HB 2086 (2021) Report (Sections 13 - 15):

Intensive Behavioral Health Treatment Services for Children and Adolescents: Capacity and Demand

December 2022

Oregon Health Authority

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Executive Summary

House Bill 2086 (2021), sections 13 through 15, require the Oregon Health Authority (OHA) to collect data from behavioral health Intensive Treatment Service (ITS) providers, Coordinated Care Organizations (CCOs) and insurers in Oregon on the demand for and capacity of intensive psychiatric residential treatment, acute inpatient treatment, or residential substance use disorder treatment for children and adolescents.

OHA is directed to use the data to monitor and track capacity, identify system gaps and develop plans to assist providers in data element modification. Additionally, the data will be utilized to develop benchmarks and performance measures for ITS capacity and to conduct research and evaluation of the children's continuum of care.

In 2019 OHA and ODHS identified a joint need for 286 functional psychiatric beds in the Oregon behavioral health ITS system. The functionality of this system declined as the COVID-19 public health emergency strained the workforce. In addition, in the fall of 2020 an unprecedented fire season forced some programs to reduce capacity or close temporarily. By April of 2021, there were a total of 172 operational psychiatric beds and 35 substance use disorder residential beds.

Data Gathered

While reporting requirements were paused during the pandemic, providers were asked to maintain, as best they could, capacity reporting for the needs of this study. Based on the available data:

- From the start of data collection in April 2021 to August 2022, the operational capacity for Psychiatric Residential Programs declined during 2021, but has been relatively stable in 2022.
- From the start of the eight months of data collection, from January 2022 to August 2022, the operational capacity for SUD Residential Programs is more even.
- Between April 2021 and October 2022, 103 youth were approved for Secure Inpatient from referral sources outside of the Secure Inpatient Provider. Of those, only 36 were admitted, with an average wait time for these admissions being 83 days.
- From 2020 to 2021, a total of 1252 individually identified (unique) youth served by OHP utilized inpatient/residential intensive psychiatric treatment services in Oregon. There were 1600 episodes of care, which means that several youth utilized multiple levels of service within the ITS inpatient and residential continuum.
- From 2020 to 2021, the number of children/youth who experienced Emergency Department Boarding (stays of longer than 24 hours) fluctuated month to month, but overall stayed level.

Next Steps and Recommendations

1. Oregon needs a robust bed registry that is trusted by all parts of the system as reliable and transparent.

2. The Intensive Treatment Services system for youth has a relatively small provider group.
    - An immediate next step is for OHA to bring the access directors from the provider group together to conceptualize a framework in which they could best collaborate on an interim central process to operate with until the final systems are in place.
    - Secondly, the central access and data solution determined should be simple, accessible, and understandable for all users.
3. In line with these recommendations, OHA can leverage the Acute Care Reporting (ACR) system, the Resilience Outcomes Analysis & Data Submission (ROADS) system, and the Behavioral Health Data Warehouse to integrate the youth Intensive Treatment Service central access needs and ensure the least amount of administrative and financial impact to providers.
4. Cost burdens to utilize these systems must be mitigated in both time and funding to ensure sustainability.

Introduction

Purpose

House Bill 2086 (2021), sections 13 through 15, require the Oregon Health Authority (OHA) to collect data from behavioral health Intensive Treatment Service (ITS) providers, Coordinated Care Organizations (CCOs) and insurers in Oregon on the demand for and capacity of intensive psychiatric residential treatment, acute inpatient treatment, or residential substance use disorder treatment for children and adolescents.

OHA is directed to use the data to monitor and track capacity, identify system gaps and develop plans to assist providers in data element modification. Additionally, the data will be utilized to develop benchmarks and performance measures for ITS capacity and to conduct research and evaluation of the children's continuum of care.

This report:

- Summarizes data gathered and barriers to gathering data from April 2021 through September 2022,
- Recommends ways of overcoming barriers to data collection, and
- Outlines plans for next steps.

Limitations

- Historic underfunding has produced a patchwork system of care delivery and oversight that is complex, fragmented, and inequitable – and lacks clear measures of impact. The COVID-19 pandemic further strained behavioral health workers and programs across the state, while increasing consumer demand for services.
- Data gathering and initial process development for this report occurred during the height of the pandemic. Recommendations are made for next steps that recognize various constraints and challenges programs currently face related to hiring and training, facility expansion and other issues.
- A capacity and access needs assessment project for the Intensive Treatment Services system was underway prior to HB 2086 passage in the 2021 session. Due to the strain on the system in the following months, several parameters were minimized.
- OHA is gathering REALD-SOGI data (Race, Ethnicity, Language, Disability-Sexual Orientation and Gender Identity) across the healthcare system; however, the data is not available at this time to cross-reference with behavioral health service capacity. OHA expects to have this data available in 2024 to further highlight the cultural and linguistic needs of Oregon youth seeking behavioral health treatment.

