DEPARTMENT OF HUMAN SERVICES
REPORT TO THE STATE EMERGENCY BOARD
June 2006

RESPONSE TO SPECIFIC INFORMATION REQUEST:
HB 5023-A Budget Note
Children's Mental Health System Change Initiative

INTRODUCTION

The Department of Human Services (DHS) was directed by a Budget Note within HB 5023-A from the 2005 Legislative Session to report to the June 2006 State Emergency Board with a report on the status of the Children's Mental Health System Change Initiative.

This report summarizes the changes made to the child and adolescent treatment system, the impact of these changes upon children, their families, and service providers, as well as the work that still needs to be completed.

BACKGROUND

The 2005 Budget Note (HB 5023-A) directed DHS to report to the Emergency Board on efforts to improve the coordination of care in the children's mental health system in response to directives from the 2003 Legislative Assembly. A copy of the 2005 Budget Note is included as Attachment A. The 2003 detailed budget note (HS-3) is Attachment B.

As directed, the report describes changes made to the system, the impact of these changes upon children, their families, and service providers, as well as the work that still needs to be completed. This work included adopting a set of principles to guide the changes to the system. On October 1, 2005, the intensive treatment services Psychiatric Day Treatment Services (PDTS) and Psychiatric Residential Treatment Services (PRTS) were included in the managed mental health care contracts. Providers contracted directly with Mental Health Organizations (MHOs). Either the MHOs or the county mental health programs for fee-for-service children assured care coordination for families and approved admission to the intensive treatment services. This represented a major shift in service delivery, support to families and for providers.

STATUS UPDATE ON CHILDREN'S MENTAL HEALTH SYSTEM CHANGE INITIATIVE

As a state-wide system reform effort, the goals of CSCI are to increase the availability and quality of individualized, intensive, and culturally competent home and community-based services so that children are served in the most natural environment possible and so that the use of institutional care is minimized. CSCI requires local or regional managed care environments to bring together isolated service components with a known, rational process for access, and provide care coordination to assist parents in accessing other supports in an integrated and collaborative manner. The children's mental health system now has a standardized method of determining a child and family's level of service need, assures care coordination, includes service flexibility and interagency collaboration, and increases accountability at a local and state level. Services are community-based with management, decision-making, and service delivery occurring at the local level.

There are numerous examples of children receiving in-home and other family support services, intensive community-based services being developed and delivered, families being supported to the point of closing their DHS voluntary placement agreements, and family involvement at the case and system level that was previously unimaginable. For example, a family receiving services through Washington County states,

> "My wife and I now feel like we have a sort of advocate to act on our and our sons' behalf. Christopher (staff) is always available to answer our questions and help us look at all of our options to ensure our son becomes a productive member of society. We are very impressed not only with Christopher, but with the mental health services that Washington County has begun to implement."

Sustainable system reform will take time to fully realize the benefit to children and their families. Providers have been required to adapt and change business practices, partner with a new set of constituents, and deliver services with different expectations. These changes have been difficult for some providers. There have been multiple successes and multiple challenges with the initiation of the Children's System Change Initiative. Everyone involved is learning from the challenges and using the information to build a successful future. The CSCI was

not designed to remedy every child serving system deficit, in fact it has further elevated the importance of the interconnectedness of all aspects of local and state systems. OMHAS is confident that as we work through the early challenges, the children's mental health system will be better organized to deliver meaningful family driven, community-based services to children and their families. The ultimate goal is to provide intensive community-based services so that children and their families receive services to keep a child at home, in school, with friends, and out of trouble.

System Design Prior to October 1, 2005

Prior to October 1, 2005, children's funding was separate and uncoordinated. Acute care and outpatient services were administered through Mental Health Organizations and Community Mental Health Programs. Psychiatric Day Treatment Services (PDTS) and Psychiatric Residential Treatment Services (PRTS) had been administered through direct state contracts outside of the local system structure. From a system design perspective they were disconnected from the rest of the children's mental health system. In general these providers made independent admission and discharge decisions and had limited involvement in Oregon Health Plan eligibility, enrollment, and payment. Care was not coordinated for children with the most intensive need for mental health services. This system design left parents and caseworkers alone to navigate a very complicated system and did not provide communities the opportunity to develop intensive community-based services.

