Multnomah County
FY 2026 Budget Work Session Follow Up

Behavioral Health

May 21, 2025

Commissioner Singleton (District 2) - Is the Bridge program in the Behavioral Health Resource Center (BHRC) funded in the FY 2026 budget?

Response:

Yes, Program Offer 40105B BHRC Shelter/Housing, which includes funding for the Bridge Housing program as well as the BHRC Shelter program is fully funded in the Approved Budget.

Commissioner Moyer (District 1) - Where are people exiting the Behavioral Health Resource Center exiting if they aren't going into more stable housing? The total proposed appropriation for this program offer is $4.12M, with $1.1M from SHS and the remainder from the County General Fund.

Response:

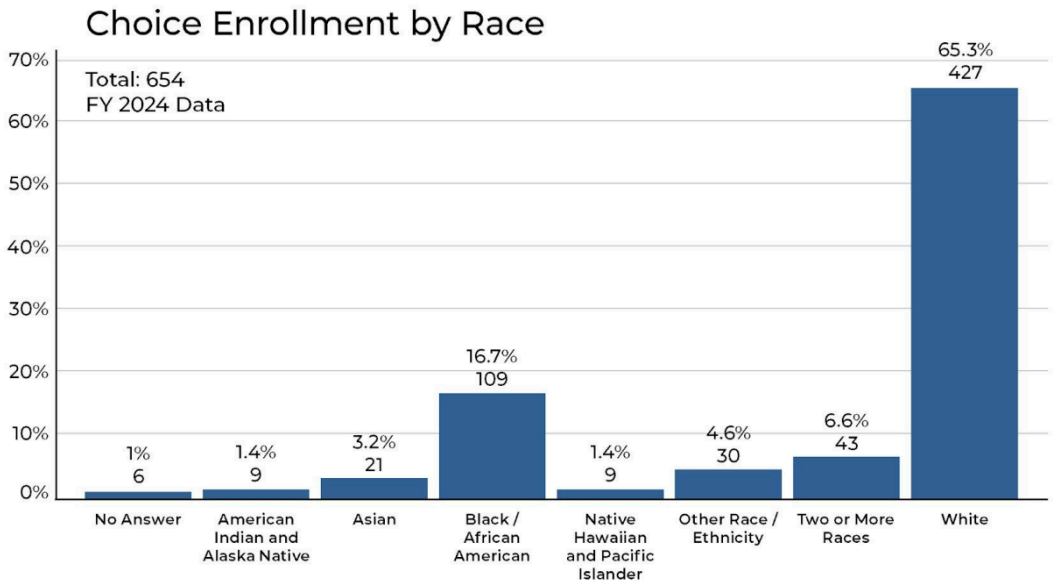
Below is the list of exit placements from BHRC Shelter and Bridge programs:

YTD FY 2025: July 1, 2024 - April 30, 2025		
Exit Placement	**Shelter**	**Bridge**
Emergency shelter, including hotel or motel paid for with emergency shelter voucher, Host Home shelter	65	23
Hospital or other residential non-psychiatric medical facility	1	1

YTD FY 2025: July 1, 2024 - April 30, 2025		
Exit Placement	**Shelter**	**Bridge**
Psychiatric hospital or other psychiatric facility	2	0
Substance abuse treatment facility or detox center	41	0
Transitional housing for homeless persons (including homeless youth)	77	4
Rental by client, no ongoing housing subsidy	3	8
Rental by client, with ongoing housing subsidy	2	2
Staying or living in a friend's room, apartment, or house	3	1
Place not meant for habitation	33	4
Jail or detention	4	0
Other housing	0	1

Commissioner Moyer (District 1) - Regarding involuntary commitments, the indigenous community is significantly overrepresented, but slide 15 doesn't show that we're serving even a number representative of that community. What outreach are we providing to native and indigenous communities?

Behavioral Health Division: Who We Serve



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Response:

The Behavioral Health Division (BHD) coordinates with Native American Rehabilitation Association of the Northwest, Inc. (NARA) and Native American Youth and Family Center who provide focused, culturally specific outpatient services. The Choice Program's outreach is rooted in consistent and ongoing connections with providers and community partners who are working with individuals with Serious and Persistent Mental Illness and have crossover with acute care admissions and involuntary episodes of care.

Choice coordinates monthly with NARA's Assertive Community Treatment program. Consideration of the importance of reaching this population will be centered both as we look at outreach opportunities and as we continue the work to ensure our demographic information is accurately captured in the Electronic Health Records of our clients.

Commissioner Moyer (District 1) - To what degree do we bill private insurers, CareOregon, or Trillium for participation in Early Assessment & Support Alliance (EASA)?

Response:

The total Budget for FY 2026 for the EASA program is $3,948,887; Medicaid revenue makes up $656,665 of this amount. We also bill private insurance for EASA services; this revenue covers a minimal portion of the program's costs (approximately 1%-5%).

Commissioner Moyer (District 1) - Does Oregon Health Authority consider EASA a medically necessary intervention?