Intensive Behavioral Treatment Services Capacity

Definition and Program Landscape

The Intensive Treatment Service System in Oregon consists of:

- Acute Psychiatric Hospital Units,
- Secure Inpatient Psychiatric (SIP) Services,
- Psychiatric Sub-Acute Residential Treatment Services (SA) and
- Psychiatric Residential Treatment Services (PRTS). In addition,
- Substance Use Disorder (SUD) Residential Treatment Services are considered Intensive Treatment Services as are Psychiatric Day Treatment Services. *Day treatment services are excluded from this report due to the variability of operation during the public health emergency*.

Programs providing intensive services are licensed for a specific number of beds; however, providers often limit capacity to a lower functional maximum. The following table provides Oregon's general system capacity for inpatient and residential services prior to the onset of the public health emergency of 2020.

Provider	Program	Licensed Capacity	Functional Capacity
Unity BH	**Acute Inpatient Hospital**	22	22
Providence Willamette Falls BH	**Acute Inpatient Hospital**	22	22
Trillium Family Services	Children's Farm Home (SIP, SA, PRTS)	86	60
Trillium Family Services	Parry Center For Children (SIP, SA, PRTS)	48	45
Jasper Mountain	SAFE Center (PRTS)	20	18
Jasper Mountain	The Castle (PRTS)	20	15
Kairos	New Beginnings East (PRTS)	15	12
Kairos	New Beginnings West (PRTS)	12	9
Albertina Kerr	Sub Acute Psychiatric (Sub Acute)	24	22
Looking Glass	Regional Crisis Center (Sub Acute)	14	12
Madrona	Substance Use Disorder Residential	26	21
Adapt Deer Creek	Substance Use Disorder Residential	15	10

Rimrock Trails	Substance Use Disorder Residential	24	18
NARA	Substance Use Disorder Residential	24	12
YES House	Substance Use Disorder Residential	31	25
DePaul	Substance Use Disorder Residential	40	12
Total **Psychiatric Residential**		**Licensed 283**	**Functional 237**
Total **SUD Residential**		**Licensed 160**	**Functional 98**

Table 1. Oregon's general system capacity for inpatient and residential services prior to the onset of the public health emergency of 2020. Source: *Oregon Health Authority. Please note there are two psychiatric residential treatment facilities (PRTF) not listed here: Clementine (for eating disorder treatment) and Discovery Mood and Anxiety Program.*

In 2019 OHA and ODHS identified a joint need for 286 functional psychiatric beds in the Oregon behavioral health ITS system. The functionality of this system declined as the COVID-19 public health emergency strained the workforce. In addition, in the fall of 2020 an unprecedented fire season occurred across the region. Programs were forced to reduce capacity, or close temporarily. Three programs closed permanently, including YES House, DePaul, and Kairos East PRTS program. By April of 2021, there were a total of 172 operational psychiatric beds and 35 substance use disorder residential beds.

To maintain remaining operational capacity, OHA supported the provider group with multiple strategies to preserve operations, including bed capacity support payments and reduced regulatory reporting requirements. Additionally, legislative funding was provided to the sector to support retention and hiring bonuses, innovative solutions such as childcare and staff supervision or relief shifts, and improvement of working conditions.

OHA provided emergency staffing resources in mid-January 2022. The following memo was sent to all licensed residential treatment providers: “Oregon Health Authority implemented strategies geared toward proactively addressing critical staffing needs to assist licensed residential behavioral health treatment programs that experienced workforce shortages due to the COVID-19 pandemic”.

Providers reported that the above resources provided tremendous support in maintaining some degree of capacity and increased workforce wages and recovery within the COVID-19 pandemic. However, as shown below, providers continue to struggle to return to operational capacity due to staffing needs.

Capacity Data Method

While reporting requirements were paused, providers were asked to maintain, as best they could, capacity reporting for the needs of this study. Providers were asked to report weekly the following:

- **Filled beds** - *number of youth currently admitted*
- **Available beds** - *number of beds open/available for admits*
- **Pending Admissions** - *number of youth approved for admit and awaiting available bed or approval by payor*
- **Referrals** - *number of referrals not yet reviewed for admission determination*
- **Discharges in the subsequent week** - *planned discharges (subject to change)*
- **Notes** - *COVID precautions, staffing challenges (1:1 or risk needs), acuity increases, workforce issues (hiring, leave, investigations, etc.)*

This reporting method created some challenges. First, these data captured moment in time information. Capacity can change day to day in some programs, and hour to hour in others. Second, this reporting method was person centered and staff driven. If the staff assigned to the task was out, the report was not completed. Finally, the reporting template had too much flexibility and was lacking interrater reliability.

