OREGON HEALTH AUTHORITY

Behavioral Health Division

OREGON DEPARTMENT OF Human Services

Child Welfare

2025 Annual Report on Children's Psychiatric Residential Treatment Facility Capacity

Executive Summary

The 2025 Annual Report on Children's Psychiatric Residential Treatment Facility (PRTF) Capacity provides an update on Oregon's efforts to expand and stabilize intensive psychiatric care for youth. Prepared jointly by the Oregon Health Authority (OHA) and the Oregon Department of Human Services (ODHS), the report highlights progress, ongoing challenges, and future priorities for delivering timely, high-quality care.

Mental Health Treatment Continuum

- The youth behavioral health system operates along a continuum, from outpatient care to inpatient hospitalization.
- Most youth receive outpatient services, but some require intensive, 24-hour residential treatment.
- PRTFs provide structured, inpatient care with therapy, skill-building, and family engagement.
- Oregon's three PRTF levels:
  - **Psychiatric Residential Treatment Services (PRTS):** Short- to medium-term stabilization.
  - **Subacute crisis psychiatric care (Subacute):** Short-term stays for acute stabilization.
  - **Secure Inpatient Program (SIP):** Highest level of care for severe psychiatric needs.
- PRTFs are licensed by OHA and ODHS, maintain national accreditation, and meet Centers for Medicare and Medicaid Services (CMS) standards.
- Funding comes primarily from Medicaid and private insurance, with some state support.

Summary of 2025 Achievements

- **Capacity Expansions:**
  - Looking Glass Regional Crisis Center (RCC), Eugene: 14-bed PRTS/Subacute expansion.

    - Monte Nido Clementine, Lake Oswego: 12-bed PRTS specializing in eating disorders.
- **Facilities in Development (opening 2026–2027):**
    - STAR Program, Boardman: 14 beds.
    - Nexus Family Healing SIP, Eugene: 12 beds.
    - Live.Grow.Share., Eugene: 6–10 beds.
    - Deschutes County and Portland projects.
- **Total PRTF program beds** increased from 236 in 2024 to **263** in 2025.
- **Legislative Support:** $10 million allocated via Policy Option Package 552 for facility acquisition, renovation, and start-up costs.
- **Priority Access:** Youth in foster care received targeted placement funding to ensure timely access.
- **Bridge Funding:** Supported new providers during the gap between opening and CMS certification.
- **Regulatory and Policy Updates:** Ongoing revisions to OAR 309-022 to strengthen standards.
- **Data and Reporting:** Improved referral and capacity management (RCM) system for better decision-making.
- **Rate Study:** Completed a comprehensive review to update Medicaid rates for youth intensive services.
- **Level-of-Care Criteria:** Developed Psychiatric Under 21 criteria to standardize eligibility for residential treatment.

Key Challenges in 2025

- **Workforce Shortages:** Limited clinical, nursing, and direct-care staff restrict capacity and reduce bed utilization.
- **Rising Acuity:** Increasing behavioral and psychiatric needs require higher staffing and specialized care.
- **SIP Bed Availability:** Shortages create long wait times and reliance on emergency departments.
- **Geographic Inequities:** Most PRTF beds are along the I-5 corridor, limiting rural access.
- **Funding Gaps:** Delays in Medicaid billing and CMS certification create financial risk for new providers.

Next Steps for 2026

- Support the opening and sustainability of new and planned PRTFs.
- Advance workforce strategies, including recruitment, retention, and training.
- Align Oregon Administrative Rule updates for clarity and equity.
- Strengthen safety and milieu management in high-acuity programs.
- Improve referral and capacity data quality to track referrals, wait times, and capacity.
- Expand community-based step-down and family-home connection supports.

- Continue interagency collaboration and increase accountability across OHA, ODHS, Coordinated Care Organizations (CCO) and providers for system-wide coordination.

Conclusion

Oregon has made measurable progress toward expanding beds in psychiatric residential capacity. Legislative investment, operational enhancements, and coordinated policy actions have strengthened the system. Workforce shortages, geographic disparities, and funding gaps remain. Sustained interagency collaboration, focused investment, and data-driven practices support access to safe, timely, and effective services for all Oregon youth in need of intensive psychiatric care.

Introduction

Since 2020, the Oregon Health Authority (OHA) and the Oregon Department of Human Services (ODHS) have jointly provided annual updates as capacity memos to the Governor's Office on the statewide status of Psychiatric Residential Treatment Facility (PRTF) capacity for children and youth. These reports document Oregon's capacity challenges during the pandemic, ongoing workforce and fiscal challenges, and the gradual building of a responsive continuum of high-acuity residential care for youth.

This 2025 report continues that series and reflects the significant policy, fiscal, and operational work undertaken by both agencies over the past year. It demonstrates the steady progress made in expanding and stabilizing PRTF services, while also identifying the remaining systemic challenges that affect the accessibility and quality of care.

OHA and ODHS remain committed to a shared vision that every young person in Oregon who requires intensive psychiatric residential treatment should be able to receive that care safely, promptly, and in a manner that demonstrates quality practice and recovery.

The Mental Health Treatment Continuum

Mental health services for youth are intended to be available on a continuum, with young people moving between different levels depending on the severity of their symptoms and progress. The majority need and receive only outpatient care. The continuum of services is intended to function seamlessly, so youth can access care based on their unique needs. There are gaps in Oregon's continuum, which can cause some youth to get 'stuck' at an inappropriate level of care for periods of time. The continuum from highest to lowest intensity of service:

- **Inpatient Hospitalization:** This is the most intensive, short-term level of care, focusing on stabilization during an acute psychiatric crisis, often in a clinical, 24/7 medically supervised setting.
- **Psychiatric Residential Treatment Facilities (PRTF):** This is a structured, 24-hour living environment with a focus on comprehensive therapy and skill-building in a less clinical, "homelike" setting (see below for more details on the three levels).
- **Day Treatment/Partial Hospitalization Program:** Young people attend treatment programs during the day for several hours during the week and live at home or in the community.
- **Intensive In-Home Behavioral Health (IIBHT):** This and similar programs offer intensive therapy in the home or community, allowing more flexibility for individuals to remain in, or integrate back into, their community.
- **Outpatient Care:** This involves regular appointments with a therapist and/or psychiatrist in a community setting.

Defining PRTF Services

Psychiatric Residential Treatment Facilities (PRTF) offer 24-hour, clinical residential care for youth with significant psychiatric challenges. Most programs serve a broad range of

psychiatric needs, while some provide specialized treatment, such as for eating disorders or court-ordered treatment. Funding for PRTF services typically comes from Medicaid or the youth's private health insurance, although some programs receive direct funding from ODHS and OHA. CCOs are responsible to ensure access to clinically recommended care, including PRTF services. In Oregon, PRTFs must meet licensure requirements through both ODHS and OHA and maintain national accreditation and specialized certification through the Centers for Medicare and Medicaid Services (CMS). These facilities must also meet the individual requirements of each CCO to be able to contract with them to serve youth on OHP in any given CCO region. PRTF providers contracted with ODHS to provide priority access to youth in foster care must also coordinate and attempt to contract with each CCO. PRTF providers determine their own policies for intake and screening to support treatment needs and milieu management. Oregon Administrative Rules (OAR) 419.400.0170 require that all PRTF providers train all program staff in one of three approved crisis response and de-escalation practices. In Oregon, the PRTF system includes three levels of care:

- **Psychiatric Residential Treatment Services (PRTS)** represent the least intensive level of psychiatric residential treatment care in Oregon and, while locked to the outside, do not meet technical requirements for a "secure" setting. Most PRTS programs aim for youth to stay between thirty and ninety days to stabilize their mental health crisis, collaborate with the family to develop sustainable safety plans, and work toward treatment goals. Services include 24-hour supervision, medication management, group therapy, skills training, and individual plus family therapy. PRTS services are covered by Medicaid or private insurance, if applicable, and coordinated through the appropriate Coordinated Care Organization (CCO) or Fee For Service (FFS).

- **Subacute crisis psychiatric care (Subacute)** is designed for shorter stays of two to four weeks with similar services to PRTS, programs are also locked to the outside and not "secure" by the state's definition. Its purpose is to stabilize youth in crisis and facilitate their return to their community for treatment and support. Subacute care provides expanded availability of medication management and psychiatric nursing care. Subacute services are covered by Medicaid or private insurance, if applicable, and coordinated through the appropriate CCO or FFS.