Response:

Yes, the Oregon Health Authority considers EASA a medically necessary intervention and includes Early Intervention for Psychosis on the Prioritized List of Health Services for the Oregon Health Plan.

Commissioner Moyer (District 1) - Regarding Slide 26: Do we have a sense, with the Homeless Services Department, how many units or beds do we have in total? Also, what is the estimated size of the population who experience substance use disorder, behavioral health issues/SPMI, or dual diagnoses?

Homelessness Prevention & Response: Program Spotlight

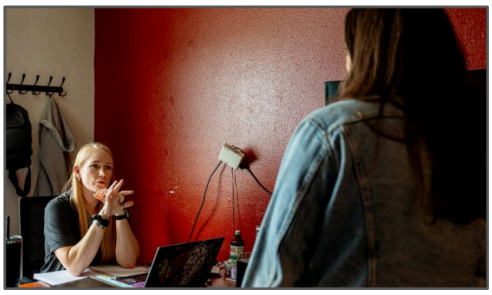
Motel Shelter Programs

Provides housing and wraparound services for up to 76 people, through 2 programs:

- Bridging Connections
- Cultivating Communities

These programs are:

- Peer informed
- Low barrier
- Person centered



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Response:

We have 365 units of Supportive Housing Service (SHS) housing and 150 regional long term assistance vouchers. The Bridging Connections and Cultivating Communities programs, featured in slide 26, represent 70 of those units.

The Point in Time Report under Disabling Conditions, page 12, provides an estimate of people who are homeless experiencing Substance Use Disorder and mental health challenges.

The report states, “A total of 1,448 community members indicated that they experienced one or more disabling conditions in 2023. This was a decrease from the 1,811 people who reported experiencing at least one disabling condition in 2022.

In 2023, the top three conditions identified by people who indicated they had a disability included adults living with a substance use disorder (25.6%), adults living with a mental health disorder (23.2%), and adults experiencing a chronic health condition (21%). Of the people who reported one or more disabling conditions, the median number of disabling conditions reported was 2 disabling conditions and the mean was 2.5 disabling conditions.”

Commissioner Moyer (District 1) - How many inpatient treatment beds are there for people with severe mental illness or dual diagnosis? What is the size of this population?

Response:

There are approximately 377 residential beds to which the county has access. There are additional residential treatment facilities within the county, but the county does not track those beds.

Residential Treatment Homes, Residential Treatment Facilities, and Secure Residential Treatment Facilities provide housing and treatment services to adults diagnosed with a qualifying mental illness and are staffed 24 hours a day. In Multnomah County, we have 90 Residential Treatment Homes, 188 Residential Treatment Facilities, and 102 Secure Residential Treatment Facility units to provide services. In addition to programs that serve people experiencing Severe and Persistent Mental Illness, many providers of treatment for Substance Use Disorder also offer co-occurring disorder services for individuals with mild to moderate mental health concerns.

Commissioner Singleton (District 2) - Do we ask about housing status in all behavioral health work?

Response:

In most Behavioral Health Division work we ask about housing status. In crisis work, housing status will only be asked if it is clinally indicated/appropriate.

Commissioner Singleton (District 2) - Do we contract to Bridgeview? What are their housing placement outcomes?

Response:

Yes, we contract with Bridgeview. Bridgeview's housing placements are as follows:

FY 2024

- 53 individuals served
- 53.8% or 28 individuals were willing to engage in a housing search
- 20% or 6 individuals willing to engage in a search were placed in permanent stabilized housing

FY 2025 Q1, July 1, 2024 - September 30, 2024

- 48 individuals served
- 62.5% or 30 individuals were willing to engage in a housing search
- 66% or 19.8 individuals willing to engage in a search were placed in permanent stabilized housing

Commissioner Singleton (District 2) - On program 40074A, there's an outcome goal related to non-county residents. Are our partner regions helping to pay for the services?

Response:

Referrals to Bridgeview of residents from outside Multnomah County is not the norm and other regions do not fund the Bridgeview program.

The Out of County Placement outcome listed in Program Offer 40074A is related to Licensed Residential Placements (Bridgeview does not fit this category) and is a relevant program data point because the state emphasizes that licensed settings are a statewide resource and requires that Multnomah County can demonstrate that the resource is being shared with other counties. Licensed residential placements are funded primarily through Medicaid.

Commissioner Singleton (District 2) - How are programs 40074A and 40074B related? Both mention the Bridgeview program.

Response:

Program Offer 40074B represents Bridgeview being added back in following the reduction of funding in the department's submission. The program offer narrative will be adjusted in the adopted budget to make this more clear.

Commissioner Singleton (District 2) - Program 40088's outcomes aren't related to the people being served. What are the person-related outcomes for this program, and what are the percentages of successful diversions?