Psychiatric Capacity Trend

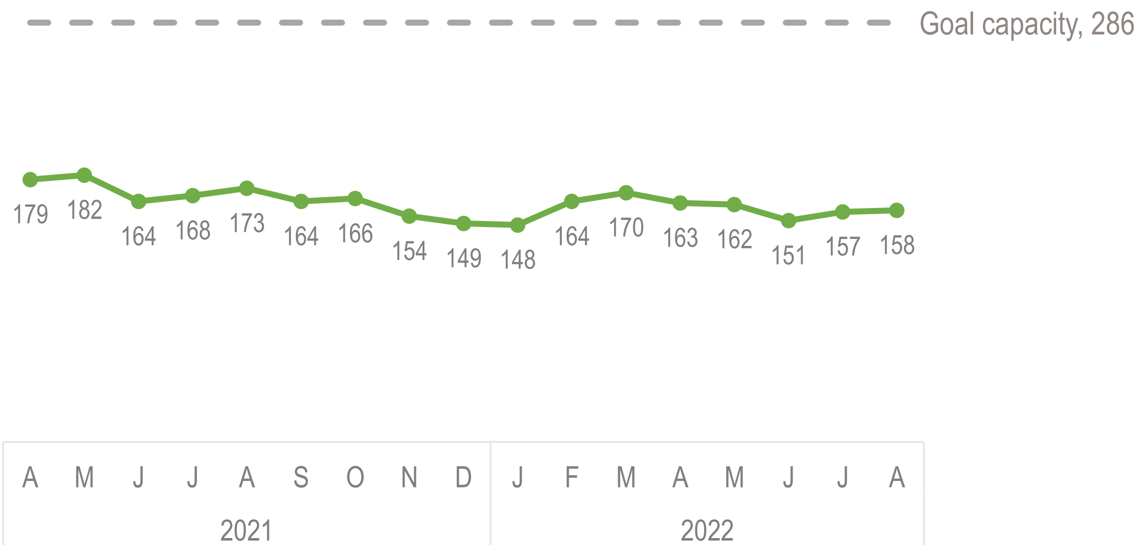


Figure 1. Psychiatric Capacity Trend, ITS Tracker, April 2021 - August 2022. Source: Oregon Health Authority direct reporting from providers.

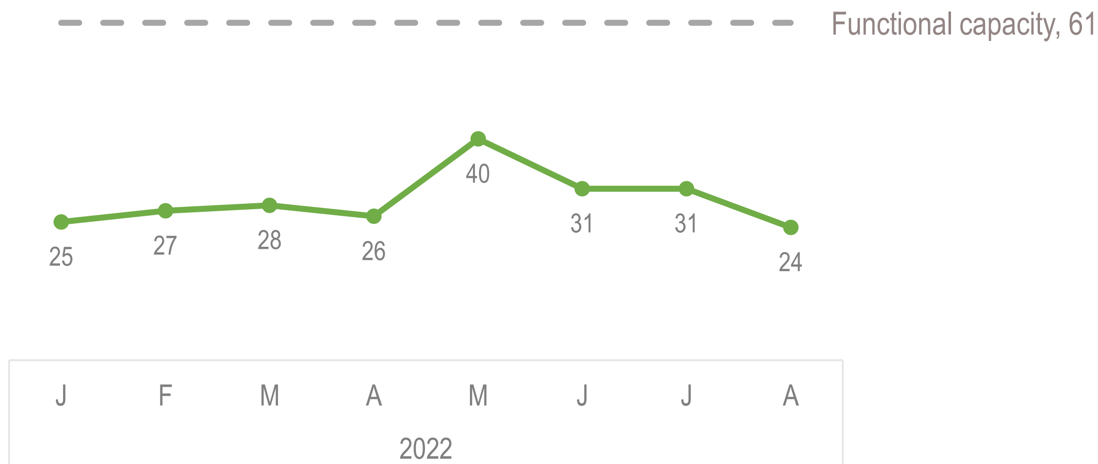
Figure 1 shows the maximum operational capacity versus the goal capacity for Psychiatric Residential Programs from the start of data collection in April 2021 to August 2022. The gap

between ITS programs' operational capacity and the goal capacity widened during 2021 and has remained relatively stable in 2022.

SUD Residential Capacity Trend

SUD residential:

Maximum operational capacity compared to functional capacity



Note: Interpret with caution. There is missing data from at least one provider for multiple weeks of each month. This compromises the accuracy of this dataset.

Figure 2. SUD Residential Capacity Trend, ITS Tracker, April 2021 - August 2022

Figure 2 shows the operational capacity versus the functional capacity for SUD Residential Programs from the start of data collection in January 2022 to August 2022.

Behavioral Health Intensive Treatment Services Access

System Demand

Currently, intensive treatment services are accessed via referral directly to providers – except for Secure Inpatient Psychiatric (SIP) which is accessed by a referral process through OHA. Providers receive referrals from multiple sources which include emergency departments, outpatient providers, other intensive service providers, payors and guardians. Some referrals, upon review, do not meet medical necessity. Some referrals, upon review, exceed the level of service the program can provide.