- **Secure Inpatient Program (SIP)** treatment services are delivered in secure residential treatment. These programs provide comprehensive residential treatment like PRTS with readily available psychiatric care on site, 24-hour psychiatric nursing, and longer lengths of stay. OHA manages referrals for SIP services. SIP represents the highest level of youth psychiatric care in Oregon, outside of acute hospitalization. It is reserved for youth with the most severe psychiatric treatment needs. All SIP services are funded through Medicaid and coordinated through OHA.

Summary of 2025 Achievements

2025 has been a productive year in Oregon's multi-year effort to expand and strengthen PRTF capacity. Several major developments advanced this goal:

- **Capacity expansions in 2025:**
    - **Looking Glass Regional Crisis Center (RCC) East, Eugene:** This expansion targets system challenges in accessing treatment for ODHS Child Welfare and Oregon Youth Authority (OYA). A 14-bed PRTF expansion and renovation was completed at a second location for Looking Glass in January 2025. Funded by ODHS Child Welfare, this additional PRTS and Subacute capacity is primarily reserved for Child Welfare-involved youth. It also supports some capacity for (OYA) and community-based access for youth through their CCO directly. This program has a "no reject, limited eject" contract requirement. The program must accept all referrals but may discharge due to physical safety needs at the discretion of the Medical Director.

    - **Monte Nido Clementine, Lake Oswego:** This new all-gender 12-bed PRTS program received its OHA license in March 2025 and began accepting clients. The Clementine program specializes in the treatment of eating disorders. This new site was funded by Monte Nido. With the CMS review completed in July 2025, Clementine can now bill Medicaid for services, which makes their services accessible to Medicaid members, in addition to private insurance recipients.

- **Facility development and pipeline growth:** This past year saw the advancement of several projects that will expand Oregon's capacity for residential psychiatric treatment for youth in the following ways. Each of these planned programs will accept Medicaid payment.

    - **Specialized Treatment and Resiliency Center** (**STAR) program, Community Counseling Solutions (CCS), Boardman:** A new 14-bed PRTS facility, the STAR program, in Boardman, Oregon by Community Counseling Solutions is near completion. As of November 2025, the facility is being furnished and receiving final inspections. CCS has hired the program administrator and several other key leadership staff and is focused on securing accreditation and state licensure as both a Child Caring Agency and a PRTF. The anticipated opening for the STAR program is April 2026.

    - **Nexus Family Healing, Eugene:** Since March 2024, Nexus Family Healing has been serving youth court-ordered into SIP services for Juvenile Fitness to Proceed Restorative Services and youth under the jurisdiction of the Psychiatric Security Review Board. In 2025, Nexus received an American Rescue Plan Act grant from OHA for the facility and start-up costs to renovate a building and create a new 12-bed SIP PRTF in Eugene. The anticipated opening is May 2026.

    - **Live.Grow.Share. (LGS), Eugene:** LGS has been serving young adults for years and is now partnering with OHA and ODHS to extend into PRTS. ODHS Child Welfare and OHA identified funding for this Lane County provider to purchase and renovate a 5-bedroom house. LGS plans to open in early Spring of 2026 to serve six to ten youth who have needs that place them at-risk of temporary lodging such as involvement with multiple systems. The small, home-like environment is intended to reduce risk of peer escalation and support enhanced individualized attention.

- **Deschutes County Project Funding**: OHA is supporting funding for a 15-bed PRTF project in Deschutes County. It is projected that the building will be completed by July of 2027, and the anticipated opening is October 2027.

- **Whole Person Health Residential Treatment, Trillium Family Services, Portland:** With funding from CCOs, Trillium Family Services is developing a 12-bed Whole Person Health psychiatric residential treatment program. This program will combine medical support, occupational therapy, expressive arts, education, and family engagement with residential care. Construction is scheduled to start in early 2026 with a planned completion date in late Spring 2027. The opening date is not yet determined. The exact age-range of this program has not been finalized.

- **Policy Option Package** (**POP 552) legislative investment:** The 2025 Legislature approved a $10 million allocation to OHA to support the launch of new PRTF projects. These funds would be available for costs of building acquisition, renovation, and start-up operations. To be considered for this, a PRTF provider needed to be ready to partner with OHA and grow the number of beds available for psychiatric residential treatment. A Request for Information (RFI) was the first step for this project. OHA and ODHS work jointly to assess provider readiness, evaluate cost realism, and align these initiatives with statewide service gaps.

- **Prioritized access for children in foster care:** ODHS Child Welfare continued to finance a tier-based capacity funding structure with general funds for three providers of residential psychiatric care to ensure available capacity and access to treatment for children who meet medical necessity and appropriateness and are in foster care. Providers include Albertina Kerr, Jasper Mountain, and Looking Glass Regional Crisis Center. This creative approach continues to be successful in providing a temporary solution to address current system gaps, ensure workforce sustainability, streamline access to care for this population, and enhance the quality and stability of programs system wide.

- **Bridge funding for CMS certification start-up gap:** After opening a facility, it takes three to six months to gather information on operations to allow CMS certification and Medicaid billing eligibility. OHA has identified one-time funding support to ensure that the new PRTF projects identified through the RFI process can sustain operations. This investment will prevent potential opening delays and improve the financial viability for this group of new providers. The Code of Federal Regulations (CFR) outlines the general requirements, operational standards, and requirements for Medicaid provider agreements[1].

[1] 42 CFR Part 411, subpart D-Inpatient Psychiatric Services for Individuals Under Age 21 in Psychiatric Facilities or Programs, 42 CFR Part 483, Subpart G – Condition of Participation for the Use of Restraint or Seclusion in Psychiatric Residential Treatment Facilities Providing Inpatient Psychiatric Services for Individuals Under Age 21 and 42 CFR Part 431, subpart D- State Plan Requirements.

- **Referral and Capacity Management (RCM) system:** Building on a pilot launched in 2024, the RCM project team shifted focus to data quality and analysis in 2025. An external quarterly report is in development. The RCM system was born out of a directive from House Bill (HB) 2086 Section 13 (2021), which updated Oregon Revised Statute (ORS) 430.717. It directs Intensive Treatment Service (ITS) providers, including psychiatric and SUD residential providers, to collect and submit data to OHA on the capacity and demand for their programs. It directs OHA to monitor ITS program capacity with the data, identify gaps in the system, and develop benchmarks. The bill also directs OHA to adopt rules outlining data collection requirements for ITS providers. These rule changes will be included in the upcoming update to Oregon Administrative Rule (OAR) 309-022.

- **Community engagement on OAR 309-022:** OHA hosted a public engagement process to revise OAR 309-022, which governs residential treatment licensing standards. Providers, family advocates, county and state partners participated in multiple listening sessions. Feedback has emphasized the need for clearer expectations regarding integration of psychiatric and substance use treatment, culturally and linguistically responsive care, expanded parent/family inclusion, and greater availability of peer support services. OHA anticipates completion of the rule revisions in 2026.

- **Rate study completion:** Rates for youth intensive services were last updated in 2022. In October 2024, OHA contracted with Myers & Stauffer to conduct a rate study and develop an updated, sustainable rate structure for service providers based on provider and market data. This is a common practice used in developing rates for other Medicaid services. The study included SIP, PRTS, Subacute Psychiatric Residential, Substance Use Disorder (SUD) Residential, Psychiatric Day Treatment, and Intensive In-Home Behavioral Health Treatment (IIBHT). The report also examined partial payments from the general fund for empty beds created when youth temporarily leave residential care for reasons like time with family or hospitalization.

  Myers & Stauffer considered staffing and non-staffing costs as reported through provider surveys and engagement, market wage and inflation data, and historical units of service to recommend updated rates for these services. OHA received a final draft of the report in September 2025. Given the current complex fiscal situation, OHA leadership is reviewing the recommendations with the Governor’s Office to determine if, or what, rate adjustments are appropriate. The report is set to be finalized and available in quarter one of 2026. Since the rate information is publicly available, rates set for Fee For Service are considered the floor for billing. CCOs use this information to negotiate contracts individually with each provider and payment rates vary.

- **Psychiatric Under 21 Level of Care criteria:** As part of Senate Bill 1557 (2024) and work related to Home and Community-Based Services for youth, Oregon is currently developing a standardized level of care criteria to determine when an individual is eligible to receive psychiatric services in a hospital or PRTF. Currently, both Oregon’s FFS Plan, administered by Comagine, and the CCOs have the flexibility to set their own specific criteria. These criteria help determine the regulatory requirements for eligibility to access 24-hour residential psychiatric treatment. PRTF Providers also establish their own admission criteria. This Psych Under 21 level of care criteria will ensure consistency and transparency in how

children, youth, and families become eligible for services. These have been developed in collaboration with OHA and ODHS teams, informed by providers, families, youth, CCOs, and other community partners. The draft was widely shared for feedback, updated based on engagement input, and is now being circulated back to the original partners for confirmation. In 2026, final criteria will advance to OHA leadership for approval, followed by rulemaking, including the 309-022 OARs for PRTF services, and implementation planning.

