Oregon Children's Mental Health System Change Initiative
Implementation Evaluation

Report of Findings

DRAFT FOR REVIEW

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Office of Mental Health & Addiction Services
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I. Executive Summary

This report examines the implementation of the Children's Mental Health Systems Change Initiative (CSCI) between October 2005 and August 2006 by the Addiction and Mental Health Division (AMH), which was formerly known as Office of Mental Health and Addiction Services (OMHAS), Oregon Department of Human Services. The CSCI was mandated in 2003 by Legislative Budget Note HS-3 to create sweeping changes in the children's mental health system to serve children and youth with serious emotional, behavioral, and mental disorders through community-based, least restrictive, culturally appropriate, evidence-based services. Core services included care coordination and a comprehensive array of services (Integrated Service Array) designed to serve youth with complex problems at home and in their communities. These changes were to be planned and carried out with the full participation of family members, including parents and other caregivers, as well as affected children and youth.

At the conclusion of the first year's implementation of the CSCI, there is evidence of

- considerable system-wide infrastructure development;
- a philosophical shift in the culture of service delivery toward a more family-focused, strengths based and coordinated system; and
- enhanced service capacity including a network of care coordinators.

In addition, the foundation has been laid for

- quality assurance and contract monitoring;
- development of culturally competent services;
- full family participation and family driven services; and
- development of a workforce to support the system change.

Recommendations focus on

- increasing vertical and horizontal communication within and across systems;
- development of creative approaches to enhancing care coordination and providing the expanded service array in all areas of the state;
- efforts to improve coordination and collaboration among state level partners and assuring the involvement of all community partners especially physical health, developmental disabilities and addiction services.

Recommendations related to resources and financing include

- continued efforts toward integrating funding across service systems;
- increased funding for training and technical assistance; and

- increasing resources allocated to supporting meaningful family and youth involvement.

System change of this magnitude is a major undertaking and will continue to require dedicated leadership and resources as well as cross system collaboration at all levels. The findings of this evaluation highlight the substantial progress that has been made to address the needs of Oregon children and youth with emotional, behavioral and mental disorders and their families.

II. Background and Purpose

The Division of Addiction and Mental Health (AMH), formerly known as Oregon Department of Human Services (DHS) Office of Mental Health and Addiction Services (OMHAS), began planning for the implementation of the Children's Systems Change Initiative (CSCI) in response to input from a series of stakeholder workgroup meetings that directly informed Legislative Budget Note HS-3. As a state-wide systems reform effort, and in accordance with this legislation, the goals of the CSCI are to increase the availability and quality of individualized, intensive, and culturally competent home and community-based services so that children with serious mental, behavioral and emotional disorders and their families can be served in the most natural and least restrictive setting appropriate for their needs.

On September 22, 2004, AMH issued a series of six policy statements that outline expectations and guidance for the CSCI. The six policies are listed below:

- Policy 1 Level of Service Intensity Determination
- Policy 2 System Structure and Functions
- Policy 3 Meaningful Family Involvement
- Policy 4 Workforce Development in Cultural Competency
- Policy 5 Outcomes
- Policy 6 Financing

In January 2005, AMH began establishing advisory committees at the State and local levels to oversee the implementation process. In October 2005, AMH officially changed the financing structure for service delivery with initiation of new MHO contracts. This date serves as the beginning point for CSCI implementation for the purposes of this evaluation.

In January 2006, AMH contracted with the Regional Research Institute (RRI) at Portland State University to conduct an evaluation of the CSCI implementation process. The RRI has a long history of conducting research and evaluation within children's mental health systems across the country. The RRI's Research and Training Center on Family Support and Children's Mental Health has been operating since 1984 and is nationally recognized for its work in promoting effective community-based, culturally competent, family-centered services for families and their children who are, or may be affected by mental, emotional or behavioral disorders. This work is accomplished through collaborative research partnerships with family members, service providers, policy makers, and other concerned persons.

The intent of this evaluation was to determine the degree to which infrastructure and service delivery changes have occurred at the State, Mental Health Organization (MHO), and local levels to address the intent of the Budget Note. In particular, the aim of this evaluation is to clarify what structures are in place, what initial activities have been implemented, and what progress has been made with respect to the CSCI implementation. Since the CSCI only began serving children and their families in October 2005, it is not feasible to report on child and family outcomes or the effectiveness of these reforms until a later date.

The RRI submitted a preliminary Phase I report in April 2006, the purpose of which was to revisit the proposed evaluation design, to provide AMH with a summary of RRI's desktop review of CSCI related background materials, and to provide the draft content for the six stakeholder interview protocols that were used for the actual evaluation activities implemented in this second phase.

The purpose of this report is to summarize the findings from the Phase II efforts including data obtained through meeting observations and interviews with key stakeholders across the children's mental health system. Analysis of this information also yields a set of proposed recommendations that AMH may use for children's mental health system-level enhancements.

III. Key Assumptions and Limitations

In developing the research design and in presenting the evaluation findings, certain assumptions and limitations have been considered including:

- The Legislative Budget Note HS-3 is a requirement for systems reform within the children's mental health system only. Therefore, expectations and outcomes pertaining to other child-serving agencies such as child welfare, the schools, juvenile justice, and public health are not the immediate focus. The evaluation does however address the CSCI's affects on interagency coordination and collaboration across these child-serving agencies at the management and direct service delivery level.

- This evaluation utilizes primarily qualitative methods and does not review or report on data available within the system. Interviews were conducted to obtain a snapshot of the CSCI implementation activities across each of the nine MHOs. Resources were not allocated to perform an in-depth onsite systems performance review of all state-level, MHO, and provider operations across all 36 counties in the state.

- Family satisfaction is being assessed through family members with knowledge of the CSCI implementation through their participation in state or local committees or via advocacy roles at various levels within the system. For the most part, families who are not involved in governance of the CSCI or employed by mental health agencies were not interviewed. These families should be included in the design of the next phase of evaluation.

- Because of the structure of mental health services in Oregon, the CSCI and hence this evaluation, is focused on those individual children and families receiving services under Medicaid and not those in the fee for service system.

IV. Overall Evaluation Design

Based upon several meetings with AMH staff, RRI proposed a design for the evaluation of the implementation of CSCI. The following evaluation questions shaped the evaluation.

Question 1. To what extent is the children's mental health system changing?

- What are the different approaches that MHOs are taking to implement the children's system change initiative?
- How do these different approaches reflect community culture, demographics, and needs in rural vs. urban areas?

Question 2.What approaches and structures have MHOs developed to establish and implement the Integrated Service Array (ISA)?

- What is the range of ISA services that are available to children and families across the state?
- To what extent were MHOs successful in ensuring that children potentially eligible for the ICTS were screened using the CASII?
    - To what extent do children who met the level of need criteria receive the full array of services as determined by their individual needs?
    - To what extent are family members and children driving the treatment plan and support process?
    - To what extent has there been an increase in community-based services and decreased reliance on more restrictive care, more diverse array of services?

Question 3. To what extent has meaningful family involvement and family leadership at the child, local, and state levels been increased?

- To what extent has OHMAS-provided activities and resources (e.g., Family Involvement Coordinator, contract requirements, training) designed to increase family involvement

and leadership been effective?
- To what extent do MHOs involve families and promote family leadership?

Question 4. To what extent does implementation of the Initiative appear to influence the nature and extent of interagency collaboration and planning at the state and local levels, including alcohol and drug treatment services?

Question 5. In what ways do MHOs serve culturally and linguistically diverse populations and communities?

- What strategies have MHOs implemented to increase their capacity to provide culturally competent services?
- How have strategies differed in response to community culture and demographics, e.g., urban and rural settings?

Question 6. How have AMH and the MHOs addressed workforce development issues that support the children's mental health systems change initiative?

Question 7. What structures and process have been implemented to oversee the CSCI at the state and local level?

- Are community based Quality Improvement Structures in place?
- What data are being collected to track performance and outcomes?
- How are AMH and the MHOs monitoring MHO compliance to contract requirements?

Question 8. What issues have been identified around the financing of the CSCI?

Evaluation Methods

During the initial phase of the evaluation, evaluation staff reviewed documents describing children's mental health delivery system at the State level as well as the nine MHOs and county mental health authority structures and functions. A more detailed analysis of this structure and operation at both the State and local level was compiled as part of the detailed interview process outlined below.

The following documents pertaining to the CSCI were reviewed:

- Budget Note HS-3
- CSCI Logic Model
- OMHAS Policy Statements 1-6

- Oregon Administrative Rule Chapter 309, Division 032 Standards for Children's Intensive Community-Based Treatment and Support Services.
- The OMHAS /MHO Contract Agreement effective January 2006
- Meeting minutes and frequently asked questions/materials from the AMH website.
- 2005 Oregon Youth Services Survey for Families

The success of systems reform initiatives and ensuring long-term sustainability can be measured using a set of indicators that are commonly used in the children's mental health research field. These indicators often are divided into two distinct domains: one for the review of infrastructure development and one for service delivery development. Within each of these domains, indicators are segmented into specific categories. For example, to assess infrastructure development, system evaluation categories might include accountability, governance and oversight; day-to-day management and operations; service array development and capacity; interagency collaborations and communication; quality monitoring; and how data is used to drive systems change. From a service delivery perspective, system assessment would focus on areas such as methods for outreach and education of providers and families; intake, eligibility determination and assessment activities; capacity of services and supports; service planning processes such as the structure and function of the child and family teams; coordination of care mechanisms; ease of access into the system; and review of information about children's placement decisions. The level of child and family involvement, interagency collaboration, and cultural competence will be evaluated across categories.