These access processes make it difficult to monitor demand. This report utilizes three sources of data to look at demand for need for ITS residential and inpatient services for children in Oregon.

Secure Inpatient Access

Referrals for Secure Inpatient go through an approval process involving the County Mental Health Programs (CMHP), a third-party reviewer, and OHA. OHA Child and Family Behavioral Health staff actively manages this approval list in prioritizing which youth are admitted. Between April 2021 and October 2022, 103 youth were approved for Secure Inpatient from referral sources outside of the Secure Inpatient Provider. Of those, only 36 were admitted, with an average wait time for these admissions being 83 days. The youth with the longest wait times waited 208 and 261 days respectively, and as of the date of this report being drafted, one of those youth is still waiting to be served.

Sources

The System of Care Data Dashboard was utilized to gather a broad overview of numbers of youth admitted to these levels of service in the previous year as a framework. Additionally, Medicaid data from emergency room utilization was reviewed and analyzed as a tool for determining demand for ITS. In an attempt at gathering more specific demand data, the psychiatric residential provider group provided monthly referral access reports from September 2021 through September 2022.

Actual Youth Served by OHP – Behavioral Health from 2020 to 2021

Intensive Treatment Service Programs	Frequency	Percent Total
Acute Psychiatric Hospital	733	46%
Psychiatric Residential Treatment	441	28%
Subacute Residential Treatment	268	17%
SCIP/SAIP Residential Treatment	158	10%
Total Unique Inpatient Persons (N = 1252)		

Table 2. Youth Served by Oregon Health Plan - BH, Ages 6 to 17, Children's System of Care Data Dashboard, 2020-2021, Medicaid Management Information System (MMIS) data source.
OHP = Oregon Health Plan (Medicaid), SCIP = Secure Children's Inpatient Treatment Program, SAIP = Secure Adolescent Inpatient Treatment Program

From 2020 to 2021 a total of 1252 individually identified (unique) youth served by OHP utilized inpatient/residential intensive psychiatric treatment services in Oregon. There were 1600 episodes of care, which means that several youth utilized multiple levels of service within the ITS inpatient and residential continuum. While youth with commercial insurance also access these programs, OHA does not have that data available for this report and it is not represented herein.

Emergency Department Boarding Data

Emergency Department Boarding is defined as any visit longer than 24 hours.

Emergency Department 24 hours+ Boarding

Number of children/youth

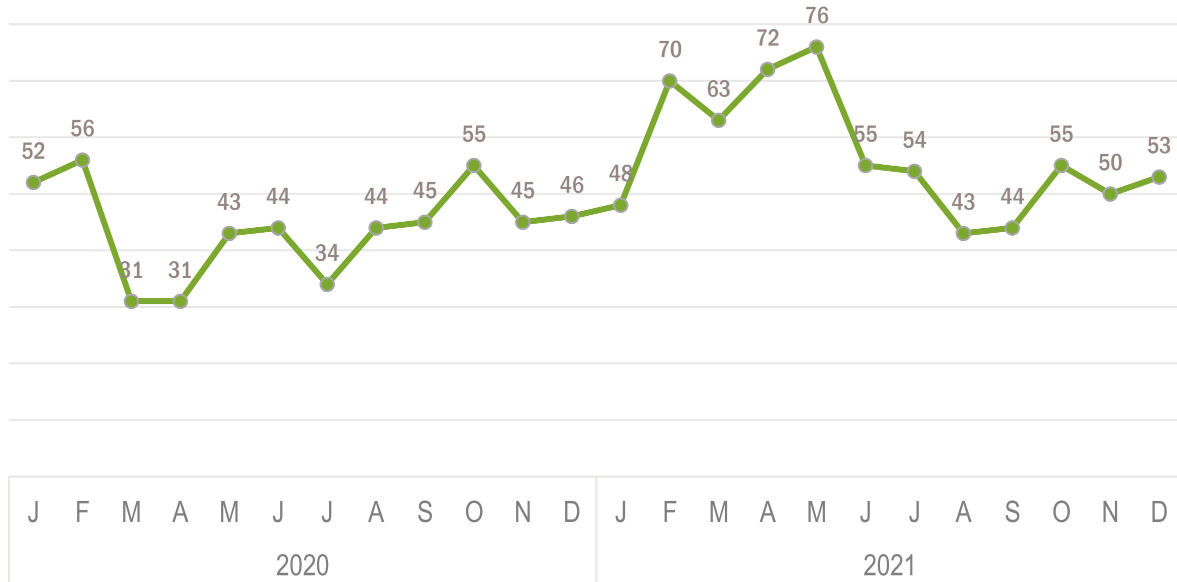


Figure 3a.

