Resources for Recovery
Agency: Office of Mental Health and Addiction Services

Problem Summary

The concept thought to have the most potential for creating a positive system impact involves system management improvements geared toward the Level III / Residential portion of the treatment continuum including transition into and out of Level III. The following system management issues will be addressed during the Policy Forum:

- Current fiscal and administrative incentives to efficiently move clients through the residential portion of the treatment continuum are insufficient.

- The residential treatment system is funded through three different fiscal mechanisms including direct contracts between OMHAS and providers, contracts with counties who sub-contract with providers, and other local financing mechanisms. Therefore, there is no standardized financing or management approach to this portion of the continuum.

- The system would greatly benefit by creating more structural supports for effective transition between the residential treatment and community-based outpatient treatment, transitional housing and other housing supports, and other recovery supports.

- Expanding implementation of motivational enhancement strategies and matching treatment services according to client readiness to change may also improve the treatment systems ability to make better client placement decisions and more effectively treat clients in a residential setting.

Program History

OMHAS contracts with counties for the provision of public-funded chemical dependency treatment services (excluding Medicaid). Regional residential services are funded through a combination of direct contracts, county contracts, and local options. Until March 1, 2003, a significant portion of the outpatient treatment capacity was funded through Oregon's 1115 Medicaid Waiver program, the Oregon Health Plan, for low-income adults. For a variety of economical and political reasons, Oregon's substance abuse service structure has evolved into a "collection of services" rather than a "system of services." For instance, one portion of the system, Outpatient, greatly expanded with the implementation of the Oregon Health Plan, while no additional services were expanded under the residential portion of the system.

A Residential Facilities Workgroup was recruited in the Spring of 1996 to study the design, funding and delivery of residential treatment services in Oregon and make recommendations to OADAP (now OMHAS) regarding improvements to the system by June 1, 1996. Problematic features of the residential system were identified including, but not limited to: Lack of transitional housing; Inadequate access to treatment in some geographic areas; Incentives to utilize a full continuum of care are lacking; Care is not "managed" at the residential level. The work group report also stated, "Level of care criteria are not uniformly applied; Residential reimbursement rates are inadequate to support required level of care; Workforce has minimal training and experience, yet are expected to work effectively with patients whose advanced stage of addiction qualifies them for Level III care; Availability of beds and the features/strengths of individual programs are neither coordinated nor communicated at a statewide level among others." A number of the issues included in the report have been resolved, however, system challenges still exist and some of the challenges identified years ago have not been adequately

addressed. The following information summarizes progress made with regard to the residential treatment continuum and challenges we still face in a few key areas.

Transitional Housing

Progress: The OADAP proposed budget for fiscal year 1999 – 01 established a goal of increasing transitional housing throughout Oregon. The budget was approved by the legislature and an additional $2,000,000 was allocated for drug-free housing in the OADAP budget. OADAP hired a housing coordinator to provide technical assistance to communities wanting to develop Oxford houses and other transitional housing options for people in recovery. OADAP coordinated with the Department of Housing and Community Services to leverage additional funds for transitional housing through their revolving loan account. The funds allocated by the legislature continue to support an outreach coordinator who assists in opening Oxford houses. There are more than 100 Oxford homes throughout Oregon today.

Challenge(s): Despite this growth in capacity for drug-free housing, there is still a service gap in terms of the availability of this support particularly for individuals transitioning from residential treatment settings back to rural areas of the state. Anecdotal reports from residential treatment providers and outpatient providers indicate there is still a great need to develop more housing supports for individuals in recovery and strengthen the linkages between transitional housing supports and components of the treatment continuum. Lack of housing may drive clients who could otherwise be served in less costly outpatient programs to use residential services instead. Because housing resources are scarce or unavailable, individuals who could benefit from less-costly outpatient treatment may be retained in residential services to accommodate their housing needs.