Using the information collected from document reviews, interviews with AMH staff, the six policy statements and the research categories outlined above, the evaluation team of the evaluation developed of six interview protocols. Each protocol was designed to collect information from a particular respondent cohort, based on an assessment of who would be the most knowledgeable about a particular infrastructure and/or service delivery domain. Respondents were selected with the objective of obtaining a balance of professional and family representative input, representation from each MHO region, and representation from a range of relevant child serving agencies. All interview schedules and data collection protocols were submitted to and approved by the PSU Human Services Research Review Committee.

Data Collection Activities

The evaluation team collected interview data and observed meetings between April and September 2006. Two approaches to data collection were used during this phase. The first and primary method for obtaining information was through face-to-face and telephone interviews with key stakeholder groups. At the state level, interviews were conducted with the AMH administrative team and with AMH's children's mental health program operations management

and staff (including the Family Involvement Specialist). A representative from each of the Family Advocacy Organizations, members of the state-level Children's Mental Health System Advisory Committee (CSAC), and leadership from each of the nine MHOs also were interviewed. CSAC family members, providers and agency staff from child welfare, OYA, and the schools also provided input. Table 1 below presents the actual number and category of individuals interviewed during Phase II.

Table 1.
Interview Respondents by Category

Protocol #	**Respondent Category**	**Number of Respondents**
Protocol 1	AMH Administrators/Staff including the Family Involvement Specialist	10
Protocol 2	Family members/Family Advocacy Organizations leadership	9
Protocol 3	MHO Directors/Children's System Coordinators	13
Protocol 4	Community Care Coordinators	10
Protocol 5	Child-serving Agency Representatives on CSAC	7
Protocol 5	Day Treatment/Residential Providers	4

The second data collection method used was meeting observation. Members of the evaluation team observed and participated in the state CSAC on a monthly basis, attended several MHO advisory committee and Community Care Coordination Committee (CCCC) meetings, and met with the Quality Data Improvement Group (QDIG). Agendas, meeting minutes, and other relevant documents from these groups were also reviewed.

The overall data collection process was strategically designed to gather information incrementally, with frequent updates provided to AMH and the CSAC about our progress. The evaluation team began by interviewing the person accountable for the CSCI in each of the nine MHOs, either the MHO Director or the Children's System Coordinators within each MHO provided this overview. This overview allowed the team to recognize the varying MHO structures, from a single county, single MHO structure, to MHOs with multiple counties. Given these variations, we needed to determine how many MHO advisory and CCCC structures were in place, and whether the MHO was a direct service provider or more of an administrative entity. The next stage of interviews involved a sample of care coordination staff within each MHO region to gain a greater understanding of the mechanisms for accessing services and the how the

Integrated Services Array (ISA) and Intensive Community Treatment Services (ICTS) are functioning.

Findings from these interviews and observations are reported in the next section of this report.

V. Findings

The CSCI implementation findings are summarized according to each of the evaluation questions outlined in the methodology section. For each question there is a link to corresponding elements within Budget Note HS-3, to Policy Statements One through Six, and to the 2006 OMHAS (AMH)-MHO agreement. Each evaluation question response includes the following:

- Accomplishments
- System Challenges
- Recommendations

At the end of the response we provide a summary statement that ties in all of the CSCI requirements and indicates the degree to which the CSCI implementation is meeting the intent of the Budget Note HS-3

Overview of the Oregon Mental Health Organization Structure

To facilitate understanding of the CSCI implementation accomplishments, challenges, and recommendations outlined in the following pages, the Findings section begins with a description of the Oregon Mental Health Organization (MHO) structure. In reviewing this structure, attempts were made to identify a service delivery archetype that could be linked to future individual MHO and/or aggregate outcomes. While one particular model did not surface, efforts were made, where feasible, to identify those MHO structural elements that are the most homogenous and those that are the most diverse. This knowledge may offer insight into the affects these structures have on both clinical and administrative processes and outcomes as the CSCI evolves. There are two other factors that may affect CSCI outcomes. One is the rural versus urban geography of the MHO service areas, and the second is the proximity of the MHO to AMH located in Salem.

Structure Prior to the CSCI

Historically, children's mental health acute care and outpatient services have been provided by local MHOs and community-based mental health programs (CMHPs). Psychiatric Day Treatment Services (PDTS) and Psychiatric Residential Treatment Services (PRTS) were

provided through state contracts, which allowed providers and consumers the ability to access these services independent of the mental health system. Providers, such as DHS/child welfare staff, also were able to work directly with these PDTS and PRTS providers to make placement decisions with limited or no mental health involvement.

Many of these same MHOs and CMHPs are serving children now through the CSCI. The primary difference in this new service delivery approach is that with the advent of the CSCI, accountability for the authorization and delivery of children's mental health services has been centralized under the auspices of the MHO. Since October 2005, Oregon Health Plan funds for all PDTS and PRTS were shifted to MHO control. The state also shifted general fund dollars to the CMHPs to enhance service capacity for children not eligible for Medical Assistance, i.e., OHP dollars.

Current MHO Structure

AMH currently contracts with nine different MHOs that serve children and their families across the state. The structures, number of covered lives, and catchment area for each of these MHOs varies. Of the nine, three have a single-county service area, five are multi-county, and one operates as a direct service provider in three counties. See Table 2 for MHO structure.

The CSCI consists of three MHOs that provide services in only one county. Washington County MHO serves Washington County, Verity Integrated Behavioral Health Systems (VIBHS) MHO serves Multnomah County, and Lane Care MHO covers Lane County. Each of these MHOs coordinates with (or is the) one CMHP, and oversees the CSCI with one advisory council and one Community Care Coordination Committee (CCCC). Multnomah and Washington counties are located near Portland and are considered relatively rich in resources. Lane County is in the Central western region of the state.

There are five MHOs that fall into a multi-county service structure. Of these, three have a five county service area.

- Accountable Behavioral Health Alliance (ABHA) covers Benton, Jefferson, Lincoln, Deschutes and Crook counties in the central and western region of the state. Each of these counties is diverse in size, landscape and affluence. ABHA has chosen to break the MHO into three distinct regions known as Coastal (Lincoln), Cascades (Jefferson, Crook and Deschutes) and Valley (Benton). Each county has a CMHP and each region has its own advisory committee and CCCC. ABHA also has an advisory council that meets twice per year to obtain input from each of the regions.

- Clackamas County (CCMH) also operates under a regional structure with Clackamas County and Mid Columbia Center for Living operating as the two CMHPs. Each of these regional entities makes its own service and fiscal decisions. Clackamas serves Clackamas County with one advisory committee and one CCCC. Mid-Columbia serves the Hood River communities of Gilliam, Sherman, Wasco and Hood River with one advisory council and one CCCC. The Clackamas MHO serves both rural and suburban populations.

- The third five-county MHO is Mid Valley Behavioral Care Network (MVBCN). MCBCN serves northwestern counties of Linn, Polk, Marion, Tillamook and Yamhill. MVBCN operates an advisory committee with representatives from each county in attendance. Each county also has its own CCCC structure.

The two remaining multi-county MHOs are Greater Oregon Behavioral Health Inc. (GOBHI) and Jefferson Behavioral Health (JBH).

- GOBHI MHO covers 12 counties, 10 counties in the eastern part of the state as well as 2 small counties in the northwest corner. GOBHI covers nearly 50 percent of the eastern region of the state and serves rural populations. GOBHI is in the process of creating its advisory committee structure and plans to have the first meeting in the fall 2006. The number and location of the CCCCs varies across the GOBHI counties.

- Jefferson Behavioral Health is the newest of all the MHO structures. It serves six counties in the southwest corner of the state. In four counties there is a advisory committee and a CCCC for each county. Two counties have combined their advisory and CCCC committees. There is also a central advisory structure at the MHO level.

The final MHO, Family Care, is a direct service provider. Family Care was formed when Magellan Health Care closed it doors. Family Care functions as its own service provider in Multnomah, Washington, and Clackamas counties. Because of its small size, MHO staff participate in the advisory committee and CCCC in the counties it contracts with.

Table 2 MHO Structure

MHO Name	Number of Counties Served	Number of Advisory Committees	Number of CCCC
ABHA	5	4	3
Clackamas	5	2	4
Family Care	3	0	0
GOBHI	12	1 in development	12?
JBH	6	7	6
Lane Care	1	1	1
Mid Valley BCN	5	1	5
Verity	1	1	1
Washington	1	1	1

Evaluation Question 1

To what extent is the children's mental health system changing?

- What are the different structures that have been implemented at the MHO level to implement the children's system change initiative?
- How do these different approaches to change reflect community culture, demographics, and needs in rural vs. urban areas?

Budget Note HS3[1]

In order to substantially increase the availability and quality (breadth, depth and intensity) of individualized, intensive, and culturally competent home and community based services so that children are served in the most natural environment possible and so that the use of institutional care is minimized, DHS is directed to take the following actions by June 30, 2005.

a. Integrate hospital, psychiatric residential, day treatment, and community care in local or regional managed care environments.

b. Ensure meaningful family involvement at policy, local or regional managed care system, provider, and individual child levels;

c. Require culturally competent skills-based staff training on evidence-based practices and family involvement;

d. Ensure continuous care coordination;

e. Create clinical and fiscal incentives to provide culturally competent care in the least-restrictive and most normative setting in the child's home community.

f. Implement a state-wide system of quality improvement and use of pertinent outcome data to achieve an effective system of care (e.g., reduce institutional care and increase the proportion of children and families who receive flexible, community-based services).