Changes Made to the System Since July 1, 2005

1. The Oregon Health Plan funds for PDTS and PRTS were moved to Mental Health Organizations (MHOs) in order to create single points of authority and accountability. Distributed additional state General Funds to Community Mental Health Programs (CMHPs) to enhance system capacity for children and families not eligible for Medicaid.

   Impact on Families: Provides local, centralized assessment of needs and access to services. Increased access to care coordination and service coordination planning. Families are provided flexible services and supports to keep a child in home and at school rather than in an institutional setting.

Impact on Providers: Increased capacity for CMHPs to be responsive to the mental health needs of families in their communities. Intensive treatment services providers have been required to develop contracts and protocols with multiple MHOs resulting in increased complexity for the providers. Communication and collaboration between system partners and providers has been improved.

2. Adopted a uniform community-based method to assess level of mental health need and to make referral to the appropriate level of mental health services.

   Impact on Families: Easier access and more timely response to identify needs and initiate appropriate planning and make referrals to needed services. A local screening and referral process is in place for children who are not Medicaid eligible but would benefit from Psychiatric Residential Treatment Services (PRTS). Multiple points of referral and a single point of access have been created to assist with accessing and connecting the right types of service most beneficial to the child and family's needs and strengths.

   Impact on Providers: Community assessment and access is standardized in contrast to being independently developed by providers. Level of need determination includes use of the Child and Adolescent Service Intensity Instrument (CASII) and consideration of other risk factors. Referrals to PRTS and PDTS are centralized at the community level as compared to the program level. These providers have had to develop new community relationships and to modify their admission procedures.

3. Added Mental Health Organization (MHO) contract expectations for assessment (level of need determination), continuous care coordination, child and family teams, coordinated service plans, community care coordination committees, local or regional advisory councils, and a state advisory committee. Revised Community Mental Health Program (CMHP) requirements to implement screening, referral and service coordination planning for children and adolescents.

   Impact on Families: Family members elevated to key participants in service planning and system oversight. Families feel more in control of treatment decisions and better supported through the process – their voices

are heard. Child and family teams focus on strengths and comprehensive planning; they provide continuity of care.

Impact on Providers: Providers must ensure that care coordination is provided. This is a significant change in service requirements that will take time to develop and integrate into existing delivery systems. There is increased collaboration and communication between MHOs, CMHPs, and providers. All parties are fully informed and share responsibility for the implementation of service planning.

4. Adopted new administrative rules that define standards for Intensive Community-Based Treatment and Support Services. Reviewed applications for and certified 51 providers of Intensive Community-Based Treatment and Support Services (ICTS).

   Impact on Families: Minimum standards defined for access to care coordination and a service planning process that is strengths-based and family-driven. Needs are identified across all domains of the family's life. The team remains involved over time and through episodes of care and across levels of care ensuring continuity of care. There is increased access to and involvement of child psychiatrists. Expanded definition of service array to include emergency and planned respite, skills training and services provided at flexible locations like the home and school. Capacity created for family members to be hired as paraprofessionals who provide supportive services to other families.

   Impact on Providers: Ensures that care coordination is provided between levels of care and providers. Responsibility is shared in the team-driven approach. There are increased opportunities for innovative solutions to service delivery and program development that allows providers to expand the array and diversity of services. Providers are challenged to meet changing demand and modify service delivery models.

5. Established working agreements with child welfare, juvenile justice, and education to assure a common understanding of the mental health system changes.

   Impact on Families: Better communication/coordination of services for children who are involved with multiple systems. In response to a recent family satisfaction survey, 59% of the families reported involvement with

mental health and two other child serving agencies. Agency collaboration is critical to family members who have children with serious emotional disorders.

Impact on Providers: Provides the ground work for a common understanding between child serving agencies. This allows providers to better organize to meet the needs of children who are involved with multiple systems. State agency level agreements are not specific enough for some communities and providers, there continues to be a need for the development of local interagency agreements.