- **Intensive In-Home Behavioral Health Treatment (IIBHT) and PRTF connections:** IIBHT is a community-based, treatment alternative to facility-based treatment for youth and young adults (through age 20) and their families. This service provides treatment for children and youth experiencing complex behavioral health needs who require intensive services and supports to live safely in their community. Youth are often at risk of losing their current placement or leaving their home due to the intensity of their challenges and are at risk of hospitalization. IIBHT served 275 youth in calendar year 2024. At intake, 82% of those youth were identified as having a history of trauma, 65% of the youth had a history of suicidal ideation/self-harm or previous suicide attempts, and 52% were identified at intake as being at risk of psychiatric hospitalization or residential treatment or were transferring back to their home or the community from an out-of-home placement. IIBHT is an important component of the children's continuum of care and serves to reduce or prevent out-of-home placements, including PRTF. IIBHT outcomes show that only 13% of the youth served in 2024 were discharged to a higher level of care, which includes any services under the ITS umbrella and/or hospitalization. Details can be found in the IIBHT 2024 Annual Report, with the 2025 report anticipated for Quarter 2, 2026.

  Collectively, these achievements create the potential for Oregon to expand youth psychiatric residential capacity while improving data integrity, fiscal accountability, and the overall quality of care.

Key Challenges in 2025

While progress has been significant, several systemic challenges continue to constrain needed residential treatment capacity.

- **Workforce shortages:** Persistent shortages in direct-care, clinical, and nursing staff continue to limit operational capacity and strain existing programs. Providers report difficulty recruiting and retaining qualified staff. This is often due to geography, workforce pipeline limitations, workload intensity, and personal safety and liability concerns. Workforce shortages persist across Child Caring Agencies (CCAs) and impact the ability to coordinate appropriate post-treatment services and placements.
- **Medicaid reimbursement gaps:** As noted above, the CMS certification process requirements create a gap of several months between the start of operations and the ability to bill Medicaid for OHP beneficiaries. This increases financial risk for new providers and was the impetus for temporary bridge funding. Future projects to expand PRTF services will need to account for this additional startup cost in project budgets.

- **SIP treatment availability:** Oregon has experienced an increase in the need for SIP, without corresponding availability in treatment beds. Children and youth are experiencing significant wait times, usually months, for treatment. They remain in settings that are not clinically recommended, such as lower levels of care, Emergency Departments and Temporary Lodging. This creates a system bottleneck, potential for further deterioration of stability, and contributes to safety and milieu concerns.

- **PRTF accessibility:** While PRTF bed capacity continues to expand, access to existing PRTF care is also affected by private insurance coverage and CCO contracting. Some youth who meet medical necessity and appropriateness criteria for PRTF experience denials, delayed admissions, or unplanned discharges. In addition, not all PRTF providers are contracted with every CCO, further constraining access. These gaps have contributed to increased reliance on state agency contracts with PRTF providers and the use of voluntary placement agreements through Child Welfare to ensure that some youth can access medically necessary care.

- **Safety and milieu management concerns:** Some Oregon providers continue to report heightened acuity in youth behaviors, including aggression and self-harm. This can challenge a provider's ability to maintain quality of care, milieu stability, and youth and staff safety. These challenging conditions require higher staffing ratios, more intensive training, environmental safety upgrades, as well as increased clarity and consideration of child abuse statutes to limit further impacts to the availability of PRTF care.

- **Regional inequities (underserved rural areas):** The concentration of PRTF beds along the I-5 corridor continues to limit access for youth in rural and frontier counties. Families in these regions often face extended travel times, reducing their ability to access treatment, visit their child, and participate in family therapy sessions.

- **Funding for PRTFs to cover home time for family connection:** Youth and families need time away from the programs to maintain bonds and practice new skills before full transition home. OHA will continue to explore alternate funding solutions for the Medicaid state plan that would allow providers to bill, at minimum, for a partial-day payment for this important family connection. OHA identified additional general funds for SIP through Trillium Family Services to support this practice.

Current PRTF Capacity (updated through Q3 of 2025)

Oregon law does not require PRTFs to maintain a set number of available beds. While both ODHS and OHA license each PRTF, the OHA license certifies the type of treatment offered, whereas ODHS licenses the number of beds. PRTFs collaborated with OHA to define a "program bed" count, representing the maximum number of youth each program aims to serve. This figure has proven reliable for understanding statewide capacity. As of late 2025, Oregon's PRTFs have a total of 263 program beds, an increase of 27 from December 2024.

OHA tracks the daily census through the Referral and Capacity Management (RCM) system, revealing that the highest number of youth served in a single day in 2025 was 215. On average, 49-65 beds remain empty monthly due to factors such as staffing shortages and the high acuity of youth, which limits programs' ability to fill beds. Understanding these barriers

and assessing demand for services remains a key focus for improving PRTF capacity. See Appendix A for the Current PRTF and SUD Residential Capacity table to review capacity by provider. This table also includes the total number of Child Caring Agency (CCA) licensed beds.

Referrals, Wait Times and Referral Outcomes Report

OHA contracts with the Oregon Health Sciences University (OHSU) Data Evaluation & Technical Assistance (DaETA) team to provide RCM project management support, data analysis reports, and system improvement recommendations. In November, the first data reports were released using data from the new RCM system.

The report contains data submitted directly to OHA by PRTF providers for quarter three (Q3) 2025. The data includes the total number of referrals made during the quarter, the length of time it takes programs to review a referral, and the average wait time for a youth to be admitted to a PRTF program. Appendix E provides notes and definitions of terminology used in the Q3 report. The full Q3 2025 report is Appendix F and includes small-number data suppression in accordance with OHA data-sharing policies.

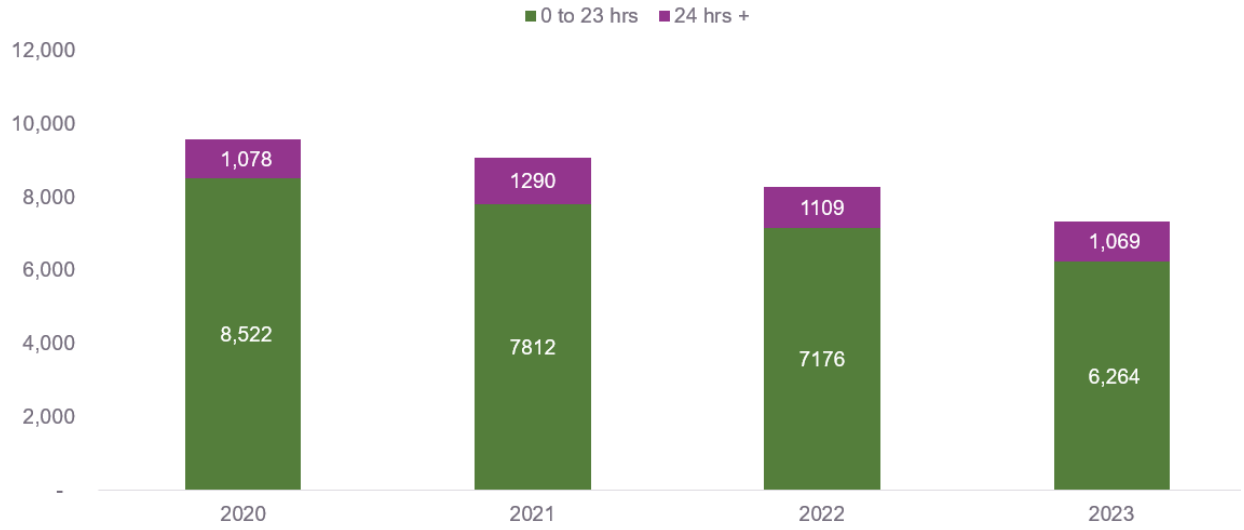
OHA and the DaETA team have worked closely to improve the data quality within RCM and begin to produce meaningful reports that speak to the experience of the youth being referred to psychiatric residential treatment programs.

