Office of Mental Health & Addiction Services

CHILD & ADOLESCENT MENTAL HEALTH INTENSIVE TREATMENT SERVICES

Pilot Project Evaluation

DHS oregon department of human services

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Table of Contents

Summary

The intensive treatment services (ITS) pilot projects integrate two children's services - psychiatric day treatment and psychiatric residential treatment - into the Oregon Health Plan. This gives providers the financial flexibility to provide children with the services that best meet their needs, without the restrictions imposed by the traditional "slot" funding system.

The pilot project was developed in response to a budget note attached to the 1997 Office of Mental Health Services appropriation. A pilot project structure, evaluation plan and implementation ground rules were crafted by cooperative effort of among staff representing OMHAS, intensive treatment service providers; the Department of Human Services' child welfare unit; Department of Education; Oregon Youth Authority, Oregon Family Support Network; and managed mental health care organizations.

The budget note outlined criteria for the pilot project evaluation. This evaluation tested the three key hypotheses specified in the note:

- **Functional outcomes**
  The evaluation tested the hypothesis that children served in the pilot project would have better clinical outcomes than children served in traditional programs. Results were inconclusive. Overall, a higher percentage of children in pilot programs showed improved clinical outcomes. However, the difference appeared to be due to differences in provider performance rather than pilot implementation.

- **Program efficiency/effectiveness**
  The evaluation tested the hypothesis that pilot services would be delivered more efficiently than traditional services. Results provided support for this conclusion. While pilot services were more costly in the short-term, some evidence suggests that they are a better long-term investment. Children in pilot programs were less likely to be re-admitted to treatment at 30- and 180-day intervals following discharge.

- **Access to services**
  The evaluation tested the hypothesis that children in the pilot project would be able to gain access to intensive treatement services at a rate comparable to traditional programs. Results were inconclusive. Focus group participants could discern little difference in ease of access to traditional versus pilot programs.

In general, time frame and variability in how the pilots were implemented makes evalution difficult. Only one pilot, the CISCO project, had operated for two full years at the time data were pulled. Children were "naturally" rather than "randomly" selected for participation in the program, introducing potential bias to evaluation results. Finally, the number of program participants was fairly low by research standard. More time is needed to study implementation results in other project sites.

Background

Children's Intensive Treatment Services

Children's intensive treatment services (ITS) are designed to improve or stabilize the symptoms of severe emotional disorders. The services encompasses a range of services which are the most intense and restrictive available in Oregon's publicly funded children's mental health system, including:

- Psychiatric day treatment,
- Psychiatric residential treatment,
- Psychiatric assessment and evaluation,
- Secure Children's Inpatient Program (SCIP) and
- Child and adolescent treatment at the Oregon State Hospital.

With the exception of day treatment, these services are provided in residential or hospital settings.

ITS Pilot

A 1997 Legislative Budget Note attached to the Office of Mental Health Services appropriation, required the Department of Human Services (DHS) to plan for and evaluate an effort to integrate intensive treatment services into the Oregon Health Plan managed mental health care system. Accordingly, OMHAS established several intensive treatment service pilot projects. The pilots create the opportunity to evaluate the effects of this change before system-wide implementation.

Participation in the pilots is voluntary; and pilot providers do not share the financial risk usually associated with capitated systems. However, the contracts give the providers the flexibility, similar to managed care contracts, to develop better integration with community resources and alternatives to typical service delivery patterns, such as wraparound services. This allows OMHAS to observe and evaluate how well intensive treatment services operate under managed care conditions, while noting the strengths and weaknesses of the system.

The 1999 Legislative Budget Note specified evaluation goals that compare intensive treatment pilot services to traditional services. The goals, as outlined in the Budget Note, are:

- Children served in the intensive treatment service pilots will demonstrate improved functional outcomes compared to children served in traditional programs.

- Children served in the intensive treatment service pilots will make a transition to other levels of service more quickly than children served in traditional programs.

- Children served in the intensive treatment service pilots will have shorter lengths-of-stay in "high end" services (particularly acute and long-term residential care) than children served in traditional programs.

- Children served in the intensive treatment service pilots will be served at the same or less cost than children served in traditional programs.

- The psychiatric residential treatment system will continue to serve the same number of children from the Department of Human Services' child welfare unit and the Oregon Youth Authority systems.

- Allied agencies will report better treatment outcomes for children served in the intensive treatment service pilots compared to children served in traditional programs.

