HEALTH SYSTEMS DIVISION
Behavioral Health Workforce Initiative, House Bill 2235 Workgroup
Tina Kotek, Governor

Oregon Health Authority

500 Summer Street NE
Salem, OR 97301
https://www.oregon.gov/oha/HSD/AMH/Pages/HB-2235-Workgroup.aspx

House Bill 2235 Workgroup AGENDA
Wednesday, March 20, 2024 1:00 – 3:00 pm
Location: https://www.zoomgov.com/j/1618065772?pwd=M0pDZFRIcXVURGc2dFgzRFl0ZkNtQT09

Members in Attendance:		OHA Staff in Attendance:
☒ Diane J Bocking	☒ Jose Luis Garcia	☒ Christa Jones
☒ Belindy Bonser	☒ David Geels	☒ Vitalis Ogbeama
☒ Kelli Bosak	☒ Qurynn Hale	☒ Tim Nesbitt
☒ Chris Bouneff	☒ Clark J Hazel	☐ Jen Eisele
☒ Cheryl Cohen	☒ Jenn Inman	☒ Daniel Page
☐ Sarah Conyers	☒ Tony Lai	☐ Kelli Taylor
☒ Deanna Cor	☒ Lucia Mendoza-Meraz	☐ Beau Rappaport
☒ Anthony R. Cordaro, Jr.	☒ Shyra Merila	
☒ Lorie DeCarvalho	☐ Michael Spencer	
☒ Melinda Del Rio	☒ Diane Benavides Wille	

Resources:
HB 2235 Draft Charter

START	TIME	END	TOPIC	OUTCOME	LEAD(S)
1:00	10 min	1:10	Welcome Roll Call and Minutes Approval	Establish quorum and approve minutes	Tim Nesbitt Vitalis Ogbeama Jen Eisele
1:10	10 min	1:20	Public Comment	Public testimony	Tim Nesbitt
1:20	5 min	1:25	Check-in from previous meetings	Group consensus	Vitalis Ogbeama
1:25	15 min	1:40	Taking time to share	Relationship building/getting to know each other	Vitalis Ogbeama
1:40	10 min	1:50	Updates (Surveys and Charters)	Data input	Tim Nesbitt
1:50	10 min	2:00	10 minute break		
2:00	50 min	2:50	Retention kick-off	Group discussion	Tim Nesbitt
2:50	10 min	3:00	Wrap up/next steps		Tim Nesbitt Christa Jones
			Next meeting:	**Wednesday, April 3 @ 1:00 pm**	

MEETING MINUTES:
(Tim Nesbitt) Welcome

(Tim Nesbitt and Daniel Page) Roll call completed; quorum established.

(Tim Nesbitt) Public comment: none

(Vitalis Ogbeama) Check in from previous meeting: New standardized open space for group to share. Lindy commented about HB 4002 passing and the current behavioral workforce crisis. Need for staffing now, not later. Deanna agrees with Lindy and where we left off last week was important to do in order to create group cohesion and moving forward with agreements. Jenn states what Lindy says is true, would like to see us as a group assess resources including human resources and professional resources in addition to funding. Jose comments on the complexities of hiring staff, as Juntos trained 25 CADCs who are ready to be hired but have organizations that say they are "not ready to hire somebody like that" in the capacity of not having culturally specific supervisors. Entry positions within BH workforce have barriers to employment with culturally specific services. Very complex situation with multiple angles and perspectives to take into consideration. Diane Bocking from OYEN would like to connect. Anthony comments that recognition of the lack of workforce from the state is needed, as the workforce crisis has not been currently addressed before adding more BH programs. Need people in order to help people. David concurs statements made, and that the impact of these new programs is on the workforce that is already overburdened; personnel shortage in specific roles not evenly across all positions. Tim elevates some chat comments, encouraging connection between members outside of the meeting.