6. Collaborated with the Oregon Department of Education on a conference to improve the partnership between education and mental health in implementing the Children's System Change Initiative (CSCI).

   Impact on Families: Better outcomes for children and families are achieved when there is collaboration between mental health and schools. Families have consistently identified frustration and difficulty navigating services between mental health and education.

   Impact on Providers: Better understanding of respective systems, improved communication/collaboration, better outcomes.

7. Provided cultural competency consultation to evaluate the children's mental health system and recommend improvements.

   Impact on Families: Increased culturally competent services and supports that are responsive to the demographics and diversity of families. Services are more supportive to their individual needs and strengths.

   Impact on Providers: Identification of strengths and areas of improvement addressed through workforce development. The competency level in the system has increased to meet the diverse needs of children and their families. There are ongoing challenges for providers in hiring and retaining staff who are able to deliver culturally competent services.

8. Revised Policy Three - Meaningful Family Involvement with input from the Children's System Advisory Council (CSAC) to include the definition of Family-Driven Care as used by the national organization Federation of Families Children's Mental Health.

Impact on Families: Clinical and system change efforts are consistent with the national definition of family-driven care. Families are active participants in case and system planning. Currently, the Oregon Family Support Network has formal relationship agreements with over 20 communities and providers throughout the state. Seven family members are employed by counties and MHOs have created family member partnership positions to develop and promote family involvement and family driven care concepts.

Impact on Providers: Better understanding of what it means to be family-driven and involve families at all levels of service provision. Challenges providers to adopt service delivery models and involve family members in case and program level planning.

9. Funded workshops facilitated by NAMI and OFSN that trained family members and professionals in collaborating as system partners. A total of 64 family members have been trained.

   Impact on Families: Improved understanding of professional partners and ability to collaborate with them. This has led to a significant increase in family involvement in some parts of the state. Training will continue to ensure all regions of the state have family members who have the knowledge, skills, and abilities to actively participate in the system.

   Impact on Providers: Improved understanding of families and ability to collaborate in a manner consistent with best practice. This change challenges providers to involve families in a new partnership model. Some providers are having difficulty either finding family members who are prepared to participate or engaging parents in the program processes.

10. Updated, with stakeholder input, Policy Six - Financing to reflect modifications to the three-year financing glide path that aims to stabilize system infrastructure and promote local system development.

    Impact on Families: Existing service infrastructure continues to be available while communities expand and enhance community-based services.

    Impact on Providers: Funding can be used more flexibly over time without destabilizing infrastructure. Financing glide path defines a time

period for providers to adjust business practices. Glide path limits a community's ability to reinvest resources that are dedicated to certain levels of care and provider types.

11. Established and continue to refine new outcome and process measures that include child/family outcomes and system information based on an agreed upon set of measures that are established in OMHAS policy.

    Impact on Families: Contribution to and understanding of desired outcomes in order to monitor the system and make improvements. Families will be able to make service choices based on data and outcomes. Families will have the benefit of data to advocate at local, regional, and state levels.

    Impact on Providers: Systematic way to measure outcomes and initiate quality improvement. The dissemination of regular reports will allow providers to objectively adjust service delivery models based on client and system outcomes. While providers have been involved in developing statewide outcomes, some providers may have to report information they have not previously collected or reported to the state.

12. Prepared performance expectations through a Quality Data Improvement Workgroup. Monitoring the system on a regular basis to ensure that funding intended and allocated for children's mental health services is used for that purpose. OMHAS distributes a revenue and expenditure report by county on a regular basis that compares the percent share of capitation payments made to MHOs to the percent share of usual and customary charges. Historically, children's mental health advocates have been concerned that funds allocated for children's mental health were being spent for adult mental health services.

    Impact on Families: Families and system advocates have uniform reporting that demonstrates revenue and expenditures to hold local system accountable for funding allocations. Contract expectations and regular reporting assures that the funding intended for children's mental health services is spent for those services.

    Impact on Providers: MHOs are contractually accountable to assure mechanisms are in place that monitors resource allocations and expenditures. Children's mental health providers can be assured that local resource allocation matches the local revenue.

