Quality of service: 4.7 percent (50)

Denial of services, particularly denials of durable medical equipment such as wheelchairs were included in these concerns.



## Consumer rights: 4.3 percent (45)



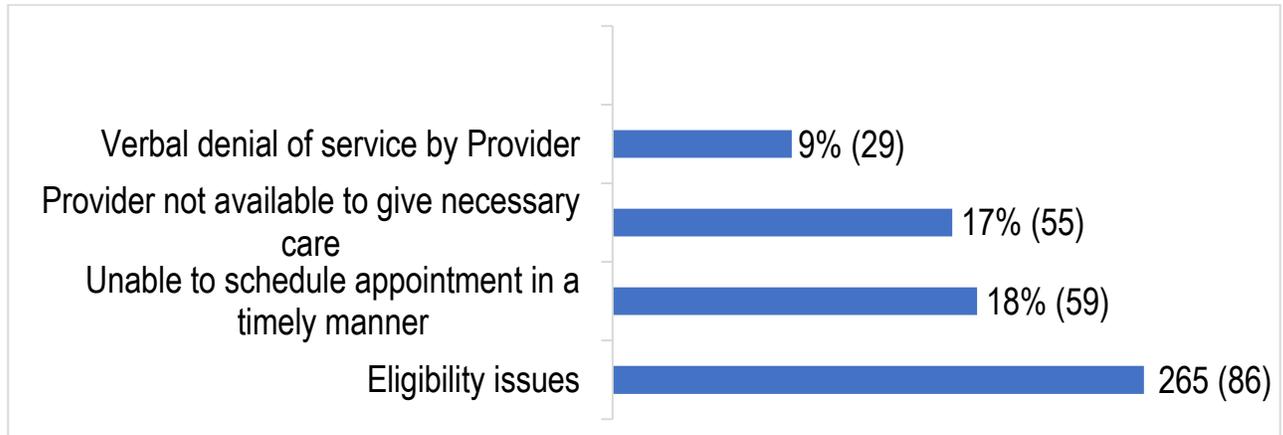
Concerns members not being provided an interpreter and “chair-side denials.” Chair-side denials occur when members receive verbal denials from a provider instead of a written denial from the CCO or OHA. This often occurs when providers assume the service is not covered, and do not request prior authorization of the CCO or OHA to confirm this belief.

## Top access to care concerns: 31.3 percent (332)

Because access to care concerns make up almost half of all Ombuds concerns, this category is discussed in further detail below.

### Chart 3: First 6 months of 2023 top access to care subcategories (261 of 332 total)

The concern subcategories provide additional details about the concerns members report regarding access to care.



### Table 4: First 6 month of 2023 top access to care subcategories (261 of 332 total)

	Q1	Q2	Q3	Q4	2023 YTD	
					% of total access concerns	N
<b>Total access concerns</b>	164	168			100.0%	332
<b>Eligibility issues</b>	46	40			25.9%	86
<b>Unable to schedule appointment in a timely manner</b>	27	32			17.8%	59
<b>Provider not available to give</b>	26	29			16.6%	55

	Q1	Q2	Q3	Q4	2023 YTD % of total access concerns	N
necessary care						
Verbal denial of service by provider	18	11			8.7%	29

- **Eligibility: 25.9 percent (86):** When individuals are confused or have concerns about eligibility, they often do not seek care. Addressing eligibility concerns is a critical first step to accessing OHP and whole health wellness.
- **Unable to schedule appointment in a timely manner: 17.8 percent (59):** This included specialty care (neurologists and cardiologists), primary care providers, diagnostic studies, dental and mental health.
- **Provider not available to give necessary care: 16.6 percent (55):** The Ombuds Program saw the most complaints in the area surrounding mental health and dental care.
- **Verbal denial of service by provider: 8.7 percent (29):** OHP members have the right to appeal or request a hearing when they receive a written denial. When clients receive a ‘verbal’ denial, they have no ability to access this right.