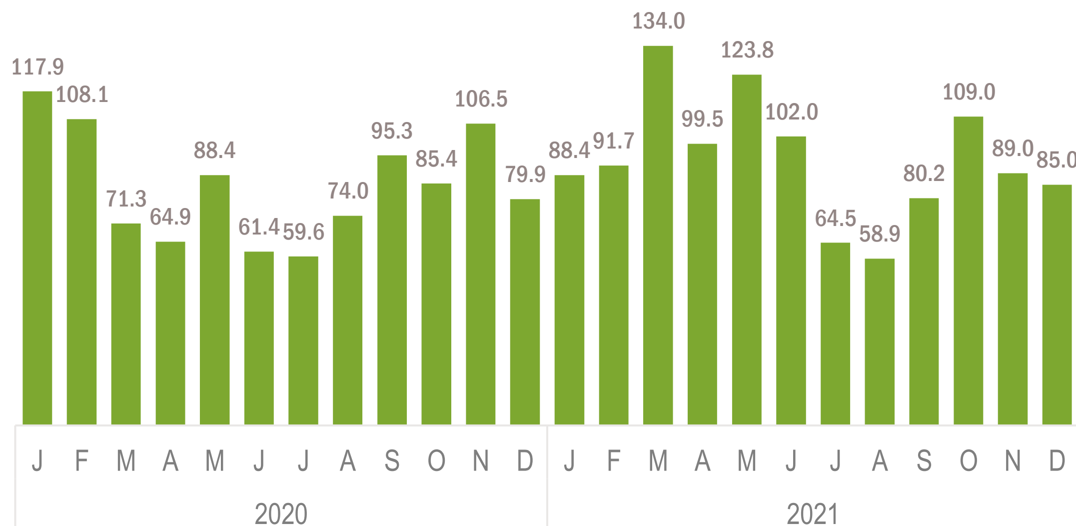


Figure 3b.

Figures 3a and 3b. Number of Children ages 5 – 17 years on Medicaid who were boarded in the Emergency Department for at least 24 hours and their Average Length of Stay in Hours, Oregon Health Authority Hospital Reporting Program (2022). Emergency Department Discharge Data, 2020-2021.

Figures 3a and 3b show the monthly number of visits that lasted at least 24 hours in an emergency department by Medicaid members and their average length of stay in hours. These data are limited to those presenting with serious emotional disorder (SED), self-harm, suicide attempt, and suicide ideation for the 2020-2021 time period. These data include all children admitted to the emergency department who are "treat and release" discharges and those that are transferred to another hospital as an inpatient. *The data does not include children who visited the emergency department who are then admitted to the same hospital as an inpatient*.

When youth are able to stabilize with supports and medical intervention in the emergency department, visits do not normally need to exceed 24 hours. Figure 3a shows an average of 50 young people per month staying in an emergency department for at least 24 hours. These young people could be waiting for placement in an inpatient bed.

Monthly Access Data

Three providers were able to provide complete access data and one provider did not, Jasper Mountain.

There are concerns with this data source and analysis:

- Table 3 is de-duplicated for *each* provider using the Unique Youth ID assigned by the providers. However, duplicates may still occur as the Unique Youth IDs are provider-

specific and cannot be used across providers to find unique members. This means a child or youth seeking a bed with multiple providers can be counted more than once.
- The amount of workforce strain on the system affected the compilation and provision of these data.

Information summary:

	Looking Glass	Trillium CFH	Trillium PCC	Albertina Kerr
N	53	291	642	938
Mean Age ± SD	14.50 ± 1.65	13.21 ± 2.84	12.64 ± 4.34	14.33 ± 2.13
Median Age	14	14	14	15
Gender				
Female	28	148	282	639
Male	19	115	177	296
Non-Binary/Transgender	6	28	57	-
Unknown/Missing	-	-	126	<5
Age Groups				
00 to 12	8	101	211	156
13 to 20	45	190	431	782
Level of Care Referred To				
PDTS	-	72	142	-
PRTS	53	109	277	-
Subacute	-	108	56	938
Determination				
Approved	53	85	72	52
Denied	-	21	68	170
Cancelled	-	58	381	358
Other	-	-	-	358
Unknown/Missing	-	127	121	-
Reason for Referral				
Aggression	14	88	61	-
Anxiety/Depression	-	48	45	-
General Behavioral Issue	17	25	23	-
Other	<10	-	<10	-
Psychosis	-	<10	<10	-
Self-Harm	-	23	16	-
Substance Use	<10	<10	<10	-
Suicidal	13	91	328	-

Unknown/Missing	-	<10	156	-

Table 3. Descriptive Statistics, Access Data, 2021-2022, source is reporting from individual providers.