Emergency Department and PRTF

The Emergency Department (ED) remains a primary pathway to seek treatment at a PRTF, with parents and Child Welfare bringing youth to an ED in crisis situations. This can establish medical acuity, create treatment recommendations and potential entry onto waitlists for appropriate levels of care. Most youth stay less than 12 hours and are discharged to home, with very few requiring either an acute or PRTF level of care. Sometimes, youth remain on a waitlist for a PRTF program after they discharge; these referrals are often not pursued. For those held in the ED, the wait for a bed in a higher level of care can last from hours to weeks. ED Boarding is defined in this report as stays greater than 24 hours. This definition was established in response to a finding in the 2020 Secretary of State Audit. It matches that used in the adult system and was agreed after extensive community, youth and family consultation in 2021. The 2025 OHSU national survey, Variations in Psychiatric Emergency Department Boarding for Medicaid-Enrolled Youths, used different boarding and diagnoses definitions.

Data are not currently available to measure all youth transitioning to higher levels of care after an ED visit, since some return to the community to wait for a bed. Data from the RCM system show high numbers of referrals originating from EDs; however, a very small percentage of these referrals are admitted to a program from the ED directly.

Total ED discharges by state financial years for primary mental health diagnoses, ages 0-25, for state financial years 2020 – 2023.



- ED boarding has remained between 11-14% of the whole (shown in purple above).
- Most mental health ED visits for Oregonians under age 25 are for young people between the ages of 18 and 25.

OHA is working on an updated data set for 2024 and has a contract with the DaETA team for a study of young people with multiple visits at major EDs. Data will be available in 2026.

Strategic Initiatives Underway

OHA and ODHS are advancing several initiatives to address these challenges and continue system modernization.

- **Bed capacity growth utilizing $10M legislative appropriation:** Funds appropriated through POP 552 will be used to support new and expanding PRTF programs identified through the RFI process. This investment is designed to ensure the fiscal viability of start-ups and reduce the time spent on waitlists for admission.
- **Revision and community engagement for amendment of OAR 309-022:** OHA has engaged a broad group of partners, providers, community-based organizations, and families to modernize residential treatment rules. This incorporates lessons from recent implementation experience, emerging provider models, and feedback from families. Proposed amendments emphasize equity, safety, data-driven practices, enhanced inclusion of family and peer supports, and integration of psychiatric and substance use treatment. Both state and national level subject matter expertise has influenced proposed amendments, including recommendations from the National Alliance on Mental Illness (NAMI) Multnomah County's report Improving Psychiatric Residential Treatment Services for BIPOC Youth in Oregon, Oregon's System of Care Advisory Council (SOCAC) Safety

Workgroup (2023), and House Bill 4092 (2024) and the Tackling Administrative Burden workgroup convened by Oregon Council for Behavioral Health.

- **Workgroup on residential capacity estimation tool:** Over the course of 2025, one of the many ways ODHS and OHA have partnered together is through joint efforts to determine the best methodology to estimate the needed psychiatric residential treatment program capacity for youth in Oregon. This workgroup includes team members from ODHS's Office of Research, Reporting, Analytics, and Implementation and Child Welfare Treatment Services, along with OHA's Health Policy & Analytics, and Child, Family and Lifespan Behavioral Health. After research, the workgroup plans to adapt an existing tool to estimate future bed capacity using data from the RCM system. Report expected in 2026.
- **Oregon Behavioral Health Coordination Center (OBCC):** OBCC is a legislatively funded program led and operated by OHSU and functions as a resource for behavioral health providers across the state for lifespan residential capacity monitoring. One way OHSU is using the data collected is to develop a capacity simulation model to show how system capacity would change in response to program expansions or reductions. Currently, the focus has been on the adult residential system.
- **OHSU Community of Practice:** OHA is funding OHSU to host a Community of Practice that brings together operational and clinical leaders in PRTFs across the state to share resources, address workforce challenges, and brainstorm. This community provides a platform for continuous improvement and collective problem-solving across the children's intensive services system.
- **Principles to Outcome Driven Practice in Residential Care:** ODHS and OHA continue to partner with the Building Bridges Initiative, the University of Kentucky Center for Innovation in Population Health and the Center for Excellence to implement a two-year quality-improvement initiative starting Fall of 2024 with five children's residential providers in Oregon. This aims to leverage provider and researcher expertise to transform residential care practices using the system of care model with a focus on measurable outcomes, youth and family engagement and co-creation. Providers receive technical assistance to implement and evaluate best practices in children's residential programs and have reported promising results. This work has been presented at multiple conferences and selected for publication in a national journal.
- **CCO Technical Assistance**: The Community Escalation Team within OHA, which focuses on Temporary Lodging cases, has incorporated more youth with complex cases into their discussions with CCOs. This includes staffing youth with higher level of care recommendations, such as entry to SIP, and providing technical assistance on best practices to support these youth.
- **Process and Guidance Development:** OHA and ODHS are collaborating to improve processes and develop guidance to support youth with complex needs at the case and system levels. Specific ongoing projects include:
    - Development and implementation of a SIP discharge protocol to clarify roles and responsibilities to support youth at this level of care discharge in a coordinated and timely manner.

    - Support for youth in the community who are waiting for SIP by working to connect them to services and supports that are clinically appropriate and comparable to a SIP level of care.
- **Ongoing collaboration:** OHA and ODHS collaborate through established workgroups to strengthen access to children's residential treatment and capacity. These include the Behavioral Health Subcabinet, Medicaid Operations Coordination Steering Committee, the bi-weekly Interagency PRTF Workgroup, and the quarterly Interagency Capacity Data Workgroup.

Next Steps for 2026

OHA and ODHS share the following priorities for 2026:

- **Sustain and support new and planned PRTFs:** Continued technical assistance and interagency coordination to ensure the successful opening, licensing, and certification of facilities initiated through the 2025 RFI process. Establishing the PRTF Community of Practice will promote shared learning among these programs and a more collaborative relationship with state oversight agencies.

- **Strengthen funding and workforce strategies:** Ongoing rate review and exploring workforce incentive programs will continue, with an emphasis on recruitment and retention of qualified staff across rural and urban regions. OHA and ODHS will continue to establish workforce clarity through the Building Bridges Initiative pilot, Community of Practice, rules and regulations on best practices for safety and predictability for both the workforce and youth receiving services.

- **Provide safety and milieu management support**: Meeting these needs requires greater workforce and environmental supports and regulatory review to ensure Oregon's Child Caring Agency standards and OHA's 309-022 rules remain aligned with the realities of serving youth with complex and high-risk behaviors.

- **Advance interagency and policy collaboration:** OHA and ODHS will continue close collaboration on children's intensive services, including coordinated oversight of capacity modeling and funding mechanisms, and solution development to address current and anticipated provider concerns – such as the rising costs of care. This also includes alignment of priorities with broader strategies to strengthen the children's continuum of care.

- **Align adjacent OAR updates:** Rule revisions under OHA's Behavioral Health and Medicaid rule divisions and ODHS licensing will be completed in alignment to ensure consistent regulatory language and expectations.

- **Develop a payment pathway for home-time practices:** OHA to explore mechanisms that recognize and support structured family-home connection as part of the treatment process.

- **Improve RCM data quality:** As the DaETA team report shows in Appendix F, continued improvements are needed to strengthen the data collection of PRTF capacity and referrals.

OHA and the DaETA team will partner with PRTF providers to reduce errors and missing data points by implementing audit protocols and closely monitoring data entry.

- **Increase understanding of the usage of the ED:** OHA, in partnership with the DaETA team will explore data to improve understanding of youth visiting an ED for behavioral health crises and the intersection with higher levels of care.

Conclusion

Oregon has made measurable progress toward expanding beds in the psychiatric residential treatment system for youth. Through deliberate investment, community partnership, and policy modernization, OHA and ODHS are working together to create sustainable capacity that better meets the needs of young people and their families.

Significant work remains. Workforce shortages, geographic inequities, and the fiscal realities of Medicaid reimbursement and overstretched budgets continue to challenge both public agencies and provider partners.

This report provides a roadmap for the continued development of a coordinated, accessible, and high-quality system of residential psychiatric care for Oregon's youth.