Intensive Outpatient and Day Treatment Capacity

Progress: The outpatient treatment provider community continued to grow between 1996 and 2003 due to the implementation of the Oregon Health Plan. Approved / licensed treatment programs grew in number by about one third and the number of treatment admissions grew from 53,200 enrollments in 1995 to 73,772 in 2002. Virtually no waiting lists for outpatient treatment existed while Oregon Health Plan chemical dependency benefits were available to the OHP expansion population. Intensive outpatient services became more accessible as treatment providers became more familiar with the ASAM criteria and adjusted their treatment models to meet the intensive outpatient treatment demand. “Program driven” services became more “individualized” in their approach to treating clients in outpatient settings.

Challenge(s): While every county in Oregon has access to outpatient treatment, a full range of outpatient services is not physically available in every county. This creates barriers and expenses to accessing treatment for people in those counties. This issue is particularly critical for adolescents in need of treatment in rural counties. The November 2002 Legislative Emergency Board cut mental health and chemical dependency benefits for more than 118,000 people who were covered under the Expansion, or Standard, benefit package. OMHAS estimates that nearly 30,000 adults will not be treated for substance abuse and mental health disorders in the 12 months beginning March 1, 2003. This action will contribute to increase wait lists for outpatient treatment services and will have a negative impact on those individuals needing access to residential services since outpatient services are the gateway into residential treatment services. OMHAS is already hearing from Child Welfare, Self-Sufficiency, and Juvenile/Criminal Justice partners that access to community-based outpatient treatment has become challenging. OMHAS conducted a survey of treatment providers following the E-Board

action to determine the degree to which the cuts have destabilized the treatment infrastructure, e.g. staffing patterns, workforce, and wait lists. 54% of the providers responded to the survey and over 20% of those responders indicated the cuts have prompted significant staff layoffs and a wait list for outpatient services. Preliminary data from the OMHAS Client Process Monitoring System suggests there has been a significant decline in the number of new treatment admissions statewide. There were 5,205 new admissions for the month of March 2002 compared to 3,094 new admissions in March 2003. Diminished outpatient treatment capacity will negatively impact residential provider's ability to effectively transition clients from Level III services to community-based outpatient services and supports. Additionally, since outpatient treatment is the "gateway" to accessing residential services, residential treatment providers will likely experience a negative impact in terms of meeting bed utilization requirements.

Residential Rates

Progress: In a 1997 budget note, the Legislative Assembly instructed OADAP (now OMHAS) to establish equitable residential reimbursement rates. Under OADAP contract, Starling and Associates (September, 1999) conducted a study of residential rates, and found the average daily cost of providing these services to be:

Average Daily Cost of Residential Treatment

Client	Facility size*	Level 3.1	Level 3.2
Adult	Small	$159.16	$181.13
	Large	$109.57	$122.10
Adolescent	Small	$185.07	$213.74
	Large	$123.75	$142.81

* Cut-off point, small to large facility = 18.5 beds

In SFY1999, OADAP established a plan to stabilize residential spending and equalize rates for all providers. OADAP established a rate of $100 per day for adults and $113 per day for youth. This restructuring was financed in part by obtaining additional federal Title XIX Medicaid reimbursement for the clinical portion of residential care.

Challenge(s):

Current fiscal and administrative incentives to efficiently move clients through the residential portion of the treatment continuum are insufficient. OMHAS monitors residential bed utilization to ensure the beds are consistently 100% utilized. However, there is no standardized monitoring approach to ensure that clients in public funded residential beds meet the placement and continued stay criteria, are progressing appropriately in treatment, and receiving adequate transition services in preparation for discharge to community settings. Insufficient staff time and resources prohibit movement on developing a system that would address this issue.

Level of Care / Patient Placement

Progress: In 1998, OADAP revised the Oregon Administrative rules governing the provision of residential treatment services to incorporate the American Society of Addiction Medicine (ASAM) Patient Placement, Continued Stay, and Discharge Criteria (PPC 2-R). This action coincided with the timing of the residential rate restructuring described in more detail above and helped to create more cohesive standards applied to all levels of service within the treatment

continuum. (The criteria applied to outpatient programs effective November 1995, coinciding with the implementation of the Oregon Health Plan, however, did not apply to residential programs.)

