Department of Human Services – Health Services
Office of Mental Health & Addiction Services

House Bill 3024 Statewide Mental Health Plan

June 2003

Foreword

House Bill 3024 (2001 Oregon Legislative Assembly) was enacted into law on July 7, 2001. The Bill amended sections of the Oregon Revised Statutes relating to the provision of mental health services. It required local mental health authorities to prepare and submit biennial service plans to the Department of Human Services, and it required the Department of Human Services, in turn, to develop guidelines for the production of the local plans. It also required the Department to use local plan information to produce a state biennial plan, including updates on the progress of local planning, for the Governor and the Legislative Assembly.

This report fulfills the Department's obligation to produce a statewide biennial mental health plan. It is organized into three sections:

- **Section 1** provides a summary and progress report on local mental health planning efforts, including:
  - *Phase One plans,* which were aimed at developing the "ideal" mental health system described by House Bill 3024 and the Mental Health Alignment Work Group, were developed before the extent of the state's revenue shortfall and the resulting cutbacks in local mental health systems was known.
  - *Phase Two plans,* which were aimed at maintaining minimum service levels, scaled back the expectations of Phase One plans to reflect state budget cuts.
- **Section 2** is a statewide plan for improvement of mental health services.
- **Section 3** includes an update on progress toward each of the Mental Health Alignment Work Group recommendations.

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Section One: Local Planning

Introduction

The "Mental Health Alignment Work Group" (MHAWG) was created in December of 1999 to analyze Oregon's mental health system and propose realignment of services and funding. The group represented a broad diversity of interests, including legislators, county commissioners, consumers and family members, representatives of state and local agencies, law enforcement personnel, judges and others. The group's report, issued in January 2001, provided a blueprint for achieving an ideal mental health system in Oregon.

The ideal system described in the Mental Health Alignment Work Group report, and enacted into law by House Bill 3024 (2001 Oregon Legislative Assembly), depended on six key principles:

1. Access to care, particularly services to stabilize disorders and maximize independence, provided by caring staff
    b. Parity with physical health
    c. Simplified enrollment in the Oregon Health Plan
    d. Subsidies for employer-based insurance
    e. Early identification and treatment
    f. Comprehensive services in the least restrictive setting
2. Safeguard human dignity, minimize coercion and maximize self-determination
    a. Ombudsperson office
    b. Policy on abuse and neglect

3. Flexibility in local services with the purpose of achieving outcomes and efficiency
    a. Block grant funding
    b. Local blueprint planning with full participation by consumers and family members
    c. Collaboration with local law enforcement and education
4. Clear, consistent standards and accountability
    a. Integrated data systems
    b. Statewide planning guidelines
    c. Statewide performance measures
    d. Criteria for standard levels of care
    e. Developmentally appropriate screening tools
5. Awareness and education
    a. De-stigmatize mental illness
6. Training and workforce development
    a. Core competencies

The Mental Health Alignment Work Group and House Bill 3024 required county mental health programs to develop biennial plans to achieve this ideal system. These were submitted to the Department of Human Services, Office of Mental Health and Addiction Services, in two phases, beginning in October of 2002.

Phase One Plans for the Ideal System

Thirty-five counties and one tribal government submitted Phase One plans. The plans identified gaps in services, and gave priority to systemic changes that would lead to the ideal system described in the Mental Health Alignment Work Group Report and House Bill 3024 (2001 Oregon Legislative Assembly).

Phase One plans were prepared before the state received revenue forecasts precipitating a dramatic decline in state budget revenues. The forecast led to unprecedented reductions in county mental health programs. Many programs – including crisis services, employment, early intervention programs for children and families, and local planning - were entirely eliminated. The following table describes the priorities listed in Phase One plans, along with the impact of subsequent budget decreases:

Priorities from Local Phase One Plans

Percent of plans	Priority service	Subsequent financial developments
42%	Case management/case coordination for adults	Oregon Health Plan standard population loses access to mental health case management.
31%	Employment training services	All state funding for employment services is cut.
28%	Culturally appropriate services and training of staff	Central training budget is cut by 63 percent (from $257,300 to $95,000).
25%	Evidence-based therapies, including outpatient models for adults	Oregon Health Plan standard and nonOHP population loses access to mental health care; supported employment program is eliminated.