[1] Key points are summarized.

g. Ensure that funding intended and allocated by the legislature for children's mental health is used for that purpose.

h. Encourage local or regional managed care organizations to create a flexible funding pool and to contract with non-traditional providers to provide a culturally competent, flexible response 24 hours-7 days a week, without requiring children to enter a facility.

i. Support the system of care through meaningful regulation and contract provisions.

Policy Two: System Structures and Functions[2]

State Level

- A State Children's Mental Health System Advisory Council (CSAC) will be formed to advise OMHAS (AMH) on oversight of the children's mental health system and mental health policies and programs for children statewide.
- The MHOs will form regional or local Children's Mental Health System Advisory Councils.

Local/Regional Level

- The MHOs will be responsible for forming regional or local Children's Mental Health System Advisory Councils. Membership of the councils will be representative of the regional or local system of care and comprised of 51% representation of family members, older adolescent or young adult members. The MHO CSAC will reflect the culture and ethnic groups of OHP covered members in the service area.

- The MHOs, in conjunction with the CMHPs, will identify a local Community Care Coordination Committee (CCCC). Membership of the committee will be representative of the local system of care. A Child and Family Team will facilitate Integrated Service Array planning. At a minimum the team will be comprised of the child, when appropriate, the family and the care coordinator.

[2] Key points are summarized. See http://www.oregon.gov/DHS/mentalhealth/child-mh-soc-in-plan-grp/policy2.pdf

2006 MHO Agreement[3]

- Contractor shall develop and implement a regional or local children's mental health system advisory council. The advisory council will advise Contractor and provide oversight of the local or regional mental health policies and programs for the Integrated Service Array (ISA), as well as ensure continuous quality improvement.
- Contractor shall develop and implement a Community Care Coordination Committee that is a community level planning and decision making body to provide practice-level consultation, identify needed community services and supports, and provide a forum for problem solving to families, ISA providers, child serving agencies, and child and family teams.
- The child and family team will support and help facilitate access to a combination of services, informal and formal supports, and other community resources.

Accomplishments

State Level Structures

- **AMH has created several bodies at the state level for sharing information and identifying and processing challenges.** These include the Children's Mental Health System Advisory Committee (CSAC) and the Quality Data Improvement Group (QDIG). In addition, there are several cross-MHO workgroups that are chaired by an AMH staff member and that meet on a monthly basis. These include the MHO Directors group, the Children's Systems Coordinator group, and the Quality Improvement Committee. These workgroups, some of which have been in existence for some time, are now focusing more regularly on children's issues.
- **There is general agreement across respondents that the state-level Children's Mental Health System Advisory Committee (CSAC) is very effective.** This interdisciplinary committee has representatives from family advocacy organizations, child-serving agencies including mental health, juvenile justice/OYA, DHS/child welfare, the schools, AMH staff, providers, and family members who have been served by the mental health system. CSAC has a major role in monitoring the overall progress of the CSCI implementation. The committee accepts feedback on implementation issues from a diverse group of stakeholders and provides feedback to AMH on how to overcome identified challenges. The requirement for 51% family representation greatly strengthens the family voice in the system.

[3] Selected statements from the MHO Contract Agreement.

Local/Regional Structures

- **MHO-CSAC. All but two MHOs have a fully operational advisory committee structure in place**. MHOs consider these committees to be very influential as advisory and recommending bodies. Respondents reported that almost all suggestions produced are implemented by the MHO. At least 75 percent of these committees have governing by-laws or charters in place to outline the participants, roles and responsibilities of the group.

- **With one exception, all MHOs are operating a local CCCC.** In most instances, MHOs with multiple counties have a CCCC operational within each county or local community. In all instances, these committees are addressing mechanisms for keeping children in home and community settings.

- **According to MHO staff, all MHO communities have a Quality Improvement Committee (QIC) structure in place.** Many of the MHOs have a QIC that integrates both adult and child mental health issues.

- **Each MHO uses a child and family team structure at the local community level to develop an individualized service plan for the child and family.** More than 50 percent of the MHOs have contracted with an external consultant to assist them in developing a wraparound process to be used by the child and family team. Providers interviewed stated that the CSCI is a good concept that promotes community partnership. It builds on past efforts congruent with CSCI values such as the DARTS, the ITS pilot projects, and federally funded System of Care grants. The intent is to keep children in the community in the least restrictive setting possible. The CSCI is seen as a means to promote child and family focus and to coordinate children's mental health services across child serving systems.

System Challenges

- **There is unanimous agreement and understanding on the part of stakeholders interviewed that change of this magnitude takes time**. Some respondents called for a more realistic time frame and expectation for accomplishments each year, especially with respect to level of care determinations.

- **Although all state level CSAC decisions have been implemented, the decision-making process seems slow to some members.** Some respondents would like CSAC to have a more direct advocacy role.
- **There is variation in respondents' assessments of how effective the restructuring of local committees has been.** The existing structure of the county-based mental health system was an important consideration for each MHO as the CSCI was initiated. In many instances existing committee structures had to be re-evaluated. Some MHOs chose to preserve interagency oversight committees that had been in operation within their communities, especially those that have benefited from a federal System of Care grant. Other MHO communities have elected to build the CSCI required advisory committees on top of or in lieu of existing committees. And in some cases, it is unclear what consideration was given to existing structures. For example, an MHO with multiple counties chose to have an advisory committee and a CCCC within each community and an MHO level advisory committee composed of participants from each local community. Another MHO had this arrangement without an oversight body for the MHO. In instances where required CSCI committees were added to existing committee structures, MHO staff reported additional stress related to numerous meetings.
- **The functioning of CCCCs varies.** Many MHOs are using this forum as a problem-solving group to identify and overcome system barriers. Some CCCCs review difficult cases; but in several MHOs, an additional committee, referred to as the Residential Determination Committee, considers difficult cases.
- **Communication needs improvement.** Many respondents commented that AMH did a good job of giving updates and reports through the CSAC and the website in the planning phase of the CSCI. However, there is still wide variation across the state as to how information is provided to the direct service provider level (e.g., case managers of the MHO), and to parents and larger providers. Information sharing about the CSCI implementation has often remained at the higher levels of management across the system. There is an over reliance on people in advisory meetings' taking information back to the MHO and sharing it with others. Some respondents stated that information is slow to filter down, and when it does the quality and quantity of information varies as it gets passed along.

Recommendations

- Even though the structures for overseeing the CSCI are in place within most MHOs**, each MHO should assess and clarify relationships among local and regional committees. This assessment should address the functioning of each group as well as relationships**

among groups, with attention to areas where participants and functions overlap and where duplicative meetings exist. The second year of implementation provides an opportunity to refine committee functions and relations across committees.

- **Mechanisms to promote communication from state to local levels (e.g., CSAC to MHOs, to staff and providers) should be developed and/or enhanced.** A number of respondents noted that expecting CSAC members to be the main information conduit was insufficient. Each MHO should develop effective ways of communicating information about implementation of the CSCI with staff, other providers and family members.
- **AMH should continue to work to develop ways of facilitating horizontal communication, the exchange of information among MHOs and among constituent groups**. It may be that the existing state level committee structures will eventually be able to fill this need, however, at this point there is no way for individuals at the staff level to learn about what is going on in other MHOs.

Summary

There is strong evidence to indicate that the children's mental health system has changed at both the state and local level since the official implementation of the CSCI in October 2005. With minor exceptions at the MHO level, all mandated committee or team structures have been implemented across the state. Though variable, key system functions such as planning, oversight at the policy and service delivery level, family involvement, interagency collaboration, and system evaluation are being addressed through these structures. System of care values are being promulgated through these structures at high levels of the state and MHO organizations. Although the structures are in place, the level of effectiveness for promoting positive change is variable depending upon the characteristics of the community system. For MHOs that have had the advantage of system of care grants or pilot projects on wraparound, ITS, or other initiatives, efforts to implement the concept of the CSCI and to enhance community collaboration have been accelerated. Even in these communities however, there are still challenges with respect to duplication of structures and burdensome administrative responsibilities.

The next year of CSCI implementation should be focused on moving these philosophies, levels of collaboration, and improved system efficiencies to the provider/caregiver level.

Evaluation Question 2
What approaches and structures have MHOs developed to establish and implement the Integrated Service Array (ISA)?

- To what extent were MHOs successful in ensuring that children potentially eligible for the ICTS were screened using the CASII?
- To what extent do children who met the level of need criteria receive the full array of services as determined by their individual needs?
- What is the range of ISA services that are available to children and families across the state?
- To what extent are family members and children driving the treatment plan and support process?

Budget Note[4]

- Integrate inpatient hospital, psychiatric residential, psychiatric day treatment, and community care in the local or regional managed care environments.
- Ensure continuous care coordination for children with serious mental and emotional disturbances.
- Encourage local or regional managed care organizations to create a flexible funding pool and to contract with one or more non-traditional providers who are positioned to provide culturally competent flexible response on a 24 hour, seven days a week basis, without requiring the children to enter a facility (even for a short period of stabilization) to access the services.

[4] Key points are summarized.

Policy One: Level of Service Intensity Determination[5]

- The Child and Adolescent Service Intensity Instrument (CASII) (for ages 6 and up) will be used as the statewide Integrated Service Array (ISA) determination tool.
- Criteria for entering the ISA will consist of: A) CASII composite scores and B) Primary DSM Axis I mental health diagnosis above the funded line from the Oregon Health Plan.
- OMHAS may adopt additional factors to consider in planning and prioritizing services.
- Specific criteria are established and used for entering the ISA. MHOs will initially prioritize children with the most serious mental health needs for the ISA.
- The MHOs must encourage ISA referrals from multiple sources.
- The ISA determination process must be clearly communicated by the MHOs to family members, legal guardians and all community stakeholders.
- ISA determinations will be made within 3 working days of completed ISA referral. Commencement of ISA services will follow timelines specified in MHO contract (emergent-24 hours, urgent-48-hours & non-emergent or routine-14 days).
- OMHAS will facilitate statewide training for Mental Health Organizations (MHO) on the CASII determination tool.
- OMHAS will collect CASII data from MHOs and analyze for quality assurance and improvement.