Response:

Recidivism rates are not made available to the Behavioral Health Division. The Aid and Assist team responds to approximately 600 court orders per year, serves several hundred individuals in the community, and facilitates discharges for more than 100 individuals at Oregon State Hospital. Statutory and contractual obligations require extensive reporting and tracking for the court and Oregon Health Authority. Criminal history records are held by the Oregon State Police's Criminal Justice Information Services (CJIS) Division.

Commissioner Moyer (District 1) - What population specifically does program 40088 serve? Do you have statistics on the percentage of individuals who are being served through program 40088 are receiving new charges?

Response:

Program Offer 40088 serves the populations engaged in Aid and Assist and served by the Mental Health Courts. We do not have access to information about people served receiving new charges.

Behavioral Health Division: Strategic Goals/Outcomes

- **Reduce criminal justice involvement** for people with unmet behavioral health needs by intervening in the jail and with the court to **create avenues to services** in the community through our Coordinated Diversion programs (PO40088)
- PATH team will continue **outreach to people with problematic substance use** who are also houseless and at risk of criminal justice system exposure, and assist individuals with placement to appropriate levels of SUD treatment and recovery support services and provide ongoing support to address deficits in social determinants of health (PO40101)

Commissioner Moyer (District 1) - Slide 32 (deflection & sobering program): What are the pros and cons of providing these services through contracted services, internal services, or through the FQHC. What are the various reimbursement rates related to that?

Behavioral Health Division: Strategic Goals/Outcomes

- **Assist individuals who may have substance use disorder**, another behavioral health disorder or co-occurring disorders in accessing community-based pathways to treatment, recovery support services, housing, case management or other services outside of the justice system through Deflection and Sobering Programs (PO40000C, PO40104A, PO40104B)

Response:

The current use of deflection-related funds aims to ensure compliance with the requirements on the County as set forth in HB 4002 by promoting a balance of essential internal capacity for program management and service provision/operational support by external contractors.

The Multnomah County deflection program adheres to both HB 4002 and the terms of the Criminal Justice Commission (CJC) grant that funds deflection. The program has been among the most successful state-wide in terms of total numbers of individuals being referred to deflection. That success is a direct result of a model that prioritizes using internal capacity to maximize coordination and collaboration across government partners, and external contractors to provide a flexible and broad range of services.

Currently, the services offered at the Coordinated Care Pathway Center for deflection are not reimbursable. The type of programming offered at the Coordinated Care Pathway Center, which offers 24/7 referrals into deflection by law enforcement, does not align with the scope of the FQHC model. For that reason, the FQHC was not previously considered for this work.

Current Deflection Program Model: Providing Services through Internal and External Components

Compliance with the state's legal requirements for deflection program implementation as set forth in HB 4002 and the deflection program grant from the Criminal Justice Commission (CJC) specifically requires the County to oversee program coordination, fund management, data tracking and reporting. Maintaining the current level of MCHD's oversight of the program through the

Behavioral Health Division (BHD) supports continued compliance with not only HB 4002, but also the requirements associated with CJC funding.

The deflection program is designed to implement a state law that puts specific requirements directly on county entities. Under the law, the direct requirements on the county are centered around inter-governmental agency coordination, data collection and reporting, management of state grant funds, and program operations and improvements. These categories of work are not traditionally contracted out as they are not direct services and, more pertinently, these functions are defined in HB 4002 as resting with the county entity responsible for the deflection program.

The BHD deflection program staff perform duties that are linked directly to the obligations set forth in HB 4002 and and the CJC grant:

- **Program coordination:** The success of deflection hinges on the continued close collaboration of BHD with law enforcement and other government partners and community partners. This collaboration builds a foundation for political buy-in as well as engagement of the officers who make deflection possible. This coordination role in general, and specifically in the context of deflection, is not one that can be effectively contracted out. The One County approach provides significant pathways between collaborators and out to other service providers. The coordination role is also statutorily required as part of the Community Mental Health Program's (CMHP) system and care coordination functions. BHD, in its role as the implementing agency of the County's deflection program, has a mandate to fulfill this convening role, providing subject matter expertise in both Mental Health and the treatment of Substance Use

Disorder. BHD's long-standing relationships with providers and partner organizations support this work, as do its role within the deflection program leadership and implementation structure and its CMHP function.

- **Data management** - Deflection requires the creation of new data systems and the integration of those new systems with the state-required databases that are used to track program effectiveness (RedCap). BHD has and will continue to use its data infrastructure to ensure compliance with all data requirements, which not only ensures compliance with the law, but also keeps costs down. If, hypothetically, this obligation were to be contracted out (note: doing so could result in compliance issues related to both the law and the grant terms), it is very likely that entirely new data infrastructure would be required, requiring significant investment.
- **Program operations and improvements** - Linked to the data requirements set forth in the law and the grant that lay out deflection program and compliance obligations, BHD has integrated key aspects of deflection programming into the Providing Access to Hope (PATH) team, which provides care coordination services for deflection clients. Integration into the PATH team is critical for ongoing client follow-up and support and will help the program measure long-term progress. The CJC grant currently funds two new PATH staff positions that are specifically assigned to the deflection program. This additional staff capacity has allowed for the effective leveraging of other county resources available through the PATH team to support the program's launch and ongoing operations.
- **Fund management** - CJC grant funds are specifically allocated to counties because the law puts the obligations related to program operations on county entities. CJC currently expects

that those funds support the Deflection Coordinator position, defined in HB 4002, to ensure effective programs are compliant with the law. Additionally, CJC expects that funds will be used to support additional essential staff.