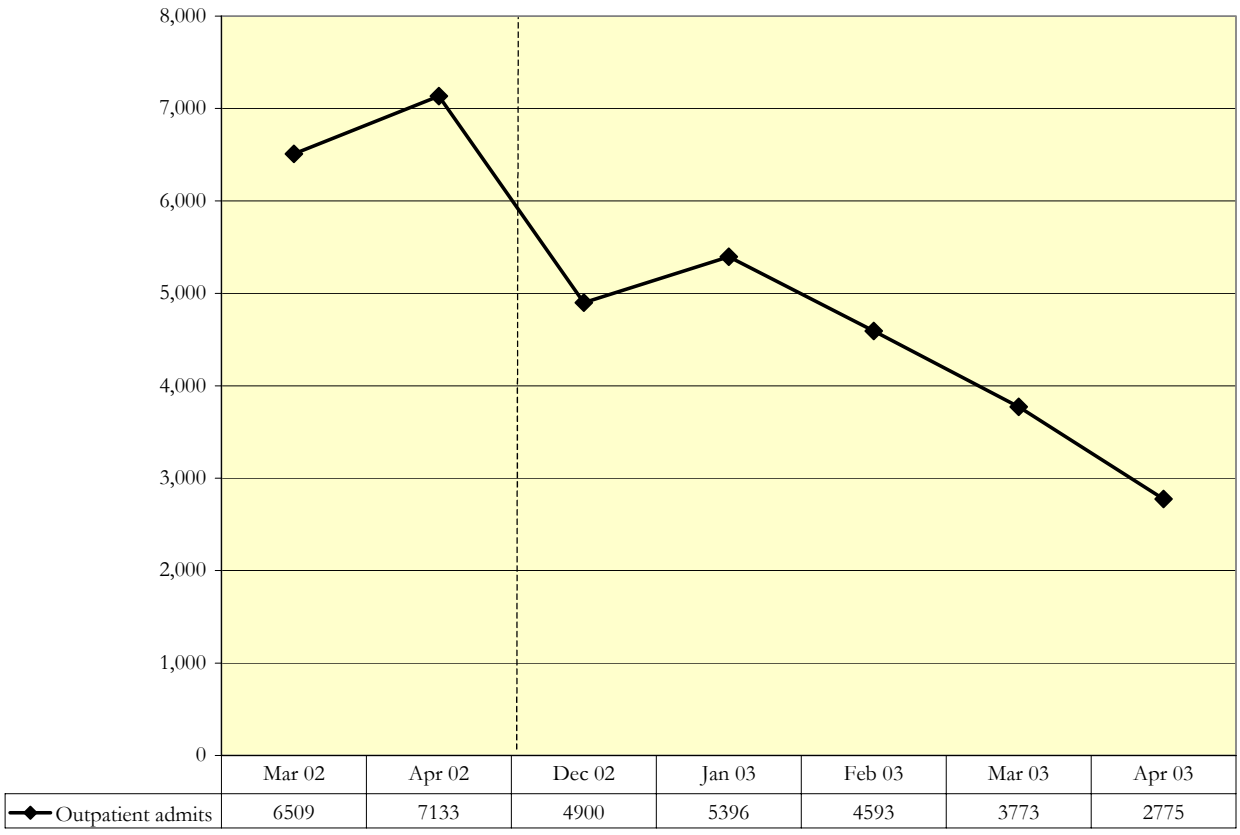
Percent of plans	Priority service	Subsequent financial developments
22%	Improved connection or coordination with schools	Psychiatric day treatment is reduced and burden shifts to schools and law enforcement.
22%	Improved connection and coordination with law enforcement and the judicial system	Psychiatric day treatment is reduced and burden shifts to schools and law enforcement. Indigent adults without the Oregon Health Plan lose access to mental health treatment, as does the standard population.
19%	Expansion of services to rural or under-served geographic locations	Oregon Health Plan standard population loses access to mental health care.
19%	Housing for adults with mental health disorders	Existing services are maintained.
17%	Family therapy and support	Oregon Children's Plan, which provides family therapy and support to parents and their first-born children, is eliminated.
17%	Evidence-based crisis services for adults	Funding for crisis services is cut.
17%	Case management and care coordination for youth and their families	Oregon Children's Plan, which provides case management and care coordinate for children and their families, is eliminated.
17%	Coordination and integration of mental health care services across the many agencies and systems that provide care, particularly physical health	Staff in community mental health agencies are cut by approximately 20 percent as a result of budget reductions.
17%	Specialized services for seniors	Most existing services are maintained.