- Allied agencies will report better case coordination for children receiving care under the intensive treatment service pilots compared to children served in traditional programs.

- Family members will report better treatment outcomes for children served in the intensive treatment service pilots compared to children served in traditional programs.

- Family members will report that they are more easily able to gain access to intensive treatment service pilot than traditional programs.

Current ITS Pilot Projects

Five projects, including seven psychiatric residential treatment facilities, are currently contracted to deliver intensive treatment pilot services. They have combined capacity to serve more than 100 children in 21 Oregon counties. The current projects are:

Current Intensive Treatment Service Pilot Projects

Date	Mental health organization	Psychiatric residential treatment providers	Counties served	Capacity
Community Integrated Support for Children in Oregon (CISCO)				
Apr-99	* Accountable Behavioral Health Systems * Mid-Valley Behavioral Care Network * Greater Oregon Behavioral Health, Inc.	Children's Farm Home	Clatsop, Columbia, Crook, Benton, Deschutes, Jefferson, Linn, Lincoln, Marion, Polk, Tillamook, Yamhill	22
Multnomah County				
Oct-00	Verity Integrated Behavioral Healthcare Systems	* Albertina Kerr * Parry Center * Edgefield * RiverBend * Christie School	Multnomah	50
Jefferson Behavioral Health and Southern Oregon Adolescent Study Treatment Center				
Mar-01	Jefferson Behavioral Health	* Souther Oregon Adolescent Study and Treatment Center	Coos, Curry, Douglas, Josephine, Jackson, Klamath	21
Clackamas County				
Aug-02	Clackamas County Mental Health	* Christie School * RiverBend * Albertina Kerr * Children's Farm Home	Clackamas	12
Washington County				
Jan-03	Washington County Health and Human Services	Christie School	Washington	4

Each of the current projects is described in further detail in the Appendix.

Each pilot is guided by a steering committee that includes representatives of the Office of Mental Health and Addiction Services, the intensive treatment service program, other community treatment providers, child welfare, juvenile justice, education, family members, and the managed mental health care organizations.

A community treatment team supports each pilot project child. The team membership is customized to the child's needs and includes individuals who are critical to the child's, and the family's continuing care plan. The team meets regularly to develop and implement a plan of care and provide case coordination and oversight.

The following diagram illustrates the difference between traditional psychiatric residential care and the ITS pilots.

Traditional PRTS Programs	ITS Pilot Programs
 Child meets PRTS level of care and it accepted into the program	 Child meets PRTS level of care and is accepted into the program
 The PRTS program is paid once the child enters the facility.	 The PRTS program is paid when the child enters the pilot program. The child can live at home, at the PRTS facility or treatment foster care and other types of care. The child must meet the PRTS level of care guidelines.
 The child is living at the PRTS program and receives traditional services at the facility such as individual, family or group therapy. There is little connection with the community.	 The ITS child is provided wraparound services at the home, facility or other type of care. Community meetings are held in the child's community. ITS pilot works with the family and not just the child.
 Child returns home. The PRTS program discharges the child. PRTS services are closed.	 While the child is in the community, the PRTS provider offers a variety of services such as in-home, natural and flexible services to the family. The child will make a transition to the community service system.
When the child is discharged there is little community involvement but the PRTS will try to connect with the community.	When the child is discharged, a plan is developed with the family, community and PRTS program.

Evaluation Hypotheses

The 1999 Legislative Budget Note stipulated that the intensive treatment services evaluation "cover a period of not less than two years." Given that each of the pilots began at different times, only the Community Integrated Support for Children in Oregon (CISCO) pilot qualified for full evaluation, especially after startup time was taken into account.

The CISCO pilot services are delivered through the Children's Farm Home (CFH), where approximately half of the capacity is used for the intensive treatment services pilot. The remainder of CFH's treatment capacity is delivered under traditional psychiatric residential treatment regulations. This allows for a comparison group to the pilot services. Services delivered at other traditional psychiatric residential treatment service sites are also presented for comparison. Preliminary data from other pilots are included where available and appropriate.

Services delivered under a managed care capitated system were expected to have better outcomes, be more efficient, and be more accessible. With this theory in mind, OMHAS solicited input from intensive treatment service providers, the Oregon Youth Authority (OYA), the Oregon Department of Education, Department of Human Services' Children, Adults and Families Cluster (formerly Services to Children and Families (SCF)), and the Oregon Family Support Network to develop a set of hypotheses to guide the pilot evaluation.