## Medicaid concerns

### *Top Medicaid concerns by service type*

Medicaid complaint categories and service types are independent of each other. An individual may have access to care concerns related to mental health or any other service type. Vice versa, a mental health service concern may be about any complaint category such as interaction with provider or plan. Service Type allows CCOs and the Ombuds Program to track the types of service about which members have concerns.

The OHP services most frequently involved in Ombuds Program concerns during the first and second quarters of 2023 were

- 1) Specialty care (10%);
- 2) Primary care (9%);
- 3) Mental health care (8%);
- 4) Dental care (8%); and
- 5) Non-emergent medical transportation (5%).

### **Chart 4: First 6 months 2023 top Medicaid concerns by service type (1,062**

## Total concerns)

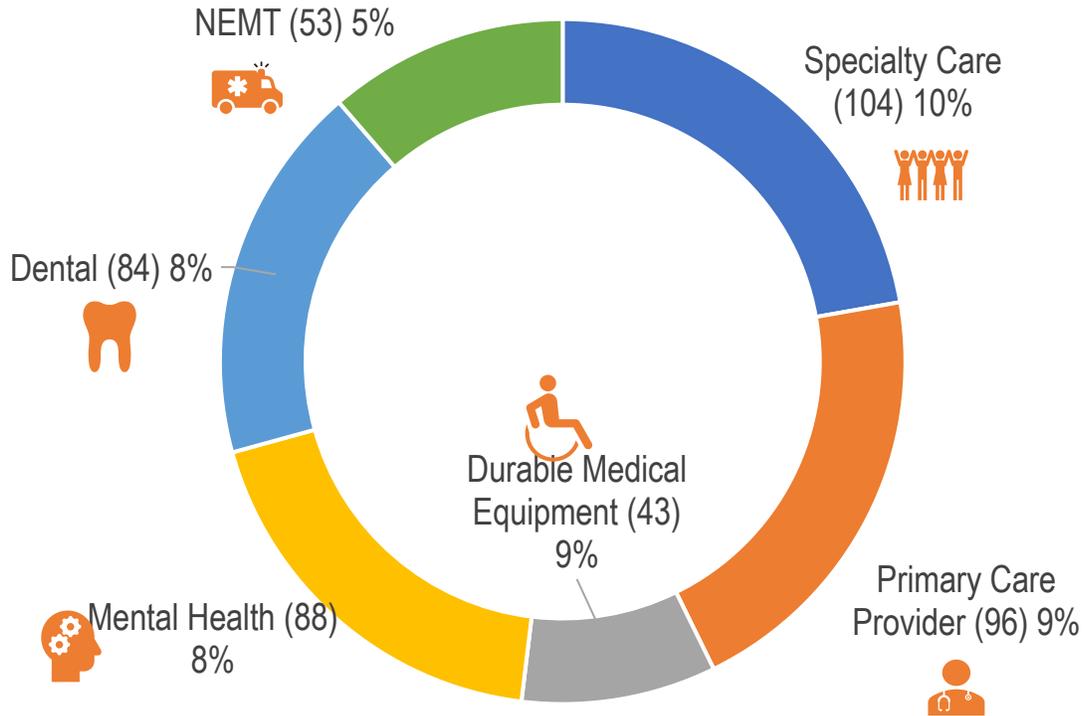


Table 5: All Medicaid concerns by service type

	Q1	Q2	Q3	Q4	2023 YTD	
					%	N
<b>Total Medicaid concerns</b>	519	543			100.0%	1062
<b>All other Medicaid</b>	130	149			26.3%	279
<b>Specialty Care</b>	57	47			9.8%	104
<b>Primary Care Provider</b>	52	44			9.0%	96
<b>Other</b>	35	56			8.6%	91
<b>Mental Health</b>	43	45			8.3%	88
<b>Dental</b>	42	42			7.9%	84
<b>NEMT</b>	30	23			5.0%	53
<b>Durable Medical Equipment</b>	12	31			4.0%	43
<b>Pharmacy</b>	25	14			3.7%	39
<b>Hospital</b>	14	19			3.1%	33
<b>Long Term Care</b>	15	9			2.3%	24
<b>CCO Plan</b>	10	13			2.2%	23
<b>Emergency Room</b>	8	11			1.8%	19
<b>Residential Rehabilitation</b>	8	7			1.4%	15
<b>Diagnostic Studies</b>	7	7			1.3%	14
<b>Pain Management</b>	4	9			1.2%	13