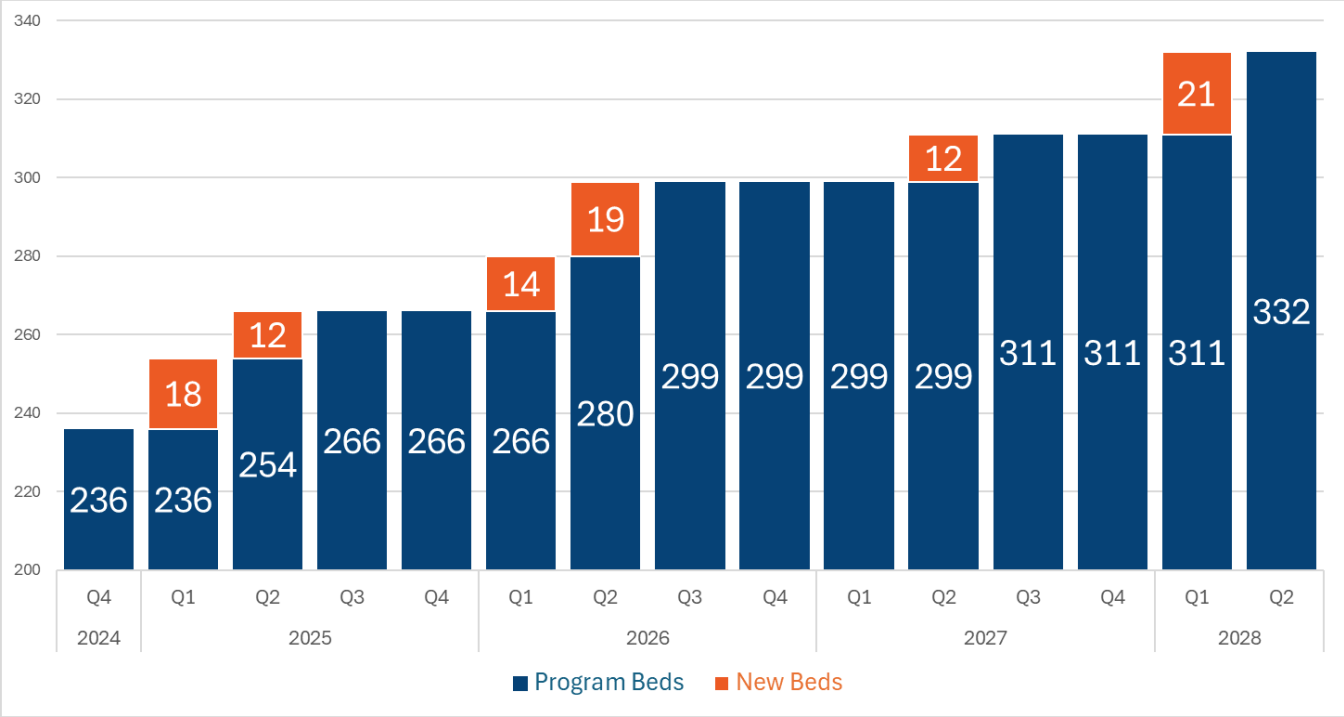
Appendix A: Table of the current totals of OHA licensed psychiatric and substance use disorder (SUD) residential treatment program beds.

Residential Programs	Program Type; Specialty	Licensed Beds	Program Beds
Albertina Kerr - Subacute Program	Psychiatric Residential; subacute only	24	23
Monte Nido - Clementine West Linn	Psychiatric Residential; Eating disorder specific treatment for female-identifying youth.	12	12
Monte Nido Clementine Lake Oswego	Psychiatric Residential; Eating disorder specific treatment for youth of all gender identities	14	12
Jasper Mountain - The Castle	Psychiatric Residential	20	20
Jasper Mountain - Crystal Creek	Psychiatric Residential	12	9
Jasper Mountain - SAFE Center	Psychiatric Residential	18	18
Looking Glass Community Services - Regional Crisis Center West	Psychiatric Residential; Specialty contracts with ODHS	30	22
Looking Glass Community Services - Regional Crisis Center East	Psychiatric Residential; specialty contracts with ODHS and OYA	21	18
Nexus Family Healing - Walden Crossing	Psychiatric Residential; specialty contract with OHA's JPSRB & Restorative Services program	6	6
Trillium Family Services - Portland Campus	Psychiatric Residential (including 12 SCIP beds)	48	45
Trillium Family Services - Corvallis Campus	Psychiatric Residential (including 20 SAIP beds)	48	48
Embark Behavioral Health, Bend, OR	Psychiatric Residential	18	12
Madrona Recovery	Psychiatric & Substance Use Disorder Residential	22	18
Total Psych Res Beds		**293**	**263**
Adapt, Inc. - Deer Creek Adolescent Residential Treatment Program	SUD Residential	15	10
NARA NW Youth Residential Treatment Center	SUD Residential	24	20
Rimrock Trails Adolescent Residential Treatment	SUD Residential	24	18
Parrott Creek SUD Residential Program Licensed as of 11/5/2025	SUD Residential; also opening 20+ Behavioral Rehabilitation Services (BRS) beds	12	12
Total SUD Res Beds excluding Madrona		**75**	**60**
Total SUD Res including Madrona		**97**	**78**

Appendix B: Table of anticipated expansion of psychiatric and substance use disorder (SUD) residential treatment programs by provider.

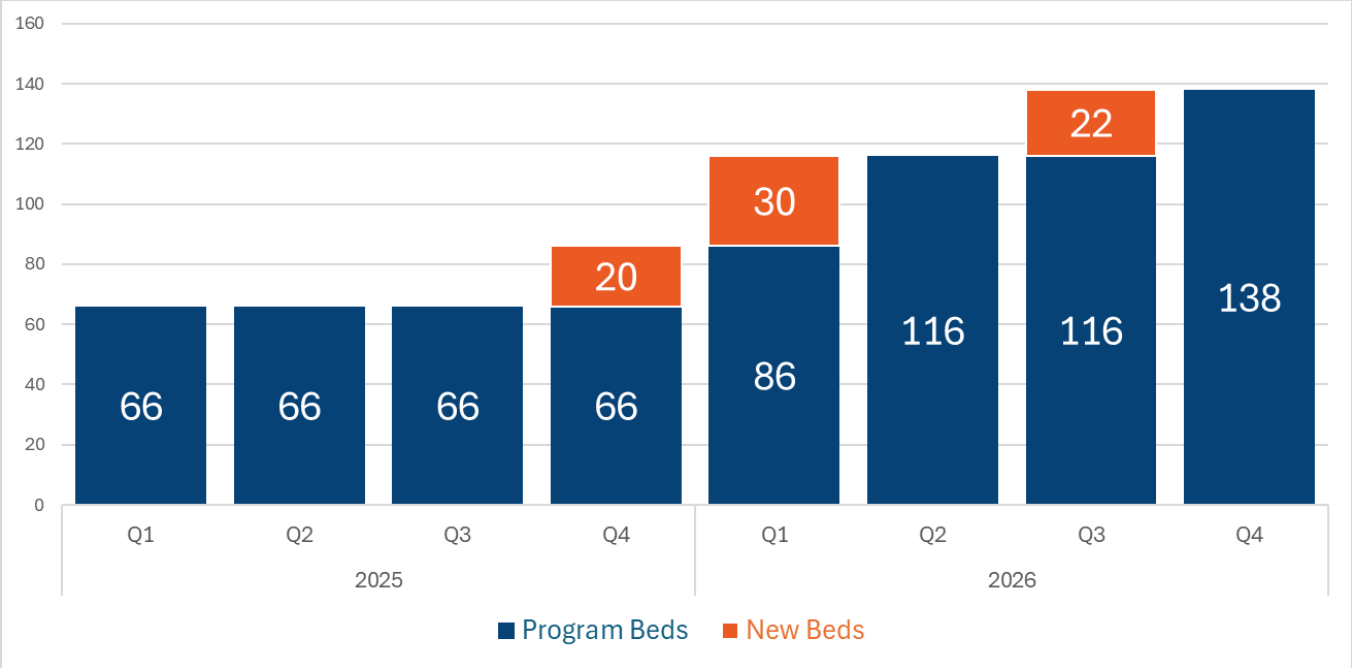
Program	Program Type; Specialty	Projected Beds	Estimated Opening
Community Counseling Solutions – Boardman, OR	Psychiatric Residential (4 – 13)	14	Apr-26
Live, Grow, Share – Eugene, OR	Psychiatric Residential; Small Home model	2-7	Spring 2026
Nexus Family Healing – Eugene, OR	Psychiatric Residential, youth forensic, secure inpatient (SIP) (10 – 17)	12	May-26
Adapt, Inc – Roseburg, OR	SUD Residential; 22 adolescent beds & 16 Parent/ Child, 6 adolescent detox	22	Fall 2026
Trillium Family Services Whole Person Health Residential – Portland, OR	Psychiatric Residential (ages TBD)	12	Jun-27
Deschutes County Residential Project – Deschutes Co., OR	Psychiatric Residential (ages TBD)	15	Oct-27
Madrona Recovery – Lake Oswego, OR	Psychiatric and SUD Residential (ages 13 – 17)	21	TBD
NARA NW – Multnomah Co., OR	SUD Residential (ages 12 – 18)	16	TBD
4D Recovery – Multnomah Co., OR	SUD Residential, also developing 8 beds young adult recovery housing	14	TBD
Anticipated Psych Res Increase		**76-81**	
Anticipated SUD Res Increase		**52**	

Appendix C: Bar chart of total statewide PRTF beds and cumulative anticipated expansion of psychiatric residential treatment programs.