Percent of plans	Priority service	Subsequent financial developments
17%	Increased capacity to serve nonOHP adults	All funding for nonOHP adults is cut.
15%	Screening and early intervention for youth and expansion of the Oregon Children's Plan	All services provided under the Oregon Children's Plan are eliminated.
14%	Services to support transitions between levels or types of care	Increase to community-based treatment for children discharged from institutions is eliminated. Transitional Living Center at Oregon State Hospital is closed.
14%	Prevention and early intervention services, including suicide prevention for adults	Early intervention services provided under the Oregon Children's Plan are eliminated.

Summary descriptions of all mental health service cuts are included in Appendix 1.

As a result of these cuts, admissions to community mental health programs plummeted. The number of new admissions fell by 57 percent, from 6,509 in March of 2002 to 2,775 in March of 03. The following figure illustrates.

March 2002 to March 2003



	Mar 02	Apr 02	Dec 02	Jan 03	Feb 03	Mar 03	Apr 03
Outpatient admits	6509	7133	4900	5396	4593	3773	2775

Number of New Admissions to Community Mental Health Services

Local mental health planners were forced to develop phase two plans, which shifted from a focus on creating the ideal system to a focus on salvaging the pieces of a crumbling infrastructure.

Phase Two Plans for Minimal System Priorities

The state's revenue crisis caused a staggering change in the dynamics of the state mental health system. The crisis reversed a long-time trend toward community-based, rather than centralized institutional care. For the first time in many years, the proposed budget for state institutions exceeded the budget for community services.

This transition was reflected in the P*hase Two* plans, which identified five disturbing trends in community services:

1. A shift away from service integration and coordination;
2. A shift toward crisis rather than restorative and preventive services designed to decrease costs and improve consumer outcomes;
3. A shift toward serving people with the most severe mental health disorders, and a resulting increase in pressure on the Oregon State Hospital to grow; and
4. Greater barriers to improving service delivery or developing infrastructure capacity to provide effective services.

Twenty-one counties submitted Phase Two plans. All indicated that they would significantly restrict access to services. In addition:

- 86 percent indicated they would shift resources away from other services to provide minimal crisis services.
- 33 percent indicated they would provide case management and coordination only for consumers with serious and persistent mental illness.
- 14 percent indicated they would shift resources away from other services and toward hospital or "hold-room" services.

Section Two: State Plan

Oregon's ongoing revenue crisis imposes major obstacles to achieving the ideal mental health system outlined in the Mental Health Alignment Work Group Report and House Bill 3024 (2001 Oregon Legislative Assembly). These include:

- The revenue crisis has shifted funds away from early intervention services, which prevent the occurrence of more serious problems, to crisis services, which are an immediate imperative.
- The revenue crisis has shifted funds away from local acute psychiatric programs and toward the State Hospital system. Yet, research indicates that programs that are close to their homes and families best serve consumers.
- The revenue crisis has cut large pieces out of Oregon's system of care. Yet, research indicates that effective programs encompass a comprehensive range of services that can be tailored to the consumer's needs.
- The revenue crisis has significantly reduced the state's capacity to collect, analyze and report consumer and program outcome data and provide technical assistance, training and support to local programs. Yet, system improvement depends on these system components.