Note: Ages 0 to 4 and 5 to 12; 13 to 17 and 18 to 20 were combined due to suppression rules for small numbers.
Numbers less than five were suppressed for gender (<5) and numbers less than 10 for everything else, were also suppressed (<10);
"-" means no cases were available.
Warning: May be statistically unreliable due to small numbers; interpret with caution.

Looking Glass gets all referrals from Child Welfare and not from other sources.

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Number of children/youth referred by gender

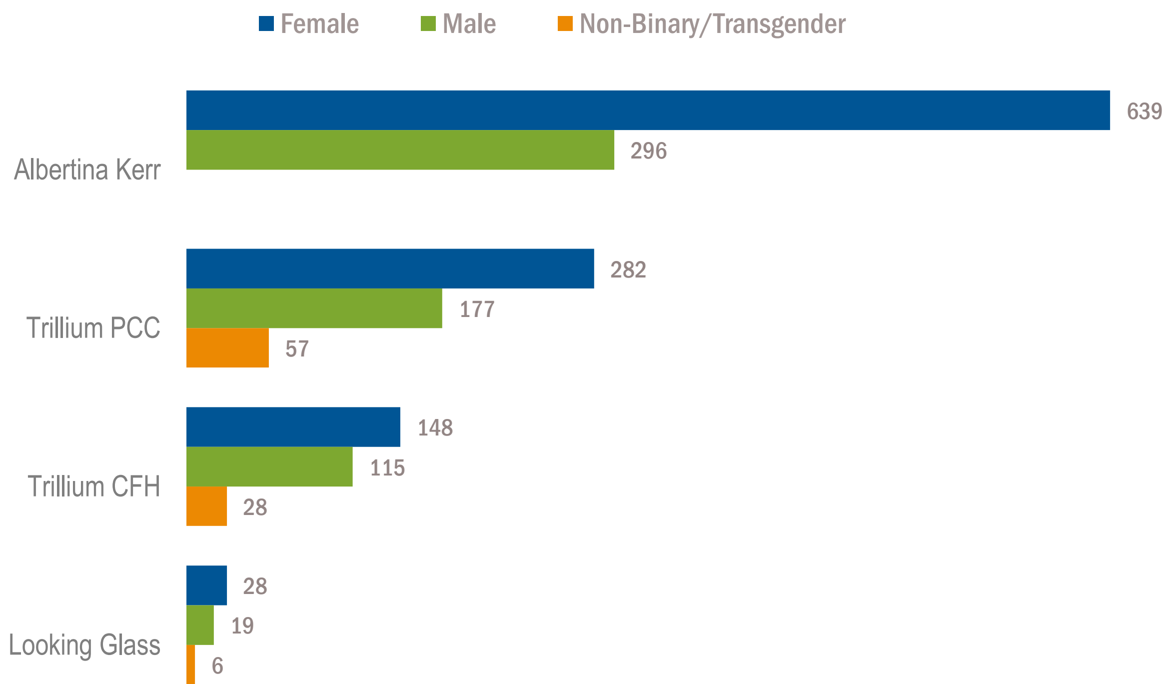


Figure 3. Number of Children/Youth Referred to Providers Due to Mental Health Reasons by Gender, Access Data reported to Oregon Health Authority by individual providers, 2021-2022.
Trillium CFH = Trillium Children Farm's Home
Trillium PCC = Trillium Parry Center for Children

Figure 4 shows the number of children/youth referred to ITS programs due to mental health reasons (i.e., aggression, anxiety/depression, self-harm, suicide attempt, suicide ideation, etc.)

by gender for the 2021-2022 time period. Females account for the highest number of referrals to all four providers.