Using externally contracted providers has enabled the program to offer deflection clients access to medical screenings and basic needs screenings as well as connections to care 24/7 following their referral to the deflection program. The contract with Tuerk House to operate a 24/7 facility made those offerings possible. Additionally, the Tuerk House contract enabled voluntary sobering to be offered to deflection participants since its launch in April 2025. Absent this contract, there is not 24/7 capacity for these aspects of the deflection program elsewhere in the County.

Commissioner Brim-Edwards (District 3) - Slides 28-32: Do we have outcomes that are more related to the strategies? What is the outcome/goal of the service, and where are we at meeting those goals, where are there gaps in services? Do we have any benchmarks to compare our data to?

Response:

The Behavioral Health Division (BHD) has program outcomes across each area of work. The outcomes defined in the FY 2026 budget map to our ongoing state requirements and the Comprehensive Local Plan Plus (CLP+). The plan was designed to reimagine our role as administrator of the Community Mental Health Program (CMHP). It builds on existing assessments to identify areas for improvement in the behavioral health system moving from the existing fragmented and siloed state to a coordinated, person-centered continuum of care.

This strategic, system-level approach centers on partner engagement to address needs and gaps, uses epidemiological analysis of population health data and is designed to achieve a desired future state that better determines resource needs and key areas of investment. This planning aims to improve service delivery, meet statutory requirements, and address the growing needs of our community. This work will evolve over time based on input from collaborators and ongoing assessments. BHD will play a key role in leading key capabilities and convening partners to achieve the goals outlined in the plans.

BHD is well positioned to serve as a convener of system partners and a driver of key capabilities that the system as a whole needs to modernize and improve, including data and epidemiology analytics and evaluation, and to bolster tracking of population level outcomes, monitor trends, identify community need and assess program performance.

System Transformation work continues in FY 2025 and FY 2026. A data group has launched to begin identifying desired outcomes, where data lives, who owns it, and who can access it. This will aid the BHD in mapping out systems and networks within the Behavioral Health Continuum of Care using dynamic data from multiple sources within a single interface. This work will define and measure our outcomes, so we can benchmark our data to review our progress.

Specific milestones for next steps include:

- July 31, 2025 - Data to be included in the systems assessment project determined by this date.
- September 15, 2025 - Initial review of preliminary display layouts and interactive visualizations completed by this date.

- November 1, 2025 - Feedback session on updated visuals with feedback from initial review incorporated will be held by this date.
- December 31, 2025 - Final presentation and tutorial will be scheduled prior to this date.

Commissioner Brim-Edwards (District 3) - Slide 8: For the outputs listed, what was the goal? For example, 1,152 individuals of how many total?

Response:

Multnomah County BHD provides training to the public through 'Get Trained to Help'. The trainings are free to the public. The number 1,152 refers to community members trained. The goal is to train as many community members as possible. The trainings lower stigma in the community and provide practical tips for community members who may experience a person in distress, and they raise awareness

of suicide risks. The number of participants we can serve is based on funding availability.

Commissioner Brim-Edwards (District 3) - Please provide more detail on Substance Use Disorder housing (slide 9).

Response:

These are non-Supportive Housing Services (SHS) funded housing units. Also, funding is blended with state, federal, and County General Fund. The Addiction and Prevention unit issues contracts for SUD services for people who are un- and underinsured and for people who have low incomes in Multnomah County. The unit's contracts cover the full continuum of Substance Use Disorder clinical services, such as withdrawal management, outpatient and residential treatment, and recovery support services like recovery supportive housing.

There are various Substance Use Disorder housing models that we fund. **Transitional housing** for people with substance use targets those who have completed and are leaving treatment services. These individuals are generally stable, working on long term recovery goals, and awaiting permanent housing or stable housing placement. Our **supportive housing** is designed for people who are still in treatment, typically either in outpatient or intensive outpatient programs. These are generally staffed by people who have lived experience and who are assisting individuals with their recovery goals, and helping them to navigate prosocial activities while living a recovery lifestyle.