Programs must also find methods for coordinating potentially fragmented services resulting from the Oregon Health Plan's split funding system. Fully capitated health plans are paid to provide physical health and addiction services, while mental health organizations manage mental health services. The state must find an effective way to integrate these services even with disparate funding mechanisms.

Despite these obstacles, DHS and OMHAS will move forward with changes in contracting, administrative rules, and outcome practices toward the goals of the Mental Health Alignment Work Group and Senate Bill 3024. OMHAS proposes a nine-point plan to:

1. **Promote Shared Responsibility**

   OMHAS is working with Lane and Clackamas Counties to test the efficacy of a pilot mental health funding system. The pilot agreements create shared responsibility and risk for the mental health system at the state and county levels by:

   - Tying resources to performance outcomes;
   - Promoting the use of evidence-based practices;
   - Combining disparate funding sources – including funds to serve people in the State Hospital system - and allowing local flexibility in funding for services;

2. **Refine Performance Outcome Measurement**

   OMHAS has worked with provider organizations and consumer groups to implement a model for measuring mental health system performance. The model, described below, uses the Oregon Progress Board "logic model" framework.

Performance-Outcome Measures

Measure	Importance	Goal
High-Level (Shared Societal) Outcomes		
Percent of consumers who are involved in community activity	Involvement in community activity is associated with increased independence	Increase
Percent of consumers who maintain or improve level of function	Shows that consumers are receiving services targeted to increases in functioning	Increase
Intermediate-Level Outcomes (Performance Measures)		
Average length of time between treatment episodes	Shows how effectively the system maintains clients in the community	Increase
Percent of consumers readmitted to hospital/acute care within 180 days of discharge	Demonstrates the effectiveness of the community care system	Decrease
Percent of consumers readmitted to hospital/acute care within 30 days of discharge	Demonstrates the effectiveness of treatment discharge planning	Decrease
Percent of consumers who receive community service within 7days of discharge from hospital/acute care	Continuity of care is important to avoid recurrence of symptoms	Increase
Percent of consumers who enter care at the community level	Ideally, the system should minimize the number of people whose first contact is at the inpatient level	Increase
Outputs (Performance Measures)		
Number of people who gain access to public mental health care	Consumers must gain access to care before they can benefit from care	Increase

These measures, which are reported to county mental health program directors quarterly, form the foundation for a continuous quality improvement system.

3. **Move Toward Evidence-Based Practices**

   The performance model and quarterly outcome reports are tools that can be used to diagnose problems in the community mental health system. OMHAS's training unit is working with program support staff to develop "tool kits" to help providers improve their performance on each of the critical measures.

   OMHAS will pursue federal grants and other non-General-Fund resources to establish at least one center on evidence-based practices for the purpose of workforce training and information dissemination.

4. **Promote Cultural Competency and Responsiveness of Mental Health Services**

   DHS will continue its commitment to culturally responsive and respectful services. The OMHAS will reconvene a group of diverse stakeholders to develop a specific action plan to focus on evidence-based practices, outcome measurement, and quality improvement initiatives in this critical area.

5. **Explore Local Match**

   OMHAS will explore options for local county funds to be used as a match to Medicaid for targeted case management. This will expand the revenues available to community mental health programs.

6. **Improve Integration with Primary Care**

Staff from OMHAS and OMAP are working together to identify effective models for the delivery of mental health care in primary care settings, and to implement these models through the Oregon Health Plan. OMHAS staff is also developing a program to train primary care physicians and mental health practitioners on the advantages and methods of linking physical and mental health care.