13. OMHAS has contracted with Portland State University (PSU) to evaluate the implementation of the CSCI. The evaluation will determine the degree to which infrastructure and service delivery changes are occurring to address the intent of the CSCI. It is not anticipated that there will be child and family level outcome data associated with this baseline assessment.

Impact on Families: Families will provide feedback and be kept informed about how the CSCI is being implemented. Evaluation methodology will closely analyze how local and regional systems and the state is organizing systems in partnership with families.

Impact on Providers: An objective evaluation of system design will be conducted to identify strengths, weaknesses, and gaps in the delivery system. This evaluation will provide qualitative analysis that demonstrates how the system is implementing the principles of CSCI.

Problems Identified and Steps Taken

1-1. Problem: Diagnostic codes not matched with PRTS procedure code.

1-2 Steps Taken: OMHAS worked with the Health Services Commission to make technical adjustments to the diagnosis code and procedure code pairings on the prioritized list for Psychiatric Residential Treatment Services (PRTS) to ensure reimbursement for provided services.

2-1 Problem: MHO enrollment instability. This resulted in greater numbers of children being in fee-for-service (FFS).

2-2 Steps Taken: Problems identified and action steps taken by DHS management and staff include:

- increasing communication between DHS units by establishing a steering committee comprised of DHS CAF, Children's Medical Project Team, OMHAS, and OMAP Health Management Unit;
- implementing an automated weekly enrollment process for MHOs instead of the current monthly process;
- filed a revised administrative rule on an emergency basis on May 4, 2006, to ensure consistent and correct MHO enrollment and limit exemptions from enrollment;
- reviewing enrollment procedures for the Children's Medical Project Team to ensure that enrollment decisions are accurate; and

- ensuring that proper and consistent procedures are followed in the OMAP, Health Management Unit, and by identifying senior staff to review all requests for action.

3-1 Problem: Higher than predicted utilization of fee-for-service billings for services provided in PRTS.

3-2 Steps Taken: Problems identified and action steps taken by DHS management and staff include:

- retroactive review of 233 children for whom FFS payments were made for PRTS;
- developed a strategy to recover duplicate payments made to PRTS providers for children who had continuous MHO enrollment (without adversely affecting the cash flow of small provider organizations);
- developed a strategy with CAF/Child Welfare to minimize the number of children who meet criteria to be exempt from MHO enrollment;
- revised the OMHAS enrollment protocol to maximize MHO enrollment;
- required CMHPs to conduct a level-of-need determination and approve the referral to PDTS and PRTS for children who are not enrolled in a MHO; and
- collaborated with county Community Mental Health Programs to improve discharge planning from PRTS for children exempt from enrollment.

4-1 Problem: Lack of clarity about roles of care coordinators from MHOs, CMHPs and providers regarding system and clinical oversight, utilization review, authorization and approval of recommended services, and identification of clinical needs.

4-2 Steps Taken: Problems identified and action steps taken by DHS management and staff include:

- collected and discussed feedback from stakeholders through the state Children's System Advisory Committee in order to identify and understand where problems are occurring in the system;
- clinical and system issues discussed and problem solved in detail at monthly state Children's Mental Health System Coordinators meetings;
- collaboration with and technical assistance provided to CMHPs and providers at CMHP certification site reviews; and
- MHOs, CMHPs, and providers collaborating and problem solving at local and area interagency committees and advisory councils.

5-1 **Problem:** Identification of and planning for workforce development needs such as care coordination and family involvement.

5-2 **Steps Taken:** Problems identified and action steps taken by DHS management and staff include:

- Collected and discussed feedback from stakeholders through the state Children's System Advisory Committee in order to identify and understand workforce development needs;
- OMHAS conducted a work group comprised of stakeholders who gathered data about current training efforts and areas where training is needed in their respective communities;
- group made recommendations about how these needs can be met by sharing resources; and
- workforce development will occur in tandem with increasing the use of evidence-based practices.

6-1 **Problem:** Difficulty in coordination and continuity of care between MHOs and CMHPs when children move from their home communities.