The following hypotheses address and expand on the suggested areas of evaluation from the 1999 Legislative Budget Note by stating expected outcomes:

- **Functional outcomes**
  - Children served under the intensive treatment service pilot will demonstrate improved psychiatric acuity scores compared to children served in traditional programs.
  - Allied agencies will report better treatment outcomes as a result of services for children receiving services under the ITS pilot compared to children not served under the pilot.
  - Family members will report better treatment outcomes for children receiving serving under the ITS pilot compared to children not served under the pilot.
- **Program efficiency/effectiveness**
  - Children served under the intensive treatment service pilot will transition to other levels of service more quickly than children served in traditional programs.
  - Children served under the intensive treatment service pilot will have shorter lengths of stay in "high-end" services (acute and long-term residential care, etc.) than children served in traditional programs.
  - Children served under the intensive treatment service pilot will be served at the same, or less cost than children served in traditional programs.

- Allied agencies will report better case coordination activities for children receiving services under the ITS pilot compared to children not served under the pilot.

- **Access to services**

  - Family members will report better access for their children receiving services under the ITS pilot compared to children not served under the pilot.

  - The same number of child welfare and Oregon Youth Authority children will receive intensive treatment services regardless of pilot status.

The evaluation relied on "quasi-experimental" methods. Children were "naturally" rather than "randomly" placed into ITS pilot and traditional residential services.

Evaluation data were collected from administrative databases, focus group interviews, clinical chart reviews, and parent/guardian and child satisfaction surveys. Unfortunately, data were not available to fully explore each of the hypotheses, and in some cases the data that were available are not strong enough to use for drawing reliable conclusions.

The following sections summarizes the findings for each of the hypotheses, including the strengths and weaknesses of the data used. The CISCO Pilot began April 1999. To allow for start up time, the general time frame for the data is from January 2000 through December 2002, excepted where noted.

Functional Outcomes

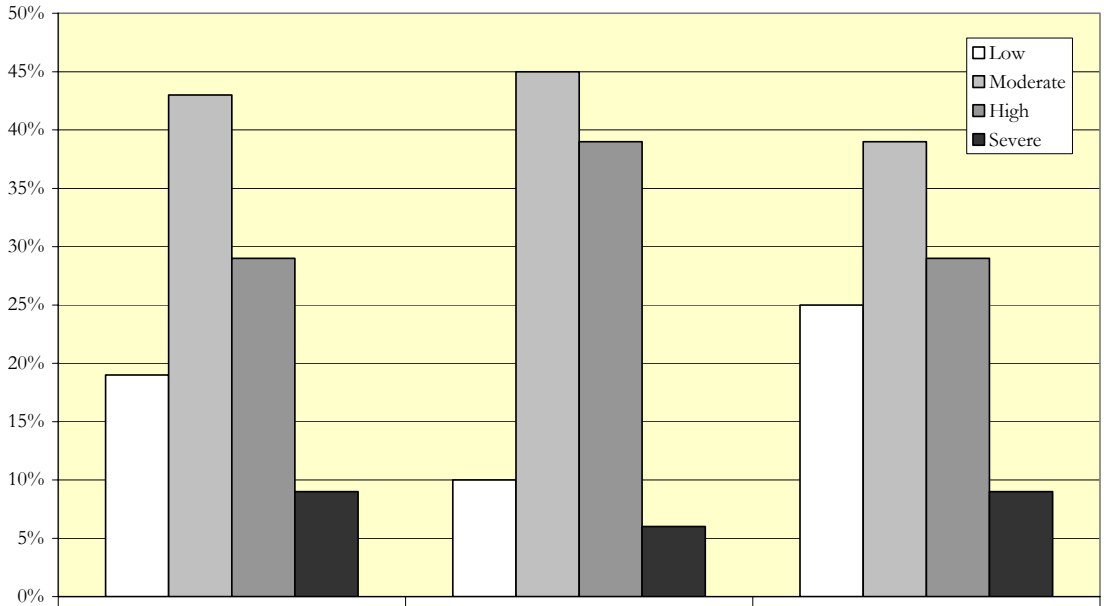
Hypothesis	Results
Children served under the intensive treatment service pilot will demonstrate improved **psychiatric acuity scores** compared to children served in traditional programs.	Inconclusive
Allied agencies will report better treatment outcomes as a result of services for children receiving services under the ITS pilot compared to children not served under the pilot.	Marginal support
Family members will report better treatment outcomes for children receiving serving under the ITS pilot compared to children not served under the pilot.	Marginal support

Psychiatric acuity scores

The pilot projects are expected to admit and treat children with similar intensity of need as the traditional programs, and data collected by the Oregon Professional Review Organization (OMPRO) demonstrates that this is the case. OMPRO conducts Childhood Acuity of Psychiatric Illness (CAPI) tests on all children in psychiatric residential treatment programs. The CAPI provides an overall psychiatric acuity score, as well as subscale scores for clinical functioning, risk behaviors, and psychiatric symptom severity.

