OPAL | OREGON STATE UNIVERSITY Policy Analysis Lab

OFFICE HOURS REPORT
COLUMBIA, CLATSOP, TILLAMOOK COUNTY

EXECUTIVE SUMMARY

1. Clatsop County needs an expansion of its capacity for detox and substance use disorder (SUD) residential services.[1]
2. The fentanyl crisis is out of hand, and OHA must go to rural communities to witness it firsthand. [2]
3. Rural communities face additional barriers in treating patients, including limited access to transportation, a shortage of prescribing doctors, and lack of nearby in-patient services. [3]
4. Rural organizations face an even steeper challenge in hiring qualified professionals. [4]
5. OHA has put more resources into oversight, rather than supporting direct providers [5]

OFFICE HOURS

OPAL hosted a virtual Office Hours session on November 3rd, 2023. Six grantees from Columbia, Clatsop, and Tillamook Counties were invited to attend (see accompanying Summary Report for full list of invitees). The session lasted one hour, and one organization attended. This report summarizes the findings from grantee partners during that session.

ATTENDEE(S)

Clatsop Behavioral Healthcare (Warrenton, OR)

BARRIERS AND CHALLENGES

1. **Substance use disorder (SUD) treatment and detox capacity are insufficient.** In Clatsop County, there is a severe lack of capacity for substance use disorder treatment. Behavioral health providers need to send patients outside the county to obtain the necessary detox or SUD treatment.

    1.1. While the need for SUD and detox services has increased dramatically, services have not expanded to meet this need. Clatsop County is dealing with a severe fentanyl crisis that has made their need for services even more dire.

    1.2. Patients needing to leave the county for treatment is complicated by the lack of medical transport options. In some cases, providers have had to rely on AA sponsors willing to volunteer to drive patients several hours to a detox facility.

    1.3. Sending the individual out of their community for treatment can help in removing them from any harmful patterns and social influences. However, sending away patients can also create challenges, including NIMBY attitudes from locals (discussed in the SUD report), lack of support for the patient, and transportation issues.

    1.4. Therefore, it's not a requirement that all services are located inside the county. However, there needs to be standardized procedures for where to send individuals, and how to get them there. Currently, there is both insufficient capacity and insufficient transportation.

2. **The fentanyl crisis has created an unprecedented emergency for providers.**. The fentanyl crisis has overtaken all other substances within communities in Oregon.

   2.1. The only type of treatment that seems to have effect seems to be Medically Assisted Treatment (MAT). Evidence-based practices have a role, but they aren't going to fix the fentanyl epidemic.

   2.2. Current required intake assessments don't work for treating fentanyl. The new ASAM requirements are not reasonable for treating fentanyl patients, who come off the street high or in discomfort from withdrawal.

   2.3. Providers are flying by the seat of their pants in treating fentanyl. Therefore, the state should not be creating any more requirements right now for the already overwhelmed providers. The best way that the state could help providers is by not making things more difficult.

   2.4. In order to properly understand this epidemic, it was recommended that OHA should observe it directly in the affected communities.

"It's not that we work with the hardest population, it's that we work with the folks who have the least amount of resources and have the least community support."

– Clatsop Behavioral Healthcare

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3. **Rural communities face additional challenges that more populated areas do not face.** Included in these challenges are a lack of transportation, a shortage of primary care doctors and psychiatrists, and an absence of detox and SUD services in the area.

   3.1. In the absence of city and county resources, rural healthcare providers often have to provide most services in-house to meet their patients' needs. This places additional strain on their overworked employees who are already stretched too thin and who face an increase in overnight calls from these new services.

   3.2. Additionally, rural transportation is insufficient. Clatsop County's public transportation system shut down in May of 2023 due to mismanagement by an executive. The community has been left without transport since.

      3.2.1. The local Housing Authority has also suffered from mismanagement, further straining the community's public services.

   3.3. Medical transport that goes through a CCO brokerage has not been sufficient for their transportation needs, and OHA's ambulance coverage for Medicaid patients is inadequate. Additionally, this transportation requires three days' notice. With SUD patients, the response time needs to be within 15 minutes to a maximum of two hours.

   3.4. There are not enough physicians providing MAT in Clatsop County. CBH has been partnering with OHSU and others to loan doctors and psychiatrists. However, they only have them for a

limited number of hours per week. Primary care doctors in the county do not have the capacity to provide services to a patient with more complicated needs.