(Vitalis Ogbeama) Taking time to share: Invitation for members who did not get to share at the last meeting to share now.
Shyra Merila: I was able to hear from everyone but didn't get a chance to share. I'm an LPC that was born and raised in Oregon, traveled around, and came back for family. I'm a deputy director for a CMHP in rural Oregon. I wanted to be part of this workgroup because CMHP leadership has been trying to solve this problem on our own, but with the complexity of the system we need the expertise from across the state. Came here to be a part of the process, how it works, what kind of movement, how meaningful and effective is this to communicating our needs to the legislature? Really passionate and curious to see if this is going to work. Would like to see meaningful action plans and meaningful changes to be made. Wholeheartedly agree with Lindy that it's challenging to have new programs/expectations come down the pipeline while simultaneously trying to solve a workforce crisis issue. Feels very tone deaf when it is known there is a problem but "here's some more programs and expectations, and staffing expectations". Feel the system is disconnected and would like to see the system be more meaningfully connected, thoughtful and mindful. Want to see organizations being responsible for providing culturally responsive environments, not just services. What is it about our organizations/communities that are unwelcoming/unsafe? Would like to see CLSS expectations change; recently hired a black male therapist from Hawaii that moved to our rural community, stayed with the organization a week before realizing the community was inherently racist, which is standard across rural Oregon, and we need to do better.
Jenn Inman: Missed you all last time, was dealing with a workforce shortage so had to be that instead. Background is in public health policy and administration, not as a clinician, so bring a different angle to our leadership teams to think about our workforce. My passion right now is the professional well-being of our colleagues in the workforce, and how to have realistic expectations of human beings who have dedicated their lives to helping other people. Current regulatory system and organizational structures aren't well aligned for doing that. Looking to create solutions so that they can do the work without having to sacrifice their own mental health. Policy can be aligned to create mental well-being of workforce a priority, and we have already discussed some ways of doing that. Triple aim, quadruple aim, haven't held that thoughtful space. BH public administration system alone can't fix issue, have to work across systems (public and private) as well as education to grow and retain a workforce. Thing that gets me out of bed everyday is taking care of the people that work here and give them a meaningful experience to do what

they've dedicated themselves to do. Our CMHP has a team participating in National Council's ECHO series on workforce development right now, great deal of resource sharing, case studies, literature, etc. Thanks all.
Tim: I would like to elevate what Lucy put in the chat: "What brought me here is the needing to have our voices heard. The workforce is out there but finding placement adds barriers. As touched on before by Shyra racism has a huge impact on not only the participants but the BIPOC staff." That goes along with what we are talking about here so wanted that out loud.
Lucy: I would also like to add, when talking about our communities we need to be brought into the space to talk about it. I feel like we are brought into the space by being talked about, but the community isn't a part of the conversation.
Vitalis: I would also like to say what you put in the chat, that "we fund systems that negatively impact communities of color faster and longer than those that provide support and services." Thanks for your comments. If you would not like to share at the meeting, please email us our reach out to us and we will share with the group.

(Tim Nesbitt) Updates (Surveys and Charters): Have had five completed committee surveys, would love to see more entries from members to align with other committees to see what expertise is available, what recommendations have been made and what efforts have been made. Members can submit the survey more than once if needed. Quick review of committees listed in survey results. Charter Updates: addressing aggressions and microaggressions, standards around Zoom. Chat from Deanna "could be community agreements. I think we should spend time developing a list here." We can facilitate that, we would like to have a template to provide feedback on, will be coming soon. Core topic priorities survey, fifteen responses so far, thank you as fantastic information gleaned so far. Reminder the purpose is to ensure all voices are heard, for OHA to be informed on needed resources for the group and to identify priorities of members to inform a topic road map. Clarification email sent for hierarchical list with a specific number to be assigned to each topic. Apologies about the confusion with the instructions and appreciations for the responses to the emails. Organizing and summarizing the responses to these surveys, will identify a better way to prioritize. Shared preliminary recommendations on retention; such a big topic and many related topics that were filtered out, such as burnout. Going to wait until all responses are submitted before diving in fully, we are getting great information from you so far. Will ask for clarifications and expansions from members once all forms are submitted.

Retention Reflections – guided questions based on members roles, hearing non-management and CLSS group members' voice, then management/representative, then all.

Break

Clark Hazel: Grant specific for Queer/Trans/BIPOC, after three years served forgiveness of student loans. 25 group cohort starting together, apply for CSWA, having colleagues with me helped me stay with the work, amount forgiven based on funding, receive training to be a board supervisor. Three tiers of licensure/supervisor training. Creating specific cohort with a career pathway.
Jose Luis Garcia: Bring the perspective of culturally and linguistically specific services. We need more leadership that can work with a diverse staff, bilingual and bicultural leaders. Looking at language specific services/providers, have to support organizations in building a system where the spoken and written language services are provided in can be translated to English for reporting purposes. As a Spanish speaker we learn the specific terminology for recovery services in Spanish so we can understand it and talk to the clients in Spanish so they can understand. If learned in English it will be difficult to fully understand, especially if English is a second language, switching back and forth, leading to lack of understanding of services. Important to provide supports to organizations that serve specific languages or communities so they can hire people who look and sound like their community in their language, translating to English. Will require policies to change so those providing services are supported in the way they need. Management needs to understand the different levels of certifications. Asking peer support