Policy Two: System Structures and Functions [6]

- The MHOs will ensure that children who are determined to be eligible for the Integrated Service Array (ISA) will be given continuous care coordination, and facilitation of access to and coordination of the ISA.
- The ISA is a full continuum of coordinated, culturally competent mental health services available to children that will be based on family choice and medical appropriateness. Services chosen from this continuum will be delivered in a coordinated, flexible and individualized manner. The continuum includes services such as:

[5] Key points are summarized. See http://www.oregon.gov/DHS/mentalhealth/child-mh-soc-in-plan-grp/policy1.pdf
[6] Key points are summarized. See http://www.oregon.gov/DHS/mentalhealth/child-mh-soc-in-plan-grp/policy2.pdf

- A comprehensive mental health assessment,
- Psychiatric evaluation and medication management,
- Care coordination,
- Home and community based individual, group, and family therapy,
- Home and community based individual and group skills training,
- Respite care and family support,
- Crisis services,
- Behavioral support services,
- Psychiatric day or partial day treatment,
- Psychiatric residential treatment services, and
- Acute or sub-acute psychiatric hospitalization.

MHO Agreement[7]

- Contractor shall ensure that the Integrated Services Array will be recovery focused, family driven, and time limited based on Medically Appropriate criteria. In communities that lack OMHAS certified psychiatric day treatment programs for children and adolescents, Contractor may develop individualized alternatives.

[7] Selected statements from the MHO Contract Agreement.

Accomplishments

- **CSCI changes are seen as allowing children to receive mental health services while living at home and in their communities.** The implementation of the CSCI has enabled MHO communities to continue to reduce the use of hospital and inpatient placement and to focus on expanding the service array of community-based programs and alternatives. Focusing the goal of services for children with high needs on stability in the home and community is seen as an important shift by respondents.

- Staff in several MHOs reported that the **CSCI has lead to a reduction in placement of children in settings that are more restrictive than necessary.** This is largely attributed to having problems solved at the child and family team level, or at the CCCC. Some MHOs have reduced residential placement from 5 children per month to 2-3.

- **Good progress has been made at developing and implementing ISA services.** There is a wide range of the ISA available to children and their families across the state depending upon where MHOs are located. In the larger, more urban counties, all of the required ISA services are being provided. In the more rural communities, new services such as crisis services and case management have been added. In general, MHO communities are providing the following required services:
    - A comprehensive mental health assessment,
    - Psychiatric evaluation and medication management,
    - Care coordination,
    - Home and community based individual, group, and family therapy,
    - Behavioral support services,
    - Psychiatric day or partial day treatment (in funded communities),
    - Psychiatric residential treatment services
    - Acute or sub-acute psychiatric hospitalization.
- **In the more urban areas there is a rich service array and more options from which creative solutions can be developed**. Types of additional services provided include 24 hour mobile, in home crisis, 24-hour intake and assessment, multisystemic therapy or MST (which is designed for ODD / conduct disorder); increased community treatment services (treatment foster

care, wraparound services to foster care); staffing on children being served by the child welfare system; step down services to transition children from residential to foster home; in home respite, and in-home skills training.

- **Having the flexibility at the local level** to develop creative, community-based, family-driven options is viewed as positive by many MHOs.
- **The development or expansion of care coordination teams at the local level is viewed as one of the greatest successes with the implementation of the CSCI**. Some direct service providers voiced excitement and noted a cultural shift in caring for children and their families. Some care coordinators stated that the system is better able to look at the child's needs and not just the problem they are experiencing. Contributing to this shift is a greater use of a wraparound approach to service planning and provision. At least two thirds of the MHOs are using wraparound and at least four MHOs have contracted with external consultants to train staff on various wraparound models.
- **Approximately half of the MHOs have developed some type of a flexible fund** for addressing child and family needs for non-traditional items that insurance will not cover.

System Challenges

- **Differences in geography and population density influence the availability of services**.
- **Families have expressed a desire to have services as close to home as possible, but many rural communities have not developed some specialized services.** Some MHOs have looked at options for regionalizing services, but long distances and rugged terrain reduce the feasibility of this option. Alternatives to specialized services (e.g., day treatment) need to be developed for eligible children in these communities.
- Although many respondents noted that more basic as well as non-traditional services have been added to the ISA, many also voiced **concern about the lack of services on the middle spectrum of the service delivery continuum**. Services with limited capacity, especially in the rural areas, include home and community based individual and group skills training, crisis, respite, family support and therapeutic foster care. Smaller counties have limited resources to develop some of the more specific service modalities.
- **There is wide variation across MHOs as to how the ISA is being administered**. The variation appears to be related to rural-urban issues,

differences in interpretation of policy requirements with respect to level of need determination, the need for clarity regarding contract and certification requirements for community treatment options, and philosophical differences about whether day treatment and residential services belong in the service array continuum. Variation across MHOs is not intrinsically problematic, but ongoing monitoring and evaluation of the outcomes of the level of need determination and service authorization practices is needed.

- **Providers and MHOs alike stated that each MHO community is implementing Level of Need (LON) determination, CCCC, and child and family team processes differently.** For example, authorization processes are handled at the local CMHP level in some areas, while in others the MHO has the final authority. Some respondents expressed concern that changes in service authorization procedures has increased the time it takes for children to access services.

- **Another variation is with the use of the CASII as the basis for ISA eligibility determination**. Approximately half of the MHOs are using the CASII score as the sole determinant of eligibility for the ISA. In the others, if the CASII score falls below the composite score threshold of 19, the child might still be considered eligible if other eligibility variables exist (e.g., an elevating or significant risk of harm to self and others, significant risk of out-of-home placement, multiple system involvement, and/or caregiver stress).

- **The processes for discharge planning vary across and within the residential and day treatment providers.**
    - Approaches to discharge planning varies. In some areas of the state, care coordination staff are able to conduct child and family team meetings within a placement setting, with the focus on the most appropriate and timely discharge and a smooth transition back to the community. In other MHOs, care coordination staff play a limited role in this transition process, with less access to the providers.
    - Some families and care coordinators expressed concern that children are being discharged from residential treatment without adequate planning and before necessary services are in place.

- **Many respondents identified a need for technical assistance.** Areas of need included:

- Interpretation of the OARs and Budget Note HS-3.
- Creating more uniform utilization management practices across MHOs.
- Discussing alternatives to day treatment and residential placement, especially in the rural areas.
- More CASII trainings (could be rotated on a regional basis).
- Education about how funding for ICTS services and the glide path works.
- More education for care coordination staff that have not had access to wraparound training

Recommendations

- In the next stage of implementation, **development of the care coordination function is key and will require careful planning and additional resources. AMH should identify and secure additional resources for training care coordinators and for bringing them together on a regular basis to share information.** The MHOs should be encouraged to collaborate and share training resources and provide networking opportunities.

- Everyone involved seems to recognize that there is variation across the MHOs regarding need determination and authorization. **AMH should examine the variation in need determination and authorization practices and monitor the data about access to identify underserved groups.**

- **Mechanisms to share information across MHOs about creative approaches to CSCI implementation (e.g., the establishment of and use of flexible funds) should be further developed**.

- **Specific attention to addressing the challenges of providing the full ISA in rural areas is needed.** Creative and flexible alternatives need to be identified and encouraged, especially with regard to specialized services such as day treatment and residential care. Consultation with rural programs in other states or with national experts may expedite this process.

Summary

MHO management and staff, and providers are accepting of the system of care principle of least restrictive and community-based services. Tensions exist in communities where there is limited collaboration around the timing and the design of

this shift in service delivery. For example, many communities recognize that there will be an increase in more community-based service options and a reduction in out-of-home placements. These communities are taking gradual steps to re-evaluate processes and procedures for accessing the full service continuum. Greater conflicts are occurring in communities where the message is that there will never be a need for residential or day treatment beds. In these situations, providers of these services are concerned about their place in the continuum of care.

Variation in implementation and practice can be positive when it promotes flexibility and individualization of services, and when it results in the addition of new services. However, in some instances, undesirable variation may exist in the availability, accessibility, and quality of services. In some rural communities, the implementation focus to date has been on simply trying to develop the required ISA. In these communities, services, such as crisis and case management, are now being offered where none were before.

Evaluation Question 3

To what extent has meaningful family involvement and family leadership at the child, local, and state levels been increased?

- To what extent has OHMAS (AMH)-provided activities and resources (e.g., Family Involvement Coordinator, contract requirements, training) designed to increase family involvement and leadership been effective?
- To what extent do MHOs involve families and promote family leadership?

Budget Note HS-3[8]

- Ensure meaningful family involvement at policy, local or regional managed care system, provider and individual child levels and explore mechanisms to ensure family involvement and control over some of the resources

Policy 3: Meaningful Family Involvement[9]

- OMHAS (AMH) will develop formal linkages with the statewide family networks
- OMHAS (AMH) will identify a staff person to function as a Family Partnership Specialist
- MHOs will identify key personnel who will work with family members

2006 MHO Agreement[10]

- Contractors shall provide services that are family-driven, strengths-based, and culturally sensitive.
- Representation by consumers, family members and child and family advocates on this advisory council shall be a minimum of 51% of total membership, with half of the representation consisting of OHP members who are adolescent consumers and family members of OHP members who are child and adolescent consumers.