Units	Target population
30	Recovery Mentor Program for graduates who are completing treatment and still in need of on-going employment, recovery, and housing supports
18	DCJ referrals, Medication Assisted Treatment (MAT)/outpatient supported individuals
10	DCJ referrals, MAT/outpatient supported individuals
10	DCJ referrals, MAT/outpatient supported individuals
32	General population
80	General population
8	General population, beds available for People Living with HIV (PLWH) under Ryan White grant
9	General population, culturally responsive services for Black/African-American men
10	Adults experiencing homelessness engaged in African American, culturally specific substance use and mental health treatment
10	Adults experiencing homelessness engaged in outpatient SUD
52	Men and women experiencing homelessness seeking recovery services for a SUD
44	Men and women experiencing homelessness seeking recovery services for a

Units	Target population
	SUD
5	Men and women experiencing homelessness seeking recovery services for a SUD
14	Latino men, culturally specific
8	LGBTQI+ community
9	Women/women with children
349	**Total Units**

Commissioner Brim-Edwards (District 3) - Please provide utilization rates for the Walk-In Clinic. Are we at capacity? Is this a best practice for delivering these services?

Crisis Services: Urgent Walk-In Clinic

Urgent Walk-In Clinic is...

- A vital part of Multco Crisis Services Continuum
- Contracted through Cascadia
- In operation 25+ years
- Open to all ages & demographics 7 days/wk
- Only urgent care behavioral health primary service in the county

Urgent Walk-In Clinic, located at 4212 SE Division St, #100

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Response:

Yes, it is a best practice to have walk-in care available for people experiencing urgent mental health challenges or crises. Everyone who presents at the Urgent Walk-In Clinic gets seen by a counselor, Licensed Medical Provider, and/or peer wellness specialist.

The Urgent Walk-in Clinic experiences consistent utilization including on weekends, with predictable slight spikes in Spring and Fall. Everyone who comes in is seen as quickly as possible. As with any urgent care facility, there are times when there are longer wait times and individuals may opt to return at a later time.

The Urgent Walk-In Clinic serves individuals from all over Multnomah County, as well those from outside Multnomah County. The clinic does not turn away residents from other counties, and will work to support them in accessing their home county resources.

Commissioner Brim-Edwards (District 3) - Please provide a breakdown of the $2 million budget for Preschool for All services in the Health Department program (40099B) and the outcomes.

Response:

In partnership with the Behavioral Health Division, the Department of County Human Services invests in our Early Childhood Prevention and Treatment team in support of Preschool for All. Early Childhood Mental Health Consultants provide a comprehensive continuum of culturally relevant mental health services to children and their families in preschool programs to promote social/emotional development and school readiness. Preschool for All services expand and draw from on our highly effective existing early childhood programming based on the Pyramid Model framework, which

includes evidence-based practices for promoting young children's healthy social and emotional development. Services include early childhood classroom consultation with educators, child mental health assessment and family-centered treatment, case management services, crisis triage, referral to community supports, and parent support and education. A hallmark of this program is Spanish-speaking staff and African American culturally specific counseling and parent support services provided to families throughout Multnomah County.

In FY 2026 the program expects to provide prevention services for 4,000 children, and culturally specific treatment services for 30 children.

Budget Breakdown for PFA:

Personnel: $1.86M*, including 10.73 FTE

- 7.00 Mental Health Consultants
- 1.12 Program Specialists
- 1.12 Program Specialist Sr.
- 1.00 Behavioral Health Supervisor
- 0.24 Data Analysts
- 0.25 Office Assistant Sr.

*Also includes other personnel expense, including premium pay, temporary staffing, indirect expense: $150,000

Internal Services: $146,713

Supplies: $5,700

Commissioner Moyer (District 1) - Regarding School Based Mental Health, was there also one-time-only funded FTE that's not being continued into FY 2026? Possibly a counselor.

Response:

The program did have a Limited Duration position assigned to the program expected to end 6/30/25.

Commissioner Moyer (District 1) - Regarding School Based Mental Health, why was a program specialist added when there is already a program specialist senior? Can the existing program specialist senior not do Medicaid billing?

Response:

An additional program specialist was added to the School Based Mental Health team to adequately support a full operations team to transition to EPIC, build out an encounter and billing maximization plan, train staff in EPIC use, and support quality improvement during the EPIC roll out. It has been our experience that moving to EPIC and rolling out a billing improvement plan requires a front-end investment in operations the first year of implementation as well as ongoing improvement and maintenance efforts.

Commissioner Singleton (District 2) - Why were there CareOregon reductions? For example, was it performance-based?

Response:

CareOregon terminated funding for non-mandatory services across several domains of work including School Based Mental Health work due to financial constraints on their end.

Chair Vega Pederson - Please provide an overall picture of the CareOregon reductions.

Response:

Effective Jan 31, 2025, we were notified that the following scopes of work within BHD were terminated due to CareOregon's financial constraints.

Terminated scopes of work included:

- PO 40082 - School Based Mental Health Outreach and Engagement: $1,000,000
- PO 40074A - Peer Support Specialist in Community Mental Health: $148,069
- PO 40081 - American Society of Addiction Medicine Team: $692,841
- PO 40101 - Projects for Assistance in Transition from Homelessness (PATH) Expansion: $352,483

Commissioner Moyer (District 1) - Do we have any gap analysis on where our Medicaid population is challenged in finding a provider for services?