	Q1	Q2	Q3	Q4	2023 YTD %	N
Vision	7	5			1.1%	12
Alcohol & Drug/Substance Use Disorder	5	3			0.8%	8
Chiropractic	3	3			0.6%	6
Physical Therapy	3	2			0.5%	5
Ambulance/Medical Transportation	4	0			0.4%	4
Imaging	2	1			0.3%	3
Occupational Therapy	1	2			0.3%	3
Outpatient	1	1			0.2%	2
Acupuncture	1	0			0.1%	1



### Specialty care: 9.8 percent (104)

Many concerns included difficulty with accessing surgery care. There were some chair side denials.

### Primary care provider: 9.0 percent (96)

Member concerns about being unable to schedule with the provider in a timely manner, either due to lack of appointment spots or due to lack of providers available in the network area.



### Other: 8.6 percent (91)

These concerns include reporting abuse, and questions about HRS requests.



### Mental health: 8.3 percent (88)

A recurring concern with members included difficulty finding an available provider, long wait times for an available appointment, and lack of available services for children and youth.

### Dental: 7.9 percent (84)

Concerns included difficulty with getting an appointment with a dental provider for both regular checkups and urgent conditions. This may indicate the need for CCOs and FFS to monitor and build adequate capacity for this service. There were several issues about coverage of a prescribed treatment and what to do if a prior authorization was denied.



### NEMT: 5.0 percent (53)

Recurring issues include members not being picked up or the member receiving the ride too early or too late.

## Durable Medical Equipment (DME): 4.0 percent (43)

DME concerns highlighted the barriers for people with disabilities who need DME. Often, members were denied medical equipment they have needed and used for years including wheelchairs and wheelchair accessories. Members report that these experiences impact their mental health and cause trauma as they are forced to fight for services that allow them to be mobile in their community.



Table 6: Demographics and populations served

	Q1	Q2	Q3	Q4	2023 YTD	
					%	N
<b>Total Medicaid concerns</b>	519	542			100.0%	1061
<b>Dual eligible members</b>	40	49			8.4%	89
<b>Limited English proficiency</b>	26	17			4.0%	43
<b>Provider concerns</b>	17				3.3%	17
<b>Individuals with identified unstable housing</b>	11	26			3.5%	37
<b>Under age 19</b>	39	31			6.6%	70
<b>Age 19-64</b>	291	288			54.6%	579
<b>Age 65 and older</b>	59	69			11.2%	119

Table 7: Race and ethnicity of OHP members served for whom demographic information is known

These race and ethnicity data are not Ombuds Program data but are rather race and ethnicity data that OHP members have chosen to share when enrolling for OHP benefits.

Race/Ethnicity	Q1	Q2	Q3	Q4	2023 YTD	
					%	N
<b>Total</b>	386	360				746
<b>Other White</b>	184	182			13.9%	366
<b>Decline to Answer</b>	62	42			5.5%	104
<b>Unknown</b>	21	20			5.1%	41
<b>Western European</b>	21	17			3.5%	38
<b>Did Not Answer</b>	17	9			3.4%	26
<b>American Indian</b>	10	15			3.4%	25
<b>Other Hispanic or Latino/a/x/e</b>	9	16			2.7%	25
<b>Hispanic or Latino/a/x/e Mexican</b>	10	10			2.1%	20
<b>African American</b>	6	10			2.1%	16
<b>Multiple racial or ethnic identity</b>	6	10			1.6%	16
<b>Other Black</b>	7	5			1.5%	12
<b>White</b>	8	3			1.1%	11
<b>Biracial or Multiracial</b>	5	3			0.9%	8
<b>Other Asian</b>	2	5			0.5%	7