This graph shows the anticipated increase in PRTF beds from the last quarter of 2024 to the second quarter of 2028. Funding sources for these projects vary and do not reflect funding allocated beyond 2025.

Appendix D: Bar chart of total statewide youth SUD residential beds and cumulative anticipated expansion of SUD residential programs



Funding sources for new projects vary and do not reflect funding allocated beyond 2025.

.

Appendix E: Supplementary information to Appendix F: Psychiatric Residential Treatment Facilities (PRTF) Capacity and Referral Report Quarter 3 (Q3): July 1 - September 30, 2025

Report notes and terminology definitions

RCM: Referral and Capacity Management – The name of the referral tracking platform developed by OHA for PRTF providers to use for data on the referrals to their individual programs and their bed capacity.

Small number suppression – Cells with numbers less than five are suppressed to maintain confidentiality. Any blank fields on tables or charts in this report represent data that has been suppressed.

Variations in the monthly data sets – There are tables in this report that include data from January 2025 through September 2025. For the first six months of 2025, the data set did not contain data from all of Oregon's psychiatric residential treatment facilities. January – June contains, at most, information from 8-9 of those programs. Data reporting compliance improved over the course of the year. Q3 data in this report are representative of all 13 PRTF programs.

Page 1

New referrals – The number of new referrals each month does not account for referrals received during previous months that are still open. This explains how the total number of new referrals received during Q3 (820) varies from the totals used in the referral decision (1045) and referral outcome (1045) pie charts.

Unique youth – This data point represents the number of youth who had one or more referrals to PRTF during a month.

Referral decision – A term used in RCM. This is the determination of program appropriateness made by the receiving program. In this report, the receiving program is the PRTF provider. A referral decision does not speak to Medicaid medical eligibility criteria.

Determination options include approved, denied, no decision and pending.

Referral outcome – A term used in RCM. This is the result of a referral as documented by the residential program. A referral is considered resolved when an outcome is assigned in RCM.

- Admitted – The referred youth has had an intake and is physically in the residential program.
- Denied – The residential program assesses that the youth is not appropriate for the program.
- Canceled – A referral is considered canceled when there is no admission or a denial. Canceled referrals may have a "no decision" assigned in RCM or an "approved" decision. Referrals are canceled for a variety of reasons. Programs document in RCM the reason for the cancellation, as reported to them by the referring provider.

Examples of why a referral is considered canceled before admission or a program denial:

- Changes in the recommended level of care: During the course of a referral, the referring provider will reassess and determine that a youth has either stabilized and can be treated at a lower level of care or has determined that an even higher level of care is required to treat the youth.
- The youth may admit to another treatment program: Many youth are referred to multiple programs at a time, including other levels of care. Providers are asked to document if a youth admitted to another residential program or an acute psychiatric inpatient unit.
- The guardian may decline admission to the residential program.

- Pending – A referral that is pending is considered open. This category includes referrals that have yet to receive a decision on program appropriateness and referrals that have an "approved" decision assigned in RCM and are awaiting an available bed to admit to the residential program.

Insurance denies admission: These are documented as canceled referrals since the residential program is not the entity making the denial.

No referral follow-up: Sometimes referrals are made, but the referring provider does not follow up to cancel these referrals when a bed is no longer needed. In these cases, the residential programs are unable to resolve the referral. Each residential program decides how long they will consider these referrals "open" before marking them as canceled in RCM.

Page 2

Youth's location at time of referral – PRTF providers are asked to track the child's location at time of referral to their program. This is different than the actual referral source. For example, in rural areas of Oregon, some hospitals have no social workers, so if a youth is seen in the ED for a mental health assessment, the county crisis team will come in to assess and coordinate referrals to higher levels of care.

Open referral – A referral that is still pending a decision regarding program acceptance and a treatment placement has not yet been identified.

Resolved referral – A referral that has been assigned a decision and an outcome in RCM.

Wait time (WT) for open referrals: The average number of days spent waiting for a resolution at quarter close (days between when a the referral was received and 09/30/2025)

Wait time (WT) for resolved referrals: The average number of days between receiving the referral and finalization of an outcome.

Page 3

Age – The age bar graph shows the distribution of the number of youth referred to a PRTF program in Q3 by their age. Total unique youth (769) referred in Q3 is the total used for this data. The table below the age graph shows the percentage of referrals for each age group that were admitted, denied, or canceled during Q3, and the associated wait time for that outcome to be finalized.

Insurance – RCM collects the type of insurance the referred youth has as it is reported in the referral. The broad categories are Medicaid, private insurance, Veteran's Administration, other, and unknown. The insurance bar graph shows the percentage of referrals received in Q3 with each insurance type. The Medicaid CCO pie chart shows the percentage of referrals received in Q3 by the assigned CCO.

Page 4

Presenting issue(s) – When PRTF providers create a referral in RCM, they are prompted to document why the young person was referred to their program. Providers choose from a drop-down list or a free-text box. Below are descriptions of the broad clinical presentation categories most often reported. (A referred youth may have than one presenting issue documented in their referral to residential care.)

- Behavioral concerns – This category includes mental health symptoms that present as maladaptive behaviors, which are often referred to as externalizing behaviors. Some of the behaviors included are fire setting, impulsivity, poor sleep habits, defiance of authority, runaway behaviors (elopement), toileting issues (enuresis and encopresis), and sexually acting out.

  Note: Aggressive behaviors are a separate category because of their frequency.

- Aggressive behaviors – Aggression can present in different forms. It includes physical and verbal aggression (kicking, hitting, yelling, threats of violence), homicidal ideation, and property damage (breaking items, throwing items, causing damage to buildings, furniture, or other objects). Providers document the settings and groups to which the aggression is directed (at home, treatment settings, school environment; parents, siblings, teachers, peers, treatment providers).

- Suicidality & self-harm –Risky or self-destructive behaviors, self-harm (scratching, head banging, cutting), suicidal ideation with and without intent or planning, and suicide attempts.

- Mood, thought, internalizing concerns – Symptoms related, but not limited to, diagnoses such as anxiety, ADHD, depression, trauma, and other mood disorders. Some of the presenting issues in this category are anhedonia, delirium/confusion, depressed mood, difficulty concentrating, dissociation, disordered eating behaviors, extreme avoidance of stressors, flashbacks, hyperactivity, hypervigilance, intrusive thoughts, irritability/agitation, nightmares, obsessive and/or compulsive behaviors, paranoia, poor social skills and socially isolating self.

- Substance use – Alcohol use, excessive substance use as a form of self-harm, illicit drug use, marijuana use, nicotine use and dependence, opioid use and dependence.

- Other – This category includes write-in answers from providers

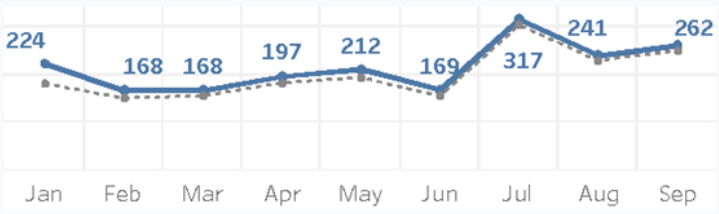
Appendix F: Psychiatric Residential Treatment Facilities (PRTF) Capacity & Referral Report Quarter 3: July 1 - September 30, 2025

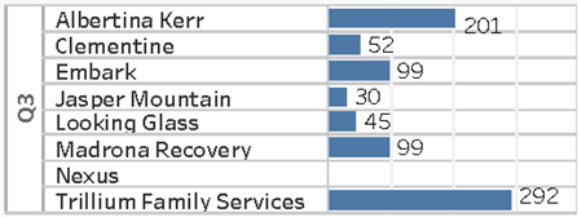
Psychiatric Residential Treatment Facilities (PRTF) Capacity & Referral Report

Quarter 3: July 1 - September 30, 2025 | Oregon Statewide Report | Page 1

This report reflects the total number of referrals received by facilities; one youth may have multiple referrals to different facilities in the same quarter.