OMHAS will build on existing DHS databases to assist primary care physicians under the OHP to:

- Identify patients with mental health disorders, or those at-risk of these conditions;
- Improve the design of the delivery of care to persons with mental health disorders;
- Guide the use of medications for mental health disorders;
- Choose measurable outcomes that reflect evidence-based practices; and
- Regularly measure these outcomes to improve patient outcomes.

7. **Improve Prescribing Practices**

OMHAS staff will work with other state agencies and higher education to develop methods to assist primary care physicians in the most effective prescribing practices for psychiatric medications. In addition, the Office of Health Plan Policy and Research will include mental health drugs in its "practitioner managed pharmaceutical project," which provides information to physicians and consumers.

8. **Manage Pharmaceutical Costs**

OMHAS staff has developed a preliminary plan to manage mental health pharmaceutical costs in an effective and efficient manner. The plan includes academic detailing, provider profiling, and collaborative drug treatment protocols. This initiative will provide up-to-date information to prescribers on evidence-based prescribing practices, and recommendations for cost effective practices.

9. **Use Public Health Approach**

Mental health disorders occur in all social classes, ages, ethnicities and backgrounds. Therefore, DHS's Health Services Cluster will implement a "population-based" or "public health" approach to mental health disorders and the burdens associated with them. This approach, which is characterized by concern for the health of a population as a whole, focuses on health promotion, disease prevention and ready access to services. The approach includes consumers and their families as active participants in their own care. This focus ultimately increases consumer success and family satisfaction, and supports the integrated and coordinated system envisioned by the Mental Health Alignment Work Group and House Bill 3024 (2001 Oregon Legislative Assembly).

Section Three:
Status of MHAWG Recommendations

Oregon has made progress in implementing many of the statewide recommendations from the Mental Health Alignment Work Group report. In most cases where recommendations have not been fully accomplished, attempts have been made or actions have been taken to make progress. DHS and OMHAS staff will continue to take the lead in advancing these recommendations, as outlined below:

Implementation of Statewide Recommendations from MHAWG Report

Recommendation	Summary of State Progress
Legislative Action	
Establish an independent ombudsperson office	A legislative solution was sought in 2001, but was not accomplished. No bill before the 2003 Legislative Assembly establishes a mental health ombudsperson, or mental health function within existing ombuds-offices.
Establish equal benefits for mental health and physical health (parity)	Three separate pieces of legislation were introduced in 2001 session. Hearings were held, but no votes were taken. Two parity bills have been introduced in 2003 session: Senate Bill 1 (mental health and chemical dependency) and Senate Bill 54 (mental health only).
Simplify OHP enrollment process and eliminate periods of non-coverage	A legislative solution was sought in 2001, but was not accomplished. The Legislature eliminated mental health coverage from OHP standard benefit package at the November 2002 E-Board.

Recommendation	Summary of State Progress
Establish a FHIAP-like subsidy program for purchase of employer-based insurance, based on a basic benefit package	Legislation was drafted for the 2001 legislative session, but no action was taken. No bill in the 2003 session establishes or adjusts FHIAP benefits for mental health.
For implementation purposes, transfer Dammasch Housing Trust Fund from DHS to OHCSD	The Governor's Office and the two Departments in December 2002 reviewed this recommendation. Reviewers determined it would not be advantageous to make this transfer.
Establish Local Biennial Blueprint Plan	House Bill 3024, passed in 2001, requires local biennial blueprint planning. In October of 2002, 35 counties and 1 tribe submitted blueprint plans.
Planning	
Establish guidelines and review of Local Biennial Blueprint Plans	Initial guidelines were distributed in July of 2002, and plans were reviewed in November and December of 2002.
Local Mental Health Authorities and Local Public Safety Coordinating Councils shall work together to address the interface between law enforcement and mental health – becoming a part of the local blueprint plans.	House Bill 3024, passed in 2001, includes such a provision. OMHAS developed a special project with the Juvenile Crime Prevention Program that targets delinquency risk factors. OMHAS also implemented a special project to support successful transition for adult offenders with mental health disorders leaving institutions or jails. The State Hospital opened a new forensics unit to meet increasing demands from criminally committed patients. Three federal block grant projects were focused on adults with mental illness in local jails. Two similar projects focused on juvenile offenders.