Response:

There continues to be gaps in behavioral health services for the Medicaid population. Multnomah County's BHD has been working on the Comprehensive Local Plan Plus (CLP+) in order to better describe and address these gaps in services – both with what we provide directly, and also in partnership with OHA, Coordinated Care Organizations (CCOs), CareOregon, and other community providers.

Commissioner Moyer (District 1) - Can we get a breakdown of the potential amount that is going to counties or how much we can apply for in the State legislation?

Oregon Legislature: Session Updates

- **Governor's budget** prioritizes increasing treatment capacity and workforce investments; $90M earmarked in HB 2059
- **Revenue forecast** due May 14; informs 2025-27 biennium budget decisions
- **HB 2059** includes:
  - New residential BH Capacity Program in Oregon Health Authority (OHA) to fund programs that increase statewide capacity for withdrawal management, residential treatment and psychiatric inpatient facilities
  - OHA to develop fund distribution guidelines incorporating partner/ practitioner input with programs funded that have greatest immediate impact on community needs

Current Status: In Committee

Budget Impacts: Unknown at this time

Oregon Legislature: Session Updates

- **HB 2024** (Workforce bill) includes:
  - OHA to establish grant/incentive payment programs to support recruitment of BH workers for entities providing BH services to individuals where at least 50% are uninsured or Medicare/Medicaid enrolled
  - Incentive payments to allow eligible entities to increase wages commensurate with wages at non-eligible entities
  - Appropriates $45M

Current Status: Waiting for hearing by Ways and Means Committee

Budget Impacts: Unknown at this time

Response:

It is too early to estimate a breakdown of potential funding to Counties or funds potentially available from the State. The following factors combine to make accurate funding predictions not possible at this time:

- It is too early in the legislative season. No bills have passed, nor have we received any indications of which bills might pass.
- Given the recent revenue forecast, there is no certainty as to the amounts that may be allocated in relation to requests.

Essentially, any statement of expected funding would be based on incomplete information and would be undoubtedly inaccurate, thus an incomplete platform for planning. We will certainly keep in close contact with the Board of County Commissioners and will share information as it becomes available.

Commissioner Singleton (District 2) - What FTE would need to be restored in program 40068 if part or all of School Based Mental Health's reductions are restored?

Response:

If the full School Based Mental Health services were restored, it is recommended to add back the two staff in Quality Management (QM) who support clinical records and billing:

- The Program Specialist manages critical functions related to billing and the elimination of this position will result in less insurance reimbursement for services. The program needs to build up insurance reimbursements to become financially sustainable. 1.00 FTE $159,973The Business Analyst Senior holds critical knowledge and subject matter expertise related to Evolv which will help the program and staff to transition and find the link between Evolv and Epic. This position will also

continue to support the many teams still working in Evolv since only part of the division is imminently moving to Epic and will provide critical support as additional teams transition over time and/or the division manages two different electronic health records over time. We anticipate this position would require ongoing funding to maintain business processes and support ongoing quality improvement efforts. 1.00 FTE $181,701

Commissioner Singleton (District 2) - Is program 40084A billing Medicaid?

Response:

This is the program offer for culturally specific services. These funds provide services and supports for culturally specific agencies that are not covered by Medicaid.

Commissioner Moyer (District 1) - For all direct service programs, can we get the number of people served?

Response:

We have provided the number of individuals served below, including both the total number of individual primary clients served for FY 2024 and the number of FY 2025 clients served to date.

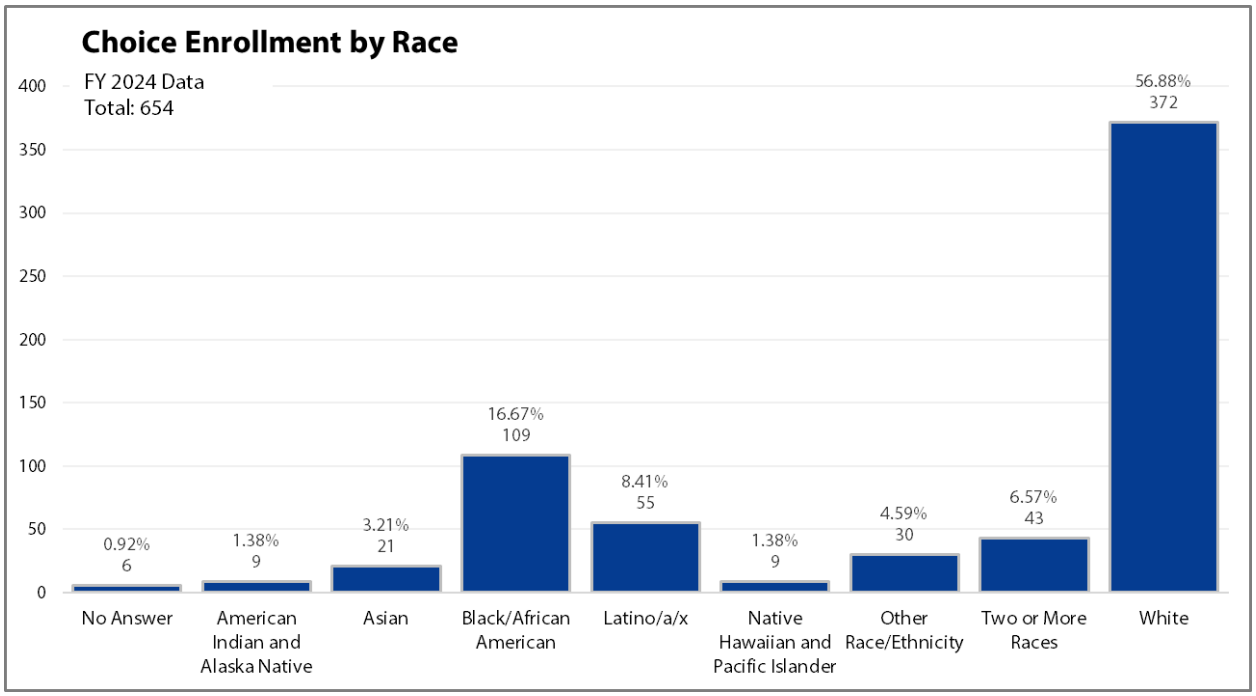
Several BHD direct service programs work with children or young people as the primary client. The service in these programs extends out significantly, as the families of these clients benefit greatly from the therapeutic services provided to their child.