The following chart illustrates that children who are admitted to the pilot programs have overall higher CAPI scores, or greater severity of symptoms, compared to children admitted to traditional programs.

Psychiatric Acuity Scores
Children Admitted to Intensive Treatment Service Pilot versus Traditional Psychiatric Residential Treatment Programs

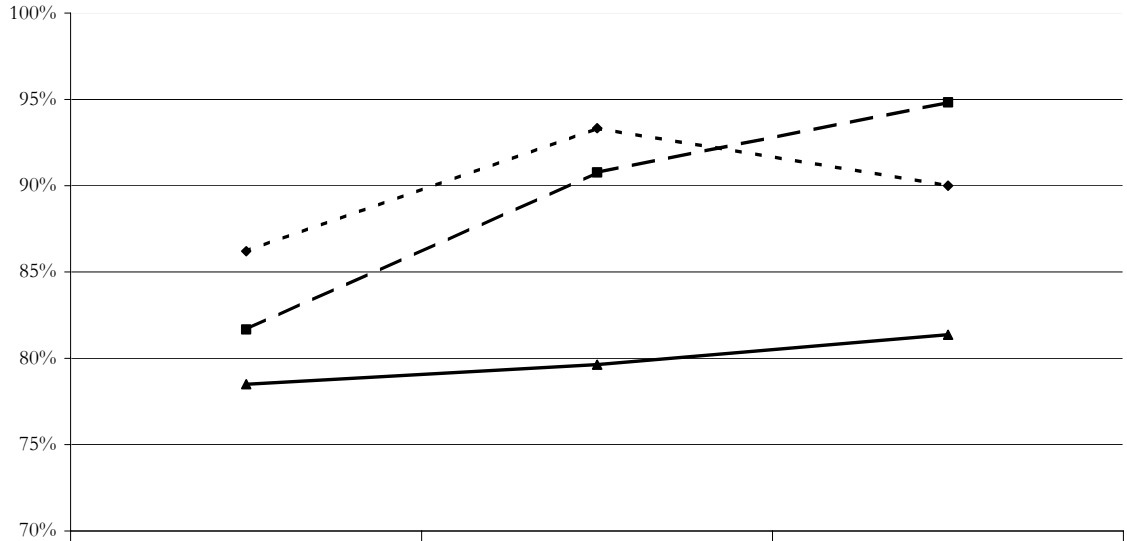


	CFH residential	CFH pilot	Other residential
Low	19%	10%	25%
Moderate	43%	45%	39%
High	29%	39%	29%
Severe	9%	6%	9%

CAPI reviews are also conducted at quarterly intervals following admission, and at discharge. A child is considered to show improvement if his/her CAPI discharge score improves by 10 percent or more from his/her admission score.

The data show that a greater percentage of children in the Children's Farm Home psychiatric residential treatment program – regardless of whether they were served in the traditional or the pilot program – showed improved psychiatric acuity scores than children served in other psychiatric residential treatment programs. The other facilities had consistently lower rates of improvement. Children's Farm Home staff attribute these results to the pilot service delivery philosophy spreading throughout the whole program. Although not illustrated, the other pilots have shown rates of improvement equal to the performance at CFH.

Percent of Children Showing
Improved Psychiatric Acuity Scores at Discharge



	2000	2001	2002
CFH Pilot	86.2%	93.3%	90.0%
CFH Traditional	81.7%	90.8%	94.8%
Other traditional	78.5%	79.6%	81.4%

Allied Agencies

Allied agency focus group participants indicated that the outcomes of services from Children's Farm Home are generally good, and the participants had a difficult timing discerning differences between the Children's Farm Home traditional versus pilot services.

Family Members

Limited survey data from family members indicated strong satisfaction with outcomes from CISCO services. However, no comparison data to traditional services offered at Children's Farm Home or to other psychiatric residential treatment service providers exists.