[8] Key points summarized.
[9] Key points summarized. See http://www.oregon.gov/DHS/mentalhealth/child-mh-soc-in-plan-grp/policy3.pdf
[10] Selected statements from the MHO Contract Agreement.

Accomplishments

- **Family involvement in state and mental health organization (MHO) governance and service delivery is viewed as the greatest achievement of the Children's System Change Initiative (CSCI) implementation.** The first year of the implementation resulted not only in increased in opportunities for family involvement, but also in improvements in the quality of family involvement at the local and state level. One family member reported that families are more united, and that they are becoming connected and organized. Another family member observed that the CSCI has built a bridge between families and agencies.
- **AMH hired a Family Partnership Specialist to be a liaison between family members, mental health organizations, community mental health programs, and AMH**. Many respondents consider this a critical role for assisting AMH with supporting family involvement.
- **Trainings have been created and implemented to support family involvement in the CSCI.** *Families and Professionals as Policy Partners* workshops were created through a contract between AMH and the Oregon Family Support Network, in collaboration with OAMI. These workshops were designed to train both family members and professionals on how to most effectively work together. These workshops also included a "train the trainers" component, in which family members were trained to provide the workshops to others in their home community. In addition, Oregon Family Support Network has created family support networks to help family members cope with the stress of care giving, so they are better prepared to participate in the CSCI.
- **MHOs are contracting with family organizations to incorporate meaningful family involvement.** Five MHOs have contracts directly with a family organization. Three MHOs include counties that contract directly with family organizations.
- **The state level Children's System Advisory Committee (CSAC) is composed of 51% family members who are actively involved in all aspects of the committee.** A family member is co-chair of this committee. Family member participants of CSAC report that they feel valued and respected in committee meetings and that they have an equal voice as professional participants. Observations of these meetings validate the level of value, input

and contribution family members make at these meetings. Family members also report that family voice has positively changed the attitudes and goals of the state

- **The CSCI has resulted in an increased focus on family driven care.** On February 9, 2006, *Policy 3: Meaningful Family Involvement* was updated to include a definition of family driven care. This definition was developed and approved by the CSAC, and it was modeled after the definition put forth by the national family organization, the Federation of Families for Children's Mental Health.
- **MHO children's system advisory committee (MHO CSAC) by-laws or charters have requirements for 51% family member and youth representation and all but one of the MHOs have accomplished this**. There is general agreement across all MHOs that family involvement has improved.
- **Many MHOs are providing stipends to family members to facilitate participation in committee meetings.**
- **Family involvement at the service delivery level has increased**. Families are active participants in the child and family team meetings to develop their child's Service Coordination Plan. Family members select the members of the team, contribute to setting goals and objectives, and have voice in selecting service options. As a result, families are voicing greater satisfaction with services provided by care coordinators. They report that they are consulted on treatment planning from beginning to end.
- **Family member involvement in quality improvement activities has increased.** Family members are participating in quality improvement at the MHO level, and a family member participant of the state level CSAC also serves on the state QDIG.

System Challenges

- **Although family involvement has increased, most of the participation beyond the child and family team level is accomplished by a few dedicated family members.** More family members need to be recruited and trained to serve on the large number of committees now open to them. Respondents reported that agencies often have difficulty recruiting family members to participate on committees. Often stipends are not provided for participation, so it is more likely that family members who work for a mental health

organization or community mental health program and who are paid to participate will do so. Family members need continued training, compensation, and support for participating in the policy process as volunteers.

- **Families voice frustration with navigating the mental health care system.** In the past, some families were familiar with going directly to providers to access the mental health system. Families have not been adequately informed about the changes in the mental health care system nor have they been given an explanation about the level of care determination process. In instances where more than one MHO serves the same county, family members are not aware that if they decide to switch to another health plan, then they often can keep the same provider.
- **Meaningful family involvement is a new concept to a few organizations, which results in difficulty accepting family voice as part of the planning and service delivery process.**
- **Much information about the CSCI is not getting to families who are not actively involved in the state-level CSAC**. Currently AMH relies on family member representatives of CSAC to report information about the CSCI back to their communities and to bring information from their communities back to CSAC. However, many feel that this single strategy is ineffective for informing families of the changes being implemented.
- **A lack of youth involvement at all levels is a barrier to full family involvement.** Typically, stipends are not available as compensation for youth to participate in committee meetings. Meetings are also held during school hours when youth are not available. In addition, youth are not yet active participants in the service planning and service provision process

Recommendations

- **The Family Partnership Specialist position should be a full time position, and its scope and authority should be expanded.** Increasing this position to full time will also allow for a larger role in helping the emerging family support networks across the state.
- **Organized family groups should receive fiscal support from all levels (state, MHO, county, providers).**

- **Families with children currently served in the system of care should be involved in assessing the effectiveness of the CSCI.** Systematically collected feedback from family service users needs to be linked into system improvement activities.
- **Involvement of youth in the CSCI requires careful planning and additional resources**. There are an increasing number of model youth involvement programs, youth involvement experts, and youth involvement literature that can help in this effort. One initial step may be to create a youth council as an adjunct to the CSAC. Staff time, initially at the state level, will be important to this process.
- **G**iven that there is still some resistance or misunderstanding about the role of families and youth in the system of care, especially in the planning and service delivery process, **AMH should provide leadership to assure that MHOs and providers are trained about how to effectively partner with family members.**

Summary

Increased family involvement is considered by family members, mental health organization directors, and Oregon Addiction and Mental Health Services (AMH) children's mental health administrators to be the foremost achievement of the Oregon Children's Mental Health System Change Initiative (CSCI). The first year of the implementation of the CSCI resulted not only in dramatic increases in opportunities for family involvement, but also in improvements in the quality of family involvement at the local and state level. The primary successes in implementing family involvement and family leadership at the child, local, and state levels are increased training and support for family members to successfully participate in local and state mental health committees and an increased focus on and understanding of family driven care. Despite the advances made in meaningful family involvement as a result of the CSCI, family members and family advocates have made it clear that there are several improvements necessary before family involvement is fully implemented. These improvements include increased youth involvement, continued training for family members, and stipends to compensate family members and youth for their time participating in meetings.

Evaluation Question 4

To what extent does implementation of the Initiative appear to influence the nature and extent of interagency collaboration and planning at the state and local levels, including alcohol and drug treatment services?

Budget Note HS-3[11]

- Ensure continuous care coordination for children with serious mental and emotional disturbances.
- Support the system of care approach through meaningful regulation and contract provisions.

Policy One: Level of Service Intensity Determination[12]

Policy Two: System Structure and Functions

- A Child and Family Team will facilitate Integrated Service Array planning. At a minimum the team will be comprised of the child, when appropriate, the family and the care coordinator. Other child serving providers, involved agencies and natural supports as identified by the family will be invited to participate in the planning, implementation, and oversight process.
- The Child & Family Team will collaborate on planning by creating and reviewing a Service Coordination Plan that will identify child and family strengths and mental health needs across all relevant life domains. The ISA plan will be coordinated with all other plans related to a child's life such as an Individual Education Plan, permanency plan, etc.
- The MHOs must encourage ISA referrals from multiple sources, including families, child welfare, schools, juvenile justice, local agencies, the faith community and health care providers.
- Membership of the councils will be representative of the regional or local system of care and comprised of statewide stakeholders.

[11] Key points summarized.
[12] Key points summarized. See http://www.oregon.gov/DHS/mentalhealth/child-mh-soc-in-plan-grp/policy1.pdf and http://www.oregon.gov/DHS/mentalhealth/child-mh-soc-in-plan-grp/policy2.pdf

MHO Agreement [13]

- Contractor shall have a system that promotes collaboration, within laws governing confidentiality, between mental health, child welfare, juvenile justice, education, families, and other community partners in the treatment of children with serious emotional, mental health and behavioral challenges.
- The advisory council shall have representation from child welfare, juvenile justice, education, developmental disabilities, physical health plan, ISA providers, and other local or regional community partners representative of the local system of care, culturally diverse populations of mental health consumers and their family members.
- A child and family team may include the child, if appropriate, family members, child-serving agencies involved with the child, school, and other community supports identified by the family.
- The Community Care Coordination Committee shall have representation that includes child serving providers and other local stakeholders representative of the local system of care.

Accomplishments

- **There is consensus across all respondents that interagency collaboration has improved with the implementation of the CSCI**. Referrals for ISA are coming from all child-serving agencies and other community based providers. There are reports across the state that interdisciplinary work and collaboration on individual child and family cases is improving. Several MHOs have reported significant improvements in relationships with DHS (child welfare).
- In both urban and rural MHO communities, **numerous examples were provided to demonstrate interagency integration across child serving agencies**. Through coordination between Oregon Youth Authority (OYA) and AMH, all youth entering OYA have an initial mental health screening and are referred for mental health services as needed. Mental health staff have been out stationed in school, juvenile justice, public health, and child welfare settings. More day treatment providers are planning to provide services in the public schools. Mental health education is being provided to primary care provider offices. While many of these efforts were begun prior to the October

[13] Selected statements from the MHO Contract Agreement..

2005 CSCI implementation date, there is general agreement that the CSCI has enhanced these collaborations and accelerated exploration of additional integration opportunities.