Challenge(s):

As described earlier, there is no standardized management approach to ensure that individuals accessing public funded residential services meet the placement, continued stay, and discharge criteria for this level of service with the exception of periodic onsite regulatory compliance reviews conducted every two years as part of the licensing / approval process. Further, there is no statewide or central management approach to coordinate or communicate residential bed specialization, e.g. cultural specificity, age limitations, dual diagnosis capacity; availability or accessibility. Legislators have raised this concern during budget hearings in the past two biennia, however, there have been no resources allocated by the legislature to implement such a system. Developing a statewide quality assurance / utilization management system for residential treatment beds in the current fiscal climate is cost-prohibitive.

Basic Program Profile

During state fiscal year 2001 – 02, a total of 64,885 individuals were served in Oregon's public funded AOD system. Types of services provided, total number of unduplicated treatment episodes by services element, and source of funds are documented below:

ASAM Level of Service	Service Element Description	# of Unduplicated Treatment Episodes* FY 01-02	Expenditures by Service and Source of funds		
			State General Funds	Other Funds**	Federal Funds***
ASAM Level .05	Education / Information	2,607		$40,700	
ASAM Level I and II	Outpatient and Intensive Outpatient Treatment (includes DUII offenders)	55,249	$2,638,300	$5,399,900	$7,727,800
ASAM Level I and II	Synthetic Opiate Replacement / Methadone	5,366	$57,900	$10,500	$58,200
ASAM Level III	Residential Treatment	6,035	$4,337,400	$4,791,400	$10,529,500
ASAM Level III	Sobering / Detoxification	4,366	$229,700	$105,400	$566,600
	Total Episodes for all Levels	73,623			
Special Projects****	Treatment Enhancement Projects	(Captured in above numbers)	$1,018,800	$290,700	$4,352,800
		Total Revenues	8,282,100	10,638,600	23,234,900

*"Treatment episodes" include individuals who may have participated in more than one service element, therefore, this number is higher than the number of individuals served for the fiscal year. Total units provided is not available as this is not something we currently collect in our data system.

**"Other funds" include Beer and Wine tax revenues, fines/fees collected through the Intoxicated Driver Program Fund, and miscellaneous revenues.

***"Federal funds" includes SAPT block grant funds and Medicaid/Title XIX revenues for residential expenditures portion only. Other Medicaid revenues supporting outpatient chemical dependency treatment are reflected in the Office of Medical Assistance Program's budget.

****"Special Projects" refers to treatment enhancement grants that were awarded to select counties for the purpose of addressing gaps in the service continuum. These projects encompass service delivery to a variety of populations including youth, adult, families, and in a variety of levels in the continuum, therefore are not easily categorized for the purposes of this task.

Treatment Gap: An estimated 405,266 individuals need substance abuse treatment in Oregon each year. During fiscal year 2001-02, 16% of those individuals accessed treatment services, leaving the treatment gap at around 84%.

Medicaid Expenditures: Total Medicaid expenditures for outpatient chemical dependency treatment for FY 01-02 were $22,914,311. Barring legislative action that may occur before the current session ends, expenditures for outpatient treatment will decrease considerably effective March 1, 2003 due to cuts in the OHP Standard benefit package. 01-02 Medicaid expenditures for residential chemical dependency treatment were $7,659,744.

Project

1. ***Strategies and Objectives*** – The Oregon team will pursue the following strategies and objectives during the Policy Forum.

- **Barrier:** Current fiscal and administrative incentives to move clients through the residential portion of the continuum more efficiently are insufficient. **Strategies/Objectives:** During the policy forum, Oregon's team will work on identifying and/or developing fiscal and administrative incentives to move clients through the residential portion of the continuum more efficiently.
- **Barrier:** The system lacks structural supports to effectively transition clients in a continuum care approach. Particularly, the system lacks a seamless continuum from residential treatment to community-based outpatient treatment, housing supports, and other recovery supports. **Strategies/Objectives:** Oregon's team will identify effective transition models and develop a strategy to implement these models for individuals leaving Level III services and transitioning back to community-based outpatient services and supports. Oregon's team will engage stakeholders from housing supports, faith community, cultural groups, the recovering community, outpatient and residential treatment providers, and other stakeholders to develop an effective model. Oregon's team will explore use of Medicaid resources within Oregon's 1115 Waiver (Oregon Health Plan) and/or under Targeted Case Management and Outreach to assist individuals transitioning from residential treatment programs to community-based services and supports. Options to increase flexibility for service providers delivering residential services will be explored and developed.