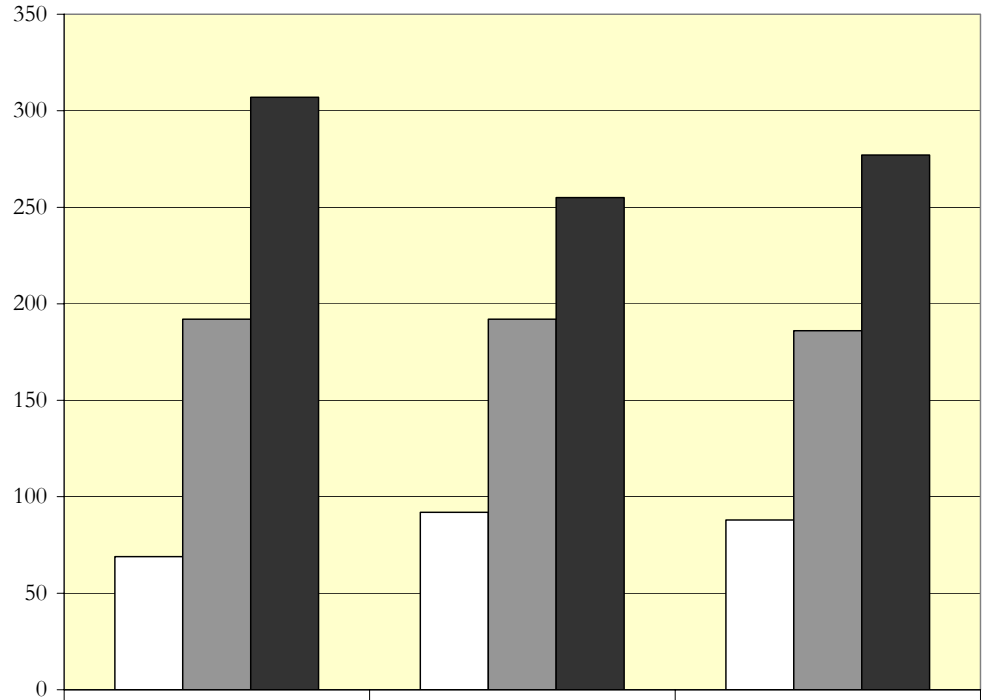
Efficiency

Hypotheses	**Results**
Children served under the intensive treatment service pilot will **transition to other levels of service** more quickly than children served in traditional programs, and will have shorter lengths-of-stay in higher end services than children served in traditional programs.	Support
Children served under the intensive treatment service pilots will be more likely to be **discharged to their own or a relative's home**.	Marginal support
Children served under the ITS pilot will be served at the same, or less **cost** than children not served under the pilot.	Marginal support

Transition to other levels of service

The total length-of-stay in CISCO pilot services – including the whole range of services available to the children – is usually longer (217 days) than the total length-of-stay for children receiving traditional residential services at the Children's Farm Home (187 days). However, the time spent in the psychiatric residential treatment facility is considerably less for the children in the pilot program (88 days) versus the traditional program (186 days). Children in the pilot program spend more time in the community making a transition to lower levels of service. The following graph illustrates the difference in length-of-residential-stay:

Length of Stay in Psychiatric Residential Treatment

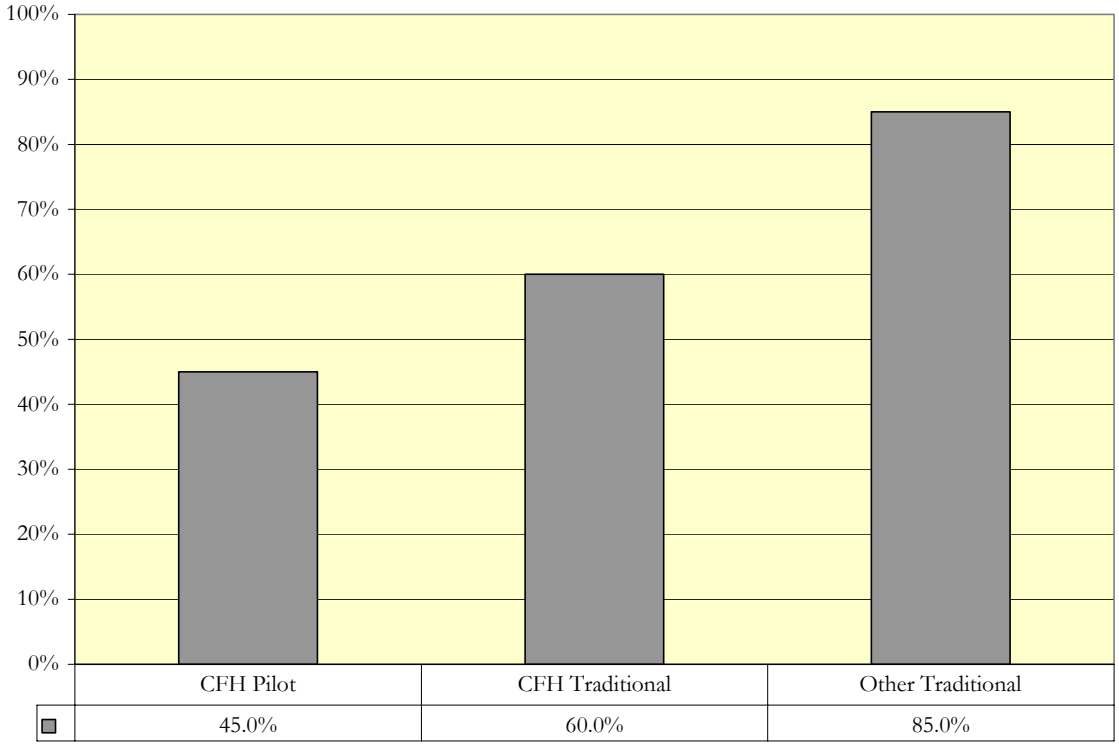


	2000	2001	2002
CFH Pilot	69	92	88
CFH Traditional	192	192	186
Other Traditional	307	255	277

Discharge to Home or Relative

During this same period of time, 70% of the children in the CISCO program were discharged to family members or relatives compared to 50% of the children in Children's Farm Home traditional services. Other psychiatric residential treatment programs discharged about 47% of their children to familiy members. However, some evidence suggests that children with more stable home environments are more likely to be in pilot services. Families tend to prefer these services, while DHS child welfare caseworkers tend to prefer the traditional programs. The following figure illustrates.

Children in Department of Human Services Custody

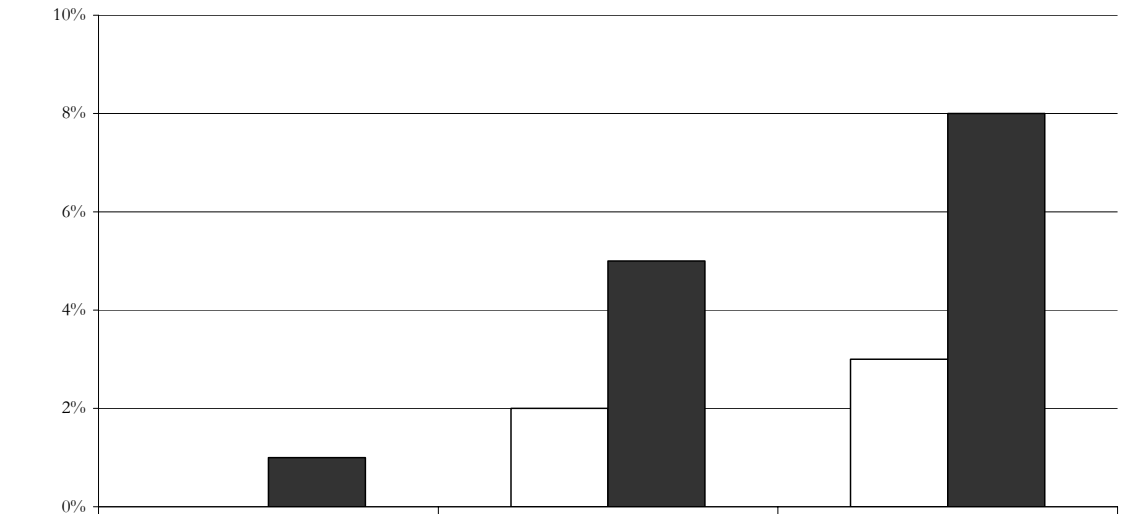


Cost

The actual daily costs for children in the CISCO pilot project is $265.20 a day, while tradional services at the Children's Farm Home cost $243.98 a day. (This rate difference is due to an eight percent administrative fee for the managed mental health care organizations.) Short-term costs are greater in the CISCO pilot project, since the the daily rate is higher and the average length-of-stay is longer. However, long term costs may be less because a higher proportion of pilot children are discharged to lower levels of service. Additionally, children in the pilot program have lower rates of readmission.