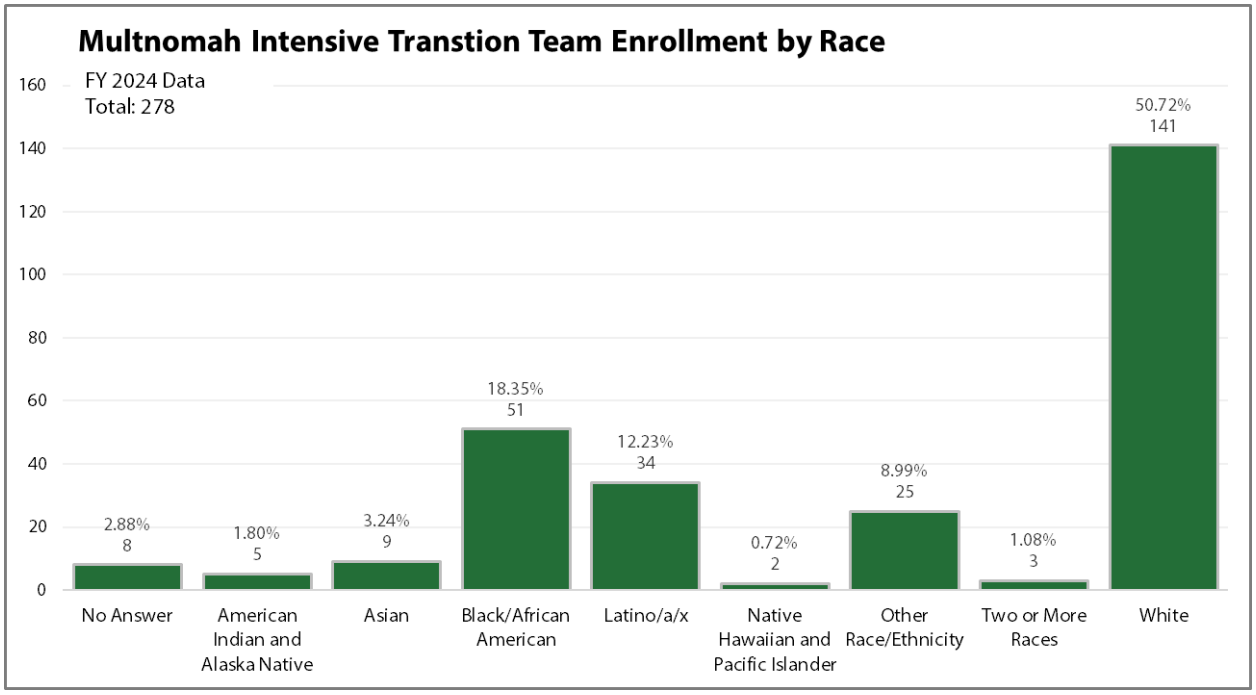
Program	FY 2024 total	YTD FY 2025
Children/Young People Served		
Early Childhood	17	34
K12	174	157
SBMH	494	377
Gun Violence Impacted Families	39	25
Preschool for All	11	3
EASA	195	90
Adults Served		
Bridge Treatment	18	31
PATH	446	675
Multnomah Intensive Transition Team	283	380
Choice	657	659
Children/Youth & Adults Served		
Intensive Care Coordination	305	409
Wraparound Services	188	160