- **Barrier:** The residential treatment system is funded through three different fiscal mechanisms including direct contracts between OMHAS and providers, contracts with counties who sub-contract with providers, and other local financing mechanisms. This portion of the continuum is fragmented and managed independently from the rest of the continuum. **Strategies/Objectives:** Oregon's team will identify integrated management approaches to apply to residential treatment system as part of the service continuum. Methods for routine, consistent monitoring of client placement, continued stay, and discharge decisions will be analyzed. Strategies for centralizing management of residential bed access and utilization will also be developed.
- **Barrier:** Placement, continued stay and discharge decisions are primarily driven by the client's medical necessity for treatment in a particular level of service (via ASAM criteria) with minimal consideration of the client's level of motivation or readiness to change. Certain services may be better suited for individuals who are in the "preparation / action" stage of the change process vs. individuals in "pre-contemplation / contemplation." **Strategies/Objectives:** Oregon's team will explore the concept of structuring levels of service within the treatment continuum according to the "stages of change" model (Prochaska, DiClemente) whereby the client's level of motivation is assessed as a criterion in making placement decisions. In addition, the team will explore other levels of service that are not provided in the existing service structure that may resolve the barrier.

2. *Outcomes*

The following table explains each of the alcohol and drug treatment meaures and its importance as an indicator of treatment success. It also provides a performance report. (Measures to be refined during the Policy Forum are in bold italics.)

Alcohol/Drug Treatment Performance Measures

Measure	Importance	Goal & Results		
High-Level (Shared Societal) Outcomes				
Percent of clients who reduce use of public services	***Shows how effectively system prepares clients to live independently***	Goal: Increase		
		FY98	FY00	FY02
		In development		
Percent of clients exiting treatment who are employed	Shows how effectively system prepares clients to live independently	Goal: Increase		
		FY98	FY00	FY02
		53.7%	55.2%	52.0%
Intermediate-Level Outcomes (Performance Measures)				
Average length of time between treatment episodes	***Shows how effectively system maintains clients in community***	Goal: Increase		
		FY98	FY00	FY02
		In development		
Percent of clients who complete treatment and are not abusing drugs	Shows how effectively the system supports clients to reduce alcohol/drug use	Goal: Increase		
		FY98	FY00	FY02
		50.9%	53.1%	54.6%
Percent of clients with reduced use upon disenrollment	Shows how effectively the system supports clients to reduce alcohol/drug use	Goal: Increase		
		FY98	FY00	FY02
		69.2%	69.1%	69.9%
Percent of clients retained in treatment	Length of treatment is correlated with other measures	Goal: Increase		
		FY98	FY00	FY02

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Measure	Importance	Goal & Results		
90 or more days ***This measure will be revised to assess transition from residential to community-based services and supports***	of success ***Effective transition between residential services and community-based outpatient is associated with positive treatment outcomes***	62.0%	63.4%	64.4% ***To be developed during RWJ Policy Forum***
Percent of clients who enter treatment after positive assessment	Shows how effectively the system motivates clients to enter treatment	Goal: Increase		
		FY98	FY00	FY02
		91.5%	91.4%	92.3%
Percent of clients who enter care at an appropriate level ***An additional measure will be added to assess client continued stay / discharge in public funded residential settings***	Shows whether system places clients at level of care most likely to result in successful outcomes ***Shows whether system retains clients at appropriate level or moves clients to level of service most likely to result in successful outcomes***	Goal: Increase		
		FY98	FY00	FY02
		NA	NA	65.9% ***To be developed during RWJ Policy Forum***
Outputs (Performance Measures)				
Percent of people in need who gain access to treatment* ***A measure will be developed to assess clients "stage of change" at treatment access points beginning with residential treatment.***	Tells how effectively system encourages individuals in need to seek care ***Demonstrates "Stage of Change" is used as criteria for accessing types of services in the continuum.***	Goal: Increase		
		FY98	FY00	FY02
		46,935	52,605	59,462

* This figure differs from totals shown elsewhere in this proposal because the figure is sampled from a fiscal year rather than a calendar year.