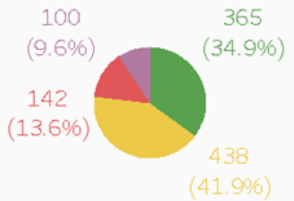
New Referrals during Q3	820
Unique Youth	769





Referral Decisions made by facilities during Q3; referral may have been received in previous quarter

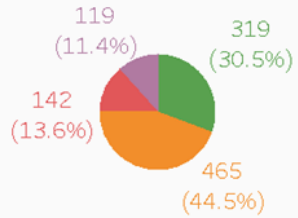
Approved: the facility approved the youth for admission
Denied: the facility denied the youth
No Decision: the facility did not make a decision before the referral was cancelled
Pending: the facility has not made / documented a decision



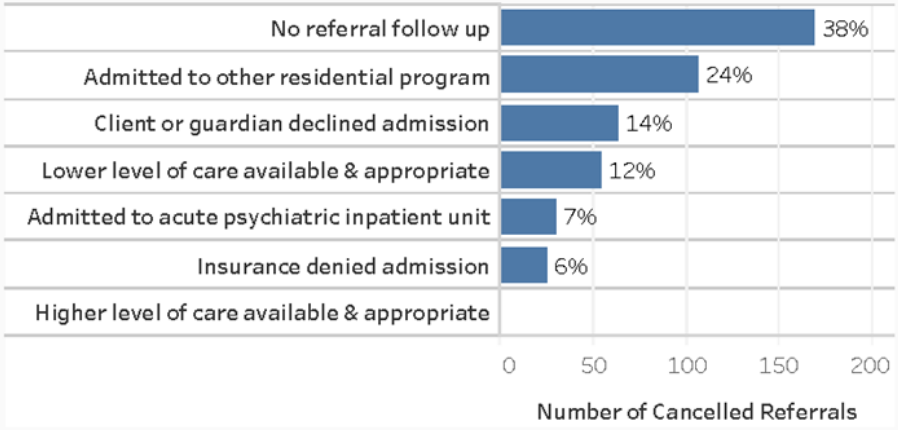
Outcome of decisions made during Q3; referral may have been received in previous quarter

Resolved
Admitted: the youth was admitted to the facility
Denied: the facility denied the youth
Cancelled: the referral was cancelled or withdrawn

Pending: the facility has not documented an outcome



Referral Cancellation Reasons



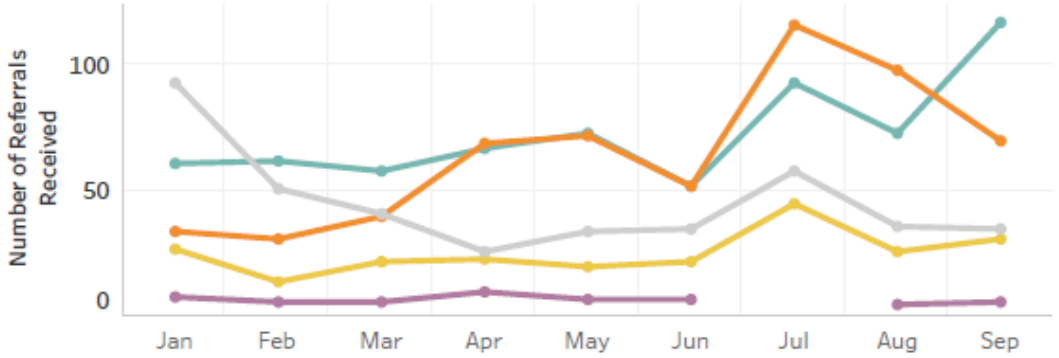
	Approved						No Decision		Denied		Pending		Grand Total	
	Admitted		Cancelled		No Outcome		Cancelled		Denied		No Outcome			
	#	%	#	%	#	%	#	%	#	%	#	%	#	%
Grand Total	**319**	**30.5%**	**27**	**2.6%**	**19**	**1.8%**	**438**	**41.9%**	**142**	**13.6%**	**100**	**9.6%**	**1,045**	**100.0%**
Albertina Kerr	44	22.0%	16	8.0%			97	48.5%	41	20.5%			**200**	**100.0%**
Clementine	24	46.2%					24	46.2%					**52**	**100.0%**
Embark							43	43.4%	51	51.5%			**99**	**100.0%**
Jasper Mountain	12	22.2%					17	31.5%	20	37.0%	5	9.3%	**54**	**100.0%**
Looking Glass	35	50.7%			11	15.9%	22	31.9%					**69**	**100.0%**
Madrona Recovery	117	58.8%					49	24.6%	11	5.5%	18	9.0%	**199**	**100.0%**
Nexus														
Trillium Family Services	83	22.4%	7	1.9%			186	50.3%	15	4.1%	76	20.5%	**370**	**100.0%**

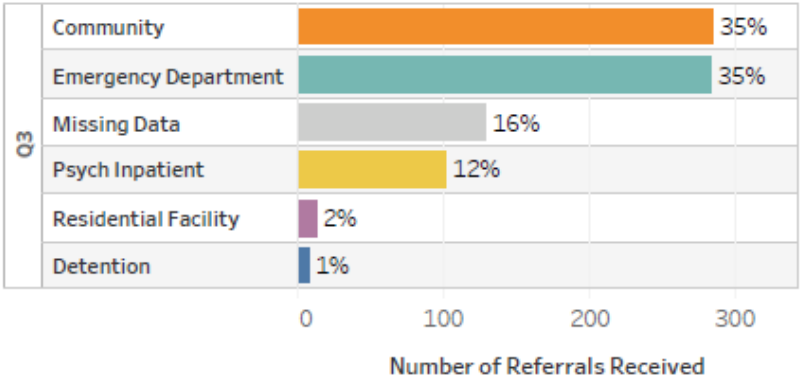
Data auditing efforts are underway to reduce the amount of missing data and improve data quality
% reflects percentage of decision/outcome across total row
Cells with n < 5 are suppressed to maintain confidentiality

Psychiatric Residential Treatment Facilities (PRTF) Capacity & Referral Report

Quarter 3: July 1 - September 30, 2025 | Oregon Statewide Report | Page 2

Number of New Referrals Received by Youth's Location at Time of Referral





Referral Outcome by Youth's Location at Time of Referral

Referral Source	Admitted			Denied			Cancelled			No Outcome		
	#	%	WT*	#	%	WT*	#	%	WT*	#	%	WT**
Grand Total	317	30%	21.6	142	14%	13.9	464	45%	23.5	119	11%	86.2
Community	102	27%	30.6	83	22%	15.0	148	40%	46.4	38	10%	28.6
Detention	7	78%	25.7									
Emergency Department	49	15%	8.5	30	9%	0.7	199	62%	3.2	43	13%	121.0
Psych Inpatient	57	51%	13.7				45	41%	12.9	5	5%	42.6
Residential Facility	7	35%	121.3				8	40%	61.2			
Missing Data	95	45%	24.4	22	10%	31.6	63	30%	79.1	30	14%	123.0

Wait Time

Wait Time for Resolved (Admitted/Denied/Cancelled) Referrals*

Minimum	WT*	Maximum
0.0 days	21.9 days	246.0 days

Wait Time for Open / Pending Referrals**

Minimum	WT**	Maximum
1.0 days	116.2 days	258.0 days

Data auditing efforts are underway to reduce the amount of missing data and improve data quality
Cells with n < 5 are suppressed to maintain confidentiality
* WT for resolved referrals: wait time as defined by the average number of days between when the referral was received and when the outcome was finalized
** WT for open referrals: wait time as defined by the average number of days spent waiting for a resolution at quarter close (days between when referral was received and 09/30/2025)
% reflects percentage of outcome within individual row