Recommendation	Summary of State Progress
Develop standardized level of care criteria linked to local plans.	OMHAS sought and received grants to promote evidence-based practices. The OMHAS Extended Care Management Unit placed 139 adults and 134 children from institutional mental health settings to less restrictive, appropriate community-based settings. OMHAS also established two facilities to provide post-acute intermediate treatment services to adults as an alternative to the State Hospital. OMHAS expanded the intensive treatment services project to serve 109 children from 21 counties at 5 mental health organizations. OMHAS safely closed the children's ward at the State Hospital and provided community-based treatment for an increased number of children.
Provide public mental health funds through a block grant for purpose of implementing local blueprint plans.	OMHAS is currently meeting with two counties, Clackamas and Lane, to explore a flexible block grant funding system that meets federal funding regulations.
Develop a statewide plan consistent with MHAWG and derived from local plans	This report is statutorily required under ORS 430.630. This document is the first report.
Administrative	
Governor and state agencies to make changes necessary to integrate administrative functions to support local service delivery	DHS integrated the administrative offices and functions of alcohol and drug and mental health, resulting in reduction of 14 FTE.

Recommendation	Summary of State Progress
Create a seamless data system using an information system guidance committee to inform the process	OMHAS has created a mental health treatment outcome improvement report steering committee. OMHAS has initiated improvement in the Client Process Monitoring System to make the mental health and alcohol/drug forms more consistent. OMHAS conducts desk data audits to assess and report on the timeliness, accuracy and completeness of data.
Develop or adopt statewide performance measures and allow for additional local measures. Coordinate with data system development	OMHAS adopted the Oregon Progress Board "logic model" to provide a construct for organization of performance measures. These measures were included in local blueprint planning guidelines and the 03-05 Agency Request Budget. OMHAS is currently working with the treatment outcome improvement report steering committee to further develop and refine performance measures.
Establish developmentally appropriate screening tools for children and adolescents	As part of the Oregon Children's Plan implementation, DHS developed a screening tool for early childhood mental health.
Education	
Form a consortium of public and private groups to provide public education	No action has been taken.
Conduct a study and analysis of the needs of the mental health workforce. Identify core competencies and develop training across systems	No specific analysis has been completed. However, work on evidence-based practices illuminated the need for increasing the competencies of the mental health workforce. Linkages are being developed with Rogue Community College and Portland State University to create courses in evidence-based practices.

Recommendation	Summary of State Progress
Develop abuse/neglect policy	OMHAS adopted a trauma policy in fall of 2002. The state's policy regarding investigation of abuse allegations is in OAR 309-40-200-290. Senate Bill 18 (2003) would expand the state and local statutory responsibilities for reporting and investigating abuse to include neglect of persons with mental health disorders. The bill has currently passed the senate.

CONCLUSION

Mental health is the catalyst for communication, thinking skills, resilience to problems and self-sufficiency – all of which are important for revitalizing Oregon's economy. Recovery from mental health disorders is real. Science has identified effective treatments, preventions, services and supports that assist with recovery.

Despite substantial progress over the last two years, Oregon's mental health services, particularly at the local level, do not have the capacity to function as an integrated system. Budget cuts have forced a higher priority on crisis services and a greater reliance on institutions at the state level. Without restoration of resources; however, Oregon's mental health services will become more costly and ineffective, and shift away from the goal of recovery. This risk is already a reality in some Oregon communities.