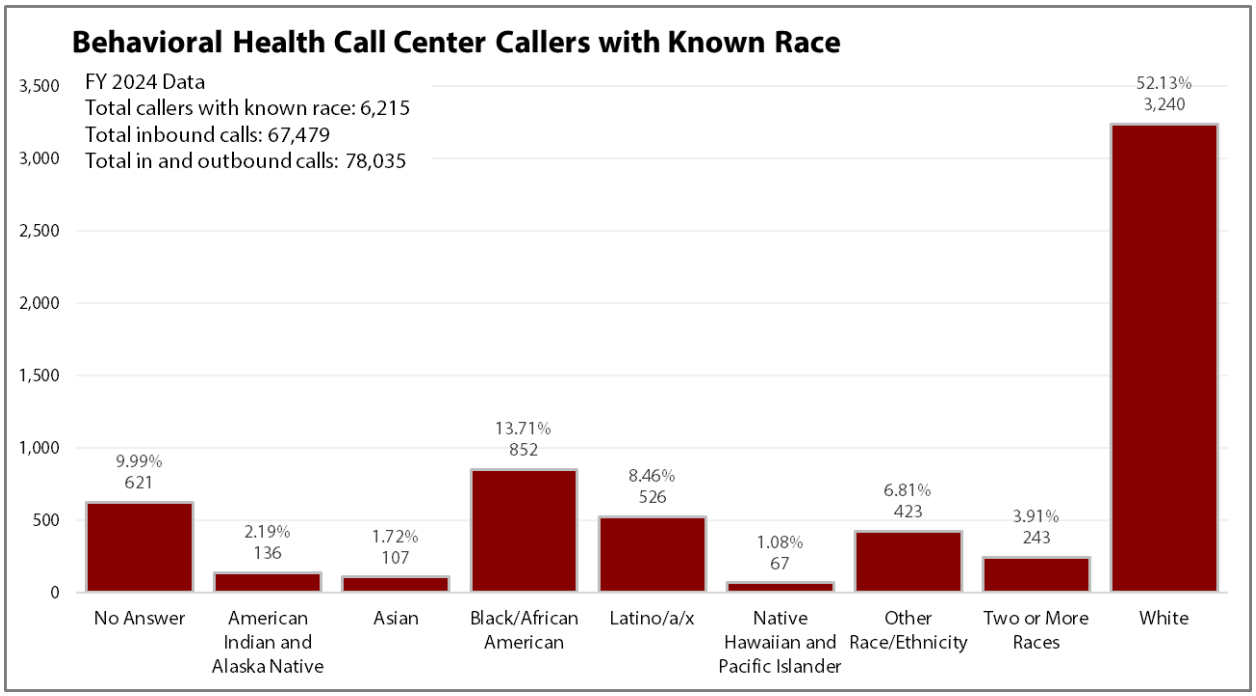
Chair Vega Pederson - Please re-provide all demographic information in the slides with a breakdown that includes the Latinx population.

Response:

The following charts include a specific “Latino/a/x” category separate from “Other race/ethnicity.”




Multnomah Intensive Transtion Team Enrollment by Race
FY 2024 Data
Total: 278
160
140
120
100
80
60
40
20
0
2.88%
8
1.80%
5
3.24%
9
18.35%
51
12.23%
34
0.72%
2
8.99%
25
1.08%
3
50.72%
141
No Answer
American Indian and Alaska Native
Asian
Black/African American
Latino/a/x
Native Hawaiian and Pacific Islander
Other Race/Ethnicity
Two or More Races
White


Behavioral Health Call Center Callers with Known Race
FY 2024 Data
Total callers with known race: 6,215
Total inbound calls: 67,479
Total in and outbound calls: 78,035
3,500
3,000
2,500
2,000
1,500
1,000
500
0
9.99%
621
2.19%
136
1.72%
107
13.71%
852
8.46%
526
1.08%
67
6.81%
423
3.91%
243
52.13%
3,240
No Answer
American Indian and Alaska Native
Asian
Black/African American
Latino/a/x
Native Hawaiian and Pacific Islander
Other Race/Ethnicity
Two or More Races
White

Chair Vega Pederson - Please provide an update on the CLP+ plan and what is the work planned for FY 2026.

Response:

The Behavioral Health Division (BHD) has embarked on a System Transformation project designed to rethink what it means to be the administrator of the Community Mental Health Program (CMHP) beyond a statutory lens. This process is intended to focus on determining what we need, not just what we do, and to move us away from fragmented systems of care to a continuum of care that is centered on people and services where any person can get the care they need where and when they need it. Consensus across partners is that BHD is well positioned to serve as the convener of system partners and to drive key capabilities that the system as a whole needs to modernize and improve, including data analytics, evaluation, and epidemiology.

This System Transformation work of our CLP+ will continue in FY 2026. The Behavioral Health Division will map out systems and networks within our community's behavioral health continuum of care using dynamic data from multiple sources within a single interface so that we can understand and address needs and gaps to create a comprehensive, person-centered system of care. This will guide the BHD to understand areas of greatest need and to work with systems partners to create a continuum of services that are accessible, helpful for those who need them, and of benefit to our community as a whole.