specialists to do clinic/clinician work, provide training to be a clinician if doing clinical work, as putting peer support specialists at risk when sending them out to people with high acuity or dual diagnosis. Peer support is not supposed to be an entry position, but it is treated like it is, and then throw them out there to do clinical work. We need more clinical people, and we need our peer support, both are essential to the work. Peer support may not know how to deal with various de-escalations; have to understand where people are so we're not putting them at risk, which causes staff to leave because they are in a situation they are not ready for.
Lucy Mendoza: I received funding from HB 4071 to train peer supports and the focus was the workforce. When peers did the survey, for many it was the first-time practicing self-care. We're in this field, acknowledge that employees need time to take care of themselves, and not only own their own time. At the retreats we do CEUs, and a lot of them didn't have the opportunity to do CEUs due to barriers, such as children/higher needs. Many want to continue to leadership roles but the education and pathway to education is a barrier. Documentation systems are barriers as well, we sometimes work with families that speak only Spanish, have to translate our documentation into an English system. Have great peers out there that could do the work, but the systems don't work alongside them.
Melinda Del Rio: Wanted to add that that language portion of the documentation takes time to translate into English. If there's if not a way to automate translation, reimbursement of time is needed. At my agency I give the staff time for the translation, but it isn't billable time.
Tim Nesbitt: Thank you so much. Reminds me of what Clark mentioned about a culturally specific provider being the only one in the location, which is important to have that connection and representation for both patients and providers but leads to burnout for that single clinician. Especially on the linguistic side, and reimbursement for that time could be a recommendation. Any other voices from non-management or CLSS members? Please reach out or write down your question and we can come back to it at the next meeting. Let's move on to management and representative members. Melinda?
Melinda Del Rio: From what I noticed with retaining current staff is flexibility. I'm at a very small organization, can't compete with benefits, wages, or bigger organizations. Make up for that with flexibility by people being able to make their own schedules, maneuver things, having autonomy. Being able to move things has been a common comment staff have made.
Diane Benavides Wille: Certain organizations, mine included, benefited from the COVID relief funds. We were able to provide retention bonuses for staff, but it didn't keep them there. Throwing money at it doesn't decrease the burden. The 30% increase in rates took staff from over their heads to just above their noses. They're not living, not thriving, it's not a livable wage. What has helped is developing leadership opportunities. Read a MAHCBO study with QMHAI and QMHAII's, those that had II's had 70% retention. Community mental health organizations have been the training ground – you get the experience you get the license and move out. OHP reimbursement for private practices/small groups are basically screening out level A clients and leaving more intense and acute symptomology being referred to green staff fresh out of school. We have the most acute needs being treated by those with no experience. Have found Employee Resource Groups helpful, but they have to be managed so they don't become "Stew and Brews", but that people are coming with the time and space the organization provides, as well as find solutions to how we better support our staff.
Anthony Cordaro: Talking as the rep for OCAP as well as child psychiatry perspective. Benefits are tied into retention, not just wages. Increasing salaries, for non-child psychiatry professions, does need to happen, but better benefits for child psychiatrists need to happen. Acknowledging one of the reasons people leave is benefits, particularly healthcare, because healthcare is tied to your work. Big part of why people stay. For OHP reimbursing private care and private care having the less acute patients I think it's a good situation. For retention, bigger emphasis on benefits, retention bonuses, raising salary, leadership pathways. Something to be said for retention bonuses for employees that stick around, may get a bonus for a new job but not for sticking around.
Diane Bocking-Byrd: I work as the CCO and clinician in a small practice. One of the things that is ever present is the need to create community, primarily for people of color. Miss an opportunity to create a level of safety. Our operation is Latina owned and I am a Tribal Elder, all of our supervisors and practitioners are bilingual or bicultural. We don't have to recruit because people are knocking on our door

and saying we want to work for you. I think that means we've built a sense of community and safety. People can walk in the door and look and sound like our neighbor. When it comes to CMHP's and creating community, there's a lot of federal and state ruling that requires CMHP's to be an agency within county that is overseen by commissioners. Requirement that those programs provide the services like ACT, wraparound services, etc. Those higher level of care services sit with the community county partners. That is a role I would be happy to see changed, that would allow some in the communities to create fidelity model practices with the communities we're serving instead of sending them to a county. Our clinicians are seasoned enough to do that work, they want to do that work, but they can't do that work. CMHP things that do not allow for change which could be looked at. Committee looking at rules around 309's and 410's, looking for an update. Retaining providers has been easy because we do create a safe space sense of community. We go into it with a sense our clinicians will not be burnt out, that there is a safe place to talk about anything and salary is based on a forty-six-work week, which enables great benefits and PTO because they need the time off. Able to pass the majority of the revenue we receive to the clinicians as small organization. Think there are a lot of efficiencies that could be implemented in a leaner structure at CMHPs.