- **Participation in decision-making at every level of the CSCI demonstrates partnerships across system boundaries.** Interagency participation at the state-level CSAC includes mental health, child welfare, juvenile justice and schools, as well as day treatment and residential providers. Across the state, interagency participation at the MHO-level advisory committee structure consistently includes representatives from mental health, child welfare, and provider agencies. All but one MHO includes representatives from juvenile justice and the schools. At the MHO-level CCCC structure, representatives from mental health, child welfare juvenile justice and the schools are typically present.
- While relationships across child-serving agencies vary across MHOs, **those with single county structures and those who had "good" relationships before the CSCI implementation express greatest collaboration and satisfaction.**

System Challenges

- **Representatives from physical health and developmental disabilities are rarely involved at the state level CSAC**, and only two of the MHOs include representatives from physical health and developmental disabilities at MHO advisory committee and CCCC structures.
- Low levels of involvement of addiction services at both state and MHO CSAC level is a serious omission given that the rates of co-occuring disorders, especially among adolescents, are high. This could be addressed directly at the state level, because mental health and addiction services are under one administrative structure. At the MHO level, forging positive working relationships with addiction services will probably require more outreach.
- **Each child-serving system continues to have its own required plan of care and planning process**. This has been a challenge nationwide and few communities have been able to achieve the ideal of "one child, one plan." The fact remains, however, that if each team member writes a separate plan for the child and family, then some of the value and coordination possible through the Child and Family Team is lost. For example, schools continue to use the IEP

and IFSP, child welfare has its own system of case review and staffing and probation officers must conduct their own planning process. All of these are required by state and federal regulations.

- **MHOs note that there is a lack of communication between agencies when a child is moving from one service delivery system to another.** This seems to be a particular problem for children moving into or out of residential treatment settings. For example, MHOs may not know that they have a child in residential care until they are billed for services. Communication and coordination about children who were served by DHS in residential care but are now being served in the community is not consistent.
- **Non-mental health child-serving agencies report frustrations with the CSCI**. Agencies, such as schools, state that it is difficult to plan, because the CSCI was conceived as a mental health initiative and other systems have only been able to respond to it. Particular efforts should be made to inform staff at the service delivery level.
- **The child and family team process is still developing**. At a minimum the family and the mental health provider are participating in child and family teams. Most communities recognize the importance of including other involved agencies and providers. The level of this integration is still quite variable across MHOs.

Recommendations

- **Better coordination and collaboration among state-level partners, particularly including AMH and the Department of Education (DOE) should be developed**. There is a belief that coordination and collaboration will occur more easily at the local level if similar relationships are demonstrated among state system leaders. Strong support for collaboration may need to initiated by the Governor's office so that it can influence both DOE and DHS.
- **All parties should continue efforts to manage the tension between local autonomy and the need for some state level authority and control.** The second year of implementation should further address achieving a balance between local autonomy and the need for some state level authority and control. The natural tension that exists between these two perspectives is not peculiar to Oregon, and has emerged, in fact, in every state with a strong county system. The conclusion of the planning process called for each MHO to develop and adapt processes and services to meet the needs and

characteristics of the community it serves. AMH, however, is charged by legislature to provide guidance, and oversight of the implementation of the CSCI.

- **Opportunities for interagency communication and cross training need to be expanded.** AMH was recognized for its successful communication during the planning phase of the CSCI through the CSAC, stakeholder meetings and website communication. These opportunities for cross agency information sharing are particularly needed at the service provider level and could involve participation by care coordinators, case managers, caseworkers, probation officers, addiction counselors and school-based social workers and teachers, among others.
- **Both AMH and MHOs should ensure that developmental disabilities and physical health are involved in the CSCI discourse as specified in the MHO contract requirements. There should be a clear directive from AMH regarding the involvement of addiction services in the state and local CSACs.**

Summary

Interagency collaboration is seen as an area of substantial improvement under CSCI. Structures have been put into place to facilitate this level of collaboration and stakeholders at all levels recognize that getting people to sit together at the table is a major accomplishment.

Requirements of the OMHAS (AMH) Policies One and Two and of the MHO contracts related to interagency collaboration for the most part have been met. Relationship building is occurring in all MHOs. However, collaboration is stronger in some than others. The one aspect that has not been addressed adequately in planning and implementation of the CSCI is the inclusion of the developmental disability and physical health community and the role of alcohol and drug treatment providers at both the state and local MHO levels. All advisory committee should reevaluate their guidelines for membership to make sure that there is a representative from physical health, developmental disabilities and addiction services. AMH should review the MHO agreement to make sure that the requirement for involvement of addictions services is clearly specified. Monitoring of compliance of MHO agreements should explicitly address the inclusion of these three service sectors.

Evaluation Question 5
In what ways do MHOs serve culturally and linguistically diverse populations and communities?

- What strategies have MHOs implemented to increase their capacity to provide culturally competent services?
- How have strategies differed in response to community culture and demographics, e.g., urban and rural settings?

Budget Note HS-3 [14]

- Require culturally competent skills-based staff training on evidence-based practices and family involvement through prioritizing training resources and aggressively pursuing additional resources for this purpose.

Policy Four: Workforce Development in Cultural Competency [15]

- OMHAS (AMH) will contract with a Consultant whose area of expertise is cultural competence to evaluate our children's mental health system for strengths and areas for improvement.
- OMHAS (AMH) will facilitate trainings and technical assistance with a significant focus on building strengths through diversity.
- OMHAS (AMH) will use feedback from the Consultant to improve cultural competence throughout the Children's Mental Health System.
- OMHAS (AMH) will use the Youth Services Survey-Family Version to assess family perception of staff sensitivity to their culture and use this information to inform the system of needed changes.
- OMHAS (AMH) and MHO Advisory Councils will reflect the demographics and diversity of children and families covered by the Oregon Health Plan.

2006 MHO Agreement [16]

- Contractors shall provide Services that are family-driven, strengths-based, are culturally sensitive, and that enhance and promote quality, community-based service delivery.

[14] Key points summarized.
[15] Key points summarized. See http://www.oregon.gov/DHS/mentalhealth/child-mh-soc-in-plan-grp/policy4.pdf
[16] Selected statements from the MHO Contract Agreement.

Accomplishments

- **AMH contracted with a consultant with expertise in cultural competence to identify strengths and areas of opportunity regarding cultural competence within the children's mental health system.** In response to the budget note, AMH met with community partners to explore improvements for a culturally competent mental health system. AMH partners advised the state to obtain an independent assessment, so AMH secured an independent contractor to conduct an assessment of Oregon's children's mental health service delivery capacity to serve various ethnic minority groups. This report reviewed the current efforts to provide services in a culturally competent manner and to make recommendations of objectives and strategies to increase capacity and competence. This report, "Oregon State Children's Mental Health Initiative Initial Review of Cultural Competence" was submitted to AMH in September 2005 and is on the AMH web site.
- **MHOs have awareness of the need for culturally competent children's mental health services.** Interviews with MHO management and staff indicate that there is a heightened awareness of the need for more culturally competent practices at the community level. MHOs stated that they conduct population assessments and could clearly articulate what minority groups are being provided services through the CSCI.
- **For the most part, communities have the capability to address cultural linguistic needs of consumers through translation and interpreter services.** Most of the materials that have been translated into another language have been for Spanish speaking populations.
- **The Youth Services Survey – Family Version collects some information about the extent to which family members perceive staff to be sensitive to their culture.** AMH has conducted the Youth Services Survey-Family Version and results are due in early 2007. There are questions within the survey pertaining to cultural competence.
- **Family advocacy groups have identified the need for increased outreach and support to minority families.** One of the advocacy groups has advertised for families who are of different cultures to participate in monthly teleconferences.
- **Care coordination teams have encouraged individualized services, which allows for integrating more culturally appropriate services.** However, future

evaluation efforts should assess the degree to child and family teams integrate cultural considerations into assessment and planning.

System Challenges

- **There is general consensus among all respondents that the specific needs of people from diverse cultures are not being adequately addressed**. The diversity reflected in the composition of advisory committees and among service providers does not parallel the backgrounds of children and families being served.
- **The stigma of mental illness is a barrier to accessing mental health services for people from diverse cultures**. A few MHOs have implemented culturally specific outreach campaigns. In most areas, relatively few diverse family members are accessing services.
- **Most efforts to improve cultural competence have occurred at the service delivery level; changes to increase cultural competence at the system level have been minimal.**
- **MHOs and service providers report difficulty with hiring culturally diverse staff.** Some MHOs have tried and failed to hire bilingual therapists and care coordinators.

Recommendations

- **AMH should make regular reports to CSAC regarding progress in implementing the recommendations of the Children's Systems Change Initiative Cultural Competence Review.** Respondents were unclear how AMH has addressed the recommendations of the Cultural Competence Review report. Regular updates would serve to keep this important topic in the forefront of the change agenda.
- **AMH could explore opportunities to partner with groups that represent culturally and linguistically diverse populations**. These partnerships should provide cultural consultation to the implementation effort.
- **Successful strategies for the recruitment of culturally diverse staff should be identified and implemented within MHOs**. Recruitment and retention of diverse staff is a national challenge. Technical assistance from national and local cultural consultants may support this process.

Summary

Cultural competence is the least developed of all of the CSCI policy requirements. MHOs have been establishing infrastructures to support the overall systems change, but the development of culturally specific and culturally competent children's mental health services should be a priority in the coming year. The CSCI Cultural Competence Review contains a set of recommendations for improving culturally competent children's mental health services in Oregon. These recommendations could provide a framework for improving the response to the needs of culturally and linguistically diverse families at all levels of the system.

Evaluation Question 6
How have OMHAS (AMH) and the MHOs addressed workforce development issues that support the children's mental health systems change initiative?