3. ***Reusing Savings*** –

Savings that are realized as a result of the Oregon strategy will by utilized to improve and expand community-based services and supports designed to effectively transition youth and adults from public funded residential treatment settings to the community. Services improved and expanded through savings will meet the following criteria:

- Must be evidence-based practices – e.g. family-based, family-focused interventions with youth and their families, integrated case management approaches, strengths-based approaches, integrated treatment services for individuals with co-occurring mental and substance abuse diagnoses.

4. ***Relationships with Key Stakeholders*** –

OMHAS is an office within the Health Services Cluster of the Department of Human Services (DHS). The Health Services Cluster also contains the Public Health Programs and the Medicaid Program. The other Clusters of DHS are Services to People with Disabilities, encompassing senior services and disability services; and Children, Adults, and Families Cluster encompassing child welfare and self-sufficiency programs. DHS delivers all the state's human services programs. An analysis of service delivery patterns prior to the DHS reorganization effort revealed that many clients of one program also utilize other DHS services. The need for more integrated services has been acknowledged by DHS for many years, beginning with Service Integration Teams in the early 1990's. Partnerships between mental health and addictions, addictions and child welfare, etc. have been the norm within the department. A series of community forums were held around the state to problem solve and remove barriers for joint service delivery between AOD and child welfare in light of the Adoption and Safe Families Act. Child welfare continues to staff branch offices with AOD specialists who assist clients with linkages to local treatment providers. At the state level, OMHAS and representatives from the state's child welfare and self sufficiency agency collaborate on a weekly basis to resolve system issues and work on effective service delivery approaches with child welfare and TANF populations.

The addictions services delivery system operates as a system of services under the guidance of the Governor's Council on Alcohol and Drug Abuse Programs. Their biennial plan sets goals for County Local Alcohol and Drug Abuse Planning Committees, which develop Implementation Plans that guide the funding of community services. OMHAS executive leadership assists the Council in developing the plan and to provide input. Council meetings occur monthly / bi-monthly. The County Mental Health Directors, who oversee the County addiction systems, have an association (AOCMHP); OMHAS Administrator and key staff meet regularly with both this association and the Alcohol and Drug Abuse Programs Association of Oregon (ADAPAO), the association of addiction treatment agencies. ADAPAO and AOCMHP have a joint working group that also meets regularly to address system issues. OMHAS also meets regularly with the Oregon Indian Council on Addictions (OICA), an advocacy group focusing on treatment and prevention issues for Native Americans.

OMHAS coordinates services with the state and local juvenile and adult justice agencies, the Oregon Judicial Department, Office of the State Court Administrator, and state correctional institutions. Through these partnerships, Oregon has instituted measures to expand Juvenile Drug Courts, Integrated Treatment Courts, Adult Drug Courts and Family Dependency Drug Courts. OMHAS staff members participate in quarterly meetings with the Oregon Judicial Department to review progress, resolve systems issues and develop strategic direction for the state's 20+ operating drug courts. Additionally, OMHAS participates with corrections in extensive planning and implementation of transition services for juvenile and adult inmates leaving state institutions and returning to their communities.

5. ***Current Analytical Capacity*** –

The OMHAS currently complies with Center for Substance Abuse Treatment (CSAT) core requirements to collect the administrative-level Treatment Episode Data Set (TEDS) enrollment data on all clients receiving services from licensed, funded alcohol/drug treatment providers.

The DHS Office of Information Services (OIS) maintains both the CPMS/TEDS and the Medicaid Management Information System (MMIS)/Medicaid encounter systems:

- CPMS data are stored on an IBM AS/400 model B70 with 18 input/output channels. This operates under AS/400 and includes 192 Mb of main memory storage. The system also has 17 mirrored gigabytes of disk storage space and a 20-cartridge tape drive. The system has 20 controllers with capacity for 800 devices in total. Approximately 650 devices are currently attached. Researchers run CPMS reports on the mainframe using TSO FOCUS. Participating agencies share system-operating costs.