Nevertheless, the opportunity still exists to ensure that the parts of the mental health system that survive the budget reductions are focused on the most effective and efficient community services possible. This means taking steps to ensure those services that survive are connected into an integrated service system are evidence-based and achieve real outcomes for consumers in the context of their lives, cultures and communities. OMHAS remains committed to taking these steps.

Appendix 1

Impact of Budget Cuts

In the next biennium, reductions made in the current budget (2001-2003) may continue. While the ultimate effect of reductions is yet unknown, it is very likely that fewer Oregonians with mental health disorders will be able to receive care, and that the infrastructure at state and local levels needed to provide effective and appropriate care will be significantly reduced for those who continue to qualify for services. These factors change the ability of Oregon's current mental health system to operate effectively, and to do so in the manner mandated in ORS 430.630.

This section summarizes reductions in the mental health system and the estimated number of Oregonians impacted in FY 02-03, and anticipated results.

Cuts to the 2001-2003 Mental Health Budget

Reduction	Result	01-03 Impact
Reduce funding to counties for 24-hour, 7-day crisis response to those experiencing a severe mental health crisis.	These people will be at increased danger of harming self or others.	9,725 children & adults
Do not increase community-based mental health treatment for children & adolescents that allow discharge from institutional levels of care.	These children will remain in more expensive levels of care and do less well at recovering. The state is also put at heightened risk of lawsuit.	45 children

Reduction	Result	01-03 Impact
Delay opening of forensic unit at Oregon State Hospital.	Failure to open this ward January 2003 as originally budgeted creates census problems at OSH, raises patient and staff safety concerns and puts the state at heightened risk of lawsuit.	Forensic program, over 5 months, has been 28-34 patients over capacity.
Eliminate supported employment program.	These people will be at risk of hospitalization, homelessness and criminal activity.	109 adults
Reduce number of psychiatric day treatment slots for children.	Costs and burden will shift to schools, juvenile justice system and inpatient treatment settings.	262 children & adolescents
Eliminate funding for community mental health services for non-Medicaid clients.	These are people who currently function well in their communities. They likely will not continue to be able to do so because they will not have access to their medication and treatments.	10,450 adults
Restructure adult residential treatment beds.	122 residents will receive care in an alternative setting.	33 beds lost in adult residential and a net loss of 16 beds in the overall system
Close the Transitional Living Center at Oregon State Hospital.	Increase in already over-crowded conditions at OSH, reduced ability to place inmates from local jails at OSH, creates difficulty in serving mandated populations. Jeopardizes	Loss of capacity of 26 beds serving an estimated 44 adults

Reduction	Result	01-03 Impact
	public safety.	
Do not increase community mental health residential capacity to facilitate discharge of long-term hospital patients with special needs for successful community placement.	These individuals will remain in the state hospital because of lack of community-based care options.	25 adults
Remove mental health benefit from OHP-standard.	Some cost shift will occur to physical and hospital care due to increased medical emergencies.	Over 118,000 adults
Change beginning of eligibility date for OHP-Plus.	Clients will incur increased expenses, providers may not receive reimbursement for services provided, and costs will shift to hospitals and law enforcement as these people show up in emergency rooms and jails.	Approximately 120,000 children, adults & families will be without insurance coverage for periods of up to 6 weeks
Terminate contracts with hospitals and private psychiatric units for the purposes of long-term care.	Hospitals must find other options for paying for these clients in the event the state is unable to move them (likely through uncompensated care or increased health care costs).	17 community-based hospitals
Eliminate funding for Office of Consumer Technical Assistance.	Limits support to all areas of the state in developing support networks and services run by consumers	Loss of 2.5 FTE mental health consumers in local jobs.

Reduction	Result	01-03 Impact
	of mental health care.	
Eliminate mental health services under the Oregon Children's Plan.	Children and families with mental health disorders will not be diagnosed and treated early – resulting in more significant problems and higher cost of care later in life, impacting child welfare and juvenile justice.	Loss of services for 545 families with young children