Readmission rates contribute to the long-term costs of treatment. In general the readmission rate into psychiatric residential treatment programs is low. But as can be seen in the next chart, readmission into the CISCO Pilot Program has been extremely low at both 30 and 180 days.

30 and 180-Day Readmission Rates



	CFH Pilot	CFH Traditional	Other Traditional
30 Days	0%	2%	3%
180 Days	1%	5%	8%

These results should be viewed with caution, however, as the total number of children in the comparison samples is quite low.

Access

Hypothesis	Results
Access is perceived to be the same or improved from the percpective of **allied agencies and family members**.	Inconclusive

The main source of data for measuring access was qualitative in nature. Data were collected from a series of focus groups conducted with allied agencies, including local mental health, juvenile justice, and DHS child welfare.

Focus group participants expressed several common concerns. Many participants felt that access into any psychiatric residential treatment program is difficult, and that the CISCO pilot project was no different. The wait time for services could last over three months, similar to wait times for other psychiatric residential programs. Participants also expressed that the referral process was cumbersome and difficult to understand. The referral processes did not vary between the pilot and traditional program.

However, family members who participated in a satisfaction survey indicated that access for the CISCO pilot project was good. However, no comparison group exists, as these data were not collected from family members of traditional consumers.

Other Findings

Several other findings of administrative significance emerged from the evaluation.

Child welfare and Oregon Youth Authority

A goal for the ITS pilot project services was to insure continued access to psychiatric residential services for children in the custody of child welfare. No information gathered during the focus groups indicated that access was diminished for children in the custody of DHS child welfare. However, administrative data collected through Oregon Medical Professional Research Organization indicated that a greater percentage of children in the custody of child welfare were enrolled in traditional residential beds at the Children's Farm Home. Child welfare caseworkers found the requirements related to traditional psychiatric residential services at Children's Farm Home to be more expedient.

Eligibility for Household of One Children

Children who are not otherwise eligible for the Oregon Health Plan become eligible for the Health Plan when they physically move to an out-of-home treatment setting. When these children return to their family homes, they often lose their eligibility. This makes it difficult for these children to continue in the program.

Payment for Services

The current payment system for the ITS pilots is a variation of the traditional retrospective payment system. The system guarantees that the ITS pilot providers will receive payment for a specific number of children. This creates a burden on state administrative staff to ensure that services payments are correct.

ITS Pilot Project Transition

The state does not have a fully integrated system of care for children with severe emotional disorders. ITS services are not available in some communities. In communities where ITS services exist, appropriate care may not be available once a child is discharged. Wraparound services and community-based resources must be developed so that children may receive care in the least restrictive environment.

Education

Coordination between education officials and ITS providers is often lacking, due to a variety of communication and funding issues.

Summary and Recommendations

The intensive treatment service pilots have been in existence only a short time. To this point, data regarding pilot outcomes is inconclusive.

- Overall, a higher percentage of children in pilot programs showed improved clinical outcomes. However, this may be the result of differences in performance among residential treatment programs.

- Children in the pilot programs had shorter lengths-of-stay in "high end" (residential and acute) services, and were more likely to be discharge to their families or relatives' homes. However, some evidence indicates that children from stable home environments were more likely to be selected for participation in the pilot program.

- While pilot services are more costly in the short-term, some evidence suggests that they are a better long-term investment. Children in pilot programs are less likely to be re-admitted to treatment at 30- and 180-day intervals following discharge. However, these differences may be due to differences in home environment.

While much of the data for this evaluation came from the Children's Farm Home, preliminary results from other pilot projects indicate similar outcomes. For example, high percentages of children in other pilot programs were discharged to family and relatives. However, other results are dissimilar. For example, lengths-of-stay at other pilots appear to be longer.

In general, time frame and variability in how the intensive pilots were implemented makes evalution difficult. However, based on the available data and OMHAS program staff experience, several recommendations are made:

1. To truly assess the impact of managed care on costs and quality of service, place child and adolescent psychiatric residential services under risk based capitated systems;

2. Create stronger partnerships with local school districts to better insure the child's education needs are met, especially in the transition from facility to community-based settings;

3. Create more comprehensive systems of care so local communities can support the needs of children who receive mental health intensive treatment services;

4. Create more effective transition and wraparound plans with family, community and facility-based partners and as a result there will be a more seamless system of care; and

5. Create a DHS tracking process to ensure equitable availability of PRTS programs for all counties.

Appendices

Pilot Descriptions

Community Integrated Support for Children in Oregon

The Community Integrated Support for Children in Oregon, which began on April 1, 1999, is a partnership among the Children's Farm Home in Corvallis and three mental health organizations: (1) Accountable Behavioral Health Alliance, (2) Mid-Valley Behavioral Care Network and (3) Greater Oregon Behavioral Health Inc.