Eastern European	1	3			0.4%	4
Filipino/a	2	1			0.4%	3
Hispanic or Latino/a/x/e South American	2	1			0.4%	3
Other Race or Ethnicity	1	2			0.4%	3
Vietnamese	2	1			0.3%	3
Black	1	1			0.3%	2
Middle Eastern	2				0.3%	2
Other Pacific Islander	1	1			0.3%	2
South Asian	2				0.1%	2
Asian Indian	1				0.1%	1
Communities of the Micronesian Region	1				0.1%	1
Hispanic or Latino/a/x/e Central American	1				0.1%	1
Other African (Black)	1				0.1%	1
Samoan		1			0.1%	1
Slavic		1			0.1%	1
Somali		1			0.1%	1

**Table 8: Event-related concerns**

	Q1	Q2	Q3	Q4	2023 YTD	
					%	N
<b>Total Extreme weather: Fire, heat event, other extreme weather</b>	1	47			3.4%	48
<b>OHP Members</b>	0	13			0.9%	13
<b>Unknown or non OHP members</b>	1	35			2.6%	36

This table tracks concerns that result from major climate, environmental or public health crises.

## Non-Medicaid concerns

OHP/Medicaid members often have needs related to their housing, food and nutrition, and needs due to climate change including smoke and extreme weather. These needs often impact their health and are often called social determinants of health. Even though these needs are not uniformly included as Medicaid concerns, CCOs can choose to support these needs through care coordination, health-related services, and coordination with other state and local government services. **As Oregon expands weather and housing related benefits under its new 1115 Demonstration Waiver, these concerns should be reported as Medicaid or OHP related concerns by Oregon’s FFS program and CCOs in order to track complaints and grievances related to new waiver benefits.**

Table 9: OHA concerns

	Q1	Q2	Q3	Q4	2023 YTD %	N
<b>Total OHA concerns</b>	47	59			100.0%	106
<b>Public Health Division concerns</b>	11	16			25.5%	27
<b>Other OHA general concerns</b>	9	12			19.8%	21
<b>Licensing: Other</b>	7	11			17.0%	18
<b>Licensing: Public Health (hospital air, water food, pool, lodging, etc.)</b>	7	4			10.4%	11
<b>Oregon State Hospital concerns</b>	3	7			9.4%	10
<b>Licensing: Behavioral health (DUI, outpatient, etc.)</b>	6	3			8.5%	9
<b>Marketplace</b>	3	0			2.8%	3
<b>Civil rights or ADA violation</b>	0	2			1.9%	2
<b>Equity and Inclusion: Interpreter and translation (non-member access)</b>	0	1			0.9%	1
<b>Human resources</b>	0	0			0.0%	0
<b>Public records request</b>	0	0			0.0%	0

Table 10: Other government agencies’ concerns

	Q1	Q2	Q3	Q4	2023 YTD %	N
<b>Total non-OHA concerns</b>	130	99			100.0%	229
<b>Oregon Department of Human Services</b>	26	40			28.8%	66
<b>Other (included housing and medical licensing board complaints)</b>	44	21			28.4%	66
<b>Medicare</b>	28	15			18.8%	43
<b>Department of Consumer and Business Services (private insurance concerns)</b>	21	10			13.5%	31

	Q1	Q2	Q3	Q4	2023 YTD %	N
Local government issue	8	8			7.0%	16
HIPAA violation – Health and Human Services	3	2			2.2%	5
Veterans’ Affairs	0	2			0.9%	2
Housing & Community Services	0	1			0.4%	1

## CONCLUSION

Each person who seeks Ombuds Program assistance deserves nurturing and support. The stories they share often illustrate challenges many others experience. Each story brings lessons for ways to improve Oregon’s Medicaid delivery system and to understand the impact of health inequities on Oregonians who receive or are eligible for the Oregon Health Plan.

The Ombuds Program is honored to work within an agency that embraces Oregon Health Plan member experience as essential to successful transformation. The Ombuds Program supports Oregon’s efforts to ensure health equity through advancing better health, lower costs, and improved patient experience for all people in Oregon, particularly populations experiencing health inequalities. The Ombuds Program is committed to identifying and advocating for the state of Oregon to reprioritize resources and power to address social and structural racism that facilitate inequities impacting health and wellbeing.