Budget Note HS-3 [17]

- Require culturally competent skills-based staff training on evidence-based practices and family involvement through prioritizing training resources and aggressively pursuing additional resources for this purpose.

Policy Three: Meaningful Family Involvement [18]

- The OMHAS (AMH) Family Partnership Specialist is responsible for developing and coordinating a technical assistance and training plan that will include an anti-stigma campaign.

Policy Four : Workforce Development Around Cultural Competency

- OMHAS (AMH) will facilitate trainings and technical assistance with a significant focus on building strengths through diversity.

2006 MHO Agreement [19]

- Contractor shall assure that service coordination will be provided by a person or persons who have a strong child and adolescent mental health background, extensive knowledge of the children's system of care, and experience working with families.
- Community Care Coordination shall provide guidance and case management services in the planning, facilitating, and coordination of the child's service coordination plan.

[17] Key points summarized.
[18] Key points summarized. See http://www.oregon.gov/DHS/mentalhealth/child-mh-soc-in-plan-grp/policy3.pdf and http://www.oregon.gov/DHS/mentalhealth/child-mh-soc-in-plan-grp/policy4.pdf
[19] Selected statements from the MHO Contract Agreement.

Accomplishments

- **AMH recognizes the need for workforce development and cross agency training.** AMH held a focus group in early June 2006 about workforce development, and cross agency training was recommended. AMH has created a Workforce Development Taskforce.

System Challenges

- **Respondents report that there is variation in the training and skill level of care coordinators**. A coordinated statewide training and development effort in the area of care coordination is needed.
- **There is no mechanism for coordinating training opportunities.** Some MHOs have initiated and developed trainings for their own staff. However, these training have not been shared across the state.
- **More trained and qualified staff members are needed to provide the services outlined within the service array.** Respondents reported difficulty in recruiting a sufficient number of entry level staff who are knowledgeable about philosophy and values of system of care and who have a skill set consistent with the interagency and team work required.

Recommendations

- **AMH should implement specific workforce training that addresses topics such as roles and expectations of care coordinators, CASII administration, and effective wraparound implementation.** Further collaboration with higher education should aim to create a workforce prepared to implement system of care principles.
- **AMH should develop and strengthen coordination of training opportunities**. Coordination among local offerings and the development of more statewide trainings could increase the efficient use of training resources and improve the consistency of training content.
- **The efforts and products of the Workforce Development Taskforce should be regularly reported to the CSAC.**

Summary

Developing the skills of the care coordinators to conduct effective wraparound should be a top workforce priority for the CSCI. All child serving staff should be trained regarding administration of CASII, and recruitment and training related to cultural competence and family involvement. In the future, attention will need to be given to developing a workforce that can provide the variety of services outlined in the Integrated Service Array. Collaboration with higher education will be necessary to meet these workforce demands.

Evaluation Question 7

What structures and processes have been implemented to oversee the CSCI at the state and local level?

- Are community based Quality Improvement Structures in place?
- What data are being collected to track performance and outcomes?
- How are OMHAS (AMH) and the MHO's monitoring MHO compliance to contract requirements?

Budget Note HS-3 [20]

- Ensure an effective system of care for children and families through a statewide system of quality improvement and use of pertinent outcome data (e.g., reducing the amount of time children spend in institutional care and increasing the proportion of children and families who receive flexible, community-based services).

Policy Five: Outcomes [21]

- Monitor the CMHP and MHO performance regarding child, family and system outcomes.
- Each CMHP, MHO and all subcontractors will track specific outcomes and performance measures and report them on a regular basis.
- MHOs will use the Mental Health Statistics Improvement Program's Youth Services Survey for Families.
- MHOs will use standardized instruments to collect clinical outcome data.
- OMHAS (AMH) will develop a Quality Data Implementation workgroup (QDIG).

[20] Key points summarized.
[21] Key points summarized. See http://www.oregon.gov/DHS/mentalhealth/child-mh-soc-in-plan-grp/policy5.pdf

MHO Agreement [22]

- Contractor shall be required to submit additional reports and information as identified by OMHAS (AMH) for the purposes of quality assurance and monitoring activities of the ISA. Contractor shall work with OMHAS (AMH) to identify specific outcomes and performance measures that will be tracked and reported on a quarterly basis.
- Contractor shall collect and analyze CASII data for quality assurance and quality improvement activities. Contractor shall submit to OMHAS (AMH), within 60 days of the end of each calendar quarter, a report on Level of Need Determination Data.
- Contractor shall develop a process for collecting and reporting data on outcome and performance measures in the following domains:
    - School;
    - Home, life, and family;
    - Client functioning; and
    - Critical incidents.

Accomplishments

- **AMH has created the Quality Improvement Data Group.** The state-level Quality Improvement Data Group (QDIG) is considered to be a positive forum for addressing process and outcome data.
- **QDIG has identified categories of data elements that are considered key to meeting Policy Five goals** (see QDIG meeting agenda 9/6/06). These categories are:
    - Quarterly reports admission, readmissions, and length of stay
    - Use of funds designated for children's mental health services-
    - Delivery of non-traditional, community-based services
    - Involvement of CSCI enrolled children with other child serving agencies
- **All local communities have a Quality Improvement Committee (QIC) structure.** Many of the MHOs have used an existing QIC structure to address both adult and children's mental health issues.

[22] Selected statements from the MHO Contract Agreement.

- **CASII and other screening and demographic information are being submitted quarterly to the state as required under contract.**
- **AMH conducted the Youth Services Survey to help the state with monitoring and improving mental health services to youth and their families.**
- **AMH contracted for an evaluation of the implementation of the CSCI with an independent entity.**

System Challenges

- **The goal of providing timely information to MHOs for quality assurance and monitoring activities of the CSCI has only been partially addressed.** MHOs recognize the value of data for assisting with day-to-day quality assurance and improving system performance. Some of the MHOs have developed their own internal data systems and are looking forward to reviewing aggregate information that can be used for overall system improvement.
- **Respondents identified the "lack of information about performance expectations" as a problem. There is a lack of clarity regarding how overall MHO contract compliance is being monitored by AMH.**
- **Assembling data for contract compliance is complicated**. Multiple departments within AMH and external review entities appear to be involved in monitoring and oversight.

Recommendations

- **The mechanisms for monitoring MHO contract compliance should be clarified and communicated.**
- **AMH should conduct a detailed analysis of all aspects of its quality improvement and program evaluation activities**.

Summary

AMH and the MHOs are in an early stage of implementation, and they are beginning to put structures and processes in place to monitor the CSCI. Outcome data will become available as these mechanisms mature and become more fully developed. The QDIG has

recently identified clearly defined indicators for system-wide monitoring across MHOs that can be used during the next year to improve system performance. Stakeholder groups identified the need for more real time data. AMH has the opportunity to work more closely with the MHOs, some of whom have this data within their own databases.

Evaluation Question 8
What issues have been identified around the financing of the CSCI?

Budget Note HS-3[23]

- Create clinical and fiscal incentives to provide culturally competent care in the least-restrictive and most normative setting in the child's home community.
- Ensure that funding intended and allocated by the legislature for children's mental health is used for that purpose.

Policy Six: Financing[24]

- Create clinical and fiscal incentives to provide culturally competent care in the least-restrictive and most normative setting in the child's home community.
- Ensure that funding intended and allocated by the legislature for children's mental health is used for that purpose.
- Contract with MHOs, CMHPs and ITS Providers to fund the statewide continuum of comprehensive children's mental health services.
- Establish procedures for financing Psychiatric Residential Treatment Services, and Psychiatric Day Treatment Services
- Spend identified funds with ITS providers
- Encourage MHOs to contract with ITS providers
- Prioritize children with the most serious mental health needs for the ISA
- Ensure availability of secure inpatient services for court ordered youth.

MHO Agreement 3[25]

- Contractor shall develop a process to assure that funding intended and allocated for children's mental health is used for that purpose.
- Performance targets for the percentage of expenditures on services to children and

[23] Key points summarized.
[24] Key points summarized. See http://www.oregon.gov/DHS/mentalhealth/child-mh-soc-in-plan-grp/finance-policy.pdf
[25] Selected statements from the MHO Contract Agreement.

adolescents shall be equal to the percentage of revenues based on child and adolescent OHP Members.

- OMHAS (AMH) will provide Contractor with performance targets that identify funding amounts that are to be spent with organizations certified to provide intensive treatment services under Oregon administrative Rule 309-032-1100 through 309-032-1230. OMHAS (AMH) will take into account Contractor's formal efforts to contract with ITS providers. Funds may be used to purchase non-traditional as well as traditional mental health services.
- Contractor shall have policies and procedures in place to assure timely reimbursement to Providers participating in the ISA.
- Whenever Contractor reimburses a non-contract provider of Psychiatric Day Treatment Services or Psychiatric Residential Treatment Services for services identical to those purchased by OMHAS (AMH) through direct contracts, the reimbursement shall be no less than the amount paid by OMHAS (AMH) for the same services.

Accomplishments

- **Many respondents voiced satisfaction with allowing the MHOs the flexibility and creativity to use the dollars as needed for the communities they serve.**
- **There is general support for finding ways to integrate or blend funds across service systems, especially when required to serve a child who is involved in multiple systems**.

System Challenges

- **There is wide variation in levels of understanding about how the CSCI has changed financing of services**. Many are confused about the glide path, about how dollars can be moved around across the service continuum, and about how much financial flexibility is available to the MHOs.
- **Respondents expressed considerable concern about financing services for children who are not eligible for Medicaid.** Medicaid eligible children are easier to serve because payment is assured. Children with an "open card," who are indigent, or whose families or insurance companies pay on a fee-for-service

basis are more difficult to serve because there are fewer affordable services. There is concern that this phenomenon will lead to a two-tiered system.