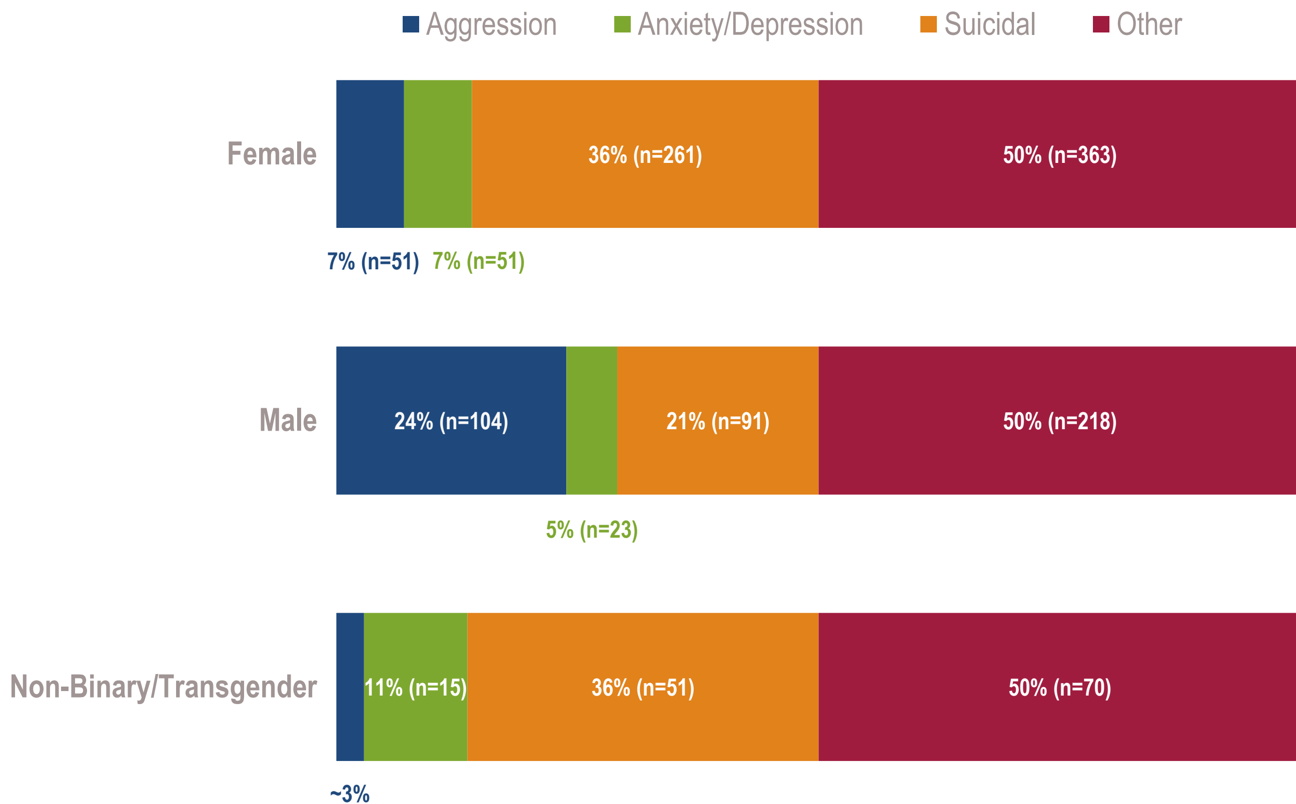


Figure 4. Top 4 Reasons for Referral by Gender, All Three Providers Combined (excluding Albertina Kerr), Access Data reported to Oregon Health Authority by individual providers, 2021-2022
Suicidal = suicide attempt, suicide ideation or overdose
Other = general behavioral issue, psychosis, self-harm, substance use, or unknown

Figure 5 shows the top four primary reasons for referral by gender from three providers (Looking Glass, Trillium Children's Farm Home, and Trillium Parry Center for Children) for the 2021-2022 time period. The suicidal attempt/ideation group accounts for the highest number of referrals overall (N=403). Suicidal tendencies were also the most common reason for referral within female and non-binary/transgender groups (36% and 35% respectively). The most common referral amongst males was aggression (24%), which was noticeably higher than either the female or the non-binary/ transgender groups (7% and ~3% respectively).

Implementation

All too often, there is simply no help available when families and youth request and need intensive behavioral health services. They wait lengthy periods for appointments. Families show up repeatedly at the most intensive levels of care to get prioritized for help and support. Even at the most intensive levels, help and support can be difficult to access. Families and youth wait in emergency departments, in juvenile detention, at home or on the streets. These difficulties are compounded for people from communities disproportionately impacted by health inequities such as people of color, people from rural communities, people who experience intellectual and developmental disabilities, people who are LGBTQIA2S+[1] and other groups.

In April 2021, the Substance Abuse and Mental Health Services Administration (SAMHSA) published a paper titled *Improving Access to Behavioral Health Crisis Services with Electronic Bed Registries.* It defines "bed registries" as regularly updated, web-based electronic databases of available beds in behavioral health settings.

While many states have sought to improve coordination of behavioral health services by making web-based bed registries accessible to front-line crisis counselors in local behavioral health agencies, mobile crisis teams, crisis call centers, and hospital emergency departments, there are challenges. One of the main needs for the success of the implementation of a registry is early and frequent community engagement in the planning process.

On November 15, 2021, OHA convened the Behavioral Health Committee defined in HB 2086 (2021). The Committee is identifying its first metric concepts in the beginning of the 2023 legislative session. These initial concepts will then enter the development and testing phase with OHA staff, while the Committee continues identifying additional metric concepts from topic areas not yet addressed.