This project has the capacity to serve 22 children from 12 different Oregon counties. These are: Clatsop, Columbia, Crook, Benton, Deschutes, Jefferson, Linn, Lincoln, Marion, Polk, Tillamook and Yamhill.

The CISCO Program is based on three principles:

1. Community engagement. Each participant is supported by an "essential provider team." Each member of the team is committed to and accountable for the child's success upon return to the community.

2. Short-term residential treatment. The child will return to home and community still needing professional mental health and other supportive services.

3. Community support. The Children's Farm Home offers intensive in-home skills training to consumers and families, with trainers available 24-7. Respite care and additional community and recreational programs are also made available when needed.

Multnomah County

The Multnomah intensive treatment services pilot is a partnership among the Multnomah County Office of Addictions and Mental Health Services, Verity Integrated Behavioral Healthcare Systems and five different psychiatric residential and psychiatric day treatment programs:

- Albertina Kerr Youth and Family Center;
- Edgefield Children's Center;
- Christie School;
- RiverBend Youth Center; and
- Parry Center.

The project began on October 1, 2000. The program has the capacity to serve 50 Multnomah County children.

The primary goals of this project are to:

1. Improve the continuity of care as the child enters and leaves Psychiatric Day Treatment and Psychiatric Residential Treatment levels of care.
2. Develop intensive community-based alternatives to Psychiatric Day and Psychiatric Residential Treatment programs.
3. Improve the coordination between child serving systems (mental health, education, child welfare, juvenile justice, etc.) and ITS Pilot Programs.

4. Increase family involvement in the planning and implementation of services.

Jefferson Behavioral Health and Southern Oregon Adolescent Study and Treatment Center

The Jefferson Behavioral Health and Southern Oregon Adolescent Study and Treatment Center (JBH/SOASTC) pilot project began on March 1, 2001. The project, which is located in Grants Pass, has the capacity to serve 21 children in six different Oregon counties. The counties are: Coos, Curry, Douglas, Josephine, Jackson; and Klamath.

The goal of the pilot is to provide a "seamless system of care" for participating families. The pilot organizations have established partnerships with the child welfare, juvenile justice, education and county mental health systems. SOASTC works with the families from the time the child enters residential services, and continues working with the families after the children are returned home. SOASTC reports that because of the pilot:

- SOASTC has been able to serve more children.
- The Community Alternative Treatment Program has been implemented.

The Community Alternative Treatment Program assists families to avoid or reduce the length of out-of-home placements for their children. The program helps families identify community supports that "wraparound" the families in times of crisis or prolonged need.

Clackamas County

The Clackamas County pilot project program began on August 1, 2002. The program is a partnership with the Clackamas County Mental Health Organization and four different psychiatric residential treatment programs:

- Albertina Kerr Youth and Family Center;
- Christie School;
- RiverBend Youth Center; and
- Childrens Farm Home.

The project has the capacity to serve 12 Clackamas County children.

The Clackamas project supports an expanded system of care for children with serious emotional disorders and their families. The goals of the project are to provide:

- A wider array of services to meet the needs of children with serious emotional disorders and their families,
- Expanded access to the appropriate intensity of interventions when and where they are needed and smoother, more timely transitions between treatment settings, and
- Increased capacity to serve county residents needing an intensive array of mental health and related services.

Washington County

The Washington County ITS Pilot Project began on January 1, 2003. The project is a collaboration among the Washington County Department of Health and Human Services, Providence Behavioral Health Connections and Christie School. The project has the capacity to serve four children.

The program has four goals:

- Reduce the length of stay in the facility by improving access to wrap around and community services and serving on average 8 – 12 children/year.
- Increase successful re-integration of youths into their homes by involving family members at each stage of the treatment process.
- Reduce the length of time between the referral and agency admission.
- Use therapeutic foster homes to reduce length of stay in the facility. Also examine the possibility of using therapeutic foster homes as a primary treatment modality.