- **Administrative costs associated with the implementation of CSCI are cited as a major burden for MHOs and providers**. Providers that serve multiple MHOs across the state report concern about the administrative burden associated with additional reporting costs and numerous and different authorization procedure requirements. These costs were not factored into the planning for CSCI.
- **Development of individualized services across youth serving systems is often hampered by fiscal policy**. This occurs both at the state and local levels. For example, OYA cannot pay for room and board so that youth can move into treatment foster care. At the same time, youth in OYA residential facilities are not eligible for Medicaid supported mental health care.
- **Additional resources may need to be allocated for care coordination**. Although care coordinator positions have been established statewide, there is concern that more coordinators need to be hired to reduce high staff-to-family ratios and to effectively implement care coordination and monitoring activities. Cost and possible savings in various parts of the service system should be carefully tracked to identify areas where savings can be realized and used to address areas of need.

Recommendations

- **State leadership should support efforts to achieve integration of funding across systems within DHS and DOE.** National experts are available to assist the state with assessing policy and procedural barriers and developing strategies for integrating fiscal streams.
- **AMH should address the need for technical assistance to local communities regarding blended funding.**
- **AMH should review the administrative burden associated with CSCI implementation, especially with regard to reporting requirements.**
- **AMH should lead a process to review Policy Six and either eliminate or simplify the complicated transitional financing systems** (e.g. glide paths).

Summary

The financing policies of the CSCI are probably the most difficult part of the Initiative to understand, and they are the most crucial to successful implementation of the initiative. Like many other states, the problem of integrating funds across service silos is a major issue. However, the fact that this issue is being discussed means that the state is trying to grapple with the challenge of providing mental health services to children in multiple systems rather than insist that they be served by one system at a time.

VI. Summary and Recommendations

The 2003 Budget Note HS-3 has been a catalyst for promoting positive change within the Oregon children's mental health system. At the conclusion of the first year's implementation of the Children's Mental Health System Change Initiative (CSCI), there is evidence to support considerable system-wide infrastructure development. This is a major accomplishment in a short period of time and can be attributed to the foundation created through the state's system change efforts, such as the development of the six AMH policy statements, the framework for state and local committee structures and the MHO contracts. Earlier change efforts, such as the ITS pilot projects and four federally funded community-based children's mental health system of care grants, also helped to pave the way for these changes.

There has been a philosophical shift in the culture of service delivery toward a more family-focused, strengths based and coordinated approach to planning and service provision. Service capacity has been enhanced with the addition of new services and expansion of existing ones. While there is still a feeling of confusion in roles and responsibilities, especially at the direct service provider level, this is not uncommon with a system wide change.

Sustainability of system reform is predicated upon infrastructure development. The CSCI implementation has demonstrated several key efforts toward this goal:

- OMHAS (AMH) policies and Budget Note requirements are incorporated into MHO Agreements.

- Interagency governance, planning, care coordination, and monitoring structures are in place at both the state and local levels with family involvement occurring at all levels.

- Flexible funds are being used to promote community-based service delivery.

- AMH is participating in state level interagency problem solving structures that include system partners such as DHS, CAF, and Medical Assistance. In addition, AMH has established working agreements with other child serving agencies, such as juvenile justice and education, to facilitate interagency collaboration about mental health policy issues.

- Funding has shifted to the MHO level to allow for flexibility in service provision.

As the next year of implementation begins, it will be important for AMH, MHOs, family advocates and system providers to establish and clearly articulate the expected outcomes for year two. The focal points should be on workforce development with particular attention to cultural and linguistic competencies, and continued enhancements to the service delivery structure and processes by which services are accessed, authorized, provided and monitored. Also, AMH should work with providers and MHOs toward more collaborative and creative approaches for promoting community-based, least restrictive service options. While it is not likely that a decrease in categorical funding can be accomplished in the next year, focused attention needs to be paid to the integration of funding streams across services systems.

The next period of CSCI implementation can build on progress to date by refining communication mechanisms, by providing training, technical assistance, and other support in areas such as care coordination, family and youth involvement, and by developing individualized, comprehensive service approaches. These steps will require that adequate resources are available both to fully develop the Integrated Service Array (ISA) in communities across the state, and to mount the necessary level of training, technical assistance, and consultation needed to support the change process.

Recommendations

Evaluation Question 1: To what extent is the children's mental health system changing?

1.1 Each MHO should assess and clarify relationships among local and regional committees. This assessment should address the functioning of each group as well as relationships among groups, with attention to areas where participants and functions overlap and where duplicative meetings exist.

1.2 Mechanisms to promote communication from state to local levels (e.g., CSAC to MHOs, to staff and providers) should be developed and/or enhanced.

1.3 AMH needs to continue to develop ways of facilitating horizontal communication, the exchange of information between MHOs and among constituent groups.

Evaluation Question 2: What approaches and structures have MHOs developed to establish and implement the Integrated Service Array (ISA)?

2.1 Development of the care coordination function is key and will require careful planning and additional resources. AMH should identify and secure additional resources for training care coordinators and for bringing them together on a regular basis to share information.

2.2 AMH should examine the variation in need determination and authorization practices and monitor the data about access to identify underserved groups.

2.3 Mechanisms to share information across MHOs about creative approaches to CSCI implementation (e.g., the establishment of and use of flexible funds) should be further developed.

2.4 Specific attention to addressing the challenges of providing the full ISA in rural areas is needed.

Evaluation Question 3: To what extent has meaningful family involvement and family leadership at the child, local, and state levels been increased?

3.1 The Family Partnership Specialist position should be a full time position, and its scope and authority should be expanded.

3.2 Organized family groups should receive fiscal support from all levels (state, MHO, county, providers).

3.3 Families with children currently served in the system of care should be involved in assessing the effectiveness of the CSCI.

3.4 Involvement of youth in the CSCI should receive careful planning and additional resources.

3.5 AMH should provide leadership to assure that MHOs and providers are trained about how to effectively partner with family members.

Evaluation Question 4: To what extent does implementation of the Initiative appear to influence the nature and extent of interagency collaboration and planning at the state and local levels, including alcohol and drug treatment services?

4.1 Better coordination and collaboration among state-level partners, particularly AMH and the Department of Education (DOE), should be developed.

4.2 All parties should continue efforts to manage the tension between local autonomy and the need for some state level authority and control.

4.3 Opportunities for interagency communication and cross training need to be expanded.

4.4 Both AMH and MHOs should ensure that developmental disabilities and physical health are involved in the CSCI discourse as specified in the MHO contract requirements. There should be a clear directive from AMH regarding the involvement of addiction services in the state and local CSACs.

Evaluation Question 5: In what ways do MHOs serve culturally and linguistically diverse populations and communities?

5.1 AMH should make regular reports to CSAC regarding progress in implementing the recommendations of the Children's Systems Change Initiative Cultural Competence Review.

5.2 AMH should explore opportunities to partner with groups that represent culturally and linguistically diverse populations.

5.3 Successful strategies for the recruitment of culturally diverse staff should be identified and implemented within MHOs.

Evaluation Question 6: How have AMH and the MHOs addressed workforce development issues that support the children's mental health systems change initiative?

6.1 AHM should implement specific workforce training that addresses topics such as roles and expectations of care coordinators, CASII administration, and effective wraparound implementation.

6.2 AHM should develop and strengthen coordination of training opportunities.

6.3 The efforts and products of the Workforce Development Taskforce should be regularly reported to the CSAC.

Evaluation Question 7: What structures and processes have been implemented to oversee the CSCI at the state and local level?

7.1 The mechanisms for monitoring MHO contract compliance should be clarified and communicated.

7.2 AMH should conduct a detailed analysis of all aspects of its quality improvement and program evaluation activities.

Evaluation Question 8: What issues have been identified around the financing of the CSCI?

8.1 State leadership should support efforts to achieve integration of funding across systems within DHS and DOE.

8.2 AHM should address the need for technical assistance to local communities regarding blended funding.

8.3 AHM should review the administrative burden associated with CSCI implementation, especially with regard to reporting requirements.

8.4 AHM should lead a process to review Policy Six and either eliminate or simplify the complicated transitional financing systems (e.g. glide paths).

VII. Table of Acronyms

ABHA	Accountable Behavioral Health Alliance
CAF	Children, Adults, and Families
CASII	Child and Adolescent Service Intensity Instrument
CCCC	Community Care Coordination Committee
CCMH	Clackamas County Mental Health
CMHP	Community Mental Health Programs
CSAC	Children's System Change Initiative
CSCI	Children's System Change Initiative
DARTS	Day and Residential Treatment Services
DHS	Department of Human Services
FFS	Fee for Service
GOBHI	Greater Oregon Behavioral Health Inc.
ICTS	Intensive Community Treatment Services
ISA	Integrated Services Array
JBH	Jefferson Behavioral Health
LON	Level of Need
MHO	Mental Health Organization
MST	Multisystemic Therapy
MVBCN	Mid Valley Behavioral Care Network
OAR	Oregon Administrative Rule
ODD	Oppositional Defiant Disorder
OHP	Oregon Health Plan
OMHAS	Office of Mental Health and Addiction Services
OYA	Oregon Youth Authority
PDTS	Psychiatric Day Treatment Service
PMAC	Planning and Management Advisory Committee
PRTS	Psychiatric Residential Treatment Services
QDIG	Quality Data Improvement Group
QIC	Quality Improvement Committee
RRI	Regional Research Institute
U&C	Usual and Customary
VIBHS	Verity Integrated Behavioral Health Systems