Next Steps

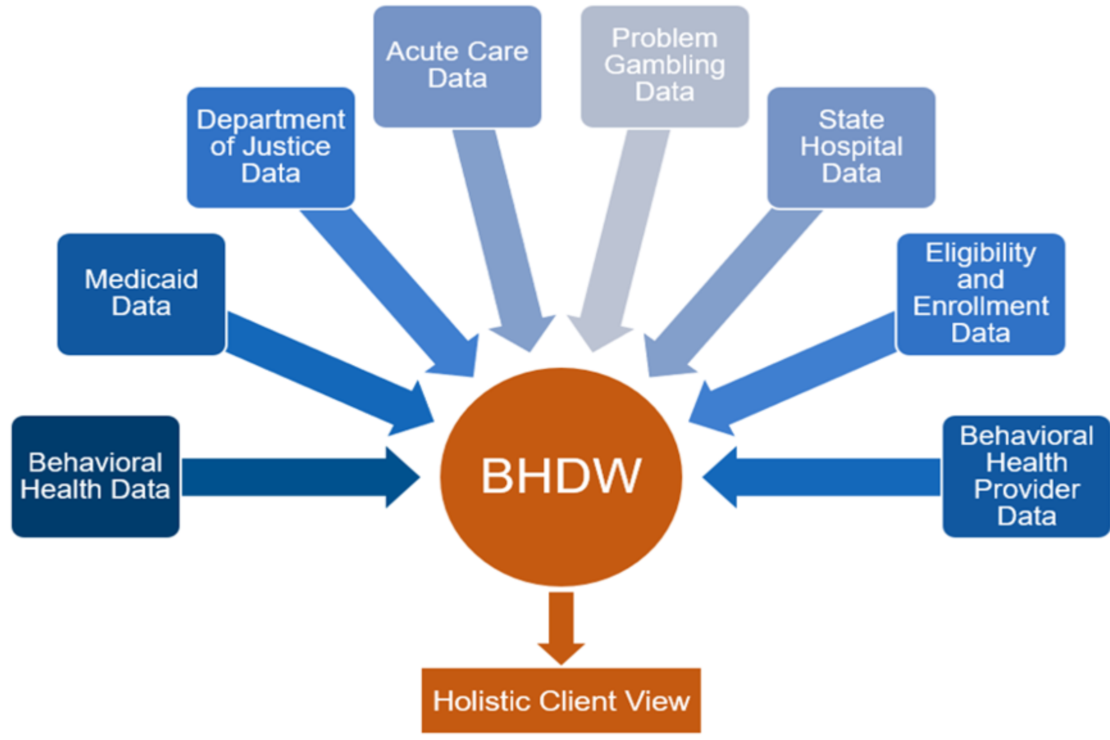
1. Oregon needs a robust bed registry that is trusted by all parts of the system as reliable and transparent.
   - This needs to be developed and agreed to by the whole community, including input from youth and families, referring entities and all providers.
   - The central access and data solution must be simple, accessible, and understandable for all users.
   - The system needs to accommodate the needs of providers that have lower levels of technology.

2. The Intensive Treatment Services system for youth has a relatively small provider group.

[1] Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, Asexual, Two-Spirit, and all the other ways people may identify their sexual orientation and/or gender, including non-binary.

- It is recommended an immediate next step is for OHA to bring the access directors from the provider group together to conceptualize a framework in which they could best collaborate on an ***interim central process*** *to operate with until the final systems are in place.*
- Secondly, the central access and data solution determined should be simple, accessible, and understandable for all users.

3. In line with these recommendations, OHA can leverage the Acute Care Reporting (ACR) system, the Resilience Outcomes Analysis & Data Submission (ROADS) system, and the Behavioral Health Data Warehouse to integrate the youth Intensive Treatment Service central access needs and ensure the least amount of administrative and financial impact to providers. There will likely be some limited financial costs to providers associated with minor adjustments to their Electronic Health Record interface with the systems.
    - Acute Care Reporting (ACR) is a data platform designed to collect admission and discharge data for behavioral health (BH) clients at acute care hospitals. ACR collects status (demographic, etc.) and non-Medicaid service data. These data provide information on services and events within the treatment episode. The ACR system is currently operational and new fields or measures may be added through a standard change request process.
    - The Resilience Outcomes Analysis & Data Submission (ROADS) system is currently in development and will replace the Measures Outcomes Tracking System (MOTS) as the system of record containing behavioral health data for Oregon mental health and addiction clients. ROADS will include enhanced capabilities to collect granular data on children's intensive services, facility capacity, and referral tracking. The new ROADS system is scheduled to come online in Fall 2023.
    - The Behavioral Health Data Warehouse (BHDW) is currently in development and is designed to be the central repository for behavioral health data that interfaces with behavioral health program applications and databases. The BHDW provides comprehensive analysis and reporting for state, federal, and ad hoc data requests. Data in the BHDW includes Medicaid claims, BH treatment episodes, acute care treatment, problem gambling services, Oregon State Hospital data, eCourts violations, and the demographic data from the Integrated Eligibility (ONE) system. The BHDW is scheduled to go live in the first quarter of 2023 and will include reporting capabilities responsive to the needs of HB 2086.



4. Cost burdens to utilize these systems must be mitigated in both time and funding to ensure sustainability.