4. **Service capacity is limited by the inability to hire qualified professionals in rural counties.** Rural providers' challenges do not stem from working with the hardest population, but rather working with the fewest resources, least community support, and often witnessing the most dire daily situations.

    4.1. Rural providers suffer disproportionately from workforce shortages, due to a lack of qualified, certified professionals in the area. Recruitment of local QMHP is difficult due to competition over a small pool of professionals.

        4.1.1. CBH has had an incredibly difficult time filling open roles. Many positions, including Chief Business Officer, have been open for over 1 year.

        4.1.2. CBH is currently assisting community members to get their master's degree in order to hire qualified professionals.

    4.2. The amount of housing available in Clatsop County is so low that the professionals who try to move to the area cannot find a place to live.

    4.3. The wages organizations can offer are not competitive with the private sector. Most qualified staff end up leaving for higher pay in the private sector.

    4.4. Rules that prohibit the behavioral health organizations from hiring individuals with past felony convictions add an additional barrier to hiring staff. Many positions can be filled by individuals in recovery who are passionate about this work but are unable to be employed due to past SUD convictions.

        4.4.1. Individuals with past SUD experience make successful staff, including as 'peer allies,' going into the community to develop relationships, and engaging people to enter SUD treatment.

        4.4.2. CBH estimates that this one change may help fix their workforce problem by about 15%.

> *"My organization doesn't exist without the workforce. We're not anything. We are the people who work in this organization. And I will do anything to hold on to them, and support them to take care of them, and let them know how valuable they are."*
>
> – Clatsop Behavioral Healthcare

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5. **OHA should shift its resources from oversight, to supporting direct providers.** The past relationship between OHA and providers has been hierarchical and authoritative, which has created feelings of frustration and distrust among providers.

    5.1. OHA has historically used its authority to create more requirements for providers. The subtext has been interpreted that providers aren't providing service well enough, or a different evidence-based practice would work better.

5.2. Many state resources have been diverted to agencies overseeing the organizations, and away from behavioral health organizations who are directly performing the work on the ground.

5.3. OHA has created many 'off-ramps' for people to leave the behavioral health field and go into oversight roles, effectively de-recruiting from the workforce. The oversight system is now made up of staff that burned out and left the field, and now are telling current staff how to provide services better. This pattern has a demoralizing effect on providers.

5.4. For all the reasons above, past OHA policies have created a significant amount of distrust among county providers. Alongside this, proposals to dissolve the county-based behavioral health system, or to fine counties for every person admitted to the state hospital, have further damaged county trust for OHA.

RECOMMENDATIONS

1. Expand substance use disorder (SUD) and detox residential treatment across the state.

   1.1. Provide funding for medical transport options to bring patients to treatment centers.

   1.2. Expand SUD and detox capacity across the state, with the goal of giving patients and providers a choice about whether to receive treatment locally or across the state.

   1.3. Create standardized operating procedures for where to send individuals to get treatment.

2. Invest resources specifically targeted towards the state-wide fentanyl crisis.

   2.1. Expand capacity for Medication Assisted Treatment (MAT) to treat patients struggling with fentanyl.

   2.2. Remove ASAM assessment requirements for treating fentanyl patients.

   2.3. Eliminate the requirements for intake and assessment of fentanyl patients to ease the burden on overwhelmed providers.

   2.4. Travel to the communities across Oregon dealing with the fentanyl crisis to experience the epidemic firsthand.

3. Create a fund specifically for rural areas to cover basic needs and fill the current gaps in their community services.

   3.1. Target funding to fill the gaps in rural communities, including local transportation, housing assistance, and medical providers.

   3.2. Provide medical transport that is available within 15 minutes to 2 hours of a request being made.

4. Invest in building the workforce in the behavior health field.

   4.1. Higher wages for behavioral health workers, that compensate for the level of education and skill required, the stress involved in the work, and rising costs of living and housing.

4.2. Offer wages that are comparable to the private sector.

4.3. Provide financial incentives and/or workforce housing for qualified professionals who work in rural areas.

4.4. Lift the restriction on hiring and recruiting individuals with a felony charge on their record.

5. OHA should move its resources away from oversight and towards directly supporting behavioral health providers.

5.1. Transition from an authoritative role over providers to a collaborative role with them. Recognize that without local providers, there would be no health care system in the state.

5.2. Move resources away from oversight programs, and directly to the providers on the ground.

5.3. Encourage providers to remain working in the field, rather than leaving to join OHA.