- MMIS data are stored on a large third generation IBM-compatible mainframe application system with close to two million lines of COBOL code. The system was originally designed to support paper claims. It has since been modified to support electronic payment, maintain client eligibility, and generate operational, management, and compliance reporting. DHS is in the process of replacing MMIS as part of its HIPAA compliance plan.

Approximately 75% of admissions and discharge data (about 10,000 forms per month) are submitted on paper. OMHAS has developed a public domain, executable electronic form (E-Form) that works on a Windows desktop. The E-Form has built-in edits that prohibit inaccurate responses, reducing errors. The E-Form also gives the provider ready access to the organization's TEDS data.

The following table summarizes OMHAS current capability and proposed modifications for future data collection.

Measure	Current status	Proposed modifications
Alcohol use	Similar information is currently collected at enrollment and discharge	Minor modifications to CPMS paper and E-forms and ASCII editor
Other drug use	Similar information is currently collected at enrollment and discharge	Minor modifications to CPMS paper and E-forms and ASCII editor
Criminal justice involvement	Similar information is currently collected at enrollment and discharge	Propose to link to criminal justice data to provide external validity to current measures
Status of employment	Similar information is currently collected at enrollment and discharge	Propose to link to employment data to provide external validity to current measures
Services to pregnant women	This field is collected in CPMS	Propose to develop estimate of need for treatment among pregnant women
Early intervention to HIV/AIDS	This information is not collected through CPMS	Propose to develop administrative checklist and link information to client/program data repository
Access to services for individuals with TB	This information is not collected through CPMS	Propose to develop administrative checklist and link information to client/program data repository
Co-occurring MH and SA	This information is not collected through CPMS	Propose to standardize mental health/alcohol and drug forms and

Measure	Current status	Proposed modifications
		joint site review tool and link information to client/program repository

The Office of Medical Assistance Programs (OMAP) also collects treatment encounter data on clients who are enrolled in the Oregon Health Plan (OHP). The OHP administers federal Title XIX (Medicaid) programs in Oregon. It serves approximately 450,000 clients annually through 19,000 plus participating healthcare providers. OMHAS has developed matching criteria to link episodic TEDS data to Medicaid encounter data. This enhances OMHAS's ability to link to treatment encounters and other health information of Medicaid eligible clients reported using UB92 and HCFA 1500. OMHAS has entered into a written agreement with the Office of Medical Assistance Program (OMAP) to enhance the methodology and automate the linkages.

6. ***Challenges and Barriers***

Political – Lack of support for adequate funding to support high-quality services, due to assumption that treatment often doesn't result in desired outcomes. There is general frustration with the growing number of addicted persons in the state systems, and a backlash that has stigmatized this population. This circumstance makes it very difficult to develop a climate of positive change; rather, the addiction treatment community feels that it is under pressure to produce unrealistic outcomes.

Historical structure – Statute dictates that the Counties manage the community treatment services; the OHP has developed a separate managed care system with overlap between its structure and the counties in some areas; the residential treatment system has a regional provider structure, which is not effectively linked with either of the other systems. Although some of the providers are funded within each system, the funding mechanisms are cumbersome, and do not allow flexible use of dollars in the most effective manner.

Outdated technology systems – Currently, OMHAS relies on a complex network of – mostly – outdated technology systems to meet its data processing needs. Several of OMHAS's data processing programs (including CPMS/TEDS) are written in COBOL. Contract data are processed through Rbase, software that is no longer supported by its manufacturer. None of the systems use compatible client and/or program identifiers, and data transfer is most often accomplished by manual processes. Medicaid data are collected through a large third generation IBM-compatible mainframe application system with close to two million lines of COBOL code. This system was designed simply to support claims payment of paper claims submitted by providers, maintain the eligibility of clients, and generate operational, management, and compliance reports. DHS is in the process of replacing MMIS.