Psychiatric Residential Treatment Facilities (PRTF) Capacity & Referral Report

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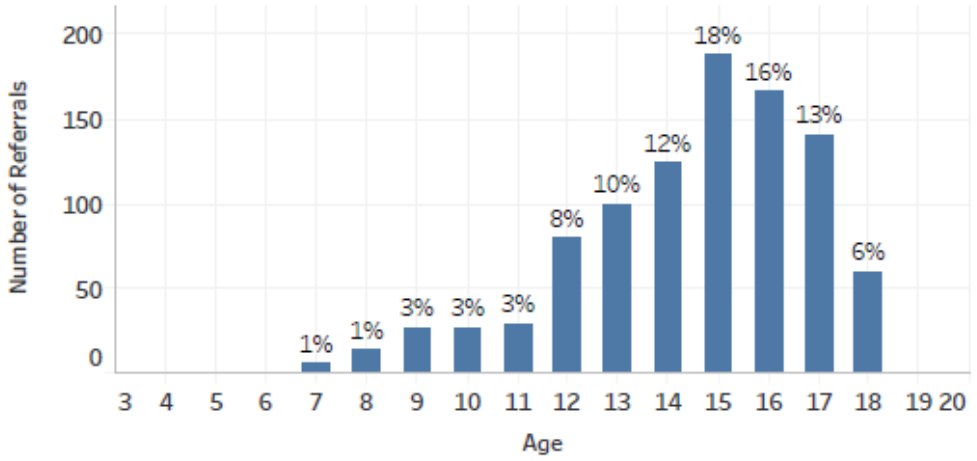
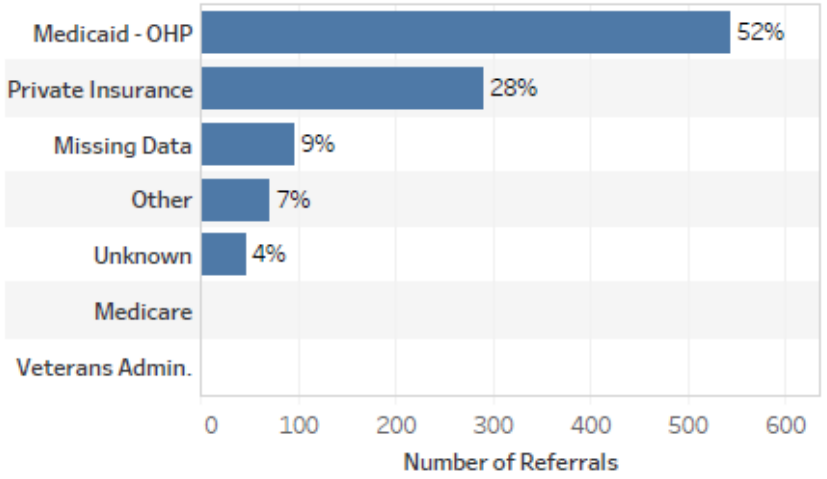
Age



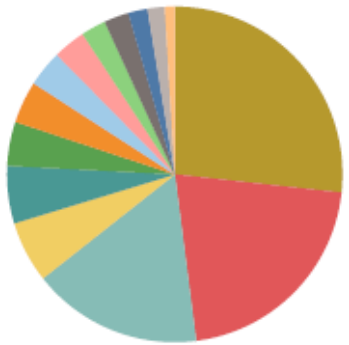
	5 and under		6-8		9-11		12-14		15-17		18-20	
	%	WT*	%	WT*	%	WT*	%	WT*	%	WT*	%	WT*
Admitted			25%	78.5	19%	27.6	27%	22.0	38%	19.2	42%	13.7
Denied			35%	32.8	19%	14.8	14%	15.8	7%	6.2		
Cancelled			25%	23.4	46%	29.5	47%	31.2	43%	16.8	42%	17.2
	%	WT**	%	WT**	%	WT**	%	WT**	%	WT**	%	WT**
No Outcome					16%	43.7	12%	84.8	11%	103.6	12%	148.1

Data auditing efforts are underway to reduce the amount of missing data
Cells with n < 5 are suppressed to maintain confidentiality
* WT for resolved referrals: wait time as defined by the average number of days between when the referral was received and when the outcome was finalized
** WT for open referrals: wait time as defined by the average number of days spent waiting for a resolution at quarter close (days between when referral was received and 09/30/2025)
% reflects percentage of outcome within each demographic

Insurance



Medicaid Coordinated Care Organization (CCO)



- Health Share of Oregon (27%)
- PacificSource Community Solutions (21%)
- Missing Data (16%)
- InterCommunity Health Network CCO (6%)
- Jackson Care Connect (6%)
- Columbia Pacific CCO (4%)
- Care Oregon (4%)
- AllCare CCO (4%)
- Trillium Community Health Plan (3%)
- Eastern Oregon CCO (2%)
- Umpqua Health Alliance (2%)
- Advanced Health (2%)
- Yamhill Community Care (2%)
- Cascade Health Alliance (1%)

Psychiatric Residential Treatment Facilities (PRTF) Capacity & Referral Report

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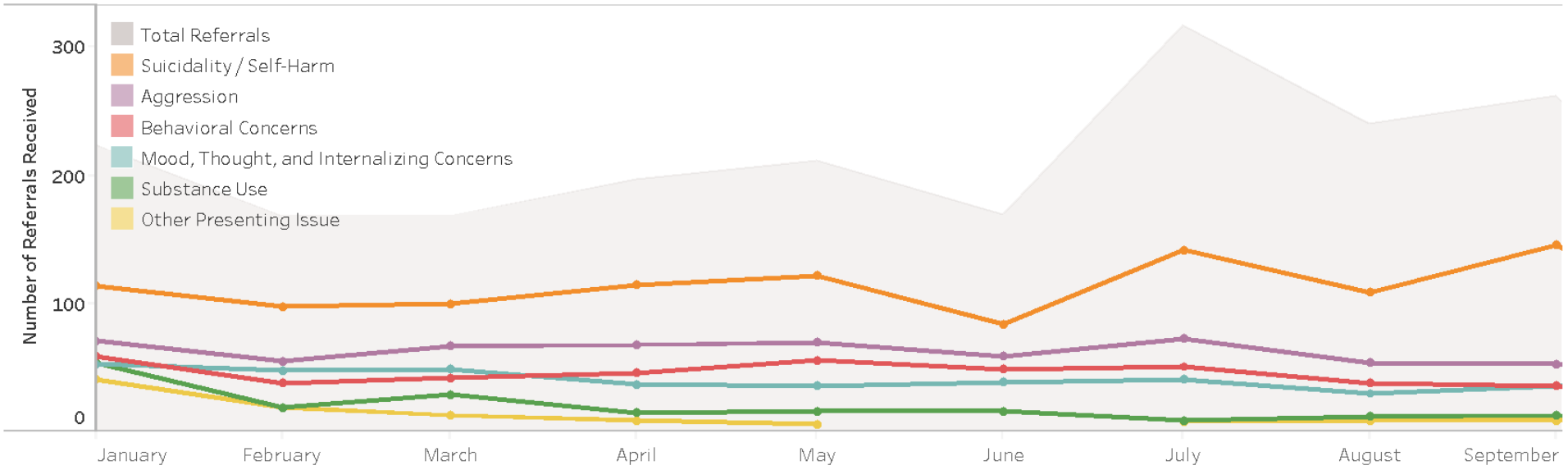
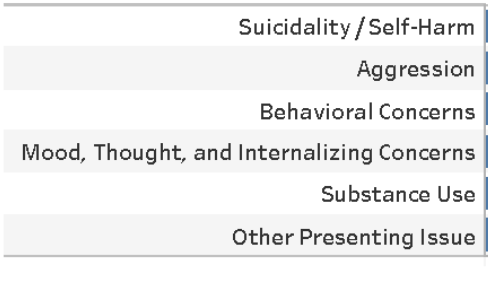
Presenting Issue

Number of Referrals Received by Presenting Issue



Referral Outcome by Presenting Issue

* youth may have more than one presenting issue



	Admitted		Cancelled		Denied		No Outcome	
	%	WT*	%	WT*	%	WT*	%	WT**
Suicidality / Self-Harm	28%	15.0	50%	17.8	9%	16.9	13%	89.9
Aggression	27%	32.8	42%	50.6	14%	26.5	17%	58.0
Behavioral Concerns	35%	30.2	41%	61.8	11%	36.9	14%	60.7
Mood, Thought, and Internalizing Concerns	37%	28.6	40%	47.6	6%	14.8	17%	80.7
Substance Use	54%	36.6	21%	81.7			25%	133.5
Other Presenting Issue	36%	24.3	32%	63.4			28%	87.3

Data auditing efforts are underway to reduce the amount of missing data and improve data quality

* WT for resolved referrals: wait time as defined by the average number of days between when the referral was received and when the outcome was finalized

** WT for open referrals: wait time as defined by the average number of days spent waiting for a resolution at quarter close (days between when referral was received and 09/30/2025)

% reflects percentage of outcome within individual row