Shyra Merila: Wanted to add a couple of things that I think are working at Clatsop BHC. Provide $1500/year for continuing education including 40 hours training time. Just changed this from training dollars to wellness dollars. Four-day work week, providers work nine-hour shifts with 30 minute paid lunch. Work/life balance of four-day work week has made a difference in retention. Open network has been a problem; just lost two of our specialty providers on our child and family team for private practice. Trying to run intensive services with two clinicians. We need some change and support. Limited number of providers that can bill OHP, especially in small communities because our providers are going to go there where they can deal with clients with less acuity, pushing high acuity clients back to the CMHP. Would like to highlight housing, have had applications be rescinded because they can't find or afford housing in the area. Childcare is also a barrier, not enough and it's expensive. I couldn't participate in the last meeting due to lack of childcare.

Jenn Inman: What's helped is that we've made investments in quality clinical supervision and clinical training, which is different than required training to meet fidelity models. Shortage of folks that can provide clinical supervision licensure. Addressing both physical and psychological safety needs of staff, have to acknowledge it and talk about it, be thoughtful and make it a real conversation. People need to feel cared about personally, not just their work, but them personally are valued but they feel they are cared about, not just by manager or supervisor, but by their team. Team delivery service model has been a retention factor for CMHP. Community connections to meet basic needs in community chosen to live in, whether that's housing, social connections, hobbies, and recreational opportunities aren't being met as folks can't meet their basic needs or housing becomes untenable. Loan repayment isn't attracting any new folks, tuition reimbursement, grants, scholarships, those get people into and through school. No one comes to us because we're an NHSC clinic anymore. Loan repayment is a bygone era, funds need to be up front for the workforce, doesn't matter if they stay in a publicly funded program if they're in the field the work will be better. Wellness coaching would be an option for those that don't want EAP. We've heard that this isn't the work they thought they were going to be doing in school. It's too disassociated from the reality of the work in CMHP. Flexing/autonomy of schedules are difficult when regulations around hours and tasks have to be demonstrated to overseers. Fidelity model. Overnight shift expectations make staff leave, as well as few hours between rotations. People say no to offers of sign on or retention bonuses, even though it takes a year to get folks trained in the fidelity models and they are saying no to 18 month commitments.

David Geels: Ditto. It's at the QMHP and clinical management level for retention. Peers and QMHA's are around a four year average, QMHP year and a half. QMHP's have an idea about what they are going to do which is feasible in telehealth but not here. I wouldn't be able to provide a flexible/autonomous schedule otherwise operations aren't covered. Revenue needs to cover costs, if I have three no shows in a day those three no shows don't bring in revenue, same with team meetings. I have staff that have to work harder for certain services. Transportation and time are costs in rural areas, those costs need to be reimbursable. The people that do stay are those that feel community within the organization and team.

Tim Nesbitt: We will be addressing wrap up through email if time runs out today and we are revisiting this

and collecting data and information from you as we go.
Kelli Bosak: Everything on my list got checked off by others. Come from a non-CMHP setting, BH in primary care. Essential to have quality management training to create the sense of community and team. Organizational buy-in from executive leadership level throughout the whole organization of the importance of BH. If it's not in the organization, they will leave for private practice.
Shyra: Would love to participate in the disconnect between the education BH professional receive compared to how it looks like. Had a provider start straight out of school on the Mobile Crisis Team and she was scared shitless and was not equipped to deal with the level of need that is present when dealing with lack of necessities. Resource scarcity within continuum of care – when our providers can't meet clients' needs due to lack of resources, they feel helpless, and the client feels hopeless, and the cycle continues. We might be able to engage folks into detox, but if the residential facility isn't there why are they going to go through detox? Continuum of care needs to be addressed so our providers can feel confident in the care they provide, and the cycle can be stopped.

(Tim Nesbitt) Wrap up/Next steps

Record of Vote
Topic: Approval of 2.21.24 and 3.6.24 meeting minutes
Outcome: Minutes approved

Y	N	Abstain	Absent	
☐	☐	☒	☐	Diane J Bocking
☒	☐	☐	☐	Belindy Bonser
☒	☐	☐	☐	Kelli Bosak
☒	☐	☐	☐	Chris Bouneff
☒	☐	☐	☐	Cheryl Cohen
☐	☐	☐	☒	Sarah Conyers
☒	☐	☐	☐	Deanna Cor
☒	☐	☐	☐	Anthony R. Cordaro, Jr.
☒	☐	☐	☐	Lorie DeCarvalho
☒	☐	☐	☐	Melinda Del Rio
☒	☐	☐	☐	Jose Luis Garcia
☒	☐	☐	☐	David Geels
☒	☐	☐	☐	Qurynn Hale
☒	☐	☐	☐	Clark J Hazel
☒	☐	☐	☐	Jenn Inman
☒	☐	☐	☐	Tony Lai
☒	☐	☐	☐	Lucia Mendoza-Meraz
☒	☐	☐	☐	Shyra Merila
☐	☐	☐	☒	Michael Spencer
☒	☐	☐	☐	Diane Benavides Wille