6-2 **Steps Taken:** Problems identified and action steps taken by DHS management and staff include:

- ongoing collaboration between OMHAS, CAF/Child Welfare, and providers to improve service coordination;
- increase proactive planning and preventive approaches to decrease need for crisis placement;
- provided consultation to MHOs, CMHPs, and providers to ensure that enrollment policy and procedures are well understood and practice is consistent with policy; and
- timely communication with affected stakeholders when policies and procedures are revised.

7-1 **Problem:** Inconsistent communication about the system change and lack of uniformity in its implementation.

7-2 **Steps Taken:** Problems identified and action steps taken by DHS management and staff include:

- reviewed working agreements with other state child-serving agencies;
- identified and removed barriers to the development of collaborations at the local level;
- provided guidance and technical assistance to local and area interagency committees and advisory councils;

- developed strategies to improve communication about and uniform implementation of the system change at the local level; and
- analyzed and disseminated data on a regular basis to monitor progress with implementation and inform system improvements.

CONCLUSIONS AND NEXT STEPS

The 2003 Legislative Assembly directed the Department of Human Services to implement significant changes to the children's mental health system. That Budget Note emphasized that children and adolescents with severe emotional disorders need and benefit from services that are coordinated, comprehensive, culturally competent, delivered in natural environments and often require multiple interventions to be successful.

System of care research and evidence-based practice clarifies the need for continuation of the Children's System Change Initiative. It is well known that children with severe emotional disorders need and benefit from:

- assessment that looks across all life domains and uses family input;
- care coordination that includes multiple system collaboration;
- in home and in community supports that includes behavioral supports, crisis services, treatment services, and natural supports;
- a child and family team process; and
- a broad array of treatments and supports based on the individual needs and strengths of the child and family.

The Children's System Change Initiative has been an ongoing effort among families, advocacy agencies, MHOs, CMHPs, non-profit providers, and state agencies. There have been changes in financial allocations, contracts, family and advocacy involvement, system collaboration, service delivery, administrative procedures, workforce development, and system oversight. The CSCI has affected all aspects of the children's mental health system. The children's mental health system has experienced multiple successes and multiple challenges since the initiation of the Children's System Change Initiative. OMHAS will work from the community up and administration down to ensure that meaningful services are delivered to children and their families.

Families have experienced a different system in the past year; one family shared the following experience with services now being delivered in many parts of the state:

> "I would like to tell you how much my family and I have benefited from the coordination of services that your department has provided.
>
> My son has been getting services from the school districts since he was 2 years old. It was always a time consuming process to get new services as he needed them. Last summer he participated in the extended school year until the middle of August. For the next two months the school and ESD tried to figure out some program for him to be in for the regular school year. During this time, he was not attending school except for a couple of hours a week of tutoring (4 sessions total).
>
> Then, we got connected with the wrap-around services program. What a difference! All of the sudden people were calling me to set up family counseling, evaluations of my son for mental health problem as well as medications. Staff got all the ESD and school people to work together and figure out a place for him to go to school.
>
> With help and support we have gotten from this program, our lives have literally gone from chaos to manageability. And my son goes to school five days a week. Thank you so much for all your help. Keep up the good work."

From the providers' perspective, the changes have been challenging and an opportunity to form new relationships and expand services into new regions or develop alternative services.

Change of this magnitude takes time to stabilize. At this point, the system is in the early stages of change and there continues to be concerns, problems, and frustrations; however, it seems clear from the perspective of families, we are on the right track.

Next Steps:

- DHS will continue to resolve the problems with managed care enrollment and fee-for-service reimbursements for youth in PRTS.
- Problem solving technical assistance will be targeted where most needed.
- The work to define and collect outcome measures will be completed and the outcomes added to currently produced reports by Fall 2006.
- The financial reporting comparing managed-care revenue and expenditures by age group will continue. OMHAS staff will work with MHOs and Counties where there is a seeming under expenditure on services to children.
- Completion of the Portland State University Regional Research Institute evaluation of the implementation of CSCI will be completed by November 2006.
- OMHAS will use this to target additional training and technical assistance.
- Report monthly to the Children's Services Advisory Committee on the progress of the CSCI and OMHAS actions.

Attached to this report is:

Attachment A – 2005 Budget Note
Attachment B – 2003 Budget Note